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STIGMA AND SILENCE IN SEXUAL REPRODUCTIVE HEALTH DIALOGUE: EXPLORING PSYCHOSOCIAL BARRIERS AMONG ADOLESCENTS AT ABOMSA PUBLIC SECONDARY SCHOOL

BY

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ACRONYMS AND ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome

ANOVA – Analysis of Variance

CSA – Central Statistical Agency [Ethiopia]

CVI – Content Validity Index

EDHS – Ethiopia Demographic and Health Survey

FGD – Focus Group Discussion

HIV – Human Immunodeficiency Virus

IDI – In-Depth Interview

IRB – Institutional Review Board

KII – Key Informant Interview

MOH – Ministry of Health [Ethiopia]

ODK – Open Data Kit

OR – Odds Ratio

QUAL – Qualitative (research component)

QUAN – Quantitative (research component)

SD – Standard Deviation

SDG – Sustainable Development Goal

SPSS – Statistical Package for the Social Sciences

SRH – Sexual and Reproductive Health

SSA – Sub-Saharan Africa

STI – Sexually Transmitted Infection

UNICEF – United Nations Children's Fund

WDA – Women's Development Army

WHO – World Health Organization

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Abstract

This research is intended to examine the overall psychological, social, spiritual, and cultural exposures regarding stigma and silence related to adolescents' sexual and reproductive health (SRH) dialogue in the given study area. When conducting this study, 58participants from diverse backgrounds and statuses, including adolescents, parents, community/religious leaders, and officials, participated and provided fruitful data by giving their honest and lived experience perspectives on the subject matter. To get the data, the researcher adopted in-depth interviews (IDI) and focus group discussions (FGD), and finally, the responses that were received were transcribed and analyzed using a thematic analysis approach.

Depending on the responses drawn from the respondents, the research found important conditions, such as the community discriminating and considering those who actively search for information regarding SRH as deviant. Apparently, boys, conversely, are not suffering this just because they are boys in nature but for other reasons. The attached stigma does not stop at individuals; it also passes through the family, ultimately discouraging discussion and creating a sense of fear. Adolescents face multiple psychosocial barriers, including fear of judgment and family shame; internalized shame (saalfii), peer ridicule and stigmatizing labels (*ijeedha, shaankiisadheera);* low self-efficacy; institutional failures (locked MHM rooms, nonfunctional clubs), and gendered norms that punish girls while exempting boys.

Keywords: Adolescent SRH, stigma, silence, psychosocial barriers, safuu, Arsi Oromo, Ethiopia, gendered social control

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ASSURANCE OF INVESTIGATOR

The below signature assured that the researcher and the prospective advisor had a consensus regarding the Research and Publication Directorate and/or School of Psychology at Addis Ababa University's prerequisites for the overall research's technical and ethical responsibilities accordingly.

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Members of the Board of Examiners of the Addis Ababa University Open Defense Examination are writing this to officially certify that, after critical evaluation and examination, which was conducted by Garuma Kekeba Elfata. We suggest that this thesis can be considered and formally accepted as completing the whole requirements to be included in the thesis for the Master's of Psychology (Social Psychology).

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CHAPTER 1: INTRODUCTION

1.1. Background

Global adolescent and reproductive health (SRH) communication was widely recognized as a protective factor that improves knowledge, delays sexual debut, and increases safe behaviors. However, research consistently shows that SRH dialogues between adolescents and adults remain severely limited due to embarrassment, cultural taboos, and fears that discussing sexuality will encourage early sexual activity (Castleton et al., 2025). A global thematic synthesis was found that parents across diverse regions, including Europe, Asia, and Africa, often avoid SRH discussion because they feel unprepared, fear moral consequences, or believe such conversations are inappropriate for young people (Usonwu et al., 2021). Teenagers, on the other hand, fear stigma and condemnation, which causes them to suppress themselves and turn to their peers or uncontrolled media for knowledge. This trend reflects more general psychosocial dynamics outlined in stigma theory (Goffman, 1963), where feelings of shame and fear of social categorization suppress free communication about sexuality. Crucially, these global trends show that stigma and silence were pervasive issues that need context-specific research rather than being exclusive to any one area.

Cultural norms, religious beliefs, and intergenerational hierarchies that frame sexuality as morally sensitive and unsuitable for discussion with young people had a significant influence on teenage SRH communication throughout Sub-Saharan Africa (Usonwu et al., 2021). According to Usonwu et al. (2021), parents in many African nations report feeling ashamed or morally torn about talking about SRH, which leads to communication that is rare, ambiguous, or restricted to hazard warnings rather than candid conversation. If they raise SRH inquiries, adolescents themselves frequently fear being called "spoiled," "immoral," or sexually active; this anxiety compels them to keep quiet and drives them toward peers or dubious media sources (Gizaw et al., 2025). Additionally, regional data revealed that health services were shunned by adolescents who dread being seen by familiar adults or being judged by providers, while teachers often steer clear of SRH themes because of fear of community backlash, lack of training, or personal discomfort (Usonwu et al., 2021). These obstacles are exacerbated by gender norms: boys may be deterred from showing vulnerability or seeking SRH care, while girls are subjected to stronger monitoring and moral judgment. When taken as a whole, these African studies show how deeply ingrained stigma, silence, and psychological challenges were in family structures, educational institutions, and community norms, supporting the necessity for context-specific research like the current Ethiopian study.

In Ethiopia, where young people between the ages of 10 and 24 make up almost 30% of the population, adolescent sexual and reproductive health (SRH) continues to be a top public health concern (Central Statistical Agency [CSA] & ICF, 2016). Adolescents still experience severe health issues despite major government initiatives like the Adolescent and Youth Reproductive Health Strategy (2016–2020) and school-based health programs. According to the 2016 Ethiopian Demographic and Health Survey (EDHS), 13% of women between the ages of 15 and 19 have started having children, and there is still uneven awareness of comprehensive HIV prevention strategies (CSA & ICF, 2016). These figures highlight the ongoing disconnect between policy goals and actual conditions, especially in rural and peri-urban areas such as the Arsi Zone.

Social discourse in the Oromia Regional State is heavily influenced by cultural and religious conventions, particularly when it comes to sexuality. The Arsi Zone offers a distinctive socio-ecological setting for teenage development, owing to its significant Islamic and Orthodox Christian influences, combined with Oromo aadaa (customary law) (Abera et al., 2015). In this context, deeply rooted traditions that link premarital discussion of sexuality to moral violation and familial disgrace frequently restrict free discourse on SRH (Tiruneh et al., 2016). As a result, the school setting, which was supposed to be a place of education and safety, often becomes a contentious arena where local sociocultural norms and national health curricula collide.

Stigma and silence were two potent, interconnected social control mechanisms. According to Goffman's (1963) groundbreaking research, stigma is a deeply damaging characteristic that transforms a person "from a whole and ordinary person to a tainted, discounted one" (p. 3). Adolescents may be stigmatized in SRH environments not only for having sex but also for just looking for information, leading to their labeling as morally reprehensible or deviant. To maintain current power structures and social hierarchies, this stigma promotes a culture of silence and general avoidance of conversation (Chandra-Mouli et al., 2015). For teenagers, this silence is an active, enforced state rather than a passive lack of speech that produces serious psychological hurdles, such as fear, shame, anxiety, and internalized guilt, which prevent them from seeking assistance or getting accurate information (Yadeta, 2018).

A crucial microcosm where these forces come together is found in high schools like Abomsa Public High School. Adolescents must balance the demands of both biological development and intricate social expectations from their peers, teachers, and the larger community.

Previous studies on SRH in Ethiopia have mostly concentrated on measurable results such as service consumption, HIV education, and the prevalence of contraception (Desalegn et al., 2022; Wudineh et al., 2018). These studies are useful, but they often ignore the communication and psychosocial mechanisms that drive these effects. In-depth qualitative research that examines how stigma is experienced and enacted, how silence is upheld, and the ensuing psychological consequences for teenagers in a culturally limited school context like Abomsa is scarce.

I was inspired to conduct this study by my extensive observations made while I was working around Abomsa Secondary School. I realized that the widespread problems of stigma and silence surrounding teenage SRH discourse are not coincidental and necessitate thorough research. In particular, there is an urgent need to investigate the psychosocial obstacles that prevent teenagers from freely discussing their sexual and reproductive health; this study seeks to close this gap.

1.2. Statement of the problem

Teenagers, particularly girls, are routinely suppressed when attempting to discuss sexual and reproductive health (SRH), according to my long-standing observations at Abomsa Secondary School. The severity of the issue is concerning: 13% of females between the ages of 15 and 19 have started having children nationwide (CSA & ICF, 2016), while the rate of teenage pregnancy in the Arsi Zone is 23.6%, far higher than the norm for sub-Saharan Africa (Dejene et al., 2025). Although 72% of parents in Asella town (Arsi Zone) are well-versed in SRH, only 23.1% of parents and adolescents really discuss SRH; the primary reasons for this are "shame/taboo" and "fear that it may initiate adolescents to sexual practice" (Kebede et al., 2022). Nearly 95% of young adults nationwide lack the self-efficacy abilities to preserve their sexual health, and over 90% have negative views toward SRH issues (Bitew et al., 2022). Despite 35% of young people participating in high-risk sexual behavior, only 8.7% of them seek SRH services (Bitew et al., 2022). There are dire repercussions: 42% of unwanted pregnancies result in abortions, and almost 75% of these are carried out in an unsafe manner (IPPF Africa, 2025).

Students at Abomsa Public Secondary School do not receive a consistent, culturally relevant SRH education in spite of these startling statistics. For fear of "encouraging immorality," educators and parents steer clear of SRH themes, and curious girls are silenced and called "promiscuous" due to "moral order" (Mekonnen et al., 2022; Usonwu et al., 2021). Prior

Ethiopian research has mostly overlooked the psychosocial aspects of stigma and silence in a traditional rural school setting like Abomsa in favor of quantitative outcomes (service utilization and knowledge levels). This project is to investigate the psychosocial barriers that prevent teenagers from openly disclosing SRH, as silence can result in misconceptions, anxiety, unwanted pregnancy, and unsafe abortion. The goal is to produce practical insights for culturally based, stigma-reducing interventions.

1.3. Objectives

1.3.1. General Objective

To explore the psychosocial barriers that contribute to stigma and silence in sexual and reproductive health dialogues among adolescents at Abomsa Secondary School, Arsi Zone, Oromia Regional State, Ethiopia.

1.3.2. Specific Objectives

To identify adolescents' perceptions of stigma related to SRH communication in school and influence the silence in SRH dialogues

To investigate the psychological and social barriers that may influence the silence in SRH dialogues.

To assess the role of gender, teachers, parents, and cultural norms in shaping the adolescents' unwillingness to engage in SRH discussion

To explore gender-based differences in SRH communication among adolescent students

1.4. Significance of the Study

This study has significant theoretical, practical, and policy implications. Theoretical significance: The study is expected to contribute to the body of knowledge on health communication and stigma by applying the theory in the specific socio-cultural context of the Arsi Oromo. Applications: The study results would aid in designing intervention activities for Abomsa Public High School to develop a specific, stigma-removing counseling and peer education program. Concerning the broader Arsi Zone health and education offices, the study results help design culturally friendly SRH programs for adolescents. Last but not least, the study aimed to help make the voices of adolescents, their parents, and community leaders audible by contributing to the widening of the silence cycle and ultimately improving adolescents' well-being.

1.5. Scope of the Study

The study was geographically scoped to Abomsa Public Secondary School and the surrounding community in the Merti woreda of Arsi Zone, Oromia. It places specific focus on adolescents aged 15-19 years; key community norm bearers and family or caregivers (elders and religious leaders); and institutional actors (health center, health office expert, and teachers) who shape their social environment. The result was context-specific, but transferable insight for similar agro-pastoralist communities of Oromia was obtained.

A key dilemma was the focus on psychological and community barriers rather than a broad assessment of SRH knowledge or clinical service provisions. Social desirability biases might have affected the response to sensitive topics, which this study addressed through a confident data collection procedure, triangulation of methods, and building rapport.

The study purposefully excludes out-of-school youth, primary school students, and health-service quality assessments in favor of focusing only on in-school adolescents aged 15–19 and important adult stakeholders within Abomsa town and its immediate rural kebeles. It also focuses only on psychosocial barriers of stigma and silence rather than clinical SRH outcomes or more general health-system factors, and it uses only FGDs, IDIs, and KIIs, leaving out longitudinal, observational, or experimental methods.

1.6. Organizations of the Thesis

This thesis consisted of five chapters. Following the introduction, Chapter Two reviews relevant theoretical and empirical literature. Chapter Three describes the research design and methodology. The findings from the qualitative data are presented and analyzed in chapter four. Finally, chapter five discusses the integrated findings, draws conclusions, and gives practical recommendations for policy and intervention.

1.7. **Concepts' Definitions**

Stigma: refers to a socially discrediting attribute that reduces a person "from a whole and ordinary person to a tainted, discounted one" (Goffman, 1963, p. 3). In the context of adolescent SRH, stigma is activated when young people – especially girls – seek or discuss sexual and reproductive health information, leading to labeling, social exclusion, and internalized shame.

Silence: According to Chandra Mouli et al. (2015) and Yadeta (2018), silence is an active, enforced state in which people avoid talking about SRH topics because they fear stigma,

judgment, shame, or punishment. It is a socially produced mechanism that maintains moral order and protects family honor.

Psychosocial Barriers: - Psychosocial barriers are interrelated psychological (internal) and social (external) factors that impede individuals from engaging in desired behaviors. (Munea et al., 2022; Usonwu et al., 2021).

SRH Dialogue (Sexual and Reproductive Health Dialogue): SRH dialogue refers to any verbal or nonverbal communication between adolescents and others (peers, parents, teachers, health workers) regarding puberty, body changes, contraception, pregnancy, menstruation, relationships, and sexually transmitted infections (WHO, 2020; UNESCO, 2018). It includes both formal (school lessons, health talks) and informal (friend conversations, secret chats) exchanges.

Adolescence: Adolescence, spanning the ages of 10 to 19, is defined by the World Health Organization as the period of life between childhood and adulthood. It is a period of rapid physical, cognitive, and psychosocial development, during which individuals begin to form sexual identities and relationships.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction to Related Literature

This chapter reviews the existing body of literature relevant to adolescent sexual and reproductive health (SRH) communication, with a particular focus on the psychosocial barriers of stigma and silence. It begins by examining the magnitude of the problem globally, in Sub-Saharan Africa, and specifically in Ethiopia and the Arsi Zone, highlighting key statistics and trends. The review then delves into the major psychosocial barriers—including sociodemographic factors, individual factors (shame, fear of judgment, and low self-efficacy), interpersonal factors (parent-adolescent communication, peer influence, and teacher attitudes), institutional factors (school environment and access to youth-friendly services), and community and cultural factors (taboos and gender norms) as documented in empirical studies. Subsequently, the chapter presents the theoretical frameworks that underpin this study: Goffman's stigma theory, Bronfenbrenner's social-ecological model, and cultural schema theory, demonstrating how each has been applied in similar research. Finally, the empirical framework of the study is outlined, showing how previous qualitative investigations

have shaped the present inquiry. By synthesizing these diverse sources, this literature review identifies the research gap that justifies the current exploratory qualitative study on stigma and silence in SRH dialogue among adolescents at Abomsa Public Secondary School.

2.2.Psychosocial Mechanisms Underlying Sexual and Reproductive Health Silence

International evidence highlights that the cultural norms and gender expectations deeply shape SRH communication. In many societies, sexuality is framed as morally sensitive, and discussing it openly is discouraged, especially for girls. The studies showed that adolescents fear being labeled "immoral" or spoiled if they ask SRH questions, reinforcing silence and limiting help-seeking behavior (Usonwu et al., 2021). In addition, the school environment also reflects these cultural constraints: teachers often avoided SRH topics to discuss due to community pressure or lack of training or awareness, whereas adolescents also perceived schools as a judgmental space rather than as a supportive one (Gizaw et al., 2025). These global patterns of stigma, silence, and psychosocial barriers were not unique to any one region but were spread challenges that required context-specific investigation, such as norms, religious beliefs, and intergenerational hierarchies that framed sexuality as morally sensitive in the present study in Ethiopia (Usonwu, 2021).

Parents in many African countries report feeling embarrassment or morally conflicted about discussing SRH, resulting in communication that is infrequent, vague, or limited to warning about absenteeism and danger rather than open dialogues. (Usonwu et al., 2021). Adolescents themselves often fear being labeled "spoiled," immoral, and sexually active; they ask SRH questions, which forces silence and pushes them toward peers or media for information. These patterns reflect broader African cultural expectations, which reflect broader African cultural expectations where respect for elders, sexual purity, and obedience, especially for girls, make SRH conversations socially risky and emotionally uncomfortable (Usonwu et al., 2021)

Regional evidence also shows that schools, peers, and health care providers play significant roles in reinforcing or challenging SRH silence. Although many African countries have adopted school-based sexuality education. Although many African countries have adopted school-based sexuality education, teachers frequently avoid SRH topics due to fear of community backlash, lack of training, or personal discomfort (Usonwu et al., 2021). Adolescents report that teachers are often judgmental or evasive, which discourages them from asking questions or seeking guidance (Gizaw et al., 2025). Fear of stigma also extends to health facilities, where adolescents worry about being seen by familiar adults or judged by

providers, especially in close-knit rural communities (Usonwu et al., 2021). Gender norms intensify these barriers: girls face surveillance and harsher moral judgment, while boys may be discouraged from expressing vulnerability or seeking SRH support (Usonwu et al., 2021). Together, these African studies demonstrate that stigma, silence, and psychosocial barriers were deeply embedded in family structures, school systems, and community norms, justifying the need for context-specific research such as the present study in Ethiopia (Gizaw et al., 2025).

The study showed that because of the cultural taboos, parental talk about sexuality and its concerns promotes early sexual behavior; due to this, teenage sexual and reproductive health communication was restricted throughout Ethiopia(Gizaw et al., 2025). The majority of teenagers have never talked about SRH with either parent, according to national research, and when they did, it's usually one-sided, moralistic, and warning-based rather than open or encouraging (Yadeta,2014). Ethiopian teenagers often cite low confidence, embarrassment, and fear of being judged as the main psychosocial obstacles to starting SRH interactions, particularly with adults (Munea et al., 2022). Due to cultural sensitivity, a lack of training, and a fear of community backlash, teachers also report avoiding SRH themes, which perpetuates silence in classrooms (Gizaw et al., 2025).

Gender norms further intensify these barriers, with girls facing stronger stigma and reputational risks when discussing SRH, leading to greater silence and lower service-seeking behaviors (Munea et al., 2022). Together, Ethiopian evidence shows that stigma, silence, and psychological social barriers are deeply embedded in family, school, and community structures, limiting adolescents' access to accurate SRH information (Yadeta et al., 2014). The study conducted in Oromia shows similar patterns with adolescents experiencing fear, shame, and cultural restrictions as major obstacles to SRH dialogues (Gizaw et al., 2025). In many oromian communities, discussing sexuality with young people is viewed as culturally inappropriate, and parents often believe SRH communities "spoil" adolescents or encourage sexual experimentation (Munea et al., 2022).

The study conducted in the Oromia region stated that teachers are judgmental or unapproachable, which is the main factor for restricting adolescents from asking questions about SRH in a school setup (Gizaw et al., 2025). Another strong psychosocial factor in school as well as out of school was peer pressure: fear of gossip, ridicule, or being labeled as "immoral" if they showed interest in SRH topics. (Yadeta et al., 2014). Gender norms and

stigma in the Oromia region placed strong restrictions on girls, who face stronger social control and stigma, which became the reason for being silent, decreased SRH service utilization, and lower health service-seeking behavior compared to boys (Munea et al., 2022). These localized or regionally specific fining highlighted the need for localization, cultutally sensitives approaches to SRH communication. Although limited published research exists specifically for Abomsa, studies from the Arsi Zone and nearby districts show that adolescents' experiences highlight very high levels of stigma and silence around SRH discussion.

In different local communities, SRH discussions are taken as taboos, and adolescents fear being labeled "badmannered" or sexually active if they ask questions about SRH topics (Munea et al., 2022). In the Arsi Zone, school environments were described as restrictive, with teachers avoiding SRH topics due to cultural expectations and fear of parental complaints (Gizaw et al., 2025). Adolescents report that they rely on their peers for SRH information, even though peers may provide inaccurate or incomplete guidance (Yadeta et al., 2014). Gendered expectations were particularly strong in Arsi, where girls face stricter social surveillance and greater reputational risk, leading to deeper silence and lower SRH service-seeking behavior (Munea et al., 2022). These local partners justify the need for the study in Abomsa Public Secondary High School, where psychosocial barriers such as stigma, fear, and silence likely shape adolescents' SRH communication experience.

2.3.Theoretical Review

Three crucial aspects in this study consider stigma and silence, which are the society's perceptions, and also their culture, shaped as well as significantly embraced at various times. Goffman's (1963) stigma theory recommends that adolescents become open and enthusiastic, which is known as "micro-interactional grammar." Consecutively, they will try to find solutions for their fear of stigma and control their rude personality in the form of formatting their browser histories and ensuring that they can keep silent and avoid gossip in society.

The other important model is Bronfenbrenner's Social-Ecological Model, which indicates that the processes and systems that contribute to stigma within society can happen in five stages. The intrapersonal level (internal) conceptualizes what the people in the Oromo region call Saffu, which literally means ritual impurity. The second one is interpersonal (external), which asserts what friends think, talk, and believe, and the students' families' strictness. The third one is at the institutional level. Unfortunately, it explains the context where teachers don't

raise the concept of contraception, which is important for students, due to the fear of society's judgment. The next level, which is the community level, encompasses respected Abba Gadda and leaders in various religions. The fifth and final level is the policy level, which is the highest level as it contains and assesses, revealing Ethiopia's national adolescent health strategy by contextualizing the local given community norms and values.

The third concept, which is named Cultural Schema Theory (Strauss & Quinn, 1997), is a fundamental prerequisite to understanding the cognitive aspects. It asserts that the cognitive models that the society accepts, including safuu, nyaachisuu (deference), and seera Oromo (customary law), direct the youths to think that discussing or explaining sexuality is totally unacceptable and destroying (Strauss & Quinn, 1997).

2.4.Empirical Review

The research's empirical framework is a totally qualitative design that aimed to deploy a constructivist paradigm to figure out the past, tangible, promising, and lived experiences of stigma and not talking in Abomsa Public High School. The targets of the study were adolescents, and to conduct this study, three main data collection tools were used, including in-depth interviews (IDIs), key informant interviews, and focus group discussions (FGDs). As per the principle of data saturation, in which the study does not need to gather information anymore once the researcher conveys that sufficient information is collected, it additionally used maximum variation purposive sampling with approximately 35 participants. The study consisted of different segments of society, including adolescents, parents, sector representatives, teachers, and community leaders, with the intention of gathering multidirectional views and perspectives on the topic. After the data is gathered, the next step is analyzing it. The best fit analysis for this research, which is reflexive thematic analysis, was applied. This analysis contains six stages, including data familiarization, coding, identification and development of themes, review, definition, and reporting.

In general, the research figured out and discovered different viewpoints, attitudes, perceptions, and personal suggestions in SRH among adolescents in the given study area, which are important for other practitioners, policymakers, and academia.

2.5.Psychosocial Barriers

2.5.1. Socio-Demographics

It was observed that adolescents' SRH communication systems and approaches are strongly shaped by their social and demographic statuses, which result from their family, physical environment, and the society in which they reside. The studies also showed that when adolescents are old enough, they are more likely to engage in SRH discussions than young adolescents, which helps us understand how age and maturity level matter and are determinants (Munea et al., 2022). As mentioned in other studies above, gender is also an exposure factor for girls, which makes them stigmatized, discriminated against, labeled, and feel isolated, which finally forces them not to ask when they face anything and not be willing to participate in SRH dialogue (Yadeta, Bedane, & Tura, 2014).

The educational status and awareness of one's family, as well, have a significant impact in this regard in the sense that if adolescents' families are knowledgeable, they will create an environment that is open and friendly for open SRH discussions and explanations (Munea et al., 2022). Regarding the social and demographic aspects of the respondents who participated in the studies done, in terms of their ethnic background, most of them are Oromo,comprising91%; others include Amhara, Tigri Dugassa, Fekadu, & Negash (2019). Religion is a major human identity indicator, and, in this research, different religious perspectives have been taken, including Sunni Islam (48%), Ethiopian Orthodox (38%), Protestant (11%), and indigenous Waaqeffata (3%).

2.5.2. Individual Factors

Shame

It is imminent that shame is a critical obstacle that damages the confidence, interest, and feelings that people, including adolescents, have concerning SRH, too. As the community has already considered girls innocent and polite, they are highly affected by shame (Munea et al., 2022). The consequence extends to low confidence and assurance when they want to ask and fear they will not be accepted. This emotional barrier reduces confidence and prevents adolescents from seeking accurate information.

Fear of Judgment

Basically, people prefer to be silent when they feel that they will be judged by their responses among the community, which is a huge way for adolescents to stay silent. Adolescents in various areas respond that they would rather choose not to raise questions about SRH, with

the reason that they will not be enforced, stigmatized, and unsupported by parents, teachers, and peers (Usonwu, Ahmad, & Curtis-Tyler, 2021). Obviously, this fear of judgment from others will limit them from searching for information by themselves and make them depend on others, which may not be reliable and valid.

Low Self-Efficacy

This concept determines most how adolescents are really able to have meaningful and straightforward discussions of SRH. Several research studies have discovered that self-efficacy in adolescents has a positive and supportive result, in which adolescents who have good self-efficacy are more likely to openly discuss SRH and vice versa (Munea et al., 2022). If someone has low self-efficacy, it is more associated with norms and cultures that support not discussing, and there are no encouraging systems of communication for adolescents.

2.5.3. Interpersonal Factors

Parent–Adolescent Communication Style

Empirical evidence witnesses that families in Ethiopia are not democratic most of the time. They want their children to feel fear and frustration, and this makes them feel uncomfortable unleashing their emotions and questions (Yadeta et al., 2014). Additionally, it is believed that it requires advanced SRH awareness and ideas to discuss, and the communication is conservative, tight, and unsupportive at all (Munea et al., 2022).

Peer Influence

As we all know, adolescents are highly pressured by their peers. Given this, their peers can contribute negatively by encouraging the stigma they face among the community regarding SRH. It is critical that at this stage, they likely hear and receive information from their friends. This happens due to the fact that they think adults don't understand their emotions and perspectives (Gizaw et al., 2025).

Teacher Attitudes

Teachers' discomfort, lack of training, and fear of community backlash limit school-based SRH communication. Ethiopian students report that teachers avoid SRH topics or deliver them in a judgmental manner, reinforcing silence (Gizaw et al., 2025).

Teachers in many school settings are not willing to openly discuss and argue about SRH because they don't feel comfortable, they don't get the desired technical training, and even if

they raise such a topic, they just label others, which ultimately makes the students keep silent rather than asking or seeking information about SRH (Gizaw et al., 2025).

2.5.4. Institutional Factors

School Environment

The impact that the school considers as values and norms has a profound effect on the willingness that adolescents show in SRH discussion. Schools in our country are evidence that propose keeping silent due to cultural background, having a crowded environment, and low teacher knowledge and skills (Yadeta et al., 2014).

Access to Youth-Friendly Services

Adolescents are still confused and afraid of asking in a smooth environment, as they don't want to be the center of attention of others and checked by their relatives or friends (Gizaw et al., 2025). They finally stop seeking support from others and go to other sources of information, which are not recommended and not formal, due to the discrimination they think they will face.

2.5.5. Community and Cultural Factors

Cultural Taboos

Normally, in our country as well as our continent, there is no safe environment that allows youths to clearly express their opinions regarding sexuality, which is not encouraging. Family and teachers perceive that discussing such issues will lead them down the wrong way of the future and finally expose them to be sexually deviant from the community (Usonwu et al., 2021).

2.5.6. Gender Norms

Whenever society exists, it has its own values, cultures, norms, rules, and unwritten laws that guide, shape, and influence it. Gender norms are also the major influencers and indicators of those who keep silent in SRH issues, in which the girls are most affected and stigmatized in this regard (Munea et al., 2022).

CHAPTER 3: MATERIALS AND METHODOLOGY

3.1.Introduction

This chapter presents the methodological framework employed to explore the psychosocial barriers of stigma and silence in adolescent sexual and reproductive health (SRH) dialogue at Abomsa Public Secondary School, Arsi Zone, Oromia Regional State, Ethiopia. The study adopted an exploratory, qualitative design (Yin, 2018), with the school serving as the bounded case and multiple subunits (adolescent boys and girls, parents, teachers, community and religious leaders, and government officials) embedded within it. The chapter describes the study area, including the socio-cultural and demographic characteristics of Abomsa town and the surrounding rural kebeles. It then details the purposive sampling strategy, the development and piloting of semi-structured interview and focus group discussion guides in Afaan Oromo and Amharic, and the procedures for data collection over a three-month fieldwork period. Subsequently, the chapter outlines the data processing and analysis plan, which follows Braun and Clarke's (2006, 2019) reflexive thematic analysis using NVivo software, and discusses the strategies employed to ensure trustworthiness (credibility, transferability, dependability, and confirmability) based on Lincoln and Guba's (1985) criteria. Finally, the chapter addresses ethical considerations, including informed consent, confidentiality, and the right to withdraw, all of which were rigorously observed to protect participants' rights and well-being.

3.2.The Study area

The Abomsa secondary public high school is geographically located in the Arsi Zone of the Oromia regional state of Ethiopia,220 km from the capital city of Addis Ababa, and holds a strong cultural identity under the guidance of the Gada system and Aadaa (customary law). Teaching and awareness of the Oromo customs, Islam, and Orthodox Christianity have a promising impact on Arsi's socio-cultural fabrics, shaping their norms about sexuality, communication, and teenage behaviors (Alemayehu, Haider, & Habte, 2020). Such techniques were unique, seeing speech is actively regulated by community values that respect the elders (Jaarsummaa), family honor (kabaja Abbootii), and social peace, especially when it comes to delicate subjects like sexual and reproductive health. Therefore, national educational curricula should negotiate local norms and taboos in a contextualized manner at Abomsa public secondary school and also in similar setups in the Arsi Zone.

Students attending their school at Abomsa Secondary School majorly commuted from nearby kebeles, where subsistence farming is prevalent, and the region's economy is typified by a mixed agro-pastoralist lifestyle (Central Statistical Agency [CSA], 2007). The population's school rural-urban interface with metropolitan media, formal health services, and contemporary views on sexualities. The school itself functions as the social arena, a hub where the information currents of contemporary education and the educational moral economy of the rural community converge to create a powerful and frequently contentious background for teenage growth and SRH discourse (Mekonnen, Dune, & Perz, 2022). Interpreting how stigma and silence were specifically expressed and enforced among teenagers at Abomsa Public Secondary School requires an understanding of this particular demographic and cultural co-influence.

3.3.Study Design

To inductively produce a culturally grounded understanding of how stigma and silence around SRH are produced, maintained, and negotiated with in the Arsi Oromo context, the study uses an exploratory qualitative study design in which Abomsa High School serves as the bounded case and several subunits (adolescent boys, adolescent girls, teachers, health experts and healthcare providers, parents, and community and religious leaders) are examined through semi-structuredFGD, KII, and IDIs.

3.4.Populations

The defined study population represents groups of students in a similar setup in Abomsa Secondary School and Arsi Zone, in which individuals navigate the intersections of biological maturation, formal education, and potential socio-cultural norms governing communications about sexuality. In the study area context, a specific choice of single school populations was an in-depth, context-specific study into how stigma and silence were socially constructed and experienced within a bounded, dynamic institutional setting, where peer influence, teachers'authority, and community expectations actively converged.

For the success of this study, different sampling frames were identified from the general population. The qualitative study was utilized for purpose-driven maximum variations sampling to recruit a strategically selected subgroup of adolescents aged from 15 to 19 years of age, ensuring representativeness across age, grade, gender, and religious and cultural background, from religious leaders and community representatives. Data were captured for

the wide spectrum of experiences. Such a multiphased nature in sampling ensures that the research achieves a distribution of identified psychosocial barriers.

3.4.1. Source Population

The source population for this study comprised all individuals enrolled in Abomsa Public Secondary School whose experiences, roles, or authority shape adolescent sexual and reproductive health (SRH) discourse. About 850 teenagers between the ages of 15 and 19 who were enrolled in grades 9 through 12 at the school during the 2025–2026 academic year, as well as their parents or guardians; teachers; school administrators; community leaders like Abba Gadaa and Haadha Siinqee; religious leaders from all major faiths (Sunni Islam, Ethiopian Orthodox, Protestant, and indigenous Waaqeffata); and government representatives from the Woreda Health Office and Youth Friendly Service, comprised this group. This wide source population was purposefully chosen to guarantee that the study could access a variety of viewpoints on stigma and silence, as well as to capture the multilayer influences on SRH communication from individual and interpersonal to institutional and community levels.

3.4.2. Study Population

The study population was considered to be the accessible part of the source population during the time period available for data collection (February 2026). This includes all teenage students enrolled in Abomsa Public Secondary School in the target age group at the time of this study, as well as the parents, teachers, and leaders in the community who are willing to take part. Though the source population defines the ideal population, it is important to acknowledge that study populations define the feasible population to be reached in the study. Perspectives such as absenteeism, availability, and willingness to be part of the study come into play.

3.4.3. Study Unit

The study unit was the individual participant from whom data was collected. In conducting qualitative analyses through interviews and focus group discussions, the main study unit is an individual adolescent, as well as parents, teachers, and leaders in the community. Each study unit is considered a distinct source of in-depth information regarding stigma and silence. The personal experiences of each study participant contribute to an overall thematic construct of psychosocial barriers within the school and community setting.

3.4.4. Data Adequacy

Following Malterud (2016), sample size adequacy in qualitative studies is guided by the concept of information power rather than statistical power. Information power is determined by five key items: (a) the aim of the study, (b) sample specificity, (c) the use of established theory, (d) the quality of dialogue, and (e) the analysis strategy. This study had a narrow and specific aim—to explore stigma and silence in SRH dialogue within a single bounded case (Abomsa Public Secondary School). Participants were purposefully chosen and stratified by gender, grade, residence, religion, and institutional role from a clearly defined enrollment zone, making the sample extremely specific. The study was grounded in established theory—Goffman's stigma theory, Bronfenbrenner's ecological model, and Oromo cultural schema theory, which provided a strong analytical framework. The researcher established rapport with the community through extended engagement, and semi-structured guides were pilot-tested and conducted in the local languages (Afaan Oromo and Amharic). As a result, the dialogue quality was good. The analysis strategy was cross-case thematic analysis (reflexive thematic analysis) that compares seven embedded subunits (adolescent boys, adolescent girls, parents, community leaders, religious leaders, teachers, and government officials). A cross-case analysis seeking variation across multiple subunits requires a larger sample than, for example, an in-depth single-case narrative analysis. Thus, while the narrow aim, high sample specificity, strong theory, and good dialogue reduce the needed number of participants, the requirement to capture meaningful variation across seven distinct stakeholder groups necessitates a larger sample. The final sample of 58 participants provided sufficient information to address all research questions, and the richness and repetitiveness of themes observed during analysis confirmed that no further participants were required.

3.4.5. Sampling size determination

Following Malterud (2016), sample size adequacy in qualitative studies was determined by information power; the more relevant information a sample holds, the fewer participants are needed. This study had a narrow, specific aim (exploring stigma and silence in one school); a highly specific sample (32 student IDIs equally distributed by language, gender, and grade; 4 FGDs with 6–8 adolescents each; 6 community IDIs including parents and traditional leaders; and 9 KIIs with government officials and religious leaders); a strong theoretical foundation (Goffman, Bronfenbrenner, and cultural schema); good dialogue quality (pilot tested, local language guides, and rapport built); and a cross-case thematic analysis comparing multiple subunits. The need to capture variation across diverse stakeholder groups (students by language/gender/grade, parents, community representatives,

officials, and religious leaders) and peer dynamics through FGDs requires a larger sample than a single group study. The total sample of approximately 51 participants provides sufficient information power, and theme repetition confirmed that no further data were needed.

The sample size is also consistent with comparable qualitative SRH studies in Ethiopia (Mekonnen et al., 2022, N=64; Gizaw et al., 2025, N=52) and was logistically feasible within the three-month fieldwork period. No further data collection was deemed necessary because the combination of information power and theoretical saturation (i.e., themes became clearly defined and repetitive) was judged sufficient by the researcher and advisor.

Table 1: Groups of participants in the data collection

S. No	Participant group	IDI	KII	FGD	Description
1	Adolescentsstudent	32		4	2 IDI from each grade of 9-12 for both Amharic and Oromo, and each FGD for both languages, and also two participants from disabled people of either gender, as well as both male and female adolescents, for a total of 48 participants, will be included here
2	Parents	2			Those students selected to participate in FGD will be requested to present their parents for IDI, in which one of the Afan, Oromo, and Amharic participants will be selected.
3	Community representatives	4			Abba gadaa, Hadhaa siinqee, women CBO leaders, and community elders
4	Religious leaders		4		Muslim, Christian orthodox, protestant, and wakefata
5	Governmental Sectoral Office		5		Woreda health office, YFS provider, club leader, teachers (2), women and child affairs office
		38	9	4	A total of 51 participants will be involved in this qualitative study by considering the field notes.

3.5.Eligibility criteria

3.5.1. Inclusion criteria

Adolescents between the ages of 15 and 19 who were enrolled in grades 9 and 12 at Abomsa Public Secondary School and who spoke Afaan Oromoor Amharic and talked about sexual and reproductive health issues, or adult key informants (teachers, parents, school staff,

religious leaders, abba gadaa, and haadha siinqee) who have lived in the Abomsa area for at least a year and frequently interact with or influence adolescents' SHR decisions.

3.5.2. Exclusion criteria

To ensure contextual and data quality, adolescents under the age of 15 or over the age of 19, out-of-school youth, individuals with severe cognitive or communication impairment that prevents informed assent or coherent discussion, and any student or adult who declines to provide consent or assent or whose parents refuse permission will be excluded. Additionally, adults who have lived around Abomsa for less than a year or who do not regularly interact with adolescents regarding SHR matters will not be recruited.

3.5.3. Variables

Given the exploratory nature of this study and the inductive analytical approach (reflexive thematic analysis), variables were not predefined as independent or dependent as in quantitative research. Instead, the concept of "variables" was treated as emerging themes that capture the psychosocial dynamics of stigma and silence. The central phenomenon of interest was communication restriction itself—the process by which adolescents are prevented from openly discussing SRH. These emergent variables were examined through the lenses of gender (boys vs. girls), generation (age grade levels), religion (Orthodox, Muslim, Protestant, and Waaqeffata), and experts' and local community structures' aspects. The inductive analysis to capture how stigma and silence vary across these social dimensions without imposing a priori causal assumptions.

3.5.4. Data Quality Assurance

All in-depth interviews (IDIs), key informant interviews (KIIs), and focus group discussions (FGDs) were conducted in private, participant-preferred settings (e.g., vacant school classroom, a health center office, or participants' homes). Each IDI lasted 30-40 minutes, KIIs 30-60 minutes, and FGDs 60-90 minutes. All sessions were audio-recorded using two smartphone recorders, supplemented by field notes. Semi-structured guides in Afaan Oromo and Amharic were developed from the theoretical frameworks, pilot-tested at Merti Jeju High School, and refined for clarity and cultural appropriateness. Participants were recruited through purposive maximum variation sampling: adolescent students were stratified by language, gender, and grade; parents, community representatives (Abba Gadaa, Haadha Siinqee, and elders), religious leaders (Orthodox, Muslim, Protestant, Waaqeffata), and government officials were identified through school and local administration contacts. Written

informed consent (or assent plus parental consent for minors) was obtained after a 24-hour reflection period. The researcher, a male Oromo master's student, acted as the primary data collection instrument; a female assistant was present during all interactions with female adolescents. The researcher engaged in prolonged community presence (two weeks before data collection), kept a reflexive journal to bracket personal biases, and conducted peer debriefing sessions with his advisor and a colleague to enhance credibility, dependability, and confirmability.

3.6.Data Processing and Data Analysis

In this particular qualitative research, the analysis phase utilized reflexive thematic analysis using the six-step process by Braun and Clarke (2006,2019). This, therefore, involves using an inductive constructive procedure in which the themes were developed inductively from the participants'discourse. The process involved verbatim transcripts in the two native languages (Afan Oromo/Amharic). The initial coding was done using the NVivo software program, involving the semantic meaning and latent meanings, while retaining the in-vivo codes (such as the nyaara haddatte). The codes are subsequently grouped under the possible themes, which were carefully evaluated before being defined. Triangulation of the methods/instruments: triangulation of data sources through multiple

The method of data collection would include analyzing information obtained from adolescents, parents, teachers, and other community leaders. Additionally, member checks would be utilized for validation of results in order to ensure their accuracy among participants. Triangulation of methods/instruments would further be applied for gaining in-depth analysis of the results based on various levels of the social-ecological model of individual, interpersonal, community, and institutional levels, along with specific reference to both Goffman's stigma theory and cultural schema theory.

3.7.Dissemination

The findings from this research were submitted to Addis Ababa University, School of Psychology. In addition, the finding was delivered to the ARSI Zone Education office and peer-reviewed journals in the field for publication, contributing to the existing body of knowledge. The findings will be presented at relevant conferences and seminars, providing an opportunity for discussion and feedback from other experts in the field, as per the opportunities available.

3.8.Ethical Considerations

The Addis Ababa University institutional review board first granted ethical clearance. All participants who were 18 years of age or older provided written informed consent, and adolescents between the ages of 15 and 18 years will provide written assent along with parental/guardian consent. Both forms will be bilingual in Afaan Oromo and Amharic. Pseudonyms, the elimination of identifiable location names, and password-encrypted audio and transcript storage will be used to protect confidentiality; field notes and final reports will not contain any names. Small refreshments given during FGDs won't be considered undue inducement, and participants were informed of their freedom to skip questions or leave at any moment without incurring penalties

CHAPTER 4: RESULTS

4.1.Introduction

The findings are organized into seven themes. Four themes directly address the research objectives: stigma as gendered social control (Objectives 1 and 4), the spiral of silence (Objective 2), sources of pressure to remain silent (Objective 3), and institutional and policy culture conflicts (Objective 3). Three additional themes emerged inductively from the data: trusted versus risky information sources, covert information-seeking strategies, and perspectives of traditional and religious authorities. These emergent themes capture unanticipated but important patterns that enrich the analysis and provide a fuller understanding of how adolescents navigate stigma and silence.

Table 2: Demography of the study Participants

Participant Category	Method	N	Gender	Age Range in years	Grade/Level of education	Language	Key Roles
Adolescent Students	IDI	32	16 Male / 16 Female	15–19	Grades 9–12	16 Afaan Oromo / 16 Amharic	Students at Abomsa Secondary School
Adolescent Students	FGD	24–32	Mixed (gender-separated groups)	15–19	Grades 9–12	Afaan Oromo & Amharic	4 FGDs (6–8 per group)
Parents / Caregivers	IDI	2	1 Male / 1 Female	30–50	Secondary to level four	1 Afaan Oromo / 1 Amharic	One from each language community.
Community Representatives	IDI	4	2 Male /2 Female	40–70	Elemntory	Afaan Oromo	Abba Gadaa, Haadha Siinqee, 2 elders
Religious Leaders	KII	4	4 Male	36–65	Secondary and above	Afaan Oromo & Amharic	Orthodox, Muslim, Protestant, Waaqeffata
Government Officials	KII	5	4 Male / 1 Female	30–50	All are degree holders	Afaan Oromo	Health, Education, Women and Children's Social Affairs, YFS, Teachers
TOTAL=IDI + FGD + KII =51							

4.2.Stigma as Gendered Social Control

The findings revealed that adolescent girls who openly sought or discussed SRH information were subjected to a range of stigmatizing labels. Female participants in focus groups reported that outspoken girls were called “Ijeedha” (forward), while the term “shaankisaadheeraa” (promiscuous girl) was used to imply moral deviance. Additional labels included “soqolattee” (loose woman) and “baalagee” (vulgar), and being described as “disgraceful” or a “crime” under Safuu. One female student explained, “If a girl asks about menstruation or how to avoid pregnancy, they call her shaankiisadheera.” The Haadha Siinqee confirmed that such girls are “looked down upon and condemned” and that openly seeking SRH information is “considered a crime, something very ugly that the people despise.” The

label highly encouraged girls to remain silent as they feared the social consequences of being shamed.

In contrast to the experience of girls and boys, participants consistently reported that boys face no significant stigma for discussing SRH topics freely. A female focus group participant stated that “with males, it’s normal to talk about sexuality and nothing is said about him even if head well.” Another girl added, “If the man says whatever he wants, nothing is considered. It’s considered his because he has the right.” Male students themselves acknowledge this double standard: one grade 11 boy noted,” As far as I know, stigma and silence were not affecting men as much….” Men don’t face problems.” According to the health expert's observation,” if a man speaks about or does whatever he wants, nothing is against him because he is a man.” Thus, male SRH talk was normalized, tolerated, or even encouraged, while identical behaviour in girls attracted severe public censure.

The stigma surrounding girls seeking SRH information affects them and their families more than it does men. The participants described how girls perceived moral transgression brought collective shame upon relatives and their parents. Haadha siiqqee explained that,” people will say, 'So-and-so's daughter got pregnant out of wedlock, and because of that her parents cannot look people in the eye within the community; they are completely humiliated. " One female student echoed this: "Nothing that a girl who asks SRH questions brings 'a massive negative impact on that girl's chance of getting married,' and the families' and the communities' perceptions of her become very low." A parent participant confirmed that “if the community hears, they will say, 'The daughter of so-and-so became like this,' and this brings a massive negative impact." Thus, the shame of SRH disclosure was not borne by the girls alone but also experienced as a familiar disgrace, reinforcing silence as a means of protecting family honor.

4.3.The Spiral of Silence – a dynamic and enforced phenomenon

Participants asserted that they would rather keep silent when SRH topics are raised among their peers, family, or other people because they know that they will be socially devalued if they openly discuss and recommend such topics. What one female student said made it clear and real. “I am concerned about what other people around me say and think about me. It is imminent that people will hear my secret. At the same time, the other grade 9 student underlined that ‘’ You know you prefer to be silent when you think about what I, how they will understand the context, and even they may bully or laugh at me, which is discouraging’’. The family influence to feel ashamed was another important point raised by the respondents.

One female participant described that '' Obviously, what I talk about today with my best friends will be heard by my family, as we are very close with each other, people worry about others''. Eventually, this will result in adolescents not disclosing their needs, confusions, emotions, and questions to others as they don't want to be stigmatized, rejected, and discriminated against by their family and community.

The research discovered that respondents use non-verbal indicators to show that they are happy with something or not feeling comfortable, and a female focus group participant noticed some students leave the class and feel ashamed. The teacher/club leader underscored that even the students feel discomfort and shame when SRH-related topics are discussed among them, which shows their mentality and feelings about it. One female student expressed that she gets confused and stressed when she tries to talk about it. All the above signs and feelings indicate that the students are in a position where they cannot openly discuss SRH topics that need awareness and capacity building to make them confident.

Another remark that the study came with is that adolescents prefer to talk about SRH outside of the school, so as not to be exposed to stigma and being judged. One female student noted that she always chooses not to discuss at school because if she does so, it is imminent that her secret will reach others, and then she feels uncomfortable continuing her friendship with others, as everyone has heard about what she said. Another option they adopt is using phones. A male student said To secure privacy and feel okay, secret chats are common''. Plus, they chat with hidden addresses on Telegram, including couples. We can understand from this finding that while school was supposed to be the place of comfort and knowledge of SRH, adolescents explained they prefer other places, such as off-campus settings, hidden places, and digital platforms, which help them feel well and far from the community stigma and discrimination.

The research revealed that Adolescents have some coded expressions which they use to talk about SRH that other people may not understand. One female student reminded that girls used to say that thing to come to indicate that she is in the menstrual cycle, and when they say this, they don't name it, but they easily communicate. Additionally, they may say 'Fonka' to express that he/she fallen in love. The Orthodox religious leader also gave his opinion that it is not common to discuss SRH as a culture, but it should be improved, as it is not important. This will result in conclude that such codes don't come accidentally, students don't prefer them for no reason, but the codes are the safe doors and roads where they student go through

to have free discussions about SRH topics which does no come up with stigma, judgement, and shame as only the owner knows about the conversations as they are coded and not easy for others to understand. These coded phrases allowed adolescents to communicate about sensitive SRH matters while maintaining a veneer of propriety, effectively circumventing the community's prohibition on direct sexual talk.

4.4.Trusted vs. Risky Information Sources

Generally, there are different ways that adolescents choose to acquire information on SRH and related issues. But the research revealed that adolescents go through three basic and important sources of information to grasp SRH information. Even though this is the time of globalization and technology, where social media has almost become our personality, the students explained that social media is their first-ever option to check any information about SRH. When we say social media, it includes many, but they specifically selected Facebook, WhatsApp, and Telegram over others. Regarding this, a female student expressed the following. "Why I choose social media is that if you share your thoughts, he/she may tell others unless it is someone you trust more. But social media is confidential. At the same time, the other respondent said that "I most of the time use ChatGPT as a source of information, as I trust it somehow."

On the other hand, a female student gave an idea that is contrary to the above one.

'' Why couldn't my friend be a source of information and take it as a secret since we never know what happened to her then?'' Formally, health professionals are a tangible and trusted source of information as they are professional, evidence-based, and skilled. During FGD, one among them recommended that ''we should consider them as reliable and foundational sources of information''. The Orthodox religious leader suggested that religion also supports consulting health professionals while keeping the religious aspect. Among the health professionals, female biology teachers and the Menstrual Hygiene Management (MHM) club teacher are taken as trusted sources among students rather than others. Another girl had a memory when she was in grade nine, the teacher used to advise them, allow them to share their feelings and challenges, and she would solve them, which is encouraging and gives the students hope and trust. Nevertheless, the teacher/club leader noticed that it is normal that sometimes students are not eager to ask, while the teachers are really interested in responding to their questions accordingly and politely, as they fell shame and shy to ask. The crucial point here is that the teachers are doing a great job, categorizing boys and girls and giving SRH

topics. The students found this important, and they thanked their teachers for doing this. Students should consider female biology and MHM club teachers as a way to get help, but what matters here is that the community norms and culture still limit them from openly asking what they want and taking the teachers as trusted sources of information.

Unfortunately, the research unveiled that the Family members, parents, and community elders are the one which make the students feel uncomfortable and feel ashamed to express their questions freely. As they judge and make them shy, they don't ask SRH information, and they even want to avoid them. One female focus group participant said Let us say a girl from this compound goes out and seeks information from others, the community does not have positive feelings toward her, which is discouraging''.

The research discovered that adolescents are using some invisible ways to get SRH information. They actually still suffer from society's blaming, but they try to avoid it. It is known that time is the power of social media, and then the students are adopting it as the first and foremost way to find SRH information. Amazingly, when they use WhatsApp and Telegram, they use a password-locking system, and they even want to hide their names and replace them so as not to disclose their privacy and communications to others, which gives them more comfort. One male participant expressed it as follows. "I am not even interested in letting them know what is going on, as we may communicate to the other person that we don't want others to know, which is our privacy." Additionally, they said that secret chats and coded language helped them to easily communicate secretly by securing their privacy. Sometimes, they use coded language to communicate with each other, like they say "the thing has come," to tell their friends that they are menstruating, which others may not understand. At the same time, they used to say "fonkaatu" when they fell in love with someone.

4.5.Covert Information-Seeking Strategies

Furthermore, they also use non-verbal communication, which is more common to show interest or acceptance than talking openly. The research identified that eye contact and holding hands are the most descriptive signs that unleash the student's romantic life. One male student noticed that they don't just communicate, they first see others' intentions, and then they look each other in the eye, and then they discuss and express their feelings non-verbally. In addition to this, friendship is also another important matter among them. They tell their feelings and whom you love to their friends, and their friends will tell that to the person loved.

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4.6.Sources of Pressure to Remain Silent (Ranked)

Apparently, family is the most crucial part of life that shapes, teaches, and supports adolescents socially, physically, emotionally, and spiritually. As they hear everything about their child, it is unfortunate that the research participants cited as a core reason for silence and fear regarding SRH.

One female student said, You know my family is my huge problem and pressure in this regard, and what I worry is they usually hear what I said at school''. A male student also reminded that he is more concerned about his family, as the result will not be good, and even if they consider that he is having a girl, they will understand from another view. The respondents agreed that the community was their pressure factor next to family. Their fears include social discrimination, an unsuitable marriage history, and people's talk.

The point they raised here is that it will not be good if one girl comes into the attention of the community when she seeks SRH information, she may not have a stable and long-lasting marriage, and may come up with negative attitudes from society. Peer influence and teachers' answers come after community pressure, having the third and fourth reasons consecutively. At adolescent age, peer pressure is highly effective as they tend to hear their friends discuss different issues. The research respondents described it in the form of laughing, being socially discriminated against, and being stigmatized. Let us see what one male student said to confirm this. '' You should ask them, as they will laugh and they even get surprised that you got the moral to ask, which is not fair. Far better, the teachers are doing a great job by teaching SRH-related lessons for boys and girls separately, which makes them feel free and not ashamed. Unfortunately, they responded that most of the students were not willing. The teacher/club leader responded, which shows the community's negative contribution in making students shy and unable to ask about what they don't understand; this effect should be improved.

4.7.Institutional and Policy–Culture Conflicts

The school environment is also among the challenges that can be considered critical barriers to students' SRH communication. The Menstrual Hygiene Management (MHM) room is not open currently, which was established with the intention of creating a friendly or smooth space for the girls to open up.

Moreover, health-related clubs are not actively engaging the students, and the supervisor agreed that discussions about health activities are not held with the intention of empowering the students; rather, they are just to say we conducted them and report to the higher officials.

CHAPTER 5: DISCUSSION

5.1.Introduction to the Discussion

This chapter discusses the key findings presented in Chapter 4 in relation to the study's theoretical frameworks (Goffman's stigma theory, Bronfenbrenner's socioecological model, and Oromo cultural schema theory), existing empirical literature, and the research questions that guided this enquiry. The study explored the psychological barriers, specifically stigma and silence, that shape an adolescent's sexual and reproductive health (SRH)dialogue at Abomsa Public Secondary School, Arsi Zone, Ethiopia. The findings from this study revealed that stigma operates through gendered labeling, that silence is actively enforced across multiple ecological levels, and that mechanism produces severe psychological, educational, and health consequences for adolescents as well as young people, particularly girls. Five well organized thames well oragnizd for this discussion: (1) gendered nature of SRH stigma, (2) the spiral of silence and its psychological mechanism, (3) consequences of silence, (4) Information source aand convert strategies, and (5) Institutional constraints and potential rupture points.

5.2.Gendered stigma as a Mechanism of Social control

5.2.1. The asymmetry of stigma: girls as targets, boys as exempt

One of the most striking findings of the study was the profound gender asymmetry in SRH stigma. Girls who sought or discussed SRH information were subjected to a rich vocabulary of derogatory labels- ijeedha(shameless, forward),shaankisadheera(promiscuous),soqolattee(loose),baalagee(vulgar), and being called" disgraceful" or a "crime" in contrast male participants consistently reported that boys faced no equivalent stigma; male SRH talk was described as "normal" a" right" and something that doesn't affect men much." the finding aligns with goffman's(1963) concept of the discrediting attribute" where a single characteristic(girl asking an SRH questions)becomes a master status that overrides all other aspects of her identity .for boys the same behavior carries

no discredit, instead it may even enhance their social standing(as one male student noted, they are considered" heroes").

This gendered double standard is well documented in sub-Saharan African SRH literature. Studies from Ethiopia (Munea et al,2022; Gizaw et al,2025), Ghana (Osunwu et al,2021), and Uganda (Nalwadda et al,2010) have consistently found that girls face stricter surveillance and harsher moral judgment than boys. This study extends fidingy by documenting the specific local terminologies used to enforce this symmetry in the Arsi Oromo context. The presence of multiple nuances has led the community to develop a sophisticated discursive apparatus for governing female sexuality.

5.2.2. Courtesy Stigma and Family Honour

According to the findings from the study, the stigma remains confined to the individual girl. Participants repeatedly described

Importantly, the stigma did remain confined to the individual girl. Participants repeatedly described how a girl perceived moral transgression disgraced her entire family. The haadha siinqee explained," People will say,' soandso's daughter got pregnant out of wedlock, ' and because of that, her parents cannot look people in the eye within the community; they are completely humiliated." This phenomenon corresponds to Goffman's (1963) concept of "courtesy stigma," where individuals associated with a stigmatized person also become discredited. In collectivist societies like Ethiopia, family honor is paramount, and a girl's behaviour is seen as a direct reflection of her parents'moral upbringing. Thus, the threat of family shame operates as a powerful mechanism of social control, silencing not only the girl but also her parents, who may preemptively restrict her access to information to avoid community censure. This finding resonates with research on honor-based cultures in the Middle East and South Asia (Vandelio and Cohen,2023), suggesting cross-cultural parallels in how female sexuality is regulated through familial reputation.

5.2.3. The spiral of silence: Mechanisms and Manifestations

5.2.3.1.Active self-silencing and Anticipated Stigma

The study found thas adolescent did not remain silent because they lacked questions or curiosity. Rather, they actively chose silence to avoid anticipated negative consequences. One female student captured this succinity. What will be said about tomorrow? My script will come out…. As I asked, they may insult me and make me for fun of me." This is a classic example

of what Link and Phelan (2001) call" anticipated stigma," the expectation that one will be negatively labeled, rejected, or discriminated against if one's stigmatized status becomes known. The adolescent had internalized the community's punitive attitudes toward SRH inquiry, and these internalizations produced self-censorship even before any actual punishment occurred.

This result is consistent with the "spiral of silence" theory (Noelle-Neumann, 1974), which holds that those who believe their opinions are different from the majority would keep quiet out of fear of being alone in the abomsa setting. The majority opinion, which is supported by peers, parents, and religious authorities, is that talking about SRH is morally risky and deplorable. The perception of a unified community norm against SRH speaking is reinforced when adolescents who may otherwise want to ask inquiries withdraw from public debate because they see themselves as a minority.

5.2.3.2.Visible signs of discomfort as embodied silence

A variety of nonverbal signs, including turning away, covering one's mouth, leaving the classroom, hiding beneath desks, and uneasy laughter, were all noted in the study as indicators of discomfort and avoidance. These outward manifestations are not accidental; rather, they reflect the body's reaction to expected feelings of guilt and anxiety. These embodied behaviors, according to Bourdieu (1977), are a type of habitus—deeply rooted tendencies that are picked up through socialization and turn into "second nature." Through continuous observation of how others respond to SRH themes, adolescents in Abomsa have learnt that withdrawing, hiding, or laughing uncomfortably is the proper body response. The culture of silence is further reinforced by these actions, which convey to instructors and peers that SRH subjects are risky.

5.2.4. Relocation and Coded Language as Resistance

Teenagers were not helpless victims despite the widespread silence. They came up with inventive ways to get knowledge and show interest without overtly going against social norms. Common tactics included utilizing password-protected phones to move conversations outside of school grounds, altering names on Telegram, and using coded language (such as "the thing has come" for menstruation and "fonkaatu" for love). These behaviors are examples of what de Certeau (1984) refers to as "tactics," which are the inventive, commonplace strategies used by subordinate groups to negotiate and undermine dominant power structures. Adolescents

might create covert venues (physical, digital, and linguistic) where information could flow even while they were unable to openly oppose the community's ban on SRH discourse.

The design of the intervention will be significantly impacted by this financing. Programmers should acknowledge that teenagers are already actively looking for information through unofficial means rather than presuming they are uninformed or reluctant to learn. By offering a secure, private, and kid-friendly digital platform (such as anonymous chatbots or moderated WhatsApp groups) that complements teenagers' preferred communication methods, interventions can expand on these current tactics.

5.3.Information sources: Trust, Risk, and the Avoidance of Family

5.3.1. The Paradox of Trust: Social Media Anonymity vs Family Risk

Because social media is anonymous, participants rated it as the most reliable source of SRH information. One female student clarified, "My secret is invisible to anyone else." This result is in line with global trends that indicate teenagers are increasingly using the internet to obtain sensitive health information (Guse et al., 2012). However, there are risks associated with relying on uncontrolled internet sources, including exposure to dangerous content, misinformation, and a lack of context.

The family was at the other extreme of the trust continuum. Elders in the community, parents, and even distant relatives were frequently identified as high-risk sources. It was believed that asking a family member about SRH would result in condemnation, humiliation, and sometimes even punishment. The idea that families are the main and most suitable source of SRH education is refuted by this study. The family is a place of risk rather than safety in the Abomsa context. This has significant ramifications for SRH programming: if parents are unprepared or reluctant to talk about SRH without stigma, therapies that depend on parent-child communication may be damaging or unsuccessful.

5.3.2. Health Extension Workers as Under-Utilized Allies

Although their use was restricted, health extension workers (HEWs) were mentioned as trustworthy and private sources. The instructor pointed out that there was no regular schedule for the school health service, only campaigns. Health professionals were accused by the parents of "sending them away by simply saying there is no medicine." Therefore, institutional hurdles (infrequent presence, dismissive attitudes, lack of youth-friendliness) restrict teenagers from accessing HEWs, even though they have the potential to be trusted partners.

The results thus demonstrate the necessity of ongoing, planned, and youth-friendly health care in or around schools.

5.4.Institutional Contradictions and Policy-Culture Gaps

5.4.1. The locked MHM room: symbolic vs actual support

Although the MHM room was physically present, it was locked, and only one teacher had the key. This represents a larger trend in Ethiopian school health programs: infrastructure and procedures are in place on paper, but they are only partially implemented. Numerous activities were carried out "for reporting purposes..." with the photograph supported, the supervisor acknowledged. This result is consistent with critical development literature that criticizes "performance" treatments in which real change is replaced by the appearance of activity (reports, photos) (Mosses, 2005). A secure safe area is completely ineffective for teenagers.

5.4.2. Government Policy vs Cultural Practice

A significant conflict arose between local cultural customs (early marriage, exchange marriage, gabbara) and government policy (which prohibits underage marriage and encourages females' education). Both the instructor and the health specialist explained how girls as young as 14 are forced into marriage against their will, frequently as a result of becoming pregnant. Teenagers receive conflicting messages as a result of this policy-culture gap: culture encourages early marriage, while policy advises staying in school. Policy will be ineffective without clear, culturally relevant interventions that involve community gatekeepers, such as religious leaders and elders. The Muslim leader's narrow-minded perspective suggests that religious diversity needs to be handled carefully, while the progressive position of the orthodox leader gives a possible route.

5.5.Points: where silence is Broken Rupture

The study found several "rupture points"—people and connections where teenagers might talk honestly without fear—despite the widespread stigma. These included the orthodox religious leader, health extension workers, progressive instructors who separated boys and girls during SRH lessons, a supportive mother, and longtime friends of the same gender. The design of the intervention depends on these rupture sites. Programs can find and assist current allies, giving them platforms, resources, and training to broaden their influence, instead of attempting to transform the entire community at once. For instance, the orthodox leader's support for medical referrals could be used to develop faith-consistent SRH programs that uphold religious principles and advance factual knowledge.

5.6.Theoretical contributions

5.6.1. Synthesis of Findings: The Stigma-Silence Spiral as an Emergent Framework

Based on the findings of this study, a coherent pattern emerged that integrates Goffman's stigma theory (1963), Bronfenbrenner's ecological model (1979), and Oromo cultural schema (Strauss & Quinn, 1997) into an emergent framework – tentatively termed the Stigma-Silence Spiral. This framework should be understood as a heuristic synthesis of the study's findings rather than a fully developed theory. It illustrates how stigma and silence operate as a self-reinforcing cycle across multiple ecological levels in the Arsi Oromo context.

The spiral operates as follows: first, a cultural schema (e.g., safuu, the belief that "talking spoils children") encodes the idea that SRH discussion is morally dangerous. Second, when an adolescent, particularly a girl, asks an SRH question, stigma is activated through labeling (e.g., ijeedha, shaankiisadheera). Third, this stigma extends to the family through courtesy stigma, threatening family honour and social standing. Fourth, anticipating this punishment, the adolescent engages in active self-silencing – hiding questions, avoiding adults, using coded language or digital platforms. Fifth, this silence reinforces the appearance of community unanimity against SRH talk, thereby strengthening the original cultural schema. The spiral is continuous: consequences such as unintended pregnancy, school dropout, or early marriage are interpreted by the community as proof that SRH discussion is dangerous, which further entrenches stigma.

This emergent framework offers a dynamic, multi-level explanation of how stigma and silence reproduce themselves over time. It also identifies potential intervention points, including challenging the cultural schema through trusted leaders (such as the Orthodox religious leader who distinguishes culture from religion), reducing anticipated stigma through confidential, youth-friendly information channels (e.g., health extension workers, moderated digital platforms, supportive teachers), and creating safe dialogue spaces within schools. Breaking the spiral at any level – cultural, interpersonal, or institutional – could interrupt the cycle and enable adolescents to access SRH information without fear of shame or punishment. However, it is important to note that this framework is tentative and emergent, derived from a single-case exploratory study; it requires further empirical testing and theoretical refinement through future research.

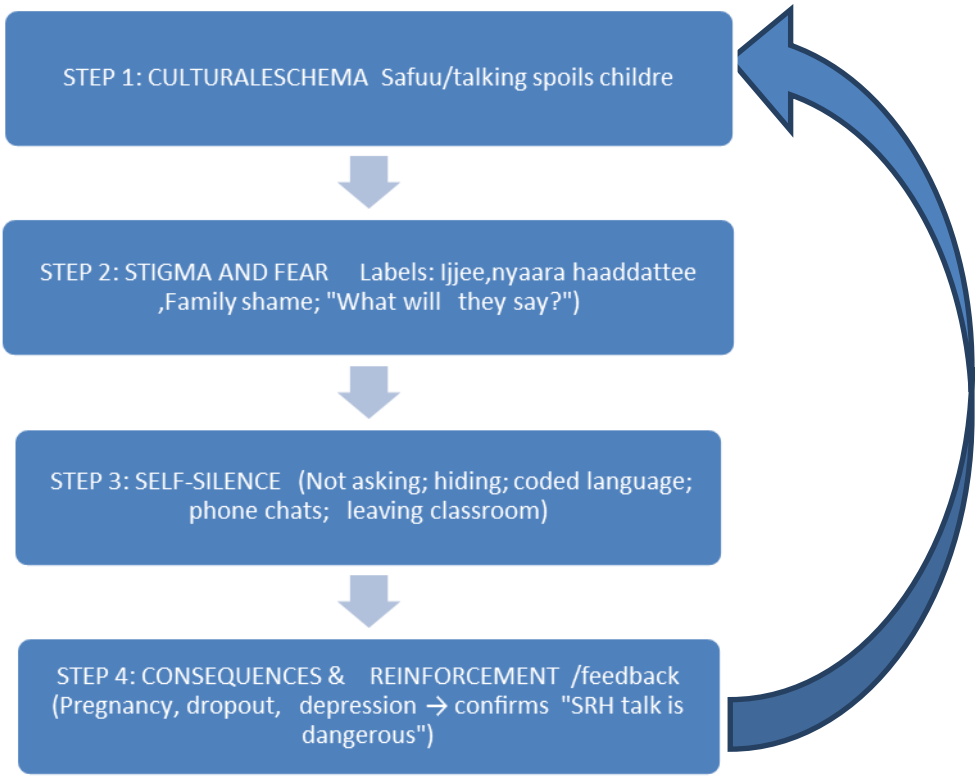


Figure 1: The "emergent stigma-silence spiral" framework

5.6.2. Extending Goffman to a Collectivist Context

Goffman's (1983) work focused primarily on individual management of spoiled identity. This study extends his theory by showing how stigma operates collectively in a collectivist society. The threat is not only to the individual 'sself-concept but also to the family's social standing. Thus, the intervention must address family and community levels, not individual attitudes.

5.6.3. Bronfenbrenner Practice

The finding vividly illustrates Bronfenbrenner's (1979) ecological levels: individual (shame, fear), interpersonal (peer gossip, teacher avoidance), institutional (locked MHM room, non-functionality of clubs like minimidia, MHM clubs), community (safuu, aadaa, religious teaching and policy government versus culture). This study demonstrates that intervention only taraging only one level (individual knowledge) are insufficient to achieve the lasting change required for coordinated action across all levels.

5.7.Comparison with Existing Literature

5.7.1. Consistency with Ethiopian and Sub-Saharan African Studies

The finding is very consistent with previous qualitative studies in Ethiopia. Mune et aI. (2022) and Gizaw et al. (2025) also found that shame, fear of gossip, and parental discomfort were major barriers to SRH communication. The present study adds to this literature by documenting the specific local labels (ijjee, ija hin fuunee, nyaara haaddattee) and by highlighting the role of safuu as a cultural schema that transcends individual attitudes. The finding that girls face harsher stigma than boys is also well supported by (Usonwu et al., 2021; Yadeta, 2018).

5.7.2. Divergence from Assumptions about Religion

Interestingly, the Orthodox religious leader's progressive stance -that culture, not religion, is the barrier- irevenges from assumptionthat allreligious leaders oppose SRH education. This result is consistent with previous research conducted in Ethiopia (Tiruneh et al., 2016), which demonstrates that religious leaders can be allies provided they are treated with respect. The Muslim leader's limited position, however, implies that religious diversity needs to be properly considered. Intervention must engage each faith group independently, drawing on internal, diverse, and progressive perspectives; it cannot be approached from a single religious perspective.

5.7.3. The silence -Harm Link

The specific instance of the Ethiopian Calendar's newborn abandonment in 2016 offers compelling proof that silence causes serious suffering. The current study adds a vertical, community-specific example that can be used in awareness campaigns to refute the notion that "talking spoils children," even though earlier research has demonstrated unwanted pregnancy and dropout (Desalegn et al., 2022).

5.8.Implication for Policy and Practice

5.8.1. School Level Interventions

Unlock the management room at Menistral High School, which is available to female teachers and members of student health organizations. To make it harder to identify menstruating girls, place the room next to the latrines rather than in a prominent location. Create active youth groups with frequent, student-led events for reasons other than reporting. teaches club advisors how to communicate without passing judgment.

Use age-appropriate, gender-segregated workshops to incorporate the SRH into the normal curriculum outside of biology classes. Teach all educators—not just those teaching biology—how to respond to SRH inquiries without feeling guilty or avoiding them. Establish a complete library with SRH books that students can browse without feeling stigmatized.

5.8.2. Community-Level Interventions

Engage traditional and religious leaders as allies. The orthodox leader's endorsement of health referrals should be amplified through community dialogues. For Muslim communities, work within thesheri'ah framework to identify permissible ways to discuss SRH (eg. Framing it as protecting health for marriage. Use art-based methods (drama, poetry, comedy) to change the myth that "talking spoils children." The parent participants explicitly recommended this approach. Target elders, clan leaders, and haadha siinqee with awareness programs that acknowledge safuu while presenting evidence that silence leads to harm (e.g., the 2016 of ethioipian calander inftant abandonment case)

5.8.3. Family Level Interventions

Create a parent education program that dispels the myth that SRH conversations promote sexual activity. To demonstrate different strategies, use language from the parents of positive outliers (such as the mother participant who freely counsels her kids). Create parent education initiatives that dispel the fallacy that talking about SRH promotes sexual activity. To illustrate different strategies, use the stories of positive outlier parents (such as the mother participant who freely counsels her kids).

Give parents communication scripts that respect cultural conventions while yet offering vital information.

Instead of just sporadic campaigns, establish a regular school health schedule (e.g., every Tuesday afternoon) with a youth-friendly health extension worker.

The health facility should maintain the medical stock and ensure that the service and logistical availability at any service is demanded time

5.8.4. Digital Intervention

Leverage adolescents' existing use of social media by creating moderated, anonymous whatApp ot Telegram groups where youth can ask SRH questions without revealing their identity

Develop a local language chatbot (Afan Oromo/Amharic) that provides accurate SRH information with links to youth friendly service.

5.8.5. Strengths and Limitations

5.8.5.1.Strengths

Rich, contextual data from multiple stakeholders (students, parents, teachers, health workers, health experts, traditional leaders, religious leaders) provided triangulation and depth.

Theoretical grounding in Goffman, Bronfenbrenner, and Cultural Achema theory allowed a systematic interpretation of findings.

Concrete example (infant abandonment) provide power evidence for advocacy

5.8.5.2.Limitations

Generalizability to other Ethiopian contexts is limited by a single-case design (one town, one school). Transferability to comparable rural and peri-urban settings, however. Thick description could create an environment that is culturally conservative.

Responses may have been influenced by social desirability bias, especially Haadha Siinqee's statement that "no problem left." This was lessened by the triangulation of teenage data. Despite having a female assistant, the researcher's gender (male) might have deterred some female participants from speaking candidly. The depth of the FGD and IDI data, however, indicates that this was not a significant obstacle.

While longitudinal research tracks changes over time, cross-sectional designs provide a snapshot.

Although field notes from the MHM room were included, there was no observational data on real parent-child or teacher-student interactions.

CHAPTER 6: CONCLUSION AND ECOMMENDATIONS

6.1.Conclusion

This study provides a thorough, multilateral understanding of as psychosocial barriers to SRH conversations among teenagers at Abomsa Public Secondary School in Ethiopia's Arsi Zone. The results show that stigma is strongly gendered, with boys suffering no comparable repercussions while girls are subjected to a wide range of disparaging designations. Family pressure, rumors in the community, mockery from peers, and institutional features (such as locked MHM rooms and dysfunctional clubs) all actively enforce silence. Silence has serious repercussions, including psychological suffering, school dropout, unwanted pregnancy, unsafe abortion, home birth, infant abandonment, and early marriage.

Importantly, rupture points, reliable friends, encouraging mothers, progressive educators, health extension agents, and orthodox religious leaders who provide avenues for intervention were also found by the study. A theoretical framework for comprehending how stigma spreads throughout the ecological level is provided by the emerging Stigma-silence Spiral model. It is feasible to break the cycle and establish a setting where teenagers can obtain the SRH knowledge they require to develop into healthy adults by addressing all levels at once, from personal shame to societal norms (safuu) to policy-culture gaps. knowledgeable grownups. A community-based action plan is being established to implement the findings, which have been shared with Abomsa's school administrators, health officials, and community leaders.

It is feasible to end the cycle and establish a setting where teenagers can obtain the SRH knowledge they require to develop into knowledgeable, healthy adults. A community-based action plan is being created to put the recommendations into practice after the findings were presented to Abomsa's school administrators, health officials, and community leaders. In the end, this study adds to the worldwide endeavor to guarantee that no adolescent is denied access to sexual and reproductive health information, which is a basic right and a requirement for accomplishing the Sustainable Development Goals.

6.2.Recommendations for Future Research

For Schools

Unlock and make the Menstra Hygiene Management (MHM) tool functional and available at any time

- Unlock and make functional the Menstrual Hygiene Management (MHM) room; locate it near latrines to reduce stigma.
- Revive active, student-led health clubs (e.g., Mini-media, MHM clubs) with regular, not just reporting-based, activities.
- Train all teachers (not only biology teachers) in non-judgmental, age-appropriate SRH communication; continue gender-segregated sessions.
- Create confidential safe spaces such as anonymous question boxes and a school library with accessible SRH books.

For Families

Develop parent education programs that debunk the myth that “talking spoils children” using testimonials from positive outlier parents.

- Provide parents with culturally respectful communication scripts to discuss SRH without violating local norms.

For Community & Religious Leaders

Engage traditional leaders (Abba Gadaa, Haadha Siinqee) and progressive religious leaders (e.g., Orthodox) as allies in community dialogues.

- Use art-based methods (drama, poetry, comedy) and real-life cases (e.g., 2016 infant abandonment) to challenge harmful norms like safuu and exchange marriage (gabbara).

For Health Services

Establish a regular, weekly youth-friendly health service schedule at school, not just intermittent campaigns.

- Train health extension workers on confidential, non-judgmental adolescent care.

For Digital Interventions:

- Create moderated, anonymous WhatsApp or Telegram groups and a local-language chatbot (Afaan Oromo/Amharic) for confidential SRH information.

For Future Research:

- Conduct interventional research testing the "Stigma-Silence Spiral" model.
- Use longitudinal and observational methods to track changes over time.

For Policy Makers:

- Enforce anti-child marriage laws at the local level, specifically targeting gabbara (exchange marriage) that forces girls into early marriage after pregnancy.

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Appendix A: Consent Form

I, _____, hereby permit to take part in the qualitative study "Stigma and Silence in SRH Dialogue among Adolescents at Abomsa Public High School," which is being carried out under the direction of Professor HaptamuWondimu by graduate student GarumaKekebaElfata at Addis Ababa University, School of Psychology. This study aims to investigate how adolescent sexual and reproductive health discussions in our community are impacted by stigma and silence. I am aware that my participation will consist of a single 30- to 40-minute audio-recorded interview or focus group discussion in Afaan Oromo or Amharic. Your involvement in the study is completely voluntary; you may decline to respond to any questions or leave at any moment without incurring any fees or losing any advantages. Your identity will be replaced with a code by the researcher, and all recordings and transcripts will be stored in password-protected files before being destroyed after five years. Reports and publications won't contain any identifying information. The results may aid in the creation of stigma-free health programs for youth in Arsi Zone, even if I won't get paid directly. I understand that talking about delicate subjects could be a little uncomfortable, and if I'm upset, AbomsaHealth Center has a certified counselor on hand. I am also aware that the researcher is required by law to report any sexual abuse event to the Women and Children's Affairs Office in an anonymous manner.

I fully agree to participate----------Date----------

Appendix B: IN-DEPTH INTERVIEW (IDI) GUIDE FOR ADOLESCENTS

Section A: Opening & Context

1. Tell me a bit about yourself, your grade, what you enjoy at school, and what you do outside of school
2. How would you describe the general social environment among students here? What are the unspoken rules about what is okay and not okay to talk about SRH Issues?

Section B: Mapping the Landscape of SRH Communication

3. Think about topics related to growing up, body changes, relationships, or sexual health. How are these topics generally treated in conversations here at school?
4. Can you tell me different ways your peers might come across information on these topics? (e.g., from friends, teachers, books, phones, health club)
5. Among these sources, which feels the most accessible to you ? which you feel the most trustworthy? Why is there a difference?

Section C: Deep Dive into stigma perception and experience

6. If the students at Abomsa High School were known to be actively seeking information or asking questions about SRH, what words or labels might get attached to them by their students? By teachers, by the community? Probe: Can you give me specific examples of the terms you ‘ave heard
7. By the community? Probe: Can you give me specific examples of terms you've heard? (e.g., shaankiisadheera, lafaba'aa, 'spoiled'). What do those terms imply about a person's character?
8. Describe a specific situation you have witnessed or heard about someone who faced negative treatment, gossip, or examination, because of something related to SRH. Prob: who was involved? What exactly happened? What was the consequence?
9. How does the fear of being judged in this way shape students' actual behavior? For example, does it change how the fear of being judged in this way shape studens aculayy do? For example, does it change where they go, whom they talk to, hey questionsthey ask?
10. In your view, is the experience of judgement and fear different for boys and girls? How? Differ for boys and girls? How so?

Section D: Exploring the Mechanics of Silence

11. Silence isn't just not talking. What are the visible signs of this silence in the classrooms, hallways, or among friends when an SRH comes up? (prob: for behaviours: changing subject, nervous laughter, looking away from the room, etc)

12. When you have a question but decide to ask the question openly, what are the main reasons? Is it more about your own internal feelings, like shame or embarrassment, or about external consequences (like punishment or gossip)?

13. Are there hidden or creative ways that students here get information despite the silence? e.g., secret chats, coded languages, trusted confidences)

Section E: Sources of Stigma & Visions for Change

14. Think about your family, school, and family-which groups or institutions do you feel apply the strongest pressure to stay silent on these topics? Why them?

15. If you could redesign one thing about how this school handles SRH information to reduce fear and stigma, what would you change first?

16. Is there anyone in your life- a specific person, whom you feel you could talk to about thesethings with out fear? What makes that person different?

Section F: Closing&Member check

Is there anything important about this topic that we haven't discussed that you feel I should understand?

Thank you. Your insights are invaluable.

Appendix C: FOCUS GROUP DISCUSSION (FGD) GUIDE FOR ADOLESCENTS (MALE AND FEMALE IN SEPARATE GROUPS)

Participants codes	Gender	Age(Years)	Grade	Language	Residence(Rural or Urban)
01					
02					
03					
04					
05					
06					
07					
08					

Part 1: Introduction & Ground Rules

Explain the purpose of m confidenciality with in group, respect for all opinions, and use of pseudonyms.

Icebreaker: "Let's go around and say your favorite subject or hobby.

Part 2: Exploring Shared Perceptions

1. As a group, how would you describe the common attitude in our community to ward yound peoples discusiing topics like relationships, puberty, or contraceptives?
2. Imagine the student from another asked you, " What's the riskiest thing about asking an SRH question at Abomsa Secondary School? What would tell him/her?
3. Simulus question:" I have heard some students use terms like (mention a mild, common term you haven't heard when talking about peers interested in

Part 3: Group Dynamics & Norms

4. How do friends' groups here enforce the rules about cab can't be talked about? What happens if someone breaks those rules? SRH haven/t heard when talking about peers'interests
5. Is there a difference between what is said publicly in the classroom and what is shared privately among close friends? Can you give me an example?
6. How do teachers usually react when an SRH topic comes up in class (in biology)? Does their reaction set a tone for students?

Part 4: Collective Coping & Solutions

7. Despite the challenges, where does accurate information still manage to flow? What are the workarounds?
8. If this group could give one piece of advice to the school administration to make things better, what would it be?
9. In one word or short phrase, how does the culture/norm/religion/Community customs around talking about SRH here make you feel?

APPENDIX D: KEY INFORMANT INTERVIEW (KII) GUIDE FOR PARENTS/CAREGIVERS

APPENDIX D: KEY INFORMANT (KII) GUIDE FOR PARENT/CAREGIVER

PART 1: INTRODUCTION AND GROUND RULES

Good morning/afternoon. Thank you for taking the time to join us today. My name is

_____ from Addis Ababa University, and I am conducting a study to understand batter how families and the community in Abomsa can best support the health and well-being of our adolescents.

Today we are having a conversation – there are no right or wrong answers. We want to hear your honest opinion and experiences. Everything said here is confidential. We asked that what is shared in this room stay here to protect everyone`s privacy.

Please speak one at a time and respect each other`s views. We will record the discussion to ensure we don`t miss any of your valuable points, but your names will never be used 0908295406

PART 2: WARM-UP: PERCEPTION OF ADOLESCENCE

1. Thinking about teenagers today compared to when you were their age, what would you say are the biggest 'challenges' they face growing up in Abomsa and around the community

Probe: social challenges? technology? Education pressure?

2. What are your biggest 'hopes and fears' for your child during their teenage years?

PART 3: EXPLORING COMMUNITY NORMS '' THE SILENCE''

3. In our community, there are certain topics that families talk about openly and others that are more private. Where would topics like body changes, relationships, marriage, and sexual health fall on that spectrum? Why is that?
4. There`s a common saying, `if you talk to them about these things, you will spoil them. As a group, what are your thoughts on this belief? Where does it come from?

Probe: is about protecting innocence or fearing the consequences of all knowledge?

5. What are the unwritten community rules ('aadaa') or expectations regarding how parents should guide their adolescents on matters of sexuality and relationships?

Probe: Is direct conversation expected? What is the role of modelling behaviour, warnings, or proverbs?

6. If a parent in this community was known to have open, direct conversations about SRH with their teenage child, how might other community members view that parent?

Probe: Would they be respected, criticized, or seen as irresponsible?

PART 4: PARENTAL DILEMMAS AND BARRIERS

7. Let`s talk about the experience of talking to your child. What makes having a conversation about these topics with your own adolescent difficult or uncomfortable for you?

Probe for specific barriers: lack of knowledge/ words, shame (‘saalfii’), fear of encouraging curiosity, generation gap, not knowing where to start.

8. Who or what do you fear would judge you if you were more open? (e.g., other parents, religious leaders, elders, the school, your own spouse/extended family).
9. How do you navigate the difference between what you feel your child needs to know for their safety and health, and what you feel is culturally appropriate to say?

probe for negotiation strategies: using indirect messages, relying on the school, using same-gender parent.

10. Do you think mothers and fathers face different challenges or have different responsibilities in the conversation? How so?

PART 5: LOOKING FOR SOLUTIONS AND SUPPORT

11. If the silence is broken, what do you fear might be the negative consequence? Conversely, what positive benefits do you imagine could come from open dialogue?
12. What kind of support would make you feel more confident and prepared to have the necessary conversation with your children?

Probe: community forums? guidance from religious leaders? Material from the school/health center? Learning from other parents?

13. Imagine a future where adolescents in Abomsa are well-informed, healthy, and make safe choices. What one change in how families or the community communicates would be most important to reach the future?

PART 6: CLOSING

14. To close, let`s go around one last time. In one sentence, what is the most important thing you want school officials and health workers to understand about a parent`s perspective on this issue?

Thank you all profoundly for your honesty and wisdom. Your insights are crucial. The results of this study will be shared with the school and local offices to help develop better support for families. Are there any final questions or comments for us?

Appendix E: KEY INFORMANT INTERVIEW (KII) GUIDE

(For Teachers, Sectors, Health Workers, and Community Leaders)

Part A: Role and Perspective

1. What is your role in relation to the adolescents at Abomsa High School/community?
2. From your position, what are the most pressing health or social concerns for adolescents here?

Part B: Observing Communication & Barriers

3. In your observations, how comfortable do adolescents seem when topics of sexuality or reproductive health come up? What are the signs of their comfort or discomfort?
4. What do you believe are the biggest 'social' or 'cultural' barriers that prevent open dialogue about SRH between adults and youth here?
5. Can you describe an instance where you saw stigma or judgment affect an adolescent seeking information or help? What happened?

Part C: Institutional & Cultural Norms

6. How do the formal rules (school policy, health protocol) and the informal community norms ('aadaa', religion) interact—or conflict—when it comes to adolescent SRH?
7. What are the perceived risks for an adult (like a teacher or parent) who tries to discuss these topics openly with adolescents?
8. In your opinion, how do gender norms specifically shape the dialogue—or silence—around these issues?

Part D: Pathways Forward

9. Based on your deep understanding of this context, what would be a culturally respectful yet effective way to break the silence on these topics?
10. Is there a person, a platform, or a tradition within the community that could be a positive bridge for this conversation?
11. **Any final thoughts?**

Thank you very much!!

Appendix F: Sample data _Key Informant Interview

- Category of the participant: Woreda Health Office expert
- Town: Abomsa Town
- Sex: male
- Marital Status: Married
- Age: 36 years

- Education Level: Bachelor's degree
- Organizations: Health office
- Position/Responsibility: Male
- Audio Durations: 00:33:11

Interview Date: 29/04/2026

Number	Questions	Response in Afan Oromo	Translated into English
1	What is your role in relation to the adolescents at Abomsa High School/community?	Tole ani hojjeetaa buufata fayyaa Abomsaatii, kutaa YFS bufatafayyaa irraan hojedha. Akka orgeessaa fayyaa buufata kanaatti dagaggeessi tokko gara buufata fayyaa kanaa dhufuu akka inni tajaajila fayyaa friendly ta'ee kan dargaggeessi nannoo kanaa gara buufata kanaa dhufuudhaan akka tajaajila fayyaa agatu gochuudha. Akka magaalaa kanaatti gumiileen addaa turani kan har'a diigaman haata'u malee. Hubannoo hawaasaaf kennuudhaan akka hubannoo argatan gochaa turre jechuudh.	Well, I am an employee of Abomsa Health Center. I work from the YFS department of the health center. As a health professional at the station, one of the developments is to come to the health station so that it is a friendly health service that the youth of this area can come to the station and get health services. As a city, there were special congregations that have been dissolved today, however. It means that we were making them aware by raising awareness in the community.
2	From your position, what are the most pressing health or social concerns for adolescents here?	Rakkoon guddaan gama fayyaa dargaggootiin jiru akka aanaa kanaatti rakkoo guddaatu jira. Kunumoo adaan wal qabatee, safuundhaan amanataadhaan fi duudhaa hawaasaa naannootiin wal qabatee rakkoo hiddaa gadi fageeffatee jirudha. Kunis maalinnii fakkeenyaaf dargaggeessi tokko gara buufata fayyaa osoo deemtuu yookaan osoo deemuu yoo argame hawassani akka waan isheen yookaan innii dhima biraaf yookaan sagaagaluudhaaf gara magaalaa adeemtuutti fudhata. Rakkoo tajaajila isaan barbaachisullee ifa baasanii maatiitti himachuun ni ulfaata , ni sodaatu, kanaaf callisanii adeemuu yoo adeemanimmoo akkaa waan mucaan isaanii balagatteetti fudhatu jechuudha. Daragaggeessi tokko osoo shamarran waliin adeemana akka amantaattis akka , akka aadaatti baay'ee jibbamaa yookaan cigaasisaadha. Dargaggoo	The biggest problem in terms of youth health is that there is a big issue in this district, which is a deep-rooted problem related to culture, morality, trust, and local social traditions. This is because, for example, if a young person is seen going to or walking to the clinic, the community assumes that she or he is going to the city for some other purpose or to prostitute herself. They find it difficult to even disclose the service problems they need to the family; they are afraid, so if they go quietly, they will assume that their child has disappeared. A young man seen

		sanarraa darbee salphina maatiis ni ta'aa jechuudha. Kan biraan har'a heerumni umurii malee akkamalee ni mul'ata. Dargaggeessi umurii malee araada addaatiif saaxilamu jechudha. Kanammoo kan fidee hubannoo fi beekumsa dhabuu akkasumas yaadaa fi fedhii isaani ifaa baasanii hubachuu dhabuutu jira.	going with the girl, according to religion, as well as according to culture, he is very hateful or a cigarette. It means it will be a shame not only to the young man but also to the family. Another thing is that underage marriage is very common today. It means that a young person is exposed to special greed without age. This is caused by a lack of understanding and knowledge, as well as a lack of understanding of their thoughts and desires.
3	In your observations, how comfortable do adolescents seem when topics of sexuality or reproductive health come up? What are the signs of their comfort or discomfort?	Ammaa communication yookaan waliin haasa'uun kunii baay'eema garidha. Of keessaa baasanii dubbachuuf carraa argatuu ogeessi iddoon rakkoo eessaadhaa isa jedhu sirriitti ni hubataa jechuudha. Isaan baay'ee ni sodaatuu bakka namni lamaafi isaa olajiruutti waan saalaan wal qabatu kana hin dubbatani , kanaaf sirriitti gadi qabdee itti haasa'uun barbaachisaadha. Bakkaa isaniitti gadi of buustee, hasoofsiisu qabda yoo akks ta'e waan keessoo isaanii baasanii dubachuu eegalu jechuuhda. Yoo amma jaalroslii waliin walitti makeenimmoo hubannoo kennanii jettuu akka waan safuun hawaasaa cabeetti fudhatama walumaa galatti soda guddaa qabu.	This is then a great shame. There is great fear in the youth and in the family. This is because fear of religion is deeply rooted in morality and culture. The culture of silence and stigma can only be broken if we have the opportunity to educate these young people. It is very important to sit down and educate the community and involve the clergy and families. If so, these young people gain courage because they lack confidence. According to this environment, neither girls nor young men can talk to their families. Why, if she's found talking about that and she's starting something else, my baby says. Lack of knowledge comes from the family expectation, and it is

			also evident in the school.
4	What do you believe are the biggest 'social' or 'cultural' barriers that prevent open dialogue about SRH between adults and youth here?	Kuni egaa saalfii guddaatu jira. Dargaggoo keessaa sa maatii keessa soda guddaatu jira. Kunis maaliifi soda amantii safuu fi aadaan hida fageeffatee wal keessa jira. Aadaa callisuu (silence) fi stigma gamaknaan jiru cabsuun kan danda'amuu yoo carraan dagaggoowwan kunneen argannee barsiisuun dha. Kannfimmo gadii taa'anii hawwas barsiisuunii fi abbootii amantaafi maatii hirmaachisanii barsiisuun baay'ee barbaachisaadha. Yoo akkkas ta'ee dargaggoonwwan kunneen ija jabina horatu hir'ina confidence qabuu waan ta'eef. Akkaa naannoo kanaatti shamarris ta'e drgaggeessi maatii isaanii waliin haasa'uu hin danda'ani. Maaliifi yoo waan akkasii osso haasoftuu argamtee waan biraa jalqabdee jirti mucaan kiyy jedhu. Hanqinni beekumsaa kan dhufee maatii keessaa eegaaa, mana barumsaa keessaatis ni mul'ataa.	
5	Can you describe an instance where you saw stigma or judgment affect an adolescent seeking	Hawaasani yeeroo barnoota fayyaa kanaaf bakka tokko qopheessunii ija shakkiin nu ilaalu jechuudha. Safuun cabee , nu hin beekneetu nu keessa dhufee jedhu jechuudha. Dur ijooleen dhalattee ija maatii iyyuu hin ilaaltu kan amma kunimmoo waan aadaa keessaa hin nutti fiddee jedhanii dubbatu. Kunimmoo addatti "dur hin jirree" jedhanii waamu, dargageessii yookaan shamari tokko waan saalaan wal qabatu kana ifa baasteelle kan dubbattu taatee "kun kana nyaara haaddattedhaa, kan hin saalfanneedhaa, isheerraa darbee kana maatii akkamiitu guddisee jedhanii kaasu, boru yoo heerumeteele kan abbaa manaa bulfacuu hin dandeenyedha, kan nu irraa hin fuudhamtuu jedhanii kaasu. Jachuudha. Akka makmaaksaattis "kan si fuudhe si galachaa kan sidhalteef yelbanii" jedhaani itti qoosuu jechuudha.	It means that the community sets up a place for this health education and looks at us with suspicion. It means that morality is broken, that someone who doesn't know us has come into us (hin beekamnee). In the past, children were born and didn't even look into the eyes of their families. This is specifically what they call "not before", even if a young man or woman reveals this sexually explicit thing, "this is this literal shaved eyebrow (Nyaara haaddattee, shameless (hin saalfannee), what kind of family raised this

		Walumaa galattii kunii baalageedhaa jedhanii kaasu	beyond her, if she marries tomorrow, she will not be able to manage her husband married you, thanking you for giving birth to you." No one is interested to may such girls, and her chances of getting a husband are very low within that community. They generally mention that this is a ballad.
6	How do the formal rules (school policy, health protocol) and the informal community norms ('aadaa', religion) interact—or conflict—when it comes to adolescent SRH?	Wanti guddaan qaawwi mul'attu rakkoo hubannoo dhabuuti. Gama policy dhaan wal qabatee nama yaada isaalle ibsachuu hin dandeenyetu achi keessa jira. Namni yaada ibsachuu hin dandeenye , yaada nama biraas fudhachuu hin danda'u. nani achitti aadaadhaan hawaasa qabee rakkisu heduun isaa nama waa murteessuu danda'u miti. Akka fakkeenyaf dubara gudeeedamtee achuma hawaasatti hafutu jira. Dubartootni mana barumsaa keessatti ifa baasnaii dubbachuu mitii gudeedamanii daandii irratti gatamaniyuu ni callaisu malee hin dubbatanii. Kun egaa guutumma gutuutti.	The main gap is the problem of a lack of understanding. In terms of policy, there is someone who cannot even express his opinion. A person who cannot express an opinion cannot accept another person's opinion. Many of the nani there who traditionally hold the community together are not decisive. For example, there are women who are raped and left in the community. Women who are raped and thrown on the streets, not speak out in schools, remain silent but do not speak out. This is then completely.
7	What are the perceived risks for an adult (like a teacher or parent) who tries to discuss these topics openly with adolescents?	.kunii baay'ee murteessaadha, hawaasni hin beekan waan ta'eef waa'ee waliin haasa'uu , dargaggoo hirmmachisuu waan jedhamu hin beeku. Kanaaf osoo opn dialogue kun gara lafa qabachuun kooyyuu baay'ee barbaachisaadha. Kanaaf yooma barsiisuuf kaatelle sirraa hin fudhatani jechuudha.	This is very crucial; the community doesn't know about it, and doesn't know about communication and youth involvement. Therefore, this open dialogue must take place. So it means they won't take it from you whenever you set out to teach.

8	In your opinion, how do gender norms specifically shape the dialogue—or silence—around these issues?	Akkuma waliigalattiilee dubartiin baay'ee dubbattuu hawaasa keessatuu iddoo hin qabdu yookaan kabaja hin qabdu. Irraa caalaatti kan haasa'u dhiirumaa dhimma barbaachisu haasa'a malee dubartiin ni caallisti. Murtoos ofumaisaa murteessa,wanti aaddaan akkasii kun hiddaagadi fageeffachuuirraan kan yaada isaanii ibsachuu irratti baay'ee rakkatu, irraa caalaati yeroo baay'ee yaada kan ibatu dhirumadha jechuun barbaada. Dubartootni callisuumaan bira darban stigma gama dubartootaa biratti bal'inaan wal qabatee baay'ee hidda fageefatee jira.	In general, a woman who talks too much has no place or respect in society. Mostly, the man who talks about the necessary issues and makes all decisions by himself, but the woman is better. The decision makes itself, what I mean is that such a culture has a lot of trouble expressing itself from deepening its roots, and it is often the male who expresses himself. Women are quietly ignored, and the stigma among women is widespread and very ingrained.
9	Based on your deep understanding of this context, what would be a culturally respectful yet effective way to break the silence on these topics?	Addaan jiruu gama Kanaan dhaloota barate ammaa kana caalayyuu kan durii sanatu caala jechuun ni danda'ama. Maaliifii, akka aadaa oroomootti dubartootni yoo rakkaatan 'Ateetee facaafatanii ' keessatti yaada isanii ibsatu yoo rakkan. Kan amma kun garuu aadaa ateetee sanans of harkaa hin qabani. Dubartiin gaafa rakkoon isheerraa ga'ee haadha siinqee gadi baateetu siinqee kanatti himachuudhaan itti gaafatamaa taasisu jechuudha. Yeroos namni dubartii kan miidhe dhiyyate gara abbaa gadaan itti murtessuu jechuudha. Fakkeenyaaf dhur haati tokko deessee guyyaa 45 osoo hin guutiin yoo dhiirri bira ga'ee yookaan qunnamtii saalaa waliin raawwatee haadha siinqeetti himtti , haati siinqee dhimma kana gara abbaa gadaatti geessitee akka namni kun adabbii isaaf malu fudhatu taasifama jechuudha. Kan bara ammaa kana yoo fudhannee waan lammatuu hin jiru akka aadaa hin jennee aadaa sana keessa galee sirriitti hubatee hin hojiirraa oolchaa hin jiru. Mala saaynsawaa kan ammaayyaa yoo jennees isas	The difference in this regard is that the educated generation is almost better than the old one. Why, according to the Oromo culture, if women are in trouble, they have trouble expressing themselves in 'Ateetee facaafatanii '. The current ones, however, don't have that 'ateetee' tradition in their hands either. When a woman is in trouble, the 'Haadha sinqee' comes out and makes the sinqee responsible. It means that the person who has assaulted the woman is brought before the chief and judged. For example, in the past, if a mother approached or had sexual intercourse with a man less than 45 days after giving birth, she was

		hoijiirraa oolchaa hin jiru. Kanaaf kan garaagarummaan saala gidduutti uumamee tokko miidhamaa tokkommoo qama miidhaa geessisu ta'ee kan mul'atu jechuudha.	told by the mother of the bride, the bride took the matter to the chief, and the person was made to take the punishment he deserved. If we take the current one, there is nothing secondary that he is not saying about culture, and he is not going into that culture, and not understanding it properly, and not applying it. Even if we say modern scientific methods, he is not implementing them either. Therefore, the difference between the sexes means that one is the victim and the other is the perpetrator.
10	Is there a person, a platform, or a tradition within the community that could be a positive bridge for this conversation?	Akka aadaatti ni jira akkuma armaan oliitti siif kaasuu yaalee dhaaloota ammaa kana irraa kan durii santu fooyyee qaba beeki. Plat form'n aadaa san keessaa jiru garee hawaasaa kamuu miidhuuf kan dhiriire hin jiru.hunduu toora qaba. Wanti abdii namatti horuu caasaa diriiree jiru kanatti fayyadamuun murteessaadha. Jaarsa biyya , abbaa gadaa, haadha siinqee fi abbootii amantaa kunneen fayyadamuudhaan hojii reform barbaachisu lafa qabsiisuun ni danda'ama.	Traditionally, there is, as I tried to mention above, to you know that the old one is better than the current generation. No platform in that culture is designed to harm any social group. Everything is designed in a very balanced way. What is promising is that it is crucial to use this established structure. These elders, chiefs, Haadha sinqee, and religious leaders can be used to ground the necessary reforms.