

ETHIOPIAN PUBLIC HEALTH ASSOCIATION



YOUNG PEOPLE'S HIV/AIDS & REPRODUCTIVE HEALTH NEEDS AND UTILIZATION OF SERVICES IN SELECTED REGIONS OF ETHIOPIA

DECEMBER 2005

ADDIS ABABA

ETHIOPIA

This Publication is sponsored by the US Centers for Disease Control and Prevention (CDC) in accordance with the EPHA-CDC Cooperative Agreement No. U22/CC UO 22179-03.

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Table of Contents

Acknowledgements	i
List of Tables	ii
List of Figures	iii
List of Appendices	iii
Abbreviations	iv
Message from the President	v
Executive Summary	vi
I. Introduction	1
II. Literature Review	4
1. Issues in Young People’s Sexual and Reproductive Health	4
2. Factors Exacerbating Young People’s SRH Problems	6
III. Study Objectives	11
1. Specific Objectives	11
IV. Study Methodology and Material	12
1. Study Design and Period	12
2. Study Areas and Selection Procedures	12
3. Study Population and Sampling Procedure	12
4. Principal Data Collection Methods	13
5. Data Management and Analysis	14
6. Ethical Considerations	15
7. Operational Definitions	15
V. Results of the Study	17
1. Socio-demographic Characteristics of the Study Population	17
2. Knowledge, Attitudes and Perceptions (KAP) Of Young People about SRH and HIV/AIDS services (VCT, PMTCT and ART)	23
3. Young People’s Health Services Utilizations, Preferences and Attitudes towards Youth-Friendliness of the Services	37
4. Perceptions and Attitudes of Health Service Providers	43
5. Results of Visits and Observation at Selected Health Institutions	44
6. Perceptions and Attitudes of Parents and Community Members	47
7. Implications of Promoting Youth-Friendly SRH Services for HIV/AIDS Preven- tion and Control Programs	48
VI. Discussion	50
VII. Limitations of the Study	55
VIII. Conclusions	56
IX. Recommendations	58
X. References	61
XI. Appendices	64

Acknowledgements

This is to acknowledge that Ato Ambaye Degefa (Lead Consultant), and his team members Dr. Yared Mekonnen and Ato Gugsu Yimer conducted the study on Young People's HIV/AIDS & Reproductive Health Needs and Utilization of Services in Selected Regions of Ethiopia.

EPHA is deeply indebted to the study Team's contribution and commitment in realizing the activities EPHA entrusted upon. Therefore, I would like to acknowledge the diligence and professionalism demonstrated by Ato Ambaye Degefa and his team members in accomplishing this assignment, and once again EPHA congratulates them on their success.

Sincerely yours,

Ashenafi Negash MD.MPH

Executive Director, EPHA

Recognitions

None of this work would have been possible without the willingness of the study subjects. Hence, we would like to express our sincere appreciation to the study subjects; to the young and older people and service providers who participated in questionnaire interviews, FGDs, IDIs and responded patiently to rather lengthy questions.

We would also like to express our gratitude to all those organizations and individuals in Addis Ababa and the Regions that provided us with the necessary information, documents and support in facilitating the data collection and fieldwork.

The Ethiopian Public Health Association EPHA and CDC/USA have financially supported this study. We would like to acknowledge EPHA and CDC/USA for the financial and administrative support.

In particular, we wish to extend our sincere thanks to EPHA Executive Committee Members, reviewers, the EPHA/CDC project Research and Dissemination officer Ato Berhanu Legesse, for his genuine help and useful suggestions from the very beginning of selecting the research proposal and throughout the course of this work.

Ambaye Degefa (PI)

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List of Tables

Table	Title	Page
Table 1	Socio-demographic characteristics of study subjects.	19
Table 2	Characteristics of sexually active study subjects.	20
Table 3	Distribution of reported SRH problems by selected characteristics.	22
Table 4	Level of knowledge of what SRH is and major growth changes at puberty, by selected characteristics.	25
Table 5	Knowledge of HIV and STIs, by selected characteristics.	28
Table 6	Knowledge of PMTCT and ART by selected characteristics.	32
Table 7	Proportion of respondents ever visiting health institutions for SRH services.	38
Table 8	Proportion of respondents ever visiting VCT centres.	38
Table 9	Young people's preferences of health institutions and service providers.	42
Table 10	Distribution of health institutions observed by type of ownership.	44

List of Figures

Figure	Title	Page
Figure 1	Socio-demographic characteristics of sexually active young people	21
Figure 2	Level of knowledge about the most fertile time of the menstrual cycle.	26
Figure 3	Proportion of sexually active ever-users of contraceptives.	39

List of Appendices

Appendix	Title	Page
Appendix 1	Questionnaire for study in to Young People's Needs, Utilization and Friendliness of Reproductive Health and HIV/AIDS Services.	64
Appendix 2	Open-ended questions and guidelines of in-depth interviews and focus group discussions with young people.	75
Appendix 3	Open-ended questions and guidelines of in-depth interviews and focus group discussions with parents and older community members.	76
Appendix 4	Open-ended questions and guidelines of in-depth interviews and focus group discussions with health workers and service providers.	77
Appendix 5	Consent form for research into young people's needs for SRH and HIV/AIDS services.	78
Appendix 6	Inventory of observed health institutions.	79

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ARH	Adolescent Reproductive Health
ART	Antiretroviral Therapy
BCC	Behavioral Change Communication
BSS	Behavioral Surveillance Survey
CBRHA	Community Based Reproductive Health Agent
CORHA	Consortium of Reproductive Health Associations
CSWs	Commercial Sex Workers
CDC	Centers for Disease Control and Prevention
CRLP	Center for Reproductive Law and Policy
EPHA	Ethiopian Public Health Association
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FHD	Family Health Department
FLE	Family Life Education
FP	Family Planning
GOs	Government Organizations
HIV	Human Immunodeficiency Virus
HP	Health Professional
IDI	In-depth Interview
ICPD	International conference on Population and Development
IEC	Information Education Communication
ISY	In School Youth
KAP	Knowledge, Attitudes and Perceptions
MD	Medical Doctor
MOH	Ministry Of Health
MOLSA	Ministry Of Labour and Social Affairs
MHPs	Modern Health Professionals
MOYSC	Ministry Of Youth, Sport and Culture
NGO	Non-Governmental Organization
OCP	Oral Contraceptive Pill
OSSA	Organization for Social Services for AIDS
OSY	Out of School Youth
PA	Peasant Association
PMTCT	Prevention of Mother to Child Transmission
PO	Participant Observation
QS	Questionnaire Survey
RH	Reproductive Health
RHAPCO	Regional HIV/AIDS Prevention and Control Office
SRH	Sexual and Reproductive Health
SRHPs	Sexual and Reproductive Health Problems
SRHSs	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
UNAIDS	United Nations programs on HIV/AIDS
UNFPA	United Nations Population Fund

Message from the EPHA President

This report summarizes important work into the sexual and reproductive health needs of young Ethiopians. The generation of young people now in their late teens and early twenties is faced by unprecedented choice, but also daunting challenges. The combined effects of rapid urbanization and loosening cultural ties influence these young men and women at the same time that the impact of HIV/AIDS is being felt throughout Ethiopian society.

The central findings of this study are that young people lack understanding of reproductive health issues, experience significant problems related to their sexual and reproductive health, and yet are reluctant to seek help for these problems. If available at all, the reproductive services provided in most regions are not designed with young people in mind and so may appear unwelcoming or unattractive. Health personnel are often ill-equipped to provide management and advice tailored to the needs of young people.

However, there are positive elements to the study findings. The mould-breaking Model Youth Centers of the Family Guidance Association of Ethiopia demonstrate that it is possible to achieve accessible, attractive centers in which young peoples' sexual and reproductive needs are tended to in the context of the wellbeing of the whole individual.

All those interested in the health of young people in Ethiopia will find information that will both challenge and inspire in this report, I would therefore encourage you to apply the recommendations forwarded by the researchers.

Finally, EPHA would like to thank the US Centers for Disease Control and Prevention (CDC) for supporting the EPHA-CDC Project, also wish to extend its sincere appreciation for the commitment demonstrated by the researchers in undertaking this important work.

Sincerely Yours

Getnet Mitike MD. MPH

Vice-President, EPHA

Executive Summary

In the past, young people's specific needs for sexual and reproductive health (SRH) information and services have been poorly understood or served in most countries of the world. These days, however, since young people's SRH problems are becoming a serious public health issue in many countries, the need for specific youth-friendly SRH services for young people has gained recognition.

The main objective of this study was to systematically investigate young people's knowledge and specific needs for SRH and HIV/AIDS prevention and treatment services, their utilization patterns and the youth-friendliness of the services. In addition, the study intended to identify the nature of the existing problems and gaps and to indicate solutions. The study was conducted between October 1 and December 10, 2004 in eight selected regions of Ethiopia. The study subjects were young people in the age range of 10-24 years.

The study employed qualitative (FGD, IDI and PO) and cross-sectional quantitative survey design. The atmosphere (youth-friendliness) of existing health institutions was assessed employing field visits and participant observation methods. Data analysis was performed using SPSS/PC+ software for quantitative data and appropriate thematic and content analysis technique for qualitative data.

The study revealed that young people lack adequate early information, education and sound guidance on SRH matters. Their level of knowledge about what SRH is and their capacity to reproduce in the early teenage years was found to be inadequate. A considerable proportion of young people were found to be practicing risky behaviors: about 39.2% reported having had sexual intercourse and 7.6% of them had early sexual debut before age 15 years. Moreover, 45.1% acknowledged having had more than one sexual partner, 15.8% admitted having had sexual intercourse with commercial sex workers, and 34.9% reported having had reproductive health problems, of whom 28.7%, 24.1% and 45.1% claimed to have had unwanted pregnancy, abortion or STIs, respectively, in their lifetime.

Utilization of SRH services by young people was found to be low. Only 6.7% and 2.4% reported ever visiting the existing health institutions for SRH and VCT services, respectively. This was mainly due to lack of specific and youth-friendly health facilities that meet the needs of young people. 94.4% of young people reported that the existing public health institutions were not youth friendly. Health service providers also agreed that the needs of young people for SRH services were poorly served in many public health institutions. Observation of the existing health institutions also showed that they were not located in youth-friendly environments, except for the Model Youth Centers of FGAE.

In conclusion, in the current HIV/AIDS crisis, young people's needs for SRH-related information and services have not received serious attention and are not well addressed by the existing health services. For positive impact in the reduction of HIV incidence and SRH problems in Ethiopia, promoting specific youth-friendly SRH and HIV/AIDS prevention and control services is thus mandatory. Hence researchers recommend that organizing youth-friendly SRH and HIV/AIDS services should be given urgent attention by decision makers, public health planners and health service providers with the involvement of young people, particularly girls, at all levels of the endeavor.

1. Introduction

At present, the world is experiencing unprecedented and escalating health hazards of young people (1,2,3). When viewed from various behavioral, cognitive and developmental perspectives, young people can be labeled as a vulnerable group (1, 2). As a group they suffer from a serious and disproportionate share of health problems (2-4), and above all are threatened by sexual and reproductive health problems (2, 3).

These days, most young people are exposed to risky behavioral practices in their teens (2, 3). Above all, because they practice risky behaviors without precautions, they are exposed to various SRH problems, including STIs and HIV/AIDS. In addition to this, the well-being of females is jeopardized by unwanted teenage pregnancy, unsafe abortion-related complications, drop-out from schools, and separation from the family (4-6).

Especially these days, all over the world, young people are highly suffering from the tragedy of HIV/AIDS. Since the beginning of the HIV/AIDS epidemic, millions of young people have been infected with HIV and millions of them have died of AIDS (6-8). Globally young people account for

half of all new cases of HIV infection (5, 8). For this reason, young people around the world have been termed the "AIDS generation". Not a single boy or girl under 20 years of age has known a world without HIV (10). In addition to this, cases of STIs, unwanted pregnancy, and induced abortion have increased considerably among young people (9, 10).

Young people throughout the world and particularly those in developing countries have been exposed to these health risks because they do not have adequate information, knowledge or guidance about STIs, HIV/AIDS, SRH and related problems (11-14). From an early age, they lack adequate support and guidance from parents, communities or other concerned bodies. Moreover, they have limited access to health services, or there are no health facilities that have been arranged for them to solve the problems they face (14). In addition, comprehensive national youth SRH policies and strategies that specifically address and meet young people's needs are scarce and relatively uncommon in most countries (15, 3). As a result, in many settings young people have few places to look for accurate information and sound guidance, counseling and treatment on SRH, HIV/AIDS, STI (14, 15). The problems that young people currently

face warrant meaningful consideration.

Ethiopian young people have problems similar to young people elsewhere. Although they have profound reproductive health needs, these have been neglected for many years. Their needs of SRH information and services have not been recognized (16-20). Some studies and assessments carried out in recent years in different parts of the country have indicated that Ethiopian young people (aged 10-24) have emerged as the segment of the population most susceptible to a broad spectrum of serious SRH problems including STI and HIV/AIDS infections, unwanted pregnancies and unsafe abortions (16-20, 22-29). Several studies have shown that issues related to SRH must be addressed urgently.

Unfortunately to date there are no practical activities addressing specific SRH services for young people in Ethiopia (18-20). Some recent assessments indicate that the major problems of Ethiopian youth are related to lack of SRH services designed for them (21-25). That is, there is scarcity of special youth SRH and HIV/AIDS prevention and treatment services, whether integrated with the existing health facilities or free standing and ideally providing basic services and reliable information to young people

in affordable, confidential and youth-friendly environment. The existing public health programs and services cater to a wider range of age groups, and have limited coverage of young people (21,22).

However, except for a few studies that have been conducted in specific areas there is a lack of systematically collected information on young people's SRH knowledge, needs and utilization of SRH services. Furthermore, rigorous assessment has not been undertaken so far to identify whether special and youth-friendly SRH and HIV/AIDS prevention and treatment services (GO, NGO, Private etc) exist in the country for young people, or how far the services that are provided meet the needs of young people.

This study is therefore undertaken to systematically investigate young people's SRH and HIV/AIDS prevention and treatment services, their utilization patterns and youth-friendliness from the point of view of youth, service providers, parents and community members. The study also endeavor to pinpoint the existing problems and gaps in providing SRH and HIV/AIDS prevention and treatment services for young people.

This study generates significant and relevant information on young people's needs for SRH and HIV/AIDS services, on their utilization of health services and on the youth-friendliness of existing services. It provides ideas on the importance of promoting specific youth-friendly SRH and HIV/AIDS prevention and treatment services for young people. It also forwards suggestions on how to make interventions in these areas and fill critical gaps in the design of youth-friendly SRH and HIV/AIDS services in the country.

II. Literature Review

1. Issues in Young People's Sexual and Reproductive Health

Young people, particularly those living in the developing countries, are vulnerable to various health risks. In the past, health services often regarded this group as risk free and not in need of priority action, and so provided a minimum subset of health services with no adjustment for their special needs (3, 4, 13,14). However, nowadays, various studies have indicated that numerous biological, psychological and social pressures that emerge in adolescence predispose young people to SRH disorders and problems (32).

Young people are engaged in teenage and premarital sexual practices and are at risk of unwanted and teenage pregnancy, induced abortion and death due to its complications, school drop-out and STIs, in particular HIV infection (15). A recent survey of young people aged 15 to 19 years in Brazil, Hungary and Kenya found that more than a quarter reported having sex before they were 15 years old (5). Among African countries, in Kenya, in a large adolescent study, it was found that 4% were sexually active before the age of 10 years, and in Ghana 12% of teenag-

ers had sexual relations before age 15 (5, 38).

Likewise, in Ethiopia recent studies conducted on adolescent fertility and reproductive risk behavior, have shown that adolescents begin sexual practice before the age of 15. The mean age reported for first sexual initiation is between 13.6 and 19 years (17-20, 27-29,42). In a study done in Addis Ababa, it was found that the earliest reported age of initiation of sexual intercourse for girls was 14 years (mean age 15.30 years), and for boys earliest initiation was at 12 years (mean age 16.45 years) (44).

In most cases, unwanted and unplanned teenage pregnancy, which has many negative consequences on the health and wellbeing of girls, is one of the greatest problems they face due to early and most often unprotected and unsafe sexual practices (3,5,11). In developing countries, approximately 60% of pregnancies and births to married and unmarried adolescents are unintended (35); and complications of unwanted pregnancy are the leading cause of death among young girls aged 15 to 19 years. A study on adolescent fertility in Sub-Saharan Africa revealed that 50-75% of first teenage pregnancies in adolescents, in five out of eight countries surveyed, were un-

wanted and unplanned (38,39). Likewise in Ethiopia, 15% to 60% of adolescent pregnancies are unwanted or unintended, resulting from unprotected sexual intercourse (23). In Harar, 15% of adolescent pregnancies were unwanted (46,47); in Gondar, 30.1% (48); and in Kola Deba, 50% (27).

Often unwanted teenage pregnancies lead to serious health risks as well as social and economic problems. Early and unplanned marriage, teen parenthood, school drop out, and unsafe and complicated abortion (11,32) rank high among these problems. According to WHO estimation, worldwide, as many as 4.4 million adolescent girls seek unsafe abortions each year (3,49). It is also estimated that in developing countries about 2 million adolescent women undergo unsafe abortions each year and a third of all women seeking hospital care for abortion complication are under the age of 20. In Nigeria, for instance, 50-70% of women hospitalized for complications of abortion were younger than 20 years. In one study in Ghana, 25% of women under the age of 20 years had terminated their pregnancy through illegally induced abortion, mostly under dangerous conditions (39).

Studies carried out in Ethiopia also indicate that illegal abortion due to unwanted and unplanned teenage preg-

nancy places many young women at high risk, primarily because it is usually performed under unsafe conditions (20, 50-53). Different hospital-based studies have revealed that 25-57.5% of induced abortions are among young women aged 15 to 20 years (50-53). A very recent report on unsafe abortion made public by the Ethiopian Society of Obstetricians and Gynecologists (ESOG) indicates that over 45% of cases who visited health facilities because of abortion were adolescents in the age group 15-19 (53).

Other potential negative outcomes of early teenage and unsafe sexual practices are high risk of contracting STIs and HIV, through high rates of unprotected sex with multiple partners among young people. These days the number of cases of STIs is considerably increasing. According to WHO estimates, out of the expected 333 million new cases of STIs, excluding HIV, that occur in the world every year, over 100 million occur among young people less than 25 years of age (3,7). In Sub-Saharan Africa, it has been estimated that about 10-20% of sexually active young people have STIs (9).

In Ethiopia, because STIs are mostly self-treated at home by individuals and are therefore concealed, it is difficult

to estimate their magnitude accurately. However, available data from health institutions demonstrate a high incidence of STIs among youth in the country. According to the MOH 1993 report, analysis of the distribution of STI cases attending STD clinics during 1991-1992 showed that prevalence was highest among 15-24 year-olds (53.6%), followed by the 25-35 age group (26.3%) (23). In studies done in Awassa among out of school adolescents, prevalence of STIs was found to be 6.5% and 4% in 1995 and 1998, respectively (28, 54).

Above all, these days, HIV/AIDS is one of the serious reproductive health problems affecting young people. Reports from different countries show that young people are the main victims of HIV/AIDS worldwide. To date, according to UNAIDS 2002 data, an estimated 11.8 million young people aged 15-24 are living with HIV/AIDS (8). Each day, nearly 6,000 young people aged 15-24 become infected with HIV. Sub-Saharan Africa contains almost two-thirds (62%, i.e. 6.2 million people) of all young people living with HIV, and of these 75% are young females (9). In Ethiopia, according to the report of the MOH on HIV/AIDS, the highest prevalence of HIV infection is in the age group 15 to 24 years (12.1%) (55). HIV prevalence is esti-

mated to be 6 to 9 percent among young men aged 15-24, and 10 to 13 percent among young women in the same age group.

2. Factors Exacerbating Young People's Problems

Lack of information and guidance

Although the 1994 ICPD of Cairo endorses the right of young people to get SRH care, information and services that meet their needs, of the one billion young people worldwide, most still lack adequate SRH information and appropriate guidance (31). Due to this, the vast majority of young people make unrealistic decisions about initiating sexual activity in their early teens, without understanding their vulnerability to problems such as teenage pregnancy, unsafe abortion, STIs, HIV/AIDS, drop out from school and separation from their family (3,9,11,13, 33).

In Ethiopia the same issues are observed; young people lack appropriate information, communication and guidance in SRH matters (18,19,23). Adequate systems are not yet in place to reach all young people in need of information, appropriate guidance and counseling services in the country.

Socio-cultural and economic factors

Socio-cultural and economic factors are the main barriers to young people obtaining adequate SRH information and services. Due to constraining social norms and taboos, communication between parents and young people is not open (35,59). This reflects the socio-cultural norms, religious beliefs and sense of morality that characterize Ethiopian society, where discussion of sexuality is considered taboo and open communication between children and parents or communities is discouraged (34, 59). Due to this, young people have little access to counseling and guidance on SRH matters from their family or community members. Studies performed in China (38), Kenya (39) and Sweden (60) indicate that young people feel that it is shameful to discuss physical, psychological and body changes during adolescence with parents or other community members and are embarrassed to seek SRH services if they encounter problems such as STIs. As an alternative they prefer consulting and discussing with their peers.

In Ethiopia, studies (17-20, 22-24, 29, 43,44) have shown a lack of discussion and communication between parents and young people on matters of

sexuality and reproductive health. Nevertheless, attitudes and perceptions of the parents and communities have not intensively investigated and documented so far. Moreover, some studies have shown that young people may participate in “survival sex” or “transactional” or commercial sex due to economic factors. Young females are more likely to be exposed to such activities (40).

Absence of SRH policies and guidelines

An alarming increase in teenage and premarital sexual experience, teen pregnancy rates and unsafe abortions, together with rising levels of STIs and HIV infection, have heightened the sense of urgency for action on having comprehensive national youth SRH policies and programs. The presence of supportive SRH strategies and guidelines provide legitimacy to young people's reproductive health issues (61,62).

Comprehensive national youth policies, programs and strategies that specifically address and meet young people's sexual and reproductive health needs are scarce in many countries. The absence of an overarching and standardized national youth policy is a serious obstacle to providing SRH ser-

vices and raising awareness of young people's needs (61,62). Almost 60 countries worldwide, including Ghana, Jamaica, Malawi, and Papua New Guinea, have broad national youth policies and youth co-ordinating mechanisms, and are implementing a national youth program of action (61). In the Latin American and Caribbean region, eight of 30 countries surveyed in 1996 had a national policy on adolescent health, and five more were drafting such policies (61). Among Sub Saharan African countries, Ghana has set forth a strong and comprehensive adolescent reproductive health policy and strategy (61).

In Ethiopia, like other developing countries, the needs of young people have been unrecognized or neglected until very recently. In 2004, a national youth policy was developed and endorsed. Although this youth policy encompasses very general youth issues, it also emphasizes the importance of facilitating and providing SRH and HIV/AIDS information and services to young people.

The Ethiopian Federal Ministry of Health has been pursuing various adolescent reproductive health initiatives under its Family Health Department (FHD) since the mid-1990s (23). For instance, the Department developed the "Five-Year Action Plan for Ado-

lescent Reproductive Health in Ethiopia" in 2002. The plan aims to increase access and utilization of SRH services, and to increase information and knowledge about young people's reproductive health that might lead to positive behavior change (23). In 2003, the Family Health Department developed an Adolescent Reproductive Health Extension Package Program for implementation in rural Ethiopia. However, neither program nor plan has been put into action at regional or local service delivery level. No comprehensive national Adolescent Reproductive Health program on how to meet the needs of young people has yet been developed, though in the Five-Year Action Plan of the Family Health Department, it was stated that such a strategy would be developed after reviews of the existing related government policies and programs (23).

The activities of several international agencies and local NGOs have provided an important basis for HIV/AIDS and reproductive health work in Ethiopia. Most of them have been active in HIV/AIDS and reproductive health communication activities since the early 1990s. Nevertheless, due to lack of national ARH policy and guidelines, activities and service provision in the country regarding young

people's HIV/AIDS and SRH issues remain uncoordinated.

Although about 65 international and local NGOs that are working in the areas of HIV/AIDS and SRH in Ethiopia have formed a network known as the "Consortium of Reproductive Health Associations (CORHA)" (25), they have no common SRH/ARH strategies. They largely function by developing their own programs and strategies. For instance, FGAE has designed and developed its own youth SRH programs and work plans placing a strong programmatic emphasis on services and activities that improve youth access to information and care. Its programs are specifically designed in line with youth-friendly concepts and characteristics (66). Similar NGOs have also designed and developed their own adolescent SRH programs and guidelines, and made an effort to implement them in different target areas of Ethiopia.

In general, the absence of a clear national ARH/SRH strategy and a uniformly planned service provision system within the government and NGO sectors has led to the disintegration of the few existing services.

Lack of youth-friendly reproductive health services

A number of youth SRH studies have investigated the obstacles young people face in obtaining appropriate and timely health services related to SRH problems. Lack of youth-friendly health facilities is one of the barriers identified (4, 6,14, 15, 67). In most countries, especially in developing ones, there is a lack of special health facilities for young people. Because of this, young people are forced to visit public health centers that are established to serve adults and are dominated by adults (15, 31,67). The existing public health facilities are not youth-friendly in providing SRH services to young people (68). Because public health institutions are most often organized to meet the health care needs of the general public, services provided in these public health facilities may not address young peoples' needs, and in some cases they are intimidating and unfriendly (68, 69). Due to this, young people are not encouraged to visit most public health institutions. For instance, a survey performed in Nepal regarding adolescent reproductive health services and attitudes of providers indicated that access to SRH services in public health facilities is poor and unfriendly for young girls (69). Case studies from Senegal

and South Africa also indicate that when adolescents approach clinics for help, they are often scolded, refused information, or turned away (21). In study done in Guinea, west Africa, adolescents complained of long waiting times (42%), lack of privacy and fear of being identified as sexually active by their elders (39%), poor rapport with a clinic counselor (24%), dissatisfaction with quality of services (16%) and high fees (15%) (69).

In Ethiopia, in addition to poor health service coverage for the general population, there is a scarcity of specialized health facilities for young people in youth-friendly environments. Most health facilities are geared to older adults. Certain studies (18- 20, 22-24, 70) have revealed that the major problem for young Ethiopians is related to the lack of SRH services designed for them. A needs assessment report among NGOs in Ethiopia involved in SRH revealed that, with few exceptions, health care providers and social sector professionals agree that the existing health care services do not meet the needs of today's young people (71). Likewise, assessments of the SRH needs of young people conducted by the Family Health Department of the Ministry of Health also revealed that existing health programs and services cater to a wide range of age

groups, have limited coverage of young people; and that services like family planning are mostly provided to adults and married couples (22).

Most health service providers and organizations who work in prevention and control of HIV/AIDS realized that it is crucial to address the SRH needs of young people and to increase specialized youth-friendly SRH and HIV/AIDS services in order to save the young generation from the rapidly spreading HIV epidemic (4,6,33). Young people could play a significant role in HIV/AIDS prevention if their needs are met and they get access to youth-friendly SRH and HIV/AIDS services and interactive IEC/BCC programs designed for them. The experiences of some countries who have promoted youth-friendly ARH/SRH services and HIV/AIDS programs show that these programs improve risky behavioral practices and reduce the vulnerability of young people to the epidemic (5,11,31).

III. Study Objectives

General objective

The general objective of this study was to systematically investigate young people's needs for specific SRH and HIV/AIDS prevention and treatment services, utilization patterns and

youth-friendliness of the services; to identify the nature of the existing problems and gaps and to suggest possible practical solutions.

Specific objectives

- To assess knowledge, attitudes and perceptions (KAP) of young people regarding SRH and HIV/AIDS prevention and treatment services, and problems and factors that expose them to risk,
- To identify specific SRH and HIV/AIDS prevention and treatment service needs, patterns of health services utilization, preferences and youth-friendliness of the services from the perspectives of young people,
- To discover the perceptions and attitudes of service providers towards the specific SRH and HIV/AIDS prevention and treatment services they provide to young people,
- To identify health facilities and organizations involved in providing SRH and HIV/AIDS prevention and treatment services to young people,
- To assess the state of existing health facilities and any available documents concerning their internal programs and strategies, from the point of view of youth-friendly characteristics,
- To assess parents' and community members' attitudes and perceptions towards SRH and their roles as primary educators, counselors and guides,
- To investigate the implications of promoting youth-friendly SRH and HIV/AIDS services for HIV/AIDS prevention and control programs.

IV. Study Methodology and Materials

1. Study Design and Period

The study employed both qualitative and cross-sectional quantitative survey designs and was conducted between October 1, 2004 and December 30, 2004.

2. Study Areas and Selection Procedures

The study was conducted in eight selected regions of the country, namely Addis Ababa, Oromia, Amhara, SNNPR, Tigray, Dire Dawa, Harari and Benishangul. The remaining three regions, Afar, Somali and Gambella, were excluded because of capacity limitation, time and financial constraints. Purely from a capacity and time limitation perspective we used a purposive approach in selection of the study sites. At first, two non-adjacent Zones were selected from each Region. Then from each Zone, two urban and two rural Kebeles were selected, thus the study was conducted in 32 purposively selected study sites (16 urban and 16 rural Kebeles). The rural Kebeles selected were those found within 50km of the nearest town.

3. Study Population and Sampling Procedure

The source population was all young people aged 10-24 years, parents, older community members and service providers.

For the questionnaire survey the target sample size was 2400 young people (1200 male and 1200 female, including 1200 urban and 1200 rural). This sample size was calculated using EPI Info. In calculating the sample size, the proportion of adolescents expected to be sexually active was taken into consideration. Studies done on adolescents in Ethiopia indicate that between 18 and 30 percent of young people are sexually active (18,27,42,44,75). Accordingly, taking an expected average frequency of 25% sexual activity, with 95% level of confidence, +/-5% worst acceptable result and 80% power, a target sample size of 2400 youth population (aged 10-24 years and including 300 for each study region) was calculated. At study sites, eligible youth respondents (75 from each urban and rural Kebele) were selected from every other household starting from a randomly selected household. From each household only one eligible youth was selected and interviewed.

For the FGDs and IDIs, selection of

the study population was conducted using purposive sampling. On the selection of study participants, for both qualitative and quantitative methods, emphasis was given to ensure adequate representation of youth consisting of all specific characteristics such as in school, out of school, married, unmarried, employed, unemployed etc.

4. Principal Data Collection Methods

Data collection was performed using both quantitative and qualitative techniques, including a questionnaire survey (QS), focus group discussions (FGD), in-depth interviews (IDI) and participant observation (PO). The standardized use of these principal data collection instruments was intended to explore a range of information and to make possible generation of in-depth data that complemented and triangulated each other.

Quantitative Technique - Questionnaire survey (QS)

For the questionnaire survey (QS), an anonymous, structured and close-ended, pre-tested and pre-coded questionnaire was designed and employed. The questionnaire included topics like: socio-demographic characteristics, knowledge, attitudes and perceptions of young people about SRH, STIs, HIV/AIDS, VCT,

PMTCT, ART & sources of information, (see Appendix 1). The questionnaire was adapted in order to ensure that it took into account the specific socio-cultural realities of Ethiopia, and that it was acceptable to the target population concerned. It was translated into Amharic and pilot tested. Interviewers who were the same age group as participants, and responsible for interviews with participants of the same sex, were selected at the study site, trained by the team leaders and provided with prepared interviewer guidelines and other necessary materials. Professional anthropologists were used as team leaders, supervisors and FGD- and IDI-moderators.

Qualitative Techniques

In order to generate information that could not be captured through the individual structured interview and to substantiate the quantitative data and analysis, qualitative assessment was also made throughout the survey areas. Focus group discussions (FGDs) and in-depth interviews (IDIs), including participant observations (PO) were conducted. For both FGDs and IDIs open-ended guide questions for all target groups were designed in advance to facilitate data collection, (see Appendices 2 to 4).

Focus group discussions (FGDs):

In each study region, four FGDs were conducted, in which 6-10 individuals participated. Three FGDs (one with in-school youth, one with out-of-school youth, one with representatives of parents and community members) were conducted at the study kebeles, while one FGD with health service providers was held at the zonal capital. In total 32 FGDs were conducted in which 256 discussants participated. Moderators led discussions of the FGDs. The responses were recorded on tape, transcribed and translated into English, and analyzed by the investigators. The most important findings were incorporated into this report.

In-depth interviews (IDIs): Using open-ended questions, 12 IDIs were conducted in each study region. Four informants were selected from in- and out-of-school youth, two from among key service providers, two from Health Bureaus and HIV/AIDS Secretariat office, two from adults in the community, and two from existing youth anti-HIV/AIDS clubs. Overall 96 individuals participated in the in-depth interviews. Responses were recorded on tape, transcribed and translated into English and analyzed by the investigators. The findings were also incorporated into this report.

Participant observation (PO): Using field guidelines, investigators carried out field visits and systematic participant observations to assess the state of existing health facilities from the point of view of youth-friendly characteristics, i.e., accessibility, cost, whether they are free-standing or integrated, types and quality of services they provided to young people (including whether there was a specific package for adolescents), suitability of the whole environment; including working hours, and adequacy of trained staff, and the collected data analyzed by principal investigator by triangulating with other data.

Among the health institutions existing in the study sites, those that were thought to provide SRH and HIV/AIDS services to young people were selected. They were selected from all categories, that is, from government and private hospitals, clinics, NGO clinics, pharmacies, health centers, health posts, family guidance clinics and youth centers. In total, 48 health institutions were selected, visited and critically observed.

5. Data Management and Analysis

Data editing and coding: A well-trained professional team leader and supervisor anthropologist edited each open-ended question and questionnaire

at the site. At office level all questionnaires were edited and post-coded for computerization by the investigators.

Data entry and analysis: Trained data entry clerks under the close supervision of the principal investigator entered survey data into a computer using SPSS/PC+. Both the qualitative and quantitative data were analyzed using appropriate qualitative (thematic and content analysis) or quantitative statistical data analysis (using SPSS/PC+ software) techniques. Data obtained from participant observations were also systematically analyzed and triangulation was done. Both quantitative and qualitative data results were integrated in this report in such a way as to complement each other.

6. Ethical Considerations

Participation of all respondents in the questionnaire survey, FGDs and IDIs was strictly voluntary. Measures were taken to assure the respect, dignity and freedom of each individual participating in the study. Information on the purpose and procedures of the study was given verbally to all study subjects. Verbal consent was obtained before conducting each interview, and participants were assured of complete

confidentiality of information.

7. Operational Definitions

The following terms were used in accordance to established definitions.

Youth, young people or adolescents:

Those who are in the age group 10 to 24 (using definition of UNICEF, UNAIDS & WHO) (5).

Youth-friendly service: Services that have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving young people, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits (4).

Health institutions or facilities: Refers to organizations or outlets that are providing health services.

Reproductive Health: Refers to a state of complete physical, mental and social well being in all matters relating to the reproductive system and processes, and encompasses the full range of methods and techniques required for that purpose. It also extends beyond the technical side of family planning and the absence of disease and infirmity and therefore implies sexual health, i.e. the possibility of having a satisfying and safe sex life, the

capability to reproduce and the freedom to decide if, when and how often to do so (58).

Adolescent Reproductive Health: refers to adolescents' state of complete physical, mental and social well-being in all matters relating to the reproductive system and processes (58).

Reproductive Health Problem: Such health problems as unwanted pregnancy, unsafe abortion, or STIs which young people who are sexually active encounter (54).

Age Specific Reproductive Health Services: Refers to comprehensive prevention, treatment and follow-up care that health institutions should provide specifically for young people aged 10-24 years. The services include sexual and RH education and counseling; physical examinations; STI screening, counseling and treatment; HIV testing and counseling; contraceptive methods choice, adoption and follow-up; pregnancy testing and options counseling; abortion services (where legal) and post abortion care; prenatal and postpartum care; infant care and nutritional services (4).

Youth Reproductive Health Needs: refers to young people's needs for information and education about SRH, especially that related to

physical and biological development and emotional maturation, boy-girl relationships, decision making about sex, adoption of contraceptive methods, pregnancy options, sexual and contraceptive negotiation (4).

Definitions of economic status labeling terms:

Since it is difficult to give accurate measurable definitions to economic status labeling terms such as Poor, Medium, and Rich, for this study, straightforward definitions are used. Thus:

Poor: refers to those who have little or no basic assets for living

Medium: refers to those who have basic assets for living.

Rich: refers to those who possess greater assets and whose living condition is above the average.

V. Results of the Study

1. Socio-demographic characteristics of the Study

Population

A total of 2400 young people participated in the individual questionnaire interview. Of these, 10 (0.4%) responded inconsistently and were excluded from the analysis. Hence, the final analysis was made based on 2390 completed questionnaires. The response rate was 99.58% of the 2400 calculated sample size.

A similar number of study subjects were selected from urban and rural sites. Almost equal numbers of males and females participated in the study (1198 (50.1%) and 1192 (49.9%) respectively), giving a male to female ratio of 1:1. The age range varied from 10-24 years. Mean age was 17.04 years (SD 3.84) [18.13 years (SD 3.69) for males, and 15.95 years (SD 3.68) for females]. Out of the total subjects, 45.9% were in the age group 15-19 years old. The socio-demographic characteristics of the study subjects are shown in Table 1.

576 (24.1%) of study participants were married at the time of the survey. As expected the proportion of young females who currently married were slightly higher (53.1%) than males (46.9%). In

terms of ethnicity, the respondents have quite diverse ethnic origins, which include a total of 15 ethnic groups. However, the majority of the respondents (26.9%, 25.4% and 14.4%) were Oromo, Amhara and Tigrie respectively (see Table 1). The profile of respondents in terms of religion depicts the pattern seen in the country, with 43.1% were Orthodox Christians, 35.1% Muslim and the remaining Protestant and Catholic Christians.

1045 (43.7%) and 1345 (56.3%) of study participants were in-school and out-of-school youth, respectively, at the time of survey. The number of in-school respondents was slightly higher among females than males (56.4% versus 43.6%), while the reverse was true among out-of-school youth (44.8% females and 55.2% males). The proportion of in-school and out-of-school respondents varied by age category. The number of in-school young people was high among the age group 10-14 years (44.9%) while it was low among the age group 20-24 (6.3%).

Of the out-of-school study subjects 11.4% had no job, 6.2% were daily laborers, 15.2% were farmers, 6.5% were employees in government or private sectors and 0.8% of them had a private business. Over 66.5% of the

respondents had no monthly income, and the remainder reported monthly incomes ranging from 50 to 1200 Birr.

38.2% and 24.1% of respondents reported that they are currently living with both parents or with a spouse, respectively, while nine percent were living alone. 63.7% and 65.1%, respectively, reported that their father's occupation was farming, and their family's economic status was poor. Very few respondents reported that their father's or mother's educational status was above grade 12.

Sexual Practices of the Young People

Respondents were asked if they have ever had sexual intercourse, by which was meant full penetration. Of all respondents, 939 (39.2%) reported having had sexual intercourse (see table 2). The mean age at sexual debut was 15.57 years (SD 0.96), (15.65 years (SD .92) for males and 15.46 (SD .98) for females), ranging from a minimum of 13 years to a maximum 17 years. Urban youth had earlier sexual debut (13 years) compared to their rural counterparts (14 years). Early onset of sexual activity was more pronounced among females (6.4% of them reported 13 years old) compared to males.

In this study, there were 18 male respondents who reported that they were currently married but had not commenced sexual intercourse. The proportion of young people who were sexually active rose steadily with age; and educational status also appeared to play a role in their level of sexual activity (see Table 2 above). Moreover, the proportion of sexually active in-school and out-of-school youth varied substantially by age. Out-of-school youth were more likely than their in-school counterparts to be sexually active in all age categories. 29 (3.1%) out-of-school youth aged 10-14 years were sexually active, while there were no sexually active in-school youth in the same age group. Similarly, the figures for sexually active out-of-school and in-school youth among the age groups 15-19 and 20-24 were 325 (38.7%) versus 84 (84.8%) and 491 (58.5%) versus 15 (15.2%), respectively. Early sexual debut (before age 15) was also observed among out-of-school youth; of all out-of-school youth, 62 (7.4%) (of which 44 were males and 18 females) reported starting sexual intercourse at 13 and 14 years old, in that order, while only nine male in-school youth admitted initiating sex at 14 years old.

Table 1. Socio-demographic characteristics of study subjects.

Characteristics	Male		Female		Total (N=2390)	
	Freq	%	Freq	%	Freq	%
Residence						
Rural	598	50.0	597	50.0	1195	100
Urban	600	50.2	595	49.8	1195	100
Age						
10-14	200	33.1	404	66.9	604	25.3
15-19	562	51.3	534	48.7	1096	45.9
20-24	436	63.2	254	36.8	690	28.9
Mean age (95% CI)	18.13(17.27-18.99)		15.95(15.55-6.35)		17.04	(16.56-17.52)
Marital status						
Not Married	846	49.9	851	50.1		
Currently married	270	46.9	306	53.1	1697	71.0
Religion					576	24.1
Orthodox	535	52.0	494	48.0		
Muslim	397	47.4	441	52.6	1029	43.1
Protestant	240	52.1	221	41.4	838	35.1
Catholic	26	41.9	36	58.1	461	19.3
Ethnicity					62	2.6
Amahra	319	52.6	288	47.4		
Oromo	321	50.0	321	50.0	607	25.4
Tigrie	171	49.6	174	50.4	642	26.9
Sidama	152	49.9	153	50.1	345	14.4
Gurage	35	54.7	29	45.3	305	12.8*
Hadare	65	44.5	81	55.5	64	2.7
Somali	21	39.6	32	60.4	146	6.1
Berta	114	49.0	114	51.0	53	2.2
Educational Level					228	9.5**
Illiterate	266	39.9	400	60.1		
Read & write	150	100			666	27.9
1-6 grade	246	31.7	530	68.3	150	6.3
7-12grade	466	64.0	268	36.0	776	32.5
>12grade	70	2.9	---	---	728	30.5
Currently going to school					70	2.9
Yes	456	43.6	589	56.4		
No	742	55.2	603	44.8	1045	43.7
Occupation					1345	56.3
None	99	36.3	174	63.7		
Student	455	43.5	590	56.5	273	11.4
Daily laborer	149	100	---	---	1045	43.7
Maid servant	---	---	88	100	149	6.2
House wife	---	---	296	100	88	3.7
Farmer	364	100	---	---	296	12.4
Civil servant	88	71.0	36	29.0	364	15.2
Work in private sector	24	75.0	8	25.0	124	5.2
Have private business	19	100	---	---	32	1.3
					19	0.8

Table 2. Characteristics of sexually active study subjects.

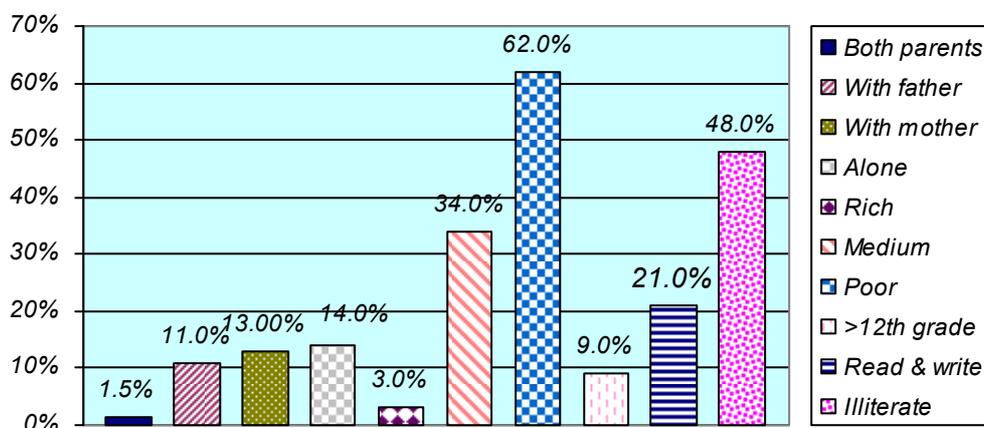
Characteristics	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
All who ever had sex	550	58.6	389	41.4	939	39.2
Residence						
Urban	242	63.0	142	37.0	384	40.9
Rural	308	55.5	247	44.5	555	59.1
Educational status						
In school youth	93	93.9	6	6.1	99	10.5
Out of school youth	457	54.4	383	45.6	840	89.5
Age Category						
10 – 14 age group	4	13.8	25	86.2	29	3.1
15 – 19 age group	230	56.9	174	42.5	404	43.0
20 – 24 age group	313	61.9	193	38.1	506	53.9
Marital status						
Married, sexually active	252	45.2	306	54.8	558	59.4
Married, not sexually active	18	3.1	---	---	18	3.1
Unmarried, sexually active	216	81.8	48	18.2	264	28.1
Live with steady partner	50	58.8	35	41.2	85	9.1
Divorced	32	3.4	---	---	32	3.4
Age at sexual debut						
Minimum age =13 years old	---	---	25	100	25	100
Maximum age=17 years old	117	69.2	52	30.8	169	18.0
Mean age	15.64 (SD 0.92)		15.45 (SD 0.99)		15.56 (SD 0.96)	
Reason for initiating sex						
Fall in love	169	66.8	84	33.2	253	26.9
Have desire	107	99.1	1	0.9	108	11.5
Get married	111	33.2	223	66.8	334	35.6
Wanted to get married	94	100	---	---	94	10.0
Forced to do so by:						
Friend	13	18.8	56	81.2	69	7.3
Employer	---	---	25	100.0	25	2.7
Copying friends	56	100	---	---	56	6.0
1st sexual act with:						
School friend	121	64.0	68	36.0	187	19.9
Out of school friend	330	82.9	68	17.1	396	42.2
Fiancé /spouse	91	60.7	56	39.3	144	15.3
Employer	---	---	25	100	25	2.7
Number of partners						
One	240	46.6	275	3.4	515	54.8
Two	178	64.0	100	6.0	278	29.6
Three	112	91.1	11	8.9	123	13.1
Four	20	87.0	3	3.0	23	2.4

The survey data also showed that young people living with both parents were less likely to be sexually active than those living with one of the parents or alone. Young people from poor economic status families tended to be more sexually active than young people whose family economic status was medium or rich. Young people from well-educated families were also less likely to be sexually active than those from less educated families (see Figure 1).

partner in their lifetime and 13.5% (of young males, 56.3% rural) of them more than one sexual partner in the last six months, (see Table 2). Moreover, 15.8% (15.3% rural and 16.5% urban) male sexually active respondents also admitted having sexual intercourse with commercial sex workers.

328 (34.9%) of the sexually active respondents admitted ever having had reproductive health problems. Of these, 28.7%, 20.1% and 45.1% admit-

Figure 1: Socio-demographic characteristics of sexually active young people.



Young People’s Experience of SRH Problems

Risky sexual behaviors were common in the study population especially among the males, with 45.1% acknowledging more than one sexual

partner in their lifetime and 13.5% (of young males, 56.3% rural) of them more than one sexual partner in the last six months, (see Table 2). Moreover, 15.8% (15.3% rural and 16.5% urban) male sexually active respondents also admitted having sexual intercourse with commercial sex workers.

Table 3. Distribution of SRH problems by selected characteristics.

Characteristics	Reported SRH problems					
	Unwanted pregnancy		Abortion		STIs	
	Freq	%	Freq	%	Freq	%
Total	114	28.7	66	24.1	148	45.1
Sex						
Male	----	----	----	---	105	70.9
Female	114	100	66	100	43	29.1
Residence						
Urban	69	60.5	47	71.1	60	40.5
Rural	45	39.5	19	20.9	88	59.5
Age Category						
10 – 14 age group	14	12.3	14	21.2	----	----
15 – 19 age group	40	35.1	10	15.2	36	24.3
20 – 24 age group	60	52.6	42	63.6	112	75.7
Educational status						
In-school youth	7	6.1	----	----	9	6.1
Out-of-school youth	107	93.9	66	20.1	139	93.9
Marital status						
Never married	23	20.2	21	31.8	35	23.6
Ever married	91	79.8	45	68.2	113	76.4

Of those who admitted experiencing SRH problems, about half (51.3%) acknowledged consulting friends or peers, while 12.6%, 10.1% and 5.8% reported asking advice from local traditional healers, community based reproductive health agents or modern health professionals, respectively. 81 (20.4%) respondents reported that they did not consult anyone or ask advice when they encountered reproductive health problems. Of these, 18 (22.2%) claimed that they did not know where to go or whom to ask for advice, 41 (50.6%) could not find an appropriate place or counselor, and 22 (27.0%)

were afraid to ask advice. Of those respondents who admitted having STIs, 80.4%, 10.8% and 8.8% of them reported having gonorrhea, chancroid and trichomonas, respectively. Among these, 35.1% reported self-treatment while 48.0% of them visited local traditional healers. About 16% and 1.4% of them reported visiting public health institutions and pharmacies for treatment.

Young sexually active females were also asked particular questions to assess their experiences related to pregnancy and abortion. Of the 389 sexually active

young females, 247 (63.5%) had experienced pregnancy, and of these 147(59.5%) were rural young females. The mean age of the first pregnancy was 16.56 years (SD1.13), with the lowest and the highest ages being 14 and 19 years respectively. Pregnancy at an early age (14 years) was observed among the rural young females; eight of them reported that they had become pregnant in their 14th year. Over all, about seventy five percent of those who reported ever having been pregnant were first pregnant before the appropriate age of pregnancy (18 years).

Of those females who had been pregnant, 113 (45.7%) stated that they had been pregnant twice in their lifetime, and 114 (46.2%) reported that their first pregnancy was unwanted. Of these, 70 (61.4%) admitted that their pregnancy ended up in marriage and giving birth, while 15 (13.2%) had had an abortion, 13 (11.4%) had dropped out of school, and 16 (14.0%) had had an abortion and dropped out of school. Furthermore, of the females whose first pregnancy was unwanted, 55 (48.2%) of them reported that they discussed their pregnancies with their friends or peers, spouses or partners and abortionists, 45 (39.5%) with their friends or peers, spouses or partners and mothers while 14 (12.3%) claimed not to have discussed with any-

body.

Regarding experiences of abortion, a total of 66 (24.1%) of those who had ever been pregnant admitted that they had had an abortion. Of these, 71.2% were young females from urban areas. All of them admitted that the abortion had taken place at an illegal abortionist's house.

2. Knowledge, Attitudes and Perceptions (KAP) Of Young People about SRH and HIV/AIDS services (VCT, PMTCT and ART)

Knowledge of SRH and physiological changes at adolescence

To assess young people's knowledge, attitudes and perceptions about SRH in the questionnaire survey a series of questions related to the issue were asked. Accordingly, in response to the question 'What is SRH about?', 1208 (50.6%) respondents mentioned family planning, while 410 (17.2%) respondents mentioned two or more correct answers (possible correct responses included - family planning, access to health information and services, the right to choose when and with whom to have sex, STD, HIV/AIDS and safe motherhood).

Knowledge was considered better if respondents mentioned more than one answer, including family planning. When knowledge was analyzed categorized by residence, gender, age and educational status, better knowledge was observed among males than females, among urban than rural young people, among the 20-24 age group than the 15-19 and 10-14 age groups, and among out-of-school than in-school respondents. The proportion of males who mentioned two and above correct answers was 20% higher than the proportion of females. Similarly, 35% more urban than rural young people were categorized as being knowledgeable (see Table 4).

The same question was raised at FGDs and IDIs with young people, and about 60% of them explained that SRH was about family planning. When further probed some of them mentioned that SRH was also about having access to reproductive health information and services. Sexuality, the right to choose when and with whom to have sex, STIs, including HIV/AIDS and safe motherhood services were also listed as part of SRH by some participants.

On the level of knowledge of major physiological changes during adolescence in girls and boys, 27.4%, 60.5%,

7.8% and 4.2% of respondents, respectively, knew two, three, four and five major changes among the known ones, like growth of penis, starting ejaculation, wet dreams in boys, breast growth in girls and starting menstruation in girls.

However, as depicted in Table 4, level of knowledge varied with sex, residence, age and educational status. The proportion of male respondents who mentioned three or four correct major growth changes was higher than females (67.7% vs 32.7%). Likewise, slightly more urban young people mentioned three and four correct major physiological changes than rural youth (53.7% vs 46.3%), as did young people in the 15-19 and 20-24 age groups compared to the younger ones. Out-of-school youth were more likely to cite three or four major physiological changes than were in-school youth.

The question of biological and physiological changes was also posed to FGD and IDI participants, and more FGD participants could describe more than two biological or physiological changes than could IDI participants. However, no study subject (survey and qualitative) described feeling more sexual as one of the major changes observed during adolescence.

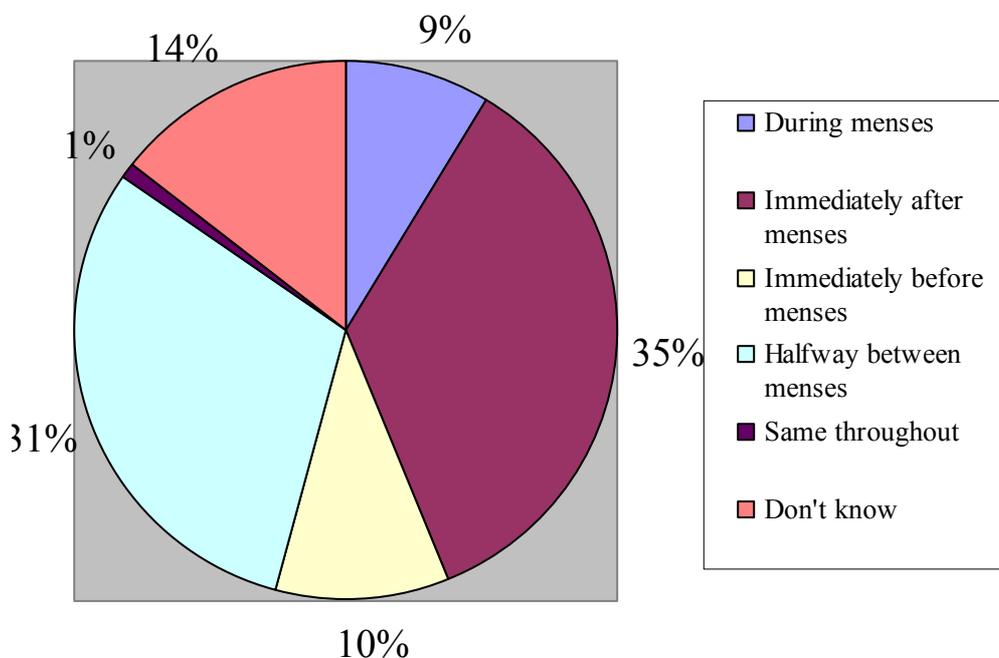
Table 4. Level of knowledge of what SRH is and major growth changes at puberty by selected characteristics.

Characteristics	Number of correct answers cited out of those given					
	About what SRH is			About major physiological changes		
	Two	Three	Four	Two	Three	Four
Total	90(12.1%)	106(4.4%)	14(0.6%)	655(27.4%)	1447(60.5)	186(7.8%)
Gender						
Male	169(58.3%)	91(85.8%)	8(57.1%)	18(2.7%)	980(67.7%)	144(77.4%)
Female	121(41.7%)	15(14.2%)	6(42.9%)	637(97.3%)	467(32.3%)	42 (22.6%)
Residence						
Urban	188(64.8%)	74(69.8%)	14(100%)	308(47.0%)	777(53.7%)	120(64.5%)
Rural	102(35.2%)	32(30.2%)	-----	347(53.0%)	670(46.3%)	66(35.5%)
Age Category						
10 – 14 group	-----	6 (5.7%)	-----	228(34.8%)	372 (25.7%)	4 (2.2%)
15 – 19 group	118(40.7%)	6 (5.7%)	-----	360(55.0%)	597(41.3%)	79(42.5%)
20 – 24 group	172(89.3%)	94(88.7%)	14(100%)	67 (10.2%)	478(33.0%)	103(55.4%)
Educational status						
ISY	81(27.9)	31(29.2)	-----	390(59.5)	610(42.2)	25 (13.4)
OSY				265(40.5)	837(57.8)	161 (86.6)

When FGDs and IDIs participants were asked the same questions, most FGDs participants and some IDIs participants had different views. They disapproved of early sexual initiation and mentioned 18 years as a minimum age and 20 and above as an ideal age to commence sexual intercourse, and 20 years as a minimum age for marriage for both females and males. To explore knowledge of the reproductive period, respondents were asked during which part of the menstrual cycle a woman has the greatest chance of pregnancy. As shown in Figure two,

735 (30.8%) participants knew that a woman is most likely to become pregnant in the middle of her cycle. Correct answers varied by such characteristics as sex, age, residence and marital status. For instance, females were more likely than males to know the most fertile time (61.1% versus 38.9%), as were ever married than never married (48.8% versus 2.4%), older than younger (56.6% versus 8.2%), and sexually active than sexually not active (56.7% versus 43.3%) young people.

Figure 2. Level of knowledge about the most fertile time of the menstrual cycle.



In connection to this, when young people were asked whether a girl could get pregnant at the first sexual intercourse or not, 1262 (52.8%) respondents believed that a girl could, whereas 817 (34.2%) and 279 (11.7%) claimed that she could not get pregnant or were not sure, respectively.

FGD and IDI youth participants were asked both these questions. A significant proportion of FGD participants identified that the most likely time to get pregnant is halfway between two periods,

whereas most male IDI participants thought it was right after her period. However, it is worth mentioning that married female respondents had better knowledge on this point than unmarried females or males. Likewise, remarkable numbers of FGD participants understood that a girl may have a chance of getting pregnant during her first sex act, while a significant proportion of IDI participants, particularly unmarried males, showed hesitation.

As regards methods of avoiding pregnancy, 677 (28.5%) questionnaire participants spontaneously mentioned more than two methods (most frequently, oral contraceptive pills, condoms and IUDS), and added one or two methods by prompting. 937 (39.2%) respondents could spontaneously cite two methods, while 776 (32.5%) spontaneously mentioned only one method and added one or two by probing.

When FGD and IDI youth participants were asked methods of avoiding pregnancy, a considerably greater proportion of focus group discussants named more than two methods spontaneously than did IDI participants. However, what was surprising was that, except abstinence, other traditional methods of avoiding pregnancy were not mentioned by any participant

Knowledge of STIs and HIV/AIDS

To measure the level of knowledge of STIs and HIV transmission, respondents were asked to spontaneously mention all the diseases they thought a person could get through sexual intercourse and ways of HIV transmission. Spontaneity was taken as a proxy measure of familiarity with an issue.

1469 (61.4%) respondents spontaneously named one STI, while 723 (30.3%) and 197 (8.3%) spontaneously named two and three commonly known STIs, respectively, and added others after prompting. HIV, gonorrhoea, syphilis and chancroid were the most commonly mentioned STIs.

Regarding modes of HIV transmission, 2042 (85.4%) of the total study population mentioned three or more modes by which a person can acquire HIV/AIDS. The three most reported ways of getting HIV were unsafe sexual intercourse (by 98.1%), sharing needles and syringes (by 87.4%) and MTCT (by 79.0%). When knowledge was analyzed by selected characteristics, as shown in Table 5, considerable knowledge differences were observed. In particular, there were some misconceptions among rural respondents. About 15.2% of them mentioned (in addition to correct ways of acquiring HIV/AIDS), mosquito and other insect bite, and casual contact with an HIV infected person. In connection to this, respondents were also asked what a person can do to avoid getting STIs and HIV/AIDS. A substantial percentage (81.1%) mentioned at least two correct methods of prevention, of which 871(36.4%) and 933 (39.0%) of them reported, respectively, two and three correct methods. However, understanding

varied by such characteristics as gender, residence, age and educational status. As indicated in Table 5, more males, urban residents, older age groups and out-of-school youth mentioned two and above methods of prevention than females, rural residents, younger age groups and in-school respondents. On whether a healthy-looking person may have HIV or not, 931 (39.0%) of respondents stated that he or she may have and 681 (28.5%) that he or she may not, while

759 (31.8%) of them were not sure. 1054 (44.1%) participants stated that they knew someone infected with HIV/AIDS or other STDs, whereas 1275 (53.3%) reported that they did not. Furthermore, while 916 (38.3%) respondents stated that a person could get HIV through his or her first sexual intercourse, 636 (26.7%) of them said he or she could not, and 731 (30.6%) were not sure.

Table 5. Percentage of respondents who spontaneously mentioned two or more STIs, modes of acquiring HIV and methods of STIs and HIV prevention, by selected characteristics.

Variables (all spontaneously cited)	Characteristics								
	Male	Female	Urban	Rural	1 [@]	2	3	ISY	OSY
	%	%	%	%	%	%	%	%	%
Number of STIs									
Two STIs	64.0		61.3	38.7	15.7	47.5	36.8	42.1	57.9
Three STIs	21.0		55.0	45.0	6.4	63.9	29.7	44.0	56.0
Four STIs	198 (100)	----	77.8	22.2	9.1	62.6	28.3	17.7	82.3
Number of modes of acquiring HIV									
2 modes	4.3		47.7	52.3	58.9	36.8	4.6	54.3	45.7
3 modes	46.5		58.8	41.2	20.3	58.4	21.3	43.8	56.2
4 modes	32.2		66.9	33.1	18.1	36.1	48.9	37.8	62.2
Number of STI & HIV preventive methods									
2 methods	28.1	71.9	42.5	57.5	28.7	49.8	21.5	44.2	55.8
3 methods	87.7	12.3	56.4	43.6	13.5	49.3	37.2	41.2	58.8
4 methods	135 (100)	---	57.0	43.0	---	56.3	43.7	26.7	73.3

[@] Numbers indicate age groups: 1 = 10 – 14; 2 = 15 -19 and 3 = 20 – 24 years

Knowledge on VCT, PMTCT and ART

To explore knowledge of VCT, participants were asked a sequence of questions related to VCT services. 1749 (73.2%) and 450 (18.8%) of the respondents mentioned two and three points about the importance of VCT, respectively. A good number of young people knew that VCT is important for voluntary HIV counseling and testing, and to find out about one's HIV status. Disaggregating the results by sex, residence, age and educational status showed that there were knowledge variations among the study subjects. Of those respondents who reported two and three significances of VCT, young males and urban youth scored slightly higher than young females and rural youth (53.3% versus 46.7% and 62.2% versus 37.8%, respectively). Furthermore, in-school youth and older age groups were more likely to cite two or three advantages of VCT than their comparable out-of-school youth and younger age groups (60.5% vs 39.5% and 41.6% vs 19.3%).

Regarding knowledge of services provided at VCT centers, 52.2% of respondents correctly mentioned more than one service (HIV testing, pre- and post-test counseling, or getting counseling when needed). Nevertheless, when asked who they thought should visit centers, 936

(39.2%) and 614 (25.7%) said those who suspected themselves to be infected by HIV, and PLWHA, respectively. Young people from urban areas and young females were more likely to believe that any person should visit VCT centers (54.0% and 56.0%, in that order). Likewise, in-school youth had better knowledge in this regard than out-of-school youth (74.5% vs 51.1%). Knowledge increased with age, thus the proportion of respondents who believed that any person should visit VCT centers was higher among 15-19 year-olds (65.5%) than 10-14 year-olds (14.2%).

Regarding the existence of specific youth VCT centers in the respondents' area, only 56 (2.3%) of participants claimed such existed. Over half (59.8%) said there was no such youth VCT center, while 476 (19.9%) reported the presence of VCT centers for the general public in their areas. Four hundred twenty eight (17.9%) study subjects did not know. Concerning problems related to VCT service provision in the study areas, 1167 (48.8%) respondents said the absence of health institutions providing VCT services was the major problem, whereas 818 (34.2%) asserted that the absence of specific youth VCT centers and the unfriendliness of the existing VCT centers were the basic problems in providing VCT services in their areas.

A considerable proportion of participants (90.2%) were aware that HIV could be transmitted from mother to child. Urban youth were more knowledgeable than rural (55.4% and 44.6%), and females more knowledgeable than males (55.3% vs 44.7%). Furthermore, differences in knowledge levels were observed among older and younger age groups, and among in-school and out-of-school youth respondents, with high knowledge levels among the 15-19 age group (46.2%) and in-school youth (55.5%). Those respondents who were aware of the possibility of HIV transmission from mother to child were asked if they knew ways of transmission and prevention, or problems existing in relation to PMTCT in their areas. 950 (44.1%) mentioned breastfeeding, 199 (9.2%) blood contact during delivery, and 1007 (46.7%) both breastfeeding and blood contact during delivery, as ways of MTCT. Here also, variations of knowledge were observed by sex, residence, age group and educational status. A higher percentage of female respondents mentioned two ways of MTCT than males (56.7% compared to 43.3%), as did a higher percentage of urban youth (73.8%) and young people aged 15-19 years (50.2%).

When respondents were asked if MTCT might be prevented, a significant number

1566 (65.5%) acknowledged the possibility of preventing MTCT of HIV while 79 (3.3%) and 745 (32.2%) responded 'not sure' and 'don't know', respectively. Young females were more likely to believe that MTCT of HIV was preventable than males (55.6% vs 44.4%), and urban than rural young people (52.4% vs 47.6%). Regarding methods of PMTCT, 945 (39.5%) participants cited one method (abortion by 24.4%, taking antiretrovirals by 8.0% and consulting a health worker by 7.2%), and 1265 (53.0%) two methods. Here also, as shown in Table 6, the proportions of respondents who mentioned two and three PMTCT methods varied by sex, residence, age and educational status.

Concerning the presence of health institutions that provide PMTCT services in the study areas, 1505 (63.0%) participants claimed that such health institutions were absent from their areas, while 885 (37.0%) were not sure or did not know. 80.1% of the study subjects stated between one and three major problems in providing PMTCT services in the study areas. Lack of PMTCT-providing health institutions, lack of knowledge of PMTCT among HIV infected young mothers, and absence of antiretrovirals for PMTCT were the major problems cited by the respondents.

Study subjects were asked if they had ever heard of ART, and 1506 (63.0%) participants reported that they had heard about ART. 841 (35.2%) respondents claimed that they had never heard of ART, and of these, 719 (85.5%) were young people from the rural areas. Of those who had heard about ART, the majority (71.2%) were urban youth. A larger proportion of females than males had heard of ART (53.5% vs 46.5%). Of females who reported having heard about ART, the majority (78.2%) were from urban areas. In-school youth were more likely to have heard of ART than out-of-school youth (62.3% vs 37.8%). Awareness differences were observed among respondents when disaggregated by age groups; among the age group 10-14, 23.5% had heard of ART, while the percentage increased to 42.2% among the age group 15-19 years.

Respondents were also asked if they knew any advantages of ART, and over half (67.7%) mentioned at least one advantage of ART, while the rest did not know. Knowledge of the advantages of ART was higher among urban than rural young people, and more young females reported at least one advantage of ART than their male counterparts (see Table 6).

When knowledge of respondents about eligibility for ART was assessed, three quarters said that any PLWHA was eligible for ART. Only 27 (1.1%) respondents, all from urban areas and mainly young males, answered correctly, stating that PLWHA whose CD4 count was < 200 cells/ml were eligible for ART. Regarding the existence of health facilities providing ART services in the respondents' areas, 1404 (58.7%) of them said there was no such facility, and 986 (41.3%) did not know. Apart from this, when respondents were asked what the main problems in providing ART services in their areas were, most (60.4%) claimed that the absence of any ART-providing health institution, and the lack and inaccessibility of ART drugs were the major problems. 20.0% of respondents also mentioned the lack of knowledge about ART among young people as a problem.

Knowledge of contraceptives

To explore knowledge of contraceptives, all study subjects were asked if they had ever heard of any contraceptive, and 93.3% said they had. Apart from 1.6% who could only name one type of contraceptive, the remaining respondents cited at least two types of contraceptives. Condoms, oral contraceptive pills, IUD (loop) and injectables were the most mentioned contraceptives

Table 6. Level of knowledge of respondents about PMTCT and ART by selected characteristics.

Variables	Selected characteristics								
	Male	Female	Urban	Rural	1 [@]	2	3	ISY	OSY
	%	%	%	%	%	%	%	%	%
HIV MTCT									
Yes	44.7	55.3	55.4	44.6	24.7	46.2	29.1	55.5	44.5
Not sure	58.4	41.6	28.9	71.1	24.3	50.9	24.9	32.9	76.1
Don't Know	59.0	41.0	16.4	83.6	47.5	21.3	31.1	47.5	52.5
Ways of HIV MTCT									
Breast feeding	40.5	59.5	75.3	24.7	22.5	50.8	26.8	53.4	46.6
During delivery	55.7	44.3	69.0	31.0	22.1	10.7	67.2	73.4	26.6
Both	43.5	56.5	73.8	26.2	28.8	50.2	21.1	53.5	46.5
Possibility of PMTCT									
Yes									
No	44.4	55.6	52.4	47.6	14.9	52.9	32.2	62.5	37.5
Don't Know	49.4	50.6	7.6	92.4	88.6	10.1	1.3	10.1	89.9
Methods of PMTCT	56.9	43.1	49.4	50.6	48.7	35.8	15.4	39.6	60.4
1 method									
2 methods	70.8	29.2	87.5	12.5	55.7	33.3	10.9	46.9	53.1
3 methods	24.2	75.8	54.3	45.7	34.7	42.8	22.5	52.2	47.8
Ever heard of ART	13.5	86.5	60.2	39.8	8.8	84.8	6.4	53.2	46.8
Yes									
No	46.5	53.5	71.2	28.8	23.5	42.2	32.3	62.3	37.8
Advantage of ART	54.1	45.9	85.5	14.5	26.3	49.7	24.0	31.3	68.7
Sustain life									
Sustain life &	44.8	55.2	66.7	33.3	24.0	48.3	27.7	49.0	51.0
prevent OIs	54.5	45.5	85.5	14.5	---	45.6	54.4	83.6	16.4
Who is eligible for ART									
Any PLWHA									
CD4<200ml	37.5	62.5	42.8	57.2	25.5	46.8	27.7	47.6	52.4
Don't Know	81.5	18.5	1.1	---	---	44.4	55.6	66.7	33.3
	34.3	60.2	20.5	79.5	25.7	44.8	29.5	70.3	29.7

The proportion of young people who knew two or more contraceptive methods varied with sex, residence, sexual activity, age category, educational and marital status. The proportion of young females who knew at least two contraceptives was slightly (3%) greater than males. A larger proportion of young urban than young rural females knew of at least two contraceptives (45.6% vs 24.2%). There was also variation in young people's knowledge of contraceptives by sexual activity. Sexually active young people were more knowledgeable than sexually inactive youth. 12%, 28% and 18% more sexually active than inactive respondents could name two, three and four contraceptives, respectively. Young people in the age group 10–14 were less knowledgeable than older youth, and the proportion of young people who could name at least two contraceptives was larger among out-of-school youth (53.1%) than in-school youth (36.9%), and among married (40.1%) than never married (24.1%) young people.

Knowledge of SRH Problems

To assess understanding of and incidence of SRH problems among young people, related questions were asked in the questionnaire survey and the qualitative studies. In the questionnaire survey,

1849 (77.4%) respondents reported that young people encountered SRH problems. Among these, 42.6% and 34.8% mentioned two and three SRH problems, respectively. The most important SRH problems among young people were unplanned pregnancy, abortion and STIs. Over 49% of respondents claimed that unplanned pregnancy, abortion and STIs were the biggest SRH problems for young people in their areas.

When knowledge of SRH problems were analysed by certain characteristics, some variations were observed. Urban youth were found to be knowledgeable than rural young people: 64.7% of urban young people mentioned two SRH problems (unplanned pregnancy and abortion) compared to only 35.3% of rural young people. Similarly, young females have better awareness than young males; 56.1% of females mentioned that unplanned pregnancy and abortion were the main SRH problems of young people, whereas the percentage of young males who mentioned these SRH problems was 43.9%.

In the FGDs and IDIs, a considerable number of participants stated that young people encountered SRH problems, and mentioned unplanned pregnancy, abortions and STIs as major SRH problems.

unprotected sexual intercourse and exhibited other risk behaviors. Nevertheless, neither the questionnaire survey nor FGD and IDI participants cited early sexual initiation as a SRH problem, nor suggested that young people suffer SRH problems due to early initiation of sexual activity.

Risk Perceptions of Young People

To identify how young people perceive their vulnerability to various SRH problems including STIs and HIV/AIDS, study subjects were asked a series of related questions. 504 (21.1%) respondents admitted practicing behaviors that may have put them at risk of HIV/AIDS and STIs. Risk perception was slightly higher among rural than urban youth (53.4% vs 46.6%), and among males than females (55.0% vs 45%).

Female study subjects were asked whether they perceived themselves to be at risk of unwanted pregnancy in the next 12 months, and 227 (19.0%) rated themselves at risk of unwanted pregnancy. When compared by residence, females from urban areas were more likely to perceive themselves at risk of unwanted pregnancy than their rural counterparts (20.7% versus 17.4%, respectively).

Perception of risk of infection with HIV and STIs was low: 1768 (74.0%) respondents stated there was no risk of infection, 103 (4.3%) slight risk, 386 (16.2%) moderate risk, and 133 (5.6%) high risk. Those who perceived no or low risk of infection gave reasons like having never had sexual contact; having had no injection with an un-sterile needle or cut from other sharp object (48.5%), abstaining from sex (7.4%), having sexual contact with only one person and trusting sexual partner (12.6%). Likewise those who considered themselves at moderate or high risk said they had had sexual contact without a condom (3.6%), had had sexual contact without condom and had had more than one sexual partner (15.5%), had had more than one sexual partner (1.3%), or had had sex with CSWs (0.5%).

When study subjects were asked whether they could be confident they could have a sexual relationship with only one person, 1663 (69.6%), 579 (24.2%) and 148 (6.2%) responded they definitely could, they were unsure and they definitely could not, respectively. Similarly, 1475 (61.7%) respondents claimed they were confident they could abstain from sex in the next 12 months, while 508 (21.3%) and 407 (17.0%) said they were unsure or definitely could not, respectively. Young male respondents

were less confident of being able to definitely restrict sexual relations to one sexual partner or to abstain from sex in the next 12 months than their female counterparts (46.2% versus 53.8%, respectively). Of the 148 (6.2%) who said they were definitely not able in both questions, 75.2% were rural males.

Access and Sources of Information about SRH and Related Issues

In this study attempts were made to assess access to and sources of information and education for young people regarding physiological changes and SRH matters. When respondents were asked about the importance of obtaining early information and knowing about physiological changes and SRH matters, 2051 (85.8%) stated that it was very important. There was no difference of opinion in this regard; the majority of urban and rural, male and female young people agreed on the importance of having early information and education about SRH issues. Regarding the appropriate period for young people to receive information and education about physiological changes, SRH and related issues, 698 (29.2%), 948 (39.7%) and 552 (23.1%) said before ten years old, starting from ten years old, and starting from thirteen years old, respectively.

Interestingly enough, youth FGD and IDI participants also emphasized how important it was to have adequate information and education for adolescents on growth changes and SRH matters, at least before ten years old. Most FGD participants explained that obtaining advance information and education could make young people more aware of SRH problems and avoid risky behavioral practices. Moreover, most FGD and IDI participants pointed out that it was primarily parents and beyond them school teachers, health professionals and other concerned bodies who have the responsibility to inform and educate adolescents early and to shape them to have good personality and behavior.

Only 414 (17.3%) respondents said that they had obtained some information and education about biological and physiological changes before they first experienced puberty. Of these, 58.0% were urban youth and 54.6% were young males. Concerning sources of information, of the 414 respondents, 183 (44.2%) cited friends, 105 (25.4%) friends and radio, 89 (19.5%) radio and TV and 45 (10.8%) posters, pamphlets, books, newspapers as sources of information regarding biological and physiological changes at puberty. About three quarters of the rural respondents said that friends and radio were their major

sources of information. However, when asked if respondents had discussed SRH, STIs and HIV/AIDS, VCT, PMTCT or ART with someone they considered to be a source of information in the last six months, 1198 (50.1%) reported that they had not discussed these issues with anybody, 26.3% had discussed them with friends, 16.2% with peer educators and friends, and 7.4% with friends, school teachers, clubs or community based reproductive health agents. A considerable proportion of respondents reported that they felt most comfortable discussing sexual maturation, SRH, ways of avoiding pregnancy, STIs and HIV/AIDS with friends and siblings (47.8%), with friends, community based reproductive health agents and health professionals (38.7%), or with schoolteachers and clubs (8.2%).

Regarding sources of information about contraceptives, most respondents mentioned at least two major sources. Friends or peers and radio (25.8%); friends, teachers and anti-AIDS clubs (17.0%); radio and TV (13.1%); friends, health professionals and community based reproductive health agents (14.8%); friends and community based reproductive health agents (11.5%); posters, pamphlets, books and newspapers (11.1%), were the most commonly mentioned sources

of information. 88.5% of urban young people cited friends, teachers and anti-AIDS clubs as their major sources of information, while over half young females and rural respondents mentioned friends and radio. 46.9% of out-of-school youth reported radio and community based reproductive health agents as their major sources of information while 76.4% of in-school youth mentioned friends, teachers and anti-AIDS clubs.

On the question of willingness of parents and family members to provide information on matters of SRH, about 50.0% of respondents claimed that both fathers and mothers would scold them if they asked questions related to SRH, and over 30.0% reported that they would turn away their face without giving them the proper answer even if they were competent and educated. Only 2.5% of the respondents acknowledged parental willingness to answer questions related to SRH and its problems. On the other hand, unlike fathers and mothers, brothers and sisters were acknowledged by over 45.0% of respondents as being willing and helpful in answering their questions, discussing and providing proper information on the matters of SRH. Moreover, 1714 (71.7%) participants agreed that the social and cultural norms of the society that they grew up in were

the major barriers to youth–parent communication on SRH matters. In connection to this, 1581 (66.2%) participants thought that parents considered discussing SRH with young people to be promoting promiscuity. In the same way 1780 (74.5%) respondents agreed that most community members viewed youth seeking SRH services at health institutions established for adults negatively.

3. Young People’s Health Services Utilization and Preferences and Attitudes towards Youth-Friendliness of the Services

In this study an attempt has been made to assess young people’s SRH service needs, their specific preferences, their utilization of the available health services, and the youth-friendliness of the services.

Only 6.7% and 2.4% of questionnaire respondents reported ever visiting existing health institutions for SRH and VCT services, respectively (see Tables 7 and 8), but none reported visiting health institutions in the last three months for these services. No respondent reported visiting a health institution for PMTCT or ART services. Of the 6.7% who had visited a health institution for SRH services, 37.2% young females reported

that they attended for prenatal or delivery care, while 28.5% visited for treatment of complicated abortion. 31.4% of young male attenders went for STI management. Among those study subjects who had visited a health institution for SRH services, 45%, 33.4% and 21.2% reported that the institution visited was a pharmacy or government clinic, a village health post, and a private clinic, respectively. Regarding the distance to the health institution, 52.7% of respondents reported that it was very remote (two and more hours travel) and 40.8% that it was nearby (not more than one hour travel).

VCT Service Utilization

When respondents were asked if they had ever visited a VCT center, only 58 (2.4%) had, of which 74.1% were males, and all were from urban areas (see Table 8). Of the 58 who had visited a VCT center, 46 (79.3%) said they went for HIV testing (and also reported that their test results were HIV negative), and the remainder said they went for information.

Table 7. Proportion of respondents who had ever visited a health institution for SRH services.

Characteristics	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Total					159	6.7
Residence						
Urban	92	57.9	38	23.9	130	81.8
Rural	20	12.6	9	5.7	29	18.2
Age Category						
10 – 14 age group	---	---	---	---	---	---
15 – 19 age group	64	40.3	28	47.5	92	57.9
20 – 24 age group	48	30.2	19	11.9	67	42.1
Educational status						
In school youth	43	27.0	25	15.7	68	42.8
Out of school youth	69	43.4	22	13.8	91	57.2
Sexual Activity						
Sexually active	81	50.9	22	13.8	103	64.8
Sexually not active	42	26.4	14	8.8	56	35.2
Marital status						
Never married	78	49.1	18	11.3	96	60.4
Ever married	43	27.0	20	12.6	63	39.6

Table 8. Proportion of respondents ever visiting VCT Centers

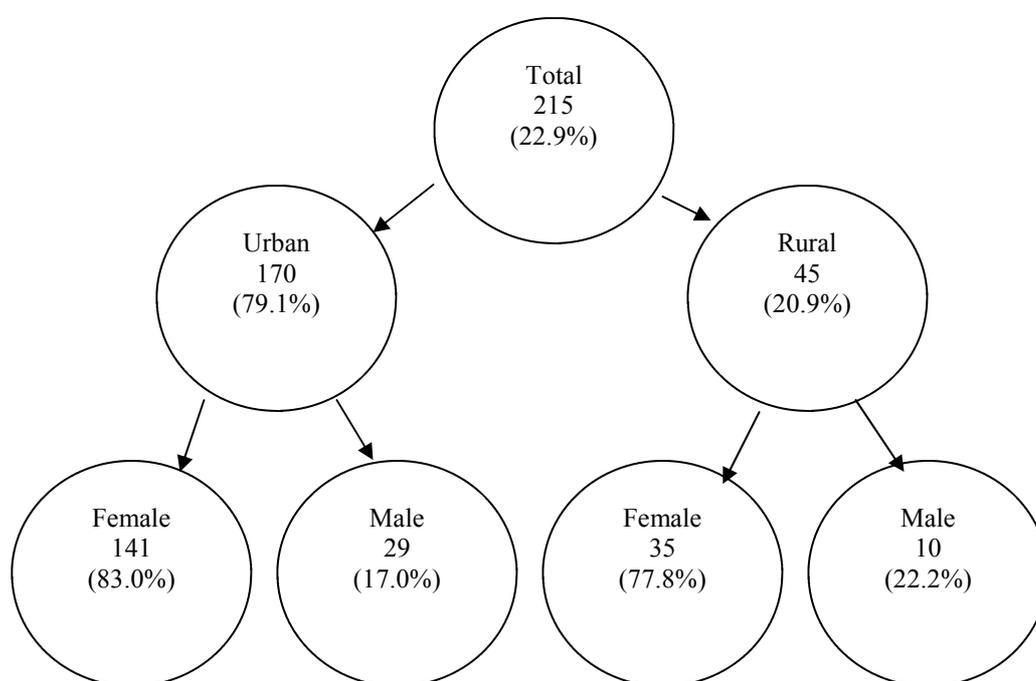
Characteristics	Male		Female		Total	
	Freq	%	Freq	%	Freq	%
Total					58	2.4
Residence						
Urban	43	74.1	15	25.9	58	2.4
Rural	---	---	---	---	---	---
Age Category						
10 – 14 age group	---	---	---	---	---	---
15 – 19 age group	27	46.6	5	8.6	32	55.2
20 – 24 age group	19	32.8	6	10.3	25	43.1
Educational status						
In school youth	26	44.8	11	19.0	37	63.8
Out of school youth	12	20.7	8	13.8	20	34.5
Sexual Activity						
Sexually active	26	44.6	12	20.7	38	65.5
Sexually inactive	14	24.1	5	8.6	19	32.8
Marital status						
Never married	28	48.3	8	13.8	36	62.1
Ever married	17	29.3	4	6.9	21	36.2

Contraceptive utilization

To explore contraceptive use pattern, sexually active respondents were asked whether they had ever used any contraceptive. 215 (22.9%) had ever used a contraceptive, and of these,

79.1% were urban youth, and 83.0% of these urban users were young females. Among the rural (20.9%) users, young females constituted 78.0% (Figure 3).

Figure 3. Proportion of sexually active ever-users of contraceptives.



Reasons given for non-use of contraceptives among sexually active young people included the wish to have children (31.7%); lack of knowledge (19.6%); resistance from husband or partner (21.2%); distance to source (13.3%); religious prohibition

(12.2%); and infrequent sex (2.9%). Among those who gave distance to contraceptive source and lack of knowledge as reasons for non-use, the majority (80% and 63.3%, respectively) were rural young people.

Among sexually active contraceptive users, only 16 (7.4%) had used a contraceptive during first sexual intercourse. Of these, 14 (87.5%) were urban youth, of whom 9 (56.3%) of them were young females. Condoms were used by 2 (12.5%) and OCP by 14 (87.5%) users at first sexual intercourse. The majority of those who had not used contraceptives at their first sexual intercourse gave reasons like not believing that pregnancy could occur at first sexual intercourse (30.6%), having had unplanned sexual intercourse (28.4%) and lack of knowledge about contraceptives (40.1%).

Of the sexually active contraceptive users, only 64 (29.8%) had used contraceptives in the last six months. Of these, 38 (59.4%) and 26 (40.6%) were young females and males, and 13 of the females and 6 of the males were rural residents. The proportion of contraceptive users was higher among never married than married, and among out-of-school youth than in-school youth.

Those who had not used contraceptives in the past six months, gave the following reasons for non-use: a desire to have children (30.7%), non-availability of contraceptives or long distance to source (26.5%), fear of side effects (21.4%), having frequent un-

planned sexual intercourse with different persons (8.6%) and religious prohibition (15.8%). Rural respondents mostly mentioned reasons like desire to have children, lack of knowledge, non-availability of contraceptives and long distance to contraceptive source.

Attitudes of young people towards youth-friendliness of the health services

68.8% of participants (65% of them urban and 34.4% rural) said there was a health institution intended for the general public in their area. The remainder, predominantly those from the rural study areas, reported the absence of any health institution in their area. Study subjects were also asked whether these health institutions provided SRH and HIV/AIDS services for young people; 522 (21.8%) and 396 (16.6%) stated that the existing health institutions provided SRH and VCT services, respectively, for youth, but none reported that the existing health institutions provided PMTCT or ART services for youth. 2267 (94.9%) said that there were no specialized health institutions offering SRH or HIV/AIDS services for young people in their area. 123 (5.1%) reported the presence of one specialized health institution for young people in their area.

A very high proportion of survey respondents (94.4%) reported that the existing public health institutions are inconvenient and do not encourage or welcome young people to use RH services. Nearly 75% of the respondents also asserted that service providers were not appealing or friendly to young people seeking RH, VCT or other related services. Moreover, 90.1% of respondents reported that staff of these institutions did not welcome youth regardless of sex, marital status or age. This was also supported by youth FGD participants. They complained that some health institution service providers were inhospitable, and criticized staff for giving more attention to married people than non-married, to the employed than unemployed and to the older than younger youth.

Young people's health institution and service provider preferences

The majority (over 72.0%) said that they would prefer to go to a separate health institution with a youth-friendly environment. Many stated that they would prefer to consult with young health professionals of the same sex (see Table 9). In the FGDs and IDIs that were held with youth, most participants stated that they would prefer RH services that were provided in specific health facilities organized for them in an accessible, conven-

ient and confidential environment. They also stressed that they would prefer service providers of the same age group. Apart from this, nearly 85% of the questionnaire study subjects complained that the existing health institutions did not have specific hours for young people and served them alongside adults. A significant proportion of respondents (74.4%) also reported that the fees asked by health institutions were unaffordable by youth. They reported that young people were asked to pay the same amount as adults. Furthermore, almost all study subjects agreed that privacy and confidentiality were very important to young people seeking SRH and HIV/AIDS services, and 1409 (59.0%) claimed that the privacy and confidentiality of young people seeking these services were not respected.

Over 90.8% of the respondents admitted that they never visited health facilities without getting permission from their parents or partner or spouse. Further, 66.0% of the respondents stated that they were afraid of being seen by parents or community elders when visiting health facilities to seek SRH and HIV/AIDS services. However, over 75% of young people stated that service providers did not ask them to come with their parents when they needed SRH and HIV/AIDS services.

Table 9. Young people’s preferences for health institutions and service providers.

Variables	Freq.	%
Health institutions preferences for RH services		
Any existing public health institutions	121	5.1
Any existing public health institutions, but with special places and approach to youth	241	10.1
Separate youth health centers	1739	72.8
Clinics in the school	286	12.0
Service providers preferences for SRH services		
Young, nurse & same sex	550	23.0
Young, MD & same sex	1121	46.9
Young, any sex &HP	617	25.8
Mature, nurse &same sex	102	4.3
Service providers preferences for VCT services		
Young, nurse & same sex	242	10.1
Young, MD& same sex	480	20.1
Young, any sex &HP	617	25.8
Mature, nurse &same sex	642	26.9
Mature, MD & same sex	406	17.1
Service providers preferences for PMTCT services		
Young, nurse & same sex	83	3.5
Young, MD & same sex	482	20.2
Young, any sex &HP	627	26.2
Mature, nurse &same sex	642	26.9
Mature, MD & same sex	556	23.3
Service providers preferences for ART services		
Young, nurse & same sex	137	5.7
Young, MD & same sex	607	25.4
Young, any sex &HP	445	18.7
Mature, nurse &same sex	590	24.7
Mature, MD & same sex	611	25.6

4. Perceptions and Attitudes of Health Service Providers

Perceptions and attitudes of health services providers towards young people's SRH and HIV/AIDS service needs were assessed using FGDs and IDIs. The majority of health workers with whom discussions held and interviews conducted, agreed that these days the common health concerns are SRH problems and the need for SRH information and services for young people. They also disclosed that the needs of young people for SRH services are poorly understood and served in many of the existing public health institutions. Most of them indicated that most existing health facilities provided very few SRH and HIV/AIDS services to young people. Most service providers explained that there were no exclusive or specific SRH services for young people in most health institutions, and that they offer the same services to young people as to adults. They suggested that services like pregnancy testing, maternal care, post abortion treatment and family planning, are not usually for young people and do not meet their needs, and that these services were mostly provided to adults and married couples. According to their explanation, such services are offered to young people without giving them special attention, but treating them as any health ser-

vice seekers. They also confirmed that they offer services for young people seeking SRH treatment at the same time as other health care users. Furthermore, they stated that because young people are served at the same time as adults, they are afraid of being identified as sexually active by their elders. They explained that young people are not at ease disclosing their secrets to adult service providers, and that health workers, too, do not feel comfortable discussing SRH matters with young people.

In the FGDs, most service provider participants stated that for many years, adolescent or youth reproductive health services were not given recognition by service providers and were not appreciated as fundamental issues for young people. They also disclosed that service providers lack adequate information and training about SRH service provision. Moreover, despite the fact that some efforts and initiatives have been undertaken by government and some private organizations to provide SRH services for young people recently, they said that practical activities were not yet visible at public health service delivery points. They also commented that there were no uniform SRH policy and guidelines at the service delivery points, and this is one basic problem in providing SRH services for young people in Ethiopia. The majority of health workers confirmed that most

young people were not used to visiting the available health facilities or seeking advice from health workers whenever they had SRH problems. They reported that the available SRH and HIV/AIDS services were underutilized by young people; for instance, although most government hospitals and some health centers provide HIV/AIDS VCT services, young people were not using these services much. They confirmed that adolescents and young people did not come for the services unless their problems had reached a critical level. They also explained that few married young people used prenatal care or family planning, and only some young females sought post-abortion treatment. Some of the health workers suggested that this health service underutilization might be due to the unwelcoming environment of many public health institutions. They further explained that young people avoided

seeking information and health services because they were afraid to disclose their private SRH secrets to adult health workers, and did not want to be seen by their parents or other community members. They also disclosed that the hours of service provision were usually inconvenient for young people and that the service provision environment was often embarrassing to them. In order to encourage young people to seek and utilize SRH services, they recommended that existing health institutions should be re-organized in such way that they meet the needs of young people by providing integrated health services in a holistic approach.

5. Results of Visits to Selected Health Institutions

In order to assess the state of existing health service provision in a subset of

Table 10. Distribution of observed health institutions by ownership

Type of health institution	Number	Ownership	Location	Specific services for youth
Hospitals	8	Governmental	Urban	None
Clinics	8	Governmental	4 urban, 4 rural	None
Health Centers	4	Governmental	2 urban, 2 rural	None
“ “	4	NGO (OSSA)	Urban	HIV/VCT
“ “	4	Private	Urban	None
Health posts	8	Governmental	Rural	None
Pharmacies	4	Governmental	Urban	None
“ “	4	Private	Urban	None
Youth centers	4	NGO (FGAE)	Urban	RH, FP, HIV/VCT, IEC/BCC, STI treatment, Contraceptive distribution, library, sport, music

health institutions, one or two institutions were selected in each study area, particularly those expected to provide SRH and HIV/AIDS services to young people. They were selected from all categories, that is, from government and private hospitals and clinics, NGO clinics, pharmacies, health centers, health posts, family guidance clinics and youth centers. Overall, as shown in Table 10, forty-eight health institutions were chosen, visited and critically observed (see inventory of selected health institutions in Appendix 6).

The selected health institutions were reviewed using participant observation methods and guiding tools from the point of view of youth-friendly service characteristics. Evaluation included: accessibility (physical location, restriction, whether they are free standing or integrated); types and quality of services provided to young people (including whether there was a specific package for adolescents); capacity and facilities (including educational or recreational activities and educational material in sufficient quantities); how the needs of young people were served; suitability of working hours; adequacy of trained staff in youth-friendly services; and appropriateness of the whole environment to meet the needs of young people.

When viewed from the point of accessibility, most of the health institutions were situated in unsuitable and unapproachable locations, even in urban areas. The few health centers and village health posts found in rural areas were also located in very distant and inaccessible places. Most health institutions lacked private rooms, waiting areas, entertainment and information facilities (audio and visual materials, publications). The health institutions assessed did not have specific service hours assigned for young people, but served them at the same time as adults. Further, confidentiality and privacy were not respected, because health centers were full of adult service seekers during working hours.

Among the health centers assessed, except for FGAE's model youth centers, most public health institutions had no specific programs or guidelines regarding the needs of young people. Almost all were not freestanding but were organized to provide health services to the general public, and were thus designed for adults, with no specific services for young people.

Fees incurred at most health facilities were problematic for young people. Providers charged young people in the same way as adults; there was no dis-

count or special fee for young people. Most service providers in the observed health institutions were older and as a result young people were afraid to consult or ask advice freely and without any embarrassment. Moreover, service providers lacked specific training on youth-friendly health service provision.

Of all the health institutions observed, only the FGAE Model Youth Centers demonstrated youth-friendly characteristics. FGAE Model Youth Centers were assessed in Desse, Awassa, Dire Dawa and Harar towns. FGAE has organized 10 Model Youth Centers in different urban areas. As stated in the Association's Profile of Youth Programs, the Model Youth Centers are so-called because they pioneer a wide assortment of SRH initiatives which have been documented as best practices and replicated by government and non-government organizations working in SRH. Model Youth Centers have an "everything at one site" approach, typically targeting young people. These Model Youth Centers engage actively in the provision of a wide range of integrated, youth-friendly services that are important to the young people and meet their needs at one place. The main services include: SRH information, education and communication that incorporates STIs and HIV/AIDS,

VCT, family planning, STI prognosis and treatment and other SRH clinical services, counseling services - at the centers and via a hot-line - contraceptive provision, home visits, outreach and community based IEC/BCC dissemination and advocacy services, and training for peer educators and service providers.

Besides these they have organized various facilities which attract youth, such as in-door and out-door games, satellite TV and video, mini-media, musical instruments, theater and literature clubs. They also have well-established libraries; in which young people can pass their leisure time reading books, newspapers, magazines or pamphlets. Integrated with these services, the youth centers also offer different vocational skills training including music and drama, food preparation, hair dressing and beauty, vehicle maintenance, basic skills in video, photography, advertising and public relations. These training courses attract young people to the centers, sometimes from great distances.

Service providers at these youth centers are young people who understand the needs and interests of other young people, and have training in providing youth-friendly services. There is no limit on service use hours; essential service

packages are provided in full on working days and most youth centers also offer youth-friendly services on Saturdays. Any young person can visit the centers at any time of the day and week. The FGAE centers encourage youth involvement in all SRH initiatives through participation in forums, panel discussions, voluntary peer service and other activities. There is a youth SRH committee which participates in the planning programs of the Model Youth Centers and in other activities, like newsletter production, mobilizing the community, contraceptive distribution, advocacy and information on SRH and family planning.

Nevertheless, these model youth centers also have limitations. They have insufficient manpower, and often carry out activities using a limited number of young service providers. They also lack enough space to organize certain youth entertainments. Financial constraints are another problem.

6. Perceptions and attitudes of parents and community members

With regard to the FGDs and IDIs that were conducted with representatives of parents and community elders, the results demonstrate that most parents and

community members were aware of the fact that youth are at high risk of early sexual initiation and consequently are vulnerable to unwanted teenage pregnancy, abortion and various STIs, particularly HIV/AIDS. However, most of them were not fully aware of the needs of SRH information and services for youth as they had inadequate information themselves. Even those who had some information were unaware of its importance in the light of other burning issues that need immediate attention.

Most elders also admitted that most parents did not discuss issues related to SRH with their children. They explained that many parents felt uncomfortable talking with children about the subject. Since many adults had never received SRH information and education themselves, they tended to shy away from actively educating young people about issues relating to SRH.

Consistent with this, both FGD and IDI participants acknowledged that they had negative attitudes towards young people who had pre-marital sex and considered them 'bad' or 'terrible' boys and girls. Most elders stated that they considered young people who had premarital sex and were involved in risky sexual behaviors to be undisciplined and to have no

respect for the social and cultural norms of society. They said that such young people are mostly separated from their families because of behavior such as promiscuity, addiction to various drugs and alcohol. They blame these young people for the further spread of HIV/AIDS in their community.

They also strongly disapproved of early sexual initiation, which they thought was common in the community these days. Substantial numbers of elder discussants also disagreed with educating adolescents in early puberty. They argued strongly, saying that educating adolescents during early puberty about SRH would encourage early premarital sexual initiation and promiscuity. However, there were also some educated parents and community members, who disagreed with these negative attitudes. They suggested that early communication with adolescents had considerable importance in changing and shaping the behaviors of young people. They also accepted that it was primarily the responsibility of parents to make their children aware of the physiological changes of puberty and RH problems in order to prevent them from practicing risky behaviors. These adults believed that young people had SRH information and service needs and that health facilities organized specifically for young people were required.

7. Implications of Promoting Youth-Friendly SRH Services for HIV/AIDS Programs

With increased early sexual activity among young unmarried people, the lack of specialized youth-friendly programs, and the rapid spread of HIV/AIDS, great health challenges have evolved throughout the world, particularly in developing countries like Ethiopia. Young people are at the center of these health challenges in terms of SRH problems, and STI and HIV/AIDS transmission, impact and vulnerability. Young people also form the greatest potential and hope for change in the struggle against fatal health problems. In those countries where HIV transmission has been reduced, it has been among young people that the most spectacular changes and reductions have occurred (5). These changes have been achieved by making health services at primary care level more accessible and acceptable, and by promoting all round youth-friendly SRH and HIV/AIDS services in which young people have participated from the very beginning.

The findings of this study indicate that in Ethiopia, the SRH services utilization habits of many young people are unfavorable. Above all, this is due to avoidance of existing health services because most available health services are constrained by operational barriers, and are not friendly to young people.

As observed from the study, if young people get opportunities to access attractive, consistent and sustained youth-friendly SRH and HIV/AIDS information and health services, they can develop knowledge, skills and vigor to change risky behaviors. Therefore, it seems likely that promoting youth-friendly SRH and HIV/AIDS services will have significant effects on HIV/AIDS prevention and control programs.

Promotion of health services that meet the needs of young people in both rural and urban areas of Ethiopia is the key in reducing their risk of a range of SRH problems, and ultimately to the defeat of the HIV/AIDS pandemic.

VI. Discussion

This study has attempted to identify problems and gaps regarding young people's knowledge of, needs for, preferences for, and utilization of SRH and HIV/AIDS services, and to assess the youth-friendliness of SRH services in eight selected regions of Ethiopia.

A considerable number of young people have an incomplete understanding of sexuality and what reproductive health is about. Not only young people, but also many adults have poorly understood the SRH concept, and most often SRH is identified with family planning alone (64). There were very few young people who knew that SRH goes beyond family planning. Most young people have inadequate knowledge about SRH because they lack proper information and education at an appropriate time, and remain poorly informed about such matters.

In this study it was found that the majority of young people were not aware of the normal age range of puberty for boys and girls, about the physiology of reproduction and of their reproductive capacity during the adolescent period. Very few young Ethiopians knew that a girl could get pregnant at first sexual intercourse, compared to a study done in Zimbabwe (76), in which about 80% of

young people responded correctly. Substantial numbers did not know the most fertile time of the menstrual cycle, although at 30.8%, the percentage was higher than that among out-of-school-youth in northern Ethiopia (19), where only 8.0% responded correctly. Young females were more knowledgeable than males (61.1% versus 38.9%), and were also more knowledgeable than women participants of all ages in the Ethiopian DHS 2000, in which 12.2% replied correctly (57).

This incomplete knowledge shows that many young people lack adequate information about reproduction, and are uninformed or misinformed about their reproductive capacity. The implications of this are immense. Those young people who wrongly think that pregnancy is not likely to occur at first sexual intercourse are at greater risk of unintended pregnancy.

There were some misconceptions about the advantages of VCT and ART. A significant proportion of young people considered seeking VCT services to be the duty of those who suspect themselves to be infected with HIV or PLWHA. This shows that most young people's perception of their susceptibility to HIV infection is still low. Few respondents consid-

ered use of VCT services to be important for all, and as a result, there were very few study subjects who had used VCT centers. Reluctance to use VCT centres may be due to unavailability or lack of appeal of existing services. The percentage of young people using VCT services in this study was slightly lower than that in the first Behavioural Surveillance Survey of Ethiopia, in which 4.6% of young respondents had ever had an HIV test (83).

In this study, the proportion of respondents who had commenced sexual intercourse (39.2%) was considerably higher than in some earlier reports (range from 18 to 30%) (18, 44, 75), but lower than others (range 31 to 49%) (19, 27, 43). As in the Behavioural Surveillance Survey (83), the proportion of respondents who had ever had sex was found to be slightly higher among males (58.6%) than females (41.4%), among rural (59.1%) than urban (40.9%) young people, and among out-of-school youth (89.5%) than in-school youth (10.5%).

In this study, there were young people who reported that they were married but not sexually active. In the study of reproductive health needs of urban and rural out-of-school adolescents, which was conducted in the northern part of Ethio-

pia (19), similar findings were obtained. Such cases may be the result of the very early marriage that is practiced in some, particularly northern, rural areas of Ethiopia, where young males do not have sexual intercourse with their spouses for some two or three years, until the young married females become fully grown.

Many studies in Ethiopia and elsewhere have showed that, these days, young people are engaged in sexual activity at a very early age. This study also confirms that this is true. In this study the reported age of first sexual intercourse ranged from 13 to 17 years old, with the mean age of 15.56 years (SD.96), which also consistent with other study results (5, 37, 38). A significant proportion (45%) of the sexually active respondents reported that they had more than one partner, which is comparable with findings of some previous studies (19); similarly, males had more sexual partners than females. Urban youth and out-of-school youth were more involved in sexual matters and risk behaviors; they tended to have more than one sexual partner, with a mean of 2.1 sexual partners. This may suggest higher risk-taking behavior among out-of-school youth. About sixteen percent of male sexually active respondents admitted having sexual intercourse with commercial sex workers.

This indicates that the rate of promiscuity and the risk of STIs, HIV and unwanted pregnancy could be high among these young people. There is urgent need to give this vulnerable group attention.

Although knowledge of contraceptives was high (over 90%), among study subjects, use of contraceptives was very low. Young people who begin sexual activity in their early teens are less likely to use contraceptives. As several studies indicate, one characteristic feature which makes young people's sexual activity high risk is their non-use or very minimal use of any contraceptive (84). This gap between knowledge and practice has been found in other studies in Ethiopia (44, 20, 74). In addition, the proportion of contraceptive users was considerably lower among males than females and among rural youth than urban counterparts. Likewise, contraceptive use at first sexual intercourse was very low; only 16 (7.4%) young people admitted using contraceptives at first sexual intercourse, and this is also comparable with some studies done in Ethiopia (43,77). Condom use reported in this study (by 12.5%) was comparable with studies done in the southern part of the country (54,45), which reported use of condoms in 13.5% of first sexual intercourse.

Young people cannot protect themselves if they do not have information and know the facts about SRH, contraceptives, STIs, HIV/AIDS and VCT. Without information they will be at high risk of various SRH problems. This study has revealed that youth lack appropriate and adequate information and knowledge about SRH, contraceptives, STIs and HIV/AIDS. Very few of them had obtained information and education on these issues. The sources of information that they mentioned most (friends, mass media (radio and TV) and publications (posters, pamphlets, books and newspapers) were similar to reports from other studies (18,29,74).

Apparently this lack of adequate prior information and education had a significant impact on young people's information-, advice-, consultation-, and service-seeking patterns. In this regard, the study subjects' habits of seeking information, advice and consultation regarding SRH, contraceptives, STIs, and HIV/AIDS issues found to be inadequate. Most urban young people acknowledged consulting and discussing with peer educators, friends and school club members while most rural youth discussed with friends. FGD and IDI participants said that friends and peer educators were the best sources of information regarding all sexual matters and RH problems.

Communication or discussion between parents and young people about sexuality and RH matters is an important intermediate step towards the eventual adoption of protective behaviors by young people. The majority of study subjects, in the questionnaire survey, the FGDs and the IDIs, strongly accepted the importance of youth-parent communication on SRH, contraceptives, STIs, and HIV/AIDS matters and early education of SRH to delay early sexual initiation in adolescence. However, as expected, the role that is played by parents and family members in terms of informing and educating adolescents about SRH is very limited. Only very few respondents, who were from educated families, acknowledged the willingness and helpfulness of fathers and mothers in answering questions related to SRH and its problems. This suggests that educated parents are more likely to communicate and discuss matters of SRH with adolescents than non-educated parents.

The findings of this study showed that most parents and elder community members consider that informing and educating adolescents during early puberty about SRH would encourage early premarital sexual initiation and promiscuity. These attitudes and perceptions were comparable with survey results from Cambodia, Haiti, Malawi and Zimbabwe, in which about 40% of adults felt that children aged 12 to 14 should not be

taught about SRH, or to use condoms and other contraceptives (44). However, a UNAIDS review of more than 50 sex education programs around the world found that young people are more likely to delay starting their sexual activity when they are provided with correct information about sexual and reproductive health (12).

Unwanted pregnancy, abortion and STIs are the major health problems among young people worldwide. Given that significant proportions of young people who commence premarital sexual activity do not consistently use contraceptives, unwanted pregnancy, induced abortion and STIs are likely to occur. In this study also, substantial numbers of sexually active young people admitted that they have encountered unwanted pregnancy, abortion and STIs in their lifetime. This is in accord with previous studies in urban Ethiopian settings (27,52).

In this study, an attempt was made to assess the magnitude of SRH service utilization by young people, the level of youth-friendliness of existing health institutions, and factors that hinder health service utilization. The proportion of young people reporting ever visiting health institutions (6.7% and 2.4%) for the sake of SRH services was very low. This result is comparable to a study conducted among urban and rural out-of-school adolescents in East Gojam in which 9% of respondents had visited health institutions (19). Other studies conducted to assess KAP of youth about HIV/AIDS and STIs have revealed that services like family planning are underutilized by young people (29,46).

Health service underutilization may be due to various hindering factors. As some youth-friendly services manuals indicate, a health service should be accessible in comfortable surroundings; have adequate separate space; convenient times (hours) set aside; specially trained staff and sufficient SRH packages; service fees should be affordable; and privacy and confidentiality should be respected (4). Previous studies conducted among young people have revealed that most public health facilities do not fulfill these youth-friendly characteristics (68).

This reality was reflected in this study. During assessment of the existing health institutions, all the major operational impediments were observed. The findings are also consistent with previous studies (18,19), including; the Reproductive Health Needs Assessment report of the Ministry of Health (22), and the Assessment of Youth Reproductive Health programs in Ethiopia report of the Family Health International Youth Net team (26). Most existing health institutions are inaccessible, unaffordable, their operation hours are inconvenient, confidentiality and privacy are not well kept, and service providers are not hospitable. These are among the major operational impediments to utilization by young people. The proportion of young people who would prefer to go to specialized health institutions that meet the needs of young people was consistent with the findings of an in-school youth study in Addis Ababa (18).

VII. Limitations of the Study

The main limitations of the study were:

- It did not represent all regions of Ethiopia;
- Even among the selected regions, the study was limited to purposefully selected urban and rural kebeles. These may not be fully representative of all kebeles in the regions selected. However, they may be seen as a useful pilot to demonstrate the problems of young people in relation to SRH and HIV/AIDS services.
- A lack of similar studies into young people's SRH and HIV/AIDS services, patterns of utilization and youth-friendliness of services from the point of view of youth, parents and community in Ethiopia to compare these results with.
- Resource constraints in terms of time, finances and transport.

VIII. Conclusion

The main findings of this study are that young people's knowledge, attitudes and perceptions on the subject of SRH are deficient. Young people lack adequate and pertinent information, education and guidance on matters of SRH. Due to this, most of them are incapable of making informed and responsible decisions to minimize their involvement in risky practices and to safeguard their health. Most young people, particularly out of school youth, are likely to be involved in risky sexual behaviors like early sexual initiation, having multiple sexual partners and low use of contraceptives, and are thus exposed to unwanted pregnancy, abortion and STI problems.

Although the level of knowledge of the study subjects concerning STIs, HIV transmission and prevention, PMTCT, VCT and ART was found to be reasonable, their perception regarding eligibility to utilize ART and VCT services was low.

As this study indicates, young people's SRH information and services seeking and utilization habits are weak. The majority of young people have not developed the habit of visiting existing health institutions whenever they encounter SRH problems. This low service utilization is mainly due to absence of specific services that meet the needs of youth and to the unfriendliness of existing health services.

Mostly young people prefer to obtain health care services in separate youth health centers served by providers of the same age group.

Health service providers acknowledged that in the past adolescent reproductive health services were given little attention, and due to this they lack adequate information and training about SRH services provision. They also recognized that there are no specific SRH services meeting the needs of young people in most of the health institutions in Ethiopia.

The assessment of existing health institutions shows a lack of standardized youth SRH policy and guidelines relevant to service delivery in the country. The state in which public health institutions are currently found is far from youth-friendliness. Only the Family Guidance Association of Ethiopia's Model Youth Centers fulfill youth-friendly health service provision characteristics. The initiatives undertaken by the FGAE in regard to promoting such Youth Centers are encouraging and should be replicated by government and NGOs working in SRH in other areas of Ethiopia.

In this study, data obtained from parents and community elders reveals that, due to socio-cultural taboos, free communication between parents and young people on matters of SRH is lacking. Most parents and community elders admitted that they have negative attitudes about communication between parents and young people on SRH matters. Most of them are of the opinion that educating children at an early stage could encourage initiation of teenage pre-marital sexual practice and promiscuity.

The high-risk behaviors practiced by young people in the context of very low health service seeking and utilization patterns signals an urgent need for promoting integrated youth-friendly SRH and HIV/AIDS intervention programs. All the problems encountered highlight an urgent need to formulate specialized adolescent SRH policy and programs, and to revise existing health services to meet the needs of young people.

IX. Recommendations

This study demonstrates gaps that need urgent filling in order to save the young generation. It is evident that keeping young people from risky behaviors requires the development of a range of innovative strategies to bring about significant behavioral changes. Based on the findings of this study, the following points are recommended:

1. Formulate legal frameworks and develop national ARH/SRH policies and programs to be adopted consistently throughout Ethiopia. The most important prerequisites for meaningful intervention measures are clear policy and strategic guidelines, thus policy makers including the Ministry of Health, the Ministry of Youth, Sport and Culture, the Ministry of Labor and Social Affairs, Youth Associations and Forums must formulate these. To achieve this, endeavors that are undertaken by the Ministry of Health regarding SRH programs must be enhanced.
 - 1.1 To identify young people's problems and formulating SRH policy and programs in Ethiopia it is vital to:
 - 1.1.1 Involve a broad range of actors such as parents, community elders, religious groups, trusted significant adults and community based organizations who have responsibility for

informing and educating young people.

- 1.1.2 Enhance collaboration between government organizations, international and local NGOs, private institutions, health associations and youth associations that are engaged in SRH and HIV/AIDS service provision.
 - 1.1.3 Promote young people's active involvement in defining their needs and in designing SRH policy and implementing programs. Becoming involved in SRH programs gives young people a sense of responsibility and pride. The process of consulting young people on the issues they face, enabling them to prioritize issues and to develop a national youth-focused action plan, is important for empowering and ensuring "ownership" of SRH information by young people.
2. Incorporate Family Life Education and SRH into formal education curricula so that young people are educated at an early stage before they actually commence sex and risky behaviors. Since schoolteachers have a significant role, it is essential to sensitize and train teachers in order to develop their capacity to educate young people about SRH, reproduc-

tive physiology, sexuality, STIs, HIV/AIDS, and contraceptives.

3. Promote improved Information, Education and Communication or Behavioral Change Communication programs through the appropriate communication channels to:
 - 3.1 Increase the understanding of all categories of young people regarding SRH and consequent problems.
 - 3.2 Sensitize parents, community members and the general public focusing on parent-child communication and discussion about SRH matters. Educating children about SRH matters is primarily the responsibility of parents, family members and the community, so strengthening transparency between parents and children has paramount importance in preventing reproductive health problems and the spread of HIV/AIDS.
4. Promote outreach and community-based SRH programs for very high-risk groups of young people. Special attention needs to be paid to groups such as: street youth, out-of-school youth, and young people in the sex trade. These groups of youth are more involved in sexual matters and risk behaviors, so should attract special efforts in terms of outreach programs and other channels.
5. Involve peer educators and service providers: Peer educators with the right training and skills in interpersonal communication can be extremely effective messengers and promoters of behavioral change.
6. Promote social marketing campaigns: This method has great potential for reaching young target groups, and appears particularly effective in relation to reaching young people in relation to SRH problems and HIV/AIDS.
7. Undertake systematic interventions to tackle the constraining socio-cultural norms and taboos of Ethiopian society: changing negative attitudes of parents and the general community is of paramount importance. Programs should advocate for young people's SRH and ensure the support of community, religious leaders, parents and the whole community.
 - 7.1 Well designed IEC/BCC materials and advocacy methods must be used, and the general public sensitized through social and civic organizations and associations including

iddirs, *qire*, and *afosha* (funeral mutual help associations), *ye tsiwa maheber* (associations organized by women in the name of different saints), *Daboo* or *Jigi* (work teams), religious institutions, kebeles, peasant associations, anti-AIDS and other clubs.

8. Promote specialized youth-friendly SRH and HIV/AIDS services for young people in free standing settings or integrated into existing public health institutions. Decision makers must address young people's specific SRH needs.

8.1 Government bodies, particularly the Ministry of Health, must improve the quality of existing primary health care facilities and enable them to introduce SRH services designed to meet the needs of young people in terms of both information and services.

8.2 The Model Youth Centers launched by the FGAE are excellent examples of integrated, sustainable and replicable youth-friendly services. Government and non-government organizations should learn from these Youth Centers and make efforts to replicate them in other parts of Ethiopia.

8.3 Service providers must be

trained in the SRH and problems of young people, and in how to provide a youth-friendly service, in order that they provide quality SRH services to young people.

9. Strengthen the capacity of Community Based Reproductive Health Agents: Since most rural young people have less access to health institutions than urban residents, CBRHAs are essential to them. The capacity of CBRHAs could be strengthened by developing an adolescent reproductive health Extension Package Programme to be implemented in rural Ethiopia.

10. Develop specific VCT centers for young people: Instead of encouraging young people to use VCT centers designed for the general public, specific VCT centers integrated with strengthened SRH services for young people should be organized in youth-friendly settings.

11. Develop further research: detailed studies on the SRH issues among young people that need further investigation are recommended.

X. References

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XI. Appendices.

Appendix 1. Questionnaire for Study into the reproductive health needs of young people and the utilization and youth-friendliness of reproductive health and HIV/AIDS services in selected regions of Ethiopia.

Part One- Questions on Socio-demographic Characteristics		
No	Questions	Alternative Choices for Response
1	Respondent's address	1.Region-----2.Zone-----3.Woreda-----4.Kebele---- 5.PA-
2	Sex of Respondent	1.male 2.female
3	Age (enter number)	-----years
4	Marital status	1. Never married 2. Currently married 3. Have steady sexual partner 4. Separated
5	Religion	1.Orthodox 2.protestant 3.Catholoc 4. Muslim 5.Others-
6	Ethnic group	1. Amhara 2. Oromo 3. Tigrie 4. Sidama 5. Gurage 6. Harari 7.Somali 8.Berta 9.Others,-----
7	Educational status	1. Literate 2. Illiterate
8	Level of education for those who are literate (Grades)	1.Read & Write 2.-----last grade
9	Are you currently going to school?	1. Yes 2. No
10	What is your current occupation? (ask those who are not currently going to school)	1.None 2.Student 3.Daily laborer 4.Maid servant 5.House wife 6.Farmer 7.Civil servant 8. Employed in private sector 9. Have private business, (mention)-----10 Others-----
11	Your monthly income (enter number)	1-----Birr 2. No income
12	With whom do you live currently?	1.With father &mother 2.With father only 3. With mother only 4. With relatives 5.With friends 6. With boy/girl friends 7. with husband/wife 8. Alone 9. Others -----
13	What is your father's occupation?	1.No occupation 2.Daily laborer 3.Civil servant 4.Farmer 5. Employed in private sector 6. Have private business, (mention)-----7 Others-
14	What is your mother's occupation?	1.Housewife 2.Daily laborer 3.Civil servant 4.Farmer 5. Employed in private sector 6. Have private business, (mention)-----7 Others -----
15	In your opinion which of the following shows your families' economic status?	1.Rich 2.Medium 3.Poor 4.DNK
16	Your father's educational status	1. Illiterate 2. Read & Write 3.-----last grade
17	Your mother's educational status	1. Illiterate 2. Read & Write 3.-----last grade

18	What can a person do to avoid getting STI & HIV/ AIDS? (Probe, more than one answer is possible, but do not read the lists, circle “1” if mentioned & “2” if not mentioned)	1. Sexual abstinence (1, 2) 2. Avoid casual sex (1, 2) 3. Remain faithful to partner (1, 2) 4. Use condoms in every act of sexual intercourse (1, 2) 5. Avoid sex with CSWs (1, 2) 6. Others -----
19	Do you know all the ways a person can get HIV/AIDS? (Probe, more than one answer is possible, but do not read the lists, circle “1” if mentioned & “2” if not mentioned)	1. Unsafe sexual intercourse (1, 2) 2. Sharing needles and syringes (1, 2) 3. Blood transfusion (1, 2) 4. MTC during pregnancy & childbirth (1, 2) 5. Mosquito & other insect bites (1, 2) 6. Through breast milk (1, 2) 7. Casual contact with a person (hand shaking, sharing food, coughing etc.) (1, 2) 8. Others-----
20	Do you know anyone who is infected with HIV or other STDs?	1. Yes 2. No 3. DNK
21	Do you think that a healthy looking person can have HIV?	1. Yes 2. No 3. Not sure 4. DNK
22	Do you think that a person can get HIV the first time he or she has sex?	1. Yes 2. No 3. Not sure 4. DNK
23	Do you think that a girl can get pregnant the first time she had sex?	1. Yes 2. No 3. Not sure 4. DNK
24	Do you think that a boy/girl should have sex before s/he gets married	1. Yes 2. No 3. Not sure 4. DNK
25	Do you think that HIV can be transmitted from mother to child?	1. Yes 2. No 3. Not sure 4. DNK
26	If yes, how ?	1. Through breast feeding 2. Through blood contact during delivery 3. DNK 4. Others-----
27	Do you think it is possible to prevent MTCT of HIV?	1. Yes 2. No 3. DNK
28	If yes, what are all the ways that can a woman reduce the risk of transmission of HIV to child? (Do not read list, circle all that are mentioned)	1. Take medication (anti retro viral) 2. Abortion. 3. Protect from blood contact during birth 4. Consult health worker 5. Nothing 6. Don't know 7. Others-----
29	In this area is there any health facility/ organization that provides PMTCT of HIV services?	1. Yes 2. No 3. Not sure 4. DNK
30	What did you think are the main problems in providing PMTCT of HIV in this area? (Probe, more than one answer is possible, but do not read the lists, circle “1” if mentioned & “2” if not mentioned)	1. Lack of any health facility/organization which provides PMTCT of HIV services 2. Lack of knowledge of PMTCT among youth of the area 3. Unavailability of medication (anti retroviral) for PMTCT 4. Others-----
31	What do you think are the advantages or importance of VCT?	1. It helps in preventing the spread of HIV 2. It helps to get counseling and testing voluntarily 3. It helps to know about one's HIV status 4. It helps to provide care and support services 5. Others-----
32	What services are provided at the VCT centers? (Probe, but do not read the lists, circle all that are mentioned)	1. HIV testing 2. Pre & post -test counseling 3. Getting counseling when needed 4. Others-----
33	Who do you think should visit VCT centers? (Probe, but do not read the lists, circle all that are mentioned)	1. Any person 2. Those who suspect themselves infected by HIV 3. PLWHA 4. CSWs 5. Others-----
34	In your area are there specific youth VCT centers or must young people use VCT centers organized for the general public?	1. Yes there is 2. No there is not 3. There are only VCT centers organized for the general public 4. DNK
35	What did you think are the main problems in providing HIV VCT services in this area? (Probe, more than one answer is possible, but do not read the lists, circle all that are mentioned)	1. Lack of any health facility/organization which provides HIV VCT services 2. Lack of knowledge of VCT among youth of the area 3. Unfriendliness of the VCT centers 4. Others-----

36	Have you ever visited VCT centers in your area or any other area?	1.Yes 2.No→Skip to Q38 3.DNK
37	If yes, to get what service?	1.HIV testing 2.pre-test counseling 3.post-test counseling 4.Others-----
38	If tested, what was your serostatus?	1.HIV negative 2.HIV positive 3. Not heard my sero status 4.Not willing to disclose my status to you
39	Have you ever heard about ART?	1.Yes 2.No→Skip to Q44 3.DNK
40	What do you think are the advantages or importance of ART? (Probe, but do not read the lists, circle all that are mentioned)	1.To sustain life of PLWHA 2.To protect from opportunistic infections 3.Others-----4.DNK
41	Who do you think should use ART? (Probe, but do not read the lists, circle all that are mentioned)	1.Any PLWHA 2.PLWHA whose CD4 is <200cells/ml 3.Any person who suspects himself to be infected with HIV 4.Others-----5.DNK
42	In your area is there any health facility providing ART services to young people?	1.Yes there is 2. No there is not 3. There are only health centers organized for the general public 4. DNK
43	What did you think are the main problems in providing ART services in this area? (Probe, more than one answer is possible, but do not read the lists, circle “1” if mentioned & “2” if not mentioned)	1 Lack of any health facility/organization which provides ART services 2.Lack of knowledge of ART among youth of the area 3. Unfriendliness of the health centers 4.Lack of ART 5.Others-----6.DNK
44	Did you obtain information, advice & education about biological & physiological changes that occur in both boys and girls during puberty before you first had them?	1.Yes 2.No→Skip to Q45 3.DNK
45	If yes, who was your major source of information? circle all that are mentioned	1.Father 2.Mother 3. Peer educators 4.Friends 5.Partner/fiance/spouse 6. Siblings 7.School teachers 8.School clubs 9. Health professionals 10.CBRHAs 11.Religious leaders 12.Elders in the village 13. Radio, 14.TV 15. Posters &pamphlets 16. Books, magazine, news paper 17.Others-----
46	Do you think it is necessary for young people to consult or discuss with someone about RH, STIs and HIV/AIDS, VCT,PMTCT and ART?	1.Yes 2.No 3.DNK
47	What is your main source of information concerning RH, STIs & HIV/AIDS, VCT, PMTCT and ART etc? circle all that are mentioned	1.Father 2.Mother 3. Peer educators 4.Friends 5.Partner/fiance/spouse 6. Siblings 7.School teachers 8.School clubs 9. Health professionals 10.CBRHAs 11.Religious leaders 12.Elders in the village 13. Radio 14.TV 15. Posters &pamphlets 16. Books, magazine, news paper 17. Nobody 18. Other-----
48	Have you discussed RH, STIs & HIV/AIDS, VCT, PMTCT, and ART in the last 6 months with any one of these? (Read him/her the lists, more than one answer is possible)	1.Yes, with father 2.Yes, with Mother 3.Yes, with Peer educators 4.Yes, with friends 5.Yes, with Partner/fiance/ spouse 6.Yes, with Siblings 7.Yes, with school teachers 8.Yes, with School clubs 9.Yes, with Health professionals 10.Yes, with CBRHAs 11.Yes, with Religious leaders 12.Yes, with Elders in the village 13. Discussed with nobody 14. Other-----
49	If you want to know more about sexual maturation, ways of avoiding pregnancy, STIs & HIV/AIDS, VCT, PMTCT and ART issues whom would you like to talk to or with whom do you feel most comfortable discussing	1. Father 2.Mother 3. Peers/friends 4.Siblings 5.School teachers 6.School clubs 7. Health professionals 8.CBRHAs 9.Religious leaders 10.Elders in the village 11. Partner/husband / wife 12.With nobody 13. Others-----

Part Three– Questions on Sexual Practices, Contraceptives Usage And Reproductive Health Problems		
1	At what age did you first start menstruation? (Ask female)	1-----years old 2.Not yet 3.DNR 4.DNK
2	At what age did you first start ejaculation? (Ask male)	1-----years old 2.Not yet 3.DNR 4.DNK
3	Have you ever had sexual intercourse? (Ask those who answered “not married” for Q5 of part one, and mark “yes” for those who are married with out asking this question)	1.Yes 2. No → Skip to Q7 3. DNK
4	If yes, at what age did you first have sexual intercourse?	1-----Age in years 2.DNR 3.DNK
5	Why did you decide to have sexual intercourse the first time? (Probe, more than one answer is possible, but do not read the lists, circle “1” if mentioned & “2” if not mentioned)	1.Fall in love (1, 2) 2.Have desire (1, 2) 3.Get married (1, 2) 4.Wanted to get married (1,2) 5.Forced to do so by boy/girl friend (1, 2) 6.To get money &other gifts (1, 2) 7.Abducted (1, 2) 8. Seeing friends doing it(1, 2) 9.Don’t remember 10.Other-----
6	With whom did you first have sexual intercourse?	1.School friend 2.Out of school boy/girl friend 3.Fiance 4.Spouse 5. A relative 6.Other -----
7	Have you ever been forced to have sex against your will?	1.Yes 2. No → Skip to Q9 3. DNK
8	If yes, what was the relation to you of the person?	1.School friend 2.Out of school boy/girl friend 3.Fiance 4.Spouse 5. A relative 6.Other -----
9	Do you think that a woman should be able to refuse (if she does not want) to have sex with her boyfriend or husband or fiancé?	1.Yes 2.No 3.DNK
10	With how many partners have you ever had sexual intercourse?	1-----number of sexual partners 2.Don’t remember 3.DNK
11	During the last six months have you had sexual intercourse?	1.Yes 2.No → Skip to Q13 3.DNK
12	With how many partners have you had sexual intercourse within the last six months?	1-----number of sexual partners 2.Don’t remember 3.DNK
13	Have you ever had sexual intercourse with commercial sex workers? (Ask male respondents only)	1.Yes 2.No 3.DNK
14	Have you ever heard of contraceptives?	1.Yes 2.No→ Skip to30 3.DNK
15	If you heard from whom do get information? (More than one answer is possible, but don’t read the lists, circle all that mentioned)	1. Father 2.Mother 3. Peers/friends 4.Siblings 5.School teachers 6.Anti HIV/AIDS clubs 7. Health professionals 8.CBRHAs 9.Religious leaders 10.Elders in the village 11.Radio, 12.TV 13. Posters & pamphlets 14. Books, magazine, news paper 15. Partner/husband/wife 16. Others-----
16	Which contraceptive method(s) have you heard of? (More than one answer is possible)	1.Condoms 2.Pills 3.IUD (loop) 4.Diaphragm 5.Rhythm 6. In-jectables 7.Norplant 8.Abstinence 9.Others-----
17	Do you know where contraceptives can be found?	1.Yes 2.No→ Skip toQ19 3.DNK
18	If yes, where can you find them? (More than one answer is possible, but don’t read the lists, circle all answers that are mentioned)	1.Shop 2.Pharmacy 3.Market 4. Clinic 5.Health Center 6. Hospital 7.Family planning center 8.Youth centers or clubs 9.Bar/guest house/hotel 10.Peer educator 11.School 12.Friend 13.Street vender 14.DKT 15. Others-----

19	Have you ever used one of these contraceptives when you had sexual intercourse?	1.Yes 2.No→Skip toQ21 3.DNK
20	If used, which type?	1.Condoms 2.Pills 3.IUD (loop) 4.Diaphragm 5.Rhythm 6. Injectables 7.Norplant 8.Abstinence 9.Others----- --
21	If no, what were the reasons (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1. I have infrequent sex 2.Want to have children 3. Fear of side effects 4. Husband/partner opposed 5.Lack of knowledge 6.Religious prohibition 7.Difficult to obtain 8.Expensive to get 9.To far where it found 10.Others----
22	Did you use contraceptives the first time you had sexual intercourse? (ask those who say "Yes" to the Q 3 above)	1.Yes 2.No→Skip to24 3.DNK
23	If used, which type?	1.Condoms 2.Pills 3.IUD (loop) 4.Diaphragm 5.Rhythm 6. Injectables 7.Norplant 8.Abstinence 9.Others----- --
24	If no, why not (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Did not believe pregnancy was possible 2. Want to have child 3. Sex was un planned 4. Husband/partner opposed 5. Fear of side effects 6.Lack knowledge of methods 7. Religious prohibition 8.Method not available 9.Method expensive 10.Found at distant 11.Others-----
25	Have you used contraceptives in the last six months?	1.Yes 2.No→Skip toQ27 3.DNK
26	If used, which type?	1.Condoms 2.Pills 3.IUD (loop) 4.Diaphragm 5.Rhythm 6. Injectables 7.Norplant 8.Abstinence 9.Others----- --
27	If no, why not (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Did not like any of them 2. Had frequently unplanned sex with different persons 3.Want to have child 4. Fear of the side effect 5. Husband/partner opposed 6.Did not know any a method 7. Religious prohibition 8.Method not available 9.Method expensive 10.Found at distant 11.Others-----
28	Do you want to use contraceptives in the future?	1.Yes→Skip toQ30 2.No 3.DNK
29	If no, why not (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Did not like any of them 2.Want to have child 3.Did not know any a method 4.Fear of the side effect 5. Husband/partner opposed 6. Religious prohibition 7.Method not available 8.Method expensive 9.Found at distant 10.Others-----
30	Have you ever had any RH problems?	1.Yeas 2.No→Skip toQ34 3.DNK
31	If yes, which problem have you come across?	1.Unwanted pregnancy 2.Abortion 3.STI 4.Others----- -
32	Whom did you consult or ask advice when you encountered these problems?	1.Father 2.Mother 3.Brother/Sister 4.Friends/peers 5.School teacher 6.Religious leader 7.MHP 8.CBRHAs 9.Elder in the village 10.LTH 11.Consult no one 12.Others--
33	If you didn't consult or ask advice, why not?	1.I do not know where to go/ whom to ask 2.I could not find an appropriate place or counselor 3.I was afraid to ask for counseling /advise 4.I didn't think it is necessary 5.Others-
34	Have you ever had any STI problems?	1.Yes 2.No→Skip toQ39 3.DNK
35	If yes, which type of STI have you had?	1.Syphilis 2.Gonorrhea 3.Lymphogranuloma venereum 4.Granuloma inguinale 5.Chancroid 6.Trichomoniasis 7.HIV/AIDS 8.Don't know its name 9.Other-----
36	What did you do first or where did you get treatment when you had STI?	1.I did nothing 2.Self treatment 3.Went to traditional healer 4.Went to pharmacy 5.Went to public health institution 6.Went to private clinic 7.Other-----

37	How long after first experiencing symptoms did you seek advice or treatment?	1.1 week or less 2.Less than 1 month but more than 1 week 3.One month or more 4.DNK
38	When you first experienced symptoms why did you not go to a health worker in a clinic or hospital?	1. Embarrassed 2.Not accessible 3. Don't trust 4..Feel shame 5.They are not friendly 6.Other-----
39	Do you think that condoms can protect from HIV and other STIs ?	1.Yes 2.No 3.Not sure 4.Not 100% 5.DNK
40	Do you think that it is easy or difficult for young people of your age to obtain contraceptives or condoms?	1.Easy 2.Difficult→Skip to Q43 3.DNK
41	If it easy, where can you find or get them? (Probe, more than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Shop 2.Pharmacy 3.Market 4.Private Clinic 5.Health Center/ Hospital 6.Family planning center 7.Youth centers or clubs 8.Bar/guest house/hotel 9.Peer educator 10.School 11.Friend 12.Street vendor 13.DKT 14.From commercial sex workers 15.Others-----
42	If difficult, why it is difficult? (Probe, more than one answer is possible, but do not read the lists, circle "1" if mentioned & "2" if not mentioned)	1.Lack of money to buy (1, 2) 2.Difficult to find (1, 2) 3.Providers disapproves (1, 2) 4.Parents disapprove (1, 2) 5.Inconvenient to find (1, 2) 6.Too far to find (1, 2) 7.Expensive to buy (1, 2) 8.Others-----
43	Have you ever used a condom? (ask those who say "Yes" to the Q 3 above)	1.Yes 2.No→Skip to 49 3.DNK
44	Did you or your partner use a condom the first time you had sexual intercourse? (ask those who say "Yes" to the Q 3 above)	1.Yes →Skip to 47 2.No 3.DNK
45	If no, why (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Not available 2.Too expensive 3.Partner objected 4.We don't like it 5.Used other contraceptives 6. In a hurry 7.Embarrassed to buy or ask for 8. Not comfortable initiating 9.I trust my partner 10.I was drunk 11. Don't trust condoms as they transmit HIV 12.Did not think it was necessary 13.Did not think of it 14.Other-----
46	Have you used a condom in the last six months?	1.Yes→Skip to Q49 2.No 3.DNK
47	If no, why (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Not available 2.Too expensive 3.Partner objected 4.We don't like it 5.Used other contraceptives 6.Embarrassed to buy or ask for 7. Not comfortable initiating 8.I trust my partner 9.I was drunk 10. Don't trust condoms as they transmit HIV 11.Did not think it was necessary 12.Did not think of it 13.Others-----
48	Do you want to use condoms in the future?	1.Yes 2.No →Skip to Q52 3.DNK
49	If yes, why?	1. Believe it prevents HIV/AIDS & STIs 2.Believe it prevents pregnancy 3.Because it is comfortable to use 4. Others-----
50	Who influenced you in your decision to use condoms in the future?	1. Myself 2.Peer educator 3.Friends 4.Partner/spouse 5. Parents 6.Anti HIV/AIDS clubs 7. Health professionals 8.CBRHAs 9.Religious leaders 10.Elders in the village 11.Radio, 12.TV 13. Others---
51	If no, why? (More than one answer is possible, but don't read the lists, circle all answers that are mentioned)	1.Not available 2.Too expensive 3.Partner objected 4.I don't like it 5.Will use other contraceptives 6. Embarrassed to buy or ask for 7. Not comfortable initiating 8.I trust my partner 9. Don't trust condoms as they transmit HIV 10.Others-----
Ask the following Questions (52-62) females only		
52	Have you ever been pregnant?	1.Yes 2.No→Skip to Q1 of part 4 3.DNK
53	How old were you when you first became pregnant? (enter number)	-----years old 2.DNK/Remember
54	What happened to you as a result of your first pregnancy?	1.Married & gave birth 2.Not married but gave birth 3.Had abortion 4. Dropped out of school 5.Separated from family 6. Separated from sexual partner 7.Others---

55	When you first became pregnant, with whom did you discuss the issue?	1.Partner/husband 2.My friends/peers 3.Mother 4.Father 5.Brother/Sister 6.Other adult member of the family 7.Health worker 8.LTH 9.Illegal abortionist 10.With nobody 11.Others---
56	How many times have you been pregnant? (enter number)	-----times
57	If you have been pregnant, were all your pregnancies wanted?	1.Yes→ Skip to Q59 2.No
58	If no, which pregnancy was unwanted?	1.The 1 st 2.The 2 nd 3. The 3 rd 4. The 4 th 5. All
59	Have you ever had an abortion?	1.Yes 2.No→ Skip to Q1 of part 4 3.DNK
60	If yes, how many times have you had an abortion?	-----times
61	If you had an abortion, whom did you discuss the issue with	1.Partner/husband 2.My friends/peers 3.Mother 4.Father 5.Brother/Sister 6.Other adult member in the family 7.Health worker 8.LTH 9.Illegal abortionist 10.With nobody 11.Others---
62	Where did you abort?	1.At PHI 2.At private clinic 3. At abortionist's house 4.I have induced it myself by ingesting different drugs 5.Others-----

Part Four – Questions on Risk Perceptions

1	Do you believe you have done any thing that may have put you at risk of getting HIV or other STIs?	1.Yes 2.No 3.DNK
2	Do you think that you are at risk of unwanted pregnancy in the next 12 months? (ask Females only)	1.Yes 2.No 3.DNK
3	How confident are you that you would be able to have a sexual relation with only one person?	1.Definitely could 2.Unsure/does not know 3 Definitely could not
4	How confident are you that you would be able to abstain from sex for the next 12 months?	1.Definitely could 2.Unsure/does not know 3 Definitely could not
5	What are your chances of getting infected with HIV or STI ?	1.No chance 2.Low chance 3.Moderate 4. High 5 .DNK
6	If your response is 'No chance', why?	1.I never had sexual contact 2.Abstained from sexual intercourse 3.I trust my sexual partner 4.No injection with unsterile needles 5.I always use condom 6.I am healthy, no contact with HIV person 7.Other-----
7	If your answer is MODERATE or HIGH, way?	1.I had sexual contact with HIV positive partner 2.I had sexual contact with out condom 3.I have more than one sexual partner 4. I had sex with commercial sex worker 5.Condom break 6. I had unsterile injection 7.Others-----

Part Five- Questions concerning social and cultural influences on RH needs of youth		
1	If you asked your father about sex related questions like menstruation, pregnancy, and sexual intercourse, STIs what would be his response?	1.Would answer helpfully 2.Would turn me away without giving an answer 3.Would scold me 4 .Not competent enough to answer 5. Others-----
2	If you asked your mother about sex related questions like menstruation, pregnancy, and sexual intercourse, STIs what would be her response?	1.Would answer helpfully 2.Would turn me away without giving an answer 3.Would scold me 4 .Not competent enough to answer 5. Others-----
3	If you asked your brother about sex related questions like menstruation, pregnancy, and sexual intercourse, STIs what would be his response?	1.Would answer helpfully 2.Would turn me away without giving an answer 3.Would scold me 4 .Not competent enough to answer 5. Others-----
4	If you asked your sister about sex related questions like menstruation, pregnancy, and sexual intercourse, STIs what would be her response?	1.Would answer helpfully 2.Would turn me away without giving an answer 3.Would scold me 4 .Not competent enough to answer 5. Others-----
5	Do you think that parents consider discussing RH or sexual issues and contraceptives with young people promotes promiscuity?	1.Yes 2.No 3.Not sure 4.DNK
6	Do you respect your parents' ideas and opinions about sex?	1.Yes 100% 2.Yes 50% 3.No 4.DNK
7	Does your religion prohibit discussion between parents/ community adults and young people about sex issues & premarital sexual intercourse?	1.Does not prohibit 2.Completely prohibits 3.Partially prohibits 4.DNK
8	Do you think that social & cultural norms of the society you grow up & live in create barriers to young people seeking information on sexual and reproductive health issues like HIV & other STIs, & VCT?	1.Yes 2.No 3. Not sure 4.DNK
9	What do people in this community think about young people of your age who have sex before marriage, have more than one sexual partner, change partners frequently, or are involved in risky sexual or health behaviors?	1.Consider as bad youth 2.View as terrible youth 3.Not trusted 4. Other-----
10	How do community members view young people who they see seeking RH services at the health facility for adults?	1.Negatively 2. Positively 3.Not sure 4.DNK
11	How do parents treat youth who receive RH services from health facilities without notifying them?	1. Squabble 2. Condemn 3.Drive away from home
12	Is it easy for you to visit health facilities to obtain RH, VCT, MTCTP & ART services without the knowledge and permission of your parents or partners?	1.Yes 2.No 3.Not sure 4.DNK
13	Do you think that adults are capable of changing their attitude regarding youth RH, VCT, MTCTP & ART needs & problems?	1.Yes 2.No 3.Not sure 4.DNK

Part 6. Questions concerning young people's preferences and utilization of health services, and the youth-friendliness of services.		
1	Are there health institutions in your area that you could visit whenever you need to obtain RH, VCT, PMTCT & ART services?	1.Yes, there are 2.No, there are not 3.DNK
2	If yes, what types of health institutions exist?	1.GO Hospitals 2.GO Clinics 3. Private Hospitals 4.private clinics 5.Village health posts 6.Family guidance 7.private Pharmacies 8. NGO clinics 9.Others-----
3	Do these health facilities provide RH services to youth?	1.Yes 2.No 3.Not sure 4.DNK
4	Do these health facilities provide VCT services to youth?	1.Yes 2.No 3.Not sure 4.DNK
5	Do these health facilities provide PMTCT & ART services to youth?	1.Yes 2.No 3.Not sure 4.DNK
6	In this area, are there special health institutions for youth who offer RH, VCT, PMTCT & ART services specifically?	1.No one 2.One health institution 3.Two health institutions 4.More than two health institutions
7	Do these health institutions have such facilities as entertainment and educational materials for youth?	1.Yes 2.No 3.Not sure 4.DNK
8	Have you ever visited health institutions for RH services?	1.Yes 2.No 3.DNK
9	Have you ever visited health institutions to get VCT services?	1.Yes 2.No 3.DNK
10	Have you ever visited health institutions to get PMTCT & ART services?	1.Yes 2.No 3.DNK
11	Which type of health institution do you mostly visit for RH, VCT, PMTCT & ART services ?	1.GO Hospital 2.GO Clinics 3. Private Hospital 4.private clinics 5.Village health post 6.Family guidance 7.private Pharmacies 8. NGO clinics 9.Others-----
12	Have you visited a health institution in the last three months to get RH, VCT, PMTCT & ART services?	1.Yes 2.No→Skip to Q14 3.DNK
13	If yes, what was the reason for your visit? (do not read the lists, circle "1" if mentioned & "2" if not mentioned)	1. Had STI(1,2) 2.For abortion(1,2) 3.For delivery(1,2) 4.For antenatal care (1, 2) 5.To get contraceptives (1, 2) 6.To get condom (1,2) 7.For counseling (1, 2) 8.For HIV test (1, 2) 9.Others-----
14	At what distance are health facilities found in your area?	1.Very remote 2.Near by 3.DNK
15	If it is very remote how much time does it take you to travel?	1.One hour 2.Two hours 3. Three hours 4.More than 3 hours
16	Would you feel comfortable going to the health institutions found in your area for RH, VCT, PMTCT & ART service?	1.Comfortable 2.Not comfortable
17	Do you think that the health institutions found in your area are encouraging & welcoming to young people?	1.Yes 2.No 3.DNK
18	Do you think that staff at the health institutions welcome youth regardless of sex, marital & age status?	1.Yes 2.No 3.Not sure 4.DNK
19	If you went to see a provider at a health institution in your area for a RH, VCT, PMTCT & ART problem, do they give you a good welcome and treatment?	1.Yes 2.No 3.Not sure 4.DNK
20	Do you think you would feel comfortable asking the provider any questions about sexuality, RH, VCT, PMTCT & ART problems?	1.Yes 2.No 3.Not sure 4.DNK

21	Do you think the provider would be able to answer all of your questions?	1.Yes 2.No 3.Not sure 4.DNK
22	To which type of health institution do you prefer to go when you need RH, VCT, PMTCT &ART services?	1.Hospitals 2.Clinics 3.Sparete youth health centers 4.Any existing HS but with special rooms and approach to young people 5.School clinics 6.Village health posts 7.Family guidance 8.Pharmacies 9. NGO clinics 10.Others-----
23	Do you have preference in terms of sex, age and category of health professional in receiving services of RH?	1.Yes 2.No 3.Don't mind 4.DNK
24	If yes, which sex, age and category of health professional do you prefer to provide you RH services?	1.Young, nurse & same sex 2.Young, MD & same sex 3.Young, any sex & HP 4. Mature, nurse & same sex 5.Mature, MD & same sex 6.Mature any sex & HP 7.Others.....
25	Do you have any preference in terms of sex, age and category of health professional in receiving services of VCT?	1.Yes 2.No 3.Don't mind/No difference 4.DNK
26	If yes, which sex, age and category of health professional health you prefer to provide you VCT services?	1.Young, nurse & same sex 2.Young, MD & same sex 3.Young, any sex & HP 4. Mature, nurse & same sex 5.Mature, MD & same sex 6.Mature any sex & HP 7.Others.....
27	Do you have any preference in terms of sex, age and category of health professional in receiving services of PMTCT?	1.Yes 2.No 3.Don't mind 4.DNK
28	If yes, which sex, age and category of health professional you prefer to provide you PMTCT services?	1.Young, nurse & same sex 2.Young, MD & same sex 3.Young, any sex & HP 4. Mature, nurse & same sex 5.Mature, MD & same sex 6.Mature any sex & HP 7.Others.....
29	Do you have any preference in terms of sex, age and category of health professional in receiving services of ART?	1.Yes 2.No 3.Don't mind 4.DNK
30	If yes, which sex, age and category of health professional you prefer to provide you ART services?	1.Young, nurse & same sex 2.Young, MD & same sex 3.Young, any sex & HP 4. Mature, nurse & same sex 5.Mature, MD & same sex 6.Mature any sex & HP 7.Others.....
31	Are the existing health institution work hours convenient for youth who seek RH services?	1.Yes 2.No 3.DNK
32	Do health institutions found in the area have specific hours for youth who seek RH services or serve at the same time with adult users?	1.Have specific hours for youth 2.No specific hours for youth , serve at the same time with adult users 3.Others-----
33	Do you think that services of the health institutions and service provider staffs are attractive and friendly for youth to seek services?	1.Yes 2.No 3.DNK
34	Do you think that youth can afford the fees asked by the health institutions for the services provided?	1.Yes, they can afford 2. No they can't 3.DNK
35	From where or whom would you get money to pay for the RH, VCT, PMTCT &ART services when you visited the health facility?	1.Father 2. Mother 3.Sister/brother 4.Spouse/partner 5.Cover by myself 6.Other-----
36	Do you think privacy and confidentiality are important for youth of your age in seeking RH, VCT, PMTCT &ART services?	1.Very important 2.Not important 3.No matter
37	Do you think that privacy and confidentiality are given to youth who seek these services at the health institutions in your area?	1.Yes 2.No 3. Not sure 4.DNK
38	Have you ever visited health facilities for RH, VCT, PMTCT &ART services without informing or permission from your parents/partner?	1.Yes 2.No 3. DNK
39	Do you visit health facilities for RH, VCT, PMTCT &ART services without fear of being seen by parents and others?	1.Yes 2.No 3. DNK
40	Dothe providers ask you to come with your parents when you seek services?	1.Yes 2.No 3. DNK

Appendix 2. Open-ended questions and guidelines for key informant in-depth interview (IDI) and focus group discussion (FGD) with youth, in selected regions of Ethiopia, 2005.

Directions: Use these questions to in depth interview of key informant in school, out school, married or unmarried youth and to conduct focus group discussion with 6-10 youth of these groups. First inform the individual participant respondent or discussant about the objectives of the study and have verbal consent and willingness for interview or discussion.

1. Respondent's address 1.Region-----2.Zone----- 3.Woreda-----4. Kebele/PA-----
2. Sex of Respondent 1.Male 2.Female (mark without asking the respondent)
3. What is your age?
4. Have you married or not?
5. What is your educational status?
6. What is your current occupation?
7. What is your monthly income?
8. With whom do you live currently?
9. What do you think ARH is about? Explain briefly what you know about it.
10. Do you think that youth encounter RH problems? What are the major ARH needs and problems of youth may have during puberty? Of the problems mentioned, which one do you think is the biggest problem for youth in your area?
11. Do you think that it is important for youth to know about RH & its problems at puberty?
12. Whose responsibility do you think it is to inform and educate adolescents about RH & its problems at the age of puberty?
13. In your opinion, what is the ideal age for female and for male youth to start sexual intercourse or to marry? By the way, have you practiced sexual intercourse? If yes, at what age?
14. During which part of the menstrual cycle does a woman have the greatest chance of pregnancy? Do you know any ways to avoid getting pregnant?
15. Do you believe that HIV is transmitted from mother to child? How it transmitted? What are the methods of prevention?
16. Have you ever heard about VCT? Are there VCT centers in your area? What do you think are the advantages or importance of VCT? What services are provided at the VCT centers? Who do you think should visit VCT centers? Have you ever visited VCT centers in your area or any other area? What was your reason for visiting a VCT center?
17. Have you ever heard about PMTCT? Are there any health centers that provide PMTCT service in your area? What do you think are the advantages of PMTCT? Who do you think should get PMTCT? Have you ever visited health centers in your area or any other area to get PMTCT?
18. Have you ever heard about ART? Are there any health centers that provide ART services in your area? What do you think are the advantages of ART? Who do you think should get ART? Have you ever visited health centers in your area or any other area to get ART?
19. Who is your source of information concerning RH, STIs & HIV/AIDS, and VCT? Do parents and elder community members of this village inform and discuss with their children about RH, STIs & HIV/AIDS and sexual matters?
20. Is it easy or difficult for young people in this area to find condoms or other contraceptives if they want to use them?
21. Do young people in this area practice sex before marriage, have more than one sexual partner, change partners frequently, or exhibit risky sexual or health behaviors? Which group of young people mostly practices these, in school or out school youth? How do community members view such young people?
22. Is it easy for young people to visit health facilities to obtain RH, VCT, PMTCT & ART services without the knowledge & permission of their parents or partner? How do community members view young people who they see seeking RH services at the health facility for adults?
23. Do you think that religious, social & cultural norms of the society you grow up & live in create barriers to young people seeking information and services concerning SRH issues like HIV & other STIs, & VCT? How?
24. Are there health institutions in your area that you could visit when you need to obtain SRH, VCT, PMTCT & ART services? Are their location, work hours, service provider staff and services youth friendly? In what way?
25. Do you think that privacy and confidentiality are given to young people who are seeking RH, VCT, PMTCT & ART services at the health institutions?
26. Do young people in this area visit health services when they encountered RH, STIs & HIV/AIDS problems? Where do youth go if they need health service or advice?
27. Do you think that utilization of health facilities by young people for RH, VCT, PMTCT & ART problems is high or low? Which young people utilize health facilities for RH, VCT, PMTCT & ART services most?
28. What is your recommendation regarding improvement of RH situation of youth? What is your recommendation regarding improvement of PMTCT situation for youth? What is your recommendation regarding improvement of VCT situation for youth? What is your recommendation regarding improvement of ART situation for youth?

Appendix 3. Open-ended questions and guidelines for key informant in-depth interview (IDI) and focus group discussion (FGD) with parents and elder community members, in selected regions of Ethiopia, 2005.

Directions: Use these questions for in depth interviews of key informants selected from parents or elder community members and to conduct focus group discussion with 6-10 per group
First inform the individual participant respondent or discussant about the objectives of the study and obtain verbal consent and willingness for interview or discussion.

1. If your son or daughter asks you about sex related questions like menstruation, pregnancy, sexual intercourse, or STIs, what would be your response? Would you explain openly and helpfully or scold him/her?
2. Do you think that it is important for young people to know about RH or sexual issues and its problems at the age of puberty?
3. Whose responsibility do you think it is to inform and educate adolescents about RH or sexual issues and its problems at the age of puberty? How?
4. Do you and other parents /adult community members of this area believe that discussing or educating young people about RH or sexual issues and access to counseling and contraceptives services encourages early sexual practice or promotes promiscuity?
5. What do you think are the most common health problems that youth face today?
6. Do parents /adult community members of this area believe that youth have specific RH, VCT, PMTCT & ART needs and problems, and thus need specific health service facilities?
7. Do you think that there should be special locations in the community that provide RH, HIV/AIDS, STI, PMTCT and ART services to youth? Why or why not?
8. Do you think that the religious, social & cultural norms of the society you grow up & live in constitute barriers to young people seeking information and services concerning sexual and reproductive health issues like HIV & other STIs, & VCT?
9. What do people in this community think about youth who have sex before marriage, have more than one sexual partner, change partners frequently, or are involved in risky sexual or health behaviors etc?
10. How do community members view youth who they see seeking RH services at the health facility for adults?
11. How do parents feel about youth who received RH services from health facilities without notifying to them?
12. How would you feel if your son or daughter visited a health facilities to obtain RH, VCT, PMTCT & ART services without your knowledge & permission? If you found him/her will you take disciplinary measures? What kind?
13. Do you think that adults are capable of changing their attitude regarding young people's RH, VCT, PMTCT & ART needs & problems?
14. Do you feel that this community supports young people to use RH, VCT, PMTCT & ART services? Explain.

Appendix 4. Open-ended questions and guidelines for key informant in-depth interview (IDI) and focus group discussion (FGD) with health workers/ service provider staffs, in selected regions of Ethiopia, 2005.

Directions: Use these questions to interview key informant service providers and to conduct focus group discussions with 6-10 service providers.

First inform the individual participant respondent or discussant about the objectives of the study and have verbal consent and willingness for interview or discussion.

1. Do you think that young people have RH, HIV/AIDS & STIs, VCT, PMTCT & ART needs and problems? Explain some of their problems from a health worker's perspective?
2. Do you think that young people need specific RH, HIV/AIDS & STIs, VCT, PMTCT & ART service facilities or you think that they should have to visit health facilities arranged for adults?
3. What are the major services that your health facility provides to youth? Do you provide such services as HIV/AIDS testing, counseling, pregnancy testing, counseling on relationships, on sexuality and sexual abuse, on condom and other contraceptive methods use and negotiation, maternal care and delivery, STI testing, counseling and treatment, abortion service, post abortion services, nutrition and immunization services, prenatal/postnatal care and other services? In your position what kind of services do you offer in general or specifically to young people?
4. Are exclusive and specific package of services available to young people in your health facility? What are they? Are there specific recreational facilities or educational materials geared towards youth? Do young people utilize them? What is their effect on young people?
5. Does your health facility have specific policies, programs, strategies or methods on RH, HIV/AIDS & STIs, VCT, PMTCT & ART issues and services for young people? Can you explain it further?
6. Do you think it is necessary for service providers to have special training on RH, HIV/AIDS & STIs, VCT, PMTCT & ART issues to offer services to young people or you think that general knowledge is enough? Have you any special training on youth RH, HIV/AIDS & STIs issues? If so what did it cover?
7. Do you think that the health facility you work for provides appropriate services for young people? Is it youth friendly?
8. How comfortable are you discussing sexual behavior and RH, HIV/AIDS & STIs, VCT, PMTCT & ART issues with young people regardless of their age, sex, marital status, work position etc?
9. Do you think that young people of the area have the habit of going to health facilities if they encountered RH, VCT, PMTCT & ART problems? Do you think that utilization of health facilities by young people for RH, VCT, PMTCT and ART problems is high or low?
10. Do young people in the area visit your health facility to get RH, HIV/AIDS & STIs, VCT, PMTCT & ART services? How many young people per day, per month, and year? Which youth population is mostly served in your health facility (by age, sex, marital status/ married or unmarried/, school status/ in or out/, work status/working or not working/, sexually active/ currently sexually active or have been sexually active but not currently active/, living area/ urban or rural/)?
11. What are the major needs and problems that they mostly visit with and want to solve?
12. How do you view young people who practice sex before marriage, have more than one sexual partner, change partners frequently, or are involved in risky sexual or health behaviors etc? What kind of services do you think they need from a health facility? Are you willing to help youth who have such behaviors and risk practices if they come to you to get help?
13. Do you as a health provider honor privacy and confidentiality with your youth clients? What guidelines about clients' privacy and confidentiality do you follow when providing service for young people?
14. What do you recommend to improve the health situation of young people regarding RH, VCT, PMTCT and ART?

Appendix 5. Consent form for research into Youth's Needs, Utilization And Friendliness of Reproductive Health And HIV/AIDS Services: In Selected Regions of Ethiopia, 2005.

My name is ----- I came from ----- I am a member of the researchers' team who are carrying out a project called 'Youth's Needs, Utilization and Friendliness of Reproductive Health And HIV/AIDS Services: In Selected Regions Of Ethiopia', supported by a grant from CDC through the Ethiopian Public Health Association (EPHA).

The purpose of this study is to assess young people's needs for RH, HIV VCT, PMTCT and ART services, patterns of utilization and youth friendliness of the services in the eight Regions of Ethiopia. Of your peers, you are selected by chance to be one of the participants in this study. The study will be conducted through interviews. We are asking you for a little of your time, about forty five minutes, to help in this study. In the end it is hoped that the information you give us could help to design appropriate and youth friendly RH, HIV VCT, PMTCT and ART services for young people of your age. The interview involves intimate and private life questions. So a private setting is needed where you and I can carry out the interview. I would like to assure you that privacy will be secured throughout. All your information will be numbered and your name will not be used. Your answers will not be given to anyone else and no reports of the study will ever identify you. If a report of the results is published, only information about the total study group will appear.

The interview is voluntary. You can refuse to participate in the interview from the beginning or refuse to answer any questions that you do not want to answer in the middle of the interview. But I would like to remind you that the information you offer will help in improving RH, HIV VCT, PMTCT and ART services and utilization and youth friendliness of the services for young people of your age in Ethiopia. I also would like to tell you that your participation/ non-participation, or refusal to answer questions will have no effect now or in the future on services that you or any member of your family may receive from health service providers.

Are you willing to participate in this study? [] Yes [] No

Identification

Region----- Zone-----Woreda-----Kebele/PA-----

Date of interview-----date-----month-----Year-----

Name and signature of the interviewer-----

Name and signature of the supervisor-----

Appendix 6. Inventory of visited and observed health institutions.

No	Name	Where found	Important Characteristics
1	Mekele Hospital	Mekele town	Provide VCT service for everybody
2	Nekemte Hospital	Nekemt town	>> >> >>
3	Asosa Hospital	Asosa town	>> >> >>
4	Desse Hospital	Desse town	>> >> >>
5	Dire Dawa Dil Cora Hospital	Dire Dawa town	>> >> >>
6	Yirgalem hospital	Yirgalem town	>> >> >>
7	Harar Hospital	Harar town	>> >> >>
8	Zewditu Memorial Hospital	Addis Ababa	>> >> >>
9	Mekele 04 Kebele Clinic	Mekele town	
10	Akaki Clinic	A.A, Kaliti Kifle ketema	Provide VCT service for everybody
11	Alaba Clinic	Alaba town	
12	Debra Markos Clinic	Debra Markos town	Provide VCT service for everybody
13	Tula clinic	Sidama wereda	
14	Asela Clinic	Tiyo wereda	
15	Alamata clinic	Alamata wereda	
16	Dessie Zuria Clinic	Desse Zuria wereda	
17	Asosa Health Center	Asosa town	
18	Nekemte Health Center	Nekemte town	
19	Debre Markos Health Center	Debre Markos wereda	
20	Bambasi Health Center	Asosa, Bambasi wereda	
21	Mekele OSSA Health Center	Mekele town	Provide VCT service for everybody
22	Awasa OSSA Health Center	Awasa town	Provide VCT service for everybody
23	Dire Dawa OSSA Health Center	Dire Dawa town	Provide VCT service for everybody
24	Desse OSSA Health Center	Desse town	Provide VCT service for everybody
25	Hayiq Wuha Private Health Center	Awasa town	
26	Jegol Ber Private Health Center	Harar town	
27	Lukman Private Health Center	A.A, 01/05 kebele K/K/K	
28	Abdi Private Health Center	Asela town	
29	Hasinge Health post	Harari, rural kebele	
30	Sibu Sire Health post	Sibu Sire wereda	
31	Bakiyalo Health post	DireDawa, rural kebele	
32	Alamta Health post	Alamata wereda	
33	Tiyo Health post	Arsi, Tiyo wereda	
34	Selga Health post	Bambasi wereda, Asosa	
35	Tita Health post	Desse, Tita wereda	
36	Qulito Health post	Alaba Qulito wereda	
37	Zewditu M/ Hospital Pharmacy	Addis Ababa	
38	Desse Hospital Pharmacy	Desse	
39	Mekele Hospital Pharmacy	Mekele	
40	Yirgalem hospital Pharmacy	Yirgalem	
41	Bonaya Rural Pharmacy (private)	Nekemt	
42	Hotte Pharmacy (private)	Desse	
43	Alaba Drug store (private)	Alaba	
44	Sumaya Pharmacy (private)	Dire Dawa	
45	Desse Model Youth Center	Desse town	All Model Youth Centers provide
46	Awasa Model Youth Center	Awasa town	RH, FP, HIV/VCT, IEC/BCC
47	Harar Model Youth Center	Harar town	STI treatment, contraceptive distribution, library, sport & music services to youth in youth friendly approaches.
48	Dire Dawa Model Youth Center	Dire Dawa town	