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Adolescents' Reproductive Health Problems, Service Preferences, and Accessibility

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In Ethiopia, the sexual and reproductive health of young people has become a major public concern, particularly with the advent of HIV/AIDS. The objective of this study was to assess adolescents' reproductive health problems, service preference, and accessibility in Adama city. The study used both quantitative and qualitative research designs. Structured questionnaire and focus group discussions were employed for data collections. A total of 252 adolescents filled the questionnaire and three focus groups discussion with selected key informants were conducted. The quantitative data obtained from participants were analyzed using descriptive statistics. From the findings of the study, it was observed that, despite having sufficient information on reproductive health issues, the adolescents were facing different reproductive health problems. Besides, regarding the accessibility, the study found that many adolescents were not served in the existing health institutions for their reproductive health needs; those who got access to it claimed that the existing health institutions were inconvenient and unattractive. Finally, based on the findings of the study, some recommendations were also forwarded.

Keywords. Reproductive health problems, service preferences, adolescents, Ethiopia

Nowadays, there are 1.2 billion adolescents aged 10-19 years worldwide, which make up 18 per cent of the world's population. Nearly 90% live in developing countries. More than half of all adolescents live in Asia. In absolute numbers, India is home to more

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adolescents around 243 million than any other country. It is followed by China, with around 200 million adolescents (United Nation's Children Fund [UNICEF], 2012). Sub-Saharan Africa, however, is the region where adolescents make up the greatest proportion of the population, with 23% of the region's population aged 10-19 years (UNICEF, 2012). The striking differences among regions in the proportion of adolescent population results from demographic transition that occurs when decline in mortality rates are later followed by decline in fertility rates. Sub-Saharan Africa's adolescent fertility rate is generally higher than for other regions in the world (United Nations Population Division [UNPD], 2010). Ethiopia is a country with an overwhelmingly young population. About 62% of the total population of Ethiopia is below the age of 25 years. Young people of ages 10-24 years are the largest group to be entering adulthood in Ethiopian history. This cohort of young people makes up 25.6 million (34.7%) of the total population (Central Statistics Agency [CSA], 2007).

Many adolescents die prematurely every year, estimated 1.7 million young men and women between ages of 10 and 19 years lost their lives to accidents, violence, and pregnancy related complications and other illnesses that are either preventable or treatable (Blum & Mmari, 2005). Adolescents' reproductive health (RH) is an increasingly important component of global health. While adolescence, generally, is a healthy period of life, many adolescents are less informed, less experienced, and less comfortable in accessing health services for RH than adults (Blum & Mmari, 2005). Adolescents often lack basic RH information, knowledge, and access to affordable confidential health services for RH. Many of them do not feel comfortable in discussing RH issues with parents (Singh, Darroch, Ashford, & Vlassoff, 2009). Likewise, parents, health care workers, and educators, frequently, are unwilling or unable to provide complete, accurate, and age appropriate RH information to young people. This is often due to parents' discomfort about the subject or the false belief that providing the information will encourage sexual activity (Singh et al., 2009).

Fifteen per cent of all unsafe abortions in low- and middle-income countries are among adolescent girls aged 15-19 years (Shah & Ahman, 2012). In 2008, there were an estimated 3.2 million unsafe abortions in developing countries among girls aged 15-19 years (World Health Organization [WHO], 2011), and adolescent girls are more seriously affected by complications than the older women. Unsafe abortion is responsible for about 13 per cent of all maternal deaths; with adolescents disproportionately affected (WHO, 2011).

Young people aged 15 to 24 years account for 41% of HIV infection worldwide. Adolescent girls are at far greater risk of contracting HIV than adolescent boys. Young women make up 64 per cent of all new infections among young people worldwide. This is not just because they are more physiologically susceptible; they are also at high risk for sexual violence and rape, both inside and outside of marriage (WHO, 2011). Regarding the preference and accessibility issues, different studies indicate that even if the service is accessible the preference of adolescent vary from place to place.

Studies conducted in four Sub-Saharan Africa countries (Burkina, Faso, Ghana, Malawi, & Uganda), show some adolescents could seek only limited types of RH services in one place, for example, the service is related to contraception, but not sexually transmitted infections (STIs).The study also indicates that barriers on preferences of the service, most of the major barriers that adolescents face are fear that others might get to know of their visit, shame about their needs, negative attitudes of providers, and lack of privacy (Ann, Biddlecom, Muntha, &Vanessa, 2007). In case of Ethiopia, according to CSA (2007), the Ethiopian youth population (aged 10-24 years), was about 25.6 million (34.7%) of the total population. After a year the magnitude increased to 35 percent of the total population (CSA, 2008). In Ethiopia, the sexual and RH of young people has become a major public concern, particularly, with the advent of HIV/AIDS.

Among the many sexual and RH problems faced by adolescents and youth in Ethiopia are gender inequality, sexual coercion, early marriage, polygamy, female genital mutilation, unplanned pregnancies, closely spaced pregnancies, abortion, STIs, and AIDS (Youth Net, 2004). Lack of education, unemployment, and extreme poverty exacerbates and perpetuate the RH problems faced by Ethiopian young people. RH is an important aspect of health, especially for women. Knowledge about the availability of health services, transportation and distance, confidentiality, ability to pay, parental notification rules, and lack of differential centers remain important issues affecting adolescents' access to RH (Ayalew & Yeshigeta, 2009).

For the proper planning of appropriate health services for adolescents, it is crucial to have knowledge of the pattern of their use. At the moment, there is little information about the extent to which adolescents utilize available health services in Ethiopia, as most studies that examined the use of health services had primarily focused on adults (Fantahun & Degu, 2003). Accessibility of RH services is an important factor on adolescent's utilization of health services (Ayalew & Yeshigeta, 2009). A better understanding of the accessibility and

utilization of RH services by adolescents will help to address the gaps in provision of youth friendly services. Therefore, the aim of this study was to assess RH problems, service preference and accessibility among adolescents 12 to 19 years old in Adama City.

According to Ethiopian youth policy, limited RH services and information and education dissemination services are being rendered through governmental organizations and nongovernmental organizations (NGOs). It is, however, impossible to assume that adequate services are being rendered. Moreover, the services do not specifically focus on adolescents, nor they are easily accessible in terms of time and place (Ministry of Health, 2006).

In Ethiopia, abortion emanating from unintended pregnancy is one of the most significant causes of maternal morbidity and mortality; it is also a major medical, social, psychological, and public health problem (Dejene, Tsion, & Tefera, 2011). Country-specific data indicates that young women who are unmarried are increasingly sexually active before the age of 15 years (CSA, 2005). Thus, unwanted pregnancy is one of the greatest problems that adolescent girl can face; this poses major public health problems in the developed and developing countries, including Ethiopia.

Study done on predictors of emergency contraceptive use among regular female students at Adama University, Central Ethiopia, shows that utilization of emergency contraceptive was low; correct use was even lower (Dejene et al., 2011). Studies conducted in Jimmatown, South West Ethiopia on service accessibility and utilization shows that the issues of accessibility were seen in different dimensions, so services were not accessible to the adolescents due to different reasons (Ayalew & Yeshigeta, 2009). Similarly, study conducted in Addis Ababa city indicated that the existing health services were inaccessible, unaffordable, and unacceptable (Fantahun & Degu, 2003).

To the best knowledge of the researcher, Adama is one of the biggest cities in Oromia region where no prior exploration has been done regarding adolescent RH problems and their service preference and accessibility. From the observed facts, adolescents' RH problems have significantly been seen in Adama city. Therefore, this study focused on the following research domains; such as prevalence of RH problems; sources of information for awareness and knowledge of sexuality; provision of existing services; challenges and obstacles that prevent the adolescents from using RH services; and factors influencing the preference and utilization of RH services among adolescents.

Method

Study Design

This study used both quantitative and qualitative methods. The issue of RH is hidden in Ethiopian context, so in order to get enough saturated information both methods were employed. As service delivery point based cross-sectional survey was employed for the quantitative study, and qualitative data was collected through focus group discussions (FGDs).

Sample

The target population for this study was adolescents who came to seek RH service at youth centers. The required information was secured from selected adolescents regarding adolescents' RH problems, service preference, and accessibility of the services. There are three youth centers in Adama city (two belong to the government; one is managed by local NGO) offering youth related activities such as library service, sports activities, establishment of youth clubs, and RH trainings. Based on the nature of the study, the researcher preferred the youth center under local NGO, as there were many adolescent clients and sound adolescent-focused RH services.

By employing systematic sample technique, a total of 252 adolescents were considered in the study with 100% response rate. Out of the total respondents, 144(57.1%) were females and age range of the study population was 12-19 years (M = 16.82, SD = 1.82). Seventy three (29%) of the respondents were attending or had completed high school, 64(25.4%) were studied up to grade six, and 59(23.4%) were in grade 7-8. Two hundred five (81.3%) of the participants were single and majority of the respondents were orthodox Christians (39.7%), followed by Muslims (30.2%). One hundred fifty one (59.9%) were living with their parents (father and mothers), while, 54(21.4%) were living with friends/spouse. The majority of participants' mothers 126 (50%) were housewives and 93 (36.9%) of their fathers were civil servants. One hundred forty seven (58.3%) were students and 2(9.5%) were jobless (family dependent), only 21(8.3%) were employed at private organizations; while, one hundred fifty two (60.3%) had their parents as current source of income.

Assessment of Variables

Quantitative data collection. The data for the quantitative section were collected from participants through self constructed dichotomous questionnaire. The questionnaire was developed from the literature review comprising three dimensions, namely, adolescent RH problems, service preference, and accessibility of the services. The questionnaire was first judged by social psychology graduate students of Adama Science and Technology University who had health back ground for its face validity. Then forward and backward translations to local languages (Afan Oromo and Amharic languages) were done by language experts. Pilot testing was conducted on 30 adolescents at the youth centre (of local NGO). Finally, the necessary modifications and corrections were performed to ensure its validity and reliability. Three questions were modified and two questions were corrected after the pilot testing. Kuder Richardson reliability of the questionnaire was found to be .72 indicating the questionnaire as dependable measure of the said construct.

Qualitative data collection. The FGD questions were developed from the relevant literature. Sample of FGD constituted adolescents who visited the youth centers for RH services. Three FGDs were conducted each consisting of 8-10 participants; while, two FGDs were conducted with exclusive homogenous groups (of male and female adolescents). Participants of third FGD included service providers (nurses, counselors) rendering RH service for adolescents, experts from health centers and health office, and NGOs that work on adolescents and youth programs.

Procedure

Formal permission was sought officially from the youth center under study and informed consent was acquired from the participants. The autonomy of each participant was assured unless they needed assistance in filling out the questionnaire. In such cases, confidentiality was assured and no personal details were recorded or produced on any documentation related to the study.

Results and Discussion

Findings related to sources and knowledge of RH information, RH service practice, prevalence of RH problems, RH service preference, and RH service accessibility were presented and discussed under each heading.

Sources and knowledge of reproductive health information. As it was indicated in Table 1, 198(78.6%) of respondents shared that they knew what RH means; 171(67.9%) and 241(95.6%) had information how to terminate unwanted pregnancy and regarding STIs and HIV/AIDS, respectively. The chi-square test also indicated that there was statistically significant difference between who receive the information or not. Furthermore, it was also observed that among 198 (78.6%) respondents understand the connotation of RH; that is, 46 of them responded that RH means family planning; 48 participants said that RH means the right choice with whom to have sex; 28 considered it as access to health information and service; 39 respondents said it is about sexually STIs/HIV/AIDS, and 37 of them responded it is about marital and child health.

Table 1

Knowledge of Reproductive Health (N = 252)

Questions	Responses	*f*	%	χ^2
Do you know what reproductive health means?	Yes	198	78.6	82.28*
	No	54	21.4	
Do you have any information how to terminate unwanted pregnancy?	Yes	171	67.9	32.14*
	No	81	32.1	
Do you know any information regarding STIs and HIV/AIDS?	Yes	241	95.6	209.92*
	No	11	4.4	

*$p < .05$.

Besides, regarding the source of information how to terminate unwanted pregnancy the majority of the respondents among 171(67.9%) clients, about 19.8% of them got the information from mass media in the first rank followed by 16.3% by friends and peers in the same rank; secondly, 19% from posters and pamphlets and 16.7% from health professionals, then 12.7% in the third rank again from mass media (Table 2). The result was encouraging in a way that media played the major role on RH issues, especially, with accomplishment of MDGs that concerned with mortality of mothers in pregnancy

related complications. With the help of information from media, adolescents can get the service they want from health professionals as indicated in the second rank. In Table 2, parents are shown to have played the least role as the source of information on how to terminate unwanted pregnancy. This was obvious that adolescents did not communicate with their parents about their sexuality perhaps due to cultural pressure in their upbringings.

Table 2
Source of Information about Termination of Unwanted Pregnancy (N = 252)

Sources of Information	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
My parents	6(2.4%)	3(1.2%)	1(.4%)
Friends/peers	41(16.3%)	22(8.7%)	30(11.9%)
Mass media	50(19.8%)	36(14.3%)	32(12.7%)
Posters and pamphlets	16(6.3%)	48/19%)	31(12.3%)
Health professionals	32(12.7%)	42(16.7%)	28(11.1%)
Religious leaders	–	–	2(.8%)
Partner/ husband wife	2(.8%)	3(1.2%)	2(.8%)
School	23(9.1%)	10(4%)	16(6.3%)

This issue was discussed in the female FGDs that parents should give information about RH issues. The same is true here regarding partners. It was one of the least sources of information on unwanted pregnancy. This indicated that even spouses are not clear with the issue of RH. The results indicated here showed that further awareness creation programs needed on the least sources of information. Regarding information on STI/HIV/AIDS mass media, friends/peers, and school are prominent as a major source of information, but religious leaders and partners are the two least effective sources. This can be interpreted as, especially, partners are the major important source for RH problems because of the fact that, if there is no discussion between the two, the problem will get worse. The result also indicates that religious leaders are not playing adequate role as the source of information. Religious leaders are influential persons in the community; therefore, they can make a difference, if they involved in RH issues.

From Table 3 the major source of information regarding STI/HIV/AIDS was mass media in the first rank as well as in the second rank which was about 74(29.4%) and 84(33.3%) respectively. The third source of information was posters and pamphlets which is 57(22.6%).

Table 3

Source of Information on STI/HIV/AIDS (N = 252)

Sources of Information	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
My parents	11(4.4%)	3(1.2%)	5(2%)
Friends /Peers	51(20.2%)	34(13.5%)	53(21%)
Mass Media	74(29.4%)	84(33.3%)	34(13.5%)
Posters and Pamphlets	17(6.7%)	71(28.2%)	57(22.6%)
Health Workers	30(11.9%)	27(10.7%)	18(7.1%)
Religious Leaders	2(.8%)	2(.8%)	1(.4%)
Partner/ Spouse	6(2.4%)	–	3(1.2%)
School	49(19.4%)	11(4.4%)	27(10.7%)
Neighbour	1(.4%)	2(8%)	9(3.6%)

In general, in all findings pertaining to the source of information and knowledge about RH, termination of unwanted pregnancy, and STIs/HIV/AIDS, major source is mass media and posters and pamphlets, along the contribution of friends and peers, health professionals, and school that are also found to be significant.

Reproductive health service practice and prevalence of reproductive health problems. Out of 252 clients, 45 were married including 35 female and 10 male clients (Table 4). The minimum age of marriage was 16 years and the maximum age was 19 years. The mean age of the married clients was 17.24 (*SD* = 1.02). The mean age of marriage was about 18.2 and 16.97 for male and female participants, respectively. The marriage took place by different ways that is, kidnapping/abduction, by interest of men only, 14(31.1%) agreed to get married on mutual interest (love marriage) having highest percentage, and arranged marriage by the agreement of their parents with lowest percentage.

From the result, it is observed that out of the 252 respondents, 146(57.9%) reported to have practiced premarital sexual activity in the past, which included 70(64.8%) of the boys and 76 (52.8%) of girls. The majority of the sexually active respondents 118(80.8%) were single, 26(17.8%) were married. The mean age at first sexual intercourse was 15.66 years and the mean age of sexual commencement for male and female participants was 16.41 and 14.57, respectively. The minimum age at first sexual intercourse for male and female participants was 15 and 13 years, respectively. This indicates that the age of sexual debut is very early and the complication of RH problems is also at large with this age. Hence, this implies that things

should be done on creating awareness and for behavioral change communications specifically for these age groups.

Table 4

Reasons of Marriage

Method	*f*	*%*
Kidnapping/abduction	13	28.9
Only by interest of men	12	26.7
We agreed to marry/love marriage	14	31.1
By our parents' agreement/arranged marriage	6	13.3
Total	45	100

Related studies conducted in different parts of the country showed that the mean age for the first sexual contact for Ethiopian adolescents is between 13.6 and 18.0 years and rural adolescents had earlier sexual onset compared to the urban ones (Mean = 13.1 versus 14.7 years, respectively; Kebede, 2003). A study conducted on the determinants of high risk sexual behavior for HIV/AIDS among out-of-school youth in Addis Ababa showed that 52.2% of the boys and 47.8% of the girls had Sexual experience, their mean age of sexual commencement being 17.7 years (Abate, 1999).

Another study on adolescent sexuality revealed that 71.9% of boys and 71.4% of girls had their first sexual contact in the age range of 15-17 years (Ethiopian Public Health Association [EPHA], August 2003). A similar study done in Bahir Dar also showed that 53% of male and 24% of female out-of-school youth were sexually active; the mean age at first sexual contact being 16.9 years of age (Fantahun & Degu, 2003). Another study conducted on sexual activity of out-of-school youth, and their knowledge and attitude about STD/HIV/AIDS in Southern Ethiopia revealed that 49% of the respondents have had their first sexual contact within the mean age of 17 years (Taffa, 1998).

From the analysis, it is also observed that the main reason for first sexual encounter includes falling in love 32 (12.7%), 31 (12.3%) sexual desire, 29 (11.5%) rape (forced to do so), and 27(10.7%) peer pressure. Having desire and friends doing it (peer pressure) were reported by 46 (18.3%) and 43 (17.1%) of respondents, respectively. Twenty two (8.7%) clients responded that their main reason for first sexual practice were peer pressure. Besides, of 166 respondents, 81(32.1%) of the respondents reported that they had sexual intercourse

with one partner. Fifty three (21%) and 20(7.9%) had sexual practice with two and three partners, respectively. One respondent had sexual practice with four partners, 11(4.4%) respondents do not remember with how much partners they had indulged in sexual practices.

Partners' age 86 clients was in the range of 12-19 years. Forty (15.9%) respondents had 20-24 years old partners. The age of partners of 31 and 9 respondents was 25-30 and above 30 years, respectively. Out of the sexually active male participants, a total of 30(11.9%) respondents reported experiencing sex with commercial sex workers. Among 82 sexually active male respondents, 52 did not have sexual practice with commercial sex workers due to different reasons. Twenty four (9.7%) were due to fear of STIs and HIV/AIDS, 7(2.8%) due to absence of pocket money, 13(5.2%) had their own girl-friends, and 8(3.2%) had information about commercial sex workers having different RH problems.

Table 5

Knowledge and Usage of Modern Contraceptive (N = 252)

Questions	Responses	*f*	%	χ^2
Do you know what modern contraceptive means?	Yes	186	73.8	57.14*
	No	66	26.2	
Have you ever used modern contraceptives?	Yes	98	38.9	.53
	No	88	34.9	

*$p < .05$.

The majority of the respondents know what modern contraceptive means, which was about 73.8% whereas 26.2% did not know (Table 5). The chi-square test also shows that there was statistically significant difference ($p<.05$) between the two. In line with this, out of 186 respondents who know what modern contraceptives means, 98(38.9%) had used the methods and 88(34.9%) did not use the methods. There was no statistically significant difference between those who used modern contraceptive or not ($p>.05$). This indicates that knowing the contraceptives options may not mean using these also (Table 5).

It can be seen in Table 6, out of 98 users of modern contraceptives, the majority about 62(24.6%) used condom in the first rank followed by emergency contraceptives 16(6.3%). Secondly, oral contraceptives were used by 22(8.7%) of the respondents. Finally, injectable contraceptives were used in the third rank. There were statistically significant differences among the users of condom and oral contraceptives, but other contraceptives were not (Table 6). A

study conducted to assess determinants of contraceptive use among urban youths in Ethiopia, reported that there is a large discrepancy between knowledge and actual practice of contraception (Tsigereda, 2004). Similarly, study indicated that nearly two third of young respondents (69.3% of male and 63.9% of female) reported to have known at least one contraceptive method, while, only about one fourth (27.0% male and 22.6% female) reported having ever used a method (Kora & Haile , 1999). Another study conducted in northwest Ethiopia showed that only 25.0% of sexually active females used modern contraceptives (Ismail, Bitsuamlak, & Alemu, 1997).

Table 6
Preference of Modern Contraceptives among Users (N = 252)

Preference for Modern Contraceptives	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
Oral Contraceptive Pills	14(5.6%)	22(8.7%)	4(1.6%)
Condom	62(24.6%)	12(4.8%)	41(.6%)
Injectable	6(2.4%)	4(1.6%)	11(4.4%)
Intra-Uterine Devices	–	–	–
Emergency Contraceptives	16(6.3%)	9(3.6%)	9(3.6%)
Norplant	–	2(.8%)	1(.4%)

On the other hand, while, asked the reasons for not using the contraceptives the result revealed that about 73(29%) of the respondents claimed that "*I am unmarried and not sexually active*", in the first rank, followed by 22(8.7%) had lack of knowledge about contraceptives, 15(6%) of them had the religious influence (religious prohibition) as the second reason, in addition, 7(2.8%) had fear of side effects of the methods. Likewise, out of the sexually active respondents, during their first sexual practices only 17(6.7%) had used contraceptives. The rest 141(56%) did not use contraceptive at their first sexual contact, the reason behind was mainly 79(31.3%) sex was unplanned, followed by belief pregnancy was not possible with 34(13.5%) in the first rank. About 28(11.1%) did not know any method.

Among the sexually active clients, 28.2% have ever used condom, only 4% of the respondents used condom at first time sexual practices, while, 23.4% of the clients had faced the problems of STDs (Table 7). The result of chi-square also indicated that there were statistically significant differences as displayed in Table 7.

Table 7

Use of Condom and Having STIs among Sexually Active Clients

Questions	Response	*f*	%	χ^2
Have you ever used condom?	Yes	71	28.2	38.08*
	No	166	65.9	
Did you /your partner use condom the first time you had sexual practices?	Yes	10	4	136.29*
	No	164	65.1	
Have you ever had STIs?	Yes	59	23.4	
	No	175	69.4	157.81*
	Don't know	18	7.1	

*$p < .05$.

Out of 144 female clients, 51(20.2%) had been pregnant (see Table 8). The mean number of the pregnancy was 1.35 (*SD* = 0.65). The minimum age of pregnancy was 14 years and the maximum was 19 years. Among 51 pregnancies, 12(4.8%) were wanted, but the majority about 39(15.5%) were unwanted. Furthermore, out of 39 unwanted pregnancies, 32(12.7%) responded the first pregnancy was unwanted, while, 7(2.8%) clients responded both the first as well as the second pregnancies were unwanted. As a result, about 21(58.3%) of abortions were among single, while, 13 (36.1%) were among married adolescents. In support of this, some studies in Ethiopia revealed that unintended pregnancy was found to be 15% in Harar, 30% in Gondar, and 50% in Koladiba around Gondar (Ashebir, 2004; Solomon, 2002).

Table 8

Issue of Pregnancy, Abortion, and Delivery (N = 252)

Questions	Response	*f*	*%*	χ^2
Have you ever been pregnant?	Yes	51	20.2	12.25*
	No	93	36.9	
Were all your pregnancies wanted?	Yes	12	4.8	14.29*
	No	39	15.5	
Have you ever had abortion?	Yes	36	14.3	16.20*
	No	9	3.6	
Have you ever given a birth?	Yes	22	9.1	.32
	No	27	10.7	

*$p < .05$.

Out of 36 abortions undergone by respondents (see Table 8), the result further indicated that about 29(11.5%) respondents had abortion once, 3(1.2%) had twice, and 4(1.6%) respondents had three times. About 7(2.8%) of the respondents discussed the issue of abortion with their partners/husband, 16(6.3%) with friends/peers, 6(2.4%) with

health workers, and 7(2.8%) with traditional healers. Besides, among those respondents who had experienced abortion, the result revealed that they got the abortion service at private clinics 15(6%), in which 9(3.6%) were done at traditional abortionist house, while 6 were induced by themselves by ingesting different drugs, and 5 clients consulted public health institutions.

Table 8 showed that 22 (9.1%) respondents had given birth, the delivery took place at private clinics, government hospitals, and health centers, while, 6(2.4%) of them took place at home. The mean age of delivery was 17.77 (*SD* = .75). The RH problems were also discussed in FGDs. The female FDG group defined RH as unwanted pregnancy and abortion. RH problems were raised and defined as unwanted pregnancy due to unprotected sex. STIs, psychological and physical trauma commonly appear due to unwanted pregnancy and resulting unsafe abortion. The female FGD groups had agreed that adolescents were victims of RH problems and commonly girls of 14-16 years were the most affected. The reasons for the occurrence of RH problems are desire for material benefit from male partner such as money, being cheated by elderly men, and failure to use contraceptives.

Reproductive health service preference. Regarding the professionals who served the adolescent, the summary of data indicated that the majority of the respondents 153(60.7%) preferred young service provider of the same sex, followed by 84(33.3%) preferring young service provider of any sex. Besides, 146(57.9%) respondents claimed that the service for adolescents should be free, 76(30.2%) and 30(11.9) responded with special discount and at the usual rate, respectively. Proximity took the highest percentage 98(38.9%) when preference was assessed in relation to the place in which they got the services. Furthermore, 86(34.1%) also preferred the place where low cost of treatment was provided. About 32(12.7%) responded that they prefer free treatments areas. Regarding the location of health service institutions, the majority of the respondents 105(41.7%) preferred near to their residence and 91(36.1%) preferred at the center of the city, the rest 50 (19.8%) and 6(2.4%) preferred far away from their residence and anywhere out of resident area, respectively. A scan be seen in Table 9, when preference was assessed by service frequency, the majority 56 (22.2%) of the adolescents had reported IEC or BCC service in the first rank, then counseling service which was about 74(29.4%) in the second rank and 58(23%) of the respondents responded that they preferred frequently VCT services.

Table 9

Preference by Service Frequency (N = 252)

Preference for Services	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
IEC and BCC Services	56(22.2%)	25(9.9%)	24(9.5%)
Counseling Service	51(20.2%)	74(29.4%)	43(17.1%)
VCT Service	49(19.4%)	36(14.3%)	58(23%)
STI diagnosis and treatment	19(7.5%)	24(9.5%)	20(7.9%)
Recreational Service	30(11.9%)	20(7.9%)	24(9.5%)
Library Service	6(2.4%)	37(14.7%)	21(8.3%)
Family Planning Service	11(4.4%)	3(1.2%)	22(8.7%)
Safe Abortion Service	–	24(9.5%)	2(.8%)
To Check for Unwanted Pregnancy	32(12.7%)	5(2%)	2(.8%)

Note. IEC = Information Education and Communication; BCC = Behavioral Change Communication; VCT = Voluntary Counseling and Testing

Reproductive health service accessibility. Out of 252 participants, 234(92.9%) reported that they had visited health institutions and 18(7.1%) had not (Table 10). More than half of the respondents 55.2% reported that the existing health institutions in their locality were not welcoming them when they needed the services (Table 10). The chi-square analysis also confirmed that statistically significant differences as depicted in Table 10.

Table 10

Accessibility Issues (N = 252)

Questions	Response	*f*	*%*	χ^2
Have you ever visited a health institution?	Yes	234	92.9	185.14*
	No	18	7.1	
Do the existing health institutions welcome you when you need the services?	Yes	92	36.5	9.56*
	No	139	55.2	

*$p < .05$.

As mentioned in Table 11, 49(19.4%) visited health institutions to get condom, 27(10.7%) visited due to the occurrence of unwanted pregnancy, and 24(9.5%) for the treatment of STIs in the first rank. Table 11 also shows that 22(8.7%) had visited to get condom and 18(7.1%) for abortion service in the second rank. In support of this, discussion in male FGD pointed out that health institutions were visited to get condom and treatment for STDs, while, female FGD indicated that those institutions were visited for unwanted pregnancy and contraceptives. Similarly, participants of FGD were of the opinion that condom should be distributed in recreational areas, meeting

places, schools, public offices, Kebele associations, and bus stations, in addition, to the usual distribution areas.

Table 11

Reasons for Visiting the Health Institutions (N = 252)

Reasons	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
I had STIs	24(9.5%)	14(5.6%)	4(1.6%)
For abortion	5(2%)	18(7.1%)	5(2%)
For delivery	6(2.4%)	4(1.6%)	7(2.8%)
For ante-natal care	3(1.2%)	11(4.4%)	2(.8%)
To get contraceptives	19(7.5%)	9(3.6%)	8(3.2%)
To get condom	49(19.4%)	22(8.7%)	2(.8%)
I had unwanted pregnancy	27(10.7%)	4(1.6%)	4(1.6%)

The frequencies of institution visited mostly as reported by respondents include 76(30.2%) Family Guidance Association of Ethiopia' (FGAE) clinic and 72(28.6%) visited public health institutions as the first options. Public health institutions and private health sectors were the two major institutions of the respondents visited in the second rank (Table 12). The result of FGD also supported that Family Guidance Association of Ethiopia' clinic in the first place and health centers in the second place were among frequently visited institutions for RH services.

Table 12

Institutions Visited for Reproductive Health Services (N = 252)

Type of Institutions	Rank 1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
Pharmacy	19(7.5%)	25(9.9%)	16(6.3%)
Private Health Sector	29(11.5%)	56(22.2%)	31(12.3%)
Public Health Institution	72(28.6%)	74(29.4%)	17(6.7%)
Family Guidance clinic	76(30.2%)	50(19.8%)	30(11.9%)
Mary Stop International Clinic	2(0.8%)	2(.8%)	10(4%)
Traditional Healer in Neighbor	13(5.2%)	8(3.2%)	10(4%)
Drug Vender	22(8.7%)	13(5.2%)	24(9.5%)

Among the common obstacles that prevent adolescents from getting clinical and counseling services in health institutions were primarily too far health institution 71(28.2%) and poor handling by

health workers 66(26.2%)in the first rank. The inconvenient health institutions 74(29.4%) and too much waiting time to get services 73(29%) were also the obstacles mentioned mostly by the respondents in the second rank (Table 13). This implies that adolescent's RH problems area not only resulted from lack of use of the existing services, but also the existence of different obstacles.

Table 13

Obstacles that Prevent Adolescent from Accessing Reproductive Health Services (N = 252)

Obstacles for Accessing RH Services	Rank		
	1st	2nd	3rd
	f (%)	*f (%)*	*f (%)*
Too far health institutions	71(28.2%)	15(6.0%)	23(9.1%)
Too expensive services	23(9.1%)	18(7.1%)	26(10.3%)
Providers fail to keep privacy & confidentiality	10(4.0%)	33(13.1%)	2(0.8%)
Poor handling of health workers	66(26.2%)	35(13.9%)	33(13.1%)
Too much waiting time to get the service	54(21.4%)	73(29%)	49(19.4%)
The health institutions are inconvenient /not conducive.	27(10.7%)	74(29.4%)	65(25.8%)

The findings about accessibility and available services as reported above were also supported in the FGDs. It was reported that among the existing youth centers, only Family Guidance Association of Ethiopia' clinic's youth center was providing RH services for adolescents. The two government youth centers were not rendering the required RH services. They were not equipped with the necessary materials and the professionals who provided the services were not assigned. The FGDs showed that accessibility could be expanded by establishing more youth centers and the activities of existing youth centers could also be expanded. For instance, the existing government youth centers should be strengthened. Mostly men were utilizing RH service more than females. Therefore, female should be encouraged to reach at these service areas.

In addition, men were observed making women vulnerable to RH problems by misusing condoms and forcing them for unwanted sex. Similarly, insufficiency of currently existing youth centers was well discussed and that few numbers of youth centers in Adama city limited accessibility for RH services. Regarding the organization of

the youth centers for future, it was suggested that, more youth centers should be established in every corner of the city to improve accessibility. The centers should be provided with trained professionals and material resources. Provision of non RH activities such as trauma management can strengthen accessibility.

As shown in Table 14, the majority 116(46%) of the adolescents had reported that they preferred health services for adolescents to be delivered during usual working hours, at week-end, and after 5:00 pm. About 51(20.2%) of them reported that they preferred during the usual health institutions' working hours and 39(15.5%) of the respondents preferred after 5 pm. This implies that the result that the majority of adolescents desired to have the required service any time they desired to have it.

Table 14

Convenient Time of the Day for Adolescents Health Service Provision

Convenience of Time	*f*	%
During the usual health institutions' working hours	51	20.2
On the special hours when other users are not around	31	12.3
At weekends	15	6.0
After 5 pm	39	15.5
During the usual health institutions' working hours, at weekends, after 5 pm.	116	46.0
Total	252	100.0

Recommendations

Since adolescents' RH related problems are widely observed in Adama city, no single governmental or nongovernmental organization can unilaterally solve this issue effectively unless cooperated with each other. Therefore, active participation and coordination among different stakeholders is required. Local administration should coordinate youth related organizations in the city and particularly in each local administration to give information on where to get adolescence RH services. The service delivery areas should be emphasized in fulfilling the necessary materials and man-power in order to deliver the satisfactory services with consideration of the proximity, service charges, and available services. Women and children as major stakeholders should be provided information on RH by collaborating with local city health office. Educating mothers and girls can decrease RH problems and may change the attitude of the society towards RH. In addition, youth centers should provide

comprehensive RH activities such as RH education, management of STIs/HIV/ AIDS, services of RH with confidentiality, and good encouraging behavior could reduce adolescent RH problems.

Conclusion

This study showed that despite having sufficient information on RH issues, the adolescents were facing different RH problems. The age at first sexual debut was too early, especially, for female adolescents. Some had sexual intercourse with two or more partners. There was also a less utilization of condom and other contraceptive methods even after first sexual practices, which was leading cause for unwanted pregnancy, unsafe abortion, and STIs/ HIV/AIDS. This indicates that RH problems widely exist and even increasing. The result of the FGDs indicated that condom should be distributed in recreational areas, meeting places, schools, public offices, local associations, and bus stations, in addition, to the usual distribution areas. Regarding the preference issues, the result indicated that in all preference approaches special emphasis should be given to their needs to tackle their RH problems. Many adolescents were not served in the existing health institutions for their RH needs. Those who have got access to it claimed that the existing health institutions were inconvenient and unattractive, professionals did not respect the clients, and waiting too long were the obstacles facing the adolescents. Additionally, the existing youth centers did not provide the RH services according to the preference of the target groups. Almost all of the respondents suggested the need for re-arrangement of youth RH institutions, exclusively.

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