ASSESSMENT ON SEXUAL AND REPRODUCTIVE HEALTH (SRH) AND RELATED ISSUES AT SAMARA UNIVERSITY, NORTH EAST ETHIOPIA

MSW Dissertation Research Project

(MSWP-001)

Prepared By

Sisay Alemayehu Kassa

Enrollment No.: 099125553

Project Supervisor

Sebsib Belay (Mr.)

Senior Researcher and Lecturer

Indira Gandhi National Open University
School of Social Work

March 2014
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DECLARATION

I hear by declare that the dissertation entitled ASSESSMENT ON SEXUAL AND REPRODUCTIVE HEALTH (SRH) AND RELATED ISSUES AT SAMARA UNIVERSITY, NORTH EAST ETHIOPIA submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and not been submitted earlier, either to IGNOU or any other institution for the fulfillment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in a whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

Place:_____ Signature:_____

Date: _____ Enrollment No.:_____

Name :_____

Address: _____

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CERTIFICATE

This is to certify that Mr./Miss/Mrs_____Student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his/her Project Work for the Course MSWP-001. His/Her Project Work entitled ASSESSMENT ON SEXUAL AND REPRODUCTIVE HEALTH (SRH) AND RELATED ISSUES AT SAMARA UNIVERSITY, NORTH EAST ETHIOPIA which he/she is submitting, is his/her genuine and original work.

I. Place:_____

Signature:_____

Date: _____ Name: _____

Address of the Supervisor: _____

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Phone No.: _____

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Sisay Alemayehu

March 2014

Abbreviations and Acronyms

AED	Academy for Educational Development
AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-retroviral Treatment
BCC	Behavioral Change Communication
CSA	Central Statistics Agency
EC	Emergency Contraceptive
FBE	Faculty of Business and Economics
FDA	Faculty of Dry Land Agriculture.
EDHS	Ethiopian Demographic and Health Survey
FDRE	Federal Democratic Republic of Ethiopia
FENG	Faculty of Engineering
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
FMHS	Faculty of Medicine and Health Sciences
FNCS	Faculty of Natural and Computational Sciences
FP	Family Planning
FSSH	Faculty of Social Science and Humanity
FVM	Faculty of Veterinary Medicine
GP	General Practitioner
HCP	Health Communication Partnership

HB	Health Bureau
HEI	Higher Education Institutions
HIV	Human Immuno Virus
HTC	HIV Testing and Counseling
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
MARPs	Most at Risk Populations
MD	Medical Doctor
MoE	Ministry of Education
MoH	Ministry of Health
NGO	Non-governmental Organization
PICT	Provider Initiative Counseling and Testing
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
UN	United Nations
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth Friendly Service

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Abstract

Sexual risk behaviour among adolescents is a major public health concern in the world. In the realm of global health research, adolescent sexual and reproductive health has emerged as an area of key concern, especially in developing nations and regions in the world. Achieving reproductive and sexual health requires more than preventing unwanted pregnancy and sexually transmitted infections, it includes developing the ability to form and maintain meaningful relationships with others and with one's own body. In addition, adolescents are more likely to engage in risk-taking behaviours than either younger children or adults. These significant factors underline the importance of meeting the reproductive and sexual health needs of this age group.

The study has both general and specific objectives. It generally aimed at assessing the Sexual, Reproductive Health (SRH) services and related issues at Samara University in North East Ethiopia. Specifically, the study intended to assess the availability, accessibility and quality components of SRH at Samara University; to identify the strengths of the available SRH components at Samara University; and to identify the constraints of the available SRH components at the University.

Non-experimental research design was employed in this study. A combination of both quantitative and qualitative research methods were also used to generate primary and secondary data from the respective sources. Regarding the quantitative research method, the researcher used descriptive sample survey using well-structured interview schedule or questionnaire. Qualitatively, the researcher organized and held semi-structured interviews, conducted four focus group discussions, organized FGDs in gender groups, undertook observations of relevant aspects of the University's setting and made documentary analyses of relevant documents. The target population at Samara University for this study was 3641 students in seven faculties and more than ten departments in the 2012/13 Academic Year. In the end, the sample size of the study was 50 students at different levels of schooling year. Purposive sampling of non-probability sampling method was generally employed to collect qualitative data from different informants. In so doing, proportionate stratified sampling method was used to select randomly the sample respondents for descriptive sample survey.

Hence from the study conducted, the sexual and reproductive health services at Samara University are found to be unavailable in terms of acceptable standards, inaccessible and poor quality services which have emanated from the existing constraints in the Health Facility.

The study recommends that Staff members, the University's Health Facility, coordinating bodies like HIV/AIDS Prevention and Control Offices, Gender offices, and the Student Dean's Office should do what they are expected to avail quality SRH service in an accessible manner to all students.ity. It is also recommended that the University should work in partnership with other stakeholders including NGOs, regional and federal level government actors.

CHAPTER I

INTRODUCTION

1.1 Background of the Problem

Sexual risk behaviour among adolescents is a major public health concern in the world. In the realm of global health research, adolescent sexual and reproductive health has emerged as an area of key concern, esp. in developing nations and regions in the world. The reproductive and sexual health needs of adolescents differ from those of adults (WHO, 2010). During adolescence, the body undergoes significant developmental changes, most notably puberty, the bodily changes of sexual maturation, and the formation of sexual identity (National Institute of Health, 2010 in WHO, 2012). Achieving reproductive and sexual health requires more than preventing unwanted pregnancy and sexually transmitted infections, it includes developing the ability to form and maintain meaningful relationships with others and with one's own body. Psychological, social, educational, environmental, and economic factors, among others, all play a role (Tolman et al., 2003 in Saba, 2006). In addition, adolescents are more likely to engage in risk-taking behaviours than either younger children or adults (Steinberg et al., 2004 in Frankenfield, 2009). These significant factors underline the importance of meeting the reproductive and sexual health needs of this age group.

Adolescence is a period of sexual maturity that transforms a child into a biologically mature adult capable of sexual reproduction and the potential consequences of that sexual activity. At the Meeting on Pregnancy and Abortion in Adolescence organized by the World Health Organization (WHO) in 1974, the concept "adolescence" was described as the period of sexual development from the initial appearance of secondary sex characteristics to sexual maturity, psychological development from child

to adult identification, and socio-economic development from dependence to relative independence (WHO, 1975). Adolescence starts with a period of very rapid physical growth accompanied by the gradual development of reproductive organs, secondary sexual characteristics and menarche in girls. Boys' adolescence is generally longer than that of girls, as girls in many societies are deemed ready for serious courtship or marriage proposals right after menarche.

Sexual and reproductive health of adolescents has been a major international concern and it has been very clearly indicated in the 1994 International Conference on Population and Development (ICPD) in Cairo (Aslihan, 2005). An assessment made by the Family Health International (FHI) (2004) highlights that "today in our world, the prevalence of SRH and related problems and their consequences are apparent." It also continued by saying that,

> Ethiopia is a nation of young people – over 65% of its population is under 25 years of age – and a nation whose youth have profound reproductive health needs. Among the many sexual and reproductive health problems faced by youth in Ethiopia are gender inequality, sexual coercion, early marriage, polygamy, female genital cutting, unplanned pregnancies, closely spaced pregnancies, abortion, sexually transmitted infections (STIs), and AIDS.

Reproductive health is, according to the WHO (1975), defined as "A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and process". Reproductive health thus addresses the human sexuality and reproductive processes, functions and system at all stages of life and implies that people are able to have "a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

Quoting Aslihan (2005), the ICP Program of Action states that "reproductive health programmes should be designed to serve the needs of women, including adolescents," and that innovative

programmes should be developed to "ensure information, counseling and services for reproductive health accessible for adolescents and adult men".

According to the study on adolescent reproductive health services conducted in Jimma town, Tesfaye et al. (2004 in FHAPCO) argue that,

> reproductive health is comprised of components, like the quality family planning services; promoting safe motherhood (such as prenatal, safe delivery and post natal care, including breast feeding); prevention and treatment of infertility; prevention and management of complications of unsafe abortion; safe abortion services; where not against the law; treatment of reproductive tract infections, including sexually transmitted infections; information and counseling on human sexuality; responsible parenthood and sexual and reproductive health; active discouragement of harmful practices (such as female genital cutting and violence related to sexuality and reproduction); and functional and accessible referral.

The Education and Training Policy of Ethiopia that was adopted in 1994 creates conducive environment for educational advancement in all corners of the sector in Ethiopia. Currently, Ethiopia has 34 public universities that are found in almost all regions. New universities are also under construction in regional urban areas which are creating positive and negative buzzes.

Different studies have been conducted on students' vulnerability to SRH problems (e.g. HIV infection in the higher education institutions of Ethiopia in Bahir Dar, Harar, Addis Ababa, Gondar and Hawassa). However, they were limited in the scope of their coverage and thus their findings couldn't show us the availability, accessibility and quality of SRH and related services in the public universities in a conclusive manner. Particularly, those newly founded public universities are facing uncertainty in handling SRH related problems (like STIs, including HIV/AIDS, and unwanted pregnancies) as the institutions don't have an empirical study-based evidence which might help them in directing their efforts of preventing and controlling SRH problems. If there are some studies conducted on those issues, it is obvious that most of them might be conducted on the well- established and big public educational institutions (i.e. Addis Ababa University, Haramaya University, Gondar University,

Hawassa University, and Bahir Dar University).

Thus, it becomes important to assess what the students are gaining from SRH interventions in terms of availability, accessibility and quality of services through social work perspectives at Samara University which is located in a relatively small and yet to grow regional capital city, Samara – North East Ethiopia.

1.2 Statement of the Problem

The purpose of this study is to assess the availability, accessibility and quality of SRH services at Samara University, North East Ethiopia. The national document on HIV/AIDS Prevention Package for MARPS and Vulnerable Groups developed by the Federal HIV/AIDS Prevention and Control Office (FHAPCO, 2011) states that young people in high schools and above are vulnerable and at risk to HIV infection due to various reasons (such as unprotected casual sex relationships and multiple sexual partners, lack of comprehensive knowledge about HIV/AIDS, sexual and reproductive health, lack of access to HIV services, sexual experimentation, early sexual debut and peer pressure, and other related factors.

There are also problems related to SRH services which include accessibility, availability, and quality. Moreover, the communication strategy for higher education institutions (MoE, 2012) reveals that health providers in most of the HEIs are not trained to respond to the needs of young persons. They are uncomfortable and sometimes judgmental in working with young clients. The shortage of youth-friendly health services and counselling pose significant challenges to address SRH issues, including HIV prevention.

In the Ethiopian higher learning institutions, there more or less are clinics that are providing some basic SRH and other medical services to their target students. The services which have been provided vary

considerably, but at a minimum include basic health monitoring and referral services. In some of the Ethiopian higher learning institutions, these clinics provide them with condoms, counselling on pregnancy and prevention of STIs, as well as referral for other contraceptive and reproductive health services. These educational institution-based services are often limited by restrictive policies, personnel shortages, lack of private areas for counselling and poor links to resources outside the institutions.

In this regard, there are inter-related problems in an effort to provide SRH services to the youth. According to the National Reproductive Health Strategy of Ethiopia (2006), the following major key actions were outlined in order to address the problems: creating awareness of SRH at the community level, providing youth-friendly services through the public sector, integrating HIV/AIDS services, and increasing capacity of human resources through appropriate training.

The National Reproductive Health Strategy of Ethiopia (2006) states that the reduction of HIV infection among reproductive age groups and stipulates to improve the quality of life of those living with the disease as a top priority agenda of the country. It further took optimizing the synergies between SRH and HIV/AIDS services as a very essential element of the Strategy. For example, level of integration of PMTCT and VCT services to routine antenatal/delivery/postpartum care, family planning service and STI clinics are the targets chosen. The Strategy has envisaged the enhancement of the reproductive health and well-being of the country's diverse populations of young people segmented design and delivery of all youth SRH-related interventions and policies by gender, age cohort, marital status, and rural/urban residence; addressing the immediate and long-term SRH needs of young people thereby strengthening multicultural partnerships to respond to young women's heightened vulnerability to sexual violence and non-consensual sex.

1.3 Research Questions

This study intended to answer the following researchable questions:

- What types of SRH services are available to the students at Samara University in North East Ethiopia?
- Are the Sexual and Reproductive Health services accessible to the students in the University?
- What are the quality standards of those SRH services which are available and accessible to the students in Samara University?
- What are the strengths of those SRH services provided to the students at Samara University?
- What are the constraints of those SRH services provided to the students in the University?

1.4 Objectives of the Study

The study has both general and specific objectives. It generally aimed at assessing the Sexual, Reproductive Health (SRH) services and related issues at Samara University in North East Ethiopia. Specifically, the study intended:

- To assess the availability, accessibility and quality components of SRH at Samara University;
- To identify the strengths of the available SRH components at Samara University; and
- To identify the constraints of the available SRH components at the University.

1.5 Definition of Key Terms

- **Adolescence –** is a period of sexual maturity that transforms a child into a biologically mature adult capable of sexual reproduction and the potential consequences of that sexual activity (WHO, 1975).

- **Sexuality** is defined as a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It further explains that sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, roles and relationships (WHO, 2002).

- **Sexual rights** are human rights that are already recognized in national laws, international human rights documents and other international agreements. These include the right of all persons, free coercion, discrimination and violence, etc. (WHO, 2002).
- **Sexual health** is a state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, 2002).
- **Reproductive rights** are rights which embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the rights to the highest attainable standard of sexual and reproductive health (UN, 1994).
- **Reproductive health** implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicitly, they are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law,

and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (UN, 1994).

1.6 Limitations of the Study

While conducting this study, the researcher faced with problems related to actual collection of both quantitative and qualitative data. The problems include: data were collected from only 50 sample students due to the length, depth of the tools and logistical reasons, there were non-responses because the study was based on used self-administered questionnaires, only one department from the seven faculties of the University was included for sake of convenience, incomplete questionnaires were traced after the completion of the data collection, the study was conducted in only one of the thirteen newly established public universities, and the study employed descriptive survey design which implied that causal relationship between those variables under investigation could not always be determined easily.

1.7 Organization of the Thesis

This thesis consists of sixth chapters. The first chapter introduces background of the problem, statement of the problem, research questions, objectives of the study, definition of key terms in the study, limitations of the study and organization of the thesis. The second chapter dwells on review of related conceptual, theoretical and empirical literature in different parts of the world. Chapter three discusses research design and methods employed while undertaking this empirical study. It also describes and explains the universe of the study in terms of delimiting its target population, study site and cross-sectional time period for collecting pertinent quantitative as well as qualitative data, including sample size. The next chapter presents the two types of data collected in integrated

manner, their analyses and interpretation in the light of addressing the study questions and objectives. The fifth chapter highlights major findings of the study and discusses them in line with those of the previous similar as well as partly related studies elsewhere in the world. Finally, based on well-empirically supported findings, the study puts together those threads of discourses on the major issues considered throughout the research undertaking, draws conclusions to answer the questions and then to address those objectives. It, therefore, suggests plausible social work interventions to be accomplished by different stakeholders in various contexts at different levels in the study area.

CHAPTER II

REVIEW OF RELATED LITERATURE

2.1 Conceptual Framework

Sexual and Reproductive Health has been defined by the World Health Organization and other UN agencies in the following manner in relations to such related concepts as sexuality, sexual rights, sexual health, reproductive rights and reproductive health at different times. Now, let us describes each concept one by one.

Sexuality

The World Health Organization (2002) defines sexuality as a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. The Organization further argues that sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, roles and relationships. As sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is also influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.

Sexual Rights

It embraces human rights that are already recognized in documents on national laws, international human rights and other international agreements. These include:

> The rights of all persons, free of coercion, discrimination and violence to receive the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek and impart information in relation to sexuality; receive

> sexuality education; have respect for bodily integrity; have a free choice of partner; decide to be sexually active or not; have consensual sexual relations; have consensual marriage; decide whether or not and when to have children; and pursue a satisfying, safe and pleasurable sexual life (WHO, 2002).

However, such rights of persons have to take into account others in a given context. The responsible exercise of human rights thus requires that all persons respect the rights of others.

Sexual Health

In 2002, WHO states that sexual health is a state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health further requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Reproductive Rights

The concept of reproductive rights embraces certain human rights that are already recognized in those documents on national laws, international human rights and other consensuses, according to UN (1994). These rights rest on the recognition of the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of sexual and reproductive health. They also include the rights of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Reproductive Health

Different definitions have been forwarded for the term Reproductive Health (RH). But most importantly, the definition taken by UN may have all important elements of most definitions. It is stated as 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 to its functions and processes (UN, 1994). Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicitly, the last conditions are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. These rights as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

2.2 Theories and Models of Health

A better theoretical understanding of the processes involved in changing people's behaviour may help them increase their practice of safe sex prevalence. Yet, many health education interventions for such practice are not based on any explicit guiding theory or principles. The absence of a theoretically grounded basis for behavioural and educational interventions on uses of SRH services may have an effect on the success of these programmes. This is of particular relevance for interventions targeting certain section of populations (i.e. adolescents) and regions such as Africa where contraceptive use is low or slowing down (Creanga et al., 2011 in Kavanauch et al., 2013).

Behavioural theory has been used for more than 50 years to guide health interventions, but use of the theory in SRH use interventions has never been comprehensively assessed. Published research often fails to provide sufficient information on the theoretical relevance of the intervention and whether it has been adequately implemented. The objective of this Cochrane review (Lopez et al., 2011) was to examine the impact of theory-based interventions on contraceptive use by systematically reviewing randomized controlled trials (RCTs) that explicitly tested a theoretical approach to improving contraceptive use, choice, and/or continuation of use.

There are some 30 psychological theories of behaviour change (Bandura, 2004). Those that are cantered on health behaviour often draw on some form of social cognitive theory, the process through which people learn to adopt new behaviours. This entails acquiring knowledge of the risks and benefits of behaviour change, developing a belief in self-efficacy (i.e. the confidence that one has the power to change health behaviour, and determining outcome expectations based on a cost-benefit analysis of different behaviour choices (Michie et al., 2005 in Lopez et al., 2011).

The specific theories and models used in the study are: social cognitive theory, social learning theory (a pre-cursor to social cognitive theory), social influence theory, the trans-theoretical model, theory of reasoned action, theory of planned behaviour, and motivation theory (including information-motivation-behaviour skills model, protection motivation theory, and motivational interviewing). Given that there is a need for consideration of these theories and models for SRH interventions, it is important to throw a light on the shadow.

2.2.1 Social Cognitive Theory

Social Cognitive Theory was originally called Social Learning Theory. It assumes that in order to the causal process behind behaviour it is worth considering outcome expectations (the expected outcome of a specific behaviour) and self-efficacy (perceived ability to perform the behaviour). Based on this Theory, Bandura (2001 in Bandura 2004) developed a model for Prediction of Behaviour which has such elements as ”goals,” subjective norms” and “outcome expectancies”.

Social Cognition Models and Social Cognitive Theory are widely used in research on health-related behaviours. One can employ These Models as well as Theory is useful for planning and conducting interventions for sexual and reproductive health behaviour among adolescents. Social cognitive theory focuses on understanding the risks and benefits of changing one’s behaviour, developing self-efficacy, and assessing outcome expectations of the change in behaviour. One study used a customized intervention programme to delay second births among adolescents and results showed that adolescents in the treatment group were less likely to have had a second birth within two years compared with usual care (the standard sex education class). However, two cluster randomized trials using enhanced school-based curricula versus usual sex education found no difference in (reported) pregnancy for both study arms. One of these studies found no significant differences in contraceptive use within gender. The other study reported that males in the intervention group were more likely to use a condom at last intercourse but not females (Klepp et al., 2008).

2.2.2 Social Cognitive Theory combined with Additional Theories

Two cluster randomized trials used school-based curricula interventions to address prevention of STIs, HIV and pregnancy using a combination of theoretical frameworks and again results were mixed. Compared with students who received standard sex education, students in the intervention group that incorporated social cognitive theory, social influence theory, and models of social change

were more likely to use an effective contraceptive method of pregnancy prevention ($p < 0.05$) or a condom ($p < 0.05$) at last intercourse at both 7-month and 31-month assessments. In contrast, another study reveals that students in the intervention group that was based on social cognitive theory, the theory of reasoned action, and the theory of planned behaviour (all of which focus on intention to change behaviour), were more likely to have used a condom at last intercourse compared with students receiving standard sex education (Klepp et al., 2008, p. 12). There were no differences in reported pregnancy by study area.

2.2.3 Other Social Cognition Models

Two studies employed interventions that were based on variations of social cognition theory and results indicated that these approaches were effective. Results from a school-based study employing a pregnancy prevention intervention based on cognitive and behavioural training were reported at 6 months follow-up. Compared with students who were not exposed to the programme, students in the intervention arm reported being more likely to use contraception routinely, as a "habit" ($p < 0.05$) and greater use of contraception at last intercourse ($p < 0.005$) (Frankenfield, 2009). Results from a trial that provided multiple intervention sessions that focused on the Health Belief Model as well as self-efficacy indicate that compounded interventions involving youth programmes, parent programmes, and booster sessions were more effective at reducing (reported) pregnancy than single interventions, although reported use of contraception was the same between the groups. Therefore, the Health Belief Model is widely used in a wide range of health related contexts. The Model has main components, such as perceived susceptibility, severity, benefits, barriers and cues to action.

2.2.4 Theory of Reasoned Action

This Theory is based on the assumption that intention leads to behaviour, but it is always not the case. The intentions are then influenced by some factors, like personal attitudes toward the behaviour and subjective norms.

2.2.5 Theory of Planned Behaviour

The Theory includes personal attitudes toward the behaviour, subjective norms, and perceived behavioural control. Generally, intentions play a key role in this Theory.

2.2.6 Motivation Theory

Four studies were designed to reduce the risk for alcohol-exposed pregnancy through motivational interviewing (a method of facilitating and engaging intrinsic motivation in clients in order to change behaviour and eliminate any ambivalence) and results were inconclusive. In two studies comparing intervention sessions with a control group that received a pamphlet on women's health, results indicate that the intervention was more effective than the control arm. In one study, the intervention group was less likely to report ineffective contraceptive use (OR 0.49, 95% CI 0.28–0.87) and in the other study the intervention group was more likely to have used contraception during the three months prior to the follow-up interviews (OR 2.12, 95% CI 1.53–2.92). However, motivational interviewing techniques in the other two studies were no more effective than the control (general counseling on women's health in one study and usual clinic follow-up care in the other) in improving contraceptive use. Tested and self-reported pregnancies were similar for both groups in both studies.

One cluster randomized trial using the Information-Motivation-Behavioural Skills Model (IBM) reported no significant differences in (tested) pregnancy or condom use between female marine

recruits in the intervention arm compared with the control arm, which had focused on group health promotion.

2.2.7 Trans-theoretical Model

This Model posits that interventions should be tailored to assist individuals through the various stages of behaviour change by recognizing the steps of the process, which include thinking about a new health behaviour, implementing it, and adhering to it. Two studies incorporated the Trans-theoretical model into a tailored intervention compared to usual care. Results show that there were not significant differences between arms in both studies for consistent condom use and (tested) pregnancy.

2.2.8 The "KAP Model"

It is a simple common-sense-based Model that has been around since the beginning of health education (Tones and Tilford, 1994 in Seife, 2007). The Model postulates that health education is carried out to increase knowledge regarding the health consequences of certain behaviour. Within KAP Model, the focus is unidirectional on how attitudes are supposed to influence behaviour. There is also the correlation between attitudes and behaviour which is assumed to be substantial. Therefore, increased knowledge is expected to lead to a change in attitudes toward health compromising behaviour as well as health enhancing or risk-reducing behaviours.

2.2.9 The "Maastricht" – Attitude, Social Influence and Efficacy (ASE) Model

This Model that intentions predict behaviour. But the influence of intentions on health behaviours depends on skills and barriers. If an adolescent intends to use condoms during the next intercourse

with his or her partner, but simply lacks the skills to use the condom properly, positive intentions are unlikely to lead to adequate use of the condom(s).

As shown in this section, there is considerable overlap between the various models and theories in the Social Cognition Theory. Finally, scholars actually succeeded in reaching consensus on eight important factors in predicting SRH behaviours (including intention, environmental constraints, ability [skills], anticipated outcome [or attitudes], norms, self-standards, emotion and self-efficacy).

2.3 SRH at International Level

Kesterton and de Mello (2010 in WHO, 2012) have reviewed limited available literature on the effectiveness of interventions aimed at generating demand for and use of sexual and reproductive health (SRH) services by young people and interventions aimed at generating wider community support for their use. They came up with the evidence-base for interventions aimed at both generating demand and community support for SRH services for young people was found under-developed and many available studies do not provide strong evidence. Finally, this study highlights that many areas for further research have been highlighted and there is a great need for more rigorous evaluation of programmes in this area. In particular, further evaluation of individual components within a multi-component approach is needed to elucidate the most effective interventions.

Sadana (2000 in HEI, 2012) further reviewed relevant studies on RH and related issues to estimate the prevalence of reproductive morbidities in some parts of the world. A detailed review of recent community or hospital based health interview validation studies conducted in Bangladesh, Bolivia, China, Egypt, India, Indonesia, Nigeria, Philippines and Turkey have provided empirical evidence

on different aspects of reproductive health and illness using interview-based surveys may provide useful information about the disability or burden associated with reproductive health and illness.

2.4 SRH in North and South Americans

Rape is a case in point related to SRH in those countries of America. During the past 20 years, Campbell and Wasco (2005 in WHO 2010) indicate that other researchers have documented the widespread problem of rape in American society. Approximately, one in four women is raped in their adult lifetime, which causes severe psychological distress and long-term physical health problems. The impact of sexual assault extends far beyond rape survivors as their family, friends, and significant others are also negatively affected. Moreover, those who help rape victims, such as rape victim advocates, therapists as well as sexual assault researchers, can experience vicarious trauma. Future research and advocacy should focus on improving the community response to rape and the prevention of sexual assault.

Tjaden and Thoennes (2000 in Yordanos, 2009) conducted a survey on violence against women to examine the extent, nature, and consequences of intimate partner violence in the United States. The survey compared intimate partner victimization rates among women and men, specific racial groups, Hispanics and non-Hispanics and same-sex and opposite-sex cohabitants. It thus examined and found out intimate partner violence was pervasive in U.S. society. Nearly, 25 percent of surveyed women and 7.6 percent of surveyed men said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time cohabiting partner, or date at some time in their lifetime; 1.5 percent of surveyed women and 0.9 percent of surveyed men said they

were raped and/or physically assaulted by a partner in the previous 12 months. According to these estimates, approximately 1.5 million women and 834,732 men are raped and/or physically assaulted by an intimate partner annually in the United States.

In the United States, Shifren et al. (2008 in MoH) estimate the prevalence of self-reported sexual problems of women (any desire, arousal, and orgasm), the prevalence of problems accompanied by personal distress, and then conclude the prevalence of distressing sexual problems peaked in middle-aged women and was considerably lower than the prevalence of sexual problems. This underlines the importance of assessing the prevalence of sexually related personal distress in accurately estimating the prevalence of sexual problems that may require clinical intervention.

Scholars were interested to describe the basic epidemiology of sexually transmitted infections (STIs) for Arctic and sub-Arctic regions of North America beginning from 2003 to 2006. In 2006, for instance, Alaska reported high rates of chlamydial infection (715 cases/100,000 population) compared with the United States as a whole; northern Canada reported high rates of chlamydial infection (1,693 cases/100,000) and gonorrhoea (247 cases/100,000) compared with southern Canada; and Greenland consistently reported the highest rates of chlamydial infection (5,543 cases/100,000) and gonorrhoea (1,738 cases/100,000) in the Arctic. Rates were thus high for both men and women, albeit the highest incidence of infection was predominantly reported for young women in their early twenties. Finally, Law et al. (2008) propose that community-based participatory research is an appropriate approach to improve sexual health in Arctic communities of North America.

SRH facilities in New York were accessible to young clients in several ways, including not requiring scheduled appointments for method refills (67%) and having flexible hours (64%). Most facilities provided outreach and/or education to young people (70%), and 27% used social network media to

do this. Most facilities took steps to ensure confidentiality for young clients. Therefore, Kavanaugh et al. (2013) conclude that improving the ability of family planning facilities to provide youth-friendly contraceptive and long-acting reversible contraception, LARC-specific methods to younger clients may increase the use of highly effective contraception in this population.

There has been significant global progress in expanding the use of contraceptives by women. By 2009 in New York, an estimated 63% of women aged 15–49 who were married or in a union were using some forms of contraception (UN, 2011). During the past decade, the annual rate of increase in contraceptive prevalence was lower than in the 1990s and unmet need for family planning remains moderate to high in many regions of the developing world, according to the same source.

In USA, a study was conducted among young black males who were attending clinics that had diagnosed and treated sexually transmitted infections. They found that the occurrence of errors in condom use and problems was largely unrelated to being drunk or high during sex. Therefore, the authors recommend that suggest that safer sex intervention programs that focus on avoiding alcohol and drug use may not be optimally serving this population.

2.5 SRH in Latin America

In the Western Region of Jamaica in Latin America, Walcott et al. (2014) conducted a cross-sectional survey of 549 men aged 19-54 years. The results of this study highlighted the need for behaviour-change interventions addressing gender norms targeting Jamaican men.

In Jackson of Mississippi, Austin et al. (2014 in HCP 2010) shows that the lesbian families and lesbian sororities and fraternities among the lesbian, gay, bisexual and transgender community have played role in meeting the sexual and reproductive health needs of marginalized populations and should be incorporated into community-based popular opinion leader or lay health advisor's

interventions.

2.6 SRH in Europe

Intimate partner and sexual violence affect a large proportion of the population in London, UK (WHO, 2010), with the majority of those directly experiencing such a violence being women and the majority perpetrating it being men. The harm they cause can last a lifetime and span generations, with serious adverse affects on health, education and employment. The primary prevention of these types of violence will therefore save lives and money. Investments made now to stop intimate partner and sexual violence before they occur will protect the physical, mental and economic well-being and development of individuals, families, communities and whole societies.

Nicolopoulou-Stamati et al. (2007) argue that the scope of environmental impact on reproduction health of females and males in United Kingdom is very large. Therefore, for women, effects include: direct lesions of the oocyte, with possibilities of chromosomal abnormalities but also malformations of the reproductive tract. For men, effects include: poor semen quality, through low numbers or reduced motility or fertilizing ability of spermatozoa, and malformations of the reproductive tract. Against this background, and with a holistic view of the world, an urgent ecological approach is warranted. It is by acting now and protecting in particular the children that we will be able to see in ten to twenty years the preventive effects in terms of reduced morbidity and mortality for several diseases, not limited to the reproductive ones.

There may be a potential gender and age differences in the performance of five condom-related behaviours in the United Kingdom. Safer sex is important and comprises of a series of five condom-related behaviours: accessing, carrying, negotiating, using and disposing. The empirical data indicated that gender differences exist for accessing, carrying and disposing behaviours. An age

difference was generally seen in accessing behaviour. Therefore, future safer sex interventions should acknowledge the potential gender and age differences in these condom-related behaviours.

Regarding emergency contraceptives (ECs) in UK, the same source indicated that the majority of respondents (92%) were positive about a pharmacist supplying a POP at the time of EC. The researchers conclude that a reasonable proportion of women requesting EC would like to start using an effective contraceptive method. Both the women and the SRH clinicians show positive about the option of a short supply of a POP being provided by the pharmacy together with EC in the UK.

2.7 SRH in Pacific and Asia Region

As little is known about sexually transmitted infection (STI) testing among Chinese men who have sex with men (MSM), a researcher studied these issues and indicated a high prevalence of STIs and low testing rates among MSW in Shanghai, China. In addition, the authors suggest that future HIV and STI interventions should be tailored to the needs of different subsets of MSW.

Vallely et al. (2014 in WHO 2010) state that there is one of the highest prevalence rates of HIV and STIs in Papua New Guinea of the Asia-Pacific Region. They undertook a longitudinal cohort study at two sexual health clinics and thus documented the prevalence and incidence of STIs, HIV and penile cutting were found to be high and over eighty percent of the follow-up was achieved at one year.

Authors argue that access to HIV treatment and care varies between countries in Asia and the Pacific because the differences between high-income economies and the rest of the Region are remarkable. Many high-income countries provide their citizens with ART, while middle- and low-income countries have rapid ART scale-up and are dependent on international funding in that the MDG of achieving universal access to ART mainly requires for targeting low- and middle-income countries.

Indian women and men had a positive attitude towards the concept and use of microbicide products, but the need for HIV chemoprophylaxis is greatest for high-risk groups (like female sex walkers and men who have sex with men. The same authors further underscore that the underlying determinants for acceptability of HIV chemoprophylaxis include the individual, couple dynamics and the larger social and cultural context.

2.8 SRH in Sub-Saharan Africa

Each year, nearly one-third of pregnancies in Burkina Faso are unintended. The vast majority of unintended pregnancies in the country are mistimed (occurred too soon) rather than unwanted (occurred after the woman had reached her desired family size) — 87% versus 13%. Of all women who currently want to avoid pregnancy, almost two-thirds are either not using any contraceptive method or are using a relatively ineffective traditional one (Guttmacher Institute, 2012). Together, these women are considered to have an unmet need for modern contraception. This measure is greatest among the poorest women: Nearly, 90% of women wishing to avoid pregnancy in the lowest wealth quintile have an unmet need for a modern contraception.

2.9 SRH in East Africa

Some factors exist which seem to be correlates of condom use among males in Sudan, East Africa. In Khartoum of North Sudan, Mohamed (2014) stated that 12% of 804 respondents aged 20-40 years reported condom use, 46.3% of them were non-users due to the main predictors like their awareness of someone who was infected with or died of AIDS, experiencing condom problems and types of sexual partners.

2.10 Policies and Strategies in Ethiopia

The National Youth Policy of Ethiopia (MoWCYA, 2004**)** covers issue of Sexual Reproductive Health (SRH), specifically that addressed most vulnerable groups (such as those out of school, youth

with special needs [female youth, pastoralist youth, and youth infected and affected by HIV/AIDS, physically and mentally impaired youth and orphans]).

In response to the Policy and in recognition of the role unemployment and poverty plays in facilitating SRH problems, the Government of Ethiopia has developed a Youth Development Package. The Package offers employment opportunities and youth centres as a space where young people could come together and engage in their own development (MoWCYA, 2010).

The National Adolescents and Youth Reproductive Health Strategy (2006 – 2015) was developed in response to the growing concern in provision of adolescent and youth SRH services and to meet goals of the health sector. The Strategy recognizes the diverse needs and vulnerabilities of adolescents and youth in Ethiopia and calls for tailored approach to those aged 10-14, 15-19 and 20-24 years of age. This particular Strategy reflects the Government's commitment to improve the sexual and reproductive health of adolescents and youth.

Complementary to this, the Strategic Planning for Multi-sectoral HIV/AIDS Management (SPM II, 2010-2015), identified young people in higher education institutions, out of school youth, to be prioritized by HIV prevention program. Key programmatic interventions and activities identified by the Second SPM for School-Based HIV Prevention Programme include: life-skills based HIV education; peer education; school community conversation; HIV information and education. including Youth-friendly services (HCT, STI and condom) through expansion of AIDS information centres; strengthening of girls clubs, anti-AIDS club, and mini-media clubs and training of teachers on management of school HIV/AIDS programs, provision of life-skills based HIV education as key strategy to strengthen school-based programs, etc. (FHAPCO, 2009).

2.11 SRH in Ethiopia

In the National Guidelines for Family Planning Services in Ethiopia, FGAE (2011) states that the modern FP services in Ethiopia were pioneered by the Family Guidance Association of Ethiopia (FGAE), which was established in 1966. The FGAE's first FP services were provided from a single-room clinic run by one nurse. FGAE's Programmatic activities and services gradually spread all over the country, with a network of eight branches, 18 clinics, 26 youth centers, 740 community-based reproductive health (RH) service outlets, 242 outreach sites, six marketplace sites, and eight workplace sites. The Ministry of Health (MOH) also began to enhance the effort through provision of maternal and child health (MCH) and FP services in health facilities. Since 1980, the MOH has further expanded its FP services through cyclic country support programs by the United Nations Population Fund (UNFPA) and other stakeholders. Following Ethiopia's adoption of a Population Policy in 1993, local and international institutions partnered with the Government of Ethiopia in expanding FP programs and services.

The MoH (1996 in MoH, 2011) released Guidelines for Family Planning Services in Ethiopia to guide stakeholders as well as to expand and ensure the quality of FP services. Moreover, other policy and strategic documents emphasize that the integration and the linkage of FP services with other RH services to enhance FP utilization. Consequently, knowledge of FP has increased to 87% among currently married women.

MoH (2011) in the National Guidelines showed that **f**ewer than 10% of married girls aged 15–19 years were found to use any types of modern FP method. According to Central Statistical Agency (2006), almost one-third (31.1%) of Ethiopian adolescents experienced an unwanted or mistimed live birth, indicating limited access to FP services or access to less youth-friendly services.

Unmarried and married youth may have different sexual, FP, and other SRH needs. FP services can create an opportunity to discuss STIs, HIV, GBV, and other SRH issues because of ignorance and psychological and emotional immaturity, adolescents' and youths' compliance with the use of FP methods.

Many women and couples in Ethiopia do not have the knowledge, tools or assistance they need to maintain their reproductive health and have the number of children they desire (Guttmacher Institute, 2011). Consequently, many women have more children than they want or can care for. Others turn to induced abortion, which remains predominantly unsafe and clandestine in Ethiopia although it may be legal under some conditions. By helping women and couples plan their families and have healthy babies, improved reproductive health care, including increased access to contraceptive services would contribute directly to attaining three of the Millennium Development Goals (MDGs): reducing child mortality, improving maternal health and promoting women's empowerment and equality. In addition, an improvement in contraceptive services would contribute to an effort of meeting three other MDGs.

With regard to components of SRH services in Ethiopia, a minimum package of youth-friendly SRH services include facilities includes the following:

- Information and counselling on sexuality, safe sex and reproductive health;
- Contraception and protective method provision (with an emphasis on dual protection);
- STI diagnosis and management;
- HIV counselling (and referral for testing and care);
- Pregnancy testing and antenatal and postnatal care;
- Counselling on sexual violence and abuse (and referral for needed services); and

• Post-abortion care (PAC) counselling and contraception (with referral when necessary) (Pathfinder, 2003 in DFID, 2011).

DFID (2011), quoting the Family Health International (2002), has identified the following list of needs and areas for improvement throughout the nation:

- Creating an environment conducive to sexual and reproductive health for Ethiopian youth;
- Involving young men and women in the design and implementation of programmes;
- Decreasing risk-taking behaviour through education and communication activities;
- Promoting the prevention of unwanted pregnancies, STIs, and HIV infections;
- Enacting policies, programmes and enforcing laws that address the harmful social norms that negatively affect girls and young women;
- Creating youth-friendly services at the local level; and
- Developing programmes for youth with special needs.

The FMoH (2011) has stated the following regarding the provision of School-based services of sexual and reproductive health services, including FP services in school settings and in institutions of higher learning, the service have the benefit of accessing an easy-to-reach and known population of youth. Student clinics in these academic institutions not only provide young people with objective information on sexuality and responsible sexual behaviors, but also they can offer opportunities for offering HIV testing, STI prevention and early management and FP services.

In the same framework, the Ministerial Office continues its description of the school-based interventions as follows:

It is building the capacity of health providers who is working in student clinics and equipping them with necessary materials, equipment and supplies. In addition, it should involve establishing and /or strengthening referral arrangement between student clinics and health facilities (hospitals and health centers) for FP services that are not offered in the student clinics. Prevention of unwanted pregnancy should be a main component of the intervention in schools. The intervention should use various strategies tailored towards the need and status of in school youth. Such strategies should include Peer education, Mini media, Youth dialogue, Talk shows, Edutainment and infotainment, Radio Programmes, Debates, Drama/Theater (Forum Theatre), IEC/BCC materials development and distribution to the Student clubs.

The document on the National Guidelines for Family Planning Services in Ethiopia suggests:

The FP services need to be youth-friendly. That is, there should be friendly procedures to facilitate easy and confidential registration, short waiting times, swift referrals, and consultations available with or without an appointment. The providers should be competent, with good communication skills, motivated and supportive, informative, and responsive to questions and concerns. Such services should be affordable, offer privacy, should maintain confidentiality, and should be conveniently located, with convenient working hours. Adolescents should be involved in planning and service delivery. Such programs should have comprehensive service packages and ways of increasing access with outreach and peer-to-peer services. The providers should have evidence-based guidelines and services with a management information system. The minimum service standards for adolescent and youth RH should be observed.

In 2011, FMoH underlined the varied RH needs of adolescents in the following manner:

Adolescents prefer RH services to be under one roof. Hence, all efforts should be made to provide FP and other RH services in youth centers and student clinics of higher learning institutions. IEC/BCC messages should be gender and age oriented and should recognize the special needs of adolescents and youth. Good counseling and support is particularly essential. Ensuring privacy and confidentiality is particularly important in addressing the FP needs of adolescents and youth. Married adolescents require FP services to delay and space childbirth. Unmarried adolescents may have more than one sexual partner, behavior that predisposes them to STIs more than older people. Hence, dual use of FP methods should be included in counseling sessions. Youth who are not sexually active should get information and education on FP. As casual and forced sex is more prevalent among youth than among older people, provision of ECPs and condoms to youth in advance is recommended. All contraceptives can safely be used by adolescents. However, specific attributes of the different FP methods for use by adolescents should be discussed during counseling.

2.12 Prevalence of SRH Related Problems in Public Universities

The level of SRH related problems and factors that intensify them are far higher than expected. This has been shown in different studies conducted in our country. Desalegn et al. (2011 in WHO, 2012) highlight that significant proportion of students do not perceive that university students to be at high-risk of HIV infection; have stigmatizing attitude towards PLWHA; and also were not tested for HIV. Other predisposing factors identified in the same study include: lack of parental control, prior expectation and outside environment (i. e. presence of video houses, chat houses and night clubs).

Health Communication Partnership (2010) shows that half of college students are at zero risk or low risk, **o**ver one third of men and almost one fourth of women are at risk of infecting with HIV. Some of the specific findings were almost 1 out of 7 women was forced to have sex, Many guys became aggressive and forced women to have sex after they had had a few drinks, love and trust are primary reasons girls and guys on campus have sex without condom. Perhaps, 1 out of 3 students that was tested for HIV and resulted positive were found to be victims of "Love and Trust".

Saba (2006) has substantiated the above situations and found out that 110(29.81%) students were found to have not yet engaged in any types of sexual intercourse; of whom 18(16.4%) were females. The mean age of first sexual debut was 17.9 years (+2.2). Among the sexually active students, 33.7% had multiple sexual partners and 37.3% had sex after alcohol consumption. Trusting one's partner and falling in love were the major reasons for not using condoms. Twenty (5.42%) of the students claimed their chance of contracting HIV/AIDS was high, while 93 (25.20%) said there was no chance at all. Aluede et al. (2006) reason out that as students of higher institutions who had resided in a separate compound and usually away from their parents, were more exposed to SRH problems than out of school youth.

Seife (2007) found out that the magnitude of SRH related problems was high. This study found out that the magnitude of sexual violence was as high as 47.9% and unwanted pregnancy was 16.9% for those who had practiced sex.

HEI (2012), citing UNAIDS (2004), states that those students at tertiary or higher education institutions are more vulnerable to HIV and AIDS than other formal institutions of learning because these institutions have been catering for sexually-active young people, mostly in their 18-30 years old category (i.e. an age group with a high rate of HIV prevalence, which is largely a result of unprotected sexual relations).

The young people in high schools and higher educational institutions are vulnerable and they are at risk to HIV infection due to various reasons that may include: unprotected casual sex and multiple sexual partners, lack of comprehensive knowledge about HIV/AIDS, sexual and reproductive health, lack of access to HIV services, sexual experimentation, early sexual debut and peer pressure, and other related factors (FHAPCO, 2011 cited in HEI, 2012).

2.13 SRH Service provision in Higher Education Institutions

Desalegn et al. (2011), based on the findings of a study conducted at 5 major higher education institutions in Ethiopia concerning their efforts of preventing and controlling HIV/AIDS, a total of 947 (16.8%) of the students considered the services provide as very good or excellent. That means, almost 84 % of the respondents did not consider them as a good one.

The same source further confirmed that there were some differences among the universities in terms of the types and quality of service provided. Mostly, HIV related services were either poor or did not get provide in the institutions. In addition, the HIV-related services in the universities, such as PICT, VCT, the involvement of students in HIV Prevention Clubs were generally found to be poor. On the

contrary, VCT service was available in the campuses of the universities, but the service appeared to be less attractive as the providers were not as such active and were not consistent.

Some female students who participated in the FGDs came up with different views on the issue under consideration while they were using other windows in the same framework. The discussants said: *We had witnessed the existence of HIV/AIDS-related services which required further improvements or strengthening. The anti-AIDS Club in the campuses of the universities have been giving good services in terms of raising first year students' awareness of HIV/AIDS in particular as well as educating the students in general." One of the key informants from anti-AIDS Clubs conformed the above-stated empirical evidence, as she expressed: Being one of the members of the Club at least I have been able to change myself thereby getting protected from the infection."*

HEI (2012), on the other hand, identified main underlying factors which may serve as that had exposed the students of HEIs to SRH problems. These factors include: HIV/AIDS; lack of youth friendly sexual and reproductive health services, economical problem, lack of proper counselling, environmental influence (night clubs, bars, chat chewing places, etc.), lack and/or absence e of condom near or inside university campus, etc.

The same Organization reveals that health providers in most of the HEIs are not trained to respond to the needs of the young persons in their respective setting. A study conducted in Addis Ababa by Yordanos (2009) may serve as empirical literature to substantiate the foregoing statements. According to this study, Clinics at Addis Ababa University were found to provide SRH services to only 14.6% its students. Most of the University's students confirmed that they preferred to look for other alternative providers for SRH service as the service providers were reported to be not friendly. Hence, shortage of youth-friendly health and counselling services has already posed significant

challenges to address the SRH issues, including HIV prevention in the public universities in Ethiopia.

On the whole, this study used inductive approach to answer those research questions and to address the objectives of the study. It mostly used empirical observations and then focused on looking at these thematic quantitative as well as qualitative data through social work perspectives.

CHAPTER III

RESEARCH DESIGN AND METHODS

3.1 Description of the Study Area

The study was conducted in Samara University. The University is found in Samara town which is the capital city of the Afar Regional State. Based on the 2007 Census conducted in Ethiopia, the CSA (2010) states that the Afar Regional State has a total population of 1,390,273; consisting of 775,117 males and 615,156 females. Disaggregated by living residence, 185135 were urban inhabitants or it accounted for 13.32% of the total population. With an estimated area of 96,707 square kilometres, this Region has an estimated density of 14.38 people per square kilometre. According to the Report on the 2007 Census, there were 247,255 households, which resulted in an average for the Region of 5.6 persons to a household, with urban households having on average 4 and rural households 6 people in a room. According to the 2011 Ethiopian Demographic and Health Survey, HIV/AIDS prevalence rate of the Region was found to be 1.8%; of which the female's HIV prevalence rate was 2.0% and that of the males (1.7%). Thus, females are more vulnerable than males.

Samara University, according to the 2011/12 Academic Year Records in the Registrar Office, there were a total of 3314 regular students; out of which 43 % of them were females. Out of the total students in the University, 973 were prospective graduating students. Accordingly, , the University at least hosts 2341 students from second year to fourth year levels in 2012/13 Academic Year. Moreover, a total of 1300 freshman students already joined the University for the Academic Year, which made the total number of student population to 3641. The University is generally structured into seven faculties and more than ten departments.

Table 3.1: Distribution of Respondents by Sex and Year of Study

Sex	Year of Study				
	1st year	2nd year	3 rd year	4th year	Total
Male	6 (14.0%)	6 (14.0%)	4 (9.3%)	6 (14.0%)	22 (51.2%)
Female	3 (7.0%)	5 (11.6%)	7 (16.3%)	6 (14.0%)	21 (48.8%)
Total	**12 (20.9%)**	**11(25.6%)**	**11 (25.6%)**	**12 (27.9%)**	**43 (100.0%)**

Source: Registrar Office of Samara University, 2013

Table 3.1 shows the total number of students in the study is 43. Equal proportion of students was taken from freshman students, and fourth year students. The same holds true for sophomore and third year students in the University. Thus, more number of male students participated in the study. There is also male dominance in the University although the concerned bodies have been performing multi-faceted activities.

As depicted in Table 3.2, more than quarter of the respondents were from FBE (26.1%) and pursued their study in the Department of Management (26.1%). Even though the Ethiopian Government's Education Policy focused on natural sciences, this study came up with empirical evidence contrary with the current practice (i. e. 70:30 which is 70% of the students from natural sciences and 30% from the social sciences).

Table 3.2: Distribution of Sample Students by Sex, Faculty and Department (2012/13)

Sex	Name of Faculty							
	FMHS	**FSSH**	**FENG**	**FVM**	**FDA**	**FBE**	**FNCE**	**Total**
Male	1 (2.2%)	4 (8.7%)	1 (2.2%)	0 (0.0%)	4 (8.7%)	9 (19.6%)	5 (10.9%)	24 (52.2%)
Female	0 (0.0%)	7 (15.2%)	1 (2.2%)	1 (2.2%)	5 (10.9%)	3 (6.5%)	5 (10.9%)	22 (47.8%)
Total	**1 (2.2%)**	**11 (23.9%)**	**2 (4.3%)**	**1 (2.2%)**	**9 (19.6%)**	**12 (26.1%)**	**10 (21.7%)**	**46 (100.0%)**
Sex	**Department**							
	Public Health	**Anthropology**	**Engineering**	**Vet. Medicine**	**Animal science**	**Management**	**Biology**	**Total**
Male	1 (2.2%)	4 (8.7%)	1 (2.2%)	0 (0.0%)	4 (8.7%)	9 (19.6%)	5 (10.9%)	24 (52.2%)
Female	0 (0.0%)	7 (15.2%)	1 (2.2%)	1 (2.2%)	5 (10.9%)	3 (6.5%)	5 (10.9%)	22 (47.8%)
Total	**1 (2.2%)**	**11 (23.9%)**	**2 (4.3%)**	**1 (2.2%)**	**9 (19.6%)**	**12 (26.1%)**	**10 (21.7%)**	**46 (100.0%)**

Source: Registrar Office of Samara University, 2013

3.2 Research Design and Methods

Non-experimental research design was employed in this study. A combination of both quantitative and qualitative research methods were also used to generate primary and secondary data from the respective sources. Regarding the quantitative research method, the researcher used descriptive sample survey using well-structured interview schedule or questionnaire. Qualitatively, the researcher organized and held semi-structured interviews with selected key informants to substantiate and triangulate the data

collected from other sources, conducted four focus group discussions composed of eight discussants from each gender in the study. Students and staff members were participating in separate FGD in their respective gender groups. In addition, the researcher undertook observations of relevant aspects of the University's setting. In the study, there were documentary analyses of relevant documents which were available as published, unpublished and web-based materials at different resource centres of different levels of the Samara University.

3.3 Universe of the Study

The major purpose of this research was to assess the availability, accessibility and quality of SRH and related information, education as well as other services at Samara University which is located in North East part of Ethiopia. Based on the 2007 Census conducted by the CSA, the target population at Samara University for this study was 3641 students in seven faculties and more than ten departments in the 2012/13 Academic Year. In the end, the sample size of the study was 50 students at different levels of schooling year.

3.4 Sampling Method

Purposive sampling of non-probability sampling method was generally employed to collect qualitative data from different informants. In so doing, proportionate stratified sampling method (which is one of the types of probability sampling method) was used to select randomly the sample respondents for descriptive sample survey.

A descriptive sample survey was undertaken to collect qualitative data on views of sampled students at different faculties and departments of Samara University. Purposefully, a total of 20 staff members and voluntary staff were selected to generate pertinent data on their views on those issues under investigation.

3.5 Data Collection: Procedures and Tools

At the outset of the actual study undertaking, the researcher collected list of faculties and number of students by sex in each faculty from the Registrar Office of the University. At the end of each class session, the sample students were informed about the study and requested for their voluntary participation in the undertakings. Afterwards, having got their respective consent, a serial number was given for each male and female student independently starting the number one. Then, the samples were selected at one step using systematic random sampling method proportional to the size of each and every faculty in the University. This allocation technique was employed to obtain reasonable number of the sample respondents from both sexes.

Before distributing the interview schedule to each respondent, the researcher first reassured the students that the pieces of information given were kept confidential and they would be used only for the academic purpose. In addition, the respondents were requested to give accurate answers about their characteristics and other issues presented in the schedule. Finally, the completeness of the information given on each item in the schedule was checked and verified on a daily basis following the data collection. Moreover, each item in the interview schedule was checked before data entry into SPSS template.

In order to collect quantitative and qualitative data on those issues, the researcher used interview schedule, interview guide/protocol, FGD schedule, observation schedule and documentary analysis template/matrix. Let us describe each of the tools one by one separately.

3.5.1 Interview Schedule

A pre-tested interview schedule or questionnaire was used to collect data from the sample students in Campuses of the University. This schedule consists of the respondents' background information, close-

ended questions on availability, accessibility, quality of SRH services of Samara University. It also consists of open-ended questions on the strengths, constraints and suggestions to improve the services provided. It was pre-tested on 20 students at private college which was not included in the study. Then, the researcher first incorporated those relevant comments and the interview schedule was edited before it was used in the actual data collection. The researcher further got aware of as to how to approach the actual data collection by the help of two staff members of the HIV/AIDS Prevention and Control Unit in the University.

3.5.2 Interview Guide/Protocol

The researcher first prepared interview guide/protocol and then used it to collect qualitative data from five selected key informants by conducting semi-structured interviews with them. The targets of the interviews were staff members of HIV/AIDS Coordinating Unit (1), Students' Dean Office (2) and the Clinic of the University (2).

3.5.3 Focus Group Discussion Schedule

In order to gain further information on availability, quality, strengths, constraints, and further suggestions to improve the provisions of SRH and related services in the University, a total of four focus group discussions (one group from each sex) were conducted. Thus, the researcher conducted four FGDs among male and female students of the University as well as the staff members of University. Totally, four discussions composed of eight discussants from each gender category. In the schedule, list of questions was prepared to conduct the sessions and was used to facilitate the focus group discussions at convenient venue by the researcher as facilitator. In addition, the FGD sessions were taken as notes by the researcher. The discussants or participants were selected on a voluntarily basis from the students of both sexes and other relevant officials/staff of the University.

3.5.4 Observation Schedule

The researcher conducted observations of the SRH and related services which were being provided to the students in the University's compounds using observational schedule. Besides, observations of other relevant aspects of the University in the light of availability, accessibility as well as quality of those services were made to triangulate the data generated using other research methods and tools.

3.5.5 Documentary Analysis Template

The researcher identified and analyzed relevant published, unpublished and web-based documents in order to generate pertinent categories of themes. For this purpose, list of working bibliography on various issues under investigation in this study was well-prepared.

3.6 Data Processing and Analysis

After the completion of the data collection, the researcher checked and verified the completeness of data for those questions in the interview schedule and other tools of qualitative data collection. Then, the quantitative data was entered into computer using SPSS Data View template and cleaning was done to maintain accuracy and internal consistency before any statistical test was run. The quantitative data analysis was done using the latest version SPSS software. The results of the data analyses were presented using descriptive statistics (such as frequencies, proportions, graphs, charts, figures, measures of central tendency and dispersion). Moreover, some measures of association and correlation were employed. The qualitative responses from semi-structured interviews, focus group discussions, observations and documentary analyses were transcribed verbatim and analyzed using thematic analysis technique. Afterwards, the qualitative findings were presented theme by theme in order to triangulate the findings of the quantitative aspect of the study. Finally, these thematic findings were integrated into those of the quantitative ones while writing-up the MSW thesis.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

4.1 Profile of the Study Participants

The study was planned to be conducted collecting data from a total of 50 students at Samara University based on equal sex basis. In the process of actual data collection, a total of 46 properly filled in questionnaires were returned to the student researcher which made the response rate of 92%. Out of them, 24 (52.1%) of them were males, while 22(47.8%) of them were females. Thus, one may deduce that there is male dominance at tertiary level educational institutions in Afar Regional State, albeit the Ethiopian Government has been working to reduce the gender disparity in the educational system.

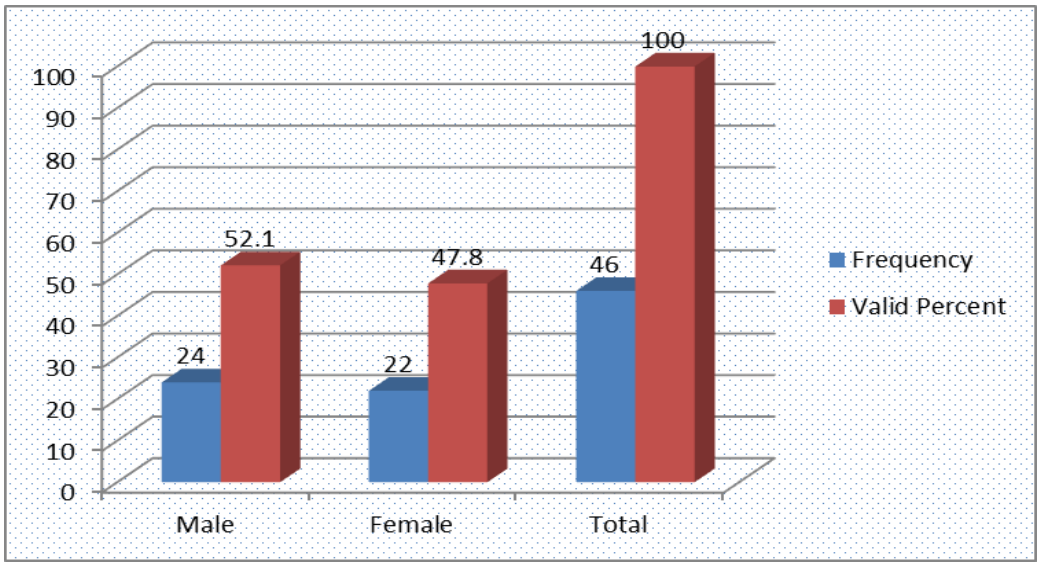

Fig. 4.1: Sex Composition of Sampled Students

Samara University, according to the 2004/05 Academic Year, already registered 4 batches of students in 7 faculties and departments. This study was undertaken by taking these facts into consideration.

Ethnicity was one of the variables requested to be filled in the questionnaire by the respondents. As shown in Table 4.2, Amhara as ethnic group appears to be a significant one. Fourteen (fifty-six percent) of them were Amharas, followed by five (twenty percent). The study documents quite surprising empirical evidence. Therefore, those students were assigned to pursue their further studies at Samara University elsewhere in the country.

Table 4.2: Ethnicity of Student Respondents in the Study

Sex	Ethnicity						
	Oromo	Amhara	Somali	Benishangul-Gumuz	Sidama	Afar	Total
Male	0 (0.0%)	9 (36.0%)	1 (4.0%)	1 (4.0%)	2 (8.0%)	0 (0.0%)	13 (52.0%)
Female	5 (20.0%)	5 (20.0%)	1 (4.0%)	0 (0.0%)	0 (0.0%)	1 (4.0%)	12 (48.0%)
Total	**5 (20.0%)**	**14 (56.0%)**	**2 (8.0%)**	**1 (4.0%)**	**2 (8.0%)**	**1 (4.0%)**	**25 (100.0 %)**

In the same way, about half (48.8%) of the respondents were found to be affiliated to Orthodox Christianity. In addition, 9(22.0%), 8(19.5%) and 4(9.8%) were Muslims, Protestants and Catholics, respectively.

Amongst 46 sampled students, an equal number of students, 23 (50.0 %) from social sciences and natural sciences was randomly selected and participated in the study. Moreover, the sex distribution of the respondents showed that 10 (21.7 %) and12 (26.1 %) of them were females who attended their schooling in different fields of study in the social science and natural science streams while they

were in high schools. Thus, the participation of female students shows some degree of skewness towards natural sciences in the secondary education cycle of Ethiopia.

4.2 Background Data on SRH at the University

In the study, the researcher wanted to know whether or not there had been SRH providing facility in the Campus of Samara University. Out of the 46 respondents, 15(33.3%) of them were found to be aware of the presence of SRH, but equal proportion of the responding students lacked such an awareness (see Table 4.3). More than two-third (65.2%) of the respondents went to the facility to get any type(s) of service(s). A significant majority (more than seventy-eight percent) of them, on the contrary, did not go to the health facility to obtain SRH services. In the same vein, half of the student respondents surprisingly did not visit the health facility for the last six months. More than three-fourth (78.3%) of them were found to be clients of the health facility at the University for unstated other SRH problem(s). Therefore, the findings of the study clearly indicated that there were striking gaps in awareness and actual practice of obtaining as well as proper utilization of the various types of SRH service at Samara University.

4.3 Availability of SRH services

In order to assess the availability of SRH services in the University, a total of twenty-two relevant questions were prepared and presented to the sample respondents. In the first place, a majority (about eight-five percent) of the respondents strongly disagreed and/or disagreed to the question which stated that there was enough number of health professionals in Samara University. Secondly, a total of 28 (63.1 %) of them were found to rate it at strongly disagree and/or disagree scale(s) because they said that the Health Facility at the University did not publicize its services to the student community members; whereas 11(23.9 %) of the respondents agreed that it publicized its services to the students. The third availability question was about the SRH-related health education

organized by the Health Facility of Samara University. A total of 46 students replied to the question posed. Out of them, more than half of the respondents, 26(56.6 %) expressed that the University did not organize such educational events, while 12(26.1 %) of the students confirmed that the Health Facility organized and conducted events on health education in the Campus. A total of 8(17.4 %) of were found in the response category of neither agree nor disagree.

Table 4.3: Background Issues about SRH Services in the University

SRH providing facility					
Yes	No	Don't know			Total
15 (33.3%)	15 (33.4%)	15 (33.3%)			45 (100.0%)
Yes		**No**			**Total**
30 (65.2%)		16 (34.8%)			46 (100.0%)
Going to facility for SRH service					
Yes		**No**			**Total**
10 (21.8%)		36 (78.3%)			46 (100.0%)
one time	**two times**	**three times**	**four times**	**not at all**	**Total**
8 (17.4%)	2 (4.4%)	10 (21.7%)	3 (6.5%)	23 (50.0%)	46 (100.0%)
For which SRH Problem(s) has/have you visited the facility?					
STI related	**FP**	**HIV related**	**All**	**Other(s)**	**Total**
1 (2.2%)	3 (6.5%)	5(10.9%)	1(2.2%)	36 (78.3%)	46 (100.0%)

Similarly, the availability question was asked in relation to SRH-related peer education.24 (52.1 %) students have replied by saying disagree or strongly disagree. On the other hand, 15 (30.0%) students said that the Health Facility or others organized SRH-related peer education sessions in the Campus of the university. The fifth question was on any linkages the peer education had with the services the Health Facility provided. Totally, 43 (86.0%) of the sampled students expressed their attitude towards the issue under investigation. Amongst of them, 29 (67.4 %) disagreed on different levels of degree, but 9(20.9 %) agreed that the Programme on Peer Education was linked to the services provided by the Health Facility to the student clients.

A total of 26 (56.5 %) respondents strongly disagreed and/or disagreed that provision of standard FP counselling service was available, but 10 (21.7%) students were found to neither agree nor disagree regarding the available of the service in the Campus (see Table 4.4.1). Twenty-eight (about sixty-one percent) of the responding students in Samara University strongly disagreed and/or disagreed to the statement on the use of different IEC materials for purpose of health education.

In the same vein, services-related to pregnancy are not put in place in the University. Eighteen (about thirty-nine percent) of the respondents agreed that there were provisions of pregnancy related services, but about one-third (30.0%) of them argued that the services were found to be unavailable in the University's Campus.

Table 4.4.1: Availability of SRH services

Indicators	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Available number of health professionals	24(52.2%)	15(32.6%)	1(2.2%)	2(4.3%)	4(8.7%)
Facility services publicized	21(45.7%)	8(17.4%)	6(13.0%)	9(19.6%)	2(4.3%)
SRH-related health education	17(37.0%)	9(19.6%)	8(17.4%)	9(19.6%)	3(6.5%)
SRH related peer education	14(30.4%)	10(21.7%)	7(15.2%)	9(19.6%)	6(13.0%))
SRH-related linkage peer to health facility services and all services programmes	16(37.2%)	13(30.2%)	5(11.6%)	5(11.6%)	4(9.3%))
Facility provides standard FP counselling service	16(34.8%)	10(21.7%)	10(21.7%)	9(19.6%)	1(2.2%)
Facility uses different IEC materials for health education	13(28.3%)	15(32.6%)	8(17.4%)	4(8.7%)	6(13.0%)

A total of 23(53.2%) disagreed on statement about the availability of provision of infertility-related services, whereas about thirty-two percent of the sampled students in the study agreed that the services were available. Regarding the availability of provisions of prevention and management of complications of unsafe abortion, a total of 21(45.6 %) of the respondents disagreed. However,

sixteen (about thirty-five percent) of the students in the study agreed that the Health Facility in the University made avail and provided services-related to prevention and management of unsafe abortion complications. A total of 29(63.0%) of the students in the study conducted at Samara University, in contrast, disagreed that the Facility did not make available and provided safe abortion service.

4.4 Accessibility of SRH Services

Tables 4.4.2 through 4.4.5 show that the responding students in Samara University strongly disagree in almost all of the indicators included in the study to assess the availability, accessibility and quality of the SRH services. Out of 46 sample students who returned the interview schedule, thirty-four (about three-fourth percent) of them disagreed that the location of the Health Facility was inaccessible to the student community in the University.

Out of the sampled students, a total of 27(about 59.0%) of the respondents in the study, in connection with the statement on the Facility being inviting for service, agreed that the Institute was found not to be inviting, while 10(about 28.0%) of them agreed that the Health Facility was inviting.

Students were asked if Health Facility members were friendly. A total of twenty-five (56.8 %) of the respondents either strongly disagreed or were uncertain about the staff members in the Facility setting were client-friendly.

The infrastructure of the Facility is well-labelled as not as such inviting (see Table 4.4.2). The majority, 33 (about 82%) of the respondents strongly disagreed and/or disagreed that the infrastructure of the Health Facility at Samara University was inviting to go for SRH services. As to their attitude towards size of the Facility, thirty-five (about four-fifth) of them strongly disagreed and/or disagreed that its size was inviting. In the same framework, twenty-eight (about sixty-one

percent) of the students in the study disagreed and/or strongly disagreed on the statement about the inviting capc8ty of the Health Facility in the University. Therefore, the study indicated that the location, as well as the different aspects of the Facility infrastructure was poor. Samar University provides the SRH services in the Health Facility which is inaccessible and has less power to catch the clients' positive attitudes.

Table 4.4.2: Attitude of the Respondents towards Accessibility of SRH Services

Indicators	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
Accessibility of the location of the facility	23(50.0%)	11(23.9%)	6 (13.0%)	5(10.9%)	1(2.2%)
Facility service inviting	16(34.8%)	11(23.9%)	9(19.6%)	8(17.4%)	2(4.3%)
Facility staff members are friendly	17(38.6%)	8(18.2%)	8(18.2%)	9(20.5%)	2(4.5%)
Facility Infrastructure inviting	28(60.9%)	5(10.9%)	1(2.2%)	9(19.6%)	3(6.5%)
Facility size is inviting	19(43.2%)	16(36.4%)	1(2.3%)	6(13.6%)	2(4.5%)
Facility paint is inviting	16(34.8%)	12(26.1%)	10(21.7%)	4(8.7%)	4(8.7%)

As shown in Table 4.4.3, the respondents disagreed and/or strongly disagreed with the Health Facility efforts of providing different types of SRH services. The operational hours of the Facility was found not to be in line with the needs of the students, according to the reflections of 29 (63.1%) of them. The Samara University health Facility is reported as not publicizing its services in a place to the students so that they can clearly see or hear. Thirty-two (about seventy percent) of the respondents strongly disagreed and/or disagreed that the Health Facility of the University publicized clearly its services put in place.

With regard to the SRH-related health education and its efforts to address to male students, about sixty-three percent of the student respondents disagreed and/or strongly disagreed that with the claim of the University to address these services. When the students were asked about the same issue but

the provisions of the services to female students, twenty-seven (about fifty-nine percent) of them disagreed and/or strongly disagreed with such a statement on the part of the health Facility of the University. Concerning the provision of the same services to the able-bodied students, about fifty-seven percent of them strongly disagreed and/or disagreed that the University provided health education on SRH-related issues which addressed those able-bodied individuals in its Campus. Equal number and proportion of the respondents in the study disagreed and/or strongly disagreed that with the Facility addressed such services to the disabled students. Thus, one can deduce that the Health Facility in the University fails to address SRH –related health education services to its the best satisfaction level of those male, female, able-bodied and disabled clients.

In the same vein, the study shows that Samara University has not yet addressed its student clients' needs in peer education on SRH-related in general. About sixty-three percent of the respondents strongly disagreed and/or disagreed with the University's claim in addressing the male students' needs for SRH-related peed education. In addition, about one-third (28.3%) of the respondents were found to be not in the category of neither agree nor disagree scale regarding the provision of the services to the female students, but about one-fourth (23.9%) of them strongly disagreed that the Institution addressed the above-stated service to the female students. About fifty-five percent (54.4%) of the respondents strongly disagreed and/or disagreed that Samara University's argument over its provision of SRH-related peer education to able-bodied students in general. Equal proportions (about one-third percent) of the respondents in the study strongly disagreed and were found not to decide on what were addressed to disabled students about peer education on SRH-related issues. Therefore, the services provided to students from both sexes and based on their physical conditions are poor in that the students do not show positive attitude towards those types of the SRH-related services.

Table 4.4.3: Students Attitude to Accessibility of SRH-related Services

Indicators	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
Operational hours fit to the needs of students	21(45.7%)	8(17.4%)	5(10.9%)	8(17.4%)	4(8.7%)
Facility publicizes its service in a place students can clearly see/hear	21(45.7%)	11(23.9%)	5(10.9%)	6(13.0%)	3(6.5%)
SRH related Health education addresses male students	16(34.8%)	13(28.3%)	7(15.2%)	8(17.4%)	2(4.3%)
SRH related Health education addresses female students	17(37.0%)	10(21.7%)	6(13.0%)	8(17.4%)	5(10.9%)
SRH related health education addresses able-bodied students	17(37.0%)	9(19.6%)	6(13.0%)	8(17.4%)	6(13.0%)
SRH related health education addresses disabled students	12(26.1%)	14(30.4%)	7(15.2%)	12(26.1%)	1(2.2%)
SRH related peer education addresses male students	17(37.0%)	12(26.1%)	6(13.0%)	9(19.6%)	2(4.3%)
SRH related peer education addresses female students	11(23.9%)	9(19.6%)	13(28.3%)	5(10.9%)	8(17.4%)
SRH related peer education addresses able-bodied students	12(26.1%)	13(28.3%)	14(30.4%)	5(10.9%)	2(4.3%)
SRH related peer education addresses disabled students	15(32.6%)	9(19.6%)	15(32.6%)	4(8.7%)	3(6.5%)
SRH related peer programs involve different students' clubs	16(34.8%)	9(19.6%)	10(21.7%)	6(13.0%)	5(10.9%)

In the University, the Programmes on SRH-related Peer Education do not involve different students' clubs. About thirty-five (34.8%) and one-fifth (21.7%) of the student respondents were found to be in the categories of either undecided or strongly disagree concerning the issue under discussion respectively. Thus, different students' clubs are not actively involved in addressing SRH-related issues through the Programmes designed for this purpose in Samara University.

Table 4.4.4: Accessibility of SRH Services

Indicators	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
Facility provision of standard FP counselling service is addressing male students	14(30.4%)	5(10.9%)	10(21.7%)	8(17.4%)	9(19.6%)
Facility provision of standard FP counselling service addressing female students	14(30.4%)	13(28.3%)	2(4.3%)	13(28.3%)	4(8.7%)
Facility provision of standard FP counselling service addressing able-bodied students	9(19.6%)	12(26.1%)	5(10.9%)	18(39.1%)	2(4.3%)
Facility provision of standard FP counselling service addressing disabled students	13(28.3%)	10(21.7%)	6(13.0%)	8(17.4%)	9(19.6%)
Facility places different IEC materials at the spot where students can easily get	20(43.5%)	11(23.9%)	4(8.7%)	6(13.0%)	5(10.9%)
Facility offers prevention and treatment of infertility to all female students.	13(28.3%)	9(19.6%)	10(21.7%)	4(8.7%)	10(21.7%)
Facility provision of prevention and management of complications of unsafe abortion is accessible to any female students	16(34.8%)	10(21.7%)	13(28.3%)	3(6.5%)	4(8.7%)
Facility provides safe abortion services to any female student	15(32.6%)	9(19.6%)	12(26.1%)	7(15.2%)	3(6.5%)
Facility provides treatment of reproductive tract infections service to any student	12(26.1%)	9(19.6%)	9(19.6%)	12(26.1%)	4(8.7%)

Table 4.4.4 presents data on standard FP counselling services addressing male, female, able-bodied and disabled students, placing different IEC materials at the spot where students can easily get, offering prevention and treatment of infertility to all female students, accessible provisions of prevention and management of complications of unsafe abortion to any female students, provision of safe abortion services to any female student, as well as the provision of treatment for reproductive tract infections service to any student in Samara University. A total of 14(30.4%), 14(30.4%), 13(28.3%), 20(43.5%013(28.3%) 16(34.8%), 15(32.6%), 12(26.1%), 15(32.6%) and

17(37.0%) of the respondents strongly disagreed with those statements about the above-stated FP counselling and related issues respectively.

As Table 4.4.5 indicated, more than half of the respondents argued that STI drugs could not be easily available in the Health Facility of the University. A little bit smaller than two-third (63.1%) of the respondents expressed their strong disagreement and/or disagreement with the Health Facility's claim for its endeavours made to avail services for STDs and other conditions to any student in the University. About fifty-seven percent of them were also found to strongly disagree with the stamen about the easy availability of the drugs after any student had got diagnosed for the infection(s). More than two-third (67.4%) of student respondents in the sample study strongly disagreed and/or disagreed that the Health Facility could easily provide the diagnosed students with HTC services.

Likewise, about one-third (30.4%) of the respondents could not decide on their actual attitude towards the provision of ART services in the University. A total of 20 (43.4%) of the responding students in this study strongly disagreed and/or agreed with the availability of the provision of information and counselling on human sexuality, responsible parenthood and sexual and RH services. About one-third (31.1%) of the students in the survey strongly expressed their disagreement with the claims of the staff members of the Health Facility already availed pieces of information and counselling on reproductive health services for any student in Samara University.

A total of 21(about forty-six percent) of the respondents were found to be in neither agree nor disagree category. Moreover, twenty (about forty-three percent) of them strongly argued their disagreement to the discourse on the provision of active discouragement of harmful practices, such as female genital cutting service. However, 21(about forty-six percent) of them could not rate their attitude to the issue under investigation as either agree or disagree.

About 44 (88%) students have returned the paper filled. Out of these 44 students, a majority 19 (43 %) said the service is not available, 13 (29.5 %) report as the service is available while the remaining 12 (27.3 %) said they are not sure. Availability of provision of referrals and linkages for additional services was also negated by 23 (50.0%).

Like the previous cases, condom cannot be easily found in Samara University. A total of 20 (about forty-four) of the sampled students strongly disagreed and/or disagreed on the statement about easy availability of condoms in the University. On the other hand, equal proportion of the respondents expressed their mixed attitude towards the easy accessibility of mobile distribution of condom in the University. Eleven (about twenty-four percent) of the respondents strongly agreed, but the same proportion of them disagreed with very easy accessibility of mobile condom distribution outlets in places where the students could obtain it. fixed condom distribution outlets was said to be present by 23 (50 %) respondents. The idea was said as true by 16 (34.8 %) students while the remaining 7 (15.2 %) said they are not sure. 46 (92 %) have returned the paper while 4 (8%) failed to return it back in both cases.

Next, the accessibility of condom in Samara University to any needy student was responded well by twenty (43.5 %) respondents who confirmed that the services to be provided were not accessible to any needy student, while 16 (34.8 %) reported otherwise. In relation to the accessibility of mobile condom distribution outlets at the University, half of the student respondents argued that the condom distribution outlets were not accessible in that they expressed this as strongly disagreed and/or disagreed with the distribution made.

Table 4.4.5: Accessibility of SRH Services

Indicators	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
Facility's service on STDs and other conditions is accessible to any student	14(30.4%)	15(32.6%)	6(13.0%)	8(17.4%)	3(6.5%)
Any student can easily get the STI drugs after s/he has got diagnosis from the Facility	17(37.0%)	9(19.6%)	9(19.6%)	8(17.4%)	3(6.5%)
Students of the University can easily get HTC service from the Health Facility	17(37.0%)	14(30.4%)	6(13.0%)	8(17.4%)	1(2.2%)
The provision of Anti-retroviral Treatment (ART) is very easy for HIV positive students	11(23.9%)	6(13.0%)	14(30.4%)	12(26.1%)	3(6.5%)
Getting information and counselling on human sexuality is accessible for any student	10(21.7%)	10(21.7%)	11(23.9%)	5(10.9%)	10(21.7%)
Getting information and counselling on reproductive health is accessible for any student	14(31.1%)	5(11.1%)	10(22.2%)	6(13.3%)	10(22.2%)
Students have access to an active discouragement of harmful practices, such as female genital cutting services	10(21.7%)	10(21.7%)	21(45.7%)	4(8.7%)	1(2.2%)
Referral and linkage for additional services to other facilities are provided to any needy student in the University	12(26.1%)	9(19.6%)	14(30.4%)	6(13.0%)	5(10.9%)
In Samara University, condom can be found very easily	13(28.3%)	7(15.2%)	10(21.7%)	11(23.9%)	5(10.9%)
Mobile condom distribution outlets can be found in accessible places in Samara University's Campus	7(15.2%)	11(23.9%)	7(15.2%)	10(21.7%)	11(23.9%)
Quality fixed condom outlets are placed in places where students can access them very easily and in a safe manner.	7(15.9%)	9(20.5%)	13(29.5%)	7(15.9%)	8(18.2%)

Lastly, the accessibility of mobile and fixed condom distribution outlets were found to be inaccessible to needy students in safe manner as clearly illustrated in Table 4.4.5. Therefore, one can conclude that the accessibility of those types of SRH services at the Health Facility of the University is viewed as less accessible when one considers the provision of such services in that given multi-faceted context.

4.5 Quality of SRH Services

In the study, quality of SRH services at Samara University was considered and then their different indicator together with appropriate indicators was indicated in Table 4.4.6 through Table 4.4.8. Based on those various indicators for SRH quality services, Samara University with the help of the SRH Health Facility has been providing male, female, able-bodied and disabled students with very poor quality services since then. Thirty-three (about seventy-two percent) of the respondents indicated the services provided by the Facility at the University were very poor and/or poor. Thus, the overall SRH services provided at Samara University are at least poor.

Students were also asked about how friendly the Health Facility members had been. Out of the 44 students who answered the question, 31(70.4%) stated that the staff members in the Facility were very poor and/or poor in their interactions with the respective clients. Therefore, the professional staff members appear to be user-unfriendly.

The attendance of staff members at the operational hours of the Health Facility is found to be very poor. Twenty-nine (sixty-three percent) of the respondents evaluated their attendance as very poor and/or poor. On the other hand, 20 (43.5%) of them rated the service providers' capacity, knowledge and skills as poor. Thus, the professionals who have been providing those services are not as such knowledgeable and skilful – incapable service providers.

Table 4.4.6 shows that the Health Facility of Samara University was very poor and/or poor in publicizing its services in that 30.4% and 34.8 % of the respondents' perception of its attempts. This failure is reflected in one way or another in its service provisions. Regarding the quality of SRH-related health education, more than half (about sixty-five percent) of the responding students also considered its quality as very poor (47.8 %) and poor (17.4 %).

In relation to the quality of SRH-related peer education, a total of 30 (65.2%) of the respondents viewed the services as very poor (41.3%) and poor (23.9 %). It is, therefore, found out that Samara University's peer education on SRH-related issues is generally poor.

Table 4.4.6: Quality of SRH Services

Indicators	Very poor	Poor	Neither good nor poor/Undecided	Good	Excellent
Quality of service provision of the Samara University Facility	24(52.2%)	9(19.6%)	5(10.9%)	2(4.3%)	6(13.0%)
How friendly staff members' of the facility are	25(56.8%)	6(13.6%)	7(15.9%)	3(6.8%)	3(6.8%)
The Attendance of staff members' at operational hours of the Samara University health facility	15(32.6%)	14(30.4%)	5(10.9%)	7(15.2%)	5(10.9%)
Service providers' capacity/knowledge/skill to provide service.	12(26.1%)	20(43.5%)	5(10.9%)	6(13.0%)	3(6.5%)
Quality of Facility's service publicizing to the students	14(30.4%)	16(34.8%)	9(19.6%)	5(10.9%)	2(4.3%)
SRH related Health education organized by the Samara University health facility or other institutions of the University	22(47.8%)	8(17.4%)	3(6.5%)	4(8.7%)	9(19.6%)
Quality of SRH related peer education organized by the Samara University health facility or other institutions of the University	19(41.3%)	11(23.9%)	7(15.2%)	7(15.2%)	7(15.2%)
Quality of involvement of different students' clubs (like Anti HIV/AIDS clubs) at different phases	24(52.2%)	7(15.2%)	6(13.0%)	6(13.0%)	3(6.5%)
Quality of provision of standard FP counselling service to male students	23(50.0%)	9(19.6%)	9(19.6%)	1(2.2%)	4(8.7%)
Quality of provision of standard FP counselling service to male students	22(47.8%)	10(21.7%)	6(13.0%)	5(10.9%)	3(6.5%)
Quality of provision of standard FP counselling service to able-bodied students	26(56.5%)	9(19.6%)	8(17.4%)	1(2.2%)	2(4.3%)
Quality of provision of standard FP counselling service to disable students	23(50.0%)	10(21.7%)	8(17.4%)	2(4.3%)	3(6.5%)

Students were also asked about the level of different student clubs' involvement in SRH-related peer programs. As indicated in Table 4.4.6, Out of the 46 (92%) students who properly responded, thirty-one (67.4 %) said the level of involvement of the clubs was either very poor (52.2 %) or poor (15.2 %). One can thus deduce that those different clubs organized and established by the students at

Samara University are poor at their involvement in SRH-related issues, such as HIV/AIDS prevention and control.

Half (50.0%) of the respondents in the study evaluated the quality of standard FP counselling service provided to male students of the University as very poor. In addition, the quality of service provided for female students was labelled by the respondents as either very poor (47.8 %) or poor (21.7 %).

With regard to quality of service the Facility provided on standard FP counselling to able-bodied students, thirty-five (about seventy-six percent) of the students in the study considered it as either very poor (56.5%) or poor (19.6%). Concerning different group of students, for example, the quality of standard FP counselling service the Facility provided to disabled students viewed as either very poor (50.0%) or poor (21.7%) which accounted for 71.7%. Generally, the different types of services-related to SRH and counselling are evaluated by the student clients as either very poor or poor.

The question related to Health Facility's quality of different IEC materials in relation to their relevance was posed to the sample students. Twenty-two (about forty-eight percent) of the students in the study evaluated the relevance of the materials as very poor (47.8%). Samara University therefore has been employing at least poor quality and irrelevant materials in raising their awareness of SRH-related issues.

The quality of different IEC materials in relation to their attractiveness was similarly labelled as very poor by about two-fifth (39.1%) of the respondents. More than three-fifth of the respondents in the study viewed the IEC materials quality in terms of their quantity as either very poor or poor.

A significant majority of the student respondents in the study are not happy with the intervention quality of the Health Facility in preventing and treating infertility on the part of female students at Samara University. Twenty-eight (about seventy percent) of the respondents' evaluated the services provided as either very poor or poor. As depicted in table 4.4.7, about fifty-seven percent of sampled

students rated the quality of Quality of provision of prevention of complications of unsafe abortion to any female students as either very poor or poor.

Table 4.4.7: Quality of IEC Materials related Services

Indicators	Very poor	Poor	Neither good nor poor/Undecided	Good	Excellent
The quality of different IEC materials in relation to their relevance	22(47.8%)	9(19.6%)	6(13.0%)	7(15.2%)	2(4.3%)
The quality of different IEC materials in relation to their attractiveness	18(39.1%)	10(21.7%)	8(17.4%)	6(13.0%)	4(8.7%)
The quality of different IEC materials in relation to their quantity	19(41.3%)	10(21.7%)	6(13.0%)	4(8.7%)	7(15.2%)
Quality of provision of prevention and treatment of infertility service to all kinds of female students	16(34.8%)	12(26.1%)	8(17.4%)	4(8.7%)	6(13.0%)
Quality of provision of prevention of complications of unsafe abortion to any female students	17(37.0%)	9(19.6%)	7(15.2%)	4(8.7%)	6(13.0%)
Quality of provision of management of complications of unsafe abortion to any female students	18(39.1%)	8(17.4%)	5(10.9%)	7(15.2%)	8(17.4%)
The provision of safe abortion services to any female student	18(39.1%)	13(28.3%)	7(15.2%)	6(13.0%)	2(4.3%)
Quality of service provision of treatment of reproductive tract infections service to any student	17(37.0%)	12(26.1%)	10(21.7%)	2(4.3%)	5(10.9%)
Quality of the service provision diagnosis on STIs and other conditions of the reproductive system to any student	15(32.6%)	10(21.7%)	10(21.7%)	6(13.0%)	5(10.9%)
Quality of any provision of STI drugs after diagnosis of STIs from the Samara Health facility	18(41.9%)	11(25.6%)	8(18.6%)	1(2.3%)	5(11.6%)

In the same framework, 26(56.5%) of the students in the study viewed the quality of provision of management of complications of unsafe abortion to any female students at Samar University either very poor or poor. The treatment of reproductive tract infections service was found to be rated at very poor level as more than one-third (39.1%) of the respondents confirmed this evaluation. The same finding regarding the provision quality of safe abortion services to any female students in the Health

Facility. Quality of service provided for treating reproductive tract infections of any students at Samara University was labelled as very poor by thirty-seven percent of the respondents. Moreover, about one-third of the respondents viewed the provision of diagnosis service on STIs and other conditions as very poor. Twenty-nine (more than two-third percent) of the responding students stated that quality of any provision of STI drugs after getting diagnosis of STIs at the Samara Health Facility was viewed as either very poor (41.9%) or poor (25.6%). Therefore, the IEC materials, as well as those services which have been provided in relation to treatment of infertility and complications of unsafe abortion to any female students are mostly poor.

Table 4.4.8: Quality of SRH Services

Indicators	Very poor	Poor	Neither good nor poor/Undecided	Good	Excellent
Quality of HTC service at the Health Facility	20(45.5%)	7(15.2%)	2(4.5%)	5(11.4%)	11(25.0%)
Quality of the Provision of ART for HIV positive students	23(50.0%)	7(15.2%)	8(17.4%)	5(11.4%)	3(6.8%)
Quality of process of information and counselling on human sexuality for any student.	20(45.5%)	11(25.0%)	7(15.9%)	3(6.8%)	3(6.8%)
Quality of process of information and counselling on human sexual and RH for any student	16 (35.6%)	12(26.7%)	6 (13.3%)	6(13.3%)	5(11.1%)
Quality of active discouragement of harmful practices, such as female genital cutting services	20(43.5%)	7(15.2%)	7(15.2%)	7(15.2%)	5(10.9%)
Quality of Referral and linkage for additional services to other facilities to any needy student	22(47.8%)	8(17.4%)	5(10.9%)	5(10.9%)	6(13.0%)
The available Condom has quality	17(37.0%)	14(30.4%)	3(6.5%)	6(13.0%)	6(13.0%)
Quality of mobile condom distribution outlets in the Samara University	18(39.1%)	8(17.4%)	4(8.7%)	9(19.6%)	7(15.2%)
Quality Fixed condom outlets (away from sun light and rain, easy for use, etc) are available	14(35.9%)	6(15.4%)	2(5.1%)	5(12.8%)	12(30.8%)

Table 4.4.8 presents data on HIV Testing and Counselling (HTC), ART, information and counselling about SRH, active discouragement of harmful practices, available condom quality, referral and

linkage for other additional services, as well as mobile and fixed condom distribution outlets. The quality of HIV Testing and Counselling (HTC) service provision of the University to students in the Campus was considered as very poor by 45.5% of the students in the study.

Half (50.0%) of the respondents evaluated the quality of provision of Anti-retroviral treatment (ART) to positive students as very poor. The quality of service on information and counselling on human sexuality for HIV positive students was further labelled as very poor by half of the students, but equal proportions (about seven percent) of them perceived the services as either excellent or good. About forty-six (45.5%) of the respondents argued that the quality of process of information and counselling on human sexuality for any students in the University, on the other hand, was very poor. As to the quality process of information and counselling on human sexual and reproductive health (RH) for any students in the University, more than one-third (35.6%) of the participants in the sample survey considered it as very poor.

Quality of active discouragement of harmful practices, such as female genital cutting services at Samara University was evaluated as very poor by 45.5% of the responding students. In addition, the evaluation of the quality of referral and linkage for additional services to any need students to other facilities by the respondents was found to be very poor (47.8%). Next, question on the quality of available condom in Samara University was presented to the sampled students. About seven-tenth (67.4%) of them viewed as either very poor or poor. In the same vein, the mobile condom distribution outlets and mobile and fixed condom distribution outlets were found to be very poor quality by about forty percent (39.1%) and about thirty-six percent (35.9%) of the respondents. Thus, it might not be a surprise that those services (e.g. voluntary HIV counselling and testing, ART, counselling about human sexuality and SRH, discouragement of harmful practices, as well as mobile and fixed condom distribution outlets) provided at Health Facility have been viewed as very poor.

On the whole, it has been argued that the availability, accessibility and quality of SRH-related services to the students at Samara University are very poor. A reasonable number and proportion of them consistently assess and evaluate the international standard indicators for this purpose as either very poor or poor.

4.6 Strengths and Constraints of the SRH Services

The researcher further considered the strengths and constraints of those services provided at Samar University. The findings of the quantitative and qualitative studies on these issues show that the Health Facility has strengths and constrains which might have emanated from both internal and external factors of its settings.

4.6.1 Strengths

Out of the 46 respondents, 10 of them tried to respond for the question related to the strengths of SRH service provision of the Health Facility at Samara University. Six of the female respondents pointed out that the Programme on condom distribution appeared to be one of its s strengths, followed by its STI syndromic approach. Other strength is related to its service provisions by the Health Facility regardless of the existing conditions in the University as most of the respondents stated:

> *With a limited available human and material resources, and lack of relevant training and capacity building; the professionals of the Facility are doing what they can do in order to serve the student clients and then to serve the student community. Some professionals are also providing the students with counselling, albeit there are no counselling rooms and trainings. The Facility is also providing FP, HTC and ART services with its limited resources.*

4.6.2 Constraints

Against these backdrops, the Health Facility could not escape its existing constraints. A few of the respondents argued that,

The Health Facility has had various types of constraints in the provision of SRH services in Samara University. These constraints may emanate from the unfavourable location of the Facility, lack of disciplined professionals and Facility staff members (e.g. absenteeism, shouting students, etc.),its working hours, lack of concern from the University's administration, lack of trainings for health professionals, and lack of resources (like medical equipment, medicines, chemicals [such as testing kits].

Let us use other window in the same framework and present views of the FGD discussants on the constraints. Some of the FGD participants expressed during the sessions the following:

The professionals in the Health Facility lack professionalism. These professionals have different disciplinary and unethical problems in that they usually come late to the service provision, lack of discipline, lack respect for the students, provide similar medicine for different diseases, and lack coordination with other departments in the University. In addition, the referral service is the weakness of the Clinic. Similarly, there is a serious shortage of medicines in the Facility. The Facility is blamed for not providing youth-friendly SRH services. In general, the service provisions don't consider the needs of the students with regard to timing. The provisions are limited only to some of the SRH services in the SRH Package as well.

Finally, a male participant in the FGDs has to say the following rhetoric expressions about the Facility's constraints, as he aired:

Once, my friend had some discharge problem with his genital. He asked me for advice and I told him to visit the Clinic. I accompanied with him to the Clinic. It was around 9:00 AM. We couldn't find the Nurse around. So, we waited him for an hour. Finally, when he showed up, he was messed up. He seemed he hadn't had a good night sleep. On his turn, my friend got in to the Medical Examination Room. He did not stay too long in the Room. He came back to me angry and crying. Later on, he told me that the nurse had disrespected him by saying;' you slept with commercial sex worker that was the reason you had got infected with STDs. My friend has never returned to that Clinic since then. Therefore, some of the nurses in the Clinic at Samara University lack discipline.

In conclusion, the SRH –related services at Samara University are not as such available, accessible and quality in terms of those standard indicators. Consequently, these gaps are vividly realized on the ground in terms of multi-dimensional constraints which might have emanated from factors inside and outside the University's setting.

CHAPTER V

MAJOR FINDINGS AND DISCUSSION

Sexual and reproductive health issues are currently considered as a human right issue. The WHO's rights-based approach promotes access to SRH services as a right for all people regardless of their marital status or age (WHO, 2005). As such, understanding the genesis of SRH risk-taking practices among adolescents has become a concern for most health policy makers in both developed and developing countries (UNFPA, 2003; UN, 1995a; 1995b). Adolescence and youth groups are entitled to these rights as most of the SRH problems are occurring on them. The Youth Policy of the FDRE (2005) stated that,

> *Limited reproductive health services and information and education dissemination services are being rendered through governmental organizations and NGOs. It is however impossible to assume that adequate services are being rendered. Moreover, the services do not specifically focus on youth. Nor are they easily accessible in terms of time and place. These problems hinder the adolescence and youth not to carry out its social and humanly obligations.*

The same Policy document is also coated to say:

> *…the youth are being exposed to unwanted pregnancy, unsafe abortion, various venereal diseases and most of all, to HIV/AIDS pandemic." Specially, youths and adolescences found at higher education institutions are liable to different SRH problems that gravely challenge them not to meet the expectations of their parents, communities and at large their country. A study conducted at 5 public higher educations of the country in 2011 showed that more than a quarter of the students in the five universities, 1702 (29.71%), ever had sexual intercourse. Out of those who were sexually active in the last 12 months, 281 (31.0%) had sexual intercourse with more than one sexual partner and 207 (26.6%) had sex without condom of these Universities. Similarly, a study done on Dire Dawa University showed that higher education students are more vulnerable to HIV/AIDS, STI and unwanted pregnancies and related SRH problems (Birhan, 2011).*

The results of the quantitative study showed that most (65.2 %) of the students did go to the Samara University's Health Facility for anyone of the services. The majority of (78.3%) of student respondents did not visit the Facility for any of SRH-related services. The findings of the qualitative

study indicated that the respondents were found not to prefer to visit the Health Facility until they found out it very mandatory. This finding of the study concurs with those of the study conducted at Addis Ababa University where only 14.6% of the sampled respondents utilized the University's Clinics for SRH services (Yordanos, 2012). HIV-related services were better utilized by 6.5% students followed by STI-related, FP-related, as well as all combined together as utilized by 4.3% of the sampled students.

Furthermore, 84.8 % of the students felt that they did not think the Facility got enough number of professionals which could carry out the tasks at Health Facility. The findings of the observation, interviews and FGDs conducted with the students and staff members of the University further confirmed the fact.

The Facility was found not to get involved in publicizing its services to the students, according to 63.1% of the respondents. The empirical findings of the qualitative methods showed that the Facility only used those orientation sessions which were organized by the University when freshman students got into the Campus to publicize the services. Similar findings were found from the study undertaken in Addis Ababa University where most students claimed that they were in need of having pieces of information on the service, but the Clinic did not provide it (Yordanos (2012).

SRH-related health education organized by the Health Facility of Samara University did not exist- according to 56.6% of the respondents and the availability SRH related Peer education (52.1%). From the qualitative study results, although the Facility professionals sometimes participated in peer education sessions that were organized by non-governmental organizations (like PSI and Beza Posterity Development Organization) in cooperation with Anti-HIV/AIDS Coordination Unit of the University when they were invited; health education sessions on SRH- related issues were not actually practised.

More than two-third (67.4%) of the student respondents stated that there was linkage of the peer education with the service of the Health Facility. This statement was substantiated by views of the key informants, such as the Facility's professionals, students and other University's staff members because they reflected similar pieces of information. The HIV/AIDS Officer and the Chairperson of the Anti-HIV Club also admitted that there were health education and peer education sessions on anti-HIV and SRH-related issues which were being run by different governmental and non-governmental organizations, including the University. In this connection, the Clinic's professional stated: "I had heard of such education sessions and even participated in some of the sessions as I was invited by the organizers. However, I also pointed out that they were just some instances of such invitations that had got nothing to do with the regular Programme of the University's Clinic."

Standard FP counselling service is reported as not available by 56.3 % respondents. However, empirical evidence generated from the qualitative study documented that there were some efforts to provide the student clients with the services along with the provisions of some FP types of service, i.e. those related to pregnancy services - the provision of pills and condoms.

The availability of use of different IEC materials for health education was reported as unavailable by 60.9% of the respondents in the study. Thus, findings of the qualitative study supported this claim in that the Facility's experience of utilizing IEC materials for health education purpose was said to be almost unthinkable due to different reasons. It was also reported by some of the key informants that they were not using any IEC materials for education purpose. The health professional told to the researcher: "Sometimes, the Clinic distributes some IEC materials that are handed over by NGOs. However, these IEC materials have no linkage with the daily routine Programme of the Health Facility."

As stated-above, the Health Facility of Samara University provided the student clients with pregnancy related services by 39.1 % the respondents; of which half percent (50.0%) of them were females. In addition, those participants in the semi-structured interviews and FGDs noted that the Facility was found to provide them with contraceptive pills, EC and condoms. The results of this finding correspond with the findings of the study conducted by Yordanos (2012) in Addis Ababa University where the students got FP related services.

The provision of infertility-related services was evaluated as unavailable service by more than half (53.2 %) the respondents. Similarly, about forty-six percent of the participants in the study argued that prevention and management of complications of unsafe abortion were not available. "If a girl gets raped and gets pregnant, she will not get the provision of safe abortion service at the Health Facility in the Campus," unanimously expressed by the FGD discussants.

Even though the provisions of treatment of reproductive tract infections service, diagnosis of STIs and of STI drugs were viewed as unavailable by 39.5%, 50.0% and 56.6% of the sampled students respectively. The researcher conducted observation in the Facility, held interviews with professionals and FGDs and then found out, "The University's Health Facility has got supports from some NGOs, like PSI regarding training to professionals on syndromic approach and provision of STI drugs. Follow ups and Technical supports were also provided." This finding was triangulated by statements documented in the progressive reports of the University which was prepared and submitted to its donating agencies and by the professional informants in the study.

The provision of diagnosis of HTC and ART are not well-served by concerned health professionals. However, the empirical evidence collected through observations and other qualitative research methods revealed different discourses. The Ethiopian Federal Ministry of Health, as well as the NGO partners have provided the Health Facility with essential test kits, medicines and trainings.

Other element of SRH services is availability of the provision of information and counselling on human sexuality, responsible parenthood and sexual and RH services. More than (52.2%) of the respondents confirmed that the service was unavailable. Some of the key informants and the FGD participants aired their views on reasons for such gaps. They uttered: "We can understand that there is a little effort being made by individual professional, albeit the existing conditions of the Facility and its infrastructure don't allow that. "

In the same framework, the findings of the semi-structured interviews, FDGs and observations ted that the referrals and linkages for additional services were not unavailable. There was some sort of disparity which had occurred due to its inaccessibility or poor quality. The referral and linkage service were provided to the needy student clients to nearby health facilities of Samara Health Centre and Dupti Hospital.

There have been the provisions of condom distribution, mobile condom distribution and the availability of fixed condom distribution outlets at Samara University. The views generated from those participants in the semi-structured interviews, FGDs and observations confirmed the foregoing statement, as they expressed: "There are some fixed condom outlets which are fixed in around the dormitories and the Clinic areas. There are services, like distribution of condom with fixed outlets (i.e. the distribution of up to 566 condoms per day); such service provision has been mentioned as strong side of the Facility."

With regard to the accessibility of services to be provided in the University, in most well established public universities in Ethiopia (like Addis Ababa University, Bahir Dar University, Mekelle and University); the health facilities are situated in an appropriate location for students to access them very easily. However, this is not the case in Samara University. The majority of respondents (73.9%) said the location of the health facility is inaccessible to the students as the Health Facility was

situated between male students' dormitories. Therefore, its location was not inviting for the female students in the University. This evidence was confirmed by almost all of the participants in the qualitative study. Moreover, the Health Facility's infrastructure, size and paint were labelled as not inviting by the majority of the respondents and informants.

The friendliness of the professionals of health facility is very crucial in the provision of youth friendly SRH services (WHO, 2002). The Reports on other studies conducted in Addis Ababa University by Yordanos (2012) and in other universities in Ethiopia evaluated labelled most of the health professionals working in these facilities as those who lacked friendliness. What was found in Samara University was not different from those studies.

Like other studies conducted in Addis Ababa by Yordanos (2012), the operational hours of the Health Facility at Samara University did not fit to the needs of the students. This stamen was further substantiated by the empirical evidence collected from both quantitative and qualitative studies in the University.

Based on the findings of the qualitative and quantitative studies, the SRH related peer education interventions document that limited number of students have got the services. This Programme addressed the needs of male, female, able-bodied and disabled students. The same holds true for the provision of standard FP counselling service to male, female, able-bodied and disabled students. The results of the data analysis in the study also showed that the safe abortion service to any female students in the Campus and the services like the treatment of reproductive tract infections, STDs and other conditions and STI drugs services were found to be inaccessible.

The inaccessibility of HIV testing and counselling (HTC) service, ART to HIV-positive students, of the information and counselling on human sexuality and the information and counselling on reproductive health services, the provisions of referral and linkage for additional services to other

facilities (like Dupti Hospital), but condom was available in Samara University - it was found to be inaccessible to any needy students. The same also holds true fixed condom distribution outlets. Some FGD participating students highlighted some problems in those services of the University.

A study conducted on Malawi suggest that health workers provide poor quality care as health workers spend little time during consultation with adolescent clients while others were judgmental as a sign of disapproval to unmarried adolescents' sexual behaviours. Other health workers tend to moralise the working spaces as well as their health promotion actions. They tend not to warmly welcome young people as it is equated to approving premarital sex in the society (Jimmy-Gama, 2009). In Samara University, the service provision of the Health Facility was poor, according to the views of the students in the study.

The students in study classified the staff members in the Facility as unfriendly in the provision of service. The attendance of staff members at the operational hours was also evaluated as very poor. Additionally, their capacity, knowledge and skills as publicizing its service; the level of different student clubs' involvement in SRH related peer programs; the quality of Samara University Health Facility's provision of standard FP counselling to male, female, able-bodied and disabled students were evaluated by the participants in the study as poor.

The treatment of reproductive tract infections service; the quality of provision of diagnosis service on STIs and other conditions; service provisions regarding the STDs and other conditions service; the quality of provision of STI drugs after diagnosis of STIs; the quality of HIV Testing and Counselling (HTC) service provision of the University's Health Facility; the provision of Anti-retroviral treatment (ART) to HIV-positive students; the quality of information and counselling on reproductive health service to the students of Samara University; referral and linkage for additional services to others were generally viewed as poor. Finally, the quality of condom in Samara

University was found to be poor in quality, and the fixed condom distribution outlets were also labelled as poor.

As to the strengths of the Facility at Samara University, empirical evidence from both quantitative and qualitative studies was in support of them. The condom distribution and its effort in providing STI syndromic approach treatment interventions has therefore been viewed as the major strengths the Health Facility at the University.

Unlike the previous claims, there are finally some constraints on the part of the Facility at Samara University. The unfavourable location of the facility as the building is situated nearby the male students' dormitory, there is no proper infrastructure, lack of professional discipline (absenteeism, shouting students, etc.) on the side of its staff members, lack of proper ethics (Yordanos, 2012), unfavourable working hours, lack of concern on the part of the University's administration, lack of training for health professionals, lack of resources (like medical equipment, medicines, chemicals, testing kits) are identified as major constraints of the University's Health Facility.

CHAPTER VI

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

It has been argued that Samara University does not avail accessible and quality SRH-related services to the students in their appropriate number of packages at the right place and time. The Health Facility at the University has no adequate number of professionals; has not yet publicized its services to the students; provided poor SRH-related health education; has less involvement in the SRH-related peer education sessions; provides poor FP counselling services; practises poor use of different IEC materials for health education; provides poor infertility-related services, prevention and management of complications of unsafe abortion, formal process of information and counselling on human sexuality, responsible parenthood and SRH services; low level of involvement in discouraging harmful practices; and engages in poor mobile condom distribution outlets.

In the setting of Samara University, the Facility has not availed some of the basic components of the SRH-related services and then they become inaccessible to the students. In the first place, the location of the health Facility is inconvenient to the student clients, its infrastructure, size and even its paints are not attractive to the clients; it lacks friendliness on the part of the health professionals; and the existence of unfit operational hours of the Facility.

Next, the Health Facility doesn't highly involve and participates in SRH-related sessions which are organized by different local and international NGOs in Samara town. In addition, the Facility does not address male, female, able-bodied and disable students regarding SRH-related issues.

In the same vein, the University makes inaccessible services related to safe abortion to any female students in its Campus; the treatment of reproductive tract infections; provision of drugs for treating

STIs, HIV Testing and Counselling; ART to those HIV-positive students in the University; information and counselling on reproductive health; provision of condom to any students and inaccessibility of fixed condom distribution outlets. Generally, the health professionals do not facilitate referral and linkage for additional SRH-related services to other health facilities. The Health Facility under the auspices of Samara University has been providing poor quality SRH-related services in that its staff members are unfriendly; usually delay operational hours; have low level of knowledge, skills and capacity; low level of involvement of the health professionals in the SRH-related peer education and in those different students' clubs; low level of participation in the related Programme on Peer Education; do not provide them with standard FP counselling services to male, female, able-bodied and disabled students; provide them with poor level of treatment of reproductive tract infections, diagnosis for STIs and other conditions; show low level of involvement in the provision of drugs for treating these infections, in ART to those students who are living positively, and in referral as well as establishing linkage for additional services to the needy students from both sexes.

Those inaccessible and poor quality SRH-related services may have emanated from the unfavourable location and working hours of the health Facility, limited capacity, absenteeism and shouting at the student clients on the part of the professionals and lack of concern on the side of the administration of Samara University which are justifiable in terms of shortage of essential resources (such as medical equipment, medicines, and laboratory chemicals). Hence, those constraints have outweighed the strengths of the Facility. However, the strengths of the Health Facility at Samara University in providing SRH-related services can be evidenced from its effective Programme on Provision of Condom Distribution and its encouraging treatment for STIs using Syndromic Approach.

Therefore, one may conclude that the unfavourable sexual and reproductive health services at Samara University can be characterized as unavailable in terms of acceptable standards, inaccessible and poor quality services which have emanated from those existing constraints in the Health Facility. Generally, the SRH-related services provided to the students at the University are labelled as unavailable, inaccessible and poor quality in comparison with those acceptable standards.

6.2 Recommendation

Based on those major findings supported by empirical evidence and the conclusions drawn from them, the researcher would suggest the following plausible practical actions and further studies:

- The Staff members of the Health Facility should observe their professional ethics and provide students with the essential SRH services in a way that respects their human dignity and diversity.
- The University's Health Facility should organize orientation sessions to publicize its services by its own, as well as with University's administration to newly coming students and senior students on a periodic and continuous manner.
- Those coordinating bodies, like HIV/AIDS Prevention and Control Offices, Gender offices, and the Student Dean's Office should involve the Health Facility in the peer education activities which are being organized by other NGOs.
- Samara University in partnership with other stakeholders should avail SRH services to the students in the Campus of the University in friendly, accessible and targeting special segments (like female students, male students, disabled and special need students) of the student community.

- Samara University should devise a mechanism for motivating its health service providers who are currently working at the Health Facility and should then ensure their professional competency.
- The administration of the University should make sure the available services are up to their standards and should be accessible to all students in the Campus by working together with all stakeholders in the area.
- The SRH services (peer educations) which are organized by the partner organizations and their projects should involve and be integrated with the University Health Facility and the activities of the students' clubs for sustainability and ownership.
- Samara University should design packages for providing services and regulation for providing SRH services in the University's Campuses with the help of the partner organizations.
- The University should provide the utmost attention to the SRH service provisions by setting up an appropriate follow up and supportive mechanisms in place.
- Samara University should find a way to move the Health Facility to a more favourable, accessible and friendly location.
- The University should strengthen its ties with other public Universities and with affiliated associations (like Higher Education Forum against HIV/AIDS to exchange experiences and improve the SRH provisions by the Health Facility).
- The administration of the University should find a way to provide the Facility with essential inputs (such as medical equipment, medicines, and chemicals).
- The University administration should facilitate different capacity building schemes (like trainings for the staff members of the Health Facility).

- The University should create good working relationships with the federal, local and other partners in Ethiopia to fulfil the gaps observed in providing accessible and quality services.
- The Ministry of Education, Ministry of Health, Afar Regional Health Bureau, Afar Region Education Bureau and other stakeholders in the Regional State should work together to strengthen the capacity of the University in providing all quality SRH services in accessible way to all students by providing materials and technical assistance.
- Other stakeholders (like NGOs should provide technical supports [e. g. Trainings] and material supports (like medicines, equipment, testing kits, etc.) to the Health Facility of the University.
- As this study employed more of quantitative research methods then qualitative research methods in order to triangulate the findings of the study, further studies should be undertaken using more of qualitative research methods to identify the causes for providing unfavourable, less available, inaccessible and poor quality SRH-related services to all students in the Campuses of Samara University using longitudinal panel quantitative and qualitative data on internationally acceptable and standard indicators for those services.

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Annexes

Annex A: Structured Interview Schedule

St. Mary's University
School of Graduate Studies, International Programmes
School of Social Work, Indira Gandhi National Open University (IGNOU)
Addis Ababa, Ethiopia
Interview Schedule to be filled by Samara University Students

Introduction

Good Morning/Afternoon, My name **is Sisay Alemayehu**, a student of Master of Social Works at Indira Gandhi National Open University (IGNOU) under the coordination of St. Mary's University, International Programs, School of Graduate studies. This interview schedule is developed to assess the SRH services and related issues at Samara University in North-eastern Ethiopia for the partial fulfilment of Master of Social Works study of IGNOU at St. Mary's University.

This study will help us to have the understanding of the magnitude of the problem in relation with the availability of SRH and related service, its accessibility and quality of service. By doing this, the study will identify the strengths and areas that needs improvement. Hence you are cordially requested to take a look at each question items carefully and reply as per each instructions provided in each respective sections.

I would like to thank in Advance for being willing to participate in this study.

1. Objectives of the Study

General Objective

The general objective of this research is to assess the Sexual and Reproductive Health (SRH) services and related issues at Samara University in North-Eastern Ethiopia.

Specific objectives

- To assess the availability, accessibility and quality components of SRH at Samara University;
- To examine the strengths of the available SRH components at Samara University; and
- To identify the weaknesses of the available SRH components in Samara University.

Please answer the following Questions according to the specific instructions given.

Please put tick mark (√) or write your reply on the space provided.

I. Background Data

i.	**Sex**	1. Male **2.** Female				
ii.	Year of study_____	**1**	**2**	**3**	**4**	
iii.	Academic Faculty_____					
iv.	Department:_____					
v.	Ethnicity:_____					

vi. Religion:_____					
vii. High school Education Stream_____					

II. Background Questions

1. Is there any facility that is currently providing SRH service in the Samara University?	A. Yes B. No C. I don't know
2. Have you ever gone to the Health Facility at Samara University for service?	A. Yes B. No
3. Have you ever gone to the Health Facility at Samara University for any SRH service(s)?	A. Yes B. No
4. How often did you visit the Health Facility in the past six months?	A. One time B. two times C. three times D. Four times and above E. not at all
5. For which SRH Problem(s) have you visited the Samara University's Health facility?	A. STI related B. Family Planning C. HIV related D. All E. Other (Specify)_____
6. For which SRH service(s) have you visited the Samara University's Health Facility?	A. STI related B. Family Planning C. HIV related D. All E. Other (Specify)_____

III. Availability

Instructions: Circle "5" if your answer is "strongly agree", "4" if your answer is "agree", "3" if your answer is "neither agree nor disagree" , "2" if your answer is "disagree" and "1" if your answer is either "strongly disagree."

Question Items	**Answer Key**				
1. I think there is enough number of health professionals in the Samara University health facility.	**1**	**2**	**3**	**4**	**5**
The Samara University health Facility publicizes the services it provides.	**1**	**2**	**3**	**4**	**5**
3. There are some SRH related health education organized by the facility or other institutions of the University in Samara University.	**1**	**2**	**3**	**4**	**5**
4. There are some SRH related peer education organized by the facility or other institutions of the University in Samara University.	**1**	**2**	**3**	**4**	**5**
5. The SRH related peer programs are linked to health facility services, and all services.	**1**	**2**	**3**	**4**	**5**
6. The Samara University health facility provides standard FP counselling service in Samara University.	**1**	**2**	**3**	**4**	**5**
7. The Samara University health facility uses different IEC materials for health education purpose.	**1**	**2**	**3**	**4**	**5**
The Samara University health facility provides pregnancy related care.	**1**	**2**	**3**	**4**	**5**

The Samara University health facility provides infertility related services.	**1**	**2**	**3**	**4**	**5**
10. The Samara University health facility provides prevention and management of complications of unsafe abortion.	**1**	**2**	**3**	**4**	**5**
The Samara University health facility provides safe abortion services.	**1**	**2**	**3**	**4**	**5**
12. The Samara University health facility provides treatment of reproductive tract infections service.	**1**	**2**	**3**	**4**	**5**
13. The Samara University health facility provides sexually transmitted infections such as measles, syphilis, etc. and other conditions of the reproductive system.	**1**	**2**	**3**	**4**	**5**
The Samara University health facility provides provision of STI drugs?	**1**	**2**	**3**	**4**	**5**
15. The Samara University health facility provides HIV Testing and Counselling (HTC) service.	**1**	**2**	**3**	**4**	**5**
16. The Samara University health facility provides Provision of Anti-Retroviral Treatment (ART)?	**1**	**2**	**3**	**4**	**5**
17. The Samara University health facility provides information and counselling on human sexuality, responsible parenthood and sexual and reproductive health.	**1**	**2**	**3**	**4**	**5**
18. The Samara University health facility provides active discouragement of harmful practices, such as female genital cutting services.	**1**	**2**	**3**	**4**	**5**
19. The Samara University health facility provides Referrals and linkages for additional services related to other facilities.	**1**	**2**	**3**	**4**	**5**
The Samara University health facility has a condom distribution programme	**1**	**2**	**3**	**4**	**5**
21. The Samara University health facility uses mobile condom outlets for distribution.	**1**	**2**	**3**	**4**	**5**
22. The Samara University health facility uses fixed condom outlets for distribution.	**1**	**2**	**3**	**4**	**5**
IV. Accessibility					
<u>Instructions</u>: Circle "5" if your answer is "strongly agree", "4" if your answer is "agree", "3" if your answer is "neither agree nor disagree" , "2" if your answer is "disagree" and "1" if your answer is either "strongly disagree."					
Question Items	**Answer Key**				
23. I like/am comfortable with the location of the Samara University health facility.	**1**	**2**	**3**	**4**	**5**
The service provision of the Samara University health facility is inviting.	**1**	**2**	**3**	**4**	**5**
The Samara University health facility staff members are friendly to go to.	**1**	**2**	**3**	**4**	**5**
26. The infrastructure of Samara University health facility invites students to come.	**1**	**2**	**3**	**4**	**5**
The size of Samara University health facility invites students to come.	**1**	**2**	**3**	**4**	**5**
The painting of Samara University health facility invites students to come.	**1**	**2**	**3**	**4**	**5**
29. The operational hours of the Samara University health facility fit to the needs of the University students.	**1**	**2**	**3**	**4**	**5**
30. The Samara University health facility publicizes the services it provides in places students can clearly see.	**1**	**2**	**3**	**4**	**5**
31. SRH related Health Education organized by the Samara University health facility or other institutions of the University addresses male students.	**1**	**2**	**3**	**4**	**5**

32. SRH related Health Education organized by the Samara University health facility or other institutions of the University addresses female students.	**1**	**2**	**3**	**4**	**5**
33. SRH related Health Education organized by the Samara University health facility or other institutions of the University addresses abled students.	**1**	**2**	**3**	**4**	**5**
34. SRH related Health Education organized by the Samara University health facility or other institutions of the University addresses disabled students.	**1**	**2**	**3**	**4**	**5**
35. SRH related Peer education organized by the Samara University health facility or other institutions of the University addresses male students.	**1**	**2**	**3**	**4**	**5**
36. SRH related Peer education organized by the Samara University health facility or other institutions of the University addresses female students.	**1**	**2**	**3**	**4**	**5**
37. SRH related Peer education organized by the Samara University health facility or other institutions of the University addresses abled students.	**1**	**2**	**3**	**4**	**5**
38. SRH related Peer education organized by the Samara University health facility or other institutions of the University addresses disabled students.	**1**	**2**	**3**	**4**	**5**
The SRH related peer programs involve different students' clubs.	**1**	**2**	**3**	**4**	**5**
40. The Samara University Health facility provision of standard FP counselling service is addressing male students.	**1**	**2**	**3**	**4**	**5**
41. The Samara University Health facility provision of standard FP counselling service is addressing female students.	**1**	**2**	**3**	**4**	**5**
42. The Samara University Health facility provision of standard FP counselling service is addressing abled students.	**1**	**2**	**3**	**4**	**5**
43. The Samara University Health facility provision of standard FP counselling service is addressing disabled students.	**1**	**2**	**3**	**4**	**5**
44. The Samara University health facility place different IEC materials at a spot where students can easily get.	**1**	**2**	**3**	**4**	**5**
45. The Samara University health facility offers prevention and treatment of infertility to all female students.	**1**	**2**	**3**	**4**	**5**
46. The Samara University health facility provision of prevention and management of complications of unsafe abortion is accessible to any female students.	**1**	**2**	**3**	**4**	**5**
47. The Samara University health facility provides safe abortion services to any female student.	**1**	**2**	**3**	**4**	**5**
48. The Samara University health facility provides treatment of reproductive tract infections service to any student.	**1**	**2**	**3**	**4**	**5**
49. The Samara University health facility's service on sexually transmitted diseases and other conditions of the reproductive system is accessible to any student.	**1**	**2**	**3**	**4**	**5**
50. Any student can easily get the STI drugs after s/he has got diagnosis from the facility.	**1**	**2**	**3**	**4**	**5**
51. Students of the University can easily get HTC service from the health facility.	**1**	**2**	**3**	**4**	**5**
52. The Provision of Anti-retroviral treatment (ART) is very easy for HIV positive students.	**1**	**2**	**3**	**4**	**5**
53. Getting information and counselling on human sexuality is available for any student.	**1**	**2**	**3**	**4**	**5**
54. Getting information and counselling on reproductive health is available for any student.	**1**	**2**	**3**	**4**	**5**
55. Students in Samara University have access to an active discouragement of harmful practices, such as female genital cutting services.	**1**	**2**	**3**	**4**	**5**
56. Referral and linkage for additional services to other facilities are provided to any needy student in the University.	**1**	**2**	**3**	**4**	**5**
57. In Samara University condom can be found very easily.	**1**	**2**	**3**	**4**	**5**

58. Mobile condom distribution outlets can be found in accessible places in Samara University's campus.	**1**	**2**	**3**	**4**	**5**
59. Fixed condom outlets are placed in places where students can access them very easily and in a safe manner.	**1**	**2**	**3**	**4**	**5**

V. Quality

Instructions: Circle "5" if your answer is "strongly agree", "4" if your answer is "agree", "3" if your answer is "neither agree nor disagree" , "2" if your answer is "disagree" and "1" if your answer is either "strongly disagree."

Question Items	**Answer Key**				
60. The quality of service provision of the Samara University facility.	**1**	**2**	**3**	**4**	**5**
61. The Samara University Health facility staff members' friendliness.	**1**	**2**	**3**	**4**	**5**
62. The Attendance of staff members' at operational hours of the Samara University health facility.	**1**	**2**	**3**	**4**	**5**
63. Service providers' capacity/knowledge/skill to provide service.	**1**	**2**	**3**	**4**	**5**
64. The Samara University health Facility's publicizing the services to the students.	**1**	**2**	**3**	**4**	**5**
65. SRH related peer education organized by the Samara University health facility or other institutions of the University.	**1**	**2**	**3**	**4**	**5**
66. SRH related peer education organized by the Samara University health facility or other institutions of the University.	**1**	**2**	**3**	**4**	**5**
67. The involvement of different students' clubs like Anti HIV/AIDS clubs at different phases starting from planning to evaluation of SRH related activities.	**1**	**2**	**3**	**4**	**5**
68. The provision of standard FP counselling service to male students.	**1**	**2**	**3**	**4**	**5**
69. The provision of standard FP counselling service to female students.	**1**	**2**	**3**	**4**	**5**
70. The provision of standard FP counselling service to able-bodied students.	**1**	**2**	**3**	**4**	**5**
71. The provision of standard FP counselling service to disable students.	**1**	**2**	**3**	**4**	**5**
72. The quality of different IEC materials in relation to their relevance.	**1**	**2**	**3**	**4**	**5**
73. The quality of different IEC materials in relation to their attractiveness.	**1**	**2**	**3**	**4**	**5**
74. The quality of different IEC materials in relation to their quantity.	**1**	**2**	**3**	**4**	**5**
75. The provision of prevention and treatment of infertility service to all kinds of female students.	**1**	**2**	**3**	**4**	**5**
76. The provision of prevention of complications of unsafe abortion to any female students.	**1**	**2**	**3**	**4**	**5**
77. The provision of management of complications of unsafe abortion to any female students.	**1**	**2**	**3**	**4**	**5**
78. The provision of safe abortion services to any female student.	**1**	**2**	**3**	**4**	**5**
79. The provision of treatment of reproductive tract infections service to any student.	**1**	**2**	**3**	**4**	**5**
80. The service provision on sexually transmitted infections and other conditions of the reproductive system to any student.	**1**	**2**	**3**	**4**	**5**

81.	Any provision of STI drugs after diagnosis of STIs from the Samara Health facility.	**1**	**2**	**3**	**4**	**5**
82.	HIV Testing Counselling service of the health facility.	**1**	**2**	**3**	**4**	**5**
83.	The Provision of Anti-retroviral treatment (ART) for HIV positive students.	**1**	**2**	**3**	**4**	**5**
84.	Getting process of information and counselling on human sexuality for any student.	**1**	**2**	**3**	**4**	**5**
85.	Getting process of information and counselling on human sexual and reproductive health for any student.	**1**	**2**	**3**	**4**	**5**
86.	An active discouragement of harmful practices, such as female genital cutting services.	**1**	**2**	**3**	**4**	**5**
87.	Referral and linkage for additional services to other facilities to any needy student.	**1**	**2**	**3**	**4**	**5**
88.	The available Condom has quality.	**1**	**2**	**3**	**4**	**5**
89.	There are mobile condom distribution outlets in the Samara University.	**1**	**2**	**3**	**4**	**5**
90.	Quality Fixed condom outlets (away from sun light and rain, easy for use, etc) are available.	**1**	**2**	**3**	**4**	**5**

VI. Strengths, Constraints and Suggestions

91. What strengths do you observe in the overall SRH services provision of the in Samara University Health Facility? Please write on the space provided.

_____
_____
_____
_____
_____

92. What type of constraints do you observe in the provision of SRH service in-Samara University Health facility? Please write on the space provided.-

_____

93. What do you suggest to improve the SRH service provision? Please write on the space provided.

A. On the part of students

_____

B. On the part of the facility Staff members.

_____

C. On the part of the support staff like coordinating bodies like HIV/AIDS prevention and control offices, Gender offices, student dean office, etc

_____
_____

D. The University as a whole

_____
_____

E. Health Bureau/Ministry of Health/Ministry of Education

_____
_____

F. Other Stake holders

_____
_____

G. Any Suggestions

_____
_____
_____

Thank You!

Annex B: Student's Consent Form

Informed Consent Form For Study Participants/Studnets

This Interview Schedule is developed to assess the SRH services and related issues at Samara University in North-eastern Ethiopia.

This study will help us to have the understanding of the magnitude of the problem in relation with the availability of SRH and related service, its accessibility and quality of service. By doing this, the study will identify the strengths and areas that needs improvement.

Hence, by participating in this study you will contribute for the improvement of SRH services of Samara University as well as the whole Ethiopian Public Universities. In addition to that, you will be instrumental in adding value to the Social Work discipline.

If you agree to participate in this study, I will have a self-administered questioner to be filled on your educational background, Samara University health facility's general SRH and related service strengths, weaknesses, things that need improvement. The questioner will take 5 to 10 minutes.

Therefore, your opinion and experience are very important to us. Your participation is absolutely voluntary. I do request you to answer honestly, because it is important that we have complete and honest responses to the questions.

The answers are strictly confidential so your responses will not be shared with anyone and do not need your name or your identification. You will not be charged for your participation in the study.

Would you be willing to participate in the study? Please mark on your choice

☐Yes ☐No

If you have any doubts or questions in future, you may contact the study investigator through the following address.

Sisay Alemayehu
Phone:- 0913893980 or
Email:- alemayehu.sisay@yahoo.com

Thank you.

_____ _____

Signature of data collector Date

Annex C: Interview Guide for Semi-structured Interviews with Key Informants

Objectives of the Study

a. General Objective

The general objective of this research is to assess the SRH services and related issues at Samara University in North-eastern Ethiopia.

b. Specific objectives

- To assess the availability, accessibility and quality components of SRH at Samara University;
- To identify the strengths of the available SRH components at Samara University; and
- To identify the constraints of the available SRH components in Samara University.

C. **Checklist for Facility Professions**

1. Number of Rooms for use...
   - Diagnosis rooms,
   - drug
   - Counselling rooms
   - Bed rooms...
   - other
   - Beds.....
2. No. Of professionals serve in the Facility..... (Specialized MD...., GP....., Nurse (BSC)....., Nurse (Diploma)....?
3. What do you think of the friendliness of the clinic?

3.1. Is the infrastructure that invites students to come? ____
3.2 Is the operational hours fit to the needs of the students? ____
3.3 Is the location of the Facility liked by the student? _____
3.4. Is the service provision inviting? _____
3.5. Do the staffs get training in adolescent sexuality and youth-friendly SRH concepts? _____
3.6. Do you publicize the services for adolescents?_____
3.7. Do you (Service providers) have access to any policies, protocols or standards/guidelines related to providing quality youth-friendly SRH services?_____
3.8. Is there any Health Education/peer education/ in campus?_____
3.9. Do SRH related peer programs linked to clinic services, and all services?_____
3.10. Does the facility provide standard FP counseling service in campus?_____
3.11. Does the facility provide information and education on SRH issues?_____
3.12. Do you use IEC materials for health education purpose?_____
3.13. What kind of SRH services are you providing?

- prenatal, safe delivery and post natal care, including breast feeding;_____
- prevention and treatment of infertility;_____
- prevention and management of complications of unsafe abortion;__
- safe abortion services, _____
- treatment of reproductive tract infections, _____
- sexually transmitted diseases and other conditions of the reproductive system;____
- Provision of STI drugs?____
- HTC service,_____
- Provision of ART?_____
- information and counselling on human sexuality, responsible parenthood and sexual and reproductive health;_____
- active discouragement of harmful practices, such as female genital mutilation;_____
- Referral for additional services related to other Facilities____

3.14. Do you have condom distribution program?_____
3.15. What kind of outlets do you use for distribution? Mobile out lets/fixed outlets/number_____
3.16. Did the staffs get training in adolescent sexuality and youth-friendly SRH concepts? _____

Annex D: Focus Group Discussion Schedule/Guide

1. Is there any facility that is currently providing SRH service in the campus?
2. Have you ever gone to the health facility for service?
3. Have you ever gone to the health facility for any SRH service?
4. How often did you visit the Health Facility in the past six months?
5. For which SRH problems and services have you visited the facility?
6. What strengths do you see in the service provided by the clinic
7. What are the weaknesses you observe on the services provided by the facility?
8. Can you list areas the clinic and its staffs should do to improve service provision?
9. What should the administration of the University do in order to improve the service provision of the clinic?
10. What about Health Bureau can do to improve the clinic service provision?
11. What do you suggest other stockholders do to improve SRH service provision?

Annex E: Observation Schedule/Checklist

- Facility location: Describe the where about _____
- Facility working hours: Morning____ Afternoon___ Evening____ Night____
- Facility environment; Favorable: _____ Not favorable_____
- Privacy: good_____ Not Good_____
- Staff: the required numbers of staff for basic RH services.
- No. of professional Staffs GP__, BSC Nurse___, Diploma Nurse___
- Basic RH training. GP__, BSC Nurse___, Diploma Nurse___
- Youth-friendly SRH services, GP__, BSC Nurse___, Diploma Nurse___
- Adolescent reproductive health: GP__, BSC Nurse___, Diploma Nurse___
- Provider attitude:
- Towards the youth: Good _____Not Good____
- Towards their job: Good _____Not Good____
- Towards the area: Good _____Not Good____
- Supervision: Available___ Not available ___
- Client volume on daily basis: __ Sts/day
- Range of SRH services provided in the Facility:
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- Quality of services: Excellent ___Good ___Bad ___Very bad___
- Equipment and supplies:
- **Rooms**
  - Rooms for Lab Yes___No____: No. ___
  - Rooms for Medicines/supplies Yes___No____: No. ___
  - Rooms for diagnosis Yes___No____: No. ___

- Room for YFS Yes___No____: No. ___
- Waiting rooms Yes___No____: No. ___
- Bed rooms Yes___No____: No. ___

Medical and other Equipment Yes___No___

- IEC/BCC materials/media Yes___ No____
- Algorisms Yes___ No____
- Service Directory Yes___ No____
- Condom Supplies Yes ___No____
- Condom distribution outlets Yes ___No____
- Planning, Data collection and reporting:
- Well documented plans Yes___No____
- Well organized report Yes___No____
- The presence of registry Yes___No____
- The presence of Algorism Yes___No____
- Presence of working Peer programs:
- Orientation program for Freshman students on SRH: Yes ____No___
- Female students focused SRH program Yes____ No____
- Youth involvement:
- The presence of Anti HIV clubs Yes___No____
- The presence of other Clubs Yes___No____
- The presence of Students union Yes___No____
- Availability of Policies/protocols:
- National Policies on
    - HIV/AIDS, Yes___No____
    - SRH : Yes___No____
    - Gender: Yes___No____
    - Other specify: Yes___No____
- University Policy
    - HIV/AIDS, Yes___No____
    - SRH: Yes___No____
    - Gender: Yes___No____
    - Other specify
- Availability of Administrative Structures:
    - Separate structure for SRH & Related issues Yes___No____
    - Separate coordinating office for SRH & related issues: Yes___No____
    - Designated HR/focal person for SRH related issues: Yes___No____

Annex F: Document Analysis Template/Checklist

- Availability of essential documents
- National SRH Policy
- University SRH/HIV AIDS policy
- National Guideline and standards on SRH____
- University Guidelines and standards on SRH ____
- Reports
- Contents of the documents and their adherence with the national and international standards.
- University SRH/HIV AIDS policy
- Guideline and standards,
- Reports

Annex G: List of NGOs/CSOs/FBOs/CBOs in Afar Regional State, North-East Ethiopia

S. No.	Name of the Organization	Type of the Organization
1	Farm Africa	International NGO
2	SCUK	International NGO
3	SCUSA	International NGO
4	Coopi	International NGO
5	ICRC	International NGO
6	Mercy Corps	International NGO
7	Amigo	International NGO
8	De Silva	International NGO
9	ACDI/VOCA	International NGO
10	LWF	International FBO/NGO
11	WVE	International FBO/NGO
12	Missionaries of Charity	International FBO/NGO
13	APDA	Indigenous/National NGO
14	Rohi	Indigenous/National NGO
15	SSD	Indigenous/National NGO
16	Mahi Difu	Indigenous/National NGO
17	Regional Development Associations	Indigenous/National NGOs
18	Ethiopian Muslims	Indigenous/National NGO
19	Muluwongel Church	Indigenous/National NGO
20	Islamic Relief Organization	Indigenous/National NGO
21	Afar Pastoralist Forum	Reg. apex/Networking Organisations - Indigenous/National NGO
22	Advocacy and Human Rights Organizations	Indigenous/National NGO
23	Cooperatives (196 in number)	Economic and business interest groups Indigenous/National NGO
24	Union of Cooperatives	Economic and business interest groups/ Indigenous/National NGO
25	Chamber of Commerce and Sector Association	Economic and business interest groups / Indigenous/National NGO
26	Enterprise Workers Associations (6 in numbers)	Trade and labour unions - Indigenous/National NGO
27	Afar Regional State Teachers Association Association	Professional Association - Indigenous/National NGO
28	Age, Gender, Health-Status and other Occupation-Related Associations	Indigenous/National NGO
29	Afar Regional State Women Teachers Association	Indigenous/National NGO
30	Afar Youth and Women Association	Indigenous/National NGO
31	Afar Youth Association	Indigenous/National NGO
32	Afar Pastoralist Youth Association	Indigenous/National NGO
33	Basic Youth Associations at District Level (26 Youth Association and 26 Afar Youth Associations at District Level)	Indigenous/National NGO
34	Afar Women Association	Associations of/for Women -Indigenous/National NGO
35	Elderly and Disability Association	Indigenous/National NGO

36	Association of PLWHA in Afar Regional state	Indigenous/National NGO
37	Free Press	Indigenous/National NGO
38	Community Based Organisations - Basic Iddirs in Assaita, Logia, Dubti, etc. Towns of Afar Regional State	Indigenous/National CBOs/NGOs