



INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural
Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso
Woreda, South West Shoa Zone.

PROJECT WORK SUBMITTED TO SCHOOL OF SOCIAL WORK, INDIRA GANDHI NATIONAL
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SOCIAL WORK

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BY

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DECLARATION

I hereby declare that the dissertation entitled **FACTOR AFFECTING EXPOSURE TO SEXUALAND REPRODUCTIVE HEALTHRISK AMONG RURAL WORK PLACEYOUTH: THECASE OF DILALA SURAYA BLOSOM FLOWER FARM, WOLISO WOREDA, AND SOUTH WEST SHOA ZONE** Submitted by me for the partial fulfillment of the MSW to Indira Gandhi Open National University. (IGNOU) New Delhi is my own original work and has not been submitted earlier, either IGNOU or to any other institution for the fulfillment of the requirement for any other programs of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from earlier work done by me or others.

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CERTIFICATE

This is to certify that Mr. Alemayehu Mamo Student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his project Work for the course **MSWP-001**. His Project Work entitled Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, and South West Shoa Zone which he is submitting, is his genuine and original work.

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Finally, would like to thank all who participated in Social Work Education and who gave me a life time opportunity to be one of the pioneers of professional trained Social Workers in Ethiopia and to get the knowledge and practice to work confidently on this study which may contributes some in improving the quality of lives on Sexual Reproductive Health of Rural Youth working in flower farm.

ACRONOMYS

AA	Addis Ababa
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adult Sexual Reproductive Health
CDC	Center for Disease Control and Prevention
CBO	Community Based Organization
DHS	Demographic Health Survey
CICPD	Cairo International Conference on population and development
FGA	Family Guidance Association
FGD	Focus Group Discussion
GOs	Government Organizations
HIV	Human Immune Virus
MOH	Ministry of Health
NGOs	Non Governmental Organization
RH	Reproductive Health
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SPSS	Statically Package for Social Sciences
UN	United Nation
UNFP	United Nation Food
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

Table of contents

Description	page
Declaration_____	i
Certificate_____	ii
Acknowledgement_____	iii
Acronyms_____	iv
Table of Content_____	v

CHAPTER ONE

1. Background of the Study

1.1. Introduction_____	1
1.2. Statement of the problem_____	3
1.3. Research Objective_____	7
1.4. Research Questions_____	7
1.5. Significance of the Study_____	8
1.6. Operational Definition_____	8
1.7. Chapterization_____	9

CHAPTER TWO

2. Literature Review

2.1 Over View of Youth SRH_____	11
2.2. Workplaces as a Subsystem for the Development of Youth Health Behaviors _____	14
2.3. Conceptual /Theoretical Frameworks _____	16

CHAPTER THREE

3. Research Design and Methodology

3.1. Study Design	17
3.2. Description of the study area	17
3.3. Study Population	18
3.4. Data Source	18
3.5. Sampling	18
3.6. Data Collection	19
3.7. Variables	20
3.8. Ethical Consideration	20

CHAPTER FOUR

4. Data Analysis and Interpretation

4.1. Findings and Analysis	22
4.2. Document Reviews and Stakeholder Analysis	29
4.3. Focus Group Discussion (FGD)	32

CHAPTER FIVE

5. Conclusions and Recommendation

5.1. Conclusion	36
5.2. Recommendation	40
Reference	42
Annex	44

CHAPTER ONE

1. Introduction

1.1. Background of the study

Youth is best understood as period of transition from the dependence of childhood to adulthood's independence. That's way, as category, youth is more fluid than other fixed age groups. Yet, age is the easiest way to define this group, particularly in relation to education and employment, because youth is often referred to a person between the age of leaving compulsory education, and finding their first jobs.

With nearly half of the world population under the age of 25, today's generation of young people is the largest in history. Youth is an age group that undergoes through physical, emotional, mental and social changes that places its life at high risk than adults for many reasons, including a willingness to take greater risks, such as having unprotected sex, unwanted pregnancy, abortion, childbearing at early age, greater vulnerability to sexual pressure, coercion and exploitation ,etc. They are growing up in a different environment, like cast system, class system, urban areas, rural areas and diversified culture than their parents: both with their opportunities such as access of basic education, creativities, interest of change in their life and working in the area of voluntary organization and highly expose for SRH problems including HIV and STI some of the challenges. One of the major challenges and powerful forces shaping today's youth is sexual reproductive health problem including HIV/AIDS (UNFPA, 2005, P .4). Reproductive health (RH) is the leading cause of morbidity and mortality world. Though almost entirely preventable, RH problems remain widespread in much of the developing world. (Ibid).

Ethiopia, having 81.2 million people is characterized with high youth population to be entering adulthood in the history of the country. This cohort who makes up 30% of the total population suffers disproportionately from negative RH outcomes. They are vulnerable to a variety of RH risks including unwanted pregnancy and sexually Transmitted Infections (STIs). Young adults are the center of the HIV/AIDS epidemic. According to the UNFPA's 2006 report, the prevalence of HIV/AIDS for male aged 15-24 was estimated between 6 and 9 % and 10_13% among women of the same age group. This age group has also the highest prevalence of sexually transmitted infections young women being highly vulnerable. (UNFPA, 2006, MOH, 2006) Different studies carried out in the country have indicated that early onset of sexual practice has resulted in series health and social problems that is 55% of the recorded maternal deaths are attributed to complications from unsafe abortion, while 13% of which occur among women under the age of 20. (MOH, 006).

However, despite these global and national scenarios with regard to the youth Sexual and Reproductive Health (SRH) problems, most reports and studies concentrate on urban areas. There is limited empirical evidence in the context of the rural areas. Particularly literature on SRH factors in emerging rural areas like as in the flower plantations areas is very scanty. The flower industry has been mushrooming in most parts of the rural area. The Exploratory interview made with some experts, stakeholders and the workforce also revealed that, the majority of the workforces within these projects are the youth, both male and female. Although the prevalence and magnitude is not well studied, various sexual and reproductive health problems are appeared to have been experienced by many youths working in these plantations. Given the increasing trend of this industry within the rural areas and concomitant increase of the RH problem,

knowledge of the links between the increasing trend of the problem and the underlying factors is useful in designing target specific programs to shed further light on appropriate social work responses.

This study is therefore aimed to identify and describe factors that affect exposure of youths working in the flower plantations to Sexual and Reproductive Health risks particularly to Sexually Transmitted Infections (STI) and unwanted pregnancies. It is intended to be conducted in Woliso Woreda, South West Shoa zone of Oromia Regional State.

1.2. Statement of the Problem

Sexually active adolescents and young people need comprehensive and age-appropriate information and services to be able to protect their sexual health and rights. The inadequacy of the information and services that young people now receive is seen in the fact that STI and HIV infection rates are highest among these age-groups; unsafe abortion levels are also very high among young people. Sexual coercion is also an important issue for young women and men, and they need the knowledge and skills to manage this risk. Many young people around the world become parents during adolescence and young adulthood and are not provided with enough information about how to prevent an unintended pregnancy and how to delay or space pregnancies. To serve them better, health care providers need information about young people's knowledge and use of contraception, including both modern and traditional methods. Information about how many adolescents and young people are having children, when they are having children and whether the children are planned provides critical knowledge for service providers, educators and advocates working to empower young people in their sexual and reproductive lives. (A Guide to Using Evidence to Improve Young People's Sexual Health and Rights, New York: Guttmacher Institute, 2013).

Since 1990s rate of sexually transmitted infection and Human Immune Deficiency virus (HIV) and levels of unsafe sexual behavior have been raising alongside continuing high rate of unintended pregnancy and abortion. Consistent data across a number of surveys indicate that youths in particular are at high risk for a number of negative health consequences related to sexual risk taking behavior, including infection with HIV and other sexually transmitted diseases and the occurrences of unintended pregnancy. Recent estimates indicates that over 60% of STI cases reported yearly among individuals under the age of 24. Globally, more than half of all HIV infections occur among 15_24 years old (Seifu, Fantahun and Worku, 2006).

As the risks associated with sexual risk behaviors continue to mount increased research efforts have been dedicated to the examination of the dynamics of rate of SRH problems, the psychosocial context in which sexual initiation and sexual risk taking behavior occur.

In Ethiopia, despite the scanty of information as compared to many sub-Saharan African Countries, different national surveys and study results indicate the youths of the country to have been confronted with a multitude of SRH problems. There is also an increasing consensus that, the trend of the sexual activity among youths has been increasing. Some studies have shown that a relatively high sexual activity rate of about 30%-60% among out of school adolescents. Sexual activity among youths in Ethiopia has resulted in large number of unintended pregnancies, and illicit abortion, which poses serious health and social problems.

The result of different researches have done so far in the area of reproductive health in general and the youth sexual and reproductive sexual risk behaviors in particular, have found out such negative health consequences to have been associated with sexual risk taking behaviors of the youths(Kotchick etal, 2001; Shabo, 2007).

Cognizant of the consequences of such risk-taking behavior based on these researches, countries have been devoted giving some attentions in devising policy instruments to prevent their occurrence. Particularly, to make these prevention efforts more effective, identification and understanding of the factors that contributed to sexual risk behavior, have been the subject of studies and the focus of many researches and agencies.

Many theoretical explanations have also been forwarded in understanding in these risk factors under different settings. Young people may also engage in sexual activities

Such as oral or anal intercourse (activities that are generally not measured in population-based surveys, including the DHS), prior to their so-called sexual debut (usually

Assumed to be first vaginal intercourse), thus increasing the value of sexual health information at an earlier age. The timing of sexual debut also indicates the latest age by

Which young people should have begun receiving guidance and support to develop decision-making skills regarding sexual activity, sexual health and sexual rights, all of which can be improved with sexuality education? .(A Guide to Using Evidence to Improve Young People's Sexual Health and Rights, New York: Guttmache Institute, 2013). Many studies and preventive approaches are directed towards knowledge of risks and means of avoiding them, attitude towards contraception, practices and accessibility of services which takes individualistic perspective, not others (Akeryod, 2006). These factors are, however, only a small subset of those that influence youth risk-taking and health-seeking behaviors. A review of the literature identified clusters of factors that are associated with risky behavior or adverse RH outcomes among U.S youths. Furthermore, the findings of previous studies suggest that, the key antecedents tend to have only small or modest effects (Menyar etal, 2003).

Accordingly, since 1990s, there have been several conceptual changes in approach to understanding of youth SRH behaviors. The range of variables shown to predict SRH behaviors, has led to statistical model emphasizing how risk or protection arises through interplay of contributions from individual, environmental and social factors (Ibid).

Thus, recent research on youth SRH has tested multiple domains of predictors, recognizing that SRH risk is not due to any significant cause but rather arises from combinations of factors: demographic variables, dispositional constructs, academic involvement, specific attitude and efficacy, community life, peers and familial support etc (Kaufman, Beals, Mitchel, Lemaster and Fickenscher, 2004).

Yet we know very little about how and which of these factors determine for having risky sexual behavior. On the other hand, many of prior researches that addresses multiple level of influences on risky sexual behaviors among the youths were concentrated primarily in the United States while developing countries where sexually transmitted infections including HIV/AIDS and other SRH problems are rampant, remained low attention (Kaufman, Clark, Menzi and May, 2004)

In Ethiopia, although some studies have attempted to identify the risk factors associated to sexual and reproductive problems in the urban and school setting, there is a particular paucity of information on the dynamics of the risk related sexual behavior of youths from the rural context, despite the fact that 85% of the population lives in rural areas (Sam brook, 2004, Francioni & Hawas, 2004). Studies on risky sexuality behaviors' in Ethiopia have very much limited themselves to the most confined and accessible adolescents in school (Alemu, 2004). Interventions attempted directly towards these problems were also emphasizing the school community. Particularly in the newly emerging floriculture industry, although more than 75 % of the workforce found to be youth and, various sexual and reproductive health problems are

appeared to have been experienced by many youths working in these plantations, no attempt was made to study the factors that predispose these youths to RH risks (BICDO, 2006).

This particular research is therefore aimed to identify and describe factors that influence risky sexual and reproductive health behavior of youths at work place setting particularly in rural workplaces of the Flower Industry found in Woliso Woreda of south West Shoa Zone.

1.3. Objective of the Study

General Objective

The general objective of this study is to identify factors that predispose youths found in the rural work places particularly in the flower industry to high risk sexual and RH behavior with respect to sexually transmitted Infections and unintended pregnancy.

Specific Objectives

- To assess individual factors that increase high risk sexual and reproductive health behaviors.
- Describe the relationship between peer influence and workplace youth sex behavior.
- Explore the effect of workplace on youth sexuality and assess their associates.

To give insight action based on the finding of the project for concerned body to take action to improve SRH of targeted population

1.4. Research Questions

The basic Research questions are:

Are there risky sexual practices that may expose the study population to STI and other RH problems?

What are potential sources of risky behaviors for youths in the project communities?

How do the youths cope with the SRH risks they face?

1.5. Significance of the Study

Carrying out such an in-depth empirical study had both basic and applied purposes. The fact that there are few empirical researches on this particular subject, the result of the research will contribute as a spring board for further study. From its practical point of view, the research as a social work practitioner was more acquainted with factors behind the study subject, existing policies, efforts and remaining gap to work on. The research finding can also serve as an input for organizations working in the area to develop appropriate strategies and approaches to address the issue.

The result of the study is believed to contribute to all stakeholders in understanding the situation of ASRH specifically STI, and AIDS in rural localities of workplaces and redesign their interventions to accommodate these emerging issues. Policy makers are also believed to benefit in reviewing the ethical standards that private firms to pursue and the contributions they have to local economies. It is also believed to be a springboard to academicians who wants further make a research on the issue

1.6. Key Concepts and Operational Definitions

For the sake of clarity and consistency in the study, the definitions of terms are given as the following:

Youths: through the word ‘Youth’ means different thing for different countries, in this study, it is defined as a segment of the society that falls in the age range of 18-24yr.

SRH Risk factors: Conditions associated with a higher likelihood of risks-taking behavior or negative outcomes, like: unsafe sex, early marriage, socio-economic status, belief and culture of the study area.

Sexual behavior / Practices: are those activities that produce sexual excitation. It includes, solitary activity (masturbation), and interpersonal activities such as kissing, touching, sexual intercourse etc (steinbug, 1985 cited in Desta, 2007i). However this study will be limited with Sexual intercourse with member of the opposite sex.

Workplaces: The workplace stands for the flower- plantation projects where workforces connect together and work in different green houses.

Kebele: -- Structural division of woreda having their own local governance limited to specific geographic area or the smallest unit of the government.

Greenhouses: is building or complex in which plant (flowers) are growing. It control over growing of plants.

Stakeholders: Organizations like: investment Office, Health Office, Women's and Child Affairs, youth and sport Office, Dilala 01kebeles interests and the ways in which these interests affect the organization's business and its viability.

Applied research: scientific investigations conducted to answer specific questions or solve practical-related problems.

Basic research: scientific investigation that involves the generation of new knowledge or development of new theories; its results often cannot be applied directly to specific situations.

1.7. Chapterazation

The first chapter was an introduction to the subject matter of SRH risk of youth. In this chapter, an attempt was made to describe the concept of SRH and STI.

Second chapter was deal with the conceptual framework and research design of the present study. A review of literature and profile of flower farm selected for study were included in this chapter.

Third chapter was consisted of research design and methodology. Fourth chapter was data entry and interpretation. Fifth chapter was conclusion and recommendation. Reference and Annex

CHAPTER TWO

2. REVIEW OF LITERATURE

2.1. Over View of Youth SRH

The issue of RH has been made as one of the global development agenda since the 1994 Cairo International Conference on population and development (ICPD), still RH problem is one of the leading cause of ill and death worldwide(UNFPA, 2005; Mohamod,2007). Despite the significant portion of the global population, youths are one of the highly affected segments of the population in terms of the RH population. They are vulnerable to RH risks for both physical as well as social reasons and often suffer long term consequences (Ibid).

In YSRH risk behavior literature; there are many models that explain the risk behavior of youths and their prevention strategies. However, the popular theories often used in the RH issues are the Social Learning Theory, the Theory of Reasoned Action, And the Health Belief Model (FHI, 1999, cited in Ali, 2007)

In the earlier years of the development of theoretical models on YSRH, the approaches were based on cognitive and attitudinal approaches to prediction of youth behaviors. However in the 1990's there have been several conceptual changes in approaches to understanding of YSRH behaviors, has led to statistical models emphasizing how risk or protection arises through an interplay of contribution from individual, environmental and social factors(Sushm&Johnson,1996 cited in international encyclopedia of Behavior and Social Science,2001. PP 106_107). Thus recent research on YSRH has tested multiple domains of predictors, recognizing that SRH risk behavior is not due to any single cause but rather arises from combination of factors.

As a result, researchers have attempted to identify those factors that influence youths sexual risk behavior so that meaningful prevention and intervention programs may be developed.

The correlates of youth sexual risk behavior identified by different researchers were well reviewed by Kotchick, Shaffer, S. Miller and Forehand, 2001. In their multi-systemic perspective Kotchick et al had identified the factors that contributed American uses to sexual risk behavior as attributed to the self, familial and extra-familial system. Research results, according to this review, showed that the self-system variables are divided into biological, psychological and behavioral correlates of sexual risk practice. While the age, pubertal development, gender and race are included as biological factors; cognitive competence and self efficacy as psychological factors; and delinquency, substance use are included as behavioral factors.

Kotchick et al in their review summary of the researches done on the self-system argued that for lack of consistency among the findings by different researchers on some variables that are commonly believed to have an influence on adolescent sexual behavior. More importantly, the relation between adolescent sexual risk behavior and knowledge about sexual risk factors and perceived personal vulnerability to undesirable outcomes of sexual activity are not well understood and concluded with the need to make more research to examine the role of self-esteem, self-efficacy, and general psychological health in the promotion of safer sex practices.

Regarding the familial influences on youth sexual activity Kotchick et al divided into two primary categories as family structure variables and family process variables. Although the latter category deserved more attention by many researchers, the former variables such as single parenting and parental education had also shown evidence of influencing individual risky sexuality behavior. The review also cites research results on this regard as parental divorce and education to have been predictors of sexual risk behavior. In terms of family processes, parenting

behavior has been identified as an important source of influence on adolescent sexual activity. Throughout the socialization process, parents transmit their own standards of conduct, both directly through their parenting practices and indirectly through their own observable behavior. In regard to the direct transmission route, three dimensions of parenting parental monitoring of adolescent behavior, parent–adolescent relationship quality, and parent–adolescent communication have been identified as important variables in contributing to youth sexual risk-taking behavior. From this review one can draw a conclusion that, within the family system, there are many important risk and protective factors for adolescent and youth sexual risk behavior.

Kotchick et al had also conducted their review from extra familial view point. According to their findings from different research results, for adolescents who are in the midst of developing their own identities and establishing more complex social networks, the point of reference by which they guide their behavior shifts from the family to the social environment. Of the three systems targeted by this review, the extra familial system is the broadest in environmental scope. As a result, distinct subsystems, such as peers, neighborhoods, and school conditions, have been subsumed under the label of the extra familial system, while Peers become an important source of reinforcement, modeling, and support concerning value and belief systems during adolescence. According to this review, this system is however, received the least empirical attention in the literature on adolescent sexual risk-taking.

Finally Kotchick et al concluded their review results by forwarding their recommendation for the need to give special emphasis and further research on, the extra familial system with respect to adolescent and youth sexual risk behaviors. Two primary reasons were forwarded for such an emphasis: First, as noted above, adolescence is a period of development characterized by the

increasing influence of factors outside the family. Therefore, these influences deserve more attention, so that we may better understand the factors involved in adolescent sexual risk behavior. Secondly, of the three systems, the extra familial system is the broadest in scope, as it encompasses the larger social context in which adolescents operate. Arguably, this broad context can serve to interact with, augment, or attenuate the influence of variables in the self or family systems, and for this reason must be included for consideration in all aspects of adolescent sexual behavior, particularly as we attempt to discover factors that increase or decrease adolescent sexual risk, and ultimately implement methods of preventing such risk.

Schensul, Levy(2003) and others (Okonkwo, Fatusi, and Ilika) also observe that the social environment to have been playing an important role in the sexual and reproductive health-related behavior of young people, and this include their friends and peers, sexual partners, family members as well as the community, school and other youth-serving institutions. The impact of peers on reproductive and sexual behavior of young people has particularly been documented to be strong. Among others, beliefs of young people as regarding the behavior of their peers have been shown to have impact on their actions in various spheres of health behavior.

2.2. Workplaces as a Subsystem for the Development of Youth Health Behaviors

It is important to conceptualize the workplace not only as a place where people earn a living but also of a distinct community where people interact, socialize and influence each other in terms of creating a shared identity(shared behavior including social behavior), and the role of “peer pressure”. The pervading feature of such shared behavior into the surrounding community and as a result of such interaction in knowledge and experience has its own impact in the likelihood of personal exposure to SRH risks such as stis, unwanted pregnancies and unprotected sex (Schensal, levy and Disch, 2003; molsa, 2004).

Different studies have established high risks of sexual behaviors are related to the working environment. Study conducted in sexual behavior among female workers of textile factory in Tirpur, India, identified that more women have been infected with HIV and that many factors predispose them to risk even if they have reasonable knowledge regarding its prevention. Having casual partner, having sexual coercion in the workplaces, low self-efficacy for condom use etc were some of the factors identified from this study (Paul et al, 2002).

Floriculture industry, as one of the workplace area, is one of the booming agro industries that linked the developing countries with the global market (Catherine and Kristi, 2003 cited in Fatuma, 2007). In terms of its social development, the flower industry is important since it creates many jobs owing to the labor intensive production system. According to Fatuma, 2007, more than 190,000 people in developing countries are employed in this industry with overwhelming majority being youths. Among the workforce, women constitute 65-70 %, P.9).

In Ethiopia, the business of cut-flower industry is a new and fast expanding industry. In 2002, the Government of Ethiopia in its Poverty Reductions and Sustainable Development Strategic paper (PRSDP) has identified the floriculture as one of the main promising sector for Ethiopian export. As a result the number of projects that were only one before 1998 was grown to 65 in the year 2006(Ministry of Trade and Economic Development, 2007).

Recent studies conducted by Fatuma, 2007 and BICDO, 2006 around Holota town revealed that on average 400 people are working in a single flower project. According to the recent statistics obtained from these farms the majority of the labor force (80%) is youths with young women took the lion share.

While there is a growing body of literature and research results that addresses the RH and health status of youth in Ethiopia, very little of it addresses rural youth specifically youths working in the flower industries that are placed in the rural or per urban areas.

The focus of this study will be guided by data on factors for YSRH risk behavior particularly STI and unintended pregnancy in the rural workplaces in this case the flower industry.

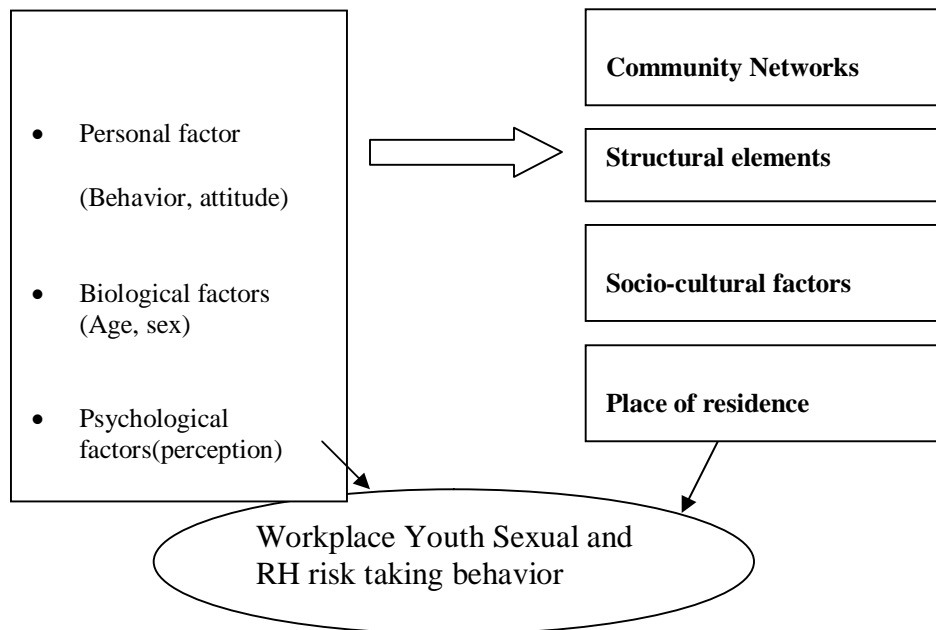
2.3. Conceptual /Theoretical Frameworks

Independent Variables

Intermediate Variables

Individual level Factors

Social-Environmental factors



Conceptual /Theoretical Frameworks were adopted from the above review of literature that can summarize the background information and used as a guide in the study of factors predisposing Youths working in the rural workplaces.

CHAPTER THREE

3. RESEARCH DESIGN AND METHODOLOG

3.1 Study Design

A cross-sectional study design with quantitative and qualitative data collection methods were used to assess factors that predispose youths in the rural work places of flower industry to high risk sexual and RH behavior with respect to sexually transmitted infections and unintended pregnancy in the study area.

3.2. Description of the study area

The envisaged research is intended to be conducted in Woliso Woreda of South West Shoa Zone, Oromia National Regional State, Ethiopia. The study specifically focuses on flower farms. Woliso Woreda is one of the 12 Woredas found in South west Shoa zone. According to 2014 estimate of Woreda Health office, the population of the woreda is estimated to be 165,280 (79,334 Male & 85,946 Female). The woreda is divided into 38 Rural and 4 urban Kebele Administration. The population of the Woreda is predominantly Oromo followed by Gurage origin. Woliso the capital town of the Woreda is located at 114 kms south west of Addis Ababa on the main highway leading to Jima. The Woreda is known to have endowed with different projects such as Green houses that are private flower Projects with their thousands of workers, and other private colleges and relatively large number of labor force.

The researcher decided to work on this topic after having made some exploratory interviews with people having an expertise on the issue, stakeholders and few target communities; reviewing relevant literature and personal observations made during field work placement a few months prior to this study.

3.3. Study Population:

To address the gaps in knowledge of factors exposing youths working in rural workplaces to sexual and reproductive health risks, a descriptive –cross-sectional study was employed in Dilala flower farm located in Woliso Woreda. The study population was selected from each green house 15 male, 20 female youths from target population working in Dilala flower farm found in Woliso Woreda and fulfilling to inclusion criteria of age 18-24yrs.

3.4. Data Source

The data source was made as wide and diverse as possible to capture reliable and objective information within the time frame. Accordingly, the possible data sources include but not limited to: Social and public health service providers, out of school ARH club members and personnel of NGOs providing social services to the local communities, workplace youths, labor Unions and workplace management; and focus groups of pertinent stakeholders such as investment Office, Health Office, Women’s and Child Affairs, youth from Woreda.

3.5. Sampling

The primary target group, the workplace youths workers sampling was multi-stage- using the stratified sampling. The proportion of youths was calculated across the establishments of forty one Greenhouses. Next the youths were proportionally taken from each type of greenhouses. Following the stratification, simple random sampling was used to select the individual respondent.

The study population was selected from each green house 15 male, 20 female youths from total population working in Dilala flower farm found in Woliso Woreda and fulfilling to inclusion criteria of age 18-24yrs.

To qualify for enrolling in the study, perspective participants have to be in the age range of 18-24yrs and working in the farm.

Purposive sampling method was employed for taking the stakeholders' group. A pool of eligible members (responsible) will be created. Criteria was developed for the selection of the respondents- relevance of organization with the question at hand and the willingness of the parties to be involved in the study are some of the possible criteria to be used.

3.6. Data Collection

Different instruments was prepared and employed to collect primary data. Following are some of the instruments were employed to collect data.

A. **Document reviews:** A review of previous studies on this subject, available policy issues being in place by different actors, Statistical pieces of information such as health, HIV, family planning education, demographic and socioeconomic profiles of the target areas will be gathered from different sources. Some of these sources of information are:

Past socio- economic survey results conducted by some of the NGO's operating in the area; and Report of Demographic and Health Survey of Ethiopian (DHS)

Different data compilation forms and checklists was prepared as a data collection tool

B. **Focus Group Discussion (FGD):** Three focus group discussions having on average 5 people in each FGD participated at both workplaces and at woreda level with different group discussants. The selection of the discussants was purposive. The discussants at woreda level was selected and invited in collaboration with Kebele leaders and some influential people having broader knowledge of the respective communities. At the workplace level, discussants were selected to accommodate, the youths, the management members and the labor union.

C. **Questionnaire:** to generate both quantitative and qualitative data pertaining to the characteristic variables of the target groups, an anonymous, structured, pre-tested questionnaire were developed and a filled by the trained enumerators/data collectors through a face to face discussions with workplace youths. The questionnaire was a combination of both open and closed –ended pre-tested before the actual survey. The questionnaire was prepared to be categorized to accommodate the available variables.

3.7. Variables

A review of the literature on a modified version of the world health organization survey instrument package (WHO 1990), youth risk behavior survey (YRBS) by the center for disease control and prevention (CDC, 1999) and others (Hofmanetal, 2004; Anebo, 2007; and Cheryl& Hawas, 2004) have identified several composite variables which among others that this study is going to measure demographic Characteristic of the target group, perceived vulnerability to STI infection and self efficacy, risk-Sexual behaviors of the participants such as engaging in premarital sex, having multiple partners, having made unprotected sex, etc, knowledge on prevention of STI and unwanted pregnancy and community and Peer influence.

3.8. Ethical Consideration

Before the commencement of the research process, the researcher had letter of introduction/cooperation from Addis Ababa, Indira Gandhi Open National University school of Social work (Study Center) to be shown to concerned stakeholders and the target group ,all respondents was participated voluntarily upon having understood and agreed the purpose of the study, time schedule and place of discussion. Research assistants (enumerators) was well oriented on such ethical issues during their training of data collection techniques prior to entering into the data collection process and throughout this study, privacy and confidentiality were emphasized. All

data was collected in a private setting, individual participants were not identified by names and the research materials were also maintained by the researcher and his assistances. The discussion with male and female was carried out separately and were conducted by same sex enumerator. Maximum effort was made to avoid description that was making the study participant to be identifiable.

CHAPTER FOUR

4. Data Entry and Interpretation

4.1. Findings and Analysis

Both the quantitative and qualitative methods were applied to reach to the necessary conclusion and recommendations.

Quantitative data was entered using appropriate software in consultation with statistical specialist. Interview questions of the questionnaire was be given sequential reference tag (No) to easily identify one respondent from the other one. Range checks and skip patterns was programmed into the data entry template to minimize possibility of data entry errors. Analysis ware made both by Microsoft excel and Statistical package for Social science (SPSS) version 20 for analysis based on its magnitude of complexity.

On the other hand FGD, stakeholder sampling and document reviews qualitative texts were coded and analyzed using content analysis and triangulation. Summaries of code data was prepared in narrative format, organized according to the topic area of inquiry. FGD transcribed and translated from Afan Oromo to English Transcription and translation was randomly checked.

Table 7.1. Shows Mean, Median, standard Deviation and Percent of Demographic characteristic factors affecting exposure to Sexual and reproductive health risk among rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm Woliso Woreda, South West Shoa Zone.

April, 2015.

	Sex of respondent	Residence of respondent	Age of respondent	Education of respondent	Ethnicity of respondent	Religion of respondent	Marital status of respondent
N	20	20	20	20	20	20	20
Mean	1.40	1.40	1.70	2.60	1.50	1.70	1.80
Median	1.00	1.00	2.00	3.00	1.00	1.50	2.00
Std. Deviation	.503	.503	.571	1.188	.827	.801	.894
% of Total Sum	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% of Total N	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

- Source: Own Survey ,2015

The above table indicates demographic characteristic of youth working in flower farm, out of 20 sample size (100%) was aged from 18-24 years and standard deviation of .571, mean of 1.70, educational status, marital status and residence of the respondent were indicate their vulnerability to risk of SRH and other STI.

Table 7.2 Shows Case Summaries of Demographic characteristic Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths. the Case of Dilala Surya Blossom Flower Farm Woliso Woreda, South West Shoa Zone. April, 2015.

	Case Number	Sex of respondent	Residence of respondent	Age of respondent	Education of respondent	Ethnicity of respondent	Religion of respondent	Marital status of respondent
1	1	Male	Rural	18-20	Illiterate	Oromo	orthodox	single
2	2	Male	urban	20-24	Primary(1-8)	Gurage	Muslim	divorce
3	3	Female	Rural	18-20	Illiterate	Oromo	orthodox	single
4	4	Female	Rural	20-24	Secondary(9-12)	Oromo	protestant	married
5	5	Male	Rural	18-20	Able to read and write	Oromo	protestant	married
6	6	Male	Rural	18-20	Illiterate	Oromo	orthodox	single
7	7	Male	urban	20-24	Primary(1-8)	Oromo	protestant	single
8	8	Female	Rural	20-24	3 Illiterate	Oromo	protestant	married
9	9	Female	Urban	20-24	Secondary(9-12)	Oromo	orthodox	divorce
10	10	Female	Urban	20-24	Primary(1-8)	Oromo	orthodox	married
11	11	Male	Rural	20-24	Primary(1-8)	Oromo	orthodox	single
12	12	Male	Rural	20-24	Illiterate	Gurage	orthodox	married
13	13	Female	Urban	20-24	Primary(1-8)	Gurage	Muslim	single
14	14	Female	Urban	20-24	Secondary(9-12)	Oromo	Muslim	married
15	15	Female	Rural	18-20	Secondary(9-12)	Oromo	Muslim	married
16	16	Female	Rural	20-24	Illiterate	Amhara	orthodox	married
17	17	Male	Urban	20-24	Secondary(9-12)	Amhara	orthodox	single
18	18	Female	Rural	18-20	Primary(1-8)	Oromo	protestant	single
19	19	Female	Urban	18-20	Primary(1-8)	Oromo	protestant	married
20	20	Female	Rural	20-24	Primary(1-8)	Gurage	orthodox	married
Total	N	20	20	20	20	20	20	20

Table 7.3. Show case summary of individual behavior of Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

	Year of service In flower farm	Availability of Media	Access to Media	ICE	Access to ICE	SRH service availability	SRH access	Habit after working hour
1	4-6year	yes	both	yes	leaflet	yes	Health post	reading
2	1-3year	yes	both	no	leaflet	yes	Health post	drinking
3	1-3year	no	both	no		yes	NGO	others
4	1-3year	yes	both	yes	leaflet	yes	NGO	reading
5	1-3year	yes	both	yes	leaflet	yes	Health post	reading
6	1-3year	no		no		yes	Health center	reading
7	4-6year	yes	radio	yes	leaflet	yes	Health center	reading
8	4-6year	no		no		yes	Health post	others
9	4-6year	yes	both	yes	magazine	yes	NGO	reading
10	4-6year	yes	both	no		yes	Health center	others
11	4-6year	yes	radio	no		yes	Health post	chewing
12	1-3year	yes	both	no		yes	NGO	chewing
13	4-6year	yes	both	yes	leaflet	yes	NGO	reading
14	1-3year	yes	both	yes	leaflet	yes	Health center	others
15	1-3year	yes	both	yes	brusher	yes	Health post	others
16	1-3year	yes	radio	no		yes	Health post	others
17	1-3year	yes	both	yes	leaflet	yes	NGO	reading
18	1-3year	yes	both	yes	leaflet	yes	Health center	chewing
19	4-6year	no	radio	yes	brusher	yes	Health post	reading
20	4-6year	yes	radio	yes	leaflet	yes	Health post	others

Table 7.4. Shows Mean, Median, standard Deviation and Percent of individual behavior of Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

		Year of Service	Availability Media	Access to media	ICE	Access to ICE	SRH service availability
N	Valid	20	20	18	20	13	20
	Missing	0	0	2	0	7	0
Mean		2.45	1.20	2.44	1.40	1.92	1.00
Median		2.00	1.00	3.00	1.00	2.00	1.00
Mode		2	1	3	1	2	1
Std. Deviation		.510	.410	.922	.503	.494	.000
Percentiles	100	3.00	2.00	3.00	2.00	3.00	1.00

Source: Survey of 2015

The above table indicates that: there is no association between work place and access of information on risk SRH for study population . Potential sources of risky behaviors for youths in the project communities' youths cope with the SRH risks their behaviors that correlate with STI rates are the number of sexual partners, age at first sexual intercourse, and condom use. This section examines data on sexual behavior related to the spread of HIV among respondents who have ever had sexual intercourse.

Table 7.5. show case summary of individual knowledge of factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015

	SRH risk	Knowledge of risk SRH	Exposure of risk of SRH	HIV and STI test	Workplace discussion on risk of SRH	HIV and STI cause	STI and unwanted pregnancy prevention
1	Yes	Unsafe sex	YES	No	yes	yes	yes
2	No			No	no	no	no
3	No		NO	Yes	yes	no	no
4	Yes	Low awareness on SRH	NO	Yes	yes	yes	yes
5	Yes	Early marriage	YES	Yes	no	yes	yes
6	Yes	Multiple sexual partners	NO	Yes	yes	yes	no
7	No		NO	Yes	yes	yes	yes
8	No		NO	Yes	yes	yes	yes
9	Yes	Unsafe sex	YES	Yes	yes	yes	yes
10	Yes	Early marriage	NO	Yes	yes	yes	yes
11	No			Yes	no	yes	yes
12	Yes	Unsafe sex	NO	Yes	yes	yes	yes
13	Yes	Early marriage	YES	Yes	yes	yes	yes
14	Yes	Early marriage	NO	Yes	yes	yes	yes
15	Yes	Low awareness on SRH	NO	Yes	yes	yes	yes
16	No		NO	Yes	no	no	no
17	Yes	Leer influence	NO	Yes	yes	yes	yes
18	Yes	Unsafe sex	NO	Yes	yes	yes	yes
19	Yes	Early marriage	NO	Yes	no	yes	yes
20	yes	Low awareness on SRH	NO	Yes	yes	yes	yes

7.6. Shows Mean, Median, standard Deviation and Percent of Knowledge of factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

Table

Descripti on of statics	SRH risk	List of SHR risks	Expose of risk of SRH	HIV and STI test	Work place discussion on SRH	HIV and STI cause	STI and unwanted pregnancy prevention
N	20	14	18	20	20	20	20
Mean	1.30	2.79	1.78	1.10	1.25	1.15	1.20
Median	1.00	2.00	2.00	1.00	1.00	1.00	1.00
Std. Deviatio n	.470	1.929	.428	.308	.444	.366	.410
% of Total N	100.0 %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Survey of 2015

The above table indicates that risk SRH and knowledge of youth on HIV and STI in relation to the absence of work place discussion on their life skill experience sharing each other made them low awareness on risky sexual practices that may expose the study population to STI and other RH problems strong link exists between sexually transmitted infections and the sexual transmission of HIV the studies have demonstrated that STIs are a co-factor for HIV transmission.

4.2. Document Reviews and Stakeholder Analysis

The inclusion of HIV testing in the EDHS offers the opportunity to better understand the magnitude and patterns of infection within the general reproductive-age population not included in sentinel surveillance surveys, especially men age 15-59. The first such exercise was conducted as part of the 2005 EDHS. The 2011 EDHS is the second EDHS survey to anonymously link HIV testing results with demographic, socioeconomic, and behavioral characteristics of survey respondents.

This chapter presents information on the HIV testing coverage rates among eligible survey Respondents, the prevalence of HIV infection among those tested, and the factors associated with HIV infection in the population. Blood collection and HIV testing methodologies used in the 2011 overall, 86 percent of all EDHS respondents who were eligible for testing were interviewed and consented to HIV testing. Four percent of respondents were interviewed but refused to be tested for HIV and did not provide blood samples. Coverage rates for HIV testing were 89 percent for women and 82 percent for men. The proportion of respondents who consented to the HIV test was higher in rural areas than in urban areas for both women and men. Ninety-two percent of women in rural areas consented to HIV testing, compared with 84 percent in urban areas. Among men 86 percent in rural areas consented to testing, compared with 72percent in urban areas. The Oromia region has the largest proportion of respondents who consented to HIV testing, at 92 percent. Caution should be used when interpreting HIV prevalence levels among women based on the number of sexual partners in the past 12 months because very few women report more than one partner. Among men HIV prevalence is highest for those who report no partners in the past 12 months (2.9 percent). Among men who report two or more partners in the past 12 months, HIV prevalence is higher among those with no

concurrent partners (3.1 percent) than among those with concurrent partners (1.3 percent). However, these bivariate associations must be considered with caution as they may be influenced by other factors, such as respondents' marital status. In addition, findings on sexual behavior in the past 12 months should not be interpreted as a complete picture of an individual's exposure to risk of HIV infection as individuals may have become infected more than 12 months before the survey. Concurrent partnerships are defined as overlapping sexual partnerships with two or more individuals during the 12 months preceding the survey. HIV prevalence increases substantially as the number of lifetime sexual partners increases, for both women and men. HIV prevalence increases from 1.3 percent for women with one lifetime partner to 5.1 percent for women with two lifetime partners and to 8.7 percent for women with 5-9 lifetime partners.

Almost one-quarter of women with 10 or more lifetime partners are HIV positive.

HIV prevalence ranges from 0.1 percent among men with one lifetime partner to 6.8 percent among men with 10 or more lifetime partners.

Condom use at last sexual intercourse is also related to HIV prevalence. For respondents who had sex in the past 12 months, a higher proportion of those who used a condom at last sex were HIV positive (8.3 percent) than those who did not use a condom (1.3 percent). This proportion is more than three times higher among women than among men. No causal association between condom use and HIV can be assumed from these results. In these data it is not possible to know the sequence of events, e.g., whether reported condom use occurred before or after HIV infection. It is likely that those who suspect that they or their partner might be infected would also be more likely to use condoms, thus reversing the expected direction of the relationship of lower HIV prevalence among those who use condoms. Condom use at last sex has been associated with higher HIV prevalence in many other cross-sectional surveys. In addition, other

factors may be influencing the relationship between condom use and HIV. For example, condom use may be higher in urban areas, among those who engage in higher risk sexual behaviors, or in other groups which are also more likely to be HIV-positive. Further analysis is required to gain a better understanding of the true relationship between condom use and HIV infection in Ethiopia.

Overall, less than 1 percent of Ethiopian youth age 15-24 tested positive for HIV.

There is little variation in HIV prevalence by background characteristics, given the low overall prevalence. Regional estimates of HIV prevalence among youth are similar, with one exception: in Gambella HIV prevalence among young women is much higher, at 9 percent, than in other regions of HIV Prevalence by Sexual Behavior among Youth.

The 2011 EDHS collected data on behaviors that correlate with sexually transmitted infection (STI) rates. Information on sexual behavior characteristics is important in designing, targeting, and monitoring HIV prevention interventions for the young adult population. Three behaviors that correlate with STI rates are the number of sexual partners, age at first sexual intercourse, and condom use. This section examines data on sexual behavior related to the spread of HIV among respondents who have ever had sexual intercourse. It is important to note that responses about sexual behavior are subject to reporting bias.

A strong link exists between sexually transmitted infections and the sexual transmission of HIV. Many studies have demonstrated that STIs are a co-factor for HIV transmission. Management and treatment of STIs can play an important role in the reduction of HIV transmission.

The 2011 EDHS asked respondents who had ever had sex if they had contracted a disease through sexual contact in the past 12 months, or if they had any symptoms associated with STIs (an abnormal discharge from the vagina or penis or a genital sore). Overall, a higher percentage of respondents with STIs or STI symptoms in the past 12 months are HIV positive (4.7 percent)

than of those with no STIs or STI symptoms (2.0 percent). This pattern is observed among both women and men. HIV prevalence is higher among those previously tested for HIV than among those who were never tested for HIV. Among those ever tested, respondents who received their results had a higher HIV prevalence (3.8 percent) than those who tested but did not receive results (1.6 percent) and those who never tested (0.9 percent).

4.3. Focus Group Discussion (FGD)

The participant of FGD was about 15(fifteen) youths out of this, 8(eight) Female and 7 (Seven) Male were participated from flower farm.

The discussion with youth working in flower farm was divided in three groups by taking an average of five individual randomly from target population.

Discussion was started in each group by the same discussion topics, and started by briefing of the objective of the project.

The discussion session was begin with risky sexual exposure of study population, may expose for STI and SRH problems. About 93 %(14) was respond risky sexual exposure caused by low awareness on SRH and STI. Sexual risky behavior was associated by peer influence in workplace and lack of access of health facilities in rural area regarding of information, communication and media.

Another discussion point was on benefit of family planning and cause of unsafe abortion for work place study population. Most of the respondent was actively participated on the benefit of family planning for individual, family and communities, 100 %(15).

The cause of unsafe abortion was not explained from the participant and some of study population was rise the cause of unsafe abortion like: nutrient of the mother, cultural influence, taboos, unmarried ladies when she was pregnant.

The mass media and interpersonal communication can be major sources of family planning

The mass media and interpersonal communication can be major sources of family planning messages. Information about public exposure to messages through a particular medium allows Policymakers to ensure the use of the most effective means of communication for various target groups in the population. To assess the effectiveness of the dissemination of family planning information through different media, interviewers asked respondents in the 2011 EDHS whether they had been exposed to any family planning messages in the past few months preceding the survey.

Interviewers asked about family planning messages on the radio or television; in newspapers among women age 15-49 community events are the most common source of family planning messages. Information about public exposure to messages through a particular medium allows Policymakers to ensure the use of the most effective means of communication for various target groups in the population. To assess the effectiveness of the dissemination of family planning information through different media, interviewers asked respondents in the 2011 EDHS whether they had been exposed to any family planning messages in the past few months preceding the survey.

Interviewers asked about family planning messages on the radio or television; in a newspaper among women age 15-49 community events are the most common source of family planning messages, at 37 percent. Radio is the second most common at 34 percent. Another common source is television, with 18 percent of women reporting exposure to family planning messages via television. Ethiopian women do not have high exposure to written sources of family planning messages. Only 8 percent of women report seeing family planning messages in a newspaper or magazine or in a pamphlet, poster, or leaflet.

In general, a higher proportion of Ethiopian men are exposed to family planning messages

than women. As for women the most common sources of family planning messages for men age 15-49 are the radio or community events (51 and 44 percent, respectively). Twenty-five percent of men report exposure to family planning messages on television, while 18 percent report exposure to messages from a pamphlet, poster, or leaflet. The least common source of family planning messages for men is a newspaper or magazine, at 15 percent.

Among women, there is a slight variation in exposure to printed family planning messages by their background characteristics. Women in the two lowest age categories, age 15-24, have higher levels of exposure to family planning messages in a newspaper or magazine or in pamphlets, posters, or leaflets than women in upper categories. A higher proportion of urban women than rural women are exposed to messages from each source. Especially pronounced gaps between urban and rural women are observed in their exposure to family planning messages on television (55 and 7 percent, respectively), in a newspaper or magazine (21 and 4 percent, respectively), and in a pamphlet, poster, or leaflet (23 and 3 percent, respectively). Similar urban-rural variations in exposure to printed family planning messages are observed among men. Urban women are more exposed to family planning messages at community events than rural women (40 and 36 percent, respectively), whereas rural men are more exposed than urban men (45 and 42 percent, respectively) to these messages. Regional differentials also suggest that women and men in relatively urbanized areas, namely Addis Ababa, Dire Dawa, and Harari, are more likely than other respondents to be exposed to family planning messages from all specified media sources. Exposure to family planning messages at community events is the exception to this pattern. Women in Tigray and Amhara are more likely to be exposed to family planning messages at community events (65 percent and 46 percent, respectively) than women from other regions including the more urbanized areas.

There is a marked difference by women's level of education in exposure to family planning messages from all media sources; 72 percent of women with more than secondary education are exposed to family planning messages through the television, whereas only 6 percent of women with no education are. Similar patterns are true for men. Both female and male respondents in the lowest wealth quintile are the least likely to be exposed to family planning messages through any of the specified sources when compared with respondents in higher quintiles.

CHAPTER FIVE

5. Conclusions and Recommendation

5.1. Conclusion

The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. The interactions between sexual and reproductive health and HIV/AIDS are now widely recognized. In addition, sexual and reproductive ill-health and HIV/AIDS share root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations. The international community agrees that the Millennium Development Goals will not be achieved without ensuring access to SRH services and an effective global response to HIV/AIDS. Ensuring universal access to sexual and reproductive health and rights and HIV prevention, treatment, care and support are essential for development, including in the post-2015 agenda. However, while there are many separate sexual and reproductive health (SRH) related and HIV related indicators, To make more significant headway toward reaching the Millennium Development Goals (MDGs) the political and programmatic importance of linking sexual and reproductive health (SRH) and HIV responses has been increasingly gaining momentum. The rationale, laid out since 2004 is indisputable the majority of HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding; and the risk of HIV transmission and acquisition can be further increased due to the presence of certain sexually transmitted infections (STIs). Moreover, sexual and reproductive ill-health and HIV share root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations.

The world is moving toward 2015 when progress toward attaining the MDGs will be ultimately judged. Increasingly these goals are recognized to be intertwined, though progress towards the goals is still insufficiently capitalizing on opportunities to strengthen a united response. The recent evidence that HIV was the leading cause of death in women of reproductive age in particular through the impact of HIV in Sub-Saharan Africa and contributing significantly to maternal mortality reverberated throughout the reproductive health and HIV communities. It was a wakeup call that the health MDGs 4 (child health), 5 (maternal health), and 6 (AIDS), are interconnected. Clearly, universal access to reproductive health services and to HIV prevention, treatment, care and support are joint goals. And together, they will contribute to and cannot be achieved without attaining MDG 3 gender equality and empowerment of women. Probably the most compelling argument for SRH and HIV linkages are that they make ‘people-sense’, acknowledging that health systems need to meet people where they are. This is a time-honored concept espoused in the Declaration of Alma Ata on primary health care for “bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”. Whether providing women with family planning services to empower them, delivering comprehensive sexuality education for young boys and girls, preventing child marriage, eliminating gender-based violence, managing sexually transmitted infections, ensuring access to female and male condoms for dual protection (against HIV/STI and unwanted pregnancy), or providing antiretroviral treatment alongside cervical cancer screening, it is critical that sound policies are in place to support these kinds of comprehensive approaches. Yet all too often the articulation of HIV and SRH programmes (both at the national level and in donor funding priorities) does not support this logical alignment. Territorialism, duplication of effort and increased stigma are often the result of this mismanagement.

Pioneered of both the 2004 Glion Call to Action on Family Planning and HIV/AIDS in Women and Children and the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health, the fundamental linkages were articulated and human rights were enshrined as the cornerstone of this joint response. Other international commitments followed. Upholding human rights is intrinsic to the linkages agenda, in particular the human rights of people living with HIV, key populations, and women and girls. SRH- and HIV-related stigma and discrimination against vulnerable people such as young person's – in Particular young women and girls, and marginalized groups such as transgender people, sex workers, men who have sex with men, people who use drugs and people living with HIV – prevent them from attaining basic rights and health.

The 1994 Programme of Action agreed to at the International Conference on Population and Development (ICPD) was a landmark consensus document in furthering women's rights.

Along with subsequent iterations, it has set a bold agenda for advancing the sexual and reproductive health and human rights of women and girls. This ICPD agenda is firmly reflected in the SRH and HIV linkages agenda, as addressing the challenges facing women and girls is one of the cornerstones of linkages - whether tackling gender-based violence, preventing mother-to-child transmission, or advancing educational attainment. There continues to be a groundswell of support for bringing women's groups on board to support the policy and programmatic approaches to linkages. Clearly, gender equality is at the forefront of linkages.

To address structural determinants affecting HIV and SRH such as gender equality, education, and economic stability, effective responses - both long and short term - must go beyond the realm of health service delivery points. Instead, linking SRH and HIV requires addressing such human rights and development concerns such as age of consent for SRH and HIV services,

gender-based violence, child marriage, sexuality education, girls' education, and the meaningful participation of key populations in planning, implementation and monitoring. Effective responses to tackle these issues require a strong multi-sectoral response, including through policy and legal reforms. In delineating the full scope of a linked SRH and HIV response a distinction has been made between linkages and integration. Bi-directionality, whereby both the SRH and the HIV communities address relevant aspects of each others' agendas has been one of the hallmarks of linkages. Therefore it is imperative that any linked responses favorably impact on both SRH and HIV outcomes. Such responses include but are not limited to: rights-based family planning in the context of mother-to-child transmission of HIV programmes, ending gender-based violence and child marriage, providing HIV voluntary counseling and testing within antenatal care, promoting condoms within family planning programmes, and comprehensive sexuality education for young people. However, despite the promise of mutual gains, a linked response has not been the norm. HIV and SRH programming still remains largely vertical and has not, until recently, begun to be linked. Several factors have contributed to this situation, including: at the outset of the HIV epidemic, the need to establish an emergency response to deal with the magnitude and severity of the impact in developing countries. The historical roots of the HIV epidemic lead to the assumption that the "traditional" clients of SRH services differ from the "most at risk" clients attending HIV services.

The emergence of divergent donor funding were streams that prioritize one area as opposed to another, instead of focusing on overall people-centered benefits and health systems strengthening required attention.

The creation of HIV units that were not linked to sexual and reproductive units and largely neglected the sexual and reproductive needs of people living with HIV.

The perception that HIV prevention and HIV treatment and care require two very separate responses, which has led to the SRH community largely neglecting ARV delivery. The perceptions held by many sexual and reproductive health providers that HIV requires specialized training and specific skills that were outside the scope and remit of sexual and reproductive health.

Despite the current financial crisis and donor fatigue, there are a number of significant global health initiatives to support national processes - including the PEPFAR-2 Strategy, the US Government Global Health Initiative, the Global Fund to fight AIDS, TB and Malaria, the International Health Partnership, the UN Health 4 partnership, the UN Secretary General global strategy for women's and children's health, and the World Bank Health Systems Strengthening platform. These initiatives recognize the importance of supporting the linkages agenda and contributing to health systems strengthening.

5.2. Recommendations

- The policy and Strategy of SRH for youth working in flower farm is require to be design and implemented by government and concerned body.
- The flower farm is required to give attention for youth working in flower industry on their health and other reproductive health components.
- Daily payment of youth workers in flower farm required to increase, the twenty birr they got an average per day cannot cover their basic needs , for this reason especially the women's, in order to get additional income they were exposed to unsafe sex.
- Involvement of stake holders is needed to be encouraged to improve SRH problem and unintended pregnancy.

- Peer discussion is required to be established on SRH and HIV in flower farm to improve individual sexual behavior of the youth.
- It is expected from policy maker to create effective means of communication on Family planning and SRH for youth working in flower farm.
- It is required from flower farm to give great attention for youth awareness on SRH and other STI in work place in collaboration with local government and others stake holders.
- It is vital to establish the youth counseling center at work place in order to prevent to prevent and rehabilitate youth that are affected by SRH problems.

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ANNEX

Table 4.1.

Shows Mean, Median, standard Deviation and Percent of individual behavior of factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

Table 4.2.

Shows Case Summaries of Demographic characteristic Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

Table 4.3.

Show case Summary of individual behavior of Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

Table 4.4.

Shows Mean, Median, standard Deviation and Percent of individual behavior of Factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

Table 4.5.

Show case Summary of individual knowledge of factors Affecting Exposure to Sexual and Reproductive Health Risk among Rural Workplace Youths: the Case of Dilala Surya Blossom Flower Farm, Woliso Woreda, South West Shoa Zone, and April, 2015.

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INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

**Factors Affecting Exposure to Sexual and Reproductive Health Risk among
Rural Workplace Youths: the Case of Dilal a Surya Blossom Flower Farm, Woliso
Woreda, South West Shoa Zone.**

PROJECT PROPOSAL SUBMITTED TO SCHOOL OF SOCIAL WORK, INDIRA GANDHI NATIONAL OPEN
UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR MASTER OF SOCIAL WORK

BY

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ACRONOMYS

AA	Addis Ababa
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adult Sexual Reproductive Health
CDC	Center for Disease Control and Prevention
CBO	Community Based Organization
DHS	Demographic Health Survey
CICPD	Cairo International Conference on population and development
FGA	Family Guidance Association
FGD	Focus Group Discussion
GOs	Government Organizations
HIV	Human Immune Virus
MOH	Ministry of Health
NGOs	Non Governmental Organization
RH	Reproductive Health
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
SPSS	Statically Package for Social Sciences
UN	United Nation
UNFP	United Nation Food
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

TABLE OF CONTENT

DESCREPTION	PAGE
1.Introduction-----	1
1.2. Statement of the problem-----	3
1.3.Objective of the study-----	7
1.4. Sigificance of the study-----	8
1.5.Key Concept and their Opretional Definition-----	8
2.Litrature Review-----	9
2.1 Workplaces as a Subsystem for the Development of Youth Health Behaviors	13
2.2.Theoretical Frame Work-----	15
3.Rsearch Design and Methodology-----	16
3.1.Study Design-----	16
3.2.Discription of the Study area-----	16
3.3.Study Population-----	17
3.4.Data Source-----	17
3.5.Sampling Procedure-----	17
3.6.Data collection Techniques-----	18
3.7.Variable-----	19
3.8.Data Entery and analisis-----	19
3.9. Ethical Considration -----	20
4. Chapteraization-----	21
5. Work plan and budget proposal-----	22
5.1. Financial Requirement-----	24
6. Reference-----	25

1. Introduction

1.1. Background of the study

Youth is best understood as period of transition from the dependence of childhood to adulthood's independence. That's way, as category, youth is more fluid than other fixed age groups. Yet, age is the easiest way to define this group, particularly in relation to education and employment, because youth is often referred to a person between the age of leading compulsory education, and finding their first jobs.

With nearly half of the world population under the age of 25, today's generation of young people is the largest in history. Youth is an age group that undergoes through physical, emotional, mental and social changes that places its life at high risk than adults for many reasons, including a willingness to take greater risks, such as having unprotected sex, unwanted pregnancy, abortion, childbearing at early age, greater vulnerability to sexual pressure, coercion and exploitation ,etc. They are growing up in a different environment, like cast system, class system, urban areas, rural areas and diversified culture than their parents: both with their opportunities such as access of basic education, creativities, interest of change in their life and working in the area of voluntary organization and highly expose for SRH problems including HIV and STI some of the challenges. One of the major challenges and powerful forces shaping today's youth is sexual reproductive health problem including HIV/AIDS (UNFPA, 2005, P .4). Reproductive health (RH) is the leading cause of morbidity and mortality world. Though almost entirely preventable, RH problems remain widespread in much of the developing world. (Ibid).

Ethiopia, having 81.2 million people is characterized with high youth population to be entering adulthood in the history of the country. This cohort who makes up 30% of the total population suffers disproportionately from negative RH outcomes. They are vulnerable to a variety of RH

risks including unwanted pregnancy and Sexually Transmitted Infections (STI). Young adults are the center of the HIV/AIDS epidemic. According to the UNFPA's 2006 report, the prevalence of HIV/AIDS for male aged 15-24 was estimated between 6 and 9 % and 10-13% among women of the same age group. This age group has also the highest prevalence of sexually transmitted infections young women being highly vulnerable. (UNFPA, 2006) Different studies carried out in the country have indicated that early onset of sexual practice has resulted in series health and social problems that is 55% of the recorded maternal deaths are attributed to complications from unsafe abortion, while 13% of which occur among women under the age of 20. (MoH,2006).

However, despite these global and national scenarios with regard to the youth Sexual and Reproductive Health (SRH) problems, most reports and studies concentrate on urban areas. There is limited empirical evidence in the context of the rural areas. Particularly literature on SRH factors in emerging rural areas like as in the flower plantations areas is very scanty. The flower industry has been mushrooming in most parts of the rural area. The exploratory interview made with some experts, stakeholders and the workforce also revealed that, the majority of the workforces within these projects are the youth, both male and female. Although the prevalence and magnitude is not well studied, various sexual and reproductive health problems are appeared to have been experienced by many youths working in these plantations. Given the increasing trend of this industry within the rural areas and concomitant increase of the RH problem, knowledge of the links between the increasing trend of the problem and the underlying factors is useful in designing target specific programs to shade further light on appropriate social work responses.

This study is therefore aimed to identify and describe factors that affect exposure of youths working in the flower plantations to Sexual and Reproductive Health risks particularly to Sexually Transmitted Infections (STIs) and unwanted pregnancies. It is intended to be conducted in Wolisso Woreda, South West Shoa zone of Oromia National Regional State, Ethiopia.

1.2. Statement of the Problem

Sexually active adolescents and young people need comprehensive and age-appropriate information and services to be able to protect their sexual health and rights. The inadequacy of the information and services that young people now receive is seen in the fact that STI and HIV infection rates are highest among these age-groups; unsafe abortion levels are also very high among young people. Sexual coercion is also an important issue for young women and men, and they need the knowledge and skills to manage this risk. Many young people around the world become parents during adolescence and young adulthood and are not provided with enough information about how to prevent an unintended pregnancy and how to delay or space pregnancies. To serve them better, health care providers need information about young people's knowledge and use of contraception, including both modern and traditional methods. Information about how many adolescents and young people are having children, when they are having children and whether the children are planned provides critical knowledge for service providers, educators and advocates working to empower young people in their sexual and reproductive lives. (A Guide to Using Evidence to Improve Young People's Sexual Health and Rights, New York: Guttmacher Institute, 2013).

Since 1990s rate of sexually transmitted infection and Human Immune Deficiency virus (HIV) and levels of unsafe sexual behavior have been raising alongside continuing high rate of unintended pregnancy and abortion. Consistent data across a number of surveys indicate that

youths in particular are at high risk for a number of negative health consequences related to sexual risk taking behavior, including infection with HIV and other sexually transmitted diseases and the occurrences of unintended pregnancy. Recent estimates indicates that over 60% of STI cases reported yearly among individuals under the age of 24. Globally, more than half of all HIV infections occur among 15-24 years old (Seifu, Fantahun and Worku, 2006).

As the risks associated with sexual risk behaviors continue to mount increased research efforts have been dedicated to the examination of the dynamics of rate of SRH problems, the psychosocial context in which sexual initiation and sexual risk taking behavior occur.

In Ethiopia, despite the scanty of information as compared to many sub-Saharan African Countries, different national surveys and study results indicate the youths of the country to have been confronted with a multitude of SRH problems. There is also an increasing consensus that, the trend of the sexual activity among youths has been increasing. Some studies have shown that a relatively high sexual activity rate of about 30%-60% among out of school adolescents. Sexual activity among youths in Ethiopia has resulted in large number of unintended pregnancies, and illicit abortion, which poses serious health and social problems.

The result of different researches have done so far in the area of reproductive health in general and the youth sexual and reproductive sexual risk behaviors in particular, have found out such negative health consequences to have been associated with sexual risk taking behaviors of the youths(Kotchick etal, 2001; Shabo, 2007).

Cognizant of the consequences of such risk-taking behavior based on these researches, countries have been devoted giving some attentions in devising policy instruments to prevent their occurrence. Particularly, to make these prevention efforts more effective, identification and

understanding of the factors that contributed to sexual risk behavior, have been the subject of studies and the focus of many researches and agencies.

Many theoretical explanations have also been forwarded in understanding in these risk factors under different settings. Young people may also engage in sexual activities

Such as oral or anal intercourse (activities that are generally not measured in population-based surveys, including the DHS), prior to their so-called sexual debut (usually

Assumed to be first vaginal intercourse), thus increasing the value of sexual health information at an earlier age. The timing of sexual debut also indicates the latest age by

Which young people should have begun receiving guidance and support to develop decision-making skills regarding sexual activity, sexual health and sexual rights, all of

Which can be improved with sexuality education? (A Guide to Using Evidence to Improve Young People's Sexual Health and Rights, New York: Guttmache Institute, 2013). Many studies and preventive approaches are directed towards knowledge of risks and means of avoiding them, attitude towards contraception, practices and accessibility of services which takes individualistic perspective, not others (Akeryod, 2006). These factors are, however, only a small subset of those that influence youth risk-taking and health-seeking behaviors. A review of the literature identified clusters of factors that are associated with risky behavior or adverse RH outcomes among U.S youths. Furthermore, the findings of previous studies suggest that, the key antecedents tend to have only small or modest effects (Menyar etal, 2003).

Accordingly, since 1990s, there have been several conceptual changes in approach to understanding of youth SRH behaviors .The range of variables shown to predict SRH behaviors, has led to statistical model emphasizing how risk or protection arises through interplay of contributions from individual, environmental and social factors (Ibid).

Thus, recent research on youth SRH has tested multiple domains of predictors, recognizing that SRH risk is not due to any significant cause but rather arises from combinations of factors: demographic variables, dispositional constructs, academic involvement, specific attitude and efficacy, community life, peers and familial support etc (Kaufman, Beals, Mitchel, Lemaster and Fickenscher, 2004).

Yet we know very little about how and which of these factors determine for having risky sexual behavior. On the other hand, many of prior researches that addresses multiple level of influences on risky sexual behaviors among the youths were concentrated primarily in the United States while developing countries where sexually transmitted infections including HIV/AIDS and other SRH problems are rampant, remained low attention(Kaufman, Clark, Menzi and May, 2004)

In Ethiopia, although some studies have attempted to identify the risk factors associated to sexual and reproductive problems in the urban and school setting, there is a particular paucity of information on the dynamics of the risk related sexual behavior of youths from the rural context, despite the fact that 85% of the population lives in rural areas (Sam brook, 2004, Franconia & Hawas, 2004). Studies on risky sexuality behaviors in Ethiopia have very much limited themselves to the most confined and accessible adolescents in school (Alemu, 2004). Interventions attempted directly towards these problems were also emphasizing the school community. Particularly in the newly emerging floriculture industry, although more than 75 % of the workforce found to be youth and, various sexual and reproductive health problems are appeared to have been experienced by many youths working in these plantations, no attempt was made to study the factors that predispose these youths to RH risks (BICDO, 2006).

This particular research is therefore aimed to identify and describe factors that influence risky sexual and reproductive health behavior of youths at work place setting particularly in rural workplaces of the Flower Industry found in Woliso Woreda of south West Shoa Zone.

Research Questions

The basic Research questions are:

- Are there risky sexual practices that may expose the study population to STI and other RH problems?
- What are potential sources of risky behaviors for youths in the project communities?
- How do the youths cope with the SRH risks they face?

1.3. Objective of the Study

General Objective

The general objective of this study is to identify factors that predispose youths found in the rural work places particularly in the flower industry to high risk sexual and RH behavior with respect to sexually transmitted Infections and unintended pregnancy.

Specific Objectives

- To assess individual factors that increase high risk sexual and reproductive health behaviors.
- Describe the relationship between peer influence and workplace youth sex behavior.
- Explore the effect of workplace on youth sexuality and assess their associates.
- To give insight action based on the finding of the project for concerned body to take action to improve SRH of targeted population.

1.4. Significance of the Study

Carrying out such an in-depth empirical study will have both basic and applied purposes. The fact that there are few empirical researches on this particular subject, the result of the research will contribute as a spring board for further study. From its practical point of view, the research as a social work practitioner will be more acquainted with factors behind the study subject, existing policies, efforts and remaining gap to work on. The research finding can also serve as an input for organizations working in the area to develop appropriate strategies and approaches to address the issue.

The result of the study is believed to contribute to all stakeholders in understanding the situation of ASRH specifically STIs, and AIDS in rural localities of workplaces and redesign their interventions to accommodate these emerging issues. Policy makers are also believed to benefit in reviewing the ethical standards that private firms to pursue and the contributions they have to local economies. It is also believed to be a springboard to academicians who wants further make a research on the issue.

1.5. Key Concepts and Operational Definitions

For the sake of clarity and consistency in the study, the following definitions of terms will be used:

Youths: through the word ‘Youth’ means different thing for different countries, in this study, it is defined as a segment of the society that falls in the age range of 18-24 year.

SRH Risk factors: Conditions associated with a higher likelihood of risks-taking behavior or negative outcomes, like: unsafe sex, early marriage, socio-economic status, belief and culture of the study area.

Sexual behavior / Practices: are those activities that produce sexual excitation. It includes, solitary activity (masturbation), and interpersonal activities such as kissing, touching, sexual intercourse etc (steinbug, 1985 cited in Desta, 2007ii). However this study will be limited with Sexual intercourse with member of the opposite sex.

Workplaces: The workplace stands for the flower- plantation projects where workforces connect together and work in different green houses.

Kebele: -- Structural division of woreda/ District having their own local governance limited to specific geographic area or the smallest unit of the government.

Greenhouses: is building or complex in which plant (flowers) are growing. It control over growing of plants.

Stakeholders: Organizations like: investment Office, Health Office, Women's and Child Affairs, youth and sport Office, Dilala 01kebeles interests and the ways in which these interests affect the organization's business and its viability.

Applied research: scientific investigations conducted to answer specific questions or solve practical-related problems.

Basic research: scientific investigation that involves the generation of new knowledge or development of new theories; its results often cannot be applied directly to specific situations.

2. REVIEW OF LITERATURE

The issue of RH has been made as one of the global development agenda since the 1994 Cairo International Conference on population and development (ICPD), still RH problem is one of the leading cause of ill and death worldwide(UNFPA, 2005; Mohamod,2007). Despite the significant portion of the global population, youths are one of the highly affected segments of the

population in terms of the RH population. They are vulnerable to RH risks for both physical as well as social reasons and often suffer long term consequences (Ibid).

In YSRH risk behavior literature; there are many models that explain the risk behavior of youths and their prevention strategies. However, the popular theories often used in the RH issues are the Social Learning Theory, the Theory of Reasoned Action, And the Health Belief Model (FHI, 1999, cited in Ali, 2007)

In the earlier years of the development of theoretical models on YSRH, the approaches were based on cognitive and attitudinal approaches to prediction of youth behaviors. However in the 1990's there have been several conceptual changes in approaches to understanding of YSRH behaviors, has led to statistical models emphasizing how risk or protection arises through an interplay of contribution from individual, environmental and social factors(Sushm&Johnson,1996 cited in international encyclopedia of Behavior and Social Science,2001. PP 106_107). Thus recent research on YSRH has tested multiple domains of predictors, recognizing that SRH risk behavior is not due to any single cause but rather arises from combination of factors.

As a result, researchers have attempted to identify those factors that influence youths sexual risk behavior so that meaningful prevention and intervention programs may be developed.

The correlates of youth sexual risk behavior identified by different researchers were well reviewed by Kotchick, Shaffer, S. Miller and Forehand, 2001. In their multi-systemic perspective Kotchick etal had identified the factors that contributed American uses to sexual risk behavior as attributed to the self, familial and extra-familial system. Research results, according to this review, showed that the self-system variables are divided into biological, psychological and behavioral correlates of sexual risk practice. While the age, pubertal development, gender and

race are included as biological factors; cognitive competence and self efficacy as psychological factors; and delinquency, substance use are included as behavioral factors.

Kotchick et al in their review summary of the researches done on the self-system argued that for lack of consistency among the findings by different researchers on some variables that are commonly believed to have an influence on adolescent sexual behavior. More importantly, the relation between adolescent sexual risk behavior and knowledge about sexual risk factors and perceived personal vulnerability to undesirable outcomes of sexual activity are not well understood and concluded with the need to make more research to examine the role of self-esteem, self-efficacy, and general psychological health in the promotion of safer sex practices.

Regarding the familial influences on youth sexual activity Kotchick et al divided into two primary categories as family structure variables and family process variables. Although the latter category deserved more attention by many researchers, the former variables such as single parenting and parental education had also shown evidence of influencing individual risky sexuality behavior. The review also cites research results on this regard as parental divorce and education to have been predictors of sexual risk behavior. In terms of family processes, parenting behavior has been identified as an important source of influence on adolescent sexual activity. Throughout the socialization process, parents transmit their own standards of conduct, both directly through their parenting practices and indirectly through their own observable behavior. In regard to the direct transmission route, three dimensions of parenting parental monitoring of adolescent behavior, parent–adolescent relationship quality, and parent–adolescent communication — have been identified as important variables in contributing to youth sexual risk-taking behavior. From this review one can draw a conclusion that, within the family system,

there are many important risk and protective factors for adolescent and youth sexual risk behavior.

Kotchick et al had also conducted their review from extra familial view point. According to their findings from different research results, for adolescents who are in the midst of developing their own identities and establishing more complex social networks, the point of reference by which they guide their behavior shifts from the family to the social environment. Of the three systems targeted by this review, the extra familial system is the broadest in environmental scope. As a result, distinct subsystems, such as peers, neighborhoods, and school conditions, have been subsumed under the label of the extra familial system, while Peers become an important source of reinforcement, modeling, and support concerning value and belief systems during adolescence. According to this review, this system is however, received the least empirical attention in the literature on adolescent sexual risk-taking.

Finally Kotchick et al concluded their review results by forwarding their recommendation for the need to give special emphasis and further research on, the extra familial system with respect to adolescent and youth sexual risk behaviors. Two primary reasons were forwarded for such an emphasis: First, as noted above, adolescence is a period of development characterized by the increasing influence of factors outside the family. Therefore, these influences deserve more attention, so that we may better understand the factors involved in adolescent sexual risk behavior. Secondly, of the three systems, the extra familial system is the broadest in scope, as it encompasses the larger social context in which adolescents operate. Arguably, this broad context can serve to interact with, augment, or attenuate the influence of variables in the self or family systems, and for this reason must be included for consideration in all aspects of adolescent sexual

behavior, particularly as we attempt to discover factors that increase or decrease adolescent sexual risk, and ultimately implement methods of preventing such risk.

Schensul, Levyard(2003) and others (Okonkwo, Fatusi, and Ilika) also observe that the social environment to have been playing an important role in the sexual and reproductive health-related behavior of young people, and this include their friends and peers, sexual partners, family members as well as the community, school and other youth-serving institutions. The impact of peers on reproductive and sexual behavior of young people has particularly been documented to be strong. Among others, beliefs of young people as regarding the behavior of their peers have been shown to have impact on their actions in various spheres of health behavior.

2.1 Workplaces as a Subsystem for the Development of Youth Health Behaviors

It is important to conceptualize the workplace not only as a place where people earn a living but also of a distinct community where people interact, socialize and influence each other in terms of creating a shared identity(shared behavior including social behavior), and the role of “peer pressure”. The pervading feature of such shared behavior into the surrounding community and as a result of such interaction in knowledge and experience has its own impact in the likelihood of personal exposure to SRH risks such as stis, unwanted pregnancies and unprotected sex (Schensal, levy and Disch, 2003; MoLSA, 2004).

Different studies have established high risks of sexual behaviors are related to the working environment. Study conducted in sexual behavior among female workers of textile factory in Tirpur, India, identified that more women have been infected with HIV and that many factors predispose them to risk even if they have reasonable knowledge regarding its prevention. Having casual partner, having sexual coercion in the workplaces, low self-efficacy for condom use etc were some of the factors identified from this study (Paul etal, 2002).

Floriculture industry, as one of the workplace area, is one of the booming agro industries that linked the developing countries with the global market (Catherine and Kristi, 2003 cited in Fatuma, 2007). In terms of its social development, the flower industry is important since it creates many jobs owing to the labor intensive production system. According to Fatuma, 2007, more than 190,000 people in developing countries are employed in this industry with overwhelming majority being youths. Among the workforce, women constitute 65-70 %, P.9).

In Ethiopia, the business of cut-flower industry is a new and fast expanding industry. In 2002, the Government of Ethiopia in its Poverty Reductions and Sustainable Development Strategic paper (PRSDP) has identified the floriculture as one of the main promising sector for Ethiopian export. As a result the number of projects that were only one before 1998 was grown to 65 in the year 2006(Ministry of Trade and Economic Development, 2007).

Recent studies conducted by Fatuma, 2007 and BICDO, 2006 around Holota town revealed that on average 400 people are working in a single flower project. According to the recent statistics obtained from these farms the majority of the labor force (80%) is youths with young women took the lion share.

While there is a growing body of literature and research results that addresses the RH and health status of youth in Ethiopia, very little of it addresses rural youth specifically youths working in the flower industries that are placed in the rural or per urban areas.

The focus of this study will be guided by data on factors for YSRH risk behavior particularly STI and unintended pregnancy in the rural workplaces in this case the flower industry.

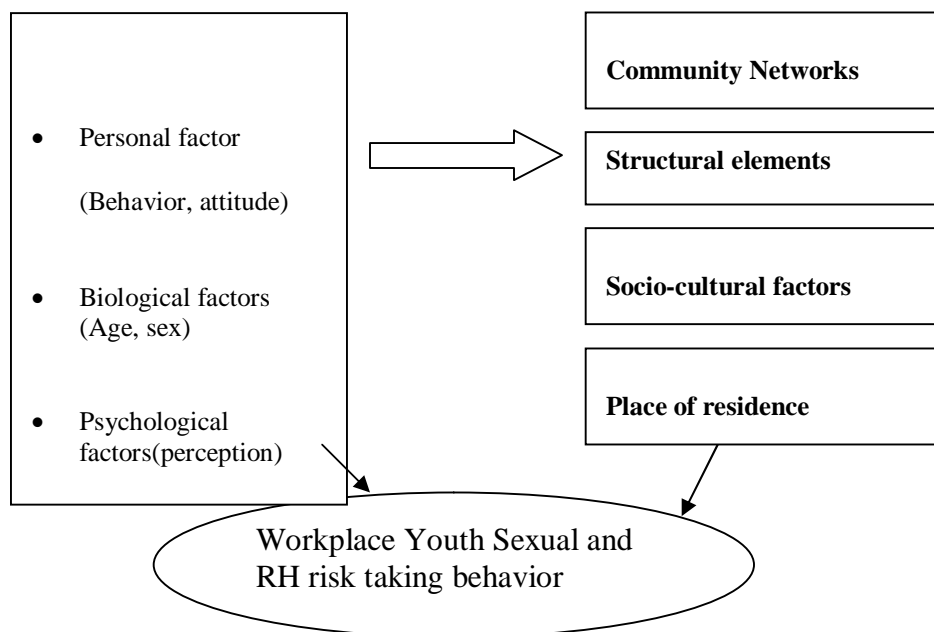
2.3. Conceptual /Theoretical Frameworks

Independent Variables

Intermediate Variables

Individual level Factors

Social-Environmental factors



Conceptual /Theoretical Framework was adopted from the above review of literature that can summarize the background information and used as a guide in the study of factors predisposing Youths working in the rural workplaces.

3. RESEARCH DESIGN AND METHODOLOG

3.1 Study Design

A cross-sectional study design with quantitative and qualitative data collection methods will be used to assess factors that predispose youths in the rural work places of flower industry to high risk sexual and RH behavior with respect to sexually transmitted infections and unintended pregnancy in the study area.

3.2. Description of the study area

The envisaged research is intended to be conducted in Woliso Woreda of South West Shoa Zone, Oromia National Regional State, Ethiopia. The study specifically focuses on flower farms. Woliso Woreda is one of the 12 Woredas found in South west Shoa zone. According to 2014 estimate of Woreda Health office, the population of the woreda is estimated to be 165,280 (79,334 Male & 85,946 Female). The woreda is divided into 38 Rural and 4 urban Kebele Administration. The population of the Woreda is predominantly Oromo followed by Gurage origin. Woliso the capital town of the Woreda is located at 114 kms south west of Addis Ababa on the main highway leading to Jima. The Woreda is known to have endowed with different projects such as Green houses that are private flower Projects with their thousands of workers, and other private colleges and relatively large number of labor force.

The researcher decided to work on this topic after having made some exploratory interviews with people having an expertise on the issue, stakeholders and few target communities; reviewing relevant literature and personal observations made during field work placement a few months prior to this study.

3.3. Study Population:

To address the gaps in knowledge of factors exposing youths working in rural workplaces to sexual and reproductive health risks, a descriptive –cross-sectional study will be employed in Dilala flower farm located in Woliso Woreda. The study population will be selected from each green house 15 male, 20 female youths from target population working in Dilala flower farm found in Woliso Woreda and fulfilling to inclusion criteria of age 18-24years.

3.4. Data Source

The data source will be made as wide and diverse as possible to capture reliable and objective information within the time frame. Accordingly, the possible data sources include but not limited to: Social and public health service providers, out of school ARH club members and personnel of NGOs providing social services to the local communities, workplace youths, labor Unions and workplace management; and focus groups of pertinent stakeholders such as investment Office, Health Office, Women’s and Child Affairs, youth from Woreda.

3.5. Sampling

The primary target group, the workplace youths workers sampling will be multi-stage- using the stratified sampling. The proportion of youths will be calculated across the establishments of forty one Greenhouses. Next the youths will proportionally be taken from each type of greenhouses. Following the stratification, simple random sampling will be used to select the individual respondent.

The study population will be selected from each green house 15 male, 20 female youths from total population working in Dilala flower farm found in Woliso Woreda and fulfilling to inclusion criteria of age 18-24yrs.

To qualify for enrolling in the study, perspective participants have to be in the age range of 18-24yrs and working in the farm.

Purposive sampling method will be employed for taking the stakeholders' group. A pool of eligible members (responsible) will be created. Criteria will be developed for the selection of the respondents- relevance of organization with the question at hand and the willingness of the parties to be involved in the study are some of the possible criteria to be used.

3.6. Data Collection techniques

Different instruments will be prepared and employed to collect primary data. Following are some of the instruments will be employed to collect data.

A. **Document reviews:** A review of previous studies on this subject, available policy issues being in place by different actors, Statistical pieces of information such as health, HIV, family planning education, demographic and socioeconomic profiles of the target areas will be gathered from different sources. Some of these sources of information are:

Past socio- economic survey results conducted by some of the NGO's operating in the area; and
Report of Demographic and Health Survey of Ethiopian (DHS)

Different data compilation forms and checklists will be prepared as a data collection tool

B. **Focus Group Discussion (FGD):** Three focus group discussions having an average of 5 people in each FGD will be held at both workplaces and at woreda level with different group discussants. The selection of the discussants will be purposive. The discussants at woreda level will be selected and invited in collaboration with Kebele leaders and some influential people having broader knowledge of the respective communities. At the workplace level, discussants will be selected to accommodate, the youths, the management members, the labor union.

C. **Questionnaire:** to generate both quantitative and qualitative data pertaining to the characteristic variables of the target groups, an anonymous, structured, pre-tested questionnaire will be developed and a filled by the trained enumerators/data collectors through a face to face discussions with workplace youths. The questionnaire will be a combination of both open and closed –ended and will be pre-tested before the actual survey. The questionnaire will be prepared to be categorized to accommodate the available variables.

3.7. Variables

A review of the literature on a modified version of the world health organization survey instrument package (WHO 1990), youth risk behavior survey (YRBS) by the center for disease control and prevention (CDC, 1999) and others (Hofmanetal, 2004; Anebo, 2007; and Cheryl& Hawas, 2004) have identified several composite variables which among others that this study is going to measure demographic Characteristic of the target group, perceived vulnerability to STI infection and self efficacy, risk-Sexual behaviors of the participants such as engaging in premarital sex, having multiple partners, having made unprotected sex, etc, knowledge on prevention of STI and unwanted pregnancy and community and Peer influence.

3.8. Data Entry and Analysis

Both the quantitative and qualitative methods will be applied to reach to the necessary conclusion and recommendations.

Quantitative data will be entered using appropriate software in consultation with statistical specialist. Interview questions of the questionnaire will be given sequential reference tag (No) to easily identify one respondent from the other one. Range checks and skip patterns will be programmed into the data entry template to minimize possibility of data entry errors. Analysis

will be made both by Microsoft excel and Statistical package for Social science (SPSS) version 20 for analysis based on its magnitude of complexity.

The specific method of data analysis will involve descriptive statistics such as mean, standard deviation and coefficient of variation, computation of frequencies and percentages to estimate the magnitude of the problem and examine the characteristics of the target groups. , Furthermore, inferential statistics such as simple correlation and multiple regression models will be employed to examine and establish statistical relationship between youth vulnerabilities to ASRH risk as a dependent variable and various independent variables. The degrees of association between dependent and independent variables will be assessed using OR and 95% CI. P-value less than 0.05 will be considered as statistically significant.

On the other hand FGD will be transcribed and translated from Afan Oromo to English. Transcription and translation will randomly be checked for accuracy. Qualitative texts will be coded and analyzed using content analysis and triangulation. Summaries of code data will be prepared in narrative format, organized according to the topic area of inquiry.

3.9. Ethical Consideration

Before the commencement of the research process, the researcher will have letter of introduction/ cooperation from Addis Ababa Indira Gandhi Open National University school of Social work(Study Center) to be shown to concerned stakeholders and the target group ,all respondents will be participate voluntarily upon having understood and agreed the purpose of the study, time schedule and place of discussion, research assistants (enumerators) will be well oriented on such ethical issues during their training of data collection techniques prior to entering into the data collection process and throughout this study, privacy and confidentiality will be emphasized. All

data will be collected in a private setting, individual participants will not be identified by names and the research materials will also be maintained by the researcher and his assistances. The discussion with male and female will be carried out separately and will be conducted by same sex enumerator. Maximum effort will be made to avoid description that will make the study participant to be identifiable.

4. CHAPTRAIZATION

The first chapter one shall be an introduction to the subject matter of SRH risk of youth. In this chapter, an attempt shall be made to describe the concept of SRH and STI.

Second chapter shall deal with the conceptual framework and research design of the present study. A review of literature and profile of flower farm selected for study shall also be included in this chapter. **Third chapter** Shall be consisted of research design and methodology. **Fourth chapter** shall be data enter and interpretation. **Fifth chapter** will be conclusion and recommendation.

5. WORKPLAN AND BUDGET PROPOSAL

Overview of Activities Schedule

Exact and detailed calendar dated schedule for the whole research work will be produced and issued in participatory manner with the stakeholders. However given the scope and intended results of study, the research is expected to be completed within six months of time covering November to April 30, 2015. Generally to materialize the intended result the research project will require following the work plan below.

Activities	Months					
	N	D	J	F	M	A
Preparatory works: elaboration of detail work plans and functions, developing of formats and tools to be used. Sampling details (sites, institutions, etc)	X					
Secure letter of collaboration from AA IGONU (Study center)	X					
Held discussions with flower farm owners, Woreda and kebele Officials on the purpose of the research, consultative meetings, and reconnaissance visits in the farms and communities in concern	X					
Identify and compile profile of institutions working in the study area and on the subject of the study.	X					
Screen and hire enumerators	X					
Train/Orient enumerators on the objectives and methods of the study and ethical considerations on data collection		X				
Conduct pre testing and make amendments on the instruments if deemed necessary		X				
Select Study units and participants		X				
Assign enumerators on their respective sampling unit/Workplaces		X				
Conduct an Interview		X	X			
Conduct Focus Group discussion			X			
Supervise the daily activities of the enumerators		X	X			
Secure and review relevant documents and reports at different level		X	X	X		
Compile and analyze data and information collected		X	X	X		
Write up first draft report				X	X	
Present preliminary findings on validation workshop with stakeholders at the Woreda level					X	
Produce post workshop report and submit it to the advisor						X
Feedback on the report received						X
Final report submitted with comments incorporated.						X

5.1. Financial Requirement

This proposal is prepared on the basis of the corresponding technical detail activities as elaborated below

S/n	Cost Item	Budget
1.	Transportation and local Travel costs	
	Transportation	
1.1	Public Transport cost fare for inter-village and Woreda transportation for the researcher during field work 1@ 20 Birr/day* 25 days	500.00
1.2	Transportation cost for the enumerators 6 @ 10 Birr/day* 21days	1,260.00
	Perdiem expense during field work	
1.3	Perdiem for the researcher 1 @125 Birr/day*35 days	3,750.00
1.4	Daily subsistence allowance for enumerators during their field work 6@ 50 birr /day *10 days	3,000.00
1.8	Lunch allowance for Woreda stakeholders during debriefing session on the results of the study 24@30 birr/person* 1/2 day	720.00
	Subtotal	9,230
2.	Training expense for enumerators/data collectors	
2.1	Perdiem for trainee 6@50 Birr/day X 2 days	600.00
	Trainer Perdiem 1@ 125 Birr/day X 2 days	250.00
2.2	Refreshment cost @ 10 birr/participant/day X 2 days X 7 participants including the trainer	140.00
2.3	Training hall rental 150 Birr/day X 2 days	300
	Subtotal	1,290.00
3.	Material and Service Costs	
3.1	Stationeries	1,101.00
3.2	Secretarial and photocopy services	1,200.00
3.3	Refreshment Cost for participants during debriefing sessions 2 persons@10 birr/person	240.00
	Subtotal	2,541.00
	Grand Total	13,061.00

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