



**PREDICTORS OF RISKY SEXUAL BEHAVIOR AMONG  
PREPARATORY STUDENTS IN DEBREBRHAN NORTH SHOA  
ETHIOPIA**

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## Abstract

**Background:** Adolescents often lack basic sexual information, knowledge and access to health services. Risky sexual behaviors are defined as sexual activities that may expose an individual to the risk of infection with human immune virus and other sexually transmitted infections, unwanted pregnancies and their complications. These risky sexual activities predispose young people to be disproportionately affected by reproductive morbidities including sexual transmitted infections including human immune virus.

**Objectives:** To assess predictors of risky sexual behavior among preparatory students in Debrebrhan Town, North Shoa, Ethiopia.

**Methods:** An institution-based cross-sectional study involving both qualitative and quantitative data collection methods were conducted from 1-15 March, 2013. A total of 325 students were recruited into the study using simple random sampling method. Data were collected using structured, self administered questionnaire. The qualitative data were generated using focus group discussion. The data were entered into EPI-INFO version 3.3.1, and then exported to SPSS for windows version 20.0. Descriptive statistics, bivariate analyses were done to characterize the study sample and the distribution of the sample by risky sexual behavior. A multivariable logistic regression analyses was employed to isolate an independent effect of the predictors.

**Results:** All the sampled students responded to the questionnaire giving a response rate 100%. Ninety one (28.0%) of the respondents was exposed at least one risky sexual behavior. A unit change of the student's knowledge of unsafe sex decreases risky sexual behavior by more than 26% (AOR= 0.734, CI=0.598, 0.901). Those who live with single biological parent were 15 times more likely (AOR=15.288, CI=1.76, 132.62) to be involved in a risky sexual behavior. Similarly, those living alone in rental house were 9 times more likely (AOR=9.026, CI=1.71, 47.48) have risky sexual behavior, while, those living with relatives were 3 times as likely (AOR= 3.333, CI=1.274, 8.721) to have risky sexual behavior than living with both biological parents. Adolescents who discussed on sexual issues with their family were 0.065 times less likely to have risky sexual behavior compared with those who did not discuss (AOR= 0.065, CI=0.008, 0.514). Pocket income (AOR=2.763, CI=1.464, 5.216) and having boy/girl friend (AOR=.078, CI=0.015, 0.404) were also among predictors of risky sexual behavior for the respondents.

**Conclusion and Recommendation:** A substantial proportion of preparatory students were engaged in risky sexual behavior. Knowledge of unsafe sex was negatively associated with risky sexual behavior. Therefore, school-based sex education programs should be designed and reach out beyond just the provision of information. More effort should make to increase parent child discussion on sexual matters and life skill to decrease engagement of school children in risky sexual behavior. In addition, inter-sectoral collaboration with parents and community should be established and maintained.

**Keywords:** Risky sexual behavior, young people, unsafe sex

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## **ACRONYMS**

- AIDS-** acquired immune deficiency syndrome
- BSS-** Behavioral Surveillance Survey
- CSA-** Central Statistical Agency of Ethiopia
- EDHS-** Ethiopia demographic and health survey
- FGD-** focus group discussion
- HIV-** Human Immune deficiency Virus
- ICE-** Information and communication education
- ICPD-** International Conference on Population and Development
- ISY-** In-school youth
- RH-** Reproductive health
- SPSS-** Statistical Package for Social Science
- SRH-** Sexual reproductive health
- STIs-** Sexually transmitted Infection
- UNAIDS-** United Nations Programmer on AIDS
- WHO-** world health organization

# CHAPTER ONE-INTRODUCTION

## 1.1 Background Information

There are about 2 billion people between 10-24 years old in the world, close to 85% of these young men and women live in developing countries where poverty levels remain high and resources are constrained (1). In these group rates of early and unplanned pregnancies, unsafe abortions, maternal deaths and sexually transmitted infections (STIs), including the HIV/AIDS are very high. It is estimated that more than half of all new HIV infections are among young people, while between one quarter and one half of adolescent girls become mothers before they turn 18. Adolescent girls are two to five times more likely to die during pregnancy or childbirth than women in their twenties (2).

An interest in youth health issues has grown dramatically in the past few decades. At the 1994 International Conference on Population and Development (ICPD), the international community for the first time acknowledged the reproductive health challenges facing young people and nations agreed to make adolescent sexual and reproductive health a priority (3). However, amid this burgeoning attention, the youth continue to be the butt of sexual activity related problems (4).

According to World Health Organization (WHO) definition young people comprise individuals between the age group of 10-24 years; and this group combines adolescents aged 10-19 years and youth aged 15-24 years. Adolescent is the period of transition from childhood to adulthood characterized by significant physiological, psychological and social changes. It also a phase with rapid changes when adolescents feel secure, making it easy for them to participate in activities considered risky such as sexual relations (5-6).

Sexual risky behaviors are defined as sexual activities that may expose an individual to the risk of infection with HIV and other STIs. These include unprotected sex, an early sexual debut, taking alcohol or drugs before sexual intercourse, multiple sexual partners and forced or coerced sexual intercourse for reward (7). These risky sexual activities make this group disproportionately affected by reproductive morbidities including STI/HIV, unwanted pregnancies and their complications. Physiologically, the changes in reproductive organs that occur in the life of adolescents often serve as a motivating force in their quest to experiment with sex. Demographic health surveys and social studies of many countries have prevailed that adolescents in now a days are experienced puberty at younger age than the previous generation. In many countries, most teenagers (60% to 70%) are sexually active (8-9).

Young people lack information partly because they lack experience. Youth is a time of experimentation; this experimentation is partly intended to acquire information about behavior, choices, and consequences, as well as to form a sense of identity and belonging. Young People choose behaviors because of the pleasure and benefits they yield. The pleasure from some of these behaviors is fleeting,

while the costs can persist. Experimentation can lead to habits and addictions, which can be destructive and extremely difficult to break (10). Lack of knowledge about HIV and AIDS and poverty have been identified as risk factors that increase the chances of young people engaging in risky sexual behavior (7). Joint United Nations Program on AIDS (UNAIDS) reported that the rate of newly acquired HIV infections are the highest in the 15-25 years age- group and that this group accounts for about 60% of the global total of HIV infected persons (11).

In Ethiopia an expanding young population characterizes the country. It is estimated that young people age 10-24 constitute about a third of the population. This group holds a strategically critical position within the context of population development. Not only does it represent a vast portion of the population, but also the behavior and attitude of this group towards sexual and reproductive health will determine the demographic scene of the country, as it is sexually most active. Therefore, Ethiopia Government and Ethiopian Ministry of Education promoted the Health and School Survey among students to learn more about the health of Ethiopian adolescents, because sexual risk behavior are preventable by a coordinated effort between families, schools, health and education agencies and community organizations (**12-13**).

## **1.2 Statement of problem**

Young people constitute a critical group in social transformation, and so their welfare has an impact on development. Although they tend to be conceived of as healthy, the consequences of their behaviors are known to surface in the long run (10). According to the World Health Organization, 70% of premature adult deaths are linked to behaviors established during adolescence, among which is the consumption of addictive substances and sexual risk behaviors (14).

Sexual and reproductive health among adolescents have become increasingly important and aroused international concerns (15). In recent years numerous surveys have shown that adolescents, especially in developing countries, have low levels of sexual knowledge affecting their attitudes towards sex and sexual behaviors (16-19). As a result of this they display sexual behaviors and developmental characteristics that place them at risk for sexually transmitted infections. A primary source of risk of HIV/AIDS for instance is unprotected /indiscriminate hetero-sexual activity. Low STI knowledge has also been shown to be connected with undiagnosed and untreated STI, unsafe sex practices and HIV (20).

An estimated 14 million adolescents give birth globally each year and more than 90% of these live births occur in developing countries. For women aged 15 to 19, complications of pregnancy, childbirth, and unsafe abortion are the major causes of death. Particularly adolescents in the Sub-Saharan Africa region have low family planning utilization rates and limited knowledge of reproductive health (RH) services. They account for a higher proportion of the region's new HIV infections, maternal mortality, and unmet need for reproductive health information and services which is linked to social, cultural, economic and gender related factors (21-22).

It is estimated that young people (10-24) in Ethiopia constitute about one third of the population (23). Early sexual debut and early marriage, in particular in rural areas, and very limited use of contraceptives have been associated with unwanted pregnancy. Studies have shown that in Ethiopia 60% of adolescent pregnancies are unwanted or unintended. The risk of dying from pregnancy related causes is in many countries is twice as high for adolescents aged 15-19 as for older women. Babies born to adolescents have higher rates of neonatal mortality (24). In addition; unwanted pregnancy among female students may lead to school dropout and a failure to complete their education. The situation is serious for those who are not physically

matured. Hence, unwanted pregnancies may end up with illegal and unsafe abortion, which may lead to death (25).

According to the 2011 EDHS, the coverage of family planning method was only 23.8% among adolescents' of 15–19 years of age. Unmet need for family planning in the same year was 25% and it is highest among adolescents of 15–19 years of age. Although the government provides contraception at no cost, these supplies are frequently not readily accessible for this age group. Childbearing also begins early, with 45% of total births in the country occurring among adolescent girls and young women (26-27). Early childbearing has been linked to higher rates of maternal and child morbidity and mortality, truncated educational opportunities, and lower future family income. Adolescent fertility has also been associated with larger completed family sizes, which in turn may lead to greater population growth rates (28).

Age at first sex is an important indicator of both exposure to the risk of pregnancy and exposure to STIs. Young people who initiate sex at an early age face a higher risk of becoming pregnant or contracting an STI than young people who delay initiation of sexual activity (26). Furthermore, early age at sexual initiation has been associated with more sexual partners during adolescence and lack of consistent condom use. According to the second round BSS in Ethiopia, it was found out that around 9.9 percent of the ISY had sexual experience. The mean and medium age of sexual debut among youth was 16 years (29).

Young people aged 15 to 24 have the highest rates of sexually transmitted infections (STIs), including HIV/AIDS. At the end of 2010, an estimated 34 million people were infected with HIV globally, including 3.4 million children less than 15 years old. In sub-Saharan Africa alone, an estimated 22.5million people were infected with HIV/AIDS. In this region, Ethiopia is among the countries highly affected by HIV. In addition, other sexually transmitted infections (STIs) have increasingly been recognized among youths in Ethiopia (30).

According to Kaiser Family Foundation teens and young adults are in the centre of the epidemic because young people age's 15-24 account for approximately half of new adult HIV/AIDS infections and 28% of the global total adults living with HIV/AIDS (31). Also United Nations Population Fund confirmed that young people are at the centre of the HIV/AIDS epidemic in terms of rates of infection, vulnerability and of the 1.5 billion young people worldwide, 11.8 million are estimated to be living with HIV. It is also reported that every day

between 5,000-6,000 young people (ages 15-24) contract HIV and that many of them still lack comprehensive and correct knowledge about to prevent the infection (32).

In HIV education, knowledge is very important. However studies of researchers like Diclement, et al. (33) have also reported a poor correlation between knowledge and sexual behavior since knowledge have been shown not to be enough, studies have shown that people practice unsafe sex despite their knowledge of HIV/AIDS. According to Adegbola, et al. (34) knowledge essentially is the recall recognition of specific and universal elements in a subject area. In the context of HIV/AIDS, having knowledge implies ability to recall facts concerning causes, transmission, prevention, concerning HIV/AIDS consequences and relation to other STI.

According to a literature review of one study, different studies have shown sex, early puberty, substance use, low parental education, parental absence, self-esteem, grade, perceived peer sexual norms, and cultural and family patterns of early sexual activity to be some of the predictors of youth sexual activity. As both Khat and alcohol are widely consumed in these groups, description of the relationship between these substances and risky sexual behavior would usefully guide national policy and decision making on HIV/AIDS and other sexual related consequences (35).

Studies in different countries show that cultural and social norms influence adolescents to adopt unsafe sex practices in most African countries including Kenya, Malawi, Nigeria, Ethiopia and Uganda (36-38). Other evidence also shows that the current rapid social, political and economic transformations in sub-Saharan Africa also appear to have a profound impact on the social norms affecting adolescents' sexual activity (39-40). Health professional are also responsible to promote and provide the sexual and reproductive health service to adolescents in health facilities. The evidence in many countries has shown that most young people do not routinely seek sexual and reproductive health service. The role of health professionals as a source of information is found to be low. Health care providers in Ethiopia are often ill equipped to address adolescent-specific needs (41).

Discussions on sex-related matters are a taboo in Africa (42) and believed that informing adolescents about sex and teaching them how to protect themselves would make them sexually active (43). In the same way, parent-youth communication on SRH issues in Ethiopia is believed to be culturally shameful. Socio-cultural taboos attached to it and lack of proper knowledge makes open discussions about sexual and reproductive health topics difficult (44). However, it is

believed that, home, as the initial focal point for investing in young people, is one of the many layers of environments for socialization. Providing avenues for child/parent connectedness, communication, and monitoring, the home is expected to serve as a stabilizing factor in the lives of young people.

A central developmental task for young people is gaining autonomy and developing close relationships with same and opposite-sex peers that help adolescents become more independent. Peers may become more powerful sexual socialization agents than parents, particularly for information about sexual intercourse. The mass media also provide models for sexual behavior. According to the social learning theory, young people can learn about sexual activity from observing others depicted in the media. Numerous studies that illustrate media's powerful influence on adolescents' sexual attitudes, values, and beliefs have verified the essence of this theory (45).

Studies suggest that adolescents in Ethiopia are exposed to various risks such as unprotected sex, early pregnancy, sexually transmitted infections (STIs) and HIV/AIDS. However, as to the knowledge of the investigator, preparatory school adolescents' risky sexual behaviors and its predictors are not assessed in the study area.

## CHAPTER -TWO

### 2.1 literature review

As noted by Kofi Annan, “Knowledge is power. Information is liberating. Education is the premise of progress, in every society, in every family”(46) With respect to protecting sexual and reproductive health, this is particularly relevant for the very young adolescents, many of whom are yet to become sexually active, so that they make informed and responsible decisions when they eventually initiate sexual activity. In order to effectively equip young adolescents with the information they need to protect themselves from the risk of unintended pregnancy and STIs, including HIV, it is important to have a good understanding of the risky sexual activity that and factors associated with it.

A study conducted Southwestern Nigeria assessed the knowledge, attitude and practice of preventive measures of HIV/AIDS among in-school adolescents with the sampling size total of four hundred and fifty respondents. The study was carried out, as a descriptive cross-sectional study design and a systematic random sampling technique was employed to select the respondents from the school register into the study. The result reveals that there were 248 males and 202 females, median age of respondents was 17years, mean age was 16.6 + 1.2 years with majority in the age group 15-19, and males were more sexually active than females. Majority, 92.0% of the respondents were aware of the existence of HIV/AIDS; commonest source of information being electronic media though their knowledge of routes of transmission and modes of prevention of the disease was erroneous and inadequate due to several misconceptions. There was generally an intolerant attitude towards HIV infected people and many respondents will like to know their status if the test was free. There was poor practice of preventive measures among the respondents (47). This study has not examined the sexual practice of participants and doesn't consider knowledge of other STI knowledge which is interrelated with the transmission of HIV/AIDS.

A study conducted in Catalonia, Spain on Gender differences in sexual risk behavior among students aged between 14 and 16 years old was carried out in 2005-2006 data obtained from the survey “Health and School”. A cross-sectional study using a two-stage sampling of the schools was carried out. This study included 4,653 boys and 4,687 girls with a mean age of 15 years. A result shows a total of 38.7% of students had had sexual relations at least once and 82.3% of boys and 63.0% of girls were engaged in sexual risk behaviors. The prevalence of sexual relations and risk behaviors was generally higher in boys than in girls, independently of the



variables analyzed. Boys had more sexual partners and used condoms as a contraceptive method less frequently than girls. Foreign origin was related to unsafe sexual activity in both genders. Alcohol consumption was also a risk factor in boys (48). This research did not use in-depth assessment of factors and risk behaviors because a study conducted on secondary data. In addition doesn't examine the difference on status of knowledge as that of sexual risk difference.

A Cross sectional study conducted by L.A.LEMA et al (2008), Kibaha District, Tanzania among youths aged between 15 and 24 years to assess Knowledge on HIV/AIDS and sexual behavior. Multistage cluster sampling design was employed and a total of 322 individuals aged 15-24 years were involved in the study. The result showed that more than 69% had sex at least once in their life time. Only about 32.3% of the youths reported to have used condom during the first sexual intercourse and 37% during the last sex. About 21.7% of the respondents acknowledged having more than one sexual partner in the last 12 months. The majority (98.4%) of the respondents have heard of HIV/AIDS. 74.8% of the respondents knew where to get HIV testing services but only 28.9% had tested for HIV infection. Of those not yet tested, 38.2% admitted that they were ready to do so. Although 98.4% respondents were aware of HIV/AIDS, and majority, 65.2% mentioned condom as the method used to prevent its transmission, only 36.3% acknowledged using them (49). However, this study didn't have qualitative data to triangulate the findings of the quantitative study for an in-depth understanding of sexual issues. Additionally didn't set the inclusion and exclusion criteria to select study population clearly.

A cross sectional study conducted in Kenya, 2007 on prevalence of sexual intercourse among school-going adolescents. The study involved secondary analysis of existing data available from the Kenya Global School-Based Health Survey conducted in 2003. A self completed questionnaire was used. The sample was selected to be representative of the Coast Province of Kenya within a national sample. A total of 136 males and 106 females participated in the study. The result reveals as overall the prevalence of sexual intercourse within the last 12 months was 22.2% in males and 5.0% in females' total 14.9%. Among males, the protective factors against having sex were being of age <15 years and ever been drunk. The risk factors for having sex among males were ever smoked, having close friends, currently drinking alcohol, ever used drugs and parental supervision. Meanwhile among female respondents, parental supervision was protective and the only risk factor was ever used drugs (50). This study used, very small sample size from the large school based survey data and doesn't showed the participants age group

which is mandatory for age specific sexual and reproductive health interventions and also doesn't consider level of knowledge which helps for behavior change. Doesn't expressed the sexual intercourse was safe or unsafe.

A study conducted among secondary school students Ekpoma, Nigeria, 2011 on knowledge, attitude and practice of contraception. Descriptive study, using a pre-tested, self administered semi-structured questionnaires. A random sample was obtained, comprising 2000 (1000 boys and 1000 girls) students aged between 12 and 24, across five schools a total of 690 and 814 questionnaires were returned in good order for males and females respectively. Analysis of data obtained shows that 398 (57.7%) and 216 (26.5%) male and female students respectively were sexually active as at the time of this study. 68 (17.0%) of the male population had their first sexual intercourse at 9 years. Analysis also showed that 292 (42.3%) and 492 (60%) males and females respectively had good knowledge of contraception while 206 (29.9%) and 122 (15%) males and females had no knowledge of contraception. Parents (25.5%), friends (17%), books and magazines (16.2%) and internet (10.7%) were the main sources of information about sex and contraception. Condom was the major available contraceptive for the males while Andrew liver salt (29%), oral pills (10.3%), 7 Up (7.4%) were the used by the females. About 40% of the total sampled population believed contraception is not safe (51). This research didn't clearly show factors related with no knowledge of contraception that used as evidence to educate adolescents based on factors.

A research conducted in South African University Campus students Sexual Behaviors and Attitudes towards Safer Sex using a target population of 362 second year Psychology students. In this study, a purposive sample of 30 students (10 male, 20 female; aged 17 – 30 years) was selected from the population. As such, the research report was based on a total of 27 participants. The final sample comprised of 9 (33.3 percent) male and 18 (66.7 percent) female participants. Both questionnaires and interviews were used to collect data in this study. The study found that the majority of (67 percent of male and 33 percent female) participants have had more than 2 sexual partners in their lives; and 68 percent of male participants had engaged in risky sexual behaviors under the influence of drugs or alcohol. Despite the availability of condoms, some university students have not changed their sexual behaviors and attitudes towards safer sex (52). This study used a small sample size with purposive sampling method limited generalizability of the results to groups of participants with similar characteristics and does not address participants with equal chance and difficult to assess prevalence rather helps to generate hypothesis.

A cross-sectional survey of college students' knowledge, attitudes and behavior about sexuality Beijing from June to July 2010 of 2080 questionnaires distributed, 2003 were returned. The response rate was 96.2%. Among the respondents, 1137 were male and 836 were female (30 missing values in the

variable of gender). The ages ranged from 15 to 26 years. The data shows that most of the college students lacked knowledge about reproductive health. Only 17.9% of the respondents knew the appropriate time of abortion. Data also shows that the respondents had high-risk attitude about sex, 58.7% could accept premarital sex, and 29.7% had negative attitude towards contraception. Moreover, sexual activity of the respondents was active. Data showed that 18.5% of the respondents had had sexual activities. Significantly more boys than girls had sex. Among the boys and girls who reported sexual history, 43.1% of the boys had impregnated girlfriend and 49.3% of the girls among those people who have sex had unwanted pregnancies. Logistic regression analysis showed that the variables the gender, grade, specialty, family situation, score of knowledge and attitude to sex activity had a significant effect on having sexual behavior (53). On this study all data came from self-reports, and may be subject to recall bias or social desirability bias. Recall bias may affect the reported behavior about sexuality, although respondents may remember this kind of experience better than more mundane events. Underreporting of sensitive behaviors may have occurred. So it is better use triangulated quantitative with qualitative method. Another drawback of this study is the representativeness of the study population for the general students in other population. Therefore, further study needed at different study sites that help to prepare suitable and effective sex health education towards target group.

A cross-sectional population-based study conducted on Lack of knowledge about sexually transmitted infections among women in North rural Vietnam using face-to-face interviews was carried out between March and May 2006 in a demographic surveillance site. In total, 1805 women aged 15–49 years were randomly selected to participate in the study. Result shows that, 78% (73% married vs. 93% unmarried) did not know any symptoms of STI, 50% could not identify any cause of STI, and 59% (54% married vs. 76% unmarried) did not know that STI can be prevented. Only 31% of the respondents (36% married vs. 14% unmarried) answered that condom use could protect against STI, and 56% considered partner treatment necessary. Of 40 possible correct answers, the mean knowledge score was 6.5 (range 0–26, median 6). Young, unmarried women and women who lived in the highlands or mountainous areas demonstrated very low levels of STI knowledge. Experience of an induced abortion was significantly associated with a higher level of knowledge (54). Nevertheless, this research was conducted on only women, whilst other evidences show that males are more exposed for risky sexual practices than females and address all age group at same time which is not adolescent focused.

A Research analyzed data for the infrequently studied group of very young adolescents aged 12–14 in four Sub-Saharan African Countries, 2004. Interviews was completed with 2605 in Burkina

Faso, 1903 in Ghana, 1849 in Malawi and 2480 in Uganda used to describe their sexual activity, knowledge about HIV, STIs and pregnancy prevention, and sources of sexual and reproductive health information, including sex education in schools. Results showed that very young adolescents are already beginning to be sexually active and many believe their close friends are sexually active. They have high levels of awareness but little in-depth knowledge about pregnancy and HIV prevention. Multiple information sources are used and preferred by very young adolescents (55).

A descriptive cross-sectional survey conducted during January-March 2003 in Bahir Dar, Ethiopia to assess factors that predispose out-of-school youths to HIV/AIDS-related risk behaviors using both quantitative and qualitative methods for data collection. The study population included all out-of-school youths residing in the town, the inclusion criteria being: age 15-24 years and not attending school or any vocational training at the time of the study. The sample population constituted 628 youths selected from all the 17 kebeles (villages) of the town proportional to the size of the population size of each kebele. Within each kebele, the required numbers of respondents were randomly selected using systematic random-sampling technique. Result shows of the 628 study subjects, 64.8% had experienced sexual intercourse at the time of the survey. The mean age at first sexual commencement was 17.7 ( $\pm 2$ ) years. Of those sexually active, 33% had sexual intercourse with non-regular partners (the proportions were 40.6% among males and 24.7% among females, suggesting that males tended to be about two times more likely to have sex with non-regular sexual partners than females (odds ratio=1.78, with 95% confidence interval 1.16-2.73). Furthermore, consistent condom-use among those who had sex in exchange for money was low (36%). Alcohol intake, chewing of Khat, low educational background, and being male were significantly associated with having sex with either a commercial or a non-regular sexual partner (56). This study didn't represent the study population attending school and knowledge of study population related to risk behaviors didn't assessed. School based investigation used as baseline data to prepare curriculum based adolescent reproductive health education.

A study conducted among High School Students of Ethiopia to investigate Reproductive Health Knowledge, Attitude and Practice. The study involved 245 (113 males and 132 females) grade 9, 10 and 11 students from Tana Haik and Ghion Senior Secondary Schools in Bahir Dar. They were randomly selected. The result showed that the students had high level knowledge of

contraceptives and where to obtain contraceptive services; however, level of use was low. Some of the reasons given for not using contraceptives include lack of access to services, carelessness, unplanned sexual intercourse and pressure from sexual partner. The study indicates that young people engage in sexual relationships at an early age without protection or with unsafe nonconventional methods. There was no significant difference between the demographic variables and contraceptive use at first intercourse. Educational level of the respondents was the only demographic variable that had significant association with sexual experience (57). This study needs further investigation at other study site to assess that knowledge did coincide with risky sexual practice.

A cross sectional study was conducted in preparatory high school students Gondar town, North West Ethiopia, 2009 to assess students' knowledge, attitudes and practices regarding HIV/AIDS and STDs. There were a total of 658 preparatory students (grade 11 and grade 12) Stratified proportionate sampling was used to select study participants. Results shows as all the students had heard about AIDS before the interview. Knowledge on some aspect of the disease was quite low in the study group. Only half of the students knew that at present, AIDS is incurable and that HIV infection can be acquired through sexual contact with a 'familiar' person. Knowledge about STI was also quite low, 39% knew that pus in the urine is a symptom of STI and 45.4% knew that acquisition of other STIs increases the chance of HIV transmission following unsafe sex with known cases. 25% of the study group had previous sexual intercourse and exposed at least one risk behavior. About 34% of the respondents had negative attitude towards AIDS and STDs (58). This study assess only knowledge of STI in relation to HIV, attitudes and prevalence of preparatory school adolescents practice but assessing knowledge of unsafe sex without observing its effect on practice considered as limitation of this study for action to information dissemination on adolescents to bring behavioral change. So that the present study focuses to assess factors associated with risky sexual behaviors of preparatory school adolescents especially effect of knowledge on it at selected study site.

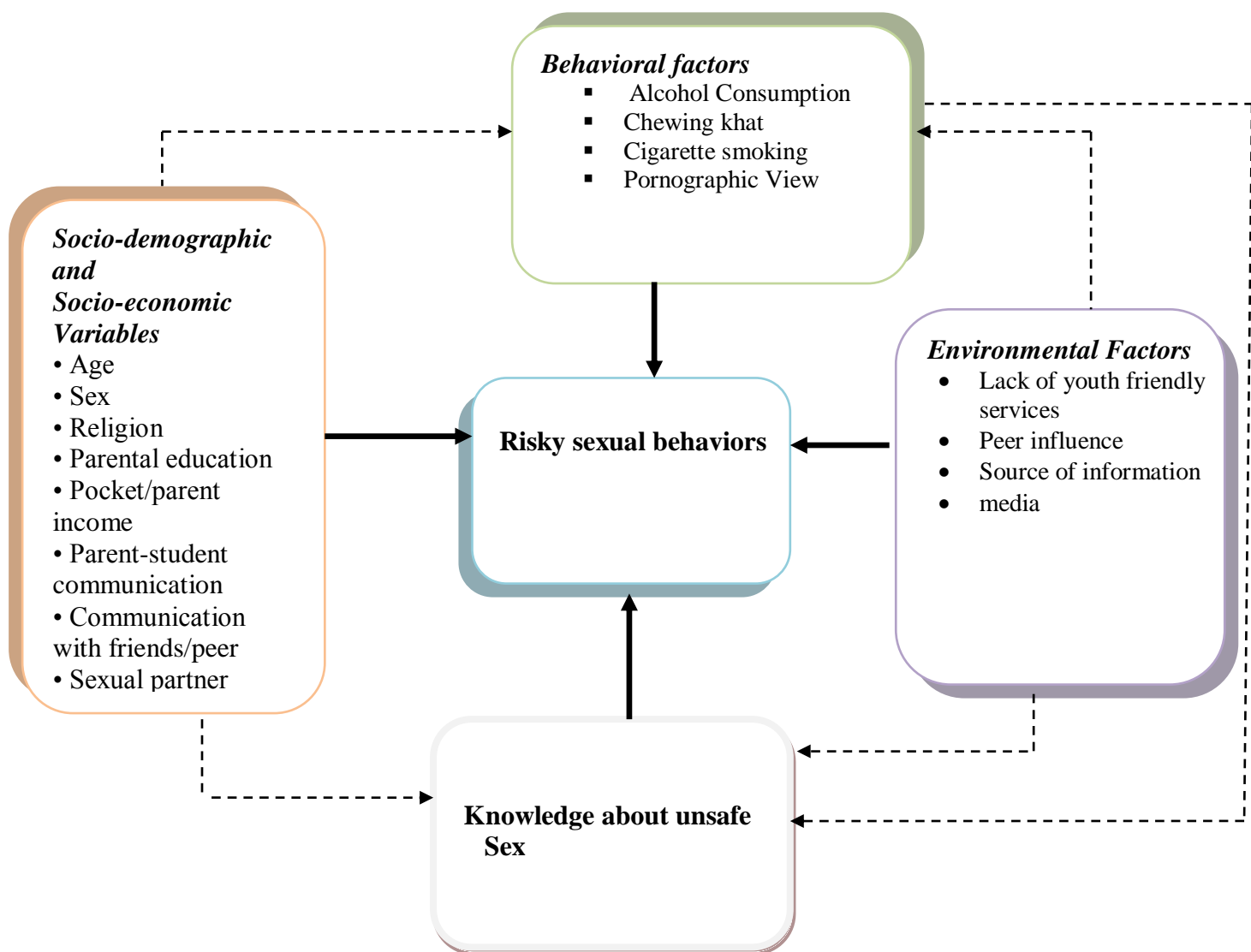


Fig 1: conceptual framework of the study  
 (Source: modified from -Pathfinder international advocates for youth)

### 2.3 significance of the study

Attainment of safe sex practices among adolescents in preparatory school is critical in promoting adolescent health and subsequent attainment of educational goals.

An urgent need, therefore, exists for young people to protect themselves against HIV/AIDS, other STDs, unwanted pregnancy, and experience safe and healthy sexual development. Efforts aimed at reaching adolescents are more promising than those intended to reach adults. This is because adolescents lack knowledge and skills to prevent pregnancy and STDs, they constitute the majority of the population, they represent a more sensible and important investment in the future for reducing fertility than fertile mothers.

Information, education and communication (IEC) programmers aimed at achieving behavior and attitude change among young people is one of the strategies designed to protect young people from STDs, unintended pregnancy and abortion. In order to design optimal IEC programmes, research on the knowledge of adolescents is needed, results of which could be used to carry out intervention programmes that are appropriate for them. This calls for investigation of the needs and concerns of young people. There is paucity of information on sexual practices and related issues of adolescents in Debrebrhan Town. Although there are few educational activities on reproductive health for the young people, they are not research based.

This research was identifying the predictors of risky sexual behaviors among preparatory school students at Debrebrhan Town.

Therefore, the study is considered significant for the following reasons:

- Literature reviewed did not reveal any previous study on factors contributing to risky sexual behaviors among preparatory school adolescents in Debrebrhan;
- Attainment of safe sex practices among adolescents could help reduce the cases of adolescent pregnancy, STI and HIV infection, thereby promoting adolescents to achieve their educational goals;
- The study will provide information to policy makers and program designers need to understand preparatory school risky sexual behaviors in study area;
- Findings of the study will assist in coming up with recommendations for improving the Adolescent Sexual and Reproductive Health services in the study site.
- The results of this study can also serve as a basis for a larger more detailed study on sexuality and risky sexual practice among preparatory students.

## **CHAPTER THREE-OBJECTIVE OF THE STUDY**

### **3.1 General Objective**

- To assess predictors of risky sexual behaviors among preparatory students in Debrebrhan, North Shoa, Ethiopia.

### **3.2 Specific Objective**

1. To assess prevalence of risky sexual behavior among preparatory students.
2. To determine the relation of knowledge of unsafe sex and risky sexual behavior among preparatory students.
3. To asses other factors associated with risky sexual behavior among preparatory school students.



## **CHAPTER FOUR-METHODS AND MATERIALS**

### **4.1 study area and period**

The study was conducted in Hailemariam Mamo preparatory school students from February 1 to March 1, 2013 at Debrebrhan Town.

Debrebrhan Town located, 695 km and 135 km from Bahir Dar and capital city of Ethiopia respectively in the North Shoa Zone of Amhara Region. Administratively, Debrebrhan District has 9 urban kebeles (smallest administrative units) with a projected total population of 65,231, of whom 31,668 are men and 33,563 women according to the 2007 national census conducted by the Central Statistical Agency of Ethiopia (CSA); the proportion of youth (15-24 years) in the town constituted about 24.4% of the total residents. Concerning major infrastructures and social facilities, the town has two secondary schools and one preparatory secondary school. In the study area there are two anti-AIDS clubs, five anti-AIDS Associations and five youth associations. Currently, the Woreda AIDS Coordination Office, Life in Abundance-Ethiopia and the Agency for the Assistance of Refugee, Displaced and Returnees are among the organizations engaged in social services on the fight against HIV/AIDS. The government organizational structure to fight the spread of HIV/AIDS in the Woreda includes the Woreda AIDS Council and the kebele AIDS committees. Formal care and support services are not available, except from the woreda HIV/AIDS Coordination Office, which allocates 100 birr per month for those who are poor and living with the virus. VCT services are available in the health center and hospital but it is not youth-friendly services.

### **4.2 study design**

An institutional based cross-sectional design including both quantitative and qualitative data collection methods was used. The qualitative study was conducted to enrich the quantitative findings and to explore some of the major results further.

### **4.3 Population**

#### **4.3.1 Source population**

The source populations for the study were a preparatory school students in Debrebrhan Town enrolled in 2012/13 academic years.

#### **4.3.2 Study population**

All preparatory school students enrolled in 2012/13 academic years enrolled into the study.

## **4.4 Inclusion and exclusion criteria**

### **4.4.1 Inclusion criteria**

- Age greater or equal to 15 years

## **4.5 Sample size determination and sampling technique**

### **4.5.1 Sample size determination**

The sample size was determined by using the following assumptions: level of confidence was 95%, a 5% margin of error ( $d= 0.05$ ) and a proportion of 50% study population has a risky sexual behavior. Based on this assumption, the actual sample size for the study was computed using one sample population proportion formula as indicated below.

$$N = \frac{(Z_{\alpha/2})^2 p (1-p)}{d^2}$$

$Z_{\alpha/2}$ = Standard normal variable at 95% confidence level (1.96).

P= the proportion of study population risky sexual behaviors (0.5)

d= the desired precision of the estimate (0.05)

n= the minimum sample size.

In addition, by considering 10% none -response rate and using correction formula for relatively small population ( $N = 1262$ ) with the above assumptions, the overall sample size calculated using STATCAL program of EPI INFO program version 6 was found to **325** students.

### **For qualitative study**

Four FGDs (two males and two females) with a group of 8 students in each group was prepared.

### **4.5.2 Sampling techniques and procedure**

A grade stratified simple random sampling technique was used to select students by considering both the inclusion and exclusion criteria. The one preparatory school residing in Debrebrhan town will be selected as study area. The total sample calculated from total students in preparatory school was distributed to the department of social science and natural science departments proportionate to their student total number. Then proportional sample was assigned for each grade level. Finally simple random sampling was used to select the sample from each grade until the sample size is fulfilled. Then the selected students were invited to participate in the survey.

### **Proportionate allocation**

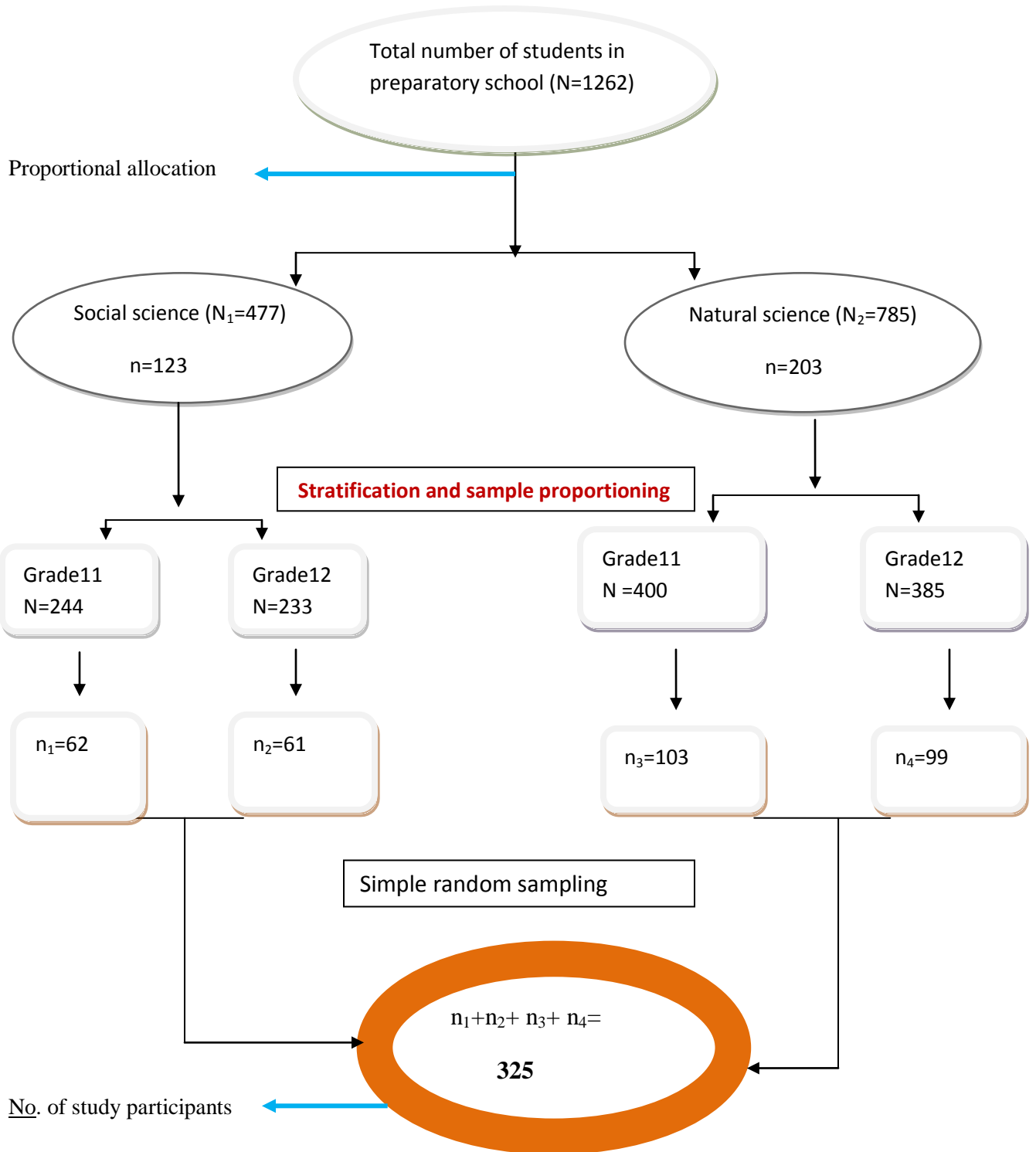
$$n_j = \frac{n N_j}{N}$$

$n_j$  = is sample size of the  $j^{\text{th}}$  grade.

$N_j$  = is population size of the  $j^{\text{th}}$  department.

$n = n_1 + n_2 + n_3 + n_4$  is the total sample size.

$N = N_1 + N_2$  is the total population size.



**Fig 2:** Diagrammatic Scheme of Sampling Procedure

Purposive sampling techniques was used to select students for the FGDs to strengthen the quantitative finding of preparatory students' common risky sexual behaviors and the knowledge about unsafe sex/unprotected sex. Four FGDs was conducted by mixing students based on their class achievement and participation in clubs related to adolescent health. The psychologist was the moderator; Co-moderators was selected from each focus group discussant. One of the data collectors was script writer and recorder.

## **4.6 variables**

### **4.6.1 Dependent variables**

- Risky sexual behavior

### **4.6.2 Independent variables**

- *Knowledge about unsafe sex:-* safe sex ,pregnancy occurrence time, contraceptive methods, STDs, STIs sign/symptoms and prevention methods, HIV transmission and prevention methods, relation of HIV/IDS and other STIs.
- *Socio-demographic and Socio-economic Variables:* - Age, Sex, Religion, Parental education, Pocket/parent income, Parent-student communication, Communication with friends/peer and Sexual partner.
- *Behavioral factors:* - Alcohol Consumption, Chewing Khat, Cigarette smoking and Pornographic View/sexually explicit film.
- *Environmental Factors:* - Media, Lack of places to spend spare time activities, Lack of youth friendly RH services and Perceived peer sexual behavior.

#### 4.7 Operational definition and definition of terms

- **Adolescent:** WHO (2003) has defined adolescent as those persons in the age group between 10-19 years. For the purpose of this study, however, adolescence refers to school adolescent aged 15-19 years.
- **Preparatory school students:** respondents who are enrolled in the current academic year in one of the classes from grade 11 and 12 during the data collection period and attending the class.
- **Risky sexual behavior:** unprotected sex with casual partner and/or having sex with multiple partners
- **Substance use:** refer use of materials like alcohol, cigarette and chat.
- **Consistent condom use:** refers to condom use reported to be 'always'
- **Multiple sexual partners:** having two or more sexual partners
- **Unsafe/unprotected sex:** Penetrative sex between a male and female, without the use of either ABC method.
- **Knowledge of unsafe sex:** Knowledge was computed as follows: Correct responses to each knowledge question were given a score of 1 and incorrect responses were given a score of zero. The values was summed to give knowledge score which was used a continuous variable in the analysis.

## **4.8 Measurement tools and data collection**

### **4.8.1 Data collection instrument**

Different data collection tools were used to collect relevant data based on the study objectives. A self-administered structured questionnaire and focus group discussion guidelines were used to collect the data. Anonymous, Structured questionnaires modified from the instrument used by a survey on Ethiopian Demographic and Health Survey (EDHS) and from a Behavioral Surveillance Survey (BSS) which comprised of three parts: Part- A student's general information, Part- B Students knowledge regarding selected sexual issues and Part- C Students sexual history.

Discussion guidelines and probes prepared for the FGDs to gather detailed qualitative information on main factors that have association with adolescents' risky sexual behaviors and to explore the major risky sexual behavior among preparatory students of study area.

### **4.8.2 Data collection procedures**

In the process of collecting the actual data, the following procedures were adopted. Four diploma nurses facilitators and one Bsc nurse for supervisor was selected from the health institutions outside the town and also one Bsc psychology professional for FGDs modulator from the university. The facilitators and the supervisor were taken training for one day on Procedures, techniques and ways of collecting the data. The questionnaires was initially prepared in English and then translated in to Amharic. The Amharic version was retranslated back to English to check for any inconsistencies or distortions in the meaning of words and concepts. Research tools was pre-tested prior to the actual data collection in 60km distance from actual study area on 10% of actual sample size with similar socio-demographic status and the same characteristics with study population. Based on the feedback obtained, the necessary modifications were made accordingly. The purpose and the process of study were explained to the respondents. All information filled was anonymous; there was no personal identification of the respondents to ensure anonymity of the responses. The actual data was collected by the data collectors in collaboration with coordinators from the study subjects. Finally, the collected questionnaires were checked for completeness and accuracy. For FGD every discussion was recorded not to miss issues discussed, and finally the data was transcribed and translated before writing the report.

#### **4.9 Data quality control**

The quality of the data was assured by using validated questionnaire, translation, retranslation and pre-test of the questionnaire. The questionnaire was translated from English to Amharic by a translator and back to English by second other translator both was a health professional to compare the consistency.

Since the instruments are modified in our context it need pre-test on the source population. Therefore the questionnaire was tested on 10% of the total sample and necessary adjustments on keeping skip order were made before use for data collection.

**Reliability** of the questionnaire Cronbatch's alpha value was 0.87 for knowledge related questions and 0.72 for sexual history questions.

**Content validity** assessed by experts to check the degree to which an instrument has an appropriate sample of items for the outcome being measured.

Furthermore, data collectors and supervisors were trained for one day on the study instrument and data collection procedure (including practical sessions). The principal investigator and the supervisor were checked the collected data for completeness and corrective measures were taken accordingly.

#### **4.10 Pre-test**

A week before the actual data collection time, pre-test was carried out using self administered structured questionnaires on 10% of actual sample size with a similar characteristics of study population in Debresina preparatory school with similar socio-demographic status with the main study area to determine the questionnaires consistency, acceptability of the questions, reaction and willingness of the respondents, time required, performance and adequacy of data collector and amendments was done.

#### **4.11 data processing, analysis and interpretation**

The data was checked for completeness and consistencies, then it was cleaned, coded and entered in to computer using epi-info version 3.3.1 then exported to SPSS windows version 20.0 for analysis.

Descriptive statistics was computed to describe variables independently. Additionally, bivariate and multivariable logistic analyses were carried out. A bivariate stage was employed in order to identify the important explanatory variables by considering 0.25 p value as statically significant which was retained in the multivariate analysis for further investigation. Multivariable logistic



regression analyses was also conducted, to assess the net effect of each factor on risky sexual behaviors by considering 0.05 p value as statically significant with 95% confidence interval.

Finally, the result was presented in the form of text, using tables, figures and charts.

Qualitative data was transcribed into English text by the principal investigator by replaying the recorded discussion. Different ideas in the text was merged in their thematic areas of unprotected sex, multiple sexual partner, adolescent-parent communication on sexual issue and knowledge of relation of HIV/AIDS with other STIs then a thematic framework analysis was employed manually.

Finally, the result was presented in narration to triangulate the findings with quantitative data.

#### **4.12 Ethical consideration**

Ethical clearance was obtained from the ethical committee of the college of public health and medical sciences Jimma University and official letter was written to the Debrebrhan preparatory school. Introduction of the study, method of the questioning and confidentiality letter was attached to cover page of the questionnaires. The participants were informed that they have full right to participate or not to participate in the study as well as to with draw any time during data collection. Strict confidentiality was assured by using attendance numbers instead of their name and was not disseminating any information to anyone who is not directly involved in the study.

#### **4.13 Dissemination of the research findings**

The result of this study will be submitted to Jimma University the department of nursing and to College of Public Health and medical science, Debrebrhan preparatory secondary school and different organizations those who have concern and responsibility in adolescents' health in the town. The outcome of the study will be presented and discussed in academic forum of Jimma University and other area; furthermore effort will be made to publish the findings in local or national or international peer reviewed scientific journals.

## **CHAPTER FIVE-RESULTS**

### **5.1 Socio-demographic Characteristics of Participants**

A total of 325 students voluntarily completed the questionnaires, making the response rate 100%. Among the respondents 192(59.1%) were males. The mean age of the respondents was 18 years ( $SD \pm 1.19$ ) and ranges from 15 to 22 years. Majority of the respondents were between the ages ranges of 18-22 years 202(62.2%). Moreover, 202 (62.2%) of the respondents were from natural science. Amhara 267(82.2%) constituted the major ethnic group followed by Oromo 45(13.8%); while most 90.8% were Orthodox Christian. Among the study population 127(39.1%) and 116(35.7 %) were regular followers and once/twice per week followers of their religion service respectively. According to this research finding, 299(92.0%) of participants were unmarried. Nearly half 166(51.1%) of the respondents were live with both biological parents (Table.5.1).

**Table 5.1- Background Characteristics of Hailemariam Mamo preparatory school students, March, 2013.**

Characteristics (n=325)		Frequency	Percent
Sex of the respondent	Male	192	59.1
	Female	133	40.9
Age of the respondent	Age15-17	123	37.8
	Age18-22	202	62.2
Educational grade stream of the respondent	Social science	123	37.8
	Natural science	202	62.2
Ethnicity of the respondent	Amhara	267	82.2
	Oromo	45	13.8
	Tigray	13	4.0
Religion of the respondent	Orthodox Christian	295	90.8
	protestant	18	5.5
	Muslim	12	3.7
Religion service attending frequency	Always	127	39.1
	Once in a week	116	35.7
	Once in a month	82	25.2
Marital status of the respondent	Unmarried	299	92.0
	Others <sup>1</sup>	26	8.0
Living condition of the respondent	With father and mother	166	51.1
	With Mother/Father	50	15.4
	Single Living	67	20.6
Equipment available* in respondents home	With Relatives	42	12.9
	Radio	171	52.6
	Television	210	63.7
	VCD/DVD	149	45.8
	Satellite receiver	62	19.1

Others<sup>1</sup>=married, boy/girl friend

\*=multiple answers possible



## 5.2 Background Characteristic of Participant Parents'

Totally, 172 (52.9%) of the respondents' fathers were with formal education. However, 209 (64.3%) of the respondents father were with no formal education. As this research result indicated 181(55.7%) of the respondents fathers' were farmers. Regarding occupation of mothers, 159(48.9%) was housewife. As respondents estimation of their family economic status by comparing with their neighbors 246(75.7%) were in medium level.

Table 5.2- Parents' Background characteristics of Hailemariam Mamo preparatory school students, March, 2013.

Characteristics(n=325)		Frequency	Percent
Respondents father educational status	no formal education	153	47.1
	formal education	172	52.9
Respondents mother educational status	no formal education	209	64.3
	formal education	116	35.7
Respondents father occupation	government employee	106	32.6
	Farmers	181	55.7
	Others <sup>1</sup>	38	11.7
Respondents mother occupation	government employee	53	16.3
	Farmers	106	32.6
	housewife	159	48.9
	Others <sup>2</sup>	7	2.2
family economy in respondent observation	Poor	46	14.2
	Medium	246	75.7
	Others <sup>3</sup>	33	10.1

Others<sup>1</sup>= self employee \$ employee in private sector

Others<sup>2</sup>= self employee \$employee in private sector

Others<sup>3</sup>=rich \$ very rich

### **5.1.3 Characteristics related to risky sexual behavior of respondents**

The survey result revealed that 146(44.9%) of the study participants earn pocket income. Only 53(16.3%) of participants was discussed with their families about sexual related issues. The majority of participants did not discuss with their parents. The reasons for not discussing with their parents were: being afraid of talking with parents(17.8%), preference to talk with someone else(18.8%), no interest to talk in this issue with their parents(22.8%), 15.7 percent of them reported that discussing with such topic irritate my parents and 8.6 percent of them reported other reasons. *Similarly, the FGD results of both sexes proved that “whatever is the educational status of our parents (educated or uneducated) discussion about sexual issues is not allowed. ”The main reasons for the closure of discussions with their parents according to the FGDs were:*

- ❖ *Cultural taboo (parents believed that discussing about sexual issues led children to sexual intercourse”.*
- ❖ *Parental way of upbringing (they are from unenthusiastic family background and wanted to up bring us in the way as they brought up).*
- ❖ *We rush to talk with somebody else other than our parents because we are not on the position to negotiate with them.*

The result of various studies indicated that, peer pressure is one of the factors to risky sexual behavior. The result of the survey indicated that 94.2 percent of the study participants reported as they discussed about sexual intercourse with friends. One hundred ninety nine (61.2%) of all respondents were aware of the existence of sexually explicit materials as defined in this study. internet were cited as the major source of sexually explicit information’s by 228(70.2%) and video films were cited as the by 116(35.7%) of the students.

**Table 5.3- Percentage distribution of participants by selected sexual risk behavior related factors**

Characteristics (n=325)	Frequency	Percent
Permanent pocket income	146	44.9
Discussion about sexual intercourse with family	53	16.3
Reason for not discussing		
I am afraid to talk with them	58	17.8
I prefer to talk with others	61	18.8
I am not interested to talk	74	22.8
This topic irritate them	51	15.7
Others <sup>1</sup>	28	8.6
Discussion about sexual intercourse with friends	306	94.2
High sexually explicit materials*		
news papers	29	8.9
megazines	46	14.2
radio	37	11.4
television	70	21.5
video film	116	35.7
internet	228	70.2

\*=multiple responses possible

Others<sup>1</sup>=family not alive and no-reason

As figure 3 shows, 248(76.3%) and 219(67.4%) of respondents documented as their major source of sexual information were friends/peers and mass media respectively. However, parents and health institution as their source of sexual information were 41(12.6%) and 50 (15.4%) respectively with multiple responses.

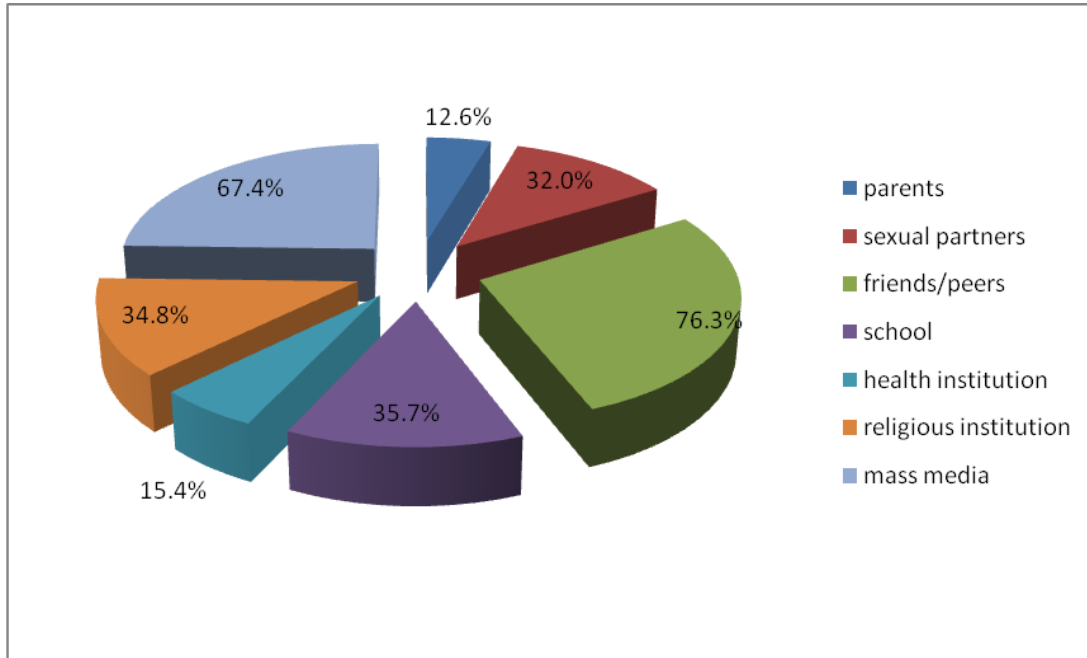


Figure 3-respondants major source of sexual information

#### 5.1.4 Substance Use and Pastime of Respondents

As table 5.4 shows, assessment of personal risk behavior among the students revealed that 108(33.2%) of the students ever has watched sexually explicit film, forty nine percent of them watched with same sex friends and forty nine percent of them(108) watched opportunistically.117(36.0%) of the respondents confirmed as they had friends who watched sexual explicit film. Regarding drugs and substances use 139(42.8%) of the respondents drunk alcohol sometimes.



**Table5.4- Percentage distribution of some behavioral risk factors**

Characteristics	frequency	Percent
Ever watched sexually explicit film(n=325)	108	33.2
Watch with(n=108)		
alone	43	39.8
same sex friends	53	49.1
sexual partners	12	11.1
How often do you watched (n=108)		
usually	43	39.8
opportunistically	53	49.1
others <sup>1</sup>	12	11.1
Had friends who watch films(n=325)	117	36.0
Ever use alcoholic beverages(n=325)		
Never	145	44.6
Sometimes	136	41.8
Othes <sup>2</sup>	44	12.1
Ever use cigarette(n=325)		
never	305	93.8
sometimes	20	6.2
Ever use chat(n=325)		
never	298	91.7
sometimes	27	8.3

Others<sup>1</sup>=once/twice per month

Others<sup>2</sup>=opportunistically

## **5.2 Knowledge of respondents about sexual issues**

As Table 5.5 shows that, only 132 (69.6%) of the respondents were mentioned abstinence followed by test and one to one 152(46.8) as safe sex practice. More than half of the respondents didn't know the correct response along the first sexual intercourse pregnancy is likely to occur. Majority 267 (82.2%) and 261 (80.3%) of the sampled population were answered during puberty age can make pregnancy or be pregnant for male and female respectively. Even if most of the respondents knew the means of avoiding pregnancy such as abstinence, using different contraceptives like oral contraceptive pills, condom, injectable...etc 233(71.1%) of the respondents has misconception regarding withdrawals as contraception method.

As survey result showed from 86.5 percent of the respondents majority (85.2%) were responded HIV/AIDS as sexually transmitted disease.

Regarding STI, 158(48.6%), 162(49.85%), 206(63.4%) and 117(36.0%) of the respondents were able to mention genital ulcers, discharge from penis/vagina, pain during urination, and genital swelling as a sign and symptom of STIs respectively. Unprotected sexual intercourse, sharing of sharp objects, blood transfusion and from mother to child were most frequently mentioned ways of HIV transmission by 301(92.6%), 242(74.5%), 184(56.6%) and 120(36.9%) respectively.

Regarding HIV prevention, abstinence and faithfulness were mentioned by majority of respondents, 271(83.4%) and 176(59.2%) respectively as ways of HIV prevention. Surprisingly only less than half, 164(39.7%) mentioned using condom as a method of HIV prevention. Concerning the relation of HIV/AIDS and other STIs only 100(30.8%) was aware.

Of 47 possible correct answers, adolescents' knowledge score was in range of 8-35. The mean knowledge score was 22.5(median=23).

**Table 5.5- participants Knowledge about selected sexual issues**

Characteristics(n=325)	frequency	Percent
Safe sexual practice*		
abstinence	132	69.6
consistent condom use	149	45.8
avoid multiple sexual partners	135	41.5
avoid casual sex	79	24.3
test and one to one	152	46.8
A girl can get pregnant with 1 <sup>st</sup> sexual intercourse	119	36.6
Boy can mature to make a girl pregnant*		
during puberty	267	82.2
before 10 years	13	4.0
starting 10 years	49	15.1
A girl can be pregnant*		
during puberty	261	80.3
before 10 years	20	6.2
starting 10 years	67	20.6
Contraceptive methods*	233	71.7
Oral pills	166	51.1
Condom use	136	41.8
Injection on arm	181	55.7
Norplant	150	46.2
Sterilization	129	39.7
Abstinence	166	51.1
Withdrawals	233	71.7
Sexually transmitted disease*	282	86.8
Gonorrhoea	179	55.1
Syphilis	203	62.5
Cancroids'	158	48.6
HIV/AIDS	212	85.2

Table continued

To prevent STDs\*

abstinence	187	57.5
be faithful	127	39.1
avoid sex before test	192	49.1
condom use	116	35.7
avoid se with commercial sex workers	94	28.9
avoid sharing sharps	131	40.3

Sign/symptoms of STIs\*

Genital ulcer	158	48.6
Abnormal genital discharge	162	49.8
Pain during urination	206	63.4
Genital swelling	117	36.0

believe HIV exist

320 95.5

transmission way of HIV/AIDS(320)\*

unsafe sexual intercourse	301	92.6
sharing sharps	242	74.5
untested blood transfusion	184	56.6
from mother to child	120	36.9

Strategy to prevent HIV/AIDS(320)\*

abstinence	271	83.4
stay faithful	196	59.2
consistent condom use	164	39.7
avoid casual sex	174	49.7
avoid using common household instrument	111	34.2

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\*=multiple responses possible

### 5.3.1 Participants Sexual history

One hundred three (31.7%) of participants were committed with their girl or boy friend at the time of the survey, of which 97 (92.4%) of them discussed about sexual intercourse. The result further revealed that 119(36.7%) of the participants reported ever having sexual intercourse. The mean age at first sexual intercourse was 17.7(17.7±1.3). Fifty (43.7%) of them reported started the first sexual intercourse with same age group compared with themselves. Among respondents who started sexual intercourse 68(58.1%) had their first sexual intercourse between the age range 18-24years; for 51 (44.0%) fall in love was the main reason to start sexual intercourse. Eighty nine (74.8%) had only one sexual partner and 22.7% had more than one sexual partner prior to the study time. Among those who had sexual intercourse 69(59.0%) used condom and 52(46.0%) used other contraceptives. From the sampled population, ninety one (28.0%) of who ever had sexual intercourse exposed to one/more of the risky sexual behavior.

*Moreover, the FGD result which was conducted separately confirmed that now a day's adolescents sexual behavior changed and exposed to risk. The main reasons that they mention:-*

- ❖ *The erosion of good culture of the country due to the negative aspect of globalization when observe different sexual explicit films.*
- ❖ *lack of open discussion with parents about sexual issues*
- ❖ *internal driving force of adolescents to test what they observe*
- ❖ *peer pressure*
- ❖ *use of different substances (like chat, alcoholic drinks, etc)*
- ❖ *to obtaining gifts and money especially for females*

**Table 5.6- Distribution of Sexual history among Hailemariam Mamo preparatory school students, March, 2013**

Characteristics	Frequency	Percent
Had boy/girl friend(n=325)	103	31.7
Ever discussed about sexual intercourse(n=103)	97	92.4
Ever had sexual intercourse(n=325)	119	36.7
Age at 1 <sup>st</sup> sexual intercourse(n=119)		
age14-17		41.9
age18-24	49	58.1
	68	
Age of partner at 1 <sup>st</sup> sexual intercourse(n=119)		
same age	52	
older	46	43.7
youngster	21	39.3
		17.0
Reason to start sexual intercourse(n=119)		
fall in love		
personal desire	51	
to get gift/money	32	44.0
got married	27	27.6
	6	23.3
		5.1
No of sexual partner(n=119)		
only one	89	

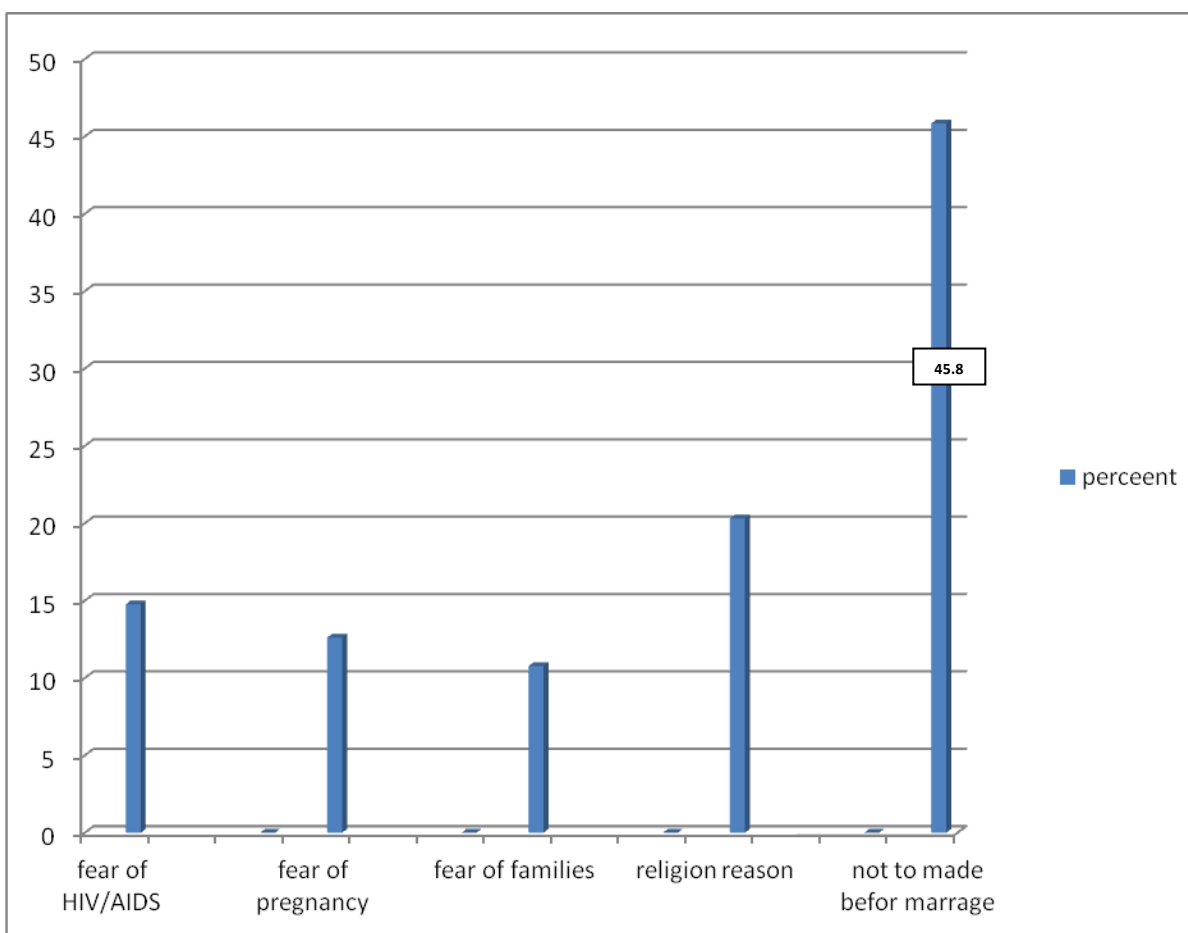
two \$ above	27	74.8
others	3	22.7
		2.5
ever used condom(n=119)	69	59.0
ever used any other contraceptives(n=119)	52	
		46.0
<b>Risky sexual behavior(n=325)</b>	<b>91</b>	<b>28.0</b>

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Others=commercial sex

### 5.3.2 Reasons for not yet started Sexual intercourse

According to survey result 207(63.7 %) of study participants not yet started sexual intercourse and they forwarded their various reasons. With multiple response possibility, majority (45.8%) of the respondent's reason were not to made before marriage.



**Figure 4- graphical representation of participants' reason not to engage in sexual practice**

#### **5.4 Multivariable Analysis Results on the predictor variables of risky sexual behavior**

As it has been indicated in the review of related literatures lots of demographic, socio-economic and behavioral variables had relationship with risky sexual behavior of adolescents. However, bivariate analysis showed; sex, age, living arrangement of the respondent, had pocket-income, discussed with parents about sexual issue, ever watched sexual explicit film, ever had boy/girl friend, and knowledge about sexual issues show significant relationship with  $p < 0.25$  for further intervention. Logistic regression analyses were conducted to further explore the possible effects of each predictor variables on risky sexual behaviors.

Among socio-demographic factors, living arrangement of participants was shown to have a significant association with risky sexual behavior.; students who lived with single biological parent were 15 times more likely to have risky sexual behavior than those who lived with both biological parents (AOR=15.288 CI=1.76,132.62). Lived alone in rental houses also 9 times more likely to had risky sexual behavior than who lived with both biological parents (AOR=9.026 CI=1.71, 47.48). In addition, living with relatives were 3 times more likely to have risky sexual behaviors than living with both biological parents (AOR= 3.333 CI=1.274, 8.721).

Communication with family about sexual issues was another important a powerful predictor variable of risky sexual behavior when other variables kept constant. Adolescents who did discuss with the family on sexual issues were 0.065 times less likely had risky sexual behavior than who did not discussed (AOR= 0.065 CI=0.008, 0.514).

The qualitative data also underline this issue.



*As one discussant explained “...It was good if there is an open discussion about sexual issue with the family, because the families teach their children from their experiences based on reality, as they have seen everything and lack of day-to-day family guidance and control, lack of experience of living by ourselves and freedom to practice whatever we want freely out of the sight of our parents, were main reasons for the starting of sexual intercourse and exposing to risky sexual behavior”.*

Pocket money was another predictor variable that shows significant relationship with risky sexual behavior. Those students who did earned pocket money were 2.7 times more likely to involved in risky sexual behavior than their counterparts (AOR=2.763CI=1.464, 5.216).

Regarding having a boy/girl friend decreased likelihood of risky sexual behavior by a factor .078 compared to who did not had boy/girl friend (AOR = .078 CI=.015,.404).

This study showed another stastically significant variable with risky sexual behavior was respondent knowledge of sexual issue. A unit change of the respondents’ knowledge score of unsafe sexual issues decrease risky sexual behavior by more than 26% (AOR= .734 CI=.598, .901).

*The FGDs results supported that, use of condom while having sex is always advised in different medias and school clubs. However, among students is not usual practice even if available in school club student’s fear to use it because the school is in the community. One of the discussants raised the followings as the main reasons for not using condom consistently: no full information about side effect and always advised to use it, “example I am the member of school club but I have no experience and enough knowledge even my families warning me not to have information to condom because if I talk they expected as I started sexual intercourse”.*



Table 7- Multivariable logistic regression analyses to predictors of risky sexual behavior among Hailemariam Mamo preparatory school students, March, 2013

VARIABLES	Risky Sexual Behavior		COR(95%CI)	AOR(95%CI)	p-value
	Had risk	No risk			
Living arrangement of the respondents(n=325)					
with mother \$ father	47(28.3%)	119(71.7%)	1	1	
with mother/father	14(28.0%)	36(72.0%)	9.23(4.28,,19.89)*	15.288(1.76,132.62)*	.013
single living	19(28.4%)	48(71.6%)	15.18(7.39,31.18)*	9.026(1.71,47.48)**	.009
with relatives	11(26.2%)	31(73.8%)	3.5(1.48,8.46)**	3.333(1.274,8.721)*	.014
pocket income(n=325)					
Having	46(31.5%)	100(68.5%)	3.02(1.83,4.98)**	2.763(1.464,5.216)**	.005
not	45(25.1%)	134(74.9%)	1	1	
Discussion sexual issue with family(n=325)					
discussed	8(15.1%)	45(84.9%)	0.041(0.006,0.301)**	0.065(0.008, 0.514)**	.000
not discussed	83(30.5%)	189(69.5%)	1	1	
Having boy/girl friend(n=325)					
yes	48(46.6%)	55(53.4%)	0.275(0.165,0.459)**	0.078(.015,.404)*	.021
not	43(19.4%)	179(80.6%)	1	1	
knowledge of unsafe sex (n=325)			0.80(0.756,0.8522)**	0.734(0.598,0.901)**	.002

\*=stastically significant p-value <0.05

\*\*= stastically significant p-value<0.01

## CHAPTER SIX: DISCUSSION

Adolescents are the steering wheels of change than other segments of the population. Hence, the future fate of the society depends on the demographic and reproductive health of this segment of the population they have to be fully informed to sex related issues and free of risky sexual behavior. In this section the finding of this study and its relation with previous studies are discussed.

This study found that nearly 37% of the respondents had sexual experience with mean age of first sexual contract were 17.4 ( $SD \pm 1.314$ ). Of all sampled population 91(28%) of the respondents had risky sexual behavior. This finding is slightly higher proportion than the one found in other study conducted in subjects approximately the same characteristics as in this study was 25% of the study group had previous sexual intercourse and exposed at least one risk behavior (58) and other study conducted among in-school and out-of-school youth in Ethiopia, 2005 over 20% of out-of-school youth had unprotected sex (57). The difference would be partly attributed to individual behavior, socio-economic factors, socio-demographic factors, as well as reporting system has been commented.

*Simmily the FGD results indicated that adolescent's sexual behavior is changed which exposes them to risk. The main reasons mentioned for this changed were:-*

- ❖ *The erosion of good culture of the country due to the negative aspect of globalization when observe different sexual explicit films.*
- ❖ *lack of open discussion with parents about sexual issues*
- ❖ *internal driving force of adolescents to test what they observe*
- ❖ *peer pressure*
- ❖ *use of different substances (like chat, alcoholic drinks, etc)*
- ❖ *to obtaining gifts and money especially for females*

A further examination of the data showed that over 23% of the sexually active respondents had multiple sexual partners and more than 42% of the respondents used condom sometimes indicating that such risky behavior can predispose the students to acquisition of STDs including HIV, unwanted pregnancy and other risky sexual behavior consequences. This finding was consistent with the result of a study done in four Sub-Saharan African countries where 43–47% of very young adolescents used condom sometimes in Burkina Faso and 18% among females in

Uganda has more than one sexual partners(55).These differences in this prevalence may due to different characteristics of study population and also socio-demographic conditions.

There were different reasons for the starting of sexual intercourse. Larger proportion (44%) of the respondents stated to start of sexual intercourse was love affairs, 27 percent reported personal desire, and 23 percent of the respondent's reason was to get money/gift, while 5.2 percent of students responded that they had sexual intercourse in order to get married. This trend is to the observations reported in previous study among youths (57).

Of all the variables studied as potential factors associated with risky sexual behavior: knowledge of unsafe sex, pocket income, living arrangement, having boy/girl friend, and discussion with parents about sexual issue showed a statistically significant association.

The survey showed that knowledge of unsafe sex was negatively associated with risky sexual behavior. A unit change of the respondents' knowledge score of unsafe sexual issues decrease risky sexual behavior by 27%.This calls emphasis the need for understanding and addressing the root causes of the gaps in knowledge and self protection.

In this study adolescents get information about sexual issue from a wide range of sources and that they often do so from more than one source. Survey result showed friends/peers (76.3%) and mass media (67.4%) are the leading sources of sexual related information for respondents. But health services (15.4%) and families (12.6%) are the least in source of adolescents' sexual information. In other African countries also, health facilities and professionals are not a major source of information for young adolescents (55). This was attributed to the presence of widespread misconceptions and incorrect information (26). There were also misconceptions in this study withdrawals considered as pregnancy preventive method by 71.1% and avoid sharing common household equipments as HIV transmission prevention mechanism with 34.2% of the respondents. This finding emphasizes the need to improve the role of health professionals and families who have a vital role to ensure adequate knowledge for sexual related issues.

Advocating increasing awareness is essential to the success of any adolescent risk free sexual behavior. In order to access information and use health services, adolescents' knowledge of sexual issues are main determinants (10). The study results showed impressively high levels of awareness of HIV/AIDS, condoms, and contraceptive methods among adolescents, approximately to levels of knowledge shown in other studies (26, 58). While, it is disturbing that knowledge of the relation between STIs and HIV and its impact in HIV spread only 30.8% of

respondents were aware; similar findings have been reported from other study in Gondar 45.4% knew that acquisition of other STIs increases the chance of HIV transmission following unsafe sex (58). This may be attributed to not being timely diagnosed and treated for both cases.

Rudatsikira E, et al (2007) in Coast Province, Kenya, lack of parental supervision was associated with sexual risk taking behaviors among adolescents. The odds of sexual intercourse among adolescents who reported having minimal or no sex was 1.21 times that for adolescents who reported being supervised by parents most of the times (50). In this study, adolescents who lived with single biological parent were 15 times more likely to have risky sexual behavior than those who lived with both biological parents. Lived alone in rental houses also 9 times more likely have risky sexual behavior than those who lived with both biological parents. In addition, living with relatives were 3 times more likely had risky sexual behaviors than living with both biological parents.

Communication with family about sexual issues was another important and powerful predictor variable of sexual behavior. Adolescents who did discuss with the family on sexual issues were nearly eight times less likely had risky sexual behavior. On the other hand adolescents who were more oriented to future goals were less likely to engage in unprotected intercourse (10). The qualitative data also underline this issue.

*As one discussant explain "...It was good if there is an open discussion about sexual issue with the family, because the families teach their children from their experiences based on reality, as they have seen everything and lack of day-to-day family guidance and control, lack of experience of living by our self and freedom to practice whatever we want freely out of the sight of our parents, were main reasons for the starting of sexual intercourse and exposing to risky sexual behavior".* Therefore the role of parents in promoting adolescent sexual health should be taken into consideration when designing and implementing intervention programmes.

Pocket money was another predictor variable that shows significant relationship with risky sexual behavior. Those students who did earn pocket money were 2.7 times more likely to be involved in risky sexual behavior than their counterparts.

Comparatively, having a boy/girl friend decreased the likelihood of risky sexual behavior by a factor .078 compared to those who do not have a boy/girl friend (55). This may be attributed to negotiation and communication about sex with partner. Good self-regulation at this age may

discourage involvement with risk-taking peers, thereby decreasing opportunities for unprotected intercourse.

## **6.2 STRENGTH AND LIMITATION OF THE STUDY**

### **Strength**

- ❖ Used qualitative and quantitative study

### **Limitation**

- ❖ Since the study was institutional based study it is not generalized for all adolescents in the community.

## **CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION**

### **7.1 Conclusion**

From this data it is possible to conclude that prevalence of sexual risk behavior is high among target groups that studied. Knowledge of unsafe sex, pocket income, living arrangement, having boy/girl friend, and discussion with parents about sexual issue were variables those predict the risky sexual behaviors of preparatory students. These contribute to their risk for STIs, HIV, or negative health outcomes of early pregnancy, with even greater vulnerability for some subgroups. A reproductive health approach recognizes that the foundations of women's health are laid in childhood and adolescence and are influenced by sexual roles.

Since young people are the future parents, workers, entrepreneurs, parents, citizens, and community leaders, the emerging evidence demonstrating the unique vulnerability of adolescents to HIV infection and unplanned pregnancies has highlighted the need to develop effective intervention programs to protect the next generation of productive and reproductive adults in Ethiopia.

### **7.2 Recommendation**

To Amhara regional health bureau, Debrebrhan Zonal Health Bureau, Debrebrhan Referral Hospital, Debrebrhan Health Centers and Hailemariam Mamo Preparatory School:

- Request to discuss with the main stakeholders in AYRH in the town and assess the status of provision of AYFRH services.
- Mechanisms of enhancing parent child communication of sexual issues and life skills is critical to prevent engagement of adolescents in risky sexual behaviors.
- Request to preparing and/or distributing policy, strategy, guidelines documents.
- In collaborate with school-club sex education IEC programs should evolve and increasingly go beyond just the provision of information like educate students about the dangers of risky sexual behaviors before they contract STI's and HIV/AIDS and students themselves should be more involved than ever in designing strategies.
- Establishes & maintains contact with parents and the community to build life skills, including negotiation and communication with parents, self-efficacy, and to empower young people that could help them cope with pressures that they face in institutions of Higher learning where some students engage in unsafe sex and to understand their right to information and services to protect their sexual health.



- ❖ For researcher: there is a need to further explore the basic causes that lead the preparatory students to such sexual risk behaviors by including parents and community.



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**Annex-1 Data Collection tools**

**JIMMA UNIVERSITY, COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES**

**In-formed verbal consent form (GUIDELINE FOR RESPONDENTS).**

Good morning/ afternoon, my name is -----I am working in a research team, which is conducted by Jimma university and we are now conducting a research in preparatory secondary school students of Debrebrhan town to assess predictors of risky sexual behaviors. You have been chosen to participate in this study by chance and you will help us by answering the questions we ask you and study will not need to do any experiment or apply any invasive procedure to you except you will spending some time for interview.

We assure you that whatever answers you give us are kept secret. We do not need your name and address. We also inform you that you have the right to withdraw from the study or stop at any time if there is any discomfort before completing the study.

***THANK YOU FOR YOUR CONSIDERATION!***

Are you willing to participate in this study?

yes

no

If yes, go to the next page, completing Questionnaire

**PART ONE – Questions on Background Informations’**

<b>Item No.</b>	<b>Questionnaire</b>	<b>Coding categories</b>	<b>Cod Number</b>
<b>101.</b>	Sex	1.male 2.female	
<b>102.</b>	Age	_____years	
<b>103.</b>	Grade Level Stream	_____ 1. Social 2. Natural	
<b>104.</b>	Ethnicity	1. Oromo 2 Amhara 3.Tigrae 4. Others	
<b>105.</b>	Religion	1. Orthodox Christian 2. Muslim 3. protestant 4. Catholic 5. Others	
<b>106.</b>	How often do you attend religious services?	1. Everyday 2. once in a week 3. once in a month 4.others	
<b>107.</b>	Marital status	1. married 2. unmarried 3. divorced 4 .others	
<b>108.</b>	Currently with whom you live?	1. with father and mother	

		<ol style="list-style-type: none"> <li>2. with mother</li> <li>3. with grand parents</li> <li>4. with relative</li> <li>5. Others (specify)___</li> </ol>
<b>109.</b>	You father's education level	<ol style="list-style-type: none"> <li>1. Illiterate</li> <li>2. Read and write</li> <li>3. grade1-8</li> <li>4. grade 9-12</li> <li>5. above 12 grade</li> <li>6. Others (specify</li> </ol>
<b>110.</b>	Your mother's educational level	<ol style="list-style-type: none"> <li>1. Illiterate</li> <li>2. Read and write</li> <li>3. grade1-8</li> <li>4. grade 9-12</li> <li>5. above 12 grade</li> <li>6. Others (specify</li> </ol>
<b>111.</b>	Your father's occupation	<ol style="list-style-type: none"> <li>1. Government employee</li> <li>2. Self employee</li> <li>3. Daily laborer</li> <li>4. Employed in private sector</li> <li>5. He is not alive</li> <li>6. Others (specify)_____</li> </ol>
<b>112.</b>	Your mother's occupation	<ol style="list-style-type: none"> <li>1. Government employee</li> <li>2. Self employee</li> <li>3. Daily laborer</li> <li>4. Employed in private sector</li> <li>5. He is not alive</li> <li>6. Others (specify</li> </ol>
<b>113.</b>	How can you classify your family's economy comparing with the neighbors	<ol style="list-style-type: none"> <li>1. Very poor</li> <li>2. Poor</li> <li>3. Medium</li> <li>4. Rich</li> <li>5. Others specify</li> </ol>
<b>114.</b>	Do have permanent	1) Yes

	pocket income?	2) No
<b>115.</b>	Have you discuss about sexual intercourse with your family?	1) yes 2) No
<b>116.</b>	If your answer for question <b>115</b> is No, what is your reason	1) I am afraid to talk with them about these issue 2) I prefer to talk with some one else 3) I am not interested in discussing these issues 4) This topic irritate them 5) Other, specify-----
<b>117.</b>	Have you discuss about sexual intercourse with your friends?	1. Yes 2. No
<b>118.</b>	What are your sources of information about sexual intercourse?	1. My parents 2. sexual partners 3. friends/peers 4. school 5. Health institution 6. religious institution 7. Mass media 8. Others
<b>119.</b>	Do you know about the presence of high sexually explicit materials?	1. Yes 2. No
<b>120.</b>	Where do you think such materials are available?	1. Newspapers 2. Magazines 3. Radio 4. Television

		5. video film
		6. Internet
		7. Others( Specify)
<b>121.</b>	Have you ever read about sexually explicit book, magazine or paper?	1. Yes 2. No
<b>122.</b>	Which Equipment is Available in your home?  (Multiple answers possible)	1. Radio 2. TV 3. VCD/DVD 4. Satellite receiver 5. Other(specify)_____
<b>123.</b>	Have you ever watched a sexually explicit film?	1. Yes 2. No
<b>124.</b>	If yes for question 123, With who did you usually watch the film?	1. Alone 2. My sexual partner 3. Same Sex Friends 4. Others( Specify)
<b>125.</b>	Have you discussed openly about the film with others?	1. Yes 2. No
<b>126.</b>	How often did you watch such materials that have sexual contents?	1. usually 2. opportunistically 3. once or twice in week 4. always 5. Other( Specify)
<b>127.</b>	Do you have friends who watch films which have sexual content?	1. Yes 2. No
<b>128.</b>	If yes for question 128, Do you think their sexual behaviour is	1. Yes 2. No

	affected by it?	
<b>129.</b>	Have you ever drink alcoholic beverages?	1. Never 2. I have drunk once or twice 3. Sometimes 4. always 5. Other
<b>130.</b>	Did you smoke cigarette?	1. Never 2. I have smoked once or twice 3. Sometimes 4. always 5. other
<b>131.</b>	<b>Did you chew chat?</b>	<b>1. Never</b> <b>2. I have smoked once or twice</b> <b>3. Sometimes</b> <b>4. always</b> <b>5. others</b>

**Part Two-Knowledge about HIV/AIDS, STI, Pregnancy and Safe Sex Practices Questions**

<b>Item No.</b>	<b>Questionnaire</b>	<b>Coding categories</b>	<b>1.Yes</b>	<b>2.No</b>
<b>201.</b>	What do you understand by 'safe sex'?	1)abstain from sex	1	2
	(More than one possible answers)	2) Using condom	1	2
		3) Avoiding multiple sexual partner	1	2
		4) Avoiding sex with people who have multiple partner	1	2
		5) tested and one to one		
		6) Other, specify_____		

<b>202.</b>	Can a girl get pregnant the first time she had sex.	1. Yes 2. No		
<b>203.</b>	When is the time that the boy can mature physically to make pregnant the girl?	1. During puberty age 2. Before 10 years of age 3. starting 10 years 4. Others, specify -----	1 1 1	2 2 2
<b>204.</b>	When is the time that the girl possibly have pregnant?	1. at the age puberty 2. Before 10 years of age 3. starting 10 years 4. Others, specify-----	1 1 1	2 2 2
<b>205.</b>	What are the strategies to avoid getting pregnant? (multiple answer is possible)	1. Oral contraceptive pills 2. Using condoms. 3. Injection on arm 4. Norplant. 5. Sterilization. 6. Abstinence 8 Withdrawals 9. Others, specify-----	1 1 1 1 1 1 1 1	2 2 2 2 2 2 2
<b>206.</b>	Do you know sexually transmitted disease?	1. Yes 2. No		
<b>207.</b>	If yes, for question 206, Which diseases do you know about?( multiple answers are possible)	1. Gonorrhoea 2. Syphilis 3. Chancroid 4. HIV/AIDS 5. Others, specify-----	1 1 1 1 1	2 2 2 2 2
<b>208.</b>	Is that possible to prevent this sexually transmitted	1. Yes 2. No		

disease?				
<b>209.</b>	If Yes, How can one prevent STI multiple answer is possible)	1. Abstain from sexual intercourse.	1	2
			1	2
		2.test and one to one	1	2
		3. avoid sex with out HIV test	1	2
		4. use condom	1	2
		5. avoid sex with commercial sex worker	1	2
		6. avoid sexually transmitted material	1	2
	7.others			
<b>210.</b>	Indicate the signs or symptoms of STI manifest.( multiple answers are possible)	1. genital ulcer	1	2
		2. abnormal genital discharge	1	2
		3. pain during urination	1	2
		4. Genital swelling	1	2
		5. Others, specify-----		
<b>211.</b>	Do you believe that HIV/AIDS exists?	1) Yes		
		2) No		
<b>212.</b>	If yes for question 211 what are the transmission ways of HIV/AIDS? [Multiple answers are possible]	1. Unsafe sexual intercourse.	1	2
		2. Sharing needles and syringes.	1	2
		3. Blood transfusion.	1	1
		4. During pregnancy and childbirth.	1	2
			1	2
	5. others			
<b>213.</b>	What are the strategies used to prevent HIV/AIDS. (More than one possible	1) Abstinence	1	2
		2) Stay faithful to partner	1	2
		3) Use of condom	1	2



	answers)	4) Avoid casual sex	1	2
		5) Avoid common house hold utensil	1	2
		6) Other, specify----- ---	1	2
<b>214.</b>	Do you know about contraceptive method?	1.Yes 2.No		
<b>215.</b>	If yes for question 215, What type of contraceptive methods do you know?	1.Condom 2.Pills 3.Calendar 4.Emergency contraceptive method 5.Loop 6.Other (specify)_____	1 1 1 1 1	2 2 2 2 2

### Part Three: sexual history

Item No.	Questionnaire	Coding categories	Cod number
<b>301</b>	Have you ever had a boy/girl friend?	1. Yes 2. No	
<b>302</b>	If yes, Have you ever discussed about sexual intercourse?	1. Yes 2. No	
<b>303</b>	Have you ever had sexual intercourse with any one?	1. Yes 2. No	
<b>304</b>	If yes, At what age do you have the first sexual intercourse?	1.Age in years_____	
<b>305</b>	How old was the person you had sex for the first time compared to you?	1.Youngester 2.The same age	

		3.Older
		4. other
<b>306</b>	What made you have your first sexual intercourse?	1. Fell in love 2. Had a personal desire 3. I got married 4. To get money and other gifts 5. Others( specify)
<b>307</b>	Since your first sexual experience, how many Sexual partners did you?	1.Only one 2.Tow and above 3.i don't have 4.other
<b>308</b>	Have you ever used condom during sexual intercourse	1. Yes 2. No
<b>309</b>	If yes, How often did you use condom?	1. Always 2. Sometimes 3. Once or twice 4. Other
<b>310</b>	Have you ever used any other contraceptive?	1. Yes 2. No
<b>311</b>	If yes, how?	1. Always 2. rarely 3. opportunistically 4. other
<b>312</b>	What type of contraceptive methods do you use?	1.Pills 2.Calendar

		3. Emergency contraceptive
		4. Loop
		5. Other (specify) _____ _____
<b>313</b>	Have you ever made a girl pregnant/ever being pregnant?	1) Yes 2) No
<b>314</b>	Have you Ever use any drugs/substance	1. Yes 2. No
<b>315</b>	If yes, what type of drug/substance do you use	1. Chat 2. Cigarette 3. alcohol 4. hashish 5. Other drugs...
<b>316</b>	Ever Had sex after used any drug/substance	1. Yes 2. No
<b>17</b>	If you had no any sexual intercourse, What was your main reason for that you never had sexual intercourse?	1) Fear of HIV/AIDS 2) Fear of pregnancy 3) Fear of parents 4) Religious reason 5) Wants to wait until marriage 6) Other, specify---

## **Qualitative Data Collection Tool**

Informed verbal consent form before conducting the discussion (guideline for respondent)

Good morning/ afternoon, my name is ----- and from research team, Jimma University. I am conducting group discussion of preparatory school students. The purpose of this FGD is to gather ideas on risky sexual behaviors of preparatory school students. You have been chosen to participate in the interview purposely, if you are involved clubs of adolescent's health. You will help me to give me appropriate answers please; feel free to any questions and to share your opinion concerning the FGD. For the success of this study, your participation is very important. Tape recorder can be used during the discussion because it will help us to remember what you are said during the discussions. The other thing I want to mention is that in any time you have a right to leave the FGD.

Do I have permission to continue?

1. Yes ----- 2. No -----

### **Questions for Focus Group Discussion (FGDs)**

(Please, read the informed consent to the participants at first. record age and grade.)

1. Let's discuss risky sexual behavior among in-school adolescents.

(Age of commencement of sexual activity, utilization of condom...)

2. Is it usual among students to have sex with more than one partner? Why?

3. Is it usual among students to use condom during sexual intercourse? How do you evaluate adolescents' use of contraceptives (especially condom)?

4. Is it common among students to use substances like chat, cigarette, and alcoholic drinks?

5. How do you evaluate the behavior of those students that take such substances (in terms of academic performance, sexual activity, delinquency, etc)? Does it have relation with HIV and other STI transmission?

6. Is there any relation between HIV and other STIs?

7. Are your parents encourage you to discuss about sexual issues with them? If not what are the reasons? You think.

# በጂማ ዩኒቨርሲቲ የህብረተሰብ ጤና ህክምና ክፍል በደብረብርሃን ከተማ የሚኖሩ የመከላከያ ትምህርት ቤት ተማሪዎች ትንቃቄ የጎደለውጾታዊ ግንኙነት ዙሪያ እና አባባሽ ችግሮችን በተመለከተ የቀረበ ጥናት

## የቃል ፈቃደኛነት ማረጋገጫ (መሠሪያ)

### ጤ ይስጥልኝ!

ይህ ጥናት የሚከናወው በጂማ ዩኒቨርሲቲ የደህረ ምረቃ ትምህርት ክፍል የእናቶች ጤ ትምህርት ተማሪ መሠሪያ ጽሁፍ ለማቅረብ ሲሆን እነዚህን ጥያቄዎች ለእናንተ የማቅርብበት ምክንያት የመከላከያ ትምህርት ቤት ተማሪዎችን ለአደጋ የሚያደግጡ ግንኙነት እና ጥንቃቄ የጎደለውጾታዊ ግንኙነት ለማወቅ ነው። አላማም ጥንቃቄ በጎደለውጾታዊ ግንኙነት ምክንያት በከፍተኛ አቅጣጫ ለሚከሰቱ የጤ ችግሮች መፍትሄ ለማግኘት ነው። ስለዚህ የእርስዎ በዚህ መጠይቅ ላይ ያሉትን ጥያቄዎች በግልጽነት እና በቅንነት ለመላስ የምታደርጉት ትብብር እጅግ የሚጠበቅ ሲሆን ለዚህ ጥናት አላማ መከላከል የራሱ የሆነ ጠቃሚ ድርሻ አለው።

የምትመልሱትን መልስ ሚጥራዊነት ለመጠበቅ ሲባል በዚህ መጠይቅ ላይ ስማችሁን መጻፍ አያስፈልጋችሁም። እንዲሁም የማንኛውም በጥናቱ ላይ የተሳተፈ ተማሪ መልስ ለየትኛውም አካል ተላልፎ አይሰጥም።

በዚህ መጠይቅ ውስጥ ያለውን የትኛውንም ለመላስ የማትፈልጉትን መልስ ወይም ጠቅላላውን ያለመላስ መባታችሁ የተጠበቀ ነው። እባክዎን ለጥያቄው መላስ ቢተባበሩን ለጥናቱ መከላከል የራስዎን ጉልህ አስተዋጽኦ ተወጡ ማለት ነው።

መልሶቼን ለመላስ ፈቃደኛ ነዎት?

አዎ.....

የለም.....

አዎ ካሉ ወደ ማቅጠው ጽ ይለፉ።

አመሰግናለሁ!!!

**ክፍል አንድ - አጠቃላይ መረጃዎችን የያዙ ጥያቄዎች**

ተ.ቁ.	ጥያቄ	የኮድ ክፍፍል	ኮድ ቁጥር
101	ጾታ	1.ወንድ 2.ሴት	
102	አድሜ	-----አመት	
103	ክፍል  ደረጃ	----- 1.11ኛ 2.12ኛ	
104	ብሔረሰብ/ሽ	1.አሮሞ 2.አማራ 3.ትግሬ 4.ሌላ (ይጠቀስ)	
105	ሀይማኖት/ሽ	1.አርቶዶክስ ክርስቲያን 2.መስሊም 3.ፕሮቴስታንት 4.ካቶሊክ 5.ሌላ (ይጠቀስ)	
106	የሀይማኖት ትምህርት/ፕሮግራም ምን ያህል ትከታተላለህ/ያለሽ	1.ሁል ጊዜ 2.በሳምንት አንድ ቀን 3.በወር አንድ ቀን 4.ሌላ (ይጠቀስ)	

107	የጋብቻ ሁኔታ	1.አግብቻለሁ 2.አላገባሁም 3.ተፋትቻለሁ 4.ሌላ (ይጠቀስ)
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108	አሁን የሚኖሩት ከማን ጋር ነዉ.	1.ከእናት እና አባቱ ጋር 2.ከእናቱ ጋር ብቻ 3.ከአባቱ ጋር ብቻ 4.ከአያቱ ጋር 5.ከዘመዶቹ ጋር 6.ሌላ (ይጠቀስ)
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109	የአባት የትምህርት ሁኔታ	1.ያልተማረ 2.ማንበብ እና መጻፍ 3.ከ1-8ኛ ክፍል 4.ከ9-12ኛ ክፍል 5.ከ12ኛ በላይ 6.ሌላ (ይጠቀስ)	
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110	የእናት የትምህርት ሁኔታ	1.ያልተማረች 2.ማንበብ እና መጻፍ 3.ከ1-8ኛ ክፍል 4.ከ9-12ኛ ክፍል 5.ከ12ኛ በላይ 6.ሌላ (ይጠቀስ)
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111	የአባት ስራ	1.የመንግስት ሠራተኛ 2.የግል ሠራተኛ 3.የቀን ሠራተኛ
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4.የግል ድርጅት ሠራተኛ

5.በህይወት የለም

6.ሌላ (ይጠቀስ)

112	የእናት ስራ	1.የመንግስት ሠራተኛ 2.የግል ሠራተኛ 3.የቤት እመቤት 4.የግል ድርጅት ሠራተኛ 5.በህይወት የለም 6.ሌላ (ይጠቀስ)	
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113	ከጎረቤቶች ጋር በማክ ጸጸር የቤተሰብ/ሽን/ሽን የኢኮኖሚክስ ደረጃ እንዴት ትመድበዋለህ/ቢዋለሽ	1.በጣም ደህ 2.ደህ 3.መካከለኛ 4.ሀብታም 5.ሌላ (ይጠቀስ)	
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114 ቆሚያ ኪስ ገቢ/ብር አለህ/ሽ

1.አዎ

2.የለም

115	በጾታዊ ግንኙነት ዙሪያ ከቤተሰቦችህ/ሽ ጋር ተወያይተህ/ሽ ታወቃለህ/ቂያለሽ	1.አዎ 2.የለም/አላወቅም	
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116	ጥያቄ 114 ማለት የለም ከሆነ ምክንያቱ ምንድን ነው	1.በዚህ ጉዳይ ላይ ከነሱ ጋር መነጋገር ስለማጥፋት 2.ከሌላ ሰው ጋር ማወራት ስለማቅለኝ 3.እንደዚህ አይነት ርዕስ ማወራት ስለማልፈልግ 4.ቤተሰቦቼ ማወራት ስለማይፈልጉ 5.ሌላ (ይጠቀስ)	
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117 ከጉደኞች/ሽጋር በጾታዊ ግንኙነት ርዕሶች/ጉዳዮች ላይ ትያያላችሁ 1.አዎ  
2.የለም

118	በጾታዊ ግንኙነት ዘሪያ ዋነኛ መረጃ ማገኛ ምንጮች/ሽ	1.ቤተሰቦቼ 2.የፍቅር ጉደኝዬ 3.ጉደኞቼ 4.ትምህርት ቤት 5.የጠፍ ተቆማት 6.የሀይማኖት ተቆማት 7.የዘገባ ምንጮች 8.ሌላ (ይጠቀስ)	
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118	ከፍተኛ የወሲባዊ ይዘት ያላቸው የመኖሪያ ወጠቶች መኖራቸውን ታወቃለህ/ቀያለሽ	1.አዎ 2.የለም	
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120	መጠሪያ/ሽ አዎ ከሆነ እነዚህን ወጠቶች የሚኑት በየትኞቹ ነ (ከአንድ በላይ መጠሪያ ይቻላል)	1.ጋዜጦች 2.መጻፍቶች 3.ሬዲዮ 4.ከቴሌቪዥን ፊልሞች 5.ከቪዲዮ ፊልሞች 6.ከአንተርኔት 7.ሌላ (ይጠቀስ)	
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121	የወሲባዊ ይዘት ያላቸውን መጻፍቶች/መጻሕፍቶች አንብበህ/ሽ ታወቃለህ/ቀያለሽ	1.አዎ 2.የለም	
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122	በናንተ ቤት የሚኑት የመረጃ ምንጮች የትኞቹ ናቸው	1.ሬዲዮ 2.ቴሌቪዥን 3.የሳተላይት ማሻራጫ	
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		4.ዲቪዥን/ቪሲዲ	
		5.ሌላ (ይጠቅስ)	
123	ግልፅ የሆነ የወሲብ ይዘት ያለውን ፊልም ትመላክታለህ/ቻለሽ	1.አዎ 2.የለም	
124	አዎ ካልክ/ሽ ከማን ጋር ነው የምትመላክተው/ችው	1.ብቻዬን 2.ከፍቅር ጉደኛዬ ጋር 3.ከተመሳሳይ የታ ጉደኛዬ ጋር 4.ሌላ (ይጠቅስ)	
125	ስለ ፊልሙከሌላ ሰው ጋር ትወያያለህ/ሽ	1.አዎ 2.የለም	
126	እነዚህን ወሲባዊ ይዘት ያላቸውን ፊልሞች ምን ያህል ትመላክታለህ/ቻለሽ	1.አልፎ አልፎ 2.እንደ አጋጣሚ 3.በሳምንት አንድ/ሁለት ጊዜ 4.ሁል ጊዜ 5.ሌላ (ይጠቅስ)	
127	እነዚህን ፊልሞች የሚመላክት ጉደኛ አለህ/ሽ	1.አዎ 2.የለም	
128	አዎ ካልክ/ሽ ፊልሙን ወሲብ ህይወታቸው ላይ ተጽእኖ አለው	1.አዎ 2.የለም	
129	እንደ ጠባብ አረቄ፣ ጠጅ፣ ቢራ የመሳሰሉ አልኮል ማጠጥን ጠጥተህ/ሽ ታወቃለህ/ቁያለሽ	1.በፍፁም 2.አንድ ወይም ሁለት ጊዜ ብቻ 3.አልፎ አልፎ 4.ሁል ጊዜ 5.ሌላ (ይጠቅስ)	

130	ሲጋራ አጫህ/ሽ ታወቃለህ/ቂያለሽ	1.በፍፁም 2.አንድ ወይም ሁለት ጊዜ ብቻ 3.አልፎ አልፎ 4.ሁል ጊዜ 5.ሌላ (ይጠቀስ)	
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131	ጫካ ቅመህ/ሽ ታወቃለህ/ቂያለሽ	1.በፍፁም 2.አንድ ወይም ሁለት ጊዜ ብቻ 3.አልፎ አልፎ 4.ሁል ጊዜ 5.ሌላ (ይጠቀስ)	
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**ክፍል ሁለት-ከፊታዊ ግንኙነት ጋር የተያያዙ በሽታዎች እወቀትን በተመለከተ**

ተ.ቁ	ጥያቄ	ኮድ ክፍፍል	የኮድ ቁጥር	
			1.አዎ	2.የለም
201	ጥንቃቄ የተሞላበት የግብረ ስጋ ግንኙነት ማለት ምንድን ነው	1.መታቀብ	1	2
		2.ኮንዶም መጠቀም	1	2
		3.ከብዙ የግብረ ስጋ ግንኙነት ጉደኛ መታቀብ	1	2
		4.ብዙ የግብረ ስጋ ግንኙነት ተጋላጭነት ካላቸው ሰዎች መታቀብ	1	2
		5.ተመርምሮ አንድ ለአንድ መወሰን	1	2
		6.ሌላ (ይጠቀስ)		
202	አንዲት ሴት በመጀመሪያ (በአንድ) የግብረ ስጋ ግንኙነት ብቻ እርግዝና ይከሰትባታል	1.አዎ		
		2.የለም		

203	ወንድ ልጅ እርግዝና እንዲከሰት የሚያስችልበት ጊዜ መቼ ነው	1.ለአቅመ አዳም ከደረሰበት ጊዜ ጀምሮ	1	2
		2.ከአስር አመት በፊት ጀምሮ	1	2
		3.ከአስር አመት ጀምሮ	1	2
		4.ሌላ (ይጠቀስ)		
204	ሴት ልጅ እርግዝና ሊከሰትባት የሚችልበት ጊዜ መቼ ነው	1.ለአቅመ ሐዘን ከደረሰችበት ጊዜ ጀምሮ	1	2
		2.ከአስር አመት በፊት ጀምሮ	1	2
		3.ከአስር አመት ጀምሮ	1	2
		4.ሌላ (ይጠቀስ)		
205	እርግዝናን ለመከላከል የሚጠቅመት ዘዴዎች የትኞቹ ናቸው	1.በአፍ የሚሞጥ ክኒን	1	2
		2.ኮንዶም መጠቀም	1	2
		3.በክንድ የሚወጋ መረፊ	1	2
		4.በክንድ ቆዳ ስር የሚቆይ መከላከያ	1	2
		5.የወንድ የዘር ፍሬን ማወካን	1	2
		6.መታቀብ	1	2
		7.የወንድ የዘር ፍሬን ከሴቱ ብልት ወይም ማጥፊያ		
		8.ሌላ (ይጠቀስ)		
206	በግብረ ሰጋ ግንኙነት ወቅት የሚላለፉ በሽታዎችን ታወቃለህ/ቂያለሽ	1.አዎ		
		2.የለም		
207	የኞቹ በሽታዎች ናቸው	1.ጤጥ	1	2
		2.ቂጥኝ	1	2
		3.ክርክር	1	2
		4.ኤች.አይ.ቪ/ኤድስ	1	2
		5.ሌላ (ይጠቀስ)		

208 እነዚህን በሽታዎች መከላከል ይቻላል

1.አዎ

2.የሉም

209	አዎ ካልክ/ሽ መከላከያዎቹ የትኞቹ ናቸው	1.መታቀብ	1	2
		2.መወሰን	1	2
		3.ሳይመረመሩ የግብር ስጋ ግንኙነት አለማድረግ	1	2
		4.በአግባቡ ኮንዶም መጠቀም	1	2
		5.ከሴተኛ አዳሪ ጋር የግብር ስጋ ግንኙነት አለማድረግ	1	2
		6.አላፈላጊ ስለታማነት ሮችን ማግኘት	1	2
		7.ሌላ		

210	የአባላዘር በሽታ ምልክቶች የትኞቹ ናቸው	1.የብልት መቅሰል	1	2
		2.ያለተለመደ የብልት ፈሳሽ	1	2
		3.ሽንት ሲሸኑ ማቃጠል	1	2
		4.የብልት ማጠጥ	1	2
		5.ሌላ (ይጠቀስ)		

211 ኤች.አይ.ቪ/ኤድስ አሁን እንዳለ ታምናለህ/ኛለሽ

1.አዎ

2.የሉም

212	አዎ ካልክ/ሽ መተላለፊያ መንገዶቹ የትኞቹ ናቸው	1.ጥንቃቄ የጎደለው የግብር ስጋ ግንኙነት	1	2
		2.ስለታማነት ሮችን በጋራ መጠቀም	1	2
		3.በደም ልገሳ ጊዜ	1	2
		4.ከእናት ወደ ልጅ በእርግዝና፣ በምጥ፣ ጠቅ በማጥባት ጊዜ	1	2
		5.ሌላ (ይጠቀስ)		

213	ኤች.አይ.ቪ/ኤድስን ለመከላከል የሚሞሰዱ	1.መታቀብ	1	2
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ጥንቃቄዎች የ ትኛቹ ናቸው	2.መወሰን	1	2
	3.ኮንዶም ማጠቀም	1	2
	4.ቁሚያ ልሆነ ጉደኛ ጋር የ ማድረግ የ ግብረ ስጋ ግንኙነትን ማስወገድ	1	2
	5.የ ቤት ወስጥ መገልገያ እቃዎችን በየ ግል ማጠቀም	1	2
	6.ሌላ (ይጠቀስ)		

214 ስለ እርግዝና መከላከያ ታወቃለህ/ቂያለሽ 1.አዎ  
2.የለም

215 አዎ ካልክ/ሽ የ ትኛቹን መከላከያ ዘዴዎች ታወቃለህ/ቂያለሽ	1.ኮንዶም	1	2
	2.በአፍ የ ማዋጥ ክኒን	1	2
	3.የ ተፈጥሮ ወርሀዊ አቆጣጠር ዘዴ	1	2
	4.ደንገተኛ መከላከያ ክኒን	1	2
	5.ሌጥ	1	2
	6.ሌላ (ይጠቀስ)		

**ክፍል ሦስት-ይጋዎ ግንኙነትን የተመለከቱ ጥያቄዎች**

ተ.ቁ	ጥያቄ	ኮድ ክፍፍል	የኮድ ቁጥር
301	የ ፍቅር ጉደኛ አለህ/ሽ	1.አዎ	
		2.የለም	
302	አዎ ካልክ/ሽ በይጋዎ ግንኙነት ዙሪያ ተነጋግራችሁ ታወቃላችሁ	1.አዎ	
		2.የለም	
303	የ ግብረ ስጋ ግንኙነት ኖሮህ/ሽ ያወቃል	1.አዎ	
		2.የለም	
304	አዎ ካልክ/ሽ በየ ትኛው የ ዕድሜ ክልል ነው የ መጀመሪያ ግንኙነት የ ጀመርከው/ሽው		

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305 የግብረ ስጋ ግንኙነት ለመጀመሪያ ጊዜ ሰታደርግ/ጊ የነበረው ሰው-እድሜውምን ያህል ነው ከራሱ ህ/ሽ አንፃር

1. ያነሰ  
 2. አንድ አይነት የዕድሜ ክልል  
 3. ትልቅ  
 4. ሌላ (ይጠቀስ)

306	ለመጀመሪያ ጊዜ የግብረ ስጋ ግንኙነት እንደታደርግ/ጊ ያደረገ ህ/ሽ ምክንያት ምንድን ነው	1. በፍቅር መወደቅ 2. ለማዳኘት ማጉጉት 3. ትዳር ለመወከረት 4. ገንዘብና ሌሎች ስጦታዎችን ለማግኘት 5. ሌላ (ይጠቀስ)	
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307 ከመጀመሪያው የግብረ ስጋ ግንኙነት ጉደኛ ጋር ስንት ጉደኛ አለህ/ሽ

1. አንድ ብቻ  
 2. ሁለት እና በላይ  
 3. ምንም የለኝም  
 4. ሌላ

308 በግንኙነት ወቅት ኮንዶም ተጠቅመህ/ሽ ታወቃለህ/ቁያለሽ

1. አዎ  
 2. የለም

309	አዎ ካልከ/ሽ አጠቃቀምህ/ሽ እንዴት ነው	1. ሁል ጊዜ 2. አልፎ አልፎ 3. አንድ ወይም ሁለት ጊዜ ብቻ 4. ሌላ (ይጠቀስ)	
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310 ሌላ የእርግዝና መከላከያ ዘዴ ተጠቅመህ/ሽ ታወቃለህ/ቁያለሽ

1. አዎ  
 2. የለም

311 አዎ ካልከ/ሽ አጠቃቀምህ/ሽ እንዴት ነው

1. ሁል ጊዜ  
 2. አልፎ አልፎ

3.እንደ አጋጣሚ

4.ሌላ

312	የትኞቹን የእርግዝና መከላከያ ዘዴዎች ትጠቀሙ/ሚገለጹ	1.በአፍ የሚገኘው ክፍት 2.የተፈጥሮ ወርሀዊ አቆጣጠር 3.ደንገተኛ መከላከያ ክፍት 4.በክንድ የሚገኝ ማራጫ 5.ሌላ (ይጠቅሱ)	
313	እርግዘሽ ወይም አስረግዘህ ታወቁያለሽ/ታወቃለህ	1.አዎ 2.የለም	
314	አደገኛ እፅ ወይም መጠጥ ተጠቅመህ/ሽ ታወቃለህ/ቁያለሽ	1.አዎ 2.የለም	
315	አዎ ካልከ/ሽ የትኛውን ነው የተጠቀሙት/የሚጠቀሙት	1.ጭቶ 2.ሰጋራ 3.አልኮል 4.ሀሽሽ 5.ሌላ (ይጠቅሱ)	
316	እፅ ወይም መጠጥ ከተጠቀሙት/ሽ በኋላ የግብረ ስጋ ግንኙነት አድርገህ/ሽ ታወቃለህ/ቁያለሽ	1.አዎ 2.የለም	
317	ምንም የግብረ ስጋ ግንኙነት አድርገህ/ሽ የሚታወቅ/ቁ ከሆነ ምን ያስተላልፏል/ሽ ምን ነበር	1.ኤች.አይ.ቪ/ኤድስን ፍራቻ 2.እርግዝናን ፍራቻ 3.ቤተሰቦቹን ፍራቻ 4.በሀይማኖት ምክንያት 5.ከጋብቻ በፊት ግንኙነት ላለማድረግ 6.ሌላ (ይጠቅሱ)	



**የቃል ፈቃደኝነት ማረጋገጫ (መመሪያ)**

**ጠፍ ይሰጥልኝ!**

እኔ \_\_\_\_\_ ስባል ይህንን ወይይት የሚከላከልበት ማረጋገጫ ለማድረግ ስለሚችል የደህረ ምረቃ ትምህርት ክፍል የእናቶች ጠፍ ትምህርት ተመሪ መመሪያ ጽሁፍ ለማቅረብ በሚጠየቀው ጥናት የመሳናዶ ትምህርት ቤት ተመሪዎችን ለአደጋ የሚያጋልጡ ጾታዊ ግንኙነትን እና ጥንቃቄ የጎደለው ጾታዊ ግንኙነት እወቅትን ለማወቅ ሲሆን አላማም ጥንቃቄ በጎደለው ጾታዊ ግንኙነት ምክንያት በከፍተኛ አቅጣጫ ለሚከሰቱ የጠፍ ችግሮች መፍትሄ ለማግኘት ነው። ስለዚህ የእርስዎ በዚህ ወይይት ላይ መሳተፍ ለዚህ ጥናት አላማ መሳካት የራሱ የሆነ ጠቃሚ ድርሻ አለው።

የምትመልሱትን መልስ ማሳተፍ ላይ ለመጠበቅ ስባል በዚህ መጠይቅ ላይ ስሞቸውን መጠቀስ አያስፈልጋችሁም። እንዲሁም የማንኛውም በጥናቱ ላይ የተሳተፈ ተመሪ መልስ ለየትኛውም አካል ተላልፎ አይሰጥም።

በወይይቱ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ.....

የሉም.....

**የመደድ ጥያቄዎች**

1. በትምህርት ቤት ወሰን ያሉ ወጣቶች ስለሚከሰቱ አደገኛ ጾታዊ ግንኙነት እንወያይ (የኮንዶም አጠቃቀም፣ መታቀጠን...)
2. ከሁለት እና ከዚያ በላይ መካከል የሚደረግ የግብረ ስጋ ግንኙነትን እንዴት ታዩታላችሁ?
3. በትምህርት ቤት ወጣቶች ያለው የኮንዶም አጠቃቀም ምን ይመስላል? ሌሎች የወለድ መከላከያ ዘዴዎችስ?
4. በትምህርት ቤት ወጣቶች ያለው የአደገኛ እፅ/መጠጥ አጠቃቀም እንዴት ነው?
5. ለእነዚህ ሰዎች መግለጥ ከወጣቶች ወጠታሚነት ጋር ግንኙነት አለው ትላላችሁ? ከኤች.አይ.ቪ መዛመት ጋር ያለውስ ግንኙነት ምንድን ነው?
6. የኤች.አይ.ቪ ቫይረስ እና የአባላዘር በሽታዎች ያላቸው ግንኙነት ምንድን ነው?
7. ቤተሰቦቻችሁ የጾታዊ ግንኙነት ወይይት ይደግፋሉ? እናንተስ?