POPULATION STUDIES AND RESEARCH CENTER
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Youth Reproductive Health Problems and Service Preferences Lalibela Town, North Wollo Administrative Zone, Amhara Region

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Masters of Population Studies

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By

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LISTS OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescents Reproductive Health
CI	Confidence Interval
CSA	Central Statistics Authority
EDHS	Ethiopian Demographic and health Survey
FGAE	Family Guidance association of Ethiopia
FHI	Family Health International
FP	Family Planning
HIV	Human Immune Virus
ICPD	International Conference on Population and development
IEC	Information, Education and Communication
MOH	Ministry of Health
OSSA	Organization for Social Service for AIDS
PIB	Population Information Bureau
SD	Standard Deviation
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	United nation Program on AIDS
UNFPA	United Nation Fund for Population Activities
WHO	World Health Organization
YRHS	Youth Reproductive Health Services

Abstract

The reproductive health of youths in Ethiopia is multiphase and interrelated. Poor socio-economic and environment, limited access to reproductive health information and services and lack of youth friendly reproductive health services aggravated the risk of youth reproductive health problems. The main objective of the study is to assess youth reproductive health problems in Lalibela town, North Wollo, Amhara region. Across-sectional based descriptive study on 400 randomly selected youths using structured questionnaire has been conducted. The collected data were computed with chi-square tests and binary logistic regression analysis. The Findings of the study indicated that, Out of the total 400 respondents, 213 (53.3 percent) were females with female to male ratio of 1:0.88. Among the study participants, 195 (48.8 percent) belong to the age 15-18. From the total, 26 (6.5 percent) of the respondents were married, out of which 26(100 percent) of them married before reaching age 18. From the youths under the study, 199(49.8 percent) were sexually active, out of which 95.5 percent exercised first sexual intercourse before reaching age 18 and out of the total sexually active youths 61.3 percent responded that their first sexual intercourse were unsafe (no condom use).There were 70 pregnant youths in the study and from those, 88.6 percent exposed to unwanted pregnancy, of those, 31.4 percent gave birth and 68.8 percent aborted. From chi-square result it was found out that sex, age marital status, attending religious program, member of the youth RH and anti AIDS club, attending school youth RH and anti HIV/AIDS program, currently going to school, having pocket money, currently living with father and mother, educational level and occupational status have shown significant association with youth reproductive health problem. Logistic regression indicates that, being younger age, living with the friends and getting pocket money were found to be the factors that resulted in youth reproductive health problem. On the contrary, attending the school youth RH and anti HIV/AIDS club that disseminate information regarding youth RH matters contributed a lot for not being affected by youth reproductive health problem. From this study it was concluded that youths in the study area were experiencing high youth reproductive health problem. Thus there is a need to collaborate different sectors and the community to facilitate youth friendly health services to promote youth health.

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CHAPTER- I

INTRODUCTION

1.1 Background of the Study

The World Health Organization (WHO) defines adolescents comprising age group between 10-19 years, youth as 15-24 and young people as 10-24. Youth is an age group that undergoes through physical, emotional, mental and social changes that place its life at high risk. consequently, most of the youths have face greater reproductive health risks than adults for many reasons, including a willingness to take greater risks in general, such as having unprotected sex, unwanted pregnancy, childbearing at an early age, a greater vulnerability to sexual pressure, coercion and exploitation, high risk of unsafe abortion and who suffer the complications that insure (UNFPA, 2004).

In addition, young peoples did not receive adequate information and services on reproductive health. Even if services are available they don't utilize properly. This situation has made the problems associated with youth reproductive health serious and complex. The weakening of social structures due to instability, poverty, HIV/AIDS has left youth with fewer resources and support systems in place to help them navigate the path to adulthood (MOH, 2004).

Ethiopia is a country which is very poor and as the case in many others developing countries the health situation in general and reproductive health in particular have suffered from in adequate staffing and allocation of resources (FHI, 1997). The country is characterized by an expanding, largely rural population. It is estimated that young people age 10-24 constitute more than a third of the total population roughly 21 million (MOH, 2004). The economic, political, and social situation in Ethiopia has seriously affected this group. Access to education and health services remains limited, particularly for young rural women and men. Reproductive health profile is characterized by, according to the results of the 2005 EDHS; the TFR calculated for the three years preceding the survey is 5.4 births .Urban-rural differentials in Ethiopia are large with rural women having an average of 3.6 children more than urban women., Very low

contraceptive prevalence with a contraceptive prevalence rate of 8.1 percent, high maternal mortality rate 673 deaths per 100,000 live births (CSA, 1994)

The reproductive health problems of young people in Ethiopia are multiphase and interrelated. Child bearing begins at an early age, 45 percent of the total births in the country occur among adolescent girls and young women. Sexual violence and commercial sex worker have become common phenomenon among young girls, as the result they have become primary victims of the HIV/AIDS crises that have spread through out the country. In general young people are at great risk for reproductive health problems; the situation is aggravated by the over all poor socio-economic, environmental, and harmful traditional practices. Because of the nature of the problems, youth reproductive health strategies demand multi-sectoral and integrated approach (Aklilu et al., 2002).

1.2 Statement of the problem

Most of the young people become sexually active in their teenage and many before their 18th birthday. Most of the time they practised unsafe sexual intercourse with multiple partners, they are exposed to STIs particularly HIV/AIDS. Along with this females in particular jeopardized by unwanted teenage pregnancy, unsafe abortion, morbidity and mortality related complications, school dropouts and separating from family, etc. (UNFPA, 1998).

Youth in many developing countries have been exposed to threatening health risks mainly because they do not have adequate information, knowledge and proper guidance about youth reproductive health, HIV/AIDS, STIs, Sexual Reproductive health (SRH) and its problems before they reach adolescences stage. This is clear from the alarming evidences about abortion, the hazardous of early pregnancy and the incidence of sexually transmitted disease, the incidence of which is increasing helped by ignorant, fear, shortage of medicines and inadequate treatments. Most of the developing nations are started with national youth policies, preventive programs and strategic plans regarding young generations sexual and reproductive health problems or issues but the national youth polices, programmes and strategies that specifically address and meet young people's sexual and reproductive health are scarce and relatively are not

popular in most developing countries (WHO, 2004). So that youth reproductive health problems and service preferences study is very important in this situation.

Ethiopian's youth facing different kinds of problems apart from reproductive health such as poverty, traditional and cultural belief and misconceptions. As an age group their material, social, health and reproductive needs have not been given the require attention (NCTPE, 1995). In Ethiopia studies that carried out in recent years in different parts of the country have indicated that youth people (aged 15-24) have emerged as the most susceptible population to a broad spectrum of serious SRH problems including HIV/AIDS infections, unwanted pregnancies and un safe abortion. Recently few studies has been done assessments indicated that the major contributing factor to youth reproductive health problems of Ethiopia are related to lack of reproductive health services designed to them or poor reproductive health services (NCTPE, 1995).

1.3 Objective of the Study

General objective

- To assess youth reproductive health problems and service preferences in North Wollo, Lalibela, Amhara region, Ethiopia.

Specific objectives

- To determine the magnitude of selected reproductive health problems of youth (early sexual activity, unwanted pregnancy, early birth and abortion)
- To assess the contributing factors for the preference and utilization of reproductive health service among youth in the study area.

1.4 Research Questions

Based on the previous studies and statements of the problems the researcher proposed some set of research questions regarding youth reproductive health problems and service preferences. Hence the researcher conducted this study that attempts to answer the following research questions.

- What are the major youth reproductive health problems?
- What are the major factors contributing to youth reproductive health problems?
- What are the major contributing factors for the utilization and preferences of youth reproductive health services?

1.5 Rationale of the study

So far there have been no in-depth studies regarding reproductive health problems of youth and health service utilizations in the study area. Therefore, youth reproductive health problems with background characteristics and the need of youth reproductive health services are the main purpose of the present study. Youngsters having lots of health problems and they are not taking proper care due to lack of knowledge and lack of service facilities. Lots of gap between youth health problems and service preferences in this area so that the present study might have fulfilled in this regards.

1.6. Significance of the Study

Youth reproductive health problem is a considered idea of overall society's health status. There is an initiative to give priority to youth reproductive health problems and service preferences. This study assessed and highlighted the process of correlating youth reproductive health problems and service preferences in Lalibela town in the Amhara region. The information gathered and analyzed in this study provides empirical evidence on the linkage between background characteristics and reproductive health problems. The findings may also be used by other social scientists, researchers, those who need to know about the relationship between socio-economic and demographic characteristics of the youths and their health problems. Utilization of reproductive health services and youth reproductive health service preferences is mainly focused in this study.

CHAPTER -II

REVIEW OF RELATED LITERATURES

2.1. Major Youth Reproductive Health Problems

According to the International Conference on Population and Development (ICPD) held in Cairo, reproductive health is a state of complete physical and social wellbeing and not merely in the absence of disease or infirmity, in matters relating to reproductive system and to its function and process. Reproductive health problems also mean that problems as related to unwanted pregnancy, unsafe abortion, or STIs which encountered youth who are sexually active (ICPD, 1994). Worldwide young people constitute a rapidly growing and the largest segment of population in human history, more than half of the world's population below the age of 25 and four out of five young people (i.e. about 85 percent) lives in developing countries (UNFPA,1998). In Ethiopia, about 36 percent of all population are younger than 15 and 30 percent are 15-24 years old and totally over 65 percent of its population is under 25 years of age (FHI, 2006).

Nowadays, the lives of millions of young people worldwide are at high risk from broad range of health problems. Above and beyond swift increment in number, the young people found in every country, more particularly those found in developing countries are vulnerable to various health risks. They face dangers and more complex risks than the pervious generations faced. In fact, in the past young people are by most societies as risk free or have no any health problems and have been neglected for many years (Yosef, 1999). For sexually active youths, particularly those who are not married, obtaining relevant reproductive health services is often difficult. Few clinics are designed or even willing to provide services to young peoples.

Many of them are consequently left with an unmet demand for contraception and other reproductive health services (UNESC, 2001) Because they engaged in unsafe sexual intercourse at an early age, they are vulnerable to unwanted pregnancy, unsafe abortion and deaths due to its complications, school drop out and STIs in particular HIV infection which predominantly affects people at this time (Yosef, 1999).

2.1.1 Early Sexual Activity

Young people are beginning sexual activity at younger ages than previous generations'. The sexual and reproductive health crises that young people face arise mainly from the increase of teenage and unsafe early sexual practice (Yosef, 1999). Studies indicate that unprotected early sexuality which is characterized as being unanticipated, unpredictable, inconsistent with values and personally uncontrollable is becoming a common feature among young people and has increased in many countries around the world (WHO, 2004 ; Yosef, 1999). In many developing countries young men and women are becoming physically and sexually mature at the younger age than in the older and people are married at a later age.

Consequence of these changes is that more young people are becoming involved in early sex usually with out using a condom or any other form of contraception. Surveys conducted of the young people age 15-19 in Brazil, Hungary and Kenya for example found that more than a quarter of respondents reported that having sex before they were 15 years (WHO, 2004).

In most African countries age of first sexual intercourse among youth has been found to be 10 to 19 years and most youth have been initiated in to sex before or by the age of 15 years. For instance, In South Africa, Kwazulu Natal study revealed that age at first sexual intercourse ranged from 10-19 years old (Meibeb,2002). In Nigeria, the average age of first sexual intercourse for girls is 16 years (UNAIDS, 2004). In Kenya, in large adolescents study found that 4 percent were sexually active before the age of 10 years and in Ghana 12 percent of teenagers had sexual relationship by the age of 15 and among adolescents of 15-19 years 59 percent were sexually active (UNAIDS, 2003).

Likewise, several studies conducted on adolescents' fertility and reproductive risk behaviour of the youth population in Ethiopia disclosed that adolescents begin sexual practice before age of 15 years. The mean age that mostly reported for the first sexual initiation is between 14-19 years (CSA, 1994). Ethiopian DHS 2000 also found out that the median age for the first sexual intercourse was 16.3 years. Moreover, young women initiate sex at an earlier age than young men. Sexual experience for most women is with in the context of marriage in contrast to men who initiate sex before marriage.

According to Ethiopian DHS 2005 women generally begins sexual intercourse at the time of their first marriage .This can be seen from the identical median in age at first marriage and at first sexual intercourse (16.1) . Men, on the other hand, are active before marriage. The median age at first sexual intercourse for men is 21.2 years. Different studies has been observed in different parts of Ethiopian cities; A study done in South Ethiopia indicated that 49.3 percent of the respondents admitted to have had sex and the mean age of starting sex was 17.2 years (MOH, 2003), about 55 percent of 18 -19 years old youth from Harer (Gebraselassie, 1996), 32 percent of unmarried youth in jimma were reported to be sexually active (Habtu, 2000). A study conducted in Addis Ababa found that the earliest reported age of onset of sexual intercourse for girls was 14 years with mean age of onset being 15.3 years and for the boys was 12 years with mean age of onset being 16.45 years (Eyob et al., 1996). Further study conducted in Addis Ababa was found that the median age at first sex for females and males was 17.7 and 18.8 years respectively (Kassahun, 2006) A study conducted in Lalibela town, the median age at first sexual debut was three years lower among female youths compared to their male counterparts (15 against 18), risky sexual behaviour is also common among youths with 11.2 percent of the male youths and 8.2 percent of the female reported two or more sexual partner in their life time. The over all mean life time number of sexual partner was 2.1 (2.5 for males and 1.7 for female youths) (Plan Ethiopia, 2005).

2.1.2 Unwanted Pregnancy

Unwanted pregnancy is one of the serious problems among teenagers especially since early pregnancy is associated with health risks to the mothers during pregnancy and delivery. Pregnancy may put a woman at risk of health, chances for education and marriage and many of her hopes and plans for the future can also be endangered, her family may even refuse to acknowledge. Many adolescents are too young, too poor, or too inexperienced too take care for a child. Consequently some young women turn to abortion where abortions are performed by unskilled providers in unsafe conditions, the risk of serious health complications and death are great (PIB, 2004).

Many societies and most religions approve of sexual intercourse and childbearing only with in marriage (defined have to include formal and consensual or cohabiting unions) and tend to discourage people from having sexual partners out side marriage. UNFPA report indicated that worldwide close to 17 million of girls under the age of 20 given birth each year, some as young as 10-14 years of age, and most of these pregnancies are unplanned and unwanted (Mekonen et al., 2002).

Youths in Ethiopia are vulnerable to unintended pregnancy because they initiate sex at a relatively early age are not knowledgeable about their sexuality, unlikely to use contraception, have little access to FP information and services and often have little control over their reproductive health. A sizable proportion of births to young women are reported to be unintended. More than half of all births to women under age 15 and more than one in the births to women age 15-19 and 20-24 at the time of birth are unintended (Aklilu et al., 2002).

Several studies in Ethiopia have documented the prevalence of unintended pregnancy among young women. A survey of adolescents conducted in Awassa, Adama and Addis Ababa, 64 percent of the respondents know of a girl whose schooling was interrupted due to unwanted pregnancy (Mengeste, 1995). A household study of adolescents in Addis Ababa found that the median age at first pregnancy was 16 years. Out of three women, two of them, becoming mothers before the age of 20. Of the 957 female's respondents, 50 percent had been pregnant in the past and 74 percent of these pregnancies resulted in abortion (FDRE, 1997). In other study it was reported that unwanted adolescents pregnancy obscured 15 percent in Harer [24] and 50 percent in koladeba (Ismaiel et al., 1997).

2.1.3 Early Marriage

Early marriage is one of the cultural traditions that expose young women to reproductive health problems. Reasons behind early marriage are complex and include cultural beliefs and socio-economic realities. Early marriage occurs across the globe but it is most common in many parts of Africa and south Asia. In Nigeria about 76 percent of girls are married by 18, in India about 50 percent and in Nepal 19 percent of girls are married before they are 15 years old and 60

percent by the time they are 18 (WHO,2004). In Mali about 70 percent of young women first married before the age of 18 (PIP, 2004).

Early marriage is common in Ethiopian's Northern highlands. It is another harmful traditional practice that has a serious determinant impact on women's reproductive rights and health. Research suggested that 35 percent of Ethiopians girls are married by the age of 15 years and 70 percent by 17 years (MOH, 2002). The highest prevalence rate of early marriage exists among the Amhara (62 percent), people of Northern Ethiopia. In some areas as engagement for marriage takes place as early as 4-5 years of age for girls (NCTPE, 1995) .In Ethiopia, the 1990 national family planning fertility survey revealed that 34 percent of women were married before age 15 (CSA, 1990) .Another closely related harmful traditional practice in Ethiopia (which is not common in other African countries) is that a forced marriage, also known as abduction. In practice a young man, usually in consult with his friends abduct the woman, he desires to take as a wife (African journal of health development, 2004). Marriage by abduction is also widely practiced, at the national level, 69 percent of respondents reported knowing that marriage by abduction took place (NCTPE, 1995).

2.1.4. Abortion

Where access to contraceptive knowledge and Contraceptive use by young adults is minimal and where knowledge of reproductive health is low, unintended pregnancies place young adults in a dilemma and most young women who do not want to carry a pregnancy to its full term resort to unsafe abortion (African journal of health development, 2004). Unwanted and unplanned early pregnancy may consequence a girl to increased and serious health risks as well as social and economic problems. It may end up in early marriage and teen parenthood, school drop out and above all unsafe and complicated abortion. Because in most societies early pregnancy has no acceptance and abortion is also illegal or restricted by age, most often young women may seek an illegal provider who may be unskilled or may practice under unsanitary conditions and unwanted pregnancies end up as cases of unsafe abortions (Yosef, 1999). Approximately 2 million adolescent women in developing countries under go unsafe abortion each year and a third of all women seeking hospital cares for abortion complications are under age 20 (FHI,2004).

A study done at a university hospital in Nigeria revealed that 72 percent of maternal deaths from unsafe abortion were accounted by teenage women (Yosef, 1999). Similarly in a study in kenyata national hospital it was found that 53 percent of abortion seekers are less than 25 years, 15.3 percent under the age of 20 years and often are single and still in school (Ahlberg et al., 2002).

In Ethiopia, abortion, which is illegal, puts many young women at risk, primarily because it is usually conducted under unsafe conditions. However, actual data on the prevalence of illegal abortion is difficult to collect; 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. The study finding revealed that there were a total of 1,603 induced abortion cases, of which 15 occurred among women under age of 15; 31 percent occurred among women aged 16-20 and 62 percent occurred among women 16-25. 45 percent of the abortions were among single women and surprisingly 42 percent were among women with only a primary school education or less (Yosef, 1999).

Data obtained from a retrospective study on abortion dimension in Jimma hospital in 1989-1992 showed that 53.8 percent of abortion cases where in those young people less than 25 years (Abdella, 1996). A very recent report on unsafe abortion made public by the Ethiopian Society of Obstetricians and Gynaecologists (ESOG) in 2002 data were collected at 15 hospitals in seven out of nine federal regions reporting on a total of 1,075 cases .The study results found that two third of women seeking treatment for abortion complications were married and that nearly 60 percent were between the ages of 20-29 and also the study indicates that other 45 percent of cases who visits health facilities because of abortion were adolescents in the age group of 15 -19 (African journal of health development, 2004).

2.1.5 Modern Contraceptive Use

Modern contraceptive use was found to be low 21 percent among the sexually active in Bugna Woreda in particular place, Lalibela town. The proportion of women who ever heard of family planning methods is 82 percent. However, 37.7 percent of the women have ever used of a family planning method in their life time (Plan Ethiopia, 2005). Knowledge of modern method of

family planning is substantially higher than knowledge of traditional methods among both women and men. Knowledge varies by method, young people in Ethiopia are most aware of the pill, which about 70 percent of all women and men having heard of it. Nearly 60 percent of women aware of injections compared with about 50 percent of men. Men are about twice as likely to report knowledge of condoms as a method of family planning as women, which accounts 60 percent and 34 percent respectively. One in five respondents has heard of female sterilization.

A national wide survey among young adults aged 15-29 years, knowledge about contraception was found to be as high as 90 percent and 87 percent for condoms and pills, respectively. But when it comes to practice, only 15 percent of the males used condom and 39 percent of the females used pills (Kassahun, 2006). Study conducted in South Ethiopia indicted that reported condom use rate during the first Sexual intercourse was 13.5 percent, while it was 27.6 percent during their resent one Study conducted in rural town in Ethiopia revealed that, 65.7 percent of sexually active group reported to have used some types of modern contraceptive in the past (Negussie et al.,1996).

2.2 Factors Contributing to Youth Sexual and Reproductive Health Problems

Different factors are contributing to youth sexual and reproductive health problems, along with these lack of knowledge, information and guidance, low level of family life education, socio-cultural and economic factor and lack of youth-friendly reproductive health services are the major issues.

Young people in Ethiopia are disadvantaged relative to older people in their ability to access information and services for their reproductive needs because of the absence of a youth-friendly services delivery system (Wess, 1997). There is an inherent bias in the healthcare system against the young this is due to the cultural tradition that girls marry at young age to preserve their sexual activity and are encouraged to beer children soon after. There is reluctance on the part of health care providers to inform young women and especially young unmarried women about the health implications of bearing children at a very young age and to inform and encourage them to adopt family planning to delay the onset of childbearing (WHO,2004).

According to a study conducted in Gonder about 75 percent of adolescents preferred to discuss about body changes that occurred during adolescents with peers of the same sex rather than elders. Apart from this, adequate systems are not yet in place to reach all of the young peoples in need of information and appropriate guidance and counseling services in the country (Senderowit, 1999).

Adolescents in many developing countries rarely discuss sexual matters explicitly with their parents. Most information for their existing knowledge often comes from peers of the same sex, who those may be uninformed or incorrectly informed (UNFPA, 2004). According to the study conducted in Zuway, Ethiopia, found that young people's knowledge on aspects of their sexuality is in complete and not enough to minimize risk taking yet, it is unacceptable to discuss growth changes and sexual issues with parents during adolescents (MOH, 2002).

Along with other problems, demographic, socio-cultural and economic factors are also the main affecting barriers on youth's sexual reproductive health and service needs. For instance, in many countries, cultural expectations encourage men to express their masculinity by initiating sexual activity at a younger age having multiple partners or visiting commercial sex workers (Ahlberg et al., 2001). Socio-cultural norms and taboos of the society that youth grow up also have great impacts in affecting adolescent's reproductive health seeking behavior and reproductive health services utilization patterns. In Ethiopia some fragmented study reported that there is lack of discussion and communications between parents and young people on matters of sexuality and reproductive health because of hampering socio-cultural norms and taboos of the society (Birhan, 2000).

Youth friendly services is simply stated, services are youth friendly if they have polices and attributes that attract youth to the facility or program, provide a comfortable and appropriate settings for serving youth meet the needs of young people and are able to retain their youth clients for follow up and respect visitors. In most countries, especially in developing nations, 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 nobody assumed the young women needed pregnancy prevention. Most developing country societies expected women to bear children soon after marriage (Shah, 2001).

2.3 Health Service Utilization and Preferences of Youths

Considering youths 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 reproductive health services for a variety of reasons including policy constraints, operational barriers, and lack of information and feeling of discomfort. Operational barriers like inconvenient hours of service delivery, 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, feelings of discomfort, like belief that the services are not intended for them, concern that staff will be hostile or judgmental, fear that their parents learn of their visit are also considered important barriers (Senderowit, 1999).

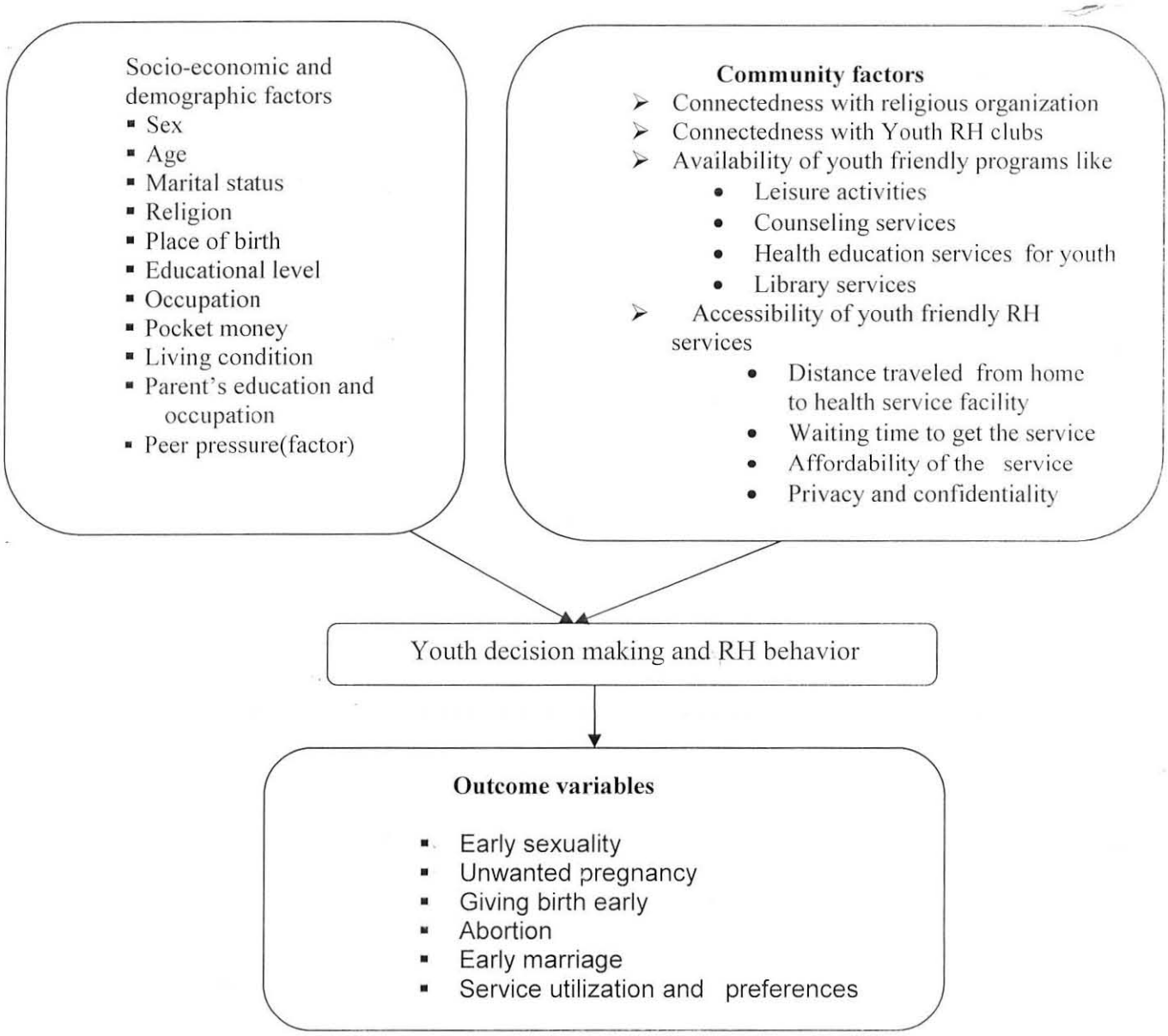
A need assessment report among NGOs in Ethiopia involved in reproductive health revealed that with few exceptions, health care providers and social sector professionals agree that the existing health care services do not meet the needs of today's young people (Fentaw et al., 2000).

Few studies were conducted on reproductive health 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 reproductive health information or services pointed out that shy, shame or believe that it is against the traditional culture think or unaware of services available were reported to be the major ones (Wess,1997). As school adolescents in Addis Ababa had mentioned, fear of being seen by parents and others, embarrassment at needing reproductive health services and expensive services to be the major barriers to use reproductive health services by adolescents. In addition, 70 percent of them preferred special hour's for adolescents, 44.3 percent young provider of the same sex and 53 percent special discount on service fees for adolescents (Birhan, 2000).

2.4 Conceptual Framework

The reproductive health issue is very crucial factor for the youths. It is affected by parents' economic status, parents' occupation status and educational level, educational level of youths, the pocket money they get, current living condition of the youths and many other factors.

Figure 1-Conceptual framework developed by the researcher



Source: Modified from Youth reproductive health problems in Ethiopia, ORC macro and CSA,2002

We can easily see the link between the dependent and independent variables related to the reproductive health problems among youths of the study area. The conceptual framework was prepared on the basis of statement of the problem and objectives of the study. All these factors affected directly or indirectly the reproductive health problems of youths. The conceptual framework clearly shows the relationship between one variable to another variable.

2.5. Operational Definitions

The following terms used in accordance to suit for this research study

Early sexual activity: Practicing of sexual intercourse before reaching age 18

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

Permanent residency: Youth in the age of 15-24 residing in the area for at least 6 months (CSA)

Risk reproductive behaviour: It includes early sexual activity, early marriage, unwanted pregnancy, abortion, unsafe sex, having more than one partner, etc.

Youth /young people /adolescent: Those who are in the age group of 15-24 (WHO)

CHAPTER- III

DATA AND METHODOLOGY

3.1. Profile of the Study Area

The study was conducted in Bugna woreda a particular place in Lalibela town. Lalibela is found in Amhara region, North Wollo zone and is located about 305 km east of Bahir Dar and it is about 700 km north of Addis Ababa. The woreda has 39 kebeles (including the Lalibela town) with a total population of 233,941(CSA, 2006). Lalibela town is divided in to two kebeles. Based on 2006 municipality information the total population living in the town is 17,022 where 8,286 are males and 8,736 are females, which is approximately 7 percent of the population of Bugna woreda. Among the total population of the town, 30 percent, which is approximately 5,107 is youths (15-24 Age).

Lalibela is renowned by its historical tourist attraction center in Ethiopia, even in the world, due to its wonderful and age-old rock. Therefore, there are many tourists and visitors from in and out side Ethiopia. In addition to this, the Ethiopian Orthodox Church followers, coming in mass from every parts of the country and pay pilgrim every Christmas. Generally the town is a major cultural and religious center for Ethiopians.

3.2 The Study Design and Study Population

This study is cross-sectional and was conducted from April to May 2007. It utilized quantitative (using structured interview) technique to assess youth reproductive health problems and service preferences in the study area. The source population for the study is all youths aged 15 to 24 years residing in the study area.

The study population, according to CSA projections (2006), the total population of Lalibela town is estimated to be17,022, which is approximately 7 percent of the population of Bugna woreda (210,000) and among the total population of the town, 30 percent, which is approximately 5,107 is youths (15-24 Age).

Exclusion criteria:

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

3.3. Sample Size Determination

The total population size of the Two (2) Kebeles of Lalibela town is around17, 022; out of which 5,107 numbers is estimated to be youths aged from 15 to 24 years. From this population, the required sample size was taking according to the size of the population in each kebele.

The sample size was determined using the formula for single population proportion and the following assumption were made, with significance level of 95 percent (x=0.05) and 5 percent margin of error are made since the pervious prevalence of reproductive health problems and service preferences of youth was not known, in the study area 50 percent prevalence was taking to obtain sufficiently large sample size, and 10 percent added to compensate for non response.

$$n = \frac{(z/2)^2\, p\,(1-p)}{d^2} + \text{15 percent non respons rate}$$

Where n=the total sample size

P=0.5 (50 percent) (The prevalence of youth reproductive health problems)

z=1.96 (Critical value at 95 percent confidence level of certainty)

d=0.05 (The margin of error between the sample and the population)

Thus, according to the above assumptions and given formula, the total calculated sample size is 442. If N (the entire population) is less than 10,000 the required sample size will be smaller .In such cases, calculate a final sample estimate (N_f) by using the formula (Kinfa Abrha, Mekele University)

$$N_f = n/(1+(n/N)$$

Where N_f = The desired sample size (when the population is less than 10,000)

n= the desired sample size (when the population is more than 10,000)

N= the estimate of population size,

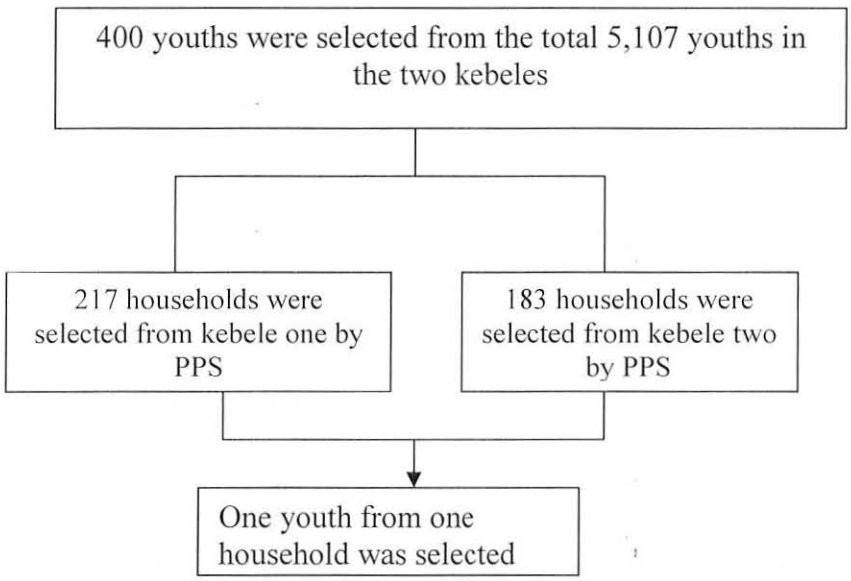
The total number of sample size is 'N_f= 400

***Source*: Lalibela town Municipality**

3.4 Sampling Technique

The required sample size allocated to each kebele is according to the probability proportional to the size of the population of each kebele. Using lottery method study units were identified and only one youth from the selected household was interviewed .The data collectors asked the parents' about number of youth aged from 15-24 in their house and they gave numbers to each youth. The data collectors used to call upon one of the youths in the house and made to call one of the numbers and who to be interviewed was determined. If the selected youth was not around, again another number was chosen by one of them. In the absence of youth in the selected house or when the house found closed, the house with the next number was selected and this was continued as it was needed.

Figure 2- Schematic presentation of the sampling technique



***Source*: Author's field survey, 2007**

3.5 Data Collection Procedure

A structured questionnaire was used for the purpose of data collection. The researcher gave training for both data collectors and supervisors. The training includes discussion of each item one by one briefly, explaining the general objective of the study, discussion about the general techniques of interviewing, approaching the respondents and keeping confidentiality and privacy and discussion how to keep close supervision using the prepared guidance and checklist.

3.6. Pre-Test

Pretest of the questionnaire was carried out in Shumsha, which have similar socio demographic characteristics with the people of Lalibela town. During the pretest, the items that frequently a rise questions were revised and become clear. Both the interviewers and supervisors assessed clarity, understandability and completeness of the questions. Pre-test was done with 40 youths.

3.7. Statistical Tools

After data collection, the responses were coded and entered in to the computer and computing using SPSS version 11.0. Cleaned data set was prepared for the analysis. Tabulation plan was done and frequency distribution of dependent and independent variables was worked out. From these some of the useful and related variables were selected based on the study aims and hypothesis. Cross tabulation was done for the purpose of each selected variables in the study. Chi-square value was employed to see the effects of each variable. Furthermore binary logistic regression model was adapted to some of the selected independent variables which link with selected dependent variable.

3.8. Ethical Considerations

Before the present study was conducted permission was taken from the concerned Lalibela town administration office. At the time of data collection, a verbal consent was asked from the participants to confirm their willingness to participate .Confidentiality and privacy of responses were ensured through out the research process.

CHAPTER- IV

RESULTS OF THE STUDY

4.1 Background Characteristics of the Respondents

Table 4.1.1 Socio economic and Demographic characteristics of youths aged 15-24 years residing in Lalibela town, North Wollo Zone, Amhara region.

Socio-demographic variable	Frequency	Percent
Sex		
Male	187	46.75
Female	213	53.25
Total	400	100
Age		
15-18	195	48.75
19-24	205	51.25
Total	400	100
Mean ± SD	18.84± 1.92	
Median	19.00	
Marital status		
Married	26	6.5
Unmarried	374	93.5
Total	400	100
Place of birth		
Urban	328	82
Rural	72	18
Total	400	100
Religion		
Orthodox	392	98
Others	8	2
Total	400	100
Religion program attending		
Yes	71	17.75
No	329	82.25
Total	400	100
Member of youth RH and anti HIV/AIDS club		
Yes	167	41.8
No	233	58.3
Total	400	100.0
Currently going to school		
Yes	334	83.5
No	66	16.5
Total	400	100
School have a youth club		
Yes	192	57.5
No	142	42.5
Total	334	100.0

Attending school youth RH and anti HIV club		
Yes	159	47.6
No	175	52.4
Total	334	100
Level of education		
Elementary	45	13.5
Secondary and above	289	86.5
Total	334	100
Occupation		
Student	149	37.25
Employed and others	42	10.5
Local guides	209	52.25
Total	400	100
With whom you live		
With the family	311	77.75
Alone	41	10.25
With friends/Partners	48	12
Total	400	100
Pocket money		
Yes	228	57
No	172	43
Total	400	100
Average Pocket money		
Less than or equal to 20	97	42.5
21-50	38	16.67
51 and above	93	40.79
Total	228	100
Drinking Alcohol		
Yes	164	41.0
No	236	59.0
Total	400	100.0

***Source*: Author's field survey, 2007**

Note: Due to rounding, the sums may not exactly add up to 100

As shown in table 4.1.1, a total of 400 youths were participated in the study, out of them, 328 (82.0 percent) and 72 (18.0 percent) were born in urban and rural areas respectively. More than half, 53.5 percent of the respondents were females with male to female ratio of 0.88:1. The age of youths in the study area ranges from 15-24 years. 195 (48.8 percent) of them are between the age of 15-18 and 205 (51.3 percent) of them are between 19-24 years. Moreover, the mean and median ages of the surveyed youths were 18.84 ± 1.92 and 19.00 years respectively. From the total respondents, 374 (93.5 percent) never married and 26 (7.5 percent) were married. Large proportion of the respondents 98.0 percent were orthodox Christians and 8 (2.00 percent) were others.

In addition, most of the youths 83.5 percent were currently attending school. Among these respondents, 45 (13.5 percent) and 289 (86.5 percent) were attending primary education (1-8 grade) and secondary school and above respectively. This study also indicated that 149 (37.2 percent) of them were students and the majority 62.8 percent were local guiders and those who are working in different sectors. This study also tried to assess the living conditions of the respondents whether they are living with the family or with other individuals. Based on this, 311(77.8 percent) of the interviewed youths were living with their family and 89 (22.2 percent) were living together with their friends or alone.

Of the total youths interviewed, 228 (57.0 percent) have earned daily pocket money and from these, 97 (42.5 percent) of them have an average money of less than 20 birr per day and the remaining 93 (39.9 percent) earn 50 and above birr per day. The study also indicated that more than half of the respondents 58.3 percent were not participated or not a member of youth reproductive health and anti HIV/AIDS club in the town and also 175 (52.4 percent) responded that they were not attending youth reproductive health programs found in the school. Out of the total respondents, 164(41.0 percent) were drinking alcohol.

Table 4.1.2 Percentage distribution of parent's occupation and educational level

Variables	Frequency	Percent
Parents alive		
Both are alive	333	83.25
Only my father is alive	5	1.25
Only my mother is alive	50	12.50
Both are dead	12	3.00
Total	400	100
Father's education		
Illiterate	202	59.6
Literate	137	40.4
Total	339	100
Mother's education		
Illiterate	330	86.39
Literate	52	13.61
Total	382	100
Father's occupation		
Daily laborer	174	51.3
Civil servant	20	5.9
Others	145	42.8
Total	339	100
Mother's occupation		
Housewife	326	87.4
Daily laborer/Civil servant	31	8.3
Others	16	4.3
Total	373	100
Perceived families economic status		
Rich	13	3.49
Medium	253	68.00
Poor	106	28.49
Total	372	100

***Source*: Author's field survey, 2007**

Note: Due to rounding, the sums may not exactly add up to 100

Table 4.1.2 indicated occupational status and educational level of the parents'. In line with this, the majority 83.3 percent of the respondents replied that both parents are alive. About their fathers and mothers educational level, out of the total interviewed, 202 (59.6 percent) and 137(40.4 percent) replied that their fathers were illiterate and literate respectively. And 330(88.4 percent) and 52 (13.6 percent) of the respondents' mothers were illiterate and literate respectively. With respect to their father and mother occupational status, 174 (51.3 percent) of the respondents' reported that their fathers are daily laborer and the majority of respondents' mothers (87.4 percent) were housewife. For question that were prepared to know their perceived families economic status 253 (67.5 percent), 106 (28.0 percent) believed their families economic status are medium and poor respectively.

4.2 Reproductive Health Characteristics

Table 4.2 Percentage distribution of reproductive health characteristics among youths in Lalibela town, North wollo Zone, Amhara region

Reproductive health characteristics	Frequency	Percent
Heard about youth Reproductive health		
Yes	260	65
No	140	35
Total	400	100
Youth have Reproductive health problems		
Yes	233	89.62
No	27	10.38
Total	260	100
Ever had sexual intercourse		
Yes	199	49.75
No	201	50.25
Total	400	100
Age at first sexual intercourse		
10-15	30	15.1
16-18	160	80.4
19-24	9	4.5
Total	199	100
Mean ± SD	16.24± 1.08	
With whom you did first sexual intercourse		
Steady boy/girl friend	126	63.3
A causal boy/girl friend	55	27.6
Husband/Wife	5	2.5
A family member	8	4
My employer	5	2.5
Total	199	100
Reason for first sexual intercourse		
Fall in love	34	17.1
My sexual interest	7	3.5
Married	1	0.5
Raped/Forced	13	6.5
Money/Other gifts	17	8.5

Peer pressure	112		56.3
Drunk	15		7.5
Total	199		100
Had Use condom in first sexual intercourse			
Yes	77		38.7
No	122		61.3
Total	199		100
Family planning Methods used			
Pills	62		51.2
Emergency pills	4		3.3
Condom	46		37.4
Injections	10		8.1
Total	122		100
Become pregnant			
Yes	70		35.18
No	129		64.82
Total	199		100
Age at first pregnancy			
Less than or equal to 18	67		95.71
Greater than 18	3		4.29
Total	70		100
Mean ± SD		16.04 ± 0.9	
Unwanted pregnancy			
Yes	62		88.6
No	8		11.4
Total	70		100.0
Aborted			
Yes	48		68.6
No	22		31.4
Total	70		100
Age at the time of abortion			
Less than or equal to 18	45		93.75
Greater than 18	3		6.25
Total	48		100
Mean ± SD		16.6± 1.4	
Gave birth			
Yes	22		31.4
No	48		68.6
Total	70		100.0
Age at first birth			
Less than or equal to 18	19		86.36
Greater than 18	3		13.64
Total	22		100
Mean ± SD		17.41± 1.08	
Age at first marriage			
Less than or equal to 18	26		100
Greater than 18	0		0
Total	26		100.0
Mean ± SD		15.38 ± 1.2	
Ideal age for female to start sex			
Less than or equal to 18	394		98.5
Greater than 18	6		1.5
Total	400		100.0
Mean ± SD		14.95± 1.92	

Ideal age for male to start sex			
Less than or equal to 18	361		90.25
Greater than 18	39		9.75
Total	400		100
Mean ± SD		16.32± 2.29	
Life time sexual partner			
One partner	36		18.1
Two and above partners	163		81.9
Total	199		100
Mean ± SD		4.26± 2.63	
Last 12 months sexual partner			
One partner	68		34.2
Two and above partners	131		65.8
Total	199		100
Mean ± SD		3.04± 2.15	

***Source*: Author's field survey, 2007**

Note: Due to rounding, the sums may not exactly add up to 100

As shown above in table 4.2, reproductive health problems of the youth were assessed and it revealed that only 260 (65.0 percent) were heard about reproductive health and among those 233 (89.6 percent) believed that youths have reproductive health problems. This study also assessed the sexual experiences of youths in the study area and out of the total 400 youths interviewed 199 (49.8 percent) were sexually active and from those 190 (95.6 percent) of the respondents exercised their first sexual intercourse before the age of 18. Accordingly, the mean and median ages at first sex for respondents were 16.24 ± 1.08 and 16 years, respectively.

With regard to reasons to have first sexual intercourse, 34 (17.1 percent) of the respondents have experienced first sexual intercourse due to love affairs, 112 (56.3 percent) replied that they were influenced by their peers and 47 (8.5 percent) have sex for the sake of getting money and other gifts. Of the youth who have admitted that they had sex, 122 (60.8 percent) revealed that their first sexual intercourse were unsafe (no used condom). Of the respondents who used modern contraceptive, 63 (51.2 percent), 46 (37.4 percent), and 10 (8.1 percent) used pills, condom and injection, respectively. This study showed that from the total youths interviewed 70 (35.18 percent) girls were pregnant. Out of these pregnant girls, 62 (88.6 percent) of them were exposed to unwanted pregnancy. The mean age for first pregnancy in the study area is 16.04 ± 0.91 years. From those who experience unwanted pregnancy, 48 (68.6 percent) of them ended their pregnancy with abortion and 22 (31.4 percent) gave birth.

The mean age of respondents at the time of abortion, first birth and marriage was 16.6 ±1.4, 17.4± 1.0, 15.4 ± 1.2 respectively. One of the methods to assess RH problems is to know the number of sexual partners participants had in their life time and in past 12 months. On the

basis of this, Number of life time sexual partner in the study area was 4.3 ± 2.6 and 3.0 ± 2.2 in the past 12 months. The mean ideal age to start sex was 16.3 ± 2.3 and 14.9 ± 1.9 for males and females, respectively.

4.3. Preference and Utilization of Youth Reproductive Health Services

Table 4.3 Percentage distribution of preference and utilization of youth reproductive health services

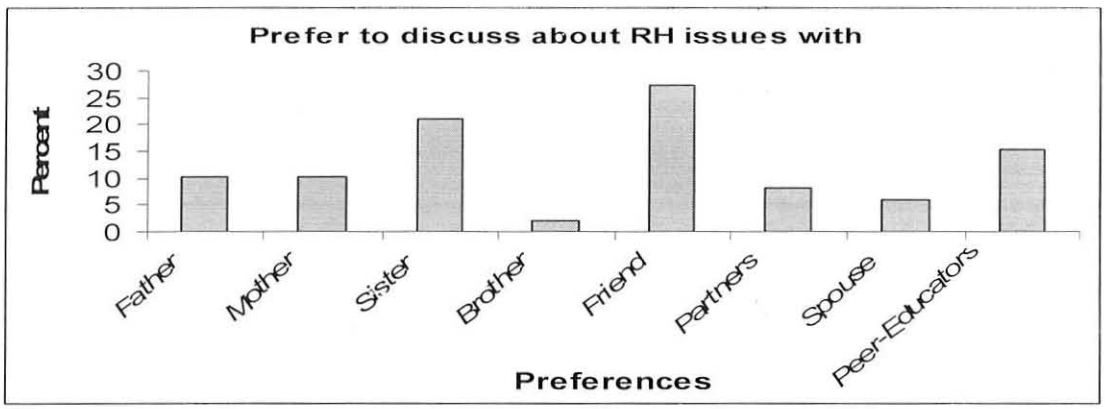
Preferences and utilization of reproductive health services	Frequency	Percent
Got reproductive health services		
Yes	158	39.50
No	242	60.50
Total	400	100.00
In which institution do you think youth reproductive health services are given better		
Private health institution	24	15.19
Government health institution	46	29.11
Youth clubs	57	36.08
School club	21	13.29
Others	10	6.33
Preferred youth reproductive health services to be rearranged		
With in the health institution as it is	37	9.25
No special attention given	24	6.00
In health institution having its own Youth reproductive health service room	195	48.75
By expanding Youth reproductive health centered	144	36.00
Convenient time for youth to get health services		
During the usual health institution working g hour	195	48.80
Special hours where no others user is around	205	51.20
Preference health service fee for youth		
With special discount for youth	172	43.00
Free of charge	228	57.00
Whom do you prefer to be youth reproductive health provider		
Young and the same sex	161	40.25
Young and different sex	143	35.75
Adult and same sex	21	5.25
Adult and different sex	32	8.00
Any one	43	10.75
Prefer to get youth-friendly reproductive health services through		
Peer education	119	13.37
Library service	185	20.79
Panel discussion	174	19.55
FP service	121	13.60
Indoor and outdoor service	78	8.76
Television program	213	23.93

***Source*: Author's field survey, 2007**

The above table 4.3 show that youth reproductive health services utilizations and preferences. As this table displayed, 242 (60.5 percent) of youths in the study area used youth reproductive health services and out of those that used youth reproductive health services, 57 (36.1 percent) of youths preferred to seek health services in youth center clubs, 46 (29.1 percent) in government clinics and 21 (13.3 percent) in school youth clubs. Need for rearrangement of youth reproductive health service was assessed and it indicated that 195 (48.8 percent) youths preferred to get health services in health institution having its own youth reproductive health service room and 144 (36 percent) need to rearrange the service by expanding youth reproductive health center. With regard to service time, 195 (48 percent) of youth respondents preferred service time to be during the usual health institution working hour, and 205 (51.2 percent) preferred in the absence of other users. About the service fee, 228 (57 percent) preferred to get the service free of charge. With regard to the service provider, 161 (40.3 percent) respondents preferred the service provider should be young and the same sex. This study also tried to assessed the preferences of youths as to the mechanisms of the services provision and, 213 (23,9 percent),185 (20.8 percent),174 (19.6 percent) youths preferred to got youth friendly reproductive health services in the form of television programs ,library services and panel discussion respectively.

4. 4 Reproductive Health Information and Factors Influencing Utilization of Youth Reproductive Health Services

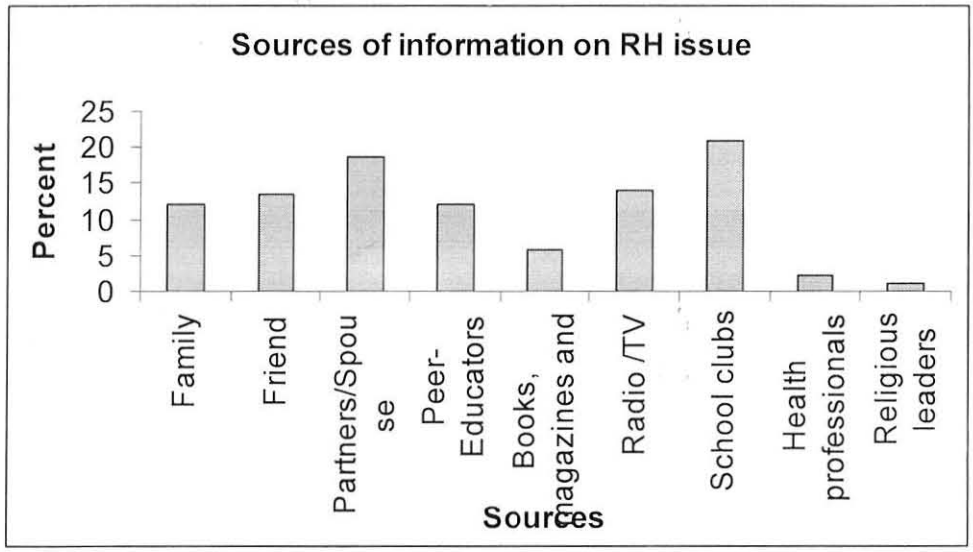
Figure 3.Youth preferences to discuss sexual and reproductive health issue



Source: **Author's field survey, 2007**

As indicated in table 4.4.1 and figure 3, most youths were preferred to discuss about their sexual and reproductive health issues with friends 327(27.4 percent), with sisters 251 (21 percent) and with peer-educators 182 (15.2 percent). Moreover, only 166 (41.4 percent) of the respondents reported that they had a habit to discuss with their parents and 219 (54.8 percent) and 242 (60.5 percent) of youths disclosed that religion and culture, respectively, have a hindrance to discuss issues on sexuality and reproductive health.

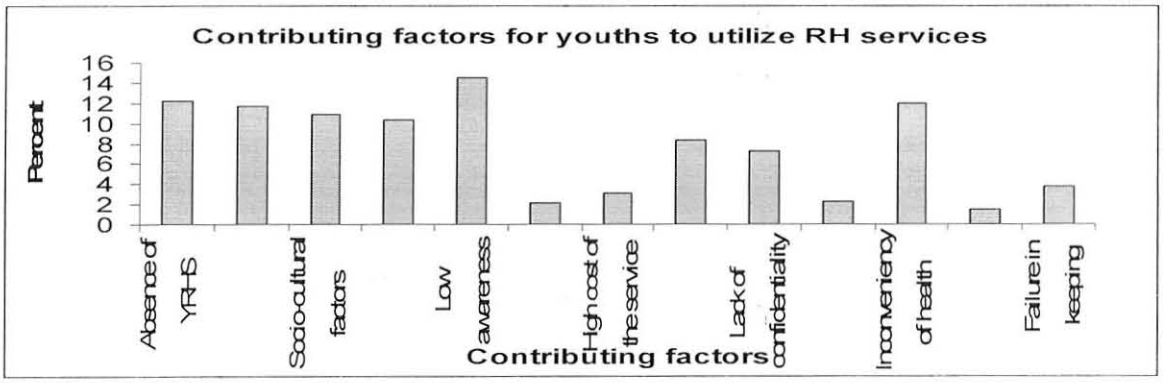
Figure 4. Source of information about sexual and reproductive health issues



***Source*: Author's field survey, 2007**

Table 4.4.2 and figure 4 indicated that school clubs were mentioned by 255 (20.8 percent), partners/spouse by 228 (18.6 percent) and Radio/TV by 173 (14.1 percent) were as the common source of information on sexual and reproductive health matters of the youths in the study area.

Figure 5.Contributing factors for youths not to utilize reproductive health services



This study also has assessed the magnitude of those contributing factors that hinder youths' utilization of sexual and reproductive health services and the data above (the table and figure) revealed that 263 (14.5 percent) replied that they did not go to the health institution because of low awareness and absence of appropriate information on youth sexual and reproductive health services, about 223 (12.3 percent) of the respondents replied absence of youth friendly reproductive health services and 218 (12 percent) claimed inconveniency of health service delivery time as the main contributing factors for youths reproductive health service utilization. Moreover, about 213 (11.7 percent) of youths believed that the service are not intended for them and socio-cultural factors were another contributing factors for some youths 198 (11 percent) not to utilize the reproductive health services appropriately. 188 (10.3 percent) of respondents also replied that feared not to be seen by parents or any one who know them. This is also a major reason not to seek the health services. In addition to this, poor treatments given by the health service provider constituted (8.36 percent) and lack of confidentiality on health services is replied by 133 (7.3 percent) respondents. This played a significant role as a contributing factor not to utilize the reproductive health services and exposed the youths to reproductive health problems. Besides, 56 (3.1 percent) of the respondents claimed that service fees were expensive, 38 (2.1 percent) replied far distance of the health center and 41 (2.3 percent) replied long waiting time to seek the reproductive health services as other additional contributing factors not appropriately utilize the right services.

4.5 Statistical Techniques Employed to Answer Research Question

Chi-square tests of independency were employed to examine and establish links between the independent (sex, age, marital status, place of birth, currently going to school, level of education, occupation, currently live with, having pocket money, parent educational status and parent occupation) and the dependent variable reproductive health problem (early sexual intercourse, condom use at the time of first sexual intercourse, unwanted pregnancy, abortion, early marriage and early birth).

The researcher has selected the above six dependent variables and recodes and compute those variables to measure youth reproductive health problems. Those variables that lies between 0-1 indicated that the youths are not exposed to youth RH problem and those lies above one are exposed to it. Based on the above approaches chi-square analysis and binary logistic regression model was employed. Analysis was conducted using the statistical package SPSS (Version 11.0) and P-value < 0.05 was considered to be significant.

Based on the study result, sex, age, marital status, attending religious program, become a member of the youth reproductive health and Anti HIV/AIDS clubs, currently going to school, attending the school youth reproductive health and Anti-HIV/AIDS clubs programs, educational level, pocket money they get, current living conditions of the youths, occupation, father educational level, mother educational level, father occupation and mother occupation have shown statistically significant association with reproductive health problems.

Table 4.4 Chi-square results of youth reproductive health problems

Variables	Reproductive health problems					
	Yes	Percent	No	Percent	X^2	P- Value
Sex						
Male	41	31.1	146	54.5	19.481	0.000
Female	91	68.9	122	45.5		
Total	132	100.0	268	100.0		
Age						
15-18	40	30.3	155	57.8	26.834	0.000
19-24	92	69.7	113	42.2		
Total	132	100.0	268	100.0		
Marital status						
Married	26	19.7	0	0.0	56.458	0.000
Unmarried	106	80.3	268	100.0		
Total	132	100.0	268	100.0		
Place of birth						
Urban	103	78.0	225	84.0	2.103	0.147
Rural	29	22.0	43	16.0		
Total	132	100.0	268	100.0		
Religion						
Orthodox	124	93.9	268	100.0	16.574	0.000
Others	8	6.1	0	0.0		
Total	132	100.0	268	100.0		
Attending religious programs						
Yes	11	8.3	60	22.4	11.966	0.001
No	121	91.7	208	77.6		
Total	132	100.0	268	100.0		
Member of the youth club						
Yes	33	25.0	134	50.0	22.729	0.000
No	39	75.0	134	50.0		
Total	162	100.0	268	100.0		
Currently going to school						
Yes	93	70.5	241	89.9	24.336	0.000
No	39	29.5	27	10.1		
Total	132	100.0	268	100.0		
Attend the school youth program						
Yes	31	33.3	128	53.1	10.525	0.001
No	62	66.7	113	46.9		
Total	93	100.0	241	100.0		

Educational level						
Elementary	18	19.4	27	11.2	3.825	0.050
Secondary and above	75	80.6	214	88.8		
Total	93	100.0	241	100.0		
Get pocket money						
Yes	92	69.7	136	56.7	12.959	0.000
No	40	30.3	132	49.3		
Total	132	100.0	268	100.0		
With whom you live						
With the Family	77	58.3	234	87.3	42.936	0.000
With Friends/partners ,Alone	55	41.7	34	12.7		
Total	132	100.0	268	100.0		
Occupation						
Student	33	25.0	116	43.3	39.969	0.000
Local Guiders and others	99	75.0	152	56.7		
Total	132	100.0	268	100.0		
Drinking alcohol						
Yes	88	32.8	76	57.6	22.377	0.000
No	180	67.2	56	42.4		
Total	268	100.0	132	100.0		
Your parents alive						
Both are alive	112	84.8	221	82.5	1.687	0.640
Only my father is alive	2	1.5	3	1.1		
Only my mother is alive	13	9.8	37	13.8		
Both are dead	5	3.8	7	2.6		
Total	132	100.0	268	100.0		
Father education level						
Illiterate	58	50.9	144	64.0	5.411	0.020
Literate	56	49.1	81	36.0		
Total	114	100.0	225	100.0		
Mother education level						
Illiterate	112	89.6	218	84.8	1.631	0.202
Literate	13	10.4	39	15.2		
Total	125	100.0	257	100.0		
Father occupation						
daily laborer	86	75.4	88	39.1	39.969	0.000
Civil servant and others	28	24.6	137	60.9		
Total	114	100.0	225	100.0		
Mother occupation						
Housewife	89	73.6	237	94.0	31.177	0.000
Daily laborer/Civil servants and others	32	26.4	15	6.0		
Total	121	100.0	252	100.0		
Perceived family economic status						
Rich	6	50	7	2.8	5.087	0.079
Medium	73	60.3	180	71.7		
Poor	42	34.7	64	25.5		
Total	121	100.0	251	100.0		

***Source*: Author's field survey, 2007**

4.6 Computation of Binary Logistic Regression Analysis

In employing logistic regression analysis, those variables that were not significantly associated with the out come variables ($p<0.05$) were not entered in binary logistic regression model due to large number of variables.

Table 4.5 Binary logistic regression coefficients and adjusted odd ratios of the determinants youth reproductive health problems

variables	B	S.E	Df	Sig.	Exp(B)	95.0% C.I for Exp(B) Lower	Upper
Age							
15-18 (RC)*							
19-24	-3.091	0.092	1	0.001	0.045	0.08	0.266
Attend the school youth program							
Yes (RC)*							
No	2.407	0.715	1	0.001	11.095	2.732	45.067
Do you get pocket money							
Yes	2.393	0.759	1	0.002	10.941	2.474	48.392
No (RC)*							
With whom you live							
With the Family (RC)*							
With Friends/ partners and Alone	1.448	0.636	1	0.023	4.253	1.222	14.801
Father education							
Illiterate	4.152	0.896	1	0.000	63.533	10.982	367.539
Literate (RC)*							
Father occupation							
daily laborer(RC)*							
Civil servant and others	-2.184	0.599	1	0.000	0.113	0.035	0.364
Mother occupation							
Housewife (RC)*							
Daily laborer/Civil servants and others	2.128	0.764	1	0.005	8.398	1.878	37.555

* **RC**- *Reference category*

* **P** < 0.05

***Source*: Author's field survey, 2007**

4.6.1 Age against Reproductive health problem

Ages of the respondents were negatively associated with reproductive health problem. The crude odd ratio showed that the youth in the age group 15-18 have 96 percent higher chance of getting reproductive health problem than that of the age group 19-24. Besides, the chi-square test of independency has shown that age has significant association with youth reproductive health problem ($X^2 = 26.834, p=0.000$)

4.6.2 Attending School Youth Reproductive Health and Anti-HIV/AIDS Program against Reproductive Health Problem

Attending the school youth reproductive health and Anti-HIV/AIDS program was found to be positively associated with youth reproductive health problem. The crude binary logistic model shows that the probability of respondents not attending youth reproductive health and Anti-HIV/AIDS program being vulnerable to reproductive health problem is 11 times higher than that of the respondents attending youth reproductive health and Anti-HIV/AIDS program. In addition, the chi-square test of independency has shown that attending the school youth RH and anti HIV/AIDS clubs programme has a significant association with youth reproductive health problem ($X^2 = 11.966, p = 0.001$)

4.6.3. Pocket money they get against Reproductive health problem

Pocket money they have got and reproductive health problem has a positive association. The crude binary logistic regression shows that youths who had pocket money was more at risk than those who have not get pocket money. Respondents who have got pocket money were 11 times at risk for youth reproductive health problem than those who have not get pocket money. Chi-square test of independency have showed that there is significant association between having pocket money and reproductive health problem ($X^2 = 12.959, p = 0.000$).

4.6.4 Currently living with against Reproductive health problem

Those respondents who are living together with friends/Alone or with parents have a positive association with reproductive health problem. The crude binary logistic regression shows that respondents living with friends/Partners or alone were 4 times vulnerable to reproductive health problem than those of respondents who are living with their family and the chi-square test of

independency have showed that there is a significant association between currently living with and youth reproductive health problem ($X^2 = 42.936, p=0.000$)

4.6.5 Father Education against Reproductive Health Problem

The study results depicts that father educational level has positively associated with reproductive health problem. The result indicates that as the educational level of their father decrease, youth reproductive health problem increase. The logistic model has also shown that those respondents whose father education level was illiterate have 64 times higher chance of youth reproductive health problem than those respondents whose father education level was literate. The chi-square also shows that father educational level and youth reproductive health problem has a significant association ($X^2 = 5.411, p=0.020$)

4.6.6 Father Occupation against Reproductive Health Problem

The independent variable father occupational status was found to negatively associate with reproductive health problem. The result is interpreted as, those youths whose fathers' work was daily labourer are 89 percent more vulnerable than those youths whose fathers' work was civil servant or others. The chi-square result shows that father occupation and youth reproductive health problem had significant association ($X^2 = 39.969, p=0.000$)

4.6.7 Mother Occupation against Reproductive Health Problem

Mother occupation and youth reproductive health problem has a positive association. The crude binary logistic regression result shows that respondents whose mother was a house wife were 8 times vulnerable to youth reproductive health problem than those whose mother work was daily labour/civil servant and others. The chi-square result shows that mother occupation and youth reproductive health problem has a significant association ($X^2 = 31.177, p = 0.000$)

CHAPTER -V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Summary

This study has assessed youth reproductive health problems (early sexuality, no condom use at first sex, unwanted pregnancy, abortion, early birth and early marriage), factors contributing to youth reproductive health problems as well as factors that influence the preference and utilization of youth reproductive health services.

The study population comprises about 46.8 percent males and about 53.3 percent of females. The age range of the participants is 15-24. From which, around 50 percent of the respondents belongs to the age group 15-18. In relation to the school youth RH and anti-HIV/AIDS club program, less than half 47.6 percent of students attend the program. Regarding their living condition, the majority (77.8 percent) of respondents indicated that they live with their family and the remaining (22.3 percent) live either with their friends/partners or alone.Out of the total respondents, who were currently attending school, 289 (86.5 percent) are in secondary and above level.

In this study, daily pocket money that the youths are getting was also assessed. This was done based on the assumption that the amount of money gained by the youths may have a relationship to the risk of youth reproductive health problem. Out of the total respondents, 228(57 percent) indicated that they get daily pocket money and 138(59.21 percent) of them stated that they get an average of 50 birr and more. In relation to educational level of respondents' parents, 59.9 percent of the subjects' fathers are illiterates. Regarding their mothers, 88.5 percent were found to be illiterates. As far as the occupation of their parents is concerned, 51.3 percent of respondents' fathers are daily laborers while 87.4 percent of their mothers are housewives.

As the assessment made on reproductive health problems indicates, 199 (49.8 percent) of the respondents were sexually active, out of these 190(95.5 percent) of them experienced first sexual intercourse before reaching age 18.The mean age for first sexual intercourse was 16.24

years. When we see this with study done before, in most African countries the age of the first sexual intercourse among youths has been found to be 10 to 19 years (Mekibeb, 2002). For instance, in Nigeria, the average age of first sexual intercourse is 16 years (UNAIDS, 2004). By the year 2005 the median age of sexual debut In Lalibela town was three years lower among female youths compared to their male counterparts (15 against 18) (Plan Ethiopia, 2005).

According to Ethiopian DHS 2005, age at first sex for female and male was 16.1 and 21.2 respectively. In the study, 56.3 percent of respondents indicated that they experienced the first sexual intercourse due to peer pressure. Moreover, 17.1 percent, 8.5 percent, and 7.5 percent was due to love affairs or in relation to love, to get money/ gifts and drunk/stoned respectively. Study done in Assebe Teferi in 2004 disclosed that youths involved in sexual intercourse because of their sexual interest (76.5 percent), peer pressures (10.4 percent) and forced sex (8.1 percent).

In this study, 61.3 percent of youths were commence unprotected sexual practice (did not use condom) at the time of first sexual intercourse. This means that only 38.7 percent of them used condom. This figure indicates relatively higher age as compared to a nation wide figure, which accounts 15 percent for the males and 37 percent for the females (Kasahun, 2006). A study conducted in Addis Ababa high schools indicated that 54 percent of sexually active youths have experienced sex with more than one partners [9]. In Lalibela town it was found that, 11.2 percent of male and 8.2 percent of female youths have two or more sexual partner in their life time. The over all mean life time number of sexual partner was 2.1(Plan Ethiopia, 2005). In this study, the figure shows that 81.9 percent and 65.8 percent of youths reported more than one sexual partner in their life time and in the last 12 months respectively. The over all mean number of life time and last 12 months sexual partner in this study were 4.26 and 3.04 respectively.

Unwanted pregnancy is a serious problem among youths and it is associated with health risks to the mother during pregnancy and delivery. Several studies in Ethiopia have documented the prevalence of unwanted pregnancies among youths. In a survey of adolescents conducted in Awasa, Adama and Addis Ababa 64 percent of the respondents mentioned that they know a girl

whose schooling was interrupted due to unwanted pregnancy. This study also indicated that there were a total of 70 pregnant girls in the first sexual intercourse, out of which 88.6 percent of the subjects' experienced unwanted pregnancy. Of those respondents who were exposed to unwanted pregnancy, 31.8 percent end their pregnancy with abortion and 31.4 percent gave births. The mean age at first pregnancy, abortion and child birth in this study were 16.04, 16.6 and 17.4 respectively. This figure indicates that youths in the study area were at great risk of unwanted pregnancy, abortion and early birth. A very recent study on unsafe abortion done by The Ethiopian Society of Obstetricians and Gynaecologists (ESOG) in 2002 revealed that 45 percent of cases who visited health canter because of abortion were adolescents between the ages of 15-19.

Most Ethiopian parents do not discuss the issue of sex and sexuality with their children, openly inform and communicate sexual issues and reproductive health matters with their children. Due to this, most youths prefer to discuss such issues with their friends (Sefiu, 2001). In this study, 41.4 percent of the respondents reported that they never discussed on sexual and reproductive health matters with their families. Besides, it was also found out that 27.4 percent of respondents indicated that they discussed reproductive health issues with their friends. Furthermore, 21.02 percent of the subjects preferred to discuss with their sisters and 7.96 percent with their partners.

The data on preference and utilization of youth reproductive health services revealed that, only 39.5 percent of the respondents have got reproductive health services. Out of these, 36.08 percent of them preferred to use the youth clubs, followed by Government Health Institutions (29.11 percent). As per the assessments regarding the rearrangement of youth reproductive health services, 48.75 percent of the respondents chosen to get the services in the existing health institution having its own separate room, followed by expansion of the centre (36.0 percent). In relation to the service time, 51.2 percent of them preferred to get the service during the time when other customers are not around. In other aspect, regarding service fees, 57.0 percent of the respondents preferred to get the service free of charge and with regard to the health service provider, 40.2 percent of them preferred young provider with the same sex. Finally, in relation to the service provision approach, youths in the study area preferred to get the services in the form of television program (23.93 percent), library service (20.79 percent) and panel discussion (19.55 percent).

The dominant contributing factors for the youths not to utilize reproductive health services were reported to low awareness level or knowledge (14.47 percent), absence of youth friendly reproductive health services (12.27 percent), thinking that the services are not intended for them (11.72 percent), inconveniency of health service delivery time (11.99 percent) and socio-cultural factors (10.89 percent).

Finally, to identify if there are association between independent variables and dependent variable (youth RH problem), chi-square tests and logistic regression analysis was employed. Accordingly, being young age 15-18 (*OR=0.045, X^2 =26.834 and p=0.000*) and having a daily labourer father (*OR=0.113. X^2 = 39.969 and p=0.000*) have been independently and negatively associated with youth reproductive health problem. While attending the school youth reproductive health and Anti HIV/AIDS club (*OR=11.095, X^2 = 10.52 and p=0.001*), having pocket money (*OR=10.941, X^2 = 12.959 and p=0.000*), currently living with friends/partners (*OR=4.253, X^2 = 42.936 and p=0.000*), having illiterate father (*OR=63.533. X^2 = 5.411 and p=0.020*) and being a housewives mother (*OR=8.398. X^2 = 31.177 and p=0.050*) had independently and positively associated with youth reproductive health problem.

As it was revealed by logistic regression, the younger age group was highly at risk as compared to the older age. This could be contributed to the fact that as age decreased there is a more eager to practice unsafe sex. Similarly, respondents who have a daily labourer fathers were at risk of reproductive health problem. Like wise, having pocket money also had a high risk factor for youth reproductive health problem. This can be explained by the fact that, in the study area, youths are giving local guiding services and usually getting money. This intern might lead them to sexual activities that could be resulted in complication. But this does not mean that it always hold true that having pocket money is associated with youth reproductive health problem. Not attending the school youth reproductive health program and living with friends/partners were high risk factors for youth reproductive health problem.

Respondent youths who did not attend the school youth RH program were found to have reproductive health problems. Furthermore, youths who live in a rented house particularly those who live with their colleges also were exposed to reproductive health problem. One of the reasons for this is peer pressure.

5.2. Conclusions

The rational of the study is to assess youth reproductive health problems in Lalibela town. On the basis of the obtained findings the following conclusions can be drawn.

- Younger age group was found to be more at risk as compared to the older age group.
- Youths who have got pocket money engaged in risk reproductive health problem.
- Youths who are living with their friends/Partners or alone were found to be at high risk of youth reproductive health problem as compared to youths living with the family.
- Youths that do not attend the program that is conducted by the school youth reproductive health and Anti HIV/AIDS club have at higher risk of youth reproductive health problem as compared to youths attending the school youth reproductive health and Anti HIV/AIDS club program.
- The findings of the study generally showed that youths lack adequate information and knowledge about sexual and reproductive health and thus initiated to perform risky sexual practices that exposed them to reproductive health problem and they were not capable to take action to protect themselves from various sexual risk exposures.
- High figure of the youths were not served in the existing health institution for their reproductive health need, even those who used to be served claimed that the existing health institution were inconvenient and not well structured for the needs of the youths.
- Most of the youths preferred to rearrange the youth reproductive health institutions separately and to be served by young and the same sex health service providers.

5.3. Recommendations

Although the area demands more detailed and frequent study, on the basis of the present findings, it is reasonable to recommend the following points

- Under the study area, the school youth RH and anti HIV/AIDS clubs play a great role in dissemination of information about RH matters and this greatly helped the youths attend the

programme from not being exposed to RH problems. Therefore, it needs an urgent move to establish and strengthen youth RH clubs in the schools and in the area to save lives of youths.

- The younger ages are relatively at risk than the older. Therefore, youth associations and concerned officials should give emphasis and prepare strategy to get them easy.
- Most youths, who came from the rural area to pursue their education by renting houses, living with their friends and relatives. This can be considered as the major cause of youth RH problems. Therefore, responsible bodies should give much emphasis on the above cited problems.
- High proportions of youths who have get pocket money are relatively at risk than those who do not have pocket money. Thus, both governmental and non governmental organizations should have to focus their attention on this group.
- Building strong social support should be given for the youths, from the community in general, particularly, from families, religious leaders, school teachers, and health service providers and administrative bodies. Orienting these groups on youth specific reproductive health problems.
- Both governmental and non governmental organizations that are working in the area should have to prepare programs for increasing the understanding of youth regarding various aspects of sexual and reproductive health.

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Dear respondents

I am going to ask you some very personal questions that some people may find it difficult to answer. I am not going to talk to anyone about what you tell me .Your name will not be written on this form and will never be used in connection with any information you tell me. You may end this talk at any time you want to .However, your honest answer to these questions will help us better understand on reproductive health problems and their utilization and preferences of youths. I would greatly appreciate your help in responding to the interview.

Would you be willing to participate in the study? -------Agree ---------Disagree

Interview control record

Interview No-----

Result of the interview

A. Completed

B. Refused

C. Partially completed

Background (Socio-Economic and demographic) characteristics

Instruction

Dear Respondents For each of the following questions, I politely request you to underline your answer from the given alternatives

101. Sex

.1 Male 2. Female

102. Age in completed years? ----------

103. Place of birth?

1. Urban 2. Rural

104. Marital status?

1. Married 2.Unmarried 3.Divorced

4. Widowe/Widower 5.Separeted

105. Religion?

1. Orthodox 2. Muslim

4. Protestant 3. Catholic

99. Other specify……..

106. Have you attend religious programs?

1. Yes 2. No

107. Are you a member of the youth RH and Anti HIV/AIDS clubs?

1. Yes 2. No

108. Are you currently gong to school?

1. Yes 2. No

109.If your response is "yes" for question number "106", In which of the following level are you currently learning?

1. One to four grade 2. Five to eight grades

3. Nine to Tenth grade 4. Eleven to Twelve grades

5. Technical and vocational education training

6. College and above

110. Do you attend the youth RH and Anti-HIV/AIDS club program in your school?

1. Yes 2. No

111. With whom do you currently live?

1. With father and mother 2. With mother only
3. with father only 4. With brother / sister
5. with relative 6. With friend
7. Alone 8. With my partner
99. Other specifies 9. With my spouse

112. What is your occupation?

1. Student 2. Private business worker
3. Guider 4.Farmer
5. Merchant 6. Private employs
7. Government employs 8. Working in the family business
9. Unemployed
99. Other specify .....

113. Does you get pocket money for daily expense?

1. Yes 2. No

114. If your response is "yes" for question number "113", how much pocket money do you get on average per day?

1. Less than 5 birr 2. 5 to 10 birr
3. 11 to 20 birr 4.21 to 30 birr 5. More than 30 birr
99. Other specify ----------

115. Are your parents alive?

1. Both are a live 2. Only my father is a live
3. Only my mother is a live 4. Both are dead

* If your response for question number "112" is from one of "one to three" alternatives

16. What is your father's educational level?

1. Illiterate
2. Only read and write
3. Primary School [one to six grades]
4. Junior secondary school [seven to Eight grades]
5. High school [nine to twelve grades]
6. Institution
7. College and above

117. What is your mother's educational level?

1. Illiterate
2. Only read and write
3. Primary School [one to six grades]
4. Junior secondary school [seven to Eight grades]
5. High school [nine to twelve grades]
6. Institution
7. College and above

118. What is your father's occupation?

1. Daily laborer 2.Civil servant
3. Farmer 4.Employed in private sector
5. Has private sector
99. Other specify----------

119. What is your mother's occupation?

1. Housewife 2.Daily laborer
3. Mild servant 4.Farmer
5. Civil servant 6. Employed in private sector
7. Has private sector
99. Other specify----------

120. In your opinion, which of the following shows your families economic status?

1. Rich 2. Medium 3. Poor 98. I don't know

2. Reproductive Health Characteristics

201. Have you ever heard about RH?

1. Yes 2. No

202. If your response is "Yes" for question no "201", do you believe that youth have RH problems?

1. Yes 2. No 98. I don't know

203. In your opinion, what is the ideal age for a female to start sexual inter course? -------

204. In your opinion, what is the ideal age for a male to start sexual inter course? ----------

205. Have you ever had sexual inter course?

1. Yes 2. No

206 If your response is "Yes" for question no. "205", how old were you when you had your first sexual intercourse? ----------

207. What is /was the relation to you of your first partner or with whom did you make your first sexual intercourse?

1. With a steady boy/girl friend
2. With a causal boy /girl friend
3. Husband /wife
4. A family member
5. My employer
6. Other specify ----------

208. What was your reason to start sexual intercourse in the first time?

1. Fell in love 2. By my sexual interest
3. I got married 4. I was raped (Forced to do so)
5. To get money and other gifts
6. Peer pressure
7. I was drunk or stoned

99. Other specify ----------

209. How many sexual partners you have had in your lifetime? ------

210. How many sexual partners you have had in the last 12 months? ----

211. Which method of avoiding pregnancy do you use most?

1. Pills 5. Norplant 9. Safe period
2. Emergency pills 6. Loops
3. Condom 7. Female sterilization
4. Inject able 8.Vascotomy
99. Other specify.....

212. Have you used condom in your first sexual inter course?

1. Yes 2. No ` 97. No response

From question number 213 to 220, it is only for females

213. In your first sexual relation have you ever become pregnant?

1. Yes 2. No

214. How old were you when you first become pregnant? ----------

215. If your answer is "Yes" for question number "214", were all of your pregnancies wanted?

1. Yes 2. No 97. No response

216. Sometimes a girl becomes pregnant and decides to abort or stop the pregnant. Have you ever aborted or stopped your first pregnancy?

1. Yes 2. No

217. Have you ever given birth? ----------

1. Yes 2. No

218. If your answer is "Yes "for question number "218" What was your age when you first gave a birth? ----------

219. Are you married?

1. Yes 2. No

220. If your answer is "Yes "for question number "219 ", how old were you at your first marriage? ----------

From question number 221 to 223, it is only for men

221. If you have had sex, do you remember any girl who was pregnant after sexual intercourse with you?

1. Yes 2.No

97. No response 98.I don't know

222. Were all of all the pregnancies were wanted?

1. Yes 2.No 97.No response

223. If your response for question number "222" is "No "did she ever aborted or stopped pregnancy?

1. Yes 2.no 97.No response 98. I don't know

3. Concerning RH information and factors influencing Utilization of RH services

301. Who is comfortable to you to discuss with Youth RH issue?

1. Father 2. Mother
3. Sister 4. Brother
5. Friends 6. Partners
7. Spouse 8.Peer-educators

99 others Specify.....

302. Which is your major source of information concerning youth RH services?

1. Father 2 Mother
3. Brother 4. Sister
5. Friends 6. Partners
7. Spouse 8. Peer educators
9. Books, magazines and pamphlets
10. Radio /TV 11. School clubs
12. Health professionals
13. Religious leaders

99. Other specify _____

303. Do you openly discuss with your parents about youth RH issue?

1. Yes 2. No

304. Do your religion inhabit you to discuss about issues on youth RH?

1. Yes 2. No 3. I don't know

305. Do your culture inhibit you to discuss about issue on youth RH?

1. Yes 2. No 3.I don't know

306. What are the contributing factors for the youths failed to go to health institution for RH services?

1. Fear of Parents
2. Low awareness about RH service
3. Far distance of the health services
4. High cost of the services
5. Poor treatment of the health services
6. Lack of confidentiality on health services
7. Long waiting time
8. Inconveniency of the health service delivery time
9. Inconsistency of service delivery
10. Absence of youth friendly reproductive heath service
11. Believed that the service are not intended for them
12. Socio- cultural factors
13. Failures in keeping privacy and confidently

99. Other specify --------

4. Preference and Utilization of youth RH services

401. Have you visited the health institution for your youth RH needs?

1. Yes 2. No

402. If your response is "Yes" for question number "401" in which of the following health institution do you think youth RH services are given better?

1. Private health center 2. Government health institution
3. Family Guidance clinic 4. Tradition healer
5. Community based RH agent's 6.School clubs

99. Other specify ----------

403 In which of he the following way do you prefer youth RH services to be rearranged?

1. With the existing health institute as it is
2. No need to give special attention
3. With in the existing health institution having its own youth RH services room
4. By expanding youth RH services in youth center
99. Other specify ---------

404. Which time do you think it is convenient for youth to got health services?

1. during the usual health institute working hours
2. on the special hours when other users are not around
3. Other specify

405. What is your preference concerning health service fees for youth?

1. at the usual rate 2. With special discount for youth
3. Free of charge
99. Other specify.....

406. Whom do you prefer to be youth reproductive health services provider

1. Young and the same sex 4. Adult and different sex
2. young and different sex 5. Any provider
3. Adult and the same sex

407. What kind of youth -friendly reproduction health services you prefer

1. Peer education 2. Library services
3. Panal discussion 4. FP services
5. Indoor and out door services 6. Television program
99. other specify ----------

5. Level of Substance use

501. Do you chew chat?

1. Yes 2. No

502. Do you smoke cigarettes?

1. Yes 2. No

503. Do you dirk alcohol

1. Yes 2. No

Thank You

DECLARATION

This thesis is my original work, has not been presented for a degree in any other university and the all source of materials used for thesis have been dually acknowledged.

Name: Awol Mohammed

Signature _____

Date – July 2007

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

Name – Dr. Sathia Susuman

Signature _____

Date 25/07/07