ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE, SCHOOL OF MEDICINE

DEPARTMENT OF NURSING AND MIDWIFERY

REPRODUCTIVE HEALTH NEEDS AND SERVICE UTILIZATION AMONG YOUTH IN BULE HORA TOWN SOUTHERN OROMIA, ETHIOPIA

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ABBREVIATIONS

A.A.U…...Addis Ababa University

ABC- Abstinence, Being faithful and Condom use

ASRH- Adolescent Sexual and Reproductive Health

AIDS……Acquired Immune Deficiency Syndrome

CORHA…Consortium of Reproductive Health Associations

CI- Confidence Interval

CSWs……Commercial Sex Workers

DALYs….Disability Adjusted Life Years

FGD- Focus group discussion

FLE- Family life education

GUD…….Genital Ulcer Disease

HIV……..Human Immunodeficiency Virus

IUD- Intra uterine device

ICPD……International Conference on Population and Development

MDG...Millennium Development Goal

STD……..Sexually Transmitted Disease

SRH…….Sexual and Reproductive Health

STI……...Sexually Transmitted Infection

US……United States

USA…….United States of America

WHO…....World Health Organization

YRH.....Youth reproductive health.

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ABSTRACT

Background: *According to the world health organization, youth age group encompasses between 15-24 years (1). Recent estimates indicate that 17.0% of the global population, 20.0% of Sub-Saharan Africa and 17.9% of Ethiopian population is composed of youth aged 15-24 years. In Ethiopia, the sexual and reproductive health of young people has become a major public concern due to a high prevalence of STIs like HIV/AIDS among young people.*

Objective*: The objective of this study was to assess reproductive health needs of youth in Bule Hora town*

Methos and material: *The community based quantitative cross sectional survey was conducted among 422 youth in Bule Hora town, Southern Oromia Region from September 2011 to may 2012. Data collection method was interview administered with structured questionnaires only for illegible participants.*

Result and discussion: *A total of 422 households were visited in three kebeles of which only 394 (93.4%) agreed to be interviewed. Generally mass media were the major source of information on the sexual maturation and STD/HIV. Out of the study subject 140(35.5%) of them had reported that there is pressure from their peers to have premarital sex and 331 (84%) reported taht there is no support from their family members not to have premarital sex. As it was revealed by logistic regression age, and marital status were found to be the main predictors, independently and negatively associated with sexual activities.But sex (being a female) was independently and positively associated with sexual activities.According to this study females have more risk of sexual engagement compared to males. The proportion of youth who ever used modern contraceptives did not go parallel with their knowledge of methods.Also after controlling for confounding variables logistic regression show that living patterns (living with both family) was found to be the main predictors, independently and negatively associated with use of modern contraceptive. Despite having all these health problems only, 47.6% of them had visited public health institutions.*

Conclusion and recommendation: *Generally there were reproductive health problems like lack of adequate information, and the existence of risk sexual and RH behaviours, inapproprate health service utilization and socio cultural factors affecting youth reproductive health.Finally, programs that comprise both promotional activities and reproductive health services that could serve the hard to reach youth should be designed and implemented as a matter of priority.*

INTRODUCTION

1.1. BACKGROUND

According to the world health organization, adolescent's age group encompasses between 10-19 years old, young people those between 10-24 years, and youth are those that lie within the age group of 15-24 years (1). Currently one third of the world's population, around 2 billion, is grouped in young people category and in Africa, at the beginning of the 21st century, one out of every four person was 10-19 years old (2).

Young people (age 15-24 years) are an important population group with a great potential for physical, mental and psychological development. Recent estimates indicate that 17.0% of the global population, 20.0% of Sub-Saharan Africa and 17.9% of Ethiopian population is composed of youth aged 15-24 years. In addition, 85.0% of the 1.2 billion adolescents (10-19 years) worldwide live in developing countries and comprise over a quarter of their population. Globally the young are facing different sexual and reproductive health (SRH) problems like unwanted pregnancy, unsafe abortion, sexual transmitted infection (STI) including human immunodeficiency virus (HIV). But people who are young are usually mistakenly perceived as healthy and as if they are not in need of special health services (3).

Young people all over the world are in need of much better education and health care related to reproduction. This is clear from the alarming evidence about abortion, the hazards of early pregnancy and the incidence of sexually transmitted disease, the incidence of which is increasing helped by ignorance, fear, shortage of drugs and inadequate treatment and increasing sexual activity. Estimates suggest that somewhere between 30 million and 35 million abortion take place each year throughout the world, and about half of them are illegal. A substantial proportion of all abortion is performed on teenagers (4).

With 1.5 billion youth and adolescents people between 10 and 25 years of age, the demographics of the world's population has caught the attention of many, although only recently has research begun to address their sexual and reproductive health needs. More than 78% of young people live in Asia and Africa, where they make up over 30% of the population (5).Improving reproductive health is central to achieving the Millennium Development Goals on improving maternal health, reducing child mortality and eradicating extreme poverty. Global variations in sexual behaviour exist and no one sexual or reproductive health intervention will work everywhere (6).

Young people in Ethiopia also disproportionately suffer from the country's unsustainable population growth. Ethiopia's population of 71 million is projected to increase to 173 million by 2050 becoming Africa's second most populous country after Nigeria. This rapid population increase will strain the government's ability to provide health care and education to young people and create conditions for even greater unemployment, poverty, and unrest. Besides unsustainable population growth, the spectre of AIDS hangs heavy over Ethiopian youth (7).

The reproductive health problems faced by Ethiopian youth are tremendous and include gender inequality, sexual coercion, early marriage, polygamy, female genital cutting, unplanned pregnancies, closely spaced pregnancies, abortion, sexually transmitted infections, and AIDS. Lack of education, unemployment, and extreme poverty exacerbates and perpetuate the reproductive health problems faced by Ethiopian youth. Another underlying problem that negatively impacts reproductive health and retards overall development is pervasive gender inequality.The reproductive health services are responsible to deal with a range of activities at community levels to overcome the above listed problems.

1.2. STATEMENT OF THE PROBLEM

Early, unprotected sex among young person's can have negative consequences. Pregnancy and sexually transmitted infection (STI), including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), result in high social, economic, and health costs for affected persons, their children, and society(8).

Of the estimated 333 million new STIs that occur in the world every year at least 111 million occurred in young people less than 25 years. There is increasing concern for young people who are disconnected from social institutions such as schools, youth clubs and workplace. The UN-estimates that 404 million or 38% of youth under the ages of 18 in less developing countries do not attend school (9). These youths are vulnerable to sexual exploitation and are at disproportionately high risk of unintended pregnancy and STIs including HIV/AIDS (10).

Globally half of new HIV infections are among young people ages 15 to 24 the ages when sexual activity typically begins. Sex education programs most easily reach young people through schools and other institutions where young people meet. Parallel programs educating parents is helpful in fostering intergenerational communication (11).

HIV prevalence is 6.6% in the adult population and a large proportion of new HIV infections occur in young people (7). In developing countries, maternal mortality is high, with 440 deaths per 100,000 live births (in sub-Saharan Africa, this figure reaches 920). One in three women gives birth before age 20 and pregnancy-related morbidity and mortality rates are particularly high in this group (6)

The AIDS epidemic in Ethiopia is a generalized one, though the HIV prevalence rate in the general population is far less than in many other Sub-Saharan countries of Africa. Data from 34 sentinel surveillance sites across Ethiopia indicate a national adult HIV prevalence rate of 6.6% with an estimated 2.2 million persons living with HIV/AIDS in 2001.

Ethiopia is now among the most heavily affected countries, with 10% of the world's HIV infections (the sixth highest in the world). At the same time, the number of HIV infections is high and in Ethiopia women represent the majority of the 980,000 people with HIV (12).

Lack of access to SRH services and information contributes to high levels of morbidity and mortality for largely preventable SRH problems, particularly in developing countries (4). The low status of women and girls and lack of male participation in family planning and AIDS prevention activities makes it especially difficult for reproductive health programs to achieve success. Societal inequalities between males and females, inequities within the family, harmful traditional practices against young girls, and the "sugar daddy" phenomenon are common in Ethiopia and are powerful forces that impede efforts to educate young women and men about reproductive health and provide them with needed services (7).A shortage of skilled and trained providers, inadequate commodities and supplies, and lack of accurate information about methods have hindered men's and women's access to modern contraception and other reproductive health services in Ethiopia (12).When young people feel unconnected to home, family, and school, they may become involved in activities that put their health at risk (13).

Moreover, behaviour, which starts in adolescence frequently, leads to health problems that only emerge in later life at increased cost to both the individuals themselves and their societies (14). Unless they are addressed, the reproductive health problems facing Ethiopian youth threaten to retard the country's development even further (Ethiopia was 168 out of 173 countries listed in the 2002 Human Development Report in order of development status) and bring greater instability to a country already suffering from high levels of unemployment, food insecurity, and widespread extreme poverty (7).

The rationale for the selection of research problem is that there are only handfuls of studies on RH in Ethiopia. Of few studies carried out on adolescent RH in the country, most are school based. Though there are very limited number of studies conducted based on youth, some of them were carried out in bigger urban centers. Therefore, there is lack of systematically collected and sound information on the reproductive health needs and service utilization of youth in general. So this research was done to fill the research gap on this issue and identify factors which would be help those who are working on sexual and Reproductive health (RH) programs to focus on youth RH needs and service utilization in order to improve perceived gap on this area. Also this study is expected to give insight into reproductive health needs and service utilization among youth. In general the study is expected to generate relevant information that could help to design appropriate RH programs for this segment of population.

1.3. SIGNIFICANCE OF THE STUDY

Youth group in general are believed to be the hopes of a country. That is why there is lots of public and nongovernmental institution trying to expand service in this country. Although there are lots of youth accounting greater than half percent of the total population in the country including in Bule Hora town, each year, the public health services are given unsatisfactory attention while health is believed to be a backbone for the production of fruitful generation.

This study serves as an input to the efforts that show the RH needs and service utilization practices of youth live in the town and the surrounding area. It guides the ways of providing SRH services those are comprehensive and friendly to this group. In addition, the study gives an insight to the opportunity of addressing lots of youth concentrated in one geographical area. It could also help policy makers and programs managers to design appropriate reproductive health services. Finally it serves as a base line data for any individual who is interested to do a research on this groups and areas.

LITERATURE REVIEW

2.1. SEXUAL ACTIVITIES

More and more young people are having sex before marriage, often without using contraception there by exposing them to the risks of sexually transmitted infections, HIV/AIDS and unplanned pregnancy (15). The current average age range for the attainment of puberty is 9-14 for boys and 8 to 13 for girls. As a result, young girls are biologically mature enough to engage in sex and become pregnant at an early age, although they may not be emotionally and physically mature enough to understand the implications (16). Sexual activity begins in adolescence for the majority of people. In many countries, unmarried girls and boys are sexually active before the age of 15. Recent surveys of boys aged 15 to 19 year in Brazil, Hungary and Kenya; for example, found that more than a quarter reported having sex before there were 15year. A study in Bangladesh found that 88 percent of unmarried urban boys and 35 percent of unmarried urban girls had engaged in sexual activity by the time they were 18 year (17).

No matter how much adults might like to ignore it, sex has great meaning in the lives of youth, whether they have had any sexual experience or not. In untied states, for example, approximately 70% of women have had intercourse by the age of 18 years (18). In another study in the same country, 18% of 15 years old, 28% of 16-year-old females are sexually active, representing increases of 24% and 34% respectively from the early 1970s (19). In previous several studies (20, 21, 22, 23, 24) the proportion of sexually active males was persistently higher, ranging from 49% - 84% compared to that of females, 14 % - 48%.

Levels of sexual activity among young unmarried women are similar in Tanzania and Uganda, but the experience reported by young Rwandan women was very different. In Tanzania and Uganda, approximately 35 percent to 40 percent of young unmarried women reported that they had been sexually active. In contrast, only 14 percent of unmarried young women in Rwanda indicated that they had ever had sex among the lowest levels in sub-Saharan Africa. The median age at first sexual intercourse for women ages 20 to 24 in both Tanzania and Uganda is 17.1 years; in Rwanda, the median age is above age 20. In Tanzania and Uganda, women ages 20 to 24 were more likely to have had sex (65 percent and 67 percent, respectively); but in Rwanda, levels of sexual activity among those ages 20 to 24 was much lower at 23 percent (25).

2.2. SEXUALLY TRANSMITTED DISEASES AND HIV/AIDS

A more accurate indicator for trends of HIV infection may be STD rates, since behaviours associated with the acquisition and transmission of STDs are identical to behaviours associated with HIV transmission (26). It is estimated that over 60% of the STD cases reported yearly are individuals under the age of 24 with one fourth between ages 15-19. In Ethiopia, it was reported that 6.5% and 4% of out of school adolescents in southern part of the country had history of STD in 1995 and in 1998 respectively (27, 28).

When youth ages 15-24 were asked to identify ways to reduce the risk of HIV and other STIs, 47 percent of women and 66 percent of men knew about using condoms; 66 and 77 percent, respectively, knew about limiting sex to one uninfected partner; 64 and 79 percent, respectively, knew about abstaining from sexual intercourse. HIV has affected more Ethiopian women than men. For example in 2005, the HIV infection rate was twice as high among Ethiopian's women as among its men (29). Also recent household survey in Kenya found that one third of respondents aged 15-19 years believed that HIV/AIDS could be transmitted via mosquito bites (30).

The proportions of infected were 0.7 percent of females ages 15-19 versus 0.1 percent of males in the same age and 1.7 percent of females ages 20-24 versus 0.4 percent of males in the same age. Among youth ages 15 to 24, 1.1 percent of women are infected with HIV in comparison to 0.2 percent of men. (29). According to the 2002 Kenya HIV/AIDS and STIs Behavioural Surveillance Survey (BSS) Although general awareness about HIV/AIDS is widespread, i.e., greater than 97% among out of-school youth, less than half of these young people are aware of HIV prevention methods and greater than 40% hold myths and misconceptions about HIV transmission(20). Knowledge, however, may be necessary but insufficient requirement to reduce high-risk activities (21, 20), and information alone is insufficient to change risky behaviours among teens (31).

Recent estimates suggest that while men and women aged 15–24 make up 25% of the sexually experienced population, they account for nearly half of all new STIs. The highest prevalence of HIV is seen in the group 15-24 years of age (12.1%).HIV/AIDS prevalence among young adults aged 19–24 is relatively low 1.06 per 1,000 but it is estimated that 15–30% of all infections are acquired before age 25 (32). Data show that the number of females infected between 15-19 years is much higher than the number of males in the same age group. This discrepancy is attributable to earlier sexual activity among young females with older male partners (7).

2.3. THE PRACTICE OF CONDOM USE

Comparative research done in Rwanda show that only 26% of sexually active boys and 15% of sexually active girls reported condom use during the last sexual intercourse. Moreover, only 13.7% of boys and 7% of girls reported consistent condom use during the last 12 months. The most significant socio-demographic correlate of condom use compared with rural residence, the urban environment is associated with more than a fourfold increase in condom use (33).

Young adults are about 2.5 times as likely as their adolescent peers to report condom use. Equally positively associated with condom use although less significantly so is education: the respondents with some education were more than twice as likely to use condoms as those with no education (33). Survey on out of school youths in Bahir Dar, revealed that 30.5% of youths were using condom (21). Similarly, a study on out of school youth in Awassa, revealed that only 27.6%of the sexually active adolescents used condom during their most recent sexual intercourse while their knowledge about HIV/AIDS was found to be 90% (27). A recent study among out of school adolescents in Addis Ababa found that 57.2% study subjects reported having had used condom (34). Negligence, embarrassment in buying from shops and pharmacies, lack of knowledge about its importance and fear of reduced sexual pleasure are frequently mentioned in these reports as reasons for non use of condom (27).

2.4. THE PRACTICE OF USING MODERN CONTRACEPTIVES

Contraceptive choice among the young women in the African and Vietnamese was restricted by their concerns about fertility and their status as women. Studies show that social disapproval of premarital sex, particularly when young women are still at school, limits young women's knowledge of, and access to, health services. Misconceptions of modern hormonal methods particularly that their use could cause infertility were common among the young women in this review. Such beliefs are often reported to be communitywide (5). Sixty nine percent of adolescent women in a UK study reported use of a modern contraceptive method at most recent sex, compared with 12% in Mali, and in the US 54% of 15–19 year old females reported condom use at most recent sex, compared with 21% in Tanzania. Overall, it is estimated that 37% of unmarried, sexually active women aged 15–24 years in sub-Saharan Africa use contraception but only 8% use a non-barrier method (5).

Several studies in the sub-Saharan Africa had reported that sexually active, unmarried adolescents are more likely than married adolescents to be relying on modern contraception (35, 36, 37,). In Ethiopia Contraception among young people remains a very limited practice. Even among currently married women 20-24 years of age, the prevalence is a mere 7.5%, with injectables being the most common method used, followed by the pill. Among married women 15-19, contraceptive prevalence is only 3.9%, with the pill being the most popular method used, followed by injectables. It is worth noting that IUDs and implants methods used for birth spacing among married women in other countries are not used at all by Ethiopian women 15-24, and used by less than 0.5 % of older women of fertile age. By contrast, use of contraception is much more common among sexually active unmarried youth, with four in ten reporting use of a method. The most common method used by these women is the pill, followed by the condom (5).

Contraceptive knowledge in previous several studies ranged from 60% in Nigeria (38), and 66% in Harar (35) to 75% in Gondar (39).For youth to engage in sexual activity and to use contraceptives including condom may be based on their judgments about their personal risk. For girls, perception of pregnancy risk may serve as deterrent to sexual activity, especially if pregnancy is seen in negative terms. As the same time, distorted perceptions of risk, like too young to become pregnant, incorrect knowledge on the fertile period, STDs and so on could lead to faulty decision making about sexual activity and to non-decision making about contraceptive and condom use (40). In 2005, in Ethiopia 16 percent of married female teens and 24 percent of married 20- to 24 year old women used a modern method of contraception, while 52 percent of sexually active unmarried females ages 15-24 used a modern method. Eighty six percent of all women knew about at least one method of contraception: 83 percent knew about the pill; 81 percent knew about injectable contraception. Less than half knew about condoms, implants, female sterilization, or intrauterine contraception (IUC). Nearly 91 percent of men knew about at least one method of modern contraception (25).

Research done in rural southern Nigeria show that the contraceptive prevalence rate (current use) was 29%, among the method ever used 27% used condom, 51% used pills and 19.4% used injectables. 71% of respondents were not using any method of contraception. Fear of side effect is the major reason followed by lack of knowledge and spouse consent (29).In Uganda, 17 percent of married young women use modern contraception; in contrast, 34 percent of unmarried sexually active young women use modern contraception. Prevalence was slightly higher in Tanzania at 15 percent of young married women and 36 percent of unmarried sexually active young women. The use of modern contraception was much lower in Rwanda, where 7 percent of married young women use modern contraception and 3 percent of unmarried, sexually active young women. In all three countries, the number of unmarried sexually active young women was relatively small, so they represent a small percentage of young women, although their contraceptive use may be higher (25).

2.5. EARLY MARRIAGE, PREGNANCY AND ABORTION

In 2005, females remained more likely than males to marry at a young age, particularly in rural areas. The median age of marriage among women ages 20-49 living in urban areas was 19.4 versus 16.1 among women living in rural areas and 23.4 for men in rural areas (29). Research done in Kenya show that, the median age at first sex has risen from 16.7 years in 1998 to 17.8 in 2003, with women living in rural areas having their first sex almost a year earlier than those living in urban areas. Customs in Ethiopia show early marriage in several ethnic groups, where girls are given away as early as seven years of age and most women have their first pregnancy as adolescents (41). In Kenya, more than half of women are married by their 20^{th} birthday (20).

Ethiopian women tend to marry early, at a median age of 16. The median age for first intercourse is also 16, suggesting relatively little premarital sex among women. In fact, 94% of sexually active adolescent girls 15-19 are married. Men, on the other hand, have higher rates of premarital sex and their median age at first intercourse (20.3 years) is three years lower than their median age at first marriage (23.3 years) (7). Among Ethiopian's young women ages 20-24, the median age at first sex was 18.2 years, an increase of more than 2.5 years over the median age at first sex (15.7) reported by women now in their 40s.(29)

Unwanted pregnancy is one of the greatest problems a young girl can face. Pregnancy may endanger her health, her chances for education and marriage, and many of her hopes and plans for the future. Her family may even disown her. Many adolescents are too young, too poor, or too inexperienced to car for a child. Consequently, some young women turn to abortion. Where abortions are performed by unskilled providers in unsafe conditions, the risks of serious health complications and death are great (42). Early child bearing has a negative impact on the education prospect of girls, including pregnancy related school dropout, thereby threatening their economic prospects and overall development. When school girls become pregnant, they either resort to illicit abortion, which is often unsafe, or carry the fetus to full term, which hampers their opportunities for socio economic advancement(3).

One quarter of the estimated 20 million unsafe abortions and 70,000 abortion related deaths each year occur among women aged 15–19 years, and this age group is twice as likely to die in childbirth as women aged 20 or over. It is estimated that 90% of abortion-related and 20% of pregnancy-related morbidity and mortality, along with 32% of maternal deaths, could be prevented by use of effective contraception. In sub-Saharan Africa, it is estimated that 14 million unintended pregnancies occur every year, with almost half occurring among women aged 15–24 years (5).

Abortion is illegal in Ethiopia, except to save a women's life or to preserve her physical or mental health. Because women are largely denied access to safe abortion, they turn to illegal and unsafe abortion. Unsafe abortion is the second leading cause of death for women of reproductive age, accounting for 55 percent of all pregnancy-related deaths (29).

2.6. SOURCE OF INFORMATION ON YOUTH REPRODUCTIVE HEALTH.

The study done among youth in kagera region Tanzania show that the Majority of the interviewees mentioned radio as the major source of the information (43). The media can also play a role in educating young people and others about HIV/AIDS through their wide reach and ability to break taboos and misconceptions. In youth surveys conducted in Algeria and Syria, around 90 percent of respondents said they had learned about HIV/AIDS via television (11). Studies also indicate that parents, in fact, do not talk to their children because they feel confused, ill informed, or embarrassed about these topics. Many adult relatives have failed to discuss sexual issues with themselves or that young people prefer not to discuss such issues with their adult relatives (38). Most adolescents reported that they felt it is culturally shameful to discuss about physical and psychological changes during adolescence with adults. The large proportion of respondents, 46% of males and 39% of females in Nigeria said their source of such information was friends and schoolmate (44).

Reports of most adolescent RH studies in Ethiopia revealed that the most common source of information on HIV/ AIDS was the media (45). Survey results also revealed that information about reproduction that young people receive from friends and the media might often be incomplete or incorrect. Because fewer than half urban young people (only 43% of females and 38%) of males who had reported their common source of information on RH was media, realized that there is a chance of pregnancy at first intercourse as many as 15 % of females and 16% of males stated that pregnancy could not occur at first intercourse (38).

2.7. HEALTH SERVICE UTILIZATION OF YOUTH AND THEIR PREFERENCES

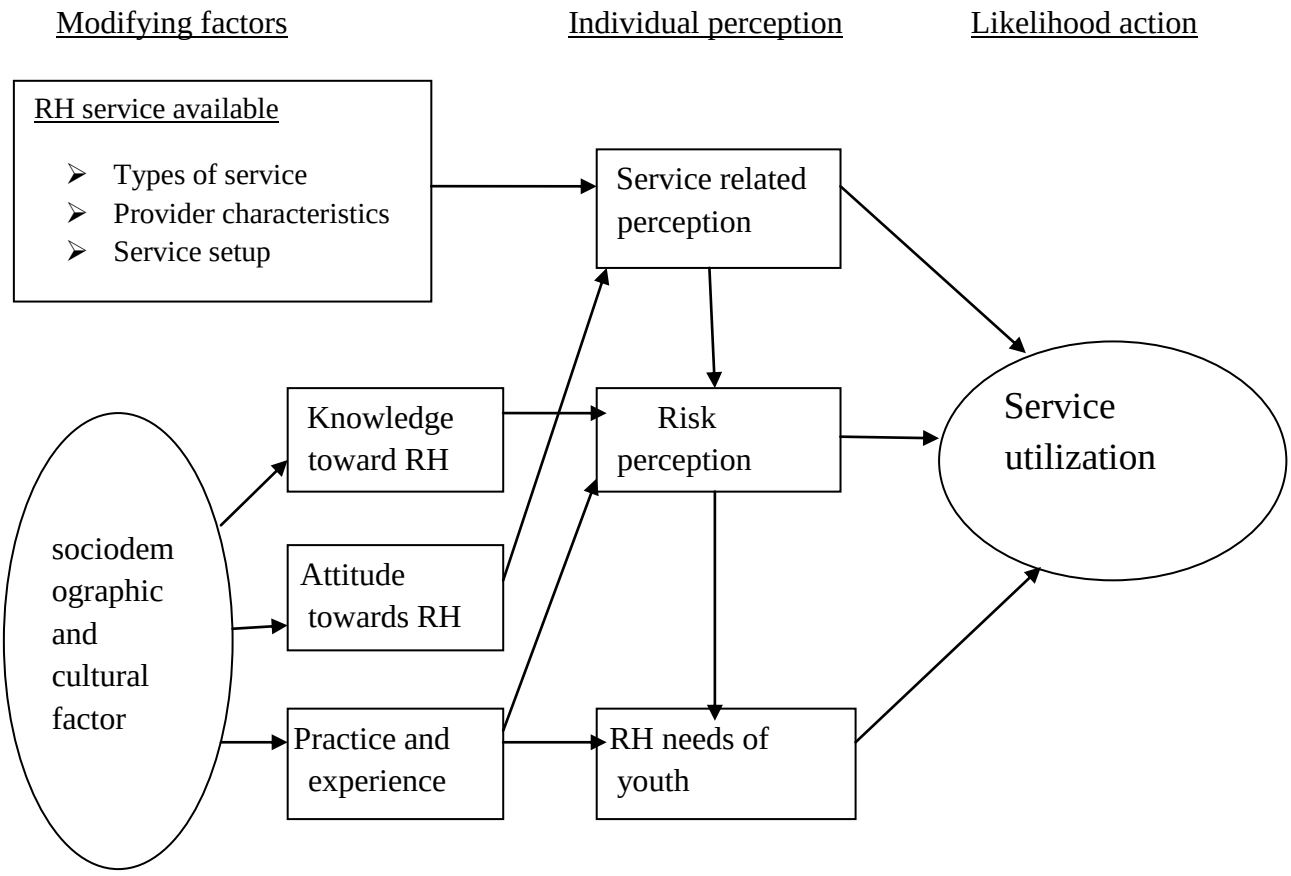
Young unmarried people in the past were not expected to need reproductive health services. If young women no matter how young were married they received the same services as older women, except no body assumed the young women need pregnancy prevention (44). A need assessment report among NGOs in Ethiopia involved in RH revealed that with few exceptions, health care providers and social sector professionals agree that the existing health care services do not meet the needs of today's young people (46). In most developing countries there are several barriers to utilization of health service by youth, of which operational and social factors to be the major ones (44,47).

Few studies conducted on service utilization patterns of adolescents in the country revealed the same fact. An interview of students at Bahir Dar provides reasons why their friends do not seek RH information or services: shy, shame, or believe that it is against the traditional culture think or unaware of services available were reported to be the major ones (48). A study conducted among school adolescents in Addis Ababa had revealed that a significant number of students reported that reproductive health services are not affordable, accessible and/ or acceptable to them (49).

In most situations, actions will be needed on several different fronts if good quality health services that are relevant to Young people's needs are to be made available and accessible to them, including polices, organization of the services, and training of health workers and young people. In addition to health promotion, health services for young people will, at a minimum need to include: emergency services, routine treatment of common diseases, regular access to non-judgmental listening and support guidance and regular access to the health supplies that young people require (15).

By fulfilling the preference of adolescents, Youth friendly services that have polices and attributes that attract Youth; health facilities can provide comfortable and appropriate services that meet the need of adolescents and retain them for follow up successfully (50). In Ethiopia young people get medical care through the network of health institutions in the country (51). Young people in Ethiopia are disadvantaged relative to older, in their ability to access information and services for their reproductive needs because of the absence of a youth – friendly service delivery system (52).

Figure 1 - Conceptual framework to show the areas of action in addressing the Reproductive Health related problems of youth in community (based on the Health Belief Model/HBM) (3)



OBJECTIVES

General objectives

To assess reproductive health needs and service utilization among youth in Bule Hora town.

Specific objectives

Specific objectives of this study are to:

1. Identify reproductive health needs among youth in Bule Hora town.
2. Assess knowledge and behaviour of youth on sexual health, pregnancy and contraception, STDs and HIV/AIDS.
3. Assess health service utilization patterns and their preferences.
4. Describe socio- cultural factors influencing reproductive health need and service utilization

METHODOLOGY

4.1. STUDY AREA

The study area was Bule Hora town Southern Oromia Borena Administrative zone, which was one of the 7 woreda in Borena zone. Bule Hora was located 467 kilometers at southeast of Addis Ababa along the high way that extends from Addis to Moyale. Bule Hora has a total area 4002 square kilometres of which 11% are covered by forest (produce coffee), 55% are arable land (produce serial foods) and 34% are deserts (pastoralist). As projected by the National population and housing census of Ethiopia, the population of the woreda currently were approximately 308,138 and contain 36980 households. In the woreda there were a total of 75 different health institutions of which one hospital, 7 public health center, 27 private clinics and 40 health post. In addition there were 3 pharmacies and 1 drug vendor. According to the report of woreda education office, there were 80 primary schools and 5 public secondary schools in the town. The woreda was located 8^0 16^1 north latitude and 28^0 8^1 east longitude. The annual rainfall of the woreda was 1400mm maximum and 900mm minimum. This woreda shared the Boundary from south by Dugda dawa, from North by Gedeb, from East by Kercha and from West by Burji.

Bule Hora town was selected to represent the urban community for this study because it was the largest town in the woreda and it has large number of youth due to various reasons. One of these reasons may be that it served as home for those different types' merchants because it was cash crop area and serve as the temporary storage place for the smugglers. The town was subdivided into 3 kebeles. According to the central statistical agency of Ethiopia the total house hold in the town was 7123with total population of 37,076 of which greater than half percents are adolescent and youth group.

4.2. STUDY PERIOD

The study was conducted from September 2011 to May 2012.

4.3. STUDY DESIGN

Study design was community based cross sectional study and was employed a quantitative data collection method to explore the reproductive health need and service utilization among youth in Bule Hora town.

4.4. STUDY POPULATION: the study population was youths who live in Bule Hora town at the time of study and fulfilling the inclusion criteria.

Inclusion criteria

- Youth who live in the town for at least six months and greater.
- Youth with in age group 15 to 24 years.
- Youth who is not mentally disabled.

4.5. OPERATIONAL DEFINITIONS

Need: Requiring services and information because they are important or useful for betterment of health and not simply one would like to have them.

Perceived needs: Needs that youth herself/himself recognized.

Reproductive health: A state of complete physical, mental and social well being not merely absence of disease or infirmity, in all matters relating to reproductive system and its functions and processes (11).

Reproductive health needs: perceived and unperceived health needs related to sexuality, contraception, pregnancy, STDs, HIV/AIDS, access to services and reproductive health information.

Sexual Activity: Is defined in this study as relation of two young of opposite sexes, which involves sexual intercourse. It is synonymous with the expressions like sexual experience and has had sex that is used in this paper.

Service utilization: the service that the youth utilize the required one to fulfil the reproductive health needs.

Unperceived needs: needs the youth himself does not recognize.

Youth: all people in the age group of 15-24 years according to WHO age classification.

4.6. MEASUREMENT VARIABLES

Questions was developed and organized in such a way that to assure measurement of the following variables. Socio demographic variables, variables on sexual health, pregnancy and contraception, variables on reproductive and sexual health information, socio-cultural influences on youth reproductive health and variables on health service utilization and preferences.

Dependent variables:

- RH Needs (Sexual activity, pregnancy, contraceptive use, condom use, and health service preferences) and health service utilization.

Independent variables:

- Socio-demographic variables (sex, age, educational status, income, family status and parent's education), residency.

4.7. SAMPLE SIZE DETERMINATION

First, to determine the sample size from an infinite population, the following assumption was applied. Since the prevalence of reproductive health needs and service utilization of youth were not clearly stated in the research done before, prevalence of 50% was taken as the baseline in this study population to get the maximum sample size, with 95 % confidence interval, and 5 % degree of precision (marginal error) and the following formula were used:

$$N = \frac{(Z\alpha/2)^2 P (1-P)}{d^2}$$

Where

N = the required sample size

$Z\alpha/2$ = Critical value (confidence interval) = 1.96

P = the prevalence of reproductive health need.

D = marginal error between the sample and the population (0.05).

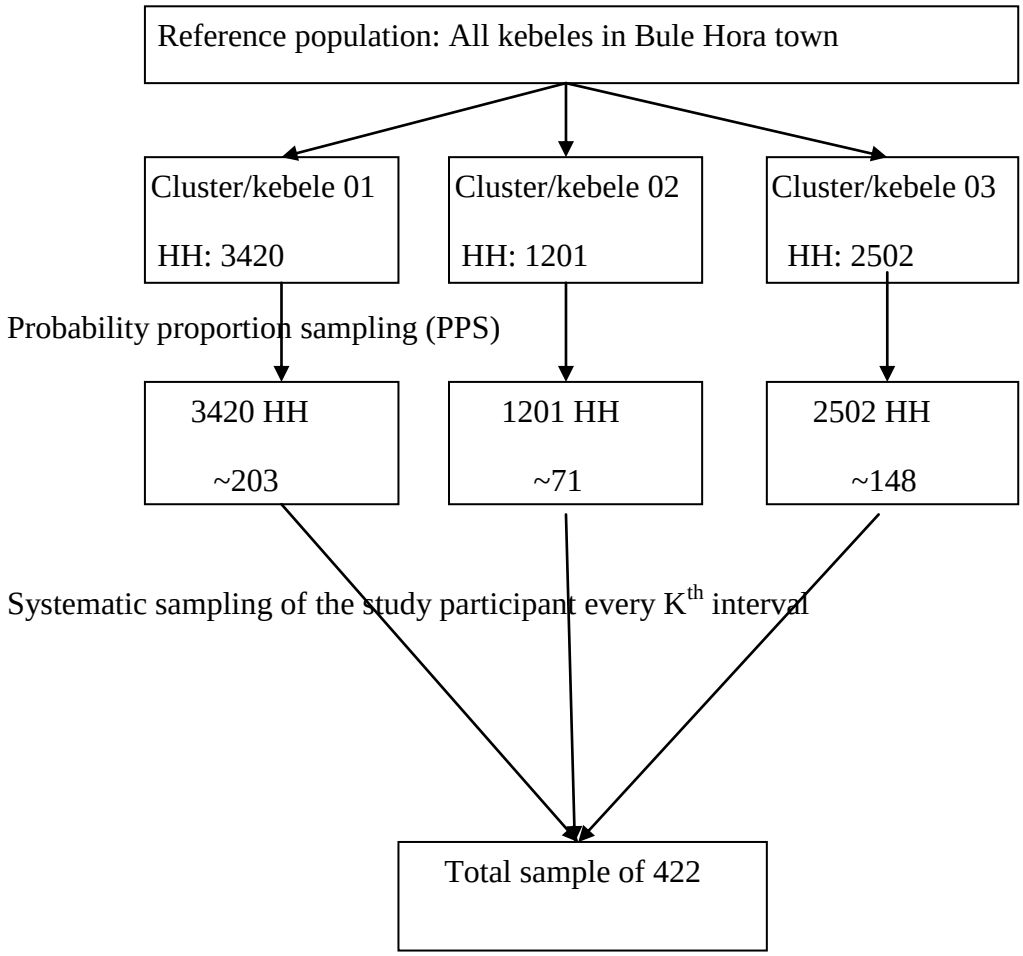
By using the above formula and with a non response rate 10% of the final result was around **422** youth are needs for the study.

4.8. SAMPLING PROCEDURE

Bule Hora town was selected purposively from this woreda because it contains large number of population. It has three distinct kebeles which separated by boundary and those of the three kebeles is included in the study. The interview questionnaires would be employed with equal proportion to all kebeles by using systematic random sampling method. The sample size for the town, 422 was divided and allocated to each of the selected kebeles according to the principle of probability proportional to size. Which means kebeles that were found to have large number of youth, based on the measure of size, would give greater probabilities.

There are around 7123 total households according to central statistical agency in the town. To get the K interval we divided the total house hold to study population (422) which become ~ 17. The first household randomly selected to start the interview from each three kebeles. Individuals aged 15-29 years in the households was randomly selected and interviewed. When there was more than one person aged 15-29 years in one household, only one person was selected using lottery method. When the person in the specified age was not found in the household, the next nearest household would be included in the survey. When eligible respondent was identify that for some reason could not be easily interviewed (Eg. when he or she was not at home) we made at least three more attempts to interview each eligible respondent identified rather than simply skipping them. If after three attempts it was not possible to interview the individual, the case would have been dropped out as a non-response.

Figure.2. Schematic presentation of sampling procedure



4.9. DATA COLLECTION INSTRUMENTS

An anonymous structured questionnaire was prepared based on literature review and adopted from the other researches which have been done before on this area and necessary modification was made. The questionnaire had detailed questions on socio-demographic characteristics of youth; their level awareness, knowledge, attitude and practice on SRH issues; youth' sexual practice and their risk perception; types of services provided to the students; the students' RH need, service preference and service utilization patterns.

4.10. DATA COLLECTION PROCESS

Data collection method was the interview administered only for illegible participant. The principal investigator was made the necessary contact with concerned bodies to get collaboration for the whole process of data collection.During data collection, the data collectors were provided counselling for emotional support and appropriate information to avoid misconceptions in RH and Service utilization issues. The collected data checked for completeness and consistency by the principal investigator throughout data collection period for data quality and completeness.

4.11. DATA PROCESSING AND ANALYSIS

Each complete questionnaire assigned to a unique code and entered using EPI INFO latest version statistical packages and then transported to latest version of SPSS for analysis. The data entry was made by the principal investigator to minimize errors. Summary statistics such as frequencies, proportions, measures of central tendencies and measures of variation used to describe the study population in relation to socio-demographic and other relevant variables. Contingency table analysis of the association between the outcome variables and explanatory variable was carried out.

The degree of associations between dependent and independent variables assessed using crude Odds ratio with 95% confidence interval. Multiple logistic regression analysis performed using SPSS latest version statistical program to control potential confounding variables.

4.12. DATA QUALITY MANAGEMENT

To manage the quality of data first the questionnaire was translated from English to Amharic and then back to English to ensure message consistency and finally administered in Amharic. Before conducting the main study, pre-test of the questionnaire was conducted in other town not selected for the study on 5% of the sample. Training of data collators and continuous supervision during data collection were made. Computer frequencies were used to check for missed variables and outliers. Any errors identified at this time were corrected after revision of the original questionnaire retrieved using the code numbers.

Recruitment and training: The data collectors recruited based on the following general criteria. Both sexes, 12th grade completed and above, age of 20 years and above, physically fit, those who have similar experience and fluent in Amharic language. After recruitment, training was given for both the interviewers and supervisors for three days before the pre-test and for a day after the pre-test. The training includes discussing the questions one by one, briefing on the general objective of the study, discussing about general techniques of interviewing and how to approach the respondents, how one would be keep confidentiality and privacy, and role-playing practices.

Supervision: During the actual data collection, the supervisors were supervised data collectors. The supervisors were checked the activities of each data collector by moving with them. Each night the supervisors had been checked all the questionnaires filled for completion, clarity and proper identification of the respondent. Then the principal investigator randomly checked at least 10% of the supervisors work each day. Incomplete and unclear questionnaires returned to the interviewer the next morning to get it complete.

4.13. ETHICAL CONSIDERATION

Initially, Ethical clearance was obtained from Institutional Review Board and centralized School Nursing and Midwifery, Faculty of Medicine prior to implementation of data collection. Bule Hora Administration was communicated and informed about the objective of the study and official permission was obtained. Finally the study participants was informed about the purpose of the study and confidentiality: the protection of their response by anonymity of the questionnaire and no family members who knew the respondent would be allowed to be involved in the interview process and the respondents themselves gave their anonymous responses to the data collectors, and would be requested an informed written consent.

Additionally, respondents' who had emotional problem supported and who had misconception on reproductive health need issues communicated with appropriate information. It was tried to assure confidentiality by minimizing disclosure of personally sensitive information through appropriate training of the interviewers on the issue, maintaining strict privacy during interviewing and by making the questionnaire anonymous.

4.6. DISSEMINATION OF THE RESULT

The result of this study is communicated to Federal Ministry of Health; Ethiopian Public Health Association, department of Nursing and Midwifery, Bule Hora administration and consortium of reproductive health association (CORHA). Besides, an effort was made to publish this paper on scientific journals.

RESULTS

5.1 SOCIO - DEMOGRAPHIC CHARACTERISTICS

A total of 422 households were visited in three kebeles (youth aged 15-24 years) of which only 394 (93.4%) agreed to be interviewed. Out of the study subjects, more than half, 270(68.5%) of the respondents were male with female to male ratio of 0.46: 1. The mean (±SD) age of the study subjects was 20.2(± 2.63) years. The dominant religion in this study were Orthodox 168(42.6%) followed by Protestant 138(35%) and Muslim 63(16%). The dominant ethnic group in the study area were Oromo 229(58.1%) followed by Amhara 67(17%) and Gurage 43(10.9). Out of the total youth who were interviewed 310(78.7%) had never married, and 84 (21.3%) had married, of which 6(7.1%) of them had already divorced (Table1).

The majority of the respondents 372(94.4%) were literate of which 47.0% were attain secondary school and 26.6% were attain college and university. Almost, 371(99.2%) of the respondant have had their own occupation of which 242(61.4%) were students. Greater than half, 239(60.7) of the study subject have no income. Out of the total respondants 155(39.3%) of them live with both family members, 37(9.4) live with a single family member while the majority 202(51.3%) of them live with other family members. One hundred eighty four (46.7%) of the mothers were housewives. The majority, 263(66.8%) of youth fathers were literate, of which most of them had formal education. Similarly, most, 224(56.9%) of youth mothers were literate.

Table: 1. Socio-demographic variables of youth in Bule Hora town May, 2012

VARIABLES	FREQUENCY	PERCENTAGE
Sex of Respondent		
Male	270	68.5
Female	124	31.5
Religion		
Orthodox	168	42.6
Protestant	138	35.0
Catholic	14	3.6
Muslim	63	16.0
Other specify	11	2.8
Age		
15-19	175	44.4
20-24	219	55.6
Ethnic group		
Oromo	229	58.1
Amhara	67	17.0
Gurage	43	10.9
Others	55	14
Marital status		
Never Married	310	78.7
Ever Married	84	21.3
Education status		
Illiterate	22	5.8
Literate	372	94.2
Occupation		
No occupation	3	0.8
Have some occupation	391	99.2
Monthly income		
No income	239	60.7
<320	26	6.6
320-1000	69	17.5
1001-1500	36	9.1
>1501	24	6.1
With whom do you live most of the time?		
With both family	155	39.3
With single family	37	9.4
With other family	202	51.3
Fathers Occupation		
No occupation	18	4.6
Have some occupation	376	95.4
Mothers' occupation		
House wife	184	46.7
Have some occupation	210	53.3
Families' economic status		
Rich	32	8.1
Medium	255	64.7
Poor	77	19.5
Don't now	30	7.6
Father's educational status		
Illiterate	131	33.2
Read and write	263	66.8
Your mother's educational status		
Illiterate	170	43.1
Read and write	224	56.9

5.2 SOURCE OF INFORMATION ON REPRODUCTIVE HEALTH

Out of the study subject, mass media 189(48%), health workers 83(21.1%), community based reproductive health association 37(CBRHA)(9.4%) and parent 30(7.6%) were mentioned to be the common source of information on sexual maturation in that order of importance(Figure 3). Female respondents had reported that they prefer health workers 46(37.1%), mother 22(17.7%), friend or peers 17(13.7%) and partner 11(8.8%) to discuss with to get more information about pregnancy respectively. Media 172(43.7%), health workers 109(27.7%), CBRHA 31(7.9%); were reported to be the major source of information on STDs/AIDS (Figure 4). Generally mass media were the major source of information on the sexual maturation and STD/HIV among the study participant.

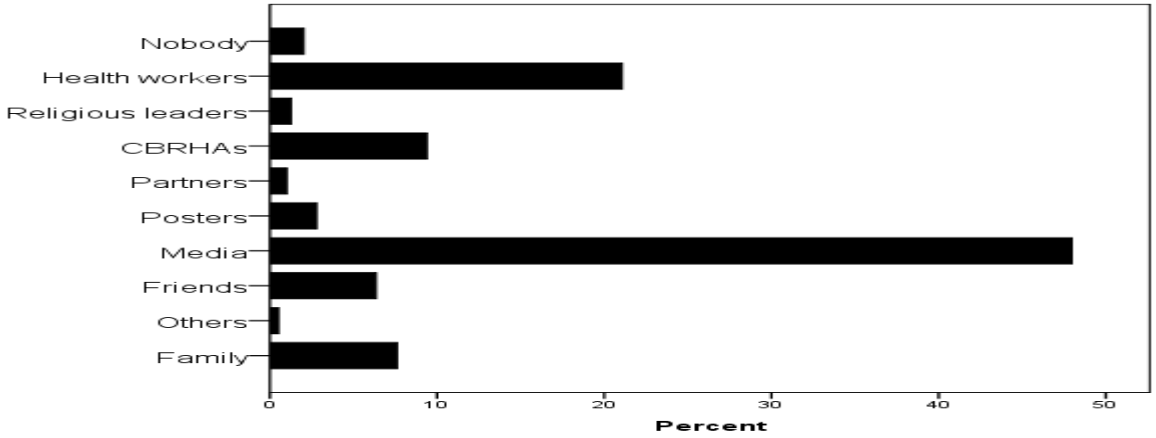


Fig.3: Source of information on sexual maturation among youth in Bule Hora town May 2012

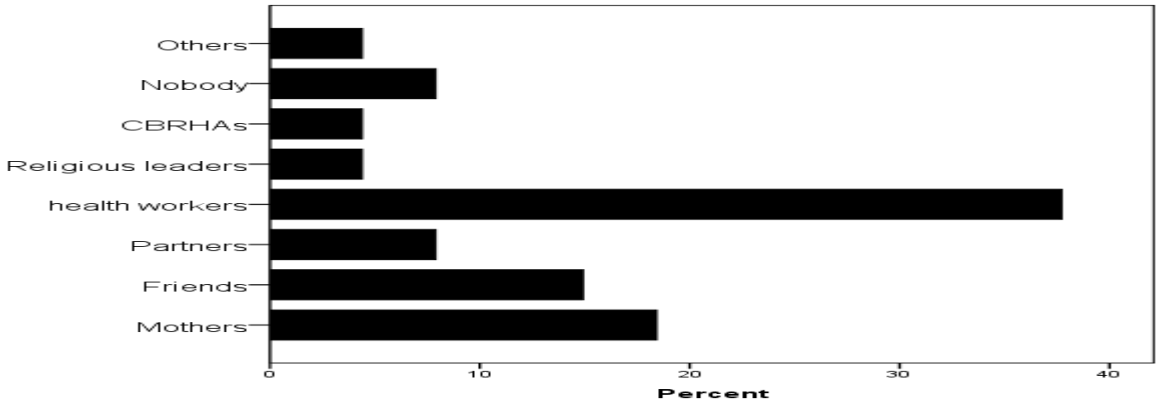


Fig.4: Females' source of information to discuss about pregnancy in Bule Hora town May, 2

5.3 KNOWLEDGE ON REPRODUCTIVE AND SEXUAL HEALTH

Out of the study subjects only 48(12.2%) of them answered that a woman is most likely to become pregnant halfway between two menses and the proportion of male and female youth who replied correctly to this question was 10.7% and 15.3% respectively. Out of the total study subjects, 350(88.8%) of them had reported that they know at least one means of avoiding pregnancy. Condoms, Oral contraceptive pills, and injectables, were the most recognized contraceptive methods that were reported by 330(94.3%), 275(78.5%) and 260(74.3%) respectively. Moreover, a sizable proportion, 98(28%) of the participants agreed douching to be one of the alternative methods of contraception (Table 2).

Three hundred eighty two (97.2%) of the participants knew diseases that a person can acquire through sexual intercourse and the proportion of male to female on this question was 98.1% and 93.5% respectively. Among 382 respondents who know at least one of the diseases that can be transmitted through sexual intercourse, almost all of them mentioned AIDS, 342(89.5%) mentioned gonorrhea and 199(52.1%) of them mentioned chancroid ,198(51.8%) stated syphilis whereas only 104(27.2%) of them mentioned lymphogranulom venereum. Out of 374 participants who mentioned there is means of preventing STDs and AIDS, most, 346(92.5%) mentioned abstinence, 323(86.4%) to avoid sex, 322(86.1%) to use condom, 321(85.8%) mentioned to remain faithful to a partner and 254(69.9%) avoid sex with Commercial Sex Workers (CSW) to be ways that a person should follow to avoid getting these diseases.

Out of the total study subjects 112(28.4%) them do not know the person or place to obtain male condom. Greater than half of the respondants know what mean by safe sex, among those, 366(92.9%) of them mentioned having sex with a single faithful partner 312(79.2%) mentioned abstainance from sex, and 263(66.8%) mentioned avoiding multiple sexual partners.

Out of 382(97.2%) of the respondents who had reported that they have heard about HIV/AIDS, 389(99.2%) stated unsafe sex, 378(96.4%) sharing syringes and needles, 375(95.6%) transfusion of infected blood and 345(88%) vertically from mother to child to be the major means of HIV transmission. Whereas 23(5.8%) and 7(1.8%) mentioned that mosquito bite and casual contact with other person were means of HIV transmission respectively.

Table.2: Knowledge of youth towards sexual and reproductive health issues in Bule Hora town May 2012.

VARIABLES	FREQUENCY	PERCENTAGE
Woman have the greatest chance of becoming pregnant		
During her period	29	7.4
Right after period is ended	70	17.8
Just before her period begins	161	40.9
In the middle of her cycle	48	12.2
The same throughout	4	1.0
Don't know	82	20.9
Do you know ways to avoid getting pregnant?		
Yes	350	88.8
No	44	11.2
If yes, what are the ways to avoid getting pregnant?		
Oral contraceptive pills	275	78.5
Using condoms..	330	94.3
Injectables	260	74.3
Norplant.	68	19.4
IUDs.	46	13.1
Sterilization.	8	2.3
Abstinence	52	14.8
Withdrawal	18	5.1
Washing the genitalia.after intercourse	98	28
Intercourse in the upright position	9	2.6
Safe period/abstinence	47	13.4
Do you know any diseases a person can get through sexual intercourse?		
Yes	382	97.2
No	12	2.8
If yes, which diseases do you know about?		
Gonorrhea.	342	89.5
HIV/ AIDS.	381	99.7
Chancroid.	199	52.1
Syphilis.	198	51.8
Lymphogranuloma Venereun	104	27.2
Is there anything a person can do to avoid getting STIs and HIV/AIDS?		
Yes	374	95.4
No	20	4.6

Table 2 continoue...

VARIABLES	FREQUENCY	PERCENTAGE
If yes, what are they?		
Sexual abstinence.	346	92.5
Avoid casual sex.	323	86.4
Remain faithful to a partner	321	85.8
Use condoms in every act of Sexual Intercourse	322	86.1
Avoid sex with CSWs.	254	69.9
Do you know any place or person to get condoms?		
Yes	282	71.6
No	112	28.4
Mostly where would you go to get a condom?		
Shop	86	30.5
Clinic	62	22
Health center	69	24.5
Hospital	30	10.6
Others	35	12.5
What dose safe sexes mean to you?		
Abstinence from sexual intercourse	312	79.2
Using condom in every sexual intercourse	249	63.2
Avoiding multiple sex partners	263	66.8
Avoiding sex with prostitutes	240	60.9
Having sex with a single faithful partner	366	92.9
Have you heard about a HIV /AIDS?		
Yes	392	99.5
No	2	.5
If yes, Please mention all the ways person can get AIDS.		
Unsafe sexual intercourse.	389	99.2
Sharing needles and syringes	378	96.4
Blood transfusion.	375	95.6
During pregnancy and childbirth	345	88
Mosquito and other insect bite.	23	5.8
Through breast milk.	296	75.5
Casual contact with a person	7	1.8

Out of the total study subjects only 20.8% of them agreed that a girl could get pregnant the first time she had sex and the proportion of male to female was 13.7% and 7.13% respectively. Among study participant about 249(63.2%) of them know that a healthy looking person can have HIV and only 35.8% agreed that a person can get HIV the first time he or she had sex. The majority, 374(94.8%) of them know what person can do to avoid getting STIs and HIV/AIDS and the proportion of male to female was 64.9% and 29.9% respectively (Table3).

Table.3. knowledge of youth towards selected sexual and reproductive health issues by sex in southern Oromia, Bule Hora town, May 2012.

VARIABLES	MALE		FEMALE		TOTAL	
	Freq	%	Freq	%	Fre	%
A girl can get pregnant the first time she had sex.						
Agree	54	13.7	28	7.13	82	20.83
Not agree	185	46.95	77	19.6	262	66.55
Disagree	31	7.8	19	4.82	50	12.62
Total	270	68.5	124	31.5	394	100
A healthy looking person can have HIV						
Agree	178	45.2	71	18	249	63.2
Not agree	78	19.8	42	10.6	120	30.4
Disagree	14	3.5	11	2.8	25	6.3
Total	270	68.5	124	31.5		100
A person can get HIV the first time he or she has sex.						
Agree	107	27.16	34	8.63	141	35.8
Not agree	118	29.9	71	18	189	47.9
Disagree	45	11.4	19	4.8	64	16.2
Total	270	68.5	124	31.5	394	100
Is there anything a person can do to avoid getting STIs and HIV/AIDS?						
Yes	256	64.9	118	29.9	374	94.8
No	14	3.5	6	1.7	20	5.2
Total	270	68.5	124	31.5	394	100

ATTITUDE TOWARDS SELECTED SEXUAL AND RH ISSUES

Out of the total respondent only 179(45.5%) of them definitely disagree that using a condom is the sign of not trusting a partners whereas as 138(35%) of them were unsure. Sixty eight (17.3%) of them were agree that boys should had sexual intercourse before he got married, while 209(53.1%) of them completely disagree and the rest of them were unsure about the ideas.out of the study subject 64(16.2%) of them agree that discussing about condom or contraceptive with young people promotes promiscuity. The majority, 278(70%) of partcipant believe that doing anything may not put a person at risk of getting AIDS virus. In contrast 92(23.4%) of youth don't know whether they are at risk of getting HIV/AIDS in the next 12 months (Table 4).

Table 4: Attitudes of youth towards selected sexual and reproductive health issues by sex in southern Oromia, Bule Hora town, May 2012.

Variables	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Using condom is a sign of not trusting your partner.						
Agree	58	14.7	19	4.8	77	19.5
Unsure	101	25.6	37	9.4	138	35
Disagree	111	28.2	68	17.3	179	45.5
Total	270	68.5	124	31.5	394	100
A boy should have sex before he gets married.						
Agree	55	13.9	13	3.3	68	17.2
Unsure	82	20.8	35	8.9	117	29.7
Disagree	133	33.7	76	19.3	209	53.1
Total	270	68.5	124	31.5	394	100
Discussing condom or contraceptive with young people promotes promiscuity.						
Agree	52	13.2	12	3	64	16.2
Unsure	68	17.3	40	10.2	108	27.4
Disagree	150	38.1	72	18.3	222	56.4
Total	270	68.5	124	31.5	394	100
Do you believe you have done anything may have put you at risk of getting AIDS virus?						
Yes	29	7.4	9	2.3	38	9.7
No	189	47.9	87	22.1	276	70
Don't know	52	13.2	28	7.1	80	20.3
Total	270	68.5	124	31.5	394	100
Do you think you are at risk of getting the AIDS virus in the next 12 months?						
Yes	10	2.5	1	0.25	11	2.76
No	198	50.3	93	23.6	291	73.9
Don't know	62	15.7	30	7.6	92	23.4
Total	270	68.5	124	31.5	394	100

The study participants were asked their opinion on the ideal age for a girl and a boy to marry. The mean ages at marriage as stated by the participants were 20.0 and 24.8 years for girls and boys respectively. Moreover, none of the participants agreed that a girl should marry before age 15, while only 2.8% of them agreed a girl should marry at this age. About 102(25.9%) of the participants said it is difficult for youth to obtain contraceptive and condom.

Out of the reasons mentioned, about half of them 52(50.9%) reported parents disapproved, about 17(16.6%) reported it is shame for youth to obtained condom from some were, about 16(15.6 %) said it is difficult to find. Two hundred fifty six (65%) of the study subjects replied that they definitely could to have sexual relations only with a single person. About 140(67.6 of those who were sexually inactive reported that they could abstain from sex for the next 12 months.

5.4 REPRODUCTIVE AND SEXUAL HEALTH BEHAVIORS

Out of 394 participants, 187(47.5%) have reported to be sexually active at least once before the time of the study, out of which 147 (78.6%) were males while 40 (21.4%) were females. Only 15 of 99(15.2%) never married female youth were sexually active compared to 88 of 211 (40.7%) never married male. The mean (±SD) age of sexually active participants at sexual onset was 18.3 (± 2.02) years. Among the reasons for engaging in sexual debut the first time, fall in love was mentioned by 113(60.4%) of the sexually active participants, have desire to do so by 104(55.6%), being married by 84(49.9%) and wanted to get married by 33(17.6%), to be the major reasons. Whereas, 10(5.6%) of the respondents, all of whom were females, mentioned that they were forced to do so. Out of 187 sexually active youth 92 (49.2%) had more than one lifetime sexual partner. The mean (±SD) lifetime number of sexual partner per sexually active participants was 2.1 (±1.56) (Table 5).

During the bivariate analysis sexual activity was found to be significantly associated with many independent variables but after controlling for confounding variables age, and marital status were found to be the main predictors, independently and negatively associated with sexual activities with (OR=0.261,95%CI(0.147,0.462), and (OR=0.026,95%CI(0.007,0.092) respectively. But sex was found to be independently and positively associated with sexual activity with (OR=3.305, 95%CI (1.768, 6.179) (Table 6).

Among sexually active married and not married youth male around 45(30.6%) had sexual intercourse with commercial sex workers.Modern contraceptive use was found to be high among the study subjects. The majority 129 (68.9%) of the sexually active had ever used modern contraceptives. Condom 101(78.3%), oral pills 76(58.9%) and injectables 71(55%) were reported to be the most frequently used methods of contraceptives. About 58(31.1%) of sexual active youth did not use modern contraceptive. Out of the reasons mentioned for not using contraceptives among non-users, desire to have children was mentioned by 21(36.2%), have infrequent sex by 17(29.3%), partner opposed by 17(29.3%). Only 98(52.5%) of the sexually active had used contraceptive during their first sexual engagement. Out of the most important reasons mentioned for not using modern contraceptives during the first time sexual intercourse among the non- users, pregnancy was impossible by 34(38.2%), unplanned sex by 19(21.3%) and partner opposetion by 18(20.2%) was reported. The proportion of sexually active never married youth who used modern contraceptives was 77 (74.8%) compared to only 52(61.9%) of those who had ever married. During multivariate analysis after controlling for confounding variables living patterns was found to be the main predictors, independently and negatively associated with use of modern contraceptive with OR=0.311,95%CI(.109,.885) (Table 7).

Out of the sexually active study subjects 28 (15%) of them reported that they have ever had STD symptoms. Fourteen (50%) were mentioned they went to public health institution, 6(21.4%) reported they went to pharmacy, 3 (10.7%) said they did nothing. The proportion of youth who have used condom during the first sexual intercourse was found to be lower than ever users. Out of the most important reasons mentioned for not using condom among the non- users, opposition of partners was mentioned by the majority 21(22.8%), used other method by 17(18.4%), don’t like it by 17(18.4%) and negligence by 15(16.3%) were also reported.

Table.5. Sexual and reproductive health behaviours among youth in Bule Hora town May 2012.

VARIABLES	FREQUENCY	PERCENTAGE
Have you ever had sexual intercourse?		
Yes	187	47.5
No	207	52.5
If yes, at what age?		
15-19	136	72.7
20-24	51	27.3
Why did you decide to have sexual intercourse the first time?		
Fall in love.	113	60.4
Have desire.	104	55.6
Wanted to married.	33	17.6
I get married	84	49.9
Forced to do so.	10	5.3
Friends doing it	11	5.5
Others,	3	1.6
With how many partners have you ever had sexual intercourse?		
One	95	50.8
Greater than one	92	49.2
During the last six months, have you had sexual intercourse?		
Yes	139	74.3
No	48	25.7
Have you ever had sexual intercourse with commercial sex?		
Yes	45	30.6
No	102	69.4
Have you ever used modern contraceptives?		
Yes	129	68.9
No	58	31.1
If yes what type? (Probe and indicate that all apply)		
Oral contraceptive pills	76	58.9
Condom	101	78.3
Injectables	71	55
If no, what were the reasons?		
I have infrequent sex	17	29.3
Want to have children	21	36.2
Husband/partner opposed	17	29.3
Too far to get contraceptives	3	5.2
Did you use contraceptive the first time you had sexual intercourse?		
Yes	98	52.4
No	89	47.6
If no, why not?		
Did not believe pregnancy was possible	34	38.2
Sex was un planned	19	21.3
Did not know any a method	7	7.8
Fear of the side effect of a method	5	5.6
Method not available	6	6.7
Partner opposed	18	20.2

Table 5 continoue...

Variables	Frequency	Percentage
Have you ever had STI.		
Yes	28	14.9
No	159	85.1
If yes what did you, do first when you had STI?		
I did nothing	3	10.7
Went to pharmacy,	6	21.4
Went to public health institution	14	50
Went to local healer	1	3.5
Went to private health institution	4	14.3
Have you ever used condom?		
Yes	101	54
No	86	46
Did you or your partner use condom the first time you had sexual intercourse?		
Yes	95	50.8
No	92	49.2
If no, please give the reasons (indicate all answers that are mentioned)		
Not available	17	18.4
Too expensive	2	2.1
Partner objected	21	22.8
We don't like them	17	18.4
Used other contraceptives	17	18.4
Did not think it was necessary	13	14.1
Did not think of it	15	16.3

Out of 40 sexually active female participants, 18(45%) of them had ever been pregnant. Out of all pregnancy, 55.6% had greater than one history of pregnancy. Twenty two percent of pregnancies were among never married females while the rest of pregnancy is among ever married females. The mean (± SD) age at first pregnancy was 18.7 (± 1.56) years. Out of 18 youth who have been pregnant 3(16.7%) of them had at least one unwanted pregnancy. Four (22.2%) of those who had ever been pregnant had abortion at least once in the past. During multivariate analysis after controlling the possible confounding variables marital status were found to be the main predictor,independently and negatively associated with pregnancy with OR=0.027, 95%CI (.002,.462) and pvalue less than 0.05 (Table 8).

Table 6: Association of sexual activity of youth with socio demographic factors in Bule Hora town, May 2012.

VARIABLES	Ever had a sexual intercourse			
	Yes	No	OR (95% CI)	Adjusted OR 95%CI
Age				
15-19	38	137	**1.00**	1.00
19-24	149	70	.130(.082, .206)	.261(.147,.462)***
Sex				
Male	147	123	**1.00**	1.00
Female	40	84	2.510(1.606, 3.921)	3.305(1.768,6.179)***
Occupation				
No occupation	2	1	**1.00**	
Some occupation	185	206	.449(.040, 4.993)	
Education				
Illiterate	14	8	**1.00**	
Literate	173	199	.497(.204, 1.212)	
Marital status				
Never married	103	207	**1.00**	1.00
Ever married	84	0	.021(.006, .067)	.026(.007,.092)***
Income				
No income	81	158	**1.00**	1.00
<320	14	12	.439(.194,.994)	1.070(0.326,3.516)
320-1000	41	28	.350(.202, .607)	1.246(0.577,2.689)
1001-1500	30	6	.103(.041, .256)	0.537(0.176,1.640)
>1500	21	3	0.073(0.021, 0.253)	0.370(0.086,1.584)
Living most of the time				
With both parents	41	114	**1.00**	1.00
With single parent	16	21	.472(.225, .991)	.571(.236,1.381)
With other family	130	72	.199(.126, .315)	.665(.364,1.215)
Father's education				
Illiterate	60	71	**1.00**	
Literate	127	136	.905(.594,1.378)	
Mother's education				
Illiterate	80	90	**1.00**	
Literate	107	117	.972 (.652,1.449)	

N.B: *=Pvalue<0.5 and ***=Pvalue<0.005

Table 7: Association of practices of modern contraceptive use of youth with socio demographic factors in Bule Hora town, May 2012.

VARIABLES	Ever used a modern contraceptive			
	Yes	No	OR (95% CI)	Adjested OR 95%CI
Age				
15-19	24	14	**1.00**	
19-24	105	44	.725(.343, 1.532)	
Sex				
Male	103	43	**1.00**	
Female	26	15	1.437(.691,2.989)	
Occupation				
No occupation	3	2	.078(.0725,1.997)	
Some occupation	126	56	**1.00**	
Education				
Illiterate	8	6	**1.00**	
Literate	121	52	1.731(.572, 5.238)	
Marital status				
Never married	76	31	**1.00**	
Ever married	53	27	1.364(.731, 2.547)	
Income				
No income	58	23	**1.00**	
<320	8	6	.944(.277, 3.223)	
320-1000	24	17	.600(.160, 2.243)	
1001-1500	20	9	.222(.044, 1.119)	
>1500	19	3	.529(.165, 1.693)	
Living most of the time				
With both parents	34	7	3.778(1.051,13.582)	0.311(.109,.885)**
With single parent	9	7	2.514(1.031, 6.130)	1.451(1.438,4.803)
With other family	86	44	1.00	1.00
Father's education				
Illiterate	38	22	**1.00**	
Literate	91	36	.691(.360, 1.326)	
Mother's education				
Illiterate	57	23	**1.00**	
Literate	72	35	1.222(.650, 2.296)	

N.B=**<0.05Pvalue

Table 8: Association of occurrence of pregnancy among youth with in socio demographic variables in Bule Hora town, May 2012.

Variables	Ever had pregnant			
	Yes	No	**OR (95% CI)**	**Adjusted OR 95%CI**
Age				
15-19	2	6	1.00	
20-24	16	16	.500(.080, 3.127)	
Income				
No income	6	12	1.00	
<320	1	2	1.000(.075,13.367)	
320-1000	8	5	.188(.036, .976)	
1001-1500	2	2	.500(.056, 4.473)	
>1500	1	1	.500(.026, 9.457)	
Occupation				
No occupation	7	10	.025(.0455,1.889)	
Have some occupation	11	12	1.00	
Living most of the time				
With both parents	1	8	1.00	
With single parent family	1	0	.091(.0134,1.252)	
With others family	16	14	.146(.016, 1.363)	
Mother's education				
Illiterate	8	7	1.00	
Literate	10	15	2.400(.607, 9.486)	
Father's education				
Illiterate	5	5	1.00	
Literate	13	17	3.462(.597,20.697)	
Marital status				
Never marred	4	12	12.00(2.147,67.067)	0.027(.002,.462)**
Ever married	14	10	1.00	1.00

N.B:=Pvalue<0.05**

5.5 HEALTH SERVICE UTILIZATION

Out of 394 participants, only 84 (21.3%) of them reported that they have visited health institutions in three months time prior to the study. Moreover, the older the age the higher is the health institution visit, that is, 62(73.8%) who visited health institutions in three months time were in the age group of 20-24 years (Table 9).

Half, 42(50%) of the participants had reported that they had visited health institutions to get condom and 14(16.6%) of them visited for counselling. The majority, 40(47.6%) and 30(35.7%) have visited public and private health institution respectively whereas the rest of them visit other institutions. Among the common reasons for preference to visit such health institutions, free or low cost of treatment mentioned by 31(36.9%), proximity by 29 (34.5%), effectiveness of treatment by 9(10.7%), and prefer for confidentiality by 6(7%). Poor handling and failure to keep privacy and confidentiality by health workers 140(35.6%), too much waiting time 81(20.6%), and it is shame for youth to visit health institutions 73(18.5%) were reported to be the major reasons that prevent youth from visiting health institutions.

During the bivariate analysis health service utilization was found to be significantly associated with many independent variables but after controlling for possible confounding variables age, sex, and income was found to be the main predictors and significantly associated with health service utilization with (OR=0.514 95%CI (0.278, 0.951), (OR=2.095 95%CI (1.116, 3.932), and (OR=0.288 95%CI (0.112, 0.742) respectively (Table 10).

Table 9: Health Service Utilization among youth in Bule Hora town, May 2012.

VARIABLES	FREQUENCY	PERCENTAGE
Have you visited a health institution In the last three months?		
Yes	84	21.1
No	310	78.9
If yes, what was the reason for your visit?		
I had STI	6	7.1
For abortion	1	1.2
For delivery and ANC	10	11.9
To get oral contraceptive	11	13.1
To get condom	42	50
For councelling	14	16.6
If you have visited a health institution, where did you go?		
Pharmacy	4	4.7
Private health sector	30	35.7
Public health institution	40	47.6
Family guidance clinic and CBRWAs	10	11.9
Could you tell me why you prefer to seek health care in this place? Indicate that all apply		
Effectiveness of treatment	9	10.7
Free or low cost of treatment	31	36.9
Proximity	29	34.5
Relative works there and Parents prefer the place	6	7.1
I prefer for confidentiality	6	7.1
Others	3	3.5
What are the main obstacles that prevent youth from getting clinical and counselling services in health institutions?		
Too far health institutions	34	8.6
Too expensive services	34	8.6
Poor handling and failure to keep confidentiality	140	35.5
Too much waiting time to get the service	81	20.6
The health institutions are inconvenient them	27	6.9
Shame to visit health institution	73	18.5
Others	5	1.3

5.6 PREFERENCES OF YOUTH FOR HEALTH SERVICE PROGRAM

Around 173(43.9%) of youth reported that health institution should have to be arranged within the existing health institution, but with special approach for youth. The majority 226(57.4%) of them had reported that they prefer health services for youth to be delivered on the special hours when other users were not around. One hundred fifty (38.1%) of them reported that they prefer any provider for reproductive health service while 100(25.4%) of them prefer youth provider of the same sex. About 196(49.7%) of them reported service fees for youth should be free and around half 198(50.3%) of them prefer health institution for youth should have to be located far from the residence. In contrast 116(29.4%) of them prefer health instiution for youth should be located near to the residence.

Table 10: Association of health service utilization of youth with socio demographic factors in Bule Hora town,May 2012.

VARIABLES	Visit health institution			
	Yes	No	OR (95% CI)	Adjusted OR 95%CI
Age				
15-19	22	153	**1.00**	1.00
20-24	62	157	.364(.213, .622)	.514(.278,.951)***
Sex				
Male	69	201	**1.00**	1.00
Female	15	109	2.495(1.362,4.568)	2.095(1.116,3.932)***
Occupation				
No occupation	0	3	**1.00**	
Some occupation	84	307	.011(.012,1.343)	
Education				
Illiterate	6	16	**1.00**	
Literate	78	294	1.413(.535, 3.732)	
Marital status				
Never married	56	254	**1.00**	1.00
Ever married	28	56	.441(.257, .755)	.695(.374,1.192)
Income				
<320	38	201	**1.00**	1.00
320-1000	5	20	.794(.282,2.235)	1.128(0.385,3.310)
1001-1500	15	54	.681(.349, 1.329)	1.031(0.496,2.142)
>1500	13	23	.334(.156, .718)	0.638(0.271,1.503)
No income	13	12	0.160(0.067, 0.384)	0.288(.112,.742)*
Living most of the time				
With both parents	27	128	**1.00**	
With single parent	6	31	1.090(.414, 2.868)	
With other family	51	151	.625(.370, 1.053)	
Father's education				
Illiterate	29	102	**1.00**	
Literate	55	208	1.075(.647,1.788)	
Mother's education				
Illiterate	32	138	**1.00**	
Literate	52	172	.767(.468,1.257)	

N.B: *=Pvalue<0.5 and ***=Pvalue<0.005

5.7 SOCIAL INFLUENCE ON YOUTH RH.

Out of the study subject 140(35.5%) of them had reported that there is pressure from their peers to have premarital sex. The majority, 331 (84%) of the study subjects mentioned that there is no support from their family members not to have premarital sex. An equal proportion, 111(28.2%) have reported that female adult and male adult family members would answer helpfully for sex related questions they raised respectively, while 84(21.3%) reported that they would turn me away without giving an answer and the rest reported in other negative ways. One hundred six (27%) of them had mentioned that it is shame or culturally not acceptable to raise such questions for adult family members. Two hundred eighty nine (73.3%) of the study subjects agreed that they have a lot of respect for their parents' ideas and opinions about sex and the majority 356(90.4%) of them agreed that their religion prohibits premarital sexual intercourse. There is a greater peers pressure on male youth than females youth to have sexual intercourse before marriage and male have a highr support than females (Table 11).

Table 11: Social influence on youth RH in Bule Hora town, May 2012.

VARIABLES	MALE		FEMALE		TOTAL	
	Freq	%	Freq	%	Freq	%
Is there a pressure from your friends so that you have sexual intercourse before marriage						
No pressure	164	41.6	90	22.8	254	64.4
A little to lot pressure	106	26.9	34	8.6	140	35.5
Do your family members support you to wait until marriage before having sexual intercourse?						
No support	224	56.8	107	27.2	331	84
A little to lot support	46	11.7	17	4.3	63	16
What is your both family member response when you asked them about SRH						
Would answer helpfully.	75	19	36	9.1	111	28.1
Would turn me away without giving answer	60	15.2	24	6.1	84	21.3
Would scold me	29	7.4	12	3.05	41	10.45
Not competent enough to answer	39	9.9	12	3.05	51	13
Others,	0	0.0	1	0.25	1	0.25
Shame to asked them	67	17	39	9.9	106	27
I have a lot of respect for my parent ideas and opinions about sex						
Agree	197	50	92	23.3	289	73.3
Not agree	46	11.7	18	4.6	64	16.3
Disagree	27	6.8	14	3.5	41	10.3
My religion prohibits premarital sexual intercourse						
Agree	241	61.2	115	29.2	356	90.4
Not agree	18	4.6	3	0.75	21	5.3
Disagree	11	2.8	6	1.5	17	4.3

DISCUSSION

A total of 422 households were visited in three kebeles of which only 394 (93.4%) agreed to be interviewed. That means there were around 6.6 non response rates because of the sensitivity of the questionnaieres. Out of the study subjects, more than half, 270(68.5%) of the respondents were male with female to male ratio of 0.46: 1. The mean (±SD) age of the study subjects was 20.2(± 2.63) years. Out of the total youth who were interviewed 310(78.7%) had never married, and 84 (21.3%) had married, of which 6(7.1%) of them had already divorced. Also in this study we found significant proportion of literacy, about 94.2% of youth to be literate. Many researches indicates that illiteracy is a personal tragedy and powerful force in preserving inequalities in several life patterns (53), improving school enrolment should be taken as one of the important steps in improving youth RH..

The study show that media was a major source of information on sexual maturation and HIV with 48% and 43.7% respectively. Similarly reports of most a youth RH studies in Ethiopia revealed that the most common source of information on HIV/ AIDS was the media (45). These indicate that awareness creation programs that would be designed have, as diversified channels as possible whereas the family involvement to educate their youth about RH issues were minimal. Studies also indicate that parents, in fact, do not talk to their children because they feel confused, ill informed, or embarrassed about these topics. Many adult relatives have failed to discuss sexual issues with themselves or that young people prefer not to discuss such issues with their adult relatives (38).

In this study over 47.5% of the respondents reported to have had sexual experience at least once prior to the time of the study. Among this, 49.2% of the sexually active respondents had reported that they had two or more lifetime sexual partners. This finding also similar with the other researche which has been done in East Gojjam (8).

This may be associated with their personal judgement and distorted perception of risks, as it was reported in one of recent study in Ethiopian (26). The mean age at first sexual debut among respondents was 18.3 and similar with the previous studies in Ethiopia (54, 21, and 28) and Uganda (25) except in East Gojjam (8).

In this study the proportion of sexually active males was persistently higher than female which was 78.6% and 21.4%. Similarly in previous several studies (21, 20, 22, 23, 24) the proportion of sexually active males was higher, ranging from 49% - 84% compared to that of females, 14 % - 48%. This proportional difference between a male and female is because female youth are less attractive for sexual relationships, due to fear of social stigma.

Logistic regression revealed that, the older age group (20-24) with (OR=0.261, 95% CI (0.147, 0.462), found to be low risk as compared to the younger age (15-19). This could be truly contributed to the fact that as younger age there is low risk perception, more sexual desire and sexual exposure, most probably having multi partners and also in many studies it was found that most young people have superficial knowledge of STDs including HIV/AIDS. Similarly, being married was found to be protective relative to the never married one with (OR=0.026, 95%CI (0.007, 0.092). This could be, because of the fact that more of the youth became to the marital lock at appropriate age. Moreover, high access to quality maternal health and comprehensive family planning contributes too much for those married not to engage in risk sexual activities.

Accordingly, female group (OR=3.305, 95% CI (1.768, 6.179), was independently and positively associated with risk sexual behaviours (activities). This means that, being females have more risk sexual activities than males of the same age. This could be true, because, females culturally suffer from early marriage, naturally from unwanted pregnancy, early child bearing, from abortion and its complications, in addition to STDs, not using condom, and multi partner, which also hold true to males.

In this study, the majority, about 97.2% who had knowledge on sexually transmitted diseases mentioned AIDS, gonorrhea and syphilis in order of importance. A research which have been done in east gojjam reported similar results too (8). This is because of the fact that there is adequate heath information dessimination in relation to STI including HIV/AIDS. Even if they are informed of STDs and HIV /AIDS, many young people may not protect themselves adequately. For example 41.7% of adolescents didn't know the person or the place to got condom (8). Youth's ignorance about sexual and reproductive behaviour is compounded by reluctance among parents and teachers to impart relevant information (8). This indicates that knowledge and awareness of STDs including AIDS and the relations between the two among the respondents are incomplete and insufficient to bring about the minimum behavioural changes needed.

Almost all of the participants in this study had mentioned that they have heard about HIV/AIDS, which is consistent with previous similar studies conducted in Ethiopia (20, 22, 34, and 55) and elsewhere (8). Unsafe sex, sharing infected syringes and needles and transfusion of infected blood in that order of importance were the three common means of HIV transmission stated by the participants which is exactly similar with the finding from eastern Gojjam and Bahir Dar (8, 21). This indicates that HIV was one of the government concern as it was divastating disease so that information reach to every individuals to the place were they live and work.

Although awareness that HIV/ AIDS are sexually transmitted has penetrated most segment of young population, misconception abound. For example, in this study 5.8% of those who have heard about HIV had mentioned mosquito bite was found to be means of HIV transmission which in favour of the above fact and is in agreement with the finding from Awassa (21). Also recent household survey in Kenya found that one third of respondents aged 15-19 years believed that HIV/AIDS could be transmitted via mosquito bites (30).

Moreover, only 63.2% of the participants agreed that a health looking person can have HIV and only 20.8% of them agreed that a person can get HIV the first time he or she had sex. All these indicate that though the majority has reported they had heard about the disease only a few of them properly understood it. Knowledge, however, may be necessary but insufficient requirement to reduce high-risk activities (20, 21), and information alone is insufficient to change risky behaviours among teens (31). For youth to reduce their risk behaviours, specifically to avoid HIV infection, they must feel personally vulnerable to contracting AIDS. Perception abound among youth that AIDS is a disease of prostitutes, foreigners and promiscuous people lead them to continue to feel that they themselves are invulnerable (56, 57).

When participants in this study were asked their believe that they have done something that has put them at risk of getting AIDS and their believe that they are at risk of getting the AIDS virus in the next 12 months, only small proportion, 20.3% and 23.4% of them replied affirmatively respectively. Similarly research which have been done in Gojjam show that only a very small proportion, 5% and 10% of them replied affirmatively respectively (8). These indicate that the subjects considered themselves low risk for HIV, unless curbed which will definitely have a negative impact on the efforts to be made to prevent and control this devastating disease, HIV.

The proportion of youth who have used condom during the first sexual intercourse was found to be lower than ever users. Out of the most important reasons mentioned for not using condom among the non- users, opposition of partners was mentioned by the majority. Many researches done in Ethiopia show similar result too (53). This is because their judgements on their personal risk. For youth to engage in sexual activity and to use contraceptives including condom may be based on their judgments about their personal risk. For girls, perception of pregnancy risk may serve as deterrent to sexual activity, especially if pregnancy is seen in negative terms.

As the same time, distorted perceptions of risk, like too young to become pregnant, incorrect knowledge on the fertile period, STDs and so on could lead to faulty decision making about sexual activity and to non-decision making about contraceptive and condom use (40).

In this study 28.4% did not know the person or place to get condom similarly In East Gojjam 41.7%(8) of out of school adolescents reported that they did not know a place or a person from where they can get condom, which indicates ignorance from both providers and youth themselves, which will definitely have a negative impact on youth sexual and RH. This shows that a greater attention has been given to educate this segment of population on relations of sexuality, contraception and the risk of pregnancy.

In this study the majority 88.8% of the sexually active had ever knew the ways of avoiding pregnancy. Condom, Pills and injectables in that order of importance were the three most commonly known methods. This is similar with the findings from Harar (35). Contraceptive knowledge in previous several studies ranged from 60% in Nigeria (38), and 66% in Harar (35) to 75% in Gondar (39). However, the proportion of youth who ever used modern contraceptives did not go parallel with their knowledge of methods, which is consistent with other several studies (20, 21 and 55). Though the discrepancy with knowledge is similar with other studies in Ethiopia (22, 55) and Nigeria (38), the proportion of ever users in this study were found to be lower. Concerning specific method use, condom, pills and injectables were reported to be the most popular methods ever used by the participants who were similar with findings of Gondar (39), Harar (22) and Nigeria (38) except pills had appeared first in all of the previous studies that can be explained by differences in composition of the study subjects. Among non contraceptive users desire to have children, have infrequent sex, partner opposed, were the three most common reasons recognized by sexually active participants. This is in agreement with the findings of studies conducted Harar (22) and that in Nigeria (38).

The study show that 74.8% of unmarried sexually active youth had reported having used modern contraceptive as opposed to only 61.9% of those married. Several studies in the sub-Saharan Africa had reported that sexually active, unmarried adolescents are more likely than married adolescents to be relying on modern contraception (35, 36, and 37). This may be due to the fact that married youth in most developing countries particularly in rural areas are not expected to use modern contraceptives but to bear a child as immediately as possible (35,37).

As revealed by logistic regression youth who live with both or single family have a low exposure to use modern contraceptive than youth who live with other group member with OR=0.311, 95% CI (.109, .885). This could be contributed to the fact that youth who live with both families have low risk of sexual activities because of the pressure and fear of family to engage in sex before marriage than those who live with other group members.

The mean ages of marriage as stated by the participants were 20.0 and 24.8 years for girls and boys respectively. Moreover, none of the participants agreed that a girl should marry before age 15, while only 2.8% of them agreed a girl should marry exactly at this age.Also a research which have been done in Harar, similarly reported that, the mean age of marriage was 22 and 27 years for females and males respectively (22). This is because as youths are the product of their communities' culture, this response is a clear reflection of the existing cultural practices of marriage in that community mostly, which should have to be supported positively but needs minimal attention from program manager to control trait that break community cultures.

There is also a low rate of divorce which was 7.1% at this significantly ages. It is very low when compared with researches which have been done in east Gojjam with a high divorce rate 54% (8).This result a little bit indicates the presence of social problems among youth in relation to their consensual unions, which, in fact have negative impact on their reproductive health.

Out of the study subjects only 12.2% of them knew that a woman is most likely to become pregnant halfway between two periods and greater proportion of female were knowledgeable than male which is lower than a similar report from adolescents in Addis Ababa (45) and It is also comparable with a study finding from southern Ethiopia (59). This is because youth who live in urban area have greater accessablity to service and information related to sexual and reproductive health than youth who live in rural area. In this study the median age at first pregnancy was 19.0 years similary the median age of at first pregnancy among women living in urban areas was 18.2. This proportion of age to marriage and pregnancy were promote WHO recommendation which may be due to higher school involvement of our study subjects, which also in agreement with other authors' finding that the less the educational level the higher the proportion, and the earlier the marriage and the reverse is true(60).

In this study around, 45% of sexually active female youth have reported that had ever been pregnant. Out of which 22.2% were among those who had never married and the mean age at first pregnancy is 18.7. This result seems similar with a finding from the study carried out in Southern Ethiopia with a mean age at first pregnancy 17.7 years (28).In addition only 20.8% of the participants agreed that girl could get pregnant the first time she has sex. These indicate that not only the sexually active but also those who were not are continuing to be exposed to unsafe sex and its negative outcomes.

Around 16.7% of all the pregnancies in this study were reported to be unwanted which is similar with a report from that in Harar (22). This is, also a signal to low level of contraceptive use, and unmet need among youth in this area. There is a natural link between youth health related behaviours and the peer relationships (60). As part of their decision making process youth often look to peers for clues regarding various aspects of sexual behaviour and to evaluate the degree to which their beliefs agree or disagree with group norms (60).

During multivariate analysis after controlling the possible confounding variables Being not married was found to be less risk of pregnancy than married one with OR=0.027, 95%CI (.002, .462). This could be because of the facts that married youth was not expected to use modern contraceptives so that they become pregnant and bear a child as immediately as possible than those never married. Also culturally pregnancy is not acceptable for never married youth female.

Only very small proportion, about 35.5% of youths in this study, reported that they had a peer pressure to have premarital sex, which is significantly higher than reports of other study among out of school adolescents in east Gojjam (23). This was one of the major reason that leads youths to ingage in risk sexual behaviours.The majority, 84% of the study subjects mentioned that there is no support from their family members not to have premarital sex. Similarly, 31.7% have reported that female adult and male adult family members would scold them or turn them away with out giving answer for sex related questions they raised while 27% of them had mentioned that it is shame or culturally not acceptable to raise such questions for adult family members. Studies also indicate that parents, in fact, do not talk to their children because they feel confused, ill informed, or embarrassed about these topics. Many adult relatives have failed to discuss sexual issues with themselves or that young people prefer not to discuss such issues with their adult relatives (38).

In this study only about 21.1% of the respondents had visited health institutions within the last three months prior to the time of the study. Out of these only, 47.6% of them had visited public health institutions. In most developing countries there are several barriers to utilization of health service by youth, of which operational and social factors to be the major ones (44,47). In others, like India, very little is known about youth's utilization of reproductive health services and the constraints, both socio cultural and program related, youth face in acquiring services (8).

Poor handling and scolding by health workers, too much waiting time to get the service, shame, lack of privacy and confidentiality, too expensive services, and far health institutions, in that order of importance were reported to be the major problems that prevent youth from visiting health institutions. Similarly A study conducted among school adolescents in Addis Ababa had revealed that a significant number of students reported that reproductive health services are not affordable, accessible and/ or acceptable to them (49).

Moreover, about 49.7% and 50.3% reported that, they prefer health service fees for youth to be free and health institutions to be located far from their residence respectively. This signals that policy and decision makers should revise the existing health programs as far as the cost reproductive health service is considered. Far location of the heath institution indicated that there is socio cultural and family influence which discourages them not to use RH service at this specific age.

In addition, those who know specific health services and methods may not use them as a result of other reasons, one of which could be services may not be available and/ or accessible to them. This implies that in addition to improving knowledge on reproductive health, there should be appropriate and feasible services that could reach youth at the grass root level. There were similar recommendations from previous studies in Ethiopia (20, 21)

Logistic regression analysis was employed on possible explanatory variables over health service utilization to establish an association. Accordingly the older group (20-24) was less at service utilization compared to the younger age (15-19). This could be contributed to the fact that as age increased there is more physical maturity and less sexual desire and sexual exposure, good knowledge, positive personal judgement on risk sexual behaviors and most probably less exposure for illness. Also in this study most of the Youngers visit health institution than olders.

As it was indicated above youth who had no income was found to be less at service utilization when compared to the one who had income. This could be true and clear, because, of the fact that income always go parallel with the personal needs as explained by many scholars, as income increase the persons physical and physiologic needs increase. The one who didn't have any income can not visit health institution as it need service charge and live living with their disease and disablity.

Sex (female) (OR=2.095 95%CI (1.116, 3.932), was found to be independently and positively associated with service utilization. Accordingly female was found to be high at service utilization when compared to the male one. As it was indicated in the previous association being females have more risk sexual activities than males of the same age. Like wise females culturally suffer from early marriage, naturally from unwanted pregnancy, early child bearing, from abortion and its complications, in addition to STDs, not using condom, and multi partner. Due to this all problem females have repeatedly utilize the service than males.

STRENGTHS AND LIMITATIONS OF THE STUDY

STRENGTHS

- This study had tried to assess and compare reproductive health needs and service utilization among youth in Bule Hora town.
- Making community based study design for youth in whole kebeles in this study has paramount importance in fulfilling the objective of the study.
- In addition, the large sample size represented in the study has helped to determine significant differences between the two study groups (male and female).
- The study tried to address most of the SRH issues as a whole rather than a single SRH problem.
- The study tried to see the SRH needs of youth from their knowledge, and behaviour, the demand and preference from youth' side.
- Multivariate analysis was used to control the possible confounding effect of covariates.

LIMITATIONS

- Though strict procedures were followed to identify the participants, some sort of error in selecting the individuals may not be excluded.
- Since sexual behavior is personally sensitive issue, determining its magnitude and risky behaviors associated with it among youth especially the unmarried ones in such face-to-face interview is difficult.
- Hence, even though we have tried to minimize it, some sort of desirability bias may not be eliminated.

CONCLUSIONS

- There is a lack of information and knowledge among youth on sexuality contraception, and HIV/AIDS and several misconceptions abound.
- Mass media is dominant source of information for youth on selected sexual and reproductive health issues whereas the family involvement to educate their youth about RH issues was very minimal.
- A substantial number of youth were found to be sexually active. Considerable proportion of them exhibited high risk sexual and reproductive behaviours that predisposed them for reproductive health problems. The risk behaviours include premarital sex, multiple sexual partners, and early sexual activity.
- Though most participants found to be involved in risky sexual behaviors, the great majority of them considered themselves low risk for HIV.
- Females were relatively more at risk sexual activities when compared to males of the same age.
- Youth Sexual and reproductive health knowledge can not go parallel with their attitude and practice.
- There is some range of misconception about mode of transmission of HIV and STIs.
- The proportion of youth who have used condom and contraceptive during the first sexual intercourse was found to be lower than ever users.
- Younger age group was found to be more at risk as compared to the older age.
- High figure of the youth not served in the existing health institution for their reproductive health need, even those who used to be served, they claimed that the existing health institutions were inconvenient and unattractive.

- The majority of the respondents preferred the need for rearrangement of youth reproductive health institutions separately and also to be served by young and the same sex health providers.
- Around half of them reported service fees for youth should be free and prefer health institution for youth should have to be located far from the residence.
- The majority of the youth mentioned that there is no support from their family members not to have premarital sex and also reported that female adult and male adult family members would scold them or turn them away with out giving answer for sex related questions they raised.
- Moreover, there is some sorts of socio cultural factors affecting youth reproductive health such as participants' general social characteristics (risk sexual behaviour, lack of support, peers pressure, inapproprate service utilization and family negligence).

RECOMMENDATION

- Strategies should be deleloped to enhance; channels that will be used to disseminate sexual and RH information as diversified as possible. In addition to media there should be other means of disseminating youth sexual and RH information for the this areas like involving peer communicators and educators, integrated health education campaigns and mass mobilization.
- Design programs that comprise both promotional activities and feasible sexual and RH services that could serve the hard to reach youth.
- To increase awareness and knowledge, carefully worded, non - threatening to the Cultural norms and simple messages on reproductive physiology, sexuality, STD and HIV/AIDS, condom and contraception should be developed and disseminated to the public in general and to youths in particular through community based approaches like, training and improving the capacity of CBRHAs, strengthening it through backup and outreach services by health workers and integration with kebele AIDS committees.
- Programs on youth RH should be individualized based on gender differences.
- Sensitization and orientation for health workers at different levels so that they understand and provide appropriate RH services to youth.
- CARE Ethiopia should have to expand its today's youth health coverage both geographically and in the type of programs, and further should have to strength already launched urban activities.
- Finally, what more important is building strong social support for the youth, from youth, from general community, particularly families, religious leaders, school teachers, health provides and administrative bodies. Orienting these groups on youth specific reproductive problems and persuading them to actively participate in the intervention programs and approve the sexual needs and services as a social norm.

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ANNEX: 1 CONSENT FORM

My Name is _____. I came from _____. I am a member of the research team of Addis Ababa University. I would like to tell you that you and I would have a short discussion concerning this study. Before we directly go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and tell me your opinion whether you agree or disagree to participate in the study.

The purpose of this study is to assess the reproductive health needs and service utilization of youth aged15-24 living in this and the neighbouring kebeles. Among your peers, you are selected to be one of the participants in the study. The study will be conducted through interviews. We are asking you for a little of your time, about forty five minutes, to help in this study. At the end, it is hoped that the information you give us could help to design appropriate reproductive health services for a youth. The interview involves intimate and private life questions. So private setting is needed in that you and the interviewer will carry out the interview. We would like to assure you that this privacy should strictly be secured throughout. All your information will be numbered and your name will not be used. Your answers to any of the questions will not be given to anyone else and no reports of the study will ever identify you. If a report of results is published, only information about the total group will appear. The interview is voluntary. Your participation/ non-participation, or refusal to answer questions will have no effect now or in the future on services that you or any member of your family may receive from health service providers

Are you willing to participate in this study?

[ ] Yes

[ ] No

Identification

Zone---------- Woreda----------Kebele----------House No---------

Date of interview -----day-----month-----year

Name and signature of Interviewer----------

ANNEX: 2 QUESTIONNAIRES ON REPRODUCTIVE HEALTH NEEDS AND SERVICE UTILIZATION OF YOUTH AGED 15-24

Respondent code number_____

Part One: **Socio-demographic variables**

No	**Questions**	**Alternative Choices for Responses**	code
1	Sex of Respondent	1. Male 2. Female	
2	Religion	1. Orthodox 2. Protestant 3. Catholic 4. Muslim 5. Others, specify ----------	
3	Age (enter number)	---------- Years	
4	Ethnic Group	1. Amhara 5.Gedio 2. gurage 6.Burgi 3. Tigrie 4. Oromo 7.Others, Specify) ----------	
5	Marital status	1. Never Married 2.Currently Married 3.Divorced 4. Widowed 5. Separated	
6	Education status	1. Literate 2. Illiterate **skip to Q 8**	
7	Level of education for those who are literate (Grades)	Read and write --------Last grade or level of education completed.	
8	What is your occupation?	1. Student 2. Daily laborer 3.Maid servant 4. Farmer 5. Civil Servant 6.Employed in private sector. 7. Have Private business, mention------ 8. Others (specify) ----------	
9	Your monthly income (enter number)	--------- Birr 2. No Income	

10	With whom do you live most of the time?	1. With father and mother 2. With father only 3. With mother only 4. With relatives 5. With friends/peers. 6. With partner/ husband or wife. 7.With boy / girl friend 8. Alone 9. Others specify	
11	What is your father's occupation?	1. No occupation 2. Daily laborer 3. Civil servant 4. Farmer 5. Employed in private sector 6.Has private business, mention 7. Others (specify)----------	
12	What is your mother's occupation?	1. Housewife 2. Daily laborer 3. Maid servant 4. Farmer 5. Civil Servant 6. Employed in private sector. 7. Has private business mention 8. Others (specify) ----------	
13	In your opinion which of the following shows your families' economic status?	1. Rich 2. Medium 3. Poor 4.Do not know	
14	Your father's educational status	1. Illiterate 2. Read and write --------Last grade or level of education completed	
15	Your mother's educational status	1. Illiterate 2. Read and write ---------Last grade or level of education completed.	

***Part Two* Concerning Reproductive Health Information (for the following three questions indicate the three most important responses made by the respondent sequentially)**			
16	Which is your major source of information concerning sexual maturation?	1. My parents 2.Friends /peers 3. Mass media 4. Posters and pamphlets 5. Partner/ husband wife 6. CBRHAs 7. Religious leaders 8. Health professionals 9 Nobody 10. Others, specify----------	
17	If you wanted to know more about ways to avoid pregnancy, whom would you talk to? For females only.	1.Father 2. Mother 3. Friend/peers 4.Partner husband / wife 5. Health professionals 6.Religious leaders 7.CBRHAs 8. No body. 9. Others, specify 10.Do not know	
18	Which is your major source of information concerning STDs and HIV / AIDS?	1. My parents 2. Friends/ peers 3. Mass media 4. Posters and pamphlets 5. CBRHAs 6. Health workers 7. Religious leaders 8. Partner/ husband-wife 9. School 10. Neighbor 11. Others, specify----------	

Part three **concerning sexuality, pregnancy and contraception**			
3.1 Concerning Reproductive health practices			
19	Have you ever had sexual intercourse?	1. Yes 2. No →**Skip to Q 45**	
20	If yes, at what age did you first have sexual intercourse? (enter number)	-------- ---Age in years 1. Don't know/ remember	
21	Why did you decide to have sexual intercourse the first time? (More than one answer is possible)	Yes No 1. Fall in love. 1 2 2 Have desire. 1 2 3. Wanted to get married. 1 2 4. I get married 1 2 5 Forced to do so. 1 2 6. To get money and other gifts. 1 2 7. Friends doing it 1 2 8. Others, specify 9. Don' t remember.	
22	With how many partners have you ever had sexual intercourse?	----------Number of partners 1.Don't know / remember	
23	During the last six months, have you had sexual intercourse?	1. Yes 2. No →**Skip to Q 25**	
24	With how many partners have you had sexual intercourse within the last six months? (Enter number)	--------- Number of sexual partners 1. Don't know /remember	
25	Have you ever had sexual intercourse with commercial sex? Workers? (Male respondents only)	1. Yes 2. No	
26	Have you ever used modern contraceptives?	1.Yes 2. No→**Skip to Q 28**	
27	If yes what type? (Probe and indicate that all apply)	1 Oral contraceptive pills. 2. Condom 3. Injectables 4. IUDs 5. Sterilization 6. Norplant 7. Others, specify----------	
28	If no, what were the reasons? (More than one answer is possible)	1. I am unmarried and not sexually active. 2. I have infrequent sex 3. Want to have children 4. Husband/partner opposed 5. Religious Prohibition 6. Lack of knowledge about contraceptives.	

		7. Fear of side effects 8. Difficult to obtain contraceptives 9. Method was expensive 10. Too far to get contraceptives 11.Others, specify----------	
29	Did you use contraceptive the first time you had sexual intercourse?	1. Yes →**Skip to Q 31** 2. No	
30	If no, why not? (more than one answer is possible)	1. Did not believe pregnancy was possible 2. Sex was un planned 3. Did not know any a method 4. Fear of the side effect of a method 5. Method not available 6. Method expensive 7.Partner opposed 8. Others specify ----------	
31	Have you ever had STI, that is, genital ulcer abnormal genital discharge or genital swelling?	1. Yes 2. No. →**Skip to Q** 33 Don't know →**Skip to Q 33**	
32	If yes what did you, do first when you had STI?	1.I did nothing 2. Self treatment 3. Went to traditional healer 4. Went to pharmacy, 5. Went to public health institution 6 Went to local healer 7 Went to private health institution 8. Others, specify ----------	
33	Have you ever used condom?	1. Yes 2. No	
34	Did you or your partner use condom the first time you had sexual intercourse?	1. Yes→**Skip to Q 36** 2. No	
35	If no, please give the reasons (indicate all answers that are mentioned)	1.Not available 2. Too expensive 3.Partner objected 4. We don't like them 5.Used other contraceptives 6.Did not think it was necessary 7.Did not think of it 8. Others, specify----------	
Ask the following questions (36- 44) for females only			
36	Have you ever been pregnant?	1 .Yes 2. No →**Skip to Q 45**	
37	If yes, how many times have you been pregnant? (Enter number)	---------- Times	

38	How old were you when you first became pregnant? (Enter number)	Age ----------years 1. Don't know/ remember	
39	If you have been pregnant, were all your pregnancies wanted?	1.Yes 2. No	
40	If no, which pregnancy was unwanted?	1.The first 2. The second 3. The third 4. The fourth 5. All	
41	Have you ever had abortion?	1 yes 2. No →**Skip to Q 45**	
42	If yes, how many times did you have abortion?	_____ Times	
43	If there was abortion, whom did you first discuss the issue with?	1. My partner/husband- 2. My friends peers 3. My parents (mother, father, brother, and sister) 4. Other adult member in the family 5 Health workers 6. Traditional healers 7. For an abortionist 8. Others, specify ----------	
44	Where did you abort?	1. At public health institution 2. At private clinic 3. At abortionist's house 4. I have induced it myself	
3.2 The following questions are concerning attitudes and believes towards reproductive health			
45	Using condom is a sign of not trusting your partner	1. Agree 2. Not sure 3. Disagree	
46	A boy should have sex before he gets married.	1. Agree 2. Not sure 3. Disagree	
47	Discussing condom or contraceptive with young people promotes promiscuity	1. Agree 2. Not sure 3. Disagree	
48	Do you believe you have done anything that may have put you at risk of getting AIDS virus?	1. Yes 2. No 3. Don't know	
49	Do you think you are at risk of getting the AIDS virus in the next 12 months?	1. Yes 2. No 3. Don't know	

50	In your opinion, what is the ideal age for a girl to marry?	Age _____ Years 1. Don't know	
51	In your opinion, what is the ideal age for boy to marry?	Age_____ years 1.Don't know	
52	Do you think that it is easy or difficult for young of your age to obtain contraceptive or condoms?	1. Easy **Skip to Q 54** 2. Difficult 3. Don't know Skip **to Q 54**	
53	If difficult, why is it difficult? (Probe and indicate one for all that apply two for those not mentioned)	Yes No 1. Lack of money to buy. 2. Difficult to find. 3. Provider disapproves. 4.Parents disapprove. 5. Distribution places are Inconvenient for them 6. Too far to find 7. Expensive to buy 8.Others specify. -------	
How confident are you that you would be able to:			
54	Have a sexual relation with only one person	1. Definitely could 2. Unsure/ does not know. 3. Definitely could not	
55	Abstain from sex for the next 12 months (For those sexually inactive)	1. Definitely could 2. Unsure/ don't know 3. Definitely could not	
3.3 The following questions are concerning knowledge on reproductive health			
56	During which part of the menstrual cycle dose a woman have the greatest chance of becoming pregnant.	1.During her period 2.Right after period is ended 3.Just before her period begins 4. In the middle of her cycle 5.The same throughout 6. Others, specify---------- 7. Don't know	
57	Do you know any ways to avoid getting pregnant?	1. Yes 2. No. → **Skip to Q 59** 3. Do not know →**Skip to Q 59**	

58	If yes, what are the ways to avoid getting pregnant?	1. Oral contraceptive pills 2. Using condoms.. 3. Injectables. 4. Norplant. 5. IUDs. 6.Sterilization. 6.Abstinence 7. Withdrawal. 8.Washing the genitalia.after intercourse 9. Intercourse in the up right position 10. Safe period/abstinence 11. Others, specify-------	
59	Do you know any diseases a person can get through sexual intercourse?	1.Yes 2. No. →**Skip to Q 61** Do not know→**Skip to Q 61**	
60	If yes, which diseases do you know about? (Probe and indicate that all apply)	Yes No 1. Gonorrhea. 1 2 2. HIV/ AIDS. 1 2 3. Chancroid. 1 2 4. Syphilis. 1 2 5. Lymphogranuloma Venereun 1 2 6.Others, specify --------	
61	A girl can get pregnant the first time she had sex.	1. Agree 2. Not sure 3. Disagree	
62	A healthy looking person can have HIV	1. Agree 2. Not sure 3. Disagree	
63	A person can get HIV the first time he or she has sex.	1. Agree 2. Not sure 3. Disagree	
64	Is there anything a person can do to avoid getting STIs and HIV/AIDS?	1. Yes 2. No. →**Skip to Q 66** 3. Don't know →**Skip to Q 66**	

65	If yes, what are they? (Probe and indicate that all apply)	Yes No 1. Sexual abstinence. 1 2 2. Avoid casual sex. 1 2 3. Remain faithful to a partner 1 2 4. Use condoms in every act of Sexual Intercourse. 1 2 5. Avoid sex with CSWs. 1 2 6. Others specify ----------.	
66	Do you know any place or person from where you can obtain male condoms?	1. Yes 2. No→ **Skip to Q 68**	

67	Where would you go to get a condom? (Probe and indicate that all apply)	1.Shop 2.Pharmcy 3.Clinic 4. Health center 5.Hospital 6. Family planning clinic 7. Bar / hotel 8. CBRHAs 9. I do not want condom 88. Others, specify----------	
68	What dose safe sexes mean to you? (Probe and indicate all that apply)	1. Abstinence from sexual intercourse 2. Using condom in every sexual intercourse 3. Avoiding multiple sex partners 4. Avoiding sex with prostitutes 5. Having sex with a single faithful partner 6. Others, specify----------	
69	Have you heard about a disease called HIV /AIDS?	1. Yes 2 No→**Skip to Q 71**	
70	Please mention all the ways you believe a person can get AIDS (indicate one for that all apply and two for those not mentioned)	Yes No 1. Unsafe sexual intercourse. 1 2 2. Sharing needles and syringes. 1 2 3. Blood transfusion. 1 2 4. During pregnancy and childbirth.1 2 5. Mosquito and other insect bite. 1 2 6. Through breast milk. 1 2 7. Causal contact with a person (hand Shaking, sharing food, coughing etc 1 2 8.Others specify----------.	
***Part four* Concerning Social Influences on Reproductive Health Needs of youth**			
71	Is there a pressure from your friends so that you have sexual intercourse before marriage?	1. No pressure 2. A little pressure 3. A moderate pressure 4. A lot of pressures.	
72	Do your family members support you to wait until marriage before having sexual intercourse?	1. No support 2. A little support 3.A moderate support 4.A lot of support.	
If you ask your father, mother or other adult family member sex related questions like menstruation, pregnancy, and sexual intercourse what would be his or her response.			
73	Mother or other adult female family member	1. Would answer helpfully. 2. Would turn me away without giving an answer 3. Would scold me 4. Not competent enough to answer 5. Others, specify 6. Don't know.	

74	Father or other adult male family member	1. Would answer helpfully 2. Would turn me away without giving an answer 3. Would scold me 4. Not competent enough to answer 5. Others specify 6. Don't know.	
For the next two questions indicate whether you agree or disagree with the statement			
75	I have a lot of respect for my parents ideas and opinions about sex	1. Agree 2. Not sure 3. Disagree.	
76	My religion prohibits premarital sexual intercourse	1. Agree 2. Not sure 3. Disagree	
P*art Five* Concerning Health Service Utilization and Preferences			
77	Have you visited a health institution In the last three months?	1. Yes 2. No →**Skip to Q 81**	
78	If yes, what was the reason for your visit?	1. I had STI. 2. For abortion. 3. For delivery. 4. For antenatal care. 5. To get oral contraceptives. 6. To get condom. 7. For counselling. 8. Others specify-------.	
79	If your have visited a health institution, where did you go for the first time, second time and the third time? Indicate the three most important answers in order of importance.	1. Pharmacy 2. Private health sector 3. Public health institution. 4. Family Guidance clinic 5. Traditional healer in the neighbor 6. CBRHAs7. Others specify ---------	
80	Could you tell me why you prefer to seek health care in this place? Indicate that all apply	1. Effectiveness of treatment 2. Free treatment 3 Low cost of treatment 4. Proximity 5. Relative works there 6. I prefer for confidentiality 7. Parents prefer the place 8. Others, specify----------	
81	What are the main obstacles that prevent youth from getting clinical and counselling services in health institutions?	1. Too far health institutions 2. Too expensive services 3. Providers fail to keep privacy and confidentiality 4. Poor handling and scolding by health workers 5.Too much waiting time to get the	

		service 6.The health institutions are inconvenient them 7.Others, specify---------- 8. Don't know	
Concerning preferences of youth for health service program ***For questions (82-86) read the alternative responses for the respondent before you ask him / her to answer***			
82	How should reproductive health services for youth be arranged in the future?	1. Within the existing health institution, but with special approach for adolescents 2. Within existing health institutions but in separate rooms for adolescents. 3. In health institution that is specially arranged for adolescents only 4. Others, specify----------	
83	Which time of the day do you think is Convenient for youth health services?	1. During the usual health institutions' working hours 2. On the special hours when other users are not around, specify ------- 3. Others, specify---------- 4. Do not know	
84	Who would you prefer the health provider be for youth reproductive health services?	1. Young provide of the same sex 2. Young provider of any sex 3. Adult provider of the same sex 4. Adult provider of any sex 5. Any provider 6. Do not know	
85	What is your preference concerning health service fees for youth?	1. At the usual rate 2. With special discount for adolescents 3. Free for adolescents 4. Don't know.	
86	Where do you prefer the health services be located for youth?	1. Near their residence 2 .Far away from their residence 3. Others, specify---------- 4. Don't know.	

Thank you for your serenity!!!!

የጥናቱ ርእስ፡ – <u>የወጣቶች ስነ –ተዋልዶ ጠፍ ፈላጎት እና አገልግሎት</u>

ጥናቱ ያጠናው ስም አቶ **ይመር ሆጠሄ**

የአማከረው ስም አቶ **ዮሴፍ ጽጌ**

- ስሜ ይመር ሆጠሄ ይባላል፡፡የምሰራው በአ/አ ዮኒቨርሲቲ ጥናትና ምርምር አባል በመሆን ነው፡ በስነ –ተዋልዶ ጠፍ ላይ በሚደረገው ጥናት ተሳታፊ እንዲሆን ተጋብዘወል፡፡ ለመሳተፍ ከመመሰኖ በፊት ጥናት ለምን እንደሚደረግ ማወቅ በጣም አስፈላጊ ነው፡ እባኮዎን ጊዜ ወስደው ቀጣዩን መጀ ያድምጠኝ ፡፡ በሚጨሻም ለመሳተፍ መመስኑን እና አለመመሰኑን እንድህም ግልጽ ያልሆነ ነገር አለ ወይም ተጨማሪ መጀ ከፈለጉ በነፃነት ለማጠየቅ ይቻላል፡፡
- የዚህ ጥናት ዋና አላማ አጠቃለይ የወጣቶች ስለ – ተዋልዶ ጠፍ ፈላጎት እና አገልግሎት በቡሌ ሆራ ከተማ ለመዳሰስ ነው፡ ለዚህም ነው በጥናቱ ላይ እንድሳተፉ ከጓደኛዎ መሪል እርሶዎ የተጋበዙት፡፡ ይህ ጥናት የምካሄዳው በጥያቄ መልክ ነው፡ ወደ 45 ያህል ደቂቃ ልወስድቡን ስለምችል ጊዜ ሰጥታቹኝ እንድታዳምጡኝ በትህትና እጠይቃለሁ፡፡በሚጨሻም የምትሰጠኝ እንፎርማሽን አሰፈላጊወን የስነ – ተዋልዶ ጠፍ አገልግሎት ለህብረተሰቡ እንደዘጋጅ ልረዳ ይችላል፡፡ በጥናቱ ለሚጠየቁት ጥያቄዎች የሚጠት ማንኛውም መጀም ሚጥራዊነቱ የተጠበቀ ነው፡ የእርስዋን ስምና ማንነት የሚልጽ መጀም በጥናቱ ስርጭት ወቅት ለማንም አይገለጽም፡
- በዚህ ጥናት ላይ ያለዎች ተሳተፎ ሙሉ በሙሉ በእርስዎ ፈቃደኝነት ላይ የተመሰረተ ነው፡ በጥናቱ ላይ ያለመሳተፍ ወይም መጠይቁን መመላት ከጀመሩ በኋላ ሜጅረጥ ከፈለጉ ያለምንም ቅደመ ሁኔታ ሜቲረጥ ይችላሉ፡፡ ሆኖም ግን እርስዎ የሚሰጡ መጀ ለጥናቱ ከፍተኛ አስተዋፅኦ እንዳለው ልናሳወቆት እንወዳለን፡፡ በጥናቱ ላይ ላለመሳተፍ ቢወስኑ ወሳኔዎ ከማንኛውም መንግታዊ ሆነ መንግታዊ ካልሆነ ድርጅት በሚገኙት የጠፍ አገልግሎት ላይ ምንም አይነት አሉታዊ ተዕእኖ አይኖረወም፡

እርስዎም በጥናቱ ለመሣተፍ ተስማምተዋል?

( ) አዎ

( ) አይደለም

የግል መረጃ

ዞን .....ወረዳ .....ቀበሌ .....ቤ.ቁ .....
ቀን.....ወር..... ዓ.ም.....
የጠየቂው ስምና ፊርማ.....

ክፍል 1 የግለሰቡ መረጃ

ተ.ቁ	ጥያቄ	አማራጭ ምላሾች	ይለፉ
1	ፆታ	1. ወንድ 2. ሴት	
2	ሀይማኖትህ/ሽ ምንድነው	1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. ካቶልክ 4. መስልም 5.ሌላ.....	
3	ዕድሜህ/ሽ ስንት ነው	..... ዓመት	
4	ብሄረህ/ሽ ምንድነው	1. አማራ 2. ኩራጌ 3. ትግሬ 4. ኦሮሞ 5. ገዶኦ 6. ቡረጅ 7. ሌላ.....	
5	በአሁኑ ጊዜ የጋብቻህ/ሽ ሁኔታ	1. በጫውሽ ያላገባ/ች 2. ያገባ/ች 3. ከባለቤቱ/ቷ ጋር አብሮ የሚኖሩ 4. ከባለቤቱ/ቷ የተፋታች	
6	የትምህርት ደረጃህ/ሽ	1. የተማረ 2. ያልተማረ (ወደ ጥ.ቁ8 ይለፉ)	
7	የትምህርት ደረጃህ/ሽ ለተማረው /ክፍል/	ማንቤብ እና መጻፍ ..... የሚጨርሻው ክፍል አሁን ያለበት	
8	ሥራህ /ሽ ምንድነው	1. ተማሪ 2. የቀን ሠራተኛ 3. የቤት ሠራተኛ 4. ገበሬ 5. የመንግስት ሠራተኛ 6. የግል ተቀጣሪ 7. የግል ስራ ያለው ይግለፁ.....	

ተ.ቁ	ጥያቄ	አማራጭ ምላሾች	ይለፉ
9	ወርሃዊ ገቢህ/ሽ	1. ..... ብር 2. ገቢ የለኝም	
10	ብዙን ጊዜ ከማን ጋር ትኖራለህ/ሽ	1. ከአባት ና እናት 2. ከአባቴ ጋር ብቻ 3. ከእናቴ ጋር ብቻ 4.ከዘመድ ጋር 5. ከቅርብ ጓዳኛ ጋር 6. ከባለቤቴ ጋር 7. ከጓዳኛዬ ጋር 8. ብቻዬን 9. ሌላ.....	
11	የአባትህ/ሽ ሥራ ምንድ ነው ?	1. ሥራ የለውም 2. የቀን ሠራተኛ 3. የመንግስት ሠራተኛ 4. ገበሬ 5. የግል ድርጅት ተቀጣሪ 6.የግል ስራ አለው ይግለው..... 7. ሌላ	
12	የእናትህ/ሽ ሥራ ምንድ ነው?	1. የቤት እመቤት 2. የቀን ሠራተኛ 3. የቤት ሠራተኛ 4. ገበሬ 5. የመንግስት ሠራተኛ 6. የግል ድርጅት ተቀጣሪ 7. የግል ስራ አላት ይገለጽ..... 8.ሌላ.....	
13	የቤተሰቦችህ/ሽ የኢኖሚ ደረጃ ምን ላይ ነው ብለህ ታስባለህ	1. ሀብታም 2. መካከለኛ 3. ደሃ 4. አላወቅም	
14	የአባትህ/ሽ የት/ት ደረጃ	1. ያልተማረ 2. መፍናማንበብ የሚችል .....የመጨረሻ የት/ት ደረጃ	
15	የእናትህ/ሽ የት/ት ደረጃ	1. ያልተማረች 2. መፍና ማንበብ የምትችል .....የመጨረሻ የት/ት ደረጃ	

ክፍል ሁለት /2/ የስነ – ተዋልዶ ጠፍ ሚጃ (Information) ሶስት ሜሌስ በቀደም ተከተል መሞላስ ጥችላሉ

16	ብዙን ጊዜ የስነ – ተዋልዶ ጠፍ ሚዳ ከምን ታገኛለህ/ሽ/	1. ከቤተሰቦቼ 2. ከቅርብ ጓደኛዬ 3. ከሚስ ሜዲያ 4. ኘስተር እና በራሪ ወረቀት 5. ከባለቤቴ 6. ከህብረተሰብ ስነ – ተወልዶ ጠፍ ድረጅት 7. ከሀይማኖት አባቶች 8. ከጠፍ ባለሞያ 9. ከማንም 10. ለላ…….	
17	ለሴቶች ብቻ የእርግዝና መከለከያ መንገድ ሞመቅ ከፈለግሽ ከማን ጋር ትነጋገሪያለሽ	1. ከአባቴ ጋር 2. ከእናቴ ጋር 3. ከቅርብ ጋደኛ 4. ከባለቤቴ 5. ከጠፍ ባለሞያ 6. ከሀይማኖት አባቶች 7. ከህብረተሰብ ስነ – ተዋልዶ ጠፍ ድረጅት ጋር 8. ከማንም ጋር 9. ስለ …… 10. አለወቅም	
18	ስለ አባለዝረ በሽታና ሚጃ ብዙን ጊዜ ከየት ታገኛለህ/ሽ	1. ከቤተሰቦቼ 2. ከቅርብ ጋደኛ 3. ሚስ ሜዲያ 4. ኘስተር እና በራሪ ወረቀት 5. ከህብረተሰብ ስነ – ተዋል 6. ከጠፍ ባለሞያ 7. ከሀይማኖት አባቶች 8. ከባለቤቴ 9. ከት/ት 10. ከጉሮቢት 11. ስለ ……..	

ክፍል 3 የግብረ ስጋ ግንኙነት ልምድ፣ እርግዝና እና ወልድ መቆጣጠሪያ

19	የግብር ስጋ ግንኙነት አድረገህ/ሽ/ ታውቃለህ/ሽ/?	1. አዎ 2. አለደረኩም / ወደ ቁጥር 45 ይለ/	
20	አዎ ካልክ/ሽ በስንት እድሜህ/ሽወያደረከው/ሽው?	..... አመት 1. አለወቅም	
21	ለመጀመሪያ ጊዜ የግብረስጋ ገንኙነት ለማድረግ ለምን ወስንሽ? / ከአንደ በላይ ሚልስ ይቻላል/	አዎን አይደለም 1. በፍቅር ስለወደኩ 1 2 2. ፍላጉት ስላለኝ 1 2 3. ለማባት ስለምፈልግ 1 2 4. ስላገባሁኝ 1 2 5. ስለተገደደኩኝ 6. ብር እና ሌላ ጥቅም ለማገኘት 1 2 7. ጓደኞቼ ስለሚደርጉት 1 2 8. ሌላ ..... 9. አላስተወስም	
22	እስከ አሁን ከስንት ሰው ጋር የግብረ ስጋ ግኙኝነት አረክ/ሽ	..... የጋደኛ ብዛት 1. አላስታወስም	
23	በለፉት ስድስት ወር ወስጥ የግብረ ስጋ ግኙኝነት አድርገሃል/ሻል?	1. አዎ 2. አላደረኩም /ወደ ጥ.ቁ 25 ይለፉ/	
24	ባለፉት ስድስት ወር ወስጥ ከስንት ሰው ጋር የግብረ ስጋ ግንኙነት አደርክ/ሽ?	..... የሰው ብዛት 1. አላስታወስም	
25	**<u>ለወንድ በቻ</u>** ከሰቴኛ አዳሪ ጋር የግብረስጋ ግንኙት አድርገህ ታውቃለህ	1. አዎ 2. አላወቅም	
26	ዘመናዊ የወልድ መቆጣጠሪያ ተጠቅመህ/ሽ ታውቅያለ/ሽ?	1. አዎ 2. አላወቅም/አልተጠቀምኩም/ /ወደ ጥ.ቁ 28 ይለፉ /	
27	አዎን ካለክ/ሽ ምን አይነት ተጠቀምክ/ሽ?	1. የምወጠወን የወልድ መቆጣጠሪያ 2. ኮንዶም 3. የሚወጋወን የወልድ መቆጣጠሪያ 4. ሉኘ 5. የምቋጠረወን የወልድ መቆጣጠሪያ 6. በተከሻ የምቀበረወን 7. ሌላ	
28	አልተጠቀምኩም ካልክ/ሽ ምክንያቱ ምን ይሆን / ከአንድ በላይ መልስ ይቻላል/	1. አላገባሁም እና ለግብረ ስጋ ግንኙት አልደረስኩም 2. ወስን የግብረ ስጋ ግንኙነት ስላደረቹኝ 3. ልጅ መውለድ ስለምፈልግ 4. ጓደኛዬ ስለሚቃወም/ ስለምትቃወም 5. ሀይማኖቴ ስለምከለክል 6. ብዙም እወቀት ስለሌለኝ 7. የጉንዮሽ ጉዳቱን ስለምፈራ	

		8. ለማገኘት ስለምከብድ 9. ወድ ስለሆነ 10. በጣም ሩቅ ነው ለማገኘት 11. ሌላ …….	
29	ለመጀመሪያ ጊዜ የግብረ ስጋ ግኙኝነት ስታደርግ/ይ የወሊድ መቆጣጠሪያ ተጠቅማክ/ሽ?	1. አዎ / ወደ ጥ.ቁ 31 ይለፉ/ 2. አልተጠቀምኩም	
30	አልተጠቀምኩም ካለክ/ሽ ለምንድ ነው / ከአንድ በላይ መልስ ይቻላል/	1. በወቅቱ እርግዝና ይከስታል ብዬ ስለሜልሰጋ 2. ያልተቀ ግብረ ስጋ ግንኙነት ስለነበረ 3. ምንም አይነት ዜዴ ስለማላወቅ 4. የጉንዮሽ ጉዳቱን ስለምፈራ 5. የመቆጣጠሪያ ዜዴ ስለሌለ 6. የመቆጣጠሪያ ዘዴው ወድ ስለሆኔ 7. ጓደኛዬ ስለሚቃወም	
31	የአባለዘር በሽታ ይዞህ/ሽ ያውቃል	1. አዎ 2. አልያዘኝም 3. አላቅም } / ወደ ጥ.ቁ 33 ይለፉ/	
32	አዎ ካልክ/ሽ ለመጀመሪያ ጊዜ ምን አደረክ/ሽ	1. ምንም አላደረኩም 2. እራሴን አከምኩኝ 3. ወደ ባህለዊ ህአንጣ አገልግሎት ሄደኩ 4. ወደ መድነሃንት ቤት ሄዳኩ 5. ወደ ህብረተሰብ ጤፍ አገልግሎት ሄደኩ 6. ወደ አካባቢ ባህላዊ አዳኝ ሄደኩ 7. ወደ ግል ጤፍ ጣቢያ ሄደኩ 8. ሌላ …….	
33	ኮንዶም ተጠቅመህ/ሽ ታውቃለህ/ሽ	1. አዎ 2. አላወቅም	
34	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስታረግ/ይ ጓደኛህ/ሽ ወይም አንተ/ች ኮንዶም ተጠቅማቹ ታውቃላችሁ	1. አዎ / ወደ ጥ.ቁ 36 ይለፉ/ 2. አናወቅም	
35	አናወቅም ካልክ/ሽ ምክንያቱ ምንድ ነው	1. ኮንዶም አልነበረም 2. በጣም ወድ ስለሆነ 3. ጓደኛዬ ስለሚቃወም 4. ማጠቀም አንወድም 5. ሌላ የወልድ መቆጣጠሪያ ዜዴ እንጠቀማለን 6. አስፈላጊ ማስሎ ስላልታየን 7. አላስታወስንም ነበር 8. ሌላ ……	

ከጥያቄ 36-44 ያለው ሴቶችን ብቻ ይመለከታል

36	አርግዘሽ ታውቅያለሽ	1. አዎ 2.አላውቅም / ወደ ጥ.ቁ 45 ይለፉ/	
37	አዎ ካልሽ ስንት ጊዜ አገዝሽ	..... ጊዜ	
38	ለመጀመሪያ ጊዜ ስታረግዥ እድምሽ ስንት ነበር	.....እድሜ 1.አላስታወስም	
39	ሁሉም እግዝናሽ በፍላጉት ነበር	1. አዎ 2.አይደለም	
40	አይደለም ካሽ የትኛው እርግዝና አላስፈላጊ/ያልታሰበ ነበር	1. የመጀመሪያው 2. ሁለተኛው 3. ሶስተኛው 4. አራተኛው 5. ሁሉም	
41	ወሮጃ ፈጽመሽ ተወቅያለሽ	1. አዎ 2. አላወቅም / ወደ ጥ.ቁ 45/	
42	አዎ ካልሽ ስንት ጊዜ አወረድሽ	..... ጊዜ	
43	ወሮጃ ለሜፀም ከፈለግሽ ጉዳዩን ከማን ጋር ትወያያለሽ	1. ከባለቤቴ ጋር 2. ከቅርብ ጓደኛዬ ጋር 3. ከቤተሰቦቼ ጋር 4. ሌላ የቤተሰብ አባል ጋር 5. ጡፍ ባለ ሞያ ጋር 6. ከባህላዊ ህኪም ጋር 7. ወሮጃ ከሚሰራው ጋር 8. ሌላ	
44	ወሮጃ የት ነው የምታደርጊው	1. ባህብረተሰብ ጡፍ አልግሎት 2. በግል ክሊኒክ 3. በወሮጃ ቤት 4. በራሴ የተለያዩ መድሃንቶችን በማጠቀም 5. ሌላ	

3.2 አማላካከትን እና እምነትን የተመለከተ ጥያቄ

45	ኮንዶም ማጠቀም ጓደኛን ያለማመን ምልክት ነው	1. በጣም እስማማሁ 2. እርግጠኛ አይደለሁም 3. በፍፀም አልስማማም	
46	ወንድ ከማባባቱ በፊት የግብረ ስጋ ግኑኝነት ማድረግ አለበት	. በጣም እስማማሁ . እርግጠኛ አይደለሁም . በፍፀም አልስማማም	
47	ስለ ኮንዶም ወይም የወልዲ መቆጣጠሪያ ዘዴ ከወጣቶች ጋር መወያየት የግብረ ስጋ ግኑኝነትን ያባብሳል፡፡	1. በጣም እስማማሁ 2. እርግጠኛ አይደለሁም 3. በፍፀም አልስማማም	
48	በአንተ/ች እምነት የምታረገው/ጊው ማንኛው ነገር ለኤድስ ያጋልጣል	1 አዎ 2 አያጋልጥም 3 አላወቅም	

49	በምቅጥሉት 12 ወራት ወስጥ በኤይስ ቫይረስ የማጩት እድል አለኝ ብለህ/ሽ ታምናለህ/ሽ?	1. አዎ 2. አላምንም 3. አላወቅም	
50	በአንተ/ቺ አማላካከት የሴት ልጅ በስንት ዕድሜ ማግባት አለባት?	.....አመት 1. አላወቅም	
51	በአንተ/ቺ አማላካከት ወንድ ልጂ በስንት እድሜው ማግባት አለበት?	..... ዓመት 1. አላወቅም	
52	በአንተ/ቺ አማላካከት በአንተ/ቺ ዕድሜ ያሉት ወጣቶች የወልድ መቆጣጠሪያ ወይም ኮንዶመ ለማገኘት ይቀላቸዋል ወይም ይከብዳቸዋል፡ ፡	1. ይቀላል /ወደ ጥ.ቁ 54 ይለፉ 2. ይከብዳል 3. አላወቅም /ወደ ጥ.ቁ 54 ይለፉ/	
53	ይከብደል ካልከ/ሽ ምንድነው ምክንያቱ	1.የገንዘብ እጥረት ልኖር ስለምቸል 2. ለማገኘት ስለሚከብድ 3. አቅራቢዎቹ ስለሚከለክሉ 4. ቤተሰብ ስለምከለክል 5. የሚፋፈልበት ባታ ስለሚታወቅ 6. በጣም ሩቅ ስለሆነ 7. ለመግዛት ወድ ስለሆነ 8.ሌላ	

ምን ያህል በራስ የመተማመን ብቃት አለህ/ሽ

54	ከአንድ ሰው ጋር ብቻ የግብረ በስጋ ግንኙነት ለሟረግ	1. በጣም እተማመናለሁ 2. እርግጠኛ አይደለሁም 3. አልተማመንም	
55	ለሟቅጥሉት 12 ወራት ምንም አይነት የግብረ ስጋ ግንኙነት ስለሟረግ /የግብረ ስጋ ግኙኝነት ፈጽሞ ላለሟረግ	1. በጣም እተማመናለሁ 2. እርግጠኛ አይደለሁም 3. አልተማመንም	

3.3 ስለ ስነ –ተዋልዶ ጠፍ እወቀት የተመለከተ ጥያቄ

56	የሴት ልጅ ከማንያው ጊዜ በላይ መቼ ነው ልታረግዝ ወይም በእርግዝና የመጻዝ እደሏ የሰፋው	1. የወር አበባ በሚሷው ወቅት 2. የወር አበባ ፈሶ ካለቀ ቦኃላ 3. የወር አበባ መፍሰስ ከመጀመሩ በፊት 4. የወር አበባ እከሌታ ላይ 5. በማናቸውም ጊዜ ተመሥሣይ ነው 6. ሌላ ..... 7. አላወቅም	
57	አርግዝና እንዳይከሰት የምከለከልበት መንገድ ተወቃለህ/ሽ	1.አዎ 2.አላወቅም/ ወደ ጥ.ቁ 59 ይለፉ/	

58	አዎ ካልክ/ሽ የምንከላከልበትን መንገድ ጥቀስ/ሽ	1. በአፍ በሚጥ ወልዲ መቆጣጠሪያ 2. በኮንዶም 3. በሚጋው ወልዲ መቆጣጠሪያ 4. በምቀበረው ወልዲ መቆጣጠሪያ 5. በሉኘ 6. በሚጠረው ወልዲ መቆጣጠሪያ 7. የግብረ ስጋ ግንኙነት ባለማድረግ 8. የወንድ ፈሳሽ ወደ ውጭ በመድፋት 9. ከግብር ስጋ ግንኙነት በኃላ ብልትን በማከበ 10. በቁም የግብረ ስጋ ግንኙነት በማድረግ 11. የወር አበባን በማከበቅ 12. ሌላ ……	
59	በግብረ ስጋ ግንኙነት የሚላለፍ በሽታ ተወቃለህ/ሽ	1. አዎ 2. አላወቅም/ወደ ጥ.ቁ 61 ይለፉ/	
60	አዎ ካልክ/ሽ የትኞችን በሽበታ ታወቃለህ /ሽ	አዎን አይደለም 1. ጨበጥ 1 2 2. ኤድስ 1 2 3. ከርክር 1 2 4. ቅጠኝ 1 2 5. ኘበ,ለ 1 2 6. ሊንፎ ግራኑሌማ ቨነረየም 1 2 7. ሌላ ……	
61	የሴት ልጅ ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስታደርግ እርጉዝ ልትሆን ትችላለች	1. በጣም አስማማለሁ 2. እርግጠኛ አይደለሁም 3. በፍፀም አልስማማም	
62	ማንኛውም ጠፍማ የሚሳል ሰው በኤች አይቪ ልኖርበት ይችለል	1. በጣም አስማማለሁ 2. እርግጠኛ አይደለሁም 3. በፍፀም አልስማማም	

63	ማንኛውም ሰው /ወንድም ሆነ ሴት/ ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ስያደርጉ በአቺ አይ ቪ ሊያዙ ይችላሉ	1. በጣም እስማማለሁ 2. እርግጠሃ አይደለሁም 3. በፍፀም አልስማማም	
64	ከአባላዘር እና ከአቺ አይቪ ባይረስ ራስን ለማላከል ማድረግ ያለበን ነገር ይኖራል ?	1. አዎ 2. አይኖርም /ወደ ጥ.ቁ 66 ይለፉ/ 3. አላወቅም / ወደ ጥ.ቁ 66 ይለፉ/	

65	አዎ ካለክ /ሽ ምንድንናቸው	አዎን አይደለም 1. መታቀብ 1 2 2. ልቅ የግብራ ስጋ ግንኙነት አለማድረግ 1 2 3. መታመን 1 2 4. ማጨስም 1 2 5. ከሴተኛ አደር ጋር አለማድረግ 1 2 6. ለላ……	
66	ኮንዶመ የምታገኝበት ቦታ ወይም ሰው ታውቃለህ?	1. አዎ 2. አላወቅም /ወደ 68/ ይለፉ	
67	ኮንደም ለማገኘት ወደት ነው የምትሄደው ?	1. ሱቅ 2. መዳኒት ቤት 3. ክሊኒክ 4. ጠፍ ጣቢያ 5. ሆስፒታል 6. የቤተሰብ መጫዜ ክሊኒክ 7. ሆቴል 8. የህብረተሰብ ስነ ተዋልደ ጠፍ ድርጅት 9. ኮንደም አለፈልግም 10. ለላ …….	
68	ተገብ/ትክክለኛ የግብረስጋ ግኑኘነት ሚለት ምን ሚለት ነው ?	1. መታቀብ 2. ኮንዶም መጠቀም 3. ለቅ የግብረ ስጋ ግንኙነት ማቆወገድ 4. ከሴተኛ አደረ ጋር አለማድረግ 5. መወሰን 6. ለላ…… 7. አለወቅም	
69	ስለ አቺ አይቪ አድስ በሽታ ሰምተህ/ሽ ታውቅያለ/ሽ ?	1. አዎ 2. 2. አላወቅም/ ወደ ጥ.ቁ 71 ይላፉ/,	
70	የመተላለፍያ መንገዱን ልትነገረኝ/ርኝ ትችላለህ/ሽ	አዎን አይደለም 1.ለቅ የግብረ-ስጋ ግኑኝነት 1 2 2.ስለታማ ነገር አብሮ መጠቀም 1 2 3.ደም በማስተላለፍ 1 2 4.በእርግዝና እና ወልዲ ጊዜ 1 2 5.በወባ ትንኝ እና ለሎች 1 2 6.በእናት ጠት 1 2 7.በመጨባበና፣አብሮመበላትእና በማስል 1 2 8.ሌላ……	

ክፍል 4 የህብረተሰብ ተፅዕኖ በተመለከተ ጥያቄ

71	ከጋብቻ በፊት /ግብረ ስጋ ግንኙነት እንድታደርግ/ይ ከጓደሃህ/ሽ በኩል ስደረግ የነበረ ግፊት ነበር ?	1. የለም 2. ትንሽ ግፊት ነበር 3. በከፊል ግፊት ነበር 4. በጣም ግፊት ነበር	
72	ቤተሰቦችህ/ሽ ከጋብቻ በፊት የግብረ ስጋ ግንኙነት እንደታረግ/ይ ይረዱሽ ነበር	1. አይረዱኝም 2. ትነሽ ይረዳኛል 3. በከፊል የረዱኛል 4. በጣም ይረዳኛል	
በተሰቦችህ/ሽን ስለ ወር አባባ ፣ እርግዝና እና ግብረ ስጋ ግንኙነት ብትጠይቅ ምላሻቸው እደት ነው?			
73	እናትህ/ሽ/ እና ቤተሰቧን	1. በሥርዓቱ ይመልሱልኛል 2. ምንም አይመልሱለኝም 3. ይቀልዱብኛል 4. ለመመለስ በቂ አይደሉም 5. ሌላ ……. 6. አላወቅም	
74	አባትህ/ሽ/ እና ቤተሰቦቹን	1. በሥርዓቱ ይመልሱልኛል 2. ምንም አይመልሱልኝም 3. ይቀልዱብኛል 4. ለመመለስ በቂ አይደሉም 5. ሌላ ……. 6. አላወቅም	

ትስማማህ /ሽ/ ወይም አትስማማም/ሚም

75	ግብረ ሥጋ ግንኙነትን በተመለከተ እኔ ለቤተሰቦቼ ሃሣብ እና አስተያየት ትልቅ ክብ አለኝ	1. እስማማሁ 2. እርግጠኛ አይደለሁም 3. አልስማማም	
76	የእኔ ሃይማኖት ከጋብቻ በፊት የግብረ ስጋ ግኙኝነት አጥብቆ ያወግዛል	1. እስማማሁ 2. እርግጠኛ አይለሁም 3. አልስማማም	

ክፍል 5 ስለ ጠፍ አገልግሎት አጠቃቀም እና ምርጫውን የተመለከተ ጥያቄ

77	ባለፉት 3 ወራት ወስጥ ወደ ጠፍ አገልግሎት መሳጫ ህደሃል/ሽ	1. አዎ 2. አልሄደኩም/ወደ ጥ.ቁ 81 ይለፉ/	
78	አዎ ካልክ/ሽ በምን ምክንያት ነው ወደዚያ የሄደኩው?	1. የአባላዘር በሽታ ይዞኝ ነበር 2. ለወሮጃ 3. ለመውለድ 4. ለቅድም ወልድ ክትትል 5. የሚጠመን የወልዲ መቆጣጠሪያ ለመውሰድ 6. ኮንዶም ለመውሰድ 7. ለምክር አገልግሎት 8. ሌላ …….	
79	አዎ ካልክ /ሽ ለመጀመሪያ፣ ለሁለተኛ እና ለሶስተኛ ጊዜ የት ነበር የሄደኩው?	1. መድሃንት ቤት 2. የግል ጠፍ ጣቢያ 3. የህብረተሰብ ጠፍ ጣቢያ 4. የቤተሰብ እቅድ አገልግሎት 5. ጉሮቤት ወዳለው ባህላዊ ህክምና 6. የህብረተሰብ ሰነ ተዋልዶ ጠፍ ድርጅት 7. ሌላ ……	
80	ለምን እዚህ ቦታ ለመሄድ መረጥክ/ሽ	1. የመድሃኒቱ ፈቱን ስለሆነ 2. በነፃ አልግሎቱን ስለሚኝ 3. ክፍያው ቀላል ስለሆነ 4. ስለሚቀርበኝ 5. የቅርብ ዘመድ እዝያ ቦታ ስለምስራ 6. ለምክጥር ጠበቅነት ቦታው ሚጠዋለው 7. ቤተሰቦቼ ስለሚጠልኝ 8. ሌላ …….	
81	ወደ ጠፍ ጣቢያ ወይም የምክር አልሎት እንዳትሄድ የምያደርህ /ሽ ዋናው ምክንያት ምንድነ ው	1. ጠፍ ጣቢያው በጣም ስለምርቅ 2. አገልገሎቱ ወድ ስለሆነ 3. አልግለሎት ሰጫዎቹ ምክጥር ስለሚይጠቡቁ 4. በቂ አልግሎት ስሌለሌ 5. ረጅም ሰዓት ስለምጠቡቅ 6. በቂ ጠፍ ጣቢያ ስሌለሌ 7. ሌላ ……. 8. አላወቅም	

ከ82-86 ያሉትን ጥያቀዎች ተጠየቅው ከሚለሱ /ሷ/ በፍት አሚጭ መልሶችን ያንብቡለት /ላት/

82	ለወደፍት ያስነ- ተዋልዶ ጠፍ አገልግሎት በምን አይነት መልኩ ብዘጋጅ ጥሩ ነው	1. አሁን ባሉት ጠፍ ጣቢያ ወስጥ ነገር ግን ለወጣቶች ለየት ባለ መልኩ 2. አሁን ባሉት ጠፍ ጣቢያ ወስጥ ነገር ግን ለየት ባለ ከፍል ወስጥ 3. ጠፍ ጣቢያ ወስጥ ለየት ባለ መልኩ 4. ሌላ …….	
83	የወጣቶች ሰኑ ተዋለዶ ጠፍ አገልግሎት በየትኛው ስዓት ወስጥ ብሰጥ ይመቻል ብለህ /ሽ/ ታስባለህ/ሽ/	1. ሁሌም በስራ ሰዓት 2. ለየት ባለ ሰዓት ማንም ታካም በለለበት፡፡ ይጥቀሱ…… 3. ለላ …….. 4. አላወቅም……..	
84	ለስነ - ተዋልዶ ጠፍ አገልግሎት ምን አይነት አገልግሎት ስጭ ግለሰብ ትመጣለህ/ሽ/	1. ውጭ ሆኖ ተመሳሳይ ፃታ ያለው/ ያላት 2. ውጭ ሆኖ ሁሉም አይነት ፃታ 3. ጉልማሳ ሆኖ ተመሳሳይ ፃታ 4. ጉልማሳ ሆኖ ሁሉም አይነት ፃታ 5. ማንኛውም የጠፍ ባለሞያ 6. አለወቅም፡፡	
85	የስኔ - ተዋልዶ ጠፍ አገልግሎት ከፍያ ለወጣቶች በምን አይነት መልኩ ብሆን ትመጣለህ /ሽ/	1. በነበረው ዋጋ 2. በቅስ ዋጋ ለወጣቶች ብቻ 3. ለወጣቶች በነፃ 4. አላወቅም	
86	የስኔ - ተዋልዶ ጠፍ አገለግሎት መስጫ ለወጣቶች የት ብሆን ትመጣልህ/ሽ/	1. ከመኖሪያ ቤት አጠገብ 2. ከመኖሪያ ቦታ ራቅ ብሎ 3. ሌላ…… 4. አላወቅም	

ወድ ጊዜዎን ስጥተው ጥያቄወን ስለመልሱልኝ ከልብ አመሠግናለ::

DECLARATION

I, the 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 thesis have been duly acknowledged.

Name ***YIMAR HOTESSA***

Signature _____

Date **May 15, 2012GC**

Place **Addis Ababa University**

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

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Signature _____

Date **May 15*, 20012GC***

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