Assessment of Sexual and Reproductive Health Status and Related problems of young people with Disabilities in Selected Associations of people with disability, Addis Ababa, Ethiopia

By

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ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
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Approved by the Examining Board

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Acronyms

- *AIDS Acquired immune Deficiency syndrome*
- *HIV Human Immuno Deficiency Virus*
- *ICPD International Conference on Population Development*
- *MOH Ministry of Health*
- *MWD Men with disability*
- *PWD People With Disability*
- *RH Reproductive Health*
- *RHS Reproductive Health Service*
- *SRH Sexual Reproductive Health*
- *SRHS Sexual Reproductive Health Service*
- *STI Sexually transmitted infection*
- *UNFPA United Nation Fund for population Activity*
- *WHO World Health Organization*
- *WWD Women with disability*
- *YFWD Young Female with disability*
- *YMWD Young male with disability*
- *YPWD Young People With Disability*

Table of Contents

List of Tables and Figures ***Page***

ABSTRACT

Back ground:-

Young people in Ethiopia face many sexual and reproductive health problems; UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural context of their lives, but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold uncompromising attitudes toward adolescent sexual behavior. In particular young people with disability are among the most stigmatized, poorest, and least educated of all the world's citizens. To date, very little is known about the sexuality of disabled youth, in general the reproductive health need and related problems of this group, whether they have access to health services and information and, if so, to what extent. Therefore, for ensuring the health of Young people with Disability, the understanding of SRH and existing problems related to sexuality and reproduction on this group of population is important.

Objective*: - The aim of this study is to assess the sexual reproductive health status and associated problems of young people with disability at selected association of people with disability, Addis Ababa.*

Method:*- A cross- sectional survey was conducted from Feb11-17, 2008 to assess disabled youth reproductive health status and related problems. The data were collected by trained data collectors using a structured questionnaire & two complementary focus group discussions were also conducted guided by semi-structured questions, a total of 384 young people with disability were selected using systematic sampling technique. Descriptive statistics was employed to examine the findings and appropriate statistical methods like chi-square, crude and adjusted odds ratio were also used.*

Result: *-A total 174(45.3%) of respondents in the study ever had sexual intercourse; out of them 100(57.5%) and 74(42.5%) were male and female respectively. Seventy three (42.0%) of them started sex between the age of 15-19 years and only 9.2% were married. Only 45.4% of the sexually experienced respondents have used some kind of contraceptive during their first sexual encounter. Rate of unintended*

pregnancy was 62.5% among young disabled females who had ever been pregnant and 50% of them had history of abortion, 87.5% of this abortion was induced type. In this study, 58.6% of the sexually active respondents had multiple life time sexual partners, 20.7% had a casual sex partner and 18.0% of sexually active males had a commercial sex partner in the past 12 months period prior to the survey. History of ever having STI was 25.3%. Only 55.5%, 33.1% and 51.8% of respondents had good knowledge on HIV transmission, STI Sign and symptom, HIV Prevention respectively and only 33.3% of respondents had utilized reproductive health services.

***Conclusion & Recommendations**: -From this study finding it can be said that YPWD are at risk for sexual and reproductive health associated problems. Many young people were engaged in sexual activity before marriage and do so at early age. Majority of the sexually experienced respondents' first sexual encounter was unplanned often without any protection against pregnancy, STIs or other potential reproductive health risks associated with unplanned sexual experiences. There fore, parents, family members and the entire community have to be sensitized about the need to provide a safe environment for YPWDs and organizing education session in the area where most YPWD benefit should be promoted and focused not only on knowledge but acquisition of essential skills (communication and negotiation skills) as well as equip YPWD with self-esteem thus improve their confidence for better RH outcomes.*

CHAPTER I

INTRODUCTION

1.1. BACKGROUND INFORMATION

Ethiopia is located in East Africa, generally known as the Horn of Africa, and shares borders with Eritrea, Djibouti, Somalia, Kenya and Sudan. It is the ninth largest country in the African continent with a total area of 1,223,600 square kilometers (1, 2). The economy is predominantly agrarian - 85 per cent of the population lives depends on agriculture. Ethiopia has diverse ethnic and culture groups, Orthodox Christianity and Islam being the two major religions. With a population of 77 million, Ethiopia is the third most populous country in Africa, after Nigeria and Egypt. The rate of population growth has escalated at an alarming speed, particularly during the second half of the 20th century and is 2.7 per cent (3).

An expanding young population characterizes the country. It is estimated that young people age 10-24 constitute about a third of the population, roughly 26.5 million (33%), while Ethiopia's youth (15-24 years) account for about 20% of the total population of the country. This group holds a strategically critical position within the context of population development. Not only does it represent a vast portion of the population, but also the behavior and attitude of this group towards sexual and reproductive health will determine the demographic scene of the country, as it is sexually most active (2, 4, 5). The rapid rate of population growth has also placed a heavy burden on the expansion and supply of social services, including health services (2).

Youth in Ethiopia face many sexual and reproductive health problems like gender inequality, sexual coercion, early marriage, polygamy, female genital cutting, unplanned pregnancies, closely spaced pregnancies, abortion, STIs, and AIDS. Lack of education, unemployment, and extreme poverty exacerbates and perpetuate the reproductive health problems faced by Ethiopian youth (6).

In particular young people with disability are among the most stigmatized, poorest, and least educated of all the world's citizens. One person in ten - 600 million individuals lives with a disability; 80% live in developing countries including Ethiopia. Although disability is often addressed solely as a medical concern, the greatest problems facing individuals with disability are social inequity, poverty, and lack of human rights protection including reproductive Health rights, not simply lack of access to medical care (7).

It is envisaged that the combination of poverty, ignorance, war, famine and drought with the absence of adequate preventive and rehabilitation services could produce high prevalence of disability in Ethiopia. There is no national disability survey in Ethiopia. However according to the 1994 national population and housing census report, there were 991,916 i.e, 1.85 % persons with disabilities in Ethiopia and 45,936 (2.18%) in Addis Ababa, out of whom 12,888 Visually, 15,320 Physically, 6,402 Hearing, 5,912 Mental, 2,673 Leprosy, 1,887 Multiple and 854 with Others types of disability (1).

Historically persons with disabilities have been subject to sexual segregation, sexual confinement, marital prohibition and legally sanctioned sterilization under the guise of patient protection from pregnancy and sexual abuse. There are many misconceptions and fallacies surrounding the sexuality of persons with disabilities. They may be regarded as asexual, i.e. they do not/should not have sexual needs and feelings. Hyper-sexuality (particularly used to describe sexual behaviour of men with disabilities) or an excess of sexual desire is the other extreme of this negative attitude. Underlying the myths and misconceptions about sexuality of persons with disabilities is the eugenics argument i.e. that the progeny of disabled persons will also be disabled and hence the need to prevent them from reproducing (8).

In addition a significant group of adolescents and youth with disabilities are not able to access programmes targeting sexual and reproductive health because the existing services/ programs do not address the specific concerns of this socially marginalized group (8). In order to ensure that all citizens of the country are guaranteed the right to health, it is imperative that the concerns of young people with disabilities to be studied. Therefore this study was conducted at selected associations of people with disability in Addis Ababa, which is the capital city of Ethiopia and sits for many international organizations like African Union (AU) and Embassies of different counties. It is a metropolitan city with a total population of 3.8 millions of various Nations & Nationalities; with different socioeconomic, demographic & cultural backgrounds.

1.2. STATEMENT OF THE PROBLEM

With an estimated 1 billion adolescents today, the world is experiencing the largest adolescent population in history. As a result, adolescent reproductive Health is an increasingly important component of global Health (9). Adolescence is a period of dynamic change representing the transition from childhood to adulthood that begins at puberty. It is a time of tremendous opportunity and change. It also is a time of heightened vulnerabilities. WHO classifies adolescents as the age group 10-19 years, "young people" as those between the ages of 10-24 years and youth as those between the ages of 15-24 years (13).

How adolescence is experienced and affects reproductive health has largely to do with the timing and sequence of sexual initiation, marriage and childbirth, the degree to which the timing and sequence of these events are socially sanctioned or forbidden; and the number and availability of options regarding education, job training and employment. Adolescents' decisions and actions particularly with regard to sexual activity can significantly affect the rest of their lives/Sexual and Reproductive health (4).

For behavioral as well as physiological reasons, early sexual debut increases adolescents' risk for infection with HIV and other STIs. Youth who begin sexual activity early are more likely to have high-risk or multiple partners and are less likely to use condoms. An individual who initiates sexual activity at age 15 will have more exposure to conception over the reproductive span than one who initiates sex at age 21. Early childbearing has been linked to higher rates of maternal and child morbidity and mortality, truncated educational opportunities, and lower future family income. Adolescent fertility has also been associated with larger completed family sizes, which in turn may lead to greater population growth rates (14, 15, 16).

Globally, almost 180 million young people between the ages of 10-24 live with a physical, sensory, intellectual or mental health disability significant enough to make a difference in their daily lives. The vast majority of these young people, some 150 million (80%) live in the Developing world, routinely excluded from most educational, economic, social and cultural opportunities, they are among the poorest and most marginalized of all the world's young people. Recent World Bank estimates suggest that individuals with disability may account for as many as one in five of the world's poorest (10). And, it is widely acknowledged that the greatest impediment to the lives of young people with disabilities is prejudice, social isolation and discrimination. Some cultures are more and others less tolerant of those with disabilities. In many,

although not all cultures, there has historically been a great deal of stigma attached to having a disability. In various cultures, being born with or acquiring a disability has been interpreted as evidence of 'bad blood', incest, or divine displeasure (10).

While all individuals with disability may be affected by this lifelong cycle of stigma and poverty, females are at increased risk. To be female and disabled is often referred to as being doubly disabled. In societies where girls are valued less than boys, the investment in education, health care or job training that families are willing to make in disabled girls are often substantially less than for disabled boys (10).

Disabled people are not only the most deprived human beings in the developing world; they are also the most neglected. Disabled people are often excluded from school or the workplace, making them among the poorest, most stigmatized and most marginalized of all the world's citizens (12).

Recent UNESCO studies suggest that only 1-2% of children with disabilities in developing countries receive an education. Boys with disabilities attend school more frequently than do girls with disabilities 40% - 70% of girls and 15% - 20% of boys with an intellectual disability will be sexually abused before the age of 18 (12).
Women with disability, while often thought of as potential sexual partners, are nonetheless often considered unmarriageable. In some countries, women with certain disabilities cannot obtain marriage licenses and may have no options other than to live in unstable relationships with a series of sexual partners. With few prospects for employment or marriage, these women have a limited ability to negotiate safer sex .Extreme poverty associated with disability status is also a factor forcing some into sex work (7). Although Women with disability are up to three times more likely to be raped than non-disabled women; boys and men with disability may face equal risk of rape and sexual abuse as these disabled women. Many people with disabilities are physically unable to defend themselves; others must relegate part or all physical care to attendants who may see them as easy victims. Hundreds of thousands of individuals worldwide live in institutions where physical, psychological, and sexual abuse from staff, visitors, and fellow patients is known to be common. In communities, outside of institution settings, individuals with disability are frequent targets of physical and sexual assault (7).

There are many barriers which young persons with disabilities face in their pursuit of marriage and parenthood. Most persons with disabilities lack the skills and training to becoming financially self-sufficient. But even if that is achieved, they still have to confront the multiple negative perceptions of non-disabled persons with regard to physical attractiveness, sexual desire and competence and parenting ability. They have to overcome social stereotypes of being regarded as child-like, vulnerable and

in need of perpetual care themselves. Being recognized as responsible adults is an uphill task for persons with disabilities. Due to lower status in society by virtue of being women, the obstacles to marriage and motherhood are even more daunting for women with disabilities than men with disabilities (8).

Poverty, discrimination, and stigma, are the major socio-economic problems faced by persons with disabilities. The reproductive health problems faced by women with disabilities include sexual exploitation, unwanted pregnancy and complications during childbirth. Exclusion from the reproductive health sensitization and awareness raising programmes is also a major problem of YPWD (11).

In Ethiopia some of the key issues of disabilities that make them vulnerable to different type of RH associated problems (1).

- *The traditionally held views that disability is seen as punishment of God on the disabled and his family. It is also considered as a curse from elders or forefathers or an attack of evil spirit.*
- *Based on the public prejudice and stereotypes against them, disabled persons develop a negative attitude of inadequacy about their capability to participate in the social and economic activities.*
- *Disabled persons are denied opportunities for employment because the employers are unwilling to employ them even in jobs which they are actually capable to performing.*
- *Lack of access to resources is an obstacle to the development and implementation of projects and programmes of different services required to meet the needs of the disabled in the country.*
- *Lack of access to training and educational programmes are factors hindering the development of qualified personnel and this implies the majority of disabled persons are illiterate and unaware of their rights including RH rights.*
- *Programmes, Services and different Infrastructures, such as roads, public places, buildings and houses are designed and constructed for the general public without taking into consideration the needs of disabled persons and are inaccessible to them.*
- *Very little has been done so far concerning dissemination of information and public awareness campaigns with a view to bringing about a positive public attitude about persons with disabilities.*
- *Persons with disabilities are denied equal opportunities in society and are subjected to various forms of discrimination and segregation. These all are factors that makes YPWD vulnerable to different type of SRH associated problems in addition to other factors common for both young people with and with out disability.*

Despite growing numbers and their striking needs, adolescents with disability have historically fallen through the cracks. General programs that are intended for adolescents and young adults rarely include those with disabilities. Programs for disabled populations where they do exist are unfortunately usually no more inclusive. Particularly outside the Developed world, programs for those with disability generally are either intended to provide services and general advocacy for all disabled members of a society or fall decisively into one of two categories - programs for disabled children or for adults with disability. The programs and advocacy for disabled children usually focuses tightly on issues of family, education and socialization. The programs and advocacy for adults with disability is largely focused on issues of employment and to some degree, housing and community integration (10).

Adolescents and young adults are rarely excluded from these child-focused or adult-focused disability programs. The needs of a disabled five-year-old however, are usually strikingly different from those of a 13 or 17 year old or adults. Therefore, such programs are of little or no relevance to older adolescents or young adults because their social, sexual, education and economic needs are so great during this period of rapid physical and psychological development (10).

Meeting the needs of youth including the disabled one today is critical for a wide range of policies and programs, because the actions of young people will shape the size, health, and prosperity of the world's future population (6, 17).UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural context of their lives, but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold uncompromising attitudes toward adolescent sexual behavior. Hence by endorsing the Cairo Programme of Action and the Beijing Platform, the global community has resolved to "protect and promote the rights of adolescents to sexual and reproductive health information and services" (18).
To date, very little is known about the sexuality of disabled youth, in general the reproductive health need and related problems of this group, whether they have access to health services and information and, if so, to what extent. Therefore, in ensuring the health of Young people with Disability, the understanding of SRH and existing problems related to sexuality and reproduction on this group of population is important.

1.3 Significance of the study.

The ensuing high rates of unintended pregnancy, abortion, HIV/AIDS and other sexually transmitted infections (STIs) among teenagers make among other things, assessing SRH needs and associated problems of YPWD imperative. Effective implementation of ICPD's recommendation on Adolescent sexual and reproductive health also requires an understanding RH needs and related problems of YPWD (16, 19).

Even though there have been many studies in the area of adolescent reproductive health in Ethiopia, many of these have largely ignored YPWD, Therefore it is crucial that an attempt be made to understand SRH status and related problems of this group of people for designing and implementing effective interventions targeting them.

As to the knowledge of the investigator, no study has been carried out among disabled young people with particular emphasis on sexual reproductive health. Without adequate and accurate data on the nature and problems of disabled youth SRH, it is difficult to prepare and design projects, future plans and programmes which are undoubtedly indispensable for the health and welfare of the disabled. This study was, therefore, undertaken with the objectives of assessing the sexual reproductive health status and related problems among young people with disability.

CHAPTER II.
LITERATURE REVIEW

2.1 Back ground

Adolescents are a large and growing segment of the world population. More than half of the world's population is below the age of 25, and four out of five young people live in developing countries. During adolescence, young people develop their adult identity, move toward physical and psychological maturity, and become economically independent. Although adolescence generally is a healthy period of life, many adolescents often are less informed, less experienced, and less comfortable accessing family planning and reproductive health services than adults. Adolescents may experience resistance or even hostility from adults when they attempt to obtain the reproductive health information and services they need. They therefore may be at increased risk of sexually transmitted infections (STIs), HIV, unintended pregnancy, and other health consequences that can affect their futures—and the future of their communities—for many years to come. In addition, gender inequities, particularly unequal power in relationships, may limit their ability to use contraceptives or seek reproductive health services (9).

Young people with disabilities have needs very similar to the needs of all other young people, as clearly stated in Article 23 of the United Nations' Convention on the Rights of the Child. They need to live in a safe and supportive environment; they need education, health services and access to sport and recreation. They also need to develop skills that will serve them well in the community and the workplace. In many cultures however, the traditional approach to a young person with a disability is to acknowledge that they are no longer children but to assume that they will never be accepted or able to function, as adults. This is often true no matter what the nature of their disability (10).

In Ethiopia the main governmental organ responsible for the provision of social and vocational rehabilitation of persons with disabilities is the Ministry of Labour and Social Affair and there are many non- governmental organizations involved in rehabilitation services in the country. Even though much attempt has been done to change the lives of these groups of the society comparing with the ever growing number, the efforts has become very limited and also most of the services provisions have been focused on institutional care and in urban areas .At present, persons with disabilities in Ethiopia has organized in various associations to overcome their problems and safeguard their rights and privileges (1). Some of the well known associations are:

- *Ethiopian Federation of Persons with Disabilities*
- *Ethiopian National Association for Physically Handicapped*
- *Ethiopian National Association for the Blind*

- *Ethiopian National Association for the Deaf*
- *Ethiopian National Association for Leprosy Patients*
- *Support Organization of the Mentally Handicapped*

Social, economic and educational issues

Social Implications:

For non- disabled young people, the transition from childhood to adulthood is a period that prepares the individual for successful adulthood. Yet for young people with disability, there is an almost universal lack of inclusion in activities that build fundamental social, educational and economic skills. This exclusion is often formally sanctioned, with adolescents and youth with disabilities being barred from participating in formal cultural and religious ceremonies that help define an individual's changing status in the eyes of the community. Disabled young people are also often left out of the less formal 'rites of passage' joining a sports team, courting, learning to drive the family truck. This exclusion distinguishes young people with disability from all other groups of young people in every society and this exclusion has profound implications for their personal lives (10).

Economic and Educational issues:

The links between poverty and disability are established early, often in early childhood and extend throughout the lifecycle. For the vast majority of young people who have been born with a disability, their initiation into their own cycle of poverty begins early when they are unable to access needed medical and rehabilitation services, and when they are denied admission to school. For those who acquire a disability later in childhood, this initiation often begins after they acquire a disability, when they find themselves dismissed from school (10).

Gender further compounds inequities found in education available to young people with disability. Cultural bias against women in general, makes many families and educational systems less willing to allocate resources and opportunities to all female students. Reduced expectations for disabled females further limits what funds families and schools are willing to spend on academic and vocational training. Although, as is true of many other aspects of adolescents with disability globally, little information exits, it is clear that the educational resources and opportunities available to adolescent girls and young women is significantly less than even the already limited resources available to comparably disabled young males(10).

Compared with their non-disabled peers, a large proportion of young people with physical disabilities have great difficulty in attaining a similar degree of independence in adult life. Disabled people are among the poorest, most stigmatized and most marginalized of the entire world's citizens. Disability and poverty form a vicious circle. Conditions of poverty such as poor nutrition and lack of access to health services or safe living and working conditions create disabilities that can occur from birth to old age. After the onset of a disability, barriers to health and

rehabilitation services, education, employment, and other aspects of economic and social life can trap people in a cycle of poverty (20).

2.2 Sexuality

Initiating sexual activity is a natural transition made nearly by all humans. Nevertheless, it is not the occurrence of this transition but its timing and the circumstances under which it occurs that has significant implications. Young peoples' sexuality and its squeal has become a major public health concern all over the world (21). Many young people engage in sexual activity before marriage and do so at early age often without any protection against pregnancy or STIs (22). Health surveys and social studies conducted in different parts of the world, in recent years have indicated that, in many countries, most teenagers (60% to 70%) are sexually active (23). A study conducted in Nazareth high schools have showed that 24% of respondents reported having experienced sexual intercourse, with 60% reported having had their first sexual experiences between the ages of 15 and 16 (24). Other Studies conducted in different parts of the country showed that the mean age for the first sexual contact for Ethiopian adolescents is between 13.6 and 18 years and rural adolescents had earlier sexual onset compared to the urban ones (Mean = 13.1 versus 14.7 years)(25, 26,27,28).

A major issue in the lives of all disabled young people is the growing physical maturation and changing social role that prepares them for marriage and children. In reality, young people with disability often have little or no say over where they will live, whom they will live with and what role they will play within their families or communities. Moreover disabled young people are often denied the right to build families of their own. Social and family constraints make it unlikely that many young people with disabilities will marry. Indeed, in some countries, individuals with some types of disability are unable to legally obtain a marriage license. This is particularly true for disabled young women (10).

Without the prospect of marriage, in many societies, these young people can not hope to be accepted as full adult members of their communities. This does not mean that young men and women with disability do not become involved in relationships, or that they do not engage in sexual activities, only that there is often no social acknowledgement (and often no sex education) provided them. This places adolescent girls and young women with disabilities in particular, at increased risk for pregnancy and sexually transmitted diseases (10).

In those societies where men are allowed to take more than one wife, a teenaged girl or young woman with a disability is more likely to become second or third wives within a larger household, than to become a first or primary wife. In these types of

arrangements, the young women with disability, and their children, often will have less right to play a key role in family decision making and significantly less claim to both household resources and inheritance (10).

Qualitative finding of the study conducted in Kampala also showed that, the two main RH problems that came up in the male FGsD were failure to identify faithful sexual partners and failure to render effective RH spousal support. This exposes them to sexual exploitation by women and some also resort to commercial sex workers. Some citations, which bring out these sentiments are:

> *"Most of the beautiful girls we find feel ashamed to associate with us as sexual partners", all agree… "We only buy women for sex not love because it's the money they want from us not love" (MWDs, Kampala) (11).*

2.3 Sexual violence and Rape

An additional issue that is often overlooked, but a key concern to the health and well being of young people with disability is their increased risk of being victims of violence. Many young people are initially disabled as a result of violence, either through interpersonal violence within the household or community, or as a result of warfare, child soldiering or other forms of civic strife. Once disabled, these individuals are at increase risk of being victims of physical and psychological abuse, domestic and sexual violence and rape (10).

Again, few statistics are available, but what statistics do exist indicate that individuals with disability are at up to three times as likely to be the victims of domestic violence, violence in the community and rape as their non- disabled peers. These young people are at risk in the home and in the community. They also face a profound lack of legal protection. In many countries, police and prosecutors will not even take complaints from disabled individuals or will not allow them to give testimony in courts - which means that such violence can continue unchecked. Indeed, in both Developing and industrialized countries, there has been a growing number of accounts of disabled young people being targeted by sexual predators specifically because they either cannot report the abuse or will not be believed when such abuse is reported (10).

Individuals with disability are at increased risk of virgin rape because of a lack of legal protection. Police, lawyers, judges, and even rape-crisis counselors often have no knowledge of how to help people with a disability. Officials often dismiss individuals with disability who report rape, assuming them to be confused or victims of a misunderstanding. Police stations and courts are often inaccessible, lacking sign-language interpreters, ramps, and support systems for individuals with intellectual impairments or mental-health disabilities. Because of these barriers,

reporting of sexual abuse by individuals with disability is infrequent, and perpetrators can expect to go unpunished. Low rates of reporting not only have legal implications but can mean that potential antiretroviral prophylaxis is not made available to disabled men and women (29).

Individuals with disability are presumably at risk both because they are, incorrectly, often assumed to be sexually inactive, hence virgins, and because they might be easy targets. Even before the advent of AIDS, women and men with disability suffered an equal, or up to three times greater, risk of rape by a stranger or acquaintance, than their non-disabled peers. Many individuals with disability are physically vulnerable. Some must relegate part or all of their care to attendants, family members, or others, or live in institutions; situations in which abuse is rife worldwide, additionally some researchers argue that individuals with disability are often psychologically vulnerable. A research for example, suggest that young disabled individuals have few opportunities to learn to set boundaries for physical contact and overprotection and internalized societal expectations make women with disability more vulnerable to psychological pressure for sex and intimacy. Studies from the UK report that men with intellectual disabilities who live in the community are often pressured into having sex with non-disabled men whom they meet in public toilets; participating because they are lonely and anxious to please their new supposed friends (29).

The results of the study conducted on Kampala indicate that the estimated median age at first sexual activity is 16 years for women with disability and 18 years for men. Noteworthy is that 22% of the women in Kampala and Rakai Districts were reported to have been raped in their first sexual encounter (11).

Qualitative finding of this study indicates that sexual exploitation by men is one of the major problems YFWD are faced with. Some of this arises out of men's fear to identify themselves with girl friends who have disabilities. One of them actually echoed:

> *"Men only come to us for sex. None of them mentions marriage. They just use us", (Female youths, Kampala District).*

Some participants also mentioned that sexual exploitation has led to risky and wreck-less behavior among the WWDs themselves. A typical response was:

> *"Girls with disabilities offer themselves to men because they think that no man would ever approach them for true love. They lead wreck-less lives in a bid to have fulfilled sexual lives like their able-bodied counterparts", (MWDs).*

2.4 Sexually transmitted infections and HIV/AIDS

Adolescents and young people are at increased risks of RH problems. They are at increased risks of sexually transmitted infections including HIV/AIDs. A more accurate indicator for trends of HIV infection may be STI rates, since behaviors associated with the acquisition and transmission of STIs are identical to behaviors associated with HIV transmission (25). As of 2001, an estimated 40 million adults and children around the world were living with the HIV and 28 million alone in sub-Saharan Africa. The highest rate of new cases of HIV transmission occurs among young people age 15-24. Half of all new HIV infections in the world occur in people aged 15–24; nearly 12 million young people are living with HIV/AIDS; and more than 7,000 and half a million young people become infected with HIV and a sexually transmitted disease every day respectively. The majority of new infections in the developing world are also among young adults. Every minute, five people under 25 are infected with HIV. Millions more have little or no knowledge of the disease and do not know how to protect themselves or take measures to prevent the spread of the disease (30, 31, 32, 33).

Too often, individuals with disability have not been included in HIV prevention and AIDS outreach efforts because it is assumed that they are not sexually active and at little or no risk for HIV infection. The Global Survey on Disability and HIV/AIDS conducted by Yale University and the World Bank has proven this assumption wrong. Individuals with disability have equal or greater exposure to all known risk factors for HIV infection. For example, adolescents and adults with disability are as likely as their non-disabled peers to be sexually active. Homosexuality and bisexuality appear to occur at the same rate among individuals with disability as among the non-disabled. Individuals with disability are as likely as non-disabled people to use drugs and alcohol. Men and women with disabilities are even more likely to be victims of violence or rape, although they are less likely to be able to obtain police intervention, legal protection or prophylactic care (20).

Results of the study conducted in Kampala indicate that, awareness about sexually transmitted infections is over 91% for either sex. Incidence of STIs (proportion ever contracted sexually transmitted diseases) is however, very high (38% of women and 35% of men). Results also show that the incidence of sexually transmitted infections is higher among women in urban areas (41%) and those with primary education (42%). Awareness about HIV/AIDS is almost universal. However, only 6% of either sex reported testing for HIV as a means of knowing one's HIV status. Most young persons with disabilities are aware that HIV is transmitted through sexual intercourse with an infected party. Vertical transmission of HIV is the least known mode of transmission (7% males and 10% females). Over half (55%) of the women with disabilities consider themselves at risk of contracting HIV/AIDS either because they

regularly involve in unsafe sex or they have multiple sexual partners. About 87% of study subjects are willing to take an HIV test. Poverty, rape, non-use of condoms, lack of awareness about reproductive health issues, polygamy and wife sharing were cited as pre-disposing factors to HIV among persons with disabilities (11).

2.5 The practice of condom use and use of other modern contraceptives

Studies widely report that condoms are understood to diminish sexual pleasure and are inconvenient to use. The results of the study conducted on Kampala among PWD indicate that Awareness about condoms is over 90% for either sex and ever use of condoms is 44% among men compared to 27% of the women with disability. Current use of condoms is only 24% and 10% of men and women respectively. The proportion ever heard of contraception is 85% of either sex. Ever use of modern methods is 33% among women and 35% among men with disability. Current use of modern methods is 21% of men and 30% of women (11).

2.6 Early marriage, pregnancy and abortion

One of the great health problems of adolescents is too-early pregnancy. One in every 10 births worldwide and 1 in 6 births in developing countries is to women age 15-19. Pregnancy-related health risks are much higher among women under age 18. In developing countries too early pregnancy frequently arises from early marriage, sometimes just after menarche and are becoming sexually active at earlier ages and pregnant prior to marriage. Young women who have not reached full physical and physiological maturity are almost three times as likely to die from complications in childbirth as older women. It has also been found that pregnant women under 15 are 4-8 times more likely to die during pregnancy and childbirth than those aged 15-19. Women who become pregnant when aged 15-19 ran a greater risk of dying, sometimes twice as high as those in their twenties and early thirties (30,31,32,34,35).

In one of the few studies of its kind, the United States National Longitudinal Study found that three to five years after completion of high school, females with disability were significantly more likely to be mothers than were either non- disabled females or disabled males. Although 23.7% of all youth in this demographic pool had had children, only 16.5% of disabled males had become fathers. In contrast, 40.6% of all disabled females in this age range had given birth to one or more children. For young women with emotional disturbances, learning disabilities or those with hearing impairments, almost 50% had become pregnant in the years immediately following high school. For disabled females who had dropped out of school, 54% had become mothers. The majority of these pregnancies occurred outside of marriage. This increases their risk of vulnerability since they already struggling to earn a living comparable to that of their non- disabled peers, the necessity of providing for a child, particularly in those cases where they are not married, places yet an additional burden on these young disabled mothers (10). Findings of the study conducted in Kampala also indicates that, 77% of the disabled Young women in the sample had

ever been pregnant and District-specific results reveal that almost half of the first pregnancies among females in Katakwi are not wanted (11).

Qualitative finding of this study showed that almost all women in FGD groups mentioned that YFWDs are abandoned by their partners when they get pregnant, while some others become pregnant after episodes of rape. This leads to unwanted pregnancies, with a resultant high incidence of single parenthood among WWDs. Some girls risk abortion with its complications including death. A sample response to echo this was:

> *"Young girls with disabilities are impregnated and abandoned without help because no man can mention to his family or friends that he has a child with a disabled women", (WWDs) (11).*

Un intended pregnancy may lead to an induced abortion, which in the case of un experienced or ashamed adolescent is likely to take place later in the pregnancy and involve greater risks to life, health and future fertility and the proportion of adolescents who seek abortion has been increasing, especially among younger adolescents (15-17years) (35). About 10% of pregnancies each year occur among teenagers. UNFPA reports that 10-14% of young unmarried women around the world have unwanted pregnancies and at least 2-4.4 million abortions occur among adolescent women in developing countries each year, the majority of these abortions take place in unsafe conditions. Adolescents may more often delay seeking care for abortion-related complications due to lack of transportation, lack of knowledge about where post abortion care can be obtained, fears of censure from their parents and health-care providers, fear of legal repercussions, or lack of money to pay for services (36).

The reproductive health problems of young people in Ethiopia are multifaceted and interrelated. Child bearing begins at an early age,37% of all women 15-24 years started child bearing, 45% of the total births in the country occur among adolescent girls and young women and more than one in three births to women age 15-19 and 20-24, at the time of birth, is unintended (37,38). Adolescent pregnancy is associated with increased risks of complications due to physiological underdevelopment of young girls. Hospital based studies reported that abortion is among the ten top reasons for hospital admission in women and that unsafe abortion is the commonest cause, accounting to 32 % of all maternal mortality in the country (39, 40).

2.7 Reproductive health services utilization and sources of information.

Adolescents and young people are at increased risks of RH problems, despite the immense RH problems faced by young people in Ethiopia, they have limited access to quality and reproductive health services, specially designed to meet their particular situation. Young people are particularly affected by the lack of access to reproductive health services and health information. Even though some efforts to meet the RH needs of adolescents and youth are made by civil society organizations, their scope is limited compared to the size of the problem. Moreover, there are few national programs specifically targeted to addressing the needs of this group (40).

The health seeking behavior of adolescent/young people particularly in relation to their sexual and reproductive health in Ethiopia is very low even when compared to many African countries. Some of the behaviors and challenges can be attributed to the lack of youth-friendly services that reassures confidentiality, service providers' biases against this section of the population, and low level of awareness among members of the community (41).

A study of adolescent reproductive health conducted in East Gojjam revealed that the most common source of information on STIs/ HIV/ AIDS was the media (82%) and neighbors (67%) for urban and rural out of school adolescents respectively and more than half, of the participants (55.2%) had reported that they had visited health institutions for reproductive health reasons. The majority (82.6%) have visited public health institutions and (11.5%) of them visited Family Guidance Association of Ethiopia' clinic and an equal proportion of them visited private health institutions. The major reasons that prevent adolescents from visiting health institutions were reported to be too expensive services, too far health institutions, poor handling and failure to keep privacy and confidentiality by health workers, too much waiting time and it is shame for adolescents to visit health institutions (25).

Considering reproductive health service utilization of YPWD, the result of the study conducted in Kampala indicates that 71% of the women and 74% of the men have ever heard of RHS and radios and friends are the major providers of reproductive health and HIV/AIDS information. Majority however; feel RH services are not accessible to persons with disabilities. This was attributed to geographical inaccessibility of health facilities, unfriendliness of the service providers, poverty, lack of awareness on reproductive health issues and lack of confidentiality (11).

Exclusion of YPWDs from the entire RH service delivery came up strongly as a major RH problem faced by YPWDs. The exclusion stretches from the RH sensitization and awareness raising programmes to the unfriendliness of the RH service delivery system. Typical responses during FGD of Kampala study were:

"I would like to go for VCT but the providers don't know any basic sign language. I want my privacy and I hate going with a translator who is likely to spread rumors about my HIV status", (YWWD, Kampala).

"We are not invited to these RH workshops which are always held at the health centers"…. another interjects "In fact people think that we are not sexually active because we are disabled", (female youths with disability).

"The blind cannot see the charts that have been displayed everywhere on HIV/AIDS"…. "Even the deaf cannot hear the programmes on the various FM stations on HIV/AIDS or reproductive health issues. I have never heard of any workshop organized by the medical team for these people", (parents of youth with disabilities).

Unfriendliness of health service providers towards YPWDs came up in all the women's focus group discussions as a major deterrent to their utilization of reproductive health services.

"Nurses ridicule, laugh and abuse us when we emerge with reproductive health problems. They always insult us by asking questions like; how did you get this pregnancy you crippled women"(WWDs) (11).

In general young people in Ethiopia are at high risk of sexual reproductive health problems. Sexual experience and Child bearing begins at an early age as revealed by findings of the Ethiopia DHS 2000, which showed 37% of all women 15-24 years started child bearing, practicing commercial sex have become common phenomena among young girls. As a result, they have become primary victims of HIV/AIDS crisis that has spread throughout the country. The situation is aggravated by the overall poor socio-economic environment and harmful traditional practices (37,42). Since traditional practices and poor living conditions often lead young people to engage in sex at an early age. Many young women are forced to practice sex for money. Lack of family support and limited educational opportunities have led many youth to turn to life on the streets which in turn increases risk of sexual encounter (43).

The very low level of economic development, widespread poverty, very poor and inadequate health services, etc., also make the consequences of adolescent sexuality much more serious in the Ethiopian context. This is reflected by the highest HIV prevalence in the group 15-24 years (12.1%), 6% to 9 % among young men aged 15–24, and 10% to 13 % among young women in the same age group; the highest prevalence of sexually transmitted infections in this age group; unintended pregnancy being a serious problem among teenagers, according to Ethiopia DHS 2000 results more than one in three births to women age 15-19 and 20-24, at the time of birth, is unintended; and abortion , which is illegal in Ethiopia, placing many young women at risk, primarily because it is usually conducted under unsafe conditions (32,37,44,45). And these all SRH problems are much more serious and

prevalent among young with disabilities as evidenced by research result indicates, Women with disability are up to three times more likely to be raped than non-disabled women. This places adolescent girls and young women with disabilities in particular, at increased risk for pregnancy and sexually transmitted diseases (10).

CHAPTER III.
OBJECTIVES THE STUDY

3.1. General Objective

The general objective of the study is to assess the sexual reproductive health status and associated problems of young people with disability at selected associations of people with disability in Addis Ababa.

3.2. Specific Objectives

The study specific objectives are:

a. *To describe the sexual reproductive health status of young people with disabilities.*
b. *To determine magnitude of selected sexual reproductive health problems of young with disability.*
c. *To assess reproductive health service utilization of young people with disabilities.*

CHAPTER IV.
METHODS and MATERIALS

4.1. STUDY DESIGN

A cross- sectional survey was employed to assess disabled young people reproductive health status and related problems with complementary focus group discussion (FGD).

4.2. STUDY AREA

This study was conducted at selected associations of people with disability namely Ethiopian National Association for Physically disabled, the Blind and the Deaf in Addis Ababa, which is the capital city of Ethiopia and sits for many international organizations like African Union and Embassies of different counties. It is a metropolitan city with a total population of 3.8.Millions of various Nations & Nationalities; with different socioeconomic, demographic & cultural backgrounds. According to the 1994 national population and housing census, there were an estimated 45,936 people with disabilities in Addis Ababa. At present, there are about six associations of persons with disabilities in Ethiopia, these are:

- *Ethiopian Federation of Persons with Disabilities*
- *Ethiopian National Association for Physically Handicapped*
- *Ethiopian National Association for the Blind*
- *Ethiopian National Association for the Deaf*
- *Ethiopian National Association for Leprosy Patients*
- *Support Organization of the Mentally Handicapped*

Addis Ababa was selected mainly because it has this number of different associations with large number of disabled inhabitants and for convenience to handle the study subjects at the existing associations.

4.3 STUDY PERIOD

The study was conducted from February 11-17/ 2008.

4.4 Population

4.4.1 SOURCE POPULATION

All disabled young people aged 10 to 24 years residing in Addis Ababa town, enrolled in different associations of PWD during the study period

4.4.1 STUDY POPULATION

The study population was the sampled young people with disability from the source population.

Inclusion criteria: *Those disabled young people aged 10 – 24 years; who were enrolled as a member of the association at the time of data collection were included in the study.*

Exclusion criteria: *Those who were critically sick at the time of study and unable to communicate and respond to questionnaire and those who were not willing to participate in the study were excluded from the study.*

4.5 Sample size and sampling technique

4.5.1. Sample size determination

There is no national disability survey in Ethiopia. However national population and housing census has been conducted in 1994. According to this report from the total population of 53 million it was revealed that 991,916 i.e., 1.85 % were persons with disabilities. In Addis Ababa, there were an estimated 45,936 (2.18%) PWD. On the other hand international reports by WHO estimate that the disabled persons account for at least 10 percent of any given National age cohort (1). Based on this estimate and considering the current population, the total number of disabled persons in Ethiopia reaches about 7.7 million. It is also estimated that young people age 10-24 constitute about a third of the population, roughly 26.5 million (33%), therefore YPWD constitute around 2.65 million.

The sample size was determined using the formula for single population proportion and the following assumptions were made. Significance level of 95% (α = 0.05) and 5 percent margin of error was taken. Since there is no previous study conducted in this specific study group up to the knowledge of the investigator, 50% prevalence was taken on sexual reproductive health related problems among study subjects to obtain sufficiently large sample size, and 10% was also added to compensate for non response. So a total of 384 disabled young people were included in the study.

The sample size was calculated by using the following formula

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

Where *n= sample size*

Z1- α /2 = confidence level corresponding to 95% CI = 1.96

P = is the maximum expected prevalence rate 0.5

d= is the margin of the sampling error to be tolerated 0.05

The sample size was calculated by a formula using prevalence rate of 50% and 95% CI and 5% margin of error.

$$n = \frac{Z^2_{1-\alpha/2}\, p\,(1-p)}{d^2} \qquad n = \frac{1.96^2 \times (0.5)\,(1-0.5)}{(0.05)^2} = 384 + 10\% = 422$$

4.5.2. Sampling technique:

A probability sampling method was undertaken to get the required sample size after census was conducted to have the sampling frame in each association.

The total sample size was proportionally allocated to all associations of PWD according to the number of YPWD in the respective associations.

Proportional allocation of the sample size was made for each association by using the following formula.

$$ni = \frac{Ni \times n}{N}$$

Where *ni = Total sample size in association i.*
Ni = Total number of disabled young people in association i
n = Total sample size determined
N = Total number of YPWD in all association.

The study subjects were selected by systematic sampling from the sampling frame, the 1st subject was picked by lottery method and the next was drawn every k^{th} for the roll № given on the sampling frame till the required sample was obtained using the following formula

$$k^{th} = \frac{Ni}{ni} \quad \text{(systematic sampling)}$$

k^{th} = *Interval*

Ni = Total no of YPWD in association i

ni = Total sample size required in association i.

The study subjects were identified using key informants on the days of the survey and those YPWD, who are eligible for the study, were identified and interviewed by the data collector. For those absent randomly selected subject on the date of data collection the next subject was substituted from the same association.

4.6. Data collection method and Instrument.

The data for the quantitative section of the study were collected by trained data collectors using a structured questionnaire extracted from standardized data collection tools which addresses all the variables. First questionnaire was prepared in English and was translated in to Amharic and again back translated in to English by another person. The questionnaire was composed of back ground information and specific information, & covers both open & close ended questions to collect relevant information needed. Data collection was conducted for seven days and data from those with hearing impairment were collected by trained data collectors who know sign language. After the collection of quantitative data two focus group discussions were conducted among purposively selected YPWD guided by semi-structured questions to explore sexual reproductive health status of disabled young people. The discussion was gender segregated and the number of participants in each group was ranged from 8-10 individuals. The discussion was conducted in

Amharic and two trained research assistants tape recorded and took note of all discussions. The discussion was transcribed and translated to English.

4.7 Pre – test

In order to determine the validity and reliability of the data collecting instrument, pilot study was conducted on small scale sample of YPWD. The questionnaire was reconstructed for additional information obtained during the pre – test.

4. 8. VARIABLES

4.8.1 Dependent variables: *- Contraceptive use, high risk sexual behavior [Multiple sexual partner, early sexual initiation…] and related problem [unintended pregnancy, Abortion, STI].*

4.8.2 Independent variables*: Socio-demographic variables [sex, age, religion, educational status, marital status, ethnicity, income, family status and parent's education, marital status].*

4.9 Operational Definitions:

Age at sexual initiation: *is age at first intercourse. It doesn't include any other non-intercourse sexual contacts (Kissing, Caressing, etc.)*

Casual sex: *is taken as sexual intercourse between young people and their partners whose length of acquaintance is short (two days or less) and involved no explicit financial or material exchange*

Early sexual initiation: *is taken as an experience of first intercourse before 18 years of age*

Multi partner sexual contact*: - having sexual intercourse with more than one partner / having more than one person for sex/.*

Reproductive Health needs*: perceived and unperceived health needs related to sexuality, contraception, pregnancy, STIs, HIV/AIDS, access to services and reproductive health information*

Perceived needs*: Needs that young people considered.*

Unperceived needs*: Needs that young does not consider.*

Risky sexual behavior (practice): *Young people who had sex earlier than 18 years of age, or have sex with non-regular sexual partner or exchange sex for money (money for sex), sexual activity under the influence of substances, or have more than one sexual partner or use condoms inconsistently / not at all.*

Sexuality*: A broad term, which covers what we physically are, what we do and feel in relation to the sex we have and the social rules and guidelines available for each gender.*

Sexual Activity*: Relation of two individuals, this involves sexual intercourse. It is synonymous with the expressions like sexual experience and has had sex.*

Young People*: - is defined as people between ages 10 and 24 years.*

Impairment: *"any loss or abnormality of psychological, physiological, or anatomical structure of function. Impairments of some organs of functions can lead to disability.*

Disability: *"any restriction of lack (resulting from an impairment) of ability to perform activity in the normal manner for a human being." Disability may be temporary, lasting for a limited period, or permanent, not expected, or later on, acquired. It can also be progressive, going for the worst, or regressive, leading to improvement or complete recovery*

Handicap: *defined as "a disadvantage for a given individual, resulting from an impairments or disability that limits or prevents the fulfillment of a role that is normal depending on age, sex, social and cultural factors, for the individual (1).*

4.10 Data analysis procedures:

Data were checked for completeness and internal consistency of responses manually. Data were then coded; entered, cleaned and analyzed using Epi Info version 3.3 and SPSS version 13 software statistical packages. Frequencies, proportions, measures of central tendencies and measures of variation were calculated and used to describe the study population; then Chi-squared test (χ^2) was used to determine the presence of statistically significant associations between the dependent variable and the independent variables. Statistical significance was considered at α. ≤ 0.05. The degree of association between dependent and independent variables was assessed using crude odds ratio with 95% confidence interval. Adjusted odds ratio was also calculated using logistic regression analysis model in SPSS version 13 statistical programs to control potential confounding variables. All focus group discussions were taped, transcribed and translated. Hard copies of the original data were kept in a safe place while soft copies of the original data were stored in back up files in different computers and the results were summarized and presented in text and using simple descriptive statistical contingency tables.

4.11 Data quality management:

The instrument was derived from standard data collection tools and the quality of data was assured through careful design, translation and retranslation of the questionnaire. It was pre-tested for clarity, sensitivity, time as well as consistency of responses by taking 5% of the sample size, was conducted in a similar population, necessary modifications was made accordingly before use. Proper training of the interviewers and supervisors, close supervision of the data collecting procedures to ensure that the information are properly collected & recorded, proper categorization and coding of the data were carried out after the information was checked again for completeness & internal consistency.

4.12 Ethical Consideration

Ethical approval was obtained from the ethical committee of School of Public Health and the Faculty of research and publication committee. A formal letter was also obtained from the University to proceed the study, the purpose of the study was explained to the respective associations and the study subjects, a written informed consent was obtained from the study subject before collecting the data to confirm their willingness to participate. For those study subjects < 18 years old separate assent was used. Those who were not willing to participate were given the right to do so. Privacy was maintained during the interview and confidentiality of the information was assured by omitting the names of the respondents from the questionnaire. In addition confidentiality was maintained by the data collector, investigator and the research assistant throughout the study.

CHAPTER V

Results

A total of three hundred eighty four young people with disability aged between 10-24 years from selected association of people with disability participated in this study and 10% was added to compensate for non response.

5.1. Socio-Demographic Characteristics

Among the respondents 194 (50.5%) were males and 190 (49.5%) females. Majority of the respondents were between the age ranges of 20-24 years.

Regarding educational status, majority 324(84.4%) of the respondents were literate, most, 138 (42.6%) of the respondents were in grade 9-12, followed by above grade 12, 93 (28.7%). Majority of respondents 238 (62%) were followers of Orthodox Christianity. Regarding their ethnicity majority 186 (48.4%) belonged to Amhara followed by Oromo 90 (23.4%), Tigrie 64 (16.7%) ethnic group. Most, 236 (61.5%), of the respondents had no any partner followed by those who had boy/girl friend (were with in stable relation) 112 (29.2%). Regarding the forms of disability blindness, deafness, impairment of the limb, accounts for 127 (33.1%), 125 (32.6%) and 100 (26%) respectively. Eighty six (22.4%) of the respondents were living with both parents. Only 118 (30.7 %) of the respondents were engaged in some kind of paid job out side of home, among them 56 (47.5%) earn 10-20 birr per day. Half of parents of the respondents, 190 (49.5%) were married and live together. Most, 178 (46.4%) of the respondents mother were illiterate. Their fathers education status was literate for 164 (42.6%) of the respondents. Half (51.3%) of the respondents perceived their family economic status as medium followed by poor 97 (25.3%) relative to their neighbors. (Table 1)

Table 1-*Socio demographic characteristics of YPWD, Sept.2007, Addis Ababa*

Characteristics	Sex				Total	
	Male		Female			
	№	%	№	%	№	%
Age group (Years)						
10-14	*1*	*0.3*	*4*	*1.0*	*5*	*1.3*
15-19	*53*	*13.8*	*38*	*9.9*	*91*	*23.7*
20-24	*136*	*35.4*	*133*	*34.6*	*269*	*70.1*
Don't know	*4*	*1.0*	*15*	*3.9*	*19*	*4.9*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Educational status						
Literate	*168*	*43.8*	*156*	*40.6*	*324*	*84.4*
Illiterate	*26*	*6.8*	*34*	*8.9*	*60*	*15.6*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Educational level						
Read and write	*2*	*0.6*	*4*	*1.2*	*6*	*1.9*
1 to 8 grade	*40*	*12.3*	*47*	*14.5*	*87*	*26.9*
9 to12 grade	*75*	*23.1*	*63*	*19.4*	*138*	*42.6*
Above grade12	*51*	*15.7*	*42*	*13.0*	*93*	*28.7*
Total	*168*	*51.9*	*156*	*48.1*	*324*	*100*
Religion						
Orthodox	*133*	*34.6*	*105*	*27.3*	*238*	*62.0*
Muslim	*22*	*5.7*	*17*	*4.4*	*39*	*10.2*
Protestant	*26*	*6.8*	*56*	*14.6*	*82*	*21.4*
Catholic	*3*	*0.8*	*7*	*1.8*	*10*	*2.6*
No religion	*8*	*2.1*	*5*	*1.3*	*13*	*3.4*
Others	*2*	*0.5*	*0*	*.0*	*2*	*o.5*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Ethnicity						
Amhara	*98*	*25.5*	*88*	*22.9*	*186*	*48.4*
Oromo	*46*	*12.0*	*44*	*11.5*	*90*	*23.4*
Tigrie	*30*	*7.8*	*34*	*8.9*	*64*	*16.7*
Other	*20*	*5.2*	*24*	*6.3*	*44*	*11.5*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Marital status						
Married	*8*	*2.1*	*9*	*2.3*	*17*	*4.4*
Within stable relation	*57*	*14.8*	*55*	*14.3*	*112*	*29.2*
Have no any partner/ unmarried	*125*	*32.6*	*111*	*28.9*	*236*	*61.5*
Divorced	*1*	*0.3*	*9*	*2.3*	*10*	*2.6*
Widowed	*0*	*0*	*3*	*0.8*	*3*	*0.8*
Separated	*3*	*0.8*	*3*	*0.8*	*6*	*1.6*
Total	*194*	*50.5*	*190*	*49.8*	*384*	*100*

Characteristics	Sex				Total	
	Male		Female			
	№	%	№	%	№	%
Forms of Disability						
Deaf	*65*	*16.9*	*60*	*15.6*	*125*	*32.6*
Blind	*74*	*19.3*	*53*	*13.8*	*127*	*33.1*
Upper limb	*4*	*1.0*	*12*	*3.1*	*16*	*4.2*
Lower limb	*44*	*11.5*	*56*	*14.6*	*100*	*26.0*
Both limb	*7*	*1.8*	*9*	*2.3*	*16*	*4.2*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Living Condition						
With Both parents	*40*	*10.4*	*46*	*12.0*	*86*	*22.4*
With Either of the parents	*24*	*6.3*	*34*	*8.9*	*58*	*15.1*
With Relatives	*23*	*6.0*	*26*	*6.8*	*49*	*12.8*
With Friends/peers.	*35*	*9.1*	*21*	*5.5*	*56*	*14.6*
With Partner	*10*	*2.6*	*8*	*2.1*	*18*	*4.7*
Alone	*32*	*8.3*	*30*	*7.8*	*62*	*16.1*
Orphanages	*24*	*6.3*	*16*	*4.2*	*40*	*10.4*
Others	*6*	*1.6*	*9*	*2.3*	*15*	*3.9*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Occupation						
Yes	*74*	*19.3*	*44*	*11.5*	*118*	*30.7*
No	*120*	*31.3*	*146*	*38.0*	*266*	*69.3*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Occupation Types						
Gov't Employee	*9*	*7.6*	*4*	*3.4*	*13*	*11.0*
Non Gov't Employee	*23*	*19.5*	*10*	*8.5*	*33*	*28.0*
Private work	*11*	*9.3*	*9*	*7.6*	*20*	*16.9*
Casual Laborer						
-Shoe shining	*7*	*5.9*	*1*	*0.8*	*8*	*6.8*
-Carrying small items	*5*	*4.2*	*0*	*.0*	*5*	*4.2*
-Delivering messages	*2*	*1.7*	*3*	*2.5*	*5*	*4.2*
-Selling small items	*10*	*8.5*	*9*	*7.6*	*19*	*16.1*
-Attending cars.	*3*	*2.5*	*3*	*2.5*	*6*	*5.1*
-Exchange of money for sex	*3*	*2.5*	*3*	*2.5*	*6*	*5.1*
-Begging	*0*	*.0*	*1*	*0.8*	*1*	*0.8*
-Others	*1*	*0.8*	*1*	*0.8*	*2*	*1.7*
Total	*74*	*62.7*	*44*	*37.3*	*118*	*100*
Income (in Birr) per day						
Less than Five birr	*6*	*5.1*	*7*	*5.9*	*13*	*11*
5 to 10 birr	*22*	*18.6*	*23*	*19.5*	*45*	*38.1*
10 to 20 birr	*42*	*35.6*	*14*	*11.9*	*56*	*47.5*
Greater than 20 birr	*4*	*3.4*	*0*	*.0*	*4*	*3.4*
Total	*74*	*62.7*	*44*	*37.3*	*118*	*100*

Characteristics	Sex				Total	
	Male		Female			
	№	%	№	%	№	%
Parental marital Status						
Married & Live together	*93*	*24.2*	*97*	*25.3*	*190*	*49.5*
Separated	*13*	*3.4*	*11*	*2.9*	*24*	*6.3*
Divorced	*16*	*4.2*	*8*	*2.1*	*24*	*6.3*
Widowed	*65*	*16.9*	*62*	*16.1*	*127*	*33.1*
Don't know	*7*	*1.8*	*12*	*3.1*	*19*	*4.9*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Mother's education						
Illiterate	*87*	*22.7*	*91*	*23.7*	*178*	*46.4*
Literate	*72*	*18.8*	*57*	*14.8*	*129*	*33.6*
Don't know	*35*	*9.1*	*42*	*10.9*	*77*	*20.1*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Father's education						
Illiterate	*63*	*16.4*	*59*	*15.4*	*122*	*31.8*
Literate	*90*	*23.4*	*74*	*19.3*	*164*	*42.7*
Don't know	*41*	*10.7*	*57*	*14.8*	*98*	*25.5*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*
Perceived family economic status						
Rich	*8*	*2.1*	*9*	*2.3*	*17*	*4.4*
Medium	*107*	*27.9*	*90*	*23.4*	*197*	*51.3*
Poor	*50*	*13*	*47*	*12.2*	*97*	*25.3*
Do not know	*29*	*7.6*	*44*	*11.5*	*73*	*19.0*
Total	*194*	*50.5*	*190*	*49.5*	*384*	*100*

5.2. Sexual reproductive health status of YPWD

All female respondents have seen their first menstruation (menarche). Age of menarche for the majority, 68 (35.8%) of female respondents was between the age of 10-14 years. One hundred seventy four (45.3%) of the respondents have started sexual intercourse. Seventy three (42.0%) of sexually experienced respondents initiated sex early (between the age of 15-19 years of age).

Ninety one (52.2%) of the sexually experienced respondents' first sexual encounter was unplanned. Just over a third, (36.7%) of the respondents' first sexual partners were older than the respondents. Only 79 (45.4%) of the sexually experienced

respondents have used some kind of contraceptive at their first sex and the type of contraceptive used by the majority 70 (88.6%) of them was condom.

Sixty six (37.9%) of the respondents' reason for initiating first sexual intercourse was being in love followed by personal desire 56(32.2%), marriage 16(9.2%), peer pressure 14(8.0%) and rape11 (6.3%). (Table 2)

Table 2. Sexual reproductive Health status of YPWD, Sept.2007, Addis Ababa

Characteristics	***N***	***%***
Age at menarche/ for females/		
10-14 years	*68*	*35.8*
15-19 years	*60*	*31.6*
>=20 years	*2*	*1.1*
Don't remember	*60*	*31.6*
Total	*190*	*100*
Ever had sexual intercourse		
Yes	*174*	*45.3*
No	*210*	*54.7*
Total	*384*	*100*
Age at first sex		
<=9 years	*2*	*1.1*
10-14 years	*5*	*2.9*
15-19 years	*73*	*42.0*
20-24 years	*52*	*29.9*
Don't remember	*42*	*24.1*
Total	*174*	*100*
First sexual partner's age		
Older than me	*64*	*36.7*
Younger or the same age as me	*90*	*51.7*
Don't remember	*20*	*11.5*
Total	*174*	*100*
Relationship with first sexual partner		
Girl fried/Boy friend	*33*	*19.0*
Husband/Wife	*16*	*9.2*
Friend	*45*	*25.9*
Fiancé	*29*	*16.7*
Acquaintance	*50*	*28.7*
Others	*1*	*0.6*
Total	*174*	*100*

Characteristics	N	%
Contraceptive use at first sex		
Yes	79	45.4
No	95	54.6
Total	174	100
Type of contraceptive used at first sex		
Condom	70	88.6
Foam	1	1.3
Oral contraceptive pills	1	1.3
Injectables	5	6.3
IUD	1	1.3
Natural method	1	1.3
Total	79	100

5.3. High risk sexual behavior of YPWD

Majority, 102(58.6%) of the sexually experienced respondents had multiple lifetime sexual partners. Among the sexually experienced respondents in the 12 months period prior to the survey, 56(32.2%) had multiple sexual partners.

Thirty six (20.7%) of the respondents had sex with a casual sex partner in the 12 months period prior to the survey and only 21(58.3%) of these used a condom consistently with a casual sex partner in the past 12 months. Eighteen (18.0%) of male respondents had sex with a commercial sex partner in the 12 months period prior to the survey and only 12(66.7%) of these have used a condom consistently with a commercial sex partner. Among those who ever had sex, 44 (25.3%) of respondents had history of STD (Table 3).

Table 3. High risk sexual behavior *of YPWD .Sept.2007, Addis Ababa*

Characteristics	***No***	***%***
Life time number of sexual partner		
One sexual partner	*72*	*41.4*
Multiple sexual partners	*102*	*58.6*
Total	*174*	*100*
Number of sexual partner in the last 12 months		
One sexual partner	*118*	*67.8*
Multiple sexual partners	*56*	*32.2*
Total	*174*	*100*
Sex with a casual sex partner in the past 12 months		
Yes	*36*	*20.7*
No	*138*	*79.3*
Total	*174*	*100*
Condom use with a casual sex partner- past 12 months		
Always	*21*	*58.3*
Mostly	*3*	*8.3*
Sometimes	*5*	*13.9*
Never	*7*	*19.4*
Total	*36*	*100*
Sex with commercial sex workers in the past 12 months		
Yes	*18*	*18.0*
No	*82*	*82.0*
Total	*100*	*100*
Condom use with a commercial sex partner - past 12 months		
Always	*12*	*66.7*
Mostly	*1*	*5.6*
Sometimes	*4*	*22.2*
Never	*1*	*5.6*
Total	*18*	*100*
Ever had STIs		
Yes	*44*	*25.3*
No	*130*	*74.7*
Total	*174*	*100*

5.4. Fertility and contraceptive use of YPWD

Majority, 256 (66.7%) of respondents have never utilized any RH services. One hundred forty seven (84.5%) of the sexually experienced respondents used modern contraceptive method, and 137 (78.7%) used in the 12 months period prior to the survey, out of them only 104(75.9%) used a contraceptive method regularly. The type of contraceptive used by the majority 113 (82.5%) of them was condom followed by inject able 24(17.5%). One hundred twenty three (70.7%) among ever sexually active respondents had ever used condom and 113(64.9%) used in the 12 months period prior to the survey. Eighty seven (77.0%) of respondents' reason for using condom was to prevent HIV/AIDS followed by 78(69.0%) to prevent pregnancy and the reason given for not using condom was trusting partner, 14(17.5%), didn't think of it, 12(15.0%), Lack of Knowledge, 11(13.8%) and ashamed to ask partner 8(10.0%).

Among those sexually experienced female, 32 (43.2%) had at least one pregnancy in the past, more than half, 20(62.5 %) of the pregnancies were unintended and 16 (50%) of them had history of abortion, out of which 14(87.5%) were induced. Regarding RHS preference, most, 277 (72.1%) of respondents prefer government facilities as source of RHS. (Table 4)

Table 4. Fertility and Contraceptive use of YPWD .Sept.2007, Addis Ababa

Characteristics	***No***	***%***
Ever Utilized any RH Services		
Yes	*128*	*33.3*
No	*256*	*66.7*
Total	*384*	*100*
Ever used modern contraceptives		
Yes	*147*	*84.5*
No	*27*	*15.5*
Total	*174*	*100*
Modern Contraceptive use- past 12 months		
Yes	*137*	*78.7*
No	*37*	*21.3*
Total	*174*	*100*

Characteristics	***No***	***%***
Frequency of contraceptive use- past 12 months		
Regular/ Always	*104*	*75.9*
Irregular/ Sometimes	*33*	*24.1*
Total	*137*	*100*
Type of contraceptive used past 12 months*		
Condom	*113*	*82.5*
Contraceptive pills	*18*	*13.1*
Injectables	*24*	*17.5*
IUD	*1*	*0.7*
Ever used condom		
Yes	*123*	*70.7*
No	*51*	*29.3*
Total	*174*	*100*
Condom use during sexual Intercourse In the last 12 months		
Yes	*113*	*64.9*
No	*61*	*35.1*
Total	*174*	*100*
Frequency of usage		
Always	*82*	*72.6*
Mostly	*9*	*8.0*
Sometimes	*22*	*19.5*
Total	*113*	*100*
Reason for using condom*		
To prevent HIV/AIDS	*87*	*77.0*
Avoid pregnancy	*78*	*69.0*
Mere suggestion by partner	*15*	*13.3*
Other	*2*	*1.8*
Reason for not using condom*		
Trust my partner	*14*	*17.5*
Did not think of it	*12*	*15.0*
Did not have knowledge	*11*	*13.8*
Ashamed to ask my partner	*8*	*10.0*
Used other method	*7*	*8.8*
Decrease sexual gratification	*6*	*7.5*
Wanted to get pregnant	*5*	*6.3*
Partner refuse	*3*	*3.8*
Not available	*2*	*2.5*
Could not afford	*2*	*2.5*
Didn't like them	*2*	*2.5*
Religion	*2*	*2.5*
Ashamed to buy	*1*	*1.3*
Other	*5*	*6.3*

Characteristics	***No***	***%***
Ever pregnant		
Yes	*32*	*43.2*
No	*42*	*56.8*
Total	*74*	*100*
Had unintended pregnancy		
Yes	*20*	*62.5*
No	*12*	*37.5*
Total	*32*	*100*
Abortion ever		
Yes	*16*	*50.0*
No	*16*	*50.0*
Total	*32*	*100*
Abortion nature		
Induced	*14*	*87.5*
Spontaneous	*2*	*12.5*
Total	*16*	*100*
Preference for Source of RHS		
Gov't health facilities	*277*	*72.1*
Private health facilities	*103*	*26.8*
Others	*4*	*1.0*
Total	*384*	*100*

***** *Multiple answer questions*

5.5- Distribution of sexual activity by socio demographic characteristics of YPWD

One hundred seventy four (45.3%) of respondents were sexually active, out of them 100(57.5%) and 74(42.5%) were male and female respectively. Majority, 150(86.2%) of sexually experienced respondent were between the age range of 20-24 and only 16(9.2%) were married while 85(48.9%) & 54(31.0%) had boy/girl friend (with in stable relation) and no any partner respectively. Regarding the educational status of sexually experienced respondents, 158 (90.8%) were educated out of whom, 66(41.8%) were grade 9-12 level. Concerning religion and ethnicity, majority, 111(63.8%) and 79(45.4%) of sexually active respondents were followers of Orthodox Christianity and belonged to Amhara ethnic groups respectively.

Among the sexually active respondents, the majority 69(39.7%) were deaf followed by those with lower limb disability, 52(29.9%).Regarding living condition of sexually

active respondents, only 47(27.0%) were living with both parents and only 75(43.1%) were engaged in some kind of paid job, out of whom 44(58.7%) had daily income of 10-20 birr. Seventy seven (44.3%) of sexually active respondents were from illiterate mother where as 93(53.4%) from educated father. Eighty three (47.7%) of sexually active respondents perceived their family economic status as medium followed by poor 52 (29.9%). (Table 5)

Table- 5 *Distribution of sexual activity by socio demographic characteristics of YPWD .Sept.2007, Addis Ababa*

Characteristics	***Ever had sexual intercourse***				***Total***	
	Yes		*No*		*№*	*%*
	№	*%*	*№*	*%*		
Sex						
Male	*100*	*57.5*	*94*	*44.8*	*194*	*50.5*
Female	*74*	*42.5*	*116*	*55.2*	*190*	*49.5*
Total	*174*	*100*	*210*	*100*	*384*	*100*
Age group (Years)						
10-14	*0*	*.0*	*5*	*2.4*	*5*	*1.3*
15-19	*18*	*10.3*	*73*	*34.8*	*91*	*23.7*
20-24	*150*	*86.2*	*119*	*56.7*	*269*	*70.1*
Don't know	*6*	*3.4*	*13*	*6.2*	*19*	*4.9*
Total	*174*	*100*	*210*	*100*	*384*	*100*
Educational status						
Literate	*158*	*90.8*	*166*	*79.0*	*324*	*84.4*
Illiterate	*16*	*9.2*	*44*	*21.0*	*60*	*15.6*
Total	*174*	*100*	*210*	*100*	*384*	*100*
Educational level						
Read and write	*4*	*2.5*	*2*	*1.2*	*6*	*1.9*
1 to 8 grade	*31*	*19.6*	*56*	*33.7*	*87*	*26.9*
9 to12 grade	*66*	*41.8*	*72*	*43.4*	*138*	*42.6*
Above grade12	*57*	*36.1*	*36*	*21.7*	*93*	*28.7*
Total	*158*	*100*	*166*	*100*	*324*	*100*
Religion						
Orthodox	*111*	*63.8*	*127*	*60.5*	*238*	*62.0*
Muslim	*16*	*9.2*	*23*	*11.0*	*39*	*10.2*
Protestant	*37*	*21.3*	*45*	*21.4*	*82*	*21.4*
Catholic	*1*	*0.6*	*9*	*4.3*	*10*	*2.6*
No religion	*8*	*4.6*	*5*	*2.4*	*13*	*3.4*
Others	*1*	*0.6*	*1*	*0.5*	*2*	*0.5*
Total	*174*	*100*	*210*	*100*	*384*	*100*

Characteristics	Ever had sexual intercourse				Total	
	Yes		No			
	№	%	№	%	№	%
Ethnicity						
Amhara	79	45.4	107	51.0	186	48.4
Oromo	38	21.8	52	24.8	90	23.4
Tigrie	39	22.4	25	11.9	64	16.7
Other	18	10.3	26	12.4	44	11.5
Total	174	100	210	100	384	100
Marital status						
Married	16	9.2	1	0.5	17	4.4
Within stable relation	85	48.9	27	12.9	112	29.2
Have no any partner/unmarried	54	31.0	182	86.7	236	61.5
Divorced	10	5.7	0	.0	10	2.6
Widowed	3	1.7	0	.0	3	0.8
Separated	6	3.4	0	.0	6	1.6
Total	174	100	210	100	384	100
Forms of Disability						
Deaf	69	39.7	56	26.7	125	32.6
Blind	39	22.4	88	41.9	127	33.1
Upper limb	9	5.2	7	3.3	16	4.2
Lower limb	52	29.9	48	22.9	100	26.0
Both limb	5	2.9	11	5.2	16	4.2
Total	174	100	210	100	384	100
Living Condition						
With Both parents	47	27.0	39	18.6	86	22.4
With Either of the parents	28	16.1	30	14.3	58	15.1
With Relatives	10	5.7	39	18.6	49	12.8
With Friends/peers.	10	5.7	46	21.9	56	14.6
With Partner	16	9.2	2	1.0	18	4.7
Alone	34	19.5	28	13.3	62	16.1
Orphanage	21	12.1	19	9.0	40	10.4
Others	8	4.6	7	3.3	15	3.9
Total	174	100	210	100	384	100
Occupation						
Yes	75	43.1	43	20.5	118	30.7
No	99	56.9	167	79.5	266	69.3
Total	174	100	210	100	384	100

Characteristics	Ever had sexual intercourse				Total	
	Yes		No			
	№	%	№	%	№	%
Income (in Birr) per day						
Less than Five birr	11	14.7	2	4.7	13	11.0
5 to 10 birr	18	24.0	27	62.8	45	38.1
10 to 20 birr	44	58.7	12	27.9	56	47.5
Greater than 20 birr	2	2.7	2	4.7	4	3.4
Total	75	100	43	100	118	100
Parental marital Status						
Married & Live together	81	46.6	109	51.9	190	49.5
Separated	13	7.5	11	5.2	24	6.3
Divorced	12	6.9	12	5.7	24	6.3
Widowed	58	33.3	69	32.9	127	33.1
Don't know	10	5.7	9	4.3	19	4.9
Total	174	100	210	100	384	100
Mother's education						
Illiterate	77	44.3	101	48.1	178	46.4
Literate	68	39.1	61	29.0	129	33.6
Don't know	29	16.7	48	22.9	77	20.1
Total	174	100	210	100	384	100
Father's education						
Illiterate	40	23.0	82	39.0	122	31.8
Literate	93	53.4	71	33.8	164	42.7
Don't know	41	23.6	57	27.1	98	25.5
Total	174	100	210	100	384	100
Perceived family economic status						
Rich	9	5.2	8	3.8	17	4.4
Medium	83	47.7	114	54.3	197	51.3
Poor	52	29.9	45	21.4	97	25.3
Do not know	30	17.2	43	20.5	73	19.0
Total	174	100	210	100	384	100

5.6. Knowledge and attitudes of YPWD towards selected sexual and reproductive health issues

Majority, 312 (81.3%) of the respondents have heard about RHS. More than half, 233 (60.7%) of the respondents didn't know the correct time along the menstrual cycle when pregnancy is likely to occur. Most 351 (91.4%) of the respondents knew

the means of avoiding pregnancy such as abstinence, using different contraceptives like oral contraceptive pills, condom, inject able…etc

Regarding STI, 240 (62.5%), 201(52.3%), 180(46.9%) and 128(33.3%) of the respondents were able to mention genital ulcers, discharge from penis/vagina, pain during urination, and genital swelling as a sign and symptom of STIs respectively.

Unprotected sexual intercourse, sharing of sharp objects, blood transfusion, pregnancy and child birth and breast milk were most frequently mentioned ways of HIV transmission by 356(92.7%), 285(74.2%), 205(53.4%),160(41.7%), and 137(35.7%) of respondents respectively.

Regarding HIV prevention, abstinence and faithfulness were mentioned by majority of respondents, 294(76.6%) and 250(65.1%) respectively as ways of HIV prevention. Surprisingly only less than half, 180(46.9%) mentioned using condom as a method of HIV prevention.

Concerning attitude of YPWD about sex; only 87(22.7%) and 72(18.8%) supported premarital sex for boys and girls respectively.

Only 27(7.0%) and 60(15.6%) of respondents supported the statement about discussing condom or contraceptive with young people promotes promiscuity and using condom is a sign of not trusting partner respectively. (Table 6)

Table 6. Knowledge and Attitudes of YPWD towards selected sexual and reproductive health issues, Sept.2007, Addis Ababa

Characteristics	***N***	***%***
Ever Heard of RHS		
Yes	*312*	*81.3*
No	*72*	*18.8*
Total	*384*	*100*
Know when in the menstrual cycle pregnancy is likely to occur		
Yes	*151*	*39.3*
No	*233*	*60.7*
Total	*384*	*100*

Characteristics	*N*	*%*
Know means of avoiding pregnancy		
Yes	*351*	*91.4*
No	*33*	*8.6*
Total	*384*	*100*
Knowledge about major STD signs/symptoms*		
Genital ulcer	*240*	*62.5*
Genital discharge	*201*	*52.3*
Pain during urination	*180*	*46.9*
Genital swelling	*128*	*33.3*
Don't Know	*26*	*6.8*
Others	*2*	*0.5*
Knowledge about ways of HIV transmission*		
Unsafe sexual intercourse	*356*	*92.7*
Sharing needles & syringes	*285*	*74.2*
Blood transfusion	*205*	*53.4*
During pregnancy & child birth	*160*	*41.7*
Through breast milk	*137*	*35.7*
Through mosquito & other insect bite	*7*	*1.8*
Casual contact with a person (Hand shaking & sharing food...)	*5*	*1.3*
Others	*4*	*1.0*
Knowledge about ways of HIV prevention*		
Abstain from sexual intercourse	*294*	*76.6*
Remain faithful to a Partner	*250*	*65.1*
Use condom in every act of sexual intercourse	*180*	*46.9*
Avoid unsafe injections	*121*	*31.5*
Avoid contaminated sharp objects	*119*	*31.0*
Avoid casual sex	*108*	*28.1*
Avoid sex with CSWs	*63*	*16.4*
Others	*1*	*0.3*
premarital sex for boys is supported		
Agree	*87*	*22.7*
Disagree	*254*	*66.1*
Not sure	*43*	*11.2*
Total	*384*	*100*
premarital sex for girl is supported		
Agree	*72*	*18.8*
Disagree	*260*	*67.7*
Not sure	*52*	*13.5*
Total	*384*	*100*

Characteristics	*N*	*%*
Discussing condom or contraceptive with young people promotes promiscuity		
Agree	*27*	*7.0*
Disagree	*314*	*81.8*
Not sure	*43*	*11.2*
Total	*384*	*100*
Using condom is a sign of not trusting your partner		
Agree	*60*	*15.6*
Disagree	*261*	*68.0*
Not sure	*63*	*16.4*
Total	*384*	*100*

***** *Multiple answer questions*

5.7- Socio demographic determinants of practices of modern contraceptive use by YPWD

Among the socio-demographic characteristics; sex, age, religion, ethnicity, marital status, occupation, parental marital status, mother's and father's education and economical status, were found to have no statistically significant association with modern contraceptive use (P>0.05). But respondents' educational status and forms of disability had significant association with modern contraceptive use (P<0.05).

Odds of modern contraceptive use was seven times higher among respondents who are literate than among those illiterate (OR=7.3, 95%CI (2.5-21.8)). Use of modern contraceptive was 35 times higher among participants with hearing impairment than among those with both limb disabilities (OR=35.4, 95%CI (3.5-362.9)) as well as 35 times higher among participants with visual impairment than among those with both limb disabilities (OR=35.0, 95%CI (3.1-394.9)). It was also 17 times higher among those with lower limb disability than among those with both limb disabilities (OR =16.8, 95% CI (1.7-167.1)). Those respondents who lives with both parents were 6 times more likely to use modern contraceptive than those who lives in orphanages (OR= 5.6, 95% CI (1.3-23.2)) and those who were raised in intact family (married and live together) 3 times more likely to use modern contraceptive than those who

were raised in a non intact family (OR=2.7, 95% CI (1.0-7.3)). Even after adjustment for socio-demographic variables, respondents' educational status and forms of disability remained to have a significant association with modern contraceptive use while respondents' sex and occupation were also found to have a significant association with modern contraceptive use. (Table 7).

Table 7. Socio demographic determinants of practices of modern contraceptive use by YPWD Sept.2007, Addis Ababa

Characteristics	***Ever used modern contraceptives***		***p-value***	***Crude OR (95% CI)***	***Adjusted OR (95% CI)***
	Yes	*No*			
	№	*№*			
Sex					
Male	*88*	*12*	*0.14*	*1.9(0.8-4.3)*	*4.2(1.0-16.9)*
Female	*59*	*15*		*1.00*	*1.00*
Age group (Years)					
10-14	*5*	*1*		*1.00*	*1.00*
15-19	*13*	*5*	*0.59*	*0.5(0.5-5.6)*	*0.1(0.0-3.0)*
20-24	*129*	*21*	*0.85*	*1.2(0.1-11.0)*	*0.2(0.0-6.0)*
Educational status					
Literate	*139*	*19*	*0.000*	*7.3(2.5-21.8)*	*13.3(2.4-73.1)*
Illiterate	*8*	*8*		*1.00*	*1.00*
Religion					
Orthodox	*92*	*19*		*1.00*	*1.00*
Muslim	*11*	*5*	*0.19*	*0.5(0.1-1.5)*	*0.1(0.0-0.7)*
Protestant	*35*	*2*	*0.95*	*3.6(0.8-16.3)*	*5.0(0.5-115.6)*
Catholic	*1*	*0*	*0.84*	*101.7(0.0-8.7)*	*30797.2(0.0-9.3)*
No religion	*8*	*1*	*0.65*	*1.7(0.2-14.0)*	*7.3(0.1-766.7)*
Ethnicity					
Amhara	*65*	*14*	*0.98*	*1.0(0.4-2.5)*	*1.4(0.3-6.4)*
Tigrie	*36*	*3*	*0.17*	*2.6(0.7-10.2)*	*3.1(0.4-23.8)*
Oromo	*46*	*10*		*1.00*	*1.00*
Marital status					
Married	*13*	*3*		*1.00*	*1.00*
Within stable relation	*74*	*11*	*0.54*	*1.6(0.4-6.3)*	*1.4(0.2-10.2)*
Divorced	*7*	*3*	*0.51*	*0.5(0.1-3.4)*	*4.6(0.2-98.3)*
Widowed	*3*	*0*	*0.79*	*309.6(0.0-3.3)*	*3373.2(0.0-1.2)*
Separated	*4*	*2*	*0.47*	*0.5(0.6-3.8)*	*0.1(0.0-3.1)*
Have no any partner/unmarried	*46*	*8*	*0.71*	*1.3(0.3-5.7)*	*5.3(0.6-48.7)*

Characteristics	Ever used modern contraceptives		p-value	Crude OR (95% CI)	Adjusted OR (95% CI)
	Yes №	No №			
Forms of Disability					
Deaf	62	7	0.003	35.4(3.5-362.9)	82.8(3.5-1952.7)
Blind	35	4	0.004	35.0(3.1-394.9)	141.8(5.3-3803.5)
Upper limb	7	2	0.055	14.0(0.9-207.6)	82.7(1.8-3774.7)
Lower limb	42	10	0.16	16.8(1.7-167.1)	182.0(7.5-4403466)
Both limb	1	4		1.00	1.00
Living Condition					
With Both parents	44	3	0.18	5.6(1.3-23.2)	2.0(0.2-22.5)
With Either of the parents	22	6	0.59	1.4(0.4-4.7)	3.5(0.3-36.0)
With Relatives	7	3	0.88	0.9(0.2-4.3)	0.7(0.1-7.4)
With Friends/peers.	9	1	0.28	3.4(0.4-31.6)	0.9(0.0-21.3)
With Partenr	15	1	0.12	5.7(0.7-50.6)	8.5(0.5-152.0)
Alone	29	5	0.21	2.2(0.6-7.7)	2.6(0.4-18.8)
Orphanage(NGO)	21	8		1.00	1.00
Occupation					
Yes	61	14		1.00	1.00
No	86	13	0.32	1.5(0.7-3.5)	7.3(1.7-31.5)
Parental marital Status					
Married & Live together	74	7	0.42	2.7(1.0-7.3)	5.1(0.8-30.6)
Separated	9	4	0.42	0.6(0.2-2.2)	0.2(0.0-1.5)
Divorced	10	2	0.76	1.3(0.3-6.6)	1.8(0.2-17.7)
Widowed	54	14		1.00	1.00
Mother's education					
Illiterate	61	16		1.00	1.00
Literate	86	11	0.09	2.1(0.9-4.7)	1.8(0.4-7.9)
Father's education					
Illiterate	31	9		1.00	1.00
Literate	116	18	0.17	1.9(0.8-4.6)	1.3(0.2-6.9)
Perceived family economic status					
Rich	35	4	0.12	2.6(0.8-8.9)	1.6(0.2-11.5)
Medium	72	11	0.14	2.0(0.8-4.9)	0.5(0.1-2.5)
Poor	40	12		1.00	1.00

5.8. Substance use by YPWD

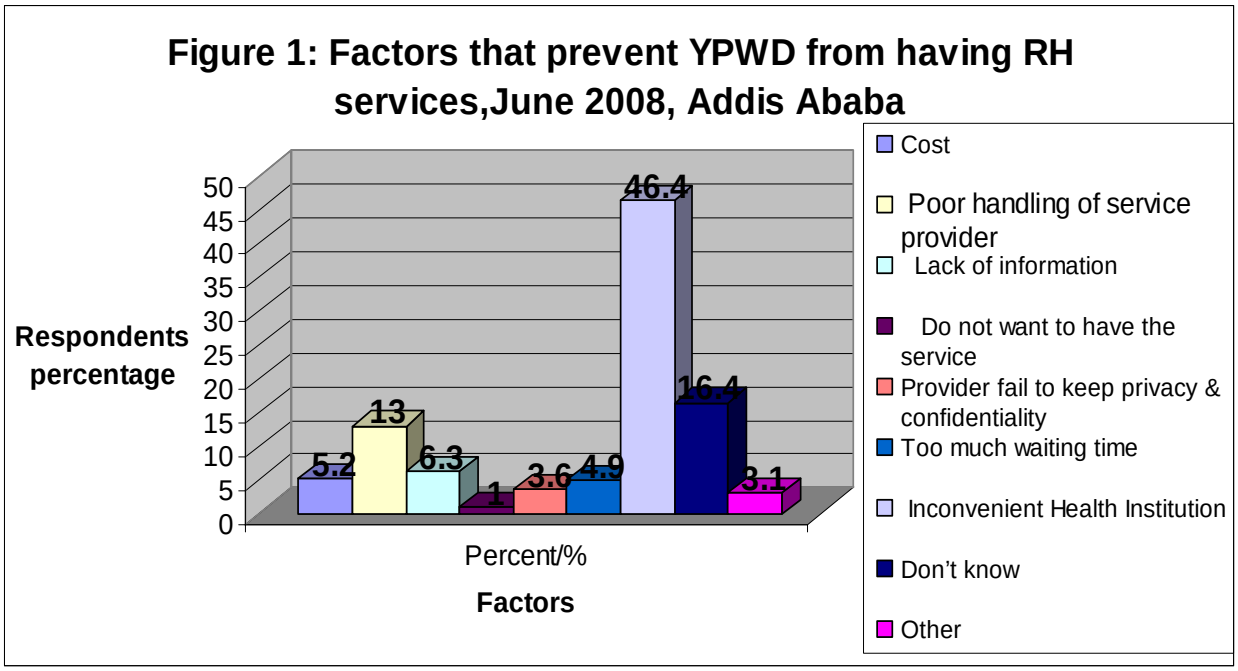
Sixty seven (17.4%) of the respondents had history of ever use of drugs (chat, cigarette, hashish, cannabis) and 150(39.1%) of respondents had history of ever intake of alcohol. Sixty seven (44.7%) of respondents who drank alcohol, drank only on holydays while 51(34.0%) drank 3-4 times a month, 32(21.3%) drank 3-4 times a week and 31 (20.7%) of respondents who took alcohol in the one month period prior to the survey had sex at the time they drank alcohol. (Table 8)

Table 8. Substance use by YPWD, Sept.2007, Addis Ababa

Characteristics	***No***	***%***
Ever use of drugs		
Yes	*67*	*17.4*
No	*317*	*82.6*
Total	*384*	*100*
Ever use of alcohol		
Yes	*150*	*39.1*
No	*234*	*60.9*
Total	*384*	*100*
Frequency of drinking		
3-4 times/week	*32*	*21.3*
3-4x/month	*51*	*34.0*
Only on holydays	*67*	*44.7*
Total	*150*	*100*
Had sex after being drank past one month		
Yes	*31*	*20.7*
No	*119*	*79.3*
Total	*150*	*100*

5.9. Factors preventing YPWD from having SRH services

Most of the respondents, 178 (46.4%), did not go for SRH service due to inconvenient health institution followed by poor handling of service provider 50 (13%). Sixty three (16.4%) of the respondents don't know any factor preventing YPWD from having SRH services. (Figure-1)



5.10. Parent-teen communication and other sources of information on sexuality and reproductive health for YPWD

Regarding the behavior of YPWD to discuss SRH topics with parents, Majority, 308 (80.2%) of the respondents did not have discussion on SRH topics.

Most, 209 (54.4%) of respondents preferred to discuss topics on sexuality and reproductive health with friends,112 (29.2%) with health professionals and 53 (13.8%) with boy/girl friends.

More than one third of the respondents 146 (38.0%) reported that they have used TV/Radio as a major sources of SRH information followed by health professional, 112(29.2%), 54(14.1%) friends and 44(11.5%) associations. (Table 9)

Table 9. Parent-teen communication and other sources of information on Sexuality and Reproductive health for YPWD, Sept.2007, Addis Ababa

Characteristics	***No***	***%***
Ever discussed SRH topics with parents		
Yes	*76*	*19.8*
No	*308*	*80.2*
Total	*384*	*100*
Prefer to discuss SRH topics with		
Friends	*209*	*54.4*
Health professional	*112*	*29.2*
Boyfriend/girlfriend	*53*	*13.8*
Mother	*19*	*4.9*
Sister	*14*	*3.6*
Father	*8*	*2.1*
Husband/Wife	*6*	*1.6*
Other	*4*	*1*
Major Source of SRH information		
*TV/Radio**	*146*	*38.0*
Health professionals	*112*	*29.2*
Friends	*54*	*14.1*
Associations	*44*	*11.5*
News paper	*38*	*9.9*
School Teachers	*30*	*7.8*
Parents	*19*	*4.9*
Partners	*1*	*0.3*
Others	*9*	*2.3*

***** *All respondents with different forms of impairment were asked.*

5.11- Results from focus group discussions

Two Complimentary focus group discussions were conducted, a total of 18 study participants participated in the discussions, and 9 were females participated in female FGDs and the rest, 9 were in males

1. Regarding sexual reproductive health matter and associated problems

All participants of the discussions agreed that Young People with Disability have similar Sexual and Reproductive need as non disabled one; how ever problems associated with sexual and reproductive Health are a major health problem for disabled than the non disabled youth. Even the problem is more serious for YFWD than YMWD. Young people with disabilities cited a number of RH problems, which they are faced with and associated factors. These include sexual exploitation, unwanted pregnancies, improper use of contraceptives and problem during pregnancy and childbirth due to lack proper treatment, abortion, STI/HIV/AIDS, lack of access to information and services, poor handling of health care provider, poor living condition and negative attitude and lack of open discussion within the family and the society etc.

Sample quotations to back this up were:

"….. let me tell you my experience, there was one elder daughter in the family, she is handicapped; all her little sisters married in ceremony, when she bring her boy friend to her family to introduce him, then she was asked as why she started it because they think as it will not be successful. Even though she is convinced, they don't want because they may not want to spend money, time…..for her marriage. They don't think it is allowed for the handicap female to marry in ceremony." (A young female participant explained)

"There are a lot of blind females, our living standard is low, and we are very near to be attacked by males, because of our problems. Due to this we may face different problems like HIV, STI, unwanted pregnancy, abortion etc." (A young female participant explained)

"Handicap women faces problem when they give birth, since their living standard is low. They have no choice and most of them will be forced to beg." (A young female participant explained)

2. Regarding substance use of YPWD

Almost all FGD discussants agreed that Young People with Disability have similar non sexual risky behaviors as the non disabled one. A young male participant explained that

"The issue of abusing drug, cigarette or alcohol, and others, may be due to being unemployed in cases of disabled young people. When YPWD wants to continue their education, the social and economical influence may make it difficult; it is rare to overcome such situation. In order to forget and escape such facts, you may chew chat. When you chew chat, it is likely to smoke cigarette, and if you smoke, you want to take alcohol. After you take alcohol you want to have sex. Then you go to do what you want in the mean time. You may be exposed to HIV and other sexually transmitted infections."

3. On SRH service issues,

Poor service provider handling and inconvenient health institution was also indicated as a factor that affects the RH status of the disabled by the majority of the participants. Typical responses were:

"In the first place, the building itself is a problem. When we see the hospitals constructed in our country, there is no health facilities designed and constructed considering the handicaps. They have a lot of floors up; it is difficult for those who use wheelchair. Secondly, if even they reach there with the help of others, they may not get appropriate treatment from the service providers"

"One female handicap was HIV positive and she used to go to hospital take the antiretroviral drugs, There was one doctor and his thinking was she couldn't be infected by HIV/AIDS, because he thinks that disabled youth are sexually inactive to acquire HIV." (A young participant explained)

"My sister has already said it, most of them are true, I have seen it also, it is in Lideta Sub city, one handicapped female was pregnant and want to the clinic to give birth, when she go there, she is asked why you being pregnant, why don't you stay quite, why you add another problem on your handicap or how you are going to care for your baby. They don't think that a handicap female can give birth and care for her baby like others do." (A young participant explained)

“For example if a physician gets young people with disability, he just let him in and does something for him. The major problem is that he acts like he is doing some humanitarian service; he doesn't consider his action as his professional duty.” (A young male participant explained)

4. On the issues of “ how YPWD have got reproductive health information

Some discussants from both categories of FGD, identified media, school specifically biology courses, Associations and families as major sources of SRH information. How ever lack of access to SRH information also identified as a major problem by majority of participants particularly by those with hearing and visual impairment.
A Sample quotations to back this up was,

“Government should do something for the handicapped people. Look even those with hearing impairment; there is nothing beyond watching TV. Those with visual impairment do not have access to much information too. There is no one who knows sign language in the facility, it would be better if pamphlets or fliers published to them. I think it is great if government make health organizations publish pamphlets that addresses PWD; and make them know about reproductive health, HIV/AIDS, sex, relationship of opposite sexes etc” (A young participant explained)

Regarding the question “Do families discuss sexuality issues openly with their family members?” Almost all participants mentioned that there is no open discussion between family members on sexuality issues.
A Sample quotations to back this up was,

“I don’t have such discussion in my family; because in my family, my mother is illiterate, let alone the illiterates, the educated one can't understand. Also when we come to the handicapped female, they are not given attention.” (A young participant explained)

CHAPTER VI

Discussion

This study represents an initial effort to assess the sexual reproductive health status and related problems of YPWD in selected associations of people with disability in Addis Ababa. It has tried to enroll young people with disability aged between 10-24 years who are currently registered as a member of the association. Almost all the participants were volunteers to participate, resulted an effective sample size of 384 for analysis. Comparison may be difficult because of lack of similar study with similar objectives, using similar method and target population in our country.

In this study 174 (45.3%) of respondents ever had sexual intercourse, out of them 100(57.5%) and 74(42.5%) were male and female respectively. Majority, 73 (42.0%) of them started sex between the age of 15-19 years and only 16(9.2%) were married. Ninety one (52.2%) of the sexually experienced respondents' first sexual encounter was unplanned. Just over a third, 64(36.7%) of the respondents' first sexual partners were older than the respondents. Only 79 (45.4%) of the sexually experienced respondents have used some kind of contraceptive during their first sexual encounter. This finding is similar with findings of a study done in different parts of the world; Health surveys and social studies conducted in different parts of the world, in recent years have indicated that, in many countries, most teenagers (60% to 70%) are sexually active (23). A study conducted in Nazareth high schools have showed that 24% of respondents reported having experienced sexual intercourse, with 60% reported having had their first sexual experiences between the ages of 15 and 16 (24). Other Studies conducted in different parts of the country showed that the mean age for the first sexual contact for Ethiopian adolescents is between 13.6 and 18 years (25, 26, 27, 28). The above facts indicate many young people engage in sexual activity before marriage and do so at early age often without any protection against pregnancy, STIs or other potential reproductive health risks associated with unplanned sexual experiences. This holds true for disabled youth, as indicated by the results of the study conducted in Kampala that the estimated median age at first sexual activity is 16 years for women with Disability

and 18 years for men (11). This has very important implications for the sexual and reproductive health of YPWD and reaffirms the need to gear the focus of available SRH service and programs not only on the non disabled youth but also on disabled one that helps YPWD in many ways.

Ever use of modern contraceptive among ever sexually experienced respondents was 84.5% and current use in the 12 months period prior to the survey was 78.7%. In this study, male respondents and those who are literate were 4 and 7 times more likely to use modern contraceptive respectively. Ever use of condom among ever sexually active respondents was 70.7% and condom use in the 12 months period prior to the survey was 64.9% in this study. This study finding is higher compared to the results of the study conducted in Kampala among YPWD which indicated that ever use of condoms is 44% among men compared to 27% of the women with disability, current use of condoms is only 24% and 10% of men and women respectively. Ever use of modern methods is 33% among women and 35% among men with disability. Current use of modern methods is 21% of men and 30% of women (11). This variation could be explained by the fact that our study considered only sexually experienced respondents as denominator while the Kampala study included both sexually experienced and non experienced YPWD (all respondents).

In this study 16.8% of all disabled female respondents had history of one or more pregnancies, as compared to the result of National Longitudinal Study in the United States, in which three to five years after completion of high school, females with disability were significantly more likely to be mothers than were either non- disabled females or disabled males, 40.6% of all disabled females in this age range had given birth to one or more children. For young women with emotional disturbances, learning disabilities or those with hearing impairments, almost 50% had become pregnant in the years immediately following high school. For disabled females who had dropped out of school, 54% had become mothers. The majority of these pregnancies occurred outside of marriage (10). The Kampala study finding indicates that, 77% of the disabled Young women in the sample had ever been pregnant (11).This variation could be explained by the fact that our study included only YFWD in the selected associations, among whom history of ever being pregnant can be low

while the above studies are a national studies included all young females with disability. Findings of the Ethiopia DHS 2000 also showed 37% of all women 15-24 years started child bearing (37), a much higher figure compared to 16.8% in this study, may be due to the fact that data collected by DHS involved both urban and rural nationally and consider all young females.

Rate of unintended pregnancy 62.5% among young disabled females who had ever been pregnant in this study was comparable with District-specific results of the study conducted in Kampala(11), and higher to Ethiopia DHS 2000 results in which more than one in three births to women age 15-19 and 20-24, at the time of birth, is unintended (37). This could be due to the fact that our study included only disabled youth among whom a pregnancy is most likely to be unintended. In reality, young people with disability often have little or no say over where they will live, whom they will live with and what role they will play within their families or communities. Moreover disabled young people are often denied the right to build families of their own. Social and family constraints make it unlikely that many young people with disabilities will marry. Indeed, in some countries, individuals with some types of disability are unable to legally obtain a marriage license. This is particularly true for disabled young women (10).

Un intended pregnancy may lead to an induced abortion, which in the case of un experienced or ashamed adolescent is likely to take place later in the pregnancy and involve greater risks to life, health and future fertility and the proportion of adolescents who seek abortion has been increasing, especially among younger adolescents (15-17years) (35).This holds true on YPWD, in this study 50% of those who had ever been pregnant had history of abortion, 87.5% of this abortion was induced type. A higher rate of unintended pregnancy as well as abortion among ever pregnant disabled youth is indicative of poor access to SRH services to this segment of youth.

High risk sexual behavior of study subjects was assessed by certain behavioral and proxy indicators. In this study, 58.6% of the sexually active respondents had multiple life time sexual partners, 20.7% had a casual sex partner, and 18.0% of sexually

active males in the past 12 months had a commercial sex partner. Ever use of drugs and alcohol among respondents was17.4% and 39.1% respectively, and 20.7% of ever use of alcohol respondents had sex after being drank in one months period prior to the survey. This finding is also supported by the results of the Global Survey on Disability and HIV/AIDS conducted by Yale University and the World Bank; it has proven that, individuals with disability have equal or greater exposure to all known risk factors for HIV infection. For example, adolescents and adults with disability are as likely as their non-disabled peers to be sexually active and to be involved in high risk sexual behavior. Individuals with disability are as likely as non-disabled people to use drugs and alcohol (20).

History of ever having STI among ever sexually active respondents was 25.3%, a lower figure compared to results of the study conducted in Kampala among PWD, that indicate, Incidence of STIs (proportion ever contracted sexually transmitted diseases) is very high (38% of women and 35% of men) (11).The lower figure of STI in this study could be due to the data collection technique used in this study (interview method) by which youth might not easily reveal such facts especially in our culture/ tradition.

In this study, only 55.5%, 33.1% and 51.8% of respondents had good knowledge on HIV transmission, STI Sign and symptom, HIV Prevention respectively, which is a much lower result as compared to results of the study conducted in Kampala that indicates, awareness about sexually transmitted infections is over 91% for either sex and awareness about HIV/AIDS is almost universal. Most young persons with disabilities are aware that HIV is transmitted through sexual intercourse with an infected party (11). In addition to this lower result, the presence of high level of high risk sexual behavior among YPWD indicates that they have low access to SRH education program that helps young people with disability to have responsible sexual practice.

Majority, (81.3%) of the respondents have heard about RHS, however, only 33.3% of respondents had utilized SRHS. Media and health care professionals were cited as major sources of information for 38% and 29.2% of respondents respectively.

This study result is similar with the study finding conducted in Kampala and lower compared to the result of a study of adolescent reproductive health conducted in East Gojjam that revealed, the most common source of information on STIs/ HIV/ AIDS was media (82%) and neighbors (67%) for urban and rural out of school adolescents respectively and more than half of the participants (55.2%) had reported that they had visited health institutions for reproductive health reasons (25). The low service utilization in this study could be due to the difference in the character of the study subjects, the available services and sources of information may not be convenient for the disabled.

Regarding respondents preference, the majority, 72.1% prefer to have the service at government/public health facilities and the major reasons that prevent YPWD from having RHS were reported to be inconvenient health institution (46.4%) and poor handling of service provider (13.0%), this result is comparable with the study result conducted in Kampala that revealed majority however; feel RH services are not accessible to persons with disabilities. This was attributed to geographical inaccessibility of health facilities, unfriendliness of the service providers, poverty, lack of awareness on reproductive health issues and lack of confidentiality (11).

During the focus group discussion the main point raised as the primary factor that affects the RH status of YPWD was societal attitude, low level of education and awareness of the family, lack of access to education, reproductive health information and services, socio economical factor and absence of employment opportunities etc. Lack of employment opportunity and negative societal attitude were cited as the main reason by YPWD to visit "khat bet" and "tella bet" which may be a sign of hopelessness and may exposes them to HIV/AIDS and other sexually transmitted infections. Among others lack of access to SRH information and services, due to poor handling, inconvenient health facilities and others were also identified as a major problem that affects the health of young people with disability by almost all FGD discussants, which is comparable finding with the qualitative finding of the study conducted in Kampala (11).

Limitation and Strength

Limitation

- *Lack of reference material for comparison was one of the limitations of the study.*
- *The sensitivity of the issue and the use of interview, might have under estimated the magnitude of the problem*
- *Some problems in collecting data from some categories of study subjects particularly from those with hearing impairment*

Strength

- *The use of focus group discussion & relatively large sample are believed to provide reliable and accurate findings.*
- *Using well trained data collectors who know sign language.*
- *Considering this marginalized group of population*

Chapter VII

Conclusion and Recommendation

7.1 Conclusion

From this study finding it can be said that YPWD are at risk for sexual and reproductive health associated problems. Many young people engaged in sexual activity before marriage and do so at early age. Majority of the sexually experienced respondents' first sexual encounter was unplanned often without any protection against pregnancy, STIs or other potential reproductive health risks associated with unplanned sexual experiences.

Over all modern contraceptive use and condom use were high while condom use in the 12 months period prior to the survey was some how low. YMWD and those who are literate were more likely to use modern contraceptive

There was high rate of unintended pregnancy and high rate of abortion among ever pregnant young female with disability. This is indicative of poor access to SRH services to this segment of population.

High proportion of sexually experienced YPWD had multiple sexual partners during the life time as well as in the 12 months period prior to the survey. Many of them were practicing sexual intercourse with a casual sex partner and commercial sex partner in the past 12 months prior to the survey. Proportion of sexually active YPWD with history of ever having STI was also high

Generally a lower proportion of YPWD had good knowledge on HIV transmission, STI Sign and symptom and HIV Prevention.

High proportions of YPWD have heard about RHS, however, lower proportion of YPWD had utilized RHS; Media and health care professionals were cited as major sources of information and the major reasons that prevent YPWD from having RHS were reported to be inconvenient health institution and poor handling of service provider.

7.2 Recommendation

The findings from this study clearly indicate the need to promote sexual and reproductive health among YPWDs as a right and to also respond to their sexual and reproductive health needs. In order to effectively address the RH needs of YPWDs, there is a need to design and implement YPWD-specific interventions. This requires commitment and involvement of different parties like individuals, families, higher officials, governmental and non governmental organizations.

- *Incorporating sexuality education in school curricula starting as early as the primary level is an important first step and organizing education session in the area where most YPWD benefit. The focus of such education should be not only on knowledge but acquisition of essential skills (communication, negotiation, and refusal skills) as well as equip YPWD with self-esteem through provision of life -skills training thus improve their esteem and confidence for better RH outcomes. Moreover education should be arranged to the specific population in order to address their specific needs according to the type of impairment. Information, education and communication (IEC) on RH for YPWDs also need to be developed with special focus not only on the messages but also special focus on the various forms of disability.*
- *Parents, family members and the entire community have to be sensitized about the need to provide a safe environment for YPWDs.*
- *Provision of skill training for YPWD in income generating activities (IGAs) also has equal importance.*
- *Political Leaders/policy makers need to play a major Role in Relation to Improvement of RH Situation of YPWDs and in empowering associations of person with disabilities to engage more effectively in the prevention activities*
- *Health or other institutions delivering RH service should work with this special community group, local institutions, associations and different organizations for YPWD to provide information about changes accompanying puberty; how pregnancy occurs; the health, emotional and socioeconomic risks of early pregnancy and about contraceptives.*

- *Reproductive health services need to be made use friendly and service providers need to distribute condoms and other contraceptives including emergency contraceptives in the best possible out lets which will be suitable for YPWD. Consideration should also be given in using these areas for the delivery of basic SRH counseling, information and services.*
- *Encourage use of condom with every act of intercourse and provide young men with information about increased risk of HIV transmission from sex workers and the special need for condom use during these sexual contacts*
- *YPWD need be encouraged to seek treatment for sexually transmitted diseases as early as possible*
- *Improving the quality of the available services and recognize and make corrective action on unfriendly attitude and behavior of health service provider's and on the construction of the building.*
- *Training of RH and HIV/AIDS service providers is also central to effectively reach YPWDs. The training requirements include: change in attitudes towards YPWDs so that they can be viewed as people with sexual and reproductive health needs*
- *Training of RH service provider in sign language in order to guarantee confidentiality among young people with hearing impairment, which is the cornerstone of RH and HIV/AIDS service utilization when this segment of populations are considered.*

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Annex I: Questionnaire and Consent Form

Questionnaires on:

Assessment of the reproductive health status and related problems of disabled youth in selected Handicapped Association, Addis Ababa.

Written Informed Consent Agreement

Dear participant,

In ensuring the health of young people with disability, the understanding of SRH status and existing problems related to sexuality and reproduction on this group of the population is important. In line with this a study is proposed to assess the SRH status

and related problems of disabled youth at selected handicapped associations and you are chosen to participate in this study. Therefore, I would like to inform you that you and I would have a short discussion concerning this study. Before we go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and tell me whether you agree or disagree to participate in this study.

The purpose of this study is to assess and generate information on sexual reproductive health status and related problems of YPWD (10-24 years) and to forward appropriate Recommendations through which the sexual reproductive health status of disabled youth will be improved.

The study will involve various intimate and private life questions, so I am going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written in this form, and will never be used in connection with any of the information you tell me. You don't have to answer any questions that you don't want to answer and you may end this interview at any time you want to. However your honest answers to these questions will help us to better understand the SRH status of YPWD and design an intervention that targets this group of population. We would greatly appreciate your help in responding to this survey. The interview is voluntary and will take about 30 minutes.

Are you willing to participate in this study?

[ ] Yes. [ ] No

Signature----------Date----------

Thank You Very Much!!

Annex I: <u>Questionnaire and Assent Form</u>

Questionnaires on:

Assessment of the reproductive health status and related problems of disabled youth in selected Handicapped Association, Addis Ababa.

Assent Form for < 18 years old participants

In ensuring the health of young people with disability, the understanding of SRH status and existing problems related to sexuality and reproduction on this group of the population is important. In line with this a study is proposed to assess the SRH status and related problems of disabled youth at selected handicapped associations and your child is chosen to participate in this study. Therefore, I would like to inform you that your

child and I would have a short discussion concerning this study. Before we go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and tell me whether you agree or disagree to let your child to participate in this study.

The purpose of this study is to assess and generate information on sexual reproductive health status and related problems of YPWD (10-24 years) and to forward appropriate Recommendations through which the sexual reproductive health status of disabled youth will be improved.

Are you willing to let your child to participate in this study?

Yes_____ No_____

Signature_____ Date_____

Dear participant,

The study will involve various intimate and private life questions, so I am going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written in this form, and will never be used in connection with any of the information you tell me. You don't have to answer any questions that you don't want to answer and you may end this interview at any time you want to. However your honest answers to these questions will help us to better understand the SRH status of YPWD and design an intervention that targets this group of population. We would greatly appreciate your help in responding to this survey. The interview is voluntary and will take about 30 minutes.

Are you willing to participate in this study?

[ ] Yes. [ ] No

Signature----------Date----------

Thank You Very Much!!

***Code No**----------*

SECTION 1: Background characteristics

Q.No	*Questions*	*Alternatives*	*Code*
101	*Sex*	*1.Male* *2.Female*	
102	*Age in years[enter number]*	*1---------- years* *2. Don't know*	
103	*Marital status*	*1. Married* *2. Have boy/girl friend* *3. Have no any partner* *4. Divorced*	

		5. Widowed *6. Separated* *7. Other, specify----------*	
104	*Religion*	*1.Orthodox* *2.Muslim* *3.Protestant* *4.Catholic* *5.No religion* *6. Others, specify----------*	
105	*Ethnicity*	*1.Amhara* *2.Tigray* *3.Oromo* *4.Others,specify----------*	
106	*Have you ever attended school?*	*1. .Yes* *2.No –Skip to Q108*	
107	*What is the highest level of school you completed?*	*1.Only read and write* *2.1 to 8 grade* *3.9 to 12 grade* *4.Above grade 12*	
108	*Forms of Disability*	*1.Deaf* *2. Blind* *3.Handicap-upper limb* *4.Handicap-lower limb* *5.Handicap-both limb* *6. others, specify----------*	
109	*With whom do you live currently?*	*1.Both parents* *2. Either of the parents* *3.Rrelatives* *4. Friends/peers.* *5.Boy / girl friend* *6.Alone* *7.Others specify----------*	
110	*Do you work to earn money for yourself?*	*1.Yes* *2.No -Skip to Q 113*	
111	*What do you do to earn money?[multiple answers are possible]*	*1 Gov't Employee* *2 Non Gov't Employee* *3 Casual Laborer* *-Shoe shining* *-Carrying small items* *-Delivering messages* *-Selling small items* *-Attending cars.*	

		-Exchange of money for sex *-Begging* *4. Others*	
112	*On average how much do you earn per day?*	*1 Less than Five birr* *2 5 to 10 birr* *3 10 to 20 birr* *4 Other specify*	
113	*What is your parents' marital status?*	*1 married & Live together* *2 separated* *3 Divorced* *4 Widowed* *5 Other, Specify----------*	
114	*Your father's educational status*	*1.Illiterate* *2. Read and write* *3. Grade 1-8* *4. Grade 9-12* *5. above 12* *6.I don't know*	
115	*Your mother's educational status*	*1.Illiterate* *2. Read and write* *3. Grade 1-8* *4. Grade 9-12* *5. above 12* *6.I don't know*	
116	*What is your father's occupation?*	*1 Daily laborer* *2 Gov't Employee* *3 Farmer* *4. Employed in private sector* *5.Has private business* *6. No occupation* *7. Others (specify)----------* *8. I don't know*	
117	*What is your mother's occupation?*	*1. Housewife* *2. Daily laborer* *3. Maid servant* *4. Gov,t Employee* *5. Employed in private sector.* *6. Has private business* *7. No occupation* *8. Others (specify) ----------* *9. I don't know*	
118	*How do you perceive your family status?[Relative to your neighbors]*	*1. Rich* *2. Medium* *3. Poor* *4.I don't know*	

SECTION -2. SEXUAL REPRODUCTIVE HEALTH HISTORY

Q.No	*QUESTIONS*	*ALTERNATIVES*	*CODE*
119	*(For Female)Age at menarche[enter number]*	*1---------- years* *2. Don't know*	
120	*Have you ever had sexual intercourse?*	*1. Yes* *2. No(skip to Q 164)*	
121	*At what age did you first have sexual intercourse?*	*1. _____Age in years* *2. Don't know*	
122	*How much older or younger was the person with whom you had your first sexual experience?*	*1. More than 10 years older* *2. 5-10 years older* *3. Less than 5 years older* *4. Younger* *5. He was an age like me* *6. Don't know*	
123	*What is/was the relation to you of your first partner?*	*1.Girl fried/Boy friend* *2.Husband/Wife* *3.Friend* *4.Fiancé* *5.Acquaintance* *6. Others*	
124	*Why did you decide to have sexual intercourse the first time?*	*1. Fell in love* *2. Had desire* *3. I got married* *4. Raped* *5. To get money and other gifts* *6. Peer pressure* *7. Was drunk or stoned* *8. Others, specify ----------*	
125	*Did you use contraceptive the first time you had sexual intercourse?*	*1. Yes* *2. No(skip to Q 127)*	
126	*What type of contraceptive used at first sex*	*1. Condom* *2. Foam* *3. Oral contraceptive pills* *4. Injectables* *5. IUD* *6. Others*	
127	*If no, why not? (Multiple answers are possible)*	*1.Did not believe pregnancy was possible*	

		2. Sex was unplanned *3. Did not know any method* *4. Fear of the side effects* *5. Method not available* *6. Method expensive* *7.Partner opposed* *8.Rape* *9.Intoxication* *10. Don't know/Remember* *11.Others specify ----------*	
128	*How many sexual partners have you had so far?*	*1. With one person* *2. With two people* *3. With three people* *4. With four people* *5. With five to nine people* *6. With ten or more people* *7.Don't know / remember*	
129	*How many people in the total have you ever had sexual intercourse with during the last 12 months?*	*1. With one person* *2. With two people* *3. With three people* *4. With four people* *5. With five to nine people* *6. With ten or more people* *7.Don't know / remember*	
130	*Have you ever used a condom?*	*1. Yes* *2. No (if no skip to Q.135)*	
131	*Did you use Condom during sexual Intercourse In the last 12 months*	*1. Yes* *2. No (if no skip to Q.134)*	
132	*How often did you use condom in the last 12 months?*	*1. Always* *2. Mostly* *3. Sometimes*	
133	*What was/is your Reason for using condom(Multiple answers are possible)*	*1. To prevent HIV/AIDS* *2. Avoid pregnancy* *3. Mere suggestion by partner* *4. Other*	
134	*Did you use a condom the FIRST time you had sexual intercourse?*	*1. Yes* *2. No*	
135	*If you have not used condom at all, or haven't used it consistently what*	*1. Not available* *2. could not have knowledge* *3. Did not think of it*	

	was the reason? (multiple answer is possible)	*4. Could not afford* *5. Partner refuse* *6. Decrease sexual gratification* *7. Ashamed to ask my partner* *8. Used other contraceptive* *9. Don't like them* *10. Wanted to get pregnant* *11. Ashamed to buy* *12. I trust my partner* *13. I was drunk or stoned* *14. My religion prohibits* *15. Others, specify----------*	
136	*[For males], have you ever had sexual intercourse with commercial sex workers in the past 12 months?*	*1. Yes* *2. No [if no skip to Q 139]*	
137	*[For males], have you ever used a condom when making sexual intercourse with commercial sex workers*	*1. Yes* *2. No [if no skip to Q 139]*	
138	*[For males], if yes, how often did you use condom when making sexual intercourse with commercial sex workers?*	*1. Always* *2. Mostly* *3. Sometimes*	
139	*Have you ever had sexual intercourse with casual sex partner in the past 12 months*	*1. Yes* *2. No (if no Skip to Q 142)*	
140	*Did you use Condom with a casual sex partner- past 12 months*	*1. Yes* *2. No(if no Skip to Q 142)*	
141	*If yes, how often did you use condom when making sexual intercourse with casual sex partner?*	*1. Always* *2. Mostly* *3. Sometimes*	
142	*Have you ever had symptoms of STI such as genital ulcer, abnormal genital discharge, and pain during urination or genital*	*1. Yes* *2. No [skip to Q 146]*	

	swelling?		
143	*If yes, whom did you first discuss the issue with?*	*1. My partner (husband/wife)* *2. My friends/peers* *3. My parents* *4. My boy/girl friend* *5. Health workers* *6. Traditional healers* *7. Local injectors* *8. Others, specify----------*	
144	*If yes where did you go for treatment? (multiple answer is possible)*	*1. Went to Traditional healer* *2. Went to public health institution* *3. I bought some drug from pharmacy* *4. Went to local injectors* *5. Went to private clinics* *6. Others, specify----------*	
145	*Could you tell me why you prefer to seek health care in this place?* *(multiple answer is possible)*	*1. Effectiveness of treatment* *2. Free treatment* *3. Low cost of treatment* *4. Proximity* *5. For the sake of confidentiality* *6. Others, specify----------*	
146	*Have you ever used modern contraceptives*	*1. Yes* *2. No (if no skip to Q 150)*	
147	*Have you ever used modern contraceptives in the past 12 months?*	*1.Yes* *2. No- Skip to Q 150*	
148	*If yes, what type? (Probe and indicate that all apply)*	*1. Oral contraceptive pills.* *2. Condom* *3. Injectables.* *4. IUDs.* *5. Norplant* *6.Others, specify----------*	
149	*How often did you use modern contraceptive in past 12 months*	*1. Always* *2. Sometimes*	
150	*If no, what were the reasons? (multiple answer is possible)*	*1. I am not sexually active.* *2. I have infrequent sex.* *3. Husband/partner opposed* *4. Religious Prohibition* *5. Lack of knowledge about*	

		contraceptives. *6. Fear of side effects* *7. Difficult to obtain contraceptives* *8. Method was expensive* *9. Too far to get contraceptives (Not accessible).* *10. Don't know/Remember* *11.Others, specify----------*	
151	*(For females) Have you been pregnant?*	*1.Yes* *2.No (if no skip to Q 164)*	
152	*If yes, how many times have you been pregnant? (Enter number)*	*1.---------- Times* *2. Don't know/Remember*	
153	*(for females) How old were you when you first became pregnant? (Enter number*	*1.---------- Age in years* *2 .Don't know/ remember*	
154	*If you have been pregnant, were all your pregnancies wanted?*	*1.Yes- skip to Q 156* *2. No*	
155	*If no, how did you become pregnant?*	*1.Contraceptive method not available* *2.Coercion (rape)* *3.Method failure* *4.Didn't think of it* *5.Don't know/ remember* *6. Other, specify----------*	
156	*(For females) Did you give birth?*	*1 Yes* *2. No →Skip to Q 159*	
157	*If yes, how many children do you born? (enter number)*	*----------children*	
158	*(For females) How old were you when you gave birth your first child (enter number)*	*1.----------years* *2.Don't know/ remember*	
159	*(For females) Have you ever had Abortion*	*1 Yes* *2. No →Skip to Q 164*	
160	*If yes, What was the nature Abortion*	*1. Induced* *2. Spontaneous*	
161	*(For females) How many*	*1.----------Times*	

	times did you have induced abortion?(enter number)	*2.Don't know/ remember*	
162	*For to have induced abortion, whom did you first discuss the issue with?*	*1. My boy friend* *2. My friends/ peers* *3. My parents* *4. Health workers* *5. Traditional healers* *6. For an abortionist* *7. Don't know/ remember* *8. Others, specify ----------*	
163	*(For females) Where did you abort?*	*1. At public health institution* *2. At private clinic* *3. At abortionist's house* *4. I have induced it myself at my home by ingesting different drugs* *5. Don't know/ remember* *6. Others, specify ----------*	

SECTION -3. Questions concerning knowledge and attitude towards sexual reproductive health

Q.No	*QUESTIONS*	*ALTERNATIVES*	*CODE*
164	*Can a girl get pregnant the first time she had sex.*	*1. Yes* *2. No* *3. Don't know*	
165	*How old does a boy need to be to be able to physically make a girl pregnant?*	*1. During and after puberty* *2. Before 10 years of age* *3. Don't know* *4. Others, specify ----------*	
166	*How old does a girl need to be to be pregnant?*	*1. During and after puberty* *2. Before 10 years of age* *3. Don't know* *4. Others, specify----------*	
167	*During which part of the menstrual cycle dose a woman have the greatest chance of becoming pregnant?*	*1.During her period* *2.Right after period is ended* *3.Just before her period begins* *4. In the middle of her cycle* *5.The same throughout* *6. Don' know* *7. Others, specify----------*	
168	*Do you know any ways to avoid getting pregnant?*	*1. Yes* *2. No. → Skip to Q 170*	
169	*What are the ways to avoid*	*1. Oral contraceptive pills*	

	getting pregnant? (multiple answer is possible)	*2. Using condoms.* *3. Injectables.* *4. Norplant.* *5. IUDs.* *6. Sterilization.* *7.Abstinence* *8 With drawal.* *9. Washing the genitalia. after intercourse* *10. Intercourse in the up right position* *11 Safe period/abstinence* *12. Others, specify----------*	
170	*Do you know/heard any diseases a person can get through sexual intercourse?*	*1.Yes* *2. No. →Skip to Q 172*	
171	*Which diseases do you know about?(multiple answers are possible)*	*1. Gonorrhea* *2. Syphilis* *3. Chanchroid* *4. Lymphogranuloma venerum* *5. HIV/AIDS* *6. Others, specify----------*	
172	*Have you heard about a disease called HIV /AIDS?*	*1. Yes* *2 No*	
173	*Please mention all the ways you believe a person can get HIV/ AIDS.[Multiple answers are possible]*	*1. Unsafe sexual intercourse.* *2. Sharing needles and syringes.* *3. Blood transfusion.* *4. During pregnancy and childbirth.* *5. Mosquito and other insect bite.* *6. Through breast milk.* *7. Casual contact with a person (hand Shaking, sharing food etc.* *8. Others specify---------*	
174	*A person can get HIV the first time he or she has sex?*	*1. Yes* *2. No* *3. Don't know*	
175	*If you look carefully, can you know if some has HIV?*	*1. Yes* *2. No* *3. Don't know*	
176	*Is there anything a person can do to avoid/prevent getting*	*1. Yes* *2. No*	

	STIs and HIV/AIDS?	*3. Don't know*	
177	*If Yes, How can one prevent STI and HIV/AIDS? (multiple answer is possible)*	*1. Abstain from sexual intercourse.* *2. Avoid casual sex.* *3. Remain faithful to a partner.* *4. Use condoms in every act of sexual Intercourse.* *5. Avoid sex with CSWs.* *6. Avoid unsafe injections* *7 Avoid contaminated sharp objects* *8. Others specify ----------.*	
178	*Please mention all the signs/symptoms do you know a person with STI manifest. (multiple answers are possible)*	*1. genital ulcer* *2. abnormal genital discharge* *3. pain during urination* *4. Genital swelling* *5. Others, specify--------*	
179	*Using condom is a sign of not trusting your partner?*	*1. Agree* *2. Disagree* *3. Not sure*	
180	*A boy should have sex before he gets married?*	*1. Agree* *2. Disagree* *3. Not sure*	
181	*A girl should have sex before she gets married?*	*1. Agree* *2. Disagree* *3. Not sure*	
182	*Discussing condom or contraceptive with young people promotes promiscuity?*	*1. Agree* *2. Disagree* *3. Not sure*	
183	*Do you believe you have done anything that may have put you at risk of getting the HIV virus?*	*1. Yes* *2. No [skip to Q 185]* *3. Don't know [skip to Q 186]*	
184	*If yes, why? (multiple answers are possible)*	*1. Have had sex without condom* *2. More than one sexual partner* *3. Have had sexual intercourse with commercial sex workers* *4. Injuries with contaminated sharps* *5.Others, specify----------*	
185	*If no, why not? (multiple answers are possible)*	*1. Have never made sexual intercourse*	

		2. I have abstained from sex *3. One to one sexual relation* *4. No contact with CSW* *5. I did not share injections* *6. I always use condom* *7. Others, specify----------*	
186	*Have you ever heard about Voluntary counseling and testing for HIV?*	*1. Yes* *2. No*	
187	*Did you ever undergo HIV test?*	*1. Yes* *2. No*	
188	*Are you voluntary to undergo voluntary counseling and testing for HIV?*	*1. Yes* *2. No* *3. I am not sure*	

Section -4.Question regarding Non-sexual risky behavior of YPWD

Q.No	*QUESTIONS*	*ALTERNATIVES*	*CODE*
189	*Have you Ever use any drugs/substance*	*1. Yes* *2. No (skip to Q 191)*	
190	*If yes, what type of drug/substance do you usually use*	*1. Chat* *2. Cigarette* *3. hashish, cannabis* *4. Other drugs*	
191	*Have you ever use alcohol*	*1. Yes* *2. No (skip to Q 194)*	
192	*If yes, How is the Frequency of drinking*	*1. I drink 3-4 times/week* *2. I drink 3-4x/month* *3. Only on holydays*	
193	*Ever Had sex after being drank past one month*	*1. Yes* *2. No*	

SECTION -5.Question Concerning Health Service Utilization and Reproductive Health Information

Q.No	*QUESTIONS*	*ALTERNATIVES*	*CODE*
194	*Have you ever Heard of RHS*	*1. Yes* *2. No*	
195	*Have you ever Utilized any RH Services*	*1. Yes* *2. No*	
196	*Have you visited a Reproductive health services in the last 3 months?*	*1. Yes* *2. No (skip to Q 198)*	
197	*If yes, what was the reason for your visit?*	*1. I had STI.* *2. For abortion.*	

		3. For delivery. *4. For antenatal care.* *5. To get oral contraceptives.* *6. To get condom.* *7. For counseling.* *8. Others specify----------*	
198	*If you have visited a health institution, where did you go preferably?*	*1. Gov't health facilities* *2. Private health facilities* *3. Drug shops/ Pharmacy* *4. TBAs* *5. Others specify ----------*	
199	*Could you tell me why you prefer to seek health care in this place? [Multiple answers are possible]*	*1. Effectiveness of treatment* *2. Free treatment* *3 Low cost of treatment* *4. Proximity* *5. Relative works there* *6. I prefer for confidentiality* *7. Parents prefer the place* *8. Others, specify----------*	
200	*Do you think that it is easy or difficult for disabled youth to obtain and use contraceptive or condoms?*	*1. Easy (skip to Q 202)* *2. Difficult* *3. Don't know (skip to Q 202)*	
201	*If difficult, why is it difficult? (Multiple answers are possible)*	*1. Lack of money to buy.* *2. Lack of information* *3. Pressure from sex partners* *4. Religious* *5. Difficult to find.* *6. Provider disapproves.* *7. Parents disapprove.* *8. Distribution places are inconvenient for them* *9. Being afraid to buy from shops/pharmacy* *10. Too far to find* *11. Expensive to buy* *12. Ignorance* *13. Do not feel at risk/ Never had sex* *14. Others specify ---------*	
202	*What are the main obstacles that prevent disabled youth*	*1. Too far health institutions* *2. Too expensive services*	

	from getting SRH services in health institutions?	*3. Providers fail to keep privacy and confidentiality* *4. Poor handling and scolding by health workers* *5.Too much waiting time to get the service* *6.The health institutions are inconvenient.* *7. Don't know* *8. Others, specify----------*	
203	*Have you ever discussed SRH topics with parents*	*1. Yes* *2. No*	
204	*Do you think most disabled youth are well informed about contraceptives?*	*1. Yes* *2. No* *3. Don't know*	
205	*From where do you think disabled youth obtain most of their information about sexual reproductive health?* *(Multiple answers are possible)*	*1. From school* *2. From their friends* *3. From their parents* *4. From the mass media* *5. From health professional* *6.No where* *7. Don't know* *8. Others, specify----------*	
206	*If you wanted to discuss and know more about SRH matters, whom would you Prefer to talk to?* *(Multiple answers are possible)*	*1. Friends/peers* *2. Mother* *3. Fathers* *4. Sister* *5. Boyfriend/girlfriend* *6. Partner (husband / wife)* *7. Health professional* *8. Others, specify----------*	
207	*Which is your major source of SRH information* *(Multiple answers are possible)*	*1. TV/Radio* *2. News paper* *3. school Teachers* *4. Parents* *5. Partners* *6. Friends* *7. Health professionals* *8. Others specify----------*	

Thank you very much!

Annex II: English FGD Guide

Introduction

Good morning! Well come to our group discussion.

My name is ----------, come from Addis Ababa University, Faculty of Medicine attending a post graduate study in School of Public Health. Currently I am doing my master thesis and we are here today to discuss a bout reproductive health status and problems disabled youth. You are free to talk whatever information you think is important. There is no right or wrong answers. All comments, both positive and negative, are well come. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up everything. We would like to confirm to you that whatever information that you give me will be very useful for the study and all your

comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion?

If yes,

Thank you for your willingness.

Guidelines for Focus Group Discussions (FGD)

Specific research questions are arranged under 4 major heading. These are

1) *Sexual reproductive health Matter and associated Problems*
2) *Non-sexual risky behavior (Substance use)*
3) *SRH service*
4) *Reproductive Health Information*

5. Sexual reproductive health Matter and associated Problems

- ✓ *Do you think Young People with Disability have different Sexual and Reproductive need than non disabled one? Why? How? Let discuss*
- ✓ *Do you think problems associated with sexual and reproductive Health are a major health problem of disabled youth? or not? Why? How? Let discuss.*
- ✓ *Probe: What are the SRH associated problems? How sever the problems are?*
- ✓ *Probe: who is most likely to suffer (age, sex, behaviors)?*
- ✓ *Probe: what do you think a solution?*

6. ***Non-sexual risky behavior (Substance use)***
   - ✓ *Do you think majority of disabled youth currently use substances? Why?*
   - ✓ *Probe: which of the substances most used? Why?*
   - ✓ *Probe: to discuss on the association between the substance and SRH problems.*
   - ✓ *Probe: their sexual filling when used the substance, even to give examples.*
   - ✓ *Probe: is it not possible to stop using? Why?*
7. ***SRH service***
   - ✓ *Do you have any information about SRHS? Does the service available in your area?*
   - ✓ *Does the existing HI deliver reproductive Health Services for Disabled youth? Who deliver it? Is the service is organized and user friendly?*
   - ✓ *Probe: major problem / accessibility, confidentiality, attractiveness, service providers, payment /*
   - ✓ *Probe: to suggest how Youth friendly RH need to be rearranged to address the SRH need of the disabled.*
8. ***Reproductive Health Information***
   - ✓ *Do you have any information about SRH?*
   - ✓ *Probe: from where do you get information about it?*
   - ✓ *Do families discuss sexuality issues openly with their family members? If not, why?*
   - ✓ *What do you think a solution?*

Declaration

I, the undersigned, declare that this thesis is my original work and has not been prepared for a degree in this or other universities, and that all sources of materials used for the thesis have been fully acknowledged.

Name: Tigist Alemu

Signature: _____

Date: _____

This thesis has been submitted with my approval as University advisor.

Name: Dr. Mesganaw Fentahun

Signature: _____

Date: _____

መጠይቅ

ይህ መጠይቅ በተመረጡ አዲስ አበባ ውስጥ በሚገኙ በአካል ጉዳተኞች ዙሪያ በሚሰሩ ማህበራት ስር በሚገኙ ወጣት የአካል ጉዳተኞች የሥነ ተዋልዶ ጤና እና ተዛማጅ ችግሮች ዙሪያ ያተኩራል (ያጠነጥናል)፡፡

በጥናቱ ለመሳተፍ የፅሁፍ የፈቃደኝነት ማረጋገጫ

ውድ ተሳታፊ፣

የአካል ጉዳተኛ ወጣቶች ጤናማ ሁነው እንዲገኙ ለማድረግ አሁን ያሉበትን የስነ ተዋልዶ ጤና ሁኔታ መዳሰስ እና የእነኝህን የአካል ጉዳተኛ ወጣቶች ከወሲብና ከመውለጃ አካላት ጋር የተያያዙ ችግሮችንም መገንዘብ ጠቃሚ ነው፡፡ በዚሁም መነሻነት የአካል ጉዳተኛ ወጣቶችን የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስ ይህን ጥናት በተመረጡ የአካል ጉዳተኛ ማኅበራት ላይ ለመስራት ታስቧል፡፡ እርስዎም በጥናቱ እንዲሳተፉ ተመርጠዋል፡፡ ስለዚህ አንድ ነገር ላሳስብዎ እወዳለሁ ይህም እርስዎ እና እኔ በዚህ ጉዳይ ላይ አጠር ያለ ውይይት እናደርጋለን፡፡ ወደ ውይይታችን ከመሄዳችን በፊት ስለጥናቱ አላማ እና አጠቃላይ ሁኔታ አነብልዎታለሁና በጥሞና አዳምጠው በጥናቱ ለመሳተፍ ፈቃደኛ መሆንዎትን ወይም አለመሆንዎትን ይገልፁልኛል፡፡ የዚህ ጥናት ዓላማ የታዳጊ አካል ጉዳተኛ ወጣቶችን (ከ10 - 24 ዓመት ያሉትን) የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስና ስለችግሮቹ ተጨባጭ መረጃ በመያዝ የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና የሚሻሻልበትን መንገድ ለማመቻቸት ነው፡፡

ጥናቱ በርካታ በግል ህይወት ዙሪያ ጥያቄዎች አሉት፡፡ የምጠይቅዎት አንዳንድ ጥያቄዎች ለአንዳንድ ሰዎች ለመመለስ የሚያሳፍሩ ሆነው ሊያገኟቸው ይችላሉ፡፡ መልስዎ በሚስጥር የሚያዝ ነው፡ በተዘጋጀው መጠይቅ ላይ ስምዎ አይገለጽም፡፡ በጥናቱ ያለመሳተፍ፣ የማይፈልጉትን ጥያቄ ያለመመለስ እና በፈለጉት ሰዓት መጠይቁን የማቋረጥ መብትዎ የተጠበቀ ነው፡፡

ስለዚህ የእርስዎ ቅንና እውነተኛ መልሶች የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስና ስለችግሮቹ ተጨባጭ መረጃ በመያዝ የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና የሚሻሻልበትን መንገድ በማመቻቸት ረገድ ከፍተኛ ጠቀሜታ አለው፡፡ ጥናቱ በትክክል የታለመለትን ግብ እንዲመታ የሚያደርጉትን ከፍተኛ ትብብር እናደንቃለን፡፡ ጥናቱ በፍቃደኝነት የሚከናወን ሲሆን ይህ መጠይቅ ወደ 30 ደቂቃ ገደማ ይጨርሳል፡፡

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ ____ አይደለሁም ____

ፊርማ _____ ቀን _____

በጣም አመሰግናለሁ!!

መጠይቅ

ይህ መጠይቅ በተመረጡ አዲስ አበባ ውስጥ በሚገኙ በአካል ጉዳተኞች ዙሪያ በሚሰሩ ማህበራት ስር በሚገኙ ወጣት የአካል ጉዳተኞች የሥነ ተዋልዶ ጤና እና ተዛማጅ ችግሮች ዙሪያ ያተኩራል (ያጠነጥናል)፡፡

ከአስራ ስምንት ዓመት በታች ለሆኑ ወጣቶች በጥናቱ ለመሳተፍ የስምምነት ማረጋገጫ

የአካል ጉዳተኛ ወጣቶች ጤናማ ሁነው እንዲገኙ ለማድረግ አሁን ያለበትን የስነ ተዋልዶ ጤና ሁኔታ መዳሰስ እና የእነኝህን የአካል ጉዳተኛ ወጣቶች ከወሲብና ከመውለጃ አካላት ጋር የተያያዙ ችግሮችንም መገንዘብ ጠቃሚ ነው፡፡ በዚሁም መነሻነት የአካል ጉዳተኛ ወጣቶችን የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስ ይህን ጥናት በተመረጡ የአካል ጉዳተኛ ማኅበራት ላይ ለመስራት ታስቧል፡፡ የእርስዎም ልጅ በጥናቱ እንዲሳተፍ/እንድትሳተፍ ተመርጧል/ጣለች፡፡ ስለዚህ አንድ ነገር ላሳስብዎ እወዳለሁ ይህም የእርስዎ ልጅ እና እኔ በዚህ ጉዳይ ላይ አጠር ያለ ውይይት እናደርጋለን፡፡ ወደ ውይይታችን ከመሄዳችን በፊት ስለጥናቱ አላማ እና አጠቃላይ ሁኔታ አነብልዎታለሁና በጥሞና አዳምጠው ልጅዎ በጥናቱ እንዲሳተፍ ፈቃደኛ መሆንዎትን ወይም አለመሆንዎትን ይገልፁልኛል፡፡ የዚህ ጥናት ዓላማ የታዳጊ አካል ጉዳተኛ ወጣቶችን (ከ10 - 24 ዓመት ያሉትን) የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስና ስለችግሮቹ ተጨባጭ መረጃ በመያዝ የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና የሚሻሻልበትን መንገድ ለማመቻቸት ነው፡፡

ልጅዎ በጥናቱ እንዲሳተፍ ፈቃደኛ ነዎት?

አዎ ____ አይደለሁም ____

ፊርማ _____ ቀን _____

ውድ ተሳታፊ፣

ጥናቱ በርካታ በግል ህይወት ዙሪያ ጥያቄዎች አሉት፡፡ የምጠይቅዎት አንዳንድ ጥያቄዎች ለአንዳንድ ሰዎች ለመመለስ የሚያሳፍሩ ሆነው ሊያገኟቸው ይችላሉ፡፡ መልስዎ በሚስጥር የሚያዝ ነው፣ በተዘጋጀው መጠይቅ ላይ ስምዎ አይገለጽም፡፡ በጥናቱ ያለመሳተፍ፣ የማይፈልጉትን ጥያቄ ያለመመለስ እና በፈለጉት ሰዓት መጠይቁን የማቋረጥ መብትዎ የተጠበቀ ነው፡፡

ስለዚህ የእርስዎ ቅንና እውነተኛ መልሶች የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና ሁኔታ እና ተዛማጅ የጤና ችግሮችን ለመዳሰስና ስለችግሮቹ ተጨባጭ መረጃ በመያዝ የአካል ጉዳተኛ ወጣቶች የሥነ ተዋልዶ ጤና የሚሻሻልበትን መንገድ በማመቻቸት ረገድ ከፍተኛ ጠቀሜታ አለው፡፡ ጥናቱ በትክክል የታለመለትን

ግብ እንዲመታ የሚያደርጉትን ከፍተኛ ትብብር እናደንቃለን፡፡ ጥናቱ በፍቃደኝነት የሚከናወን ሲሆን ይህ መጠይቅ ወደ 30 ደቂቃ ገደማ ይጨርሳል፡፡

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ ____ አይደለሁም ____

ፊርማ _____ ቀን _____

በጣም አመሰግናለሁ!!

የሚስጥር ቁጥር ----------

ክፍል አንድ - አጠቃላይ መረጃ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ
101	ጸታ	1. ወንድ 2. ሴት	
102	ዕድሜ (በዓመት)	1. ---------- ዓመት 2. አላውቀውም	
103	የጋብቻ ሁኔታ	1. አግብቻለሁ 2. የወንድ/የሴት ጓደኛ አለኝ 3. ምንም ጓደኛ/የትዳር አጋር የለኝም 4. ተፋትቻለሁ 5. ባሌ/ሚስቴ የሞተብኝ 6. ተለያይተናል	
104	ሐይማኖት	1. ኦርቶዶክስ 2. እስላም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሐይማኖት የለኝም 6. ሌላ (ይጠቀስ) ------	
105	ብሔር	1. አማራ 2. ትግሬ 3. ኦሮሞ 4. ሌላ (ይጠቀስ) ------	
106	ዘመናዊ ትምህርት ተከታትለህ/ሽ ታውቃለህ/ቂያለሽ?	1. አዎ 2. አላውቅም (አላውቅም ካሉ ወደ ጥያቄ ቁጥር 108 ይሂዱ)	
		1. ማንበብና መጻፍ ብቻ	

107	የትምህርት ደረጃዎ	2. 1-8ኛ ክፍል 3. 9-12ኛ ክፍል 4. ከ12ኛ ክፍል በላይ	
108	የአካል ጉዳትዎ አይነት	1. መስማት የተሳነው 2. ማየት የተሳነው 3. የእጅ ጉዳት 4. የእግር ጉዳት 5. የእጅና የእግር ጉዳት 6. ሌላ (ይጠቀስ) ------	
109	በአሁኑ ሰዓት የሚኖሩት ከማን ጋር ነው?	1. ከሁለቱም ወላጆቼ ጋር 2. ከአንድ ወላጄ ጋር 3. ከዘመድ ጋር 4. ከጓደኞቼ ጋር 5. ከፍቅረኛዬ ጋር 6. ብቻዬን 7. ሌላ (ይጠቀስ) ------	
110	ራስህን/ሽን ለማስተዳደር የሚሆን ገንዘብ ለማግኘት ሥራ ትሠራለህ/ሪያለሽ?	1. አዎ 2. አልሰራም (አልሰራም ካሉ ወደ ጥያቄ ቁጥር 113 ይሂዱ)	
111	ሥራ የሚሰሩ ከሆነ ሥራዎ ምንድን ነው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. የመንግስት ሠራተኛ 2. መንግስታዊ ያልሆነ ድርጅት 3. የቀን ሥራ • ጫማ ቀቢ (ሊስትሮ) • ቋጠሮ ተሸካሚ • ተላላኪ • ሱቅ በደረቴ • መኪና ጥበቃ • ገንዘብ ለማግኘት በሚደረግ የግብረ ሥጋ ግንኙነት • ልመና 4. ሌላ (ይጠቀስ) ------	
112	በአማካይ የቀን ገቢዎ ምን ያህል ይሆናል?	1. ከአምስት ብር በታች 2. ከ5 እስከ 10 ብር 3. ከ10 እስከ 20 ብር 4. ሌላ (ይጠቀስ) ------	
113	የቤተሰብዎ የጋብቻ ሁኔታ እንዴት ነው?	1. የተጋቡና አብረው የሚኖሩ 2. የተለያዩ 3. የተፋቱ 4. የሞተችበት/ባት 5. ሌላ (ይጠቀስ) ------	

114	የአባትህ/ሽ የትምህርት ሁኔታ	1. ያልተማረ 2. ማንበብና መጻፍ የሚችል 3. ከ1- 8ኛ ክፍል 4. ከ9 - 12ኛ ክፍል 5. አስራ ሁለተኛ ክፍል በላይ 6. አላውቅም	
115	የእናትህ/ሽ የትምህርት ሁኔታ	1. ያልተማረች 2. ማንበብና መጻፍ የምትችል 3. ከ1- 8ኛ ክፍል 4. ከ9 - 12ኛ ክፍል 5. አስራ ሁለተኛ ክፍል በላይ 6. አላውቅም	
116	የአባትህ/ሽ ሥራ ምንድን ነው?	1. የቀን ሠራተኛ 2. የመንግስት ሠራተኛ 3. ገበሬ 4. የግል ድርጅት ተቀጣሪ 5. በግል ሥራ ተዳዳሪ 6. ሥራ የለውም 7. ሌላ (ይጠቀስ) ------ 8. አላውቅም	
117	የእናትህ/ሽ ሥራ ምንድን ነው?	1. የቤት እመቤት 2. የቀን ሠራተኛ 3. የግለሰብ ቤት ሠራተኛ/ ተቀጣሪ 4. የመንግስት ሠራተኛ 5. የግል ድርጅት ተቀጣሪ 6. በግል ሥራ ተዳዳሪ 7. ሥራ የላትም 8. ሌላ (ይጠቀስ) ------ 9. አላውቅም	
118	በአንተ/ቺ ግመት የቤተሰቦችህ/ሽ የገቢ ሁኔታ ምን ይመስላል?- (ከጎረቤት ጋር ሲነፃፀር)	1. ሀብታም 2. መካከለኛ 3. ድሃ 4. አላውቀውም	

ክፍል ሁለት - የግብረ ሥጋ ግንኙነትንና የሥነ-ተዋልዶ ጤናን የሚመለከቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ
119	(ለሴቶች ብቻ) የመጀመሪያ የወር አበባሽን በስንት ዓመትሽ አየሽ?	1. ----- ዓመቴ 2. አላስታውስም	

	(ካወቁት ቁጥሩን ያስቀምጡ)		
120	የግብረ ሥጋ ግንኙነት አድርገህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 164 ይሂዱ)	
121	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት የፈፀምከው/ሽው በስንት ዓመትህ/ሽ ነው?	1. ---------- ዓመቴ 2. አላውቀውም	
122	ለመጀመሪያ ጊዜ በግብረ ሥጋ የተገናኘኸው/ሽው ሰው እድሜ ከአንተ/ች እድሜ አንፃር ሲታይ እንዴት ነበር?	1. ከ10 ዓመት በላይ ይበልጠኛል 2. ከ5 ዓመት እስከ 10 ዓመት ይበልጠኛል 3. እስከ 5 ዓመት ይበልጠኛል 4. ከእኔ ያንሳል 5. እኩያየ ነው 6. አላውቅም/አላስታውስም	
123	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት አብረውት ከፈፀሙት ሰው ጋር የነበረዎት ግንኙነት ምንድን ነበር?	1. የወንድ/የሴት ጓደኛ 2. ባል/ሚስት 3. ጓደኛ 4. እጮኛ 5. በአጋጣሚ የተዋወቅን 6. ሌላ (ይጥቀሱ) ------	
124	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት ለማድረግ የወሰንክበት/ሽበት ምክንያት ምን ነበር?	1. ፍቅር ይዞኝ 2. በግል የወሲብ ፍላጎቴ 3. በጋብቻ 4. ተገድጄ 5. ገንዘብና ሌሎች ስጦታዎችን ለማግኘት 6. በጓደኛ ተፅዕኖ 7. ጠጥቼ ሰክሬ/መድሃኒት ወስጄ 8. ሌላ (ይጥቀሱ) ------	
125	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት ስትፈጽም/ሚ የወሊድ መቆጣጠሪያ ተጠቅመሃል/ሻል?	1. አዎ 2. አልተጠቀምኩም (አልተጠቀምኩም ካሉ ወደ ጥያቄ ቁጥር 127 ይሂዱ)	
126	ለጥያቄ ቁጥር 125 መልስዎ አዎ ከሆነ ምን ዓይነት የወሊድ መቆጣጠሪያ ተጠቀሙ?	1. ኮንዶም 2. አረፋማ ክኒን 3. የሚዋጥ ክኒን 4. በመርፌ የሚሰጥ 5. ሉፕ 6. ሌላ (ይጥቀሱ) ------	

127	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት ስትፈጽም/ሚ የወሊድ መቆጣጠሪያ ካልተጠቀምክ/ሽ ምክንያትህ/ሽ ምንድን ነው?	1. እርግዝና ሊከሰት አይችልም ብዬ ስለማምን 2. የግብረ ሥጋ ግንኙነቱ ያልታሰበ ስለነበር 3. ምንም አይነት የወሊድ መቆጣጠሪያ ዘዴ ስለማላውቅ 4. የጎንዮሽ ጉዳቱን ፈርቼ 5. የወሊድ መቆጣጠሪያ ዘዴ ስላልነበር 6. የወሊድ መቆጣጠሪያ ዘዴው ውድ ስለሆነ 7. ጓደኛዬ ስለማትፈቅድ/ይፈቅድ 8. ተገድጄ ስለተደፈርኩ 9. ራሴን ስቼ ስለነበር 10. አላውቅም/አላስታውስም 11. ሌላ (ይጥቀሱ) ------	
128	የግብረ-ሥጋ ግንኙነት ከጀመርክበት/ሽበት ጊዜ አንስቶ እስከ አሁን በጥቅሉ ከስንት ሰዎች ጋር የግብረ-ሥጋ ግንኙነት አድርገሃል/ሻል?	1. ከአንድ ሰው ጋር 2. ከሁለት ሰዎች ጋር 3. ከሶስት ሰዎች ጋር 4. ከአራት ሰዎች ጋር 5. ከአምስት እስከ ዘጠኝ ከሚሆኑ ሰዎች ጋር 6. አስር ወይም ከዚያ በላይ ይሆናሉ 7. አላውቅም/አላስታውስም	
129	ባለፉት 12 ወራት በጥቅሉ ከስንት ሰዎች ጋር የግብረ-ሥጋ ግንኙነት አድርገሃል/ሻል?	1. ከአንድ ሰው ጋር 2. ከሁለት ሰዎች ጋር 3. ከሶስት ሰዎች ጋር 4. ከአራት ሰዎች ጋር 5. ከአምስት እስከ ዘጠኝ ከሚሆኑ ሰዎች ጋር 6. አስር ወይም ከዚያ በላይ ይሆናሉ 7. አላውቅም/አላስታውስም	
130	የግብረ-ሥጋ ግንኙነት በምታደርግበት/ጊበት ጊዜ ኮንዶም ተጠቅመህ/ሽ ታውቃለህ/ሽ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 135 ይሂዱ)	
131	ባለፉት 12 ወራት የግብረ-ሥጋ ግንኙነት ባደረግክበት/ሽበት ጊዜ ኮንዶም ትጠቀም/ሚ ነበር?	1. አዎን 2. አልነበረም (መልስዎ አልነበረም ከሆነ ወደ ጥያቄ	

		ቁጥር 134 ይሂዱ)	
132	ባለፉት 12 ወራት የግብረ-ሥጋ ግንኙነት ባደረግክበት/ሽበት ጊዜ ምን ያህል አዘውትረህ/ሽ ኮንዶም ትጠቀም/ሚ ነበር?	1. ሁል ጊዜ 2. አብዛኛውን ጊዜ 3. አንዳንድ ጊዜ	
133	ኮንዶም የተጠቀምክበት ምክንያት ምንድን ነው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ኤች.አይ.ቪ/ኤድስን ለመከላከል 2. እርግዝናን ለመከላከል 3. ጓደኛዬ እንድንጠቀም ስለፈለገች/ገ 4. ሌላ (ይገለጽ) --------	
134	ለመጀመሪያ ጊዜ የግብረ ሥጋ ግንኙነት ባደረግክበት/ሽበት ጊዜ ኮንዶም ተጠቅመሽ ነበር?	1. አዎን 2. አልነበረም	
135	ኮንዶም ቄራሽ ተጠቅመህ/ሽ የማታውቅ/ቂ ከሆነ ወይንም አልፎ አልፎ ከሆነ የተጠቀምከው/ሽው ምክንያቱ ምንድን ነበር? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ስለማይገኝ 2. ስለማላውቅ 3. አላሰብኩበትም ነበር 4. ለመግዛት አቅም ስለሌለኝ 5. ጓደኛዬ ስለተቃወመ/ች 6. እርካታ ስለሚቀንስ 7. እንጠቀም ማለት ስላሳፈረኝ 8. ሌላ የወሊድ መከላከያ ዘዴ ስለተጠቀምኩ 9. ስለማልወድ 10. ማርገዝ ስለፈለግኩ 11. ለመግዛት ስላፈርኩ 12. ከጓደኛዬ ጋር ስለምንተማመን 13. ጠጥቼ/ሌላ አነቃቂ ዕፅ/ወስጄ ስለነበር 14. ሐይማኖቴ ስለማይፈቅድ 15. ሌላ (ይገለጽ) -------	
136	(ለወንዶች ብቻ) በአለፉት 12 ወራት ከሴተኛ አዳሪ ጋር የግብረ ሥጋ ግንኙነት አድርገህ ታውቃለህ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 139 ይሂዱ)	
137	(ለወንዶች ብቻ) በአለፉት 12 ወራት ከሴተኛ አዳሪ ጋር የግብረ ሥጋ ግንኙነት በምታደርግበት ጊዜ ኮንዶም ትጠቀም ነበር?	1. አዎን 2. አልጠቀምም (መልስዎ አልጠቀምም ከሆነ ወደ ጥያቄ ቁጥር 139 ይሂዱ)	
138	(ለወንዶች ብቻ) መልስዎ አዎ ከሆነ በአለፉት 12 ወራት ከሴተኛ አዳሪ ጋር	1. ሁል ጊዜ 2. አብዛኛውን ጊዜ	

	የግብረ ሥጋ ግንኙነት በምታደርግበት ጊዜ ምን ያህል አዘውትረህ ኮንዶም ትጠቀም ነበር?	3. አንዳንድ ጊዜ	
139	በአለፉት 12 ወራት ውስጥ ምንም ከማታውቃት/ቂው ሰው ጋር የግብረ ሥጋ ግንኙነት ፈጽመህ/ሽ ታውቃለህ/ቂያለሽ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 142 ይሂዱ)	
140	መልስዎ አዎ ከሆነ በአለፉት 12 ወራት ምንም ከማታውቃት/ቂው ሰው ጋር የግብረ ሥጋ ግንኙነት በምታደርግበት/ ጊበት ጊዜ ኮንዶም ተጠቅመሃል/ሻል?	1. አዎን 2. አልተጠቀምኩም (መልስዎ አልተጠቀምኩም ከሆነ ወደ ጥያቄ ቁጥር 142 ይሂዱ)	
141	ለጥያቄ ቁጥር 140 መልስዎ አዎ ከሆነ ምን ያህል አዘውትረው ተጠቅመዋል?	1. ሁል ጊዜ 2. አብዛኛውን ጊዜ 3. አንዳንድ ጊዜ	
142	እንደ የብልት መቁሰል፣ ተፈጥሮአዊ ያልሆነ የብልት ፈሳሽ፣ በምትሸናበት/ኚበት ጊዜ የማቃጠል ስሜት ወይንም የብልት አካባቢ ብሽሽት እብጠት የመሳሰሉ ምልክቶች ታይተውህ/ሽ ያውቃሉ?	1. አዎን 2. አያውቅም (ካላወቁ ወደ ጥያቄ ቁጥር 146 ይሂዱ)	
143	ምልክቶቹ ታይተውብህ/ሽ ከነበረ ጉዳዩን በቅድሚያ ለማን አወያየህ/ሽ?	1. ለባለቤቱ (ባል/ሚስት) 2. ለአቻ ጓደኛዬ 3. ለቤተሰቦቼ 4. ለፍቅረኛዬ 5. ለጤና ባለሙያ 6. ለባህል መድሃኒት አዋቂ 7. ለመንደር መርፌ ወጊ 8. ሌላ (ይገለጽ) -----	
144	ለጥያቄ ቁጥር 143 መልስህ/ሽ አዎ ከሆነ ምልክቶቹ እንደታዩህ/ሽ ለህክምና ወዴት ሄድክ/ሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ወደ ባህል መድሃኒት አዋቂ 2. ወደ መንግስት ጤና ድርጅት 3. ወደ ፋርማሲ ሄጄ መድሃኒት ገዛሁ 4. ወደ መንደር መርፌ ወጊ 5. ወደ ግል ክሊኒክ 6. ሌላ (ይገለጽ) -----	
145	ከላይ ወደ ተጠቀሰው ቦታ ለመሄድ የመረጥከው/ሽው ለምንድን ነው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ህክምናው ፍቱን ስለሆነ 2. የነጻ ህክምና ስለማገኝ 3. የህክምናው ዋጋ ዝቅተኛ ስለሆነ 4. ቅርብ ስለሆነ 5. ሚስጥር ስለሚጠብቁልኝ	

		6. ሌላ (ይገለጽ) -----	
146	ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴ ተጠቅመው ያውቃሉ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 150 ይሂዱ)	
147	ባለፉት 12 ወራት ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎችን ተጠቀመዋል?	1. አዎን 2. አልተጠቀምኩም (መልስዎ አልተጠቀምኩም ከሆነ ወደ ጥያቄ ቁጥር 150 ይሂዱ)	
148	ለጥያቄ ቁጥር 147 መልስዎ አዎ ከሆነ የትኛውን አይነት? (የተጠቀሙትን ሁሉ ይጥቀሱ)	1. የሚዋጥ ክኒን 2. ኮንዶም 3. በመርፌ የሚሰጥ 4. በማህፀን የሚገባ 5. በክንድ ጡንቻ ውስጥ የሚቀመጥ 6. ሌላ (ይጥቀሱ) ------	
149	ባለፉት 12 ወራት ምን ያህል አዘውትረው ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎችን ተጠቀመዋል?	1. ሁል ጊዜ 2. አንዳንድ ጊዜ	
150	ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎችን ተጠቅመው የማያውቁ ከሆነ ምክንያትዎ ምንድን ነው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. የግብረ ሥጋ ግንኙነት ስለማልፈጽም 2. አልፎ አልፎ ብቻ የግብረ ሥጋ ግንኙነት ስለማደርግ 3. የትዳር አጋሬ/ ጓደኛዬ ስለምትቃወም/ሚቃወም 4. ሐይማኖቴ ስለማይፈቅድ 5. ስለ ዘመናዊ የወሊድ መቆጣጠሪያ ዘዴዎች ዕውቀት ስለሌለኝ 6. የጎንዮሽ ጉዳቱን ፈርቼ 7. የወሊድ መቆጣጠሪያ ዘዴ ለማግኘት አዳጋች ስለሆነ 8. የወሊድ መቆጣጠሪያ ዘዴው ውድ ስለሆነ 9. የወሊድ መቆጣጠሪያ ዘዴው በቅርብ ስለማይገኝ 10. አላውቅም/አላሰታውስም 11. ሌላ (ይጥቀሱ) ------	
151	(ለሴቶች ብቻ) አርግዘሽ ታውቂያለሽ?	1. አዎን 2. አላውቅም (መልስዎ	

		አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 164 ይሂዱ)	
152	አርግዘው የሚያውቁ ከሆነ ምን ያህል ጊዜ አርግዘዋል? (ቁጥሩን ያስቀምጡ)	1. ---- ጊዜ 2. አላውቅም/አላሰታውስም	
153	(ለሴቶች ብቻ) ለመጀመሪያ ጊዜ ስታረግዥ ዕድሜሽ ስንት ነበር? (ቁጥሩን ያስቀምጡ)	1. ------ ዓመት 2. አላውቅም/አላሰታውስም	
154	አርግዘው የሚያውቁ ከሆነ ሁሉንም እርግዝናዎች ፈልገዋቸው ነበር?	1. አዎን (መልስዎ አዎን ከሆነ ወደ ጥያቄ ቁጥር 156 ይሂዱ) 2. አልነበረም	
155	እርግዝናውን ፈልገውት ካልነበር እንዴት ሊያረግዙ ቻሉ?	1. የወሊድ መቆጣጠሪያ ዘዴ ስላልነበር 2. ተገድጄ ተደፍሬ 3. የወሊድ መቆጣጠሪያ ዘዴው አልሰራ ብሎ 4. አላሰብኩትም ነበር 5. አላውቅም/አላስታውስም 6. ሌላ (ይጥቀሱ) ------	
156	(ለሴቶች ብቻ) ልጅ ወልደው ያውቃሉ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 159 ይሂዱ)	
157	ልጅ ወልደው የሚያውቁ ከሆነ ስንት ልጆች ወለዱ? (ቁጥሩን ያስቀምጡ)	--------- ልጆች	
158	(ለሴቶች ብቻ) የመጀመሪያ ልጅዎን ሲወልዱ እድሜዎ ስንት ነበር? (ቁጥሩን ያስቀምጡ)	1. ------ ዓመት 2. አላውቅም/አላስታውስም	
159	(ለሴቶች ብቻ) አስዎርዶዎት ያውቃል?	1. አዎን 2. አያውቅም (መልስዎ አያውቅም ከሆነ ወደ ጥያቄ ቁጥር 164 ይሂዱ)	
160	አስዎርዶዎት የሚያውቅ ከሆነ ውርጃው እንዴት ሊከሰት ቻለ?	1. እርግዝናው እንዳይቀጥል የተለያዩ ዘዴዎችን ተጠቅሜ 2. ሳይነካካ በተፈጥሮ አለመፍቀድ ዝም ብሎ (በራሱ ጊዜ)	
161	(ለሴቶች ብቻ) ለምን ያህል ጊዜ እርግዝና እንዳይቀጥል ለማድረግ ሞክረው ያውቃሉ? (ቁጥሩን ያስቀምጡ)	1. ---- ጊዜ 2. አላውቅም/አላሰታውስም	
		1. የወንድ ጓደኛዬን 2. ጓደኞቼን/እኩዮቼን	

162	እርግዝናው እንዳይቀጥል ለማድረግ ከመወሰንዎ በፊት መጀመሪያ ማንን አማከሩ?	3. ወላጆቼን 4. ጤና ባለሙያዎችን 5. የባህል መድሃኒት አዋቂዎችን 6. ውርጃ የሚሰራ ሰውን 7. አላውቅም/አላስታውስም 8. ሌላ (ይጥቀሱ) ------	
163	(ለሴቶች ብቻ) ውርጃውን የት ፈፀምሽው?	1. የመንግስት ጤና ድርጅት 2. ከግል ክሊኒክ 3. ውርጃውን ከሰራልኝ ሰው ቤት 4. ከራሴ ቤት 5. አላውቅም/አላስታውስም 6. ሌላ (ይጥቀሱ) ------	

ክፍል ሦስት - በጸታዊ ግንኙነቶችና ሥነ-ተዋልዶ ጤና ዙሪያ ያለንን እውቀትና አመለካከት የሚያመለክቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ
164	ሴት ልጅ ለመጀመሪያ ጊዜ በምታደርገው የግብረ ሥጋ ግንኙነት ልታረግዝ ትችላለች?	1. አዎን ትችላለች 2. አትችልም 3. አላውቅም	
165	ወንድ ልጅ ለማስረገዝ የሚችለው በየትኛው እድሜው ነው?	1. በጉርምስና ጊዜው እና ከዚያ በኋላ 2. ከ10 ዓመቱ በፊት 3. አላውቅም 4. ሌላ (ይጥቀሱ) ------	
166	ሴት ልጅ ለማርገዝ የምትችለው በየትኛው እድሜዋ ነው?	1. በጉርምስና ጊዜዋ እና ከዚያ በኋላ 2. ከ10 ዓመቷ በፊት 3. አላውቅም 4. ሌላ (ይጥቀሱ) ------	
167	በየትኛዎቹ የወር አበባ ጊዜያት ነው አንዲት ሴት የማርገዝ ዕድሏ ከፍተኛ የሚሆነው?	1. የወር አበባዋ በሚፈስበት ጊዜ 2. የወር አበባዋ መፍሰስ እንዳቆመ 3. የወር አበባዋ ከመጀመሩ በፊት 4. የወር አበባዋ ፈሶ ካቆመና እንደገና በሚመጣበት ጊዜ መካከል 5. ሁሌም አንድ ነው 6. አላውቅም 7. ሌላ (ይጥቀሱ) ------	
		1. አዎን	

168	እርግዝናን ለመከላከል የሚያስችሉ ዘዴዎችን እንዳሉ ያውቃሉ?	2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 170 ይሂዱ)	
169	እርስዎ የሚያውቋቸው እርግዝናን ለመከላከል የሚያስችሉ ዘዴዎች የትኞቹ ናቸው?	1. የሚዋጥ ክኒን 2. ኮንዶም 3. በመርፌ የሚሰጥ 4. በክንድ ጡንቻ ውስጥ የሚቀመጥ 5. በማህፀን ውስጥ የሚቀመጥ 6. ማምከን 7. መታቀብ 8. የወንድ የዘር ፍሬን ወደ ውጭ ማፍሰስ 9. ከግብረ ሥጋ ግንኙነት በኋላ ብልትን መታጠብ 10. ቆሞ የግብረ ስጋ ግንኙነት ማድረግ 11. የወር አበባ ቀንን ቆጥሮ መጠቀም/ከግብረ ስጋ ግንኙነት መቆጠብ 12. ሌላ (ይጥቀሱ) ------	
170	በግብረ ሥጋ ግንኙነት ሊተላለፉ ስለሚችሉ የአባላዘር በሽታዎች ሰምተህ/ሽ ታውቃለህ/ታውቂያለሽ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 172 ይሂዱ)	
171	አዎን ካልክ/ሽ ምን ምን በግብረ ሥጋ ግንኙነት የሚተላለፉ በሽታዎች ታውቃለህ/ታውቂያለሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ጨብጥ 2. ቂጥኝ 3. ከርክር 4. ባምቡሌ 5. ኤች.አይ.ቪ/ኤድስ 6. ሌላ (ይገለጽ) -----	
172	ስለ ኤች.አይ.ቪ ኤድስ ሰምተህ/ሽ ታውቃለህ/ቂያለሽ?	1. አዎን 2. አላውቅም	
173	የኤድስ ቫይረስ የሚተላለፍባቸውን መንገዶች ግለጽ/ጪ? (ከአንድ በላይ መልስ መመለስ	1. ልቅ የሆነ የግብረ ሥጋ ግንኙነት 2. ስለታማ ነገሮችን በጋራ በመጠቀም 3. በተበከለ ደም ልገሳ 4. በእርግዝና እና በወሊድ ወቅት ከእናት ወደ ልጅ	

	ይቻላል)	5. በትንኝ ንክሻ 6. በጡት ወተት 7. በንክኪ (መጨባበጥ/አብሮ መብላት --) 8. ሌላ (ይገለጽ) -----	
174	ማንኛውም ሰው በህይወቱ ለመጀመሪያ ጊዜ በሚያደርገው የግብረ ሥጋ ግንኙነት በኤች.አይ.ቪ ሊያዝ ይችላል?	1. አዎን 2. አይችልም 3. አላውቅም	
175	አንድን ሰው አተኩሮ በመመልከት የኤች.አይ.ቪ ቫይረስ እንዳለበት ማወቅ ይቻላልን?	1. አዎን 2. አይቻልም 3. አላውቅም	
176	አንድ ሰው እራሱን ከኤች.አይ.ቪ/ኤድስ እና በግብረ-ሥጋ ግንኙነት ከሚተላለፉ በሽታዎች ለመጠበቅ ማድረግ የሚችለው ነገር አለ?	1. አዎን 2. የለም 3. አላውቅም	
177	አንድ ሰው እራሱን ከኤች.አይ.ቪ/ ኤድስ እና ሌሎች በግብረ-ሥጋ ግንኙነት ከሚተላለፉ በሽታዎች ለመከላከል ምን ማድረግ አለበት? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ከግብረ ሥጋ ግንኙነት መቆጠብ/መታቀብ 2. ድንግተኛ የግብረ ሥጋ ግንኙነት ማስወገድ 3. አንድ ለአንድ መወሰን 4. በግብረ ሥጋ ግንኙነት ወቅት ሁሌም ኮንዶም መጠቀም 5. ከሴተኛ አዳሪ ጋር የግብረ ሥጋ ግንኙነት አለማድረግ 6. ንጽህናው ካልተጠበቀ መርፌ መቆጠብ 7. የተበከሉ ስለታማ ነገሮችን አለመጠቀም 8. ሌላ (ይጠቀስ) -----	
178	አንድ ሰው በግብረ-ሥጋ ግንኙነት በሚተላለፉ በሽታዎች ሲጠቃ የሚያሳያቸውን ምልክቶች ጥቀስ/ሽ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. የብልት መቁሰል 2. ያልተለመደ ፈሳሽ ከብልት መፍሰስ 3. ሽንት ሲሸኑ ማቃጠል/ህመም 4. የብልት ማበጥ 5. ሌላ (ይጠቀስ) -----	
179	የግብረ ሥጋ ግንኙነት በምታደርግበት/ጊበት ጊዜ ኮንዶም	1. እስማማለሁ 2. አልስማማም	

	መጠቀም የትዳር አጋርን/ጓደኛን ያለማመን ምልክት ነው?	3. እርግጠኛ አይደለሁም	
180	ወንድ ልጅ ከማግባቱ በፊት የግብረ ሥጋ ግንኙነት መፈፀም አለበት?	1. እስማማለሁ 2. አልስማማም 3. እርግጠኛ አይደለሁም	
181	ሴት ልጅ ከማግባቷ በፊት የግብረ ሥጋ ግንኙነት መፈፀም አለባት?	1. እስማማለሁ 2. አልስማማም 3. እርግጠኛ አይደለሁም	
182	ከወላቶች ጋር ስለኮንዶም ወይንም ስለወሊድ መከላከያ ዘዴዎች መወያየት ልቅ የግብረ ሥጋ ግንኙነትን ያስፋፋል?	1. እስማማለሁ 2. አልስማማም 3. እርግጠኛ አይደለሁም	
183	እስካሁን ባለው ጊዜ ለኤች.አይ.ቪ/ኤድስ የሚያጋልጥ ድርጊት ፈጽሜያለሁ ብለህ/ሽ ታስባለህ/ቢያለሽ?	1. አዎን 2. አላስብም (መልስዎ አላስብም ከሆነ ወደ ጥያቄ ቁጥር 185 ይሂዱ) 3. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 186 ይሂዱ)	
184	መልስህ/ሽ አዎን ከሆነ ለምን? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ያለ ኮንዶም የግብረ ሥጋ ግንኙነት ስለፈፀምኩ 2. ከአንድ ሰው በላይ የግብረ ሥጋ ግንኙነት ስለፈፀምኩ 3. ከሴተኛ አዳሪ ጋር የግብረ ሥጋ ግንኙነት ስለፈፀምኩ 4. በተበከለ ስለታም ነገሮች ድንገተኛ ጉዳት ስለደረሰብኝ 5. ሌላ (ይገለጽ) -----	
185	መልስህ/ሽ ራስን ለኤች.አይ.ቪ ለሚያጋልጥ ስህተት አልተጋለጥኩም ከሆነ ለምን? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. የግብረ ሥጋ ግንኙነት ፈጽሜ አላውቅም 2. ከግብረ ሥጋ ግንኙነት ስለታቀብኩ 3. አንድ ለአንድ በታማኝነት ስለጸናሁ 4. ከሴተኛ አዳሪ ጋር የግብረ ሥጋ ግንኙነት ስለማልፈጽም 5. ሌላ ሰው በተወጋበት መርፌ ተወግቼ አላውቅም 6. ሁል ጊዜ ኮንዶም ስለምጠቀም	

		7. ሌላ (ይገለጽ) -----	
186	በፈቃደኝነት ላይ ስለተመሠረተ የኤች.አይ.ቪ የምክር አገልግሎት እና የደም ምርመራ ሰምተህ/ሽ ታውቃለህ/ቂያለሽ?	1. አዎን 2. አላውቅም	
187	በፈቃደኝነት ላይ የተመሠረተ የኤች.አይ.ቪ ምርመራ አድርገህ/ሽ ታውቃለህ/ቂያለሽ?	1. አዎን 2. አላውቅም	
188	በፈቃደኝነት ላይ የተመሠረተ የኤች.አይ.ቪ ምርመራ ለማድረግ ብትጠየቅ/ቂ ፈቃደኛ ትሆናለህ/ሽ?	1. አዎን 2. አልሆንም 3. እርግጠኛ አይደለሁም	

ክፍል አራት - ስለ ጾታዊ ያልሆኑ አደገኛ ባህርያት በአካል ጉዳተኞች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ
189	አደንዛዥ ዕፆችን ወይንም መድሃኒቶችን ወስደው ያውቃሉ? (የሱስ ተገዢ ነዎት)	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 191 ይሂዱ)	
190	ወስደው የሚያውቁ ከሆነ (የሱስ ተገዢ ከሆኑ) የትኞቹን ነው አዘውትረው የሚወስዱት?	1. ጫት 2. ሲጋራ 3. ሃሺሽ 4. ሌላ (ይገለጽ) -----	
191	የአልኮል መጠጥ ወስደው ያውቃሉ?	1. አዎን 2. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 194 ይሂዱ)	
192	የአልኮል መጠጥ የሚወስዱ ከሆነ ምን ያህል አዘውትረው ይወስዳሉ?	1. በሳምንት ከ3-4 ጊዜ 2. በወር ከ3-4 ጊዜ 3. በበዓላት ቀን ብቻ	
193	ባለፈው አንድ ወር ውስጥ ከጠጡ በኋላ የግብረ ሥጋ ግንኙነት ፈጽመው ያውቃሉ?	1. አዎን 2. አላውቅም	

ክፍል አምስት - ስለ የጤና አገልግሎት አጠቃቀም እና የስነ ተዋልዶ ጤና መረጃ

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	ኮድ
194	ስለ ሥነ ተዋልዶ ጤና ሰምተው	1. አዎን	

	ያውቃሉ?	2. አላውቅም	
195	ሥነ ተዋልዶ ጤና አገልግሎት ተጠቅመው ያውቃሉ?	1. አዎን 2. አላውቅም	
196	ባለፉት 3 ወራት የሥነ ተዋልዶ ጤና አገልግሎት ተጠቅመዋል?	1. አዎን 2. አልተጠቀምኩም (መልስዎ አልተጠቀምኩም ከሆነ ወደ ጥያቄ ቁጥር 198 ይሂዱ)	
197	ለጥያቄ ቁጥር 196 መልስዎ አዎ ከሆነ የትኛው ችግር አጋጥሞዎት ነው የሥነ ተዋልዶ ጤና አገልግሎት የተጠቀሙት?	1. የአባላዘር በሽታ 2. ውርጃ ለመፈጸም 3. ለወሊድ 4. ለቅድመ ወሊድ ምርመራ 5. የሚዋጥ የወሊድ መከላከያ ለማግኘት 6. ኮንዶም ለማግኘት 7. ለምክር አገልግሎት 8. ሌላ (ይገለጽ) -----	
198	ወደ ጤና ድርጅት መሄድ ካለብዎ ወደ የትኛው ቢሄዱ ይመርጣሉ?	1. የመንግስት የጤና ተቋም 2. የግል የጤና ተቋም 3. መድሃኒት ቤቶች/ፋርማሲ 4. የልምድ አዋላጅ 5. ሌላ (ይገለጽ) -----	
199	ለምን ከላይ ወደ ጠቀሱት የጤና ተቋም ለመሄድ እንደመረጡ ሊገልፁልኝ ይችላሉ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ህክምናው ፍቱን ስለሆነ 2. ህክምናው ነፃ ስለሆነ 3. የህክምናው ዋጋ አነስተኛ ስለሆነ 4. ቅርቤ ስለሆነ 5. ዘመዶቼ እዛ ስለሚሰሩ 6. ሚስጥር ስለሚጠብቁ 7. ወላጆቼ ስለሚመርጡት 8. ሌላ (ይገለጽ) -----	
200	የአካል ጉዳተኞች የወሊድ መቆጣጠሪያ ዘዴ/ኮንዶም ለማግኘትና ለመጠቀም የሚቀላቸው ወይስ የሚከብዳቸው ይመስልዎታል?	1. የሚቀላቸው (መልስዎ የሚቀላቸው ከሆነ ወደ ጥያቄ ቁጥር 202 ይሂዱ) 2. የሚከብዳቸው 3. አላውቅም (መልስዎ አላውቅም ከሆነ ወደ ጥያቄ ቁጥር 202 ይሂዱ)	
201	ይከብዳቸዋል ብለው ካሰቡ ለምን	1. ለመግዛት የገንዘብ ማጣት 2. የመረጃ ማጣት 3. የፍቅር አጋሮቻቸው ጫና	

	የሚከብዳቹው ይመስልዎታል? (ከአንድ በላይ መልስ መመለስ ይቻላል)	4. ሐይማኖታቸው 5. ለማግኘት አስቸጋሪ ስለሆነ 6. አገልግሎት ሰጪዎቹ ስለማይቀበሏቸው 7. ወላጆቻቸው ስለማይቀበሏቸው 8. ማከፋፈያ ቦታዎቹ ለአካል ጉዳተኞች ምቹ ስላልሆኑ 9. ከሱቅ ወይም ከመድሃኒት ቤት ለመግዛት ሀፍረት ስለሚሰማቸው 10. በጣም ሩቅ ስለሆነ 11. ለመግዛት ውድ ስለሆነ 12. ግድየለሽነት 13. ስለማያሰጋቸው/ የግብረ ሥጋ ግንኙነት ስለማይፈጽሙ 14. ሌላ (ይገለጽ) -----	
202	የአካል ጉዳተኛ ወጣቶች በጤና ድርጅቶች ውስጥ የሥነ ተዋልዶ ጤና አገልግሎት ተጠቃሚ እንዳይሆኑ የሚያደርጓቸው ነገሮች ምን ይመስሉዎታል?	1. እፍቅ ስለሆኑ 2. ውድ ስለሆኑ 3. አገልግሎት ሰጪዎቹ ሚስጥር ስለማይጠብቁ 4. አገልግሎት ሰጪዎቹ ስለሚያመናጭቁ 5. አገልግሎት ለመስጠት ብዙ ስለሚያስጠብቁ 6. የጤና ተቋማቱ አመቺ ስላልሆኑ 7. አላውቅም 8. ሌላ (ይገለጽ) -----	
203	ስለ የሥነ ተዋልዶ ጤና አገልግሎት ከወላጆችዎ ጋር ተወያይተው ያውቃሉ?	1. አዎን 2. አላውቅም	
204	አብዛኛዎቹ የአካል ጉዳተኛ ወጣቶች ስለ ወሊድ መከላከያ ዘዴዎች በቂ መረጃ አላቸው ብለው ያስባሉ?	1. አዎን 2. አላስብም 3. አላውቅም	
205	የአካል ጉዳተኛ ወጣቶች ስለ ተዋልዶ ጤና በአብዛኛው መረጃ ከየት የሚያገኙ ይመስልዎታል? (ከአንድ በላይ መልስ መመለስ	1. ከትምህርት ቤት 2. ከጓደኞቻቸው 3. ከወላጆቻቸው 4. ከብዙኀን መገናኛ 5. ከጤና ባለሙያ 6. ከምንም	

	ይቻላል)	7. አላውቅም 8. ሌላ (ይገለጽ) -----	
206	ስለ የሥነ ተዋልዶ ጤና ብዙ ማወቅ ሲፈልጉ ከማን ጋር ቢዎያዩ ይመርጣሉ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ከጓደኞቼ 2. ከእናቴ 3. ከአባቴ 4. ከእህቴ 5. ከፍቅር ጓደኛዬ 6. ከባለቤቴ (ከባሌ/ከሚስቴ) 7. ከጤና ሙያተኛ 8. ሌላ (ይገለጽ) -----	
207	ስለ የሥነ ተዋልዶ ጤና ብዙ መረጃ የሚያገኙት ከየት ነው? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. ከቴሌቪዥን/ ሬድዮ 2. ከጋዜጣ 3. ከት/ቤት መምህራን 4. ከወላጆቼ 5. ከትዳር አጋሬ 6. ከጓደኛዬ 7. ከጤና ሙያተኞች 8. ሌላ (ይገለጽ) -----	

በጣም አመሰግናለሁ::

Declaration

I, the undersigned, declare that this thesis is my original work and has not been prepared for a degree in this or other universities, and that all sources of materials used for the thesis have been fully acknowledged.

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This thesis has been submitted with my approval as University advisor.
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