HEALTH EXPERIENCES OF ADOLESCENTS IN RURAL SOUTH EAST ETHIOPIA

by

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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

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JUNE 2019

Dedication

I would like to dedicate this thesis to:

*My wife **Mrs Simret Abebe** who has been almost equally paid the sacrifices in my education. She has been praying day and night for protection when I move here and there for issues related to this thesis.*

*My sons **Hansnet** and **Esyeha**, their laughter and love was my fuel for motivation when I run out of energy.*

*My father **Mr Abebe** and mother **Mrs Abebech** who are my hero; they have contributed a lot for my educational success beginning from my early classes. I am from most remote rural areas in my country Ethiopia. "Thank you dad and mom".*

To all adolescents in Ethiopia, particularly who were victims of negative health experiences and shared their lived experiences genuinely for this study.

Student number: 58560173

DECLARATION

I declare that **HEALTH EXPERIENCES OF ADOLESCENTS IN RURAL SOUTH EAST ETHIOPIA** is my own work and that all 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.

11June 2019

Amene Abebe Keribo **Date**

Acknowledgment

The successful achievement of psychologically and practically long journey of PhD education is owing to the summations of inspirations and motivations I obtained directly and indirectly from many individuals and organisations. In the journey of this research, I really learned not only how to overcome educational challenges but also the difficulties of life itself. In the last four years, I had been in the journey of challenges both academically and personally but at the end, I had grown in both.

Before all, I would like to thank the heavenly father and almighty God in Jesus' name for giving me peace and health in overall educational career.

My supervisor professor Gloria Thupayagale-Tshweneagae deserves my heartfelt gratitude. She was not only an educational guide for me in the overall stages of this research; she was motherly and caring . She is committed to teach and to show the right direction. I realised her patience, support, guidance and willingness to help from the proposal phase to this final thesis. She has been motivating and energising me when I feel tired. She was appreciated my contributions for knowledge when I show her my draft works. Professor, I salute you for everything, I will never forget your assistance.

I wish to sincerely thank the study participants who were so generous and enthusiastic in providing the information I needed during the study. They were more than willing to provide an insight into what it means to be an adolescent in a rural setting. Without their willingness to participate in this study, this thesis would never have become a reality.

I would also like to thank University of South Africa (UNISA) for allowing me to pursue my PhD education and to conduct the research in my area of interest and staff of Department of Health Studies for their all round support.

University of South Africa, Ethiopia learning center staff for their cooperation, arranging learning opportunities and providing the letter of request to conduct the study in Oromia Regional State

Oromia Regional Health Bureau Health Research Ethical Review Committee members particularly Birhanu Qanate for his cooperation in the ethical review process and giving me permission letter to the respective Zonal health departments

Bale zone Health department staffs and Bale Goba District Health Office staff for their kindness and for reducing the overall challenges by full cooperation during the data collection in the highly challenging rural setting.

Ms Fekadenesh and Mrs Mebrat, my assistants during data collection, thank you for assisting me in one or other way in the field.

Mr Chokwe MJ, professional language editor for language editing of the thesis and for being part of the research.

Finally, Mrs Rinnie AT, for technical editing of the thesis.

HEALTH EXPERIENCES OF ADOLESCENTS IN RURAL SOUTH EAST ETHIOPIA

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ABSTRACT

Adolescents have been left in the mainstream of care because they are regarded as healthier than the paediatric group and adults. Adolescence is a time of transition in which childhood is left behind, and pressures to become responsible adults are strong. Owing to lack of evidence-based, effective and adolescents sensitive interventions; Ethiopian adolescents' become vulnerable for preventable health problems like unsafe abortion, substance use and abuse, unprotected sex and teenage pregnancies and STIs including HIV/AIDS and the associated morbidity and mortality.

This study was conducted among purposely selected adolescents from rural South East, Ethiopia. A qualitative, grounded theory study was undertaken to explore the experiences of adolescents and perceptions of the adolescents towards health and health-related behaviours. The study composed of 25 purposely selected adolescents from the study setting. The required data was collected by one-on-one audiotaped individual interviews, persistent observation, and supportive field notes. The collected data were transcribed to texts and translated to English for analysis. Participants' experiences and perceptions were presented using detailed textual descriptions and interpretations, supported by direct verbatim quotations of the participants. Data analysis was done following Creswell's (2014:247) framework for data collection and analysis. Categories, themes and subthemes from the data were developed following Charmaz's (2006:47-70) steps of grounded theory data analysis; initial coding, open coding, focused coding and theoretical coding.

Five major categories and 14 themes emerged from the data in the current study. The five major categories emerged from the data include: adolescence sensitive health intermediaries, health related information and communication in adolescence, health challenges faced by adolescents, social and cultural perspectives of adolescents health and suggested health promotion strategies. The categories, themes and subthemes are outline and explained in the respective headings and subheadings.

The study revealed that improved health information and communication as a core process for positive and better adolescent health outcomes and influenced by various contextual factors. Therefore, it is recommended to respective individuals, groups, governmental and non-governmental organisations working on adolescent's health promotion in Ethiopia, to improve health information and communication systems related determinant contextual factors identified in this research.

KEY TERMS

Adolescence; adolescents; adolescents health promotion; experiences; grounded theory; health; health experiences; puberty; rural adolescents; rural setting; teenagers; transition; urban adolescents; young; young people

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LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CDC	Center for Diseases Prevention and Control
CSA	Central Statistical Agency
FDRE-MOH	Federal Democratic Republic of Ethiopia-Ministry Of Health
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nation International Children's Emergency Fund
UNCRC	United Nations Convention on the Rights of Children
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

“Adolescence” is the concept that keeps on evolving. It is understood through physiological, psychosocial, temporal and cultural lenses. This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence (Steinberg 2014:110).

Adolescence is a period of many critical transitions, namely physical, psychological, economic, and social. These changes occur simultaneously and at different paces for each adolescent within each gender, with structural and environmental factors often impacting adolescents’ development. Childhood has elapsed and pressures to become responsible adults are strong. Of most importance is the need to shape an identity and develop a personality. With these transitions come challenges and choices that are strongly influenced by the gender expectations of society and families. The ability to navigate through these transitions depends on how well adolescents are supported by families and society at large (United Nations Fund for Population Activities (UNFPA) 2014:8).

Adolescent health and wellbeing is an important public health priority, because beyond benefiting young people themselves, young people constitute a decisive cohort of the world’s population. Hence, the potential of contributing to broader sustainable development and poverty reduction by increased investment on adolescents’ health and wellbeing (Siegrid 2011:2)

The world is home to 1.2 billion people aged 10–19 years. These adolescents have lived most or all of their lives under the Millennium Declaration, the unprecedented global compact that since 2000 has sought a better world for all. Adolescents across the world are generally healthier today than in previous generations. Worldwide, one third of all new HIV cases involve young people aged 15 to 24. In the developing world, one in every three girls get married before the age of 18 years. Adolescents are also still struggling with wide range of survival and health problems that emanate from several

causes, including accidents, AIDS, early pregnancy, unsafe abortions, risky behaviours such as tobacco consumption and drug use, mental health issues and violence (United Nations International Children's Emergency Fund (UNICEF) 2011a:2).

Adolescence is now quite widely accepted that it is a time of transition involving multi-dimensional changes: biological, psychological (including cognitive) and social. Biologically, adolescents are experiencing pubertal changes, changes in brain structure and sexual interest, as a start. Psychologically, adolescents' cognitive capacities are maturing. Adolescence is also an age of opportunity for children, and a pivotal time for families, community and schools to build on their development, to help them navigate risks and vulnerabilities, and to set them on the path to fulfilling their potential (Steinberg 2014:110)

There is an unacceptable rate of mortality among adolescents, as an estimated 1.3 million adolescents died in 2012; 70% of these deaths occurred in Africa and Southeast Asia. Unintentional injuries such as road traffic accidents and drowning are the leading causes of death in adolescents, while suicide, violence, infectious diseases, and teenage pregnancy are other important causes of adolescents' mortality (Salam, Das, Zohram & Bhutta 2016:4).

In many areas of risky behaviour, adolescents show a worse health profile than adults. Compared with adults aged 26 to 34, adolescents are more likely to be injured or die in motor vehicle crashes and to have related hospitalizations and emergency room visits. Adolescents are less likely to eat breakfast, less likely engage in regular exercise, and get regular physical and dental checkups, and more likely to eat fast food, contract sexually transmitted diseases, smoke cigarettes, use marijuana and other hard drugs, and engage in alcohol abuse and use ((Institute of Medicine (IOM) and National Research Council (NRC) 2015:5).

Access to and use of health care can significantly improve adolescents' health and prevent the onset of some problems in the future. Continuous health insurance coverage, with access to preventive and behavioural health services, have a crucial role in the control of chronic problems and prevention or management of issues that can disrupt school attendance or healthy development during adolescence (Human Health Services, Office of Adolescent Health (HHS, OAH) 2018:10).

1.2 BACKGROUND OF THE RESEARCH PROBLEM

According to World Health Organization (WHO) as cited in Abajobir and Seme (2014:2) adolescents are people between 10 and 19 years of age. They make 20% of the world's population, of whom 85% live in developing countries. Adolescence is characterised by significant physiological, psychological and social changes that put adolescents for high risk sexual and reproductive health (SRH) problems. This has partially been because adolescents were considered to be relatively healthy and without a heavy burden of disease.

Adolescents have been left in the mainstream of care because they were regarded as healthier than the paediatric group and adults. When a baby is born healthier it is most likely he/she will grow into a healthier adolescent and adult. Effective interventions during adolescence offer an opportunity to rectify problems that have arisen during the first decade. For example, interventions during adolescence may decrease the adverse long-term impacts of violence and abuse in childhood or of under-nutrition and prevent them from undermining future health (WHO 2014:3).

Adolescents living in rural areas face particular risks to health and well-being as they are more likely to be poor and have less access to health care services. The majority of health care issues faced by adolescents are preventable and they continue to be a concern to most of the governments of the world. In the 2016-2020 developmental goals the issues of access in rural settings is being emphasised and it can only be hoped that it shall succeed (Tilley, Fuqin,Liu, Lee & Ackers 2014:1).

Adolescence is considered to occur between the ages of 10 and 19 years (WHO 2015a:1). During these years adolescents seek independence and start to make decisions that will have implications for their life. Many of the health-related issues experienced by adolescents are preventable and are related to risky behaviours (Shannon & Broussard 2011:16).

Adolescence is a time of opportunity, but also one of the periods of risk. It presents a window of opportunity because actions could be taken during this period to set the stage for healthy adulthood and to reduce the likelihood of problems in the years that lie ahead. These include the prevention of cardiovascular diseases of adulthood through

the development of healthy eating and exercising habits. At the same time, adolescence is a period of risk; a period when health problems that have serious immediate consequences can and do occur (such as deaths resulting from road trafficking injuries, and sexually transmitted infections (STIs) and unwanted pregnancies resulting from unprotected sexual activity. On the contrary, it is also a period when problem behaviours which could have serious adverse effects on health in the future (such as tobacco smoking and alcohol consumption) are also initiated (WHO 2014:2).

According to a study conducted in the Republic of Moldova, It is hard to reach adolescents by the existing health care delivery approaches. Therefore, engaging a range of primary level health care providers to deal with the general population of adolescent people and redirecting the efforts of the health care workers and the system to reach out the adolescent people who are most at risk of health and social problems is required (Chandra-Mouli 2013:4).

Lack of confidentiality and privacy, costs and adolescents' lack of knowledge about adolescents' health services are among important barriers for utilisation of health services. Socio-cultural norms and taboos with statements such as "you want the services to engage in premarital sex". Such attitudes keep the adolescents away from health services. Adolescents need acceptance of their parents and community gatekeepers. On the contrary, any awareness prohibits adolescents from using the available health services (Viner,Ozer,Denny,Marmot,Resnick,Fatusi & Currie 2012:1642).

According to the study carried out by Obonyo (2012: IV) in Kenya, the sexual and reproductive health (SRH) issues of the adolescents remain a relatively new and sensitive area mainly owing restrictive norms and policies guiding the services. Sex and sexuality among the young people have remained a sacred area and few structures were in place to address it.

The rapid population growth in Ethiopia will strain the government's ability to provide health care and education to young people. Besides, unsustainable population growth, unplanned and unwanted pregnancies and unsafe abortion are serious public health problems of adolescents in the developing world, including Ethiopia (Central Statistical Agency (CSA) Ethiopia 2016:77)

The spectre of sexually transmitted diseases (STDs) including HIV/AIDS hangs heavy over Ethiopian adolescents. A large proportion of new HIV infection occurs in young people under 25 years of age (Abdi & Gebremariam 2011: 34; United States Agency for international development (USAID) & Family Health International (FHI) 2004:2).

In a study conducted in Ethiopia on utilisation of health services by adolescents, from the entire participant adolescents of the study (36.2%) were not using adolescent's friendly health services. From those non-users (43%) mentioned that lack of information from where to get adolescents health services was a reason not to utilise the services (Aboma 2012:21).

1.3 PROBLEM STATEMENT

Rural adolescents face many challenges to overall health. Socio-cultural factors are more determinants in rural areas than urban. Cultural practices including not bathing when menstruating and female genital mutilation (FGM) are mostly practiced in rural areas because of lack of access to education and other health care services (Leiprt, Ezer, Evans & Regan 2016:1).

Risky behaviours such as substance use and abuse, unprotected sex and adolescent pregnancies are targets by many governments, including the Ethiopian government. In addition, a study conducted in South Africa also realised that peer pressure, STIs/HIV, adolescents' pregnancy, alcohol/drug abuse and lack of information were crucial and needs attention. The respondents all agreed peer pressure among adolescent was a major issue. STIs and HIV ranked second among adolescents with pregnancy being third and alcohol/drug abuse and lack of information were ranked fourth and fifth (Rhian, Kathleen, Alexandra & Shane 2016:5).

There are many reasons for the growing attention to the health of adolescents and youth in Ethiopia. First, this group comprises a significant proportion (33.8%) of the country's population. Second, as this cohort joins the workforce, the foundations laid in health will have profound implications for social, political, and economic development. This is particularly important given the declining fertility and mortality trends in Ethiopia. Third, healthy adolescents are a key asset and resource, with great potential to

contribute to their families, communities and the nation both at present and in the future as actors in social change, not simply beneficiaries of social programs. The surge of interest in adolescent and youth health also responds to the improved global understanding of the developmental process that takes place during adolescence which guides designing and delivering tailored interventions for subgroups in this segment of the population (Federal Democratic Republic of Ethiopia, Ministry of Health (FDRE,MOH) 2016:1).

Governments of the world including the government of Ethiopia are working hard for improvement of adolescents' health and wellbeing. Unfortunately, still now many adolescents are exposed to many health problems. These include teenage pregnancy, unsafe abortion and STIs including HIV/AIDS. However, there are no qualitative exploratory studies done on health experiences of adolescents in the rural setting in Ethiopia found. The purpose of this study is to investigate health experiences of adolescents from their own perspectives in the rural setting. Against this background, this study aims to fill this knowledge gap by describing the embedded personal health experiences of adolescents in rural South East Ethiopia.

Generally, health assessments of adolescent largely influenced by biomedical approach which focuses heavily on morbidity and mortality measures and other standard measurements such as height, weight, blood pressure, temperature and others. These measurements have excluded the holistic nature of a person. Hence, this study had intended to investigate personal and holistic health experiences of adolescents in a rural setting.

Many literatures revealed that the study of adolescent health concerns were largely measurement driven, and often explored from a deficit perspective. Therefore, there remains a gap in the literature regarding the contextualised experiences of adolescents' health from their own perspective. This project used a qualitative approach to generate a model grounded in stories adolescents shared regarding their health. A dearth of knowledge in the meanings of behaviour that are assumed by adolescents in the society and the impacts of such behaviours on them is a gap in the extant literature which this thesis aimed to fill.

1.4 STUDY PURPOSE, OBJECTIVES AND RESEARCH QUESTIONS

1.4.1 Purpose of the study

The main purpose of this study was to investigate the health experiences of adolescents, their perceptions regarding health and developing a substantive grounded theory based on their experiences in rural South East, Ethiopia.

1.4.2 Objectives of the study

In order to meet the above purpose of the study, the research had intended to meet the following specific objectives:

- To explore and describe lived health experiences of adolescents in rural South East Ethiopia
- To investigate the perceptions of the adolescents regarding their own health in rural South East Ethiopia
- To develop a substantive grounded theory based on the experiences and perceptions of adolescents in rural South East, Ethiopia

1.4.3 Research questions

Following the research objectives the study will purport to answer the following research questions:

- How do personal experiences of health are socially constructed by adolescents in rural South East, Ethiopia?
- What is the perception of adolescents regarding their health in rural South East, Ethiopia?
- What a theory can be developed grounded on the health experiences of adolescents in rural South East, Ethiopia?

1.5 SIGNIFICANCE OF THE STUDY

According to Fouche and Delport (2011: 107) intends to convince the reader about the needs of carrying out the research in the first place; it provides the justification, contribution and importance of the study.

Adolescents who are the significant proportion a total population of the world are facing different health problems which compromise their contribution for the national and

global development. The aim of this study was to develop a model that will help to guide interventions targeted to promote adolescents health in Ethiopia. The contribution of this study is not only to policy makers, health services and scholarly literature but also to improve the lived health experiences of the adolescents.

Addressing the health problems of the young people also has a significant contribution on educational and health achievements of the adolescents. The researcher in this study believes that the study would benefit directly or indirectly the adolescents and also their families. The existing literature had identified the adolescents' health care utillisation and associated factors but no qualitative grounded theory study was conducted on health experiences of adolescents in rural areas of Ethiopia. The researcher strongly believes this study fills the knowledge gap in this regard. Furthermore, the study would form a basis for comparison between developing and developed countries.

1.6 DEFINITION OF KEY CONCEPTS

In order to ensure that the reader understands the purpose and direction of this study the following key concepts used in the study are defined:

1.6.1 Health

WHO defines health as the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO 1948:1).

1.6.2 Adolescence

According to (Annie 2015:5) adolescence is the period of developmental transition from childhood to adulthood. The period of adolescence can generally be considered the "gateway" and the period of youth the "pathway" to adult health. During adolescence young people begin to negotiate with puberty and the completion of growth, take on sexually appropriate body shapes, develop new cognitive skills, develop a clearer sense of personal and sexual identity, and develop a degree of emotional, personal, and financial independence from their parents.

In many societies adolescence is equated with puberty and the cycle of physical changes culminating in reproductive maturity. In other societies adolescence is understood in broader terms that encompass psychological, social, and moral terrain as well as the strictly physical aspects of maturation. In the later, societies the term adolescence typically refers to the period between ages 12 and 20 and is roughly equivalent to the word teenage (*Encyclopaedia Britannica* 2019).

The definition of adolescence is varies in terms of age, physical and the level of psychological maturity and the cultural contexts. According to the Oxford English Dictionary, the original 1482 as cited in Curtis (2015:10) definition of adolescence referred to a period between childhood and adulthood that extended between ages 14 and 25 years in males and 12 and 21 years in females. The physical changes that unfold adolescence are the development of breasts and first menstrual periods for girls, the deepened voices and broadened shoulders for boys—are the most visible and striking markers of this stage. Adolescents developing brains bring new cognitive skills that enhance their ability to reason and to think abstractly.

According to Mental Health First aid Australia (MHFA) (2014:1) adolescence refers to those aged between 12 and 18, or the years that a young person generally attends high school. However, adolescence can start earlier than 12 years and can continue through to the early 20s.

According to Center of Diseases Prevention and Control adolescents mortality and morbidity weekly report, adolescence was considered as the age in between 12-17 years (CDC 2018:103).

The above cited literature show, although many do agree in the definition of the term adolescence as a period of transition from childhood to adulthood, they do not agree in the age range of adolescence.

In Ethiopia in many adolescent and youth health development policy and strategy contextualised documents adolescence is considered as a young people in the age range of 15-19 years (FDRE-MOH 2016:3; Population Services International Ethiopia(PSI/E) 2016:6; UNICEFb 2011:128;Zhuzhi ,Pav ,Julie , Genene & Albert 2008:3).Owing to the above contextual explanations in the present study an adolescent

is a young person who is a permanent resident of Goba District and in the age range of 15-19 years of age.

Table1.1 Developmental tasks of adolescence

Adolescent development period	Biological	Psychological	Social
Early adolescence	Early puberty (girls: breast bud and pubic hair development, start of growth spurt; boys: testicular enlargement, start of genital growth)	Concrete thinking but early moral concepts; progression of sexual identity development (sexual orientation); possible homosexual peer interest; reassessment of body image	Emotional separation from parents; start of strong peer identification; early exploratory behaviours (smoking, violence)
Mid-adolescence	Girls: mid-late puberty and end of growth spurt; menarche; development of female body shape with fat deposition Boys: mid-puberty, spermarche and nocturnal emissions; voice breaks; start of growth spurt	Abstract thinking, but self still seen as “bullet proof”; growing verbal abilities; identification of law with morality; start of fervent ideology (religious, political)	Emotional separation from parents; strong peer identification; increased health risk (smoking, alcohol, etc) heterosexual peer interest; early vocational plans

Late adolescence	Boys: end of puberty; continued increase in muscle bulk and body hair	Complex abstract thinking; identification of difference between law and morality; increased impulse control; further development of personal identify; further development or rejection of religious and political ideology	Development of social autonomy; intimate relationships; development of vocational capability and financial independence

(Adapted from Kapur 2015:235)

1.6.3 Adolescent

Adolescent is the person who is in the transitional period from childhood to adult hood and the time period to be considered as an adolescent varies in the context at which adolescence is defined. In the present study, an adolescent is a young person who is a permanent resident of Goba District and is between15 to19 years of age.

1.6.4 Health experiences

Health experiences are the cumulative evaluation of the journey adolescents have in their life which are shaped by the people around them, all health related interactions, their physical setting and their expectations. Perceptions, behaviours and interactions of one's' health based on culture and environment (Jason 2014:10). Health experiences in the current study focused on social, behavioural, cultural and growth and development related health experiences of the adolescent people.

1.6.5 Conceptual model

A conceptual framework is a group of concepts that are broadly defined and systematically organised to provide focus, a rationale and a tool for the integration and interpretation of information (*Mosby's Medical Dictionary 2009*). Creswell (2014:82) further clarifies a conceptual framework as a systematic view of phenomena which specifies relations among variables using a set of interrelated constructs.

1.6.6 Health services

Health services are performed by health care professionals or by others under their direction, for the purpose of promoting, maintaining or restoring health (WHO 2013:30).

1.6.7 Adolescent health services

Adolescent health services are services that are gender sensitive, accessible, affordable, acceptable and available to adolescents and offered by personnel who are knowledgeable and skilful in dealing with adolescents (National Academy of Science (NAS) 2017:139).

1.6.8 Puberty

Puberty in human physiology is a stage or period of life when a child transforms into an adult who is capable of procreation. However, physical growth and sexual maturation varies significantly with variation of gender, race, body mass, environmental influences and overall health status of the child. The onset of puberty is 11 years, with boys beginning between the ages of 9 and 13.5 years, and girls between 7 and 13 years (Curtis 2015:8).

1.6.9 Rural setting

Rural setting is a population, housing, and territory not included within an urbanized area or recognised urban cluster. The rural portion of a country encompasses a wide variety of settlements, from densely settled small towns and “large-lot” housing subdivisions on the fringes of urban areas, to more sparsely populated and remote areas (Ratcliffe, Burd, Holder & Fields 2016:3).

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

According to Neuman (1991) as cited in (Khan 2016:224) a paradigm is a framework or a set of assumptions that explain how the world is perceived where ‘the paradigm of a science includes its basic assumptions, the important questions to be answered or puzzles to be solved, the research techniques to be used, and examples of what scientific research looks like.

Further details of paradigms was explained in Creswell (2014:20) and Polit and Beck (2012:12) as a set of philosophical assumptions or beliefs about the nature and characteristics of reality (ontology); what counts as knowledge and how knowledge claims are justified (epistemology); the role of values in a research (axiology) and the process and techniques of research (methodology).

According to Creswell (2014:25) a paradigm is about how researchers apply assumptions and denotes the use of a particular interpretive framework for qualitative

research, such as social constructivism. In Polit and Beck (2012:14), constructivists emphasise the inherent complexities of humans, their ability to shape and create own experiences and the idea that truth is the composite of reality. The four above mentioned paradigms and their application in this particular research described in the following sections.

According to Taghipour (2014:100) the Glaserian approach of grounded theory is an objectivist grounded theory and based on *etic* position, where the researcher is separate from and looks at the social realities. However, the Straussian approach is a constructivist grounded theory and based on *emic* position, where the researchers co construct the data through adopting a position of mutuality and partnership between participant and researcher and create the theory of a social process using their own perspectives, values, privileges, interactions and understanding of the social realities.

Therefore, in this study *emic* position assumption was considered, where the researcher co-constructs the data through adopting a position of mutuality and partnership between the participants and the researcher.

1.7.1.1 Ontological stance of the researcher

Ontology is about the researchers assumptions about the nature of being/reality. Ontological assumptions are concerned with what constitutes reality. It is a complex multi-disciplinary field that draws upon the knowledge of information organisation, natural language processing, information extraction, artificial intelligence, knowledge representation and acquisition (Aliyu, Singhry,Adamu & Abubakar 2015:14).

According to this paradigm researchers need to take a position regarding their perceptions of how things really are and how things really work. Thus, in this study, embracing multiple realities, the researcher seeks to explore and determine the experiences of adolescents, their own understanding of their health status and their interactions with the members of the community and their fellow adolescents the relativist interpretive ontological position was assumed. This assumption views reality as subjective and varies from person to person (Scotland 2012:11).

Polit and Beck (2012:12) described the ontological stance paradigm as - reality is not a fixed entity but rather is a construction of the individuals participating in the research and it exists within a context and many constructions are possible. Therefore, in this research, embracing the multiple realities, the researcher sought to report the results are co-constructed understandings which were shaped by both the researcher and the study participants.

1.7.1.2 Epistemological stances of the study

According to Crotty (1998:8) epistemology is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate. Based on this definition, there are two types of epistemologies "objectivist versus constructivist epistemology" which are underlying the most academic research.

The objectivist viewpoint of epistemology claims that it is possible to discover objective truth. The objectivist epistemology claims, the data already exist in the world and the researcher discovers theory from them. According to Charmaz (2006:131) the constructivist epistemology typically rejects the objectivists' view of human knowledge; contending that there is no objective truth waiting to be discovered. Therefore, truth exists only through interaction with the realities of the world. This view assumes that meaning is constructed rather than discovered (Levy 2006:373). Constructionism, by definition, permits the researcher to explore the views and comprehension of the different participants within the subject context and recognises that each may have experienced a different understanding of the same situation (Charmaz 2006:130).

The constructivist researcher gets closer to participants to gather subjective evidence about the phenomena based on participant's views. The voices and interpretation of participants are crucial and subjective interactions are primary ways to access them (Creswell 2014:21; Polit & Beck 2012:12).

Making this two epistemological views into consideration and considering the context of this specific study perspective, the constructivist epistemology paradigm have been employed. Data collection was conducted in the participants' natural setting and the

researcher interacts with the study participants through conducting individual interviews; and exploring their subjective experiences of health.

1.7.1.3 Axiological position of the researcher

Qualitative researchers claim that the experiences of people are essentially context-bound, that is, they cannot be free from time and location or the mind of the human actor. Researchers must understand the socially constructed nature of the world and realise that values and interests become part of the research process. Complete objectivity and neutrality are impossible to achieve. The values of researchers and participants are an integral part of the research. Researchers are not divorced from the phenomenon under study. This means reflexivity on their part; they must take in to account their own position in the setting and situation, as the researcher is the main research tool. Language itself is context-bound and depends on the researchers' and informants values and social location. Detailed replication or duplication of piece of research is impossible because the research relationship, history and location of participants from study- to- study (Flick 2014:8).

The constructivist researcher believes that subjectivity and values are inevitable and desirable. In this study the researcher had planned to make his values known by what Creswell (2014:22) describes as "positioning himself". In reporting the study findings, the researcher declares the value-laden nature of the study, the information gathered, the researcher's own values and biases.

1.7.1.4 Methodological perspectives of the research

This section commences with the rationale for using grounded theory methodology in this study. Constructivists believe in employing qualitative analysis to gain an in-depth understanding of the phenomena under study. In this study, a grounded theory of a constructivist paradigm was followed. Theoretical and paradigmatic underpinnings of grounded theory were introduced. The grounded theory approach located within the constructivist paradigm has been applied with in this study and the process of data analysis followed Charmaz (2006:47). Grounded theory was outlined with an explanation of data methods and tools incorporated to this approach .Finally, the section would conclude by describing the criteria by which grounded theory research can be evaluated.

1.7.2 CONCEPTUAL FRAMEWORK

This study was guided by the following operational framework that has been developed by the researcher after reviewing extant literature that are assumed to be related to the health experiences of adolescents of rural settings.

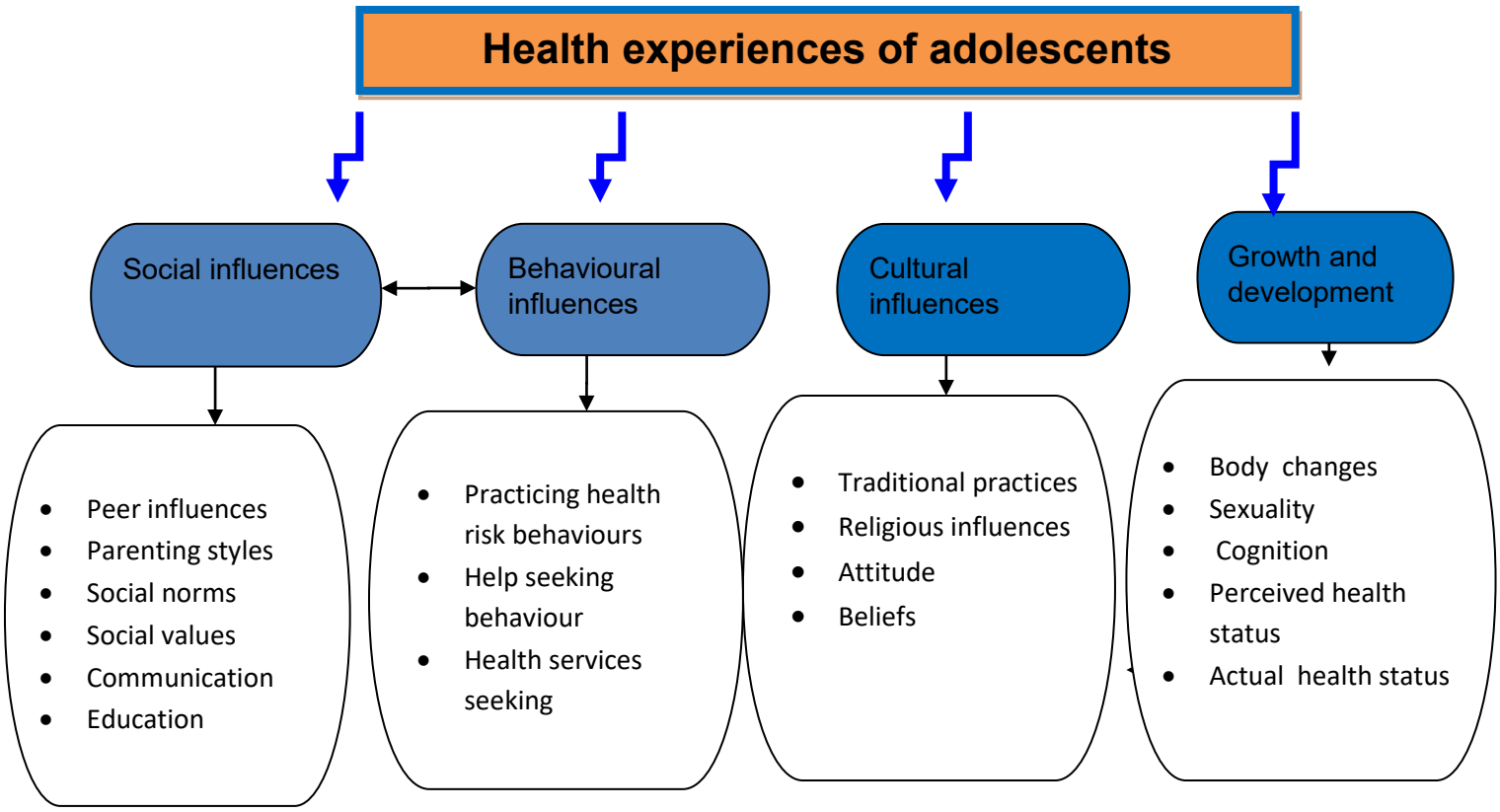

Figure 1.1: Preliminary operational framework developed by the researcher from literature reviews (Keribo 2019)

1.7.2.1 Social influences of adolescents health

The WHO Commission on the Social Determinants of Health defines the social determinants of health are defined by "the conditions in which people are born, grow, live, work and age. These conditions or circumstances are shaped by families and communities and by the distribution of money, power, and resources at worldwide, national, and local levels, and affected by policy choices at each of these levels (WHO 2008:95).

The health of adolescents is strongly affected by social factors at personal, family, community, and national levels. Nations present young people with structures of

opportunity as they grow up. Since health and health behaviours correspond strongly from adolescence into adult life, the way that these social determinants affect adolescent health are crucial to the health of the whole population and the economic development of nations. During adolescence, developmental effects related to puberty and brain development lead to new sets of behaviours and capacities that enable transitions in family, peer, educational domains, and in health behaviours. These transitions modify childhood trajectories towards health and wellbeing and are modified by economic and social factors within countries, leading to inequalities (Viner etal 2012:1641).

Risk behaviours in adolescents can lead to a lower quality of life and decreased opportunities to become a well-adjusted adult. Moreover, the consequences of these risk-behaviours may continue to complicate rural adolescents' lives with the incidents of teenage pregnancy, STDs, lower academic achievements and lower graduation rates in education and higher rate of dropping out of school. A comparative study among rural and urban adolescents' experiences of risk-behaviours shows, higher proportion of adolescents living in rural areas use drugs like cannabis than and begin consuming alcohol at earlier ages when compared to their peers in urban areas (Doolittle-Millmann 2015:26;Kumar, Kumar, Dewan ,Mengi & Razaq 2015:248).

The sources of influence on young people's health and development-for good or ill include but are not limited to internal psychological mechanisms, external educational institutions, the media, peer pressure and individual expectations for the future. Adults of both sexes from within the family and from extended family communities influence adolescents through dialogue or example, providing both positive and negative reinforcement. Role modelling and solicitation of favours in exchange for rewards also play a role in shaping behaviour, including sexual behaviour. At the same time, abuse by adults in positions of responsibility and influence over the lives of others, especially the young, is recognised as particularly compromising for personal development, sexual integrity and social stability (Venkatraman, Rena, Adaeze, Gwyn, Lakshmi, Sheena, Fran, Regina, Callie, Archana, Eva, Disha, Amy, Prateek, Arvind & Doortje 2013:3).

In low-income and middle-income countries, up to 33% of all lower secondary school age adolescents do not attend school compared with 4% in Canada, the United States of America, and Western Europe. Higher education participation is associated with

lower HIV prevalence, lower injury levels in both sexes, and fewer teenage births. Educational participation remains an important structural determinant after early childhood, protective against many new problems in adolescence, including health risk behaviours, teenage pregnancy, and injury deaths (Viner etal 2012:1644).

Adolescence is a second sensitive developmental period in which puberty and rapid brain maturation lead to new sets of behaviours and capacities that trigger or enable transitions in family, peer, and educational domains, and in health behaviours. These transitions modify childhood trajectories towards health and wellbeing. National wealth, income inequality, and access to education are among the strongest determinants of adolescent health and wellbeing. Furthermore, safe and supportive families, safe and supportive schools, together with positive and supportive peers, are crucial in helping young people develop to their full potential and attain the best health in the transition to adulthood (Sarah & Kathryn 2013:198).

Improving adolescent health worldwide requires improving young people's daily lives with families and peers and in schools, addressing risk and protective factors in the social environment at a population level, and focusing on factors that are protective across various health outcomes. The most effective interventions are probably structural changes to improve access to education and employment for young people and to reduce the risk of transport-related injury. Other crucial aspects are ensuring participation of young people in policy and service development, and building capacity in personnel and data systems in adolescent health (WHO 2015b:68).

Research evidences indicated that supportive communication between parents and children enables young people to make a safe and confident transition to adulthood. However, open and free discussion about reproductive health topics and overall health status of adolescents remains low in Ethiopia. Parents lack of essential skills how to communicate with adolescents regarding reproductive health topics and socio-cultural norms and traditions are the major barriers to make effective and all rounded discussion between parents and the young adolescents(Yadeta, Bedane & Tura 2014:6).

According to a multi-site study in Tanzania and South Africa, large proportions of adolescents reported that they never or hardly ever communicated about sexuality with their parents, other adult family members or with their teachers. The study also revealed

that in both the studied cities of South Africa and Tanzania a large proportion of girls were never or hardly ever" communicating with parents than boys (Namisi, Flisher, Overland, Bastien, Onya, Kaaya & Aaro 2009:1).

A qualitative evidence on adolescents' views of SRH in Sub-Saharan Africa friends, parents (especially mothers) and grandparents as the people with whom adolescents most commonly discuss sexual matters. However, in all the four countries included, many adolescents also mentioned that they were unable to talk with parents (especially fathers) about sexual issues because parents would shout, punish or beat them. In addition, adolescents are too shy to talk about such things with their parents, and it is culturally taboo or disrespectful to do so. The leaders of religious communities and institutions often encourage and sometimes demonstrate how individuals, families and communities can promote and protect health and provide a safe and supportive environment (Mary, Biddlecom, Ouedraogo & Vanessa 2005:6).

1.7.2.2 Behavioural influences of adolescents health

About 16 million adolescent girls between 15 and 19 give birth each year. Babies born to adolescent mothers account for roughly 11% of all births worldwide. Furthermore, 95% occur in developing countries. For some of these young women, pregnancy and childbirth are planned and wanted, but for many others they are not. Several factors contribute to this. Girls may be under pressure to marry and bear children early, or they may have limited educational and employment prospects. Some do not know how to avoid a pregnancy, or are unable to obtain contraceptives. Others may be unable to refuse unwanted sex or to resist coerced sex. Those that do become pregnant are less likely than adults to be able to obtain legal and safe abortions (WHO 2009:1).

According to a survey on 989 adolescents from 24 north-eastern Nigerian secondary schools adolescence is marked by progression from the appearance of secondary sexual characteristics to sexual and reproductive maturity. However, curiosity about bodily changes is heightened. Sexual behaviour and substance use and abuse become a major health concerns for the adolescents. They usually begin to demonstrate high-risk sexual behaviours including multiple sexual partners, initiating sexual behaviour at an early age and lack of condom use or birth control. Overall, the study also disclosed 84% of the adolescents indicated that they should be given sexuality education but only

48.3% had received and they told sexuality education should be provided for school-going adolescents through their preferred and reliable sources of information (Adeokun, Ricketts, Ajuwon & Ladipo 2009:15).

Adolescents in rural areas face at-risk behaviours at a higher rate when compared to their urban counterparts. Adolescents engaging in the at-risk behaviours experience, it can lead to dropping out of schools, teen pregnancy and contracting STDs. Impaired judgment from substances use such as alcohol or marijuana can create a multitude of problems for rural youth. Rural adolescents are exposed to significant risk factors such as isolation, early use of alcohol or drugs, and early exposure to sexual activities. Risky sexual behaviours are costly to not only the teens but to society and the health care system (Doolittle-Millmann 2015:9).

According to the centres for Disease Control and Prevention, birth rates among teens are higher in rural counties than in urban and suburban counties regardless of race/ethnicity. In 2010, the teen birth rate in rural counties was nearly one-third higher compared to the rest of the country (43 births versus 33 births per 1,000 females aged 15-19 years) (CDC 2015:13).

Rural adolescents have higher rates of alcohol consumption and are more likely to engage in risky sexual activity resulting in a higher likelihood of contracting an STD or HIV. Risk behaviours that lead to adolescent pregnancy can also lead to acquiring an STDs. Adolescents aged between 15 and 24 represent only 25 % of the sexually experienced population. However, adolescents in this age range acquire 50% of all new STIs (Kozhimannil, Enns, Blauer-Peterson, Farris, Kahn & Kulasingam 2015:20).

1.7.2.3 Cultural influences of adolescents health

A cross-sectional study in Harar Ethiopia shows significant proportion of parent-adolescent discussion about reproductive health was found to be low and is bound by traditional norms, lack of information, and limited skills of parents how to discuss and create supportive environment for adolescents. Most of the adolescents who participated in the study focus group discussions (FGDs) thought their parents have no knowledge about reproductive health issues and preferred discussing with their peers (Yadeta et al 2014:6).

A descriptive cross-sectional study in a rural Nigerian community revealed that high prevalence of early and unprotected sex, resulting in adverse reproductive health outcomes, has been reported among adolescents. The main content of parental sex education was HIV/AIDS prevention, avoidance of pregnancy, abstinence, and basic information about reproduction and biology. The same study also revealed that poor attitude to parental communication on sexuality was associated with a higher likelihood of pre-marital sex. Curiosity was the most common major reason for sexual debut. Promotion of parent-child communication about sexual issues is vital in order to improve the reproductive health of the adolescents (Asekun-olarinmoye, Dairo & Abodurin 2011:1).

The responsibility of parents to educate their offspring about the personal, physical and social aspects of sexuality, pregnancy, sex roles and sex-related matters, including STD prevention and management is a major concern in most societies and can be considered an obligation in many traditions. In situations in which both parents and traditional media fail to perform this duty, modern media may fill the gap, but not always in a health-promoting manner. The nature, timing and content of health education need to be discussed by religious, civic and community leaders and by parents, teachers and health professionals and with young people themselves (World Youth Report 2003:107).

Adolescents are generally reluctant to discuss intimate personal, SRH issues in the group but they feel free to talk about general health and nutrition related topics. Most adolescents expressed the need for a separate clinic run only by women doctors and were against combining such services with maternal and child health clinics (National Adolescence Health Information Center (NAHIC) 2005:6).

Gender inequality in a society contributes many health and social problems. Adolescent girls and boys, and their families and communities, should be challenged and supported to change inequitable gender norms. Gender and social expectations shape how adolescents think about themselves and others, and how they relate to members of the same and opposite sex. Deeply ingrained gender roles and unequal power relationships hinder the ability of girls and young women to refuse unwanted sex, negotiate condom use, make contraceptive choices, and discuss family planning and child spacing with their partners. Gender inequality also affects girls' and women's ability to seek and

obtain the health services they need, leaving many to face serious health consequences (Temin & Levine 2009:60).

1.7.2.4 Growth and development related influences of adolescents health

Recent advances in understanding the development of the adolescent brain show those there ward-seeking regions of the brain develop before the regions responsible for planning and emotional control. It is also now known that the adolescent brain has a remarkable capacity to change and adapt. This implies that the experimentation, exploration and risk-taking that take place during adolescence is more normative than pathological and that there is real potential to ameliorate negative developments that took place during the early years of life (WHO 2012:7).

The most readily recognised hallmark of adolescence is the pubertal metamorphosis orchestrating the visible transformation of a “child” into an “adult”. Adolescent physical growth and sexual maturation begin and unfold with significant variability influenced by a variety of factors including gender, race, body mass, environmental influences and overall health status (Stienberg 2014:83).

Many adolescents become sexually active before they know how to avoid unwanted outcomes of sex unwanted pregnancies and STIs. Peer pressure and pressure to conform to stereotypes increase the likelihood of early and unprotected sexual activity. In order to prevent early pregnancy, curriculum-based sexuality education must be widely implemented. These programmes must develop life skills; provide support to deal with thoughts, feelings and experiences that accompany sexual maturity and be linked to contraceptive counselling and services (WHO 2009:9).

According to a qualitative evidence of adolescents’ SRH experiences in selected districts of Malawi a significant proportion of the adolescents’ were knowledgeable about the body changes that happen to boys and girls during puberty. The growth of beards and pubic hair in males and the growth of breasts, the initiation of menstruation and the growth of pubic hair among females were mentioned more frequently than other body changes. Adolescents were more knowledgeable about body changes that occur in their sex than those occurring in the opposite sex. The majority, however, seemed not to be prepared for these body changes. In some cases, adolescents were unable to

properly describe the changes they were experiencing and sometimes even failed to attach a name to the changes they had experienced. Growth of beards, development of deep voices and growth of pubic hair were the most commonly known changes (Alister 2006:19).

1.8 RESEARCH DESIGN AND METHODS

In this study a qualitative research approach was employed. Grounded theory study following qualitative data collection procedures and analysis of the data were employed to explore and describe the health experiences of rural adolescents and their perceptions towards their own health. The study proceeded in two phases:

Phase I: The exploration of experiences and needs of the study population have been conducted. Qualitative data were collected using individual one-on-one interviews, observation and field notes.

Phase II: The development of a substantive grounded theory was inductively developed from the data. This was informed by the study findings from the Phase one. A full detailed description of this aspect was done in chapter five of the study.

1.9 SCOPE OF THE STUDY

The study involved adolescents of age 15 to 19 years in the rural South Eastern Ethiopia. Delimiting of the participants in terms of age and the geographic area considered provided that the study was of a manageable size. The fact that this study is qualitative a small sample was used. The population is from one District in the South Eastern part of Ethiopia, the findings do not let themselves to wider generalisation.

1.10 MOTIVATION OF THE STUDY

The purpose of this section was to show why the research questions raised in this thesis were of interest to the researcher. Different factors and perspectives motivated the study of health experiences of adolescents with respect to perspectives of adolescents in the rural setting.

The primary motivation for this study was a need to understand health experiences of adolescents in the context of rural areas. Insights in to local social factors, empirical implications of the study for the adolescents and personal drives were some of the motivators of the researcher to conduct the study in this area.

As a member of the rural community the researcher realised that there is a big health disparity between the urban and the rural adolescent population. Despite, initiatives made by governmental units and the major stakeholders to promote health of the adolescents; until now adolescents particularly adolescents of the rural setting are facing disproportionately many health problems. Health promotion and health risk prevention measures remain unfinished adolescent health concerns for all stakeholders.

A number of individual, social, community and cultural level factors are hampering health promotion and health risk prevention interventions. Therefore, the need for exploring the broad and lived health experiences of adolescents in the perspectives of rural community is justifiable.

The second motivation for the study is based on the current health and fertility situation in Ethiopia. Ethiopia is among the countries where unacceptably high fertility rates are recorded (Central Statistical Agency (CSA) Ethiopia 2016:77), most people survive on subsistence agriculture, children are valued for their labour as well as for the emotional and physical support they give parents, and many rural communities perceive large numbers of children as a social and religious advantage. Ethiopia's population is young. Over 50% of Ethiopia's population were under 18 in 2009. It is one of seven countries worldwide that account for half of all adolescent population (the others are Bangladesh, Brazil, the Democratic Republic of the Congo, India, Nigeria and the United States) (UNICEF 2011b:35). Owing to this fact, it is ethically and morally acceptable responsibilities to study the health experiences of adolescents to provide research evidence for policy designers and implementers able to make health promotion interventions targeting the adolescent population on research evidence.

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In the review of literatures related to the health experiences of adolescents, the researcher realised that there is a knowledge gap that helps to design the most effective interventions targeted towards solving the multidimensional health problems of the rural adolescents. In Ethiopia, many adolescents are still facing many health problems

including teenage pregnancy, unsafe abortion and STIs including HIV/AIDS. These health problems are unevenly huge in the rural context where lack of modern health facilities, economic and social problems, cultural and geographic discrimination is highly prevailing. However, there are no qualitative grounded theory studies conducted among rural adolescents in the study area where this study has been conducted.

The objectives of this study are systematic exploration and description of individual health experiences and perceptions towards health and how the adolescents socially constructed these experiences. Finally, developing and operationalising a substantive grounded model that helps to guide adolescents' health promotion interventions.

1.11 STRUCTURE OF THE THESIS

The structural outline for this study is organised into seven chapters. Each chapter presents a brief introduction on the central aspect of the chapter and ends with a conclusion:

Chapter 1: Orientation of the study

This chapter gives the introduction and background to the problem and the problem statement. It further describes the research purpose, objectives and significance. Terms to be used are described, the theoretical foundation of the study is discussed and a brief overview of the research design, methodology and scope of the study is provided.

Chapter 2: Literature review

In this chapter minimal literature review was made to avoid biasing the study. Both published and grey literatures on adolescent health experiences and health promotion were reviewed in order to locate and orientate what is already known about this issue and the knowledge gap this study fills. Available literatures on the topic were reviewed so as to evaluate the views of other researchers on the topic and to obtain deeper meaning and understanding of the current research topic. Theoretical foundation and the conceptual framework underpinning of the study are discussed. Thus, the

researcher assisted in contextualizing the study and in the overall guidance the research.

Chapter 3: Research design and method

In this chapter the study methods are explained, commencing with a discussion on the recruitment of the participants and the sampling approaches employed. Initially a purposive sampling method was undertaken but subsequently, the sampling method became theoretical in accordance with grounded theory principles.

The data collection methods and data collection procedures are also discussed along with the data analysis methods. Although the discussion separates data collection and data analysis, data collection and data analysis were actually conducted simultaneously. Data analysis commenced immediately following the completion of the first interview and continued until completion of the study; again following the grounded theory design. The chapter provides the reader a comprehensive picture of how the study initiative progressed. The research design and methodology, including setting, population and sampling methods as well as the data collection, data management and analysis plan of the study have been described. In addition, the measures to ensure trustworthiness of the data and ethical considerations are discussed in detail.

Chapter 4: Analysis, presentation and description of the research findings

Chapter 4 presents findings from the data and identifies the core process of the phenomenon under investigation. Contextual conditions which influence the experiences of adolescents and the core process was described. Qualitative data supported with direct verbatim quotations from the participants were explained.

Chapter 5: A substantive grounded theory

Based on the findings of the study, its theoretical basis and how it could be used in the promotion of adolescent health in the rural settings in Ethiopia was discussed.

Chapter 6: Discussion of the findings

This chapter provides interpretation and discussion of the findings presented in Chapter 4 and the theory presented in chapter 5. The discussion links literature review with the study findings.

Chapter 7: Conclusions and recommendations

This chapter contains an overall summary of the study, the implications of the study, recommendations derived from the findings, evaluation of the theory and the findings, and strengths and limitations of the study.

1.12 CONCLUSION

In this chapter an overview of the proposed research was presented. The background from a preliminary literature review provided the justification for conducting the study in the topic. The research problem statement, purpose and study significance are also explained. Theoretical foundations of the study were discussed and key terms identified and defined. Brief synopsis of the methodology to be used was described, with more detailed discussion to be found in the subsequent chapters.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The issue of the literature review in grounded theory remains debatable. Classic grounded theorists arguing that a literature review should not be conducted until after the analysis is completed (Glaser & Strauss 1967:261). The rationale for their argument for these early grounded theorists was based on the potential for forced theory or seeing data through the lens of earlier ideas (Charmaz 2006:165).

Glaser and Strauss's original pronouncement has been rejected by Layder (1998) and Dey (1999) as cited in Charmaz (2006:165). Glaser and Strauss are viewed by Layder (1998) and Dey (1999) as naively viewing the researcher as a *tabula rasa*, although in his treatise with Juliet Corbin, Strauss does make mention that there are no *tabula rasa* researchers as all researchers enter the field with underlying knowledge and experience (Strauss & Corbin 1998) as cited in Charmaz (2006:166).

According to Wanjohi (2014:36), literature review helps to provide a context for the research, justifies the research, ensure the research has not been done previously, shows where the research fits into the existing body of knowledge, enables the researcher to learn from previous theory on the subject, illustrate how the subject has previously been studied, highlight flaws in previous research, outline gaps in previous research, show that the work is adding to the understanding and knowledge of the field, help refine and refocus the topic.

A preliminary activity in this study was to conduct minimal review of the literature related to health experiences of the adolescents in the rural context. These reviews were undertaken to identify existing knowledge in the field and to provide a rationale for the conduct of the proposed research.

As a doctoral research student I was required to present a research proposal for candidature to be confirmed and a requirement of the proposal was a completed

literature review. There is also the requirement that a PhD thesis provides a significant original contribution to knowledge in the substantive area of the thesis and in an effort to identify an area where a dearth of knowledge exists, it was necessary to complete a literature review to identify knowledge gap in the extant literature.

Owing to the above mentioned reasons, minimal, both published and grey literature has been undertaken with regard to adolescent health and their health promotion. However, greatest possible caution has been taken not to force the data in the direction of extant literature. The researcher followed all the scientific principles of grounded theory to safeguard the study originality. The ways how the trustworthiness of the study findings maintained was clearly and explicitly explained in chapter three.

2.2 HEALTH EXPERIENCES OF ADOLESCENTS

Adolescence has often been portrayed as a period of stormy stress, but adolescents' can make an immense contribution to society if they are given proper support and space through handholding and informed interaction. The 1994 Cairo International Conference on Population and Development (ICPD) recognised adolescents and youth as 'the most important resource for future development' and made several recommendations to meet their multidimensional needs. It is clear that the most effective approach needed to serve the preventive and developmental needs of adolescents is one that is holistic in its design. Health promotion of adolescents is a relevant agenda for socio-economic development of the population, but the adolescents did not get sufficient attention (UNICEF 2006:17).

Adolescents are the most productive force of a country as they have unlimited energy, vitality and idealism and a strong urge to experiment and create a better world. With the life situation becoming more complex and challenging, there is a great need for the next generation to learn how to cope with change. Helping adolescents to acquire and practice the necessary life skills enables them to take on the challenges of life with confidence and courage and helps them to deal effectively with life's adversities and stressful moments with a sense of calm (Center Board of secondary education (CBSE) 2013:3).

Many assume that the low mortality rate among adolescents is an indication of their more than adequate health status. However, adolescents are suffering in addition to the traditional infectious illnesses and nutritional deficiencies to alcoholics, tobacco and drugs uses and are also experiencing new morbidities and mortalities from violence, self-destructive behaviours, injuries and addictions. Health professionals and the general public need to dismiss the myth that adolescents are overwhelmingly healthy and move proactively to provide them with the attention and services they so desperately need (WHO 2014:14).

Across-sectional study among adolescent students in rural schools of North Western Ethiopia found that generally the awareness of HIV was higher among the study participants; but only few have a correct knowledge of the HIV and its modes of transmission. Knowledge of HIV and correct and consistent condoms use was also lower among the students. Knowledge of STDs was generally low: 82% of adolescent males and 37% of adolescent females had some awareness of STDs. In the same study, a large proportion of the students had previously treated for STDs and almost all of whom had sexual contact with a commercial sex worker (Alene, Wheeler & Grosskurth 2004 :1).

2.3 ADOLESCENTS HEALTH AND HEALTH RELATED INFLUENCES

In this section several topics were covered. Topics such as peer influences, adolescent parenting, adolescents' health seeking behaviours, cultural influences and adolescent health risk practices.

2.3.1 Peer influences

As children become teenagers, peers take over much of the role of parents as a source of social reference. Adolescents spend most of their time with their peers and the friendships and alliances they form tend to be very strong. Peers and peer relationships are believed to play a key role in adolescent behaviour in general and health related practices. Typical for adolescence is the emergence of peer groups consisting of adolescents who share a certain lifestyle. This lifestyle is often represented in a particular music preference, clothing style, or leisure time activity (Verkooijen 2006:8).

According to a qualitative research conducted in Cape Town, South Africa on peer influences on adolescents', a number of unhealthy norms among a group of young males and females were recognised. The norms undermine the ABCD(Abstain, Be Faithful, use Condom and Delayed Sexual Activity) messages of HIV prevention initiatives and are promoted by intense peer pressure Belonging to a group norm is an important part of adolescence and deviation leads to discrimination. Many youth conform and engage in high-risk sex in order to have access to a group. Not only do boys put pressure on each other to be sexually active, but young girls influence their female peers and boys to engage in sex (Selikow, Ahmed, Flisher, Mathews & Mukoma 2009:110).

Peer influence or peer pressure is a term describing the pressure exerted by a peer group's in encouraging a person to change their attitude, behaviour and/or morals, to conform to, for example, the group's actions, fashion sense, taste in music and television, or outlook on life. Sometimes it means doing something with your friends or in front of your friends to impress them. In the other ways it means a tendency of unacceptable behaviour is normalised. This means, begin to think it is acceptable to do something simply because your peers do it. Sometimes it is positive if friends convince their friends to act wisely, through example or advice. If the peer pressure involves sex, alcohol or drugs, this increases the risks of acquiring HIV/AIDS and other STDs (Abraham, Yifru & Dejene 2014:151).

2.3.2 Adolescents parenting

A study conducted in USA revealed that adolescents who were closely monitored by their parents were more likely than their peers who were not well- monitored by their parents to demonstrate low sexual risk-taking behaviours (to have had only one sexual partner and to use a condom).In the same study 20% of respondents reported their parents "never" or "rarely" monitored their whereabouts; 46% said they were monitored "sometimes," and 34% reported experiencing parental monitoring "a lot" or "always." Fifty-eight percent of the respondents were classified their parenting styles as authoritative parenting and 42% as non-authoritative parenting (Huebner & Howell, 2003:74).

An integrative literature review in USA indicated that adolescents raised in authoritative households consistently demonstrate higher protective and fewer risk behaviours than adolescents from non-authoritative families. There is also considerable evidence to show that parenting styles and behaviours related to warmth, communication and disciplinary practices predict important mediators, including academic achievement and psychosocial adjustment. Careful examination of parenting style patterns in diverse populations, particularly with respect to physical activity and unintentional injury, will be a critical next step in the development of efficacious, culturally tailored adolescent health promotion interventions (Newman, Harrison, Dashiff & Davies 2008 :1).

A qualitatively exploratory study conducted in Dar es Salaam, Tanzania on parenting styles and practices indicated that parenting practices are highly important predictors of adolescent sexual health. The themes developed from the data in the mentioned study were parental monitoring, preventive, and punitive behaviours. Finally, the study revealed that parents of adolescents were mostly use punitive behaviours to correct or prohibit sexual behaviour; setting clear rules about appropriate sexual behaviour (e.g., modesty and abstinence). Parents were also reported to closely monitor their adolescent children's friendships and sexual behaviour to minimise sexual behaviour (Kajula, Darling, Kaaya & De Vries 2016:1).

2.3.3 Adolescents help seeking behaviour

A study conducted on African American adolescents in the United States of America shows most often adolescents discuss their problems with their family and often received divergent messages about problem resolution. In addition, absent informal network resolution of their problems, professional help would be sought, and those receiving treatment were more likely to get support from friends but were less likely to tell friends that they were actually receiving care (Lindsey, Korr, Broitman, Bone, Green & Leaf 2006. 2006:1). Children are dependent on adults to recognize their problems, determine whether they require services, and seek help on their behalf. Although parental perception of problems plays a key role in determining service use, few parents express their concerns in primary care consultations (SayaL, Tischler, Coope, Robotham, Ashworth, Day,Tylee & Simonoff 2010:476)

In a study conducted in Israeli adolescents' willingness to seek help was evaluated with respect to themselves and others, for both severe and minor problems. Adolescents were more willing to refer another person than themselves to most of the sources of support. Girls were more willing than boys to seek help from their parents and friends. Actual help-seeking behaviour was positively related to willingness to seek help from various sources of support (Amiramraviv 2000:1).

A study conducted in United Kingdom revealed that gender, challenge appraisals, and emotions were significant predictors of the degree to which child and adolescent victims of peer-aggression and bullying sought help. The study also indicated that girl adolescents were more likely than boys to seek help, as well pupils with high challenge appraisals or those experiencing high levels of negative emotion. The same study also shows girl adolescents were more likely than boys to view support as the best strategy for both stopping bullying and for helping themselves to feel better (Hunter, Boyle & Warden 2004:1).

2.3.4 Health care seeking practices

A study conducted in South Africa on adolescents visiting STDs clinics revealed that facilitation of early health care seeking is critical in curbing the threat of AIDS and STDs among adolescents. Fifty six percent of the study participant adolescents sought health care within the first six days of noticing symptoms, 23% waited between 7 to 10 days and 21% waited longer than 10 days before seeking health care. Early health care seeking was determined by perceived seriousness of STDs, an absence of self-treatment prior to seeking care and positive attitudes regarding personal autonomy in condom use behaviour (Meyer-Weitz, Reddy, Van Den Borne, Kok & Pietersen 2000:6).

Health-seeking behaviours are defined as accessing medical services. Higher proportions of males than females reported seeking healthcare. The services most commonly sought at medical clinics were predominantly because of flu-like symptoms followed by concerns about HIV and AIDS. Relative to males, a significantly higher proportion of females desired general healthcare services, counselling and reproductive health services. Adolescents reported a gap between the availability and the need for general, reproductive, and counseling services (Otwombe, Dietrich, Laher, Hornschuh, Nkala, Chimoyi, Kaida, Gray & Miller 2015:1).

Research results demonstrate that adolescent mothers are significantly more disadvantaged in terms of health care seeking for maternal and child health services and face even more challenges during pregnancy and early motherhood compared to adult mothers. Adolescent mothers are more likely to drop out of school owing to pregnancy, less likely to earn a salary, and more likely to attend ANC fewer times compared to adult mothers. Adolescent's mothers are also more likely to experience violence from parents, to be rejected by the partner, and to be stigmatized owing to their pregnancy in their early age. In early motherhood, adolescent mothers are less likely to seek for second and third vaccine doses for their children compared to adult mothers (Atuyambe, Mirembe, Tumwesigye, Annika, Kirumira & Faxelid 2008:5).

2.3.5 Adolescents health risk practices

Risk taking is common and expected in adolescence. Across the lifespan, adolescence is the time of greatest risk taking. While understanding or even over-estimating the likelihood that an action will result in harm, adolescents may place higher value on the benefits that might come from taking a particular risk. Moreover, adolescents' are more responsive to the rewards of risk (such as peer approval), may be less sensitive to feeling the ill effects of substance use (such as hangovers), and are still developing the capacities for judgment and self-control (Chick & Reyna 2012:408).

Ecological theory recognises that adolescent behaviour is shaped by the environmental contexts in which they live—the family, home, school, and community. Adolescents' health promotion can be more successful when all stakeholders bring social transformations to reduce social, cultural and economic factors that make individuals vulnerable to health problems. Promoting healthy behaviours from relying on individual level models to broader based ecological perspective is needed to amplify and extend the efficacy of health risk reduction interventions of adolescents (Brindis & Moore 2014:344).

Adolescence is a sensitive period with respect to substance use. Engagement in smoking, alcohol, and other drug use increases dramatically during this phase in life. Although increased risk taking is a normal part of growing up and becoming an adult, it also makes young people vulnerable to serious health damage. Acute health problems

may result from substance-induced accidents, violence, unsafe sex, or unwanted pregnancies (Verkooijen 2006:18).

Adolescents are more likely than older or younger individuals to engage in risky behaviours, such as drinking alcohol, taking illegal drugs, having unprotected sex, engaging in delinquent activity, and driving recklessly. Most of the adolescents are relatively healthy, but there is still significant death, illness and diseases among adolescents. Illnesses can hinder their ability to grow and develop to their full potential. Alcohol or tobacco use, lack of physical activity, unprotected sex and/or exposure to violence can jeopardize not only their current health, but often their health for years to come (Taghizadeh, Bahreini, Ajilian, Fazli & Saeidi. 2016:1423).

Adolescents mentally weigh risks against perceived benefits. When risks are engaged in “only once or twice” the odds of committing the risk behaviour appears favourable. Adults, in contrast, they do not proceed down the slippery slope of trading off serious risks (such as dying in a car accident) against immediate rewards (such as approval of peers), and their choices are better as a result (Wargo 2007:2).

2.3.6 Cultural influences and adolescents health

Whether or not adolescence is formally recognised as a distinct stage of life, virtually all cultures distinguish between young people and adults. Furthermore, most cultures institutionalise a period of preparation for adulthood that may be analogous to adolescence as we know it. Despite some uniformity, however, the structure and content of the adolescent period varies markedly from culture to culture in ways that reflect broader social and institutional patterns (Crockett 2010:111).

A qualitative study in Kenya indicated that cultural practices, like adolescent sleeping arrangements, night funeral ceremonies, replacement of a deceased sister in marriage, widow inheritance, early marriage, and preference for boys contribute to risky sexual behaviours that predispose adolescents to teenage pregnancy and STI/HIV infection. Adolescent health risk reduction programmes should be developed considering the specific cultural context, using strategies that empower communities to challenge the widely accepted cultural norms that may predispose young people in to health risks. Poverty exacerbates risky cultural practices. Therefore, prevention interventions should

target poverty and risky cultural factors such as adolescents' sleeping arrangements, participation in night funeral gatherings, sister replacement, early marriage and preferential treatment of boys over girls (Juma, Askew, Alaii, Bartholomew & Van den Borne 2014:7).

2.3.7 Adolescents body changes

Body image is the dynamic perception of one's body how it looks, feels, and moves. It is shaped by perception, emotions, physical sensations, and is not static, but can change in relation to mood, physical experience, and environment. Because adolescents experience significant physical changes in their bodies during puberty, they are likely to experience highly dynamic perceptions of body image (Singh, Ashok, Binu & Parsekar & Bhumika 2015:1).

Body image is influenced strongly by self-esteem and self-evaluation, more so than by external evaluation by others. It can, however, be powerfully influenced and affected by cultural messages and societal standards of appearance and attractiveness. Given the overwhelming prevalence of thin and lean female images and strong and lean male images common to all westernised societies, body image concerns have become widespread among adolescents (Ruffin 2009:3).

Adolescence is one of the most rapid phases of human development. Although the order of many of the changes appears to be universal, their timing and the speed of change vary among and even within individuals. Both the characteristics of an individual (e.g. sex) and external factors (e.g. inadequate nutrition, an abusive environment) influence these changes (Gupta 2011:12).

Over the course of the second decade, adolescents develop stronger reasoning skills, logical and moral thinking, and become more capable of abstract thinking and making rational judgments. Changes taking place in the adolescent's environment both affect and are affected by the internal changes of adolescence. These external influences, which differ among cultures and societies, include social values and norms and the changing roles, responsibilities, relationships and expectations of this period of life (Taghizadeh etal 2016:1425).

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

According to (McLeod 2001) people can never achieve a complete 'scientific' understanding of the human world. The best possible means that can be done is attempting to reach on the truth that makes a difference and opens up new ways for understanding the reality found in the world (McLeod 2001:4).

According to Creswell (2009:176) qualitative research is an inquiry process of understanding based on distinct methodological traditions on inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports details of informants, and conducts the study in a natural setting' (Creswell 2009:176).

According to Guba and Lincoln (1990) as described in Khan (2014:225) qualitative research is based upon the observations and interpretations of people's perception of different events and it takes the snapshot of the people's perception in a natural setting (Khan 2014:225).

Qualitative research is a means of looking at and better understanding of life's rich tapestry to reach insights into the human heart and mind. Qualitative research approach follows an inductive process; it builds theory, moving from observations and open questions to more general conclusions (Ulin, Robinson & Tolley 2005:38).

This study followed the qualitative, constant comparative method of grounded theory, which entails that the project begins with an area of interest, rather than a preconceived theoretical perspective (Glaser & Strauss 1967:104). Qualitative approaches to data collection, analysis, interpretation, and report writing differ from the traditional, quantitative approaches. Purposeful sampling, collection of open-ended data, analysis of text or pictures, representation of information in figures and tables, and personal interpretation of the findings all inform qualitative methods (Creswell 2014:23).

According to Flick (2014:8) qualitative methodology is not completely precise, because human beings do not always act logically or predictably. Researchers in qualitative inquiry turn to the human participants for guidance, control and direction throughout the research. Structure and order are, of course, important for the research to be scientific. The social world, however, is not orderly or systematic. Therefore, it is all the more important that the researcher proceeds in a well-structured and systematic way.

The researcher in this particular study practiced social constructionist principles to provide a contextualised understanding of experiences of participants within a non-oppressive setting. The methodology applied to this particular project is the principles of grounded theory, a type of qualitative research, to explore health experiences from the perspective of rural adolescents in Ethiopia.

Phases of the research project

This research was undertaken in two phases.

Phase I

In the first phase of the research the researcher systematically reviewed minimal existing literature to explore what is already known about health experiences of adolescents and study any gaps in literature
The researcher collected analysed and interpreted qualitative data. In this phase the researcher attained the first two objectives:

- To explore and describe lived health experiences of adolescents in rural South East, Ethiopia
- To investigate the perceptions of the adolescents regarding their own health in rural South East Ethiopia

Phase II

In the second phase of the research, the researcher developed a substantive grounded theory and discussed the new theory against theories in the literature.

In this phase the researcher attains the third objective that is developing a grounded substantive theory grounded on the responses of the participants.

3.2 RESEARCH DESIGN

According to Creswell (2009:18) a qualitative approach is one in which the inquirer often makes knowledge claims based primarily on constructivist perspectives (i.e., the multiple meanings of individual experiences, meanings socially and historically constructed, with an intent of developing a theory or pattern) or advocacy/participatory perspectives (i.e., political, issue-oriented, collaborative or change oriented) or both. It also uses strategies of inquiry such as narratives, phenomenologies, ethnographies, grounded theory studies, or case studies. The researcher collects open-ended emerging data with the primary intent of developing themes from the data.

According to Mohajan (2018:41) qualitative methods are useful when attempting to explore and understand the socio-cultural context of peoples' experiences and assess the specific beliefs and perceptions that influence behaviour. The different qualitative approaches and their characteristics are discussed in the table 3.1.

Table3. 1Characteristics of qualitative research approaches

Characteristics	**Narrative**	**Phenomenology**	**Grounded theory research**	**Ethnography**	**Case study**
Focus	Exploring the life experiences of an individual	Understanding the essence of experience	Developing theory grounded on data	Describing and interpreting a culture sharing group	Developing in-depth description and analysis of a case or multiple cases
Type of problem best suited for the design	Needing to tell stories of individual experiences	Needing to describe the essence of a lived phenomenon	Grounding a theory in the views of participants	Describing and interpreting shared patterns of culture of a group	Providing an in-depth understanding of a case or cases
Discipline background	Drawn from humanities including anthropology, literature, history, psychology ,and sociology	Drawn from philosophy, psychology, and education	Drawn from sociology	Drawn from anthropology and sociology	Drawn from psychology, law, political science, medicine
Unit of analysis	Studying one or more individuals	Studying several individuals that have shared the experience	Studying a process, action, or interaction involving many individuals	Studying a group that shares the same culture	Studying an event, a programme, an activity, more than one

					individual
Data collection forms	Using primarily interviews and documents	Using primarily interviews with individuals, although documents, observations and art may be considered	Using primarily interviews with 20-60 individuals	Using primarily observations and interviews but perhaps collecting other sources during extended time in field	Using multiple sources such as interviews, observations, documents artefacts'
Data analysis	Analysing data for stories, "restoring" stories, developing themes often using a chronology	Analysing data for significant statements, meaning units, textual and structural description of the "essence"	Analysing data through open coding, axial coding, selective coding	Analysing data through description of culture sharing group; themes about groups	Analysing data through description of the case and the themes of the case as well as cross case themes
Written report	Developing a narrative about the stories of an individual's life	Describing the essence of the experience	Generating a theory illustrated in a figure	Describing how a culture sharing group works	Developing detailed analysis of one or more cases

(Adapted from Khan 2016:226)

3.3 GROUNDED THEORY: THE METHODOLOGY

Grounded theory was originally developed by two sociologists; Barney Glaser, a quantitative researcher and Anselm Strauss, a qualitative researcher in the 1960s. They were unhappy about the way in which existing theories dominated sociological research. They argued that researchers needed a method that would allow them to move from data to theory, so that new theories could emerge. Such theories would be specific to the context in which they had been developed. They would be 'grounded' in the data from which they had emerged rather than rely on analytical constructs, categories or variables from pre-existing theories. Grounded theory, therefore, was designed to open up a space for the development of new, contextualised theories (Charmaz 2006:6).

Grounded theory is rooted in social sciences, best defined as a research strategy whose purpose is to generate theory from data. Grounded theory is not a theory at all; it is a method, an approach, a strategy. 'Grounded' means that the theory will be generated on the basis of data. The theory will therefore be grounded on data. 'Theory' means that the objective of collecting and analysing the research data is to generate theory. The essences of grounded theory are that theory will be developed inductively from data. The emphasis in the grounded theory research design is developing a theory based on systematically collected, analysed and interpreted data Glaser and Straus(1967) as cited in (Khan 2016:227).

According Polit and Beck (2008:229,230), the focus of grounded theory is exploration of evidences from the participants of the study and making continuous comparative analysis to produce a theory that explains why people behave in a certain ways. In grounded theory both the research problem and the process used to resolve it; is discovered during the study.

3.3.1 The various schools of thoughts of grounded theory

Grounded theory has two different perspectives. Objectivist grounded theory is rooted in post-positivist epistemology; whereas constructivist grounded theory has its roots in an interpretive tradition and relativism. The Glaserian approach is an objectivist grounded theory and based on *etic* position, where the researcher is separate from and looks at the social realities. On the contrary, the Straussian approach is a constructivist

grounded theory and based on *emic* position, where the researcher co-constructs the data through adopting a position of mutuality and partnership between participant and researcher. In the straussian grounded theory, theory is created using the social process of the participants own perspectives, values, privileges, interactions and understanding of the social realities (Taghipour 2014:100). The research design for this particular study is grounded theory.

3.4 STUDY SETTING AND POPULATION

According to Polit and Beck (2008:221) research setting for qualitative research is a real world, in natural settings. Qualitative research data can be collected in multiple sites and multiple settings. The study setting for this particular research is in rural Bale Zone, Oromia Region, South Eastern Ethiopia. Bale Zone is found in Oromia Regional State at around 430 kilo meters away from Addis Ababa the capital city of Ethiopia in the South Eastern direction.

According to Kombo and Tromp (2006:76) a population for a particular research is the entire group of individuals, objects or items that have at least one characteristic in common and it is from this group that samples are taken for measurement. The study population for this particular study were purposely selected adolescents in the age group of 15-19 years and residents of the rural areas of the Bale Zone Oromia Region Ethiopia.

3.5 THE SAMPLE SIZE AND RECRUITMENT OF THE STUDY PARTICIPANTS

According to Mason (2002:144) as cited in Thomson (2011:49) qualitative methods are usually used when the object of study is some form of social process or meaning or experience which needs to be understood and explained in a rounded way, rather than by attempting to understand, for example, causal patterns by analysing connections between static or snapshot variables. Therefore, decisions about whether or not you have included the ‘right’ number of participants depends on thinking about what it is that you need to compare, and the extent to which the sample you have generated will enable you to do the aim of the research

There have been various suggestions for what is considered to be an appropriate sample size for grounded theory studies. A systematic review conducted to characterize the sample size sufficiency in qualitative studies, identified qualitative studies conducted using as few as six interviews and significant variation in the number of sufficient sample size considered. Finally, the review recommended that data adequacy is best appraised with reference to the features that are specific to the study context at hand and saturation (Vasileiou, Barnett,Thorpe & Young 2018:155).

According to Charmaz (2006) as cited in Creswell (2014:239) data collection in grounded theory research is stopped data when the categories (or themes) are saturated: gathering fresh data no longer sparks new insights or reveals new properties. While, Creswell (2014:239) recommends the sample size in qualitative studies depends on the qualitative design being used. From his experience of review of many qualitative research studies he have found narrative research to include one or two individuals; phenomenology to typically range from three to ten; grounded theory, twenty to thirty; ethnography to examine one single culture-sharing group with numerous artefacts, interviews, and observations; and case studies to include about four to five cases.

In the current study Individual interviews were conducted with purposely selected adolescents in the study setting. A total of twenty five (25) adolescents volunteered to participate in the study and given written consent after being informed in detail about the study. Though information saturation was met on the 20th participant, the interviews were deliberately continued up until the 25th participant to ensure information richness.

In an effort to ensure an adequate pool of participants, all the adolescents who are the permanent residents of Bale Goba District were identified as potential participants and were invited to participate in the study. An invitation to participate in the study was made by home to home visit by the researcher in the identified study site and identification of the participants address was done for further contact during home-to-home visit in the study site. At the time of home-to-home visit consent was obtained from both the parents/guardians and the participants.

To avoid any anxiety of a participant owing to immediate interview the researcher and the participant negotiated for the date and time of the actual interview. Potential study participants were addressed giving consideration to age and sex ratio of the

participants. From each group 15-19 years two male and three female adolescents were voluntarily recruited for the study.

Owing to the time lapse between the invitation to participate and the negotiated date and time for actual interview, all of the participants in the latter stages of the study were contacted by telephone to determine if they were still willing to be part of the study. All participants who had initially consented were subsequently able to be contacted all of the previously consented participants willing to participated in this study and interviewed.

3.6 THE PROCESS OF SAMPLING

The process of sampling in qualitative research in general and grounded theory as part of qualitative approach uses non-probability sampling, where the sample numbers or data sources are unknown at the commencement of the study (Glaser & Strauss 1967:45; Strauss & Corbin 1990:8). In accordance with the prescription of Glaser and Strauss (1967:45), Strauss and Corbin (1990:8) and Charmaz (2010:406) the sampling then becomes theoretical, rather than purposive, in that the sampling is determined by the emerging categories and the theory.

The need for theoretical sampling is initiated during constant comparative analysis of the initial data at hand. Theoretical sampling cannot be predetermined by the researcher. Afterwards, the researcher is ready to sort and integrate memos on theoretical categories. However, the purpose of theoretical sampling varies; depending on the initiator of the stages of further data collection was open, axial or selective coding (Lawrence & Tar 2013:32).

Glaser (2002:8) proposes that the use of constant comparative method, the requirement for saturation of the data and also the linking of the sub-categories to the core category, all reduce the potential bias associated with this sampling method. However, owing to the nature of the data; being so closely linked to the participants in the study and their experiences of health in the rural setting, the findings of this study are not generalisable to the wider body of adolescent population.

Therefore, theoretical sampling refines, elaborates, and exhausts conceptual categories. Theoretical sampling prompts the researcher to retrace the steps or take a new path when the researcher has some tentative categories and emerging, but incomplete ideas. By going back into the empirical world and collecting more data about the properties of category, the researcher can saturate its properties with data and write more memos, making them more analytic as the study proceed (Charmaz 2006:98).

This study used purposive sampling to access adolescents who had a diversity of educational, social and cultural backgrounds. Purposive sampling was used in the initial stages of the sampling to recruit and secure participation. Participation was entirely based on the willingness of the participants. Diversity of the participants in terms of demographic attributes (age, sex, levels of education) and geographic settings was considered for the initial purpose sampling. The use of a purposive sampling allowed the researcher to select participants for the initial interview. The information obtained in the initial stages of the interview was used to guide the future theoretical sampling and areas of additional data collection requirement to ensure information richness.

3.7 DATA COLLECTION METHODS AND PROCEDURES

According to Creswell (2009:175) in qualitative studies the researcher is a key instrument. Qualitative researchers collect data themselves through examining documents, observing behaviour, or interviewing participants. They may use a protocol-an instrument for collecting data-but the researchers are the ones who actually gather the information. They do not tend to use or rely on questionnaires or instruments developed by other researchers. Grounded theorists shape and reshape their data collection and, subsequently, refine their collected data (Charmaz 2006:15).

Charmaz (2006:15)proposes that research methods are merely tools, with some of these tools being sharper than others in a given context. While a method provides the researcher with a “tool" to enhance what is being seen, Charmaz (2006:15) points out that methods alone do not generate good research and astute findings, let alone provide some magical insight into the data that is collected. Through the use of grounded theory methods, the researcher is able to adopt a flexible approach to data collection rather than be constrained by a rigid prescription of methods. This allows the emergent data to guide future data collection strategies in accordance with the direction

that the data is taking. This flexibility of methods has resulted in grounded theory researchers collecting data through the use of a wide variety of data collection methods (Charmaz 2006:15).

According to Holloway (2011:41) if the aim of the qualitative interview is to learn 'what is important in the mind of informants their meanings, perspectives, and definitions; how they view, categorise, and experience the world, interview method is the better method of qualitative of data collection. Qualitative interviews give participants the opportunity to describe experiences in detail and to give their perspectives and interpretations of these experiences. Interview methods provide an opportunity for the researcher and the participants to construct or reconstruct their daily lives and experiences.

According to Charmaz (2006:18) grounded theory studies are based on intensive interviewing and the key elements that should be considered before conducting the interview include:

- Participants who are selected for the interview have to be with first-hand experience and fit the research topic
- In-depth exploration of participants' experience and situations is required
- Reliance on open-ended questions
- Objective of obtaining detailed responses
- Emphasis on understanding the research participants' perspective, meanings and experience
- Practice of following up on unanticipated areas of inquiry, hints and implicit views and accounts of actions.

Owing to the above advantages interview method of qualitative data collection was used for this particular research. Interview guide was developed and used keeping flexibility in structure of conversation with the study participants. The initial semi-structured interviews were carried out with each participant individually, in a private room (without the presence or interference of others) in the rural health post. The interviews lasted between approximately 30 to 50 minutes and were audio-recorded.

3.8 DATA MANAGEMENT AND ANALYSIS

Data analysis in qualitative research particularly grounded theory follows an inductive approach. A type of reasoning that begins with study of a range of individual cases and extrapolates patterns from them to form a conceptual category. In addition, data analysis is a method of conducting qualitative research that focuses on creating conceptual frameworks or theories through building inductive analysis from the data. Hence, the analytic categories are directly 'grounded' in the data. The method favours analysis over description, fresh categories over preconceived ideas and extant theories, and systematically focused sequential data collection over large initial samples. This method is distinguished from others since it involves the researcher in data analysis. While collecting data-we use this data analysis to inform and shape further data collection. Therefore, the sharp distinction between data collection and analysis phases of traditional research is intentionally blurred in grounded theory studies (Charmaz 2006:187).

Data processing and analysis was done following the principles of grounded theory method. Data collection and data analysis was done simultaneously. Data analysis was begun immediately after completing the first one–on–one face-to-face interview. The researcher transcribed the interviews. The interviews were loaded in the computer and the audio files made play hearing using earphones. Using play pause button transcripts were typed on the computer Microsoft office word. The first-hand transcription of the interviews provided the opportunity for familiarity with the data. Transcripts and field notes collected were translated to English for writing. Detailed textual narration of each categories themes and subthemes has been done.

Audiotaped transcripts were set into texts to facilitate coding. During coding process (Charmaz 2006:102-103) steps of coding in grounded theory studies (initial coding, focused coding, axial coding and selective coding) were followed. The collected data (field notes and audiotaped transcripts) were systematically organised to address the research objectives. Each emerging categories, themes and subthemes were supported by direct verbatim quotations and scientific explanations were given discussing with the extant literature.

To ensure accuracy of the transcriptions, interview audios were replayed while re-reading the text transcripts of the interviews. This approach further assisted the researcher to become fully immersed in the data. Memo writing and constant comparative analysis was also utilised throughout the study.

3.8.1 Memoing

This is an important part of the grounded theory method. Throughout the process of data collection and analysis, the researcher maintains a written record of theory development. This means writing definitions of categories and justifying labels chosen for them, tracing their emergent relationships with one another, and keeping a record of the progressive integration of higher- and lower-level categories. Memos assisted the researcher in showing up changes of direction in the analytic process and emerging perspectives, as well as provide reflections on the adequacy of the data to answer research question (Charmaz 2008:72).

In the current research memos were taken beginning from the initial data collection stage throughout the data analysis. The memos assisted the researcher in indicating the direction of category development and indentifying the core category of the research question. The researcher also utilized the memos to identify the categories that need for theoretical sampling.

3.8.2 Constant comparative analysis

In grounded theory research constant comparison is fundamental and refers to ongoing comparisons among data, codes and categories. The researcher used constant comparative method to develop concepts from the data by coding and analysing at the same time.The constant comparative method combines systematic data collection, coding, and analysis with theoretical sampling in order to generate theory that is integrated, close to the data, and expressed in a form clear enough for further testing. Constant comparative methodology incorporates four stages: (1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory and (4) writing the theory. Throughout the four stages of the constant comparative method, the researcher continually sorts through the data collection, analyses and codes the information, and reinforces theory generation through the

process of theoretical sampling. The benefit of using this method is that the research begins with raw data; through constant comparisons a substantive theory emerges (Sharon 2012:83).

With this task in the current study, the researcher is engaged in the following comparisons:

- Sets of data within the same interview;
- Data of different interviews;
- Initial codes within the same interview;
- Initial codes between different interviews;
- Data and initial codes of the same interview;
- Data and initial codes between different interviews;
- Codes with codes of the same interview;
- Codes with codes of different interviews; and
- Codes with themes and subthemes
- Themes and subthemes with emerging categories

3.8.3 The overall steps followed during data analysis (Creswell 2014:209)

3.8.3.1 Step one: organising and preparing data for analysis

This step involves transcribing interviews, optically scanning material, typing up field notes, cataloguing all of the visual material, and sorting and arranging the data into different types depending on the sources of information.

3.8.3.2 Step two: reading through all the data

This step provides a general sense of the information and an opportunity to reflect on its overall meaning. What general ideas are participants saying? What is the tone of the ideas? What is the impression of the overall depth, credibility, and use of the information?

3.8.3.3 Step three: coding

- **Initial coding**

Coding is the process of organising the data by bracketing chunks (or text or image segments) and writing a word representing a category in the margins. It involves taking text data or pictures gathered during data collection, segmenting sentences (or paragraphs) or images into categories, and labelling those categories with a term, often a term based in the actual language of the participant called an *in vivo* term (Creswell 2014:248).

- **Focused coding**

The next stage of coding after initial coding is focused coding. Since, grounded theorists compare data with data focused coding takes the comparative process a step further. Here, researchers use the most frequent, and/or the most significant to answer research objectives and to sort and synthesise the data. Hence, focused coding prompts researchers to scrutinize data through the lens of selected initial codes and thus, puts these codes to test (Charmaz 2010:410).

- **Axial coding**

There are differences in the ways in which grounded theory researchers approach the coding process. For most grounded theorists, initial open coding involves the generation of largely descriptive labels for occurrences or phenomena. Such labels give rise to low-level categories. To establish linkages between such categories and to integrate them into higher-order analytic categories, we can use a coding paradigm. A coding paradigm sensitizes the researcher to particular ways in which categories may be linked with one another. It helps us to arrange our categories in a meaningful and hierarchical way, with some categories constituting the 'core' and others the 'periphery' (Charmaz 2006:57).

Strauss and Corbin (1990:13) propose the use of a coding paradigm that explicitly focuses upon, and thus alerts the researcher to, manifestations of 'process' and 'change' in the data. This is done by asking certain questions of the data. These include questions about the context within which a category is embedded, the interactional strategies used by participants to manage the category, and the consequences of such

interactional strategies. Strauss and Corbin (1990:14) refer to this process as 'axial coding'.

- **Theoretical coding**

Theoretical coding is the "process of integrating and refining the theory" (Charmaz 2006:63). It involves the identification of the core category or the major theme of the research from which the theory emerged. According to Straus and Corbin (1990:14) the core category is central with all other categories subsequently becoming subcategories and frequently appearing in the data. The core category is identified asking questions such as: what are the main analytic ideas presented in this research? If my findings are to be conceptualized in few words, what do I say? What does all the action/interaction seem to be about? How can I explain the variation that I see between and among the categories? The core category may emerge from the categories that are already developed or more abstract term may be used to explain the main phenomenon. The other categories always stand in a relationship with the core category as conditions, action/interactions or consequences.

3.8.3.4 Step four: description of themes generated from codes

According to Creswell (2014:209) in this step description of the small themes developed from the code concepts about people, places, or events in a setting is made. The descriptions usually display multiple perspectives from individuals and are supported by diverse quotations and specific evidence. In this research this step has been conducted in describing the subthemes developed from the codes of the data and direct verbatim quotations were used as an evidence of the concept.

3.8.3.5 Step five: representation of the themes

In this step the qualitative researcher makes detailed narration on the themes developed from the data. In this step qualitative researcher makes narrative passages to convey the findings of the analysis on the subthemes, specific illustrations, multiple perspectives from individuals, and quotations) or a discussion with interconnecting themes. In addition to the detailed textual narration, the findings of the analyses are usually displayed using visual diagrams and tables. In this research the findings of the

analyses are presented using detailed textual narration of the subthemes, themes and the categories. Comparing and contrasting of the findings of the analyses is also made giving a scientific argument in support of the concepts or against the concepts. The categories and the theory developed from the analyses are also displayed using visual text oval, tables and figures.

3.8.3.6 Step six: Interpretation of the findings

This is the final step in qualitative data analyses and where qualitative researchers interpret their findings. The findings of the recent research may confirm past information or diverge from it. The findings can also suggest new questions that need to be asked – the questions raised from the data and analysis may be that had not foreseen earlier in the study. Finally, qualitative researchers using a theoretical lens, they can form interpretations that call for action agendas for reform and change.

In this research the interpretation of the findings were made after making a detailed discussion on the findings against the theories and literatures. Based on the findings of the data and analyses the researcher forwarded the needed reforms and changes for the improvement of the adolescents health in general and rural adolescents' in particular.

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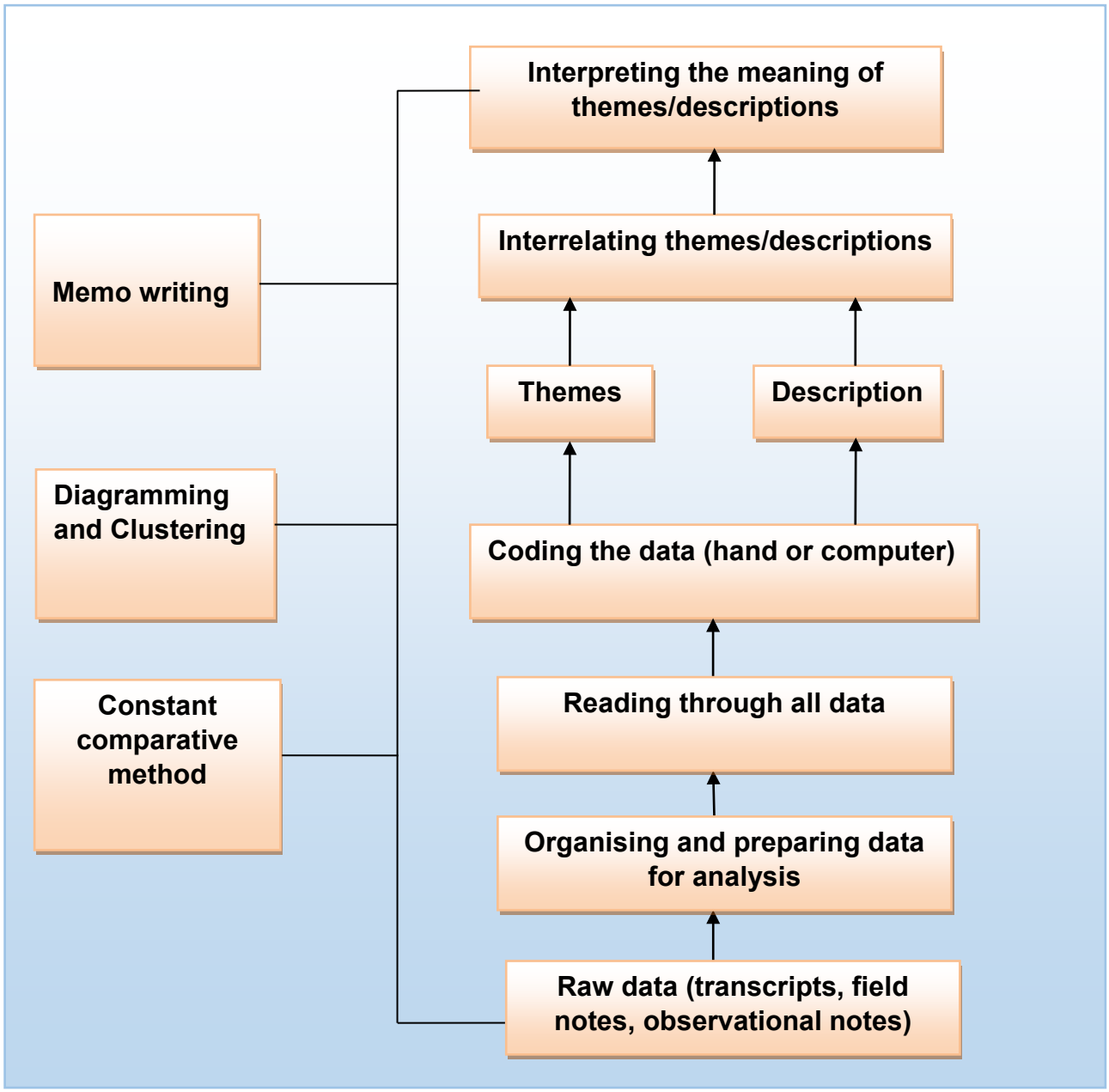

Figure 3.1: A visual presentation of the data gathering and analysis procedures (adapted from Creswell 2014:247).

3.9 ASSURANCE OF TRUSTWORTHINESS OF THE STUDY

Objectivity and truthfulness are critical to both research traditions whether it is qualitative or quantitative. However, the criteria for judging qualitative studies differ from quantitative studies. First and foremost, the qualitative researcher seeks believability, based on coherence, insight and instrumental utility and trustworthiness through a

process of verification rather than through traditional validity and reliability measures (Creswell 2014:256).

Trustworthiness is the degree of confidence that qualitative researchers have in their data and it is assessed using the criteria of credibility, transferability, dependability and conformability. The basic issues in relation to trustworthiness are questions that need to be answered such as: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked) that would be persuasive on this issue? (Lincoln & Guba 1985:290).

In determining the trustworthiness of qualitative grounded theory studies, researchers must follow strictly grounded theory methods during data collection, analysis, and interpretation of the data. Qualitative researchers need to give sufficient evidence to answer questions asked regarding trustworthiness of the study. The criteria's to ensure trustworthiness of the include: The extent to which the study accurately captures the perceptions of the participants (credibility) and whether other researchers would reach similar conclusions based on the data if repeated in the same context and same population (dependability).Furthermore, questions were asked to the analysis process is flexible enough to account for variations in experiences (flexibility); and the degree that study elements were sufficiently described to allow for comparison to other populations and study findings(transferability) (Anney 2014:275-279).

3.9.1 Credibility of the study

Credibility is a criterion for evaluating integrity and quality in qualitative studies. The ability of the study to capture what the research really aimed at studying, meaning that the results are not simply the product of research design errors, misunderstandings, or influence of unknown factors. The goal of maintaining credibility in qualitative research is to demonstrate that the enquiry was conducted in such a manner as to ensure that the subject has been accurately identified and described. It refers to confidence in the truth of the data and in the interpretation (Polit & Beck 2012:751). The following strategies employed to ensure the credibility of this study. Practical application of the criteria is shown in (Table 3.2)

3.9.1.1 Prolonged engagement

Prolonged engagement is the investment of sufficient time to achieve certain purposes: learning the "culture" testing for misinformation introduced by distortions either of the self or of the respondents, and building trust. First and foremost the researcher must deal with personal distortions. The mere fact of being a stranger in a strange land draws undue attention to the inquirer, with attendants' overreaction. Because of misconstruction of researchers questions the respondents may give normatively appropriate things or simply not being motivated to address the researcher concern fully. The period of prolonged engagement is intended to provide the investigator an opportunity to build trust (Anney 2014:276; Billups 2014:2). In this study the interviews were done taking varying contacts with the participants for one year.

3.9.1.2 Triangulation

Triangulation is a technique used to increase the trustworthiness of qualitative research (Lincoln & Guba, 1985:315). Triangulation refers to the process of comparing results from different sources, or gathered using different methods, to validate findings. In the present study, diversified participants in terms of their age, sex, education and geographic settings were included and their experiences were compared for similarities and differences (Anney 2014:277).

3.9.1.3 Referential adequacy

Referential adequacy is testing the analysis and interpretation against the documents that were used during data collection before producing the final document (Lincoln & Guba, 1985:313).

3.9.1.4 Peer debriefing

Researchers state that soliciting feedback from others is an extremely useful strategy for identifying validity threats, your own biases and assumptions, and flaws in your logic and methods. It is a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inqulry that might otherwise remain only implicit within the inquirer's mind (Lincoln & Guba,

1985:308).A peer debriefer was part of the current study. A peer debriefer was served several roles throughout the data analysis and interpretation stages including coding data, providing feedback on interpretations, and being a sounding board for the researchers' emerging insights and concerns. The peer debriefer was provided background information about the study and grounded theory methodology. After becoming familiar with the raw data, provided feedback on category lists and participated in category coding of all data during the open coding process. In axial coding, the debriefer reviewed selected passages for the main categories and provided feedback on the emerging theory. Finally, the debriefer reviewed an outline of the final draft of the theory and provided feedback on the linkages and interrelatedness between the theory proposed and the data provided by participants.

3.9.1.5 Negative case analysis

Negative case analysis involves the conscious search for data that do not fit the current working hypothesis, within existing data as well as in planned data collection. This ensures that the researcher continues to develop the emerging theory in the light of the evidence. Having identified a category, or a linkage between categories, grounded theory researchers need to look for 'negative cases' – that is, instances that do not fit (Willing 2008:36). In the current research the identification of such instances allowed the researcher to qualify and elaborate the emerging theory, adding depth and density to it, so that it was possible to capture the full complexity of the data on which the theory was founded.

3.9.1.6 Member Checks

Member checking is an activity that entails bringing back the results to the members of the studied group. Maxwell (1996) as it is cited in (Willing 2008:37) states that member checking, or soliciting feedback from participants, is the single most important way of ruling out the possibility of misinterpretation of the meaning of what they say and the perspective they have on what is going on. In the current project, each adolescent participant received the recorded transcripts of the interview. Additionally, participants were sent a list of the main ideas as interpreted by the researcher and asked to review whether their views were accurately and appropriately described.

Table3. 2 Strategies to achieve the principle of credibility

Principle	Stages of implement ation	Strategies to achieve the principle	Purposes of the strategy	Practical application of the strategy in the current study
Credibility	Research design	Purposive sampling	To involve as many experiences as possible until thematic saturation is reached and to include negative cases	- Purposive sampling and deliberate probing during the interviews has been done to ensure saturation of information and to include negative cases.
		Time sampling	To sample all possible situations, different social settings; times of day, week, and season; and interactions among different social groupings to see how research participants interact with one another in a number of contexts at different times. This strategy emphasizes the importance of the environment in which the data are collected in seeking to establish credibility.	- Data collection was done at varying the date and time of the interview. - Different data source adolescents were recruited and interviewed. - Geographic disparities was addressed by conducting the study in rural setting - The research data was collected adolescents in their natural setting

		Reflexivity	To assess the influence of the researcher's own background, perceptions, and interests on the research process	- Field notes taken during interviews reflecting researcher's feelings, thoughts, experiences and observations were carefully captured - Analysis of reflective notes was done in personal journal or memo - The researcher honestly and scholarly presented the data as original as possible.
	Data collection	Prolonged engagement in the field	To identify reappearing patterns/ themes and to build rapport	- Adequate time was spent in the field with the participants(one year) - Trust and mutual understanding was developed between the participants and the researcher
		Persistent observation	To observe phenomenon under scrutiny in the natural context	- The researcher made repeated visits to the study site that provided the researcher the chance to realise the natural experience of the participants about the phenomenon under investigation
		Peer debriefing	To discuss data and interpretation with colleagues	- The entire research process has been discussed with researchers, fellow PhD students and the supervisor at all stages. The entire process has been explicitly

				exposed to a colleague debriefer and he has been providing feedbacks on the research process and analysis of the data.
	Data analysis	Triangulation (methods, sources, researchers, theories)	To cross check data and interpretation	- In the current research the source of data are triangulated in consideration of different factors like age, sex, geography, educational status
		Negative case review	To constantly revise the hypothesis against all the texts until it accounts for all of the cases	- The researcher consciously made a search for elements of the data that do not support or appear to contradict patterns or explanations that are emerging from data analysis. - Based on the data element that found contradiction the emerging explanations were revised or broaden to confirm the patterns emerging from data analysis. - Negative case analysis also used as a means to generate for theoretical sampling
		Referential adequacy	To test the analysis and interpretation against the documents that were used	- Code recode approach was employed to ensure this dimension

			during data collection before producing the final Document	
	Writing ups	Structural coherence	To ensure coherent structure of the story line and that there is no unexplained inconsistencies between the data and their interpretations	- The researcher carefully write the idea giving much attention for logical sequence of stories told by the participants - consulting research supervisor for any deviation - Discussion of the results with colleagues
		Member checking	To constantly check the data analysis and interpretation with informants	- The results of the study given to the participants for clarity and verification of information if there is any deviation in interpretation by the researcher or if the participants mistakenly gave the information during the interview. - Formal and informal discussion of the findings with participants
		Using quotes	Using quotes To check the interpretation against verbatim accounts	- Direct verbatim quotes were used to support the categories and subcategories.

(Adapted from Johnson and Rasulova 2016:16)

3.9.2 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents – it is the interpretive equivalent of generalisability (Anney 2014:277) .Practical application of the criteria in this study is shown in table 3.3

3.9.2.1 Purposive Sampling

In contrast to random sampling that is usually done in traditional rationalistic studies to gain a representative picture through aggregated qualities, naturalistic researcher seeks to maximise the range of specific information that can be obtained from and about that context by purposely selecting locations and informants from many diverse contexts. Qualitative researchers frequently use purposive sampling as a method for extending knowledge through deliberately seeking sample participants who are known to be rich sources of data. Therefore, obviously this increases the possibility for transferability of the research results to the same context and the same population groups (Mason 2002:138).

3.9.2.2 Theoretical Sampling

As Fassinger (2005:162) notes," one of the hallmarks of grounded theory approach is the use of theoretical sampling". Theoretical sampling occurs concurrently with data analysis that has commenced immediately upon receipt of the data; the introduction of new data is directed by the gaps, unanswered questions, and underdeveloped ideas in the emerging theory. The point of theoretical sampling is to explicate and verify the categories and their interrelationships that are gradually emerging through the coding process. In addition, theoretical sampling seeks to refine the theoretical ideas and the value of early data analysis lies in its capacity to probe the emerging theory with specific cases or incidents that will lead to greater clarity, density comprehensiveness, and explanatory capacity of the theory. The underlying assumption is that sampling will cease when categorical/theoretical saturation is reached implies an avoidance of oversampling, that is, unnecessary redundancy in the data owing to excessive numbers of observations or participants (Anney 2014:278).

3.9.2.3 Thick description

Although data collection and analysis strategies are more or less similar across qualitative researches, the ways the findings are reported are diverse. Narrative texts are the most frequent forms of results presentation in qualitative studies. Qualitative researches are naturalistic studies. Therefore, the results are presented in descriptive, narrative form rather than as a scientific report. The final results of the project become a construction of the informant's experiences and the meanings they attach to them. Thick description is the most important vehicle for communicating a holistic picture of the experiences of the participants. More importantly, this allows the readers to see the clear picture of the experiences of the research participants' and helps them to explicitly judge if results can be transferred to other populations of interest (Creswell 2014:260).

Transferability of a naturalistic study depends on the extent to which the researcher collects sufficiently detailed descriptions of context sensitive data in the field and reporting the data with sufficient detail and precision to allow judgments about transferability to be made by the reader (Billups 2014:3).

In the current study detailed information about how the participants were recruited for the study and the criteria for participation was clearly discussed. After interviews, summary field notes were taken that included a review of the information provided by the participants, as well as researchers' reflections regarding the interviews.

Table3.3 A principle of transferability and strategies to achieve it

Principle	Stages of implement ation	Strategies to achieve the principle	Purposes of the strategy	Practical application of the strategy in the current study
Transfera bility	Design	Purposive Sampling	To include participants who are known to be rich sources of data for the issue under scrutiny	In the current study, adolescents of the rural setting were purposely sampled. In Ethiopia majority of the adolescents live in the rural areas this uplifts the transferability of the findings to other same population and settings. Though, unlike, to quantitative studies transferability of qualitative study findings is up to the reader.
		Theoretical sampling	To search for as many different cases as possible until new themes stop emerging	With the use of constant comparative method and memoing the researcher continuously monitored the gaps that require further data and theoretical sampling. Constant comparison was done on data with data, data with codes, codes with codes and codes with categories.
	Writing ups	Thick description	To give detailed information about the research participants, contexts and settings	Detailed explanation has been made on the methodology Detailed description the of the categories,

				themes and subthemes was done.

(Adapted from Johnson and Rasulova 2016:25)

3.9.3 Dependability

An inquiry must also provide its audience with evidence that if it were replicated with the same or similar respondents (subjects) in the same (or a similar) context, its finding would be repeated. Dependability of the study answers the questions “Are the findings stable and consistent over time and across conditions?” “Would the same data collection methods yield the same or similar results?” Ensuring that the same research process generates the same essential findings often depends on external audits, these audits (also known as inquiry audits) are an important strategy for feedback, to assess the truthfulness of preliminary findings (Billups 2014:3).

Dependability is to ensure consistent data collection without unnecessary variations to ensure repeatability of the research process. This is about being able to trace sources that the data comes from and about documenting the data, methods and decisions made during the fieldwork. Therefore, consistency in the entire research process is the key for achieving dependability. This criterion is suggested to be closely linked to credibility and be equally important for qualitative research. Establishing dependability ensures credibility. Although the strategies used to prove these two principles could be similar, their meanings are different.Credibility is about ‘accurate representation of experience while dependability focuses attention on the researcher as instrument and the degree to which interpretation is made in a consistent manner (Baxter& Eyles 1997:517). The practical application of the criteria in the current research is shown in Table 3.4

Table3.4 A principle of dependability and strategies to achieve dependability

Principle	Stages of implement ation	Strategies to achieve the principle	Purposes of the strategy	Practical application of the strategy in the current study
Dependa bility(con sistency or explicabili ty of findings)	Data collection	Low inference descriptors, mechanically recorded data	To check the level of 'agreement' between data and its interpretation through checking the field notes, quotations, and other narratives.	Descriptions very close to the participants have been used. Researcher's accounts of field notes were analysed. Direct verbatim quotations were used to present the participants idea as original as they provided.
		Audit check	To ensure that qualitative methodology was adequately followed, and that the emergent theory is grounded in the data.	An audit entails reviewing a trail of documentation created by the researcher. A peer auditor was included to audit the process and the product of this study. The auditor was provided with all raw and coded data, and emerging versions of codes and the theory.
		Inquiry audit	Checking between researchers' to check the process of the research in terms of relevant	The entire research process is done in consultation with the research supervisor. Beginning to the end all the possible

			decision making done along the way as well as introducing alternative perspectives in data analysis prior to finalizing the set of theoretical constructs.	alternative ways of study designing, participant selection, data collection and analysis and the final theory development were discussed with the research supervisor
		Thick description of methods	To generate the clearer picture of the research for the readers	Detailed descriptions of methods including their purposes, limitations, order of using them, matching them with research questions have been conducted.
	Data analysis	A stepwise replication technique	Teams or researchers work separately on the data and compare results	The supervisor of the thesis closely followed the overall thesis process. A colleague of the researcher was invited to code the portion of the data and cross checked by codes that are made earlier by the researcher
		Referential adequacy	A researcher codes a segment of data and checks its coding after a while	Constant comparative method that is back and forth with data and codes was employed from the beginning to the end of the research process Code agreement was checked by recoding of the data after a week

	Writing up	Writing up	Colleagues check the research plan and implementation	The research supervisor closely followed implementation of the research plans

(Adapted from Johnson and Rasulova 2016:23)

3.9.4 Confirmability

Confirmability is the extent to which biases, motivations, interests or perspectives of the inquirer influence interpretations. The two most important practices to ensure confirmabilty are: confirmabilty audit and reflexivity (Johnson & Rasulova 2016:20).Table 3.5 shows practical application of the confirmability criteria in this study.

3.9.4.1 Confirmabilty audit

Lincoln and Guba (1985:283) state that the audit may be the single most important trustworthiness technique available to the naturalist. An audit entails reviewing a trail of documentation created by the researcher to ensure that qualitative methodology was adequately followed, and that the emergent theory is grounded in the data. A peer auditor was included to audit the process and product of this study. The auditor was provided with all raw and coded data, and emerging versions of codes and the theory. The researcher and auditor met throughout the data analysis and interpretation process to discuss concerns and insights and to review audit trail materials.

3.9.4.2 Reflexivity

Reflexivity pertains to the analytic attention to the researcher's role in qualitative research. It is both a concept and a process. As a concept, it refers to a certain level of consciousness. Reflexivity entails self-awareness, which means being actively involved in the research process. It is about the recognition that as researchers, they are part of the social world that they study. Reflexivity as a process is introspection on the role of subjectivity in the research process. It is a continuous process of reflection by researchers on their values and of recognising, examining, and understanding how their social background, location and assumptions affect their research practices (Hesse-Biber & Piatelli 2007:17).

The key to reflexivity is to make the relationship between the influence of the researcher and the participants explicit. This process determines the filters through which researchers are working including the specific ways in which our own agenda affect the research at all points in the research process. However, this does not mean limiting what one can know about social realities. The researcher’s position does not exist

independently of the research process nor does it completely determine the latter. Instead, this must be seen as a dialogue – challenging perspectives and assumptions both about the social world and of the researcher himself. This enriches the research process and its outcomes (Palaganas 2017:427).

Table3.5 A principle of Confirmability and strategies to achieve it

Principle	Stages of implement ation	Strategies to achieve the principle	Purposes of the strategy	Practical application of the strategy in the current study
Confirma bility	Data collection	Audit trail	To follow through the progression of events and decisions made as well as the product, data, findings, interpretations to arrive at comparable findings	The supervisor followed the entire research process beginning to the end A colleague auditor was included to audit the process and product of this study. The auditor was provided with all raw and coded data, and emerging versions of codes and the theory.
		Field notes, reports, journal/notebook	.To keep the entire research related data available	All the notebooks, journals or a log of everyday events and incidents were taken as a memo during the fieldwork
	Data analysis	Reflexivity	To show the extent to which the researchers biases influenced the results	The researcher reflects on the researcher's thoughts, feelings, and assumptions clearly on the reflexivity section in the research.

(Adapted from Johnson and Rasulova 2016:21)

3.10 ETHICAL CONSIDERATIONS

The approval to conduct the study was sought from several ethics committees before commencement of data collection. The University of South Africa (Unisa) research Ethics Committee reviewed the study proposal and granted ethical clearance (Annexure A). Thereafter, the research proposal was sent to the Oromia Regional Health Bureau, where the regional health research review committee reviewed the proposal and approved its compliance with ethical standards before granting permission to conduct the study (Annexure C). Permission and approval was also sought from the Bale Zonal Health Department presenting the attached Unisa ethical clearance and Oromia Regional Health Research Ethical Review Committee permission letter (Annexure E).

Based on the permission of regional health research ethical review committee, zonal health department granted permission and written letter of permission to District health office for final permission of the study and cooperation for successful completion of the study (Annexure F).

3.10.1 Informed consent

An informed consent form encapsulated the explanation of the purpose and benefits of the study. Accordingly, informed written consent was obtained from each participant and their parents or guardians. The participants were told that they have the right to respond fully or partially to the interviews or refuse to participate at all in the study. Study participants were assured that all the information they given would be used for research purposes only. Finally, Participants were asked for their willingness of participation in the study.

3.10.2 Privacy and Confidentiality

Participant's right to both privacy and confidentiality was protected. The interview was conducted in a private room during data collection. No names or person's identification was reflected on the records of data, only codes were used. Participants were informed that the findings of the study would not be published or disclosed for any other third party for any purpose without their consent.

3.10.3 Autonomy

Autonomy means that every person has got the right to self-determination. This implies that an individual has the right to decide whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Brink, van der Walt & van Rensburg 2012: 35).

Participants were assured of freedom to refuse to participate in research study or if agreed they may withdraw from the research study without any penalty. The decision to participate in the study was entirely in voluntary (Brink et al 2012: 35). The participants were also assured that they have the right to refuse to participate or give information even after signing informed consent form.

3.10.4 Beneficence

The researcher assured he have the responsibility to secure the well- being of the participants who have the right to protection from discomfort and harm, be it psychological, spiritual, emotional, economic or legal (Brink et al 2012: 35). Questions and probing were asked in a way that does not emotionally hurt the participants. Participants' culture were also respected by being non-judgmental towards them for any information the participants are providing.

3.10.5 Justice

Fairness to all participants will be practiced and promises will be fulfilled e.g. the researcher will stick to agreed time for meeting as promised. The potential participants will be assured that their names will not be mentioned anywhere in the research project. Anonymity will be ensured by allocating each participant with a code name and their identity will remain anonymous, their responses and records will be kept confidential. Any other person who is not part of the research project was never accessed the information discussed during the study (Brink et al., 2012: 36).

3.11 CONCLUSION

This chapter described the methodological underpinnings of the study. The qualitative research approach was discussed with emphasis on how it would be used to answer the research questions. The sampling procedures and selection criteria for participants, data collection instruments used and how ethical issues were handled were clearly described. In this chapter, the researcher also gave attention on how the study trustworthiness was ensured in order to maintain the integrity and transferability of the findings of the study.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

In the previous chapters the researcher introduced the study, elaborated the research design and the methods that were used in the conduct of the research. In this section the researchers every effort focused on presenting the research findings and giving intellectual interpretations for the results that emanated from the data. During the data analysis the researcher focused on the processes, actions or interactions that constituted the participants' experience of health.

In this chapter the research findings from the data and the identified emergent categories will be presented. The presentation of the findings will start with the demographic presentation, followed by categories, themes and sub-themes. The identified major categories include: adolescence sensitive health intermediaries, health related Information and communication in adolescence, health challenges faced by adolescents, social and cultural perspectives of adolescents health, suggested health promotion strategies. The interactions and intersection of these categories resulted in the identification of the core category. This was labelled as "improved health information and communication during adolescence for better adolescents' health outcomes". After detail explication of the categories which were emergent from the data, this chapter will steps up with the development of the substantive theory commencing with an explanation of the categories and their associated properties around the core category.

4.2 DEMOGRAPHIC PROFILE OF THE STUDY PARTICIPANTS

The mean age of study participants was 17 years with the standard deviation of 1.44years. From the total of 25 study participants 15 (60%) of the participants were females while the rest 10 (40%) were males. As to the educational status of the respondents' higher proportion 15(60%) attended primary education followed by 10 (40%) have attended secondary education. There is a clear indication from the findings

that adolescents in rural settings start primary school later than their urban counterparts. In this study greater than eighty percent 21 (84%) of the participants were Oromo in Ethnicity followed by 4 (16%) were Amhara ethnicity. Fifteen (60%) of the participants subscribed to the Islam religion followed by 7 (28%) Orthodox Christianity followers and 3 (12%) were protestant Christians (Table 4.1).

Table4. 1 Demographic profile of participants

Participant code	Age	Sex	Education	Religion	Ethnicity	Marital status
Participant A	15	M	7th	Muslim	Oromo	Single
Participant B	15	M	6th	Muslim	Oromo	Single
Participant C	15	F	5th	Muslim	Oromo	Single
Participant D	15	F	7th	Orthodox	Amhara	Single
Participant E	15	F	6th	Muslim	Oromo	Single
Participant F	16	M	8th	Muslim	Oromo	Single
Participant G	16	M	7th	Orthodox	Amhara	Single
Participant H	16	F	8th	Protestant	Oromo	Single
Participant J	16	F	7th	Orthodox	Amhara	Single
Participant K	16	F	7th	Orthodox	Oromo	Single
Participant L	17	M	9th	Protestant	Oromo	Single
Participant M	17	M	8th	Muslim	Oromo	Single
Participant N	17	F	10th	Muslim	Oromo	Single
Participant O	17	F	9th	Muslim	Oromo	Single
Participant P	17	F	9th	Muslim	Oromo	Single
Participant Q	18	M	10th	Orthodox	Oromo	Single
Participant R	18	M	10th	Orthodox	Oromo	Single
Participant S	18	F	7th	Muslim	Oromo	Single
Participant T	18	F	7th	Muslim	Oromo	Single
Participant U	18	F	7th	Muslim	Oromo	Single
Participant V	19	M	10th	Muslim	Oromo	Single
Participant W	19	M	11th	Orthodox	Amhara	Single
Participant X	19	F	12th	Muslim	Oromo	Single
Participant Y	19	F	8th	Protestant	Oromo	Single
Participant Z	19	F	10th	Muslim	Oromo	Single

4.3 CATEGORIES, THEMES AND SUB-THEMES

Five major categories and 14 themes were emerged from the data in the current study. The five major categories emerged from the data include adolescence sensitive health intermediaries, health-related Information and communication in adolescence, health challenges faced by adolescents, social and cultural perspectives of adolescents health and suggested health promotion strategies. The 14 major themes identified are adolescence related changes, sexual and adolescence, adolescents perception of own health, audiences of adolescents communication, frequent topics of communication, barriers of communication, health risk experiences, sexual health challenges during adolescence, perceived foundations of adolescents health, social influence, cultural practices, health sector, government and parental support. The categories, themes and subthemes are illustrated in detail in the (Table 4.2)

Table4. 2 Summary of categories, themes and sub-themes describing the health experiences of adolescents of rural South East Ethiopia

Categories	Themes	Sub-themes
1. Adolescence sensitive health intermediaries	1.1. Adolescence related changes	1.1.1. Age
		1.1.2. Gender
		1.1.3 Physical body changes
		1.1.4 Cognitive changes
	1.2. Sexuality in adolescence	1.2.1. sexual desires in adolescence
		1.2.2. Changing affiliations in adolescence
		1.2.3. building new relationships
	1.3. Adolescents perception of own health	1.3.1. current health status
		1.3.2. awareness of the value of health
		1.3.3. Benefits of improved adolescents health
		1.3.4. Consequences of lack of health
2. Health related Information and communication	2.1. Audiences of adolescents communication	2.1.1 parents
		2.1.2 peers
		2.1.3 sexual partner

in adolescence	2.2. Frequent topics of Communication	2.2.1. Overall health conditions
		2.2.2. Delaying sex/abstinence
		2.2.3. Risk of teenage pregnancy
		2.2.4. HIV/AIDS
	2.3. Barriers of communication	2.2.1. Cultural barriers
		2.2.2. Societal taboos
		2.2.3. Fear
		2.2.4. shame
3. Health challenges faced by adolescents	3.1. Health risk experiences	3.1.1. Substance and alcohol use
		3.1.2. Violence
		3.1.3. HIV/AIDS risk
	3.2. Sexual health challenges during adolescence	3.3.1. Awareness of sexual health
		3.3.2. perceived benefits of sexual health
		3.3.3. Adolescent pregnancy
		3.3.4. Societal conceptions regarding early marriage
4. social and cultural perspectives of adolescents health	4.1. Perceived foundations of adolescents health	4.2.1. Family
		4.2.2. Neighbours
		4.2.3. Schools
	4.2. Social influence	4.2.1. Peer pressure
		4.2.2. Religion
		4.2.3. Education
		4.2.4. Societal Values
	4.3. Cultural practices	4.3.1 Traditional practices
		4.3.2 Maintaining tradition
		4.3.3 Against cultural norm behaviour and consequences
5. Suggested health promotion strategies	5.1. Health sector	5.1.3. Health care workers
		5.1.2. Health facilities
		5.1.3. Improving awareness of health risky behaviour
		5.1.4. Adolescent friendly services
		5.1.5. Promoting help seeking

		behaviour
	5.2. Government	5.2.1. Adolescent policies
		5.2.2. Need based health projects
		5.2.3. Keeping adolescents in schools
		5.2.4. Enforcement of adolescent health protection laws
	5.3. Parental support	5.3.1. Follow ups of adolescents
		5.3.2. Parenting styles
		5.3.3. Family structure

Following the principles of constructivist grounded theory the major categories, themes and subthemes identified in the current study are drawn from participants' responses. All of the reported results were derived inductively from the study participants. Each quotation is labelled with the participant's code as follows: "Participant A" first participant to "Participant Z" the last participant. All the English alphabets were used to code the participants except the letter "I". The letter "I" was left to avoid the confusion as the letter sometimes may refer to the researcher and sometimes it may refers to the participants. Fortunately, the number of participants was 25 and that has matched with the rest of letters as participant's code.

4.3.1 Category one: adolescence sensitive health intermediaries

This is the first major category inductively developed from the participant responses. The category mainly addressed participant responses of that explain attributes that particularly influence adolescents' health and how the participants relate the identified attributes to their health. The category comprised three basic themes of condensed concepts of the participant responses that elaborate the adolescence sensitive health-related attributes in multiple ways. The themes include adolescence related changes, sexuality in adolescence and adolescents perception of own health.

4.3.1.1 Theme one: adolescence related changes

Adolescence related changes emerged as a major theme from the data after the analysis on how the participants of the study understand health in general and

adolescents' health in particular. The emergent major theme is developed after the concepts related to changes that influence adolescents health occurred frequently in the data. The major theme comprise four subthemes age, gender, physical body changes and cognitive changes that are deduced concepts from codes of the data.

4.3.1.1.1 Subtheme one: age of the adolescents

Age of the adolescents was one of the significant concepts boldly identified in the data. The participants of the study almost all of the time tried to relate adolescents' health with their age. Many of the participants indicated adolescence as the period of relatively the healthiest years of life. However, maintaining the highest possible health status during adolescence is most challenging and has significant consequences in the later ages of life. The following verbatim quotation from a 17-year-old female adolescent shows the impact of age on the adolescents' health.

> *In our age everyone begins to experiment what is good and what is bad. It is possible to say that adolescence is the age of testing everything. Through this experimentation, we may engage in things that harm our health and we may end up harming our future. In this age everything attracts us but, obviously everything is not important. But we adolescents keep on until we check the things that attracted us usually we don't care or we do not know the outcomes. (*Participant N)

Adolescence is an exciting time with varied and rapid changes. It is the most confusing age for both adolescents and their parents. Adolescence is a period of neurological, physical and emotional transitions from childhood to adulthood. It is a period where adolescents strive to become independent individuals, form new relationships, develop social skills and learn behaviours that will last the rest of their lives. Adolescence is a critical part of the entire life years at which young people face a range of health risks (Lansforand & Banati 2018:3).

4.3.1.1.2 Subtheme two: gender differences in adolescence

Gender is one of the subthemes that emerged from the data. Many of the study participants expressed health in relation to their gender differences. The health of adolescents is aligned to the socially established norms and rules of the society. For

instances, the use of alcohol and other substances are health risks associated with males, while females are exposed to sexual and physical abuses by their male counterparts. Females generally experience poorer health than their male counterparts and this also an accepted norm in the community. The findings of this study also support this view. A 16-year-old male participant expressed how gender is utilised to define adolescents' health status in the following ways:

> *In our community people think health status of peoples differs in being male or females. Usually females are considered strong in responding for their illness and males are considered weak. In a family usually people do not give equal weight if male child and female become ill. They are more responsive for the male child even with mild health problem they begin to search for solutions for the male. Females usually hide their illness until it becomes severe. If a female asks for health care for mild illness no one gives ear for her issue. Owing to this fact usually females try to look healthy even with severe illnesses.* (Participant G)

Gender differences have an influence on the social understanding of health and illness. This includes the understanding of illness in men and women, and health-seeking behaviour, the availability of support networks, and the stigma associated with illness and disease. Men and women respond differently when they are ill, in terms of time before acknowledging that they are ill, recovery time, and how women and men are treated by their families and society (Vlassoff 2007:53).

4.3.1.1.3 Subtheme three: physical body changes in adolescence

Physical developments are among the dimensions described by the study participants to define health. According to the participants of this study physical development when occurs at the usual expected for age is a sign of being healthy. The following verbatim quotation from a 15- years- old female adolescent participant clearly shows how much health are related to physical body changes.

> *Attaining the required body size for the age is one of the indications of healthy adolescence. In our society, particularly parents follow their children status and they assume healthy if their children are getting the body size they assume for the age, they say my child is ok. Adolescents are most of the time assumed to be healthy relative to the children and the old.*

*People give less attention for adolescents' health. In our society people look at your physical status and they try to judge your health status. If you look normal they do not give much attention for your health aspect. Because they assume adolescence as a relatively healthiest age and they give attention for other aspects like education, your clothes and the like. The health are ignored aspect for adolescents. (*Participant C)

During the teen years, adolescents experience changes in their physical development at a rate of speed unparalleled since infancy. Adolescents have been left in the mainstream of care because they were regarded as healthier than the paediatric group and adults (WHO 2014:3; Novella 2009:350).This finding indicates that there is a misconception of considering adolescents as the healthiest people and using the misconception as a ground to give them lesser attention for health promotion and preventive interventions adolescents' relative to the attention given for the children, women and the elderly people.

4.3.1.1.4 Subtheme four: cognitive changes and adolescents health

The participants of the study indicated that the family and friends approve their health cognitive growth when adolescents behave and think maturely. People around the adolescents expect maturation in the way of thinking and actions to show a green light the adolescent is appropriately attaining the cognitive maturation to say everything is ok with their teen's health. From the many participant responses that support this concept the verbatim quotation from a 19-year-old male participant is presented as follows as a witness.

*The people in our community expect mental maturation after childhood. Beginning to think about our education and future life is expected. For example in our childhood our parents teach us everything. But in adolescence they minimize telling everything and they may begin just appreciating the good behaviour and discourage the bad behaviour. Sometimes I may practice some behaviour and my parents say you are no more kid you have to identify what is good and what is bad for your future. Attaining these expectations is the requirements to be considered as healthy adolescents. (*Participant X)

Studies also approve cognitive development of adolescents are also accompanied by emotional and behavioural characteristics of the teenagers. This is because of speedy, growth towards independence and relatively higher reasoning skills at adolescence than the childhood social affiliations of adolescents becomes outside the family circle (Griffin 2017:3). The finding from this study also approves cognitive maturation is expected at adolescence than childhood but the participants of this study indicated the parents and the society use adolescence as the age at which they are relieved from the burden of follow up and care of their adolescents assuming adolescents know the bad and the good for themselves. Again the participants of this study expressed their concern of adolescents still need close follow-up and care as are in a transition from the childhood to adulthood and they are still in experimentation of life and health challenges.

4.3.1.2 Theme two: sexuality in adolescence

Though sexual maturity of adolescents is the natural course of life, in most of the cases it is an unanticipated event both for adolescents themselves and their parents. In the current study sexuality in adolescence is a significant theme inductively developed from the data after the researcher critically analysed the data using the opportunity provided by grounded theory principles of constant comparative analysis. The theme comprises three important subthemes which are developed from the data namely, sexual desires, changes in the relationship affiliations and building new relationships.

4.3.1.2.1 Subtheme one: sexual desires in adolescence

Participants in the study noted that sexual desire as something they have to deal with as espoused by an 18-year-old male participant in the following excerpt revealed sexual desires:

> *Currently we are in the age of internal and external influences. Internal influences are the needs and desires within us. Most of us even do not know the natural changes in our desires. We engage in sexual relationships without appropriately knowing the consequences. The sex and sexuality problems are particularly huge in females. In our locality there are many female teenagers whom I know become pregnant in their early ages; some of them drop from schools and few even attempted suicides because they feel ashamed. The families of the adolescents also*

*become upset if they see their daughter in such condition and feel that the pregnancy will be the end of their daughters schooling. The society discriminates an adolescent who become pregnant. The Ethiopian culture as you know does not allow families to talk about sexual matters. Surprisingly, the same society expects the right behaviour and practice from adolescents without educating and telling them the right way. I think it is important to discuss about sexuality and sexual matters in the family in adolescence to get the right behavioural and health outcomes. (*Participant Q)

The surge in hormone levels during puberty leads to awareness of sexual development, gender identity and sexual desire in adolescents. The sexual maturation process produces sexual interest and stimulates adolescents thought of sexuality. Owing to lack of awareness of the changing sexual behaviour and developing sexual desires, adolescents may engage in sexual practices without appropriate realisation of the costs of such engagements (WHO 2017b:12).

Adolescents should be encouraged to delay sexual activity until they are physically, cognitively, and emotionally ready for mature sexual relationships and their consequences. They should receive education about intimacy, resistance to negative sexual pressures, benefits of abstinence, prevention of STIs, contraception, and delay of pregnancy. Because many adolescents are or will be sexually active, they should receive support and guidance in developing skills to evaluate their readiness for responsible sexual relationships. Unless responsibly managed sexuality and sexual behaviours leads to many avoidable costs to the adolescents themselves, the family and the society at large (Feldman 2015:17).

The above findings in the current study also suggest adolescents often seem to act impulsively rather than thoughtfully. Therefore, the provision of age appropriate health information regarding sexuality is of paramount importance.

4.3.1.2.2 Subtheme two: changing affiliations in adolescence

Participants in the study reported that, they used to be close to their parents but now their parents do not understand them and they leave them alone hence they are now

closer to their friends and school mates because they share the same needs. This notion was best expressed by a 17-year-old female in the following excerpt:

> *I am currently more of towards my friends than towards my parents. My parents sometimes do not understand my issues like my friends. I do not tell them even everything to my parents.* (Participant C)

Among the most important visible changes that occur during adolescence, development of self-concept and the development of new attachments are of significant aspects (Christie & Viner 2014:301). Young children are most strongly attached to their parents, whereas the important attachments of adolescents move increasingly away from parents and increasingly towards their peers. As a result, parents' influence on the adolescents gradually diminishes (Takele, Zewdie, Mamusha, Muluken, Asmamaw & Nyagero 2016:6).

The most worrisome for parents is the adolescents shift in reference group orientation from parents to the peer group. Parents often express concern that their adolescent child will "fall into the wrong crowd" and be persuaded by peer pressure to engage in behaviours that are self-destructive and/or counter to parental expectations (Hatchette, McGrath, Murray & Finley 2008:6).

In early adolescence, susceptibility to peer pressure increases while reliance upon parents' opinions and advice seems to decline. Association with deviant peers is one of the strongest predictors of adolescent deviant activity. There is, however, evidence that parents do retain a substantial measure of influence over the attitudes and activities of their teenage offspring (Aksarapak,Tatiana & Aphichat 2018:246).

4.3.1.2.3 Subtheme three: building a new relationships among adolescents

As adolescents moved from mid to late adolescence, they shift from having almost exclusively same-sex, same-grade friends to having more relationships with persons who are of the opposite sex and older. The following verbatim quotation supports the subtheme which is developed after redundant occurrence of the concept in the data.

Many adolescents in our age establish relationships with opposite sex. We even call each other as my wife or my husband. You know if someone is calling you as my wife or my husband it implies they are doing things that are done in marriage by husband and wife. No shame the males call their adolescent partner as my wife the females the same. Sometimes he calls not by her name he may say "miste" Amharic my wife and she also calls him in Amharic "bale" my husband. The other fellow adolescents are not concerned in the meaning because they look it as usual and normal. (Participant Y)

According to Bell, Rosenberger and Ott (2015:204) romantic relationships are among major developmental milestones during adolescence and need to give appropriate attention. These romantic relationships are linked with the adolescents growing interest in body image and looks, independence and privacy. The same above study also reports adolescents who establish early romantic relationships with their opposite sex are high-risk for early dating, more likely to have had a sexual relationship, more likely to have multiple sexual partners, more likely to face early pregnancy and to have a child at early age

4.3.1.3 Theme three: adolescents perception of own health

The theme adolescents' perception of their own health was developed after assessing the adolescents' perception regarding their own health. Appropriate realisation and holding appropriate health perception is one of the important aspects of health experiences of adolescents. The theme comprises four related but not the same subthemes. These are current health status, awareness of the value of health, benefits of improved health status and consequences of poor of health.

4.3.1.3.1 Subtheme one: adolescents current health status

The participants explained their current health status perceptions in different ways. Participants believed themselves to be healthy if they were able to participate in activities of daily living. If they were unable to participate in them, then they considered themselves not healthy. The following excerpt from a 15-year-old female participant espouses this belief:

*I see myself as fully healthy because I can do everything as usual; if I do everything else as usual, I know I am healthy. If I cannot perform activities assigned to me I know I am not healthy. If I am not healthy I may feel pain; now I have no pain, I believe I am fully healthy. (*Participant T)

Studies also show that better self-rated health status of adolescents has an implication on different health behaviours. The better self-rated health status implies the better use of medical and health care seeking behaviour, owning health insurance and planned family size in the household. Economically, poor adolescents typically experience more health and health-related problems than those from the well to do families. Overall self-reported poor health and higher rates of pregnancy, cigarette smoking and depression are common among the poor adolescents (Randy, Simonek, Ihász, Hantiu, Uvacsek, Kalabiska & Klarova 2009:111; Galán, Boix, Medrano, Ramos, Rivera, Pastor-Barriuso & Moreno 2013:8).

Adolescents from poor families and those without health insurance are more likely to seek routine medical care from a public hospital, outpatient clinic, emergency department, or public health centre and poorly rate their health status. On the contrary, adolescents from the rich families seek medical care from private medical facilities which are highly equipped with health instruments and highly skilled health care staffs and better self-rate their health status (Comett 2014:62).

4.3.1.3.2 Subtheme two: adolescents awareness of the values health

Participants reported that they are aware that most of them do not value health as much as they should and hence end up indulging in risky situations. A 19-year-old male adolescent as brought out this argument clearly:

*Many of the adolescents in our community do not give much attention about their own health. They do not value their health. Many of us do not realise the importance of health. We only recognise how much health is important when we are ill. Otherwise, we do not care much about our health. For me health is the priority of all issues. I think education, trade; earning and even going here and there all depends on the health status. Without good health one cannot do anything. (*Participant V)

Adolescents' awareness of the values of health is among the determinants of their health and self-care practices. Adolescents who have less awareness of the values of their own health are highly prone for health risk practices. Substance use, alcoholics, unsafe sexual practices; delinquencies and violence are high among adolescents with the lesser awareness of the values of their own health (Zewdie, Kora & Mulusew 2018:42).

WHO (2014:12) reports the higher the value placed upon own health; the more motivation there will be to seek out, understand, and responsibly act upon the health related behaviours. Adolescents are inundated daily with information that may be pertinent to their health by the various media, electronic and written; more specifically with the internet technology. As a result, it is too easy to learn health promoting or health affecting behaviours. Taking responsibility for one's own health and behaviour is a complex activity that demands time, practice and commitment to one's personal health.

4.3.1.3.3 Subtheme three: benefits of improved adolescents health

Participants in the study were poorly aware of the benefits of health. Participants reported on the changes that occur and 5 out of 25 participants feel their parents ignored educating them regarding their health aspect. The following verbatim quotation from a 16-year-old female adolescent shows the reasons why it is important to care for the adolescents' health:

> *Adolescence is the beginning of puberty and the beginning of a new chapter in life. We are not concerned about health and nobody taught us what to expect as our age advances and this is why we engage in risky health behaviours. The excitement makes us* (adolescents) *to experiment with a lot of things as our awareness to health is limited. The bad outcomes of these practices in turn create the burden on the adolescents, the family and on the society. For this reason, I belief giving more attention to raise adolescents knowledge regarding their health is very important.* (Participant K)

Promotion of positive behaviours good sleep habits and constructive forms of risk-taking, such as sport and preventive behaviours, early detection and treatment of

health risks; substance use disorders, mental disorders, injuries and STIs are immediate benefits of improved adolescents health. Improved adolescent health brings economic and larger societal benefits. This occurs through greater productivity, reduced health costs and enhanced social capital ((Association for Young People's Health (AYPH) 2017:1; Human Health Services, Office of Adolescent Health (HHS, OAH) 2018:12).

Healthy behaviours in adolescence; diet, physical activity and, if sexually active, condom use and reduction of harmful exposures, conditions and behaviours; obesity and alcohol and tobacco use helps in setting a pattern of healthy lifestyles and reducing morbidity, disability and premature mortality in adulthood. The promotion of emotional well-being and healthy practices in adolescence; managing and resolving conflicts, appropriate vaccinations and good nutrition, prevention of risk factors and burdens; interpersonal violence, FGM, substance use, early pregnancy and pregnancies in close succession can help protect the health of future generation (UNICEF 2011a:19).

In low- and middle-income countries, investment in adolescent health is likely to result in declines in mortality and fertility rates, which in turn contribute to accelerated economic growth. With fewer births each year, a country's young dependent population grows smaller in relation to the working-age population (aged 15–64 years), creating a window of opportunity for rapid economic growth. In high-income countries as well, investment in the health and well-being of low-income adolescents, including those who have high birth rates and are more exposed to risk factors for ill-health, can help to break the transmission of poverty and disadvantage across generations (WHO 2009:2).

4.3.1.3.4 Subtheme four: consequences of adolescents poor health

Participants had an awareness of the consequences of poor health for themselves and its impact on their families and the society at large. This is illustrated in the following excerpt from a 16-year-old male study participant.

> *Adolescents' health status has a huge impact in current health of the adolescents themselves and in the future generation. Adolescents 'health status does not only affect the adolescents but others as well. For instance, if I am not healthy, it is very difficult to have a healthy child when I get married. My health status has an*

implication also for my family and the country at large. If I get involved in health risk conditions my parents are obliged to pay for my health care services, these imposes burden on my family. When I get ill I may be absent from schools, these in turn have a long-term health and economic problems. (Participant G)

This finding is also reported in similar manner in the US, TAG play-book as adolescence is a time of rapid changes; biological, emotional and cognitive development, transformation of interests and behaviours, and transition of social roles have far-reaching consequences not only for adolescents themselves, but for the generations to come. Increased investments in adolescent health and development are crucial to generate positive results for adolescents, and also break intergenerational cycles of poor health, poverty and discrimination (Human Health Services, Office of Adolescent Health (HHS, OAH) 2018:4).

Conclusions on category one

Adolescents' are neither children nor adults; their needs and wants can be easily overlooked in policies and programmes. Appropriately addressing adolescents' rapidly changing and specific health needs and wants is a cornerstone to ensure sustainable development. When health systems and other sectors design adolescents health promotion policies and programmes to support adolescents to attain a productive, healthy, and satisfying life; they are required to take into consideration of adolescents biological, emotional, and social development and related changes (Laski 2015 :15).

The first inductively developed category from the data in this study tried to address health experiences of adolescents in relation to adolescence sensitive health intermediaries which have a big role in determining adolescents' health-related practices. This study shows adolescents health promotion and prevention policies and programmes should be made parallel with adolescence sensitive health intermediaries; physical body changes, sexuality and adolescents perception of their own health.

4.3.2 Category two: Adolescents Health related Information and communication experiences

Timely and specific health-related information and communication is the most important experience that emerged from the data in the current study. Communication with the adolescents is not similar to communicating with younger children or communicating with adults. Communication with teenagers requires appropriate identification of specific priority health information needs of the teenagers and the communication should be to fill such a gap (Mental Health First Aid Australia (MHFA) 2014:3).

Adolescence years can be difficult for many families. Young people may develop ideas, values and beliefs that are different to those of their parents and the society. This is part of the normal process of moving towards independence. The most important thing is to keep the lines of communication open, listen more than you speak, remember that we are all given two ears and one mouth. This is to remind us that we should spend twice as much time listening as talking. This is especially important when talking to teenagers, who may tell us more if we are silent long enough to give them the opportunity (Victorian Minister for Health 2019:2). This category comprises three important themes that were generated from the data: These are audiences of adolescents' communication, frequent topics of communication and barriers of communication.

4.3.2.1 Theme one: audiences of adolescents communication

An audience of adolescents' communication is one of the important themes that emerged from the data. This theme has three subthemes, namely, communication experiences of adolescents with their parents, with their peers and with their sexual partners.

4.3.2.1.1 Subtheme one: communication experiences of adolescents with their parents

The families of the adolescents are among the significant others who share individual information of the adolescents. The home environment is the best place for adolescents' communication. The first role models for adolescents are their parents. The following verbatim quotation from 15-year-female participant shows her experience of communication in the family:

We usually raise and discuss different health-related issues in our family. Most of the time discussion takes place at evening when we all back from our day duties. In our family we do not plan what to discuss each night but as I understand we discuss different health related agendas in our home. (Participant E)

According to Mental Health First Aid Australia (MHFA) (2014:1) good communication with the adolescents is one of the foundations of good parenting. Being honest is crucial component of effective communication with adolescents. Adolescents usually turn away from anyone who they presume to be dishonest. Anybody, who need to make effective communication with adolescents needs to set aside their own concerns and focus on those of the adolescents giving them full attention. Adolescents' situations and needs are unique. Being non-judgmental and treating them with respect and fairness is an important component of effective communication with adolescents.

4.3.2.1.2 Subtheme: adolescent peers communication experiences

Participants reported that, they communicate more with their peers than with their parents. This was espoused in the following verbatim by a 16-year-old male study participant:

*I discuss everything with my friends. When I discuss with my parents I select what to tell them and what not to tell them. But with my friends I do not even try to select issues of discussion. Most of the time I discuss with my parents what I need to be given or if I get ill I tell them my health conditions. I never raise issues related to sexual health and sexuality because I am afraid to talk such kind of issues. Discussions particularly regarding sex and sexuality are also a taboo in our culture. But, in our peer group we discuss openly to each other even on this issues. Because of these discussions we learn things one another. (*Participant F)

According to Hatchette etal (2008:5) as children become adolescents, they normally get more involved with peers and talk less to parents. Less communication with parents can be a normal part of establishing independence.

Research also shows in many circumstances and cultures adolescent peer communication and attachments are often linked with negative things by the parents

and the society. However, positive friendships and effective communication and attachments of teenagers with their peers can have a positive impact. Friends are considered an important source of advice and information about sex. Conversations about sex among young people tend to generate norms that influence positive or negative pressure on individuals to conform to group standards (Devi, Hastuti & Situmorang 2016:40; Takele etal 2016:4).

Based on the current finding, it is an opportunity to use adolescents peer communication and attachments as part of the chain of adolescents behavioural change communication intervention for healthy practices.

4.3.2.1.3 Subtheme three: adolescent sexual partners communication experiences

Adolescents dating partner communication is one of the important subthemes developed from the data in the current study. Participants in the study reported that they do have an open communication with their partners. A 19-year-old male adolescent participant of this study explained the ways of communication with dating partner in following ways:

> *My girlfriend and I, discuss everything open. I do not have anything that I hide from her; she is also open and tells me everything. We discuss about delaying sex until we get married, because currently we are attending education. I think our being in a friendship helped us; because we are not looking for a boy or a girlfriend. I think open communication between partners is very important because it reduces suspicion of each other and helps to build trust. If partners openly discuss their issues it makes clear everything for both parties. I believe with open and clear discussions, adolescents can build trust that lasts longer and can stay for a longer time in a partnership.* (Participant V)

Both research and consultations over the last decades have identified sexuality-related communication as an issue that requires urgent attention. Responsible and caring sexual partnership founded on effective communication and coming in agreement between adolescents sexual partners have a significant role in contributing for positive health outcomes of the adolescents. Positive health outcomes of adolescents are

associated with effective communication and attachment between the adolescent peers (Widman, Choukas-Bradley, Helms ,Golin & Prinstein 2014:10;WHO 2015b:8).

According to Aparícioa, Lopes, Ferreira and Duartea (2014:151) good communication and positive relationships have an implication in contributing for long lasting adolescents' sexual relationships and the level of connectedness between them. Adolescence has been regarded as a period of great vulnerability to intimate violence, given the emotional immaturity, inexperience with relationships and initiation into sexuality which characterise this stage. This is especially the case in younger adolescents because of poor communication and inappropriate perceptions and expectations about the partner's behaviour.

Improving adolescents' communication skills have an added value in recognising the behaviours of abuse and violence in dating relationships by its positive effect on knowledge and awareness of healthy values and attitudes that facilitate communication with partners, therefore promoting healthier relationships among the dating adolescents (Toscano 2007:10).

This finding shows that giving appropriate attention for dating adolescent communication and ensuring effective communication has a role in reducing abusive and violent behaviour in adolescent partners.

4.3.2.2 Theme two: preferred topics of communication in adolescence

This subtheme describes what the participants understood and expressed as usual and dominant issues of concern, whenever they discuss about their health. Research shows young people have enormous concerns about their health. Meanwhile, they face numerous difficulties in disclosing their health concerns to other people (Widman etal 2014:739). Obviously, communication preferences of adolescents have an impact on their health related decision-making processes, because issues raised more frequently and repeatedly have a power to be used by the adolescents as inputs for the their behavioural changing decisions. This describes the subthemes: communications of adolescents on their overall health, communications regarding delaying sex/abstinence, communications regarding risk of teenage pregnancy and on HIV/AIDS.

4.3.2.2.1 Subtheme one: adolescents communication experience on overall health conditions

Overall health conditions emerged as a concern for participants. A 17-year-old female participant has this to say about her experience of communication on overall health conditions:

> *When I am with my friends or with my parents, we discuss many issues regarding our health. I do not make selections when I speak about issues related to health I discuss on HIV, sexually transmitted diseases and the consequences of substance and alcohol use and how to get heath care whenever I caught ill. I try to keep myself healthy and I tell to my friends how to keep themselves healthy. This is because for me, education and other life achievements are dependent on good health.* (Participant P)

Based on this research finding, the promotion of discussion of adolescents on their health agendas creates a safe platform for adolescent health promotion and preventive actions. This finding resonates with Widman etal's (2014:737)findings where the study indicated adolescents not only desire more communication regarding health, but also they need practical, accurate and based on lived experiences information

4.3.2.2.2 Subtheme two: adolescents communications experiences regarding delaying sex/abstinence

The adolescent participants in the current research expressed communication regarding abstinence or delaying sex before marriage as one of important topic communication whenever they discuss about their health. Verbatim quotation from a 19-year-old male study participant illustrates the ways of discussion regarding abstinence from sex or delaying sex before marriage in the following ways:

> *Abstinence is very important particularly for adolescents. Abstinence is the single most effective strategy to prevent outcomes of sexuality. If a person abstains from sex, he has no fear of anything, even with the use of condom there is fear of breakage or leak so that there may be pregnancy or HIV infection. In our community to have sex before marriage is also forbidden religiously. Because of these reasons,*

*we discuss regarding abstinence until we get married. We also talk about the consequences of having sex in our age. If we engage in a sex early, it may result in pregnancy and it leads to societal and religious discrimination. (*Participant W)

The above result is also supported by a growing body of research that has demonstrated adolescents who are able to communicate about sexual health issues, including condom use, STDs/HIV, and abstinence, are more likely to delay intercourse and use condoms when they do become sexually active (Cederbaum & Hutchinson 2016:57; Rogers 2016:27; Widman etal 2014:732).

4.3.2.2.3 Subtheme three: adolescents communication experience on risk of teenage pregnancy

Teenage pregnancy is one of the important topics of discussion of the adolescents participated in this study. The participants expressed they routinely communicate with each other and also with their parents regarding teenage pregnancy and the associated social and cultural consequences. Research also shows family support and good communication between parents and adolescents are important factors for a healthy sexual behaviour (Iorga & Ciuhodaru 2016:341).The following verbatim quotation from a 17-year-old female adolescent supports this notion:

Teenage pregnancy is one of the unwanted and feared consequences of sexual engagement among adolescents. Based on the evaluation of the effect of teenage pregnancy we try to discuss about teenage pregnancy with our friends and sometimes with our parents. When we discuss about teenage pregnancy and its consequences the male adolescents usually try to convince the females as it would not happen. But, at the end of the day if it happens the females are going to suffer a lot. The females sometimes try to terminate the pregnancy usually by traditional abortionists and that have a serious health risk. If they avoid terminating the pregnancy still the social and cultural discrimination is huge. They may terminate education and other social and personal affairs. But, the males continue their education and even no one may know their practice that is why they try to convince the females for sexual engagement ignoring the consequences. It is always the females who are blamed for the consequences of sexual engagement, but for the same behaviour no one blames the males. Even some parents may encourage this

*behaviour for their male adolescent and feel their son did some brave action. (*Participant O)

The above finding shows the presence of awareness gap among the male adolescents regarding teenage pregnancy. The research finding implies that the male adolescents are in favour of sexual engagement as they assume they are not going to be blamed for the same behaviour equally with the females for the consequences of sexuality including teenage pregnancy. Research shows that most of the time girls have sex for the first time because of some sort pressure from the boys. Regarding communication on sexuality majority of the boys tried to convince or shared a message to influence the females to engage in a sex. Whereas, only lower proportion of females communicated messages in favour of having intercourse or showing willing to have sex (Widman , Choukas-Bradley, Helms & Prinstein 2016:326).

4.3.2.2.4 Subtheme four: adolescents communication experiences on HIV/AIDS

The current study revealed that communication regarding HIV/AIDS is a common topic whenever adolescents begin to discuss on sexual health matters. Almost all of the study participants expressed communication about HIV/AIDS is a usual agenda of discussion among adolescents. The adolescents who participated in the study also indicated that their parents or caregivers are comfortable to discuss with them the consequences of HIV infection rather than talking about the ways of transmission particularly the risky sexual practices. Whenever, their parents raise discussion regarding HIV they try to show health and other problems faced by HIV positives. One of the participants stated as follows:

My parents and my friends usually remind me HIV whenever, we begin discussion on sex and sexuality. My parents warn me don't to engage in sexual activities. They tell me the consequences of HIV presenting practical examples of people around our community. But, when we discuss with my friends sometimes they don't consider it as a big issue, they say HIV is similar to other disease, like Diabetes mellitus and they mention other diseases and try to tell you HIV as a simple health problem similar to other diseases. (Participant M)

Research also shows parents usually use their own HIV positive or negative status or others HIV positive or negative status to talk about HIV-related consequences to their own adolescent children. Parents and caretakers of adolescents usually prefer to talk about abstinence as means of HIV prevention. Parents and caregivers are usually not comfortable to talk about condom use or other means of HIV prevention to communicate with their own adolescents. Adolescents' communication about sex and HIV is more open between each other and other relatives who are not their parents and/or immediate caregivers (Christine, Angela, Nkala, Angela, Glenda & Cari 2013:167; Mkandawire & Iipinge 2017:5).

4.3.2.3 Theme three: barriers of adolescents communication

Barriers of adolescents communication was the other important theme emerged from the data in the current study. The participants of the current study mentioned many concepts that would be considered as barriers of adolescents' communication information sharing. The theme barriers of adolescents communication was inductively developed from the data after merging the subtheme concepts explaining the barriers of adolescents' communication. The theme comprises the subthemes: socio-cultural norms, environmental influences, fear, and shame.

4.3.2.3.1 Subtheme one: Socio-cultural norms and adolescents communication experiences

According to social norms theorists cultural norms are the agreed up on behavioural expectations demanded from members of the society. To get societal approval of the members of the society certain behaviours are considered as a routine practice. This routine practices finally become cultural norms (Frese 2017:1328).

According to Maclean (2006) as cited in Belita and Kulane (2011:123) young peoples' lives are strongly influenced by the social norms, expectations and also by the behaviour of adults around them. Health promotion interventions targeting the adolescent people therefore need, to consider the contextual experiences in which they live and the ways they are being socialised. Social norms and the process of socialisation have a significant role on the adolescent people health behaviour during their adolescence years and beyond. Therefore, health interventions and polices

designed targeting adolescents are need to consider the social norms of the adolescents.

In Ethiopia, usually adolescents, either boys or girls, are required to listen more and to talk less. Adolescent girls and adult women occasionally participate in a discussions made in the home or outside. These norms limit the adolescent girls' and adult women freedom of expression of ideas and their ways of communication (UKAID 2015:7). An 18-year-old female participant stated the strength of the social norms in their communication and discussion patterns in their locality in the following ways:

In our community usually we are not allowed to talk more before adults. It is a norm. Adolescents either boys or girls, to talk less and to listen more; it does not matter how much relevant the idea from the adolescents, the adults do not give their ears for adolescents talk. The case is even worse in women and adolescent girls, from the very beginning the adolescent girls and adult women are not allowed to talk sitting beside adult men. Socially their role is preparing food for the men when they are discussing different issues. *The adolescents and the women themselves even do not consider it as a discriminatory treatment.* (Participant U)

This finding shows that the higher negative influence of social norms on communication and information sharing of adolescents with their parents and their adolescent groups. Similar findings were reported in a qualitative study conducted in Kenya where social norms influenced the communication and information sharing with adults and with their parents. There are times when adolescents want to communicate with adults and parents, but the adolescents are not comfortable to talk with adults and with their parents in all issues. The same study also reported that some other portion of the adolescents expressed that they faced difficulty of communication in specific matters like, sexuality and HIV and AIDS (Belita & Kulane 2011:130;).

4.3.2.3.2 Subtheme two: environmental influences and adolescents communication experiences

Adolescents living in the rural environment face particular risks to health and well-being as they are more likely to be poor and have less access to health care services and health information and communications systems. For example, an 18-year- old male

participant stated his experience of communication in relation to his rural residence in the following ways:

> *Life in the rural environment is challenging. Adolescents of the rural community are shy to discuss issues openly. I think the environment we grow up have a big impact on the ways we express our ideas. In the rural areas there is no culture of open discussion. Whenever adults discuss, adolescents are usually required to listen or sent somewhere for other duties. If adolescents participate in the discussions, in extreme cases the adults may feel as they are disrespected. Because of this reason, adolescents of the rural environment let alone discussing specific issues like health related, they face challenges in communicating general issues. (*Participant R)

Nearly similar finding was reported in a study conducted in Pamijahan, Bogor Regency, where the study shows rural adolescents disproportionately face the problems of communication and attachment to their peers when compared to their urban counterparts. The study reported that almost all of the study participants; greater than (98%), have difficulty in communicating with their peers and they do not believe what is said to them by their friend is honest and true (Devi, Hastuti & Situmorang 2016:37).

4.3.2.3.3 Subtheme three: fear and adolescents communication experiences

The adolescents participated in this study reported that fear was one of the barriers of effective communication in their home and outside environment. The following excerpt from a 19- year- old male adolescent study participant strengthens this concept:

> *In our family usually there is discussion on different matters. However, I am afraid to speak; I fear misinterpretation of my speeches. Because, I fear my parents may misunderstand my speeches and judge me differently. When I am with my friends still I prefer talking less, most of the time they make fun for themselves repeatedly raising the mistakes I make during our communications and they start to laugh; after that I begin criticising myself what is wrong with my speech, why were they laughing and sometimes even they do not know why they were laughing, to avoid this usually I prefer being silent. (*Participant X)

Research shows fear is a surge of physiological activity in response to clear and impending danger, characterised by avoidance behaviours across several situations. Dependency exists between human beings emotions like fear and effectiveness and quality of intercommunication (Vytal, Overstreet, Charney, Robinson & Grillon 2014:321; Strumska-Cylwik 2014:173). In this study, the adolescents reported that they were fearful to make open discussions either with their parents or with their friends to avoid being misunderstood or fear of making mistakes during the discussions that assumed may ultimately lead to ridicule and fun by their friends.

4.3.2.3.4 Subtheme four: shame as barrier of communication for adolescents

In the current research shame was one of the important concepts that extracted from the data and inductively developed as a barrier of communication among the adolescents participated in the study. Adolescents who participated in this study reported that they were particularly shameful to discuss SRH related agendas with their parents and peers. A 17-year-old male adolescent study participant stated this concept in the following ways:

> *I do not talk to my parents or my friends about my sexual practices. I know my parents do not expect I am in a sexual relationships. I feel shame inside, if I disclose what I am doing, I know my parents become so angry at me. To avoid more embarrassments, I usually hide talking issues related to my sexual practices. (*Participant L)

Shame is a powerful social emotion, learned as people learn the expectations and standards imposed upon them by others. Shame is strongly rooted in culture and in language (Poulson 2014:4). Shame is a painful, disruptive emotion that often arises when individuals recognise their own negative attributes or unwanted behaviours, especially when these are observed by others (Cook, Wildschut & Scander 2017:3). The above research finding in this research is also agrees with the research finding from a cross-sectional study which was conducted at Boditi town, Ethiopia where the study reported that shame, and parents' lack of skills of communication were the major barriers of discussion on SRH issues with their adolescent boys or girls (Muluken, Seblewengel, Getu & Mengistu 2016:60).

Conclusions on category two

The key to building a positive relationship and sorting out any communication difficulties with teenagers is to keep the channels of communication open (Christine, Angela, Nkala, Angela, Glenda & Cari 2013:168). Both the parents and the society consider the importance of discussion with the adolescents when they realise something is not going as to their expectations. However, the extent and depth to which adolescents and parents make effective communication is dependent on the level of relationship built since childhood. This would encourage parent-adolescents communication when the children become adolescents (Baku, Agbemafle, Kotoh & Adanu 2018:10).This study in category two tried to address the health-related adolescents' communication and information experiences. Appropriately identifying the audiences of adolescents' communication, frequent topics of communication and barriers of adolescents' communication are keys to design and implement effective behavioural change communication with adolescents.

4.3.3 Category three: Health challenges faced in adolescence

Many adolescent health problems are related to underlying social, psychological, and economic factors. However, it is often difficult to determine which types of health promotion interventions are most needed (Global Accelerated Action for the Health of Adolescents (GAA-HA) 2017:10). Many research findings focus on the general adolescents health problems and there is no sufficient information on context-specific health challenges faced by the adolescents. In this research, the category , health challenges faced in adolescence, described some of the context-specific health challenges faced during adolescence that are inductively developed from the data. The themes included in this category are health risk experiences and sexual health experiences.

4.3.3.1 Theme one: health risk experiences of adolescents

Research shows the promotion of healthy practices during adolescence, and taking steps to better protect young people from health risks are critical for the prevention of health problems in adulthood, and for countries' future health and social infrastructure (Moghaddam, Bahreini, Abbasi, Fazli & Saeidi 2016:1428; Walsh, Bruckauf & Gaspar 2016:6). The theme health risk experience of adolescents is developed from the data after codes related to health risk practices frequently appeared from the data. The

subthemes include substance and alcohol use, Violence, HIV/AIDS, Peer pressure and lack of adequate attention.

4.3.3.1.1 Subtheme one: substance and alcohol use experiences of the adolescents

Substance and alcohol use are among the major health risk behaviours recognised in the data. The participants of this study reported that substance and alcohol use, particularly chewing chat and consuming locally brewed alcohol, were the major health risks of the adolescents in this study. A 17-year- old male adolescent participant stated the problem of substance and alcohol use in their community in the following ways:

> *Chat chewing is a common practice in our community. Almost all of our community members chew chat. Previously, purchasing a chat as well as travelling in the public was a taboo; particularly adolescents of our age are not allowed to do so. However, since recently, this social norm is almost being replaced by the opposite. Currently, no one is ashamed of purchasing and holding chat in the public. After chewing chat the adolescents usually drink alcohol.Locally, it has a name known as "chabsi". Those who can pay for modern alcohol (processed in the factories) search every possibility to get it, those who could not purchase modern alcohol drink the local alcohol (brewed in home) known as "Areke or katikala". Nowadays, adolescents are being addicted by these practices. They are dropping out of schools. If they lack money to purchase the chat and alcohol, they may even involve in a theft. The community is facing social and economic problems. Families of the adolescents with such behaviour are facing many problems. The adolescent ask their parents for money because many of them have no income of their own purchase the substances.* (Participant Q)

Research shows, adolescents in rural areas are experiencing many of the social problems that their peers in urban areas face at higher rates of incidents. Rural adolescents have higher alcohol use and drug use than their urban peers. Higher proportions of rural adolescents are observed to have ever tried cigarette smoking than their counter urban adolescents (Kumar et al 2015:246; Warren, Smalley & Barefoot 2017:62). A cross-sectional study conducted in rural Ethiopia also reported similar finding of high level of hazardous alcohol consumption among rural community and

identified home brewed alcoholic beverages were highly consumed by the community members (Solomon,Girmay, Medhin,Bhana,Hanlon & Abebaw 2016:223).

The findings of this research show, on contrary to the notion in Ethiopia, rural adolescents are sheltered from social problems such as teenage pregnancy, drug and alcohol abuse or crime because of their isolation to urban areas, closer ties with their families and religious beliefs. Rural adolescents are experiencing consumption of high and hazardous amount of alcohol and experiencing substance and drug abuse and teenage pregnancy.

4.3.3.1.2 Subtheme two: violence experiences of adolescents

Violence is any harmful act that is perpetrated against a person's will and that is based on socially ascribed differences between males and females such as sex and gender. Violence includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private (WHO, United Nations Office for Drugs and Crimes & United Nations Development Program 2014:2).

Violence is a current relevant social and public health problem, not only owing to adolescents' exposure to the risk of physical and mental injury, but also because of the possibility of continuity to the adulthood. Studies show adolescents who are the victims of any one type of violence have high chance of being perpetrators (Rakovec-Felser 2014:64;WHO 2015a:6). Many of the study participants of this study reflected in support of this idea. A 16-year-old female participant stated the problem as:

> *In the rural areas violence of different forms are common. The perpetrators are most of the time intimate people for the victims. Even though sexual violence like rape and abduction are minimised since recently still they are continued as problems of rural adolescents. Physical violence hitting or beating usually by parents or other intimates are also common experiences in the rural areas. A verbal abuse, locally known as "lekefa" by boys is a day-to-day experience of girls. Regarding verbal abuses, owing to its being too common experience, even the victim girls do not consider it as a violence.* (Participant K)

Violence affecting the victims in many forms is widespread in Ethiopia. Emotional and sexual violence in the home and community are common place. However, the underlying factors contributing to the incidence of violence against adolescents and the young in different settings in the rural areas are not well understood. Based on the evidence from this research, physical, emotional and sexual violence are still huge problems the adolescents facing in the school and out of the school environment. This study shows many forms of violence are normalised and widely accepted by victims themselves and the society. Similar finding was reported by a qualitative research conducted by United Nations Children Fund where the report indicated that the victims and the perpetrators normalised and accepted the act (UNICEF 2016a:9).

4.3.3.1.3 Subtheme three: HIV/AIDS

HIV/AIDS is one of the neglected health threats of the rural adolescents in Ethiopia. In this study the issues related to HIV/AIDS were among the frequently appeared concepts in the data regarding the health risks of the adolescents participated in the study. A verbatim quotation from an 18-year-old female adolescent study participant indicates how much HIV/AIDS is a threatening the health of rural adolescents.

> *HIV/AIDS is a neglected health problem in our community. Many adolescents from our community travel to big cities like Addis in search of jobs and they stay there for a longer period of time then come back and join our community. Many of the adolescents of our community do not know even the existence of HIV/AIDS. They make sexual relationships with this people and acquire HIV/AIDS. After the problem happen the adolescents suffer a lot for themselves as well as they impose big economic and social problems on their families. As you know the rural community are mostly poor they cannot afford for the health care services. Obviously, all the family members suffer a lot. In addition to this, the society in the rural areas are illiterate and do not know how to protect the rest of the family members. Thus, the infected member may transmit the disease to others in the house*. (Participant S)

This finding is similar with a study result in rural China where the study reported that outward migration of rural adolescents for better jobs was significant predictor of the risk of HIV infection (Rong, Chunnong, Shujuan, Lei , Qixing, Suhua, Qiang, Gang,Yu, Lin Xiao, Yuhan, Zhang, Wang, Wang & Wang 2018:4).

4.3.3.2 Theme two: sexual health challenges during adolescence

Sexual health is a label commonly used to describe a state of wellbeing in relation to sexuality across the lifespan. It is often considered to have physical, emotional, mental, social, and spiritual dimensions. Sexual health is more than merely the absence of a sexual disease or dysfunction. Sexual health refers to how a person manages the benefits, risks and responsibilities of sexual exploration. Sexual health promotes the well-being of individuals and relationships and prevents undue adverse consequences to self and others (Southern 2018:1).

Sexual health is supported by open, honest, and direct communication about sexuality throughout the lifespan. Sexuality itself includes thoughts, fantasies, desires, attitudes, values, behaviours, roles, and relationships. Therefore, a very important way to improve sexual health is to improve sexual communication. Sexually healthy individuals integrate sexuality in a manner that contributes to the wellbeing of their lives, while avoiding or reducing harmful consequences for themselves and others (WHO 2017a:2).

The adolescent participants of the current research reported that sexual health matters are among the major health concerns in the rural areas of Ethiopia. The theme sexual health challenge during adolescence was developed inductively from the data merging the subthemes related to sexual health. The theme comprises subthemes that are developed after merging the coded concepts: Awareness of sexual health, perceived benefits of sexually healthy adolescents, adolescent pregnancy, and societal conception regarding early marriage.

4.3.3.2.1 Subtheme one: awareness of sexual health

This subtheme describes the perception of the participants regarding the meaning of sexual health. Sexual health awareness of the respondents of this research was limited. Many of the participants tried to connote sexual health to delaying sexual intercourse. This idea is evidenced from the following excerpt from a 16-year- old female participant whom responded for the question raised as “how do you describe your sexual health?”.

uhu'u (laugh like sound indication of the researcher is breaching social taboo in asking about sexual health and sexuality, looking down then rolling her eyes) *I am not sure what sexual health means, but just to try I think sexual health is about abstinence from sex until marriage.*(Participant K)

Some other study participants described sexual health in relation to having healthy children when they get married and others indicated sexual is about the health of sexual organs. This concept is well demonstrated in the following verbatim quotation taken from a 19-year-old male adolescent participant:

I think sexual health is related to the health and maturity of sexual organs. If we see the other way round it can also be about having a healthy child when we become adults. (Participant W)

The available literature also suggests that the level of SRH is among rural adolescents in Ethiopia is poor (Woog & Kågesten 2017:13; Zewdie, Kora & Mulusew 2018:42). The current research and the available literature indicate that the level of awareness of SRH among rural adolescents in Ethiopia is very poor. Adolescent policy makers and programme designers need to incorporate raising the level of awareness of the rural adolescents regarding sexual health issues has an enormous contribution in the health promotion of adolescents of the rural Ethiopia.

4.3.3.2.2 Subtheme two: perceived benefits of sexually healthy adolescents

The adolescents participated in this study expressed different benefits they believed to be the results of being sexually healthy. The participants indicated the economic and social benefits of adolescents' sexual health. This is best demonstrated by the following evidence from a 17-year-old male adolescent participant:

Sexual health issues cannot be seen separately from the overall health of the person. If a person lacks sexual health in one or other way, it affects the overall health status of the person. In the rural areas if a person becomes ill the treatment cost is very high. The person may be required to travel to health facilities in the cities and required to pay for transportation, accommodation and for food this all make the problem severe. The health care services cost is also very high particularly for

adolescents like us in the rural settings. This all brings additional burden on the person affected and the families of the adolescent. In addition to the suffering of the affected person, sexual health issues are sensitive and the society gives different meanings for sexual health problems. They may consider it as happened because the person is having sex with multiple partners or commercial sex workers. The person may be considered as someone who cannot control himself and the related stigma and discrimination for sexual diseases is too much in the society. (Participant M)

The other respondent of this research expressed the benefits of being healthy in terms of sexual health matters in relation to getting healthy child when the adolescents are get married. This was also clarified in the following verbatim quotation from a-15-year old female adolescent participant:

If an individual is sexually not healthy he cannot get a healthy child when the person reaches to the age appropriate for marriage. Maintaining the highest possible sexual health status benefits not only the current adolescent generation but also it has an implication for the coming generation. So I believe the adolescents need to take care of themselves in all perspectives of sexuality. (Participant D)

Research shows adolescents, particularly females, in the rural area are vulnerable to a wide range of reproductive health problems including STIs, unwanted pregnancies, unsafe abortion, and the associated social and economic stigma and discriminations. They have limited access to reproductive health services that focus on the special needs of female adolescents. Appropriate recognition and addressing of the sexual health needs of adolescents and the young people can have life-long protective benefits (Godi, Olenja, Hofman & van den Broek 2014:1; Hailay, Mebrahtu & Abebe 2019:1).

4.3.3.2.3 Subtheme three: adolescent pregnancy experiences

Adolescents who participated in this study explained that adolescent pregnancy in or out of marriage one of the core problems in their community. This is notion was demonstrated by a direct quotation taken from a 16-year-old female participant:

Adolescent pregnancy is a common experience in the community. Adolescents, particularly females are being forced by their parents to marry people who are not matching in terms of age or other aspects. Many girls dropped out of schools and become housewives whose major responsibility is looking after a child. In addition to this, adolescents themselves have sexual intercourse out of marriage and end up with pregnancy. The adolescents who faced this problem have big psychological and social pressure in the community. (Participant G)

Every year, an estimated 21 million girls aged 15 to 19 years and 2 million girls aged under 15 years become pregnant in developing regions (UNFPA 2013:20). Teenage pregnancy remains a challenge requiring urgent resolution all over the world. Approximately 95% of teenage pregnancies happen in developing countries with 36.4 million women becoming mothers before age 18 and 5.6 million having a live birth before age 15. In the sub-Sahara region teenage mothers account for more than half of all the births, an estimated 101 births per 1000 women aged 15 to 19,which is unacceptably the highest figure (UNFPA 2015:7).

According to the last Ethiopian Demographic and Health Survey Report, teenage pregnancy in or out of marriage is a major health concern in Ethiopia. Childbearing during adolescence is known to have adverse social consequences, particularly regarding educational attainment, as women who become mothers in their teens are more likely to drop out of school. In Ethiopia, 13% of women age 15-19 have begun childbearing: 10% have already given birth, and an additional 2% are pregnant for their first child at the time the survey. It is a major direct or indirect contributing factor for high maternal mortality and morbidity in Ethiopia (CSA, Ethiopia 2016:77).

According to research findings conducted in rural Ethiopia, adolescent women are forced to get married as early as at the age of 14, without their consent. Women in Ethiopia, particularly adolescents, who get married before legal age of 18 years, are deprived of critical aspect of autonomy. More than (61%) of adolescents who have ever married the decision to marry is made by their parents, while (3%) of the adolescents marriage are decided by other family members or relatives against the adolescents will for marriage (Mihiretu & Mengistu 2017:215; CSA Ethiopia 2016:260).

4.3.3.2.4 Subtheme four: societal conceptions regarding early marriage

The conception regarding early marriage is a subtheme derived from the data and describes the common societal conceptions about early marriage. Early marriage is the common experience in the current study setting and the participants expressed the society gives different justifications for the act. The following evidence from a 16-year-old female study participant confirms this idea:

> *Early marriage seems declined from the past, but still there is early marriage in the community. Girls are being forced by the parents or relatives to marry men who are really not match in different perspectives like age, education status and the like. As you know in the rural area the parents hardly afford the needs of their children and the household. The parents push their girl daughter to marry the rich regardless of differences in age or whatever. For some others the reason is different, they support early marriage because they assume children born at old age become cognitively and physically weak. You know in Ethiopia it is exclaimed "ohh! child means in childhood" in Amharic" "ልጅ ማለት በልጅነት ነዉ" which is proverb massively encouraging the adolescents as well as the parents for early marriage. Some other portion of the society believes child bearing at the older age is dangerous for the mother and the child, so they support early marriage.* (Participant F)

Early marriage in Ethiopia is the common experience. Young age at marriage is an important determinant of adolescent pregnancy and the associated pregnancy and child bearing related health risks. More than (41%) Ethiopian women aged 20-24 years married before the legally allowed age for marriage 18 years (World Bank 2016:17).

Ethiopia is one of the countries, which have the highest proportion of early marriage throughout the world. The intact and deepening tradition, religion, and economic motives are the major reasons for the persistence of this discriminatory practice in the country. Because of underage and immature family formation, girls are suffering from psychological and emotional traumas, various violence, and denial of social services, reproductive health problems and migrations (Mengistu 2015:4). Therefore, sensitising the stakeholders, educating girls, and supporting the runaways and others who would otherwise the victims of early marriage are the way forward to reduce the adverse consequences of child marriage in Ethiopia.

Conclusions on category three

In the major category, health challenges faced in adolescence health risk experiences and sexual health related challenges which impose risk on the overall health of the adolescents were described in detail. There is a need to appropriately address these challenges by prevention of the health challenges particularly risky practices and perceptions on substance and alcohol use, violence and HIV/AIDS and sexual health related challenges. In addition, poor awareness regarding sexual health and sexuality, perception of benefits of own health, adolescent pregnancy and conceptions toward early marriage is of a paramount importance for any stakeholders who are working on the health promotion interventions of adolescents particularly in the rural set ups.

4.3.4 Category four: social and cultural perspectives of adolescents health

Socio-cultural perspectives of adolescents' health is one of major categoriesin this research and describes the socio-cultural perspectives of health of the adolescents in the rural set ups. According to Atwater (1992 as cited in Ogunjuyigbe 2014:345), the overall experiences of adolescents is heavily influenced by one's socio-cultural environment. Every society whether simple or complex, has its own system for training and educating its youth with much emphasis on education for good life in the future. In a countries like Ethiopia, where the cultural and social perspectives have a significant influence on the health status of adolescents, health promotion interventions are required to incorporate the social and cultural perspectives of adolescents for effective implementations. This category was extracted from the data in the current research and the category comprises: perceived foundations of adolescent's health, social influences and cultural practices.

4.3.4.1 Theme one: perceived foundations of adolescents health

This major theme emerged after analyses of the understandings of how the participants perceive the foundations or determinants of their health. The researcher tried to form sub-themes for this theme with the major codes from the data were assembled according to their underlined messages under the major theme perceived foundations of

adolescents' health. The subthemes emerged from the data under this theme are the family, schools and neighbours.

4.3.4.1.1 Subtheme one: the family as adolescents health experiences defining entities

The family from where the adolescents' belong is one of critical aspects of adolescents' health. It would therefore seem that adolescents need close support not only from their parents but also from all other members of the family who are contributing for their health. As it is quoted below from a 16-year-old female adolescent:

> *My family particularly my parents are very crucial for all of my health-related behaviours I learn everything from my parents first. It is after that I engage with other people friends' schoolmates and all others. The healthy environment in the family is very important not only for the adolescents but also all the members of the family. You know* (referring to the researcher) *if one of the family members gets ill, everyone else is going to suffer so the health of the family is the basic for all the members of the family* (Participant H)

According to a qualitative study conducted on links between family and adolescent behavioural outcomes family strengths are the set of relationships and processes that inherently satisfy, support and protect families and family members, especially during times of adversity and change. Adolescents who are bonded with caring parents are less likely to engage in risky behaviours. Parents who supervise and are involved with their adolescents' activities are promoting a safe environment for them to explore opportunities (Moore,Whitney & Kinukawa 2009:1).

4.3.4.1.2 Subtheme two: neighbours and adolescents health experiences

The neighbours of adolescents identified as a significant entities that are contributing for adolescents' health experiences. Initially, some of the study participants mentioned the significance of neighbours and the researcher tried to further probe interviews for elaboration using the opportunity of flexibility and theoretical saturation provided by grounded theory method. Finally, the subtheme becomes very relevant for exploration and description from the data. The following verbatim quotation from an 18-year-old

male adolescent shows how much neighbours are a significant people in adolescents' health experiences:

> *We grow up sharing everything with our neighbours. All of our experiences are the consequences of our family and our neighbours. We share sad and happy experiences with our neighbours. When we grow up as a child before anybody else, we get our neighbouring children and our behaviour becomes almost the same. Neighbouring adolescents contact everyday more than anybody else our behaviour knowingly or unknowingly becomes similar. All of our preferences and needs become the same. Health-related behaviours are also the shared experiences with our neighbouring adolescents. Neighbours have very great role in all of our behaviour and practices*. (Participant R)

Adolescents who are grown up in a distressed neighbourhood with high rates of poverty are at higher risk for exposure to violence and a variety of negative health and behavioural outcomes, including poor physical and mental health, delinquency, and risky sexual behaviour (Coley, Leventhal, Lynch & Kull 2013:16; Galster 2014:1).

4.3.4.1.3 Subtheme three: schools as adolescents health experiences

In almost all countries, the majority of adolescents spend most of their time in schools. Even though the main target of schools is behavioural change for good of adolescents through education, the effect of schools environment on adolescents' development is multidimensional, encompassing their physical and mental health, safety, peer engagement, and social development. The following verbatim quotation from a 19-year-old male adolescent clearly expresses the impact of schools is beyond the educational task:

> *As you know* (referring to the researcher) *in our country currently almost all adolescents in our age are attending schools. This means we are spending higher portion of our time with our classmates and teachers. As it is known we adolescents are very open to discuss everything with our classmate friends than even with our parents. Our friends' especially of similar age and sex openly discuss everything because we are at the same age group and we share many of the changes at the same time. Sometimes in a friends group there are influential adolescents and we*

may accept and follow their ideas without questioning. The idea may be bad and may cause bad health outcomes. Similarly we learn also good behaviour. This shows how much our school environment influences our behaviour. (Participant A)

The impact of school environment on the adolescents overall behaviour and particularly on their health related behaviour is very much significant. The school environment puts its effects through a variety of ways including formal pedagogy, after-school programmes and caretaking activities as well as the informal social environment created by school adolescents and staffs on a daily basis (Pilar & Brett 2008:3).

4.3.4.2 Theme two: social influences and adolescents health experiences

According to Berns, Capra, Moore and Noussair (2010) and Zaki (2011) as cited in Knoll, Magis-Weinberg and Speekenbrink (2015:389), other people's behaviour can have a significant impact on one's own behaviour. Children and adolescents are highly susceptible to social influences than adults do. Social influence is a determinant factor in shaping the adolescents risk taking and risk avoiding behaviour and people change their behaviour to fit in with other people. The subthemes developed from the data, in this theme include peer pressure, religion, education, and societal values.

4.3.4.2.1 Subtheme one: peer pressure in adolescence

In the current study, peer pressure is among the significant concepts extracted from the data. Peer pressure has a huge role of increasing or decreasing the risk taking and the risk avoiding behaviour among the study participants. A19-year-old female study participant said:

Here (referring the rural setups)*, we build a friendship with other adolescents. You know* (the researcher*) the level of awareness of the rural adolescents is poor, it is easy to manipulate to good or bad behaviour in the rural settings particularly if the idea is initiated in our peer group. Most of the time as an adolescent we are excited to practice something new, we do not see the upcoming cost. If an idea is raised in our peer group, we do not see the other way round but just we end up in a hurry to practice. I think peer influence is very big in adolescents' life.* (Participant Y)

This research finding is supported by a study conducted in Tigray, Ethiopia where the study demonstrated that peer groups of adolescents have an overwhelming impact on the overall and in the specific health experiences of adolescents. In the same study, both sex participants, boys and girls, reported that the peer environment is characterised by a significant pressure to conform to peer expectations, and deviations from such expectations usually lead to negative peer experiences (Kenny, O'Malley-Keighran & Molcho 2016:768;Znabu, Azeb & Bazzano 2019:5). Adolescents spend more time with their peers than with their families and they are more likely to engage in risky behaviour, when they are with their peers than when they are alone (Albert & Steinberg 2011:219). This study shows adolescent peer influence on their health experiences was very big. Appropriate identification of the relevant peer of the adolescents and empowering them with the necessary information and life skills has a significant role in shaping the adolescents behaviour for contribution of positive behavioural outcomes.

4.3.4.2.2 Subtheme two: religion and adolescents health experiences

In this research, the role of religion in adolescent's health and behavioural outcomes was a recurrence in the data. Religion was one of the significant concepts recurring in the data and it has both external and internal influence on the adolescents' health experiences. The internal influences are based on the adolescents' own spirituality and the level of conformability to the requirements of the religion the adolescent follow, whereas the external component is the expectations of the religious leaders and religious peers. The excerpt of a verbatim quotation from a 16-year-old female study participant supports this idea:

> *I believe there is a big relationship between religion and adolescents' health experiences. Adolescents' who are strong in their religion keep themselves from practicing things that are not allowed. However, those who are loose in the religion do whatever they need to and they also invite other adolescents to their experience. The Muslims in our community are very strict for their religious requirements; for example, Muslim adolescents are not allowed drinking alcohol and close relationship with the opposite sex before marriage. In Christianity, it is also the same. Whenever adolescents or adults become sick they pray to God for healing. In Christianity, we*

*go for spiritual water (*Tsetsebel in Amharic*) in extreme cases of illness.* (Participant H)

Ethiopia religious composition comprises 62.8% Christians (43.5% of the Ethiopian Orthodox Church and 19.3% of other denominations); 33.9% Muslims, 2.6% traditional faiths and 0.6% others (UNFPA 2016:13). A study conducted on the adolescents behavioural outcomes and religion shows adolescents who attended religious institutions at least once in a week for religious services was positively associated with greater life satisfaction and positive effects, a number of character strengths, lower probabilities of marijuana use and early sexual initiation, and fewer lifetime sexual partners. The same study also reported that encouraging service attendance and private practices in adolescents who already hold religious beliefs had a meaningful positive behavioural outcome in adolescents' health and well-being (Chen &Vander-Weele 2018:2355).

Almost all of the Ethiopian population is tied strongly to different religions. This research finding indicates that religion in Ethiopia has a direct and indirect role in determining the adolescents and adults behaviour. Religious institutions and religion in Ethiopia are among the poorly utilised opportunities in adolescents' behavioural change interventions.

4.3.4.2.3 Subtheme three: education and adolescents health experiences

Education was among the relevant concepts that occurred frequently in the data as adolescents' health experiences determinant. The role of education was very broad and has greater impact in determining the adolescents' health-related experiences and decision-making power. Adolescents who are illiterate are prone for different abuses and their rights are easily violated. The participants of this research indicated education has a power to increase their knowledge of how to avoid health risk and how to promote healthy life. The following excerpt from a 19-year-old female study participant captures these views:

I think education and health have strong relationship. If one society is illiterate they cannot know about their health. If you are illiterate you just think blindly, you do not

know anything. Life without education is just like walking in a deep darkness in the night. If you are literate you can make wise decision regarding your health and other things. In our locality many people are illiterate and they do not care much about their health. So education is very important for our health. (Participant Z)

Education is one of the most important aspects of socio-economic development. Education improves capabilities and is strongly associated with various socioeconomic variables such as lifestyle, income, and fertility for both individuals and societies (CSA Ethiopia 2016:14). Despite relative improvement in educational enrolment in recent years, still now many adolescents and school age children are out of school and education in Ethiopia. Seventeen percent of 10-14 year old, 18% of 15-19 year old and 39% of those aged 20-24 years had not attended formal education (UNFPA 2016:13).

4.3.4.2.4 Subtheme four: societal values and adolescents health experiences

The participants of this study expressed their understandings of the societal values and what is expected from the adolescents. The society has many values regarding adolescents' health in general and SRH in more specific. One of the repeatedly raised concepts by the respondents of this research was sexual cleanliness before marriage. The idea is expected from both boys and girls. However, it is more relevant and big deal particularly for girls. If a girl is virgin and has sex for first time with her husband, the families and the relatives of the girl assume they are successful in their investment on their daughter's discipline unless they consider it as failure. Virginity of a girl is also considered as the guarantee for trust in between the girl and her husband when she gets married. The girl who has lost her virginity before marriage is more likely loss trust from her husband because her husband loses his trust on her as he has no guarantee she will not repeat the behaviour in marriage. The following excerpt from an18-year-old female study participant indicates this view:

Our society is serious in adolescents' health particularly sexual and reproductive health issues. The society gives more attention on sexual and reproductive health issues of adolescents. If a girl lacks her virginity before marriage it has a big implication for the girl, her families and relatives. They feel proud in their daughter if the families of her husband send confirmation message their daughter is virgin. If

they do not get the confirmation, it is equally bad they feel embarrassed, ashamed and failed in their child upgrading project. (Participant V)

The participants of this research also expressed the value of SRH purity in the society is being declined in the younger generation. The adolescents particularly the boys bring different reasons to have sex with a virgin girl. One of these reasons is they tell them as virginity does not matters in marriage. Rather they may tell them as being virgin until marriage means the girl was not attractive or not wanted by men before she is get married. A verbatim quotation from a17 year old female study participant supports this view:

Usually the boys bring different reasons to have sex with girls. In our community particularly the ones who have stayed in cities and comeback use different strategies to fool the girls for sex. They tell them if they are virgin until they get married, as it is an indication of she was not wanted by men. So her husband loses his confidence on his wife when she gets married, because he may think something was wrong with his wife and that was why she did not wanted by men virgin until she marries him. When they tell them this way the girls are cheated and say ok for sex. The girls who are experienced sex in this way, begin to promote the idea to their girl peers and it becomes the value of the society (Participant P)

The above finding in the current research is also parallel with the results of a cross-sectional study conducted in Nigeria where the study reported that the process of modernisation and urbanisation is changing the traditional values and social practices. Adolescent sexuality and reproductive behaviour have been influenced by religion, mass media and globalisation. Traditional sex education practices and adolescent control systems are being abandoned with no other functional system to replace them, forcing some important traditional values and social practices including premarital sexual norms to undergo changes in unpredictable directions (Ogunjuyigbe 2014:343).

4.3.4.3 Theme three: cultural influences and adolescent health experiences

In some cultures, young people believe that external factors (such as fate or luck) determine what happens to them. In others, young people believe that their own capacity or skills and efforts determine what happens to them. In general, young people

who think they can determine what happens within the range of available options will be more likely to make their own decisions and therefore feel greater commitment to these decisions and get more satisfaction from their decision than those who believe fate determines the outcomes (FDRE,MOH 2015:17).

Adolescents living in low- and middle-income countries face a variety of socio-cultural factors that place them at risk of poor health. Adolescent girls and young women often lack a full range of opportunities and are devalued because of gender bias and low social status. In many cultures, girls are more likely than boys to be married as children to drop out of school and to experience forced sexual initiation (Kapungu & Petroni 2017:2). Ethiopia is a mosaic of cultural diversity with over 80 distinct cultural groups and religious diversity where many forms of good and harmful cultural practices are tremendously influencing the health of the adolescent population (CSA Ethiopia 2016:315). The theme cultural influences on the adolescents' health in this research describe the conceptually related subthemes: traditional practices, against cultural norm behaviours and consequences and ways of maintaining the tradition.

4.3.4.3.1 Subtheme one: the influence of traditional practices and adolescents health

The participants of the current study described many forms of traditional practices are being conducted in their locality. Many of the participants emphasised that traditional practice particularly FGM is widely practiced in their community. This idea is manifested in the excerpt taken from a 15 year old female participant of the study:

> *There are many forms of traditional practices in our locality. Some of the practices are performed openly to everybody and some are performed hidden. In our community, almost all of the girls are circumcised but no one knows. The government officials usually search for the performers, but they hardly get the offenders as well as the victims. The community members never disclose female genital mutilation; they hide it entirely. This is due to, they know it if it reaches to the ears of government bodies, they are to be penalised. If the government bodies as a chance get the females who undergo mutilation, the family as well as the neighbours say she is sick and that is why she is on the bed. Then, they go back.* Participant (Participant D)

Although, the government of Ethiopia gave an emphasis to eliminate harmful tradition practices, still they are continued to be among the major social and health risks of the people. A cross-sectional study conducted in the northern Ethiopia reported traditional practices are still continued challenging the health of the adolescent people and the general population. As to the mentioned study Ethiopia has identified 11 major harmful traditional practices that need intervention. These are FGM, early marriage, uvula cutting, milk teeth extraction, marriage by abduction, food prohibition, work restriction, massaging of the abdomen of pregnant women, excessive feasts, body incisions for traditional purpose, and inheritance marriage (Yohannes & Negesse 2018:2).

4.3.4.3.2 Subtheme two: maintaining the traditional practices

The current study shows that the society tries to maintain the traditional practices regardless of their importance. Some of the practices are harmful for the health of the adolescents while others are useful. However, the adolescents who participated in the research reported they do not care for the importance; they give more attention for majority acceptance of the practices. The following verbatim quotation from 15-year-old female adolescents echoes this idea:

> *The community still believes and give attention in maintain the commonly accepted practices. The people do not care which practice is important and which is harmful. Female genital mutilation was told many times as it is bad for the health of the girls, but the people still insist in conducting it. In our community, it is believed if a girl is not circumcised, she breaks the utensils. The underlying meaning of this belief is sexual desire of the uncircumcised girl is too high and she always thinks how to go out of house, so that she is out of her head and break utensils. The other issue the people insist in maintaining is early marriage, still now the people believe early marriage as good thing because they believe that if you bear a child in the early ages the child reaches to adulthood before the parents become too old to look after them.*(Participant B)

4.3.4.3.3 Subtheme three: behaviours against cultural norm and consequences

This study shows many useful cultural norms are being breached by the adolescent generation in the study area. The traditionally established penalties for such acts are also being degraded and replaced by permissive and toleration of the breaches. The following verbatim quotation from a 19-year-old female participant supports this notion:

> *Currently it is very much difficult for parents and the community to control their adolescent boys and girls. In this community majority of the parents of the adolescents are illiterate. The adolescents are getting education and they try to present the useful cultural norms as useless and outdated to their parents and the adults. You know our people particularly, the illiterate respect the educated and accept their idea. Owing to this fact*, *the adolescents behave in a ways that are against the societal norms. The important cultural norms are being degraded and being replaced by the adolescents bad modernizations. previously, the consequences of breaching this cultural values was very harsh, but now days no one really cares too much, it seems all is allowed; premarital sex, chat chewing alcoholics all are practiced by the adolescents but the society preferred being silent.*(Participant Z)

This finding was also reported by the Ethiopian demographic and health survey report where it described as public attitudes regarding adolescent behaviour is being changed in many ways. Previously, more strictly forbidden behaviours are becoming more permissive in the recent days. The public tolerance of premarital sex and childbearing increased among adults, along with the acceptance of divorce and cohabitation. Adolescent behaviour patterns appear to mirror these broader societal trends. In Ethiopia, estimates of the trends of premarital sexual intercourse and having multiple sexual partners among adolescents are increasing (CSA Ethiopia 2016:228).

Conclusion on category four

In the fourth category, this research described the socio-cultural influences of adolescents' health. The socio-cultural perspective of opportunities and challenges are among the important conditions that need to be adequately and appropriately addressed. The health of the adolescent population is directly affected by the socio-cultural and economic context in which they live. Adolescent population in Ethiopia are facing multiple and interrelated social, economic and health problems (UNFPA

2016:17). Appropriately considering the identified key themes perceived foundations of adolescent's health, social influences and cultural practices and their respective subthemes is a key aspect for designing and implementing adolescent health promotion programmes and projects.

4.3.5 Category five: suggested health promotion strategies

Suggested health promotion strategies is the last major category in the current research and describes the strategies and the needed changes regarding adolescents health indicated by the adolescents. The category comprises three themes that are conceptually related and inductively developed from the data. These include the health sector, the government and parental support

4.3.5.1 Theme one: the health sector

During adolescence, foundations for future health or ill-health are established. In today's world, the structures of social and physical environments are rapidly changing, which have an impact on health-related behaviours and associated outcomes. The health sector needs to be appropriately, effectively and efficiently responsive to the needs of the adolescent population health. The health sector in this research is a broad theme in the category suggested health promotion strategies and describes the issues normally handled by the health sectors. The subthemes include health care workers, health facilities, improving awareness of health risky behaviour, adolescent friendly services and promoting help seeking behaviour

4.3.5.1.1 Subtheme one: the health care workers

The health care workers are the front-runners not only regarding adolescents health, but also in the overall health interventions for all age groups. The importance of health care workers is described by the 16-year-old female participant as:

> *Health care workers have to be more accessible to the adolescent people. The adolescents usually do not go to the health facilities where they get the health care workers unless they are severely ill. So that the health care workers should design*

strategies to address the health problems of adolescents in their places like schools, clubs, and in their communities. (Participants J)

The participants of this research have reported that they demand more from health care workers for more health promotion of the adolescents. This finding agree with UNICEF (2016b:16) action document where it indicates that health care providers have crucial role in reducing the stigma and discrimination against health conditions. In addition, UNICEF (2016b:16) also advocates for the promotion of health through community dialogue and education, the rights to health, of children and adolescents, and equip them with clear action steps and/or guidance to fulfil these rights and to develop compelling and contextually appropriate messaging to promote prevention and care-seeking behaviours.

4.3.5.1.2 Subtheme two: the health facilities

Health facilities in Ethiopia are inadequate in terms of the service quality, accessibility and affordability of the services. In the rural areas, the problem is worse. The following except from a 17-year-old male participant describes this notion:

In our community, no health facility is present. There is a health post, the existing health post also have no the necessary equipment. Whenever, we need health services we are usually obliged to travel to Goba hospital, which is too far. (Participant L)

According to an inventory research conducted in health facilities, health care facilities environments are the crucial components in determining the adolescents' health care seeking behaviour. The presence of signage system for services and where to go's, can increase the accessibility of the services and the providers. Usually, the significance of this aspect is neglected in the health facilities. Adolescents need privacy and confidentiality of information they provide to the health care workers. However, these aspects are usually overlooked by the health facilities. Adolescents privacy and confidentiality was kept in only 63.64% of the assessed health facilities and none of the health facilities had training records and Information Education and Communication (IEC) material (Dixit ,Jain, Mansuri & Jakasania 2017:820).

4.3.5.1.3 Subtheme three: raising awareness on health risk behaviour

One of the important activities of the health sector for the improvement of adolescents' health and wellbeing is raising the awareness of the adolescent people regarding health promoting and health risk behaviours. The leading causes of illness and death among adolescents are largely preventable and the health outcomes are frequently both behaviourally mediated and linked to multiple social factors. Shaping the behaviour of the adolescents in the ways of health promotive manner has a significant impact in reducing the cost of curative medicine and increases the productivity of the adolescents. This idea is supported by the following direct verbatim quotation obtained from a 16-year-old female adolescent participant:

> *The adolescents of our community have poor awareness regarding health risk behaviour. They usually involve in all kind health risk activities. They are practicing many forms of health risk like chewing chat, drinking alcohol, unprotected sex, and early sexual début. I think the health sector needs to use different strategies to address these problems.* (Participant H)

Providing health education on key health and behavioural topics has a significant role in promoting healthy adolescence and preventing unfavourable health outcomes. According to a study conducted in India (Shankar, Dudeja, Gadekar & Mukherji 2017:137), the majority of adolescent participants of the study were unaware of the development of secondary sexual characters and use of condoms and oral contraceptive pills as means of contraception. Adolescent girls, especially those living in an urban slum locality, are vulnerable to sexual advances by not only young boys in their immediate neighbourhood but also to sexual abuse and violence by men in their families or community. Improving awareness adolescents increased their use of services. Those interviewed highly appreciated the same-sex peer approach as effective in establishing approachable sources of information within school, higher education and community settings.

4.3.5.1.4 Subtheme four: improving adolescent friendly services

Adolescents of the current research reported that the services given in the adolescents friendly clinics are poor both in terms of the quality and service delivery system. The

adolescent services in their surrounding health centre and health post is integrated with other services. This limits adolescents from accessing the services and they indicated they are afraid to share the service delivery outlets with other people. The adolescents need more privacy and intimacy than the other people. This idea is disclosed by a 15-year male adolescent study participant in the following ways:

> *Adolescents need separate and private system to talk issues related to their health. Most of the health risk activities adolescents perform are in a hidden ways. They feel they are going to be penalised if their issues are disclosed to their parents and the society. Adolescent friendly services need to be given more attention to address the health needs of the adolescent population.* (Participant A)

Adolescents are generally reluctant to discuss intimate personal, SRH issues in the group. They are usually inclined to talk in groups about general topics related to health and nutrition. Adolescent friendly services need to be designed in the ways to fill such gaps and need to be accessible, acceptable, and appropriate for adolescents. They have to be in the right place, at the right price (free where necessary) and delivered in the right style to be acceptable to the adolescents. They have to be ensured whether they are effective, safe and affordable and meeting the individual needs of the adolescent, so that they return when they need to and recommend the services to their friends (United States Agency for International Development (USAID) 2017:VIII).

It is hard to reach adolescent population by the existing usual health care delivery approaches. Adolescent-friendly services (AFHS) should be able to attract young people, meet their needs comfortably and with sensitivity, and retain young clients for continuing (follow-up) care. However, the services designed for adolescents were highly fragmented, poorly coordinated and uneven in quality. This problem accompanied with the adolescents' lack of basic health knowledge and access to affordable and confidential health services exposed the adolescents to limited utilisation of adolescent services (Kerbo, Tefera, Kuti & Nur 2018:17).

A research conducted in Gujrat India reported that the majority of the adolescents participated in the research expressed the need for a separate clinic and were against combining adolescent services. This is because they often find mainstreamed primary care services were unacceptable because of perceived lack of respect, privacy and

confidentiality, fear of stigma and discrimination, imposition of the moral values of health-care providers (Dixit et al 2017:821).

4.3.5.1.5 Subtheme five: promoting help seeking behaviour of adolescents

Adolescents usually try to hide their problems and try to solve by their own. Adolescent participants of the current research reported that their help seeking behaviour is poor. This view was supported by a 17 year old female study participate in the following ways:

> *Adolescents usually do not disclose their problems for other people. If I tell you my own experience, whenever I face problems, first I try to solve it myself. If I disclose to my parents or friends they rush to judge me rather than indicating options of the solution.* (Participant N)

Help seeking and having access to and using social supports are generally protective factors for many adolescent health and developmental outcomes. Having and using social supports is associated with lower rates of suicide, safer sexual behaviour, lower rates of substance use, later sexual debut and lower rates of delinquency or perpetration of violence. Improving the help-seeking behaviour of the adolescents, whenever it is relevant is based on raising the adolescents level of awareness of recognition of the severity of the problems and overcoming the perceived barriers to change their intentions to action (Magaard , Seeralan, Schulz & Brutt 2017:17).

4.3.5.2 Theme two: the government

This major category was developed after recognition of frequent occurrence of ideas related to recommendations and expectations from the government for health promotion of adolescents in the data. The major category comprises adolescent policies, need based health projects, keeping adolescents in schools, and enforcement of adolescent health protection laws.

4.3.5.2.1 Subtheme one: adolescent policies

The participants of this research indicated that the government policies regarding adolescents' health need to be practical and achievable. Many policies are developed to

ensure the health and wellbeing of adolescents each year. However, there is a gap in changing the policies in to practice. A 19-year-old female study participant stated this view in the following ways:

> *The Ethiopian government develops many health and wellbeing policies to address the overall welfare of the Ethiopian adolescents. However, there is little progress in implementation of the policies. More recently, the government introduced adolescent fund to solve the economic problems and the associated health problems of the adolescents. But, owing to corruption and mismanagement of the money at each level of the government administrative ladder only little changed to the intended action. Lack of jobs and educational opportunities are increasing. This in turn, increasing the vulnerability of adolescents' to health risk practices.* (Participant S)

The above finding agrees with (UNFPA 2016:12) report where it reports that a number of policies have been developed to promote the health and wellbeing of adolescent population in Ethiopia, but none of the polices changed to practices as they expected. In the report listed policy documents include: the National Youth Policy of 2004, the adolescent SRH Strategy of 2006 and the Education Policy and subsequent Education Development Strategies have been enacted to translate provisions that articulate healthy development of adolescents in Ethiopia.

4.3.5.2.2 Subtheme two: need based health projects

The participants of the current research also indicated that whenever, health programmes and projects are designed to promote the health and wellbeing of the adolescents, need assessments are rarely done. They are following the top to down approach. The following direct verbatim quotation taken from a 19-year-old female study participant supports this concept:

> *They usually tell us what to do and what not to do, but do not know our current need. Since the final goal of the programs and projects is to improve our health and wellbeing, I think it is better to discuss with the adolescent what to do before getting in to implementations.* (Participant U)

4.3.5.2.3 Subtheme three: keeping adolescents in schools

Adolescents who are out of school are more likely to practice health risk than those who stay in schools. Realising this problem, Ethiopia is implementing legislation and established national programmes to introduce universal and free education system all over the country. The Education Sector Development Programme was initiated in 1998 with the aim of providing universal education by 2015. The programme covers education from basic to tertiary level, including: building educational infrastructures, upgrading and renovating schools; reforming educational curriculum; improving teachers' skills; and increasing the provision of equipment and books (Ministry of Health Ethiopia, Partnership for Maternal and Child Health, WHO, World Bank, Alliance for health policy and systems research and participants in the Ethiopia Multi-stakeholder Policy Review 2015:17).

Education is a social vaccine for achieving positive result in almost all indicators of health outcomes. A systematic analysis of global data between 1990 and 2013 reveals that improvements in education have substantial health benefits, including decreases in adolescent fertility, HIV prevalence, and mortality rates among young people. Positive health outcomes are greatest among young women and those from low-income countries, particularly in South Asia and sub-Saharan Africa. The study also reported that highly significant association in the reduction of mortality and HIV in young men who are attending schools (Vinera, Hargreavesa, Warda, Bonellb, Mokdadc & Pattond 2016:162). A 15-year-old male study participant indicated his views regarding education and adolescents' health and the government role in the following ways:

> *Keeping adolescents in schools has significant implication for the adolescents themselves and the parents. Adolescents who are out of schools and education begin thinking bad and harmful things for their health. Early marriage, chewing chat, alcoholics and early sexual debuts are common in adolescents who are not attending schools. The government has to give more attention for education. In our community many adolescents are attending education, but still there are some adolescent who are not going for education.* (Participant B)

This was further supported by another female participant of age 17 years who indicated the power of education in changing the mentality of adolescents' parents and the society in the following ways:

> *The parents of the adolescents of the rural setting usually begin thinking for marriage, if their offspring are out of schools. There are adolescents who get married in their early ages in our locality. If you get the chance and ask their parents why that happens they may say what he/she do in home, as long as he/she is not attending education and if you ask the same question why is this not happening on those attending schools they may say because he/she is attending schools.*(Participant O)

The above finding shows the multidimensional effect of education on adolescents' health and wellbeing. The government and all other stakeholders are expected to give more attention on improving both accessibility and quality of education.

4.3.5.2.4 Subtheme four: Enforcement of adolescent health protection laws

The participants of the current research expressed that adolescents' health protection laws are not being implemented as prescribed in the law. Many illegal things are happening that are against the law. Gender-based violence, verbal and physical abuses on females are among the common experiences in their communities. The following verbatim quotation from an18-year-old female participant captures this view:

> *The laws are not appropriately being implemented. It is day to day experience to see breaches of the law. On the paper everything is there, but in practice there is much gap. Verbal abuses of females in schools, on the road are common. The perpetrators are usually not punished by the law. I think enforcing the law as it is on the paper may reduce the act.* (Participant T)

The Ethiopian Constitution of 1994 which is until now being practiced is a fundamental document and in article 34, it provides the legal basis of protection for adolescents and youth SRH (Constitution of the Federal Democratic Republic of Ethiopia, 1994:10). Related to this, the revised and recent Family Law of Ethiopia took important steps in protecting the SRH of young people. The law sets out concrete measures to address gender-based violence and harmful traditional practices. It criminalises the act of rape

and abduction, FGM and renders these acts punishable by law. The revised Family Law has also set a minimum age of 18 years for marriage for girls and sets strong punishments for breaching the law (Federal Negarit Gazetta of the Federal Democratic Republic of Ethiopia 2000:3).

4.3.5.3 Theme three: Parental support

Parent to adolescent interaction and relationships are among the most important components of adolescents' behavioural determinants. The initial role models of adolescents are their parents. A family and its members provide valuable role models for a range of behaviours, including effective communication, relationship skills, and socially acceptable behaviours. The ways in which conflict and disagreements are negotiated within the family are important blueprints for dealing with issues outside the home environment (Kobak, Abbott, Zisk & Bounoua 2017:140).

Research shows changes in adolescents' motivations and capabilities pose unique challenges to parents who play a continuing role in ensuring the youth's safety and well-being. The relationship between the parents and the adolescents need to be flexible to adapt to the teenager's changing needs. As the adolescents grow older, parents are expected to assume flexibility in their relationships, their role changes from more authoritative approach, to a more collaborative approach. Parents have to learn to 'let go', not of the relationship, but of their dreams for the young person, and their authority over the young people, so that they may allow a young person to develop their own dreams and greater self-responsibility (Aksarapak etal 2018:236; Kobak et al 2017:137).

Therefore, parental supervision and support is the crucial component of adolescents' behavioural moulding and contributes significantly for positive health outcomes of the adolescents. This theme describes the expectations and recommendation of the current research participant adolescents' views on the follow ups of adolescents by their parents, parenting styles and family structure.

4.3.5.3.1 Subtheme one: parental follow ups of the adolescents

The participants of this research expressed their concerns of the occurrence of increasing trends of absence or looseness of the follow-ups and supervision of parents

of their adolescents. This view is illustrated by the following verbatim quotation from a 19-year male study participant:

> *When I compare with what heard from my elderly brothers and sisters, I think nowadays a parental supervision and control light. These days, very little children do not hear their parents' instructions, they go following their wishes. I believe listening to parents is very important; they have much experience to share with adolescent people.* (Participant W)

Parents function as role models in socialising their children into specific patterns of behaviour. Greater parental monitoring is associated with less initial adolescent involvement with alcohol and other substances, lower rates of misuse over time , and an increase in the age of an adolescent's first sexual intercourse, as well as decreased sexual risk behaviour. During adolescence, parents' knowledge of their children's whereabouts and friends becomes important for reducing and preventing problem behaviours (Hoskins 2014:511).Therefore, improving adolescent parent connection and follow-ups has an important implication for positive adolescent behavioural outcomes.

4.3.5.3.2 Subtheme two: parenting styles and adolescents

Parenting styles have a significant role in adolescents' behavioural outcomes. The adolescent participants of this research expressed their concern of their parents usually use punishment of different forms to shape their problem behaviours. This view is captured in the following except from a 15-year-old female study participant:

> *In our home, we usually not allowed to discuss with our parents. The adults usually talk to the adults. If I am disobeying the rules of my parents they may punish me. The punishment ranges from avoiding food for some time to physical hits and shouts. Our parents order us what to do and what not to do; usually they do not tell us the reason why they say like that.* (Participant E)

Parenting style is a significant factor in psychosocial development of children and adolescents. Parents parenting styles have great influence on children life domain. Positive parent and child relationship is the foundation of healthy home environment. Children spend most time at home and parent's attitudes, behaviours, life standards and

communication with children has great impact on child's future life. If parents are too much strict or too much submissive, that has worse impact on their life. But supportive, caring and flexible attitude of parents produce behaviourally disciplined adolescents and adults (Bibi,Chaudhry,Awan &Tariq 2013:93).

4.3.5.3.3 Subtheme three: family structure

Family structure is among the important concepts that occurred frequently in the data. The participants of this research indicated that variation in handling and discipline of adolescents occurs in between adolescents who live with their biological parents and with those living with relatives or other people. They have further stressed that variation in the behavioural and health outcomes. This notion is captured in the following excerpt from a 16-year-old female study participant:

> *I grow up in my relatives' house. I lost my father in my early ages. My mother could not provide what I need. We are six in the house sometimes we lack even food to eat. So that she sent I to her brother's house and I were there since I was 7 year. It was not so bad, or it was not so good; everything was available in my relatives' house, but they do not equally treat me and their children. I care for their children I were the one to cook, to fetch water and collect firewood but their children sent to school and when they come back they are allowed to study their subjects. I wake up early and go to bed after everybody went to sleep. They send me school, but I have no time to study my subjects. I do not have time to work on my home works or to be prepared for exams.* (Participant G)

The above finding agrees with the research findings of (Hoskins 2014:517) where the study reports that adolescents in married, biological two-parent families generally better disciplined and handled than children in single-mother, cohabiting stepfather, and married stepfather families. Family structure serves as a risk factor for adolescents, since adolescents from divorced or single parent families are two to three times more likely to display problem behaviours when compared to adolescents who live in married, biological two-parent families. Adolescents in two biological parent households are more likely to have greater socioeconomic resources, as well as greater investments of parental time, attention, and support than adolescents of divorced or single-parent

families. Therefore, all efforts have to be done to enable adolescents to live with their married biological families unless otherwise it is mandatory to do so.

Conclusion on category chapter four and category five

This chapter illustrated the findings from the responses of the participants of the research. Holistically broad perspectives which are positively or negatively affecting adolescents' health were illustrated. The major five categories and fourteen themes which are inductively developed from the participant responses were clearly described. The categories, the themes and subthemes developed from the data are sufficiently discussed comparing the findings with the existing literature. Direct verbatim quotations of the participants were used to support each boldly and repeatedly occurred subtheme. Different suggestions of the adolescent research participants were presented in the final and fifth category to incorporate the adolescents' views for better design and implementation of adolescents' health promotion interventions. In this chapter the first two objectives were addressed and in the next chapter the final objective and the ultimate goal of grounded theory research, developing a substantive theory derived from the data, which is intellectually interpreted will be explained.

CHAPTER 5

A SUBSTANTIVE THEORY: IMPROVED HEALTH INFORMATION AND COMMUNICATION DURING ADOLESCENCE FOR BETTER ADOLESCENTS HEALTH OUTCOMES

5.1 INTRODUCTION

The last objective of this study was to develop a substantive theory based on health experiences of the rural adolescents. The purpose of the chapter was to describe how higher level of abstraction of concepts from the data were inductively developed to show where to act to solve the health problems of the adolescents and further promote their health. The conceptual relationship between the categories, themes and subthemes in the model are described in detail. Discussion of the constructs of the emergent theory from the data in line with existing literature is also made.

In accordance with the methods of grounded theory, concepts were progressively and inductively derived from the data. The concepts subsequently grouped in increasingly higher order subthemes, themes and then categories. The relationships between and within these categories were described. This approach has been utilised to provide the basis for the development of the substantive theory emerging from the participant responses of their health experiences in the rural setting.

5.2 THE SUBSTANTIVE THEORY

According to Creswell (2003) in Hussein, Hirst, Salyers, and Osuji (2014:5), in grounded theory the researcher attempts to derive a general, abstract theory of a process, action, or interaction grounded in the views of participants in a study. This process involves using multiple stages of data collection and the refinement and interrelationship of categories of information. Charmaz (2006:159) suggests scrutinising the categories through constant comparative analysis for their power, purpose and pattern, if they lack relevance for analysis, argument, or audience, dropping them out. Two primary characteristics of grounded theory design are the constant comparison of data with emerging categories and theoretical sampling of different groups to maximise the

similarities and the differences of information. In this research, to attain this principle, constant comparative analysis of the categories and themes were done and after identification of the core category this way, theoretical sampling and further interviews were done for themes and subthemes of the core category to increase further richness and to attain theoretical saturation of the initial data.

According to Creswell (2014:37), a social constructivist researcher generates knowledge through discussions and interactions with the participants of the research in their naturalistic setting. The meanings created to a subject under investigation or research problems are subjective meanings of the participants. Owing to variability and the complexity of views of participants on the subject under investigation, the emergent core category or basic social process identified from initial data was further enriched with theoretical sampling, in which further samples of participants were contacted and interviewed for clarification of selected concepts on the identified core category. The core category assumed to be strongly interrelated and interconnected to the themes and subthemes with in the category and substantially related to other categories was identified. Finally, the core category was used as benchmark to develop the substantive theory. Figure 5.1 shows the theory developed in this research is presented in the following text oval.

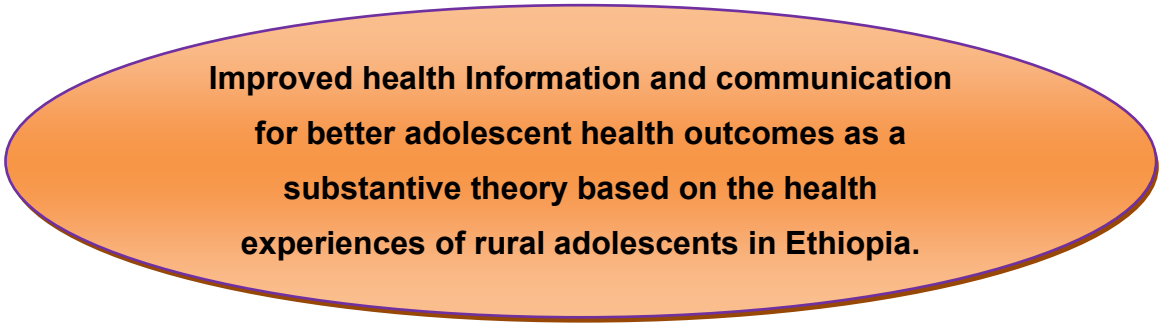

Figure 5.1 Visual presentation of the theory developed from the data in the text oval

The theory developed in this research is based on the perceptions and experiences of adolescents in the rural setting in Ethiopia. The theory is based on the core category *improved health information and communication for better adolescent health outcomes* is influenced by the other contextual dimensions like adolescence sensitive health

intermediaries, health challenges faced by adolescents, social and cultural perspectives of adolescents health and the changes suggested by the adolescents. The contextual dimensions indicated here would be either impacted or have an impact on the core category either positively or negatively. Figure 5.2 provides a visual representation of the developed substantive theory and the interrelationship and interconnection of the core category with other categories

5.3 CONSTRUCTION OF THE MODEL

According to Charmaz (2017:39) grounded theorists ordinarily focused on “what is happening” without examining how social, historical, temporal, and situational contexts of research affected their definitions and explanations. In this study, all of the study participants mentioned that improvement of the health information and communication systems has a significant contribution to achieve holistic positive adolescent health outcomes.

Charmaz (2006:76) stated an emergent substantive theory from a data functions in conditions, the circumstances or situations that form the structure of the studied phenomena; actions/interactional strategies, participants' routine or strategic responses to issues, events, or problems; and consequences, outcomes of actions/interactions. Conditions answer the why, where, how come, and when questions, actions/interactions answer by whom and how a question, while the consequences answer questions of what happens because of the actions or interactions. In the current study, the conditions in which the health experiences of the studied adolescents occur in adolescence sensitive health intermediaries, social-cultural perspectives of adolescents health and the health challenges faced by the adolescents leading to a coping strategies and interactions depicted by the changes required, and the outcome or the consequence of this all is the final better health outcomes among the adolescent population.

5.3.1 The core category: Improved health information and communication during adolescence

The core category, according to Strauss and Corbin (1990; 1998) in Creswell (2014:246) in grounded theory research is the centrepiece of the model. It is an

abstraction that represents the main theme of the research, and it demonstrates the analytic power of the research in which it pulls the other categories as a central phenomenon of the result of the whole research process. The core category might emerge from among the categories already identified or a more abstract term may be needed to explain the main phenomenon. The other categories always stand in relationship to the core category as conditions, action/interactional strategies, or consequences. The core category in this research was identified based on the principles of the grounded theory approach as stated in Glaser (2005:4) and the following factors were considered:

- Based on the centrality of the category; that is, related to as many other categories and their properties as than other candidate categories for being the core category. The criterion of centrality is a necessary condition for making the category as a core category, because, it indicates that the category accounts for a significant portion of the variation in a pattern of behaviour.

- Based on the frequency and recurrence of the category in the data. By its frequent recurrence the core category comes to be seen as a stable pattern and becomes increasingly related to other variables.

- Based on meaningfulness and ease to be related with other categories.

- Based on the level of dependency on the other variables and the level of modifiability of the category.

5.3.2 Adolescence sensitive health intermediaries

Adolescence sensitive health intermediaries are among the categories and conditions in which the core category functions. Adolescence related changes, sexuality in adolescence, adolescents perception of own health are inductively developed themes in the research and assumed to be significantly contributing factors for variation in the core category and variation of the whole health behaviour among rural adolescents.

5.3.3 Health challenges faced by adolescents

The category-health challenges faced by adolescents- is the other categories developed from the participant responses as a significant higher-level abstract category which has a power of impacting and being impacted by the core category and a condition in which the adolescents' experiences are operated. Health risk behaviours and sexual health challenges are the immediate lower level themes of the category.

5.3.4 Social and cultural perspectives of adolescents

The study has shown that the socio-cultural perspectives of adolescents influenced the core category – improved health information and communication and the overall health experiences the adolescents participated. The identified socio-cultural perspectives of adolescents, particularly their perceived foundations of health, cultural practices, and social influences are essential contexts for the adolescents to build understanding of their health experiences and to successfully engage in positive behaviours.

5.3.5 Suggestions for change

The participants of the current research indicated the needed change across different organisations and systems for favourable behaviour in adolescents. The categories formed under the needed changes were the recommendations towards the health sector, government, and parents of the adolescents.

5.3.6 Better adolescents' health outcomes

Better adolescents' health outcomes are the attributes of improved health information and communication systems. However, this does not mean positive adolescents' health outcomes are solely dependent on improved health information and communication systems. The above categories developed from the data are also having a determinant role; this is to show direction of the needed attention of the participants is towards improved health information and communication systems for improved adolescent health outcomes. Positive health outcomes in adolescents are holistic improvements in adolescents' health status that ultimately contributes for the healthy development of adolescents who would contribute significantly in the socio-economic development of the country overtime.

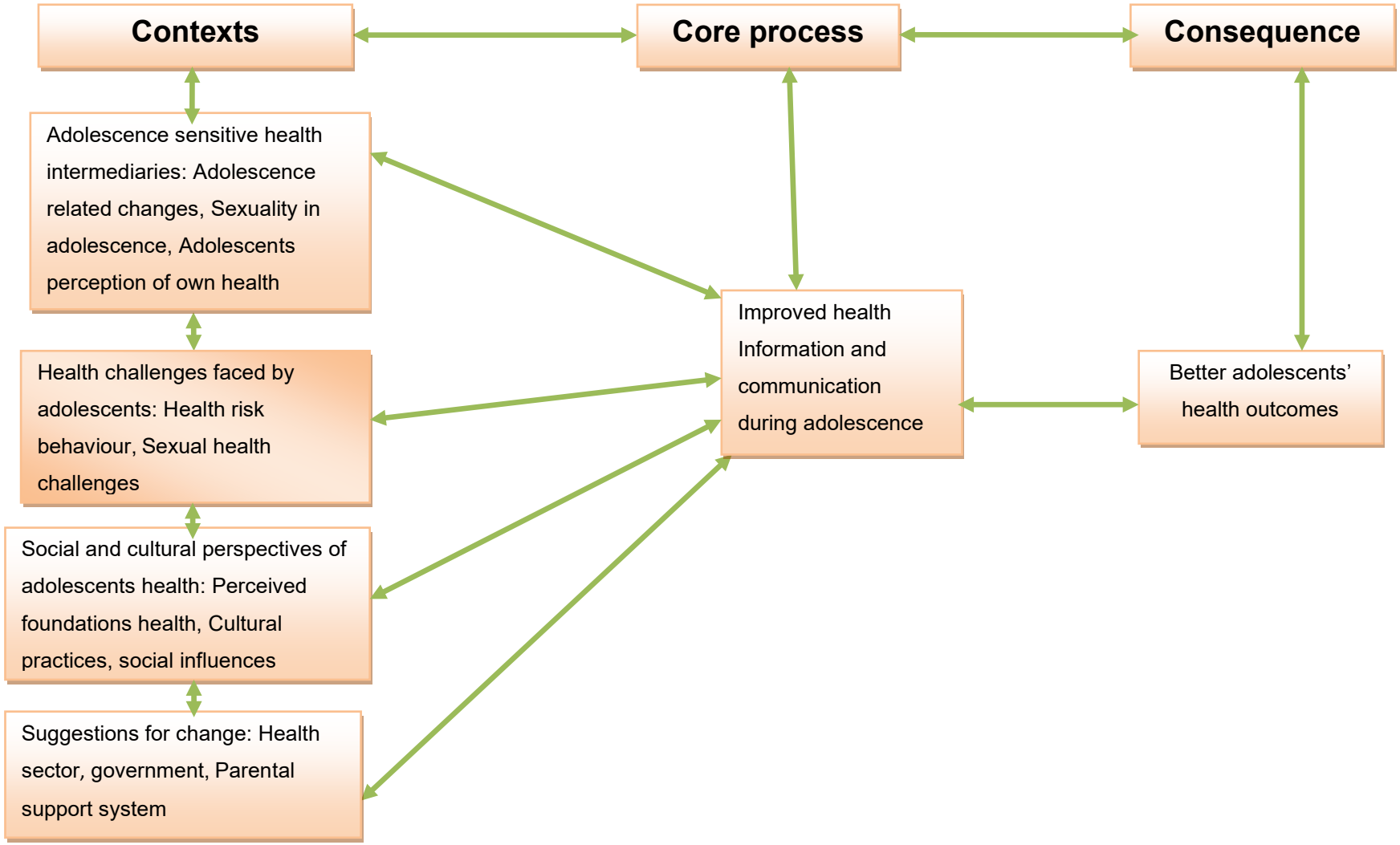

Figure 5.2: Representation of the substantive theory: Improved health Information and communication for better adolescent health outcomes

Conclusion

In this chapter the substantive model developed from the data in this research is described. The constructs of the model, core process and the consequences of the process were discussed.

According to Charmaz (2006) in Creswell (2013:87) a social constructivist researcher advocates for a social constructivist perspective that includes emphasising diverse local worlds, multiple realities, and the complexities of particular worlds, views, and actions. According to Charmaz (2006) in Creswell (2013:87) a focus of theory that developed depends on the researcher's view, learning about the experience within embedded, hidden networks, situations, and relationships, and making visible hierarchies of power, communication, and opportunity. In addition, Charmaz (2006:87) recommends more emphasis on the views, values, beliefs, feelings, assumptions, and ideologies of individuals being studied than on the methods of research, although she does described the scientific and practical ways of gathering rich data, coding the data, memoing, and using theoretical sampling instead of embracing the study of a single process or core category.

As this research followed the guiding principles of constructivist grounded theory, the theory developed described the complex relationships of multiple contexts and conditions on the adolescents' behaviour and the linkages of this conditions and contexts on the consequences as explained in the model above.

CHAPTER 6

DISCUSSION OF THE FINDINGS

6.1 INTRODUCTION

The aim of this chapter is to compare and contrast the findings of this study with the existing literature. Through discussion of the major findings of the research, further synthesis of the findings will be made. Synthesis will be based on the analyses conducted in the previous chapters and the key findings will be linked to the extant literature. The discussions are made particularly focusing on the core category and related themes and subthemes. Improved health information and communication during adolescence is a core category identified in the study from the participants responses.

Before giving detailed accounts of discussion on the construct themes and subthemes of the identified core category particularly focusing on adolescents' health, the general impact of the health information and communication will be made to obtain the general insight and relevance of the health information and communication on the overall public health. The discussion of the findings begins with the process (the health information and communication), the contexts (categories, themes and subthemes with relative higher significance and repetition in the data) in which the process is operated. Finally, the barriers or the challenges which limit the delivery of health information and communication effectively and the suggested changes which are required to cope to overcome the barriers or challenges to bring the required behavioural change and ultimately positive health outcomes will be discussed in detail.

6.2 IMPROVED HEALTH INFORMATION AND COMMUNICATION DURING ADOLESCENCE

A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status. Health information system (HIS) is the intersection between healthcare business process, and information systems

to deliver better healthcare services (United States Agency for International Development (USAID) 2013:9).

According to Ngigi and Busolo (2018:86) knowledge and awareness are personal factors that are rarely enough by themselves to bring about behavioural change because other factors can override it. Providing information is the first step towards influencing behavioural change rather than an end point.

According to WHO (2009:2) all member countries of the United Nations agreed and accepted the United Nations Convention on the Rights of the Child (UNCRC).The latter stipulates that adolescents have the right to obtain the health information and services they need to survive and to grow and develop to their full individual potential. The UNCRC also recommends giving special emphasis for those adolescents who are more vulnerable than others to develop health problems because of social, economic and cultural factors. Rural adolescents are among the ones who are the most vulnerable and easily affected by health problems because of the fact that, they live in geographically remote and low or absent health information infrastructures.

Provision of appropriate and timely health information is a process of behavioural change communication interventions. Human behaviour, including utilisation and acceptability of healthcare services is greatly influenced by utillisation of different behavioural change communications. It has a significant role in scaling up adolescents awareness on issues related to health. Health information and communication is directly or indirectly influences the decision-making capacity of adolescents (Tull 2017:2).

Health communication is the study and practice of communicating promotional health information, such as in public health campaigns, health education, and between doctor and patient. The purpose of disseminating health information is to influence personal health choices by improving health literacy. However, the people around adolescents providing tough task to resist serious health risks, before they have adequate information, skills and experience to avoid or counteract them (Ngigi & Busolo 2018:85).

This research shows adolescents particularly adolescents of the rural areas are struggling to assume healthy behaviour in a setting where their own behaviour and external social, cultural and economic influences are huge. The identified constructs of

improved health information and communication and their assumed linkages and influences one in other and on the final outcome, better adolescent health outcomes is depicted in the (Figure 6.1).

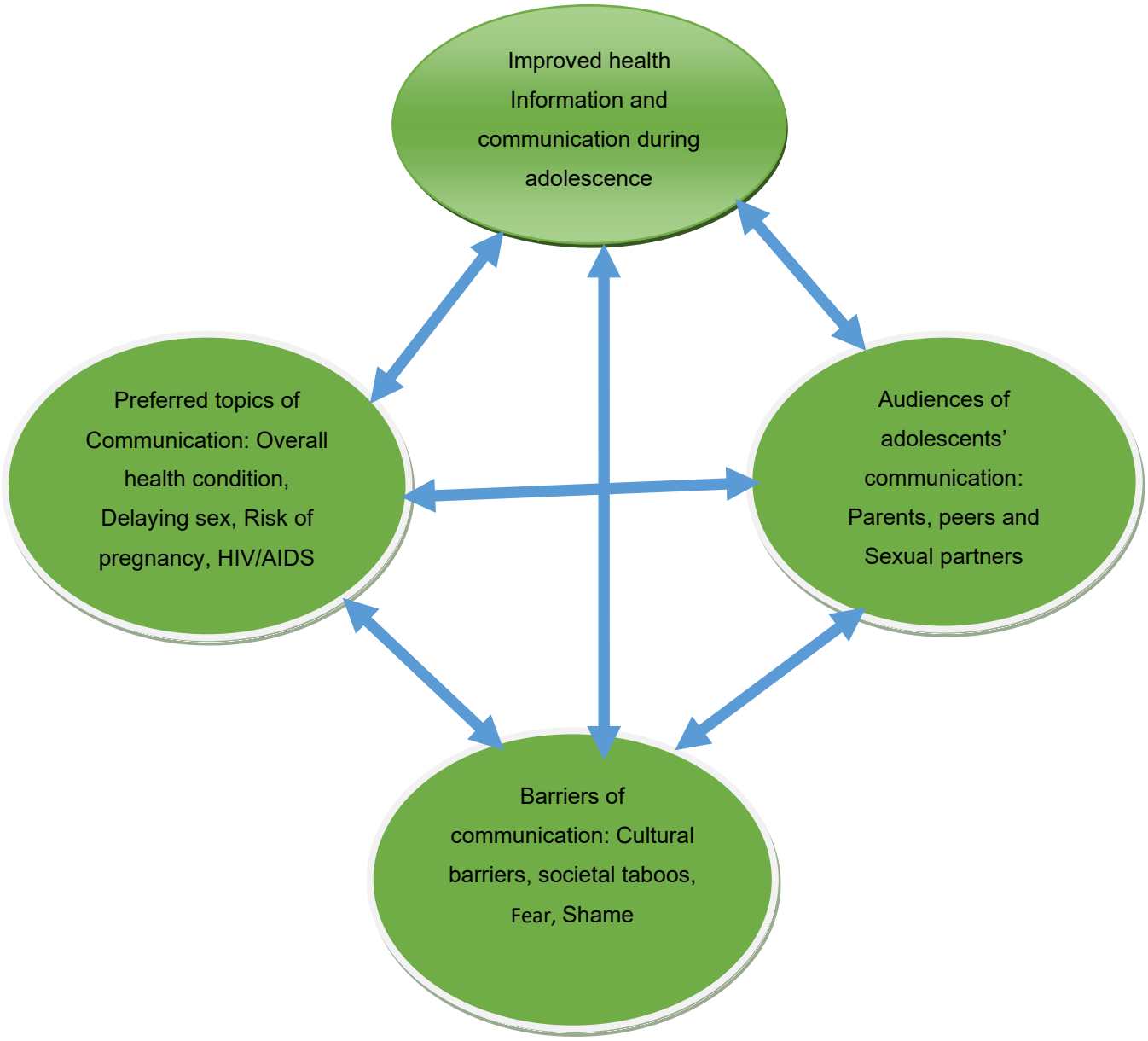

Figure 6.1: Visual linkages of the constructs of core category, improved health information and communication

6.2.1 Audiences of adolescents' communication: Parents, peers and Sexual partners

Audiences of adolescents communication was a concept inductively developed from the data and occurred repeatedly in the participants responses of this research. Appropriate and accurate identification of the type of information need and the audiences of adolescent communication is a relevant aspect of effective health information dissemination.

6.2.1.1 Parents

This study identified parents as a key audience of adolescents' health information communication. Improving parent-adolescent communication regarding health and health outcomes has a significant role in improving the adolescents' decision-making capacity on issues related to their health. This result is also agreement with the WHO report that indicates that the transition to healthy adulthood is dependent on the social environment in which adolescents live, learn and earn. Parents and families are a crucial part of this social environment (WHO 2014:8).

Existing literature shows communication between the adolescents and the parents is mainly focusing on the SRH related topics. However, the role of parents is beyond getting health adolescents in terms of SRH. An effort to prevent adolescent health risk behaviours and promote healthy development is highly dependent on the level of openness of parents in engaging adolescents. Open and genuine communication between parents and adolescents is a critical feature of both connection and respect for individuality. Therefore, programmes that aim to protect or enhance the health of adolescents and/or foster their social competence should give particular attention to connection and the resulting effective communication for better adolescents' health outcomes.

Parents who are warm and involved provide firm guidelines and limits to have appropriate developmental expectations, and encourage the adolescent to develop his or her own beliefs tend to be most effective. These parents tend to use reasoning and persuasion, explain rules, discuss issues, and listen respectfully. Adolescents who come from homes with this style of parenting tend to perform better in school, report less depression and anxiety.

In the developing world, the lives of adolescents are being compromised and cut short by ill-health owing to unsafe sex, substance use, violence, HIV/AIDS, and mental health problems

6.2.1.2 Adolescent peers

Adolescence is a unique stage of development. At this stage, the teens become more independent, and togetherness intensity with peers increases. However, adolescent relationships with peers can have appositive or negative effect on adolescents' health and wellbeing related behaviour (Devi 2016:34). This study indicated that adolescents' peers are the close and all round information sharing entities. For the health sector as well as other stakeholders who are working in the health promotion interventions that target adolescents, provision of health related topics of discussion and creating an enabling environment for discussion among adolescents is an opportunity to address the unfinished task of promotion of adolescent's health and wellbeing. Using adolescent peers as target groups for health information dissemination is an easy path to reach the bigger mass of adolescents' for the intended information dissemination.

6.2.1.3 Sexual partners

In the current research, the sexual partners are identified as important audiences of adolescents' discussion. It is a relevant but less utilised opportunity to identify the adolescent sexual partners and to use them as an important target to transfer behavioural change communications among the larger mass of adolescent population.

This result has been reported in the same way in Toscano (2007:7) where the study described that positive relationships exist when dating couples have common beliefs, shared values and interests. The same study also indicated that a positive relationship is something that did not only last a long time, consisted of emotional and physical closeness, but also that included mutual respect and good communication. Therefore, it gives sense to use sexual partners of adolescents and to use them as health promotion interventions targets for health information dissemination ultimately to get better overall health outcomes among adolescents.

6.2.2 Preferred topics of communication during adolescence

The usual topics of discussion in adolescence whenever they intend to discuss were identified in the current research. The topics of communications with the preferred audiences describe above include their overall health condition, delaying sex, risk of pregnancy, and HIV/AIDS.

6.2.2.1 Communication on the overall health condition

This subtheme was one of the recurring concepts in the data of the participants' responses. This research revealed that the participants are not worried too much in selecting topics of communication whenever they intend to discuss health-related issues. However, the details and areas of discussion are determined on the level of closeness to whom the information is being communicated and the perceived capacity of the person in keeping the confidentiality of the information.

The same finding was reported in Muhwezi, Katahoire, Banura, Mugooda, Kwesiga, Bastien and Klepp (2015:110) where the study indicated that perceptions of adolescents tended to point to more open and frequent communication with mothers than fathers and to cordial relationships with mothers. The same study also said adolescents tended to generally discuss more private issues sexual issues with mothers. Therefore, it is relevant to improve communication and information sharing among adolescents on the overall health conditions.

6.2.2.2 Delaying sex/abstinence

This study also shows one of the important topics of discussion in adolescence is about abstinence. In a similar study, Widman (2014:734) also shows abstinence as relevant topic of discussion among adolescents. Improving the communication and information sharing of adolescents about avoiding sexual activity before they are prepared to do so, is an important element of addressing adolescent's health-related issues. Absence or delaying sex has multiple benefits for the adolescent population, because it avoids the risk of pregnancy and HIV and also the worries related to consequences of these sexual practices until the adolescents' age, psychological and social preconditions allow. Therefore, the promotion of the communication and information sharing among

adolescent population has direct and indirect contributions in the overall health experiences of the adolescents.

6.2.2.3 Risk of teenage pregnancy

Teenage pregnancy is among the relevant concepts developed from the data in this research. Almost all of the adolescents who participated in the study reported that talking about risk of early pregnancy between the adolescents or with their parents is a usual topic of discussion. This study shows that effective communication and information sharing is an important enabling factor of the decision-making capacity of the teens.

This finding agrees with Chumbler et al (2016) as cited in Iorga and Ciuhodaru (2016:344) where they reported developing technologies to make health information accessible in the rural areas was advised, because rural adolescents face both the problem of lack of medical access and appropriate health information to avoid negative consequences of their sexual practices.

Ethiopia is among the countries in which a heavy burden of adolescent pregnancy and early child bearing are being practiced. According to Ethiopian demographic and health survey report teenagers in rural areas of the country are three times more likely to have begun childbearing than their urban peers: 15% of rural teenagers have had a live birth or are pregnant, as compared with 5% of urban teenagers. Teenage pregnancy is among the major health concerns in Ethiopia, because of its association with higher morbidity and mortality for both the teen mother and the child. Childbearing during adolescence is known to have adverse social consequences, particularly regarding educational attainment, as women who become mothers in their teens are more likely to drop out of school (CSA,Ethiopia 2016:81). Therefore, improving the communication and information sharing regarding teenage pregnancy is an important strategy of creating enabling environment for appropriate, responsible and informed decision-making during adolescence.

6.2.3 Barriers of health information and communication in adolescence

According to the participants of this research, the core process (improving adolescents' health information and communication) is impacted by concepts developed from the data and include cultural barriers, societal taboos, fear, and shame, how this subthemes influence health information and communication is discussed in detail in adolescence chapter four

6.3 THE CONTEXTS OF ADOLESCENTS' HEALTH EXPERIENCES

According to Strauss and Corbin (1990:15) context represents structural conditions that shape the nature of situations, circumstances, or problems to which individuals respond by means of action/interactions strategies. In this research those structural condition which are undertaken in the management of central phenomenon

Bronfenbrenner's (1979) theory of ecology of human development as cited in Christensen (2016:22) guided the explanation of the interpretation of the context in this study. According to Bronfenbrenner's (1979) theory of ecology of human development the context contains four distinct systems: micro, meso, exo and macro systems and each has either a direct or indirect influence on the child's development. According to the theory an individual's development is determined by the interactions of the person and the ecology of development. The four distinct systems of human development and the factors identified in the current research are described in the appropriate distinct system as follows. To avoid repetition of concepts detail explanation and interpretation of the factors had been made in chapter 4 in the results section.

Micro-system

The microsystems are the systems closest to the child and comprises immediate family members, school, peers and the neighbourhoods in which a person spends more time. The interactions between the person and the subsystems determine the development of behaviour. The home environment is expected to provide protective factors like parental warmth, love and acceptance as well as provision of material needs for the adolescent. The home should also provide the adolescent with physical and psychological security as well as positive role modelling.

The home environment and the people around are the micro-system factors identified in the current research. The identified micro-system factors include parents, family structure, neighbours, parenting styles, parental follow-ups. These micro-system factors are important contextual determinants that influence the core category, influence the behaviour of the adolescents, and finally would determine the health outcome of the adolescents.

Meso-system

The meso-system is composed of interactions between the significant entities. This pertains to relations between micro-systems or connections between contexts. The interaction and the effect of interactions of family experiences to school experiences, school experiences to church experiences, and family experiences to peer experiences contribute a significant role in determining the adolescents' health experiences. The peer world is both influential and instrumental to adolescents' behaviours. The meso-system factors identified in this research which has an important role in determine the adolescents' behaviour include the interactions and the effect of interactions of health care workers, peers, parents, families of the adolescents, and religious institutions.

Exo-system

The broader community within which the child lives comprises the exo-system. Such networks include the family, the societal norms and values and education policies. In the current study the exo-system factors identified include: adolescent policies, traditional practices, societal values, education, religion, fear, shame, cultural barriers, and societal taboos.

Macro-system

The outer layer, called the macro-system, contains the collective attitudes, ideologies and values of an individual's larger society. The school operates at the macro-system level and if it provides health education and organises programmes to teach adolescents about the consequences of taking part in certain behaviour. It becomes a positive contributing factor unless and otherwise it may contribute adolescents to assume health risk behaviours. Factors assumed to be acting in the macro- system in

this study include adolescent policies, health facilities environment and the education system.

6.4 THE CHALLENGES OF PROMOTION OF POSITIVE ADOLESCENTS' HEALTH EXPERIENCES

The health promotion and preventive interventions targeted towards adolescents are usually not effective as they are expected to be by the adolescents. The participants of this study forwarded different forms of challenges of implementation of health promotion interventions targeting adolescents.

The health sectors in Ethiopia are poor to appropriately, effectively and efficiently respond to the health needs of the adolescent population. The participants mentioned that poor accessibility and effectiveness of the health care workers, lack of favourable and properly adolescent friendly health facilities, and lack of quality services were among the mentioned challenges for appropriately addressing the health problems of the adolescents.

Several challenges were mentioned for effective implementation of the adolescents' health promotion interventions. They include lack of full commitment of government administrative stages to change the adolescent policies into practice, lack of need assessment whenever adolescent health projects are planned, many adolescents particularly in the rural areas are still out of schools in Ethiopia and poor enforcement of adolescent health protection laws.

According to Kobak etal (2017:137) in the recent days, adolescents are more likely to experiment and make decisions in contexts that involve minimal adult supervision. The increased time that adolescent spend without adult supervision creates new opportunities and risks. On one hand, experimentation allows adolescents to test and develop their capacities for making autonomous decisions that consider the potential benefits and risks of a particular activity. On the other hand, adolescents may be predisposed toward overvaluing the benefits and undervaluing the potential risks of an activity, leaving them vulnerable to engaging in risky behaviours such as unprotected sexual activity, substance abuse and delinquency. The participants of this research

expressed their concerns of the occurrence of increasing trends of absence or looseness of the follow-ups and supervision of parents.

6.5 Strategies/actions and interactions of the adolescents to their experiences

Therefore, considering all the conditions and context in regard to adolescents, they engage with a certain kinds of actions/ interactions/ strategies that have their own role to play to cope with different experiences. The findings of this research indicated that the adolescents use substance and alcohol as a coping strategy for their perceived negative experiences that may or may not be health-related. This finding is corroborated by research findings in Kingston, Rose, Cohen-Serrins and Knight (2017:6) where the study reported that the adolescents' substance and alcohol use experience is related to lack sufficient parental follow-up of the adolescents and it is in response to harsh parental punishments experience for problem behaviours.

The other coping strategies of rural adolescents for a negative experience are their movement from the rural areas to the cities or other areas. Many adolescents migrate within the country from one area to the other as well as out of the country in search of better education or job opportunities. This notion is supported by captured by the verbatim quotation from a 15-year-old female adolescent in the following ways:

> *The adolescents of our locality usually move to the other area whenever, they experience some forms of bad experiences like when they are not successful in their education, lack jobs, or sometimes they may accidentally engage in sex and that may end up with pregnancy. You know the implications of this issue are very harsh in our community they travel to other areas; they may even do not know where they are going.* (Participant D)

This finding is also reported in a qualitative study conducted in Ghana where the researcher questions "why adolescents leave Ghana?" The results show that better lives abroad, improved standard of living, employment opportunities, and the prospects for further education were the prominently featured discourses about intended emigration from the country (Dako-Gyeke 2015:1).

Moreover, the participants strategies/actions/interactions in response to the contexts and conditions mentioned above, the action /strategies/interactions were in the form of sexual activity particularly early sexual debuts and early marriages. This idea was also boldly described by a 15-year-old female study participant as it is stated in the following quote:

> *Early sexual debuts are major practices of the adolescents who experience one or more negative life experiences. For instance, adolescents who fail examinations, particularly the higher education entrance examinations, and adolescents who perceive they have no something big they wait in the future engage in early sexual activities and early marriages. It is obviously, very difficult to cope again the consequences of these experiences, their whole life come to be complicated at the end.* (Participant C*)*

Therefore, this finding signals the urgency of action by the respective organisations and individuals to take practical solutions to change the identified strategies /actions /interactions in the positive ways.

6.6 Consequences the strategies/actions /interactions

The strategies/actions/interactions of the adolescents with certain experiences have a consequence or final impact on the core process as well as the overall health status. This research revealed that the outcomes of interactions and actions with regard to different life experiences mentioned above were teenage pregnancy, injuries and accidents, unintended pregnancy, abortion, STIs including HIV/AIDS, dropping out of schools, and poor school achievements.

Conclusion

This chapter discussed the findings of this research with the existing literature. The core category and the constructs of the core category described providing scientific arguments of the current research with extant literature. The core category “improved health information and communication during adolescence,” and the constructing concepts which were developed from the data were explained in detail. The constructs

of the core process are the areas that need promotion in health information and communication during adolescence. The contexts identified in this research were described and tried to show how they fit with known existing contexts in Bronfenbrenner's (1979) model of human development. The model constructs, the micro, meso, exo and macro systems were explained with regard to the contexts identified in this research. The challenges faced in promoting the adolescents health relative to the existing contextual determinants were explained. The strategies/actions/interactions made by the adolescents to cope with the challenges were described. Finally, the consequences of the strategies/ actions/ interactions as explained by the adolescents were described providing verbal quotations of the adolescents as a supportive evidence for the described ideas.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

Creating favourable conditions for the young people to make a safe and healthy transition from adolescence to adulthood, acquire the skills they need to find good jobs and succeed in a dynamic economy, enjoy their rights and realise their full potential is a foundation for success in countries growth and development agendas. Healthy young people are in a better position to realise their potential and to seize opportunities as they mature and enter the labour force. Adolescents and youth are better equipped to reach their full potential when they are healthy and well-educated (African Union (AU) 2016:21).

Failure to invest in the health care of adolescents increases the number of dependent population in the next generation and negatively influences the health of future generations. It is therefore imperative to work toward improving adolescent health in order to ensure a brighter future for the next generations. Meeting the health needs of the adolescents requires a specific focus on modes and channels of delivering targeted interventions via specialised health services (such as clinics, health posts, health centres, and district hospitals), school-based delivery, youth organisations, community-based delivery, information communication technology, and mass media. To achieve holistic health needs of adolescents and the youth, ministries of health and the health sector more generally need to transform the health systems in a ways responsive to the health needs of adolescents (Salam etal 2016:5).

Therefore, based on this general understanding in this chapter, the main findings of the study would be concluded. The implications of the study would be explained based on the main findings of the study; responsible bodies specified recommendation would be made then evaluation of the findings of the study will be described against the criteria's of Charmaz (2006:182). Finally, the strengths and limitations of the study and unique contributions of the study for knowledge would be described.

7.2 CONCLUSIONS

In this section, the main findings in the identified categories, themes and subthemes of the research would be concluded. This study comes with a new insight for filling knowledge gaps for effective interventions targeted health promotion of adolescents particularly in the rural settings. In this study, five categories and 14 themes were identified from the data. The identified categories, themes and subthemes were described providing scientific arguments with the existing literature. Based on the findings of the research the following conclusions were made:

- The findings of this research revealed that adolescents are experiencing a number of health related difficulties in the course of their life.

- Adolescence is the age of experimentation. However, adolescents' age related physical, psychological and social changes were poorly realised by the parents and the society.

- The health of adolescents is aligned to the socially established norms and rules of the society. Gender differences have an influence on the social understanding of health and illness. It takes longer time for females before they acknowledge they are ill. It is an established social norm for females to assume their day-to-day activities struggling with their illness until it becomes severe.

- The society judges the cognitive maturity of the adolescents in terms of their physical growth and development.

- lack of awareness of the changing sexual behaviour and developing sexual desires among adolescents; they are being engaged in sexual practices without appropriately realising the consequences of such engagements

- The study revealed that participants rate their health status based on the level of accomplishing their routine day-to-day activities.

- The level of awareness of the value of health among the adolescents was poor; they perceive health as something that only matters when they are ill.

- All of the adolescents participated in the study revealed that adolescence is a new chapter in life. However, they have no appropriate, adequate and age-specific health information.

- Parents, peers and sexual partners/dating partners were identified as adolescents preferred audiences of communication.

- The home environment is the ideal places for adolescents' communication regarding sex and sexuality. However, it is a deep-rooted social taboo for parents to discuss sexual matters with their own child.

- The usual and frequent topics of adolescents health-related communication included communication on their overall health, communications regarding delaying sex/abstinence, communications regarding risk of teenage pregnancy and communications regarding HIV/AIDS

- The adolescents participated in the study expressed their concern regarding mismatch between the expectations of the community for positive behaviour and lack of open and genuine communication culture in the society on what is good behaviour and what is bad for the health adolescents.

- Fear, shame and environmental and limited health information infrastructures in the rural settings are the top priority challenges for poor health information and communication in adolescence.

- The study shows substance and alcohol use is highly practiced in the study setting by the adolescents

- Violence particularly, verbal violence, is a wide spread health risk behaviour particularly for females in the study area.

- The study shows lack of adequate attention for HIV/AIDS prevention and control among the adolescents of the study area.

- This research shows the level of awareness of SRH among rural adolescents is poor.

- Early marriage and adolescent pregnancy are still widely practiced health challenges of the females in the study area.

- Families, the schools and the neighbours have significant impact on the adolescents' behavioural development.

- The role peers was high in determining health risk taking or health risk avoiding behaviour of the adolescents.

- The education positively influences adolescents' behaviour in and improves their decision-making capacity.

- Social value of SRH purity in the society is being degraded in the younger generation. For instance, being virgin or abstinence until marriage previously was a determinant for successful marriage. However, these days the adolescents give different reasons to breach this social value.

- Harmful traditional practices, particularly FGM are a widely occurring practice in the society.

7.3 IMPLICATIONS OF THE RESEARCH FINDINGS

According to Hasa (2018:1), the implications of a research are of utmost importance in explaining the importance of the findings of the study. In this section, the importance of this study for policy, practice, theory and subsequent research studies are discussed below.

7.3.1 Implications of the research findings for policy makers

- The need for integration of the adolescents' health services like adolescents' friendly health services, in the health extension packages to increase the accessibility of the services for rural adolescents.

- Harmful traditional practices particularly FGM, adolescent marriage and violence are experiences of the rural adolescents. Policy makers and programmers need to revise the adolescents' health protection laws and strict follow-up of their implementations.

- Working in collaboration with Ministry of Education to implement basic health education in the primary school curriculum.

- Policy makers need to revise HIV/AIDS prevention and control policies and should make the policies and programmes that are responsive in the contexts of the rural adolescents

- Policy makers need strictly make follow-ups in the implementations of substance and alcohol use laws particularly in relation to the rural settings.

7.3.2 Implications of the research findings for practice

- The health care practitioners need to make an attitude change regarding adolescents' health status. Adolescents are prematurely judged as healthiest group of the population. This increased adolescents' susceptibility to different health problems.

- Adolescents' health services need to be improved in a ways that it can sufficiently satisfy the health care needs of the adolescent population.

- Health care providers of adolescents need to be adequately trained on how to handle adolescent population. This is because the health care needs of adolescents differs that of the children and adults.

7.3.3 Implications of the research findings for theory

- The findings of this research indicated that adolescents health care practices need to be shifted from medical curative only way, to holistic health promotion and prevention interventions model.

- Even though, the theory developed in this research is open for further refinement and enhancement, it indicated that holistic adolescent's health promotion and prevention approach is a better way to achieve better adolescents' health outcomes.

7.3.4 Implications of the research findings for subsequent research

- This study comes up with a new insight in knowledge for adolescents' health promotion and prevention interventions. This study indicated new ways for researchers how to achieve tough seemingly new research design in the rural context in Ethiopia and broad research questions.

- The findings of this research are believed to be a baseline study for other research studies to be conducted in similar settings and using grounded study design.

7.4 RECOMMENDATIONS

In this section the responsible organisations and individuals specified recommendations based on the study findings will be made.

Recommendations to the Federal Ministry of health, Ethiopia

- Ministry of Health is recommended to give high attention for ensuring the implementation of policies and programmes designed for health promotion of adolescents.

- Harmful traditional practices are continued to challenge the health of adolescents particularly, FGM. Therefore, it is recommended that the Ministry of Health needs to

revise the laws regarding this issue and design strategies to ensure implementation of the law.

- Lack of health information infrastructures, specifically lack of information and communication technologies related to health, rural adolescents could not make informed health-related decisions. The Ministry of Health and other concerned sectors are recommended to work on expansion of health information communication technologies.

- Since the health of adolescents is particularly linked with other sectors like education and culture, the Ministry of Health should strengthen the collaboration with Ministry of Education and Tourism and Culture. The Ministry of Health needs to work with the Ministry of Education to include health education in the primary education school curriculum and to promote education in the rural areas with particular attention since many adolescents are out of schools in the rural areas. Literate adolescents can make responsible health-related decisions. The Ministry of Health needs to work with the Ministry of Tourism and Culture because the study shows culturally good practices are being degraded and replaced to promote culturally good practices related to health.

- The Federal Ministry of Health needs to integrate adolescents' health services in the primary health care services particularly as a health extension packages at the health posts level.

Recommendations to Oromia Region Health Bureau

- There needs to be coordination and ensuring of the achievements of the set goals for adolescents' health promotion in zonal health departments.

- Oromia Regional Health Bureau needs to follow-up the integration of adolescents' health services in the existing health extension programme.

- The Regional Health Bureau should strengthen the follow-up of implementation of the laws designed for adolescents' health protection.

- Ensure the availability and accessibility of the adolescent friendly health services in the rural primary health care units health centres as well as in the District hospitals level.

- The Regional Health Bureau should strengthen the link between the health sectors and other relevant sectors which have a significant role to play for adolescents' health, like education sector.

- The Regional Health Bureau need to give attention for HIV/AIDS prevention and control in the rural areas of the region particularly in Bale Zone where this study is conducted.

- Oromia Regional Health Bureau should follow for the inclusion of basic health education in the regional educational curriculum.

- Facilitate adolescents' health information and communication infrastructural expansion in the region particularly in the studied Bale Zone.

Recommendations to Bale Zone Health Department and Goba District Health Office

- Adolescence is the age of transition and at this age, adolescents engage in different life practices before they are appropriately being informed the positives and the negatives. Bale Zone Health Department and the District Health Office are recommended to work closely in upgrading the health promoting and health risk behaviours in adolescence.

- Gender differences are playing a role in the social understanding of health and illness. Females are given less attention in the society when they are ill and it takes longer time before they disclose their health status to other third party or before they seek health care. The zonal health departments in collaboration with other stakeholders need to work on creating awareness of the society on the relationship of health and illness with gender differences.

- Health education and community conversations need to be established giving attention to the differences and similarities of adolescents' body changes and cognitive maturity.

- Health education and health information dissemination should be given for adolescents on sex and sexuality, before they engage sexual activity to make responsible decisions for the outcome of the act.

- Adolescents of the studied area still consider health as something that needs to be worried about only when it is lost. Therefore, the zonal and district health departments need to work increasing the level of knowledge of adolescents how to engage in health promotive activities like exercise, screening programmes, vaccinations designed for adolescents, life skill trainings.

- The Zonal and District health departments are need to teach the consequences of substance and alcohol use practices and its consequences on the future as well as on the current health of the adolescents

- The Zonal and District health departments are recommended to give health education for the community on the consequences of early marriage and work with the respective law executive bodies to implement the law in case of breach of the law

- Social values which positively contribute for adolescents' health need to be maintained. The Zonal Health Department and District Health Office need to work in collaboration with relevant stakeholders in promotion of maintaining the useful social values.

- The Zonal Health Department and District Health Office need to work closely with Oromia Region Health Bureau and the Ministry of Health in improving the availability, accessibility and quality of adolescents' friendly health services beyond the SRH issues.

Recommendations to families of adolescents and the community

- Families of adolescents and the community need to develop a culture of open, honest and all rounded communication in the home and in the community regarding health of the adolescents.

- Adolescents' take more lessons from what has been practiced than what has been said. Families of adolescents and the community need to make it a social norm to live exemplary lives before their adolescents.

- Families of adolescents and the community need to treat male and female adolescents equally when caring for their health needs regardless of the gender differences.

- Discuss openly and honestly with their children regarding their sexuality, reproductive health and related issues before they learn by experiment.

- To make appropriate supervision of their adolescents and providing advises on their peer selection, what to engage and what avoid.

- Families and the community need to develop the culture of own experience sharing sessions for their adolescents considering the age of the adolescents and their level maturity.

- Families of adolescents and the community need to promote ways of avoiding harmful traditional practices particularly FGM which have current and future health impacts on the adolescents.

Recommendations for further research

The aim of this research was to explore and understand the lived health experiences of adolescents in the rural setting and investigating their perceptions regarding health. Though the research achieved the set aims, further research is recommended on:

- This research did not include the experiences of adolescents in relation to nutrition. Nutritional experiences may have influences on the adolescents health

experiences and perceptions regarding health, it is recommend for further research on the nutritional experiences of adolescents

- This research has been conducted in Bale Zone and Goba District, further similar study is recommended in other zones. This is because there may be differences in the contexts of other zones.

- In this research the experiences and perceptions of disabled adolescents were not included. Further research is recommended including this group of population, because the health needs and experiences of adolescents with disabilities may differ from that of disability free adolescents in one or the other ways.

- This research was undertaken using purely qualitative research design which limits the generalisability of the findings. Though generalisability was not the aim of this research rather the aim of this research was transferability of the findings; further research is recommended using mixed methods approach because mixed methods research may minimizes the concerns of both the transferability and generalisability of the findings.

- This research finding indicated that significant variation in the health care services expectation by the adolescents and the actual health services provided in terms of quality, the accessibility and availability for adolescents. It is recommended for further research on the level satisfaction and quality of the services provided for the adolescents.

- This study explored and described the health experiences of adolescents and their perceptions regarding health among adolescents of age group 15 to19 years. Further study is recommended on adolescents' age 10 to14 years. This is because there may be variation in the health experiences in this age group.

7.5 EVALUATION OF THE GROUNDED THEORY

The following evaluation of the study findings would reflect what looks like the entire journey of the research. The evaluation would also have an implication for the readers because it indicates the strength and the plausible scientific process employed in the overall research process.

According to Charmaz (2006:181), the usefulness of the method employed in the research process is only judged based on the quality of the final result of the research. The method utilised in the process of the research differs from what is gained from the process. The sense made in the entire research process is reflected in the sense it gives for the completed work. The endpoint portrayed makes sense to readers because the researcher has been immersed in the process.

To ensure whether the criteria of grounded theory have been met in this study, the researcher will review the entire effort against the criteria of credibility, the criteria of originality, the criteria of resonance and the criteria of usefulness of the study in the following sections.

7.5.1 Credibility of the findings

Credibility of this study is achieved through a complete familiarity with that of the researcher with the phenomenon under investigation, because it was the researchers day and night issue to think and search for knowledge in each and every aspect of the study for the last four years.

As the researcher is the resident of the study site, this has facilitated not only the deeper understanding of the problem, but also helped to report the co- constructed views of the study participants and the researcher. This is also the added opportunity for the increased familiarity of researcher with the topic of interest for the study. The data for this study is collected from diversified population groups in terms of sex, location, age and educational status. This provided the opportunity for the researcher to systematically compare the experiences of the participants.

7.5.2 Originality of the findings

The findings of this research are original and provided new insight in the subject researched. The categories, themes and subthemes are new and never addressed in the way this research addressed the phenomenon in the existing body of knowledge. The analysis of data following the principles of social constructivist grounded theory rendered a new conceptual model that would be used to guide adolescents' health promotion interventions particularly in the rural setting.

Both the social and theoretical significance of the findings were ensured in this study. The social significance of the study could be explained in many ways. Ethiopia is a young country, with 45% of the Ethiopian population is under the age of 15 years and 65% of the population is under age 24 (Index Mundi 2018:1).Because of this reason, it is morally as well as from human rights point of view, the right thing to investigate and appropriately address the problems of the adolescent population in Ethiopia.

The theoretical significance of this study is the study developed a theory based on the health experiences of adolescents in the rural setting. This theory has an implication for current health practice in Ethiopia in the way the health of the adolescent is beyond addressing the specific health problems based on the medical model. Adolescents are prematurely judged as the healthiest population group relative to the children and adults. This view forced the health care workers and medical practitioners to give more attention for the children and the elderly. However, adolescents are being challenged by many internal and external factors as described in the results section of this research. This research brought new insight in that; adolescents' health care and health promotion practices should be based on considering the holistic nature of adolescents' physical, psychological and social development.

The developed substantive theory is closely and entirely related to participants' responses. The categories, themes and subthemes developed were explained sufficiently and supported with direct verbatim quotations of the study participants. The above-described aspects of the research process ensured the credibility of this particular research and provided sufficient evidence for independent verification of the findings in the study setting.

7.5.3 Resonance of the study findings

Resonance in this study is ensured realising whether the categories developed portrayed fullness of the studied phenomena of health experiences of the adolescents in the rural settings. To ensure this aspect the study the researcher used the opportunity provided by the principles of grounded theory that recommends using constant comparative analysis and theoretical saturation as strategies to achieve fullness of the studied experience. Constant comparative method allowed the researcher to identify any initial concepts and categories that need further enriching with data. Theoretical sampling was used to reach to ensure theoretical saturation. Theoretical saturation was achieved when the researcher is unable to draw new insight from the data or no indication in the data for further inquiry was reached.

This study revealed that the meanings drawn from the data could be linked to the larger adolescent population in Ethiopia. The socio-demographic and cultural contexts of the Ethiopian adolescents particularly in the rural settings are with little or no differences. It is possible to link the meanings drawn from this study to the larger adolescent population particularly in the studied zone or more generally in the studied region.

The theory developed is believed to provide a deeper and holistic understanding of the health experiences of adolescents particularly in the rural setting. The theory developed from the participants' responses explicates deeper understanding for the adolescents of their experiences and it also provides guidance for those who are working in adolescents health affairs.

7.5.4 Usefulness of the study findings

The analytic categories and interpretations in this research indicated a range of implications for parents, the community, and the government bodies who are dealing with adolescent issues. Regarding the contribution of this study for the existing body of knowledge, it is believed that based on the findings of this research the customary adolescents' health care and health promotions practices will be changed in the direction of giving a focus to the holistic nature of adolescents' development. The analysis of this research sparked a further research for other substantive theory on the experiences of adolescents with different types of disabilities, because their health needs and experiences may be different from the ones included in this study.

7.6 STRENGTHS AND LIMITATIONS OF THE STUDY

7.6.1 Strengths of the study

In this section, the strengths and limitations of this research will be pin-pointed. After briefly and clearly describing the strengths of the research, limitations of the research will be explained in terms of different parameters.

This research shares the strengths mentioned in Cho and Lee (2014:17) where the qualitative report indicated that grounded theory provides an opportunity of inquiry when no relevant theory exists regarding the phenomenon under scrutiny by indicating a creative approach without confining the researcher into the realm of theory that already exists. It also allows the researcher to look at a phenomenon with new eyes and from new perspectives without restriction within already existing hypotheses. The researcher conducting research using grounded theory method understands the phenomenon holistically. Compared to other qualitative research methods, grounded theory has a better defined procedure in the coding process.

Practically this research achieved the mentioned strengths in the following ways:

This research has been conducted on the population and setting that previously had no grounded theory study was conducted. As majority of Ethiopian adolescents are living in the rural areas of the country, this study tried to address the majority of population which presumed to be justified by moral and justice dimensions of researchers. This study was conducted in a rural setting where usually not preferred for research owing to a number of challenges that could be faced by the researcher. For instance, the researcher was obliged to confront challenges of lack of transportation and obliged to use dangerous for life local transportation systems, shortage of budget, lack of electricity, lack of clean drinking water, shortage of food and lack of accommodations and lack of communication systems and networks in rural areas.

Adolescents' health needs were usually overlooked in policies and programmes. This study come up with new insights for policy makers and program planners to base their

decisions on evidence for adolescents of the study area and to transfer to other similar settings. Transferability of the research findings were ensured by applying the criteria's of purpose sampling, theoretical sampling and thick descriptions of the results for readers.

This study tried to provide evidence which have a power of indicating paradigm shifting in the adolescents' health promotion and prevention interventions which previously largely dependent on the curative medical model. The paradigm shift after this research evidence; the health care practitioners need to understand and address the holistic nature of adolescents' health care needs and address accordingly.

This study applied the principles of grounded theory, when compared to other qualitative methods which have better defined coding procedures. The concepts, subthemes, themes and the categories of this research were developed following the data coding stages of Charmaz (2006:248), which are initial coding, focused coding, axial coding and selective (theoretical) coding that increases the dependability of the findings.

The justifications how grounded theory approach is suitable to this study context was explained in detail in Chapter 3. According to Hussein et al (2014:6), where the author of the article raised a concern of probable stage of introducing error usually by novice researchers was researchers may only use purpose sampling and use only interviews as a method of required data collection technique in grounded theory research. To minimise these methodological errors prolonged engagement with persistent observation of the phenomena under investigation was conducted. During data collection detail field notes were recorded, memos of the research process were taken, constant comparative analysis of the data was done and theoretical sampling was applied. In addition to that, there was a close guidance and discussions with the supervisor of the research at each stages of the research process.

7.6.2 Limitations of the study

The main purpose of this study was to explore, describe and investigate the health experiences of adolescents in the rural settings and developing a substantive theory based on responses of the participants. The study quite surely achieved the study

objectives. However, it shares the limitations of all qualitative studies in general and there are also contextual specific limitations to this study. One of the general limitations of this study is as the study is conducted using purposely selected small sample size. Therefore, the possibility of generalisability of the findings to other larger adolescent population is not the aim of the research and not possible, but the door is open for the readers to transfer the finding to similar contexts and settings.

According to Charmaz (2006:127), no researcher is completely objective. In grounded theory research, specifically the meanings of a phenomenon under investigation are co-constructed with the researcher and the participants of the study. Even though all the rules and principles of trustworthiness were strictly followed in this research to reduce researcher bias, still there may be probability of introducing bias because the researcher was also a health professional and part of the entire research process.

As the researcher is novice in grounded theory approach, the substantive theory developed in this research is open for further development in other contexts that may further improve the transferability and improve further enhancement to formal theory.

The other limitation of this study is language limitation when transcripts of data are translated to English for analysis and write up. There may be possibility of deviation in some too local and contextual expressions of the participants.

This research addressed the broad area of adolescents' health experiences and their perceptions regarding health and wellbeing. This may have limited the extent of detail explanation of all of the related concepts and there may be issues left not addressed.

7.7 UNIQUE CONTRIBUTIONS OF THE STUDY FOR KNOWLEDGE

One of the unique contributions of this study is the study produced research evidence on broad area of concern on health experiences of rural adolescents and their perceptions regarding health to base decisions regarding adolescents' health promotion and preventive interventions. The existing literature shows specific adolescents' health-related issues have been extensively explored. However, no study has been conducted in the same depth and design to this study on the same study participants in the rural settings.

The categories, themes and subthemes and their possible linkages was developed based on the rural adolescents' responses after building a rapport between the researcher and the participants. The study findings and their interpretations are co-constructed meanings with the participants. Because of this reason, the possibility of the study findings being owned by the participating adolescents was improved.

For the first time, policy makers and programme designers for Ethiopian rural adolescents will have a substantive theory, to base their decisions regarding adolescents' health on research evidence.

7.8 CONCLUSION

In this final chapter of this research, the main findings of the research were concluded, the implications for policy, practice, theory and for further research has been explained. Based on the pertinent findings of the research, responsible bodies for action specified recommendation were made. The achievement of the set objectives of this research was evaluated using the criteria's indicated by Charmaz (2006:182).Practical strengths of qualitative research indicated in Cho and Lee (2014:17) and Hussein et al (2014:6) were also judged providing scientific justifications how the strength was achieved. The limitations of the research findings were explained both in terms of limitations consistent with all other qualitative researches and to this study context. Finally, the unique contribution of this study for knowledge in the field was briefly and clearly discussed.

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ANNXURES

ANNXURE A1

Ethical Clearance Certificate:

Department of Health Studies, Unisa

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

27 March 2017

HSHDC/678/2017
Mr AA Keribo
Student: 5856-017-3
Supervisor: Prof GB Thupayagale-Tshweneagae
Qualification: D Tech
Joint Supervisor: -

Dear Mr AA Keribo

Decision: Ethics Approval

Name: Mr AA Keribo

Proposal: Development of a model for improving sexual practices of adolescents in rural South East Ethiopia.

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 27 March 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applic national legislation, professional codes of conduct, institutional guidelines scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be cle indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with intended research participants, as well as with the Research Ethics Commit Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

ANNXURE A2

Letter of approval, change of title:

Office of Graduate Studies, UNISA

MEMO

To:

Mrs LS Madiseng
Post-graduate Studies
Eskia Mphahlele Building
Sunnyside

From:

Prof GB Thupayagale-Tshweneagae
Department of Health Studies
X2195

11 April 2017

STUDENT: **Mr AA Keribo**

STUDENT NUMBER: **5856-017-3**

CHANGE OF TITLE

PREVIOUS TITLE: **Development of a model for improving sexual practices of adolescents in rural South East Ethiopia.**

NEW TITLE: **Health experiences of adolescents in rural South East Ethiopia.**

Supervisor: **Prof GB Thupayagale-Tshweneagae (Personnel no 90177002)**
E-mail: tshweg@unisa.ac.za

Joint Supervisor: **-**

Prof GB Thupayagale-Tshweneagae
COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Approved by:

Prof MPJ Madise
Manager: Office of Graduate Studies
College of Human Sciences

ANNXURE B

Letter of request for cooperation to Oromia Regional Health Bureau, Ethiopia: Unisa Ethiopia Learning Centre

UNISA university of south africa

15 SEPTEMBER, 2017

UNISA-ET/KA/ST/29/15-09-17

OROMIA REGIONAL HEALTH BUREAU

ADDIS ABABA

Dear Madam/Sir,

The University of South Africa (UNISA) extends warm greetings. By this letter, we want to confirm that Mr. Amene Abebe Keribo (student number 58560173) is a PhD student in the Department of Health Studies at UNISA. Currently, he is at the stage of data collection on his doctoral research entitled "***Health experiences of adolescents in rural South East Ethiopia***".

This is therefore to kindly ask you to assist the student in any way that you can. Attached, please find the ethical clearance that he has secured from the Department of Health Studies.We would like to thank you in advance for all the assistance that you will provide to the student.

UNISA REGIONAL LEARNING CENTRE
PO BOX 13836 ADDIS ABABA ETHIOPIA
TEL +251-114-350141
FAX +251-114-350078
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Sincerely,

Tsige GebreMeskel Aberra

Deputy Director – Academic and ICT Support

University of South Africa
Regional Learning Center
P.O. Box: 13836, Addis Ababa, Ethiopia
Telephone: +251 11 435 2244 / +251 11 435 0078
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ANNXURE C

Letter of granting permission to conduct a study Oromia Region Health Bureau, Health Research Ethical Review Committee

BIIROO EEGUMSA FAYYA/ OROMIYAA

OROMIA HEALTH BUREAU
የኦሮሚያ ጤና ጥበቃ ቢሮ

Lakk /Ref No/ቁጥር BEFO/HBTPH/1-8/137
Guyyaa /Date/ቀን 9/6/2010

Wajjira E/Fayyaa Go/Baalee tiif
Roobee
Dhimmi: Xalayya Deggersa Kennuu Ilaala.

Akkuma beekamu Biiroon Keenya Ogeyyii, dhabbile akkasumas namoota qorannoo fi Gamaggama jalqabaa fi Xumuraa(baseline and Endline Evaluation) geggessuuf propozaala dhiyeffatan propoozaala isaanii madaaluun akkasumas iddoo biratti ilaalchisani fudhatama argatan (approved) dhiyeffatan, propoozaala isaanii ilaaluudhaan waraqa deggersa ni kenna. Haaluma kanaan mata duree **"Health experiences of adolescents in rural south East Ethiopia"** jedhuun irratti Godinaa Baalee keessatti hojjechuudhaaf propoozaala isaani koree "**Health Research Ethical Review Committee**" Biiroo keenyatti dhiyeffatani jiru.

Haaluma kanaan koreen "**Health Research Ethical Review Committee"** Biiroo keenya piropoozaali kana ilaaluun mirkanesse qorannoon kun akka geggeeffamuu murtesse jira. Kanaafuu, hojji qorannoo kana irratti deggersa barbaachisa akka gootaniifii gaafachaa; **Obbo Amanaa Abbabaa Qariboo,** qorannoon kun qacceffamee eerga xumuramee booda firii isaa koppii tokko **BEFO** tiif akka galii godhan galagalcha xalayaa kanaan isaan beeksifna. Anis, **Obbo Amanaa Abbabaa Qariboo,** wayitti qorannoon kun qaaceffame xumuramu firii isaa koppii tokko BEFO tiif galii gochuuf mallattoo kootiin ni mirkanessa.

Nagaa Wajjin

Birhaanuu Qanaatee
Qindessaa Qorannoo fi Qo'annoo Fayyaa

Maqaa; **Obbo Amanaa Abbabaa tiif**
Mallattoo_____
Bilbila; 0913183781
G/G
Obbo Amanaa Abbabaa Qariboo tiif
B/J

Tel: 0113-69-01-17/0113-69-01-19/0113-69-01-30 Fax 0113-71-72-88/0113-71-72-27
P. O. Box. 24341 E-mail: ohbhead@telecom.net.et ADDIS ABABA/FINFINE-ETHIOPIA

ANNXURE D

Letter of request for permission to conduct a study Bale Zone Health Department

31/08/2018

To: Bale Zone Health Department
Bale Robe, Oromia Region, Ethiopia

From: Amene Abebe Keribo
ameneabe@gmail.com
Madda Walabu University
Bale Goba, Ethiopia

Dear/Sir,

Re: Permission to conduct a research in Bale Goba District, Bale Zone, Oromia Region

My name is Amene Abebe Keribo, I am a public health professional. Currently, I am studying for a PhD with the University of South Africa. As a fulfilment of the requirements for the PhD degree I am conducting a research project on the title **"Health experiences of adolescents in rural South East, Ethiopia"**. The purpose of the study is exploration and description of the health experiences of adolescents, investigating the perceptions regarding health and developing a substantive grounded theory based on their experiences and perceptions.

To achieve this purpose, I am collecting the related data on the mentioned title. The data will primarily be collected interviewing the selected adolescents. The interview will probably lasts 30-50 minutes and the conversation will be recorded after obtaining informed consent from the prospective participants and their parents or guardians.

Looking forward, hoping I will get favourable response in favourable time for the success of the project.

Sincerely yours,

Amene Abebe Keribo

ANNXURE E

Letter of granting permission to conduct a study Bale Zone Health Department

WAAJJIRA EEGUMSA FAYYAA
GODINA BAALEE

BALE ZONE HEALTH OFFICE
የባሌዞን ጤና ጥበቃ ጽ/ቤት

Lakk. BF6/11843

Guyyaa 28/12/2010

Waajjira Eegumsa Fayyaa Aanaa Goobbaatiif
Goobbaa

Dhimmii: **Xalayaa Deggarsa Kennuu Ilaala.**

"Health Research Ethical Review Committee" BEFO propoozaala qorannoo mata duree **"Health Experience of Adolescence in Rural South East Ethioipia"** jedhu irratti **Obbo Amanaa Abbabbaa Qoriboo** tiin gaggeefamuu haayyamu isaa xalayaa lakk **BEFO/HBTIH/1-8/137** guyyaa **09/06/2010** barreeseen nuuf ibsee jira.

Kanaafuu isinis kanuma beekuun gama keessaniin deggarsa barbaachisaa ta'ee akka gotaniif isiin beeksifna. **Obbo Amanaa Abbabbaa Qoribootiis** dhuma qorannoo kana irratti firii isaa koppii tokko waajjira keenyaaf akka galchitan garagalcha xalayaa kanaan isiin beeksifna.

Nagaa Wajjin

Lugdaychu Dakeba
B/B/IA Waajjiraa

GG
Obbo Amanaa Abbabbaa Qoribootiif
BJ

Tel. 0226651325 /26 /27 / 0226651416 / 0226651432 / 0222445614
Email: bzhoplan@yahoo.com Address: BALE ROBE/OROMIA ETHIOPIA

ANNXURE F

Letter of request for permission to conduct a study Goba District Health Office

31/08/2018

To: Bale Goba District Health office
Bale Goba, Oromia Region, Ethiopia

From: Amene Abebe Keribo
ameneabe@gmail.com
Madda Walabu University
Bale Goba, Ethiopia

Dear/Sir,

Re: Permission to conduct a research in Bale Goba District, Bale Zone, Oromia Region

My name is Amene Abebe Keribo, I am a public health professional. Currently, I am studying for a PhD with the University of South Africa. As a fulfilment of the requirements for the PhD degree I am conducting a research project on the title **"Health experiences of adolescents in rural South East, Ethiopia"**. The purpose of the study is exploration and description of the health experiences of adolescents, investigating the perceptions regarding health and developing a substantive grounded theory based on their experiences and perceptions.

To achieve this purpose, I am collecting the related data on the mentioned title. The data will primarily be collected interviewing the selected adolescents. The interview will probably lasts 30-50 minutes and the conversation will be recorded after obtaining informed consent from the prospective participants and their parents or guardians.

Looking forward, hoping I will get favourable response in favourable time for the success of the project.

Sincerely yours,

Amene Abebe Keribo

ANNXURE G

Letter of granting permission to conduct a study Bale Goba District Health Office

Waajira Eegumsa Fayyaa
Godina Baaleetti Waajira Eegumsa
Fayyaa Aanaa Goobbaa

Lakk X.2-7/2459/A
Guyyaa 29/12/2006

Ganda Qotee Bulaa Walta'ii toshaatiif

Ganda Qo/Bulaa I/Suraatiif

Ganda Qo/Bulaa Aloshee Xilootiif

Ganda Qo/Bulaa Shedamtiif

GandaQo/Bulaa Riraatiif

Ganda Qo/Bula Walta'ii Maakidaatiif

B/J

Dhimmi:- Deegarsa Gaafachuu Ilaala.

Ogeessaa fayyaa kan ta'an Obboo **Amaan Abbabaa Qoriboo** qorannoo adda addaa waa'ee fayyaa irratti akka gaggeessaa qajeelchii eegumsa fayyaa Godina Baalee xalayaa lakk BF6/11843 guyyaa 28/12/2010 barreefameen nu gaafatani jiru.

Waan kana ta'eef ogeessi maqaan isaa asiin olitti tuqame kun qorannoo waa'ee fayyaa barbaachiisaa ta'e ganda keessan irratti akka gaggeessuuf deegarsa barbaachisaa ta'e hundaa akka taasifataniif kabajaan isiin gaafachaa deegarsa taasiftaniif galatnii keenya ol'aanaa ta'a.

Waajira Eegumsa Fayyaa Godina Baaleetti Waajira Eegumsa Fayyaa Aanaa Goobbaa

Nagaa Waajjin

Zannabach Tarrafa Ulatuu
Hoogganaa Eegumsa Fayyaa
Aanaa Goobbaa

G/G

- Obboo Amaan Abbabaa tiif

B/J

ANNXURE H

Information leaflet and informed consent

INFORMATION LEAFLET AND INFORMED CONSENT

TITLE OF THE STUDY

HEALTH EXPERIENCES OF ADOLESCENTS IN RURAL SOUTH EAST ETHIOPIA

Dear Participant,

My name is Amene and I am a public health professional. Currently I am studying for a PhD with the University of South Africa. As a health professional I will always work to safeguard your best interest. As a resident of Bale Goba District, you have purposely been selected to participate in this study. This study is being conducted on adolescents in your community after getting the permission from your District Health Office. This information leaflet contains information that believed to be helpful to you to understand your role in the study. If there is any need for further inquiry, please feel free to contact the researcher or the research supervisor or the university at any time you assume it is convenient for you. Full contact address of the researcher, the supervisor of the research and the university is given at the end of this information leaflet.

1. The nature and purpose of this study

The fact that you are a young person between the ages of 15 and 19 and you will come across with a number of health related experiences in your life. There may be a number of adolescent health issues that need to be adequately addressed. However, addressing all adolescent health issues at one time is not possible because of shortage of resources. Finding out what needs immediate intervention is very much important. Therefore, your effective participation in the study that seeks to develop a grounded theory for promotion of adolescents' health is very crucial. In order to achieve this aim the researcher must first explore and describe your social, behavioural, cultural and growth and development related health experiences in detail.

2. Explanation of the procedure to be followed

Taking part in this study involves being interviewed. Interviews will take around 30-50 minutes and will be done at (NAME OF THE SITE). I will bring some questions with me, but I want you to add anything important that you think I have missed. I also want you to tell me how to do the interviews better. All the interviews will be recorded so I can listen to you

without writing notes. After the interview, I may ask you if you would like to come to a group meeting at the end of the research to see if the information you gave sound right. We can also use this time to discuss what you think is the best way to get these messages across to all adolescents in your locality.

3. Benefits for taking part in the study

There are no direct payments for participation in this study. As this study is conducted for PhD there is no any fund gained for this purpose. However, the researcher will cover the participant's transportation and refreshment costs. Adolescents' health promotion model that the study seeks to develop will be used to assist the young people by indicating the better ways to be able to cope with the various challenges posed by adolescence and thus improve their health status. Your voice is important, and it is important that if it is heard in the right way. What you tell me will also be used to help health policy makers understand you and design better health promotion programs to meet your health needs.

4. Risk and discomfort involved

There is no any discomfort foreseen for the interview. However, I understand that not all health experiences are positive ones. If, at any point, you become upset we can stop. We will only continue if you want to do so. If you bring up issues that need further attention, there will be an opportunity for debrief after the recorder is switched, since I am a health professional I may advise you about the best services to help you or refer you from where to get the services. In addition to the issues raised above your identity as a participant will be kept confidential. Your participation into this study will also require some of your time, patience and effort.

5. Participants right

Participation in this study is entirely in a voluntary basis. You have the right to respond fully or partially to the interviews or even to refuse to participate at all in the study. All the information provided will be used for the intended research purpose only. You have the right to refuse or withdraw at any time during the study without giving any reason and no penalty for doing so.

6. Ethical approval

The research has been granted ethical clearance and approval by the Department of Health Studies Higher Degrees Committee of University of South Africa. Permission to undertake this study has also been obtained from the Oromia Regional Health Bureau Health Research Ethical Review Committee, Bale Zone Health Department and Goba District Health Office sequentially.

Additional information

If you have any questions about the research you are welcome to contact the Higher Degrees Committee in the Department of Health Studies, University of South Africa, through Ethiopia regional learning center, Addis Ababa or directly.

University of South Africa
Ethiopia, Regional Learning Centre
P.o.box:13836, Addis Ababa, Ethiopia
Telephone: +251114352244
Fax: +251114351242
Cell phone: +251912191483

In addition to the above for any question about your participation in this study, you can contact the researcher, Amene Abebe Keribo.

Contact No. Home: +251913183781
Email address: ameneabe@gmail.com

Alternatively you can contact the research supervisor

Prof G.Thupayagale-Tshweneagae
Work: 012 4292195
Email address:tshweg@unisa.ac.za

PARTICIPANT CONSENT FORM

Name of the researcher: Amene Abebe keribo

Participant code: _____

Please read all the check lists and confirm (make a ✓ in each box)

1. Confirm that I have read and understand the information sheet ☐
2. I have had the opportunity to discuss about the research project and I have had a minimum of 24 hours to decide that I want to participate ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. If I chose to withdraw ☐
4. I understand it is my right to have all information I have given removed from the study even after the study is on the process. ☐
5. I have been given the opportunity to inform my parent/guardian about the study. ☐
6. I agree to the interview being recorded. ☐
7. I understand that the final results of the study will be presented in thesis and may be included in future journal papers and conference presentations. ☐
8. I agree to take part in the above study. ☐

_____	_____	_____
Name of the Researcher	Signature	Date
_____	_____	_____
Name of the Participant	Signature	Date
_____	_____	_____
Name of Parent/Guardian	Signature	Date

ANNXURE I

Interview guide

INTERVIEW GUIDE

1. Demographic questions

1. Age of the respondent ----------
2. Sex----------
3. Highest level of education----------
4. Ethnicity----------
5. Religion----------
6. Marital status ----------

2. Interview schedule for the objectives of the study

1. Would you tell me how do you understand the term health?
2. Do you feel adolescents' health issues need to get more attention?
3. What do you think are the health risks of adolescents in your locality?
4. Was there any health related experience in your life that you feel it was risk for your health?
    - ✓ (think about for lifestyle issues and contextual factors that conflicted with your health)
5. What did you done to overcome the health risk you told me above?
    - ✓ Did you manage it before it caused serious health problem on you?
6. Did you told to your family or somebody else about the issue?
7. Do you feel your family or somebody else whom you told the issue understood you?
8. Can you tell me about how this people communicated with you?
9. How well do you think they listened to your concerns?
    - ✓ (think what facilitated or blocked your communication about the issue)
10. Did you consider visiting a health care worker regarding your health?
    - ✓ Think when you feel to seek health care
11. Do you think there are cultural practices in your locality that affect adolescents' health?
    - ✓ (Think issues usually done in your community that you feel create health problems on adolescents)

12. Did you experienced any practices that you feel they have an impact on your health and assumed to be traditional practices in your community?
13. How do you see the local beliefs of your community regarding adolescents' health?
    - ✓ Think how they care for the health of adolescents
14. How do you see the influence of religion on your health?
15. Do you think growth and development of adolescents' are linked to health related behaviours in adolescents?
16. Was there any experience that you feel related to your health happened because of change in your body as you grow up?
17. How do you describe your sexual experience as you grow up?
18. How do you see your current health status?
19. Please tell me health related experiences in your life that changed as your growth and development status changes?
20. Do you think social influences in your locality leading adolescents to experience health risk practices?
21. How do you see the influence of your peer group on your health related behaviours
22. How do your parents treat you (what looks their way of parenting)
23. What social values and norms do you think are there that positively or negatively influence your health condition
24. How do you see your communication with your parents or other important people regarding health related issues
25. How do you see the effect of education on your health
    - ✓ Think of behavioural changes related to your health either positive or negative

ANNXURE J

Language Editor's Certificate

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

23 June 2019

TO WHOM IT MAY CONCERN

This certificate serves to confirm that I have edited and proofread the report for Ms AA Keribo's thesis entitled, **"HEALTH EXPERIENCES OF ADOLESCENTS IN RURAL SOUTH EAST ETHIOPIA".**

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:

Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

Professional EDITORS Guild