Sexual Socialization of Adolescents in Addis Ababa: the Case of Adolescents in Ayer Tena Secondary and Preparatory School

A Thesis Presented to the School of Graduate Studies

Addis Ababa University

In Partial Fulfillment of the Requirements for the Degree of Master of Arts in Developmental Psychology

By: Roman Tadesse

June/ 2015

Addis Ababa University

School of Graduate Studies

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Acknowledgements

The completion of this thesis would not have been possible without the support of many people. First and for most my special thanks goes to my advisor Yekoyealem Desie (Ph.D) who should receive much credit for giving me valuable comments, suggestions and corrections.

I extend particular thanks to Ayer Tena Secondary and Preparatory School; especially to Ato Birhanu (the school director), Ato Fitsum (a coordinator of research project related issues at the school) and the participants of the study who make it possible the goal of this thesis with full cooperation during data collection and allowing me to use their resource.

I wish to thank my dear friends for their constant support, comments and encouragement throughout the research.

Lastly, my deepest thanks goes to my family who have been with me all these years helping and encouraging me to accomplish my study successfully.

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Lists of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
EDHS	Ethiopia Demographic and Health Survey
HIV	Human Immune Virus
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SS	Sexual Socialization

ABSTRACT

The purpose of the study was to investigate how adolescents get socialized about sexuality; the sources, areas/contents of sexual information/ and socialization and to identify whether there was gender difference in sexual socialization of adolescents. In addition, the study also aimed at examining the relationship between perceived adolescents sexual socialization and RH knowledge. The study design is a descriptive survey where a situation and the prevalent issues under the problem of the study were described. Data were collected from 259 adolescents (150 female and 109 male) using self-reported questionnaire. To select the participants stratified random sampling technique was employed. The finding indicated that with respect to both adolescents' preferred and current source of sexual information, peer groups were reported as the first source. Parents, particularly mothers were reported as the second preferred source while they were the least with respect to the current sources of sexual information for adolescents. The result of the study also indicated that adolescents were found informed/and socialized with specified areas of SRH issues such as about contraceptives; condoms and birth control, unplanned pregnancy, STIs and STDs including HIV/AIDS. The result of independent samples t-test revealed that there was a significant difference between female and male adolescents in parental sexual communication, perceived parent and peer approval of sexual behavior. Finally, the study indicated that RH knowledge has weak significant positive relationship with peer sexual communication, media SS, perceived parent and peer approval of sexual behavior. To conclude, peer groups were the main source of sexual information for adolescents followed by media and adolescents were found socialized with specified areas of sexual issues. The finding suggests a need to promote parents awareness about the importance of open parent-adolescent sexual communication in the effort to promote adolescents reproductive health and sexual behavior. In addition, there is a need for future in-depth study of the issue.

Key words: Adolescent, Sexuality, Sexual Socialization, Reproductive Health

Chapter One

Introduction

1.1Background of the study

Adolescence is a time between childhood and adulthood roughly corresponding to the second decade of the life span. It is a period of biological, psychological, social, legal, and economic transitions (Steinberg, 2011). The above statement suggests that adolescence is a time of transformation in many areas of an individual's life and where adolescents' need parental and other community members' guidance.

Adolescence is a developmental period where individuals are required to be educated, trained and socialized with different kinds of skills in life, including about sexuality in order to full fill a useful role in the society (Arnett, 1992). This is because as Shtarkshall, Santelli, and Hirsch (2007) and Steinberg (2011) stated, sexuality is an essential component of healthy development for adolescents and at the same time adolescence is the most important period in the life span for sexuality development.

Sexuality refers to the biological development and cultural components that include "sexual values, beliefs, thoughts, feelings, relationships and behavior" (Arnnet, 2004, p. 285).

Adolescence incorporates three major developmental changes that trigger the development of human sexuality; suggesting a particular need for sexual socialization at this time. According to Steinberg (2011), the first change observed is physical changes of puberty which is marked with hormonal changes resulting in a dramatic sexual development and

reproduction among adolescents. Second, there is a growth of sophisticated thinking or intellectual capabilities which results in the increased capacity of adolescents to understand and think about sexual feelings leading to develop interest in sex. Third, in this period there is a new social meaning attached to sexual and dating behavior in the life cycle of individual's that makes sexuality an important psychosocial concern during this period. In other words, adolescence is a turning point in the development of sexuality because it marks the onset of deliberate sexually motivated behavior that is recognized both by oneself and others as mainly sexual in nature (Steinberg, 2011) and adolescents require guidance/ and socialization on healthy sexual behavior.

Like any other aspects of psychosocial growth, the development of sexuality and sexual behavior is determined by its context in which children and adolescents are taught and trained about through sexual socialization process (Steinberg, 2011).

Sexual socialization sometimes called sexualization refers to a lifelong process by which a person acquire and develop sexual skills, knowledge, values, attitudes, and expectations for sexual relationships within specific cultures and contexts from such source as parents, peers, media, and the school/ or teachers (L'Engle & Jackson, 2008; Lloyd, 2007).

Sexualization begins at home during childhood period where children are exposed to messages about modesty, and privacy, including gender-specific messages about proper conduct and also takes place outside the family context as children and adolescents start to observe community norms, use media, participate in cultural and religious activities and attend school (Shtarkshall et al., 2007; Joshi, 2012).

Sexual socialization may include learning about moral values around sexuality, dating and sexual behavior, about premarital sex, unplanned pregnancy, STDs, AIDS, contraceptives; condoms and birth control pills (Lefkowitz & Stoppa, 2006; Shtarkshall et al., 2007; Joshi, 2012).

Literature indicated that even though sexualization of adolescents' starts at an early age and incorporate different topics, it takes place differently across cultures and gender.

As stated in Steinberg (2011), with respect to ways of adolescent sexual socialization, cultures generally classified in to three broad categories as restrictive, semi-restrictive, and permissive.

There is also a double standard in the cultural view of adolescent sexuality in many cultures where expected sexual behavior differs considerably between boys and girls. In many cultures boys are more or less expected to become sexually experienced before marriage while girls are expected to be virgin till marriage (Conger, 1991; Santrock, 2003). Similarly, in Ethiopian context many cultures clearly disapprove of premarital sex particularly for girls (Negussie, Sundby, Holm-Hansen, & Bjune, 2002).

In addition, Joshi (2012) stated that in the contents of teen magazines, one of the most important sources of sexual information for adolescents, there is more sexual risk and negative consequence of sex messages for girls than for boys showing gender-specific nature of contents of sexual information in sexualization (SS) process. This gender difference in sexualization may reinforce the dominance of boys and the subordination of girls in sexual relationships creating a condition which may weaken girl's autonomy to negotiate for safer sex in sexual relationships

(Munthali, Chimbiri, & Zulu, 2004) which intern may affect reproductive and sexual health of female adolescents.

However, sexual socialization; particularly parent-child sexualization and sexual communication is assumed to be important influence of adolescents' sexual beliefs, attitudes, and behaviors which is linked to a later onset of sexual activity, and healthy sexual behaviors such as less sexual risk taking, a more consistent use of condoms and other contraceptives among adolescents (Hutchinson & Cederbaum, 2011). Socializing adolescents with skills that leads to healthy sexual behavior will help to prevent and control reproductive health problems including STI's among adolescents and the general public.

Sexual and RH becomes a major area of concern during the period of adolescence since sexual activity is one of the risky behaviors observed at this time than the rest of other developmental period (Arnett, 1991) and adolescents becomes victims of negative health consequences including sexually transmitted infections (STIs), HIV, unplanned pregnancy, and unsafe abortions (Arnett, 1992; Kotchik, Shaffer, Forehand, & Miller 2001; DiClemente & Crosby, 2003). In addition, adolescent's lack of awareness and knowledge about such sexual health problems (Mehta, Kaur, Kumar, Chawla, Malik, & Kharti, 2013) has increased a concern about sexual and reproductive health issues during this period. These issues and other related factors make sexualization important during this period in the effort to prevent those sexual and RH problems. Therefore, in this study adolescent sexual socialization and the association with reproductive health knowledge were assessed.

1.2 Statement of the problem

From the researcher's observation, adolescents particularly those living in urban areas seems become sexually active and involve in risky sexual activity may influenced by peer pressure and exposure to different kinds of socializing agents like social media where they may not get the right information about sexuality. This condition combined with their low level of awareness and knowledge about sexual and reproductive health issues lead adolescents to different kinds of sexual and RH risks. In addition, the increase in the age of marriage, particularly in urban areas increased the likelihood of premarital sex (Brooks-Gunn & Pailkoff, 1997, cited in Crockett et al., 2003) that may carried out with inadequate knowledge about its consequences. The lack of awareness and knowledge about SRH issue among adolescents seem resulted from lack of sexual socialization/ and communication between agents of sexualization and adolescents.

Furthermore, the sexual risk taking behavior of adolescents' combined with the absence of sexual knowledge and skills in sexual activity among adolescents, particularly in a country like Ethiopia where the adolescents constitute the highest percentage of the population (47 percent; Ethiopia Demographic and Health Survey [EDHS], 2011) will be the source of many health and social problems including sexually transmitted infections (STIs), HIV, unintended pregnancy, and unsafe abortions and other RH related problems which may continue throughout adulthood.

In an attempt to assess the efforts made by different sexual socializing agents in providing adolescents with sexual skill and knowledge, there were different studies conducted in our country on such topics as parent-adolescent communication on sexual and RH matters, RH

knowledge and attitude among adolescents, factors affecting parent-adolescent discussion on RH issues (Tegegn et al., 2008; Yadeta et al., 2014, & Shiferaw et al., 2014) and other related topics. However, those studies were carried out among adolescents who were living in a context different from Addis Ababa. In addition, they have not clearly stated areas of adolescent's sexual socialization and the association between sexual socialization and reproductive health knowledge.

Therefore, the present study assessed adolescent sexual socialization and the relationship between sexualization (SS) and reproductive health knowledge among adolescents in Addis Ababa.

1. How do adolescents get socialized about sexuality (sources of sexual information, areas/contents and contexts of sexual socialization)?
2. Is there gender difference across the contexts in areas/contents of sexual socialization of adolescents?
3. Is there a relationship/association between perceived adolescent's sexual socialization and adolescent reproductive health (RH) knowledge?

1.3 Objectives of the study

The general objective of the study is to examine the sexual socialization of adolescents in Addis Ababa.

The specific objectives of the study are to:

- Examine the sources and areas of sexualization and which developmental context is the most source of sexual information for adolescents in terms of sexual socialization.

- Assess whether there is gender difference across the contexts in terms of adolescent sexual socialization.
- Assess whether there is a relationship between adolescent sexualization and reproductive health knowledge.

1.4 Significance of the study

Assessing present problems in adolescent sexual socialization may contribute to aware those who are working on adolescent's SRH issues to intervene on the gaps that would be investigated so that it would help to develop reproductive health knowledge and healthy sexual behavior among adolescents. In addition, the study will serve as a base for those who may have interest to explore the issue further.

1.5 Delimitation

The scope of the study was delimited to assess adolescent sexual socialization and to see the association between perceived adolescent sexual socialization and adolescent reproductive health knowledge. The setting of the study was delimited to Ayer Tena Secondary and Preparatory School which is found in Kolfe Keraniyo Sub-city; wereda 04. The sub-city is the most populous sub-cites of Addis Ababa constituting a total population of 428, 895, of this adolescents account for about 104, 512 (Office of Population Census Commission, 2007). The Sub-City is divided in to 15 administrative weredas. And wereda 04 which is previously known as Kebele 01/05 constitute about 76, 076 size of population out of the sub-city's total population (Office of Population Census Commission, 2007). The study is delimited to Ayer Tena Secondary and Preparatory School due to resource and time limitations.

1.6 Limitation

In the assessment of sexual socialization, the study participated adolescents from one preparatory school which may limit the researcher to make generalization of the findings to the general adolescent population. Limitation of the available related literature and studies conducted in the Ethiopian context was the other constraint of the study.

1.7 Operational definitions

- Adolescent: in this study refers to students who are attending preparatory class (grade 11 & 12).
- Sexual socialization: in this study refers to the process through which adolescents educated/trained and get exposure about sexuality to acquire sexual skills, knowledge, and values (Spanier, 1997; Steinberg, 2011).
- Reproductive health knowledge: refers to the knowledge adolescents have about safe sexual practice/ or the means to protect themselves from STIs, including HIV and unplanned pregnancy.
- Healthy/positive sexual behavior: in this study refers to such behavior as practicing safe sex (using contraceptives/condom and birth control pills) and having sexual relationship with a single partner/ or having such perception.
- Areas of sexualization: refers to those areas of sexuality that adolescents received awareness about such as sexual relationship, STIs, including HIV/AIDS, unintended pregnancy and safe sexual practice /or use of contraceptives (condom and birth control pill).

Chapter Two

Review of Literature

2.1 Meaning of Adolescence

As it is used today, the term adolescence has a broader meaning. It refers to the span of years between childhood and adulthood- roughly corresponding to the teenage years. That is, the second stage of development in the life span (10-19years). It is a period of transition in individuals' biological, psychological, social, legal, and economic status and, a time of growing up, moving from the immaturity of childhood in to the responsibility of adulthood and a time where individuals prepare themselves for the future (Steinberg, 2011). Similarly, in Moshman (2005) adolescents are described as individuals encompassing ages from 10 through 19 /or sometimes from ages 11 through 22; roughly referring to teenage years or teenagers. All of these definitions reflect a widely shared understanding of an adolescent as an individual who is no more a child but not an adult too.

Adolescence is a developmental period where individuals required to educate, trained and socialized with different kinds of skills in life so that they can able to fulfill the societal expectations (Arnett, 1992).

According to Mehta et al. (2013), there are about 1.2 billion adolescents in the world and nine out of ten living in developing countries. This figure is also true for Ethiopia where the young generation constitutes the highest percentage (47 percent) of the total population and adolescents or individuals aged 10-19 years alone account for 25 percent, while only about 4 percent of Ethiopians are over age 65 (EDHS, 2011).

2.2 Sexual socialization of adolescents

2.2.1 Sexuality during adolescence

Adolescence is a developmental period accompanied by sexuality which poses fundamental challenges for young people, including adjusting to the changes in appearance and functioning of a sexually maturing body, confronting with societal sexual attitudes and values, experimenting with sexual behaviors, and integrating these feelings, attitudes, and experiences into a developing sense of self. Adolescents' response to these challenges is strongly influenced by the social and cultural contexts in which they are living in (Crockett, Raffaelli, & Moilanen, 2003). In many societies adolescent sexuality has been viewed as inappropriate and worrying rather than as normal and healthy; reflecting cultural mores about premarital sexual activity and a concern about the risks of sexual activity (Crockett, et al., 2003; Steinberg, 2011).

Suggesting the various cultural practices and values that may influence young people's behavior, attitudes and motivations related to sexual and reproductive health issues; one of which is the sexual socialization process.

2.2.2 Meaning of sexual socialization

Sexual socialization is a broad term referring to several interrelated social-psychological components of the developmental process including development of gender roles and identity, acquisition of sexual skills, knowledge, values and attitudes which collectively determine one's own sexual self-concept, values, attitudes and behavior (Spanier, 1997).

Similarly, L'Engle and Jackson (2008) defined SS as a lifelong process beginning during the period of childhood increases in adolescence, and continues throughout adulthood by which a

person learn and internalize sexual knowledge, skills, attitudes, norms, and expectations for sexual relationships within specific cultures and contexts.

With respect to ways of adolescent sexual socialization, cultures generally classified in to three broad categories as restrictive, semi-restrictive, and permissive. Restrictive cultures place strong prohibition on adolescent premarital sexual activity that could be enforced in different ways such as strict separation of boys and girls from early childhood, placing strong social norms, physical punishment and public shaming. On the other hand, in semi-restrictive cultures, even if there is prohibition on premarital sex, the prohibition is not that much strongly enforced. Adults in this culture tend to ignore evidence of premarital sexual behavior as long as young people are fairly discreet. Conversely, permissive cultures encourage and expect adolescent sexual activity (Steinberg, 2011).

Sexualization begins at home where parents have the opportunity to emphasize their most deeply held values; whether or not it is shared by the larger society and it continues to take place outside the home as children and adolescents begin to take part in the larger cultural/social contexts, including observing community norms, listen/or view media, and participate in cultural and religious activities (Shtarkshall et al., 2007).

2.2.3 Sources of sexual socialization

It is important to note that many research findings indicated that most psychological traits and behaviors in adolescence are influenced both by nature and nurture (Steinberg & Morris, 2001). Similarly, Kotchick, Shaffer, and Forehand (2001) supported the influence of nurture (social contexts) on adolescent sexual behavior in their review on adolescent sexual risk-taking

behavior. That is the social contexts including family, peer, school, media and the neighborhood in general were found to be the sources of sexualization and play influential role for the development of adolescent's sexual behavior (Kotchick et al., 2001; Mehta et al., 2013).

For instance**,** Tegegn, Yazachew, and Gelaw (2008) conducted a community-based cross - sectional study in Jimma Town, South West Ethiopia to determine reproductive health knowledge, attitude and providers preferences among adolescents. A sample size of 1130 adolescents in the age group 15 to 19 years participated in the study. From 21 kebeles found in Jimma town, 9 kebeles were included in the study using lottery method. The first respondent from each kebele was identified using lottery method and then systematic sampling techniques were used to identify the other respondents. A pre-tested structured questionnaire was administered to adolescents.

The result showed that the respondents know the major health service for RH (reproductive health). That is, about 95% adolescents know family planning services followed by voluntary counseling and testing for HIV/AIDS (92.4%). Most of the adolescents know the major service providers for RH. In addition, the finding stated that the major sources of information for the respondents on RH issues were media; radio (80.4%) followed by television (73%), school teachers (71.8%), peer groups (69.9%) and family/relatives (40.3%). And the researchers have concluded that the level of knowledge and attitude about health service for SRH, sources of information for these services, and service provider centers is encouraging whereas the role of health professionals and families as the source of information for the adolescents seems low. In this study although the level of their importance as a source of information is low, in terms of sexual socialization, family was found to be one of the sources of

sexual and reproductive health information for adolescents following media, particularly radio and TV.

This finding suggests the existence of some factors that affected/prevented parents from becoming the main source of sexual information for adolescents. For example, a cross-sectional study conducted on factors affecting parent-adolescent discussion on reproductive health (RH) issues in Harar town, Eastern Ethiopia by Yadeta, Bedane, and Tura (2014) identified a number of factors affecting parent-adolescent sexual communication. Multistage sampling techniques were used for the study; stratified the population by weredas (districts) and from each wereda one kebele was selected using simple random sampling technique then a systematic sampling method was employed to select the households. 751parents of 10 to 19 year-old age adolescents; who were randomly selected participated in the face-to-face interview, conducted using a structured standard questionnaire which consisted questions on socio-demographic characteristics, knowledge about RH, attitudes towards reproductive health, and discussion of RH related questions. The interviews were conducted with the local language (Amharic) in a private place. Socio-demographic characteristics related to parent's knowledge, attitude, socio-cultural norms, time constraints, and perception of initiating discussion about sex were used as independent variables, while discussion was used as dependent variable. To supplement data obtained through quantitative method, focus group discussion (FGD) was employed between purposively selected parents of the sample who completed the survey.

Yadeta et al. (2014) came up with the finding that more than one-fourth (28.76%) of parents reported discussing RH issues with their adolescent in the last six months and parents who have confirmed good RH knowledge and positive attitude towards RH issues were six times

and seventy percent higher in disusing RH issues with their adolescents than their counterparts, respectively. The researchers concluded parent-adolescent discussion about RH issues rarely occurs and is restricted by lack of knowledge, socio-cultural norms, and parental concern that discussion would encourage premarital sex.

Similarly a school based study conducted by Shiferaw, Getahun, and Asres (2014) to assess adolescents' communication on sexual and reproductive health matters with parents and associated factors among secondary and preparatory schools' students in Debremarkos town, North West Ethiopia. A sample size of 679 respondents who were selected using simple random sampling technique was participated in the study. A structured self-reported questionnaire with close ended questions after pretest was employed to collect the data. Shiferaw et al. (2014) found that although the majority (88.7%) of participants accepted the importance of discussing SRH issues only about 36.9% were found discussing on at least two topics of SRH issue with one of their parents. That is about 25.9% were found discussing with their parents, particularly mother (18.5%) on contraceptives, followed by friends 20.5%. 57% of participants found having knowledge about SRH issues.

Among mentioned sources of information for SRH issues by participants TV and school accounted 48.3% and 42.6% respectively while friends and parents, particularly mothers accounted only for 28.8% and 24.3% respectively. Similar with previous study, media were found play an important role in informing adolescents about SRH issues (such as about premarital sex, unplanned pregnancy, STIs, contraceptives, and condom). Of the reasons not to discuss SRH issue with parents, the study found somehow similar influencing factors including parents' lack of knowledge and communication skills on SRH issues which accounted 21.8% and

20.8% respectively. In addition, shame to discuss particularly on unplanned pregnancy and condom accounted for 23.5%. Furthermore, adolescents' willingness or level of acceptance to discuss on SRH issues, adolescents' previous exposure to such SRH information, and adolescents' level of experience on sexual activity (sexual intercourse) were found to be an important variables positively associated with parent-adolescent communication on SRH issues while being grade 12 student and having less than three family size found to be negatively associated with parent-adolescent communication on SRH issues (Shiferaw et al., 2014).

The researchers concluded that parent-adolescent communications on sexual and RH issues is low, only about one third of the students reported communicating on SRH issues with their parents. The findings from this research like the other previous studies indicated low level of parent- adolescent communication on SRH issues and the available one is mainly between the mothers and the adolescents; suggesting limited communication between father and adolescents. Similarly, parental lack of knowledge and communication skills about SRH issues and cultural mores to talk on such issues with adolescents were found as the reason for low level of parent-adolescent sexual communication. In addition, family socio-economic status including family size, adolescents' willingness to discuss about the issue, previous exposure to such information and experience of sexual activity, and grade level were found to determine the level of parent-adolescent communication/discussion on SRH issues.

However, though there is limited parent-adolescent sexual communication and there is likelihood of adolescents to experience sexual socialization from other sources; including schools, media, and peer groups, parents found continue to play a major role in providing unique messages and interpreting messages from other sources (Lefkowitz & Stoppa , 2006).

L'Engle and Jackson (2008) conducted a study on socialization influences on early adolescent's cognitive susceptibility and transition to sexual intercourse. Similarly, the finding identified parents, schools, peers, and media as socializing agents in the development of sexual behavior among adolescents; showing that how the contexts or the environment where adolescents are living in and interacting with has influence on their sexual behavior. One of the most influential contexts in the adolescents' development is the school where adolescents are expected to spend much of their time and which have positive influence particularly on adolescent sexual and reproductive health development. Schools are contexts where sexual socialization is carried out formally through sex education class/or other health promotion programs with the intention to promote sexual literacy among adolescents by which many health and social problems such as STDs, unintended pregnancy and other health problems would be prevented (Shtarkshall et al., 2007).

Similarly, Lloyd (2007) carried out a review of study on the role of schools in promoting adolescent sexual and reproductive health and found that school played the most important role in the socialization of the young, has the potential to influence students' aspirations, motivations, and risk taking behaviors. That is, the teacher's behavior and attitude towards their students found to affect the likelihood of adolescent's to engage in premarital sex while they are in school, as well as performance on exams and the likelihood of dropout, particularly for girls. In addition, Lloyd (2007) stated that students with better socioeconomic and more supportive families, those doing well academically and receiving encouragement from their teachers were more likely than others to avoid the risk of school dropout by either avoiding sex, engaging in protected sex, conducting safe abortion, or negotiating with parents to refuse or delay early

marriage arrangements. This review, similarly with previous studies, showed the role played by schools (the teachers) in socializing adolescents with responsible and health seeking behavior and skills in the effort to promote adolescent sexual and reproductive health.

In addition, Lloyd (2007) stated the socioeconomic status of families affect the development of health seeking behavior of adolescents as a factor determining parent-adolescent sexual communication in terms of sexual socialization to promote adolescent sexual and reproductive health.

A study conducted on adolescent reproductive and sexual health in India by Mehta et al. (2013) similar with previous studies stated that every single day influence of parents helps in shaping up adolescent's life. That is, parents play a great role in influencing adolescents' risk-taking behavior and other self-distractive tendencies in the process to improve adolescents' health. Apart from parents, Mehta et al. (2013) stated teachers/ school and health programs play an influential role in determining adolescents' health by screening for common disorders, providing nutritional counseling, reproductive and sex education.

Furthermore, Mehta et al. (2013) stated proper psychological environment prevents risk-taking behavior, unsafe sex and spread of STIs and HIV. It also provide adolescents' with health service that has established in a way to provide service in a separate timing to ensure confidentiality and use the opportunity not only to treat medical problems but also to counsel about diet, life style, positive health practices that needs to be adopted among adolescents which further prevent health problems in adulthood.

2.2.4 Areas of sexual socialization

Lefkowitz and Stoppa (2006) conducted a review of study on positive sexual communication and socialization. In their review they identified the process of communication as important as what is actually communicated/ or the contents in adolescent sexual socialization for positive sexual development. Parents found socialize adolescents about sexuality, particularly their daughters' through their belief systems, content of conversation, style and process of communication and parental belief systems (values and attitudes) about sexuality found to influence parent-adolescent sexual communication.

Accordingly, some parents found follow risk-preventive perspective in teaching their children particularly their daughters' to avoid the risks of sexual activity or provide protecting mechanisms form STDs and pregnancy by encouraging the use of contraceptives; condom and birth control pills while some other parents generally focus on teaching about sexuality. In addition, an individual belief system found influence what behavior the person describe as acceptable and appropriate; that is, some parents believe in abstinence until marriage while others accept sexual activity in a committed relationships as long as it is safe, or others believe that their children should wait until a certain age or set age limit to proceed with sexual activity and try to transfer such belief to their children through sexual communication and socialization (Lefkowitz & Stoppa, 2006).

For instance, the study of Raffaelli and Ontai (2001) found limited parent-adolescent discussions on sexual issues such as menstruation, physical development, sexual intercourse and pregnancy, morality around sexuality, appropriate behavior, and dating while there were extensive discussions on the risks of sexual activity. And those sexual communications were

found to be indirect expectations, lacked openness and provided little information on how to prevent negative sexual outcomes; which indicates parental belief systems on what sexual issue to give focus in sexualization and how to transmit such messages.

However, some of the topics that most frequently discussed between parents and adolescents include STDs and AIDS, sex, dating and sexual behavior, pregnancy, abstinence, and particularly physical development, puberty and menstruation with younger adolescents (Shtarkshall et al., 2007; Joshi, 2012).

In addition, Regnerus (2005) stated parent-adolescent sexual communication/discussion also include the moral and religious aspects of sexuality including such topics as whether premarital sex is okay, about the regrets resulting from not waiting until marriage, and the general moral aspects related to sexuality.

In general, apart from the above mentioned areas of sexual issues that adolescents get socialized with, sexual communication and socialization may include other sexual behaviors such as private sex (masturbation or wet dreams), kissing and making out, oral sex, holding hands, other affectionate gestures, messages about sexual identity and sexual orientation; which could take place both at home and outside the home (Lefkowitz & Stoppa, 2006).

For instance, teen magazine; which is one of the media source of sexual information for adolescent in terms of sexualization, provide information to adolescents on sexual desires; including about feelings of sexual pleasure, and sexual danger/risks like women's abuse and harassment, virginity loss, rape, and similar with parents provide information on unplanned

pregnancy and STDs (Joshi, 2012) suggesting some difference in contents of sexual messages transferred to adolescents across different sources of sexualization.

The messages transferred to adolescents from parents seems range from the risks of sexual activity to the protective mechanisms and to some extent about physical development/changes; while medias found to provide some additional or different messages like sexual desire that was not covered at home by family members. In their communication, parents were found both concerned with risk-prevention and teaching about the general aspects of sexuality. Which suggests in both cases of their concern parents can socialize adolescents with the risks of sexual activity and the means to protection mechanisms from negative consequences of sexual activity, or teach them the necessary skills in their sexual interaction, transfer moral values and attitudes related to sexuality which will in turn determine overall sexual behavior of adolescents.

The above studies have shown how the areas/content of sexual socialization is broad. However, the main areas of sexualization were found to be on moral values related to sexuality, physical development, puberty, menstruation, dating and sexual behavior, sex, abstinence, pregnancy, STDs and AIDS.

Hutchinson and Cederbaum (2011) conducted a study to examine late-adolescent females' reports of their fathers' contributions to their sexual socialization. A sample of 234 young women, between the age of 19 and 21, selected using convenient sampling method were participated in the study. Interview schedule (including both close and open-ended questions) consisted of sections that begin with basic demographic questions and followed by sections on

parent-teen relationships, sexual communication with mothers, and sexual communication with fathers were used.

The finding stated that, fathers' contributions were found to be supportive rather than informational. That is, father's were found providing a frame of how one should be treated and the implications of engaging in sexual behavior which was intern found to provide participants with a guide for making choices about engagement in sexual activity. In addition, fathers found empowered their daughters to make healthier choices about relationships and sexual behavior by sharing their viewpoints with their daughters (Hutchinson & Cederbaum, 2011).

Ballard, Sugita, and Gross (n. d.) conducted a qualitative investigation of the sexual socialization of emerging adults to examine the influence of social context on sexual development and behavior using an ecological approach. A sample of 20 emerging adults (10 male and 10 female, who were selected from variety of academic majors and four ethnic back ground (Caucasian; n= 12 or 60%, African America; n= 4 or 20%, Hispanic; n= 3 or 15%, and multiracial; n= 1or 3%), 60% of which grown up in suburbs, 90% (n= 18) from average to well of families, and 90% (n= 18) with heterosexual orientation, 50% were single and not involved in sexual relationships at the time of investigation, and 50% who were casually dating or cohabiting participated in the study. In-depth interview with semi-structured questions were used to collect the data on sexual socialization of emerging adults during their high school years. Questions were developed on such main topics like community level norms, religion, education, personal decision making, family, peers, and media then piloted two times prior to the final study. Interviews which lasted for approximately 45 minutes each were tape recorded and transcribed.

Data were analyzed using NVivo and thematic analysis including open coding, axial coding, and selective coding.

Finding stated that respondents had parental mentoring on their dating, internet use and TV show programs viewing. Both boys and girls found learned the importance of condoms and other contraceptives (pills) to avoid risks of sexual activity like unplanned pregnancy and STDs at schools. And media were found to influence respondents in normalization of sexuality and desensitization. Medias' normalization of sex were expressed in terms of such show like teenage pregnancy and teen mom shows which were presented as something normal to be viewed and talk about in public. Apart from this, respondents have reported that; the videos, movies, and the way artists (movie stars and musicians) dress and act were in a way of throwing sex directly in to peoples' face; as a normal thing to do and fit in the society (Ballard et al., n. d.).

2.2.5 Gender difference in sexual socialization

Raffaeli and Ontai (2001) conducted an exploratory study of sexual socialization in Latino families using scripting theory, which states sexual behavior as a product of the interplay between cultural scenarios, interpersonal scripts, and intra psychic scripts (Simon & Gagnon 1986, 1987 cited in Raffaelli & Ontai, 2001). The study participated 22 Latino/Hispanic women; aged 20-45 years old, who had grown up in Spanish speaking families and lived in USA for at least 8 years, drew on an opportunity sample of those who responded to mailings to Latino faculty and staff at Midwestern University. To collect the data in-depth interview guided by interview schedule constituting both open-ended and structured questions dealing with three main topic areas i.e., sexual communication and family reaction to daughter's emerging sexuality, early romantic and sexual experiences including parental rules and messages about

dating, and sexuality related beliefs, attitudes, and behaviors including pregnancy history, contraceptive use, and life-time partner were used. Interviews were lasted an hour to an hour and half, and tape recorded. Data to open-ended questions transcribed professionally, checked for accuracy and corrected by trained research assistants then marked in qualitative data analysis and patterns of responses across respondents were tabulated while responses to structured questions entered in to an SPSS data file and analyzed using quantitative analysis techniques.

Raffaelli and Ontai (2001) came up with the finding that parents were concerned regarding their daughters interactions with boys and men during adolescence. The major cause for parental concern were found to be parental mistrust of males which was linked to fear of premarital pregnancy, worries about the family's image in the community which might be affected by their daughter's behavior and a fear that US-style of dating might violate their traditional forms of courtship and marriage. Therefore daughter's dating behavior was taken as the major source of dishonor to the family and may affect the family image in the community creating a tension on adolescents resulting from the conflicting interests between traditional courtship style and the reality of life in the USA.

In addition, due to their concern about their daughters sexual behavior during adolescence, Raffaelli and Ontai (2001) stated parents used different mechanisms to control their daughter's romantic activity; for example by setting such rules like age and location restrictions for dating; and some parents try to protect their daughter from male attention by prohibiting the use of makeup and revealing cloths while others even did not allow girls to have social contact with males which resulted in dating and sexual behavior of daughter's characterized by not having a dating or secret dating and sexual involvement; suggesting the prevalence of sexual

activity that may taken place without the knowledge of its risks/negative consequences which may result in negative health outcomes. For example, the finding stated that 19 of the 22 respondents found engaged in secret dating and premarital sexual intercourse; of which 11 respondents did not use birth control the first time they had sex, 6 respondents became pregnant soon after they began having sex. Concluded family practices related to sexuality have important implications for the intra psychic scripts formed by women.

Apart from parental concern about their daughters sexual behavior, the issues of gender difference in sexual socialization also explained in terms fathers discomfort /embarrassment to discuss sexual issues with their daughter while they were found comfortable to discuss sexual topics with their sons (Hutchinson & Cederbaum , 2011). In addition, gender difference in sexualization was observed in the contents of sexual information/messages that are transferred through media. For example, in the cross-national study of adolescent sexualization and teen magazine content analysis, Joshi (2012) found an emphasis on men's sexuality. And this prioritization of men's sexuality was found to be associated with women's lack of sexual desire; suggesting that girls are provided with sexual messages that would teach them to subordinate their own interest. In addition, Joshi (2012) stated in US magazines women were positioned as sex object, victims of men's strong sexual desire, and sexual risks like STDs while men were appeared not endangered as women; even though boys are also victim of the risks of sexual activity just as girls do.

This gender difference in the contents of sexual information coupled with the prevalence of double standard between boys and girls in the process of sexual socialization of adolescents may have an implication to the irresponsible actions of boys in their sexual behavior like rape.

For instance, while unwanted pregnancy is presented as negative outcome of girls sexual behavior, boy were not considered as responsible for such kinds of negative sexual consequence (Joshi, 2012).

2.3 The association between sexual socialization and sexual behavior

L'Engle and Jackson (2008) conducted a study to examine the relationship between perceived socialization from parents, school, peers, and media and adolescents' cognitive susceptibility to initiating sexual intercourse and predict the transition to intercourse 2 years later, in Central North Carolina school district, in 2001. Precoital adolescents' perception of sexual socialization from parents, school, peers, and media were analyzed to examine the relationship between perceived socialization from those socializing agents and adolescents' cognitive susceptibility to initiating sexual intercourse and transition to intercourse 2 years later. A sample size of 854 adolescents out of 1,200 (at the baseline) who were randomly selected from within four equal-sized race and gender strata, who at the baseline were 12-14 years old, seventh and eighth graders from three schools, and had not engaged in sexual intercourse completed baseline and follow-up survey. Data was collected by conducting in-home audio-computer assisted self-interview survey. Instruments were developed by the researchers and reviewed by experts. Piloting was conducted to test the comprehensibility and relevance of measures for the adolescent sample.

Findings showed that stronger connections to parents and schools and less exposure to permissive sexual norms from peers and media were associated with less susceptibility to sexual intercourse and sexual behavior, specifically among white adolescents. L'Engle and Jackson (2008) concluded that positive connections to parents and schools, less exposure to permissive

sexual norms from peers and media had health promoting associations with teens' sexual behavior. Similarly with previous studies, this research showed an important role parents, peers, schools and media play in socializing adolescents on positive sexual behavior which intern have an implication on the level of knowledge that adolescents would have about reproductive health issues. Particularly, parental and school connectedness and less exposure to permissive media were found to promote health seeking behavior among adolescents. However, it would be difficult to avoid adolescents' exposure to permissive media on sexual matters since at this time individuals are capable of searching for /or have exposure to such permissive media as they are interacting with the larger neighborhood/community as opposed to the childhood period where individuals are confined only to home or family context in their search for any information.

A similar study was conducted on the role of sexual socialization in the development of healthy sexuality among African American girls and young women by Day (2010) hypothesizing that certain sexual messages would impact a young women's feelings and beliefs surrounding her sexual experiences. The study aimed to address the role of developmental stages and assess the dynamic development of sexual socialization across adolescence, assess the role of peer communication, measure the content of parental and peer communication and investigate the role of sexual socialization in the development of healthy sexual outcomes. The research has been framed as separate studies conducted in two age groups; study 1 with college students and study 2 with high school students.

Study 1 was comprised of 334 participants who were emerging adults (aged 18-24; M=19.95, SD=1.31) recruited from a large Midwestern University with a population of 115, 299, all the participants were female African American undergraduate students and the majority

(80.7%) with heterosexual orientation. Participants completed measures assessing amount and content of sexual messages received from parents and peers, sexual assertiveness, condom use self-efficacy, and their feelings about their level of sexual experience (positive, negative, and shameful).

Day (2010) found both parents and peers communicate messages emphasizing sexual agency and a relational orientation to a similar degree and exposure to agency message from parents was associated with more positive affect, sexual assertiveness, and condom use self-efficacy. And many associations differed depending on participants' virginity status; showing that virgins receiving sex is natural messages from their peers reported higher negative sexual affect; conversely, coitally experienced participants receiving abstinence messages from peers showed higher level of negative affect.

In Study 2 measures assessing all of the same communication and subjective outcomes were completed by 73 participants (aged 14-18; with a mean age of 15.5years) selected from Midwestern high school with a population of 22,362, all of them were female African American adolescents with the majority (75%) having a heterosexual orientation, using Likert-type scale. Founding stated that although no messages were associated with sexual assertiveness, greater communication with parents was connected with positive affect and any communication with peers was connected with negative affect; and concluded that sex positive messages were associated with greater levels of condom-use self-efficacy (Day, 2010).

Findings across the studies indicated that African American girls and young women were receiving a wide range of sexual communication and several components of this communication

appear to facilitate their ability to negotiate desires and needs with a sexual partner, feel better and less shameful about their sexuality, and be comfortable in making use of condom (Day, 2010) which are indicative of the association of sexualization with the development of healthy sexual behavior among adolescents. Similarly, Lefkowitz and Stoppa (2006) stated more extensive sex-related communication, which is one expressions of parent-adolescent connectedness, has been found to be associated with reduced frequency of intercourse and unprotected sex.

Bastien, Kajula, and Muhwezi (2011) conducted a review of literature published between 1980 and April 2011on parent-child communication about sexuality and HIV/AIDS in Sub-Saharan African. Studies investigating the frequency, content, style, tone of discussions, preferences, as well as associations with and barriers to sexuality communication which related to behavioral outcomes associated with sexuality communication (sexual initiation, condom or contraceptive use) were reviewed. In addition, studies which examine behavioral associations with parent-child sexuality communication, and intervention studies to improve parent-child sexuality communication were examined. Parent-child sexuality communication has been identified as a protective factor for adolescent sexual and reproductive health promotion, including HIV infection prevention (Bastien et al., 2011). In addition, they have found wide variation in terms of frequency of discussions, with a range of socio-demographic and other factors associated with sexuality communication; discussions were tend to be authoritarian and uni-directional, characterizes by vague warnings rather than direct, open discussions (Bastien et al., 2011). The finding identified a number of barriers to open dialogue, including lack of knowledge and skills, as well as cultural norms and taboos. According to Bastein et al. (2011)

findings were less clear when it comes to association between parental communication and adolescent sexual activity and contraception use. However, Bastein et al. (2011) concluded that discussion on topics related to sexuality has been associated with a range of psychosocial attributes including increased knowledge, better interpersonal communication skills, including sexual negotiation skills, and self-efficacy. And communication about sexuality between parents or caregivers and children were found to be a protective factor for a range of sexual behaviors, including a delayed sexual debut, particularly for females.

Even though sexual socialization has been found to promote healthy sexual behavior among adolescents, there were found different kinds of barriers to effective sexual communication and socialization. For example, Wilson, Dalberth, Koo, and Gard (2010) conducted a study in four states of the United States to identify qualitative perspectives of parents on the factors that influence their communication with their preteenage children about sex and related issues using the framework of health belief model. A sample size of 131 parents of children aged 10-12; mothers/female guardians (67) and fathers/male guardians (64) who were between the age of 27 and 54, and recruited using telephone (for those households known to have a child between the ages of 10 and 12) supplemented by flyers, advertisements and contacts with community organizations and social workers participated in the study. To collect the data 16 focus groups; eight for fathers/ male guardians and eight for mothers/ female guardians; which involved 6 to 11individuals in one group were applied. Group discussions were lasted approximately an hour and a half and done separately across different demographic group (blacks, whites, English-speaking Hispanics, and Spanish-speaking Hispanics) and by moderators who were similar in gender and race with the participants to facilitate open

discussions and investigate the difference across such demographic variables. All discussions were tape recorded and transcribed by professional transcribers then content analysis was used to identify the main subject of discussion and patterns. While there were few guardian participants, the majority of participants (70%) came from intact nuclear families; where both the parents and their 10-12 year old child lived in the same household. Participants had educational status which is above the U.S average.

The finding came up with four discussions. Parent's perceptions of the threat to their children from sex related issues, benefits of talking to their children about sex, barriers to such communications and facilitators of such communication (Wilson et al., 2010). Parent's perceived threats of sex related issues were found to involve such issues as sexual messages in the media and the internet (i.e., easily accessibility of pornography on the internet and negative role models on TV, the explicit sexual contents of music and video games, and advertising), increasing teenage sexual behavior, peer pressure to have sex, HIV and AIDS, new technologies; text messaging, the internet and social networking sites make it difficult for participants to mentor their children's lives (Wilson et al., 2010). However, the study stated that participants were agreed that parents should talk to their children about sex to protect their children from negative consequences of sexual activity, including STIs and unplanned pregnancy. In addition, because children might get sexual information from various sources, participant parents felt that it is important to contribute their own input to correct any inaccurate information that their children might hear/see and to communicate their own values about sex.

As Wilson et al. (2010) stated participants perceived barriers to talk to children about sex were found to include parents perception that children are too young/not ready to hear about sex

(11%), lack of sexual communication skills (18%), lack of time (14%), lack of interest in parts of children and parent's embarrassment or discomfort to talk about sex with their children (39%), not giving attention about the need to talk about sex with their children; thinking that someone else could do it better (37%) and parents perception that talking about sex might encourage children to have sex (32%), and cultural barriers and poor parent-child communication (15%) Wilson et al. (2010). Apart from this, the finding stated factors that facilitate parent-child sexual communication such as developing and maintaining good relationship and open communication with children, creating opportunities to talk about sex; spending time with children, using books, religious teachings and church community as a support. In addition, discussing with children about what is happening in children's sex education classes (Wilson et al., 2010).

2.4 Summary and Implications

Sexual socialization generally defined as a lifelong process that begins in childhood and continues throughout adulthood; by which individuals learn and internalize sexual knowledge, attitudes, skills, norms, expectations for sexual relationships within specific cultures and contexts (L'Engle & Jackson, 2008). It begins at home and continues to take place outside the home as children and adolescents start to take part in different cultural and religious activities and use mass media (Shtarkshall et al., 2007).

Social contexts including parent, peer, school/ teachers, media, and the neighborhood in general were found to be the sources of sexualization and play influential role for the development of adolescent's sexual behavior (Kotchick et al., 2001; Tegegn et al., 2008, & Mehta et al., 2013). However, the level of contributions that each sources has in sexualization of adolescents were explained differently across the studies. For instance, Tegegn et al. (2008)

stated Media as the major source of sexual information for adolescents in the areas of the risks of sexual activity including STIs, STDs and unplanned pregnancy followed by school teachers while Lloyd (2007) found school play the most important role in the sexual socialization of the young. However, Lefkowitz and Stoppa (2006) stated that although as individuals reached the period of adolescence tend to experience sexual socialization from other different sources including school, media, and peer, parents continue to play a major role in providing unique messages and interpreting messages from other sources.

Adolescents get socialized in different areas including on the general moral values, beliefs and attitudes related to sexuality (Regnerus, 2005) by their parents based on their belief system. That is some parents believe in abstinence until marriage while others accept sexual activity in a committed relationships as long as it is safe, or others believe that their children should wait until a certain age or set age limit to proceed with sexual activity and try to transfer such belief to their children through sexual communication and socialization (Lefkowitz & Stoppa, 2006). Some other parents focus on teaching their children about the risks of sexual activity such as STDs and STIs, including HIV/AIDS, unplanned pregnancy while others focus on protective mechanisms of the risks of sexual activity, that is about the use of contraceptives; birth control and condom (Lefkowitz & Stoppa, 2006).

Study's on adolescent sexualization also showed some level of gender difference in socialization. That is sexual socialization and communication is mostly carried out between parent and female adolescent particularly, between mother and daughter (Raffaeli & Ontai, 2001; Shiferaw et al., 2014). In addition, there is a double standard for boys and girls in sexual socialization. That is in many cultures boys are more or less expected to become sexually

experienced before marriage while girls are expected to be virgin till marriage (Conger, 1991; Santrock, 2003). However, these studies have conducted in different cultural context and since sexual socialization is an issue mostly influenced by one's cultural and social context it needs to be investigated based on the study subjects social and cultural context before reaching in to conclusion about the issue based on the findings obtained from other different contexts. In addition, these studies have not stated the relationship/association between adolescents' perceived sexual socializations and reproductive health knowledge; which might be important in understanding adolescent sexual behavior and to promote the reproductive health and sexual behavior of adolescents.

Chapter Three

Research Methodology

3.1 Design of the study

The study design is a descriptive survey. This is because the study attempted to describe a situation and what is prevalent with respect to the issue/problem under study (Kumar, 2005).

3.2 Population

The study population was Ayer Tena Secondary and Preparatory School students. There were about 2592 preparatory students (1090 male and 1502 females) enrolled in 2007 (E.C) Academic Year.

3.3 Sample and sampling procedure

The researcher employed stratified random sampling technique. This technique was used because the researcher was required to divide the population in strata on the basis of gender and from each of these smaller homogeneous group (strata) draw at random a predetermined number of units (Kumar, 2005; Singh, 2006).

To determine number of participants the researcher used the "rule of thumb" estimate for sampling (Yount, 2006). The study population was 2592 constituting 1090 male and 1502 female students; about 1658 were grade 11 and the remaining (934) were grade 12. According to thumb rule the researcher has to take 5% from each stratum (see appendix 1). However, based on the suggestions/or a rule that the larger the sample size, the more accurate and representative will be the finding (Kumar, 2005; Yount, 2006), the researcher took 10% from each strata. That is, 1,090

*10/100 = 109 (male) and 1502 *10/100 = 150.2 (female) participants ranged from 16 to 20 years of age and of these about 123 were from grade 11 and 136 from grade 12 have taken part in the study.

3.4 Measures

To obtain the data the study employed self-reported questionnaire. The questionnaire which has included both open and close ended questions consists 46 items; 28 items were constructed by the researcher based on literature review while 18 of the items were adapted from other source (L'Engel & Jackson, 2008). In the process of adaptation items which were more relevant to Ethiopian context were selected. For example, adapted items include items like have you ever talked with your parents/ guardian how you should act on a date? Have you ever talked with your parents/guardian on the consequences of not using contraceptives? Have you ever talked about STI, including HIV, and other STDs with your friends? Items constructed by the researcher for example, include such items like from whom do you get most information on sexual matters? If you had a question on sexual and reproductive health issues whom do you prefer to ask? Have you ever talked about the consequences of having multiple sexual partners with your friends? Is there sex education class in your school?

The questionnaire is classified in to four parts.

Part I: This part of the questionnaire has 8 items. The purpose of these items was to collect data on the general background information of the respondents.

Part II: The second part of the questionnaire which consists 2 items was designed so as to get data on the most sexual information provider for adolescents. The items were prepared in such a way that adolescents give their response about their most information source on sexual matters.

The questions were designed to be answered by the respondents whom they prefer to ask about sexual issues and to rank as first, second, third and fourth separately their current sources of sexual information from the given choices/lists of sources of sexual information.

Part III: The third part of the questionnaire which consists of 32 items was designed to measure adolescent sexual communication and socialization (SS). The items were prepared in such a way that adolescents give their response on the areas of sexual communication and socialization (SS) that they have experienced through sources/agents of sexualization.

Items which were included in this part were designed to measure SS from four major sources.

1. **Parental sexual communication/socialization**

   There were 12 items under this sub-scale. The purpose of these items was to obtain data about whether or not adolescents have communicated with their parents on some identified sexual topics and to measure adolescents' perceived parent approval of sexual behavior, and also to measure whether or not there found gender difference in parental sexualization.

2. **Peer sexual communication/socialization**

   Under this sub-scale 8 items were included. The purpose of these items was to obtain and measure whether or not adolescents had sexual communication with their friends on some identified sexual topics and adolescents' perceived peer approval of sexual behavior.

3. **Media as source of sexual information**

   This sub-scale consists four items. The purpose of these items was to examine whether or not adolescents received information/ or socialized through media on identified sexual topics.

4. **School as source of sexual information**

   In this sub-scale 8 items were included. The purpose of these items were to measure whether or not adolescents communicated and /or received messages from school/ teachers on identified sexual matters and to assess adolescents' perceived teacher approval of sexual behavior.

Part IV: The fourth part of the questionnaire was designed to measure adolescent's common reproductive health knowledge. This part of the questionnaire consists 4 items.

Respondents' reported their response as (Yes or no) and 5 scales (Strongly agree, agree undecided, disagree, and strongly disagree).

3.5 Pilot test

Before the instrument was used for the actual data collection, it was translated in to Amharic and tested on a sample of 30 adolescents who were similar with study population (That is, the pilot test included both female and male adolescents from preparatory class; grade 11 and 12), on March, 5/2015. The purpose of the pilot test was to check the appropriateness or to improve the clarity, validity and reliability of the instrument. The validity of the instrument was checked by the advisor of the study and one health officer then the approval for the instrument content validity was obtained.

Another purpose of the pilot was to determine the time needed to administer the instrument. Accordingly, respondents took 20-30 minutes to fill out the questionnaire.

Based on the responses given on the pilot test items which lack clarity were rephrased while poor and vague items; that is, items which had lower reliability in the Item-Total Statistics result were discarded.

Finally, the reliability of the instruments tested for sexual communication and socialization questionnaire and common reproductive health knowledge and the reliability coefficients were found to be Cronbach alpha .74 and .94 respectively.

3.6 Procedures of data collection

In the process of data collection the following procedures were followed

1. One research assistant was employed on per diem bases and given orientation on how to distribute and collect the questionnaire.
2. Target group who were included in the study were gathered together and the questionnaire was distributed.
3. The purpose of the study was briefed for the participants so that they give their response freely.
4. Finally, after respondents completed the questionnaire, the data was collected.

3.7 Methods of data Analysis

After data collection, the process of coding instruments was done that is converting responses to numbers for the data entry. In addition, organizing open-ended and unstructured

information was made to analyze the information. Then data entry and analysis was made quantitatively using SPSS data processing program version 20.

Frequency, mean and cross-tabulations were used for descriptive statistics. The difference among variables was determined using independent samples t-test and One-Way ANOVA while Bivariate correlation were employed to see the relationship among variables.

In the process of quantitative data analysis, "Yes" and "No" responses were given 1 and 0 score respectively while strongly agree, agree, undecided, disagree, and strongly disagree/ or strongly approved, approved, undecided, disapproved, and strongly disapproved responses were given 5, 4, 3, 2, and 1 score respectively. For negatively stated items the scores were reversely given.

Finally, scores for each person/ participant consists the addition of the scores on each of the items under the scale. For example, scores on parental sexual communication scale; which is done for each participant were obtained through the sum scores of the 6 items under the scale which gave a maximum and minimum score of 6 and 0 respectively.

3.8 Ethical consideration

Prior to data collection the school director was contacted and informed about the whole process of the research project. Similarly, respondents were informed about the objective of the study and their right to participate or not to participate in filling the questionnaire. Furthermore, students told that their answer will be held confidential. Then after gaining verbal consent, the questionnaire was administered.

Chapter Four

Findings

This section deals with the description of main findings. In this section background information, descriptive analysis of variables, difference and relationships among variables were presented one after the other.

4.1 Background information

Table 1. Background information of the respondents (age and grade level)

		Grade		Total
		11	12	
Age	**16**	10	1	11
	17	47	18	65
	18	48	64	112
	19	9	40	49
	20	3	11	14
Total		117	134	251

Adolescents who were included in this study were from grade 11 and 12. As shown in Table 1 of the respondents who have reported their age (n= 251), the majority (n= 112) were 18 years of age and belong to grade 12. The maximum and minimum ages of respondents were 20 and 16 years old respectively.

Table 2. Respondents distribution by parents' education level and religion

	Father/male guardian		Mother/female guardian	
	N	%	N	%
Read and write	51	19.8	86	33.3
Completed primary education	53	20.5	61	23.6
Completed secondary education	70	27.1	67	26
Have college diploma	42	16.3	21	8.1
Have college degree and above	42	16.3	23	8.9
Total	258	100	258	100
Religion	N		%	
Orthodox	146		57	
Muslim	64		25	
Protestant	43		16.8	
Catholic	3		1.2	
Total	256		100	

Concerning parents' educational level 19.8% of fathers and 33.3% of mothers were found able to read and write. Only 16.3% of fathers and 8.1% of mothers were diploma holders and 16.3% fathers and 8.9% mothers were degree holders.

As indicated in Table 2 of the participants who have reported their religious affiliation, the majority (n= 146, 57%) were belong to orthodox religion followed by Muslims (n= 64, 25%) while there were a small amount of participants (n= 3, 1.2%) who were catholic religion followers.

4.2. Sexual Socialization of Adolescents

Adolescents sexual socialization was examined in terms of sources of sexual information and/ socialization, areas/contents and contexts of sexual socialization.

4.2.1 Sources of sexual information/and socialization

In order to assess the major sources, respondents were asked of their preferred and current sources of sexual information.

Table 3. Respondents' preferred sources of sexual information

	N	%
Mother/ female guardian	44	17.8
Father/ male guardian	8	3.2
Friend	179	72.5
Teacher	**7**	2.8
Sister/brother	6	2.4
Books and internet	3	1.2
Total	247	100

As indicated in the Table 3, friends were found to be the major preferred source of sexual information for the majority of the respondents (n= 179, 72.5%) followed by parents, particularly mother (n= 44, 17.8%)

Table 4. Current sources of sexual information

(by order of importance to the respondents)

Rank order	Family		Friend		School/teachers		Media	
	N	%	N	%	N	%	N	%
First	24	10	131	53.3	19	7.9	80	32.7
Second	27	11.3	77	31.3	36	15	101	41.2
Third	44	18.4	29	11.8	125	52.1	38	15.5
Fourth	144	60.3	9	3.7	60	25	26	10.6
Total	239	100	246	100	240	100	245	100

As indicated in Table 4, of the developmental contexts including parent, peer, school and media which were found to be source of sexual information/and SS for the adolescents peer groups/ friends were found to be the first and the most current source of sexual information for the respondents' (n= 135, 53.1%) followed by media (n= 104, 41.1%), school/teacher (n= 129, 52%) and parent (149, 60.3%) in the second, third, and fourth order respectively. In other words, peer, media, school and parent were given first, second, third and fourth rank order respectively by respondents according to their importance to the respondents as the current source of sexual information/ and SS.

This result supports the respondent's response to the question that aimed to asses whom respondents' prefer to ask questions on sexual matters. That is; about 179 (72.5%) of the respondents were preferred to ask their friends than others (see Table 3).

4.2.2 Areas/contents of sexual socialization

Areas/contents of adolescent sexual socialization were assessed through adolescents' level of sexual communication with parent, peer groups and whether they have seen or heard from media about specific areas of SRH issues and through adolescents perceived parent, peer and teacher approval on specific areas of sexual behavior.

Accordingly, concerning areas of sexual communication and socialization, Table 5 shows the majority of respondents (90.3%; n=130 female, n=104 male and 88%; n= 132 female, n= 96 male) were socialized about STIs including HIV/AIDS, unplanned pregnancy and consequences of not using contraceptives (birth control and condom) respectively while 87.6% (n= 132 female and 96 male) respondents were socialized about how they should act on a date through media. About 123, particularly female adolescents (47.5%; n= 87 female, n= 36 male) and 112 (43.4%; n= 71 female, n= 41 male) respondents were found communicated with their parents about the physical and psychological changes associated with puberty respectively (see Table 5).

Table 5. Areas/contents of sexual communication and socialization

Variable	Parent				Peer				Media			
	Female	Male	Total		Female	Male	Total		Female	Male	Total	
	N	N	N	%	N	N	N	%	N	N	N	%
About physical changes	87	36	123	47.5	-	-	-	-	-	-	-	-
About psychological changes	71	41	112	43.4	-	-	-	-	-	-	-	-
About how to act on a date	51	24	75	29	106	80	186	71.8	132	95	227	87.6
About contraceptives; condom and birth control	42	18	60	23.2	83	72	155	59.8	132	96	228	88
About consequences of having multiple sexual partners	67	34	101	39	109	77	186	71.8	127	96	223	86.4
About unplanned pregnancy, STIs and STDs including HIV/AIDS	74	50	124	48.1	87	79	166	64.1	130	104	234	90.3

4.3 Difference in sexual socialization of adolescents

Difference in adolescents' sexual socialization was assessed in terms of difference among female and male adolescents' in areas/contents of sexual communication and/ socialization, in parental age limitation to start on a date, in RH knowledge and difference in parental sexual communication as a function of parental educational level and religious affiliation.

Table 6. Independent sample t-test between female and male adolescent's for areas /contents of sexual socialization across the contexts

Variables	Gender	N	*M*	*SD*	t	Df	Sig.(2-tailed)
Parental sexual communication	Female	149	2.63	1.745	3.311	255	.001**
	Male	108	1.88	1.863			
Peer sexual communication	Female	150	2.57	1.308	-1.620	257	.106
	Male	109	2.83	1.216			
Perceived parent approval of sexual behavior	Female	150	8.19	3.076	-3.866	257	.000***
	Male	109	9.62	2.741			
Perceived peer approval of sexual behavior	Female	150	10.59	3.028	-4.245	257	.000***
	Male	109	12.21	3.028			
Perceived teacher approval of sexual behavior	Female	150	8.27	3.309	-1.358	257	.176
	Male	109	8.87	3.747			
Media sexual socialization	Female	150	3.47	1.034	-.985	256	.325
	Male	108	3.59	.843			
School sexual socialization	Female	150	8.81	3.451	-1.432	257	.153
	Male	109	9.47	3.865			

****** Significant at $P < 0.01$ *** Significant at $P < 0.001$

To find whether there is a significant difference between female and male adolescents in areas of sexualization that is in parental and peer sexual communication, perceived parent, peer, and teacher approval of sexual behavior, media sexualization (SS), and overall school sexualization (SS) independent sample t-test was used. According to the result of the study significant difference was observed among female and male adolescents with regard to parental sexual communication [t (255) = 3.311; $P < 0.01$], perceived parent approval of sexual behavior

[t (257) = -3.866; $P < 0.001$] and perceived peer approval of sexual behavior [t (257) = -4.245; $P < 0.001$].

However, there was no significant difference between female and male adolescents in areas/contents of peer sexual communication, perceived teacher approval of sexual behavior, media SS and overall School SS ($P > 0.05$; see Table 6).

This result suggests that female adolescents have communicated with their parents on many different topics of sexual issues than male adolescents and similarly there is more parent and peer disapproval of female adolescents' premarital sexual behavior than male adolescents. In other words, compared to male adolescents there is less parent and peer approval of female adolescents' premarital sexual behavior.

In addition, gender difference in sexualization were also assessed by for whom (whether for female or male respondents) that parents mostly set age limitation to start on a date and with whom (mother or father) that respondents communicate most on sexual issues; using both descriptive statistics/cross tabulation and independent t-test.

The result of descriptive statistics indicated that compared to male respondents (n= 24, 22%) large number of female respondents (n= 59, 39%) were provided with age limitation to start on a date by their parents. That is the result suggests parents mostly set age limitation to start a date for their female adolescents/girls than boys.

Similarly, parental communication on sexual matters were mostly found between mother and respondents (n= 135) particularly between mother and daughter (n= 93; see appendix 2).

Table 7. Independent sample t-test between female and male adolescents for RH knowledge

Variable	Gender	N	*M*	*SD*	t	Df	Sig.(2- tailed)
RH knowledge	Female	150	14.49	3.576	-.516	257	.607
	Male	109	14.72	3.553			

P > 0.05

In addition, gender difference tested for whether there is a significant difference between female and male adolescents for reproductive health knowledge using independent sample t-test. The result indicated that there is no significant difference between female and male adolescents [t (257) = -.516; *P* > 0.05].

Table 8. One-way ANOVA for parental sexual communication as a function of Fathers' educational level

Sources of variation	**Sum of squares**	**df**	**Mean square**	**F**	**Sig.**
Between groups	26.795	4	6.699	2.032	.090
Within groups	830.676	252	3.296		
Total	857.471	256			

P > 0.05: two tailed

As Table 8 shows there is no significant difference in terms of father's educational level in parental sexual communication [F (4, 252) = 2.032; *P* > 0.05]. This implies difference in

father's educational level does not make a significant difference in parent-adolescent sexual communication.

Table 9. One-way ANOVA for parental sexual communication as a function of Mother's educational level

Sources of variation	Sum of squares	df	Mean square	F	Sig.
Between groups	26.930	4	6.732	2.043	.089
Within group	830.541	252	3.296		
Total	857.471	256			

P > 0.05: two tailed

Similarly, as Table 9 indicates there is no significant difference in terms of mother's educational level in parental sexual communication [F (4, 252) = 2.043; *P* > 0.05]. This suggests difference in mother's educational level does not make a significant difference in parent-adolescent sexual communication.

Table 10. One-way ANOVA for parental sexual communication as a function of Religious affiliation

Sources of variation	Sum of squares	df	Mean square	F	Sig.
Between groups	24.690	3	8.230	2.525	.058
Within group	814.837	250	3.259		
Total	839.528	253			

P > 0.05: two tailed

As Table 10 shows there is no significant difference in terms of adolescents' religious affiliation in parental sexual communication [F (3, 250) = 2.525; *P* > 0.05]. This implies difference in religious affiliation does not make a significant difference in parent-adolescent sexual communication/and socialization. In other words religion is not a factor for parent-adolescent sexual communication.

4.4 Relationship between adolescents' perceived sexual socialization and reproductive health knowledge

Table 11. Correlation between adolescents' perceived sexual socialization and RH knowledge

	Variables	*M*	*SD*	1	2	3	4	5	6	7	8
1	Reproductive health knowledge	14.59	3.562	1							
2	Parental sexual communication	2.32	1.830	-.082	1						
3	Peer sexual communication	2.68	1.274	.131*	.090	1					
4	Perceived parent approval of sexual behavior	8.80	3.018	.139*	-.016	.068	1				
5	Perceived peer approval of sexual behavior	11.27	3.126	.162**	-.095	.041	.480**	1			
6	Perceived teacher approval of sexual behavior	8.53	3.506	.097	.014	.067	.227**	.288**	1		
7	School sexual socialization	9.09	3.638	.074	.001	.075	.194**	.251**	.983**	1	
8	Media sexual socialization	3.52	.959	.129*	.022	.305**	-.074	.036	.096	.092	1

*Significant at 0.05 ** Significant at 0.01

To see whether there is a significant relationship between adolescents' perceived sexual socialization and reproductive health knowledge Bivariate Correlation was used.

Accordingly, the result of the correlation between adolescents' peer sexual communication and RH knowledge, adolescents' perceived parent approval of sexual behavior and RH knowledge, and media sexual socialization and RH knowledge indicated a significant positive relationship (r = .131, .139, and .129 respectively at $P < 0.05$) even though the relationship was found to be weak. Similarly, significant weak positive relationship was observed between perceived peer approval of sexual behavior and RH knowledge (r= .162 at $P < 0.01$).

However, there was no relationship between parental sexual communication and RH knowledge, adolescents' perceived teacher approval of sexual behavior and RH knowledge and overall school sexual socialization and RH knowledge of adolescents (that is; r = -.082, .097 and .074 respectively; $P > 0.05$; see Table 11).

Chapter Five

Discussion

In an investigation of the sources of sexual information for adolescents, the result of the study indicated that friends/ peer groups were found to be the first/ the most preferred and current source of sexual information for the respondents followed by media in the second, teacher/school, and parent (in the third and fourth place respectively with regard to current source of sexual information). However, the results of adolescents' areas/contents of sexual communication and socialization across the contexts indicated media as the major source of information on the sexual areas that adolescents found socialized with (see Table 5).

This finding is somehow consistent with other study of (Shiferaw, Getahun, & Asres, 2014) which is conducted in Debremarkos town and Tegegn, Yazachew, and Gelaw (2008) which is conducted in Jimma town). According to the results of the findings of these researchers', media were found the main information source for adolescents on SRH issues. While parents were found to be the least source of sexual information for adolescents, and the available parent-adolescent sexual communications were mainly between the mother and the respondents.

Suggesting that media were playing their role in desensitizing adolescents about SRH issue as it was stated in the study of (Ballard, Sugita, & Gross, n. d.) who were found that media were influencing adolescents through its desensitization role on sexual issues. In addition, this finding suggests that adolescents' might have been afraid to ask about and discuss on sexual issues with their parents and rather preferring to ask/ discuss with their friends and listen/view media to have answers for their questions on sexual issues. Therefore, this might be the reason

why there was found low level of parental sexual communication/and socialization ,compared to other sources of sexualization, on assessed specific areas of SRH issues that respondents were found socialized with (see Table 5).

In an investigation of the areas of adolescent sexual communication and socialization, the result of the present study indicated that most of the respondents were found communicated/ and socialized with specific areas of sexuality such as contraceptives; condom and birth control, unplanned pregnancy, STIs, including HIV/AIDS, the physical and psychological changes of puberty and how they should act on a date. However, respondents were found socialized on those sexual issues mostly through media followed by friends/peer groups. In addition, the result indicated the majority of the respondents were socialized with disapproval of premarital sexual behavior, particularly parental disapproval of premarital sexual relationship and sexual intercourse for female adolescents.

This finding is consistent with the studies of (Lefkowitz & Stoppa, 2006; Regnerus, 2005) which are conducted on parent-adolescent sexual communication. In their finding these researchers stated that parents follow risk-preventive perspective in teaching their children particularly their daughters' to avoid the risks of sexual activity or provide protecting mechanisms form STDs and pregnancy by encouraging the use of condom and birth control pills while some other parents generally focus on teaching about sexuality; including the moral aspects. Similarly, Regnerus (2005) stated that parent- adolescent sexual communication/discussion include the moral and religious aspects of sexuality including whether premarital sex is accepted or approved, and the regrets that occur due to not waiting until marriage.

With regard to the investigation of gender difference in the process of adolescent sexual socialization (in areas/contents of SS across the contexts), the result of independent samples t-test showed that there was a significant difference between female and male adolescents in parental sexual communication, perceived parent and peer approval of sexual behavior.

According to the result obtained the mean value of parental communication was lower for male than that of female adolescents while the mean value of perceived parent approval of sexual behavior was lower for female than that of male adolescents. This shows that there was more parental sexual communication with female than male adolescents and there was more parent disapproval of sexual behavior for female than that of male adolescents. This may be due to as found in the present finding female adolescents are the one having the most sexual communications and socialization, particularly parental sexual communication and at the same time female adolescents have perceived greater parent disapproval on premarital sexual behavior than male adolescents, particularly in terms of premarital sexual intercourse.

In addition, the results from descriptive statistics indicated difference between female and male adolescents in parental age limitation to start a date. The result of the finding indicated that compared to male respondents' large number of female respondents found provided with parental age limitation to start a date. This suggests that parents tend to set age limitation to start a date for female than male adolescents. This is may be due to; as stated in Raffaelli and Ontai (2001) parental concern regarding their daughters' interactions with boys and men during adolescence. The major explanations they gave for parental concern were parental mistrust of males which was linked to fear of premarital pregnancy, worries about the family's image in the community which might be affected by their daughter's behavior. So that parents try to use

different mechanisms to control their daughter's sexual behavior/ activity including age and location restrictions for dating.

From the researchers observation and the results of the finding it is possible to conclude that this difference in parental sexual socialization and concern about female adolescents' sexual behavior during adolescence seems to be true for Ethiopian parents in general where there is observed societal and found statistical difference in parental reaction to female and male adolescent children's sexual behavior in which boys sexual behavior is more tolerable than that of the girls.

This finding is also consistent with studies of Shiferaw et al. (2014) who have stated the available parent-adolescent sexual communication was mainly between the mothers and the adolescents, particularly with female adolescents similarly suggesting parental concern about female adolescents' sexual behavior.

In addition, the present study revealed gender difference in perceived peer approval of sexual behavior. As the result of independent samples t-test shows there was significant difference between female and male adolescents in perceived peer approval of sexual behavior. According to the result obtained the mean value of female adolescents was lower than that of male adolescents. This shows that female adolescents experienced more peer disapproval of premarital sexual behavior than that of male adolescents. In other words compared to male adolescent peer groups there was more disapproval of premarital sexual behavior among female adolescent peer groups; suggesting the direct effects of difference in parental sexual socialization of their female and male adolescent children.

Furthermore, the study assessed difference in parental sexual communication as a function of parents (fathers' and mothers') educational level and religious affiliation. However, as the result of One-way ANOVA revealed parental educational level and religious affiliation does not make a significant difference in parent-adolescent sexual communication. This suggests that there might be greater influence of cultural contexts (accepted cultural/societal moral values related to parent-adolescent sexual communication) than parental educational level and religious affiliation on parental sexual socialization of adolescents and other factors that needs to be investigated.

In an investigation of the relationship between the two (adolescents' perceived sexual socialization from parent, peer groups, teachers/ school and media and reproductive health knowledge) the result of Bivarite Correlation revealed a significant weak positive relationship between adolescents' perceived sexualization (peer sexual communication, perceived parent and peer approval of sexual behavior, media SS) and reproductive health knowledge. The correlation was high for perceived peer approval of sexual behavior (0.162, $P < 0.01$) than perceived parent approval of sexual behavior (0.139, $P < 0.05$), peer sexual communication (0.131, $P < 0.05$) and media sexual socialization (0.129, $P < 0.05$; see Table 11).

This positive association between adolescents' perceived sexual socialization and reproductive health knowledge suggests that adolescents open discussion and having information on sexual issues and parental teachings of moral values around sexuality will promote adolescents sexual behavior and increase their knowledge about SRH issues.

Chapter six

Summary, Conclusion, and Recommendation

6.1 Summary

The study was conducted with a main objective of assessing the relationship between adolescent sexual socialization and reproductive health knowledge. In doing so the study first investigated how adolescents get socialized about sexuality; the sources of sexual information/socialization for adolescents, areas of sexual socialization, and attempted to identify whether there was difference in adolescents' sexual socialization across the contexts; that is in terms of gender difference in areas of sexual communication, parental age limitation to start a date/romantic activity, and difference in parental sexual communication as a function of parental educational level and religious affiliation.

To achieve these objectives the research employed self- reported questionnaire which was completed by a sample of 259 respondents (150 female and 109 male adolescent) who belong to preparatory class; about 123 were grade 11 and 136 were grade 12 and who were within the age group of 16 to 20. The sample size was determined based on the "rule of thumb" estimates of sampling and participants were selected based on the principle of stratified random sampling technique.

The measures used are structured questionnaire incorporated both open and close ended questions. Items included in the questionnaire are background information, sources and areas/contents of sexual information/and socialization and items that are designed to assess common reproductive health knowledge. The questionnaire that deals with the sources of sexual

information were designed to be answered as first, second, third and fourth source separately and the questionnaire that deals with specific areas of sexual socialization were designed to be answered as yes or no while the questionnaire dealing with perceived approval of sexual behavior and reproductive health knowledge were formulated by the principle of Likert scaling and designed to be answered accordingly.

The result of the study shows the main current source of sexual information for adolescents were friends followed by media similarly friends were also the main preferred source of sexual information for adolescents followed by parents, particularly mothers. However, with respect to current source of sexual information parents were the least sexual information provider. In addition, parental sexual communication was mainly with female adolescents and between the mother and daughter. Respondents were found socialized with the specific areas of sexual issues that were assessed such as the physical and psychological changes of puberty, consequences of not using contraceptives; condom and birth control, STIs including HIV/AIDS, unplanned pregnancy and consequences of having multiple sexual partners, particularly through media.

Adolescents perceived sexual socialization; that is parent-adolescent sexual communication, and peer sexual communication, adolescents' perceived parent, peer and teacher approval of sexual behavior, parental age limitation to start a date/romantic activity, media SS and overall school SS outcome measures of female and male adolescents were compared using the mean of the two groups. The test used was Independent sample test comparing similar variable mean for two different groups. The result of the test shows that the difference of mean value of female and male adolescent is significant in parental sexual communication and parental

age limitation to start a date (at $P < 0.01$), significant in perceived parent and peer approval of sexual behavior (at $P < 0.001$). However, the variation in peer sexual communication, perceived teacher approval of sexual behavior, media SS and overall school SS measures is not statistically significant at 0.05 level ($P > 0.05$).

We can conclude that female adolescents experienced/had more sexual communication with their parents and similarly parents mostly set age limit to romantic activity/ to start a date for female adolescents/girls than boys and there is more perception of parent and peer disapproval of sexual behavior among female adolescents. In other words female adolescents were more socialized with disapproval of premarital sexual behavior compared to male adolescents.

Adolescents' perceived sexual socialization measures are assessed for whether they have a relationship with adolescent' common reproductive health knowledge. The test used is Bivariate Correlation. The result of the test shows a statistically significant positive relationship between peer sexual communication and RH knowledge, perceived parent and peer approval of sexual behavior and RH knowledge, and between media SS and RH knowledge. However, there is no a statistically significant relationship found between parental sexual communication and RH knowledge, perceived teacher approval of sexual behavior and RH knowledge, and between overall school SS and RH knowledge.

6.2 Conclusion

This study attempts to investigate how adolescents get socialized about sexuality; the sources of sexual information and the most sexual information provider for adolescents,

difference in adolescents' sexual socialization across the contexts. In addition, the study tries to assess the relationship between perceived adolescents' SS and adolescents' common RH knowledge.

The participants of the study were both female and male adolescents who were attending preparatory class; grade 11 and 12. The samples selection was guided by the principle of drawing representative sample. The method used was stratified random selection.

The study identified major sources of sexual information for adolescents. Accordingly friends are found to be the current and preferred primary source of sexual information and the most sexual information provider for adolescents followed by media, school/teacher and parents in the second, third and fourth place respectively. However, parents, particularly mothers are in the second place in terms of preferred sources of sexual information. On the other hand, the finding of areas of sexual socialization across the contexts identified media as the most source of sexual information for the adolescents.

Similarly, the study identified that adolescents are socialized on the most of specified areas of sexual issues although the role of parents were found low. The study indicated that adolescents are socialized with the consequences of not using contraceptives; condom and birth control, about STIs and STDs including about HIV/AIDS, unplanned pregnancy, and consequences of having multiple sexual partner, particularly through media.

In assessing gender difference in areas of sexual communication and socialization of adolescents across the context, the finding indicated that male adolescents scored low in parental sexual communication while they have scored high in both parental and peer approval of sexual

behavior which is vice versa for female adolescents. Therefore, it is possible to conclude that there is gender difference in sexual socialization of adolescents. In addition, the assessed difference in parental sexual communication as a function of parental educational level and religious affiliation indicated that parental educational level and religious affiliation does not make a significant difference in parent-adolescent sexual communication.

Finally, although it was a weak relationship the result of the study indicated significant positive correlation between RH knowledge and perceived peer and parent approval of sexual behavior, peer sexual communication and media SS. This suggests it is possible to conclude that adolescents' perceived sexual socialization is a factor in understanding adolescents' sexual behavior and RH knowledge.

6.3 Recommendation

Based on the findings of the study; the following recommendations were provided.

- With respect to sources of sexual information, there is a need for developmental psychologists / and other professionals to promote and increase parents role as a source of sexual information for adolescents; which could be done using media as a bridge to increase the awareness of parents about the importance of open parent- adolescent sexual communication to promote SRH of adolescents.
- There is also a need to promote sexual communication/ and socialization at school level through the promotion of extra-curricular activities and adolescents participation in extra-curricular activities such as HIV/AIDS and Reproductive Health clubs. In addition,

school should promote awareness about SRH issue among adolescents through school mini-media, counseling and guidance service.

- The concerned bodies such as Addis Ababa Health Bureau and the Sub-city Health Office in collaboration with Education Bureau should assist and facilitate school extra-curricular activities that are intended to promote adolescents' reproductive health and sexual behavior.
- Finally, there is a need for further in-depth study of the issue in the future. Future study in the area would be better to involve views of parents, teachers/ the school and other professionals and investigate factors that hinder and promote SS of adolescents.

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Appendix 1: Rule of thumb estimate for sampling

	Size of population	Sampling percent
1	0- 100	100%
2	101- 1,000	10%
3	1,001- 5,000	5%
4	5,001- 10,000	3%
5	10,000+	1%

Appendix 2: Respondents distribution by parental age limitation to start on a date and with whom (mother or father) they communicate most

		Have your parents/guardian set age limitation for you to start on a date		
		No	Yes	**Total**
Gender	**Female**	90	59	149
	Male	81	24	105
Total		171	83	254

		With which one of your parents/guardian do you discuss most on sexual issues			
		Mother/female guardian	Father/male guardian	Have no discussion	Total
Gender	**Female**	93	29	22	144
	Male	42	31	26	99
Total		135	60	48	243

Appendix 3: Questionnaire

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Department of Developmental Psychology

Aim of the questionnaire: this questionnaire is intended to assess sexual socialization of adolescents and the relationship/association with reproductive health knowledge: the case of Ayer Tena Secondary and Preparatory School students. The information that you are going to give is strictly confidential and you are not required to write your name; so that, you are expected to give the actual (right) information.

Thank you for your cooperation

Instruction: Please circle or put thick (✓) mark under your response for close ended question while you are required to give the answers for open ended questions in written words.

Part one: demographic information

1. Grade: A/ 11 B/12
2. Age: ----------
3. Gender: A/ Female B/Male
4. Religion: A/ Orthodox B/ Muslim C/ Protestant D/ Catholic

   E/ If any other please specify ----------

5. Father/male guardian education level

   A/ read and write B/ completed primary education

   C/ completed secondary education D/ have college diploma

   E/ have college degree and above

6. Mather/female guardian education level

   A/ read and write B/completed primary education

   C/ completed secondary education D/ have college diploma

   E/ have college degree and above

7. How would you describe your relationship with your mother/female guardian?

   A/ Poor B/ Fair C/ Good D/ Very good E/ Excellent

8. How would you describe your relationship with your father/male guardian?

   A/ Poor B/ Fair C/ Good D/ Very good E/ excellent

Part two: Sources of information on sexual matters

1. From whom do you get most information on sexual matters? Please give them a rank order (1^{st}, 2^{nd}, 3^{rd}, and 4^{th}) rank in front of the choices given based on their order of importance for you.

   Parent

   Friend

   School/teachers

   Media

   If any other, please specify----------

2. If you had a question on sexual and reproductive health issues whom do you prefer to ask?

A/ Mother/female guardian B/ Father/male guardian

C/ Friend/peer group D/ Teacher E/ If any other, please specify----------

Part three:

3.1 Areas of sexual communication/socialization. Please put thick (✓) mark under your response (yes or no).

S. n	**Items**	**Response**	
I	**Parental sexual communication/socialization** **-Have you ever talked with your parents/guardian about**:	**Yes**	**No**
1	The physical changes associated with puberty?		
2	The psychological changes associated with puberty?		
3	How you should act on a date?		
4	The consequences of not using contraceptives/birth control pill and condoms?		
5	The consequences of having multiple sexual partners?		
6	STIs including HIV/AIDS, other STDs and unplanned pregnancy?		
7	Have your parents/guardian set age limitation for sexual relationship?		
II	**Peer sexual communication/socialization** **-Have you ever talked with your friends about:**		
8	How you should act on a date?		
9	The consequences of not using contraceptives (birth control pill and condoms)?		
10	Unplanned pregnancy, STI, including HIV, and other STDs?		
11	The consequences of having multiple sexual partners?		

III	**Media as a source of sexual information** **-Have you ever seen/heard from media (TV, radio, movies, music video and artists) about:**	**Yes**	**No**
12	How you should act on a date?		
13	The consequences of not using contraceptives or birth control and condoms		
14	About unplanned pregnancy, AIDS or other STDs, and STIs?		
15	About the consequences of having multiple sexual partners?		
IV	**School sexual socialization**		
16	Is there sex education class in your school?		
17	If your response is yes to the question no.16, please specify the most discussed topics ----------		
18	Is there HIV/AIDS and RH clubs in your school?		
19	If yes, have you participated in the HIV/AIDS or RH clubs?		
20	If your response is yes to question no. 19, please specify the most discussed topics ----------		

21. With which one of your parents/guardian do you discuss most on sexual issues?

A/ Mother/female guardian B/ Father/male guardian C/ Have no discussion

3.2 perceived approval of sexual relationship from parent, peer and teachers.

Please put thick (✓) mark under your response.

S. n	Items	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
22	Parents/guardians are permissive of sexual intercourse as long as it is carried out in love relationship and safe					
23	Parents/guardian are permissive of sexual intercourse and relationship as long as it is kept secret					
24	Parents/guardians disapprove premarital sexual intercourse and relationship					
25	Teachers are permissive of sexual intercourse as long as it is in a love relationship and safe					
26	Teachers are permissive of sexual intercourse and relationship as long as it is kept secret					
27	Teachers disapprove premarital sexual intercourse and relationship					
28	Friends are permissive of sexual intercourse and relationship as long as in love relationship and safe					
29	Friends disapprove premarital sexual intercourse and relationship					
30	Friends are permissive of sexual intercourse and relationship as long as it is kept secret					
		Strongly approve	**Approve**	**undecided**	**disapprove**	**Strongly disapprove**
31	How would your parents/guardian feel about you having sex at this time in your life?					
32	How would your friends feel about you having sex at this time in your life?					

Part IV: Items assessing common reproductive health knowledge. Please put thick (✓) mark under your response						
S. n	**Items**	**Strongly agree**	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**
33	Sex without contraception is not that much problematic					
34	Someone with multiple partner is at the risk of STIs					
35	Sex with contraception is safe					
36	Sex with someone known only casual is normal as long as it is safe.					

Appendix 4: Questionnaire Amharic Translation

አዲስ አበባ ዩኒቨርሲቲ

የትምህርት እና ባህሪ ጥናት ኮሌጅ

የሳይኮሎጂ ትምህርት ቤት

የመጠይቁ ዋና አላማ፡ ይህ መጠይቅ የተዘጋጀዉ ወጣቶች ስለ ተቃራኒ ፆታ ግንኙነት፣ስነ-ተዋልዶ ጤና፣ የግብረስጋ ግንኙነት እና ሌሎች ተዛማጅ ጉዳዮች ላይ ያላቸዉን የግንዛቤ ደረጃ ለመዳሰስ እንዲሁም የወጣቶች የግንዛቤ ደረጃ አሁን ካላቸዉ የስነ-ተዋልዶ ጤና ግንዛቤ/ባህሪ ጋር ያለዉን ትስስር/ተዛምዶ ለማጥናት ነዉ፡፡ እርስዎ የሚሰጡት መረጃ ሚስጢራዊነቱ የተጠበቀ ነዉ፡፡ ስለሆነም እባክዎ ትክክለኛ መረጃ እንዲሰጡ በትህትና እንጠይቃለን፡፡

ስለ ትብብርዎ በቅድሚያ እናመሰግናለን፡፡

ክፍልአንድ፡ አጠቃላይ መረጃ. እባክዎ መልስዎ ላይ ያክቡ ወይም የቲክ (✓) ምልክት ያድርጉ

1. ክፍል፡ ሀ/ 11ኛ ለ/ 12ኛ
2. ዕድሜ፡ ----------
3. ፆታ፡ ሀ/ ሴት ለ/ ወንድ
4. ሀይማኖት፡ ሀ/ኦርቶዶክስተዋህዶ ለ/ ሙስሊም

ሐ/ ፕሮቴስታንት መ/ካቶሊክ ሠ/ሌላ ከሆነ ቢገለፅ ----------

5. የአባት/ወንድ አሳዳጊ የትምህርት ደረጃ፡

ሀ/ ማንበብና መፃፍ ለ/ አንደኛ ደረጃ ትምህርት የጨረሰ

ሐ/ሁለተኛ ደረጃ ትምህርት የጨረሰ መ/ ኮሌጅ ዲፕሎማ

ሠ/ ኮሌጅ ዲግሪ እና ከዲግሪ በላይ

6. የእናት/ሴት አሳዳጊ የትምህርት ደረጃ፡

ሀ/ ማንበብና መፃፍ ለ/ አንደኛ ደረጃ ትምህርት የጨረሰች

ሐ/ ሁለተኛ ደረጃ ትምህርት የጨረሰች መ/ ኮሌጅ ዲፕሎማ

ሠ/ኮሌጅ ዲግሪ እና ከዲግሪ በላይ

7. ከእናት/ከሴት አሳዳጊህ/ሽ ጋር ያለህን/ሽን ግንኙነት/ቅርበት እንዴት ትገልፀዋለህ/ሽ?

ሀ/ ደካማ ለ/ ደህና ሐ/ ጥሩ

መ/ በጣም ጥሩ ሠ/ እጅግ በጣም ጥሩ

8. ከአባት/ከወንድ አሳዳጊህ/ሽ ጋር ያለህን/ሽን ግንኙነት/ቅርበት እንዴት ትገልፀዋለህ/ሽ?

ሀ/ ደካማ ለ/ ደህና ሐ/ ጥሩ

መ/ በጣም ጥሩ ሠ/ እጅግ በጣም ጥሩ

ክፍል ሁለት፡ ስለ ተቃራኒ ፆታ ግንኙነት፣ወሲባዊ ተራክቦ፣ ስነ-ተዋልዶ ጤና እንዲሁም በሌሎች ተያያዥ ጉዳዮች ዙሪያ ያሉ የወጣቶች መረጃ ምንጮች

1. ስለ ተቃራኒ ፆታ ግንኙነት፣ወሲባዊ ተራክቦ/የግብረስጋ ግንኙነት፣ስነ-ተዋልዶ ጤና እና ሌሎች ተያያዥ ጉዳዮች ዙሪያ የተሻለ መረጃዎችን ከየት ታገኛለህ/ታገኚያለሽ? እባክህ/ሽ ለተዘረዘሩት የመረጃ ምነጮች ለአንተ/አንቺ ባላቸዉ የተሻለ የመረጃ ምንጭነት ደረጃ መሰረት ቅደም ተከተል (1ኛ፣2ኛ፣3ኛ ወይም 4ኛ) ደረጃ በተዘረዘሩት አማራጮች ፊትለፊት በማስቀመጥ ሀሳብዎን ይግለፁ፡፡

   ከቤተሰብ ( )

   ከጓደኛ ( )

   ከትምህርት ቤት/ከአስተማሪ ( )

   ከሚዲያ ( )

   ከነዚህ ከላይ ከተዘረዘሩት የመረጃ ምንጮች ሌላ ካለ ቢገለፅ ----------

2. በተቃራኒ ፆታ ግንኙነት፣ወሲባዊ ተራክቦ፣እና ስነ-ተዋልዶ ጤና ዙሪያ ጥያቄ ቢኖርህ/ሽ በቅድሚያ ማንን ትጠይቃለህ/ሽ? እባክዎ ከተዘረዘሩት አማራጮች ሀሳብዎን በማክበብ ወይም የ ቲክ (✓) ምልክት በመድረግ ይግለፁ፡፡

   ሀ/ እናት/ሴት አሳዳጊ ለ/አባት/ወንድ አሳዳጊ ሐ/ ጓደኛ

   መ/ አስተማሪ ሠ/ሌላ ካለ ቢገለፅ ----------

ክፍል ሦስት፡ ለሚከተሉት ጥያቄዎች መልስዎን /የእርስዎን ሀሳብ በትክክል በሚገልፀዉ

ቦታ ላይ የ (✓) ምልክት በማድረግ ሀሳብዎን ይግለፁ፡፡

ተ.ቁ	ጥያቄዎች	አዉቃለሁ	አላዉቅም
1	ከወላጆችህ/ከአሳዳጊዎችህ/ሽ ጋር ከጉርምስና ጋር ተያይዘዉ ስለሚከሰቱ አካላዊ ለዉጦች ተነጋግረህ/ሽ ታዉቃለህ/ታዉቂያለሽ?		
2	ከወላጆችህ/ከአሳዳጊዎችህ/ሽ ጋር ከጉርምስና ጋር ተያይዞ ስለ ሚከሰት ስነ-ልቦናዊ ለዉጦች ተነጋግረህ/ሽ ታዉቃለህ/ሽ?		
3	ከወላጆችህ/ከአሳዳጊዎችህ/ሽ ጋር በፍቅር ግንኙነት ወቅት ምን ማድረግ እንዳለብህ/ሽ ተነጋግረህ/ሽ ታዉቃለህ/ሽ?		
4	ከወላጆችህ/አሳዳጊዎችህ/ሽ ጋር የወሊድ መከላከያ እና ኮንዶም አለመጠቀም ሊያስከትሉ ስለሚችሉት ችግሮች ተነጋግረህ/ተወያይተህ/ሽ ታዉቃለህ/ሽ?		
5	ከወላጆችህ/አሳዳጊዎችህ/ሽ ጋር ከአንድ በላይ የፍቅር ጓደኛ መያዝ/የፍቅር ግንኙነት መመስረት ሊያስከትል ስለሚችላቸዉ ችግሮች ተነጋግረህ/ተወያይተህ/ሽ ታዉቃለህ/ሽ?		
6	ከወላጆችህ/አሳዳጊዎችህ/ሽ ጋር ስለ ኤች አይ ቪ ኤድስ እና ሌሎች በግብረስጋ ግንኙነት ስለሚተላለፉ በሽታዎች እነዲሁም ስለ ያልተፈለገ እርግዝና ተነጋግረህ/ሽ ታዉቃለህ/ሽ?		
7	ከጓደኞችህ/ሽ ጋር በፍቅር ግንኙነት ወቅት ምን ማድረግ እንዳለብህ/ሽ ተነጋግረህ/ተወያይተህ/ሽ ታዉቃለህ/ሽ?		
8	ከጓደኞችህ/ሽ ጋር የወሊድ መከላከያ እና ኮነዶም አለመጠቀም ሊያስከትል ስለሚችለዉ ችግር ተነጋግረህ/ሽ ታዉቃለህ/ሽ?		
9	ከጓደኞችህ/ሽ ጋር ስለ ያልተፈለገ እርግዝና፣በግብረስጋ ግንኙነት አማካኝነት ስለ ሚተላለፉ በሽታዎች/ወይም ኢንፌክሽን እንዲሁም ኤች አይ ቪ ኤድስን ጨምሮ ተነጋግረህ/ተወያይተህ/ሽ ታዉቃለህ/ሽ?		
10	ከጓደኞችህ/ሽ ጋር ከአንድ በላይ የፍቅር ጓደኛ/ግንኙነት መመስረት ሊያስከትል ስለሚችለዉ ችግር ተነጋግረህ/ሽ ታዉቃለህ/ሽ?		
11	በፍቅር ግንኙነት ወቅት ምን ማድረግ/መደረግ እንዳለበት ከሚዲያ (ቲቪ፣ሬድዮ፣ፊልሞች፣የሙዚቃ ቪዲዮ እና ዘፋኞች) አይተህ/ሽ ወይም ሰምተህ/ሽ ታዉቃለህ/ሽ?		
12	የወሊድ መከላከያ እነዲሁም ኮነዶም አለመጠቀም ስለሚያስከትለዉ ችግር ከሚዲያ አይተህ/ሽ ወይም ሰምተህ/ሽ ታዉቃለህ/ሽ?		
13	ስለ ያልተፈለገ እርግዝና፣በግብረስጋ ግንኙነት አማካኝነት ስለሚተላለፉ ኢነፌክሽን እና በሽታዎች፣ኤች አይ ቪ ኤድስን ጨምሮ ከሚዲያ አይተህ/ሽ ወይም ሰምተህ/ሽ ታዉቃለህ/ሽ?		
14	ከአንድ በላይ የፍቅር ጓደኛ/ግንኙነት መመስረት ሊያስከትል ስለሚችለዉ ችግር ከሚዲያ አይተህ/ሽ ወይም ሰምተህ/ሽ ታዉቃለህ/ሽ?		

15. ወላጆችህ/አሳዳጊዎችህ/ሽ የፍቅር ግንኙነት ለመመስረት የምትችልበት/ይበት

የጊዜ/ዕድሜ ገደብ አስቀምጠዋል?

ሀ/አስቀምጠዋል ለ/አላስቀመጡም

16. ከወላጆችህ/ሽ መካከል በተቃራኒ ፆታ ግንኙነት፣ስነ-ተዋልዶ ጤና፣የግብረስጋ

ግንኙነት እና ሌሎች ተዛማጅ ጉዳዮች ዙሪያ በይበልጥ ዉይይት/ንግግር የምታደርገዉ/ጊዉ

ከማን ጋር ነዉ?

ሀ/ ከእናት/ሴት አሳዳጊ ጋር ለ/ ከአባት/ወንድ አሳዳጊ ጋር ሐ/ ተወያይተን አናዉቅም

17. በትምህርት ቤትህ/ሽ የስነ-ተዋልዶ ጤና የትምህርት ክፍለ ጊዜ አለ?

ሀ/ አለ ለ/ የለም

18. ለጥያቄ ቁጥር 17 መልስህ/ሽ አለ ከሆነ በስፋት ለዉይይት የቀረቡ ርዕሰ-ጉዳዮች/

ሀሳቦች ቢገለፅ ----------

19. በትምህርት ቤትህ/ሽ የኤች አይ ቪ/ኤድስ ወይም የስነ-ተዋልዶ ጤና ክበብ አለ?

ሀ/ አለ ለ/የለም ሐ/አላዉቅም

20. ለጥያቄ ቁጥር 19 መልስህ/ሽ አለ ከሆነ አንተ/አንቺ በኤች አይ ቪ/ኤድስ ወይም

የስነ-ተዋልዶ ጤና ክበብ ዉስጥ ትሳተፋለህ/ሽ? ሀ/እሳተፋለሁ ለ/አልፋተፍም

21. ተሳትፎ ካለህ/ሽ በስፋት ዉይይት የተደረገባቸዉ ርዕሰ-ጉዳዮቹ ቢገለፁ ----------

ክፍል ሦስት የቀጠለ፡

ለሚከተሉት ጥያቄዎች መልስዎን /የእርሰዎን ሀሳብ በትክክል በሚገልፀዉ ቦታ ላይ የ (✓) ምልክት በማድረግ ሀሳብዎን ይግለፁ፡

ተ.ቁ	ጥያቄዎች	በጣም እስማማለሁ	እስማማለሁ	እርግጠኛ አይደለሁም	አልስማማም	በጣም አልስማማም
22	ወላጅ/አሳዳጊ ከፍቅረኛ ጋር በጥንቃቄ የሚፈፀም የግብረስጋ ግንኙነት አይቃወምም፡፡					
23	ወላጅ/አሳዳጊ የፍቅር ግንኙነት እንዲሁም የግብረስጋ ግንኙነት በድብቅ እስከ ተፈፀመ ድረስ አይቃወምም፡፡					
24	ወላጅ/አሳዳጊ ከጋብቻ በፊት የሚመሰረት/የሚፈፀም የፍቅር ግንኙነት እና የግብረስጋ ግንኙነት ይቃወማል፡፡					
25	አስተማሪ/መምህር የግብረስጋ ግንኙነት ከፍቅረኛ ጋር በጥንቃቄ እስከተፈፀመ ድረስ አይቃወምም፡፡					
26	አስተማሪ/መምህር የፍቅር ግንኙነት /የግብረስጋ ግንኙነት በድብቅ እስከተፈፀመ ድረስ አይቃወምም፡፡					
27	አስተማሪ/መምህር ከጋብቻ በፊት የሚፈፀም የፍቅር ግንኙነት እና ወሲባዊ ተራክቦ ይቃወማል፡፡					
28	ጓደኛ/ባልንጀራ የግብረስጋ ግነኙነት ከፍቅረኛ ጋር በጥንቃቄ እስከተፈፀመ ድረስ አይቃወምም፡፡					
29	ጓደኛ/ባልንጀራ ከጋብቻ በፊት የሚፈፀም የግብረስጋ ግንኙነት ይቃወማል፡፡					
30	ጓደኛ/ባልንጀራ የፍቅር ግንኙነት /የግብረስጋ ግንኙነት በድብቅ እስከተፈፀመ ድረስ አይቃወምም፡፡					
		ከፍተኛ ድጋፍ	**ድጋፍ**	**እርግጠኛ አይደለሁም**	**ተቃዉሞ**	**ከፍተኛ ተቃዉሞ**
31	በአሁን ወቅት/በዚህ ዕድሜህ የግብረስጋ ግንኙነት ብትፈፅም/ሚ ወላጆችህ/አሳዳጊዎችህ/ሽ ስለ አንተ/አንቺ ምን ዓይነት ስሜት ይኖራቸዋል?					
32	በዚህ ዕድሜህ/ሽ ወይም በአሁን ወቀት የግብረስጋ ግንኙነት ብትፈፅም/ሚ ጓደኞችህ/ሽ ስለአንተ/አንቺ ምን ዓይነት ስሜት ይኖራቸዋል?					

ክፍል አራት፡ በስነ-ተዋልዶ ጤና ዙሪያ ያለ የግንዛቤ ደረጃን ለመዳሰስ የቀረቡ ጥያቄዎች

ለሚከተሉት ጥያቄዎች መልስዎን /የእርሰዎን ሀሳብ በትክክል በሚገልፀዉ

ቦታ ላይ የ (✓) ምልክት በማድረግ ሀሳብዎን ይግለፁ፡

ተ.ቁ	ጥያቄዎች	በጣም እስማማለሁ	እስማማለሁ	እርግጠኛ አይደለሁም	አልስማማም	በጣም እስማማለሁ
33	ያለመከላከያ የሚፈፀም የግብረስጋ ግንኙነት/ወሲባዊ ተራክቦ ያን ያህል ለክፉ አይሰጥም፡፡					
34	ከአንድ በላይ የፍቅር ጋደኛ/ግንኙነት ያለዉ ግለሰብ በግብረስጋ ግንኙነት ለሚተላለፉ በሽታዎች ተጋላጭ ነዉ፡፡					
35	መከላከያ በመጠቀም የሚፈፀም የግብረስጋ ግንኙነት ከችግር የፀዳ/ከስጋት ነፃ ነዉ፡፡					
36	የግብረስጋ ግንኙነት ለጥቂት ጊዜ ከምናዉቀዉ ግለሰብ ጋር ቢፈፀም መከላከያ እስከተጠቀምን ድረስ ጤናማ ነዉ፡፡					