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**Determinants of Reproductive Health Service  
Utilization among Youth: The Case of Students in  
Higher Education Institutions of Addis Ababa**

By

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**ADDIS ABABA UNIVERSITY**  
**COLLEGE OF DEVELOPMENT STUDIES**  
**CENTER FOR POPULATION STUDIES**

**DETERMINANTS OF REPRODUCTIVE  
HEALTH SERVICE UTILIZATION AMONG  
YOUTH: THE CASE OF STUDENTS IN HIGHER  
EDUCATION INSTITUTIONS OF ADDIS ABABA**

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**JUNE, 2018**

## DECLARATION

I, Kiflu Kemal, hereby declare that this thesis is original and has never been presented in any other institution. To the best of my knowledge and belief, I also declare that any information used has been duly acknowledged.

Name: Kiflu Kemal

Signature\_\_\_\_\_

The dissertation has been submitted for examination with my approval as University

Advisor: Chalachew Getahun (PhD)

Signature \_\_\_\_\_

## **Approval Sheet by the Board of Examiners**

This thesis by Kiflu Kemal entitled: “**Determinants of Reproductive Health Service Utilization among Youth: The Case of Students in Higher Education Institutions of Addis Ababa**” is accepted in its present form by the board of Examiners as satisfying thesis requirement for the degree of Masters of Science in Population Studies(Reproductive Health).

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June, 2018  
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## Abbreviations and Acronyms

AAEB	Addis Ababa Education Bureau
AAIT	Addis Ababa Institute of Technology
AAUR	Addis Ababa University Registrar
AJORH	Africa Journal of Reproductive Health.
ANC	Antenatal Care Service
CDS	College of Development Studies
CPS	Center of Population Studies
CSA	Central Statistical Agency
EDHS	Ethiopian Demographic Health Survey
FDREYP	Federal Democratic Republic Ethiopia Youth Policy
FMOH	Federal Ministry of Health
HAPCO	HIV/AIDS Prevention and Control Office
HEI	Higher Education Institute
HEW	Health Extension Workers
HEWs	Health Extension Workers
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
MOFED	Ministry of Finance and Economic Department
PAC	Post abortion Care Service
PFI	Pathfinder International
PNC	Postnatal Care Service
PRB	Population Reference Bureau
RH	Reproductive Health
RHS	Reproductive Health Service
SMUR	Saint Mary University Registrar
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
STDs	Sexually Transmitted Diseases
UNAIDS	Joint United Nation Program on HIV/AIDS
UNFPA	United Nations Fund for Population Agency
UNICEF	United Nations Children's' Fund
USAID	United States Agency for International Development
UUR	Unity University Registrar
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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## **ABSTRACT**

*An integrated and inclusive approach is indispensable to scale up youth utilization of reproductive health services (contraceptive use and voluntary counseling and testing). This requires baseline survey of youth users of reproductive health services by investigate determinants of reproductive health services utilization among youths of the study area. Institutional based cross sectional study was conducted among 424 Addis Ababa and Unity University students starting from 12, March 2018 to June 2018, using a multi stage sampling technique. Self administered questionnaire was used to collect the data. The collected data was entered using Epi Data soft ware and analyzed using SPSS version 20. Utilization of contraceptive services and voluntary counseling and testing was 47.2% and 66.7% respectively. Females 2.3 times more likely uses contraceptive than males AOR: 2.3, 95% CI (1.062, 5.068), non health department youth 3.1 times more likely uses contraceptive than youth in health department AOR: 3.1, 95% CI (1.294, 7.216). As class year increases students awareness also increases as a result contraceptive utilization also increases year five youth 4.1 times more likely uses contraceptive than year one AOR: 4.1, 95% CI (0.83, 20.400). The more they have money regularly in their pocket, then the more they use contraceptive easily than those who had not; 94% less uses than those who have with AOR: 0.06, 95% CI (0.05, 0.872); class year of students had an association with voluntary counseling and testing service utilization of youth in the study area negatively year five and above youth 13% less uses voluntary counseling and testing than year one with AOR: 0.87, 95% CI (0.224, 3.356); head of house hold of the respondents being both father and mother was 1.25 times more likely to uses voluntary counseling and testing than other with AOR: 1.25, 95% CI (0.623, 2.508). Attitudes of reproductive health service providers leangth of time and convenient time preferred by youth were some of the additional determinants which found to have an association with reproductive health service utilization among students of the study area; So ministry of health, other government organizations, non government organizations who work on reproductive health issues and higher education institutions have to lend a hand each other in order to minimize the reproductive health risks faced by youth.*

**Keywords:** *Reproductive health, contraceptive use, voluntary counseling and testing, Higher education institutions*

# CHAPTER ONE

## 1.1. INTRODUCTION

Some countries define the word “youth” as young persons whose age bracket ranges between the end of childhood and the beginning of adulthood (FDREYP, 2004). Based on the same source some other countries define “youth” as the period when they start to engage themselves in activities that are considered by the community to be expression of adulthood. In Ethiopia, youth is defined as part of the society who is between 15-29 years old (FDREYP, 2004). In the world youth comprises about 20% of the world’s population, of which 85% live in developing countries (UNDP, 2009). They are faced with many reproductive health problems such as unintended pregnancy, induced abortion, STIs, including HIV/AIDS, sexual and reproductive ill-health are the major causes of RH problems (Bearinger *et al.*, 2007; Blum *et al.*, 2005; WHO, 2013).

Reproductive health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes”. It encompasses the ability to reproduce, freedom to control reproduction, the ability to go through pregnancy and childbirth safely, with successful maternal and infant survival and outcomes, the ability to obtain information about and access to safe, effective and affordable methods of family planning, the ability to have a satisfying, safe sex life, free from fear of pregnancy and disease, the ability to minimize gynecologic disease and risk throughout all stages of life (Laurel, 2007). Youth need to have updated, accessible, integrated and comprehensive reproductive health services (Julie, 2016). They have been neglected by considering them relatively healthy as compared with infants and adults (Warenius, 2008). Have to be sure for their confidentiality in RH service providers (WHO, 2002). Reproductive health service is a service provided by a health worker to a patient (or clients) aimed at preventing a reproductive health problem, or detecting and treating one. It often includes the provision of information, advice and counseling (WHO, 2012).

Using RH services properly by youth helps to prevent unwanted pregnancy, to respond to unwanted pregnancy when it occurs, to support healthy pregnancy and to prevent problems during pregnancy, to respond to problems when they occur during pregnancy, to prevent sexually transmitted infections (STI), to respond to STI when they occur, to prevent HIV infection, to respond to HIV infection or HIV related illnesses when they occur, to prevent sexual violence and to respond to sexual violence when it occurs (WHO, 2012). Special

consideration has to be given to youth in order to have sustainable health and economic sector development because it is a period of great opportunities and hope (Laurel, 2007).

In Ethiopia, there are 27 youth friendly services (MOH, 2010), and these services are integrated with the existing health facilities and provide SRH information and condom, as well as counseling services related to STI and HIV. But utilization of RH services by sexually active youth was low and full of risks such as unsafe sex, having multiple sexual partners exposed to STIs including HIV/AIDS (Amsale and Yemane, 2012).

Therefore, studying on determinants of RH service utilization is helpful in order to minimize the risks faced by youth in the study area, since RH problem affect their ability to attend school, to work and to their overall health (Kristen *et al.*, 2016).

## **1.2. Statement of the Problem**

In the world there are 1.2 billion youth and made up the largest cohort in history (PRB, 2017). In Ethiopia, these people contribute more than quarter 34.7% of the total population of the country (Fentie *et al.*, 2010). Risky sexual activities, early pregnancies and sexually transmitted infections (STIs) including HIV/AIDS infection rates are increasing among youth mainly in developing countries (Ingwersen, 2001; WHO, 2006). HIV/AIDS continues to affect many youth in sub-saharan Africa (PRB, 2017) in Addis Ababa, almost all (90 percent) people living with HIV/AIDS are believed to have acquired the infection before the age of 25 mainly due to not using RH services properly (FDRE, 2010); 29 percent women of age (25-49) had first sexual intercourse before age 15, and 62 percent of them are at age 18; by age 25 the majority 88% of women have had sexual intercourse (CSA, 2011). Contraceptive prevalence rate was 35 percent for the country and 64 percent for Addis Ababa; many of youths were less experienced and less comfortable in utilizing reproductive health services (Helpdesk Report, 2011; Wassie *et al.*, 2016; CSA, 2016). Sexually active students in lower grade have multiple sexual partners who are not using reproductive health services consistently (Amsale and Yemane, 2012). In Addis Ababa university health and non-health department students, there was attitudinal differences towards HIV risk reduction strategies and the perception of risk for acquisition of HIV infection and utilization of VCT services were low (Desalegn *et al.*, 2017) .

Similarly, among sexually active students of Madawalabu University; only 27.7% ever used contraceptives (Negasa *et al.*, 2015).

On the other hand, a sizeable proportion of Ethiopian youth know about modern methods of contraceptives (Hailom and Pav, 2002); here knowing about contraceptive methods does not give guarantee but using it effectively.

There are some studies related to RH in the study area such as risky HIV sexual behavior and utilization of voluntary counseling and HIV testing and associated factors among undergraduate students in Addis Ababa Ethiopia (Desalegn *et al*, 2017), Peer pressure on risky sexual behavior among school adolescents in Addis Ababa (Amsale and Yemane, 2012), Risk factors for unsafe sexual behavior among preparatory youth students of Addis Ababa (Azeb, 2009) and so on. In all cases the RH service prevalence of the student was low and the studies are concerned with RH risks.

Though there are many RH and related studies in the study area, there is no specific research that is concerned with determinants of RHS utilization for both youths in public and private higher education institutions of Addis Ababa. Reproductive health is important for their health development and provides an immense contribution to which they become when they matured into adulthood (MOH, 2006). Therefore, researching on the determinants of RH service utilization primarily helps to know the reason behind not using the RH services effectively while they are engaged in risky sexual practices; to minimize the RH risks faced by sexually active youth, to have proper guidance and to inform stakeholders such as ministry of health, non-governmental organizations who work on reproductive health services about the issue.

### **1.3. Objectives**

#### **1.3.1. General objective**

The main objective of this study is to investigate the main determine factors of reproductive health service utilization of youth in the study area.

#### **1.3.2. Specific objectives**

- To describe the status of reproductive health service utilization among youth in the study area.
- To analyze the determine factors of reproductive health service utilization of youth in the study area.

#### **1.4. Research Questions**

- What is the extent of reproductive health service utilization among youth in the study area?
- What are the main factors that determine reproductive health service utilization among youth in the study area?

#### **1.5. Significance of the Study**

This research is a study conducted on reproductive health service utilization and associated factors among youth of the study area. It generates important and reliable information on the extent of reproductive health service utilization and influencing factors; which is crucial for effective intervention of youth reproductive health service. This research can contribute by filling the gap untouched by other studies using different predictor variables. The study is also useful for future researchers in the area of reproductive health service utilization.

#### **1.6. Scope and Limitations of the Study**

##### **1.6.1. Scope**

The study covered the issues related to reproductive health service utilization among youth in the study area and concerned on identifying the major demographic, institutional, socio-economic and psychological factors that significantly affect the sample respondents.

##### **1.6.2. Limitations**

This research had the following limitations. The researcher does not look design effect for sample size due to financial shortage. If the number of the sample size was bigger than this the outcome might be more relevant and sound. In addition, it does not use all the students of the selected departments as sample respondents, i.e. the responses of year four engineering; medicine and clinical nurse students are not included. The study outcome is based on the truthfulness and openness of respondents as the information sought was considered personal and sensitive. Some socio-economic and demographic factors like family income were asked categorically in the questionnaire.

## CHAPTER TWO

### 2. REVIEW OF THE LITERATURE

#### 2.1. Conceptual Literature on Reproductive Health

##### 2.1.1. Reproductive Health and sexual intiations

According to Laurel reproductive health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.” It encompasses: the ability to reproduce, freedom to control reproduction, the ability to go through pregnancy and childbirth safely, with successful maternal and infant survival and outcomes, the ability to obtain information about and access to safe, effective and affordable methods of family planning, the ability to have a satisfying, safe sex life, free from fear of pregnancy and disease, the ability to minimize gynecologic disease and risk throughout all stages of life (Laurel, 2007).

Most men and women become sexually active during the age of adolescent. It is the period of experimentation and engagement of a wide range of behaviors characterized by puberty, which involves changes in physical appearance and developing reproductive ability that make them vulnerable to different sexual and reproductive health problems such as unplanned pregnancy, unsafe abortion, STIs including HIV/AIDS etc. These problem exposed high risk on their life (Glasier *et al.*, 2006; UNFPA, 2010; Kristen *et al.*, 2016). This is may be due to the following factors: their young age, ignorance of matters related to sexuality and reproductive health, lack of factual knowledge about contraception and their inability or unwillingness to use most family planning and health services (Mago *et al.* 2005). In order to avoid such risks they have to use reproductive health services effectively.

##### 2.1.2. Reproductive Health Service and its Characteristics

###### a. Reproductive Health Services

Reproductive health service is a service provided by a health worker to a patient (or clients) aimed at preventing a reproductive health problem, or detecting and treating one. It often includes the provision of information, advice and counseling (WHO, 2012).

Above 165 countries agreed to access reproductive health services to their populations by 2015(Laurel, 2007).The ICPD+5 in 1999 showed that countries had not allocated sufficient resources and had limited institutional capacity to achieve these goals (RHM, 2006). Due to this and other reasons, youth awareness of RH faces obstacles when they want to use the

service in addition to poverty and gender inequality. Some of the problems are related to the availability, accessibility, acceptability and equity of health services (WHO, 2003; PFI, 2012).

### **b. Characteristics of Reproductive Health Services**

Fundamental characteristics of reproductive health services include: provider characteristics, facility characteristics and aspects of program design. Characteristics that were often mentioned as necessities include: staff that are specially trained to meet the needs of young people, staff that respects the privacy and confidentiality of the services rendered, staff that spend adequate time to attend to the client, clinics where peer educators are available to young people, separate space and time for young people, hours that is convenient to young people, convenient location of services, youth involvement in services, short waiting time, affordable or free services and a wide range of available services with limited need to refer (AJORH, 2005).

Youth need to have updated, accessible, integrated, and comprehensive reproductive health services by building the capacity of health service facilities (Julie, 2016). The above conditions also considered as barriers in developing countries including Ethiopia (AJORH, 2005; Jane and McCauly, 1998). In Ethiopia, in addition to other service centers RH services addressed through HEWs (MOH, 2006). The responsibility of using RH service such as contraceptive falls too heavily on women than male (Lawrence *et al.*, 2003). So, men should play a greater role in using the services, participating in contraceptive decisions and supporting women.

Now a day, there are the largest cohort of youth in history, it is essential to continue to carefully design interventions and review their impact to assure that adolescents have tools to make healthy choices concerning their sexual and reproductive health (Michelle and Adesegun, 2009; PRB, 2017).

Failure to use health services expose youth to preventable health conditions (Heflinger and Hinshaw, 2010). Most youth prefer to receive reproductive health information not from the right source but from friends, printed materials and informal sources (Jejeebhoy, Shah and Yount, 1999).

## 2.2. Empirical Studies on Reproductive Health

One of the most important factors influencing the RH status of Ethiopians is poverty (MOH, 2006). In addition to economic problem of the population there are reasons for low prevalence of using the service provided and it is severe among youths. Different studies reveal that the following are some of the factors that account for low use of reproductive services by youth such as: feeling that reproductive health services are for adults or married people, lack of privacy (WHO, 2001; Warenius, 2008). Factual misinformation or perceptual bias by youth that use reproductive health services is for promiscuous or infected people (Belmonte *et al.*, 2000). Further, remoteness of the reproductive centers (Aninanya *et al.*, 2015) and high cost of service are among the list (Singh *et al.*, 2012).

Most adolescents all over the world are sexually active and engage in pre-marital sexual activities (Jegeebhoy *et al.*, 1999; Gubhaju, 2002; Reboucas, 2008). For instance, youth in Uganda start sexual activities at an early age with an increase in the median age for first sex experience among adolescent of 16 years in 1998 - 1999 to 18.3 years in 2000 – 2001 (Neema *et al.*, 2004). The median age for first sex in Ethiopia was 18.1 years in urban area, 16.1 years in rural area and 16.58 years in Addis Ababa high school students (Haile *et al.*, 2013). Half of all adolescents attending general health facilities reported having sexual experience, with an average age of sexual debut of 25 years (Jegeebhoy *et al.*, 1999). Based on the same source, more than one third of all women requiring delivery services were adolescents. They clearly need sexual and reproductive health services (Jegeebhoy *et al.*, 1999).

Lack of health care service for reproductive health or difficulty in accessing them is some of the RH problem (Tilahun *et al.*, 2012). Most youth in Addis Ababa failed in RH risks (Azeb, 2009). Most of pre-marital sexual intercourse is unprotected. Sexually active adolescents are increasingly at risk of contracting and transmitting sexually transmitted infections including HIV/AIDS (Gubhaju, 2002). In Ghana-Dodowa, among adolescents in senior secondary schools (SSS) and junior secondary schools, the findings were that dropping out of schools were largely attributed to inability to pay school fees and pregnancies for girls (Afenyadu and Goparaju, 2003).

When we compare youth and adults, youth were less likely than adults to know a place where they could get the RH service (CSA, 2011). Knowledge of a place to get RH services increases steadily with education and wealth (CSA, 2016). Among unmarried sexually active

adolescents in Sub-Saharan Africa, contraceptive use ranges from a low of 3% in Rwanda to a high of 56% in Burkina Faso (Khan and Mishra, 2008).

In Asia, contraceptive use among 'sexually active adolescents' has been reported low (Gubhaju, 2002). Contraceptive prevalence rate for Ethiopia is 35%, which is nearly half of the projection of Federal Democratic Republic of Ethiopia and many of youth less experienced and less comfortable in utilizing such kind of reproductive health services (CSA,2016; MOH, 2006; Wassie *et al.*, 2016).

In Addis Ababa, the RH service prevalence of students is low (Azeb, 2009; Girma, *et al.* 2015; Amsale and Yemane, 2012; Dawit and Teferi, 2013). In addition to this, youth are exposed to high risk activities (behaviors like alcohol drinking and use of addictive substances like chat chewing and shisha smoking) it is obviously associated with reproductive health risks (Tadess *et al.*, 1996).

In Uganda, it was found that while contraceptive knowledge among adolescents was high, but the level of actual use among sexually active adolescents is low (Neeman *et al.*, 2004). On the other hand, a sizeable proportion of Ethiopian youth know about modern methods of contraceptives from different sources (Bantayerga *et al.*, 2002). Study in Cameroon, Guinea, South Africa and Botswana reveals that while youth are aware of that condoms are the best way to protect themselves from HIV/AIDS and sexually transmitted infections, many still believe that condoms are for prostitutes (USAID, 2000). Based on the same report, a young Guinean woman stated that people who like using condoms are those who are sick and are trying to avoid disclosing their illness. The various studies outlined above, therefore, indicate that knowledge of contraception alone does not predict actual use. Many youths are less informed, less experienced and less comfortable in utilizing reproductive health services and exposed to the risks of unintended pregnancy, unwanted childbearing and abortion, as well as HIV and other STIs (Wassie *et al.*, 2016; Michelle and Adesegun, 2009). A study in Ghana showed that school going youth who reported parent-child communication about HIV/AIDS were more likely to have used condoms at last sex (Adu-Mireku, 2003). Women who were part of a multifaceted intervention were more likely to use RH services than those who were not to report communication with their children and other members of their household about issues related to sex and condom use (Phetla *et al.*, 2008).

A pregnant young woman in Shanghai- China, the reason behind of her non-use of contraception was fear of disclosure or embarrassment (Jejeebhoy *et al.*, 1999). Many young people often feel unwelcome citing that they encounter with providers who are judgmental, rude or who deny them services (Erulkar *et al.*, 2005). In Uganda, it was identified that lack of knowledge about how to use condoms is associated with its cost, availability, fear and distrust about condom effectiveness including the fear that condoms themselves are the sources of HIV viruses (Neema *et al.*, 2004). Sometimes there may be other reasons in a single society for not using RH services properly even if access and cost are not a problem. These could be social and religious barriers (Kofi *et al.*, 2002). In Swaziland, services are also seen not to be friendly including unfavorable attitudes of the health care providers (Jejeebhoy *et al.*, 1999). In Ethiopia, nearly one third (30%) of health care workers had negative attitudes toward providing RH services to unmarried adolescents (Tilahun *et al.*, 2012).

A number of studies speculate that youths' reproductive health needs would be better served in service environments (Bender, 1999; AJORH, 2005). Programs for young people must be designed well in order to address the RH services for young, but in Ethiopia, as well as in sub-Saharan Africa generally, they tend to deliver generic, age- and gender-blind messages that fail to recognize the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls (MOH, 2006).

The stakeholders have to work on addressing effective reproductive health services to all, specifically to youth. The limited access to targeted reproductive health care and services for young people contributes to, and exacerbates, many of the reproductive health problems (MOH, 2006).

### **2.3. Summary of Literature Review**

From the above literature review it is evident that all over the world adolescents involved in pre-marital sex at an early age are followed by RH problems. A number of risks as a result of pre-marital sex like sexually transmitted infections including HIV/AIDS, abortions, dropping out of schools, psychological problems and other socio-economic problems have surfaced from studies. Despite the awareness of some of the risks and reproductive health services, the adolescents' behavior is contrary. Factors that prevent adolescents from utilizing the available sexual and reproductive health services have also surfaced such as fear of disclosure/ embarrassment or shyness, lack of knowledge on how to use a condom, socio cultural

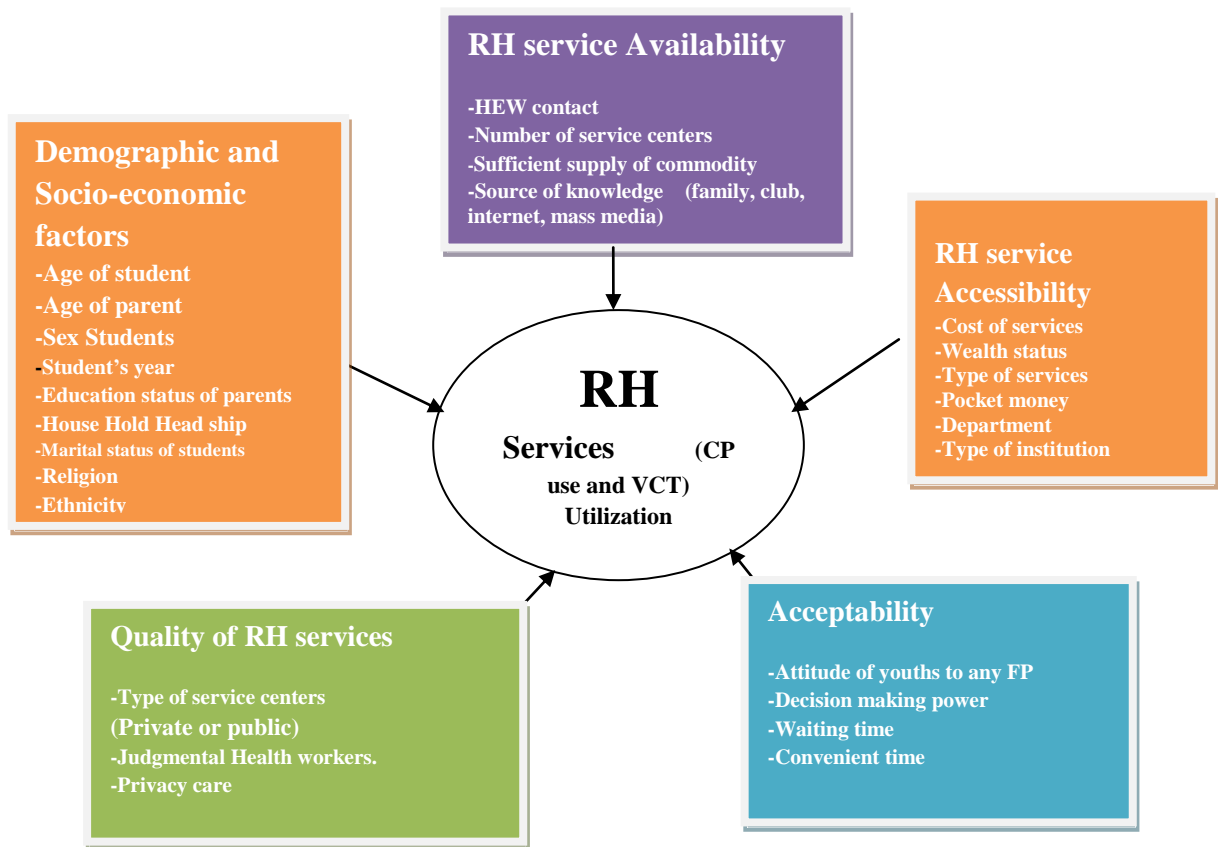
problem and not practicing the RH services. Other reasons have been related to poor quality of services, unfriendly attitude by providers of services, lack of RH service access and fear of being questioned by the nurses. In addition to that most youth perceive condom use as for prostitutes, infected people and thinking of using RH service is only for adults. Lastly, the literature suggests that RH needs of youth are taken seriously by using improved skills, empowerment and changed attitudes and behavior by stating the fundamental characteristics of reproductive health services.

#### **2.4. Conceptual Framework**

In this study, efforts are made to identify determinants of RH service utilization from literature, practical experiences and personal observation. The conceptual framework of this study is based on the assumption that the RH service utilization is influenced by a number of personal characteristics such as age, sex, education, sexual relation, HEW contact, type of service, decision making power and source of knowledge; socio cultural and economic characteristics such as religion, ethnicity, house hold head ship, wealth status, cost of services and pocket money; institutional and psychological factors such as number of service centers, type of service centers, kind of RH service in the university, sufficient supply of commodity, attitude of youth to family planning, information seeking behavior, waiting time, convenient time, judgmental health workers and privacy care. The conceptual framework in Figure 1 presents the most important variables hypothesized to influence the RH service utilization among youth in the study area.

The interaction of personal characteristics, socio cultural and economic characteristics and institutional and psychological characteristics are presented in the form of characteristics such as demographic, availability of RH services; access of RH services, quality of RH service and acceptability of the services and their influence on RH service utilization.

**Figure1: Conceptual framework of the study**



Source: Modified from (Azeb, 2009)

## **CHAPTER THREE**

### **3. Research Methodology**

#### **3.1. Description of the Study Area**

Addis Ababa is located at the heart of the country, at an altitude ranging from 2,100 meters at Akaki in the south to 3,000 meters at Entoto Hill in the North. The city occupies a total area of 540 Sq.Km (BoFED, 2013). The City has potential health service coverage of 100%. There are 11 government hospitals and 62 health centers (MOE, 2013). The research was conducted among public and private higher learning education institutions students of Addis Ababa who enrolled in the academic year 2017/18.

#### **3.2. The research Approach**

Only quantitative research approach was implemented due to time and financial constraints to analyze the collected type of data. It involved measurement of outcomes using numerical data under standardized conditions (Freedman, 2014). Since 424 sample respondents were selected scientifically using single proportion ratio and gave their response for the questionnaire.

#### **3.3. The Research Design**

The study was non experimental and institution based cross-sectional in nature. There are different reasons for using institution based cross-sectional study. It helps to determine the previous RH service utilization story of the study participants, to examine the potential link between predictor and outcome variables (Freedman, 2014).

#### **3.4. The Research Method**

##### **3.4.1. Study population and sampling**

Regular undergraduate students from Addis Ababa and Unity University were the study population. The source of population was all Addis Ababa and Unity University students in the study period.

##### **Inclusion criteria**

All voluntary and regular program higher education institute students who were in 15-29 age groups were included in the study.

## Exclusion criteria

Higher institutes and students with peculiar socio-demographic characteristic composition and inconveniences to conduct the study were excluded; regarding this the following higher education institution students were not included in the study.

- i. Students who had foreign background
- ii. Evening or distance learners

## Ethical consideration

Letter of ethical approval was obtained from Center of population studies of AAU and a letter of consent was obtained from the College of Business Education, Addis Ababa Institute of Technology, School of Medicine and Unity University Dean office. The purpose of the study was explained to study participants and a verbal informed consent was obtained from them.

Confidentiality of information was maintained.

### 3.4.2. Sampling technique

Sampling and sample size are crucial issues in research, which seek to make statistically based generalizations from the study results to the given population (Nick *et al.*, 2009). To generalize in this way about the population, it is essential that both the sampling technique used and the sample size should be appropriate in order to make the results representative, and that the statistics can discern associations or differences within the results of a study (Nick *et al.*, 2009). The researcher took the sample from the given population in the following fashion.

Let  $p$  be the proportion of students who utilize reproductive health service. In the absence of  $p$  and  $q$ , we can assign the product  $p*q$  will achieve a maximum possible value of 0.25, when  $p=0.5$  and  $q=0.5$ . Moreover, in most social science researches the desired level of significance is 95%, that is

$\alpha=5\% = 0.05$ . From the normal distribution table  $Z_{\alpha/2} = 1.96$

Therefore,  $n_0 = \frac{(Z_{\alpha/2})^2 * P * q}{e^2}$ , used to have sample size when the total population is

unknown (Gujarati., 2004).

Then the appropriate sample size was calculated by using the following assumptions:

- The estimate of population to be studied is to be within 5% the maximum acceptable error margin (degree of precision), i.e.,  $e=0.05$ .
- The desired level of confidence is 95%.

$$Z_{\alpha/2} = 1.96.$$

- Prevalence of RH risk in the population is assumed to be 0.5.
- 15 % contingency.

Using the above formula the sample size ( $n_0$ ) is:

$$n_0 = \frac{(1.96^2) * 0.25}{0.05^2} = 384.6 = 385$$

$$(n_0) \text{ *with out contengency* } = 385$$

Based on the data obtained from (AAUR and UUR) the total number of regular students for the academic year was 16, 576 and 6,214 respectively from (Year one-Year five or above). Initially, I chose higher education institutes of Addis Ababa and stratifying them as public and private universities, there are five public(Addis Ababa University, Addis Ababa Science and Technology University, Civil Service University, Kotebe Metropolitan University, Defense University) and five private (Unity University, St. Mary University, Rift Valley University, Alpha University and Admas University) universities in the city. By giving a chance for all of Addis Ababa Hiegher Education Institutions, I selected two universities, namely Addis Ababa and Unity University using simple random sampling technique. Three faculties were selected in the same manner from AAU namely (Addis Ababa Institute of Technology, College of Business and Economics and School of Medicine) and two Campuses of Unity University namely Gerji Campus and Selam Campus. Totally for the study I selected 424 students from twelve different departments obtained by simple random sampling technique from addis Ababa University; such as Pre-Engineering, Civil Engineering, Accounting and finance, Economics, Anesthesia, DDM, Midwifery, Medical Laboratory, Medical Radiography, Pharmacy, Nursing and Medicine, and from four departments from Unity University; such as Accounting, Marketing, Computer science and Clinical nurse.

Table 3.1. The study Population and Sample respondents

Departments	AAU Total	(AAU) Sample Respondents	Male	Female	UU Total	(UU) Sample Respondents	Male	Female
Pre-Engineering	585	34	24	10	-	-		
Civil Engineering	1,104	64	44	20	-	-		
Accounting and finance Management	348	20	13	7	-			
Economics	-	-			426	16	7	9
Marketing	297	18	14	4	-	-		
Computer science	-	-			1380	54	26	28
Anesthesia	-	-			735	28	20	8
Nursing	172	10	5	5	-	-		
Midwifery	145	10	3	7	-	-		
DDM	132	8	5	3	-	-		
Medical Laboratory	86	5	3	2	-	-		
Medical Radiography	97	6	4	2	-	-		
Medicine	162	10	5	5	-	-		
Pharmacy	1,719	100	66	34	-	-		
Clinical nurse	250	15	8	7	-	-		
	-	-			678	26		
<b>Total</b>	<b>5,097</b>	<b>300</b>	<b>194</b>	<b>106</b>	<b>3,219</b>	<b>124</b>		

Source: Own construction

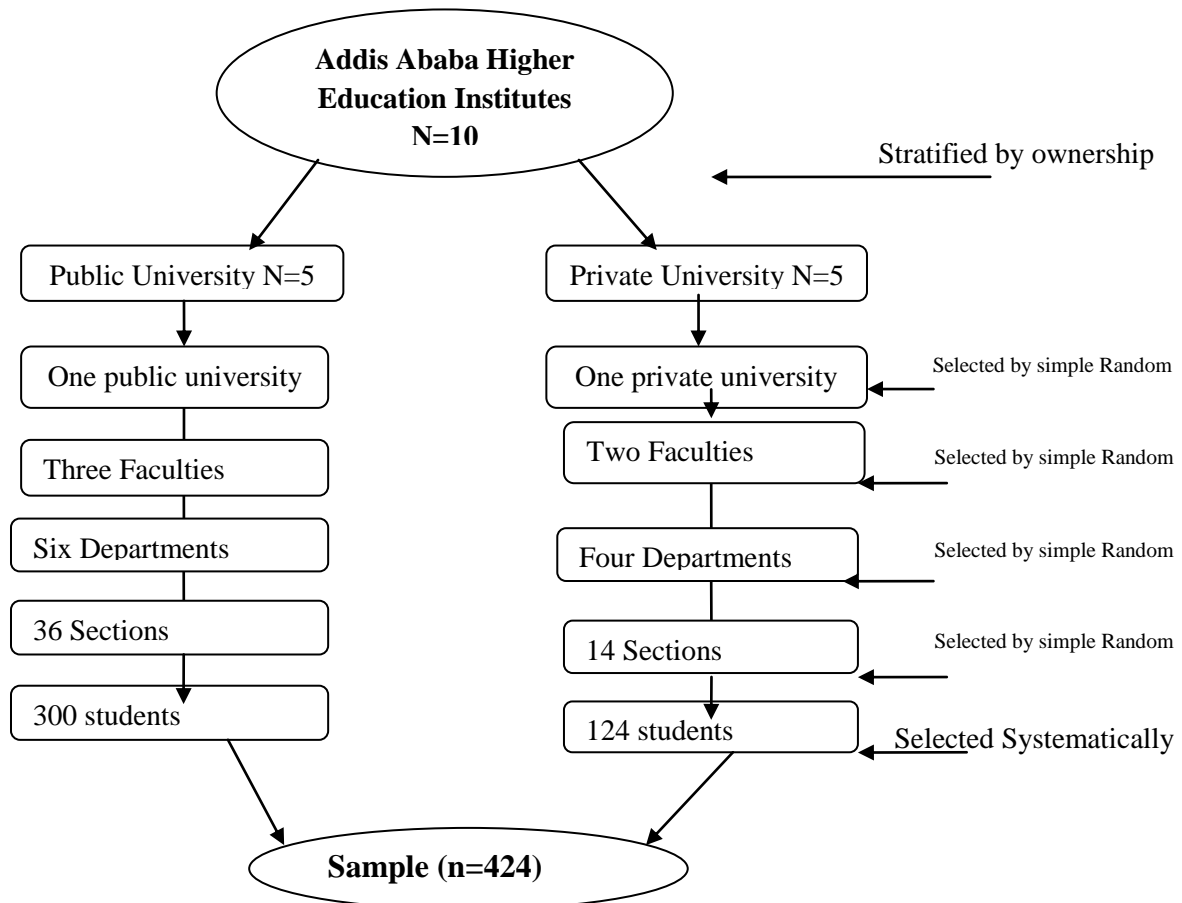
Total number of AAU students in the academic year 2017/18 was 16,576 whereas the total number of students in UU was 6,892 the sample respondents from AAU was 70.6% of the total sample=300 and the sample respondents from UU was 29.4% of the total sample =124

Now the sum of the students (N) in the selected department was 8,316.

$$\text{The new sample size } n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}} = \frac{385}{1 + \frac{(385 - 1)}{8316}} = 368 = 368 + 15\% \text{ of } 368 = 423.3 = 424$$

To give a chance to the total population a sample of 424 students would be selected by systematic sampling method from their attendance sheet for the study. In order to address this sample, the researcher did the following schematic diagram.

**Figure2: Schematic representation of the sampling procedure.**



Source: Modified from (Hailay *et al.*, 2017)

### 3.4.3. Data collection techniques

The primary data necessary for this study was collected from sample respondents by using structured questionnaires from (12, March 2018 to 6, April 2018) for the purpose of:

- i. Keeping uniformity of the questionnaires each respondent receive the same set of questions phrased exactly in the same way.
- ii. Keeping the standardization of the questionnaire helps to control the answer of the respondent.

The questions divided in to four major categories: Background characteristics that include questions related to demographic factors, reproductive health knowledge and health worker contact, attitude of youth towards RH services and reproductive health behaviors as (Dawit and Teferi, 2013).

The questionnaire was developed in English and translated to Amharic (local) language and back to English to check for its consistency. The final questionnaire was in Amharic version which was used as a self-administered one. By conducting repeated revisions, the questions were made as simple as possible to be answered by the students. In order to ensure the quality of data, the questionnaire was undergone pre-testing from 40 students in the same setup having similar age group as the target group, but from non-selected university students. Vague questions that were difficult to be answered by most of the students were emphasized and corrected accordingly after the pretest.

For the collection of data four enumerators who had knowledge related to socio-economic and reproductive health would be trained and employed for the data collection.

#### **3.4.4. Data analysis techniques**

The collected data was edited and entered to Epi Data version 3.1 in order to avoid possible errors then exported to SPSS Version 20 for analysis purpose. Descriptive statistics is employed for the description of different demographic and socio-cultural factors, availability, accessibility, acceptability and quality of care services and acceptability of the RH service characteristics of the sample respondents. These are mean, percentage and frequency. Moreover, the inferential statistics would be dummy/categorical variables and Binary logit model in order to analyze the result.

### **Model specification and the variables**

#### **i. Binary Logit Model**

This econometric model is used for analysis of determinants of RH service utilization of youth. The selection of binary models follow that individuals faced a choice of two alternatives and their choice depend on their characteristics. Hence, the objective of a binary choice model is to decide the probability that an individual within the given set of options will do one choice rather than the alternative (in the binary dependent variable, the response is coded 1 for yes, 0

otherwise). It is in this regard that over the linear probability models, binary logit and probit are the possible alternatives.

**a. The Logit and Probit Models**

The logit model assumes cumulative logistic probability function, whereas the probit probability model is associated with the cumulative normal distribution. For the purpose of the study, the logit model is chosen because it is simpler to work with and the interpretation of parameter estimates is simple. Although logit and probit yield similar parameter estimates, the logistic distribution (logit) has an advantage over others in the analysis of dichotomous outcome variable in that it is extremely flexible and easily used function from mathematical point of view and subjects itself to meaningful interpretation (Adersi, 1990; Hosmer and Lemeshew, 1989). The logit model has advantages over the probit model in that it transforms the problem of predicting probabilities within (0, 1) interval to the problem of predicting the odds of an event occurring within the real line.

**b. Specification of the Logit Model**

The dependent variable RH(CP and VCT) service utilization of youth is a dummy variable, which took a value one when youth was a user and zero otherwise; whereas the independent variables were either continuous or dummy/categorical variables expected to affect utilization of RH services. Following (Hosmer and Lemshew, 1989) the logistic distribution functions for analyzing the utilization of RH services:

$$P_i = \frac{1}{1 + e^{-Z_i}} \text{----- (1)}$$

Where  $P_i$  is the probability decision to use RH services for the  $i^{\text{th}}$  youth.

$$Y_i = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_m X_m \text{----- (2)}$$

Where  $Y_i$  is a function of  $m$  explanatory variables ( $X_i$ )

$\beta_0$  is the Y-intercept and  $\beta_1, \dots, \beta_m$  are slope parameters in the model. The slope indicates how the log-odds in favor of decision to use the RH services change as the explanatory variable change.

Since the conditional distribution of the outcome variable follows a binomial distribution with a probability given by the conditional mean  $P_i$ , interpretation of the coefficient will be understandable if the logistic model can be rewritten in terms of the odds and log of the odds,

(Gujarati, 2004). The odds to be used can be defined as the ratio of the probability that youth uses ( $P_i$ ) to the probability he/she does not use ( $1-P_i$ ).

But from (1), it follows that

$$1 - P_i = \frac{1}{1 + e^{Z_i}} \text{-----(3)}$$

$$\frac{P_i}{1 - P_i} = \frac{1 + e^{Z_i}}{1 + e^{-Z_i}} = e^{Z_i} \text{-----(4)}$$

$$\frac{P_i}{1 - P_i} = \frac{1 + e^{Z_i}}{1 + e^{-Z_i}} = e^{\beta_o} + \sum_{i=1}^m \beta_m X_m \text{----- (5)}$$

Taking the natural logarithm of the odds ratio of equation (5) will result the Logit model as follow:

$$\ln\left(\frac{P_i}{1 - P_i}\right) = \ln\left[e^{\beta_o} + \sum_{i=1}^m \beta_m X_m\right] = Z_o \text{-----(6)}$$

If the disturbance term  $U_i$  is considered the logit model becomes:

$$Z_o = \beta_o + \sum_{i=1}^m \beta_m X_m + U_i \text{-----(7)}$$

Where:  $U_i$  known as the disturbance, or error, term, is a random (stochastic) variable that has well-defined probabilistic properties. The disturbance term  $U_i$  may well represent all those factors that affect RH service utilization but are not taken into account explicitly.

### 3.4.5. Variables and Operational Definitions

#### 3.4.5.1. Dependent variable

**The reproductive health service** considered in this study was contraceptive use and voluntary counseling and testing (VCT) service; the percentage of youth who attend health facilities for contraceptives, voluntary counseling and testing and sexually transmitted infections treatment service are one of the indicators of the immediate and long term RH needs of young people (Kirby D., 1994). The dependent variable is RH service utilization. It is explicitly explained below:

**Reproductive health** is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.

**Service:** RH related function provided by any health institution for youth.

**Utilization:** The ability to use the RH service by youth of the study area for any RH purpose.

**Utilization of RH services:** Is dummy variable and take a value *1*; if youth used reproductive health services in their life time and *0* otherwise. Addis Ababa higher education institution students who use RH service for any RH purpose considered as user, and if they do not use they were called non users. For analysis of the data I use the binary logit model as (Haile, 2007; Tilahun, 2008; Feleke *et al.*, 2013; Nagasa *et al.*, 2015; Wassie *et al.*, 2016) used the model for the same reason in different study participants and study area.

### 3.4.5.2. Independent variables

The total numbers of the independent variable in this study were 24.

1. **Demographic and socio-economic** factors such as age of student, age of parent, sex, educational status of students and parents, sexual relation of student and religion.
2. **Factors related to availability of RH services** were health extension workers (HEW) contact, number of service centers, source of knowledge and sufficient supply of commodity.
3. **Factors related to accessibility of RH services** were cost of services, wealth status, type of services (private clinics or public) and pocket money.
4. **Factors that affect quality of RH services** such as type of service centers, kind of RH Services in school, judgmental health workers, convenient time and privacy care will be taken as independent variables.
5. **Factors related to acceptability of the RH services** were attitude of youth to any FP, information seeking behavior, waiting time and decision making power.

**Gender (GDR):** It is a dummy variable and takes (1) if the respondent is male and (2) otherwise.

**AGE of students (AGOS):** It is a continuous variable and expected that, increase in age would have an influence on degree of RH service utilization positively. The age of youth has a positive impact on the RH service utilization when it increases from 15 to 29.

**Sexual partner (SP):** It is a categorical variable and takes (1) if you are single, (2) if you are married, (3) if you are divorced, (5) if you are separated, and (6) if your answer is other than the above alternatives. It affects youth life negatively as they have more than one sexual relation.

**AGE of parents (AGOP):** It was a continuous variable and expected that, increase in age would have an influence on degree of RH service utilization negatively.

**Class year (CY):**It is measured as categorical and takes(1) if you are Year one student,(2) if you are Year two student,(3)if you are Year three student,(4) if you are Year four student,(5)if you are Year five or above year five student. Educational status is a variable which increases youth's capacity and empowerment in their life skill. So it is assumed that this variable would have positive relationship with the RH service utilization (Tilahun, 2008) reported in their study existence of positive relationship between education, information/knowledge and utilization RH services.

**Department (DPT):** It is measured as dummy and takes (1) if you are health department and (0) otherwise.

**Type of institution (TPI):** It is measured as dummy and takes (1) if you are public university student and (0) otherwise.

**Parent Education (PE):** It considered as a categorical variable which takes a value (1) if parents cannot read and write, (2) if their parents could read and write, (3) if their parent are at primary school education (1-8), (4) if their parents were secondary school students(9-10), (5) if their parents were preparatory school students), (6) if their parents had diploma or above and (7) their parents had degree or above. The variable is expected to have a positive association with the RH service utilization among youth in the study area. It is expected that as education level of parent increases RH service utilization of youth's in that family also increase.

**Religion (RLG):** It is a categorical variable and takes the value of (1) if the religion of youth is orthodox, (2) if youth is Muslim, (3) if youth is protestant and (4) otherwise. Religion is one of the important factors that determine RH service utilization. It is hypothesized that youth with firm religious belief have less RH service and use less RH services.

**Ethnicity (ECT):** It is a categorical variable and takes (1) if your ethnic group is Oromo, (2) if your ethnic group is Amhara, (3) if your ethnic group is Tigre, (4) if your ethnic group is Gurage, (5) if your ethnic group is other.

**Wealth status (WS):** It is a categorical variable that is measured in terms of the total monthly income that the respondents' parents have. The variable is expected to influence RH service utilization positively.

**Source of knowledge (SKG):** Source of knowledge plays important role in conveying information about RH services. It is a categorical variable which could be (1) family are your source, (2) schools (teachers), (3) if your source of knowledge is social media, (4) if your source of knowledge was mass media and (5) posters. The variable was expected to have positive association to RH service utilization among youth in the study area.

**Pocket money (PM):** Is any amount of money given to youth by parents for various purposes regularly. It is a dummy variable and takes 1 if there was a pocket money and 0 otherwise. It is expected to influence the RH services positively.

**Type of services (TS):** Is defined as the RH service used by students such as contraceptive, VCT, post abortion care service, etc. It is categorical variable which could be (1) when the service used is contraceptive, (2) when the service used is VCT, (3) when the service used is post abortion care services and (4) otherwise in all RH centers found in their surroundings. It is expected to influence the RH service utilization of youth positively if they use one of the services.

**Health Extension contact (HEC):** It is defined as frequency of contact between the health extension workers and the respondents at least once in the previous six months. This variable is expected to have positive relationship with utilization of RH services by students; the more they were youth contact with HEW the more they use RH services. The variable is a dummy and takes the value of (1) if youth has contact with extension health workers on issues related to RH services and (0) otherwise.

**Number of service center (NSC):** It tell us the number of health institution or anti HIV/AIDS and RH clubs or Voluntary counseling center that found in their surroundings that help them to have the RH service. It is expected to influence the RH service utilization of youth positively. It measured as continuous variable.

**Sufficient supply of commodity (SSOC):** It is defined as the availability or unavailability of contraceptives and goods related to RH services sufficiently during the time that youth want to use it and influences the RH service utilization of youth positively. It is a dummy variable and takes 1 if student has never received and 0 otherwise.

**Attitude towards family planning (ATFP):** Youth perception towards RH service it is used as dummy variable. It takes 1 if an individual perceived to obtain RH service and 0 otherwise. It affects the RH service utilization positively.

**Cost of service (COS):** It is the cost paid for the RH service they use. It is a dummy variable and takes 1 if the cost is fair and 0 otherwise.

**Decision making power of partner (DMPP):** Is the power of youth in order to decide to use the RH services when necessary. It is a categorical variable. It takes (1) if the decision made by male, (2) if the decision made by female and (3) if the decision made by both couples' when the RH service is necessary. It is expected to affect youth RH service utilization positively.

**Waiting time for RH service (WTM):** It is the length of time perceived by students' passed in the health institution when they need to use the RH services. It is a categorical variable and takes (1) if the waiting time is too short, (2) if the waiting time is short, (3) if the waiting time is long, (4) if the waiting time is too long. It is expected to affect youth RH service utilization negatively if the length of time is too long.

**Type of service centers (TSC):** Is ownership of RH service center chosen by you. It is a dummy variable and takes 1 when the service is from public (health post, health center, clinics and hospitals) and 0 otherwise. It is expected to influence the RH service utilization of youth positively.

**Availability of RH services in the university (ARHSU):** is the RH service provided to you in their university. It is dummy variable and takes 1 if any of the RH service is available in their university compound and 0 otherwise. It is expected to influence the RH service utilization of youth positively if the service is available in their compound.

**Judgmental health workers(JHW):** Is the decision whether or not health workers decide on the type of service you need judgmentally when you want to use the RH services in any of the service center. It is dummy variable and takes 1 if they are judgmental and 0 otherwise. It affects the dependent variable negatively when the health worker is judgmental.

**Convenient time (CT):** Is the time chosen by youth to use the RH service. It is Likert scale and expected to affect the RH service utilization of youth positively if they strongly agree in the usual time service provision.

**Privacy care (PC):** Is the confidentiality of health workers for youth RH problems. It is a Likert scale and expected to influence the RH service utilization of youth positively if they are strongly confident on the confidentiality of the health workers.

**Campus Residency (CR):** Is the place where you reside in the past six months. It is a categorical variable and takes (1) if you reside in campus dormitory, (2) if you reside in rent house alone, (3) if you reside with your family and (4) other. It is expected to affect your RH service positively if you reside with alone.

**Table 3.2. Summary of the independent variables**

<b>Variables</b>	<b>Definition</b>	<b>Themes</b>	<b>Scale of measurement</b>	<b>Expected sign of Independent Variables</b>
<b>AGOS</b>	AGE of students	<b>Demographic</b>	Continuous	+
<b>SP</b>	Sexual partner	<b>Demographic</b>	Dummy	+
<b>AGOP</b>	AGE of parents	<b>Socio economic</b>	Continuous	-
<b>CY</b>	Class year of students	<b>Demographic</b>	Categorical	+
<b>ESP</b>	Educational status of parents	<b>Socio economic</b>	Categorical	+
<b>RLG</b>	Religion	<b>Demographic</b>	Categorical	-
<b>WS</b>	Wealth status	<b>Socio economic</b>	Categorical	+
<b>SKG</b>	Source of knowledge	<b>Individual</b>	Categorical	+
<b>PM</b>	Pocket money	<b>Individual</b>	Dummy	+
<b>TS</b>	Type of services	<b>Socio economic</b>	Categorical	+
<b>HEC</b>	Health Extension contact	<b>Individual</b>	Dummy	+
<b>NSC</b>	Number of service center	<b>Institutional</b>	Dummy	+
<b>SSOC</b>	Sufficient supply of commodity	<b>Institutional</b>	Categorical	+
<b>ATFP</b>	Attitude towards contraceptives	<b>Individual</b>	Dummy	+
<b>COS</b>	Cost of service	<b>Socio economic</b>	Categorical	+
<b>DMP</b>	Decision making power	<b>Individual</b>	Categorical	+
<b>WTM</b>	Waiting time	<b>Institutional</b>	Dummy	-
<b>TSC</b>	Type of service center	<b>Institutional</b>	Categorical	+
<b>RHSU</b>	Kind of RH service in the university	<b>Institutional</b>	Dummy	+
<b>JHW</b>	Judgmental health workers	<b>Individual</b>	Dummy	-
<b>CT</b>	Convenient time	<b>Institutional</b>	Categorical	+
<b>PC</b>	Privacy care	<b>Individual</b>	Likert scale	+

*Source:* Modified from (Derib, 2010)

## CHAPTER FOUR

### 4. RESULTS AND DISCUSSION

#### 4.1. Introduction

This part consists of the overall findings of the study presented under different sections. The result section is presented using descriptive statistics findings and binary logistic regression model for the characteristics of the sample respondents. Out of 424 randomly selected respondents 407 were participated in the study which gives a response rate of 96%, the majority 298(70.28%) were from Addis Ababa university and 109(25.71%) were from Unity university. During data cleaning 53(13%) of the questionnaire were excluded from analysis due to not giving their response for the dependent variable. Finally; 354 students of whom 214(60.5%) male and 140(39.5%) female respondents were used for the analysis.

##### 4.1.1. Demographic and Socio-economic characteristics of the study population

The average age for male respondents was 21.4( $\pm SD$  1.9) whereas 20.9( $\pm SD$  1.6) was for females. 258(73.3%) were single followed by 79(22.4%) unmarried but have lover; 14(4.0%) were currently married and only 1(0.3%) were separated. There is no significance association between male and female class year, the majority 101(28.5%) were year three and the least 31(8.8%) were year four students. 214(60.5%) were Orthodox Christians and the least 10(2.8%) were Catholic. 133(38.2%) of them were from Amhara ethnic group followed by Oromo 83(24.0%) as described on table 4.1 below.

**Note:** For all tables the 354 students not respond for each questionnaire; some of the respondents miss to give the expected answer consciously or carelessly.

**Table 4.1: Demographic and Socio-economic characteristics of sample students in selected HEI of Addis Ababa June, 2018.**

Variables	Male (n,%)	Female (n,%)	Total (n,%)	$X^2$ test	P value
<b>Sex</b>	214(60.5)	140(39.5)	354(100.0)		
18-20	78(36.5)	55(39.3)	133(38.0)	27.452	0.000*
<b>Age</b> 21-23	85(40.5)	81(57.9)	166(47.4)		
24-26	46(21.5)	4(2.9)	50(14.3)		
27-29	1(0.5)	0(0.0)	1(0.3)		
<b>Total</b>	210(60.0)	140(40.0)	350(100)		
<b>Marital status of student</b>					
Single	205(96.7)	132(94.3)	337(95.7)	8.136	0.43
Married	6(2.8)	8(5.7)	14(4.0)		
Separated	1(0.5)	0(0.0)	1(0.3)		
<b>Total</b>	212(60.23)	140(28.41)	352(100)		
<b>Class Year</b>					
Year one	53(24.8)	32(22.9)	85(24.0)	0.542	0.969
Year two	52(24.3)	37(26.4)	89(25.1)		
Year three	60(28.0)	41(29.3)	101(28.5)		
Year four	20(9.3)	11(7.9)	31(8.8)		
Year five and above	29(13.6)	19(13.6)	48(13.6)		
<b>Total</b>	214(60.45)	140(39.55)	354(100)		
<b>Religion</b>					
Orthodox Christian	132(61.7)	82(58.6)	214(60.5)	13.576	0.009*
Muslim	22(10.3)	32(22.9)	54(15.3)		
Protestant	40(18.7)	21(15.0)	61(17.2)		
Catholic	8(3.7)	2(1.4)	10(2.8)		
Others	12(5.6)	3(2.1)	15(4.2)		
<b>Total</b>	214(60.45)	140(39.55)	354(100)		
<b>Ethnicity</b>					
Oromo	50(23.8)	33(24.3)	83(24.0)	2.467	0.651
Amhara	83(39.5)	50(36.8)	133(38.4)		
Tigrie	19(9.0)	17(12.5)	36(10.4)		
Guragie	22(10.5)	18(13.2)	40(11.6)		
Others	36(17.1)	18(13.2)	54(15.6)		
<b>Total</b>	<b>210(60.7)</b>	<b>136(39.3)</b>	<b>346(100)</b>		

Source: Own Survey, 2018

#### 4.1.2. Sources and types of RH knowledge

The crucial factor for using RH services is the available knowledge about (Contraceptives, VCT, PAC, ANC, etc.).

As described on table 4.2 below student uses different sources to have RH knowledge such as parental talk, teachers(schools), health workers, friends, newspapers, posters, mass media social media and other sources; 262(74.2%) and 225(63.7%) get their knowledge from teachers and Mass media respectively. 318(90.1%), 304(86.4%) and 179(49.3%) of the students know about voluntary counseling and testing (VCT), contraceptives and treatment for sexually transmitted infection (STIs) respectively.

From RH services 236(66.7%) of the respondents used VCT, 167(47.2%) of the respondents used contraceptives and 104(29.4%) of the respondents used both contraceptive and VCT at the same time.

**Table 4.2: Individual characteristics of sample students in selected HEI of Addis Ababa June, 2018.**

Variables		Male(n, %)	Female(n, %)	Total(n, %)	$X^2$ test	P value
Knowledge about RH services (CPS, VCT, PAC, etc.)? (N=354)	Yes	214(60.5)	139(39.3)	353(99.7)	1.533	0.216
	No	0(0.0)	1(0.3)	1(0.3)		
<b>Sources of information(N=353)</b>						
Parental talk	Yes	32(9.1)	42(11.9)	74(21.0)	11.847	0.001*
	No	182(51.6)	97(27.5)	279(79.0)		
Teachers(schools)	Yes	164(46.5)	98(27.8)	262(74.2)	1.656	0.198
	No	50(14.2)	41(11.6)	91(25.8)		
Health workers	Yes	79(22.4)	37(10.5)	116(32.9)	4.050	0.044**
	No	135(38.2)	102(28.9)	237(67.1)		
Friends	Yes	35(9.9)	35(9.9)	70(19.8)	4.128	0.042**
	No	179(50.7)	104(29.5)	283(80.2)		
News papers	Yes	23(6.5)	14(4.0)	37(10.5)	0.041	0.840
	No	191(54.1)	125(35.4)	316(89.5)		
Posters	Yes	19(5.4)	13(3.7)	32(9.1)	0.023	0.880
	No	195(55.2)	126(35.7)	321(90.9)		
Mass media	Yes	140(39.7)	85(24.1)	225(63.7)	0.665	0.415
	No	74(21)	54(15.3)	128(36.3)		
Social media	Yes	63(17.9)	45(12.8)	98(27.8)	2.432	0.119
	No	161(45.6)	94(26.6)	255(72.2)		
Other sources	Yes	3(0.85)	3(0.85)	6(1.7)	0.289	0.591
	No	211(59.8)	136(38.5)	347(98.3)		
<b>Types of RH services known by the students(N=353)</b>						
Contraceptive methods	Yes	182(51.6)	122(34.7)	304(86.4)	0.804	0.370
	No	32(9.1)	17(4.8)	49(13.9)		
Treatment for sexually transmitted infections(STDs)	Yes	107(30.3)	67(18.9)	174(49.3)	0.109	0.741
	No	107(30.3)	72(20.4)	179(50.7)		
Voluntary counseling and testing (VCT) including HIV AIDS	Yes	198(56.1)	120(34)	318(90.1)	3.618	0.057**
	No	16(4.5)	19(5.4)	35(9.9)		
Post abortion care services	Yes	42(11.9)	42(11.9)	84(23.8)	5.211	0.022**
	No	172(48.7)	97(27.5)	269(76.2)		
Antenatal care	Yes	60(17)	56(15.9)	116(32.9)	5.732	0.017**
	No	154(43.6)	83(23.5)	237(67.1)		
Postnatal care	Yes	52(14.7)	51(14.4)	103(29.2)	6.262	0.012**
	No	162(45.9)	88(24.9)	250(70.8)		
Others	Yes	5(1.4)	3(0.9)	8(2.3)	0.010	0.920
	No	209(59.2)	135(38.2)	344(97.5)		
<b>Types of RH services used by respondents (N=354)</b>						
Contraceptive methods	Yes	116(32.8)	51(14.4)	167(47.2)	10.733	0.001*
	No	98(27.7)	89(25.1)	187(52.8)		
Voluntary counseling and testing(VCT) including HIV AIDS	Yes	146(41.2)	90(25.4)	236(66.7)	0.591	0.442
	No	68(19.2)	50(14.1)	118(33.3)		
Post abortion care services	Yes	0(0.0)	4(1.12)	4(1.12)	6.184	0.013**
	No	214(60.5)	136(38.4)	350(98.9)		
Antenatal care	Yes	1(0.3)	5(1.4)	6(1.7)	4.894	0.027**
	No	214(60.2)	135(38.1)	348(98.3)		
Any contraceptive and VCT for HIV/AIDS	Yes	72	32	104	4.75	0.029**
	No	142	108	250		

Source: Own Survey, 2018

### 4.1.3. Places and Quality of RH services preferred by youth

The type of service center preferred by youths' that have its own impact in RH service utilization.

On table 4.3 below 350 respondents were given their response for the type of service center they were interested to use; 186(53.1%) of the youth used government and any health institution around their resident places followed by 52(14.9%) private health institution.

Only 13 students were used the campus clinic for RH services. 268(76.1%) of the respondents did not want to use RH services when other users were found around the service center. During their sexual intercourse, 50(30.1%) male decide by themselves as 5(3%) female only give their decision. Where totally 84(24.3%) of them decide jointly.

For 324(91.5%) of respondents waiting time in the service center is not a problem. This reveals that most youths in higher institutes go to any service center more probably to buy condom or any other contraceptive; since 102(66.2%) uses condom during their sexual intercourse.

**Table 4.3: Institution characteristics of sample students in selected HEI of Addis Ababa, June 2018.**

Variables		Male (n, %)	Female (n, %)	Total (n, %)	$X^2$ test	P value
<b>Types of service centers</b>						
Place of RH services (N=350)	Government(Hospital)	60(17.1)	33(9.4)	93(26.6)	27.132	0.000*
	Private(Hospital)	23(6.6)	29(14.9)	52(14.9)		
	Pharmacy	32(9.1)	4(1.2)	36(10.3)		
	Traditional method	1(0.3)	0(0.0)	1(0.3)		
	Any health institution	61(17.4)	31(8.9)	92(26.3)		
	Never used before	35(10)	41(11.7)	76(21.7)		
RH service in campus clinic (N=13)	Pills	-	-	-	4.852	0.183
	EC	2(15.4)	0(0.0)	2(15.4)		
	Injection	0(0.00)	2(15.4)	2(15.4)		
	Condom	1(7.7)	1(7.7)	2(15.4)		
	VCT	5(38.5)	2(15.4)	7(53.8)		
Convenient time for RH service (N=352)	With other users	40(11.4)	35(9.9)	75(21.3)	5.357	0.069***
	Other users are not around	170(48.3)	98(27.8)	268(76.1)		
	Any time	3(0.9)	6(1.7)	9(2.6)		
Decition making power in using the contraceptive(N=166)	My self	50(30.1)	5(3.0)	55(33.1)	35.814	0.000*
	My partner	8(4.8)	19(11.5)	27(7.8)		
	Joint decision	54(32.5)	30(18.1)	84(50.6)		
Length of time for RH service (N=354)	Yes	20(5.7)	10(2.8)	30(8.5)	0.53	0.467
	<b>No</b>	<b>194(54.8)</b>	<b>130(36.7)</b>	<b>324(91.5)</b>		

*Source:* Own Survey, 2018

#### 4.1.4. Perception of students to the Availability and Accessibility of contraceptive services

Similarly on table 4.4 below 169 respondents were given answer for their contact with health extension workers so 108(63.9%) have contacts with health workers. The more they contact with health workers, the more they use VCT service than those who have no contact. 73(43.2) have contact with health workers and uses VCT services but 22(13%) of them have no contact and not used the service with no association between gender and the health workers, and no association between health extension workers contact and VCT service ( $X^2=1.357$ , P value at 24.4%) and ( $X^2 =0.23$ , P value at 63%) respectively.

274(78.1%) of them did not face any commodity shortage when they want to use any VCT service in their life time with a significance association with gender but not with VCT service ( $X^2=12.32$ , P value at 1%) and ( $X^2=3.01$ , P value at 22%).

For the cost of the service 189(53.4%) of youths' interested to have free service for utilization of VCT with no significance association between gender ( $X^2=5.8$ , P value at 12%) but there is association between users and non users( $X^2=7.78$ , P value at 5.1%). 338(95.5%) of youth have pocket money regularly and it helped 224(63.3%) of them to use VCT and there is a significance association ( $X^2=3.032$ , P value at 10%) between gender but not with VCT users and non users ( $X^2=0.52$ , P value at 47%).

**Table 4.4. Individual and Institutional characteristics of sample students with VCT utilization in selected HEI of Addis Ababa, June 2018.**

Variables		Male (n, %)	Female (n, %)	Total (n, %)	$X^2$ test	P value	Using VCT service		$X^2$ test	P value
							Yes(n,%)	No(n,%)		
<b>Health Extension Contact</b>										
Health Extension Contact(N=169)	Yes	70(41.4)	38(22.5)	108(63.9)	1.36	0.24	73(43.2)	20.7	0.23	0.63
	No	34(20.1)	27(16)	61(36.1)			39(23.1)	22(13)		
<b>Total</b>		<b>104(61.5)</b>	<b>65(38.5)</b>	<b>169(100)</b>			<b>112(66.3)</b>	<b>57(33.7)</b>		
<b>Number of service center</b>										
<b>Sufficient supply of commodity</b>										
Shortage to have RH services (N=351)	Yes	16(4.6)	7(2.0)	23(6.6)	12.4	0.002*	19(5.4)	4(1.1)	3.01	0.22
	No	174(49.6)	100(28.5)	274(78)			181(51.6)	93(26.5)		
	I don't try	21(6.0)	33(9.4)	54(15.4)			34(9.7)	20(5.7)		
<b>Total</b>		<b>211(60.1)</b>	<b>140(39.9)</b>	<b>351(100)</b>			<b>234(66.7)</b>	<b>117(33.3)</b>		
<b>Cost of services</b>										
Service fee for youth (N=354)	As usual	24(6.8)	28(7.9)	52(14.7)	7.78	0.051*	26(7.3)	26(7.3)	7.78	0.051*
	Discount	66(18.6)	39(11)	105(29.7)			72(20.3)	33(9.3)		
	Free	120(33.9)	69(19.5)	189(53.4)			132(37.3)	57(16.1)		
	I don't know	4(1.13)	4(1.13)	8(2.3)			6(1.7)	2(0.6)		
<b>Total</b>		<b>214(60.5)</b>	<b>140(39.5)</b>				<b>236(66.7)</b>	<b>118(33.3)</b>		
<b>Pocket money</b>										
Regular supply of pocket money (N=354)	Yes	201(56.8)	137(38.7)	338(95.5)	3.03	0.08**	224(63.3)	114(32.2)	3.03	0.08**
	No	13(3.7)	3(0.8)	16(4.5)			12(3.4)	4(1.1)		
<b>Total</b>		<b>214(60.5)</b>	<b>140(39.5)</b>				<b>236(66.7)</b>	<b>118(33.3)</b>		

Source: Own Survey 2018

#### 4.1.5. Acceptability of RH services

Some RH services were not acceptable by youths due to different reasons. Some of the reasons were their attitude for the service, fearing of judgment of health workers in service center, the duration it takes to have RH service and loss of confidence on the service givers in keeping the users secret of using the RH services.

On table 4.5 below 318(89.8%) of youths merely agree or strongly agree on the importance of RH services for them, on the other hand 220(62.1%) respondents agree or strongly agree on the unlikely of the health workers judgment on behalf of them with a significance association of( $X^2=11.469$ , P value at 5%).

Hence; judgmental health workers were creating unfavorable condition for youth to use RH services. Convenient time to have the service and confidentiality of the health workers also create unlikely condition since 241(68.1%) and 320(90.4%) respectively agree or strongly agree on the issue with no gender significance association.

**Table 4.5: Individual characteristics of sample students concerning attitudes in selected HEI of Addis Ababa, June 2018.**

Variables		Male (n, %) (N=354)	Female (n, %) (N=354)	Total (n, %) (N=354)	$X^2$ test	P value
<b>Attitude of youth</b> RH service is important for youth like me?	Strongly agree	123(34.8)	85(24)	208(58.8)	0.78	0.941
	Agree	70(19.8)	40(11.3)	110(31.1)		
	Neutral	15(4.2)	11(3.1)	26(7.3)		
	Disagree	4(1.1)	3(0.9)	7(2.0)		
	Strongly disagree	2(0.6)	1(0.3)	3(0.8)		
<b>Judgmental health workers</b> RH service is unlikely if the health workers are judgmental?	Strongly agree	41(11.6)	34(9.6)	75(21.2)	11.47	0.022*
	Agree	94(26.6)	51(14.4)	145(41.0)		
	Neutral	42(11.9)	26(7.4)	68(19.2)		
	Disagree	37(10.5)	23(6.5)	60(16.9)		
	Strongly disagree	0(0.0)	6(1.7)	6(1.7)		
<b>Convenient time</b> Using RH service is unlikely if the waiting time in the service center is too long?	Strongly agree	66(18.6)	43(12.2)	109(30.8)	4.64	0.326
	Agree	87(24.6)	45(12.7)	132(37.3)		
	Neutral	35(9.9)	25(7.1)	60(16.9)		
	Disagree	22(6.2)	23(6.5)	45(12.7)		
	Strongly disagree	4(1.14)	4(1.14)	8(2.3)		
<b>Privacy care</b> Using RH service is unlikely if the service providers are not confidential?	Strongly agree	146(41.2)	111(31.4)	257(72.6)	5.510	0.239
	Agree	45(12.7)	18(5.1)	63(17.8)		
	Neutral	13(3.7)	7(1.9)	20(5.6)		
	Disagree	7(2.0)	3(0.9)	10(2.8)		
	<b>Strongly disagree</b>	<b>3(0.9)</b>	<b>1(0.3)</b>	<b>4(1.1)</b>		

*Source:* Own Survey, 2018

#### 4.1.6. Sexual experiences of respondents by their institutes

As described in table 4.6 below 122(47.8%) and 53(53.5%) of public and private university students respectively had sexual experience at least with one sexual partner in their life time

without significant association between their sexual experience and the kind of institute they enrolled ( $X^2=0.924$ , P value at 33.6%).

In addition, 91(74.6%) and 37(69.8%) of public and private university students respectively have more than one sexual partner. Generally, 128(73.14%) of both institutes students were engaged in multiple sexual practices without significant association in the same comparison ( $X^2=4.275$ , P value at 23.3%).

**Table 4.6: Sexual characteristics of sample students by their institute in selected HEI of Addis Ababa, June 2018.**

Variables		Public (n,%) N=255	Private (n, %) N=99	Total (n, %)	$X^2$ test	P-value
Sexual experience	Yes	122(47.8)	53(53.5)	175(49.4)	0.924	0.336
	No	133(52.2)	46(46.5)	179(50.6)		
Number of sexual partners (N=122 and N=53) for public and private respectively.	one	31(25.4)	15(28.8)	46(26.4)	4.275	0.233
	two	45(36.9)	13(25.0)	58(33.3)		
	three	21(17.2)	7(13.5)	28(16.1)		
	More than	25(20.5)	17(32.7)	42(24.1)		
	four	<b>91(74.6) have two or more sex partners</b>	<b>37(69.8) have two and more sex partners</b>	<b>128(73.14) have two and more sex partner in both institutes</b>		

*Source:* Own Survey, 2018

#### 4.1.7. Sexual behavior and contraceptive use of respondents

On table 4.7 below nearly half 175(49.4%) of them were sexually active. In which 118(33.3%) and 57(16.1%) were male and female respectively. There was a significant association ( $X^2=7.046$ , P value at 1%) where more males were sexually active than females. Out of 173 sexually active respondents, the average age of respondents at first sex for male and female respondents was 19( $\pm SD$  2) and 18( $\pm SD$  3) respectively. Hence, there is a significant association ( $X^2=9.143$ , P value at 5%).

The average age of sexually active youths of first sexual partner were 17( $\pm SD$  2) for male; 23( $\pm SD$  4) for females. From 174 sexually active respondents 106(60.9%) of them uses any one of contraceptive at first sex without significance association ( $X^2= 0.393$ , p value at 53.1%).

79(73.8%) sexually active youth use condom followed by 13(12.1%) Emergency contraceptive (EC) (used by females after sex). There is a significant association between male and female users.

From 154 sexual active respondents 102(66.2%) and 21(13.0%) use condom and injection respectively; with a significance association ( $X^2=50.02$ , P value at 1%) between male and

female users. From 174 sexually active youths 112 of them give their reason for not using contraceptive during their sex, then the reason of 43(38.4%) and 34(30.4%) were; forced not to use any contraceptive by their girl/boyfriend and afraid to buy the contraceptives respectively, with no significance association( $X^2=7.119$ , P value at 21.2%) indicate that the reason given by the number of sexually active males and females is the same.

Finally, from the total 354 respondents 283(79.9%) have interest to use contraceptives in their future life without a significance association ( $X^2=0.00$ , P value at 98.3%).

**Table4.7: Sexual characteristics of sample students in HEI Addis Ababa June, 2018**

Variables		Male(n,%)	Female(n,%)	Total(n,%)	$X^2$	P-value
Sexual experience (N=354)	Yes	118(33.3)	57(16.1)	175(49.4)	7.046	0.008*
	No	96(27.1)	83(23.5)	179(50.6)		
<b>Total</b>		<b>214(60.5)</b>	<b>140(39.5)</b>	<b>354(100)</b>		
Age at first sex (N=173)	15-17	18(10.4)	15(8.6)	33(19.1)	9.143	0.027**
	18-20	70(40.5)	37(21.4)	107(61.8)		
	21-23	27(15.6)	4(2.3)	31(17.9)		
	24-26	2(1.2)	0(0.0)	2(1.2)		
<b>Total</b>		<b>117(67.6)</b>	<b>56(32.37)</b>	<b>173(100)</b>		
Age of your first sexual partner (N=173)	15-17	59(34.1)	2(1.2)	61(35.3)	106.912	0.000*
	18-20	50(28.9)	7(4.1)	57(32.9)		
	21-23	6(2.5)	20(11.6)	26(15.0)		
	24-26	2(1.2)	16(9.3)	18(10.4)		
	27-29	0(0.0)	11(6.4)	11(6.4)		
<b>Total</b>		<b>117(67.6)</b>	<b>56(32.37)</b>	<b>173(100)</b>		
Using any contraceptive at first sex(N=174)	Yes	70(40.2)	36(20.7)	106(60.9)	0.393	0.531
	No	48(27.6)	20(11.5)	68(39.1)		
<b>Total</b>		<b>118(67.8)</b>	<b>56(32.2)</b>	<b>174(100)</b>		
Type of Contraceptive at first sex? (N=107)	Pills	2(1.9)	2(1.9)	4(3.7)	13.4	0.010*
	EC	5(4.7)	8(7.5)	13(12.1)		
	Injection	0(0.0)	8(7.5)	8(7.5)		
	Condom	59(55.1)	20(18.7)	79(73.8)		
	Safe period	2(1.9)	1(0.9)	3(2.8)		
<b>Total</b>		<b>68(63.6)</b>	<b>39(36.5)</b>	<b>107(100)</b>		
Type of contraceptives usually use (N=154)	Pills	5(3.3)	6(3.9)	11(7.1)	50.0	0.000*
	EC	8(5.2)	6(3.9)	14(9.1)		
	Injection	2(1.3)	19(12.3)	21(13.0)		
	Condom	85(55.2)	17(11)	102(66.2)		
	Safe period	1(0.7)	2(1.3)	3(1.9)		
	Withdrawal	3(1.9)	0(0.0)	3(1.9)		
<b>Total</b>		<b>104(67.5)</b>	<b>50(32.5)</b>	<b>154(100)</b>		
Reason for not using any contraceptives during sex(N=112)	Not knowing the place to buy	3(2.7)	0(0.0)	3(2.7)	7.12	0.212
	Afraid to buy	25(22.3)	9(8.1)	34(30.4)		
	Not knowing how to use	0(0.0)	1(0.9)	1(0.9)		
	Not having money to buy	2(1.8)	0(0.0)	2(1.8)		
	My friend force me not to use	25(22.3)	18(16.1)	43(38.4)		
	Forget using	21(18.8)	8(7.1)	29(25.9)		
<b>Total</b>		<b>76(67.9)</b>	<b>36(32.2)</b>	<b>112(100)</b>		
Intended to use contraceptives in the future (N=354)	Total	76(67.9)	36(32.1)	112(100)	0.00	0.983
	Yes	171(48.3)	112(31.6)	283(79.9)		
	No	43(12.2)	28(7.9)	71(20.1)		
<b>Total</b>		<b>214(60.5)</b>	<b>140(39.5)</b>	<b>354(100)</b>		

Source: Own Survey, 2018

#### **4.1.8. Contraceptive use and parental characteristics of respondents**

On table 4.8 below the majority 107(35.9%) of the respondent's fathers followed by 90(30.2%) of fathers' age lie in the age range of 51-58 and 43-50 respectively with no significance association for gender ( $X^2=3.82$ , P value at 43%) and for contraceptive use ( $X^2=0.243$ , P value at 99.3%). Where the majority 164(53.1%) followed by 94(30.4%) of their mothers' age lie in the range of 43-50 and 35-42 with no significance association for gender ( $X^2=0.413$ , P value at 98.1%) and contraceptive use ( $X^2=3.919$ , P value at 41.7%). 127(39%) followed by 71(21%) of respondents fathers have degree or above and certificate or diploma respectively and 89(25.9%) followed by 70(20%) of respondents mother have diploma or certificate and degree or above with significance association with gender but not with contraceptive use ( $X^2=14.18$ , P value 2.8%) and ( $X^2=6.773$ , P value at 34.2%) respectively.

Similarly there is a significance association between mothers education and gender but not with contraceptive utilization ( $X^2=19.61$ , P value at 1%) and ( $X^2=0.924$ , P value at 98.8%) respectively. 114(34.7%) were private employee followed by government employee and own small scale business 72(21.9%) , 61(18.5%) respectively with significance association ( $X^2=25.71$ , P value at 1%) with no significance association between fathers' occupation and contraceptive use of respondents( $X^2=2.411$ , P value at 87.8%) .

Majority of contraceptive user 54(16.4%) followed by 33(10%) fathers have certificate, diploma, degree or above. In this study, the majority of mothers were housewives 136(39.4%) followed by government and private employees 72(20.9%), 60(17.4%) respectively with a significance association between( $X^2=11.09$ , P value at 5%) not occupation and contraceptive use ( $X^2=3.984$ , P value at 55.2%) the result in Table 4.8 described that 62(18%) of contraceptive user mothers were housewives followed by 32(9.3%) of government employees. Out of 352 respondents 208(59.1%) were fathers followed by 90(25.6%) both father and mother with no significance association ( $X^2=0.870$ , P value at 64.7%).

Similarly, most of the contraceptive users were respondents who raised by their father 93(26.4%) followed by 49(13.9%) raised by both father and mother with no significance association ( $X^2=2.42$ , P value at 29.8%).

**Table 4.8: Socio-economic and some demographic determinants of contraceptive use among sample students in selected HEI of Addis Ababa June, 2018.**

Age of respondents father	Male (n, %) N=298	Female (n, %) N=298	Total (n, %)	X <sup>2</sup> test	P value	Using any contraceptives N=298		X <sup>2</sup> test	P value
						Yes(n,%)	No (n,%)		
35-42	9(3.0)	7(2.4)	16(5.4)	3.82	0.43	7(2.4)	9(3.0)	0.243	0.993
43-50	55(18.5)	35(11.8)	90(30.2)			40(13.4)	50(16.8)		
51-58	73(24.5)	34(11.4)	107(35.9)			50(16.8)	57(19.1)		
59-66	40(13.4)	31(10.4)	71(23.8)			32(10.4)	39(13.1)		
67-74	7(2.4)	7(2.4)	14(4.7)			7(2.4)	7(2.4)		
<b>Total</b>	<b>184(61.7)</b>	<b>114(38.3)</b>	298(100)			<b>Total</b>	136(45.6)		
<b>Age of respondents mother (N=309)</b>									
35-42	57(18.5)	37(12.0)	94(30.4)	0.413	0.981	36(11.7)	58(18.8)	3.919	0.417
43-50	105(34.0)	59(19.1)	164(53.1)			83(26.9)	81(26.2)		
51-58	26(8.4)	17(5.5)	43(13.9)			20(6.5)	23(7.4)		
59-66	3(1.0)	2(0.7)	5(1.6)			2(0.7)	3(1.0)		
67-74	2(0.7)	1(0.3)	3(1.0)			1(0.3)	2(0.7)		
<b>Total</b>	<b>193(62.5)</b>	<b>116(37.5)</b>	309(100)			<b>Total</b>	142(46.0)		
<b>Education level of father (N=326)</b>									
Read and write	35(10.7)	9(2.8)	44(13.5)			20(6.1)	24(7.4)		
Primary school(1-8)	15(4.6)	9(4.6)	23(7.1)			12(3.7)	12(3.7)		
Secondary school(9-10)	18(5.5)	5(1.5)	37(11.3)			11(3.4)	12(3.7)		
Preparatory school(11-12)	19(5.8)	18(5.5)	71(21.8)			17(5.2)	20(6.1)		
Certificate or Diploma	46(14.1)	25(7.7)	127(39.0)			41(12.6)	30(9.2)		
Degree and above	68(20.9)	59(18.1)	<b>326(100)</b>			50(15.3)	77(23.6)		
<b>Total</b>	<b>201(61.7)</b>	<b>125(38.3)</b>	<b>326(100)</b>			<b>Total</b>	<b>151(46.3)</b>		
<b>Education level of mother (N=343)</b>									
Read and write	45(13.1)	15(4.4)	60(17.5)			28(8.2)	32(9.3)		
Primary school(1-8)	20(5.8)	17(5.0)	51(14.9)			16(4.7)	21(6.1)		
Secondary school(9-10)	38(11.1)	13(3.8)	36(10.5)			25(7.3)	26(7.6)		
Preparatory school(11-12)	25(7.3)	11(3.2)	89(25.9)			19(5.5)	17(5.0)		
Certificate or Diploma	44(12.8)	45(13.1)	70(20.4)			41(12.0)	48(14.0)		
Degree and above	39(11.4)	31(9.0)	343(100)			33(9.6)	37(10.8)		
<b>Total</b>	<b>211(61.5)</b>	<b>132(38.5)</b>	343(100)			<b>Total</b>	162(47.2)		
<b>Occupation of father (N=329)</b>									
Has no job	4(1.2)	8(2.4)	114(34.7)	25.71	0.000*	6(1.8)	6(1.8)	2.411	0.878
Private employer	59(17.9)	55(16.7)	72(21.9)			54(16.4)	60(18.2)		
Government employer	47(14.3)	25(7.6)	21(6.4)			33(10.0)	39(11.9)		
Own small business	17(5.2)	4(1.2)	61(18.5)			10(3.0)	11(3.3)		
Own medium business	35(10.6)	26(7.9)	20(6.1)			29(8.8)	32(9.7)		
Own large business	14(4.3)	6(1.8)	29(8.8)			12(3.6)	8(2.4)		
Farmer	27(8.2)	2(0.6)	329(100)			11(3.3)	18(5.5)		

<b>Total</b>	<b>203(61.7)</b>	<b>126(38.3)</b>	329(100)	Total	<b>155(47.1)</b>	<b>174(52.9)</b>			
<b>Occupation of mother(N=345)</b>									
House wife	83(24.1)	53(15.4)	60(17.4)	11.0 9	0.05**	62(18)	74(21.5)	3.984	0.552
Private employer	33(9.6)	27(7.8)	72(20.9)			28(8.1)	32(9.3)		
Government employer	37(10.7)	35(10.1)	21(6.1)			32(9.3)	40(11.6)		
Own small business	18(5.2)	3(0.9)	39(11.3)			14(4.1)	7(2.0)		
Own medium business	28(8.1)	11(3.2)	17(4.9)			17(4.9)	22(6.4)		
Own large business	11(3.2)	6(1.7)	345(100)			9(2.6)	8(2.3)		
<b>Total</b>	<b>210(60.9)</b>	<b>135(39.1)</b>	345(100)	Total	<b>162(47.0)</b>	<b>183(53.0)</b>			
<b>House hold head ship (N=352)</b>									
Father	124(35.2)	84(23.9)	54(15.3)	0.87 0	0.647	93(26.4)	115(32.7)	2.420	0.298
Mother	31(8.8)	23(6.5)	<b>90(25.6)</b>			25(7.1)	29(8.2)		
<b>Father and mother</b>	<b>58(16.5)</b>	<b>32(9.1)</b>	<b>352(100)</b>			49(13.9)	41(11.7)		
<b>Total</b>	<b>213(60.5)</b>			Total	<b>167(47.4)</b>	<b>185(52.6)</b>			

Source: Own Survey, 2018

#### 4.1.9. VCT use and parental characteristics of respondents

On table 4.9 below the majority 107(35.9%) of the respondent's fathers followed by 90(30.2%) of fathers' age lie in the age range of 51-58 and 43-50 respectively with no significance association for gender ( $X^2=3.82$ , P value at 43%) and for VCT use ( $X^2=6.72$ , P value at 15%). Where the majority 164(53.1%) followed by 94(30.4%) of their mothers' age lie in the range of 43-50 and 35-42 with no significance association for gender ( $X^2=0.413$ , P value at 98.1%) and VCTs use ( $X^2=6.56$ , P value at 16%). 127(39%) followed by 71(21%) of respondents fathers have degree or above and certificate or diploma respectively and 89(25.9%) followed by 70(20%) of respondents mother have diploma or certificate and degree or above with significance association with gender VCT service users and non users. use ( $X^2=14.18$ , P value 2.8%) and ( $X^2=14.42$ , P value at 2.5%) respectively.

Similarly there is a significance association between mothers education and gender but not with VCT service utilization ( $X^2=19.61$ , P value at 1%) and ( $X^2=5.55$ , P value at 35%) respectively. 114(34.7%) were private employee followed by government employee and own small scale business 72(21.9%) , 61(18.5%) respectively with significance association ( $X^2=25.71$ , P value at 1%) a significance association between fathers' occupation and VCT service utilization of respondents( $X^2=12.34$ , P value at 6%) .

Majority of VCT users 80(24.5%) followed by 45(13.8%) fathers have degree or above and certificate or diploma respectively. In this study, the majority of mothers were housewives

136(39.4%) followed by government and private employees 72(20.9%), 60(17.4%) respectively with a significance association ( $X^2=11.09$ , P value at 5%).

There was a significance association between occupation father and VCT service ( $X^2=12.34$ , P value at 6%) the result in Table 4.9 described that 89(25.8%) of VCT user mothers were housewives followed by 49(14.2%) of government employees with no significance association( $X^2=3.21$ , P value at 67%). VCT users in father head house hold were 136(38.6%) with no significance association ( $X^2=1.68$ , P value at 43%).

**Table 4.9: Socio-economic and some demographic determinants of VCT service utilization among sample students in selected HEI of Addis Ababa June, 2018.**

Age of respondents father	Male (n, %) N=298	Female (n, %) N=298	Total (n, %)	$X^2$ test	P value	Using VCT Service		$X^2$ test	P value
						Yes(n,%)	No (n,%)		
35-42	9(3.0)	7(2.4)	16(5.4)	3.82	0.43	10(3.4)	6(2)	6.72	0.15
43-50	55(18.5)	35(11.8)	90(30.2)			60(20.1)	30(10.1)		
51-58	73(24.5)	34(11.4)	107(35.9)			64(21.5)	43(14.4)		
59-66	40(13.4)	31(10.4)	71(23.8)			53(17.8)	18(6.0)		
67-74	7(2.4)	7(2.4)	14(4.7)			12(4.03)	2(0.7)		
<b>Total</b>	<b>184(61.7)</b>	<b>114(38.3)</b>	298(100)	<b>Total</b>		199(66.8)	99(33.2)		
<b>Age of respondents mother (N=309)</b>									
35-42	57(18.5)	37(12.0)	94(30.4)	0.413	0.981	55(17.8)	39(12.6)	6.56	0.16
43-50	105(34.0)	59(19.1)	164(53.1)			109(35.3)	55(17.8)		
51-58	26(8.4)	17(5.5)	43(13.9)			33(10.7)	10(3.2)		
59-66	3(1.0)	2(0.7)	5(1.6)			4(1.3)	1(0.3)		
67-74	2(0.7)	1(0.3)	3(1.0)			3(0.97)	0(0.0)		
<b>Total</b>	<b>193(62.5)</b>	<b>116(37.5)</b>	309(100)	<b>Total</b>		204(66.0)	105(34.0)		
<b>Education level of father (N=326)</b>									
Read and write	35(10.7)	9(2.8)	44(13.5)			39(12.0)	5(1.5)	14.42	0.025**
Primary school(1-8)	15(4.6)	9(4.6)	23(7.1)			18(5.5)	6(1.8)		
Secondary school(9-10)	18(5.5)	5(1.5)	37(11.3)			13(4.0)	10(3.1)		
Preparatory school(11-12)	19(5.8)	18(5.5)	71(21.8)			21(6.4)	16(4.9)		
Certificate or Diploma	46(14.1)	25(7.7)	127(39.0)			45(13.8)	26(8.0)		
Degree and above	68(20.9)	59(18.1)	326(100)			80(24.5)	47(14.4)		
<b>Total</b>	<b>201(61.7)</b>	<b>125(38.3)</b>	326(100)	<b>Total</b>		216(66.3)	110(33.7)		
<b>Education level of mother (N=306)</b>									
Read and write	22(7.2)	3(1.00)	25(8.2)			20(6.5)	5(1.6)	5.55	0.35
Primary school(1-8)	23(7.5)	12(3.9)	35(11.4)			24(7.8)	11(3.6)		
Secondary school(9-10)	38(12.4)	13(4.2)	51(16.67)			29(9.5)	22(7.2)		
Preparatory school(11-12)	25(8.2)	11(3.6)	36(11.8)			23(7.5)	13(4.2)		
Certificate or Diploma	44(14.4)	45(14.7)	69(22.6)			56(18.3)	33(10.8)		
Degree and above	39(12.7)	31(10.1)	70(22.9)			50(16.3)	20(6.5)		

Total	<b>191(62.4)</b>	<b>115(37.6)</b>	306(100)	Total	202(66.0)	104(34)			
<b>Occupation of father (N=329)</b>									
Has no job	4(1.2)	8(2.4)	114(34.7)	25.7 1	0.000*	8(2.4)	4(1.2)	12.34	0.06*
Private employer	59(17.9)	55(16.7)	72(21.9)			72(21.9)	42(12.8)		
Government employer	47(14.3)	25(7.6)	21(6.4)			41(12.5)	31(9.4)		
Own small business	17(5.2)	4(1.2)	61(18.5)			15(4.6)	6(1.8)		
Own medium business	35(10.6)	26(7.9)	20(6.1)			40(12.2)	21(6.4)		
Own large business	14(4.3)	6(1.8)	29(8.8)			16(4.9)	4(1.2)		
Farmer	27(8.2)	2(0.6)	329(100)			26(7.9)	3(0.9)		
<b>Total</b>	<b>203(61.7)</b>	<b>126(38.3)</b>	329(100)	Total	<b>218(66.3)</b>	<b>111(33.7)</b>			
<b>Occupation of mother(N=345)</b>									
House wife	83(24.1)	53(15.4)	60(17.4)	11.0 9	0.05**	89(25.8)	47(13.6)	3.21	0.67
Private employer	33(9.6)	27(7.8)	72(20.9)			42(12.2)	18(5.2)		
Government employer	37(10.7)	35(10.1)	21(6.1)			49(14.2)	23(6.67)		
Own small business	18(5.2)	3(0.9)	39(11.3)			11(3.2)	10(2.9)		
Own medium business	28(8.1)	11(3.2)	17(4.9)			25(7.3)	14(4.1)		
Own large business	11(3.2)	6(1.7)	345(100)			13(3.8)	4(1.2)		
<b>Total</b>	<b>210(60.9)</b>	<b>135(39.1)</b>	345(100)	Total	<b>229(66.4)</b>	<b>116(33.6)</b>			
<b>House hold head ship (N=352)</b>									
Father	124(35.2)	84(23.9)	54(15.3)	0.87 0	0.647	136(38.6)	72(20.5)	1.68	0.43
Mother	31(8.8)	23(6.5)	<b>90(25.6)</b>			40(11.4)	14(4.0)		
<b>Father and mother</b>	<b>58(16.5)</b>	<b>32(9.1)</b>	<b>352(100)</b>			58(16.5)	32(9.1)		
<b>Total</b>	<b>213(60.5)</b>			Total	<b>234(66.5)</b>	<b>118(33.5)</b>			

Source: Own Survey, 2018

#### 4.1.10. Utilization of Contraceptives by different aspects of respondents

On table 4.10 below out of the total number of respondents 167(47.2%) used any one of contraceptives in their life time and there is a significance association between male users and female users ( $X^2=10.733$ , P value at 1%) the majority 116(32.8%) were male users out of the total respondents. Regarding their institute, 115(45.1%) and 52(52.5%) were public and private university respondents respectively; there is a significance association between contraceptive utilization of each of the two institutes respondents ( $X^2=3.993$ , P value at 5%) and ( $X^2=11.06$ , P value at 1%) respectively.

122(47.8%) public university respondents and 53(53.5%) private university respondents were sexually active. 167(47.2%) of both university respondents have used one of contraceptives in their life time, without any significance association ( $X^2=1.579$ , P value=0.209). 75(46.9%)

of health and 92(47.4%) non health respondents used any one of contraceptives in their life time with significance association ( $X^2=4.012$ , P value at 5%) and ( $X^2=6.862$ , P value at 1%) respectively.

The majority 48(13.6%) respondents were year three followed by year two respondents 45(12.7%) and year one respondents 37(10.6%) were used any one of contraceptives in their life time with no significance association ( $X^2=5.149$ , P value at 27.2%).

**Table 4.10: Individual characteristics of sample students concerning contraceptive use by institution in selected HEI of Addis Ababa June, 2018.**

Variables		Contraceptive use		$X^2$ test	P value
		Yes (n, %)	No (n, %)		
Sex(N=354)	Male	116(32.8)	98(27.7)	10.733	0.001*
	Female	51(14.4)	89(25.1)		
	Total	167(47.2)	187(52.8)		
<b>Type of institute</b>					
public respondents (N=255)	Male	82(32.2)	83(32.6)	3.993	0.046**
	Female	33(12.9)	57(22.4)		
	Total	115(45.1)	140(54.9)		
Private respondents (N=99)	Male	34(69.4)	15(30.6)	11.063	0.001*
	Female	18(36.0)	32(64.0)		
	Total	52(52.5)	47(47.5)		
General (N=354)	Public	115(32.5)	140(39.6)	1.579	0.209
	Private	52(14.7)	47(13.3)		
	Total	167(47.2)	187(52.8)		
<b>Department</b>					
Health (N=160)	Male	48(30)	41(25.6)	4.012	0.045**
	Female	27(16.9)	44(27.5)		
	Total	75(46.9)	85(53.1)		
Non-health (N=194)	Male	68(35.1)	57(29.4)	6.862	0.009*
	Female	24(12.4)	45(23.2)		
	Total	92(47.4)	102(52.6)		
N=354	Health	75(21.2)	85(24)	0.011	0.918
	Non health	92(26)	102(28.8)		
	Total	167(47.2)	187(52.8)		
<b>Class Year(N=354)</b>					
Year one		37(10.6)	48(13.6)	5.149	0.272
Year two		45(12.7)	44(12.4)		
Year three		48(13.6)	53(14.9)		
Year four		19(5.4)	12(3.4)		
Year five and above		18(5.1)	30(8.5)		
<b>Total</b>		<b>167(47.2)</b>	<b>187(52.8)</b>		

Source: Own Survey, 2018

#### **4.1.11. Utilization of VCT service by different aspects of respondents**

On table 4.11 below out of the total number of respondents 236(66.7%) used VCT service and there is no a significance association between male users and female users ( $X^2=0.59$ , P value at 44%) the majority 146(41.2%) were male users out of the total respondents. Regarding their institute, 163(63.9%) and 73(73.7%) were public and private university respondents respectively uses VCT services at least once in their life time; there is no a significance association between VCT service utilization of each of the two institutes respondents ( $X^2=0.48$ , P value at 49%) and ( $X^2=0.73$ , P value at 39%) respectively.

Out of the total respondents 163(46.1%) public university respondents and 53(53.5%) private university respondents were sexually active. 73(20.6%) of both university respondents have used VCT service at least once in their life time, with significance association ( $X^2=3.1$ , P value=8%). 95(59.4%) of health and 141(72.7%) of non health respondents used VCT service at least once in their life time with no significance association ( $X^2=1.8$ , P value at 18%) and ( $X^2=0.39$ , P value at 53%) respectively.

The majority 74(20.9%) respondents were year III followed by year II respondents 66(18.6%) and year I respondents 46(13.0%) were used VCT service at least once in their life time with a significance association ( $X^2=10.75$ , P value at 3%).

**Table 4.11: Individual characteristics of sample students concerning VCT service use by institution in selected HEI of Addis Ababa June, 2018.**

Variables		Using VCT Services		X <sup>2</sup> test	P value
		Yes (n, %)	No (n, %)		
Sex(N=354)	Male	146(41.2)	68(19.2)	0.59	0.44
	Female	90(25.4)	50(14.1)		
	Total	236(66.7)	118(33.3)		
<b>Type of institute</b>					
Public respondents (N=255)	Male	108(42.4)	57(22.4)	0.48	0.49
	Female	55(21.6)	35(13.7)		
	Total	163(63.9)	92(36.1)		
Private respondents (N=99)	Male	38(38.4)	11(11.1)	0.73	0.39
	Female	35(35.4)	15(15.2)		
	Total	73(73.7)	26(26.3)		
General (N=354)	Public	163(46.1)	92(26.0)	3.1	0.08*
	Private	73(20.6)	26(7.3)		
	Total	236(66.7)	118(33.3)		
<b>Department</b>					
Health (N=160)	Male	57(35.6)	32(20)	1.8	0.18
	Female	38(23.8)	33(20.62)		
	Total	95(59.4)	65(40.6)		
Non-health (N=194)	Male	89(45.9)	36(18.6)	0.39	0.53
	Female	52(26.8)	17(8.8)		
	Total	141(72.7)	53(27.3)		
N=354	Health	95(26.8)	65(18.4)	6.98	0.008***
	Non health	141(39.8)	53(15.0)		
	Total	236(66.7)	118(33.3)		
<b>Class Year(N=354)</b>					
Year I		46(13.0)	39(11.0)	10.75	0.03**
Year II		66(18.6)	23(6.5)		
Year III		74(20.9)	27(7.6)		
Year IV		19(5.4)	12(3.4)		
Year V and above		31(8.8)	17(4.8)		
<b>Total</b>		<b>236(66.7)</b>	<b>118(33.3)</b>		

Source: Own Survey, 2018

## 4.2. Determinants of RH Service Utilization

### 4.2.1. Contraceptive use and its determinants

A multivariate logistic regression analysis was done to identify determinants of RH services (CP and VCT utilization). Totally there were 24 predictor variable for the study; among the total number of variables only 14 predictor variables such as sex, age, department, type of institution, class year, religion, ethnicity, pocket money, educational level of father and mother, head of house hold, type of service center, number of service center, and cost of service had used for the regression model where the rest assumed predictor variables had co

linearity effect and not used in the regression model for regression analysis by considering the value of their variance inflation factor (VIF) greater than ten.

Among the above 14 predictor variables only sex, department, class year, ethnicity, pocket money, types of health center and cost of service had a significant association with contraceptive use as described as follow.

In the multivariate result on table 4.12 below female more likely 2.3 times uses contraceptive than male and there was a significant association AOR: 2.3, 95% CI(1.06,5.07).

When students class year increasing from year one to year five or above, then the contraceptive service utilization of youth also increased or decreased as described as follow. Year two youth 1.5 times more uses contraceptives than year one AOR: 1.5, 95% CI (0.56, 4.05). Year three youth 22% less uses contraceptive than year one AOR: 0.78, 95% CI (0.24, 2.52), year four youth 4% less uses contraceptive than year one AOR: 0.96, 95% CI (0.36, 10.74) and youth who were year five and above 19% less uses contraceptive than youth of year one AOR: 0.81, 95% CI (0.83, 20.4), this shows that as class year increases contraceptive utilization decreases.

Ethnicity was one of the predictor variables that have association with contraceptive utilization of youth. As youth have ethnic group other than Oromo, Tigrie or Guragie; 1.1 times more likely uses contraceptive than being Amhara with AOR: 1.1, 95% CI (0.284,4.057).

Department was one of the determinant that has association with using or not using contraceptives. Non-health department students were 3.1 times more uses contraceptive than youth in health department AOR: 3.1, 95% CI (1.29, 7.23).

Pocket money found to have an association contraceptive use. Youth who had no pocket money regularly had 94% less use contraceptive than who had AOR: 0.06, 95% CI (0.05, 0.87).

Types of health institution were a predictor variable that affects the outcome variable. Using contraceptives in government health center or hospital were 83% less AOR: 0.17, 95% CI (0.052, 0.539), private health center or hospital 97% less AOR: 0.13, 95% CI (0.009, 0.129), pharmacy, 99% less AOR: 0.01, 95% CI (0.002, 0.053) and other health institution 95% less AOR: 0.05, 95% CI (0.015, 0.16) use contraceptives than using in any health institution

respectively. Number of service center was also a predictor variable that found to have an association with the outcome variable.

Cost of service also were a predictor variable for the multivariate analysis. When cost of service was not a problem for youth, then 2.4 times more use contraceptive than cost of service were a problem AOR: 2.4, 95% CI (0.045, 5.670) with significance association.

One can consider the association of the other predictor and outcome variables from table 4.12 below.

**Table 4.12: Multivariate analysis of determinants of contraceptive service utilization of sample students in HEI Addis Ababa June, 2018**

Variables	Characteristics	Contraceptive Use (CPS)	
		COR 95% C.I	AOR 95% C.I
Sex (N=354)	Male	1.00	1.00
	Female	2.1(1.34, 3.2)***	2.3(1.062, 5.068)**
Age of respondents N=350	18-20(Reference)	1.00	1.00
	21-23	0.83(0.53, 1.32)	0.64(0.237, 1.719)
	24-26	0.56(0.29, 1.08)*	0.65(0.159, 2.673)
Class Year (N=354)	Year I(Reference)	1.00	1.00
	Year II	0.75(0.415, 1.37)	1.5(0.557, 4.046)
	Year III	0.85(0.477, 1.52)	0.78(0.242, 2.516)
	Year IV	0.49(0.21, 1.13)*	1.96(0.357, 10.739)
	Year V and above	1.29(0.622, 2.65)	4.1(0.830, 20.400)*
Department	Health	1.00	1.00
	Non-Health	0.98(0.643, 1.49)	3.1(1.294, 7.216)***
Religion	Orthodox Christian(Reference)	1.00	1.00
	Muslim	0.99(0.55, 1.82)	0.92(0.163, 5.187)
	Protestant	0.83(0.47, 1.47)	0.18(0.028,1.206)*
	Catholic	0.57(0.16, 2.09)	0.46(0.078,2.757)
	Others	1.29(0.44, 3.76)	2.3(0.195,27.202)
Type of institution (N=354)	Public	1.00	1.00
	Private	0.74(0.47, 1.18)	0.68(0.295,1.578)
Ethnicity(N=346)	Amhara(Reference)	1.00	1.00
	Oromo	1.1(0.64, 1.9)	0.24(0.076, 0.779)**
	Tigrie	0.92(0.42, 2.01)	0.28(0.093,0.871)**
	Guragie	2.13(0.97, 4.68)	0.44(0.109,1.757)
	Others	1.49(0.75, 2.98)	1.1(0.284,4.057)
Pocket money (N=354)	Yes	1.00	1.00
	No	0.28(0.089, 0.89)**	0.06(0.05,0.872)**
Education level of	Degree or above(Reference)	1.00	1.00

father (N=326)	Read and write	0.72(0.348, 1.50)	3.6(1.283,14.392)**
	Primary school(1-8)	0.65(0.27, 1.56)	1.9(0.456,7.854)
	Secondary school(9-10)	0.71(0.29, 1.73)	1.4(0.264,7.326)
	Preparatory school(11-12)	0.76(0.37, 1.60)	0.98(0.298,3.193)
	Certificate or Diploma	0.48(0.26, 0.86)	0.59(0.229,1.506)
Education level of mother (N=343)	Degree or above(Reference)	1.00	1.00
	Read and write	0.944(0.42, 2.13)	0.4(0.032, 0.811)**
	Primary school(1-8)	1.17(0.53, 2.61)	4.7(0.959, 23.299)**
	Secondary school(9-10)	0.93(0.45, 1.91)	1.4(0.414,4.595)
	Preparatory school(11-12)	0.80(0.36, 1.79)	0.76(0.202,2.824)
House hold head ship (N=352)	Certificate or Diploma	1.04(0.56, 1.96)	0.75(0.257,2.166)
	Father(Reference)	1.00	1.00
	Mother	1.48(0.899, 2.43)	1.9(0.567,6.386)
Type of Health center (N=350)	Both	1.39(0.705, 73)	0.65(0.295,1.433)
	Health institution nearby(Reference)	1.00	1.00
	Any govt. health centers/Hospital	0.52(0.26, 1.03)*	0.17(0.052,0.539)***
	Any private health centers/hospital	0.10(0.034, 0.314)***	0.034(0.009,0.129)***
	Pharmacy/Drug store	-	0.01(.002, 0.053)***
Number of service center(N=321)	Other	9.6(3.79, 24.31)***	0.05(0.015,0.160)***
	Yes	1.00	1.00
Cost of services (N=312)	No	1.29(0.89, 1.88)	1.4(0.690, 2.742)
	Yes	1.00	1.00
	No	3.79(2.56, 6.38)***	2.4(.045, 5.670)**

**Note:** \*P<0.10, \*\*P<0.050, \*\*\*P<0.01

#### 4.2.2. Voluntary counseling and testing services and its determinants

A logistic regression analysis was done to identify determinants of VCT services. Among the above 14 variables only age, ethnicity, education level of father, class year of student and types of health center were statistically significant association with VCT use and described below.

In the multivariate result on table 4.13 below shows age of youth found to have an association with VCT utilization. 21-23 years old youth were 35% less use VCT than 18-20 years old youth AOR: 0.65, 95% CI (0.254, 1.676), 24-29 years old youth 48% less use VCT than 18-20 years old youth AOR: 0.52, 95% CI (0.143, 1.88).

Ethnicity was one of the predictor variables that have association with voluntary counseling and testing service utilization of youth. Ethnic group of youth being Oromo 4% less uses VCT than youths of Amhara AOR: 0.96, 95% CI (0.225, 1.095).

Class year of student had an association with VCT use of youth. Year two youth had 45% times less to use VCT than year one AOR: 0.55, 95% CI (0.218, 1.36), year three youth 39% less to use VCT than year one AOR: 0.61, 95% CI (0.211, 1.78) and had significant association, year four 1.01 times uses VCT than year one AOR: 1.01, 95% CI (0.216, 4.74) and year five and above 13% less use VCT than year one youths AOR: 0.87, 95% CI (0.224, 3.356).

Education level of father was a predictor variable that affects the outcome variable. When education level of father was read and writes 77% less likely to use VCT than those who had degree or above AOR: 0.23, 95% CI (0.05,1.068) with significance association, primary education 1.48 times more likely to use VCT than degree or above AOR: 1.48, 95% CI (0.367, 5.93), secondary education 3.5 times more uses VCT than those who were degree or above AOR: 3.5, 95% CI (0.91, 13.37) with significance association, preparatory school students 1.2 times more likely to use VCT AOR: 1.2, 95% CI (0.423, 3.433) and certificate or diploma 1.1 times more likely to use VCT than degree or above degree holder fathers AOR:1.1, 95% CI (0.427,2.339) .

Type of health institution was a predictor variable that affects the outcome variable. Using VCT in government health center or hospital 87% less use VCT than nearby health institution AOR: 0.13, 95% CI (0.046, 0.337), private health center or hospital 73% less uses VCT than nearby health institution AOR: 0.273, 95% CI (0.094, 0.788), pharmacy 61% less VCT than nearby health institution AOR: 0.39, 95% CI (0.126, 1.229) and using VCT in other health institution were 69% less than using in any health institution nearby with AOR:0.311, 95% CI (0.127, 0.759) with significance association. Number of service center was also a predictor variable that found to have an effect on the outcome variable. Similarly one can consider the association of the other predictor and outcome variables from table 4.13 below.

**Table 4.13: Multivariate analysis of determinants of voluntary counseling and testing (VCT) service utilization of Sample students in HEI Addis Ababa June, 2018**

Variables		VCT Service	
		COR 95% C.I	AOR 95% C.I
Sex N=354	Male	1.00	1.00
	Female	1.19(0.76, 1.87)	1.1(0.531, 2.25)
Age of respondents N=350	18-20 (Reference)	1.00	1.00
	21-23	0.496(0.31, 0.805)***	0.65(0.254, 1.676)*
	24-26	0.47(0.23,0.96)**	0.52(0.143, 1.88)
Class Year N=354	Year I (Reference)	1.00	1.00
	Year II	1.55(0.75, 3.21)	0.55(0.218, 1.36)
	Year III	0.64(0.298, 1.36)	0.61(0.211,1.778)*
	Year IV	0.67(0.32, 1.39)	1.01(0.216, 4.74)
	Year V and above	1.15(0.45, 2.93)	0.87(0.224, 3.356)
Department N=354	Health	1.00	1.00
	Non-Health	0.55(0.35, 0.86)***	0.63(0.289, 1.35)
Religion N=354	Orthodox Christian(Reference)	1.00	1.00
	Muslim	3.16(0.69, 14.39)	3.2(0.547, 18.78)
	Protestant	4.47(0.92, 21.79)*	3.65(0.578, 23.049)
	Catholic	3.41(0.7, 16.56)	2.43(0.402, 14.704)
	Others	2.79(0.37, 20.82)	4.41(0.347, 55.978)
Type of institution N=354	Public	1.00	1.00
	Private	0.63(0.38, 1.06)*	1.21(0.538, 2.72)
Ethnicity N=346	Amara(Reference)	1.00	1.00
	Oromo	0.8(0.33, 1.92)	0.96(0.225,1.095)*
	Tigrie	1.68(0.79, 3.55)	0.43(0.139,1.315)
	Guragie	1.4(0.79, 2.78)	0.72(0.259,1.99)
	Others	2.36(1.33, 4.22)	0.62(0.239,1.613)
Pocket money N=354	Yes	1.00	1.00
	No	0.66(0.21, 2.08)	(0.065,0.972)
Education level of father N=326	Degree and above(Reference)	1.00	1.00
	Read and write	0.26(0.094, 0.71)**	0.23(0.050, 1.068)*
	Primary school(1-8)	0.57(0.21, 1.53)	1.48(0.367, 5.93)
	Secondary school(9-10)	1.31(0.533, 3.22)	3.49(0.910,13.37)*
	Preparatory school(11-12)	1.29(0.62, 2.73)	1.21(0.423,3.433)
	Certificate or Diploma	0.98(0.54, 1.79)	1(0.427,2.339)
Education level of mother N=343	Degree and above(Reference)	1.00	1.00
	Read and write	1.15(0.047, 2.77)	3.17(0.552, 18.260)
	Primary school(1-8)	1.06(0.44, 2.54)	1.52(0.352, 6.547)
	Secondary school(9-10)	1.89(0.88, 4.05)	1.5(0.530, 4.256)
	Preparatory school(11-12)	1.41(0.60, 3.32)	1.22(0.393, 3.807)

	Certificate or Diploma	1.47(0.75, 2.89)	0.9(0.382, 2.184)
House hold head ship N=352	Father(Reference)	1.00	1.00
	Mother	0.66(0.34, 1.29)	1.18(0.392,3.56)
	Both	1.04(0.62, 1.75)	1.25(0.623, 2.508)
Type of Health center N=350	Health institution nearby(Reference)	1.00	1.00
	Any govt. health centers/Hospital	0.21(0.103, 0.41)***	0.125(0.046,0.337)***
	Any private health centers/hospital	0.42(0.199, 0.086)**	0.273(0.094,0.788)**
	Pharmacy/Drug store	0.54(0.24, 1.22)	0.39(0.126,1.229)
	Other	0.34(0.18, 0.64)***	0.311(0.127,0.759)***
Number of service center N=321	Yes	1.00	1.00
	No	1.16(0.78, 1.72)	1.03(0.590,1.797)
Cost of services N=312	Yes	1.00	1.00
	No	1.41(0.9, 2.22)	0.81(0.389,1.686)

**Note:** \*P<0.10, \*\*P<0.05, \*\*\*P<0.01

### 4.3. Discussion of the Study

#### 4.3.1. Discussion of descriptive result

The study conducted to determine the determinants of RH service utilization of youth in Addis Ababa higher education institutes. For the study 214(60.5%) male and 140(39.5%) female students were participated from both universities. The average age for male was 21.4( $\pm SD$  1.9) and for females 20.9( $\pm SD$  1.6). The majority 258(73.3%) of them were single followed by 79(22.4%) unmarried but had lover; 101(28.5%) of them were year three but the least 31(8.8%) of them were year four students. The number of fourth year students were less due to apparent ship program of some department students namely medicine, engineering, and clinical nurse students.

214(60.5%) of youths were Orthodox Christian believers and the least 10(2.8%) were Catholic believers. Students from Amhara were the highest 133(38.4%) ethnic group followed by students of Oromo 83(24.0%) in Addis Ababa higher education institute; the difference might be the majority of the students (50.8%) birth place was Addis Ababa and the population of Addis Ababa was dominated by Orthodox Christian 74.6%(CSA, 2008).

#### 4.3.2. Contraceptive use and associated factors

Almost all of the respondents 353(99.7%) have information about RH services; this is in line with the previous community study in North Shewa (93.9%), Bahirdar town (92.5%) and Gondar town(93.4%) (Wassie *et al.*, 2016; Hailay *et al.*, 2017; Feleke *et al.*, 2013). The main source of RH knowledge were teachers (schools) 74.2% followed by mass media 63.7% in

line with the study in South Wollo and Harrar (Wubetu *et al.*, 2014; Aboma, 2012) ; this revealed that schools and mass medias were working as good agents in giving awareness about contraceptive use.

Among all students, 47% public and 53.5% private university students were sexually active; in both cases the result was a bit higher than the study in Jimma University, Wolaita Sodo University and Bahirdar University students which were 26.9%, 32.1% and 38.9% (Gurmesa, 2012; Bereket *et al.* 2013, Heaven, 2015) respectively; which is parallel with a study conducted in private college of Bahirdar 50.7% (Zelalem, 2013) out of sexually active youths 74.6% in public and 69.8% of private youths had more than two sexual partner in their life time or involved in multiple sexual practice.

The median age for first sex was found to be ( $19 \pm SD 2$ ) as median age of their first sexual partner ( $18 \pm SD 3.7$ ) years old; the reason for this result might be most of youths start having sex when they are far from their birth places and forced by peer pressure. In lower grade, they give more concern for their education with parental control.

Only 39.1% of them used contraceptive during their first sex. Condom was the best contraceptive used by youth 73.8%; the majorities 30.4% of youths in the study area were not used contraceptive due to fear of the people around them this is in line with the reason obtained from FGD in South Wollo (Wubetu *et al.*,2014).

Generally, contraceptives were utilized by 47.2% of participants, which is consistent with the findings from Namibia (40%), Nigeria (45%), Kazakhstan (38%), and Kenya (46.7%) (Denison *et al.*, 2009; Potter J, 2009; Oshi *et al.*, 2007; Lawrence and Rose, 2007). However, the finding in this study was higher than a study conducted in Asia (28%) and lower than the studies conducted in Brazil and England (62.1% and 89.2%, respectively) (Godeau *et al.*, 2008; Correia *et al.*, 2009). A possible reason for the difference could be that the Brazil and England studies only included sexually-experienced adolescents, whereas the current study included both sexually-experienced and inexperienced youth.

The Asia study only assessed contraceptive utilization during the first sexual intercourse, but the current study assessed contraceptive use at any time. The other differences might be geographic nature of the studied participants; the studies conducted in England and Brazil may have more knowledge access and better attitudes towards using contraceptives. The current study included both students from rural and urban region. The rural area youths might

have poor knowledge and attitudes towards contraceptive use. In addition, culture and religion also had impact on contraceptive service utilization. Youths of this study area were culturally tightened and religiously strong and appreciate sex only after marriage 68.7%. Youth with younger father and mother use contraceptive more likely than older mother; this is in line with studies conducted in East Gojjam zone and the UK (Alemayehu *et al.*, 2006; Lawrence DEI, 2007).

Youth with highly educated father and mother use contraceptives more likely than less educated; this tells us education has its own impact on contraceptive use. Youth with father as a head of household use contraceptive more likely than mothers or both. This revealed that majority of fathers discuss about contraceptive use. Youth with private employer parents more likely to use contraceptive than others; this indicates us that the more the parents educated the more they give awareness about contraceptive use.

The result obtained from the regression model: sex, department, ethnicity, pocket money, types of health center and cost of service had statistically significant with contraceptive use.

Female youths 1.3 times more likely to use contraceptive than their male counterpart; the reason might be to protect themselves from unwanted pregnancy and STDs.

Department was one of the determinant that affect using contraceptives. Non-health students were 4.1 times more likely to use contraceptive than youth in health department; this tell us being health student in contraceptive use does not have any impact; in addition to this the majority 55% of sexually active youths in the study area were students of non-health departments; this revealed that the more they engaged in sexual practice then the more they plan to use contraceptive services.

Class year of student had an effect on contraceptive use of youth. Year two youths were 50% less likely to use contraceptives than year one. Year three youths were 22% less likely to use contraceptive than year one, year four youths were 96% less likely to use contraceptive than year one and youth who were year five and above have significantly associated and 4.1 times more likely to use contraceptive than youth of year one; generally as class year increases students awareness also increases, as a result, contraceptive utilization also increases.

Pocket money is found to have an association with contraceptive use. Youth who had no pocket money regularly were 6% less likely to use contraceptive than who had with significance association; this revealed that the more they have money regularly in their pocket, then the more they use contraceptive easily; as 30% and 53.4% of this study

participants responded to have discount and free RH services respectively; this result also agrees with cost of RH services. When cost of service was not a problem, then a significant association was observed and 2.4 times more likely to use contraceptive than when cost of service were a problem. In order to avoid such problems, parents should pay pocket money regularly, government and other stake holders have to make the RH service easily available for youth in order to protect the productive population.

In addition, type of institution had its own impact in using or not using contraceptives significantly. Types of health institution found to have a significant effect in contraceptive use. Using contraceptives in government health center or hospital, private health center or hospital, pharmacy, and other health institution were 83% less likely, 97% less likely, 99% less likely, 95% less likely to use contraceptives than using in any health institution respectively. So that youths in Addis Ababa higher education institute were more likely use the available health institute in their surrounding; this reveals that all stake holders have to create favorable condition for the RH services in all private and government health institution in order to address youth who did not use RH services regularly if needed.

### **4.3.3. Voluntary counseling and testing (VCT) and associated factors**

Voluntary counseling and testing (VCT) is proven to be one of the weapons in halting the spread of HIV/AIDS; and known to be a very important component of this sexually transmitted disease. For this study, 66.7% youth use VCT services; this is consistent with the study in Bahirdar University, Debre Markos University, Gondar town and North Shewa 66.6%, 58.5%, 72.5%, 72.2% respectively; and in contrary to a study conducted in Wollisso 5.3%, and in rural Butajira 6% and South Africa 10.3% ( Heaven, 2015; Girmay *et al.*, 2011; Feleke *et al.*, 2013; Wassie *et al.*, 2016; Mekonnen and Demissie , 2005; Molla *et al.*, 2009; Hutchinson and Mahlalela, 2006). This is because the perception of risk of HIV/AIDS among sexually active adolescents was less than the results of this study. In addition, in the Wollisso area, there was low access to VCT service since there were only 3 facilities which provide VCT services at the time of study. Moreover, lack of continuous supply of HIV testing, awareness creations by different strategies, re-agents and kits were the other problems which discouraged adolescents from utilizing VCT services.

The difference in the findings of Butajira study might be that the Butajira study was predominantly conducted among rural youth, in which the majority were out of school and had high levels of illiteracy not having awareness about VCT services. This, in turn, could be

due to the fact that youth in rural areas have low access to information and VCT services in similar manner.

The study in South Africa was conducted in the rural areas of Eastern Cape Province, where HIV rapid tests were available at a small minority (approximately 10%) of clinics. According to the 2002 facility survey, HIV/AIDS counseling was routinely available in the rural areas of South Africa, but access to testing procedures was less common in contrary to this study.

From the regression result, only age, class year, ethnicity of students, education of parents and types of health institution found to have significant association with VCT service utilization. Youths that their age lie in the age range (21-23) 35% less likely uses VCT, than (18-20) and youths of age (24-29) years old were 48% less likely uses VCT than (18-20) years old youth respectively. This result informs that the more they were older the less they use the service in line with the study in North Shewa (Wassie Ngash *et al.*, 2016). Youth in their lower classes have good awareness about HIV/AIDS and how they protect themselves from such transmitted disease and cautious; based on the same source most NGOs, including Red Cross, work with lower grade students in campaign.

Class year of students had an effect on VCT service utilization of youth in the study area negatively. Year two youth 45% less likely uses VCT service, year three youth 39% less likely uses contraceptive with significant association, year four youth 1.01times more likely, year five and above youth 13% less uses VCT than youth of year one; this is in line with the finding in age group of youth in the study area.

Education level of parents had an important predictor variable in determining VCT service utilization of the given study participants. Youths in the study area had father whose education level starting from reading and writing literate up to degree or above degree level. For this study, education level of father affects the outcome variable in the following manner. When education levels of fathers were at reading and writing, are 77% less uses VCT than fathers whose education level were degree or above. When education levels of fathers were at primary education, are then 1.48 times more likely uses VCT than fathers whose education level were degree or above. When education levels of fathers were at secondary, then 3.5 times more likely uses VCT than degree or above. When education level of fathers were at preparatory school, then 1.2 times more likely use VCT than degree or above. When education level of father was at certificate or diploma, then 1.1 times more likely uses VCT than degree or above degree holder fathers. Generally, the above multivariate result revealed that the more the fathers were educated the more they create awareness regarding RH service issues to their families.

Type of health institution chosen by youth in the study area was a predictor variable that affects the outcome variable significantly. Their choice in using VCT services in government health center or hospital was 87%, in private health center or hospital was 73%, in pharmacy was 61% and other health institution was 69% less likely than in any health institution. So, the above result reminded us that all health institutions (public and private) in the town were giving RH services for the society specifically for youth.

## CHAPTER FIVE

### 5. CONCLUSION AND RECOMMENDATIONS

#### 5.1. Conclusion

This study provides important and reliable information on the extent of contraceptives and voluntary counseling and testing users. On the determinant of RH service utilization among youth in the study area.

All of the respondents have knowledge about RH services, with positive attitude towards RH services, start doing sex during or after joining higher education institutions, nearly half of the total respondents used contraceptives and usually prefer condom as a contraceptive, more of sexually active youth have multiple sexual partner, all sexually active youth did not use RH services regularly and exposed to risky sexual practice.

Age of students, gender, department, class year, ethnicity, pocket money, type of health institution, cost of service, education level of father were the basic determinants of contraceptives and voluntary counseling and testing service utilization that have positive or negative association in using or not using the RH services as obtained from the logistic regression model.

Clinics in both public and private higher education institutions have to appreciate youth to have the RH services with confidential and privacy care service; Ministry of Health, Non-government health organizations and Ministry of Education have to work in partnership in order to build awareness for both youth and health workers; life skill training for students of both public and private higher education institutions is needed.

## **5.2. Recommendations**

Youth have to use Reproductive Health services regularly if needed and remind to boost up their previous experiences for their future endeavor.

Ministry of health, campus clinics and Non-government health organizations needed to enhance the practice of using the service in order to minimize related RH problems.

Parents should give pocket money for their son or daughter in order to save their family from RH risks.

Capacity building training for health care service providers to improve the service given and to win the trust of the youths in dealing with them; so that they may be friendly and appealing to them, this will attract them to the clinics or facilities and in turn improves utilization of the RH services.

This result might be changed or sound more; if one increases the number of sample respondents or using additional predictor variables or using qualitative data in addition to the quantitative.

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## APPENDICES

### Annex I

#### Participant Information Sheet

Here, I undersigned, at Addis Ababa University, college of development studies, department of population studies, and graduate studies program; currently I will be conducting research on a topic entitled as “*Determinants of reproductive health service utilization among youth in higher education institutes in Addis Ababa*”.

**1. Objectives of the study:** The objective of this study is to investigate the determinants of reproductive health service utilization of youth and to analyze the main factors that affect youth reproductive health service utilization in your surrounding or campus by asking knowledge, attitudes and experiences regarding to the determinants of reproductive health service utilization.

**2. Participants to be included:** Students in selected public and private higher education institution of Addis Ababa.

**3. Procedure and guidelines:**

- i. The study will be carried out by asking predetermined self administered questionnaires.
- ii. Filling the questionnaire will take (40 to 60) minutes, so you are kindly requested to fill the questionnaire.
- iii. If you get the questionnaire astonishing please put the questionnaire upside down on the table and stay in your seat till others finish.

**4. Confidentiality:** All information you give will be kept confidential and won't be accessible to any third party.

**5. Benefits and risks of the study:**

- i. **Risks:** The procedure does not bear any physical or psychological trauma.
- ii. **Benefits:** For your participation in the study no payment will be granted or has no any special privilege to you, but participating in the study and giving your genuine information will provide great input to bring change in youth reproductive health status.

**6. Consent:** Your participation in the study is totally based on your willingness.

You have the right not to participate from the beginning, or you may stop participating at any time after starting the participation. You won't be forced to give information that you do not know.



120	Education level of your father?	1. Can't read and write 5. Preparatory 3. Primary school (1-8) 6. Certificate/Diploma	2. Read and write only 4. Secondary school (9-10) 7. Degree and above.
121	Occupation of your father?	1. Has no job 3. Employed (govt.) 4. Own Small business 6. Own large business -----	2. Employed (private) 5. Own medium business 7. Farming 8. Others(specify)-----
122	Age of your mother?	_____	
123	Education level of your mother?	1. Read and write only 5. Preparatory 3. Primary school (1-8) 6. Certificate/Diploma	2. Can't read and write 4. Secondary school (9-10) 7. Degree and above.
124	Occupation of your mother?	1. House wife 3. Employed (govt.) 5. Own medium business 6. Own large business -	2. Employed (private) 4. Own Small business 7. Others(specify)-----
125	What is your parent's estimated monthly income?	1. < 1000 4. 3001-4000	2. 1001-2000 5. 4001-5000 6. >5001 3. 2001 -3000
126	Number of members in your household?	_____	
127	Head of household in your family?	1. Mother 2. Father 3. Other(specify)_____	
128	Your preparatory education.	1. Government Other_____	2. Private 3.
129	Place of your preparatory school.	1. Addis Ababa	2. Out of Addis Ababa

## Part II Reproductive health knowledge and health worker contact

201	Do you have information about any reproductive health services?	1. Yes	2. No(Skip to 204)
202	If your answer is (Yes for Q201); What are the RH service you know? (Multiple response permitted) 1. Contraceptive methods 2. Treatment for sexually transmitted infections(STDs) 3. Voluntary counseling and testing (VCT) for HIV/AIDS 4. For Abortion case 5. Post abortion care services 6. Antenatal care 7. Postnatal care 8. Others (specify)_____	1. Yes 1. Yes 1. Yes 1. Yes 1. Yes 1. Yes 1. Yes 1. Yes	2. No 2. No 2. No 2. No 2. No 2. No 2. No 2. No
203	If your answer is Yes for Q 201 from where you obtain the information? (Multiple response permitted) 1. Parent talk 2. Teacher (schools) 3. Health workers 4. Friend 5. News paper	1. Yes 1. Yes 1. Yes 1. Yes 1. Yes	2. No 2. No 2. No 2. No 2. No



### Part III Attitude of youth towards RH services

Please decide the extent to which you agree/disagree with the following statements

301	RH service is important for youth like me?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
302	Each youth should be aware of the importance of RH service?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
303	Youth have harder time to get RH service than adults?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
304	Use of RH service is unlikely if health provider is judgmental?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
305	Use of RH service is unlikely if the waiting time in the service center is too long?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
306	Use of RH service is unlikely if RH service providers are un friendly?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
307	Use of RH service is unlikely if the RH service is not confidential?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
308	Use of RH service is unlikely if cost of RH service is expensive?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree
309	Use of RH service is unlikely if number of RH service providers are less around my resident?	1. Strongly agree 3. Neutral 5. Strongly disagree	2. Agree 4. Disagree



416	If your answer is ( <b>YES</b> ) for Q (415); What can be your possible reason for this?	1. To avoid unwanted pregnancy 2. To protect from different STIs including HIV/AIDS 3. For spacing purpose 4. Other reason-----
417	If your answer is ( <b>NO</b> ) for Q (415); What can be your possible reason?	1. It is forbidden in my culture 2. It is forbidden in my religion 3. I don't worry about my future 4. It is against rule of God 5. Other----
418	If your answer is ( <b>No</b> ) for Q402; Why you didn't have sexual intercourse still?	1. It is not the right time 2. Does not have boy/girl friend 3. I fear having sex 4. Others ( specify) ----- -----
<b>For Females only</b>		
<b>2. Pregnancy and Abortion Experience</b>		
419	Have you ever been pregnant?	1. Yes 2. No (skip to 426)
420	If your answer is ( <b>YES for 419</b> ); What happened to the pregnancy?	1. Currently pregnant 2. Abortion 3. Miscarriage 4. Live-birth
421	If the pregnancy is ended by abortion from where you get the service?	1. Govt. Health centers/Hospital 2. Pharmacy/Drug store 3. Traditional attendant centers/Hospital 4. Any private Health centers 5. Others (specify)----- -----
422	If you aborted; did you serve <b>post abortion care</b> service from any health institution?	1. Yes 2. No
423	If your answer is ( <b>NO for Q422</b> ); What is the possible reason for not using the <b>post abortion care</b> service?	1. Does not have money 2. Don't know where to go 3. Cultural against 4. Fear of parents 5. Inconvenient location 6. Inconvenient time of services 7. Feeling healthy 8. Distance to facility 9. Others ( specify) ----- -----
424	How many times have you been pregnant?	1. Once 2. 2 times 3. 3 and above times
425	How many times you made abortion?	1. Never 2. Once 3. 2 times 4. 3 and above times
426	Did you ever use EC (Emergency contraceptive) after unsafe sexual intercourse?	1. Yes 2. No
427	If your answer is ( <b>Yes for Q426</b> ); how many times you use EC after your sexual intercourse?	1. Once 2. 2 times 3. 3 times 4. 4 or more times
<b>3. Voluntary Counseling and Testing (VCT) for STI and HIV/AIDS</b>		
428	Have you ever had a voluntary counseling and testing service (VCT) for HIV/AIDS? If your answer is <b>Yes</b> from	1. Govt. Health centers/Hospital 2. Pharmacy (drug store) 3. Any private Health centers/Hospital

	where you tested?	<b>4. Others (specify)</b> -----
429	Did you have voluntary counseling and testing service (VCT) before your first sexual intercourse? If your answer is <b>No</b> why?	<b>1.</b> Too young to go to the services <b>2.</b> Do not have money <b>3.</b> Do not know the purpose <b>4.</b> Do not know where to have the test <b>5.</b> Fear of parent <b>6.</b> Inconvenient location <b>7.</b> Inconvenient time of services <b>8.</b> Feel healthy <b>9.</b> Long distance to facility <b>10.</b> Others (specify) -----
430	How often did you go for voluntary counseling and testing service (VCT)?	<b>1.</b> When exposed to risk <b>2.</b> Every three month <b>3.</b> Every 6 month <b>4.</b> Every year <b>5.</b> Other (specify) -----
431	Have you ever had symptoms of STIs such as, genital ulcer, genital discharge or genital swelling?	<b>1.</b> Yes <b>2.</b> No( <b>skip to 434</b> )
432	How many time you affected by STDs?	<b>1.</b> Once <b>2.</b> Twice <b>3.</b> More than two times
433	What did you do first when you had STIs?	<b>1.</b> I did nothing <b>2.</b> Self treatment. <b>3.</b> Went to campus clinic <b>4.</b> Went to pharmacy <b>5.</b> Went to public health institution <b>6.</b> Went to private clinic/hospital <b>7.</b> Went to traditional healer

#### **4. Availability of RH services and Utilization**

434	Is there any RH service in your Campus compound?	<b>1.</b> Yes <b>2.</b> No ( <b>skip to Q438</b> )
435	If your answer is ( <b>Yes for Q434</b> ); did you ever use the RH service?	<b>1.</b> Yes <b>2.</b> No
436	If your answer is ( <b>Yes for Q435</b> ); which service you use in the campus?	<b>1.</b> Pills <b>2.</b> EC (Emergency Contraceptive) <b>3.</b> Injection <b>4.</b> Condom <b>5.</b> For VCT service <b>6.</b> Post abortion care service <b>7.</b> Other----- -----
437	If your answer is ( <b>No for Q435</b> ) What is/are your possible reasons?	<b>1.</b> I fear the service provider. <b>2.</b> Did not find all the RH service I want. <b>3.</b> The RH service providers are not friendly. <b>4.</b> I use the service center only for other ill cases. <b>5.</b> Other(Specify)----- -----
438	Where do you likely to receive RH services? ( <b>Multiple response permitted</b> )	<b>1.</b> Any govt. health centers/Hospital <b>2.</b> Any private health centers/hospital <b>3.</b> Pharmacy/Drug store <b>4.</b> Traditional method <b>5.</b> Any health institution nearby <b>6.</b> Others (specify)-----



**መረጃ ለመስጠት ያላቸው ፍቃደኝነት ማረጋገጫ**

እኔ ተማሪ ክፍሉ ከማል በአዲስ አበባ ዩኒቨርሲቲ በሃገር ልማት ጥናት ኮሌጅ በስነ-ህዝብ ትምህርት ክፍል ተመራቂ ተማሪ ስሆን በአሁኑ ሰዓት የመመረቂያ ጽሁፌን “አዲስ አበባ ከፍተኛ ትምህርት ተቋማት ውስጥ ሚማሩ ወጣቶች የስነ-ተዋልዶ ጤና አገልግሎት አጠቃቀም እና ተዛማጅ ጉዳዮች ” በሚል ርዕስ ጥናት ለማድረግ መረጃ በመሰብሰብ ላይ እገኛለሁ።

1. የጥናቱ ዓላማ፡ የዚህ ጥናት ዓላማ የተማሪዎችን ዕውቀት፣ ዝንባሌ እና ተማሪዎች በስነ-ተዋልዶ ጤና አገልግሎት አጠቃቀም እና ተዛማጅ ጉዳዮች ላይ ያላቸውን የህይወት ተሞክሮ በመረዳት ሳይንሳዊ ትንታኔ መስጥት ነው።

2. በጥናቱ ላይ ተሳታፊዎች፡ በዚህ ጥናት ላይ በተመረጡ የመንግስት እና የግል ከፍተኛ ትምህርት ተቋማት ላይ በ2010 ዓመተ ምህረት የሚማሩ ተማሪዎች ብቻ ናቸው።

**3. ስለመጠይቁ የሚያስረዳ መመሪያ እና ቅደም ተከተል**

ሀ. ይህንን ጥናት ተግባራዊ ለማድረግ በባለሙያ የተዘጋጀ በተጠያቂው የሚሞላ መጠይቅ ተዘጋጅቷል፤

ለ. መጠይቁን ለመሙላት ፍቃደኛ የሆነ ተማሪ የተዘጋጀውን መጠይቅ ከ40 እስከ 60 ደቂቃ ውስጥ ሞልቶ ሊጨርስ ይችላል።

ሐ. የተዘጋጀው መጠይቅ ያንተን/ቺን ስነ-ልቦና የሚነካና ያልተጠበቀ ከሆነ መጥይቁን ገልብጦ በማስቀመጥ ሌሎች ተማሪዎች እስኪጨርሱ ሊጠብቅ ወይም ልትጠብቅ ይገባል/ባታል።

**4. የተሞላው መጠይቅ ምስጢራዊነት**

ማንኛውም ተጠያቂ የሚሰጥው መረጃ በሚስጥር የሚጠበቅ እና ለሶስተኛ ወገንም ተላልፎ አይሰጥም።

**5. ተማሪዎች ጥናቱ ላይ ያላቸው ተጠቃሚነት እና መጠይቁን ሲሞሉ የሚከሰቱ ጉዳዮች**

ሀ. መጠይቁን ሲሞሉ የሚከሰቱ ጉዳዮች፡ መጠይቁን ሲሞሉ ቅደም ተከተል ጠብቀው ባይሞሉም እንኳን ምንም አይነት ቅጣት አይደርስቦትም።

ለ. በዚህ መጠይቅ ላይ ተሳትፎ ሆነው ያሉትን የህይወት ልምድ በማካፈሎ ምክንያት የወጣቶችን ስነ-ተዋልዶ ጤና አጠባበቅ ደረጃን ከማሳደግ በስተቀር ምንም አይነት ክፍያ እና ጥቅማ ጥቅም የሌለው መሆኑ ሊታወቅ ይገባል።

**6. ፍቃደኝነት፡ በዚህ ጥናት ላይ ለመሳተፍ የተማሪው ሙሉ ፍቃደኝነት ያስፈልጋል፤**

ማንኛውም ተማሪ ጥናቱ ላይ አለመሳተፍ፣ መሳተፍ ከጀመረ በኋላ ማቋረጥ እንዲሁም መጠይቁ ላይ ያልተረዳውን ጥያቄ አለመመለስ የሚችል መሆኑን ሊያውቅ ይገባል።



		7. ለብቻዬ	8. ሌላ ካለ ጥቀስ/ሽ-----
112	ላለፉት ስድስት ወራት ይበልጥ የኖርከው/ሽውየት ነው?	1. ከቤተሰቤ ጋር 3. ዶርም	2. በክራይ ቤት 4. ሌላ ካለ ጥቀስ/ሽ____
113	በቀን ወይም በምሽት ክለብ ትሳተፋለህ/ፊያለሽ?	1. አዎን	2. አልሳተፍም(ወደ 115)
114	ለጥያቄ 113 መልስህ/ሽ አዎን ከሆነ ምን ያህል?	1. በየሳምንቱ በየ3ት ወሩ 5. በየ6 ወሩ	2. በወር 2ት ጊዜ ብቻ 6. በየዓመቱ 7. ሌላ መልስ ካለ ጥቀስ/ሽ_____
115	ከቤተሰብህ/ሽ የኪስ ገንዘብ ይሰጥሃል/ሻል?	1. አዎን	2. አይሰጠኝም(ወደ 117)
116	ለጥያቄ 115 መልስህ/ሽ አዎን ከሆነ በየስንት ጊዜ ታገኛለህ/ሽ?	1. በየሳምንቱ ወሩ 5. በየ6 ወሩ	2. በወር 2ት ጊዜ 6. በየዓመቱ 7. ሌላ መልስ ካለ ጥቀስ/ሽ_____
117	የአባትህ/ሽ የጋብቻ ሁኔታ	1. አብረው የሚኖሩ 4. በህይወት ያለው አባት ብቻ ነው	2. ተለያይተው ሚኖሩ 5. በህይወት ያለችው እናቴ ብቻ ናት
118	የእናትህ/ሽ የጋብቻ ሁኔታ	1. አብረው የሚኖሩ 4. በህይወት ያለው አባት ብቻ ነው	2. ተለያይተው ሚኖሩ 5. በህይወት ያለችው እናቴ ብቻ ናት
119	የአባትህ/ሽ(ወንድ አሳዳጊህ/ሽ)ዕድሜ ስንት ነው?	_____	
120	የአባትህ/ሽ(ወንድ አሳዳጊህ/ሽ) የትምህርት ደረጃ ምን ያህል ነው?	1. ማንበብ እና መጻፍ አይችልም 2. ማንበብ እና መጻፍ ብቻ ይችላል 3. ከ1ኛ እስከ 8ኛ 4. ከ9ኛ እስከ 10ኛ 5. የመሰናዶ ትምህርት 6. በሰርተፊኬት ወይም የዲፕሎማ ተመራቂ 7. ዲግሪ እና ከዝያ በላይ	
121	የአባትህ/ሽ(ወንድ አሳዳጊህ/ሽ) ስራ ምንድን ነው?	1. ስራ የለውም 2. የግል መስሪያ ቤት ስራተኛ 3. የመንግስት ስራተኛ 4. አነስተኛ ነጋዴ 5. መካከለኛ ነጋዴ 6. ከፍተኛ ነጋዴ 7. ግብርና 8. ሌላ ካለ ጥቀስ/ሽ_____	
122	የእናትህ/ሽ(ሴት አሳዳጊህ/ሽ) ዕድሜ ስንት ነው?	_____	

123	የእናት-ህ/ሽ(ሴት አሳዳጊህ/ሽ) የትምህርት ደረጃ ምን ያህል ነው?	1. ማንበብ እና መጻፍ አትችልም 2. ማንበብ እና መጻፍ ብቻ ትችላለች 3. ከ1ኛ እስከ 8ኛ 4. ከ9ኛ እስከ 10ኛ 5. በሰርተፊኬት ወይም የዲፕሎማ ተመራቂ 6. ዲግሪ እና ከዝያ በላይ
124	የእናት-ህ/ሽ(የሴት አሳዳጊህ/ሽ) ስራ ምንድን ነው?	1. የቤት እመቤት 2. የግል መስሪያ ቤት ሰራተኛ 3. የመንግስት መስሪያ ቤት ሰራተኛ 4. አነስተኛ ነጋዴ 5. መካከለኛ ነጋዴ 6. ከፍተኛ ነጋዴ 7. ሌላ ካለ ጥቀስ/ሽ_____
125	የቤተሰብህ/ሽ አማካይ የወር ገቢ በግምት ስንት ነው?	1. ከ1000ብር በታች 2. ከ1001-2000ብር 3. ከ2001-3000ብር 4. ከ 3001-4000ብር 5. ከ4001-5000ብር 6. ከ5001ብር በላይ
126	የቤተሰብህ/ሽ ብዛት ስንት ነው?	_____
127	የቤተሰብህ/ሽ አስተዳዳሪ ማን ነው?	1. አባት 2. እናት 3. ሌላ ካለ ጥቀስ/ሽ_____
128	መሰናዶ ትምህርት የት ት/ቤት ተማርክ/ሽ?	1. የመንግስት 2. የግል 3. ሌላ_____
129	መሰናዶ ትምህርት የት ሃገር ተማር/ሽ?	1. አዲስ አበባ 2. ከአዲስ አበባ ውጪ

## ክፍል፪

**ከህክምና ባለሙያዎች ጋር ያላቸው ቅርርብ እና ስለ ስነ-ተዋልዶ ጤና ያላቸው እውቀት**

201	ስለ ማንኛውም ስነ-ተዋልዶ ጤና አገልግሎት እውቀት ወይም ግንዛቤ አለህ/ሽ?	1. አዎን 2. የለኝም(ወደ ጥያቄ 205)
202	ለጥያቄ 201 መልስህ/ሽ አዎን ከሆነ የትኞቹን የስነ-ተዋልዶ አገልግሎቶችን ታውቃለህ/ሽ? (ከአንድ በላይ መመለስ ይቻላል)	1. የእርግዝና መከላከያ ዘዴዎች 2. ለአባልዘር በሽታ ህክምና 3. የኤች አይቪ ኤድስ ምርመራ እና ምክር አገልግሎት 4. የውርጃ አገልግሎት 5. ከውርጃ በኋላ የህክምና አገልግሎት 6. ቅድመ ወሊድ ክትትል 7. ከወሊድ በኋላ ክትትል 8. ሌላ መልስ ካለ__
203	ለጥያቄ 201 መልስህ/ሽ አዎን ከሆነ መረጃውን ከየት አገኘህ/ሽ? (ከአንድ በላይ መመለስ ይቻላል)	1. ከቤተሰብ 2. ከመምህራን/ክት/ቤት 3. ከጤና ባለሙያዎች 4. ከጓደኞቹ 5. ከጋዜጣ 6. ከበራሪ ጽሁፍ 7. ከራድዮ እና ቴሌቪዥን 8. ከኢንተርኔት 9. ሌላ ካለ ጥቀስ/ሽ_____
204	ጥያቄ 202 ላይ ከተዘረዘሩት አገልግሎቶች ውስጥ ከዚህ በፊት የተጠቀምካቸውን/ሻቸውን ተራ ቁጥራቸውን ብቻ ጻፍ/ፊ?	_____
205	ስለ ስነ-ተዋልዶ ጤና እውቀት ወይም ግንዛቤ እንዲኖርህ/ሽ ትፈልጋለህ/ሽ?	1. አዎን 2. አልፈልግም
206	ጤና ኤክስቴንሽን ባለሙያዎችን ታውቃለህ/ሽ?	1. አዎን 2. አላውቃቸውም(ወደ ጥያቄ 210)
207	ከ ጤና ኤክስቴንሽን ባለሙያዎች ጋር የምትገናኝበት አጋጣሚ አለ?	1. አዎን 2. የለም(ወደ ጥያቄ 209)
208	ለጥያቄ 207 መልስህ/ሽ አዎን ከሆነ በምን ያህል ጊዜ ትገናኛላችሁ?	1. በዓመት አንድ ጊዜ 2. በዓመት ሁለት ጊዜ 3. በዓመት ሶስት ጊዜ 4. በዓመት አራት ጊዜ እና ከዚያ በላይ 5. ሌላ መልስ ካለ_____
209	ለጥያቄ 207 መልስህ/ሽ የለም ከሆነ ምክንያትህ/ሽ ምን ሊሆን ይችላል?	1. መገናኘት ስለማልፈልግ 2. ባለሙያዎቹ እኛ ግቢ ውስጥ ስለሌሉ 3. አገልግሎት አሰጣጣቸው ስለማይስደስት 4. ስለማላውቃቸው 5. ሌላ ምክንያት ካለ_____
210	ለወጣቶች ስነ-ተዋልዶ ጤና ማን ሃኪም ቢሆን ትመርጣለህ/ሽ?	1. ወጣት ሆኖ ተመሳሳይ ጾታ 2. ወጣት ሆኖ ተቃራኒ ጾታ 3. ወጣት ሆኖ ማንኛውም ጾታ 4. አዋቂ ሆኖ ተመሳሳይ ጾታ 5. አዋቂ ሆኖ ተቃራኒ ጾታ 6. አዋቂ ሆኖ ማንኛውም ጾታ 7. ሌላ መልስ ካለ_____

211	በቀን ወይም በምሽት የመዝናኛ ፕሮግራም ላይ መሳተፍ ጥንቃቄ ለጎደለው ወሲብ ጥቃት ያጋልጣል?	1. ሁል ጊዜ 3. አያጋልጥም	2. አልፎ አልፎ
212	አልኮል መጠጣት፣ ጫት መቃም፣ ወይም ሌሎች እጾችን መጠቀም በወሲብ ሰአት የስነ-ተዋልዶ ጤና አገልግሎት(ኮንዶም፣ፒልስ ወዘተ) እንዳልጠቀም ያደርገኛል?	1. ሁል ጊዜ 3. ምንም ችግር የለውም	2. አልፎ አልፎ
213	ፊልም መመልከት የአርግዝና መከላከያ እንድጠቀም ይረዳኛል?	1. ሁል ጊዜ 3. አይጠቅምም	2. አልፎ አልፎ

**ክፍል፣ ወጣቶች ለስነ-ተዋልዶ ጤና አገልግሎት ያላቸው ዝንባሌ**

**ለሚከተሉት ጥያቄዎች የተስማማህበትን/ሽበትን እና ያልተስማማህበትን/ሽበትን በመወሰን ምረጥ/ጭ**

301	የስነ-ተዋልዶ ጤና አገልግሎት እንደ እኔ ላለው ወጣት ጠቃሚ ነው?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
302	እያንዳንዱ ወጣት ስለ-ስነ ተዋልዶ ጤና አገልግሎት ጥቅም መረዳት አለት?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
303	የስነ-ተዋልዶ ጤና አገልግሎት ለማግኘት ከአዋቂዎች ይልቅ ወጣቶች ይቸገራሉ?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
304	ጤና ባለሙያው/ዋ ስለ እኔ ህክምና በእኔ ቦታ ሆኖ/ሆና ሚወስን/ትወስን ከሆነ የስነ-ተዋልዶ ጤና ህክምናውን ምቹ አያደርገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
305	በስነ-ተዋልዶ ጤና ህክምና መስጫ ቦታ ላይ ለረጅም ሰዓት ምቹይ ከሆነ ህክምናውን ምቹ አያደርገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
306	የስነ-ተዋልዶ ጤና የህክምና ባለሙያዎች ተግባር ካልሆኑ ህክምናውን ምቹ አያደርገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
307	የስነ-ተዋልዶ ጤና ህክምና ባለሙያዎች ሚስጥር ጠባቂዎች ካልሆኑ ህክምናውን ምቹ አያደርገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
308	ለስነ-ተዋልዶ ጤና ህክምና የሚከፈለው ክፍያ ውድ ከሆነ ህክምናውን ምቹ አያደርገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም
309	እኔ በምኖርበት አካባቢ በቂ የስነ ተዋልዶ ጤና አገልግሎት መስጫ ባለመኖሩ ህክምናውን ምቹ አላደረገውም?	1. በጣም እስማማለሁ 3. መካከለኛ 4. አልስማማም	2. እስማማለሁ 5. በጣም አልስማማም

**ክፍል፬ የስነ-ተዋልዶ ጤና ጋር ተያያዥነት ያላቸው መጠይቆች**

<b>1. ግብረ ስጋ ግንኙነትና የእርግዝና መከላከያ ዘዴ አጠቃቀም</b>		
401	ከዚህ በፊት ስንት የወንድ/ሴት ጓደኛ ነበረህ/ሽ?	1. 1ድ 2. 2ት 3. 3ስት 4. 4ትና ከዚያ በላይ 5.ሌላ መልስ ካለ_____
402	ከስንቶቹ ጋር የግብረ ስጋ ግንኙነት ፈጽመሃል/ሻል?	1. 1ድ 2 2ት 3. 3ስት 4. 4ትና ከዚያ በላይ 5. አልጀመርኩም(ወደ 414)
403	በመጀመሪያ ግብረ ስጋ ግንኙነትህ/ሽ ወቅት እድሜህ/ሽ ስንት ነበር?	_____
404	በመጀመሪያ ግንኙነትህ/ሽ ወቅት የሴት/የወንድ ጓደኛህ/ሽ እድሜ በግምት ስንት ነበር?	_____
405	በመጀመሪያ ግብረ-ስጋ ግንኙነትህ/ሽ የእርግዝና መከላከያ ተጠቅመሃል/ሻል?	1. አዎን 2. አልተጠቀምኩም(ወደ 407)
406	ለጥያቄ 405 መልስህ አዎን ከሆነ የተጠቀምኩህ/ሽው የወሊድ መከላከያ የትኛው ነው?	1. በየቀኑ ሚዋጥ ክኒን(ፒልስ) 2. በ72 ሰዓት ውስጥ ሚዋጥ የእርግዝና መከላከያ 3. በየ 3 ወሩ የሚወጋ መርፌ 4. የወንድ ኮንዶም 5. የወር አበባ ኡደት በመከተል 6. ሌላ መልስ ካለ_____
407	ለመጨረሻ ጊዜ ግብረ ስጋ ግንኙነት ያደረግኩህ/ሽው መቼ ነው?	1. ባለፈው ሳምንት 2. ባለፈው አንድ ወር 3. ባለፈው ስድስት ወር 4. ባለፈው አንድ ዓመት 5. ከአንድ ዓመት በፊት
408	ባለፉት ሶስት ወራት ውስጥ ከምን ያህል ሴቶች/ወንዶች ጋር ወሲባዊ ግንኙነት ነበረህ/ሽ?	1. ከአንድ 2. ሁለት 3. ሶስት 4. አራት 5. ከአራት በላይ 6. ሌላ መልስ ካለ_____
409	እስካሁኑ ዕድሜህ/ሽ ድረስ ከስንት ሴቶች/ወንዶች ጋር ግብረስጋ ግንኙነት አድርገሃል/ሻል?	1. ከአንድ 2. ከሁለት 3. ከሶስት 4. ከአራት 5. ከአራት በላይ 6. ሌላ መልስ ካለ-----
410	የግብረ ስጋ ግንኙነት ስትፈጽም ሁልጊዜ የእርግዝና መከላከያ ትጠቀማለህ/ሽ?	1. አዎን 2. አልጠቀምኩም(ወደ 413)
411	ለጥያቄ 410 መልስህ አዎን ከሆነ ውሳኔው የማን ነው?	1. የሴት ጓደኛዬ 2. የወንድ ጓደኛዬ 3. የሁለታችን ውሳኔ
412	ለጥያቄ 410 መልስህ አዎን ከሆነ የትኛው የመከላከያ ዘዴ ይበልጥ	1. በየቀኑ ሚዋጥ ክኒን(ፒልስ) 2. የ72 ሰዓት የእርግዝና መከላከያ

	ትጥቀማለህ/ሽ?	3. የ3 ወር መርፌ 4. ኮንዶም 5. የወር አበባ ኡደት በመከተል 6. ዘርን ከማህጸን ውጪ ማፍሰስ 7. ሌላ መልስ ካለ _____
413	በግብረሰጋ ግንኙነት ወቅት ማንኛውንም አይነት የእርግዝና መከላከያ የማትጠቀም/ሚ ከሆነ ምክንያት-ህ/ሽ ምን ሊሆን ይችላል?	1. የእርግዝና መከላከያውን መግዣ ቦታ ስለማላውቅ 2. መግዣ ቦታውን ባውቅም መግዣት ስለምፈራ 3. አጠቃቀሙን ስለማላውቅ 4. መግዣ ብር ስለማይኖረኝ 5. የፍቅር ጓደኛዬ ስለማትወድ/ማይወድ 6. በግብረ ሰጋ ግንኙነቱ ወቅት ስለምረሳው 7. ሌላ ምክንያት ካለ ጥቀስ/ሽ _____
414	የቀን ወይም የምሽት ጭፈራ ስትሳተፍ ጥንቃቄ ለጎደለው የግብረ ሰጋ ግንኙነት ተጋልጠህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላውቅም
415	በወደፊቱ ህይወት-ህ/ሽ የወሊድ መከላከያ እጠቀማለሁ ብለህ/ሽ ታስባለህ/ሽ?	1. አዎን 2. አላስብም(ወደ 417)
416	ለጥያቄ 415 መልስህ/ሽ አዎን ከሆነ ምክንያት-ህ/ሽ ምን ሊሆን ይችላል?	1. ያልተፈለገ እርግዝናን ለመከላከል 2. ከአባላዘር በሽታ ለመከላከል 3. አራርቆ ለመውለድ 4. ሌላ ምክንያት ካለ ጥቀስ/ሽ _____
417	ለጥያቄ 415 መልስህ/ሽ (አላስብም) ከሆነ ምክንያት-ህ ምን ሊሆን ይችላል?	1. በባህላችን መጠቀም ክልክል ስለሆነ 2. በሐይማኖቱ ስለማይፈቀድ 3. ስለወደፊት ህይወቴ አሁን ማሰብ ስለማልፈልግ 4. ከፈጣሪ ህግ ውጪ ስለሆነ 5. ሌላ ምክንያት ካለ ጥቀስ/ሽ _____
418	ለጥያቄ 402 መልስህ/ሽ (የግብረ ሰጋ ግንኙነት ማድረግ አልጀመርኩም) ከሆነ ምክንያት-ህ/ሽ ምን ሊሆን ይችላል?	1. በዚህ ዕድሜዬ መጀመር ስለማልፈልግ 2. የወንድ ወይም የሴት ጓደኛ ስለሌለኝ 3. ግብረ ሰጋ ግንኙነት ማድረግ ስለምፈራ 4. ሌላ ምክንያት ካለ ትቀስ/ሽ _____

**ለሴቶች ብቻ ሚጠየቅ(ከ419-427)**

**2. እርግዝናና ውርጃ**

419	ከዚህ በፊት በፍቅረኛሽ/በባለቤትሽ ወይም በሌላ ወንድ እርግዝሽ ታውቋልህ?	1. አዎን 2. አላውቅም(ወደ 426)
420	ለጥያቄ 419 መልስሽ አዎን ከሆነ የእርግዝናው መጨረሻ እንዴት ነበር?	1. አሁን እርጉዝ ነኝ 2. አስወረድኩት 3. በህመም ምክንያት ጽንሱ ተቋረጠ 4. ተወለደ
421	እርግዝናውን የተቋረጠው በማስወረድ ከሆነ የማስወረድ ህክምናውን የት ተጠቅምሽ?	1. በመንግስት ህክምና ተቋም 2. ከመድሃኒት ቤት መድሃኒት በመግዛት 3. በባህላዊ መድሃኒት 4. ሌላ መንገድ 5. ከግል ህክምና መስጫ ተጠቅመሽ ከሆነ ግለጭ
422	እርግዝናው የተቋረጠው በማስወረድ ከሆነ ካስወረድሽው በኋላ የህክምና አገልግሎት ተጠቅመሻል?	1. አዎን 2. አልተጠቀምኩም
423	የህክምና አገልግሎቱን ካልተጠቀምሽ ምክንያትሽ ምን ሊሆን ይችላል?	1. የአገልግሎቱ ክፍያ ወድ ስለሆነ 2. አገልግሎት ማግኛቸው ቦታውን ስለማላውቀው 3. በባህላችን ክልክል ስለሆነ 4. ቤተሰቦቼን/ሚያውቁኝን ሰዎች ስለምፈራ 5. አገልግሎት መስጫ ቦታው አማካይ ቦታ ላይ ስላልሆነ 6. አገልግሎት መስጫ ጊዜው ምቹ ስላልሆነ 7. የህመም ስሜት ስላልተሰማኝ 8. አገልግሎት መስጫ ቦታው ሩቅ ስለሆነ 9. ሌላ ምክንያት ካለ ጥቅሽ/ስ?
424	ከዚህ በፊት ለምንደክል ጊዜ እርግዝና ተከስቶብሽ ያውቃል?	1. ለአንድ ጊዜ 2. ለሁለት ጊዜ ብቻ 3. ለሶስት እና ከዚያ በላይ ጊዜ
425	ከዚህ በፊት ለምንደክል ጊዜ አስወርደሽ ታውቋልህ?	1. አስወርጄ አላውቅም 2. ለአንድ ጊዜ ብቻ 3. ለሁለት ጊዜ ብቻ 4. ለሶስት እና ከዚያ በላይ
426	ከግብረ ስጋ ግንኙነት በኋላ በ72 ሰዓት ውስጥ የሚዋጥ የእርግዝና መከላከያ ተጠቅመሽ ታውቋልህ?	1. አዎን 2. ተጠቅሜ አላውቅም
427	ለጥያቄ 426 መልስሽ አዎን ከሆነ ለምን ያህል ጊዜ ተጠቅመሽ?	1. ለአንድ ጊዜ ብቻ 2. ለሁለት ጊዜ ብቻ 3. ለሶስት 4. አራት እና እና ከዚያ በላይ ጊዜ

**3. ለአባላዘር በሽታ እና ለሌሎች አይቪ ኤድስ የተደረገ የምክር አገልግሎት**

428	የኤቸ አይቪ ኤድስ ምርመራ ወይም የምክር አገልግሎት አግኝተህ/ሽ ታውቃለህ/ሽ? መልስህ/ሽ አዎን ከሆነ ከየትኛው ተቋም አገልግሎቱን አገኘህ?	1. የመንግስት ጤና ተቋም/ሆስፒታል 2. ፋርማሲ ውስጥ 3. የግል ጤና ተቋም/ሆስፒታል 4. ሌላ ካለ ጥቅስ/ሽ-----
429	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት ከማድረግህ/ሽ በፊት የምክር አገልግሎት አግኝተህ/ሽ ታውቋልህ? መልስህ/ሽ አላውቅም ከሆነ ምክንያትህ/ሽ ምን ሊሆን ይችላል?	1. እድሜዬ ትንሽ ስለሆነ 2. በቂ ገንዘብ ስለሌለኝ 3. ጥቅሙ ስለማይገባኝ 4. ቦታውን ስለማላውቅ 5. ቤተሰቦቼን ስለምፈራ 6. ቦታው ስለማይመች 7. ሰዓቱ ስለማይመች 8. ህመም ስላልተሰማኝ 9. መመርምሪያው ርቀት ስላለው ካለ 10. ሌላ ምክንያት
430	የምርመራ እና የምክር አገልግሎት መቼ መቼ ትጠቀማለህ/ሉሽ?	1. ጥንቃቄ የሳደለው የግብረ ስጋ ግንኙነት ስፈጽም በየ 3 ወሩ 2. በየ 6 ወሩ 3. በየ 6 ወሩ 4. በየአመቱ 5. ሌላ ካለ

431	ከዚህ በፊት በአባላዘር በሽታ ተይዘህ/ሽ ታውቃለህ/ሽ?	1. አዎን	2. አላውቅም(ወደ 434)
432	መልስህ/ሽ አዎን ከሆነ ምን ያህል ጊዜ?	1. አንድ ጊዜ	2. ሁለት ጊዜ 3. ከሁለት ጊዜ በላይ
433	የአባላዘር ህመም ይዞህ/ሽ ከነበረ ምን መፍትሄ ወሰድክ/ሽ?	1. ምንም አላደረግኩም እና ዳንኩ	2. በግሌ አከምኩት 3. በዩኒቨርሲቲው ሃኪም ሴት ታከምኩ 4. መድሃኒት ሴት ሄድኩ 5. ሌላ የመንግስት ህክምና ተቋም ታከምኩ 6. የግል ህክምና ተቋም ታከምኩ 7. በባህላዊ ህክምና ታከምኩ
<b>4. የስነ ተዋልዶ ጤና አገልግሎት እና አጠቃቀም</b>			
434	በምትማርበት ዩኒቨርሲቲ ግቢ ውስጥ የስነ-ተዋልዶ ጤና አገልግሎት ይሰጣል?	1. አዎን	2. የለም(ወደ 438)
435	ለጥያቄ 434 መልስህ/ሽ(አዎን) ከሆነ አገልግሎቱን ተጠቅመህ/ሽ ታውቃለህ/ሽ?	1. አዎን	2. አላውቅም
436	ለጥያቄ 435 መልስህ/ሽ (አዎን) ከሆነ የትኛውን አገልግሎት ተጠቀምክ/ሽ?	1. በየቀኑ ሚዋጥ ክኒን(ፒልስ)	2. የ72 ሰዓት የእርግዝና መከላከያ
		3. የ3 ወር መርፌ	4. ኮንዶም ለመውሰድ
		6. ከውርጃ በኋላ የህክምና አገልግሎት	5. ለምክር አገልግሎት
		7. ሌላ ከሆነ _____	
437	ለጥያቄ 435 መልስህ/ሽ አላውቅም ከሆነ ምክንያትህ/ሽ ምን ሊሆን ይችላል?	1. ሃኪሞቹን ስለምፈራ ስለማላገኝ	2. የምፈልገውን ህክምና ስለማይከባከቡ
		3. ሃኪሞቹ ህመምተኛን ስለማይመኙ	4. ህክምና ቦታው ለመታከም ስለማይመች
		6. ሌላ ምክንያት ካለ/ሽ _____	5. የስነ-ተዋልዶ ጤና ህክምና ከዩኒቨርሲቲ ውጪ ስለምታከም
			6. ሌላ _____
438	የስነ-ተዋልዶ ጤና አገልግሎትን የት መጠቀምን ታዘወትራለህ/ሽ? (ከ አንድ በላይ መልስ መመለስ ይቻላል)	1. የመንግስት ጤና ተቋም/ሆስፒታል	2. የግል ጤና ተቋም/ሆስፒታል
		3. ፋርማሲ ውስጥ	4. ባህላዊ ህክምና
		6. ሌላ ካለ ጥቀስ/ሽ _____	5. በቅርብ ያለ ሆኖ ማንኛውንም የህክምና ተቋም እጠቀማለሁ
439	አንተ/ቺ በምትኖርበት/ሪበት አካባቢ ያሉት የስነ-ተዋልዶ ጤና አገልግሎት መስጫ ማዕከሎች በቂ ናቸው ትላለህ/ሽ?	1. አዎን	2. በቂ አይደሉም
440	የስነ-ተዋልዶ ጤና አገልግሎት መስጫ ማዕከሉ የት አካባቢ ቢሆን ትወዳለህ/ሽ?	1. የትም አካባቢ ቢሆን ይመቸኛል	2. ከመኖሪያ ሰፈር ውጪ ሆኖ መንገድ ዳር
		3. ከመኖሪያ ሰፈር ውጪ ሆኖ ሰዋራ አካባቢ	

		4. ሌላ መልስ ካለ _____
441	የስነ-ተዋልዶ ጤና አገልግሎት ለማግኘት ፈልገህ/ሽ ረጅም ሰዓት ጠብቀህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላውቅም
442	የስነ-ተዋልዶ ጤና አገልግሎት ለወጣቶች ምቹ ሰዓት የትኛው ይመስልሃል/ሻል?	1. በመደበኛው ሰዓት ሆኖ ከሌሎች ታካሚዎች ጋር 2. ሌሎች ታካሚዎች በሌሉበት መታከም 3. ሌላ መልስ-- -----
443	በየትኛውም ጤና ተቋም ከዚህ በፊት የስነ-ተዋልዶ እና ጤና አገልግሎት ተጠቅመህ/ሽ ከሆነ የእርግዝና መከላከያ(ኮንዶም፣ፒልስ፣የመሳሰሉት) አልቋል ተብለህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላውቅም
444	የስነ ተዋልዶ ጤና አገልግሎት(ኮንዶም ወይም ሌሎች የወሊድ መከላከያ) ለመጠቀም ገንዘብ በማጣት የተቸገርክበት ጊዜ አለ?	1. አዎን 2. የለም
445	ለጥያቄ 444 መልስህ አዎን ከሆነ ችግሩን እንዴት ተወጣክው/ሽው?	_____
446	የስነ-ተዋልዶ ጤና አገልግሎት ክፍያው እንዴት ቢሆን ትመክራለህ/ሽ?	1. ባለው ይቀጥል 2. ለወጣቶች በቅናሽ ቢሆን 3. በነጻ ቢሆን 4. ሌላ ሃሳብ ካለህ/ሽ _____
447	ያንተ/ቺ ሃይማኖተኛ መሆን እና አለመሆን በስነ ተዋልዶ ጤና አገልግሎት አጠቃቀም ላይ ተጽኖ አለው ትላለህ/ሽ?	1. አዎን 2. የለውም
448	ከወላጆችህ/ሽ(አሳዳጊዎችህ/ሽ) ጋር ስለ ስነ-ተዋልዶ ጤና(ጾታዊ ጉዳዮች) ላይ ትወያያለህ/ሽ?	1. አዎን 2. አልወያይም
449	የምትወያይ/ዩ ከሆነ በምን ያህል ጊዜ?	1. ሁልጊዜ 2. አልፎ አልፎ 3. ሌላ መልስ__