

**PERCEPTION OF RISK OF HIV/AIDS AND INTENTION
TO ADOPT PREVENTIVE BEHAVIORS AMONG DIRE
DAWA UNIVERSITY STUDENTS**

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Acronyms

BSS – Behavioral Surveillance Survey

EPP - Extended Parallel Process

FGD – Focus Group Discussion

HAPCO – HIV/AIDS Prevention and Control office

HIV/AIDS – Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

MANOVA – Multivariate Analysis Of Variance

PBC – Perceived Behavioral Control

STI – Sexually transmitted infections

TPB- Theory of Planned behavior

TRA – Theory of Reasoned Action

VCT – Voluntary counseling and testing

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Abstract

Background : An "epidemiological synthesis" exercise commissioned by HAPCO and World Bank in 2007 indicated that in recent years a number of new training and higher learning institutions have been opened in Ethiopia. These sites and their student populations have not been studied, but there is some anecdotal evidence suggesting widespread unsafe sexual practices.

Objective: To assess the sexual behavior, perception of risk of HIV/AIDS and intention to adopt preventive behaviors using constructs of Theory of Reasoned Action among Dire Dawa University students

Methods: A cross sectional qualitative and quantitative study was conducted in Dire Dawa University on March 2009. Quantitative data were collected in a self-administered questionnaire and guiding questions were prepared for the focus group discussions used to gather qualitative data. Analysis was done using the Chi-squared test of significance, correlation, multiple linear regression and Cronbach's reliability test .The qualitative data were transcribed and translated into English, and then manipulated manually by grouping the ideas into similar thematic groups.

Results: Questionnaires filled by 369 (90.2%) students were used for analysis. 129 (35%) of the students were females and the mean age (SEM) of the study subjects was 20.3 ± 1.6 . One hundred and ten (29.81%) had ever had sexual intercourse, of whom 18 (16.4%) were females. The mean age of first sexual debut was 17.9 years (± 2.2). Among the sexually active students, 33.7% had multiple sexual partners and 37.3% had sex after alcohol consumption. Trusting one's partner and falling in love were the major reasons for not using condoms. Twenty (5.42%) of the students claimed their chance of contracting HIV/AIDS was high while 93 (25.20%) said there was no chance at all. Attitude and subjective norms were significantly correlated with intention and subjective norm was found to be the major predictor of intention to abstinence and to use condoms for both males and females.

Recommendation: The risky sexual behaviors observed in the university need the close collaboration of the University's anti-AIDS club, the University and the government.

1. Introduction

1.1 Background

An estimated 38.6 million [95% confidence interval (CI) 33.4 million–46.0 million] people worldwide were living with HIV at the end of 2005. An estimated 4.1 million [95% CI 3.4 million–6.2 million] became newly infected with HIV and an estimated 2.8 million [95% CI 2.4 million–3.3 million] lost their lives to AIDS (1).

Favorable trends in incidence in several countries are related to changes in behavior and prevention programme (1). Ethiopia is one of the Sub-Saharan countries most severely affected by the HIV/AIDS pandemic. Currently the national adult HIV prevalence rate is estimated at 2.1% and an estimated number of 901,893 people are living with HIV/AIDS. Although there are some encouraging signs, surveillance results indicate us that the epidemic is still progressing though at a slower rate than previously predicted (2).

1.2 Statement of the problem

In Ethiopia, higher-risk sex among both women and men is most prevalent among those living in urban areas, in Addis Ababa, those with a secondary or higher education, and those in the highest wealth quintile. Among men, the prevalence of higher-risk sex is also notably high among men living in Gambela, Dire Dawa, Harari, Tigray and Afar (3).

According to the second round HIV/AIDS Behavioral Surveillance Survey (BSS) in Ethiopia it was found that 9.9% of the in school youth (14.6% of males and 5.3% of females) had sexual experience. The mean and median age of sexual debut among youth was 16 years. Only 41.8% of in school youth who had sex with non-commercial partners reported consistent use of condoms (2).

An "epidemiological synthesis" exercise commissioned by HAPCO and World Bank in 2007 indicated that in recent years a number of new training and higher learning institutions have been opened. These sites and their student populations have not been

studied, but there is some anecdotal evidence suggesting widespread unsafe sexual practices (4).

2. Literature review

2.1 Theoretical framework

Investigations should be based on theoretical formulations and models, which facilitate the development of both future investigations and effective interventions (12). Among these models is the theory of reasoned action (TRA), introduced in 1967. It is based on the assumption that human beings are usually quite rational and make systematic use of the information available to them, and that people consider the implications of their actions before they decide to engage in a given behavior. According to the theory of reasoned action, intention to perform a behavior is the immediate determinant of behavior. Intention is determined by (a) attitudes toward the behavior and (b) perceived subjective norms. Attitude toward the behavior is in turn determined by behavioral beliefs, specifically the perceived outcomes of the behavior and the value placed on those outcomes. Perceived subjective norms are determined by normative beliefs i.e. perception of significant referents' beliefs about whether one should engage in a behavior and motivation to comply with those referents (8).

Relevance of theory of reasoned action

The theory of reasoned action is particularly relevant to sexual education because it focuses on cognitive factors — beliefs and values. It is vital to understand these cognitive factors in order to intervene because beliefs and values about sexuality influence young people's decision-making about their sexual behavior. Beliefs and values differ significantly from one person to the next and from one population to the next. In terms of designing interventions, it is important to tease out whether a particular behavior is most significantly influenced by a person's attitudes, perceived subjective norms, or both. Interventions targeting specific attitudes would look quite different from those targeting subjective norms held within a particular community or population (20).

TRA has been tested in numerous studies across many areas including dieting, using condoms, consuming genetically engineered foods and limiting sun exposure. In its simplest form, TRA can be expressed as the following mathematical function

$$BI = W1 (AB) + W2 (SN)$$

BI = Behavioral Intention

W = empirically derived weights

AB = one's attitude toward performing the behavior

SN = one's subjective norm related to performing the behavior

There are limiting conditions like on goal versus behaviors i.e. distinction between a goal intention (an ultimate accomplishment such as losing 10 pounds) and a behavioral intention (taking a diet pill), the presence of choice may dramatically change the nature of the intention formation process and the role of intention in the performance of behavior since there are clearly times when what one intends to do and what one actually expects to do are quite different.

TRA has a strong predictive utility, even when utilized to investigate situations and activities that do not fall within the boundary conditions originally specified for the model. That is not to say, however that further modifications and refinements are unnecessary, especially when the model is extended to goal and choice domains.

The aim of the TRA is to explain volitional behaviors. Its explanatory scope excludes a wide range of behaviors such as those that are spontaneous, impulsive, habitual, the result of cravings or simply scripted or mindless. Such behaviors are excluded because their performance might not be volitional or because engaging in the behaviors might not involve a conscious decision on the part of the action.

The theory has even been revised and extended by Ajzen himself into the Theory of planned behavior (TPB). This extension involves the addition of one major predictor, perceived behavioral control, to the model (30). The question is whether this new, more complex model (TPB) really does improve the predictive capacity of the previous model

(TRA). In the literature we find results in favor or against this theory. Possibly the main cause for this variability in the data is that Perceived Behavioral control (PBC) does not seem to have the same meaning for all authors (19).

2.2 Sexuality of Youth in Universities

In a study done among University students in China, of the 5 067 students who provided valid answer sheets, 50.05% were female and 49.95% were male, 14.86% were medical students, and 85.14% had non-medical backgrounds. A total of 38.4% of respondents had received reproductive health education previously. The majority of students supported school-based reproductive health education, and acquired information about sex predominantly from books, schoolmates, and the Internet. Premarital sexual behavior was opposed by 17.7% of survey participants, and 37.5% could identify all the three types of STIs listed in the questionnaire. Although 83.7% knew how HIV is transmitted, only 55.7% knew when to use a condom and 57.8% knew that the use of condoms could reduce the risk of HIV infection. (6)

According to a study done in Ghana on the intention of University students, respondents who intended to use condoms consistently ("intenders") and those with no such intentions ("non intenders") were equally motivated to comply with the wishes of their significant referents (sexual partners, close friends, parents and medical doctors). The critical difference was that intenders consistently held a stronger belief than non intenders that their significant referents approved of condom use. Significantly, whereas intenders believed that their sexual partners would approve of condom use, the non intenders held the opposite belief that their partners would disapprove of such behavior (8).

On a study done to examine HIV knowledge, perceived risk and sexual behavior of 370 undergraduate students in selected universities in southern Nigeria MANOVA confirmed females to have significantly higher overall HIV knowledge than males. In addition, more females than males reported significantly higher knowledge on the risk of HIV transmission through oral sex ($p = 0.001$). Females scored higher on the erroneous belief

that antibiotics protect a person from HIV. Females showed greater knowledge on the risk of needle sharing in steroid use but less knowledge on the erroneous assumption that women are tested for HIV during their Pap smear assessments. T-test on sexual behavior risk confirmed that males engage in more risky behaviors than females. T-test showed a significant gender difference with males reporting greater overall susceptibility for HIV than females (7).

In a study done on Addis Ababa University students on HIV/AIDS and reproductive health knowledge, attitude, practice and behavior (KAPB), a significant number of students, about 281 reported that they chew chat, drink alcohol, visit nightclubs and practice sex either with their regular sexual partners (girl/boy friends) or with commercial sex workers accessible in the surroundings of the University.

Their knowledge and awareness on HIV/AIDS, STIS and RH was assessed, however, only 32% of the respondents were able to explain how to prevent transmission of HIV/AIDS. Accordingly, consistent use of condom, faithfulness to one's sexual partner (spouse) was mentioned as the alternatives to avoid contracting the AIDS virus. The results from FGD analysis confirm that, on the one hand, the promotion of condom use encouraged youths to be more active towards sexual interaction. Some of the group who participated in the study expressed their worries and concerns about the little behavioral change observed among the university students although they know much of the mode of transmission of the AIDS virus (10).

In another study to assess the reproductive health needs of Addis Ababa university students, respondents were asked to list the common methods of preventing HIV/AIDS they knew. The most common methods mentioned were abstinence, being faithful to their sexual partner, not sharing sharp materials and using condoms consistently. Among the 595 (97.7%) students that responded about the methods of HIV/AIDS prevention, 506 (85.0%) of them knew three or more methods of preventing HIV/AIDS.

Most students perceived their HIV infection risk to be either low 251 (41.2%) or none at all 186 (30.5%). On the other hand, 100 (16.4%) did not know their risk level and 56 (9.2%) admitted to be at higher risk of HIV infection. (11)

A cross sectional study was conducted based on the extended parallel process (EPPM) in December 2003 among Bahir Dar University students. In the study 456 second year and above students participated. The result showed that 166(34.6%) of the students, more males than females ($P < 0.001$) had ever had sexual intercourse. Condom use among those who had sex in 12 months prior to the survey was about 52%. A belief of personal susceptibility was very low particularly for females (1.8 ± 1.05), ($P < 0.001$) perceived severity was moderately high (3.8 ± 1.32) and the perception of efficacy was high for abstinence (4.5 ± 0.97) and seems undecided for condom (2.9 ± 1.09). Females strongly agreed (4.2 ± 1.15) ($P < 0.001$) than males (3.7 ± 1.28) that they could be able to be abstinent. The study participants reported low self efficacy regarding condom use. Male students moderately agreed (3.5 ± 1.16 ; $P < 0.001$) than females (2.6 ± 1.25) for self efficacy of condom use. They had extremely positive attitude towards abstinence (4.5 ± 0.83) good for monogamy (4.0 ± 1.06) and fair attitude (3.1 ± 1.15) towards condom use. Correlation and regression analysis of risk communication and outcome variables showed that perceived response efficacy, self efficacy towards condom and perception of susceptibility were predictors for condom use and self efficacy was predictor for being abstinent. Credible source of information were cited as persons living with HIV/AIDS, religious persons and health personnel. Most important type of messages was with real experience and preferred way of learning was reported as religious affiliated, peer education and discussion with families. (15)

In a study done among Gonder university students about one fourth (25.3%) of the study subjects reported being sexually active, of whom 5.2% were females. The mean age at sexual onset was 17.7 (± 2.57) years. One fourth of the sexually active study participants (24.5%) had 2-5 life time partners and 15.3% more than 5. Only male students reported more than one lifetime partner. Of sexually active students, 39 (40.6%) had never used a

condom and 24 (25%) used condoms occasionally. 12 (12.5%) had genital symptoms of STI and 18 (21.7%) reported having sex after an alcohol bout.

There was a significant association between intention to remain faithful and perceived benefits and perceived behavioral control. Similarly, there was a significant association between intention to use condoms and knowledge of HIV/AIDS, motivation to comply, perceived benefits, perceived behavioral control, normative belief and self-efficacy. (12)

2.3 Significance of the study

Students of higher institutions are the future of a country, and great hopes rest on them. Much previous research, particularly in developing countries, has concentrated on the phenomenon of sexuality at the level of the individual, while neglecting societal, normative and cultural contexts. Focusing on the individual level assumes that sexual behavior is the result of rational decision-making based on knowledge. In reality, the complex nature of sexuality means that adolescents conduct their sexual lives through experiences and beliefs that have been generated through their membership of particular societies and communities. A wider level of the other levels of influence therefore needs to be utilized (5). Studies also show that, although awareness of AIDS and risk reduction measures like condom use is high, this knowledge is not transformed into positive attitudes and behaviors like consistent condom use (8). Considering the high risk sexual activities of University students, identifying factors deterring them from using preventive behaviors is of paramount importance. This study is intended to identify important predictors of abstinence before marriage, faithfulness and condom use, which will help in the design of appropriate interventions.

3. Objectives

3.1 General objective

To assess the sexual behavior, perception of risk of HIV/AIDS and intention to adopt preventive behaviors among Dire Dawa University students

3.2 Specific objectives

- To assess the sexual experience of Dire Dawa University students
- To describe the perception of risk of HIV/AIDS among Dire Dawa University students
- To assess intention to adopt preventive behaviors among University students using constructs from the Theory of Reasoned Action

4. Materials and methods

4.1 Study area

Dire Dawa administrative council is found about 525Km east of the capital city Addis Ababa, Ethiopia. The study was conducted in Dire Dawa University which is found in Sabian kebele 02 of the administrative council. In 2005 it was opened as part of Haramaya University by the name Dire Dawa University college and recently in 2007 it was officially opened as an independent institution by the name of Dire Dawa University. It is one of the 13 Universities newly established by the government of Ethiopia.

The University provides regular as well as summer continuing education programs. Presently it has 5 faculties (Faculty of Natural Science, Social and Language Faculty, Faculty of Business and Economics, Faculty of Technology and Faculty of Law) and 28 departments with a total student population of around 4846. The University has one clinic and an Anti AIDS club for students.

4.2 Study design

The study design was cross-sectional and used both quantitative and qualitative approaches (Focus group discussion). The data was collected from the University students attending the regular programme only excluding those enrolled under continuing education programme.

4.3 Study population

The study population was students attending their studies in the regular programme.

Inclusion criteria:

- * A day time regular student
- * Age range between 18 and 29

Exclusion criteria:

* Students attending in the non regular programme were not included in the study since they are different from the regular ones with respect to their age, maturity and employment.

* Age less than 18 or greater than 29

4.4 Sample size

The sample size for the quantitative study was calculated using the single population proportion formula. The value of p was taken as 50% as there is no previous study done in the study area. 5% margin of error and 95% level of confidence was taken.

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

By this the sample size was 384. Finite population correction formula was used since the total population was less than 10,000.

$$n_f = \frac{n_i}{(1 + \frac{n_i}{N})} = \frac{384}{1 + \frac{384}{4846}} = 355.8 \sim 356$$

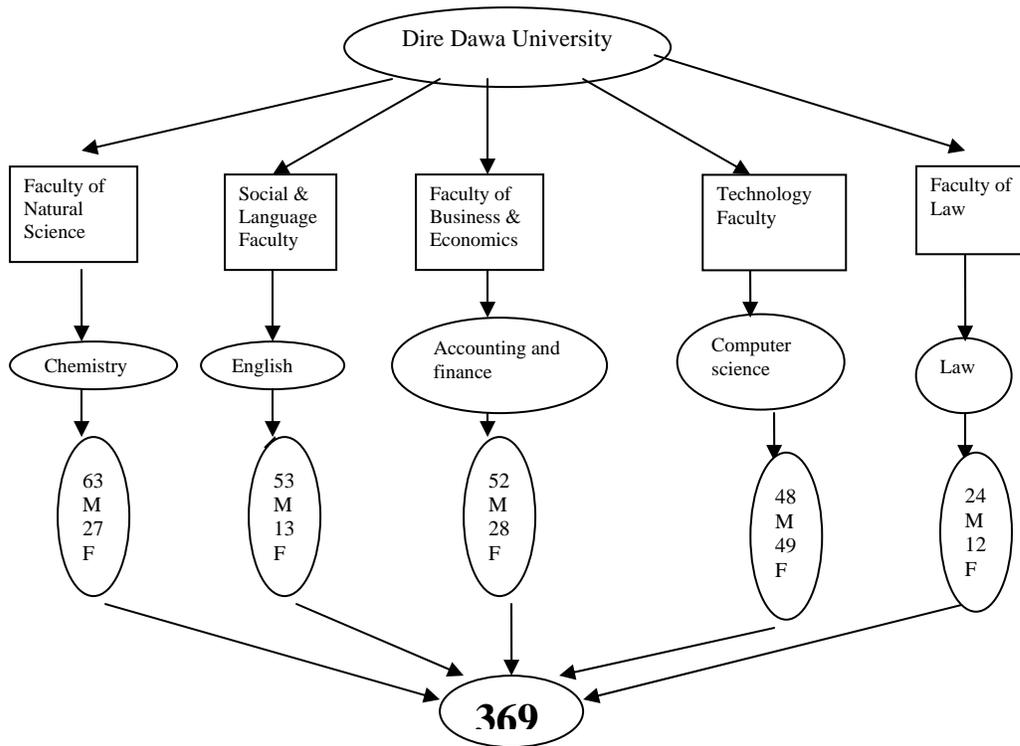
Since the questionnaire was self administered a non-response rate of 15% was allowed for, making the final sample size 409.

4.5 Sampling procedure

4.5.1 Quantitative study

One Department was selected from each of the five faculties found in the University by simple random sampling. Then the students from the selected department were stratified

by year of registration and sex. After stratification potential participants in the quantitative study were identified by simple random sampling proportional to the composition of the strata.



4.5.2. Qualitative study

The qualitative data were collected prior to the quantitative data. Two focus group discussions were conducted (one male group and one female group) with purposely selected participants excluding those who participated in the quantitative part.

4.6 Operational definitions

Intention: was measured with one item for each of the three preventive behaviors: “From now on I intend to abstain before marriage or limit sexual partner or use condoms”.

Responses were structured on a five point Likert scale ranging from strongly agree to strongly disagree.

Attitude (Advantage): was assessed with three pairs of statements relating to the advantageous outcomes of the three preventive behaviors identified in the qualitative data for each of the three preventive behaviors. Each pair comprised a behavioral (outcome) belief item with a corresponding outcome evaluation item. Statements like “For me avoiding sex before marriage will protect me and my partner from having unwanted pregnancy” and for outcome evaluation statements like “To what extent is it good or bad to avoid unwanted pregnancy” were used. These questions were structured on a five point Likert scale.

Attitude (Disadvantage): was also assessed with three pairs of statements relating to the disadvantageous outcomes of the three preventive behaviors identified in the qualitative data. Statements like “I may lose my partner if I say no to sex” and “To what extent is it good or bad to lose your partner” were used. Similarly they were structured on a five point Likert scale.

Subjective norms: the construct assessed respondent’s perceptions of the likelihood that significant others would approve of their being abstinent, limiting sexual partner or condom use and the extent of their motivation to comply with such referents. Statements like “The following people would approve of my being faithful to my partner” and “I would like to do what my think I should” referring to each of the individuals identified in the qualitative data.

4.7 Data collection instruments

Quantitative data were collected using a self-administered questionnaire first prepared in English then translated into Amharic. The questionnaire was back translated into English and checked for consistency. The Questions were prepared using constructs from the theory of Reasoned Action. The questionnaire was pre-tested in Lucy College, Dire Dawa. The variables included were -

Independent Variables

Socio demographic characteristics (age, sex, religion, ethnicity, marital status, department, educational and occupational status of both parents), sexual experience of respondents (number of lifetime partners, frequency of condom use, history of genital symptoms of STI, sexual contact with high risk partners and having sex after an alcohol bout), attitude and subjective norm constructs.

Dependent variables

Intention to adopt preventive behaviors (abstinence, limit sexual partner and condom use)

Guide questions were used in order to moderate the focus group discussions. The questions for the constructs derived from the health model were measured using a five point measurement scale ranging from 5 (strongly agree) to 1 (strongly disagree). This scoring was subsequently reversed for the negative statements, so that the higher the score, the stronger the positive construct. The sums of the scores for the items were used as summary statistics to measure the specific construct for the specific behavior.

4.8 Data collection procedure and data quality management

Quantitative data were collected just before the start of classes. Seating arrangements meant that no student's questionnaire was visible to any other student. The self-administered questionnaire was distributed to the students by the principal investigator and coordinators after explanation of the purpose of the study. The questionnaires were collected by the principal investigator and facilitators upon completion. The qualitative component was undertaken by the principal investigator with the assistance of facilitators. The FGDs were conducted in the students' HIV/AIDS club office at a convenient time for the participants and tape recorded.

4.9 Data processing and analysis

The quantitative data were entered and cleaned using Epi Info version 6 statistical package. Statistical analysis was performed using SPSS version 11. The qualitative was transcribed and translated into English. After that it was manipulated manually by grouping the ideas into similar thematic groups.

There were three intention questions (i.e. intention to abstinence before marriage, limit sexual partner and condom use) which were ranked from 1-5. For each intention question three pairs of statements regarding the advantage of the behavior and its disadvantage were used as measures of attitude. Each variable for the theoretical model was measured with the help of a five point Likert scale ranging from strongly agree to strongly disagree. Each behavioral belief score for the advantage was multiplied by its corresponding outcome belief score and the resulting cross products were summated to obtain the overall score for "advantage" and "disadvantage" of the intention respectively.

Four items about normative belief about each preventive behavior with respective motivation to comply with referents were constructed. Each normative belief score for intention to perform the three preventive behaviors was multiplied by its corresponding

motivation to comply score and the four cross products were summated to obtain the overall score for subjective norms.

To assess the relationship between theory of Reasoned Action concepts towards the three preventive behaviors Pearson's correlation coefficient was used. A coefficient of correlation above 0.4 was taken to indicate high correlation, 0.30-0.40 showed moderate correlation, 0.10-0.20 indicate low correlation (28).

In order to identify which theory of Reasoned Action variables were significant predictors of intention, a stepwise linear regression was done. In order to measure how strongly each predictor variable influenced the dependant variables the standardized regression coefficients (Beta) was used. The correlation coefficient (R) was used to measure the correlation between the observed value and the predicted value of the dependant variables. The adjusted R^2 is the square of this measure of correlation and indicates the proportion of the variance in the dependant variable (intention) which is accounted for the chosen set of predictor variables. Cronbach's reliability test (alpha coefficient) was used in order to check the internal consistency of the constructs.

4.10 Ethical considerations

Response to the survey was anonymous. A letter introducing the need for and benefits of conducting the study, the method of questioning and confidentiality was attached to the cover page of the questionnaire. In addition participants were told why consent was needed for research and facilitators discussed the content of the letter before the participants started to fill the questionnaires. Participants were also informed that they had every right to discontinue or to refuse to participate in the study. Ethical clearance was obtained from the ethical review committee of the School of Public Health and Medical Faculty Institutional Review Board of Addis Ababa University. A letter of support was written from Addis Ababa University to Dire Dawa University.

4.11 Dissemination of the study result

The findings of the study will be submitted to Addis Ababa University, School of Public Health. They will also be submitted to Dire Dawa University and the sponsor of the study. Publication on a peer reviewed journal will also be considered.

5. Result

I. Qualitative findings

i) Sexual behavior of students at Dire Dawa University

At first since the issue was sensitive it took time to have a fruitful discussion. Then points started to be raised one by one. It was suggested the situation of campus students was different to those at home since the former are outside of their homes take the responsibility for their own action. Starting at University is the time when students experience a sudden change in environment and try to practice real freedom.

“There is a perspective of spending a good time (life mekchet) so they are going to respond to their emotions more easily and they can be influenced by the opinion of others” third year male participant

Another point that was raised as contributing to behavior was the practice of students renting houses in the town and living off-campus in order to have a suitable place to study free of the tensions of the campus. Participants claimed that few derived the benefit from doing this and many get hurt. They also mentioned a tendency to find a boyfriend or girlfriend and engage in unsafe sexual practices to find relief from academic stress.

Other participants also mentioned two major contributing factors to student sexual behavior i) satisfaction and ii) for financial reasons

‘Satisfaction’ is the tendency of many students to over-react to the freedoms of University, leading them to become involved in unsafe sexual practices in search of further happiness.

Becoming engaged with unsafe sexual practices for financial reasons was said to be more common among females.

“It is not uncommon to observe cars drop students at the main gate early in the morning after spending the night somewhere else” second year female participant

Dire Dawa University is found in one of the larger cities in Ethiopia. There are a lot of bars and nightclubs to be found. On campus, there are not enough things to do, so almost all students spend a lot of their spare time in the town, where there are places to chew ‘chat’ and smoke “Shisha”.

“There is a place called Gende Kore where females chew chat usually. We found students there and while we asked them what they were doing they answered Monday is dark day (bad news)” female participant

“Often, while enjoying time in the town, the time that students have to be back on campus passes by, so they spend the night where they are” female participant

A few students work as sex workers and the sex workers in the town claimed that they had taken their jobs. During a panel discussion with the surrounding community, some said that they were afraid of sending their youngsters to other universities having observed the students in Dire Dawa.

“ Previously I used to like being a University student but these days our names are spoiled specially in Dire Dawa so I have become ashamed of being a University student currently” female participant

Male participants emphasized that male students usually became involved in bad habits and unsafe sexual practices when they did not achieve high enough grades to carry on. Other male participants said that successful students claimed it was good only to have sex occasionally, rather than to fall in love and have a decrease in academic achievement.

ii) Risk perception

Some students said it was in the hands of God whether you get infected or not. Others claimed that they understood that there was a risk, but asked how they were meant to remember their campus life if they didn't gain wide experience. Male and female participants agreed that there was a spectrum of understanding of the risk associated with HIV infection from so many perspectives.

iii) Intention towards abstinence before marriage

Both groups of participants agreed that abstinence before marriage was difficult to achieve for those at University, and thought it was more practical for people without education.

“There is a saying ‘gentility without ability’ if someone claims to be abstinent” male participant

“You are going to be laughed at if you claim that you are a virgin. Nobody is going to believe you” a female participant

“I personally advise my sister to be abstinent till she finishes her studies and that’s what I used to believe when I came from home but things may change after I have joined campus” third year male participant

The fear of seeming sexually weak, losing one's partner and finding a better partner were the reasons identified as making abstinence difficult for implementation.

iv) Intention towards limiting sexual partner

The attitude towards being faithful is that love from a distance won't work. This is to say that a student may have a boyfriend or girlfriend in their hometown but may spend their time with another while on campus.

“It is not uncommon to observe females taking off their engagement rings after some time on the campus” male participant

“There are females who say the boyfriend at hometown is my ‘major’ and the one here is my ‘minor’” male participant

However, limiting sexual partners was also taken as a sign of care for one’s partner.

V) Intention towards condom use

Respondents said that females were both more afraid to ask to use condoms and more ashamed to buy them than males. Males discussed their experiences about these things more freely than females.

“I have seen students who make a sign of cross on their face while the subject of using condoms is raised” female participant

It was mentioned that condoms might create some kind of doubt between partners. Important information like sources of condom, how to check their efficacy and how to use was not equally distributed among students. It was usually the ones in the various University clubs who had adequate information. Respondents also said that the number of students was increasing each year, but there are no mechanisms designed to address the problem.

By the end of the discussion with both groups, it was tried to identify the most influential people in relation to sexual matters to university students. Based on the frequency of being mentioned and agreement of both the male and female participants “sexual partner”, “close friends”, “parents” and “religious leaders” were found as the major themes identified. These groups were used to develop subjective norm questions for the quantitative data.

II. Quantitative findings

Background information

A total of 409 questionnaires were distributed to students and returned but only 369 (90.22%) were fully completed and used for further analysis. There was no a statistically significant difference between the age ($t_{407} = -0.33$, $P > 0.05$) and sex ($\chi^2 = 0.39$, $P > 0.05$) composition of study subjects who filled the questionnaire fully and those who returned incomplete questionnaire. Of those who filled the questionnaire fully 240(65%) were males and 129(35%) were females. The mean age of the study subjects was 20.29 with standard deviation of 1.59. One hundred and twenty three (33.33%) of the students were below 20 years of age and 240 (65.04%) were aged 20-24 years.

Table 1: Socio-demographic characteristics of students, Dire Dawa, March 2009.

Variable	Male (%)	Female (%)	Total (%)
Sex	240 (65.00%)	129 (35.00%)	369 (100%)
Ethnicity			
Amhara	80 (33.33%)	58 (44.96%)	138 (37.39%)
Oromo	78 (32.50%)	30 (23.26%)	108 (29.27%)
Tigre	41 (17.08%)	18 (13.95%)	59 (16.00%)
Other	41 (17.08%)	23 (17.83%)	64 (17.34%)
Religion			
Orthodox	163 (67.92%)	92 (71.32%)	255 (69.12%)
Protestant	33 (13.75%)	22 (17.05%)	55 (14.91%)
Catholic	4 (1.67%)	1 (0.76%)	5 (1.36%)
Islam	38 (15.83%)	13 (10.08%)	51 (13.82%)
Other	2 (0.83%)	1 (0.78%)	3 (0.81%)
Marital status			
Married	12 (5.00%)	10 (7.75%)	22 (5.96%)
Not married	228 (95.00%)	119 (92.25%)	347 (94.04%)
Father currently alive			
Yes	205 (85.42%)	117 (90.70%)	322 (87.26%)
No	35 (14.58%)	12 (9.30%)	47 (12.74%)
Mother currently alive			
Yes	233 (97.08%)	122 (94.57%)	355 (96.21%)
No	7 (2.92%)	7 (5.43%)	14 (3.79%)

Sexual experience of students

One hundred and ten (29.81%) of the study subjects had ever had sexual intercourse, and 18 (16.36%) of these were females. There was a statistically significant gender difference in the proportion of males and females ever having sexual experience ($\text{Chi}^2 = 23.83$, $\text{df} = 1$, $P < 0.001$). The mean age of first sexual debut was 17.9 years (± 2.2) with the minimum age being 7 years.

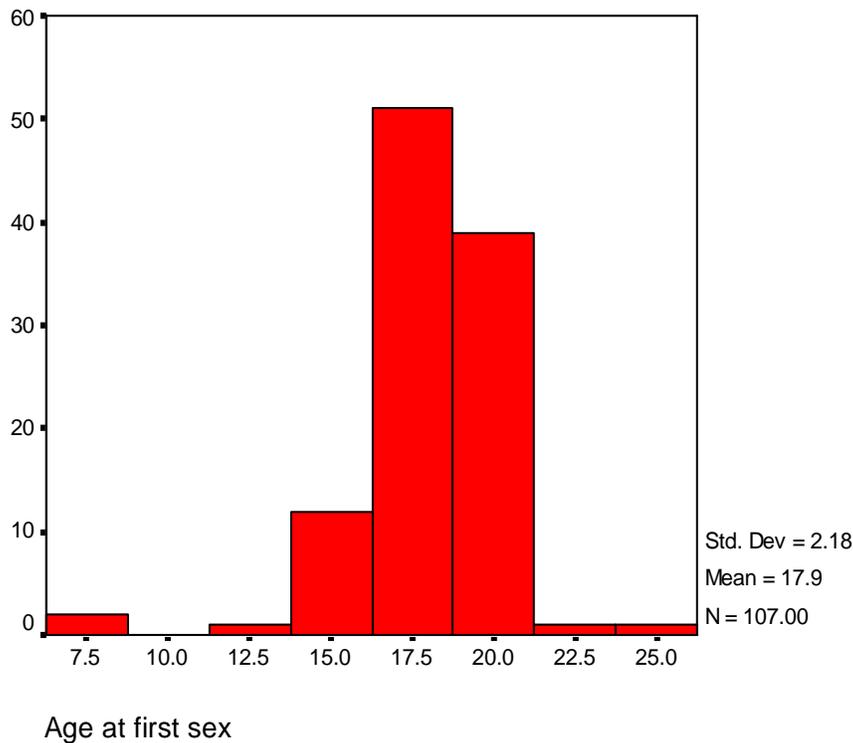


Fig1. Age distribution of sexual debut, Dire Dawa, March 2009

Among the sexually active students 73 (66.36%) had only one lifetime partner, 30 (27.27%) had 2-5 partners and 7 (6.36%) had more than 5 lifetime partners. Only males reported having had more than five lifetime partners and only 3 (16.67%) of the sexually active females had two to five partners.

Thirty seven (33.64%) of the sexually active study participants never used condoms while 34 (30.90%) always used condoms. Among the female sexually active students 9 (50.00%) had never used condoms in their history of sexual contact. Five (4.55%) of the

study participants had a history of STI, 41 (37.27%) of sexual contact after alcohol consumption, however 35 (85.37%) of these students had used condoms during sex after alcohol consumption.

Table 2: Sexual behavior of sexually active students, Dire Dawa, March 2009

Lifetime sexual behavior	Male (%)	Female (%)	Total (%)
Lifetime sexual partner			
One	58 (63.04%)	15 (83.33%)	73 (66.36%)
2-5	27 (29.35%)	3 (16.67%)	30 (27.27%)
>5	7 (7.61%)	0 (0.00%)	7 (6.36%)
Frequency of condom use			
Never used	28 (30.43%)	9 (50.00%)	37 (33.64%)
Sometimes	22 (23.91%)	4 (22.22%)	26 (23.64%)
Most of the time	13 (14.13%)	0 (0.00%)	13 (11.82%)
Always	29 (31.52%)	5 (27.78%)	34 (30.91%)
Had genital symptoms of STI			
Yes	4 (4.35%)	1 (5.56%)	5 (4.55%)
No	88 (95.65%)	17 (94.44%)	105 (95.45%)
Sexual contact with high risk partner			
Casual partner	40 (43.50%)	6 (33.30%)	46 (59.70%)
Commercial sex worker	6 (6.50%)	1 (5.60%)	7 (11.70%)
Person who has multiple partners	22 (23.90%)	0 (0.00%)	22 (28.60%)
Had sex after alcohol			
Yes	35 (38.04%)	6 (33.33%)	41 (37.27%)
No	57 (61.96%)	12 (66.67%)	69 (62.73%)

Ten (9.09%) of the sexually active students never discussed their sexual life with anybody while 72 (65.45%) discussed with their friends. Only 6 (5.45%) had the habit of discussing sexual matters with their parents.

Table3. Reasons for not using condoms among sexually active students in the past 12 months, Dire Dawa, March 2009

Reasons	Male (%)	Female (%)	Total
Difficult to find condoms	6 (6.520%)	0 (0.00%)	6 (5.45%)
Fall in love with partner	19 (20.65%)	0 (0.00%)	19 (17.27%)
Condoms are expensive	2 (2.20%)	0 (0.00%)	2 (1.82%)
Trust my partner	19 (20.65%)	5 (27.78%)	24 (21.82%)
No reason to use	4 (4.35%)	0 (0.00%)	4 (3.64%)
Sure that partner is HIV free	16 (17.39%)	4 (22.22%)	20 (18.18%)
Never discussed about using condoms	6 (6.52%)	1 (5.56%)	7 (6.36%)

Three hundred and fifty two (95.39%) of the study participants had learned about HIV/AIDS at school and 308 (83.47%) knew a person who has HIV/AIDS. Three hundred and thirty two (89.97%) students said that condoms could be found at health institutions, 237 (64.23%) in shops, and 144 (39.02%) in hotels or bars.

Perception of risk of HIV/AIDS

Twenty (5.42%) of the students claimed that their chance of contracting HIV/AIDS was high while 93 (25.20%) said there was no chance at all. One hundred and six (28.73%) did not know their risk status. Only 1 (0.78%) of the females thought she had a high chance of contracting the disease. Of the students who gave a reason for being at high risk, 12 (29.30%) said they did not use condoms consistently and 16 (27.60%) that they never used them. One hundred and eighty two (57.40%) of the students thought they were a low risk since they were not sexually active, and 224 (60.70%) thought the likelihood of risk low because of their current sexual behavior.

The effect of gender on the variables

Intention to abstinence before marriage and condom use was significantly different between females and males ($t_{282.6} = -3.1, P < 0.05$ and $t_{367} = 2.5, P < 0.05$) while intention to limit sexual partner did not vary significantly ($t_{291.2} = -1.6, P > 0.05$).

In intention to abstinence the attitudinal disadvantage varied significantly between females and males ($t_{367} = -3.7, P < 0.01$) while attitudinal advantage and subjective norm did not vary significantly ($t_{367} = -0.39, P > 0.05$ and $t_{367} = -0.9, P > 0.05$). In intention to limit sexual partner attitudinal disadvantage varied significantly between females and males ($t_{353.9} = -5.5, P < 0.01$) and in intention to condom use subjective norm varied significantly ($t_{291.6} = 4.1, P < 0.05$). For these reasons the data were analyzed for males and females separately.

Intention to abstinence before marriage

Intention to abstinence before marriage was strongly correlated with subjective norm among males (0.63, $P < 0.01$) and females (0.51, $P < 0.01$). A significant correlation was observed with all the components of the constructs among males as shown in table 4.

Table 4: Pearson correlations of intention to abstinence with constructs of theory of Reasoned Action for both males and females, Dire Dawa, March 2009.

Variable	<u>Males</u>				<u>Females</u>			
	1	2	3	4	1	2	3	4
1 Intention								
2 Advantage	0.25**	0.82			0.32**	0.89		
3 Disadvantage	0.35**	0.21**	0.67		0.33**	0.12	0.84	
4 Subjective norm	0.63**	0.18**	0.26**	0.71	0.51**	0.14	0.17	0.81
Mean	3.41	67.16	57.70	52.09	3.97	67.73	63.86	54.47
Standard deviation	1.70	13.08	15.88	24.22	1.55	13.29	14.08	25.12
Range	1-5	3-75	3-75	3-75	1-5	3-75	3-75	3-75

**P < 0.01

Internal consistency reliability (alpha coefficient) is presented in the diagonal for both males and females

Table 5 shows linear regression of abstinence with attitude and subjective norm. The three factors together explained 44% of the variance for males and 36% for females.

Among both males and females subjective norm takes the larger share of the variance.

The attitudinal disadvantage explained more variance among males than females while among females attitudinal advantage explained better.

Table5: Multiple linear regression of intention to abstinence before marriage on constructs of Theory of Reasoned Action for males and females, Dire Dawa, March 2009

<u>Males</u>					
Variables	Adj. R ²	R ² change	Standardized Beta coefficient (β)	P value	
1 Subjective norm	0.39	0.4	0.63	0.000**	
2 Subjective norm	0.43	0.04	0.58	0.000**	
Disadvantage			0.21	0.000**	
3 Subjective norm	0.44	0.01	0.56	0.000**	
Disadvantage			0.91	0.000**	
Advantage			0.11	0.025	
<u>Females</u>					
1 Subjective norm	0.25	0.26	0.51	0.000**	
2 Subjective norm	0.31	0.06	0.48	0.000**	
Advantage			0.25	0.001**	
3 Subjective norm	0.36	0.05	0.44	0.000**	
Advantage			0.23	0.002**	
Disadvantage			0.23	0.002**	

** P<0.001

Intention to limit sexual partner

The correlation matrix presented in table 6 shows a significant correlation between most of the theoretical variables. However, the observed inter correlation is weak ranging from -0.15 (subjective norm – disadvantage) among females up to 0.41 (subjective norm – intention) among males.

Table 6: Pearson correlations of intention to limit sexual partner with constructs of Theory of reasoned action for both males and females, Dire Dawa, March 2009.

Variable	<u>Males</u>				<u>Females</u>			
	1	2	3	4	1	2	3	4
1 Intention								
2 Advantage	0.27**	0.64			0.27**	0.84		
3 Disadvantage	0.27**	0.17**	0.83		0.10	0.04	0.81	
4 Subjective norm	0.41**	0.26**	0.08	0.57	0.26**	0.28**	-0.15	0.61
Mean	4.4	64.78	58.96	67.87	4.57	65.89	67.47	65.77
Standard deviation	1.13	12.65	17.78	20.18	0.99	13.06	11.57	21.40
Range	1-5	3-75	3-75	3-75	1-5	3-75	3-75	3-75

**P < 0.01

Internal consistency reliability (alpha coefficient) is presented in the diagonal.

In order to identify the intention determinants a linear regression of the theoretical variables was applied. A variation was observed among the predictor variables among males and females.

Among males, subjective norm was the first predictor of intention to limit sexual partner (explaining 17% of the variance) followed by attitudinal disadvantage (explaining 6% of the variance) and attitudinal advantage. As displayed in Table 7, among females, advantage was the first predictor of intention to limit sexual partner (explaining 7% of the variance) followed by subjective norm (explaining 4% of the variance).

Table 7: Multiple linear regression of intention to limit sexual partner on constructs of Theory of Reasoned Action for both males and females, Dire Dawa, March 2009

Variables	Adj. R ²	Males		
		R ² change	Standardized Beta coefficient (β)	P value
1 Subjective norm	0.17	0.17	0.41	0.000**
2 Subjective norm	0.22	0.06	0.39	0.000**
Disadvantage			0.24	0.000**
3 Subjective norm	0.23	0.02	0.36	0.000**
Disadvantage			0.21	0.000**
Advantage			0.14	0.017
<u>Females</u>				
1 Advantage	0.07	0.07	0.27	0.002**
2 Advantage	0.10	0.04	0.22	0.014
Subjective norm			0.20	0.027

**P<0.01

Intention to use condoms

A significant inter correlation is observed among all the constructs of theory of reasoned action among both males and females as shown in table 8. A strong correlation is observed between intention to use condoms and subjective norm (0.77, P< 0.01) and disadvantage component of the attitude (0.45, P<0.01) among males. Similarly, a strong correlation is observed between intention to use condoms and subjective norm (0.67, P<0.01) among females.

Table 8: Pearson correlations of intention to use condoms with constructs of Theory of Reasoned Action for both males and females, Dire Dawa, March 2009.

Variable	<u>Male</u>				<u>Female</u>			
	1	2	3	4	1	2	3	4
1 Intention								
2 Advantage	0.36**	0.89			0.39**	0.94		
3 Disadvantage	0.45**	0.37**	0.77		0.58**	0.42**	0.86	
4 Subjective norm	0.77**	0.38**	0.39**	0.90	0.67**	0.38**	0.51**	0.89
Mean	3.32	62.16	47.83	48.40	2.85	60.07	46.42	35.40
Standard deviation	1.66	15.73	18.42	31.64	1.72	18.79	20.58	27.89
Range	1-5	3-75	3-75	3-75	1-5	3-75	3-75	3-75

**P < 0.01

Internal consistency reliability (alpha coefficient) is presented in the diagonal for both males and females.

Upon linear regression of intention to use condoms the advantage component of attitude does not have a significant influence on the dependant variable for both males and females as shown in Table 9. The rest explain 62% and 51% of the variance among males and females respectively.

Table 9: Multiple linear regression of intention to use condoms on constructs of Theory of Reasoned Action for both males and females, Dire Dawa, March 2009

<u>Males</u>					
Variables	Adj. R ²	R ² change	Standardized Beta coefficient (β)	P value	
1. Subjective norm	0.60	0.60	0.77	0.000**	
2. Subjective norm	0.62	0.03	0.70	0.000**	
Disadvantage			0.18	0.000**	
<u>Females</u>					
1. Subjective norm	0.44	0.45	0.67	0.000**	
Subjective norm	0.51	0.08	0.50	0.000**	
Disadvantage			0.32	0.000**	

**P < 0.01

6. Discussion

In the study 90.22% of the returned questionnaires were analyzed since the rest were incomplete. This may be ascribed to the nature of data collection (self administered questionnaire) and the sensitive nature of the issue. The study subjects who provided incomplete responses do not vary significantly in terms of age and sex composition.

Nearly all (98.3%) of the study participants were aged below 24 years and 65% were aged 20-24 years. This age composition is where highest HIV prevalence occurs and is representative of youth which needs to be addressed in terms of sexual issues (1, 4).

Almost 30% of the students were sexually experienced, and males were more likely to be sexually experienced than females. There was also a similar finding in a study done at Gonder University (12), though the proportion reported here is a little higher. In a study among students in Ghana, 89.1% had ever had sexual intercourse which is much higher than the findings mentioned above (8) . This might be because the students in Ghana were older than those in Dire Dawa or Gonder (mean age = 24.36 ± 2.3 , 20.3 ± 1.59 , and 20.5 ± 1.89 , respectively).

The mean age of first sexual debut is almost the same as at Gonder University (12). But when compared with the findings of other countries, it is higher (8). This might be due to the Ethiopian cultural taboo of premarital sexual engagement and other socio economic reasons. The minimum age of sexual onset was found to be 7 years which is very low when compared with other studies (5-12). One individual reported this age as the age of first sexual onset, which may suggest the presence of child abuse which needs further investigation and a different intervention to that directed against teenage sexual engagement.

In the qualitative finding the fact that dismissed students usually engage in unsafe sexual practices is a thing which needs emphasis. It can be clear that these students are prone to have a feeling of hopelessness which might lead them to involve in irresponsible acts which makes not only their lives but also the life of others in their surrounding in danger.

The study revealed that the majority of the students would prefer to communicate with friends about sexual matters rather than with their parents. It is possible that many parents are uncomfortable talking about sex with their children or because they did not receive reproductive education they are not equipped with enough knowledge or skill to broach this difficult topic with their children. This discomfort over talking about sex with children is a common problem in many countries. Students indicated willingness to discuss sexual issues with school mates or peers. Actually peer education is an excellent supplement to school based education but it is essential to ratify the competency of peer educators (6).

One third (33.6%) of sexually active study participants never used condoms and more females reported to never use condoms than males, which is in accordance with what has been reported from earlier studies in Ethiopia (22). Trust and falling in love were the major reasons for not using condoms. Trust was never based on a negative HIV test or discussion about sexual histories. Taking appearance and reputation to determine trustworthiness has also been observed by other studies (5) and is a dangerous way of generalization.

A very small proportion of the students reported a history of STI, possibly due to the asymptomatic nature of these diseases, or to low awareness of the signs and symptoms of STIs as found in other countries (6).

In a study done among Chinese University/college students they still feel that fate, rather than their own behavior, determined whether an individual was infected with HIV or not (6). In the findings of a study done among Addis Ababa university students, the majority of students perceived their risk to be either low or zero (11). Similarly 60.7% of the study participants identified their risk as very low given their current behavior, potentially putting them at great risk when the findings of the qualitative study (showing widespread unsafe sexual practices among the students) are taken into consideration.

As has been discussed, intention to abstain before marriage is commonly taken as a sign of backwardness. Many of the FGD participants agreed that even though being abstinent has a lot of advantages, it is hard to do. Premarital sex is still taboo in Ethiopian culture (22) which might have led to apparently positive attitudes regarding abstinence. However, the age of students (youth) and their sexual feelings were considered to make abstinence hard to implement. These impressions were supported by the quantitative finding that subjective norm is strongly correlated with intention to abstain and explains a large proportion of the variance.

In a study done in South Africa (5), abstinence was found to be practiced by young men who were highly knowledgeable about HIV and were members of church groups that forbade sex before marriage and exerted peer pressure to abstain.

It was found that the advantages of being abstinent before marriage were more sensed among the females than males. This finding is also supported by the study done among youth in Addis Ababa (25) and Bahir Dar (15) where more females preferred sexual abstinence to condom use. This might be because in a society of male dominance, perceived capacity for action in females becomes a factor of gender interaction more than personal motivation since sexual abstinence is much more under their volitional control.

Subjective norm was found to explain 17% of the variance related to intention to limit sexual partners, followed by attitudinal disadvantages among males. However, among females, attitudinal advantages were the major predictor of intention to limit sexual partners. Normative belief was also found to be a strong predictor of intention to limit sexual partners (12). This finding suggests that the young are greatly influenced by the social norm of having a single sexual partner.

Attitudinal advantage was found to explain a greater percentage of variance of intention to limit sexual partners among the females possibly because they perceive that it might be the second best alternative if sexual abstinence does not work for the reasons discussed in the qualitative data. The disadvantages of limiting sexual partners were more strongly

related to intention than advantage among males. This might be because the disadvantages are more sensed by the male students than the given advantages.

The correlation found among the components of the constructs for limiting sexual partners was weak possibly because polygamous marriage is accepted in some parts of Ethiopia (22). The other probable reason might be that as the educational level of an individual increases, their mobility from place to place increases (15) which might contribute to partner change, as mentioned by the focus group participants.

Among the three preventive behaviors, the theory of reasoned action explained a large proportion of the variance in intention to use condoms for both males and females (62% and 51% respectively). This is almost double that found among Ghanaian students (8).

The regression results suggested that when it came to intention to use condoms, the most critical factors were the belief that significant others think sexually active people should use condoms and the motivation to comply with the wishes of these significant referents.

The perceived disadvantages of condom use in reducing sexual pleasure have a significant impact on intention, whereas the advantages of condom use were less correlated and had less impact on intention, as supported by the qualitative study.

The findings are in agreement with the findings among Ghanaian University students (8), and shift attention from students themselves to the people who hold influence over them. AIDS education interventions targeted to University students must focus on how to avoid the perceived disadvantages of condom use by explaining how to make condom use enhance rather than decrease sexual pleasure.

7. Strengths and limitations of the study

Strengths

- The study employed qualitative on top of the quantitative methods so that the findings in the quantitative were supplemented by the qualitative findings.
- The qualitative was conducted prior to the quantitative which helped to modify the contents of the questionnaire taking into consideration cultural context in addition to literature review of the theory of reasoned action
- The study tried to provide an insight of the situation in the newly established Universities
- The study tried to address the three major preventive behaviors of HIV/AIDS among the youth so it provides a comprehensive image of the situation for intervention
- Both the quantitative and qualitative study were conducted in the presence of the principal investigator

Limitations

- Incomplete questionnaires (because the study used self administered questionnaire)
- The study was conducted in only one of the thirteen newly established universities
- The study design was cross sectional which implies that causal relationship can not always be determined

8. Conclusion

- Almost 30% of the study subjects reported ever having sexual intercourse in their lifetime. 59.7% of the students had sexual contact with a casual partner, 11.7% with commercial sex workers and 28.6% with a person who had multiple partners
- Trusting one's partner and falling in love were the major reasons for not using condoms
- 5.4% of the students perceived their risk of HIV/AIDS infection to be high, while 25.2% said there was no chance at all. 60.7% of them identified their risk of being infected as very unlikely with respect to their current sexual behavior.
- Subjective norm was found to be the main predictor of intention to abstinence before marriage and intention to condom use among both males and females.
- In intention to limit sexual partners, attitudinal advantage was found to be the major predictor among females while subjective norm was the main predictor among males.

9. Recommendations

Anti AIDS Club of the University

- Programs related to HIV/AIDS must address the whole student population rather than specific subgroups.
- Students must be made aware of the consequences of taking appearance and reputation to determine trustworthiness in relation to STI and HIV infection.
- Students should be made to develop a feeling of personal vulnerability to HIV infection
- The club must reinforce its communication with local NGOs and other organizations to have a continuous training of peer educators

Dire Dawa University

- Emphasis must be given to students who have been dismissed so that they do not by default become engaged in unsafe sexual behavior.
- Should reinforce and strengthen anti AIDS club to function with full potential

Federal Government

- AIDS educators in Ethiopia's Universities need to focus on students' perceptions of what their significant referents think about HIV/AIDS preventive behaviors and their perceptions of the outcomes of these behaviors particularly the negative outcomes (disadvantages).
- Interventions must be targeted at students in the newly established Universities, where there is a need for capacity building and sharing of experience with the older Universities.

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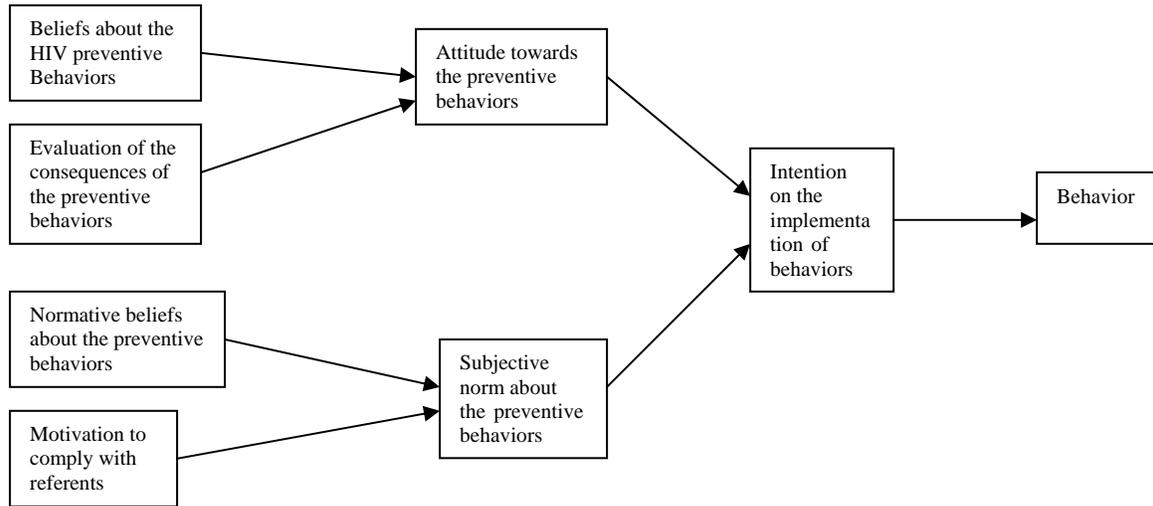
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Annex

Annex 1: Conceptual framework adapted from the theory of reasoned action as applied to preventive behaviors



Annex II: Information sheet

Title of the study: Perception of risk of HIV/AIDS and intention to adopt preventive behaviors among Dire Dawa University students

Name of the investigator: Saba Hailemeskel

Advisor: Dr. Gail Davey

Dear student,

In ensuring the health of the youth the understanding of existing problems and related behaviors of this group of the population is important. In line with this a study was proposed to Addis Ababa University, School of public health for partial fulfillment of Master of Public health by the investigator to assess the health behaviors of University students and you are chosen to participate in this study. The choice was done randomly using a lottery type of approach.

The purpose of this study is to generate information on behavior of college students that can be used to design an appropriate intervention. The study will involve various intimate and private life questions. In order to effectively attain the goal we are asking you for your help. Here is a survey for you to complete. There is no need to put your name on the survey; no individual responses will be reported. It is your full right to refuse any or all of the questions. If you don't want to participate you can leave the format on the table. But you are requested to remain in your seat until others finish filling the format. Please take a few minutes to answer to the questions.

የጥናቱ መረጃ

የጥናቱ ርዕስ: የድሬዳዋ ዩኒቨርሲቲ ተማሪዎች ለኤች አይ ቪ ኤድስ የመጋለጥ ሁኔታ ግንዛቤ እና የመከላከል የባህሪ ዝንባሌ

የአጥኝው ስም: ሳባ ኃይለመስቀል

የአማካሪው ስም: ዶ/ር ጌይል ዴኤቪ

ውድ ተማሪ፣

የወጣቶችን የጤንነት ሁኔታ ለማረጋገጥ በእናንተ መካከል በአሁኑ ወቅት ያለውን ችግርና ተያይዘው ያሉ ባህሪያትን መረዳት አስፈላጊ ነው። በዚህም መሰረት ለአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና ትምህርት ቤት ለሁለተኛ ዲግሪ ማሟያ ስለ የዩኒቨርሲቲው ተማሪዎች የጤና ባህሪያት ለመገንዘብ በዋናዎ አጥኝ ጥናት ስለታቀደ በዚህ ጥናት እንድትሳተፍ/ፊ ተመርጠሃል/ሻል። ምርጫው የተካሄደው ማንኛውም ተማሪ ሊመረጥበት በሚችል የሎተሪ ዘዴ ነው።

የጥናቱ አላማ ችግሩን ለማሻሻል የሚረዳ በዩኒቨርሲቲ ተማሪዎች ባህሪ ላይ መረጃ ለማግኘት ነው። ጥናቱ የግል ህይወትን የሚዳስሱ ጥያቄዎችን ይዟል። የጥናቱን አላማ ለማሳካት የአንተን/የአንቺን እርዳታ እንጠይቃለን። ከዚህ ቀጥሎ በግል የሚሞሉ ጥያቄዎች አሉ። በመጠይቁ ላይ ስም መጻፍ አያስፈልግም። በጥናቱ ውጤት ላይ የግል ሁኔታን የሚገልፁ መረጃዎች (የግለሰብ መልሶች) ለብቻቸው አይቀርቡም። ሁሉንም ወይም አንዳንዱን ጥያቄዎችን ላለመመለስ ትችላለህ/ሽ በጥናቱ ለመሳተፍ የማትፈልግ/ሊ ከሆነ የመጠየቅ ቅፁን አለመሙላት ትችላለህ/ሽ ነገር ግን ሌሎች ተማሪዎች ሞልተው እስኪጨርሱ በመቀመጫህ/ሽ ላይ እንድትጠብቅ/ቁ እናሳስባለን። ጥቂት ደቂቃዎችን ወስደህ/ሽ ጥያቄዎቹን እንድትመልስ/ሽ በትህትና እንጠይቃለን።

Annex III: Consent form

As it is described in the information sheet the information you provide is of much help for the planning and implementation of effective intervention programme.

I have read and understood the condition stated above, and I am willing to participate in the study.

No _____ (Discontinue the study)

If yes please sign and go to the next page

Signature _____

Date _____

For further information contact

Principal investigator: Saba Hailemeskel
Tel. 0911331560

Addis Ababa University Medical Faculty Institutional Review Board (IRB)
Tel. 0115538734

Thank you!!

የስምምነት መስጫ ቅጽ

ከላይ እንደተገለጸው የምትሰጠው/ጩወ መረጃ ችግሩን ለማሻሻል የሚረዳ ውጤታማ ተግባር ለማቀድና ለማስፈጸም በጣም ጠቃሚ ነው።

ከላይ የተጠቀሰውን መረጃ አንብቤ ተረድቻለሁ ስለዚህ በጥናቱ ለመሳተፍ ፈቃደኛ ነኝ።
አይደለሁም _____ (ጥናቱን ማቆም ትችላህ/ያለሽ)

በጥናቱ ለመሳተፍ ፈቃደኛ ከሆንሽ/ክ እባክህን/ሽን ወደሚቀጥለው ገፅ ሂድ/ጂ።

አዎ

ፊርማ _____

ቀን _____

ለበለጠ መረጃ

የአጥኚው ስም: ሳባ ኃይለመስቀል
ስልክ ቁጥር 0911331560

የአዲስ አበባ ዩኒቨርሲቲ ህክምና ፋክልቲ የጥናት ማረጋገጫ ቦርድ
ስልክ ቁጥር 0115538734

በጣም እናመሰግናለን።

Annex IV: Student self reporting questionnaire to be filled by students of Dire Dawa University

Part I: General information

The following are general questions and statements for you

1.1	Department	1.Law 2.Accounting and finance 3.Chemistry 4.English 5.Computer science
1.2	Year of student	1. 1 st year 2. 2 nd year 3. 3 rd year
1.3	Age in years	-----
1.4	Sex	1. male 2. female
1.5	Marital status	1. married 2. not married
1.6	Religion	1. Orthodox 2. protestant 3. Catholic 4. Islam 5. Others
1.7	Ethnicity	1. Amhara 2. Oromo 3. Tigre 4. other (specify_____)
1.8	Family size	-----
1.9	If the father is alive, educational status	1. Unable to read and write 2. read and write 3. grade 1-4 4. grade 5-8 5. grade 9-12 6. grade above 12
1.10	Father's occupation	1. Unemployed 2. government employee 3. privately employed 4. others specify-----
1.11	If the mother is alive educational status	1. Unable to read and write 2. read and write 3. grade 1-4 4. grade 5-8 5. grade 9-12 6. grade above 12
1.12	Mother's occupation	1. Unemployed 2. government employee 3. privately employed others specify-----

Part II: Sexual experience

	Questions	Choice	Skip
2.1	Have you ever had sexual intercourse in the past?	1. Yes 2. No	If no skip to 2.17
2.2	At what age did you have your first sexual intercourse?	_____	
2.3	How many sexual partners have you had in the past?	1. only one partner 2. two to five partners 3. more than five	
2.4	How frequently were you using condoms during your sexual intercourse?	1. never used 2. sometimes 3. most of the time 4. always	
2.5	Have you ever had genital symptoms of STIs (Ulceration around your genitalia and/or discharge) in the past?	1. Yes 2. No	
2.6	Have you ever had sex with	1. casual partner 2. commercial sex worker 3. person who has multiple partners 4. person who has STIs	
2.7	Do you currently have a steady sexual partner/someone with whom you have been having sex for at least three months?	1.Yes 2.No	
2.8	Have you ever discussed your sexual history with any of the following individuals? (mark all applicable)	1.never discussed 2. friends 3. parents 4. sexual partner 5. teachers 6. other person(s)	
2.9	Have you ever had sex after having alcohol?	1. Yes 2. No	If no skip to 2.11
2.10	If yes, was a condom used?	1. Yes 2. No	
2.11	Have you had sexual intercourse in the past 12 months?	1. yes 2. No	If no skip to 2.16
2.12	How many different sexual partners have you had in the past 12 months?	1. only one 2. two to five 3. more than five	
2.13	How frequently were you using condoms during sexual intercourse in the past 12 months?	1. never used 2. sometimes 3. most of the time 4. always	
2.14	The reasons you used condoms were (mark all applicable)	1. I never used a condom 2. to prevent pregnancy 3. didn't discuss about it with my partner 4. to prevent HIV/AIDS	

		<ul style="list-style-type: none"> 5. don't trust my sexual partner 6. don't know my sexual partner well 7. other reasons 	
2.15	The reasons you did not use condoms were (mark all applicable)	<ul style="list-style-type: none"> 1. I used condoms always 2. partner dislikes condoms 3. didn't discuss with sexual partner 4. couldn't find condoms 5. I am in love with my partner 6. condoms are expensive 7. I trust my partner 8. didn't have reason to use 9. sure that my partner is disease free 10. other reasons _____ 	
2.16	From where have you heard about HIV/AIDS in the past? (you can mark more than one answer)	<ul style="list-style-type: none"> 1. family 2. church/mosque 3. health facility 4. neighbors 5. theater/cinema 6. school 7. poster/pamphlets 8. radio 9. television 10. newspaper 11. other specify _____ 12. never heard 	
2.17	Have you been taught about HIV infection at school?	<ul style="list-style-type: none"> 1. yes 2. no 	
2.18	Did you know anyone who has/had HIV/AIDS?	<ul style="list-style-type: none"> 1. yes 2. no 	
2.19	Where do you think one can get condoms if necessary (mark all possible sources)	<ul style="list-style-type: none"> 1. school 2. hotels/bars 3. health facility 4. theater/cinema 5. shops 6. pharmacy 7. church/mosque 8. other place 9. I don't know 	

Part III: Risk perception

	Questions	Choice
3.1	How great is your chance of contracting HIV/AIDS?	1. high 2. low 3. no chance at all 4. I don't know
3.2	What makes you at higher risk of contracting HIV/AIDS?	1. I have multiple partners 2. I never use condoms 3. I don't use condoms consistently 4. Other specify_____
3.3	What makes you at lower risk of contracting HIV/AIDS?	1. I have never had sex 2. I am faithful to my partner 3. I use condoms consistently 4. Other specify_____
3.4	How do you evaluate your chance of being infected with HIV/AIDS with your current behavior?	1. very likely 2. likely 3. neutral 4. unlikely 5. very unlikely

Part IV

Preventive behaviors (Behavioral intention)

Abstinence

Here are statements regarding abstaining from sex before marriage. Mark a tick in the boxes provided according to your degree of agreement to these statements.

4.1	For me avoiding sex before marriage will protect me and my partner	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.1.1	From having unwanted pregnancy	<input type="checkbox"/>				
4.1.2	from getting sexually transmitted diseases	<input type="checkbox"/>				
4.1.3	From getting HIV/AIDS	<input type="checkbox"/>				
	To what extent is it good or bad to avoid	very good	good	neutral	bad	very bad
4.1.4	unwanted pregnancy	<input type="checkbox"/>				
4.1.5	sexually transmitted diseases	<input type="checkbox"/>				
4.1.6	HIV/AIDS	<input type="checkbox"/>				
		Strongly agree	Agree	Neutral	Disagree	Strongly disagree

4.2	Refusing sex with a casual partner will make it seem that I am sexually weak	<input type="checkbox"/>				
4.3	I may lose my partner if I say no to sex	<input type="checkbox"/>				
4.4	To get a better partner I must try several partners with sexual intercourse	<input type="checkbox"/>				
	To what extent is it good or bad to	very good	good	neutral	bad	very bad
4.4.1	seem sexually weak	<input type="checkbox"/>				
4.4.2	lose your partner	<input type="checkbox"/>				
4.4.3	not being able to find a better partner	<input type="checkbox"/>				
		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.5	My lover won't accept my idea of avoiding sex before marriage	<input type="checkbox"/>				
4.6	My close friend would make a fool out of me if I avoid sex before marriage	<input type="checkbox"/>				
4.7	My parents/relatives would approve of my being abstinent	<input type="checkbox"/>				
4.8	Religious leaders are in favor of my being abstinent	<input type="checkbox"/>				
4.9	I would like to do what	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.9.1	My sexual partner thinks that I should	<input type="checkbox"/>				
4.9.2	My close friend(s) think(s) that I should	<input type="checkbox"/>				
4.9.3	My parent(s) think(s) that I should	<input type="checkbox"/>				
4.9.4	My religious leader(s) think(s) that I should	<input type="checkbox"/>				
4.10	From now on I intend to avoid sex before marriage	<input type="checkbox"/>				

Limit sexual partners

The following statements are concerning limiting the number of sexual partners to only one. Show your agreement or disagreement by marking a tick in the boxes provided under your choice.

4.11	Remaining with one steady sexual partner	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.11.1	Will protect me from getting sexually transmitted diseases	<input type="checkbox"/>				
4.11.2	Protect myself from getting HIV/AIDS	<input type="checkbox"/>				
4.11.3	show my lover that I care about his or her health	<input type="checkbox"/>				
	To what extent is it good or bad to	very good	good	neutral	bad	very bad
4.11.4	be protected from STD	<input type="checkbox"/>				
4.11.5	be protected from HIV/AIDS	<input type="checkbox"/>				
4.11.6	to show care to your lover	<input type="checkbox"/>				
		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.12	Limiting my sexual desire to only one partner will reduce my sexual pleasure	<input type="checkbox"/>				
4.13	To avoid sex with partners other than my steady sexual partner will make me seem sexually weak	<input type="checkbox"/>				
4.14	Refusing sex with a casual partner will make it seem that he/she has AIDS	<input type="checkbox"/>				
	To what extent is it good or bad if something	very good	good	neutral	bad	very bad
4.141	reduces sexual pleasure	<input type="checkbox"/>				
4.142	makes seem sexually weak	<input type="checkbox"/>				
4.143	makes the other partner seem having HIV/AIDS	<input type="checkbox"/>				
4.15	The following individuals will approve of my remaining with one steady sexual partner	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.15.1	My lover	<input type="checkbox"/>				
4.15.2	My close friend	<input type="checkbox"/>				
4.15.3	My parents/relatives	<input type="checkbox"/>				
4.15.4	Religious leaders	<input type="checkbox"/>				

4.16	I would like to do what	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.16.1	My sexual partner thinks that I should	<input type="checkbox"/>				
4.16.2	My close friend(s) think(s) that I should	<input type="checkbox"/>				
4.16.3	My parent(s) think(s) that I should	<input type="checkbox"/>				
4.16.4	My religious leader(s) think(s) that I should	<input type="checkbox"/>				
4.17	From now on I intend to limit my sexual contact to only one sexual partner	<input type="checkbox"/>				

Condom Use

The following are concerning condom use. Show your agreement or disagreement by marking a tick in the boxes provided under your choice.

4.17	I think using a condom at sexual intercourse would	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.17.1	Prevent my partner/me from becoming pregnant	<input type="checkbox"/>				
4.17.2	Protect me from getting a sexually transmitted disease	<input type="checkbox"/>				
4.17.3	Protect me from getting HIV/AIDS	<input type="checkbox"/>				
	To what extent is it good or bad to	very good	good	neutral	bad	very bad
4.17.4	prevent pregnancy	<input type="checkbox"/>				
4.17.5	protect from STD	<input type="checkbox"/>				
4.17.6	protect from HIV/AIDS	<input type="checkbox"/>				
		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.18	Condoms are difficult for me to use	<input type="checkbox"/>				
4.19	Condoms create doubt between sexual partners	<input type="checkbox"/>				
4.20	Condoms are shameful for me to buy	<input type="checkbox"/>				
	To what extent is it good or bad if something	very good	good	neutral	bad	very bad
4.20.1	is difficult for use	<input type="checkbox"/>				
4.20.2	creates doubt between partners	<input type="checkbox"/>				
4.20.3	is shameful to buy	<input type="checkbox"/>				

4.21	The following people would approve of my using condoms during sexual intercourse	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.21.1	My lover	<input type="checkbox"/>				
4.21.2	My close friend	<input type="checkbox"/>				
4.21.3	My parents/relatives	<input type="checkbox"/>				
4.21.4	Religious leaders	<input type="checkbox"/>				
4.22	I would like to do what	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.22.1	My sexual partner thinks that I should	<input type="checkbox"/>				
4.22.2	My close friend(s) think(s) that I should	<input type="checkbox"/>				
4.22.3	My parent(s) think(s) that I should	<input type="checkbox"/>				
4.22.4	My religious leader(s) think(s) that I should	<input type="checkbox"/>				
4.23	I intend to use condom at the next sexual intercourse	<input type="checkbox"/>				

Part V
Future plan

5.1	Assume the test for HIV is available , would you be interested to be tested for HIV/AIDS	1. Yes 2. No
5.2	Assume you are tested for HIV/AIDS, would you be willing to hear the results of your test?	1. yes 2. No

Thank you!!

በድራደዋ ዩኒቨርሲቲ ተማሪዎች በግል የሚሞላ ቅጽ

የክፍል አንድ፡ ጠቅላላ መረጃ

1.1	ትምህርት ክፍል	<ol style="list-style-type: none"> 1. ህግ 2. አካውንቲንግ እና ፋይናንስ 3. ኬሚስትሪ 4. እንግሊዝ 5. ኮምፒውተር ሳይንስ
1.2	ስንተኛ አመት ነህ/ሽ	<ol style="list-style-type: none"> 1.1^ኛ ዓመት 2.2^ኛ ዓመት 3.3^ኛ ዓመት
1.3	ዕድሜ	-----
1.4	ፆታ	<ol style="list-style-type: none"> 1. ወንድ 2. ሴት
1.5	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> 1. ያገባ/ች 2. ያላገባ/ች
1.6	ሃይማኖት	<ol style="list-style-type: none"> 1. ኦርቶዶክስ 2. ፕሮቴስታንት 3. ካቶሊክ 4. ሙስሊም 5. ሌሎችም
1.7	ብሔረሰብ	<ol style="list-style-type: none"> 1. አማራ 2. ኦሮሞ 3. ትግሬ 4. ሌላ ይጥቀሱ
1.8	የቤተሰብ ብዛት	-----
1.9	አባት-ህ/ባትሽ በህይወት ያሉ ከሆነ የትምህርት ደረጃ	<ol style="list-style-type: none"> 1. ማንበብና መጻፍ የማይችል 2. ማንበብና መጻፍ የሚችል 3. ከ1^ኛ-4^ኛ ክፍል 4. ከ5^ኛ-8^ኛ ክፍል

		5. ከ9 ^ኛ -12 ^ኛ ክፍል 6. ከ12 ^ኛ ክፍል በላይ
1.10	የአባት-ህ/ሽ የሥራ ሁኔታ	1. ስራ አጥ 2. የመንግስት ሠራተኛ 3. የግል ተቀጣሪ 4. ሌላ ይጠቀስ
1.11	እናት-ህ/ሽ በህይወት ያሉ ከሆነ የትምህርት ደረጃ	1. ማንበብና መጻፍ የማይችል 2. ማንበብና መጻፍ የሚችል 3. ከ1 ^ኛ -4 ^ኛ ክፍል 4. ከ5 ^ኛ -8 ^ኛ ክፍል 5. ከ9 ^ኛ -12 ^ኛ ክፍል 6. ከ12 ^ኛ ክፍል በላይ
1.12	የእናት-ህ/ሽ የሥራ ሁኔታ	1. ስራ አጥ 2. የመንግስት ሠራተኛ 3. የግል ተቀጣሪ 4. ሌላ ይጠቀስ

ክፍል ሁለት

2.1	ከዚህ በፊት የግብረ ስጋ ግንኙነት አድርገህ/ሽ ታውቃለህ/ሽ?	1. አውቃለሁ 2. አላውቅም	የሚታወቅ/ቂ ከሆነ ወደ 2.16 ሂድ/ጂ.
2.2	የመጀመሪያ የግብረ ስጋ ግንኙነት በስንት አመት-ህ/ሽ አደረግህ/ሽ?	-----	
2.3	ከዚህ በፊት ስንት የተለያዩ የፍቅር ጓደኞች ነበሩህ/ሽ?	1. አንድ ብቻ 2. ከሁለት እስከ አምስት 3. ከአምስት በላይ	
2.4	ከአሁን በፊት ግብረ ስጋ ግንኙነት ያደርጉ በነበሩ ጊዜ ኮንዶም ትጠቀም/ሚ ነበር?	1. በፍፁም አልተጠቀምኩም 2. አንዳንድ ጊዜ እጠቀም ነበር 3. አብዛኛውን ጊዜ እጠቀም ነበር 4. ሁሉ ጊዜ እጠቀም ነበር	

2.5	የአባላዘር በሽታ ምልክቶች ማለትም (በብልት አካባቢ ቁስለት ወይም ፈሳሽ) ታይተውብህ/ብሽ ያውቃል?	1. አውቃለሁ 2. አላውቅም	
2.6	ከሚከተሉት ውስጥ ከዚህ በፊት ከየትኞቹ ጋር ወሲብ ፈፅመህ/ሽ ታውቃለህ/ሽ?	1. ከሶስት ሳምንት በታች ከመውቀው የፍቅር ጓደኛዬ ጋር 2. ከሴተኛ አዳሪ ጋር 3. ከአንድ በላይ የፍቅር ጓደኞች ካሉት/ሏት 4. የአባላዘር በሽታ ካለበት ሰው ጋር	
2.7	በአሁኑ ወቅት ቋሚ የሆነ የፍቅር ጓደኛ (ቢያንስ ለሶስት ወር ያክል የግብረ ስጋ ግንኙነት አብረህ/ሽ የምትፈፅመው) አለህ/ሽ?	1. አለኝ 2. የለኝም	
2.8	ከአሁን በፊት ስለግል የወሲብ ታሪክህ/ሽ ከማን ጋር ተወያይተህ/ሽ ታውቃለህ/ሽ? (የሚመለከተው ሁሉ ምልክት አድርጉ)	1. ተወያይቼ አላውቅም 2. ከጓደኞቹ ጋር 3. ከወላጆቹ ጋር 4. ከፍቅር ጓደኛዬ ጋር 5. ከመምህራኖቹ ጋር 6. ከሌሎች ሰዎች ጋር	
2.9	መጠጥ ጠጥተህ/ሽ የግብረ ስጋ ግንኙነት አድርገህ/ሽ ታውቃለህ/?	1. አውቃለሁ 2. አላውቅም	
2.10	መልስህ/ሽ አውቃለሁ ከሆነ ኮንዶም ተጠቅመህ/ሽ ነበር?	1. አዎ 2. አልተጠቀምኩም	
2.11	ባለፉት 12 ወራት ውስጥ የግብረ ስጋ ግንኙነት ፈፅመህ/ሽ ታውቃለህ/ሽ?	1. አዎ 2. አላውቅም	የማታውቅ/ቁ ከሆነ ወደ 2.16 ሂድ/ጂ.
2.12	ባለፉት 12 ወራት ውስጥ ስንት የፍቅር ጓደኞች ነበሩህ/ሽ?	1. አንድ ብቻ 2. ከሁለት እስከ አምስት 3. ከአምስት በላይ	
2.13	ባለፈው 12 ወራት በነበረህ/ሽ የግብር ስጋ ግንኙነት ኮንዶም ትጠቀም/ሚ ነበር?	1. በፍፁም አልተጠቀምኩም 2. አንዳንድ ጊዜ 3. አብዛኛውን ጊዜ 4. ሁል ጊዜ	
2.14	ኮንዶም የተጠቀምክባቸው/ሽባቸው ምክንያቶች (መልስ	1. ተጠቅሜ አላውቅም	

	የሆነው ሁሉ ምልክት አድርጉ)	<ol style="list-style-type: none"> 2. እርግዝናን ለመከላከል 3. ስለዚህ ጉዳይ ከጓደኛዬ ጋር ተወያተን አናውቅም 4. ከኤች አይ ቪ ኤድስ ለመከላከል 5. የፍቅር ጓደኛዬን ስለማላምናት ነው 6. የፍቅር ጓደኛዬን በደንብ ስለማለውቀው/ቃት 7. ሌሎች ምክንያቶች
2.15	<p>በግብረ ስጋ ግንኙነት ወቅት ኮንዶም ያልተጠቀምክባቸው/ሸባቸው ምንያቶች (መልስ የሆነው ሁሉ ላይ ምልክት አድርጉ)</p>	<ol style="list-style-type: none"> 1. ኮንዶምን ሁሉ እጠቀማለሁ 2. የፍቅር ጓደኛዬ ኮንዶም ስለማይወድ/ትወድ 3. ከፍቅር ጓደኛዬ ጋር ተወያይተንበት አናውቅም 4. ኮንዶም ማግኘት ስላልቻልን 5. ከጓደኛዬ ጋር ፍቅር ስለያዘኝ 6. ኮንዶም ወድ ስለሆነ 7. የፍቅር ጓደኛዬን ስለማምነው/ምናት 8. የምጠቀምበት ምክንያት ስላልነበረኝ 9. የፍቅር ጓደኛዬ ከበሽታ ነፃ መሆኑን እርግጠኛ ስለሆንኩ 10. የፍቅር ጓደኛዬ ኮንዶም ስለማይወድ/ትወድ 11. ሌላ ምክንያት
2.16	<p>ከዚህ በፊት ስለኤች አይ ቪ ኤድስ ክየት ነው የሰማህው/ሸው?</p>	<ol style="list-style-type: none"> 1. ከቤተሰብ 2. ከቤተክርስቲያን/መስኪድ 3. ከጤና ተቋም 4. ከጎረቤት 5. ከቴያትር/ከሲኒማ 6. ከትምህርት ቤት 7. ከፖስተር/ማስታወቂያ ወረቀት 8. ከሬዲዮ

		9. ከቴሌቪዥን 10. ጋዜጣ 11. ሌላ 12. ስምቹ አላውቅም
2.17	ስለ ኤች አይ ቪ ኤድስ ትምህርት ቤት እያለህ/ሽ ተምረህ/ሽ ታውቂያለሽ/ህ?	1. አውቃለሁ 2. አላውቅም
2.18	ከዚህ በፊት ኤች አይ ቪ ኤድስ ያለበት ሰው ታውቃለህ/ሽ?	1. አውቃለሁ 2. አላውቅም
2.19	አንድ ሰው ኮንዶም ቢፈልግ ከየት ማግኘት የሚችል ይመስልህ/ሻል? (መልስ የሆነውን ሁሉ ላይ ምልክት አድርጉ)	1. ትምህርት ቤት 2. ሆቴል/መጠጥ ቤት 3. የጤና ተቋም 4. ቲያትር/ሲኒማ ቤት 5. ሱቅ 6. ከመድሀኒት ቤት 7. ቤተክርስቲያን/መስጊድ 8. ሌላ ቦታ 9. አላውቅም

ክፍል ሦስት

ለበሽታው የመያዝ ሁኔታ ግንዛቤ

		ምርጫ
3.1	በኤች አይ ቪ ኤድስ የመያዝ ዕድል/ሽ ምን ያህል ነው?	1. ከፍተኛ 2. ዝቅተኛ 3. በፍፁም አይዘኝም 4. አላውቅም
3.2	በኤች አይ ቪ ኤድስ ለመያዝ ያለህን/ሽን ዕድል ከፍተኛ የሚያደርገው ምንድን ነው?	1. ብዙ የፍቅር ጓደኞች ስላሉኝ 2. ኮንዶም ተጠቅሜ ስለማላውቅ (ስለማልጠቀም) 3. ኮንዶም ሁል ጊዜ ስለማልጠቀም 4. ሌሎች ካሉ ይጥቀሱ

3.3	በኤች አይ ቪ ኤድስ ለመያዝ ያለህን/ሽን ዕድል ዝቅተኛ የሚያደርገው ምንድነው?	1. የግብረ ስጋ ግንኙነት ፈፅሜ ስለማላውቅ 2. ለፍቅር ጓደኛዬ ታማኝ ስለሆንኩ 3. ኮንዶም ሁልጊዜ ስለምጠቀም 4. ሌሎች ካሉ ይጥቀሱ
3.4	በአሁኑ ሰዓት ካለህ/ሽ ባህሪ አንፃር በኤች አይ ቪ ኤድስ የመያዝ ሁኔታህ/ሽ ምን ያህል ነው	1. በጣም ከፍተኛ 2. ከፍተኛ 3. ሊይዘኝም ላይዘኝም ይችላል 4. ዝቅተኛ 5. በጣም ዝቅተኛ

ክፍል አራት

የመከላከል ባህሪያት (የባህሪ ዝንባሌ)

መታቀብ

		በጣም እስማማለሁ	እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም
4.1	ከጋብቻ በፊት የግብረ ስጋ ግንኙነት አለማድረግ እኔንና ጓደኛዬን	<input type="checkbox"/>				
4.1.1	ካልተፈለገ እርግዝና ይከላከላል	<input type="checkbox"/>				
4.1.2	የአባላዘር በሽታ እንዳይዘን ይከላከልልናል	<input type="checkbox"/>				
4.1.3	ኤች አይ ቪ ኤድስ እንዳይዘን ይከላከልልናል	<input type="checkbox"/>				
	የሚከተሉትን ነገሮች ማስወገድ ምን ያህል ጥሩ ወይም መጥፎ ነው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.1.4	ያልተፈለገ እርግዝናን	<input type="checkbox"/>				
4.1.5	የአባላዘር በሽታን	<input type="checkbox"/>				
4.1.6	ኤች አይቪ ኤድስን	<input type="checkbox"/>				
4.2	ከቅርብ ጊዜ ጓደኛዬ ጋር የግብረ ስጋ ግንኙነት እንቢ ማት የወሲብ ስሜቴን ደካማ ያስመስለዋል	<input type="checkbox"/>				
4.3	የግብረ ስጋ ግንኙነትን እንቢ ካልኩ የፍቅር ጓደኛዬን ላጣ እችላለሁ	<input type="checkbox"/>				

4.4	የተሻለ የፍቅር ጓደኛ ለማግኘት ከብዙ ሰዎች ጋር የግብረ ስጋ ግንኙነት አድርጎ መሞከር አለብኝ	<input type="checkbox"/>				
	የሚከተሉት ሃሳቦች ምን ያህል ጥሩ ወይም መጥፎ ናቸው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.41	በወሲብ ደካማ መሆን	<input type="checkbox"/>				
4.42	የፍቅር ጓደኛን ማጣት	<input type="checkbox"/>				
4.43	የተሻለ የፍቅር ጓደኛ አለማግኘት	<input type="checkbox"/>				
4.5	ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ያለመፈጸሜን የፍቅር ጓደኛዬ አይቀበለውም	<input type="checkbox"/>				
4.6	የቅርብ ጓደኛዬ ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ባለመፈጸሜ ሊቀልድብኝ (ልትቀልድብኝ) ይችላል (ትችላለች)	<input type="checkbox"/>				
4.7	ቤተሰቦቼ (ዘመዶቼ) የኔን ከጋብቻ በፊት መታቀብ ይስማሙበታል	<input type="checkbox"/>				
4.8	የሃይማኖት መሪዎች የኔን ከጋብቻ በፊት መታቀብ ይደግፋሉ	<input type="checkbox"/>				
4.9	እኔ ማድረግ የምፈልገው.....					
4.9.1	ፍቅረኛዬ እንዳደርግ የሚጠበቅብኝን ነው	<input type="checkbox"/>				
4.9.2	የቅርብ ጓደኛዬ(ኞቼ) እንዳደርግ የሚያስቡትን ነው	<input type="checkbox"/>				
4.9.3	ወላጅ(ጆቼ) እንዳደርግ የሚጠብቁኝን ነው	<input type="checkbox"/>				
4.9.4	የሃይማኖት መሪዎች እንዳደርግ የሚጠብቁኝ ነው	<input type="checkbox"/>				
4.10	ከአሁን ጀምሮ ከጋብቻ በፊት የግብረ ስጋ ግንኙነት ላለመፈጸም ሃሳቤ ነው	<input type="checkbox"/>				

በአንድ የፍቅር ጓደኛ መወሰን

የሚከተሉት አርፍተ ነገሮች ስለመወሰን የሚናገሩ ናቸው። ከተሰጡት ምጫዎች ውስጥ

የምትስማሙበትንና የምትቃወሙትን ምልክት በማድረግ አሳዩ

4.11	መወሰን (በአንድ የፍቅር ጓደኛ መወሰን)	በጣም እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም
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4.11.1	የአባላዘር በሽታ እንዳይዘኝ ይከላከልልኛል	<input type="checkbox"/>				
4.11.2	ከኤች አይ ቪ ኤድስ ይከላከልልኛል	<input type="checkbox"/>				
4.11.3	በአንድ የፍቅር ጓደኛ መወሰን ከወሲብ አእማገኘውን ደስታ ይቀንስባኛል	<input type="checkbox"/>				
	የሚከተሉት ሃሳቦች ምን ያህል ጥሩ ወይም መጥፎ ናቸው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.11.4	የአባላዘር በሽታን መከላከል	<input type="checkbox"/>				
4.11.5	ኤች አይቪ ኤድስን መከላከል	<input type="checkbox"/>				
4.11.6	ለፍቅር ጓደኛ ጤንነት መጨነቅ	<input type="checkbox"/>				
4.13	ከረጅም ጊዜ የፍቅር ጓደኛዬ በተጨማሪ ከሌሎች ጓደኞቼ ጋር ወሲብ አለመፈፀሜን በወሲብ ደካማ የሆንኩኝ ያስመስልብኛል	<input type="checkbox"/>				
4.14	ከአጭር ጊዜ ጓደኛዬ ጋር ወሲብ ያለመፈፀሜ ጓደኛዬ ኤድስ ያለበት/ባት ያስመስልብኛል	<input type="checkbox"/>				
የሚያደርግ ከሆነ ምን ያህል ጥሩ ወይም መጥፎ ነው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.141	ከወሲብ የሚገኘውን ደስታ የሚቀንስ ከሆነ	<input type="checkbox"/>				
4.142	በወሲብ ደካማ የሚያስመስል ከሆነ	<input type="checkbox"/>				
4.143	ጓደኛን ኤድስ ያለበት የሚያስመስል ከሆነ	<input type="checkbox"/>				
4.15	የሚመለከቱ ሰዎች የኔ በአንድ የፍቅር ጓደኛ መወሰን ይስማሙብታል	በጣም እስማማለሁ	እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም
4.15.1	ፍቅረኛዬ	<input type="checkbox"/>				
4.15.2	የቅርብ ጓደኛዬ	<input type="checkbox"/>				
4.15.3	ወላጆቼ (ቤተሰቦቼ)	<input type="checkbox"/>				
4.15.4	የሃይማኖት መሪዎች	<input type="checkbox"/>				
4.16	እኔ ማድረግ የምፈልገው...	በጣም እስማማለሁ	እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም
4.16.1	ፍቅረኛዬ እንዳደርግ የሚጠበቅብኝን ነው	<input type="checkbox"/>				

4.16.2	የቅርብ ጓደኛዎች(ኞቹ) እንዳደርግ የሚያስቡትን ነው	<input type="checkbox"/>				
4.16.3	ወላጅ(ጆቹ) እንዳደርግ የሚጠብቁኝን ነው	<input type="checkbox"/>				
4.16.4	የሃይማኖት መሪዎች እንዳደርግ የሚጠብቁኝ ነው	<input type="checkbox"/>				
4.17	ከአሁን ጀምሮ በአንድ የፍቅር ጓደኛ ለመወሰን ሃሳቤ ነው	<input type="checkbox"/>				

ኮንዶም መጠቀም

የሚከተሉት ዐርፍተ ነገሮች ስለ ኮንዶም መጠቀም የሚናገሩ ናቸው። ከተሰጡት ምጫዎች ውስጥ የምትስማሙበትንና የምትቃወሙትን ምልክት በማድረግ አሳዩ

4.17	በግብረ ስጋ ግንኙነት ወቅት ኮንዶም መጠቀም	በጣም እስማማለሁ	እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም
4.17.1	እኔን (የፍቅር ጓደኛዬን) ከእርግዝና የከላከላል	<input type="checkbox"/>				
4.17.2	የአባላዘር በሽታ እንዳይዘኝ ይከላከልልኛል	<input type="checkbox"/>				
4.17.3	ከኤች አይ ቪ ኤድስ ይከላከልልኛል	<input type="checkbox"/>				
	የሚከተሉት ሃሳቦች ምን ያህል ጥሩ ወይም መጥፎ ናቸው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.17.4	እርግዝናን መከላከል	<input type="checkbox"/>				
4.17.5	የአባላዘር በሽታን መከላከል	<input type="checkbox"/>				
4.17.6	ኤች አይቪ ኤድስን መከላከል	<input type="checkbox"/>				
4.18	ኮንዶም ለኔ ለመጠቀም አስቸጋሪ ነው	<input type="checkbox"/>				
4.19	ኮንዶም በፍቅረኛዎች መካከል ያለመተማመንን ያመጣል	<input type="checkbox"/>				
4.20	ኮንዶም መግዛት ያሳፍረኛል	<input type="checkbox"/>				
የሚያደርግ ከሆነ ምን ያህል ጥሩ ወይም መጥፎ ነው።	በጣም ጥሩ	ጥሩ	መካከለኛ	መጥፎ	በጣም መጥፎ
4.20.1	ለመጠቀም አስቸጋሪ	<input type="checkbox"/>				
4.20.2	በፍቅረኞች መካከል አለመተማመንን የሚያመጣ	<input type="checkbox"/>				

	ከሆነ					
4.20.2	ለመግዛት የሚያሳፍር ከሆነ	<input type="checkbox"/>				
4.21	የሚከተሉት ሰዎች የኔን ኮንዶም መጠቀም ይስማሙብታል	በጣም እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም	
4.21.1	የፍቅር ንደኛዬ	<input type="checkbox"/>				
4.21.2	የቅርብ ንደኛዬ	<input type="checkbox"/>				
4.21.3	ወላጆቼ (ዘመዶቼ)	<input type="checkbox"/>				
4.21.4	የሃይማኖት መሪዎች	<input type="checkbox"/>				
4.22	እኔ ማድረግ የምፈልገው...	በጣም እስማማለሁ	ልጠቃም ላልጠቃም እችላለሁ	አልስማማም	በጣም አልስማማም	
4.22.1	ፍቅረኛዬ እንዳደርግ የሚጠበቅብኝን ነው	<input type="checkbox"/>				
4.22.2	የቅርብ ንደኛዬ(ኞቼ) እንዳደርግ የሚያስቡትን ነው	<input type="checkbox"/>				
4.22.3	ወላጄ(ጆቼ) እንዳደርግ የሚጠብቁኝን ነው	<input type="checkbox"/>				
4.22.4	የሃይማኖት መሪዎች እንዳደርግ የሚጠብቁኝ ነው	<input type="checkbox"/>				
4.19	ከአሁን ጀምሮ በምፈፀመው የግብረ ስጋ ግንኙነት ኮንዶም መጠቀም ሃሳቤ ነው	<input type="checkbox"/>				

ክፍል አምስት

የወደፊት ዕቅድ

5.1	የኤች አይ ቪ ኤድስ ምርመራ አስ እንበል ለመመርመር ፈቃደኛ ትሆናለህ/ኛለሽ?	1. አዎ 2. አልሆንም
5.2	የኤች አይ ቪ ኤድስ ምርመራ አድርገሃል/ሻል እንበል የምርመራውን ውጤት ለመስማማት ፈቃደኛ ትሆናለህ/ኛለሽ?	1. አዎ 2. አልሆንም

በጣም እናመሰግናል!!

Declaration

I, the undersigned, declare that this is my original work and has not been presented in this or any other university and all sources of materials used for this thesis have been duly acknowledged.

Name *Saba Hailemeskel*

Signature _____

Date _____

Place _____

This thesis has been submitted for examination with my approval as University advisor.

Dr, Gail Davey

Associate Professor

School of Public Health

Addis Ababa University

Signature _____

Date _____

Place **Addis Ababa University**