

**Running head: ADOLESCENTS' REPRODUCTIVE BEHAVIOR IN
SLUM AREAS**

**A Study on Contributing Factors to Adolescents'
Reproductive Behavior in Slum Areas
of Addis Ababa: The Case of Teklehaimanot Area**

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Abstract

Adolescents' reproductive behavior is mostly determined by interrelated factors. Therefore, this study has tried to see the underlying environmental factors and reproductive behavior of slum adolescents. For this purpose, 186 adolescents, in the age range of 15-19 and are residents of Teklehaimanot slum area, were identified through systematic random sampling. Among them, 54.8 percent and 45.2 percent are female and male, respectively. Descriptive data and bivariate analysis were used to explore the existence of association between different variables. Accordingly, both male and female adolescents are well aware of the social values towards pre-marital sex and have perception of their vulnerability to reproductive problems. However, the majority are engaged in early sexual practice. The study has found that factors like dropping out of school, poverty, involvement in risky behaviors contribute for their sexual behavior. Therefore, a well integrated, social work intervention, implemented at different levels, is very crucial.

1 CHAPTER ONE

1.1 Background

Adolescence is a transition from childhood to adulthood during which young people experience changes in their physical, psychological and social conditions. It is a time of learning and exploring, and can be a good time to establish healthy attitudes and behaviors for life. It is a stage, an individual begins to assume adult roles and make decisions, which could have a long-term effect on the up coming adult life. This is especially true when it comes to sensitive areas such as sexual and reproductive health and gender relations.

Many governments in sub-Saharan Africa view the threatening reproductive health indicators of rapid population growth, high birth rates, and escalating rates of HIV infection (Advocates for Youth, 2005) * which affect all segments of the population including the youth. According to the report of Family Health International (FHI); adolescents' needs for reproductive health services are often misunderstood, unrecognized or underestimated. This results in devastating situations. To mention some; each year 15 million girls age 15 to 19 have babies, two to four million adolescents in developing countries have unsafe abortions per year, nearly half of all HIV infections worldwide occur among people under age 25 and seven in 10 new Sexually Transmitted Infections (STIs) occur among individuals 15 to 24 years old (FHI, 2005).

According to the report analysis of *Youth Reproductive Health in Ethiopia*; which was conducted based on the 2000 Ethiopia Demographic and Health Survey (DHS); the existing

* All the years used in this document are in the Gregorian Calendar

tradition and poor living conditions lead young people to engage in sex at an early age and face the consequences. The traditional practices like early marriage, marriage by abduction and female genital mutilation are known as the major contributing factors, which are mostly followed by early or unintended pregnancy, which is highly associated with health risks to the mother during pregnancy and delivery. Unintended pregnancy is mostly followed by unsafe abortion, which places many young women at risk. In relation with this, the prevalence of sexually transmitted diseases (STDs) like HIV/AIDS is relatively high among young people in Ethiopia (Govindasamy, Aklilu¹ & Hailom², 2002).

Traditionally, premarital sex has been discouraged in most societies; though many condone it in some form, at least for boys. However, this condition is changing, and sex among unmarried teenagers, both male and female, is a problem that most societies must learn to confront. Study conducted in urban areas of Ethiopia revealed that adolescents are sexually active. A survey on adolescents' reproductive health in Addis Ababa, which was conducted by the National Population Office (1999), showed that 36% of adolescents who have never married reported that they have had sexual experience. Among these sexually active youth, nearly half of them experienced their first sexual relationships while they were in the age range of 16-18 years (NPO, 1999). Early initiation of sex poses health risks for both male and female adolescents; with more risk to female adolescents. In addition, early marriage, poverty, gender discrimination, lack of reproductive right, sexual violence, having multiple sexual partners are some of the major contributing factors spelled out (UNFPA, 2003).

^{1& 2} In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

Youth living in disadvantaged communities with high poverty rates and low levels of socioeconomic status have a greater risk of early sexual initiation and a greater risk of adolescent pregnancy and childbearing. Slum areas are part of urban areas characterized by poverty, inequality and social exclusion. The dwellers in these parts of towns and cities are deprived of proper housing or infrastructure and basic rights and services (DFID, 2004). About 80 % of the total population of Addis Ababa lives in slum areas. About 41% of the slum dwellers earn less than 13 Birr (1.5 USD) per day. Only 1.3% of the population has access to modern sanitation and 24% use pit latrines (Elias ³, 2004). Hence, adolescents residing in slum areas are vulnerable since they are deprived of access to health services, pure water, latrine and proper housing.

Poor adolescents are likely to live in environments that do not support health-promoting activities. It is not only specific behaviors that place adolescents at risk, but also the fact that the environment in which they find themselves often prohibits them from getting the information, motivation, skills and money required to make healthy choices. The disadvantages of poverty are also overlaid by disparities arising from age, culture, law and gender (WHO, 2004). Hence, this study will try to assess the reproductive behavior of adolescents residing in the slum area of Teklehaimanot area. In addition, analyze the relationship of the underlying factors with that of the reproductive behavior of the study population. The knowledge acquired from this study will serve as groundwork for further studies.

³ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

Considerable work remains to be done in the research area of the study presented in this paper. Since, environmental impact could have a significant impact on the development of personal behavior; it is crucial to have direct evidences whether reproductive behavior of adolescents is related with their place of residence and surrounding conditions.

1.2 Geographical Location

The target area is known as Teklehaimanot area located in the south-central part of Addis Ababa, between Merkato and Piassa areas. Based on the new structure of Addis Ababa city administration, it is classified under Lideta sub city. This area is one of the slum areas characterized by high population density, poor infrastructure and sanitation problem. Most of the houses, which are built very close to one another, are found in a highly deteriorated condition. Approximately 37 percent (1495 units) of all housing units require major and minor repairs (IHA/UDP, 2001). The total population of Teklehaimanot area is estimated to be 30,000. The sex ratio is 1:1.22 implying 45 percent male and 55 percent female. It has an estimated density of one person per square meter of occupied space. Eighty percent of the population is considered to be below the poverty line. This area is highly inhabited by residents engaged in various economic activities such as petty trade, daily labor and others. Approximately 86 percent of the youth population is unemployed. Twenty five percent of the school age children are out of school and involved in all kinds of survival-promoting activities, some of which might be illegal. Children and youth represent approximately 66 % of the total population. Curative health services are accessible to only 23 percent of the population (ibid). According to the MOH report of 2004, the HIV prevalence exhibited at Anti Natal Care (ANC) site of Teklehaimanot is 15.1% (MOH, 2004).

1.3 Objective of the Study

1.3.1 General Objective

- To assess the existing adolescent's sexuality and analyze their sexual behavior in consideration of contributing factors for the development of such behavior of both male and female adolescents residing in Teklehaimanot slum area.

1.3.2 Specific Objectives

- To describe sexual behavior of adolescents and identify high risk sexual behavior among adolescents of Teklehaimanot area
- To assess the non reproductive factors (contextual factors) associated with adolescents reproductive behavior of Teklehaimanot area
- To assess the degree of risk perception (sense of vulnerability) towards bad effects of unsafe sex particularly to HIV/AIDS among adolescents of Teklehaimanot area
- To assess prevalence of contraceptive use
- To assess the degree bias in exercising sexual rights among adolescents of Teklehaimanot area
- To recommend social work intervention to address the existing problem

1.4 Research Methodology

- 1. Study Design:** The study is a descriptive and analytical study on the reproductive behavior of adolescents of Teklehaimanot area.
- 2. Study Population:** The population under study is both boy and girl adolescents in the age range of 15-19 who are residents of Lideta sub-city around Teklehaimanot area specifically in Kebele 07. In the draft document of the 2005 Ethiopian population

census; the percentage of urban adolescents who belong to the age range of 15-19 is indicated to be 13% of the total urban population (Census, 2005). By using the total population of kebele 07 (14,331), adolescents belonging to the age range of 15-19 had been calculated to be 1863.

3. Sampling Procedure: The kebele administration of the study area provided the list of house numbers in kebele 07 (sampling frame). Then by using 10% of the total population of adolescents in Kebele 07 (1863); the sample size was determined to be 186 adolescents who were selected by the application of systematic random sampling technique. With the application of the house numbers adolescent who belongs to every tenth household was interviewed. During data collection; if the selected respondent was not found at his/her home, an adolescent who is a resident at the next house was used as a replacement. Among the respondents 102 (54.8%) are females and 84 (45.2%) are males. In addition to this, people from the kebele had assisted in locating the selected houses.

4. Inclusion and Exclusion criteria:

Inclusion Criteria

- Adolescents who are in the age range of 15-19.
- Resident of Teklehaimanot area in Lideta sub-city kebele 07
- Adolescents' and Parents' full consent to participate in the study

Exclusion Criteria

- Adolescent who are in the age range of 10-14.
- Adolescents who are not resident of Lideta sub-city kebele 07

- Adolescents' and Parents' who are not willing to participate in the study

5. Instrument of data collection: An interviewer-administered questionnaire was developed and pre- tested for possible improvement or clarity, comprehensibility and flow. The questionnaire had five sections. The first section was about the socio-demographic characteristics of respondents (including personal information like sex, age, educational level, school attendance level, living arrangement, place of origin, family structure, family size, parents'/guardians educational level, source of income...etc). The second section was concerned in the reproductive behavior of adolescents with sub-divisions assessing adolescents' attitude towards reproductive health issues with the application of Likert scale and also questions evaluating adolescents' sexual behavior- sexual experience, number of sexual partners and use of contraceptive. The third section was composed of questions which assess adolescents' access to reproductive health services whereas the fourth section incorporated questions which review adolescents' involvement in risky behaviors and lastly but not least the fifth part was concerned with reproductive health problems.

In addition to the primary resources, secondary resources such as books, journals, magazines and electronic information were used as source of data.

1.5 Ethical Concerns

In this research, each respondent and any other participating body were briefed with the purpose of the study and were ensured regarding the confidentiality of his/her identity. For this purpose, each questionnaire included the stated information and ensured the

respondents' consent. For adolescents who are under age 18; parents were consulted and briefed about the study.

1.6 Limitation of the Study

The primary data for this study had been collected from adolescents' only. It would have been more detailed and explanatory if other bodies (like adolescents' parents, service providers and others) were included in the study. However, this was not possible due to time constraint.

1.7 Operational Definition

- **Adolescents Reproductive Behavior:** refers to the sexual manner of adolescents', which is the outcome of a process involving a series of individual decisions and actions occurring within social, economic, ecological, cultural and political contexts. It could be assessed by considering elements like, age at first sexual intercourse, number of sexual partners and contraceptive use.
- **High Risk Sexual Behavior:** refers to sexual indulgence or involvement of adolescents with no regard to safety. In this study, non-use of condom, having multiple sexual partners, visiting commercial sex workers, taking alcohol or drug are considered as factors related to high risk sexual behaviors.
- **Perception of Vulnerability:** refers to the degree of sensing the risks of unsafe reproductive behaviors that could result in reproductive health problems. In this study, adolescents' awareness of the risks and their vulnerability to reproductive health problems is taken as a measure to perception of vulnerability.
- **Non-Reproductive Factors:** are contextual factors, which are either directly or indirectly associated with adolescents' reproductive health behavior. In this study this

variable is treated as socio-demographic characteristics of adolescent's namely educational status, family background, living arrangement, housing condition and religious affiliation.

- **Reproductive Health Problems:** refers to unintended consequences or health problems which results from unsafe sexual behavior. In this study, unintended pregnancy, unsafe abortion, STD and HIV/AIDS are considered as reproductive health problems.

2 CHAPTER TWO

2.1 *Slum Adolescents and Reproductive Behavior*

2.1.1 **Slum Areas and Conditions of Living**

Definitions for slum areas are given by different bodies or literatures; however, most of the definitions have common elements of physical description of the area. As UN-HABITAT (2003:6) cited in '*Urban Slum and Monitoring*' of Turkstra and Raithelhuber (2004); defined 'slum' as "*a contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services. A slum is often not recognized and addressed by the public authorities as an integral part of the city*". This definition had been qualified further by describing slum households as households lacking five features-such as;

- *Access to improved water,*
- *Access to improved sanitation,*
- *Security of tenure (the right to effective protection by the state against arbitrary, unlawful eviction),*
- *Durability of housing (including living in a non-hazardous location) and*
- *Sufficient living area (no overcrowding) (UN-HABITAT (2003:6) as cited in Turkstra and Raithelhuber, 2004).*

As a criterion Zulu et al (2002) have also used three basic household facilities as a measure for urban slum residence. The three amenities are water, electricity and flush toilets. The absence of all of the three facilities in a household can be used as an indicator of slum residence, and on the other hand, the presence of the three implies that the household is a non-slum residence. However, in slum areas there are households, which have one or two of the three facilities hence these are grouped in an 'intermediate' category. Yet in this case, the availability or absence of all of the facilities is used to distinguish households from being non-slum residence with that of slum residence (Zulu, Dodoo & Alex, 2002).

The Common Country Assessment (1999) compiled by the World Bank for the purpose of identifying poverty indicators has distinguished accessibility of safe water and sanitation facility as one way of specifying the degree of poverty (Common Country Assessment, 1999). Accordingly, the 1994 census has identified that about 76% and 87 % of households throughout the country have no access to safe water and sanitation facilities respectively. In Addis Ababa, about 2.5 and 43 percent of households have no access to safe water and sanitation facilities (Census, 1994). The UN-Habitat had used Monitoring Urban Inequality Program (MUIP)⁴ to identify those urban households having access to 'improved water'⁵ which is the concept of having access to a water pipe located around their residence from where they fetch water (Turkstra, et al, 2004).

Considering the devastated condition of slum areas one of the components of the Millennium Development Goals is to ensure the improvement of the lives of 100 million slum dwellers and ensure their human right by year 2020 (Amuyunzu-Nyamongo, 2005). However, the above criterion used to define the slum is more of concerned on the physical status of the areas rather than on the social settings or residents of such places. Monson has related the human aspect with that of the physical setting and tried to see in a different perspective. In most definitions, there exists an idea of physical condition, which further implies the violation of human dignity resulting on frustration and hopelessness of slum residents (Monson, 1995).

⁴ In order to address the problems of slums and assess the difference between the living conditions of the poor and the rich, UN-HABITAT launched the "Monitoring Urban Inequities Program" (MUIP). MUIP was specifically designed to gain information and knowledge about inequality and intra-city differentials in development. The programme aims at filling gaps of information especially on the impact level thus contributing to monitoring of the Millennium Development Goals. Using the results of MUIP, development stakeholders will be in a better position to support local policy formulation and develop effective, locally embedded intervention programs to improve the living conditions of slum dwellers.

⁵ The MUIP surveys had also used the concept of "Improved water", which combines the variable on the water source, availability (a minimum of 20 litres per person per day), time spend daily on collecting water (less than 1 hour per household per day) and affordability (a maximum of 10% of monthly income spent on water). Only households fulfilling all these criteria are considered to have access to improved water.

It is an undeniable fact that poverty goes hand-in-hand with poor quality of housing, inadequate hygiene and sanitation facilities, and people living in overcrowded slum areas are frequently denied of these basic rights. As a basic need, every human being should have relatively acceptable access for shelter, food and clothing. However, in slum areas, due to reasons like poverty people are forced to live in a devastating condition, which puts their welfare in a big question.

Over population of slum, areas can be due to both natural and non-natural increase i.e due to high birth rate and migration respectively. According to the study made on the slums of Nairobi, Zulu et al (2002) have stated that new or incoming residents of the cities are forced to live in a highly devastated condition, which is characterized by high unemployment, having low access to facilities like water, electricity, proper sanitation and other required services. This situation is collaborated with lack of health and family planning services together with low income, and illegal or informal residence. The over crowded settlement and lack of health services make slum dwellers to be vulnerable to various kinds of health problems (Zulu et al, 2002).

According to the UN- HABITAT report of 2003, the population of slum dwellers reached 924 million people in the year 2001 representing about 32% of the world's urban population. The same report stated that about 43% and 78.2 % of the urban population of all developing areas and the urban population of least developed countries was slum dwellers respectively (UN-HABITAT, 2003). Similarly, according to Elias (2004), about 80 % of the total populations of Addis Ababa live in slum areas. About 41% of the slum dwellers earn less

than 13 Birr (1.5 USD) per day. Only 1.3% of the population has access to modern sanitation and 24% use pit latrines (Elias, 2004).

Since adolescents are the integral part of a given society; the following part of the paper describes what adolescence is and then considers adolescents living in slum areas followed by the description of their reproductive behavior and the consequence of adolescents' risky reproductive behavior or reproductive health problems.

2.1.2 What is Adolescence?

Adolescence is transition period from childhood to adulthood during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood (Kimmel and Weiner, 1995). According to UNFPA report, words like “adolescents”, “youth” and “young people” are being used interchangeably. However, the roles and responsibilities attached to each specified categories (age groups) depends on the existing social context. Important life events like marriage, sexual debut, employment, child bearing, acceptance in to adult organizations, political participation occur at different times between and with in societies. This situation made it difficult to have a common specified age interval for the period of adolescence. However, the UNFPA has categorized “adolescents”, “youth” and “young people” in the age group of 10-19 years, 15-24 years and 10-24 years of age, , respectively (UNFPA, 2003: p.3).

The name and age range attached to the period of adolescence is highly associated with the social context of a given society. Kimmel and Weiner (1995) have also highlighted this

point in their book entitled '*Adolescence: A Developmental Transition*'. According to them, there is no clear demarcation for the beginning and an end of adolescence, yet customarily its' beginning is marked by the individual's biological maturation whereas its' ending is defined by the person's social age attached to the ending of adolescence (Kimmel et al, 1995). The World Health Organization (WHO) has also defined '*adolescence*' as '*the progression from the appearance of secondary sexual characteristics (puberty) to sexual and reproductive maturity, the development of adult mental process and adult identity, and transaction from total socio economic dependency to relative independence*' (WHO (1975), as cited in NPO, 1999). Therefore, the interaction between the biological change and the surrounding environment determine the different developmental stage of adolescence.

The period of adolescence is divided into different developmental stages. Kimmel et al (1995) identified three stages depending on the developmental tasks through which adolescents pass. The first one is referred to as *early adolescence*, which is the period in which young people are growing rapidly, both physically as well as intellectually and beginning to take on adult sexual characteristics. The primary developmental task during *early adolescence* involves adapting to these biological and mental changes and accepting how one looks and learning to use one's body and mind effectively. The second stage is called *middle adolescence*, a period in which adolescents attain developmental tasks of becoming physically self-reliant and realizing psychological autonomy from their parents; becoming comfortably involved in expanding peer relationships and achieving the capacity for intimate friendship; and learning to handle heterosexual relationships, dating and sexuality. In the third stage or *late adolescence*, the youth develop a reasonably clear, consistent sense of their personal identity

in relation to others, and began to define their social roles and interpersonal relatedness (Kimmel et al, 1995). Even though, Kimmel and Weiner claimed that there are three different developmental tasks of adolescence; many literatures state there are only two. This is because; they combine the middle developmental stage with that of the late adolescence stage. This might be due to the difficulty of demarcating the developmental stages of adolescents.

During the stage of adolescence, an individual passes through a number of changes namely biological, psychological and social changes. Accordingly, each sequence of developmental stage is related with the physical, psychological and social changes. Yet, the stages of development are not clearly demarcated from one another since they are highly inter-related and interdependent to one another.

Regarding the physical change, both adolescent boys and girls experience physical changes with that of their sex organs becoming matured and ready for sexual intercourse (Ministry of Health, 2003). The physical change of adolescents is easily recognized and it can serve as a mark for the beginning of puberty or the stage of adolescence. In this stage, the secondary sexual characteristics like the first menstrual cycle (menarche) will also mark the physical change.

During the stage of adolescence, together with the physical change there also occur psychological changes. In this period, both boys and girls become aware of their physical change, which imply their consciousness of sexuality and develop sexual desire towards the opposite sex. Adolescents develop feelings of happiness and proud along with disturbances

and confusion having an impact on their behavior. Adolescents might also feel a sense of guilt, fear of discovery and disapproval from parents, or complete rejection. Hence, this can be a major psychological trauma for the teenagers. This is mostly because; young people start to develop their autonomy and try to avoid parents' control. However, adolescents need advice and support from the family and the community (ibid). This stage of change shows the interrelation between the mental development and the surrounding condition which starts from the family. In addition, adolescents' search for identity and independence can trigger parent-child conflict during the period of adolescence (Geas & Seff, 1990).

As adolescents try to define their autonomy they learn to make decisions by their own which could be used as a step towards adulthood. Their decision can depend on their social context such as religion, culture and other aspects. Erikson also agrees that the stage of adolescence is a period in which *ego identity* or a stage in which answers to questions like '*who am I? and where is my place in the society*' is developed. However, in this stage, adolescents face a problem of role confusion and this could create conflict with their parents (Crain, 2000). On the other hand, Schvaneveldt and Adams (1983) describe the stage of adolescence in terms of decision-making process. According to them, during childhood, parents are expected to make decisions for their children however in this particular stage adolescents try to develop independency which requires an element of decision making (Schvaneveldt & Adams, 1983).

The social adjustment or change of adolescents is marked by rituals or ceremonies in order to grant them recognition as being adults implying new responsibilities and new freedom

as well. In most African societies, being accepted as an adult is determined more by tradition and cultural values rather than by age or physical size (Kimmel et al, 1995). On the other hand, the school system could also be used as a mark for entering adolescence such as becoming junior high or high school student can be used as a demarcation for the developmental stage.

Schvaneveldt et al (1983) explained 'adolescence' as a beginning stage of becoming an adult hence society makes an effort to induct and prepare young people so that they can develop adult patterns of behavior. Their training includes formal education, driver education, scouts, "young political groups", religious affiliations, and a host of other activities for personal as well as social development (Schvaneveldt et al, 1983).

As discussed above; all adolescents have to pass through the three major changes in order to be an adult. However, the development of adolescents might go hand in hand with their surrounding social systems and the elements included in the systems. The proceeding part of this paper will try to discuss in recognition of the multiple aspects of adolescents' life in slum areas and tries to relate it with the development of adolescents' reproductive behavior.

Adolescents, being part of the overall population of any country, had been nearly 1.1 billion in 1995 of which 913 million lived in developing countries and 160 million in developed countries. Accordingly, one in every five people in the world is an adolescent, and 85 of every 100 adolescents live in developing countries (Silva, 1998). In Ethiopia, adolescent population aged 10-19 accounts for 25 percent, which is one-fourth of the total population

(NPO, 1999). According to the 1994 population census, adolescents in the age range of 15-19 in Addis Ababa accounts for 14% of the total population of the city. The census report also stated that about 24% of adolescent population with in the age range of 15-19 is migrants to the capital city (Census, 1994). Even though statistics showing the magnitude of adolescents living in slum areas is highly scant both the countrywide and regional population census give a clue for the existence of high adolescent population, which need attention in all aspects of life.

2.1.3 Adolescents' Reproductive Behavior and Underlying Factors in Slum areas

According to FHI report of 2002 on the issue of youth, it was stated that early puberty and late marriage are becoming common incidents all around the world. This situation is creating a gap for young people to be engaged in premarital sex. Accordingly, the majority of youth will engage in sexual interactions by the age of 20 (FHI, Youth Net Program; 2002). Urbanization could be one factor for the occurrence of late marriage among the youth. This is because, in cities, there is high school enrolment compared to the rural resulting in delaying marriage and increasing early sexual engagements.

According to Bongaarts and Cohen (1998), adolescents' fertility is highly determined by the social context in which they live. Urbanization, the rise in formal education and income and the availability of modern contraceptives will contribute positively towards the reproductive behavior of adolescents. This is because; it plays a role in avoiding the adverse effect of unintended pregnancy and other reproductive health problems (Bongaarts & Cohen,

1998). Even though Bongaarts et al (1998) tried to show the positive impacts of the social context, the whole scenario can be reversed when one considers the conditions in slum areas.

Yordanos had stated that, sexual behavior is influenced by non-sexual behavioral determinants such as access to formal and informal education, religious affiliation, family and societal norms, peer pressure and access to reproductive health information and substance use. On the other hand, the value a society attaches to virginity or chastity affects the sexual behavior of adolescents (Yordanos ⁶, 2000). In other words, Yordanos has considered the social value, which acknowledges virginity until marriage. Even though the value should be applied on both male and female, the society expects mostly girls to stay virgin until marriage; since pre-marital sex for boys is considered as a sign of masculinity. Lundgren (2000) had tried to explain this situation, as the behavioral expression of masculinity is not in-born instead; it is learned through socialization process. Adolescent boys internalize the attitude of the society's definition of masculinity from their environment that is from the family, peers, neighbors, mass media and observing adults. This situation will determine the sexual performance of male adolescents, which will be considered as an identity of masculinity (Lundgren, 2000).

Seleshi (2005) has tried to explain the contribution of the societal factors on the individual adolescents' decision-making. Even though, the social pressure through norms, values and attitudes might have a role in determining adolescents' sexual behavior the individual character such as adolescents' socioeconomic conditions like educational level,

⁶ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

employment status and living arrangement might play a role in determining sexual behavior. Accordingly, the contextual factors like school attendance, peer behaviors and community connectedness have a pressure on initiation of sex and extent of condom use. However, condom use is determined by adolescents' personal character, like gender role perceptions, as well as communication with partners concerning pregnancy and STD risks (Seleshi ⁷, 2005).

Poverty is the integral element of the social context of slum areas. Unemployment is one of the peculiar features of slum dwellers who are mostly engaged in informal sector or are completely idle. This is mainly due to lack of access to formal job and credit facilities. Slum areas are also characterized by high crime rate and insecurity (UN-HABITAT, 2003). Hence, this situation goes hand in hand with economic problem, which further affects the different elements of the social context. For instance, there could be family breakdown resulting in increase in street children, reproductive health problem including HIV/AIDS. In other words, the miserable economic condition has a great contribution for adolescents' engagement in an early sexual intercourse and having multiple sexual partners.

The family welfare in slum area is highly affected by problems like congestion, poor sanitation, bad housing and poverty. This situation may serve as one factor for the occurrence of family break down and social disorganization. Children born to families residing in the slums experience a great deal of misery, which could create tension and frustration. This pressure could also be manifested in the upcoming generations. Hence, the problems existing in slum areas form a vicious circle, which needs to be broken (Monson, 1995). Poverty and the

⁷ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

overall poor functioning of family enhance the degree of vulnerability of children or adolescents. As various literature state, children in adolescence stage exhibit multifaceted changes both with in their bodies as well as their social position therefore, they require understanding and care from the surrounding community, which starts from the family. However, children who come from poor functioning families can be exposed to risks, which could affect their future endeavor.

As family serves as a fundamental institution for the socialization of children, it is highly dependent on the social environment, which directly or indirectly affects the process. Socializing being the basic activity undertaken by family, adolescents should have the opportunity to have access to reproductive health information. Hence, parents are the ideal source of information. However, here the availability of parents as well as the capability of parents (socio-economic condition) might play a significant role.

Miller & Simon (1974) have also stated that social institutions like the family as well as the church have a role in controlling adolescents' sexual behavior. The family control over adolescents' reproductive behavior has a goal in preventing adolescents from engaging in sexual practices, which could have an adverse effect on the marriage market and labor force participation. However, religious institutions are more committed in the conformity to a system of ethics, which usually prohibits pre-marital sexual experience. Even though both institutions have concerns for the future orientations of adolescents, neither of them are successful. Customarily, adolescents' disconformities to these values are considered as misbehavior (Miller & Simon, 1974).

There are different forms of families like single parent, shared custody, adoptive, blended, foster, traditional dual and others- however the structure does not have significant impact on adolescents' reproductive behavior yet parent-child relationship or bond is highly crucial for better emotional development, better school performance and engagement in fewer high-risk activities such as drug use (American Psychological Association, 2002). Developing close parent-child relationship is highly beneficial and has great contribution in many aspects and also serves as a way of transmitting education or experiences from generation to generation. The same is true for the transfer of reproductive health information. However, in the Ethiopian context, this theory might not work since reproductive health issues are not discussed openly and is considered as a taboo.

Based on the study made on Merkato and Kazanchis slum areas of Addis Ababa, out of 1076 interviewed adolescents, it was found out that, only some live with both of their parents (35 percent of boys and 24 percent of girls). In other words, adolescents in these slum areas live with either only one of their parents or they are orphans or fostered (Erulkar, Tekle-Ab⁸, Negussie⁹ & Tsehai¹⁰, 2004). This implies that either due to the absence of parents or due to the traditional value which considers the issue of sexuality as a secret matter; adolescents of slum areas might have minimal access to parental guidance regarding issues like reproductive health.

^{8&9} & ¹⁰ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

Living arrangement is also a factor, which goes in close association with the family structure. Housing problem is a big issue in slum areas hence squatter settlements and overcrowding is common. As it has been indicated and is the reality in the slum areas of most developing countries, having one room to share with the whole family is a common phenomenon. According to the 1994 census, the average household size of the city is about 5.2 persons per household and the poor, who constitute probably not less than 60% of the city's population, tend to have larger families sharing a room (Census1994). However, this situation does not allow privacy for sexual intercourse with in the households, which indirectly motivates adolescents to be in sexual relationships in an early age. These sexual practices of adolescents together with their low level of condom use create a great risk against their health condition (Zulu et al, 2002).

High youth population is exhibited in Addis Ababa since the city serves as a center of almost all socio-economic activities such as education and employment, which can attract the youth from all around the country. As it had been stated in the CCA (1999), 33% of the Addis Ababa population belongs to the child population (0-14) whereas 27 % is the youth population (15-24) (Common Country Assessment, 1999). Since slum areas are well known for providing low cost and affordable housing, which allows migrants to keep their savings, most people who migrate to urban areas settle in slum areas (UN-HABITAT, 2003).

The survey report of MOLSA (1991), which was based on Adolescents' of Urban Ethiopia, stated that; out of 4216 adolescents interviewed 39% have migrated to urban areas due to various reasons like family transfer, schooling and employment (MOLSA,1991). Migrant youth settle in the slum of Addis Ababa since they get services like shelter, schooling

and other necessities in low cost. As the majority of urban dwellers are engaged in informal sectors like petty trading, daily labor and earn irregular income, they have a wide opportunity of participating in such labor market, which indulges them to be involved in risky behaviors.

Other than looking for job or formal education in the city, adolescents are forced to migrate to urban areas in order to run away from harmful traditional practices as well as poverty. The study, made on slums of Addis Ababa - namely Merkato and Kazanchis, states that adolescent girls migrate to urban areas in order to escape from forced early marriage. Hence migrated girls were more likely to live without their parents and were considerably poorer than others and are not likely to have family support even in their places of origin. Therefore, they engage in low paid exploitive jobs, especially domestic work that makes them vulnerable to different kinds of abuse and use sex as an exchange for money or gifts (Erulkar et al 2004).

By late adolescence, school attendance has dropped for both boys and girls. Hence, a considerable proportion of young people are neither in school nor in working (ibid). This contributes to youth unemployment, which indirectly plays a role in aggravating the risky reproductive health behavior. In line with this, adolescents resort to deviant behaviors such as prostitution, theft and other criminal acts. This affects the economy of a nation in two aspects. One, it curtails efforts made towards human resource development and it lays high social cost on hardly existent health and other social services (Yordanos, 2000). On the other hand, adolescents in slum areas attempt to dropout of school since the schools are overcrowded and there is poor supervision from teachers as well as parents.

Adolescents' reproductive behavior and their risk for HIV/AIDS are affected by education, family and culture. Girls who are educated or those who go to school have less probability of being infected with HIV and are more likely to be concerned with their career. Therefore, they delay their marriage, child bearing and have well planned family size (FHI, Youth Net Program; 2002). Zubeida (1992) has also found out that educational level of adolescents' have a positive impact on their sexual behavior namely contraceptive use (Zubeida¹¹, 1992).

According to FHI (2002), norms with defined rules of behavior in a given social context play crucial role in shaping the reproductive behavior of adolescents. However, there are norms having negative impact on reproductive health behaviors; such norms include gender discrimination, having low regard to education, stigma towards using condom, having culturally restricted early age for marriage and others (FHI, Youth Net Program; 2002).

The notion of a “youth culture” is the other value, which has control over the sexual behavior of adolescents. The popular and most important institution for adolescents is the peer group. Adolescents live simultaneously in two cultures one dominated by the values of parents, the other, perhaps in opposition to the first, dictated by peers. Even though, the peer culture does not completely replace the value and totally affect parent-adolescent relationship, it replaces specific elements of parents' value system with that of peers', which could result in conflict between the two parties. Sexual behavior is among the values replaced by peers'

¹¹ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

alternative values (Miller et al, 1974). Adolescents are easily influenced by their peers since they want to get recognition hence they tend to engage in sexual behavior.

The social attitude towards masculinity also affects the behavior of adolescents' reproductive behavior. In many countries, girls are expected to stay virgin until they get married whereas practicing pre-marital sexual intercourse is acceptable manner among young boys. Seleshi (2005) has also described this situation as the notion of '*dual social norm*' (Seleshi, 2005). Hence, girls are encouraged to get married at an early age than boys. These conditions make both boy and girl adolescents to be in a risky situation which makes them vulnerable to reproductive health problems and can be a threat for their healthy development (FHI, Youth Net Program; 2002). This is because; girls might be faced with early pregnancy regardless of other hazards, which put their health at risk, whereas boys might be faced with Sexually Transmitted Diseases (STDs) including HIV/AIDS.

All in all, according to different literature, the reproductive behavior of adolescents which is depicted by the use of contraceptive, number of sexual partners and age at first sexual intercourse could be determined by non reproductive behaviors or environmental factors.

2.1.4 Adolescents' Reproductive Health Problems

Adolescence is the period of physical change in which youth develop and become aware of their sexuality. They also involve in a risky behaviors, which could affect their future endeavor. Being in the age of risk taking, adolescents would like to explore everything; out of

which sexual activity is one of them. As to different literatures, adolescents' lack of information about reproductive health issues and having risky sexual behavior are the major causes for the occurrence of reproductive health problems.

Seleshi's study has confirmed that, regardless of the high knowledge of risks, adolescents practice risky sexual behavior. Especially, young men are highly involved in risk taking since they want to confirm to the societal expectation of male dominance, early sexual experience and having more than one partner (Seleshi, 2005). Zulu et al (2002), has also found that, even though urban residents are aware of the means through which HIV is transmitted, women in slum areas do not site abstinence and practice the use of condom as a prevention of HIV infection. According to the comparison made between women living in slum and non-slum areas, condom use among women who are slum dwellers is lower than that of non-slum residents (Zulu et al, 2002).

FHI, Youth Net Program (2002) has also pointed out that the majority of adolescents fail to use contraceptives and even those who do use do not regularly utilize for various reasons. Condom being one of the contraceptives which is highly used by adolescents, it is considered as a sign of mistrust between couples which results in the reduction of intimacy and sexual bliss (FHI, Youth Net Program; 2002). Non-use of condom, having multiple sexual partners and visiting commercial sex workers are some of the risky sexual behaviors, which can result in reproductive health problems.

In Ethiopia, reproductive health problems are highly interconnected. Out of the total birth in the country, about 45% belong to girls and young women implying that early age sexual intercourse and low use of contraceptives results in pregnancy. Hence, this situation leads to high rate of abortion, Sexually Transmitted Diseases (STDs) and HIV/AIDS. In relation with this, girls could also be victims of sexual violence, commercial sex work that all have a great probability of acquiring HIV/AIDS (Govindasamy et al, 2002).

Based on the study made on sex workers in Addis Ababa, it was found out that; most young girls who work in 'red light houses'¹² are brought to Addis Ababa from the rural areas in order to assist with housework and cleaning, and to serve clients. However, through time, the girls were encouraged to become involved in commercial sex in which the income is shared with the house owners. According to this study, commercial sex workers are settled in establishments located mostly in slum areas of Addis Ababa. The establishments could be hotels, bars, motels, red-light houses, *tella bets*¹³ etc.) (FHI – Ethiopia & AACAHB, 2002). These situations aggravate adolescents' involvement in risky behaviors like taking alcohol, drug and involve in unprotected sexual intercourse, which could result in reproductive health problems.

Similarly, Unemployment or low paid jobs are the elements, which could also force women and girls to be active in multiple sexual relationships and prostitution, which could result in reproductive health problems like unwanted pregnancy, STDs and HIV/AIDS. A

¹² Usually, a single room for residence and for commercial sex. Sometimes two sex workers share a room.

¹³ A house where local beer (*tella*) is served. Some but not all *tella* sellers are sex workers.

study made on the sexual risk taking of slum residents has found out that in the slums of Nairobi, men exploit women sexually for payment, which is very little as 15 cents (Zulu et al, 2002). Hence, this implies that in slum areas, poverty has become one of the factors, which drive women or young girls to engage in sexual intercourse.

On the other hand, the finding of the study made on adolescents residing in slums of Addis Ababa stated that; among the 91 sexually active adolescents, one quarter of girls and 18 percent of boys were coerced into their first sex; and a considerable number of both boys and girls have had sex with a much older partner. It was also found out that 65 and 54 percent of the sexually experienced boys and girls used condom respectively. However, the condom use is not consistent and the sexual experience of young people is often not within their control, many were not able to refuse sex or not able to use condom when they want to (Erulkar et al, 2004).

Erulkar's (1998) study on '*The Experience of Sexual Coercion among Young People in Kenya*'; emphasized that most literatures assume that adolescents' engagement in sexual intercourse is mostly done on agreement between sexual partners, however this is not the case. Hence, either in slum areas or other places adolescents might be faced with coercion. Moreover, the study emphasized that, most perpetrators are those people who have intimate relationship with the victim. This study has also identified association between coercion with having had a reproductive tract infection (Erulkar, 1998). The same condition could also be seen in slum areas since it is highly swamped with criminal acts and insecurity out of which the act of coercion could be one.

Unintended pregnancy and childbearing, abortion, sexually transmitted disease (STDs) and HIV are among the major reproductive problems faced by adolescents.

2.1.4.1 Unintended Pregnancy

Due to various reasons adolescent girls involve in unsafe sexual practices and fail to use contraceptives, which lead them to end up being pregnant which could have serious health risks for both the mother and the child. Unintended pregnancy could be followed by illegal abortions for reasons like social, economic and legal situations. As early pregnancy could bring a health problem to the mother as well as the baby; it could also lead to school dropout and enhance the level of poverty (FHI, Youth Net Program; 2002). This situation could be more severe in the case of slum areas where there is lack of health services together with poor prenatal and postnatal care for the mother and the child as well (Assefa¹⁴ & Dilnesaw¹⁵(1996), in Habtamu¹⁶ 1996).

According to a report on the effects of contraception on obstetric outcomes, unintended pregnancy could be characterized by poor or late antenatal care, difficulties during delivery, problem in immunization of the child and low birth weight and poor child growth (Marston and Cleland, 2004). All of the listed situations become more severe when the mother is in the stage of adolescence. This is because during adolescent stage the pelvis or bony birth canal of

¹⁴, ¹⁵ & ¹⁶ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

a girl has not yet developed completely. Hence, this makes the labor more difficult, which could endanger the lives of both the mother and the child.

A one-year retrospective analysis of 504 adolescent patients who visited St. Paul Hospital for any kind of treatment had shown that high female death had occurred than that of male which is 57% and 43% respectively. Pregnancy related problems like abortion and uterus rupture are identified as the main causes for the death of female adolescents (Assefa & Dilnesaw (1996), in Habtamu 1996). This is because, adolescent girls have not yet become adult; they find it difficult to provide motherly care for their newborn which could result in poor child growth. Here adolescents could be faced with role confusion which is composed of; a role of a mother and adolescent.

Teenage pregnancy has negative impact on the advancement of self as well as the larger community. At an individual level, it can have a draw back effect on the physical, emotional and psychological status. The social impact is on the rate of fertility and maternal mortality of a given community or society (ibid). Hence, this indicates that unintended pregnancy and early child bearing of adolescents residing in the slums might have a negative impact on self, family and the community. Hence, this will further degrade the situations in slum areas.

UNFPA (2003) had also listed the contributing factors for early pregnancy and child bearing and its consequences for self as well as the community or society. Among the listed contributing factors; early marriage, sexual violence, poverty, gender discrimination, lack of information, inability to negotiate contraceptive use and lack of reproductive rights are some

of them. The consequences for self are risks of complications from pregnancy (such as obstructed labor, obstetric fistulas, anaemia/haemorrhage, death), school dropout, unsafe abortion, diminished employment and income earning options which leads to poverty, unbearable responsibilities of child raising, and psychological development and potential for self- development will also be curtailed (UNFPA, 2003).

Lastly but not least, the consequences upon the community include higher health care and social welfare costs, abandonment of newborn and increase in poverty level (ibid). From this; one can conclude that, unintended pregnancy and child bearing has multifaceted and highly interrelated causing factors and consequences towards individual as well as the community's advancement.

2.1.4.2 Abortion

The other reproductive health problem that follows from unintended or unwanted pregnancy is abortion, which is characterized by illegal act and high risk resulting in illness, disability and death. Abortion is the process by which the products of conception are expelled from the uterus via the birth canal before the 28th week of gestation. Abortion can be classified in to spontaneous and induced abortion.

In Ethiopia, abortion is an illegal act. Because of this reason, many girls commit the act in an unsafe condition and a non-professional manner, which makes them vulnerable to a number of problems. The actual data on the prevalence of illegal abortion is difficult to collect since it is carried out secretly. According to the findings of six months study based on 5

hospitals in Addis Ababa, there were a total of 1,603 induced abortion cases, of which 15 percent occurred among women under the age of 15; 31 percent occurred among women age 16-20; and 62 percent occurred among women 16-25. Forty-five percent of the abortions were among single women, and 42 percent were among women with only a primary school education or less (Yoseph¹⁷, 1993 as cited in Govindasamy et al, 2002). This data indicates that abortion act is at an alarming position and points out the high occurrence of unwanted pregnancy and early sexual engagement of Addis Ababa girls.

Some of the major reasons for the occurrence of abortion are; lack of appropriate information on sex and reproductive health, victims' lack of access to adequate financial and other supports and communities' disregard of effective use of available family planning services to prevent and control abortion. The majority of teenage pregnancies are unplanned, unwanted, and come as a complete shock. Hence, many teenagers attempt to terminate their pregnancy. However, they usually lack the finances and the information to get a safe abortion; which makes them resort to illegal, unskilled abortionists who operate with dirty instruments in unclean surroundings. The results of unsafe abortions can be tragic; it can include infection, injury to the reproductive organs, or even death. Other common consequences are pelvic inflammatory disease (PID) and infertility (MOH, 2003). Since the majority of slum adolescents are characterized as poor, they have a chance of practicing induced abortion.

The study conducted by MOLSA (1991) had pointed out some of the major reasons for abortion which are pre-marital pregnancy, unwillingness of partner and rape pregnancy and

¹⁷ In accordance with Ethiopian custom, the first name or given name is substituted for the surname and the father's name.

health problem (MOLSA,1991). Among the listed reasons most of them indicate that the existence of power imbalance between adolescent male and female and uneven responsibility sharing of the consequence of sexual behavior. It also shows the danger facing adolescent girls who are the bearers of the consequences of abortion.

2.1.4.3 Sexually Transmitted Diseases/STDs/HIV/AIDS

Sexually transmitted diseases (STDs) like other reproductive health problems emanates from improper use of contraceptives or non- use of contraceptives. The consequence of STDs can be infections, which could end up in the infertility of the victim. It could also create complication if pregnancy occurs and stimulate HIV infection (Temin, Okonofua, Omorodion, Renne, Coplan, et al, 1999).

Based on a comparative study conducted on young women residing in the slum and non-slum areas of Kenya, Nairobi; it was found out that those slum resident women who are in the age range of 15-24 practice high risk sexual behavior. Among the risky behavior; early age sexual intercourse and having multiple sexual partners are the major ones. However, the finding of the same study indicated that regardless of the residential area women have the knowledge about HIV and prevention methods (Hollander, 2003). Even though, this finding opposes the point, which states having no-access to information indulges slum dwellers to practice risky sexual behavior; it highlights the existence of another push factors, which are responsible to their sexual behavior. Hence, in the case of slum dweller, regardless to their knowledge poor women or girls might be engaged in risky sexual behavior because most of them use multi sexual practice as a means of income.

On the other hand, Zulu et al (2002) argues that young girls might be less likely to know how to avoid STIs than are their older counterparts. Young girls in relationships are also more likely to be sexually disadvantaged, if not exploited, because of their greater economic dependence and youthfulness in a society where the young are expected to show respect to their elders (Zulu et al, 2002). This implies that poor girls in slum areas are obliged to engage in sexual relationships with older men either due to fear and respect or as a means of income.

UNFPA (2003) has identified the major contributing factors and consequences of Sexually Transmitted Diseases and HIV/AIDS on either individual level and societal or community level. The suggested contributing factors include; lack of information on safer sex, gender discrimination (lack of decision making power) , lack of access to methods of protection , sexual abuse, violence and exploitation, poverty (leads to transactional or intergenerational sex) and multiple sexual partners. The consequence of STDs including HIV/AIDS; on self is the occurrence of pre-mature death, discrimination, infertility, increased poverty and its impact on the community or societal level could be; low productivity and economic development etc.(UNFPA, 2003). Having this fact in mind, the Ethiopian Ministry of Health (2004) reported that, HIV prevalence among urban youth (15-24) attended antenatal care is 11.9% (MOH, 2004). Even though, this figure shows only those girls who have ante natal care one can imagine the infection probability of their male partners and also those who have unintended pregnancy who do not have ante natal care and are not included in the figure. Hence, all these assumptions can increase the figure indicating high prevalence rate.

All in all, the three most commonly cited reproductive health (RH) problems by urban slum residents are unwanted pregnancies, abortion and HIV and AIDS. The health situation is worsened by inadequate healthcare services, characterized by lack of supplies and poor quality of services. HIV and AIDS continue to be a major problem in urban areas.

3 CHAPTER THREE

Findings and Discussion

Respondents' Background Information

A total of 186 adolescent boys and girls who are residents of Tekelehaimanot area and are in the age range of 15 to 19 were interviewed. The instrument had different sections which questioned about respondents' socio demographic background, their attitude towards reproductive health issues, availability of reproductive health services, about risky behavior and reproductive health problems.

Accordingly, out of the total respondents; 54.8% are females and 45.2 % are males. The majority (65.6%) of the respondents are Christians, while the rest 34.4% of them are Muslim. The respondents are also composed of diversified ethnic groups dominated by Amhara (32.8%) ethnic group and the least goes to the Tigre (10.2%) ethnic group.

Slum areas are well known for poor housing conditions and unstructured settlement patterns. Hence, about 48.9% and 40.9% of the total respondents indicated that they live in houses having two and one room/s respectively. Accordingly, the mean family size is calculated to be five. Regarding the physical facilities of the houses, about 55.7% of adolescents indicated that their house does not have easy access to water tap, 28.5% do not have electric power and 75.3% do not have their own compound.

The respondents were asked about their level of education and educational attendance status. Hence, the majority (62.2%), out of which 35.7% male and 64.3% female are in the elementary educational level (1-8 grades) and the rest (27.6%) (60.8% male, 39.2% female)

are high school students (9-10 grade), 7 % (53.8. % male, 46.2% female) are at the level of 10+1-10+2 and 2.7% (all male) of them were above 10+2. The data shows that high proportion of female adolescents is in the elementary educational level whereas high proportion of male adolescents is at high school level and above.

Out of the interviewed adolescents, 48.9% (38.5 % male and 61.5% female) stated that they are currently attending school whereas 46.2 % (51.2% male and 48.8% female) have dropped out of school. Among those who dropped out of school, 37.8%, i.e 48.4% male and 51.6% female, claimed that they dropped out of school due to family problem and others (24.4%) (70% male and 30% female) indicated that economic problem made them quit school and 17.1% of which 42.9% male and 57.1% female mentioned lack of interest, 8.5% (14.3% male and 85.7% female) and 12.2% (30% male and 70 % female) stated reproductive health problem and problem at school, respectively. From this, one can understand that female adolescents are more affected by reproductive health problem rather than male.

Among the various determining factors of reproductive behavior of adolescents, marital status defines the expected reproductive behavior in a given social context. Accordingly, the great majority (94.1%) of respondents, out of which 46.3% male and 53.7% female are single. Among these single adolescents, 52.2% live with both parents and 24.2% live with single parent, mostly with their mother. There are also who reported that, they live with relatives (6.5%), siblings (9.1%) and alone (8%). Moreover, the majority (77.7%) of the sample population were born and raised around Teklehaimanot area, others (8.7%) came from other areas, and stayed there for over six years, whereas, the rest (13.6%) have lived in the

area for not more than six years. Out of those who came to the study area, 45.2% stated that they used to live in the rural areas, 14.3% were in other towns and the rest (40.5%) used to reside in other parts of Addis Ababa. This data contradicts the literature, which states that the majority of youth adolescents are rural- urban migrants.

Parents' educational background has an impact on the upbringing of their children. Among the respondents' parents or guardians, the majority are categorized at low educational level out of which 57% and 32.2% of mothers and fathers are found to be illiterate, respectively. Relatively speaking, fathers' educational level is better than that of mothers. Only 5.5 % of parents, out of which the majority are fathers, have completed high school. Moreover, it has been reported that there are 44.9 % and 30.2 % of fathers and mothers respectively with educational level of elementary and secondary level.

Table 1: Type of Current Occupation of Parents/Guardians

Type of Current Occupation	Frequency	Percent	Valid Percent	Cumulative Percent
Daily Labor	27	14.5	20.1	20.1
Petty Trading	44	23.7	32.8	53.0
Civil servant	14	7.5	10.4	63.4
Other	49	26.3	36.6	100.0
Total	134	72.0	100.0	
Not Applicable	50	26.9		
99 (Missing)	2	1.1		
Total	52	28.0		
	186	100.0		

As to Turkstra et al (2004) put it, cities do not offer sufficient employment opportunities for their rapidly increasing population hence as a result, many cities are characterized by high incidence of informal employment opportunities, which are unstable and yield only low income (Turkstra et al,2004). Similarly, adolescent parents in this study are highly engaged in informal sector, which do not require high level of skills. About 52.9% are engaged in daily labor and petty trading both characterized by irregular and insufficient income to support their family. As the data shows only 10.4% are employed in the formal setting and the rest, (36%) are engaged in other activities like working as a guard and other stuffs. This situation prohibits them from being employed or getting fair amount of money in order to support their family. Therefore, it results in economic problem as well as family problem; forcing adolescents to dropout of school and engage in income generating activities which are more likely to be in the informal sector and also an immediate solution for the existing problem (Table 1) .

Adolescents' Attitude towards Reproductive Issues

In this section, an attempt had been made to assess adolescents' attitude towards reproductive health and related issues. For this purpose, Likert scale was applied together with six statements. Hence, respondents had reflected their attitude towards different reproductive health issues like; pre-marital sex, reproductive right, abortion, responsibility sharing between male and female partners and risky behavior. Consequently, one can understand the position of adolescents towards reproductive health issues and identify environmental factors, which contribute for the development of such attitude.

Table 2: Attitude towards pre-marital sex

	Sex of respondents			
	Male		Female	
	Frequency	Percent	Frequency	Percent
Strongly agree	9	10.7%	13	12.7%
Agree	4	4.8%	3	2.9%
Can't decide	2	2.4%	5	4.9%
Disagree	32	38.1%	45	44.1%
Strongly disagree	37	44.0%	36	35.3%
Total	84	100.0%	102	100.0%

Respondents were asked to determine their attitude towards practicing sex before marriage. As it is shown in the table, the majority of both male (82.1%) and female (79.4%), respondents, reflected their opposing stand towards practicing premarital sex. Even though, a great proportion of respondents claimed that they disapprove premarital sex, yet the reality on the ground is completely different. According to the literature, this might be due to reasons like environmental factors like peer pressure, poverty, their stage of development, lack of parental supervision and so on (Table 2).

Table 3: Ever Had Sex Vs Sex of respondents

Ever Had Sex	Sex of respondents		Total
	Male	Female	
Yes	54(51.4%)	51(48.6%)	105(100.0%)
No	6(35.3%)	11(64.7%)	17(100.0%)
Total	60(49.2%)	62(50.8%)	122(100.0%)

As to the marital status of the sample population; the majority (94.1%) of the total population or 175 adolescents are single, among this group of people 46.3% are male and

53.7% are female. Moreover, among the single respondents, 122 (69.7%) adolescents, out of which 50.8% females, 49.2% males, indicated that they had partners at the time of interview. As indicated in Table 3, 105 (51.4% males and 48.6% females) adolescents had had sexual intercourse. Therefore, this data shows that; the majority of the sample population is single; however, high proportion is engaged in practicing pre-marital sex. Hence, this implies that; adolescents are aware of the societal value, which condemns premarital sex; yet, they face difficulty in putting it to practice (Table 3).

On the other hand, an attempt had been made to find out adolescents' attitude towards the right of equal participation of both sexual partners on reproductive health decisions, which is mostly concerned with issues like when to have sex, what method of contraceptive should be used and others. Accordingly, 76.2% male and 87.3% female adolescents indicated their positive attitude towards the issue. In relation with this, adolescents who have/had sexual partner were also asked if they ever had discussion on reproductive health issues with their partners, and 38.2% of them stated that they had had discussion and 59.2% of the discussion was initiated by male partners whereas 40.8% were initiated by females. This shows that, females are reluctant to open discussion about sexual matters. This could be due to the culture, which does not allow girls to speak up about any issues especially reproductive issues. Moreover, adolescents were asked to reflect their attitude towards the responsibility sharing of partners in avoiding unintended pregnancy. Hence, 35.3% of the total respondents believed that only females are responsible in preventing unwanted pregnancy, among this group of respondents 14.3% are male and 53% are female, whereas, 60% of the total population (78.6% of male and 38% of female) stated that both partners have the

responsibility of avoiding unwanted pregnancy. This data shows that adolescent girls are less aware of the fact that there should be equal responsibility sharing among sexual partners.

A statement had been also used to assess adolescents' attitude towards their right to use reproductive health services. Accordingly, table 4 shows the majority (86%) of the respondents agreed upon the idea of adolescents' right to use available reproductive health services, out of which 80.9% are male adolescents and 90.2% are female adolescents. This might be used as an indicator of adolescents' need to reproductive health services and can also be used as an indirect proof for adolescents' understanding and perception of their vulnerability to reproductive health problems (Table 4).

Table 4: Attitude towards adolescents' right to use available reproductive health services

	Sex of respondents			
	Male		Female	
	Frequency	Percent	Frequency	Percent
Strongly agree	31	36.9%	63	61.8%
Agree	37	44.0%	29	28.4%
Can't decide	2	2.4%	1	1.0%
Disagree	4	4.8%	1	1.0%
Strongly disagree	10	11.9%	8	7.8%
Total	84	100.0%	102	100.0%

On the other hand, adolescents' view towards risky behavior of having multiple sexual partners had also been assessed and 87.1% of the respondents (86.8% male and 90.6% female) disapproved such behavior. However, in order to determine the risky sexual behavior of

respondents; a question had also been asked about the number of their sexual partners. In response to this question, out of those who are sexually active, 54.9% (66.7% of male and 33.3% of females) of them indicated that they had more than one sexual partner at the time of the interview. This shows that male adolescents are highly inclined to have multiple sexual partners, which emanates from the social value that attaches such behavior with masculinity. Moreover, this indicates high-risk level of being affected with reproductive health problems like sexually transmitted diseases (STDs) including HIV/AIDS.

Respondents were also asked to indicate factors, which might be responsible for molding their attitude and behavior since environmental factors can play a vital role in determining the sexual or any other behavior of individuals.

Table 5: Causes for Developing Attitude towards Reproductive Health Issues

Factors	Frequency	Percent	Cumulative Percent
Religion	36	19.4	19.4
Culture	12	6.5	25.8
Family Influence	20	10.8	36.6
Peer Pressure	30	16.1	52.7
Access to Sex Education	37	19.9	72.6
Other	51	27.4	100.0
Total	186	100.0	

Accordingly, adolescents mentioned different factors like religion (19.4%), culture(6.5%),family influence (10.8%), peer pressure (16.1%) and access to sex education (19.9%) as contributing factors for the development of their attitude. Under ‘other’ factors,

27.8% of the respondents stated that they developed negative attitude towards practicing premarital sex based on the negative consequences they observed on adolescent victims of reproductive health problems (like unintended pregnancy) (Table 5).

Sources of Reproductive Health Information

Having access to reproductive health information is a decisive factor in determining the reproductive behavior of adolescents. Hence, adolescents of the sample population were asked to indicate their source of reproductive health information. Accordingly, the majority 58.6% of the respondents indicated that they use mass media (radio and television) as their major source of reproductive health information, out of this group of respondents 53.2% are males and 46.8% are females. About 18.8% (31.4% males and 68.6% females) of adolescents reported that they got information from reproductive health service, whereas, the rest 8.1% got from family that is 40% of males and 60% of females, 5.9% from peers and among this group 54.5% are males and 45.5% are females and school (4.3%) (12.5% of males and 87.5% of females) and others (4.3%) (25 %of males and 75% of females) indicated that they do not have any access to information.

Adolescents were also asked about the availability of reproductive health services in their neighborhood. Even though, all adolescents belong to the same neighborhood all of them do not have similar information about the availability of reproductive health services; hence, among the total population only 34.9 % stated that the service is available in their area. Out of these adolescents, 70.1% indicated that the service is provided by health center, whereas, the rest 29.9% pointed out that the service is provided by non-governmental organizations, private

sectors and other bodies. As the figure, implies adolescents in slum areas are deprived of social services like reproductive health services. For this reason, most adolescents do not have easy access to reproductive health information; therefore, one of their possible options could be using parents as an ideal source of information. However, in most Ethiopian families, having open discussion on reproductive health issues is regarded as a taboo. Hence, this condition makes it difficult for adolescents to get information.

On the other hand, it has been found that the type of contraceptive method used by adolescents is related with the availability of reproductive health service. For that reason,; those adolescents who do not have easy access to reproductive health services use condom, whereas, those who have access to services use contraceptives like injections, pills and others. This is due to high accessibility of condom, while, other contraceptives stated above are available only at pharmacies or health centers. In general, a relationship between availability of reproductive health service and type of contraceptive used by adolescents does exist (Table 6).

Table 6: Type of Contraceptive Used Vs Availability of Reproductive Health Service

Type of Contraceptive	Availability of Reproductive Health Service		Total
	Yes	No	
Condom	21(45.7%)	51(71.8%)	72(61.5%)
Pills	4(8.7%)	6(8.5%)	10(8.5%)
Abstinence	4(8.7%)	8(11.3%)	12(10.3%)
Injection	13(28.3%)	2(2.8%)	15(12.8%)
Calendar method	4(8.7%)	4(5.6%)	8(6.8%)
Total	46(100.0%)	71(100.0%)	117(100.0%)

Significance= $p < .05$

Slum Adolescents and Reproductive Behavior

In Teklehaimanot area, the majority of the population lives in a destitute living condition. Hence, adolescents who are born and raised in this particular slum area have internalized the misery and discomfort of the living condition. Almost all adolescents live in houses, which do not have the necessary facilities like water, electricity and latrine. Along with this, the whole family shares one or two room/s which inhibits the right of having privacy also challenges the human right of having access to basic necessities including healthy living condition.

As it is indicated above, most of the respondents are living in a house, which has single, or two rooms. According to Zulu, sharing one room for the whole family contributes to early sexual engagement of adolescents since parents might be unable to have the privacy to make sexual intercourse (Zulu et al, 2002). However, the finding of this study states that there is no association between sexual engagement of adolescents with that of their living arrangement or sharing a room with their parents ($p>.05$).

Out of the total respondents, 56.5% of adolescents practiced sexual intercourse, among the total male and female population 64.3% and 50%, respectively, are sexually active. Among the sexually active adolescents, 60.6% of them stated that they began sex while they were in the age range of 14-16. The mean age for sexual debut has been found to be 16 and 15 for male and female adolescents respectively. From the sexually active boys and girls; 50% (71.7% boys and 28.3% girls) have partners who are in the age range of 15-19 and 41.5% out (22.7% and 77.3% boys and girls, respectively) have partners in the age range of 20-24.

Unlike most literature which say that slum adolescents have much older partners, this study has found that , in Tekelehaimanot area adolescents are involved more with partners who are in similar age range or a little older. In other words, there exists relationship between age of partner with that of sex of adolescents ($p < .05$).

Out of the various factors motivating initial sexual intercourse, the majority of adolescents reported that their eagerness and excitement played a major role in their sexual engagement. Accordingly, 62.9% of the sexually active adolescents (50% male and 50% female) declared that they did it willingly and due to the request of their partners whereas 30.5% out of which 62.5% male and 37.5% female said due to peer pressure. Moreover, others identified lack of income (3.8%) (50% of males and 50% of females) and coercion (2.9%) (all females). On the other hand, out of the sexually active adolescents; 59.8% use condom as contraceptive method whereas others use injections, pills, calendar and other means (Table 7).

Table 7: Causes for Sex at First Intercourse

	Frequency	Percent	Valid Percent	Cumulative Percent
Peer pressure	32	17.2	30.5	30.5
Lack of income	4	2.2	3.8	34.3
Coercion	3	1.6	2.9	37.1
Specify	66	35.5	62.9	100.0
Total	105	56.5	100.0	

Adolescents' early engagement in sexual intercourse can be influenced by their socialization. One of the institutions responsible for the socialization of adolescents is the school. It may serve as a source of information, which is useful for the healthy development of adolescents. However, as this study found out, high proportion of adolescents of both sex

dropout of school due to reasons like family problem and economic problem. In addition, most of those parents are found to be illiterate and/or in lower educational levels. Besides, they are engaged in informal sector activities, which cannot provide reasonable income to run their family. Therefore, those dropout adolescents are not in a position to have access to information and are denied from having proper socialization since they lack the schooling system.

Accordingly, based on the cross- tabulation made between variables of having means of income and school attendance status; it was found that adolescents who dropped out of school are more likely to be engaged in income generating activities. As the table shows 65.1% of those who dropped out of school are engaged in income generating activities (Table 8).

Table 8: School Attendance Status Vs Earning an Income

School Attendance Status	Do you earn an income?		Total
	Yes	No	
Currently Attending	34 (37.4%)	57 (62.6%)	91 (100.0%)
School dropout	56 (65.1%)	30 (34.9%)	86 (100.0%)
Did not succeeded in 10 grade National Exam	4 (44.4%)	5 (55.6%)	9 (100.0%)
Total	94 (50.5%)	92 (49.5%)	186 (100.0%)

Significance = $p < .05$

On the other hand, the cross- tabulation of adolescents' school attendance status with that of ever having sexual intercourse; shows the existence of association between the two variables. As it is clearly shown on the table, the number of adolescents who were sexually active and attending school at the time of the interview is much less than that of those

adolescents who dropped out of school and were sexually active. On the other hand, those who are not sexually active and are dropouts are much less (Table 9).

Table 9: Ever Have Sex Vs School Attendance Status

		School Attendance Status			Total
		Currently attending	School Dropout	Did not succeeded in 10 grade National Exam	
Ever Have Sex	Yes	28	71	6	105
	No	10	5	2	17
	Total	38	76	8	122

Significance= $p < .05$

Among the working adolescents of the sample population, about 51.6% started working while they were in the age range between 10-14. Among these adolescents, 55.3% and 44.7% are male and female, respectively. Accordingly, the majority (64.2%) (62.3% male and 37.7% female) of these adolescents are engaged in small businesses. This might be due to the location of the study area, which is near the largest market area- *Merkato*. These children are engaged in small businesses like selling chewing gum, candy, roasted beans, boiled potato and other stuffs. Moreover, 12.6% ,out of which 25% male and 75% female, are employed at individuals' home and 23.2% (50% male and 50% female) are engaged in other service providing activities like bar-tend. These working adolescents have great probability of getting in touch with people having diverse background, which might have an impact on their behavior. Among the behavior they could learn, sexual behavior is one. Besides; most adolescents engage in sexual intercourse by the year they start working. In other words, there exists an association between adolescents' age at first sexual intercourse with that of their age at first work ($p < .05$) (Table 10).

Table 10: Age at First Sexual Intercourse Vs Age at First Work

Age at First Sexual Intercourse	Age at First Work			Total
	<10 years	10-14	15-19	
10-13	2(40.0%)			2(2.9%)
14-16	3(60.0%)	29(76.3%)	9(34.6%)	41(59.4%)
17-19		9(23.7%)	17(65.4%)	26(37.7%)
Total	5(100.0%)	38(100.0%)	26(100.0%)	69(100.0%)

Significance= p<.05

In relation with this, the majority of respondents who are engaged in income generating activities have partners who are either non- employed or students (28.6% and 51.4% respectively). Among those male and female respondents who generate income 68.3% and 28.1% respectively have partners who are students. Moreover, 19.5% and 43.8% of male and female respondents have unemployed partners. Hence, this indicates that those adolescents who earn an income incline to have relationship with those adolescents who do not have any means of income. In other words, having an income is associated with partner's occupation (Table 11).

Table 11: Sex of respondents * Occupation of partner * Earning an income

Do you earn an income?	Sex of respondents	Occupation of Partner				Total
		Student	Unemployed	Self employed	Employed	
Yes	Male	28(68.3%)	8(19.5%)	4(9.8%)	1(2.4%)	41(100.0%)
	Female	9(28.1%)	14(43.8%)	6(18.8%)	3(9.4%)	32(100.0%)
	Total	37(50.7%)	22(30.1%)	10(13.7%)	4(5.5%)	73(100.0%)
No	Male	8(53.3%)	5(33.3%)	1(6.7%)	1(6.7%)	15(100.0%)
	Female	4(14.3%)	10(35.7%)	6(21.4%)	8(28.6%)	28(100.0%)
	Total	12(27.9%)	15(34.9%)	7(16.3%)	9(20.9%)	43(100.0%)

Significance= $p < .05$

Adolescents' Risky Behavior

Adolescence can be considered as a '*risky period*' since young people are eager to explore almost everything around them. Accordingly, 51.6% (53.1% male and 46.9% female) of adolescents stated that they regularly take alcohol, smoke cigarette and chew '*chat*',¹⁸. Out of these adolescents 46.9% (48.9% male and 51.1% female) drink alcoholic beverages only, 18.8% (72.2% male and 27.8% female) chew chat only, 3.1% only smoke cigarette (66.7% male and 33.3 % female) and 31.3% (67% male and 33% female) use alcohol, chat and cigarette.

Related with this; about 90% of the total population claimed that there are establishments in their neighborhood which sell homemade beverages and other alcoholic beverages and small kiosks selling '*chat*'. One of the reasons for this situation could be the

¹⁸ A plant with small green leaves which are chewed in order to have high spirit

engagement of most parents (especially mothers in slum areas) in small businesses like selling home-made alcoholic drinks such as ‘*tella*’¹⁹ and ‘*corefe*’²⁰ at their households. In addition; settlement patterns in slum areas is characterized by congested type of arrangement in which houses are built very close to one another. Similarly, according to the data, the houses in which the majority (75.3%) of respondents reside do not have their own compound hence there could be a pub or ‘*tella bet*’ right beside their home. This might lead adolescents to develop risky behavior like regular intake of alcohol.

Those adolescents who earn an income are more likely to be engaged in practicing sexual activity as well as practicing risky behaviors like chewing chat and taking alcohol. This could be due to the working environment they are engaged in (for example; selling roasted beans around ‘*tej bet*’²¹ or ‘*tella bet*’, as a cashier on taxis (‘*woyalla*’)...etc) (Table 12).

Table 12: Regularly take Alcohol * Earn an Income * Ever had Sex

Ever had Sex			Do you earn an income?		Total
			Yes	No	
Yes	Regularly take drug/alcohol	yes	58	32	90
		no	10	5	15
	Total		68	35	105
No	Regularly take drug/alcohol	yes	1	1	2
		no	5	10	15
	Total		6	11	17

Significance= p<.05

¹⁹ Home made beer

²⁰ Similar to *tella*. *Corefe* is un-distilled *tella*. It is cheap and is normally consumed by the very low-income population.

²¹ A house where home made alcoholic drink made of honey or sugar

Out of the multiple reasons for their involvement in risky behavior like drinking alcohol, chewing chat and smoking cigarette, adolescents identified factors like peer pressure(35.4%), unavailability of recreational centers(25%), unemployment (15.6%) and others (24%) stated reasons like stress (due to the devastating living conditions in slum areas). In relation with this risky behavior, among the sexually active male adolescents, 10.8% stated that they visit commercial sex workers and out of which 40% of them did not use condom during their last visit. This shows high risk of adolescents of being infected with sexually transmitted diseases including HIV/AIDS.

In order to assess adolescents' awareness of youth vulnerability; respondents were asked whether they consider youth vulnerability to reproductive health problems or not. Regardless of the facts indicated above, the majority of adolescents indicated their awareness of youth vulnerability to reproductive health problems. Accordingly, 95% (44.7% males and 55.3% females) of the sample population reported that young people are highly vulnerable to reproductive health problems. However, based on the above stated findings, one can say that the reality on the ground is directly opposite to their perception of vulnerability.

Reproductive Health Problems

Risky behaviors like having multiple sexual partners, taking alcohol and improper use or not using contraceptives, are followed by reproductive health problems such as unwanted pregnancy, sexually transmitted diseases (STDs) and others. Among the sexually active girls, 9.7% had had unintended pregnancy. Out of those adolescents who faced early pregnancy;

57.9% were obliged to face early child bearing, whereas, 42.1% had abortion due to reasons like rejection from sexual partner; did not want to give birth and other related reasons. Some male adolescents had also stated that there were times when their girlfriend got pregnant and have it aborted.

Besides, some girl respondents had also pointed out that they had had both experiences of giving birth as well as getting abortion. According to them, they faced the negative effect of abortion, which resulted in a lot of bleeding during the performance of the act and gynecological problem. Many of the respondents have also indicated that the abortion took place at health center. From the Likert scale used to determine adolescents' attitude towards abortion; it has been found that 23.1% of adolescents approved abortion as the first alternative for avoiding unintended/unwanted pregnancy. On the other hand, 67.7% (78.6% male and 58.9 % female) of the respondents disapproved the act and the rest (23.1%), out of which 14.3% male and 30.4% female, agree with the idea of abortion. In addition to this, none of the respondents had reported the occurrence of sexually transmitted diseases. This finding seems odd based on the existing reproductive behavior of adolescents however; this shows adolescents' reluctance to discuss the issue of being victimized due to their sexual behavior.

4 CHAPTER FOUR

Summary of Major Findings and Implication for Social Work

Summary of Major Findings

Adolescents can be members of different social systems like the family, peers, community, school and others. The characteristics of the community in which they live can have a fundamental impact on adolescents' socialization. Community factors includes such as the socioeconomic characteristics of one's neighborhood, the types of resources available, the service systems within the community (including schools), religious organizations, the media, and the people who live in the community. Some communities are rich in resources that provide support and opportunity for adolescents. Unfortunately, many communities, particularly in inner cities or poor areas, do not (American Psychological Association, 2002). The same truth applies to Teklehaimanot area.

Slum areas are part of a city characterized by devastating conditions such as squatter settlement, devastated housing conditions without facilities and inhabited by poor people. Unemployment, poverty and lack of services are some of the features of slum areas. Like that of other slum residents, adolescents are deprived of different services. Even tough, the stage of adolescence is a determining stage of development; young people in slum areas do not get the attention required. Cognizant of this fact, in this study, an attempt had been made to determine the contributing factors for the development of reproductive behavior (i.e, age at first sexual intercourse, number of sexual partners and condom use) of slum adolescents.

The reproductive behavior of slum adolescents is the out come of various factors, which are interrelated with one another. Hence, it has been found that the majority of adolescents have developed acceptable attitude towards issues like avoiding premarital sex, the right to use reproductive health services, having multiple sexual partners, responsibility sharing between partners and performing abortion. However, most of their practice is contrary to their attitude. Religion, sex education and life experience of others had been mentioned as contributing factors for the development of such attitude towards reproductive health issues.

It is also found that the mean family size is five and most families live in one/two room house which do not have facilities like water, electricity and pit latrine. Housing being a big problem in slum areas, a room or two is shared by the whole family. Based on this fact; literatures have pointed out that in slum areas parents (regardless of their privacy) share a room with adolescents which might have an impact on adolescents' reproductive behavior. However, this study has not found any relationship between number of rooms and sexual experience of adolescents.

School attendance status is found as one of the factors contributing to the reproductive behavior of adolescents. According to the data, 46.2% had dropped out of school due to various reasons. The identified reasons forcing adolescents to quit school begins from the individual adolescent and extend to the household level. The individual factor could be lack of interest towards education, whereas, the family factor could be having insufficient family income or having dysfunctional family. For these reasons, adolescents dropout of school and

become engaged in income generating activities. Accordingly, among the school dropouts 65.1% are engaged in income generating activities.

According to the finding of the study, those adolescents who are engaged in income generating activities are more likely to have a risky behavior of taking alcohol and drug and also become sexually active at an early age. This is might be due to the environment as well as type of work they do. It has also been found that those adolescents who are employed have partners who do not have any means of income.

Among the total respondents, 56.5% reported that they have sexual experience and the mean age at first sexual intercourse has been calculated to be 15 and 16 for male and females, respectively. Some of the causes for their sexual intercourse were reported as peer pressure, self-belief, and pressure from partner and others. The majority of respondents have also indicated that they had more than one sexual partner at the time of interview. Moreover, high proportion of the respondents indicated that their partner belong to the same age group or a little older.

Among the sexually active adolescents, the majority (59.8%) use condom as a means of contraceptive. It has also been found that, even though all adolescents belong to the same area, not all of them have information about the availability of reproductive health service. Hence, the type of contraceptive used depends on the availability of reproductive health service. Accordingly, it was found that those adolescents who do not have easy access to reproductive health services use condom; whereas those who claimed they use injections and

other medically recommended contraceptives are those who have easy access to reproductive health services.

Regarding the reproductive health problem, only 9.7% girls reported that they had had unintended pregnancy and 57.9% of them gave birth and 42.1% had had abortion. On the other hand, some male respondents had also stated that their girl friends had been pregnant. In addition, some girl respondents pointed out that they had had both experiences of giving birth as well as getting abortion. Surprisingly, there is no respondent has reported having sexually transmitted diseases (STDs).

Thus, a well-integrated social work intervention is highly crucial to prevent reproductive health problem as well as rehabilitate those affected by the problem. For this purpose, a special program or intervention should be designed to address the need of slum adolescents.

Implication for Social Work

Slum areas are part of the city deprived of resources, which inhibits the proper/healthy development of adolescents. It is part of urban areas in which a cocktail of social problems; such as unemployment, housing problem, lack of social services and violation of human right exist. Adolescence is a period that young people face new experiences, new ideas and opportunities yet this stage of development can also be full of vulnerabilities to biological and socio-cultural problems, which would further be complicated by the realities of the socio economic situation of the environment. Moreover, social, economic and political forces are rapidly changing the ways that young people must prepare for adult life. These changes have

enormous implications for adolescents' education, employment, marriage, childbearing and health. Neglect of this population, as it is highly observed in slum areas, has major implications for the future, since reproductive and sexual behaviors during adolescence have far-reaching consequences for people's lives as they develop into adulthood.

Therefore, adolescents in slum areas are burdened with double-barreled problem. Hence, slum adolescents need to be guided and helped through the process of their identity formation as well as their decision-making process. Adolescence being the stage of development in which secondary sexual characteristics and sexual behavior develop there should be an interrelated effort to ensure the healthy development of reproductive behavior.

As to the International Federation of Social Workers (IFSW), social work is defined as a profession which works towards the well being of a society working through individuals, groups, or communities to improve their capacity by focusing on the interaction between people and the environment (IFSW, 2000). Therefore, social work has a wide range of client system, which works to alleviate the problem of different groups by intervening at several levels in order to mitigate reproductive health problems of adolescents. Hence, in order to provide a comprehensive aid specific to adolescents; social workers should work with the family, the school, and the community.

Family

Family is the main institution for the socialization and molding of adolescents' behavior. However, the proper functioning of a family could be affected due to the after effect of urbanization. Urban poverty, which is characterized by economic problem, unemployment

and low access to services have an impact on the well functioning of the family. Since adolescence is a developmental stage in which young people make decisions that could affect their upcoming life. Hence, they need attention and understanding from their surrounding environment. Therefore, family is the closest environment, which could serve as an entity responsible for molding adolescents' behavior.

Being the head of family, parents could serve as a reference point for adolescents' behavior. They are responsible for the proper socialization of the youth and can serve as a guide and source of information to their children. For this purpose, there needs to be a close relationship between parents and adolescents and a harmonious family interaction. This could allow adolescents to have easy access to information including reproductive health information that would be provided by parents. However, in the Ethiopian tradition having open discussion on sexual matters is very rare since it is considered as a taboo. Therefore, most adolescents do not get reproductive health information from their parents. The effect of this situation becomes worse in the condition of slum areas where the availability of formal sources of information is rare.

Hence, social worker intervention with its various forms is crucial. The first step would be, understanding the principles and values underlying the family interaction and recognize the problems inherent in dysfunctional family relationships and then facilitate conditions to make awareness about the possible risks and enlighten parents to take responsibility in providing guidance to their adolescents.

Social workers are expected to provide developmental (educational), preventive and curative services to adolescents in their family context to enhance their awareness on reproductive health. They also provide clinical services such as family therapy and counseling to increase mutual understanding between parents and adolescents regarding adolescents' reproductive decision-making roles. Furthermore, social workers also work on the prevailing parenting style. This could help in the development of harmonious and democratic relationship between parents and adolescents and allow parents to understand adolescents' psychological development as well as behavioral change and give them room to entertain such changes. This can make adolescents responsible for their actions and be able to make the right decision regarding sexuality. Hence, this can have a great impact on combating the effects of reproductive health problems.

School

School is the other institution, which can be responsible for the development of healthy reproductive behavior of adolescents. As it has been stated, due to the existing tradition, adolescents do not get the necessary reproductive health information from their family or parents. Therefore, they seek information from their peers and other sources, which could be a wrong source of information.

Therefore, school could be an ideal place to serve as a source of information. In the school setting it would be good to include sex education in the curriculum. This sex education should not only be concerned with biological issues but include social issues like family planning, love and marriage, up brining children, achieving good success in life and be self

supportive... etc. In addition, by inculcating the life history of role models or famous individuals, the school can play a major role in motivating adolescents to plan for a bright future or continue their education and work harder towards to their career. In addition, social workers can also provide adolescents with adequate information through peer education, mini-media and other means on similar issues and the potential consequences of their behavior in relation to the reproductive health problems.

Regardless of this fact, in slum areas, the majority of adolescents are school dropouts, which imply their inaccessibility to such services. Hence, social workers could play a major role in preventing school dropout as well as in facilitating situations for adolescents to return to school. Social workers can be counselors at school and try to work upon the factors, which impose pressure on adolescents forcing them out of school. Such problems could be; trouble at school (conflict between adolescents or students and teachers), family problem, reproductive health problem, poor interest towards school ...etc.

In addition, the school system can also serve as an information center for adolescents on issues like gender issues. Through this process, girls may have an opportunity to be empowered in recognizing their right to participate in reproductive health decisions and discuss reproductive health issues.

Community

As it has been stated; the inter linkage of the impact of reproductive behavior of adolescents upon each level of the society (individual, family, community), it is also crucial to

act against the problem from the community level. Cognizant of the fact that reproductive health problem of adolescents in Ethiopia is embedded in the prevailing cultural and socioeconomic conditions; social workers should have a significant role in addressing the issue at the larger context. Even though, there is legislation and policies regarding adolescents' reproductive health, social workers should be able to advocate for the formulation and implementation of policies and legislations, which recognize adolescents with in diverse situations.

Since social workers have communication and organizational skills, they have to work to impact change through community intervention by developing multifaceted programs based on needs and available resources. While designing such programs questions like; what are adolescents' needs concerning sexual and reproductive health? How can we increase their ability to make informed reproductive choices? How do we enhance their access to reproductive health services that are acceptable, unthreatening, and affordable? What kind of information do they need in order to exercise these choices and access services? How can we tailor programs to deliver information and services? Moreover, how can programs improve communication between adolescents and adults? should be entertained.

Social workers may also play a major role in administration and monitoring various intervention services for adolescents along with their families such as family support services, adolescent guidance centers, service for teenage parents (continue their education, accessible health care services, employment and training services, financial assistance...etc.). In addition to this, since adolescents' reproductive needs and behavior differ depending on their

socioeconomic situation; programs that are designed to marginalized adolescents like those who live in slum areas should address their special needs and work on the factors, which contribute, to their behavior. Therefore, programs, which consider the income generating of families and adolescents and prevent the risky behavior of adolescents could be designed and implemented.

Since research is an enabling process in social work, social workers need to recognize the need for scientific answers to adolescents' reproductive health problems to obtain access to new facts, techniques and skills to design alternative solutions and appropriate methods of intervention from our client's perspective i.e. with its cost effectiveness, stability, reliability, flexibility, communicability, acceptability and invulnerability... etc.

Generally speaking, social workers can become advocates, lobbyists and community activists, helping to shape policy and to make social organizations and institutions(GOs and NGOs, CBOs ...etc) more responsive to the reproductive needs of slum adolescents in particular and the society in general. In relation with this, as it has been stated above the finding of this study reported that adolescents have more or less acceptable attitude towards reproductive behavior such as premarital sex, abortion, and having multiple partners. However, their practice is in contrast with their attitude thus social workers can work more on teaching adolescents the impact of risky behaviors and try to make them realize the benefit of the social values and put them in to practice.

As social work has developed out of the community, recognition of the existing need, to provide appropriate services is crucial. Hence, developing appropriate interventions on cultural practices is needed. The social worker, therefore, should consider the pros and cons of western- originated theory and knowledge in order to adapt to the Ethiopian context. In addition, to generate appropriate social work intervention methods from our effective cultural values, religious values, beliefs, and indigenous helping networks those are responsive to adolescents' need. This could result in acceptance and view of diversity as assets, which strengthen relationships and better communication stemming from those differences. This approach also avoids marginalization of culturally diverse interpretation (conceptualization, communication processes and relationships) of reality and human experiences on reproductive problems of adolescents.

On the other hand, a social worker can use the available strength of the community and apply it to mitigate the existing problem. One example of this kind could be, using those adolescents, who had the experience of reproductive health problem, as a resource person to teach others based on their life experience and show others the consequence of reproductive health problem. This can be one of the multitude strengths available in the community, which can play a preventive role.

Recommendations

- As to one of the findings, slum adolescents are well aware of the societal value of delaying premarital sex and other values. However, their practical experience is completely the opposite. Therefore, various institutions especially the school can play a major role in

tackling this problem. This could be done by including sex-education in the educational curriculum which would include various social issues. Social workers can also play a significant role in awareness creation at different levels of the community.

- As poverty has been found to be one of the major reasons for slum adolescents to development risky reproductive behavior; launching a well integrated program is very crucial. This program will facilitate the improvement of the socioeconomic condition of the family/parents which indirectly discourages adolescents' school dropout. Moreover, social workers should also work with school dropouts and facilitate conditions so that they could return back to school.
- In Ethiopian culture, having parent-child discussion on sexual matters is considered as a taboo. Therefore, adolescents do not get reproductive health information from their parents hence; they should have access to reproductive health information. In other words, improved access to non-judgmental and user-friendly sexual health services is crucial for slum adolescents. Thus, more effort should be forwarded towards improved provision of reproductive health services to slum adolescents in the field of preventing reproductive health problems and rehabilitating those affected by reproductive health problems.
- Slum adolescents should be well aware of their responsibility and act in consideration of their role in relation to both their own sexual health and that of their partners and programs should also be designed and implemented for young women. In addition, the wider community should also change the wrong attitude of masculinity and work against risky

reproductive behavior of young men which jeopardize their own health and the health of others.

- Lastly but not least, further studies which assess the condition of reproductive behavior of slum adolescents should be conducted. Hence it will help to have more detailed information about the situation and helps to design responsive interventions.

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8. If the answer for Question no. 7 is 'dropped out of school'; why?

[Do not read aloud the choices; Let the respondent come up with his or her answer and mark if the answer mentioned is included in the list]

- a. due to economic reason
- b. due to family problem
- c. lack of interest
- d. reproductive health problem

9. Living Arrangement

9.1 For how long have you lived in this area?

- a. less than a year
- b. 1-3 years
- c. 3-6 years
- d. more than 6 years
- e. starting from birth

9.2 If you are a migrant then where were you living before?

- a. in rural area
- b. in other part of Addis Ababa
- c. in other town
- d. Other specify _____

9.3 How many rooms does your house have?

- a. Three
- b. Two
- c. One
- d. Other specify _____

9.4 Does the household have;

	Yes	No	Additional Explanation
a ¹ . easy access to water tap			
b ² . own pit latrine			
c ³ . own electricity			
d ⁴ . own compound			
e. other specify			

10. Family Structure

- a. I live with both of my parents
- b. I live with one of my parents
- c. I live with my relatives or guardians
- d. I live with my siblings
- d. I live alone
- e. Other specify _____

11. Family size including parents (guardians)

- a. 3-5 family members
- b. 5-7 family members
- c. 7- 10 family members
- d. Other Specify _____

12. Parents'/Guardians' educational background

	Educational Background	Father/Guardian	Mother/Guardian
a.	Illiterate		
b.	Able to read and write only		
c.	Elementary (1-6 grade)		
d.	Secondary (8-12 grade)		
e.	12 plus		
f.	Other specify		

13. What is your parent/s' (guardians') occupation?

- a. Both are unemployed
- b. Only one of them is unemployed
- c. Both are self employed
- d. One of them is self employed and the other is unemployed
- e. Other specify _____

14. What do your parents' (guardians) do for a living?

15. Do you earn an income?

- a. Yes
- b. No

[If the answer for question no.15 is 'No' skip the following questions i.e 16 &17]

16. If the answer for question no.15 is 'yes'; what do you do to earn your income?

[Do not read aloud the choices; Let the respondent come up with his or her own answer and mark if the answer mentioned is included in the list]

- a. employed at individual's home
- b. small business (shoe shining, petty trade, car washing...etc)
- c. Other specify _____

17. At what age did you start working?

- a. < 10 b. 10-14 c. 15-19

II. REPRODUCTIVE BEHAVIOR

1. Practicing premarital sex is one of the ways, which helps one to find the right person for marriage.

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

2. Both males and females should have equal rights on reproductive decision.

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

3. Adolescents have the right to use available reproductive health services

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

4. Abortion is preferable mechanism against unwanted pregnancy.

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

5. Females are responsible in preventing unintended pregnancies.

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

6. Having multiple partners is an acceptable behavior.

- a. strongly agree b. agree c. can't decide d. disagree e. strongly disagree

7. Can you identify the reason why you developed your attitude towards practicing premarital sex? [*Let the respondent answer with out you reading the list of choices*]

- a. Due to religion b. Due to the culture c. family influence
d. peer influence e. sex education
f. Other specify _____

8. Do you have a partner?

- a. Yes b. No

9. If yes, how long have you been together?

- a. less than a month b. 1-6 months
c. from 6months-1year d. more than one year

10. If the answer for question no 8 is 'yes'; have you ever engaged in sexual relationship with your current or past partner?

- a. Yes b. No.

11. If yes, what was your age at first intercourse?

- a. 10-13
- b. 14-16
- c. 17-19
- d. Other Specify _____

12. What motivated you to involve in sexual activity? [*Let the respondent answer with out you reading the list of choices*]

-
- a. Peer influence
 - b. Lack of income
 - c. Coercion
 - d. Other specify _____

13. If the answer for Q. 12 is 'coercion' can you describe the circumstance in which it took place? (*Coercion: refers to a range of experiences that force a person to have sex against her or his will in which the experiences could be violence, threats, verbal insistence, deception, cultural expectations and economic circumstances*)

14. How many sexual partners did you have (from beginning until now)?

- a. 1
- b. 2-3
- c. more than 3
- d. Other specify _____

15. What is the average period of your relationship with your former partner/s?

- a. < 1month
- b. 1- 6months
- c. 6months- 1year
- d. > 1 year
- e. Other specify _____

16. What is the average age of your partner/s?

- a. younger than 14 years
- b. 15-19
- c. 20-24
- d. 25-30
- e. older than 30 years
- f. Other specify _____

17. What is the occupation of your partner/s?

- a. student
- b. unemployed
- c. self employed
- d. employed
- e. Other specify _____

III. REPRODUCTIVE HEALTH RIGHT

1. What is your **source of information** about reproductive health?

- a. family
- b. peers
- c. health service provider
- d. mass media
- e. school
- f. Other specify _____

3. If yes, what factor made you involve in such activity?
 - a. peer influence
 - b. no access to other recreational institutions
 - c. unemployment
 - d. Other Specify _____
4. Are there places in your neighborhood, which provide/sell such services?
 - a. Yes
 - b. No
5. Are there commercial sex workers in your neighborhood?
 - a. Yes
 - b. No

Questions no 6 and 7 will be asked for male respondents only;

6. Have you ever visited commercial sex workers?
 - a. Yes
 - b. No
7. If yes, did you use condom when during your last visit to?
 - a. Yes
 - b. No

V. REPRODUCTIVE HEALTH PROBLEMS

1. Have you ever faced with Sexually Transmitted Diseases (STDs)?
 - a. Yes
 - b. No
2. If yes, what was your response?

3. Have you ever faced with unintended pregnancy?
 - a. Yes
 - b. No
4. If yes, what was your response?

5. Had your girl friend been faced with unintended pregnancy?
 - a. Yes
 - b. No
6. If yes, what was your response?

7. Have you ever used induced abortion, which is the deliberate termination of pregnancy as a solution for unintended pregnancy?

- a. Yes b. No

8. If yes, where did it take place?

- a. health center b. traditional practitioners c. home
d. Other Specify _____

9. What made you decide to perform abortion?

10. Is there any problem related with the abortion? If yes, explain.

- a. Yes b. No

11. What kind of measures do you use to prevent unintended pregnancy?

- a. Condom b. Pills c. Loop d. Norplant e. Injections
f. Safe Date (Rhythm) g. Other specify _____

[Thank you for your collaboration]

መለያ ቁጥር: _____

የጠያቂው ስም: _____

ቃለ-መጠይቅ

የዚህ ጥናት ዋና ዓላማ በተክለሐይማኖት አረብ የሚገኙ ታዳጊ ወጣቶች (ማለትም ከ15-19 የዕድሜ ክልል ውስጥ ያሉ) ሥነ-ተዋልዶን አስመልክቶ ያላቸውን ተሞክሮ (ጠባይ) መረዳት ሲሆን ከዚህም በተያያዘ አረብያቸው ባላቸው የሥነ-ተዋልዶ ፀባይ ላይ ያለውን አስተዋፅኦ መገንዘብ ይሆናል።

ከዚህ ቃለ-መጠይቅ የሚገኝ ማንኛውም መረጃ በሚስጥር የሚጠበቅ ሲሆን ይህንንም መረጃ መሠረት በማድረግ የሚፃፉ ማብራሪያዎች የመረጃው ምንጭ የሆነውን ግለሰብ ማንነት አይገልፁም።

(በመጀመሪያ በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ሆነህ/ሽ በመገኘትህ/ሽ ክልብ አመሰግናለሁ።)

1. የግል መረጃ

1. ዕድሜ _____
2. የታ ሀ. ወንድ ለ. ሴት
3. ሐይማኖት ሀ. ክርስቲያን (ኦርቶዶክስ፣ < ቶሊክ ፣ ፕሮቴስታንት፣ አድቤንቲስት)
 - ለ. ሙስሊም
 - ሐ. ሌላ _____
4. ብሔር: _____
5. የጋብቻ ሁኔታ

ሀ. ያላገባ/ች	ለ. ያገባ/ች	ሐ. በህግ የተፋታ/ች
መ. የተለያየ/ች	ሠ. የሞተችበት/የሞተባት	
6. የትምህርት ደረጃ

ሀ. ማንበብም መፃፍም አልችልም	ለ. ማንበብ እና መፃፍ ብቻ እችላለሁ
ሐ. 1ኛ - 8ኛ ክፍል ተምራያለሁ	መ. 9ኛ -10ኛ ክፍል ተምራያለሁ
ሠ. 10+1 - 10+2 ክፍል ተምራያለሁ	ረ. ከ 10+2 በላይ
ሰ. ሌላ _____	
7. የትምህርት ክትትል ሁኔታ

ሀ. በክትትል ላይ እገኛለሁ	ለ. አቋርጫለሁ
ሐ. የ10ኛ ክፍል ብሔራዊ መልቀቅያ ፈተና ወስጄ ውጤት አልመጣልኝም	
መ. ሌላ _____	

8. የጥያቄ 7 መልስ 'አቋርጫለሁ' ከሆነ፤ ምክንያትህ/ሽ ምንድን ነው? [የተዘረዘሩትን ምርጫዎች አታንብብ/ቢ ቃለ-መጠይቁን የሚመልሰው ሰው የራሱን/ሳኚ መልስ እንዲናገር/እንድትናገር ዕድሉን ስጥ/ጭ]

-
- ሀ. በድህነት ምክንያት
 - ለ. በቤተሰብ ችግር ምክንያት
 - ሐ. የትምህርት ፍላጎት ማጣት
 - መ. በሥነ- ተዋልዶ ችግር ምክንያት
 - ረ. ሌላ _____

9. የአኗኗር ሁኔታ

9.1 በዚህ አረባዊ ለምን ያህል ጊዜ ኖረሃል/ሻል?

- ሀ. ከ 1 ዓመት ያነሰ
- ለ. ከ1-3 ዓመት
- ሐ. ከ3-6 ዓመት
- መ. ከ 6 ዓመት በላይ
- ረ. ከተወለድኩ ጀምሮ

9.2 እዚህ አረባዊ ለምን የተወለድኩ/ሽው ማለትም ከሌላ አረባዊ ከሆነ የመጣኸው/ሽው፤ በራት የት ነበር የምትኖረው/ረው?

- ሀ. ገጠር
- ለ. አዲስ አበባ ሆኖ ሌላ አረባዊ
- ሐ. ሌላ ከተማ
- መ. ሌላ _____

9.3 የምትኖርበት/ረበት ቤት ምን ያህል ክፍል አለው?

- ሀ. ሦስት
- ለ. ሁለት
- ሐ. አንድ
- መ. ሌላ _____

9.4 የምትኖርበት/ረበት ቤት የሚከተሉትን ነገሮች ያሟላልን?

	አለው	የለውም	ተጨማሪ ማብራርያ
ሀ. የውሃ አቅርቦት			
ለ. የግል መፀዳጃ ጉድጓድ			
ሐ. የግል የመብራት ቆጣሪ			
መ. የግል ግቢ			
ሠ. ሌላ			

10. የቤተሰብ ሁኔታ

- ሀ. ከሁለቱም ወላጆቹ ጋር ነው የምኖረው
- ለ. ከአንድ ወላጅ ጋር ነው የምኖረው
- ሐ. ከዘመዶቹ ወይም አሳዳጊዎቹ ጋር ነው የምኖረው
- መ. ከእህት እና ወንድሞቹ ጋር ነው የምኖረው
- ሠ. ብቻዬን ነው የምኖረው
- ረ. ሌላ _____

11. የቤተሰብ ብዛት ወላጅን (አሳዳጊን) ጨምሮ

ሀ. ከ 3-5 የቤተሰብ አባል

ለ. ከ 5-7 የቤተሰብ አባል

ሐ. ከ 7-10 የቤተሰብ አባል

መ. ሌላ _____

12. የወላጅ (የአሳዳጊ) የትምህርት ደረጃ

	የትምህርት ደረጃ	ወላጅ አባት/አሳዳጊ	ወላጅ እናት/አሳዳጊ
ሀ.	ማንበብ እና መጻፍ አይችልም/ አትችልም		
ለ.	ማንበብ እና መጻፍ ብቻ ይችላል/ ትችላለች		
ሐ.	1ኛ - 6ኛ ክፍል ተምሯል/ራላች		
መ.	8ኛ- 12ኛ ክፍል ተምሯል/ራላች		
ሠ.	ከ 12ኛ ክፍል በላይ ተምሯል/ራላች		
ረ.	ሌላ		

13. የወላጅ (የአሳዳጊ) የሥራ ሁኔታ

ሀ. ሁለቱም ሥራ አጥ ናቸው

ለ. ከሁለት አንዳቸው ሥራ አጥ ናቸው

ሐ. ሁለቱም የራሳቸውን ሥራ ነው የሚሠሩት

መ. አንዳቸው የራሳቸውን ሥራ አንደኛቸው ደግሞ ሥራ አጥ

ሠ. ሌላ _____

14. ወላጅህ/ሽ (አሳዳጊህ/ሽ) የሚሰራው/የምትሰራው የሥራ ዓይነት ምንድነው?

15. ለራስህ/ሽ ገቢ የም ታገኝበት/ኒበት ሥራ አለህን/ሽን?

ሀ. አለኝ

ለ. የለኝም

(የ15ኛው ጥያቄ መልሱ የለኝም ከሆነ የሚከተሉትን ጥያቄዎች ማለትም ከ16 እና 17 ይዘለል)

16. የ15ኛው ጥያቄ መልሱ 'አለኝ' ከሆነ፤ ምንድን ነው የምትሰራው/ረው?

ሀ. ሰው ቤት እሰራለሁ

ለ. አነስተኛ የንግድ ሥራ (ሊስትሮነት፣ጉልት፣መኪና ማጠብ ... ወ.ዘ.ተ)

ሐ. ሌላ _____

17. ሥራ ስትጀምር/ሪ ዕድሜህ/ሽ ምን ያህል ነበር?

ሀ. ከ10 ዓመት በታች

ለ. ከ10-14 ዓመት

ሐ. ከ15-19 ዓመት

2. የሥነ-ተዋልዶ ፀባይ

1. ከጋብቻ በፊት የሚደረግ የግብረ-ሥጋ ግንኙነት የወደፊት የትዳር ጓደኛ የሚሆንን ሰው ለመምረጥ የሚረዳ አንዱ እና ዋናው መንገድ ነው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

2. ወንድም ሆነ ሴት ሥነ-ተዋልዶን አስመልክቶ ለሚደረጉ ውሳኔዎች እኩል መብት አላቸው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

3. ታዳጊ ወጣቶች ያለውን የሥነ-ተዋልዶ አገልግሎት የመጠቀም መብት አላቸው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

4. ያልተፈለገ እርግዝናን ለማስወገድ ፅንሰን ማቋረጥ አማራጭ የሌለው ዘዴ ነው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

5. ያልተፈለገ እርግዝናን መከላከል የሴቶች ሐላፊነት ነው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

6. ብዙ የፍቅር ጓደኛ መያዝ ተቀባይነት ያለው ፀባይ ነው።

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. መወሰን ያስቸግረኛል
መ. አልስማማም ሠ. በጣም አልስማማም

7. ከጋብቻ በፊት የሚደረግ የግብረ-ሥጋ ግንኙነትን አስመልክቶ ከላይ የሰጠኸውን/ኸውን አመለካከት እንድታዳብር/ሪ ያደረገህ/ሽ ምክንያት ምንድነው? [የተዘረዘሩትን ምርጫዎች አታንብብ/ቢ ቃለ-መጠይቁን የሚመልሰው ሰው የራሱን/ሳጌ መልስ እንዲናገር/እንድትናገር ዕድሉን ስጥ/ጭ]

ሀ. የጓደኛ ግፊት ለ. ባህል ሐ. የቤተሰብ ጫና መ. ሐይማኖት
ሠ. የሥነ-ተዋልዶ ትምህርት ረ. ሌላ _____

8. የፍቅር ጓደኛ አለህ/ሽ ?

ሀ. አለኝ ለ. የለኝም

9. የጻፍው ጥያቄ መልስ 'አለኝ' ከሆነ፤ ምን ያህል ጊዜ ይሆናችኋል?

ሀ. ከ1ወር ያነሰ ለ. ከ1-6ወር ሐ. ከ6ወር- 1ዓመት መ. ከ1ዓመት በላይ

10. የ8ኛው ጥያቄ መልስ 'አለኝ' ከሆነ፤ አሁን <ለህ/ሽ የፍቅር ጓደኛህ/ሽ ጋርም ሆነ ከሌላ ሰው ጋር የየግብረ-ሥጋ ግንኙነት ፈፀመህ/ሽ ታውቃለህ/ቅያለሽ?

ሀ. አውቃለሁ ለ. አላውቅም

11. የ10ኛው ጥያቄ መልስ 'አውቃለሁ' ከሆነ፤ የግብረ-ሥጋ ግንኙነት ለመጀመሪያ ጊዜ ስትፈፀም/ሚፈፀምህ/ሽ ምን ያህል ይሆን ነበር?

ሀ. ከ10-13 ለ. ከ14-16 ሐ. ከ17-19 መ. ሌላ _____

12. የግብረ-ሥጋ ግንኙነት እንድትፈፀም/ሚፈፀም ምን ገፋፋህ/ሽ?

ሀ. የጓደኛ ግፊት ለ. የገቢ ማጣት ሐ. በማስገደድ

መ. ሌላ _____

13. የጥያቄ 12 መልስ 'በማስገደድ' ከሆነ፤ የወሲብ ጥቃቱ እንዴት ሊፈፀምብህ/ሽ እንደቻለ ብታበራራ/ሪ? (የወሲብ ጥቃት፡ ማለት አንድን ሰው በተለያዩ ምክንያት በመጠቀም ክፍላጎቱ/ቷ ውጭ የግብረ-ሥጋ ግንኙነት እንዲፈፀም/እንድትፈፀም ማስገደድ ሲሆን ይህም ሃይል መጠቀምን፣ ማስፈራራትን ፣በቃል መውትወትን፣ መዋሽትን እና በገንዘብ መደለልን ያጠቃልላል።)

14. ከምን ያህል ሰው ጋር የግብረ-ሥጋ ግንኙነት ፈፀመህ/ሽ ታውቃለህ/ቅያለሽ (ወሲብ ከጀመርክ/ሽበት እስከሁን)?

ሀ. ከአንድ ለ. ከ2-3 ሐ. ከ3 በላይ

መ. ሌላ _____

15. ከዚህ በፊት ከነበሩህ/ሽ (ከነበረህ/ከነበረሽ) የፍቅር ጓደኞች(ጓደኛ) ጋር በአማኝ ምን ያህል ጊዜ ቆይተሃል/ሻል?

ሀ. ከ1ወር ያነሰ ለ. ከ1-6ወር ሐ. ከ6ወር- 1ዓመት መ. ከ1ዓመት በላይ

ሠ. ሌላ _____

16. የፍቅር ጓደኛህ/ጓደኛሽ (ጓደኞችህ/ጓደኞችሽ) ዕድሜ በአማኝ ምን ያህል ይሆናል?

ሀ. ከ14 ዓመት ያነሰ ለ. 15-19 ሐ. 20-24 መ. 25-30

ሠ. ከ30 ዓመት በላይ ረ. ሌላ _____

17. የፍቅር ጓደኛህ/ሽ መተዳደሪያ ሥራ ምንድነው?

ሀ. ተማሪ ለ. ሥራ አጥ ሐ. የግል ሥራ

መ. ቅጥር ሠራተኛ ሠ. ሌላ _____

2. መልሱ 'እጠቀማለሁ' ከሆነ፤ የምትጠቀመው/ሚው ምንድነው?

ሀ. ሲጋራ ለ. የአልኮል መጠጥ ሐ. ጫት መ. ሁሉንም
ሠ. ሌላ _____

3. የ1ኛው ጥያቄ መልስ 'እጠቀማለሁ' ከሆነ፤ እንድትጠቀም ያደረጉህ/ሽ ምክንያቶች

ምንድናቸው? [የተዘረዘሩትን ምርጫዎች አታንብብ/ቢ ቃለ-መጠይቁን የሚመልሰው ሰው እራሱ/ሷ መልሱን እንዲናገር/እንድትናገር ዕድሉን ስጥ/ጭ]

ሀ. የጓደኛ ግፊት ለ. የመዝናኛ ቦታ እጠት ሐ. ሥራ አጥነት
መ. ሌላ _____

4. በአብዮት/ሽ መጠጥ ቤት እና ጫት መሸጫ ቤቶች አሉን?

ሀ. አሉ ለ. የሉም

5. በአብዮት/ሽ ሴተኛ አዳሪዎች ይገኛሉን?

ሀ. ይገኛሉ ለ. አይገኙም

(ጥያቄ 6 እና 7 ለወንድ ተጠያቂዎች ብቻ)

6. ሴተኛ አዳሪዎች ጋር ሄደህ ታውቃለህ?

ሀ. አውቃለሁ ለ. አላውቅም

7. የ6ኛው ጥያቄ መልስ 'አውቃለሁ' ከሆነ፤ የመጨረሻ ጊዜ የሄድክ ጊዜ ኮንዶም ተጠቀመሃልን?

ሀ. ተጠቅሜያለሁ ለ. አልተጠቀምኩም

5. የሥነ-ተዋልዶ ጤና ችግሮች

1. ለአባላዘር በሽታዎች ተጋልጠህ/ሽ ታውቃለህ/ታውቅያለሽን?

ሀ. አውቃለሁ ለ. አላውቅም

2. የአንደኛው ጥያቄ መልስ 'አውቃለሁ' ከሆነ፤ ምን እርምጃ ወሰድክ/ሽ?

3. ላልተፈለገ እርግዝና ተጋልጠሽ ታውቅያለሽን?

ሀ. አውቃለሁ ለ. አላውቅም

4. የጥያቄ 3 መልስ 'አውቃለሁ/ታውቃለሽ' ከሆነ፤ ምን እርምጃ ወሰድሽ?

5. የፍቅር ዳደኛህ ላልተፈለገ እርግዝና ተጋልጣ ታውቃለችን?

- ሀ. ታውቃለች
- ለ. አታውቅም

6. የጥያቄ 5 መልስ 'ታውቃለች' ከሆነ፤ ምን እርምጃ ወስዳችሁ?

7. ያልተፈለገ እርግዝናን ለማስወገድ ፅንሰ ማቋረጥን (ማለትም ሆነ ብሎ ፅንሰ ማስወጣትን) ተጠቅመሽ ታቅያለሽን?

- ሀ. አውቃለሁ
- ለ. አላውቅም

8. የገኛው ጥያቄ መልስ አውቃለሁ ከሆነ፤ የት ተደረገ?

- ሀ. የጤና ጣብያ
- ለ. ባህላዊ ሃኪሞች ጋር
- ሐ. ቤት

ሠ. ሌላ _____

9. ፅንሰ ለማቋረጥ እንዴት ልትወስኝ ቻልሽ?

10. ከፅንሰ ማቋረጡ ጋር በተያያዘ ያጋጠመሽ ችግር አለን? <ለ ብታብራራ::

11. ያልተፈለገ እርግዝናን ለመከላከል የትኛውን የመከላከያ ዘዴ ትጠቀማለህ/ሚያለሽ?

- ሀ. ኮንዶም
- ለ. የእርግዝና መከላከያ ኪኒን
- ሐ. ሱፐር
- መ. መወሰን
- ሠ. የሚቀበረውን
- ረ. መርፌ
- ቀ. ቀን በመቁጠር
- በ. ሌላ _____

(ላደረሰው/ገሸው ትብብር ታላቅ ምስጋናዬን አቀርባለሁ)

Declaration

This thesis is my original work and has not been presented for a degree in any other university, and that all sources of material used for this thesis have been acknowledged.

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