ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES SCHOOL OF ALLIED HEALTH SCIENCES DEPARTMENT OF NURSING AND MIDWIFERY

ASSESSMENT OF UTILIZATION OF YOUTH FRIENDLY REPRODUCTIVE HEALTH SERVICES AMONG COLLEGE YOUTH IN ASELA TOWN, OROMIA REGIONAL STATE, ETHIOPIA

By: Tolessa Kebede Bedho (BSc CN)

April 2014 G.C

Addis Ababa, Ethiopia

A Thesis submitted to School of Graduate Studies of Addis Ababa University, College of Health Sciences, School of Allied Health Sciences Department of Nursing and Midwifery in Partial Fulfillment of the Requirement for the degree of Masters in Adult Health Nursing (MSc in Adult Health Nursing).

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Advisor: Fekadu Aga (BSc, MSc,)

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Acknowledgement

First and for most, I give honor to God, the omnipotent for every protection he did to me and my families and his mother the Virgin St. Marry. I would like to extend my deepest gratitude to my advisor, Fekadu Aga (Bsc, Msc), for his friendly approach, assistant, concern, and support in each and every step of my Research.

My deepest gratitude also goes to all who assisted me in searching and providing me relevant literature references in particular to AAU College of Health Sciences librarians for their help in literature searching.

I am pleased to thank my all family for their help in different aspect specially in giving moral.

The last but not the least I would like to extend my gratitude to my friends for their direct or indirect contribution to development of this research study.

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ABSTRACT

Background

The reproductive and sexual health of the youth remains a relatively new and sensitive area mainly due to restrictive norms and policies guiding the services and also the access and utilization of YFRHS among the college youth are dependent on many factors which include demographic, economic, college, socio-cultural and health system factors. This study was conducted to assess the utilization of youth friendly reproductive health services (YFRHS) among college youth in Asella town.

Methods

The study used quantitative approaches to collect data. The study was utilize survey research adapting descriptive cross sectional design and a questionnaire to interview 423 college youth in Asella town. Quantitative data was analyzed using Epi Info & Statistical Package for Social Sciences (SPSS). Descriptive statistics and chi-square tests were performed to determine significant associations.

The study was performed for a total of six months starting from December 2014 up to May 2014.

Result

The study establish that sex, age, level of education, and youth's awareness about existence of reproductive health facility and services. Age, sex, knowledge had no significant influence on utilization of almost all YFRHS such as family planning, voluntary counseling and treatment of STI. As indicated by the test result of family planning ($\chi 2= 17.915$, $p = 0.593$), VCT ($\chi 2= 17.84$, $P = 0.598$) and treatment for STIs ($\chi 2= 24.336$, $p = 0.228$) they had no significant association to utilization of the service. Again age was not also significant association with knowledge of YFRHS and their utilization $\chi 2= 38.968$, $P = 0.472$. On sex and utilization, significance was not seen in sex and utilization of family planning because ($\chi 2= 4.53$, $P=0.104$).

Conclusion and Recommendation

The recommendations arising from this study are: this study recommends active sensitization of the youth in college through different activities that creates an opportunity where such information can be shared to scale up their knowledge on the YFRHS and the facilities that are available, this will in turn increase utilization of the services.

CHAPTER – ONE

INTRODUCTION

1. BACKGROUND OF THE STUDY

Globally, there are 1.7 billion young people aged 10 to 24 years, representing one-quarter of the world's population, with over 85% living in developing countries (1). In Ethiopia about 63% of the total population is below the age of 25 years and out of these the young people of ages 10–24 which makes up 25% of the total population, are the largest group to be entering adulthood in Ethiopian history (2).

International Conference on Population and Development (ICPD) 1994 identified and recommended that, Adolescent, sexual and reproductive health issues are addressed through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence and the provision of appropriate services and counseling specifically suitable for that age group and countries were encouraged to ensure that program and attitudes of health-care provider don't restrict youth access to & utilization of the services and information they need (3).

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, youth friendly reproductive health services (YFRHS) have been recognized as an appropriate and effective strategy to address the sexual and reproductive health (SRH) needs of adolescents (3). The concern about adolescent sexual and reproductive health (ASRH) has grown following reports that sexual activity, early pregnancies and sexually transmitted infections (STIs) including HIV infection rates are increasing at unprecedented rates among adolescents(4). Youth friendly reproductive health service is defined as services accessible, acceptable and appropriate for the youth, in the right place at the right price (free where necessary) and delivered in the right style to be acceptable to young people and are effective, safe and affordable and they include counseling, family planning, voluntary counseling and testing and treatment of sexually transmitted infections (4).

Because of the stigma attached to adolescent sexuality, there have been pockets of opposition to youth access to SRH information and services for fear of promoting promiscuity among the age group. For that reason, there have been few efforts by policymakers, government leaders, and SRH service providers to promote provision of youth-friendly SRH services. As a result of that lapse, there has been a feeling by SRH stakeholders that such services can only be provided by Non-Governmental Organizations (NGOs), rather than through the public health delivery system.

However, public health facilities have great potential for scaling-up and sustaining youth-friendly SRH services due to a variety of reasons, foremost of which is that these facilities already exist and are more likely than NGO facilities to exist in the future. Thus, this study was aimed at assessing the utilization of youth friendly reproductive health services by school and college youths from public health facilities in the Asela town in Oromia regional state.

1.2 Problem Statement

Adolescence is a period of transition from childhood to adulthood during which adolescents develop biologically and psychologically and move towards independence (5). Although we may think of adolescents as a healthy group, many die prematurely and unnecessarily through accidents, suicide, violence and pregnancy-related complications and some of the serious conditions of adulthood (for example, sexually transmitted infections (STIs), like HIV; and tobacco use) have their roots in adolescent behavior (6).

Ethiopian youth face a multitude of problems caused by poverty, traditional beliefs, and misconceptions, as an age group, their material, social, health and reproductive needs have not been given the required attention (6). Although Government policies and programs so far have tried to address the needs of youth along with those of the general population, there is now greater recognition among government leaders that youth have special needs that require different policies and program efforts (7).

Despite their numbers, adolescents have not traditionally been considered a health priority in many countries, including Ethiopia.

While the country has been implementing major interventions to reduce child mortality and morbidity, interventions addressing the health needs of young people have been limited. According to Ministry of Health (MOH) 2005a,Young people often have less access to information, services and resources than those who are older (8). Health services are rarely designed specifically to meet their needs and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health. It is perhaps not surprising therefore that there are particularly low levels of health-seeking behavior among young people (8). Similarly, young people in a variety of contexts have reported that access to contraception and condoms is difficult (9).

As a response to the reproductive health needs of youth, the Ministry of Health integration process of priority concerns into the Ethiopian Essential Package for Health Program at the especially the community level of health care (9).

The Adolescent Reproductive Health and Development Plan of Action 2005-2015 was developed to guide the implementation of the policy and later a National Guideline for Provision of youth-friendly services has been developed and funds have been provided all in the effort of meeting the sexual and been provided all in the effort of meeting the sexual and reproductive health needs of the youth (9). Other than the government of Ethiopia, Non-Government Organizations (NGO) have also tried to increase access to reproductive health services by the youth through various initiatives. For example, Pathfinder International came up with University Based Peer Education in 1988 which aimed at addressing the social, reproductive health and informational needs of the youth in Ethiopian Universities. The effects of all these efforts have not been felt across the Ethiopian learning institutions as is evidenced by persistent reproductive health problems and challenges of the youth such as unwanted pregnancy and its consequences, Sexually Transmitted Infections (STIs) and HIV/AIDS (10). Particularly, we have little scientific evidence that help us to understand the utilization pattern of youth friendly reproductive health services in Asela town where many youth population reside similar with the other parts of the country.

Therefore, this study was conducted with the aim of assessing students utilization of youth friendly reproductive health services in different college of the Asella town.

1.3 Significance of the study

The study on utilization of youth friendly reproductive health services was the key for the improvement in the quality of life of the youth. The knowledge acquired from this study would be ultimately facilitated the understanding of pattern of demand and uptake of reproductive health services among the college youth in Asella town.

Health care planners might utilize information generated from the study to improve service delivery to college youth. The college youth too could benefited from the awareness derived by the health care providers targeting them and this in turn would equip them with adequate information helped them made informed reproductive health choices.

CHAPTER – TWO

2. LITERATURE REVIEW

Our country, Ethiopia is characterized by an expanding, largely rural, youth population. It is estimated that young people age 10-24 constitute more than a third of the population, roughly 21 million (11). The economic, political, and social situation in Ethiopia has seriously affected this group. Access to education and health services remains limited, particularly for young rural women and men, and unemployment is a problem, particularly among young people living in urban areas (12). According to the Ministry of Labor and Social Affairs (MOLSA), 87 percent of all registered job seekers are between the ages of 15 and 29. Among registered job seekers only 5 percent reported that they were able to get jobs (13). Youth migrate from rural to urban areas looking for jobs. Young women are increasingly employed in menial jobs and may work as housemaids, cleaners, or commercial sex workers. Young men often end up as day laborers and become exposed to and engage in various types of risk behavior including unsafe sex and use of alcohol and drugs (14).

The access to and utilization of YFRHS services is a primary concern surrounding the promotion of sexual and reproductive health and rights (3). This is attributed to the sensitive nature of sex and sexuality issues among youth which have not been fully addressed and to a large extent the way the reproductive health services are being offered to them (7). The need to have a healthy youth is of great value to nation's socioeconomic development because if they use YFRHS promptly, a lot of health problems will be reduced hence better performance at school and better future adult population (15). Studies by Family Health International (FHI) in 2006 further showed that attracting the youth to the clinical services has remained a challenge and that there is need to create demand and improve health seeking behavior of the youth. It is these revelations that prompted this study (12).

2.1 Reproductive health services

2.1.1 Barriers to Utilization of Youth friendly Reproductive Health Services (YFRHS) Globally

Globally, existing barriers to access and utilization include poor access, availability and acceptability of the services (16). Lack of clear directions and services on offer, crowding, lack of privacy, appointment times that do not accommodate young people's work and school schedules, little or no accommodation for walk-in patients, and limited services and contraceptive supplies and options calling for referral are also impediments (17). Senderowitz and others in a study on rapid assessment of Reproductive Health Services reported that significant barriers posted by the current state of most RH services are perceived unwelcoming to the youth (18). A study in Cambodia showed that the barriers to youth access to reproductive health services included lack of confidentiality, shyness, poor relations with health staff, illiteracy and low prioritization by parents for reproductive health services (14).

PATH in a study to evaluate youth friendly services(YFS) in Shanghai found that although there was good infrastructure, equipment, staff and good environment at the city, district, and school level, few youths used YFS due to insufficient publicity, insufficient full time and skilled professional health service providers, poor services and a weak referral system (15). The youth aged 15-18 year olds in Russia are served by paeditricians but health reports show that these young people who had a long relationship with paediatricians are often embarrassed to discuss difficult issues such as contraception or sexually transmitted infections (STIs) and may also worry about breaches of confidentiality (19).

2.1.2 Barriers to Utilization of Youth Friendly Reproductive Health Services in Africa

Most African countries as a follow up to ICPD (1994) have put up youth friendly health services with the combined partnership between The United Nations Population Fund (UNFPA), Pathfinder International through The African Youth Alliance (AYA) program in Botswana, Uganda, Tanzania and Ghana but despite these efforts, most countries in sub-Saharan Africa, youth still encounter significant obstacles to receiving sexual and reproductive health services to obtaining effective, modern contraception and condoms to protect against sexually transmitted infections (STIs), including HIV (19).

In South Africa activities geared towards the youth are being implemented but are still limited (19). A study to evaluate factors that discouraged the youth from using youth friendly reproductive health services in South Africa found that inconvenient hours or locations, unfriendly staff &lack of privacy were among the reasons adults gave for not using YFRHS (20).

A study conducted in Zimbabwe on factors affecting Africans on reproductive health found that 12% of the youth did not visit RH because the distance was too great, 11% were too busy while 11% were shy and also in Zanzibar, the policy on reproductive health does not allow unmarried youth to get reproductive health services (20). Another study in Zambia on vulnerability and sexual and reproductive health among Zambian secondary school students concluded that boys and girls lacked adequate information about human reproduction and STIs including HIV (14).

A study done by Motuma on youth-friendly services (YFS) utilization and factors in Harar, Ethiopia concluded that most youth had positive attitude towards YFS but had poor knowledge on the services. The same study also reported that only one facility provided YFS in Harar thus pointing the limitations in offering YFRHS in that region (21).

2.1.3. Reproductive Health Service Provision in Ethiopia

The Ministry of Health began working toward a policy to address adolescent reproductive health needs in 1996 and has produced a Five-Year Action Plan for Adolescent Reproductive Health in Ethiopia (9). The document describes the reproductive health problems of youth and identifies HIV/AIDS infection, abortion and its health complications, early marriage and motherhood, and high-risk pregnancies as critical ARH issues. The following ARH strategies are outlined in the document (9):

- Promotion of a positive policy and program environment;
- Provision of knowledge and skills; and
- Provision of quality reproductive health services for adolescents/youth.

The characteristics of AYFRH services relate to the service providers, the health facility itself, and the program design (22).

Health facility characteristics

. Convenient space/location

. Convenient hours

. Comfortable surroundings

. Peer counselors available.

Characteristics of the service provider

The service provider is trained in adolescent and youth-friendly services and they should have respect for young people. Privacy and confidentiality are also another characteristics of service provider which ensures that there is privacy and keeps the matters regarding the RH problems of the young person confidential. The service provider gives enough time to interact with the young person. Health facilities that give adolescent- and youth-friendly service have a convenient space or room which young people who are in need of sexual and reproductive health services can use without being seen and heard by others. If there is no such space for the young people, they will be waiting for services in the midst of older clients and this will make them uncomfortable (2).

2.2 Ethiopian AYFRH service standards

Following the development of the National Adolescent and Youth Reproductive Health Strategy, the Federal Ministry of Health has developed the following standards for youth-friendly services (23).

1. The service outlet provides service supported by the existing national policies and processes that give due attention to the rights of young people.
2. Appropriate health services that cater to the reproductive and sexual health needs of young people are available and accessible.
3. The service outlets have a physical environment that is organized in a way that is conducive to the provision of AYFRH services.
4. The service outlet has drugs, supplies and equipment necessary to provide the essential service package for youth-friendly health care.

5. Information, education and communication (IEC)/behavioral change and communication (BCC) consistent with the minimum service package is provided.
6. The service providers in all service outlets have the required knowledge, skills and positive attitudes to effectively provide youth friendly RH services.
7. Young people receive an adequate psychosocial and physical assessment and individualized care based on the national standard case management guidelines/protocols.
8. The service outlet has a system that ensures that the necessary referral linkage is made and ensures continuity of care for young people.

2.3 Services intended to be provided in adolescent and youth-friendly Services

The services intended to be provided in the youth friendly reproductive service settings include (23):

- Information and counseling on sexual and reproductive health issues
- Promotion of healthy sexual behaviors through various methods including peer education
- Family planning information, counseling and FP methods including emergency contraceptive methods
- Condom promotion and provision
- Testing services: pregnancy, HIV counseling and testing
- Management of STIs
- Abortion and post-abortion care
- Antenatal care (ANC), delivery, postnatal care (PNC) and pregnant mother-to-child transmission (PMTCT) services
- Appropriate referral linkage between facilities at different levels.

2.4 Demographic Factors that influence Utilization of YFRHS

2.4.1. Age

Age is a demographic factor that affects utilization of health services. Reports from HS 2010/11 revealed an increased uptake of family planning services among age 20-24 years as compared to 10-19 year old youth (24). The youth hardly perceive the seriousness of sickness or health need and this is a major impediment to the youth in accessing and utilizing health services.

A study by Senderowitz, et al on rapid assessment reproductive health services concluded that youth are unwilling to seek care due to the national laws and policies restricting care based on age and/or marital status, poor understanding of their changing bodies and insufficient awareness of risks associated with early sexual debut, STI/HIV and pregnancy (18).

2.4.2 Socio-economic and Socio-cultural Factors that influence Utilization of YFRHS

The economic costs of health care seeking include not only payment for treatment but also loss of productive or school time for the pupil/student, and the travelling expenses. This means that persons of low socio-economic status can have difficulty in affording the costs associated with utilization of healthcare making utilization unlikely unless they are provided with subsidized costs. Poverty has led some school youth to engage in pre-marital sex in exchange for gift or economic support further exposing them to RH risks (25). User fee charged at the health facilities may hinder the youth from utilizing youth friendly services (26).

2.4.3 Education and Awareness of YFRHS

Studies have revealed that the more educated youth are more likely to seek youth friendly health services as they possess better understanding of their health needs (27). A study done in Burkina Faso, Ghana, Malawi, and Uganda in 2004 showed that contraceptive, STI and VCT services are still under-utilized by the youth due to lack of knowledge about the services also found out that lack of understanding of the importance of sexual health care or knowledge of where to go for care may discourage young people from using the services and therefore health education is a major component in passing health information and which in turn can increase utilization of services (16).

2.4.4 Religion

Most religious groups have stringent rules and norms that tend to view use of family planning among unmarried youth as sinful and believe that engaging in pre-marital sex is sin. These religious norms to some extent have played a role in controlling the youth from involving themselves in indiscriminate sex in Ethiopia but these efforts have been eroded by increased urbanization which has led to most youth living on their own without religious guidance and control (28).

2.4.5 Traditional Beliefs and Ethnicity

Senderowitz reported that breakdown in traditional communication channels through which adults used to pass information and guidance to the young has broken down due to urbanization thus leaving the youth vulnerable to sexually related problems, most ethnic moral/ traditional codes prohibit premarital sex and pregnancy and any youth discovered to be using family planning services is reprimanded thus fear is instilled among the youth especially on family planning use (18). When there is community involvement where by communities are engaged in positive dialogue to promote the value of health services and encourage parental and wider support for the provision of quality services to youth, utilization is likely to increase (19).

2.5 Barriers to RH service utilization

There are many factors that affect the utilization of available sexual and reproductive health services by young people. We can categorize these as: individual/personal factors, institutional factors, and social/cultural factors (26). Limited access to targeted RH care and services for young people contributes to, and exacerbates, many of the RH problems outlined above. Over a quarter of all pregnant youth and adolescents feel that their pregnancies are mistimed, reflecting this population's limited access to FP as well as their vulnerability to broader social problems such as early marriage, nonconsensual sex, and sex work. These unwanted pregnancies entail significant risks for maternal health, including high rates of delivery-related complications and high abortion rates (25).

2.6 The Health System Factors that Determine Youth Utilization of RHS

2.6.1. The Health Facility Organization

Provision of good quality health services to the youth can be achieved through favorable policy environment, improved clinical and communication skills of providers and their supportive attitude (29). The National Guidelines for provision of YFS in Ethiopia categorizes qualities of a facility which make it youth friendly and which are likely to increase utilization by the youth. These includes; the services should be in a place that is easily accessible, have flexible working hours, offer privacy, offers wide range of services at affordable cost or free and friendly health service providers (23).

2.6.2 Health Worker's Attitude

Negative provider's attitudes have been identified as a major barrier as it discourages young people from seeking or returning for care (10). A study done among Kenyan and Zambian midwives revealed that reproductive health services are underutilized due to judgmental attitude of health providers and lack of competence coupled with lack of knowledge in youth friendly service provision irrespective of training. A study in Ethiopia on health workers' attitude toward sexual and reproductive health services for unmarried youth concluded that some health workers were setting up penal rules and regulations against premarital sex (17).

2.7 Problems Faced by Youth

Traditional practices and poor living conditions often lead young people to engage in sex at an early age. In a survey conducted among high school students in Addis Ababa, 38 percent reported that they were sexually active (30). Of these sexually active students, 71 percent experienced first sex between the ages of 14 and 16. Similar situations have been observed in other Ethiopian cities: 58 percent of students from the Gondar Medical School (31), 55 percent of 18- and 19-year-old youth from Harar (21), and 32 percent of unmarried youth in Jimma were reported to be sexually active (31).

Harmful traditional practices such as early marriage, female genital cutting (FGC), and marriage by abduction affect the health of young women. Early marriage is one of the cultural traditions that expose young women to reproductive health problems (28). The 1990 National Family and Fertility Survey revealed that 34 percent of women were married before age 15 (29). FGC is widely practiced in Ethiopia. Marriage by abduction is also widely practiced: at the national level, 69 percent of respondents reported knowing that marriage by abduction took place in their area (28).

Unintended pregnancy is a serious problem among teenagers, especially since teenage pregnancy is associated with health risks to the mother during pregnancy and delivery. Several studies in Ethiopia have documented the prevalence of unintended pregnancies among young women (32).

A household study of adolescents in Addis Ababa found that the median age at first pregnancy was 16 years with two in three women becoming mothers before the age of 20. Of the 957 female respondents, 50 percent had been pregnant in the past and 74 percent of these pregnancies resulted in abortions (32).

Abortion, which is illegal in Ethiopia, places many young women at risk, primarily because it is usually conducted under unsafe conditions. However, actual data on the prevalence of illegal abortion is difficult to collect (32). The study collected data from 5 hospitals in Addis Ababa during a period of six months. Findings revealed that there were a total of 1,603 induced abortion cases, of which 15 percent occurred among women under the age of 15; 31 percent occurred among women age 16-20; and 62 percent occurred among women 16-25. Forty-five percent of the abortions were among single women, and 42 percent were among women with only a primary school education or less (33).

Many young women are forced to practice sex for money. It is difficult to estimate the number of commercial sex workers, but it is believed to be in the thousands. Most of the prostitutes are quite young. A study on child prostitution in Addis Ababa showed that most prostitutes are migrants (66 percent) and most are under 18 years of age; the mean age is 15 years (32). Young prostitutes are exposed to many types of violence. A study, conducted in Addis Ababa among commercial sex workers age 9-18 years found that 82 percent of these girls had their first sexual contact before age 16, and 50 percent of these contacts had been coerced, including rape (33). Financial need was cited by 85 percent of respondents as the reason for resorting to prostitution (32). Another study estimated that 35,000 females (about 7 percent of all adult females) in Addis Ababa practice multipartner sexual contact. The consequences of childhood prostitution include health problems resulting from physical abuse, early and unwanted pregnancy, STDs, HIV/AIDS, and abortion, as well as psychological problems, low self-esteem, hopelessness, and stigma (33).

2.8 Reproductive Health Service Provision in Asella Town

As I mentioned earlier in the beginning of literature review based on the reproductive health service, even though there is sufficient health institution with competent professionals I couldn't find any type of literature explaining the youth friendly reproductive health services utilization pattern in the area.

2.9 Conceptual Framework

The study used Andersen's Phase Two Model of Health Service Utilization (17) to investigate reproductive health service utilization among school going and college youth in Asella town.
As shown in figure 1 below, this behavioral model provides a systems perspective to investigate a range of individual, environmental and provider related variables associated with decisions.

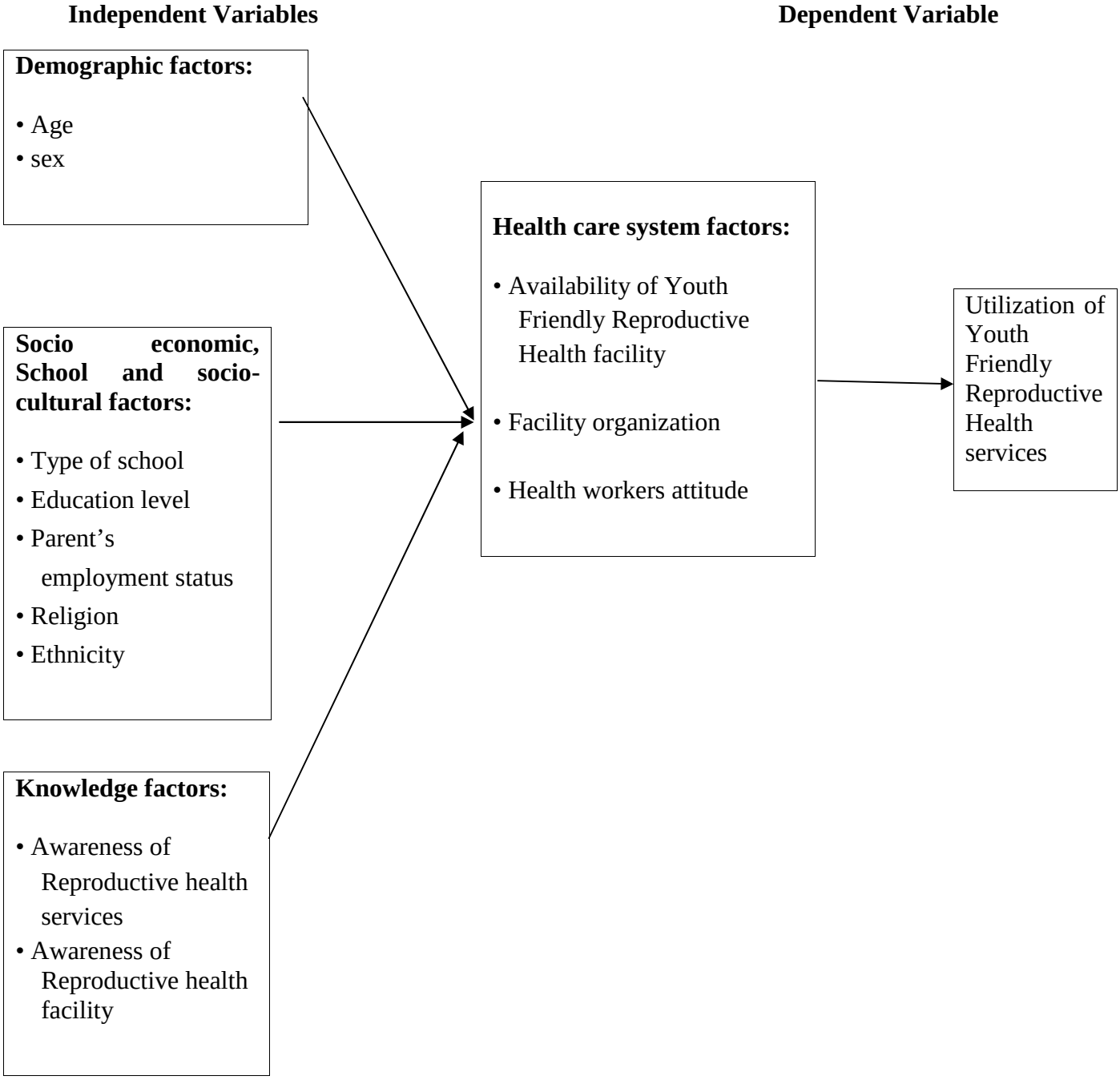

Figure 1. Operational Framework of the study (adopted from Andersen & Newman, 2005**)**

CHAPTER – THREE

3. OBJECTIVES

3.1 GENERAL OBJECTIVE

- To assess utilization of youth friendly reproductive health service among college youth in Asella town.

3.2 SPECIFIC OBJECTIVES

- To assess the prevalence of youth utilization of youth friendly reproductive health service (YFRHS) services.
- To determine the demographic factors associated with the utilization of youth friendly reproductive health services among the study samples.
- To determine the social, economic, and cultural factors associated with the utilization of youth friendly reproductive health services among the study sample.
- To determine the awareness factors associated with the utilization of youth friendly reproductive health services among the study samples.
- To determine health system factors associated with the utilization of youth friendly reproductive health services among the study samples.

CHAPTER – FOUR

4. RESEARCH METHODOLOGY

4.1 STUDY DESIGN

The study adopted a cross-sectional design that aimed at analyzing the demographic, socioeconomic, college and socio-cultural and health system factors that influence utilization of youth friendly reproductive health services (YFRHS) among the youth.

4.2 Study Area

The study was done in Asella town, Arsi zone, south-east oromia region. It is situated along 175 kilometers from Addis Ababa city. The town covers an area of 29.3 Square kilometers. The population of youth aged 15-24 in the town is estimated as 21062 as recorded in 2010 G.C Asella town health Records.

The town is inhabited by people of different ethnic groups with diverse cultural backgrounds although majority of the inhabitants are oromo ethnic group who are the natural inhabitants of the region. The residents are mainly, civil servants, factory workers, and small scale business men and women. Main industries include Asella Malt plant factories, Different flour factory, bakeries and others.

Asella town have five health facilities one is government hospital, two health centers, and two NGO family health clinics. The town has a total of 7 primary schools, 3 secondary schools, 2 technical training institutions 1 university and several middle level and business colleges. Total college student population is 12321.

4.3 Study period

Study was conducted from December 2014 to May 2014

4.4 Variables

4.4.1 Independent Variables

These are factors which literature review reveal and have significance on the utilization of YFRHS by the youth. These are; demographic factors such as age and sex, socioeconomic and college factors such as level of education and awareness about existence of youth friendly reproductive health facilities and services. Socio - cultural factors was studied including religion and ethnicity. Health system factors including health facility organization and service delivery, health provider attitude and availability of youth-friendly health services within the college and the town.

4.4.2 Dependent Variables

The dependent variable in this study is utilization of youth-friendly reproductive health services measured through the dichotomous response of yes or no. The utilization of youth-friendly reproductive health services available in the reproductive health centre such as family planning, counseling services, VCT and treatment of STIs will be considered.

4.5 Target Population

Source population

All college students in Assela town attending different level of education.

Study population

The study was focused on college youth aged 16-24 years in sample colleges.

4.6 Sampling

4.6.1 Sample Size Determination

The sample size was determined using Fisher's et al, 2003 Formula (33). The formula use to estimate the smallest possible categorical sample size since the population of the school youth is above 10,000.

$$n = \frac{z^2 pq}{d^2}$$

Where: n = The desired sample size (N>10000),

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

p = The proportion of target population estimated to have a particular characteristics (those whose age is between 16-24 and studied for they are utilizing friendly reproductive health services).

In this case estimates for Asella town was not known therefore 50% (0.5) will be Used.

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

q = 1 – p; (1- 0.5=0.5).

Therefore n=1.96*1.96*0.5*0.5/0.05*0.05=384.16

Thus the sample size 384 plus 10% (39) sample population's extra questionnaires to safeguard against non-response or low return rate. This is necessary because when using Fisher's method, the sample size arrive at is taken to be the minimum estimate and therefore any response rate below it will have a negative effect to the study.

4.6.2 Sampling Technique

Systematic sampling was used to select study sample using a list of students in the colleges provided by the college registrar office as a sampling frame. Systematic random sampling technique was used and random numbers was used to pick the first respondent in each cluster, followed by every 7th person from the group to ensure randomness until 423 respondents were picked.

4.7 Inclusion Criteria

The youth aged 16-24 years who are studying in secondary school and college

4.8 Exclusion Criteria

The youth who declined to give informed consent and those below 16 years or above 24 years will be excluded.

4.9 Research Instruments

The study employed the following self-administered questionnaires which was pretested and revised before final data collection.

Self-administered structured questionnaires to collect data from the college youth in tertiary learning institutions. The questionnaire contain about three parts: part- I- Socio-demographic, economic, school and socio-cultural information,

part-II- Knowledge and utilization of youth friendly reproductive health services and

part-III- Health system factors.

4.10 Data quality control

The quality of data was assured by using properly designed questionnaire, conducting pilot study, proper training of interviewers and supervisors about data collection procedures and coding of the questionnaire. Every day the completed questionnaires was viewed and checked for completeness and relevance by supervisor and principal investigator. The necessary feedback was given to research team every morning before the actual procedure and analysis.

4.11 Data analysis and management

All returned questionnaires was checked for completeness and consistency of response manually. After checking data was coded, enter into EPI-INFO-7 and was exported to SPSS. Appropriate descriptive and analytical (frequency, mean, standard deviation, and the like) was used to determine the prevalence and statistically significant association between the independent and dependant variables.

When $p < 0.05$ we generally refer to this as a significant difference. The most common alpha value seen and one which is considered an acceptable level of significance by researchers worldwide is 0.05, or 5 percent. By comparing the alpha value to a p value, when the value of the computed test statistic exceeds the critical value, (i.e. tcalc > tcrit) we can reject the null hypothesis. Because $p < \alpha$ and tcalc < tcrit, we can reject the null hypothesis and state that there is a significant difference between the two events.

4.12 Operational Definitions

1. **Age** – measured at the last birth date in year
2. **Socio-economic**
   - 2.1. **Social**– the interaction of the students with different people when they want to use the reproductive health services.
     It is measured by student's response to a specific question about his/her feeling resulting from other peoples reaction when using reproductive health services.
   - 1.2. **Economy** - is measured by student's response based on their financial support of their parent and of an individual's family income and parental occupation.
3. **Socio-cultural** – described by particular question that responded by the students whether they are affected by cultures, societies and religion to use the utilization of youth friendly reproductive health services.
4. **Counseling** – measured by response of the students to the presence of access and consultation for the youth in school and college about the reproductive health services. And advice or guidance, especially as solicited from a knowledgeable person.
5. **Utilization** – the ability to consume service or usage of the youth friendly reproductive health Service by the students whether they are using or not.

4.13 Ethical considerations

Ethical clearance letter was obtained from Addis Ababa University, College of Health Sciences; Department of Nursing and Midwifery. A written consent was obtained from Asela education bureau. Additionally an informed verbal consent was obtained from each respondent after providing adequate information on the purpose of study.

Anyone unwilling to participate in the study was assured of doing this as full right and never affected in any way for doing so. To ensure the confidentiality of respondents was clearly informed not to write on the questionnaire.

4.14 Dissemination of results

The final result of this paper was given to Addis Ababa University College of Health Sciences Department of Nursing and Midwifery, and published to be used as input for researchers that are interested in the field of study.

CHAPTER – FIVE

RESEARCH RESULT

5.1 Introduction

This chapter displays results which is organized as follows; descriptive information of the study variables, factors may or may not significantly associated to utilization of YFRHS and discussion of findings.

5.2 Descriptive Information of Study Variables

The study involved a total of 384 participants aged between 16 - 24 years. Table 1 summarizes the descriptive information of the study participants.

Table 1: Background Characteristics youth of college in Asella town, 2006 e.c

Factors	Category	Frequency (n)	Percentages (%)
Age groups (years)	16-18	32	8.4
	19-24	351	91.6
Sex	Male	204	53.3
	Female	174	46.7
Education Level	First year	145	37.9
	Second year	123	32.1
	Third year	115	30.0
School type	Boarding	0	0
	Day school	384	100.0
Religion	Orthodox Christian	204	53.3
	Protestant Christian	8	2.1
	Catholic Christian	10	2.6
	Muslim	156	40.7
	Others	2	0.5
Ethnicity	Oromo	220	57.4
	Amhara	124	32.4
	Gurage	22	5.7
	Tigray	7	1.8

Table 1 shows that the majority of the respondent were aged 19 - 24 years 351 (91.6%) and were males 204 (53.3%).

The study covered youth in tertiary levels of education and each level was covered equally. Of the youth studied all were in day schools. On religious affiliation, 204 (53.3%) of those interviewed were Orthodox Christians, 156 (40.7%) were Muslims, which covers about 94% of the respondent. Majority of the youth interviewed were from the Oromo community forming 220 (57.4%), followed by Amhara who were 124 (32.4 %), others are insignificant in numbers.

5.3 Demographic, Socioeconomic, School and Socio-cultural Factors and YFRHS Utilization

The main youth-friendly reproductive health services utilized by the youth were counseling services, family planning, VCT and STI treatment.

Table 2 summarizes the number of youth and how much they utilized each of the youth-friendly reproductive health services mentioned.

Table 2 : Reproductive Health Service Utilized by Youth college in Asella town, 2006 e.c

RHS	Utilized	Not Utilized	Total
Family planning	155	229	384
Counseling services	191	193	384
VCT	77	307	384
STI treatment	51	333	384

The results in table 2 indicate that 191 (49.9%) of youth utilized counseling services, and 155 (40.4%) utilized family planning 77 (20.0%) utilized VCT.

Table 3 : Demographic Factors and Utilization of YFRHS youth of college in Asella town, 2006 e.c

Factors		Age/Sex	Utilized	Not utilized	Percentage(%)	χ2, p value
Family planning (n= 223)	Age	16-18	9	23	8.4	χ2=17.915
		19-24	145	206	91.6	P=0.593
	Sex	Female	85	79	46.7	χ2=4.53
		Male	104	100	53.3	P=0.104
Counseling (n= 264)	Age	16-18	8	4	2.1	χ2=22.384
		19-24	252	116	65.6	P=0.321
	Sex	Female	97	44	25.3	χ2=0.322
		Male	167	76	43.5	P=0.851
VCT (n= 253)	Age	16-18	9	3	2.3	χ2=17.84
		19-24	241	128	62.8	P=0.598
	Sex	Female	98	43	25.5	χ2=3.919
		Male	155	88	40.4	P=0.141
Treatment of STI (n= 213)	Age	16-18	7	3	1.8	χ2=24.336
		19-24	203	168	52.8	P=0.228
	Sex	Female	77	76	20.0	χ2=1.075
		Male	136	95	35.4	P=0.584
Knowledge of YFRHS	Age	16-18	12	20	8.4	χ2=38.968
		19-24	244	109	91.6	P=0.870
	Sex	Female	85	79	46.7	χ2=4.563
		Male	104	100	53.3	P=0.472

Table 3 shows that age influenced utilization of the four major reproductive health services whereby older school youth tended to utilize the YFRHS more compared to younger ones.

Age had no significant association to utilization of family planning (χ^2= 17.915, p = 0.593), VCT (χ^2= 17.84, P = 0.598) and treatment for STIs (χ^2= 24.336p = 0.228). Age was also not associated with utilization of counselling services (χ^2= 22.384, P=0.321). Again age has no significant association with knowledge of YFRHS and their utilization χ^2= 38.968, P = 0.472. On sex and utilization the thing is seen.

Table 4: Socioeconomic and School Factors and Utilization of Family Planning Services youth of college in Asella town, 2006 e.c

Utilization of FP services		Utilized	Not Utilized	Total	χ2, p value
Education level	First year	85	60	145	χ2 = 7.645
	Second year	83	40	123	P= 0.105
	Third year	61	54	115	
Type of school	Boarding	0	0		
	Day School	155	229	384	
Parent's Employment status	Employed	27	41	68	χ2= 4.158
	Not employed	127	189	316	P= 0.843

Chi square test and P-value was carried out in order to establish the relationship between school and socioeconomic factors utilization of family planning. The school and socioeconomic factors were compared with the utilization of family planning. The results of the chi square test and P-value are displayed in table 4.

Table 4 show there is no significant relationship between level of education and utilization of family planning services ($\chi2= 7.645$, $p = 0.105$). And also parent's employment status had no role in family planning utilization ($\chi2= 4.158$, $P= 0.843$).

Table 5: Socioeconomic and School Factors and Utilization of Counseling Services youth of college in Asella town, 2006 e.c

Utilization of counseling services		Utilized	Not Utilized	Total	χ2, p value
Education level	First year	69	76	145	χ2= 7.937
	Second year	74	49	123	P= 0.094
	Third year	55	60	115	
Type of school	Boarding				
	Day School	185	199	384	
Parent's Employment status	Employed	35	32	67	χ2= 5.354
	Not employed	153	163	316	P= 0.719

Chi square test and P-value was carried out in order to establish the relationship between school and socioeconomic factors utilization of counselling services.

The school and socioeconomic factors were compared with the utilization of counselling services. The results of the chi square test and P-value are displayed in table 5.

Table 5 shows that there was no significant association between level of education and utilization of counselling services χ2= 7.937, P= 0.094. Parent's employment status had also not showed a significance to counselling χ2= 5.354, P= 0.719.

Table 6: Socioeconomic and School Factors and Utilization of VCT services youth of college in Asella town, 2006 e.c

Utilization of VCT services		Utilized	Not Utilized	Total	χ2, p value
Education level	First year	25	120	145	χ2= 2.904
	Second year	19	104	123	P= 0.574
	Third year	25	90	115	
Type of school	Boarding				
	Day School	69	315	384	
Parent's Employment status	Employed	16	51	67	χ2= 7.050
	Not employed	53	163	316	P = 0.531

In the following section, Chi square test and P-value was carried out to establish the relationship between school and socioeconomic factors utilization of VCT services whereby the school and socioeconomic factors were compared with the utilization of VCT services. The results of the chi square test P-value are displayed in table 6.

Table 6 shows that there was no significant relationship between level of education and utilization of VCT services χ2= 2.904, P= 0.574. Parent's employment status had also no significance to VCT utilization, with χ2= 7.050 and P= 0.574.

In the following section, chi square test and P-value was carried out to establish the relationship between school and socioeconomic factors utilization of STI services whereby the school and socioeconomic factors were compared with the utilization of STI services. The results of the chi square test and p-value were displayed in table 7.

Table 7: Socioeconomic and School Factors and Utilization of STI treatment services youth of college in Asella town, 2006 e.c

STI Treatment		Utilized	Not Utilized	Total	χ2, p value
Education level	First year	18	127	145	χ2= 3.102
	Second year	10	113	123	P= 0.541
	Third year	15	100	115	
Type of school	Boarding				
	Day School	43	341	384	
Parent's Employment status	Employed	9	58	67	χ2 = 11.073
	Not employed	34	282	316	P = 0.198

Table 7 displays how treatment for STIs in relationship to education level and parent's employment status. Education level and STI treatment have no significance (χ2= 3.102, P= 0.541).

The relationship between religion and ethnicity with utilization of family planning was tested through chi square test and P-value. Socio-cultural factors were compared to utilization of family planning.

Table 8 displays the results.

Table 8: Socio-Cultural Factors and Utilization of Family Planning Services youth of college in Asella town, 2006 e.c

Utilization of FP services		Utilized	Not Utilized	Total	χ2, p value
Religion	Orthodox	81	126	207	χ2= 9.254
	Muslim	66	90	114	P= 0.508
	Catholic	6	0	6	
	Protestant	4	1	5	
	Others	2	0	2	
Ethnicity	Oromo	94	126	220	χ2= 11.103
	Amhara	44	80	124	P= 0.196
	Gurage	12	10	22	
	Tigray	2	8	10	
	Others	2	5	7	

The table 8 above shows that religion was not associated to utilization of family planning services.

Table 9: Socio-Cultural Factors and Utilization of Counseling Services youth of college in Asella town, 2006 e.c

Utilization of counseling services		Utilized	Not Utilized	Total	χ2, p value
Religion	Orthodox	100	107	207	χ2= 10.686
	Muslim	75	81	156	P= 0.382
	Catholic	7	3	10	
	Protestant	2	6	8	
	Others	1	1	2	
Ethnicity	Oromo	115	105	220	χ2= 16.593
	Amhara	51	73	124	P= 0.035
	Gurage	14	8	22	
	Tigray	1	9	10	
	Others	4	3	7	

Relationship between socio-cultural factors and utilization of counselling services was assessed by performing a chi square test P-value and results reflected in table 9.

Table 9 indicates the absence of significant association between religion of the youth and utilization of counselling services ($\chi2$= 10.686, P= 0.382). There was an association between ethnicity and utilization of counselling services at the required threshold ($\chi2$= 16.593, P= 0.035).

Table 4.10: Socio-Cultural Factors and Utilization of VCT Services youth of college in Asella town, 2006 e.c

VCT services		Utilized	Not Utilized	Total	$\chi2$, p value
Religion	Orthodox	33	174	207	$\chi2$= 15.080
	Muslim	32	124	156	P= 0.129
	Catholic	9	1	10	
	Protestant	5	3	8	
	Others	0	2	2	
Ethnicity	Oromo	46	174	220	$\chi2$= 9.962
	Amhara	18	106	124	P= 0.268
	Gurage	2	20	22	
	Tigray	1	9	10	
	Others	2	5	7	

Chi square test and P-value was carried out in order to establish the relationship between socio-cultural factors and utilization of VCT services. Socio-cultural factors were compared with the utilization of VCT services.

The results of the chi square test and P - value are displayed in table 10.

Table 10 shows no significance between religion and utilization of VCT services $\chi2$= 15.080, P= 0.129.

Table 11: Socio-Cultural Factors and Utilization of STI Treatment Services youth of college in Asella town, 2006 e.c

STI Treatment		Utilized	Not Utilized	Total	χ2, p value
Religion	Orthodox	23	184	207	χ2 = 7.760
	Muslim	18	138	156	P= 0.652
	Catholic	1	9	10	
	Protestant	1	7	8	
	Others	0	2	2	
Ethnicity	Oromo	32	188	220	χ2= 11.133
	Amhara	9	115	124	P= 0.194
	Gurage	2	20	22	
	Tigray	0	10	10	
	Others	**0**	**7**	**7**	

To establish the relationship between socio-cultural factors and utilization of STI treatment services, Chi square test and P-value was carried and socio-cultural factors were compared with the utilization of STI treatment services. The results of the chi square test and P-value are displayed in table 11.

From table 11, there was no association between religion and ethnicity to utilization of STI treatment at the required threshold of (χ2= 7.760, P= 0.652) and (χ2= 11.133 P= 0.194) respectively.

5.4 Health Knowledge and Awareness of YFRHS

The college youth knowledge on YFRHS was assessed by asking them whether they knew about any facility offering reproductive health services and the services being offered as reproductive health services. Those who knew about the YFRHS services were further asked to state their source of information and the responses are reflected in figure 2.

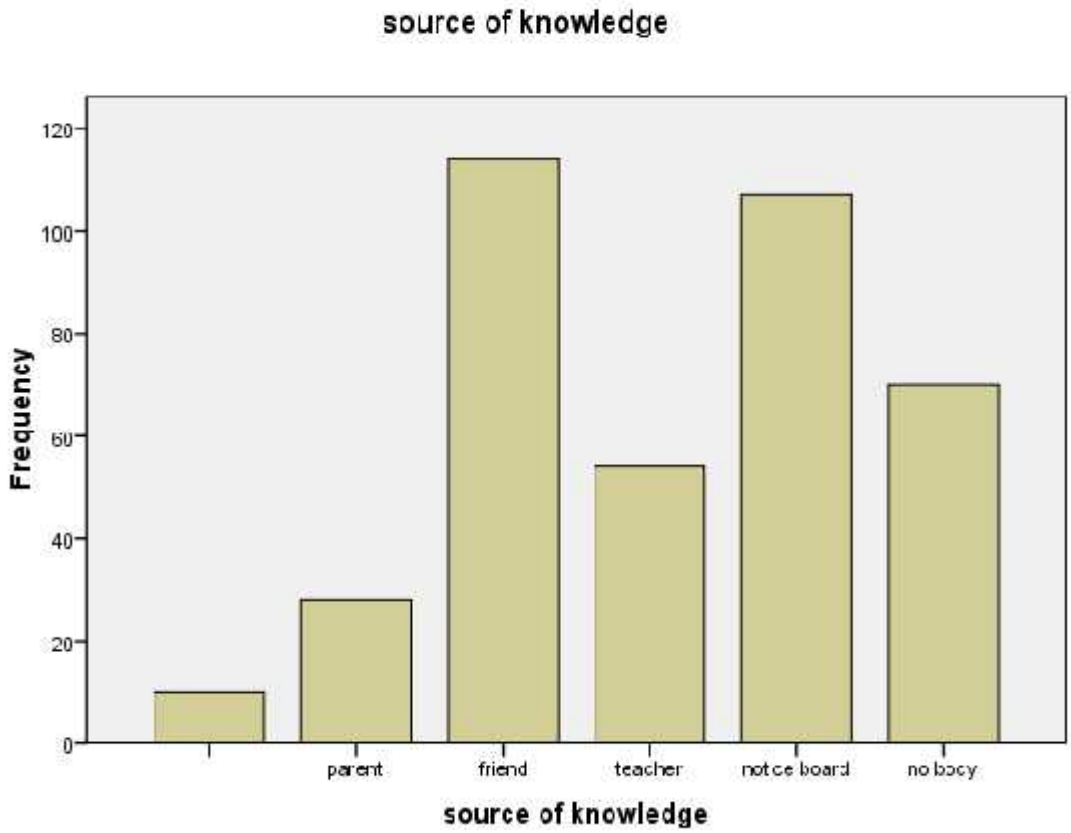

Figure 2 Source of information on RHS

Figure 2 shows that majority of the college youth (30.3%) had received information on YFRHS from their friends. However among those who knew about YFRHS, 29.2% got the information from their notice board, while parents 16.7% and 12.3% asked no body and teacher respectively and about 6.3 and 2.6 had got information from parents and unknown source respectively.

5.5 Health System Factors and Utilization of YFRHS

Health facility factors that encouraged or discouraged the youth from utilizing YFRHS were investigated. Factors such as availability of reproductive health services within the college, distance to reproductive health service, staff treatment/handling of the youth and cost of the services were assessed. The youth were asked whether there was a reproductive health facility within the college.

5.5.1 Availability of Reproductive Health Facility

The youth were asked whether they had a reproductive health facility within the college and 75.7% said they had no YFRH facility while 24.3% said they had the facilities.

5.5.2 Distance of YRHS Facility and Utilization of YFRHS

The respondents were further asked to estimate the distance from the nearest facility using transport fare as an estimate.

Table 12 Distances of YFRHS Facility

	Frequency	Percent	Cumulative Percent
Near, short walking	185	48.3	48.3
Near, but requires above #1.00 Eth. Birr	131	34.2	82.5
Far, requires # 1.50 Eth. Birr	67	17.5	100.0
Total	383	100.0	

Table 12 shows that most youth resided nearer to health facility as suggested by 185 (48.3%) of the youth who said that it was a walking distance to the nearest facility while 131 (34.2%) said that the nearest facility required transport fare of 1.00 Eth. Birr. Others, that is, 67 (17.5%) said that the nearest facility required transport fare of 1.50 Eth. Birr. Fare/money was used as an estimate for distance because it was difficult to do the estimate of distances in terms of kilometers as the roads within the town are not all marked showing distances.

5.6 Health Facility Organization

The youth were asked if they had ever sought for YFRHS but did not get them and 78.9% of the youth indicated that they actually did not get the services. Those who sought but did not get the services were asked to state the reasons that made them miss the services. Figure 4.3 displays the reasons for missing the services as stated by the youth.

Figure 3: Reasons for Missing YFRHS

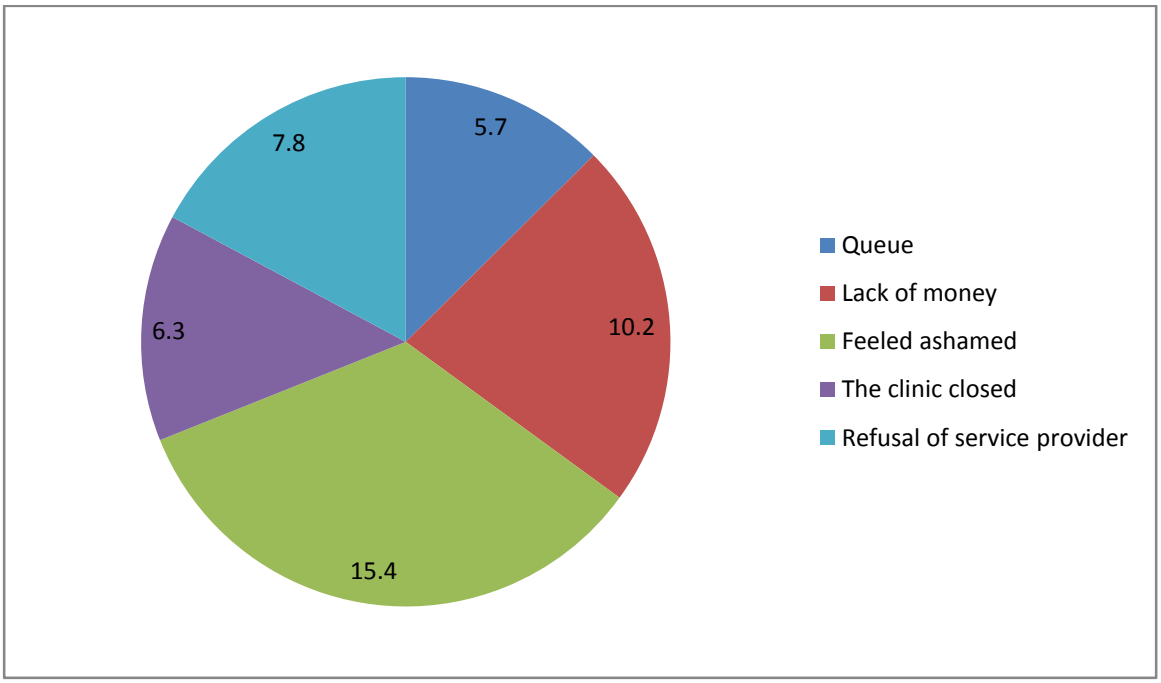

Figure 3 shows the reasons cited by the youth for not receiving the services required as; long queues at the facility (5.7%), facility closure at the time of arrival at the facility (6.3%), lack of money to pay for the services (10.2%) while (15.4%) said they met neighbors/relatives at the facility and felt embarrassed. Some 7.8% of the youth were turned back by service providers.

CAPTER SIX

Discussion of Results

6.1 Demographic Factors and Utilization of YFRHS

The statistical tests (Chi square analysis and P-value) showed that age and sex of an individual were not associated with utilization of almost all reproductive health services by the youth. This finding is not expected because younger youth have lower knowledge of reproductive health issues and this is in agreement with a study by United Nations (1995a) (3) which reported low utilization of RHS among young people due to poor understanding of their changing bodies and insufficient awareness of risks associated with early sexual debut, STI/HIV and pregnancy and shyness.

The older youth are sexually active and have freedom to make their choices as was found out by this study that majority of youth aged 19-24 made self decisions when they needed the services.

6.2 Socioeconomic and Level of education Factors and Utilization of YFRHS

The employment/ or occupation of the youths' parent showed no significant association to utilization of YFRHS service. Actually this would not confirm the finding that there is a cost attached to treatment as was mentioned by some youth because being the farmers family members had no matter concerning income. STI management a lot of time involves syndromic approaches that are not charged for irrespective of whether the individual is a college youth or not thus explaining the connection between employment status and this utilization. This means that without money the youth might access and utilize the service.

This finding is in agreement with a study that was done by PATH (1999) (15) which showed that generally health service utilization including RHS was tied to economic aspects of an individual. The implication of this finding is that majority of the youth are likely not to seek medical care and treatment for these infections in time and this can lead to serious reproductive health complications such as infertility in future. The implementation of YFRHS should be done in totality such that no fee should be charged at all for all services offered at YFRH facility.

6.3 Socio- cultural Factors and Utilization of YFRHS

Religion had no association to utilization of reproductive health services. It was established that some religions prohibited the youth from utilizing YFRHS. But this was evidently brought out when descriptive, chi square, and P-value all showed no significant relationships. Ethnic group had no significant association to utilization of all services thus disagreeing with a study report in Godia, P (2010) (17) which stated that most ethnic groups prohibit premarital sex and pregnancy and youth were reprimanded for using family planning.

6.4 Health Knowledge and Awareness Factors and Utilization of YFRHS

College youth at all levels had generally low knowledge on YRFHS services a fact that led to low utilization of these services. The one who reported knowing of the specific services given and the YFRHS facility registered increased utilization than those who did not know as was also confirmed by the chi square analyses (table 3). These findings agree with studies by Godia, P (2010) (17) which reported that lack of knowledge by the youth was a major factor that caused underutilization of youth friendly reproductive/sexual services. Further stated that lack of understanding of the importance of sexual health care or knowledge of where to go for care may discourage the youth from using YFRHS as also discussed in study of Godia, P (2010) (17). On sources of RH information, majority (30.3%) of the college youth sought information from their friend and (29.2%) from the notice board with somewhat few 16.7 %, 12.3% and 6.3% asking from no body, from teachers and parents respectively. This implies and confirms that the youth due to the sensitive nature of reproductive health issues they don't share the issue with others whom they fear might raise judgment of early sexual debut.

6.5 Health System Factors and Utilization of YFRHS

On health system factors, the study established that utilization of YFRHS were affected by health facility organization, key among them were; long queues, facility closure at the time of arrival at the facility. Others were that the youth met neighbors/relatives at the facility and felt ashamed and being turned back by service provider respectively. Lack of money to pay for the services also featured.

The findings point to the fact that the reproductive health services were not youth friendly because the feeling ashamed of neighbors resulting from serving out of college and college youth at the same point, early facility closure and charging a fee for the services is against the recommendations contained in Adolescent Reproductive Health and Development policy which requires all the aspects of reproductive services to be free for the youth (23). The findings are also in agreement with other studies which pointed out similar reasons such as unfavourable operation hours which do not accommodate the youth's school schedules, lack of clear directions and services on offer, crowding, lack of privacy as the main impediments to utilization of reproductive health services by the youth (4,2).

6.6 Implications of the Findings

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

Limitations

The study focused on college youth and therefore generalization of the findings for out of the school youth may not be feasible. The study outcome depended on the truthfulness and openness of respondents as the information sought was considered personal and sensitive.
The economic aspect could not come out clearly given that financial matters are so sensitive and questionnaire focuses on parent's occupation rather than their income/ earnings. It could have been assessed more effectively if the youth were asked the family income/ earnings.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION

This chapter gives conclusion from the findings from quantitative data and recommendations based on research findings of the independent factors studied as follows; Demographic, socioeconomic and college factors, socio-cultural factors and utilization YFRHS, Health knowledge factors and Health system factors and utilization of reproductive health services. Finally summary of the key findings are also outlined. The findings show clearly that there are a lot of barriers to successful utilization of YFRHS. Results show that demographic, economic and facility barriers are still impeding utilization of YFRHS.

The study established that older youth not utilized the services more than the younger youth. The study therefore concludes that the college youth utilization of YFRHS is low and creating awareness of these services to them is important to enable increase their knowledge and understanding and in turn scale up their utilization.

On other hand Health service factors pointed mainly to the facility organization where both youth and adults were served in the same area thus creating unnecessary long queues which did not favour college youth who were impatient to wait and therefore left without the services.

7.2 Recommendations

The recommendations arising from this study are: this study recommends active sensitization of the youth in college through youth forums such as seminars, rallies, and any other gathering like drama that creates an opportunity where such information can be shared to scale up their knowledge on the YFRHS and the facilities that are available, this will in turn increase utilization of the services. There is need to train more school and college peer educators to compliment the health service providers in passing the youth friendly reproductive health information to their peers.

The integrated model adopted by most government health facilities have not favoured the youth therefore efforts by the government and partners should be geared towards increasing the number of facilities offering exclusive youth friendly services. This will increase the confidence of the youth and at the same time bridge the distances and bring these services nearer to the college youth for easier accessibility and in turn enhance utilization by the college youth. The government and partners should try mobile clinic approach and in cooperating them in college health services so that these services are taken to the colleges on specific days as a temporary measure as they look for modalities of increasing the number of YFRHS facilities. Need to train more service providers in dealing with the youth so that they may be friendly and appealing to them, this will attract them to the clinics or facilities and in turn improve utilization of the services. The government and partners should increase funding towards YFRHS to enable service providers to offer these services completely free of charge to enable the college youth access them without any constraints. The health care service providers should be mandated to adjust the working days and hours , that is, the facilities should remain open for longer hours up to 6.30 pm and be operated on weekends too to accommodate the college youth schedules.

7.3 Areas of further research

Similar studies need to be done in other area involving more schools to generate more supportive evidence. That a comparative study between the urban and rural school and college youth should be done to gauge their utilization patterns for reproductive health services and to inform policy adjustments and formulation. An age- related research needs to be done to cater for specific age groups for easier generalization.

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APPENDEXES

APPENDEX I : Subject Information Sheet (English Version)

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

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

Therefore, you will not be obliged to answer any question that you do not want to and you may end this interview at any time you want to. There are also no obligations for not participating in the interview. The interview will take about_____minutes.
If you have questions regarding this study or would like to be informed of the results after its completion, please do not hesitate to contact Ato Tolessa Kebede(091-200-9912)

Appendix 2: Subject Information Sheet (Afan Oromo Version)

Heeloo, akkam jirta? Maqaan koo_____jeedhamma. Amma quanoo University Finfineeti, Kollejii Saayinsii Fayya, dipartimantii narsii fi deesistu kesati adeemsifamufi fedhi kee yoota'e gaafifi deebi goonna.

Sababiin quanno kanasi tajaajilla fayya walhormaatati feedhiidhan fayadamuu dargagootaa hammam tokko akka ta'ee beekudhaafi. Kanaafu dhima armaan oliti isamee irate gaafillee tkko toko sigaafachuun barbaadaa.

Buu'an qu'anoo kunisi dhima armaan oliti ibsame irate namoota seerafi karroraa baasaniifi gargaarssa gudaa akka ta'uu nihubachiisnaa.

Hirmaanaan keetillee askeesati bu'aa gudaa akka ta'uu ni'abdanaa. Hirmmanna keetin walqabatee amoo sodaan wayituu akka siti hini'uumamnee nibeeksisnaa. Maalifi yoo jeetee gaafillee irati maqaan kee hinbareefamuu waan ta'eefi, kanaafu ichiitiin siriiti eegamma. Akasumasi amo feedhii kee male hirmaatufi dirqamaa hinqabduu.

Gaafillee kuni hangaa sa'aati daqiiqaa_____ fudhachu nidanda'aa.

Qu'anoo kana ilaalchisee gaafii yoo qabbatee ykn bu'aa issa beekufi yoo barbaadee obbo Tolassa Kabbadaatiin qunamtii godhuudhafi hinlaafin. Lakk. Bilbilla 091-200-9912.

Appendix 3: Oral Consent Form (English Version)

I have read the information sheet concerning this study (or have understood the verbal explanation) and I understand what will be required of me and what will happen to me if I take part in it. I also understand that any time I may withdraw from this study without giving a reason and without me or my families' routine service utilization being affected for my refusal.

Participant's signature _____ Date_____

Interviewer signature certifying that the informed consent has been given verbally.

Interview's name _____ signature _____ Date _____

May I continue the interview?

1. Yes _____Continue the interview
2. No _____Stop the interview and thank the respondent

Result: (to confirm for completeness)

A. Questionnaire completed _____
B. Questionnaire partially completed _____
C. Participant refused _____
D. Others (please Specify) _____

Checked by Supervisor:

Supervisor's Name _____ Signature _____Date _____

Appendix 4: Oral Consent Form (Afan Oromo Version)

Waraqaa odeefanoo qu'anoo kanaa ilaalchisee armaan oliti barrayee dubisee naadubisameesi hubanoo keesa galchee jiraa, wanta naraa barbaadamusi naafgallee jiraa.

Ida'amaanisi wayitiin barbaadameeti sababii tokko mallee osso annafi maati kiyarati rakko hinuumini addan kutuu akkan danda'uullee beekee jiraa.

Mallatto hirmaataa_____guyyaa_____

Mallattoo abaa gaafi dhiiyeesee mirkaneesu.

Maqaa_____Mallattoo_____guyaa_____

Amma gaafii ittifufuu danda'aa?

1. Eyeeni_____ittifufuu
2. Lakki_____gaafachu dhiisuu fi gaafi deebisa galateefachuu.

Appendix 5: Questionnaire for Youth (English Version)

QUESTIONNAIRE

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

PARTICIPANTS' INSTRUCTIONS

Do not write your name; tick only one correct response and multiple responses where applicable. Only youth aged between 19-24 years are eligible for this study. The acronym YFRHS stands for youth-friendly reproductive health services

Part One-Socio-demographic, economic, school and socio-cultural Information

1. What is your Sex? a. Male b. Female
2. What is your age in years? _____
3. What is your current level of education you are pursuing now or which year you are?
   a. First year b. Second year C. Third year
4. What is the type of school you attend? a. Boarding school b. Day school
5. What is your religion?
   a. Orthodox Christian b. catholic c. protestant d. Muslim e. Other
6. Does your religion restrict utilization of youth friendly reproductive health service (YFRHS)?
   a. Yes b. No
7. If your answer is yes describe it_____
   _____
8. What is your ethnicity?
   a. Oromo b. Amhara c. Guragie d. Tigrie e. Other
9. What is your parent(s) occupation?
   a. Formal employment (Teacher, civil servant, NGO worker etc)
   b. Casual laborer c. Self employment/business d. Farmer

Part Two - Knowledge and Utilization of Youth-friendly Reproductive Health Services (YFRHS)

10. Do you know of any Reproductive Health facility? a. Yes b. No
11. If yes who told you about it?
    a. Parent/Guardian b. Friend/Peer c. Teacher
    d. I read on a notice board e. I do not know of any
12. Which services are being offered in reproductive health facility? Tick all correct answers
    i. Family planning services (Contraceptives, condoms)
    ii. Voluntary Counseling and Testing(VCT)
    iii. Treatment of all the diseases
    iv. Treatment of sexually transmitted Infections/diseases
    v. Care of pregnant young persons
    vi. General health information/counseling
    vii. Sports and recreational activities

Utilization of YFRHS

Have you ever used any of these services?

13. Counseling services a) Yes b) No
14. Family planning a) Yes b) No
15. VCT services a) Yes b) No
16. Treatment of STI a) Yes b) No
17. Antenatal services a) Yes b) No

Part three: Health System Factors

18. Is there youth-friendly reproductive health (YFRHS) facility in your school?
    a. Yes b. No
19. If yes in no.18, state the reason for not getting the service
    a. The queue was long
    b. I have no money for the service
    c. I found neighbors and felt ashamed
    d. The clinic is closed
    e. The service provider refused to give the service/ was harsh

20. How far is youth friendly reproductive health facility from your school?
    a. Near, a short walking distance
    b. Near but requires about # 1.00 Eth birr for transport
    c. Far, requires # 1.50 Eth birr and above for transport
21. If you have ever used a reproductive health service facility, how would you describe how you were handled by service provider?
    a. Good-Friendly, welcoming, handled me well and gave me the service I required
    b. Moderate-welcomed me but asked too many unnecessary questions before giving me service
    c. Bad, he/she was harsh, rude and denied me service
22. Have you ever visited youth friendly reproductive health service but missed the service you required? a. Yes b. No

Appendix 6: Questionnaire for Youth (Afan Oromo Version)

Guyyaa_____Nanno qu'anoo_____Koodii gaffii_____

Qajeelfamaa hirmaatoota

Maqaa kee hinbarreesini, deebii siriidha jetee tokkicha irate mallatto godhi, yoo barbaachisa ta'esi tokko oli irate godhu nidanda'amaa.

Boqanna tokko: Odeefanoo soshio-dimograafiki, qabeeyna, mana barnootafi Aadaa

1.Saali kee kamiidha? A. Dhiira B. Dhalaa

2. Umiriin kee meqaa? _____

3. Sadarkaan baruumsa kee ama irra jirtu maaliidha ykn wagaa meeqaffaadhaa?_____

A. Waga tokkoffaa B. Waga lamaffaa C. Waga sadaffaa

4. Akkaakun mana barnoota ittibaratuu kamiidhaa?

A. Kankeesa bulani B. Kan oolani galani

5. Ammantaan kee kamiidhaa?

A. Chiristaana Orthodoxii

B. Chiristaana kaatoliki

C. Chiristaana proteestaantii

D. Musliima

E. Kanbirra

6. Ammantaan kee fayyadama tajaajila fayyaa walihormaataa nidhorkaa?

A. Eeyeeni B. Lakkii

7. Deebin kee eeyeeni kanjeedhu yoo ta'ee ibssa keni

_____

_____

8. Gostii kee kami?

A. Oromoo B. Amaaraa C. Guraagee D. Tigree E. Kanbirra

9. Hojiin wara/gudiftuu keeti maaliidhaa?

A. Hoojataa mootumaa (Barsiissa, siivil sarvaantii, hojataa miti mootuma, etc…)

B. Hoojataa humnnaa

C. Hoojataa dhuunfaa/nagaadee

D. Qootee bulaa

Boqanna Lama: Beekumsafi fedhiidhan ittifayadamuu tajaajila fayaa walhormaata dargagoota

10. Dhaabata tajaajila fayyaa walhormaata keenu kan beektu jirra?

A. Eeyeen B. Lakki

11. Deebin kee yoo eeyeeni kanjedhuu ta'ee waaya issaa eenyutu sitihimee?

A. Wara/gudiftuu B. Hiriiyaa C. Barsiissa

D. Beeksiisa irrati dubisee E. Hoomaa hinbeeku

12. Dhaabata fayyaa walhormaata keesatitajaajili isin argatani maalfa'aa?

A. Qusannoo maatii (kiniinii ulfa ittisuu, kondoomi)

B. Tajaajila fedhiidhani marii'achuufi qormaatamu

C. Yaalii dhukuba hundaa/waliigalaa

D. Yaalii dhukuba walqunamtii saalaatin dadarbani

E. Gargaarsa dubartii ulfa daa'umaa qabanii

F. Odeefannoo fayyaa waligalaa

G. Sosochii espoortiifi bashananna

Fayyadama dargagootaa fedhiidhan tajaajila fayyaa walhormaataa argachuu

13. Tajaajila marii? A. Eeyeen B. Lakki

14. Qusannoo maatii? A. Eeyeen B. Lakki

15. Tajaajila fedhiihdan marii'achufi qormaatamu? A. Eeyeen B. Lakki

16. Yaalii dhukuba walqunamtii saalatin dadarbani? A. Eeyeen B. Lakki

17. Tajaajila hordofii ulfa? A. Eeyeen B. Lakki

Boqannaa sadi: Sirna keniinsa tajaajila fayyaa

18. Mana baruumsa kee keesati dhaabani dargagootafi fedhiidhan tajaajila fayyaa walhormaata keenu jirraa? A. Eeyeen B. Lakki
19. Deebin gaaffi 18ffaa eeyeen kan jedhuu yoo ta'ee, sababii dhabinsa tajaajilichaa kamiidha?
    A. Hirririi issa dheeraa waanta'efi
    B. Qarshii tajaajila keenamu waanhiqabneefi
    C. Namootan beeku yoon argee waanani qaana'uufi
    D. Dhaabatichi yerroo baayee chuuffaa waanta'eefi
    E. Tajaajila kennaani fedhii waan hinqabneefi yerroo hunda waan mudamuufi
20. Dhaabani tajaajila fayyaa walhormaata dargagootafi fedhiin kenuu mana baruumssaa irraa hammam fagaataa?
    A. Baayee dhiyoo
    B. Dhiyoodha garuu geejibaafi qarshii 1.00 nibarbaachisa
    C. Baayee fagodha geejibaafi qarshii 1.50 oli nibarbaachisa
21. Dhaabata tajaajila fayyaa walhormaatati fayyadamtee jirta yoo ta'ee, haali keesumeesu namoota tajaajilichaa kenanii maalfakaata?
    A. Baayee gaariidha; akka hiriyaati nakeesumeesani, tajaajilan barbaadu hundasi naafkenani
    B. Gidugaleesan nakeesumeesan, gaafiwan barbaachisa hinta'inisi nagaafatani
    C. Baayee gaarii mitti, mudamaafi jibiinsaan nakeesumeesu
22. Dhaabata tajaajila fayyaa walhormaata dhaqxxee beekta, garuu tajaajila barbaadu guyyan hin argatin jirraa? A. Eeyeen B. Lakki

Declaration

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

Name: Tolessa Kebede

Signature: _____

Date: _____

Place: Addis Ababa University, College of Health Sciences, Department of Nursing and midwifery

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

Ato Feqadu aga (Bsc, Msc)

Signature: _____

Date: _____

Place: Addis Ababa University, College of Health Sciences, Department of Nursing and midwifery

APPROVAL COMMITTEE/EXAMINER

1. **EXAMINER NAME** **SIGNATURE**

_____ _____

DATE

_____