

COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCE
DEPARTMENT OF POPULATION AND FAMILY HEALTH



**MAGNITUDE AND FACTORS ASSOCIATED WITH SEXUAL
DEBUT AMONG IN-SCHOOL ADOLESCENTS IN ASELLA
TOWN, ARSI ZONE, OROMIA REGIONAL STATE, SOUTHEAST
ETHIOPIA**

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**Magnitude And Factors Associated With Sexual
Debut Among In-School Adolescents In Asella
Town, Arsi Zone, Oromia Regional State,
Southeast Ethiopia**

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SUMMARY

Background: Sexual activities among adolescents have been reported to be increasing worldwide. Over the past decade, adolescent sexual and reproductive health concerns have increasingly been on national agendas. Sexual debut on this period exposes adolescents to various risks such as unprotected sex, early pregnancy and STIs/HIV/AIDS. The aim of this study is to assess the magnitude and factors associated with sexual debut among in-school adolescents in Asella town, Arsi Zone, Oromia Regional State, Southeast Ethiopia.

Methods: A school based cross-sectional study with qualitative and quantitative data collections method was employed on a total of 362 students of randomly selected from four schools of Asella town from May 30 to June 20 2012 using simple random sampling. Sexual debut is the dependent variable and demographic, socio-economic and knowledge are independent variables. The quantitative data were collected using structured self-administered questionnaire and analyzed by SPSS version 16.0 through bi-variate and multi-variable analysis and qualitative data were gained using in depth interview with students and analyzed thematically.

Results: Three hundred sixty high school adolescents participated in the study. One hundred nine (30.3%) of the participants had sexual debut at the time of the survey, of which 210 (58.3%) were males. While age greater than 18 years AOR 2.7 (1.5, 5.1), living apart from parents so that renting alone AOR 2.2 (1.0, 4.7), pushed by a friend to smoke AOR 4.0 (1.5, 16.1) and have sex 4.5 (2.1, 9.2), spending spare time with boy/girl friend AOR 7.5 (2.3, 24.0) and watching pornography AOR 2.9 (1.2, 6.5) were positively associated with sexual debut in the study area. Being female gender AOR 0.54 (0.29, 0.99), avoiding use of substances like alcohol AOR 0.26 (0.07, 0.92) and cigarette AOR 0.19 (0.09, 0.46), intention to delay sexual practice and communicating with fathers about sexual matters AOR 0.35 (0.13, 0.94) was found to be protective against sexual debut.

Conclusion: One hundred nine (30.3%) of the respondents experienced sexual intercourse which might predispose them to different sexual and reproductive health problems. Increasing awareness about sexual and reproductive health problems by strengthening youth friendly services and using IEC/BCC materials is recommended.

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Lists of Abbreviations

AIDS: Acquired immune deficiency syndrome

ASRH: Adolescent sexual and reproductive health

BCC: Behavioral change communication

CSA: Central statistical agency

EDHS: Ethiopia demographic and health survey

FGD: Focus group discussion

HAPCO: HIV/AIDS prevention and control office

HIV: Human immune deficiency virus

ICPD: International conference on population and development

IEC: Information, education and communication

MDG: Millennium development goal

MOH: Ministry of health

STIs: Sexually transmitted infections

UNAIDS: United nation program on AIDS

UNFPA: United nation population fund

WHO: World health organization

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

The World Health Organization (WHO) defines adolescent people as those between the ages of 10 to 19 years (UNDO/UNFPA/WHO, 2003). Adolescence is the time of transition from childhood to adulthood during which young people experience changes following puberty (Consensus statement, 2000). Adolescents are undergoing tremendous physical, emotional, social, and intellectual changes. During this period, many young adolescents go through puberty, have their first sexual experiences, and in the case of girls, may be married prematurely (UNFPA and population council, 2005).

Sexual activities among adolescents have been reported to be increasing worldwide. Several studies in Sub-Saharan Africa have also documented high and increasing premarital sexual activities among adolescents (Federal Ministry of Health, 2001). Premarital sex is one of the reproductive health problems witnessed in adolescence. Studies have revealed that the prevalence of premarital sex among in-school youth is higher in Oromia (31.3%) than nationally (19%) (HAPCO, 2000).

Sexual activity during adolescence, however, can be a life-altering and destabilizing experience if the young person is not yet physically matured and emotionally and psychologically prepared to deal with its possible adverse consequences. For instance, early transition to sexual activity marks the beginning of exposure to potential risks of unplanned pregnancy and sexually transmitted infections.

The very low level of economic development, widespread poverty, very poor and inadequate health services make the consequences of adolescent sexuality much more serious in the Ethiopian context than those of the developed countries. This is reflected by the highest HIV prevalence in the group 15-24 years 12.1%, (6% -9 % among young men aged 15–24, and 10%-13 % among young women in the same age group) (Fikadu and Alemayehu, 2009). The ensuing high rates of unintended pregnancy, abortion, HIV/AIDS and other sexually transmitted infections (STIs) among teenagers make it imperative that, among other things, there is a need to understand and assess the factors that are associated with early or late sexual initiation. Effective implementation of International Conference on Population and Development (ICPD) recommendation on adolescent sexual and reproductive health also requires an understanding of the causes and consequences of early

initiation of reproductive-related behaviors. It is crucial for designing and implementing effective interventions targeting youths. (Fikadu and Alemayehu, 2009).

1.2 STATEMENT OF THE PROBLEM

Over the past decade, adolescent sexual and reproductive health concerns have increasingly been on national agendas. For many countries, this concern has been driven

by the high prevalence of HIV/AIDS among young people. In other countries, a central concern has been early childbearing; and still others have focused predominantly on sexual behaviors among adolescents (WHO, 2004).

Sexual activities among adolescents have been reported to be increasing worldwide. Several studies in Sub-Saharan Africa have also documented high and increasing premarital sexual activities among adolescents (Department of Family Health, 2001). However, viewing adolescents as a specific group with their own needs is a relatively recent practice, especially in developing countries (Judith, 1999).

The age of sexual activities among adolescents has been reported to be decreased and there are an increasing proportion of young people who had sexual intercourse before the age of sexual consent. Increased prevalence of sexual debut also affects poor countries like Ethiopia by exposing adolescents to unprotected sex, early marriage, STI/HIV/AIDS, early and unintended pregnancy, and unsafe abortion and generally increased maternal mortality and morbidity. Studies have shown that in Ethiopia 60% of adolescent pregnancies are unwanted or unintended (Fikadu, 2000).

Early onset of sexual intercourse is associated with increased lifetime prevalence of sexual partners, thereby increasing the risk exposure to sexually transmitted diseases, including HIV/AIDS and pregnancy. Early sexual debut also increases the risk of HPV infection, due to cervical immaturity; and thus the risk of cervical cancer increases (Ludicke et al, 2001). Additionally, given the risk of pregnancy, early sexual initiators are less likely to complete their schooling thereby limiting their social and vocational futures.

Adolescent sexuality continues to be an important social concern because of its connection to adolescent pregnancy and sexually transmitted diseases. The teenage pregnancy rate in the United States is the highest among Western industrialized nations (Jones et al, 1986) and results in approximately half a million births each year (Hayes, 1987).

The timing of an adolescent's first sexual intercourse is a key variable results these negative outcomes. Adolescents who initiate sex at younger ages, for example, may be at increased risk for an unintended pregnancy because they are less likely to practice effective contraception (Hayes, 1987; Zelnik and Shah, 1983). Sexually active young adolescents may also be at increased risk for contracting sexually transmitted diseases: a recent survey of adolescent males indicated that boys who initiate sex in early adolescence are less likely

to use condoms than those who become sexually active at later ages (Sonnenstein, Pleck, and Ku, 1989). Given the need to prevent early adolescent pregnancy and sexually transmitted diseases, uncovering the factors associated with early initiation of intercourse merits continued study.

Research studies from diverse cultural settings consistently show that the transition to adulthood is marked by a series of interrelated events. These transition events may serve as precursor events that either facilitate or delay the transition to sexual activity. For instance, studies have established that early departure from home and school hasten sexual debut.

Because of cultural taboos adolescents in many developing countries rarely discuss sexual matters explicitly with their parents. Most information for their patchy knowledge comes from peers of the same sex who may themselves lack adequate information or are incorrectly informed (HAPCO, 2000). Studies also suggested that adolescents have limited knowledge about sexual and reproductive health and know little about the natural process of puberty. This lack of knowledge about reproductive health may have grave consequences (HAPCO, 2000).

Moreover, sexual activities are occurring in the midst of an HIV/AIDS pandemic that disproportionately affects adolescents and young adults (Judith, 1999). On the other hand, young people often face enormous pressure to engage in sex, especially from peers, exposure to unlicensed erotic video films and the desire for economic gain (Taffa et, at, 2002). As the result of this, a significant number of adolescents are involved in sexual activities at an early age (Alexander & Hickner, 1997, Taffa et, at, 2002, and Taffa et, at, 1999).

CHAPTER TWO: LITERATURE REVIEW

The emerging sexuality that accompanies adolescence poses fundamental challenges for young people. These include adjusting to the altered appearance and functioning of a sexually maturing body, learning to deal with sexual desires, confronting sexual attitudes and values, experimenting with sexual behaviors, and integrating these feelings, attitudes, and experiences into a developing sense of self. The challenge is accentuated by the unfamiliar excitement of sexual arousal, the attention connected to being sexually attractive, and the new level of physical intimacy and psychological vulnerability created by sexual encounters.

ADOLESCENT SEXUALITY

It refers to sexual feelings, behavior and development in adolescents and is a stage of human sexuality. Sexuality is often a vital aspect of teenagers' lives (Lynn, 2000). The sexual behavior of adolescents is, in most cases, influenced by their culture's norms and mores, their sexual orientation, and the issues of social control such as age of consent laws.

Mature sexual desire usually appears with the onset of puberty, this can be expressed through masturbation or with sex partner. Sexual activity has various risks like unwanted pregnancy, STI including HIV/AIDS, unsafe abortion and so on.

Worldwide, early sexual debut is at an increasing rate among adolescents both in the community based and school based studies. The majority of US adolescents experience intercourse by age 18. In recent national surveys, 50 percent of 9th–12th-graders reported they had had sex (Blum et al., 2000; CDC, 2000). In Europe; study conducted in Oslo with prevalence of early sexual debut among 16 years old in-school adolescents was 25% (Ann-K et al; 2005). The most recent estimates of 'current sexual activity' in the Western Australian Aboriginal community, indicate that 43.9% of 16 year olds and 33.4% of 15 year olds had initiated intercourse (Blair et al; 2005). In some of the countries in Africa; for example, the incidence of adolescents reported to be sexually active at the study conducted in Tanzania was 48.7% (Elia John et al; 2012) and on the national survey employed in Nigeria on adolescents aged 15-19, the prevalence of early sexual intercourse was 80.2% (Adesegun and Robert, 2008).

The national finding from 2000 study was 19% and study conducted at Oromia survey 31.3% (HAPCO, 2000). Studies from different regions of Ethiopia show the prevalence. In Nekemte, for example, the prevalence was 21.5% (Assefa and Dessalegn, 2008). In Harar where 65% of males and 20% of females were sexually active (Bisrat, 1992). In Addis Ababa, for example, the proportion was 39.8% for males and 5.6% for females (Eshetu et al; 1999). In Gondar, it was 46.2% and 16.2% for males and females, respectively (Dawud, 2003). At the study conducted in Bahir dar town 44.4 percent of females and 47.5 percent of male respondents had already exposed to sexual intercourse at least once (Mohammed, 2008).

In several studies age at which adolescents are engaged in sexual practice falls around 15 and 16. Median age of first sexual intercourse in China was 16 years (Mee-Lian et al; 2009). In some of the countries of Africa studies also have been shown; for example, in Tanzania the mean age at sexual debut was 14.6 ± 2.3 years (Elia John et al; 2012), the median age of sexual debut in Nigeria was 15 years for males and 16 years for females (Adesegun and Robert, 2008). Several studies conducted on adolescent fertility and reproductive risk behavior of youth population in Ethiopia disclosed that adolescents begin sexual practice before age of 15 years. The mean age that mostly reported for the first sexual initiation is between 14-19 years (CSA, 2005). Ethiopian DHS (2000) also found out that the median age for the first sexual intercourse was 16.3 years. In local studies almost equivalent findings are available; study conducted at Nekemte, the mean age at first sexual intercourse was about 16.2 years for males and 15.2 years for females, in Bahir Dar town was 15.45 years for females and 16.7 years for males (Mohammed, 2008) and mean age of sexual initiation in Desse study was 16.8 years (Fekau and Alemayehu, 2009).

BIOLOGICAL AND PERSONAL FACTORS

Biological/physical maturity of adolescents increases the susceptibility of practice sexual intercourse. The likelihood of intercourse increases with age, so that by 12th grade, approximately two-thirds of students in US have had sex (CDC, 2000). However, this age was found to be protective against sexual practice. For instance; in Tanzania increase in age from 18 years and above was significantly associated with decreasing rate of early sexual debut among male adolescents but not among females (Elia John et al; 2012). In

Nekemte, age less than 18 years was found to be protective against premarital sexual practice (Assefa and Dessalegn 2008) and in Desse younger age group was tend to initiate sexual intercourse earlier (Fekau and Alemayehu, 2009). In studies gender being female was found to be risk for early sexual debut. For example, in Desse (Fekau and Alemayehu 2009), being female were tend to initiate sexual intercourse earlier and A.A shows trend among females toward earlier initiation of sexual activity (Mohammed 2008). However, other study reversed this risk factor for being male, study in Nekemte in which male adolescents were more likely to report premarital sexual experience than females (Assefa and Dessalegn 2008).

Studies found that when adolescents lived away from home at an early age, they were more likely to have had sex compared with those who stayed at home. For example, in Philippines found that males who experienced separation from home had a 30% greater likelihood of premarital sex compared with those who had not experienced living away from home. Among females, the likelihood of premarital sex increased by 52% (WHO, 2005). In Bahir Dar, currently living with their parents has higher chances of avoiding early sex than those who were not living with their parents.

Sexual activity has been found to be an indicator of a larger lifestyle pattern of unhealthy risk behaviors, including using tobacco, alcohol, and illicit drugs. Kirby (2001) suggests two plausible interpretations of the relationship between substance use and risky sexual behavior: (1) they are all part of a general inclination to take risks and an environment that supports such behavior and (2) drug and alcohol use diminish both inhibitions and rational decision-making, thereby increasing the likelihood of unprotected sex.

In US those who were current smokers or former smokers were significantly more likely to have engaged in sexual intercourse than youth who had never used cigarettes (CDC, 1998). Also almost one-quarter (22%) of sexually active high school students reported using alcohol or drugs during their most recent sexual encounter (The Henry J. Kaiser Family Foundation, 2009). A survey of a representative sample of the Australian population of aged 16 years indicated that, of secondary school students who had experienced sexual intercourse, 22.7% were under the influence of drugs or alcohol their first time (Smith et al; 2002). Ten studies were analyzed from developing countries that explored the relationships among risky non-sexual behaviors and sexual initiation among adolescents,

for example three out of five studies found that smoking cigarettes was significantly associated with an increased likelihood of having sex. Eight out of nine studies found that using alcohol significantly increased the odds that an adolescent has already engaged in sex (WHO, 2005). In Nigeria those who reported drinking were about twice as likely to report having had sexual intercourse (Adesegun and Robert, 2008). Similarly in Amhara region Desse those who drink alcohol were two times more likely to initiate sexual intercourse before the age of 18 (Fekadu and Alemayehu, 2009).

A large number of other factors that influence sexual behaviors do so indirectly, through their impact on intent. For example, knowledge of the potential impact of early sexual onset reduces the intent to engage in early sexual activity, which in turn delays sexual initiation. In Melbourne, Australia, a strong intent to engage in early sexual activity is thought to increase the likelihood of adolescent actively seeking sexual encounters (Fishbein & Ajzen, 1975). Similarly, in Malaysia, found that adolescents with more permissive sexual attitudes were five times more likely to be sexually experienced, compared to those with conservative attitudes (WHO, 2005).

INTERPERSONAL INTERACTIONS: FAMILY AND PEERS

Peer influence specially related with the effect of perception of social environment as opposed to reality of the social situation; an article review, Kirby (2003) found that when adolescents believed that their peers were having sex, they were more likely to have sex themselves. It is general knowledge that peers influence the sexual behaviors of teenagers. A common dimension of peer relationships that was measured by more than one study was talking with peers about sexuality issues and influenced to engage in early sexual practice. A number of studies have indicated that increased pressure from peers to engage in sexual behaviors (Laflin, Wang, & Barry) 2008 can increase the risk of early sexual onset. On other explanation in Tanzania not having a history of past or current boy/girlfriend or not having a friend who is in relationship or engages in sexual activity was associated with adolescent reduced likelihood of engaging in early sexual debut (Elia John et al; 2012).

Specific parent-child communication about sexual issues has been examined as a potential protective factor against early sexual onset. Through establishing an effective dialogue with their child, a parent can convey information on the risks of early sexual onset. Parents

who clearly communicate to their child the importance of delaying sex can help reduce the risk that their child will engage in sexual activity. In Tanzania, lack of parental communication with regards to puberty, relationship, delayed sex, impact of early sex, teen pregnancy, HIV and parent not knowing friends of his/her child was associated with higher hazard of early age at sexual debut (Elia John et al; 2012). In Bahir Dar study, those who regularly discuss sexual issues with parents are respectively, 50 percent and 57 percent less likely as others to have become sexually active (Mohammed, 2008) and in Desse participants who didn't find it easy to discuss about important matters with their mother were more likely to initiate sex-earlier (Fekadu and Alemayehu, 2009). Whereas other studies failed to find an effect, one study conducted in Africa identified that parent/child communication about sex prior to the onset of puberty acted as a *risk factor* for early initiation of sexual intercourse (Amoran et al; 2004).

MEDIA INFLUENCE

Teen sexuality is influenced by the mass media today more than any other time in history (Brown, 2002). Internet, television, music video and sexually explicit lyrics all contribute to adolescents' attitudes and behavior concerning sexual activity. Only 9% of the sex scenes on 1,300 of cable network programming discusses and deals with the negative consequences of sexual behavior (Casey, Getz & Galvan, 2008). The Internet and the anonymity therein allow adolescents real concerns relating to false information on health issues, sexuality, and sexual violence in the world of intimate sexual relationships (Subrahmanyam, et.al, 2006). This was also similarly exhibited in other studies both country and worldwide, in Asian countries (Mee-Lian, 2009) those who viewed pornography were approx. six times more likely than those who did not do so to engage in sexual intercourse.

The rate of adolescent's sexual experience is increasing; also the age at which they begin sexual intercourse is decreasing. Sexual activity has various risks like unwanted pregnancy, STI including HIV/AIDS, unsafe abortion and so on. Research studies shown that personal and biological factors, interpersonal interactions with family and peers and media influence have influence and association with early coitus up on adolescents. At this

study, investigation will be performed to assess the level at which the students (aged 15 to 19) are practicing sexual intercourse and the factors that can be associated with the act.

CONCEPTUAL FRAMEWORK

The reproductive health issue is very crucial factor for adolescents. Parent's economic status, parent education, respondent knowledge, discussion with peer, parents or others, age-sex differences, living arrangement and other factors affect it differently. We can easily see the link between the dependent and independent variables to the reproductive health problems among adolescents of the study area.

In this study, efforts made to investigate the direct influence of them mentioned variables on sexual initiation on the adolescents of Asella town.

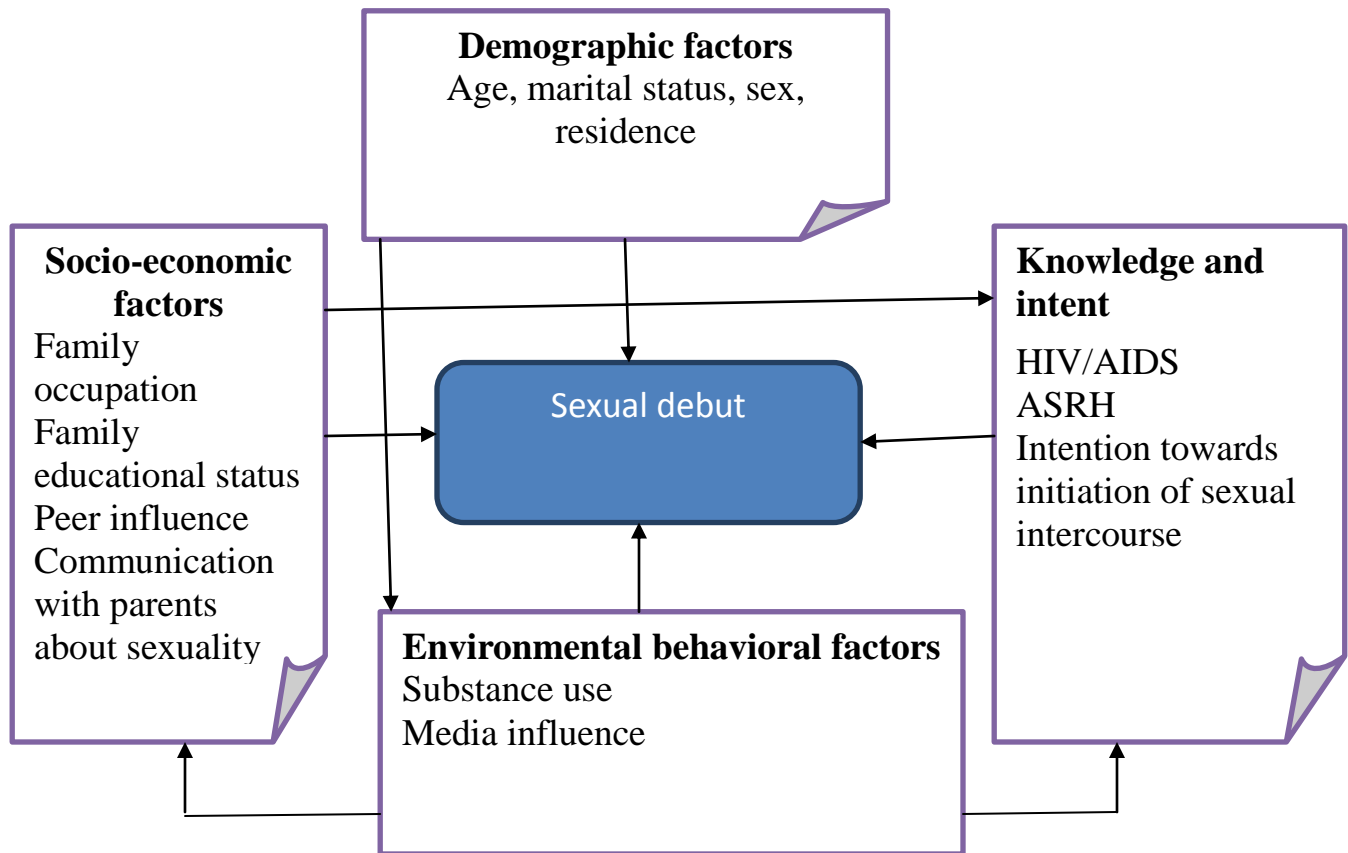


Figure 1: Conceptual Framework for the Study of Adolescent Sexual Activity in Asella town

SIGNIFICANCE OF THE STUDY

For many countries, the concern of adolescent sexuality been driven by the high prevalence of HIV/AIDS among young people. In other countries, a central concern has been early childbearing; and still others have focused predominantly on sexual behaviors among adolescents.

Despite the high rates of early pregnancy and the associated sequel relating to sexual debut in sub-Saharan Africa including Ethiopia, to date there has been no research that has explored the magnitude and prevalence of the timing of sexual intercourse among adolescents at this area.

Increasing our knowledge of adolescent sexuality is essential to equip prevention efforts that meet the needs of youth with different sexual expectations and experiences. Also adolescent sexual health or generally adolescence sexual and reproductive health is the main concern of government policy as the component of MDG combating HIV/AIDS and promoting maternal and child health.

As a result, the aim of this study is to add information in this area and fill the gap, specifically to assess the magnitude and factors associated with sexual debut among in-school adolescents in Asella town.

OBJECTIVE

GENERAL OBJECTIVE

To assess the magnitude and factors associated with sexual debut among in-school adolescents in Asella town 2012.

SPECIFIC OBJECTIVE

1. To assess the magnitude of sexual debut among in-school adolescents in Asella town.
2. To describe the associated factors of sexual debut among in-school adolescents in Asella town.

CHAPTER THREE: METHODOLOGY

3.1 STUDY AREA AND PERIOD

The study area, Asella, is situated at about 175 km southeast of Addis Ababa in a highland plateau region rising to a height of 2000-3000 meter above sea level. Both Arsi zone and Asella are characterized by mild subtropical weather with maximum and minimum temperatures ranging from 18°-28°C and 5°-10°C, respectively. There are 7209 adolescents the schools of the town. There is FGAE works on Youth health and local NGOs that acts on adolescents in the town on prevention of HIV/AIDS and counseling.

The study was conducted on the adolescent students of high school and preparatory school of Asella town that constitutes 1 preparatory school, 2 governmental high schools and 1 private high school from May 30 to June 20 2012.

3.2 STUDY DESIGN

A school based cross-sectional study design with quantitative and qualitative methods of data collection was used.

3.3 DETERMINATION OF POPULATION

3.3.1 Source population

The source population for the study was all adolescents aged 15-19 years in Asella town who were attending the school during the study period.

3.3.2 Study population

All randomly selected adolescents aged 15-19 years who were attending class during the study period in the schools.

3.4 SAMPLE SIZE AND SAMPLING TECHNIQUE

3.4.1 Sample size determination

The required sample size for the study was determined using single-population proportion. Using the formula for single population proportion and taking 31% prevalence, the proportion of respondents for the study was determined. 95% confidence interval, 5% precision and 10% non-response rate was taken.

$$n = \frac{(Z_{\alpha/2})^2 p (1-p)}{d^2} = \frac{(1.96)^2 0.31(0.69)}{(0.05)^2} = 329$$

Where n = the maximum sample size

P=an estimate of proportions of premarital sex among in-school youth, 31% from study conducted in Oromia region. (HAPCO, 2000).

d= of sampling error tolerated

Using the above formula sample size of 329 were obtained and adding contingency 10% it becomes 362.

3.4.2 Sampling techniques

A simple random sampling design was used to identify the study subjects. The three high schools and one preparatory school, Alem, Andinet and Chilalo high schools and Asella preparatory are selected for the study. There were a total of 7209 students; the sample was selected from each school using probability proportional to size allocation. Then the number of study subjects from the each grades of the schools determined proportional to the size allocation. Finally, simple random sampling without replacement was used to select the subjects from every section of the single grade.

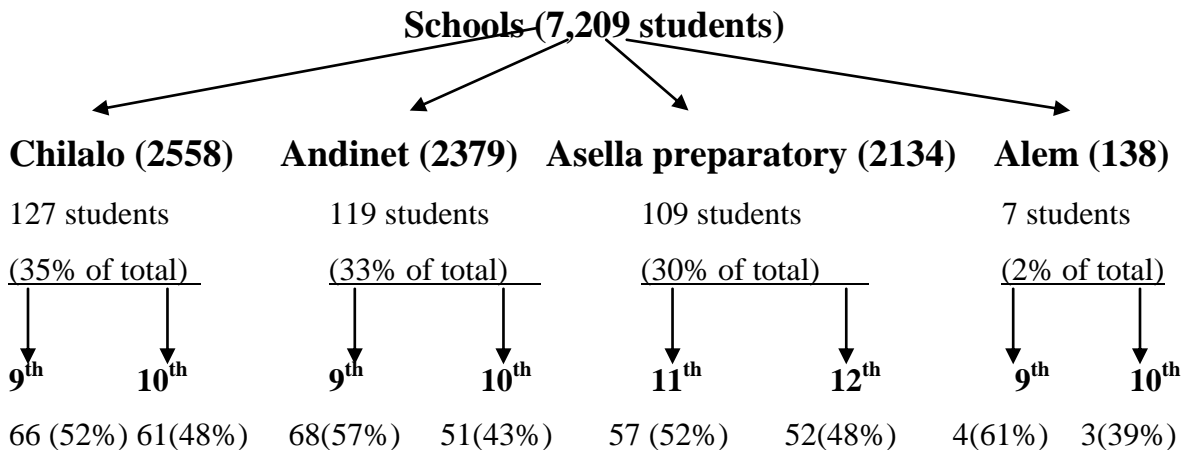


Figure 2 Schematic Presentation of sampling technique

Inclusion criteria

All regular day time students aged 15 to 19 years at the time of data collection were included.

3.5 VARIABLE

Dependent variable

Sexual debut

- Zero labeled as never experience sexual intercourse
- One labeled as ever experience sexual intercourse

Independents variables

Socio-demographic

- Age, sex, marital status and residence

Socioeconomic variables

- Substance abuse (alcohol, khat, and drugs),
- Family income
- Peer influence
- Media influence
- Communication about sexuality with parents

Knowledge and intent towards sexuality

- HIV/AIDS and ASRH knowledge and
- Intention to have sexual intercourse

3.6 DATA COLLECTION AND MEASUREMENTS

3.6.1 Quantitative data collection instruments

The data collection instrument was an anonymous closed and open-ended self-administered questionnaire. Questions were grouped according to objective that they should address. The structured questionnaire, which were developed in English translated into Amharic language and then back-translated in to English by different individuals to ensure validity and keep its conceptual equivalence. Moreover, pre-test has been done in 18 (5%) of the students in one of the schools (“Andinet” high school) and not included in the actual data and appropriate modification was made to have the final version.

Data collectors were allocated and supervisors facilitated the process of data collection.

3.6.2 Qualitative data collection technique

In depth interview was conducted after the collection of quantitative data using in-depth interview guide. This was employed in eight students from the schools. The students were selected from records at the counseling units who have history of risky sexual behaviors.

3.7 DATA PROCESSING AND ANALYSIS

3.7.1 Data handling

To keep its completeness and internal consistency, the collected data was checked, coded and stored appropriately. The soft copies and hard copies of the data stored properly and kept safely.

3.7.2 Data analysis

3.7.2.1 Quantitative data analysis

After checking, data entry in to SPSS program version 16.0 was carried out. During the process of analysis, frequencies and percentages of different variables were determined. Bi-variate and multi-variable logistic regression model used to assess factors affecting sexual initiation. This was done by entering each independent variable separately into bi-variate analysis. Then variables that showed statistical association with p-value of less than 0.25 on bi-variate analysis were selected as candidates for the multi-variable logistic regression analysis and significant association was declared at p-value less than 0.05.

3.7.2.2 Qualitative data analysis

In the qualitative data was transcribed and analyzed thematically. The document was coded using text marker manually to generate issues and ideas expressed by the participants were brought in to a single category labeled by a word taken from the data. Reading and coding was started in the process of data collection.

3.8 QUALITY CONTROL MEASURE

Before the data collection started two days of training was given to the ten college student data collectors and two supervisors and pre-test was done on 5 % of the study population. During data collection, supervisors did close field supervision to overcome any mistakes

from data collectors and reported to the principal investigator daily. On each data collection day, 5 percent of the collected data was reviewed by principal investigator. After data collection was completed, data was critically checked for its completeness, entered, coded, edited, cleaned, properly organized and analyzed using the above mentioned software according to the standard.

3.9 ETHICAL CONSIDERATIONS

Research permission was taken from Jimma University and ethical clearance was obtained from the ethical review committee. The letter was submitted to higher officials of the schools for the purpose of permitting data collection.

Information was provided to all on the objective of the study. Privacy was kept by separating the rooms for male and female respondents while filling questionnaires. The respondents assured that information will not be used for other purposes and names were not stated to confirm confidentiality. The participants were assured that they have full right to participate or not in the study.

DISSEMINATION AND UTILIZATION OF RESULT

The finalized paper will be submitted to Jimma University in three copies. A copy of this material will be given to the schools and efforts will be done to publish the findings in a scientific journal.

3.10 OPERATIONAL DEFINITIONS AND TERMS

Sexual debut: refer to the age at first sexual intercourse.

Adolescent: for the purposes of this study, adolescence is considered to encompass approximately ages 15-19 (middle and late adolescence period). (WHO, 2003)

Multiple partners: the likelihood of having more than one of sexual partners at a time in the last 3- months before the survey.

Substance use: defined as consumption of drugs, alcohol, and tobacco in this period.

Peer influence: the strong influence of a group, on members of that group to behave as everyone else does.

Spend spare time with: defined as the time that adolescents spend the time out of school and might expose them to peer pressure.

Media influence: refer to the powers/persuade/control in which mass media affect how their audiences think and behave in sexual matters.

Communication with parents about sexuality: refer to the chance of adolescents to have open discussion about sexual matters with their parents.

CHAPTER FOUR: RESULT

4.1 RESULT OF QUANTITATIVE DATA

4.1.1 Socio-demographic characteristics of the study population

Three hundred sixty of the total 362 school adolescents who were invited completed the survey questionnaire making the response rate of 99.5%. Two questionnaires (0.5%) were disregarded due to incompleteness. Among the total of 360 participants, 210 (58.3%) were males, while more than half of them 199 (55.3%) were aged between 15-17 years. Nearly all the respondents 357 (99.2%) were unmarried and 165 (45.8%) were orthodox Christians and 132 (36.7%) were Muslims. Most 230 (63.9%) of the adolescents were from Oromo ethnicity while two third (66.1%) were members of nuclear family and 254 (70.6%) of the adolescents were living with their parents during the survey. (Table 4.1)

Table 4.1: Socio-demographic characteristics of the study population, Asella, 2012

Variables		Frequency	Percentage
Age	15-17	199	55.3
	18-19	161	44.7
Sex	Male	210	58.3
	Female	150	41.7
Marital status	Single	357	99.2
	Married	3	.8
Religion	Orthodox	165	45.8
	Muslim	132	36.7
	Protestant	46	12.8
	Others	17	4.7
Ethnicity	Oromo	230	63.9
	Amhara	98	27.2
	Gurage	18	5.0
	Others	14	3.9
Family structure	single parent	83	23.1
	nuclear family	238	66.1
	extended family	39	10.8
Currently leaving with	rented alone	66	18.3
	rented with friends	40	11.1
	live with family	254	70.6
Total		360	100.0

Thirty nine (10.8%) and 88 (24.4%) of the respondents' fathers and mothers were illiterate respectively. Almost half (49.2%), of fathers of the adolescents were government employees while about one-third (34.2%) of their mothers had no job at the time of the study. Resource-wise, 80.3%, and 94.4% of the respondents had TV and radio at their houses respectively (Table 4.2).

Table 4.2: Description of parents of the study population by education, occupation and economic status, Asella, 2012.

Variable		Frequency	Percentage
Father educational level	Illiterate	39	10.8
	grade 8	96	26.7
	grade 12	88	24.4
	college +	137	38.1
Mother educational level	Illiterate	88	24.4
	grade 8	121	33.6
	grade 12	92	25.6
	college +	59	16.4
Father's job	Governmental employee	177	49.2
	NGO employee	37	10.3
	Merchant	34	9.4
	Bar tender	2	.6
	Farmer	97	26.9
	No job	11	3.1
Mother's job	Governmental employee	86	23.9
	NGO employee	17	4.7
	Merchant	53	14.7
	Cashier	11	3.1
	Farmer	66	18.3
	No job	123	34.2
Have TV at home	No	69	19.2
	Yes	289	80.3
Have radio at home	No	20	5.6
	Yes	340	94.4
Total		360	100.0

4.1.2 Sexual history of the adolescents

The magnitude of sexual debut among adolescents was 109 (30.3%) at the time of the survey, of which 82 (75.2%) were males. The mean age at first sexual intercourse was 16.8 years. Among those who started sex 37 (33.9%) had sexual intercourse within the last three

months, while 11 (29.7%) had more than one sexual partner, 21 (56.7%) had unprotected sex (without condom) and more than three quarter (75.7%) of the respondents did not use alcohol before sexual intercourse. (Table 4.3).

Table 4.3: Description of study population by their past 3 months sexual history, Asella, 2012.

Variables		Frequency	Percentage
Sex in the past three months (n=109)	Yes	37	33.9
	No	72	66.1
Multiple partner (n=37)	Yes	11	29.7
	No	27	70.3
Unprotected sex (n=37)	Yes	21	56.7
	No	17	43.3
Sexual intercourse after alcohol use (n=37)	Yes	9	24.3
	No	28	75.7

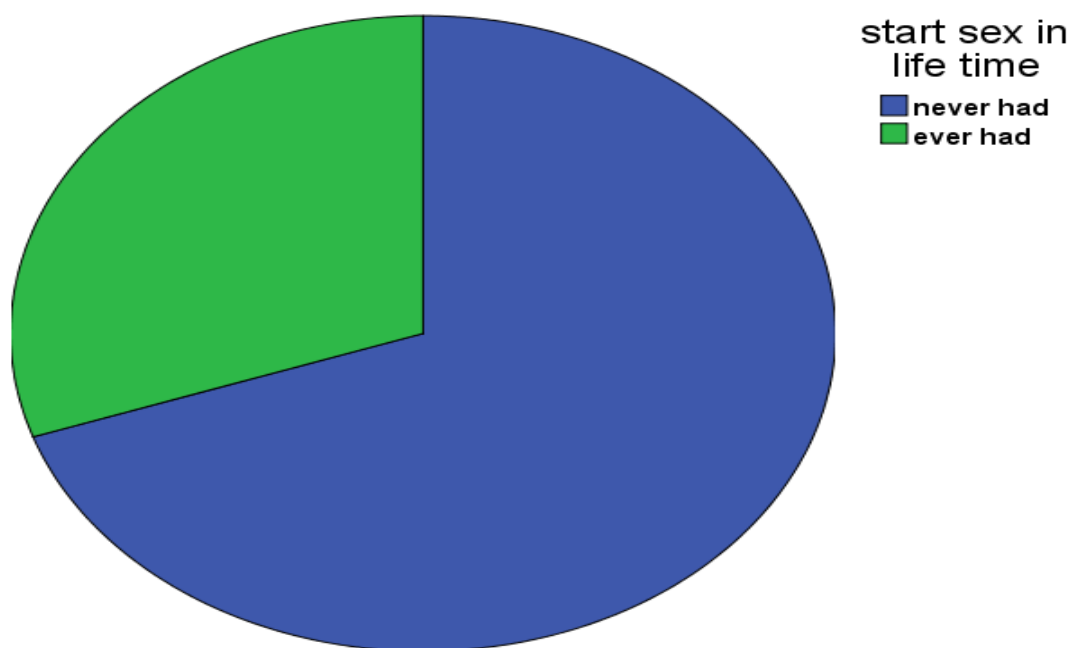


Figure 3: Sexual experience among school adolescents in Asella, 2012

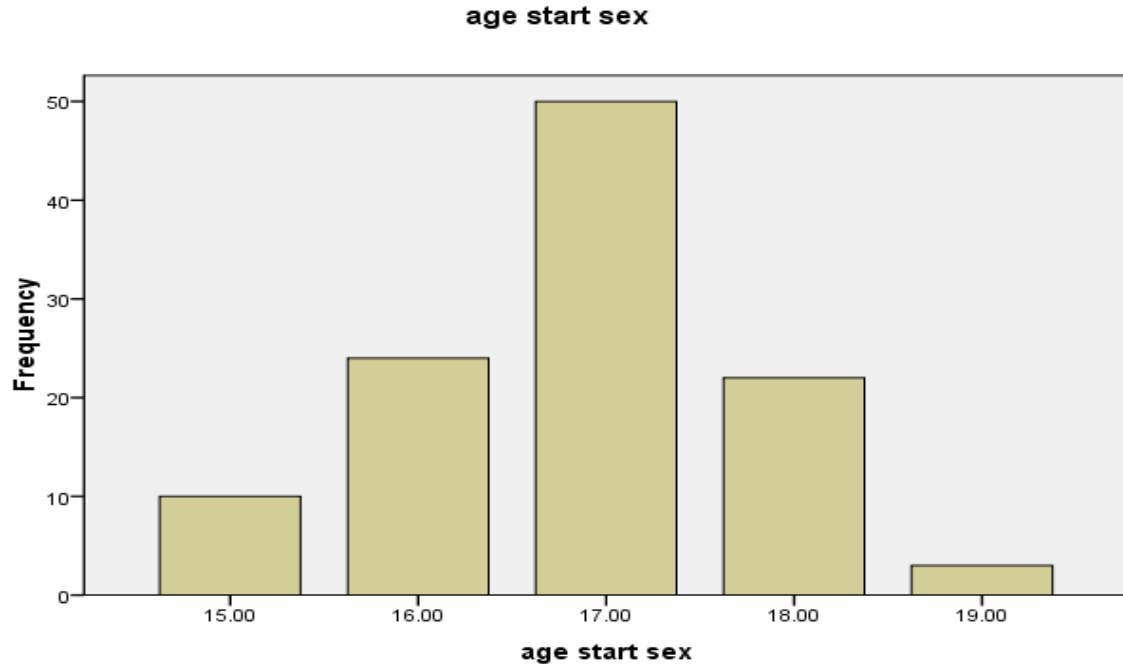


Figure 4: Presentation of age at which sexual intercourse started with in study population, Asella, 2012.

4.1.3 Bi-variate and multi-variable factors associated with sexual debut

In uni-variate analysis, demographic factors including age ($p=0.00$), being female gender ($p=0.00$) and renting alone ($p=0.00$) were associated. Among socio-economic variables; having literate parents, availability of resources in the house of the adolescents like TV $P=0.08$ and radio $p=0.1$, formal employees of parents $p=0.02$ and $p=0.05$ for the mother and father respectively, substance use (cigarette $p=0.006$, chat $p=0.00$ and alcohol $p=0.00$), peer influence which was evaluated by spending spare time other than families, deciding issues by themselves without influence ($p=0.00$) and pressure from peers to have sex ($p=0.00$), clubbing ($p=0.00$) and smoke ($p=0.00$) whereas, media influence was assessed through viewing pornography ($p=0.00$) alone or with boy/girl friend had significant association with the outcome variable. Intention towards starting sex out of school and having a chance to communicate with parents and teachers about sexual matters were variables used to assess knowledge and perception of the adolescents and found to be significantly associated.

Multivariable logistic analysis was used to identify the factors associated with sexual debut among adolescents aged 15-19 in the schools. Among the socio-demographic data age of the respondents in category, sex residence family structure father's educational level and father's job were evaluated and found significantly associated. Accordingly, adolescents from 18-19 age group were more likely report sexual debut AOR 2.7 95% CI (1.5, 5.1) while the odds having sexual debut among female adolescents was 0.54 times that of male adolescents AOR 0.54 95% CI (0.29, 0.99), adolescents who rented alone had twice an increased risk than those who lived with their families AOR 2.2 95% CI (1.0, 4.7). Adolescents from father who has no job had an increased experience of early sexual intercourse than employed fathers AOR 7.2 95% CI (1.1, 45.9) after controlling for other confounding variables.

Among socio-economic data; substance use, peer influence and media exposure and influence were found to be significantly associated. Accordingly, the odds having sexual debut among non-smoker adolescents and non-alcohol user was 0.26 and 0.19 times that of smoker and alcohol user adolescents AOR 0.26 95% CI (0.07, 0.92) and AOR 0.19 95% CI (0.09, 0.46) respectively, while adolescents who spent their spare time with their boy/girlfriends were more than seven times likely reported sexual experience than spent with their families AOR 7.5 95% CI (2.3, 24.0) and pushed by their peers to smoke and have sex had four times an increased compared to never pushed to report early sexual activity with AOR 4.1 95% CI (1.5, 16.1) and 4.5 95% CI (2.1, 9.3) respectively. Adolescents who watched pornography were nearly three times more likely to experience sex AOR 2.90 95% CI (1.2, 6.5) after controlling other confounding factors. In addition, the odds having sexual debut among adolescents who were comfortable to talk with their fathers was 0.35 times those of uncomfortable AOR 0.35 95% CI (0.13, 0.94) after controlling other confounding factors.

Among sexuality knowledge and intention towards sexual intercourse data; intent to engage in sexual activity has significant association with the dependent variable. Compared to adolescents intended to have sex in the school, those who reported after finishing school and after marriage were less likely to engage in sexual activity AOR 0.25 95% CI (0.09, 0.64) and 0.01 95% CI (0.04, 0.64) respectively. (Table 4.4.1 and 4.4.2)

Table 4.4.1: Variables evaluated for possible association with sexual debut among in-school adolescents, Asella 2012

VARIABLES	Sexual debut		OR (95%) CI	
	Never had	Ever had	Crude	Adjusted
Age				
15-17	165 (65.7)	34 (31.2)		
18-19	86 (34.3)	75 (68.8)	4.23 (2.61, 6.85)	2.8 (1.5, 5.1)
Sex				
Male	128 (51.0)	82 (75.2)		
Female	123 (49.0)	18 (24.8)	0.47 (0.21,0.56)	0.54 (0.29, 0.99)
Residence				
Live with family	191 (76.1)	63 (57.8)		
Rented with friends	28 (11.2)	12 (11.0)	1.29 (0.62,2.70)	0.78 (0.29,2.11)
Rented alone	32 (12.7)	34 (31.2)	3.22 (1.83,5.64)	2.2 (1.0, 4.7)
Father's job				
Employed	166 (66.1)	48 (44.9)		
Non-employed	81 (32.3)	52 (48.6)	1.60 (0.72,3.53)	1.76 (0.76, 4.09)
No job	4 (1.6)	7 (6.5)	2.06 (0.93,4.55)	7.2 (1.1, 45.9)
Cigarette smoking				
Yes	7 (2.8)	11 (10.1)		
No	244 (97.2)	98 (89.9)	0.26 (0.0,0.68)	0.26 (0.07, 0.92)
Alcohol use				
Yes	17 (6.8)	33 (30.3)		
No	234 (93.2)	76 (69.7)	0.17 (0.09,0.32)	0.19 (0.09,0.46)

Table 4.4.2: Variables evaluated for possible association with sexual debut among in-school adolescents, Asella 2012

VARIABLES	Sexual debut		OR (95%) CI	
	Never had	Ever had	Crude	Adjusted

Spent spare time with				
Family	100 (39.8)	22 (20.2)		
Relatives	11 (4.4)	10 (9.2)	4.13 (1.56,10.93)	2.32 (0.54,9.80)
Friends	127 (50.6)	55 (50.5)	1.97 (1.12,3.44)	0.83 (0.37,1.86)
Boy/girlfriend	13 (5.2)	22 (20.2)	7.69 (3.37,17.58)	7.5 (2.3, 24.0)
Pushed by friend to smoke				
Never insisted	242 (96.4)	83 (76.1)		
Ever insisted	9 (3.6)	26 (23.9)	8.42 (3.79,18.71)	4.9 (1.5, 16.1)
Pushed by friend to have sex				
Never insisted	210 (83.7)	46 (42.2)		
Ever insisted	41 (16.3)	63 (57.8)	7.01 (4.23,11.64)	4.51 (2.2, 9.3)
Watched pornography				
No	137 (54.6)	27 (24.8)		
Yes	114 (45.4)	82 (75.2)	3.65 (2.21,6.02)	2.9 (1.3, 6.5)
Intent to start sex				
In the school	14 (5.6)	50 (45.9)		
After finishing school	56 (22.3)	25 (22.9)	0.12 (0.06,0.27)	0.25 (0.09,0.64)
After marriage	181 (72.1)	34 (31.2)	0.05 (0.03,0.11)	0.11 (0.04,0.25)
Level of comfort with father				
Uncomfortable	169 (67.3)	95 (87.2)		
Comfortable	77 (30.7)	14 (12.8)	0.32 (0.17,0.60)	0.35 (0.13,0.94)

CHAPTER FIVE: DISCUSSION

The proportion of adolescents who started sex in the current study was 30.3%. Worldwide, sexual debut is at an increasing rate among adolescents both in the community based and school based studies. The current study's prevalence was found to be less than some of the

developed countries and some of developing countries. For instance US with the prevalence was 50% of 9th to 12th graders report (Blum et al; 2000, CDC, 2000). In Europe; higher magnitude than the study conducted in Oslo with prevalence of sexual debut among 16 years old in-school adolescents was 25% (Ann-K et al; 2005). The most recent estimates of 'current sexual activity' in the Western Australian Aboriginal community, indicate that 43.9% of 16 year olds and 33.4% of 15 year olds had initiated intercourse (Blair et al; 2005). The magnitude of sexual debut was also found to be less comparing to some of the countries in Africa; for example, the incidence of adolescents reported to be sexually active at the study conducted in Tanzania was 48.7% (Elia John et al; 2012) and on the national survey employed in Nigeria on adolescents aged 15-19, the prevalence of early sexual intercourse was 80.2% (Adesegun and Robert, 2008).

The finding was higher than national survey conducted in Ethiopia in 2000 which was 19%. However, it is almost equivalent with the study obtained in Oromia survey 31.3% (HAPCO, 2000). Early sexual debut among school adolescents in the study area is higher than some other study findings. In Nekemte, for example, the prevalence was 21.5% (Assefa and Dessalegn, 2008). This was substantiated by the in-depth interview which emphasized that early sexual activity in the study area was uncommon and currently becoming practicable. Although the studies were comparative, the current study has lower magnitude than different areas in Ethiopia. For example, in Harar where 65% of males and 20% of females were sexually active (Bisrat, 1992). In Addis Ababa, for example, the proportion was 39.8% for males and 5.6% for females (Eshetu et al; 1999). In Gondar, it was 46.2% and 16.2% for males and females, respectively (Dawud, 2003). At the study conducted in Bahir dar town 44.4 percent of females and 47.5 percent of male respondents had already exposed to sexual intercourse at least once (Mohammed, 2008).

In this study, the mean age at first sexual intercourse was about 16.8. The mean age of the adolescents at first sexual intercourse in the current study falls within the range of other similar studies both in the country and in the continent. The median age of first sexual intercourse in China was 16 years (Mee-Lian et al; 2009). The mean age at sexual debut in Tanzania was 14.6 \pm 2.3 years (Elia John et al; 2012). The median age of sexual debut in Nigeria was 15 years for males and 16 years for females (Adesegun and Robert, 2008).

Ethiopian DHS (2000) also found out that the median age for the first sexual intercourse was 16.3 years. Mean age of sexual initiation in Desse study was 16.8 ± 2.25 years (Fekau and Alemayehu, 2009). Study in Bahir Dar town was 15.45 ± 2.3 years for females and 16.7 ± 1.28 years for males (Mohammed 2008). Compared to a study conducted in Nekemte the mean age at first sexual intercourse was $15.3 + 1.45$ for both sexes (Assefa and Dessalegn 2008) the current finding's mean age at which they started sex was increased.

The results of the analysis in this study unlike other studies showed late adolescents were nearly three times more likely report sexual debut. For instance; in Tanzania increase in age from 18 years and above was significantly associated with decreasing rate of early sexual debut among male adolescents but not among females (Elia John et al; 2012). In Nekemte, age less than 18 years was found to be protective against premarital sexual practice (Assefa and Dessalegn 2008) and in Desse younger age group AOR 2.82 (1.95, 4.08) was tend to initiate sexual intercourse earlier (Fekau and Alemayehu, 2009). Gender being female was found to be protective from sexual debut. Likewise, study in Nekemte in which male adolescents were more likely to report premarital sexual experience than females (Assefa and Dessalegn 2008). However, in Desse (Fekau and Alemayehu 2009), being female were tend to initiate sexual intercourse earlier and A.A shows trend among females toward earlier initiation of sexual activity (Mohammed 2008). The protectiveness of being female in the study area could be related to cultural norm, practicing sex before marriage for females is not accepted by majority of the community and this norm is factual not only for the study area but also in Ethiopia females are presumed to have sex with in wed lock.

Adolescents who rented alone had twice an increased risk than live with their families this mostly shows that they are separated from their families. From other studies living away from home was also proven to be an important factor to adolescent sexual behavior. Studies found that when adolescents lived away from home at an early age, they were more likely to have had sex compared with those who stayed at home. For example, in Philippines found that males who experienced separation from home had a greater likelihood of premarital sex compared with those who had not experienced living away

from home. (WHO, 2005). In Bahir Dar, currently living with their parents has higher chances of avoiding early sex than those who were not living with their parents.

Adolescents from father who has no job had an increased experience of sexual intercourse than employed fathers. Having no job as a father might indicate that the source of income for the family is from other means and probably not adequate for daily living, teaching children and the likes. So adolescents from such type of family might intrude to a life style pattern of unhealthy risk behavior towards sexual activity to gain money especially females. The finding that no parental occupation appeared to trend toward higher odds of reporting initiation of sexual activity requires further exploration.

In general peer pressure has effect on the behavior of adolescents. Pushed by their peers to smoke and have sex had four times an increased compared to never push to report early sexual activity and adolescents who spent their spare time with their boy/girl friends were more than seven times likely reported sexual experience than spent with their families so that this will be subsequent by prone to lax behavior towards sexual activity.

The available longitudinal evidence indicates that the perception of increased peer sexual activity and the perception of positive peer attitudes toward sex significantly increase the risk of early sexual onset of adolescents (Carvajal et al., 1999; Kinsman et al., 1998). A number of studies have indicated that increased pressure from peers to engage in sexual behaviors (Laflin, et al) 2008 can increase the risk of sexual onset. On other explanation in Tanzania not having a history of past or current boy/girlfriend or not having a friend who is in relationship or engages in sexual activity was associated with adolescent reduced likelihood of engaging in sexual debut (Elia John et al; 2012).

It is also emphasized on qualitative study as it was explained that both males and females students are influenced by peers especially in their compound, particularly female students started sex for the exchange of gifts from rich people and mark from their teacher when their grade declines.

Media exposure is evaluated in study through watching sex materials like pornography; adolescents who watched pornography were nearly three times more likely to be experiencing sex. This was also similarly exhibited in other studies both country and

worldwide, in Asian countries (Mee-Lian, 2009) those who viewed pornography were approx. six times more likely than those who did not do so to engage in sexual intercourse.

The in-depth interview also pointed out that adolescents spent their spare time by watching pornography through internet and VCD may be seduced for sexual interaction with opposite sex.

Sexual activity has been found to be an indicator of a larger lifestyle pattern of unhealthy risk behaviors, including using tobacco, alcohol, and illicit drugs. Non-smokers and of non-alcohol users were more likely to be protected from sexual debut; several studies in one or other way shown the same association. For instance, in US those who were current smokers or former smokers were significantly more likely to have engaged in sexual intercourse than youth who had never used cigarettes (CDC, 1998). Also sexually active high school students reported using alcohol or drugs during their most recent sexual encounter (The Henry J. Kaiser Family Foundation, 2009). A survey of a representative sample of the Australian population indicated that, of secondary school students who had experienced sexual intercourse, 22.7% were under the influence of drugs or alcohol their first time (Smith et al; 2002). Ten studies were analyzed from developing countries that explored the relationships among risky non-sexual behaviors and sexual initiation among adolescents, for example three out of five studies found that smoking cigarettes was significantly associated with an increased likelihood of having sex. Eight out of nine studies found that using alcohol significantly increased the odds that an adolescent has already engaged in sex (WHO, 2005). In Nigeria those who reported drinking were about twice as likely to report having had sexual intercourse (Adesegun and Robert, 2008). Similarly in Amhara region Desse those who drink alcohol were two times more likely to initiate sexual intercourse before the age of 18 (Fekadu and Alemayehu, 2009).

Compared to adolescents who intended to have sex while they are attending their schooling, adolescent who have plan to have sex after finishing school and after marriage were less likely to experience sex. In Melbourne, Australia, a strong intent to engage in early sexual activity is thought to increase the likelihood of adolescent actively seeking sexual encounters (Fishbein & Ajzen, 1975). Similarly, in Malaysia, found that adolescents with more permissive sexual attitudes were five times more likely to experience sex,

compared to those with conservative attitudes (WHO, 2005). Specific parent-child communication about sexual issues has been examined as a potential protective factor against early sexual onset. Through establishing an effective dialogue with their child, a parent can convey information on the risks of sexual practice during this period. Parents who clearly communicate to their child the importance of delaying sex can help reduce the risk that their child will engage in sexual activity. Likewise, adolescents who are comfortable to talk with their fathers about sexual issues in the current study were less likely to experience early sexual debut. In Tanzania, lack of parental communication with regards to puberty, relationship, delayed sex, impact of early sex, teen pregnancy, HIV and parent not knowing friends of his/her child was associated with higher hazard of early age at sexual debut (Elia John et al; 2012). In Bahir Dar study, those who regularly discuss sexual issues with parents are less likely as others to have become sexually active (Mohammed, 2008) and in Desse participants who didn't find it easy to discuss about important matters with their mother were more likely to initiate sex-earlier (Fekadu and Alemayehu, 2009). Whereas other studies failed to find an effect for example, One study conducted in Africa identified that parent/child communication about sex prior to the onset of puberty acted as a *risk factor* for early initiation of sexual intercourse (Amoran et al; 2004).

The other factor identified from the qualitative assessment of this study was "*girls' bad clothing styles*" such as tight trousers, short skirts and short T-shirts that expose their body, which increases boy's attention. One interviewee stressed, "*Girls' clothing styles mislead boys' when they come with that kind of cloth we will be tempted, so it is better to have appropriate closing*".

CHAPTER SIX: CONCLUSION AND RECOMMENDATION

6.1 Conclusion

One hundred nine (30.3%) of adolescents in the current study started sexual intercourse. Residence, peer pressure, substance use, media influence and attitude about sexual initiation and parental communication about sexual matters were the factors associated with sexual debut.

While age of the adolescents greater than 18 years, renting alone, pressure from peers to unhealthy risk behaviors like smoking and sexual activity, spending spare time with boy/girlfriend and media influence mentioned as watching pornography were positively associated (found to be risk) with sexual debut in the study area.

Being female gender, avoiding use of substances like alcohol and cigarette, intention to delay sexual practice and communicating with fathers about sexual matters was found to be protective against sexual debut (negatively associated).

6.2 Recommendation

- Generally it is better to increase awareness about sexual intercourse and its negative effects during this period. This will be achieved by maximizing the availability and accessibility of youth friendly services to maintain sexual and reproductive health of adolescents. In addition, accessing IEC and BCC materials in the schools through anti-HIV/AIDS and related clubs to transfer information about adolescent reproductive and sexual health can increase their awareness.
- Peer and media influence can be minimized in collaboration with the families, school teachers and adolescents themselves. Parents should raise their children by building self-esteem and with open discussion so that they can be able to decide bigger issues independently regardless of peer pressure and they can realize different issues during transition period.

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ANNEX

Jimma University
College of Public Health and Medical Science
Department of Population and Family Health
Questionnaire

I am graduate student from Jimma University College of Public Health and Medical Science Department of Population and Family Health. I am here to conduct a research on Sexual debut of adolescents aged 15-19 with the objective of identifying the magnitude and associated factors of sexual initiation in Asella in-school students for the purpose of fulfilling the requirement for masters on RH. The study will provide information about the high school adolescent community of this area for developing future plans in protection and intervention programs at zonal level and for policy makers nationally. Attending in the study does not cause any harm for you or anyone in the school.

You have full right to participate or not in the study. For the purpose of privacy and confidentiality your name will not be written on this questionnaire, and will never be used in connection with any of the information you delivered. You are selected for this study only by chance, not intentionally, so I would be thankful if you spend some time answering questions.

Your honest answers to these questions will help us for better findings. I would greatly appreciate your help in responding this research. May I get your permission to continue?

Yes

No

Thank you!

I. Demographic information

1. Age

15 16 17 18 19

2. Sex

M F

3. Marital status

Single Married

4. Residence

Rented alone Rented with friends Live with family

5. Religion

Orthodox Catholic
Muslim Protestant Other

6. Ethnicity

Amhara Tigre
Oromo Gurage Other

II. Socioeconomic data

7. What is your family structure?

Single parent Large family
Nuclear family

8. Father's educational level

Illiterate Up to grade 8
Complete up to grade 12 College and above

9. Mother's educational level

Illiterate Up to grade 8
Complete up to grade 12 College and above

10. Do you have Television in your house?

Yes No

11. Do you have radio in your house?

Yes No

12. What is your father's job?

Governmental employee Bartender

Non-governmental employee Farmer

Merchant No job

13. What is your mother's job?

Governmental employee Cashier

Non-governmental employee Farmer

Merchant No job

14. Who pays for your school fee?

Parents Relatives Boyfriend Husband

15. Do you smoke cigarette? Yes No

16. If yes, how much per day? _____

17. Do you chew chat? Yes No

18. If yes, in what interval per month _____

19. Do you drink alcohol Yes No

20. If yes, how often _____

21. With who do you spent your spare time?

Families Friends Relatives Boy/girl friend

22. How are you connected with your friend?

I hangout a lot with my friends/peers

I tend to follow what my peers/friends do, even if other people disapprove of it

I am accepted by my friends/peers

I decide things even though they push me not to

23. Does your friend insist you to smoke with her/him?
- Always Sometimes Never
24. Does your friend ask you to go to club with her/him?
- Always Sometimes Never
25. Does your friend push you to have sexual intimation with rich persons?
- Always Sometimes Never
26. Have you read or watched TV/movies about persons with STI/HIV/AIDS?
- Always Sometimes Never
27. Have you read/watch pornography?
- Always Sometimes Never
28. Have you watched pornography with your girl/boy friend?
- Always Sometimes Never
29. How is your relation with your mother?
- She supports every of my actions
- She opposes every of my activities
- She tells me what's wrong and right
- She doesn't even want to see me
30. How is your relation with your father?
- He supports every of my actions
- He/he opposes every of my activities
- He/he tells me what's wrong and right
- He/he doesn't even want to see me

31. How comfortable or uncomfortable would you feel talking about sexual matters with?

Your father Comfortable Uncomfortable

Your mother Comfortable Uncomfortable

Your teachers Comfortable Uncomfortable

III. Sexuality knowledge

32. Do you know how HIV is transmitted from one person to another?

Yes No

33. From where did you hear it?

My parents told me

From media

In the school

Other, specify _____

34. Do you have a council who communicates about sexual health issues in your school?

Yes No

35. If yes, what are the issues

The effect of early sexual initiation

The importance of condom use

Physiological changes (puberty)

Other, specify _____

36. What is your stand about sexual intercourse?

Sex in the school is possible

I will not have sex until I finish my education

I will not have sex until I have got married

IV. Sexual experience

37. Have you involved in sexual intercourse in your life time?

Ever had

Never had

38. Age of the first sexual intercourse

15

16

17

18

19

39. Have you had sexual intercourse in the past three months?

Yes

No

40. If had, among sexual intercourse with the past 3 months

Partners more than one

Yes

No

Unprotected sexual intercourse

Yes

No

Sexual intercourse while drunk

Yes

No

Thank you!

1. °ÉT@

15 1 17 18

2. i}?

°É c?f

3. %4Öw%oo G<'@?

ÁLNv /ř ÁÑv/ç

4. %4S*]Á G<'@?

Kw%oo uÿ=^Ã uÿ=^Ã uÖ^ Ÿu? ð'

5. GÁT*f

*„Êje =i K?

S<eK=U ýa,eʃʃ

6. wN?'

*aV ,T^ Ñ<^Ñç fÓ_

7. የ ቤተሰብ አወቃቀር

ከእናቴጋር / ከአባቴጋር ብቻን ወደ ምኖረው

ከአባትና እናቴጋርን ወደ ምኖረው

አያቶቼ እና ዘመድ ከእኛ ጋር ይኖራሉ

8. %vfl/i %f/f Å[í

ÁM}T[eÿ 8- jðM

12— jðM ÁÖ"kk እ" ÿ³ uLÃ

9. %እ"fl/ñ %f/f Å[í

ÁM}T[ç eÿ 8— jðM

12— jðM ÁÖ"kkç እ" ÿ³ uLÃ

10. ,K?y=»" እu?ታ:G< :K;

>- ¾KU

11. _ÉÄ λu?ϰG< ϰK;

>- ¾KU

12. ¾vfl e^ U"É" <;

¾S"Óef c^}— j,M c^}—

S"Óeϰ⊙ ϰMJ' É'İf c^}— Ñu

'ÒÈ Y^ ¾K" <U

13. ¾λ"fl/l e^ U"É" <;

¾S"Óef c^}— 'ÒÈ

S"Óeϰ⊙ ¾MJ' É'İf c^}— Ñu

Ñ"²w Á» Y^ ¾LfU

14. ¾f/f u?f jöÁl"/i" T" " < ¾T>ÿöMMI/i

u?}cw/(λ "f/ v f) ²SÉ ("ÉU²λİf ϰÔf)...

¾"É /¾c?f ÒÁ— vM/T>ef

15. c=Í^ (fUv) ϰϣÁΛϷ(i)

>- KÍeU

16. KlØ' "16"ØÁoSMcl/i >- ÿj' uk" U"ÁIM; _____

17. Ýf fpTKI/i; >- >Mp

18. KlØ' "18"ØÁoSMel/i >- ÿj' u" " <eØ KU" ÁIM Ñ>²? _____

19. >MϰM/SÖØ fÖ×KI/i; >- >L' <pU

20. KØÁo lØ' "20"SMel/l >- ÿj' U" ÁIM _____

21. f'ö Ñ>2?l" (ÿf/u?f) "ü ÁK" Yr" Ö' ታdMóKI/i

ÿu?}cw pSÉ ከጻሎ— ÿ"É/ÿc?f öp[—

22. ÿÖÄ™i/i ÁKI Ó"—'f

አብሬ ብዙ ሰአት አሳልፋለሁ

ያሉኝንበሙ እፈጽማለሁ ሌላሰው እንኳንባይስማም

በጓደኞቼ ዘንድ ተቀባይነትን አገኛለሁ

ወሳኔዎችን በራሴ እፈጽማለሁ በጓደኛ ሳልገፋ

23. ÖÄ™i/i c=í^ እ"ÉfÖ× ÄÑóñGM/hM; ጎ- ጎw³—" > Ñ>2 ጎ"É

ጎ"É Ñ>2? ጎuß^i

24. ÖÄ™i/i "Ä Sgታ u??f/SÖØ u?fእ"ÉfN?É/í= ÄÑðñGM/hM;

ጎ- ጎw³—" > Ñ>2? ጎ"É Ñ>2? ጎuß^i

25. ÖÄ™i/i "c=w "ÉfðíU/T>ÄÑðóGM/iM;

ጎ- ጎw³—" > Ñ>2 ጎ"É ጎ? ጎuß^i

26. ÖÄ™i/i ÿK?L c"< Ö'/GwታU/ "c=w ጎ"ÉfðíT>ÄÑðñhM;

ጎ- ጎw³—" > Ñ>2? ጎ"É ? ጎuß^i

27. HIV/AIDSuÄT†"< "eØeLLv†"< c-< ጎ"wl/i "ÄU uTV,Ä}l/Ä}ñታ"<mÁKU/ñ;

ጎ- w²< Ñ>2? Ñ>2 ጎ?uß^i

28. ¾"c=w ðMU ጎÄ}l/i²"<nKI/i;

ጎ- w²< Ñ>2? ጎ"É Ñ>2 ጎuß^i

29. ¾"c=w ðMU ÿ"É/ÿc?f ÖÄ—i/l Ö' ጎÄ}g/l <ፈያለሽ /ህ;

ጎ- w²< Ñ>2? ጎ"É ጎ"É Ñ>2? ጎuß^i

30. HIV/AIDSÿc"< "Ä c"<እ"Éfእ"ÄT>}LKðታ"<nKI/i;

›- ›L¨<pU

31. KØÁolØ "31"SMel/g ›- ÝJ' ÝT"Ý¾f ÆTI/i;

Ýu?}cw Ç=Á (ÉÄ/+y=/Ò²?×) Ýf/u

K?L ÄÓKi<_____

32. uf/u?fI/i ¨<eØeK c'~}ªMÊ Ö?" Ó"ªu? ¾T>cØ }sU/iuw»K;

›- iKU ›K¨<pU

33. KØÁolØ "33"SMel/l ›- ÝJ' uU" ²<Á

ወሲብ አስቀድሞ መጀመር እና ጉዳቱን

ስኮንደም ጥቅም

በአድሜ ስለሚገጥሙ በሰውነት ላይ ስለሚጋዩ ለወጣች

ለለ (ጥቀስ) _____

34. eK ¨c=w ÁKI/g ›sU

አሁንም ት/ቤት ወስጥ ብጀምር ችግር የለወም

f/, "እcÝUÚ'e ¨c=w Sðiu »MðMÓU

ÝfÇ' uòf ¨c=w Sðiu »MðMÓU

35. Ý "fI/i Ò' ÁKI/i Ó"~'f U" ÁIM ¨<

¾TÄ'Ñ¨<" 'Ñ' ÖpLLfÄÓóK;

¾TÄ'Ñ¨<" 'Ñ' ÖpLLfn'TK;

¾f~¨< fjiM ¾f~¨<SØö »'ÁJ' f'Ó[—K; @" »fðMÓU

36.Ý »vfI/i Ò' ÁKI/i Ó"~<'f U" ÁIM ¨<

¾TÄ'Ñ¨<" 'Ñ' ÖpLLÄÄÓóM

¾TÄ'Ñ¨<" 'Ñ' ÖpLLÄn'TM

¾f—“< fiiM ¾f—“<SØö :”ÅJ’ Å’Ó[—M

Ⓜ’@” T¾f ,”E” ,ÃðMÓU

37. eK “c=w ;“ ScM Ñ<ÇÄ:” uÓMê eKT“<^f

ÿ,vfI/i Ò’ ÅS†—M ,ÅS†~U

ÿ,“fI/I Ò’ ÅS†—M ,ÅS†~U

ÿ,e}T|I/i ÅS†—M ÅS†~U

38. “c=w ðiSI/I ,#“<nKI/i; >- ,K“<pU

39. KSËS]Á Ñ>? “c=w ¾ðiuuf/¾ðiuuf °ÉT@

15 18

40. vKñffñf“^f “<eØ “c=w ðiS%M/hM;

>- ðiUÿ<U

41. KØÁolØ’ “40”SMel/i >- ÿJ’

ÿ,“É uLÃ c-< Ò’ “c=w ðiSIM/hM;

>- ÿ<U

Ø”no ¾ÔÅK“< “c=w(ÁKϕ”ÊU...) ðiSIM/hM;

>- ÿ<U

ue” S”ðe “<eØ J’l/g “c=w ðiSGM/hM;

>- Jÿ<U

¾ScÓ“KG<!