ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

PREMARITAL SEXUAL PRACTICE AND ASSOCIATED FACTORS AMONG ORPHAN ADOLECENTS IN SELECTED CHARITY ORGANIZATIONS OF ADDIS ABABA, ETHIOPIA, 2014.

BY- MEHERET TENA (BSc)

ADVISOR- ASSEFA SEME (MD, MPH)

A Thesis submitted to Addis Ababa University College of Health Sciences, School of Public Health in partial fulfilment of the requirements for the Degree of Master of Public Health (MPH).

July, 2014
Addis Ababa, Ethiopia.

ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

PREMARITAL SEXUAL PRACTICE AND ASSOCIATED FACTORS AMONG ORPHAN ADOLECENTS IN SELECTED CHARITY ORGANIZATIONS OF ADDIS ABABA, ETHIOPIA, 2014.

BY- MEHERET TENA (BSc)

Approved by the examining board:-

Chairman Dep. graduate committee-	**Signature**
----------	**----------**
Advisor-	**Signature**
----------	**----------**
Examiners-	**Signature**
----------	**----------**
----------	**----------**

ACKNOWLEDGMENTS

I am highly indebted to my Advisor Dr.Assefa Seme for his unreserved advice and meticulous comments I received through out my thesis work. He assisted me with devotion and concern in each and every step of the study.

Deep gratitude also goes to School of Public Health of Addis Ababa University for facilitating the funding process & librarians for providing the necessary materials.

I am also grateful to Dr. Alemayehu Mekonnen, Mrs. Hiwot Getachew, Mr. Fentie Ambaw, Mr. Muluken Gizaw and Mr.Wondmu Ayele that helped me a lot during the beginning of the study. My gratitude should also go to Mr.Yonas Tesfaye and his colleagues from city government of Addis Ababa women's, children & youth affairs bureau for their hospitality and provision of necessary information.

Many thanks shall also go to my friends and those project coordinators of charity organizations of the study areas who arranged, devoted themselves on making the research work pleasant. I would like to express my gratitude to all participants who volunteered to participate in the study.

My deepest and sincere appreciation also goes to my parents, my brother Mr.Abenezer Tena, Ephrata Hailu & her family for their marvellous support, encouragement and invaluable help through out the years of my study.

It gives me a great honour and privilege to thank my Heavenly Father for motivating me, for His encouragement & special support during difficult times. The attention and thoughtfulness I got from my fiancé Sabom Desalegn Teklu will not be forgotten that it is his belief in, understanding and support of me that gave me the courage to step out.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES Page

ACRONYMS

AIDS- Acquired Immunodeficiency Syndrome

AOR- Adjusted Odds Ratio

BSS- Behavioural Surveillance Survey

COR- Crudes Odds Ratio

FGD-Focus Group Discussion

HIV-Human Immunodeficiency Virus

IGA- Income Generating Activities

MDG-Millennium Development Goal

NGO- Non Governmental Organization

OVC- Orphans and Vulnerable Children

REC- Research Ethics Committee

RH- Reproductive Health

SD-Standard Deviation

STD-Sexually Transmitted Diseases

UNAIDS- United Nations Programme on HIV/AIDS

UNICEF- United Nations Children Fund

WHO- World Health Organization

ABSTRACT

Background: Adolescence is a period of great physical, mental and emotional turmoil; teenagers in curiosity to prove their sexuality start experimenting sex. Premarital sex during adolescence is often unprotected against unwanted pregnancies and sexually transmitted infections (STIs). Ethiopia counts one of the largest populations of orphans in the world. Orphans may not receive the adequate caregiver monitoring that deters risky sexual behaviour. There is little or no information about the prevalence of premarital sexual risks among orphan adolescents in Ethiopia.

Objective: To assess pre-marital sexual practice and associated factors among orphan adolescents (15-18 years) in Addis Ababa charity organizations.

Methods: The study used mixed methods approach by combining institution based cross-sectional survey of orphan adolescents (15-18 years) who were beneficiaries of community based support in charity organizations. A total of 422 sample size was calculated using single population proportion formula & simple random sampling technique was used to select the study units.
The survey was complemented with qualitative FGDs and in-depth interviews with purposively selected orphan adolescents and guardians that work as child development projects in those selected charity organizations. For quantitative data Epi-Info version 3.5.4 software was used for data entry then data exported to SPSS Version 21 software for analysis. Bivariate logistic regression analysis was used to assess the presence and degree of association between dependent and independent variables. Multivariate logistic regression model was applied to identify the important determinants for premarital sex and used to control for possible confounding effects. The transcribed and translated qualitative text data was imported into Open Code program and coded. Then codes were categorized and thematically described.

Result: From the selected charity organizations that provide community based support, a total of 393 orphan adolescents aged 15-18 completed the questionnaire, giving a response rate of 93.1%. Eighteen (4.6%) orphan adolescents have ever had sex. The mean and median age at first sex were 14.5 (SD+-3.69) and 16 years respectively. Nearly 53% of the respondents were females; the majority (82.4%) were in the age group of 15-16 with mean age of 16 (SD 1.12). More than a quarter (26.7%) orphan adolescents were encouraged by their peer friends to have sexual partners. However, 86.5% of respondents had drunk alcohol but 3.8% of them practice sex after drinking alcohol. About one third (33.3%) of respondents viewed pornographic materials.

In multiple logistic regression after controlling for confounders, age (17-18 years old), alcohol use, having boy/girl friend and peer pressure were found to be significantly associated with the out come variable.

Conclusions and Recommendations: In the current study though the prevalence of sexual practice was smaller when compared to earlier studies done in other countries; those orphan adolescents affected by peer pressure, alcohol use & who had boy/girl friend were more exposed to premarital sexual practice. Thus, sex education programs that focus on risky sexual behaviours shall be designed at school levels. Further studies shall also be conducted on premarital sexual risks of orphan adolescents.

1. INTRODUCTION

1.1 Background

Adolescence, as the world Health organization (WHO) defines it; the age between 10 and 19 years, is a period of sexual maturity that transforms a child into a biologically mature adult capable of sexual reproductions and the potential consequences of that sexual activity. (1)

Early initiation of sexual intercourse without having proper protection has been one of the concerns. Studies have also documented early sexual initiators were more likely to report undesired consequences of sexual initiation such as teenage motherhood, not using condom at first sex and sexually transmitted infections (STIs). Adolescents are also likely to have a sexual partner who is five or more years older and be involved in multiple sexual partnerships. (2-4)

Adolescents may feel resentment and anger at the death of a parent or close family member. They may seem to be coping, but at the same time they can experience depression, hopelessness, and increased vulnerability. This can lead to a sense of alienation, desperation, risk-taking behaviour, and withdrawal. Orphans may be particularly challenged by the developmental tasks of adolescence. Psychosocial and economic distress can lead to risk-taking behaviour linked with unsafe sexual practices.(5, 6)

According to United Nations Children's Fund (UNICEF), an orphan is a child under 18years of age whose mother, father or both parents have died from any cause.(7) Over 153 million children worldwide are orphans; of the 132 million orphans who live in developing countries, an estimated 13 million have lost both parents. (8)

War, AIDS, malaria, cholera and famine have gradually turned Africa into a continent full of orphaned children and teenagers. According to the latest statistics released by the UNICEF and the Joint United Nations Programme on HIV/AIDS (UNAIDS), there are 48.3 million orphans south of the Sahara desert, one-quarter of whom have lost their parents to AIDS. Between 1990 and 2000, the number of orphans in Africa rose from 30.9 million to 41.5 million, and those orphaned by AIDS increased from 330,000 to seven million. Projections by the two U.N. agencies suggest that by 2010, there will be 53.1 million children under 18 bereft of their parents, 15.7 million of whom will have had parents who died of AIDS, caused by the human immunodeficiency virus (HIV). (9)

Ethiopia counts one of the largest populations of orphans in the world: 13 per cent of children throughout the country are missing one or both parents; this represents an estimated 4.6 million children – 800,000 of whom were orphaned by HIV/AIDS by the year 2011. The country has seen a steady increase in the number of children becoming orphaned because of AIDS. In the past, famine, conflict and other diseases were the main factors that claimed the lives of parents.(10)

It was estimated that there were a total of 179,381 orphans in Addis Ababa in 2005. Of these, the majority 109,130 were AIDS orphans. Of the AIDS orphans 40,989

were double orphans. By the year 2010, it was estimated that in Addis Ababa there were a total of 171,320 orphans (0-17 years old); 40, 119 were double orphans. Paternal orphans represent the majority of orphans in the country that accounts for 117, 461.(11)

1.2 Statement of the problem

Adolescence, a transitional period of physical, emotional, and social maturation, is often characterized by the clarification of sexual values and experimentation with sexual behaviours. Early initiation of sexual activity among adolescents has been identified as a major risk factor for a number of negative reproductive health outcomes, including early childbearing and associated implications for maternal and child health outcomes, as well as increased risk for STIs including HIV.(15)

Worldwide it is estimated that more than 15 million children under 18 have been orphaned as a result of the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), of which more than 12 million live in sub-Saharan Africa. As HIV infections increase among the adult population in Africa, millions more children will lose their parents to the AIDS epidemic, leading to the death of millions of parents worldwide, leaving an ever increasing number of children growing up without one or more parents. (16, 17)

It is estimated that globally of the number of orphans, about 55% are aged 12–17, or are adolescents. This is significant because adolescents are in a different developmental stage and at an age where they should engage in activities that prepare them for adulthood. Orphaned adolescents may be especially vulnerable to early sexual debut through several mechanisms. For instance, orphans‘ living arrangements may increase their susceptibility to early sexual activity. Lack of close adult supervision may lead to more opportunities to engage in sexual activity. Psychosocial distress, as measured by depression, anxiety, and low self-esteem, is another mechanism through which orphans may engage in early sexual activity.(16-18)

Loss of a parent disrupts interpersonal relationships, requiring children to build or shift relationships with new caregivers. In some cases, the death can also lead to decreased social support particularly if children are required to move. Orphans may be more likely to engage in early sexual activity to facilitate social connections. Further, they may lack the communication with caregivers that has been identified as a potential protective factor. Orphans have been found to have a higher likelihood of being sexually active, initiate sex at an earlier age, and have unprotected sex and multiple partners.(16, 18)

The number of children experiencing orphanhood is increasing at an alarming rate. In Ethiopia, there are around 4.6 million orphans—defined as children less than 18 years of age who have lost one or both parents. Orphanhood, both biological and social, is a significant structural feature of Ethiopian society. Thus ever increasing number of orphans is becoming one of the serious agendas that command due attention. (12, 19)

Yet few studies explore the links between orphanhood and risky sexual behaviour in some African countries, and it is important to examine whether orphans are more likely than non orphans to engage in risky sexual behaviour in order to better design

targeted interventions. To design effective public health responses for these adolescents, we need a clearer understanding of the consequences of parental death in the context of sexual behaviours and risky sexual activities. In Ethiopia, studies rarely assessed adequately the sexual behaviour of adolescents, particularly orphans and the contexts in which the behaviour occurs. So this study can help to gain insight on sexual behaviours of orphan adolescents, particularly on pre-marital sexual debut and its associated factors in Addis Ababa.

1.3 Significance of the study

The need to safeguard adolescent sexual health has fuelled much research on factors that predispose adolescents to risky sexual behaviours including unprotected sexual intercourse, early sexual debut, and multiple sexual partnerships. At the same time, a number of programs have been designed to address adolescent sexual health with a focus on delaying sexual initiation and increasing condom use among those who are sexually active.

Orphaned adolescents may be especially vulnerable to premarital sexual risks and they lack communication about risky sexual behaviour. The information obtained from this study is believed to provide insight into the sexual and reproductive health of orphaned adolescents (15-18 years). At the same time, it will contribute to carefully design initiatives that are targeted to address the reproductive and sexual health needs of orphaned adolescents.

This study topic is chosen as a priority to gain insight on sexual behaviours of orphan adolescents keeping in mind that healthy adolescents are cores in the process of development so that it will contribute to the process of development by availing the most complete and recent information about risk behaviours affecting the reproductive health, orphaned adolescents are particularly affected by different reproductive health problems and also since due emphasis given to youth by government of Ethiopia in the social, political, economical and developmental role.

In Ethiopia the ever increasing number of orphans is becoming one of the serious agenda that command due attention, yet few studies explore the links between orphanhood and risky sexual behaviour in some African countries particularly in Ethiopia, and it is important to examine whether orphans are likely to engage in risky sexual behaviour in order to better design targeted interventions.

Though there is a wealth of research on sexual behaviour of adolescents, but studies have only begun to examine the effect of orphan hood on sexual risks. So that this study will help to plan programs that prevent reproductive health problems and promote healthy behaviours specifically to orphan adolescents. In line with this it also helps as a reference for any reproductive behavioural research activity to be carried out in the future concerning orphan adolescents of the study area.

2. LITERATURE REVIEW

Many governments and agencies have realized that attaining Millennium Development Goals, MDGs in the future, involves designing intervention strategies that impact on the transition to adulthood. The transition to adulthood is defined as a period of social, psychological, economic and biological change. It is during this period that most young people normally begin school, have their first sexual encounter and begin to develop sexual relationships, enter the labour force and set up a new home. During this period young adults can establish behaviour patterns that can be detrimental to their health and wellbeing and lead to negative outcomes later in life. (20)

In many countries concern about adolescents‘ sexual and reproductive health is increasing, in part because of real or perceived increases in their sexual activity and rates of pregnancy outside marriage, and in part because of high rates of HIV infection and AIDS, because sexual debut generally occurs during adolescence or young adulthood, experiencing the death of a parent during this developmental period may contribute to riskier behaviours and places young people at considerable risks of unwanted pregnancy, unsafe abortion, and STIs including HIV/AIDS.(21, 22)

During the transition to adulthood, adolescents, both orphans and non-orphans, experience important life events such as sexual debut, marriage, and childbearing. These events, not always under the control of adolescents themselves, can place them at increased risk of their health. Particularly, this is evident in orphans; Studies indicate that male and female orphans are more likely than their non-orphan counterparts to have engaged in sexual activity.(23) An orphan is a child under 18 years of age whose mother, father or both parents have died from any cause. Orphans from all causes can be more specifically described as follows: Single orphan – a child who has lost one parent and double orphan–a child who has lost both parents. Maternal orphan – a child whose mother has died (includes double orphans) where paternal orphan – a child whose father has died (includes double orphans). (7, 15)

A study done in Zimbabwe, obtained slightly different results. In their study, both paternal and maternal orphans, regardless of gender, are more likely than non-orphans to have initiated sexual activity. They found that increased psychosocial distress explained some of the increased risk of early sexual debut and HIV infection experienced by orphans in Zimbabwe. Educational differences are another pathway that may affect orphans‘ vulnerability to early sexual debut and marriage. The role of education in early sexual debut among adolescents in Sub-Saharan Africa has been researched extensively. Despite numerous studies, the literature examining this relationship remains inconclusive. (15, 24)

A study carried out in Tororo District in Eastern Uganda showed that orphaned girls were more vulnerable to early sexual debut and to sexual abuse than their male counterparts and non-orphans (especially the non orphan girls). Many of the orphaned girls were either lured into having sex, or began having sex for material gain. While the consequences of poverty seemed to contribute significantly to risky sexual behaviour for all adolescents, this study indicated that orphaned adolescent girls are especially at risk. Orphaned adolescents, particularly females, are more easily tempted to indulge in risky sexual behaviour due to the needy situations in which they live.

The caregivers cannot afford to provide for their basic needs like food, clothing, school requirements and sanitary pads.(17)

As one study in Kenya among youths in secondary school indicates that across orphanhood, data revealed that orphans and non orphans had sexual intercourse at a mean age of 13 years and 14 years respectively. Independent sample t-test indicated significant mean differences between orphans and non-orphans in sexual risk-taking behaviours suggesting that orphans were more likely to be involved in sexual risk-taking behaviour than non-orphans $t=14$, $df=334$, $p<5$ respectively. This difference could be associated with search for sense of belonging and solace especially when they feel rejected by the families which are supposed to take care of them. It could also be attributed to lack of basic needs by orphans after the death of their parents and the hard economic times and the extra burden to the new families. For example, after the death of their parents, their guardians may not be able to fully cater for their needs alongside the guardians‘ children which make them vulnerable to engage in sex for gifts.(25) Several studies have been published suggesting that orphans are at increased sexual health risk. We also found that, amongst female adolescents, maternal and double orphans were significantly more likely to have started sex than non-orphans in countries with high HIV prevalence but were not at increased risk in low HIV prevalence countries. The same pattern of risk was not observed for male adolescents; male orphans were not more likely to have started sex than non-orphans. This suggests that orphaned adolescent women are an important target group for HIV prevention and that efforts should be made to integrate prevention messages into existing support programmes for orphans and vulnerable children.(26)

Adolescent orphans girls are likely to experience an identity crisis; a situation where they do not have a sense of belonging anywhere, not knowing who they are and/or where they are going. The issue of identity, to a large extent, relates to their self-image (a person‘s mental model of themselves) and gender identity, as it dictates how they view themselves in relation to other people, ideas and nature. These young girls are now beginning to explore their sexuality; they are entering into relationships and some of them are beginning to share intimacy, yet they, in most cases lack someone to guide them in proper and safe methods in sexual encounters. (27, 28)

One study that was done in Zimbabwe revealed that; when compared to female non-orphans, orphans are more likely to have had sex, irrespective of their marital status. Female orphans who were married at the time of the survey were also more likely to report having had pre-marital sex compared to their non-orphan counterparts. The majority of female youth (over 85%) reported that they had their first sex with a partner that was older, while the corresponding figure was less than 20 percent for boys.(29)

Orphans not living with a surviving parent may also lack needed affection from their new family, especially if they are treated differently from the caretakers‘ biological children.(12) Because they feel neglected, some orphaned adolescents may use sexual activity as a way to gain love and affection that is not provided at home. In addition to emotional needs, orphans often lack money and material goods such as food, clothing, and shelter, as well as education. Orphans also may not receive the adequate caregiver monitoring that deters risky sexual behaviour. Especially, female orphans with less supervision may be more likely to engage in transactional sex. In general, the number

of orphans may overwhelm existing support systems, decreasing the available caregiver and family influences that may prevent risky sexual behaviour. (13, 14)

In another study done in Kenya, Adolescents, caregivers and community informants reported that, to meet basic needs, some adolescents engage in varied income generating activities (IGAs). The most commonly discussed IGAs included fishing, bicycle taxi services, herding and casual farm work for boys while girls engaged in domestic live-in work (household chores for pay) away from home. Adolescents reported that boys who engaged in IGAs used their earnings to entice girls into sex, go to discos and video shows, buy alcohol and drugs, and engage in other behaviours that were thought to increase sexual risk outcomes such as teenage pregnancies, STIs or both. They described domestic work as increasing girls‘ vulnerability to sexual abuse and exploitation by the male members of such households. Transactional sex often occurs with older partners and the power imbalance in such exchange reduces adolescent ability to negotiate safe sex, thus predisposing them to unprotected sex.(30)

One systematic review and meta-analysis done on sexual behaviours of orphans showed that; in One study it was revealed that female orphans were more likely to have multiple partners than female non-orphans, the same three studies assessed forced or unwilling sex ever or at first sex. One of these found a significantly greater likelihood of forced or unwilling sex among orphans compared with non orphans. The same three studies assessed transactional sex, defined as ever exchanging sex or receiving basic needs from a current sexual partner, results in one study indicated significantly greater risk among orphans than among non-orphans. (31)

In Ethiopia, early initiation of sexual intercourse without having proper protection has been one of the concerns. Studies conducted in Ethiopia identified inconsistent predictors of sexual debut. In study done in eastern part of the country showed that, a large proportion of the in-school adolescents initiated pre-marital sex. (32)

The various estimates and projections of the percentage of children who are orphans (losing one or both parents due to all causes, including HIV/AIDS) are high – 12.4 percent (1995), 13.2 percent (2001), and 14.0 percent (2010, projected) by *Children on the Brink 2002*, and 10.7 percent (2000) by the Demographic and Health Survey (DHS). The number of orphans in Ethiopia is likely to increase throughout the decade and surpass 5 million by 2010. The estimated percentage of children orphaned by AIDS, as opposed to other causes, increased from 9.6 percent of all orphans in 1995 to 25.8 percent in 2001. By 2010, it is estimated to increase to 43 percent of all orphans. In all regions of the country, at least 10 percent of children under the age of 15 are orphans, as shown in table 2. The percent of children orphaned is especially high in the Afar region (20.7 percent) and Addis region (15.7 percent). Paternal orphans represent the majority of orphans in the country, averaging 6.6 percent of all children.(33)

As indicated on above, currently the orphan estimate for Ethiopia is 4.6 million according to UNICEF, despite the rapidly growing burden of orphans and vulnerable children (OVC) in sub-Saharan Africa due to the spread of the HIV/AIDS epidemic, many countries in the region do not have effective programs to support OVC and their caregivers. This problem is mainly due to a lack of detailed information on the

prevalence and spread of OVC in various population groups and regions in these countries. To fill these gaps, we need a clearer understanding on this area, mainly with predictors of sexual debut and associated factors among orphan adolescents so as to design targeted interventions.

Conceptual frame work

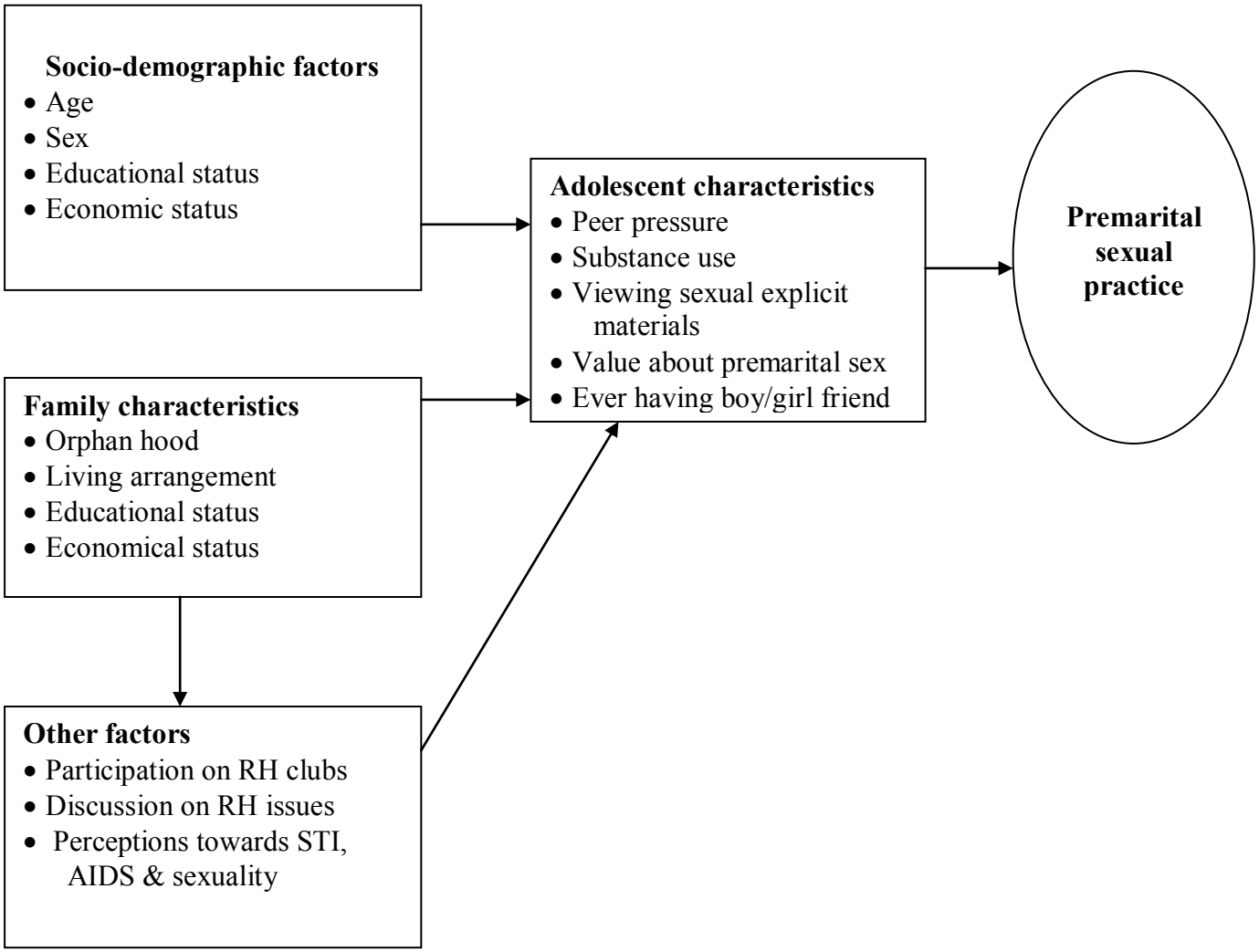

Fig.1: -Conceptual framework: Premarital sexual practice and associated factors among orphan adolescents (15-18 years) in Addis Ababa, 2014.

3. OBJECTIVES

3.1 General objective

- Assessment of pre-marital sexual practice and associated factors among orphan adolescents (15-18 years) in Addis Ababa.

3.2 Specific objectives

- To determine the prevalence of pre-marital sexual debut among orphan adolescents (15-18 years) in Addis Ababa.
- To identify factors associated with pre-marital sexual practice among orphan adolescents (15-18 years) in Addis Ababa.

4. METHODOLOGY

4.1 Study area

The study was conducted in Addis Ababa, a capital city of Ethiopia. It is the largest city in the country, with a population of 3,384,569 according to the 2007 population census. It is composed of 10 sub-cities and 100 kebeles, and its total area covers 540 square kilometres. (34, 35)

There are around 245 charity organizations providing different services including support to orphan and vulnerable children in Addis Ababa. From these, few give boarding and lodging type of support to orphan adolescents where living quarters and other basic necessities are given with that set up.

Other organizations includes adoption agencies, governmental and private charity organizations with operational areas of maternal health, child protection against abuses and violence, projects on street children, elders, children in relation to autism, child labor and trafficking , women on violence, Income generating activities (IGAs), handicapped & disability focused organizations.

From all those charity organizations majority of institutions provide community based service which is a type of assistance provided to orphans while they are living within the community like with their parents (alive mother or father), extended families, guardians or volunteers in the community. This type of support is given among those local NGOs, International NGOs and faith-based organizations that are related with different religions.(19, 36, 37)

4.2 Study design

Institution based cross-sectional quantitative study was carried out from Oct. 2013-May 2014 with mixed methods approach by complementing four FGDs and four in-depth interviews so as to supplement the quantitative survey in the study area.

4.3 Sample population

4.3.1 Source population-

- Orphan adolescents (15-18 years) who were beneficiaries of charity organizations that give community based support in Addis Ababa.

4.3.2 Study population-

- Orphan adolescents (15-18 years) who were randomly selected & fulfil the inclusion criteria from the selected charity organizations that give community based support in Addis Ababa.

4.4 Sample size determination

To determine the number of orphan adolescents to be included in the study a single population proportion formula was employed which was based on the following assumptions:-

Prevalence of 49%, Sexual risk behaviour among South African adolescents: is orphan status a factor? (23)

95% confidence level (Z α/2), 5% margin of error (d) and 10% non response rate

$$n = \frac{z^2 * p(1-p)}{d^2} = \frac{(3.8416) \times 0.49 \times 0.51}{0.0025} = 384$$

Assuming a non-response rate of 10% =384 x 10/100= 38.4

Final Sample size= 384+38.4=422

4.5 Sampling procedures

For the quantitative study-

From a total of 128 charity organizations in Addis Ababa town, those organizations that provide different services other than community based support to orphan adolescents like adoption agencies, boarding types charity organizations and those that support non-orphan children and orphans who are less than the age 15 were excluded since on the EDHS 2011, sexual debut is commonly reported beyond middle adolescence which is also supported by different literatures.

A total of 36 charity organizations that give community based support were filtered from the main list due to the above reasons; from these 10 organizations (Yezelalem minch children & community development organizations, Hope Enterprises, Mothers and Children Multi sectoral development organization, Gelegela Integrated charity organization, Care For the Poor, Hope for children Ethiopia Australia limited, Bright for Evert kids organization, Kotebe Muluwengel child sponsorship project, Wabe children aid and training organizations and Compassion International Ethiopia Child sponsorship project) were selected randomly by lottery method.

Sample size was assigned proportionally to each selected charity organizations and the lists of orphan adolescents (15-18 years) from the registration file in each institution were used as a sampling frame. By using simple random sampling each study unit was selected by lottery method.

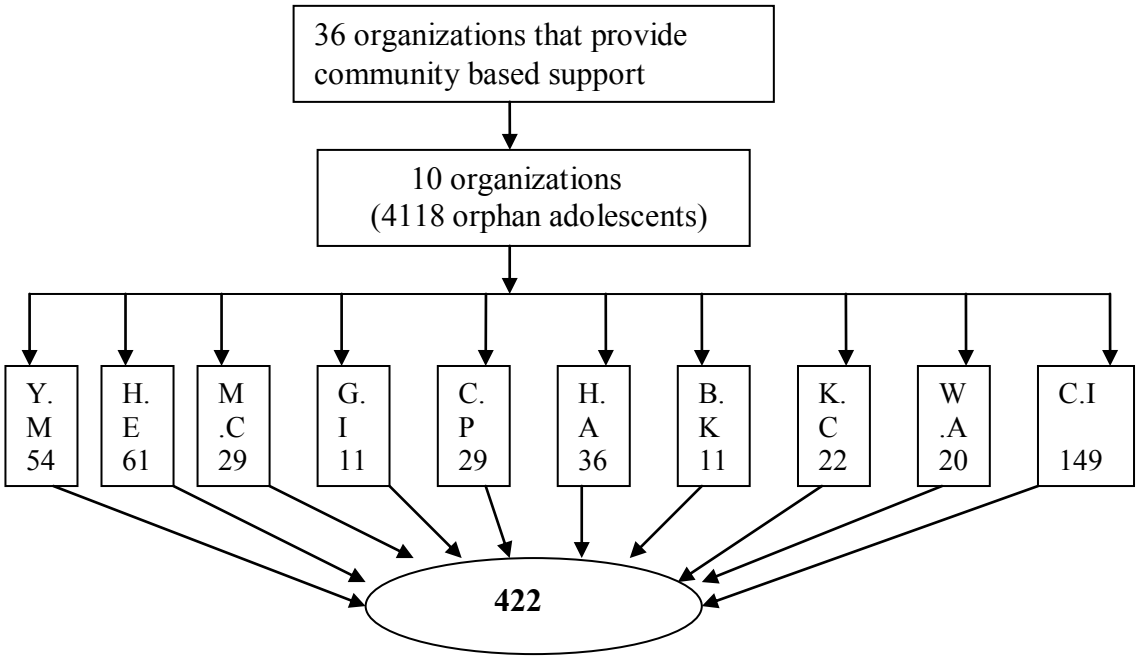

Figure shows schematic diagram of sampling procedure

N.B- By Proportionate allocation: nj=(n/N) Nj
– nj is sample size of the jth stratum
– Nj is population size of the jth stratum
– n = n1 + n2 + ...+ nk is the total sample size; N = N1 + N2 + ...+ Nk is the total population size; proportional allocation of study units conducted using this formula.

For the qualitative study-

Theoretical sampling technique was employed, four In-depth interviews were held with caregivers/guardians in selected charity organizations and four Focus group discussions (FGD) with male and female orphan adolescents (8 discussants in each FGDs) until information saturation was reached. The selection of FGD discussants were done with purposive sampling from those selected charity organizations with high number of orphan adolescents.

4.6 Eligibility criteria

Inclusion criteria-

- All orphan adolescents that are within the age range of 15-18 years.
- Those orphan adolescents (15-18 years) that get community based support within charity organizations.
- Those orphan adolescents (15-18 years) that get the permission of child development project coordinators‘ consent as their guardians to participate in the study and also their assent.

Exclusion criteria-.

- Orphan adolescents (15-18 years) that can‘t communicate due to physical, mental and other health problems.

4.7 Variables of the study

Dependent variable

- Pre-marital sexual risks

Independent Variables

- Socio-demographic status (Age, Sex, Educational status, availability of paid job and pocket money)
- Family characteristics
- Living arrangements- (family structure where orphan adolescents were reared till age 14 and their current residence)
- Peer norms and pressure- (peer pressure and norms regarding premarital sex)
- Communication with peers, guardians/family members about sexual activity, participation on clubs and connectedness with religious institution.
- Ever having a boy/girl friend
- Non-sexual risky behaviours- (Reading and viewing sexual explicit materials, alcohol, drug and cigarette use)
- Perceptions towards risks of sexual activities. i.e STIs, HIV/AIDS & premarital sex
- Reproductive health information regarding puberty, pregnancy & contraception.

4.8 Data collection techniques and materials

4.8.1 Quantitative part-

A structured pre-tested standardized but locally adopted and modified self-administered questionnaire was utilized. The questionnaire was first prepared in English and translated to Amharic by other person to make it understandable by the study subjects and to check wether the translation was consistent with the English version, then back translated to English by two individuals.

Before the actual data collection, the questionnaire was pre-tested by selecting 5% from the total sample size and based on the pre-test, necessary modification was made on the questions and participants was involved in the actual data collection and analysis.

Trained facilitators with the principal investigator were assigned at the time of data collection to ensure the completeness of the questionnaire and to respond to those questions that may result in misunderstandings and uncertainties.

Data collection was conducted from Feb.1st 2013 to April 30th during afternoons & on Saturdays since the study participants are students and are available only during their visit to the selected charity organizations.

4.8.2- Qualitative part-

For In-depth interviews, interviewees were purposively selected from each selected charity organizations as key informants to participate in the study based on their experience and close interaction to orphan adolescents in each institution and were 4 child development project coordinators.

For the Focus group discussions, a total of 32 discussants were purposively enrolled from each selected charity organizations and were 16 male and 16 female orphan adolescents.
The main purpose of these In-depth interviews and focus group discussions were to complement the data that were generated by the quantitative survey. The interviews and FGDs were moderated by the principal investigator assisted by data collectors/facilitators and for both FGD and in-depth interviews, a semi-structured both open and closed ended question guides were used. Tape recording and note taking were done by both the facilitator and co-facilitator. The interviews and FGDs were conducted in quite places and permission was obtained from participants.

4.9 Data quality control measures

The questionnaire was derived from standard data collection tools that is prepared by FHI and WHO; after it was locally adopted and prepared specifically for study participants, it was pre-tested for consistency of responses by taking 5% of the sample size, three charity organizations (around Piassa, Wellosefer and Sidist kilo areas of Addis Ababa) were selected that very few number of orphan adolescents that were within the age of 15-18 were found in these organizations). After pre-test was done, necessary modifications were made to the questionnaire accordingly before it was used in the actual survey. Training was given to the data collectors/facilitators and the principal investigator had close follow up to the day-to-day data collection process and ensures completeness and consistency of the collected questionnaire daily.

4.10 Data processing and analysis

4.10.1Quantitative part-

After the filled-in questionnaires were collected, checked for completeness, given ID number, data was coded and entered after a template was created in EPI-Info (version 3.5.4.) then it was exported to SPSS (version 21.0) for analysis.
After the data is cleaned, descriptive statistics (frequency tables, graphs and diagrams) were used for describing the study population with regard to variables then bivariate analysis was done for the independent variables with the outcome variable to select the needed variables for the multivariate analysis. Bivariate logistic regression analysis using crude odds ratio (COR) with its 95% confidence interval was used to assess the presence and degree of association between dependent and independent variables. Finally, variables which showed significant association with the dependent variable on the bivariate analysis were entered to multivariate logistic regression model to identify their independent effects. Multivariate logistic regression model using adjusted odds ratio (AOR) was applied to identify the presence of statistical significance between the dependent & independent variables and used to control for possible confounding effects.

4.10.2 Qualitative part-

The recorded ideas of FGDs and In-depth interviews was transcribed and translated into English manually. The transcribed data was analysed using Open code 3.6B1 soft ware through steps of content analyses. The transcribed data was investigated repeatedly to explore and understand different perspectives and experiences of participants. Analysis started by reducing transcribed text while preserving the core meaning of the data. The data was coded and grouped in to categories; the categories were then abstracted into a theme that supports the quantitative survey.

4.11 Ethical consideration

Ethical clearance was obtained from Addis Ababa University; College of Health Sciences, Research Ethics committee (REC). After the approval and support letter were given by the school of public health, the city government of Addis Ababa women's, children & youth affairs bureau wrote support letter for those concerned charity organizations so as to enable the data collection. Each selected organizations in response to the letters that were showed; they gave their verbal agreements so as to conduct the study.

During the data collection, respondents were oriented about the objectives, significance of the study and told that privacy is strictly maintained throughout the study process; by which a code number was given to identify every participant and no name or personal address was used. They were asked assent and ensured that their participation/non-participation, or refusal to respond to the questions is not related with the current and/or in the future on services that they or any member of their family may receive from any service providers. Since the study participants were under the age 18, consents were taken from each selected charity organizations that the child development coordinators signed on the consent form as a guardian to each study subjects after their agreements and being oriented to the above stated information about the study.

Before the beginning of the interview and FGDs, participants were oriented about the objectives, significance of the study and rules of the discussion. The selected participants were agreed to participate and their verbal consents were obtained. Efforts were made to maintain the confidentiality and privacy that all the discussions and interviews were arranged in a manner that can ensure their privacy. For the FGDs codes were given to the respondents so as to use during the discussion time; before the start of the discussions and interviews few background information were collected as age, sex, educational background of FGD participants and work related experiences to those interviewees. The discussions and interviews were tape recorded that efforts were made to ensure the privacy and confidentiality of the data obtained. For those who participated on the FGD, there was financial compensation for the time they spent though it was difficult to do similarly for the quantitative survey participants due to financial restriction.

4.12 Dissemination of findings

The final report is presented as partial fulfilment of the degree of Master of Public Health to School of Public Health, College of Health Sciences, Addis Ababa University, copy of the report will be given to city government of Addis Ababa women's, children & youth affairs bureau-children affairs office and those charity organizations. Effort will be also made to disseminate it through different publications and conferences.

4.13 Operational definition

- Adolescents- those who are in the age group of 10-19 years (WHO)
- Orphan- is a child under 18 years of age whose mother, father or both parents have died from any cause, Single orphan – who lost one parent; Double orphan- who lost both parents (UNICEF)
- Pre-marital sexual risks- include the first intercourse (vaginal-penile penetration) other than non-intercourse sexual contacts (kissing, dating and homosexual practices)

5. RESULTS

5.1 Orphan adolescents' socio-demographic characteristics-

From the selected charity organizations that provide community based support, a total of three hundred ninety three orphan adolescents aged 15-18 completed the questionnaire, giving a response rate of 93.1%; imputation technique was used to handle missing data. Nearly 208 (53%) of the respondents were females. Among 393 participants, the majority 324 (82.4%) were in the age group of 15-17 with mean age of 16 (SD 1.12). One hundred seventy (43.9%) were Amhara and 125 (32.3%) were Oromos. Majority of the orphan adolescents were followers of Orthodox Christianity 299 (76.1%) followed by Protestant 67 (17%).

About 387 (98.5%) of orphan adolescents were enrolled in school and 100% of them were not married; the reasons for not attending school at the time of survey for those 6 (1.5%) participants who were not enrolled in school were 4 (66.6%) academic failure, health related and financial problem accounted for (16.7%) each. Two hundred and three participants (52.5%) were students in high school and preparatory (9-12 grade) while 155 (40%) of them were in elementary followed by 29 (7.5%) who were of 10+2 and above. Majority of the participants 286 (72.8%) didn't have pocket money and of the 40 (37.7%) who had pocket money of less than 100 Ethiopian Birr (per month) that most of them 74 (69.8%) obtain it monthly. From those 107 participants who had pocket money, nearly 55 (52%) of the source of their pocket money was from family followed by 43 (41%) from charity organizations.

Table-1: Socio demographic characteristics of the study participants in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Sex of respondents (393)		
Male	185	47.1
Female	208	52.9
Age of respondents (393)		
15-17	324	82.4
18-19	69	17.6
Ethnic group (387)*		
Amhara	170	43.9
Oromo	125	32.3
Tigray	37	9.6
Guragie	37	9.6
Others *	18	4.7
Religion (390)*		
Orthodox	299	76.1
Protestant	67	17.0
Muslim	20	5.1
Others**	2	0.5
Currently attending school (393)		
Yes	387	98.5
No	6	1.5
Educational level for those attending school (387)*		
Grade 1-8	155	40
Grade 9-12	203	52.5
Grade 10+2 and above	29	7.5
Have own income (393)		
Yes	16	4.1
No	376	95.9
Have pocket money (393)		
Yes	107	27.2
No	286	72.8
Pocket money (106)*1 missing		
<25 ETB	36	34
26-100 ETB	40	37.7
>100 ETB	30	28.3
Frequency of getting pocket money (106)		
Daily	16	15.1
Monthly	74	69.8
Others***	16	15.1
Source of pocket money (106)		
From Family	55	51.9
From Charity organizations	43	40.6
Others****	8	7.5

Others*- Hadiya, Gamo, Selite and Welayita ;Others**-Catholic, Apostolic Faiths and no religion; Others***- on holidays, once in 2 months, weekly ; Others****-friends, in combination from family and charity organizations, part time job taken rarely/not monthly ; Variables*-has missing values

Regarding the family characteristics of the study participants, two hundred fifty five (64.9%) of them were paternal orphans and 34 (8.7%) maternal orphans. Majority 289 (73.5%) of them were single orphans that lost their mother or father and the rest 104 (26.5%) double orphans who lost both parents. About two third of orphan adolescents were reared by single parent that accounted for 256 (65.1%); (i.e with mother only- 225 (57.3%), with father only- 16 (4.1%)) but only 39 (9.9%) with both parents till age 14; besides those 215 (54.7%) of respondents live currently with their mother and 16 (4.1%) with their father.

Nearly 87 (38%) of mothers were not formally educated where only 6 (2.6%) of them were above 12 grade. Concerning mother's occupation, 93 (36.5%) were house wives and 46 (18%) were house maids. Similarly from those 34 (8.7%) of participants whose father was alive, 12 (41.4%) of their fathers were not formally educated and regarding their occupation 12 (35.3%) were daily labourers.
From those 77 (19.6%) of participants who knew their family monthly income, 44 (57.1%) reported that their family had a monthly income of greater than 500 Ethiopian Birr (per month). (See Table-2 and figure-2)

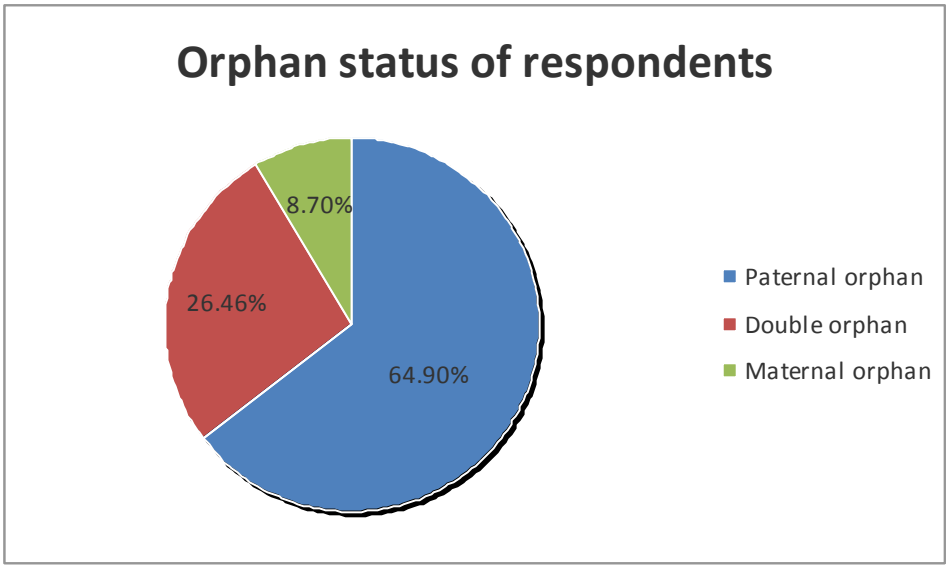

Figure-2 Orphan status of respondents in selected charity organizations, Addis Ababa, Ethiopia, 2014.

Table-2 Socio demographic characteristics of families of respondents in selected charity organizations, Addis Ababa, Ethiopia, 2014.

Variables	Frequency	Percent (%)
Mother alive (393)		
Yes	255	64.9
No	138	35.1
Mothers' educational status (231)*		
No formal education	87	37.7
Grade 1-6	68	29.4
Grade 7-12	70	30.3
Above 12	6	2.6
Mothers' occupation (255)		
Government employee	54	21.2
House wife	93	36.5
Merchant	39	15.3
House maid	46	18
Others*	23	9
Father alive (393)		
Yes	34	8.7
No	359	91.3
Fathers' educational status (29)*5 missing values		
No formal education	12	41.4
Grade 1-6	2	6.9
Grade 7-12	11	37.9
Above 12	4	13.8
Fathers' Occupation (34)		
Government employee	8	23.5
Daily labourer	12	35.3
Merchant	10	29.4
Others**	4	11.8
Family's monthly income, (77)+		
< = 500 ETB	33	42.9
> 500 ETB	44	57.1
Place the respondents live till age 14 (393)		
With Mother and father	39	9.9
Single parent	256	65.1
Relatives	98	24.9
Current residence of the respondent (393)		
With mother	215	54.7
With father	16	4.1
With brothers	21	5.3
With sisters	22	5.6
With relatives	109	27.7
Others***	10	2.5

Others*-no occupation, farmer, work in private organizations
Others**-car driver, guard, farmer, waver, work in private organizations
Others***- live with their brothers/sisters together, with friends
Family income+ is for those who answered- ―I know my family income"
Variables*-has missing values

5.2 Orphan adolescent's perception towards sexual initiation and information on peer pressure of respondents-

One hundred five (26.7%) of orphan adolescents were encouraged by their peer friends to have sexual partners but friends of 349 (88.8%) of them didn't encourage them to have sex. A majority 323 (82.2%) of them disagreed on the opinion that having sex during teenager age is normal where as 331 (84.2%) and 275 (70%) of them also disagreed with the view that boys should have sex before marriage and on the opinion that discussion regarding reproductive health issues including contraception promotes promiscuity respectively. (See Table-3)

Table-3 Information on peer pressure and perception towards premarital sex of the study participants in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Encouraged by peer friends to have sexual partner(393)		
Yes	105	26.7
No	288	73.3
Encouraged by peer friends to have sex(393)		
Never	349	88.8
Yes	44	11.2
Having sex at teenager age is normal(393)		
Agree	27	6.9
Not sure	43	10.9
Disagree	323	82.2
Boys shall have sex before marriage(393)		
Agree	18	4.6
Not sure	44	11.2
Disagree	331	84.2
Discussion on RH with teenagers promotes promiscuity(393)		
Agree	30	7.6
Not sure	88	22.4
Disagree	275	70

5.3 Substance use and other risky behaviours among orphan adolescents in selected charity organizations-

Most of the respondents 382 (97.2%) never used drugs, among those who reported as they used such drugs 11 (2.8%), 7 (77.8%) of them were kchat users and the rest 1 (11.1%) of each were marijuana/hashish and benzene users.

However, 53 (86.5%) respondents had ever drank alcohol and the age at first alcohol consumption was between the age of 15-18 accounted for 33 (62.3%). From those 53 (86.5%) respondents who reported as they ever drank alcohol, only 2 (3.8%) of them practiced sex after drinking alcohol.

Majority of participants 383 (97.5%) reported as they didn't smoke cigarette. About one third 131 (33.3%) of respondents viewed pornographic materials and the minimum age by which pornographic materials were viewed was 9 years where 84 (64.1%) of them found to be with the age range of 15-18 years when they view such materials. Besides, 79 (60.3%) of them viewed pornographic materials in the last six months that nearly 81 (62%) viewed non-printed pornographic materials such as sex films & videos; 30 (22.9%) viewed printed materials such as magazines, pictures and photos where the rest of respondents accounted for 20 (15.3%) viewed both types of pornographic materials. (See Table-4 & Fig.3)

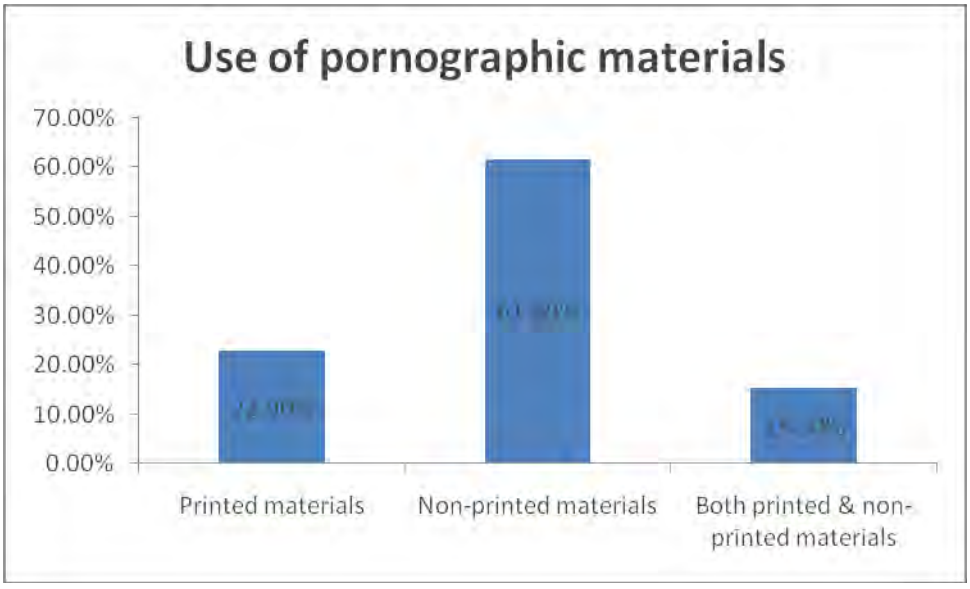

Figure-3 Type of pornographic materials used by the respondents in selected charity organizations, Addis Ababa, Ethiopia, 2014.

Table-4 Substance use and other risky behaviours among orphaned adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Ever used substances(393)		
Yes	11	2.8
No	382	97.2
Ever used such substances to arouse sexual desire (11)		
Yes	2	18.2
No	9	81.8
Alcohol use by the respondents(393)		
Yes	53	86.5
No	340	13.5
Age when alcohol is first consumed(53)		
10-14	20	37.7
15-18	33	62.3
Sexual practice after taking alcohol (53)		
Yes	2	3.8
No	51	96.2
The frequency of alcohol consumption(53)		
Always/daily	1	1.9
Often(3-4 times in a week)	3	5.7
Sometimes(1-4times in a month)	7	13.2
Rarely(on holidays)	42	79.2
Cigarette smoking (393)		
Smoke	10	2.5
Don‘t smoke	383	97.5
View pornography(393)		
Yes	131	33.3
No	262	66.7
Age at viewing pornography (131)		
<14	47	35.9
15-18	84	64.1
Viewed pornography in the last 6 month(262)		
Yes	79	60.3
No	52	39.7

5.4 Sexual history of orphan adolescents in selected charity organizations, Addis Ababa, 2014-

There were fewer respondents who had sexual partners 74 (18.8%) than those who didn't have (319 (81.2%)). More than two third 48 (67.6%) of those couples spent together in relationship of less than 12 months (n=71), the rest were missing values. The majority 71 (95.9%) of them were non-cohabiting partners.

Eighteen (4.6%) orphan adolescents have ever had sex; about 7 (38.9%) of them were found to be within the age range of 15-16 years, 6 (33.3%) found with the age range of less than 14 years and 5 (27.8%) of them found within 17-18 years. (See Fig.3) Sexual partners of half 9 (50%) of those who ever had sex were with the same age of the respondents where 7 (38.9%) of them had sexual partners older than their age; regarding the type of relation ship with the respondent of whom who had sex with about half 9 (50%) had sex with their lovers where two third 12 (66.7%) of sex was not planned when practiced.

About 7 (38.9%) of respondents reported that they did sex because they fell in love however less than half of 7 (46.7%) them didn't discuss on contraception before having sex but 9 (64.3%) of them reported as they used contraception before sex. From those respondents who used contraception, 8 (88.9%) used condom. More than half of the respondents 10 (58.8%) had sex in the last 12 months where 4 (40%) of them used contraception which was condom from the total ten respondents who had sex in the last 12 months.

From 16 orphan male adolescents who ever had sex, only 2 (13.3%) of them had sex with commercial sex workers. (See Table-5 & Fig. 4)

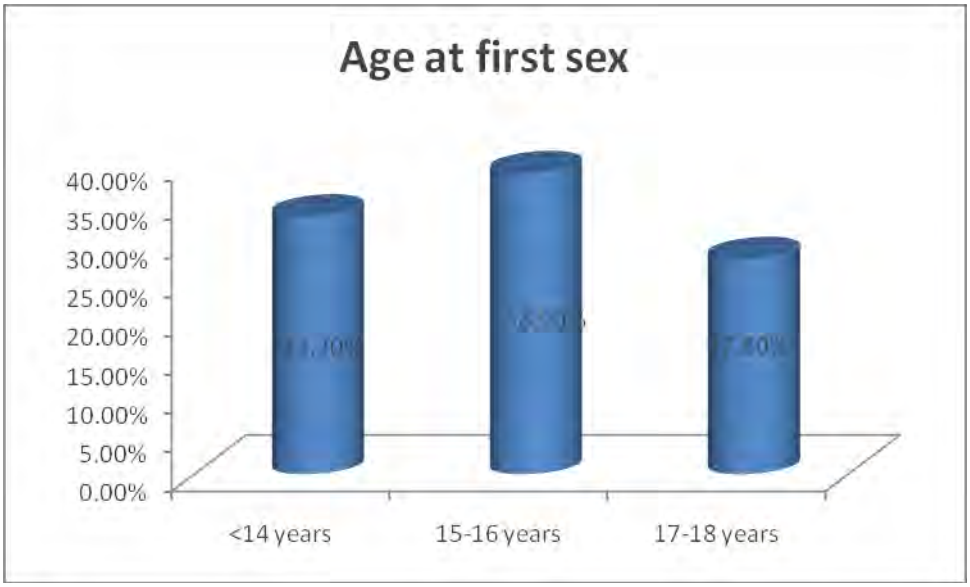

Figure-4 Age at first sex of respondents in selected charity organizations, Addis Ababa, Ethiopia, 2014.

Table-5 Sexual history of orphaned adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Have Boy/girl friend(393)		
Have partner	74	18.8
Don‘t have	319	81.2
Time spent together (71)*		
< =12 months	48	67.6
>12 months	23	32.4
Kind of relation ship (74)		
Co-habiting(live-in) partner	3	4.1
Non- co-habiting partner	71	95.9
Ever had sex(393)		
Yes	18	4.6
No	375	95.4
Age of sex partner(18)		
Same as the respondent	9	50
Less than the respondent	2	11.1
Older than the respondent	7	38.9
Planned sex(18)		
Planned	6	33.3
Not planned	12	66.7
Reason for having sex(18)		
Fell in love	7	38.9
Desire to know	5	27.8
Believed that I could do it because my age is older	1	5.6
False premise	2	11.1
Pornographic pressure	3	16.7
Use of contraceptive before sex(14)*		
We used	9	64.3
We didn‘t use	3	21.4
Do not remember	2	14.3
Type of contraceptive used(9)		
Pills	1	11.1
Condom	8	88.9
Ever had sex in the last 12 months (17)*		
Yes	10	58.8
No	7	41.2
How often contraceptive is used in these times (10)		
Used	4	40
Never used	6	60
Sex with Commercial sex workers(16)*		
Yes	2	13.3
No	13	86.7

Sex with CSWs (16)*-the rest 2 were females from the total 18 who have had sex; Ever had sex in the last 12 months (17)*1 missing value; Use of contraceptive before sex (14)*4 missing values; Time spent together (71)*3missing values

5.5 Orphan adolescents' background on reproductive health issues in selected charity organizations-

About 224 (57.4%) of orphan adolescents discussed on sex related issues and 130 (58%) of them held the discussion with their friends that about 97 (44%) of them conducted it sometimes when they were asked to report the frequency of their discussion. From all the respondents 318 (84.4%) were taught on school about the anatomy of reproductive system of male and females while 306 (81.2%) of them learnt about how pregnancy occurs.

Only one fourth 97 (25.5%) of the respondents participated on reproductive health clubs in school or out side school where 280 (71.8%) of them knew about contraception.

From the methods of contraception reported abstinence were the major 200 (71.4%) followed by condom 112 (40%). Almost 319 (82%) of orphan adolescents heard about STIs that pain during urination and genital ulcer were the two commonly reported symptoms of STIs 233 (73.3%) and 205 (64.5%) respectively. From the source of information for STIs, health institutions were the major ones where 82 (25.8%) from Medias like TV and radio. From 246 (76.4%) who knew STI prevention methods, abstinence accounted for 199 (79.9%).

About 382 (98.7%) reported as they knew HIV/AIDS; majority of them 353 (91.7%) knew unprotected sex as the way of transmission while 14 (3.6%), 17 (4.4%) and 26 (6.8%) of respondents had misconception that they reported that HIV is transmitted by greeting, material exchange with HIV infected person and mosquito bite respectively. Regarding HIV prevention, the three –A"s were reported as 314 (81.6%) for abstinence, 264 (68.6%) for being faith full to partner and 241 (62.6%) for using condom. (See Table-6 and 7)

Table-6 Information on reproductive health related issues of orphan adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Discussion on sexual issues (393)		
Yes	224	57.4
No	167	42.6
With whom is discussed (224)		
Family	34	15.2
Friends	130	58
Boy/girl friend	10	4.5
Others taught at school/charity organizations	50	22.3
How often it is discussed (222)*		
Always	2	0.9
Sometimes	97	43.7
Often	11	5
Rarely	104	46.8
Others*	8	3.6
Ever taught at school about (377)*		
Menses	288	76.4
Anatomy of sex organs	318	84.4
How pregnancy occurs	306	81.2
Contraceptive methods	268	71.1
Participation on reproductive health clubs (381)*		
Yes	97	25.5
No	284	74.5
Do you know contraception (390)*		
Yes	280	71.8
No	110	28.2
Contraception methods(280)-		
Abstinence	200	71.4
Coitus interrupts	46	16.4
Pills	87	31.1
Depo	77	27.5
Implanon	96	34.3
IUD	81	28.9
Male/female sterilization	35	12.5
Condom	112	40
Calender method	57	20.4

Others*-once in 15 days, at school when the topic is raised
Variables *- missing values

Table-7 Information on knowledge of STIs and HIV related issues of orphan adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
Heard about STI (390)		
Yes	319	81.8
No	71	18.2
Symptoms known (318)*		
Genital discharge	141	44.3
Pain during urination	233	73.3
Genital ulcer	205	64.5
Do not know symptom	23	7.2
Source of information (319)		
Family	51	16
Lover	5	1.6
Relatives	7	2.2
Boy/girl friend	65	20.4
Peers	76	23.8
Health institutions	184	57.7
Religious leaders	17	5.3
Magazines-posters	46	14.5
Radio-TV-medias	82	25.8
Know ways of prev.(319)		
Yes	249	78.1
No	70	21.9
Methods(249)- Abstinence	199	79.9
Avoiding unprotected sex	89	35.7
Being faithful to partner	115	46.2
Using condom during sex	124	49.8
Avoiding sex with CSWs	81	32.5
Know HIV(387)*		
Yes	382	98.7
No	5	1.3
Ways of transmission(385)*		
Unprotected sex	353	91.7
Mother to child	272	70.6
Sharp materials	274	71.2
Blood transfusion	145	37.7
Kissing with HIV infected person	37	9.6
Greeting with HIV infected person	14	3.6
Material exchange with HIV infected person	17	4.4
Insect/mosquito bite	26	6.8
Do not know symptom	7	1.8
Ways of protection (385)		
Abstinence	314	81.6
Being faithful to partner	264	68.6
Using condom	241	62.6
Material exchange	219	56.9
Avoiding any contact with HIV infected person	25	6.5

Variables*- missing values

5.6 Orphan adolescents' connectedness with religious institutions in selected charity organizations-

About one third 129 (33.3%) of orphan adolescents reported as often attended Church/Mosque in the past 12 months and 205 (53%) of them pray daily when they were asked how often they pray. (See Table-8)

Table-8 Information on connectedness with religious institution of orphan adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Frequency	Percent (%)
How often respondent attend Church/Mosque (387)*		
Always	103	26.6
Sometimes	110	28.4
Often	129	33.3
Rarely	41	10.6
Do not have religion	3	0.3
Others*	3	0.8
How often the respondents pray (387)*		
Daily	205	53
Once in a week	34	8.8
Sometimes	131	33.9
Never prayed	9	2.3
Others**	8	2.1

Others*- **- twice in a week, once in a week, long time since I do that
How often respondent attend Church/Mosque (387)* and How often the respondents pray (387)*- six missing values

5.7 Factors affecting premarital sexual practice among orphan adolescents in selected charity organizations, Addis Ababa, 2014-

5.7.1 Bivariate analysis of selected independent variables and premarital sexual debut-

In bivariate analysis using Crude odds ratio (COR), socio-demographic variable; Sex (95%CI=9.75(2.21-43.01)), Males were ten times more exposed to premarital sexual risks when compared to females. Age (95%CI=5.25(2.00-13.77)), as age increases exposure to premarital sex increases five times. Have pocket money (95% CI=2.83(1.09-7.33)), those who had pocket money were three times more exposed to premarital sexual risks.

Regarding perception about premarital sex & peer pressure; those who were encouraged by peer friends to have sexual partner were three times more exposed to premarital sexual practice (95%CI=2.91(1.12-7.53)), and those who were encouraged by peer friends to play sex (95%CI=12.54(4.64-33.89)) were significantly associated with premarital sexual risks among orphan adolescents.

On the other hand, variables regrading substance use & risky non-sexual behaviours (those who ever used drugs were fifteen times more exposed t premarital sexual risks (95%CI=15.02(3.94-57.33)), Alcohol use by the respondents (95%CI=12.46(4.58-33.89)), View pornography (95%CI=11.16(3.17-39.31)) were significantly associated with the out come variable.

Besides variables regarding sexual history and reproductive health related information of respondents as having boy/girl friend (95%CI=10.09(3.65-27.92)), Discussion on RH related issue (95%CI=3.62(1.02-12.82)) were found to be significantly associated with the dependent variable premarital sexual risks. (See Table-9)

Table-9 Bivariate analysis to show the association between premarital sex and selected variables of orphan adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Premarital sex		COR (95% CI)	P-value
	Yes	No		
Sex (393)				
Male	16 (8.6%)	169 (91.4%)	**9.75(2.21-43.01)**	**0.003**
Female	2 (1.0%)	206 (99.0%)	1	
Age(393)				
15-17	9 (2.8)	315 (97.2)	1	
18-19	9 (13)	60 (87)	**5.25(2.00-13.77)**	**0.001**
Educational status of those who are currently attending school (387)				
Grade 1-8	3 (1.9)	152 (98.1)	1	
Grade 9-12	13 (6.4)	190 (93.6)	3.47(0.97-12.39)	0.560
Grade 10+2 & above	2 (6.9)	27 (93.1)	3.75(0.59-23.5)	0.158
Have own income (393)				
Yes	1 (6.3)	15 (93.8)	1	
No	17 (4.5)	359 (95.5)	1.41(0.18-11.29)	0.747
Have pocket money (393)				
Yes	9 (8.4)	98 (91.6)	**2.83(1.09-7.33)**	**0.032**
No	9 (13.1)	277 (96.9)	1	
Mother alive (393)				
Yes	9 (3.5)	246 (96.5)	1	
No	9 (6.5)	129 (93.5)	1.91(0.74-4.92)	0.182
Mothers' educational status (231)				
No formal education	2 (2.3)	80 (97.7)	0.42(0.08-2.38)	0.329
Grade 1-6	2 (2.9)	66 (97.1)	0.55(0.09-3.08)	0.492
Grade 7-12 & above	4 (5.3)	72 (94.7)	1	
Father alive (393)				
Yes	1 (2.9)	33 (97.1)	1	
No	17 (4.7)	342 (95.3)	1.64(0.21-12.72)	0.636
Family monthly income (77)				
< =500 ETB	2 (6.1)	31 (93.9)	0.65(0.11-3.75)	0.626
>500 ETB	4 (9.1)	40 (90.9)	1	
Place the respondents live till age 14 (344)				
Mother & father	3 (7.7)	36 (92.3)	1	
Single parent	10 (3.9)	246 (96.1)	0.49(0.13-1.86)	0.293
Relatives	5 (5.1)	93 (94.9)	0.65(0.15-2.84)	0.562

Variables	Premarital sex		COR (95% CI)	P-value
	Yes	No		
Encouraged by peer friends to have sexual partner (393)				
Yes	9 (8.6)	96 (91.4)	**2.91(1.12-7.53)**	**0.028**
No	9 (3.1)	279 (96.9)	1	
Encouraged by peer friends to have sex (393)				
Never	8 (2.3)	341 (97.7)	1	
Yes	10 (22.7)	34 (77.3)	**12.54(4.64-33.89)**	**0.000**
Ever used substances (393)				
Yes	4 (36.4)	7 (63.6)	**15.02(3.94-57.33)**	**0.000**
No	14 (3.7)	368 (96.3)	1	
Alcohol use by the respondents (393)				
Yes	11 (20.8)	42 (79.2)	**12.46(4.58-33.89)**	**0.000**
No	7 (2.1)	333 (97.9)	1	
View pornography (393)				
Yes	15 (11.5)	116 (88.5)	**11.16(3.17-39.31)**	**0.000**
No	3 (1.1)	259 (98.9)	1	
Have Boy/girl friend (393)				
Have partner	12 (16.2)	62 (83.8)	**10.09(3.65-27.92)**	**0.000**
Don‘t have	6 (1.9)	313(98.1)	1	
Time spent together (71)				
<12 months	9 (18.8)	39 (81.3)	0.65(0.16-2.67)	0.550
>12 months	3 (13)	20 (87)	1	
Discussion on sex related issues (393)				
Yes	14 (6.3)	210 (93.8)	**3.62(1.02-12.82)**	**0.460**
No	3 (1.8)	163 (98.2)	1	
Participation on RH clubs (381)				
Yes	5(5.2)	92(94.8)	1	
No	11(3.9)	273(96.1)	0.74(0.25-2.19)	0.588
Know Contraceptive methods (390)				
Yes	12(4.3)	268(95.7)	1	
No	5(4.5)	105(95.5)	1.06(0.37-3.09)	0.910
Heard about STI (390)				
Yes	16(5)	70(98.6)	1	
No	1(1.4)	303(95)	0.27(0.04-2.07)	0.208
How often respondents pray (387)				
Daily	7(3.4)	198(96.6)	1	
Once in a week	2(5.9)	32(94.1)	1.77(0.35-8.89)	0.489
Sometimes	5(3.8)	126(96.2)	1.12(0.35-3.61)	0.846
Never prayed	1(11.1)	8(88.9)	3.54(0.39-32.27)	0.263
Others**	1(12.5)	7(87.5)	4.04(0.44-37.46)	0.219

Others*- **- twice in a week, once in a week, long time since I do that

5.7.2 Multivariate logistic regression analysis

Those variables that showed significant associations at P value < 0.05 were entered to multivariable logistic regression analysis. The analysis indicates that being male or female were not associated with premarital sexual initiation however the analysis shows that those who were on age group 18-19 years were 6.7 times more likely to initiate sex early when compared to those 15-17 years orphan adolescents, [AOR= 6.72; 95% CI- (1.89-23.89)]. P-Value=0.003

The presence of pocket money and peers encouragement for having boy/girl friend is not significantly associated with the out come variable, premarital sex where as those orphan adolescents who were encouraged by their peers to play sex with sexual partners were four times more likely to initiate premarital sex when compared to those who were not, [AOR= 4.34; 95% CI- (1.05-17.93)]. P-Value=0.043

In relation to non-sexual risky behaviours, the use of drugs were not associated with early sexual debut however those who drank alcohol were more than five times more likely to initiate premarital sex when compared to those who didn‘t drink, [AOR= 4.76; 95% CI- (1.26-17.97)]. P=Value-0.021

Watching pornographic materials were not significantly associated with premarital sexual debut in those who viewed such materials. Similarly, after adjusted for other variables, a discussion on reproductive issues was not found to be significantly associated with premarital sexual initiation.

Regrading the sexual history of respondents, those who have partner were four times more likely to be engaged in premarital sex when compared to those who didn‘t have boy/girl friend, [AOR= 4.38; 95% CI- (1.31-14.61)]. P-Value=0.016 (See Table-10)

Table-10 Multivariate logistic regression analysis showing determinants of premarital sexual practice among orphan adolescents in selected charity organizations, Addis Ababa Ethiopia, 2014.

Variables	Premarital sex		AOR (95% CI)	P-value
	Yes	No		
Sex (393)				
Male	16 (8.6%)	169 (91.4%)	4.29(0.71-26.11)	0.114
Female	2 (1.0%)	206 (99.0%)	1	
Age (393)				
15-17	9 (2.8)	315 (97.2)	1	
18-19	9 (13)	60 (87)	**6.72(1.89-23.89)***	**0.003***
Pocket money (393)				
Yes	9 (8.4)	98 (91.6)	1.59(0.45-5.64)	0.468
No	9 (13.1)	277 (96.9)	1	
Encouraged by peer friends to have sexual partner(393)				
Yes	9 (8.6)	96 (91.4)	0.92(0.26-3.28)	0.890
No	9 (3.1)	279 (96.9)	1	
Encouraged by peer friends to have sex (393)				
Never	8 (2.3)	341 (97.7)	1	
Yes	10 (22.7)	34 (77.3)	**4.34(1.05-17.93)***	**0.043***
Ever used substances (393)				
Yes	4 (36.4)	7 (63.6)	1.19(0.17-8.18)	0.860
No	14 (3.7)	368 (96.3)	1	
Alcohol use by the respondents (393)				
Yes	11 (20.8)	42 (79.2)	**4.76(1.26-17.97)***	**0.021***
No	7 (2.1)	333 (97.9)	1	
View pornography (393)				
Yes	15 (11.5)	116 (88.5)	1.53(0.30-7.79)	0.607
No	3 (1.1)	259 (98.9)	1	
Have Boy/girl friend (393)				
Have partner	12 (16.2)	62 (83.8)	**4.38(1.31-14.61)***	**0.016***
Don‘t have	6 (1.9)	313(98.1)	1	
Discussion on sex related issues (393)				
Yes	14 (6.3)	210 (93.8)	0.75(0.16-3.55)	0.715
No	3 (1.8)	163 (98.2)	1	

*Statistically significant at p-value < 0.05

5.8 QUALITATIVE STUDY RESULT-

A total of four FGDs and four In-depth interviews were held with purposively enrolled thirty two orphan adolescents in selected charity organizations for the FGDs. Four project coordinators of child development in each selected charity organizations were recruited for the in-depth interview based on their closeness and intimacy to orphan adolescents in their work place.

Majority of beneficiaries were females in one of the selected charity organization, Mothers and children multi-sectoral development organization (MCMDO) and similarly males in Yezelalem minch community and children development, but in Hope Enterprise both male and female were found to be proportional and FGDs conducted with both sexes. Two FGDs were conducted only with female participants where the other two with male participants. Regarding their age and educational background, participants were 15-18 years old and majority were high school students. From participants of both sexes most of them were 15 years old and 9th grade students.

For the in-depth interview, the four selected interviewees had more than 3years of experience on their field as child development project coordinators and had close intimacy as a guardian with orphan adolescents in their work place.

5.8.1 Theme, Categories and codes

Table-11- Theme, Categories and codes identified from the qualitative data of both FGDs and In-depth interviews-

Theme: The worth of delaying sex with its challenges, consequences, preconditions & recommendations targeting orphaned adolescents.							
Categories-	**Deprivations due to orphanhood status**	**Having control over the problem**	**Preconditions to delay premarital sex**	**Challenges to defer sex**	**Consequences beyond premarital sex**	**The worth beyond delaying sex**	**Recommendations to be undertaken**
Codes-	-Careless -Change -Compensation -Difficulty -Economical dependency -Effect of parent's death -Effect of place of residence -Exposed for risk -Face challenges -Facing blames -Father's role -False promise -Forced -Family background -Homelessness -Hopelessness -Ignorance -Impose change -Intimacy-close bond -Loneliness -Lost appropriate care -Misunderstood -Misery -Missed opportunity -More exposed -Need affection -Needy -Negligence -Negotiation -New world -Poverty affects -Pressing needs for survival -Pressure exerted -Priorities -Question of survival -Raise appropriately -Rape -Reluctant -Scarification -Sense of despair -Senseless -Suffering -Sexual assault -Suspicious -Understanding -Unable to support one self -Unstable life -Use of parents supervision -Walk away -Vulnerability	-Commonly seen -Different perspectives -Effect of substance use -Every stake's responsibility -Fail to be a role model -Felt problem -Forbid for their sake -Forbidden -Impression -Improper guidance -Influential -In secured -Interested -It is a right -Lack of awareness -Lack of commitment -Limited -Limits needed -Likeness -Lacks ability -Lacks satisfaction -Manner of guardian -Misunderstood -Lack of openness -Lack of role model -Mutual agreement -Nature -Negative impact -No one to over see -Not accountable -Parent's complain -peer pressure -Poor communication -Pornographic materials -Power of money -Reliving stress -Responsibility on shoulder -Role of community -School level specific -Strong link with care givers -Unnoticed advantages -Utility matters	-Accountability -Ability to solve problems -Active participation -Advise -Awareness needed -Be alert -Being careful -Being considerate -Being for one another -Being reasonable -Being selective -Beyond sexual desire -Calmness -Care for each other -Disciplined -Economical sustainability -Financial sustainability -Faith governed life -Fear of God -Frankness -Focus on life's goal -Helping each other -It depends -Learn life's lessons -Looking ahead -Maturity -No exposure -Patience -Patience of love -Personal strength -Self support -Self control need -Spiritual maturity -Stand firm -Taking care -Taking precautions -Timing matters -Trainings needed -Waiting for the right time	-Absence of guardians -Adaptation -Age specific -Being influenced -Being reluctant -Burning issue -Cant overcome -Cant tolerate -Cheated -Concealed problem -Desire to practice -Difference matters -Difficult to predict -Doesn't matter -Don't care -Eagerness -Early engagement in relationship -Easily accessible -Effect of older children personality Embarrassment -Emotionally susceptible -Environmental effects -Hidden personalities -High desire -Impact of age-puberty -Impact of education -Impact of frankness -Knowledge gap -Modernization -Over controlling -Petting -Predispose to sexual act -Preference -Shyness -Taking care -Traditions prevails -Want badly -Want freedom -Willingness -Wisdom	-Bad consequences -Betrayal -Bitterness -Confidence lost -Core of dispute -Detainment -Discriminations -Disrespect -Ending relationship -Failure -Harmful -No importance -Have effect -HIV -Long term effect -Not advantageous -Not matured -Not planned -Obstacles -Obvious effect -Resign from project -School drop outs -Shame -STI -Stigma -unexpected	-Much benefits -Acceptance -Achieving a plan -Advantages -Affection & love -Avert the problem -Built trust -Kept promise -Confidence uplifting -Strength -love Won't fail -Maintained relationship -Life long partnership -Merits of delaying sex -Pass obstacles -Protection Psychological impact -Successful marriage -Respecting decisions -Respect by the society -Using opportunity -Virginity preferred -Uses of wedlock -successful life -Maintain communication	-Abstinence -Attractive ways -Awareness creation -Avoiding embarrassment -Project benefits -Being insider -Breaking - unwanted bond -Choices made -Close supervisions -Simple methods -Condom -Different clubs -Different ways -Early intervention -Encouragement -Establishing clubs -Experience sharing -Faithfulness -Favourable conditions -Focus -Friendly -Free discussions -Good interaction -Government -Guidance -Helpful -Jointly working -Opportunities -Overcoming traditions -Oversee -Participatory -Play role -Communication power -Positive influence -Religious values -Safe environment -Share ideas -Social interaction -Social medias -Strict follow up -Tackle the problem -Teach & council -Teaching aid -Trainings -The "A" rules -Service type -Vows help

5.8.2 Categories with their explanations-

1. Deprivations due to orphanhood status-

Participants of the FGDs and in-depth interviews expressed their different perspectives on how these orphan adolescents are more exposed for premarital sex when compared to those who live with their parents. Insecurity is the common mentioned problem; these orphan adolescents face sexual harassment in different ways even by their own relatives. Since they are economically instable, they might be expected to support themselves and their family members financially. Particularly females are forced to negotiate for sex with older men and with those men who are able to support their financial crisis. Thus, they are exposed for premarital sex.

Being an orphan can make vulnerable to different risks since these children are in need of affection that is lost from their parents as one respondent mentioned and this by it self make them vulnerable especially if they are engaged in relationship with opposite sex as one informant mentioned-

"These orphan adolescents are more exposed to premarital sexual risks, we see stability among those who live with their parents since the main thing that a family provide is love and most children who live with parents get that. Though there are exceptional but the orphans lack this and are in need of love, they strive to get this affection in every way so this makes them vulnerable for different risks. The other case is, since love is misinterpreted in these age group and mainly they focus on physical relationship/interaction that finally end up in sexual intercourse because they are in hunger of love and to get that affection they lack from the deceased parent, they expect to get from their girl friend and the same is true for the female orphans to looking for affection from their boy friend. So they have a tendency to get engaged in sex early when compared to non-orphans and mostly they don't protect themselves." (Male, project coordinator with 3 years experience-Interviewee)

After the death of their parents, these orphan adolescents become vulnerable since they won't get parental supervision after math so that they are exposed for different risks as it was mentioned repeatedly by the FGD participants. Many adolescents don't see the long-term benefit of parental supervision which is a pillar for their future life. Today's children & adolescents feel uncomfortable with parental supervision temporary. One of the discussant mentioned,

"I can say that these orphan adolescents are widely affected when compared to those who are with their parents; parents means a lot for children, their responsibility is merely beyond supporting them economically; they guide them through a lot of ways though children don't like this part for a while but their supervision for them is very crucial that keep them from falling and one day in the future they may appreciate this when they truly understand their role. So if one doesn't have a family that can supervise then it is similar with "Balebet endelelew wusha". For instance, a girl may come late in the night and there may not be anyone who is going to ask where she has been if she doesn't have a parent and this by itself can put her at different risk." (18 years old female, 11th grade FGD discussant)

The living arrangements, economical and educational background of the guardians have also effect, for instance as it is indicated by most of the discussants, these adolescents whose parents are deceased live with their relatives. Especially those who

live with their aunts & uncles may be in secured as it is mentioned above, sexual harassment is common- *"There are a lot of cases in our project in relation to this issue; for instance recently one girl who lost her father got sexually abused and raped repeatedly by her step grand parent so the case is being investigated by the law and the police; so this shows that since she is orphan she got exposed for such problem that her mother had to leave her child to grand parent so as to work."* (Male, project coordinator with 3 years experience-Interviewee)

Other condition where such children are exposed to early sex is due to poverty; particularly females are affected thus exchange sex for money with out thinking the consequences as one FGD discussant mentioned- *"For instance, in my village I know one case, a girl who learn in my school was in need of money for school payment & she didn't have any way to get that money; she didn't tell this for any of us but there was one boy whose family is with good economic background and when she asked him he wanted her to have sex with him so that she will be given the money. All she was planning was getting the money and didn't think of the consequences of having unplanned sex. But then after She got pregnant and was dismissed from the school. So such kinds of conditions make the girls to be more vulnerable for early sex.*" (17 years old male, 9th grade FGD discussant)

As it was mentioned by one interviewee, poverty is one factor that exposes these children for premarital sex particularly females are burdened to support their guardians financially by engaging themselves in different risky activities. Besides as it was reported by discussants, there is negligence towards orphans that is seen by most guardians. Loss of follow ups, supervision & free discussions are not common. Since most guardians are not educated they are not able to teach their children even on common reproductive health issues in addition to lack of openness that leads to embarrassment when such discussions are held on. These children are not understood by their guardians and take the blame when things happen abnormally. It is also suggested that economic problems are also the major bases because most guardians are not able to provide the basic necessities for orphan adolescents they raise. It leads to vulnerability because these (shelter, food and clothes) are the pressing needs for survival.

"The living arrangements and economical background can affect a lot, since most economically poor families have a tendency to be careless towards their children if they are fed, where they spent their days or any other issues, they don't care! Even guardians like aunts and uncles are careless to such orphans, no one can follow and care like real parents so these all things can predispose for unplanned sex." (16 years old male, 9th grade FGD discussant)

"As to me, there is one Amharic saying; "ye ayat lej keneetu", so that living arrangement by itself have effect and also the way these orphan adolescents reared is also a very big issue. In our project there are some orphans who live with their grand parents, some single orphans and other double orphans, and offcourse they are exposed to such problems mainly because of improper guidance by their family, even the grand parents should strictly follow their grand children with good supervision as if they rear their own children so that they protect them from such risks." (Male, project coordinator with 8 years experience-Interviewee)

2. Challenges to defer sex-

Contradicting opinions emerged from discussants on the provision of RH information and education to their children. As mentioned above, guardians‘ educational status has effect on how to raise these children. It was mentioned that those educated families can help and teach their children, especially teaching girls on sexuality, HIV and the like but in contrary some FGD participants indicated that it is free communications and understanding that matters rather than being educated or not. One of the discussant said, *"...my mother is educated only till grade 6 but she strives all her best to support and meet my need, she understand me well and have free discussion with me, so its not about being educated or not but it depends on the level of understanding and communications we have with our families."* (17 years old male, 9th grade FGD discussant)

The other point that is reflected by most participants was that guardians impose tight supervision and their being over controlling for such children by itself exposes these orphan adolescents to early sex since everything seem to be new for them; the power of adventure- Young people want to test/experiment new thing and try to practice what they are told not to do.

"First of all, every teenager doesn't like strict supervision and pressure including myself; when we are forbidden to do something then we want to do it. Had we been with our parents, then they can understand and make us free, but if we live with other relatives like aunts and uncles they won't make you free as their children but here they may not take it for harm but these things by itself can affect us negatively as I said before." (17 years old female, TVET student FGD discussant)

"Those children who live with their grandparents are free in different aspects for instance I live with my grand parents and brothers and so I am free to do what ever I want. Because I know what is there outside so I care a lot, and my girl friend also live with her grand parents and she is not eager for sex like other girls since she knows also different things out there from home with the good and bad consequences. Other girls who are strictly followed at home by their families and/or guardians like their aunts mostly fail easily if they are asked for sex by their boy friends." (17 years old male, 10th grade FGD discussant)

Orphan adolescents may get engaged in sex unexpectedly due to their age-puberty and are unable to control themselves that even don‘t give a reason for their act. In addition to that, in contrary to the above point, some FGD participants mentioned that orphan adolescents are not predisposed to premarital sex when compared to non-orphan adolescents because those children who live with their parents are strictly followed where as those orphans have the freedom to do what ever they want so are not eager to have sex-

"for me, I think those who live with their parents are more exposed for premarital sex when compared to orphans…these children only can go out to their school and back to home but they may hear their friends at school talking about sex so this makes them to be eager to know sex but those who don't live with their parents can go out where ever they want in freedom and this makes them not to be eager to for such things, these children know a lot of things so they protect themselves though they have freedom to do any thing they want." (17 years old male, 10th grade FGD discussant)

"I think the reason for premarital sex is lack of transparency among family members and the intensity of parents being over controlling to their children which leads to a desire to explore the other side of the world that is seen newly for them. Lack of having safety precautions and failure to pick a peer with a good influence, lack of control from the school officers and using drugs are also factors." (16 years old female, 10th grade FGD discussant)

3. Having control over the problem-

It was mentioned by most discussants that peer pressure is the underlying problem that predispose orphan adolescents to use substances and view pornographic materials which inturn expose them for premarital sex. Some discussants reflected that, these orphan adolescents use substances to get relief from such stresses related to heavy economical burden and other crises. Besides it was mentioned that the feeling of hopelessness and despair is also a factor that forces them to use such things. On the contrary, few discussants mentioned that a well to do children that live with their parents are more exposed for substance abuse.

"Those adolescents with good economic background are more affected mostly in using such substances by their money I can see this in some of my friends but those who are poor economically focus on supporting themselves rather than spending money for such things." (16 years old male, 7th grade FGD discussant)

"Yes it (substance use) can put them at risk! since mostly using these substances is related for the purpose of reliving the stress these orphan adolescents have…for getting and letting go such stresses from their over controlling parents/relatives and the age or being a teenager by itself affect them a lot. (15 years old female, 8th grade FGD discussant)

Substances have the power to impose changes that orphan adolescents may not be able to control themselves from sex if they use such things. For instance one male FGD discussant said- *"substance can affect any person and there is no hero that can overcome the consequences of it if it is used; so substance can change the ability to control one self so that those who use are exposed for such risks (premarital sex)."* (17 years old male, 9th grade FGD discussant)

The reason that most adolescents including orphans became vulnerable for different pornographic materials is it's easily accessibility. Easy access to such materials was the main driving factor to the initiation of premarital sex as claimed by most discussants, both among orphaned and non orphaned adolescents. An 18 years old female, 11th grade FGD discussant stated: *"As to me, such videos, posters and the like can predispose these children to early sex indeed, especially most student"s cell phones at school have such materials and any one that have internet access can get it easily so by using such things „what kind of things they are going to think and want to practice?"...The other point is about substances, they have a tendency to make one"s behaviour changed from the normal condition, so they also affect the emotions/feelings we have, so if any one that use such substances may be exposed to practice sex if there is an opportunity to do so."*

It seemed like a debate that some participants said that there is no specific age to start relationship (to have boy/girl friend) since what matters is maturity, personal strength

and the manner of our partner, but others opposed the idea that if relationship is started by this age, then there is a high chance for exposure to early sex because of age-being teenage; since it is the time where almost all adolescents are students they will face difficulties with their education when engaged in relationship. Similarly some participants suggested that free discussions concerning sexual issues with peer friends may aggravate the problem where as some said it can help a lot since due to the prevailed traditions of our society mostly sexual issues are not discussed frankly among guardians and children so these children can be protected a lot when they share their ideas and secrets with their friends.

"...for all teenagers it is difficult to share their secrets to their families, for instance I won't tell anything to my parents if I encountered a problem on Saturday but then it will be challenging to wait till Monday so that I can get my friends at school to share what happened to me. Peer friends can help a lot even on the case if that a girl failed and had sex, having a solution is very much significant between friends and it is obligatory to help your friend; here we can also learn from one others" experiences."(17 years old female, TVET student FGD discussant)

"As to me, such communications more expose to premarital sex; for instance in the past times, such kinds of communications were not there and that generation was safer from such things when compared to the generation we have today and for us, it is just merely a non-sense modernism! So as to me, its better not to have such communications since most of it can end up in bad consequences but if there is a discussion, better to conduct it with older ages since they can share their experiences. If our friends raise such issues then we see their perceptions and take it easily and decide by ourselves." (18 years old female, 11th grade FGD discussant)

4. Consequences beyond premarital sex and the worth beyond delaying sex-

It was reflected by most discussants that premarital sexual debut end up in HIV, STI, unwanted pregnancy and this by it self put girls in discrimination by the society. Participants also suggested that delaying sex benefits for one's futurity that is for having successful marriage. It helps to have a better generation ahead, to raise children appropriately and to avert the psychological problem that may be impacted due to first sex later in marriage life. For a girl if she stays virgin till she gets married then she is respected by her husband & accepted by the society.

"For instance if one woman stays virgin till marriage, she can save her marriage life, I know married people that failed to trust each other after marriage when the husband got his wife being not virgin, so delaying sex can really save marriage life especially when disputes occurred between partners. Virginity is respected by the family, society and also by religion too; her husband can also respect, love and trust her." (15 years old female, 8th grade FGD discussant)

5. Preconditions to delay premarital sex and recommendations to be undertaken-

It was suggested by different discussants as there are different stakes that are responsible for averting premarital sex among these orphan adolescents. It was

mentioned that the family is the first responsible body; parents are responsible for the children they brought to this world, raising children appropriately is not only left for mothers but also for fathers too, they have to share this burden together. The society and the government have also stakes. As it is was stated above, lack of openness and frankness is a serious problem among families. Thus, rather than putting strict supervision on children, as one project director mentioned it is better to be friendly & helpful to such children.

"So in our project, there is what we call, "Christian world view" here, we give awareness so that children are aware so as to keep themselves from using substances…family should have friendly relation with children…know how to handle and rear children starting from early childhood; even depending on each religion the family has to teach God's Holy word, show them the advantages and disadvantages, guiding them…so as the word of God tells; "lejen bemihedebet menged meraw beshemegelem gize kesu fekek aylem" so we also start the service since childhood, we help them to learn weekly. Even the society shall play a role, there is a saying…."ande lejen setegn ene be….gize meri arge efeterewalew" so if we work on them since the time of childhood then it will be easy." (Male, project coordinator with 3 years experience-Interviewee)

The government shall reduce some ―Shisha" houses so that these orphan adolescents can have safe environment where they can enjoy by different recreational activities, it has to give trainings so as to create awareness on such issues. Free discussions are also important between peers that it was reported by one FGD participant, even Biology teachers are embarrassed when they teach on sexuality topics, so trainings are needed.

Most orphan adolescents that are community based support beneficiaries in this survey are strictly followed by care givers, volunteers and social workers, even they get counselling services concerning sexual issues from those charity organizations and most are faith-based organizations as one project director explained- *"The thing that differentiate these orphan adolescents is their vulnerability when we compare them with those who live with their parents. Concerning this issue since HOPE is religious organization it has its own rules, there are counsellors that council the children in each day before class that they teach them in different enjoyable ways. So because of the strict supervision we don't see such cases within the organization but in the outside, there are different challenges."* (Male, project coordinator with 6 years experience-Interviewee)

It was indicated by some respondents that so as to delay sex till marriage, feelings shall be controlled and personal strength is needed. The manner of guardians is also the other problem that has to be focused.

"What I faced in my life for instance is, I used to live with my step mother when I was around 8, I suffered a lot by the life I lived with her so I went out from home and became street dweller around Merkato, then after I got different friends but on those times there were conditions where I got exposed to such risks; but I controlled myself but had it been that I got exposed to HIV infected girl out there then the life I have today might be miserable due to my step mother. So it depends on the type of manner and personality of the guardian/family we have." (17 years old male, 9th grade FGD discussant)

For those who are sexually active orphan adolescents, free discussion between partners is needed so as to be protected from the bad consequences of premarital sex, a 17 years old male, 10th grade discussant stated: *"...any how I wonder if any one of you among us didn't try sex, as for me I am not embarrassed when I tell you this, I did sex but it was protected; really if we did it carefully then there will not be harm if it is done by plan and discussion; but here it might affect the life beyond marriage for girls as it said before*; *there has to be free discussion between partners, both should agree on the same point other wise it will be difficult if there is a contradicting ideas between them."*

It was mentioned that delaying sex till marriage is helpful to achieve one's life goals. Sex educations, free discussions, participations on clubs at school, youth centres and on kebele levels are also recommended by the discussants. It was suggested that to have a calm looking of situations, spiritual maturity, being selective to have peer friends & to be careful when watching films not to get exposed to pornographic materials were indicated as recommendations. In addition to the above mentioned ones that delaying sex can boost up confidence, protect from STIs including HIV- *"...Its better to work more on the children…by inviting those people that can be role model so that they will teach on how they pass the challenge of these ages; individual and group counselling, sharing our experiences and giving them advise, helping them to be spiritually strong so that he/she will respect her family, fear God, giving them love, getting close to them; by allocating human recourses for instance, counsellors, psychologists and the like…"* (Male, project coordinator with 6 years experience-Interviewee)

"I believe every one of us should not be engaged in premarital sex because the chances of ending relationships which happen prior to marriage are high though many promises and hopes are being given to it. Hence, we should be patient enough to wait for the right moment to do it if not we will let ourselves to regret by being a problem to ourselves, family and the community…." (15 years old female, 9th grade FGD discussant)

As some other respondents commented that other than using the three ‗ABC' rules, tackling early sexual initiation helps to have a peaceful family- *"The other very important thing of delaying sex till marriage is, one can know his/her father very well when it is in wedlock. It is known that most men walk away after impregnating their partner, so had it been sex is in wedlock such kind of problems may not happen. It is good for children to be reared by their parents; particularly by knowing their father and mother."* (16 years old male, 9th grade FGD discussant)

6. DISCUSSION

Early initiation of sexual intercourse without having proper protection has been one of the concerns. Studies have also documented early sexual initiators were more likely to report undesired consequences of sexual initiation. In this study, almost all orphan adolescents aged 15-18 years old who were beneficiaries of community-based type support within charity organizations in Addis Ababa were students; majority of them were single orphans that lost their mother or father and similarly most orphan adolescents were reared by single parent till age 14 years old. The quantitative data supported by the qualitative FGDs and in-depth interviews showed that orphaned adolescents were exposed for premarital sex due to their age, peer pressure and substance use. Since these orphans are in need of love & affection that they lack from deceased parent they got engaged in sexual relationship in early age and having a boy/girl friend expose them to premarital sex.

The mean and median age at first sexual intercourse in this finding were 14.5(SD=3.69) and 16 years respectively which range from 6-18 years. Only 4.6% of orphan adolescents in this study have had sex. A study done in Nepal among adolescents shows that prevalence of premarital sex was 18.32%. It was more common among boys (25.8%) than girls (9.2%) and it was consistently increasing with increase in age.(5) Also one study done on youth beneficiaries of world vision international organization in Rwanda suggest that small proportions of both females and males are sexually experienced at an early age; in the age 15-19 almost 46% of respondents reported having had sex. The variation with the current study can be due to difference in study settings & designs; since that study was conduced at house hold level besides it included youths but not specifically orphans. As of the study in Rwanda indicated that the mean age of first sex among those sexually experienced was 14 years for males and 16 years for females which was similar to the current one 15.5 for male and 18 years for females. (38)

In one study in South African conduced among orphan adolescents of age 14-18, it was found that both male and female orphan adolescents significantly more likely to have engaged in sex as compared to non-orphans (49% vs. 39% respectively), orphans were nearly one and half times more likely than non-orphans to have had sex. Among sexually active youth, orphans reported younger age of sexual intercourse with 23% of orphans having had sex by age 13 or younger compared to 15% of non-orphans.(23) Prevalence of the above findings are quite high when compared to the present study this can be due to the study setting; the current study was conducted among beneficiaries of community based programs in charity organizations. As it was mentioned in the qualitative study, most charity organizations were faith-based organizations where supervision, follow-ups and reproductive health trainings were given for orphan adolescents. In addition, variations in study design & sampling can be the cause of difference in the finding with the current one.

In Ethiopia, different studies were conducted on sexual behaviours of adolescents but not specifically on orphans. In the 2011 Ethiopian EDHS, the median age at first sexual intercourse is 18.8 years for women currently age 20-24; men tend to initiate sexual activity later in life than women. The median age at first sex for men age 25-49 is 21.2 years which is about six years later than for women. The result of this finding (15.5 for male and 18 years for females) is similar with the median age of first sex for

females and however it is smaller to that of males; this differences may be EDHS interviewed those who were 25-49 years that may be subjected to recall bias, difference in study setting and population. (39)

A comparative study conducted in North Eastern Ethiopia indicated that about half, (51.3%) of the youths (15-24 years) have ever had sex with rural youths initiating sexual intercourse at lower age than their urban counterparts with mean (±SD) (16.49+2.11) for rural and (17.18+2.32) for urban youths. The median age at sexual debut was 16 years for rural and 17 years for urban. The mean of current finding is slightly lower when compared with this study it can be due to variation in study population, study setting and design.(40) In addition, a study conducted among adolescents in Eastern Wollega showed that more than one-fifth (21.5%) of the participants had had premarital sexual intercourse at the time of the survey, of which 102 (70.3%) were males.(41) The mean age of first sexual initiation (17.07) in the study conducted in Gamo Gofa zone among 15-24 years youths is slightly higher when compared to the current study.(42) These differences can be due to since studies were done on youths 15-24 years whom were selected from health institutions which is varied with the current study that only included orphan adolescents aged 15-18 years under community based support of charity organizations besides study area (rural and urban setting) has also effect when compared to the prior study.

The characteristic features that make these orphan adolescents to be vulnerable in the current study are peer pressure, substance use like that of alcohol use and having a sexual partner. These all are comparable to similar surveys in North East Ethiopia. Substances such as alcohol use and viewing pornographic materials were other factors associated with early sexual initiation that were identified in the current study. Drug trafficking and drug abuse, although not problems in the past are becoming more common in Ethiopia. According to the MOH Department of Pharmacy report for 2000/01, it is exacerbated by lack of employment opportunities and general feelings of hopelessness. Similarly, though use of pornographic materials was not found to be significantly associated in multivariate analysis, substances like that of alcohol enforce these adolescents to be engaged in sexual intercourse early. (40, 42)

In addition to the reports of the above studies, a study done in East wollega showed that male adolescents were more likely to report premarital sexual experience than females AOR=2.23, (1.35, 3.68), ever having a sexual partner AOR=22.3 (13.1, 37.9) were found to be associated significantly with premarital both before and after controlling for confounders; even though having regular pocket money and ever drinking alcohol were found to be positively associated with premarital sex in the crude analysis, the association did not remain significant after multiple logistic regression analysis. In the current study however, drinking alcohol is significantly associated with premarital sex even after controlling confounders. Having asexual partner is associated with premarital sex as it is also seen in the above study. (40, 41)

A study done in Northern Malawi, examined the effects of orphanhood status on the timing of first sexual intercourse among youth 12-18 years. Results of this study showed that orphanhood is a significant predictor of age at first sex. Male double orphans experienced first sexual intercourse earlier than their male non-orphan peers. Similarly, female maternal and paternal orphans had their sexual debut faster than their non-orphan counterparts. A study done in Tanzania surveyed on risk factors of

engaging in unsafe sex among orphans and non-orphans. Findings showed that among young people who reported having unsafe sex, those who were female orphans were more likely to state that they _had to have sex‘ to acquire food and clothing for their households. Similarly, the qualitative part of this study revealed that females were more likely to engage in early sex due to different economical problems though the quantitative study didn‘t show same finding. (43, 44)

Since the subject matter of the study is sensitive, social desirability bias may be encountered as a limitation to the study but efforts was made to orient well the study participants on the confidentiality, privacy and assured that their participation or non-participation was not related with the services they were provided from the charity organizations. Besides, the use of self-administered questionnaire rather than face-to-face interviews likely lessened the shortcoming. The numbers of orphan adolescents who ever had sexual intercourse were small; thus, major responses about the determinants and consequences of premarital sex were given by those orphan adolescents who had not sexual intercourse.

7. STRENGTHES AND LIMITATIONS

7.1 STRENGTHS

- The use of qualitative data to supplement findings of the survey.

7.2 LIMITATIONS

- There might be social-desirability bias due to sensitive subject matter of the study though self-administered questionnaire were used rather than face-to-face interview.
- The study is institution based and the focus on those who were found at selected charity organizations during data collection precludes generalization to all other orphan adolescents that might have different life experiences & might be affected by selection bias.

8. CONCLUSION

- The finding of this study have shown that though the prevalence of sexual practice was smaller when compared to studies done in other countries orphan adolescents whom were beneficiaries of community based type support among charity organizations were exposed for premarital sex. The prevailing sensitivity of the subject might result in under reporting.

- For those orphan adolescents that were found in selected charity organizations, those beyond 17 years were seven times more exposed to premarital sexual practice. Besides, those who were affected by peer pressure and who used alcohol were four and five times more exposed to premarital sex respectively. In addition, those who were engaged in boy/girl friendships were four times more exposed for premarital sex when compared to those who didn‘t have.

- The other point that was reflected by most participants of the qualitative study was that guardians impose tight supervision; their being over controlling for such children by itself exposes these orphan adolescents to premarital sexual practice.

9. RECOMMENDATIONS

- Starting sexual education programs at earlier ages to orphan adolescents and trainings on risky sexual behaviours with special emphasis on substance use shall be designed at school level.
- Programs are needed to convince parents/guardians of the need to focus on enhancing informed choice among orphan adolescents rather than imposing tight supervisions.
- Establishing a well designed documentation system & databases of beneficiaries in charity organizations is needed in collaboration with Addis Ababa city women, children & youth affairs bureau.
- Further nationwide study at country level, and or community based comparative study shall be conducted on determinants of premarital sex among orphan adolescents.

10. REFERENCES

1. Durojaye N. Realising access to sexual health information and services for adolescents through the protocol to the African Charter on the rights of women. 2009.
2. Baumgartner JN. The influence of early sexual debut and sexual violence on adolescent pregnancy: a matched case-control Study In Jamaica. 2009.
3. FHAPCO. MoH. Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response. (2004-2008).
4. Klavs I. Factors associated with early sexual debut in Slovenia: results of a general population survey. Sex Transm Infections. 2006;82:478-83.
5. Singh sk., Krishna G., Manandhar N. A study on prevalence of premarital sex among adolescent students. Journal of Institute of Medicine. August, 2006;28(2):35-8.
6. The Joint United Nations Programme on HIV/AIDS UNAIDS, UNICEF, USAID. Children on the Brink. 2004, July.
7. UNICEF, UNAIDS Secretariat. Africa's orphaned and vulernable generations children affected by AIDS. 2006.
8. Busuttil F., Douziech C., Ahlgrim A. Hartburn S. Report on orphans. 2011.
9. UNICEF-Ethiopia. Steady increase in street children orphaned by AIDS. wwwuniceforg/protection/ethiopia_30783html. Jan 20, 2006
10. Childinfo.org:monitoring the situation of women and children. Statistics by Area - HIV/AIDS - Orphan Estimates. April,2013.
11. MOH:FHAPCO. AIDS in Ethiopia-sixth report-Technical document for the sixh report-Estimates and projections on HIV prevalence and incidence in Addis Ababa. 2005.
12. Abebe T, Aase A. Children, AIDS and the politics of orphan care in Ethiopia: the extended family revisited, in: Social Science and Medicine 2008.
13. Makame V, Ani C, Grantham-McGregor. Psychological well-being of orphans in Dar Es Salaam,Tanzania. 2002.
14. Oleke C, Blystad A, Fylkesnes K, Tumwine JK. Constraints to educational opportunities of orphans: a community-based study from northern Uganda 2007.
15. Chae S. Does Timing of Orphanhood and HIV Prevalence Matter? A Look at Orphans‘ Transitions to Sexual Debut and Marriage in Four Sub-Saharan African Countries Philadelphia: University of Pennsylvania.
16. Meyer J. Adolescent male orphans affected by HIV and AIDS, poverty and fatherlessness: A story of marginalisation? . 2013.
17. Munaaba F., Ower J., Baguma P., Musisi S., Mugisha F., Muhangi D. Comparative studies of orphans and non-orphans in Uganda: Boston University School of Public Health. Oct. 2004.
18. Perrino T, Soldevilla G., Szapocznik J. The role of families in adolescent HIV prevention: A review. 2000
19. Hope for African Children Intiative-HACI Ethiopia. Orphan and Vulnerable Children service mapping in Addis Ababa and surrounding towns-service directory. Oct,2005.
20. Letsoalo PT. Trends and determinants of sexual behaviour in western cape, south Africa: A study of young adults transitioning to adulthood using the cape area panel study. 2009.
21. Hughes J, AP. M. Improving the Fit: Adolescents` Needs and Future Programs for Sexual and Reproductive Health in Developing Countries, Studies in Family planning. 1998.

22. WHO-publication. An assessment of Reproductive Health Needs in Ethiopia-2003.
23. Thurman TR., Brown L., Richter L., Maharaj P., Magnani R. Sexual Risk Behavior among South African Adolescents: Is Orphan Status a Factor? Springer Science+Business Media, Inc. 2006.
24. Nyamukapa C., Gregson S, Lopman BS. "HIV-Associated orphanhood & children's psychosocial distress: Theoretical framework tested with data from Zimbabwe". 2008.
25. Lylian A., Paul O., Lucas O. Sexual Risk-taking Behaviors among Youth in Secondary Schools in Bondo District, Kenya. Greener Journal of Educational Research. Jan.2013;3(1):001-6.
26. Robertson L. , Gregson S., Garnett G.P. Sexual risk among orphaned adolescents: is country level, HIV prevalence an important factor? AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV. Jun.2010;22(8):927-38.
27. Eve S. Puffer, Anya S. Drabkin, Allison L. Stashko, Sherryl A. Broverman, Rose A. Ogwang-Odhiambo, Kathleen J. Sikkema. Orphan Status, HIV Risk Behavior, and Mental Health Among Adolescents in Rural Kenya. 2011.
28. Michielsen G, Lang BP. The Preparation Of The Future: Techniques Of Anticipation. 2008.
29. Hazel MB Dube, Heidi Tucker. Assessing the Sexual Risks and Reproductive Health Needs of Orphans and Vulnerable Youth in Zimbabwe. Feb.2006.
30. Juma M., Alaii J., Bartholomew L., Askew I. Understanding orphan and non-orphan adolescents‘ sexual risks in the context of poverty: a qualitative study in Nyanza Province, Kenya. BMC international health and human rights. 2013;13(32).
31. Operario D., Underhill K., Carolyn C., Cluver L. . HIV infection and sexual risk behaviour among youth who have experienced orphanhood: systematic review and meta-analysis. Journal of the international AIDS society. 2011;14(25).
32. Oljira L., Berhane Y., Worku A. Pre-marital sexual debut and its associated factors among in-school adolescents in eastern Ethiopia 2012. BMC Public Health. 2012;12(375).
33. ETHIOPIA-USAID. Country Data Profile: Orphans-Countries Targeted by the Emergency Plan for AIDS Relief. Oct.2003.
34. Addis Ababa City-Government. report on- Addis Ababa. 2013.
35. Addis Ababa City Administration Health Bureau. annual activity and performance report,Addis Ababa. 2011/2012.
36. Addis Ababa city government women-children and youth affairs. Lists of charity organizations in Addis Ababa. 2013.
37. The FDRE charity and socities agency. lists of charity organizations in Addis Ababa. 2013.
38. Ntaganira J., J Hass L., Hosne S., Brown L., B Mock N. Sexual risk behaviors among youth heads of household in Gikongoro, south province of Rwanda. BMC public health. 2012;12(225).
39. Federal Republic of Ethiopia Central Statstical Agency. The 2011 Ethiopian Demographic and Health Survey, Addis Ababa, Ethiopa.CSA. 2011.
40. Mazengia F., Worku A. Age at sexual initiation and factors associated with it among youths in North East Ethiopia. Ethiop J Health Dev. 2009;23(2):154-62.
41. Seme A., Woritu D. Premarital Sexual Practice among School Adolescents in Nekemte Town, East Wollega. EthiopJHealth Dev. 2008;22(2):167-73.

42. Tilahun M., Ayele G. Factors associated with age at first sexual initiation among youths in Gamo Gofa, South West Ethiopia: a cross sectional study. BMC Public Health. 2013;13(622).
43. Mkandawire P, Tenkorang E, Luginaah I. Orphan status and time to first sex among adolescents in northern Malawi. AIDS and Behavior. 2012:1-12.
44. Mmaria K., Michaelisa A., Kirob K. Risk and protective factors for HIV among orphans and non-orphans in Tanzania. Pub Med Central. 2009.

ANNEX-1 Questionnaire for quantitative study-English

Addis Ababa university, College of Health Sciences, School of Public Health, Questionnaire for Assessing pre-marital sexual debut and its associated factors among orphan adolescents (15-18 years) in Addis Ababa.

Code no…….

Hello dear respondent, my name is……. I am working in Addis Ababa University, College of Health Sciences research team. This study is proposed to assess pre-marital sexual practice and associated factors among orphan adolescents (15-18 years) in Addis Ababa and you are selected to participate in this study just by chance.

I hope your honest and genuine participation and response to these questions will help guiding the planning of services that are targeted on orphan adolescents' reproductive health. The questions involve intimate and private life questions. We would like to assure you that this privacy should strictly be maintained throughout the study process. A code number will be given to identify every participant and no name will be used. Your responses to any of the questions will not be given to anyone else except the study team and no reports of the study will ever identify you. If a report of results is published, only information about the total group will appear.

None of your answers will be available to anyone and do not give me your name; please be reminded that all the information you give me will be kept in private and secure place. Anyone who will not be willing to participate in the study will have the right to discontinue on this point. The study will be conducted through self administered questionnaire. We are asking you for a little of your time, about 20-40 minutes, to help us complete this questionnaire.

Finally, we hope that the information you give us could help to design appropriate reproductive health services for orphan adolescents. The participation is voluntary. Your participation/ non-participation, or refusal to respond to the questions will have no effect now or in the future on services that you or any member of your family may receive from any service providers

Addis Ababa University, College of Health Sciences, School of Public Health, Questionnaire for Assessing pre-marital sexual debut and its associated factors among orphan adolescents (15-18 years) in Addis Ababa

Consent/assent form-

I fully understand the information given about the objectives, rights, confidentiality and the benefit of the study towards improving reproductive health of orphan adolescents and the participation/non-participation which has no effect from receiving services from any service provider. So that, I agree for the participation of my child in the study.

Signature of the guardian……..Date……

In case you need to contact:

Addis Ababa University- School of Public Health
Contact address of the investigator- Name: Meheret Tena
Tel. no. +251-1910-06-85-98
E-mail address- mercyna_tena@rocketmail.com or mercynafeker@gmail.com

Part-I Respondent background information

101	What is your sex?	1. Male 2. Female
102	How old are you?	…….years
103	To which Ethnic group do you belong?	1. Amhara 2.Oromo 3.Tigre 4. Others, (specify)…….
104	What is your religion?	1. Orthodox 2. Protestant 3. Catholic 4. Muslim 5. Others, (specify)…….
105	What is your marital status?	1.Never Married 2.Currently Married 3.Divorced 4. Widowed 5. Separated
106	Are you currently attending a school?	1. Yes- If Yes is your answer then specify your completed educational status…… 2. No If your answer is No, please skip to Q 107
107	If Not attending school, why did you stop your education?	1.Economical problem 2. Academic failure 3.Pregnancy 4. Lack of interest 5. Health problem 6.Other reason (Specify)……
108	Do you have income of your own?	1. Yes 2. No If No, please skip to Q 110
109	What is your average monthly income?	……Birr (specify the amount)
110	Do you have pocket money?	1. Yes 2. No If No, please skip to Q 114
111	How much is your pocket money?	……Birr (specify the amount)
112	How often do you get it?	1.Daily 2.Monthly 3.Bi annually 4.Annually 5.Others, (Specify)……
113	From where do you get the pocket money?	1.Family 2.Friends 3.From charity 4.organizations that supports orphans 5.Others, (Specify)……

Part-Two- Respondent family information-

114	Is your mother alive?	1. Yes 2. No
115	Is your father alive?	1. Yes 2. No
116	With whom did you live until age 14?	1. With biological parents 2.With my mother only 3.With my father only 4.With my mother and step father 5.With my father and step mother 6.With my grand parents 7.Others, (Specify)……..
117	Where do you live currently?	1.with father or mother 2.with brothers 3.with sisters 4.with relatives 5.with friends 6.Others,(Specify)……..
118	**Please answer this question if your answer to Q 114 is Yes-** Mother‘s educational status?	1.Illiterate 2.Only read and write 3.Grade 1-6 4.Grade 7-12 5.Above 12 grade 6.Do not know 7.Others,(Specify)……..
119	**Please answer this question if your answer to Q 114 is Yes-** Mother‘s Occupation?	1.Government employee 2.House wife 3.Merchant 4.House maid/daily labourer 5.Others,(Specify)……..
120	**Please answer this question if your answer to Q 115 is Yes-** Father‘s educational status?	1.Illiterate 2.Only read and write 3.Grade 1-6 4.Grade 7-12 5.Above 12 grade 6.Do not know 7.Others,(Specify)……..
121	**Please answer this question if your answer to Q 114 is Yes-** Father‘s Occupation?	1.Government employee 2.car driver 3.Merchant 4.Daily labourer 5.Others,(Specify)……..
122	How much is the income of your family?	1…….Birr monthly income 1.Do not know

Part-Three- Information on Peer Influence-

123	Have you ever been encouraged by other boys or girls or your friends to have boy/girl friend?	1.Yes 2.No
124	Have you ever encountered pressure from your friends to have sexual intercourse?	1. Never 2. Yes 3. Sometimes
125	Having sex while I am a teenager would just be doing what everybody else is doing	Agree Not sure Disagree
126	A boy should have sex before he gets married	1. Agree 2. Not sure 3. Disagree
127	Discussing condom or contraceptive with young people promotes promiscuity	1. Agree 2. Not sure 3. Disagree

Part-Four- Information related on substance use and other risky behaviours-

128	Have you ever used any drug/substances?	1.yes 2.No If No, please skip to Q132
129	What drugs have you used to enhance a sexual experience? (more than one answer is possible)	1.Heroin and or Cocaine 2.Chat 3.Marijuana 4.Benzene 5.Others (specify)……..
130	Have you ever used a drug to enhance a sexual experience?	1.Yes 2.No
131	Which drug did you used to enhance a sexual experience?	1.Heroin and or Cocaine 2.Chat 3.Marijuana 4.Benzene 5.Others, (specify)……..
132	Have you ever drunk Alcohols?	1.yes 2.No If No, please skip to Q 136
133	How old were you when you first drank Alcohols?	Age……..years
134	Do you usually have sex after drinking alcohols?	1.Yes 2.No
135	How frequently do you drink alcohols?	1.Always/daily 2.Often(3-4 times/week) 3.Occasionally(1-4 times/month) 4.Rarely(on Holy days) 5. Others, (specify)……..
136	Do you smoke cigarettes?	1.Always/daily 2.Often(3-4 times/week)

		3.Occasionally(1-4 times/month) 4. Rarely(on Holy days) 5. Do not smoke
THE FOLLOWING QUESTIONS ARE ON- PORNOGRAPHIC MATERIALS- THE TERM PORNOGRAPHIC MATERIAL REFERS TO NEWS PAPERS, MAGAZINES, BOOKS, PHOTOGRAPHS, VIDEO TAPES, FILMS…ETC THAT ARE SEXUALLY EXPLICIT		
137	Have you ever viewed pornographic material?	1.Yes 2.No, please skip to Q 141
138	How old were you when you first viewed pornographic material?	1……..years 2. don‘t know
139	Have you ever viewed pornographic materials in the last six months?	1.No 2.Often(3-4 times per week) 3.Occasionally(1-4 times/month) 4.Once in a month Others, (specify)……..
140	What type of pornographic materials did you view the last time? (more than one answer is possible)	1.News paper/Magazine 2.Movies and videos 3.Photograph and pictures 4. Others, (specify)……..

Part-Five- Information on sexual behaviour of the respondent-

141	Do you have boy/girl friend currently?	1.Have only one girl/boy friend 2.Have more than one girl/boy friend 3.Don‘t have , please skip to Q 144
142	How long have you been together with your girl/boy friend?	……..please specify the time(if in years, months and weeks)
143	Please describe the nature of your relationship with your partner?	1.Spouse 2.Cohabiting(Live-in boy friend/girl friend) 3.Boy/girl friend not living together 4.Others, (specify)……..
144	Have you ever had sexual intercourse?	1.yes 2.No If No, please answer Q 145 and skip to Q 171
The following questions from Q 146-170 are filled by those who answer Q 144-Yes, so if your answer is No, please skip to Q 171		

145	At what age did you have the first sexual intercourse?	……..Please write the age
146	How older or younger was the person with whom you had your first sexual intercourse?	1.He was an age like mine 2. By more than 10 years older 3.By more than 5 years older 4.By less than 5 years older 5.Younger than me 6. Others, (specify)……
147	At the time you had first sexual intercourse, what was your relationship with your partner?	1.Wife/Husband 2.Fiancé 3.Girl friend/Boy friend 4.Friend 5.Acquaintance 6.Relative 7.Teacher 8.Don‘t remember 9.Others, (specify)……
148	Would you say the first sexual intercourse was planned or unexpected?	1.Planned 2.Unexpected
149	What do you think were the reasons to have the first sex?	1.fell in love 2 Had desire. 3. I got married 4.Raped 5. To get money to support my self and family 6.Peer pressure 7. was drunk or stoned. 8. I was obligated because of gifts 9. Cheated/false premises 10. After taking Chat, alcohol… 11. My partner/boy/girl friend insisted me to do so 12. Others, (specify)……..
150	Before you had sex for the first time, did you and your partner talk about using contraception?	1.Yes 2.No 3.Don‘t remember
151	At the time you had the first sex, did you or your partner use any contraceptive method?	1.Yes 2.No

152	Which contraceptive method did you or your partner use at the first sexual intercourse?	1.Pills 2.condom 3.Depo/Injectables 4.Implanon 5.IUD 6.Natural method…….please specify
153	Have you ever had sex in the past 12months?	1.Yes 2. No, please skip to Q 159
154	How often did you and your partner use a contraceptive method in the past 12 months?	1.Always 2.Quite often 3.Sometimes 4.Rarely 5.Never
155	Which contraceptive methods do you or your partner use?	1.Pills 2.condom 3.Depo/Injectables 4.Implanon 5.IUD 6.Natural method…….please specify
156	How many sexual partners have you had in the past 12 months?	1……..partners 2. Don‘t remember
157	How many people have you had sex with during your life time?	1……..partners 2.Don‘t remember
158	How many people have you had sex with during your life time?	1……..partners 2.Don‘t remember
THE FOLLOWING QUESTIONS(159-160) ARE ONLY FOR MALES; FEMALES PLEASE SKIP-		
159	Have you ever had sex with a commercial sex partner?	1.Yes 2.No If No, please skip to Q 170
160	How often did you and/or your commercial sex partner use condom in the past 12 months?	1.Yes 2.No
THE FOLLOWING QUESTIONS(161-170) ARE ONLY FOR FEMALES; MALES PLEASE SKIP-		
161	Have you ever been pregnant?	1.Yes 2.No, please skip to Q 166
162	What was your age at your first pregnancy?	……..years (enter number)
163	How many times have you been pregnant?	……...times (enter number)
164	Sometimes a girl becomes pregnant and decides to abort or stop the pregnancy. Have you ever aborted	1.Yes 2.No, please skip to Q

	or stopped a pregnancy?	166
165	If the abortion was an induced one. How did it take place?	1.I took drug 2.By health professional 3.By non-health professional 4.Others, (specify)…….
166	Have you ever used modern contraceptives?	1.Yes 2.No If No, please skip to Q 169
167	If yes, what kind of modern contraceptive did you use?	1.Pills 2.condom 3.inject able contraceptive 4.Implanol 5.Intra uterine device 6.Others, (specify)…….
168	Do you use any type of contraceptive currently?	1.If yes, (please specify the type)..... 2.No
169	If no, what are the reasons? (more than one answer is possible)	1. I have infrequent sex 2. Husband/partner opposed 3. Parents opposed 4. Religious Prohibition 5. Lack of knowledge about contraceptives. 6. Fear of side effects 7.health service providers have negative attitude 8.Service not available 9. Want to have children 10. Others, (specify)…….
170	Have you ever had the following symptoms?	1.Genital ulcer 2.Itching around genital area 3.offensive discharge 4.Pain during urination 5.Don‘t encountered 6.Other, (specify)…….

Part-Six- Information on sexuality and Reproductive Health-

172	Have you ever discussed sex related issues?	1.yes 2.No If No, please skip to Q 174
172	If yes, With whom did you discuss sex related issues?	1.family 2.friends 3.boy/girl friend 4.Others, (specify)……

173	How often did you discuss sex related issues?	1.often 2.occasionally 3.rarely 4.Others, (specify)……
174. Were you ever been taught at school or other than school about the following? A. Menstrual cycle 1. Yes 2. No B. Male/Female reproductive system? 1. Yes 2. No C. How pregnancy occurs? 1. Yes 2. No D. Contraceptive methods 1. Yes 2. No		
175	Do you participate on reproductive health clubs in school/other clubs outside school?	1.yes 2.No
176	Do you know any ways to avoid unwanted Pregnancy?	1.Yes 2.No If No, please skip to Q 178
177	If yes, what are the ways to avoid getting pregnant? (**More than one answer is possible**)	1.abstinence 2.Withdrawal 3.Oral contraceptive pills 4.Injectables. 5.Norplant. 6.IUDs. 7.Female sterilization. 8.Male sterilization 9.Condom 10.Safe period 11.Others,(specify)……
178	Have you ever heard about Sexually transmitted disease?	1. Yes 2. No If No, please skip to Q 183
179	What are the symptoms of Sexually transmitted diseases? (**More than one answer is possible**)	1.Offensive discharge 2.Pain during urination 3.Genital ulcer 4.Don‘t know symptom 5.Other, (specify)…….
180	If yes to Q 136, from which person or from where do you get more information about Sexually transmitted disease? (**More than one answer is possible**)	1.My family 2.sexual partner 3.(husband/wife) 4.Other family members 5.Boyfriends /girl friends 6.Friends /peers 7.Health institution 8.Religious leaders 9.Newspapers, posters, or pamphlets 10.From Radio 11.Others, (specify)……
181	Is there anything a person can do to avoid getting sexually transmitted disease?	1.Yes 2. No 3. I do not Know If No or Do Not know, please Skip to Q 183
182	What can a person do to avoid getting Sexually	1.Sexual abstinence.

	transmitted disease including HIV/AIDS? (**More than one answer is possible**)	2.Avoid casual sex. 3.Remain faithful to a partner. 4.Use condoms in every act of sexual intercourse. 5.Avoid sex with 6.Commercial sex workers 7. Others (specify)……
183	Do you ever heard about HIV/AIDS?	1.Yes 2.No
184	How do people get infected by HIV/AIDS? (**More than one answer is possible**)	1.Unproteced sex 2.Mother-to-child 3.By sharp materials 4.By blood transfusion 5. kissing with HIV infected person 6.By greeting 7.By material exchange 8.By mosquito bite 9.Do not know 10.Others (specify)……
185	How do adolescents protect themselves from HIV/AIDS? (**More than one answer is possible**)	1.Abstinence 2.Being faithful 3.using condom 4.Avoiding borrowing of sharp materials 5.Avoiding any type of contact with HIV infected person 6.Others (specify)……

Part-Seven- Information on Connectedness with Religious Institutions

186	In the past 12 months, on religious days in which you should attend Church/Mosque, how often did you go?	1.Always 2.Sometimes 3.Often 4.Rarely 5.Don‘t have religion 6.Others (specify)……
187	How often do you pray?	1.Daily 2.At least once a week 3.Sometimes 4.Never prayed 5.Others (specify)……

Thank you for your participation!

Guide to Qualitative study- FGDs and In-depth interviews-

Addis Ababa university, College of Health Sciences, School of Public Health, Questionnaire for Assessing pre-marital sexual debut and its associated factors among orphan adolescents (15-18 years) in Addis Ababa.

Hello participants' good morning/good afternoon!
My name is…….. My colleague near to me is called……we came from Addis Ababa university, College of Health Sciences research team.

Please Read the following as it is…

–After a brief introduction we will be talking about sexual initiation and the determinants of early sexual initiation among orphan adolescents particularly (in age group of 15-18). The research will be helpful to tackle the sexual, reproductive and other problems of orphan adolescents and also will help us to develop services and educational programs. We hope that the discussion we are going to have is very useful to assess what people think and perceive about pre-marital sex and factors associated with it from different perspectives.

For this discussion, I will raise some questions concerning pre-marital sex and factors associated with it then, you will discuss.

We will eventually conclude the session by asking for your recommendations on ways to bring about changes in orphan adolescents to postpone early sexual intercourse until later age/typically until marriage following the development of certain appropriate interventions basically attributed to your comments and suggestions."

Would you be willing to participate in the discussion?

If yes, proceed.

If no, thank and stop the discussion.

Signature……..
(Signature of the moderator certifies that consent has been obtained verbally)
Date……..Time…….

(Introducing each other)- Age, Sex, Educational background

Before I start, I would like to thank all of you for voluntary participation

Topic guide line –

1**.** What do you perceive about early sex, its factors (causes, prevention, and its consequences and in relation to Sexual behaviours that predisposes them to unwanted pregnancy, abortion, STIs including HIV)

2. Who will be involved/ who is responsible body in the adverse effect of early sex? (Probe!)

3. In your opinion, what are the major reasons that predispose orphan adolescents to early sexual debut?

4. What effects does the socio demographic background have on orphan adolescents' sexual behaviour?

- Socio-economic status of parents?
- The presence of parents?
- Living arrangements?
- Educational status?

5.What about substance abuse, does it relate with premarital sexual practice of orphan adolescents? * Chat, Cigarette, alcohol, drugs… and Do watching sexual explicit movies, pictures…have association with premarital sexual practice?

6.When to start relation ship/which time is appropriate to have boy/girl friend? Does it relate to premarital sexual practice?

7. How do you see the role of communication with peer friends, connectedness between parents/guardians and orphan adolescents and strict supervision in relation to early sex and delay of sex?

8. What are the things Orphan adolescents do to prevent early sex and the consequences if it happens? What are the factors for delaying sex until later/until marriage?

9.What are the advantages of delay of sex both for youths, family and society?

10. Do you suggest any comment or recommend mechanisms from your own opinion to avert early sexual debut and its associated factors among orphan adolescents so as to tackle the sexual and reproductive health problems of orphan adolescents?

Which ways are better and essential for creating awareness among orphan adolescents concerning reproductive health? (Reproductive Health education in school, Clubs, youth centres…)

We thank you so much!!

ANNEX-2 Amharic questionnaire

በአዲስ አበባ ዩንቨርስቲ÷ የጤና ሳይንስ ኮሌጅ÷ የህብረተሰብ ጤና ትምህርት ክፍል÷ የቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶችን ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች (15-18 እድሜ ክልል ውስጥ) ዙሪያ ለማጥናት የተዘጋጀ መጠይቅ

የመጠይቁ መለያ ቁጥር.....

ጤና ይስጥልኝ ውድ ተጠያቂ! እኔ.....እባላለው÷ በአዲስ አበባ ዩንቨርስቲ÷ የጤና ሳይንስ ኮሌጅ÷ የህብረተሰብ ጤና ትምህርትና ምርምር ክፍል ነው የመጣሁት÷ ይህ መጠይቅ የተዘጋጀው ለድህረ-ምረቃ ዲግሪ ፕሮግራም ማሚያ ለሚሆን ጥናት ነው:: ***እርስዎ የተመረጡት በአጋጣሚ እንደ እድል ነው÷ ይህን መጠይቅ ለመሙላት ፈቃደኛ ሆነው ትክክለኛ እና እውነተኛ መልስ በመሙላት ይረዱናል ብለን ተስፋ እናደርጋለን÷ ይህም ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች የስነ-ተዋልዶ ጤና ዙሪያ ለሚሰሩ መልካም ስራዎች እንደ ግብአት ይሆናል::***
አንዳንድ ጥያቄዎች በግል ህይወቶት ውስጥ በጥልቀት ይገባሉ÷ ነገር ግን የሚሰጡት መልሶች በማንኛውም ጊዜ ለየትኛውም ሰዉ ግልጽ አይሆኑም÷ የሚሰጡት መረጃ በሙሉ በሚስጢር ይጠበቃል ***÷ሰምትን በመጠይቁ ላይ በፍጹም አይጻፉ÷ ለእያንዳንዱ መጠይቅ የሚሰጥ መለያ ኮድ ሰለሚኖር በየትኛውም ሁኔታ በዚህ ጥናት ዙሪያ ለሚወጡ መግለጫዎች÷ የጥናቱም ውጤት ይፋ ሲሆን የእርስዎ ምላሾች በፍጹም በቀጥታ አይወጡም÷ ማንም ሰዉ በግል ሊያውቆት አይችልም::*** ጥናቱ እንደዚህ በመሰለ በግል ተሞልቶ በሚምለስ መጠይቅ ነው የሚካሄደው÷ መጠይቁን ለመሙላት ከ 20-40 ደቂቃ ሊወስድ ይችላል÷ ጊዜዎትን ወስደው ምላሽ ስለሚሰጡን በቅድሚያ እናመሰግናለን! **በመጨረሻም የጥናቱ ውጤት ወላጆቻቸውን በተለያየ ምክንያት ላጡ ታዳጊ ወጣቶች የስነ-ተዋልዶ ጤና ችግሮችን ለማሻሻል የሚወጡ የመፍትሄ እርምጃዎችን ለመቅረጽ ይረዳል::**

ይህን መጠይቅ ላለመሙላት ወይም ላለመሳተፍ ከፈለጉ አሁን ማቆም ይችላሉ÷ በዚህ ጥናት አለመሳተፍ ወይም መሳተፍ ምክንያት ከየትኛውም ተቋም የሚያገኙት ጥቅም ጋር በፍጹም አይያያዝም::

በአዲስ አበባ ዩንቨርስቲ÷ የጤና ሳይንስ ኮሌጅ÷ የህብረተሰብ ጤና ትምህርት ክፍል÷ የቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶችን ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች (15-18 እድሜ ክልል ውስጥ) ዙሪያ ለማጥናት የተዘጋጀ መጠይቅ

<u>የስምምነት ቅፅ-</u> ተመራማሪዉ የጥናቱን አላማ በሚገባ አስረድተዉኛል::: ልጄ መጠይቁን እንዲሞላ ደግሞም የጥናቱ አላማ ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች የስነ-ተዋልዶ ጤና ችግሮችን ለማሻሻል እንደሚረዳ÷ የሚሰጡትም ምላሾች በሚስጥር እንደሚጠበቁ÷ በጥናቱ በመሳተፍም ሆነ ባለመሳተፍ ከየትኛውም ተቋም ከሚገኝ አገልግሎትና ጥቅም ጋር እንደማይያያዝ÷ጉዳትም እንደሌለው ተረድቼ ልጄ እንዲሳተፍ እፈቅዳለው::

የአሳዳጊው ፊርማ..... ቀን.....

<u>ለተጨማሪ መረጃ-</u>
በአዲስ አበባ ዩንቨርስቲ÷የህብረተሰብ ጤና ትምህርት ክፍል
የጥናቱ ተመራማሪ ስም- ምህረት ጠና
ስልክ ቁጥር- +251-1910-06-85-98
ኢ-ሜል አድራሻ- mercyna_tena@rocketmail.com or mercynafeker@gmail.com

ክፍል-1 አጠቃላይ የግለሰቡ መረጃ

101	ጾታህ/ሽ ምንድነው?	1.ወንድ 2.ሴት
102	እድሜህ/ሽ ስንት ነው?	……..አመት
103	ብሄርህ/ሽ ምንድነው?	1. አማራ 2. ኦሮሞ 3. ትግሬ 4.ሌላ ካለ ይገለጽ……
104	ሀይማኖትህ/ሽ ምንድነው?	1. ኦርቶዶክስ 2.ፕሮቴስታንት 3. ካቶሊክ 4.ሙስሊም 5.ሌላ ካለ ይገለጽ…….
105	የትዳር ሁኔታህ/ሽ ምን ይመስላል?	1.ያላገባ/አግብቶ የማያውቅ 2.ባለትዳር 3.አግብቶ/ታ የፈታ/ች 4.የትዳር አጋር የሞተበት/ባት
106	አሁን በትምህርት ላይ ነህ/ሽ?	1.አዎ- መልስዎ አዎ ከሆነ እስካሁን ያጠናቀቁትን የትምህርት ደረጃ/ክፍል ይገለጽ…… 2.አይደለሁም መልስዎ አይደለሁም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 107 ይለፉ
107	ትምህርት ላይ ካይደለክ/ሽ ትምህርትህን/ሽን ለምን አቆምክ/ሽ?	1. በገንዘብ ችግር 2. ከትምህርት ወድቄ 3. አርግ□ 4. መማር አልፈለኩም 5. በጤና ችግር 6.ሌላ ካለ ይገለጽ……
108	የራስህ/ሽ ገቢ አለክ/ሽ?	1. አዎ 2. የለም መልስዎ የለም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 110 ይለፉ
109	አማካይ ወርሃዊ ገቢዎ ስንት ነው?	……ብር (የብር መጠኑ ይገለጽ)
110	የኪስ ገንዘብ አለክ/ሽ?	1.አዎ 2.የለም መልስዎ የለም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 114 ይለፉ
111	የኪስ ገንዘብዎ ምን ያህል ነዉ?	……..ብር (የብር መጠኑ ይገለጽ)
112	በምን ያህል ጊዜ ነው የኪስ ገንዘብዎን የሚያገኙት?	1.በየቀኑ 2.በየወሩ 3.በአመት ሁለቴ 4.በየአመቱ 5.ሌላ ካለ ይገለጽ……..
113	የኪስ ገንዘብዎን ከየት ነዉ የሚያገኙት?	1.ከቤተሰብ 2.ከጓደኛ 3.ወላጆቻቸውን ያጡትን ከሚረዱ በጎ አድራጊ ተቋማት 4.ሌላ ካለ ይገለጽ……

ክፍል-2 የቤተሰብ ሁኔታ መረጃ

114	እናትክ/ሽ በህይወት አሉ?	1. አዎ 2. የሉም
115	አባትክ/ሽ በህይወት አሉ?	1. አዎ 2. የሉም
116	እስከ አስራ አራት አመትህ/ሽ ከማን ጋር አደክ/ሽ?	1.ከእናቴ እና አባቴ ጋር 2.ከእናቴ ጋር ብቻ 3.ከአባቴ ጋር ብቻ 4.ከእናቴና እንጀራ አባቴ ጋር 5.ከአባቴና እንጀራ እናቴ ጋር 6.ከአያቶቼ ጋር

		7.ሌላ ካለ ይገለጽ.....
117	አሁን የት ነው የምትኖረው/ሪው?	1.ከወላጅ አባቴ/እናቴ ጋር 2.ከወንድሞቼ ጋር 3.ከእህቶቼ ጋር 4.ከዘመዶቼ ጋር 5.ከጓደኞቼ ጋር 6.ሌላካለ ይገለጽ.....
118	ለጥያቄ ቁ. 114 መልስዎ **አዎ ከሆነ ብቻ ይህን ይመልሱ** - የእናትህ የትምህርት ደረጃ?	1.ያልተማሩ 2.ማንበብና መጻፍ ብቻ 3.ከ1ኛ-6ኛ ክፍል 4.ከ7ኛ-12ኛ ክፍል 5.12ኛ በላይ 6.አላውቅም 7.ሌላካለ ይገለጽ.....
119	ለጥያቄ ቁ. 114 መልስዎ **አዎ ከሆነ ብቻ ይህን ይመልሱ**- የእናትህ ሙያ/ስራ?	1.የመንግስት ሰራተኛ 2.የቤት እመቤት 3.ነጋዴ 4.የቀን ሰራተኛ/የቤት ሰራተኛ 5.ሌላካለ ይገለጽ.....
120	ለጥያቄ ቁ. 115 መልስዎ **አዎ ከሆነ ብቻ ይህን ይመልሱ**- የአባትህ/ሽ የትምህርት ደረጃ?	1.ያልተማሩ 2.ማንበብና መጻፍ ብቻ 3.ከ1ኛ-6ኛ ክፍል 4.ከ7ኛ-12ኛ ክፍል 5.12ኛ በላይ 6.አላውቅም 7.ሌላካለ ይገለጽ.....
121	ለጥያቄ ቁ. 115 መልስዎ **አዎ ከሆነ ብቻ ይህን ይመልሱ**- የ አባትህ/ሽ ሙያ/ስራ?	1.የመንግስት ሰራተኛ 2.ሹፌር 3.ነጋዴ 4.የቀን ሰራተኛ 5.ሌላካለ ይገለጽ.....
122	የቤተሰብህ/ሽ የገቢ ሁኔታ ምን ያህል ነው?	1.....ብር የወር ገቢ 2. አላውቀውም

ክፍል-3 የጓደኛ ተጽእኖ መረጃ

123	ጓደኞችህ/ሽ የፍቅር ጓደኛ እንድትይዝ/ዢ አበረታተውህ/ሽ ያቃሉ?	1.አዎ 2.አያቁም
124	የግብረ-ሥጋ ግንኙነት እንድታደርግ/ጊ ጓደኞችህ/ሽ አበረታተውህ/ሽ ያቃሉ?	1.በፍጹም አያቁም 2.አዎ 3.አልፎ አልፎ
125	በታዳጊ ወጣትነት ጊዜ የግብረ-ሥጋ ግንኙነት ባደርግ/ማድረጌ ማንኛውም ሰው የሚያደርገው ስለሆነ እንደጥፋት መቆጠር የለበትም?	1.እስማማለሁ 2.እርግጠኛ አይደለሁም 3.አልስማማም
126	ወንድ ልጅ ከማግባቱ በፊት የግብረ-ስጋ ግንኙነት ማድረግ አለበት?	1. እስማማለሁ 2. እርግጠኛ አይደለሁም 3. አልስማማም
127	ከወጣቶች ጋር ስለ ኮንዶም እና ወሊድ መከላከያ ዘዴዎች መወያየት ልቅ የግብረ-ስጋ ግንኙነትን ያስፋፋልን?	1. እስማማለሁ 2. እርግጠኛ አይደለሁም 3. አልስማማም

ክፍል-4 ተጉዋዳኝ ሱሶች እና ሌሎች ለአደጋ አጋላጭ ባህሪያት ጋር የተያያዘ መረጃ

128	ሱስ የሚያስይዙ መደሃኒቶችን ወይም እጾችን ተጠቅመህ/ሽ ታውቃለህ/ሽ?	**1.**አዎ 2.ተጠቅሜ አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.132 ይለፉ
129	የትኞቹን እጾች ነበር የተጠቀምከው/ሽው? (ከአንድ በላይ መመለስ ይቻላል)	1.ሄሮይን/ኮኬይን 2.ጫት

		3. ሀሺሽ/ማሪዋና 3.ቤንዚን 4.ሌላካለ ይገለጽ.....
130	የወሲብ ፍላጎትህ/ሽ እንዲጨምር እነዚን መድሃኒቶች/እጾች ተጠቅመህ/ሽ ታውቂያለሽ/ህ?	1.አዎ 2.አላውቅም
131	የትኞቹን መድሃኒቶች ነበር የግንኙነት ፍላጎትህ/ሽ እንዲጨምር የተጠቀምከው/ሽው?	1.ሄሮይን/ኮኬይን 2.ጫት 3.ህሽሽ/ማሪዋና 3.ቤንዚን 4.ሌላካለ ይገለጽ.....
132	የአልኮል መጠጦችን ተጠቅመህ/ሽ ታውቂያለሽ/ህ?	1.አዎ 2.ተጠቅሜ አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.136 ይለፉ
133	ለመጀመሪያ ጊዜ አልኮል ስትጠጣ/ጪ አድሜህ/ሽ ስንት ነበር?	.....አመት
134	አልኮል ከጠጣህ በኋላ ብዙ ጊዜ ወሲብ ታደርጋለህ/ሽ?	1.አዎ 2.አላደርግም
135	በአማካኝ ምን ያህል ጊዜ የአልኮል መጠጦችን ትጠቀማለህ/ሽ?	1.ሁልጊዜ(በየቀኑ) 2.ብዙጊዜ (ከ3-4 ጊዜ በሳምንት) 3.አልፎ አልፎ(ከ1-4 ጊዜ በወር) 4.በበአላት ጊዜ(በአጋጣሚ) 5.ሌላካለ ይገለጽ.....
136	ሲጋራ ታጨሳለህ/ሽ?	1.ሁልጊዜ(በየቀኑ) 2.ብዙጊዜ (ከ3-4 ጊዜ በሳምንት) 3.አልፎ አልፎ(ከ1-4 ጊዜ በወር) 4.በበአላት ጊዜ(በአጋጣሚ) 5.አላጨስም
ቀጣዮቹ ጥያቄዎች ወሲብ ነክ የሆኑ ወይም ወሲብ ቀስቃሽ ነገሮችን (ፖርኖግራፊክ ማቴርያልስ የምንላቸው ጋዜጦች÷ፊልሞች÷ስእሎች÷መጽሃፍትንና ቪድዮን ያመለክታል)		
137	ወሲብ ቀስቃሽ የሆኑ ፊልሞችና ስእሎችን አይተህ/ሽ ታውቂያለሽ/ህ?	1.አዎ 2.አይቼ አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.141 ይለፉ
138	እነዚህን ወሲብ ቀስቃሽ ፊልሞችና ስእሎችን ስታይ/ዩ ስንት አመትህ/ሽ ነበረ?	.....አመት
139	በአለፉት 6 ወራት ውስጥ ስንት ጊዜ ወሲብ ቀስቃሽ ፊልሞችና ስእሎችን አይተሃል/ሻል?	1.አላየሁም 2.ብዙ ጊዜ(ከ3-4 ጊዜ በሳምንት) 3.አልፎ አልፎ(ከ1-4 ጊዜ በወር) 4.በወር አንድ ጊዜ ብቻ 5.ሌላካለ ይገለጽ.....
140	የትኞቹን አይነት ወሲብ ቀስቃሽ ነገሮችን አይተህ ታውቃለህሽ? (ከአንድ በላይ መመለስ ይቻላል)	1.ጋዜጦች 2.ፊልሞችናቪድዮን 3.ስእሎችና ፎቶግራፎችን 4.ሌላካለ ይገለጽ.....

ክፍል-5 የታዳጊ ወጣቶች የስነ-ተዋልዶ ባህሪያት መረጃ

141	የፍቅር ጓደኛ አለክ/ሽ?	1.አንድ ብቻ የፍቅር ጓደኛ አለኝ 2.ከአንድ በላይ የፍቅር ጓደኞች አሉኝ 3.መልስዎ የለኝም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 144 ይለፉ
142	አሁን ካለክ/ሽ የፍቅር ጓደኛ ጋር ምን ያህል ጊዜ አብራችው ቆያችው?	.....እባክዎ ጊዜውን በአመት ከሆነ በአመት; በወር ከሆነ በወር; በሳምንት ከሆነ በሳምንት ይግለጹ

143	እስኪ ከፍቅረኛህ/ሽ ጋር ስላለህ/ሽ ግንኙነት ግለጽልኝ/ጪልኝ?	1.ባለቤቴ 2.ፍቅረኛ በአንድ ቤት የምንኖር 3.ፍቅረኛ በአንድ ቤት የማንኖር 4. ሌላ ካለ ይጠቀስ
144	የግብረ-ስጋ ግንኙነት አርገህ/ሽ ታውቂያለሽ/ህ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ ጥያቄ ቁ 145 ሰርተው እባክዎ ወደ ጥያቄ ቁ. 171 ይለፉ
145	የግብረ-ስጋ ግንኙነት ያላደረክበት/ሽበት ምክንያቱ ምንድነው?	1.ዝግጁስላልሆንኩ(በአእምሮ) 2. እርግዝና ስለምፈራ 3.የምፈልገውን አይነት ሰው ስላላገኘው 4.እድሉን አላገኘውም 5.በሽታ ስለምፈራ 6.በሃይማኖት/እምነቴ ስለማይፈቅድ 7.በቤተሰብ ተጽእኖ 8.እድሜዬ ገና ነው 9.ከጋብቻ በፊት ማረግ ስለሌለብኝ 10.ሌላካለ ይገለጽ.....
ከዚህ በመቀጠል ያሉት ጥያቄዎች በግብረ-ስጋ ግንኙነት ታሪክ ጋር የተያያዙ ስለሆኑ ለጥያቄ ቁ.144 አዎ ከሆነ መልስዎት ብቻ እስከ ቁ 169 ይመልሱ- *ካልሆነ ከ170 የቀጥሉ*		
146	በመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት የጀመርሽው/ከው በየትኛው እድሜሽ/ክ ነው?	እባክዎን እድሜዎትን ይግለጹ……..
147	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት አብርሃት/ሽው የፈጸምከው/ሽው ሴት/ወንድ እድሜ ልዩነት ምን ያህል ነው?	1. እኩያዬ ነው/ናት 2. ከእኔ በ10 አመት ይበልጣል/ጣለች 3. ከእኔ በ5 አመት ይበልጣል/ጣለች 4. ከእኔ ከ5 አመት ባነሰ ጊዜ ይበልጣል/ጣለች 5. በእድሜ ያንሳል/ሳለች 6. ሌላ ካለ ይገለጽ……
148	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት አብረሃት/ሽው የፈጸምከው/ሽው ከማን ጋር ነው?	1.ባሌ/ሚስቴ 2.እጮኛዬ 3.ፍቅረኛዬ 4.ጓደኛዬ 5.አብረን ነዋሪ/ጎረቤት 6.ዘመድ 7.መምህሬ 8.አላስታውስም 9.ሌላ ካለ ይገለጽ……
149	የመጀመሪያው የግብረ-ስጋ ግንኙነት ታስቦበት ነው ወይስ ሳያታሰብ?	1. ታስቦበት 2. ሳያታሰብ
150	የግብረ-ስጋ ግንኙነት ለመጀመሪያ ጊዜ ለመፈጸም ያነሳሳህ/ሽ ዋና ነገር ምንድነው?	1. በፍቅር 2.ተገድጀ/በመደፈር 3.ጋብቻ 4.ገንዘብ ለማግኘት/ድህነት 5.ለማወቅ ካለኝ ፍላጎት/ጉጉት/ለመሞከር 6.እድሜዬ/ደርሻለው ነው ብዬ ስላሰብኩ 7.ተሸውጀ ነው 8.በማያቸው ፊልሞች ተገፋፍቼ 9.ጫት/አልኮል ወስጀ ነበር 10.ስጦታ ስለተሰጠኝ 11.ጓደኞቼ ከፍቅረኞቻቸው ጋር ስለሚያደርጉ

		12.ሌላ ካለ ይገለጽ.....
151	መጀመሪያ ግንኙነት ከማድረጋችሁ በፊት ከፍቅረኛህ/ሽ ጋር ስለ እርግዝና መከላከያ ተወያይታችሁ ነበር?	1.አዎ 2.አልተወያየንም 3.አላስታውስም
152	ግንኙነት ስታደርጉ ፍቅረኛህ/ሽ ወይም አንተ/ቺ እርግዝና መከላከያ ተጠቅማችው ነበር?	1.አዎ 2.አልተጠቀምንም 3.አላስታውስም
153	የትኛውን አይነት እርግዝና መከላከያ ዘዴን ነበር የተጠቀማችሁት?	1.ፒልስ/የሚዋጥ እንክብል 2.ኮንዶም 3.መርፌ/ዲፖ 4.በክንድ የሚቀበር/ኢንፕላኖል 5.በመሃጸን የሚቀበር/አዩዲ 6.በተፈጥሮ የመከላከያ ዘዴ.....ይጠቀስ 7.ሌላ ካለ ይጠቀስ
154	ባለፈው አንድ አመት (12 ወራት) ውስጥ ግንኙነት አድረገህ/ሽ ነበር?	1.አዎ 2.አላደረኩም .መልስዎ አላደረኩም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 159 ይለፉ
155	በነዚህ ጊዜያት ከፍቅር ጓደኛህ/ሽ ጋር ምን ያህል ጊዜ እርግዝና መከላከያ ትጠቀማላችሁ?	1.ሁልጊዜ 2.አልፎ አልፎ 3.ብዙ ጊዜ 4.አንዳንድ ጊዜ 5.ተጠቅመን አናውቅም
156	በነዚህ ጊዜያት ከፍቅር ጓደኛህ/ሽ ጋር የትኛውን አይነት እርግዝና መከላከያ ዘዴን ነው የምትጠቀሙት?	1.ፒልስ/የሚዋጥ እንክብል 2.ኮንዶም 3.መርፌ/ዲፖ 4.በክንድ የሚቀበር/ኢንፕላኖል 5.በመሃጸን የሚቀበር/አዩዲ 6.በተፈጥሮ የመከላከያ ዘዴ.....ይጠቀስ 7.ሌላ ካለ ይጠቀስ.....
157	በአለፉት 12 ወራት ውስጥ ከምን ያህል ሰው ጋር የግብረ-ስጋ ግንኙነት ፈጽመሃል/ሻል?	1..... ፍቅረኞች 2. አልስታውስም
158	የግብረ-ስጋ ግንኙነት መፈጸም ከጀመርክ/ሽ ጊዜ አንስቶ ከምን ያህል ሰው ጋር ግንኙነት ፈጽመሃል/ሻል?	1..... ፍቅረኞች 2. አልስታውስም
159-160 ለወንዶች ብቻ የሚጠየቁ ጥያቄዎች ናቸው ሴቶች እባካችው እለፉት-		
159	ከሴተኛ አዳሪ ጋር የግብረ-ስጋ ግንኙነት ፈጽመህ ታውቃለህ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 170 ይለፉ
160	ከሴተኛ አዳሪ ጋር የግብረ-ስጋ ግንኙነት ስትፈጽም ኮንዶም ተጠቅመህ ታውቃለህ?	1.አዎ 2.አላውቅም
161-170 ለሴቶች ብቻ የሚጠየቁ ጥያቄዎች ናቸው ወንዶች እባካችው እለፉት-		
161	አርግዘሽ ታውቂያለሽ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.166 ይለፉ
162	ለመጀመሪያ ጊዜ ስታረግ እድሜሽ ስንት ነበር?	በአመት እድሜሽን ጻፊ.....
163	አርግዘሽ የምታውቂ ከሆነ ለስንት ጊዜ እርግዝና አጋጥሞሽ ያውቃል?	.....በባዶው ቦታ በቁጥር ግለጪ
164	አንዳንድ ጊዜ ድንገተኛ እርግዝና ሲከሰት እርግዝናውን ለማቆም/ለማጨንገፍ አንዲት ሴት ትወስናለች÷ አንቺስ እርግዝናውን ለማቆም/ለማስወረድ ወስነሽ አስወርደሽ	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ

	ታውቂያለሽ?	ወደ ጥያቄ ቁ.166 ይለፉ
165	አስወርደሽ ከነበረ ያስወረደልሽ ሰው ማን ነበር?	1.እራሴ መድሀኒት ወስጀ 2.በሀኪም 3.ሃኪም ባልሆነ ሰው 4.ሌላ ካለ ይጠቀስ.....
166	ዘመናዊ የሆኑ የእርግዝና መከላከያዎችን ተጠቅመሽ ታውቂያለሽ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ. 169 ይለፉ
167	መልስሽ አዎ ከሆነ÷ ምን አይነት የእርግዝና መከላከያ ነው የምትጠቀሚው?	1.ፒልስ/የሚዋጥ እንክብል 2.ኮንዶም 3.መርፌ/ዲፖ 4.በክንድ የሚቀበር/ኢንፕላኖል 5.በመሃጸን የሚቀበር/አዩዲ 6.ሌላ ካለ ይገለጽ.....
168	አሁን የእርግዝና መከላከያ እየተጠቀምሽ ነው?	1.አዎ መልስዎ አዎ ከሆነ እባክዎ የሚጠቀሙትን የእርግዝና መከላከያ አይነት ይጻፉ ..... 2. አልጠቀምም
169	የእርግዝና መከላከያ የማትተቀሚ ከሆነ ምክንያትሽ ምንድነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1.ብዙ ጊዜ የግብረ-ስጋ ግንኙነት ስለማላረግ 2.የትዳር/የፍቅር ጓደኛዬ ስለሚቃወም 3.ወላጆቼ ስለሚቃወሙ 4.ሃይማኖቴ ስለማይፈቅድልኝ 5.ስለ እርግዝና መከላከያዎች ግንዛቤው ስለሌለኝ 6.የእርግዝና መከላከያዎቹን ተከትለው ያሉትን የጤና እክሎችን ስለምፈራ 7.የጤና ባለሙያዎች ጥሩ አመለካከት ስለማያሳዩ 8.ያልታቀደ የግብረ-ስጋ ግንኙነት ስለነበር 9.የእርግዝና መከላከያውን በአቅራቢያ ስለማላገኝ 10.ሌላ ካለ ይገለጽ.....
170	በአባላዘር በሽታዎች ምክንያት ከሚመጡ የህመም ስሜቶች የትኞቹ አጋጥመውህ/ሽ ያቃሉ?	1.እንደ ዘር ፍሬዎች መቁሰል 2.የብልት ማሳከክ 3.መጥፎ ሽታ ያለው ፈሳሽ ነገር መውጣት 4.ሽንት ሲሸና የማቃጠልና የመለብለብ ስሜት 5. አላጋጠመኝም 6. ሌላ ካለ ይገለጽ.....

ክፍል-6 ከስነ-ተዋልዶ ጤና ጋር የተያያዘ መረጃ

171	የግብረ-ስጋ ግንኙነት በተመለከተ ተወያይተህ/ሽ ታውቃለህ/ሽ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.174 ይለፉ
172	ስለግብረ-ስጋ ግንኙነት ተወያይተው የሚያውቁ ከሆነ ከማን	1.ከቤተሰብ ጋር

	ጋር ተወያዩ?	2.ከጓደኞቹ ጋር 3.ከፍቅር ጓደኛዬ ጋር 4.ሌላ ካለ ይገለጽ……
173	የግብረ-ስጋ ግንኙነትን በተመለከተ በምን ያህል ጊዜ ይወያያሉ?	1.ሁልጊዜ 2.አልፎ አልፎ 3.ብዙ ጊዜ 4.አንዳንድ ጊዜ 5.ሌላ ካለ ይገለጽ……
174. በትምህርት ቤት/ከትምህርት ቤት ውጪ ቀጥሎ ስለተዘረዘሩት ተምረሃል/ሻል? 1.ስለ ወር አበባ ኡደት 1.አዎ 2. አልተማርኩም 2.ስለ ወንድ/ሴት የመራቢያ አካላት 1.አዎ 2. አልተማርኩም 3.እርግዝና እንዴት እንደሚከሰት 1.አዎ 2.አልተማርኩም 4.ስለ ወሊድ መቆጣጠሪያ ዘዴዎች 1.አዎ 2. አልተማርኩም		
175	ስለ በትምህርት ቤት/ሰፈር ውስጥ የወጣቶች/የስነ-ተዋልዶ ክለብ ትሳተፋለህ/ሽ?	1. አዎ 2.አልሳተፍም
176	ያልተፈለገ እርግዝናን ለማስወገድ የሚረዱ ዘዴዎችን ያውቃሉ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.178 ይለፉ
177	ያልተፈለገ እርግዝናን ለማስወገድ የሚረዱ ዘዴዎችን ካወቁ የትኞቹን መንገዶች ነው የሚያውቁት? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. መታቀብ 2. በግንኙነት ጊዜ የወንዱን ፈሳሽ ከሴቷ ብልት ውጪ በማፍሰስ 3.ፒልስ/የሚዋጥ እንክብል 4. መርፌ/ዲፖ 5. በክንድ የሚቀበር/ኢንፕላኖል 6.በመሃጸን የሚቀበር/አዩዲ 7.ሴቶች እንዳይወልዱ በሚደረግ ቀዶጥገና 8. ወንዶች እንዳይወልዱ በሚደረግ ቀዶጥገና 9. በኮንዶም 10.ከወር አበባ በኋላ ባለው ነጻ የግንኙነት ጊዜ በቀን መቁጠርያ በመጠቀም 11.ሌላ ካለ ይገለጽ……
178	በግብረ-ስጋ ግንኙነት ስለሚተላለፉ የአባላዘር በሽታዎች ሰምተህ/ሽ ታውቃለህ/ሽ?	1.አዎ 2.አላውቅም መልስዎ አላውቅም ከሆነ እባክዎ ወደ ጥያቄ ቁ.183 ይለፉ
179	የአባላዘር በሽታ ምልክቶች ምን ምን ናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1.ከብልት የሚወጣ ፈሳሽ 2.ሽንት ሲሸና የሚሰማ ማቃጠል/ህመም 3.በብልት አከባቢ የሚታይ ቁስለት 4.ምንም ምልክት አላውቅም 5.ሌላ ካለ ይገለጽ……
180	ስለአባላዘር በሽታዎች ሰምተህ/ሽ የምታውቅ/ቂ ከሆነ ከማን ነው የሰማሃው/ሽው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ከቤተሰብ 2. ከፍቅር ጓደኛ 3. ከዘመዶቼ 4. ከወንድ/ከሴት ጓደኛ 5. ከእኩያ ጓደኞቼ

		6. ከጤና ተቋም 7. ከሃይማኖት አባቶች 8. ከጋዜጣ ÷ፖስተር 9. ከሬድዮ 10. ሌላ ካለ ይገለጽ.....
181	አንድ ሰው እነዚህን የአባላዘር በሽታዎችን ለማስወገድ የሚያደርገው ዘዴ አለ?	1. አዎ 2. የለም ÷እባክዎ ወደ ጥያቄ ቁ.183 ይለፉ 3. አላውቅም ÷እባክዎ ወደ ጥያቄ ቁ.183 ይለፉ
182	መልስዎ አዎ ከሆነ÷ የአባላዘር በሽታዎችች ኤች አይ ቪን ጨምሮ ለማስወገድ በየትኛው ዘዴ እንችላለን? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በመታቀብ 2.ድንገተኛ የግብረ-ስጋ ግንኙነት በማስወገድ 3.ለትዳር/ጓደኛ አጋር ታማኝ በመሆን 4.በግብረ-ስጋ ግንኙነት ወቅት ኮንዶም በመጠቀም 5.ከሌተኛ አዳሪዎች ጋር ግንኙነት አለመፈጸም 6. ሌላ ካለ ይገለጽ.....
183	ስለ ኤች አይ ቪ ኤድስ ሰምተህሽ ታውቂያለሽ?	1. አዎ 2. አላውቅም
184	ስዎች እንዴት ኤች አይ ቪ ኤድስ ይያዛሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1.ጥንቃቄ በጎደለው የግብረ-ስጋ ግንኙነት 2.ከእናት ወደልጅ 3.በስለታማ ነገሮች 4.በደም ልገሳ 5.ቫይረሱ ካለበት ሰው ጋር በመሳሳም 6.ሰላምታ በመስጣጠት 7.እቃ በመለዋወጥ 8.በትንኝ በመነከስ 9.አላውቅም 10.ሌላ ካለ ይገለጽ.....
185	ወጣቶች እንዴት እራሳቸውን ከኤች አይ ቪ ኤድስ መከላከል ይችላሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1.መታቀብ 2.አንድ ለአንድ መወሰን 3.ኮንዶም መጠቀም 4.ስለታም ነገሮችን አለመዋዋስ 5.ኤድስ ከያዘው ሰው በየትኛውም ግንኙነት መራቅ 6.ሌላ ካለ ይገለጽ.....

ክፍል-7 የሃይማኖት ሁኔታ መረጃ

186	ወደ ቤተ ክርስቲያን/መስጊድ በአለፈው አንድ አመት ውስጥ ስንት ጊዜ ሄደሻል/ሃል?	1.ሁልጊዜ 2.አልፎ አልፎ 3.ብዙ ጊዜ 4.አንዳንድ ጊዜ 5.ሀይማኖት የለኝም 6.ሌላ ካለ ይገለጽ.....
187	ምን ያህል ጊዜ ትጸልያለህ/ሽ?	1.በየቀኑ 2.በሳምንት አንድ ጊዜ 3.አልፎ አልፎ 4.ጸልዬ አላውቅም 5.ሌላ ካለ ይገለጽ.....

ስለ ትብብርዎ በጣም አመሰግናለሁ!

ANNEX-3 Guide to qualitative study-FGD and In-depth interview

በአዲስ አበባ ዩንቨርስቲ÷ የጤና ሳይንስ ኮሌጅ÷ የህብረተሰብ ጤና ትምህርት ክፍል÷ የቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶችን ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች (15-18 እድሜ ክልል ውስጥ) ዙሪያ ለማጥናት የተዘጋጀ መጠይቅ

ጤና ይስጥልኝ ውድ ተሳታፊዎች!! ስሜ.....እባላለሁ: አጠገቤ የሚገኘው የስራ ባልደረባዬ ሲሆን ስሙም.....ይባላል:: ሁለታችንም በአዲስ አበባ ዩንቨርስቲ÷ የጤና ሳይንስ ኮሌጅ÷ የህብረተሰብ ጤና ትምህርትና ምርምር ክፍል ቡድን አባል ነን::

Please read the following as it is-

"**እርስ በርሳችን በአጭሩ ከተዋወቅን በሁዋላ ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች (15-18 እድሜ ክልል ውስጥ) የቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶችን እንነጋገራለን:: ጥናቱም የሚጠቅመው ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች የስነ-ተዋልዶ ጤና ዙሪያ ላሉት ችግሮች መፍትሄ ማበጀት ይሆናል:: በተጨማሪም በስነ-ተዋልዶ ጤና ዙሪያ ያሉትን አገልግሎቶች እና የትምህርት ፕሮግራሞችን ለማዘጋጀት ይጠቅማል::**

አሁን በሚኖረን ውይይት ሰዎች በቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶች ዙሪያ ስላላቸው ግንዛቤ መረጃ እንድናገኝ ይጠቅማል ብለን ተስፋ እናደርጋለን:: ለዚህም ውይይታችን የሚሆን አንዳንድ ጥያቄዎችን አነሳለው እናንተም በሚነሱ ጥያቄዎች ላይ ሃሳብ ትሰጡበታላችው::

በመጨረሻም ውይይታችንን የምናጠናቅቀው ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች በቅድመ-ጋብቻ የግብረ-ስጋ ግንኙነት ጅማሬ እና ተያይዘው ያሉ ምክንያቶች ዙሪያ እስከ ጋብቻ/ተገቢው ጊዜ ድረስ እንዲዘገይ የናንተን የመፍትሄ ሃሳብ በመቀበል ይሆናል::"

በውይይቱ ለመሳተፍ ፈቃደኞች ናችሁ? መልሳችሁ አዎ ከሆነ proceed!
አይደለም ከሆነ- አመሰግነህ/ሽ ውይይቱን እዚህ ላይ ይቁም::

ፊርማ.....(የውይይቱ መሪ ፊርማ የሚያሳየው የተሳታፊዎቹን የቃል ስምምነት ነው)

ቀን..... ሰአት.....

እርስ በርስ መተዋወቅ!! (AGE, SEX, EDUCATIONAL BACKGROUND)

ከመጀመራችን በፊት ሁላችሁንም ለመሳተፍ ስለፈቀዳችው እናመሰግናለን!!

የመጠይቁ መሪ ሃሳቦች-

1. **ያለ እድሜ ስለሚጀመር የግብረስጋ ግንኙነት ምን ታስባላችው? (ምክንያቶች መከላከያ መንገዶች እንዲሁም ውጤቶች ከግብረስጋ ገኙነት ባህሪያት በተገናኘ- ያልተፈለገ እርግዝና; HIV/AIDS የአባላዘር በሽታዎች እና ውርጃን ከሚያጋልጣቸው አንጻር)** ያለ እድሜ በሚጀመር የግብረስጋ ግንኙነት ከHIV/AIDS እና ሌሎች የአባላዘር በሽታዎች እንዲሁም ካልተፈለገ እርግዝና አንጻር አንዴት ታዩታላችው?
2. ያለ እድሜ በሚጀመር የግብረስጋ ግንኙነት አሉታዊ ተጽእኖዎች/ውጤቶች ተጠያቂዎቹ እነማን ናቸው?
3. በናንተ እይታ/አመለካከት **ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች** ያለ እድሜ ለሚጀመር የግብረስጋ ግንኙነት የሚያጋልጣቸው ዋና ዋና ነገሮች ምንድናቸው?
4. **ወላጆቻቸውን በተለያየ ምክንያት ያጡ ታዳጊ ወጣቶች** ከአኗኗር ዘይቤያቸው ጋር ማለትም (የእናት/አባት በህይወት ከመኖር አንጻር ከወላጅ;ዘመድ;አክስት;አጎት;አያቶች/አሳዳጊዎች ጋር መኖራቸው -የትምህርት ደረጃቸው(የአሳዳጊዎች እና የልጆች) -የኢኮኖሚ አቅም/ከኑሮ ደረጃ አንጻር ከግብረስጋ ግንኙነት ጋር በተያያዘ/ባላቸው ባህሪያቸው ምን ግንኙነት ይኖረዋል?)
5. ከሌሎች ትንዳኝ ሱሶች (ጫት;ሲጋራ;አልኮል;አደንዛ□ እጾች) ጋር ከጋብቻ በፊት የሚደረግ የግብረስጋ ግንኙነት ምን ተዛማጅነት ይኖረዋል? ከወሲብ ቀስቃሽ ፊልሞች/ጋዜጣ/ሳእሎች/ፎቶዎችስ አንጻር)?
6. የወንድ/የሴት ንደኛ/ፍቅረኛ የሚያዝበት ትክክለኛው ጊዜ መቼ ነው ብላችው ታስባላችው? (ከጋብቻ በፊት ስለሚደረግ የግብረስጋ ግንኙነት ጋር ይያያዛል ብላችው ታስባላችው?)
7. ከንደኞቻችው/እድሜ እኩዮቻችው ጋር ያለ እድሜ በሚጀመር የግብረስጋ ግንኙነት እና እስከ ጋብቻ ድረስ ስለመዘግየቱ የምታደርጉት የሃሳብ ልውውጥ ምን ሚና ይኖረዋል? (የአሳዳጊዎችስ ክትትልና ቁጥጥርስ?)
8. **ወላጆቻቸውን በተለያየ ምክንያት ያጡ ታዳጊ ወጣቶች** ያለ እድሜ በሚጀመር የግብረስጋ ግንኙነት እንዳይኖር እንዴት ይከላከላሉ? ከተፈጠረስ በኋላ ስለሚኖረው ውጤቶችስ ምን ያደርጋሉ?
9. የግብረስጋ ግንኙነት እስከ ጋብቻ ድረስ ለማዘግየት የሚያስችሉ ነገሮች ምንድናቸው? የግብረስጋ ግንኙነትን እስከ ጋብቻ ድረስ የማዘግየት ጥቅሞቹ (በተለይም **ወላጆቻቸውን በተለያየ ምክንያት ባጡ ታዳጊ ወጣቶች** እና ህብረተሰቡ አንጻር) ምንድናቸው?
10. በመጨረሻ **ወላጆቻቸውን በተለያየ ምክንያት ያጡ ታዳጊ ወጣቶች** ያለ እድሜ በሚጀመር የግብረስጋ ግንኙነትለማዘግየት እንዲሁም ተያይዘው የሚነሱ ችግሮችን ለማስቆም ምን የመፍተሄ እርምጃዎች ቢወሰዱ መልካም ነው ብላችው ታስባላችው? በስነ-ተዋልዶ ጤና ዙሪያ ምን አይነት የግንዛቤ ማስጨበጫ መንገዶች ቢኖሩ ትመርጣላችው? (የስነ-ተዋልዶ ጤና ትምህርት-ትምህርት ቤት/በተለያዩ ክለቦች/የወጣቶች ማእከል)?

በጣም እናመሰግናለን!!

Declaration

I the undersigned, declare that this thesis is my original work, has never been presented in this or any other university, and that all the resources and materials used for the thesis development, have been acknowledged as complete references.

Name: Meheret Tena
Signature: _____
Date of submission: _____

This thesis work has been submitted for examination with our approval as university primary advisor.
Name: Dr. Assefa Seme
Signature: _____
Date: _____