ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

Association between Comprehensive Sexuality Education and Adolescent Risky Sexual Behavior, Addis Ababa, Ethiopia

Investigator-Bethel Atnafseged (BSc)

Advisors-

- **Dr. Assefa Seme**
- **Mr. Nigussie Assefa**

A thesis submitted to the school of Public Health of Addis Ababa University in partial fulfillment of the requirements for the degree of masters of Public Health in Reproductive Health

June, 2017

ACKNOWLEDGEMENT

I would like to express my heartfelt gratitude to my advisors Dr. Assefa Seme and Mr. Nigussie Assefa for their unreserved, invaluable and constructive comments and continuous support throughout the whole research work. I am grateful to officials working in FGA, UNFA and employees of Addis Ababa Bureau of Education. I would also like to extend my thanks to the directors and teachers of the respective schools for their cooperation. Finally, I want to extend my appreciation to the students who willingly participated in this thesis.

Table of Contents

LIST OF TAB1ES

LIST OF FIGURES

ACRONYMS AND ABRIVATIONS

AAU: Addis Ababa University

AIDS: Acquired Immunodeficiency Syndrome

CSE: Comprehensive Sexuality Education

FGA: Family Guidance Association

LGBT: Lesbian, Gay, Bisexual and Transgender

HIV: Human Immunodeficiency Virus

ICPD: International Conference on Population and Development

SIDA: Swedish International Development Cooperation Agency

SRH: Sexual and Reproductive Health

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infections

ABSTRACT

Background: Adolescents transit into adulthood with conflicting and confusing messages about sexuality and gender. They lack adequate information and preparation on sexual and reproductive health (SRH), which leaves them vulnerable to risky sexual behavior, coercion, abuse and exploitation which intern exposes them to unintended pregnancies and sexually transmitted infections (STIs) including HIV/AIDS.

Objective: To assess the association between Comprehensive Sexual Education and Adolescents' Risky Sexual Behavior among In School Adolescents in Addis Ababa, Ethiopia

Method: The study used a cross sectional study design with internal comparison to assess the association between Comprehensive Sexuality Education and Risky Sexual Behavior. Gullelie sub city was purposively sampled as it was the only sub city that had Comprehensive Sexuality Education given to students. The study was conducted from November 2016-June 2017. Data were collected using structured self-administered questionnaires which was pre-tested on 30 students from non-selected but similar school in the sub city. The collected data were entered into Epi Info version 7 and cleaned before transferring the data to Stata Version 14 for analysis. Bivariate analysis was done to see the association of each independent variable with the outcome variable. Variables with P-Value of <0.25 were considered for multiple logistic regression analysis. In addition to text description, tables and graphs were used to summarize and present the data.

Result: A total of 383 students participated in the study with a response rate of 98.2% The mean age (±SD) of the respondents is 16±1.4. From the total respondents, 61 (16.1%) adolescents had already started having sexual intercourse of which 48 (88.9%) had early initiation of sex. Prevalence of risky sexual behavior among respondents is 15%. From the total respondents, 27.4 % took Comprehensive Sexuality Education and it is found to be protective against risky sexual behavior putting those who did not take CSE at odds of [AOR=2.82 95% CI [1.02-7.75].The study revealed that gender, having friends with the experience of sexual activity, perceived parental control, *watch pornographic movies, exposure to CSE* were found to affect risky sexual behavior among the study participants

Conclusion and conclusion: CSE has a positive effect on preventing adolecents risky sexual behavior. Watching pornographic movies and having friends with sexual experience were drivers of high risk sexual behavior while parental control, and exposure to CSE were protecting against risky sexual behavior development. According to the result of this research it is recommended that CSE be given on a larger scale.

1. INTRODUCTION

1.1. BACKGROUND

The World Health Organization (WHO) defines adolescents as those in the age group of 10-19. More than 1 billion people in the world (20%) are between the ages of 15 and 24, and most (85%) live in developing countries.(1) The adolescent population in Ethiopia has been increasing during the last few decades. Recently, adolescents constitute about 24% while young adults 10-24 years constitute about 30% of the total population.(2)

Globally, although attainment of adulthood is getting later, age at first sex is decreasing. Pertaining to this there has been a significant increase in the number of abortions and STIs among adolescents due to risky sexual behavior of adolescents.(3) This is also true in Ethiopia and other developing countries where adolescents transition into adulthood with conflicted and confused about sexuality and gender. They lack the adequate information and preparation on sexual and reproductive health (SRH), which leaves them vulnerable to coercion, abuse and exploitation which intern exposes them to unintended pregnancies and sexually transmitted infections (STIs) such as HIV. (4)

Sexuality education is still controversial in many parts of the globe especially among conservative societies. Sexuality education was first introduced in 'Western' school curricula in the late 1950s, often as part of biology lessons(5). It was largely aimed at discouraging people from having sex outside of marriage. In recent years, more attention has been paid to the emotional, physical and protective aspects of sexual relations and a rights' based approach to sexuality.(6)Although comprehensive sexuality education has many definitions over the years, according to the health briefs by SIDA it is defined as, "*a rights-based and gender-focused approach to sexuality education, whether in school or out of school, by embracing a holistic vision of sexuality and sexual behavior, not only focusing on prevention of pregnancy and sexually transmitted infections (STIs)*".

There are scares researches found done on CSE in Ethiopia or most of Africa, reviewed papers reveal that Comprehensive Sex Education is expected to be a vital tool in addressing this serious issue at the root.(7) Comprehensive sex education addresses the root issues that help adolescents make responsible decisions to keep them safe and healthy by introducing age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision making, abstinence, contraception, and disease prevention.(8)

1.2. STATEMENT OF THE PROBLEM

Since International Conference on Population and Development (ICPD) 1994, recognition has gradually increased that young people not only have the right to sex education, but also to access to health service tailored for their needs. Adolescents who begin sexual activity at early age are more prone to unsafe sex and to have multiple sexual partners.(9) Early sexual initiation basically increases young peoples' risk of acquiring infections like HIV and other STIs.(10). Each day half a million of adolescents are infected with Sexually Transmitted Diseases , (3) more than 7,000 become infected with HIV, and nearly 12 million are living with HIV/AIDS.(11)

Review of existing literatures have revealed that risky sexual behaviors are common among young people in Sub-Saharan Africa with several associated factors (12, 13). For Ethiopia, a nation dominated by young population, the HIV/AIDS epidemic is mainly attributed to the risky sexual behavior among adolescents and youth (14).

1.3. RATIONLAE OF THE STUDY

Comprehensive Sexuality education (CSE) in the schools is a sensitive issue because it is closely related with social, cultural, and parental perception of right and wrong, and the communities' attitude. However sex education serves a very important public health purpose that is to reduce STIs, HIV/AIDS, and unintended pregnancy among adolescents. (15) Evaluations of CSE programs show that CSE can help youth to delay the age of onset of sexual activity, reduce the frequency of sexual activity and number of sexual partners, and increase condom and contraceptive use. Importantly, the evidence shows that youth who receive comprehensive sexuality education are less likely to become sexually active, increase sexual activity, or experience negative sexual health outcomes.(16)Keeping in mind that adolescents comprise about 24% of the population in Ethiopia, it is important to understand their inclination towards risky sexual behavior and the contribution of CSE in reducing risky sexual behavior and reproductive health problems among school adolescents.

Thus, it is expected that this study would contribute to the development and implementation of appropriate health promotion programmers to reduce both the incidence and prevalence of sexual risk behaviors and their associated problems, including HIV/AIDS. It could also help different stakeholders like family, religious leaders, teachers and instructors in that area be more submitted to the cause and for advocate a jump-off point to push program planners to implement comprehensive education as a curriculum.

2. LITERATURE REVIEW

Adolescent sexual health

Many serious diseases in adulthood have their roots in adolescence. For example, tobacco use, sexually transmitted infections including HIV, poor eating and exercise habits, lead to illness or premature death later in life.(17)Adolescent sexual health has not been given enough attention by many countries regardless to the fact that there has been high demand for it. Among the various challenges adolescents are facing this days some of them are: early pregnancy, HIV and STIs, trouble accessing contraception and safe abortion and these have been associated with different factors like psychosocial norms, substance use, socio-demography and perceived risk.(18) Information delivery has been hindered by factors like political, economic and socio cultural aspects; even health care workers most of the time act as an obstacle by not giving young people helpful, unbiased and proper service.(19)

Sexuality education

In 1950s Sexuality education was introduced for the first time at a Western school as part of the biology lesson in the curricula. The very use of sexual education back then was to keep people from engaging in sexual intercourse outside of marriage. Recently though in western and non-conservative countries, emphasis has been given to the emotional side of sexual relations including LGBT relationships.(20) Sexuality education in low and middle income countries is used in providing the young people important information about the physical and emotional aspects of sex and reproduction. Currently the delivery of Sexuality education is being handled by teachers in media with the help of health workers. (21)

Comprehensive sexual education

Dictates the best way to save yourself from STI and unplanned pregnancy is abstinence but also teaches about the use of contraceptive method and condom to avoid or decrease the possibility of getting STIs and unplanned pregnancy. It encompasses varies aspects of issues ranging from physical and biological aspects of sexuality to emotional and social aspects of sexuality. It can also be a helpful tool for parents and teachers in giving accurate and truth full information to young people about the very essence of sexuality. In addition to that it can also be used in decreasing the impact of negative or inaccurate sexual information's to young people about their knowhow in sexuality(22)

According to WHO 333 million new cases of curable STIs occur each year worldwide, with highest rates among 20-24 year old followed by 15-19-year-old. Young people aged 15–24 accounted for almost half of all new HIV infections among individuals aged 15 and older in 2010.(23) Since the International Conference on Population and Development (ICPD) in Cairo in 1994, recognition has gradually increased that young people not only have the right to sex education, but also to access to health service tailored for their needs.

In many developed and developing countries, increasing numbers of young people delay marriage until they are older which subsequently means they have also become more likely to have sex before marriage; thus premarital pregnancy rates and STD rates are increasing.(24)

Results from the 2011 Arizona Youth Risk Behavior Survey (YRBS) Results, indicated that youth need school based comprehensive sexuality education by pointing out that; almost half (Forty-seven percent) of students that were interviewed have already had intercourse at some point in their lives, while 65% of high school seniors included in the study reported having sexual intercourse, with more than half (52.6%) reporting to having sexual intercourse in the past three months. And of the students that reported being sexually active, fifteen percent (15%) did not use any method to prevent pregnancy and STI's during the last intercourse.(25)

From the sexual behavior aspect, by the time students reached 12th grade, 24.2% had four or more sexual partners during their lifetime and of students who report having sexual intercourse, 22.4% report drinking alcohol or using drugs before sexual intercourse. In that same study, ten percent(10%) of the students reported being "physically forced to have sexual intercourse when they did not want to." and eleven percent (11%) of students report being "hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months before the survey was done.(25)

Putting the current status of youth Sexual behavior and STI status in view, a lot could be argued about the importance of comprehensive education in learning institutions.

There have been many researches done to support the effectiveness of comprehensive sexually education in learning facilities in terms of delaying the onset of sexual activity, reducing the number of partners and frequency of sex and increasing use of contraceptives.

Initiation of sex

In Ethiopia the mean age of sexual initiation is presumed to be 16.8 years.(26) In the rural areas first sex among adolescents is initiated mainly with the husband or wife 41% of the time while in their urban counterparts, it's with their "girl or boy friend" 32 % of the time. Sixty-one percent of adolescents in Ethiopia started their sexual intercourse before the age of 18, 2.4% initiated their first sex with commercial sex workers (CSW) and 8.7% with causal partner. Moreover first sexual practices are unplanned 39% of the time and of those 65% are unprotected.(27)

An important measure of sexual behavior is the timing of initiation of sex. A review study of 83 papers mentioned that CSE programs in general did not facilitate the initiation of sex in any way and in the contrary most delayed it. Of the 52 studies that measured impact of CSE on initiation of sex, 22 (42%) found that CSE programs significantly delayed the initiation of sex among one or more groups for at least 6 months.(24)

In another review it mentioned that of the 40 studies that measured impact on the initiation of sex, 16 (40 percent) found that the programs significantly delayed the initiation of sex, and 24 (60 percent) found no significant impact.(28) A meta-analysis done on low and middle income countries also pointed out that participants who received the intervention (CSE) had a 34% reduction in odds of initiating sexual intercourse during follow-up compared to control or comparison groups (OR = 0.66, 95% CI = 0.54–0.83, p,0.001). (29)

Number of sex partners

Another measure of sexual behavior is number of sexual partners during a specified period of time prior to the survey. In two systemic reviews one reported that thirty four papers reviewed the impact of CSE on number of sex partners and 12 (35%) found a decrease in the number of sexual partners, while 21 (62%) found no significant impact, and one 1 (3%) found a negative impact while the other reported that across studies students receiving interventions demonstrated a 25% reduction in odds of reporting more partners compared to control or comparison groups (OR = 0.75, 95% CI:0.67–0.84, p,0.001). (28, 29)

Sexual risk taking

From a review of twenty eight papers studied the composite of sexual risk taking like, non-use of condoms and multiple sexual partners, it was found that half of them found that CSE significantly reduced sexual risk taking while none of them found increased sexual risk-taking.(24) 54 studies measuring program

impact on condom use, almost half (48%) showed increased condom use among those who received CSE and none found decreased condom use. Of the 10 studies that measured impact on STD rates, 2 found positive impacts, 6 found no significant impact, and 2 found negative impacts.(24, 28, 29)

Overall, these studies strongly indicate that these programs were far more likely to have a positive impact on behavior than a negative impact. Across all 83 studies, two thirds (65%) had a significant positive impact on one or more of these sexual behaviors or outcomes, while only 7% had a significant negative impact on one or more of these behaviors or outcomes.

An examination of the National Survey of Family Growth to determine the impact of sexuality education on sexual risk-taking for young people ages 15-19, revealed that teens who received comprehensive sexuality education were 50% less likely to report a pregnancy than those who received abstinence-only education. (30) Evaluations of comprehensive sex education programs show that these programs can help youth delay the onset of sexual activity reduce the number of sexual partners, and increase condom and contraceptive use.(31)In a comprehensive review of 83 studies carried out in 2007 on the impact of sexuality education, the results strongly indicate that the programs were far more likely to have a positive impact on behavior than a negative impact. Two-thirds of the studies found a significant positive impact on one or more of the above mentioned sexual behaviors or outcomes, while only 7 % found a significant negative impact.(32)

CONCEPTUAL FRAME WORK

There are several interlinked factors that influence the sexual risk-taking behavior of adolescents. Here is a framework of factors that influence this type of behavior.

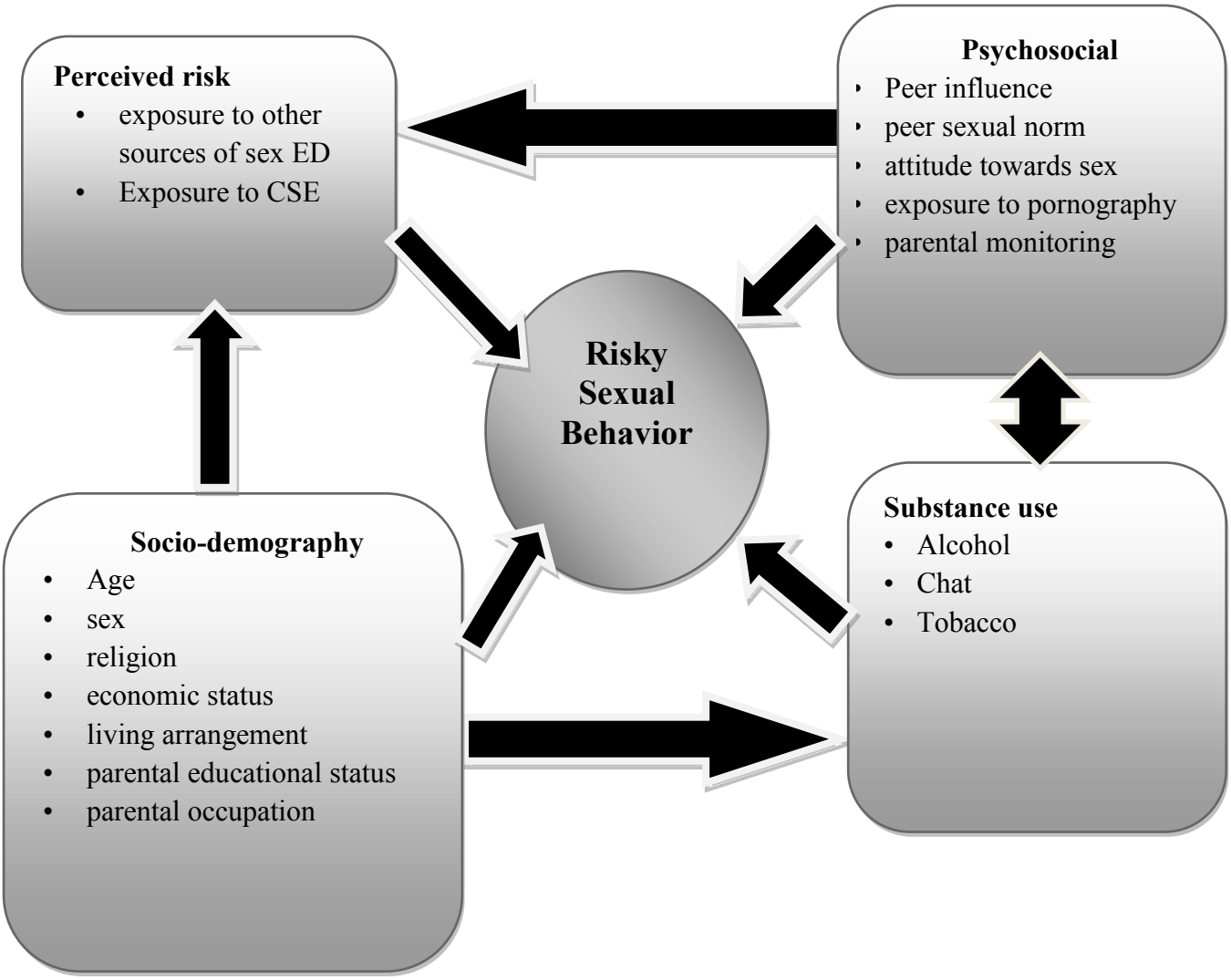

Figure 1 diagrammatic presentation of the conceptual framework adopted and modified from kotchick 2001 for Association between Comprehensive Sexuality Education and Adolescent Risky Sexual Behavior, Addis Ababa, Ethiopia - 2016/17

3. OBJECTIVES

3.1. GENERAL OBJECTIVES:

- To assess the influence of Comprehensive Sexuality Education on Adolescents' Risky Sexual Behavior among in School adolescents in Gullelie sub-city, Addis Ababa, Ethiopia

3.2. SPECIFIC OBJECTIVES:

- To measure the magnitude of risky sexual behavior among in school adolescents in Gullelie sub-city, Addis Ababa
- To compare the magnitude of risky sexual behavior between in school adolescents who took Comprehensive Sexuality Education and those who did not in Gullelie sub-city, Addis Ababa,
- To determine factors associated with risky sexual behavior among in school adolescents in Gullelie sub-city, Addis Ababa

4. METHODS AND MATTERIALS

4.1. STUDY AREA AND PERIOD

The study is conducted in Gullelie sub city, in Addis Ababa, the capital of Ethiopia from November 2016-May 2017. According to Addis Ababa Regional Health Bureau (AARHB) report in 2013/14, Addis Ababa covers an area of 540.14 square kilometers with 3,272,237 regional total populations with annual growth rate of 2.1.Addis Ababa has three layers of Administration: City Government, 10 Sub City Administrations, and 116 Woreda Administrations. There are 21 high schools under the Gullelie administration. From those 2 were missionary schools, one is owned a church, 6 are governmental schools and the rest are private schools.

4.2. STUDY DESIGN

A school based cross sectional study design was used to recruit study participants from government high schools in Gullele sub city.

4.3. SOURCE POPULATION

The source population for this study are in school adolescents age 14-19 years, in all government high schools in Gullelie sub-city, Addis Ababa Ethiopia.

4.4. STUDY POPULATION

The study population for this study were all in school adolescents (9^{th}- 12^{th}grade adolescents) enrolled at the selected schools at the time of the survey.

Inclusion criteria

Students in the selected schools age 14-19 years, (9^{th} to 12 th grade)

Exclusion criteria

Students who were critically sick and those who had visual or auditory impairment were excluded.

4.5. SAMPLE SIZE DETERMINATION

Using a single population proportion formula**,**

$$n_0 = (Z^2 1\text{-}\alpha * P\ (1\text{-}P)/\ d^2$$

Where,

n= the desired sample size

p= Prevalence of early initiation of sex which is 20.4% (33), prevalence of not condom use which is 56.9% (26) and the prevalence of Multiple Sexual partner which is 24.7% (26)

Z= is the standard normal score set at 1.961 (95% confidence interval)

d= is the margin of error to be tolerated (5%)

Prevalence of Early Initiation of sex P=20.4%	$n = \frac{(Z\alpha/2)^2\ p\ (1-p)}{d2}$ = 244
Prevalence of not using condom P=56.0%	**$n = \frac{(Z\alpha/2)^2\ p\ (1-p)}{d2}$** **=376**
Prevalence of Multiple sex partners P=24.7%	**$n = \frac{(Z\alpha/2)^2\ p\ (1-p)}{d2}$** **= 307**

The largest sample size (376) was taken and considering 5% none response rate the final sample size was determined to be **395.**

4.6. SAMPELING PROCIDURE

There are different organizations trying to implement CSE in Ethiopia. From these various organizations Family Guidance Association of Ethiopia (FGAE) is one of the main stakeholders working in Addis Ababa, specifically in Gullelie sub-city. FGAE has been giving CSE in school and out of school for … years before it was discontinued two years earlier. So Gullelie Sub-City was purposively selected for the current study. In this sub-city there are 4 high schools (9-10) and 2 preparatory (11-12) schools run by government. From these 3 were directly exposed to CSE (Dilber, Kechene-Debreselam and Medhanialem), and these were also purposively selected. The total sample size, 395, was proportionally allocated to the selected schools in the study based on their school student population. In each school, sections and students were randomly selected respectively

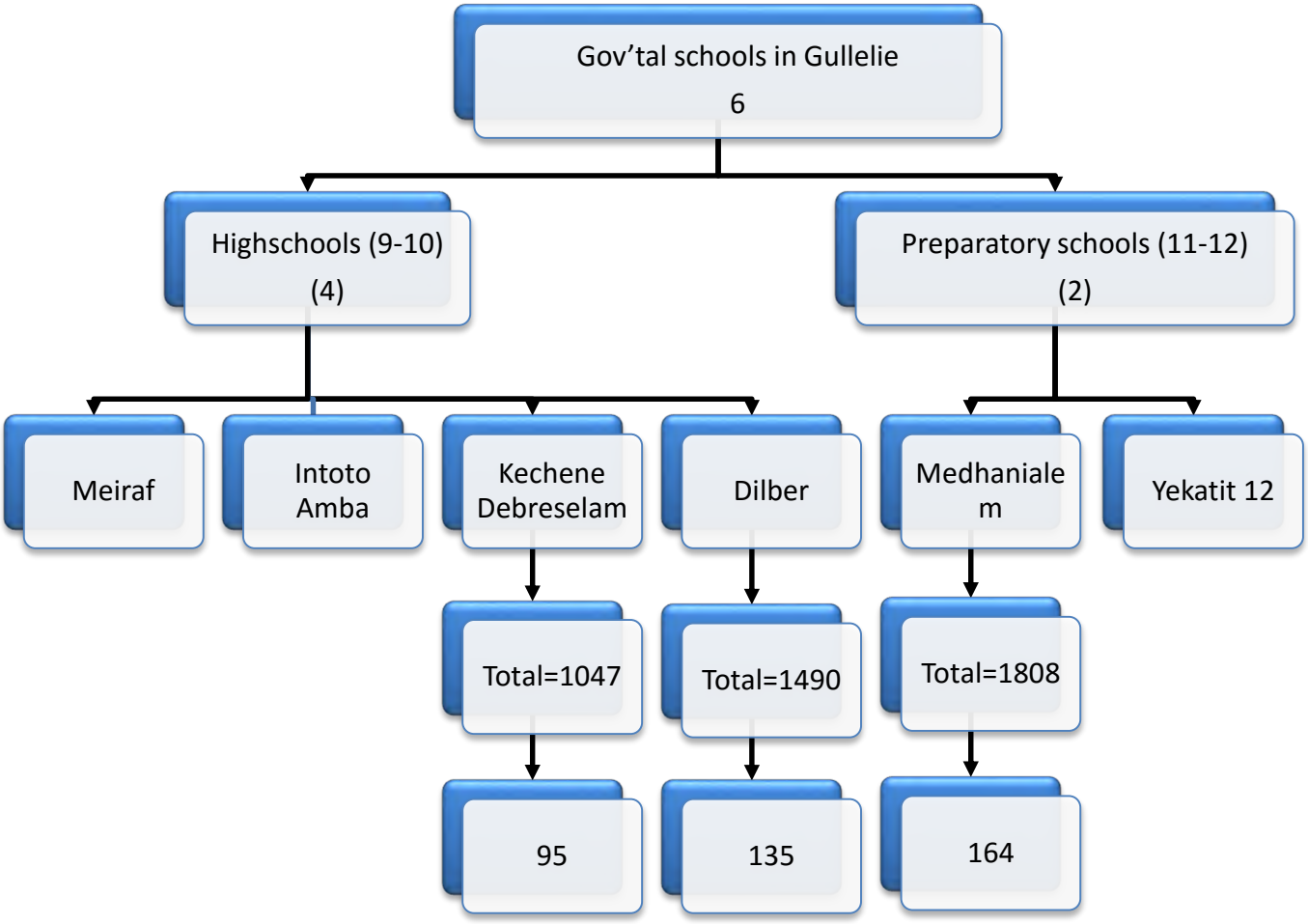

Figure 2 Schematic representation of the sampling procedure for Association between Comprehensive Sexuality Education and Adolescent Risky Sexual Behavior, Addis Ababa, Ethiopia, June 2017

4.7. DATA COLLECTION PROCEDURE

Data were collected using a structured, pre-tested and self-administered questioners. A brief explanation on the objectives of the study was given by the investigator on the questioners and further questions were answered by the supervisor/facilitator. The questions were given in an objective type of questions with multiple choices. The questions were grouped in to sections dealing with general information of socio demographic characteristics, knowledge and attitude and sexual behavior. The questioners were translated from English in to Amharic by expert in the field at first and then translated back to English by another expert to ensure consistency and that the meaning is not lost during translation. To insure privacy of students and to decrease contamination of data, students were asked to sit away from each other and no personal identifiers were written on the questionnaires.

4.8. OPERATIONAL DEFINITIONS

In school adolescents: For the purpose of the present study, In school adolescents are those between the age group 14-19 years

Risky sexual behavior: Having or practicing any one of the following behavior (Multiple sex partners, non-use of condom during penetrative sexual intercourse or Sex for money/incentives)

Early initiation of sex: Vaginal Penetrative sex before the age of 18

Knowledge on HIV: Is assessed by eight questions about HIV and those who answered at least four of the questions correctly is assumed to be knowledgeable.

Knowledge on STI: Is assessed by four questions about STI and those who answered at least two of the questions correctly is assumed to be knowledgeable.

CSE: Students are labeled as having taken CSE if they took at least 5 of the 8 subjects given in the FGA CSE teaching manual.

Current Risky Sexual Behavior: Risky sexual behavior in the past 12 months

4.9. DATA ANALYSIS PROCEDURE

The collected data were entered using Epi-info version 7 and analyzed using Stata version 14 software. Frequencies and Percentages were calculated for categorical variables while measures of centrally tendency was calculated for continuous variables and the presented in tables. Odds ratio, chi-square, 95%CI and P-value were used to assess presence of association and its statistical significance. Binary Logistic regression model was used to see the effect of each independent variable on the dependent variable. Variables with P-value of 0.25 or less were considered for multivariable logistic regression model which was used to see the adjusted effect.

4.10. DATA QUALITY MANAGEMENT

To assure the quality of the data properly designed data collection instruments were developed. Training was given to supervisors on the instruments used. Every day the collected data were reviewed and checked for completeness and consistency by supervisors and principal investigator. Problems encountered were reported to principal investigator for immediate action. Discussions were made with the supervisors at the end of the day and in the morning to minimize errors committed during collection and to take corrective actions timely

4.11. ETHICAL CONSIDERATION

Ethical clearance was obtained from the Ethical Committee of the School of Public Health, Addis Ababa University (AAU). Informed consent was obtained from each student and teacher prior to data collection and the purpose and benefit of the study was explained to the respondents. Confidentiality of the information they provide was assured and privacy of the respondents was maintained. Participation was on voluntary basis. Respondents were assured that they can skip any question that they feel uncomfortable with or can stop responding to all questions at any time.

4.12. DISSEMINATION OF RESULT

The result of this study will be disseminated to the following institutions personally via hard copy and by email soft copy according to the requirements

- Addis Ababa University School of public health, college of health science as a partial fulfillment of the MPH degree requirement.
- UNFPA and FGA head office
- To Addis Ababa Education Bureau
- To the perspective schools

5. RESULT

5.1. DESCRIPTIVE STATISTICS

5.1.1. SOCIO-DEMOGRAPHIC FACTORS

Out of a total of 395 questionnaires that was disseminated to the students, 390 students participated and of these 7 respondents were excluded from the sample because of incomplete response to the questionnaires. The final sample included 383 adolescents who had complete records. The response rate was 97%. The mean age ±SD of the respondents was 16.72(±1.39). As indicated in Table 1 below, more than half of the respondents 207 (54.2%) are in the 9th and 10th grade. Majority of respondents 315 (82.5%) are followers of Orthodox Christianity followed by Muslims, 42(11%) and protestant 25 (6.5%). Only 5 (1.3%) of the respondents live alone or with a friend while the rest 378 (98.7%) lived with their family or relatives. More than half 201(53.6%) of the students do not receive pocket money.

Table 1. Socio-demographic characteristics of adolescents in Government secondary schools in, Gullelie sub-city, Addis Ababa, Ethiopia, June 2017

Variable	*Frequency*	*Percent*
Sex		
Male	164	43.04
Female	217	56.96
Age		
14-17	236	90.8
18-19	33	9.2
Class		
Grade 9	96	25.13
Grade 10	111	29.06
Grade 11	89	23.30
Grade 12	86	22.51
Religion		
Orthodox	315	82.46
Muslim	42	10.99
Protestant	25	6.54
Living Arrangement		

With parents/relatives	378	98.69
Friends/alone	5	1.31
Pocket Money		
Yes	174	46.40
No	201	53.60

5.1.2. FAMILY CHARACTERISTICS

Table 2 presents the percentage distribution of respondents by family structure, parental educational level and occupation. Respondents replied married 279(73.0%) if the parents are currently living together and separated 103(27%) if the parents are divorced, widowed or not living together. Three hundred thirty-one (86%) responded that their father is alive and 251(76.1%) responded that their father lives with them. Mothers of 359(94.2%) respondents are still alive and 300 (84.0%) responded that they currently live with their parents. Educational status of the parents was reported as 116(36.4%) of fathers and 157(45.2%) of mothers to have a highest educational attainment of basic to primary education.

Table 2. Family characteristics and living arrangement status of adolescents in Government secondary schools in, Gulelie sub-city, Addis Ababa, Ethiopia, June 2017

Variable	***Frequency***	***Percent***
Family marital status		
Married (live together)	27	73.04
Separated /Divorced/widowed	103	26.96
Father alive		
Yes	331	86.42
No	52	13.58
Father live with you		
Yes	252	76.13
No	79	23.87
Fathers Educational status		
Primary (0-8)	116	36.36
Secondary (9-12)	92	28.84
Technical (10^{+})	45	14.11
University and above	66	20.69

Mother alive		
Yes	359	94.23
No	22	5.77
Mother live with you		
Yes	300	84.03
No	57	15.97
Mothers Educational status		
Primary (0-8)	157	45.24
Secondary (9-12)	97	27.95
Technical (10^{+})	48	13.83
University and above	45	12.97

5.1.3. KNOWLEDGE ON STIS AND HIV/AIDS

As described in table 3 below the knowledge on both HIV/AIDS and STIs are relatively good with 374 (97.6%) and 349(91.1) being knowledgeable on STIs and HIV/AIDS, respectively. Of all the sample 105(27.4%) reported as having taken the Comprehensive Sexuality Education (CSE) course.

Table 3. Knowledge on STIs, HIV/AIDS and CSE status of adolescents in Governmental secondary schools in, Gulelie sub-city, Addis Ababa, Ethiopia, June 2017

Variable	***Frequency***	***Percent***
Knowledge on STIs		
Poor	9	2.35
Good	374	97.65
Knowledge on HIV/AIDS		
Poor	34	8.88
Good	349	91.12
CSE		
Yes	105	27.42
No	278	72.58

5.1.4. PSYCHOSOCIAL FACTORS

Psychosocial factors like Peer influence, 73(19%) reported pressure from friends to have sex. Peer sexual norm, 133(35.1%) of respondents' friends watch pornographic movies, 87(22.8%) reported their close friend had sexual intercourse, 42(11.1%) of respondents' friends have sex with prostitutes and 33(8.8%) of friends had had sex for money. There is perceived parental monitoring among 300(79.2%) of respondents. There is a high attachment to religious institutions among 224(59.3%) of respondents.

Table 4. Substance use, Psychosocial factors and Exposure to media among adolescents in Government secondary schools in, Gulelie sub-city, Addis Ababa, Ethiopia, June 2017

Variable	***Frequency***	***Percent***
Do your friends have sex		
Yes	87	22.83
No	294	77.17
Pressure from friends to have sex		
Yes	73	19.26
No	306	80.74
Friends had sex with prostitutes		
Yes	42	11.05
No	338	88.95
A friend having sex for money		
Yes	33	8.78
No	343	91.22
Friends watch pornographic movies		
Yes	133	35.09
No	246	64.91
Parental control		
Yes	300	79.16
No	79	20.84
Religious attachments		
Attends frequently	224	59.26

Attends sometimes/not at all	154	40.74

5.1.5. SUBSTANCE USE AND EXPOSURE TO MEDIA

Substance use among respondents is 55 (14.5%).268(70.5%) of respondents currently use different types of social media and 73(19.2%) watch pornographic movies

Table 5. Substance use, Psychosocial factors and Exposure to media among adolescents in Government secondary schools in, Gulelie sub-city, Addis Ababa, Ethiopia,, June 2017

Variable	***Frequency***	***Percentage***
Substance use		
Yes	55	14.47
No	325	85.53
Watch pornographic movies		
Yes	73	19.21
No	307	80.79
Use social-media		
Yes	268	70.53
No	112	29.47

5.1.5. SEXUAL BEHAVIOR

Sexual behavior among respondents as seen in the table below was 61(16.1%) reported having had sex among whom 49(89.1%) had sex before the age of 18. Unprotected sex, Multiple Sexual Partners (MSP) and sex for money was 25 (40.32%) 20 (32.79S%) and 9 (14.75%), respectively.

Table 5. Sexual behavior among adolescents in Governmental secondary schools in, Gulelie sub-city, Addis Ababa, Ethiopia,, June 2017

Variables	***Frequency***	***Percent***
Ever had sex (n=380)		
Yes	61	16.05

No	319	83.95
Age at first sex(n=61)		
<17	49	89.09
>=18	6	10.91
Unprotected sex in the past 12months(n=61)		
Yes	25	40.32
No	36	59.68
MSP in the past 12months(n=61)		
Yes	20	32.79
No	41	67.21
Sex for money(n=61)		
Yes	9	14.75
No	52	85.25
Current Risky Sexual Behavior		
Yes	56	14.62
No	327	85.38

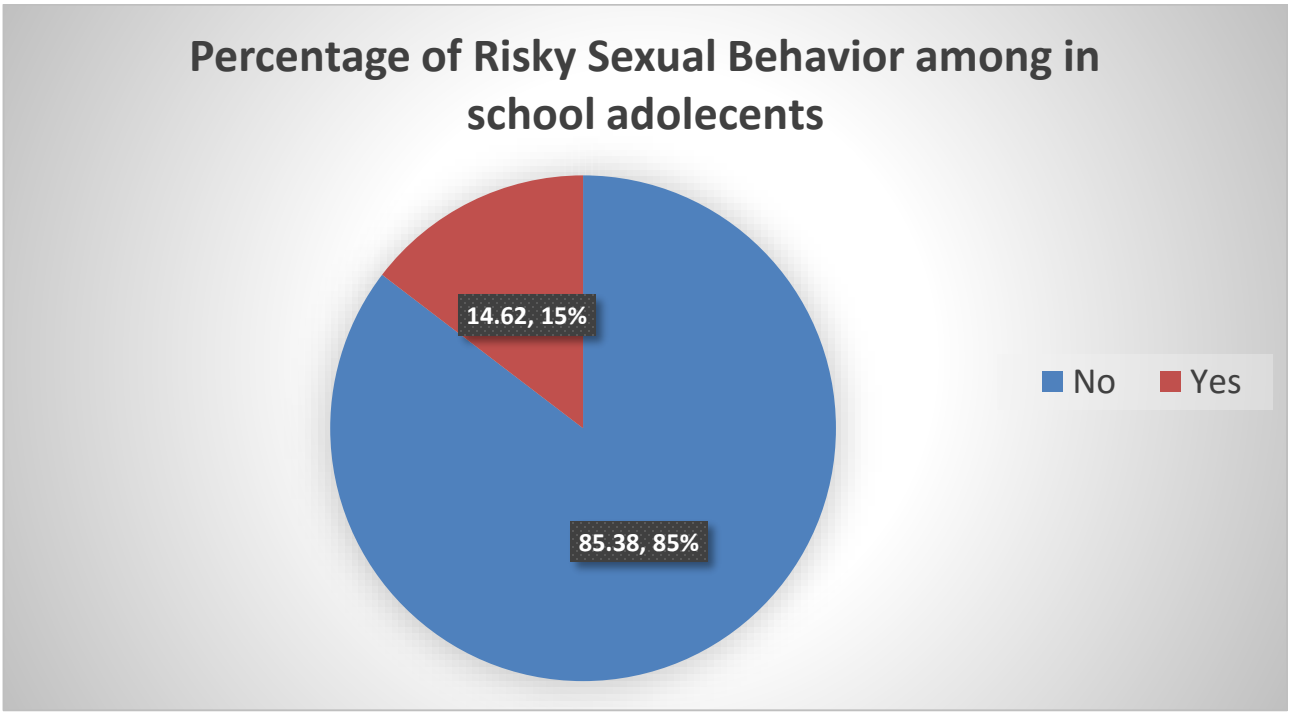

Figure 3. Risky sexual behavior of in school adolescents in Gullelie sub-city, Addis Ababa, Ethiopia, June 2017

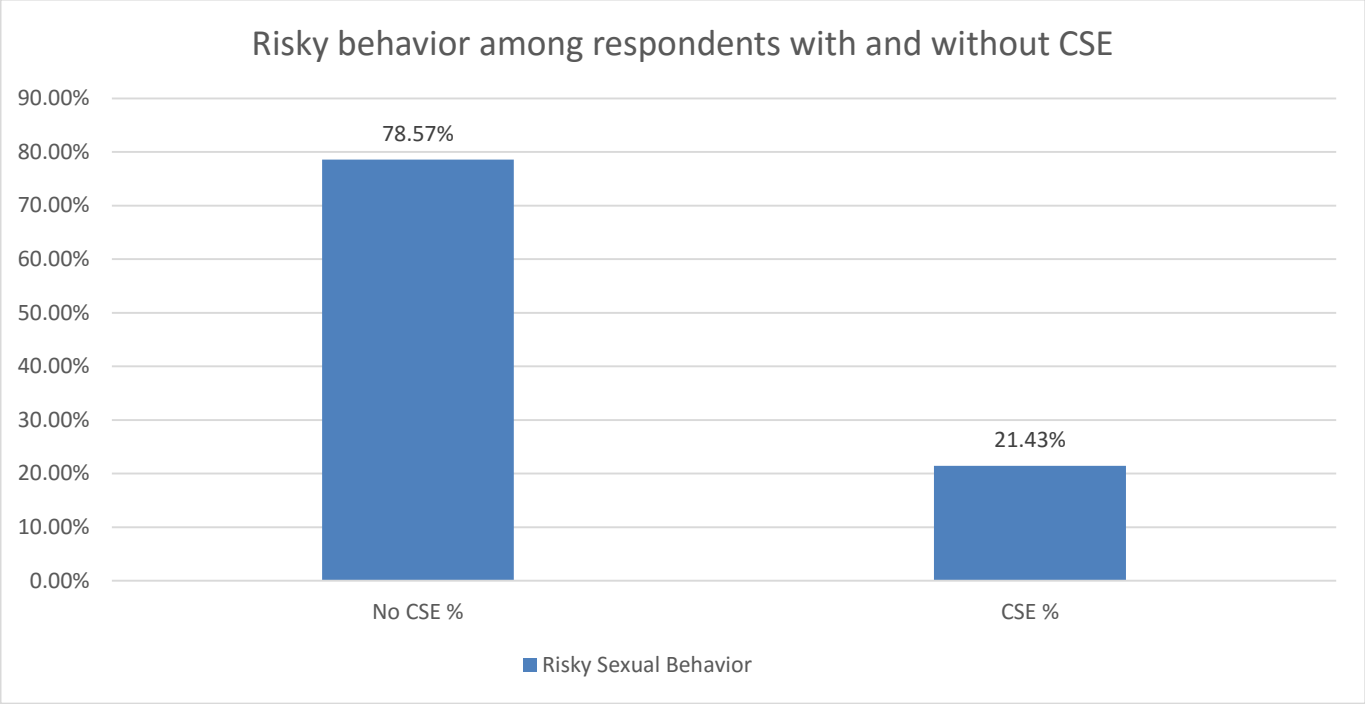

Figure 4. Percentage of Risky Sexual Behavior among respondents who did and did not take Comprehensive Sexuality Education, In Government Schools in Gullelele Sub City, Addis Ababa, June 2017

6. RISK PERCEPTION ON HIV AND STIS

Among those who took and those who did not take CSE,,low percieved Risk to STIs and HIV was found to be 102(97.14%) and101(97%) respectively for those with CSE, and 207(98.9%) and 266(97.44%) respectively for those that did not take CSE. Frome respondents with CSE 96(91.43%) and 81(77.88%) answered that they were not afraid of getting STI and HIV respectively and among the group that did not take CSE 259(95.22%) and 229 (83.58%) replied that they were not ofraid of acquiring STIs and HIV respectively.

Table 7. Risk perception to STIs and HIV/AIDS among in school Adolecents, in Gullelie subcity Addis Ababa Ethiopia, June 2017

Variable	***CSE***	***No CSE***

	Frequency	Percent	Frequency	Percent
Risk to STIs				
No/low	102	97.14	207	98.9
Mediumrisk/High/very high risk	3	2.86	3	1.10
Risk of HIV				
No/low	101	97.12	266	97.44
Mediumrisk/High/very high risk	3	2.88	7	2.56
Fear of STIs				
Not/A little afraid	96	91.43	259	95.22
Somewhatafraid/ Highly/Veryhighly afraid	9	8.57	13	4.78
Fear of HIV				
Not/A little afraid	81	77.88	229	83.58
Somewhat afraid/ Highly/Very highly afraid	23	22.12	45	16.42

5.2. RESULT OF BIVARIATE ANALYSIS

As presented in table 8, among adolescents in the sub-city, significant factors influencing risky sexual behavior with a P-value less than 0.05 comprised of; Age OR=3.50 CI (1.93-6.33), Grade OR=2.42 CI(1.34-4.36), pocket money OR=1.81 CI [1.02-3.22], Knowledge of STI and HIV with OR=0.2 CI (0.05-0.78), OR=0.11 CI (0.04-0.34) respectively and also Sexual experience of friends and friend sexual behavior. Exposure to social media and watching pornography films/videos with OR=9.64 CI (5.14-18.06) were also found to be highly associated in the bivariate analysis including perceived parental control OR=0.13 CI (0.07-0.25).

5.3. RESULT OF MULTIVARIATE ANALYSIS

The multivariable logistic regression model included all variables in the binary logistic regression with p-value less than 0.25 which included from Socio-demographic variables (age, grade, religion, pocket money and mothers education) knowledge variables (knowledge of STI & HIV), CSE from psycho-social substance use, friends having sex, friends having sex for money, friends having sex with prostitutes,

friends watching pornographic movies, using social media, watching porn, parental control, religious attachments and finally from perception of risk perceived Risk of HIV & STI and fear of HIV & STI. And those variables that are known to be associated to risky sexual variable but with a P-value greater than 0.25 have been included

The multivariable logistic regression analysis revealed that socio-demographic variables were not associated to risky sexual behavior among adolescents. It also showed that taking CSE is protective against risky sexual behavior with those who did not take CSE trainings were having the highest odds of risky sexual behavior AOR=2.82, CI [1.02-7.75]. Respondents who had friends who were sexually active are found to be 14.1times more likely to have risky sexual behavior with p-value of 0.0001. Watching pornographic movies puts respondents at higher odds for risky sexual behavior, AOR= 3.81 CI [1.07-13.55] than those who did not watch. Perceived parental monitoring is also found to be protective from risky behavior compared to those without or with low parental control, AOR= 8.07 CI [2.88-22.61].

Table 8. Bi-variable and multivariable logistic regression analyses of factors associated with risky sexual behavior among adolescents of governmental schools in Gullelie sub-city, Addis Ababa, Ethiopia, June 2017

Characteristics	***Current RSB***		***COR(95%CI)***	***AOR(95%CI)***
	Yes (n, %)	**No (n, %)**		
Socio-demographiv variables				
Respondent age (years)				
10-17 years	20(8.47)	216(91.53)	1	
18-19 years	36(24.49)	111(75.51)	3.50(1.93-6.33)	
Sex				
Male	47(28.66)	117(71.34)	9.28(4.39-19.62)	3.42(1.07-11.06)
Female	9(4.15)	208(95.85)	1	1
Respondent class				
9th grade & 10th grade	20(9.66)	187(90.34)	1	
11th grade & 12th grade	36(20.57)	139(79.43)	2.42(1.34-4.36)	
Religion				
Orthodox Christian	49(15.56)	266(84.44)	1	
Muslim	6(14.29)	36(85.71)	0.9(0.36-2.26)	
Protestant	1(4.00)	24(96.00)	0.23(0.03-1.71)	
Pocket money				
Yes	33(18.97)	141(81.03)	1.81(1.02-3.22)	
No	23(11.44)	178(88.56)	1	
Family characteristics				
Living arrangement				
With parents/ relatives	54(14.29)	324(85.71)	0.28(0.04-1.53)	
With friends/ Alone	2(40)	3(60)	1	
Family marital status				
Married (live together)	41(14.70)	238(85.30)	1	
Divorced/widowed/ Separated	15(14.56)	88(85.44)	0.99(0.52-1.87)	
Father alive				
Yes	49(14.80)	282(85.2)	1	
No	7(13.46)	45(86.54)	0.89(0.38-2.1)	
Father live with you				
Yes	38(15.08)	214(84.92)	1	
No	18(13.74)	113(86.26)	0.9(0.5-1.64)	
Fathers Educational status				
Primary (0-8)	17(14.66)	99(85.34)	0.58(0.27-1.26)	

Secondary (9-12)	14(15.22)	78(84.78)	0.61(0.27-1.37)	
Technical (10+)	3(6.67)	42(93.33)	0.24(0.06-0.9)	
University and above	15(22.73)	51(77.27)	1	
Mother alive				
Yes	53(14.76)	360(85.24)	1	
No	3(13.64)	19(86.36)	0.91(0.26-3.19)	
Mother live with you				
Yes	45(15)	255(85)	1	
No	11(13.25)	72(86.75)	0.87(0.43-1.76)	
Mothers Educational status				
Primary (0-8)	23(14.65)	134(85.35)	0.53(0.24-1.19)	
Secondary (9-12)	11(11.34)	86(88.66)	0.4(0.16-1.0)	
Technical (10+)	7(14.58)	41(85.42)	0.53(0.18-1.51)	
University and above	11(24.44)	34(75.56)	1	
Knowledge on STIs/ HIV				
Knowledge on STIs				
Poor	4(44.44)	5(55.56)	1	
Good	52(13.90)	322(86.10)	0.20(0.05-0.78)	
Knowledge on HIV/AIDS				
Poor	8(57.14)	6(42.86)	1	
Good	48(13.01)	321(86.99)	0.11(0.04-0.34)	
CSE				
Yes	33(14.10)	201(85.90)	1	0.35(0.12-0.99)
No	23(15.44)	126(84.56)	1.46(0.74-2.88)	1
Substance use and psychosocial factors				
Substance use				
Yes	25(45.45)	30(54.55)	7.90(4.13-15.09)	
No	31(9.54)	294(90.46)	1	
Do your friends have sex				
Yes	42(48.28)	45(51.72)	18.67(9.44-36.91)	15.65(4.57-53.57)
No	14(4.76)	280(95.24)	1	1
Pressure from friends to have sex				
Yes	32(43.84)	41(56.16)	9.17(4.91-17.09)	
No	24(7.84)	282(92.16)	1	
Friends had sex with prostitutes				
Yes	23(54.76)	19(45.24)	11.19(5.52-22.66)	
No	33(9.76)	305(90.24)	1	
A friend having sex for money				
Yes	20(60.61)	13(39.39)	13.12(6.02-28.6)	

No	36(10.50)	307(89.50)	1	
Friends watch pornographic movies				
Yes	42(31.58)	91(68.42)	7.65(3.99-14.67)	
No	14(5.69)	232(94.31)	1	
Parental control				
Yes	24(8.00)	276(92.00)	0.13(0.07-0.25)	8.07(2.88-22.61)
No	31(39.24)	48(60.76)	1	1
Religious attachments				
Attends frequently	24(10.71)	200(89.29)	1	
Attends sometimes/not at all	31(20.13)	123(79.87)	2.10(1.18-3.74)	
Exposure to media				
Use social-media				
Yes	46(17.16)	222(82.84)	2.11(1.02-4.35)	
No	10(8.93)	102(91.07)	1	
Watch pornographic movies				
Yes	32(43.84)	41(56.16)	9.64(5.14-18.06)	3.88(1.05-14.28)
No	23(7.49)	284(92.51)	1	1
Risk perception				
Risk to STIs				
No/low	54(14.52)	318(85.48)	1	
Medium risk/ High/very high risk	2(33.33)	4(66.67)	2.94(0.53-16.47)	
Risk of HIV				
No/low	52(14.17)	315(85.83)	1	
Medium risk/ High/very high risk	3(30.00)	7(70.00)	2.6(0.65-10.36)	
Fear of STIs				
Not/A little afraid	50(14.08)	305(85.92)	1	
Somewhat afraid/ Highly/Very highly afraid	6(27.27)	16(72.73)	2.29(0.85-6.12)	
Fear of HIV				
Not/A little afraid	42(13.55)	268(86.45)	1	
Somewhat afraid/ Highly/Very highly afraid	14(20.59)	54(79.41)	1.64(0.85-3.24)	

6. DISCUSSION

The main aim of this study was to assess the sexual risk taking among adolescents by focusing on the difference of behavior among those adolescents who took CSE and those who did not take CSE and measure the difference in outcome. Risky sexual behavior was measured here by the presence of either

unprotected sex, multiple sexual partner or sex for money or incentives in the past twelve months. In addition to this the study also tried to examine other factors that could influence the behavior of the adolescents with respect to sexual risk taking including Socio-demographic, Psychosocial, Knowledge, Perception and exposure to media. It analyzed these factors independently including taking CSE, to see the association with risky sexual behavior among the adolescents and added those variables that had a P-value less than 0.25 to multivariate analysis to find its adjusted odds. Not only that, the study also included aspects that to measure the magnitude of early initiation of sex among the respondents.

The participants in the study were in school adolescents ranging from age 14 to 19. The mean age of the respondents was 16.72 which is not in accordance with another research done in Addis Ababa which puts the mean age of adolescents in school as 17.3 (34) which could be attributed to the fact that students are now enrolling in schools at a younger age than in previous years. From the total participants only 27.42% took CSE from different sources. This is a reasonable percentage considering the fact that this course is not given in most parts of Addis Ababa and that only students that participated in extracurricular activities are exposed to the information. From the total three-hundred and eighty-three respondents, sixty-one or 16.05% of the adolescents had already started having sexual intercourse of which forty-eight or 88.9% had sex before the age of 18.

As revealed in the analysis when compared to students that did not take the CSE course, students that did had a decreased chance of involving in a sexual behavior that is risky putting those without CSE in a 2.82 times of more odds to be involved in the behavior. When we see the percentages of each action that defined risky sexual behavior in this study, among the total 105 students that participated in the CSE course, only 5 (4.8%) engaged in unprotected sex in the past 12 months while of the 278 students that did not, 20 (7.2%) had the same experience; same goes for multiple sexual partners and sex for money / incentives having higher parentages of the behavior,17 (6.1%) and 8 (2.9%) respectively, than those who did which is 3 (2.9%) and 1(0.95%) respectively. This goes well with the expectation that giving young people tailored and holistic information with decision making and communication skill course can help them make smarter and safer decisions that could impact them throughout their adult life.

When we come to the overall prevalence of risky sexual behavior in our study, it revealed that approximately 15% of the adolescents are currently engaged in risky behavior. This result is very low compared to another institutional based research done in Addis Ababa which put the risk behavior of adolescents to be 26.7% using the same variables to define risky sexual behavior as this one (early initiation of sex, multiple sexual partners, not using condone and sex for money or incentives)(34). Again

when we see the variables separately; the prevalence of non-condom use among sexually active students is 66.7% for this grope of respondents. When we compare it to a study done in Dilla (35) with a prevalence of 14.9 we see that the result is a bit high. This high variation though could be due to the age difference in the respondents. The study in Dilla sampled youth currently enrolled in a university while this study sampled in school adolescents. Even though the age difference is low it is normal to assume that as they get older it is likely that they start making better decisions to protect themselves. Coming to multiple sexual partners, the prevalence of in our stud y is 32.8% and it is ci accordance with another research done in Haramoya (36) with a prevalence of 31,3%,which could attribute the slight variation to the difference in setting where Addis Ababa is a highly urbanized city and Harmoya is not as such.

The mean age for initiation of sex among the respondents is 15.6(±1.6) and the majority which is similar to the study done in Boditti (37) with mean age of 16.6(±2). 89.1% of the sexually active respondents have engaged in early initiation of sex as defined by our paper as having sex before the age of 18. Early initiation of sex is also higher among men which is 88.88% thane those females of the same sample. The reason for the discrepancy could be mentioned as that of higher percentage among men for risky behavior that is cultural and psychosocial reasons. This theory could be supported by the finding of this study that perceived parental control is higher in females (61.5%) than males.

From the overall analysis, the ones that were found to affect risky sexual behavior include if any of the respondents friends have sex , perceived parental control, if respondent watch pornographic movies, if respondent took CSE and the sex of the respondents. When we see gender, being male puts adolescents at an odds of 3.42(AOR=3.42 95%CI [1.07-11.06]) times more risky than their female counterparts whic is similar to a study done in Boditti Ethiopia (37) reviling that being female is protective with AOR=3.42 95% CI(1.07-11.06). Much can be said about the reasons for this like the fact that our cultural influence puts females at home with more responsibilities than that of males which are usually allowed with unrestricted freedom. Going forth, from the mentioned associations', friends having sex is highly associated with risky behavior putting those respondents who have friends like that at a higher risk of AOR=15.6 95% CI (4.57-53.57)times more. Then perceived parental control at AOR= 8.07 95% CI(2.88-22.61),Watch pornographic movies AOR=3.81 95% CI (1.07-13.55) and lastly NOT taking CSE AOR=2.82 95% CI (1.02-7.75).

The Ethiopian Educational bureau has banned CSE from schools not to be discussed in any way in the compound of a school. Even tough it was included as policy as a vital tool in the Ethiopian policy it has not been implemented. This could be due to the fact that CSE in other developed countries

include aspects that are illegal and tabooed in our country like Homosexuality, Masturbation and the like. But UNFPA, FGA and other non-governmental organizations have coined the course to be more suitable to our setting mainly focusing on skills that could help adolescents avoid putting themselves in situations that could harm them like communication skills and Skills of negotiating sexual exposure in addition to abstinence and contraception

As far as I know, there has been no research done in Ethiopia or other neighboring African countries in the same setting that study the influence of CSE on adolescent sexual behavior to compare the results of this finding to. One qualitative research done in Addis about CSE did not focus on the influence of the education on the students but on the cultural barriers of the community, both teacher and student, to the reception of the course (4.) Other researches done in the western countries used a prospective cohort study design and followed the students to assess the effect of the education as the students got older. It did not focus only on assessing the risky behavior among the samples but also on frequency of sex and physical abuse.

The main limitation of this study is that it is a cross-sectional study and it is very difficult to conclude that the implementation of this course is the reason for the decline in the outcome behavior. Another thing is that it used a self-administered questioner to collect the data which could help for privacy as the questions are a bit intrusive, but on the other side could be subjected to bias as the students are of young age and their response could be driven from making fun of the questions or out of boredom. Another limit is that this study used age at first sex to assess the magnitude of Early Initiation of Sex but it should have also included the aspects of first sex kike coercion, abuse and rape or if it was of free will. . Because this program was administered in only a small part of the city, the sample size to the study is very low resulting in assessments high odds ratio and a vast confidence interval making the generalizability of the result extremely hard.

7. CONCLUSION AND RECOMMENDATION

In Conclusion, the results revealed that CSE really decreases the chance of adolescents in imparting in risky sexual behavior. We also see that there is high prevalence of risky sexual behavior among adolescents in governmental high schools and among others sex of the respondent, parental control, watching pornographic movies, friends having sex and CSE course are highly associated.

Even tough Ethiopia has banned CSE from the schools, the finding clearly indicate that taking CSE could decrease the odds of risky sexual behavior among adolescents as they need information not only about physiology and a better understanding of the norms that society has set for sexual behavior, but they also need to acquire the skills necessary to develop healthy relationships and engage in responsible decision-making about sex, especially during adolescence when their emotional development accelerates in return producing a generation that is safe and responsible when it comes to sexual behaviors. Based on the findings, we recommend that

1. Advocate for policy change

From the results of this paper and other literatures, it is clear that CSE is vital for the SRH of our adolescents and it should be incorporated into the curriculum. Children spend their majority of time in schools so we should use this opportunity to sculpt them into responsible adolescents, youth, and adults. The course should not be given at the time of adolescence but before that so that kids are equipped with knowledge previous to when they experience the changes.

2. Encourage parents

Parents should be encouraged to talk freely to their children and teach them what to expect as they transition into adolescence. Timely and appropriate conversations should be done with their children at every milestone of their growth. And also parents should pay great attention as to what their child does, and who they are with when they are at school and away from school.

3. Restrict access to pornographic movies

Children and adolescents not should be allowed to have access to this kind of material as they are under aged. It should be illegal to rent this type of movies to iners by asking for it before renting or selling movies with this content.

4. Further research

I recommend that further study be done using a different study design superior to this one.

7. REFERENCE

1. Organization WH. Adolescent Health and Development, Department of Child and Adolescent Health and Development. Development DoCaAHa; 2004.
2. Central Statistical Agency OMEaC, Maryland,USA. Ethiopia Demographic and Health Survey 2011.Addis Ababa,. 2012.
3. Barbara S MJ, Grant A, BlancK. The Changing Context of Sexual Initiation in SubSaharan Africa.
4. Browes NC. Comprehensive sexuality education, culture and gender: the effect of the cultural setting on a sexuality education programme in Ethiopia 2015; 15, (. 6, 655–670). Epub 21 June 2015.
5. Carlson DL. The Education of Eros:A History of Education and the Problem of Adolescent Sexuality. 2012.
6. Marques MaNR. The sexuality education initiative: a programme involving teenagers, schools, parents and sexual health services. Reproductive Health Matters. 2013;Vol 21(41):124-35.
7. Trisha E. Mueller MPH, Lorrie E. Gavin, Ph.D., and Aniket Kulkarni, M.B.B.S., M.P.H. The Association Between Sex Education and Youth's Engagement
in Sexual Intercourse, Age at First Intercourse, and Birth Control Use
at First Sex. Journal of Adolescent Health 42 (2008) 89 –96. 2008.
8. United Nations Population Fund U. Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender. 2014.
9. Li J1 LS, Yan H2, Xu D3, Xiao H4, Cao Y2, Mao Z5. Early sex initiation and subsequent unsafe sexual behaviors and sex-related risks among female undergraduates in Wuhan, China. 2014.
10. FHI U, , Ethiopia,. Youth Net Assessment Team:
Assessment of Youth Reproductive Health Programs
in Ethiopia .Addis Ababa. 2004.
11. (UNICEF) UNCsF. Young People and HIV/AIDS; Opportunity in Crisis. 2002.
12. WHO Ua. Sub-Saharan Africa: AIDS Epidemic Update Regional Summary. 2008.
13. Chapman R WR, Shafer LA, Pettifor A, Mugurungi O, Ross D, Pascoe S, Cowan FM, Grosskurth H, Buve A. Do behavioral differenceshelp to explain variations in HIV prevalence in adolescents in sub-Saharan Africa? 2010.

14. (FHAPCO) FHAPaCO. Multi-sectoral HIV/AIDS response: annual monitoring and evaluation report 2010. 2010.

15. Chris Collins MPPPA, J.D. Todd Summers, Stephen F. Morin, Ph.D. AIDS Policy Research Center & Center for AIDS Prevention Studies AIDS Research Institute University of California, San Francisco Policy Monograph Abstinence Only vs. Comprehensive Sex Education: What are the arguments? What is the evidence? 2002.

16. Organization WH. Does Sex Education Lead to Earlier or Increased Sexual Activity in Youth? et al Baldo M. 1993.

17. WHO. Adolescent health. 2016.

18. DESTA B. THE INFLUENCE OF LIVING ARRANGEMENT ON ADOLESCENTS' RISKY SEXUAL BEHAVIOR IN SEBETA TOWN, OROMIA REGIONAL STATE, ETHIOPIA:
SCHOOL BASED COMPARATIVE CROSS-SECTIONAL STUDY. 2007.

19. Kurt Conklin M, MCHES. Adolescent Sexual Health and
Behavior in the United States
Positive Trends and Areas in Need of Improvement. 2012.

20. UNESCO. PROCEEDINGS OF THE CONSULTATION
WORKSHOP ON COMPREHENSIVE
SEXUALITY EDUCATION. 2016.

21. AGENCY SIDC. Comprehensive Sexuality Education. 2016.

22. Hadd-Wissler V. Why Support Comprehensive Sexuality Education? Planned Parenthood Arizona, 2009.

23. UNAIDS. UNAIDS Report on the Global AIDS Epidemic. 2012.

24. Douglas B. Kirby PD, B.A. Laris, M.P.H., and Lori A. Rolleri, M.S.W., M.P.H. . Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World. 2009. Epub Manuscript received April 22, 2006; manuscript accepted November 30, 2009.

25. Survey AYRB. 2011.

26. Almaz Gizaw DJaKK. Risky Sexual Practice and Associated Factors among High School Adolescent
in Addis Ababa, Ethiopia. Family Medicine & Medical Science Research. 2014.

27. Fekadu Mazengia AW. Age at sexual initiation and factors associated with it among youths in North East Ethiopia. Ethiop J Health Dev. 2009;23(2).

28. Kirby D. Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. National Campaign to Prevent Teen and Unplanned Pregnancy. (2007.

29. Virginia A. Fonner KSA, Caitlin E. Kennedy , Kevin R. O'Reilly , Michael D. Sweat. School Based Sex Education and HIV Prevention in Lowand Middle-Income Countries: A Systematic Review and Meta-Analysis.

30. Abstinence-only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy. Journal of Adolescent Health.42((4)): 344-51.

31. Achievement AfYCSEaAS-EPFS. Comprehensive Sex Education and Academic Success-Effective Programs Foster Student Achievement
2010.

32. Kirby D, Laris., B and L. Rolleri .:. Sex and HIV education programs: Their impact on sexual behaviours of young people throughout the world. Journal of Adolescent Health. (2007); 40(3):206-17.

33. Dereje Bayissa D MG, Guta Bayisa and Mekuanint Y. Assessment of Early Sexual Initiation and Associated Factors among Ambo University Undergraduate Students, Ambo, Ethiopia. Journal of Contraceptive Studies. 2016.

34. Gizaw A JD, Ketema K Risky Sexual Practice and Associated Factors among High School Adolescent in Addis Ababa, Ethiopia. journal of Family Medicine & Medical Science Research. 2014.

35. Tadesse M. Substance abuse and sexual HIV-risk behaviour among. International Research Journals. 2014.

36. Hirbo Shore AS. Risky sexual behavior and associated factors among youth in Haramaya Secondary and Preparatory School, East Ethiopia, 2015. Journal of Public Health and Epidemiology 2015.

37. Deresse Daka DS. Magnitude of risky sexual behavior among high school adolescents in Ethiopia:A cross-sectional study. journal of Public Health and Epidemiology. 2014.

ANNEX

ANNEX1: ENGLISH VERSION OF THE INFORMATION SHEET

English Version of Participant's Consent and Information Sheet Addis Ababa University, College of Health Sciences, School of Public Health.

Questionnaire to assess the influence of CSE on adolescent risky sexual behavior in Addis Ababa Ethiopia.

Hi, my name is _____this questionnaire was prepared by Bethel Atnafseged, a post graduate student from AAU, school of public health. I am here to collect information on the Association between CSE and Risky sexual behavior of adolescents. I am requesting you to participate in this study which would require your response to this questionnaire. The study findings would also be used to design and implement control strategies in the study area in the future. Your name will not be written in this form and will never be used in connection with any information you tell us. All information given by you will be kept strictly confidential. Your participation is purely voluntary and you are not obligated to answer any question you do not wish to answer. If you feel discomfort with the questions, you can withdraw any time after you get involved in the study. The questions will take about 30 minutes.

ANNEX 2. CONSENT FORM

Do I have your Permission to continue?

1. If yes, continue the interview.

2. If no, skip to the next participant by writing reasons for his/her refusal.

_____

For any questions you have, you can contact the Principal Investigator by: 09 11 30 09 28

Supervisor: Name _____ Signature_____

ANNEX 3: ENGLISH VERSION QUESTIONNAIRE

Part one: Socio-demographic questions

Questions	Coding categories		Skip to
1.1. Sex	Male Female	1 2	
1.2. Date of Birth	___ / ___ / ___		
1.3. How old were you on your last birthday/	_____ years		
1.4. What grade are you	Grade 9 Grade 10 Grade 11 Grade 12	1 2 3 4	
1.5. Religion	Orthodox Muslim Catholic Protestant Other_____	1 2 3 4	
1.6. What is your current living arrangement?	With family With relatives With friends Alone Other _____	1 2 3 4	
1.7. Did you receive pocket money in the last 3 months?	Yes No	1 2 →	 Part 2
1.8. How much did you receive?	_____ birr		

Part two: Family Characteristics

Questions	Coding category		Skip to
2.1. Parental marital status	Married/ living together	1	

	Divorced/widowed Separated Single	2 3 4	
2.2. Is your father alive?	Yes No	1 2	 2.8
2.3. Does he live in the same house with you?	Yes No	1 2	
2.4. How old was your father on his last birthday?	____ years		
2.5. What is your fathers highest educational attainment?	Primary (1-8) Secondary (9-12) Technical (10+) University Postgraduate	1 2 3 4 5	
2.6. Is your father currently employed?	Yes No	1 2	 2.8
2.7. What is your fathers employment?	Government work Private work Commercial/Business Farmer/ Agricultural work Other_____	1 2 3 4	
2.8. Is your mother alive?	Yes No	1 2 →	 2.14
2.9. Does your mother live with you in the same house?	Yes No	1 2	
2.10. How old was your mother on her last birthday?	____ Years		
2.11. What is your mothers highest educational attainment	Primary (1-8) Secondary (9-12) Technical (10+) University Postgraduate	1 2 3 4 5	
2.12. Is your mother currently employed?	Yes	1	

	No	2 →	2.14
2.13. What is your mothers' employment?	Government work Private work Commercial/Business Farmer/ Agricultural work Other_____	1 2 3 4	
2.14. What is the size of your family?	_____people		

Part three: Knowledge

Questions	**Coding category**		**Skip to**
CSE questions			
3.1. Have you ever taken Comprehensive Sexuality Education	Yes No	1 2 →	 3.4
3.2. Where did you take this education?	School School Clubs From Health workers From NGOs	1 2 3 4	
3.3. What topics were discussed (multiple answers are possible)	Anatomy and Physiology PubertyandAdolescent Development Identity Pregnancy and Reproduction (contraceptives) Sexually Transmitted Diseases and HIV Healthy Relationships	1 2 3 4 5 6	
STI Knowledge Questions			
3.4. Do you know about STIs	Yes No	1 2 →	 3.9

3.5. Can STIs be transmitted?	Yes No	1 2	
3.6. Is it necessary to treat a partners STI?	Yes No	1 2	
3.7. Can STIs be cured?	Yes No	1 2	
3.8. Can STIs be prevented?	Yes No	1 2	
3.9. Do you know about HIV/AIDS?	Yes No	1 2 →	 Part 4
3.19. Can HIV be transmitted by skin contact or sharing a drinking glass with an infected person?	Yes No	1 2	
3.11. Washing genitalia after sex prevents HIV infection.	Yes No	1 2	
3.12. All pregnant women infected with HIV will have HIV positive babies.	Yes No	1 2	
3.13. People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV	Yes No	1 2	
3.14. There is female condom that can decrease a women's chance of getting HIV	Yes No	1 2	
3.15. Taking a test for HIV one week after having sex will tell a person if she or he has HIV	Yes No	1 2	

Part four: Psychosocial and Substance use

Questions	**Coding Category**		**Skip to**
4.1. Do you consume alcohol frequently (at least once a week)	Yes No	1 2	
4.2. Do you chewed chat frequently	Yes No	1 2	
4.3.Do you smoke cigarettes (up to 6 cigarettes a day)	Yes	1	

	No	2	
4.4. Think of your best friend, Has he/she ever had sex?	Yes No	1 2	
4.5. Is there pressure from your friends for you to have sexual intercourse	Yes No	1 2	
4.6. Have your friends ever had sex for money?	Yes No	1 2	
4.7. Do you know if any of your friends had sexual intercourse with prostitutes?	Yes No	1 2	
5.9. Do You currently use social media(internet, face book)	Yes No	1 2	
5.10. Do your friends watch pornographic movies?	Yes No	1 2	
5.11. Have you ever seen pornographic movies?	Yes No	1 2	
5.12. Do your parents know where you are when not at school and away from home	Yes No	1 2	
5.13. Your parents know who you were with when you are not at school and away from home	Yes No	1 2	
5.14. Do you have an attachment to religious institutions? (How often do you go)	Attends frequently (more than twice a month) Seldom attends (less than or equal to twice a month) Does not attend at all	1 2 3	

Part five: Sexual behavior

Questions	**Coding category**		**Skip to**
5.1. Have you ever had sexual Intercourse? [By sexual intercourse, I mean vaginal penetrative sex (penis and vagina)]	Yes No	1 2 →	 Part 6

5.2. Have you had sexual intercourse in the past 12 months?	Yes No	1 2	
5.3. Have you ever had unprotected sex?	Yes No	1 2 →	 5.5
5.4. Have you had unprotected sex in the past 12 months?	Yes No	1 2	
5.5. Have you ever had more than one sexual partner?	Yes No	1 2 →	 5.7
5.6. Have you had more than one sexual partner in the past 12 months?	Yes No	1 2	
5.7. Have you ever traded sex for money?	Yes No	1 2 →	 5.9
5.8. Have you traded sex for money in the past 12 months?	Yes No	1 2	
5.8. How old were you the first time of sexual intercourse?	_____ years		

Part six: Perceived Risk

Questions	**Coding Categories**		**Skip to**
8.1 Do you think that you have the Risk of getting Sexually Transmitted infections?	No Risk Small risk Somewhat risk High" risk Very high risk	1 2 3 4 5	8.3
8.2. How much are you afraid of getting Sexually Transmitted infections?	Not afraid at all Afraid a little Afraid somewhat Highly afraid Very Afraid	1 2 3 4 5	

8.3. In your opinion, do you think have a chance to get Sexually Transmitted infections in the future?	no chance small chance somewhat chance High" chance Very high chance	1 2 3 4 5	
8.4. Do you think that you have the chance to get HIV/AIDS?	no chance small chance somewhat chance High" chance Very high chance	1 2 3 4 5	
8.5. Are you afraid of getting HIV/AIDS?	Not afraid at all Afraid littel Afraid somewhat Highly afraid Very high chance	1 2 3 4 5	
8.6. In your opinion, do you have a chance to get HIV/AIDS in the future?	no chance small chance somewhat chance High" chance Very high chance	1 2 3 4 5	

ANNEX FOUR: AMHARIC VERSION INFORMATION SHEET

አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና አጠባበቅ የት/ት ክፍል

የጥናቱ መግለጫ እና የፍቃደኝነት መግለጫ ቀፅ

ጤና ይስጥልኝ፤

ስሜ----------

□ባላል እዚህ የመጣሁት በአዲስ አበባ ዩኒቨርስቲ በህብረተሰብ ጤና የት/ት መስክ የድህረ ምረቃ ተማሪ የሆነችውን ቤትኤል አጥናፍሰገድ ወክዬ በአጠቃላይ የስነተዋልዶ ት/ት እና አጋላጭ ወሲባዊ ባህሪያ ተያያዥነት ስላለው ጉዳይ በሁለተኛ ደረጃ ተማሪዎች መhከል ጥናት ለማጥናት ነው።ጥያቄዎቹን በመመላት እንዲሳተፉ በትህትና እጠይቃለሁ።ለዚህ ጥናት የተወሰኑ ጥያቄዎች እንዲመልሱልን እጠይቃለሁ።ከአንተ/እንቺ የማገኘውን መረጃ በሚስጥር እጠብቃለ።ይህንንም መረጃ ከአንት/አንቺ ስም ጋር አይየያያዝምበዚህ ጥናት ውስጥለመሳተፍ በቅትሚ□ □ተሳታፊውን ፍቀደኝነት እንጠይቃለን።

መልስ መስጠት የማትፈልገውን/የማትፈልጊውን ጥያቄ ከለ መመለስ አትገደድም/አትገደጂም

ANNEX FIVE: AMHARIC VERSION CONSENT FORM

የፈቃደኝነት መግለጫ ቅፅ

በዚህ ጥናት ለመሳተፍ ፈቃደኛ ነህ/ህ?

1 አዎ 2 አይደለሁም

መልሱ አይደለሁም ከሆነ አመስግነው መጠይቁን ያቁርጡ::ለጥናቱ ፍቃቃኛ የልሆኑበትን ምክንያት ለጥናቱ ተቆጣጣሪ ሪፖርት ያድረጉ::

ለማንኛውም አይደነት ጥያቄ ዋና አጥኝዋን ማነጋገር ይችላሉ::

ስልክ ቁጥር 0911300928

ANNEX SIX: AMHARIC VERSION QUESTIONER

□አ ል 1 □ማህበራዊ እና ስነ ህዝባዊ ጥያቄዎች

ዓ □ቄ	□መልስ መስ□		□እለአ
1.1. ኖታ	ወንድ ሴት	1 2	
1.2. የትውልድ ቀን	---/---/----		
1.3 □ዝለ□□ ልደትህ/ሽ እትሜህ/ሽ ስንት ነበር	--------- ዓመት		
1.4. □□አ ል □ረጽ	9ኛ □አ ል 10ኛ □አ ል 11ኛ □አ ል 12ኛ □አ ል	1 2 3 4	
1.5. ሀይማኖት	ኦርቶዶክስ መስሊም ካቶሊክ ፕሮቴስታንት ሌላ -------	1 2 3 4	
1.6. ከማን ጋር ነው የምትኖረው	ከቤተሰብ ጋር ከዘመድ ጋር ከጎ□ኛ ፉር ብቻዬን ሌላ---------	1 2 3 4	
1.7. የኪስ ገንዘብ ይስጥህል/ይሰጥሻል	አዎ አይ	1 2 →	□አ ል 2
1.8. ስንት ብር	------ ብር		

ክፍል ሁለት፡ □ቤተሰብ ሁኔታ

ዓ □ቄ	□መልስ ምር□		□ለአ
2.1. □ቤተሰብ ጋብቻ ሁኔታ□	□ተፉቡ/አብሮ የሚኖሩ የተፋቱ/በሞት የተለያዩ □ተለ□□ □ላገባ	1 2 3 4	
2.2. አባትህ/ሽ በሕይወት አሉ	አዎ አይ	1 2 →	2.8
2.3. አባትህ/ሽ ከአንተ/አንቺ ጋር አንድ ቤት ነው	አዎ	1	

የምትኖሩት	አይ	2	
2.4. የአባትህ/ሽ □ክትሜ	----------		
2.5. የአባትህ/ሽ የትምህርት □ረጽ	1ኛ □ረጸ(1-8) 2ኛ □ረጸ(9-12) □ሙ□(10+) ዩንቨርስቲ ሁለተኛ ቴፅሪ	1 2 3 4 5	
2.6. አባትህ/ሽ ስራ አላቸው	አዎ አይ	1 2 →	2.8.
2.7. የአባትህ/ሽ ስራ ምንድን ነው	የመንግስት ሠራተኛ □ፅል ሠራተኛ ነጋዴ ቹሬ ሌላ-----	1 2 3 4	
2.8. □እናትህ/ህ በሕ□ወት አሉ	አዎ አይ	1 2	2.14
2.9. □እናትህ/ሽ ከአንተ/ቺ ጋር አንድ ቤት ነው የምትኖሩት	አዎ አይ	1 2	
2.10. □□እናትህ/ሽ □ክድሜ ስንት ነው	----------		
2.11. □እናትህ/ሽ ያላቸው የትምህርት □ረጽ	1ኛ □ረጸ(1-8) 2ኛ □ረጸ(9-12) □ሙ□(10+) ዩንቨርስቲ ሁለተኛ ቴፅሪ	1 2 3 4 5	
2.12. □እናትህ/ሽ በአሁኑ ሰዓት ስራ አላቸው	አዎ አይ	1 2	2.14.
2.13. □እናትህ/ሽ ስራ ምንድን ነው	የመንግስት ሠራተኛ □ፅል ሠራተኛ ነጋዴ ቹሬ ሌላ-----	1 2 3 4	
2.14. □ቤተሰብ ቁጥር ስንት ነው	----------ሰዎች		

□ሉ ል 3 □እውቀት ዓ □ቱ

ዓ□ቱ፡ አጠቃላይ የስነተዋልዶ ትምህርት ጥያቄ	መልስ ምር□		
3.1. ከዚህ በፊት አጠቃላይ የስነተዋልዶ ትምህርት ወስደህ/ሽ ታወቃለህ/ሽ?	አዎ አይ	1 2 →	3.4.
3.2. የት ነው ትምህርቱን የወሰድከው/ሽው	የት/ቤት ሚድያ የት/ቤት ክበብ ከጤና ባለሞያ ከመንግስታዊ ያልሆነ ድርጅት	1 2 3 4	
3.3. ምን ምን ርዕሶች ተጠቀሱ (ከአንድ በላ□ ምር□ መምረጣ □ቻላል)	□ ኖታዊ ጤና ፣ ደህንነት እና ስብአዊ መብቶች ስነ ያታ ስነ ተዋልዶ □እርስ በእርስ ግንኙነት □ሀሳብ ል□·□·ጣ እና ውሳኔ የመስጠት ችሎታ ስለ ሰውነት ክፍሎች ፣ ጉርምስና እና ተኻል□ ኖታዊና የስነ ተዋልዶአዊ ጤንነት አጠባበቅ □ኖታዊ ጤና፣ እኩልነት እና መብቶች መ□በቅ	1 2 3 4 5 6 7 8	
ስለ አባላዘር በሽታ እውቀት			
3.4.ስለ አባላዘር በሽታዎች ታ□·ቃለህ/ሽ	አዎ አይ	1 2 →	3.6
3.5. የአባላዘር በሽታዎች ተላላፊዎች ናቸው?	አዎ አይ	1 2	
3.6. ባል □እና ሚስት የአባላዘር በሽታን□ መታከም አለባቸው	አዎ አይ	1 2	
3.7. የአባላዘር በሽታ ይድናል ብለህ/ሽ □ታሰባለህ/ታስቢ□ለሽ	አዎ አይ	1 2	

3.8. የአባለዘር በሽታን መከላከል ይቻላል	**አዎ** **አይ**	**1** **2**	
3.9. ስለ ኤች አይ ቪ ኤድስ □ታ□ቃለህ /ሽ	**አዎ** **አይ**	**1** **2** →	**□አ ል4**
3.10. ኤች አይ ቪ ኤድስ ይተላለፋል?	**አዎ** **አይ**	**1** **2**	
3.11. ኤች አይ ቪ ኤድስ በንክኪ ወንም በአንድ አይነት መጠጫ በመጠቀም ይተላለፋል?	**አዎ** **አይ**	**1** **2**	
3.12. ከግብረ ስጋ ግንኙነት በሁላ የሽንት መሽኛን መታጠብ ኤች አይ ቪ ኤድስን ይከላከላል?	**አዎ** **አይ**	**1** **2**	
3.13. ኤች አይ ቪ ኤድስ ያለባት □እናት ሁሌም ኤች አይ ቪ ያለበት ህፃን ትወልዳለች?	**አዎ** **አይ**	**1** **2**	
3.14. ኤች አይ ቪ ከለበት ሰው ጋር መሳሳም ኤች አይ ቪን እን□ተላለአ □□ረፉል?	**አዎ** **አይ**	**1** **2**	
3.15. ኤች አይ ቪ በሽታን የሚከላከል የሴቶች ኮንዶም አለ?	**አዎ** **አይ**	**1** **2**	
3.16.□ፅብረ ስጋ ግኙኝነት ከተደረገ 1ሳምንት በሁላ የሚደረግ ኤች አይ ቪ ምርመራ ውጤት ትክክለኛ ነው?	**አዎ** **አይ**	**1** **2**	

□አ ል 4 የኣእምሮ ማህበራዊ□እና እ□ መ□ቀም

ዓ □ቱ	**□መልስ ምር□**		**□እለአ**
እ□ መ□ቀም			
4.1. አልኮል ዘወተር (ቢያንስ በሳምነት አንዴ) ትጠቀማለህ/ሽ	**አዎ** **አይ**	**1** **2**	
4.2. □ ት ትጠቀማለህ/ሽ	**አዎ** **አይ**	**1** **2**	
4.3. ሲፃራ □□ ሳለህ/ሽ	**አዎ** **አይ**	**1** **2**	
4.4. ያንተ/ቺ ቅርብ ጉደኛ □ሲብ □□ንማል	**አዎ** **አይ**	**1** **2**	
የጃደኛ ግፊት			
4.4. ጉደኞችህ ወሲብ □እንድትፈጽም/ጽሚ	**አዎ**	**1**	

□ቶኛ'ህል/ሻል	አይ	2	
4.5. ለገንዘብ ወሲብ የሚፈጽሙ ጓደኞች አሉ□/ሽ	አሞ አይ	1 2	
4.7. ከቅርብ ጉደኞችህ መከከል ከሴተኛ አዳሪዎች ጋር □ሲብ □ሚ□ንም ተ□ቃለህ	አሞ አይ	1 2	
ሚቂ□ ተጋላጭነት			
4.8. የማህበራዊ ድህረ ገፅ (ፊስ ቡክ ዋትስ አፕ ቫ□በር የመ ሳሰሉትን) ትጠቀማለህ/ሽ	አሞ አይ	1 2	
4.9. ጉደኞችህ/ሽ የወሲብ ፊልም ይመለከታሉ	አሞ አይ	1 2	
4.10. አንተ/ቺ የወሲብ ፊልም ትመለከታለህ/ቻለሽ	አሞ አይ	1 2	
□ቤተሰብቁጣ ጉ ር			
4.11. ትምህርት እና ቤት ባልሆንክበት/ሽበትሰዓት ቤተሰቡችህ/ሽ የት እነደሆንክ/□ □□ቃሉ	አሞ አይ	1 2	
4.12. ትምህርት እና ቤት ባልሆንክበት/ሽበትሰዓት ቤተሰቡችህ/ሽ ከማን ጋር እንደሆንክ/ሽ □□ቃሉ	አሞ አይ	1 2	
4.13. ወደ ሀይማኖት ተቋም መሄድ ታዘወትራለህ/ሽ	አብዛኛውን ጊዜ (በ□ር ውሰጥ ከሁለት ጊዜ በላ□) አልፎ አልፎ አልሄድም	1 2 3	

ክፍል 5. ወሲባዊ ባህሪያት

ጉ□ቄ	□መልስ ምር□		□እለአ
5.1. □ሲብ (የግብረ ስጋ ግንኙት) ከሴት ጋር □ንመህ/ ከወንድ ጋር □□መሽ ታ□ቃለህ/ለሽ	አሞ አይ	1 2 →	 □አ ል6
5.2. ባለፈው 12 ወራት ውስጥ □ሲብ(የግብረ ስጋ ግንኙት) አድርገህል	አሞ አይ	1 2	
5.3. ጥንቃቄ የጎደለው ወሲብ (ያለኮንዶም) □ንመህ/ሽ ታ□ቃለህ/ሽ	አሞ አይ	1 2 →	 5.5
5.4. ጥንቃቄ የጎደለው ወሲብ (ያለኮንዶም) በዚህ 12 ወር □ስጥ □ንመህ/ሽ □ታ□ቃለህ/ሽ	አሞ አይ	1 2	
5.5. ከአንድ በላይ የወሲብ ጉደኛ ኖሮህ/ሽ ያውቃል	አሞ	1	

	አይ	2 →	5.7
5.6. ከአንድ በላይ የወሲብ ጉደኛ በ□ህ 12 ወር ውስጥ ኖሮህ/ሽ ያውቃል	አዎ አይ	1 2	
5.7. ለገንዘብ ብለህ /ሽ ወሲብ ፈፅመህ/ሽ ተውቃለህ/ሽ	አዎ አይ	1 2 →	 5.9
5.8. ለገንዘብ ብለህ /ሽ በ□ህ 12 ወር ውስጥ □ሲብ □ንመህ/ሽ ተ□ቃለህ/ሽ	አዎ አይ	1 2	
5.9. ለመ□መሬ□ ቂ□ ወሲብ ስትፈፅም/ሚ ስንት ዓመትህ/ሽ ነበር	-------ዓመት		

□ፍል 6 ለአባላዘር በሽታዎች እፉለ□ለሁ ብሎ ማሰብ

ዓ□ቄ	□ምር□ መልስ		□እለአ
6.1. የአባላዘር በሽታ ተፉላ□ ነኝ ብለህ/ሽ □ታስባለህ/ሽ	አላስብም ትንሽ መጠነኛ ከፍተኛ በ□ም ከፍተኛ	1 → 2 3 4 5	6.3
6.2. የአባላዘር በሽታ □□□ኝ ይሆናል ብለህ/ሽ ምን ያህል ትፈራለህ/ሽ	አልፈራም ትንሽ መጠነኛ ከፍተኛ በ□ም ከፍተኛ	1 2 3 4 5	
6.3. በኣንተ/ቺ ኣስተሳሰብ ወደፊት ለአባላዘር በሽታ□እፉለ□ለሁ ብለህ/ሽ □ታስባለህ/ሽ	አላስብም ትንሽ መጠነኛ ከፍተኛ በ□ም ከፍተኛ	1 2 3 4 5	
6.4. ለኤች አይ ቪ ኤድስ ተጋላጭ ነኝ ብልህ/ሽ □ስባለህ/ሽ	አላስብም ትንሽ መጠነኛ ከፍተኛ በ□ም ከፍተኛ	1 2 3 4 5	
6.5. ኤች አይቪ እና ሌላ የአባለዘር በሽታዎች□እንዳይዘህ/ህ	አል□ራም	1	

ትፈራለህ/ሽ?	ትንሽ መጠነኛ ከፍተኛ በ□ም ከፍተኛ	2 3 4 5	
6.6. ወደፊት ኤች አይ ቪ ሊይዘኝ ይችላል ብለህ/ሽ ታስባለህ/ሽ	አላስብም ትንሽ መጠነኛ ከፍተኛ በጣመምከፍተኛ	1 2 3 4 5	

ስለተሳተፋችሁ አመሠግናለሁ::