Awareness, Utilization and Barriers of Sexual Reproductive Health Service among Adolescent Age 15-19 YRS Old in Arsi Zone Oromia Region Ethiopia

Solomon Tejineh[1*] and Hailu Fekadu[1]

Department of Public Health, College of Health Science, Arsi University, Asela, Ethiopia

[*]Corresponding author: Solomon Tejineh .Email; stejineh@yahoo.com

Abstract

Background: In Ethiopia most of sexual reproductive health services are design for adults and they have no favorable condition for youth to utilize the service. Study conducted in Ethiopia indicated that only32% of youth utilized reproductive health service.

Objective: To assess awareness, utilization and barriers of sexual and reproductive health service among adolescent age 15-19 old years in selected district of Arsi zone, Ethiopia.

Methods: community-based cross sectional study supported with qualitative study design conducted among 734 youth reside in Arsi Zone, Oromia region, Ethiopia. Systematic random sampling technique was used to select the study participants, while purposive sampling used to select focus group. Data entry and analysis were carried out by EPI-info version 3.5.4, and SPSS version 21. Multivariate logistic regression analysis was performed to test significant level and association of variables with 95% confidence interval and p-value <0.05 was taken as statically significant.

Result: Out of 734 participants**,** 331 (43.7%) of adolescent had awareness about youth sexual and reproductive health service. The overall utilization of

sexual reproductive service of adolescents were 30.1%. Adolescent had Pocket money AOR=1.73, 95% CI: 1.14- 2.80, adolescent accessed or near by the service AOR=2.53, 95% CI: 1.35- 4.45 were significantly associated with utilization of the services.

Conclusion: This study had found that majority of adolescents were not utilizing the reproductive health service of adolescent. Among the factors that affect utilization of sexual and reproductive health service of adolescents were, Adolescent have pocket money and adolescents easily access sexual and reproductive health prone to more utilize the service than their counter parts. To improve utilization, awareness and accessibility of services the responsible bodies like, government, ministry of health, the regional government, the local leaders and parents should be actively involved in the program.

Key words: Young people**;** Adolescent, Awareness, Utilization, Barriers, Sexual and reproductive health.

Introduction

Adolescence is defined as the period between10 and 19years of age. It is a continuum of physical, cognitive, behavioral and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive in dependence from adults (Save the children, 2009).

The need of adolescent sexual reproductive health (ASRH)had grown from time to time in Ethiopia, the cohort of young people in Ethiopia makes up

25% of the total population, the sexual reproductive health of young people is directly affected by the socio-cultural and economic context in which they live, and this young section of the population in Ethiopia is faced with multiple and interrelated social, economic and health problems due to lack of accessible sexual and reproductive health services (FMoH, 2011).

Young people in Ethiopia face greater reproductive health risks than adults, despite efforts that were made on youth to utilize reproductive health service; studies show that there is little information about the extent to which youth utilize available health services. For the proper planning of appropriate health services for youth, it is crucial to have knowledge on the pattern of their use and its associated factors (Abebe M, 2014).

Adolescents' access and utilization of sexual and reproductive services is limited due to socio-cultural norms and taboos (leading them to fear and feel shame), judgmental attitude of service providers, lack of confidentiality and privacy, costs and lack of sexual reproductive health knowledge, and unfavorable attitude of parents and negative community perceptions towards health seeking behaviors of adolescents (Ayehu A, 2016).

Despite the mass media and community mobilization efforts that engage parents, school teachers, community and religious leaders to promote health services for reproductive health, little is understood about their influence on adolescent knowledge and attitude towards health services for RH, as segmentation of interventions is desirable to address the diverse needs and contexts of adolescents' lives (Ayalew T, 2008). The Ethiopian government developed national adolescent and youth reproductive health strategies in addition to the health extension program ,adolescent reproductive health

strategies were included to promote adolescent sexual and reproductive health service utilization in urban and rural setups .Despite those efforts done ,there is little information about ASRH service utilization and factors that affects its utilization in both urban and rural adolescents (FMoH, 2016).

Investing in the health of adolescents helps to prevent the estimated 1.4 million deaths that occur globally every year due to road traffic injuries, violence, suicide, HIV and pregnancy related causes, it can also improve the health and well-being of many millions of adolescents who experience health problems such as depression, anemia or HIV infection; and promote the adoption of healthy behaviors that help prevent health problems that occur later in life, such as cardiovascular diseases and lung cancer resulting from physical inactivity and tobacco use initiated during adolescence. Finally, investing in adolescent health can prevent problems in the next generation such as prematurity and low birth weight in infants born to very young mothers (WHO, 2009).

Pregnant girls face a higher risk of maternal morbidity and maternal mortality than adult women and girls between 15 and 19 years of age are two-timing more likely to die during pregnancy than women 20 years of age or older (WHO, 2011). Preventable complications arising from pregnancy and childbirth are the leading cause of death amongst adolescent girls in developing countries. In addition, three million unsafe abortions occur annually amongst girls between 15 and 19 years of age (WHO, 2011). Contrary to popular beliefs, there is a significant burden of disease during the adolescence years. Indeed, nearly 35% of the global disease burdens have their roots in adolescence (WHO, 2016). Today there are 1.2 billion

adolescents worldwide with nearly 90% of them living in developing countries (UNICEF, 2012).

It is during adolescence that young people develop the physical capacity to have sex and reproduce. They also experience an increasing interest in sex, learn social and relationship skills, develop their own sexuality and sexual identity, and, for many, adolescence marks the onset of sexual activity. However, this transition also occurs during a time when young people may not have fully developed impulse-control or rational decision-making capacity. This contributes to a period of vulnerability, when young people take risks but may not have the knowledge and life-skills necessary to be able to negotiate safe and consensual sex (WHO, 2015).

Methods

Study design and setup

Community based cross sectional study supported with qualitative study design was undertaken in Arsi Zone Oromiya region, Ethiopia, from January to May, 2017. Assela the capital town of Arsi Zone, is located 175 km from South East of Addis Ababa. The zone shares boundaries with East Showa, West Hararghe, Bale zones, and west Arsi zone. The Arsi zone administratively, divided into 24 districts and 2 administrative towns. Having an area of 23,679.7km. Based on 2007 Housing and population census, the total population of Arsi zone projected was 3,280,667 million in 2016, of which 90% of the population is estimated to be rural residents.

Sample size determination and sampling procedure

The sample size (n) required for this study was calculated using single population proportion formula by taking the proportion (p) of utilization of sexual reproductive health in Bahirdar , 32 % , with 95% confidence interval ,5% margin of error and using 2 design effect . By adding 10% of non-response rate the final sample size was 734 adolescents.

Multi-stage sampling technique used to select the study subjects. First, 3 woredas were selected using simple random sampling technique from 24 available woredas. Then, 3 kebeles were selected from each woredas randomly. Finally, sample size was allocated proportional to the household of each kebeles. The first household from each kebele was identified using lottery method, and then, systematic random sampling technique was applied to identify the next household followed North, East, South and West direction at the interval of every fourth house hold**.**

Qualitative study

To triangulate quantitative and qualitative study for having an in depth understanding, two focus group discussion were conducted among purposely selected 12 adolescents for each group. Open ended/guiding questionnaire, two sessions of FGD were undertaken to explore cultural and social experience of the adolescent regarding utilization of sexual reproductive health service and their reasons. After explaining the purpose of the study and obtaining informed consent the focus group discussion conducted by principal investigator and note taker.

Data quality control

The data collection instrument was pretested on 5% of the total sample size in other district not selected for actual study but have similar setup. Adjustment of the tool was made based on the assessment of its appropriateness. Training of data collectors who have previous experience of data collection, data clearing and editing, and strict supervision of data collectors and commenting the problems at spot was made. Rechecking was made before the analysis of the data.

Operational definition

Utilization: The ability to access and make use of, one or more sexual and reproductive health services that are available.

Adolescent(s): According to this study young people who are in the age group between 15-19 years old.

Youth Friendly Reproductive Health Service: Services that is accessible, acceptable and appropriate for the youth.

Reproductive health: a state of complete physical mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes.

Data entry and analysis for qualitative parts

The data was entered by Epi Info version 3.5.4 statistical package and then exported to SPSS version 21 for analysis. Association between dependent and independent variables were assessed by using logistic regression. Bivariate binary logistic regression analysis was also used to identify factors associated with birth preparedness and complication readiness. Variables

with p-value of ≤0.25 were considered as candidate variable for multivariate analysis. Significance level and association of variables were tested by using 95% (C.I) and OR. P-value less than 0.05 were taken as statistically significant.

Analysis of qualitative data

To analyze the qualitative data obtained from focus group discussion the data immediately transcribed and written in narrative forms supplemented by notes taken during the focus group discussion. Finally, results were extracted and written into summery findings.

Ethical consideration

An ethical clearance letter was obtained from Arsi University college of health science ethical review committee, district administrative, and kebele administrative. Finally, the objective of the study and the procedure was explained to the study participants that no harm happen on them when the study was conducted. Norm of the community was considered and respected in the process. Information from the respondents were treated confidentially. Confidentiality was ensured by keeping sensitives information of the study participants found in data collecting tools. The information collected were keep confidentially not to make accessible to anyone. Code was used instead of name of participants throughout the study process to identifies the participants.

Result

Socio- demographic characteristics of the respondents

Response was obtained from all 734 adolescents making the response 100%. Among the participants 362 (49.3%) were male and 372 (50.3%) were female. Three hundred eighty-three (52.2%) were in the age group of 17-19 years old and 351(47.8%) were between the age of 15-16-year-old. The mean age of the adolescent was 16 years old with the standard deviation of 1.35± years. Religious distribution of the respondents 372(50.7%) were orthodox Christian and 362(49.3%) muslin. Six hundred fifteen (83.8%) of the respondents were Oromo followed by 98(13.4%) Amhara.

Concerning the educational status of the participants 410(55.9%) were attend primary education while 208 (28.8%) in secondary. Out of 734 respondents 455 (62%) were living with both parents, 142 (19.3%) living with one of their parents and the others 90(12.3%) were living with relatives. Related to participants pocket money majority of 433 (59 %) had no pocket money and 301 (41%) had pocket money (Table 1).

Table 1: Socio-demographic characteristics of adolescent of Arsi zone selected district, May, 2017

Variables	Frequency (n= 734)	Percentage
Age		
Mean age 16.7±1.35		
15-16	351	47.8
17-19	583	52.2
Sex		
Male	362	49.3
Female	372	50.7
Current educational status		
Never read &write	31	4.2
Read &write	40	5.4
Primary education	410	55.9
Secondary education	208	28.3
College &above	45	6.1
Religion		
Orthodox	372	50.7
Muslim	255	34.7
Protestant	107	14.5
Ethnicity		
Oromo	615	83.3
Amhara	98	13.4
Others	21	2.86
Living characteristics		
With both parent	455	62
With single parent	142	19.3
With relative	90	12.3
With others	47	6.4
Pocket money		
Yes	301	41
No	433	59
Father education		
Never read &write	200	27.2
Read &write	149	20.3

Primary education	264	36
Secondary education	75	10.2
College &above	46	6.3
Mother education		
Never read &write	294	40.1
Read &write	187	25.5
Primary education	191	26
Secondary education	45	6.1
College &above	17	2.3

Awareness, accessibility and availability of service for SRHS for adolescents

Among 734 participants 321 (43.7%) were have awareness about the health facility that gave sexual and reproductive health service for adolescent. From 321 (43.7%) those have awareness about sexual and reproductive health services the first common source of information the adolescent to get the awareness of sexual and reproductive health service was peer 125 (38.9%) followed by school teacher 119 (37.1%), and the list source of information was television 13 (4.05%). This was further evident in qualitative data where adolescent did not get more information by mass media like radio and television rather than peers. A 16 years old female adolescent said that *"Mass medias like Radio, Television didn't address the issue of sexual and reproductive service of adolescent, so government should need to plan media coverage to increase awareness of adolescent"*.

About 264 (82.2%) of respondents can easily access sexual and reproductive health services given for adolescents. Two hundred twenty-six (70.4%) of adolescents the service were always available for them. Among the health institutions that give sexual and reproductive health services most of the

participants 278(86.9%) were use public health center and public hospital 22 (6.9%).

Table 2: Awareness, accessibility and availability of service for SRHS for adolescents in selected district of Arsi zone May, 2017

Variables	Frequency n= 734	Percentage
Awareness of SRHS		
Yes	321	43.7
No	413	56.3
Source of information for SRHS n=321		
Friends /peer	125	38.9
Teachers	119	37.1
Parents	34	10.6
Radio	30	9.35
Television	13	4.05
Easily access service N=322		
Yes	266	82.2
No	56	17.8
Service availability at all time		
Yes	226	70.4
No	95	29.6
Types of accessible service		
Public health center	278	86.9
Public hospital	22	6.9
Private health facility	13	4
Youth center	8	2.5

Service offered and utilization of sexual and reproductive health services of participants

Out of the total respondents 213 (66.6%) of them identified as family planning services were offered by sexual and reproductive services, 52 (16.2%) voluntary and counseling test of HIV/AIDS, 26 (8.1 %) treatment of all diseases, 7 (2.2%), care of pregnant for young lady ,17 (5.3%) counseling on general health information, 3 (0.9%) sport and recreational activity. The experience of sexual and reproductive health service utilization out of 734 participants 221 (30.1%) utilized adolescents sexual and reproductive health services. Of 221 who utilized the services, 96 (43.7%) were utilized contraceptive, 65(30%) voluntary counseling and testing of HIV/AIDS, 52 (23.5) treatment of disease, 6 (2.7%) general health service. As it is mention above very limited number of adolescents mentioned some very important services given in sexual reproductive health services. This was also supported by focus group discussant, 19 years old female adolescent mention that: "*Due to lack of adequate information it is very difficult to identify which services given in the sexual and reproductive health service of adolescents, so health professionals and concerned body should need to give information to the adolescents to utilize sexual and reproductive health services at all level ".*

Table: 3 Identifying services offered and utilization of sexual reproductive health services for adolescent in Arsi zone selected district, 2017

Variables n=320	Frequency	Percent
Identifying Service afford by SRH		
Contraceptive /condom	213	66.6
Voluntary counseling &testing of HIV/AIDS	51	15.9
Treatment of all disease	26	8.1
General health information	17	5.3
Care for pregnant young	7	2.2
Sport &recreational activity	3	0.9
Utilization of any of sexual &reproductive health n= 734		
Yes	221	30.1
No	513	69.9
Types of service utilized by the respondents n= 221		
Contraceptive	96	43.4
Voluntary counseling &test of HIV/AIDS	65	29.4
Treatment of diseases	52	23.5
General health information	6	2.7

Barriers of sexual and reproductive health service utilization of adolescents

From study participants 193 (26.3%) were missed the service .The reason why they missed the service after they arrived were found 83 (43%) seen by neighbor and felt ashamed, 43 (22.3%) had no money, 26 (13.5) the clinic was closed, 24 (12.4%) the queue was long 17 (8.8%) were refused by health professional. Others reason not to utilize sexual and reproductive health service were 124 (16.9%) fear of parents, 126 (17.2%) lack of confidentiality, 74 (10.1%) health service fees was expensive.

The distance of sexual and reproductive health services from the adolescent were 135 (18.4%) within walking distance, 426 (58%) thirty minute walk, 105 (14.3%) one hour walk, 68 (9.3%) outside of place of resident .concerning preferable sexual and reproductive health service for adolescent were 98 (13.1%) existing health service special approach to the adolescent , 211 (28.7%) special room within existing service, 224 (30.5%) in separate adolescent health institution, 125 (17%) in school health service, 78 (10.6%) in youth center. The above mentioned constraints like lack of separated place of the sexual reproductive health for adolescent ,poor approach with parents discuss on the issue of sexual and reproductive health and lack of confidentiality are inhabited service utilization , this is also supported by the discussant of focus group;

"A 17 years old female adolescent said, since the service is not given separately from adult in the health institution most of the adolescents missed the service by feeling ashamed seen by one of the relatives "

Table 4: Barriers of sexual and reproductive health service utilization of adolescents in selected district Arsi zone May, 2017

Variables	Frequency	Percentage
Participants missed service n=734		
Yes	193	26.3
No	541	77.7
Reason to miss the service n=193		
The queue was long	24	12.4
Had no money	43	22.3
Fond neighbor &felt shame	83	43
Refusal by service provider	17	8.8
The clinic was closed]]	26	13.5
Reason not to utilize SRHS n=734 Fear of parent	124	16.9
Yes	610	83.1
No		
Lack of confidentiality	126	17.2
Yes	608	82.8
No		
Service fee was expensive		
Yes	74	10.1
No	660	89.9
Distance of health institution n=734		
Walking distance	135	18.4
30-minute walk	426	56
1hour walk	105	14.5
Outside residence	68	9.3
Preference service for adolescent		

Existing H.S with special approach	98	13.1
Special room with existing service	211	28.7
In separate adolescent H.I service	224	30.5
In school health service	125	17
In youth center	78	10.6

Professional preference and service fee for adolescents sexual and reproductive health services

Related to preference of professional during seeking service by adolescent were 293 (39.9%) young of the same sex, 213 (29%) young of any sex, 144 (19.6%) matured and the same sex, 84 (11.4%) mature and any sex. Sexual and reproductive health service fee preference among the adolescent were most of 354 (48.2%) choose free of charge for adolescent, 275(37.5%) special discount, 93 (12.7%) at the usual rate, 12 (1.6%) they don't know to judge about service fee.

The preferable distance of sexual and reproductive health service among the respondents most of them 603 (82.2%) preferred near residency area, 102 (13.9%) outside residency area, 29 (4%) they don't know which distance preferable for them. the convenient time to utilize the service 281(38.3%) were early in the morning, 209 (28.5%) afternoon, 148 (20.2%) week end, 64 (8.7%) evening, 32 (4.4%) the convenient time were holiday. Service accessibility and convenient time is crucial point to address the need of utilization of sexual and reproductive health of adolescents this is also supported by the participant of focus group discussant eighteen years old male adolescent *:" since most of adolescent live in place where they are not*

accessed and lack of information for youth friendly services and appropriate health professionals, so it is better if emphasis is given for the youth who are living in marginalized group of population to address their sexual and reproductive health needs ".

Table 5: Service provider preference, service fee and distance of SRH for adolescents in selected district of Arsi zone May, 2017

Variables	Frequency	Percentage
Service provider preferable for adolescent		
Young of the same sex	293	39.9
Young and any sex	213	29
Matured and the same sex	144	19.6
Matured and any sex	84	11.4
Affordable service fee		
At the usual rate	93	12.7
Discount for adolescent	275	37.5
Free of charge	354	48.2
Don't know	12	1.6
Appropriate distance of SRH		
Near residence area	603	82.2
Outside of residency area	102	13.9
Don't know	29	4
Convenient time for SRHS		
Early in the morning	281	38.3
Afternoon	209	28.5
Evening /night	64	8.7

Weekend	148	20.2
Holiday	32	4.4

Factors associated with utilization of sexual and reproductive health services of adolescent

A logistic regression analysis was done to identify factors that have association with utilization of adolescent on sexual and reproductive health service. Among socio demographic and socio-economic factors pocket money were found to have statically significant association with utilization of sexual and reproductive health services, but respondents' age, sex religion, ethnicity and educational status of respondents and parents were not statically significant. Other respondents like easily access to sexual and reproductive health service, type of service providers, time preference and confidentiality were having statically significant association.

In the bivariate analysis those respondents have pocket money more likely to utilize sexual and reproductive health services than their counter parts (COR=1.74, 95% CI: 1.06, 2.80). Easily accessed adolescent to sexual and reproductive health services more utilized the service with (COR=2.48, 95%, CI: 1.38, 4.48).Respondents preferred afternoon time to utilize sexual and reproductive health service of adolescents more likely to utilize SRHS services (COR=2.53, 95% CI: 1.02, 6.28). Participants preferred the young and the same sex of sexual and reproductive health services providers more likely to utilize the service (COR=2.22, 95% CI: (1.042, 4.75).

In multi variate analysis adolescent have pocket money and easily access the service were found to have statistically significant association with

utilization of sexual reproductive service of adolescent. Adolescent have pocket money more utilize the service than adolescents did not have pocket money (AOR=1.73, 95% CI: 1.14, 2.80) Adolescents easily accessed sexual reproductive health service were more likely to utilized the service than their counter parts (AOR=2.53, 95% CI: 1.35, 4.45).

Table 6: Bivariate and multi variate analysis of factors affecting adolescent reproductive health service utilization among adolescents in Arsi zone selected woreda, May, 2017

Variables	SRH utilization	COR, 95%CI	AOR, 95%CI	P.V < 0.05
Got pocket money				
Yes	301(41%)	1.74(1.06,2.80) *	1.73(1.14,2.80) **	0.023
No	433(59%)	1	1	
Easily accessed SRH				
Yes	320(43.6%)	2.48(1.38,4.48) *	2.51(1.37,4.56) **	0.03
No	414(56.5%)	1	1	
Convenient time				
Early morning	281(38.3%)			
Afternoon	209(28.5%)	2.53(1.02,6.28) *	0.36(0.12,1.05)	0.5
Evening	64 (8.7%)	1	1	
Weekend	148(20.2%)			
Holiday	32 (4.3%)			
Service provider preference	293(39.9%)			
Young of the same see	213(29%)	1.85(0.64,3.02)*	2.22(1.04,4.75)	0.4
Young& any sex	144(19.6%)			
Matured &the same	84(78.6%)			

***= significant at p< 0.05**

Discussion

This study was conducted to assess sexual and reproductive health service awareness, utilization and barriers among adolescents age 15 to 19 years old in selected district of Arsi zone. From the finding of the study awareness of sexual and reproductive health service of adolescent was 43.7%. This finding is greater than the study conducted in Nigeria in 2016 the awareness of adolescent on sexual and reproductive health service was 27% and it is less than the study done in Badewach district Hadiya zone Ethiopia in 2014 which was 50% Gonder 93.4% (Kiran B, 2015; Abiodun O, 2016).

Related to source of information for sexual and reproductive health service among the adolescent the participants mentioned that friend /peer, school teachers, parents and mass media like Radio, Television as their source of information. The most popular source of information was peer 38.9% followed by school teacher 37.1% ,radio 9.4% and the least source of information was television 4% .The finding was less than the study conducted in Gonder town the most popular source of information of sexual and reproductive health service of adolescents was peer 88.5% and Pakistan 71% .This is may be due to lack of peer educators and still adolescents in the study area didn't get an opportunity to exchange information on sexual and reproductive health issues with their peers (Sinafikish A, 2013; Sarosh I, 2017).

Utilization of sexual and reproductive health service of adolescent is prerequisite to have healthy and productive youth. This study revealed that 30.1% of study participants utilized sexual and reproductive service of adolescent at least once preceding the survey. This finding is less than the study conducted in Dejen district Ethiopia which is 45.5% (Dagnew T, 2012). The reasons why the difference between the two studies may be due

to lack of awareness creation program in the study area. Among adolescent utilized the service most of them 66% identified as family planning service was the first line service given by sexual and reproductive health service, but the similar study finding in Harar town show that the most identified service by adolescents given by sexual and reproductive service was STIs including HIV/AIDS which was 57.4% (Aboma M, 2016).

From those participants get access to sexual and reproductive health services greater number 86.9% were use governmental health centers. It is also positively associated with utilization of sexual and reproductive health service that accessed the service. The result of this study was greater than the similar study in Nigeria most of adolescent utilize private health institution but access and utilization of governmental health institution were 37.8% .The finding difference can be due to socio demographic characteristics difference that most of the private health institute in Ethiopia their service cost is not affordable for adolescents (Omobuwa O, 2012).

Barriers embedded in the perception of the community still hinder adolescents to utilize sexual and reproductive health services. Among the reason to miss service utilization in this study majority of 43% afraid of seen by parents and neighbors felt ashamed .The similar study in Burkina Faso, Ghana, Malawi and Uganda revealed barriers to getting sexual and reproductive health service note that the adolescent mentioned more than one barriers some of them were feeling afraid, embarrassed or shy were 42% to 64% (Ann E, 2007). The issue of confidentiality has also a great impact on SRHS utilization, about 17.2% participants reported that as one of the reason not to utilize the SRHS. The finding of this study was less than similar study

in Nepal which is 71% of adolescents didn't use the service due to fear of confidentiality (Kiran B, 2015). The distance or accessibility of sexual and reproductive health service from adolescent is a key element to utilize SRH service. The maximum distance of the SRH service from the adolescent residential area were one hour for 14.3% of adolescent on foot walking .this was less than the study finding conducted in Hadiya zone Ethiopia the maximum walking distance were two hours for 10.5% of adolescents .This difference may be due to increase number of health of institution due to time variation (Niguss C, 2015).

To enhance sexual and reproductive health service utilization of the adolescent making the service friendly to the adolescent is indispensable, in this study related to preference of service providers nearly about 40% of adolescent preferred the service provider of young of the same sex. Due to limited number of untrained and high turnover of the youth friendly health providers, still it is one challenge for adolescents to seek the service without fear. The same thing was also true by the study conducted in Ghana and Nigeria on meeting of health service need of adolescent, about 17.2% of youth , the staff do not well come or approve of the young people to access the service, due to unfriendly nature of the staff they did not visit the service subsequently). In relation to preference of health professional also, according to the study conducted in Nigeria on utilization sexual and reproductive health service of adolescent, more than half of respondents 56.4% had no preference about the sex of health professional while 36.6% preferred health professional. This indicated that shaping sexual and reproductive health service of adolescent based on the preference of adolescent in Africa is mandatory (Saratu O, 2016; Dapaah, J, 2015; Abiodun O, 2016). Among the

factors associated with sexual reproductive health service in this study, adolescent had pocket money were 1.74 times more likely to utilize the service and adolescent had found the service easily accessible to them were two and half times more to utilize the service than their counter parts. The positively associated factors of easily accessible service to utilize sexual reproductive health in this study was less than the finding of adolescent in rural Nepal, adolescents easily access the sexual and reproductive health service were seven times greater than utilized the service than who did not access (Kiran B, 2015).

Conclusion

This study had found almost 70% of adolescents were not utilizing the reproductive health service of adolescent. Among the factors that affect utilization of sexual and reproductive health service of adolescents were, Adolescent have pocket money and adolescents easily access sexual and reproductive health prone to more utilize the service than their counter parts.

Recommendation

To improve utilization, awareness and accessibility of services the responsible bodies like, government, ministry of health, the regional government, the local leaders and parents should be actively involved in the program. Intersectoral collaboration to enhance the service with different organizations, for instance with school, adolescent recreation centers and residential areas is important. The local health institutes should facilitate sustainable sexual reproductive health awareness creating program to fill the awareness gap. Means of income generation or making the service totally free is very mandatory for adolescents to utilize the service.

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