ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE SCHOOL OF PUBLIC HEALTH

ASSESSMENT OF REPRODUCTIVE HEALTH SERVICE UTILISATION BY SECONDARY SCHOOL ADOLESCENTS IN ADDIS ABABA

by

AKLILE TEBEBE

Advisor: -Dr Assefa Seme (MD,MPH)

Co-Advisor:- S/r Meselech Roro (Bsc, MPH, PhD fellow)

Thesis submitted to Addis Ababa University College of Health Science School of public Health in partial fulfilment of the requirements for master's degree in public health

June, 2018

Addis Ababa Ethiopia

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Abstract

Background: Young people compromise almost half of the world's population, which is nearly 85% for developing countries. Since youth is an intermediate time that makes a pavement to adulthood and is important for laying the foundation of good health in later time, effective intervention of sexual and reproductive health service of the youth protects both the old age and the coming generation. But, there is lack of resources and trained man power for comprehensive sexual and reproductive health services.

Objective: to assess the magnitude of reproductive health service utilisation among secondary school adolescents in Addis Ababa.

Methods: School-based quantitative cross sectional study was carried out among age 15-19 years age old selected secondary schools adolescents in Addis Ababa. Using the random sampling a total of 844 school adolescents (aged 15-19 years) were proportionally allocated and interviewed from 10 high schools. A pretested structured questionnaire was employed to obtain the necessary information after getting both written and verbal permission from the concerned bodies. The collected data was interred in to Epidata and analyzed using SPSS version 20 statistical packages and the degree of association between dependent and independent variables were assessed using bivariate and multivariate analysis.

Result:-From the total 844 participants assessed on utilization of reproductive health services 305(36.1%) respondents utilize at least one from the five main RH service options. The odds of utilization among respondents who said RH service available in their school was 1.682(1.232, 2.295) times higher than those who have no RH service in their school. The odds of utilization among respondents who have Knowledge on type of reproductive health services types were 2.934(1.906, 4.515) times higher than those who do not have knowledge on type of RH service types.

Conclusions: - Generally this study disclosed that RH service utilization among High school adolescent's in Addis Ababa was 36.1%. Knowledge about RH facilities that provide services and availability of services of choice by adolescents were significant predictors of RH utilization.

Recommendations:-

Conducting promotion about the services that are given in RH facility is mandatory to increase access by high school students.

Availing RH facilities by type of services that adolescents wanted will increase access to utilization.

Acronyms and Abbreviations

CI	Confidence Interval
EDHS	Ethiopian Demographic and Health Survey
FMOH	Federal ministry of health
HIV	Human Immune-Deficiency Virus.
IEC	Information, Education and Communication
NGO	Non-Governmental Organization.
RH	Reproductive health
YFRHS	Youth friendly Reproductive Health Service
RHS	Reproductive Health Service
SRHS	Sexual and Reproductive health service
STI	Sexually Transmitted Infection.
VC T	Voluntary Counseling and Testing.
WHO	World health organization
OR	Odds Ratio
AOR	Adjusted Odds Ratio
COR	Crude Odds Ratio

1. INTRODUCTION

1.1Background

In 2008 About 16 million adolescent girls between 15 and 19 years of age give birth each year. Babies born to adolescent mothers account for roughly 11% of all births worldwide, 95% of them are from developing countries (1). Early child bearing affects the health of both the mother and the new born. Early marriage and early child bearing are planned and wanted for some of the youth but for many others theses early marriage and early child bearing are not planned (1). These un-planed pregnancies leads to unsafe abortion as youth are less likely than adults to obtain legal and safe way of terminating the pregnancy. Early marriage, which results with low use of contraception prior to the first child, multiple pregnancy and short spacing is harmful for the health of both the mother and the child. Adolescents' reproductive desires are strongly influenced by social norms and expectations of gender roles. The belief that a girl's primary value and role in society is that of a wife and/or mother can impact greatly her family planning desires and decisions. Additionally, a child born to a young mother (12-20 years old) is at greater risk of dying before the age of five, being stunted, being under weight, and suffering from anaemia (2).

Even though sexual and reproductive health and rights (SRHR) are usually understood as the rights of all people, regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being (3).Young people are experiencing a time of transition, consisting of physical, psychological, emotional and economic changes as they leave childhood and enter adulthood. The decisions that are made during this period of life affect not only the individual wellbeing of young people, but also the wellbeing of entire societies (4).

Analysis of 61 countries' DHS data set suggests that an estimated 33 million female youth have an unmet need for FP. Among unmarried and married female youth in West and Central Africa, unmet need is 41.7 per cent and 29.3 per cent, respectively. In general, married adolescents aged 15-19 experience greater unmet need than "all" married women. Overall, rates of contraceptive use remain very low in all regions in sub-Saharan Africa among 15-to-19-yearold and 20-to-24-year-old married women (4). Ethiopia is a country where cultural

and social barriers to gender equality are very strong, resulting in poor sexual and reproductive health indices and high prevalence of harmful traditional practices, including early marriage, female genital mutilation, gender-based violence, etc. This gender disparity negatively impacts the well-being and health of the poor, diminishing their productivity. The high total fertility rate (TFR) and rate of natural increase (RNI) mean greater demand for social services, especially education and health (4).

For girls, child marriage is also associated with an increased risk of sexually transmitted infections and unwanted pregnancies. Research suggests that adolescent pregnancy is related to factors beyond girls' control (6). Investing in sexual and reproductive health knowledge and services for early adolescents is critical for several reasons. The first is that some adolescents are engaging in sexual relations in early adolescence; international household survey data representative of the developing world, excluding China, indicate that around 11 per cent of females and 6 per cent of males aged 15–19 claims to have had sex before the age of 15 (6).

Young people face myriad obstacles excluding them from health that are closely linked with poverty, marginalization, and discrimination. The disproportionate impact of these issues is high on low-income and poorly educated (7). Young women tend to become sexually active at a young age in Sub-Saharan countries, often within or shortly before marriage. The international standard for the legal age of marriage for girls is 18, but in many of these countries, the legal age is 16 and girls are often married at much younger ages. In most of these countries, the median age of first sexual experience among women is between ages 16 and 18, and the median age of first marriage is between 18 and 20. Men tend to have a longer interval between first sex and marriage; on average they initiate sex between ages 15 and 20, and marry between ages 22 and 26 (8).

Of the estimated 22 million unsafe abortions that occur every year, 15% occur in young women aged 15–19 years and 26% occur in those aged 20–24 years. In Africa alone, an estimated 3 million girls are at risk of undergoing female genital mutilation every year (9).

Pregnancy-related complications are consistently among the leading causes of death among girls aged 15-19 in developing countries. For example, research in Ethiopia found that girls

who had given birth between the ages of 15 and 19 were twice as likely as those aged 20-24 to experience obstetric fistula, and three times as likely as those aged 25-29.(9).

Lack of essential equipment and supplies (medication and contraceptives), non-comprehensive services, lack district management support, lack of anonymity and privacy and high work load by health service providers are barriers to service delivery (12,13). Studies conducted in Bahirdar and Jimma towns about level of knowledge and reproductive health service utilisation among the adolescents and barriers of the service utilisation revealed that the level of knowledge about health services for RH, source of information for these services and service provider centres is moderate to high. Moreover, adolescents had favourable attitude towards use of health services for RH issues and problems. However, the role of health professionals and families as sources of information for the adolescents seems to be insignificant or low and concerning the service utilization, only 32% of youth utilized youth reproductive health service. Barriers in utilizing reproductive health services, for 31% of the students were due to inconvenience hours and 28.5% were due to fear of being seen by parents or people whom they know. Among socio-demographic predictors, age and reproductive health problems showed a significant association with utilization of youth reproductive health services (14, 15).

Even though there are studies in different areas that reveal adolescents' knowledge and practices of reproductive services, not much is known about the status of sexual and reproductive health service utilization of secondary school adolescents and the barriers to utilise the services in Ethiopia.

1.2. Statement of the Problem

Adolescents in Ethiopia have limited access to sexual and reproductive health information as well as quality adolescent- and youth-friendly reproductive health services (16) Despite of the high rate of sexual and reproductive health problems; the access of acceptable sexual and reproductive health services to adolescents is very low. Based on published reports, some of the factors contributing to the low access are low level of health knowledge, decreased awareness of the adolescents about availability of reproductive health services in the facility, poor staff treatment/handling, unfavourable facility organization, socio-economic factors, and unfavourable attitude of youth towards the behaviour of the service providers (17, 18, and 19). This poses a major public health problem such as maternal deaths and other complications resulting from early marriage, unplanned pregnancy unsafe abortion in the country and is associated with far reaching effects such as jeopardizing youths' educational progress and future careers. Therefore it is important to further investigate what other factors affect the utilisation and what are these factors in the context of Addis Ababa and to gain a better understanding of the reasons for low uptake of the service as a first step towards the reduction of teenage pregnancy, unsafe abortion, sexually transmitted diseases and other reproductive health problems. The aim of this study is to assess reproductive health services utilisation of adolescents in high schools in Addis Ababa Ethiopia. Determining the magnitude of reproductive health service utilization in Addis Ababa will contribute to pave the identified gaps and solve the problems related to the service utilisation.

1.3. Significance of the Study

The study of the utilization of reproductive health service will help to improve quality of life of adolescents by providing available information about utilization of the available adolescent sexual and reproductive health services and possible factors that affect the utilization by secondary school adolescents in Addis Ababa. This will assist in the planning for adolescents' reproductive health services. The rendering of adolescent reproductive health services in an appropriate way would enable the secondary school adolescents to utilize the reproductive health services thereby reducing on the cases of unwanted pregnancies, sexually transmitted infections including HIV/AIDS in the cities secondary schools and ultimately reduce the numbers of infection cases in the district and nation as a whole.

2. LITERATURE REVIEW

2.1. Adolescence and adolescent sexuality

There are several important aspects of sexual and reproductive health that apply particularly to young people. The majority of people become sexually active during adolescence. The use of contraceptives and condoms among young people, however, is low and unprotected sex is the second largest contributor to health risk in terms of the burden of disease in young people. As a consequence, each year, there are at least 100 million cases of sexually transmitted infections among young people, as well as more than 2.5 million unsafe abortions recorded for adolescents. There are 15.9 million infants born to adolescent mothers each year and maternal mortality accounts for 15% of the total number of deaths among young women. The impact of adolescent pregnancy includes intergenerational effects on new-born health. Infants of adolescent mothers, for example, have a higher risk of dying in the first two years of life (1).

A large number of adolescents, both married and unmarried are sexually active. A 2005 study of sexual behaviour in different regions of the world found that by age 15, nine to 21 per cent of girls had had sex, compared to 12 to 31 per cent of boys.8 By age 18, this had increased to 41 to 59 per cent for girls and 40 to 73 per cent for boys. By age 20, the vast majority of both young women (61 to 77 per cent) and young men (61 to 87) had had sex, regardless of marital status.9 This study also found that one-third of *unmarried* adolescent girls under age 19 in sub-Saharan Africa and nearly one-quarter in South America had ever had sex (2).

During adolescence, the rapid brain maturation leads to new sets of behaviours and capacities that may hinder or enhance the transitions of adolescents in the family, peer groups, educational domains and in health behaviours. These transitions have an impact on the health and wellbeing during adulthood (24). The socio-economic determinants of adolescent health include policies and environments that support access to education, provide relevant resources for health (e.g. contraception), and create opportunities to enhance young people's autonomy, decision-making capacities, employment, and human rights to promote positive transition to adulthood (24). Different societies define adolescence differently in terms of age and social roles. The social-role changes, the hopes and aspirations of adolescents across the world are widely affected by economic and sociocultural factors in their environment (25).

2.2. Knowledge and access to reproductive health services

A study in Tanzania revealed that most participants were aware of the dangers of STIs to themselves and their unborn babies, but did not perceive themselves as at risk of acquiring STIs. They viewed condoms as ineffective for preventing STIs and pregnancies and unnecessary for those in committed relationships. Stigma, long waiting times, and lack of privacy in the clinics discouraged adolescent girls from seeking reproductive health care (26).

According to a study conducted in Assela town, Ethiopia, Majority (97.3%) of the respondents have heard about family planning methods. The first common source of information for family planning was mass-media (62.5%) and the least source of information (8.3%) was internet. Out of sexually active respondents (61%) of them currently using contraceptive methods. Females from urban (AOR=4.60, 95%CI =1.06-19.96) and those who satisfied with family planning service (AOR=9.75, 95%CI=1.62- 58.71) were utilized family planning than their counter parts (27).

2.3. Adolescent sexual and reproductive health risks

The period of adolescence presents vulnerabilities and risks to adolescent reproductive health. The marked adolescence emotional, sexual, and psychological transformations increase experimentation with behaviours and practices that can have longstanding implications for their health and wellbeing (28, 29). The health of young people has been largely neglected in global public health because this age group is perceived as healthy (30). Sexually transmitted infections including HIV/AIDS, teenage pregnancy and unsafe abortions are among the major negative yet preventable effects of the risky behaviours during adolescence. Today, there are more than 4 million young people living with HIV in developing countries. HIV prevalence rates among young women, ages 15-24, in sub-Saharan Africa are twice as high as they are for their male peers. (6)

The second reason concerns the alarming and consistent disparity in practice and knowledge of sexual and reproductive health between adolescent males and adolescent females. Adolescent males appear more likely to engage is risky sexual behaviour than adolescent females. In 19 selected developing countries with available data, males aged 15–19 were consistently more likely than females to have engaged in higher-risk sex with non-marital, non-cohabiting partners in the preceding 12 months (6).

Young people often lack the comprehensive and accurate information that they need in order to protect themselves from HIV. Few know their HIV status, which increases their risk of transmission. In sub-Saharan Africa, only 10 per cent of young men and 15 per cent of young women ages 15-24 know their HIV status (31).

Investing in sexual and reproductive health knowledge and services for early adolescents is critical for several reasons. The first is that some adolescents are engaging in sexual relations in early adolescence; international household survey data representative of the developing world, excluding China, indicate that around 11 per cent of females and 6 per cent of males aged 15–19 claim to have had sex before the age of 15.13 Latin America and the Caribbean is the region with the highest proportion of adolescent females claiming to have had their sexual debut before age 15, at 22 per cent (there are no equivalent figures for young men for this region). The lowest reported levels of sexual activity for both boys and girls under 15 occur in Asia.

2.4. HIV/AIDS other STIs

Age at first sex is the indicator to determine the average age at which young people become sexually active. It can also provide some insight into when most young people are exposed to risks related to pregnancy and sexually transmitted infections. Adolescents rarely use protection when having sex for the first time and younger adolescents face a greater risk than older adolescents of acquiring sexually transmitted infections, including HIV. In most countries with available data, the median age of first sexual experience for young women is between ages 16 and 18. The average age at first sex in countries—including Niger, Sierra Leone, Liberia, Guinea and Uganda—is younger than 17. These countries are identified as "red" since adolescents under the age of 18 are at a higher risk for sexually transmitted infections and poor reproductive health outcomes due to pregnancy and early childbearing (4).The main causes of the transmission of HIV among young people are: unprotected sex with an HIV-positive person or contact with infected blood or other fluids through the sharing of non-sterile injecting equipment. In addition, many adolescents living with HIV were born with the virus (6).

Today, there are more than 4 million young people living with HIV in developing countries. HIV prevalence rates among young women, ages 15-24, in sub-Saharan Africa are twice as high as they are for their male peers.6 Young people often lack the comprehensive and

accurate information that they need in order to protect themselves from HIV. Few know their HIV status, which increases their risk of transmission. In sub-Saharan Africa, only 10 per cent of young men and 15 per cent of young women ages 15-24 know their HIV status (31).

The rapid roll-out of anti-retroviral treatment programmes has made it possible for prenatally infected infants to live through adolescence and adulthood, thereby engaging in dating and sexual relationships (32). However, the sexual and reproductive health needs of this unique and rapidly increasing population are largely unmet.

Therefore, HIV remains a major threat to the reproductive health of young people globally. Yet due to their age, social or economic status the young people may have limited access to information and services. In 2012, it was estimated that 2.1 million (5.9%) of the people living with HIV are adolescents aged 10–19 years in middle and low income countries (33).

HIV-related deaths among adolescents increased by 50%, while the global number of HIV-related deaths fall by 30% (34). Globally, around 2500 new cases of HIV infections occur among adolescents and youth ages 15–24 every day. Additionally, approximately 712 new cases of HIV are diagnosed each day in children less than 15 years of age due to vertical transmission and sexual coercion (35).

2.5. Pregnancy

Although there has been a slight decline in adolescent birth-rates in developing countries over the last two decades, sub-Saharan Africa continues to have some of the highest rates of adolescent fertility in the world, showing almost no decline since 1990.29 Among the 14.3 million adolescent girls that gave birth in 2008, one of every three was from sub-Saharan Africa. Often, early childbearing is the result of child marriage, the negative consequences of which are described in greater detail in the "Gender Equality and Social Protection "section. But unmarried adolescents are also at risk for unintended pregnancy if they do not have access to comprehensives education and family planning services. Nearly half of the countries with available data are categorized as "red", meaning they have an adolescent fertility rate of more than 100 births per 1,000 adolescent girls. Niger, the Democratic Republic of the Congo and Mali are particularly high, with 192, 168 and 167 births per 1,000 adolescent girls, respectively. And high rates of adolescent childbearing are not limited to any one region in sub-Saharan Africa; the 10 "red" countries with the highest adolescent fertility rates include countries from West Africa, Central Africa, East Africa and Southern

Africa (4). Adolescent pregnancy comes with high risks. Girls between the ages of 15 -19 are twice as likely as older women to die from pregnancy-related causes due to physical, social, and economic factors.4 In fact, maternal mortality is the second leading cause of death among girls in this age range (31).

2.6. Barriers to Reproductive Health Care

The immense pressure that these and other social norms and expectations place on girls can constrain their ability to understand and exercise their right to make decisions around their own sexual and reproductive health, including family planning (2).

While early marriage can provide social recognition and approval for sexual relations, it also places pressure on girls to prove fertility and bear children.(13). Child marriage is associated with low use of contraception prior to the first child, followed by multiple, shortly spaced pregnancies.(14) Additionally, double standards related to what is socially acceptable in regard to pre-marital sex place pressure on boys to engage in sexual activity and girls to remain chaste.(15).

Adolescents' reproductive desires are strongly influenced by social norms and expectations of gender roles. The belief that a girl's primary value and role in society is that of a wife and/or mother can impact greatly her family planning desires and decisions. Early marriage often exacerbates these pressures. This can lead to girls who engage in pre-marital sex feeling embarrassment and shame in regard to seeking to use family planning methods. In many cultures, girls are taught to be passive, to not think for themselves or voice their opinions, and rather are instructed to do as they are told.(16).

Adolescents often face steep, social, logistic, economic and legal barriers to exercising their sexual and reproductive rights and accessing the health care they need. Social and cultural norms around adolescent sexuality may discourage young people from seeking services, particularly if they are concerned that their confidentiality and privacy won't be maintained at health facilities. Young people often face provider bias, making it difficult to receive the comprehensive care they need. In addition, the location and hours of operation of facilities and the cost of services may further hamper young people's ability to access needed services (31).

2.7. Conceptual frame work of the study

This study will use Andersen's Phase Two Model of Health Service Utilization(37). to investigate secondary school adolescents' reproductive health service utilization in Addis Ababa. This behavioural model provides a systems perspective to investigate a range of individual, environmental and provider related variables associated with decisions to seek health care. It proposes that the use of health care services is a function of three categories of determinants; Predisposing characteristics which mainly explains the association of demographic factors such as age, sex and education level and consumption of health services. Enabling characteristics such as family income or economic status, location of residence, access to health facilities and availability of person for assistance is key factors in health seeking behaviour. Most of the youth are largely dependent on parents/guardian and the infrastructure within their residence. Need characteristics explores perceived need for health services, and expected benefit from treatments. Health care system includes health policy, resources and organization which refers to how health care system manages its resources and consumer satisfaction determine individual's use of health service.

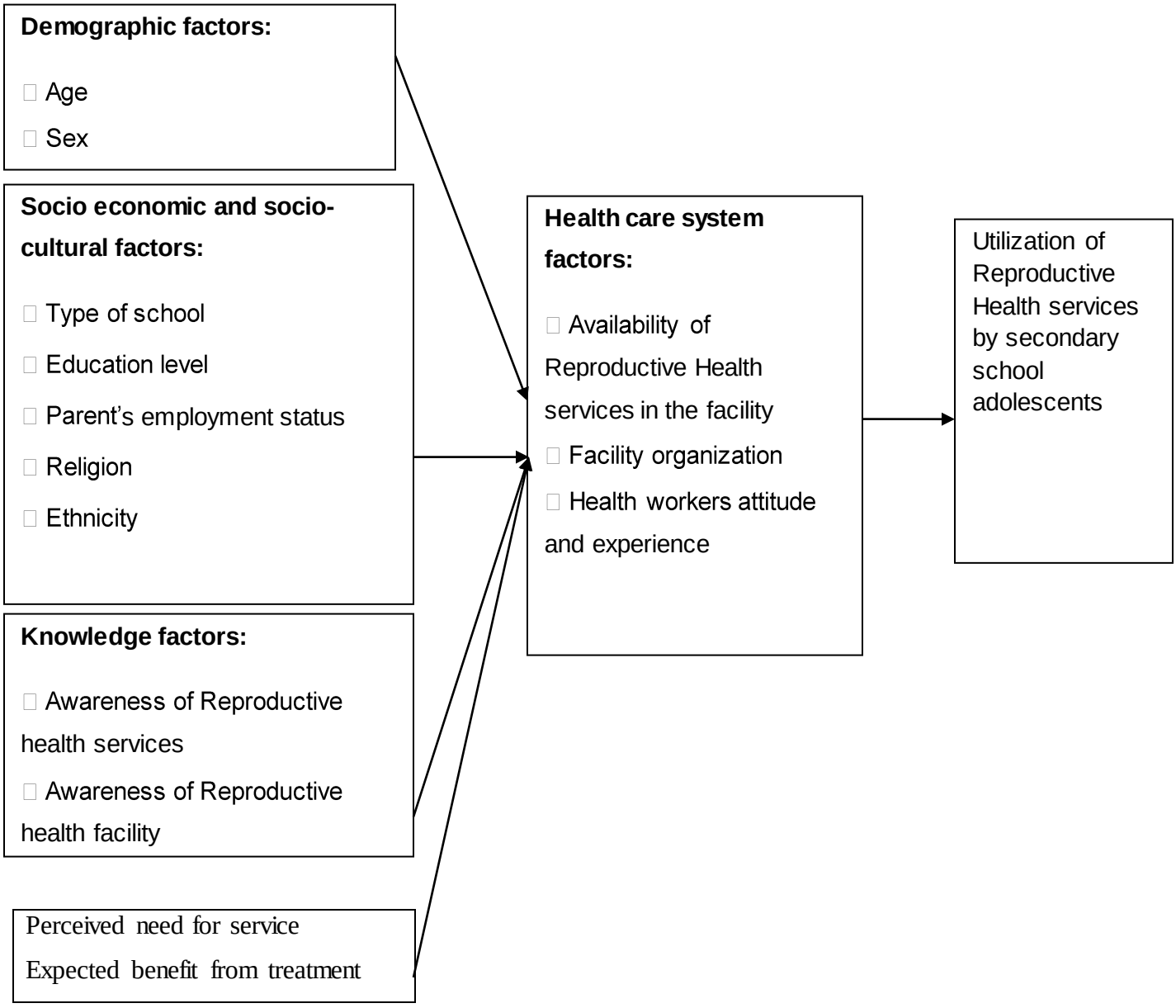

Figure 1: Conceptual Framework adopted from Andersen & Newman, 2005)

3. OBJECTIVES

3.1. General objective

The study assesses the magnitude of reproductive health service utilization and to identify factors that affect utilization of reproductive health service among secondary school adolescents in Addis Ababa.

3.2. Specific objectives

1. To determine magnitude of reproductive health service utilization among secondary school adolescents in Addis Ababa
2. Identify factors that affect utilization of reproductive health services among secondary school adolescents in Addis Ababa

3.3. Research questions

What is the level of utilization of the existing adolescent and reproductive health services among secondary school adolescents in Addis Ababa?

What factors affect the utilization of reproductive health services among secondary school adolescents in Addis Ababa?

4. METHODS AND MATERIALS

4.1 Study Design

A cross-sectional quantitative research was conducted among 15-19 years old secondary Schools adolescents in Addis Ababa with the aim of assessing the demographic, socioeconomic, school and health system factors that influence utilization of reproductive health services by high school adolescent students.

4.2 Study Setting

This Study was conducted in both government and private secondary schools in Addis Ababa. Addis Ababa is the capital city of Ethiopia with 10 sub-cities and 113 Woreda. The city Lies 9°1′48″N latitude and 38°44′24″E longitude and located at the heart of the country, at an altitude ranging from 2,100 meters at Akaki in the south to 3,000(9,800ft)meters at Entoto Hill in the North. This makes Addis Ababa the third highest city in the world, after La Paz and Quito in Latin America. Its time zone is categorized in East Africa Time (UTC+3). The city occupies a total area of 540 Sq.Km2. The total number of High schools in Addis Ababa was 308 and total number of students being 140,076 in 2009e.c According to Addis Ababa education office.

4.3 Study period:

The data were collected from May1-15, 2017

4.4 Source population:

The source population of this study were all secondary school adolescents in the in Addis Ababa.

4.5 Study population:

The study population were all private and government students in the age group between 15-19 years old among selected secondary schools in Addis Ababa.

4.6. Inclusion criteria and exclusion criteria

4.6.1. Inclusion criteria

All day time students in the age between 15-19 years were included in the study.

4.6.2. Exclusion criteria:

The students who declined to give informed consent and age below 15years or above19years were excluded.

4.7 Variables

4.7.1 Dependent variable

The dependent variable in this study is utilization of reproductive health services by the secondary school adolescents.

4.7.2 Independent variables

Predisposing Factors: - Socio-demographic, attitude, knowledge.

Enabling Factors: - Health institution.

Need Factors: - The need for health care service.

4.8 Sampling

4.8.1. Sample size determination

The sample size were been calculated using the formula below.

$$n = (z^2 x\, pq)/_{d^2}$$

Where n = minimum sample size required in each study setting

n = the desired sample size (N>10000),

z = the standard normal deviate, usually set at 1.96 which corresponds to 95% Confidence level,

p = the proportion of target population estimated to have a particular characteristics (Those whose age are between 15-19 years and studied for utilizing reproductive health services).Therefore 50% (0.5) was used.

d = Permitted error (5%, if the confidence level is 95%); 0.05,

q = 1 – p; (1- 0.5=0.5).

Therefore, final sample size,

$$n = \frac{(Z\alpha/2)2\ P\ (1-P)}{d2}$$

$$= \frac{(1.96)2 \text{ x } (0.5)\ (0.5)}{(0.05)2}$$

=384

Adding 10 % of non-response rate the sample was 422. Because multistage sampling method was used the sample of 422 is multiplied by design effect of 2 and the final sample size was 844.

4.8.2 Sampling Method

In this study multistage sampling technique was employed and the Primary Sampling Unit (PSU). 5 Sub- Cities were selected using lottery method and then in the secondary sampling unit SSU. Ten high schools were selected, in which there were 5 from government and 5 from the private using lottery method. In the third stage, using simple random sampling method, 2sections were selected from each grade and finally students from each section were been selected by proportional allocation based on the number of students using systematic random sampling method. Student lists from selected sections were used as sampling frame and to find the first interval.

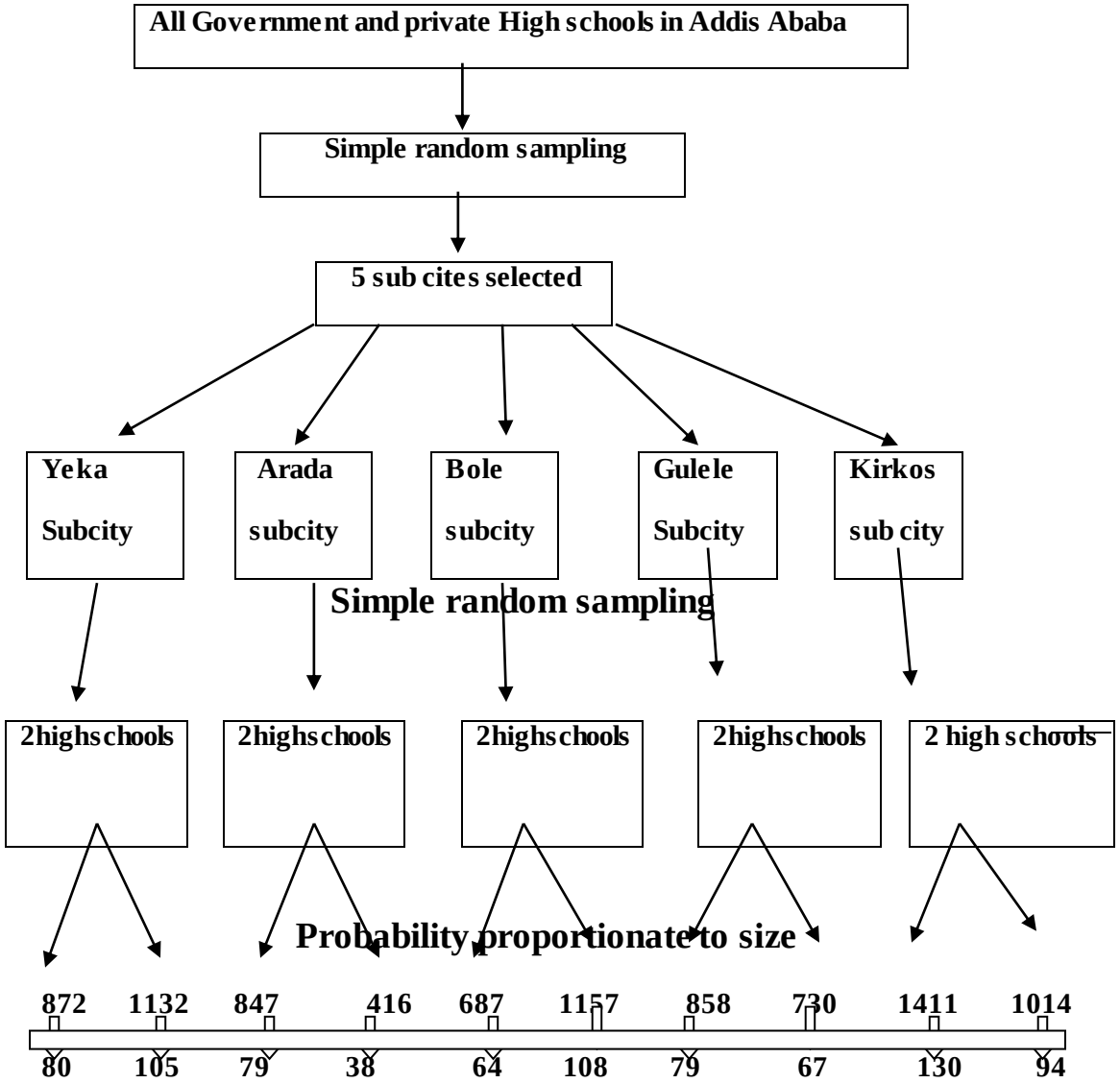

Figure 2: Schematic presentation of sampling procedure

4.9 Data collection instrument

For data collection, a structured self-administered questionnaire of English version was adapted after review of different literatures and modified depending on the local situation and the research objective. It was initially developed in English and then translated in to Amharic and back translated in to English to check its consistency. The questionnaires contained questions on socio demographic characteristics, Health institution characteristics, adolescents knowledge related and attitude towards RH service.

4.10. Data collection

Quantitative data were collected using self-administered structured questionnaire. One school facilitator on each high school was selected the day before the data collection who is unit leader of each high school and the purpose of the study was explained briefly to them. In order to identify the clarity of questions and their sensitiveness as well, pre-testing of the instrument was done on 5% of the study subject in a school other than the selected schools. During the pre-testing discussion was held with the students on the problems they encountered during filling the questionnaire and correction was incorporated in the final questionnaire. The participants were asked to sit in a classroom by facilitators and after explaining the purpose of data collection the questionnaires have distributed to the adolescents who are agreed to the informed consent and for those less than 18 years by getting Assent from the families one day before data collection .The questionnaires didn't bear any names of participants but rather numbers were used to represent the total number of participation. After the questionnaires were filled, the facilitators collected them and submitted to the researcher for analysis.

4.11. Data quality assurance

The quality of data was assured through careful, design, translation and retranslation and pretest of the questionnaire, proper training of the facilitators on the data collection procedures. Every day, questionnaires were reviewed and checked for completeness by the facilitator and principal investigator and the necessary feedback were offered to facilitators in the next morning before data collection.

4.12. Data Analysis

The data obtained from each study participant were checked for its completeness, coded, entered, edited, cleaned, and analyzed using Epidata version 3.5 and SPSS-version 20 statistical package. Frequencies mean, standard deviation, and percentage were used to describe the study population in relation to socio-demographic and other relevant variables. The degree of association between independent and dependent variables was assessed using logistic regression. Variables with P value less than 0.25 in binary regression and those considered important based on literatures were interred in to multiple logistic regression. Variables which have p-value <0.05 were considered as statistically significant predictor of RH service utilization of adolescent's and 95% confidence interval was used. Before multivariate analysis, independent variables were cheeked for multi collinearity effect using variance inflation factor.

4.13. Operational Definitions

Counseling service– measured by response of the students to the presence of access and consultation for the youth in school and health facility about the reproductive health services.

Reproductive health service utilization: The reproductive health service utilization was assessed based on ever utilization of counseling service, family planning service, HIV counseling and testing service, sexually transmitted disease treatment service and antenatal care service from any health facility and rated as utilized if at least one of the services mentioned utilized.

School adolescent: adolescent who was enrolled in the secondary schools.

Youths: those persons with in the age group of 15-24 according to WHO definition.

Good:-Friendly, welcoming, handled me well and gave me the service I required

Moderate;-welcomed me but asked too many unnecessary questions before giving me the service.

Bad: - he/she was harsh or rude or denied me service.

4.14. Ethical Considerations

Ethical clearance was obtained from Addis Ababa University, collage of health science, school of public health ethical review committee. Permission was obtained from Addis Ababa education bureau and from respective schools. Written informed consent was obtained from individual respondent for age greeter than 18 and from their parents by sending the Assent form to the adolescent's parent the day before data collection for those

less than 18 years of age. Confidentiality of the information was assured and privacy of the respondent was maintained. Questionnaire was anonym zed, and the respondents were told that they have the right to be involved or not to be involved in the study, and that non-involvement otherwise will not affect them in any way.

4.15. Dissemination of results

The final result of this paper will be given to Addis Ababa University College of Health Sciences School of public health, and published to be used as input for researchers that are interested in the field of study.

5. Result

A total of 844 students were participated in the study with response rate of 100%.From the respondents 496(58.8) were females, and 537(63.6) were from grade 9 and 307(36.4) were from grade 10 students, their ethnic backgrounds were Amhara 414 (49.1), Oromo 206(24.4), Gurage116 (13.7), Tigrie 78(9.2), Other 30 (3.6) by order. Occupation of head of household of respondents were Government Employee 339(40.2), Daily laborer 122(14.5), Private 315(37.3), others 67(7.9) found.

5.1. Socio Demographic Characteristics of the Respondent

Table 1: Socio-demographic characteristics of high school students, Addis Ababa, Ethiopia, 2017
N=844

Characteristics Option		Frequency	Percent
Sex of respondent	Male	348	41.2
	Female	496	58.8
Age group	15-17	775	91.8
	18-19	69	8.2
The respondents level of education	Grade 9	537	63.6
	Grad e 10	307	36.4
Religion of respondent	Orthodox	623	73.8
	Catholic	96	11.4
	Protestant	49	5.8
	Muslim	74	8.8
	Other	2	0.2
Ethnic background of the respondent	Oromo	206	24.4
	Amhara	414	49.1
	Gurage	116	13.7
	Tigrie	78	9.2
	Other	30	3.6
occupation of household Head	Government Employee	339	40.2
	Daily Laborer	122	14.5
	Private	316	37.4
	Other	67	7.9

5.2. Knowledge and Information on RH facility

From all 844 participants' assessment if they know any health facility which provide reproductive health service 606 (71.8) know health facility. From 606 (71.8) participants 241(28.6) of them mentioned family as a source of information about reproductive health facility190 (22.5) of them mentioned friends as a source of information about reproductive health facility, 259(30.7) of them mentioned teachers as a source of information about reproductive health facility, 158(18.7) mentioned Billboard as a source of information about reproductive health facility and 171(20.3) of respondents have more than one source of information.

Table 2: Knowledge on health facility and information Secondary School Adolescents in Addis Ababa, 2017 N=838

Knowledge on health facility and source of Information		Frequency	Percent
Knowledge of health facility that provide RH service	Yes	606	72.3
	No	232	27.7
Family as source of information	Yes	241	28.6
	No	349	41.4
Friends as source of information	Yes	190	22.5
	No	395	46.8
Teachers as source of information	Yes	259	30.7
	No	339	40.2
Billboard as source of information	Yes	158	18.7
	No	425	50.4
Information triangulation	use only one source	673	79.7
	use more than one source	171	20.3
No any source of Information	Yes	4	0.5
	No	1	0.1

5.3. Knowledge of students about health services that are given in RH facilities

From total of 844 participants assessed on knowledge of services that are given on reproductive health facilities 531(62.9%) mentioned family planning, 407(48.2%) mentioned HIV counseling and testing, 330(39.1) mentioned sexually transmitted infection, 345(40.9) mentioned general health information and 135(16%) of participants mentioned sport and entertainment as a service that is given on Reproductive Health facility.

Table 3: knowledge of services that are given in RH facility among high school adolescents in Addis Ababa, 2017

RH service Utilization		Frequency	Percent
Family planning service	Yes	531	62.9
	No	297	35.2
HIV Counseling and Testing	Yes	407	48.2
	No	419	49.6
Sexually transmitted infection treatment	Yes	330	39.1
	No	493	58.4
General Health Information	Yes	345	40.9
	No	484	57.3
Sport and Entertainment service	Yes	135	16
	No	671	79.5
Knowledge composition on type of RH services given	Know only one RH of service	444	52.6
	Know more than one RH services given	400	47.4

5.4. Reproductive Health service utilization

From the total 844 participants assessed on utilization of reproductive health services, 200 (23.7%) counseling service, 172(20.4%) HIV counseling and testing service, 62(7.3%) family planning, 8(0.9%) sexually transmitted infection treatment (STI) service, 5(0.6) Antenatal service utilize. Generally 305(36.1) respondents utilize at least one from the five main RH service options and 539(63.9) reported not utilize any of the RH service options. But participants reported counseling services 642(76.1%), family planning services 779(92.3%), HIV counseling and testing service (HCT) 672(79.6%), sexually transmitted infection treatment (STI) 835(98.9%), Antenatal care service (ANC) 838(99.3%) did not ever use these services from reproductive health facility.

Table 4: RH service Utilization among Secondary School Adolescents in Addis Ababa, 2017

RH service Utilization	Utilized	Not Utilized
Counseling service	200(24%)	642(76%)
Family planning service /FP/	62(7.3%)	779(92%)
HIV counseling and testing service /HCT/	172(20%)	672(80%)
Sexually transmitted infection treatment/STI/	8(0.9%)	835(99%)
Antenatal care service /ANC/	5(0.6%)	838(99%)

5.5. Reproductive Health Service availability, utilization and reasons for not utilizing RH

The availability, utilization and barrier for utilization were assessed as shown in table5 below. Based on the assessment on availability of RH service at school 618(73.2) said unavailable. Assessment on unavailability of service options show 539(84.7) report they were never go to any of RH facility. From those who do not utilize their reason was 77(9.1) due to facility closed, 23(2.7) embarrassed due to friends around, 18(2.1) due to lack of money was reported as reason for not utilize. On the approach of service provider 208(66.2) good and inviting, 97(30.8) medium, and 9(2.8) said not good was reported by the respondents.

Table 5: The reproductive health service availability, utilization and reasons for not utilizing services in Secondary School Adolescents in Addis Ababa, 2017

Variables	Option	Frequency	Percent
Reproductive service utilization	No	539	63.9
	Yes	305	36.1
Reason for not utilizing the service	No money for the service	18	2.1
	Embarrassed due to friends around	23	2.7
	The facility is closed	77	9.1
	Due to maltreatment of the provider	9	1.1
	No need of the service	266	

Distance estimation of the RH service from the school	short walking distance	280	33.2
	short one tax drive	316	37.4
	far more than one taxi drive	59	7
	Missing	189	22.4
Have you ever visit RH clinic for RH service and get the service	No	539	69
	Yes	305	31
Approach of the service provider of the clinic	Good and Inviting	208	66.2
	Medium Approach	97	30.8
	Not Good and not get the service	9	2.8
Missed availability of the Needed services	No	393	72.9
	Yes	146	27.0

5.6. Bivariate Analysis

Based on this assessment 305(36.1) respondents reported use at least one of the reproductive health services mentioned. From socio- demographic factors, Educational level, religion, and age of respondents show significant association with RH service utilization on bivariate analysis.

5.6.1 Socio-demographic Factor affecting RH service utilization

Table 6: Socio demographic factors and Reproductive health service Utilization among adolescents in Addis Ababa, 2017

Socio-Demographic characteristics		Utilize	Not Utilize	Total	**χ2, p value ,COR**
Sex	Male	124(14.7%)	224(26.5%)	348(41.2%)	χ2=.066
	Female	181(21.4%)	315(37.3%)	496(58.8%)	p=0.798
Education	Grade 9	183(21.7%)	354(41.9%)	537(63.6%)	χ2=29.106
	Grade 10	122(14.5%)	185(21.9%)	307(36.4%)	p=0.000
Religion	Orthodox	223(26.4%)	400(47.4%)	623(73.8%)	
	Catholic	35(4.1%)	61(7.2%)	96(11.4%)	χ2=2.272
	Protestant	22(2.6%)	27(3.2%)	49(5.8%)	p=0.686
	Muslim	24(2.8%)	50(5.9%)	74(8.8%)	

		Other	1(0.1%)	1(0.1%)	2(0.2%)	
	Religious	No	268(31%.8)	427(50.6)	695(82.3%)	COR=1.9
	Restriction	Yes	37(4.4%)	112(13.3%)	149(17.7%)	(1.271, 2.839)
		Oromo	66(7.8%)	140(16.6%)	206(24.4%)	$\chi 2$=2.376
		Amhara	158(18.7%)	256(30.3%)	414(49.1%)	p=0.667
		Gurage	42(5.0%)	74(8.8%)	116(13.7%)	
		Tigrie	29(3.4%)	49(5.8%)	78(9.2%)	
	Ethinicity	Other	10(1.2%)	20(2.4%)	30(3.6%)	
		Government				$\chi 2$=2.395
		Employee	115(13.6%)	224(26.6%)	339(40.2%)	p=0.495
		Daily laborer	47(5.6%)	75(8.9%)	122(14.5%)	
	Parental	Private	121(14.4%)	194(23%)	315(37.4%)	
	occupation	Other	21(2.5%)	46(5.5%)	67(7.9%)	
Age	15-16		418(77.6%)	192(63%)	610(72.3%)	COR=0.49
Group	17-19		121(22.4%)	113(37%)	234(27.7%)	(0.331-0.66)

5.6.2. Barriers that affect RH service Utilization

The Chi-square test done to identify barriers that affect RH service utilization like availability of RH service at the school COR=1.682 (1.232, 2.295), distance of the RH service from the school ($\chi 2$=4.226 P=0.121), approach of the service provider ($\chi 2$=17.752 P=0.000), availability of the needed service in the RH facility COR=1.056 (0.725, 1.537), knowledge on type of reproductive health services COR=2.934(1.906, 4.515), knowledge on health facility that provide RH service COR=4.68(3.145, 6.964) have been done. Based on the odds ratio and chi-square test done availability of RH service at the school, distance of the RH service from the school, approach of the service provider, availability of the needed service in the RH facility, knowledge on type of reproductive health services, and knowledge on health facility that provide RH service show significant association.

Table 7: Barriers to RH service utilization among scondary school adolecents in Addis Ababa, 2017

Variables		Reproductive health Service Utilize	Not Utilize	Total	$\chi 2$, P, COR
Availability of RH service at the school	Yes	102(12.1%)	124(14.7%)	226(26.8%)	COR=1.682 (1.232, 2.295)
	No	203(24.1%)	415(49.20)%	618(73.2%)	
Distance estimation of the RH service from the school	short walking distance	136(20.8%)	144(22.0%)	280(42.7%)	$\chi 2$=4.226 p=0.121
	short one tax drive	145(22.1%)	171(26.1%)	316(48.2%)	
	far more than one taxi drive	20(3.1%)	39(6.0%)	59(9.0%)	
Approach of the service provider	Good and Inviting	208(70.8%)	0(0%)	208(66.2%)	$\chi 2$=17.752 P=0.000
	Medium Approach	97(29.2%)	0(0%)	97(30.8%)	
	Not Good and not get the service	0(0%)	9(2.9%)	9(2.9%)	
Availability of the service of choice in the RH facility	Yes	78(13.4%)	68(11.7%)	146(25.1%)	COR=1.056 (0.725, 1.537)
	No	227(39.0%)	209(35.9%)	393(74.9%)	
Knowledge on type of reproductive health services	Know	276(32.7%)	412(48.8%)	688(81.5%)	COR=2.934 (1.906, 4.515)
	Do not Know	29(3.4%)	127(15.0%)	156(18.5%)	
Knowledge on health facility that provide RH service	Yes	270(32.2%)	336(40.1%)	606(72.3%)	COR=4.68 (3.145, 6.964)
	No	34(4.1%)	198(23.6%)	232(27.7%)	

5.6.3. Odds Ratio of RH service utilization among different groups

The odds ratio has been calculated to see the association of socio demographic factors and barriers with RH service utilization. The odds of utilization among respondents who have religious restriction to use RH service was 0.52(0.35, 0.78) were less by 48% from those who do not have religious restriction to use RH services. The odds of utilization among respondents who said RH service available in their school was 1.68(1.23, 2.29) times higher than those who have no RH service in their school. The odds of utilization among respondents who have Knowledge on type of reproductive health services types were 2.934(1.90, 4.51) times higher than those who do not have knowledge on type of RH service types. The odds of RH service utilization among age group 15-16 was 0.492(0.33, 0.66) times less than 17-19 age groups.

Table 8:- Bivariate regression for barriers and factors for RH service utilization among secondary school students in Addis Ababa, 2017

				95% CI AOR	
		p-value	AOR	Lower Bound	Upper Bound
Age Group	15-16	.000**	.377	.228	.621
	17-19				
Level of Education	Grade 9	.100	.784	.587	1.048
	Grade 10				
Religious restriction	Yes	.002**	.526	.352	.787
	No				
Knowledge on health facility which provide RH	Yes	.000**	4.680	3.145	6.964
	No				
Availability of RH service at school	Yes	.001**	1.682	1.232	2.295
	No				
Availability of needed service on facility	Yes	.000**	2.934	1.906	4.515
	No				

5.7. Multivariate Analysis

The multivariate analysis show knowledge on health facility that provide RH service P 0.003, AOR. 4.531 (1.66, 12.30) Availability of service of choice by adolescents p=0.009, AOR.242 (.084, 699). Age, knowledge on type of RH services, and availability of RH facility at school even though show association at bivariate level of association on multivariate analysis could not establish significant association in this study.

Table 9: Multivariate analysis result for factors and barriers affecting RH utilization among secondary school adolescents in Addis Ababa, 2017

Variables				95% CI AOR	
		P-value	AOR	Lower	Upper
		.104			
Age or respondent	15-16	.404	.519	.111	2.425
	17-19				
Respondents religion restriction on RH use	Yes	.137	.448	.156	1.291
	No				
Knowledge on health facility that provide RH service	Yes	.003**	4.531	1.668	12.307
	No				
Availability of RH service at the school	Yes	.886	1.069	.429	2.669
	No				
Distance estimation of the RH service from the school	Short walking distance	.786	.804	.167	3.865
	Short one tax drive	.534	1.686	.325	8.740
	Far more than one taxi drive				
Approach of the service provider	Good and Inviting	.302	2.023	.530	7.714
	Medium approach	.285	2.125	.534	8.462
	Not Good				
availability of service of choice in RH facility	No	.009**	.242	.084	.699
Knowledge on type of reproductive health services	Know	.361	.506	.117	2.181
	Do not Know				

**significant at 0.01 level of significance, *significant at 0.05 level of significant

6. Discussion

The assessment revealed that utilization of reproductive health service is 36.1.which is higher than study done in Bahir Dar town was 32.2% .(36) This finding is also lower than community-based, cross-sectional study undertaken in Harar, 63.8% of youths used YFS in the past five months [18]. Similarly report of this study is lower than another community based study done in Jimma which was 41% (16).The difference may be due to difference in source population to assess RH service utilization.

The bivariate analysis showed that age and of an individual was associated with utilization of almost all reproductive health services by the adolescents.(table 7). This finding is expected because younger youth have lower knowledge of reproductive health issues and this is same with a study by United Nations (38) which reported low utilization of RHS among young people due to poor understanding of their changing bodies and insufficient awareness of risks associated with early sexual debut, STI/HIV and pregnancy and shyness.

The employment of parents/ or occupation of the adolescent's showed no significant association to utilization of RHS service. Actually this would not confirm the finding that there is a cost attached to treatment. STI management a lot of time involves syndromic approaches that are not charged for irrespective of whether the individual is adolescent or not thus explaining the connection between employment status and this utilization. This means that without money the adolescent's might access and utilize the service. This finding is in agreement with a study that was done by PATH (39).Which showed that generally health service utilization including RHS was tied to economic aspects of an individual. The implication of this finding is that majority of the adolescents are likely not to seek medical care and treatment for these infections in time and this can lead to serious reproductive health complications such as infertility in future. The implementation of YFRHS should be done in totality such that no fee should be charged at all for all services offered at YFRH facility.

School adolescents at all levels had generally low knowledge on RH services a fact that led to low utilization of these services. The one who reported knowing of the specific services given and the RHS facility registered increased utilization than those who did not know as was also confirmed by the bivariate and multivariate analysis (table 8, 9). These findings agree with studies by Godia, (37) which reported that lack of knowledge by the youth was a

major factor that caused underutilization of reproductive/sexual services. Further stated that lack of understanding of the importance of sexual health care or knowledge of where to go for care may discourage the adolescents from using RHS as also discussed in study of Godia, (37).

Adolescent's responses to source of information (28.6%) of them mentioned family as a source of information about reproductive health facility. This is lower than study done in Jimma found which was (40.3%) of adolescents had information about RH health services from their parents or close relatives (16). Obviously, parents are a key source of information, although they may feel ill-informed or embarrassed to discuss these topics with their children, or simply may disapprove of young people expressing an interest in RH issues.

On assessment of utilization of reproductive health services, 200 (23.7%) counseling service, 172(20.4%) HIV counseling and testing service, This study revealed that the utilization of family planning service among adolescents was 62(7.3%), which is much lower in studies done in Gondar (79.10%) and jimma which was (19.6), 8(0.9%) sexually transmitted infection treatment (STI) service, 5(0.6) Antenatal service utilized(19,36).

The study findings show that utilization of RHS by adolescents is still very low and this has serious implications on adolescent sexuality and growth. The school adolescents in particular are at a great risk of suffering the consequences of poor reproductive health such as Sexually Transmitted Infections, HIV and AIDS, unwanted pregnancy and abortions, and high levels of school dropout rate especially among females, the very problems which the Adolescent Health policy sought to reverse (12). The suggestions brought forth by health service providers that the services need to be made accessible to the school adolescents through adjustment of operation hours are valid if success in having the school adolescents fully utilize the RHS is to be achieved. The low level of awareness of RHS among the school adolescents means that there is a big gap between policy makers and the community which needs to be bridged by improving on the structures of RHS information dissemination to the adolescents.

7. Limitation of the study

This study was based on cross-sectional data, which implies that the direction of causal relationships cannot always be determined.

8. Conclusion and Recommendations

Conclusion

Generally this study disclosed that RH service utilization among High school adolescent's in Addis Ababa was 36.1%. Knowledge about RH facilities that provide services and availability of the needed services by adolescents were significant predictors of RH utilization.

Recommendation

For Health Facilities

Conducting promotion about the services that are given in RH facility is mandatory to increase access by high school students.

Availing RH facilities by type of services that adolescents wanted will increase access to utilization.

For Schools

Establishment of RH facilities in secondary schools should be advocated to increase access of services by adolescents because availability of RH clinics in secondary schools is low.

For Researchers

Similar studies need to be done in other area involving more schools to generate more supportive evidence

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10. Annex's

Annex1Questionnaire

Date……..... Study Site……. Code of the interview……

Do not write your name; tick only one correct response and multiple responses where applicable. Only youth aged between 15-19years are eligible for this study.

Part One-Socio-demographic, economic, school and socio-cultural Information		
S.no	Questions	Responses
1	What is your Sex?	Male……..……...0 Female……..…...1
2	What is your age in years?	
3	What is your current level of education?	Grad 9……..…..1 Grad10……...….2 Grad 11……..3 Grad 12……4
4	What is the type of school you attend?	Boarding school……1 Day school……..2
5	What is your religion?	Orthodox Christian……...…1 Catholic……..…...2 Protestant…….……..……..3 Muslim……4 Other…….…….……5
6	Does your religion restrict utilization of youth friendly reproductive health service (YFRHS)?	Yes…….……..…1 No…….……..….2
7	If your answer is yes describe it_____ _____	

	_____ _____	
8	What is your ethnicity?	Oromo……..…1 Amhara…….……..….2 Guragie…….3 Tigrie……4 Other…….……..……..5
9	What is your parent(s) occupation?	Formal employment (Teacher, civil servant, NGO worker etc.)…….…….....1 Casual labourer……..…2 Self-employmentbusiness……..3 Others specify……4
Part Two - Knowledge and Utilization of Reproductive Health Services (SRHS)		
10	Do you know of any Reproductive Health facility?	Yes…….……..….1 No…….……...2
11	If yes who told you about it?	Parent/Guardian……..1 Friend/Peer…….…….2 Teacher…….…….…….. 3 I read on a notice board…..…….4 I do not know of any……5
12	Which services are being offered in reproductive health facility? Tick all correct answers	Family planning services (Contraceptives, condoms)……1 Voluntary Counseling and Testing(VCT)…….…..2 Treatment of all the diseases…… …..3 Treatment of sexually transmitted Infections/diseases…..…….……4

		Care of pregnant young persons…….5 General health information/counselling..6 Sports and recreational activities…….7
Utilization of Sexual and Reproductive health service Have you ever used any of these services?		
13	Counselling services	Yes…….....1 No…….2
14	Family planning	Yes…….....1 No…….2
15	VCT services	Yes…….....1 No…….2
16	Treatment of STI	Yes…….....1 No…….2
17	Antenatal services	Yes…….....1 No…….2
Part three: Health System Factors		
18	Is there sexual and reproductive health service (SRHS) facility in your school?	Yes…….....1 No…….2
19	If yes in no.18, state the reason for not getting the service	The queue was long……..1 I have no money for the service…….2 I found friends and felt ashamed……3 The clinic is closed……..4 The service provider refused to give the service/ was harsh……5
20	How far is sexual and reproductive health facility from your school?	Near, a short walking distance……1 Near but requires about # 1.50 Eth birr for transport…….……2 Far, requires # 1.50 Eth birr and above for transport……3

21	Have you ever Visited any RH clinic for RH service	1. Yes 2. No
22	If you have ever used a reproductive health service facility, how would you describe how you were handled by service provider?	Good-Friendly, welcoming, handled me well and gave me the service I required…1 Moderate-welcomed me but asked too many unnecessary questions before giving meservice……2 Bad, he/she was harsh, rude and denied me service……...3
23	Have you ever missed the service you required?	Yes…….....1 No…….…..2

Annex 2Amharic Questionaries'

ቀን ---------- የጥናትቦታ---------- የመጠይቁ መለያቁጥር----------

ስም አይፃፍም በመረጡት መልስ ላይ ምልክት ያድርጉ ከአንድ በላይ መልስ ካለ ምልክት ያድርጉ እድሜያቸው ከ15-19 የሆኑ ታዳጊዎችብቻ በዚህ ጥናት ይካተታሉ

ክፍልአንድ፡ ስለማህበራዊሁኔታመረጃ

ተ.ቁ	ጥያቄዎች	መልስ
1	ፆታ	ወንድ----------1 ሴት----------2
2	ዕድሜ	
3	የትምህርደረጃ	9ኛ ክፍል----------1 10ኛ ክፍል----------2 11ኛ ክፍል----------3 12ኛ ክፍል----------4
4	የትምህርቤቱአይነት	አዳሪ ት/ቤት----------1 የቀን ት/ቤት----------2
5	ሀይማኖት	ኦርቶዶክስተዋህዶ----------1 ካቶሊክ----------2 ፕሮቴስታንት---------- 3 ሙስሊም----------4 ሌላካለይግለፁ----------5
6	የሚከተሉትሀይማኖትየስነተዋልዶጤናአገልግሎትመጠቀምይንከለከላል	አዎ----------1 አይደለም----------2
7	ለጥያቄቁጥር6መልሱአዎከሆነይብራራ---------- ---------- ---------- ---------- ----------	
8	ብሔር	ኦሮሞ----------1

		አማራ----------2 ጉራጌ----------3 ትግራይ----------4 ሌላካለይግለፁ----------5
9	የቤተሰብየስራሁኔታ	መደበኛቅጥር (የመንግስትሰራተኛ. መንግስታዊያልሆነድርጅትስራወ.ዘ.ተ)----------1 የቀንሰራተኛ----------2 የግልስራ----------3 ሌላካለይገለጽ----------4
10	የምታውቂውየስነተዋልዶጤናአገልግሎትተቋምአለ	አዎ----------1 አይደለም----------2
11	ለጥያቄቁጥር 10 መልሱአዎከሆነሰለአገልግሎቱማንነገረህ/ሽ	ቤተሰብ----------1 ጓደኛ----------2 መምህር----------3 ከማስታወቂያአነበብኩ----------4 የማውቀውየለም.....5
12	ምንአይነትአገልግሎትበስነተዋልዶጤናተቋማትይሰጣል ትከከኛየሆነውላይሁሉምልከትአድርግ/ጊ	የቤተሰብምጣኔአገልግሎት(የእርግዝናመከላከያ፤ ኮነዶም---- ----------1 በፍቃደኝነትላይየተመሰረተየኤችአይቪምክርናምርመራአገልግ ሎት----------2 የአባላዘርበሽታህክምናአገልግሎትለአረገዙሴቶችየሚሰጥ---3 ስለአጠቃላይየጤናሁኔታመረጃ ሠ/ምክር----------4 ስፖርትእናመዝናኛአገልግሎት----------5
ስለስነተዋልዶጤናአገልግሎትአጠቃቀም		
	ከታችየተጠቀሱትንአገልግሎቶችተጠቅመህ /ሽ ታውቂያለሽ	
13	የምክርአገልግሎት	አዎ----------1 አልተጠቀምኩም----------2
14	የቤተሰብምጣኔ	አዎ----------1 አልተጠቀምኩም----------2
15	በፍቃደኝነትላይየተመሰረተየኤችአይ ቪ	አዎ----------1

	ምክርናምርመራአገልግሎት	አልተጠቀምኩም----------2
16	የአባላዘርህክምና	አዎ----------1 አልተጠቀምኩም----------2
17	የቅድመወሊድምርመራአገልግሎት	አዎ----------1 አልተጠቀምኩም----------2
ክፍል 3 የጤናአገልግሎትተቋምበኩል		
18	በትምህርትቤትውስጥየስነተዋልዶተቋምአለ	አዎ----------1 የለም----------2
19	የጥያቄ ቁ 18 መልሱአዎከሆነየማትጠቀምበትን/ሚበትንምክንያትግለጥ/ጪ	ለአገልግሎቱገንዘብስለሌለኝ----------1 ጓደኛስላገኘሁአፍሬ----------2 ተቋሙዝግስለነበር----------3 አገልግሎትሰጪባለሙያውበአግባቡስላላስተናገደኝ------4
20	የስነተዋልዶጤናአገልግሎትተቋሙከት/ቤቱምንያህልይርቃል	ቅርብእናበእግርአጭርመንገድነው----------1 ቅርብነውግንየኢትዮጵያአንድብርከሃምሳሳንቲምለመጓጓዝያስወጣል----------2 ሩቅነውየኢትዩጲያ 1.50 ብር በላይያስወጣል----------3
21	የስነተዋልዶጤናአገልግሎትከተጠቅመህ/ሽ የአገልግሎትሰጪውንአቀባበልእንዴትትገልፃለህ/ሽ	ጥሩአቀባበልእናየሚጋብዝነውየምፈልገውንአገልግሎትበአግባቡተሰቶኛል----------1 መካከለኛአገልግሎትአሰጣጥነውብዙአላስፈላጊጥያቄዎችን ከአገልግሎትበፊትተጠይቄያለሁ----------2 ጥሩአቀባበልአልነበረምእሱ/እሷሀይለኛነበሩአገልግሎቱምአልተሰጠኝም----------3
22	የስነተዋልዶጤናአገልግሎትተቋምየፈለከውን/ሽውንአገልግ ትአጥተህ/አጥተሽታዊቂያለሽ	አዎ----------1 አላጣሁም----------2

Annex 3 client Information Leaflet and Informed Consent

Name of Study: Assessment of Sexual and Reproductive Health Services Utilisation by Secondary School Adolescents in Addis Ababa

Primary Researcher: AklileTebebeTeklemariam

Subject Information Sheet (English Version)

Hi, how are you? My name is_____. This is an interview to be done with you for a study that is being conducted at Addis Ababa University, College of Health Sciences, and department of Public health.

The purpose of the study is to assess utilization of sexual and reproductive health services among adolescents in secondary schools of Addis Ababa.

We would like to ask you some questions that are related to the above topic. We believe that the results of this study will assist policy makers, planners and health service providers for making considerations regarding utilization of sexual and reproductive health services. Your contribution has a great input for the study and I would greatly appreciate your participation. There is no possible risk associated with participating in this study. Your name will not be written in the questionnaire and please be assured that all the information you give will be kept strictly confidential. Your participation is completely voluntary.

Therefore, you will not be obliged to answer any question that you do not want to and you may end this interview at any time you want to. There are also no obligations for not participating in the interview. The interview will take about 30 minutes.

If you have questions regarding this study or would like to be informed of the results after its completion, please do not hesitate to contact AklileTebebe (091-204659

Annex 4 Assent Form

STUDY TITLE: ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES UTILISATION BY SECONDARY SCHOOL ADOLESCENTS IN ADDIS ABABA

Your parent/Guardian knows we are going to ask you to participate in this study by asking you questions. I want to know about your experiences about your access to sexual and reproductive health service utilization in health facilities. The interview may take 30 minutes to one hour. The questions and your answers will be audio-taped. Your name will not be written anywhere on the research instrument. No one will know these answers came from you personally.

If you do not want to participate, you can stop at any time. There will be no bad feelings if you do not want to do this. You can ask questions if you do not understand any part of the study.

Do you understand? Would you like to participate? Yes/No

Name: ……..

Signature: …….

Date: ----------

Researcher's name: ----------

Researcher's Signature: ----------

Date: ----------.

Annex 5: Information sheet (Amharic)

ሰላም እንዴት ነህ/ሽ? ስሜ----------ይባላል፡፡

ይህ መጠየቅ ከአንተ/ቺ ጋር የሚደረገው በአዲስአበባ ዩኒቨርስቲ የህክምና ኮሌጅየህብረተሰብ ጤና ት/ትክፍል ውስጥ ለሚደረግ ጥናትነው፡፡የዚህ ጥናት አላማበሁለተኛ ደረጃ ትምህርት ቤቶች ውስጥ ያሉተማሪዎችን የስነ-ተዋህዶ ጤና አገልግሎት አጠቃቀም ዳሰሳማድረግነው፡፡ የተወሰኑ ጥያቄዎች ከርዕሱ ጋር በተገናኘ በመጠይቅ እናስሞላለን፡፡ የጥናቱ ውጤትም ለፓሊሲ አውጪዎች፣ ለእቅድ አውጪዎች እና ለጤና አገልግሎት ሰጪዎች ስለ ስነ-ተዋልዶ ጤና አገልግሎት ትኩረት እንዲሰጡይረዳል፡፡የአንተ/ቺ ተሳትፎም ለጥናቱ ትልቅ ግብአት ይሆናል፡፡ ለተሳትፎህ/ሽ በቅድሚያ እናመሰግናለን፡፡

እዚህ ጥናት ውስጥ በመሳተፍህ/ሽ ምንም የሚደርስብህ/ሽ ጉዳት የለም፤ ስምህ/ሽ ጥያቄው ላይ ስም አይጻፍም፤ የምትሰጠው/ጪው መረጃበሙሉ በሚስጥር የሚያዝ ሲሆን ተሳትፎህም/ሽም በፍቃዳኝነት ላይየተመሰረተነው፡፡ ስለዚህ መልስ መስጠት ያልፈለከበትን/ሽበትን ጥያቄ አለመመለስ ይቻላል፡፡

እንዲሁም በማንኛውም ሰዓት ቃለመጠይቁን ማቋረጥመብትነው፡፡በመጠየቁ ውስጥያለመሳተፍ ሙሉመብትአለህ/ሽ፡፡ መጠይቁ የሚወስደው ጊዜ 30ደቂቃነው፡፡

Annex 6: consent form (Amharic)

<u>የጥናቱርዕስ፦</u>በሁለተኛደረጃትምህርትቤቶችውስጥያሉተማሪዎችንየስነ-
ተዋልዶጤናአገልግሎትአጠቃቀምየዳሰሳጥናትማድረግነው፡፡

ቤተሰብህ/ሽ ወይምአሳዳጊህ/ሽ በጽሁፍ ጥያቄዎችንእንደምንጠይቅህ/ሽ አሳውቀናል፡፡ ስለስነ- ተዋልዶ ጤና አጠቃቀም ያለህን/ሽ ልምድ እንድትገልጽልን/ጪልን እንፈልጋለን፡፡መጠይቁ እስከ 30 ደቂቃሊወስድይችላል፡፡ ስምህ/ሽ በመጠይቁ ላይ በየትኛውም ቦታ አይገለጽም እንዲሁምአንተ/ቺ የመለስከውን/ሽውን መልስ ማንም እንዲያውቅ አይደረግም፡፡ በጥናቱ ውስጥ መሳተፍ ካፈለክ/ሽ በማንኛውም ሰአት ማቋረጥ ይቻላል፡፡በማቋረጥህ/ሽ ምክንያት ምንምየሚፈጠርችግርየለም፡፡ በመጠይቁ ውስጥያልገባህ/ሽ ነገር ካለጥያቄመጠየቅይቻላል፡፡

የተናገርኩትን ተረድተሃል/ሻል? አዎ_____.አልተረዳሁም_____.

ጥናቱ ውስጥ ትሳተፋለህ/ሽ? አዎ_____.አልሳተፍም_____.

የተሳታፊው ፊርማ_____.ቀን_____.

የጠያቂው ስም_____.ፊርማ_____.ቀን_____.

<u>የፈቃደኝነት መጠየቂያ ቅጽ (በአማርኛ)</u>

ጥናቱን በተመለከተ የተጻፈውን መረጃ ወረቀት አንብቤአለሁ (በቃል የተሰጠኝን ማብራሪያ ተረድቻለሁ) እናም ከእኔ ምን እንደሚጠበቅና እኔ ጥናቱ ውስጥ ብካተት ምንም የሚፈጠርብኝ ችግር እንደሌለ ተረድቻለሁ:: በተጨማሪም ከጥናቱ በማንኛውም ሰአት ምክንያት ሳያሰፈልገኝ ጥናቱን ማቋረጥ እንደምችልና በማቋረጤም ምክንያት በእኔም ሆነ በቤተሰቦቼ ላይ በአገልግሎት አሰጣጥ ላይ ችግር እንደማይገጥመኝተረድቻለሁ::

የተሳታፊው ፊርማ---------- ቀን----------

የጠያቂው/ዋ ስም----------.ፊርማ----------ቀን----------.

ጥያቄውን ልቀጥል እንችላለን?

1. አዎ ቀጥል/ይ
2. አትቀጥል/ይ _____. ጥያቄ መጠይቁ ይቁምእና መላሹን አመሰግን/ኚ

ውጤት (ሙሉመሆኑንለማረጋገጥ)

ሀ) ጥያቄው አልቋል_____.

ለ) ጥያቄው በግማሽ አልቋል_____.

ሐ) ተጠያቂው/ዋ አቋርጧል/ለች_____.

መ) ሌላ ካለ ይብራራ

በተቆጣጣሪ ተረጋግጧል

የተቆጣጣሪ ስም---------- .ፊርማ----------. ቀን ----------

Declaration

The researcher, undersigned, declare that this is my original work and has not been presented in this or any other University and all sources of materials used for this research have been fully acknowledged.

Name of the Researcher: - Aklile Tebebe

Signature: _____

Date: _____

Place: Addis Ababa University, College of Health Sciences, School of Public Health.

This research has been submitted for examination with my approval as University advisor

Name of primary Advisor:-Dr Assefa Seme (MD, MPH)

Signature: _____

Date: _____

Name of Internal Examiner:-

Signature: _____

Date: _____

Name of External Examiner:-

Signature: _____

Date: _____

Place: Addis Ababa University, College of Health Sciences, School of Public Health.