Major reproductive health problems, service preference and Utilization among high school adolescent girl students in Adama town, Oromiya region, Ethiopia

By

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Addis Ababa, Ethiopia

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DECLARATION

I hereby declare that the thesis entitled *ADOLESCENT GIRLS REPRODUCTIVE HEALTH PROBLEMS, SERVICE PREFERENCES AND UTILIZATION AMONG HIGH SCHOOL STUDENTS IN ADAMA CITY submitted by* m*e for the in partial fulfillment of MSW to Indira Gandhi National University, (IGNOU) New Delhi* is my own original work and has not been submitted earlier, either to IGNOU or any other institution for the fulfilment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or other.

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CERTIFICATE

This is to certify that Mr. **Ephrem Tesfaye** student of MSW from Indira Gandhi Open University, New Delhi was working under my supervision and guidance for his project work for the course MSWP-001. His project work entitled, major reproductive health problems, service preference and Utilization among high school adolescent girl students in Adama town, Oromiya region, Ethiopia, which he submitting is his genuine and original work.

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Abstract

Adolescents face a range of health problems, including those related to sexual and reproductive health (SRH), substance use, mental health, nutrition, violence and accidents. HIV and maternal mortality are two of the most important health problems for adolescents in developing countries. A descriptive cross- sectional community based study was employed in Adama high school, with the main objectives of assessing major reproductive health problems, service preference and Utilization. Based on probability proportionate to the population size of each high school clusters and simple random methods was used to identify the study population. Structured questionnaire and focus group discussions were employed for data collections. Out of targeted Adolescents' aged 10-19, all responded to questioners and three focus group discussions were conducted. This study revealed that Adolescents' had practiced premarital first sexual activity at the mean age of 16.86 years. Because of unsafe sexual practice, Adolescents' had history of unwanted pregnancy were ended with abortion and STDs respectively in the last one year prior to this study. Besides, regarding service preference and utilization, the study found that although the majority of the respondents have information about RH services making use of it was very low. Additionally the existing health institutions didn't provide the RH services according to the preference of the target groups; those who have got access to it complained that the existing health institution was not welcoming when needing a service, the reasons they were mentioned health professionals are judgmental towards adolescent RH needs and prolonged waiting for the service. This study also revealed that majority of the adolescents had preferred IEC/BCC service, followed by counseling service, HIV services, contraceptive services, STI services. From this study it was concluded that Adolescent girls were exercising high risky reproductive behaviors that exposed them to various RH problems. Finally, based on the findings of the study, some recommendations were forwarded.

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LIST OF ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome

ARH – Adolescent Reproductive Health

CDC – Center for Disease Control

CSA- Central Statistics Agency

EDHS - Ethiopian Demographic and Health Surveys

EPHA- Ethiopian Public Health Association

EC – Emergency Contraceptives

FGAE - Family Guidance Association Ethiopia

FGD – Focus Group Discussion

HIV – Human Immunodeficiency Virus

NGOs – Nongovernmental Organizations

RH – Reproductive Health

SD – Standard Deviation

STD- Sexually Transmitted Disease

STI – Sexually Transmitted Infections

UN – United Nations

UNAIDS – United Nations Program on HIV/AIDS

UNESC- United Nations Economic and Social Council

UNFPA – United Nations Population Fund

UNICEF- United Nation's Children Fund

UNPD – United Nations Population Division

VCT – Voluntarily Counseling and Testing

WHO -World Health Organization

Chapter One

1. Introduction

1.1 Background of the study

Now a day, there are 1.2 billion adolescents aged 10–19 years worldwide, which make up 18 per cent of the world's population. Nearly 90 per cent live in developing countries. More than half of all adolescents live in Asia. In absolute numbers, India is home to more adolescents around 243 million than any other country. It is followed by China, with around 200 million adolescents (UNICEF, 2012).

Sub-Saharan Africa, however, is the region where adolescents make up the greatest proportion of the population, with fully 23 per cent of the region's population aged 10–19 (UNICEF, 2012).

The striking differences among regions in the proportion of adolescent population result from demographic transition that occurs when declines in mortality rates are later followed by declines in fertility rates. Sub-Saharan Africa's adolescent fertility rate is generally higher than for other regions in the world (UNPD, 2010).

During 1980 the world began to focus increasing attention on the needs and problems of young people. The United Nation named 1985 the international year of youth. At the global level, the Program of Action of the International Conference on Population and Development, held in Cairo in 1994, placed great emphasis on the problems and needs of adolescents.

Adolescents often lack basic reproductive health (RH) information, knowledge, and access to affordable confidential health services for reproductive health (RH). Many of them do not feel comfortable in discussing reproductive health (RH) issues with parents (Guttmacher institute & UNFPA, 2009). Likewise, parents, health care workers, and educators frequently are unwilling or unable to provide complete, accurate, age appropriate RH information to young people. This is often due to parents discomfort about the subject or the false belief that providing the information will encourage sexual activity (Guttmacher institute & UNFPA, 2009).

Young people constitutes one third of the total population in Ethiopia. Their number is estimated to grow from 20.3 millions in 2000 to 25 millions in 2010. The reproductive health problem of young people in Ethiopia is multifaceted and integrated. Child bearing begins at an early age: forty-five percent of the total births in the country occur among adolescent girls and young

women. Sexual violence and commercial sex work have become common phenomenon among young girls. As a result, they have become primary victims of the HIV/AIDS crises that have spread throughout the country (Family health international, 2004).

In general, young people are at great risk for reproductive health problems. The situation is aggravated by the over all poor socio economic, environment and harmful traditional practices. Because of the complex nature of the problems, youth reproductive health strategies demand multi-sartorial and integrated approach (Family health international, 2004). Following the Cairo, 1994 International Conference on Population and Development (ICPD), some national and international NGOs have been starting implementing youth focused SRH programs in Ethiopia.

1.2. Statement of the Problem

In developing countries young people often face with enormous pressure to engage in sex, especially from peer's exposure to unlicensed erotic video films and the desire for economic gain (Family health international, 2004). This indicate that the necessity of reproductive health interventions at adolescence age. In general young people are at risk of reproductive health problems, which are aggravated by the overall poor socio-economic and demographic, environment and harmful traditional practices (Aklilu, Hailom, & Gouindasamy, 2002).

Adolescents face a range of health problems, including those related to sexual and reproductive health (SRH), substance use, mental health, nutrition, violence and accidents. HIV and maternal mortality are two of the most important health problems for adolescents in developing countries: a large proportion of new HIV infections each year occur in adolescents, with a higher level of incidence in young women than young men; and pregnancy-related problems are a leading cause of death for adolescents, due mainly to complications from unsafe abortion and childbirth (WHO, 1997).

Access to quality health services, including sexual and reproductive health services such as STI (Sexually Transmitted Infection) management, antenatal care and contraception, is essential in addressing these problems. However, adolescents usually have very limited access to health services. Policy makers may not prioritize adolescents and therefore services may not be available. Where services are provided, adolescents may not know about them, or be embarrassed to seek them and have concerns about confidentiality. In addition, services may be

inappropriate, costly, and unwelcoming to adolescents due to factors such as staff attitudes, long administrative processes, inappropriate opening hours or location (WHO, 1997).

Ethiopia is one of the developing African countries where HIV/AIDS is fueling and striking its population of all age including adolescents. As is the case elsewhere in Africa, transmission of HIV/AIDS is almost exclusively through heterosexual contact and about 1.4 percent of adult age 15-49 were living with HIV in 2005 (EDHS, 2005).

Many adolescents are sexually active. (UNFPA, 1998) Sexual activities put adolescents at risk of various reproductive health problems. Each year about 15 million adolescents aged 15-19 years give birth, as many as 4 million obtain an abortion, and up to 100 million become infected with a curable STIs (UNAIDS & WHO, 1997).

The reproductive health problems of young people in Ethiopia are multifaceted and interrelated. Lack of education, unemployment, and extreme poverty exacerbates and perpetuate the sexual health problems faced by Ethiopian youth. The low statue of women and girls also makes the AIDS prevention activities difficult for reproductive health programs to achieve success (Youth Net, 2004).

The legal age of marriage in Ethiopia is 18 for both males and females, but it is widely ignored. First births have elevated risks and the youngest first-time mothers and their children are especially vulnerable to poor health outcomes. Among married girls aged 15–19 in Ethiopia, almost half have already given birth. The vast majority of births occurring to girls before age 18 are first births (77 percent), and nearly all of these first births occur within marriage (96 percent) (Population counseling briefing paper, 2004).

Adolescents in Ethiopia were exposed to various risks such as unprotected sex, early marriage, premarital sex, early pregnancy, induced abortion, sexually transmitted infections (STIs) and HIV/AIDS, unemployment, drug abuse and crime (Gracy, ViKram & Jayashree, 2003). Sexual violence and commercial sex work have also become common phenomenon among young girls (Aklilu, Hailom, & Gouindasamy, 2002). Although studies have been conducted to assess situation of adolescent sexual reproductive health, still the reproductive health problems of adolescents are not well addressed for every parts of the country.

Regarding Adama town, which is one of the main commercial and industrial centers in Oromia region. A motor linking Addis Ababa to Djibouti passes through Adama city. These factors make

Adama and its surrounding a potent base for investment, such as hotels, recreational centers, small and heavy industries. Following these investments more people come in and out of the city every day. Hence reproductive health issue is one of the main concerns that can be raised with the topography of the city.

The few research works has been done in major towns by neglecting this study area. Therefore, investigating the magnitude of Adolescent reproductive health problem, service preference and utilization in general and the adolescents in particular are very vital in designing, implementing and monitoring effective adolescent friendly intervention programs.

Research Questions

1. What are the major reproductive health problems among high school adolescent girl students in Adama city?
2. How do the existing health institutions service availability, high school adolescent girl students SRH service preferences and utilization look like in Adama town?
3. What are the factors that affect high school adolescent girl students' service preference and utilization in Adama city?
4. What are the major sources of information of high school adolescent girl students on their awareness and knowledge of SRH and available services in Adama city?

1.3 Objectives of the study

1.3.1 General objective:

- To assess major reproductive health problems, service preference and Utilization among high school adolescent girl students in Adama town, Oromiya region, Ethiopia.

1.3.2 Specific objectives:

- To assess major adolescent girl's reproductive health problem
- To assess adolescent girl's SRH service preferences and utilization
- To identify factors that affect adolescent girl's service preference and utilization
- To assess the sources of information of adolescent girls on their awareness and knowledge of SRH and available services.

1.4 Significance of the study

Now a days it is known that the reproductive health issues are the leading problems that affect adolescent age groups not only health wise but also psychologically, academically and socially. This research results will create an opportunity for the high school adolescent girl students of the Adama town to know about their reproductive health (RH) issues, the services they prefer and utilization of the services. Therefore, they will get ways to access the information about the prevalence of reproductive health problems that they face and how and where they access the service that they prefer specifically in Adama city. The other significance is for government organizations and stakeholders working on adolescent and who want to engage in this area in the city to easily access as recent information, policy maker better include sexual and reproductive health issues in curriculum and can revise the existing strategies and also design new ones to tackle the problem. In addition to this it would help as reference material/ literature for other research.

Beneficiaries of this study would be adolescent themselves, institutions that are found in the city such as, educational institutions specifically targeted high schools, Adama town health office, Three government youth centers, NGOs like Family Guidance Association of Ethiopia, Merrystopes international Ethiopia. In addition to this it would help as reference material/ literature for other research.

1.5 Delimitation of the Study

This study is delimited to high school adolescent girl students in Adama city; though the issue is very important to other places where adolescent girl are found and even involve adolescent boys to improve the sexual behavior of them. However, due to the problem of finance, time and human resources, the researcher confined himself to high school adolescent girl students in Adama city.

1.6 Limitation of the Study

Due to various problems such as Shortage of recently conducted related studies, unavailability of any research document in this area, the problem of respondents to reply the questionnaire, the characteristics of the young people of impatience to respond long discussion forums limits to compare the result widely.

1.7 Definition of operational terms (concepts)

Child: it is defined as a person up to age of 18 years.

Adolescence: defined as the 10-19 age groups of people.

High school students: includes **9th** and **10th** grade students according to Ethiopian Education ministry tier system

Youth-friendly health services: those that can attract youth to the facility or program, provide a comfortable and appropriate setting, and meet young people's needs

Reproductive health services: is the services provided for adolescent such as abortion and post abortion care, IEC/BCC, SRH counseling, family planning, Emergency contraception, HCT, medical checkup, sexual transmitted infection treatment and likes

Accessibility: defined as the sum of economic, physical (geographical), cultural accessibility and not merely the physical presence of reproductive health services

Chapter Two: Review of Related Literature

2.1 Adolescent Sexual and Reproductive Health

Adolescence is the rapidest of growth (after infancy) in the human life span. An individual's weight doubles and his/her height increased by 25%. (Hoffman & Greydanus, 1989) Adolescence is the process whereby an individual makes the gradual transition from childhood to adulthood (Paxman & Zukerman, 1989).

Nearly 1.7 billion people, about one-third of the world's total population, are between the ages of 10 and 24, with the vast majority living in developing countries. As they mature, young people are increasingly exposed to reproductive health risks such as sexually transmitted infections (STIs), unintended or early pregnancies, and complications from pregnancy and childbirth (United Nations, 2001).

2.2 Adolescent sexual and Reproductive Health Problems

The major health problems of adolescents include STDs, HIV/AIDS, absence of family planning method choice, unwanted pregnancy, Lack of abortion care services, mental illnesses, crime and violence (EPHA, 2003).

Worldwide, adolescents suffer from a disproportionate share of early marriage, unwanted pregnancies, and unsafe abortions, sexually transmitted infections (STIs) including HIV/AIDS, female genital mutilation, malnutrition and anemia, infertility, sexual and gender based violence, and other serious reproductive health problems (Stella, Nakanyike, & Richard, 2004).

Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher level of morbidity and mortality. Early childbearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world (United Nations, 2001).

Teenage Sexual activity

Sexual activity begins in adolescence for the majority of people. In many countries, unmarried girls and boys are sexually active before the age of 15. Recent surveys of boys aged 15 to 19 year in Brazil, Hungary and Kenya; for example, found that more than a quarter reported having sex before there were 15year. A study in Bangladesh found that 88 percent of unmarried urban boys and 35 percent of unmarried urban girls had engaged in sexual activity by the time they were 18 year (UNICEF, 2002).

The current average age range for the attainment of puberty is 9-14 for boys and 8 to 13 for girls. As a result, young girls are biologically mature enough to engage in sex and become pregnant at an early age, although they may not be emotionally and physically mature enough to understand the implications (United Nations, 2001).

In Ethiopia the median age at which women age 25 – 49 first had sexual intercourse is 16. Three in ten women in this age group have had sex by age 15, two in three by age 18, and more than 80 percent by age 20 (Aklilu, Hailom, & Gouindasamy, 2002). A study conducted in Nazareth high schools have showed that 24.0% of respondents reported having experienced sexual intercourse, with 60.0% reported having had their first sexual experiences between the ages of 15 and 16 years (Tadelle, 2000).

Teenage Pregnancy

The average fertility rate among teenagers in the least developed countries is five times greater than that of the more developed regions. On average, one third of young women in developing countries give birth before age of 20 years. According to UNFPA report, each year, an estimated 14 million adolescents between the ages of 15 and 19 give birth globally and more than 90% of these live births occur in developing countries (McDevitt, Adlakha, Fowler, & Harris-Bourne, 1996). Sub-Saharan Africa's adolescent fertility rate is generally higher than for other regions in the world (McDevitt, 1996).

Some studies conducted in Ethiopia have also shown that teenage pregnancies and delivery are common practice. According to some studies conducted in various parts of the country among sexually active students aged between 15-49 years, 50% of teenage girls had history of pregnancy at least once in Koladiba, 15% in Harar and 18% in Addis Ababa. Subsequent study done in East- Gojam among out-of-school teenagers girls revealed 43% of them had at least one pregnancy (Ismail, Bitsuamlak, & Alemu, 1997 & Berhane, 2000, & Seifu, Fantahun, & Worku, 2006, Korra, & Haile, 1999).

Modern Contraceptive Use

Relatively few adolescent women are currently using contraceptives. A study conducted to assess determinants of contraceptive use among urban youths in Ethiopia, reported that there is a large discrepancy between knowledge and actual practice of contraception (Tsigereda, 2004).

Similarly, evidence from Harar, indicated that nearly two thirds of young respondents (69.3% of males and 63.9% of females) reported to have known, at least one contraceptive method while only about one fourth (27.0% males and 22.6% females) reported having ever used a method (Kora , & Haile, 1999). Another study conducted in northwest Ethiopia showed that only 25.0% of sexually active females used modern contraceptives (Ismail, Bitsuamlak, & Alemu, 1997). Another study conducted in northwest Ethiopia, contraceptive prevalence in Dembia District revealed that 49% of sexually active adolescents knew one or two contraceptive method and 30 % having ever used the methods (Kebede, 2006).

The Practice of Condom Use

Several misconceptions abound among adolescents concerning condom use. In Zimbabwe, for example, concerns that condom are off-putting that insisting on condom use suggests that one has AIDS were important predictors of intended condom non-use among males. Some girls feel that a partner's wish to use condom suggests that they, the girls, are not clean, that they are commercial sex workers or that they have involved in extra relationship sexual activity (Anastasia, 1998). In Ethiopia, a study conducted among high school students in Addis Ababa revealed that only 43.2% of the sexually active ones knew about condom on their first coital encounter and a small proportion, 17.6% of them used it on their first sexual encounter (Eshetu, David, & Kebede, 1997).

A study in northwest Ethiopia, found that 45.7% of rural high school adolescents were found using condom (Ismail, Bitsuamlak & Alemu, 1997). Survey on out of school youths in Bahir Dar, revealed that 30.5% of youths were using condom (Fantahun & Chala, 1996). Similarly, a study on out of school youth in Awassa, revealed that only 27.6%of the sexually active adolescents used condom during their most recent sexual intercourse while their knowledge about HIV/AIDS was found to be 90% (Taffa,1998).

Abortion

Unintended pregnancy may lead to an induced abortion, which in the case of an experienced or ashamed adolescent is likely to take place later in the pregnancy and involve greater risks to life, health and future fertility. The proportion of adolescents who seek abortion has been increasing, especially among younger adolescents (15-17years) (WHO, 2010). About 10.0% of pregnancies each year occur among teenagers. UNFPA, (2009) reported that 10-14% of young unmarried

women around the world have unwanted pregnancies and at least 2.0- 4.4 million abortions occur among adolescent women in developing countries each year.

Adolescents may more often delay seeking care for abortion-related complications due to lack of transportation, lack of knowledge about where post abortion care can be obtained, fears of censure from their parents and health-care providers, fear of legal repercussions, or lack of money to pay for services (IPAS, 2004). Unsafe abortion is one of the leading causes of maternal morbidity and mortality in Ethiopia. Nearly one third of pregnancy related deaths are caused by the complications of unsafe abortion. Studies have shown that unsafe illegal abortion is most prevalent among single women, teenagers, students, and factory workers (Population counseling briefing paper, 2004).

STI and HIV /AIDS

Biologically, the immature reproductive and immune systems of adolescent girls translate to increased susceptibility to STIs and HIV transmission; pregnancy and delivery for those with incomplete body growth exposes them to problems that are less common in adult women. Many societal issues also contribute to risks for adolescents (Prof. Linda, Prof. Renee, Jane, & Vinit, 2007).

New data suggest over 7,000 new infections per day among those 15- to 24-years-old in sub-Saharan Africa. Nonetheless, in Malawi, nine out of 10 teenage boys, (50 percent of who report at least one casual sex partner in the past year) feel invulnerable to HIV (UNFPA, 1998). According to the 2011 Ethiopian Demographic and Health Survey Among sexually active youth aged 15–19 years, women and men who were tested for HIV test were only 24% and 27% respectively.

HIV/AIDS and SRH Situation among adolescent and youth

Most youths face greater reproductive health risks than adults for many reasons, including involving in activities with greater risks such as having unprotected sex, unwanted pregnancy, childbearing at early age, greater vulnerability to sexual pressure, coercion and exploitation, unsafe abortion and suffer the complications it endangers (UNFPA, 2004). In addition, the adolescents don’t receive adequate information and services on reproductive health. With regard to HIV/AIDS, only a fraction of them know they are infected with HIV along with increased exposure to STIs and unintended pregnancy. This situation has made the problems associated

with adolescent reproductive health serious and complex like social stigmas, conflicts with family, and higher risk to unsafe abortions (UNICEF, UNAIDS & WHO, 2002). In addition, even if services are available they don't utilize them. Stigma, service costs, and provider bias pose formidable barriers to Ethiopian young people's ability to access HIV/AIDS and sexual reproductive health (SRH) services (IFHP, 2012).

About three in ten unmarried adolescent women in Sub-Saharan Africa have ever had sex. Adolescent women in the developing world had an estimated 14.3 million births in 2008. Of these births, five million was occurred in Sub-Saharan Africa and each year, adolescent women account for 16% of all births in Sub-Saharan Africa. In Sub-Saharan Africa, slightly more than half of all people living with HIV are women and girls and young women aged 15–24 years are as much as eight times more likely than men to be HIV positive. Since most of these pregnancies and sexual activities are expected to be un-safe, the vulnerability of youth and adolescents to HIV is unquestionable. Many young women report that their first sexual experience was not consensual with considerable health implications (HIV/AIDS and SRH Minimum Package for Youth Centers in Ethiopia, (MINISTRY OF WOMEN, CHILDREN AND YOUTH AFFAIRS, Federal HIV/AIDS Prevention and Control Office Ministry of Health, 2013)**.**

INFORMATION SOURCE ON ADOLESCENT REPRODUCTIVE HEALTH

The most critical element in creating a safe and supportive environment is to engage adults as positive actors in young people's lives. Little can be done to improve the sexual and reproductive health of adolescents without support of adults. Moreover, when they are surveyed many parents and young people alike reported that they prefer parents to be the main source of adolescents` information about sexuality and RH (Hughes & McCauley, 1998). Most adolescents reported that they felt it is culturally shameful to discuss about physical and psychological changes during adolescence with adults (Senderowitz, Taffa, Himanot, & Desalegn, 1999). The large proportion of respondents, 46% of males and 39% of females in Nigeria said their source of such information was friends and schoolmate (Senderowitz, 1999). The second most common source of information was the mass media. Reports of most adolescent RH studies in Ethiopia revealed that the most common source of information on HIV/ AIDS was the media (Tadesse, Gudufa & Mengistu, 1996, Regina, Mohamed, & Michael, 1998, Berhane, 2000).

It is an accepted fact that social norms shape the behavior and attitude of young people about appropriate sexual activity. It has been said; a loving but firm environment that encourages a gradually increasing degree of independence will build self-esteem in the adolescent. However, with neither the guidance of traditional cultures, the information to make educated choices, nor the facilities for reproductive health services, adolescents are left on their own. They often experiment with their sexuality sometimes with immediate disastrous results (The Center for Development and Population Activities, 1998).

2.3 Access and Utilization of Services

In developing countries, among married women who are 15–19 years old, only 17 percent practice family planning methods currently, and among unmarried sexually active adolescents, the use of contraception is believed to be even lower (Kirby, 1994). In many countries in sub-Saharan Africa, young people encounter significant obstacles to receiving sexual and reproductive health services and lack access to the services they need to protect themselves from HIV, other STIs and unwanted pregnancy (James-Traore, 2002).

Study conducted on the reproductive health knowledge, attitude and practice of high school students in Bahir Dar, Ethiopia. It revealed that the students had high level knowledge of contraceptives and where to obtain contraceptive services; however, level of use was low. Some of the reasons given for not using contraceptives include lack of access to services, carelessness, unplanned sexual intercourse and pressure from sexual partner (Kibret, 2003).

Another study conducted on adolescent health service utilization pattern and preference in Addis Ababa indicated that the existing health services were not fully accessible, affordable and acceptable to adolescents. It also indicated that adolescents prefer to consult either peers or suffer in silence when they face reproductive health problems (Frehiwot, Yemane & Mesganaw, 2005).

2.4 Adolescent Reproductive Health service preferences

Youth friendly health services can be free standing clinics or attached to existing clinics or recreational facilities. Ideally, they provide a full range of services and information to the youth. The services are provided under a setup where people are welcoming, confidentiality is ensured, and services are conveniently located and affordable (Miz-Hasab Research Center, 2002).

In many countries in sub-Saharan Africa, Evidence on adolescents' health-seeking behavior is scant—we know very little about the sequence of steps that adolescents take in trying to get help for a health problem, especially problems like STIs that are often stigmatized. What we do know is that although young people have reproductive health needs, many rarely use clinic services and tend to use more informal sources of care (James-Traore, 2002).

In Ethiopia young people get medical care through the network of health institutions in the Country (Children and Youth Affairs Organization, Ethiopian youth basic challenges and prospects, 1995 A.A.). Young people in Ethiopia are disadvantaged relative to older, in their lack of access to information and services for their reproductive needs because of the absence of youth friendly service delivery system (Miz-Hasab Research Center, 2002). Another study conducted on adolescent health service utilization pattern and preference in Addis Ababa indicated that adolescents prefer to consult either peers or suffer in silence when they face reproductive health problems (Frehiwot, Yemane & Mesganaw, 2005).

Chapter Three: Methodology of the Study

3.1. Design of the Study

A descriptive cross- sectional community based study was employed to assess Adolescent girl's reproductive health problems and their service preference and utilization. In this research the questionnaire was adapted from different literatures and used to the target population and structured and open/closed ended interview was administered. In addition to this, FGD/focus group discussion/ was conducted with the target groups.

3.2. Back ground description of the study Area

The study was conducted in Oromia region, Adama town from April 2014 to July 2014. The town is located in the rift valley region, 100 Km east of capital city. Administratively the town is divided in to 14 local administrative units called Kebeles. The total number of population of the town estimated as of 2007 CSA report is **299,216** (2005 EFY) of which Male are 148,060(49.5%) and Females are 151,156 (50.5%) and Out of the total population the number of young people accounts 30%. It shares boundaries with Adama & Boset Woreda in the East & North West, Adama & Lume Woreda also in the southwest.

The total land area estimated was about 13,000 Hectare. The city had diverse topographic features that range from one of the part of rift valley areas and now a day it is becoming a site of attraction for many people in an assumption that it is a place to find business opportunities. Geographically the altitude varies from 1590-1700meters. The annual average rainfall is about 838 ml. The annual mean temperature of the city ranges from 14 to 30 ^{o}c with mean temperature of 22 ^{o}c.

The majority of the populations are Merchants, which depend on subsistence daily & governmental workers. The city government has been implementing comprehensive economic reform programs over the last 20 years majority focusing on social and economic infrastructure. Accordingly, capital budget allocations to the health sector have reached Birr 4,561,495 in 2003 EFY. The health infrastructures available in the city are 1 hospital, 4 health centers, which are owned by the government. Moreover, the city has 2 hospitals, 2 health centers 38 Medium & Higher Clinic owned by other governmental, non-governmental and private organizations.The potential health service coverage of the city in terms of health centers are 60% by 2003 EFY.

Currently, there are 98 health professionals of all categories in office &Health centre. Ninety six urban health extension professionals & thirteen supervisors are providing health care services (CSA, 2007).

3.3 Study population

The proportion of young people constitute 30% of the total population, therefore, the required study population from all high school adolescent girl students was identified based on the sampling unit produced from each clustered high schools, according to probability-proportionate to size.

3.4 The sample size determination

Total population size of the town clustered high school students was **7,595**. From this target population the required sample size had taken according to the size of population in each high school. Sample size was determined using the formula for single population proportion, and the following assumptions were made. Significance level of 95% (x=0.05) and 5 percent margin of error was taken. Since the previous prevalence of adolescent reproductive health problems and service preference and utilization of adolescent with emphasis to reproductive health was not known, in the study area, 50% prevalence was taken to obtain sufficiently large sample size, and 10% was added to compensate for non response. A total of 423, high school Adolescent girls were needed.

3.5 Sample and Sampling Procedure

A total of nineteen (19) High schools in Adama town were grouped into three clusters of each two and one consisting respectively three and four high schools based on their geographical location and neighborhood. Then, from each cluster high school was selected randomly making a total of three high schools and then respondents from class category (9th and 10th) and class sections was selected through by giving equal chance and simple random methods. The total number of the target population was taken from the town education office. The sample size for the study, 423 was divided and allocated to each of the selected high school according to the principle of probability proportional to size. This means high schools that had large number of adolescents, based on the measure of size, and was given greater probabilities.

3.6. Data Collection Instrument

Instruments used for data collections were questionnaire and focus group discussion (FGD). Questionnaire was developed from different literatures and used to study the target groups. Most of the items in the interview schedule were structured as close ended questions; few questions were open ended. Questionnaire that investigates targets socio-demographic, adolescent girl student's sexual and reproductive problems, service preference and utilization with both qualitative and quantitative type of study. Focus Group Discussion (FGD) was conducted using an interview guide. It was also facilitated by the researcher.

3.7 Data Collector Recruitment and Training

Data collectors was recruited based on the following general criteria; 12th grade completed and above, unmarried age of 20 years and above, physically fit, and those who had had experience in data collection and fluent in both Amharic and Afan oromo. Based on these criteria Three female interviewers was selected. I myself was carried out supervisor role. A thorough training was given to the interviewers for two days before the pretest and for one day after the pretest. The training was included discussing the questions one by one, briefing on the general objective of the study, discussing about the general techniques of interviewing and how to approach the respondents, how to keep confidentiality and privacy and how to keep close supervision using the prepared guidance and check list. The Interviewers were given an interview guide prepared in Amharic and Oromifa. Data was collected using structured questionnaire. A Supervisor supervised three pairs of data collectors. He thoroughly checked the activity of data collectors, by taking a sample they were counterchecking high schools, and each night he checked all the questionnaires filled, for completion, clarity and proper identification of the respondents.

For FGD, Two paramedical, who had had experience in similar research, was selected. A two day orientation and practical exercise was carried out at special Zone Education office compound. Three focus group discussions were carried out in selected three high school compound. Every discussion was tape recorded not to miss all issues discussed and finally transcribed.

3.8 Methods of data analysis and interpretation

Data was coded, entered and finally analyzed using scientific calculators and also presented through narration and tabulation. After the data were cleaned frequency distributions, percentages and using correlation (odds ratio with 95% confidence interval) was calculated to ascertain the association between dependent and independent variables as appropriate.

3.9 Variables

Dependant variable;

- Major Adolescent girls SRH problems and their service preference and utilization

Independent variables:

- Socio demographic factors /sex, age, educational level/

3.10 Ethical considerations

During the interview, maximum effort was made to keep privacy of respondents and explained to them the purpose of the survey to give us their opinion what they feel. Data was collected on prior approval of the respondents or after obtaining verbal consent from participants before preceding the interview. Those who were not willing to participate were given the right to do so.

CHAPTER FOUR: RESULT OF THE STUDY

4.1 Socio - Demographic Characteristics of the study Participants

A total of 423 adolescents participated in the study, with 100% response rate. The mean age of the study population was 17.45 years with standard deviation of 4.5122. The majority of the respondents were not married and Christians 414 (97.8%) and 375 (88.7%) respectively, followed by Muslim, (11.3%). two hundred sixty seven (63.1%) were living with their parents (father and mothers) while 115 (27.2%) were living with mothers only. The majority of the respondents were family dependant 324 (76.6%). About eighty one (82%) of who had own income, their current source of income is their parents and average range of daily income of them was b/n 10 to 20 birr (see Appendix A).

4.2. Magnitude of selected reproductive health problems and Concerning Reproductive Health Service Practice

Out of 423 clients 264 had boy friend; the average range educational level of having boy friend was Grade7 to 10. Out of the 423 respondents, 165 (39%) reported to have practiced premarital sexual activity in the past. The mean age at first sexual intercourse was 16.86(±3.808 SD) years. The minimum and maximum age at first sexual intercourse for respondents was 14 and 18 years respectively.

The main reason for first sexual encounter includes 'by interest' 54 (32.7%), 38(23%) peer pressure, 37(22.4%) cheated, 9(5.4%) rape (forced to do so), 27(16.36%) didn't know. 57 (34.5%) Of respondents had practiced protected first sexual intercourse and the rest was not. Among respondents who have practiced first sexual intercourse, 74 (44.8%) of the faced unwanted pregnancy, 18(10.9%) unwanted pregnancy and defaulted school, 7(4.2%) STI 66(40%) nothing faced (Table 1).

Table: 1 Reproductive Health Problems

	Frequency	Percent
Ever had sexual intercourse, - Yes - No	 165 258	 39 61
How the first intercourse take place		
Interest	54	32.7
peer pressure	38	23
Cheated	37	22.4
Rape	9	5.4
didn't know	27	16.36
Respondents had practiced protected first sexual intercourse, - Yes - No	 57 108	 34.5 65.5
Consequences of first intercourse, - unwanted pregnancy - unwanted pregnancy and defaulted school - nothing faced - STI	74 18 7 66	44.8 10.9 4.2 40

Of 165 respondents who have practiced premarital sexual intercourse in last one year, 119 (72%) of the respondents reported that they had sexual intercourse with one partner. 28 (17%) and 9 (5.5%) have sexual practice with two and three partners respectively. One respondent had sexual practice with four partners, 9(5.5%) respondents do not remember with how much partners they had sexual practices.

Of 165 respondents who have practiced premarital sexual intercourse, 68 (41.2%) of respondents used modern contraceptives method and 97 (58.8%) did not use the methods. 137 (83%) did not use condom and 28 (17%) had used in their resent sexual intercourse (Table 2).

Table 2: Usage of Modern Contraceptive and condom was Assessed As Follows

		F	%
Have you ever used modern contraceptives?	1.yes	68	41.2
	2.No	97	58.8
Have you used condom in your resent sexual intercourse?	1.yes	28	17
	2.No	137	83

Among 423 respondents, 7 (1.65%) of them had faced the problems of sexually transmitted diseases. 92 (21.7%) of respondents had ever been pregnant, among them pregnancy get ended with 83 (90%) abortion and 9 (10%) Preterm. The mean age of pregnancy was 17.68(±4.627). The minimum age of pregnancy was 15 years and the maximum was 19 years (Table 3).

Table 3: the Issue of Pregnancy and had sexually Transmitted Infections could be seen as Follows

		f	%
Have you ever been pregnant?	1.yes	92	21.7
	2.No	331	78.3
Have you ever had sexually transmitted infections?	1.yes	7	1.7
	2.No	320	75.6
	3.don't know	96	22.7

4.3 Factors Influencing Utilization of RH service among Adolescent girls

Out of 423 participants, 266 (62.9%) of them reported that the existing health institutions were not convenient to the secret use of adolescents reproductive health service and also 348(82.2%) were not welcoming them when they need the services (Table 4).

Table 4: Accessibility Issue

		F	%
Do the existing health institutions **convenient to the secret use of adolescents' reproductive health service**?	1.yes	62	14.6
	2. No	266	62.9
	3. I do not know	95	22.5
Do the existing health institutions welcome you when you need the services?	1.yes	75	17.7
	2.No	348	82.3

Among the common obstacles that prevent adolescents from getting clinical and counseling services in the existing health institutions were primarily health professionals are Judgmental towards Adolescent RH needs 139 (32.8%) in the first rank, long waiting time for service 55 (13%) in the second rank and the rest obstacles mentioned by the respondents accounts the remaining parentage (Table 5).

Table 5: possible factor that are not well coming for Adolescent Accessing RH Services

	frequency	Percentage
1. Too far health institutions	9	2.1%
2. Too expensive services	9	2.1%
3. lack of confidentiality	9	2.1%
4. Health professionals are Judgmental towards Adolescent RH needs	139	32.9%
5. Too much waiting time to get the service	55	13%
6. Inconveniency of service delivery	28	6.6%
7. Fear of being seen by parents or others who know them	9	2.1%
8. Adolescents get embarrassed at needing reproductive health service	36	8.5%
9. Inconveniency of service delivery time	27	6.3%
10. I Don't know	27	6.3%

4.4. Preference and utilization of Health Service

107 (25.3%) and 100 (23.6%) of respondents reported that they thought better place for provision of SRH Services at public health institutions and private clinics respectively. 258 (60.9%) respondents responded that utilizing the existing health institution for their reproductive health need but the rest 165 (39.1%) was not (Table 6).

Table 6: Better Institutions for RH Services suggested by respondents'

	frequency	Percentage
1. Government health institute	107	25.3
2. Government youth centers	19	4.49
3. Private health institute	100	23.6
4. Ethiopia Family Guidance Association clinics	42	9.9
5. School Clinics	15	3.54
6. merry stops	24	5.67
7. Other Specify - Health extension workers	25	5.91
- I do not know	27	6.38
- Multiple institutions	64	15.13

While assessing health institutions preference of adolescents for RH services, 222 (52.4%) of respondents preferred to be seen at public health institutions, 174 (41.1%) preferred at private health institutions and the rest did not know their preference for RH services (Table 7).

Table 7: Institutions preferred For RH Services

	As 1st Rank	
	Frequency	**%**
1. Government health institute	157	37.1
2. Government youth clinics	65	15.3
3. Private health institute	81	19.1
4. Ethiopia Family Guidance Association clinics	49	11.5
5. by none licensed provider	0	-
6. Other Specify		
- Merry stopes clinic	44	10.4
- do not know their preference	27	6.3

As stated in Table (8), 205 (48.5%) of respondents preferred reproductive health services to be rearranged in health institute that arranged for Adolescent reproductive health as the first options, 138 (32.6%) by expanding Adolescent reproductive health services in youth center in the second rank. 33 (7.8%) and 26 (6.2%) preferred to be Within the existing health institution as it is and within the existing health institution having its own Adolescent reproductive health service rooms and private clinics respectively. while others 21(4.9%) preferred private clinics and said no need to give special attention for services.

Table 8: Ways of Adolescent reproductive health service to be rearranged

		Frequency	Percent
	Within the existing health institution as it is	26	6.2
	No need to give special attention	7	1.6
	Within the existing health institution having its own Adolescent reproductive health service rooms.	33	7.8
	In health institute that arranged for Adolescent reproductive health	205	48.5
	By expanding Adolescent reproductive health services in youth center	138	32.6
	Specify. Private clinics	14	3.3

•

Majority 207 (48.9%) the adolescents had reported that they prefer health services for adolescents to be delivered in the usual health institute working hours. About 111(26.3%) of them reported that they preferred in the hours when other users are not around. The rest 69 (16.3%) and 36 (8.5%) was preferred both (in the usual health institute working hours working hours and on the special hours when other users are not around) and at weekends respectively. As stated in Table 9.

Table 9: Convenient time of the day for adolescent health service provision

S.no		Frequency	Percent
1	In the usual health institute working hours	207	48.9
2	In the hours when other users are not around	111	26.3
3	Other specify • both in the usual health institute working hours working hours and on the special hours when other users are not around • at weekends	69	16.3
		36	8.5

173 (40.9%) preferred the place where low cost of treatment is provided. About 149 (35.2%) and 101 (23.9%) responded that they prefer free treatments areas and at usual rate respectively (Table 10).

Table 10 Service fees for Adolescent

S.no		Frequency	Percent
1	At usual rate	101	23.9
2	With discount for Adolescents	173	40.9
3	Free of charge	149	35.2

Regarding the location of health service institutions, the majority of the respondents 306 (72.3%) preferred at the center of the city, 81(19.2%) preferred anywhere out of resident area, the rest 27 (6.4%) and 9 (2.1%) preferred at one end of the town and near to their residence respectively (Table 11).

Table 11 Location for Adolescent reproductive health services

S.no		Frequency	Percent
1	Anywhere out of resident area	81	19.2
2	In the center of the town	306	72.3
3	At one end of the town	27	6.4
4	Other specify • Near to their residence	9	2.1

Regarding the professionals who served the adolescent, the majority of the respondents 166 (39.3%) preferred young provider of the any sex, followed by 157 (37.1%) preferred young provider of same sex. 91 (21.5%) and 9 (2.1) preferred adult provider of the same sex and any provider respectively (**Table 12**).

Table 12 health provider for Adolescent reproductive health services

S.no		Frequency	Percent
1	Young provider of the same sex	157	37.1
2	Young provider of any sex	166	39.3
3	Adult provider of the same sex	91	21.5
4	Any provider could be	9	2.1

As mentioned in Table 13, When preference was assessed by service frequency, the majority 147 (34.8%) of the adolescents had reported IEC/BCC service in the first rank, then counseling service which was about 92 (21.8%) in the second rank and 79 (18.7%) of the respondents responded that they preferred frequently HIV services. The rest 56 (13.2%), 28 (6.6%) and 21 (4.9%) responded contraceptive services, STI services and did not have knowledge about RH services respectively.

Table 13: Preference by Service Frequency

	frequency	**percent**
1. Information education and communication (IEC) &Behavioral change Communication (BCC).	147	**34.8**
2. Counseling service	92	**21.8**
3. HIV services	**79**	18.7
4. contraceptive services	**56**	13.2
4. STI diagnosis and treatment	28	6.6
5. I do not know	21	4.9

Part 4.5 Sources of information of adolescent girls on SRH and available services

As it was indicated in Table 14: 336 (79.4%) of respondents responded that they know what reproductive health means, Among 79.4% respondents who knows what reproductive health is, 106 of them responded as RH means family planning, 97 responded it is marital and child health, and 84 respondents said it is known about sexually transmitted \infections/STIs/HIV/AIDS & 49 of them responded it is access to health information and service.

296 (69.9%) and 406 (95.9%) have information how to terminate unwanted pregnancy and regarding sexually transmitted infections and HIV/AIDS respectively. The chi-square test also indicates that there is statistically significant difference between who gets the information and not.

Table 14: Knowledge of Reproductive Health

		F	%
Do you know what reproductive health (RH) means?	1.yes	336	79.4
	2. No	87	20.6
Do you have any information how to terminate unwanted pregnancy?	1.yes	296	69.9
	2.No	127	30.1
Do you know any information regarding sexually transmitted infections and HIV/AIDS?	1.yes	406	95.9
	2.No	17	4.1

Major source of information concerning reproductive health was mass media in the first rank as well as in the second rank which was about 157 (37.1%) and 107 (25.3%) respectively. The third source of information was posters and pamphlets which is 110 (26%), (Table 15).

Table 15: Source of Information on Reproductive Health in Rank (RH)

Your major source of information Concerning reproductive health?	Rank		
	1st	2nd	3rd
1. My parents	20 (4.7%)	27(6.4%)	18(4.2%)
2. Friends /peers	**39 (9.2%)**	59(13.9%)	**31(7.3%)**
3. Mass media	**157(37.1%)**	**107(25.3%)**	90(21.2%)
4. Posters and pamphlets	105 (24.8%)	**69(16.3%)**	110(26%)
5. Partner/ husband wife	**9 (2.1%)**	49(11.6%)	19(4.5%)
6. Religious leaders	**8 (1.9%)**	14(3.3%)	28(6.6%)
7. Health professionals	56 (13.2%)	71(16.7%)	99 (23.4)
8. school	29 (6.8%)	27(6.4%)	28(6.6)

Regarding the major source of information how to terminate unwanted pregnancy the majority of the respondents among 423 clients 34.2% of them got from Posters and pamphlets in the first rank followed by 24.5%, friends and peers in the same rank, secondly 50.1% from mass media and 17.2% Friends /peers, then 21.5% in the third rank from health professionals (Table 16).

Table 16: Source of Information on Unwanted Pregnancy in Rank

Your major source of information Concerning how to terminate unwanted pregnancy?	**Rank**		
	1st	**2nd**	**3rd**
1. My parents	5(1.2%)	11(2.6%)	46(10.8%)
2. Friends /peers	**104(24.5%)**	73(17.2%)	77(18.2%)
3. Mass media	**56(13.2%)**	212(50.1%)	**60(14.2%)**
4. Posters and pamphlets	145(34.2%)	**7(1.6%)**	53(12.5%)
5. Health professionals	31(7.3%)	**9(2.1%)**	91(21.5%)
6. Religious leaders	50 (11.8%)	22(5.2%)	20(4.7%)
7. Partner/ husband wife	**14(3.3%)**	51(12%)	12(2.8%)
8.School	18(4.2%)	38(8.9%)	64(15.1%)

From Table 17 the major source of information regarding STI/HIV/AIDS was mass media 144(34%) in the first rank followed by 142(33.5%), Posters and pamphlets in the same rank, secondly 167 (39.5%) from School and 102 (24.1%) from Posters and pamphlets, then 145(34.2%) in the third rank again from mass media.

Table 17: Source of Information on STI/HIV/AIDS

Your major source of information on STI/HIV/AIDS.	**Rank**		
	1st	2nd	3rd
1. My parents	46(10.8%)	17(4%)	71(16.7%)
2. Friends /peers	**20(4.7%)**	17(4%)	46(10.8%)
3. Mass media	**144(34%)**	**57(13.4%)**	145(34.2%)
4. Posters and pamphlets	142(33.5%)	**102(24.1%)**	**8(1.9%)**
5. Health workers	8(1.9%)	37(8.7%)	68(16%)
6. Religious leaders	**22(5.2%)**	15(3.5%)	53(12.5%)
7. Partner/ husband wife	4(.9%)	11(2.6%)	11(2.6%)
8.School	37(8.4%)	167(39.4%)	21(4.9%)

In general in all cases the source of information's bounded mostly in two sources among clients who responded "we know what RH means", "we got information on how to terminate unwanted pregnancy" and "information regarding STI/HIV/AIDS", such as mass media & posters and pamphlets, in fact the contribution of friends/peers, health professionals and school are also significant.

CHAPTER FIVE

5.1 DISCUSSION OF FINDINGS

This study assessed major reproductive health problems, service preference and Utilization among high school adolescent girl students in Adama town. The mean age of the study population was 17.45 years with standard deviation of 4.5122. The distribution of socio demographic characteristics of the study population was that, the majority of the respondents were not married and Christians and respectively, followed by Muslim. Greater than sixty percent of the respondents were living with their parents (father and mothers) while the rest were living with mothers only, father only, relatives and alone by renting houses. As the above analysis result indicated, the majority of the participants was not married adolescents and was on the age of sexually active behavior and also the average range educational level of having boy friend was Grade 7 to 10, this supports the fact that they were more vulnerable to RH problems. Hence, its implication is that more and more activities have to be done, especially on empowering adolescent girls regarding their reproductive health rights and ensuring the accessibility of services.

Based on the assessment made on reproductive health problems, Out of the 423 respondents, 39% reported to have practiced premarital sexual activity in the past. The mean age at first sexual intercourse was 16.86(±3.808 SD) years. Related studies conducted in different parts of the country showed that in Ethiopia the median age at which women age 25 – 49 first had sexual intercourse is 16. (Aklilu, Hailom, & Gouindasamy, 2002). Another study conducted in Nazareth high schools have showed that 24% of respondents reported having experienced sexual

intercourse, with 60% reported having had their first sexual experiences between the ages of 15 and 16 years (Tadelle, 2000).

This indicates that the age of sexual debut is very early and the complication of reproductive health problems is also at large with this age. Hence, this implies that things should be done on awareness creation and behavioral change communication interventions as well as developing and executing structural interventions specifically on these age groups.

In this study, out Of respondents who have practiced premarital sexual intercourse, more than eighty percent of them did not use**.** More than 50% of the sexually active groups believe that their first intercourses were unsafe (not used condom), and the occurrences of unwanted pregnancies, among them pregnancy get ended with abortion, were due to unsafe sexual practices.

Similarly, out of respondents who have practiced premarital sexual intercourse few of them reported they were using modern contraceptive methods, although they were know what modern contraceptives mean. This indicates that only half of the clients were using modern contraceptives among who knew what modern contraceptive means. This can be interpreted in different ways. Some of them did not get contraceptives at the time of the sexual intercourse; some of them may feel ashamed of asking for the contraceptives, some of them may not know where to get the methods and some of them did not believe pregnancy occurs with one contact. Finally with one or two different reasons mentioned above, they can be the victims of unwanted pregnancy.

In Ethiopia, a study conducted among high school students in Addis Ababa revealed that only 43.2% of the sexually active ones knew about condom on their first coital encounter and a small

proportion, 17.6% of them used it on their first sexual encounter (Eshetu, David, & Kebede, 1997).

Similar studies conducted in northwest Ethiopia, contraceptive prevalence in Dembia District revealed that 49% of sexually active adolescents knew one or two contraceptive method and 30 % having ever used the methods (Kebede, 2006). Although the majority of the respondents know what modern contraceptive means, making use of it was very low, especially during the first sexual contact. 54% of pregnancies to girls under the age of 16 years are unwanted (EDHS, 2011).

The above mentioned reproductive health problems were also discussed by Focus Group Discussion (FGD) participants as follows. They defined reproductive health as family planning, Sexuality, pregnancy and abortion related issues. They were also defined as unwanted pregnancy due to unsafe sex resulting unsafe abortion. Most of FGD participants have declared that adolescent girls aged 13-18 years are suffer from reproductive health problems and are more affected. Males influence females in worsening reproductive health problems. Rural adolescent girl's coming to the town for educational purposes are easily cheated by Males who may have multiple sexual partners.

They were also stated reasons for the occurrences of reproductive health problems are being cheated by men because they are economically dependent compared with male and failing to use contraceptives. The best Solutions for the above problems stated as educating and empowering adolescent girls to exercise their RH rights. Parents have to openly discuss about reproductive health issues with their adolescent children's as well also adolescents with peer groups. Mass media has to give special attention for adolescent reproductive health issues and it should be included in formal education curriculum specifically starting from secondary school.

Factors that influence utilization of RH services were assessed as follows. Regarding the accessibility issue, most of the respondents reported that the existing health institutions in their locality were not welcoming and convenient for them respectively, when they need the services.

Among the common obstacles that prevent adolescents from getting RH services in the existing health institutions were primarily healths professionals are Judgmental towards Adolescent RH needs in the first rank, long waiting time for service in the second rank and the rest obstacles mentioned by the respondents accounts the remaining parentage. This indicates that adolescent reproductive health problems are not only resulted from non use of the existing RH services by the respondents, but also the existence of various barriers mentioned above. A study conducted on adolescent health service utilization pattern and preference in Addis Ababa indicated that the existing health services were not fully accessible, affordable and acceptable to adolescents (Frehiwot, Yemane & Mesganaw, 2005).

An assessment of the preference of adolescent reproductive health service revealed that, regarding health institutions preference of adolescents for RH services, half of the respondents were preferred to be seen at public health institutions as primary choice. However, others were also suggested the services to be rearranged in public institutions that arranged for adolescent reproductive health. Respondent's prior preferred young provider of the any sex, followed by preferred young provider of same sex. Similarly as it was also underlined in FGDs, the majority of participants suggested young professionals of the any sex.

Further over, majority of respondents prefer service with special discount for adolescents, followed by service fee for adolescents to be free. Regarding the location of health service institutions, majority of the respondents preferred at the center of the city, hence proximity issue was also another factor that influences the preference and utilization of the services. One third of

the adolescents had preferred that IEC/BCC service in the first rank, followed by counseling service, HIV services, contraceptive services and STI services. As it was stated in the FGDs, RH service preference of the adolescents was not matching with existing situations, so this creates a great impact on preference and utilization of the services. Thus, this implied that there should be rearrangements of the service delivery locations and service packages, which includes appropriate RH service, service fee and service providers, convenient service time etc, with special focus in the future.

The above issue of preference and utilization of the services similarly it was supported by the focus group discussions sessions conducted with the FGD groups. It was reported that among the existing youth centers in the city, only few government and FGAEs youth center was providing youth friendly services. The government youth centers were not rendering the full package of RH services, since they were not well organized with the necessary materials and not assigned professionals as per the national standards. The FGD groups concluded that; similarly insufficiency of currently existing youth centers were well discussed and this few numbers of youth centers in Adama city limits accessibility for RH services. Preference and utilization of RH service among adolescents ensured by establishing more stand alone youth centers and strengthening the activities of existing youth centers inters of trained professionals and necessary material. Provision of non RH activities like physical and mental trauma management can strengthen accessibility.

Regarding the source of information on reproductive health, most respondents know what reproductive health means. Their sources of information were in the first rank as well as in the second rank were mass media, followed by posters and pamphlets. Religious leaders and Partner/ husband wife were reported as the least source of information. This report indicates the fact that,

there is no open discussion between Religious leaders and followers and among partners in most of Ethiopian context. This implies that the issue of reproductive health problems is not regarded as their concerns, although they are the victims of the problems. Hence each community member expected to give special attention to fight against the problem starting from open discussion.

In case of unwanted pregnancies and STI/HIV/AIDS, two third of respondents have information how to terminate unwanted pregnancy and also majority of them have information on sexually transmitted infections and HIV/AIDS. The major sources of information on how to terminate unwanted pregnancy were Posters and pamphlets followed by friends/peers. With the help of information from Posters and pamphlets, adolescents can get the service they want from health professionals. In the same table parents played the least role as the source of information on how to terminate unwanted pregnancy. This indicates that adolescents did not discuss with their parents about the issue.

Reports of most adolescent RH studies in Ethiopia revealed that the most common source of information on HIV/ AIDS was the media (Tadesse, Gudufa & Mengistu, 1996, & Regina, Mohamed, & Michael, 1998, & Berhane, 2000)

This issue was discussed by FGD groups that parents as well as male partners should get information about reproductive health issues, since it was one of the least sources of information on unwanted pregnancy. The results indicated here showed that, further awareness creation programs needed on the least sources of information. Regarding information on STI/HIV/AIDS mass media and Posters and pamphlets are the major source of information but religious leaders and partners are the two least sources. This can be interpreted as especially partners are the major aggravating bodies of reproductive health problems because of the fact that, if there is no discussion between the two, the problem will get worse. The result also indicated that religious

leaders were not playing adequate role as the source of information. Religious leaders are influential persons in the community; therefore they can make a difference, if they involved in RH issues.

In general the source of information bounded mostly in two ways among clients who responded "we know what RH means", "we got information on how to terminate unwanted pregnancy" and "information regarding STI/HIV/AIDS", such as mass media & posters and pamphlets, in fact the contribution of friends/peers, health professionals, school, even Religious leaders, Partner/ husband wife, My parents are also significant.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 SUMMARY

As it has been mentioned on the statement of the study few research works has been done in major towns by neglecting this study area. As literatures stated that adolescents face a range of health problems, including those related to sexual and reproductive health (SRH), substance use, mental health, nutrition, violence and accidents. HIV and maternal mortality are two of the most important health problems for adolescents in developing countries. Therefore, this study tried to investigate the magnitude of Adolescent reproductive health problem, service preference and utilization, factors that affect usage and major sources of information about available SRH service among high school female students in Adama town.

The study were employed a descriptive cross- sectional community based study. Based on probability proportionate to the population size of each high school clusters and simple random methods was used to identify the study population. Out of targeted Adolescents' aged 10-19, all responded to the structured questionnaire. Out of the 423 respondents, 165 (39%) reported to have practiced premarital sexual activity in the past. The mean age at first sexual intercourse was 16.86(±3.808 SD) years. Among respondents who have practiced first sexual intercourse, 44.8% of them faced unwanted pregnancy, 10.9% unwanted pregnancy and defaulted school. Ever use of Modern Contraceptive was found to be 41.2% among the sexually active group, while condom utilization at the recent intercourse was 17% among unmarried. Because of unsafe sexual practice, Adolescents' had history of unwanted pregnancy were ended with abortion and STDs respectively in the last one year prior to this study.

Regarding preference and utilization, the study found that many adolescents were not served in the existing health institutions for their reproductive health needs; those who have got access to it complained that the existing health institution was not welcoming when needing a service, the reasons they were mentioned health professionals are judgmental towards adolescent RH needs and prolonged waiting for the service. Majority of adolescents had preferred that IEC/BCC service, followed by counseling service, HIV services, contraceptive services, STI services.

Regarding major source of information, this study revealed that a major source was mass media, followed by posters and pamphlets. Religious leaders and Partner/ husband wife were reported as the least source of information. Because of lack of access to adequate information about and not using RH services, many Adolescents respondents had history of sexual and reproductive health problems were ended with different complications. Finally, based on the above findings, the study concluded and also forwarded some recommendations below.

6.2 CONCLUSIONS

The study shows that even though adolescent girls having sufficient information on reproductive health issues, they are more vulnerable to different reproductive health problems. The age at having first sexual intercourse is very early and the complication of reproductive health problems is also at large with this age. There is also a low utilization of condom and other contraceptive methods even after first sexual practices, which leads them to unwanted pregnancy, unsafe abortion and sexually transmitted infections/ HIV/AIDS. This indicates that RH problems widely exist and even increasing.

The result of the FGDs indicated that condom should be availed in youth clubs and associations, recreational areas, market places, schools, public gatherings, different associations and work

places in addition to well known sites sine it has a great role on the reduction of the occurrence of RH problems.

Regarding the preference and utilization issues, the result indicated that many adolescents were not served in the existing health institutions for their reproductive health needs. Those who have got access to it claimed that the existing health institutions were inconvenient and not welcoming, professionals did not respect the clients and waiting too long were the obstacles facing the adolescents. Although the majority of the respondents have information about RH services making use of it was very low. Additionally the existing health institutions didn't provide the RH services according to the preference of the target groups. Almost all of the respondents suggested the need for rearrangement of Adolescents reproductive health institutions separately. Activities should be done on awareness creation and behavioral change communications specifically on these age groups.

6.3 RECOMMENDATIONS

Reproductive health related problems are widely observed on Adama town high school adolescent girl's students, no single governmental or nongovernmental organization can solve this issue alone effectively unless like minded stakeholders cooperated together. Therefore active participation and coordination among different stake holders is mandatory. Every stakeholder has their own contributions for the well being of the adolescent since the ultimate goal is to assure quality, accessibility, fulfill preferences and motivate utilization of adolescent reproductive health services.

The local government has to consider the seriousness of the issue and coordinate youth related programs in the town and particularly the town health, children and women, youth and sport and education sector offices has to take the lead for coordination, provision of information on where

to get and expansion of adolescent reproductive health services. In addition they should mobilize resources and lands to construct youth reproductive centers and clinics, should invite NGOs which is willing to work on youth reproductive programs.

The government sector offices along with NGOs which are working on youth oriented programs should participate in strengthening the activities of existing youth centers, capacitating the existing less functioning youth centers as well as organizing and establishing additional youth centers. As a result adolescent reproductive health services can be strengthened in government youth centers. And also service delivery points should get emphasis in fulfilling the necessary materials and man power in order to deliver the satisfactory services with consideration of the accessibility and affordability, service quality and youth friendliness, convenience of time and comprehensiveness and continuum of care. Educating mothers and girls can reduce reproductive health problems and changes the attitude of the society towards RH. Each government and non government sector office has to discharge their role and responsibilities as stated below,

- The Adama town youth & sport and health offices are the key stakeholder that should take part on adolescent and youth reproductive health programs. They have enough information on the issue, designed program, basic facts on the adolescent and youth RH in the city. Therefore, the RH program would be improved through establishment of networking and partnership with likeminded organization to address the target groups. The existing government and non government youth centers in Adama, ideally provide comprehensive reproductive health services and information to the youth such as Information and communication/behavioral change and communication on RH (IEC/BCC), Contraception services, management of STIs/HIV/ AIDS, Comprehensive abortion care, counseling services, different

recreational and reading services and capacity building trainings. The services are provided under a setup where young people are welcoming, confidentiality is ensured, and services are conveniently located and affordable to address adolescent reproductive health needs.

- Emphasis should also be given on least information sources by designing programs that supports promotional activities like awareness raising programs on RH issues by the government, particularly religious leaders, partners and parents.
- The education sector office as a policy maker better include sexual and reproductive health issues in curriculum, since it is obvious that most of adolescent age girls found in school.

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Appendix A Socio-demographic profile/variable of the participants

Variables	frequency	percent
1. Age 14-18 years. Mean =16.86 & SD=3.808		
2. What is your Educational status?		
1. Grade 9	162	38
2. Grade 10	261	62
3. What is your current marital status?		
1. Single	414	97.8
2. Married	9	2.1
4. What is your religion?		
1. Orthodox	316	74.7
2. Catholic	9	2.1
3. Protestant	41	9.7
4. Muslim	48	11.4
5. Other (specify) - Johva	9	2.1
5. With whom do you live?		
1 .With father and Mother	267	63.12
2 .With mother only	115	27.18
3 .With father only	5	1.1
4 .With relatives	18	4.25
5. Other specify - alone by renting house	18	4.25
6. Are you currently having your own income?		
1. Yes.	99	23.4
2. No	324	76.6
7. If you have your own income, Where do you get your income?		
1. My parents	81	19.14
2. My relatives	9	2.1
3. From fellowship	9	2.1
8. How much money do you get on average per day?		
1. Less than five birr	9	2.1
2. b/n 5 to 10 birr	35	8.27
3. b/n 10 to 20 birr	37	8.74
4. Other specify - Greater than 20 birr	18	4.25

Appendix B

This is a questionnaire for assessment of Adolescent girl's reproductive health problems, service preference and utilization among high school students in Adama town, Oromia region Ethiopia.

Introduction: I am __________________Working as date collector in this study that assess Adolescent girls reproductive health problem and service preference and utilization among high school students at Adama town, that to run by IGNOU, Department of Social work. On this questionnaire your name will not be written and I am going to ask some questions that touch personal life and secrets, in which all your answers kept completely confidential. In this study, interview will be made to Adolescent girls who attending high school courses and selected to be interviewed. You do not have to answer any questions that you do not want to answer; even you may end this interview at any time you want too. However, your honest answers to those questions will help us better understand Adolescent girl's reproductive health problems, service preference and utilization for developing strategies and organizing future Adolescent health service. We would greatly appreciate your truthful and keen participation in responding to this questionnaire.

Identification Number

1. Name high school _________________________________ 2. Kebele _______________
3. Ketena ___________________ 4. Date of interview ________________
5. Interviewer name __________________________

Part I. Socio Demographic characteristics

1. How old were you at your last birthday**?** _______
2. What is your current level of education? __________
3. **What is your current marital status?**
   a. Unmarried
   b. Married
   c. Divorced
   d. Widowed

e. No answer

4. **What is your religion?**
   a. Orthodox
   b. Catholic
   c. Protestant
   d. Muslim
   e. Other (specify)
5. **To which ethnic group do you belong?**
   a. Oromo
   b. Amhara
   c. Tigirie
   d. Gurage
   e. Other specify
6. **Whom do you live with?**
   a. With father and Mother
   b. With mother only
   c. With father only
   d. With relatives
   e. With friends
   f. Alone by renting house
   g. Other specify
7. Are you currently having your own income?
   a. Yes.
   b. No.
8. If Yes, Where do you get your income?
   a. My parents
   b. My friends
   c. My relatives
   d. From fellowship.
   e. If Others specify______
   f. No answer

9. How much money do you get on average per day?

a. Less than five birr
b. b/n 5 to 10 birr
c. b/n 10 to 20 birr
d. Other specify __________

Part II. Magnitude of selected reproductive health problems and Concerning Reproductive Health Service Practice

1. **Do you have a Boy friend now?**

   a. Yes
   b. No

2. **What was your educational level while you are having a boy friend?**
   a. Not attended School
   b. Only reading and writing
   c. Grade 1 to 6
   d. Grade7 to 10
   e. Don't know

3. **Have you ever had premarital sexual intercourse?**
   a. Yes
   b. No

4. **How old were your, when you had your first sexual intercourse? _______________**

5. **How were you exposed to first sexual intercourse?**
   a. By my interest
   b. By pear pressure
   c. I was cheated
   d. I was raped
   e. On my marriage
   f. Don't known

6. **Did your first sexual intercourse was protected (did you used condom)?**
   a. Yes
   b. No

c. Don’t know
d. No response

7. Which of the following consequence you faced from your first sexual exposure?

a. STDs
b. Pregnancy
c. School dropout
d. Nothing was happened
e. No response

8. How many sexual partners you have had in the last one year? _________________

9. Have you ever used any of modern contraceptives?

a. Yes
b. No

10. Have you used condom in your resent sexual intercourse?

a. Yes
b. No

11. **Have you had any of STI symptoms during the last one year**?

a. Yes
b. No

12. In your sexual relationship with any of your partner, have ever been pregnancy happened?

a. Yes
b. No

13. If yes to question 13, how did the pregnancy get end?

a. It was aborted
b. Preterm
c. Live birth
d. Don’t know

14. **Have you ever given birth?**

a. Yes
b. No

15. **What was your age when you first gave a birth?**
    a. Age in year_____
    b. Don't know
    c. No response

Part III. Factors Influencing Utilization of RH service among Adolescent girls

1. **Do the existing Health Institutions are convenient to the secret use of adolescents reproductive health service.**
    a. Yes
    b. No
    c. do not know
2. **Do the existing health institutions are well coming when you need the service.**
    a. Yes
    b. No
3. **If No to Que. 2, please answer any of the following possible factors.**
    a. Health institutions are located at far distance.
    b. Fear of being seen by parents or others who know them.
    c. Health professionals are Judgmental towards Adolescent RH needs
    d. Lack of confidentiality
    e. Adolescents get embarrassed at needing reproductive health service.
    f. Inconveniency of service delivery time
    g. Health service fee is expensive.
    h. Long waiting time for service.
    I. In consistence of service delivery

Part IV. Preference and utilization of Health Service

1. **In which of the following health institution do you think Adolescent reproductive health service is given better?**
    a. Government health institute
    b. Government youth clinics

c. Private health institute
d. FGAE Clinics
e. School Clinics
f. Other Specify ___________________________

2. Are you utilizing in the existing health institution for your reproductive health need?

a. Yes
b. No

3. In which of the following health institutions do you prefer to be served for your reproductive health need?

a. Government health institutions
b. Government youth centers
c. Private
d. FGAE clinic
e. by none licensed provider
f. Other specify _________________________________

4. In which of the following way do you prefer Adolescent reproductive health service to be rearranged?

a. Within the existing health institution as it is
b. No need to give special attention
c. Within the existing health institution having its own Adolescent reproductive health service rooms.
d. In health institute that arranged for Adolescent reproductive health
e. By expanding Adolescent reproductive health services in youth center
f. Other specify.___________________

5. Which time do you think it is convenient for Adolescent health service?

a. In the usual health institute working hours
b. In the hours when other users are not around
c. Other specify ___________________

6. **What do you prefer on service fees for Adolescent?**
    a. At usual rate
    b. With discount for Adolescents
    c. Free of charge
    d. Other specify ____________________________
7. **Whom do you prefer to be Adolescent reproductive health provider?**
    a. Young provider of the same sex
    b. Young provider of any sex
    c. Adult provider of the same sex
    d. Any provider could be
    e. Other specify ____________________________
8. **Where do you prefer Adolescent health service to be located?**
    a. Anywhere out of resident area
    b. In the center of the town
    c. At one end of the town
    d. Other specify __________________________________
9. **What type of RH services do you preferred?**
    Specify ____

Part V. Sources of information of adolescent girls on SRH and available services

1. **Do you know what reproductive health (RH) means?**
    a. Yes
    b. No
2. **Do you have any information how to terminate unwanted pregnancy?**
    a. Yes
    b. No

3. **Do you know any information regarding sexually transmitted infections and HIV/AIDS?**

    a. Yes

    b. No

4. **What are your major sources of information concerning reproductive health?**

1. My parents	5. Partner/ husband wife
2. Friends /peers	6. Religious leaders
3. Mass media	7. Health professionals
4. Posters and pamphlets	8. School

5. **What are your major sources of information concerning how to terminate unwanted pregnancy?**

1. My parents	5. Partner/ husband wife
2. Friends /peers	6. Religious leaders
3. Mass media	7. Health professionals
4. Posters and pamphlets	8. School

6. **Your major source of information on STI/HIV/AIDS.**

1. My parents	5. Partner/ husband wife
2. Friends /peers	6. Religious leaders
3. Mass media	7. Health professionals
4. Posters and pamphlets	8. School

Appendix B FGD Guide

Introduction

Good morning/good afternoon! Well come to our group discussion**.**

My name is **-----------------------------** and I work for --------------- & I come from --------------------. We are here today to discuss about Adolescent reproductive health problems and their service preferences and utilizations. There is no right or wrong answers. All comments, both positive and negative, are well come. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up everything. We would like to confirm to you that all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion? If yes, thank you for your willingness. 10 Specific research questions are arranged under 4 major heading. These are

1) Problems associated with sexual characteristics

2) Attitude and practice of utilizing the existing Health Institutions for RH need.

3) Matter related to RH and HIV /AIDS

1. Problems associated with sexual characteristics.

- **Do you think problems associated with sexual characteristic are a major health problem of Adolescent or not? Why? How? Let discuss.**
  - Probe: What are they?
  - Probe: who is most likely to suffer (age, sex, behaviors)?
  - Probe: what do you think a solution?

2. Health service

- Does the existing Health Institution deliver Adolescent reproductive HS? Who deliver it? Is the service is organized?
  - Probe: major problem / accessibility, confidentiality, attractiveness, service providers, payment /
  - Probe: to suggest how Youth friendly RH need to be rearranged.

3. Matter related to RH services

- Do you have any information about RH? Does the service available in your area?

What arrangements need to increase service accessibility?

- Probe: from where do you get information about it?
- Probe: what type of RH services do you preferred?