**JIMMA UNIVERSITY**

**COLLEGE OF EDUCATION AND BEHAVIORAL SCIENCES**

**DEPARTMENT OF PSYCHOLOGY**

# FOCTORS FOR RISKY SEXUAL BEHAVIOR AND PRACTICE AMONG HIGH SCHOOL AND COLLEGE STUDENTS IN SHAMBU TOWN


**BY**

**MOKONNEN KITISSA JALU**

**ADVISERS: FISSEHA MIKRE (Dr.) and YASMIN MOHAMMED**


ATHESIS SUBMITTED TO COLLEGE OF EDUCATION AND BEHAVIORAL SCIENCE DEPARTMENT OF PSYCHOLOGY IN PARTIAL FULFILLMENTS OF THE REQUIREMENTS FOR THE AWARD OF DEGREE OF MASTERS OF ARTS (MA) IN COUNSELING PSYCHOLOGY

**OCTOBER, 2020**

**JIMMA, ETHIOPIA**

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ADVISERS**:** FISSEHA MIKRE (PHD) and YASMIN MOHAMMED

JIMMA-OROMIA, ETHIOPIA
JUNE 2021

# DECLARATION

I, the undersigned, declare that this thesis entitled “Risky for sexual behavior and practice among high school and college students in Shambu town” is my original work and has not been presented by any other person for award degree in any other university, and that all sources of materials used for this has been duly acknowledge. The thesis has been submitted in partial fulfillment for degree master of Arts in Psychology

Name: Mokonnen Kitissa Jalu

Place: Jimma University

Date of Submission: _June, 2021

Jimma University

College of Education and Behavioral Science

Department of Psychology

This is to certify that the thesis prepared by Mokonnen Kitissa Jalu entitled “Risky sexual behavior and practice among high school and college students in Shambu town “which is submitted in partial fulfillment for degree master of Arts in Psychology, complied with regulation of the university, and meets accepted standards with respect to standards to originality and quality.

Approved by Board of examiner:

| Advisor | Signature | Date |
|---|---|---|
| _____ | _____ | _____ |
| Internal Examiner | Signature | Date |
| _____ | _____ | _____ |
| External Examiner | Signature | Date |
| _____ | _____ | _____ |
| Chairperson | Signature | Date |
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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| ARC | AIDS Resource Center |
| BSS | Behavioral surveillance survey |
| CBOs | Community Based Organizations |
| CSOs | Civil Society Organizations |
| EDHS | Ethiopia Demographic Health Survey |
| FBOs | Faith Based Organizations |
| FSW | Female Sex Workers |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HEIs | Higher Education Institutions |
| ISY | In School Youth |
| KAP | Knowledge Attitude Practice |
| MARPs | Most at Risk Populations |
| MoE | Ministry of Education |
| NGOs | Non-Governmental Organizations |
| PLWHA | People Living With HIV/AIDS |
| RH | Reproductive Health |
| TVET | Technical and Vocational Education and Training |
| WHO | World Health Organization |

# Abstract

*The purpose of this study was to examine factors for risky sexual behavior and practice among high school and college students in Shambu town. The researcher employed descriptive research design. The target populations are sample portion of young adults aged 10-24 years both female and male who are attending regular day school at the time of the study. The reference population is both private and governmental secondary schools and college adolescents and youths (young adults) in Shambu Town. The instruments for data collection were questionnaire, interview, and focus group discussion. The data were analyzed and interpreted using both qualitative and quantitative techniques.*

The *findings of this study strongly indicated that a considerable proportion of youths in among high school and college students in Shambu town in general are sexually active. Similarly, the finding shows that students at the study were asked with whom they were living alone and with their both parents respectively. Most of students were have addicted to different addiction causing substances like smoking cigarette, chewing chat, drinking alcohol, and using shisha respectively in decreasing orders but some of them were using all substances. On the other hand, most of them were watching sexual practice film while few of them were not. Furthermore, the study shows that most of the study participants were using of sexual risk factors that both act as motivators of sexual intercourse and risky avoiders while practicing unsafe sex. Majority of the study participants were practiced sex with one friend while some of them were had done sex with two, three partners. The major finding regarding to other sexual transmitted diseases of them did heard and knew about sexually transmitted diseases specially Gonorrhea and Syphilis respectively even though few of them also heard and knew about HIV and Chancroid diseases as they also considered as sexually transmitted diseases. It is suggested that high schools and college students should expand and improve good practices and good habits in the high schools and college students on gender, sexuality, HIV/AIDS and STIs that has been implemented and enable students to handle or resist peer influence, to develop negative attitude towards risky behaviors, to control early sexual initiations and develop the habit of consistent and proper condom use so that the students can become conscious.*

# CHAPTER ONE: INTRODUCTION

This chapter of the study deals with the background of the stud, statements of the problem, and the objective of the study, the significance of the study, the scope of the study, limitation of the study, definition of key terms and organization of the study.

## 1.1 Background of the Study

Over the past ten years, we have witnessed significant changes in adolescent sexual behavior. Specifically, there has been an overall decline in early onset sexual activity and an overall increase in contraceptive use (Brener, Kann, Lowry, and Wechler, 2006). Despite these improvements, adolescent risky sexual behavior (RSB) remains a significant public health challenge. Rates of sexually transmitted infections (STIs) and sexually transmitted diseases (STDs) have continued to grow, reaching epidemic proportions. Adolescents, for example, comprise approximately 50% of all new STI cases (Weinstock, Berman, and Cates, 2004) and of concern are the increases in the rates of HIV infection in this group. Since the development of a vaccine or cure for HIV/AIDS remains a remote possibility, researchers and clinicians have focused their efforts on prevention. The most obvious way is according to the behavior itself: unprotected vaginal, oral, or anal sexual intercourse. This can be happened with the following risk factors; multiple sexual partners, sexual intercourse with no condom, childhood sexual abuse, and early onset of puberty and due to the following barriers: substance abuse, low parental education, low parental monitoring, low self-esteem, poverty, sexual active peer group, perception of sexual activity among cohort, media portrayals of sex and sexuality etc. Japheth, (1996) stated that sexually active youth are at risk of contracting sexually transmitted diseases, including Human Immune Deficiency Virus (HIV) infection.

There are psychological and behavioral factors associated with the risk of sexually transmitted diseases like HIV/AIDS, (Gebregiorgis, 2000). The same study reported that understanding sexual risk behaviors is one of the most important issues in preventing the spread of HIV and AIDS. Doing so will result in the design and implementation of health education programmers with the view of preventing these infections or at least minimize their occurrence. At the beginning of the new millennium, more than a quarter of the world's population, were between

the ages of 10 and 24, and 86 percent of these youths were living in less developed countries (Solomon, 2004).

It is reiterated in several publications that these youths are tomorrow's parents (Solomon, 2004,). While some authors appear to support this view, they also consider the term "youth" as a period during which people explore and discover a range of life events or behaviors, such as early onset of sexual intercourse (Kauffman, Orbe, Johnson and Cooke-Jackson, 2013,) and over four million are diagnosed with a sexually transmitted disease (STD) (Kauffman *et al*., 2013,).

Socio-demographic characteristics, particularly gender, location, and age, are significantly correlated with sexual and preventive behaviors (Gebregiorgis, 2000). It is therefore important to explore these factors in research studies, as engaging in sexual risk behaviors could result in negative consequences. For example, sexual risk behaviors could lead to unwanted pregnancy, which in turn has negative implications. Sexual behavior and sexuality are very important for adolescents' health and well-being. Adolescents have their first relational and sexual experiences, and must learn what they like and dislike, how to make sexual experiences mutually rewarding, and how to prevent potentially negative consequences of having sex. Ideally these experiences are safe and pleasurable for both partners.

Some studies conducted among higher education students of Ethiopia had also confirmed that higher education students were engaged in risky sexual behaviors like other students of the world; a study conducted among Addis Ababa university students had revealed that multiple sexual partnership and unprotected sexual intercourse were reported by 37% and 28.5% of sexually active respondents respectively.

These mentioned studies above are indications that college adolescents and high school young adults were practicing risky sexual behaviors and are at heart of HIV pandemic. Therefore, it is necessary to focus on young students to prevent the spread of the HIV infection. Specially determining the sexual behavior of college and high school students is a part of foot step to stop risky sexual behavior and practice. Hence the aim of this study was to examine factors for risky sexual behavior and practice among high school and college students in Shambu town.

## 1.2 Statement of the Problem

Sexual and reproductive health problems are among the main causes of death, disability, and disease among young people worldwide particularly in Africa. Youths' sexual behavior affects

their physical, psychological, and social well-being leading to death. The largest proportion of STIs occur in developing nations, led by south and Southeast Asia, followed by Sub-Saharan Africa, Latin America, and the Caribbean (WHO, 2002). Ethiopia, like sub-Saharan African countries with high HIV prevalence, with a total estimated number of 1,116,216 people living with HIV in 2009, of which 658,843 are females (WHO/UNAIDS, 2014).

Even though HIV prevalence tends to be higher in urban settings than in rural areas, Ethiopia has the most pronounced difference in HIV prevalence where urban dwellers are eight times more likely to be HIV infected than people living in rural areas (MOH, 2014).

Adolescents and young adults are risk takers more likely to make decisions about the future without adequately considering the consequences people were engaged in risky sexual activities, which could result sexually transmitted diseases including HIV infection (James, 1999). It was suggested that many young people have information from different sources about HIV/AIDS; however, the problem is to bring about behavioral change (Petere and Michael., 2002). Globally, 45 percent of all new HIV infections worldwide are occurring among young people aged 15 to 24 years, 500,000 young people are infected with STI per day, approximately 80 million women have unwanted pregnancies every year (Coley, Medeiros and Schindler, 2008). The numbers of people newly infected with HIV in 2009 were 2.6 million and there were a total of 1.8 million AIDS related deaths. Since the beginning of the epidemics, almost 60 million people have been infected with HIV and 25 million people have died of HIV related causes. In 2009, the global adult prevalence (15-49) was 0.8% (MOH, 2014).

In adolescents and young people risky sexual behavior is a priority public health concern because of the high prevalence of HIV/AIDS and sexually transmitted infections (STIs). High exposure of youths to STIs associated with unsafe sexual practices, such as unprotected sex is an important and sensitive issue in sexually active age groups (Animaw, 2009). The consequences of young people's sexual behavior when not using contraception have become a global issue mainly because it is associated with pregnancy and STIs (Turnbull, 2010).

The incidence and prevalence of HIV among youths are generally higher relative to cases in adults (Turnbull,2010). This is probably because of their sexual activeness and tendency to

frequently engage in unsafe sexual practices, such as unprotected sex (Guzman and Bosch 2007). This is also noted among youths in Ethiopia and hence, the high prevalence of HIV/ AIDS cases in this population. Despite this, very limited research has been done in this regard in Ethiopia and to date there are no published empirical studies on factors relating to sexual risk behaviors in the Enemay District, East Gojam Zone of Ethiopia (Animaw 2009).

Young people have limited access to reproductive health services that focus on the special needs of adolescents and these youths are at high risk for risky sexual behaviors and reproductive health problems, (OCR Macro, 2002). Risky sexual behavior is any behavior that increases the probability of negative consequences associated with sexual contact, including HIV/AIDS or other sexually transmitted diseases (STDs), abortion and unplanned pregnancy. Risk factors are characteristics of individuals, families, schools, and communities that make people more vulnerable to adverse consequences, (Cooper, 2002).

The family and school are the contexts for social interaction, cultivation of interpersonal skills, formation of peer groups, self-expression, and development of self. Several studies have demonstrated that the social context of the school and family has important implications for determining the likelihood that an adolescent will follow a prosaically path through adolescence as opposed to becoming involved in delinquent behavior (WHO, 2002). There is an increase of young people who engage in premarital sex and multiple sex partner behavior. Therefore, Risky sexual behavior among college students remains a serious problem and these behaviors may even be on the increase (Pluhar, Fongillo, Stycos, and Dempster-Mc Clain, 2003).

There is a general perception that students at educational the institution engage in high risk sexual behavior (MOH, 2014), that puts them at risk of contracting HIV, STIs and unplanned pregnancy. Multiple sex partners' behavior among students portrays negative implications to the family and community at large. On individuals, it builds a state of disrespect, mistrust, and loss of dignity especially in the community one is dwelling. Such behavior is associated with unintended pregnancy for girls and the risk of acquiring sexually transmitted diseases (STDs) including HIV/AIDS. Since Shambu is the capital city of Horro Guduru Wollega Zone, which is formed as a new zone under Oromia regional state, there is an increase institution, population density and new habits are reflecting in the community especially on the adolescents because of

this sexual behavior among young people need more attention. The vulnerability of young people to sexually transmitted diseases and HIV infection in Shambu town has made it urgent to conduct this research. Hence, this study has explored the factors that may influence youths to engage in unsafe sexual behaviors with the aim of providing appropriate recommendations for reducing or preventing unsafe sexual practices among youths in colleges and senior secondary schools.

## 1.3.Research Question

### 1.3.1 General Research Questions

Based on the statement of the problem, the researcher formulated the following general research questions:

What is the extent of risky sexual behavior and practice among high school and college students in Shambu town?

### 1.3.2 Specific Research Questions

To achieve the objective of the research the study aims to answer the following specific research questions:

1. What are the major factors influencing the youth to sexuality risky behavior and practice?

2. Why do high school and college students engage in high risk sexual behavior?

3. What is the association between background information of students and risky sexual behaviors?

4. What is the association between value orientation such as condom use, risk perception, willingness for VCT and sexual behavior in young adults?

5. How gender difference affects sexual risky behavior?

## 1.4 Objectives of the Study

The main intension of this research was identifying and describing Adolescents Perceptions about factors influencing sexual risk behavior and to develop recommendations for interventions

to reduce sexual risky behaviors. In this research the researcher going to operate based on the following specific objectives were:

- Assess the current sexual behavior of young adults in Shambu Town and to find out the level of awareness and misconceptions that young adults have about sexually transmitted disease (STDs)/HIV).
- Determine the level of risky sexual practices among young adults based on their self-report.
- Identify young adults' intended decision on protected sexual behaviors.
- Assess the view of young adults in addressing their sexual problems.
- Assess young adult's personal attitudes as predictors of risky sexual behaviors.

## 1.5 The significance of the study

The aim of this research was primarily, investigate the problems which are affecting the life of tomorrows parents to trigger the concerning body's attention especially educational institutions leader, designer of the college training program towards the issue of college student's residence and accommodation during their training life time. The issue of sexual risky behaviors among youths in Ethiopia is very important for the prevention of problems relating to unwanted pregnancy and Sexually Transmitted Infections (STIs), including HIV/AIDS. Thus, it is expected that this study would contribute to the development and implementation of appropriate health promotion programmes to reduce both the incidence and prevalence of sexual risk behaviors and their associated problems, including HIV/AIDS.

The outcome of this study will have implications for further policy making and practice. The study outcome will enable healthcare workers to identify individuals (students) at risk of contracting sexually transmitted infections and motivate them to reduce factors that may influence sexual risky behaviors through education on safe sexual practices and consequences of early sexual practices. An example of these consequences is unwanted pregnancy. Additionally, the study outcome will contribute to the development of health promotion strategies for addressing sexual risk behaviors of the study population. Taking the issue of health promotion further, this study has the potential of saving cost in that the implementation of health promotion strategies may considerably result in the reduction of sexual risk behaviors, which in turn would

reduce the incidence and prevalence of sexually transmitted diseases and the cost of curative measures.

## 1.6 Delimitation of the study

Now a day's sexual risk behavior is a problem of society at large all over the country. However, this study was involved students of colleges and secondary schools of Shambu Town. Even though, adolescents to be those in the age group 10-24 years, youths in the age of 15-24 and young adults in the age group 10-24 years, (UNDPA, 1998)., are more likely to engage in risky behaviors, such as substance use and unsafe sexual practices, different stages of societies found other than the mentioned years gap is also affected by sexual related problems.

To make the study manageable or handle, the study was delimited to students those aged 10-24 years, both sexes, those who were school attending-regular day school and the research excluded those who were not attending regular day school at the time of the study, junior high school students, night school students, the other shift and university students.

## 1.7. Limitation of the Study

The limitation of the study may have been that there were specific questions regarding students' sexual behaviors and practices. Since sexual practice is strictly hidden or not open, some respondents may have been hesitant /shy to answer all questions honestly or may have answered the questions in a socially acceptable way. Here the researcher is expected to add items that would check and identify respondents that are answering items in a manner mentioned above. This was not done in a proper way due to the fear that the questionnaires become too long to be properly addressed by respondents

## 1.8 Definition of Terms

**Inconsistent condom use:** Irregular use or none use of a condom during sexual intercourse encounters.

**Risky Sexual Behavior means**: Early start of sexual intercourse, unprotected vaginal, oral, and anal intercourse, multiple sexual partners, and sex while under the influence of drugs or alcohol.

**Risk Factors**- are early onset of puberty, Substance abuse, childhood sexual abuse, Low parental education, Low parental monitoring, Low self- esteem, poverty, Sexually-active peer group, Perception of sexual activity among cohort and Media portrayals of sex and sexuality.

**Consequences of risky sexual practice and behavior**- are teen Pregnancy, Low Self Esteem and Sexually Transmitted Infections (STI)

**Some Common Sexually Transmitted Infections (STls) -** are Bacterial (curable): Chlamydia, Gonorrhea, Syphilis, Bacterial vaginosis and Trichomoniasis.

**Young adult**-WHO considers as the period between 10 and 24 age group or combination of adolescents (10-19) and youth (15-24).

**Sexual intercourse**– for this study it is defined as vaginal or anal penetrative sexual inters course.

**Sexual partners** – according to this study is taken as none commercial and only one non-commercial partner.

## 1.9. Organization of the Study

The organizations of this study are divided into chapters. This study has organized with five chapters and several sub titles within each chapter. Chapter one of the studies is titled as introduction with the subtitles - background of the problem, statement of the problem, research questions, Objective of the Study, definition of terms, limitations of the study and organization of the Study. The second section or chapter of this study is literature review. Research design and methodology of this study is organized under chapter three of the study. Description of the study area, research design and methods, universe of the study, sampling technique, sample size determination, data collection techniques and procedures data processing and analysis are sub titles that are placed under this section of the study. The Interpretation and discussion part of the study was placed under chapter four of the study. The other section of this study is that the conclusion and recommendation of the study which is organized under chapter five of the study

# CHAPTER TWO: LITRATURE REVIEW

## 2.1. Introduction

This study gave attention to sexual risk behaviors and factors influencing them. This chapter provides an overview of the available literature on factors relating to sexual risk behaviors among colleges and secondary school youths. The chapter concludes with a summary of the key issues that emerged from the literature sources.

## 2.2 Definition of Sexual behavior

Sexual behavior is influenced by a complex set of interactions of biology and genetics, individual perceptions, personality characteristics, and socio-cultural norms and Values (Renee and Sieving, 2002).

The Family Planning Association defines sexual health as: …enjoying the sexual activity you want without causing yourself or anyone else suffering or physical or mental health. In more detail, the World Health Organization (WHO) defines sexual health as: … a state of physical, emotional, mental, and social well-being. In relation to sexuality it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence (WHO, 2012).

Puberty is a biological process universal to children everywhere. Adolescence on the other is a cultural phenomenon unique to each civilization or society, because of this WHO/UNFPA jointly defined adolescents to be those in the age group 10-19 years, youths in the age group 15-24 and young adults in the age group 10-24 years. The period of adolescence is further divided in to three stages of early (10-13) years, middle (14-16) years and late (17-19) years (Hofmann, 1999)

## 2.3. Sexual health

Despite that the term sexual health has become increasingly used the understanding and definition of sexual health behavior is not straight forward. Several definitions and aspects of healthy and unhealthy sexual behavior can be found in recent literature sources. Some

researchers, from a strictly medical point view see safe sexual behavior only in terms of prevention of STIs and unintended pregnancy (Kane and Wellings, 1999; Krivohlavy, 2003). The Family Planning Association defines sexual health as: …enjoying the sexual activity you want without causing yourself or anyone else suffering or physical or mental health. In more detail, the World Health Organization (WHO) defines sexual health as: … a state of physical, emotional, mental and social well-being. In relation to sexuality it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence (WHO, 2012). At first sight we can see that sexual health is not just about the occurrence or prevention of negative outcomes, such as sexually transmitted infections (STIs) and unintended pregnancies. It really is something more, which is reflected by the previous definitions which express that sexual health is also about enjoyment and pleasure (Coleman *et al*., 2007).

## 2.4 . Sexual risk behavior in adolescence and young adults

Adolescents and young adults in particular have been found to be the group at the highest risk for negative health consequences related to sexual risk-taking behavior, including STIs like e.g. chlamydia, gonorrhea, syphilis, human immunodeficiency virus (HIV), and the occurrence of unintended pregnancies (Aggleton, 1995). The key markers and indicators of sexual risk behavior (SRB) include an early age of sexual initiation, inadequate contraception use, promiscuous behavior and sexual contact with an unknown partner (Kirby *et al*., 2010).

The potential risks associated with sexual behavior among 15 year old are mainly linked to the emotional and behavioral characteristics of this developmental period (Gabhainn *et al*., 2009). It is known that early sex has implications for one's self-perception, social status and future health behavior. Unprotected or poorly protected sexual intercourse increases the risk of unintended pregnancy with its myriad of possible unfavorable outcomes for this age group, including abortion, early motherhood and adoption – each of which presents educational, economic, social and health challenges (Ellison, 2003). Moreover, for those not employing barrier methods of protection, there is also the risk of STIs with serious short and long-term attendant medical, health and social implications (Gabhainn *et al*., 2009).

Condoms and hormonal contraceptive pills are considered the most appropriate methods of protection from STIs and from unintended pregnancies, respectively. Possible use of dual methods – both contraceptive pill and condom at the same time – confers an effective protection against pregnancy and a moderately effective protection against STIs (Blythe *et al*., 2007). The adequacy and effectiveness of contraception methods depends on many interacting factors related to the contraceptive itself (e.g. efficacy, availability, cost, convenience); the sexual activity (e.g. type of sexual behavior, frequency of intercourse, risk of STIs); the person and/or partner (e.g. age, ethnicity, culture, religious beliefs, educational level, family characteristics); the broader context (e.g. historical, cultural, religious and social context) (Sales *et al*., 2007; Heavey et al., 2008) and inter-personal relationship dynamics (e.g. the duration of relationship, age difference between partners, trust) (Gabhainn et al., 2009). Moreover recent literature (Pitts and Emans, 2008; Bonny *et al.*, 2011; Gronich *et al*., 2011; Isley and Kaunitz, 2011; Gordon and Pitts, 2012) showed a potential side effect of contraception pills on migraine headaches, thrombosis risk, hypertension, weight gain, and obesity. However, the evidence about these issues is not consistent and the causality is not clear. Nevertheless, following the previous findings, for very young adolescents it seems to be unwise to engage in sexual intercourse and if so the type of contraception has to be carefully chosen to prevent unfavorable health outcomes.

The most recent international study which explored sexual behavior of school age adolescents in 42 European and North American countries (Currie, *et al*., 2012) showed that adolescents from the Central European region including Slovakia reported the lowest rates of sexual activity. Adolescents of 15 years of age were less experienced with sexual intercourse (10% girls and 15% boys) than their peers from most Western countries (HBSC average in 2010: 23% girls and 29% boys) while the average age of sexual initiation in the Slovak population is 17.8 years (Harris Interactive, 2009). The differences regarding contraception use are less striking at the age of 15. Condom use during last sexual intercourse was reported by 76% of the girls and 77% of the boys in comparison to the HBSC average of 76% of the girls and 79% of the boys (Durex. 2012). The hormonal contraception use among 15 years Slovak girls steeply increased from 3% in 2006 (Currie *et al*., 2008) to 22% in 2010 while the HBSC average in 2010 was 26% (Currie *et al.*, 2012).

Despite having the lowest rates of STIs in Europe, patterns in sexual behavior among adolescents and young adults in Central and Eastern Europe seem to be changing. A decrease of the age at which they become sexually active is evident, particularly among females, leading to a narrowing of the gap between boys and girls regarding the time of sexual initiation (Rabusic and Kepakova, 2003). Moreover the young adolescent girls reported increased levels of hormone contraceptive pills.

## 2.5 Factors associated with sexual risk behavior among adolescents and young adults

Several models have been developed to describe and schematize the various factors associated with sexual risk behavior among adolescents. Our approach in this thesis was inspired by Bronfenbrenner's Ecological Systems Theory, which emphasizes the reciprocal relation among multiple systems associated with a person's behavior (Bronfenbrenner, 1989). According to this perspective, an accurate and comprehensive understanding of adolescent sexual risk behavior must necessarily include some knowledge of both the personal and the social factors which may contribute to the decon to become sexually active and subsequently, the decon to engage in risk/promoting or risk reducing sexual behavior (Kotchick *et al.*, 2001).

We assume that psychological factors (e.g. extroversion, well-being, self-esteem), behavioral factors (e.g. early sexual onset, alcohol and tobacco use) and social factors (e.g. family structure, parental monitoring and support) are significantly linked to adolescents and young adult sexual risk behavior.

### 2.5.1. Psychological and behavioral factors

#### 2.5.1.1.Psychological factors

Psychological factors like self-esteem, well-being, religiousness and personal values have been shown to be associated with sexual behavior but findings regarding this from the Central European region are missing (Mann *et al.,* 2004). Self-esteem plays an important role in risk-taking behavior, that may also be relevant for SRB but evidence regarding this is still inconclusive (Mann *et al.,* 2004). Several studies (Davies *et al*., 2003; Lejuez *et al.,* 2004; Preston, *et al*., 2004) support the link between low self-esteem and sexual risk behavior (e.g.

early sexual intercourse, inconsistent contraceptive and condom use) and the consequences of sexual risk behavior such as unwanted pregnancies and STI. Low self-esteem was related to sexual risk behavior in a sample of adults residing in a residential drug-treatment program (Lejuez *et al.*, 2004) and low self-esteem predicted sexual risk behavior in a sample of rural men as well (Preston, *et al*., 2004). Magnani (2001) reported that low self-esteem predicted both early onset of sexual activity and unprotected sex on a large cross-sectional sample of adolescents in Peru. In general, it seems that high self-esteem is positively associated with less sexual risk behavior. However, Spencer (2002) found that the probability of having sex was increased by high self-esteem in boys but by low self-esteem in girls, contrary to Paul (2000) who found that girls with higher self-esteem were more likely to have had an earlier first sexual intercourse compared to those with a low self-esteem. Moreover, a review of studies which explored the role of self-esteem on sexual behavior showed that 60 % of the studies found no associations between both variables and thus, an expected protective role of self-esteem was not shown.

A number of other factors, such as the educational aspiration level and psychological well-being, have been hypothesized as being associated with (sexual) risk behavior, but the evidence remains inconclusive. A higher aspiration level has mostly been shown to be associated with less sexual risk behavior (Bonell *et al.*, 2005), but the few studies which have examined the association between the attitude to school and teenage pregnancy have provided inconsistent findings (Mott *et al.*, 1996). Also some other studies demonstrate the important roles of psychological factors, particularly stress, anxiety and depressive mood, on adolescents' health risk behavior (Callas *et al.*, 2004; Klavs *et al*., 2005). Therefore if mental health is a positive attribute for health in general then mental health promotion is a strong reason for healthy and valuable adolescent's development.

Associations between personality traits and sexual risk taking have been replicated across multiple studies (Hagger-Johnson *et al*., 2011). Eysenck (1975) found that extraverts tended to endorse more favorable attitudes than did introverts toward having multiple sex partners and trying out different sexual positions. Extraverts also engaged in sexual intercourse at younger ages than introverts, as well as having sex more frequently and with more partners than introverts did (Eysenck, 1975). Similar associations between extraversion and more promiscuous sexual desires have been found by others (Costa *et al*., 1992).

Extraversion also has been linked to promiscuous sexual behavior (Pinkerton and Abramson, 1995; Schmitt and Buss, 2000) and to unsafe sexual practices (Mc Cown, 1991).

Neuroticism is rooted in negative emotionality, including anxiety, depression, and anger (Widiger and Costa, 1994). Neuroticism has been correlated with several features of problematic sexuality, including sexual dissatisfaction and marital distress (Gottman *et al.*, 2002). It was found that people who score high in neuroticism tend to have more permissive sexual attitudes (Lameiras Fernandez and Rodriguez Castro, 2003) and engage in more sexual risk-taking including the practice of unsafe sexual practices (Mc Cown, 1991).

The most consistent predictor of sexual risk taking is sensation seeking (Hagger-Johnson *et al*., 2011). Sensation seeking is a trait that overlaps considerably with conscientiousness and some elements of extraversion in the comprehensive 'big five' model of personality (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness) (Bogg and Roberts, 2004). Low conscientiousness shares variance with impulsive sensation seeking, and extraversion overlaps with need for activity and sociability (Zuckerman, 1993). Because it was a later addition to the big five, fewer studies have examined conscientiousness as a risk factor for sexual risk taking. Several recent studies have however replicated findings in the expected direction; with lower conscientiousness scores predicting increased sexual risk taking (Trobst *et al.*, 2002; Schmitt, 2004; Hagger-Johnson *et al*., 2011). The contribution of extraversion is fairly consistently replicated, with higher extraversion scores associated with increased risk. This effect does however appear more robust in relation to multiple sexual partners per se rather than condom use specifically (Bourdage *et al*., 2007; Schmitt and Shackelford, 2008).

In summary, several psychological factors that have been found to relate to an adolescents and young adults sexual status have also been found to be associated with their sexual risk behavior. However, some variables are not associated consistently with sexual behavior such as the relation between adolescent sexual risk behavior and knowledge about sexual risk factors and perceived personal vulnerability to undesirable outcomes of sexual activity (Kotchick *et al*., 2001). More research is also needed to examine the role of self-esteem, self-efficacy, and general psychological health in the promotion of safer sexual practices

### 2.5.1.2. Behavioral factors

Sexual risk taking behavior has been reported together with a number of other behaviors (van Nieuwenhuijzen *et al*., 2009), including delinquency, substance use, and other indices of sexual activity in general (HalpernFelsher *et al.,* 1996; Staton *et al.,* 1999; Kotchick *et al.,* 2001; Patrick and Maggs, 2009; Cavazos-Rehg *et al*., 2010).

### 2.5.1.3. Sexual risk behavior and other types of health risk behavior

The belief that alcohol causally disinhibits sexual behavior is firmly ingrained. Most people believe that drinking increases the likelihood of sexual activity, enhances sexual experience, and promotes riskier sexual behavior. Young people sometimes attribute risky sexual experiences to the fact that they were drinking and report drinking (or plying their partner with alcohol) to exploit alcohol's alleged disinhibiting effects on sexual behavior (Cooper, 2006).

Consistent with such belief, empirical research has generally supported this idea, with alcohol consumption being positively related to engaging in high-risk sexual behaviors (Leigh and Stall, 1993) including deciding not to use condoms (Conner *et al.,* 1999) and engaging in casual sex (Conner and Flesch, 2001). These types of behavior are more likely to occur when one or both sexual partners are under the influence of alcohol or drugs (Cooper, 2006; Parkes *et al.*, 2007). For example, the average alcohol consumption was correlated with engaging in high-risk sexual behaviors (Anderson and Dahlberg, 1992), the use of alcohol with sexual activity was correlated with the frequency of high-risk sexual behaviors (Leigh, 1990), and the use of alcohol is related to the likelihood of sex on a first date (Cooper and Orcutt, 1997). Moreover, a study by MacDonald (1996) found that alcohol decreases the likelihood of condom use during casual sex. Also binge-drinking teens have been found approximately three times less likely to use condoms, and recent marijuana users are almost two times less likely to use condoms (Tapert *et al.*, 2001). The use of marijuana, cocaine or other illicit drugs by adolescents has been shown to be associated with increased rates of sexual intercourse in general, having multiple sexual partners and lower rates of condom use, particularly for users of illicit stimulant drugs (Lowry e*t al.,* 1994).

### 2.5.1.4. Sexual risk behavior and other aspects of sexual behavior

However, not only other risk behaviors (alcohol or drug use) correlate with sexual risk behavior, but also the other aspects of sexual behavior. An early age of sexual initiation is considered as a main pattern of sexual risk behavior that is particularly important in adolescence. It seems also to be correlated with others aspects of sexual risk behavior such as a higher number of sexual partners, inconsistent contraception use, unintended pregnancies, higher rates of STIs and further gynecological problems. Although, to indicate what is the accurate age for first sexual intercourse is a very ambitious task, because numerous indicators have to be taken into account. One of the most important factors is the physical and mental maturity of adolescents.

Adolescents' physical immaturity contributes to an increased risk of acquiring STIs compared with adults. Female adolescents, for example, do not have the same ability to combat STIs as adults, because their cervix is less able to exclude infections from the upper genital tract until two to three years after menarche. The risk is so great that a sexually active 15 years old girl has a ten times higher risk of acquiring pelvic inflammatory disease (PID) compared with a 24 year old woman (Duncan *et al.,* 1990).

As mentioned in the previous paragraph, early sexual initiation seems to be a strong predictor of further sexual behavior. Early sexual activity can have consequences for young people's health and well-being, in particular if it occurs prior to being physically and mentally mature enough to cope with it (Godeau *et al.,* 2008). Moreover early initiation of sexual behavior has been associated with adverse health outcomes such as increased risk of STIs and unintended pregnancies (Godeau *et al.,* 2008), poor mental health (Sabia and Rees, 2008) and lower academic performance (Sabia, 2007). Early sexual activity, particularly when associated with inconsistent or non-use of contraception, has serious short and long-term health-com priming consequences, as such activity happens before young people are developmentally equipped to handle the consequences. Moreover early sexual initiation has been associated with other risk behaviors such as smoking tobacco (mainly for girls), higher levels of drunkenness and cannabis use and frequent evenings out with friends. In addition, early sexual intercourse has been associated with more frequent psychosomatic complaints among boys and lower health-related quality of life among girls.

### 2.5.2 Social factors

Social variables, including family structure, parenting practices, and peers were frequently found as relevant factors regarding SRB of adolescents and young adults (Di Clemente *et al.,* 2001; Sieverding *et al.,* 2005; Wight *et al.,* 2006; Potard *et al.,* 2008; De Graaf *et al.,* 2010). Familial environment is a multidimensional construct comprised of heterogeneous psychological and social factors (Di Clemente *et al.,* 2001). The family system and its influences on adolescent sexual behavior can be divided into two primary categories: family structure variables (single parenting, socioeconomic status, parental education) and process variables (parental monitoring and support, connectedness, communication between parents and child and quality of relationship). In general, the process variables received more attention than the family structure category (Kotchick *et al.,* 2001). However, there is evidence that structural factors, such as single parenting, SES, and parenting education, should not be ignored.

#### 2.5.2.1. Family structure

According to the family structure several studies have shown that living with parents is protective against SRB (Metzler *et al.,* 1994). While these results show that living with at least one parent serves a protective role, other findings suggest that living with two parents can further protect adolescents from engaging in SRB. According to a study by Klavs (2005) the main factor associated with early sexual intercourse was not living with both parents up to the age of 15. Devine (1993) found that parental divorce during early adolescence was a significant predictor of sexual risk behavior for females in later adolescence. Several studies confirmed that family structure can influence also other types of health risk behavior. A study on Slovak young adolescents found that parental divorce may increase the likelihood of drunkenness more than other factors such as low parental support and poor socioeconomic position (Tomcikova *et al*., 2009). However, a study by Langille (2003) found no significant associations between the family arrangement and sexual behaviors, except between living with both parents and contraception use.

#### 2.5.2.2. Parenting

Parenting practices comprise a constellation of dynamically interrelated factors including but not limited to parental supervision, affect, communication, and involvement (Bersamin *et al*., 2008).

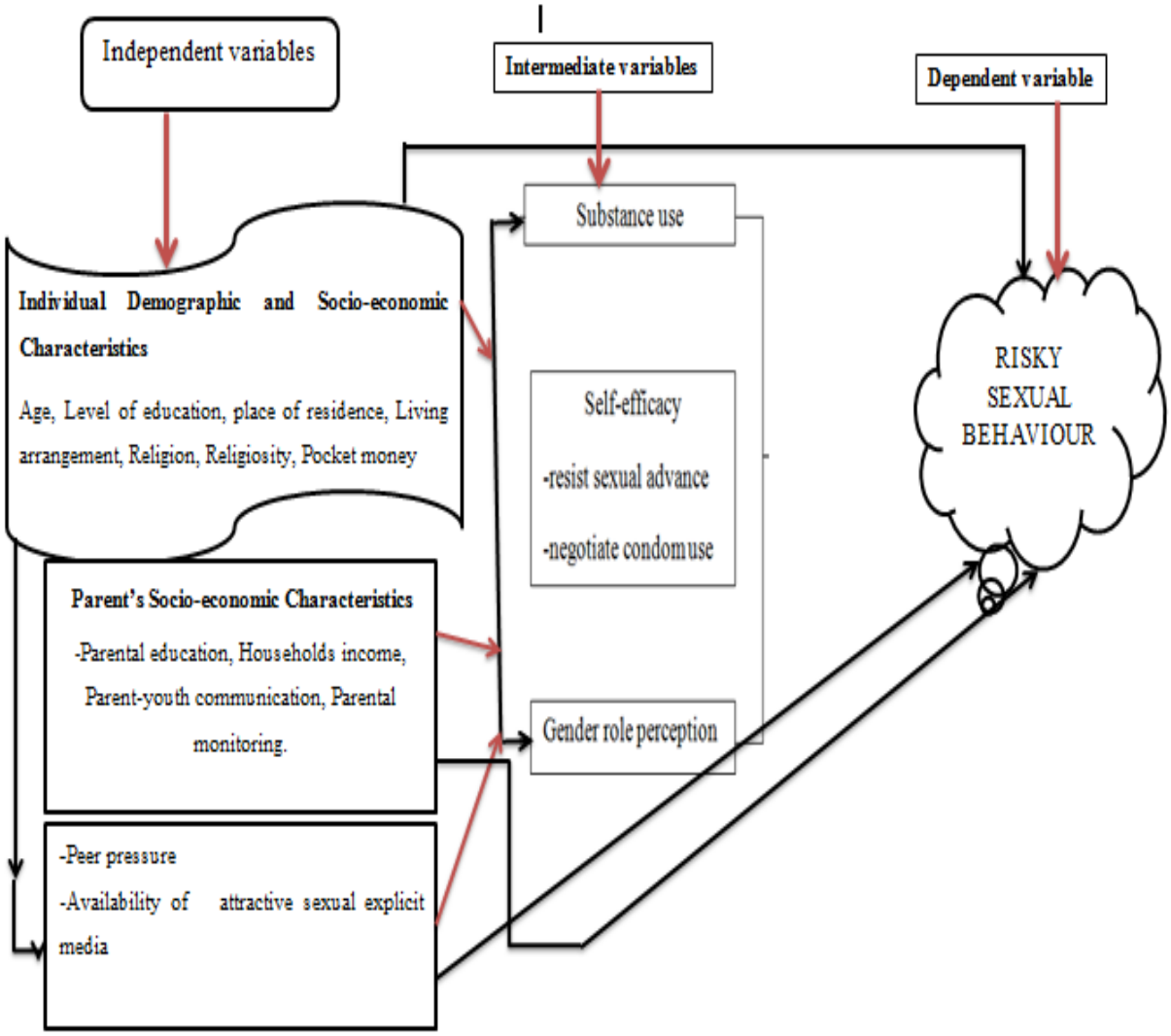
The influence of parents on adolescent behavior is multifaceted and cannot be understood by isolating and focusing on a single construct (Dishion & McMahon, 1998). Several studies have found associations between aspects of parenting and sexual behavior e.g. (Borawski *et al.*, 2003; Bersamin *et al.*, 2008; De Graaf *et al.*, 2011). Parental monitoring and parental support are the two most studied aspects of parental processes associated with sexual risk behavior of adolescents. Warmth, responsiveness, and child-centeredness can characterize parental support. Monitoring is usually defined as the parents' knowledge of their child's whereabouts. According to previous studies there are indications that both a high level of parental monitoring and support are associated with a later age of first sexual intercourse (Bersamin *et al.*, 2008); with a more consistent contraceptive use (DeGraaf *et al.*, 2010); with a more consistent condom use (Huebner and Howell, 2003); and with lower levels of STIs (Crosby *et al*., 2002). However, most of these studies explored parental monitoring and parental support without differentiation between the mother and father. Moreover, parental monitoring and support were mostly explored as single variables. Therefore, information about which of the parents is more/less likely to influence a child's sexual behavior is rather unclear.

### 2.5.2.3. Peers and others

According to Wierson and Forehand (1993) adolescents are in the process of developing their own identities and establishing complex social network shifts from the family to the social environments. This broad environmental scope targeting variables such as peers, neighborhoods, and school conditions. However, these factors received the least empirical attention in the literature on the sexual behavior of adolescents (Kotchick *et al.*, 2001). During adolescence, peers become a crucial source of modeling, reinforcement, and support concerning their own behavior, value, and beliefs system (Forehand & Wierson, 1993). Therefore, peers' behaviors and attitudes are related to adolescent sexual risk behavior – especially those adolescents whose peers are sexually active are more likely to be sexually active themselves (Miller *et al*., 2000). Moreover, signs of SRB among adolescents' peer groups (e.g. pregnancy, inconsistent condom use) were related to increased adolescent sexual risk (Gillmore *et al.*, 1997). In a more subjectively way, adolescents' perception of their peers' behaviors was related to sexual risktaking. Brown (1992) found that consistent condom use was associated with the perception of consistent condom use among friends and peers. It was repeatedly found that involvement with

deviant peer groups (e.g. using alcohol and drug use or being delinquent) was related to the participation in high risk sexual practices (Metzler *et al.,* 1994; Miller *et al*., 2000). In addition, a study by Scaramella (1998) showed that deviant peer affiliations comprised a strong pathway to sexual risk in the overall model of adolescent sexual risk behavior. Peers during adolescence are the preferential sources of information about sexuality. Therefore, their behavior may serve as reference norm for others with high potential of impact (Potard *et al.,* 2008). The perception of their peers about sexual behaviors is an important normative predictor of intention (Hollander, 2001) about the beginning of sexual relations and engaging in sexuality (Prinstein *et al.,* 2003; Sieving *et al.,* 2006), including oral sex (Halpern *et al.,* 1996). Peers can also have a positive influence by enticing youths to apply contraceptive measures and to use condoms for protection against STIs (Lagana, 1999; Bobrova *et al.,* 2005).

## 2.6 Conceptual Frame Work of the Study




Based on review of related literatures, the following frame work is developed to organize our knowledge systematically and to see how concepts are interrelated to one another. As observed in figure 1, Based on the review of the literature and objectives of the study the researcher adopted the conceptual Frame work. Socio demographic, Knowledge factors, Psycho-social factors and living environment related variables have been included in the conceptual framework as an explanatory variable. Risky Sexual behavior was taken as dependent variables. This conceptual framework shows clear connection of the variables. It indicates the direct and indirect relationship between the variables. The framework was immense useful in this juncture, because this framework itself included most of the independent and dependent variables (see fig. 1).

# CHAPTER THREE: RESEARCH DESIGN AND METHODS

This chapter deals with the research design, rresearch method, source of data, sample and sampling techniques, instrument of data collection, procedure of data collection, method of data analysis, validity and reliability and ethical consideration

### 3.1 The Research Design

As argued by Kumar (1999) descriptive research design is used to describe the nature of the existing conditions. Seyom and Ayalew (1995) also agreed, "Descriptive survey method of research is more appropriate to gather several kinds of data on a broad size to achieve the objectives of the study". This was because it enabled the researcher to collect and describe a large variety of data related to the general picture of factors for risky sexual behavior and practice among high school and college students in Shambu town.

## 3.2 Research Method

The research method is a style of conducting a research work which is determined by the nature of the problem (Singh, 2006). Thus, in this study, the researchers use both quantitative and qualitative approach as the leading method which emphasized to examine factors for risky sexual behavior and practice among high school and college students in Shambu town that was better to understand by collecting both quantitative and qualitative data.

### 3.2.1 Sources of Data

#### 3.2.1.1 Primary sources of data

In this research the learners, administrators, administrative bodies of Fincha Valley Collage, Shambu College of teachers' education, Shambu TVET, Shambu secondary School, Shambu town educational and health office, Shambu hospital and health center were the concerned data sources from which relevant samples were selected for data collection.

#### 3.2.1.2 Secondary Data Sources

The secondary sources of data are written documents of colleges and schools, files, minutes of relevant meetings, decision passed with the school and colleges plan and reports

### 3.2.2 The target population and sampling technique

#### 3.2.2.1 The Target Population;

The reference population is both private and governmental secondary schools and college adolescents and youths (young adults) in Shambu Town. The study populations are sample portion of young adults aged 10-24 years both female and male which are attending regular day school at the time of the study.

Inclusion criteria: will include those aged 10-24 years, both sexes, those who are school attending-regular day school.

Exclusion criteria: Those who are not attending regular day school at the time of the study, junior high school students, night school students, the other shift and university students.

#### 3.2.2.2 Sample Size Determination

The number or the size of the population was determined at the arrival of the researcher in the study areas and accordingly the sample which used to represent the population was also be determined based on the number of the student's enrolment of 2018/2019 academic year. Although the actual size of the students is not known yet, the sample size was necessarily selected to represent all youths those aged 10-24 years, both sexes, those who are school attending-regular day school. Priority was given to visit the study area; this was helpful for the researcher to get background information about the number of subjects. The sample size for quantitative study was determined using the following assumptions: The standard normal deviate-1.96 which corresponds to level of confidence taken to be 95%, and 5% margining of error. The proportion in the target population to have a characteristics (P) assumed to be 50.0% as there was no existing previous data which can serve as base line in this specific study population, as to obtain maximum sample size. Based on the above assumptions the actual sample size for the study was computed employing the formula for single population proportion.

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

Where, n = sample size

Z a = Critical value=1.96

P= assumed prevalence of high risk sexual behavior (.5)

d= precision (marginal error) =0.05

$n = \frac{(1.96)^2(0.5*0.5)^2}{(0.05)^2}$ =384

Remember: 95% -Z-score =1.96

Thus, by adding 10% for possible non-response, a total sample size of 422 will be obtained. They will be from high schools and the colleges available in the town. The researcher will use stratified random sampling approach to get the expected number of the subjects.

Therefore, the school status was considered as a stratification character and the division was become one shift of Governmental High school, Private High School, any two departments of Governmental College and Private College.

**Table 3.1 Sample of study participants in Shambu Town, in 2019.**

| Schools | Male | | Female | | Totals samples | | |
|---|---|---|---|---|---|---|---|
| | Total | Sample | Total | Sample | male | Female | totals |
| Abishe Gerba Secondary School | 163 | 30 | 191 | 30 | 30 | 30 | 60 |
| Shambu Secondary School | 763 | 31 | 664 | 30 | 31 | 30 | 61 |
| Fincha Valley Secondary School | 82 | 30 | 138 | 30 | 30 | 30 | 60 |
| Total secondary schools | 1008 | 91 | 993 | 90 | 91 | 90 | 181 |
| Shambu Teachers Training Collage | 845 | 31 | 811 | 30 | 31 | 30 | 61 |
| Fincha Valley Collage | 367 | 30 | 1108 | 30 | 30 | 30 | 60 |
| Dandi Boru Collage | 347 | 30 | 366 | 30 | 30 | 30 | 60 |
| Shambu Polly Technique Collage | 543 | 30 | 320 | 30 | 30 | 30 | 60 |
| Totals colleges | 2102 | 124 | 2605 | 120 | 121 | 120 | 241 |

## 3.3 Data collection instrument and procedure

To conduct this research, primary sources of information was collected through the following instruments:

**For quantitative data**

### 3.3.1 Questionnaires

Self-Administered Survey Questionnaire was used to collect quantitative data. Because of its inexpensiveness in time, human and financial resources as well as its anonymity and due to the subject matter's sensitive nature.

It is desirable that participants complete the questionnaire by themselves. Hence, pre-tested self-administered structured questionnaire was used for data collection which is initially adapted from similar survey reviews that have been carried out with in the country and in other countries with similar situation. A structured and close ended questionnaire was used to collect the quantitative data of the study. The English language questionnaire was used to collect data. But to simplify the activity the English language questionnaires was translated to Amharic language. Selected sample students were seated in a classroom one seat apart from each other and could respond to the questionnaire without interference from other students and the writing materials (pencils) were provided for them, which makes the data collection ease & motivates the participants.

**For qualitative data**

### 3.3.2. Interview

The data was collected through open ended question, focus group discussion with in-depth interview. This was applied to assess the overall situation of the past and the current Situations of young adult's sexual practices and the services had been given such as skill training, information, knowledge provided etc.

### 3.3 .3 Focus group discussion

The focus group discussion is another qualitative data gathering tools which can be implemented to unmask the participants' deep understandings and unconscious interests in the relation of the problems central question of this research.

In other ways this instrument was used to generate the suggestive congruent solution for the central issues of the studies. In this data gathering the expectation of the current researcher was to involve the decision makers and crucial role players based on the availabilities of the participants. Through this, relevant information gathered from the young adults themselves. Interview was held in Amharic.

## 3.4. Procedures of Data Collection

To ensure the data collection, the necessary relationship created with the concerned bodies in the high schools and colleges. This is done by providing an official letter to them and informing the objective of the study. Then when to get appropriate respondents and relevant documents for data collection was set. Unfortunately, contact made and orientation is given to selected respondents on how to fill the questionnaires, conduct an interview. After giving the orientation, the set of questionnaires distributed to fill and collected back by the researcher and to gathering with conducted documents analysis

### 3.5 Data analysis methods

In methods of data analysis both qualitative and quantitative approach were employed. The quantitative data were collected using the researcher designed socio-demographic and psychosexual questionnaires. The questionnaires were then checked for completeness and arranged according to codes then entered for computer analysis. Data were presented in descriptive statistics that include frequencies, proportions. The data of interview, observation and focus group discussion was analyzed qualitatively based on their relevance's. Finally, both quantitative and qualitative data were combined to feed the discussion and conclusion of the research; the quantitative data was analyzed using SPSS version 20 production software statistical packages. P-value $<0.05$ was used to declare statistically significant variables.

## 3.6 Validity and Reliability of the Instruments

Pilot Test: - To check the appropriateness of the items, a pilot test among high school and college students in Shambu town which were not included in the sample study.

A pilot study conducted as a preliminary step to avoid errors. Its main objective was to detect possible weaknesses related to ambiguity due to poor morphological formulation and enables the researcher to make the necessary corrections and adjustments. To this end, the draft questionnaire was administering to 10 randomly selected experts. After the questionnaires filled and returned, the reliability &validity of items measured by using Cronbach's alpha method with the help of SPSS version 26. Accordingly using Cronbach alpha, reliability of the questionnaire design filled by students.

It indicates that, the extent to which the items in a questionnaire were related to each other. Its normal range is between 0-1 and the higher value reflects more internal consistency. Based on this, Cronbach's coefficient alpha was calculated for each field of the questionnaire and the entire questionnaire. As a result, the reliability coefficient of the school teachers 'instrument found to be 0.735 (73.5%), implying that it was taken to be reliable. As stated by George and Mallery (as cited in Jemal, 2013), the Cronbach 's alpha result >0.9 is excellent, 0.9 is very good, 0.8 good 0.7-0.8 is acceptable, 0.5-0.6 is questionable, <0.5 is poor. Moreover, Drost (2004), if the result of Cronbach 's coefficient alpha is 0.7(70%) and above it is satisfactory, indicating questions in each construct are measuring a similar concept

To be sure of the validity sensor colleagues are invited to provide their comments. The participants of the pilot test should also first informed about the objectives and how to filled, evaluated, and give feedback on the relevance of the contents, item length, clarity of items, and layout of the questionnaires. Moreover, to verify the content validity of the instrument, the questionnaire with enough items addressing all objectives of the study were administered to among high school and college students in Shambu town.

## 3.7 Ethical consideration

The process of this research from the beginning to the final report writing was concerned first with the issue of plagiarism by reviewing the literature which can be easily triangulated, and restricted to acknowledge the authors of previous studies and theories. The result, discussion,

conclusion, and recommendation will be only organized and reported based on the gathered data. Secondly it was concerned with the rights of the participants in relation to that to get information from them depends on their consent in every data collecting ways. Under this the data collection procedure will be employed by caring for social, moral, and cultural values of the participants and surrounding members. In the process of gathering data from the other institutions the organizational culture will be respected, and generally it was free from any possibilities of forcing others to get the required data. Since the design of the research is not experimental the chance to deceive others will be more advantageous than costing the participants.

# CHAPTER FOUR:ANALYSIS, PRESENTATION, AND INTERPRETATION OF DATA

## 4.1. Introduction

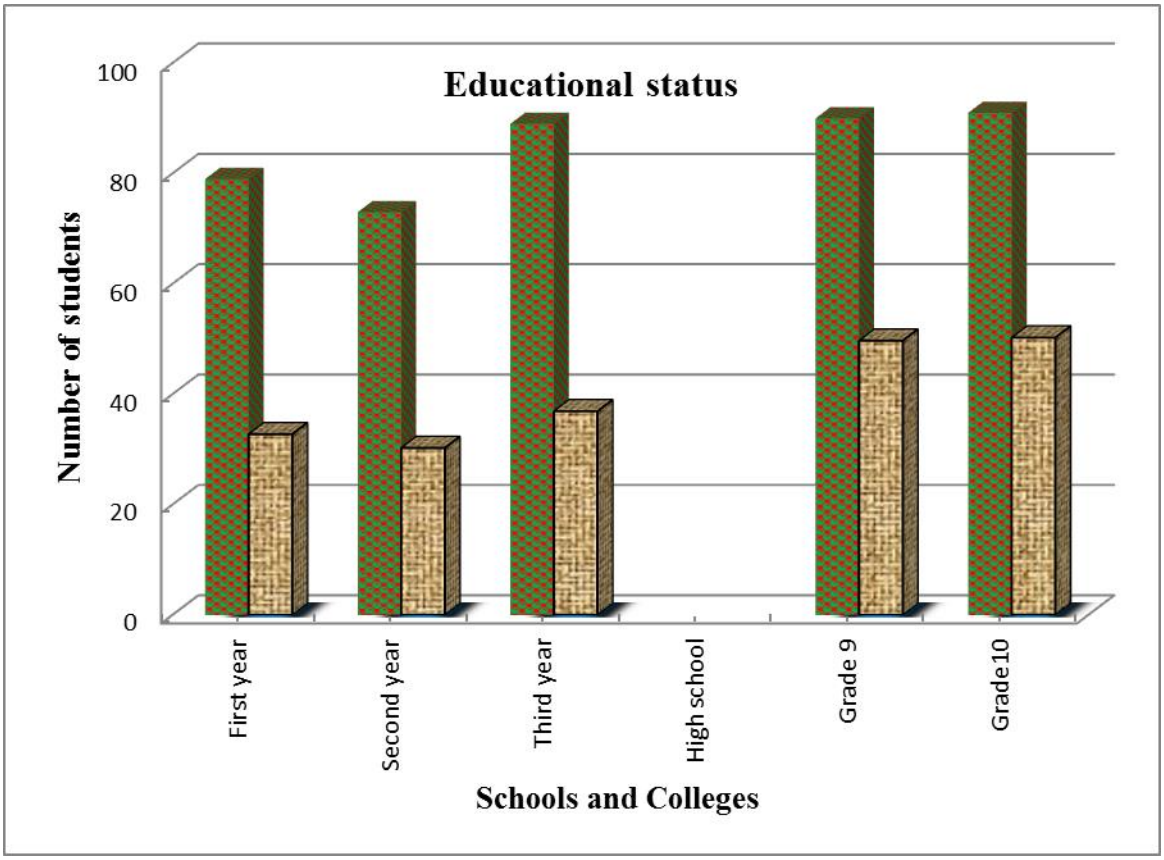
From the total of 6708 students that were found at three secondary high schools and four colleges, 422 them were identified for the study, all of them were participated in the study, thus the yielding the response rate of 100%. The researcher has taken 181(43%) students from three high schools while 241(57%) of them were interviewed from four colleges that are found in the study area. 50.2% of the study participants were males while 49.8% of them were females (Table.1).

## 4.2 Socio-demographic characteristics of the respondent

Table 4.1 Socio-demographic characteristics of the respondents (n=422) in Horo Guduru High schools and College students, 2019**.**

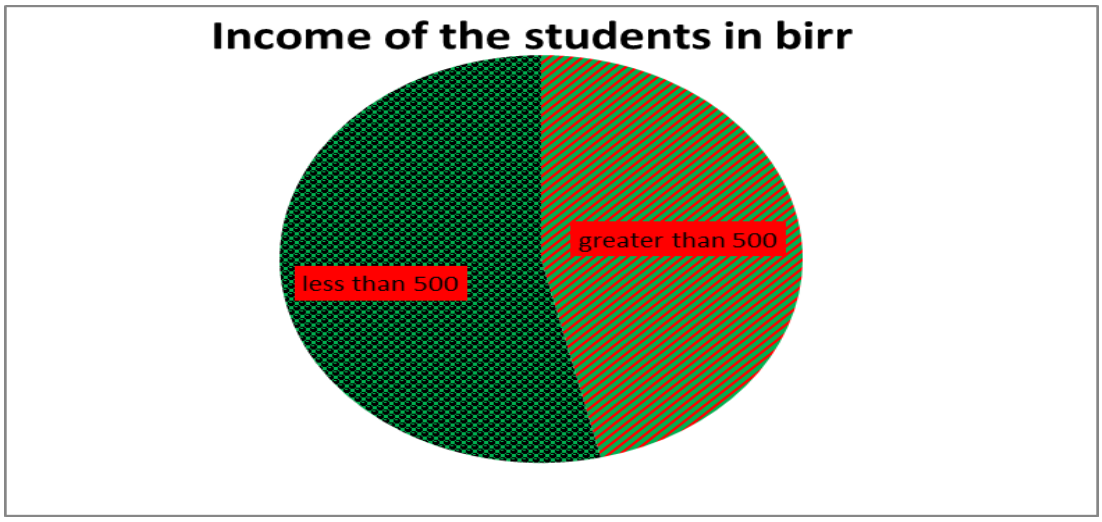
| Variables | | frequency | Percentage |
|---|---|---|---|
| Sex | Male | 212 | 50.2 |
| | Female | 210 | 49.8 |
| | Total | 422 | 263.8 |
| Age | 14-19 | 251 | 59.5 |
| | 20-25 | 114 | 27.0 |
| | 26-30 | 57 | 13.5 |
| | Total | 422 | 100 |
| Religion | Orthodox | 137 | 32.4 |
| | Muslim | 46 | 10.8 |
| | Protestant | 205 | 48.6 |
| | Others | 34 | 8.1 |
| | Total | 422 | 100.0 |

**Figure.1. Educational status of (n=422) ShambuTown schools and College students, 2019.**




According to figure 1, a total of 422 study subjects were participated in this study with 100% response rate and of which 212 (50.2%) were males and 210 (49.8%) were females. The mean age of the respondents was 17.5. From the total population of 4228 students, 2514 (59.5%) of them were between the age of 14-19 years. Most of the respondents, 205 (48.6%) were protestants. Figure1 showed the educational status of the students at the study area, accordingly 89(36.9%) and 79(32.8%) of them were college students of third year and first year respectively while 91(50.3%) of them were grade 10 students.

**Figure 2 Income of the students (n=422) Horo Guduru High schools and College students, 2019.**




Based on the figure 2, the pocket money of the students was interviewed in that 227(53.8) of them were getting less than five hundred but 195(46.2%) of them were getting greater than five hundred birr per month.

## 4.3 Risk factors

**Table 4.2 Exposing factors of students to sexual risky behaviors of Horo Guduru High schools and College students, 2019.**

| Parameters | | Frequency | Percent |
|---|---|---|---|
| With whom You are living | With both parents | 101 | 23.9 |
| | With relatives | 62 | 14.7 |
| | Alone | 259 | 61.4 |
| | Total | 422 | 100 |
| Addiction involved in | Chewing chat | 46 | 10.9 |
| | drinking alcohol | 36 | 8.5 |
| | shisha | 29 | 6.9 |
| | have no addiction | 173 | 41.0 |
| | smoking cigarette | 104 | 24.6 |
| | Using all | 34 | 8.1 |
| | Total | 422 | 100.0 |
| Do you always watch a film which shows sexual practice? | Yes | 228 | 54.0 |
| | No | 194 | 46.0 |

## .4.4 Knowledge on STDs and HIV

### 4.4.1 Possibility and means of avoid getting STI and HIV/AIDS

**Figure 3 what Possibility and means of avoid getting of HIV /ADIS and STI**

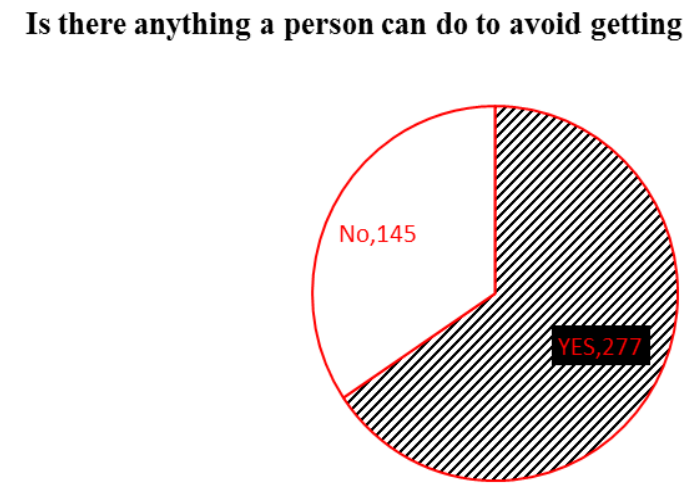
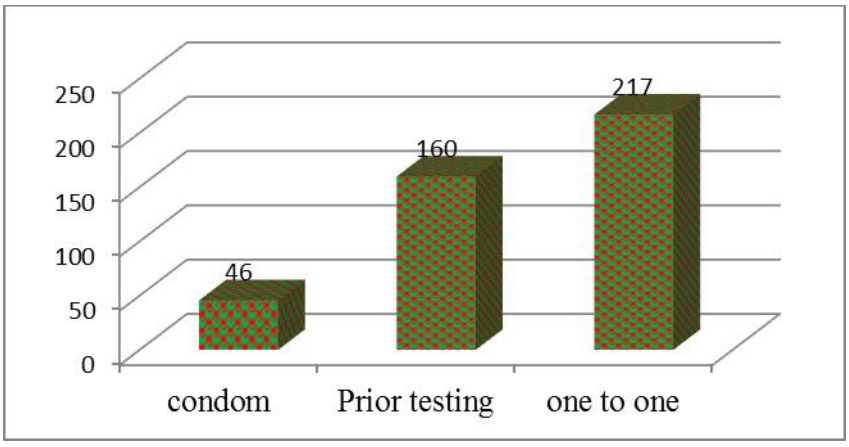



**Figure .4 what Possibility and means to avoid getting of HIV /ADIS and STI**




Even though respondents did not have tangible clinical diagnosis-based evidence for them responses, a view based on recorded educational histories, overall knowledge about AIDS prevention was high among the respondents. According to Figure 3,277(65.6%) and 145(34.4%) of the study participants were know how could they avoid getting of STI and HIV/AIDS respectively. Thus, majority of the respondents (65.6 %%) were aware of HIV or the disease AIDS. Besides their knowledge of the case 217(51.4%) and 160(37.9%) of them knew the

means to avoid of getting the case by one to one opposite sex friends and prior test of the case respectively while 46(10.9%) of them were said using condom one can avoid getting of the case (Figure 4)

**Table 4.4 Curability, First Time sex and means of transmission of HIV /ADIS**

| Variables | | Frequency | Percent |
|---|---|---|---|
| Is AIDS curable? | Yes | 80 | 19.0 |
| | NO | 205 | 48.6 |
| | I do not know | 137 | 32.5 |
| A person can get HIV the first time he or she has sex. | Yes | 182 | 43.1 |
| | No | 125 | 29.6 |
| | I do not know | 114 | 27.0 |
| A person who looks healthy but has the AIDS virus can pass the virus to other People. | Yes | 399 | 94.5 |
| | No | 11 | 2.6 |
| | I do not know | 11 | 2.6 |
| Please mention all the ways you believe a person can get AIDS: | Unsafe sexual Intercourse | 312 | |
| | Sharing needle and Syringes | 156 | |
| | Blood transfusion | 89 | |
| | During pregnancy and childbirth | 70 | |
| | Mosquito and another insect bite | 25 | |
| | Through breast milk | 26 | |
| | Hand shaking | 15 | |

According to table 4.4, 205(48.6%), 137(32.5%) and 80(19%) were known as AIDS is not curable, have no idea and know as it is curable respectively.182 (43.1%) knew that a person can get HIV at the first time sex practice while 125(29.6%) and 114(27%) were not know as a person could not be get HIV at first sex practice and have no idea about the issue respectively. Majority of the study participants knew that a person who looks healthy but has the AIDS virus can pass the virus to other People. The main modes of transmission of HIV known by the students were unsafe sexual intercourse 312 and Contaminated injection needles 156). While blood transfusion 89, during pregnancy and child birth70, through breast milk 26 and mosquito bite 25 were the major misconceptions reported by the students.

**Table 4.5 Other sexual transmitted diseases**

| Variables | | Frequency | Percent |
|---|---|---|---|
| If you heard about STDs, which diseases do you know about? | Gonorrhea | 319 | 75.7 |
| | Syphilis | 57 | 13.5 |
| | Chancroid | 11 | 2.7 |
| | HIV/AIDS | 34 | 8.1 |
| Can condom protect us from Gonorrhea and Syphilis? | Yes | 319 | 75.7 |
| | No | 34 | 8.1 |
| | I do not know | 68 | 16.2 |
| If a person once had STD (like syphilis) he/she cannot catch it again | Yes | 187 | 44.4 |
| | No | 166 | 39.4 |
| | I do not know | 68 | 16.2 |
| From which person or from where do you get truer information about HIV and STI? | Parents | 250 | 13.6 |
| | Sexual partner | 125 | 6.84 |
| | Other family members | 205 | 11.2 |
| | Peers | 365 | 19.9 |
| | Health institution | 263 | 14.4 |
| | Religious leader | 390 | 21.35 |
| | Media | 228 | 12.4 |
| Is it possible for a girl to become pregnant the first time she makes sexual intercourse | Yes | 228 | 54.1 |
| | No | 57 | 13.5 |
| | I do not know | 137 | 32.4 |

According to Table 4.5,319(75.7%) and 57(13.5%) of them did heard and knew about sexually transmitted diseases specially Gonorrhea and Syphilis respectively even though few of them also heard and knew about HIV and Chancroid diseases as they also considered as sexually transmitted diseases. Though 68(16.2%) of the respondents have no idea as a condom protect a

person from gonorrhea and syphilis, 319(75.7%) knew the positive impact of condom to protect from the case. Majority of the students answered the source of their true information were Religious leader, peers, parents, media, and other family members respectively according to decreasing order. Among the respondents, 137(32.4%) of them have no idea as a girl going to be pregnant on the first day of sex while 228(54.1%) of them confirmed as they knew as pregnancy would be happened during first day sex practice for a girl**.**

### 4.5 Sexual practice and behavior

Table 4.6 (A) Sexual Practice of the study participants

| Variables | | Frequency | Percent |
|---|---|---|---|
| Have you ever had sexual intercourse? | Yes | 262 | 62.2 |
| | No | 160 | 37.9 |
| | Total | 422 | 100 |
| At what age did you first have sexual intercourse? | 14-19 | 240 | 56.8 |
| | 20-25 | 114 | 27.1 |
| | 26-30 | 68 | 16.1 |
| | Total | 422 | 100 |
| With whom did you make your first sexual intercourse? | With my steady friend | 99 | 37.8 |
| | with my casual friend | 142 | 54.1 |
| | with a stranger | 7 | 2.7 |
| | with commercial sex workers | 14 | 5.4 |
| | Total | 262 | 100.0 |
| Why did you decide to have Sexual intercourse at the first time? | Fell in love. | 105 | 40.1 |
| | Had desire. | 82 | 31.3 |
| | To get money and other gifts | 21 | 8.0 |
| | Peer pressure. | 42 | 16.0 |
| | Was drunk or chewed chat or used drug | 12 | 4.6 |
| | Total | 262 | 100.0 |

As indicated on the Table 4.6, 262(62.2%) of the students had sexual intercourse before the researcher collected data. Of all who had practice sexual intercourse, more than twice of the study groups were 14-19 age groups which was 240(56.8%) while 114(27.1%) were age groups 20-25 years.142(54.1%) ,99(37.8%) and 14(5.4%) were practiced sex at first time with their causal friends, constant friends, and commercial workers respectively. The reasons why the study participants started sex were discussed.

Accordingly,105(40.1%),82(31.3%) and 42(16%) were fell in love, have had desire for sexual intercourse and due to peer pressure respectively though all risky factors were played their role on the reasons behind performing sex.

**Table 4.6 (B) Sexual Practice of the study participants**

| Variables | | Frequency | percent |
|---|---|---|---|
| How older or younger was the person with whom you had your first Sexual intercourse? | 14-19 | 77 | 29.4 |
| | 20-30 | 102 | 38.9 |
| | 31-40 | 69 | 26.3 |
| | greater than 40 | 50 | 19.1 |
| | Total | 298 | 113.7 |
| What type of sexual practice do you exercise? | Heterosexual | 210 | 80.2 |
| | Homosexual | 1 | 0.4 |
| | No response | 51 | 19.5 |
| | Total | 262 | 100.0 |
| With how many partners have you had sexual intercourse with in the last school year? | Two | 82 | 31.3 |
| | Three | 32 | 12.2 |
| | One | 100 | 38.2 |
| | More than three | 18 | 6.9 |
| | No response | 30 | 11.5 |
| | Total | 262 | 100.0 |
| Did you use condoms whenever you make sexual intercourse? | Yes always | 108 | 41.2 |
| | Yes some times | 98 | 37.4 |
| | No at all | 56 | 21.4 |
| | Total | 262 | 100.0 |
| Do you believe you have done anything that may put you at risk of getting the HIV virus? | Yes | 115 | 43.9 |
| | No | 55 | 21.0 |
| | I do not know | 92 | 35.1 |
| | Total | 262 | 100.0 |
| How many times have you faced STD in the last school years? | One times | 46 | 17.6 |
| | Two times | 16 | 6.1 |
| | Three times | 0 | 0.0 |
| | Not faced | 200 | 76.3 |
| | Total | 262 | 100.0 |

Based on the above table 4.6(B) the data collected majority of the students had practiced sex with an age interval of 20-30 which were in number 102, though 31-40 and greater than 40 years old were participated in the study in performing sex with students. Among students who had done sex,80.2% of them were opposite sexual intercourse while 19.5% of them were not give response to the questions. At student level 0.4% students practiced homosexual intercourse means may be though that needs great commitment to cease it.

100(38.2%) of the study participants were practiced sex with one friend while 31.3%,12.2% and 11.5% of them were had done sex with two, three partners and has not given any response respectively.108(41.2%),98(37.4%) and 56(21.4%) were using condoms always, sometimes, and not using condom at all respectively.115(43.9%), 55(21%) and 92(35.1%) were asked whether what they did put them in risky or not accordingly accepted did not know and assumed as it was not put in the risk respectively. Because of not sexual safe protection ,46(17.6%) and 16(6.1%) of them faced from STDs one times and two times per years respectively while 200(76.3%) were not faced from STDS.

**4.6 Attitudes or believes as predictors of sexual behaviors**

Table 4.1 Attitudes or believes as predictors of sexual behaviors.

| S.No | Attitudes | | S/ Agree | Agree | Disagree |
|---|---|---|---|---|---|
| 1 | It is not necessary to discuss about sexual affairs with sexual partner and parents. | Frequency | 80 | 138 | 204 |
| | | Percent | 19.0 | 32.7 | 48.3 |
| 2 | Peers help to bargain the needed sexual partner | Frequency | 125 | 182 | 114 |
| | | Percent | 29.6 | 43.1 | 27.3 |
| 3 | Drinking alcohol, using drugs, and chewing chat motivate sex and avoid terror not to be disturbed by the consequence of risky sexual practice. | Frequency | 125 | 171 | 125 |
| | | Percent | 29.6 | 40.5 | 29.6 |
| 4 | Making sex with different persons before marriage gives enjoyment and necessary for being loyal during marriage | Frequency | 23 | 160 | 240 |
| | | Percent | 5.5 | 37.9 | 56.9 |
| 5 | Since there is love and internal force to make sex, abstain does not have place. | Frequency | 160 | 46 | 217 |
| | | Percent | 37.9 | 10.9 | 51.4 |
| 6 | Condom minimize sexual pleasure; | Frequency | 160 | 114 | 148 |
| | | Percent | 37.9 | 27.0 | 35.1 |
| 7 | In my age, not need of being faithful to one person. | Frequency | 34 | 65 | 323 |
| | | Percent | 8.1 | 15.4 | 76.5 |
| 8 | If money is given I make sex with anybody. | Frequency | 30 | 92 | 300 |
| | | Percent | 7.1 | 21.8 | 71.1 |
| 9 | Better to live without blood testing. | Frequency | 102 | 120 | 200 |
| | | Percent | 24.2 | 28.4 | 47.4 |

The above table 4.7 indicated that attitudes of the students were analyzed based on the data collected from the study participants. As issues of sexual affairs discussion with sexual partners and parents, in that 138(32.7%) agreed that discussion is not necessary about sexual affairs with sexual partners and parents while 204(48.3%) disagrees that it is necessary to discuss about the issue with parents and sexual partners. The help of peers in bargaining of the need of sexual partners were interviewed then 72.7% of the students have positive attitudes on the issue while 27.3% of the disagreed with idea. According to this study 296(70.1%) of the study participants were strongly agreed and agreed while 29.9% of them disagreed on the using of sexual risk factors that both act as motivators of sexual intercourse and risky avoiders while practicing unsafe sex. Status of an individual student in performing sex with different persons pre-marriage was discussed in that 160(37.9%) agreed with the statements in that it gives enjoyment and even loyal to couples after marriage while 56.9% of the study participants disagreed that making sex with different persons before marriage could not leads to enjoyment and loyal after marriage.

206(48.8%) of the students agreed that since Love and internal force have great position in performing sex so that abstaining from did not play a role while 217(51.2%) of the study participants have attitudes of love and internal force have positive trends with abstain from sex (Table 4.7).

### 4.7. Qualitative Analysis

#### 4.7.1 The result of the Interviews

Measures to be taken regarding improvement of risk sexual behavior in high schools and college students

Discussant three recommended; we should emphasis to resolve different risk factors like pornography films, culturally deviant theaters, implementation of rules and regulation on those groups tried to make coercive sex. Discussant said “if I stretched my hands and one clench and the other not, children egger and tried to see the clenched one. Therefore, the best remedy for risk sexual behavior is open discussion among family members about issues related to sexual and reproductive health.” Discussant one added that risk sexual behavior should be considered location and type of businesses when licensed especially around the school surrounding. Most

discussants suggested school-based life skill & peer education measures should be done by other governmental and nongovernmental organizations working on sexual behaviors, HIV prevention and control responses. Key informant five stated that primarily sexual and reproductive health services should be accessible in the schools. According to him schools were the most important places to avail such services to regular school students. He also added that nongovernmental organizations and other stake holders who give the same services may help to alleviate the risky sexuality of regular school students. Interviewee six explained that primarily community awareness is very important to protect risk sexuality of regular school students. The community and their family should drive those pupils to get sexual and reproductive health services in the nearby health institutions. Interviewee seven powerfully argued that for various social-economic factors sexually and reproductive services were not accessible and comfortable to regular school students. Therefore, in school counselors need to be arranged for regular shift students at their favor.

# CHAPTER FIVE: DISCUSSIONS

Adolescence is the stage of life during which individuals reach sexual maturity. It is the period of transition from puberty to maturity. At the same time, adolescents are the greatest hope for turning the tide against sexually transmitted infections, AIDS, and early pregnancy because adolescence is a period of physical, social and emotional transition and development. This study attempted to assess the risky sexual behavior and factors that related to risky sexual behavior among high school and college students in Shambu Town, Oromiya Regional State.

Early sexual activity may lead to later adulthood risky behavior. When adolescents are taking risks whether it is with substance abuse and early sexual activity, they "lose" many things which can include: friends, family, education, dreams, goals, and hope. What tends to happen is that parents think back to times when they may have felt they lost something and this becomes a challenge for them. Parents may possibly refuse to refuse to talk about these risky sexual behaviors because "they will return to these moments of deprivation and loss, and in order to repair what went wrong, they need to attempt to re-find what was lost" (Sex Education, 58). Early sexual activity is also contributing to more serious problems including other risky behaviors and the onset of disease: STD's, HIV, and AIDS amongst teenagers. According to a division of CDC, approximately 18% of all new HIV diagnoses are among young people aged 13-24 and teens and young adults have the highest rates of sexually transmitted diseases (STDs) of any age group. Internet surfing, alcohol consumption, sexting, experimenting with drugs and other risky behavior all may contribute to early sexual activity (CDC, 2009).

According to this study findings, majority of the study participants were under the age of late adolescent period which means 251 (59.5%) of them were between the age of 14-19 years. This age classification also in agreement with the period of adolescent age done by ( Hofman & Grey,1999),since adolescent is the time of transition from childhood to adulthood, there will be change in physical, psychological and social changes. Another researchers in supporting the change of such transition said the physical maturation during adolescence is subject to these changes,( Berhane, 2000).

Though the educational status of the parents was not interviewed, educational status of the parents has influence on the adolescent age of their students. As this finding done on the college and high school students who were on the period of adolescent age, majority of them were in the risk of the exposing factors. One study done by Desalegn agreed with statement in that Youths of literate parents are less likely to engage in early sexual risk behavior, with early meaning before marriage (Desalegn, 2006).

According to this study, 259(61.4%) were living alone which leads the students to the sex practice, this agrees with the study done by Klavs (2005) the main factor associated with early sexual intercourse was not living with both parents up to the age of 15 and parental divorce also plays such role according to Devine (1993) finding that parental divorce during early adolescence was a significant predictor of sexual risk behavior for females in later adolescence**.** In another way, 249(59%) were addicted to different addiction causing substances like smoking cigarette, chewing chat, drinking alcohol and using shisha respectively in decreasing orders. These also have high contribution on the leading to sexual intercourse at the age of teens which agreed with the study done by (Eisen, 2000**)** for many teens and young adults alcohol and drug use are closely linked to sexual decision-making and risk taking. Nearly nine out of ten say that their peers use alcohol or drugs before having sex. On the other hand, 228(54%) of them were watching sexual practicing film. All these factors are the initiating factors that lead not only students but also every person for sex practice. And another research done by Demie and his colleagues also confirmed that Globalization, peer pressure, substance abuse, financial constraint and lack of parental control were among the main reasons for sexual practices (Demie, *et al*,2017).In addition the research done at Aksum University confirmed that(Awoke K et al,2017) nearly half about 46.7% of the participants uses alcohol which is comparable with a study done in Haramaya University in which 41.7% uses alcohol, but the prevalence of chat chewing is lower than by half (14.3%) from the study conducted in Haramaya University in which 30.3% of study participants uses chat (**Deres, et al,2014)**. This may be due to the cultural background of the study area and the accessibility of the substance respectively. Since chat is accessible in Harramaya but not in Aksum university.

Even though respondents did not have tangible clinical diagnosis-based evidence for their responses, a view based on recorded educational histories, overall knowledge about AIDS prevention was high among the respondents. Accordingly 277(65.6%) and 145(34.4%) of the study participants were know how could they avoid getting of STI and HIV/AIDS respectively. Thus majority of the respondents (65.6 %%) were aware of HIV or the disease AIDS. In Ethiopia, many literatures showed that school youths engaged in the sexual activities of which the majority was unsafe sexual intercourse (Gurmesa et al., 2012). This study also found that 23.5% of the students were involved in risky sexual behaviors prior to the survey. This study finding is higher than the previous study done in Addis Ababa among school youths and much higher than the study done among in-school adolescents at national level of Ethiopia (Amsale & Yemane, 2012). The higher result might be due to knowledge gap related to sexual issues including condom use and reproductive health problems between the subject of the study area and previous studies. The other reason might be widespread notion that having a sexual partner seen is a sign of modernizing. Besides their knowledge of the case 217(51.4%) and 160(37.9%) of them knew the means to avoid of getting the case by one to one opposite sex friends and prior test of the case respectively while 46(10.9%) of them were said using condom one can avoid getting of the case. Encouraging safe sexual behavior is one of the strategies in the prevention of HIV and other sexually trans-mitted infections However, prevalence of condom uses especially among youths is still very low despite the efforts made so far to improve the utilization ( Lemessa et al., 2012).

According to this finding, 205(48.6%), 137(32.5%) and 80(19%) were known as AIDS is not curable. 182 (43.1%) knew that a person can get HIV at the first time sex practice while 125(29.6%) and 114(27%) were not know as a person could not be get HIV at first sex practice and have no idea about the issue respectively. Majority of the study participants knew that a person who looks healthy but has the AIDS virus can pass the virus to other People. The main modes of transmission of HIV known by the students were unsafe sexual intercourse 312 and Contaminated injection needles 156). While blood transfusion 89, during pregnancy and child birth70, through breast milk 26 and mosquito bite 25 were the major misconceptions reported by the students. This finding agreed with the study done at different times with diffent areas about non-curability from HIV/AIDS, the highest worldwide priority has been

given to the control of the epidemic. The mechanisms of transmission for HIV call attention to sexual, reproductive, and addictive behaviors, comparatively sensitive and problematic areas for intervention. These are domains often viewed as more appropriate for-private decision making than for imposition of public policies. Also, one must obtain and take into account various perspectives of the epidemic from inside the communities at risk. It is now very clear that HIV infection is spread mainly through identifiable and voluntary behaviors of individuals, Louse A.,Rachel Cullen, and Symons WamlaKhalokho. (2000), and also means of protecting from the case similar with the study done at among college students in Addis Ababa (n=1214), results indicated that most of the students (74.4%) considered being faithful to a single lover as the best preventive measure against HIV/AIDS. Similar to the findings of the study on freshman's attitudes and knowledge of AIDS in Gondar, the number of students who reported using condoms as a method of protection against infection with HIV was very low indicating lack of regional difference in the behavior of college students in their response to HIV/AIDS. This again is similar to the report of surveys on heterosexually active college: students from other parts of the world, MOH, (2002). 262(62.2%) of the students had sexual intercourse before the researcher collected data. Of all who had practice sexual intercourse ,more than twice of the study groups were 14-19 age groups which was 240(56.8%) while 114(27.1%) were age groups 20-25 years.142(54.1%) ,99(37.8%) and 14(5.4%) were practiced sex at first time with their causal friends, constant friends and commercial workers respectively. The reasons why the study participants started sex were discussed.Accordingly,105(40.1%),82(31.3%) and 42(16%) were fell in love, have had desire for sexual intercourse and due to peer pressure respectively though all risky factors were played their role on the reasons behind performing sex. Based on the data collected majority of the students had practiced sex with an age interval of 20-30 which were in number 102, though 31-40 and greater than 40 years old were participated in the study in performing sex with students. Among students who had done sex, 80.2% of them were opposite sexual intercourse while 19.5% of them were not giving response to the questions. At student level 0.4% students practiced homosexual intercourse means may be though that needs great commitment to cease it.100(38.2%) of the study participants were practiced sex with one friend while 31.3%,12.2%

and 11.5% of them were had done sex with two ,three partners and has not given any response respectively. 108(41.2%),98(37.4%) and 56(21.4%) were using condoms always, sometimes and not using condom at all respectively. 115(43.9%), 55(21%) and 92(35.1%) were asked whether what they did put them in risky or not accordingly accepted did not know and assumed as it was not put in the risk respectively. As a result of not sexual safe protection, 46(17.6%) and 16(6.1%) of them faced from STDs one times and two times per years respectively while 200(76.3%) were not faced from STDS.

Majority of the respondents (82.5%) perceive the severity of HIV and believed AIDS affects youths at a high proportion than any other group. This is interesting and it should be encouraged as perceived severity and perceived susceptibility are important components for behavioral change. We noted that students' attitudes towards AIDS were combined with their concepts of sexual morality. A majority of the students' believed that AIDS was a consequence of deviation from the 'moral' life. Majority of the students were sympathetic towards AIDS patients and were against isolating AIDS patients from society.

Half of the students' were believed that a woman was more responsible for prostitution compared to men. Many studies have reported good knowledge on HIV/AIDS but negative attitude is still prevalent (Derese, *et al*, 2014) .From our study, although students had good knowledge regarding HIV/AIDS, they still harbor negative attitude towards HIV and HIV/AIDS patients. Knowledge alone is not enough to change attitude**s** towards peopl**e** having HIV/ AIDS, but deep seated social and cultural factors such as religion, attitude towards ill-health and risk behaviors especially sexual behaviors can affect attitude too.

# CHAPTER SIX: UMMARY, CONCLUSION AND RECOMMENDATIONS

## 6.1. Introduction

This chapter deals with the summary, conclusion, and recommendations of the study. The major purpose of this study was risky sexual behavior and practice among high school and college students in Shambu town. The study also tried to answer the following basic research questions

1. What are the major factors influencing the youth to sexuality risky behavior and practice?

2. Why do high school and college students engage in high risk sexual behavior?

3. What is the association between background information of students and risky sexual behaviors?

4. What is the association between value orientation such as condom use, risk perception, willingness for VCT and sexual behavior in young adults?

5. How gender difference affects sexual risky behavior?

### 6.2. Summary of the findings

1. The finding regarding to socio-demographic characteristics of the respondents

The result of study shows that a study subjects were participated in this study with 100% response rate and of which fifty percent were males and forty nine percent were females. This indicated that males dominated females. The mean age of the respondents was 17.5. Most of students were between the ages of 14-19 years. Most of the respondents were Protestants. The finding showed that the educational status of the students at the study area were college students of third year and first year respectively while fifty percent of them were grade 10 students. The finding show that the pocket money of the students was getting less than five hundred but forty-six of them were getting greater than five hundred birr per month.

## 2. The major finding regarding to the factors influencing the youth to sexuality risky behavior and practice.

The finding shows that students at the study were asked with whom they were living alone and with their both parents respectively. Most of students were have addicted to different addiction

causing substances like smoking cigarette, chewing chat, drinking alcohol, and using shisha respectively in decreasing orders but some of them were using all substances. On the other hand, most of them were watching sexual practice film while few of them were not.

### 3. The result of study concerning to the possibility and means of avoid getting STI and HIV/AIDS

Even though respondents did not have tangible clinical diagnosis-based evidence for them responses, a view based on recorded educational histories, overall knowledge about AIDS prevention was high among the respondents. The finding shows that most of participants were know how they could avoid getting of STI and HIV/AIDS respectively. Similarly, majority of the respondents were aware of HIV or the disease AIDS. Besides their knowledge of the case were knew the means to avoid of getting the case by one to one opposite sex friends and prior test of the case respectively while some of them were said using condom one can avoid getting of the case.

### 4. The major finding about curability, first time sex and means of transmission of HIV /ADIS

The major finding about curability, first time sex and means of transmission of HIV /ADIS were known as AIDS is not curable, have no idea and know as it is curable respectively. The result of finding furthermore knew that a person can get HIV at the first-time sex practice while most of the participants were not know as a person could not be getting HIV at first sex practice and have no idea about the issue respectively. Majority of the study participants knew that a person who looks healthy but has the AIDS virus can pass the virus to other People. The main modes of transmission of HIV known by the students were unsafe sexual intercourse 312 and Contaminated injection needles 156). While blood transfusion 89, during pregnancy and child birth70, through breast milk 26 and mosquito bite 25 were the major misconceptions reported by the students.

## 6.3 The major finding regarding to other sexual transmitted diseases

The major finding regarding to other sexual transmitted diseases of them did heard and knew about sexually transmitted diseases specially Gonorrhea and Syphilis respectively even though few of them also heard and knew about HIV and Chancroid diseases as they also considered as sexually transmitted diseases. Though of the respondents have no idea as a condom protect a

person from gonorrhea and syphilis, knew the positive impact of condom to protect from the case. Majority of the students answered the source of their true information were Religious leader, peers, parents, media, and other family members respectively according to decreasing order.

The major finding shows that of them has no idea as a girl going to be pregnant on the first day of sex while of them confirmed as they knew as pregnancy would be happened during first day sex practice for a girl**.**

## 6.4 The major finding concerning to sexual practice and behavior

The major finding concerning to sexual practice and behavior of the students had sexual intercourse before the researcher collected data. Besides**,** of all who had practice sexual intercourse, more than twice of the study groups were 14-19 age groups which was high while some of respondents were age groups 20-25 years. Furthermore, was practiced sex at first time with their causal friends, constant friends, and commercial workers respectively. The reasons why the study participants started sex were discussed. Accordingly, the result of finding shows that most of respondents were fell in love; have had desire for sexual intercourse and due to peer pressure respectively though all risky factors were played their role on the reasons behind performing sex. Based on the data collected majority of the students had practiced sex with an age interval of 20-30 which were in number 102, though 31-40 and greater than 40 years old were participated in the study in performing sex with students. Among students who had done sex,80.2% of them were opposite sexual intercourse while 19.5% of them were not give response to the questions. At student level 0.4% students practiced homosexual intercourse means may be though that needs great commitment to cease it. Majority of the study participants were practiced sex with one friend while some of them were had done sex with two, three partners and has not given any response respectively. The result of finding shows that most of participants were using condoms always, sometimes, and not using condom at all respectively. Similarly, some of them were asked whether what they did put them in risky or not accordingly accepted did not know and assumed as it was not put in the risk respectively. Because of not sexual safe protection, most of them faced from STDs one times and two times per years respectively while majority of them were not faced from STDS.

## 6.5 The major finding shows that the attitudes or believes as predictors of sexual behaviors

The major finding shows that the attitudes or believes as predictors of sexual behaviors of the students were analyzed based on the data collected from the study participants. As issues of sexual affairs discussion with sexual partners and parents, in that most of respondents agreed that discussion is not necessary about sexual affairs with sexual partners and parents while some of them were disagrees that it is necessary to discuss about the issue with parents and sexual partners. The help of peers in bargaining of the need of sexual partners were interviewed then majority of the students have positive attitudes on the issue while some of them disagreed with idea. The study shows that most of the study participants were strongly agreed and agreed while some of them disagreed on the using of sexual risk factors that both act as motivators of sexual intercourse and risky avoiders while practicing unsafe sex. Status of an individual student in performing sex with different persons pre-marriage was discussed in that majority of them agreed that the statements in that it gives enjoyment and even loyal to couples after marriage while some of the study participants disagreed that making sex with different persons before marriage could not leads to enjoyment and loyal after marriage. The finding shows that some of the students agreed that since love and internal force have great position in performing sex so that abstaining from did not play a role while majority of the study participants have attitudes of love and internal force have positive trends with abstain from sex.

# 6.6. Conclusions

Significant segment of students have risk sexual behaviors which increase individuals' risk of acquiring HIV/AIDS. Substance use and peer pressure were revealed as predisposing factors for the existence of sexual risk behaviors. Risky sexual behavior such as having multiple sexual partner and unsafe sexual practice with non-regular partner exists. Many of the students were living alone which leads the students to the sex practice, In another way more than half of the students were addicted to different addiction causing substances like smoking cigarette, chewing chat ,drinking alcohol and using shisha respectively in decreasing orders these also have high contribution on the leading to sexual intercourse at the age of teens.

Even though respondents did not have tangible clinical diagnosis-based evidence for their responses, a view based on recorded educational histories, overall knowledge about AIDS

prevention was high among the respondents. Accordingly many of the study were know how they could avoid getting of STI and HIV/AIDS respectively. Thus majority of the respondents were aware of HIV or the disease AIDS. Majority of the respondents (82.5%) perceive the severity of HIV and believed AIDS affects youths at a high proportion than any other group. This is interesting and it should be encouraged as perceived severity and perceived susceptibility are important components for behavioral change. We noted that students' attitudes towards AIDS were combined with their concepts of sexual morality. A majority of the students' believed that AIDS was a consequence of deviation from the 'moral' life. Majority of the students were sympathetic towards AIDS patients and were against isolating AIDS patients from society.

## 6.7. Recommendations

Based on the findings the following recommendations were forwarded

1.It is suggested that high schools and college students should expand and improve good practices and good habits in the high schools and college students on gender, sexuality, HIV/AIDS and STIs that has been implemented and enable students to handle or resist peer influence, to develop negative attitude towards risky behaviors, to control early sexual initiations and develop the habit of consistent and prober condom use so that the students can become conscious, responsive and practice safe sexual behavior.

2. It is recommended that high schools and college students establish a well-organized, easily, and freely accessible condom outlet and in place the information resource center especially on HIV/RH and other issues on well-organized and equipped manner.

3. It is advisable that it is better to implement life skill education; peer and other sexuality, HIV/AIDS/STIs and gender based educational interventions should be given in a regular manner.

4. It is recommended that Parents' and other important peoples of student's involvement in interventions of the high schools and college students is crucial to enhance safe sexual behaviors

5. It is suggested that the high schools and college students should give more attention to fresh students than other students.

6. It is advised that high schools and college of students should implement activities that will improve the psychological self -efficacy and confidence of its students to perform safe sexual behavior.

7. It is suggested that the study documented greater safe sexual behaviors among males than females. Therefore, the high schools and college students give due focus on female students.

8. It is advisable that the interventions of the high schools and college students should basically focus on factors such as perceived behavioral control- student's perception of the ease or difficulty of performing safe sexual behavior, listening rap music, and/or watching rap videos and drank alcohol and/or chewed chat.

9. It is proposed that sexuality education should be included in the education curricula of the high schools and college students as passing criteria without grading.

10. It is suggested that behavioral change communication programs should be expanded by giving attention to condom use techniques and condom utilization; volunteerism and club and participation of students, and VCT service utilization.

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# Appendix – I

## Jimma University

## Collage of Education and Behavioral Science

## Post Graduate Studies

## Department of Psychology

**Questionnaire for Students**

The objective of this questionnaire is to gather information from young adults'

1. Pertinent back ground
2. Knowledge on STOs and HIV transmission and prevention, preventing pregnancy and effective condom usage
3. Their current sexual practice and behavior
4. Intended decision on sex and
5. Attitudes and believes towards predictors of sexual practice and behaviors. Consequently, the research would be -effective and useful for all young adults when you give concrete or true information about yourself.

Therefore, beforehand, we thank a lot for your genuine answer to each of the question clearly printed as follows.

Attention

No need of writing your name and Roll number, so confidentiality of your response will be maintained.

Part -One, Pertinent background information

Fill in your response

Q1.School: _____

Q2.Sex: _____

Q3.Age: _____

Q4. Religion _____

Q5. Amount of Birr you get monthly from parents or other sources? _____

Under line or circle your response

*MORE THAN ONE RESPONSE IS POSSIBLE;*

Q6. With whom do you live? 1. *with* my *mother.* 2. *with* my *father*

3. *With both* my *father and* my *mother* 4.*with relatives* 5. *Alone in rent house*

6. N*o response*

Q7. In which addiction are you involved? 1. Chewing chat 2. drinking alcohol 3.Shisha. 4. Smoking Cigarette. 5. None

Q8. Do you always watch a film which shows sexual practice? 1. Yes 2. No

**Part - Two, Knowledge on STDs and HIV transmission and prevention, Preventing pregnancy, effective condom usage and effective methods of safe sex.**

Q9. Is there anything a person can do to avoid getting STI and HIV/AIDS?

1. Yes. 2. No., then by what? 1.Condom 2.Prior testing 3.One to one 4.abstain from

Q10. If you look carefully, you can know someone has HIV.

1. Yes. 2. No.3. Don't know.

Q11. Is AIDS curable? 1. Yes. 2. No. 3. Don't know.

Q12. A person can get HIV the first time he or she has sex.1. Yes. 2. No 3. Don't know.

Q13. HIV enters into the body through: 1. Mucous membrane of anus. 2. Mucous Membrane of penis. 3. Mucous membrane of vagina. 4. Wound of the body.

5. Don't know

Q14. The most effective method for safe sex is: 1. Abstinence. 2. being faithful.

3. Using condom

Q15. A person who looks healthy but has the AIDS virus can pass the virus to other people. 1. Yes 2. No 3. Don't know/ Not sure

Q16. Please mention all the ways you believe a person can get AIDS:

1. Unsafe sexual Intercourse 2. Sharing needle and Syringes

3. Blood transfusion 4. During pregnancy and childbirth

5. Mosquito and other insect bite6. Through breast milk

7. (Hand shaking 8. Sharing food. 9. Breathing

Q17. If you heard about STDs, which diseases do you know about? 1. Gonorrhea. 2. Syphilis 3. Chancroid. 4. LymphogranulomaVenereun. 5. HIV/AIDS.

Q18. Can condom protect us from Gonorrhea and Syphilis?

1. Yes. 2. NO.3. Don't know

Q19. If a person once had STD (like syphilis) he/she can't catch it again.

1. Yes 2. No 3. Don't know

Q20What is the sign or symptoms of STDs? 1. Genital discharge. 2. Burning pain during urination. 3. Genital ulcer/sores. 4. Swelling in groin area.

Q21. From which person or from where do you get more true information about HIV and STI?

1. My parents. 2. Sexual partner. 3. Other family members.

4. Friends /peers. 5. Health institution. 6. Religious leaders. 7. Newspapers, posters,or pamphlets and others media

Q22. Is it possible for a girl to become pregnant the first time she makes sexual intercourse. 1. Yes. 2. No.3. Don't know.

Q23, During which part of the menstrual cycle does a woman have the greatest Chance of becoming pregnant? 1. during her period. 2. Right after period is ended. 3. Just before her period begins 4. In the middle of her cycle.

5. Don't know.

## Part - Three, Sexual practice and behavior.

Q24. Have you ever had sexual intercourse? 1. Yes. 2. *No.*

Q25. At what age did you first have sexual intercourse?

Q26. With whom did you make your first sexual intercourse?

*1. With my steady (stable) friend* 2. *with my casual (informal) friend.* 3. *with* a *stranger.* 4. *with commercial* sex *workers*

Q27. Why did you decide to have Sexual intercourse the first time? 1. *Fell in love.*

*2. Had desire.* 3. *Raped.* 4. *To get money and other gifts.* 5. *Peer pressure.*

6. Was *drunk or chewed chat or used drug*

Q28. How older or younger was the person with whom you had your first

sexual intercourse? Age: 1.14-19 2. 20-30 3.31-40 4.greater than 40

.

Q29. What type of sexual practice do you exercise? 1. *Heterosexual.* *2. Homosexual.* 3. *No response.*

Q30. With how many partners have you had sexual intercourse with in the last school year? 1.Yes 2. No 3. No response

Q31. Did you use condoms when ever you make sexual intercourse?

1. Yes, *always.* 2. Yes, some *times* *3.No, I don't use.*

Q32. Do you believe you have done anything that may have put you at risk **o**f getting the HIV virus? 1. *Yes.* 2. *No.3. Don't know.*

Q33. How many times have you faced STD in the last school year? 1. One times 2. Two times 3. Have not faced 4.Four times

## **Part - Five, Attitudes or believes as predictors of sexual behaviors**.

| | | Agree | Uncertain | Disagree |
|---|---|---|---|---|
| Q34 | It is not necessary to discuss about sexual affairs with sexual partner and parents. | | | |
| Q35 | Peers help to bargain the needed sexual partner | | | |
| Q36 | Drinking alcohol, using drugs, and chewing chat motivate sex and avoid terror not to be disturbed by the consequence of risky sexual practice. | | | |
| Q37 | Making sex with different persons before marriage gives enjoyment and necessary for being loyal during marriage | | | |
| Q38 | Since there is love and internal force to make sex, abstain does not have place. | | | |
| Q39 | Condom minimize sexual pleasure; | | | |
| Q40 | In my age, not need of being faithful to one person. | | | |
| Q41 | If money is given I make sex with anybody. | | | |
| Q42 | Better to live without blood testing. | | | |

Give only short answer

1. What are the risky sexual behaviors those the young adults show?

2. What do those young adults who showed change of sexual behavioral do?

3. What will be done to bring behavioral change on the young adults?

_____
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_____ Thank You!