YOUTH REPRODUCTIVE HEALTH PROBLEMS AND SERVICE PREFERENCES, ASSEBE TEFERI WEST HARARGHE

BY

AHMED ABUBEKER

ATHESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MPH IN DEPARTMENT OF COMMUNITY HEALTH FACULITY OF MEDICINE

April, 2004

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

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West Harereghe,Assebe Teferi

by

Ahmed Abubeker

Department of Community Health
Faculty of Medicine, Addis Ababa University

Approved by the Examining board

Dr. DAMEN HAYLEMARIAM _____
Chairman, Dep .Graduate Committee

Dr. NUGUSSE DAYYESA _____
Advisor

_____ _____
Examiner

_____ _____
Examiner

DECLARATION

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in this or another university and that all sources of materials used for the thesis have been fully acknowledged.

Name	Ahmed Abubeker
Signature	_____
Place	Addis Ababa
Date of Submission	April 29, 2004.

This thesis work has been submitted for examination with my approval as university advisor.

Dr. Nugusse Dayyesa	_____
Advisor's Name	signature

Acknowledgement

First of all, I would like to forward my deepest appreciation and thanks to my advisors, Dr Fikru Tesfaye and Dr Nugussie Dayessa , for their constructive advice, and support during the whole process of the study. The Department of Community Health deserves at most thanks for cultivating me to come to this level. The advisory contribution of Dr. Shimals Ganna , starting from the selection of study topic, in facilitating of study fund, and continuous advice in the process of my research is invaluable. I would like to extend my special thank to CAR Ethiopia for their concern in securing study fund.

I am indebted to Mr. Afendi Mutaki and Galan Muazem for their contribution in cleaning up of daily collected questionnaire, particularly Mr Afendi, for his contribution of secretarial service. I would like to pass my special thanks to Muktar, Ameyu and Wazira, for their coordinated effort in providing me personal computer that I used in write up of my Thesis. My thanks also go to Dr. Mohamed Yusuf, Dr. Kebede , and Ato Wolde, For their constructive comments and contribution in questionnaire development and data collection. Last, not least I would like to acknowledge Yewobdar Mamo, for her help in providing information and printing copies from web site.

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LIST OF ABBREVIATIONS

CI	Confidence Interval
FGAE	Family Guidance Association of Ethiopia.
FGD	Focus Group Discussion
HI	Health Institution
HIV	Human Immune-Deficiency Virus.
KAP	Knowledge, Attitude and Practice.
NGO	Non Governmental Organization.
OR	Odds Ratio
SD	Standard Deviation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection.
VCT	Voluntary Counseling and Testing.
YRHS	Youth Reproductive Health Service.

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Abstract

World wide, young women and men suffer a disproportionate share of unplanned pregnancies, sexually transmitted diseases, including HIV/AIDS, and other serious reproductive health problems. This cross-sectional community based descriptive study was conducted in West Harargie, Assebe Teferi, with the main objectives of assessing magnitude of risky reproductive health behaviors of youth, level of substance use, magnitude of factors that influence the preference and utilization of health services and examining youth attitude and willingness to VCT. Based on probability proportionate to the population size of each kebele and sub zones, lottery method was used to identify the study population.

Out of targeted 844 youth aged 15-24, 774 responded to the structured questionnaire, out of which 375 (48.4%) were male, with male to female ratio of 1:1.06. Among the study participants, 490 (63.3%) belong to age 15-19, and 106 (13.7%) were married. Sixty seven percent of them married before reaching to age 18, with mean age 17.2 $\pm$ 2.4 years. It was also identified that 9% of the marital lock were by abduction.

Out of the total respondents, 35.6% were sexually active, comprising 34.53% married and 65.47% unmarried. Eight point one percent of the sexually active group had reported that during their first sexual intercourse they were being victims of rape. In addition to this, hundred forty two (70.65%) of unmarried sexually active group had unsafe sex at their first intercourse, (not used condom). Consequently, 13 (4.2%) and 32 (10.4%) of them encountered STDS and Unwanted Pregnancy at their first sexual exposure, respectively. Ever use of Modern Contraceptive was found to be 25.7% among the sexually active group, while condom utilization at the last intercourse was 63.2% among unmarried. Because of unsafe sexual practice, 29 (9.41%) of the sexually active had history of STDs in the last one year prior to this study, out of which 2.3% of the cases were among married. It was also reported that 102 (33.2%) of the sexually active youths encountered unwanted pregnancy in

their life time sexual relations with partners, out of which 30.4% of the cases were ended with abortion.

The magnitude of substance use among the youth was assessed and it revealed that 420 (54.3%) of the respondents had exposure to the substance use and thirty eight percent of them reported that their sexual desire rises following substance use. In the assessment of utilization and preference of the health institution, thirty six point seven percent of the respondents preferred to be served in FGAE clinic. On the other hand, 18.7% of the study group claimed that the existing HI was not welcoming when needing a service, the reasons were, 73.4% and 58.3% of them complained prolonged waiting for the service and service inconsistency, respectively. Because of these, youth friendly health service was suggested to be available and 316 (41%) of the youth indicated the need to rearrange in the existing health institution having its own unit, and thirty six point seven percent of the them preferred to be served by young and of the same sex. This study also revealed that 88.5% of the respondents have VCT information and 92.2% of them reported that they need to have VCT.

Logistic regression analysis indicated that, female were more vulnerable to risk reproductive behaviors as compared to their male counterpart. On the other hand, the older group was found to have more risky reproductive behavior as compared to the younger one. It was also observed that married group had risky reproductive behaviors as compared to non married. Similarly, those who used the substance and those who had pocket money were also indicated to have an association with risky reproductive behaviors. From this study it was concluded that youth in the study area were exercising high risky reproductive behaviors that exposed them to various RH problems, and Youth focused health services were not well organized thus needs the collaboration among different sectors and the community to facilitate youth friendly health services to promote youth health.

1 INTRODUCTION

The World Health Organization (WHO) defines adolescents comprising age groups between 10-19 years, youth as 15-24 and young people as 10-24 (1). As a result of remarkable achievements of the child survival and development revolution the world will live to become adolescents. Young people, 10-24 years old currently accounts for over 30% of the world's total population and trends are upwards, particularly in the urban areas of developing countries (1).

During 1980 the world began to focus increasing attention on the needs and problems of young people .The united nation named 1985 the international year of youth (2). At the global level, the Program of Action of the International Conference on Population and Development, held in Cairo in 1994, placed great emphasis on the problems and needs of adolescents. The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services (3).In the same way UNICEF is concerned about youth because what happens during this period of growth and development has a profound impact on young people's health as adults and the health of their children, more over adolescents develop life long attitudes and behavior during this period of transition between child and adulthood (1).

The second decade of life is a period of rapid growth and development for young people's bodies, minds and social relationships (1). It is the period of grate opportunities, new ways of thinking about things, of new influences, of changing roles and responsibilities. The age between 15 and 24 years is a critical stage in a person's life, representing the

transition from childhood to adulthood. During this period, certain decisions that have an impact on an individual's future are made, including whether to stay in school, find employment, initiate sexual relations or try drugs, to name a few (4).

There is a growing evidence from around the world that even if young people want to act in ways that promote their health, they often have formidable barriers to overcome before they can turn their intentions in to action .Once they have acquired the knowledge, have developed the life skills and are motivated to act in ways that promote their health and development, the services that they need are frequently either non-existent or inappropriate (2).

World wide, young women and men suffer a disproportionate share of unplanned pregnancies, sexually transmitted disease, including HIV, and other serious reproductive health problems (5).

While most young people become healthy and productive adults, many millions, unfortunately, do not (1).Early and unwanted pregnancy among women is a common feature in the world. The sub-Saharan Africa has the highest rate of early child bearing of the entire world (6).

Millions of young Africans are at risk for unwanted pregnancies, HIV/AIDS and other reproductive health problems. The statistics are staggering: every minute, six young people are infected with HIV; of them, five live in Africa (7).

Young people constitutes one third of the total population in Ethiopia. Their number is expected to grow from 20.3 millions in 2000 to 25 millions in 2010.The reproductive health problem of young people in Ethiopia are multifaceted and integrated. Child bearing begins at an early age: forty-five percent of the total births in the country occur among adolescent girls and young women. Sexual violence and commercial sex work have become common phenomenon among young girls. As the result, they have become primary victims of the HIV/AIDS crises that have spread through out the country. In general, young people are at great risk for reproductive health problems. The situation is aggravated by the over all poor socio economic, environment and harmful traditional practices. Because of the complex nature of the problems, youth reproductive health strategies demand multisectorial and integrated approach (8).

For young girls the consequences of premarital pregnancy are more common among women who have not reached reproductive maturity, there are important social, educational, and economic consequences (9).

Sexual activity among youth in Ethiopia, particularly those residing in urban areas, has resulted in large numbers of unwanted pregnancies, and illegal abortions, which pose serious health and social problems. Studies carried out in the country indicate that complications from unsafe abortion accounted for almost 55 percent of all recorded maternal deaths, some 13 percent of which occur among women under the age of 20. The

number of cases of sexually transmitted disease (STD}, including HIV/AIDS, is also increasing (5).

Studies on sexuality, awareness and attitude of adolescent's on reproductive health issues in Ethiopia have very much limited themselves to the most confined and accessible adolescents in school. Intervention attempts directed towards these problems were also emphasizing the school community. Evidences, on the other hand, show that out-of-school youth comprise majority of youth at large and most of at the risk group as far as sexual activity and its consequence is concerned (11, 12, and 13).

In this study area, it is recently that youth centered program activities were launched with more emphasis on Recreational Activities and HIV/AIDS prevention and VCT service which is supported by Care Ethiopia.

Therefore, this study aimed at assessing the magnitude of youth reproductive health problems (Early Marriage, Abortion, STD, Early Pregnancy and Sexual activities), level of substance use, factors that affect utilization and preference of the health service, attitude and willingness of the youth to have VCT. It is hoped that, the out come of this study would shade some light as to the importance of organizing youth reproductive health service as one of the strategies to promote youth health, in general to have good future citizens that have knowledge and skills to determine on their sexual and developmental issues in life.

2 REVIEW OF LITRATURE

2.1 Back ground

Young people aged between 10 and 24 accounts for about 30 percent of the world's population, about 1.7 billion people in total, but are by no means a homogeneous group. At the lower end of the age range, they consist of pre-teenage girls and boys, most of whom are not yet sexually active. At the upper end, they consist of physically and sexually mature young women and men, virtually all of whom have been sexually active for several years and in many cases have children of their own (14).

Young people all over the world are in need of much better education and health care related to reproduction. This is clear from the alarming evidence about abortion, the hazards of early pregnancy and the incidence of sexually transmitted disease, the incidence of which is increasing helped by ignorance, fear, shortage of drugs and inadequate treatment and increasing sexual activity. Estimates suggest that some where between 30 million and 35 million abortion take place each year through out the world , and about half of them are illegal. A substantial proportion of all abortion is performed on teenagers (2).

Despite global calls for action, the barriers to young people's access to information, counseling skills and service related to reproductive health, HIV/AIDS and substance abuse remain unsolved. Many young men and women continue to see health services as inaccessible and irrelevant (15).

For sexually active youth, particularly those who are not married, obtaining relevant reproductive health service is often difficult. Few clinics are designed, or even willing, to provide services to young people. Many of them are consequently left with an unmet demand for contraception and other reproductive health services. Adult discomfort with young people's sexuality is almost universal, and there are similar difficulties in speaking about substance abuse openly (15).

The major challenges that young people today face are: Education; it is clear that with out education young people are handicapped in finding jobs and even in taking care of their own families. Employment; Young people often have trouble in finding jobs. Unemployment among those under age 20 is 2 to 10 times as high among older worker. Marriage, is another major challenge, the age at which women marry is increasing in much of the world. This means more time for education, more time to learn job skills, and more time to mature physically and socially before starting families (16).

Regarding reproductive health; early sexual activity, which may be increasing in some countries, can expose young people to: Sexually transmitted diseases, un wanted pregnancy, Life-threatening Complications and risks from pregnancy and child birth, most common in very young mothers, more infant sickness and deaths, and Social and economic handicaps for young parents and their children (16).

Young people also are increasingly exposed to drinking, smoking, drug use, and other activities, seemingly grown- up and sophisticated, and often disastrous(16).

In most parts of the world, mid or late adolescence is a time for experimentation and risk-taking, often with little regard for the possible consequences. One feature common to young people in many parts of the world, however, is their potential vulnerability to HIV and other sexually transmitted diseases (14).

2.2 Youth Reproductive Health Problems

The reproductive health crisis facing young people arises basically from the increase of early and premarital sexual behavior resulting in problems of teenage pregnancy, illegal abortions and STD- HIV /AIDS (17).

The extent of sexual activity, pregnancy, and their health and social consequences among young people of fertile age is only now being recognized as a major health and social problem in many countries (16). Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher level of morbidity and mortality. Early childbearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world (3).

2.2.1. Teenage Sexual activity

More and more Young people are having sex before marriage, often with out using contraception there by exposing them to the risks of sexually transmitted infections, HIV/AIDS and unplanned pregnancy (1).

The current average age range for the attainment of puberty is 9-14 for boys and 8 to 13 for girls. As a result, young girls are biologically mature enough to engage in sex and become pregnant at an early age, although they may not be emotionally and physically mature enough to understand the implications (3).

Sexual activity begins in adolescence for the majority of people. In many countries, unmarried girls and boys are sexually active before the age of 15. Recent surveys of boys aged 15 to 19 year in Brazil, Hungary and Kenya; for example, found that more than a quarter reported having sex before there were 15year. A study in Bangladesh found that 88 percent of unmarried urban boys and 35 percent of unmarried urban girls had engaged in sexual activity by the time they were 18 year (18).

In many developing countries young men and women are becoming physically and sexually mature at the younger age than in the past, and people are marring at a later age. At the same time, traditional taboos against premarital sex are breaking down. One consequence of these changes is that more young people are becoming involved in pre marital sex, usually without using a condom or any other form of contraception. In Nigeria, for example, the average age of first sexual intercourse for girl is 16 years', but this figure conceals wide HIV through unprotected sexual intercourse (14)

Problems related to sexuality play an important role in the physiological and sexual development of youth, Physical and sexual maturity of youth inevitably leads to sexual involvement. Lack of proper sex education often leads youth to such problems as

unwanted pregnancy, abortion, illegitimate birth, sexually transmitted diseases, HIV etc. Weakening of the economic, social and Cultural base of the family, particularly in urban areas, is pushing more and more people to become almost norm less concerning youth sexuality. Hence, youth are forced to seek Knowledge and advice about sexuality from in appropriate sources, leading themselves often to undesirable end-results (19).

In Ethiopia sexual and reproductive health is characterized by early marriage, more or less corresponding with menarche and early frequent child bearing with a consequent high rate of population growth. Contraception is rare and abortion is illegal and unsafe (19).

The median age at which women age 25 – 49 first had sexual intercourse is 16. Three in ten women in this age group have had sex by age 15, two in three by age 18, and more than 80 percent by age 20. There is gradual increase in the proportion of young women who have ever had sex. This increase is more pronounced among experienced compared with nearly one in four women age 16year, 27 percent of women age 17year, and about one in two women age 18 and 19. The percentage of women who have ever had sex increases gradually from 70 percent among women age 20 to 84 percent among women age 24, with the largest percent increase between age 19 and 20. On the other hand, men initiate sex an average of four years later than women (8).

One of the study conducted in south Ethiopia, indicate that, Hundred eight five (49.3%) of the respondents admitted to have had sexual intercourse some time in the past. Mean

age of starting sex for study subjects was 17± 2 years, (16.7±2.3 years for males and 17 ±1.8 years for females). Eight four percent of them started between the age 15 and 19 years. Males were more likely to be sexually active compared to their female counterparts (OR=2.3, 955 CI: 1.4 9, 3.56, p<0.0001) (20).

Hundred and eight (31.5%) of the 343 students were reported to have had sexual contact before the date of the survey and males were significantly higher in number (OR= 8.9, 95% CI=4.1, 17.3,p< 0.001) (21).

Sexual relationships for girls were frequently motivated by gain in the form of money, gifts, job position or a promise to send abroad. This mostly happens with much older men and there are no cultural sanctions against it. It appears from their description that these men simultaneously satisfy the economic need of the girl and get the advantage getting young and apparently free from disease clients for sex (22).

Another study conducted in the eastern part of the country revealed that age at first intercourse, the highest proportion, 48.1% of males and 37.85 of females, had their first sexual intercourse at age of 15 – 17 years. About one third of the respondents had their first experience of sexual intercourse at the ages of 20 years and only 13.6% above the age 20 years. The mean age at first sexual intercourse is found to be 17.2 years among unmarried youth, 16.9 years foe males and 18 years for females (9).

Similarly other study conducted in Addis Ababa, indicate the proportion of single adolescent who reported having had sexual intercourse rises with age, from 35% in the age group 20 to 24 years. Among single adolescents who were under the age of 20 years, over two fifth have experienced sexual intercourse. The highest proportion of adolescents (24%) had their first intercourse at the age of 18 years. Nearly half of the respondents had their first experience of sexual intercourse at age 16, 17, and 18 years. Only 6 % of the respondents had experienced sexual intercourse under the age of 15 (23).

Therefore, young people need adult assistance to deal with the thoughts, feelings and experience that accompany physical maturity (18).

2.2.2 Early marriage

Early marriage occurs across the globe, but it is most common in parts of Africa and south Asia. In Nigeria, 76 percent of girls are married by 18, and in India, 50 percent. In Nepal, 19 percent of girls are married before they are 15 years old and 60 percent by the time they are 18 (18).

Study conducted in Asia and Pacific region indicate that the mean age at marriage for females is fairly high in the majority of countries in the Asia and pacific region. However, in some countries in south and south-west Asia, such as Bangladesh, India, Maldives and Nepal the mean age at marriage for female is less than 29 years. Fore example, in Bangladesh ,47 percent of women aged 20 to 24 had been married by age 15, and 73 percent and 82 percent of this women had been married by age 15, and 20,respectively. A similar high rate of adolescent marriage is observed in India and

Nepal. Among women aged 20 to 24, over 70% of women in these countries had already been married by age 20 (3).For urban adolescents, pregnancy is mostly extramarital and almost always ends up in early marriage is one of the cultural traditions that expose young women to reproductive health problems. The 1990 Family and Fertility survey revealed that 34 % of women were married before age 15(26). Marriage by Abduction is also widely practiced; at the national level, 69 % of the respondents reported knowing that the marriage by abduction took place in their area (27).

2.2.3 Teenage Pregnancy

Unwanted pregnancy is one of the greatest problems a young girl can face. Pregnancy may endanger her health, her chances for education and marriage, and many of her hopes and plans for the future. Her family may even disown her. Many adolescents are too young, too poor, or too inexperienced to car for a child. Consequently, some young women turn to abortion. Where abortions are performed by unskilled providers in unsafe conditions, the risks of serious health complications and death are great (16).

Early child bearing has a negative impact on the education prospect of girls, including pregnancy related school drop out, thereby threatening their economic prospects and over all development. When school girls become pregnant, they either resort to illicit abortion, which is often unsafe, or carry the fetus to full term, which hampers their opportunities for socio economic advancement(3).

For urban adolescents, pregnancy is an extramarital and almost always ends up in abortion. (10). In developing Countries, up to 60% of pregnancies in teenage are unwanted (24).

More than half of all young women (54%) have at least one child by the time they are 20 years old (24). Another study show that 28% of pregnancies recorded at Yaoundé maternity hospital are among adolescent girls , representing 70 % of all gynecological complication cases. (25)

Ethiopia has one of the highest rates of infant and maternal mortality in the world. The data show that the children born to mother in their teens have substantially greater risk of dying young (3).

In Ethiopia, the magnitude of unwanted pregnancy among adolescents was reported to be 15 % in Harar (28), and 30.1 % in Gonder (29).

2.2.4 Abortion

One third of all births taking place each year many of which are unplanned or unwanted are among adolescents. Which some girls choose to keep their infants, other may resort to unsafe abortions with little medical care afterwards, which can lead to infections, infertility and even death. The problem of early child bearing is not only biomedical but can also hamper young girls' educational and economic opportunities, perpetuating a cycle of poverty (3)

Approximately 2 million adolescent women in developing countries under go unsafe abortions each year, and a third of all women seeking hospital care for abortion complications are under age 20. For young women who undergo unsafe abortion, short term problems can include infection or injuries from the procedure itself, such as a perforated uterus, cervical lacerations or hemorrhage. Long term complications include increased risk of entopic pregnancy, chronic pelvic infection and possible infertility (5).

In developing countries where abortion is illegal and performed in unsafe clandestine conditions, morbidity and mortality due to its complications are very high (30).

In Nigeria 50-70 % of women hospitalized for complication of abortion were younger than 20 years. A 13- year's review at a university hospital in Nigeria revealed that 72% of maternal deaths from unsafe abortion were accounted by teenage women (31).

Abortion, which is illegal in Ethiopia, places many young women at risk, primarily because it is usually conducted under unsafe conditions. However, actual data on the prevalence of illegal abortion is difficult to collect, to date; the most comprehensive study on abortion in Ethiopia was conducted in 1993. The study collected data from 5 hospitals in Addis Ababa during a period of 9 months. Finding revealed that there were a total of 1603 induced abortion cases, of which 15% occurred among women under age of 15; 31 percent occurred among women aged 16 to 20; and 62 percent occurred among women

16 to 25. Forty five percent of the abortions were among single women, 42 percent were among women with only a primary school education or less. (32)

A three years retrospective study on abortion was conducted in Jimma Hospital between 1989 and 1992, during this period there were a total of 1540 abortions. The mean age of patients was 24.4 years; the youngest patient was 13. Fifty- four percent of the cases were under age 25; with 23 percent age 13-19 and 31 percent age 20 – 24. Fifteen of the abortions –related deaths (54%) were to women under 25 years of age (33).

In the other study conducted in Jimma Hospital on illegal abortion revealed that 57.5% of the cases to be in the age group 15-20 years, out of which 35% of them were students (34).

Similar to most developing countries, in Ethiopia, abortion is illegal except on medical grounds. Hence, young women resort to illicit abortion to terminate unwanted pregnancies with great risks to their health (19).

2.2.5. STD and HIV /AIDS

Sexually transmitted diseases (STDs) are a major health problem among young people world wide (16). Sexually transmitted diseases affect people in both developing and industrialized countries. Those aged 20-24 is at highest risk of infection. STDS have

important repercussion on reproductive health and have been shown to increase the risk of infection with the AIDS virus (35).

The fact that relation prior to marriage tend to be unprotected increases the risk of unwanted pregnancy and STDs, including HIV/AIDS, among youth. Young people are increasingly at risk of being infected with STDs. Of the estimated 333 million new cases of STDs that occur in the world every year, at least 111 million occur to youth under age of 25(15).

The presence of STDs in the body increases a person's chance of contracting HIV by two to five times. This is especially true of any STDs that produce sores or weeping lesions, such as herpes, syphilis, or cancroids. Sexually active youth are at substantial risk not only for HIV but also for other STDs because they tend to have multiple sex partners, to engage in unprotected sex and among young women to have older men a sex partner (35).

Report from different countries; show that young people are the most victims of AIDS (18). Of the over 60 million people who have been infected with HIV in the past 20 years, about half became infected between the ages of 15 and 24. Today, nearly 12 million young people are living with HIV/AIDS. Young women are several times more likely than the young men to be infected with HIV (35)

The rise in HIV/AIDS in Asia and Pacific adds a new lethal angle to the vulnerability of youth to STDs. By the end of 2000, 6.4 million people were living with HIV/AIDS in the

Asia and pacific region, and the epidemic is rapidly on the rise in many countries. Youth are especially vulnerable to the epidemic, and account for over 50 percent of all new infection (3)

In the eight African countries with an HIV prevalence rate over 15 percent, approximately one third of all teenagers living today will die of AIDS. Due to the socio economic disadvantages that adolescent girls find themselves in, they are up to six times as likely as boys their age to be HIV positive(7). In nearly 20 Africa countries, 5% or more of women ages 15 to 24 are infected. Such statistics underscore the urgent need to address HIV/AIDS among youth (35).

In sub Saharan Africa, it is estimated that about 10-20% of the sexually active to have STD (17).HIV/AIDS prevalence in the population aged 15 to 49 in Cameroon is 11.8%. And about 7 in 10 STI cases in the country occur in adolescents under the age of 25, suggesting that youth also make up a disproportionate number of new HIV cases (24).

Nine out of 10 people living with HIV/AIDS do not know they are infected. Each day, in the world nearly 6000 young people between the age of 15 and 24 become infected with HIV. Yet only a fraction of them know they are infected (18).

Yet studies have shown that young people have a strong interest in knowing their HIV status. More than 75 percent of Young people survived in Kenya, and about 90 percent in Uganda, indicated that they would like to be tested while still healthy (1).

Sexually transmitted infections (STI) are an additional risk to young Ethiopians. The prevalence of sexually transmitted disease (STDs) like HIV/AIDS is relatively high among young people (8). According to the HIV sentinel Surveillance of mothers seeking antenatal care , HIV/AIDS prevalence is 11 percent among women age 15-19 and 15 percent among those aged 20 -24. The two major factors among youth in Ethiopia are the practice of having multiple sexual partners and the limited use of condoms (36).

In Ethiopia, according to the MOH 1998 report the prevalence in the general population was estimated to be 7.4%. The peak age for AIDS cases were 20-29, and the peak age for new infections were 15-24 years (37).

Up until now, only a small percentage of those with HIV/AIDS have had access to reliable voluntary counseling and testing services. As there is no cure for HIV/AIDS, voluntary HIV counseling and testing remains a key strategy to control the spread of HIV and to provide support to those who are positive (38).

There is away to halt the spread of HIV/AIDS, we must focus on young people. More than half of those newly infected with HIV today are between 15 and 24 years old. (1)

2.2.6 Modern contraceptive use

In specific countries like USA, West Germany and Mexico 50-60 percent of both sex did not use any fertility regulation method at their first sex. In Ethiopia, those unmarried,

Youth age 25-29 at the time of the survey reported that they first started using FRM, on average at the age of 20.5 for males and 20.8 for Females (39).

In a nation wide survey among young adults aged 15-29 years, knowledge about contraception was found to be as high as 90% and 87% for condoms and pills, respectively. But when it comes to practice, only 15% of the males used condom and 39% of the females used pills (40). A study conducted in high school in Addis Ababa indicated that 54 percent of sexually active youth have experienced sex with more than one partner, but only 18 percent said they had ever used condom (41).

Other study conducted in south Ethiopia indicted, reported condom use rate during the first sexual intercourse was 13.5%, while it was 27.6% during their resent one(20).Study conducted in rural town in Ethiopia revealed that ,65.7% of sexually active group reported to have used some form of modern contraceptive in the past (21).

The evidence demonstrates that early sexual activities coupled with none or low FRM use causes unintended pregnancies, which is in most cases end up with illegal abortion (42).

2.2.7 Substance Use

Young people are increasingly at risk of abusing substances. The substances used by youth are usually those ready available, including alcohol, tobacco, pharmaceuticals, volatile solvents, illicit drugs and other psychoactive substances. Experimentation with drugs often begins at childhood or adolescences (3).

Consumption of alcohol among Young people has become an issue of great concern. Generally in developed and developing countries, drinking alcohol has shown a sharp increase (38).

In developed world, during the last quarter of century, drugs have invaded the society especially the Youth. Presently it is also in rapid spread in the developing world including our country due to urbanization and exposure to western life style. Large number of Youth somehow decides daily whether or not to use drugs with out adequate knowledge (42).

In a rapid assessment of the situation of substance abuse in selected urban areas in Ethiopia, the age at first use was found to be in 44.9% cases at less than 15 years and 34.6% at the age of 15 to 19 years (43).

In one of the community based study conducted on effect of chat in Jimma town indicate that 65.90% of the users were Youth (44).

2.2.8 Youth Health Services

Youth friendly health services can be free standing clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and information to Youths people and are welcoming, confidentially, conveniently located and affordable (18).

In most situations, actions will be needed on several different fronts if good quality health services that are relevant to Young people's needs are to be made available and accessible to them, including polices, organization of the services, and training of health workers and young people (1).

In addition to health promotion, health services for young people will, at a minimum need to include: emergency services, routine treatment of common diseases, regular access to non-judgmental listening and support guidance and regular access to the health supplies that young people require (1).

By fulfilling the preference of adolescents, Youth friendly services that have polices and attributes that attract Youth; health facilities can provide comfortable and appropriate services that meet the need of adolescents and retain them for follow up successfully (44).

In Ethiopia young people get medical care through the network of health institutions in the country (19). Young people in Ethiopia are disadvantaged relative to older, in their ability to access information and services for their reproductive needs because of the absence of a youth – friendly service delivery system (8).

1. OBJECTIVES

1.1. **General:** -

To assess Youth Reproductive health problems and service preference in west

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1.2. **Specific**: -

1. To determine the magnitude of selected reproductive health problems of youth (sexual activity, unwanted pregnancy, early marriage, abortion, STI/and contraceptive use),

2. To determine the level of substance abuse (tobacco, alcohol, khat, shisha)

3. To assess magnitude of factors influencing the preference and utilization of RH service among youth.

4. To examine awareness about and, willingness to utilize VCT services among youth.

4. Methodology

4.1. The study area

The study was conducted in West Hararghe, Assebe Teferin. West Harerghe Administrative Zone is one of the 12 zones in Oromia Regional State. It lies in the South East part of the country sharing boundaries with Somali and Afar Regional State to the North, with Bale Zone to the South, East Harerghe Zone to the East, and Arsi Zone and East Showa Zone to the west. It covers an area of 17,230 km^2. Administratively West Hararghe Zone is subdivided to 11 districts within which there are 290 peasant association and 20 rural towns.

In west Hararghe administrative Zone, there are 6 urban towns having administrative city council. These are namely called Assebe Teferi, Mieso, Badessa, Hirna, Galamso and Mechara.

Assebe Teferi, Zonal capital and study area is located at 333 km from Addis Ababa on the main road to Dire Dewa, There is one district Hospitals in the Assebe Teferi called Chiro Hospital, with 60 beds capacity. The town is sub divided in to 4 kebeles and each keble consistes 3 sub Zone. The town of Assebe has a council that is responsible for political and administrative affairs. It is estimated that, 20,000 people living in the town, of which about 4000 were youth. There are a total of 7 health institutions in the town, out of which 1 is Governmental Hospital, 3 medium clinics privately owned and the rest 3 medium clinics belong to other governmental organization.

4.2. Study design

A descriptive cross- sectional community based study was employed to assess youth reproductive health problems and service preference.

4.3. Source population

The source populations for the study were all youth aged 15 to 24 years residing in Assebe Teferi town.

4.4. Study Population

The proportion of youth constitute 19.66 percent of the total population, therefore, the required study population from all kebeles' sub zones were identified based on the sampling unit produced from each kebele and each sub zone , according to probability-proportionate to size.

Exclusion criteria

- Youth who are guest to the study area.
- Youth who were critically sick at the time of study and unable to communicate and respond to questionnaire?

4.5. Sample size determination

Total population size of the town estimated to be 20000, out of which 3932 is estimated to be youth aged from 15-24 years age. From this target population the required sample size was taken according to the size of population in each kebeles.

Sample size was determined using the formula for single population proportion, and the following assumptions were made. Significance level of 95% (x=0.05) and 5 percent margin of error was taken. Since the previous prevalence of health problems and service preference of youth with emphasis to reproductive health is not known, in the study area, 50% prevalence was taken to obtain sufficiently large sample size, and 10% was added to compensate for non response and it was multiplied by two for the design effect. A total of 844, youth between the ages of 15 to 24 was needed.

$$n = \frac{(Z/2)^2\, p(1-p)}{d^2} + 10\% \text{ non response}$$

where n= sample size

p= 0.5 (50%)

z= 1.96

d=0.0025 (5%)

4.6. Sampling procedure

A multistage sampling procedure was under taken; the required sample size was allocated to each kebeles according to the probability proportionate to the size of the population. From allocated sample size to each Kebele, the study unit of each sub zone was determined according to probability proportional to sampling unit assuming one youth in one house hold (number of house hold were Obtained from Kebele Administrator, 2002 updated numbering) . Using lottery method study units were identified, and only one youth from the selected house hold was interviewed. The data collectors were asked the parents number of youth aged 15 -24 in their family and then determined the range of

code to each house holds equal to the number of the youth in the house hold. The smaller number represented the younger one and the next small number represented the second younger one and it was done so on. The data collectors were used to call upon one of the youth in the house hold and were made to call one of the numbers in the specified range and who to be interviewed was determined. If the selected guy was not around, again another number was chosen by one of them. In the absence of youth in the selected house hold or when the house hold get closed , the house holed with the next higher number was selected and this was continued for the next three house holds and then back in the opposite way and was done in similar way as it was needed. .

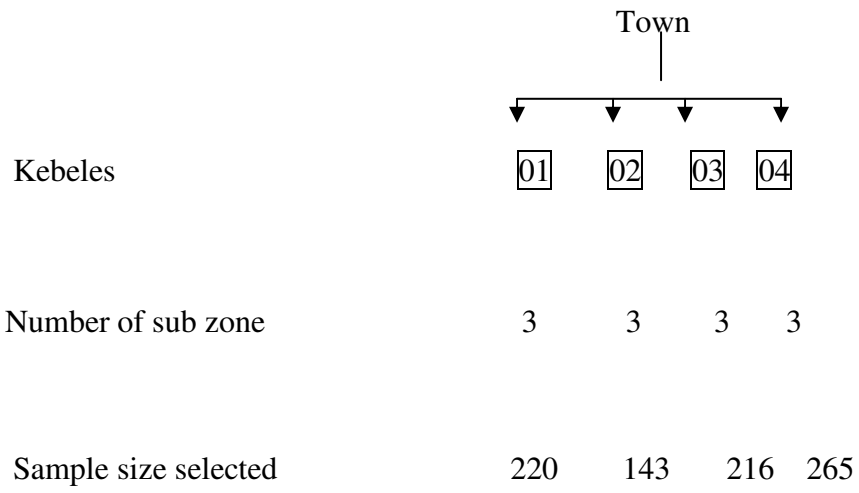

Fig 1 Sampling architecture

4.7 Data Collection

4.7.1 Quantitative

4.7.1.1 Questioner Development

Structured questionnaire was developed first in English. The questions and statements were arranged according to particular objectives that they could address. Then the first draft of questioner was submitted to the advisors and colleagues for comments. The valuable suggestions were considered to improve the instrument. Accordingly, redundancy, vagueness and logical flow of the questions get corrected. After extensive revision, the final version of the English questionnaire was translated to Amharic version and then back to English to ensure understandability and message consistency and then pre tested on 40 Youth at Hirna, because it has similar Characteristic and setting with Assebe Teferi.

4.7.1.2 Pretest

Pretest of the questionnaire was carried out in one urban kebeles that have similar socio demographic characteristics with the people of the study area. During the pretest, the questions that were frequently asked were documented for further consideration. Both the interviewers and supervisors assessed clarity, understandability and completeness of questions. After the result of the pretest, some correction and changes were made as necessary.

4.7.1.3 Data collector recruitment and Training

The data collectors were recruited based on the following general criteria; 12th grade completed and above, unmarried age of 20 years and above, physically fit, and those who have had experience in data collection and fluent in both Amharic and Afan oromo. Based on these criteria Six female and six male interviewers who worked in pair, for Gender matched interview were selected.

The recruitment of supervisors was done together with zonal Health Department. Two paramedical, who have had experience in similar research, were selected. A thorough training was given for both the interviewers and supervisors for two days before the pretest and for a day after the pretest. The training included discussing the questions one by one, briefing on the general objective of the study, discussing about the general techniques of interviewing and how to approach the respondents, how to keep confidentiality and privacy and how to keep close supervision using the prepared guidance and check list.

Both the Interviewers and Supervisors were given an interview guide prepared in Amharic, which was developed during the training. Data were collected using structured questionnaire. The actual data collection had taken from Nov 10 to 17/2003 using trained 12th grade complete students

Each supervisor was supervising three pairs of data collectors. They were checking the activity of data collectors, by taking a sample they were counterchecking house holds, and each night they were checking all the questionnaires filled, for completion, clarity and proper identification of the respondents.

Then the principal investigator was randomly checking on average about 10% of the supervisors' work each day. Incomplete and unclear questionnaires were given back to the interviewer the next day to get it completed.

4.7.2 Qualitative

Para medical health professionals, two males and two females, who have experience were selected as gender matched moderators. A two day orientation and practical exercise was carried out at Zonal Health Department compound. Four focus group discussions, two of male and two of female were carried out in the same compound. Every discussion was tape recorded not to miss all issues discussed and finally transcribed.

4.8 Data Quality issues

The quality of data was assured through careful, design, translation and retranslation and pretest of the questionnaire, proper training of the interviewers and supervisors, close supervision of the data collecting procedures, proper categorization and coding of the data.

4.8 Measurement variables

Dependent:

-Reproductive health related problems, i.e. (sexual activity, teenage pregnancy, Abortion, STD and contraceptive use)

- Substance use: (alcohol, cigarette, khat and Shiisha)

- Service utilization and service preferences.

- Acceptance of VCT.

Independent variables:

Socio demographic variable (sex, age, educational status, ethnicity, religion, family educational level, pocket money, martial status)

4.10 Data Analysis

After data collection, the responses were coded and entered in to a computer using EPI version 6.4 statistical programs. To clean data, print out of frequency was used to check for outliers and referring to the raw data whenever needed. Then the frequency distribution of dependent and independent variables was worked out. To establish associations between dependent and independent variable crude odds ratio with 95% confidence interval were calculated from a cross-tabulations using EPI info. Adjusted odds ratios that control for potential confounding variables were calculated using logistic

regression model in SPSS version 10 statistical programs. Statistical significance was considered at $\alpha. \leq 0.05$.

4.11 Ethical Considerations

Ethical clearance was obtained from the Faculty of medicine, Addis Ababa University. At Local level, necessary arrangements were made concerning this issue. At the time of data collection, a verbal consent was asked from the participants to confirm their willingness to participate. Those who were not willing to participate were given the right to do so. Confidentiality and privacy of responses was ensured through out the research process**.**

OPRATIONAL DEFINITION

Alcohol user: Youth who drink alcohol regardless of the frequency of use.

Contraceptive method: Include all modern contraceptive except condom.

Early sexual activity: Regardless of marital status, practicing of sexual intercourse before reaching to age 18.

Factors that affect service utilization: This includes accessibility of the health institution, confidentiality of the service, fee charge for the service, service time, consistence of the service, waiting for the service.

Risk reproductive behaviors: it include early sexual activity, early marriage, premarital sex, unwanted pregnancy, abortion, unsafe sex, having more than one partner.

Khat chewer: youth who chew khat regardless of the amount and frequency of use.

Shisha: It is Tobacco that bur slowly.

STDs: Sexually transmitted disease other than HIV/AIDS.

Smoker: youth who smokes cigarette regardless of the amount and frequency of use.

Un employment: Youth who older than age 18, not having his own regular job and dependent on other.

Voluntary counseling and testing (VCT): is process by which an individual undergoes
counseling that enabling him or her to make informed choice.

Substance user: Youth who takes any one of the four substances (alcohol, Cigarette, Khat or shisha)

RESULTS

Socio Demographic Characteristic

From the total of 844 youth who were targeted for the study, 774 responses were obtained, while 21 refused to participate, 36 could not be available after repeated visiting and 13 respondents were excluded for their inconsistency and incompleteness. Thus the response rate was 91.6% of the targeted sample size.

As it was shown in table1, out of 774 respondents, 375 (48.4%) were male with the male to female ratio of 1:1.06. Out of the total respondents, 490 (63.30%) of them belong to the age 15 to 19 years, 622 (79.96 %) attended secondary school and above and 668 (86.5%) were unmarried. This study also indicated, 518(66.89%) of the study subject were Christian, and 351 (45.3%) were Amhara in their ethnic group. Out of the total interviewee, 503(65.0%) of them were student and 366 (47.30%) were living with both parents, and 282(36.4%) of the youth had daily pocket money and 139(49.3%) of them get maximum of 5 birr per day.

Table 1 Socio Demographic Characteristics of Urban Youth, Assebe Teferi Town, December 2004.

Variables	Number	Percent
Sex		
Male	375	48.40
Female	399	51.60
Age		
15 _ 19	490	63.30
20 _ 24	284	36.70
mean ± SD	17.8±3.6	
Ever entered to school		
Yes	735	95.00
No	39	5.00
Educational level		
Illiterate	39	5.00
Primary	113	14.80
Secondary	588	75.56
12 +	34	4.40
Marital status		
Unmarried	668	86.50
Married	73	9.40
Divorced/Widowed	33	4.70
Religion		
Orthodox	461	59.56
Other christen	57	7.33
Muslim	256	33.11
Ethnic group		
Oromo	326	42.10
Amhara	351	45.30
Guraghe	85	11.00
Others	12	1.60
Occupation		
Student	503	65.00
House Wife	41	5.30
Unemployed	125	16.10
Govt employ	18	2.30
Others	87	11.20
Living most of the time with		
Both parents	366	47.30
Either of the parents	151	19.50
Husband or Wife	73	9.40
Other relative	184	23.70
Parents working status		
Both works outside	206	26.60
Either of them works outside	416	53.80
Both not work	152	19.60
Pocket many		
Yes	282	36.40
No	492	63.60
Average pocket money		
Not more than 5 birr	139	49.30
5 _10 birr	108	38.30
10 _ 20 birr	35	12.40
Total	**774**	**100**

Reproductive Health problems

Reproductive health problems of the youth were assessed and it revealed that 67% of the youth married at age 13 -18 years, and more than 10% of them came to the marital lock with out their interest, either by abduction or influenced by their male counter part. It had been reported that 57% of the respondents were reached to secondary school at a time of their marriage. As it is indicted in table 2, three hundred and seven (39.7%) of the respondents were sexually active, and 79 (25.7%) of them exercised their first intercourse before reaching to age 16 years. For more than eight percent of them, their first intercourse was rape, moreover, 147(47.9%) of them believe that their first intercourse were unsafe (not used Condom), and consequently resulted in more than 15 % of them being victims of STDs, Unwanted pregnancy and school drop-out.

In the other hand, contraceptive use was assessed ,and nearly twenty six percent of the sexually active group were used modern contraceptive, while more than 47% of them clamed ,that they used condom at their last intercourse. As the consequence of unsafe sex, 29 (9.4%) of the sexually active youth had history of STDs in the last one year prior to this study, while 102(33.2%) of them were encountered unwanted pregnancy at least once in the life of sexual relation with their partner, out of which 30.4% ended in abortion, almost 4% pre term and more than 65 % were gave birth with out their interest and 53 .7% of them became mother before reaching to age 18.

Table 2. Reproductive Health Problems among Youth , Assebe Teferi, December 2004

Variables	Number	Percent
Ever had sexual intercourse		
Yes	307	39.7
No	467	60.3
Age at first intercourse		
≤ 15 years	79	25.7
16 _ 18 years	167	54.4
19 _ 21 years	45	14.7
22 _ 24 years	16	53.0
How the first intercourse take place		
My interest	235	76.5
Pear pressure	32	10.4
Forced by opposite sex	25	8.1
On my marriage	15	4.9
Other	0	0.0
Age on marriage		
13 _ 18	71	67.0
19 _ 24	35	33.0
mean ± SD	17.2± 2.4	
How marriage takes place		
Abduction	9	8.6
Only by the interest of male	5	4.6
Both interests	75	70.8
Other	17	16.0
Perception on Safety of their first intercourse		
Yes	147	47.9
No	160	52.1
Consequences of first intercourse		
STDs	13	4.2
Unwanted pregnancy	32	10.4
School dropout	6	2.0
Nothing	256	83.4
Ever use of modern contraceptive		
Yes	79	25.7
No	228	74.3
Condom use at last intercourse		
Yes	147	47.9
No	160	52.1
Any symptom of STDs in the last 1 year		
Yes	29	9.4
No	278	91.6
Ever occurrence of unwanted pregnancy		
Yes	102	33.2
No	205	66.8
How pregnancy ends		
Aborted	31	30.4
Pre Term	4	3.9
Give birth	67	65.7
Age at which first birth gave		
13 to 15	2	2.9
16 to 18	34	50.7
19 to 21	23	33.3
22 to 24	9	14.4
Total	**774**	**100**

Level of Substance use

Substance use and sexual desire of the youth were assessed and it revealed that, more than 56.5% of both or either parents of this study subjects used to chew khat, while 235 (30.4%) of the youth had reported chewing khat daily. Sixty percent of those who used to chew khat reported that they used to chew because they were idle and to spend time, as the consequence of the addiction, 3.6% of them were facing difficulty to carry out their day to day activities when in lack of the substance.

Cigarette smoking found to be less common as compared to khat and alcohol use. Thirty-nine (5%) of the respondents used to smoke every day, while 19 (2.5%) of them reported using it when chewing Khat. This study also revealed that, 225(29.9%) of the youth used to drink alcohol frequently. More over, 38.1% of the respondents reported that their sexual desire increase just after the substance use.

Table 3. Level of substance use among youth, Assebe Teferi, December 2004

Varibles	Number	Percent
Khat		
Parents		
Either	254	32.9
Both	183	23.6
Neither	337	43.4
Youth		
Never use	409	52.8
Use occasionally	130	16.8
Use daily	235	30.4
Reason to chew khat		
For better performance	134	36.7
To spent time	168	46.0
Because I am idle	51	14.0
Other wise I can't work properly	13	3.6
Others	40	11.0
Cigarette		
Never use	716	92.5
Use always	39	5.0
Use with khat and alcohol	19	2.5
Shisha		
Never use	685	88.5
Use with khat only	81	10.5
Use daily	8	1.0
Alcohol		
Never use	533	68.9
Use it	225	29.1
Always after chewing	16	2.1
Sexual desire, with use of any one of these substances		
Increases	165	38.1
Decreases	124	28.6
Don't know it	137	31.6
Other specify	7	1.6
Filling when lacks the substance		
Poor social communication and discomfort	113	31.0
Face difficulty to work	182	49.9
Headache	3	0.8
Other	67	18.3
Total	**774**	**100**

Attitude of the youth to the existing HI and magnitude of factors that affect utilization of YRHS.

Youth attitude toward the existing YRHS was assessed and it revealed that, 284(36.7%) of them had believe that they could get better youth health service in FGAE clinic, and 133(17.2%) of the respondents claimed that the existing health institutions were inconvenient for secret use of RH need. Among the health service user, 139(18.7%) reported that the existing health institution were not welcoming in need of the service.

This study also assessed the magnitude of those factors that hinder utilization of YRH service and it revealed that 42.5% of those who claimed the existing health institution was not welcoming, reported distance was one of the factors, while 56(40.5%) were feared not to be seen by parents or any one who know them, and 24(17.3%) of them claimed the service providers were judgmental when Youth needs RHS. In addition to these, lack of confidentiality, embossment by youth at needing reproductive health service and inconvenience of service time were reported by 50(36%), 80(57.5%) and 67(48.2%) of the respondents as factor that affects the service respectively. On the other hand, 28(20.1%) of the respondents claimed as service fees were expensive and 102(73.4%) reported prolonged waiting for service, as factors that limited them to use the service.

Table 4. Attitude toward the existing HI and magnitude of problems related to Youth reproductive health service delivery, Assebe Teferi, December 2004

Variables	Number	Percent
Believe on Hi to deliver better YRHS		
Governmental	246	31.8
Private	234	30.2
EFGA	284	36.7
Other	10	1.3
Convenience of existing HI for secret use of YRHS.		
Yes	632	81.7
No	133	17.2
Don't know	9	1.3
Attractiveness' of HI when in need of RH service		
Yes	625	80.7
No	139	18.7
Don't Know	10	1.3
Problem related to service delivery		
HI located at far distance		
Yes	59	42.4
No	80	57.6
Fear of being seen by parents or other		
Yes	56	40.3
No	83	59.7
Service Providers are judgmental		
Yes	24	17.3
No	115	82.7
Lack of confidentiality		
Yes	50	36.0
No	89	64.0
Embarrassment at needing RHS by Youth		
Yes	81	58.3
No	58	41.7
Inconvenience of service time		
Yes	67	48.2
No	72	51.8
Service fees are expensive		
Yes	28	20.1
No	111	79.9
Prolonged waiting for service		
Yes	102	73.4
No	37	26.6
Inconsistency of service delivery		
Yes	81	58.3
No	58	41.7
Total	**774**	**100**

Utilization and preference of YRHS.

As indicated in table five, an assessment of preference and service utilization of YRHS revealed that 325(42.1%) of the total respondents were not served in the existing health institutions and 36.7% of them preferred to be seen at FGAE clinic. Need for rearrangement of YRH service was assessed and it indicated, 316(41%), and 232(30%) of the youth preferred reproductive health service to be arranged in the existing HI having its own unit and in separately located YH institution respectively. Three hundred and twenty two (41.6%) respondents preferred service time to be in the absence of other user and 446(57.6%) preferred to have service free of charge. Two hundred and eight (36.2%) preferred service provider to be young and of the same sex and 624(85.9%) preferred service to be located at the center of the town.

An assessment of the program of service preference revealed that out of the total respondents above 87% preferred to have sexual education, family planning service, partner relation guidance, information and education on STDS and HIV/AIDS and information center for YRH.

Table 5 preference and utilization of YRHS among youth, Asbe Tefri, December 2003

Variable	Number	Percent
Utilization of existing HI for RH		
Yes	447	57.9
No	325	42.1
HI preferred for YRH service use		
Gov't	247	31.8
Private	234	30.2
EFGA	284	36.7
Other	10	1.3
Preference for YRH service arrangement		
In existing health institution having its own unit	316	41.0
In school health service	219	28.3
In separate Youth HI	232	30.0
In youth center	6	0.7
Preference by time		
Usual working hour	452	58.4
On the absence of other user	322	41.6
Other		
Service fees		
At usual rate	130	16.8
At special discount	198	25.6
Free of charge	446	57.6
Others		
Service providers		
Young and of the same sex	280	36.2
Young and any sex	228	29.5
Adult and the same sex	149	19.3
Adult and any sex	117	15.1
Others		
Preference by location		
At the center of the town	624	85.9
Any where out of residence area	40	5.2
At one end of the town	69	8.9
Other		
Type of health service preferred		
Sexual education		
Yes	678	87.6
No	54	7.0
Don't Know	42	5.4
Family planning service		
Yes	750	96.9
No	16	2.1
Don't Know	8	1.0
Partner relation Guidance		
Yes	707	91.1
No	57	7.4
Don't Know	10	1.5
Information and education on STDs and HIV/AIDS		
Yes	759	98.1
No	7	0.9
Don't Know	8	1.0
Information center on Youth RH		
Yes	742	95.9
No	15	1.9
Don't Know	17	2.2
Total	**774**	**100**

Attitude and willingness to VCT

As indicated in table 6, an assessment of the attitude and willingness to VCT revealed, 685(88.5%) of the respondents had VCT information and 509(65.8%) of them had perception that, its main advantage is to maintain health and 192(24.8%) understand it is to limit HIV/AIDS transmission. In the contrast, 2(.2%) of the respondents claimed it could enable to take revenge if the test become HIV positive. In general, 714(92.2%) of the respondents reported they need to have VCT.

This study also assessed, how to support and arrangement that need to be made for those who live with HIV virus, accordingly 285(36.8%) reported to encourage them to join Tesfagoh, and 126(16.3%) to provide treatment and access to antiretroviral drugs and 179(23%) suggested to organize them locally while 193(24.9%) claimed it is their fault and let them solve.

Table 6 Attitude and Willingness to VCT by youth, Assebe Teferi, December 2003

Variables	Number	Percent
Having VCT information		
Yes	685	88.50
No	89	11.50
Thinking advantage/disadvantage of having VCT which weigh		
Advantage	738	95.30
Disadvantage	36	4.70
Advantage of having VCT		
To maintain our health	509	65.80
To limit HIV/AIDS transmission	192	24.80
To take revenge if test reveled positive	2	0.30
Don't know	71	9.20
Willingness' to have VCT		
Yes	714	92.20
No	60	7.80
What need to do for those whose test becomes positive?		
Encourage to join Testator	285	36.80
Have to provided treatment and means of prolonging life	126	16.27
It is their felt and let them safer	184	23.77
Organize them locally at their residence area	179	23.13
Other		
Discussing with parents on HIV/AIDS and VCT.		
Yes	418	54.00
No	356	46.00
Total	**774**	**100**

Regression analysis

Regression analysis of possible explanatory variables over the reproductive health problems was carried out, while controlling the effect of possible confiders. Accordingly, sex, age, marital status, having pocket money and substance use have shown to have statistically significant association with Risk RH Behaviors. Male group (OR= .35, 95% CI: .22, .59), age category 15-19,

(OR= .48, 95% CI:(.29 ,.59), Marital status unmarried (OR= .21, 95% CI(.11,.39) and being not substance user (OR=.33, 95%CI(.21,.54) were independently and negatively associated with risk reproductive health behavior. But having pocket money (OR= 1.7, 95% CI: 1.11, 2.75) was independently and positively associated with risk reproductive behavior. The same table indicates that the rest of the variables do not have significant association

Table 7. Logistic Regression analyses of possible explanatory Variables over Youth risk reproductive behavior, Assebe Teferi, 2004.

Variables	Total No	Risk RH Behavior %	Crud OR (95% CI)	Adjusted OR (95% CI)
sex				
Male	375	14	.66 (.58, .76)	.35 (.22,.56)
Female	395	33	1	1
Age				
15-19	490	14	.52 (.44, .62)	.48 (.29, .78)
20- 24	284	35	1	1
Marital status				
Not married	668	15	.14 (.10, .21)	.21 (.11, .39)
Married	106	76	1	1
School enrolment				
Enrolled	735	22	.42 (.23, .77)	.53 (.22, 1.23)
Not enrolled	39	41	1	1
Religion				
Christian	518	23.17	1.01 (.84, 1.37)	.99 (.63, 1.56)
Muslim	256	21.48	1	1
Living with				
Parents	483	17	.59 (.49, .72)	.96 (.59, 1.55)
Relative/other	291	29	1	1
Occupation				
Student	503	13	.43 (.37, .52)	.77 (.46, 1.25)
Unemployed/other	271	40	1	1
Pocket money				
Yes	282	20	1.55 (1.30, 1.85)	1.7 (1.11, 2.75)
No	492	18	1	1
Substance use				
No	344	13	.66 (.59, .74)	.33 (.21, .54)
Yes	430	30	1	1

Focus Group Discussion Summary Result

In this study, 12 specific questions were prepared under four major headings. These include problems associated with sexual characteristics, substance use, attitude and practice of utilizing existing HI for RH need, and matters related to VCT.

The group discussion was started with the general question whether the discussants perceive problems associated with sexual characteristics as major health problem or not. From four FGD, 2 of males and 2 of females, the two female groups suggested that having more than one partner, not using condom and premarital sex, as major reproductive health problems, while male groups perceived it as, not using condom, having intercourse with commercial sex worker as a major problems. Female group came to a consensus that almost all women once reached to puberty had sexual partner on average at age 15. They also indicated that, males of the same age used to start sex later than female of the same age, and they justify this, because females are continuously asked for sexual relation by a number of males once she reached to puberty and some times harassed for delayed and negative reactions. In addition to these they indicated that, female were invited by well-matured and older men (sugar daddy) and cheated. There were also older pear of the same sex usually pressurize the younger one to commence sex. Both groups indicated as males are a cause for multi partner, because they consider rejecting of the previous and having other as fame. In the contrast to this one of the male focus group discussant aged 22 and 11 grade student suggested, females are usually

looking for male who at better status and could fulfill her cosmetic needs. Finally, all group members indicated the time is too risk and need to be faithful or abstain if possible. As it was revealed on the discussion of substance use, they said having khat considered as a sign of disciplined person. They believe that having khat made them to stay at home and enable to work hard. They perceived that Khat has strong association with other substance once used together. Three of FGD believe as chewing is means of working hard if used at appropriate dose, while one of the group claims its health effect could be pronounced latter. All group claimed that smoking and alcohol as well as shisha were used by fewer number of youth , because they are something imported, man made, and have health effect and relatively expensive. They also believe that, it is alcohol consumption that had strong positive association with sexual desire, and as if khat had less association. The male groups suggested that, Khat chewing resulted in sexual unfitness but it increases desire." one of the Focus Group discussant who was attending 12 grade and at age 24 , said " yekamku ken kashinti gar yesimet fesashe yifesal, neger gin andu guadenyaye keqaamin buhuaala mengad lay qoomo lafitwatasigaaw ishii yemitlawen lamagnyet iska ikula laliit qoomo yitabikal." this mean , he said "it is the usual for me to ejaculate while I used to urinate after I chewed , in similar way, he said, I had male friend who always after chewing, stand on the road, looking for any volunteer girl until the mid night, despite whom ever she is, to get his sexual relief.

On discussion of their attitude to utilize existing HI for RH need, female groups came to the consensus that, there were no health institutions to deliver organized YRHS , it was like any client youth get access to general health service. All group said they fear to raise

RH matter at government HI, the reason was, there were no specified person to give the service and it lacks confidentiality.

They also discussed on the source of YRHS information, and reported were getting it from mass media and informal information from pears. In addition to this they indicated that there was anti AIDS clubs that deliver HIV/AIDS matter through pear education and it lacks other reproductive health information.

The groups were invited to discuss the most feasible method of preventive measure for HIV/AIDS infection and willingness to have VCT. Both sex of the younger age group reported to be one to one, while the older group member preferred condom, as a faithful partnership lacks among youth. The younger group indicated that problem in condom utilization were reduced pleasure, some time it gate erupted, not available in antecedent sex occasion and doubt of effectiveness

All group members reported they had VCT information. However, most of them did not aware VCT service existence at their local. However, they were willing to have VCT, providing the confidentiality of their blood test result. Even though the majority reported, there is discrimination of those living with virus in the community; they suggested the government and other concerned body should act on activities to avoid or reduce discrimination and also to institutionalize those who are living with the virus at local.

Discussion

Ethiopian youth are confronted with many challenges. Their reproductive health problems are multifaceted and interrelated. This study assessed magnitude of selected reproductive health problems (Sexual activity, Abortion, unwanted pregnancy, early marriage, STI), level of substance use, magnitude of factors that influence preference and utilization of youth RH services and awareness and willingness to voluntary counseling and test.

Distribution of socio demographic characteristic of the study population, male to female ratio was 1:1.06 and 63.30% of the respondents belong to age 15-19.Out of the total respondents, 95% were literate and 86.5% were unmarried. In this study, unlike the other similar study, rather than family income daily pocket money given to youth for an expense was assessed. This was done by assumption that it is very difficult to get appropriate estimation of their family income from the study group and also it is the amount of many to be spent by youth that may contribute to their reproductive health.

Out of the total respondents, 65% were the student, followed by 16.15% un employed, 5.3% house wife, 2.3% Government employee and the rest 11.20% were others..

As the assessment made on reproductive health problems, Out of 106 married respondents, 67% of them came to marital lock at age 13-18 and 15.1% at age less than 15 years with mean marital age 17.2 ± 2.4. This finding goes with other study that indicated 34% of the marriage was take place at < 15 (26). Further more it is indicated that, 8.6% of the marital lock were by abduction and 4.6% were with out the interest of the female. It was also revealed that almost 40% of the respondents were sexually active, out of which 66.47% engaged in premarital sex and 25.7% of them exercised first intercourse before reaching to age 15. When we see this with study done before, which indicated 84% of the study subjects became sexually active before age 15 and 19) (20), it not has much difference. In this study, 8.1%of the first intercourse were rape, 70 .8 % of unmarried sexually active group commence unsafe sex (not used condom) at first intercourse, this means, only 29.45 % of them were used condom. This figure indicates improvement in condom utilization at first intercourse in relative to previous studies findings (9).This improvement might be contributed either to health information through mass media or anti Aids club activity.

More than 50% of the sexually active group believe that their first intercourses were unsafe (not used condom), and it led more than 15%of them to acquire STDs, unwanted pregnancy, or School drop out. This

figure, clearly give an insight, how much the youth at the study area is in danger.

In this study, 25.7% of the sexually active group reported they were using modern contraceptive, while condom utilization rate at last intercourse was 63.2% among unmarried. As indicated by this study, Contraceptive use rate was found lower, when we see it with study done at nation wide that indicated 39% of the female were used pills (40).Similarly the finding by another study conducted in southern Ethiopia indicated higher contraceptive prevalence rate than this study. On the other hand, this study shows an improvement in Condom utilization among the youth, when we see it with other studies (20, 40).However there is an improvement in condom utilization, in the contrast with today's high rate of HIV transmission, it indicates high proportions of the sexually active group are at risk.

It was also revealed that, 9.4% of the sexually active group had the history of STD in the last one year prior to this study, out of which 2.3% were married. From 102 (33.22%) who were sexually active and reported unwanted pregnancy, 26.5% were aborted and 3.92 were preterm among unmarried.80% of abortions were among single while it is 20% among married.

In the study area, rate of unwanted pregnancy was high as compared to similar study done at Harer town (9).This might be contributed to better access to different health information sources and Youth health activity which lacks at this study area as indicated in FGD. Rate of abortion found to be lower than it reported in the other studies 74% and 45% (23, 32). Out of 67 respondents, who gave birth, more than 52% and 3% became the mother before reaching to age 18 and 15 years respectively with the mean age 18.73±2.13. These figures indicate that, more than 50% of the sexually active women aged 15 – 24 were at great risk of pregnancy.

The level of substance use were assessed considering as it is predisposing factor to youth reproductive health problems, consequently, 30.4% of the respondents were found to chew khat on daily base, followed by 29.1% Alcohol user, 10.5% Shisha smoker and 5% cigarette smoker. Chewing khat is very common in the study area, and 36.7% of the users claimed that they use it for better performance, while 46% of them were using because they were idle. As it was indicated in FGD, in this study area, using khat was considered as a social norm and sign of disciplined person, while Alcohol and cigarette users were considered as wrong practitioner

An assessment of the preference and utilization of youth reproductive health service revealed that, 36.7% of the youth preferred to be served in FGAE clinic, followed by Governmental Health Institution (31.8%). Among those who reported the existing health institutions were not

attractive for secret use of YRHS, 18.7% and 73.4% claimed of prolonged waiting for service, while 58.3%, 58.3%, 48.2%, 40.3% and 36% claimed of inconsistency of service delivery, embarrassments of youth when in need of service, in convenient of service time, fear of being seen by the parent and lack of confidentiality, respectively. All these factors could hold true in poorly structured and scares number of existing Health Institution, this was supported by FGD.

As per the assessment for the rearrangement of YRH services, 41% of the respondents preferred to have youth health service arrangement in existing Health Institution having its own unit, followed by 30% in separate, convenient area. More over, 58.4% of them preferred service time to be in normal working hour, while 41.6% preferred to be in the absence of other users.

In the other aspect, 57.4% of the respondents preferred service to be free of charge, and 36.7% of them preferred young and of the same sex service provider. In our context, to be young and of the same sex may create comfort to youth to tell their health problems and feelings by considering they share common problems. Similarly, if the service is free of charge, it could make comfort to those who cannot afford, but those who can afford may prefer to be seen in other health institution.

Sexual education, family planning service, partners relation guidance, STD and HIV/AIDS information and education and YRH information and reading center were preferred to be rearranged.

Willingness to VCT and attitude toward HIV /AIDS victims are another important parameter that have relevance to promote and maintain youth health. In this regard, youth attitude and willingness to voluntary counseling and test were assessed and it revealed that, 88.5% of the respondents had information about VCT and 95.3% believe, VCT advantage weigh its disadvantage. Further more, 65.8% of them know that to have VCT helps to know self-status and to maintain their health, consequently, 92.2% of the respondents reported that they need to have VCT.

This willingness most probably contributed either to mass media or Anti AIDS Clubs activity and VCT project launched in this study area by CARE Ethiopia. There are 4 functional Anti AIDS clubs and one Drama and Theater team that are run by youth program funded by CARE Ethiopia. There are also pear education program that run by CARE Ethiopia .Their service includes, condom distribution, pear education session with prepared guideline by CDC and care. However, this program lacks activity targeted to minimize HIV patient discrimination, certainly, it is contributing invaluable share in youth health, particularly on HIV/AIDS prevention and behavioral charge of the youth.

This study also assessed what need to rearrene for those who live with HIV virus, in which case more than 36% of the respondents suggested to encourage them to join Tesfa Goh Ethiopia, While 179 (23%) of them indicated to organize them at the local, followed by 126 (16%) who preferred to arrange means of treatment for opportunistic diseases and antiretroviral drugs.

In the reverse, 193(18%) of the respondents had negative perception and they said it is their felt and it is up to them to solve or suffer. This indicates HIV patients' discrimination is high at the study area.

Today one of the great problems in HIV/AIDS prevention, which remain difficult, is lack of open discussion between the parents and their children. In this study, 46% of the respondents reported that they had no discussion on HIV/AIDS mater. This indicates, the role of parents' infighting with HIV/AIDS was not given emphasis both by Government as well as those organizations working on HIV prevention.

Finally, to establish an association, Logistic regression analysis was employed on possible explanatory variables over risk reproductive behaviors. Accordingly, male group (OR= .35, 95% CI: .22, .56) was found to be independently and negatively associated with risk reproductive behaviors. This means that, being females have more risk

reproductive behavior than males of the same age. This could be true, because, females culturally suffer from early marriage, naturally from unwanted pregnancy, early child bearing, from abortion and its complications, in addition to STDs, not using condom, and multi partner, which also hold true to males. Similarly, being younger age 15 – 19 (OR =.48, 95% CI: .29, .78) and Marital status, not married (OR=.21, 95% CI: .11, .39) and non substance use (OR=.33, 95% CI: .21, .54) have shown to be independently and negatively associated with risk reproductive behaviors. While having pocket money (OR=1.7, 95% CI: 1.1, 2.7) found to be independently and positively associated with risk reproductive behavior.

As it was revealed by Logistic regression, the younger age group was les at risk as compared to the older age. This could be contributed to the fact that as age increased there is more physical maturity and more sexual desire and sexual exposure, most probably having multi partners. Similarly, being not married found to be protective relative to the Married one. This could be, because of the fact that more of the youth became to the marital lock at early age with out plan and interest. Moreover, despite too earl and successive child bearing, low access to quality maternal health and comprehensive family planning contributes too much. As it was indicated above, being a substance user has association with risk reproductive behaviors. This might be holding true, because of the

reason that when the substances were used, sexual desire could increase and ability to rationalize decrease, as it was supported by focus group discussion. Like wise, having pocket money has shown to have positive association with risk reproductive behaviors. This can be explained by the fact that in these study area, parents are usually giving money for their youth, specifically to use it to have Khat. This intern might lead them to sexual activities that could be resulted in complication, but this do not mean it always hold true that having pocket money associated with risk reproductive behavior.

STRENGTH AND LIMITATION OF THE STUDY

Strength

- Ethical clearance from AAU, necessary arrangement with concerned body and verbal consent from study subjects were obtained.
- Data collectors who have had experience were used, and similar sex interviewers were employed.
- Qualitative data were collected to compliment the study.
- For better validity of the test, appropriate test static's were done.
- Confidentiality of the responses were maintained.

Limitation

- Measurement of the indicators were retrospective self reporting of behaviors, which is difficult to get all in all the write responses, however, we believe that the respondents persuaded as much as possible to give the write response.

- Shortage of recently conducted studies limited me to made comparative discussion.

Conclusions

Bearing in mind the limitations of the study, it is possible to conclude the following:-

- Considerable proportion of the youth exhibited high risk reproductive behaviors that predisposed them for reproductive health problems. The risk behaviors include, premarital sex, multiple sexual partners, early sexual activity, in consistent or non use of condom.
- Females were relatively more at risk reproductive behavior as compared to males of the same age.
- Older age group was found to be more at risk as compared to the younger age.
- Level of the substance use was found high among the youth and the majority of them engaged in risk reproductive behaviors.
- High figure of the youth not served in the existing health institution for their reproductive health need, even those who used to be served, they claimed that the existing health institutions were inconvenient and unattractive.
- Almost half of the respondents preferred the need for rearrangement of youth reproductive health institutions separately, and also to be served by young and the same sex health providers.
- Family health service, sexual education, partner relation guidance, information and education on STD/HIV AIDS and to have information center were preferred almost by all respondents.
- Almost all respondent have VCT information, and need to have it.

- Most of the respondents reported to encourage those who live with HIV virus to join Tesfagoh Ethiopia, or to organize them locally and to arrange means for opportunistic disease treatment and life prolonging drugs.
- Misconception on those living with HIV virus was high.

Recommendation

- Strategies should be developed to enhance female self reliance, in order that, they will have decision making power to say no to sex as well as able to negotiate for condom use.
- Both Governmental and non governmental organization that working in the area should have to invest on facilitating youth friendly health services with out long dalliance, since high proportion of youth are at grate risk in this HIV era.
- The older age group relatively at risk than the younger age group, therefore, youth association should be considered as one of the strategy to get them easy.
- High proportion of respondents need to have VCT service, therefore, strategies should be careful designed to mobilize youth and to welcome to the services.
- Advocacy and education on the interaction of substance use and risk reproductive behaviors should have to be addressed.
- Those existing anti AIDS clubs should have to work in minimizing discrimination.

- CARE Ethiopia should have to expand his today's youth health coverage both geographically and in the type of programs, and further should have to strength already launched urban activities.

- Finally, what more important is building strong social support for the youth, form youth, from general community, particularly families, religious leaders, school teachers, health provides and administrative bodies. Orienting these groups on youth specific reproductive problems and persuading them to actively participate in the intervention programs and approve the sexual needs and services as a social norm rather than limiting to the individual youth calls for special attention.

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Annex 1

This is a questionnaire for assessment of youth reproductive health problems and service preference at Assebe Teferi, West Harareghe.

Introduction: I am _____Working as date collector in this study that assess youth reproductive health problem and service preference at Assebe Teferi, West Hararghe, that to run by Addis Ababa University, Department of Community Health in collaboration with CARE Ethiopia. On this questionnaire your name will not be written and I am going to ask some questions that touch personal life and secrets, in which all your answers kept completely confidential. In this study, interview will be made to youth aged from 15 to 24 who reside in Assebe Teferi and selected to be interviewed.

You do not have to answer any questions that you do not want to answer; even you may end this interview at any time you want too. How ever, your honest answers to those questions will help us better understand youth reproductive health problems and service preference for developing strategies and organizing future youth health service. We would greatly appreciate your truthful and keen participation in responding to this questionnaire.

Identification Number

001 Kebele _____

002 Ketena _____

04 House Number _____

005 Code Number _____

006 Date of interview _____

007 Interviewer name _____

008 Supervisors _____

Part I. Socio Demographic characteristics

No	Questions	Coding categories	Skip to
101	Sex of respondents	Male 1 Female 2	
102	How old were you at your last birthday?	-Age in completed years_____ - Don't know 88 - No response 89	
103	Have you ever attended the school?	Yes 1 No 2	105
104	What is the highest level of education you completed?	Only read and write 1 1 to 6 grade 2 7 to 10 grade 3 11 to 12 grade 4 Above grade 12 5	
105	What is Your current marital status?	Unmarried 1 Married 2 Divorced 3 Widowed 4 No answer 5	
106	What is your religion?	Orthodox 1 Catholic 2 Protestant 3 Muslim 4 Other (specify)	
107	To which ethnic group do you belong?	Oromo 1 Amhara 2 Tigirie 3 Gurage 4 Other specify 5	
108	Whom do you live with?	With father and Mother 1 With mother only 2 With father only 3 With relatives 4 With friends 5 Other specify 90	

109	What is Your occupation?	Student 1 House wife 2 Un employed 3 Merchant 5 Government employee 6 Working in the family business 7 Other specify 90	
110	What is your current source of income, if you are unemployed?	- humanitarian organization 1 - Relative 2 - Spouse 3 - Friends 4 -Parents 5 - Others specify 90	
111	What is your parents' job status?	-Both work outside of home 1 -Only my father works 2 -Only my mother works 3 -Both do not work 4	
112	Do you get pocket money for your daily expense?	Yes 1 No 2	201
113	How much pocket money do you get on average per day?	Les than Five birr 1 5 to 10 birr 2 10 to 20 birr 3 Other specify_____ 90	

Part II. Magnitude of selected reproductive health problems

No	Questions	Coding categories	Skip
201	How old were you at your first marriage?	_____	
202	How did your marriage take place?	Kidnapping 1 Only by interest of men 2 We agreed to marry 3 By our parents agreement 4 No response 89 Other specify 90	
203	What was your educational level during your first marriage?	Not attended School 1 Only reading and writing 2 Grade 1 to 6 3 Grade7 to 10 4 Grade11 to 12 5 Don't know 88	
204	Have you ever had premarital sexual intercourse?	Yes 1 No 2	301
205	How old were your, when you had your first sexual intercourse?	_____	
206	How were you exposed to 1st exual intercourse?	By my interest 1 By pear pressure 2 I was cheated 3 I was raped 4 On my marriage 5 Don't known 88	
207	Did your first sexual intercourse was protected (were you used condom)	Yes 1 No 2 Don't know 88 No response 89	
208	Which of the following consequence you faced from your first sexual exposure?	STDs …… 1 Pregnancy … 2 School drop out 3 Nothing was happened 4 No response 89	
209	How many sexual partners you have had in the last one year?	_____	
210	Have you ever used any of modern contraceptives?	Yes 1 No 2 Don't know 89	

211	Have you used condom in your resent sexual intercourse?	Yes 1 No. 2	
212	Have you had any of STD symptoms during the last one year?	Yes 1 No 2 Don't know 88	
213	In your sexual relation ship with any of your partner, have ever been pregnancy happened?	Yes 1 No 2	301
214	If yes to question 213, haw did the pregnancy get end?	It was aborted 1 Preterm 2 Live birth 3 Don't know 4	
215	Have you ever gave a birth?	Yes 1 No 2	
216	What was Your age when You first gave a birth?	Age in year_____ Don't know 1 No response 2	

Part III. Level of substance use

No	Questions	Coding categories	Skip
301	Do your parents chew khat?	- Only father 1 - Only Mothers 2 - Both chew 3 - Both not chew 4	
302	Do you chew khat?	- Have never chewed 1 - Chewing once in month 2 - Chewing weekly 3 - Chewing daily 4 - Only on holy days 5	304
303	Why do you chew khat? (You can choose more than one choice).	- For good performance 1 - To spent time 2 - For social purpose 3 - Peer influence 4 - There is no work to be done 5 - It is considered as a culture 6 - I can't work unless I chew 7 - It has nutritional value 8 - Other specify 90	
304	Do your parents smoke cigarettes?	- Only fathers 1 - Only Mothers 2 - Both smoke 3 - Neither of them smoke 4	
305	Do you smoke cigarettes?	- Have never smoked 1 - Smoking on holydays 2 - Smoking once a week 3 - Smoking daily 4 - Only when I take alcohol 5 - Other Specify 90	307
306	Why do you smoke cigarette?	- Because I was addicted. 1 - To get relief from stress 2 - For good performance 3 - To meet pear norm. 4 - Other specify 90	

307	Do you smoke Shisha?	- Have never used 1 - Smoking with alcohol 2 - Smoking with chewing khat 3 - Smoking Daily 4 - Other specify 90	309
308	Why do you smoke Shisha	- It enhance stimulation 1 - Because it is a fashion 2 - For social purpose 3 - It helps as appetizer 4 - Other specify 90	
309	Do you drink alcoholic drinks like Tela , Taji, Areke, Beer and the likes ?	- Have never drunk 1 - I drink it on holidays 2 - Always after chewing 3 - On weekly base 4 - Daily 5 - Other specify 90	311
310	Why do you drink alcohol?	- To get pleasure 1 - I was addicted 2 - After I chewed khat, to get sedated from khat stimulation 3 - It is good for health 4 - Other specify 90	
311	How do you feel about your sexual desire, after you chewed Khat?	- Increase than the usual 1 - I do have les feeling 2 - No difference than usual 3 - I don't know 88 - No response 89 - Other specify 90	
312	How do you feel about your sexual desire, after you drink Alcohols?	- Increase than the usual 1 - I do have les feeling 2 - No difference than usual 3 - I don't know 88 - No response 89 - Other specify 90	

Part IV. Factors Influencing Utilization of RH service among youth

No	Questions	Coding categories	Skip
401	Do the existing Health Institutions are convenient to the secret use of youth reproductive health service.	- Yes 1 - No 2 - do not know 88	
403	Do the existing health institutions are well coming when you need the service.	- Yes 1 - No 2	501
	If No to Que. 403, please answer Yes {write 1) or No (write 2) to the following possible factors.		
404	Health institutions are located at far distance.		
405	Fear of being seen by patents or others who know them.		
406	Health professionals are Judgmental towards youth RH needs		
407	Lack of confidentiality		
408	Youth get embarrassed at needing reproductive health service.		
409	Inconveniency of service delivery time.		
410	Health service fee is expensive.		
411	Long waiting time for service.		
412	In consistence of service delivery		

Part V. Preference and utilization of Health Service

No	Question	Coding pattern	Skipping
501	In which of the following health institution do you think youth reproductive health service is given better?	- Government health institute 1 - Private health institute 2 - FGAE Clinics 3 - School Clinics 4 - Other Specify 5	
502	Are you utilizing in the existing health institution for your reproductive health need?	-Yes 1 -No 2	
503	In which of the following health institutions do you prefer to be served for your reproductive health need?	-Government 1 -Private 2 -FGAE clinic 3 -by none licensed provider 4 -Other specify 90	
504	In which of the following way do you prefer youth reproductive health service to be rearranged ?	-Within the existing health institution as it is 1 - No need to give special attention 2 -Within the existing health institution having its own youth reproductive health service rooms. 3 -In health institute that arranged for Youth reproductive health 4 -By expanding Youth reproductive health in youth center 5	

		-Other specify._____ 90	
505	Which time do you think it is convenient for youth health service?	-In the usual health institute working hours 1 -In the hours when other users are not around 2 -Other specify 90	
506	What do you prefer on service fees for youth?	-At usual rate 1 -With discount for youth 2 -Free of charge 3 -Other specify 90	
507	Whom do you prefer to be youth reproductive health provider?	- Young provider of the same sex 1 - Young provider of any sex 2 - Adult provider of the same sex 3 - Any provider could be 4 -Other specify 90	
508	Where do you prefer youth health service to be located?	-Any where out of resident area 1 -In the center of the town 2 -At one end of the town 3 -Other specify 90	

Type of RH service to be preferred

Services	Yes	No	I don't know
I would like to have sex education			
I would like to have family planning service			
I would like to have partner relation guidance			
I would like to have an information and education on STDs and HIV AIDS			
I would like to have youth health information center			

Part VI. Awareness and willingness to Voluntary Counseling and Testin

No	Questions	Coding pattern	skipping
601	Do You have information on Voluntary counseling and testing?	Yes 1 No 2	
602	Which of the following is hold true about VCT?	Its advantage weigh 1 Its disadvantage weigh 2	
603	What do you think as an advantage of voluntary counseling and testing?	-It can enable us to maintain our health once our HIV status is Known 1 - It can enable to interrupt HIV/AIDS transmission 2 - It do not have any advantage 3 - It can enable to take revenge 4 -Don't know 88	
605	Are you interested to have voluntary HIV counseling and testing service?	Yes 1 No 2 No response 89	
606	What do you think, it need to be rearranged for those whom their blood test become HIV positive?	-Should be encouraged to join Tesfagoh Ethiopia 1 - It is better to keep them in prison 2 - Should be provided with means of treatment for opportunistic disease and antiretroviral drugs 3 - Its their felt, and let them look for solution 4 -It is good to organize them at local 5 -No response 89	
607	Do you ever used to discuss with your parents on HIV maters.	-Yes 1 -No 2	

Annex 2 English FGD Guide

Introduction

Good morning! Well come to our group discussion**.**

My name is **----------** and I work for ---------- & I come from ----------. We are here today to discuss a bout youth reproductive health problems and service preferences. There is no right or wrong answers. All comments, both positive and negative, are well come. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up every thing. We would like to confirm to you that all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion? If yes,

Thank you fro your willingness.

10 Specific research questions are arranged under 4 major hading. These are

1) Problems associated with sexual characteristics
2) Substance use
3) Attitude and practice of utilizing the existing Health Institutions for RH need.
4) Matter related to VCT and HIV /AIDS

1. Problems associated with sexual characteristics.

Do you think problems associated with sexual characteristic are a major health problem of youth or not? Why? How? Let discuss.

Probe: What are they?

Probe: who is most likely to suffer (age, sex, behaviors)?

Probe: what do you think a solution?

2. Substance Use

Do you think majority of youth currently use substances? Why?

Probe: which of the substances most used here? Why?

Probe: to discuss on the association between the substance and risk reproductive behaviors.

Probe: their sexual filling when used the substance, even to give examples.

Probe: is it not possible to stop using? Why?

3. Health service

Do the existing HI deliver youth reproductive HS? Who deliver it? Is the service is organized?

Probe: major problem / accessibility, confidentiality, attractiveness, service providers, payment /

Probe: to suggest how Youth friendly RH need to be rearranged.

4. Matter related to VCT

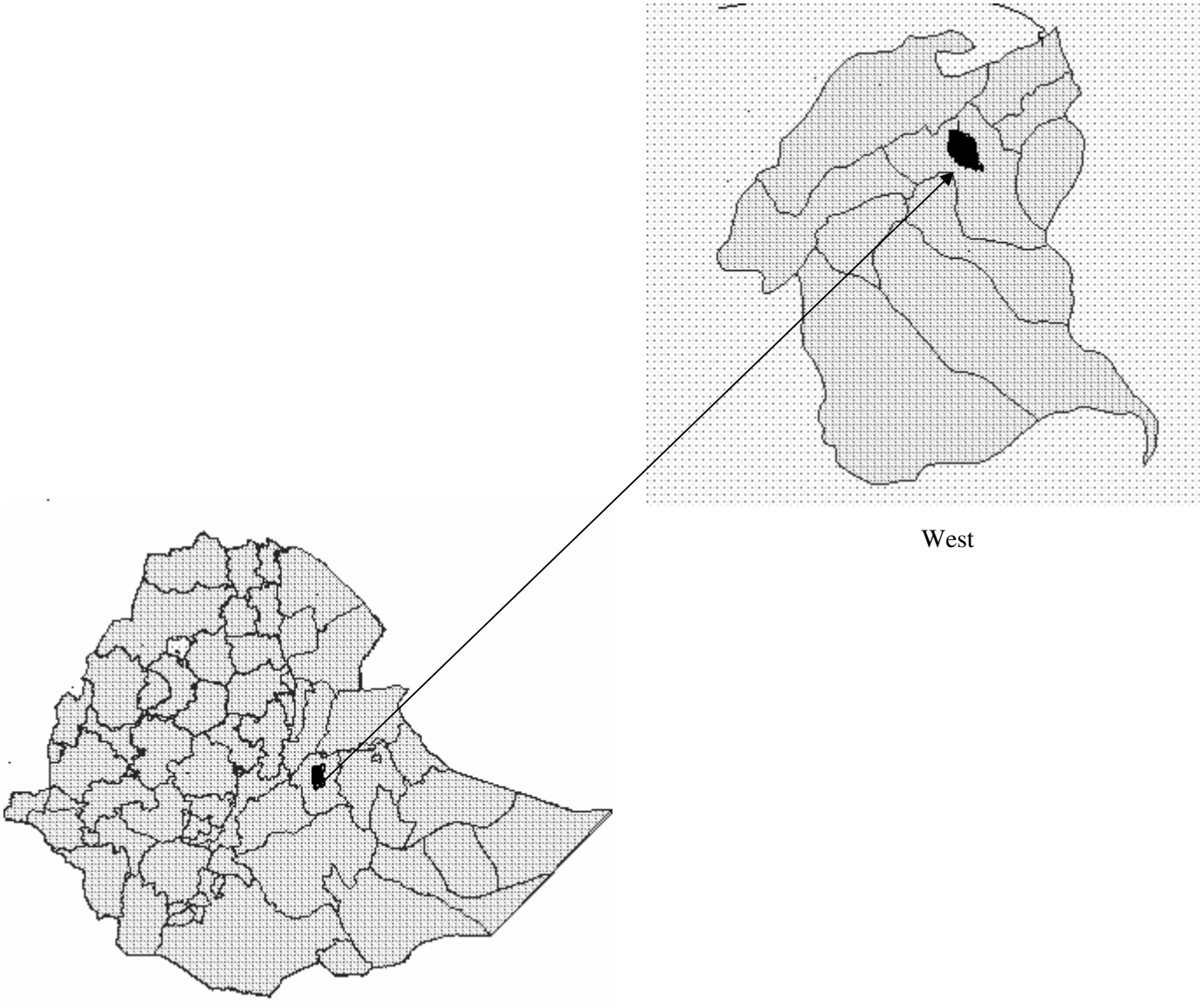
Do you have any information about VCT? Does the service available in your area?

What arrangements need to rearrange for those who live with the virus?

Probe: from where do you get information about it? ,

Annex 3.

Map showing the study area in relation to the national and Zonal, as it indicated by black spot



West

Ethiopia