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ASSESSMENT OF THE REPRODUCTIVE HEALTH NEEDS OF HIGH SCHOOL STUDENTS IN HOSSANA, ETHIOPIA

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LIST OF ABBREVIATIONS

AAC-Anti-AIDS Club

AAU-Addis Ababa University

AIDS-Acquired Immune Deficiency Syndrome

ARH-Adolescent Reproductive Health

DHS-Demographic and Health Surveys

FDRE-Federal Democratic Republic of Ethiopia

HIV-Human Immune deficiency Virus

IRB-Institutional Review Board

ICPD-International Conference on Population and Development

IEC –Information, Education and Communication

MOH-Ministry of Health

NGOs-Non Governmental organizations

OR-Odds Ratio

RH-Reproductive Health

SNNPRG-Southern Nations, Nationalities, and Peoples Representative Government

SPSS-Statistical Package for Social Sciences

SRH-Sexual and Reproductive Health

STD-Sexually Transmitted Disease

STI-Sexually Transmitted Infection

USA-Untied States of America

VCT-Voluntary Counseling and Testing

WHO-World Health Organization

ABSTRACT

Background

Sexual and Reproductive Health problems that the young people are facing are not localized to one geographic location or one part of the world. Worldwide, 15 million adolescents experience pregnancy each year. Since most of these pregnancies are unwanted, young women tend to have induced abortions, whether legal or not. Moreover, half of new HIV infections are observed in the 15-24 age groups. On top of this, studies about STI in adolescents show that the incidence is increasing. Today, each year, one in 20 adolescents suffers from an STI other than HIV (1).

Objectives and methods

A cross sectional institution based study was conducted to assess the reproductive health needs of high school students in Hossana Town. 422 study subjects were identified by using multi stage sampling method. Data was collected using structured questionnaire, entered and analyzed using EPI info and SPSS statistical program respectively.

Results

About 35.8%, of the respondents had experienced penetrative sexual intercourse and 59.5% of the respondents reported that their first sexual intercourse had been unplanned. About 16.9% of the respondents have more than one sexual partner. Among sexually active students, 45.7 % had used condom during their first sexual intercourse as a means of preventing pregnancy and/or STIs including HIV/AIDS. Majority (70.4%) of sexually active female respondents have ever been pregnant out of which 52.9% of them had induced abortion.

Conclusion

In spite of the students need to get SRH services, the school clinics are not providing their services adequately. The health service delivery system should consider the special needs of youth and work out comprehensive and effective policies and strategies to provide young people with the services appropriate to their needs.

1. INTRODUCTION

1.1 Background Information

Youth represent one of the main pillars of any society. Recent estimates indicate that 17.0% of the global population, 20.0% of Sub-Saharan Africa and 17.9% of Ethiopian population is composed of youth aged 15-24 years. In addition, 85.0% of the 1.2 billion adolescents worldwide live in developing countries and comprise over a quarter of their population. Globally the young are facing different SRH problems like unwanted pregnancy, unsafe abortion, STI including HIV. But people who are young are usually mistakenly perceived as healthy and as if they are not in need of special health services (1).

Young people face a realm of challenges during their transitional years and need information, skills, opportunities, and services to make healthy choices. Meanwhile, health service providers and caring adults also need information and skills to address young peoples' concerns and support them in their effort to maintain their health. With youth becoming an increasing percentage of the population, this is a growing concern in the public health field. Today, youth between the ages of 15 and 24 make up 50% of new HIV infections with an estimated 6,000 youth being infected every day. 70,000 adolescent girls die each year from pregnancy-related complications. Different cultural norms around the world lead to early marriage and childbirth, early age of sexual debut, a lack of communication between adults and youth, and limited access to reproductive health services (2).

Ethiopia is a nation of young people – over 65% of its population is under 25 years of age and a nation whose youth have profound reproductive health needs. Among the many sexual and reproductive health problems faced by youth in Ethiopia are gender inequality, sexual coercion, early marriage, polygamy, female genital cutting, unplanned pregnancies, closely spaced pregnancies, abortion, sexually transmitted infections (STIs), and AIDS. Lack of education, unemployment, and extreme poverty exacerbates and perpetuate the reproductive health problems faced by Ethiopian youth (3).

Young people in Ethiopia also disproportionately suffer from the country's unsustainable population growth. Ethiopia's population of 71 million is projected to increase to 173 million by 2050, becoming Africa's second most populous country after Nigeria. This rapid population increase will strain the government's ability to provide health care and education to young people and create conditions for even greater unemployment, poverty, and unrest. Besides unsustainable population growth, the specter of AIDS hangs heavy over Ethiopian youth. HIV prevalence is 6.6% in the adult population and a large proportion of new HIV infection occurs in young people under 25 years of age. A sign at the entrance to Addis Ababa University proclaims "Get Addis Ababa University Degree, Not HIV Positive Certificate (4, 5, 6).

Young people, having survived all childhood health problems, have been enjoying a relatively low morbidity and mortality period in the past. At present, due to changing conditions due to civilization, urbanization and life style, the health of adolescents is increasingly at stake. Sexually transmitted diseases, HIV/AIDS and other reproductive health problems are the greatest threats to their well-being. However, despite the growing needs, there is no adequate health service or counseling specifically suitable for this specific age group unlike children, mothers or adults (7, 8, 9).

Factors for youth vulnerability to sexual and reproductive health problems are several and complex, i.e. lack of awareness and lack of correct information about the risks of unwanted pregnancies and STIs are more common among this group. Peer and other social pressures, lack of skills needed to resist such pressures and to practice safe behavior, lack of youth-friendly sexual health and counseling services, poverty, traditional/cultural norms that give young women a low social position, and little power to resist persuasion or coercion into unwanted sex predispose them to many risks (10).

In Ethiopia where approximately 40.0% of the population falls between the ages of 10-29 (11), a considerable proportion of the youth practice unsafe sex and sex at early age (12). This was evidenced in the study conducted among high school students in Addis Ababa, young students in Gonder University, youth aged between 15 and 19 years in Harar town and Jimma where more than 30.0% of the study population were sexually active (13). Besides, knowledge of the youth about the modes of HIV prevention was found to be low. For instance, only 37.0% of women and 63.0% of men in this age category know that one can protect himself/herself from HIV by using condom consistently (14).

Adolescent reproductive health issues were given particular attention after the 1994 ICPD carried out in Cairo. Ethiopia was one of the countries that have agreed and signed the ICPD program of action. However, most sensitive issues like special health needs of youth were not properly addressed in the health policy. Health services that exist in the country mainly provide services for adults and children and youth friendly services are not existent. Though there are very limited number of studies conducted based on school adolescents and street youth, most were carried out in bigger urban centers. To date, little is known about the sexuality of school youth, in general the reproductive health behavior of this group, whether they have access to health services and information and, if so, to what extent (15, 16).

1.2. Statement of the problem

Ethiopia is one of the highest-ranking countries in reproductive health risk worldwide with a maternal mortality rate of 1800 per 100,000 deliveries; trained personnel attend only 6 percent of birth and 42 percent of pregnant Ethiopian women have anemia. Besides almost in all of the countries rural areas, no clinical services tailored for young adults in the public sector though young adulthood is a newly acknowledged life phase in many regions (17).

Generally, the youth Reproductive health issue in Ethiopia is characterized by the following:

- There is great difficulty for unmarried adolescents in accessing to reproductive health services.
- Most of the adolescents are too embarrassed to attend an open family planning or reproductive health clinic and they anticipate the negative attitudes they will experience from clinic staffers.
- Teenage pregnancies and adolescent ignorance of their sexuality and their reproductive right.
- Young women who become pregnant will be shunned by their parents and forced to leave home
- Schoolgirls who become pregnant rarely return to school whether they are married or not.
- After pregnancy women's decisions is mostly influenced by male partners.
- Negative cultural practices coupled with poverty have a devastating effect on ARH of young women and sexually Transmitted infections (STI) are another challenge for young people in the country. And the problems will become aggravated if further actions are not taken (17). As a response to the above-mentioned problems, this study seeks for potential solutions as to how the problems can be minimized (if not alleviated) through creating public awareness on youth reproductive health. Besides, it shows direction for providing SRH services that can address the SRH needs of the students.

2. LITERATURE REVIEW

Reproductive health is a major concern of the young adult period, in part because young women are reaching menarche earlier and, in some countries, marrying later. As a result, a significant number of adolescents of childbearing age around the world are sexually active, and an increasing proportion of sexual activity is occurring outside of marriage (10).

It is undeniable that today's youth face more complex dangers than previous generations did. By and large, in-school youth specially reside in a separate compound and are usually away from their parents, which may expose them to many Sexual and Reproductive Health (SRH) problems even worse than other out of school youth. Moreover, in-school youth would have serious concerns in areas like love, relationship and physical health problems; academic and school related problems; and serious psychological concerns (18).

Adolescence is traditionally regarded as a period of relatively free of health problems (19).But health is clearly more than the lack of illness. That is, in addition to surviving it also encompasses thriving (20). Long-standing views of adolescent as period of optimal physical health and therefore topic undeserving of research attention have been challenged by recent empirical reports (21). The dramatic biological changes that accompany this transition are essentially the same as they have been for millennia, but the social context in which they occur is very different from earlier times and continues to change rapidly (22). Changes in the economic structure, the media and the community have all affected the way youth live and interact with peers and with the rest of the society. The reasons for this rising interest include an increased focus on education and concern about industrialization of developing countries, which has disproportionate impact on young people. Moreover, social environments like the existence or lack of favorable policies, attitudes and norms including religious and cultural beliefs; relations with family, friends, and other adults have important implications on youth health (23).

In addition to social changes that influence youth RH, there are several individual behavioral factors. Youth frequently participate in behaviors that place their health at risk or impair their social competence, often called risk taking or health compromising behaviors. Risk taking behaviors relatively common among youth include early and unsafe sexual activities, premarital sex, having multiple sexual partners, use of alcohol and drugs, violence and school underachievement and school dropout (24).

2.1. Sexuality of the youth

One of the most sensitive issues associated with youth is sexuality. They receive inadequate educational guidance and services that help them make the transition to adulthood. Often they are denied complete access to reproductive health information and services. With their limited knowledge about their bodies and their sexuality, they are vulnerable to sexually transmitted diseases and infections including HIV/AIDS, substance abuse, sexual exploitation and violence. Girls are further vulnerable and face higher risks due to their lower educational status and inability to negotiate on issues related to reproductive and sexual health (25, 26).

The lives of millions of youth worldwide are at risk because they don't have the information, skills, health services and support they need to go through sexual development during adolescence and postpone sex until they are physically and socially mature, and able to make well-informed and responsible decisions. The main issues in adolescence sexual and reproductive health include sexual development and sexuality including puberty, sexually transmitted diseases/HIV/AIDS and unwanted and unsafe pregnancies (27).

Initiating sexual activity is a natural transition made nearly by all humans. Nevertheless, it is not the occurrence of this transition but its timing and the circumstances under which it occurs that has significant implications. Young peoples' sexuality and its squeal is a major public health concern all over the world (28). Many young people engage in sexual activity before marriage and do so at early age often without any protection against pregnancy or STIs (15).

Health surveys and social studies conducted in different parts of the world, in recent years have indicated that, in many countries, most teenagers (60.0% to 70.0%) are sexually active (29). A study conducted in Nazareth high schools have showed that 24.0% of respondents reported having experienced sexual intercourse, with 60.0% reported having had their first sexual experiences between the ages of 15 and 16 years (15). The findings from out of school youth in Ethiopia have showed that the rate of sexual activity is relatively higher (42.0% to 55.0%) among out of school adolescents than high school students (16, 26, 30).

Sexuality is a pivotal component of adolescent development and the hallmark achievement of adolescent sexuality is the establishment of intimacy with another human being (27). No matter how much adults might like to ignore it, sex has great meaning in the lives of youth, whether they have had any sexual experience or not. Adolescents are becoming sexually active at increasingly earlier ages. It has been extensively documented that premarital sexual intercourse is relatively common in many industrialized nations, with the majority experiencing their sexual debut during their teen years. In untied states, for example, approximately 70% of women have had intercourse by the age of 18 years (20). In another study in the same country, 18% of 15 years old, 28% 16-year-old females are sexually active, representing increases of 24% and 34% respectively from the early 1970s (22).

2.2. Sexually transmitted infections and HIV/AIDS

The AIDS epidemic in Ethiopia is a generalized one, though the HIV prevalence rate in the general population is far less than in many other Sub-Saharan countries of Africa. Data from 34 sentinel surveillance sites across Ethiopia indicate a national adult HIV prevalence rate of 6.6% with an estimated 2.2 million persons living with HIV/AIDS in 2001.Ethiopia is now among the most heavily affected countries, with 10% of the world's HIV infections (the sixth highest in the world). The highest prevalence of HIV is seen in the group 15-24 years of age (12.1%). Data show that the number of females infected between 15-19 years is much higher than the number of males in the same age group. This discrepancy is attributable to earlier sexual activity among young females with older male partners (5).

Sexually transmitted diseases, including HIV/AIDS, pose serious threats for all sexually active people, but they constitute a particular risk to young people due to physical, psychological and social factors. Often, young adults do not understand how to protect themselves against sexually transmitted diseases. Because most societies frown on premarital sex, young people may be embarrassed to seek help and may be turned away if they do (31).

A more accurate indicator for trends of HIV infection may be STI rates, since behaviors associated with the acquisition and transmission of STIs are identical to behaviors associated with HIV transmission (16). As of 2001, an estimated 40 million adults and children around the world were living with the HIV and 28 million alone in Sub-Saharan Africa. The majority of new infections in the developing world are among young adults. Every minute, five people under 25 years are infected with HIV. Millions more have little or no knowledge of the disease and don't know how to protect themselves or take measures to prevent the spread of the disease (32).

AIDS challenges our ethical and moral foundations as no other disease has ever done (33). HIV/AIDS outranks every other disease as the top killer in Africa (34). The continent has lost nearly 15 million people to AIDS since the early 1980s. An estimated 860000 children in sub Saharan Africa had lost their teachers to AIDS in 1999, 51000 of them were Ethiopian children. In our country, out of cases officially reported to WHO in 1998, 5% (2% of males and 10% of females) were adolescents (35). This figure raised to 44 % among those aged 20-29. As the report from the MOH in 2000 indicated the peak ages for AIDS cases are 20-29 years for females and 25-34 years for males (36).

Family members lack appropriate information on the causes of HIV/AIDS and the risk faced by young people, especially girls. In addition, parents rarely discuss sexual matters with their children and how to avoid unsafe behavior. Families may promote discriminatory and harmful traditional practices involving adolescent girls that increase the risk of contracting HIV (37).

Denial remains one of the problems with regard to youth and HIV and AIDS. The assumption that HIV and AIDS is somebody else's problem is common. Perceived risk of encountering HIV and AIDS has been remained very low among youth. Lack of youth friendly facilities coupled with the stigma associated with HIV and AIDS discourage most youth from finding out their HIV status. Without adequate information and the requisite skills to protect themselves, youth are among the most vulnerable group susceptible to sexually transmitted infections (STIs) and HIV infection (37).

2.3. The practice of condom use

Studies widely report that condoms are understood to diminish sexual pleasure and are inconvenient to use (16, 38). Perceived negative consequences are among the most frequently reported reasons for nonuse in Ethiopia. Fear of reduced sexual pleasure and perceived unreliability of condoms because of presumed susceptibility to tearing and slippering off during intercourse have often been cited (15). Studies conducted in Afar (Dubti) and Eastern Gojam reported that 53.6% and 64.6% out of school youth do not use condom consistently and urban out of school adolescents used condom better than rural out of school adolescents during their last sexual intercourse in Eastern Gojam (1.3% Versus 30.6%) and in South Gondar none of them reported consistent condom use during commercial sex (16, 26, 39).

A study conducted among high school students in Addis Ababa revealed that only 43.2% of the sexually active ones knew about condom on their first coital encounter and a small proportion, 17.6% of them used it on their first sexual encounter (40). A study in northwest Ethiopia, found that 45.7% of rural high school adolescents were found using condom (41). Survey on out of school youths in Bahir Dar, revealed that 30.5% of youths were using condom (42). Similarly, a study on out of school youth in Awassa, revealed that only 27.6% of the sexually active adolescents used condom during their most recent sexual intercourse while their knowledge about HIV/AIDS was found to be 90% (43).

A recent study among out of school adolescents in Addis Ababa found that 57.2% study subjects reported having had used condom (44). Negligence, embarrassment in buying from shops and pharmacies, lack of knowledge about its importance and fear of reduced sexual pleasure are frequently mentioned in these reports as reasons for non use of condom (43, 45).

2.4. Contraception

Access to modern contraceptive methods is still sorely limited for adolescents, perhaps more importantly though, several cross-sectional studies reported inaccurate and low levels of knowledge about modern methods and relatively high levels of knowledge about methods for inducing an abortion. Many of the studies recommended improved sexual health education or family life education and the wider availability of Youth Friendly family planning services in places where young men and women congregate. The importance of these recommendations for the prevention of unwanted pregnancy cannot be overlooked; however, it is also necessary to address issues of legal and induced abortion among young people if we want to save lives. Intervention research that tests the operational effectiveness of new community-based programs and learning instruments will become even more salient in the future (46).

Young people, especially those unmarried, seldom use contraception. Sexually active single young people who have sex with a steady partner often claim that intercourse is not the result of premeditated or conscious decisions but just “happens”, so they are unlikely to be prepared with contraception . In addition, many young people have limited knowledge of contraception. Ability to name one or more contraceptive methods does not necessarily mean knowledge about use or source of supply. Many young men believe that the use of condom violates their beliefs, causes “weakness” or hampers sexual pleasure (47).

A study conducted to assess determinants of contraceptive use among urban youths in Ethiopia, reported that there is a large discrepancy between knowledge and actual practice of contraception. In this study the most widely (90%) known contraceptive method among sexually active male respondents was condom while pill was the most (87%) widely known among females. However, only 15% of males and 39% of females had used condom and contraceptives respectively. Most adolescents mentioned, fear of side effects, believe that pregnancy could not occur particularly at first coital encounter; partner opposed, and desire to have children to be the most important reasons for not using modern contraceptives (48, 49).

2.5. Early marriage, pregnancy and abortion

In developed countries the issue of early marriage is not the case. The trend over the past decades, in United States, has been towards increasing births outside marriage. In 1970, 30% of all births to adolescents occurred outside of marriage, this figure has now risen to 67%. In rural community in USA, 20% of girls became pregnant as teenagers and 12% were mothers before age 20 while in the suburban community there was virtually no adolescent child bearing (24).

To the young mother, pregnancy can be a health risk. A young woman is usually not ready for childbirth until she is at least 18 years old. Yet approximately 15 million young women ages 15 to 19 give birth every year, accounting for more than 10 per cent of all babies born worldwide. Pregnancy is much more dangerous for teenagers four times riskier than for 25 to 29 year olds. For girls aged 10 to 14, maternal mortality rates may be five times higher than for women in their early twenties, and their children are also more likely to fall sick or die in infancy. Biological and socio-economic factors, including physical immaturity, poverty, lack of education and lack of access to appropriate medical care, increase an adolescent's risk of pregnancy-related complications. Very often, young pregnant women face severe social problems. Many girls find themselves mothers on their own without responsible fathers for their child. Women who become mothers during their teens generally end up with less education and fewer job opportunities. This, in turn, exposes them to greater risk of poverty. In a minority of cases, this may also work the other way around: getting pregnant and being supported by a man can be a survival mechanism for a poor, uneducated woman (50).

One of the great health problems of adolescents is too-early pregnancy. Women in Algeria, Bangladesh, Ethiopia, Indonesia and Nigeria who become pregnant when aged 15-19 ran a greater risk of dying, sometimes twice as high as those in their twenties . Demographic health surveys of 11 Sub-Saharan African countries showed, in many cases, sexual experience precedes marriage. Early marriage is particularly common in Mali, Mozambique and Uganda. In Mali, 70% of young women first married before age 18. In all of the countries surveyed, more than one fifth of recent births were being reported as unintended. Similarly, in Ethiopia, unintended pregnancy was found to be 15% in Harar, 30% in Gondar and 50 % in Koladiba around Gondar (30, 41, 51).

A study conducted in Addis Ababa among youth reported that 50% female respondents were pregnant in the past, of which 74% end in illicit abortion. In another study conducted in southern Ethiopia, the lifelong prevalence of teenage pregnancy among adolescents was estimated to be 37%. Though these may not be representative, a study done to assess induced abortion and prevalence of STDs and contraceptive behavior among abortion cases in Gambella Hospital revealed that all of the induced abortion cases were less than 30 years of age. Similarly out of 148 abortion cases admitted to Debremarkos Hospital from July 1999 to June 2000, 140 (94.6%) were induced abortions under 30 years of ages (52, 53, 54).

Similar to most developing countries, in Ethiopia, abortion remained illegal for several years but now improved according to article 551 of the Penal Code of the FDRE. Hence, young women resort to illicit abortion to terminate unwanted pregnancies with great risks to their health. 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 15.0% occurred among women under age of 15 years; 31.0% occurred among women aged 16 to 20 years; and 62.0% occurred among women 16 to 25 years. Forty five percent of the abortions were among single women, 42.0% were among women with only a primary school education or less (32).

2.6 The SRH problems of young people

The different SRH problems that the young are facing are not localized to one geographic location or one part of the world. Worldwide, 15 million adolescents experience pregnancy each year. Since most of these pregnancies are unwanted, young women tend to have induced abortions, whether legal or not. According to WHO projections, nearly half of the induced abortions occur under unsafe conditions. Moreover, half of new HIV infections are observed in the 15-24 age groups. On top of this, studies about STI in adolescents show that the incidence is increasing. Today, each year, one in 20 adolescents suffers from an STI other than HIV (1).

This is also true in Africa. In a rare study conducted in Morocco, 40.0% of STIs recorded were among young adults aged 15 to 29, putting the estimated number of new infections among this age group at 240,000 per year (9). The poor knowledge that the young have and their risky sexual practices would add fuel to the already existing fire. The 2005 DHS in Egypt revealed that only 18.0% of married women aged 15 to 24 had heard of Gonorrhea, Syphilis or Chlamydia. And it is only in 4 out of 19 Sub-Saharan countries, where more than 10.0% of unmarried adolescents use modern contraceptives (1).

The situation in Ethiopia is not different from that of other countries mentioned above. In a study conducted to investigate young people's SRH needs and utilization of services in selected regions of Ethiopia, a considerable proportion of young people were found to be practicing risky behavior: about 39.2% reported having had sexual intercourse and 7.6% of them had early sexual debut before the age of 15 years. Moreover, 45.1% acknowledged having had more than one sexual partner, 15.8% admitted having had sexual intercourse with commercial sex workers, and 34.9% reported having had reproductive health problems, of which 28.7%, 24.1%, and 45.1% claimed to have had unwanted pregnancy, abortion and STI, respectively in their life time (1).

2.7. Health service utilization of adolescents and their preferences

Viewing adolescents as specific group with their own needs is a relatively recent practice, especially in developing countries. Young unmarried people in the past were not expected to need reproductive health services. If young women –no matter how young – were married they received the same services as older women, except no body assumed the young women need pregnancy prevention. Adolescents avoid using existing RH services for a variety of reasons, including policy constraints, operational barriers, lack of information and feeling of discomfort. Laws in many countries restrict access to certain kinds of health services according to age, marital status, or both. Operational barriers like inconvenient hours of operation, lack of convenient transportation and high costs of services were considered the most important reasons adolescents avoid using existing health services even though policies allowed them to use. Moreover, current programs and health personnel in many developing counties are usually ill equipped to reach and assist such young people (55).

A need assessment report among NGOs in Ethiopia involved in RH revealed that with few exceptions, health care providers and social sector professionals agree that the existing health care services do not meet the needs of today's young people. Few studies conducted on service utilization patterns of adolescents in the country revealed the same fact. An interview of students at Bahir Dar provides reasons why their friends do not seek RH information or services: shy, shame, or believe that it is against the traditional culture think or unaware of services available were reported to be the major ones. As school adolescents in Addis Ababa had mentioned, fear of being seen by parents and others, embarrassment at needing RH services and expensive services to be the major barriers to use RH services by adolescents. In addition, 70% of them preferred special hours for adolescents, 44.3% young provider of the same sex and 53% special discount on service fees for adolescents. It was also found that the concept of RH had not properly understood by health care providers and health administrators at different positions in the country (56).

2.8. Major youth focused activities in Ethiopia

Provision of a package of youth-friendly services including VCT in the youth centers: This service includes counseling services, diagnosis and treatment of STI, provision of diagnosis and treatment of opportunistic infections, skill building training. This service is available for youth in six youth centers in Addis, Gonder, Dire Dawa and Jijiga (37).

Building the capacity of in-and out-of-school youth groups: Several youth focused capacity building endeavors have been underway. Such capacity building activities have enabled wider majority of youth to actively participate in various youth development and HIV/AIDS prevention and control activities. The various capacity building strategies include:

- Youth group management and leadership to Anti-AIDS club (AAC) leaders.
- Peer education and life skills training in all regions;
- Youth programming training to club leaders to ensure youth to claim their rights, make informed decisions, draw programs that concerns them and take steps to participate in various interventions;
- Training on VCT for youth volunteers to avail counseling services at community level;

• Establishment of networks among Anti-AIDS youth groups to promote cross fertilization of experiences;

• Development of standardized training materials on life skills and peer education, youth programming, youth focused VCT; and

• Operational researches on youth and youth clubs, which feeds in to programming (37).

Building the capacity of coordinating counterparts: Creating conducive environment for youth involvement requires advocacy and capacity building of stakeholders working with and for youth. To this effect, a number of activities have been supported by UNICEF and implemented by counterparts at national, regional and woreda levels. These include:

• Series of advocacy activities for partners and the public at large in the form of panel discussions, media briefing and public gatherings to promote the need to involve youth in various forums;

• Youth programming training have also been provided to partners to better equip them with skills that may help them to draw youth focused plans of action; and

• Provide opportunities to get first hand experiences from other countries with regard to youth programming (37).

2.9. The SRH of students in high schools

Sexuality and Reproductive Health/HIV education are often controversial because some individuals believe that talking about sexuality in schools may increase sexual activity. However, according to two exhaustive reviews of studies by the World Health Organization (WHO) and the United States National Campaign to Prevent Teenage Pregnancy, sexuality education programs do not lead to an increase in sexual activity among young people. Even more encouraging, the reviews found that effective SRH/HIV education in schools can result in delaying first intercourse or, if young people are already sexually active, increasing use of contraception (57).

The need to provide SRH services to this segment of the population necessitated to take special measure by countries like Iran and Tunisia. Iran has gone further in developing an age appropriate reproductive health curriculum for senior high school students, which also requires all university students to take a course on population and development that includes some aspects of reproductive health. Across the region, high schools and universities are beginning to take on extra-curricula activities on HIV/AIDS education, for example, by establishing anti-AIDS clubs (55).

In Ethiopia, very little is done to address the SRH of students in high schools and universities. According to a qualitative research conducted in four government universities of Ethiopia, many students of the higher learning institutions are not well aware of RH issues. Those who are marginally aware of the issues believed that unwanted pregnancy, abortion and STIs including HIV/AIDS, are among the RH problems affecting many students. It was also stated that, despite the high prevalence of the problem, the absences of appropriate health care and other related interventions and the tendency to keep reproductive health secret, are the most important factors that have aggravated the health problems of students (58).

In summary, though adolescents are considered by the societies relatively disease free, they are at greater risk of various health problems, like early and unsafe sexual activity, unintended pregnancy, STDs and AIDS. There are also several misconceptions abound concerning HIV/AIDS, pregnancy, condom and contraceptive. Moreover, they lack adequate sexual and RH information to make appropriate decisions. There are rapid social changes resulting in decreasing age at menarche, increasing age at first marriage, unemployment and urbanization. There are also western cultural diffusions and erosions of traditional cultures in the developing world all of which have a disproportionate effect on the adolescents' health. Due to fear of social disapproval and lack of convenient health services for them, only very small numbers of adolescents were found utilizing health services in many developing countries (56).

2.10. Significance of the study

Addressing the reproductive health preferences of youth to the different attributes of health services and ensuring supportive environment from parents and relevant others ensuring the involvement of youth together with the community and government agencies in planning, implementation and evaluation of interventions meant for them should be a prerequisite for the successful implementation of youth reproductive health services . But there are very limited number of studies conducted based on school youth to address their reproductive health needs.

Although there are lots of students joining high schools, the in-school RH services are given unsatisfactory attention while health is believed to be a backbone for the production of fruitful generation.

Therefore, this study serves as an input to the efforts that show the RH needs of youth attending their high school studies at Hossana town and guides the ways of providing RH services that are comprehensive and friendly to this group. In addition, the study gives an insight to the opportunity of addressing lots of youth concentrated in one geographical area that is High school campus. Moreover, the study will serve as baseline information for further studies.

3. OBJECTIVE OF THE STUDY

3.1 General objective

- To assess the reproductive health needs of high school youths in Hossana town.

3.2 Specific objectives

- To assess knowledge, attitude and practice of high school youths on RH issues
- To determine RH problems and service needs of high school youths
- To assess health service utilization patterns and preferences of high school youths.
- To describe socio- cultural factors influencing reproductive health needs of high school youths

4. METHODOLOGY

4.1. Study area

The study was carried out in Hossana city administration, the capital of Hadiya zone, SNNPRG. Hadiya zone is one of the 13 zones in the region and is located 230 kms away from Addis Ababa and 200kms away from Hawassa, the capital of SNNPRG. Hadiya zone has a total area of 3542.6km^2 and rainfall of 15632-46597 mm. The zone has a total population of 1,243,776, out of which 618,245(49.7%) are males and 625,531(50.3%) are females. Hadiya zone is bordered by Gurage in the north, Kambata Tembaro in north-east, Silte and Alaba special woreda in the north-east, and Oromo and Yem special woreda in west and north-west (59).

The capital of the zone, Hossana, was selected to represent the urban community for this study because it is the largest town in the zone and it has large number of school adolescents due to various reasons. One of these reasons may be that it may serve as home for rural migrants of the zone. The total population of the town is 54, 231, out of which 26,676 are males and 27,555 are females (59).

There are two high schools (Yekatit 25/67 high school and Heto high school) and one preparatory school in Hossana city administration. The total number of students in both high schools (Yekatit 25/67 and Heto high school) is 6731, out of which 3205(47.6%) are males and 3526(52.4%) are females (59).

4.2 Study design and period

School based cross sectional study was used to assess the reproductive health needs of youths in high schools from September 2009-June 2010.

4.3. Source and study population

The source population of the study was all high school students in Hossana city administration. The study population was youth (age 15 to 24 years) attending high schools at the time of study.

Inclusion criteria: Those students in the age group 15 to 24 years and attending regular day schools at the time of the study. Although, the WHO definition of youth includes all young people within the age group 10 to 24 years, almost all of the high school students are >14 years.

Exclusion criteria: Those students whose age is <15 years and >24 years, students attending night schools, school dropouts, and students who have not been willing to give an informed consent.

4.4. Sample size determination

Sample size for the quantitative study was computed based on the formula for single population proportion.

$$n = \frac{Z^2 P(1-P)}{d^2}$$

Since the prevalence of the knowledge of the reproductive health needs among study subjects is not known from previous studies, the value of p was assumed to be 50.0%. A z-value of 1.96 will be used at 95% CI and d of 5% (n=sample size, p= proportion, d= tolerable margin of sampling error).

Therefore; $$n = \frac{(1.96)^2 \times 0.5(1-0.5)}{(0.05)^2} = 384$$

With adjustment for non-response (10% contingency), the final sample size for exit interview was: 384 + 0.1(384); which equals to 422.

4.5. Method of sample selection

The two high schools (Yekatit 25/67 and Heto high schools) in Hossana city administration were the study schools. There were 5827 students (males=2708, females=3119) in Yekatit 25/67 high school and 904 students (males=497, females=407) in Heto high school. The schools were grouped in to two (grade 9 and grade 10) of each consisting sub-groups (sections). The sample size for the study, 422 was divided and allocated to each high school according to the principle of probability proportional to size. Which means, high school that was found to have large number of students, based on the measure of size, was given greater probabilities. Finally, group (grade 9 or grade 10) in each high school that was found to have large number of students was given greater probabilities and sub-groups (sections) were randomly selected from each high school. Accordingly, 365 students were selected from Yekatit 25/67 high school and 57 students were selected from Heto high school making a total of 422 study subjects. Generally, a multi-stage sample technique was applied to undertake this study.

4.6. Variables

4.6.1. Independent variables

- Age
- Ethnicity
- Religion
- Sex
- Marital status
- Socioeconomic status
- Educational status
- Service fee

4.6.2. Dependent variables

- Reproductive health needs
- Reproductive health service preferences and utilization

4.6.3. Operational definitions

- **Adolescents:** All young people in the age group 10-19 years (60).
- **Reproductive health:** A state of complete physical, mental and social well being not merely absence of disease or infirmity, in all matters relating to reproductive system and its functions and processes (61).
- **Reproductive health needs:** perceived and unperceived health needs related to sexuality, contraception, pregnancy, STDs, HIV/AIDS, access to services and reproductive health information (61).
- **Reproductive health service preference-** the reproductive health services provision modalities and service types that students would like to get (61).

- **Sexual and Reproductive Health (SRH**)*:* in this study it refers to the reproductive health in relation with HIV/AIDS, STI, Family Planning, Abortion and Gender Based Violence (61).
- **Youth:** All young people in the age group 10-24 years (60).
- **Youth-friendly services***:* are services with policies and attributes that attract youth to the facility or programme, provide a comfortable and appropriate setting for youth, meet the needs of young people and are able to retain their youth clients for follow up and repeat visits **(37).**

4.7. Data collection instrument

After review of relevant literatures, a great number of questions that can address the objectives of the study were gathered and adapted from previous similar studies and other materials. Standardized Illustrative Questionnaire for Interview-Surveys with Young People developed by John Cleland was modified and used in the study. The questions and statements were grouped and arranged according to the particular objectives that they can address. Then, the first draft of the questionnaire was produced and submitted to the advisors for comments. Valuable suggestions were taken from these individuals to improve the instrument. Accordingly, redundancy, vagueness, and logical flow of the questions were corrected. After extensive revision, the final version of the English questionnaire was developed. An individual who has a very good ability of both English and Amharic languages translated this final English version to Amharic. Another individual of similar ability then translated the final or the agreed Amharic version of the questionnaire back to English with the first to see consistency in the content of the instrument.

4.8. Pretest and data quality assurance

For validity and reliability of the questionnaire, data collection instrument was piloted on 5% of the students in Wachamo preparatory school before being applied to the study subjects. The quality of the data to be collected was assured by checking all questionnaires at the evening of the date of collection for its completeness and unclear items were written in clear and easily understandable language by the principal investigator.

4.9. Data processing and analysis plan

Data cleaning and entry was carried out by the principal investigator using Statistical Package for Social Sciences (SPSS) version 12.0. Descriptive and analytic analysis was computed with summary frequencies, tables, figures, crude and adjusted OR using EPI INFO software.

4.10. Ethical consideration

Ethical clearance was obtained from the ethical review committee of the Centralized School of Nursing, Medical Faculty of AAU. A letter of support from the Centralized School of Nursing was given to the Hossana city education office and selected high schools in Hossana city administration where the study was conducted. A consent form and information sheet translated into Amharic was attached to the self–administered questionnaire and the students were instructed to carefully read the consent and sign.

5. DISSEMINATION OF THE FINDINGS

The result of the study was submitted to the Centralized School of Nursing, AAU, Hossana city administration education office, Hadiya zone so as to inform the output of the study which would have important contribution for the program improvement. There was also presentation of the study to parties interested and possibly for publication.

6. RESULTS

6.1 Socio-demographic characteristics

A total of 422 students participated in the study. The non response rate was 19 (4.5%). The majority 228 (56.6%) of the respondents were females. Most 240(59.9) of the respondents were found to be aged 16-20 years. The religious affiliation of the respondents was dominated by protestant 258 (64.7%) and most of them 255 (64.5%) belonged to Hadiya ethnic group. Majority 347(86.7%) of the respondents were single. The detail on sociodemographic characteristics of the respondents is illustrated in Table below.

Table 1. Sociodemographic characteristics of the respondents (n=403), Hossana, 2010

Characteristics	Frequency	Total
Sex		
Male	175(43.4%)	403
Female	228(56.6%)	
Age		
Less than 16 years	150(37.4%)	401
16-20 years	240(59.9%)	
21-25 years	11(2.7%)	
Religion		
Protestant	258(64.7%)	399
Orthodox	82(20.6%)	
Muslim	30(7.5%)	
Others	29(7.3%)	
Ethnicity		
Hadiya	255(64.5%)	395
Amhara	67(17%)	
Oromo	16(4.1%)	
Tigre	7(1.8%)	
Others	50(12.6%)	

Marital status		
Single	347(86.7%)	400
Married	18(4.5%)	
Divorced	9(2.3%)	
Widowed	8(2%)	
Others	18(4.5%)	
Level of education		
Grade 9	222(55.4%)	401
Grade 10	179(44.6%)	
Monthly income		
Less than 50 ETB	70(17.9%)	390
50-100 ETB	21(5.4%)	
101-200 ETB	10(2.6%)	
Greater than 200 ETB	17(4.4%)	
None	272(69.7%)	
Do you ever go to clubs?		
Yes	255(66.4%)	384
No	129(33.6%)	
Do you ever drink alcohol?		
Yes	26(6.9%)	375
No	349(93.1%)	
Do you ever smoke cigarette?		
Yes	10(2.7%)	377
No	367(97.3%)	

6.2. Source of information on SRH issues

Health professionals were found to be the most common source of information on sexual and reproductive health issues for the respondents 195(51.5%) followed by school teachers 70(18.5%), parents or family members 39(10.3%), friends 30(7.9%) and mass media 29(7.7%) respectively. Majority 234 (61.1%) of the respondents have reported that it is easy for them to talk about sexual and reproductive health issues with their parents and 225(57.3%) of the respondents have ever discussed sex related matters with their parents.

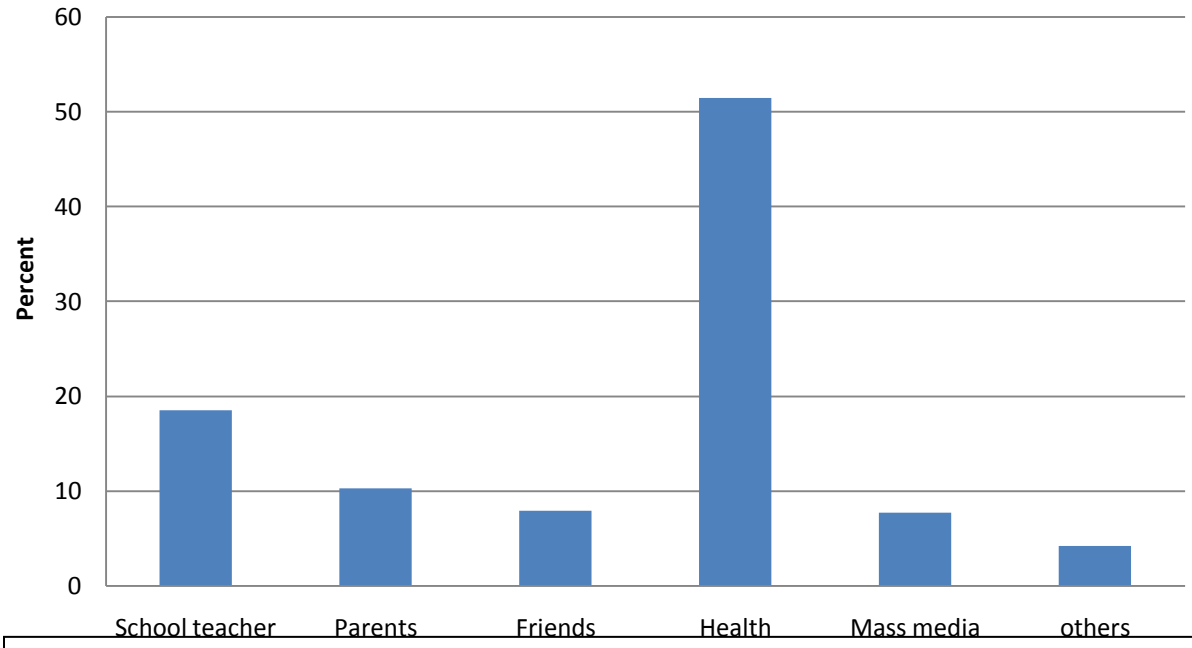

Figure 1. Shows common sources of information on SRH issues for high school students, Hossana, 2010

6.3. Reproductive Health Need Assessment, Health Service Utilization and Preferences of high school students in Hossana

The students were asked the most common SRH problems that students in their compound are facing. Majority 195(46.9%) of the respondents have reported that sexually transmitted infections including HIV/AIDS were the most common reproductive health problems that the students are facing followed by unintended pregnancy 124(29.8%) and gender based violence 74(17.8%) respectively.

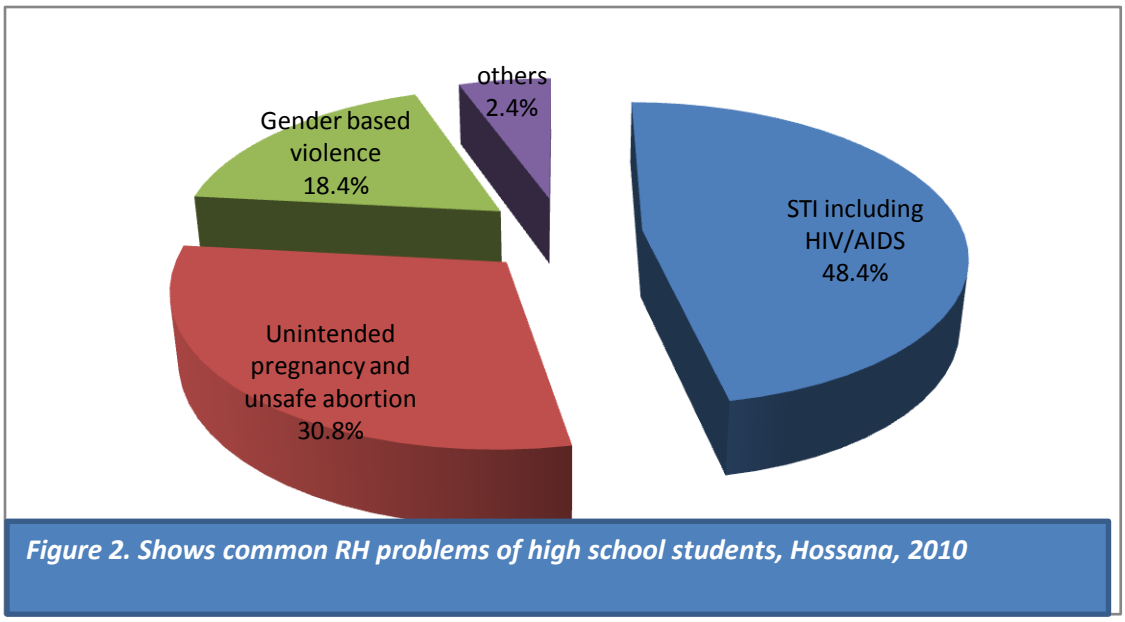

Figure 2. Shows common RH problems of high school students, Hossana, 2010

Majority 252(62.7%) of the respondents would like to get information and education on reproductive health. About 70(17.4%) of the respondents would like to get diagnosis and treatment of sexually transmitted infections. The type of reproductive health services that students would like to get is illustrated in the graph below.

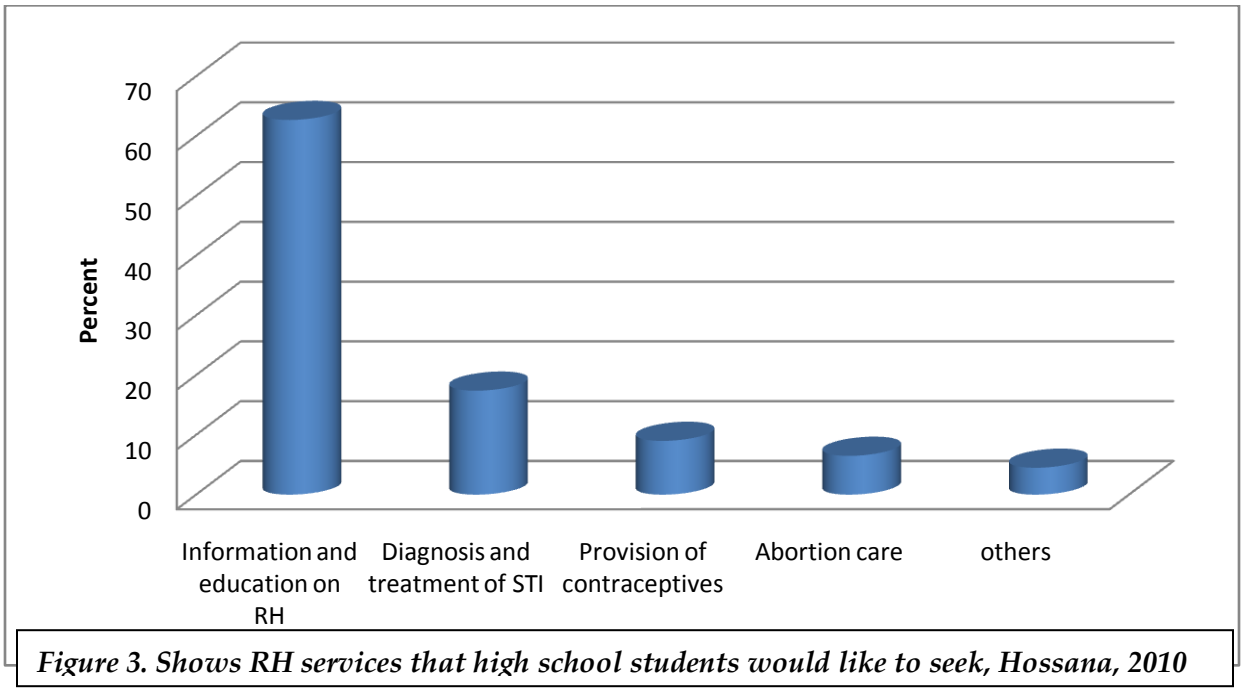

Figure 3. Shows RH services that high school students would like to seek, Hossana, 2010

Majority 330(86.4 %) of the respondents have claimed that there are no clinics in the school compound and about 295(73.9%) of the respondents have visited clinics outside school compound to seek SRH services. About 49(49.5%) of the respondents have said that they prefer to seek care outside because of the availability of qualified health professionals. Most 138(36.8%) of the respondents would prefer young providers of the same sex to be RH service providers. The detail on RH service need assessment, service utilization and preferences is illustrated in the table below.

Table 2. RH need assessment, service utilization and preferences of high school students, Hossana, 2010

Characteristics	Frequency	Total
Common RH problems of the students:		
STIs including HIV/AIDS	195(48.4%)	403
Unintended pregnancy and unsafe abortion	124(30.8%)	
Gender based violence	74(18.4%)	
Others	109(2.4%)	
RH services that students would like to seek:		
Information and education on RH	252(62.7%)	402
Diagnosis and treatment of STIs	70(17.4%)	
Provision of contraceptives	36(9%)	
Abortion care	26(6.5%)	
Others	18(4.5%)	
Is there clinic in the school compound?		
Yes	52(13.6%)	382
No	330(86.4%)	
Students who have visited school clinic:		
Yes	43(12.6)	342
No	299(87.4%)	

Reasons for visit of school clinic:		
To get condom	7(17.9%)	38
To get RH information	14(35.9%)	
For treatment of STIs	13(33.3%)	
For abortion care	1(2.6%)	
Other	4(10.3%)	
Students who have visited health institutions other than school clinic for RH services in the past 12 months:		
Yes	104(26.1%)	403
No	295(73.9%)	
Reasons for visiting health institutions outside the school compound:		
For confidentiality	6(6.1%)	99
Free services	22(22.2%)	
Availability of qualified health professionals	49(49.5%)	
Convenient working hours	12(12.1%)	
Others	10(10.1%)	
Preferences of RH service providers:		
Young providers of the same sex	138(36.8%)	375
Young provider of any sex	114(30.4%)	
Adult provider of the same sex	37(9.9%)	
Adult provider of any sex	51(13.6%)	
Others	35(9.3%)	

Bivariate analysis

Bivariate analysis was computed to determine the effect of socio demographic and selected behavioral characteristics on school health service utilization. Accordingly, the pattern of school health service utilization was not significantly associated with socio demographic and behavioral characteristics.

Table 3. Shows the effect of sociodemographic and behavioral characteristics on school health service utilization by high school students, Hossana, 2010

Characteristics	**Utilization of SRH services within school clinic**		**OR(95% CI)**	
	yes	No	Crude	Adjusted
Sex				
Male	16	138	.69(.35-1.33)	
Female	17	161	1	
Age				
<16 years	17	109	1.4(.16-11.7)	
16-20 years	24	180	1.2(.14-9.89)	
21-25 years	1	9	1	
Marital status				
Never married	38	260	.84(.27-2.560	
Ever married	4	23	1	
Level of education				
Grade 9	25	167	1.08(.56-2.06)	
Grade 10	18	130	1	
Do you ever go to club?				
Yes	19	131	1.17(.60-2.290	
No	20	162	1	
Do you ever drink?				
Yes	1	19	.36(.04-2.79)	
No	38	262	1	
Do you ever smoke?				
Yes	1	6	1.28(.15-10.99)	
No	36	278	1	

Knowledge score in SRH issues			
<4.4(poor)	31	210	1.09(.53-2.22)
>4.5(good)	12	89	1
Attitude towards SRH issues			
>3(-ve)	15	101	1.05(.53-2.05)
=<3(+ve)	28	198	1

6.4. Sexuality, pregnancy and contraception

6.4.1. Sexual experiences

About 144(46.0%) of the respondents have ever had only one boy/girl friend where as 53(16.9%) of the respondents have ever had multiple sexual partners. About 117(31.2%) of the respondents have ever had physical contact with their boy/girl friends and 138(35.8%) of the respondents have experienced penetrative sexual intercourse. Majority 78(59.5%) of the respondents have reported that their first sexual intercourse was unplanned. Most 61(44.5%) of the respondents started sexual intercourse by their personal desire where as about 30(21.9%), 23(16.8%), and 10(7.3%) by peer pressure, exchange for money, and rape respectively.

Majority 65(46.4%) have had sexual intercourse with a steady boy/girl friend where as 28(20.0%), 19(13.6%), and 12(8.6%) with relatives, causal friends, and commercial sex workers respectively. As indicated in the table below, about 58(35.6%) of the respondents have experienced penetrative sexual intercourse in the past 12 months out of which 33(56.9%) were unplanned. Out of the respondents who have had sexual intercourse in the past 12 months, 13(22.4%) of them have ever been drunk while having sexual intercourse.

About 38(45.7%) of the respondents have reported that they have used condom as a means of preventing pregnancy and/or STIs during their first sexual intercourse where as 11(12.6%) have used injections and safe periods and 8(9.2%) have used pills. Most 88(57.1%) of the respondents have never used contraceptives apart from the time they had their first sexual intercourse and 43(27.9%) of the respondents have occasionally used contraceptives. Religious prohibition was the most 34(31.8%) commonly mentioned reason for not using contraceptives as a means of preventing pregnancy and/or STIs followed by unplanned sex, lack of knowledge about contraceptives, opposition from sexual partners, and inaccessibility of contraceptives respectively.

Table 4. Sexual experiences of high school students in Hossana, 2010

Characteristics	**Frequency**	**Total**
Have you ever had a boy/girl friend?		
Yes	161(40.8%)	395
No	234(59.2%)	
How many boy/girl friends have you had?		
Only 1	144(46.0%)	313
2-3 boy/girl friends	27(8.6%)	
4-5 boy/girl friends	26(8.3%)	
Unknown	116(37.1%)	
Did you and your boy/girl friend have any physical contact?		
Yes	117(31.2%)	375
No	258(68.8%)	
Have you ever had sexual intercourse?		
Yes	138(35.8%)	386
No	248(64.2%)	

At what age did you first start sexual intercourse?		
Less than 10 years	5(3.6%)	138
11-15 years	56(40.6%)	
16-20 years	71(51.4%)	
21-25 years	6(4.3%)	
Was the first sexual intercourse planned?		
Yes	53(40.5%)	138
No	78(59.5%)	
How did you start sexual intercourse?		
Peer pressure	30(21.9%)	137
Financial purpose/exchange for money	23(16.8%)	
Rape	10(7.3%)	
Personal desire	61(44.5%)	
Others, specify	13(9.5%)	
With whom did you make your first sexual intercourse?		
With Husband/wife	6(4.3%)	140
With a steady boy/girl friend	65(46.4%)	
With causal boy/girl friend	19(13.6%)	
With a relative	28(20.0%)	
With commercial sex worker	12(8.6%)	
Others, specify	10(7.1%)	
Have you had sexual intercourse in the past 12 months?		
Yes	58(35.6%)	163
No	105(64.4%)	
Have you ever had unplanned sexual intercourse in the past 12 months?		
Yes	33(56.9%)	58
No	25(43.1%)	

Have you/your partner ever been drunk while having sexual intercourse?		
Yes	13(22.4%)	58
No	45(77.6%)	
On the first time that you had sexual intercourse, did you and/or your partner do anything to avoid pregnancy or STI?		
Yes	57(38.8%)	147
No	90(61.2%)	
What method did you use?		
Condom	38(43.7%)	87
Pills	8(9.2%)	
Injection	11(12.6%)	
Safe period	11(12.6%)	
Other, specify	19(21.8%)	
Apart from the first time, did you and your partner ever use a method to avoid pregnancy and STI including HIV/AIDS?		
Yes, always	23(14.9%)	154
Yes, occasionally	43(27.9%)	
Never	88(57.1%)	
Reasons for not using contraceptives:		
Inaccessibility of contraceptives	11(10.3%)	107
Religious prohibition	34(31.8%)	
Sex was unplanned	24(22.4%)	
Opposition from boy/girl friend	18(16.8%)	
Lack of knowledge about contraceptives	20(18.7%)	
Others, specify	0	

Bivariate analysis

To determine characteristics that predict sexual activity of high school students in Hossana, bivariate analysis was done on different variables. Accordingly, sexual activity of the students has shown protective association with being male [AOR of .47(95% CI=.28, .81)], being unmarried [AOR of .28(95% CI=.11, .74)], but positive association with being drunk [AOR of 6.75(95% CI=2.38, 19.12)].

Table 5. The effect of socio-demographic and behavioral factors on sexual experiences of high school students, Hossana, 2010

Characteristics	**Ever had sexual intercourse**		**OR(95% CI)**	
	yes	**No**	**Crude OR**	**Adjusted OR**
Sex:				
1. Male	49	119	.59(.38-.91)*	.47(.28-.81)**
2. Female	89	129	1	
Marital status:				
1. Never married	107	225	.22(.10-.48)**	.28(.11-.74)**
2. Ever married	23	11	**1**	

Monthly income:				
1. <50 ETB	16	50	.53(.29-.99)*	.56(.27-1.14)
2. 50-100ETB	8	13	1.03(.41-2.58)	
3. 101-200 ETB	4	6	1.12(.30-4.06)	
4. >200 ETB	9	8	1.89(.70-5.06)	
5. None	97	163	1	
Do you ever drink?				
1. Yes	20	6	7.17(2.79-18.3)***	6.75(2.38-19.12)***
2. No	106	228	1	1
Knowledge score SRH issues:				
1. <4.4(poor)	104	166	1.51(.94-2.41)	
2. = >4.4 (good)	34	82	1	
Attitude towards SRH issues:				
1. >3(-ve)	52	78	1.31(.85-2.03)	
2. = <3(+ve)	86	170	1	

***p< 0.05; **p<0.01 ; ***p<0.001**

The variables entered in the model were: Sex, Marital status, Monthly income, Drinking alcohol , Average knowledge score, and Attitude towards SRH issues

6.4.2. Pregnancy and abortion

As indicated in the table below, about 38(70.4%) of sexually active females respondents have ever been pregnant out of which 18(51.4%) had only one pregnancy. Most 25(73.5%) of sexually active female respondents have reported that their pregnancies were unintended and 18(52.9%) of them have ever had induced abortion.

Table 6. Pregnancy and abortion among high school students in Hossana, 2010

Characteristics	*Frequency*	*Total*
Have you ever been pregnant?		
Yes	38(70.4%)	54
No	16(29.6%)	
How many times have you been pregnant?		
Only once	18(51.4%)	35
2 times	9(25.7%)	
3 times	8(22.9%)	
If you have been pregnant, were all your pregnancies wanted?		
Yes	9(26.5%)	34
No	25(73.5%)	
Have you ever had induced abortion?		
Yes	18(52.9%)	34
No	16(47.1%)	
How many times did you have abortion?		
Only once	20(66.7%)	30
2 times	7(23.3%)	
3 times	3(10.0%)	

6.5 Knowledge, attitude, and practice on SRH issues

The majority of the students have heard about SRH mainly from mass media 135(29.8%), school teachers 131(28.9%), and friends 73(16.1%). Most of the students 281(69.7%) have poor (<4.4) knowledge on SRH issues whereas only 122(30.3%) students have good (>4.5) knowledge on SRH issues.

Table 7. Shows knowledge score and attitude towards SRH issues of high school students, Hossana, 2010

Characteristics	Frequency	Total
Knowledge score in SRH issues		
1. < 4.4 (poor)	281(69.7%)	403
2. >4.4 (good)	122(30.3%)	
Mean ± sd	4.55 ± 2.70	
Attitude towards SRH issues		
1. >3 (-ve)	135(33.5%)	403
2. ≤3 (+ve)	268(66.5%)	
3. Mean ± sd	3 ± 2.06	

6.5.1 Knowledge on STIs

About 319(81.8%) of the students have heard about STIs. Those that said they have heard of STIs were again asked about the types of STIs they knew. Accordingly, about 96(22%) of the respondents knew more than two types of STIs. The most common types of STIs mentioned to be known were HIV/AIDS 289(57.9%), Gonorrhea 86(17.2%), and syphilis 75(15.0%).

As indicated in the table below, about 66(16.5%) of the students have reported that they have had symptoms of STIs like burning/pain on urination, genital ulcer and/or urethral/vaginal discharge. Out of the students who have had symptoms of STIs, only 22(33.3%) of them have sought treatment.

Table 8. Knowledge of high school students on SRH issues, Hossana, 2010

Characteristics	*Frequency*	*Total*
Have you ever heard of RH?		
Yes	267(68.6%)	389
No	122(31.4%)	
What was the source of information?		
Mass media	135(29.8%)	453
Friends	73(16.1%)	
School teachers	131(28.9%)	
Family	52(11.5%)	
Youth club	43(9.5%)	
Others	19(4.2)	
Have you ever heard of STIs?		
Yes	319(81.8%)	390
No	71(18.2%)	
Which type of STI do you know?		
Gonorrhea	86(17.2%)	499
syphilis	75(15.0%)	
HIV/AIDS	289(57.9%)	
Others	49(9.8%)	

Have you ever had burning/pain on urination, genital ulcer, and urethral/vaginal discharge?		
Yes	66(16.5%)	399
No	333(83.5%)	
If yes to the above question, did you seek treatment from health institution?		
Yes	22(33.3%)	66
No	44(66.7%)	

6.5.2 Knowledge and practice of family planning methods

About 202(50.2%) of the respondents reported that they knew more than two methods family planning. The most frequently mentioned family planning methods were condom 180(29.8%), abstinence 173(28.6%), and oral contraceptive pills 111(18.3%). Only 59(15.6%) of the students have ever used contraceptives as means of preventing pregnancy and/or STIs. Majority 157(40.7%) of the respondents claimed that contraceptives including condom should be made available in the school ompound.

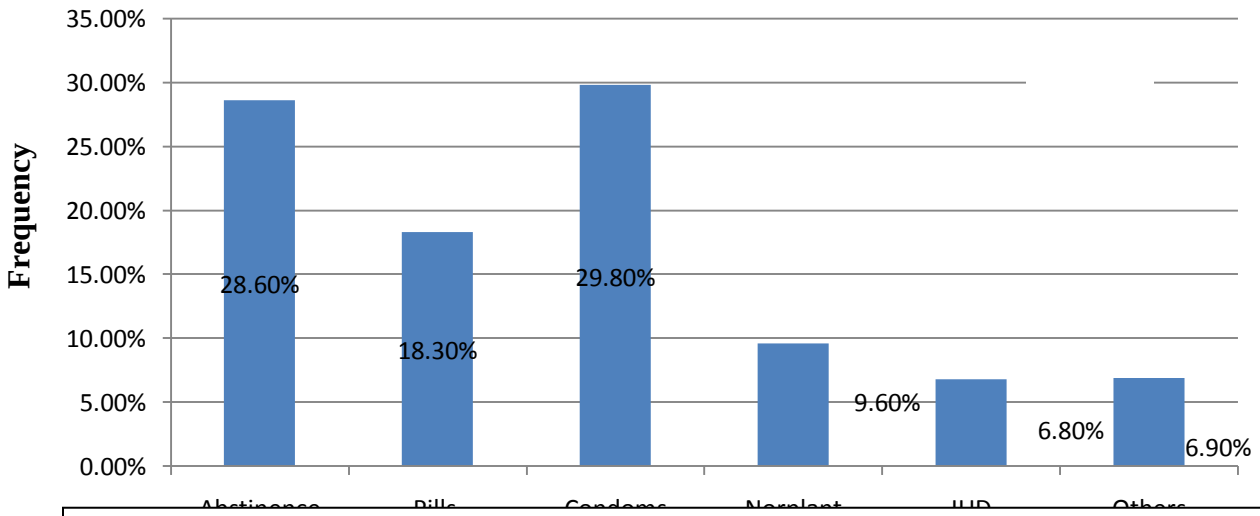

Figure 4. Knowledge of high school students about different methods of family planning, Hossana, 2010

6.5.3 Knowledge on HIV/AIDS

About 175(44.9%) of the respondents said that they knew someone who was infected with HIV or died of AIDS. The students were also asked about the methods of preventing HIV/AIDS. The most common methods mentioned by the students were abstinence 189(33.8%), using condom 165(29.5%), and being faithful 151(27.0%) to sexual partner.

Nearly half 191(49.9%) of the respondents were not concerned that they might contract HIV/AIDs from their sexual partner and majority 248(66.7%) of the students were not able to do anything to reduce the risk.

About 239(64.1%) of the respondents have reported that they did not know where they could get HIV test and about 269(69.0%) of the respondents claimed that VCT service should be made available in the school compound. As indicated in the table below, about 220(56.3%) of the students have never undergone VCT.

Table 9. Knowledge of high school students about HIV/AIDS, Hossana, 2010

Characteristics	*Frequency*	*Total*
What methods of preventing HIV/AIDS do you know?		
Abstinence	189(33.8%)	559*
Being faithful	151(27.0%)	
Using condom	165(29.5%)	
Others	54(9.7%)	
Were you ever concerned that you might catch HIV/AIDS or other STIs from your boy/girl friend?		
Yes, very much concerned	115(30.0%)	383
Yes, somewhat concerned	77(20.1%)	
No, not concerned	191(49.9%)	
Were you able to do anything to reduce the risk?		
Yes	124(33.3%)	372
No	248(66.7%)	

Do you know where you could get HIV test?		
Yes	134(35.9%)	373
No	239(64.1%)	
Have you ever undergone VCT?		
Yes	171(43.7%)	391
No	220(56.3%)	
Should VCT service be available in the school?		
Yes	269(69.0%)	390
No	57(14.6%)	
Don't know	64(14.4%)	

*-Due to multiple responses

6.6 Attitude of high schools students towards sexuality, gender and norms

As depicted in Table below, most students have favorable attitude towards sexuality, gender and norms. About 268(66.5%) of the students have +ve (=<3) attitude towards selected SRH issues whereas 135(34.5%) of the students have –ve (>3) attitude towards selected SRH issues.

Table 10. Attitude of high school students towards sexuality, gender and norms, Hossana, 2010

Characteristics	**Frequency**			**Total**
	Agree	**Disagree**	**Don't know**	
I believe it's all right for unmarried boys and girls to have dates	182(46.2)	123(31.4%)	87(22.4%)	392
I believe it's all right for boys and girls to kiss, hug and touch each other.	59(15.5%)	244(64.2%)	77(20.3%)	380
I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	57(14.5%)	247(63.0%)	88(22.5%)	392

I think that sometimes a boy has to force a girl to have sex if he loves her.	53(13.6%)	264(67.7%)	73(18.7%)	390
A girl who agrees to have sex regrets afterwards	97(25.2%)	155(40.3%)	133(34.5%)	385
Most boys and girls who have sex before marriage regret it afterwards	121(32.2)	127(33.8%)	128(34.0%)	376
A boy and girl should have sex before they become engaged to see whether they are suited to each other.	65(16.9%)	204(53.1%)	115(30.0%)	384
I am confident that I can insist on condom use every time I have sex.	156(40.6)	100(20.0%)	128(39.4%)	384
It is mainly the woman's responsibility to ensure that contraception is used regularly.	148(39.1)	113(29.8%)	118(31.1%)	379
I feel that I know how to use a condom properly.	153(40.1)	84(22.0%)	145(37.9%)	382
Men need sex more frequently than do women	141(37.0)	115(30.2%)	125(32.8%)	381
I would refuse to have sex with someone who is not prepared to use a condom	160(41.0)	99(25(4%)	131(33.6%)	390

7. DISCUSSION

This study has revealed that high school students in Hossana have huge unmet SRH needs. Moreover, the study gives an insight in to the gap in the student's knowledge on SRH issues and their poor service utilization though there are risky sexual behaviors among students in Hossana.

Majority 330(86.4%) of the students claimed that there are no clinics in the school compound. This points out that there is poor SRH seeking behavior among the students. Those that wanted to seek help on SRH issues had to go to clinics outside the school compound. This makes SRH service seeking very difficult for students with lesser time and financial constraint as perceived barriers are one of the factors that evoke health concerns according to Health Belief Model (62). Small proportion 43(12.6%) of the respondents have reported that they have visited school clinic. Desire to get SRH information, treatment of STIs and access to condom were the three most commonly mentioned reasons for visiting school clinics.

Sexually transmitted infections including HIV/AIDS 195(46.9%), unintended pregnancy 124(29.8%) and gender based violence 74(17.8%) were the most common SRH problems that the students in their compound are facing. This is almost comparable to the study conducted on Addis Ababa University students (63). High prevalence SRH problems among high school students might be due to the earlier engagement in sexual practice during which most adolescents lack accurate knowledge about sexuality and reproduction and lack of access to reproductive health information including contraception.

This study has demonstrated that the students need SRH services like SRH information and education, STI diagnosis and treatment, provision of contraceptives including condom and abortion care. This result is comparable to the study conducted on Addis Ababa University (63). The sexual practices of the students also verify the need to avail SRH services with the knowledge and skills of utilizing the available services.

A significant proportion 138(35.8%) of the students have reported they have had penetrative sexual intercourse. Out of the students that had experienced sexual intercourse, the majority 58(35.6%) said they were sexual active in the past 12 months. This finding is comparable with the results of KAPB (knowledge, Attitude, Practice and Behavior) assessment on Addis Ababa University. Accordingly, 34.9% of the respondents had sexual experiences and 20.6% had sex during the year before the survey (64). It is also consistent with the study conducted in school youth in Nekemte (35.4%) (65). It is higher from the study conducted in school youth in Debre Birhan (28.6%) (38).

This study has also pointed out that unsafe sexual practices are surprisingly high. Accordingly, 53(16.9%) of the respondents have had history multiple sexual partners. Out of the students who had sexual intercourse, 19(13.6%) had causal sex and 12(8.6%) had visited commercial sex workers. Moreover, out of the respondents who were sexually active in the past 12 months, 13(22.4%) of them were drunk while having sex. This result is comparable to the study conducted in school youth in Dessie in which case 14.9% of the study subjects had sexual intercourse with commercial sex workers (66).

The sexual experience of the students has shown protective association with being male [AOR of .47(95% CI=.28, .81)]. Males were found to be .47 times less sexually active than females. This might be due to high engagement females in risk taking behaviors.

Protective association was also found between sexual practice and being unmarried [AOR of .28(95% CI=.11, .74)]. Unmarried study subjects were .28 times less sexual active than married ones. Married study subjects have increased access and freedom to be engaged in sexual activities than unmarried study subjects. This might explain why sexual activity has shown protective association with unmarried study subjects.. Further studies should be conducted to appreciate the association between sexual activity and marital status of the respondents.

On top of this, the significant association between sexual practice and being drunk [AOR of 6.75(95% CI=2.38, 19.12)] is suggestive of the unsafe sexual practices among the students. Two possible explanations can be suggested for the association between sexual practice and being drunk. First, substance use and premarital sexual intercourse may both indicate a general inclination to take risks. Second, substance use tends to diminish the ability to make rational decisions, thereby increasing the likelihood of risky sexual contact (67).

Of all sexually active study subjects 66 (16.5%) reported history of signs/symptoms of STIs. This finding is lower than a study conducted among homeless youth in Korea (43.8%) however it is higher than reports from south Gondar (2.7%), Eastern Gojam (5.3%) and Bahir Dar (9.6%)(68,69, 70). Self report on STI signs/symptoms lacks sensitivity and specificity and hence explains these varying results.

This study has revealed that 202(50.2%) of the respondents knew more than two methods of family planning. However, the proportion of youth who ever used contraceptives did not go parallel with their knowledge of methods (15.6% versus 50.2%), which is consistent with the study done in Bahir Dar (70). Condom was reported to be the most frequently used methods of contraception. Easy accessibility of condom compared to other contraceptive methods might explain why condom is most frequently used method. However, consistent use of condom was low; only 23(14.9%) reported consistent use of condom which is lower than reports from Debre Birhan (44.9%) and Ghana among school youth (21.0%)(38, 71). The reported low consistent use of condoms implies that high risk behaviors are widely practiced by the study group. Inaccessibility of condoms, reduced perception of the risk and inadequate knowledge on SRH issues probably explains the lower level of condom use in their sexual exposure in this study.

Out of the female study subjects who were sexually active, 25(73.5%) had history of unwanted pregnancy which is higher than studies conducted on street youth in Dessie (25%) and out of school adolescents in Eastern Gojam (43.4%), out of which 18(52.9%) of them reported history of induced abortion at least once (16, 72). This result might be attributable to the fact that students have poor access to SRH services including information and education and provision of condoms in the school compound. The problems faced by youth are multidirectional; including abandonment of school, hasty and unpromising marriages, health problems, lesser employment opportunities, legal and cultural problems (73). This calls for an urgent need to protect young men and women from such incidences through information and education on safe sex.

This study has demonstrated that almost half 191(49.9%) of the respondents were not concerned that they might catch HIV/AIDs or other STIs from their boy/girl friends and 248(66.7%) of the respondents were not able to reduce the risk. This might be due to reduced risk perception of the youth that predisposes to high risk sexual activity as supported by this study. Unplanned sex, lack of knowledge, opposition from sexual partners, and inaccessibility of condoms might be additional reasons which explain why they practice risky sexual behaviors and don't bring behavioral change. This study found out that only 43(12.6%) of the study subjects have visited school clinics. The major reason mentioned as barriers to use SRH service in the school compound was its unavailability. About 104(26.1%) of the respondents have visited clinics outside the school compound for SRH services. The main reasons for these were availability of qualified health professionals, free services, convenient working hours and confidentiality respectively. These findings, when compared with the set standard for youth friendly services, give the general picture on the friendliness and status of the SRH services in school clinics for addressing the needs of students (74).

8. STRENGTHS AND LIMITATIONS OF THE STUDY

8.1 Strengths

- Pre testing of questionnaires and close supervision by principal investigator were used to maintain the reliability of the data
- The study addressed most important components of SRH as a whole rather than focusing on a single SRH problem

8.2 Limitations

- Non response because the study used self-administered questionnaires
- Risk factor analysis for some of the dependent variables (e.g., sexual experiences) was difficult because of the small sample size.

9. CONCLUSION

In spite of the students need to get SRH services, the school clinics are not providing their services adequately. Evidences indicate that in our set up, the existing health services delivery system is not suitable for youth. The health service delivery system should consider the special needs of youth and work out comprehensive and effective policies and strategies to provide young people with the services appropriate to their needs.

10. RECOMMENDATIONS

- A clear program perspective about the rights of youth to a full range of SRH information and services need to be communicated to the public to create an enabling policy environment for the provision of SRH services.
- Planning of youth health care services should be initiated with participation of youth, so that the services will be more users friendly.
- Ensuring the involvement of youth at all levels of the planning, implementation, and evaluation processes as well as properly addressing their family and community in which they live is highly recommended to successfully provide friendly health services to youth.
- Building the capacity of in-school youth groups: peer educators could play a very effective role in awareness programmes since friends and peers are the most preferred sources of information for boys and girls on SRH issues. Investigating ways that providers, social workers, peer educators and other working youth can help them develop the necessary skills to negotiate condom use.
- Assessing missed opportunities for meeting the unmet SRH needs of youth within the context of existing services in order to understand the root causes of service gaps including replication of studies similar to this one in other settings.
- High schools in Hossana with other stake holders need to avail SRH services to students in all schools in a way that is friendly, accessible and targeting special segments like female students.
- School administrators in collaboration with education and health offices of Hossana city administration should device a mechanism for motivating the health service providers in-school clinics and need to insure their competency.
- Curriculum based programmes should be adopted on SRH issues as this can show promising results on preventing adverse outcomes of youths SRH problems. There fore, Ministry Of Education has to device a mechanism to incorporate SRH information and education in curriculum development.

- IEC campaigns should be established in schools by concerned bodies and emphasis should be put on SRH issues to encourage youth to delay sex and negotiate condom use.
- The SRH services provided by external organizations and projects should be integrated to the school clinics and students' clubs in the long run, for sustainability and ownership.

11. REFERENCES

1. Training in Sexual Health Research, Fonds Chalumeau/GFMER/WHO, 2005.
2. Ethiopian Public Health Association (EPHA), Young people's HIV/AIDS and reproductive health needs and utilization of services in selected regions of Ethiopia, December 2005.
3. U.S. Bureau of the Census, International Data Base generated at http: //www.census.gov/cgi-bin/ipc/idbagg.
4. Population Reference Bureau. *2003 World Population Data Sheet.* Washington: PRB, 2003.
5. Disease Prevention and Control Department, Ministry of Health and The Futures Group International (Policy Project). *AIDS in Ethiopia. Fourth Edition.* October 2002.
6. HIV/AIDS Behavioral Surveillance Survey (BSS) Ethiopia 2002.
7. Berhane F. Assessment of Reproductive Health Service in Front Line Health Institution, under Addis Ababa Health Bureau. Residency Report, Department of Community Health, Faculty of Medicine, Addis Ababa University. September 1999.
8. Pathfinder International African Regional Office. Adolescent Reproductive Health in Africa: Path into the next century, 1999.
9. Senderowitz J. Adolescent Health reassuring the passage to adulthood, World Bank discussion paper, World Bank Washington DC No: 272, 1995
10. Adolescent Reproductive Health 1997-2004. www.rho.org.Accessed on September 2009
11. CSA and ORC Macro Ethiopia Demographic and Health Survey 2005. CSA and ORC Macro. Addis Ababa, Ethiopia and Calverton, Maryland, USA, 2006.
12. Attwell K.. Assessment of Youth Reproductive Health Programs in Ethiopia, Mobilizing Youth Participation in the National HIV/AIDS Program, Washington DC. Social and Scientific Systems, The Synergy Project, 2004.
13. Govindasamy Pav et.al, Youth Reproductive Health in Ethiopia, Calverton, Maryland: ORC Macro, 2002.

14. United Nations Population Fund (UNFPA), Population, Health and Socio-Economic Indicators/Policy development, 2006. http://www.unfpa.org/profile/ethipia.cfm.Accessed on September 2009
15. Tadelle G. Sexuality and HIV/AIDS risk and perception, among Male street youths in Dessie. North East African Studies (new series), 2000; 7 (1):109-126
16. Seifu A. Reproductive health needs of urban and rural out of school adolescent in East Gojam, December 2001.
17. Country Profile HIV/AIDS-Ethiopia, Dec.2003
18. Aluede et.al, Academic, career and personal needs of Nigerian university students, Journal of Instructional Psychology**,** March 2006.
19. Friedman LH and Edstron GK. Adolescent Reproductive Health: an approach to planning health services research. WHO, Geneva, 1983.
20. Schulenburg J, Maggs JL. And Hurrelmann K. Negotiating Developmental Transitions During Adolescence and young adulthood: Health Risks and Opportunities. In: Schulenberg J., Maggs JL and Hurrelmann K. editors. Health Risks and Developmental Transitions During Adolescence. 1997; 1-19.
21. Chassin L. Forward. In: Schulenberg J., Maggs J., and Hrrelmann K editors. Health risk and developmental transitions during adolescence. 1997.
22. Susan GM, Elena ON, AAnne CP. et al. Promoting healthy development of adolescents. Journal of American Medical Association. 1993; 269 (11): 1413- 1415
23. WHO. Programming for adolescent health and development. Report of WHO/UNFPA/UNICEF study group on health programming for adolescents. Technical report series No. 886. WHO, Geneva, 1999
24. Brenda W, Deanis M, Doyle, Unam Cadegan. The challenge of adolescent health: views from Catholic Social teaching and Medical Sciences. University Press of America, 1997.
25. WHO. Research on Reproductive health at WHO. Biennial report, Geneva, 2000-2001.
26. Dawud A. Perception of the risks of sexual activities among out-of-school adolescents in South Gonder Administrative Zone, Amhara Region, June 2003.
27. Hoffman AM, Greydanus DE. Adolescent Medicine. Second Edition, 1989, USA.

28. Arthu Elster, Naomi Jkuznets. Guideline for Adolescents Preventive Services: Recommendations and Rational. Department of Adolescent Health, Chicago, 1994.
29. Ministry of Health, Ethiopia. Technical Guideline in Maternal and Newborn Care, Addis Ababa, 1998.
30. Kora A, Haile M. Sexual behavior and level of awareness on reproductive health among youths: Evidence from Harar, Eastern Ethiopia. Ethiop. J. Health Dev. 1999; 13(2): 107-113.
31. Taffa N, Johanne S, Carol Holm-Hansen Et.al. HIV prevalence and socio- cultural contexts of sexuality among youth in Addis Ababa, Ethiopia. Ethiop. J. Health Dev.2002; 16(2):139-145
32. Miz-Hasab Research Center. Youth Reproductive Health in Ethiopia, Addis Ababa, Ethiopia, November 2002.
33. WHO. AIDS: Images of the Epidemic. 1994, Geneva
34. United Nations Children's ' Fund (UNICEF). The Progress of Nations 2000. March 2000, New York.
35. UNAIDS /WHO. Epidemiological fact sheet on HIV/AIDS and STDs. UNAIDS / WHO working group on HIV/ AIDS and STDs Surveillance. Geneva, June 1998.
36. MOH. Disease prevention and control department. AIDS in Ethiopia: third edition, November 2000.
37. United Nations Children's Fund Communication Section; awalker@unicef.org.Accessed on October 2009
38. Zewdie Z. Assessment of HIV risk perception and condom use among youth in Debre Birhan Town, Amhara Region, April 2005.
39. Assefa T. Sero prevalence of HIV-1 infection among antenatal care attendants and determinants of high risk behavior among different population subgroups in Dupti town of Afar Region, April 2002.
40. Eshetu F, David Z, and Kebede D. The attitude of students, parents, and teachers towards the promotion of condoms for adolescents in Addis Ababa (Dissertation) Department of community health, Faculty of Medicine, Addis Ababa University.

41. Ismail S, Bitsuamlak H and Alemu K. High Risk Sexual Behaviors for STD/ HIV, Pregnancies and contraception among high school students in rural town of northwest Ethiopia. Ethiop. J. Health Dev. 1997; 11(1): 29 - 36.
42. Fantahun M and Chala F. Sexual Behavior, and knowledge and attitude towards HIV/AIDS among out of school youth in Bahar Dar town, Northwest Ethiopia. Ethiop. Med. J. 1996; 34(4): 233 - 242.
43. Taffa N. Sexuality of out of school youth, and their knowledge and attitude about STDs and HIV/ AIDS in southern Ethiopia. Ethiop. J. Health Dev.1998; 12(1): 17- 22.
44. Abate S. Determinants of high-risk sexual behavior for HIV/AIDS among out of school youth in Addis Ababa, Ethiopia. (Dissertation) Department of Community Health, Faculty of Medicine, Addis Ababa University. December 1999.
45. Hughes J and McCauley AP. Improving the Fit: adolescents` needs and future programs for sexual and reproductive health in developing countries, Studies in Family planning. 1998; 29(2): 233-245.
46. Kwast B.E., Rochat R.W. and Widad Kidane Mariam. 1986. *Maternal mortality in Addis Ababa, Ethiopia.* Studies in Family Planning, 1986; 17 (6/1): 288-301.
47. Population Reports. Meeting the Needs of Young Adults. 1995;1-38.
48. Hailu A, Lisanework T, Negeri C, et al. Knowledge, attitude and practice on HIV/AIDS among pupils of rural high school in northwestern Ethiopia. (Abstract: presented at the fourth annual conference of the Ethiopian Public Health association.) Ethiop. J. Health Dev. 1993; 7(2): 132.
49. G. Selassie Tesfayi. Determinants of contraceptive use among urban youth in Ethiopia. Ethiop. J. Hlth. Dev. 1996; 10(2): 97-104.
50. Fortuna Hassen. Analysis of factors for unwanted pregnancy among women in reproductive age group attending health institutions in Jimma town, South-western Ethiopia, 2000.
51. WHO. The Health of Young People: A challenge and a promise. 1993, Geneva.
52. Tadesse E, Gudufa A and Mengistu GA survey of adolescent reproductive health in the city of Addis Ababa. Ethiop. J. Health Dev. 1996; 10(1): 35 – 39

53. Berhane F. health problems and service preferences of school adolescents in Addis Ababa with emphasis on reproductive health (Dissertation). Department of Community Health, Addis Ababa University. December 2000.
54. Seifu A. Attitude of health workers towards adolescent reproductive health service organization in Debremarkos town. Residency II (Unpublished). Department of Community Health, Addis Ababa University. June 2001.
55. Jocelyn De Jong et.al, Population Reference Bureau. Young People's Sexual and Reproductive Health in the Middle East and North Africa, April 2007.
56. Mekbib. Tekle-ab Reproductive health: Conceptual and operationalization challenges. Ethiop. Med. J. 2001; 39(1): 61-73.
57. Washington, DC: National Campaign to Prevent Teen Pregnancy Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, 2001.
58. Consortium on Reproductive Health Association (CORHA). Assessment of the reproductive health situations/ problems of students in the Addis Ababa, Bahirdar, Jimma, and Mekele Universities, 2005.
59. Hadiya zone education office, 2009.
60. WHO, Programming for adolescent health and development report of WHO/UNFPA/UNICEF study group on programming for adolescent health WHO, technical report series 886, Geneva 1999.
61. Germain A and Kyte R. International Women's Health Coalition. The Cairo Consensus: The Right Agenda for the Right Time. Second edition, 1995.
62. National Institute for Health(NIH), Theory at a Glance-A Guide for Health promotion practice, NIH 2005.
63. Belayneh Y. Reproductive health needs and service utilization of Addis Ababa university students, 2008
64. African AIDS Initiative (AAI), Knowledge, Attitude, Practices and Behaviour Survey of Addis Ababa University Students, 2005.
65. Egata G. Assessment of level of knowledge of reproductive health and sexual behavior among adolescents in Nekemte Town, April 2005.

66. Shiferaw S. The effect of living arrangements and parental attachment on sexual risk behaviors and psychosocial problems of adolescents in Dessie preparatory school, Ethiopia, April 2004.
67. Mohammad Reza Mohammadi et al, Reproductive Knowledge, Attitude and Behavior among adolescent males in Teheran, International Family Planning Perspectives, 2006.
68. Seung-Ju Lee, Yong-Hyun Cho, Chul Sung Kim et.al. Screening for Chlamydia and Gonorrhea by Strand Displacement Amplification in Homeless Adolescents Attending Youth Shelters in Korea. J. Korean Med. Sci. 2004; 19: 495-500
69. kebede A. Sexual behavior of urban and rural out of school youths towards STD/ HIV/AIDS and factors associated with these behaviors in Dera Woreda comparative cross sectional study, April 2003.
70. Alemu H. Factors predisposing out of school youth to high risk sexual practice with respect to HIV infection in Bahir Dar Town, NorthWest Ethiopia, June 2004.
71. William K. Adih, Cheryl S. Alexander. Determinants of Condom Use to Prevent HIV Infection among Youth in Ghana. Journal of Adolescent Health. 1999; 24:63-73.
72. Yimam E. Assessment of reproductive health behavior and needs of street youth in Dessie Town, Amhara Region, July, 2007.
73. Clarke ET. Youth education and services for health and family life situation analysis in Lesotho, 1985.
74. WHO, Adolescent Friendly Services, an Agenda for Change, 2003.

12. ANNEXES

ADDIS ABABA UNIVERSITY, FACULTY OF MEDICINE, CENTRALIZED SCHOOL OF NURSING

Annex-I. Consent form

In signing this document, I am giving my consent to participate in the study titled as"assessment of the reproductive health needs of high school students in Hossana".

I have been informed that the purpose of this study is to assess the reproductive health needs of high school students in Hossana. I understood that I am selected randomly to participate in this study from high school students.

I have understood that the participation in this study is entirely voluntarily. I have been told that my answers to the questions will not be given to any one else and no reports of this study ever identify me in any way. I have also been informed that my participation or non-participation or my refusal to answer questions will have no effect on my grades and me. I understood that participation in this study does not involve risks.

I understood that Tadele Kegnu is the contact person if I have questions about the study or about my rights as a study participant.

Address of the principal investigator:

Tadele Kegnu

Mobile number: 0911702001

E-mail**:** **tadele_kegnu@yahoo.com**

Address of Addis Ababa University, faculty of Medicine, Institutional Review Board:

Telephone number: 0115538734

E-mail: **aaumfirb@yahoo.com**

Respondent's signature_____

Date_____

Signature: _____ Date: _____

ADDIS ABABA UNIVERSITY, FACULTY OF MEDICINE, CENTRALIZED SCHOOL OF NURSING

Annex-II. Information sheet

Survey questionnaire prepared to collect data on the assessment of the reproductive health needs of high schools students in Hossana, student's self-reporting questionnaire.

Dear students,

Good morning/Good afternoon?

My name is _____. I am here today to collect data on the assessment of the reproductive health needs of high school students in Hossana. The questions which you will be asked are intended to come up with responses which are very essential for the program improvement. All information you provide to us will be kept confidential and your name will not be asked to maintain anonymity. No other person participating in this study will be told any information about you.

The information which you provide us will be a feedback for both the governmental and non governmental organizations to improve the quality of reproductive health services. Therefore, you are kindly requested to respond voluntarily with patience. You have a full right not to participate in the study or withdraw yourself from the study at any time.

If you have any question, you can contact the principal investigator.

Address of the principal investigator:

Tadele Kegnu

Mobile number: 0911702001

E-mail: **tadele_kegnu@yahoo.com**

Address of Addis Ababa University, Faculty of Medicine, Institutional Review Board:

Telephone number: 0115538734

E-mail: **aaumfirb@yahoo.com**

Are you willing to respond to the questionnaire? Yes, go to the next page

No, thank you!

Supervisor's Name_____Signature_____Date_____

ADDIS ABABA UNIVERSITY, FACULTY OF MEDICINE, CENTRALIZED SCHOOL OF NURSING

Annex-III. Questionnaire

Instruction: Dear students/participants, you are politely requested to respond to the following questions honestly, your confidential response is crucial for the success of my study. The result of this survey will be utilized for future planning of quality reproductive health service in the study area.

Section 1-Sociodemographic characteristics

Q.No.	Questions/Items	Alternative options
101	Sex	1. Male 2. Female
102	Age	1. <16 years 2. 16-20 years 3. 21-25 years 4. > 25 years
103	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Others, specify_____
104	Ethnicity	1. Amhara 2. Tigray 3. Oromo 4. Others, specify_____
105	Marital status	1. Single 2. Married 3. Divorced 4. Widowed 5. Others, specify_____

106	Level of education	1. Grade 9 2. Grade 10
107	How much do you earn in a month (monthly income)?	1. <50 birr 2. 50-100 birr 3. 101-200 birr 4. >200birr 5. None
108	What is the source of income?	1. Parents(family) 2. Part-time work 3. Donors 4. Others, specify_____
109	What is your family's economic status?	1. Rich 2. Medium 3. Poor 4. Others, specify_____
110	Do you ever go to clubs or parties where young people dance?	1. Yes 2. No
111	IF Yes to Q.110, how often?	1. Every night 2. Twice per week 3. Weekly 4. occasionally
112	Do you ever drink alcohol?	1. Yes 2. No
113	Do you ever smoke cigarettes?	1. Yes 2. No

Section 2-Sources of information on, and knowledge of reproductive health

201	What has been the most important source of information for you on the sexual and reproductive health issues?	1. School teacher 2. Parents/family members 3. Friends 4. Health professionals 5. Mass media/films, video 6. Others, specify_____
202	From whom, or where, would you prefer to receive more information on this issues?	1. School teacher 2. Parents/family members 3. Friends 4. Health professionals 5. Mass media/films, video 6. Others, specify_____
203	Some schools have classes on puberty, on sexual and reproductive systems and on relationships between boys and girls. Did you ever attend school classes on any of these topics?	1. Yes 2. No 3. Not sure
204	Do you think that there should be more classes on these topics, fewer classes or were the number about right?	1. More 2. Less 3. No idea
205	Do you find it difficult or easy to talk with your parents about things that are important to you?	1. Easy 2. Difficult 3. Not sure
206	Have you ever discussed sex-related matters with your parents?	1. Yes 2. No
207	If Yes to Q.206, how often?	1. Often 2. Occasionally

208	A woman can get pregnant on the very first time that she has sexual intercourse.	1. True 2. False 3. Don't know
209	Masturbation causes serious damage to health.	1. True 2. False 3. Don't know

Section 3-Reproductive Health Need Assessment, Health Service Utilization and Preferences

301	In your opinion what are the most common reproductive health problems that students encounter?	1. Sexually transmitted infections including HIV/AIDS 2. Unintended pregnancy and unsafe abortion 3. Gender based violence 4. Others, specify_____
302	What are the reproductive health services that you would like to get?	1. Information and education on reproductive health 2. Diagnosis and treatment of sexually transmitted infections 3. Provision of contraceptives 4. Abortion care 5. Others, specify_____
303	Is there any clinic in your school compound?	1. Yes 2. No
304	Have you ever visited the school Clinic for reproductive health service in the past 12 months?	1. Yes 2. No, if No skip to Q.307

305	What was the reason for your Visit?	1. To get condom 2. To get reproductive health information 3. For treatment of STI 4. For abortion care 5. Others, specify_____
306	Were you satisfied with the service you received from the School Clinic?	1. Yes 2. No
307	Have you visited health institution other than the school clinic for RH service in the past 12 months?	1. Yes 2. No, if No skip to 309
308	Why did you prefer to seek care out side, rather than the school clinic?	1. For confidentiality 2. Free service 3. Availability of qualified health workers 4. Convenient working hours 5. Others, specify_____
309	What are the barriers to use RH services in the school?	1. Violation of confidentiality 2. Inadequacy of the service 3. Long waiting time&repeated appointment 4. Others, specify_____

310	Where do you prefer the school clinic to be located?	1. In a hidden place in the school compound 2. Anywhere in the school compound 3. Outside the school compound 4. Others, specify_____
311	Who would you prefer to be the RH service provider?	1. Young providers of the same sex 2. Young providers of any sex 3. Adult provider of the same sex 4. Adult provider of any sex 5. Others, specify_____

Section 4- Sexuality, pregnancy, and contraception

401	Have you ever had a girl/ boy friend? By girl/boy friend, I mean someone to whom you were sexually or emotionally attracted and whom you 'dated'	1. Yes 2. No
402	How many girl / boy friends have you had?	1. Only 1 2. 2-3 girl/boy friends 3. 4-5 girl/boy friends 4. Unknown
403	When you started you relationship with your boy/girl friend, was he/she a full time student, working or neither?	1. Full-time student 2. Working 3. Neither
404	Did you and your boy/girl friend have any physical contact, such as holding hands, hugging or kissing?	1. Yes 2. No

405	Have you ever had penetrative sexual intercourse?	1. Yes 2. No→ skip to part 5
406	At what age did you first have sexual intercourse?	1. <10 years 2. 11-15 years 3. 16-20 years 4. 21-25 years 5. >25 years
407	Was your first sexual intercourse planned or unexpected?	1. Planned 2. Unexpected
408	How did you start sexual intercourse?	1. Peer pressure 2. For financial purpose/exchange for money 3. Rape 4. Personal desire 5. Others, specify_____
409	With whom did you make your first sexual intercourse?	1. With Husband/wife 2. With a steady boy/girl friend 3. With causal boy/girl friend 4. With a relative 5. With commercial sex worker 6. Others, specify_____
410	On the first time that you had sexual intercourse, did you and/or your partner do anything to avoid pregnancy or STI?	1. Yes 2. No

411	What method did you use?	1. Condom 2. Pills 3. Injection 4. Safe period 5. Other, specify_____
412	Apart from the first time, did you and your partner ever use a method to avoid pregnancy and STI including HIV/AIDS?	1. Yes, always 2. Yes, occasionally 3. Never
413	If no to Q.312, why not? (Multiple answers are possible)	1. Inaccessibility of contraceptives 2. Religious prohibition 3. Sex was unplanned 4. Opposition from boy/girl friend 5. Lack of knowledge about contraceptives 6. Others, specify_____
414	Have you had sexual intercourse in the past 12 months?	1. Yes 2. No→ skip to section 5
415	Have you ever had unplanned/ unintended sex in the past 12 months?	1. Yes 2. No
416	Have you ever received money/gifts to have sex in exchange in the past 12 months?	1. Yes 2. No
417	Have you/your partner ever been drunk while having sex in the past 12 months?	1. Yes 2. No
418	Have you ever been pregnant?	1. Yes 2. No→ skip to section 5

419	If yes to Q.318, how many times have you been pregnant?	1. Only once 2. 2 times 3. 3 times 4. 4 times 5. More than 5 times
420	How old were you when you first became pregnant?	1. < 16 years 2. 16-20 years 3. 21-25 years 4. > 25 years
421	If you have been pregnant, were all your pregnancies wanted?	1. Yes 2. No
422	If no to Q.421, what happened to your pregnancy?	1. Abortion 2. Miscarriage 3. Live birth 4. Currently pregnant 5. Not sure
423	Have you ever had induced abortion?	1. Yes 2. No
424	How many times did you have abortion?	1. Only once 2. 2 times 3. 3 times 4. 4 times 5. More than 5 times
425	Whom did you first discuss the issue with to have induced abortion?	1. Husband/boyfriend 2. My peers 3. My parents 4. Health workers 5. Others, specify_____

426	Where did you abort?	1. At public health institution 2. At private clinic 3. At abortionist's home 4. Others, specify_____

Section 5-Knowledge, Attitude and Practice about reproductive health issues

501	Have you ever heard of Reproductive health	1. Yes 2. No
502	What was the source of information?	1. Mass media 2. Friends 3. School education 4. Family 5. Youth club 6. Others, specify_____
503	Have you ever heard of Sexual Transmitted infections	1. Yes 2. No
504	Which type of Sexually Transmitted Infections do you know?(multiple answers are possible)	1. Gonorrhea 2. Syphilis 3. HIV/AIDS 4. Others, specify_____
505	Have you ever had burning pain during urination, genital discharge or genital ulcer?	1. Yes 2. No
506	If yes to Q.505, did you seek a medical treatment from a health institution?	1. Yes 2. No
507	What type of contraceptives/ methods of preventing pregnancy do you know?(multiple answers are possible)	1. Abstinence 2. Pills 3. Condoms 4. Norplant 5. IUD 6. Others, specify_____

508	Have you ever used any contraceptives?	1. Yes 2. No
509	Do you know some one who was infected with HIV or had died of AIDS?	1. Yes 2. No
510	What methods of preventing HIV/AIDS do you know? (multiple answers are possible)	1. Abstinence 2. Being faithful 3. Using condom 4. Others, specify_____
511	Were you ever concerned that you might catch AIDS or another sexually transmitted disease from your boy/girl friend?	1. Yes, very much concerned 2. Yes, somewhat concerned 3. No, not concerned
512	Were you able to do anything to reduce the risk of infection?	1. Yes 2. No
513	What did you do?	1. Use condoms 2. Take medicine 3. Others, specify_____
514	Do you know where you could get a confidential HIV test?	1. Yes 2. No
515	Have you ever undergone voluntary HIV testing?	1. Yes 2. No
516	Does the school clinic provide SRH services?	1. Yes 2. No

517	What component of RH services does it provide? (multiple answers are possible)	1. Counseling&Health education 2. Distribution of educational materials 3. Condom distribution 4. Diagnosis&treatment of STI 5. Abortion related care 6. VCT for HIV 7. Others, specify_____
518	Should contraceptives including condom be easily available in the school compound?	1. Yes 2. No 3. Don't know
519	Should VCT service be available in the school compound?	1. Yes 2. No 3. Don't know
520	What would you do when you have Sexually transmitted infections (STI)?	1. Talk to parents 2. Talk to friends 3. Go to school clinic 4. Go to private clinic 5. Others, specify_____
521	Where would you go to when you want to get counseling services?	1. Talk to parents 2. Talk to friends 3. Go to school clinic 4. Go to private clinic 5. Others, specify_____
522	Where would you go to when you want to get information on reproductive health issues?	1. Talk to parents 2. Talk to friends 3. Go to school clinic 4. Go to private clinic 5. Others, specify_____

Section 6-Sexuality, gender and norms

601	I believe it's all right for unmarried boys and girls to have dates	1. Agree 2. Disagree 3. Don't know
602	I believe it's all right for boys and girls to kiss, hug and touch each other.	1. Agree 2. Disagree 3. Don't know
603	I believe there is nothing wrong with unmarried boys and girls having sexual intercourse if they love each other.	1. Agree 2. Disagree 3. Don't know
604	I think that sometimes a boy has to force a girl to have sex if he loves her.	1. Agree 2. Disagree 3. Don't know
605	A boy will not respect a girl who agrees to have sex with him.	1. Agree 2. Disagree 3. Don't know
606	Most boys and girls who have sex before marriage regret it afterwards.	1. Agree 2. Disagree 3. Don't know
607	A boy and a girl should have sex before they become engaged to see whether they are suited to each other.	1. Agree 2. Disagree 3. Don't know
608	I am confident that I can insist on condom use every time I have sex.	1. Agree 2. Disagree 3. Don't know
609	It is mainly the woman's responsibility to ensure that contraception is used regularly.	1. Agree 2. Disagree 3. Don't know

610	I feel that I know how to use a condom properly.	1. Agree 2. Disagree 3. Don't know
611	Men need sex more frequently than do women	1. Agree 2. Disagree 3. Don't know
612	I would refuse to have sex with someone who is not prepared to use a condom	1. Agree 2. Disagree 3. Don't know

Thank you very much for your patience and confidential information!

በአዲስ አበባ ዩንቨርሲቲ የህክምና ፋኩሊቲ አጠቃላይ ነርስ ት/ቤት

አባሪ I የስምምነት ቅጽ

በዚህ ሰነድ ፊርማዬን ሳስቀምጥ ‹‹የሆሳእና ሁለተኛ ደረጃ ት/ቤት ተማሪዎች የስነ-ተዋልዶ ጤና ፍላጎት ጥናት›› ላይ የጥናቱ ተሳታፊ መሆኔን የሚያሳይ ስምምነት ነው፡፡ የዚህ ጥናት ዓላማ እንደተገለፀልኝ ከሆነ ጥናቱ በሆሳእና ከተማ ሁለተኛ ደረጃ ት/ቤት ተማሪዎች የስነ-ተዋልዶ ጤና ፍላጐት ለማጥናት የተደረገ ነው፡፡ እኔም በዚህ የሁለተኛ ደረጃ ት/ቤት ተማሪዎችን ባሳተፈ ጥናት በፅጣ ተሳታፊ እንዲሆን የተመረጥኩ መሆኔን ተገንዝቤለሁ፡፡

እንዲሁም በዚህ ጥናት ላይ የሚሳተፉ ተሳታፊዎች ሁሉ በጎ ፍቃደኞች መሆናቸውን ተረድቻለሁ፡፡ እንደተነረኝ ለጥያቄዎቹ የሚቀርብላቸው መልሶች በሙሉ ለሌላ ሰው የማይተላለፉ መሆናቸውንና የጥናቱም ሪፖርት እኔን ለይቶ የሚያወጣ መንገድ እንደሌላው ተረድቻለሁ፡፡ እንዲሁም ተሳታፊ ቢሆን ወይም ባልሆን ወይም ምላሽ ለመስጠት ባልፈልግ ባለኝ የትምህርት ውጤት ምንም ተጽእኖ የማያመጣ መሆኑን አውቃለሁ፡፡ በተጨማሪም በዚህ ጥናት ላይ መሳተፍ ምንም ዓይነት ጉዳት እንደማያደርስ ተረድቻለሁ፡፡

አቶ ታደለ ቀኙ የዚህ ኮንትራት ባለቤት መሆናቸውን ተረድቻለሁ፡፡ ስለዚህ ጥናቱን ወይም መብቴን በተመለከተ ያልገባኝ ነገር ቢኖር አቶ ታደለ ቀኙን ማነጋገር እንዳለብኝ አውቃለሁ፡፡

የዋና ተመራማሪ አድራሻ

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የመልስ ሰጪ

ፊርማ ----------

ቀን ----------

በአዲስ አበባ ዩንቨርስቲ የሕክምና ፋኩልቲ አጠቃላይ ነርስ ት/ቤት

አባሪ II የመረጃ ገፅ

በሆሳዕና ከተማ ሁለተኛ ደረጃ ት/ቤት ተማሪዎች ላይ የሚደረገው የስነ-ተዋልዶ ጤና ፍላጎት ጥናት አስመልክቶ የተዘጋጀና በተሳታፊዎች ብቻ የሚሞላ መጠይቅ፡፡ ውድ ተማሪዎች/ተሳታፊዎች እንደምን አደራችሁ/ አረፈዳችሁ?

ስሜ ---------- ይባላል፡፡ የመጣሁት በሆሳእና ከተማ ሁለተኛ ደረጃ ት/ቤት ተማሪዎችን ያሳተፈ የስነ ተዋልዶ ጤና ፍላጎት ጥናት ለማድረግ ነው፡፡ ለምትጠየቁት ጥያቄዎች የምትሰጡት ምላሽ/ መረጃ ለዚህ ፕሮግራም መጎልበት በጣም ጠቃሚ ነው፡፡ የምትሰጡት መረጃ በሙሉ በሚስጥር የሚያዝ ነው፡፡

ውድ ተሳታፊዎች የምትሰጡት መረጃ በመግንስትና መንግስታዊ ባልሆኑ ድርጅቶች አማካይነት የሚደረግ የስነ-ተዋልዶ ጤና አገልግሎት ላቅ እንድል ትልቅ አስተዋጽኦ አለው፡፡ ስለዚህ ጥያቄዎቹን በትዕግስት እንድትመልሱ በትህትና እጠይቃለሁ፡፡ በዚህ ጥያቄና መልስ ያለመሳፍ ሙሉ መብት እንዳለህ/ሽ ላስገነዝብ እወዳለሁ፡፡ ካልፈለክ/ሽ በማንኛውም ሰአት ራስህን/ሽን ከጥናቱ ውጪ ማድረግ ትችላለህ/ሽ፡፡ ምናልባት የምትጠይቀው ነገር ካለህ/ሽ ዋና ተመራማሪውን ልታገኘው/ኝው ትችላለህ/ሽ፡፡

የዋና ተመራማሪ አድራሻ

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ይህን የመጠይቅ ጥያቄ ለመመለስ ፈቃደኛ ከሆንክ/ሽ ወደ ቀጣይ ገጽ ሂድ/ጂ፤ ፈቃደኛ ካልሆንክ/ሽ ግን አመሰግናለሁ!

የተቆጣጣሪ ስም _____ **ፊርማ** --------- **ቀን** ----------

በአዲስ አበባ ዩኒቨርስቲ የህክምና ፋካሊቲ አጠቃላይ ነርስ ት/ቤት

አባሪ III የቃለ መጠይቅ ፎርም

<u>መመሪያ</u>

ውድ ተማሪዎች/ተሳታፊዎች እነዚህ እንደሚከተሉት ለምትጠየቋቸው ጥያቄዎች ትክክለኛ ምላሽ እንድትሰጡ በትህትና እጠይቃለሁኝ፡፡ ትክክለኛና እርግጠኛ ምላሻችሁ ለዚህ ጥናት ውጤት ጠቃሚ ነው፡፡ የዚህ ጥናት ውጤት የወደፊቱን የስነ ተዋልዶ የጤና አገልግሎት ጥራትና ብቃት ለማሳደግ የሚረዳ ነው፡፡

ክፍል 1 ማህበራዊ አቅጣጫና ሁኔታ

ተ.ቁ	**የጥያቄዎች ዝርዝር**	**አማራጭ ምላሾች**
101	*ፆታ*	1.ወንድ 2. ሴት
102	እድሜ	1. ‹16 ዓመት 2. 16-20 ዓመት 3. 21-25 ዓመት 4. ›25 ዓመት
103	ሐይማኖት	1.ኦርቶዶክስ 2. መስሊም 3. ፕሮቴስታንት 4. ሌላ (ጥቀስ/ሺ)_____
104	ጎሳ/ብሔር	1. አማራ 2. ትግሬ 3. ኦሮሞ 4. ሌላ (ጥቀስ/ሺ)_____

105	የጋብቻ ሁኔታ	1. ያላገባ/ች 2. ያገባ/ች 3. የፈታ/ች 4. ባልም ወይም ሚስት የሞተባት/ የሞተችበት 5. ሌላ (ጥቀስ/ሽ)_____
106	የትምህርት ደረጃ	1. 9 ክፍል 2. 10 ክፍል
107	በወር ምን ያህል ገንዘብ ታገኛለሽ/ህ (ወርሃዊ ገቢ)?	1. ከ50 ብር በታች 2. ከ50-100 ብር 3. ከ101-200 ብር 4. ከ200 ብር በላይ 5. ምንም የለም
108	የገቢ ምንጭህ/ሽ ምንድን ነው?	1. ቤተሰብ (ከወላጅ) 2. በፈረቃ ስራ 3. እርዳታ 4. ሌላ (ጥቀስ/ሽ)_____
109	የቤተሰቦችህ/ሽ የኢኮኖሚ ደረጃ ምንድ ነው?	1. ሀብታም 2. መሀከለኛ 3. ደሀ 4. ሌሎች (ጥቀስ/ሽ)_____
110	ወጣቶች ወደሚሄዱበት ክበብ ወይም ፓርቲ ሄድህ/ሽ ታውቃለህ/ሽ	1. አዎን 2. የለም

111	በጥያቄ 110 መልስ/ሽ አዎ ከሆነ ምን ያህል ጊዜ?	1. በየምሽቱ 2. በሳምንት ሁለቴ 3. በየሳምንቱ 4. አልፎ አለፎ
112	አልኮል ጠጥተህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም
113	ከአሁን ቀደም ሲጋራ አጭስህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም

ክፍል 2- የመረጃ ምንጭ እና የስነ-ተዋልዶ የጤና ግንዛቤ

ተ.ቁ	የጥያቄዎች ዝርዝር	አማራጭ ምላሾች
201	ስለየታ ግንኙነትና የጤና ማስፋፊያ ጉዳይ ጠቃሚ የመረጃ ምንጭ ነው የምትለው ማን ነው?	1. ት/ቤት 2. ወላጅ/ቤተሰብ አባላት 3. ጓደኛ 4. የጤና ባለሙያ 5. መገናኛ ብዙሃን (ፊልም ቪድዮ) 6. ሌላ (ጥቀስ/ሽ)_____
202	ይህን ጉዳይ አስመልክቶ መረጃውን የትና ከምን ለማግኘት ትመርጣለህ/ሽ	1. ከት/ቤት መምህር 2. ከወላጅ /ቤተሰብ አባላት 3. ከጓደኛ 4. ከጤና ባለሙያ 5. ከመገናኛ ብዙሃን (ፊልም ፣ቪዲዮ) 6. ሌላ (ጥቀስ/ሽ)_____

203	አንዳንድ ት/ቤቶች ስለ ስነ-ተዋልዶ ጤና እንዲሁም በወንድና ሴት ያለ ግንኙነትን በተመለከተ ትምህርት ይሰጣሉ፡፡ በእነዚህ ርዕስ አስመልክቶ የክፍል ትምህርት ተምረህ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም 3. እርግጠኛ አይደለሁም
204	በዚህ ርዕስ ላይ ብዙ የክፍል ትምህርት እንዲኖር አስበህ ታውቃለህ/ሽ ወይም እንዲቀንስ	1. ብዙ 2. ትንሽ 3. አስቤ አለዉቅም
205	ለአንተ/ቺ ጠቃሚ የሆነውን ነገር ከቤሰብ (ወላጆች) ጋር መነጋገር ከባድ ነው ትላለህ/ሽ ወይስ ቀላል?	1. ቀላል 2. ከባድ 3. እርግጠኛ አይደለሁም
206	ከወላጆችህ/ሽ ጋር ስለ ፆታ ግንኙት ነክ ወይይት አድርገህ/ሽ ታወቃለህ?	1. አዎን 2. አላዉቅም
207	በጥያቄ 206 መልስ/ሽ አዎ ከሆነ ምንያህል ጊዜ?	1. ሁሉ ጊዜ 2. አልፎ አልፎ
አሁን በፆታ ግንኙነት እና ስነ-ተዋልዶ ትንሽ ጥያቄዎች ለቅርብ፡፡ አረፍተ ነገሮችን ላንብብልህና/ሽና አረፈተ ነገሩ ትክክል ከሆነ አዎ በል ካልሆነም ሐሰት በል ወይም አላዉቅም በል/ይ		
208	ሴት የፆታ ግንኘነት ለመጀመሪያ ጊዜ ስትፈፅም ታረግዛለች?	1. አዎን 2. ሐሰት 3. አላውቅም

209	ማስተርቤሽን በጤና ላይ ቀጥተኛ ጉዳይ ያመጣል ?	1. አዎን 2. ሐሰት 3. አላውቅም
ክፍል 3 ስነ-ተዋልዶ ጤና ፍላጎት፣ አገልግሎትና አማራጭ		
301	በአንተ/ቺ አመለካከት ተማሪዎች የሚገጥማቸው ዋነኛ የስነ ተዋልዶ ጤና ችግር ምንድን ናቸው፡፡	1. በየታ ግንኙነት የሚተላለፍ የአባላዘር በሽታ ኤች አይቪ/ኤድስን ጨምሮ 2. ያልተጠቀበቀ እርግዝናና ምቹ ያልሆነ ማስወረድ 3. የታን መሰረት ያደረገ ጥቃት 4. ሌሎች (ጥቀስ/ሽ)_____
302	ልታገኘው/ኝው የምትፈልገው/ጊው የስነ ተዋልዶ ጤና አገልግሎት የትኛው ነው?	1. የስነ-ተዋልዶ ጤና መረጃና ትምህርት 2 ዓይነትና ተላላፊ የአባለ ዘር በሽታ ሕክምና 3. የወሊድ መከላከያ አቅርቦት 4. የዉርጃ አገልግሎት 5. ሌሎች (ጥቀስ/ሽ)_____
303	በት/ቤታችሁ አጥር ግቢ ክሊኒክ አለ?	1. አዎን 2. የለም
304	ካለፉት 12 ወራቶች ውስጥ በትምህርት ቤት ውስጥ ወደ ሚገኘው ክሊኒክ የወሊድ ጤና አገልግሎት ፈልገህ ሄደህ/ሽ ነበር?	1. አዎን 2. አልሄድኩም (መልስህ/ሽ አልሄድኩም ከሆነ ወደ ጥያቄ 307 ሂድ/ጂ)

305	የሄድክበት/ሽበት በምን ምክንያት ነበር?	1.ኮንዶም ለማግኘት 2. የወሊድ ጤና መረጃ ለማግኘት 3. ተላላፊ የአባላ ዘር በሽታ ለመታከም 4. ለዉርጃ አገልግሎት 5. ሌላ (ጥቀስ/ሽ)_____
306	በትምህርት ቤት ክሊኒክ በተሰጠህ አገልግሎት ረክተሃል/ሻል	1. አዎን 2. አልረካሁም
307	ባለፉት 12 ወራቶች ውስጥ ለሥነ-ተዋልዶ ጤና አገልግሎት ከት/ቤት ክሊኒክ ውጭ ወደ ጤና ተቋም ሄደህ/ሽ ነበር?	1. አዎን 2. አልሄድኩም
308	ከት/ቤት ክሊኒክ በሸገር ለምን የውጭ አገልግሎት መረጥክ/ሽ	1. ሚስጥር ስለሚጠበቅ 2. ነፃ አገልግሎት ለማግኘት 3. ብቃት ያላቸውን የጤና ሰራተኞች ፈልጌ 4. ምቹ የስራ ሰዓት ስላለ 5. ሌላ (ጥቀስ/ሽ)_____
309	በት/ቤት የስነ-ተዋልዶ ጤና አገልግሎት እንዳትጠቀም/ሚ የሚያደርጉት ምንድን ናቸው?	1. ሚስጥር ስለማይጠበቅ 2. አገልግሎት ብቃት ማነስ 3. ረዥም የጥበቃ ጊዜ እና የቀጠሮ ድግግሞሽ 4. ሌላ (ጥቀስ/ሽ)_____

310	የት/ቤት ክሊኒክ ቦታው የት እንዲሆን ትመርጣለህ/ሽ?	1. በት/ቤቱ አጥር ግቢ ድብቅ ቦታ 2. የትኛውም ቦታ በት/ቤት ቅጥር ግቢ ውስጥ 3. ከት/ቤት አጥር ግቢ ውጪ 4. ሌሎች (ጥቀስ/ሽ)_____
311	የስነ-ተዋልዶ ጤና አገልግሎት ማን እንድሰጥህ ትፈልጋለህ/ሽ?	1. ተመሳሳይ ፆታ ያላቸው ወጣቶች 2. ማናቸውም ፆታ ያላቸው ወጣቶች 3. ተመሳሳይ ፆታ ያላቸው ጎልማሶች 4. ማናቸውም ፆታ ያላቸው ጎልማሶች 5. ሌላ (ጥቀስ/ሽ)_____

ክፍል 4 የፆታ ግንኙነት፣ እርግዝና እና የወሊድ መከላከያ

401	ከአሁን በፊት የወንድ/ የሴት ጓደኛ ነበረህ/ሽ?	1.አዎን 2.አልነበረኝም
402	ስንት የሴት/የወንድ ጓደኛ አለህ/ሽ?	1. አንድ ብቻ 2. 2-3 ሴት/ወንድ ጓደኞች 3. 2-5 ሴቶች/ወንዶች 4. አላውቀውም
403	ከሴት/ወንድ ጓደኛ ጋር ትውውቅ/ግንኙነት ስትጀምር/ሪ እሷ/እሱ የሙሉቀን ተማሪ ወይም ሰራተኛ ነበረች/ረ?	1. የሙሉ ቀን ተማሪ 2. ሰራተኛ 3. ምንም አይደለም/ችም
404	አንተ/ቺ እና የወንድ/የሴት ጓደኛ ጋር ማናቸውም አስካላዊ ንክኪ (እጅ መያያዝ፣ መተቃቀፍ/ መሳሳም) አድርጋቹሃልን?	1.አዎን 2.አላደረግንም

405	ከአሁን ቀደም የግብረ-ስጋ ግንኙነት ፈጽመህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም መልስህ/ሽ አላዉቅም ከሆነ ወደ ክፍል 5 ሂድ/ጂ
ከ406-417 ያሉት ጥያቄዎች ከዚህ በፊት የግብረ ስጋ ግንኙነት ፈጽመው የሚያውቁ ተማሪዎች የሚመለከት ነው።		
406	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት የፈፀምከው/ሽው በስንት አመትህ/ሽ ነው?	1. <10 ዓመት 2. 11-15 ዓመት 3. 16-20 ዓመት 4. 21-25 ዓመት 5. ›25 ዓመት
407	የመጀመሪያ ግብረ-ስጋ ግንኙነት ታቅዶ የተደረገ ነው ወይስ ያልታቀደ ነበር?	1. በእቅድ ነው 2. ያልተጠበቀ ነው
408	የግብረ ስጋ ግንኙነት እንዴት ነበር የጀመርከው/ሽው?	1. በእኩያ ተፅእኖ/በጓደኝ ግፊት 2. ገንዘብ ለማግኘት በማቀድ /ገንዘቡ ተከፍሎኝ 3. ተደፍሬ 4. በፍላጎቱ 5. ሌሎች (ጥቀስ/ሽ)_____
409	የመጀመሪያው የግብረ ስጋ ግንኙነት ከማን ጋር ነበር የፈጸምከው/ሽው?	1. ከባሌ/ከሚስቱ 2. ከወንድ/ሴት ጓደኛዬ 3. ከወንድ/የሴት ጓደኛ ከነበረ ጋር 4. ከዘመድ ጋር 5. የሽቀጥ የወሲብ ስራ ላይ 6. ሌሎች (ጥቀስ/ሽ)_____

410	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስትፈጽሙ አንተ/ቺ ወይም ጓደኛ/ሽ እርግዝና እና የአባላዘር በሽታን ለመከላል ያደረጋችሁት ነገር አለ?	1. አዎን 2. የለም
411	የትኛው የመከላከል ዘዴ ነበር የተጠቀማችሁ?	1. ኮንዶም 2. ክኒን 3. መርፌ 4. ምቹ ፔሪዶ 5. ሌላ (ጥቀስ/ሽ)_____
412	ከመጀመሪያ ጊዜ ወዲህ አንተ/ቺ እና ጓደኛህ/ሽ እርግዝና፣ ተላላፊ የአባላዘር በሽታ እንዲሁም ኤድስ/ኤች አይ ቪ ኤድስን ለመከላከል የተጠቀምከው/ሺ ዘዴ አለ?	1. አዎን ሁል ጊዜ 2. አዎን አልፎ አልፎ 3. የለም
413	በጥያቄ 312 መልስህ/ሽ የለም ከሆነ ምክንያቱ ምንድ ነው?	1. የእርግዝና መከላከያ ስላላገኘሁ 2. በሐይማኖት ስለማይፈቀድ 3. ያለዕቅድ የተፈፀመ ስለሆነ 4. የእርግዝና መከላከያ ዕውቀት ማነስ 5. ሌላ (ጥቀስ/ሽ)_____
414	ባለፉት 12 ወራቶች የተቃራኒ የፆታ ግንኙነት አድርገህ/ሽ ነበር?	1. አዎን 2. አላደረኩም (መልስህ/ሽ አላደረኩም ከሆነ ወደ ክፍል 5 ሂድ/ጂ)

415	ባለፉት 12 ወራቶች ያለዕቅድ /ያልታሰቡ የተቃራኒ ፆታ አድርገህ/ሽ ነበር?	1.አዎን 2.አላደረኩም
416	ባለፉት 12 ወራቶች የተቃራኒ ፆታ ግንኙነት አድርገሽ/ህ የተቀበልከው/ሺው ገንዘብ/ስጦታ አለ?	1.አዎን 2.የለም
417	አንተ/ቺ ከጓደኛህ/ሽ ጋር ባለፉት 12 ወራቶች ውስጥ ጠጥታችሁ የተቃራኒ ፆታ ግንኙነት አድርጋቹሃልን?	1.አዎን 2.አላደረግንም
ከጥያቄ 418-425 ለሴቶች ብቻ የሚቀርብ ነው		
418	ከዚህ በፊት አርግዘሽ ነበር?	1.አዎን 2.አላረገዝኩም (መልስህ/ሽ አላረገዝኩም ከሆነ ወደ ክፍል 5 ሂድ/ጂ)
419	አዎ ከሆነ ጥያቄ 319 ስንት የእርግዝና ጊዜያቶች ነበር?	1. አንዴ ብቻ 2. 2 ጊዜ 3. 3 ጊዜ 4. 4 ጊዜ 5. ከ5 ጊዜ በላይ
420	የመጀመሪያ እርግዝናሽ ጊዜ ስንት አመትሽ ነበር?	1. ከ16 ዓመት በታች 2. 16-20 ዓመት 3. 21-25 ዓመት 4. ከ25 ዓመት በላይ

421	እርግዝናው የመጣው በፍላጐትሽ/በፍቃድሽ ነበር?	1.አዎን 2.አይደለም
422	ጥያቄ 421 አይደለም ከሆነ እርግዝናሽ እንዴት ሆነ?	1. አስወረድኩት 2. ተጨናገፈ 3. ወልጃለሁ 4. አሁን ነው ያረገዝኩት 5. እርግጠኛ አይደለሁም
423	ካሁን ቀደም ፅንስ ማስወገድ ፈፅመሻል?	1.አዎን 2.አይደለም
424	ስንት ጊዜያቶች ያህል ፅንስ አስወርደሻል?	1. አንዴ 2. 2 ጊዜ 3. 3 ጊዜ 4. 4 ጊዜ 5. ከ5 ጊዜ በላይ
425	ፅንስ ያስወረድሽው የት ነበር?	1. በሕዝብ የጤና አገልግሎት 2. በግል በክሊኒክ 3. ፅንሱ አስወራጅ ቤት 4. ሌላ (ጥቀሽ)_____
ክፍል 5 የስነ ተዋልዶ ጉዳዮች እወቅት፣ዝንባሌ እና ተሳትፎ		
501	ስለ ስነ ተዋልዶ ጤና ከዚህ ቀደም የሰማኸው/ሺው አለ?	1.አዎን 2.የለም
502	የመረጃ ምንጮችህ/ሽ ምን ነበር?	1. መገናኛ ብዙሃን 2. ጓደኞች 3. ትምህርት 4. ቤተሰብ/ወላጆች 5. የወጣቶች ክለብ 6. ሌሎች (ጥቀስ/ሽ)_____

503	ከዚህ በፊት ስለ ተላለፊ በሽታዎች ሰምተህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም
504	የትኛውን ተላላፊ የአባላዘር በሽታ ታውቃለህ? ብዙ መልስ መመለስ ይችላላ፡፡	1. ጨብጥ 2. ቅጭኝ 3. ኤች አይቪ/ኤድስ 4. ሌሎች (ጥቀስ/ሽ)_____
505	ከዚህ ቀደም ሽንት የማቃጠል ስሜትና ብልትህ/ሽ አካባቢ ቁስል ወይም የህመም ስሜት ኖሮ ያውቃል?	1. አዎን 2. አያዉቅም
506	በጥያቄ 505 መልስ/ሽ አዎ ከሆነ ከጤና ተቋማት የህክምና አገልግሎት አግኝተህል/ሻል?	2. አዎን 3. አላገኘሁም
507	የትኛው የወሊድ/ፅንስ መከላከያ ዘዴ ታውቃለህ/ሽ?	1. መታቀብ 2. ክኒን 3. ኮንዶም 4. በክንድ የሚቀበር መድሃኒት 5. በማህፀን የሚከተት መድሃኒት 6. ሌሎች (ጥቀስ/ሽ)_____
508	ከዚህ ቀደም የወሊድ መከላከያ ተጠቅመሃል/ሻል?	1. አዎን 2. አልተጠቀምኩም
509	በኤች አይ ቪ/ ኤድስ የተያዘ ሰው ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም

510	ምን አይነት የኤድስ/ኤች አይቪ የመከላከያ ታውቃለህ/ሽ (ብዙ መልስ ይቻላል)	1. መታቀብ 2. ታማኝ መሆን 3. ኮንዶም 4. ሌሎች (ጥቀስ/ሽ)_____
511	ከወንድ ወይም ሴት ጓደኛህ ኤድስ ወይም ሌላ አባላዘር በሽታ ሊይዘኝ ይችላል ብለህ አስበህ/ሽ ታውቃለህ/ሽ?	1. አዎ በጣም አስብበታለሁ 2. አዎ በጥቂቱ 3. አይደለም አስቤበት አላውቅም
512	በበሽታው የመጠቃት ዕድልህ/ሽን ለመቀነስ የሚያስችል ነገር አድርገህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላዉቅም
513	በጥያቄ 512 መልስህ/ሽ? አዎ ከሆነ ምን አድርገህ/ሽ?	1. ኮንደም እጠቀማለሁ 2. መድሃኒት እጠቀማለሁ 3. ሌላ (ጥቀስ/ሽ)_____
514	ሚስጥር የሚጠብቅ የኤድስ ምርመራ አገልግሎት የት ማግኘት እንምትችል/ይ ታዉቃለህ/ሽ	1. አዎን 2. አላዉቅም
515	በበጎ ፈቃድ የኤች አይቪ ምርመራ አድርገሽ/ህ ታዉቃለህ/ሽ	1. አዎን 2. አላዉቅም
516	በትምህርት ቤት ውስጥ ያለው ክሊኒክ የስነ-ተዋልዶ ጤና አገልግሎት ይሰጣል?	1. አዎን 2. አይሰጥም

517	ምን አይነት የጤና አገልግሎት ያቀርባል (ብዙ መልስ መስጠት ይቻላል) ?	1. ምክር እና የጤና ትምህርት 2. የትምህርት መሳሪያዎች ማሰራጨት 3. የኮንዶም ስርጭት 4. የአባላዘር በሽታዎች የህክምና አገልግሎት 2. የፅንስ ውርጃና ተያያዥነት ያላቸው የጤና አገልግሎቶች 3. ከኤች አይ ቪ ተጋላጭነት መከላከል 4. ሌሎች (ጥቀስ/ሽ)_____
518	የፅንስ መከላከያ ኮንደምን ጨምሮ በትምህርት ቤት አጥር ግቢ በቀላሉ መኖር አለበት ትላለህ/ሽ	1. አዎን 2. አይደለም 3. አላውቅም
519	የምክርና ምርመራ አገልግሎት በትምህርት ቤት አጥር ግቢ መገኘት አለበት ትላለህ/ሽ	1. አዎን 2. አይደለም 3. አላውቅም
520	የአባላዘር በሽታ ብኖርብህ/ሽ ምን ታደርጋለህ/ሽ?	1. ወላጆቼን አናገራለሁ 2. ጓደኞቼን አናገራለሁ 3. ወደ ት/ቤት ክሊኒክ እሄዳለሁ 4. ወደ ግል ክሊኒክ እሄዳለሁ 5. ሌሎች (ጥቀስ/ሽ)_____
521	የምክር አገልግሎት ማግኘት ስትፈልግ/ጊ የት ትሄዳለህ/ሽ?	1. ወላጆቼን አናገራለሁ 2. ጓደኞቼን አናገራለሁ 3. ወደ ት/ቤት ክሊኒክ እሄዳለሁ 4. ወደ ግል ክሊኒክ እሄዳለሁ 5. ሌሎች (ጥቀስ/ሽ)_____

522	በስነ ተዋልዶ ጤና ጉዳዮች መረጃ ስትፈልግ/ጊ ወዴት ትሄዳለህ/ሽ?	1. ወላጆቼን አናገራለሁ 2. ጓደኞቼን አናገራለሁ 3. ወደ ት/ቤት ክሊኒክ እሄዳለሁ 4. ወደ ግል ክሊኒክ እሄዳለሁ 5. ሌሎች (ጥቀስ/ሽ)_____
ክፍል 6- የታዊ ግንኙነትና ስነ-የታ ልማዶች ስለ ግንኙነቶች ተዳጊ ወጣቶች የተለያዩ አይነት አመላካከት ይኖርባቸዋል። አንዳንድ ሃሳቦችን ለአንተ/ቺ አቀርባለሁኝ። እስማማለሁ፣ አልስማማም ወይም አላውቅም በማለት መልስ/ሽ?		
601	ያላገቡ ወንዶች እና ሴቶች መገናኘት እና መቀጣጠር አለባቸው ትላለህ/ሽ?	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
602	ያላገቡ ወንዶች እና ሴቶች መሳሳምና ግንኙነት ማድረግ ችግር የለውም ትላለህ/ሽ?	1. እስማማለሁ 2. አልስማማም 3. አላዉቅም
603	ያላገቡ ወንዶች እና ሴቶች ወሲባዊ ግንኙነት ማድረግ ችግር የለውም ትላለህ/ሽ?	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
604	አንዳንዴ የምወዳት ከሆነ ወንዱ ሴትዋን ወሲባዊ ግንኙነት አንድታደርግ ማስገደድ አለበት ትላለህ?	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
605	ወሲባዊ ግንኙነት እንድታደርግ የተስማማች ሴት ከድርጊቱ በኋላ ትፀፀታለች ትላለህ/ሽ?	1. እስማማለሁ 2. አልስማማም 3. አላውቅም

606	ከጋብቻ በፊት ወሲባዊ ግንኙነት የሚፈጽሙት ወንዶች እና ሴቶች ከድርጊቱ በኃላ ይፀፀታሉ?	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
607	በወሲባዊ ህይወታቸው የማይጣጣሙ መሆናቸው ወይም አለመሆናቸው ለማወቅ ወንዱና ሴት ጋብቻ ከማድረጋቸው በፊት ወሲብ ማድረግ አለባቸው ብዬ አምናለሁ	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
608	ወሲባዊ ግንኙነት በሚደርግበት ጊዜ ኮንዶም እንደምጠቀም እምነት አለኝ	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
609	የፅንስ መከላከያን የመከታተል ሃላፊነት ያለባት ሴትዋ ነት	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
610	ኮንዶም በአግባቡ እንዴት መጠቀም እንዳለብኝ አውቃለሁ ብዬ አስባለሁ	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
611	ወንዶች ከሴቶች ይልቅ ወሲባዊ ግንኙነት ይፈልጋሉ ብዬ አምናለሁ፡፡	1. እስማማለሁ 2. አልስማማም 3. አላውቅም
612	ኮንዶም ለመጠቀም ዝግጁ ካልሆነ ሰው ጋር ወሲባዊ ግንኙነት ለማድረግ ፈቃደኛ አይደለሁም	1. እስማማለሁ 2. አልስማማም 3. አላውቅም

በትዕግስት ጥያቄዎቹን ስለመለስክ/ሽ አመሰግናለሁ!

Annex IV. DECLARATION

I, the undersigned, declare that this thesis is my original work in partial fulfillment of the requirements for the degree of Master of Adult Health Nursing. All the sources of materials used for this thesis and all people and institutions who gave support for this work have been fully acknowledged.

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Date of Submission: _____

This thesis has been submitted for examination board with my approval as University advisor.

Name of the advisor: Sr. Tekebash Araya (RN, B.Sc., MPH)

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Date:_____

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3. **Advisor**: Tekebash Araya (RN, B.Sc., MPH, lecturer)
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8. **Abstract**

Introduction: Sexual and Reproductive Health problems that the young people are facing are not localized to one geographic location or one part of the world. Worldwide, 15 million adolescents experience pregnancy each year. Since most of these pregnancies are unwanted, young women tend to have induced abortions, whether legal or not. Moreover, half of new HIV infections are observed in the 15-24 age groups. On top of this, studies about STI in adolescents show that the incidence is increasing. Today, each year, one in 20 adolescents suffers from an STI other than HIV (1).

***Objectives*:** The main objective of this survey was to assess the reproductive health needs of high school youth in Hossana.

Methods: A cross sectional institution based study was conducted from September, 2009 to June, 2010. 422 study subjects were identified by using multi stage sampling method. Data was collected using structured questionnaire, entered and analyzed using EPI info and SPSS statistical program respectively.

Results: About 35.8%, of the respondents had experienced penetrative sexual intercourse and 59.5% of the respondents reported that their first sexual intercourse had been unplanned. About 16.9% of the respondents have more than one sexual partner. Among sexually active students, 45.7 % had used condom during their first sexual intercourse as a means of preventing pregnancy and/or STIs including HIV/AIDS. Majority (70.4%) of sexually active female respondents have ever been pregnant out of which 52.9% of them had induced abortion.

Conclusion

In spite of the students need to get SRH services, the school clinics are not providing their services adequately. The health service delivery system should consider the special needs of youth and work out comprehensive and effective policies and strategies to provide young people with the services appropriate to their needs.