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COMMUNITY PERCEPTION AND FEMALE ADOLESCENTS LIKELIHOOD ON UTILIZATION OF REPRODUCTIVE HEALTH SERVICES USING THE HEALTH BELIEF MODEL IN MARAKA DISTRICT, DAWURO ZONE, SOUTHERN ETHIOPIA

BY:

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A THESIS SUBMITTED TO THE DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCES, COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR DEGREE OF MASTERS OF PUBLIC HEALTH IN HEALTH EDUCATION AND PROMOTION

JUNE 2014

JIMMA, ETHIOPIA

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ABSTRACT

Background: According to the World Health Organization, adolescents were defined as persons between 10 -19 years of age and were characterized by significant physiological, psychological, and social changes; these were put them at high risk for Reproductive health problem.

The objective of the study: It was assessed community perception and female adolescent's likelihood on utilization of reproductive health services in the Mareka district based on health belief model.

Methods: A community based cross sectional design with both quantitative &qualitative was conducted in Mareka district, southern Ethiopia from February 20th to April 30th 2014. Sample size was 844 and calculated using single population proportion formula. Interviewer administered structured questionnaire was used to collect data. Four FGDs were conducted for qualitative study. Frequency table and cross tabulation was done. AOR and OR with 95% CI were considered for statistical significance. Bivariate analysis was used to determine presence of crude association. Multivariate logistic regression model was employed to control confounding variable.

Result: Majority of the respondents had high score of perceived susceptibility for RHP, perceived severity for RHP, and perceived barrier for utilization. The minimum and maximum scores of the model constructs were (9, 45), (6, 30), (9, 45), and (7, 35) respectively. The likelihood of utilizing reproductive health services by adolescent female was significantly associated with perceived susceptibly of RHP, perceived severity of RHP, and perceived barrier with PV<0.05 and CI of 95%.

Conclusion: Almost one third of adolescent females were not utilized RH services which were more stressing despite there were health post in each kebele and four health centers in the woreda to introduce reproductive health problems preventive massage to increase perceived susceptibility and perceived severity on adolescent females. The role of community leaders, parents, religion leader, teachers, media, and IEC materials had significant positive influence on the use of RH services by the adolescent females.

Recommendation: Multi-sectoral integration was required to increase reproductive health services utilization by the adolescent female because she was the primer victim for many reproductive health problems due to various reasons but she was vital for gene preservation.

Key words: Community perception, likelihood of adolescent female, RH services, & HBM

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ACRONYMS

AFRHS Adolescent-Friendly Reproductive Health Services

AIDS Acquired Immune Deficiency Syndrome

AOR Adjusted Odds Ratio

ASRH Adolescent Sexual and Reproductive Health

CI Confidence Interval

FGD Focus Group Discussion

FP Family Planning

HBM Health Belief Model

HIV Human Immune Deficiency Virus

HW Health Worker

ICPD International Conference on Population Development

JU Jimma University

KAP Knowledge Attitude Practice

MOH Ministry Of Health

OR Odds Ratio

PI Principal Investigator

RH Reproductive Health

RHS Reproductive Health Services

RHS Reproductive Health Services

SNNPR Southern Nation and Nationality Peoples Region

SRH Sexual and Reproductive Health

STI/SID Sexual Transmitted Disease

TV Television

YFS Youth Friendly Service

CHPTER ONE: INTRODUCTION

1.1 **Background**

Globally, most people become sexually active during adolescence. Premarital sexual activity was common and was on the rose worldwide. Millions of adolescent females were bearing children, 40 percent of all new human immunodeficiency virus (HIV) infections were occurred among 15-24 year olds; recently estimated that 7,000 were infected each day. These health risks were influenced by many interrelated factors (1-4).

According to World Health Organization (WHO), adolescent is defined as a person between 10 up to 19 years of age and youth is a person between15 up to 24years of age. Adolescents were characterized by significant physiological, psychological and social changes that placed their life at high risk and making up about 20% of the world's population, of whom 85% lived in developing countries. This had at least partially been because adolescents were considered to be a relatively healthy age group, without a heavy burden of disease.

The concern about adolescent sexual and reproductive health (ASRH) had grown following reports that sexual activity, early pregnancies and sexually transmitted infections (STIs) including human immune deficiency virus (HIV) infection rates were increasing at unprecedented rates among adolescents. Since the 1994 international conference on population development (ICPD) in Cairo, Egypt, adolescent friendly reproductive health services (AFRHS) had been recognized as an appropriate and effective strategy to address sexual and reproductive health (SRH) needs of adolescents. Despite 35% of the world population being in the 15-24 age groups, the RH needs of adolescents had neither been researched nor addressed adequately (1- 4).

The rates were highest in sub Saharan Africa, where as more than half of girls aged 15-19 were sexually experienced and more than half of women gave birth before age of 20 year. Pregnancy was poorly tolerated in many societies. If it happens, the blame was usually put on the girl. Each year about 15 million adolescents aged of 15-19 year gave birth, as many as four million obtained an abortion and up to 100 million become infected with a curable

sexually transmitted disease. Nevertheless, the needs of the young people remain poorly understood (5, 6, 7).

Early and unprotected sexual activity and misconceptions about HIV/AIDS were prevalent in rural adolescents (8-10). There were a few studies on knowledge, attitude and practice of adolescents in relation to their reproductive health in Ethiopia showing a significant discrepancy between knowledge about and the level of services utilization in particular and poor access to RH services in general as study in North West Ethiopia (10-12).

Sexual activity put adolescents at risk of various reproductive health challenges. Ethiopia was one of the country in sub Saharan Africa regions with rapid population growth trend from these rapid growing population young people constitute one-third of the total population. Their number was expected to grow from 20.3 million in 2000 to 25 million in 2010.

The reproductive health problems of young people in Ethiopia were multifaceted and interrelated. Childbearing was begun at an early age; 45 percent of the total births in the country occurred among adolescent girls and young women. Sexual violence and commercial sex work had become common phenomena among young girls. As a result, they had become primary victims of the HIV/AIDS crisis that had spread throughout the country (13 - 15).

1.2 Statement of the problem

In the world majority of adolescent female in the age group 15-19 years had been at risk of many RH problems. Therefore many adolescent females were exposed to HIV/ADIS infection and other RHP due to their engagement in unsafe sex & unsafe abortion, less achievement of academic performance and absenteeism of school. So that adolescent females were tried suicidal attempt due to many factor which affect RHS utilization (1).

In Africa alone, an estimated 1.7 million young people were exposed to many RH problems. Most religious groups had stringent rules and norms that tend to view use of family planning among unmarried youth as sinful and believe that engaging in pre-marital sex was sin (2).

The religious norms to some extent had played a role in controlling the youth from involving themselves in indiscriminate sex in Kenya but these efforts had been eroded by increased urbanization which had led most youths living on their own without religious guidance and control (17).

Among both sex non-users of youth friendly services, 43% of them did not knew where to go for these services and 18.7% said that the location was inconvenient. A total of 7.1% were reported too shy, 4.9% were too busy, 11% of the youth participants did not visited RH services, and 11% were said clinic was too a great distance (12). There was no study on utilization of RHS by adolescent females to address them alone because she was the primer victim of RHP which was the gap to carry out this study.

Stigma, service costs, and provider bias were posed formidable barriers to Ethiopian young people's ability to access sexual and reproductive health services. To address these barriers, in 2005 Pathfinder International and the Ethiopian Federal Ministry of Health were partnered to introduce and scale up youth-friendly services in the Ethiopian public health system. YFS an evidence-based approach to reduce barriers to service uptake among young people & which support the foundation of Ethiopia's health system to meet the SRH needs and rights of the largely underserved adolescent and youth population. But up take was low as study conducted in Addis Ababa, Ethiopia (32).

CHAPTER TWO: LITERATURE REVIEW

In Ethiopia, services for reproductive health problem were included as one of the strategy for STI prevention in HIV/AIDS policy (7). Female student especially those from rural areas, students living outside the campus, new comer student, academically poor /low achiever students were the most victims of reproductive and sexual health problems and gender/sexual harassment related problems as study conducted in north west Ethiopia(12).

The in-depth interviews with the service providers at the public health care facilities throughout Harar indicated that they did not provided specific sexual and reproductive health services for youths. Sexual and reproductive health services were provided to youths without giving them special attention; youths were treated as adult health services seekers in these public institutions as study show in the Hara. Female focused group discussants were reported that majority of students prefer remaining silent and in some cases they were seek help from their friends. An experience noted by a female participant as; *"... female students did not want to seek care for their SRH problems. For example for the last case of abortion (happened in dormitory) the student simply complained abdominal pain and it took place in dormitory" (14).*

The main obstacles from the adolescents' perspective refraining them from getting RH services from health institutions were not thinking of the services, unnecessary of the services, lack of knowledge and being young were listed by 128 (50.6%), 87 (34.4%), 65 (24.3%) and 44 (17.4%) of the adolescents respectively among others (15).

Three quarters of the adolescents had never discussed RH topics with their parents due to worthlessness 63 (24.9%), fear 188 (74.3%), social and cultural restriction 52 (20.6%) and others 18 (7.1%). The 174 (46.4%) of the adolescents preferred to discuss RH issues to friends, followed by health professionals 105 (28%) and mothers 41 (10.8%). Accordingly, adolescent females were found to be less knowledgeable than their male counterparts for reproductive health. Factor affecting RH services utilization by adolescent was associated with IEC, adolescent-parent discussion of SHR topics and RH knowledge (14).

For unmarried adolescent females, services were offered as part of child health care and did not encompassed sexual and reproductive health as study carried out on university student in south east Ethiopia (15). Very long waiting time for adolescents and youth at health facilities were exposing them to other adult members of the community and minimizing their privacy (18). 'Money was everything, if you hadn't money it means no services, just go home and die, didn't waste your time, FGD of Medium wealth category (19).

Adolescent females of age 15-19 were up to twice as likely to died during pregnancy or delivery as women aged 20- 34year (20-24). Comprehensive knowledge about HIV/AIDS and knowledge of the three programmatically important HIV prevention methods were higher among males than females (26, and 29).

The majority of health workers had positive attitudes. However, nearly one third (30%) of health workers had negative attitudes toward providing reproductive health services to unmarried adolescents. Close to half (46.5%) of the respondents had unfavorable responses toward providing family planning to unmarried adolescents. About 13% of health workers agreed to setting up penal rules and regulations against adolescents that practice pre-marital sexual intercourse study on HW attitude in Ethiopia as show study conducted in Addis Ababa in 2012 (30).

Health belief model was the best model to assess the acceptance of the service when the service was available and the consumption rates were low in some target group. There were six constructs in HBM such as perceived susceptibility, perceived severity, perceived barrier, perceived benefit, cue to action, and self efficacy. If individual perceives that perceived benefit was higher than perceived barrier then they were utilized the services and even if they were try to overcome the barriers.

Strength of HBM; it provided a useful theoretical frame work for researchers of cognitive determinants of a wide range of behaviors for over 30 years. Its common sense constructs were easy to non psychologists to assimilate and apply. It had focused on easily modifiable behaviors.(31).

Theory of reasoned action /theory of planed behavior model was based on individuals attitude towards any behavior and subjective norms the purpose of this theory. To predict

and understand motivational influences on behavior that was not under individual's volitional control, to identify how and where to target strategies for changing behavior, and to explain virtually any human behavior such as why a person buys a car was absent from a work or engages in premarital sexual intercourse. Weakness of it was in suggesting that behavior was under the control of intension this theory restricts itself to volitional behaviors and behaviors which required skills, resources or opportunities were not considered.

Tran's theoretical model or stages of change model tries to explain why people didn't easily change their behavior, even when they were knowledgeable or even directly affected by the condition. There were 6 stages of change individuals used to change their troubled behavior these were pre-contemplation, contemplation, preparation, action, maintenance, and termination.

Social cognitive theory model stipulates that human behavior was an interaction between cognitive, behavior and environmental determinants.

Why HBM was selected? As it was known that since reproductive health services was available, the acceptance had increased and the service was gradually wide spread but different studies were showed that for various reasons the acceptance of RHS varied among selected population group in a wide range. In general it was now believed that people were take action if they regarded themselves as susceptible and potentially damaging and also the anticipated barrier of taking action were outweighed by its benefit so to assess this the HBM were more appropriate than others.

Reproductive health problem was very wide however, the researcher operationalized the most prevalent case by reviewing many literatures therefore the following reproductive health problem was prioritized such as abortion and its complication, unwanted pregnancy, and STI and its complication.

The following gaps were identified from the literature review; such as their study subjects were both male and female adolescent but the study subjects in current study was adolescent female only to address female issue alone, they did not considered community perception but the current study was consider it by triangulating respondent, they did not use HBM in availability of services to assess acceptance of the services but the current

study was used it, all of their studies were institution based but the current study was community based. In general there was no study done on perception of the community and adolescent female likelihood on RHS utilization in the country and in SNNPRs which was the gap identified to carry out the study but it was tried in school youth in both male &female adolescent. So I used prevalence of adolescent female utilizing RHS was 50% to estimate sample size because there was no study on utilization of RHS by adolescent female alone.

Assessing community perception on RHS utilization by adolescent female was vital to improve the way of approaches while delivering the services to those girls live with their parents and not married.

SNNPR was one of the regions which were implemented youth-friendly service strategy by establishing youth-friendly service center in each wereda in the selected health institution to increase utilization of reproductive health services by youths as data from Dawuro Zone main health department.

The Mareka district was one of the wereda in SNNPR which open youth-friendly service in waka health center in June 1st 2009. However; reproductive health services utilization by adolescent female in all health institution of the wereda was 9% and youth-friendly service utilization by adolescent female in the waka youth-friendly service center was very low, which was 2% in prevalence, as Mareka wereda health office data.

Hence this study was assessed adolescent female's likelihood towards susceptibility of reproductive health problem, severity of reproductive health problem, self-efficacy to utilize reproductive health services, perceived benefits of reproductive health services utilization, perceived barriers of reproductive health services utilization and reviled specific community perception on reproductive health services utilization by adolescent females before marriage using health belief model.

2.1 Significance of the study

Especial in rural community adolescent female's rate of attending health institution before marriage was very low compared to male adolescent as study taken in both sex in Kenya, Nigeria, and South West Ethiopia.

Utilization of reproductive health services in adolescent female was very low in many study carried out on reproductive health problems in both sex. But adolescent females were prone for many reproductive health problems due to their work load in the house hold, their physiological structure, their anatomical structure, lacks of open discussion with in the family, and negative behavior from peer pressure.

The rural environment was a unique and potentially challenging socio-cultural context for adolescent health and more restrictive regarding issue related to reproductive health and sexuality for adolescent female (33).

Therefore the findings of the study would helpful to expand and improve the reproductive health services utilization by adolescent female and to decrease the RH problems and to identify factors which affecting the utilization of reproductive health services by adolescent female. Finally the finding of the study would help programmers, community members and researcher to meet the need of adolescent female in the country by yielding relevant information for them.

2.2 Conceptual framework

Modifying factors Individual perception Likelihood of action

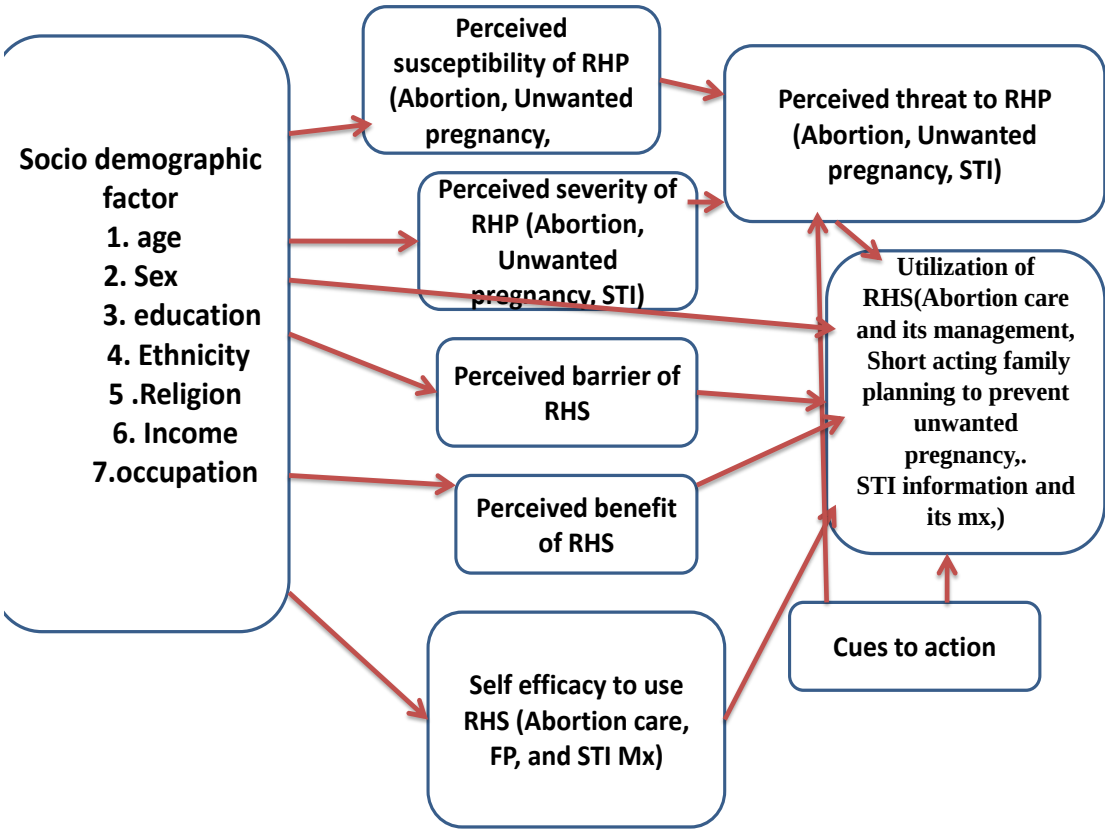

Figure 1 Schematic presentation of conceptual framework (Turner L, Hunt S, Diberzzo R, Johon C. Health Belief Model. Am. J. Heal. study. 2004;19(2):115–21).

CHAPTER THREE: OBJECTIVE

3.1 General objective of the study

To assess community perception and adolescent females likelihood on utilization of reproductive health services by using the Health belief Model in the Mareka district.

3.2 Specific objective of the study

1. To assess the community knowledge, belief, attitude, and practice about utilization of reproductive health service by adolescent females among community leaders in Mareka district.
2. To assess the perceived susceptibility to reproductive health problems and the perceived severity of the reproductive health problems by adolescent females among adolescent females in Mareka district.
3. To assess perceived benefits of adolescent females to utilize the reproductive health services and perceived barriers of adolescent females to utilize the RH services among adolescent females in Mareka district.
4. To assess factors affecting adolescent females to utilize RHS; like modifying factors, and cue to actions among adolescent females in Mareka district.
5. To assess self efficacy of adolescent females on RHS utilization among adolescent females in Mareka district.

CHAPTER FOUR: METHODS AND MATERIALS

4.1 Study area

The study was conducted in selected Kebele of Mareka District. Mareka District was one of the six Districts in Dawuro zone. Dawuro Zone was one of the thirteen Zones in Southern Ethiopia, which was located South West of Ethiopia 500 km apart from Addis Ababa which was capital City of Ethiopia, 275 km apart from Hawassa which was regional City of SNNPR.

The Dawuro Zone had five Wereda and one City administration. Based on central statistics agency report of 2007, the projected total population in 2013/14 was 600121. From these females were 49% (294,352) and males were 51% (305,769). Approximately 92% of the populations' are rural dwellers and 8% of the populations are urban dwellers 85% of their income source was agriculture and the remains 15% was trade and others.

The potential health coverage of the Dawuro Zone was 91%. In the Zone there were one General hospital, 21 health center and 175 health posts, and one YFS center. YFS center was located in mareka wereda. This YFS center was established in June 1st 2008 with collaboration of IFH which was local NGO of the region to serve youths found in the Dawuro Zone.

Mareka Wereda was one of the Wereda in Dawuro Zone in which zonal city was established namely Terecha and the Mareka Wereda city was 17 km apart from Zonal City namely Waka. The Wereda was administratively divided into 37 kebeles. The potential health coverage of the Wereda was 85%. There are 4 health center, 33 health post, one YFS center, 44 primary schools and 4 secondary schools and 1 preparatory school.

Based on central statistics agency report of 2007, the projected total population in 2013/14 was 143616. From these populations females were 48% (69,575) and males

were 52% (74,041). Youth accounts one third of Woreda total populations which was approximately 33% (47,872) in both sexes. From these 33% of youths; adolescent female were 50% (23,936).YFS utilization rate by adolescent female was 21% (5,026) from total adolescent female in the Mareka Wereda.

Ninety one percent of the Wereda populations were rural dwellers, and the remaining nine percent of the Wereda populations were urban dwellers and Waka is one among these nine percents of urban dwellers. Approximately 89% of their income source was agriculture and the remain11% of their income source was from trade and others.

The district covered an area of 46620 hectares from these 41.77% was high land, 50% was mid land, and the remaining 8.23% was low land. The district was rich in rivers and mountains of different shapes and size.

4.2 Study period

Data was collected from February 20th to March 30th in 2014.

4.3 Study design

Community based cross sectional design was conducted by using both quantitative and qualitative methods for triangulation.

4.4 Population

4.4.1 Source population for quantitative study

All adolescent females of age 10 – 19 year old found in the Dawuro Zone populations.

4.4.2 Source population for quantitative study

4.4.2 Study population for quantitative study

All adolescent females of age 10 - 19 year old found in Mareka District.

4.4.3 Study population for qualitative study:

All communities leaders found in Mareka District.

4.4.4 Sampling unit for quantitative study

House hold

4.4.5 Study subjects for quantitative study:

Adolescent females of age 10 - 19 year old found in Mareka District in selected Kebele of Mareka District.

4.4.6 Study subjects (respondents) for qualitative study

Community leaders found in selected Kebele of Mareka District.

4.5 Inclusion and exclusion criteria

4.5.1 Inclusion criteria for quantitative study

All adolescent females who were 10-19 years old, not married, found in the selected Kebele and found in the selected house hold during interview of the Mareka District**.**

4.5.2 Exclusion criteria for quantitative study:

All adolescent female who was not 10-19 years old, severely ill, married, and not found in the selected Kebele and not found in selected house holed during interview of the Mareka District**.**

4.6 Sample size and sampling techniques

4.6.1 Sample size determination for quantitative study

The Sample size was calculated using single population proportion formula and EPI-INFO soft ware using the following the assumptions. Since there was no previous study conducted in Ethiopia and particular in study area in this specific study group which comprises single sex up to the knowledge of the investigator. Therefore the following assumption to estimate maximum sample size such as; a prevalence level was 50%, margin of error was 5%, non-respondents rate was 10%, confidence interval level was 95%, and the design effect of two was considered to obtain sufficiently large sample size because there was steps during recruitments. Based on these assumptions the total samples size was calculated using the formula indicated below gave 844 respondents.

$$n = \frac{\left(\frac{z\alpha}{2}\right)2\ p(1-p)*2}{d2} \quad = \quad 3.8416*0.25/0.0025*2 = 768.52$$

Where: n was minimum possible sample size, N was actual sample size.

Z α/2 was standard score value for 95% confidence interval level of two sides normal distribution which was 1.96, and d^2 was margin of error which was 5%.

P was proportion of adolescent females who were utilized RHS which was 50%.

Then minimum possible sample size was n = 768. Considering 10% non-response rate total sample size was equal to n+n*10%. Then N was equal to 768+76 =844. Hence 844 adolescent females were involved in the study.

4.6.2 Sampling technique for quantitative study

There were 37 Keble in the wereda and we were sampled 11 Keble for the study because many literature suggest that 25% up to 50% was sampled to get representativeness. In the first step these eleven kebele was selected on simple random sampling by using lottery method. The sample unity in selected kebele was house hold and sample unity was proportionally allocated to all selected Kebele by. Therefore sample unity was approximately 76 in each kebele by dividing 844 to eleven.

Secondly the study unit was proportional allocated to sample unity which was one for each sample unity and interval from each study unity was approximately 10.
Thirdly by giving clear orientation for data collector's to make land mark on first house hold then adolescent female was selected through systematic sampling technique (every 10^{th} study unit by using code which was given during 2002 elections of Ethiopia) from the sample unit and it was checked by supervisors.

Finally the study unity was identified by using key informants on the day of the survey and those who was eligible for the study was identified and interviewed by the data collectors, if absent the next nearest study unity was used.

4.6.3 Sampling procedure for quantitative study:

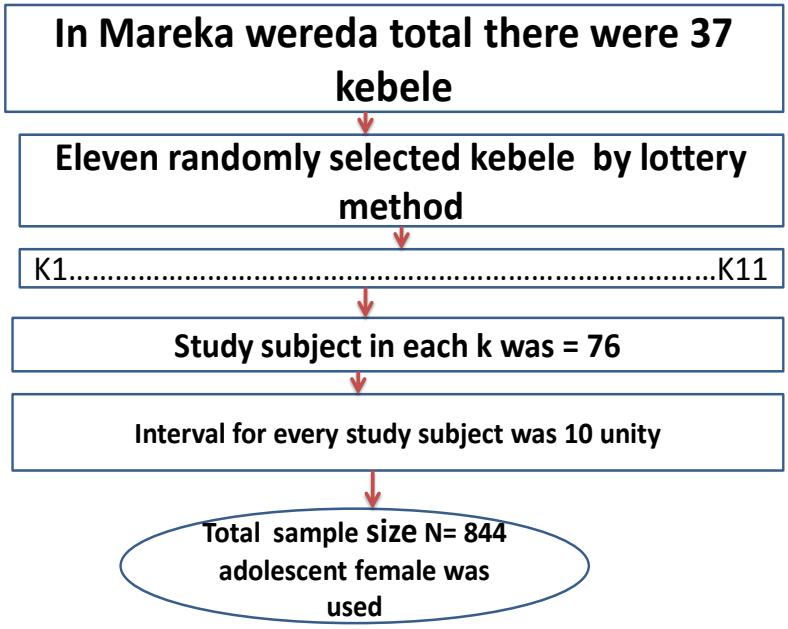

Figure 1 Schematic presentation of sampling of female adolescents

4.7 Data collection technique for quantitative study

The data for the quantitative section of the study was collected by face to face interview with 5 trained data collectors for 7 days who were diploma nurse/HO /BSC nurse with some experience in data collection. Interviewer administered structured questionnaire was used to collect data. The instrument was adapted from web site, IFH guide line for youth and modified (18, 26, and 45).

4.8 Instrument & measurements

There were 10 parts in instrument with different response formats and different items to assess the dependent variables. Such as, socio-demography assessing instrument with 16 item, perceived susceptibility assessing instrument with 10 item, perceived severity assessing instrument with 6 item, perceived barrier assessing instrument with 10 item, perceived benefit assessing instrument with 10 item, cue to action assessing instrument with 4 item, self efficacy assessing instrument with 11 item, RHS utilization assessing instrument with 5 item, knowledge assessing instrument with 4 item, attitude assessing

instrument with 2 item and total there were 78 items. Coding of tools was carried out. The Cronbach`s alpha for attitude assessing 36 items were equal to 0.74.

4.9 Sample size determination and sampling technique for qualitative study

For qualitative study participants were recruited by homogenous sampling technique. Homogeneity for participants was on the basis of sex categories. Total 4 FGDs of community leaders were used.

4.10 Data collection technique for qualitative study

Four FGDs (two FGDs with men, two FGDs with women were conducted in four kebele. Each FGD comprised of ten to twelve participants. For the FGDs with community leaders, religious leaders, community based insurance scheme ("Idir") chairpersons; other key community resource people like shaman, witchcraft, traditional service providers; participants were purposely selected from four kebeles those kebeles that was not included in quantitative parts. A total of 50 community leaders found in Mareka district (26 males and 24 females) were included. The age of the participants ranged from 25 to 41 years. The average time taken for each FGD was 45 minute. All participants engaged well with the topic and responded excitedly to the questions.

4.10.1 Procedure for FGD

FGD was conducted in four kebeles that was not included in quantitative parts such as; Waka 01 kebele, Waka 02 kebele, Eyessuse kebele, and Gozo Bamush kebele. For the focus group discussion, appropriate rapport was established before starting the focus group discussion. The respondents were assured that their responses were kept confidential. The principal investigator moderated all focus group discussion session, and the two trained supervisors were assisted in note taking of all the discussions. After the focus group discussion is over, the facilitator thanks the participants for taking the time to participate. After each group discussion the principal investigator gave appropriate feedback. The principal investigator and supervisors transcribed the minutes. Preliminary coding of transcript was done and a consistent theme that was directly related to the objectives of the study was identified.

4.11 Variables

4.11.1 Dependent variable

Utilization of reproductive health services (FP, abortion care and its management, and SIT management).

4.11.2 Independent variables

1. Modifying factors/back ground factor that affects utilization of reproductive health services like:
    - Educational status
    - Age
    - Religion
    - Ethnicity
    - Knowledge and attitude toward reproductive health services.
2. Self-Efficacy of girls to utilize reproductive health services.
3. Perceived Benefit of RHS utilization.
4. Perceived Barriers to utilize reproductive health services.
5. Perceived Susceptibility to reproductive health problems.
6. Perceived Severity of reproductive health problems.
7. Cues to utilize or reminders to utilize reproductive health services like:
    - Media information
    - Appointment card from health facility
    - Teachers
    - Neighbor
    - Family

4.11.3 Operational definitions

Utilization of reproductive health services: Adolescent females who received at least one component of reproductive health services (FP, abortion care, and STI managements) in the past 12 month which was appropriate for her ages.

Reproductive health services: A reproductive health service was a service which was gave by health workers to adolescent female at health center, health post and hospital of Government or private institution such as; abortion care and its management, short acting

family planning to prevent unwanted pregnancy, and sexual transmitted infection information and its management to prevent reproductive health problems.

High perceived susceptibility: Adolescent females who had score of susceptibility greater than or equal to twenty-five had high perceptions toward reproductive health problems while adolescent females who had score of susceptibility less than or equal to twenty-four had low perception toward reproductive health problems.

High perceived severity of reproductive health problems: Adolescent females who had score of perceived severity greater than or equal to twenty-five had high perceptions toward severity of reproductive health problems while adolescent females who had score of perceived severity less than or equal to twenty-four had low perception toward severity of reproductive health problems.

High perceived benefits of reproductive health services use: Adolescent females who had score of perceived benefit greater than or equal to twenty-five had high perceptions toward benefit of reproductive health services utilization while adolescent females who had score of perceived benefit less than or equal to twenty-four had low perception toward benefit of reproductive health services use.

High perceived barriers to take reproductive health services: Adolescent females who had score of perceived barriers greater than or equal to forty had high perceptions toward barriers to use reproductive health services while adolescent females who had perceived barriers score less than or equal to forty had low perception toward barriers to use reproductive health services.

Self-efficacy: Adolescent females who had score of self-efficacy greater than or equal to eight had high self-efficacy to use reproductive health services while adolescent females who had self-efficacy score less than seven had low self-efficacy to use reproductive health services.

Cue to use reproductive health services: The respondents who had factors that would start to utilize reproductive health services by remembering. Like follow up cared, media, and persons.

Attitude towards reproductive health services: Adolescent females who were said yes for the attitude items and prefers credible professions had positive attitude and those who were said no for the attitude items had negative attitude toward reproductive health services

Knowledge of reproductive health services: Adolescent females with knowledge score greater than or equal to ten were considered as knowledgeable and knowledge score less than or equal to nine were considered as less knowledgeable.

4.11.4 Key terms definition

Adolescent Female: Girl whose age was between 10-19 years.

Youth female: Girl whose age was between 15-24 years.

Reproductive health services: Services which includes educating about safe sex, educating about unwanted pregnancy prevention, provision of family planning, antenatal care, delivery care, postnatal care, abortion management, sexual transmitted infection management, and counseling about sexual transmitted infection.

Community perception about reproductive health services utilization: Feeling and belief of the community on reproductive health services utilization (learned predisposition to respond consistently to certain objectives).

Adolescent female likelihood on utilization of reproductive health services: Probability of utilization of reproductive health services by adolescent females.

Utilization: The ability to consume a service.

Perceived susceptibility: An individual's assessment of his or her chances of getting the disease.

Perceived severity or seriousness: An individual's judgment that the disease was sever.

Perceived benefits: An individual's conclusion as to whether the new behavior was better than what he or she is already doing.

Perceived barrier: An individual's opinion that would stop him or her from adopting the new behavior.

Self-efficacy: Beliefs about one's ability to perform the recommended response.

Cue to action: Those factors that would start a person on the way to change behavior or strategies to activate one's readiness to utilize any services

4.12 Data analysis

For quantitative study, data was entered to computer using Epi data version 3.1, and exported to SPSS 16.0 soft ware. The following descriptive variable analysis methods were considered such as; Frequency table, cross tabulation, OR and AOR with 95% CI and P

value less than 0.05 were considered for statistical significance in pear-sons' chi square test. Bivariate analysis was done to determine presence of crude statistical association between independent variables and the dependent. Variable with p-value less than 0.2 or 0.25 in bivariate analysis was considered as a candidate to be entered in multivariate logistic regression. Multivariate logistic regression model was employed to control confounding variable.

Multivariate regression was usefully to examine three or more variable at a time. The goal of multivariate regression was to arrive at the set of 'B' value called regression coefficient for the explanatory variables or independent variable.

For qualitative study, the data was analyzed by thematic approach and merged in to quantitative findings.

4.13 Data quality assurance

Data collectors & supervisors had diploma /bachelor degree and who were trained for five day on the objective of the study, and method of data collection, interview technique & content of questionnaire. Two supervisors were assigned to maintain data quality by coordinating the Kebele and facilitating the logistics.

Data was checked for completeness, accuracy, and consistency by supervisors & principal investigator after the data collection on daily base. Double entry was performed to assure quality of data. The questionnaire was prepared first in English and translated into Amharic retranslated in English. Pretesting of the questionnaires in the same wereda on those who was not included as the study subject was done. The Cronbach's alpha for attitude assessing 36 items were equal to 0.74.

4.14 Ethical consideration

Ethical approval and clearance was obtained from the Jimma University Ethical Clearance Committee of Public Health & Medical Science College.

Letter of cooperation to Mareka woreda was obtained from Dawuro Zone chief administrative office and Zone health department office to respective woreda health office, Waka YFS center, Waka health centers, and selected Keble administration. Informed

consent was obtained from study participant and parents when adolescent female was below 18 year of age by informing the purpose of the study.

4.15 Dissemination plan

The findings of this study was presented to JU, regional health bureau, Dawuro zone health department, Dawuro zone administration, Mareka Woreda administration and other organizations who were working on RHS services.

The findings would be presented in different seminars, meetings and workshops and published in a scientific journal.

CHAPTER FIVE- RESULT

5.1 Socio-demographic characteristics

Eight hundred forty-four adolescent females were responded the interviewer administered structured questionnaires of which eight hundred forty-four were returned completely making a response and the response rate was 100%.

The mean age of the adolescent female was 17.35 with SD of 1.63 and from total users 360 (61.20%) respondents had age equal to the mean and above the mean.

Seven hundred seventy-four (92.7%) were attended the school, of which 335(43.33%) respondents were attended grade 7-8, and 320(41.33%) respondents were attended grade 9-12. Four hundred fifty five (53.9%) of respondent had pocket money from their family to do some of their need. Majority of the female adolescent 727(86.1%) were live with both father and mother.

Seven hundred thirty-nine (87.6%) respondents were orthodox Christians, 101 (11.9%) respondents were protestant Christians, and, 4 (0.5%) respondents were catholic by religion.

The adolescent females were dominantly Dawuro in their ethnicity that consisted of 826(97.9%). Current occupation of the respondent was student, merchant, private employed and, Government employed.

Ninety seven percents of the family marital statuses of the respondents were lived together. Six hundred fifty two (77.3%) of the respondent's fathers were farmer. 703(83.3%) of respondent's fathers could read and write.

Seven hundred eighty three (92.8%) of the respondent's mother was house wife. 586 (69.4%) of respondent's mother could read and write. (Table 2)

Table1: Socio demographic characteristics adolescent females in Mareka Wereda south west Ethiopia, March, 2014 (N=844)

Variable	Frequency	Percent
Attendance rate of the school		
Yes	774	91.70
No	70	8.30
Level of education		
Only read and write	6	0.80
Grade 1-6	81	10.50
Grade 7-8	335	43.30
Grade 9-12	320	41.30
Diploma	29	3.70
Degree	3	0.40
Current occupation		
Student	485	57.50
Unemployed	169	20.00
Merchant	74	8.80
Private employed	67	7.90
Government employed	43	5.10
Other	6	0.70
Religion		
Orthodox	739	87.60
Protestant	101	12.00
Catholic	4	0.50
Ethnicity		
Dawuro	826	97.90
Wolayita	18	2.10
Mother's educational status.		
Illiterate	175	20.70
Read and write	586	69.40
Primary school	70	8.30
Secondary school	2	0.20
Diploma	3	0.40
Degree	8	0.90
Occupation of the mother		
House wife	783	92.80
Mother not alive	27	3.20
Merchant	16	1.90
Government employed	12	1.40
Farmer	5	0.60
Private employed	1	0.10
Father's educational status		
Illiterate	72	8.50
Write and read	703	83.30

Primary	43	5.10
Secondary	17	2.00
Diploma	1	0.10
Degree	8	0.90
Father's occupation		
Farmer	652	77.30
Merchant	149	17.70
Government employed	24	2.80
Father not alive	19	2.30
Live with		
Both father and mother	727	86.10
Father	52	6.20
Alone	26	3.10
Mother	13	1.50
Relative	13	1.50
Friends	13	1.50
Marital status of the family		
Live together	722	85.50
Widowed	94	11.10
Separated	14	1.70
Divorced	14	1.70

5.2 Knowledge and attitude towards RHS utilization

5.2.1 Knowledge of RHS and information sources

Mean score of knowledge was taken after coding from total score of 17 and the mean score for knowledge was 9. Six hundred seventy-nine (86.7%) of respondents were less knowledge for RHS. However majority of the respondents 359 (42.5%) were heard from radio and radio was the main source of information.

This was supported by the first focus group result with adult Men. In this focus group the discussants were agreed that they know RHS, which was given nearby in our kebele from health post and health centers such as, FP, RH information, and STI managements RHS is known in the local languages and Amharic as "yelota patsatthsa goaatatta" and "senetewalido-tsena ageliglot", respectively. Discussants were also agreed that they heard RHS from health extension workers, neighbor, radio and TV. "It is a service which is given by health professionals such as PF, STI treatment and RH information". (34 year, religious leader, male)

Table2: Source of information to remember utilization of reproductive health services and type of the services in Mareka wereda south west Ethiopia, March, 2014 (N=844)

Variable	Source	Utilization of RHS		
		Yes (Percent)	No (Percent)	Total (Percent)
Source of information	Radio	237 (28.10)	105 (12.40)	342 (40.50)
	TV	14 (1.70)	5 (0.60)	19 (2.30)
	Family	29 (3.40)	12 (1.50)	41 (4.90)
	Teacher	141 (16.70)	63 (7.50)	204 (24.20)
	Health worker	83 (9.80)	38 (4.50)	121 (14.30)
	Teacher and HW	56 (6.60)	23 (2.80)	79 (9.40)
Type of services heard	**Type of services**			
	STI management	30 (3.50)	7 (0.80)	37 (4.30)
	FP	448 (53.08)	215(25.40)	663 (78.50)
	RHS information	44 (5.20)	17 (2.00)	61 (7.20)
	All	38 (4.50)	7 (0.80)	45 (5.30)

5.2.2 Attitude towards RHS utilization

The result indicated that 676 (80.1%) respondent were willing to fee for the services and preferred medical doctor/health officer, Nurse, and health extension workers. Majority of adolescent females had positive attitude toward RHS utilization, which comprised 603 (72.5%).

5.3 Perception about RHS utilization

The adolescent females with high score for perceived susceptibility, perceived severity, perceived barrier, perceived benefit, and their correlation coefficient with outcome variable by chi-square test was shown in next table (Table 3).

Table3: The scores of theoretical construct and their correlation b/n utilizations of reproductive health services in Mareka wereda south west Ethiopia, March, 2014 (N=844)

Theoretical variable	**Utilization of RHS** in percent		**Beta**
	Non user n (%)	User n (%)	
Perceived susceptibility RHP			
Low	22[20.80]	84[79.20]	1.00
High	**234[31.70]**	**504[68.30]****	**0.57**
Perceived severity for RHP			

Low	41[19.50]	169[80.5]	1.00
High	**215[33.90]**	**419[66.10]****	**0.75**
Perceived barrier for RHS			
Low	78[35.5]	142[64.50]	1.00
High	177[28.50]	444[71.50]	-0.32
Perceived benefit			
Low	47[29.90]	110[70.10]	1.00
High	209[30.40]	478[69.60]	1.02

P means PV< 0.05.**

5.3.1 Perceived susceptibility

The mean score of perceived susceptibility was 36.19 with SD of 5.60. Adolescent female perceived susceptibility toward RHP was assessed and the result indicated that 106 (12.6%) of adolescent females had low score of perceived susceptibility for RHP.

This was supported by FGD result with adult men. In this FGD the discussants were agreed that when adolescent female utilized RHS before marriage they believed that she was very high in sex. "When adolescent female is utilize RHS before marriage the community claim that she was very high in sex and this show that her mother's was hyperactive on sexuality".(30 year, male community leaders) "UH!!! (Strong felling) see girl's mothers to marry girl because she reflects her mother's behavior as proverb of Dawuro". (37year, male)

5.3.2 Perceived Severity

The mean score for perceived severity was 23.72 with SD of 1.01 for adolescent female. Six hundred thirty-four (75.1%) of the respondents had high score of perception towards severity of RHP.

This was supported by the FGD result with adult women. In this focus group the discussants were agreed that when female adolescent was pregnant before marriage she was go to traditional healer and drinks traditional medicine to abort the fetus because it was not acceptable in the community. When the girl was pregnant before marriage she would go to traditional healer and drank traditional medicine to abort the fetus then she was became very sick and hidden the problem for the family by saying I had abdominal

cramping and finally she was end up with death and the family lost her. "One female adolescent in our village was drank detergent (berekina in local language) to make abortion then she was admitted to hospital and the hospital said that she had throat damage due to what was she taken to made abortion then, her mother in our village soled her one ox to cover medical cost of her girl and she was out of Ethiopian school leaving certificate examination took in that year so her families were suffered". (32 year, female)

5.3.3 Perceived Benefit

The mean score for the perceived benefit of RHS was 44.10 with SD of 3.09 for adolescent female. Six hundred eighty-seven (81.4%) of the respondents had high score of perception toward benefits of RHS. Seven hundred eighteen (92.4%) of respondents were strongly agreed that utilization of RHS is an effective way for preventing STI, and abortion. Majority of the respondents 812 (96.2%) were believed that utilization of RHS could improve productivity of the community. Seven hundred eighty-nine (93.5%) of the respondents were believed that RHS utilization could improve school performance by decreasing absenteeism due to RH related problems such as abortion, unwanted pregnancy by female adolescent.

This was supported by FGD result with adult men. In this FGD the discussants were agreed that it was very good for community but it was not good for adolescent females. "It is very good for married women and bar lady but it is not good for adolescent female when she is not married, b/c if she practice it before marriage it decrease social value of the girls and her family". (36 year, male)

5.3.4 Perceived Barrier

The mean scores of perceived barriers were 26.95 with SD of 2.73 for females adolescent. The result indicated that six hundred twenty-one (73.5%) of the respondent had high score of perceived barrier for utilization of RHS.

This was supported by FGD result with adult women. In this group the discussants were agreed that there is stigma when adolescent female utilizes FP before marriage and there was high cost to get abortion services utilization. "FP is free but there is stigma when the

girl use FP before marriage therefore I do not allow for her until marriage". (34 year, female)

5.3.5 Self-efficacy

The mean scores of self-efficacy were 14.97 with SD of 2.20 for adolescent female. The result indicated that eight hundred thirty-seven (99.2%) the respondents had high score of self efficacy to uptake reproductive health services.

5.3.6 Cues to action

The study was indicated that from total study subjects 806 (95.5%) of the respondents were used different cues to utilize reproductive health services in different way. Three hundred forty-two (40.5%) of respondents were used radio as cues to utilize reproductive health services followed by 24% of respondent was used teachers as cues. Three hundred thirty (56.1%) adolescent females were not get appointment cards from health institutions after starting utilization of the services from total users of reproductive health.

5.4 RHS utilization

The result showed that there were 588 (69.70%) reproductive health services user adolescent female and 256 (30.30%) reproductive health services non user adolescent female by asking past twelve month's use of reproductive health services from the date of interview. Among users of reproductive health services 455(77.3%) were used FP while 53 (9%) were used reproductive health services information, 45(7.6%) were used STI management, 19(3.2%) were used abortion care, and 16(2.7%) were used VCT. It revealed that from total 588 (69.7%) users of reproductive health services 330(56.1%) adolescent females were not get appointment cards from health institutions after starting utilization of the services so that 223 (37.9%) respondents were not utilized reproductive health services more than one time for their age.

This was supported by FGD conducted with adult women in Waka 02 kebele. In this focus group the discussants were agreed that utilization of RHS by female adolescent before marriage was not good b/c when her uptake was knew in the community then the community under minded her family and her family feel shame; therefore she was

discontinued when her utilization was knew by others. "I do not want to hear and see when she utilizes the RHS before marriage b/c that shows she was started sexual contact before marriage, and if it happened I will not allow to live with me in my home because the claim from the community is to me and it is not acceptable in the community". (39year, male community leader)

5.5 Bivariate logistic regression of Socio-demographic and theoretical variable of the study subject with dependent variables

Socio-demographic variables and theoretical variables had association with utilization of reproductive health services in bivariate logistic regression and two variables had significant association with utilization of reproductive health services (Table 5).

Table 5: Bivariate logistic regression of socio-demographic and theoretical variable of the study subject with dependent variables in Mareka wereda south west Ethiopia, March, 2014 (N=844)

Variable	Utilization of RHS in percent		OR of 95% CI
	Non user n [%]	User n [%]	
Perceived susceptibility			
Low	22[20.80]	84[79.20]	**1.00**
High	**234[31.70]**	**504[68.30]**	**1.77(1.08,2.91)****
Perceived severity for RHP			
Low	41[19.50]	169[80.5]	**1.00**
High	**215[33.90]**	**419[66.10]**	**2.12(01.45, 3.09)***
Perceived benefit of RHS			
Low	47[29.90]	110[70.10]	**1.00**
High	209[30.40]	478[69.60]	1.02(0.70, 1.45)
Perceived barrier to RHS			
Low	78[35.5]	142[64.50]	**1.00**
High	**177[28.50]**	**444[71.50]**	**0.73 [0.52, 1.01]*****
Self efficacy for use of RHS			
Low	3[42.9]	4[57.1]	**1.00**
High	253[30.20]	584[69.80]	0.58 [0.13,2.60]
Cues to utilization of RHS			
Low	131[29.6]	311[70.4]	**1.00**
High	224[30.90]	277[69.10]	1.06 [0.89,1.0]
Knowledge of RHS			

Less knowledgeable	219[31.4]	478[68.6]	**1.00**
knowledgeable	**26[24.30]**	**81[75.70]**	**1.43 [0.89,2.28]*** **
Attitude toward RHS			
Low	73[31.90	156[68.10]	**1.00**
High	252[29.86]	424[70.3]	1.12 [0.80,1.54]
Age			
11-15	39[33.30%]	78[66.7%]	1.00
15-19	217[29.80%]	510[70.20%]	0.85[0.56,1.29]
Family members in the house			
Less than five	174[29.1]	424[70.9%]	1.00
Greater than five	82[333]	164[66.70]	1.22[0.89,1.68]
Occupation			
Government employed	15[5.90]	28[4.80]	**1.00**
Private employed	19[7.40]	48[8.20]	0.88[0.40,1.92]
Merchant	28[10.90]	46[7.80]	1.62[0.79,3.32]
Unemployed	42[16.40]	127[21.60]	1.19[0.62,2.28]
Student	151[59.00]	334[56.80]	2.68(0.29,25.07
Level of education			
Only Read and write	1[0.40]	5[0.90]	**1.00**
Grade 1-6	21[9.20]	60[11.00]	10.00[0.40,250.4]
Grade 7-8	91[39.70]	244[44.80]	5.71 [0.49,66.31]
Grade 9-12	105[45.90]	215[39.40]	5.36 [0.48, 59.86]
Diploma	9[3.90]	20[3.70]	4.10 [0.37, 45.68]
Degree	2[0.90]	1[0.20]	4.44 [0.36, 55.58]
Religion			
Orthodox	223[87.10]	516[87.80]	**1.00**
Protestant	31[12.10]	70[11.90]	0.43[0.32, 16.53]
Catholic	2[0.80]	2[0.30]	0.44 [0.30, 16.77]
Ethnicity			
Dawuro	252[98.40]	574[97.60]	**1.00**
Wolayita	4[1.60]	14[2.40]	0.65 [0.21, 2.00]
Mother's education			
Illiterate	45[17.60]	130[22.10]	1.00
Read and write	117[13.86]	409[69.60]	0.96[0.19,4.94]
Primary school	28[10.90]	42[7.10]	0.77 [0.15,3.85]
Secondary school	1[0.40]	1[0.20]	0.50 [0.09,2.66]
Diploma	3[1.20]	0[0]	0.33 [0.01,8.18]
Degree	2[0.80]	6[1.00]	0.0
Mother's occupation			
House wife	232[90.60]	551[93.70]	**1.00**
Government employed	5[2.00]	7[1.20]	1.40[0.63,3.10]
Private employed	0[0]	1[0.20]	0.82[0.21,3.30]
Merchant	7[2.70]	9[1.50]	9.50[0.00,0.00]
Farmer	2[0.80]	3[0.50]	0.76[0.22,2.66]
Mother's not alive	10[3.90]	17[2.90]	0.88[0.13,6.22]

P*means PV <0.01, P means PV <0.05, and P*** means PV<0.2 P means PV > O.2**

5.5. Independent predictors of RHS utilization by adolescent females.

The variables with PV<0.2 in bivariate logistic regression were entered in to multivariate logistic regression to get independent predictors of RHS utilizations and the following independent predictors had significant association with utilization of RHS such as perceived susceptibility to RHP, perceived severity for RHP, perceived barrier to utilize RHS. The association in multivariate logistic regression revealed that an adolescent females with high score of perceived susceptibility for RHP were more likely utilize RH services than those with low score of perceived susceptibility [AOR 2.01, 95% CI (1.20,3.37)] with PV<0.05, an adolescent females with high score of perceived severity for RHP were more likely utilized RH services than those with low score of perceived severity [AOR 2, 95% CI (1.35,2.95)] with PV<0.01, and an adolescent females with high score of perceived barrier to use RHS were less likely utilized RH services than those with low score of perceived barrier to use RHS [AOR 0.69, 95% CI (0.49,0.97)] with PV <0.05.

Table6: Multivariate logistic regression of socio-demographic and theoretical variable of the study subject with dependent variables in Mareka wereda, March, 2014 (N=844)

Variable	Utilization of RHS		AOR of 95% C
	Nonusers n[%]	User n[%]	
Perceived susceptibility for RHP			
Low	22[20.80]	84[79.20]	**1.00**
High	234[31.70]	504[68.30]	**2.01[1.20,3.37]****
Perceived severity for RHP			
Low	41[19.50]	169[80.5]	**1.00**
High	215[33.90]	419[66.10]	**2[1.35,2.95]***
Perceived barrier to RHS			
Low	78[35.5]	142[64.50]	**1.00**
High	177[28.50]	444[71.50]	**0.69[0.49,0.97]****
Knowledge of RHS			
Less knowledgeable	219[31.4]	478[68.6]	1.00
knowledgeable	26[24.30]	81[75.70]	0.92[0.85,0.98]

P means PV<0.05 and P* means PV<0.01.**

CHAPTER SIX-DISCUSSION

This study was assessed a range of possible predictors including demographic, socioeconomic, knowledge, attitude, perceived susceptibly, perceived severity, perceived benefit, perceived barrier, self efficacy, and cues toward reproductive health services utilization by adolescent females.

The mean age of the adolescent female was 17.35 with SD of 1.63 and from total non-users of reproductive health services (75%) of non-users of reproductive health services had age mean and above the mean but youth with age range between 15-24 was very vulnerable for many reproductive health problems as national reproductive health strategies (9).

Six hundred seventy-nine (86.7%) of respondents were less knowledge for RHS. Main source of information was the radio (42.8%) and followed teachers (25.3%). But a study conducted in Jimma, the main source of information about sexual and reproductive health services for both sex adolescent was also the school (22).

It showed that from 774 (91.7%) respondents who were attended the school, 672 (86.8%) of the respondents had high susceptibility score for reproductive health problems, and 582(75.2%) of the respondents had high perceived severity score for reproductive health problems hence increasing educational status of adolescent female was mandatory for increment of reproductive health services utilization by adolescent female. It revealed that an adolescent female with high score of perceived susceptibility for RHP were more likely utilize RH services than those with low score of perceived susceptibility [AOR 2.01, 95% CI (1.20, 3.37)] with PV<0.05 and an adolescent female with high score of perceived severity for RHP were more likely utilized RH services than those with low score of perceived severity [AOR 2, 95% CI (1.35, 2.95)] with PV<0.01.

This was supported by FGD result with adult men. In this FGD discussants were agreed that when the adolescent female was pregnant before marriage and she was not attended the school, she was went to traditional healer and drank traditional medicine to abort the fetus then she was became very sick and hidden the problems for the family by saying I had abdominal cramping and finally she will end up with death and the family lost her.

The study showed that majority of the respondents had high score of perceived susceptibility for reproductive health problems, perceived severity for reproductive health problems, self efficacy to use RHS, perceived benefit of RHS, and perceived barrier for reproductive health services utilization.

In this study majority of respondents (80%) were verified that reproductive health services were relevant services for them. It showed that 96.2% of respondents were believed that utilization of reproductive health services were improved productivity of the community, and 93.5% of the respondents were believed that RHS utilization could improve school performance of adolescent female by decreasing absenteeism due to reproductive health related problems by adolescent females which was similar with study conducted in University of Limpopo South Africa in both sex youth (16).

The study showed that 73.8% of the respondent had high score of perceived barrier on reproductive health services utilization and the cited reasons were 64% were strongly agreed on "providers fail to keep confidentiality of the client" and "usual working time was inconvenient to up take the services because their privacy was not kept and they were seen by others" this was similar with study conducted in Addis Ababa (18). Adolescent females with high score of perceived barrier to use RHS were less likely utilized RH services than those with low score of perceived barrier to use RHS [AOR 0.69, 95% CI (0.49,0.97)] with PV <0.05.

The finding from the study was pointed out that, usual working time was inconvenient time for adolescent female to utilized RH services in Government health institution and the most frequently cited reason for inconveniences were health workers gave more time for symptomatic individual rather than health adolescent females in health institution, there was lack of confidentiality, there was fear or stigma, and there was too much waiting time in health institution to get reproductive health services.

This was supported by focus group discussion results with adult women. In this FGD the discussants were not agreed on utilization of reproductive health services by adolescent females before marriage because when their uptake were knew in the community then the community under minded their family and their family felt shame. "…..I do not want to hear and see when she utilizes the reproductive health services before marriage because

that shows she was started sexual contact before marriage, and if it happened I will not allow to live with me in my home because the claim from the community is to me and it is not acceptable in the community". (39 years, old man) Which was similar a study conducted in Jimma and Butajera on both sex youth (22).

It indicated that two hundred twenty seven (26.9%) the respondents had low self efficacy to uptake reproductive health services. Mostly cited reasons for low self efficacy for uptake of the services were nearly half of adolescent females (48.30%) were not discussed reproductive health problems with their parents, and among two hundred fifty-six non-users of reproductive health services 87.90% of adolescent females were not discussed reproductive health problems or reproductive health services with their parents, which was a bit high as compared with similar study conducted in Harar and Addis Ababa on both sex adolescent (14 and 18).

In this study reproductive health services utilization was 69.70% by asking past twelve month's use of reproductive health services from the date of interview. Among users of reproductive health services 77.30% were used FP while 9% were used reproductive health services information, 7.60% were used STI management, 3.20% were used abortion care, and 2.70% were used VCT.

Utilization of reproductive health services were low as compared to a report from Tanzania where as 75% of adolescent were utilized health services for reproductive health in Tanzania, to a study conducted on both sex in Jimma city where as 75.80% of adolescent were utilized health services for reproductive health in Jimma city, and northern Ethiopia 74% of adolescents were utilized RHS. In addition to this continuation of utilizations were low because the study showed that from total utilizers 37.9% were not utilized reproductive health services more than one time for their age.

On the other hand, two hundred fifty-six (30.3%) adolescent females were non utilizers of reproductive health services by asking past twelve month's use of reproductive health services from the date of interview which was high compared to a study conducted on both sex in Jimma city where 24.2%, and northern Ethiopia were 26% (22, and 24). In other words, this much proportions of adolescent females not utilized reproductive health

services was more stressing than the high proportion of adolescent female's utilizations because several studies had reported that non utilization of reproductive health services at adolescent age was strongly associated with late age reproductive health problems (25).

In this study the likelihood of utilizing reproductive health services by adolescent female was significantly associated with perceived susceptibly of reproductive health problems, perceived severity of reproductive health problems, and perceived barrier to use reproductive health services with PV<0.05. In addition to this perceived susceptibly of reproductive health problems, perceived severity of reproductive health problems were positively associated with reproductive health services utilization while perceived barrier was negatively associated with reproductive health services utilizations with PV<0.05.

The study showed that an adolescent female with high score of perception on susceptibility of reproductive health problem were more likely utilized reproductive health services than those with low score of perception on susceptibility of reproductive health problems [AOR 2.01, 95% CI (1.20,3.37)], an adolescent female with high score of perceived severity were more likely utilized RHS than those had low score of perceived severity score [AOR 2, 95% CI (1.35,2.95)], and an adolescent female with high score of perceived barrier were less likely utilized reproductive health services than those with low score of perceived barrier [AOR 0.69,95% CI (0.49,0.97)] with PV <0.05. These were in line with study conducted in BSS on HIV in Addis Ababa Ethiopia, Deber Markos University and Zambia in adults (26, 28).

Strengths and limitations of the study

Strengths

- The questionnaire was adopted from validated instruments and pretested in the local context.
- The response rate was 100%.
- It used both qualitative and quantitative methods

Limitation of the study

- Since some questions included sensitive issues, responses were sorted and could create desirability bias or response bias.

- There were others social cognitive variables which were highly predictive of behaviors in other models were not incorporated
- The results were interpreted for the catchment population.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

7.1 Conclusion

This study had found out that almost one third (30.30%) of adolescent females were not utilizing reproductive health services: A reproductive health service was a service which was gave by health workers to adolescent female at health center, health post and hospital of Government or private institution such as; abortion care and its management, short acting family planning to prevent unwanted pregnancy, and sexual transmitted infection information and its management to prevent reproductive health problems despite there were health post in each kebele and four health centers in the woreda to introduces reproductive health problems preventive message to increase perceived susceptibility and severity on adolescent females. *Community's leaders were not agreed on utilization of reproductive health services by adolescent female before marriage……* contrary to there were health extension workers and health development armies in each kebele to create awareness about reproductive health services utilizations in the community at large.

It showed that respondent's who were attended the schools had high susceptibility score for reproductive health problems and had high perceived severity score for reproductive health problems. Hence increasing educational level of adolescent female was mandatory for increments reproductive health services utilization by making adolescent females to understand the reproductive health problems nature. *Because when the girl was pregnant before marriage, and she was not attended the school she would go to traditional healer and drank traditional medicine to abort the fetus then she was became very sick and hidden the problem for the family by saying I had abdominal cramping and finally she would end up with death and the family lost her. But when she was attended the school, she was searched money from the different angle and migrate to town to make abortion by getting modern methods, this was better than drinking traditional medicine.*

It clearly showed that discussion about reproductive health problems or reproductive health services between adolescent female and parents, maintains of confidentiality by services providers for increasing self efficacy of adolescent females, increasing perceived susceptibility message on adolescent females about reproductive health problems, increasing perceived severity message on adolescent females about reproductive health problems, and decreasing perceived barriers to utilize reproductive health services like fear of adolescent female for parents and communities were very crucial to increase reproductive health services utilization by adolescent females.

This study showed that there was statistically significant association between perceived susceptibility of reproductive health problems, perceived severity of reproductive health problems, and perceived barrier of adolescent females with utilization of reproductive health services with PV<0.05.

The role of community leaders, and religion leaders, parents, teachers, media, and Information, education and communication materials had significant positive influence on utilization of reproductive health services by the adolescent females in addition to health worker because the study revealed that majority of adolescent females fear community leaders and religion leaders to utilize RHS before marriage, adolescent females who heard RHP had high perceived susceptibility to utilize the RHS. Therefore multi-sartorial integration was required to increase reproductive health services utilization by the adolescent female because she was the vital components in intergeneration life cycle however, she was the primer victims for many reproductive health problems due to various reasons.

7. 2 Recommendation

- Information, education and communication programs should be strengthened and emphasis should be given to encourage the parents openly discuss with their adolescent females about reproductive health services utilization and reproductive health problems preventions at all level of health structure in the district.
- Teacher, religious leader, community leader and parents should be involved to decrease fear of adolescent females to utilize a reproductive health services in addition to health worker.

- Ethnographic study should be done to assess the influence of native culture on reproductive health services utilizations by adolescent females by other researchers.

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LIST OF ANNEX

Annex I. Questionnaires - English version for quantitative study

Research Subject Information and Consent Form

Title: Community perception and female adolescent's likelihood on utilization of RHS.

Sponsor: Jimma University

Investigator: Teshome Negash

Site: Mareka woreda

Introduction: Hello. My name is _____.I am working as data collector in this study that assess Community perception and female adolescent's likelihood on utilization of youth reproductive health services uptake among female youth that to run by JU of public health and medical science. Thank you for allowing us to share your precious time for a brief discussion about a study to be conducted in Mareka woreda. This study is being conducted among youth aged 15-24 years old and you are selected to participate in the study. The purpose of this study to assess community perception and female adolescent's likelihood on utilization of reproductive health services using Health Belief Model in the mareka district. The information you give us could help to design appropriate RHS programs for youth. The study will be conducted through interviews. I'm going to ask you some general and in depth personal questions. Your answers are completely confidential; your name will not be written on this form, and will never be used in connection with any of the information you tell me. If you don't want to answer any questions, you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand for our study objective and for future action. We would greatly appreciate your helping. Are you willing to participate in the study? If yes, ____ (1) continue. No ___ (2) stop.

Signature of interviewer_____ (Signature of interviewer certifying that informed consent has been given verbally by respondent)

Kebele _____

House Number _____

Interviewer name _____

Interviewee code /____/___/

Self-administered questionnaire for female adolescent general information

1. Participant's code number: _____

2. Date of interview: __dd/__mm/2014 E.C.

PART I. socio-demographic

No	Questions and Filters	Response Coding categories
101	Age in years (completed year)	_____year
102	Have you ever attended a school?	1. Yes 2.no
103	Level of education, if yes for Q3	1. Not read and write 2. Only Read and write 3. Grade 1-6 4. Grade 7-8 5. Grade 9-12 6. Diploma 7. Degree
104	To which religious group do you belong?	1. Orthodox Christian 2. Muslim 3. Protestant Christian 4. Catholic Christian 5. Other(specify)_____
105	To which ethnic group do you belong?	1. Dawuro 2. Wolayita 3. Amhara 4. Oromo 5. Other (specify)_____
106	What is your family marital status	1. They live together

2. Not living together
3. Separated
4. Divorced
5. Widowed

107 Whom do you currently live with?
1. Both
2. Father
3. Mother
4. With relatives
5. With friends
6. Alone

108 What is your current occupation?
1. Government employ
2. Private employ
3. Merchant
4. Unemployed
5. Student
6. Others (specify)

109 What is your average income per month? _____birr

110 How many family members do you have? ----------

111 What is your parents income per month _____birr

112 What is your mother's educational status?
1.illetrate
2.Read and write only
3.Primary school
4. Secondary school

		5. Diploma
		6. Degree
		7. mother not alive
113	What is your Father's educational status?	1.illetrate
		2.read and write only
		3.Primary school
		4. Secondary school
		5. Diploma
		6. Degree
		7. father not alive
114	What is your mother's occupation?	1.House wife
		2.employed (private)
		3.employed (gov't)
		4.Small scale merchants
		5. farmers
		6. mother not alive
		7. others
115	What is your father's occupation?	1.empolyed (private
		2.empoplyed (gov't)
		3.small scale merchants
		4.farmers
		5. father not alive
		6.others------
116	Do you have pocket money?	1. yes
		2. No

Part II -perceived susceptibility to RHP

117	You are likely to develop RHP.	1Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
118	It is possible that you will get RHP.	1Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
119	Your sexual experiences will not put you at risk for RHP	1.Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
120	You may have had sex with someone who was at risk for RHP.	1. Yes 2.No
	It is likely that you will get Abortion, unwanted pregnancies STI.	1.Stronglydisagree 2. Disagree 3. Neutral
121		4. Agree 5.Strongly agree
122	You may face abortion and its complication in this age.	1.Stronglydisagree 2. Disagree 3. Neutral

		4. Agree
		5.Strongly agree
123	You may face unwanted pregnancy its complication in this age.	1Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
124	Your age put you at risk for STI.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
125	Your sexual experiences will put you at risk for STI.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
126	RHP is only the problem of high risk female adolescent.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree

Part III -perceived severity to RHP

127	RHP is severe with possibly serious complications	1.Stronglydisagree
		2. Disagree
		3. Neutral

		4. Agree
		5.Strongly agree
128	RHP can be easily complicated	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
129	Some RHPs are fatal	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
130	Abortion can cause life threatening condition in adolescent female.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
131	Unwanted pregnancy may end up with loss of life.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
132	If STI not treated early it may cause permanent damage to reproductive organ.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree

Part IV- perceived barrier to use RHS

133	Have you visited health institution for RHS?	1. Yes 2. No
134	Providers fail to keep privacy and confidentiality of RHS utilization.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
135	If yes; there is too much waiting time to get the RHS in health institute.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
136	RHS is too expensive for adolescent.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
137	There is stigmatization for female adolescent when she uses RHS before marriage.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree

138	There are problems to access RHS for utilization.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
139	If you agree, what is that?	1. Fear of parents or others 2. Lack of confidentiality 3. Inconveniency of service delivery time 4. Health service fee is expensive 5. Stigma 6. Long waiting time for service 7. Distance to the facility
140	Weekends are convenient time for female adolescents to utilize RH service.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
141	The usual working hours are convenient time for female adolescents to utilize RH service.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
142	If disagree what was your reason?	1. Lack of confidentiality. 2. Health workers give more time for symptomatic person rather than health

female adolescents.

3. Stigmatization by adult

Part V- self efficacy to use RHS

143	Utilization of RHS is very easy.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
144	Do you ever used to discuss with Your parents on RHP matters?	1. yes 2. No
145	Have you recommended RHS service to anyone else?	1. yes 2. No
146	Do you have the desire to have RHS Whether you have it before or not?	1. yes 2. No
147	Utilization of RHS is very difficult.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
148	Family and religious leaders are accountable for un-utilization of RHS by female adolescent.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree

149	If disagree who was accountable?	1. Teachers 2. Health workers 3. Community workers 4. Only family 5. All 6. Teachers &Health workers 7. Teachers &Community workers 8. Community workers & Health workers
150	Are you confident enough that you are going to utilize RHS?	1. Yes 2. No
151	Are you willing to pay a reasonable fee for RH service?	1. Yes 2. No
152	If yes What do you think is a reasonable fee for RHS services?	____Ethiopian Birr
153	Do you discuss RHP matters with health worker?	1. Yes 2. No

Part VI- cues to utilize RHS

154	Have you ever heard of reproductive health services?	1. Yes 2. No
155	If yes, what was the source of information to remember you about RHS up take?	1. .Radio 2. TV 3. Newspapers 4. Family 5. School teacher

		6. Health worker 7. All 8. Radio &TV 9. Family & teacher 10. Teacher & Health worker 11. Symptom of RHP
156	Have you visit health institution for RHS?	1. Yes 2. No
157	Was the health institute give appointment card to you?	1. Yes 2. No

Part VII- perceived benefit of RHS

158	RHS utilization by female adolescent before marriage is important.	1.Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
159	RHS utilization by female adolescent is right	1.Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
160	RHS uptake by female adolescent is important to improve productivity of the community.	1.Stronglydisagree

		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
161	Utilization of RHS by female adolescent is sin.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
162	Utilization of RHS by female adolescent prevents STI.	1.Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
163	Utilization of RHS by female adolescent prevents abortion.	1Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
164	Utilization RHS by female adolescent prevent unwanted pregnancy.	1Stronglydisagree
		2. Disagree
		3. Neutral
		4. Agree
		5.Strongly agree
165	Utilization of RHS improves school performance in	1Stronglydisagree

	decreasing absenteeism due to RH related problems by female adolescent.	2. Disagree 3. Neutral 4. Agree 5.Strongly agree
166	Utilization of RHS by female adolescent decrease incidence of STI in the community.	1Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree
167	Utilization of RHS by female adolescent improves productivity of public.	1Stronglydisagree 2. Disagree 3. Neutral 4. Agree 5.Strongly agree

Part-VIII utilization of RHS

168	Have you utilized the RHS in the past 12 month?	1. Yes 2. No
169	If yes what type of the services you got?	1. Abortion care 2. STI managements 3. FP 4. VCT of HIV /ADIS Reproductive health information& counseling.
170	Have you utilized the RHS more than 1 time for your age?	1.Yes 2.NO
171	If yes how many time you had?	_____times
172	Do you ever used to discuss with health worker on RHP matters?	1. Yes 2. No

Part IX Knowledge related to reproductive health services.

173	Have you ever heard of reproductive health services?	3. Yes 4. No
174	Which service do you know?	1. Abortion care 2. STI managements 3. FP 4. VCT of HIV /ADIS 5. Reproductive health information& counseling.
175	What is the source of information if the answer is yes?	1. Radio 2.Television 3. Magazine 4.Health institution and profession 5.Friend 6.Neighbour 7. All 8. Radio &Television 9.Radio, Television, magazine, Health institution, and profession 10.Friend and neighbors 11. Other specify_____
176	Is there RH service providing institution in your surrounding?	1. Yes 2. No

Part X Attitude related to reproductive health services.

177	Do you feel that RHS up take is necessary?	1. Yes 2. No
178	By Whom do you prefer RHS be given?	1. By physician 2. By Nurse 3. By health extension worker4. By health development army 5. By religious leader 6. All are needed.7. Only by health profession.

Result of interview

a. Completed

b. Refused

c. partially completed

Time interview begun_____

Time interview ended_____

Name of Interviewer_____ age ___years, sex male 01 female 02

Questionnaires-English version for qualitative study

Semi-structured questionnaire of focus group discussion

Title: Community perception and female adolescent likelihood on RHS utilization.

Sponsor: JU

Investigator: Teshome Negash

Site: Dawuro zone Mareka Woreda

Confidentiality and Consent form

Good morning! Well come to our group discussion. My name is _____, my colleague besides me is called_____ and we came from JU and ……..respectively. We are here today to discuss about RHS uptake increasing factors and challenges to uptake the RHS. The information we are going to gather will be utilized to improve the RHS utilization for female adolescent particularly in the mareka woreda in a better way and in the Zone in general. There is no right or wrong answers. All comments, both positive and negative, are well come. We would like to have many points of view and each and every option/idea/ is important and be wanted. We want this to be a group discussion, so you need not wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up everything. We would like to confirm to you that all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion? If yes, thank you for your willingness.

1) Opening question

1. Tell us what reproductive health services are?

2) Introductory Question

2. Please tell us about how much of a threat do you think reproductive health problem is to your community?

Probe

- What is the burden of RHP in your community, for family?

3) Transition question

3. What you heard about reproductive health services?

Probe

- From where you hear it?

4. What do you know about reproductive health services?

Probe

- What are the services it includes?

5. What do you think about reproductive health services?

Probe

- Is it important for adolescent girl?

4) Key Questions.

6. What are the usual reasons for female adolescent which force them to go for reproductive health services in this area?

Probe

- What is the common RH problem seen in female adolescent in your area?

7. What are challenges to access reproductive health services?

Probe

- What is the cost for the RHS? What is the distance for you?

8. What is the benefit of reproductive health services utilization?

Probe

- Does it prevent RHPs? Which RHPs? Would you give me example?

9. What are harms of reproductive health services utilization?
10. How your parent fell when you utilize reproductive health services before marriage?
11. What will be the reaction of the parents if their female adolescent wants to RHS?

Probe

- How they express their reaction?

12. Do you have the intention to ask your girls for reproductive health services utilization? Why?

13. How about the cost issue for reproductive health services utilization?

Probe

- Does your girl ask you money for RHS up take? What amount?

14. What are the options to increase reproductive health services utilization by female adolescent?

Probe

- Would you give me an example?

15. What are cultural and religious practices in the area that could promote reproductive health services utilization?

Probe

- How? In what way?

16. What are cultural and religious practices in the area that could prevent reproductive health services utilization?

Probe

- Does your religion promote RHS utilization?

17. What could be done by family, community and government to encourage female adolescent go for reproductive health services utilization?

18. What organization do you think appropriate to give reproductive health services for female adolescent rather than health center?

Probe

- How?

19. Who should be involved to make reproductive health services better utilized by female adolescent in your community?

Probe

- How?

20. What type of people do you think be involved in reproductive health services provision? Why?

21. What is misconception of RHP in your area?

Probe: How they express?

5) Ending Questions

22. Thinking about the issues we have discussed, what recommendation /suggestions would you give on reproductive health services utilization by female adolescent to increase?
23. Is there anything else on reproductive health services utilization by female adolescent that you can tell us? If not thank you for your concern! We would like to confirm to you that all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality.

Guidelines for content part of field notes

1. Describe the setting.
2. Describe the activities that took place in that setting. Reproduce the sequence of actions and behaviors.
3. Describe the people who took part in the activities and their roles in the activities.
4. Describe the meaning of what was observed from the perspective of the participants.
5. Record exact quotes or close approximations of comments that relate directly to the observation activity.
6. Describe any impact you might have had on the situation &you observed.

Guidelines for reflective part of field notes

1. Include sentences and paragraphs that are subjective. These include a more personal description of what you observed.
2. Emphasizes ideas, feeling, impressions, etc.
3. Includes unanswered questions that have arisen from reflecting on the observation data as well as ideas for future action.
4. Clarify points and correct mistakes and misunderstandings in other parts of field notes.
5. Include insights or speculation about what you are observing.

Tip of effective moderators

1. Establish personal contact with each respondent early.
2. Help respondents feel relaxed early on.
3. Win respondents to your side.
4. Deal with loud respondents; but don't under estimate other respondents.
    - Don't look at them when you ask questions.
    - Don't acknowledge their raised hands.
5. Deal with inconsistent, unclear answers by mobilizing the group to help.
6. Create an environment where anything a respondent wants to say is acceptable.
7. Don't assume you know what a respondent means by an ambiguous answer.

Annax2: የአማርኛ መጠይቆች

በጥናቱ ለመሳተፍ ፍቃደኝነት ና ምስጥራዊነት ማረጋገጫ

□መ□□ቅ መለ□ ቁ□ር----------

ጤና ስጥልኝ ስሜ ----------ይባላል የመጣሁዉት----------ነዉ፡፡ በጅማ ዩኒቨረስቲ ስነህዝብና ህክምና ሳይንስ ኮለጅ ዉስጥ የጤና ትምህርትና ስነ ባህር ትምህርት ክፍል የሚያከሄደዉን የጥናት መረጃ ለማሰባሰብ ነዉ፡፡ስለዝህ ኤነና እርሶ ለአጭር ጊዜ በዉይይት ቆታ ይኖረናል፡፡ ወደዋናዉ ዉይይተችን ከመግባተችን በፍት ስለጥናቱ አጠቃለይ ሃሳብና ሁኔታአነብሎታለሁና በጥሞና አዳምጠዉ በጥናቱ ለመሳተፍ መስማማተዎን ይገልፀልኛል፡፡ይህ ጥናት በማረቃ ወረ□ ዬ ስ□ □ሚ□ኙ ዉጣት ሴቶች አመለከከትና የማብረሰብ ዝንባለ በስለ-ተ□ል□ ጤና አግልግሎት አጠቃቀም ተደራሽነት ዙረያ ያሉ ችግሮችን ለመዳሰስ ነዉ፡፡

የዝህ ጥናቱ ዋና አላማዉ ለምርመር፤ለጥናትና ለትምህርት ስሆን በዝህ መጠይቀ ላይ የሚሰጡት መረጃ ምስጥራዊነቱ የተጠበቀ ነዉ፡፡ እያንዳንዱ መጠይቅ የራሱ መለያ ቁጥር □ሚኖረዉ ሲሆን በተዘጋጀዉ መጠይቅ ስምዎ አይገለፅም፡፡ በማንኛዉም ጊዜ ይህን ጥናት ዉጠት ማሳተም ቢያስፈልግ እንኩን ዉጠቱ የሚገለፀዉ የጠቅላላዉን የተሳታፈ ዉጠት ፡፡ በቃለመጠይቁ ወቅት ያለመሳተፍ የሚፈለጉትን ጥያቀ ያለመመለስ እና በፈለጉ ሰዓት መጠይቁን የማቐረጥ መብትዎ የተጠበቀ ስሆን በጥናቱ ሲሳተፉ ግን ጥናቱንለሚሰሩትና ጥናት ተኩረት ላደረገባችዉ የማህበረሰብ አባለት ጥቅሙ ላቅ ያለ ነዉ፡፡ በመሆኑማ ከእርሶ የሚናገኛዉ ቅንና እዉነተኛ መልሶች ጥናቱ ለሚዳሰሳችዉ ፅንሰ ሃሳቦች ወጣት ሴቶች አመላካከትና የማህበረሰብ ዝንባለ በስነተዋልዶ ጤና አግልግሎት ላይ ያላቸዉን ዕዉቀት እንደሁም የአግልግሎት ተደራሽነት ለማወቅ ከፍተኛ ግባአት ከመሆኑም በላይ ከምርምሩ የሚገኘዉ ዉጠት ያለዉን ተጨባጭ ሁኔታና በቀጣይ መሰራትና መወሰድ የሚገባችዉን እርምጃዎች መጠቆሚያ ይሆናል፡፡ ጥናቱ በትክክል የታለመለትን ግብ እንዲመታ የሚያደርጉትን ከፍተኛ ትብብር እና ደንቃለን፡፡ ስለጥናቱ ግልፅ ነገር ወይም ጥያቀ ካሎት የጥናቱን ተመራማሪ ማነጋገር ይችላሉ፡፡ የተሰጠዉ መረጃና የጥናቱ አላማ ግልፅ ነዉ?

አዉ 1 አይደለም 2

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት? አዉ 1 አይደለም 2

የጥናቱ ተከፋይ ፊርማ ----------

ፊቃደኝነቱን ያረጋገጠዉ መረጃ ሰብሳቢ ስም---------- □ርማ----------

ስል□ ቁ□ር----------ኢሜል አድራሻ----------

መ□□ቅ

ክፍል አንድ መሠረተዊና ማህባራዊ ጥያቄዎች

ተቁ	□□ቀ	መ□ለ□
101	ክ□ሜ	------አመት
102	ትምህርት ተምረሻል?	1. አዉ
		2. አይ
103	አዉ ከልሽ የትምህረት ደረጃ እስከ ስንት ነዉ?	1. ማንበብና መፃፍ የሚችሉ
		2. 1-6
		3. 7-8
		4. 9-12
		5. ድፕሎማ ያላት
		6. ድግረ ያላት
104	ሀይማኖትሽ ምንድነዉ?	1. ኦርቶዶክስ
		2. መስልም
		3. ጫሮትስታንት
		4. ከቶለልክ
		5. ለሎች
105	ብሄረሰብሽ ምንድነዉ?	1. □ዬ ሮ
		2. - ላ□ተ □
		3. አማረ
		4. ኦሮሞ
106	የሥላጆች የጋብቻ ሁኔታ ምንድነዉ?	1. አብሮ የሚኖሩ
		2. አብሮ አይኖሩም
		3. ተለ□□ተዉ
		4. □ተ□ቱ
		5. የሞተባት/በት

107 ከማን ጋረ ትኖራልሽ?

1. ከእናት ና ከአባት
2. ከአባት ጋረ ብቻ
3. ከኢናት ጋረ ብቻ
4. ከዘመድ ጋረ
5. ከጎደኛ □ረ
6. ለየብቻ

108 የአንች ሥረ ሁኔታ ምንድነዉ?

1. ተቀጣረ(በመንግሥት)
2. ተቀ□ረ(በ□ል)
3. ነጋደ
4. ሥራ አጥ
5. ተማሪ

109 □እንች አማከይ የወር ገብሽ ምን ያህል ነዉ? ----------ብር

110 የበትሰብሽ ኣባላት ብዛት ስንት ነዉ?

111 □ኬትሰብሽ ወር ገቢ ምን ያህል ነዉ?

1. -------ብር
2. አላዉቅም

112 □እናትሽ ትምህረት ደረጃ እስከ ስንት ነዉ?

1. ማንበብና መፃፍ የማይችሉ
2. ማንበብና መፃፍ የሚችሉ
3. 1-6
4. 7-8
5. 9-12
6. ድፕሎማ ያላት
7. ድግረ ያላት

113 የአባትሽ የትምህረት ደረጃ እስከ ስንት ነዉ?

1. ማንበብና መፃፍ የማይችሉ
2. ማንበብና መፃፍ የሚችሉ
3. 1-6
4. 7-8
5. 9-12

6. ድፕሎማ ያላት

7. ድግረ ያላት

114 **□እናትሽ ሥራ ሁኔታ ምንድነዉ?**

1. □ቤት እሜበት

2. ተቀጣረ(በመንግሥት)

3. ተቀ□ረ(በ□ል)

4. ነጋደ

5. □በሬ

6. ሞታለች

7. ሌላ ከለ

115 **የአባትሽ ሥራ ሁኔታ ምንድነዉ?**

1. ተቀጣረ(በመንግሥት

2. ተቀ□ረ(በ□ል)

3. ነጋደ

4. □በሬ

5. ሞተ□ል

6. ሌላ ከለ

116 **ከቤትሰቦችሽ የሻይ ገንዘብ ታ□ኛልሽ?**

1. አዉ

2. □ለም

ክፍል ሁለት ለስነተዋልዶ ጤና ተጋላጭነት

117 አንች ለስነተዋልዶ ጤና ችግሮች ተጋላጭ ነሽ፡፡

ı. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
1. በጣም እስማማለሁ

118 በቀላሉ የስነተዋልዶ ጤና ችግሮች ሊያጠቁሽ ይችላሉ፡፡

ı. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

119 ያአንች ዉስባዊ ልምድሽ አንችን ለስነተዋልዶ ጤና ችግሮች አያጋለጡሽም::

ı. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

120 ለስነተዋልዶ ጤና ችግሮች ተጋላጭ ከሆነዉ ስዉ ጋረ ዉስብ ታደረግልሽ?

1. **አዉ**
2. **አይ**

121 አንች ለስነተዋልዶ ጤና ችግሮች በቀላሉ ተጋላጭ ነሽ፡፡

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

122 **በዝህ ዕድሜሽ ዉረጃና የዉረጃ ችግሮች □□□ሙሻል፡፡**

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

123 **በዝህ ዕድሜሽ ያለተፈለገ ዕርግዝና የዕርግዝ ችግሮች ያገጥሙሻል፡፡**

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

124 **የአንች ዕድሜሽ አንችን ለአባለዘር በሽተሞች □□ረ□ሻል፡፡**

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

125 **ያአንች ወስባዊ ልምድሽ አንችን ለአባለዘር በሽተሞች ያጋለጡሻል፡፡**

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

126 **የስነተዋልዶ ጤና ችግሮች የተጋላጭ ጎልማሳ ሴቶች ችግር ብቻ ነዉ፡፡**

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

ክፍል ሦስት የስነተዋልዶ ጤና ችግር ስጋቶች መጥይቅ

127 ስነተዋልዶ ጤና ችግሮች በጣም ከባድና **በቀላሉ** የሚወሳሰብ ነዉ፡፡

1. በጣምአልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

128 የስነተዋልዶ ጤና ችግሮች በቀላሉ የስነተዋልዶ ስዉነት ክፍሎችን ያዛባሉ ስለዝህ የስነተዋልዶ ጤና አግልግሎት መጠቀም አለብሽ፡፡

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

129 የስነተዋልዶ ጤና ችግሮች የስነተዋልዶ ጤና **ህክምና** ከልተወሰድ ገዳይ ነዉ፡፡

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

130	**በጎልማሳ ሴቶች ለይ ወረጃ ህይዋት ሊያሳጡ የሚችሉትን ክስተቶችን የፈጥራል፡፡**	1. በጣም አልስማማምበ 2. በከፊል አልስማማም 3. አላዉቅም 4. በከፊል እስማማለሁ 5. በጣም እስማማለሁ
131	**ያለተፈለገ ዕረግዝና የወጣት ሴቶች ህይወት ይቀጥፋል፡፡**	1. በጣም አልስማማምበ 2. በከፊል አልስማማም 3. አላዉቅም 4. በከፊል እስማማለሁ 5. በጣም እስማማለሁ
132	**የአባለዘር በሽተ በጊዜ ከልተከሙ በስነተዋልዶ አከል ክፍል ላይ የማይመለስ ጉዳት ያስከትላል፡፡**	1. በጣም አልስማማምበ 2. በከፊል አልስማማም 3. አላዉቅም 4. በከፊል እስማማለሁ 5. በጣም እስማማለሁ

ክፍል አራት የስነተዋልዶ ጤና አግልግሎት ለመጠቀም መስናክሎች መ□□ቅ

133	**የስነተዋልዶ ጤና አግልግሎት ስጭዎች ምስጠር አይጠብቁም፡፡**	**1.** በጣም አልስማማም **2.** በከፊል አልስማማም **3.** አላዉቅም **4.** በከፊል እስማማለሁ **5.** በጣም እስማማለሁ
134	**ለስነተዋልዶ ጤና አግልግሎት ጤና ተቆም ትጎበኛለሽ?**	**1. አዉ** **2. አይ**
135	**አዉ ከልሽ ስነተዋልዶ ጤና አግልግሎት ለማገኝት ብዙ ሰዓት ያስጠብቃሉ፡፡**	**1.** በጣም አልስማማም **2.** በከፊል አልስማማም **3.** አላዉቅም **4.** በከፊል እስማማለሁ **5.** በጣም እስማማለሁ
136	**የስነተዋልዶ ጤና አግልግሎት ለጎልማሳ ሴቶች በጣም ዉድ ነዉ፡፡**	**1.** በጣም አልስማማም **2.** በከፊል አልስማማም **3.** አላዉቅም **4.** በከፊል እስማማለሁ 5. በጣም እስማማለሁ
137	**ማህብረሰብ ከማግባት በፍት የስነተዋልዶ ጤና የሚትጠቅም ጎልማሳ ሴት ያገልላሉ፡፡**	**1.** በጣም አልስማማም **2.** በከፊል አልስማማም **3.** አላዉቅም **4.** በከፊል እስማማለሁ **5.** በጣም እስማማለሁ
138	**ስለስነተዋልዶ ጤና አግልግሎቶች ለማግኘት** በዙ የሚያሳስቡ ችግሮች አ፡፡	**1.** በጣም አልስማማም **2.** በከፊል አልስማማም **3.** አላዉቅም **4.** በከፊል እስማማለሁ **5.** በጣም እስማማለሁ
139	እስማማለሁ፡ካልሽ እነሱ ምንድናቸዉ?	**1. በትስብ ፍራቻ** **2. ምስጥራዉነት ዕጥረት** **3. የአግልግሎት አስጣጥ ጊዘ አመች አለመሆን** **4. የአግልግሎት ክፍያዉ ዉድ ስለሆነ** **5. ማብረስብ ማ□ለል** **6. ብ□ □□ ስለሚስ□ብቁ ለአግልግሎት**

7. የተቀሙ ረቀት

140 የሳምንት መጨረሻ ቀናት ለጎልማሳ ሴቶች የስነተዋልዶ ጤናአግልግሎት ለመጠቀም ምቹ ናቸዉ::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

141 መ□በኛ የሥራ ሰዓት ለጎልማሳ ሴቶች የስነተዋልዶ ጤናአግልግሎት ለመጠቀም ምቹ ናቸዉ::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

142 አልስማማም ከልሽ ምክንያቱ ምንድነዉ?

1. ምስጥራዉነት ዕጥረት
2. □ማብረስብ ማ□ለል
3. የጤና ባለሙያ ትኩረት የሚሰጠዉ ለተመሙ ብቻ ነዉ ሌሎችን ትኩረት ሰጥተዉ አይጠይቁም

ክፍል አምስት ስለ ስነተዋልዶ ጤና ተደራሽነትና የመጠቀም ችሎታ

143 ስነተዋልዶ ጤና አግልግሎት መጠቀም ቀላል ነዉ::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

144 የስነተዋልዶ ጤና ችግሮች የተጋላጭ ጎልማሳ ሴቶች ችግር ነዉ አኔ ተጋላጭ አይደለሁም::ስለዝህ አልፈልግም::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

145 አንች ሌሎች ስነተዋልዶ ጤና አግልግሎት እንድጠቀሙ ትናግረለሽ?

1. አዉ
2. አይ

146 ለአንች ስነተዋልዶ ጤና አግልግሎት ለመጠቀም ፊላጎቱ አለሽ?

1. አዉ
2. አይ

147 የስነተዋልዶ ጤና አግልግሎት መጠቀም በጣም ከባድ ነዉ::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

148 ቤትሰብናሐይማኖት መሪዎች ጎልማሳ ሴቶች ስነተዋልዶ ጤና አግልግሎት ከልተጠቀሙ ተጠያቅነት አለባችዉ::

1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

149 የማትስማም ከሆነ ማናዉ ተጠያቅ?

1. አስተማረ
2. ጤና ባለሙያ
3. የጤና ልማት ሠራዊት ቡድን መሪ
4. ቤትሰብ ብቻ
5. ሁሉም
6. አስተማረና ጤና ባለሙያ

7. አስተማረና ጤና ልማት ሠራዊት ቡድን መሪ
8. ጤና ልማት ሠራዊት ቡድን መሪና ጤና ባለሙያ

150 የስነተዋልዶ ጤና አግልግሎት ለመጠቀም በራስሽ ትተማመኝልሽ?
1. አዉ
2. አይ

151 ለስነተዋልዶ ጤና አግልግሎት ክፍያ ለመክፈል □ቃ□ኛነሽ ወይ?
1. አዉ
2. አይ

152 አዉ ከልሽ ምን ያህል ብሆን ጥሩ ነዉ? ---------የኢትዮጰያ ብር

153 ስለ ስነተዋልዶ ጤና ችግሮች ከጤና ባለሙያዎች ጋር ተዋያይተህ ታዬ ቅለሽ?
1. አዉ
2. አይ

ክፍል ስድስት ስለስነተዋልዶ ጤና አግልግሎት ለመጠቀም የሚያስታዉሱ ነገሮች መጥይቅ

154 ስነተዋልዶ ጤና አግልግሎቶች ሰምተሽ ታዬ ቅለሽ?
1. አዉ
2. አይ

155 አዉ ከለሽ ለአንች የስነተዋልዶጤና አግልግሎት ለመ□ቀም □ሚ□ስታወሱሽ ምንድናችዉ?
1. ሬ□□
2. ተልቭዥቦን
3. □□□
4. ቤትሰብ
5. አስተማረ
6. የጤና ባለሙያ
7. ሁሉም
8. ሬረደዮናተለቭዢን
9. ቤትሰብና አስተማረ
10. አስተማረናጤና ባለሙያ

156 ለስነተዋልዶ ጤና አግልግሎት ጤና ተቆም ትጎበኛለሽ?
1. አዉ
2. አይ

157 ጤና ተቋም የቀጠሮ ከርድ ይሰጣሉ ለአንች?
3. አዉ
4. አይ

ክፍል ሳባት ከስነተዋልዶ ጤና አግልግሎት የሚሰጠችዉ ጥቅሞ□

158 ሴት ልጅ ከማግባት በፍት ስነተዋልዶ ጤና መጠቀም ጠቃም ነዉ::
1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

159 ሴት ልጅ ስነተዋልዶ ጤና መጠቀመዋ መብት ነዉ::
1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

160 ስት ልጅ ስነተዋልዶ ጤና መጠቀመዋ የማህብርሰብ ዕድገት ያሻሽላል::
1. በጣም አልስማማም
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

161 ሴት ልጅ ስነ ተዋልዶ ጤና ከማግባት በፍት መጠቀመዋ ሀጥት ነዉ::
1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

162 ስነተዋልዶ ጤና አግልግሎት መጠቀማችዉ ጎልማሳ ሴቶችን
1. በጣም

ከአባለዘር በሽተ ይከላከላል።

1. አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

163 ስነተዋልዶ ጤና አግልግሎት መጠቀማችዉ ጎልማሳ ሴቶችን ከዉሪጃ ይከላከላል።

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

164 ስነተዋልዶ ጤና አግልግሎት መጠቀማችዉ ጎልማሳ ሴቶችን ከለተፈለገ ዕርግዝና ይከላከላል።

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

165 ስነተዋልዶ ጤና አግልግሎት መጠቀማችዉ ጎልማሳ ሴቶች በተለያዩ ስነተዋልዶጤና ችግሮች ከትምህርት ቤት አንዳይቀሩ በማድረግ የትምህርት ቤት አፈፃፀማቸዉን ያሻሽላል።

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

166 ስነተዋልዶ ጤና አግልግሎት ጎልማሳ ሴቶች መጠቀማችዉበማህብርሰብ ዉስጥ አድስ ሰዉ የመያዝ ዕድል ይቀንሳል።

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

167 ለእኔ ስት ልጅ ስነተዋልዶ ጤና መጠቀመዋ የማህብርሰብ ምረታማነትን ያሻሽላል።

1. በጣም አልስማማምበ
2. በከፊል አልስማማም
3. አላዉቅም
4. በከፊል እስማማለሁ
5. በጣም እስማማለሁ

ክፍል ስመንት፡ ስነተዋልዶ ጤና አግልግሎቶችን ስለመጠቀም

168 አንች ባለፈዉአስራ ሁለት ዎራት ዉስጥ የስነተዋልዶ ጤና

1. አዉ

	አግልግሎቶችን ተ□ቅመሻል?	2. አይ
169	አዉ ከልሽዉ ምን ዓይነት አግልግሎት ነዉ ያገኘሽዉ?	1. ዉረጃ ህክምና 2. አባለዘር በሽታ ህክምና 3. የቤትሰብ ምጣኔ አግልግሎት 4. በፊቃደኝነት ላይ የተመሠረትየኤች አይቪ ኤድስ ምክርና ምሪመራ 5. የስነተዋልዶጤናአግልግሎቶችን የሚገልፅ መረ□
170	በ□ህ ክ□ሚሽ ስነተዋልዶ ጤናአግልግለት ከሁለት ጊዜ በላይ ተ□ቅመሻል?	1. አዉ 2. አይ
171	አዉከልሽ ስንት ጊዜ?	_____□□
172	ስለ ስነተዋልዶ ጤና ችግሮች ከጤና ባለሙያዎች ጋር ተ□□□ተህ ታዬ ቅለሽ?	1. አዉ 2. አይ

ክፍል ዘጠኝ፡- ስነተዋልዶ ጤና አግልግሎቶች ያላቸዉ ዕዉቀትና ዝንባሌ መጥይቆች

173	ስነተዋልዶጤናአግልግሎቶች ሰምተሽ ታዬ ቅለሽ?	1. አዉ 2. አይ
174	አዉ ከልሽ ምንድናቸዉ?	1. ዉረጃ ህክምና 2. አባለዘር በሽታ ህክምና 3. የቤትሰብ ምጣኔ አግልግሎት 4. በፊቃደኝነት ላይ የተመሠረትየኤች አይቪ ኤድስ ምክርና ምሪመራ 5. የስነተዋልዶጤናአግልግሎቶችን የሚገልፅ መረ□
175	አዉ ከልሽ የመርጃ ምንጩ ምንድናቸዉ?	1. ሬ□□ 2. ተልቪዥን 3. □□□ 4. የጤና ባለሙያ የጤና ተቀም 5. ጎደኛ 6. ጎረቤት 7. ሁሉም 8. ሬረደዮናተለቪዥን 9. ሬ□□ ተልቪዥን ጋዜጣ የጤና ባለሙያ የጤና ተቀም 10. □□ኛ ጎረቤት .
176	በአከባብሽ ስነተዋልዶጤና አግልግሎቶች የሚሰጡ ተቀማት አለ?	1. አዉ 2. አይ
177	አንችስነተዋልዶጤናአግልግሎቶ ችን መጠቀም አስፈላግ ነዉ ብለሽ ትገምችለሽ?	1. አዉ 2. አይ

178 ስነተዋልዶጤናአግልግሎቶችን ማን ብሰጡ ትመረጭለሽ?

1. በሐክም 2. ምነርስ 3. በጤና ኤክስተሽን
3. በጤና ልማት ሠራዊት 5. በሃይማኖት መሪ 6. በሁሉም 7. ነጤና ባሌሙ□ ብቻ

□መ□□ቅ ዬ ጤት

ሀ. በሙሉ ተሞልተዋል

ለ. በከፍል ተሞልቶል

ሐ. ተቆረጦል ። መጠይቅ የተጀመረበት ሰዓት----መጠይቅ የቆመበት ሰዓት-----የጠያቅዉ ዕድሜ------□ርማ

ቡዱን ተኮር መዉያያ

በጥናቱ ለመሳተፍ ፍቃደኝነት ማርጋገጫ

ዕርስ፡ የማህብርስብ ዝንባሌና የጎልማሳ ሴቶች አመለከከት በስነተዋልዶ ጤና አግልግሎት አጠቃቀም ላይ

የገንዝብ ምንጭ፡ ጅማ ዩኒቨርስት

የጥናቱ ፈፃሚ፡ ተሸመ ነጋሽ

የወይይት መለያ ቁጥር----------

ቦታዬ ፡ በ□ዬ ሮ ዞን ማረቃ ወረዳ

እንከን ደህና መጡ ለወይይት፡፡ ስሜ ----------ይባላል የመጣሁት ከጅማ ዩኒቨርስት ነዉ፡፡ ከአኔ ጋረ ያለዉ የጎገኛ□ ስሙ----------□ባላል፡፡ የመጣዉም ከ----------ነዉ፡፡ወደዋናዉ ዉይይተችን ከመግባተችን በፍት ስለጥናቱ አጠቃለይ ሃሳብና ሁኔታ አነብሎታለሁና በጥሞና አዳምጠዉ በጥናቱ ለመሳተፍ መስማማተዎን ይገልፀልኛል፡፡ይህ ጥናት በማረቃ ወረዳ ዉስጥ የሚገኙ ዉጣት ሴቶች አመለከከትና የማብረሰብ ዝንባለ በስለ-ተዋልዶ ጤና አግልግሎት አጠቃቀም ተደራሽነት ዙረያ ያሉ ችግሮችን ለመዳሰስ ነዉ፡፡ ማንኛዉም ሀሳብ በወይይት የተነሳዉ ተቀባይነት አለዉ፡፡ ይህ አቻለአቻ ዉይይት ስለሆነ ሃሳብ ለመስጠት ስማችሁ እስ□ሚ□ራ መ□በቅ የለባችሁም፡፡ እኛ ማንኛዉም ሃሳብ በወይይት የተነሳዉ እንዳያመለጠን ቴፕ አንጠቀማለን፡፡

ስለዝህ ተራ በተራ ሃሳብ ለመስጠት ሞክሩ። በዝህ መዉይይት ላይ የሚሰጡት መረጃ ምስጥራዊነቱ የተጠበቀ ነዉ። አሁን ዉይይቱን እንጀምር? አሽ ከላችሁ አመስግናለሁ።

ቡድን ተኮር መዉያያ ነጥቦች

1. ሥነተዋልዶ ጤና አግልግሎት ማለት ምን ማለት? አስት ለአኛ ትሸንህ ግለጹልን
2. ሥነተዋልዶ ጤና ችግሮች በአከባብያሽ ምን ያህል አስጊ ነዉ ብለህሽ ታስብለሽ?
3. ስለሥነተዋልዶ ጤና አግልግሎቶች ምን ሰሚተሻል? ከማን?
4. ከስነተዋልዶ ጤና አግልግሎቶች ምን ታዉቅለሽ? ምን ምን ያካትታሉ?
5. ሥነተዋልዶ ጤና አግልግሎቶች ስባሉ ምንድነዉ የሚታስብዬ ?
6. በአከባብያሽ ጎልማሳ ሴቶች ወደ ስነተዋልዶ ጤና አግልግሎት የሚሄዱ ዋና ዋና ምክናቶች ምንድናቸዉ?
7. ስነተዋልዶ ጤና አግልግሎቶችን ለማግኘት ፈተናዋች ምንድናቸዉ?
8. ስነተዋልዶ ጤፍ አግልግሎት ጥቅሞች ምንድናቸዉ?
9. ስነተዋልዶ ጤናአግልግሎት ጉዳቶች ምንድናቸዉ?
10. ጎልማሳ ሴትች ከማግባተችዉ በፍት ስነተዋልዶ ጤና አግልግሎት ብጠቀሙ ለቤትሰብ ምን ይሰማቸዋል?
11. ጎልማሳ ሴት የስነተዋልዶ ጤና አግልግሎት ዕጠቀማለሁ ብላ ብትናገረ ለቤተሰቦች ምን ይሰማቸዋለል? እንዴት ይገለፃል?
12. ለአንች ቤተሰቦችሽን ስለተዋልዶጤና አግልግሎት ለመጠየቅ ዓላማ አሌሽ? አንዴት? ለምን?
13. የስነተዋልዶጤና አግልግሎቶች ክፍያ ምን ይመስላል? ምን ብሆን ይሻላል?
14. የስነተዋልዶ ጤና አግልግሎቶችን ጎልማሳ ሴቶች በሠፍዉ አንድጠቀሙ የሚያግዙ አማራጮእምንድናቸዉ?
15. በአከባብያሽ ስነተዋልዶ ጤናአግልግሎትን የሚያጎለብቱ ባህላዊና ሐይማኖተዊ ልምዶች ከሉ ምንድናቸዉ? ምን በማድረግ? እንዴት?
16. በአከባብያሽ ስነተዋልዶ ጤናአግልግሎትን የሚከልክሉ ባህላዊና ሐይማኖተዊ ልምዶች ከሉ ምንድናቸዉ? ምን በማድረግ? እንዴት?
17. ጎልማሳ ሴቶች ስነተዋልዶጤና አግልግሎት በሠፍዉ እንድጠቀሙ ከመንግስት ከማበረሰብ ከግለስብ ምን ይጠበቃል? ማናዉ ባለቤት?
18. ከጤና ጣብያ በስተቀር በየትኞቹ ተቋማት ስነተዋልዶ ጤና አግልግሎት ብሰጥ ለጎልማሳ ሴቶች ይሻላል? ስማቸዉ?
19. በአከባብያሽ ጎልማሳ ሴቶች በሰፍዉ የስነተዋልዶ ጤና አግልግሎት እንድጠቀሙ እነማን ብከተቱ ይሻላል?

20. ማን የስነተዋልዶ ጤና አግልግሎት ብሰጥ ይሻላሉ ብለሽ ትመሪጪለሽ? ለምን?
21. እኛ የተነጋገረነዉ እንዳሌ ሆኖ ሌላ የሚትሰጪዉ ሃሳብ ወይም ጥቆማ በስነተዋልዶጤና አግልግሎት ዙሪያ ለጎልማሳ ሴቶች መደረግ አለበት የሚትዩ ነገር ከለ ምንድነዉ?
22. በተጨማሪ ሌላ ሀሳብ አለሽ? ከለሌ አመስግናለሁ!ይህ የሰጣችሁ ማንኛዉ ም ሀሳብ የሚዉለዉ ለጥናቱ ብቻ ነዉ::ስማችሁ አይገለጽም ምስጥሩ የተጠበቀ ነዉ ለማለት ነዉ::

□□ል□ ማስታዉሻ ይዘቶች

1. የዉይይት አከባብዉን መግለጽ
2. በአከባብዉ እየተፈፀሙ ያሉትን ተግባራት ባህሪ መግለጽና ማደራጀት
3. የግለሰቦች ተሳትፎና ድርሻችን መግለጽ
4. ግለስቦችየሚገልፀትን ሃሳቦችና ለሚተዩ ነገሮች ትርጉም በነሱ አባባል መግለጽ
5. ለሚተዩና ለተሰጡ አስተያየቶች ትክክለኛ ወ□ም ተቀራራብ አባባሎችን መፃፍ
6. ያጋጠሙትንና የተዩ ተጽኖ መግለጽ

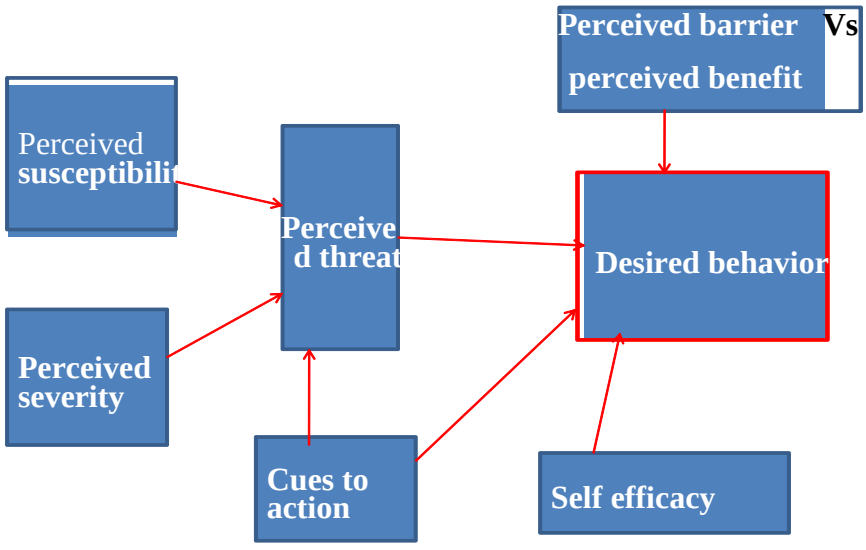
በፍልድ ማስተዉሻ ገላጭ ሁነተዎች

1. በራስ አባባል የተዩ ነገሮችን ና የተሰጡ ሃሳቦች ዓረፍተ ነገረ መልክ ና በአንቀጽ መለክ መግለጽ
2. ሃሳቦችንና ስሜቶችን ማጉላት
3. ያለተመለሱ ጥያቀዎችና ምክንያተችዉ አንደሁም ወደፍት የሚወሰዱ መፍተሔዎች
4. ስህተቶችንና የአረዳድ ግድፍቶች ማስተከከል
5. □ታዩ ነገሮችንና ሃሳቦች በተለያዩ አቅጣጫ መረዳት ና መግለጽ

ከአወያይ የሚጠበቁ ነገሮች

1. ከተሳተፍዎች ጋር ቀደም ብሎ መገነኝት
2. ተሳተፍዎች ነፃነትን ማስፈን
3. ተሳተፊዎች ከሃሳብ ወጣ ስሉ መመለስና በሃሳብ ማሸነፊ
4. ግልጽ ባለሆኑ ነጥቦቸ ተሳተፊዎችን ግልጽ አንድያደረጉ ማነቃነቅ
5. የግለሰቦች የሚያነሱት ሃሳቦች ተቀባይነት አንድኖረዉ ማድረግ
6. ተሰምነት ከለዉ ግለሰብ ጋር መዎያየት ለሎችን አያሳተፉ
7. ይህ ማለት ምን ማለት ነዉ ብሎ ተሳተፊዉን አለማስጨነቅ

Annex 3: The model used/Theoretical frame work of the study



Annex 4 work plan and budget

Table 1 Gantt chart for work plan

S.NO	Activities	Time for activities in month										Responsible body
		Aug	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	
1	Topic submission &selection											PI & dep't
2	Draft proposal development & discussion with advisor											PI(principal investigator) &advisors
3	Submission of draft proposal											PI(principal investigator)
4	Proposal defense & comment accommodation											PI(principal investigator)r
5	Proposal submission to ethical review committee & receive feed back											PI(principal investigator)
6	Securing a fund &other logistics											PI(principal investigator)
7	Training of data collectors											PI(principal investigator)
8	Data collection											PI & data collectors
9	Data entry & analysis											PI(principal investigator)

10	Report writing											PI(principal investigator)
11	Submission of draft report to advisor& mock defense											PI(principal investigator)
12	Final thesis submission & presentation of final report											PI(principal investigator
13	Dissemination of paper to JU & other concerned bodies											PI (principal investigator)

Budget

Table 2 Budget summary

S.NO	Title	Required budget in ETB	B/ source
1	Personnel cost	5,000.00	JU
2	Stationary material cost	7,356.00	Dawuro Zone
	Total cost	12,356.00	

Table 3 Stationary materials cost

S.NO	**Item**	**Unit**	**Quantity**	**Unit cost in Birr**	**Total cost Birr**	**B/ source**
1	Questionnaire duplication	Piece	617 questionnaire x 6 pages = 3702 pages	0.50/page	1851.00	
2	Pencil with eraser	N^{o}	2 x 5 data collectors = 10	3.00	30.00	
3	Clip board	N^{o}	1 x 5 data collectors = 5	25.00	125.00	
4	Printing proposal	N^{o}	1 x 50 pages =50 pages	1.00/page	50.00	
5	Duplication of proposal	N^{o}	2 x 50 pages =100 pages	0.50/page	50.00	
6	Printing final theses	N^{o}	1 x 80 pages = 80 pages	1.00/page	80.00	
7	Duplication of theses	N^{o}	3 x 80 paces = 240 pages	0.50/page	120	
8	Binding	N^{o}	2 proposal + 3 theses =5	10.00	50.00	
	Sub total				2,356.00	

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Table 4 Personnel cost

S.NO	**Activity**	**N^{o} of Participants**	**Qualification**	**N^{o}of days**	**Unit Cost**	**Total Cost**	**B/ Source**

					in Birr	in Birr	
I	**TRAINING**						
1	Data collectors	5	HO/BSc Nurse	1	96	480.00	Marek Wereda & Jimma University
2	Supervisor	2	HO/BSc Nurse	1	96	192.00	
3	Trainer	1	MPH HEHP	1	96	96.00	
4	Assistant	5	HEW	1	50	250.00	
	Sub total					1,018.00	
III	**DATA COLLECTION**						
	Recorders of data and collectors	10	Completed grade 10	$1^1/2$	50	7,38.00	
6	Moderators	5	HO/BSc Nurse	8	96	3,940.00	
7	Supervisors	2	HO/BSc Nurse	8	96	1,536.00	
8	Principal Investigator	1	MPH HEHP	8	96	768.00	
9	Assistant	5	HEW	8	50	2,000.00	>>
	Sub total					8,982.00	

DECLARATION

Declaration

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name: _____

Signature: _____

Name of the institution: _____

Date of submission: _____

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

Name and Signature of the first advisor

_____

_____

Name and Signature of the second advisor

_____

_____

Name and signature of the department head

_____

_____