STRATEGIES TO SUPPORT POSITIVE SEXUAL BEHAVIOUR AMONG ADOLESCENTS ATTENDING HIGH SCHOOLS IN ETHIOPIA

by

AMARE BAYEH DESTA

Submitted in accordance with the requirements

for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR JM MATHIBE-NEKE

November 2017

Student number: 57640580

D E C L A R A T I O N

I declare that **STRATEGIES TO SUPPORT POSITIVE SEXUAL BEHAVIOUR AMONG ADOLESCENTS ATTENDING HIGH SCHOOLS IN ETHIOPIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Amare Bayeh Desta **25 November 2017**

ACKNOWLEDGEMENTS

It is a great pleasure to acknowledge certain forms of indebtedness during the work on this research project. First and foremost, I would like to thank The Great Almighty God for giving me the time, courage and strength to complete this endeavor.

I would like to express my deep appreciation and sincere thanks to my supervisor Professor JM Mathibe-Neke, University of South Africa, for her unreserved advice and all rounded support during the whole process of this PhD work. Her great patience, kindness, constructive advice and encouragement are unforgettable. It was indeed a privilege for me to go through the hard task of writing this thesis under her supervision and guidance.

The whole process of the PhD work and writing this thesis report have been a very rewarding experience that I enjoyed. I had the opportunity to participate in many seminars and workshops organized by UNISA and learned quite a lot from different scholars in the field of health studies.

I am highly indebted to Addis Ababa Bureau of Education, Sub-city education offices, all schools, school administrators and adolescents who responded the lengthy questionnaires and group discussions we had during data collection. Without their kind participation this thesis work would never have been possible.

It is also my pleasure to acknowledge my colleagues of JSI/UI-FHS and friends for their support and encouragement during the work on this research project.

It is also my pleasure to extend my gratitude to my brothers and sister for their encouragement during the research work.

My wife (Yehuwalashet) and children (Markon and Sofanias) paid a high price for this work.

Finally, I would like to acknowledge the University of South Africa (UNISA), for its kind assistance in funding the whole research project.

ABSTRACT

The understanding of the patterns of association between positive sexual behaviours and protective factors that have greater impact helps to design appropriate strategies not only on positive sexual behaviour but also for reproductive health outcomes.

The purpose of the study was to explore the protective factors and develop strategies to support positive sexual behaviours among high school adolescents.

A concurrent mixed method research design was employed to explore the protective factors for positive sexual behaviours. A total of 990 adolescent students attending regular classes were selected using systematic sampling technique for the quantitative study and 33 focus group participants for qualitative study. Pre-tested, self-administered questionnaire was used for the quantitative whereas focus group discussions were employed for the qualitative phase. Protective factors were assessed at family, community/ neighbourhood, school, peer and individual levels. Quantitative data was analyzed using SPSS version 23. Descriptive statistics and binary logistic regression analysis were employed to identify protective factors. Variables with significant association in bivariate analysis were entered into logistic regression to control confounding effects. The qualitative data management, analysis and interpretation followed thematic analysis principles. Illuminating verbatim quotations used to illustrate findings.

RESULTS: adolescents follow parents' rules about sexual activities [AOR=0.462, 95%CI: 0.285-0.748], authoritative [AOR=0.075, 95%CI: 0.021-0.265] and authoritarian [AOR=0.091, 95%CI:0.025-0.331] parenting styles were protective factors. Adolescents' communication with parents was more likely to have positive association [AOR=0.56, 95%CI:0.31-0.94] than counterparts. Parental greater monitoring [AOR=0.604, 95%CI:0.38-0.959], clear rules and consequences [AOR=0.378, 95%CI: 0.233-0.613] and need for permission to go anywhere [AOR=0.387; 95%CI: 0.235-0.637] were significantly associated.

School performance [AOR=0.141, 95%CI:0.055-0.362], perception that teachers are supportive [AOR=0.447, 95%CI:0.266-0.752], sex education [AOR=0.424, 95%CI: 0.243-0.742], people approved contraceptive use [AOR=0.319, 95%CI: 0.165-0.619] and discussion with health workers on sexuality AOR=0.545, 95%CI:0.318-0.932] were strongly associated with positive sexual behaviour. Positive sexual behaviour associated with peer influence resulted in preferred later sexual debut [AOR=0.444, 95%CI: 0.248-0.797] and bonding with peers AOR=0.531, 95%CI: 0.327-0.862].

CONCLUSION: protective factors are not utilized to build positive sexual behaviours of adolescents. Parental and adults' knowledge gap, social norms and weak integration of sexual behaviour and reproductive health activities at each domain hinder positive sexual behaviour. Strategy promoting positive sexual behaviour were proposed.

KEY WORDS: Adolescents; positive sexual behaviour; high school; strategy; support.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

LIST OF ABBREVIATIONS

AA	Addis Ababa
AIDS:	Acquired Immune Deficiency Syndrome
AOR	Adjusted Odds Ratio
ASRH	Adolescent Sexual and Reproductive Health
CAMH	Child and Adolescent Mental Health
CDC:	Centre for Disease Prevention and Control
CI	Confidence Interval
CSA:	Central Statistics Agency
DHS	Demography and Health Survey
FGD	Focus Group Discussion
FHAPCO:	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
FMOH:	Federal Ministry of Health
HIV:	Human Immune Deficiency Virus
HSTP	Health Sector Transformation Program
IAWG	Inter-Agency Working Group
JSI/UI-FHS	John Snow inc/ Family Health Services
MWCY	Ministry of Women, Child and Youth
NICE	National Institute for Health and Clinical Excellence
PhD	Doctor of Philosophy
PPS	Probability Proportionate to size
SPSS	Statistical Package for Social Science
SRH:	Sexual and Reproductive Health
SRE	Sexual and Reproductive Education
STDs:	Sexually Transmitted Diseases
STIs:	Sexually Transmitted Infections
TOT	Training of Training
UN	United Nations
UNAIDS:	United Nations program on HIV and AIDS

UNESCO United Nations Educational, Scientific and Cultural Organization

UNFPA: United Nations Fund for Population Activities

UNICEF: United Nations International Children Emergency Fund

UNISA University of South Africa

US United States

USA United States of America

USAID: United States Agency for International Development

WHO: World Health Organization

X^2 Chi-square

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter provides a general overview of the background information including adolescence and important societal factors to their sexual behaviours. It also provides the overview of research problem, purpose, objective, and questions that the study seeks to address. The chapter also details significance of the study, key concepts and definitions, research paradigm and theoretical framework, research design and method. It also describes the scope of the study and the overall structure of the thesis.

1.2 BACKGROUND INFORMATION TO THE RESEARCH PROBLEM

Adolescence is defined as a period in which a person is no longer a child, and not yet an adult (World Health Organization 2010:11). It is an age of transition when an individual experiences rapid growth and development, both physically and psychologically, and changes from being a child to an adult. The World Health Organization (WHO 2010:12) has defined adolescence as an age of 10 to 19 years.

Adolescents today live in multiple social centres that shape their attitudes and behaviours. One of such forces is globalization of both the “youth culture” and the world’s economy. But there are other forces as well – forces that are more proximal to individual young people including changes at the national and community levels (e.g., the shift from rural to urban living), and in the family, schools, and the workplace (Kristin and Simran 2013:562-572). All of these environments are interconnected in shaping how young people act and interact; and each can be a source of risk or protection to young people.

Historically, the field of adolescent health has focused on those risk factors that predispose to health and social problems. These include Human immunodeficiency virus or sexually transmitted infections HIV/STI acquisition or early pregnancy. Interventions have focused on reducing risk and risky behaviours that lead to poor outcomes (Kristin and Simran 2013: 562-572).

Protective factors are factors that can increase the likelihood of positive health behaviours or outcomes (e.g., using condoms and contraception) or moderate and discourage behaviours that might lead to negative health. Protective factors also include personal characteristics such as a positive view of one's future; frequent parental presence in the home at key times (e.g., after school, at dinner time); and behaviours such as active participation in school activities (CDC 2009: 5).

Protective factors are those that discourage behaviour that could lead to a pregnancy or sexually transmitted diseases or that encourage behaviours that can help prevent them (Kirby and Lepore 2007:2). These factors can be labeled as protective if they either discourage negative behaviours or encourage positive behaviours that might prevent pregnancy or STIs, such as using contraception (Kristin and Simran 2013: *562-572*).

Similarly, factors are labelled "risk" if they increase the likelihood of negative health behaviours and outcomes or discourage positive behaviours that might prevent them (Kristin and Simran 2013: *562-572*).

There is a growing body of research, however, that suggests that one may achieve greater improvement for youth by focusing not only on those factors that predispose to risk, but also on those factors that protect young people from harm or poor health outcomes *(*Kristin and Simran 2013*: 562-572).*

Increasingly research and program experience has shown that it is neither feasible nor productive to focus on one isolated behaviour without addressing a broader set of adolescent sexual and reproductive health concerns. *(*Kristin and Simran 2013*: 562-572).* In addition, there is mounting evidence that the most effective interventions are to enhance protective factors of young people and not to simply attempt to reduce risk. (WHO 2010:3).

A study by Siyan, Krishna, Junko, et al (2010: 477) on the sexual knowledge and practices of adolescents reveals that a substantial number of boys and girls in many developing countries engage in sexual intercourse before their 15th birthday. Early and unprotected sexual initiation can trigger a succession of harmful physical, emotional, and social outcomes, especially for girls. Moreover, compared with adults, adolescents are less likely to have the foresight, skills, cognitive maturity, information, and support they need to protect themselves from unwanted pregnancy, HIV, and sexually transmitted infections.

There are also tremendous individual and societal burdens of many risky adolescent sexual and reproductive health behaviours (e.g., commercial sex work, failure to use a condom when having sex, abusive relationships, polygamy) *(*Kristin and Simran 2013 :562-572). Yamada and Walker (2011: 292-296) states that risky sexual behaviour of adolescents often impose burdens of poor health outcomes (i.e., premature birth, intrauterine the theoretical foundation of the growth retardation, low- birth-weight babies, and prenatal complications). This is related to the behavioural effects and socio-economic costs (i.e., childbearing, single motherhood, impeded school achievement, low education attainment, involvement in teenage pregnancy, poor-earning potential, and future low economic status), and medical costs, including the detection and treatment of sexually transmitted diseases. As a result, risky sexual behaviours among adolescents continue to be a public health priority (Tetsuji, Chia-Ching, John and Martin 2011: 1-12).

Individual factors, such as pubertal development, problem behaviours and attitudes, are often the strongest correlates of adolescent sexual behaviours (Zimmer-Gembeck and

Helfand 2008:153-224). Recognizing that sexuality is an important developmental task of adolescence has resulted in a foundational shift toward a developmental research agenda that focuses on positive sexual health promotion (Zimmer-Gembeck, Ducat and Boislard 2011: 927-938).

Efforts to improve child and adolescent health have typically addressed specific health risk behaviours, such as early initiation of sexual intercourse, tobacco use or violence. However, results from previous studies suggest that greater health impact might be achieved through enhancing protective factors that help children and adolescents to avoid multiple behaviours that place them at risk for adverse health and educational outcomes (CDC 2014:24). Research has also repeatedly shown that a wide range of individual, peer, family, school, and community factors influence sexual decisions (Kirby 2007:2; and Pilgrim and Blum 2015: 5-23).

Parents and other concerned adults cannot control teens' sexual behaviour directly, but they can attempt to affect the factors that influence teens' sexual decisions and behaviour. Logic and experience suggest that the more people know about those factors and the more effectively people address them, the more success they'll have in reducing sexually risky behaviour (Kirby 2007:3:55). Understanding the factors that influence teen sexual behaviour is necessary not only for changing behaviour, but also for identifying teens who are most at risk of having sex and having unprotected sex. First people can use these factors to identify those teens at greater risk; then they can address the important factors affecting teen behaviour (Kirby 2007: 3:55).

1.3 STATEMENT OF THE RESEARCH PROBLEM

According to Tetsuji, et al (2011:1-12); Yamada and Walker (2011: 292-296); and Sasaki and Kameoka (2009: 1886–1892), risky sexual behaviours among adolescents continue to be a public health priority. There is mounting evidence that the most effective interventions for adolescent sexual behaviours is to enhance protective factors and do not simply attempt to reduce risk. Although Adolescent's behaviour is strongly influenced by a range of social, cultural, political and economic inequalities, little is known

in Ethiopia about the patterns of positive sexual behaviours among adolescents attending high schools. Similarly, there are no any evidence regarding the association between positive sexual behaviours and protective factors such as the family, community, peers, school and other institutional structures in enforcing the positive sexual behaviours.

In-depth understanding of patterns of associations with protective factors will promote positive sexual behaviours and enhance development of strategies to support positive sexual behaviours among adolescents.

1.4 RESEARCH PURPOSE

The purpose of this study is to explore the protective factors that enhances positive sexual behaviours and develop strategies to support positive sexual behaviours among adolescents attending high schools in Ethiopia.

1.5 RESEARCH OBJECTIVES

- To explore and describe the patterns of protective factors among adolescents attending high schools in Ethiopia.
- To determine the associations between positive sexual behaviours and the protective factors.
- To propose strategies to support positive sexual behaviours among adolescents attending high schools in Ethiopia.

1.6 SIGNIFICANCE OF THE STUDY

Understanding the patterns of association between positive sexual behaviours and protective factors that have greater impact will help in designing appropriate strategies not only on positive sexual behaviour but also for reproductive health outcomes among adolescents.

As a result, exploring the potential factors or positive assets where adolescents interact with in day-to-day life situations in levels such as family, community, peers, schools and institutional structures will allow policy makers and program managers to develop effective interventions that target those factors known to enhance positive behaviours, and hence, outcomes.

1.7 DEFINITIONS OF KEY CONCEPTS

Adolescent: World Health Organization (WHO) has defined adolescence as an age of 10 to 19 years, and in terms of phase of life marked by special attributes (WHO 2010: 12).

Adolescence: is a period of dynamic change representing the transition from childhood to adulthood and is marked by emotional, physical, and sexual maturation. Habits that are formed during adolescence had major effects in adulthood (FMOH 2007: 43).

Young People: are people of age 15-25 years (Ethiopian social security and development policy 2010:4)

Protective Factors: are factors that can increase the likelihood of positive health behaviours or outcomes (e.g., using condoms and contraception) or moderate and discourage behaviours that might lead to negative health outcomes (e.g., having sex with many partners, having an unwanted pregnancy). Protective factors also include personal characteristics such as a positive view of one's future; life conditions such as frequent parental presence in the home at key times (e.g., after school, at dinner time); and behaviours such as active participation in school activities (Center for Disease prevention and Control: 2009: 5).

Protective factors are characteristics within the individual or conditions within the family, school or community that help young people successfully cope with life challenges.

When youth can successfully negotiate their problems and deal with pre-existing risk factors, they are less likely to engage in problem behaviour such as: substance abuse, violence, suicide, or early sexuality activity. Protective factors are instrumental in healthy development; they build resiliency, skills and connections (Alaska Division of Behavioural Health 2011: 5).

Risk Factors: Factors are labelled **"risk"** if they increase the likelihood of negative health behaviours and outcomes or discourage positive behaviours that might prevent them (Center for Disease prevention and Control: 2009: 5).

Sexual Behaviour: person's sexual practices, i.e., whether she/he engages in heterosexual activity. It deals with all things relating to sex, conception and satisfaction (Kirby 2007:15).

Positive sexual behaviour: person's sexual activity that includes abstinence, late sexual debut, safer sex, use of condoms and contraception, avoiding multiple concurrent sexual partners (Kirby 2007:15).

Adolescent sexual and reproductive health: refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion (FMOH 2007:10).

Safe sex: defined in this study as having safe sexual relationship which includes delaying time of initiating sexual activity or use of contraceptives and condoms to prevent STI's and unwanted pregnancies, avoiding concurrent multiple sexual partners (Amar and Manoj 2010:1-12).

Community: community can be defined in several ways: through its geographic boundaries; through the predominant racial or ethnic makeup of its members; or through the shared values and practices of its members. Most persons are part of several communities, including neighborhood, school or work, religious affiliation, social groups, or athletic teams. Whatever the definition, community influence on the sexual health of those who comprise it is considerable, as is its role in determining what responsible sexual behaviour is, how it is practiced and how it is enforced (Advocates for youth:2015:5).

Parents: parents are defined to encompass "all those who provide significant and/or primary care for adolescents, over a significant period of the adolescent's life, without being paid as an employee," including biological parents, foster parents, adoptive parents, grandparents (WHO 2007:7).

Peer pressure: is defined as pressure from peers to "do something or to keep from doing something else, no matter if you personally want to or not" (Kirby, Karin Forrest, et al 2011:78).

Strategy: *A strategy is a particular method or approach consistently used in the course of the intervention activities. An example of a strategy would be to use peers to provide the instruction during a group level intervention presentation (Hayes 2009:5).*

Sex education: it is the provision of information about bodily development, sex, sexuality, and relationships, along with skills-building to help young people communicate about and make informed decisions regarding sex and their sexual health (Advocates for Youth 2008: 5).

School-based sex education: is defined as a strategy designed to enhance positive sexual behaviours delivered in school settings (Advocates for Youth 2008:5-6).

.

1.8 OPERATIONAL DEFINITIONS

1.8.1 Dependent variable

- Positive sexual behaviour: person's sexual practices that enhance safer heterosexual activity such as abstinence, late initiation of debut, condom use, contraceptive use, single sexual partner.

1.8.2 Independent variable

- Protective factors (domains): factors that support positive sexual behaviours such as community, family, Peers, and schools.

1.9 THEORETICAL FOUNDATION OF THE STUDY

1.9.1 Research paradigm

Pragmatism is the most commonly applied approach in Mixed Method Research. It is oriented towards realistic and real world problems to be researched or solved (Feilzer 2010:6-16). Pragmatism does not have orientation on assumptions related to the nature of knowledge (Teddlie and Tashakkori 2009:541). However, the criticism on Pragmatism paradigm is its excess design, which is higher than any typology cover (Harrits 2011:161).

According to Taylor, Kermode, and Roberts (2007:5), a paradigm is “a broad view or perspective of something”. Additionally, Michel (2008:28) definition of paradigm means how research could be affected and guided by paradigms and they state that, “paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished”

According to (Bowling 2009:129) a research paradigm is a perspective based on a set of assumptions, concepts, values, and practices that are held by a researcher, and it is essentially an approach to thinking about and doing research. In this study, the research paradigm will be a positivist paradigm.

The paradigm underlying the traditional scientific approach, which assumes that there is a fixed, orderly reality that can be objectively studied. This method allowed the researcher to ask all the respondents the same questions with predetermined responses, which allowed objective data to be collected throughout the study.

According to Taylor, Kermode, and Roberts (2007: 5), a paradigm is “a broad view or perspective of something”.

Paradigm is defined as how research could be affected and guided by paradigms and they state that, “paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished”. Therefore, to clarify the researcher’s structure of inquiry and methodological choices, an exploration of the paradigm adopted for the study should be discussed prior to any discussion about the specific methodologies utilized in the study. Due to the complex nature of the research study, there was no single paradigm that could satisfactorily deal with all of the required methodological aspects. Therefore, the researcher found it necessary to combine the quantitative/positivist paradigm with the qualitative/interpretive paradigm (**research**online.nd.edu.au/cgi/viewcontent.cgi? filename=2; Date accessed: June 5 2015).

1.9.2 Theoretical framework

A set of interrelated concepts that symbolically represent and convey a mental image of a phenomenon (Alligood 2013:15).

A set of interrelated concepts that symbolically represent and convey a mental image of a phenomenon (Alligood 2013:1-22). A framework provides an explicit explanation why the problem under study exists by showing how the variables relate to each other (Sinclair 2007:39). Theoretical framework is thought of as a map or travel plan that helps to consider relevant theory underpinning the knowledge base of the phenomena under study; and kinds of questions that cross our minds (Sinclair 2007:39).

Theoretical framework guides the conceptual basis for study, describes how variables relate to one another and also provides a rationale for predictions about the relationships among the study variables (Alligood 2013:1-22).

The theoretical framework of this study showed how protective factors in each domain enhances positive sexual behaviour amongst adolescents.

1.9.3 Conceptual framework

Conceptual framework of a study is the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs the research and is a key part of research design (Robson, 2011: 79-93). It is like a process that involves mapping out or visualizing these theoretical threads to form some diagrammatic representation of inter-relatedness (Sinclair 2007:39).

The conceptual framework for this study has been adapted from Alaska Division of Behavioural Health (2011: 2-7**).** The conceptual framework helped this study to identify various protective factors that enhance positive sexual behaviours. It also used to describe the relationships among protective factors and positive sexual behaviours.

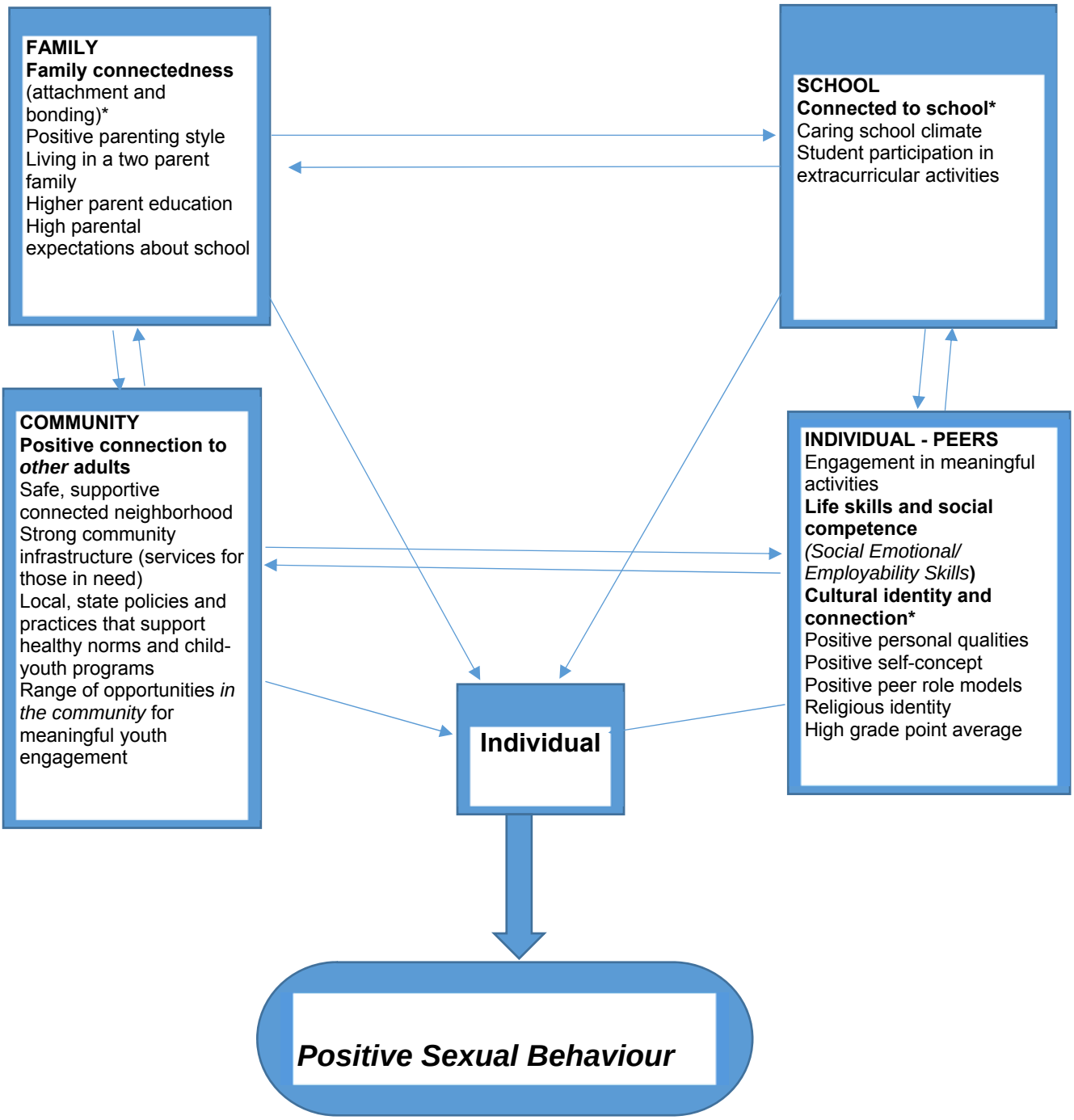


Figure 1 1 Theoretical framework of the study

1.10 RESEARCH DESIGN AND METHOD

According to Bowling (2009:158) and Burns and Grove (2009:40)), research design refers to the overall structure or of how the researcher intend conducting the research and focuses on the logic of research. The research design is a blueprint for maximizing control over factors that could interfere with a study's desired outcome. The type of design directs the selection of a population, sampling procedure, methods of measurement, and a plan for data collection and analysis. The choice of data collection depends on the problem and purpose for the study, and the desire to generalize the findings.

The purpose of the research design is to guide the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. This control increases the probability that the study results are accurate reflections of reality. A strong design makes it more likely the study will contribute to the evidence base for practice. The research design must therefore be appropriate to the purpose of the study, feasible given realistic constraints and effective in reducing threats to validity (Burns and Grove 2009:218 and 226).

With the development and perceived legitimacy of both qualitative and quantitative research in the social and human sciences, mixed methods research, employing the combination of quantitative and qualitative approaches, has gained popularity. This popularity is because research methodology continues to evolve and develop, and mixed methods is another step forward, utilizing the strengths of both qualitative and quantitative research (Creswell 2009:188). A mixed methods approach is one in which the researcher tends to base knowledge claims on pragmatic grounds (e.g., consequence-oriented, problem-centered, and pluralistic). It employs strategies of inquiry that involve collecting data either simultaneously or sequentially to best understand research problems. The data collection also involves gathering both numeric information (e.g., on instruments) as well as text information (e.g., on interviews) so that the final database represents both quantitative and qualitative information. (Creswell 2009:120-121).

According to Creswell (2009; 10:192) Sharon and Elizabeth (2009; 3:38), the researcher collected both quantitative and qualitative data concurrently using a cross-sectional design and integrated the two databases by transforming the qualitative themes into counts and compared these counts with descriptive quantitative data. In this case, the mixing consists of integrating the two databases by actually merging the quantitative data with the qualitative data.

The intent of this concurrent mixed methods study was to explore and describe positive sexual behaviours among high school adolescents. In the study, self-administered questionnaire was used to measure the relationship between protective factors and positive sexual behaviour. At the same time, the protective factors were explored using focus group discussion with selected adolescents' high schools attending regular classes. The reason for combining both quantitative and qualitative data; therefore, was to better understand the research problem by converging both quantitative and qualitative data and to design strategies supporting positive sexual behaviour among adolescents.

1.12 SCOPE OF THE STUDY

Potential limitations of this study will be acknowledged. For in-school adolescents' information was obtained from those adolescent who were available in the classroom during the survey day(s). Therefore, students who will not be in the classroom will be excluded and it is possible that their experiences and/or understandings may be different from those who attended class on the assessment day. In addition, cross-sectional nature of the study might not able to infer causation. The study result of both quantitative and qualitative approaches expected to guide policy formulation/ revision and the development of effective intervention strategies for positive sexual behaviours.

1.13 STRUCTURE OF THE THESIS

This Thesis has eight chapters. The first chapter provides the introduction and background information to the research problem, the theoretical foundation, objectives, paradigm, research design and methods and scope of the research.

Chapter two presents the literatures reviewed. This chapter details a review of adolescence as a concept and critical lifespan. In addition, the chapter outlines review of researches on protective factors at family, school, community, peer and individual

Chapter 3 discusses the methodology. This includes the research design and methods used, settings, sampling methods, data collection methods and procedures for both quantitative and qualitative designs. Furthermore, the chapter includes data validity, reliability and analysis. Ethical considerations is also addressed well in this chapter.

Chapter 4, presents key findings of the quantitative method of the study. These include the socio-demographic information of the participants, impact of family support, school situation, community and peer support and individual factors.

Similarly, chapter five describes key findings of the focus group discussions The chapter presents the findings using major themes and sub-themes. It also states all quotations in which the participants articulated. The quotations were described based on literature reviewed comparing similarities and dissimilarities of findings in global and national perspectives.

Chapter six presents the discussion part of the study. The chapter combined both qualitative and quantitative findings and explaining with regard to similar studies. In addition, the chapter includes researcher's suggestions based on the research purpose.

Chapter seven presents the strategy part of the study. The strategy included interventions at parental and family, community and neighbourhood, school, peers and individual levels.

Finally, chapter eight draws conclusions from the research findings, pinpoints the limitations of the study, makes recommendations, and makes suggestions about further research.

1.14 CONCLUSION

The orientation of the study chapter discussed the concept of adolescents and different protective factors/domains for positive sexual behaviour. The study framework was also elaborated how the protective domains interconnected to support positive sexual behaviour. The rationale for doing the study was also discussed under the statement of the problem and the significance of the study. The research purpose, objectives and questions the study intends to answer are also discussed in the first chapter.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents the review of literature accessed from various sources. Sources used included, books, journals, articles, monographs, government and agency reports and dissertation done in topics related to factors to support positive sexual behaviours among high school adolescents. Studies done on adolescence and protective factors that supports positive sexual behaviour were reviewed. Topics in this review will cover adolescence as a concept and the main protective domains to support positive sexual behaviour including family, community and neighbourhood, school, peers and individual factors.

2.2 ADOLESCENCE AS A CONCEPT

The term "adolescence" is a concept first popularised in the early 20th century by researchers such as psychologist (Stanley Hall (Conklin 2012:1). Generally, it refers to the period of transition from childhood to young adulthood, but its exact meaning is imprecise (Conklin 2012:1).

The word adolescence is derived from the Latin verb − adolescere which means grow to maturity. Adolescence is defined as a period in which a person is no longer a child, and not yet an adult. It is an age of transition when an individual experiences rapid growth and development, both physical and psychological, and changes from being a child to an adult (WHO 2010:11). The WHO (2010:12) has defined adolescence as age of 10 to 19 years and in terms of a phase of life marked by special attributes. It is also a period when development of the reproductive system, sexual maturation, formation of identity, gender roles and related problems arises (Anjali, Bhagyalaxmi and Shikha 2009:1-2).

Adolescent is also a period between childhood and young adult life as reflected in an individual's different areas of psychosocial functioning (Pyrjmachuk 2011:333) describe adolescence from a biological point of view. Pyrjmachuk (2011:333) refers to it as a

developmental phase with a set of mini stages in an individual's life that separate childhood from adulthood. A couple of key developmental challenges characterises adolescence, and these include development of psychological autonomy, establishing of intimate relationships, and developing sense of identity (Petersen, Bhana and Swartz 2012: 411-416).

Adolescents are a critical target population with regard to influencing global public health outcomes. Young people below 25 years of age represent almost 50% of the world's population (WHO 2011:12). Adolescence marks the period between childhood and adulthood when hormonal changes transform boys and girls into young men and women able to have children of their own. Increasingly, adolescents wait until they reach the age of maturity before they have sex (WHO 2011:12).

Globally, the adolescent population is estimated to be 1.25 billion. Among these, 513 million are between 15–19 years old (WHO 2008). Furthermore, nearly 85% of the world's adolescent population lives in developing countries. In a number of countries in sub-Saharan Africa, population below 15 years of age is five times greater than the population over 55 years of age (WHO 2011:12). This subset of the world's population is often disproportionately affected by social and economic inequities that characterise the development landscape which makes them more vulnerable to poor health outcomes, especially outcomes related to sexual and reproductive health (WHO 2011:12).

2.3 ADOLESCENCE AS A CRITICAL LIFE SPAN

Under normal circumstances, an adolescent has to attain positive mastery of these key developmental challenges without any interference.

Though disparities between adolescent's cognitive, emotional, social and physical development may exist, these can be resolved as the adolescent moves towards maturity and independence. But at times these together with heightened emotional arousal which may compromise rational decision making, can act as vulnerabilities that predispose adolescents to a range of internalising mental disorders such as anxiety and depression

and externalising behavioural disorders such as conduct disorder and aggression (Petersen, et al 2012:413; Rawatlal and Petersen 2012: 346–357; and Shirvam and Vostanis 2011:228). Individual capacity to deal with these adversities is dependent on the availability of support in the immediate social environment as well as coping skills.

During the transition from childhood to adulthood, adolescents establish patterns of behaviour and make lifestyle choices that affect both their current and future health. Serious health and safety issues such as motor vehicle accidents, violence, substance use, and risky sexual behaviours can adversely affect adolescent and young adults (Centres for Disease Control and Prevention 2015:24).

Young people between the ages of 10 and 19 years are often thought of as a healthy group. Nevertheless, many adolescents do die prematurely due to accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable (WHO 2015:12). Many more suffer chronic ill-health and disability. In addition, many serious diseases in adulthood have their roots in adolescence. For example, tobacco use, sexually transmitted infections including HIV, poor eating and exercise habits, lead to illness or premature death later in life (WHO 2015:12).

Besides the demands posed on the adolescent by this critical life period, a significant number of them do also experience mental distress due to exposure to traumatic life events and violence, as well as harsh, inconsistent or abusive parenting factors, family breakdown, bullying and loss due to death of significant others which could weaken their emotional stability (McKenzie, Murray, Prior, et al 2011: 67-82; and Petersen et al 2012:413).

Graczyk (2008:1) shows that given the right tools, young people have the potential to take responsibility for their sexual and reproductive health. Parental involvement and culturally competent programs that provide complete and accurate information can go a long way toward helping youth make good decisions; but socioeconomic, cultural, and educational disparities must be redressed in order for all youth to lead successful and healthy lives.

Because adolescents are in developmental transition, they need education, skills training, self-esteem, promoting experiences, and appropriate services related to sexuality, along with positive expectations and sound preparation for their future roles as partners in committed relationships and as parents. Addressing the positive development of young people facilitates their adoption of healthy behaviours and helps to ensure a healthy and productive future adult population (McNeely and Blanchard 2009: 129-145).

There are a number of protective factors that shape human sexual behaviour and can have an impact on sexual health and the practice of responsible sexual behaviour. These include parents and other family members, schools, community and neighborhood, peers and individual factor and the availability of reproductive and sexual health services.

2.4 IMPACT OF PARENTS AND FAMILY SUPPORT

Parents are the first socializing agents, teachers, leaders and counselors to their children (Amsale and Yemane 2015:2). Parent's guidance and support is always important; however, it is highly needed in the period of adolescence (WHO 2010:12). Healthy sexuality is a developmental process which needs investments from parents (Amsale and Yemane 2015:2).

Positive parenting style involves high expectations, clear family rules, fair and consistent discipline practices and age-appropriate supervision and monitoring of behaviour, friends and whereabouts (Alaska Division of Behavioural Health 2011:5).
A supportive, responsive parenting style helps youth feel safe and enables them to plan positively for the future (CDC 2010: S1-S96). In turn, this orientation toward the future

makes it more likely that youth will avoid high-risk behaviours. Parental monitoring -- so long as it does not become over controlling -- helps youth maintain health. Family connectedness and good parent-adolescent communication, including communication about sex, condoms, and contraception, help young people achieve positive sexual health outcomes (CDC 2010: S1-S96). An abundance of research has documented the positive effects of authoritative parenting, parental monitoring and supervision, and communication on adolescent development (Amsale and Yemane 2015: 6:2).

A similar study in Ethiopia also shows that parenting styles and practices have paramount influence on the sexual behaviour of adolescents. Adolescents raised in authoritative and authoritarian home, live with both parents, feel connected with parents, communicated with parents about sexuality and monitored and supervised by parents are less involved in sexual risk behaviour (Amsale and Yemane 2015; 6:2).

Parenting styles and practices have paramount influence on the sexual behaviour of adolescents. Adolescents raised in authoritative and authoritarian home, live with both parents, feel connected with parents, communicated with parents about sexuality and monitored and supervised by parents are less involved in sexual risk behaviour. Adolescents' perception of parents as supportive and as authoritative are linked to fewer occurrences of risky behaviour (Joyce, Angela, Mark, et al 2011:106 and Amsale and Yemane 2015:2). Parents and members of the extended family have always been important in the sexual and reproductive knowledge and development of young people (Biddlecom et al 2009: 72-81). Research from African and other settings shows that the communication between adolescents and parents on issues such as sexual relationships, early pregnancy, HIV, and contraception is often very limited (Biddlecom, et al 2009:72-81). Barriers to communication about sexuality include a lack of parental knowledge, reliance on school teachers, and a perception that talking about sexuality encourages sex (Bastien, et al 2011:25).

Parents play an extremely important role in reducing both the physical and emotional risks associated with sexual behavior. Parents, unlike a majority of educators, peers, or others, have a strong emotional bond to the adolescent and can draw on this relationship to educate their adolescent regarding the risks of sexual behavior both physically and emotionally. It is through joint efforts of parents, educators, and communities that adolescents gain knowledge regarding the risks of sexual behavior (Caroline, Rosemary and Larry 2014: 1-18).

Youth who live with both of their parents are less likely to engage in certain risky sexual behaviours (CDC 2010: S1-S96; and Kirby and Lepore2007: 6-7). A national research in Tanzania also shows that children who grow up in a family with two parent families, Higher Parent education and high parental school expectations are less likely to engage in risk behaviours (Alaska Division of Behavioural Health 2011:5-7). Concurring with evidences from previous studies, students living with both parents were less likely to be involved in risky sexual behaviour (Biddlecom, et al 2009: 72-81). This could be explained that students living with both parents may be more secured and parents may also be available and have more time to support, show love, communicate and monitor their children (Amsale and Yemane 2015:6:2). Higher family income and higher levels of parents' education are also protective factors (CDC 2010: S1-S96).

A majority of studies finds that adolescents living with both parents are less likely to become pregnant (or cause a pregnancy) or to give birth (or father a child). If biological parents divorce or separate, their children are more likely to initiate sex at an early age than if the parents do not divorce or separate. Adolescents whose parents are more educated are less likely to become pregnant than adolescents whose parents have less education. Family income is also a factor: the majority of studies found that adolescents in families with higher incomes were less likely to become pregnant or to bear children. These findings regarding parents' education and income may reflect the emphasis that many such parents place on obtaining an education, pursuing a career, and avoiding early childbearing, as well as, to some extent, the greater resources available to support adolescents in these pursuits (Kirby and Lepore 2007: 6-7).

Positive parent-adolescent relationships are centrally important in shaping adolescent's sexual activity (Coley, Votruba-Drzal and Schindler 2009:808–827) since parents are the agents to provide emotional connections, behavioural constraints, and modeling. This, in turn, will affect the children's development of self-regulation which will influence their decision-making and expectations regarding their sexual behaviours and intimate relationships (Hauser-Kunz and Grych 2013: 78-94).

Adolescents who report higher levels of these forms of parental monitoring are more likely to report delaying the onset of sexual activity and to report use of condoms and contraceptives (Patricia, Shannon, Jefrrey, et al 2015: 1-15).

When parents' express disapproval of sex in adolescence, or support for contraception if an adolescent does have sex, youth are more likely to act on those values (CDC 2010: S1-S96; and Kirby and Lepore 2007: 6-7). However, studies also show that parental monitoring appears to be consistently associated to a lower likelihood of risky sexual behaviour (Joyce, et al 2011:106). Similarly, in different studies, investigators have examined the assumption that parent-adolescent communication about sex actually reduces adolescent sexual risk taking by either delaying sex or using condoms or other forms of contraception (Kirby, et al 2011: 108).

If adolescents experience considerable parental support and feel connected to their parents, they are less likely to initiate sex at an early age, and they have sex less frequently. If parents monitor and supervise their adolescents appropriately, they are likely to have fewer sexual partners than if parents do not monitor. At the extreme, if adolescents have been maltreated and physically abused by their families, then they are much more likely to have sex at an early age and to become pregnant. Family abuse of alcohol or drugs increases the chances that adolescents will have sex more frequently and with more partners. There are two possible reasons for this effect: family substance abuse may encourage young people to drink and use drugs themselves, which can lead to more frequent sex with more partners, or family substance abuse may simply be a marker for more general family dysfunction, which can lead to sexual risk taking by adolescents (Kirby and Lepore 2007: 6-7).

Besides, findings from a small number of intervention studies in Zimbabwe in 2010 show that if parents are given support to develop the attributes of parental responsiveness, they can and will communicate with their children about sexuality (Joar, et al 2015: S7–S14). It is possible to improve the content of the discussions and to raise awareness of and challenge social and cultural norms that hinder communication about sexuality (Bastien, et al 2011:25). For example, a parent-centered program to strengthen seventh graders' families' abilities to communicate with their teens, provide support, use positive parenting, and increase their involvement was conducted among low-income Latino households in Miami. After 3 years, youth in the intervention groups were less likely to report an STI and unprotected sex at last sex than peers in the two control groups (Prado, Pantin, Briones, *et al 2007:* 914–926).

A similar study shows that teaching parents how to cope with stress, communicate clear expectations, eliminate coercive parenting, and reward positive behaviours appears to prevent and deter children and youth from engaging in risky behaviour (Mary, et al 2011: 3). Kirby and Lepore (2007:6-7) highlighted that when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased. This effect is most likely to occur when the teen is a daughter (as opposed to a son), when the parent is the mother (as opposed to the father), when the teens and their parents feel connected to one another, when the parents disapprove of teens having sex or support contraceptive use, and when parents can discuss sexuality in an open and comfortable manner.

Parent engagement in schools is a shared responsibility in which schools and other community agencies and organizations are committed to reaching out to engage parents in meaningful ways, and parents are committed to actively supporting their children’s and adolescents’ learning and development. This relationship between schools and parents cuts across and reinforces children’s health and learning in multiple settings-at home, in school, in out-of-school programs, and in the community. Engaging parents in their children’s school life is a promising protective factor. Research shows that parent

engagement in schools is closely linked to better student behaviour, higher academic achievement, and enhanced social skills (CDC 2014:7).

2.5 SCHOOL ATTACHMENT

School connectedness and involvement in school activities, liking school and finding it important, bonding with teachers and peers, feeling safe and fairly treated -- protects against sexual risk taking. Academic achievement and aspirations lead youth to make healthy decisions about sex (CDC 2010: S1-S96). According to Alaska Division of Behavioural Health (2011:5-6), a caring school climate (positive school atmosphere) has an impact on risky sexual behaviours, rates of absenteeism, delinquency, substance use, and emotional disturbances. Characteristics that contribute to a positive school climate include: High expectations for student academics, behaviour and responsibility; Use of proactive classroom management strategies, interactive teaching and cooperative learning and maintain a positive atmosphere; Consistent acknowledgement of all students, and recognition for good work and student voice in school activities and classroom management. Adolescents who feel connected to their schools are less likely to bully or be bullied, to engage in delinquent behaviour and to use drugs and alcohol (Mary, et al 2011:4).

Adolescents participation in sports is related to delayed initiation of sex, less frequent sex, greater use of contraception, and lower pregnancy rates. These studies suggest that girls' participation in sports motivates them to avoid pregnancy, which, in turn, delays initiation of sex (Kirby and Lepore 2007:12)

Schools may have these effects on sexual risk-taking behaviour for any of several reasons. Schools structure students' time; they create an environment which discourages unhealthy risk-taking particularly by increasing interactions between youth and adults; and they affect selection of friends and larger peer groups.

Just as schools are critical settings for preparing students academically, they are also vital partners in helping young people to take responsibility for their own health. School health programmes can help youth to adopt lifelong attitudes and behaviours that support overall health and well-being including behaviours that can reduce the risks for HIV and other sexually transmitted diseases (CDC 2011:1-168). Schools often have access to training and communications technology that is frequently not available to families or clergy. This is important because parents vary widely in their own knowledge about sexuality, as well as their emotional capacity to explain essential sexual health issues to their children. Schools also provide an opportunity for the kind of positive peer learning that can influence social norms (CDC 2011:1-168).

The Centre for Disease prevention and Control (2009:5) has also demonstrated a strong relationship between school connectedness and educational outcomes (school attendance; staying in school longer; and higher grades and classroom test scores) and risky behaviours. Students who do well academically are less likely to engage in risky behaviours. School connectedness was found to be the strongest protective factor for both boys and girls to decrease not only early sexual initiation but also substance use, school absenteeism, violence and risk of unintentional injury.

When adolescents stay in school, feel connected to their schools, earn good grades, do not fall behind in school, have plans for higher education beyond high school, avoid problems in school, or do all of these, they initiate sex later and are less likely to have children. Several studies have found that involvement in school organizations is related to less sexual risk-taking. A methodologically strong study in America found that simply belonging to school organizations had no impact on adolescent childbearing; however, the study did find that substantial involvement in school organizations, particularly in school-based religious organizations among non-Hispanic white teens and in school clubs among African–American teens, was related to lower rates of teen childbearing (Kirby and Lepore 2007:10).

2.6 COMMUNITY SUPPORT

Community connectedness refers to young adolescent's perception of feeling safe, valued, attached, and-belonging to all their neighbourhood, community, or in some cases, youth programs. Adolescents who have a strong religious affiliation are less likely to initiate sex, and some studies indicate that adolescents who attend religious services frequently are less likely to have sex. The direction of causality is not entirely clear, by just as attachment to faith communities may affect sexual behaviour, sexual behaviour may also affect attachment to faith communities. For example, adolescents who have had sex may feel less comfortable in places of worship and may be less likely to attend services (Kirby and Lepore 2007:10-11).

Adolescents who report that they have positive relationships with adults and those who receive mentoring in the context of a long-term supportive relationship are more likely to succeed on multiple fronts (Mary, et al 2011:5).

Adolescents who live in safe, supportive communities are less likely to use drugs, exhibit aggressive behaviour, risky sexual behaviours, commit crimes, and drop out of school (Mary, et al 2011:4). Specifically, community support can shift individual behaviours, including contraceptive behaviours, either by changing norms or individual knowledge and attitudes (Storey et al 2011:1-89).

To have the most positive impact on adolescent health, community organisations, and other community members must work together in a comprehensive approach. Providing safe and nurturing environments for our nation's youth can help ensure that adolescents will be healthy and productive members of society (CDC 2014:1-172).

Positive social norms are maintained when community members have high expectations for adolescents and monitoring and accountability refers to the degree to which neighbours watch out for each other and monitor the whereabouts and behaviours of their children, as well as hold them accountable for their behaviours (Alaska Division of Behavioural Health 2011:5-6).

Communities with high levels of trust, cohesiveness, and social capital help young people avoid risky sexual behaviours and pregnancy. Neighbourhoods of this kind are also supportive of positive and attentive parenting styles. Neighbourhoods that offer youth many opportunities -- such as after-school programs, sports, and job training -- support positive sexual health, including decreased teen pregnancy (CDC 2010; 46: S1-S96).

Youth development programs including sex education programs that discuss both the benefits of abstinence and the need to use condoms and contraception to prevent the risks associated with sexual intercourse among adolescents and young people have been effective in changing their behaviour when implemented in schools, clinics or community settings (Kirby 2011:1-15)

Studies indicate that having a mentor, participating more in community activities and being involved in more community organizations also protect against sexual risk-taking. When youth are attached to such entities, they may spend less time unsupervised and, consequently, have less opportunity to take sexual risks (Kirby and Lepore 2007: 15-18).

2.7 PEER SUPPORT

Peer pressure is the direct influence on people by peers or the effect on an individual who gets encouraged to follow their peers by changing their attitudes, values or behaviours to conform to those of the influencing group or individual (Marquis and Andras 2016:1325-1341).

Sexual behaviour is one of the many areas in which adolescents are influenced by their best friends and peers. Adolescents are more likely to have sex if their best friends and peers are older, use alcohol or drugs, or engage in other negative behaviour.
Similarly, literature reviews show that adolescents are more likely to have sex if they believe their friends have more positive attitudes toward childbearing, have permissive values about sex, or are actually having sex. If adolescents believe their friends support condom use or actually use condoms, chances are greater that they will use condoms themselves (Kirby and Lepore 2007: 8).

Peers play an important role in adolescent development and socialization. Peers can influence one another either positively or negatively (Mmari and Sabherwal 2013: 53: 562–572).

Peer education found that some interventions increased SRH knowledge and condom use; delayed first intercourse; promoted gender-equitable attitudes; and prevented STIs (Villa-Torres and Svanemyr 2015: S51–S570)

A review of studies between 1990 and 2010 on risk and protective factors for ASRH found that having peers or friends who had had sex was a risk factor across health outcomes (Mmari and Sabherwal 2013: 53: 562–572).

Positive peer role model as a protective factor relates to adolescents who have friends with the following qualities: a positive attitude about health, good grades, no involvement in risk behaviours, and close relationships with parents (Alaska Division of Behavioural Health 2011:1-17).

Youth have a tendency to reflect peer social norms, which may be protective or may increase risk. For example, if they believe their peers disapprove of sex, they are less likely to become sexually active. If they believe their peers are having sex, they are more likely to become sexually active (CDC 2010: 46: S1-S96).

Five reviews that assessed the effectiveness of peer education found that some interventions increased SRH knowledge and condom use; delayed first intercourse; promoted gender-equitable attitudes; and prevented STIs (Villa-Torres and Svanemyr 2015 56: S51–S57).

Programs in several settings have noted the importance of providing mentors and positive role models to young people as a key to improving SRH outcomes as well as aspirations

for fertility, education, and work (Beaman, Chattopadhyay, Duflo, et al 2009*:* 124:1497-1540).

If adolescents believe their friends are engaging in sexual activity, they are much more likely to be sexually active themselves. Similarly, if they believe their friends are using condoms or contraception when they have sexual intercourse, they are more likely to use condoms or contraception themselves. Multiple studies confirm this, providing support for these theories. In a review of 25 studies that measured the impact of perceptions of peer norms about sexual behaviour or perceptions of actual peer behaviour on adolescents' own initiation of sexual activity, 24 found that these perceptions of peer norms or behaviour were significantly related to adolescents' initiation of sexual activity (Kirby, et al 2011: 6:76). Multiple studies have also consistently demonstrated that adolescents' perceptions of their peers' norms about sexual activity and condom or contraceptive use do affect their own sexual and contraceptive behaviour (Kirby, et al 2011: 6:80).

2.8 INDIVIDUAL FACTORS

Individual factors found to be particularly influential on adolescents' sexual behaviour include biological factors, race and ethnicity, connection to family, connection to school and to doing well in school, connection to religion, connection to other organizations or adults in the community, involvement in gangs, alcohol and drug use, aggressiveness, involvement in problem or sensation seeking behaviour, paid work, involvement in sports, cognitive and personality traits, sexual beliefs, attitudes, skills, motivations, intentions, relationships with romantic partners and previous sexual behaviour (Kirby and Lepore 2007: 9).

As stated by having plans for a positive future and believing in the ability to control one's own life are protective factors. Spirituality and religious affiliation help youth avoid risky sexual behaviour. Initiating sex at an older age is associated with better sexual health. Beliefs and attitudes about sex, condoms, and contraception can be protective or can increase risk. For example, a positive attitude toward condoms is protective; a permissive attitude toward sex increases risks. Having the skills and intention to use condoms and

contraception, as well as belief in one's own ability to successfully use those skills, protects young people against early pregnancy and STDs/HIV (CDC 2010: 46: S1-S96).

2.9 CONCLUSION

In this chapter literature related to adolescent and protective factors including family, schools, community and neighbourhood with and peers and individual factors that enhance positive sexual behaviour among adolescents were reviewed. Study findings related to strategies to support positive sexual behaviours at global, regional and country levels were also presented in this chapter.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

Chapter 3 presents the research design and methods used in this research to address the research problem and answer the research questions. It discusses the research design, methods, the study population and sampling, data collection and analysis methods, the strategies used for ensuring the validity and reliability of the study, and the ethical considerations complied to. The study was used concurrent design in a mixed-method which combined elements of qualitative and quantitative research approaches for the purpose of breadth and depth of understanding the phenomenon of positive sexual behaviour amongst adolescence attending high school in Ethiopia and its corroboration.

3.2 RESEARCH PARADIGM

Paradigm is a model or framework for observation and understanding, which shapes both what one sees and how understands it (Earl 2008; 2:59). ‘‘paradigms’’ based on Morgan (2007:48-76): ‘‘Systems of beliefs and practices that influence how researchers select both the questions they study and methods that they use to study them’’.
Paradigms are not static, unchanging entities that restrict all aspects of the research process. Instead, paradigms can help frame one’s approach to a research problem and offer suggestions for how to address it given certain beliefs about the world. Thus, paradigms are seen as a guide that the researchers can use to ground their research (Shannon-Baker 2016: 319–334). According to Denise and Cheryl (2010,1:30). a paradigm is a world view, a general perspective on the complexities of the real world.

According to Bowling (2009:129), a research paradigm is a perspective based on a set of assumptions, concepts, values, and practices that are held by a researcher, and it is essentially an approach to thinking about and doing research. In this study, the research paradigm is a positivist paradigm. The paradigm underlying the traditional scientific

approach, which assumes that there is a fixed, orderly reality that can be objectively studied. This method allowed the researcher to ask all the respondents the same questions with predetermined responses, which allowed objective data to be collected throughout the study.

According to Taylor, Kermode, and Roberts (2007: 5), a paradigm is “a broad view or perspective of something”. Additionally, Paradigm is the philosophical underpinnings from which specific research approaches stem (Sharon and Elizabeth 2009:18).

Paradigm means how research could be affected and guided by paradigms and they state that “paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished”. Therefore, to clarify the researcher’s structure of inquiry and methodological choices, an exploration of the paradigm adopted for the study was discussed prior to any discussion about the specific methodologies utilized in this study. Due to the complex nature of the research study, there was no single paradigm that could satisfactorily deal with all of the required methodological aspects. As a result, the researcher found it necessary to combine the quantitative/positivist paradigm with the qualitative/interpretiveparadigm**research**online.nd.edu.au/cgi/viewcontent.cgi?filename =2; Date accessed: June 5 2015).

Therefore, the data collection was involved gathering both numeric information (questionnaire) as well as text information (focus group discussion) so that the final database represented both quantitative and qualitative information. With the development and perceived legitimacy of both qualitative and quantitative research in the social and human sciences, mixed methods research, employing the combination of quantitative and qualitative approaches, has gained popularity. This popularity is because research methodology continues to evolve and develop, and mixed methods is another step forward, utilizing the strengths of both qualitative and quantitative research (Creswell 2009; 10:188). Mixed methods is a rich field for the combination of data because with this

design “words, pictures, and narrative can be used to add meaning to numbers” (Sharleen 2010; 1:18).

A mixed methods approach is one in which the researcher tends to base knowledge claims on pragmatic grounds (e.g., consequence-oriented, problem-centered, and pluralistic). It employs strategies of inquiry that involve collecting data either simultaneously or sequentially to best understand research problems. The data collection also involves gathering both numeric information (e.g., on instruments) as well as text information (e.g., on interviews) so that the final database represents both quantitative and qualitative information. (Creswell; 2009: 120-121).

In other words, what ones generally consider qualitative data “Words, pictures, and narrative” can be combined with quantitative, numerical data from a larger-scale study on the same issue, allowing our research results to be generalized for future studies and examinations (Sharleen 2010; 1:18).

3.2.1 Quantitative approach

Quantitative research denoted the systematic empirical investigation of social phenomena by means of mathematical and statistical techniques (Given 2008:699). It involved collecting data in numerical form and analysing by statistical methods (Mackey and Gass 2011:220). Its research objective is to develop mathematical models, theories or hypotheses about certain social phenomena and in an aim to make use of them (Fei Ma 2015: 566-571).

The main idea behind quantitative research is to be able to separate things easily so that they can be counted and modelled statistically, to remove factors that may distract from the intent of the research. A researcher generally has a very clear idea about what is being measured before they start measuring it. Quantitative is ideal for testing hypotheses, and for hard sciences trying to answer specific questions (Quantitative and Qualitative Research:From:http://wilderdom.com/research/QualitativeVersusQuantitativeResearch.html (accessed on 15 January 2016).

In quantitative research the researchers analyze data with the help of statistical knowledge and tools, hoping the data will yield an unbiased result which can be generalized to a larger population (Fei Ma 2015: 566-571). Quantitative research methods are research methods dealing with numbers and anything that is measurable in a systematic way of investigation of phenomena and their relationships. It is used to answer questions on relationships within measurable variables with an intention to explain, predict and control a phenomenon (Fei Ma 2015: 566-571). The quantitative research is usually deductive, fit for more breadth of information across a large number of samples with more generalizable result ((Hennink, Hutter, and Bailey 2011: 111-112). The quantitative method employed in the present study was the principal component designed to collect data useful to have an empirical understanding of the patterns of positive sexual behaviours among adolescents attending high schools.

At the time of the survey, adolescents were selected systematically in randomly selected high schools. In addition, probability sampling was employed in each school to draw study subjects in terms of number and sex of study participants.

3.2.2 Qualitative approach

Qualitative research is a paradigm of inquiry that allows researchers to examine human behaviour in depth and the reasons that govern such behaviour (Fei Ma 2015: 566-571). The researcher acts as a listener and interpreter of the data ‘given’ by the participant; the researcher’s interpretation is brought to the fore in the analysis process. In order to credibly interpret a participant’s story, therefore, the researcher needs to understand and make explicit their position in relation to the phenomenon under scrutiny. This requires a degree of self-reflexivity (Sharon and Elizabeth 2009; 7:128).

Qualitative research is useful for exploring new topics or understanding complex issues, e.g. for explaining people’s beliefs and behaviours or for identifying the social norms of a society. Thus qualitative research is most applicable for addressing ‘why’ questions to

explain and understand issues or ‘how’ questions that describe process or behaviour (Hennink, et al 2011: 111-112).

According to Sharon and Elizabeth (2009; 7:128) an interpretive researcher uses a theoretical framework to interpret the significance of the participants’ self-understandings. The qualitative data is generally termed ‘soft’, i.e., rich in description of people, places, and conversations, which is not easily handled by statistical procedures (Fei Ma 2015: 566-571).

Qualitative research is often an inductive process, fit for in-depth exploration of small samples with a less generalizable result (Fei Ma 2015: 566-571). In this study, the qualitative study (i.e., focus group discussion) was not a separate one but a part of the cross-sectional survey that aimed at substantiating and complementing the main quantitative study. In this regard, the necessary preparations were made to undertake a qualitative study that included selected adolescents.

The justification behind such an additional arrangement was to get a complete and comprehensive picture of the intended objectives. In fact, the need for the undertaking of a qualitative study becomes evident as a result of the emergence of new phenomena requiring further inquiry into some of the issues which was not be captured by the quantitative research method.

3.3 RESEARCH DESIGN

According to Bowling (2009:158) and Burns and Grove (2009:40), research design refers to the overall structure or of how the researcher intend conducting the research and focuses on the logic of research. The research design is a blueprint for maximizing control over factors that could interfere with a study’s desired outcome. The type of design directs the selection of a population, sampling procedure, methods of measurement, and a plan for data collection and analysis. The choice of data collection depends on the problem and purpose for the study, and the desire to generalize the finding.

The purpose of the research design is to guide the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal. This control increases the probability that the study results are accurate reflections of reality. A strong design makes it more likely the study will contribute to the evidence base for practice. The research design must therefore be appropriate to the purpose of the study, feasible given realistic constraints and effective in reducing threats to validity (Burns and Grove 2009:218 and 226).

According to Creswell (2009 10:192) and Sharon & Elizabeth (2009 3:38), the researcher collected both quantitative and qualitative data concurrently using a cross-sectional design and integrated the two databases by transforming the qualitative themes into counts and compared these counts with descriptive quantitative data. In this case, the mixing consists of integrating the two databases by actually merging the quantitative data with the qualitative data.
According to (Bowling 2009:158 and Burns and Grove 2009:40), research design refers to the overall structure or of how the researcher intend conducting the research and focuses on the logic of research. The research design is a blueprint for maximizing control over factors that could interfere with a study's desired outcome. The type of design directs the selection of a population, sampling procedure, methods of measurement, and a plan for data collection and analysis. The choice of data collection depends on the problem and purpose for the study, and the desire to generalize the finding.

For this study, cross-sectional study was conducted in order to explore and describe protective factors associated with positive sexual behaviours among urban in- school adolescents in Ethiopia.

A cross-sectional study is a type of descriptive, observational study which involves measuring different variables in the population of interest at a single point in time. (http://www.ehow.com/info_8758457_advantages-disadvantages-crosssectional-studies).

Cross-sectional research-A design in which an investigator studies groups differing on some characteristic (e.g., age) at the same time (Bernard and Maureen A. 2012: 13:313).

This simultaneous data gathering is often thought of as a snapshot of conditions present at that instant. Its most important application lies in the field of epidemiology and disease research. It offers several advantages, such as the ease of assessing the prevalence of diseases(http://www.ehow.com/info_8758457_advantages-disadvantages-crosssectional-studies).

3.4 RATIONALE FOR USING MIXED METHOD

It is highly possible that there are both singular and multiple versions of truth and reality in human society. The truth and reality is sometimes subjective and sometimes objective, sometimes scientific and sometimes humanistic (Cohen, Manion and Morrison 2011:319).

A single quantitative or qualitative paradigm will only yield a partial understanding of the phenomenon being investigated (Greene 2008: 7-22). Mixed Methods Research is a combination of qualitative and qualitative designs, methods, analysis or interpretation in a research process (Denzin 2010: 421-2; Johnson and Christensen 2008: 34).

As Sharleen (2010:21) states one can clearly see the positive power and synergy of using these methods to complement one's research findings. Quantitative information delivered in a "hard data" format is amenable to statistical analyses and standardized tests of reliability and validity. Qualitative data add an in-depth understanding of research results and allow the researcher to explore anomalies or subgroups within the data. Working with both methods gives many researchers a cross-check on their research results. Qualitative data illuminate the meaning of statistical results by adding a narrative understanding to quantitative research findings (Sharleen 2010; 1:21).

In this study the mixed-methods research helped in answering a broader range of research questions as it combined the strengths of both qualitative and quantitative

designs. Hence, it provides strong evidence for conclusion and adds better insight and understanding of the issue under study (Migiro and Magangi 2011: 3757-3764).

Mixed methods research should be driven by the underlying principle that the collection of qualitative and quantitative data will provide the best means to answer the research question. Reporting the results separately without some kind of mixing of the data, in most studies, will reduce the power of the findings (Sharon and Elizabeth 2009; 8:137).

Concurrent procedures, in which the researcher converged quantitative and qualitative data in order to provide a comprehensive analysis of the research problem. In this design, the investigator collected both quantitative and qualitative forms of data at the same time during the study and then integrated the information in the interpretation of the overall results.
Also, in this design, the researcher nested one form of data within another, larger data collection procedure in order to analyse different questions or levels or units in an organization (Creswell 2011:19).

The intent of this concurrent mixed methods study was to explore and describe positive sexual behaviours among high school adolescents. In the study, self-administered questionnaire was used to measure the relationship between protective factors and positive sexual behaviour. At the same time, the protective factors were explored using focus group discussions with selected high school adolescents attending regular classes. The reason for combining both quantitative and qualitative data; therefore, was to better understand protective factors by converging both quantitative and qualitative data and to design strategies supporting positive sexual behaviour among adolescents.

3.5 SETTING

Ethiopia is the oldest independent and second most populous country in Africa. It has a unique cultural heritage with a diverse population mix of ethnicity and religion (HSTP 2016:18). According to the 2017 revision of the World Population Prospects, the total population was 99,465,819 with total growth rate 0f 2.9%.

The pyramidal age structure of the population has remained predominately young with 44.9% under the age of 15 years and 15-24 years constitute 19.98% (From: https://en.wikipedia.org/wiki/Demographics_of_Ethiopia date accessed April 15,2018). While the sex ratio between males and females is almost equal, women of reproductive age constitute 23.4% of the population. The average fertility is 4.1 births per woman (EDHS 2014).

Addis Ababa is the capital and largest city of Ethiopia. According to Ethiopian National population and housing census projection (CSA 2014:30) the population is estimated to be 3,195,569 with annual growth rate of 3.8%. Among these adolescents are estimated to be around 637132 (19.9%). The city is administratively divided in to 10 sub-cities as shown in the figure 3.1.

Source: *Addis Ababa demographic and socioeconomic indicators, 2010*

Figure 3 1 Map of Addis Ababa city administration by sub-city.

Among ten sub-cities, two sub-cities were selected randomly; namely, Addsi Ketema and Kirkos Sub-cities. Both Addis Ketema and Kirkos Sub-cities are administratively divided into 10 woredas (districts) each. According to Addis Ababa city Bureau of education (2016), Addis Ketema sub-city has a total of four (3 public and 1 private) and Kirkos sub-city has five (4public and 1private) high schools. Among these three high schools were randomly selected from each sub-city considering socioeconomic and other factors are normally distributed. The private schools were a non-governmental/ non- profit schools supported by NGOs whereby socioeconomic and other factors similar with public high schools.

3.6 Population sample and sampling technique

3.6.1 Population

Burns and Grove (2009:42) state that population is all the elements (individuals, objects or substances) that meets certain criteria for inclusion in a given universe. It is also defined as a group of persons, elements, or both that share a set of common characteristics as predefined by the investigator (Elizabeth and Laura 2011: 161-162) The study population was those high school adolescents regularly attending in preparatory schools.

3.6.2 Target population

Elizabeth and Laura (2011:162) state target population as a useful entity, referring to the group of individuals or elements from which the investigator is able to select a sample.

The target population for a survey the entire set of units for which the survey data are to be used to make inferences. Thus, the target population defines those units for which the findings of the survey are meant to generalize. Target populations must be specifically defined, as the definition determines whether sampled cases are eligible or ineligible for the survey. The geographic and temporal characteristics of the target population need to be delineated, as well (Brenda, David and Nanjamma, et al 2008: 186).

For this study, adolescents aged 15-19 years, who were regularly attending, in six preparatory schools in Addis Ketema and Kirkos sub-cities were the target population.

3.6.3 Sample and sampling methods

3.6.3.1 Sample size

According to Lyman and Longnecker (2010:5) sample is any subset of measurements selected from the population (set of all measurements of interest to the sample collector).

A sample size is a subset of the population elements that the researcher works with (Polit and Beck 2013: 306).

For the Quantitative element of the study, the research used the formula for single population proportion study with random sampling (Mitchel and Jolley 2010: 284- 285) to set the sample size.

To determine the minimum number of students to be included in the study, the single population formula was used with the proportion of expected prevalence of protective factors for adolescent sexual behaviours is 50%.

A three stage sampling were used to select study participants from the source population. In the first stage high schools were selected randomly from the two sub-cities. The sample size was assigned proportionate to the total student population for each selected school.

Number of male and female study participants were also selected proportionally in each school. The study participants were selected by simple random sampling from each school based on the predetermined sampling frame. When selected student is absent during the survey days, the researcher replaced with other one randomly.

Accordingly, the required sample size, **n**, at confidence interval of 95% with 4% margin

of error was calculated based on the formula,

$$n = \frac{(Z^{*}\alpha/2)^{2} P(1-p)}{d^{2}}$$

Where, p= 0.05(proportion of protective

factors), d=0.04 (assumed standard error)

Design effect = 1.5

then, **$n = \frac{(1.96)^{2} * 0.5(1-0.5)}{(0.04)^{2}} = 600$**

Then n = 600 * 1.5(design effect) = 900.

With 10% non-response rate = 990

For the qualitative study, Focus Group Discussions (FGD) were conducted only in two schools since the discussion points were saturated. A total of four focus group discussions were conducted having 7-9 participants. Focus group discussions participants were recruited purposely through discussion with school administrators who have participated in different extra- curricular activities voluntarily in two schools.

3.6.3.2 Sampling Methods

Sampling is the statistical process of selecting a subset (called a "sample") of a population of interest for purposes of making observations and statistical inferences about that population (Anol 2012:65).

Burns and Grove (2009:361) state that in quantitative research, the sample size must be large enough to identify relationships among variables or determines differences between groups and generalizing the result. That means the findings can be applied to more than just the sample under study. The sampling criterion to allow generalization is power which is the capacity of the study to detect difference or relationship that actually exists in the

population (Burns and Grove 2009:357). A sample is usually much smaller in size than population; hence sampling can save time and money, staff and resources and more-in-depth information better quality data are obtained (Bowling: 2009:196).

In this study, a multi-stage sampling technique was employed in order to select the study units and probability proportionate to sample size (PPS) was also used to determine the sample proportion for each grade (grades 11 and 12) and sex so as to achieve a greater representativeness in the sample of the population

(From: http://www.who.int/tb/advisory_bodies/impact_measurement; Data accessed December 2017).

Fifty percent of sections from each grade in all high schools was identified by using simple random sampling. According to school administrators, average number of students in each class was estimated to be 40. In order to select study participants systematically in randomly selected sections, total number of students in selected grades in all high schools were obtained from school administrators by section and sex. According to Babbie (2010:208) and Burns & Grove (2009:348), the lists of adolescents in each section were obtained. The pictorial diagram below showed the process of study area and participants selection (Table 3.1)

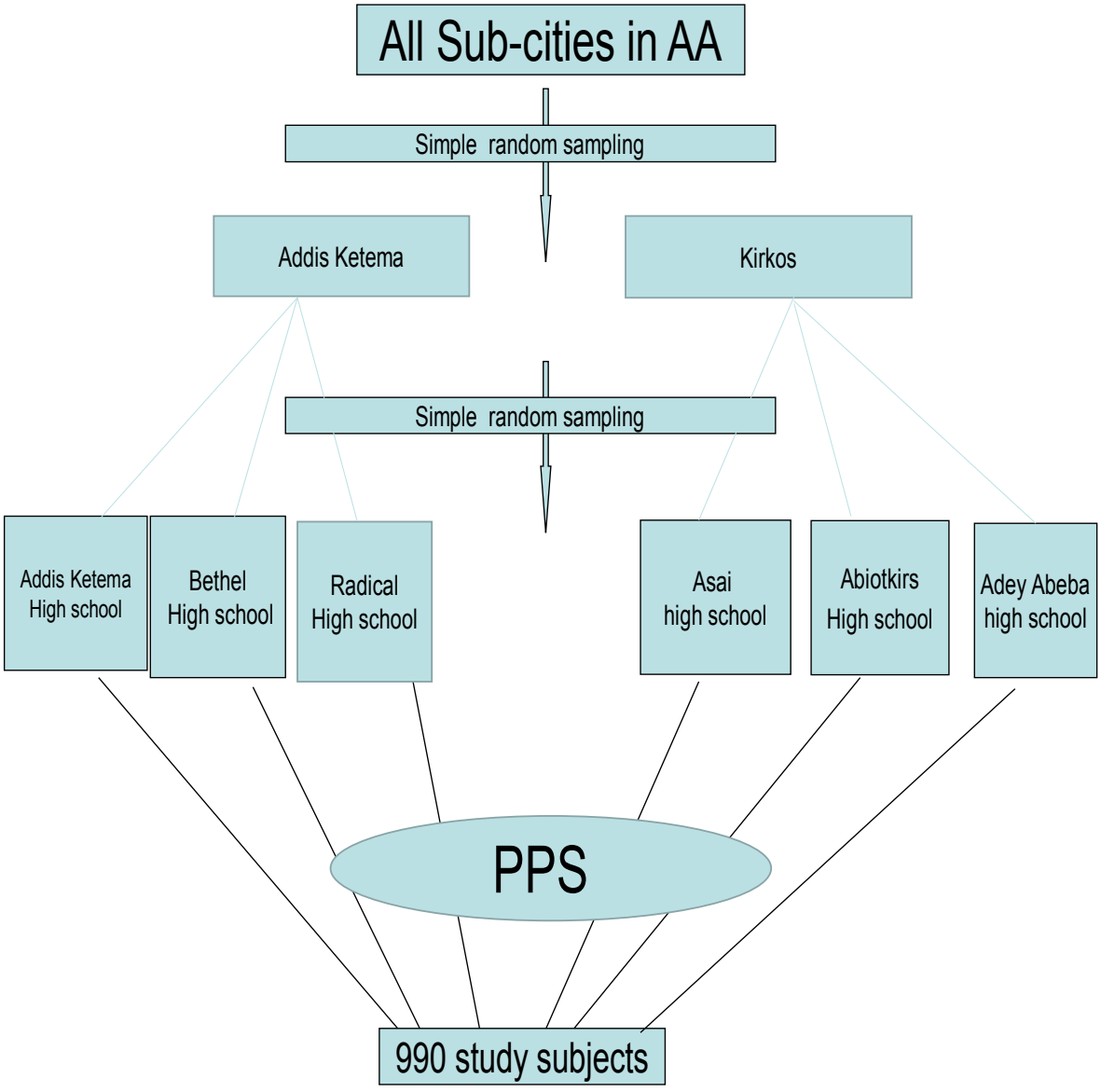


***Figure 3 2* Schematic presentation of sampling procedure (Study architecture)**

Finally, 990 study subjects (adolescents) were selected systematically. In addition, probability proportional to size technique was employed in each school to draw study subjects in terms of number and sex of study participants.

3.7 DATA COLLECTION METHODS AND PROCEDURES

3.7.1 Data collection methods

3.7.1.1 Quantitative method

Quantitative data was collected using a structured, self-administered questionnaire in each school anonymously. The data collection tools (questionnaire) (Annexure G) were prepared by taking account of the culture, language, etc. of the study populations and the structured questionnaire was developed after relevant literature reviewed to incorporate and measure important variables in the study. The data set included basic socio-economic characteristics of the students, patterns of positive sexual behaviours and protective factors for positive sexual behaviours. Data collection instrument was originally prepared with English language and translated to Amharic language (National official language of Ethiopia) by experts and then back to English for consistency of meanings. In addition, the instrument was pre-tested in schools other than study sites for clarity, understand-ability, and coherence of the questions. Experienced data collectors were recruited and trained on the overall data collection process using training manual. To facilitate data collection processes, manual containing a detailed description of the questions, operational definitions and other administrative issues were prepared and used. Data was collected in randomly selected six high schools from November 2-25, 2016 using self-administered questionnaire. Data completeness, accuracy and consistency were strictly monitored by supervisors throughout the process to ensure the reliability and validity of data.

3.7.1.2 Qualitative method

The selection of participants and the formation of the focus group discussions were facilitated by the trained senior experts who have an ample experience on similar studies using guiding and probing questions.

The process of data collection was continued until saturation or redundancy was reached. This actually took a number of cycles of inquiry based on the leads that were generated

during the discussions. The discussions were also recorded on tape in addition to note taking. After the collection of the required data with a tape recorder and by taking notes, the task of transcribing was performed in Amharic (Ethiopian National language) and later was translated into English by technical and linguistic experts.

Data was collected with a combination of audio record and note taking to ensure complete capture of the discussion. Triangulation in data analysis considers transcribing the data using Amharic and English languages to maintain the consistency of meanings. In addition, the transcribed data was reviewed by experts.

3.8 DATA VALIDITY AND RELIABILITY

3.8.1 Quantitative approach

3.8.1.1 Reliability of the study

Reliability refers to the stability of a research design (Elizabeth and Laura 2011: 94). Reliability in quantitative research refers to the degree of reproducibility and stability of a particular instrument or technique to yield the same result each time it is applied to the same subject (Earl, 2010: 150-152). Reliability refers to the degree of consistency with which an instrument measures an attribute. Reliability is an indicator of the ability of an instrument to produce similar scores on repeated testing occasions that occur under similar conditions. The reliability of an instrument is important to consider to ensure that changes in the variable under study represent observable variations and not those resulting from the measurement process itself (Elizabeth and Laura 2011:201).

In this study, the investigator provided theoretical and practical training to the data collectors. In addition, the supervisor verified the reliability of selected questions from study participants during the fieldwork. Data completeness, accuracy and consistency were strictly monitored by supervisors throughout data collection. The Data Clark entered the data into SPSS version 23 software. Another 15 randomly selected questions were

selected and entered into SPSS software and checked for consistency. We found inconsistencies in only two of them implying that the data entered were consistent.

3.8.1.2 Validity of the study

In quantitative part of the study, the concept of validity as it applies to design refers to the extent to which your study answers the research questions and your findings are accurate or reflect the underlying purpose of the study (Elizabeth and Laura 2011: 90).

According to Elizabeth and Laura (2011; 90-200) validity addresses the critical issue of the relationship between a concept and its measurement. It asks whether what is being measured is a reflection of the underlying concept. It also refers to the extent to which your study answers the research questions and your findings are accurate or reflect the underlying purpose of the study. The closer an instrument comes to representing the "true" definition of the concept, the more valid the instrument.

According to Elizabeth and Laura (2011: 90), internal validity is maintained when the research design answers the research question accurately. If a design has internal validity, the investigator can state with a degree of confidence that the reported outcomes are the consequence of the relationship between the independent variable and dependent variable and not the result of extraneous factors (Elizabeth and Laura (2011:90-91).

External validity refers to the capacity to generalize findings and develop inferences from the sample to the study population stipulated in the research question. External validity answers the question of "generalizability." (Elizabeth and Laura 2011: 93).

The goal for this study was to select designs that maximize both internal and external validity by establishing a minimum requirement for meeting the criteria of external validity. The factors that might affect validity such as related to selection of subjects, study conditions, and type of observations were carefully undertaken.

In the quantitative part of this study, data from the study subjects was collected by using structured self-administered questionnaires. The structured questionnaire was developed after relevant literature review to incorporate and measure important variables in the study. Moreover, the researcher incorporated important comments and suggestions from statisticians and epidemiologists to improve the validity of the instrument that reflects the concept it is supposed to measure. Operational definitions developed to key terms in relation to the research concept and approach.

The researcher and supervisors were closely examined the items in the questionnaire to ensure that they can measure the intended variables. Pre-test of the questionnaire was also carried out in other schools which had almost similar socio demographic characteristics. The result of the pre-test was discussed and assessed and some corrections and changes were made as necessary.

3.8.2 Qualitative approach

3.8.2.1 Trustworthiness

Researchers substitute trustworthiness data instead of focusing on reliability and validity in qualitative researches (https://www.thebalance.com/establishing-trustworthiness-in-qualitative-research-2297042 ; Date accessed October 24, 2017). Grove, Burns and Gray (2015:392) define trustworthiness as a determination that a qualitative study is rigorous enough and high quality.

Grove et al (2015:392) and Polit and Beck (2009:511) further explain that the trustworthiness of a qualitative study is determined by the extent to which it is dependable, confirmable, credible, transferable and authenticity. It is worth noting that these criteria are inter-related and the more confirmable and dependable a study is, the more credible it is (Grove et al 2015:392).

3.8.2.1.1 Credibility

Credibility in qualitative research is defined as the extent to which the data and data analysis are believable and trustworthy. Credibility is analogous to internal validity, that is, how research findings match reality. However, according to the philosophy underlying qualitative research, reality is relative to meaning that people construct within social contexts.*(researchonline.nd.edu.au/cgi/viewcontent.cgi? filename=2; Date accessed: June 5 2015).*

The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results
(From: https://www.socialresearchmethods.net/kb/qualval.php; date accessed October 24, 2017).

In order to enhance the credibility of this study the researcher attended all discussions and had spent sufficient time interacting with the discussion participants to develop a rich understanding of their perceptions on factors supporting positive sexual behaviour. Members check was also performed during the discussion by reading out what was documented in the field note to the participants and confirming that is what they wanted to say. Probing questions were used to confirm that the researcher got their opinions rightly.

In addition, each focus group was held in a very quiet hall that facilitates a circle seating arrangement in each school that encourages participants to share points of view, experiences, wishes and concerns without pressurizing participants to vote or reach consensus. During the discussion both verbal and non-verbal communication were carefully followed. Triangulation was accomplished by asking same research questions of different study participants of the FGD and the quantitative study helped to corroborate the qualitative results (Hurley, Denegar and Hertel 2011:119).

3.8.2.1.2 Dependability

Dependability which is analogous to reliability in qualitative research entails to the judgement about the repeatability or the interpretation of the research findings (Hurley, Denegar and Hertel 2011:119). This study tried to ensure dependability by asking the same question among all focus group discussions. Accurate note taking during focus group discussions also helped to improve reliability of the data. In order to enhance the dependability in this study, the researcher was maintained an audit trail in which the research design, methods of data collection and analysis implemented were properly documented. During data analysis, the researcher also used test-retest method to test the reliability of the coding. The researcher did recoding two months after the first coding without looking the results of the first coding. Then, differences were resolved by qualifying the coding categories.

In addition, after the researcher transcribed and coded data, discussion was held with an expert who has experience on qualitative research. The inputs helped to improve the reliability of the process. The researcher did a comparison with in the themes. This allowed checking regularities in the data to identify contextual meaning among discussants.

3.8.2.1.3 Confirmability

Confirmability refers to objectivity, which has the potential for congruence between two or more independent people about the data's accuracy, relevance, and how to interpret it (De Vos, Strydom, Fouche and Delport 2007:352 and Polit and Beck 2008:539). Confirmability also refers to the degree to which the results could be confirmed or corroborated by others. There are a number of strategies for enhancing confirmability. The researcher documented the procedures for checking and rechecking the data throughout the study https://www.socialresearchmethods.net/kb/qualval.php;date accessed October 24, 2017). The researcher ensured that the findings reflected the participants' voices and the condition of inquiry, not the biases, motivations or perspectives of the researcher (Polit and Beck 2008:539). In order to enhance the

confirmability of the study, the researcher also used an audit trail and thick description to authenticate confirmability.

3.8.2.1.4 Transferability

Transferability refers to the generalisability or the extent to which the findings can be transferred or have applicability to other settings and target populations (De Vos et al 2007:352;

The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research. https://www.socialresearchmethods.net/kb/qualval.php;date accessed October 24, 2017 The researcher has identified and described sufficient data and compiled the report such that it became easier for the consumers to evaluate the applicability of the data to other settings/contexts (Polit and Beck 2008:539). In this case, the researcher provided the background information to establish the context of the study and a detailed description of the phenomenon to allow comparisons to be made.

3.8.2.1.5 Authenticity

Authenticity refers to the extent to which the researcher has given a fair, faithful, honest and balanced account of social life from the viewpoint of someone who lives it every day, showing a range of different realities (Polit and Beck 2008:540). In this study the researcher had provided a true report that invites readers to share experiences regarding the protective factors to support positive sexual behaviours of adolescents (Polit and Beck 2008:540).

3.9 DATA MANAGEMENT AND ANALYSIS

3.9.1 Quantitative data analysis

The quantitative data collected from the study population was entered and analysed into appropriate statistical software (SPSS version-23). Then, cleaning and organizing were

done in such a way that enabled analysis within the framework of the study objectives. This was included entering all questionnaires into a database immediately after manual edition and check-up for completeness. Then after cleaning, the entered data was analysed using SPSS version 23.0 software package. Descriptive statistics, and binary logistic regression analysis were employed to identify protective factors associated with positive sexual behaviours. Variables with significant association in the bivariate analysis were entered in to logistic regression to control confounding effects. Analysis of variance was used to compare means among the study subjects.

3.9.2 Qualitative data analysis

A deductive approach was used in the qualitative data analysis since the larger component of this research is quantitative. The main data analysis took place immediately following the completion of each focus group discussion. In this regard, the usual principles that guide qualitative analysis was taken into account and a sequence of interrelated steps (reading, coding, displaying, data reduction and interpreting) were employed while analyzing the data.

The procedure that was used to process the raw data for the purposes of classification, summarization and tabulation was thematic analysis. The basic idea here was to identify the extracts of data that was informative in some way and to sort out the important messages hidden in the mass of each focus group discussion. The key statements, ideas, and attitudes expressed by the participants were listed for each topic. That was done using the discussants own words. Categorization of statements for each topic was undertaken. All quotations that emerged from the focus group discussions were selected to explain thickly the main ideas.

3.10 ETHICAL CONSIDERATIONS

Ethical concerns focus on the rights of human research participants to full knowledge of the purpose of the study and the nature and scope of their involvement; the specific behaviours or conduct of the investigator; and the ethics underlying the research question

or query, boundary-setting strategies, and design procedures that was implemented (Elizabeth and Lauren 2011: 2:21)

The ethical protection of adolescents was maintained throughout this study. Before the study began, ethical clearance was obtained from the Research and Ethics Committee of the Department of Health Studies at UNISA (Annexure A). Institutional consent was also obtained from Addis Ababa Regional Education Bureau and respective administration Education offices in selected sub-cities after communicating with them through an application letter together with UNISA ethical clearance (Annex C).

3.10.1 Informed consent

Johnson and Christensen (2012:107) define an informed consent as "agreeing to participate in a study after being informed of its purpose, procedure, risks, benefit, alternative procedures and limits of confidentiality".

According to Streubert-Speziale (2007:63), informed consent is also grounded on the ethical principle of autonomy in that "it encompasses the notion of being a self-governing person with decision-making capacity".

As a result, informed consent was obtained by using parental consent form (Annex F) from the families for those below 18 years of age and for those who were above 18 years of age Informed consent was obtained from respondents before they filled in the questionnaires. The participant who were included in the study were given enough information in order to understand the nature of a research project and make an informed decision. The possible benefits of the study and the right to withdraw at any time were communicated to the study subjects. Each piece of information that was given by every responding subject was strictly confidential. A statement that address this issue was shown upon the first page of each questionnaire. It was only when the respondent gave his/her written consent for questionnaire and verbal consent for FGD that the data collection was taken place.

3.10.2 Freedom to with draw from the study

Respect for person's autonomy requires ensuring that the research participants participate in the research voluntarily and after being fully informed about the research (Bordens and Abbott 2011:200). In this study, participants were informed that they are free to with draw from the study any time without prejudice.

3.10.3 Confidentiality or anonymity of the participants

Confidentiality means that no person other than specified members of the research team can have access to the respondent's information, unless those who have access to the data are identified to the participants before their participation (usually stated in informed consent); and the information provided by a respondent cannot be linked to the person's identity (Elizabeth and Lauren 2011:150).

Similarly, anonymity is the practice of maintaining records so that nobody can identify which individual is associated with a certain set of data (Bernard and Maureen 2012; 2:32).

With regard to this study, confidentiality of the study participants was ensured in such a way that anybody outside a research project did not have any access to the data. Study participants did not write their name on the questionnaire paper, participants name were never used when reporting findings and data were analysed as group data so that individuals cannot be identified by their responses. Similarly, anonymity of the participants was strictly maintained through keeping records and information so that nobody can identify which individual is associated with a certain set of data.

3.11 CONCLUSION

In this chapter the research design which deals with the overall structure and which is also a blueprint for maximising control over factors that could interfere with study's desired outcome were presented. The type of the study design which is a cross- sectional by type using quantitative and qualitative method are also discussed. Under the research method, the research population, sample population, sampling frame, and sample size

determination based on the standard formula and sampling techniques which was the process of drawing study subjects from the population were thoroughly discussed. For the data collection, the process of development of the data collection instruments, the procedures that had to be followed for data collection as well as how to keep data quality were clearly stated. Finally, ethical issues that had to be considered for data collection such as the steps to be followed to get ethical clearance and how to get participants informed consent before they can participate in a study as well as the right of the participants to be involved or with draw from the study and the importance of confidentiality were also well addressed.

In this study, the ethical concern focused on the rights of human research participants to full knowledge of the purpose of the study and the nature and scope of their involvement, the specific behaviours or conduct of the investigator and the ethics underlying the research questions, strategies, and designing procedures.

CHAPTER FOUR

QUANTITATIVE RESULTS

4.1 INTRODUCTION

The chapter presents quantitative findings. The data is analysed using descriptive and analytic statistics. Descriptive statistics, and binary logistic regression analysis were employed to identify protective factors associated with positive sexual behaviours. Variables with significant association in the bivariate analysis were entered in to logistic regression to control confounding effects. Analysis of variance is also used to compare means among the study subjects.

4.2 RESULTS OF THE STUDY

From the 990 eligible respondents, 954 (96.4%) high school adolescents fully responded to the self-administered questionnaire. The data collected from self-administered questionnaire, represents respondents' perceptions on positive sexual behaviour among adolescents. The quantitative data is analysed and presented based on the question sequences in the questionnaire under the different sub-headings: socio-demographic information, impact of parents and family support; school situation, peer support, community and neighbour support; sexual activity and factors supporting positive sexual behaviour.

4.2.1 Socio-demographic information

Table 4.1 shows the socio-demographic information of the participants. There were 595 (62.4%) females and 359 (37.6%) males who participated in the study. The majority of the students were in the age group 17 -19 years (89.8%). The distribution of students by grade were 367 (38.5%) and 587 (61.5%) in grade 11 and 12 respectively.

Table 4.1: Socio-demographic characteristics of high school adolescents.

Variable	Frequency	Percent
Sex		

Male	359	37.6
Female	595	62.4
Age Group		
14-16	70	7.3
17-19	857	89.8
20-24	27	2.8
Grade		
Eleven	367	38.5
Twelve	587	61.5

4.2.2 Educational and economic status of the families

The questionnaire also included questions on the educational and economic status of the families of the respondents as shown in table 4.2.

Educational status of parents of adolescents who participated in the study showed that 352 (36.9%) and 265 (27.8%) fathers and mothers were diploma and above in qualification respectively.

More than half of students 531 (55.7%) were living with both parents. About 636 (66.7%) of respondents perceive their families' economic status to be average whereas 101 (10.6%) and 39 (4.1%) of respondents perceive their families' economic status to be very poor and very rich respectively.

Table 4.2: Educational and economic status of the families and living and status of the respondents.

Variable	Frequency	Percent
Maternal education		
Illiterate	60	6.3
Read and write	210	22
1-12 grade	368	38.6
Diploma and above	265	27.8
Do not know	36	3.8
No response	15	1.5
Paternal education		
Illiterate	36	3.8
Read and write	186	19.5
1-12 grade	296	31.0
Diploma and above	352	36.9
Do not know	55	5.8
No response	29	3.0
Living with		
Both parents	531	55.7
Mother only	174	18.2
Father only	66	6.9
Other arrangement	173	18.1
No response	10	1.0
Family economic status		
Very poor	101	10.6
Average	636	66.7
Good economy	86	9.0
Very rich	39	4.1
Do not know	62	6.5
No response	30	3.1

4.2.3 Impact of parent and family support

Family situation of the respondents are categorized and summarized into Parental-connectedness, communication, monitoring and parenting style.

4.2.3.1 Parental connectedness and other family relationships respondents

Parental connectedness of the respondents is summarized in Table 4.3. Majority of the respondents reported that family members are ask each other for help, spend free time together, feel very close to each other and eat meal together satisfied with family discussion and relationships 810 (87.4%), 723 (78.9%), 747 (82.5%), 696 (86.4%) respectively. Similarly, Adolescents reported that they are satisfied with family discussion and relationships 349 (53.0%) and perceived that adolescents should follow parents' rules about sexual activities 663 (77.4%). On the contrary, ever had conflict with parents 586 (66.4%), feel parents mistreated me 198 (22.4%), belief that parents' belief and respondents' belief is similar on sexual values 368 (44.4%) and adults in the household fight each other 559 (70.8%).

Table 4.3: Parental connectedness and other family relationships among respondents.

Variable		Frequency	Percent
Family members ask each other for help			
	Yes	810	87.4
	No	117	12.6
Family members like to spend free time with each other			
	Yes	723	78.9
	No	193	21.1
Family members feel very close to each other			
	Yes	747	82.5
	No	159	17.5
Think easily of things to do together as a family			
	Yes	653	72.7
	No	245	27.3

Listen to what other family members have to say even when I disagree		
Yes	467	53.4
No	407	46.6
Available when others in family want to talk to me		
Yes	626	71.6
No	248	28.4
Family does things for fun		
Yes	734	80.7
No	175	19.3
Family members eat meal together		
Yes	696	86.4
No	110	13.6
Satisfied with your family discussion, connectedness and relationships regarding to your sexual activity		
Yes	349	53.0
No	309	47.0
Belief that you should follow parents' rules about sexual activities		
Yes	663	77.4
No	194	22.6
Think that your belief and your parents' belief is similar on sexual values		
Yes	368	44.4
No	460	55.6

4.2.3.2 Parent-adolescent communication

Parental connectedness of the respondents is summarized in Table 4.4. Only 155 (20.0%) of the respondents mentioned that parents talk to their adolescents about sex. Similarly, less than one-third (31.8% and 30.6%) adolescents talk to their parents about pregnancy and STI including HIV/AIDS; and their parents accept and support contraceptive use by adolescents respectively. The main reasons that adolescents not discussing with parents about sex, pregnancy, STI/HIV/AIDS and contraceptive use include do not feel comfortable (34.4%), parents may suspect that adolescents started sexual activity (16.6%) and parents never give a chance to adolescents to talk about sex (15.1%). Nevertheless, 46.2% adolescents discuss sexual issues with other family members.

More than half (52.4%) of adolescents reported families talk to adolescents about the changes occur during adolescence. However, majority (73.5%) of adolescents responded that they will be punished if parents discover their sexual activity.

Table 4.4: Adolescent - Parent/ guardian communication.

Variable	Frequency	Percent
Parent(s) talk to me about sex		
Yes	155	20.0
No	620	80.0
Parent(s) talk to me about pregnancy, STI including HIV/AIDS		
Yes	222	31.8
No	476	68.2
Reason for not discussing sexual issues with your parents		
Culturally wrong to talk about sex with parents	46	8.4
Parents have never given the chance to talk about sex	83	15.1
Parents suspect adolescents if he/she asks them about sexual activity	91	16.6
Feel that parents will not tell all the information I want	34	6.2
Do not feel comfortable	189	34.4
Other	44	8.0
Do not remember	62	11.3
Parent(s) accept and support contraceptive by adolescents		
Yes	186	30.6
No	422	69.4
Parent(s) talk about the changes occurring during adolescence		
Yes	406	52.4
No	369	47.6
Parent(s) talk to me about school		
Yes	525	63.7
No	299	36.3
Parent(s) communicate positively		
Yes	537	67.8
No	255	32.2
Parent(s) will punish if they discover my sexual activity		
Yes	534	73.5
No	193	26.5
Parent(s) think it is okay for teenagers to have sex		
Yes	211	25.1

	No	628	74.9
Parent(s) discuss with about substance use (alcohol, khat, cigarettes and drugs)			
	Yes	561	63.3
	No	325	36.7
Discuss about sexual issues with other member of family			
	Yes	386	46.2
	No	450	53.8

4.2.3.3 Parental monitoring and parenting style

Parental monitoring and parenting styles of respondents are summarized on Table 4.5. More than sixty-six percent of adolescents said that they need permission from their parents to go anywhere and 44.6% responded that their parents know all their friends. More than one third of adolescents (38.0%) also reported that their parents do not mind if adolescents get boy/girlfriends.

Less than half of the adolescents (46.5%) perceived that there is a greater compatibility between their parents' and their expectations. Concurrently, 68.7% and 58.9% adolescents claimed that there is a greater parental strictness and influence on their personal decisions respectively. Regarding, parenting style 529(59.2%) of respondents perceived that their parents follow authoritative parenting style, 231(25.8%) authoritarian parenting style, 119(13.3%) permissive parenting style and 15(1.7%) neglectful parenting style.

***Table 4.5: Parental monitoring and parenting style among adolescents attending* high school.**

Variable		Frequency	Valid Percent
Parent(s) allow me to stay at friends' houses overnight if I want to			
	Yes	166	21.4
	No	608	78.6
Parent(s) know all my friends			
	Yes	357	44.6

No	444	55.4
Need permission from my parent(s) to go anywhere		
Yes	527	66.7
No	263	33.3
Parent(s) know where I am if I am not at home		
Yes	443	55.9
No	350	44.1
Parent(s) have clear rules and consequences		
Yes	586	71.9
No	229	28.1
Parent(s) do not mind if I get a boyfriend/ girlfriend		
Yes	313	38.0
No	510	62.0
Feel a greater compatibility between your parent(s) and your expectations		
Yes	364	46.5
No	418	53.5
Feel a greater parental influence on your personal decisions		
Yes	508	58.9
No	354	41.1
Greater parental monitoring (curfew in place)		
Yes	600	68.7
No	273	31.3
Family parenting style		
Authoritarian	231	25.8
Authoritative	529	59.2
Permissive	119	13.3
Neglectful	15	1.7

Family connectedness, communication and parenting and monitoring styles are related with adolescents positive sexual behaviour as depicted on Table 4.6. Parental connectedness and other family relationships such as eating meals together (X2=28.89, P=0.00), belief that adolescents should follow parents' rules about sexual activities (X2=16.41, P=0.000) and adolescents' belief and parents' belief is similar on sexual values (X2=5.70, P=0.013) are significantly associated with positive sexual behaviour.

In addition, Parental communication including Need permission to go anywhere (X^2=32.34, P=0.000), parents talk to adolescents about sex (X^2=4.18, P= 0.029), parents accept and support contraceptive by adolescents (X^2=8.1, P=0.003) and parents have

clear rules and consequences (X^2=9.39, P=0.002) are statistically significant with adolescents positive sexual behaviour.

Similarly, there are statistically significant factors related to parental style and monitoring like greater parental monitoring (X^2=5.16, P= 0.023), parenting style (X^2=28.51, P=0.000), and need permission to go anywhere (X^2=32.34, P=0.000).

Table 4.6: Respondents sexual activities.

Characteristics	Ever had sex before				X^2 (P-value)	
	YES		NO			
	Number	Percent	Number	Percent		
Greater parental monitoring (curfew in place)						
Yes	62	12.6	432	87.4	5.159	0.023**
No	43	19.4	179	80.6		
Living with						
Both parents	65	15.5	355	84.5	15.67	0.016**
Mother only	14	10.2	123	89.8		
Father only	7	11.3	55	88.7		
Other arrangement	22	16.7	110	83.3		
Family parenting style						
Authoritarian	28	13.7	176	86.3	28.507	0.0000**
Authoritative	49	11.6	374	88.6		
Permissive	20	21.5	73	78.5		
Neglectful	7	63.6	4	36.4		
Family members eat meal together						
Yes	66	12.7	455	87.3	28.893	0.0000**
No	34	34.3	65	65.7		
Need permission to go anywhere						
Yes	37	9.5%	354	90.5%	32.336	0.0000**
No	59	26.9%	160	73.1%		
My parent talk to me about sex						
Yes	27	22.7%	92	77.3%	4.179	0.0290**
No	71	14.5%	419	85.5%		
Parents accept and support contraceptive by adolescents						
Yes	35	22.9%	118	77.1%	8.118	0.003**
No	42	12.2%	301	87.8%		
Parents have clear rules and consequences						

Yes	55	11.9%	408	88.1%	9.386	0.002**
No	41	21.1%	153	78.9%		
My parent do not mind if I get a boyfriend/girlfriend						
Yes	62	23.9%	197	76.1%	28.585	0.000**
No	36	8.9%	370	91.1%		
Belief that should follow parents' rules about sexual activities						
Yes	59	11.1%	471	88.9%	16.406	0.000**
No	41		130	171		
Adolescents' belief and your parents' belief is similar on sexual values						
Yes	33	10.8%	273	89.2%	5.696	0.013**
No	66	17.6%	310	82.4%		

*** p-value <0.05*

The parental correlates of protective sexual behaviour are shown in Table 4.7.

Parental connectedness such as belief that adolescents should follow parents' rules about sexual activities is significantly associated with positive sexual behaviour [AOR=0.462, 95%CI: 0.285-0.748]. Whereas there is no association between positive sexual behaviour and living arrangements with parents/guardians among adolescents [AOR=1.092, 95%CI: 0.644-1.853].

There was significant association between parenting style and positive sexual behaviour. Respondents from authoritative and authoritarian parents were more likely to have positive sexual behaviour [AOR=0.075, 95%CI: 0.021-0.265] and [AOR=0.091, 95%CI :0.025-0.331] respectively.

Adolescents who perceived their parents' close communication to them were more likely to have positive sexual behaviour. [AOR=0.56, 95%CI: 0.31-0.94] than their counterparts. Parental monitoring was significantly associated with positive sexual behaviour. Parental greater monitoring [AOR=0.604, 95%CI: 0.38-0.959], clear rules and consequence [AOR=0.378, 95%CI: 0.233-0.61395%CI] and need permission to go anywhere [AOR= 0.387, 95% CI: 0.235-0.637] were significantly associated with positive sexual behaviour.

Table 4.7: Factors associated with Sexual activities among high school students.

Variables	Sexual Activity (Number)		Adjusted OR (95% CI)
	Yes	No	
Family parenting style			
Authoritarian	28	176	0.091(0.025-0.331)
Authoritative	49	374	0.075(0.021-0.265)
Permissive	20	73	0.157(0.042-0.589)
Neglectful	7	4	1
Greater parental monitoring (curfew in place)			
Yes	62	432	0.604(0.38-0.959)
No	43	179	1
Need permission from parents to go anywhere			
Yes	37	354	0.387(0.235-0.637)
No	59	160	1
Parents have clear rules and consequences			
Yes	55	408	0.378(0.233-0.613)
No	41	153	1
Belief that adolescents should follow parents rules about sexual activities			
Yes	59	471	0.462(0.285-0.748)
No	41	130	1
Living arrangement			
Both parents	65	355	1.092(0.644-1.853)
Mother only	14	123	1.757(0.857-3.602)
Father only	7	55	1.571(0.633-3.904)
Other arrangement	22	110	1

4.3 SCHOOL SITUATION

In an attempt to consider the school situation of the respondents in the analysis of positive sexual behaviour, a few questions were asked in relation to school situations as summarized on Table 4.8. Accordingly, only 253 (28.8%) of the adolescents said that they participate in some sort of adolescent clubs in their respective schools. With regard to sexual and reproductive health counselling services and sex education, only 203 (26.6%) and 146 (19.8%) of adolescents said such services are available in their respective schools respectively. Four hundred seventy-one (59.8%) of adolescents perceive that their teachers are supportive or greater connection with their teachers.

One hundred and nine (12.9%) of adolescents usually missed their class and spend somewhere else during class time.

Table 4. 8: Information on school situation.

variable	Frequency	Percent
Participate in any adolescent/youth clubs (e.g. anti HIV/AIDS, mini-media, music, drama or sport activities) in your school		
Yes	253	28.8
No	625	71.2
Where do you spend your leisure time		
Stadium	45	4.7
Cinema	107	11.2
Meet friends and chew chat	90	9.4
Go to the bars and have some drink	51	5.3
Read fictions	163	17.1
Meet my partner	57	6.0
Watch films in local video houses	63	6.6
Don't know how to spend my time	308	32.3
other	70	7.3
Availability of sexual and reproductive health counsellor in your school		
Yes	203	26.6
No	560	73.4
Sex education in school?		
Yes	146	19.8
No	592	80.2
Perceive that teachers are supportive or greater connection to teachers		
Yes	471	59.8
No	317	40.2
Ever failed an exam (repeated the same class)		
Yes	98	11.7
No	737	88.3
In relation to classmates, your school performance		
Clever	102	11.8
Average	645	74.9
Weak	114	13.2
Ever missed a class and spent your school time somewhere else		
Yes	109	12.9
No	734	87.1

The bi-variate analysis showed that there was a relationship between adolescent's positive sexual behaviour with school situations as summarized on Table-4.9.

Sex education (X^2=7.33, P=0.007), adolescents' perception as teachers are supportive (X^2=7.50, P=0.004) and school performance (X^2=22.35, P=0.000) were statistically significant with positive sexual behaviours.

Table 4.9: Relationship of Adolescent sexual activity with selected variables

Characteristics	Ever had sex before				X^2, (P-value)	
	YES		NO			
	Number	Percent	Number	Percent		
Sex education in your school						
Yes	29	24.0%	92	76.0%	7.329	0.007**
No	63	13.4%	406	86.6%		
Perceive that teachers are supportive						
Yes	45	12.4%	318	87.6%	7.498	0.004**
No	55	20.8%	209	79.2%		
Ever failed an exam						
Yes	23	31.9%	49	68.1%	16.611	0.000**
No	77	13.0%	516	87.0%		
In relation to your classmates, your school performance						
Clever	14	16.7%	70	83.3%		
Average	56	10.9%	456	89.1%	22.348	0.000**
Weak	29	28.7%	72	71.3%		
Ever missed a class, spent your school time somewhere else						
Yes	39	39.8%	59	60.2%	55.52	0.000**
No	60	10.4%	517	89.6%		

*** P-value <0.05*

Binomial regression analysis indicated that there was an association between positive sexual behaviour and school related factors as shown on Table 4.10. Positive sexual behaviour is strongly associated with school performance [clever, AOR=0.141, 95%CI 0.055-0.362) and average, AOR=0.19, 95%CI:0.103-0.351)], adolescents' perception that teachers are supportive [AOR=0.447, 95%CI: 0.266-0.752] and sex education [AOR= 0.424, 95%CI:0.243-0.742].

Similarly, adolescents' sexual behaviour is strongly associated with not missing class [AOR=0.207, 95% CI: 0.115-0.371] and never failed an exam [AOR=0.301, 95%CI: 0.163-0.556].

Table 4.10: Associates of positive sexual behaviour among high school adolescents.

Variables	Sexual Activity (Number)		Adjusted OR (95% CI)
	Yes	No	
In relation to your classmates, your school performance			
Clever	14	70	0.141(0.055-0.362)
Average	56	456	0.19(0.103-0.351)
Weak	29	72	1
Perceive that teachers are supportive			
Yes	45	318	0.447(0.266-0.752)
No	55	209	1
Sex education in your school			
Yes	29	92	0.424(0.243-0.742)
No	63	406	1
Ever missed a class, spent your school time somewhere else			
Yes	39	59	1
No	60	517	0.207(0.115-0.371)
Ever failed an exam			
Yes	23	49	1
No	77	516	0.301(0.163-0.556)

4.4 COMMUNITY /NEIGHBOURHOOD SITUATION

In an attempt to consider the social environment of the respondents in the analysis of positive sexual behaviour, related questions were asked about community and neighbourhood situations as summarized on Table 4.11.

Only 158 (16.6%) and 61 (96.4%) respondents said adolescents mostly spend their leisure time going to stadium and cinema respectively.

However, 165 (17.3%), 91 (9.5%), 54 (5.7%), and 48 (5.0%) adolescents mostly spend their leisure times in chewing chat (Khat) with friends, go to bar and have some alcohol drinks, meet his/her girl/boyfriend and watch films in local video houses respectively. Less than one-third (30.4%) adolescents perceive their community with better quality and 26.3% adolescents perceive that there is good neighbourhood. However, only 13.4% adolescents perceived that there is cohesion among adults and adolescents. Two hundred and twenty-four (26.8%) and 225 (26.4%) adolescents perceive that people approve to use contraceptives and /or condom use by adolescents. In addition, ever discussed on sexual activity, condom and contraceptive use and STI/HIV/AIDS with health service providers in the community respectively. Regarding to misbehaviour of adolescents, 10.0% the respondents said that they ever been accused of some delinquent behaviour that leads to school suspension, expulsion or police intervention.

Table 4.11: Community /neighbour situation.

Variable	Frequency	Percent
Where to spend their leisure time		
Stadium	158	16.6
Cinema	61	6.4
Meet friends and chew chat	165	17.3
Go to the bars and have some drink	91	9.5
Read fictions	23	2.4
Meet my partner	54	5.7
Watch films in local video houses	48	5.0
Don't know how to spend my time	317	33.2
other	37	3.9
What do think about your community		
Better quality	269	30.4
Slum area	147	16.6
Good neighbourhood	233	26.3
Cohesion among adults and youths	119	13.4
Don't know	117	13.2
Perceive that adults care about adolescents in the community		
Yes	332	37.8
No	305	34.7

Don't know	242	27.5
Ever witnessed woman/girl violence in your community		
Yes	215	24.2
No	165	18.6
Don't know	509	57.3
Do you usually involve in sports in the community		
Yes	287	33.3
No	574	66.7
Think people important to you (parents, other adults or peers) approve of contraception or condoms use		
Yes	224	26.8
No	283	33.8
Don't know	330	39.4
Ever discussed on sex, condom use, contraception, STI/HIV/AIDS with health service providers in your community		
Yes	225	26.4
No	189	22.2
Don't know	439	51.5
How often do you usually attend religious services in church/mosque or other meetings in your community?		
Once a month	166	19.9
Once a week	278	33.3
Two to three times a week	237	28.3
Daily	122	14.6
Once a year	20	2.4
Not at all	13	1.6
Ever been accused of any delinquent behaviour		
Yes	70	10.0
No	392	56.1
Don't know /remember	237	33.9

As summarized on Table 4.12, the bi-variate analysis showed that adolescents Involved in sport activities [X^2 =19.44, P= 0.000] and think that people are important to approve of contraception or condoms use [X^2 =7.53, P=0.007] were statistically significant with adolescents positive sexual behaviour.

Table 4.12: Comparison of respondents sexual activities with selected variables.

Characteristics	Ever had sex before				X^2, (P-value)
	Yes		No		
	Number	Percent	Number	Percent	

Involved in sports in the community						
Yes	52	21.8%	187	78.2%	19.439	0.000**
No	44	9.4%	423	90.6%		
Think people important to you approve contraception or condoms use						
Yes	41	22	149	78	7.533	0.006**
No	27	11	211	88		

** *P-value <0.05*

Whereas adolescents think that people are important to approve of contraception or condoms use and ever discussed with health workers on sex, condom use, contraception and STI/HIV/AIDS were strongly associated with positive sexual behaviour [AOR= 0.319, 95%CI: 0.165-0.619] and AOR=0.545, 95%CI:0.318-0.932] respectively as indicated on Table 4.13.

Table 4.13: Associates of respondents sexual activities with selected variables.

Variables	Sexual Activity (Number)		Adjusted OR (95% CI)
	Yes	No	
Think people are important to adolescents approve of contraception or condoms use			
Yes	41	149	0.319(0.165-0.619)
No	27	211	1
Ever discussed sex, condom use, contraception and STI/HIV/AIDS with health workers			
Yes	35	166	0.545(0.318-0.932)
No	25	125	1

4.5 PEER SUPPORT

In relation to peers support for positive sexual behaviour, relevant questions were provided to adolescents including peers' attachment, norm and social behaviour.

4.5.1 Peer attachment

Attachment to peer/ friends, as measured by a Likert scale revealed that 749 (83.7%) of adolescents completely agree to feel closely attached to their peers as shown on Table 4.8.

Concurrently, 555(73.0%) and 507 (66.7%) of respondents believed that peer support or social activities with peers prevent sexual risks; and more peer influence on decisions respectively.

Table 4.14: Peers attachment.

Variable	Frequency	Percent
Feel closely attached to my friends		
Completely agree	749	83.7
Partly agree	106	11.8
Partly disagree	19	2.1
Completely dis agree	21	2.3
My friends value my opinion		
Completely agree	538	60.0
Partly agree	280	31.3
Partly disagree	57	6.4
Completely disagree	21	2.3
I can help/ support my friends		
Completely agree	625	70.0
Partly agree	197	22.1
Partly disagree	47	5.3
Completely disagree	24	2.7
I can count on my friends when I need a help		
Completely agree	687	77.0
Partly agree	143	16.0
Partly disagree	29	3.3
Completely disagree	33	3.7
Do you believe the importance of friends or more peer influence on decisions		
Yes	507	66.7
No	253	33.3
Do you think that peer support, bonding with peers or social activities with peers prevent sexual risks		
Yes	555	73.0
No	205	27.0

4.5.2 Peers norms and involvement

Four hundred and two (45.6%) of adolescents reported that at least one of their peers has a permissive value about sex during adolescence. Similarly, 475 (56%) of adolescents said that at least one of their peers supports condom use.

Regarding to sexual debut, 646 (73.2%) of adolescents perceived it is better to initiate sex when older. Four hundred and three (44.8%) and 375 (42.7%) adolescents believe that boys gain respect if sexually active and it is okay to have sex with multiple partners respectively as summarized on Table 4.15.

Table 4.15: Peers norms and involvement.

Variable	Frequency	Percent
Do your peers have a permissive value about sex		
At least some	402	45.6
None of them	326	37.0
Do not know	154	17.4
Do you think your peers support for condom or contraceptive use		
At least some	475	55.0
None of them	188	21.8
Do not know	201	23.2
Do your peers believe that it is better to initiate sex when older		
At least some	645	73.2
None of them	110	12.5
Do not know	126	14.3
Do your peers believe/think it is okay to have sex with multiple partners		
At least some	375	42.7
None of them	377	43.0
Do not know	125	14.3
Do your friends think that boys gain respect if sexually active		
At least some	403	44.8
None of them	320	35.6
Do not know	175	19.5
How many of your friends you know have had STIs		
At least some	165	51.7
None of them	75	23.5
Do not know	79	24.8

4.5.3 Peers sexual behaviour

Two hundred and ninety-two (36.8%) admitted that they have friends who have been accused of delinquency (Table 4.16). Two hundred twenty-one (29.6%%) of the adolescents claimed that their friends have had no sex while 342 (45.8%) reported that at least some of their peers were sexually active. A considerable number of the adolescents 183 (24.6%) did not know the sexual activity of their peers. Among the respondents, 236 (73.0%) of adolescents reported that at least some of their peers use contraceptive during sex whereas 26 (8.0%) of them do not use any contraceptive during sex. Similarly, 162 (80.3%) of adolescents mentioned that at least some of their peers use condom during sex whereas 50 (15.4%) and 14 (4.3%) of respondents reported that they do not know whether their sexually active peers used condom during sex. Of the respondents who have sexually active friends, 165 (51.7%) adolescents reported that at least one of their friends had a history of STI.

Table 4. 16: Peers' sexual behaviour.

variable	Frequency	Percent
Have any of your friends been accused of delinquency		
Yes	292	36.8
No	502	63.2
Do your friends use alcohol, khat, smoking, shisha or other drugs		
None of them	432	51.2
At least some	301	35.7
Do not know	110	13.1
About how many of your friends do you think have had sex		
At least some	342	45.8
None of them	221	29.6
Do not know	183	24.6
How many of your friends use contraceptive pills during sex		
At least some	236	73.0
None of them	26	8.1
Do not know	61	18.9
Do your peers use condoms during sex		
At least some	162	80.3
None of them	14	4.3
Do not know	50	15.4

Adolescents sexual behaviour was assessed in relation to their peers support as depicted on Table 4.17. The bi-variate analysis depicted that adolescents who felt closely attached with their peers and counted on their friends when they need a help were statistically significant with positive sexual behaviour [X^2 = 20.99, P= 0.000 and X^2 = 59.54, P= 0.000] respectively. In addition, respondents who perceived that they can help their friends and friends value their opinion were also statistically significant with respondents' positive sexual behaviour [X^2 =50.35, P= 0.000 and $\mathbf{X^2}$=36.80, P= 0.000].

Respondents sexual behaviour were statistically significant with peer's attachment, norms and involvement and sexual behaviour. Respondents sexual behaviour were statistically significant with peers' permissive value about sex (X^2=39.00, P=0.000), believe it is okay to have sex with multiple partners (X^2=36.21, P=0.000), peers that have been accused of delinquency (X^2=25.24, P=0.000) and peers use substances (alcohol, khat, smoking, shisha or other drugs) (X^2=32.61, P=0.000).

Concurrently, respondents sexual behaviour were also statistically significant with peers who support for condom or contraceptive use (X^2= 13.31, P=0.000), believe that it is better to initiate sex when older (X^2=7.56, P=0.000), bonding with peers/social activities with peers (X^2=6.39, P=0.006) and peers who have had sex before (X^2= 50.31, P=0.000).

Table 4.17: Relationship of adolescents' sexual activity with peers' support.

Characteristics	Ever had sex before				X2, (P-value)	
	YES		NO			
	Number	Percent	Number	Percent		
Feel closely attached to my friends						
Completely agree	78	12.6%	540	87.4%	20.994	0.000**
Partly agree	13	15.5%	71	84.5%		
Partly disagree	4	26.7%	11	73.3%		
Completely dis agree	10	52.6%	9	47.4%		
My friends value my opinion						
Completely agree	46	10.2%	403	89.8%	36.801	0.000**
Partly agree	37	16.4%	188	83.6%		
Partly disagree	13	27.7%	34	72.3%		
Completely dis agree	9	56.3%	7	43.8%		
I can help/ support my friends						

Completely agree	54	10.6%	454	89.4%	50.346	0.000**
Partly agree	26	15.4%	143	84.6%		
Partly disagree	13	35.1%	24	64.9%		
Completely dis agree	12	57.1%	9	42.9%		
I can count on my friends when I need a help						
Completely agree	68	12.1%	492	87.9%	59.537	0.000**
Partly agree	15	12.5%	105	87.5%		
Partly disagree	4	15.4%	22	84.6%		
Completely dis agree	18	64.3%	10	35.7%		
Do your peers have a permissive value about sex						
At least some	84	23.8%	269	76.2%	39.00	0.000**
None of them	13	4.9%	250	95.1%		
Do you think your peers support for condom or contraceptive use						
At least some	84	20.2%	331	79.8%	13.31	0.000**
None of them	10	6.8%	138	93.2%		
Do your peers believe that it is better to initiate sex when older						
At least some		13.5%	474	86.5%	7.55	0.006**
None of them	21	25.9%	60	74.1%		
Do your peers believe/think it is okay to have sex with multiple partners						
None of them	18	6.1%	277		36.21	0.000**
At least some	80	23.8%	256	76.2%		
Do your friends think that boys gain respect if sexually active						
None of them	14	5.8%	228		29.76	0.000**
At least some	83	22.7%	283	77.3%		
Do you think that peer support, bonding with peers or social activities with peers prevent sexual risks						
Yes	60	12.9%	405	87.1%	6.386	0.012**
No	39	21.2%	145	78.8%		
Have any of your friends been accused of delinquency						
Yes	60	22.6%	206		25.24	0.000**
No	35	8.5%	376	91.5%		
Do your friends use alcohol, khat, smoking, shisha or other drugs						
None of them	27	7.3%	343	92.7%	32.61	0.000**
At least some	58	24.0%	184	76.0%		
How many of your friends do you think have had sex						
None of them	4	2.0%	194	98.0%	50.31	0.000**

At least some	84	26.0%	239	74.0%		
Do your peers use condoms during sex					0.70	0.403
At least some	71	28.6%	177	71.4%		
None of them	6	42.9%	8	57.1%		

*** P-value<0.05*

As represented on Table 4.18, the binary logistic regression showed that adolescents sexual behaviour was associated with peers' support. Respondents who perceive that their peers prefer later sexual debut, bonding with peers were strongly associated with adolescents positive sexual behaviour [AOR=0.444, 95%CI:0.248-0.797 and AOR= 0.531, 95%CI: 0.327-0.862]. Respondents who completely agreed that they count on their peers' help, support their friends and perceive that their peers value their opinion were associated with their positive sexual behaviour [AOR=0.105, 95%CI:0.044-0.251; AOR=0.124, 95%CI: 0.043-0.358 and AOR=0.203, 95%CI:0.058-0.712] respectively.

Table 4. 18: Adolescents sexual activity associated with peers' support.

Variables	Sexual Activity (Number)		Adjusted OR (95% CI)
	Yes	No	
Initiate sex when older			0.444(0.248-0.797)
Yes	74	474	
No	21	60	1
Think that peer support/ bonding with peers or social activities with peers			0.531(0.327-0.862)
Yes	60	405	
No	39	145	1
I can count on my friends when I need a help			
Completely agree	68	492	0.105(0.044-0.251)
Partially agree	15	105	0.103(0.038-0.28)
Partially disagree	4	22	0.119(0.031-0.459)
Completely disagree	18	10	1
I can help/ support my friends			
Completely agree	54	454	0.124(0.043-0.358)
Partially agree	26	143	0.19(0.063-0.569)
Partially disagree	13	24	0.552(0.164-1.852)
Completely disagree	12	9	1
My friends value my opinion			
Completely agree	46	403	0.203(0.058-0.712)
Partially agree	37	188	0.301(0.085-1.066)
Partially disagree	13	34	0.408(0.111-1.493)

Completely disagree	9	7	1

4.6 RESPONDENTS SEXUAL ACTIVITY

One hundred and eleven (14.7%) of respondents had experienced sexual intercourse at the time of the study (Table 4.19). Of which 67.6% and 32.4% were males and females respectively (Figure 4.1). Of the sexual experienced adolescents, 39 (41.9%) were initiated sexual intercourse before 16 years of age. The main reason for first initiation of sex were personal desire 52 (51.0%) followed by peer pressure (13 (12.7%), pornographic films (10 (9.8%), forceful sex 8(7.8%) and to get money 6 (5.9%). Among sexually experienced respondents, 50 (63.3%) of respondents have had two or more partners in the last 12 months. Less than half 42 (49.4%) of the respondents used condom consistently in the last 12 months of sexual intercourse.

More than fifteen percent of the respondents also ever contracted one of the sexually transmitted infections. Among female respondents, 15 (46.6%) have ever had unwanted pregnancy.

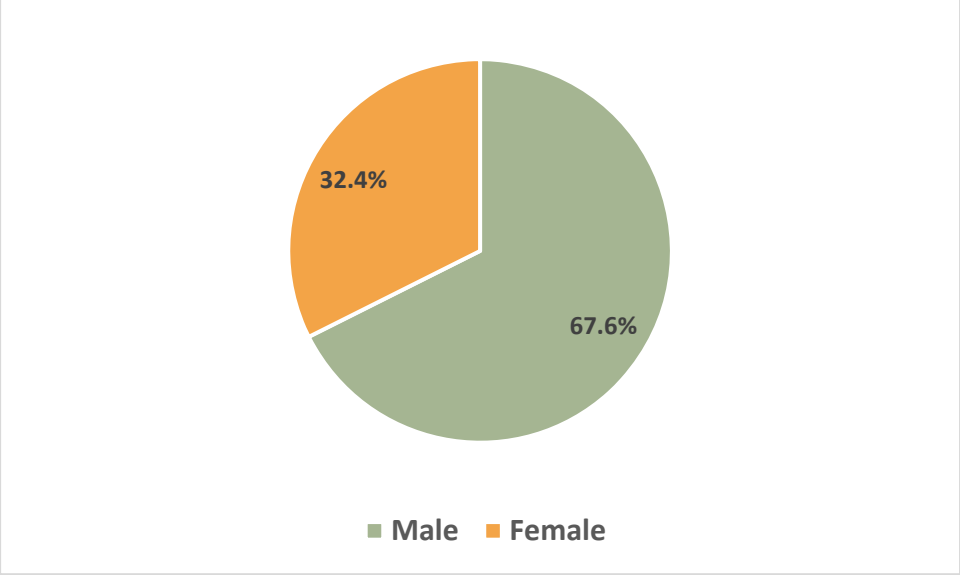


Figure 4 1 Ever had sexual intercourse by gender.

Table 4.19: Sexual activity of respondents.

Variable	Frequency	Percent
Ever had sex before		
Yes	111	14.7
No	646	85.3
At what age your first coital debut		
Below 16 years	39	41.9
16 and above years	54	58.1
Number of partners in the past 12 months		
One	29	36.7
Two or more	50	63.3
Have you ever contracted any sexually transmitted infections (STI)		
Yes	14	15.2
No	78	84.8
Have you ever had un wanted pregnancy		
Yes	15	44.1
No	19	55.9
Have you ever had an abortion		
Yes	15	46.9
No	17	53.1
What type of sexual partner did you have first		
Steady friend	43	44.3
Commercial sex worker	9	9.3
Causal partner	15	15.5
Stranger	17	17.5
Other	13	13.4
Have you used condom during the first time you had sex		
Yes	42	43.3
No	29	29.9
Do not remember	26	26.8
Could you remember how many sexual partners have you had after your first partner		
No one	25	36.8
Two-four	31	45.6
Do not remember	12	17.6
The last time you had sex did you and/or your partner use a condom		
Yes	36	41.9
no	38	44.2
Do not remember	12	14.0

The main reasons for first initiation of sexual intercourse were personal desire (55.9%) followed by peer pressure (14.0%), watching Pornographic films (10.8%), coercion (8.6%), to get money (6.5%) and substance use (4.3%) (Figure 4.2).

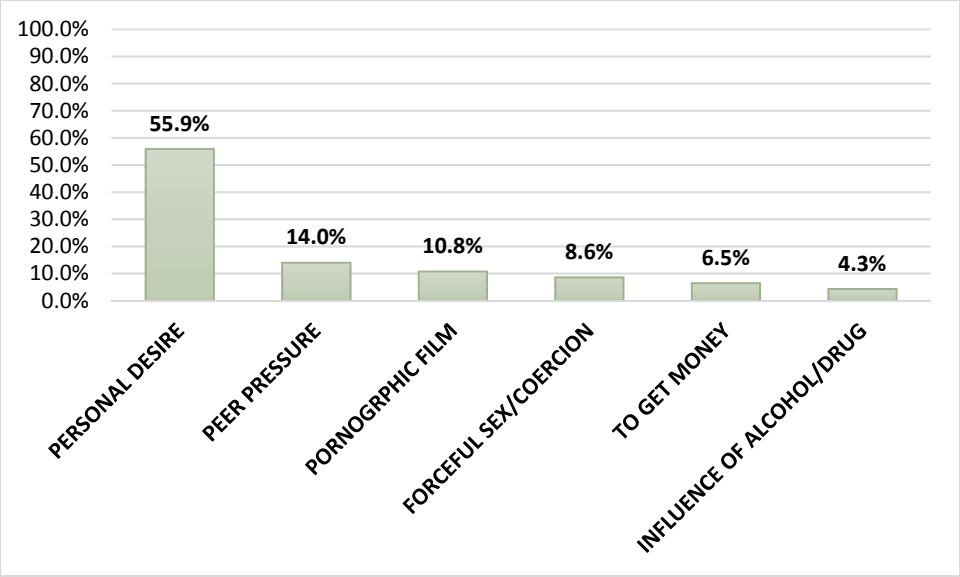


Figure 4 2 Reasons for first initiation of sexual activity.

The pie chart (Figure 4.3) showed that 64.1% of adolescents reported that they had sexual intercourse in the last 12 months. As indicated on Figure 4.4, only 38.0% of sexually active adolescents used condom consistently in the last 12 months of their sexual activity. The main reasons for not using condom consistently were unavailability (25.5%), too expensive (19.6%), not comfortable (17.6%) and reduces sexual pleasure (11.8%) (Figure 4.5).

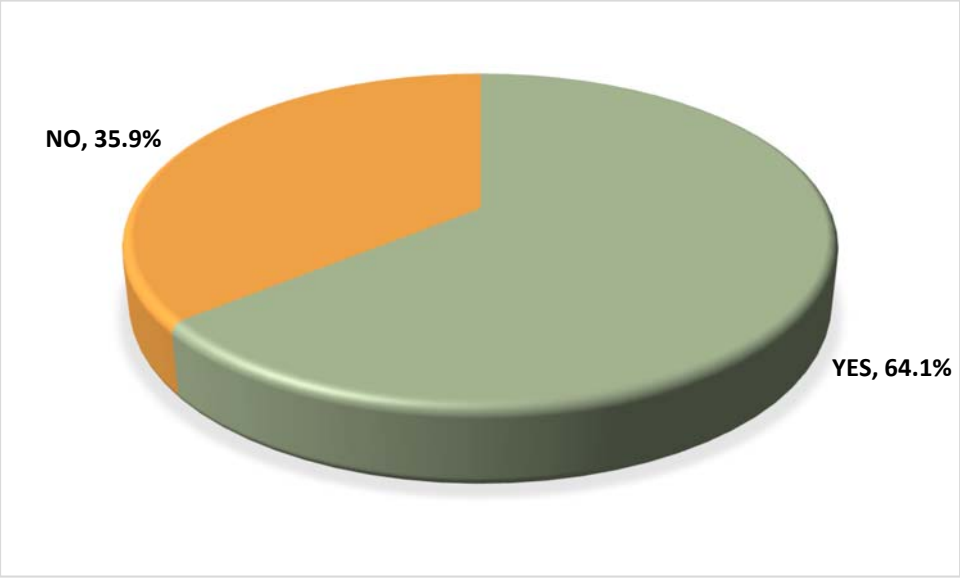


Figure 4 3 ***Sexual activity in the last 12 months.***

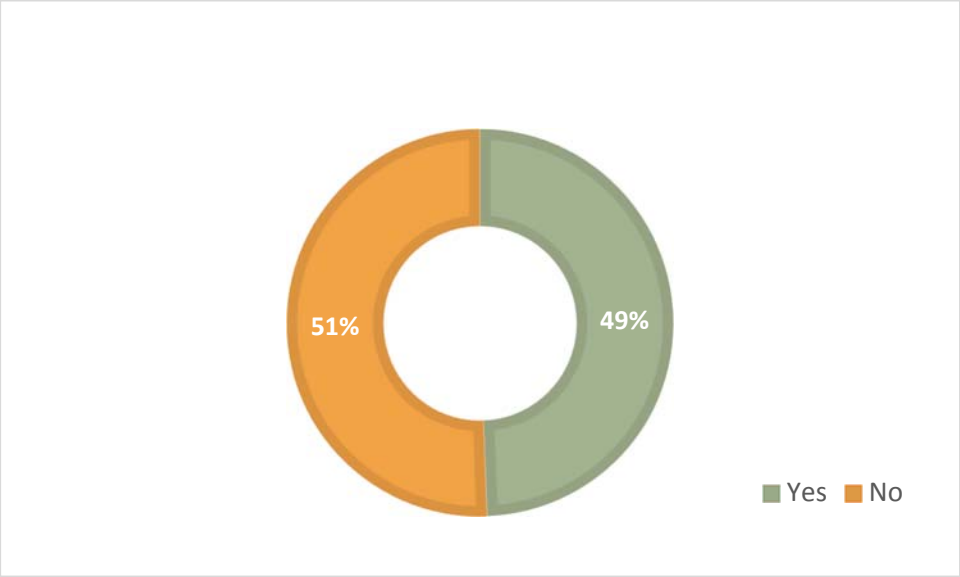


Figure 4 4 ***Consistent condom use in the last 12 months of sexual activity.***

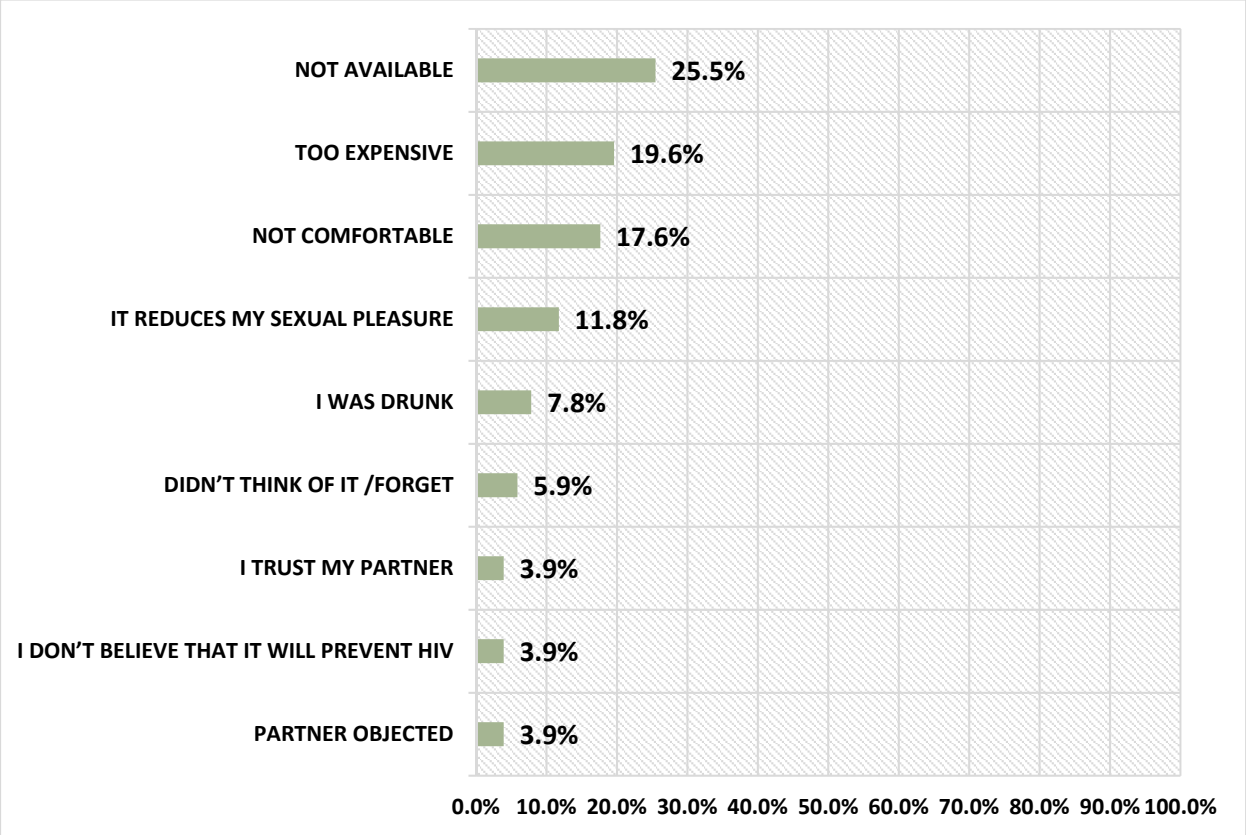


Figure 4 5 ***Reasons for not using condom consistently during sex in the last 12 months.***

4.7: FACTORS INFLUENCING POSITIVE SEXUAL BEHAVIOUR

Factors that influencing positive sexual behaviours summarized on Table 4.20. Adolescents perceived that factors related to family such as family structure 388(46.0%), socioeconomic status 427 (51.6%), upbringing 646 (77.7%) and parental supervision and guidance 609 (72.8%) has a role on adolescents positive sexual behaviours. On the contrary, a number of respondents did not know whether family related factors including family structure 175(20.7%), socioeconomic status 164 (19.86%), upbringing 80 (9.6%) and parental supervision and guidance 79 (9.4%) has a role on adolescents positive sexual behaviours.

Similarly, adolescents perceived that neighbourhood situation 493 (59.5%) and students' academic performance 343 (41.5%) were also influenced positive sexual behaviours. On the other hand, 134 (16.2%) and 162 (19.6%) of respondents did not know whether neighbourhood situation and academic performance influence adolescents positive sexual behaviours respectively.

Table 4.20: Factors influencing positive sexual behaviour.

Variable	Frequency	Percent
Family structure		
Yes	388	46.0
No	281	33.3
Don't know	175	20.7
Socioeconomic status of families		
Yes	427	51.6
No	236	28.5
Don't know	164	19.8
Upbringing		
Yes	646	77.7
No	105	12.6
Don't know	80	9.6
Parental supervision and guidance		

	Yes	**609**	**72.8**
	No	**148**	**17.7**
	Don't know	**79**	**9.4**
Neighbourhood situation			
	Yes	493	59.5
	No	202	24.4
	Don't know	134	16.2
Academic performance			
	Yes	343	41.5
	No	321	38.9
	Don't know	162	19.6

As summarized on Table 4.21, adolescents sexual behaviour was statistically significant with families' socio-economic status (X^2=5.57, P=0.013), upbringing (X^2=44.78, P=0.000), parental supervision and guidance (X^2= 9.64, P=0.001), neighbourhood situation (X^2= 6.46, P=0.011) and adolescents' academic performance (X^2=4.24, P=0.04).

Table 4.21: Factors influencing adolescents sexual behaviour.

Characteristics	Ever had sex before				X^2, (P-value)	
	YES		NO			
	Number	Percent	Number	Percent		
Socio-economic status of families						
Yes	45	12.1%	327	87.9%	5.565	0.013**
No	40	19.8%	162	80.2%		
Upbringing						
Yes	53	9.6%	499	90.4%	44.783	0.000**
No	33	35.9%	59	64.1%		
Parental supervision or guidance						
Yes	58	11.1%	463	88.9%	9.642	0.001**
No	28	22.0%	99	78.0%		
Neighbourhood situation						
Yes	49	11.6%	372	88.4%	6.464	0.011**
No	35	20.0%	140	80.0%		
Academic performance						
Yes	36	12.1%	262	87.9%	4.239	0.040**
No	50	18.7%	218	81.3%		

***P-value <0.05*

The binomial regression analysis showed that adolescents' positive sexual behaviour strongly associated with upbringing [AOR=0.313, 95%CI: 0.163-0.601], Parental supervision and guidance [AOR=0.459, 95%CI: 0.269-0.781], adolescents' neighbourhood situation [AOR=0.573, 95%CI:0.335-0.979)] and academic performance [AOR=0.57, 95%CI: 0.33-0.986] (Table 4:22).

Table 4. 22: Associates of adolescents sexual behaviours.

Variables	Sexual Activity (Number)		Adjusted OR (95% CI)
	Yes	No	
Upbringing			0.313(0.163-0.601)
Yes	45	327	
No	40	162	
Parental supervision and guidance			0.459(0.269-0.781)
Yes	58	463	
No	28	99	
Neighbourhood situation			0.573(0.335-0.979)
Yes	49	372	
No	35	140	
Academic performance			
Yes	36	262	0.57(0.33-0.986)
No	50	218	1

4.8 CONCLUSION

In this chapter the quantitative findings of the study have been presented. The quantitative study showed that adolescents have risky sexual behaviours at different levels. The study also depicts a number of protective factors already available at family, school, community and peer levels that help adolescents to build positive sexual behaviours. However, the study shows those protective factors at each domain are not utilized or at least under-utilized to build positive sexual behaviours of adolescents.

CHAPTER FIVE

QUALITATIVE RESULT

5.1 INTRODUCTION

This chapter presents and discusses the qualitative data findings of a mixed study. The qualitative finding presents data from focus group discussions with adolescents. The qualitative information is presented according to the theme developed during the data collection and analysis. The qualitative data obtained through focus group discussion is coded, categorized and developed into themes. The themes are presented within five major topics.

The key statements, ideas, and attitudes expressed by the participants were listed for each topic. All quotations that emerged from the focus group discussions were selected to explain thickly the main ideas.

The chapter also presents narrative descriptions of issues of concern to adolescents and suggestions made for supporting positive sexual behaviour among the study groups.

5.2 DATA COLLECTION PROCESS

The qualitative part of this study aimed at substantiating and complementing the main quantitative study. As part of this study, the researcher chose focus groups discussion, a commonly employed qualitative data collection method. Focus groups are a useful methodology to explore through group discussion a particular topic, experience or phenomena of interest (Elizabeth and Lauren 2011:222). Within a focus group a number of questions are put to the group and participants freely respond, often also interacting with each other, to the question (John, Glenn, Julie, et al 2010:57). Focus group approach is used when it is believed that the interactions and group discussions will yield more

meaningful understanding than single, independent interviews (Elizabeth and Lauren 2011:222).

Focus groups are a particularly good way of getting a rich vein of qualitative data because people in focus groups are not only talking about their own views and experiences, as in a one-to-one interview, but also on their responses to others' own views and experiences (John, Glenn, Julie, et al 2010:121).

5.2.1 Participants

Participants for focus group discussions (FGD) were recruited purposely through discussion with school administrators who have participated in different active extra-curricular activities voluntarily in two schools. Those participants were from grade 11 (n=15) and 12 (n=18) who regularly attended their classes. The age range of the participants were between 16-19 years. All the FGD participants were living with their families and unmarried as shown on Table 5.1. The purpose of the study was explained. Voluntary participation and anonymity was ensured with all discussion participants (Annexure G1).

Participants in this focus group discussions were identified according to group number and participant number: Group 1 Participant 1 (G1/P1), Group 2 Participant 1 (G2/P1), Group 3 Participant 3 (G 3/P3), etc. that were used on the analysis part to represent each verbatim.

Table 5.1: Focus Group Discussion(FGD) participants among high school adolescents, Addis Ababa, Ethiopia.

Focus group	No participants
1	9
2	9
3	7
4	8
Total	**33**

5.2.2 Instrument

Based on the literature review (Elizabeth and Lauren 2011:189), six broad focus group questions (Annexure G1), with some of the questions having multiple parts (sub topics), that assessed the five major themes of interest (Table-5.1) were employed. The major themes of interest included: Parental and family support, School situation, community/ neighbourhood support, peers' support and individual factor.

The questions were conversational, easy to say with clear meaning, short and open-ended, one-dimensional, with local language (Amharic) and use of words commonly used by participants. In addition, the responses to the questions after the first focus group was conducted were examined, and some of the questions were revised accordingly.

5.2.3 Data collection

The principal investigator served as the moderator for all focus group discussions with one experienced note taker. Four focus groups (two males and two female groups) were conducted as part of this investigation. As suggested by John, Glenn, Julie, et al (2010:121), each focus group was held in a very quiet hall that facilitates a circle seating arrangement in each school that encourages participants to share points of view, experiences, wishes and concerns without pressurizing participants to vote or reach consensus. Each focus group was completed within an hour on average. In addition to taking notes of focus group discussions, each session was audiotaped (with participants' permission) to ensure a more reliable data gathering process.

The focus group discussion in the study, therefore achieved a chain or cascaded effect, where participants could listen to each other's memories and experiences and triggered ideas in other participants (Gray 2014:470).

The researcher transcribed the audiotapes, a common procedure used to analyze qualitative data (Elizabeth and Lauren 2011:237).

These transcripts were compared with written notes to prevent misinterpretation of the data and to supplement the data collected on the audiotapes. Once the final transcripts were completed, the principal investigator and the note taker met to discuss how to identify themes and code the responses of each group based on the four domains. Then the researcher with linguistic expert translated the identified themes into English language and then back to Amharic language to check the consistency of meanings. The principal investigator, then, analysed and compared the results of each focus group to describe commonalties and differences in the responses of each group. This process resulted in several themes that were then coded in specific categories. In addition, the researcher selected specific quotes from the data to show common themes in all focus groups.

5.3 *PRESENTATION AND DISCUSSION OF THE FINDINGS*

Young people's behaviours are influenced at the individual, peer, family, school, community, and societal levels. Because many societal sectors contribute to adolescent health, safety, and well-being, collaborative effort to engage multiple partners is necessary. Such joint efforts can help to promote a more comprehensive approach to addressing adolescent health that views each adolescent as a whole person, recognising and drawing upon his or her assets and not just focusing on risks (CDC 2014:5).

Protective factors are characteristics within the individual or conditions within the family, school or community that help young people successfully cope with life challenges. When youth can successfully negotiate their problems and deal with pre-existing risk factors, they are less likely to engage in problem behaviour such as: substance abuse, violence, suicide, or early sexuality activity. Protective factors are instrumental in healthy development; they build resiliency, skills and connections (Alaska Division of Behavioural Health: 2011: 7).

Although the purpose of the study mainly focuses on protective factors, the qualitative study presents both risk and protective responses that were detailed in participants' responses which helps in turn to design a comprehensive strategy to develop positive sexual behaviour of adolescents based on major themes; namely: family support, community support, school situation, peers' support and individual factor. The major themes were coded into sub-themes to classify responses of participants as shown in Table 5.2.

Table 5.2: Major themes and sub-themes of participants' responses, Addis Ababa, Ethiopia

Major themes	Sub-themes	Sub-categories
Impact of parents and family support	Parental connectedness and other family relationships Adolescent - Parent communication Parental monitoring and parenting style	Feel warmth, love and support Open discussion on sexual issues Clear rules, guidance and consequences
Sexual behaviour amongst School adolescent	School based sex education, Adolescent sexual and reproductive health (ASRH) counselling Teachers support Mini-media Parents school involvement	Better knowledge on SRH Personality building, Positive attitude to condom and contraceptives Adolescent-teacher interaction Good school performance
Community support	Community engagement on ASRH programs, ASRH services in health facilities, Availability and easy accessibility of condom and contraceptives, Monitoring local video shops, Positive opportunities and social norms	Adult role model and mentor Friendly SRH services Lesser sexual risk taking and safer sexual activity Prevention of STIs, unwanted pregnancy and abortion

Major themes	Sub-themes	Sub-categories
Peer support	Peer Attachment Peer norm and involvement Peer sexual behaviour	Assertive Avoiding participating from risk behaviours Abstinence, condom and contraceptive use, monogamy
Individual factors	Knowledge on sexual and reproductive health problems (STI/HIV.AIDS, unwanted pregnancy, abortion), Avoiding substance abuse Skills to resist pressure Stay longer in school	Abstinence, late sexual debut, safer sex Self-efficacy (confidence and competence) Good school performance

5.3.1 Sexual behaviours among school adolescents

Having plans for a positive future and believing in the ability to control one's own life are protective factors. Spirituality and religious affiliation help youth avoid risky sexual behaviour. Initiating sex at an older age is associated with better sexual health. Beliefs and attitudes about sex, condoms, and contraception can be protective or can increase risk. For example, a positive attitude toward condoms is protective; a permissive attitude toward sex increase risk. Having the skills and intention to use condoms and contraception, as well as belief in one's own ability to successfully use those skills, protects young people against early pregnancy and STDs/HIV (CDC 2010: 46: S1-S96). In line with these concepts, discussion participants were asked about their beliefs concerning sexuality. Most focus group discussion participants agreed that sexual activity at this age is acceptable and expected.

G1/P3: "Now a day's abstinence is not acceptable and there are multiple sexual partners in most school adolescents".

A sense of belonging was also a challenge to participants as reflected in the following response.

G3/P2: "Virginity is good but currently it is viewed as a backwardness especially in schools. If a girl is not kissed, having not boyfriend considered as" Fara in Amharic" [meaning "backward"].

In addition, participants were asked about the predisposing factors for risky sexual behaviours. Most discussants mentioned that the use of alcohol, drugs and indulging to have sex for money increase the likelihood of that sexual intercourse will occur.

Siyan, Krishna, Junko, et al (2010, 10:477) stated that substance use was one of the most powerful predictors of risky sexual behaviour among both boys and girls. The finding extends the widespread evidence that substance use and risky sexual practices tend to co-occur among adolescents. This is also consistent with findings from previous research in developing countries, which has linked illicit drug or alcohol use with adolescent premarital sex and non-use of condoms (*Mmari and Blum 2099, 4: 350-366)*.

G3/P1:" Drugs and alcohol help decrease their inhibitions and increase their sexual pleasure….".

Sime and Wirtu (2008:167-173) suggest that adolescents often face enormous pressure to engage in risky sexual activity, especially the desire for economic gain. Another study in Addis Ababa among schools revealed that 20.6% adolescents were involved in sex at the exchange of money (Amsale and Berhane 2012: 159-164). The result of this is significant numbers of adolescents are involved in sexual activities at an early age (Sime and Wirtu 2008:167-173).

Economic reasons for sexual behaviour were also highlighted by discussion participants.
G2/P1:" Sex for money in school is not uncommon in both sexes"

G4/P1: "One girl in our class convinced her friend to have sex with old man for money in addition to her regular student partner/boyfriend…she said her enjoy with the "Sugar daddy"

Qualitative data from Tanzania (Harrison, 2008: 175-189) and Cape Town, South Africa (Selikow, Ahmed, Flisher, Mathews, and Mukoma, 2009:107-112) suggest that norms related to adolescent sexual activity may be gendered, with adolescent boys being more likely than girls to be pressured by their peers into sexual activity, and to believe that they can derive status within peer groups through having sexual partners

In addition, students said that their views about sexuality are also influenced by what they see on films (pornography), unsupervised social events, information they receive from friends, and what they see as social expectations (i.e., okay for boys to engage in sexual activity). Gender perspectives also has an impact on adolescent sexual behaviour.

*G1/P8: "Boys are very explorative and adventurous to have multiple sexual partner concurrently" In Amharic '**wotat yenebir tat'...**.*

G1/P7: "Social events such as party, substance use, community that perceives to have had sex is adventurous, are the most favourable factor to have more than one partner concurrently among adolescents".

In agreement with this finding, evidence also showed that there are predisposing factors that influence adolescents sexual behaviour. Studies also suggested that adolescents have limited knowledge about sexual and reproductive health and know little about the natural process of puberty. This lack of knowledge about reproductive health may have grave consequences. Moreover, sexual activities are occurring in the midst of an HIV and AIDS pandemic that disproportionately affects adolescents and young adults. On the other hand, young people often face enormous pressure to engage in sex, especially from peers, exposure to unlicensed erotic video films and the desire for economic gain. The result of this is significant numbers of adolescents are involved in sexual activities at an early age (Sime and Wirtu 2008:167-173).

Furthermore, studies conducted at different parts of the world also show that the younger boys and girls are less likely to say that they or their partners have used protection during sexual relationships (WHO: 2011: 25).

On the contrary, some participants of this focus group discussion emphasized the importance of waiting virgin until marriage or at least accomplish their school.

Research also indicated that adolescents' self-efficacy (i.e., confidence and competence) that they can avoid health risk behaviours in a variety of populations (Jia, Betty, Iyekiyapiwin, et al 2013: 1199–1207). A literature review by Baban and Craciun (2007:45-67) also showed self-efficacy in intervention projects successfully reduced sexual risk behaviours.

G2/P5: "A lot of people honour sex, and wait until they get married".

G2/P7: "Some people hold strong to their morals (i.e., waiting to be married)."

G4/P6: "Abstinence is most important to successfully accomplish our school performance but most students in our school do not practice it…, there are female students that I know who become pregnant and dropped out of school".

In regard to school performance and sexual activity, students expressed their points of view. Participants stated that sexual activity (having boy/girlfriend) does not affect academic performance.

G1/P9: *"It is possible to have sexual activity at the same time to achieve a good school performance".*

G4/P8: *"…mostly refraining adolescents from sexual activity is rather provokes the adolescent to engage in risk sexual activities".*

G3/P4: *"…but this sexual activity takes more time, school non-attendance, and he/she will think about his/ her girl/boyfriend that affects study time".*

G2/P3 "Love affair affects our study time and class attendance by giving more attention and thinking to the beloved ones".

The rate of contraceptive services utilisation among adolescents varies between countries and communities. Studies have shown that, among unmarried sexually active adolescents in Sub-Saharan Africa, contraceptive use ranges between 3% in Rwanda and 56% in Burkina Faso (Khan and Mishra 2008:19); 6% in Tanzania (Celina, Danga and Njau:2013:1-8); and 9.3% in Zimbabwe (Ehlers 2010: 14-26). Similarly, WHO (2011:25) Student Health Surveys among 13–15-year-old boys reported condom use rates ranging between 21% in northwest Namibia to 88% in Uruguay. Previous studies on contraceptive utilisation in Ethiopia among adolescents also reported as low as 17.6% in Jimma town and as high as 79% in Gondor town (Feleke, Koye, Demissie and Mengesha: 2013: 294).

Regarding to contraceptive and condom use among adolescents, discussion participants emphasized that it is important to use contraception and condoms. But when probed about how many of them and their friends use condoms, participants agreed contraception and condom use is low because most sexual activities happened accidentally.

G1/P5:*" Most students do not use condom because sexual activity is done emotionally and casually in various occasions".*

Studies in various parts of Ethiopia showed that adolescents are at risk of sexual and reproductive challenges including STIs and HIV/AIDS. (Abera, Mekonnen and Jara 2014: 149; Reproductive Health Matters 2011:879 and Daba 2015:119). Similarly, other study shows that only 3% of the total sexually active respondents had used condom consistently and 7.2% of the respondents had used condom during their first sexual contact. About

11.5% also had history of self-reported symptoms of sexually transmitted disease (Abdisa 2012:36).

Amidst the discussion, students were also asked what type of sexual issues they face in schools during their sexual activities. For the most part, students are concerned about sexual consequences including pregnancy, sexually transmitted disease and condom use. Some of them said that they were more concerned about pregnancy than STIs.

G2/P8: "There is an emergency pills that most students use after accidental sex repeatedly even in one cycle. that cannot prevent HIV/AIDS and other sexually transmitted infections".

G4/P6: "Most female students use emergency pills after accidental sex but it cannot *prevent HIV/AIDS and other sexually transmitted infections".*

G3/P7: "Condom is available in all nearby pharmacies and most kiosks."

G1/P9: "But asking and buying condom is embarrassing for most of us".

G1/P3: "…No if I want to buy it, I will simply ask condom…but I do not want to be heard by a nearby person around…".

There is growing recognition of the importance of addressing the sexual and reproductive health of adolescents (WHO 2014:24). Different SRH programs have been initiated at community and school levels in order to reach adolescents. For instance, a school based intervention in India has proven successful in addressing the knowledge of students on sexual and reproductive health (Nair, Mini, Leena, et al 2011:1-5).

Ethiopian Reproductive Health strategy (2015:27) depicts that SRH services are known and used in various parts of Ethiopia. However, research in northern Ethiopia (Selamawit, Mark, Geert, et al 2015:14-18) showed lack of accurate information on adolescent SRH. Early initiation of sexual activity and multiple sexual partners confirmed this fact; in

addition, unwanted pregnancies and abortions reported by females should not be ignored in line with economic factors, peer influence, and lack of support from families.

The participants of the focused discussion were also asked whether they visit health facilities for SRH information. However, most discussants did not use it.

G4/P3: "Sexual and reproductive health services are available in health facilities; however, we fear to visit the facility for SRH service unless we seek other medical treatment while illness".

G1/P3: "In some places (Health Facilities, Kebelle offices), there are condom boxes but still most adolescents fear to pick it up easily".

5.3.2 Impact of parents and family support

The family is an important overarching protective factor alluded to the type of parenting, in particular, as well as to the level of warmth (including responsiveness and communication) and appropriate discipline (discipline accompanied by reasoning and discussion) (Emily, Den and Tracey 2016: 16–43.). Family connectedness was the major protective factor against sexual activity; youth who felt connected to their families were less likely to have engaged in sexual intercourse (Nanlesta and Robert 2010: 5–23)

On the other hand, study show that poor parental involvement and lack of discussion on safe sexual life leads to lack of skill that helps youth to make important decisions about their sexuality (Diriba 2015 2015: 1857-7881; Kasiye 2014: 1-10 and *Reproductive Health* 2014:11: 2**).**

Different views were raised by participants regarding sexuality discussion between adolescents and families. However, responses showed that families are not open to discuss sexual issues with their adolescents. Because of cultural taboos and sensitivity of the topic adolescents in many developing countries rarely discuss sexual matters

explicitly with their parents (Bastien, Kajula and Muhwezi 2011: 25; Biddlecom, Awusabo-Asare and Bankole 2009: 72–81; and Sime and Wirtu 2008:167-173).

In addition, many research and consultations over the last decades have identified poor sexuality-related communication between adolescents and families as an issue that needs urgent attention (Akwasi, *Kofi, Ann, et al* 2007: 132-149).

G2/p1: "Our families are strict and do not allow to freely discuss about sexual and other reproductive health issues with them".

G4/P5: "If parents were aware about their children engaged in sexual activity, having condom in his/her bag, contraceptive pills, etc., the family automatically punish us".

G4/P4:" If a girl is traced as having a boyfriend, parents will take a serious punishment such as to withdraw from her relationship with her boyfriend, insult, bite, etc.".

Participants stated that adolescents especially girls are not accepted to have boyfriends and strictly monitored because the family and community have low awareness about sexual behaviours of teenagers. However, still both boys and girls have had risky sexual behaviour because they do not have an open discussion with the family how to avoid risky sexual activities. In line with this finding, evidence showed that inability to discuss sexually related issues with families and strict upbringing also contributes to premarital sex (Abdisa 2012:36-41).

G1/P5: "If…I told to my mam that I have got a girlfriend she will not be happy and she perceived that I am not a good child for her".

According to Tsala, Dimbuene and Kuate (2012:351-361) and Markham, Lormand, Gloppen, et al (2010::23-41), parent adolescent connectedness is protective against risky sexual behaviour. Besides, a survey of youth showed that parents are the strongest

influence on their decisions about sex, and that they want more open communication about sexual and reproductive health from their parents (Wight and Fullerton 2013:4–27).

Similarly, other study reported that parental monitoring appears to be consistently associated to a lower likelihood of risky sexual behaviour (Amsale and Yemane 2015:2; and Nanlesta and Robert 2010: 5–23).

A study in Dares Salaam, Tanzania showed that high level of parental monitoring is associated with more consistent condom use among male students (Linda, Krishna, Bruno, et al 2012: 1061).

Emily, et al (2016:16–43) indicated that an important protective function of the family system is having someone adolescent feels comfortable communicating with and who will provide him/her with support and encouragement to make healthy sexual decisions.

Participants in this focus discussion viewed that free family discussions are very important to build the skills how to deal with such behaviours. In addition, they added that appropriate family supervision is important to adolescents so that they will focus to their academic activities.

G3/P6: I have very close relationship with my Dad and Mam, they always approach and advise me, ask me about my daily activities and whereabouts, they know my close friends…".

G2/P9: "My mam usually tells me how early initiation of love… before completing school… affects academic performance and results different psychological or emotional and health problems".

Most parents seem not to support adolescent sexual behaviour, however there was also an indication that some parents are supportive as reflected:

G3/P1:" My dad and mam always advise me to save my life using condom every time".

As Wight and Fullerton (2013; *52:*4–27) highlighted, the discussion participants also emphasized that families should create an open and supportive mechanism to their adolescents.

As Emily et al (2016: 16-43) highlighted discipline is an important protective factor at the family level in which adolescents have a "healthy fear" of or respect for their parents that stemmed from knowing that there were consequences for their behaviours.

G2/P7: "Family is the first institution for social life including sexual behaviours"

G2/P6: "Parents should tell their adolescents' how early sexual debut affect their life, how adolescents become responsible, self-controlled and assertive for their sexual behaviour".

G4/P2: "Families should have adequate knowledge and skill how to build personality capacity and focus on positive assets rather than becoming strict and disapproval".

G3/P7: "Families should have a capacity to share not only their previous personal experience but also their wishes that they want how adolescents lead a healthy life in their future".

G1/P9:" Awareness creation for families on how to establish an open discussion with adolescents at home regarding sexuality".

As participants suggested that discussing sex and related issues with families and others can significantly decrease premarital sexual practices. They also added that, those who want to practice sexual activity should use protective measures like condom. Therefore, families are expected to create discussion avenues on issues related to sexual activities

and explain clearly to their adolescents the consequence of unprotected sexual practices. This study has also revealed that families are further expected to educate their adolescents about the importance of abstinence before marriage.

Evidence shows that training parents on how to nurture their adolescents have supreme importance in risk behaviour reduction. Interventions targeting the current and would be parents about proper parenting practices, skills and styles is important (Amsale and Yemane 2015:6). Furthermore, a report in Indonesia found that parental monitoring can act as protective factor in early adolescent premarital sexual behaviour. Therefore, risk reduction interventions with adolescents should include their parents to learn about monitoring skill and develop a skill that will allow them to buffer negative influences (Linda, Djauha, Yayi, et al 2015: 211-219).

Parents' communication with their adolescents has diverse and life-long effects on their adolescents' behaviour. After all, parents communicate their knowledge, beliefs, values, expectations and many other messages, all of which affect their adolescents' behaviour (Kirby, et al 2011:107). A research in American- Indian in-school adolescents found that parental knowledge of adolescents' friends and activities was strongly related to a reduced violence risk among female Indian adolescents (Jia, Betty, Iyekiyapiwin, et al 2013: 1199–1207).

Adolescents who have family members who can provide a reason for not engaging in risky sexual behaviours by explaining the consequences of these behaviours and enforcing family rules appear less likely to engage or want to engage in risky sexual behaviours. From this study finding, it is clear that open communication and support from family can help impart a feeling of pride and confidence to make healthy sexual decisions. Given these findings, it is evident that family awareness on adolescents sexual behaviour and appropriate communication and supervision should be the utmost priority.

5.3.3 School situation

Schools are said to be safe places when they provide protection to young adolescents' health and welfare by exposing girls and boys to friends and mentors and create a conducive environment for enhancing love, learning and creativity. But schools can also be unsafe places that provoke humiliation, alienation and fear. Discriminatory attitudes and practices (the "hidden curriculum of gender") selectively affect boys and girls as well as members of different socio-economic groups, as measured by students' treatment by teachers, their progress through grade levels, their academic and vocational course options and opportunities for extracurricular activities such as sports, and their expectations for the future (WHO 2011:20).

Another important protective factor within the school system was engagement in extracurricular activities (specifically sports), which provide youth with a sense of belonging. Extracurricular activities may further serve as a protective factor because they encourage adolescents to take responsibility in their commitment to a larger team (Emily et al 2016: 16-43).

Sadiq, Charles, Sarah, et al (2016:1069) underlined school-based sexual health education has the potential to provide an inclusive and comprehensive approach to preventive education and training among adolescents. The increased access to secondary schools is a good opportunity to capture youngsters for sexuality and reproductive health education. It is important to educate adolescents about safe sex, prevention of STIs, teenage pregnancies and abortion.

Just as schools are critical settings for preparing students academically, they are also vital partners in helping young people to take responsibility for their own health. School health programmes can help youth to adopt lifelong attitudes and behaviours that support overall health and well-being including behaviours that can reduce the risks for HIV and other sexually transmitted diseases (CDC 2011:7).

A structured literature review indicated that school-based sex education is an intervention that has been promoted to increase HIV-related knowledge and shape, safer sexual behaviours to help prevent new infections among this vulnerable group. As sexual debut is common in adolescence, so are the associated risks of engaging in transactional sex, having multiple concurrent partnerships, and experiencing sexual violence and coercion, all of which increase risky sexual activities (Mmari and Blum 2009:350–366).

Considering that media and school education were the major source of SRH information, strong collaboration between the media and school SRH services is needed in order to do more research to assess the type of the information provided and then to provide accurate information for adolescents on a regular basis in order to improve their knowledge and bring behavioural changes (Selamawit, Bilal, Mark, et al, 2015:14-18).

In these regard, FGD participants were asked how sexual and Reproductive Health services are addressed in schools. Participants mentioned that there are no any Sexual and Reproductive Health services in our school. We do have a mini media but it always airs different entertainments mainly music.

G1/P3: "*Currently, there is no any mini-media in our school that provides adolescent sexual behaviour information but while I was in other school, there was a mini-media that provides sexual behaviour information, HIV/ AIDS and other youth focused issues initiated by a female teacher. But the sexual behaviour information topics were not adequately addressed and supported by other teachers and students in the school".*

There is evidence of minimal support for adolescent sexual behaviour from teachers as reflected in the following response.

G1/P6: "Teachers even do not counsel us when they see a student has boy/girlfriend in the school how to deal with such issues during adolescence.

Negative reactions from teachers regarding their perceptions of adolescent sexual behaviour as crime rather than a developmental stage were revealed by participants.

G3/P2: Even some teachers consider it as a crime".

G4/P1: "If sexual behaviour topics are presented with a mini-media particularly about sexual behaviours, students will not be comfortable to listen and even the students perceive the presenter as not having a good manner that he/she presents such sensitive issues via media [in Amharic "Balege"]. This is the overall negative impact of public awareness about adolescents' sexual activity. Even, when a biology class presents about reproductive system students will not attend comfortably like other biology topics… which is the attribute of cultural and bringing-up phenomena at both family and community domains….

On the contrary, other participants reported that sexual education within the school system is important. A research indicated that adolescents should begin sexual education early which may increase the likelihood that they will apply this information to positive and responsible sexual health, including behaviours and decision making later in life, providing early, appropriate sexual education appears to be an important step (Emily et al 2016:16-43).

G2/P5: "There should be not only culturally sensitive comprehensive adolescents' sexuality and reproductive health education in secondary schools to cope up with the increasing vulnerability of adolescents towards STIs, teenage pregnancies and abortion including life skill education, self-control and efficacy".

Advocate for youth (2015:5) also addressed that comprehensive sexual health education helps young people take steps to protect their health, including delaying sex until ready, and using condoms and contraception when they do become sexual active.

National and international research shows that good quality SRE has a protective function as young people who have had good SRE are more likely to choose to have sex for the first time later (National Institute for Health and Clinical Excellence 2010:350 and UNESCO 2009: 221).

Participants strongly suggested that expanding and strengthening the existing mini-media programs in schools by including adolescent sexual and reproductive health. They further suggested that the existing mini-media should be equipped with electronic materials and further training should be given to mini-media facilitators on how to select and disseminate important and relevant information to school adolescent.

With this finding and various evidences, school based activities and relationships formed within the school context were believed to be significant protective factors in the sexual health and behaviours of adolescents. The information centres should be equipped with relevant materials such as, leaflets, magazines, books, pamphlets, posters, computer and internet services and others for students to receive relevant information regarding sexual and reproductive health issues on time.

5.3.4 Community support

Community mobilization can foster intergenerational communication in support of adolescent sexual behaviour (Kesterton and Cabral de 2010:7; and Denno, Hoopes, and Chandra-Mouli 2015: S22-S41). Adolescents who report that they have positive relationships with adults and those who receive mentoring in the context of a long-term supportive relationship are more likely to succeed on multiple fronts (Mary et al: 2011; 24:5).

The Inter-Agency Working Group (IAWG) (2007:2) highlighted adults influence young people's access to sexual and reproductive health (SRH) information and services, as well as their ability to make healthful decisions.

To ensure sustained positive behaviours among adolescents, the community must view these behaviours as beneficial, and community members must support change (IAWG 2007:2). In addition, a quasi- experimental study finding clearly demonstrated that the intervention with significant community participation yielded more positive results than the control sites; the most apparent results were changes in community norms and values that influence ASRH (IAWG 2007:2).

In relation to this notion, participants of the focus group discussions of this study were asked about their respective community or /neighbourhood perception on adolescents' sexual issues, they viewed that adults are not much supportive on positive sexual behaviour of adolescents.

G2/P2: *"Most adults and community dwellers impose the adolescents like insulting, harassing, asking simply for invitation (tea/coffee), sexual activity, …commonly called '**mefoger**' in Amharic*".

Access to youth friendly health services is vital for ensuring sexual and reproductive health (SRH) and well-being of adolescents (Donna, Andrea and Venkatraman 2015: 22-41). Despite the growing needs, there is no adequate health service or counselling specifically suitable for this specific age group and research on the role of parents in this process has yielded inconsistent results (Wondemagegn, Mulat, and Bayeh 2013: 2).

Comparative research could throw light on the processes through which male and female adolescents at different ages and developmental cognitive stages make decisions about how to deal with STIs/HIV and unanticipated pregnancies, and how they are affected by them (e.g. who bears the greatest costs). It could also identify ways in which adolescents' capacities not only to prevent but also to manage such outcomes safely and effectively can be supported by making sure that they have access to comprehensive information and services when they need them (WHO 2011:29-30). However, the participants of this study agreed that SRH service uptake by adolescents are very limited.

G1/P3 *"We know through media that there are sexual and reproductive health services in nearby health facilities but we do not use the service for any sexual related services"*.

G1/P8: *"mostly we seemed as if we know more about HIV/AIDS, condom use, etc. that makes us not using health facilities for sexual and reproductive health service"*.

A quasi- experimental study finding clearly demonstrated that the intervention with significant community participation yielded more positive results than the control sites; the most apparent results were changes in community norms and values that influence ASRH (IAWG 2007:2).

Although efforts have focused on not only ensuring health service availability but also making its provision adolescent friendly that is, accessible, acceptable, equitable, appropriate, and effective (WHO 2009:12), recommendations shows that research is needed to establish the extent to which younger and older (male and female) adolescents know about, have access to, use, and are satisfied with the existing adolescent reproductive health services; as well as establish to what extent young people are denied, scolded, discouraged, threatened, or sent home by providers in public health posts, private clinics, community based non-governmental organizations (NGOs), pharmacies and family planning facilities (WHO 2011:29).

In line with this recommendation, participants of this study, nevertheless, articulated that fear to visit SRH services and the service was not comprehensive as a major concern to get the service.

G4/P1: *"If we visit HFs for sexual and reproductive health service and our families, friends and community adults aware about our visit to get the services, they assume that we are just engaged in sexual activities; they also consider that the girl visited the health facilities for STI treatment, abortion…. and really if they know exactly that the girl visited the facility for sexual and reproductive health service, they give low*

respect for her …. even some families punish her (slap, insult in front of other family members and neighbours, etc.)".

A limitation in adolescent reproductive health programs was reported by participants as reflected in the responses:

G3/P3: *"There are adolescent sexual and reproductive health programs in the community but it only focuses on HIV prevention and individuals living with HIV how to lead their positive life but it does not address other adolescent sexual issues to build positive behaviours".*

Adolescents often face enormous pressure to engage in risky sexual activity, especially exposure to unlicensed erotic video films. The result of this is significant numbers of adolescents are involved in sexual activities at an early age (Sime and Wirtu 2008:167-173).

Participants also stated that there are contributing factors for risky sexual behaviours in the community. For example, pornography and substance abuse are the major factors.

G2/P5: "Pornographic films are easily available and accessible to students in the community that urge adolescents to experiment what they watch".

G1/P1: "Substance use like shisha, khat, cigarette is common in most places in our community".

WHO (2009:12) showed that programs that promote access to and uptake of adolescent sexual and reproductive health services are most effective when adolescent-friendly facility-based approaches are combined with community acceptance and demand-generation activities. In line with this evidence, participants were asked for their suggestion on how to improve community and neighbourhood involvement to build adolescents' positive sexual behaviour.

G3/P4 *“There are people who are supportive and respect adolescents in our community”.*

G1/P4: “Well-designed media, club or forum to aware parents and community… as sexual activity is a natural phenomenon that really requires adequate knowledge on how to help adolescents to lead healthy life…”.

The post pill seems to be popular as illustrated in the responses below:

G1/P6: “Media should also selectively address adolescent sexual behaviours. For example, benefit of post pill that advertised in media should also include the side effects and the minimum interval between the subsequent doses.

G1/P7: “As I Know many students take post pill repeatedly even in one cycle since most of them have had accidental sexual intercourses without condom”.

G4/P2: “Students use post pill as a routine contraceptive pills not for emergency purpose… due to post pill availability, students are reluctant to use condoms even those who have condom access”.

A suggestion was shared with reference to enhancing the use of reproductive health services.

G1/P9: “Integrating adolescent sexual and reproductive health services with HIV/AIDS programs (HIV/AIDS program is widely supported at different levels) is one area of focus to improve community awareness towards positive sexual behaviour of adolescents.

Above all, community support can shift individual behaviours, including contraceptive behaviours, either by changing norms or individual knowledge and attitudes (Storey et al., 2011: 1-89).

5.3.5 Peer support

Ali and Dwyer (2011:183-190) highlighted individuals' behaviours take place within a wider social environment and in the context of their social relationships. Adolescents' peers have been found to be influential on sexual behaviour in other settings.

Most information for their patchy knowledge comes from peers of the same sex who may themselves lack adequate information or are incorrectly informed (Sime and Wirtu 2008:167-173)

In this regard discussants mentioned that peer norms are one of the factors that influence sexual initiation and subsequent sexual behaviours among adolescents.

G1/P6: "Peer is very influential for both negative and positive sexual and other behaviours".

Sexual behaviour is not based on love as evidenced by multiple sexual partners.

G3/P5: "*During adolescence, true love is uncommon, one to one is very rare, concurrent partners are common.*

Multiple partnership is also considered a boost to one's self esteem mainly in boys.
G1/P9: *Having more than one partner is a proud especially in boys".*

Peer pressure also seems to play a significant role in adolescent sexual behaviour.

G4/P7: "Now a day there is high peer pressure"

G1/P6:" Students accept their friends' opinion and imitate their friends' behaviour whether the behaviour is right or not…And this is due to lack of self-confidence on how to be insistent to avoid it.

G3/P7: "…. If you want to study when there is free class in classrooms, students will insist you to stop reading and join them for jokes, move out of class…otherwise, they will discriminate you and give a nick name…Fara (Amharic) meaning un-modernized/ uncivilized, etc.

However, the discussions are not beneficial as the focus is mostly not on sexual behaviour.

G3/P6: "…. but no discussion on condom and contraceptive use".

There is evidence that peer-based strategies have been effective in reducing HIV and other sexual risk behaviours among adolescents (Simoni, Nelson, Franks et al., 2011: 1589–1595). Besides a study in the United States have shown that adolescents who report more restrictive attitudes toward sex among their friends are less likely to have had sex themselves (Kapidia, Frye, Bonner, et al 2012:27-40).

Adolescents with strong social and emotional competence are less likely to engage in risky behaviours related to sexual risk taking (Mary, Kristine and Kristin 2011:12-24)**.** Skills related to social and emotional competence include communication skills, emotional awareness, peer-refusal skills and emotional regulation (Mary, et al 2011:12-24). These skills promote positive social development in multiple ways.

They assist adolescents in developing close friendships, having positive peer relations, engaging in positive social behaviours (and selecting and attracting friends with positive behaviours) and avoiding negative social influences (Mary, et al 2011:12-24).

Evidence shows that social and emotional competence can be improved by intervention. High-quality school-based programs have been found to achieve positive results for adolescents (Mary, et al 2011:12-24).

In this regard the participants suggested how to build positive peer support regarding to sexual behaviours including self-efficacy and skills on how to break peer pressure.

The importance of education regarding teenage reproductive health was emphasized by the participants.

G1/P7: "Some form of education will help adolescents to break negative peer pressure and develop self-confidence".

G1/P1: "The impact of peer pressure depends on individual's strong belief to indulge and engage in some risk behaviours".

G4/P1: *"Adolescents should build the capacity how to tackle peer pressure, at the same time, they should have the ability to refrain themselves from such peers that influence others to risky sexual behaviours".*

G3/P8: *"Free talk with peers on positive sexual behaviours (late sexual debut, abstinence, condom use and contraceptive use) should be the major discussion issues among adolescents as far as sexual behaviour is concerned".*

With this finding and evidence, peer behaviours and influence emerged as strong predictors of adolescent sexual behaviour.

5.4 CONCLUSION

The qualitative findings have given an insight in which there are enormous gaps on how to build an enabling environment for positive sexual behaviours at family, school, community and neighbourhood, peer and individual levels. This qualitative finding also explored the potential protective factors substantiating the quantitative finding that indicated those efforts necessary for designing appropriate strategy to support positive sexual behaviours at each domain.

CHAPTER SIX

THE INTEGRATION OF QUANTITATIVE AND QUALITATIVE DATA

6.1 INTRODUCTION

This chapter of the study provides insight into the operation of protective factors in different domains to predict positive sexual behaviour among adolescents. The chapter presents and discusses both quantitative results and qualitative findings of the study in line with strategies to support positive sexual behaviours among high school students. Quantitative results were first interpreted to help answer the quantitative study questions stated in chapter 4 and then the focus group discussions that were aimed at answering research questions in the qualitative part of the study as described in chapter 5. The chapter presents the quantitative stance, while, at the same time, the addition of qualitative data and approaches to assist interpretations (Johnson, Onwuegbuzie and Turner 2007:112-133). Integration of data was based on the purpose and the objectives of the study, quantitative and qualitative research questions and the rationale for using mixed-research methods.

The major findings of this study had been explained and compared with other similar study results and personal judgments on the difference and similarities of those findings.

This chapter also includes conclusions and suggestions based on the predetermined study objectives and findings.

6.2 DATA COLLECTION PROCESS

Quantitative data was obtained using a self-administered questionnaire in regularly attending high school adolescents, whereas, qualitative data was extracted from focus group discussions amongst adolescents as shown on Figure 6.1.

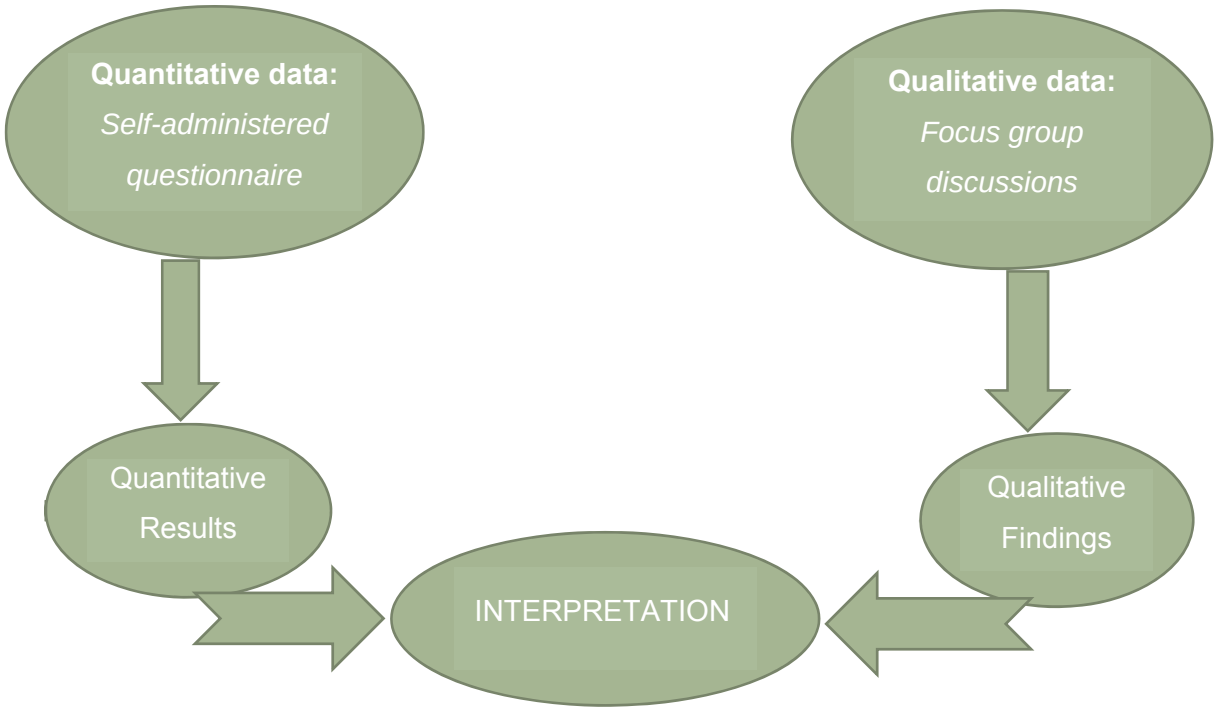


Figure 6 1 **Quantitative and Qualitative data sources**

6.3 MIXED-METHOD BACKGROUND

A mixed methods research design is a procedure for collecting, analyzing, and "mixing" both quantitative and qualitative methods in a single study or a series of studies to understand a research problem (Creswell and Plano 2011:211). Quantitative and qualitative methods were used concurrently in this study. The rationale for using mixed methods for this study was to obtain a better understanding (Migiro and Magangi 2011: 3757-3764) of protective factors at family, community, school and peer levels for positive sexual behaviours amongst adolescents. Mixed methods help to converging numeric data from quantitative data with specific details from qualitative data to develop variables that need to be described in patterns of protective factors. Using mixed methods also help to answer a broader range of research questions as it combined the strengths of both qualitative and quantitative designs (Sharleen 2010:21). Mixed methods overcome the weaknesses of both quantitative and qualitative approaches (Sharon and Elizabeth 2009:137).

The quantitatively explained and qualitatively explored data were grouped into sections in relation to protective factors and positive sexual behaviours of adolescents.

6.3.1 Quantitative questions

- What is the impact of parents and families support on adolescents' sexual behaviour?
- Does parent-adolescent communication, parental monitoring and parenting style influence adolescents' sexual behaviour positively?
- To what extent is sex education included within high school curriculum?
- To what extent is the community/ neighbourhood support adolescents in their sexual activities?
- To what extent is peer influence adolescent's positive sexual behaviour?
- What are the strategies to enhance positive sexual behaviours of adolescents?

6.3.2 Qualitative questions

- What are the opinions of adolescents regarding sexual behaviours in general?
- How adolescents interact or discuss with families (mother, father, other siblings) regarding to their sexual activities in day to day life?
- How are sexual and reproductive health issues addressed in schools?
- How adolescents interact with their peers regarding to sexual activities?
- How community support adolescents in relation to sexual behaviours?
- What do you think how are these social centres (families, school, community and peers) influencing sexual behaviours in adolescents like you?
-

These questions are related to the study objectives and were addressed through quantitative and qualitative data collection methods that are described under the methodology (chapter three).

6.4 MIXED-METHOD ANALYSIS

In this study, multiple strategies for mixed-method analysis were used. The techniques that were applied are case oriented and variable oriented analyses as described by Onwuegbuzie, State, Leech, et al (2009: 3:13-31). Strategies that were used were merging quantitative and qualitative data through discussion, through a matrix, by data transformation, and through data interpretation (Creswell 2012:15:551; and Creswell and Plano 2011: 7:249). Merging through a discussion facilitated interpretation of results by comparing findings from the two methods and data transformation addressed data from both quantitative and qualitative perspectives that could indicate a new variable with further analyses and occurred at the level of data analyses. The fundamental principle of data analysis, as described by Onwuegbuzie et al (2009:13-31), was applied to this study. They describe four major types of generalization applied by mixed methods researchers as external statistical generalization, internal statistical generalization, analytical generalization and case-to-case transfer.

6.4.1 Case-oriented analyses versus variable-oriented analyses

Any specific analytical technique can be operationalized as representing either a case-oriented or a variable-oriented analysis (Onwuegbuzie et al 2009:13-31).

Case-oriented analyses are analyses that focus exclusively on selected cases to analyze and interpret the perceptions, attitudes and opinions of participants, whereas variable-oriented analyses are conceptual and theory-centered and involve the identification of relationships. Case-oriented are applicable to qualitative data but can also be used in quantitative approaches. Variable-orientated analyses can also be used for qualitative data, for example examining themes that cut across cases, that, within the context of this study, could be between different focus group discussions or themes generated from the review of multiple documents and records (Onwuegbuzie, et al 2009: 3:13-31).

The combination of case-oriented and variable-oriented analyses led to a two-dimensional representation of findings and results as reflected in Figure 6.2

(Onwuegbuzie et al 2009:13-31). The vertical axis represents the quantitative phase with variable-oriented analysis on one side and case-oriented analysis at the opposite end. The horizontal line represents the qualitative phase with variable and case-oriented analyses located at opposite poles. Quadrant 1 reflects variable-oriented analysis for both qualitative and quantitative data. Quadrant 2 reflects variable-oriented analysis for quantitative data combined with case-oriented analysis for qualitative data. Quadrant 3 reflects variable-oriented analysis for qualitative data combined with case-oriented analysis for quantitative data. Quadrant 4 reflects case-oriented analysis for both qualitative and quantitative data.

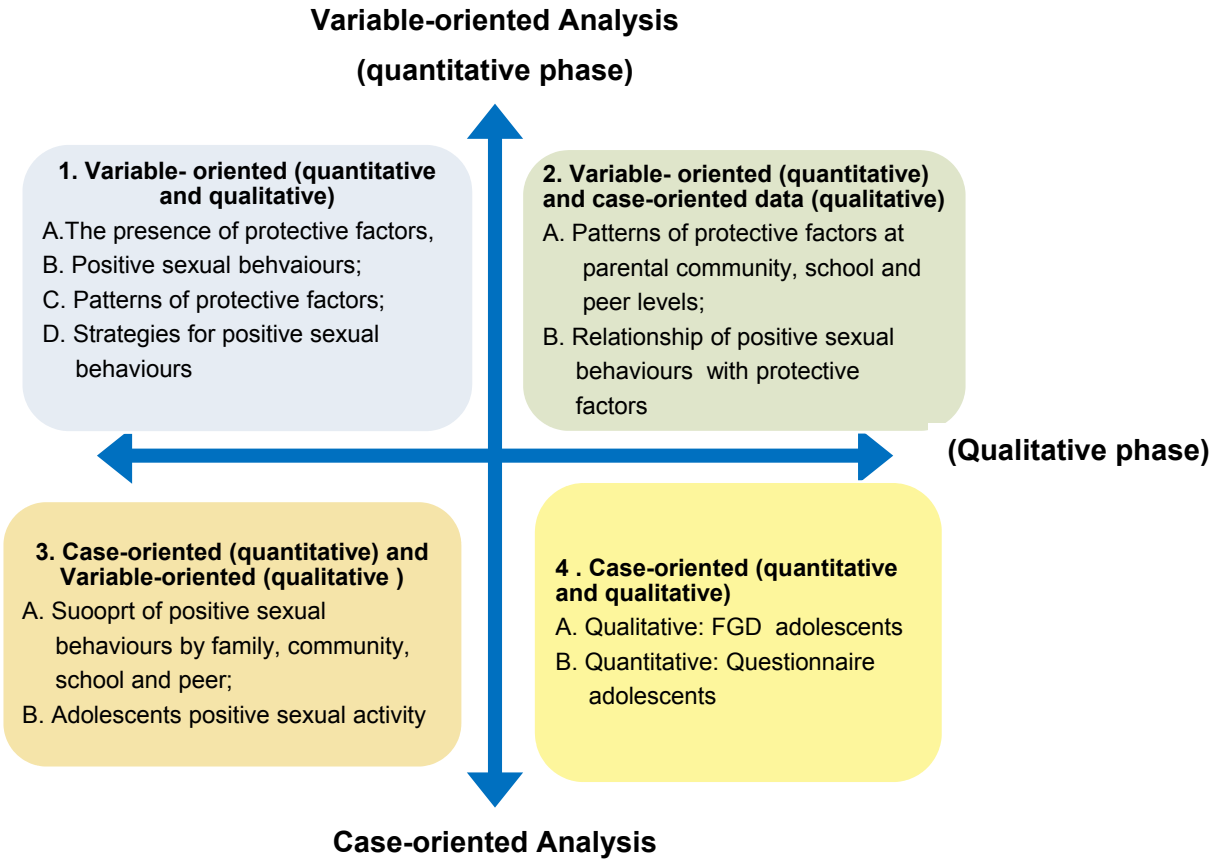


Figure 6 2 A two-dimensional representation of variable and case oriented analyses

6.4.2 Case-oriented analysis

According to Onwuegbuzie et al (2009:13-31), case-oriented analysis focuses on the selected cases as data sources. The goal of case oriented analysis within this study was to analyze and interpret the opinion of adolescents regarding to positive sexual behaviours in general and the perception of adolescents on protective factors.

6.4.2.1 The qualitative data case:

- Four focus group discussions held with adolescents

6.4.2.2 Quantitative data case:

- Survey conducted amongst adolescents attending high schools in Addis Ababa

6.4.3 Variable-oriented analysis

Variable-oriented analysis, as described by Onwuegbuzie et al (2009:13-31), was conducted through the development of themes across qualitative and quantitative data. Themes were based on the purpose of the study, the objectives of the study, the qualitative and quantitative questions and the findings and the results of the study.

6.4.3.1 Quantitative variables

- The patterns of protective factors among adolescents attending high schools in Ethiopia
- Association of positive sexual behaviours with protective factors such as the family, peers, community, schools and other institutional structures
- The strategy used to enhance positive sexual behaviour among adolescents

6.4.3.2 Qualitative variables

- The opinion of adolescents regarding sexual behaviours in general
- The interaction of adolescents with their families (mother, father, other siblings) regarding to their sexual activities in day to day life
- Perception of adolescents on school based sexual and reproductive health services
- The interaction of adolescents with their peers regarding to sexual activities
- Community support on adolescents' sexual behaviours
- Suggestions on how the social centres (families, school, community and peers) are influencing sexual behaviours amongst adolescents

6.5 MAJOR FINDINGS OF THE STUDY

Given the evident disparities in the outcomes associated with risky sexual behaviours among adolescents, studies to date have focused primarily on deficit-based sexual health and behaviour models (Emily, DenYelle, and Tracey 2016: 16-43). These models often overlook potential sources of resilience and strength that may be present (Emily, et al 2016: 16-43). In working to address this limitation, this study utilized a strength-based approach to identify sexual behaviour protective factors for adolescents.

Results from a growing number of studies suggest that greater health impact might be achieved by also enhancing protective factors that help adolescents avoid multiple behaviours that place them at risk for adverse health and educational outcomes (CDC 2010: S1-S96).

6.5.1 Impact of parents and family support

Risk factors and protective factors influence the occurrence of premarital sexual behaviour in adolescents (Kirby and Lepore 2007:2).

The same source mentioned that family environment is a protective factor and prevention of risky behaviour in adolescents Moreover, family is the main factor affecting adolescence development, although they are also influenced by peers, school friends and the society (Kirby and Lepore 2007:2).

There is also considerable evidence that characteristics of families, and particularly parent-adolescents relationships, have a major influence on adolescents sexual decision-making (Mmari and Blum 2009: 350–366).

Parents and members of the extended family have always been important in the sexual and reproductive knowledge and development of adolescents (Biddlecom, Awusabo-Asare and Bankole 2009: 35:72-81; and Kesterton and Cabral 2010:7).

When parents affirm the value of their adolescents, they more often develop positive, healthy attitudes about themselves (Alicia 2009:1-5).

This study intended to assess the effect of different parental and family support on positive sexual behaviour of adolescents. The study showed that factors related with family such as family structure, socioeconomic status, upbringing and parental supervision and guidance were statistically significant and strongly associated with adolescents positive sexual behaviour. In this study family support to influence positive sexual behaviour is categorized into parental connectedness and other family relationships, parent-adolescent communication and parental monitoring and parenting style.

Research evidence showed that parental practices such as parent adolescent connectedness, parental monitoring and parents and adolescents' communication about sexuality is protective against risky sexual behaviour (Downing, Jones, Bates, et al 2011: 808-833).

6.5.1.1 Parental connectedness and other family relationships among respondents

Kirby (2011:15) highlighted that connection with parents appears to be a stronger factor than connection with other groups. Parent–adolescent connectedness protected 'the ethics of adolescent' and helped prevent adolescents from risky sexual behaviour (Joyce and Daniel 2014: 169–178). It is likely that parents' presence has a protective influence on their adolescents in several different ways, for instance, initially by strengthening parent-adolescent connections and later by allowing greater parental monitoring (Wamoyi, Fenwick, Urassa, et al 2011a:106).

The World Health Organization defines 'connectedness' as being made up of behaviours that convey to adolescents that they are loved and accepted' (WHO 2007:7).

A major study showed that adolescents who reported feeling connected to parents and their family were more likely than other adolescents to delay initiating sexual intercourse (Emily, Den, Baete, et al 2016: 16-43).

This study shows parental connectedness and other family relationships such as eating meals together (86.4%), belief that adolescents should follow parents' rules about sexual activities (77.4%) and adolescents' belief and parents' belief is similar on sexual values (44.4%) are associated with positive sexual behaviour. In line with research evidences elsewhere, the findings of this study shows that parent-adolescent connectedness is protective against risky sexual behaviour (Longmore, Giordano and Manning 2009:969-982; Markham, Lormand, Gloppen, et al 2010: 23-41; Barber and Schluterman 2008: 209-216; Kayembe, Mapatano, Busangu, et al. 2008: 585-593; and Tsala and Kuate 2012: 351-361).

Parental warmth, love and support increase the quality of parent adolescent relationship. Thus, strategies and intervention activities that strengthen connectedness and relationship need priority attention.

Research results Mary et al (2011:1-12) highlights caring and connectedness can be powerful tools to protect adolescents from negative behaviours and help them develop good social skills and a more positive identity. The study showed that adolescents with higher feelings of parental connectedness were at lower risk of engagement in sexual risk behaviour. Participants of this study also discussed the importance of caring and connectedness to as a main protective factor. So, even though adolescents were more likely to report being sexually active, they were also more likely to engage in safe sexual practices. In agreement with this study finding, a survey of youth showed that parents are the strongest influence on their decisions about sex, and that they want more open communication about sexual and reproductive health from their parents (Wight and Fullerton 2013: 4–27).

This could be explained that students with good relationships and who feel connectedness may be more secured and parents may also be available and have more time to support and show love for their adolescents.

This study also shows that 56.7% of respondents live with both parents. Whereas in this study, there is no association between positive sexual behaviour and living arrangements with parents unlike other research findings in Ethiopia and other countries (Amsale and Yemane 2015:2 and Biddlecom, et al 2009: 72–81; and Fearon, et al 2015: 62-74). This difference might be due to study settings.

Accordingly, appropriate parental counselling should be in place and special attention should be given to interventions that aim the development of positive family life.

6.5.1.2 Parent -adolescent communication

Communication about sexuality issues within the family appears to be important (Bastien, Kajula and Muhwezi 2011:25).

Emily, Den, Baete, et al (2016: 16–43) also suggested confident, loving parent-adolescent communication leads to improved contraceptive and condom use, improved communication about sex, and fewer sexual risk behaviours among adolescents. However, the result of this study showed only 20.0% of the respondents mentioned that adolescents talk to their parents about sexuality issues. A focus group participant also illustrated *"Free parent-adolescent communication is very limited*".

Existing studies that tried to examine sexual and reproductive health communication have revealed that the communication practice is in the range of 20%- 43% and the factors associated with the communication are parental education, adolescent's age and living arrangements, type of parents, and parents' sexual and reproductive health knowledge and attitude (Ayalew, Mengistie, Semahegn 2014:77; GebreYesus and Fantahun 2010:89-95; Melaku, Berhane, Kinsman, et al 2014:252; and Tesso, et al 2012:9).

Research from African and other settings shows that the communication between adolescents and parents on issues such as sexual relationships, early pregnancy, HIV, and contraception is often very limited (Biddlecom et al 2009:72–81). However, most adults want adolescents to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted infections (STIs), parents often have difficulty communicating about sex (Emily 2016: 16–43). Communication about sexuality with adolescents is hindered by parents' lack of knowledge, reliance on teachers, and the perception that talking about sexuality encourages sex (Joar, Avni, Omar, et al 2015: S7–S14).

Parents find it difficult to talk to their children about sexual and reproductive health matters due to cultural norms. A qualitative study found that only a few parents talk about sexual matters with their adolescents (Wamoyi, Fenwick, Urassa, et al 2010: 6-10). Such communication is often abstracted and focuses on adverse outcomes of sexual behaviours such as HIV/AIDS and unwanted pregnancy rather than practical life skills (Wamoyi, Fenwick, Urassa, et al 2010: 6-10).

For example, when parents talk about HIV/AIDS, they expect their children to understand all matters related to sexual and reproductive health (Wamoyi, Fenwick, Urassa, et al 2010: 6-10). According to the same study, only a few parents talk to their children about condom use (Linda, Krishna, Bruno, et al 2012: 1061). Other study suggests that when parents are given support, they can and will communicate with their children about sexuality (Joar, et al 2015: S7–S14).

This study also shows only 31.8% and 30.6% adolescents talk to their parents about pregnancy and STI including HIV/AIDS; and their parents accept and support contraceptive use by adolescents respectively. Other studies showed that the frequency of adolescents who discuss sexuality issues with their families' ranges from 20% in Lesotho, 27% in Tanzania and other parts of Ethiopia such as Debremerkos (36.9%) Bullen District (29%), Hawasa (30.4%) (Shiferaw, Getinet and Asires 2014:1-12). The main reasons for the very limited communication could be conservative norms around sexuality, limited parental RH knowledge, and fear that such communication would encourage sexual activities. Barriers to communication about sexuality include a lack of parental knowledge, reliance on school teachers, and a perception that talking about sexuality encourages sex (WHO 2009:7).
It is important to note that making comparison is not easy due to inconsistent measurements of parent-adolescent sexual and reproductive health communication in literature (Bastien, Kajula and Muhwezi 2011:8 and Sales, Milhausen, Wingood, et al 2008: 332–345).

This study finding is also in agreement with researches from African and other settings that showed the communication between adolescents and parents on issues such a sexual relationship, early pregnancy, HIV, and contraception is often very limited (Abdisa 2012:36-41; Bane 2015:137; Hargreaves and Boler 2014:113-119; WHO 2009:12; and Biddlecom, et al 2009:72-81). However, many research and consultations over the last decades have identified poor sexuality-related communication between adolescents and families as an issue that needs urgent attention, studies in Ghana and other Sub-Saharan

African countries have shown that parent-child communication about sex-related matters is relatively uncommon (Akwasi 2007:132-149).

Despite the fact that the study shows relatively low parent-adolescent communication, both quantitative and qualitative findings of this study evidenced the association of parent-adolescent communication and positive sexual behaviour. Adolescents who perceived their parents' close communication to them were more likely to have positive sexual behaviour than their counterparts. Similarly, the FGD shows that free family discussion is very important to build the skills how to deal with sexual issues to avoid negative impacts. This is in agreement with other studies that shows parent-adolescent communication about sexuality issues appears to have an impact on positive sexual behaviour among adolescents as evidenced from various researches (Amsale and Yemane 2015:1-12; Bastien, et al 2011:25; and Kumi, et al 2007:72-81).

The main reasons that adolescents not discussing with parents about sex, pregnancy, STI/HIV/AIDS and contraceptive use include do not feel comfortable (34.4%), parents may suspect that adolescents started sexual activity (16.6%) and parents never give a chance to adolescents to talk about sex (15.1%). The focus group participant also elaborated this as "If parents were aware about their children engaged in sexual activity, having condom in his/her bag, contraceptive pills, etc., the family automatically punish us".

Previous studies in the country have also indicated an aligned finding that sexual and reproductive health communication is infrequently occurring and often compounded by discomforts (Tesso, Fantahun and Enquselassie 2012; and GebreYesus and Fantahun 2010). The conservative norm and taboos on sexuality, and ill-preparation have largely limited the parents' involvement on sexual and reproductive health communication with their adolescents (Bastien, et al 2011: 20-21).

Thus, parents should be helped to develop effective communication skills on adolescent sexual matters. In addition, the extent of communication, the content of the information

that is communicated; and the timing of the communication should be given a due consideration.

For example, findings from a small number of intervention studies suggest that if parents are given support to develop the attributes of parental responsiveness, they can and will communicate with their children about sexuality (WHO 2009:4-7). It is possible to improve the content of the discussions and to raise awareness of and challenge social and cultural norms that hinder communication about sexuality (WHO 2009:4-7).

6.5.1.3 Parental monitoring and parenting style

Monitoring parental to adolescent is significantly associated with adolescent risk behaviour. Many studies have been done showing that adolescents who get high parental monitoring, causes less behaviour risk rather than youth with low parental monitoring (Suwarni, Djauhar, Yayi, et al 2015: 211-219).

Parenting styles are important to consider when examining parent adolescent relationships. Parental monitoring may reduce risky sexual behaviours among adolescents in Ethiopia, as in other countries (Biddlecom, et al 2009: 72-81). In this way, parents may set rules to guide their children into safer behaviours. In Ethiopia, adolescents usually spend most of their time every day outside the home, unsupervised by their parents, either at school or on public transport to and from home. During such times, they may associate particularly with their peers and other non-parental figures. This might constitute a vital time for adolescents to engage in risky activities such as substance use and sexual activities.

This study indicates 66% and 44.5% adolescents reported that they need permission from their parents to go anywhere and their parents know all their friends respectively. Parental monitoring appears to be consistently associated to a lower likelihood of risky sexual behaviour in previous studies (Amsale and Yemane 2015:2; Joyce, Angela, Mark, et al

2011:106). This study is in concord with these evidences. Adolescents who have greater Parental monitoring reported more positive sexual behaviour than their counterparts.

Similarly, the focus group discussion participant noted *"Family is the first institution for social life including sexual behaviours".* Parents also provide social norms related to appropriate behaviour, as well as having an important function in the supervision and monitoring of adolescents' tendencies towards inappropriate behaviour (Siyan 2010:1-17).

A meta-analysis finding also showed that higher levels of parental monitoring were associated with lower likelihood of adolescents ever having engaged in sexual intercourse and greater likelihood of sexually experienced adolescents using both condoms and contraceptives (Patricia, Dittus, Shannon, et al 2015:136).

The sizeable influence of parenting style on adolescent sexual behaviour is also one of the family support component in which this research examines adequately. The substantial influence of parenting style on adolescent development is also clear. This study shows respondents from both authoritative and authoritarian parents were more likely to have positive sexual behaviour than permissive and neglectful parenting styles. The study finding is similar with other researches (Amsale and Yemane 2015: 2-5). The focus group participant of this study also elaborated that parents should tell their adolescents' how early sexual debut affect their life, how adolescents become responsible, self-controlled and assertive for their sexual behaviour.

When adolescents feel they have high quality interactions with their families, when they feel the support of their families, and when they feel connected to their families, they are less likely to have sex and avoiding risk taking (Kirby 2011:16). Notwithstanding, this study shows that Families should have adequate knowledge and skill how to build personality capacity and focus on positive assets rather than becoming strict and disapproval. This necessitates that family level intervention strategies are vital with parental monitoring and parenting style playing a significant role.

Generally, programs that work directly with parents to build effective communication skills around sexuality, support parent-adolescent relationships, and help parents develop monitoring strategies have shown promise to promote positive sexual behaviours among their adolescents (Wight and Fullerton 2013: 72-81).

6.5.2 Sexual behaviour amongst adolescents

This study shows that only 26.6% and 19.8% of adolescents reported sexual and reproductive health counselling services and sex education are available in their respective schools respectively. This finding is the lowest as compared to a study in USA (95%) (Martinez, Abma and Copen 2010: 1-8); even lower as compared with study in Uganda (32.4%) (Lule , Ovuga, Mshilla, et al 2013:18-20) and a report from Guttmacher Institute (2008:1-54). Likewise, the discussion participant particularized that currently, there is no any mini-media in our school that provides adolescent sexual behaviour information.

Despite the fact that sex education in schools is very low, this study shows that sex education in schools is strongly associated with positive sexual behaviours of adolescents. This is in line with other study in Uganda (26.5%) (Lule, et al 2013:18-20).

However, U.S. Department of Health and Human Services (2010:1-25) states that schools have unique opportunities to provide education and information, as well as structured activities that discourage unhealthy risk taking. The same source added school attendance reduces adolescent sexual risk-taking behaviour and schools often have access to training and communications technology that is frequently not available to families. This is important because parents vary widely in their own knowledge about sexuality, as well as their emotional capacity to explain essential sexual health issues to their adolescents. Schools also provide an opportunity for the kind of positive peer learning that can influence social norms (U.S. Department of Health and Human Services 2010: 1-25).

In line with this notion, the qualitative finding of this study stated *"There should be culturally sensitive comprehensive adolescents' sexuality and reproductive health education in secondary schools to cope up with the increasing vulnerability of adolescents towards STIs, teenage pregnancies and abortion including life skill education, self-control and efficacy".*

This study shows positive sexual behaviour of adolescents is strongly associated with not missing class. A study conducted in South Africa (Hargreaves, Morison, Kim, et al 2008: 113–119) supports that adolescents who stay in school longer are less likely to engage in sexual risk behaviours. A randomized control trial study conducted in US shows sex education in schools reduces early initiation of any types sex by 35% among both male and female adolescents. The same study indicates sex education reduces early initiation of any types sex by 55% among female students. Besides, the randomized control trial shows that sex education decreases engaging in unprotected sex by 33% at last vaginal intercourse, either by using a condom or abstaining from sex (Christine, Susan, Melissa et al 2017: 279–288).

A study found that school-based sex education is an effective intervention for developing positive sexual behaviour including delaying sexual debut, increasing condom use, and decreasing numbers of sexual partners (Amy, Caitlin, Kevin, et al 2009: 181-206). A similar study in Nigeria depicts that interventions for Nigerian students found changes in self-reported sexual behaviour patterns including delaying sexual debut, increasing condom and other contraceptives use and reducing frequency of sexual *activity (*Fonner, Armstrong, Kennedy, et al 2014:2-14*).*

This study finding indicates that only 28.8% of the adolescents indicated that they participate in some sort of adolescent clubs in their respective schools. But in the study conducted in south Ethiopia found that those who have been a member of reproductive health club and had discussion about reproductive and sexual right have a better knowledge (Adinew, Worku and Mengesha 2013:2-7).

The review of studies found strong evidence that sex education can improve values and attitudes about sex, condoms, risky sexual behaviour; self-efficacy to refuse sex and to use condoms; intention to abstain from sex or restrict sex and numbers of partners (Kirby, Laris, and Rolleri 2007). Furthermore, studies showed that sex and HIV education among adolescent decrease sexual risky behaviour and increase the use of condom and contraceptives (Kirby 2007:2). This implies that individuals with better knowledge have the likelihood of resisting pressure from their peer and will have healthy relationship.

Research has repeatedly found that sex education which provides accurate, complete, and developmentally appropriate information on human sexuality, including risk-reduction strategies and contraception helps young people take steps to protect their health, including delaying sex, using condoms or contraception, and being monogamous (Alford, et al 2008:9).

Kirby (2011:1-25) stated that in most countries, schools provide the best venue to reach large numbers of adolescents with different socio-economic backgrounds via structured programs that are replicable and can become sustainable. By reaching adolescents early in puberty, school settings can provide young people with the information and skills they will need to make responsible decisions about their future sexual lives. Through those programs, educators have the opportunity of encouraging adolescents to delay the onset of sexual activity and of training them to behave responsibly when they eventually engage in sexual activity, particularly by using condoms and other modern methods of contraception (Kirby 2011:1-25).

This study shows more than half (59.8%) of adolescents perceive that their teachers are supportive or greater connection with their teachers and strongly associated with positive sexual behaviour. But the qualitative findings of this study show a minimal support for adolescent sexual behaviour from teachers even some teachers have a negative reaction toward adolescent sexual behaviour in schools. Teachers spend a considerable time with students, it is seemingly easier for them to execute and integrate such interventions in the existing curriculum.

Nevertheless, research strongly suggests that by training teachers to impart the decision-making skills that adolescents need to rely on, teachers can become not only trusted sources of information but also agents of change (Kirby 2011:8-25). Researches in Uganda (Lule, et al 2013:18-20) and Tanzania (Kawai, Kaaya, Kajula, et al 2008:879-888) similarly reported that determining what exactly teachers communicate and what challenges they face while teaching sexuality to their students is crucial, since effective student-teacher communication is associated with delayed sexual initiation.

The study has also shown that school performance is strongly associated with positive sexual behaviour (P=0.000). This is in concord with Centre for Disease control and prevention report which states that students who do well academically are less likely to engage in risky behaviours; and school connectedness was found to be the strongest protective factor for both boys and girls (CDC 2009:5). A study conducted in Ethiopia showed that students who perceived connected to school were less likely to be engaged in risky sexual behaviour (Amsale and Yemane 2012:159-164).

A comprehensive adolescents' sexuality and reproductive health education is a crucial weapon to develop a positive sexual behaviour including late initiation of sex, safer sex, use of condoms and contraception. Although highly acceptable in a number of studies, including the current study, sex education is not emphasized in school settings thus poor knowledge and reflected low levels of awareness of different components of a comprehensive adolescent sexual and reproductive health amongst adolescents.

6.5.3 Community /neighbourhood support

Community mobilization can foster intergenerational communication in support of adolescent sexual behaviour (Kesterton and Cabral 2010:7; and Denno, Hoopes, and Chandra-Mouli 2015: S22-S41). Adolescents who report that they have positive relationships with adults and those who receive mentoring in the context of a long-term supportive relationship are more likely to succeed on multiple fronts (Mary et al 2011:5).

In line with these evidences, this study shows that only 30.4% adolescents perceive their community with better quality and 26.3% adolescents perceive that there is good neighbourhood and only 13.4% adolescents perceived that there is cohesion among adults and adolescents. Evidence showed that Neighbourhoods that offer youth many opportunities -- such as after-school programs, sports, and job training -- support positive sexual health, including decreased teen pregnancy (CDC 2010: S1-S96).

Studies indicate that having a mentor, participating more in community activities, and being involved in more community organizations also protect against sexual risk-taking. When adolescents are attached to such entities, they may spend less time unsupervised and, consequently, have less opportunity to take sexual risks (Kirby and Lepore 2007:2). However, this study identifies only 16.6% and 6.4% respondents said adolescents mostly spend their leisure time going to stadium and cinema respectively. The qualitative finding of this study also shows that there is very weak caring relationship between adults in the community and adolescents. This deduces that community involvement to create an enabling environment to enhance positive sexual behaviour of adolescents is very limited.

Adults influence adolescents' access to sexual and reproductive health information and services, as well as their ability to make healthful decisions. To ensure sustained positive behaviours among adolescents, the community must view these behaviours as beneficial, and community members must support change (UNFPA 2007:1-39). Similar study in Ethiopia showed that availability of sexual and reproductive health integrated services and involvements of peer counsellors are protective factors. These protective resources are vital in developing the capacity of adolescents for safe sexual behaviour (Diriba 2015:79-96).

In this regard, this study indicates only 26.8% of respondents perceive that adults in the community approve to use contraceptives and/ or condom use by adolescents. Despite the fact that this result is low, the finding shows people approve of contraception or condoms use by adolescents are statistically significant with adolescents' positive sexual behaviour.

The qualitative part of this study substantiates this weak support from adults in the community on adolescent sexual behaviour. Participants indicated adults give low respect if adolescents visit health facilities for their sexual and reproductive health services.

This result is in line with WHO's report which states that despite recognition of the importance of community participation in adolescent programs and several efforts in developing countries to foster such participation, this component remains weak in programming for adolescent health and development (WHO 2009:12).

Social and behaviour change interventions showed that community support can shift individual behaviours, including contraceptive behaviours, either by changing norms or individual knowledge and attitudes (Storey, Lee, Blake, et al, 2011:1-89). Research evidences that when teens are more involved in their communities and have mentors, they are less likely to engage in sexual behaviour (Kirby and Lepore 2007:2).

Similarly, this study shows that ever discussed on sexual activity, condom and contraceptive use and STI/HIV/AIDS with health service providers in the community is statistically significant with positive sexual behaviour. On top of this, the focus group discussion identified that integrating adolescent sexual and reproductive health services with HIV/AIDS programs (HIV/AIDS program is widely supported at different levels) is one area of focus to improve community awareness towards positive sexual behaviour of adolescents.

As Donna, et al (2015: S22-S41) highlighted, improving health service use also involves generating demand for services among adolescents and acceptance among gatekeepers in the community, such as parents and community leaders, who may question or oppose the provision of sexual and reproductive health services for adolescents

6.5.4 Peer support

Peers play an important role in adolescent development and socialization. Peer group attitudes about sex influence the attitudes and behaviours of teenagers (Joar, et al 2015: S7–S14).

In adolescence, the most influential point of reference is the social environment and more specifically peers. Sexual behaviour is one of the many areas in which adolescents are influenced by their best friends and peers (Kirby and Lepore 2007:6-7).

There is evidence that peer-based strategies have been effective in reducing HIV/STI risk behaviours in in adolescent populations (Simoni, Nelson, Franks, et al., 2011: 1589–1595).

Peer influence extends and has far reaching implications in both sexual as well as nonsexual behavioural patterns. In this study, in relation to peers support for positive sexual behaviour, relevant questions were provided to adolescents including peers' attachment, norm and social behaviour.

6.5.4.1 Peer attachment

At the relationship level, strategies that are being implemented and seem promising include efforts to build peer support networks (Joar, et al 2015: S7–S14).

This study shows that attachment to peers and friends, as measured by a Likert scale revealed that 83.7% of adolescents are completely agree to feel closely attached to their peers. Concurrently, 73.0% and 66.7% of respondents reported that they believe that peer support or social activities with peers prevent sexual risks; and more peer influence on decisions respectively. This finding is similar with a study in Ghana which stated that adolescents tend to do what they believe their friends are doing (Jeffrey. Bingenheimer, Elizabeth, et al 2015:136).

This study also indicates that adolescents' sexual behaviour is statistically significant and very strongly associated with their peers' attachment. Furthermore, respondents who perceived that they can help their friends and friends value their opinion were also statistically significant and strongly associated with respondents' positive sexual behaviour. In line with this correlation, a study in the United States have shown that adolescents who report more restrictive attitudes toward sex among their friends are less likely to have had sex themselves (Kapidia, Frye, Bonner, et al 2012: 27-40).

In corroboration of this study, the broader literature on adolescent development and behaviour has long emphasized the growing importance of friends and peers as socializing agents during this stage of the life course (Smetana, Campione-Barr and Metzger 2006 255-284).

6.5.4.2 Peer norms and involvement

There are a variety of mechanisms by which peers could be influential on sexual behaviour. Van de, Reitz, Sandfort, et al (2014:1-32) stated that adolescents could be influenced via normative mechanisms, with norms being either 'descriptive', that is the perceived prevalence of a behaviour amongst peers, or 'injunctive', that is the perceived peer approval of a behaviour.

This study shows that 73.2% of adolescents perceived it is better to initiate sex when getting older. Regarding to condom use, 56% of adolescents reported at least one of their peers supports condom use. The study also shows that positive sexual behaviour of respondents were statistically significant and strongly associated with peers who support for condom or contraceptive use, believe that it is better to initiate sex when older and bonding with peers/social activities with peers. The focus group discussion revealed that peer norms are one of the factors that influence sexual initiation and subsequent sexual behaviours among adolescents. Participants stated peer is very influential for both negative and positive sexual and other behaviours.

Similarly, the study discovered that there is high peer pressure now a day; and Students accept their friends' opinion and imitate their friends' behaviour whether the behaviour is right or not which might be due to lack of self-confidence on how to be insistent to avoid pressures. Others also found that adolescents often face enormous pressure to engage in sex, especially from peers, exposure to unlicensed erotic video films and the desire for economic gain. The result of this is significant numbers of adolescents are involved in sexual activities at an early age (Sime and Wirtu 2008:167-173).

However, there is evidence that peer-based strategies have been effective in reducing HIV and other sexual risk behaviours among adolescents (Kapidia, Frye, Bonner, et al 2012:27-40;Simoni, Nelson, Franks et al., 2011: 1589–1595).

The findings of this study reinforce the paramount importance of building positive peer support regarding to sexual behaviours including self-efficacy and skills on how to break peer pressure. Evidence also shows that social and emotional competence can be improved by intervention (Mary, et al 2011:12-24). For example, high-quality school-based programs have been found to achieve positive results for adolescents (Mary, et al 2011:12-24). These include communication skills, emotional awareness, peer-refusal skills and emotional regulation that can promote positive social development in multiple ways and thereby assist adolescents in developing close friendships, having positive peer relations, engaging in positive social behaviours and avoiding negative social influences (Mary, et al 2011:12-24).

6.5.5 Peer sexual behaviour

The study shows that 45.8% respondents' reported that at least some of their peers were sexually active. The study also depicts that 44.8% and 42.7% adolescents believe that boys gain respect if sexually active and it is okay to have sex with multiple partners respectively; and these were also raised in the focus group discussion. Participants stated that during adolescence, true love is uncommon, one to one is very rare, concurrent partners are common and having more than one partner is a proud especially in boys".

This result is consistent with studies which showed that adolescents who perceive sexual activity will increase the extent to which they are respected by peers are more likely to engage in sex (Amsale and Yemane 2012:159-164; Jeffrey, Bingenheimer, Elizabeth, et al 2015:1-19).

Additionally, qualitative data from Tanzania (Harrison 2008:175-189) and Cape Town, South Africa (Selikow, et al 2009: 107-112) suggest that norms related to adolescent sexual activity may be gendered, with adolescent boys being more likely than girls to be pressured by their peers into sexual activity, and to believe that they can derive status within peer groups through having sexual partners.

A systematic literature reviews on factors affecting adolescent sexual behaviour globally found that most studies showed that perceiving more peers to be sexually active increased the likelihood that adolescents reported ever having had sex themselves (Fearon, Wiggins, Pettifor, et al 2015: 62-74; Buhi and Goodson 2007: 4–21; and Kristin and Simran 2013:12-24).

Among the respondents of the study, 73.0% of adolescents reported that at least some of their peers use contraceptive during sex. Similarly, 80.3% of adolescents mentioned that at least some of their peers use condom during sex. A report from similar studies showed that adolescents' connections to their peers could help to buffer them against stresses and potentially decrease risky sexual behaviours (Barker 2007:1-76; Markham, Lormand, Gloppen, et al 2010: S23-S41).

In support of these findings, participants discussed the impact of peer pressure depends on individual’s strong belief to indulge and engage in some risk behaviours. They also raised amid the discussion, free talk with peers on positive sexual behaviours (late sexual debut, abstinence, condom use and contraceptive use) should be the major discussion issues among adolescents as far as sexual behaviour is concerned. Other study supported that communication might enforce norms or provide information. Peers provide social connections to other adolescents.

Adolescent's position within the overall structure of social ties might influence, or be reflective of, decisions about sexual behaviour (Moody 2009: 257-269). The participants also added adolescents should build the capacity how to tackle peer pressure, at the same time, they should have the ability to refrain themselves from such peers that influence others to risky sexual behaviours. Research findings in Ghana (Jeffrey, et al 2015:136) and KwaZulu-Natal (Harrison 2008: 175-189) which found that social norms in those settings generally equate adolescent sexual activity with sin and a lack of personal respectability which might have contextual differentials to this study.

This study clearly showed that peers have significant influences on adolescents' behaviour. It also deduces a need to design a priority intervention strategy to promote positive peer-to-peer influence to augment safer sexual behaviour among high school students. Therefore, strengthening school peer education programs to create a culture of positive peer influence is critical.

6.5.6 Respondents' sexual activity

The study shows that 14.7% of respondents had experienced sexual intercourse preceding the study. The finding is lower than a study report in other part of Ethiopia Ambo- 33.1%(Bane 2015:137) and Addis Ababa-20.4% (Amsale and Yemane 2012: 159-164). Even the finding is far lower than other countries study globally such as in Spain 38.7% (Puente, Zabaleta, Rodríguez-Blanco, et al 2011:13-19), Tanzania 32% (Kazaura and Masatu 2009:1) and USA 66.7% (CDC 2010b: S5). Similarly, about 73% of black Americans, 58% Hispanic, and 44% of whites' high school students reported having had sexual intercourse (Schwarz 2010:931). The discrepancies of the study finding from global figures could be due to cultural tie and influence to report sensitive personal experiences including sexual activities, the characteristics of the study population, methodology, socio-cultural factors, religious backgrounds and exposure to highly sexualised media readily accessible to young people.

Individual factors, such as pubertal development, problem behaviours and attitudes, are often the strongest correlates of adolescent sexual behaviours (Zimmer-Gembeck and Helfand, 2008: 927-938). Risky behaviours, such as substance use (i.e. especially alcohol use), antisocial and delinquent behaviours, are highly correlated with each other. Alcohol use and antisocial behaviours also have some of the strongest correlations with early onset of sexual intercourse, inconsistent condom uses and multiple sexual partnerships, for both males and females (Boislard and Poulin, 2011: 289-300; Boislard, Poulin, Kiesner, et al 2009:265–276; and Price and Hyde 2009: 1059-1071).

The study also indicates that first initiation of sexual intercourse is multifaceted such as personal desire (55.9%), peer pressure (14.0%), watching pornographic films (10.8%), coercion (8.6%), to get money (6.5%) and substance use (4.3%).

Many factors also identified in participants' discussion as a predictor for risky sexual activities including easily accessible Pornographic films and substance use like shisha, khat and cigarette in most places in our community. Likewise, a study in northern Ethiopia showed that engaging in risk behaviours such as Khat chewing, drinking alcohol, attending night clubs and watching porno videos were independently associated with likelihood of ever had sex and having multiple sexual partners (Wondemagegn, Mulat and Bayeh 2013:20-21). This could be due to risk perception ability decreases with alcohol and khat consumption as a result, students may not be capable of rational judgment and they also may not be able to predict the serious consequence of their action.

A study found that adolescents' behaviours take place within a wider social environment and in the context of their social relationships (Ali and Dwyer 2011: 183-190) that can prone them to some risky activities. The study finding also shows that respondents have had different risky sexual activities in the last 12 months preceding the study including concurrent multiple partners (63.3%), inconsistent condom use (44.2%), contracted one of the STIs (15.2%), unwanted pregnancy (44.1%) and abortion (46.9%). The study finding is similar with other studies in Ethiopia (Amsale and Yemane 2015:159-164; Bane 2015:137; Fentahun and Mamo 2014:59; and Abera, Tsion and Netsenet 2013:498-506).

This implies that strengthening programs to promote safe sex practice could be an essential tool to reduce these and other sexual and reproductive health related negative outcomes. This would include interventions such as direct engagement of adolescents in program planning and implementation, strengthening information dissemination, provision of safe abortion services, increasing access to contraceptives and increasing correct and consistent use of contraceptive methods, monitoring and evaluation of the programmes. It is clear that adolescents with better knowledge have the likelihood of resisting pressure from their peer and will have healthy relationship. Similarly, a study in west Ethiopia showed that individuals' sexual and reproductive health knowledge and life motives are identified as a protective at individual level (Diriba 2015: 79-96).

Generally, attachment to people or institutions that discourage sex, unprotected sex and early childbearing and that encourage responsibility, either sexual responsibility or responsibility more generally also reduce sexual risk taking. Multiple studies show that when adolescents are more strongly attached to their parents, their schools, or communities, or when they are more involved in their communities, they are less likely to have sex and unprotected sex (Kirby 2011:10-16).

The present study clearly realizes that families, schools, peers, and communities play in preventing adolescent risky behaviour. Evidence supports prevention programs that target shared risk and protective factors across a number of social contexts and equip adolescents with critical knowledge and skills needed to avoid risky behaviours (Mary, et al 2011:1-12).

6.6 CONCLUSION

This chapter shows that concurrent interactions and multi-directional influence of the community, school, family, peers, and individual has a high impact on adolescents behaviours and outcomes. Likewise, protecting adolescents from early sexual debut, STIs, unwanted pregnancies and unsafe abortions calls for a concerted effort from parents, schools community and peers.

To do so, helping adolescents to achieve cognitive, social, and behavioural competence may reduce the likelihood of sexual activity and unwanted pregnancy, abortion, and increase contraceptive use. How adolescents' make decisions about relationships, abstaining or participating in sex, and protecting themselves and others from sexually transmitted diseases and pregnancy is influenced by numerous factors. Making good decisions and responsible choices about sexual activity during adolescence can have immediate and lasting implications for overall health outcomes of adolescents.

CHAPTER SEVEN

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

7.1 INTRODUCTION

The chapter presents summary of study findings. Based on the major findings of the study, the chapter proposes strategies to support positive sexual behaviours among high school adolescents at family, school, community, peer and individual levels. Families, schools, and communities all need to work together to create an environment that facilitates not only positive sexual behaviours but also health development of adolescents. Consequently, empowering families and communities with knowledge and information, strengthening school based sexual and reproductive health program, addressing peer influences, and promoting academic competence of individuals are important goals for enhancing positive sexual behaviour and its short and long term impacts of adolescents. The chapter also presents important activities in each domains, monitoring and evaluation of implementation of strategies and activities. It also includes key indicators for monitoring and evaluation.

7.2 SUMMARY OF THE RESULTS

Coalition to Advance Adolescent and Youth Sexual and Reproductive Health (2009:11) states: adolescence is a crucial time for sexual and reproductive health interventions, as it provides an opportunity to influence adolescents during a period when they are establishing lifelong behaviour patterns. In line with this evidence, the present study finding clearly shows that there are protective factors at parent and family, community and neighbour, school, peer and individual levels.

Familial factors associated with positive sexual behaviour include family attachment, parental monitoring and supervision, rule-setting, and parent-adolescent relationships characterized by support, shared activities and open communication.

School connectedness and programs such as good performance, avoid missing classes, sex education and sexual and reproductive health counselling, teachers' support, mini-media and participating in extra-curricular activities are also indicated in this study to be associated with positive sexual behaviour. Similarly, the study identified that community and peers support have a direct effect on adolescents sexual behaviour.

However, this study evidences that there are huge gaps among these domains to support positive sexual behaviour of adolescents that increase adolescents' vulnerability to sexual and reproductive health risks (e.g., early sexual debut, unsafe sex, sexual coercion, early pregnancy, unsafe abortion and STIs/HIV/AIDS) and pose barriers to their access to sexual and reproductive health information and services.

Addressing these underlying determinants by working with various stakeholders such as parents, schools, community, peers and policy makers, is essential for adolescents to realize their positive sexual behaviours.

Adolescents' behaviours are influenced at the individual, peer, family, school, community, and societal levels. Because many societal sectors contribute to adolescent health, safety, and well-being, collaborative effort to engage multiple partners is necessary (CDC 2014:1-47).

Similarly, Coalition to Advance Adolescent and Youth Sexual and Reproductive Health (2009:11) states that providing access to comprehensive information and services that respond to the realities of their lives, and a supportive social environment, adolescents and their future families are more likely to engage in healthy decision making and behaviors over the long-term.

Furthermore, safe and supportive families, safe and supportive schools, together with positive and supportive peers are crucial to helping adolescents develop to their full potential and attain the best health in the transition to adulthood.

Improving adolescent health worldwide requires improving young people's daily life with families and peers and in schools, addressing protective factors in the social environment at a population level, and focusing on factors that are protective across various health outcomes (Russell, Elizabeth, Simon, et al 2012: 1641-1652).

With such evidences, designing an appropriate strategy is utmost and first step to enhance positive sexual behaviours of high school adolescents.

According to national Ministry of Health of Ethiopia (2011:1-48), most parents, caretakers and community members, health workers and adolescents are not well aware about the reproductive health rights and needs of adolescents. In agreement with the notation, this study finding indicated that there are huge gaps to support positive sexual behaviour of adolescents at family, community, school, peer and individual levels.

As a result, it is strongly believed that this strategy will have an added value for the adolescents themselves, their parents and the rest of the community as well as the health care providers working at different service outlets to be informed and made aware about the sexual behaviour and reproductive health needs and rights of adolescents.

7.3 SUPPORTIVE STRATEGIES

7.3.1 Purpose of the strategy

A strategy is a particular method or approach consistently used in the course of the intervention activities. An example of a strategy would be to use peers to provide the instruction during a group level intervention presentation (Hayes 2009:5). The purpose of this strategy is enhance the involvement of families, community and neighborhoods, schools and peers in supporting adolescents' positive sexual behaviour.

7.3.2 Specific objectives

- Formulate strategies that will enable the involvement of families, community and neighborhoods, schools and peers to achieve positive sexual behaviour of adolescents.
- Identify priority activities to support positive sexual behaviour of adolescents at families, community and neighborhoods, schools and peer levels
- Facilitate effective management of a sustainable support for adolescent positive sexual behaviours

7.3.3 Family and parental support

The aim is to secure support from families and communities in addressing adolescent sexual and reproductive issues and to maintain and strengthen available "social capital" for support of adolescents.

Even though parent-adolescent relationships have a major influence on adolescents sexual decision-making (Mmari and Blum 2009:350-366), this study finding showed that parent- adolescent relationships (connectedness, communication and monitoring and parental style) are very weak. This study also shows there are knowledge and skill gaps among parents and families on how to establish and maintain the relationships to equip adolescents on how to avoid risks and taking a responsible sexual activity in their life.

This study has in addition, revealed that there is a need to enhance family's and parent's knowledge on the nature of adolescent sexual behaviour and build their skill on how to create connectedness, communication, rule-setting, supervision, and parenting style in general with their adolescents.

Parent-based intervention programs target adolescent behaviours but use the parents of adolescents as change agents.

This includes advising parents on how to become effective change agents and to help parents implement advices to prevent adolescent problem behaviours (James and Nicole 2013:1-33).

7.3.3.1 Strategies to engage parents and families in supporting positive sexual behaviour

- Engage local health (especially health extension workers), education, women, children and youth offices, administration and other institutions to sensitise families and communities in raising awareness about adolescent sexual behaviours and reproductive health. Community sensitisation can be implemented at community and government gatherings, (example, school family days, open days, official government meetings and religious congregations).
- Create task forces and committees to lead family and community activities on different adolescent sexual behaviour and reproductive health activities. The committees should be constituted by representatives of the community, adolescents, health offices/institutions, school teachers, religious leaders, NGOs and others.
- Organise regular consultative meetings with the task forces and community representatives to evaluate the activities.
- Use different approaches to disseminate to adolescents' feedback given during the taskforce and committee meetings.

7.3.3.2 School support

Despite various studies found that school-based education is an effective intervention to have a better knowledge on sexual and reproductive health, and for developing positive sexual behaviour (Adinew, et al 2013:2-7; and Amy, et al 2009: 181-206), this study finding showed that only 26.6% and 19.8% of adolescents reported sexual and reproductive health counselling services and sex education are available in their respective schools.

A number of studies (Amsale and Yemane 2012:159-164 and CDC 2009:5) including the current findings suggested that a comprehensive adolescents' sexuality and reproductive health education is a crucial weapon to develop a positive sexual behaviour including late initiation of sex, safer sex, use of condoms and contraception.

Center for Disease Prevention and control Division of Adolescent and School Health (2010:1-2) states that as schools are critical settings for preparing students academically, they are also vital partners in helping young people take responsibility for their own health. School health programs can help youth adopt lifelong attitudes and behaviors that support overall health and well-being including behaviors that can reduce their risk for HIV and other sexually transmitted diseases (STDs). The same source indicated sexual and reproductive health programs implemented by schools include prevention education programs designed specifically to reduce sexual risk behaviors and youth asset-development programs, which provide adolescents with more general skills that help them engage in healthy behaviors and solve problems.

7.3.3.2.1 Sex education in school

Research shows that well-designed and well-implemented sexual and reproductive health programs in schools can decrease sexual risk behaviors among students, including: delaying first sexual intercourse, reducing the number of sex partners, decreasing the number of times students have unprotected sex and increasing condom use (DiClemente, Wingood and Rose 2009:1112-1121; Jemmott, Jemmott L and Fong 2010: 152-159 and Tortolero, Markham, Peskin, et al 2010: 169-179).

WHO recommends that sexual and reproductive health education be provided within the context of schools that promote health (WHO 2008:1-24).

- **Activities to design effective sex education program in school**

Sex education program requires a meticulous curriculum development, designing appropriate and feasible content and approach; implementation and monitoring plan. These activities developed based on the research findings of both quantitative and qualitative methods of the present study. In addition, it is reviewed from different literatures and adapted from scientific and practically tested concepts (WHO 2008:1-24 and Senderowitz and Kirby 2006:38).

- **Curriculum development**

    - Involve people with different backgrounds in theory, research, and sex education.
    - Plan specified health goals and identified behaviours affecting those goals, protective factors affecting those behaviours, and activities to address factors.
    - Assess relevant needs and assets of adolescents.

- **Content and approach**

    - Incorporate a means to assure a safe environment for participating and learning.
    - Include multiple activities to change each of the targeted protective factors.
    - Incorporate instructionally sound and participatory approaches.
    - Use activities, messages, and methods that are appropriate to the culture, age, sex and sexual experience of targeted populations.
    - Address gender issues and sensitivities in both the content and teaching approach.
    - Cover topics in a logical sequence.
    - Present information that is scientifically and medically accurate.
    - Focus narrowly on specific sexual behaviours that lead to these health goals (e.g. abstaining from sex, using condoms, avoiding unwanted pregnancy);

give clear messages about these behaviours; addressed how to avoid situations that might lead to these behaviours.

- Target several psychosocial protective factors affecting these behaviours (e.g. knowledge, perceived risks, attitudes, perceived norms, self-efficacy).
- Include multiple activities to change each of the targeted protective factors.
- Use teaching methods that actively involved adolescent participants, and helped them to personalize the information.

- **Implementation**

  - Make relevant authorities and gatekeepers (school administrators, health authorities, community, etc.) aware of the program's content and timetable, keep them informed, and encourage them to support the programme.
    - Establish a process resulting in the selection of appropriate and motivated educators.
    - Selected educators with desired characteristics, and provided quality training in curriculum.
    - Have in place management and supervision needed for implementation and oversight.
    - Recruit adolescents and overcome barriers to their involvement in programme.
    - Implement activities to retain and monitor adolescent participants.
    - Establish monitoring and assessment systems to improve programme effectiveness on a continual basis.
    - Include activities to address all key topics designated by the curriculum and implement the activities in the order presented.

- **Establishing and strengthening mini-media: school sexual and reproductive health information centre**

This program should be prepared targeting adolescents by using highly interactive approaches, sound and appropriate messages about adolescent sexual and reproductive health issues. Mini-media centres should be strengthened and established in the schools, supported and monitored by the school management and parents in order to actively work on protective factors among school adolescents. This min-medias should be equipped with relevant materials for students to receive relevant information regarding sexual and reproductive health issues on a comprehensive way.

- **Strategies for establishing and strengthening of mini-media: sexual and reproductive health information centres in the schools**

  - Establish mini-media and adolescent sexual and reproductive health information centres in schools.
  - Strengthen mini-media by assigning the right persons to lead the centres and equip them with relevant materials such as leaflets, magazine, books, pamphlets, posters, computer and internet services and other electronic materials.
  - Develop adolescent sexual and reproductive health related programmes for dissemination by the mini-media.
  - School managements should monitor and evaluate the programmes regularly.

- **Adolescents dialogue programme in school**

Adolescent dialogue is a forum that draws participants from as many groups of adolescents as possible to exchange information face to face, share personal stories and experiences, honestly express perspectives, clarify view points, and develop solutions to adolescent concerns. It develops common values and allows participants to express their own interests.

During the dialogue, participants may question and re-evaluate their assumptions. Through this process, adolescents are learning to work together to enhance their positive sexual behaviours (FHAPCO 2014:30)

- **Activities to conduct adolescents dialogue**

  - Based on the pre-set criteria, select facilitators and conduct training for facilitators on adolescent dialogue programmes.
  - Based on the locally identified risk and protective factors, identify the issues for discussion (example, do you believe that boys should practice sex before marriage? Do you think early sexual debut affects school performance?).
  - Decide where and when to meet for the dialogue (the place and the time should be decided by the adolescents themselves).
  - Conduct effective dialogues.
  - Clearly discuss on activities to promote sexual behaviour.
  - Build consensus on recommendations.
  - Commit to next steps.
  - Warp-up and adjourn.
  - Evaluate the dialogues and give feedback.

7.3.3.3 Community/ neighbourhood support

Both the quantitative and qualitative findings of this study deduces that community involvement to create an enabling environment to enhance positive sexual behaviour of adolescents is very limited despite the fact that various studies indicated community mobilization can foster intergenerational communication in support of adolescent sexual behaviour, and positive adult relationship and mentoring in the context of a long-term supportive relationship to succeed on multiple fronts (Denno, et al 2015:S22-S41; Kesterton and Cabral 2010:7; and Mary et al 2011:5).

Furthermore, the study findings show that adults in the community and neighbours should involve in adolescents' sexual and reproductive health programs to create an enabling environment for adolescent positive sexual activities.

Adolescent programmes intended to be introduced at the youth centres and health facilities should be implemented with full involvement of the community including families as they are core in identifying protective factors for adolescents' positive sexual behaviours. Community and neighbourhood adults can be used as sources for sexual and reproductive health information and promoters for the use of the services by the adolescents with confidence.

These community representatives organized in the form of support groups/committees could have a formal linkage (network) with the youth (the beneficiaries) and health workers working in SRH provision at various service delivery points located in specific localities/settings like Kebeles and Woredas.

7.3.3.3.1 Strategies to sustain involvement of community and neighbour in adolescent sexual and health programs

Community awareness, involvement and participation are essential for successful adolescent sexual behaviour and reproductive health programming. It facilitates empowerment of community leaders and community health volunteers on their roles and responsibilities in creating community awareness about sexual behaviour and reproductive health services. A well informed community is more likely to have better adolescent sexual behaviour and reproductive health status and service utilization (National policy on sexual and reproductive health 2013:1-34).

- Establish networks with communities including governmental bodies, non-governmental organisation, and associations such as youth associations, women's associations, hotels, bars, ‘‘Idir’’ or local organisations for social support and others.

- Organise awareness creation programs through workshops and events in collaboration with the community.
- Form task force groups to facilitate coordination and follow up of the implementation of sexual and reproductive health services at the youth centres. Strengthen community level institutions to increase demand for SRH services. Establish and strengthen sexual and reproductive health program in health facilities
- Capacity building of health professionals on adolescent sexual and reproductive health issues.
- Equip health facilities with sexual and reproductive health materials like IEC, equipment and commodities. Provide supportive supervision and management at all levels through strengthening of SRH training and supervision system.
- Conduct edutainment, experience sharing programs, film and video shows, and other programmes to enhance the contribution of the youth centres in the awareness creation of the communities on adolescent sexual and reproductive health.
- Conduct mass mobilisation for adolescent sexual and reproductive health awareness creation and service promotion.
- Involve other organisations along with community on adolescent sexual and reproductive health activities. This include:
    - Mapping of partners who are engaged on adolescent sexual and reproductive health activities.
    - Establish sexual and reproductive health forum.
    - Conduct joint operational plan development on sexual and reproductive health activities with stakeholders.
    - Conduct regular meetings with the stakeholders.
    - Conduct experience sharing activities between the stakeholders.
    - Document good practices for dissemination to others.
    - Conduct regular joint annual programs reviews and improve as per the recommendation given.

- Ensure involvement of the representatives of adolescents on joint planning, regular meetings/forums, and annual review meetings.

7.3.3.4 Peer support

In adolescence, the most influential point of reference is the social environment more specifically peers (Kirby and Lepore 2007:6-7) and peer group attitudes about sex influence the attitudes and behaviours of adolescents (Joar, et al 2015: S7–S14).

Similarly, this study finding show that 73.0% and 66.7% of respondents reported that they believe that peer support or social activities with peers prevent sexual risks; and more peer influence on decisions respectively. Concurrently, the qualitative part of the study revealed that *"Peer is very influential for both negative and positive sexual and other behaviours". "Now a day there is high peer pressure" and "Students accept their friends' opinion and imitate their friends' behaviour whether the behaviour is right or not…".*

This clearly indicates a need to design a priority intervention strategy to promote positive peer-to-peer influence to augment safer sexual behaviour among high school students.

7.3.3.4.1 Peer education

Peer education training of trainers' manual (UN Interagency Group on Young People's Health 2011: 25-57) highlights, a young person's peer group has a great influence on the way he or she behaves. This is true of both risky and safe behaviour. Peer education makes use of peer influence in a positive way. Young people get a great deal of information from their peers on issues that are especially sensitive or culturally taboo. Peer education is also a way to empower young people: it offers them the opportunity to participate in activities that affect them and to access the information and services they need to protect their health (UN Interagency Group on Young People's Health 2011: 25-57).

Peer education is a process which involves selecting, training and supporting members of a specific group to educate members of their peer group about a subject matter. In peer education programs, peer groups can be referred to as the target group or population, beneficiaries or beneficiary population (Peer Education TOT Guideline) (FMOE 2014:4).

Peer education occurs when people of a similar interest, age, background or friend circle educate other people in that group. Peer education is a teaching or co-teaching relationship between people who are in some way equals. Peer education could be formal education programs, outreach programs, workshops, on-demand or by-request peer education or situation-specific peer education. Peer education has an advantage of using low resource costs, the potential of a high degree of contact and growth for both educator and learner.

Common topics to be addressed in peer education:

- Communication and counselling skills
- Abstinence and safe sex practices
- Contraception and condom use
- STIs and HIV/AIDS, testing and treatment pathways
- Healthy Relationships and conflict resolution
- Substance use and risk reduction
- How to educate and support each other
- Available services and referral

- Strategies for an effective peer education programme for adolescents' positive sexual behaviour
  - Develop relevant curricula for Training of Trainers (TOTs) on peer education.
  - Develop comprehensive criteria for selecting peer educators.
  - Recruit peer educators based on the developed selection criteria.
  - Train peer educators using those who have been trained as Training of Trainers (TOTs).
  - Establish linkages and referral systems with local youth-friendly service providers.

- Reward and incentivise peer educators as motivation for better achievements.
- Conduct refresher trainings for peer educators on regular basis.
- Institute regular monitoring, supervision, evaluation and feedback of peer education activities by those engaged in adolescent sexual and reproductive health activities.

7.3.3.5 Building individual protective factors using life skills

It is clear that individual factors, such as pubertal development, problem behaviours and attitudes, are often the strongest correlates of adolescent sexual behaviours (Zimmer-Gembeck and Helfand, 2008: 927-938). This study finding identified that adolescents had experienced different risky sexual activities in the last 12 months preceding the study such as concurrent multiple partners (63.3%), inconsistent condom use (94.2%), contracted STI (15.2%), unwanted pregnancy (44.1%) and abortion (46.9%). Similarly, the study showed that there are risk factors for first initiation of sexual activity among adolescents including personal desire, peer pressure, pornographic films, substance abuse, coercion and to get money.

These signify that designing a feasible strategy and strengthening programs building knowledge and skills of adolescents on how to promote safer sex practices. Behavioural intervention and life skills are among the major approaches to promote safer sexual activities of adolescents.

Behavioural intervention strategies involve comprehensive knowledge, stigma reduction, increased health service seeking behaviour, delay onset of sexual intercourse, decrease in number of sexual partners, increase in condom use, increase in use of family planning services (HIV/AIDS and minimum service packages for youth centres (FMOH and MWCY 2013:22).

Life skills are the abilities for adaptive and positive behaviours that enable individuals to deal effectively with the demands and challenges of everyday life (African AIDS Initiative International Inc 2008:1-51). A Life skills programme is a comprehensive behavioural change approach that concentrates on the development of the skills needed for life such as communication, decision making, critical thinking, managing emotions, assertiveness, self-esteem building, value clarification, peer pressure resistance and relationship skills for adolescents(FHAPCO2013:24). The approach for imparting life skills is usually interactive, using role plays, games, puzzles, group discussion, and a variety of other innovative teaching techniques to keep the participants fully involved in the session. Application of "Youth Action Kit" activities promotes the development of the following five Fundamental Life Skills:

- **Making good decisions:** Learning to make responsible personal decisions requires practice. Adolescents must make decisions frequently, ranging from simple to major decisions, such as: What shall I wear today? Shall I have sexual relations?

- **Being more assertive:** Being assertive is about being positive and confident. It is known that everyone deserves respect. In the Ethiopian culture, this skill is especially important for women. Women must learn to assert themselves when men propose them to have sex before they are ready or to have sex without a condom.

- **Setting realistic goals:** Adolescents who have thought through their personal priorities and have a plan for the future are more likely to remain at low risk. Changing personal behaviour is also directly related to the ability to set realistic, achievable goals.

- **Boosting self-confidence:** In general adolescents are eager to boost their self-confidence. Self-confidence is a foundation skill because it underpins the other four skills and makes each one easier to carry out.
- **Resisting peer pressure:** Giving into peer pressure is one of the leading reasons for adolescents getting involved in risky situations. Fortunately, there are skills and

techniques that allow students to develop the ability to not to follow the crowd and stand on their own feet say *"No"* to risky situations.

7.3.3.5.1 Strategies to develop life skills among adolescents

- Develop relevant life skills training manuals on adolescent sexual and reproductive health.
- Develop clear selection criteria for selecting life skills training facilitators.
- Recruit facilitators based on the developed selection criteria.
- Train Trainers (TOT) based on the developed life skills education curriculum.
- Cascade life skills training to the rest of the students/adolescents using facilitators who have taken TOT.
- Establish linkages and referral systems with local youth friendly service providers.
- Reward and incentivise facilitators and adolescents.
- Build adolescent's skills to abstain, to be faithful, to be consistent and to properly use condom.
- Prepare and provide strong messages and sound information on abstinence and other self-protection options like use of contraception methods and condom, abortion care, prevention and treatment seeking behaviour of STIs and HIV/AIDS such as dramas, role plays, videos, experience sharing with those practicing abstinence and others.
- Promote correct and consistent use of condoms.
- Produce and distribute IEC/BCC materials relevant to adolescent sexual and reproductive health.
- Reward adolescents practicing abstinence and faithfulness.
- Facilitate referral linkages with local health facilities for better treatment and consultation.
- Utilise trained teachers and students in the provision of risk reduction counselling, condom and contraceptive use including emergency contraceptives to prevent unintended pregnancy and HIV/AIDS.

- Equip selected teachers/volunteers (specifically biology teachers) with basic knowledge on family planning methods through training so that they can provide correct information to the adolescents.
- Design workable monitoring and evaluation strategies.

7.4 MONITORING AND EVALUATION OF IMPLEMENTATION OF STRATEGIES TO SUPPORT ADOLESCENT POSITIVE SEXUAL BEHAVIOURS

Monitoring and evaluation helps stakeholders, beneficiaries and the community understand what the program is doing, how well it is meeting its objectives, and whether there are critical needs inhibiting one's progress.

Follow-up of this strategy and activities and providing timely feedback is essential to continually guide and redirect the inputs and the overall direction of the programmes to reach the intended goals.

As part of monitoring and evaluation of sexual and reproductive health intervention package, all intervention activities should be systematically collected, recorded by experts using systematically designed formats. The progress of the programme should be monitored and collected data should be analysed and be used to generate strategic information for the program improvement, re-planning and decision making. The output of the monitoring and evaluation processes should be disseminated to the adolescents, implementers, policy makers, and the partners for effective utilisation.

Furthermore, sexual and reproductive health programmes need to be evaluated (process, outcome and impact evaluation) to see whether the intervention has brought any change, effective and met its ultimate objectives.

The aim of monitoring and evaluation of this strategy is to ensure timely generation and utilisation of information to enhance evidence-based decision making in support of positive sexual behaviours of adolescents.

7.4.1 Strategies to achieve monitoring (M and E) and evaluation of activities

- Assign sexual and reproductive health monitoring and evaluation to focal person in schools, and communities.
- Develop adolescent sexual and reproductive health M and E implementation and training manual.
- Conduct training for sexual and reproductive health focal persons on M and E manual.
- Enhance dissemination and utilisation of monitoring and evaluation indicators.
- Conduct regular supportive supervision and provide technical support on monitoring and evaluation activities.
- Provide written feedback based on the findings of supportive supervision for better improvements of adolescent sexual and reproductive health programmes.

7.4.2 Key indicators for monitoring and evaluation

Monitoring and evaluation of the implementation of strategies effectively depends on well-articulated measurable indicators. Based on various sexual and reproductive health monitoring and evaluation frameworks, the following are the proposed indicators to monitor and evaluate the strategies to enhance positive sexual behaviours among school adolescents (CDC 2011: S1-S96; FHAPCO 2014:17-30; FMOH 2011:1-48 and Kirby 2011:1-15).

- Number (%) of life skills and sexual and reproductive health training manuals and implementations guidelines developed and distributed.
- Number (%) of peer educators trained.
- Number (%) of life skills and sexual and reproductive health facilitators trained.
- Number (%) of adolescent dialogue facilitators trained.
- Number/type of BCC/IEC materials developed and distributed to adolescents.
- Number (%) of schools established mini-media.

- Number (%) of schools which established counselling centre, Adolescent sexual and reproductive health information centres.
- Number of peer education training manuals and implementation guidelines developed and distributed.
- Number (%) of stock outs of commodities distributed to youth centres during a given period of time.
- Number (%) of centres which conducted peer education sessions weekly.
- Number (%) of centres which conducted youth dialogue sessions weekly.
- Number (%) of adolescents reached with BCC materials.
- Number (%) of adolescents reached in peer education on sexual and reproductive health.
- Number (%) of adolescents reached with youth dialogue on sexual and reproductive health
- Number (%) of adolescents reached with life skill education on sexual behaviour and reproductive health.
- Consistent condom utilization rate.
- Number (%) of adolescents utilized counselling services.
- Number (%) of adolescents used STI diagnosis and treatment services.
- Number (%) of adolescents referred and linked to other services.

7.5 CONCLUSION

This chapter has presented details of the strategy framework for addressing positive sexual behaviours of adolescents. The study has demonstrated that several protective factors to promote adolescent positive sexual behaviour and reproductive health at family, community, school, peer and individual levels.

Furthermore, key intervention strategies targeting family, community, school, peer and individual are well articulated. The involvement of adolescents in designing and implementing adolescent friendly services and ensuring the participation of parents and community members, schools, peers and other stakeholders to contribute towards a

sustainable use-friendly service in their respective localities require the creation of a mechanism that ensure formal linkages.

The role of effective monitoring and evaluation has also been described. The chapter has also emphasised that success of the proposed strategies depends on development of specific, realistic and attainable activities which require trained and skilled human resources. The chapter has proposed several measurable indicators which can be applied during development of specific activities. It is expected that specific tools have to be developed and the personnel assigned to monitor and evaluate the implementation of the planned activities and that personnel have to be trained on how to use the proposed measurable indicators. Involvement of adolescents, families, schools, communities and neighbourhood, peers and other stakeholders or implementers in the monitoring and evaluation have been emphasised.

It is intended that the study has provided a framework from which family and community agents, schools, training institutions, health professionals, policy and decision-makers will use in the review of curricula, policies and operational procedures for promoting positive sexual behaviour of adolescents.

CHAPTER EIGHT

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

8.1 INTRODUCTION

This chapter presents the general conclusion and recommendations based on the major findings to at family, schools, community and neighbourhoods, peer, individual levels. The contribution of the study and its limitation as well as concluding remarks were also stated in this chapter.

8.2 RESEARCH DESIGN AND METHOD

In this study both quantitative and qualitative data were collected concurrently using a cross-sectional design and integrated the two databases by transforming the qualitative themes into counts and compared these counts with descriptive quantitative data. In this case, the mixing consists of integrating the two databases by actually merging the quantitative data with the qualitative data.

The intent of this concurrent mixed methods study was to explore and describe positive sexual behaviours among high school adolescents. In the study, self-administered questionnaire was used to measure the relationship between protective factors and positive sexual behaviour. At the same time, the protective factors were explored using focus group discussion with selected adolescents in high schools attending regular classes.

8.3 CONCLUSION

The present study finding substantially shows that there are protective factors at parent and family, community and neighbour, school, peer and individual levels.

Parental and familial factors associated with positive sexual behaviour include family attachment, parental monitoring and supervision, rule-setting, and parent-adolescent relationships characterized by support, shared activities and open communication. School connectedness and programs such as good performance, avoid missing classes, sex education and sexual and reproductive health counselling, teachers' support, mini-media and participating in extra-curricular activities are also indicated in this study to be associated with positive sexual behaviour. Similarly, the study identified that community and peers support have a direct effect on adolescents sexual behaviour. Adolescents who are emotionally healthy, having good knowledge and skills on sexual and reproductive health, doing well in school, have plans for the future, and adolescents with friends performing well in school and avoiding a wide range of risky behaviours are less likely to have sex and unprotected sex.

However, this study evidences that there are huge gaps among these domains to support positive sexual behaviour of adolescents that increase adolescents' vulnerability to sexual and reproductive health risks including early sexual debut, concurrent multiple partners, unsafe sex, sexual coercion, early pregnancy, unsafe abortion, STIs/HIV/AIDS and out of school; and pose barriers to their access to sexual and reproductive health information and services.

Focus Group Discussion participants generally agreed there is low parent-adolescent communication related to sexual issues supported as follows: *"Our families are strict and do not allow to freely discuss about sexual and other reproductive health issues with them"*.

Sexuality issues are not openly discussed in the community and within families as shown by a significant proportion of respondents who do not talk about sex related issues with their families, friends and relatives. The study has indicated that accurate information on adolescent reproductive health is not readily accessible to the majority of adolescents.

Significant proportion of families and community adults are not supporting adolescents to visit health facilities for sexual and reproductive health services even they give “Low respect to adolescents if they aware that adolescents’ visit health facilities for SRH services”.

This study further demonstrated that majority of schools do not have sex education and reproductive health counselling programs. In addition, significant number of schools with mini-medias do not adequately addressed SRH issues and the mini-media centres have no the necessary resources. The qualitative part of the study findings shows a minimal support for adolescent sexual behaviour from teachers even some teachers consider it as a crime. The study also demonstrated that there is high peer pressure and the impact of peer pressure depends on individual’s strong belief to indulge and engage in some risk behaviour. On top of this, the findings showed that adolescents believe boys gain respect if sexually active and have sex with multiple partners.

The present study substantially realizes that families, schools, communities and neighbour and peers play in a remarkable role to promote positive sexual behaviour. As a result, a strategy targeting families and parents, community and neighbourhood, schools, peers and individual adolescent on how to support and promote positive sexual behaviour of adolescents were proposed.

8.4 RECOMMENDATIONS

Both quantitative and qualitative findings suggesting the importance of the parents and family to engage in the promotion of positive sexual behavior and risk reduction programs for adolescents. Prevention program goals may include facilitating communication between parents, guardians, the extended family or adults, and adolescent to assist in building decision-making skills likely to impact their sexual behaviours.

Findings from this study suggest the potential importance of the school system in providing culturally relevant and comprehensive sex education and SRH counselling services focusing on positive outcomes wherein adolescents can engage with and feel accountable to their schools and communities. Further, prevention programs could engage both adults and peers to provide needed sexual education and support. The following are the recommendation based on the findings of this study:

8.4.1 Recommendations to families and the community

- Promote free discussion between parents, families, community adults and neighbourhoods and adolescents on sexuality issues and consequences.
- Promote abstinence and faithfulness through different approaches such as cultural dramas, role plays and experience sharing with those practicing abstinence and others.
- Promote cultural beliefs that do not encourage risk sexual practices among adolescents.

8.4.2 Recommendations to schools and health facilities

- Strengthen health facilities providing sexual and reproductive services, make it use-friendly and active involvement of adolescents
- Schools and health institutions should raise community awareness about the importance of discussing about sexuality with adolescents. This can be implemented through official government gatherings, school family days, open days and religious congregations.
- Regularise delivery of school health education programmes by the local health workers focusing on adolescent sexual and reproductive health.

- School-based sexual reproductive health and sexual relationships education should be introduced as part of social studies curricula early in primary schools and incorporate increasingly advanced messages about reproductive health and sexuality to higher grades.
- Establish Anti-AIDS clubs, VCT and adolescent sexual and reproductive health information centres, mini-media centres in schools which should be supported and managed by the school management.
- Incorporate demonstration of appropriate condom uses in the health education programmes given to adolescents.
- Public and private health institutions should give priority to the adolescents need for early diagnosis, treatment of sexually transmitted diseases and safe abortion services.
- Provide evidence-based information related to pregnancy and promote use of contraceptives including emergency contraceptives and condom use.
- Use peer educators and school teachers to educate adolescents on the benefits of HIV testing and family planning services utilisation.

8.5 CONTRIBUTION OF THE STUDY

The study suggested that there are huge gaps between parents and families, community and neighbour, schools, peer and individual levels; and adolescents relationship to support positive sexual behaviour of adolescents which can increase adolescents' vulnerability to sexual and reproductive health risks including early sexual debut, concurrent multiple partners, unsafe sex, sexual coercion, early pregnancy, unsafe abortion, STIs/HIV/AIDS and out of school; and pose barriers to their access to sexual and reproductive health information and services. The study was valuable because it was carried out within a specific study context. The proposed strategy will help policy makers and program managers to develop effective interventions that target those protective factors known to enhance positive sexual behaviours, and hence, outcomes of adolescents.

This study can further serve as a basis for further similar studies among adolescents in different settings in Ethiopia.

8.6 LIMITATION OF THE STUDY

The major limitation of this study was the cross sectional nature of the study which may not explain the temporal relationship between the outcome variables and some of the explanatory variables. The study topic assessed personal sensitive issues related to sexuality which might have caused social desirability bias. Although the study was conducted in urban settings among secondary school adolescents with a wide range of socio-economic background, the findings are valid for adolescents attending secondary schools in urban settings that may not necessarily generalize students living in rural areas and out-of-school adolescents whose living conditions and life style may be different.

8.7 CONCLUDING REMARKS

Adolescent sexual behaviour is a major concern because of its attendants and if their concerns are not properly addressed the cycle becomes more viscous and the problems become more compounded. Despite the predominant focus on sexual risk-taking, developmental researchers increasingly acknowledge that sexuality is normative during adolescence and that it is a critical time when adolescents must take steps toward competently interacting with peers in order to eventually fulfill their needs for intimacy, emotional and sexual closeness (Marie-Aude and Zimmer-Gembeck 2012:17).

This changing focus will make future research even more useful for understanding the range of adolescent sexual experiences, for moving toward a developmental agenda for the study of adolescent sexuality, and for guiding educational and intervention programs. Positive sexual behaviour and romantic development are critically important components of general health and well-being (Halpern 2010: 6-7 and Zimmer-Gembeck et al 2011: 927-938), and may be essential elements for other important adolescent developmental tasks, such as the development of self-identity and autonomy.

Therefore, to effect this, involving family and community, schools, peers and relevant institutions were crucial to intervene the identified sexual and reproductive health gaps. Such joint efforts can help to promote a more comprehensive approach to addressing adolescent sexual behaviour and health that views each adolescent as a whole person, recognising and drawing upon his or her assets and not just focusing on risks (CDC 2014:1-172).

REFERENCES

Abdisa, B. 2012. Assessment of premarital sexual practices and its consequences among female Ambo University students. 36-41; MPH thesis. Addis Ababa: Ethiopia.

Abebe, M, Tsion, A and Netsanet, F. 2013. Living with parents and risky sexual behaviours among preparatory school students in Jimma Zone, South west Ethiopia. African Health Sciences.13(2):498-506.
From: (http://dx.doi.org/10.4314/ahs.v13i2.42) (accessed 15/8/ 2017).

Abend, G. 2008. The Meaning of Theory:" *Sociological Theory*. 26:173–199.

Abera, H. Mekonin, M. and Jara, D. 2014. Knowledge, attitude, utilization of emergency contraceptive and associated factors among female students of Debre Markos higher Institutions. Family Medicine Science. 4:149.

Adinew, M, Worku, G and Mengesha, B. 2013**.** Knowledge of reproductive and sexual rights among University students in Ethiopia: institution-based cross-sectional study. *BMC international health and human rights.* 13 (1):2-7.

Advocates for youth. 2015. Sexuality education; building an evidence- and rights-based approach to healthy decision-making.5. (advocatesforyouth.org) (accessed 5/9/2017).

African AIDS. 2008. A Strategic Approach**:** HIV and AIDS and Education**.** 1-54.

Akwasi, K. 2007. Influence of Social Connectedness, Communication and Monitoring on Adolescent Sexual activity in Ghana. US National library of Medicine. 46(1): 132-149.

Alaska Division of Behavioral Health. 2011. Risk and protective factors for adolescent substance use (and other problem behavior). 5-6.

Alford, S, et al. 2008. Science and Success: Sex education and other programs that work to prevent teen pregnancy, HIV and sexually transmitted infections. 2nd ed. Washington DC: Advocates for Youth.

Ali, MM and Dwyer, DS. 2011. Estimating peer effects in sexual behavior among adolescents. *Journal Adolescent Health* 34: 183-190.

Alicia, W. 2009. Parent-child communication: Promoting sexually healthy youth. *Advocate for Youth* 1-5.

Alligood, MR. 2013. *Introduction to nursing theory*: Its history, significance, and analysis. *Nursing theorists and their work-e-Book*.1-22.

Alligood, MR. 2013. *Nursing theories and their work*. 2nd edition. Philadelphia: Lippincott Williams and Wilkins. From: (www.nursinglibrary.org/vhl/bitstream/10755/.../3/Killarney_86187_References.pdf) (accessed 12/11/2017). 15.

Amsale, C and Yemane, B. 2012**.** Peer pressure is the prime driver of risky sexual behaviors among school adolescents in Addis Ababa, Ethiopia. *World journal of AIDS (*2):159-164.

Amsale, C and Yemane, B**.** 2015. Assessment of parenting practices and styles and adolescent sexual behavior among high school adolescents in Addis Ababa, Ethiopia. *AIDS and Clinical research* 6:2.

Amy, M, Caitlin, K, Kevin, O and Michael S. 2009. Effectiveness of Peer Education Interventions for HIV Prevention in Developing Countries: A Systematic Review and Meta-Analysis*. AIDS Education and Prevention*. 21(3):181-206 Wamoyi, J, Fenwick, A, Urassa, M, et al 2010. Parent–child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. Reproductive Health;7:6-10.1186/1742-4755-7-6.ViewArticlePubMedPubMed Central Google Scholar.

Anjali, SA, Bhagyalaxmi and Shikha J. 2009. Awareness on HIV/AIDS amongst adolescents in Gujarat under school adolescent education programme. Indian *Journal of Preventive and Social Medicine* 40: 1-2.

Anol, B. 2012. *Social Science Research*: Principles, Methods, and Practices. 65. From: (http://scholarcommons.usf.edu/oa_textbooks/3) (accessed 4/12/2016).

Ayalew, M, Mengistie, B and Semahegn, A. 2014. Adolescent—parent communication on sexual and reproductive health issues among high school students in Dire Dawa, Eastern Ethiopia: a cross sectional study. *Journal of reproductive health* 11:77.

Babalola, S. Tambashe, BO and Vondrasek, C. 2005**.** Parental factors and sexual risk taking among young people in Côte-d'Ivoire. *African Journal of Reproductive Health* 9:49-65.

Baban, A and Craciun, C. 2007. Changing health-risk behaviors: a review of theory and evidence-based interventions in health psychology. *Journal of Cognitive and Behavioral Psychotherapies* 1:45–67.

Bane, D. 2015. Intervention strategies for the reduction of sexual risk practices among adolescents. PhD dissertation, Ethiopia. 137.

Barber, BK and Schluterman, JM. 2008**.** Connectedness in the lives of children and adolescents: A call for greater conceptual clarity. *Journal of Adolescent Health* 43:209-216.

Barker, G. 2007. Adolescents, social support and help-seeking behaviour: An International literature review and programme consultation with recommendations for action: WHO discussion papers on adolescence. *World Health Organization*.

Bastien, S, Kajula, LJ and Muhwezi, WW. 2011. A review of studies of parent–child communication about sexuality and HIV/AIDS in sub-Saharan Africa**.** *Reproductive health* journal 8: 25.

Beaman, L, Chattopadhyay, R, Duflo, E, Pande, R and Topalova, P. *2009.* Powerful women: Does exposure reduce bias? QJE 124:1497–1540

Bernard, C, and Maureen A. 2012. Research Methods and Statistics; 4th edition; 2:32; 4: 81; 11:257 and 13: 311and 313.

Biddlecom, A, Awusabo-Asare, K and Bankole, A. 2009. Role of parents in adolescent sexual activity and contraceptive use in four African countries. *International Perspective of Sex and Reproductive Health* 35: 72-81.

Boislard, M.A and Poulin, F. 2011. Individual, familial, friends-related and contextual predictors of early sexual intercourse. *Journal of Adolescence 34:* 289-300*.*

Boislard, M.A, Poulin, F, Kiesner, J and Dishion, TJ. 2009. A longitudinal examination of risky sexual behaviors among Canadian and Italian adolescents: Considering individual, parental, and friend characteristics. *International Journal Behavioural Development* 33(3):265-276.

Bordens, KS and Abbott, B. 2013. *Research design and methods: a process approach*.9th Edition. Boston: McGraw-Hill. 200.

Bowling, A. 2009: *Research methods in health*: Investigating health and health services. 2nd edition. Philadelphia: Open University Press.129, 158, 196.

Brenda, G, David, A and Nanjamma, C, Anders, C, Michael, J and Phillip, S. 2008: Business survey methods. New York: JOHN WELIY and SONS. INC. From: (http://dx.doi.org) (accessed June 2, 2016).186.

Brenda, G. 2008. Evaluating evidence. *Aorn journal* 87(1):124-141. From: (*http//dx.doi.org)* (accessed 20/5/2016).

Buhi, ER and Goodson, P. 2007**.** Predictors of adolescent sexual behavior and intention: a theory-guided systematic review. *Journal of Adolescent Health* 40: 4-21.

Burns, N and Grove, S. 2009. Research design and methodology. University of Pretoria. 3:40-42; 4:357 and 361.

Caroline, P, Rosemary, V and Larry, F. 2014. Parental Involvement during Adolescence and Contraceptive Use in College. *Journal of Adolescent and Family Health* 6(2): 1-18.

Celina, M, Danga, T and Njau, B. 2013. Knowledge, attitude and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. *Tanzania Journal of Health Research* 15(1): 1-8.

Celina, M, Danga, T and Njau, B. 2013.Knowledge, attitude and practices on family planning services among adolescents in secondary schools in Hai District, northern Tanzania. Kilimanjaro Christian Medical University College, Community Health Department, Moshi: Tanzania.

Center for Disease Prevention and Control. 2009. School connectedness; strategies for increasing protective factors among youth: Youth Risk Behaviour Surveillance. Atlanta: US Department of Health and Human Services,

Centers for Disease Control and Prevention. 2010. Positive youth development promoting adolescent sexual and reproductive health: A review of observational and intervention research [Supplement]. *Journal of Adolescent Health* 46: S1-S96.

Centers for Disease Control and Prevention. 2010b**.** Youth risk behaviour surveillance: United States, surveillance summaries, MMWR:59 SS-5.

Centers for Disease Control and Prevention. 2014. *Reported STDs in the United States*. Atlanta:Georgia.From:(http://www.cdc.gov/nchhstp/newsroom/docs/STD-Trends-508.pdf)(accessed23/1/2016). Centers for Disease Control and Prevention. 2014. Youth Risk Behaviour Surveillance-United States, *Morbidity and Mortality Weekly Report, 63*(4): 1-172.

Centers for Disease Control and Prevention. 2015**.** Youth Risk Behaviour Surveillance. United States: Atlanta: 1-180

Christine, M, Susan, R, Melissa, F, Ross, S, Melnie T, Elizabeth, R, Robert, C, Soledad, Liliana EC, Belinda, R and Leah, R 2012. Sexual risk avoidance and sexual risk reduction interventions for middle school youth: A randomized controlled trial. *Journal of Adolescent Health* 50(3): 279–288.

Coalition to Advance Adolescent and Youth Sexual and Reproductive Health. 2009. Protecting the sexual and reproductive health of adolescents and youth: *An urgent programmatic and policy priority for the Global Health Initiative 11.*

Cohen, L, Manion, L and Morrison, K. 2011. Research Methods in Education. 7th edition. Abingdon: Routledge.

Coley, R, Votruba-Drzal, E and Schindler, H. 2009**.** Fathers' and mothers' parenting

Considering individual, parental, and friend characteristics. *International Journal of reproductive health* 808–827.

Creswell, W and Plano, C. 2011). *Designing and conducting mixed methods research. India: SAGE. 211.*

Creswell, W. 2009. Research design: Quantitative, Qualitative and mixed approaches. 3rd ed. SAGE.10:188 and 192.

De Vos, AS, *Strydom*, H, *Fouché,* CB and *Delport,* CS. 2007. Mixed methods research: Research at the grass roots for the social sciences and human service professions. 4th edition. Pretoria: JL Van Schaik 352.

Denise, F and Cheryl, T. 2010. *Essentials of Nursing research*: appraising evidence for Nursing practice. 7th edition. New York: Lippincott Williams and Wilkins. 1:30.

Denno, DM, Hoopes, AJ and Chandra-Mouli, V. 2015**.** Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *Journal of Adolescent Health* 56: S22–S41.

Denzin, N. 2010. Moments, mixed methods, and paradigm dialogs: *Qualitative Inquiry*.Thousand Oaks, CA: Sage. 16(16): 419-42.

DiClemente, R, Wingood, G, Rose, E, Sales, E, Lang, D, Caliendo, A, Hardin, J and Crosby R. 2009. Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services: a randomized controlled trial. *Archives of Pediatric and Adolescent Medicine* 163(12):1112–1121.

DiClemente, RJ, Salazar, LF, Crosby, RA. 2007. A review of STD/HIV preventive interventions for adolescents: Sustaining effects using an ecological approach. *Journal of Pediatric Psychology*; *32*: 888–906.

Diriba, M. 2015. Factors affecting the sexual behaviour of youth and adolescent in Jimma town, Ethiopia. *European Scientific Journal* 11(32):79-96.

Donna, M, Andrea, J and Venkatraman, CM. 2015**.** Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support. *Journal of Adolescent Health* 56: S22-S41

Downing, J, Jones, L, Bates, G, Sumnall, H and Bellis, MA. 2011. A systematic review of parent and family-based intervention effectiveness on sexual outcomes in young people. *Health Education Research* 26: 808-833.

Earl, B. 2008. Basics of social research. 4th edition. Australia: Thomson Wadsworth. 2:59.

Ehlers, VJ. 2010. Adolescent mothers' non-utilization of contraceptives in Zimbabwe. University of South Africa: Department of Health Africa. *Journal of Nursing and Midwifery* 12 (2):14–26.

Eisenberg, ME, Sieving, RE, Bearinger, LH, Swain, C and Resnick, MD. 2006. Parents' communication with adolescents about sexual behavior: a missed opportunity for prevention? *Journal of Youth Adolescence* 35: 893–902.

Elizabeth, D and Laura, N. 2011**.** Introduction to research: Understanding and applying multiple strategies. 4th edition. United States of America: ELSVIER.2:21; 6:67; 8:87; 9:102; 16: 90, 93, 194, 201, 203; and 17:222, 237.

Emily, R, Den, Y, Baete, K and Tracey R. 2016. Identifying sexual health protective factors among northern plains American- Indian youth: an ecological approach utilizing multiple perspectives; *American Indian Alaska Native Mental Health Research* 23(4): 16–43.

Fearon, E, Wiggins, RD, Pettifor, AE and Hargreaves, JR. 2015. Is the sexual behaviour of young people in sub-Saharan Africa influenced by their peers? A systematic review. *Social science and medicine* 146: 62-74.

Federal HIV and AIDS Prevention and Control Office. 2013.HIV/AIDS and SRH minimum service package for youth centres. Addis Ababa, Ethiopia.

Federal Ministry of Health Ethiopia. 2011. National youth friendly strategy of Ethiopia: standards on youth friendly reproductive health services.1-48.

Federal Ministry of Health. 2011. Standards and Minimum Service Delivery Package on YFRH Services. Ethiopia.1-48.

Fei, M. 2015. Theory and Practice in Language Studies. 5(3): 566-571.From: (DOI: http://dx.doi.org/10.17507/tpls.0504.01) (accessed may 2017).

Feilzer, M. 2010. Doing mixed methods research pragmatically: implications for the rediscovery of pragmatism as a research paradigm. *Journal of mixed methods research*; 4(1): 6-16.

Feleke, SA, Koye, DN, Demssie, AF and Mengesha, ZB. 2013. Reproductive health service utilization and associated factors among adolescents (15-19 years old) in Gondar town, Northwest Ethiopia. *BMC health services research 13:* 294.

Fentahun, N and Mamo, A. 2014**.** *Risky sexual behaviours and associated factors among male and female students in Jimma zone Preparatory Schools, South West Ethiopia*. *Ethiop. Journal of Health Science* 24(1). 59- 68.

Fonner, VA, Armstrong, KS, Kennedy, CE, Kevin, RO and Sweat, MD. 2014. School based sex education and HIV prevention in low-and middle-income countries: A systematic review and meta-analysis. 2-14. BMC Public Health. From: (https://doi.org/10.1186/s12889-016-3715-4) (accessed:September1/9/2107).

Gebreyesus, D. and Fantahun, M. 2010**.** Assessing communication on sexual and reproductive health issues among high school students with their parents, Bullen Woreda, Benishangul Gumuz Region, and North West Ethiopia. *Ethiopian Journal of Health Development* 24: 89–95.

Given, L. 2008**.** The Sage encyclopaedia of qualitative research methods. Los Angeles: Sage. Eds. 699.

Graczy, K. 2008. Adolescent maternal mortality: an overlooked crisis. Washington, DC: USA. 1.

Gray, E. 2014. *Doing research in the real world:* Theoretical perspectives and research methodologies. Singapore: SAGE. 2:470.

Greene, J. 2008**.** Is mixed methods social inquiry a distinctive methodology? *Journal of Mixed Methods Research* 2(1), 7-22.

Grove, S, Burns, N and Gray, J. 2015. *The practice of Nursing research*: Appraisal, Synthesis, and Generation of Evidence. 7th edition. United States of America: Imprint: Saunders.:392)

Guttmacher Institute. 2008**.** Protecting the next generation in Uganda: New evidence on adolescent sexual and reproductive health needs. US: New York.

Hargreaves, JR, Morison, LA, Kim, JC, et al 2008. The association between school attendance, HIV infection and sexual behaviour among young people in rural South Africa. *Journal of Epidemiology and Community Health* 62(2):113–119. [PubMed]

Harrison, A. 2008**.** Hidden love: Sexual ideologies and relationship ideals among rural South African adolescents in the context of HIV/AIDS. *Culture, Health and Sexuality* 10:175–189.[PubMed].

Harrits, GS. 2011.More than methods? A discussion of paradigm difference within mixed method research. *Journal of Mixed Methods Research* 5(2):150-166.

Hauser-Kunz, J and Grych, H. 2013**.** Parental psychological control and autonomy granting: distinctions and associations with child and family functioning. Parenting: *Science and Practice*78-94.From:(http://hrweb.mit.edu/worklife/raising-teens/parenting-adolescents.html) (accessed 31/10/ 2017).

Hayes, FE. 2009. Effective HIV intervention and strategies. Department of health, HIV prevention and education services. 5.

Hennink, M, Hutter, I and Bailey, A. 2011. Qualitative research methods. Critical Public health, London: SAGE. 22(1):111-112.

Hurley, W, Denegar, C, andHertel, J. 2011. Research methods; A framework for evidence-based clinical practice.5 th Ed. Philadelphia. Lippincott Williams and Wilkins. 119.

Inter-Agency Working Group. 2007**.** The role of community involvement in adolescent sexual and reproductive health. Community pathways to improved adolescent sexual and reproductive health: a conceptual framework and suggested outcome indicators. Washington (DC): IAWG. From: (http://www.unfpa.org/sites/default/files/resource-pdf/asrh_pathways.pdf) (Accessed 8/1/2017) 2.

James, J and Nicole, L.2013. Parent-based interventions to reduce adolescent problem behaviours: New directions for self-regulation approaches, edited by Oettingen, G and Gollwitzer, P. Self-regulation in adolescence. New York: Cambridge University Press.1-33.

Jeffrey, B, Elizabeth, A, and Clement, A. 2015. Peer Influences on Sexual Activity among Adolescents in Ghana. PMC 46(1):1-19.

Jemmott, J, Jemmott, L and Fong G. 2010. Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents. *Archives of Pediatrics and Adolescent Medicine* 164(2):152–159.

Jia, P, Betty, C, Iyekiyapiwin, D, Patricia, KK, Jeanne, L and Dale, W. 2013**.** Protective Factors in American Indian Communities and Adolescent Violence. *Maternal and Child Health Journal* 17(7): 1199–1207.

Joar, S, Avni, A, Omar, J and Margaret, E. 2015. Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A framework and promising approaches. *Journal of Adolescent Health* 56(1): S7–S14.

John, M, Glenn, W, Julie, M and Liz, D. 2010. *Research Methods for Nursing and Healthcare.* London: Pearson Education Limited. 3:57; 5:121.

Johnson, B and Christensen, L. 2008. *Mixed research. Educational research: quantitative, qualitative, and mixed approach.* Delhi: Sage publications, Inc. 34.

Johnson, B and Christensen, L. 2012.*Educational research: Quantitative, qualitative and mixed approaches*. 5th edition. Los Angeles. SAGE. 107.

Johnson, R, Onwuegbuzie, A and Turner, L. 2007. "Toward a definition of mixed methods research". *Journal of Mixed Methods Research* 1(2): 112-133.

Joyce, W and Daniel, W. 2014**.** Mum never loved me.' How structural factors influence adolescent sexual and reproductive health through parent–child connectedness: A qualitative study in rural Tanzania. *African Journal of AIDS Research 13(2): 169–178.*

Joyce, W, Angela, F, Mark, U, Basia, Z and William, S. 2011. Parental control and monitoring of young people's sexual behaviour in rural North-Western Tanzania: Implications for sexual and reproductive health interventions. *BMC Public Health* 11: 106.

Junko, Y, Keiko, O, Omary, U, et al 2012**.** A call for parental monitoring to improve condom use among secondary school students in Dares Salaam, Tanzania. *BMC Public Health* 12:106.

Kapidia, F, Frye, V, Bonner, S, Emmanuel, PJ, Samples, CL and Latka, MH. 2012. Perceived peer safer sex norms and sexual risk behaviors among substance-using Latino adolescents. *AIDS Education and Prevention* 24:27-40.

Kasiye, S, Frehiwot, G and Getahun, A. 2014. Assessment of adolescents' communication on sexual and reproductive health matters with parents and associated factors among secondary and preparatory schools' students in Debremarkos town, North West Ethiopia. *Reproductive Health Journal* 11(2):1-10.

Kawai K, Kaaya SF, Kajula L, Mbwambo J, Kilonzo GP, Fawzi WW. 2008. Parents' and teachers' communication about HIV and sex in relation to the timing of sexual initiation among young adolescents in Tanzania. *Scandinavian Journal of Public Health* 36(8):879–888.

Kayembe, KP, Mapatano, MA, Busangu, FA, Nyandwe, KJ, Mashinda, KD, Musema, MG, Kibungu, JP, Matamba, TL and Mayala, MG 2008. Correlates of ever had sex and of recent sex among teenagers and young unmarried adults in the democratic republic of Congo. *AIDS Behaviour* 12: 585-593.

Kazaura, MR and Masatu, MC 2009. Sexual practices among unmarried adolescents in Tanzania. *BMC Public Health* 9:373. From: *(doi: 10.1186/1471-2458-9-373)* (Accessed 14/9/2017).

Kesterton, AJ and Cabral de Mello, M. 2010. Generating demand and community support for sexual and reproductive health services for young people: A review of the literature and programs. *Reproductive Health Journal* 7.

Khan, SH and Mishira, V. 2008. Youth sexual and reproductive health. DHS comprehensive report. No. 19. USA: Calverton:

Kirby D, Forrst, A, Lori, R, et al 2011. Reducing Adolescent sexual risk: A theoretical guide for developing and adapting curriculum-based programs 1:107; 6: 75 and 80; 9:108

Kirby D. 2007. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: National campaign to Prevent Teenage Pregnancy;

Kirby, D and Gina L. 2007. Sexual risk and protective factors: factors affecting teens sexual behaviour, pregnancy, childbearing and sexual transmitted diseases 6-7.

Kirby, D and Gina, L. 2007. Sexual risk and protective factors affecting teen sexual behaviour, pregnancy, childbearing and sexually transmitted disease 2.

Kirby, D, Laris, BA and Lori, R. 2007. Impact of Sex and HIV Education Programs on Sexual Behaviours of Youth in Developing and Developed Countries; FHI; Youth research working paper series; 2.

Kirby, D, Lepore, G. 2007. "Sexual risk and protective factors. Factors affecting teen sexual behaviour, pregnancy, childbearing and sexually transmitted disease: Which Are Important? Which can you change?", Washington. DC: ETR Associates and The National Campaign to Prevent Teen and Unplanned Pregnancy 2.

Kirby, D. 2011. The impact of sex education on the sexual behaviour of young people. *United Nations Department of Economic and Social Affairs.* 1-15

Kristin, M and Simran, S. 2013. A review of risk and protective factors for adolescent sexual and reproductive health in developing countries: An Update *53: 562- 572.*

Kumi-Kyereme, A., Awusabo-Asare, K., Biddlecom, A. and Tanle, A. 2007. Influence of social connectedness, communication and monitoring on adolescent sexual activity in Ghana. *African Journal of Reproductive Health* 11: 133-149.

Linda, B, Krishna, C, Bruno, F, Jessie, K, Junko, Y, Keiko, O, Omary, U and Masamine, J. 2012. A call for parental monitoring to improve condom use among secondary school students in Dar es Salaam, Tanzania. *BMC Public Health* 12:1061.

Linda, S, Djauhar, I, Yayi, S and Adiyanti, MG 2015. Perceived Parental monitoring on adolescence premarital sexual behaviour in Pontianak City, Indonesia. *International Journal of Public Health Science* 4(3): 211-219.

Longmore, MA, Eng, AL, Giordano, PC and Manning, WD. 2009. Parenting and adolescents' sexual initiation. *Journal of Marriage Fam* 71: 969-982.

Lule, H, Ovuga, E, Mshilla, M, Ojara, S, Kimbugwe, G, Adrawa, AP and Mahuro, N. 2013. Knowledge, Perceptions and Acceptability to Strengthening Adolescents' Sexual and Reproductive Health Education amongst Secondary Schools in Gulu District, Uganda. National Center for Biotechnology Information: U.S. National Library of Medicine.

Lyman, R, and Longnecker, T, 2010.An Introduction to Statistical Methods and Data Analysis. 5thedition.From:https://aberuthven432.blogspot.com/2012/02/i889ebook-ebook-download-introduction.html) (accessed 4/5/2015).5.

Mackey, A and Gass, SM. 2011. Second language research: methodology and design. New York; London: Routledge. Eds; 220.

Magdalena, A and Marquis, D. 2014. Research for Advanced Practice Nurses; From Evidence to Practice. 2nd edition. New York: APRINGER 5:92.

Maguen, S and Armistead, L. 2006. Abstinence among female adolescents: Do parents matter above and beyond the influence of peers? *American Journal of Orthopsychiatry* 76:260–264.

Marie-Aude, B and Zimmer-Gembeck, J. 2012. Adolescent sexual behavior: current knowledge, challenges and implications for research and practice. From: (http://www.researchgate.net/publication/224981598/17) (Accessed 18/10 2017).

Markham, CM, Lormand, D, Gloppen, KM, Paskin, MF, Flores B, Low, B and Duane, L. 2010. Connectedness as a predictor of sexual and reproductive health outcomes for youth. *Journal of Adolescent Health* 46: 23-41.

Marquis, C and András, T. 2016. "institutional equivalence: how industry and community peers influence corporate philanthropy". *Organization Science*. 27 (5): 1325–1341. From: (doi:10.1287/orsc.2016.1083. ISSN 1047-7039) (Accessed 13/8/2017).

Martinez, G, Abma, J and Copen, C. 2010. Educating teenagers about sex in the United States. *NCHS Data Brief 44*:1–8.

Mary A. Kristine M and Kristin, A. 2011. Research to results: Preventing multiple risky behaviors among adolescents. Seven Strategies 24:1-12

McKenzie, K, Murray, GC, Prior, S and Stark, L. 2011. An evaluation of a school counselling service with direct links to Child and Adolescent Mental Health (CAMH) Services. *British Journal of Guidance and Counselling* 39 (1): 67-82.

McNeely, C and Blanchard, J. 2009 The Teen Years Explained: A Guide to Healthy Adolescent Development. *Johns Hopkins Bloomberg School of Public Health, Center for Adolescent Health, Baltimore* 129-145.

Melaku YA, Berhane Y, Kinsman J, and Reda HL. 2014. Sexual and reproductive health communication and awareness of contraceptive methods among secondary school female students, northern Ethiopia: a cross-sectional study. *BMC Public Health* 14:252.

Michel, CM. 2008. Implementing a Forensic Educational Package for Registered Nurses in Two Emergency Departments in Western Australia, University of Notre Dame: Australia. From: (http://research online.nd.edu.au/theses/28) (Accessed: 20/2/ 2016).

Migiro, S.O and Magangi, B.A. 2011. Mixed methods: a review of literature and the future of the new research paradigm in *Afr. Journal of Business Management* 5(10):3757-3764.

Ministry of labour and social affairs. 2010. Ethiopian Social Security and development policy. 4.

Mitchel, L and Jolley, M. 2010. Research design explained. 7th edition. Australia: Wadsworth Cengage Learning. 284- 285.

Mmari, K and Blum, RW. 2009. Risk and protective factors that affect adolescent reproductive health in developing countries: A structured literature review. *Global Public Health* 4:350-366 [PubMed].

Mmari, K. and Sabherwal, S. 2013. A review of risk and protective factors for adolescent sexual and reproductive health in developing countries: An update. *Journal of Adolescent Health* 53:562–572.

Moody, J. 2009**.** Social Capital and Social Network. American Behavioural Scientist. *Journal of Research on Adolescence* 26(2): 257-269.

Morgan, D. 2007. Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research* 1(1), 48-76.

Nair, MKC, Thankachi Y, Paul Mini K, Leena ML, George Babu, Russell PS and Vijayan H. 2011. Effectiveness of a reproductive sexual health education package among school going adolescents in India. *Indian Journal of pediatrics* 1-5.

Nanlesta, A and Robert, W. 2010. Protective and risk factors associated with adolescent sexual and reproductive health in the English-speaking Caribbean: A Literature Review. *Journal of Adolescent Health* 50: 5–23.

National Institute for Health and Clinical Excellence. 2010**.** *Public Health draft guidance; School, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education. 350. From:(*http://www.nice.org.uk/nicemedia/live/11673/49240/49240.pdf)(Accessed 15/8/2017).

National policy on sexual and reproductive health. 2013. The Kingdom of Swaziland ministry of health. 1-34.

Nnko, S, Boerma, JT, Urassa, M, Mwaluko, G and Zaba, B. 2004. Secretive females and swaggering males? An assessment of the quality of sexual partnership reporting in rural Tanzania. *Social Science and Medicine* 59:299–310.

Onwuegbuzie, J, Slate, J, Leech, L, and Collins MT. 2009. International Journal of Multiple research approaches. *Content Management Pty ltd* 3(1):13-31.

Patricia, J, Shannon, L., Jeffrey, S, Kari, M, Katharine MC and Vincent, GR. 2015. Parental monitoring and its associations with adolescent sexual risk behaviour: A Meta-analysis. *Journal of pediatrics* 6:136.

Petersen, I, Bhana, A and Swartz, L. 2012. Mental Health Promotion and the Prevention of Mental Disorders in South Africa. *African Journal of Psychiatry* 15:411-416.

Pilgrim, N and Blum, RW. 2012. Protective and risk factors associated with adolescent sexual and reproductive health in the English Caribbean: A literature review. *Journal of Adolescent Health* 50:5-23.

Polit, F and Beck, T. 2012. Resource mapping for nursing research: generating and assessing evidence for nursing practice. 9th edition. Philadelphia: Lippincott: Williams and Wilkins. 306.

Prado, G, Pantin, H, Briones, E., Shwartz, SJ, Feaster, D Huang, S, Sullivan, S, Tapia, MI, Sabillon, E, Barbara Lopez, B and Szapocznik, J. *2007.* A randomized controlled trial of a parent-centered intervention in preventing substance use and HIV risk behaviours in Hispanic adolescents. *Journal of Consult Clinical Psychology* 75(6):914–926.

Price, MN and Hyde, JS. 2009. When two isn't better than one: Predictors of early sexual activity in adolescence using a cumulative risk model. *Journal of Youth and Adolescence, 38*: 1059-1071.

Pyrjmachuk, S. 2011: *Mental Health Nursing*: An evidence based introduction. SAGE. 333.

Rawatlal, KV and Petersen, I. 2012. Factors impeding school connectedness: A case study. *South African Journal of Psychology* 42(3): 346–357.

Robson, C. 2011. *Real world research:* a resource for social scientists and practitioner-researchers. *2nd edition. UK: Blackwell.* 79-93.

Russell, M, Elizabeth, M, Simon, D,Michael, M, Michael, R, Fatusi, A and Currie, C. 2012**.** Adolescence and the social determinants of health. *The Lancet* 379 :1641–1652.

Sadiq, S, Charles, A, Sarah, D and Susan, B. 2016**.** School-based sexual health education interventions to prevent STI/HIV in sub-Saharan Africa: a systematic review and meta-analysis. *BMC Public Health* 16:1069.

Sales, JM, Milhausen, RR, Wingood, GM, Ralph, JD, Salazar, LF and Crosby, RA. 2008. Validation of a parent-adolescent communication scale for use in STD/HIV prevention interventions. *Health Education Behaviour* 35: 332–345.

Sasaki, Y and Kameoka, A. 2009. Ethnic variations in prevalence of high-risk sexual behaviors among Asian and Pacific Islander adolescents in Hawaii. *American Journal of Public health* 99 (10): 1886–1892.

Schwarz, SW. 2010**.** Adolescent reproductive and sexual *health facts for policymakers. From: http://www.nccp.org/publications/pub_931.html (accessed 14/9/ 2017).*

Selamawit, M, Mark, S, Geert, J and Roman, B. 2015. Utilization of sexual and reproductive health services in Ethiopia- Does it affect sexual activity among high school students? *Sexual and Reproductive Healthcare* 6: 14–18.

Selikow, T, Ahmed, N, Flisher, AJ, Mathews, C and Mukoma, W. 2009. A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. *Scandinavian Journal of Public Health* 37:107–112. [PubMed]

Shannon-Baker, P. 2016. Making paradigms meaningful in mixed methods research*. Journal of Mixed Methods Research* 10(4): 319–334.

Sharlene, NH. 2010. *Mixed Methods Research*: Merging Theory with Practice. New York: The Guilford press.1:18-21.

Sharon, A and Elizabeth, H. 2009. Mixed methods research for nursing and health sciences. United Kingdom: Wiley- Black-well. 3:38.

Shiferaw, K, Getahun, F and Asres, G. 2014**.** Assessment of adolescent communication on sexual and reproductive health matter with parent and associated factors among secondary and preparatory school students in Debremerkos town, South West Ethiopia. *Journal of Reproductive Health* 11:2. From: (doi:10.1186/1742-4755-11-2) (Accessed 5/9/ 2017).

Sime, A and Wirtu, D. 2008. Premarital Sexual Practice among School Adolescents in Nekemte Town, East Wollega. *Ethiopian Journal of Health Development* 22(2):167-173.

Simoni, JM, Nelson, KM, Franks, JC, Yard SS and Lehavot, K. 2011**.** Are peer interventions for HIV efficacious? A systematic review. *AIDS and Behavior* 15:1589–1595.

Sinclair, M. 2007. Editorial: A guide to understanding theoretical and conceptual frameworks. *Evidence Based Midwifery* 5(2): 39.

Siyan, Y, Krishna, CP, Junko, Y, Paula, HP, Songky, Y and Masamine, J. 2010. Role of risk and protective factors in risky sexual behavior among high school students in Cambodia: 10:477.

Smetana, JG, Campione-Barr, N and Metzger, A. 2006. Adolescent development in interpersonal and social contexts. *Annual Review of Psychology* 57:255–284.

Storey JD, Lee K, Blake C, Lee P and Lee, HY. 2011. Social and behaviour change interventions landscaping study: A global review. Baltimore (MD): Johns Hopkins Bloomberg School of Public Health, Centre for Communication Programs1-89.

Streubert-Speziale, HJ. 2007. Designing data generation and management strategies: Qualitative research in nursing: Advancing the humanistic imperative, edited by HJ Streubert-Speziale and DR Carpenter. Philadelphia, PA: Lippincott Williams and Wilkins. 63.

Suwarni, L, Djauhar, I, Yayi, SP and Adiyanti, MG. 2015. "The impact of parental monitoring and peers to premarital sexual behavior in Pontianak city". *Indonesian Health Promotion Journal* 4(3):211-219.

Svanemyr, J, Amin, A, Omar JR and Margaret, E. 2015**.** Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches; *Journal of Adolescent Health 56(1):* S7-S14.

Teddlie, C, and Tashakkori, A. 2009. Foundations of mixed methods research. Thousand Oaks, CA: SAGE. 541.

Tesso, DW, Fantahun, MA and Enquselassie, F. 2012. Parent-young people communication about sexual and reproductive health in East Wollega zone, West Ethiopia: Implications for interventions. *Reproductive Health Journal* 9.

Tetsuji, Y, Chia-Ching, C, John, S, and Martin, JF.2011. "Behavioral risk reduction and health interventions for adolescents", Mindshare: *International Journal of Research and Development* 2(2): 1-12.

Tortolero, S, Markham, C, Peskin, M, Shegog, R, Addy, R, Escobar-Chaves, SL and Baumler, E. 2010. It's your game: keep it real: delaying sexual behaviour with an effective middle school program. *Journal of Adolescent Health*; 46(2):169–179.

Tsala, DZ and Kuate, DB. 2012. Family environment and premarital intercourse in Bandjoun (West Cameroon). *Arch Sex Behaviour* 41: 351-361

U.S. Department of Health and Human Services. 2010**.** The surgeon general's call to action to promote sexual health and responsible sexual behavior 1-25.

UN Interagency Group on Young People's Health. 2011. Standards for Peer Education Programs: Youth peer education kit. 25-57.

United Nations Educational, Scientific and Cultural Organization. 2009. *International guidelines on sexuality education; an evidence informed approach to effective sex, relationships and HIV/STI education*. Paris: UNESCO

United Nations Fund for Population Agency. 2007. Community pathways to improved adolescent sexual and reproductive health: A conceptual framework and suggested outcome indicators. 1-39.

Van de, BD, Reitz E, Sandfort T and **Deković**, M. 2014**.** A meta-analysis of the relations between three types of peer norms and adolescent sexual behaviour. Personality and Social Psychology Review;1–32. [PubMed].

Villa-Torres, L. and Svanemyr, J. 2015**.** Ensuring youth's right to participation and promotion of youth leadership in development of sexual and reproductive health policies and programs; Journal of Adolescent Health, 56: S51–S57.

Wamoyi J., A. Fenwick, M. Urassa, B, Zaba, B and Stones, W. 2011. "Parental Control and Monitoring of Young People's Sexual Behaviour in Rural North-Western Tanzania: Implications for Sexual and Reproductive Health Interventions." BMC Public Health11 (1): 106.

Wight, D and Fullerton, D. 2013**.** A review of interventions with parents to promote the sexual health of their children. *Journal of Adolescent Health; 52:*4–27.

Wondemagegn, M, Mulat, Y and Bayeh, A. 2013. Sexual behaviours and associated factors among students at Bahir Dar University: a cross sectional study, *Reproductive Health* 2014. 11:1-26.

World Health Organization. 2007**.** Ethical challenges in study design and informed consent for health research in resource-poor settings; 23.

World Health Organization. 2007. Helping parents in developing countries improve adolescents' health. Maternal, newborn, child and adolescent health, Geneva.1-37.

World Health Organization. 2008**.** Promoting adolescent sexual and reproductive health through schools in low income countries: an information brief; Department of Child and Adolescent Health and Development; Geneva; 1-24.

World Health Organization. 2009. Generating demand and community support for sexual and reproductive health services for young people: A review of literature and programs. Department of Child and Adolescent Health and Development, Geneva

World Health Organization. 2009. Generating demand and community support for sexual and reproductive health services for young people; A review of the literature and programs: Department of Child and Adolescent Health and Development; Geneva, Switzerland; 1-112.

World Health Organization. 2009. Quality assessment guidebook: A guide to assessing health services for adolescent clients. Geneva.12.

World Health Organization. 2011. *The sexual and reproductive health of younger adolescents.* Geneva, Switzerland; 20.

World Health Organization. 2014. Addressing sexual and reproductive health of adolescent. *The European Magazine for* Sexual and Reproductive Health. 24

World Health Organization. 2014. Health for the world adolescents: A second chance in the second decade Geneva: Switzerland. 1-20.

World Population Prospects. 2017. United Nations Department of Economic and Social Affairs, Population Division. 4-19.

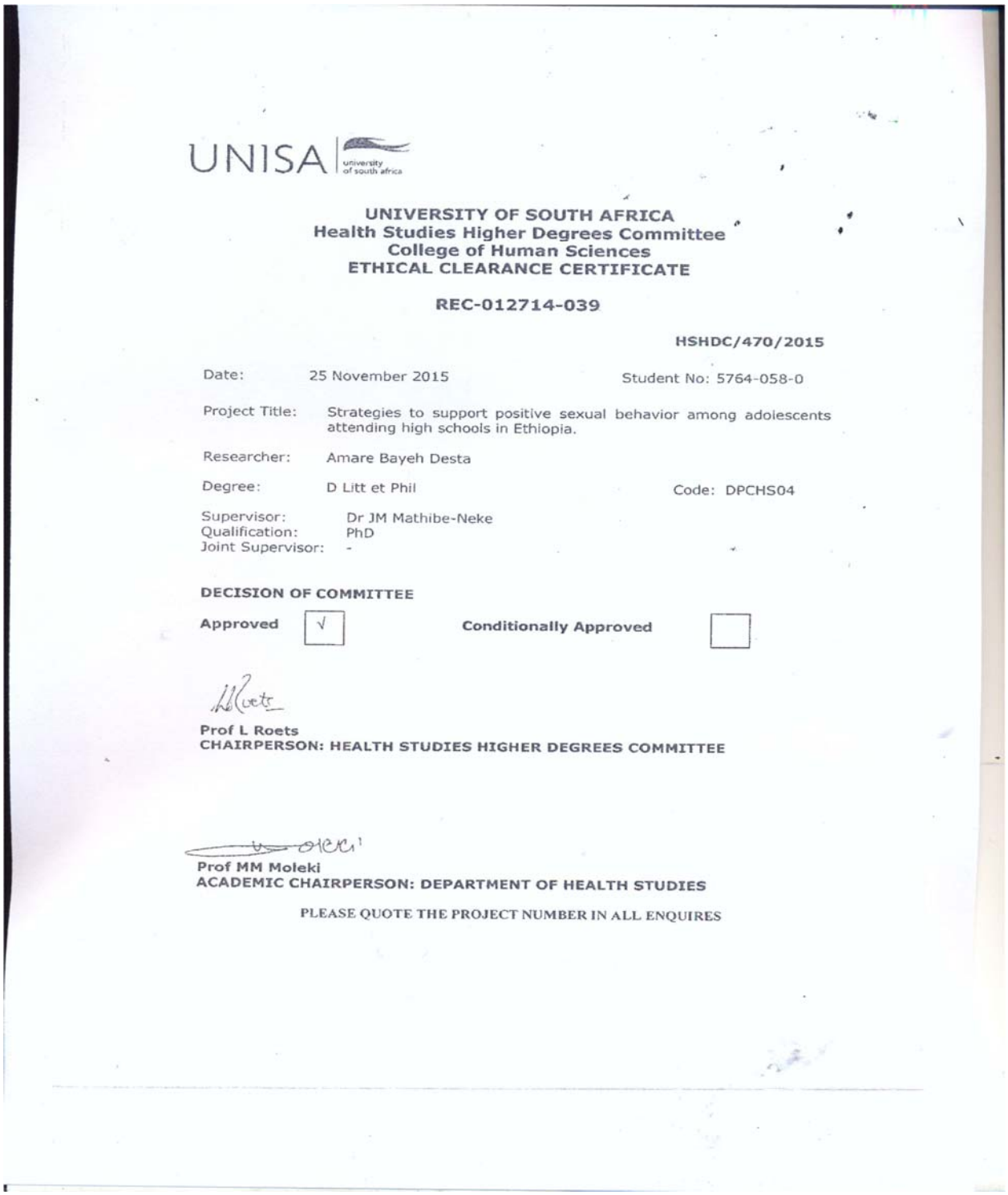
Yamada, T and Walker, EM. 2011. Estimating the cost-effectiveness of a classroom-based abstinence and pregnancy avoidance program. The Journal of Abnormal Psychology 14(4): 292-296.

Zimmer-Gembeck, MJ and Helfand, M. 2008. Ten years of longitudinal research on U.S. adolescent sexual behavior: Developmental correlates of sexual intercourse, and the importance of age, gender and ethnic background. *Developmental Review 28*: 153-224.

Zimmer-Gembeck, MJ, Ducat, WH. and Boislard, PM. 2011. Age, sex and romantic status as correlates of females' sexual body-esteem, entitlement, efficacy and reflection over one year. *Archives of Sexual Behaviour,* 40: 927-938.

ANNEXURE

ANNEXURE A Ethical clearance from the department of health studies, UNISA.



UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/470/2015

Date: 25 November 2015 Student No: 5764-058-0

Project Title: Strategies to support positive sexual behavior among adolescents attending high schools in Ethiopia.

Researcher: Amare Bayeh Desta

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Dr JM Mathibe-Neke
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B Letter granting to conduct the study on strategies to support positive sexual health behaviours among adolescents attending high schools.

UNISA university of south africa

16 NOVEMBER, 2016

UNISA-ET/KA/ST/29/16-11-16

ADDIS ABABA CITY ADMINISTRATION EDUCATION BUREAU

ADDIS ABABA

Dear Madam/Sir,

This is to confirm that Mr. Amare Bayeh Desta (student number 57640580) is a PhD student in the Department of Health Studies at the University of South Africa (UNISA). Currently, he is at the stage of data collection on his Doctoral research entitled "***Strategies to support positive sexual behavior among adolescents attending high schools in Ethiopia***."

This is therefore to kindly ask you to please assist the student to get data from the high schools of his target under your esteemed bureau. Attached, please find the copy of the ethical clearance that he secured from the Department of Health Studies, UNISA.

Sincerely,

UNISA REGIONAL LEARNING CENTRE
PO BOX 13836 ADDIS ABABA, ETHIOPIA
TEL +251-114-360141
+251-114-360078
FAX +251-114-351243
MOBILE +251-912-191483

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

UNISA – ETHIOPIA Centre

University of South Africa
Regional Learning Center
P.O. Box: 13836, Addis Ababa, Ethiopia
Telephone: +251 11 435 2244 / +251 11 435 0078
Facsimile: +251 11 435 1242/ 43/ 44
Mobile: +251 912 19 1483
www.unisa.ac.za

ANNEXURE C Letter requesting permission to conduct the study on strategies to support positive sexual health behaviours among adolescents attending high schools.

November 25, 2016

The Chairperson
Addis Ababa City Administration Bureau of Education Ethics Committee
Addis Ababa City Administration Bureau of Education Research institution
Addis Ababa

Subject: Application for Ethical Clearance

Dear Sir/Madam

I am a doctoral student of the University of South Africa, Pretoria. I hereby request permission to conduct a study entitled Strategies to support positive sexual behaviours among adolescents attending high schools in Addis Ababa, Ethiopia. The purpose of the study is developing strategies to support positive sexual behaviours among adolescents attending high schools in Addis Ababa.

I am doing this study under supervision of Prof JM Mathibe-Neke +27 (0)271545086 mathiji@unisa.ac.za

Attached here with for your proposal are:

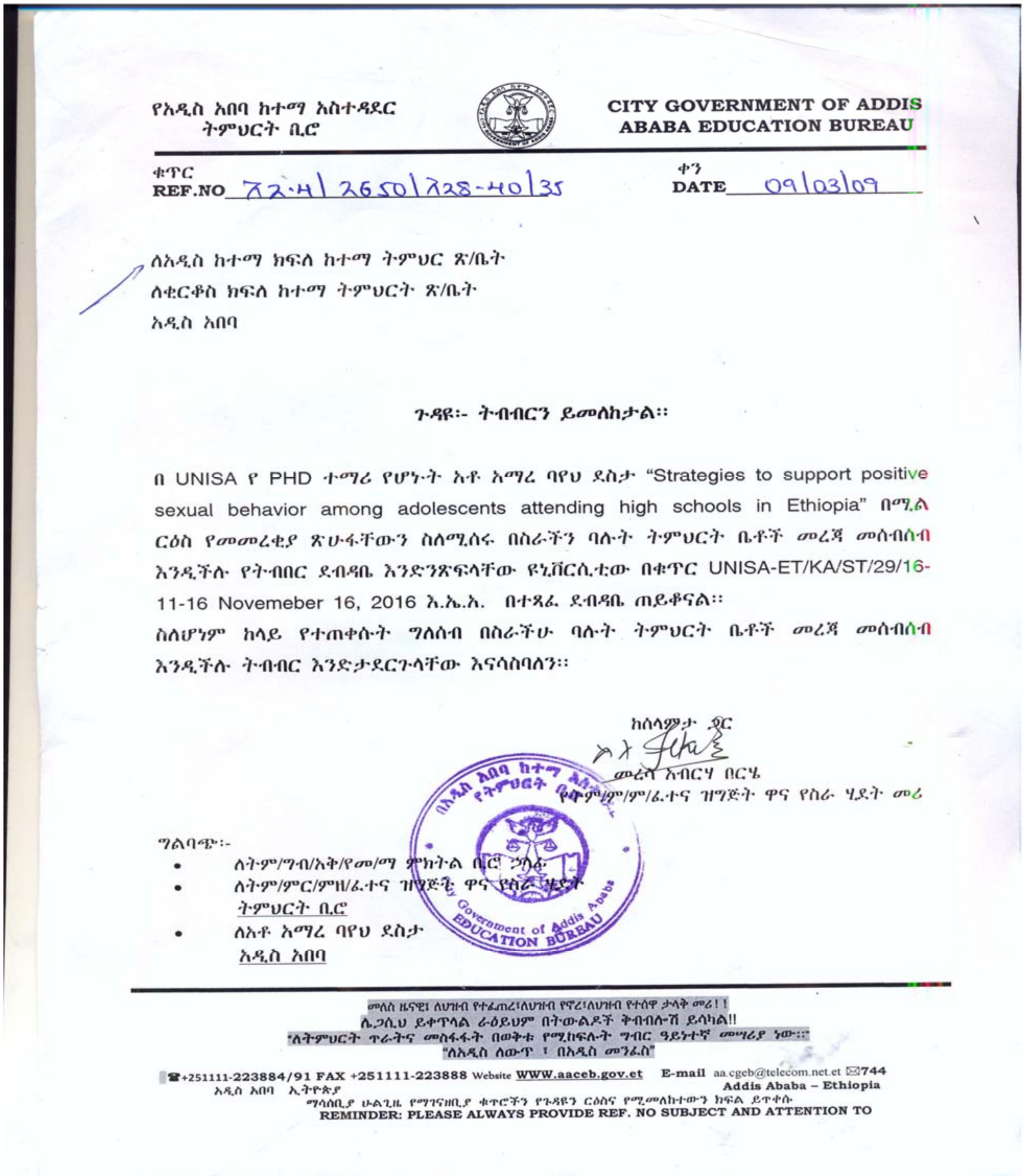
1. Filled Application form for ethical clearance
2. Proposal summary sheet
3. Informed consent and assent forms
4. Researcher's Biographical sketch
5. Research proposal

I look forward to hearing from you, please.

Sincerely!

Amare Bayeh Desta bayehamare@gmail.com

ANNEXURE D Letter of permission from Addis Ababa city Education Bureau to conduct the study on_strategies to support positive sexual health behaviours among adolescents attending high schools.



የአዲስ አበባ ከተማ አስተዳደር
ትምህርት ቢሮ

CITY GOVERNMENT OF ADDIS ABABA EDUCATION BUREAU

ቁጥር
REF.NO 72·4| 2650|728-40|35

ቀን
DATE 09|03|09

ለአዲስ ከተማ ክፍለ ከተማ ትምህር ጽ/ቤት
ለቂርቆስ ክፍለ ከተማ ትምህርት ጽ/ቤት
አዲስ አበባ

ጉዳዩ፡- ትብብርን ይመለከታል፡፡

በ UNISA የ PHD ተማሪ የሆኑት አቶ አማረ ባየህ ደስታ "Strategies to support positive sexual behavior among adolescents attending high schools in Ethiopia" በሚል ርዕስ የመመረቂያ ጽሁፋቸውን ስለሚሰሩ በስራችን ባሉት ትምህርት ቤቶች መረጃ መሰብሰብ እንዲችሉ የትብበር ደብዳቤ እንድንጽፍላቸው ዩኒቨርሲቲው በቁጥር UNISA-ET/KA/ST/29/16-11-16 Novemeber 16, 2016 እ.ኤ.አ. በተጻፈ ደብዳቤ ጠይቆናል፡፡
ስለሆነም ከላይ የተጠቀሱት ግለሰብ በስራችሁ ባሉት ትምህርት ቤቶች መረጃ መሰብሰብ እንዲችሉ ትብብር እንድታደርጉላቸው እናሳስባለን፡፡

ከሰላምታ ጋር

መረሳ አብርሃ በርሄ
የትም/ም/ም/ፈ.ተና ዝግጅት ዋና የስራ ሂደት መሪ

ግልባጭ፡-
- ለትም/ግብ/አቅ/የመ/ማ ምክትል ቢሮ ኃላፊ
- ለትም/ምር/ምዘ/ፈ.ተና ዝግጅት ዋና የስራ ሂደት
  ትምህርት ቢሮ
- ለአቶ አማረ ባየህ ደስታ
  አዲስ አበባ

መለስ ዜናዊ፤ ለህዝብ የተፈጠረ፤ለህዝብ የኖረ፤ለህዝብ የተሰዋ ታላቅ መሪ!!
ሌጋሲህ ይቀጥላል ራዕይህም በትውልዶች ቅብብሎሽ ይሳካል!!
"ለትምህርት ጥራትና መስፋፋት በወቅቱ የሚከፍሉት ግብር ዓይነተኛ መሣሪያ ነው፡፡"
"ለአዲስ ለውጥ ፣ በአዲስ መንፈስ"

☎+251111-223884/91 FAX +251111-223888 Website WWW.aaceb.gov.et E-mail aa.cgeb@telecom.net.et ✉744
አዲስ አበባ ኢትዮጵያ Addis Ababa – Ethiopia
ማሳሰቢያ ሁልጊዜ የማገናዘቢያ ቁጥሮችን የጉዳዩን ርዕስና የሚመለከተውን ክፍል ይጥቀሱ
REMINDER: PLEASE ALWAYS PROVIDE REF. NO SUBJECT AND ATTENTION TO

ANNEXURE E: Editor's Letter

TELOS
Consulting

EDITORIAL CERTIFICATE

[7 January 2018]

STRATEGIES TO SUPPORT POSITIVE SEXUAL BEHAVIOUR AMONG ADOLESCENTS ATTENDING HIGH SCHOOLS IN ETHIOPIA

by

AMARE BAYEH DESTA

This serves to confirm that above named document has been edited for language. In terms of linguistic dimension, the following aspects were closely addressed:

1. General aspects such as hyphenating, compound adjectives such as decision-making and suggesting more appropriate words for a given concept e.g. instead of saying 'do research', it is scholarly to say, 'conduct research'.
2. Spelling
3. Tense use at different stages of the write-up
4. Logical flow of argumentation, and logical timing of new ideas
5. Cohesion and coherence of the thinking process as expressed verbally, e.g. repetition of same ideas, lack of agreement between subject & object of sentence

Mekitew Letebo (MD, MPH, DTM&H), Managing Director

Telos Consulting

Tel: +251116684020
Mobile: +251978787855

E-mail: telosconsulting@outlook.com
mekitew@gmail.com

ANNEXURE F: INFORMED CONSENT

I.STUDENT CONSENT

Individual consent form for the study on strategies to support Positive Sexual Behaviours among adolescents attending high schools in Ethiopia,

My name is **Amare Bayeh Desta**, I am a PhD student at the University of South Africa (UNISA).

I am conducting a study at schools to develop strategies to support Positive Sexual Behaviours among adolescents attending high schools in Addis Ababa**,** Ethiopia**.**

You are selected randomly as one of the participants of this study as you meet the criteria.

I would like to assure you that your name will not be mentioned in the questionnaire and the information that you will give us will be kept confidential. The information will be used for educational and publication purposes and presented in aggregated form. This is a self-administered anonymous questionnaire. You have a full right to quit to participate in the study at any time. Your honest answers to these questions will help us better understand what people think, say and do about certain kinds of positive sexual behaviours and associated protective factors such as the family, community, peers and schools. The information that you will give us is also quite useful to explore and describe patterns of positive sexual behaviours that will help to formulate policies, design strategies and programs to enhance positive sexual behaviours among adolescents.

Do you voluntarily agree to participate in this study?

A. Yes B. No

If the answer is yes, thank you! Complete and return the self-administered questionnaire.

If the answer is no, thank you. Do not force the individual to participate in the study.

Researcher's contact no: +251 911 689957

II.**PARENT/ GARDIAN CONSENT (ASSENT) FORM**

Title of Study: **STRATEGIRES TO SUPPORT POSITIVE SEXUAL BEHAVIOURS AMONG ADOLESCENTS ATTENDING HIGH SCHOOLS, ETHIOPIA**.

Student Researcher: AMARE BAYEH DESTA (DLitt et Phil (Doctor of Literature and philosophy in Health Studies)

Address

P.O.Box: 5059

Telephone: +251 116 180026

Mobile: +251911 689957

E-mail: myLife: 57640580@mylife.unisa.ac.za

Alternative: bayehamare@gmail.com

Your child is invited to participate in the abovementioned research project. the purpose of the research project is to develop strategies to support positive sexual behaviours among adolescents attending high schools in Addis Ababa.

Your child's participation is entirely voluntary and you may choose that your child should not participate. If you choose for your child to participate, or if you withdraw your consent and stop your child's participation in the study, your decision will involve no penalty or loss of benefits normally available for you or your child.

If you have any questions about the study, please contact **Mr. Amare Bayeh** (researcher).

There is a questionnaire for your child to complete and there is no need to put his/her name on the questionnaire. His/her honest answers to these questions will help us in better understanding of adolescent's thinking, say, do and interact with different situations or conditions in relation to positive sexual behaviours so we request your child's truthful and keen participation.

Any information obtained from this study will remain confidential. Your child's responses will not be linked to his or her name. The data collected will be used for educational and publication purposes and presented in aggregated form.

You are making a decision about allowing your child to participate in this study. Your signature below indicates that you have read the information provided above and have

decided to allow your child to participate in the study. You are free to withdraw consent for your child to participate in this study at any time by contacting the **Mr Amare Bayeh** (researcher) using the address mentioned. You will be given a copy of this consent form for your record.

Thank You!

Name of the child: _____

Name and Signature of parent/guardian

Name_____

Signature: _____

Date:_____

ANNEXURE G Assessment of data collection instrument

1. ANNEXURE G1: Quantitative questionnaire:

QUESTIONNAIRE FOR QUANTITATIVE DATA COLLECTION

PART-I: Background Information

No.	Questions	Coding categories	Skip pattern
101	Address of the respondent	School name: _____	
102	Grade	Tenth 1 Eleven 2 Twelve 2	
103	Sex of the respondent	Male 1 Female 2 No response 99	
104	How old are you? (age in years)	_____	
105	What religion are you following?	Orthodox 1 Catholic 2 Protestant 3 Muslim 4 No Religion 5 Others _____6 No response 99	
106	Maternal literacy	Illiterate 1 Literate(non-formal) 2 Formal school 3 Do not know 4	
107	Paternal literacy	Illiterate 1 Literate(non-formal) 2 Formal school 3 Do not know 4	
108	Whom do you live with presently?	Alone 1 With both biological Parents 2 With biological father only 3 With biological mother only 4	

		With siblings 5 With family (relatives) 6 With employer 7 With peers/friends/coworker /students 8 Other_____ _____9 No Response 99	
109	In relation to other families in your neighbourhood, what would you say about your family?	We are very poor.1 We are average.2 We are of moderate economy.3 We have good economy.4 Others_____ 5 Do not know.88 No response.99	
110	Who pays school fees and supplies	Mother 1 Father 2 Both Mother and father 3 Relative 4 My sex partner/husband/wife 5 Gov't/ NGO support 6 Myself 7 Other_____ 8 No response 99	
111	Do you work to earn money for yourself/family?	Yes 1 No 2 No response 99	
112	What do you do to earn money? (Multiple answer possible)	Government employee.1 Employee of NGO.2 Construction work(Labour work).3 Hair dresser or barber.4	
		Broker.5	
		Shoe Shining.6 Taxi assistant.7	

		Domestic worker .8 Shop worker /Tea /Pastry.9 Commercial sex work.10 Small scale trade.11 Buy and sell.12 Other _____.13 No Response.99	
113	Are you supporting any one (Children, parents or others) by the money you get now?	Yes 1 No 2 No Response 99	
	PART-II: INFORMATION ON Family situation		
No.	**Questions**	**Coding categories**	
201	Family members ask each other for help	Yes 1 No 2 No response 99	
202	Family members like to spend free time with each other	Yes 1 No 2 No response 99	
203	Family members feel very close to each other	Yes 1 No 2 No response 99	
204	We can easily think of things to do together as a family	Yes 1 No 2 No response 99	
205	I listen to what other family members have to say, even when I disagree.	Yes 1 No 2 No response 99	
206	I am available when others in the family want to talk to me.	Yes 1 No 2 No response 99	
207	My family does things for fun together	Yes 1 No 2 No response 99	
208	The adults in my household fight	Yes 1 No 2 No response 99	
209	The children in my household fight	Yes 1 No 2 No response 99	

210	Family members eat meal together at least	Yes 1 No 2 No response 99	
211	My parent(s) /guardians talk to me about sex	Yes 1 No 2 No response 99	
212	My parent(s) /guardians talk to me about pregnancy	Yes 1 No 2 No response 99	
213	My parents/guardians accept and support contraceptive use by adolescents?	Yes 1 No 2 No response 99	
214	My parent(s) /guardians talk to me about the changes occurring during adolescence	Yes 1 No 2 No response 99	
215	My parent(s)/guardians talk to me about school	Yes 1 No 2 No response 99	
216	My parent(s) /guardians communicate positively	Yes 1 No 2 No response 99	
217	My parent(s) /guardians are willing to provide advice and counselling	Yes 1 No 2 No response 99	
218	My parent(s) /guardians have clear rules and consequences	Yes 1 No 2 No response 99	
219	My Parents/ guardians will punish if they discover my sexual activity?	Yes 1 No 2 No response 99	
220	My parent(s)/guardians know where I am if I am not at home	Yes 1 No 2 No response 99	
221	My parent(s) /guardians know all my friends	Yes 1 No 2 No response 99	
222	I need permission from my parent(s)/guardians to go anywhere	Yes 1 No 2 No response 99	
223	My parent(s)/guardians allow me to stay at friends' houses overnight if I want to	Yes 1 No 2 No response 99	

224	My parent(s)/guardians do not mind if I get a boyfriend/ girlfriend	Yes 1 No 2 No response 99	
225	My parent(s)/guardians think it is okay for teenagers to have sex	Yes 1 No 2 No response 99	
226	My parents discuss with me about substance use (alcohol, khat, cigarettes, and drugs)?	Yes 1 No 2 No response 99	
227	What is the reason for not discussing sexual issues with your mother/father/both? ***(If not discussed)***	It is culturally wrong to talk about sex with parents. 1 My parents have never given me the chance to talk about sex .2 My parents will suspect that I am sexually active if I ask them about sex. 3 I feel that they will not tell me all the information I want. 4 I do not feel comfortable.5 Other_____ _____.6 Do not know.88 No response.99	
228	Do you satisfied with your family discussion, connectedness and relationships regarding to you sexual activity?	Yes 1 No 2 No response 99	
229	Do you discuss about sexual issues with other member of your family? (***skip if you are living alone or with friends***)	Yes 1 No 2 No response 99	
230	Greater compatibility between parent and expectations of adolescent	Yes 1 No 2 No response 99	
231	Have you ever had conflict with your parents /Guardians?	Yes 1 No 2 No response 99	
232	Do you feel that your family maltreated you	Yes 1 No 2 No response 99	
233	Have you ever communicated with your parents about sex prior to the initiation of sex?	Yes 1 No 2	

		No response 99	
234	Have you communicated with your parent/ guardian about STI including HIV/AIDS prevention?	Yes 1 No 2 No response 99	
235	Do you belief that you should follow parents' rules about sexual behaviour	Yes 1 No 2 No response 99	
236	Do you think that your belief and you parents' belief is similar on sexual values?	Yes 1 No 2 No response 99	
237	Greater parental influence on personal decisions	Yes 1 No 2 No response 99	
238	Greater parental monitoring or strictness (curfew in place)	Yes 1 No 2 No response 99	
239	**How do you rate you families parenting Style**	Authoritarian 1 Authoritative 2 Permissive 3 Neglectful 4	
	PART-III: INFORMATION ON SCHOOL SITUATION		
No.	**Questions**	**Coding categories**	
301	What issues do you most often discuss with your friends at school? ***(Multiple answers possible)***	About sexual issues.1 About academic issues.2 About relationships.3 About future plans.4 About families.5 About politics.6 Spiritual things.7 About sport.8 Other_____ _____.9 Do not know.88 No response.99	
302	Do you participate in any adolescent/youth clubs e.g. anti HIV/AIDS, mini-media, music, drama or sport activities in your school?	Yes 1 No 2 No Response 99	
303	Where do you spend you leisure time?	I go to stadium.1 I go to the cinema.2 I meet friends and chew chat.3	

		I go to the bars and have some drink.4 I read fictions.5 I will meet my partner.6 I watch films in local video houses.7 I do not know how I spend my time.8 Other_____.9 No response.99	
304	Is there sexual and reproductive health counsellor in your school?	Yes 1 No 2 No response.99	
305	Is there Sex education in your school?	Yes 1 No 2 No response.99	
306	Are there contraception and condom instruction/ education in school?	Yes 1 No 2 No response.99	
307	Do you perceive that teachers are supportive or greater connection to your teachers?	Yes 1 No 2 No response.99	
308	Have you ever failed an exam? (Have you ever repeated a class?)	Yes 1 No 2 No response.99	
309	In relation to your classmates, how do you evaluate your school performance?	I am a clever student.1 I am an average student.2 I am a bit weak academically .3 Other_____.4 Do not know.88 No response.99	
310	Have you ever missed a class and spent your school time somewhere else?	Yes .1 No. 2 No response.99	
311	What future plans and vision do you have? ***(Multiple answer possible)***	I will join higher education.1 I will find job.2 I will have a better life in any way.3 I do not have any bright future.4 I do not have vision at all.5	

		Others_____ .6 Do not know.88 No response.99	
	PART-IV: INFORMATION on COMMUNITY (NEIGBORHOOD)		
No.	**Questions**	**Coding categories**	
401	Where do most of the young people like you spend their leisure time? (***Multiple response is possible***)	I go to stadium.1 I go to the cinema.2 I meet friends and chew chat.3 I go to the bars and have some drink.4 I read fictions.5 I will meet my partner.6 I watch films in local video houses.7 I do not know how I spend my time.8 Other_____ _9 No response.99	
402	In your neighbourhood, are there recreational places where young people of your age can spend their time?	Yes 1 No 2 Do not know 88 No response 99	
403	What do you think about your community?	Better quality 1 Slum area 2 Good neighborhood 3 cohesion among adults and youths 4 Do not know 88 No response 99	
404	Do you perceive that adults care about you in the community?	Yes 1 No 2 Do not know 88 No response 99	
405	Have you ever witnessed woman/ girl violence in your community?	Yes 1 No 2 Do not know 88 No response 99	
406	Do you usually involve in sports in the community?	Yes 1 No 2 Do not know 88 No response 99	
407		Yes 1	

	Do you think people important to you (parents, other adults, or peers) approve of contraception or condoms use?	No 2 Do not know 88 No response 99	
408	Have ever discussed on sex, condom, contraception, STI/HIV/AIDS with health service providers in your community?	Yes 1 No 2 Do not know 88 No response 99	
409	How often do you usually attend religious services in church/Mosque or other meetings in your moral community?	Once a month .1 Once a week .2 Two to three times a week .3 Daily .4 Once a year .5 Not at all.6 Other _____ ____ .7 Do not know .88 No response .99	
410	Have you ever been accused of any delinquent behaviour? (Homicide, misbehaviour of any sort which may have led to school suspension ,expulsion or police intervention)	Yes .1 No. 2 Do not know/Do not remember .88 No response .99	

PART-V: INFORMATION ON PEERS

No.	Questions	Coding categories	
501	When you think about your friends, would you say that : 1. I feel closely attached to my friends 2. My friends value my opinion 3. I can help/support my friends 4. I can count on my friends when I need a help 1. CA= Completely Agree 2. PA= Partly Agree 3. PD=Partly Disagree 4. CD=Completely Disagree 99. No response	CA 1 PA 2 PD 3 CD 4 NR 99	

502	How many of your friends are sexually active?	All.1 Many.2 Some.3 None.4 Other_____ _____.5 Do not know.88 No response.99	
503	How many of your friends you know have had STD(s)?	Many.1 Some.2 None.3 All.4 Other_____.5 Do not know.88 No response.99	
504	Have any of your friends been accused of delinquency?	Yes.1 No.2 Do not know.88 No response.99	
505	Do your friends use alcohol, khat, smoking or other drugs?	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
506	Do your peers have a permissive value about sex	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88	
		No response 99	
507	Do you think that your peers support for condom or contraceptive use	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
508	Do your Peers use condoms?	None of them 1 A few of them 2	

		About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
509	Do you think that your close friends are sexually active?	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
510	About how many of your friends do you think have had sex?	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
511	Do your peers believe it is better to initiate sex when older	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
512	Do your peers believe/ think it is okay to have sex with multiple partners	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
513	Do your Friends think that boys gain respect if sexually active	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	

514	Do your peers believe with later sexual debut?	None of them 1 A few of them 2 About half of them 3 Most of them 4 All of them 5 Do not Know 88 No response 99	
515	Do you believe the importance of friends or more peer influence on decisions?	Yes.1 No 2 No response.99	
516	Do you think that peer support, bonding with peers or social activities with peers prevent sexual risks?	Yes.1 No 2 No response.99	

PART-VI: SEXUAL ACTIVITIES/ HEBAVIOURS

No	Questions	Coding categories	
601	Ever had sex before? (If no, go to Q 617)	Yes 1 No 2 No response 99	
602	Age at first coital debut	Below 16 years 1 16 and above years 2 No response 3	
603	Had sex past 12 months	Yes 1 No 2 No Response 99	
604	Number of partner/s past 12 months sex	One 1 Two 2 More than two 2 No response 3	
605	Consistent Condom use in the past 12 months sex	Yes 1 No 2 No Response 99	
606	Have you ever contracted any Sexually transmitted infections (STI)?	Yes 1 No 2 No Response 99	
607	Have you ever had unwanted pregnancy? ***(Females)***	Yes 1 No 2 No Response 99	
608	Have you ever had abortion?	Yes 1 No 2 No Response 99	

609	What was your age at your first menstruation? ***(Females)***	Age in years_____ ___	
610	What type of sexual partner did you have first?	Steady friend.1 Commercial sex workers.2 Casual partner.3 Stranger.4 Other_____ ___.5 Do not know.88 No response.99	
611	What was your reason for first initiation of sex?	Personal desire.1 Peer pressure.2 Influence of alcohol or drug.3 Forceful sex/Coercion.4 To get money.5 Pornographic film.6 Other----------.7 Don't Remember /Don't Know.88 No response.99	
612	Have you used condom during the first time you had sex? (Includes both male and female condom)	Yes 1 No 2 Don't Remember /Don't Know 88 No Response 99	
613	Could you remember how many sexual partners have you had after your first partner?	No one.1 Two to four.2 More than four.3	
		Don't remember.88 No response.99	
614	Have you had sexual intercourse in the last 6 months?	Yes 1 No 2 No Response 99	
615	The last time you had sex did you and/ or your partner use a condom? (includes both male and female condom)	Yes.1 No.2 Don't Remember /Don't Know.88 No Response.99	
616	If no, for Q 617, why didn't you and your partner use a condom that time?	Not available.1 Not comfortable.2	

		Too expensive.3 Partner objected.4 Embarrassed to buy or ask for.5 I do not believe that it will prevent HIV.6 Didn't think of it /forget.7 I trust my partner.8 It reduces my sexual pleasure.9 Frustrated with frequent breakage.10 Do not know how to use it .11 I was drunk.12 Other _____ __.13 Do not remember.88 No response.99	
617	What factors do you think influence sexual behaviour of people of your age? (Read out the list) 1.Family structure (single parent) 2. Socioeconomic status of families 3. Upbringing 4. Parental supervision and guidance 5. Neighbourhood situation 6. Academic performance	Yes Don't know No NR 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99	
	7. Knowledge about HIV 8. Opportunity of income generation for self 9. Gender role in society 10 Financial problems	1 2 88 99 1 2 88 99 1 2 88 99	

II. ANNEXURE G2: Quantitative questionnaire: Amharic

የተማሪዎች መጠየቅ

የሚከተሉትን ጥያቄዎች በተቻለ መጠን ለመመለስ ይሞክሩ (አንዳነድ ጥያቄዎች ከአንድ በላይ መልስ ሊኖራቸዉ ስለሚችል የጥያቄዎችን *መመሪያ* ልብ በለዉ ይመልከቱ)

የምርምሩ ርዕስ፡ በሁለተኛ ደረጃ እና መሰናዶ ት/ቤት ትምህርታቸዉን የሚከታተሉ ታዳጊ ወጣቶች ጤናማ የስነ-ተዋልዶ እና የግብረ ስጋ ግንኙነት ባህሪ እንዲኖራቸዉ የሚያስችል ስትራቴጂ

የት/ቤቱ ስም፡----------

ክፍል-1፡ መሰረታዊ መረጃዎች

ተ.ቁ.	ጥያቄ	ኮድ	ወደ ሚቀጥለዉ ጥያቄ
101	የክፍል ደረጃ	11ኛ 2 12ኛ 3	
102	ፆታ	ወንድ 1 ሴት 2 መልስ የለም 99	
103	እድሜ ስንት ነዉ?	14-16 ዓመት 1 17-19 ዓመት 2 20-24 ዓመት 3 መልስ የለም 99	
104	የእናት/ የአሳዳጊ የትምህርት ደረጃ	ያልተማሩ 1 መጻፍና ማንበብ 2 1-12 ኛ ክፍል 3 ዲፕሎማና ከዚያ በላይ 4 አላዉቅም 5 መልስ የለም 99	
105	የአባት/ የአሳዳጊ የትምህርት ደረጃ	ያልተማሩ 1 መጻፍና ማንበብ 2 1-12 ኛ ክፍል 3 ዲፕሎማና ከዚያ በላይ 4 አላዉቅም 5 መልስ የለም 99	
106	በአሁኑ ወቅት ከማን ጋር ነዉ የምትኖረዉ/የምትኖሪዉ	Alone ለብቻዬ 1 ከወላጅ እናትና አባቴ ጋር 2 ከወላጅ እናቴ ጋር 3 ከወለጅ አባቴ ጋር 4 እህትና ወንድሞቼ ጋር 5 ከዘመድ ጋር 6 ከቀጣሪዬ/ አሰርዬ ጋር 7 ከትምህርት ወይም ከስራ ጓደኛ ጋር 8 ሌላ_____9 መልስ የለም 99	
107	ከእናነተ ጎረቤት/ ከአካባቢ ጋር ሲነጻጸር የእናንተ ወርሃዊ ገቢ ምን ይመስላለል	ድሃ 1 መካከልኛ.2 ሀብታም .3 በጣም ሀብታም.4 አላዉቅም.88 መልስ የለም.99	
108	የትምህርትና ልዩ ልዩ ወጪዎችን የሚሸፍንልህ/ ልሽ ማን ነዉ	ወላጅ እናቴ 1 ወላጅ አባቴ 2 ወላጅ እናቴ እና አባቴ በጋራ 3	

		Relative ዘመድ 4 ፍቅረኛዬ ወይም የትዳር ጓደኛዬ 5 ድርጅት ወይም መንግስት 6 ራሴን በራሴ 7 ሌላ_____ 8 መልስ የለም 99	
109	የራስህን/ የራስሺ ገቢ ለማግኘት ስራ ትሰራለህ/ ተሰሪያለሽ	አዎ እሰራለሁ 1 አልሰራም 2 መልስ የለም 99	መልሱ አልሰራም ከሆነ ወደ ጥያቄ ቁጥር 201 እለፍ/እለፊ
110	ገንዘብ ለማግኘት ምን ትሰሪያለሽ/ ትሰራለህ ***(ከአንድ በላይ መልሰ ይቻላል)***	የመንግስት ስራ.1 የድርጅት (NGO) ስራ.2 ልዩ ልዩ የቀን ስራ.3 ጸጉር በት .4 የድለላ ስራ.5 ሊስትሮ.6 የታክሲ ረዳት.7 የቤት ዉስጥ ስራ .8 ሱቅ፤ ካፌ ወይም ምግብ ቤት .9 ልላ ካለ ይገለጽ _____.12 መልስ የለም.99	
111	ሰርተህ/ሽ በምታገኘዉ/ኚዉ ገንዘብ ሌሎች የቤተሰብ አባላትን ትረዳለህ/ትረጃለሽ	አዎ እረዳለሁ 1 ልረዳም 2 መልስ የለም 99	
	ከፍል-2፡ ስለ ቤተሰብ አጠቃላይ መረጃ		
ተ.ቁ	**ጥያቄ**	**ኮድ**	
201	የአንተ/የአንች የቤተሰብ አባላት በቤት ዉስጥ ይተጋገዛሉ	አዎ 1 አይተጋገዙም 2 መልስ የለም 99	
202	የአንተ/የአንች የቤተሰብ አባላት ጊዜያቸዉን አብረዉ ያሳልፋሉ	አዎ 1 አያሳልፉም 2 መልስ የለም 99	
203	የአንተ/የአንች የቤተሰብ አባላት በሚገባ የመቀራረብና የመተሳሰብ ሁኔታ አለ	አዎ 1 የለም 2 መልስ የለም 99	
204	በአንተ/ አንች ቤተሰብ ዉስጥ የቤተሰብ ጉዳዮችን በጋራ ትወስናላችሁ	Yes አዎ 1 No አይደለም 2 መልስ የለም 99	
205		አዎ 1 አልቀበልም 2	

	የአንተ/ የአንች ቤተሰብ ወይም የቤተሰብ አባላት ስለአንተ/አንች የሚነገረዉን ሀሳብ ሁልጊዜ ትቀበላለህ/ ትቀበያለሽ	መልስ የለም 99	
206	የቤተሰብ አባላት ስለእኔ ሲያወሩ በመሀከላቸዉ እገኛለሁ	አዎ 1 አልገኝም 2 መልስ የለም 99	
207	የአንተ/ች ቤተሰብ በቤት ዉስጥ አብረን እያለን ልዩ ልዩ ቀልዶችን እናወራለን	አዎ 1 አናወራም 2 መልስ የለም 99	
208	በአንተ/ች ቤተሰብ አባላት መካከል ፀብ ተከስቶ ያዉቃል	አዎ 1 አያዉቅም 2 መልስ የለም 99	
209	የአንተ/ች ቤተሰብ አባላት በሙሉ አብረዉ ምግብ ይመገባሉ	አዎ 1 አይመገቡም 2 መልስ የለም 99	
210	የአንተ/ች ወላጆች ወይም አሳዳጊዎች ከጓደኛህ/ሽ ቤት ለማደር ይፈቀድልሃል/ሻል	አዎ 1 አያፈቀድልኝም 2 መልስ የለም 99	
211	የአንተ/ች ወላጆች ወይም አሳዳጊዎች ሁሉን ጓደኞችህን/ ሺን ያዉቃሉ	አዎ 1 አያዉቁም 2 መልስ የለም 99	
212	ከቤት ዉጭ ስወጣ ሁል ጊዜ ወልጆቼን/ አሳዳጊዎቼን አስፈቅዳለሁ	አዎ 1 አላስፈቅደም 2 መልስ የለም 99	
213	የአንተ/ች ወላጆች/ አሳዳጊዎች ከቤት ዉጭ የት እንዳለህ/ሽ ሁል ጊዜ ያወዉቃሉ	አዎ 1 አያዉቁም 2 መልስ የለም 99	
214	የአንተ/ች ወላጆች/ አሳዳጊዎች ስለወሲብ አዉርተዉህ/ሽ ያዉቃሉ	አዎ 1 አያወሩም 2 መልስ የለም 99	
215	የአንተ/ች ወላጆች/ አሳዳጊዎች ስለእግዝና፤ የአባለዘር በሽታዎች እና ኤች አያቪ ኤድስ ተወያይታችሁ ታዉቃላችሁ	አዎ 1 ተወያይተን አናዉቅም 2 መልስ የለም 99	መልሱ **አዎ** ከሆነ ወደ ጥያቄ ቁጥር 217 እለፍ/ፊ
216	***ተራ ቁጥር 115 መልሰ*** <u>"ተወያይተን አናዉቅም"</u> ከሆነ ምክንያቱ ምንድን ነዉ?	በባህላችን ስለ ወሲብ ማዉራት ይፈቀድም 1 sex ወላጆቼ ስለ ወሲብ እንዳወራ በፍጹም አይፈቅዱም 2 ስለ ወሲብ ከጠየቅሁ ወይም ካወራሁ ወሲብ አንጀመርኩ ይጠራጠራሉ 3 የምፈልገዉን መልስ ከወላጆቼ ላላገኝ ስልምችል 4 ስለወሲብ ከወላጆቼ ጋር ለማዉራት ነጻነት ወይም ምቾት አይሰማኝም .5 ሌላ ካለ ይገለጽ_____.6 አላዉቅም 88 መልስ የለም 99	
		አዎ 1	

217	የአንተ/ች ወላጆች/ አሳዳጊዎች ታዳጊ ወጣቶች የወሊድ መከላከያ እንዲጠቀሙ የይፈቅዳሉ	አይፈቅዱም 2 መልስ የለም 99	
218	ወላጆችህ/ሽ በጉርምስና ወቅት የሚፈጠረዉን የአካልና የስሜት ለዉጥ ነግረዉህ/ሽ ያዉቃሉ	አዎ 1 አያዉቁም 2 መልስ የለም 99	
219	ወላጆችህ/ሽ ጋር ስልትምህርት በየጊዜዉ ትወያያላችሁ	አዎ 1 አንዎያያም 2 መልስ የለም 99	
220	ወላጆችህ/ሽ ስላነተ/ች ጥሩ ባህሪ ሁልጊዜ ያናገራሉ	አዎ 1 አይናገሩም 2 መልስ የለም 99	
221	ወላጆችህ/ሽ ስላንች/ተ የፍቅር ግንኙነት ወይም ወሲብ መፈጸም ቢሰሙ ይቆጡሃል/ ሻል ወይም ይቀጡሃል/ ሻል	አዎ 1 አይቆጡም 2 መልስ የለም 99	
222	ወላጆችህ/ሽ በአፍላ ወጣትነት ጊዜ ገበረ-ስጋ ግንኙነት መፈጸም ችግር የለዉም ብለዉ ያስባሉ	አዎ 1 አያስቡም 2 መልስ የለም 99	
223	ወላጆችህ/ሽ ጋር ስለአልኮሆል መጠጥ፤ ጫት፤ ሲጋራ፤ ሺሻ እና አደንዛዥ እፆች አዉርታችሁ ታዉቃላችሁ	አዎ 1 አናዉቅም 2 መልስ የለም 99	
224	በቤት ዉስጥ የወላጅ/አሳዳጊዎች መመሪያ፤ ተዕዛዝና የሚያስከትለዉን ዉጤት በግልጽ ይታወቃል	አዎ 1 አይታወቅም 2 መልስ የለም 99	
225	የአንተ/ች ወላጆች የፍቅር ጓደኛ መያዝህን/ መያዝሽን ቢያዉቁ ችግር የለዉም	አዎ 1 ችግር አለዉ 2 መልስ የለም 99	
226	ከወላጆችህ/ሽ ጋር ያለዉ ግልጽ የሆነ የፍቅር ጓደኛና የወሲብ ዉይይት፤ እንዲሁም አጠቃላይ የወላጅ ቅርርብና ግግንኙነት ደስትኛ ነህ/ነሽ	አዎ 1 አይደለሁም 2 መልስ የለም 99	
227	ከሌሎች የቤተሰብ አባላት (እህት፤ ወንድም፤ ዘመድ) ጋር ስለፍቅረኛና ወሲብ ተወያይታችሁ ታውቃላችሁ ***(ለብቻ የምትኖር/ሪ ከሆነ ጥያቄዉን አለፈዉ/ፊዉ)***	አዎ 1 አናዉቅም 2 መልስ የለም 99	
228	በአፍላ ወጣትነት ጊዜ ስለሚኖረዉ የፍቅርና የወሲብ ግንኙነት በተመለከተ የወላጅና የአንተ/ች አመለካከት የተጣጣመ ነዉ	አዎ 1 አይደለም 2 መልስ የለም 99	
229	ከቤተሰቦችህ/ሽ ጋር ተጣልተህ/ሽ ታዉቃለህ/ሽ	አዎ 1 ተጣልቸ አላዉቅም 2 መልስ የለም 99	
230	ከቤተሰቦችህ/ሽ ከአሁን በፊት ጉዳት አድርሰዉብህ/ሽ ወይም በድለዉህ/ሽ ያዉቀቃሉ	አዎ 1 አያዉቁም 2 መልስ የለም 99	

231	በአንተ/ች አመለካከት በአፍላ ወጣትነት ወቅት የፍቅር/ የወሲብ ግንኙነትን በተመለከተ የወላጅን/አሳዳጊን ትዕዛዝ ወይም መመሪያ ማከበር ተገቢ ነዉ ትላለህ/ትያለሽ	አዎ ተገቢ ነዉ 1 ተገቢ አይደለም 2 መልስ የለለም 99	
232	በአፍላ ወጣትነት ወቅት የፍቅር/ የወሲብ ግንኙነትን በተመለከተ የአንተ/ች አስተሳሰብና የወላጅ አመለካከት ተመሳሳይ ነዉ ብለህ/ሽ ታስባለህ/ታስቢያለሽ	አዎ 1 አላስብም 2 መልስ የለም 99	
233	አንተ/ች በምትወስነዉ/ኚዉ ዉሳኔ የቤተሰብ ተጽዕኖ አለበት ብለህ ታስባለህ/ሽ	አዎ1 አላስብም 2 መልስ የለም 99	
234	ወላጆችህ/ሽ በአንተ/ች ላይ ከፍተኛ ቁጥጥር ያደረገሉ (ለማሳሌ፡ የስዓት እላፊ ቁጥጥር)	አዎ 1 አያደርጉም 2 መልስ የለም 99	
235	የአንተን/ችን የቤተሰብ ክትትልና ቁጥጥር እንዴት ታመዝነዋለህ/ ታየዋለህ	ቁጥጥሩ በጣም የበዛ (ፈላጭ ቆራጭ) 1 አሰማኝና ሚዛናዊ ቁጥጥር 2 ነፃ ማድረግ 3 ቸልተኛ 4 መልስ የለም 99	

ክፍል-3፡ *ሥለ ትምህርት ቤት መረጃ*

ተ.ቁ	**ጥያቄ**	**ኮድ**	
301	***በት/ት ቤት ዉስጥ አብዛኛዉን ከጓደኞችህ/ሽ ጋር ስለምን ጉዳዮች ትወያያላችሁ (<u>ከአንድ በላይ መልስ ይቻላል</u>)***	ስለፍቅርና ወሲብ በተመለከተ 1 ስልትምህርት2 ልዩ ልዩ ማህበራዊ ግንኙነቶች 3 ስልወደፊት የህይወት እቅድ 4 ስለቤተሰብ5 ስለሃይማኖት/ መንፈሳዊ ህይወት 7 ስለስፖርት 8 ሌላ ካለ ይገለጽ_____ 9 መልስ የለም 99	
302	በት/ት ቤት ዉስጥ በልዩ ልዩ ክለቦች/ ክበብ ትሳተፋለህ/ሽ	አዎ 1 አልሳተፍም 2 መልስ የለም 99	
303	ትርፍ ጊዜህን/ሽን *በአብዛኛዉ ጊዜ የት ታሳልፋለህ/ሽ*	ስትዲየም በመሄድ 1 ሲኒማ ቤት 2 ከጓደኞቼ ጋር ጫት በመቃም 3 ወደመዝናኛ በመሄድ አልኮሆል በመጠጣት 4 መፃህፍትን በማንበብ 5 ከፍቅር *ጓደኛየ ጋር* 6 የሰፊር ልዩ ልዩ ፊልሞችን በማየት 7 የት እንደማሳልፍ በትክክል አላዉቀዉም 8	

		ሌላ ካለ ይገለጽ_____ 9 መልስ የለም 99	
304	በት/ት ቤታችሁ ዉስጥ የስነ-ተዋልዶ ጤናና ተያያዥ ጉዳዮች አማካሪ ባለሙያ አለ	አዎ 1 የለም 2 መልስ የለም 99	
305	በእናንተ ት/ት ቤት የስነ-ፆታ ትምህርት (Sex education)፤ ስለእርግዝና መቆጥጠሪያ፤ ኮንዶም አጠቃቀማ እና ሌሎችም ት/ት ይሰጣል	አዎ 1 አያሰጥም 2 መልስ የለም 99	
306	በአንተ/ች አመለካከት መምህራን ለአንተ/ች ጥሩ አጋዥና መልካም ግንኙነት አለን ብለህ/ሽ ታስባለህ/ስቢያለሽ	አዎ 1 አላስብም 2 መልስ የለም 99	
307	ፈተና ወደወቀህ/ሽ ት/ት ደግመህ/ሽ ታዉቃለህ/ሽ	አዎ 1 አላዉቅም 2 መልስ የለም 99	
308	የአንተን/ችን የት/ት ክህሎትና ዉጤት ከክፍል ጓደኞች/ሽ ጋር ሲነጻጸር ምን ይመሰላል	በጣም ጎበዝ 1 መካከልኛ 2 ዝቅተኛ 3 መልስ የለም 99	
309	በት/ት ሰአት ከክፍል በመጥፋት (በመፎረፍ) ሌላ ቦታ ታሳልፋለህ	አዎ 1 አላሳልፍም 2 መልስ የለም 99	
310	የወደፊት ራዕይ እና እቅድህ/ሽ ምንድን ነዉ **(ከአንድ በላይ መልስ ይቻላል)**	ኮሌጅ/ዩኒቨርስቲ መቀጠል 1 ስራ መፈለግ 2 በማንኛዉም መንገድ ጥሩ ህይወት መኖር 3 ግልጽ የሆነ የወደፊት እቅድ የለኝም 4 ምንም አይነት ራዕይ የለኝም5 ሌላ ካለ ይገለጽ _____ 6 መልስ የለም 99	
	ክፍል-4፡ ሥለ ጎረቤትና አካባቢ ሁኔታ መረጃ		
ተ.ቁ	**ጥያቄ**	**ኮድ**	
401	በእናንተ አካባቢ ወጥቶች ትርፍ ጊዜያቸዉን የት ያሳልፋሉ **(ከአንድ በላይ መልስ ይቻላል)**	1.ሥቴድየም በመሄድ 2.ሲኒማ ቤት 3.ከጓደኛ ጋር ጫት በመቃም፤ ሺሻ በመሳብና በመሳሰሉት 4. አልኮሆል አየጠጡ መዝናናት 5.በማንበብ 6.ከፍቅረኞቻቸዉ ጋር 7. በየሰፈሩ ባሉ ፊልም ቤቶች ልዩ ለዩ ፊልሞችን በማየት 8. እንዴት እንደሚያሳልፉ አላዉቅም 9_____ ሌላ ካለ ይገለጽ	

		መልስ የለም.99	
402	በእናንተ አካባቢ ወጣቶች ጊዜያቸዉን የሚያሳልፉበት መዝናኛ አለ	አለ 1 የለም 2 አላዉቅም 88 መልስ የለም. 99	
403	ስለአንተ/ች አካበቢ አጠቃላይ ሁኔታ ምን ትላለህ/ ትያለሽ	ጥሩ የሆነ የኑሮ ደረጃ 1 የተጨናነቀና መጥፎ ሁኔታ 2 ጥሩ የሆነ ጉርብትና 3 በወጣቶችና አዋቂዎች መካከል ጥሩ ግንኙነት አለ 4 አላዉቅም 88 መልስ የለም 99	
404	በአንተ/ች አመለካከት በአካበቢ ያሉ አዋቂ ሰዎች ለወጣቶች አስፈላጊዉን እንክብካቤ ያደርጋሉ ብለህ/ሽ ታምናለህ	አዎ 1 አይደለም 2 አላዉቅም 88 መልስ የለም 99	
405	በአንተ/ች አካባቢ የፆታ ጥቃት ሲፈፀም አይተህ/ሽ ታዉቃለህ/ታዉቂያለሽ	አዎ 1 አይደለም 2 አላዉቅም 88 መልስ የለም 99	
406	በምትኖሩበት አከባቢ በተለያዩ የስፖርት አየይነቶች ትሳተፋለህ/ሽ	አዎ 1 አይደለም 2 አላዉቅም 88 መልስ የለም 99	
407	በአንተ/ች አመለካከት ወላጆቸ፤ አሳዳጊዎች፤ ታላላቅ ሰዎች እንዲሁም ጓደኞቻችሁ የወሊድ መቆጣጠሪያ እንዲሁም ኮንደም መጠቀምን ያበረታታሉ	አዎ 1 አይደለም 2 አላዉቅም 88 መልስ የለም 99	
408	በምትኖሩበት አከባቢ ስለ ተቃራኒ ፆታ ግንኙነት፤ ኮንደም አጠቃቀም፤ የወሊድ መቆጣጠሪያ እን የ አባላህር በሽታዎች አግልገሎት አግኝታችሁ ታዉቃላችሁ	አዎ 1 አይደለም 2 አላዉቅም 88 መልስ የለም 99	
409	ወደ ቤተክርስቲያን፤ መስጊድ ወይም ልዩ ልዩ የእምነት ተቋማት በየስንት ጊዜዉ ትሄዳለህ/ ትሄጃለሽ	በወር አንዴ 1 በሳምንት አነዴ 2 በሳምንት ከ2-3 ጊዜ 3 በየቀኑ 4 በአመት አንዴ 5 ፈፅሞ አልሄድም6 ሌላ ካለ ይገለፅ _____ 7 አላዉቅም 88 መልስ የለም 99	
410	ባልተገባ ባህሪ ምክንያት ትምህርት ማቋረጥ ወይም መባረር፤ ራስን ለማጥፋት መሞከር፤ በፖሊስ ቁጥጥር ስር መሆን አጋጥሞህ/ሽ ያዉቃል	አዎ 1 አይደለም 2 አላዉቅም/ አላስታዉስም 88 መልስ የለም 99	

	ክፍል አምስት: ሥለ አቻ ጓደኛ መረጃ		
ተ.ቁ	ጥያቄ	ኮድ	
501	ሥለ ጓደኞችህ/ሽ ምን ትላለህ/ ትያለሽ	እስማማለሁበከፊልእስማማለሁበከፊል አልስማማም ፈፅሞ አልስማማም መልስ የለም	
	1. ጥሩ የሆነ ቅርርብ አለኝ	1 2 3 4 99	
	2. ጓደኞቼ የኔን አስተያየት/ ሀሳብ ይቀበላሉ/ ያከብራሉ	1 2 3 4 99	
	3. ለጓደኞቼ የምችለውን እገዛ አደርጋለሁ	1 2 3 4 99	
	4. የጓደኞቼን እገዛ ወይም ምክር ሲያስፈለገኝ እቀበላለሁ	1 2 3 4 99	
502	ከጓደኞችህ/ሽ ዉስጥ ምን ስንቶቹ ወሲብ ፈፅመዉ ያዉቃሉ	ሁሉም1 አብዛኞቹ.2 ትቂቶች ብቻ.3 ሁሉም ወሲብ ፈፅመዉ አያዉቁም.4 ሌላ ካለ ይገለፅ_____.5 አላዉቅም.88 መልስ የለም.99	
503	ከጓደኞችህ/ሽ መካከል ስንቶቹ የአባላዘር በሽታ (ቂጥኝ፣ ከርክር፣ የብልት ፈሳሽ፤ ኤች አይቪ ኤድስ እና ሌሎችም) ተይዘዉ ያዉቃሉ	ሁሉም1 አብዛኞቹ.2 ትቂቶች ብቻ.3 ሁሉም ወሲብ ፈፅመዉ አያዉቁም.4 ሌላ ካለ ይገለፅ_____.5 አላዉቅም.88 መልስ የለም.99	
504	ከጓደኞችህ/ሽ መካከል በልተገባ/ መጥፎ ባህሪ የተነሳ ተከሶ ወይም ተይዞ ያዉቃል	አዎ.1 የለም.2 አላዉቅም.88 መልስ የለም.99	
505	ከጓደኞችህ/ሽ መካከል አልኮሆል፤ ቻት፤ ሲጋራ፤ ሺሻ እና ሌሎች አደንዛዥ እፆች ተጠቅመዉ ያዉቃሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
506	የአንተ/ች ጓደኞች በአፍላ ወጣትነት ጊዜ ወሲብ መፈፀምን ይደግፋሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
507		ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2	

	የአንተ/ች ጓደኞች ኮንደም ወይም የወሊድ መቆጣጠሪያ መጠቀምን ይደግፋሉ	ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
508	የአንተ/ች ጓደኞች ኮንደም ይጠቀማሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
509	ከአንተ/ች ጓደኞች መካከል ስንቶቹ ወሲብ ፈፅመዉ ያዉቃሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
510	ከአንተ/ች ጓደኞች መካከል ስንቶቹ በአፍላ ወጣትነት ጊዜ ወሲብ ከመፈፀም መታቀብን ይደግፋሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
511	ከአንተ/ች ጓደኞች መካከል ስንቶቹ ከብዙ ሰዉ ጋር ወሲብ መፈፀም ችግር የለዉመ ብለዉ ያምናሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
512	የአንተ/ች ጓደኞች ወንድ ልጅ ወሲብ መፈፀም ይኮራል ብለዉ ያምናሉ	ምንም የለም 1 የተወሰኑት ይጠቀማሉ 2 ግማሾቹ ይጠቀማሉ 3 አብዛኞቹ ይጠቀማሉ 4 ሁሉም ይጠቀማሉ 5 አላዉቅም 88 መልስ የለለም 99	
513	የአንተ/ች የፍቅርና ልዩ ልዩ የግል ዉሳኔዎች ዉስጥ የጓደኞችህ/ሽ ጠቀሜታ/ አስተዋፆ የነላ ነዉ	አዎ 1 አይደለም 2 መልስ የለም 99	

514	የጓደኛ እገዛ፤ መልካም ግንኙነት እና ልዩ ልዩ ማህበራዊ የጓደኛ ግነንኙነቶች አላስፈላጊ የወሲብ ተጋላጭነትን የከላከላሉ ብለህ/ሽ ታስባለህ/ሽ?	አዎ 1 አይደለም 2 መልስ የለም 99	

ክፍል- VI፡ ስለ ተቃራኒ ፆታ ግንኙነት በተመለከተ

ተ.ቁ	ጥያቄ	ኮድ	
601	ከአሁን በፊት ወሲብ ፈፅመህ/ሽ ታዉቂያለሽ (መልሱ የለም ከሆነ ወደ ጥያቄ ቁጥር 617 እለፍ/ፊ)	አዎ 1 የለም 2 መልስ የለም 99	(መልሱ የለም ከሆነ ወደ ጥያቄ ቁጥር 617 እለፍ/ፊ)
602	ወሲብ መፈፀም የጀመርከዉ/ የጀመርሺዉ በስንት አመትህ/ሽ ነበር	ከ16 ዓመት በፊት 1 ከ16 ዓመት በኃላ 2 መልስ የለም 3	
603	ባለፈዉ 12 ወር ዉስጥ ወሲብ ፈፅመህ/ሽ ታዉቃለህ/ሽ	አዎ 1 የለም 2 መልስ የለም 99	
604	ባለፈዉ 12 ወር ዉስጥ ከምን ያህል ሰዉ ጋር ወሲብ ፈፅመህል/ ፈፅመሻል	አንድ ሰዉ ብቻ 1 ሁለት ሰዉ ጋር 2 ከሁለት ሰዉ በላይ 2 መልስ የለም 3	
605	ባለፈዉ 12 ወር ዉስጥ ወሲብ ስትፈፅም ኮንደም ሁልጊዜ ትጠቀም/ ትጠቀሚ ነበር	አዎ 1 የለም 2 መልስ የለም 99	
606	ከአሁን በፊት የአባላዘር በሽታ ተይዘህ/ሽ ታዉቃለህ/ታዉያለሽ	አዎ 1 የለም 2 መልስ የለም 99	
607	ከአሁን በፊት ያልተፈለገ ዕርግዝና ኢጋጥሞሽ ያዉቃል	አዎ 1 የለም 2 መልስ የለም 99	
608	ከአሁን በፊት ፅንስ አስወርደሽ (abortion) ታዉቂያለሽ	አዎ 1 የለም 2 መልስ የለም 99	
609	) የመጀመሪያ የወር አበባ በስንት አመትሽ ነበር ያየሺዉ	_____ዓመት	
610	መጀመሪያ ወሲብ የፈፀምከዉ/ የፈፀምሺዉ ከምን አይነት ሰዉ ጋር ነበር	ከፍቅር ጓደኛየ ጋር.1 ከቡና ቤት ሴት ጋር .2 በኢጋጣሚ ካገኘሁት ሰዉ ጋር.3 ከማላዉቀዉ ሰዉ ጋር .4 ሌላ ካለ ይገለፅ_____.5 አላዉቅም.88 መልስ የለም.99	
611		በራሴ ፈፍላጎት .1	

	ለመጀመሪያ ጊዜ ወሲብ ስትጀምር/ሪ ምክንያትህ/ሽ ምን ነበር	የጓደኛ ግፊት.2 መጠጥ ወይም አደንዛዥ እፅ በመጠቀም/በመዉሰድ .3 ተደፍሬ.4 ገንዘብ ለማግኘት.5 የወሲብ ፊልም በማየት ተገፋፍቸ.6 ሌላ ካለ ይገለፅ----------.7 አላስታዉስም.88 መልስ የለም.99	
612	ለመጀመሪያ ጊዜ ወሲብ ስትፈፅም ኮንደም ተጠቅመህ ነበር (የወሲብ አጋርሽ ኮንደም ተጠቅሞ ነበር)	አዎ 1 No የለም 2 አላስታዉስም/ አላዉቅም 88 መልስ የለም 99	
613	ከመጀመሪያ የወሲብ አጋር በጎላ ከምን ያህል ሰዉ ጋር ወሲብ ፈፅመሀል/ ፈፅመሻል	ከማንም ሰዉ ጋር ፈፅሜ አላዉቅም.1 ከ2-4 ሰዉ ጋር.2 ከ4 ሰዉ በላይ ጋር.3 አላስታዉስም.88 መልስ የለም.99	
614	ባለፈዉ 6 ወር ዉስጥ ወሲብ ፈፅመህ/ ፈፅመሽ ታዉቃለህ/ ታዉቂያለሽ	አዎ 1 የለም 2 መልስ የለም 99	
615	በቅርብ ጊዜ ወሲብ ስትፈፅም/ሚ አንተ/ች ወይም የወሲብ አጋርህ/ሽ ኮንደም ተጠቅማችሁ ነበር	አዎ.1 የለም.2 አላስታዉስም/አላዉቅም .88 መልስ የለም.99	
616	ጥያቄ ቁጥር 617 መልሱ የለም ከሆነ ምክንያቱ ምን ነበር	ኮንደም ስላልነበረ1 ኮንደም ስለማይመች .2 ኮንደም ዉድ ስለሆነ.3 ጓደኛየ መጠቀም ስለማይፈልግ.4 ኮንደም መግዛት ስለሚያሳፍር .5 ኮንደም ኤች አይቪ ይከላከላል ብየ ስለማላምን.6 ሥለማማስታዉስ.7 ጓደኛየን ስለማምዉ/ስለማምናት.8 ኮንደም ደስታን ስለመቀንስ.9 ሰክሬ ስለነበር.10 ሌላ ካለ ይገለፅ _____.11 አላሰታዉስም.88 መልስe የለም.99	
617	በአንተ/ች አመለካከት በአፈላ ወጣትነት ጊዜ በወሲብ ባህሪ ላይ ተፅኖ የምተላቸዉ	አዎ የለም አላዉቅም መልስ የለም	

	1. በእናት ወይም በአባት ብቻ በተናጠል ማደግ	1	2	88	99	
	2. የቤተሰብ የገቢ ሁኔታ	1	2	88	99	
	3. የልጆች አስተዳደግ ስርዓት	1	2	88	99	
	4. የወላጆች/አሳዳጊዎች ቁጥጥርና ክትትል	1	2	88	99	
	5. የአካባቢና የጎረቤት ሁኔታዎች	1	2	88	99	
	6. የትምህርት ዉጤት	1	2	88	99	
	7. ሥለ ኤችአይቪ እን አባላዘር በሽታዎች አጠቃላይ እዉቀት መኖር	1	2	88	99	
	8. የራስ ገቢ እንዲኖር የሁኔታዎች መቻቸት	1	2	88	99	
	9. የስነ-ፆታ ስርዓት መኖር	1	2	88	99	
	10. የገንዘብ እጦት	1	2	88	99	

መጨረሻ

እናመሰግናለን!!!!

III. ANNEXURE G3 Focus group guide (Qualitative)

1. What is your opinion regarding adolescents' sexual behaviours in general?

Probing questions

- Beliefs about delay sexual debut or abstinence
- Attitude on more than one partner at a time or concurrent partners
- Value of virginity?
- School absenteeism (truancy) or academic performance vs sexual activity
- Attitude or belief about sex for money(girls) or sex with commercial sex workers (boys)
- Causal sex, coercion
- Participate on delinquencies
- Feelings after having sex (proudness/ regrets.)
- Belief/ attitude (confidence, partners appreciation ..) on using condoms and contraception
- Attitude on substance use (cigarette, alcohol, khat, shisha, injecting drugs….) and its relation with sexual activities.

2. Do adolescents/students interact or discuss with families (mother, father, other siblings, etc.) regarding to their sexual activities in day to day life?

Probing questions

- Delay sexual debut or abstinence
- Use of condoms and contraception
- Having multiple sexual partners
- STI/ HIV/AIDS
- Pregnancy, abortion
- Families attitude/reaction if the aware about your (adolescent) sexual activities

3. How are sexual and reproductive health issues addressed in your schools?

Probing questions

- Use of mini media
- Regular sexual and health education (knowledge and skill on sexual health, skill to negotiate about sex or say “no”, risk/outcome of substance use, condom and contraception, academic performance/outcome vs sexual activity)
- Teacher- student interaction related to sexual behaviours
- Regular student counselling system in the school (conflict resolution, academic, student absenteeism, risk reduction…)

4. Do adolescents/students interact or discuss with their peers regarding to sexual activities?

Probing questions

- Discussion about sexual activities
- Substance use
- Delinquencies (deviant gangs)
- Respect/ unrespect if boys/ girls have sex with girl/boyfriends, more than one partner
- Value of virginity?
- Use of condom and contraception
- Help each other in sexual issues

5. How does your community support adolescents/students in relation to sexual behaviours?

- Adults mentor or support in the neighbourhood
- Conflict, violence in the community
- Access to condom and contraception
- Health care services in the community
- Health care providers approach toward your sexual health needs?

6. What do you think how are these social centres (families, school, community and peers) influencing sexual behaviours in adolescents like you?