

**ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES**

**THE INFLUENCES OF FAMILY, PEERS  
AND SCHOOL CLUBS ON ADOLESCENTS'  
SEXUAL BEHAVIOR AND RISK PERCEPTION**

**BY  
WAKGARI MEGERSA AGA**

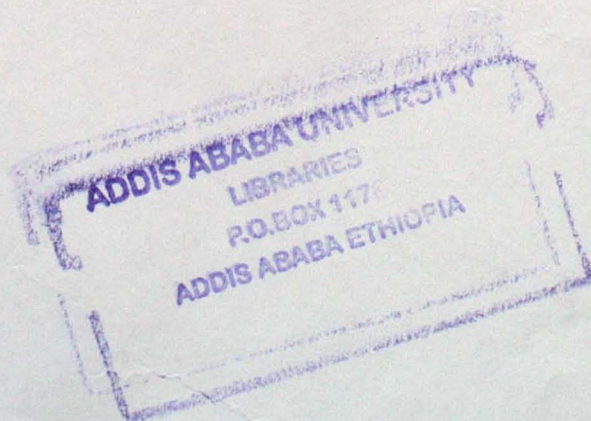


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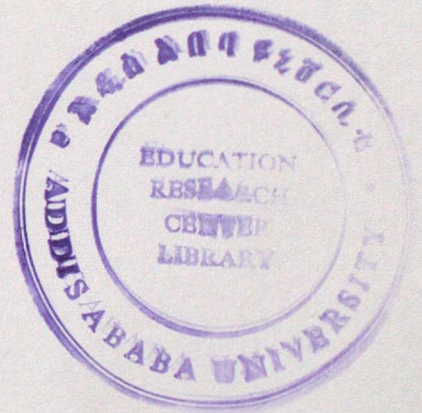
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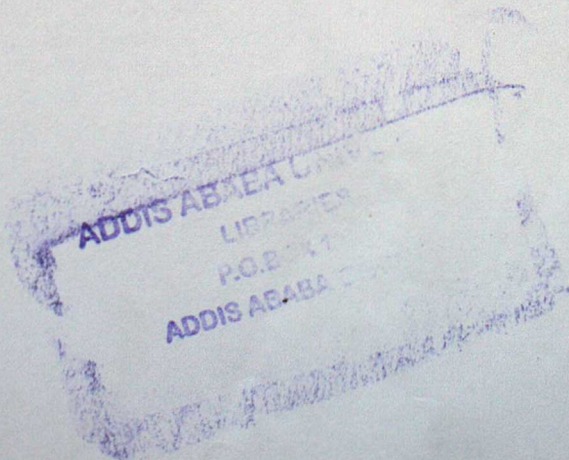
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**A Thesis Submitted To the School of Graduate Studies  
of Addis Ababa University in Partial Fulfillment of the  
Requirements for the Degree of Master of Arts in  
Developmental Psychology**



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ADDIS ABABA**

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## **ACRONYMS**

**AIDS-Acquired Immunodeficiency Syndrome**

**CYAO-Children and Youth Affairs Organization**

**FGAE- Family Guidance Association of Ethiopia**

**HIV- Human Immunodeficiency Virus**

**MOLSA-Ministry of Labor and Social Affairs**

**STDs- Sexually Transmitted Diseases**

**UNAIDS-United Nations Jointed Program on HIV/AIDS**

**UNICEF-United Nations Children's Fund**

**WHO-World Health Organization**

## *Abstract*

*Today premarital intercourse is becoming common among adolescents because of many factors such as decline in the age of puberty and delaying marriage. In addition, this early sexual initiation can be attributed to many factors such as family related variables, peer pressure and perceived peer group sexual activity. Provision of information and guidance on sexuality for adolescents is low or non-existent. Consequently, adolescents can make uninformed sexual decisions resulting in risks like HIV/AIDS and unplanned pregnancy. Hence, this study was intended to assess family, peers and school clubs as predictors of sexual behavior and risk perception of high school adolescents of two selected towns (Adama and Shashamanne) from each of which 2 schools were randomly selected. Using stratification 360 participants, 184 males and 176 females, were selected. To collect the necessary data, close-ended questionnaire whose validity and reliability were tested using test-retest method and semi-structured FGDs were employed. The study indicated that nearly one-thirds of the respondents were sexually active. Males and older adolescents accounted for the higher proportion of the sexually active adolescents. Most of them never or inconsistently used condom during the first intercourse and during intercourse with their regular partners. Risky sexual behavior was associated with single parenting and low economic background for girls than for the boys. Adolescent-family communication on sexual matters was found to be uncommon. Participation in clubs and parental education had significant correlation with risky sexual behaviors. Though peers were reported as the major source of information, the relationships between risky behavior and peer communication was not significant. Therefore, the problem investigated in the study should be intervened through establishing adolescent health policy and provision of awareness and practical skills on sexual issues.*

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the study

Adolescence is a stage of human development between childhood and adulthood, including individuals in the age ranges from 10 to 21 years, though the definition varies across cultures. The period is the time of progression from appearance of secondary sex characteristics to sexual and reproductive maturity (National Conference on Adolescent Reproductive Health (2002)). It is the period when individuals develop adult mental processes and identity. The period encompasses the development to sexual or psychological maturing and to relative economic independence. It is a period of new developments and excitements linked with searching, discovering, and living from day to day to the best of one's ability in a complicated social world of new friendships, new feelings and different responsibilities and expectations (Cobb, 2001). With pubertal changes, sexuality becomes the most important aspect of development during adolescence (Laurence, 1993). Figuring out how to deal with sexual desires and how to incorporate sex into social relationships become one of the major tasks of adolescents. Thus, sexual activities such as masturbating, sexual dreams and fantasies, and tentative explorations of sexual behavior with others are prevalent (Conger, 1991; Cobb, 2001).

Today, regardless of the differences in gender, socio-economic classes, religions and places of residence, premarital intercourse is becoming very common than ever before among adolescent (Kelly, 1995). This prevalence of sexual activities are mainly attributed to the lowering in the time of maturity, the increase in the age at marriage, the changes in today's family structure and the liberalization of the sexual standards in different societies (Unger and Crawford, 2000 ; Perloff, 2001 and Laurence, 1993). Concerning this problem, the situation in Ethiopia is also similar with what is prevailing in the other countries of the world. Surveys conducted by FGAE (1995) and MOLSA

(1991), for instance, indicated that premarital intercourse initiated at the very earlier ages in Ethiopia is becoming very common.

Adolescents' sexual activities are affected by the inadequate context in which they are grown. The conservative views in different societies in general and families in particular, with regard to discussions on sexual issues resulted in limited knowledge and uninformed sexual choices among adolescents. Therefore, adolescent involvement in risk sexual activities like early sexual initiation, sex with multiple partners, and unprotected sex are due to lack of proper guidance and information from the sides of their parents and other adults (UNICEF, 2002). Consequently, adolescents are often vulnerable to risks like HIV/AIDS, unwanted pregnancy, unsafe abortion or child birth. Peer pressure and inadequate sex education programs and guidance in schools are also the major variables resulting in adolescent's involvement in risk sexual activities.

Most adolescents, even when they have the necessary knowledge, involve in risk sexual activities such as sex without condoms, perceiving their risks of vulnerability as very low or non-existent (Unger and Crawford, 2000). In addition, the inequality of power in making sexual decisions between partners, feelings of embracement in discussing about condoms, failure to plan for sex in advance, lack of knowledge from where to get condoms and having sex under the influences of drugs or alcohols are some major factors limiting adolescents' condom use (UNICEF, 2002)

Therefore, in this study, family related variables (i.e. parental educational and economic backgrounds, parent adolescent communication and family structures), peer groups and school programs/ clubs will be assessed as the major correlates of adolescents' sexual behaviors (i.e. number of sexual partners, ages at first intercourse, trends in condom use) and the extent to which the sexually active adolescents view their vulnerability to risks.

## **1.2 Statement of the problem**

Adolescence is a transitional period between childhood and adulthood when individuals exhibit varieties of changes such as physical, cognitive and social changes which are linked with behavioral changes. It is the time when young people develop the knowledge,

attitudes and skills that become the foundation of psychologically healthy adulthood. It is a period characterized by rapid changes and the need to achieve several significant developmental tasks.

Because of many factors, adolescents often encounter some challenges. Puberty is a biological factor which is a potential cause for adolescents' behavioral problems (Berger, cited in Children And Youth Affaires Organization, 1995). Emotional disturbances emanating from parental restrictiveness hinder adolescents from learning desirable standards of behavior and create the chance to produce spoiled and irresponsible actions. Pathogenic family structure is also a major factor that increases adolescents and youth vulnerability to some behavioral problems (Hetherington, cited in CYAO, 1995). In addition, the period is the stage when the issues of sexuality is associated with risks like STDs and AIDS, unwanted pregnancy, unsafe abortion and child birth become prevalent.

Most adolescents make misinformed or uninformed sexual decisions because of lack of proper guidance and information from the sides of their parents and other members of the society (Kimmel and Weiner, 1985). Today, when the world wide epidemic disease (AIDS) is striking people hard, premarital sexual intercourse is becoming very common. Factors like the decrease in the age of puberty, increase in the age at marriage, increase in the changes of the family structure, changes in the traditional views about sex and the like resulted in early sexual initiation among adolescents (Rutter, 1995). Thus, the increase in the prevalence of sexual activities among adolescents is the major precipitating factor for the spread of HIV/AIDS ( Perloff, 2001). While adolescents are tempted by the above factors to involve in sexual activities, proper information and guidance are inevitable which actually most of them are deprived of.

Peer pressure and perceived peer group sexual activities are the other major factors that often influence adolescents' sexual decisions. i.e., adolescents are initiated to engage in sexual activities. In addition, the more adolescents perceive their friends are engaged in sexual activity, the more likely they would engage in it.

Most adolescents fail to use contraceptive methods mainly because of the gender inequality of power on sexual decisions, failure to plan for sex as the result of fear of public criticisms, trusting one's own partner, limited information on where to get and how to use contraceptive methods, misconception in considering their individual risks as low or non-existent, and the like are major factors leading adolescents in sexual activities resulting in risks like HIV/AIDS, unwanted pregnancy and unsafe abortion (Phillips, 1998; Perloff, 2001; Lamanna and Riedman, 1985; Unger and Crawford, 200).

Therefore, in this study, the following major research questions were addressed.

- ✓ 1. Are there statistically significant differences in the sexual behavior (practices) of adolescents as the function of:
  - ✓ i. Differences in ages, gender and grade level?
  - ii. Differences in the family variables such as parental educational and economic backgrounds, the nature and degree of communication with their children, and family structure?
  - ✓ iii. Differences in the frequency of participation in school programs/ clubs?
- ✓ 2. Who are the major sources of information on sexual issues for the adolescents?
3. How and to what extent are adolescent sexual behavior influenced by their peers?
- ✓ 4. What are the major factors affecting adolescents' contraceptive usage?
- ✓ 5. What is the level of adolescents' understanding of human sexuality and related issues like STDs and AIDS, pregnancy & condoms? Are there any differences in their sexual activities as the function of their knowledge?
- ✓ 6. How do the sexually active adolescents perceive their individual risks associated with their sexual activities? Are their risk perceptions age and gender related? Can adolescents' risk perception predict their sexual behavior?

### **1.3 Rationale of the study**

The investigator through reading different books found that many educators and developmental psychologists consider adolescence as a period of human development. Most of them try to describe that the period is relatively full of challenges and identified some

contributing variables. The understanding the researcher developed was that sexual activity associated with health risks begins in adolescence, young people are deprived of the necessary information and guidance from their parents and other adults, adolescence is the stage of indulging in drugs and alcohols, young people accounts for the greater proportion in sexual activity, adolescent girls are highly vulnerable because of different variables, adolescence is the period when the patterns of relationships are shifted, and the like prompted him to study the problem in the selected contexts. The investigator, through critically observing and informally communicating with in and out- of- school adolescents, identified that there is some gap with regard to adolescents' sexual activity. In addition, the investigator went back to his own personal experience in retrospect, tried to analyze what was happening to him, his brothers and sisters in the family. All the factors described above, cumulatively, add some kinds of knowledge to the investigator's previous understanding and created interests in his mind.

#### 1.4 Purposes of the Study

**General Objective:** - the major objective of this study is to assess the influences of family, peers and school clubs as predictors of adolescents sexual behaviors and their perceptions of individual risks associated with their sexual actives.

**Specific Objectives:** the study was intended to:

- ✚ find whether there are statistically significant differences in the sexual behaviors of adolescents as the function of
  - Their ages, genders and grade levels
  - Familial variables
  - Frequencies of participation in the school programs/ clubs.
- ✓ ✚ Identify the major sources of information on sexuality and HIV/AIDS for the school adolescents
- ✚ Assess in what ways and to what degree adolescents sexual behaviors are influenced by their peer groups
- ✓ ✚ Identify the major variables limiting adolescents contraceptive usage
- ✓ ✚ Assess the levels of adolescents knowledge on human sexuality and related risks such as STDs including HIV/AIDS, pregnancy and contraceptive methods

- ✓ ↓ Assess to what extent their knowledge can predict their condom use
- ↓ Investigate how the sexually active adolescents perceive their individual risks related with their sexual activities; and check whether or not their risk perceptions vary with their ages and genders
- ↓ Investigate whether there is statistically significant difference in adolescents' sexual behavior as the function of their risk perception?

### **1.5 Significance of the study**

This study is important in that it could provide adolescents the necessary knowledge and awareness in improving their misinformed or uninformed sexual choices. The study is also important in creating awareness on the sides of parents, extended families, peers, communities, religious people, health professionals and schools in guiding and supporting young people to make safe choices such as postponing intercourse and consistent contraceptive usage. The study can improve the perceptions that most parents and other adults have with regard to open discussion on sexual issues. Moreover, it can provide a better awareness for the school teachers and other responsible personnel on the role of curricular and co-curricular programs in shaping the sexual behaviors of school adolescents.

The study, being sensitive issue, can attract the attentions of governmental and non-governmental organization working on social problems and policy makers to identify the major correlates of adolescents risk sexual behaviors and enables them design preventive strategies.

Finally, this study may indicate further directions to other professionals to conduct a better problem solving research on the issue.

### **1.6 The delimitation and limitation of the study**

This study was delimited to investigate the roles of the major home- related variables, peer groups and co-curricular programs/clubs in predicting the sexual behaviors and risk perceptions of adolescents in selected high schools of two towns-Adama and Shashemene. The study was delimited to only these two towns because of the inadequate budget, time and human resource. Taking into account the conservative view of the participants in expressing

their sexual history, the researcher took longer time in giving orientation to convince the participants. Nevertheless, significant number of questionnaires was left unresponded and unreturned.

### 1.7 Definition of terms

1. **Family factors-** refer to family economic status, their educational backgrounds, parent-adolescent communication and family structure. In this context, family economic status has three levels (high, medium and low), their education has also three levels (high school complete or more, elementary education and illiterate), and family structure has three levels (single parenting, both parenting and step parenting).
2. **Peer Pressure-** refers to the ways by and extents to which the sexual decisions of adolescents are influenced by their friends. It also includes the degree to which adolescents are engaged in sexual activities perceiving that their peers are engaged in it.
3. **School clubs-** refers to programs/ clubs providing sexual information for the school adolescents and their roles in predicting school adolescents' sexual behaviors. With regard to school clubs participants are categorized in to three levels (those who enjoy with participating, those who can't decide and those who are not happy with participating in clubs).
4. **Sexual behaviors-** refers to sexual activities (i.e. being active or not), the nature and number of sexual partner and the trends in contraceptive usages among the school adolescents. It refers to sexual activities (being sexually active or not), the nature of their sexual partners (regular/casual), the number of sexual partners (four or more, three, two, one), and trends in condom use. It is a dependent variable with four levels (high risk behavior, at-risk, lower risk and non-risk behavior).
5. **Regular partner-**refers to a sexual partner with whom an adolescent girl/ boy has sexual intercourse. Depending whether the adolescents had a single sexual partner or not the variable was made to have two levels.
6. **Casual Partner:** - partners with whom an individual had sexual intercourse for a night-stands. With whom one has not had intercourse regularly.
7. **Risk Perception:** - refers to the degree to which the sexually active adolescents perceive their vulnerability to risks associated with their sexual activities. The variable is treated as dependent variable with four levels.

## **1.8 Theoretical framework**

Theory is a set of testable statements derived from axioms of a model (Cobb, 2000). Different theories emphasize on different aspects of development and give different justifications for developmental changes. This study, specifically, concerned with a developmental change that is associated with the stage of adolescence. i.e., adolescents' sexuality. In this respect, selected theories and models are seen in relation to sexual initiation during adolescence, variables to which risk sexual behaviors are attributed and theory based approaches to the interventions of risky sexual behaviors are presented. Because theory-based approaches have the potential to specify critical factors to target for change, to suggest effective methods for change and to guide us in evaluating risky intervention processes (Fisher, cited in Yoseph, 2006).

Therefore, some selected theories and models related with adolescents' behaviors in general and their sexual behaviors in particular as well as theory based intervention approaches to risky sexual behaviors are presented.

### **Biological theory of adolescent sexuality**

Adolescence is the most important period for the development of sexuality. This, from the view of biological theory of adolescent development, is because of the increase in the amount of hormones which comes with the emergence of puberty. i.e., it is the increased levels of hormones that lead adolescents to greater sexual desires. These sweeping biological changes involving body growth, sexual maturation, ejaculation in boys, breast growth and menstruation in girls would lead to a period of significance transition and change (Weiner and Kimmel, 1985; Feshbach & Weiner, 1986).

### **Ecological theory**

Ecological theory is concerned with the influences of multiple systems on individuals' behaviors. Some of these systems are the microsystem and macrosystem. The most direct social agents take place with parents, peers, and neighborhood. The culture in which individuals live including the patterns of behavior, beliefs, and all other products of groups are encompassed in the macrosystem. And these can positively or negatively influence the

behaviors of adolescents (Nancy cited in Julyata, 2006). Feshbach and Weiner (1986) also justified that it is the social-cultural context in which the adolescents grow which determine their behaviors. They also suggested that contextual theory emphasize on physical environment like place of residence, income, size of school, ethnic background and religion play vital roles in predicting adolescents' behaviors.

### **Social learning theory**

According to this theory, individuals' behaviors (risky or risk-free) are acquired through modeling (Cobb, 2000). For instance, adolescents' behaviors could be attributed to the behaviors and actions of their parents, peers, teachers or other adults. This theory, said Perloff (2001), emphasize on provision of information to increase awareness, teaching self-management skills, strengthening perceived self-efficacy , and creating social supports (parental, peers, or other adults) and reinforcing efforts could modify risk sexual behaviors. This clearly shows that adolescents' involvement in risky sexual behaviors is the result of the absence of sufficient information, good models and social supports.

### **Theory of reasoned actions**

Reasoned action theorists believe that peoples behavior in general & adolescents sexual behaviors in particular are governed by their intentions to behave in the ways they are behaving, their attitudes to wards that behavior (i.e. their beliefs about the consequences of putting that behavior into actions), and their own subjective norms (i.e., their inclinations to go along with the views of people they respect). External factors like individual's health history or cultural contexts can affect their intentions by affecting their attitudes and subjective norms which determines whether they will involve in risk behaviors or not (Perloff, 2001).

### **Health Belief Models (HBM)**

According to this model, it is the belief about the threat of a particular disease and ways of coping with the illness that determine their likelihood of involving in a certain behavior. Fore example, the more adolescents perceive the risk of HIV/AIDS as highly threatening, the less their probability of involving in risk sexual behaviors.

In this case, health beliefs are influenced by social and demographics factors, beliefs trigger a motivation for health protective actions, and cues in the social environments lead to action. Socio-demographic factors like age, gender, race, ethnicity, and economic level determine the degree of adolescents' perceived susceptibility to risks like HIV/AIDS, perceived severity of the disease, perceived benefits of actions ( for example, using condoms), and perceived barrier to actions (i.e., barriers to purchasing & using condoms), and these all perceptions & expectation determine their sexual behaviors (Perloff, 2001).

### **Extended parallel process model**

As to this model, communication should contain a threat and efficacy component. For instance, when teaching adolescents about risky sexual behaviors we should convince that they are susceptible to a sever threat like HIV/AIDS (threat component), and we should also tell them what they can do to avert the threat (Perloff, 2001).

### **AIDS Risk Reduction Model (ARRM)**

According to AIDS Risk Reduction Model (ARRM), factors like failure of individuals to label their risky behaviors as problematic, lack of commitment to reduce the behavior or to take steps to change their behaviors result in involvement in risk sexual behaviors. In addition, lack of social supports and constructive communication between partners also lead to sexual risk taking behaviors (Perloff, 2001).

### **Tran theoretical Model**

In reducing risk-sexual behaviors to the Tran theoretical model, five steps must be considered. These are:-

1. The pre-contemplation stage in which individuals have no desire to change their behavior
2. The contemplation stage where people recognize they have a problem
3. The preparation stage in which people actively plan to change their risky behaviors,
4. The action stage in which people actually modify their risk behavior, and
5. The maintenance stage in which people sustain behavioral changes over a long period of time (Perloff, 2001).

Generally, sexual initiation during adolescence, variable contributing to their sexual behaviors in general and their sexual behaviors in particular and measures to be taken to intervene their risky behaviors are seen from difference theoretical view points.

This study, specifically, intended to see how and to what extent family backgrounds and peers as well as school programs influence adolescents' sexual behaviors & risk perception. Therefore, social learning theory and Health Belief Model are considered as the bases for this study.

## CHAPTER TWO

### REVIEW OF RELATED LITERATURE

This chapter theoretical concepts and related research studies are presented. They are concepts on adolescent sexuality, correlates of adolescent sexual behaviors, their contraceptive behaviors, their perceptions of risks associated with sexual activity.

#### **2.1 Adolescents' sexuality**

It is familiar fact that adolescence is a period of transition from childhood to adulthood. At this period different aspects of developmental changes, psychological changes and the like are exhibited.

Adolescence is a very important period for the development of sexuality as the result of the link between pubertal changes and sexuality. Sexual needs increase as the result of hormonal changes during adolescence. That is, beginning from early adolescence males begin to ejaculate and females begin to ovulate (Laurence, 1993).

The nature and meaning of sexual behavior for adolescents are different from that of children in that adolescents are mature enough and pregnancy is a possible outcome of adolescents' sexual activity. That means, though one can find children kissing, petting or masturbating or even having sexual intercourse such activities are different from that of adolescents (Kimmel and Weiner, 1985). In addition to the physical changes of puberty the changes in thinking capacity on sexuality in adolescence, the new social meanings given to sex and the dating behaviors at this period make sexuality different during the period (Laurence, 1993). Thus, puberty –a physiological transition that gives boys and girls adult bodies alters how adolescents perceive themselves as well as perceived and treated by others (Lerner and Galambos and Smith cited in Call et. Al., 2002). Dealing with sexual desires and incorporating sex appropriately into social relationships are the developmental tasks of adolescents. Adolescents need to add the new sexual feelings and behaviors emerge with pubertal changes into their senses of identity (Cobb, 2001). Masturbations, sexual dreams and fantasies, day dreams and tentative explorations of sexual behaviors with others, romantic fantasies, feelings of fall-in-love, writing poetry, feeling

attracted by love scenes in movies and the needs to be near sexually attractive person are very common among adolescents (Kimmel and Weiner,1985).

Because of many factors premarital sexual activity is becoming highly prevalent among today's adolescents than ever before. A survey conducted in Kenya, for instance, showed that early onset of pubertal changes, social changes and modernization, delayed age at marriage, the deterioration of traditional family- centered parenting styles on sexuality and the like resulted in early initiation of sexual activity among adolescents (Gyepi Garbrah, cited in Family Guidance Association of Ethiopia, 1995). The prevalence of premarital sexual activities, however, varies with age, sex, culture, religion, place of residence (i.e. being urban or rural) and so forth.

## **2.2 Predictors of adolescents' sexual behaviors**

Some adolescents involve in risk sexual activities such as sex at a very earlier age, unprotected sex, sex with multiple partners and so on. Whereas, other adolescents are in safe positions such as postponing their sexual activities or consistently using contraceptive methods. These differences in their sexual behaviors can be attributed to a number of variables some of which are discussed as follows.

### **2.2.1 Family related variables**

Adolescents' sexual behaviors can be influenced by family related variables such as their educational background, socio-economic status, their nature of communication, their techniques of disciplining, family structure and the like.

#### **Adolescent-family communication**

As it has been discussed in the different parts of this study, parental communication is the major factor determining the sexual behaviors of adolescents. However, in many societies discussions about sexual issues with children and adolescents are considered as some thing taboo. In addition, many people mistakenly believe that withholding factual information about sex from young people will discourage them from becoming sexually active at an early age (UNIADS, 1997). In conservative families, since adolescents are deprived of the necessary guidance and information, they often make uninformed or misinformed decisions (Cobb, 2001).

A report by UNICEF (2002) showed that evidences from around the world have clearly shown that providing information on human sexuality from the side of parents and other adults in the family create mature and responsible attitudes among adolescents. Especially, mother's communication with both adolescent boys & girls is associated with late and safe sexual intercourse, though father's communication with adolescent boys is some times associated with early sexual intercourse because of the double standards for sexuality (Kahn, et. Al., cited in Unger& Crawford, 2000).

### **Family structure**

Whether adolescents are brought up by single parents, both parents or step parents makes a difference in their sexual behaviors. Thus, one family factor which makes a difference, especially for adolescent girls, is the household composition. i.e. adolescents who live in a single parent household are more likely to be sexually active as the result of the fact that single parent homes are more permissive than two parent homes (Laurence, 1993). Similarly, a survey conducted by UNIADS (1999) suggested that girls who live with a single parent, with other relatives or in families with low economic level or drug addiction problems are in a high risk of involving in risky sexual activities.

### **Family economic and educational background**

Research studies showed that the economic situation of the family is one of the predictors of children's & adolescents' behaviors. Involvement with drugs and low level of religious involvement can result in risky sexual behaviors (Laurence, 1993). Specially, for girls lower economic status results in early age of sexual intercourse (Zelink, et.al., cited in Crawford & Unger,2002). It is also suggested in several surveys that parental educational background can influence the behaviors in general and the sexual behaviors in particular among their children and adolescents. Fore instance, the more educated they are the more likely they become open in the provision of information on sexuality for the adolescents.

### **2.2.2 The influence of Peers**

In different societies, specially where sex is not openly discussed between adolescents and their parents or other adults, peer groups remain the major sources of information for the adolescents

(UNICEF, 2002). In many surveys conducted on adolescents in different towns of Ethiopia most respondents reported their friends as one of the major sources of information on sexual issues, while they report that parents provide little or no information on the issue (Family Guidance Association of Ethiopia, 2001). On the other hand, peer pressure, the ways they act and behave or the ways an adolescent boy/girl perceives the actions of his/her peers can influence his/her sexual decisions. For instance, someone whose friend has positive attitudes towards premarital intercourse is likely to support premarital intercourse (Conger, 1991). In addition, the way an adolescent perceives his/her peer group norms is the most powerful variable determining the early sexual activity. In other words, most adolescents start sexual activities because they think their friends are doing so (Kinsman, cited in Papalia, 2001; Furstenberg, et al., cited in Unger & Crawford, 2000).

### 2.2.3 Roles of school-based clubs/ programs

There are controversies and misunderstandings on whether or not adolescents should be given information on sexuality. Some people believe that giving adolescents information about sexuality will encourage them practice it. The assumption, here, is they won't think about sex unless someone around them brings up the issues (Zastrow & Ashman, 1997). In this case, as described by Zastrow & Ashman, assuming adolescents to have very little information on sex & perceiving adolescents to automatically try any thing they hear about are wrong assumptions. However, almost all adolescents learn about sex from their friends. In addition, they get information through different media. A similar study by UNICEF (2002) in Cambodia, Haiti, Malawi and Zimbabwe showed that many adults wrongly perceive that informing young adolescents about sex and teaching them how to protect themselves will make them sexually active. Thus, it was found that at least 40% of adults felt that children aged 12-14 shouldn't be taught to use condoms. However, many studies suggest that information provided by parents and other adults, through school programs and by their friends has a positive outcome in helping them make responsible decisions.

Levinson, et. al., cited in Cobb, (2001), suggested for instance, programs that provide information on sexual issue don't make adolescents engage in sexual activity; rather they help them delay from engaging in the activity, and even make those who are already engaging in it to

use contraceptives. Adolescents who actively involve in such programs who were at risks of becoming pregnant due to low income and family background were more than twice as likely to effectively use contraceptives as age mates who were not involved in such programs Levinson .et. al., cited in Cobb (2001). So, young people are likely to delay starting sexual intercourse when they are allowed to involve in different programs (UNICEF, 2002).

An assessment of a youth club in Mathare Valley in Nairobi by UNIADS (1997) showed that girls who involved in the club became more confident and begun to involve in other different activities. In addition, boys were becoming to have more respect for girls and starting to question whether sex is the only way in which they can relate to girls. It was suggested, therefore, that if such attitudes are promoted and fostered more widely it is possible to prevent the spread of HIV/AIDS.

Different surveys conducted in different towns of Ethiopia also showed that one of the major sources of information for the adolescents on sexual issues is school. A survey conducted by the Family Guidance Association of Ethiopia (1997) among adolescents living in Harar town, for instance, showed that their school was their major source of information. A similar study conducted on Jimma youth by the Family Guidance Association of Ethiopia (2001) suggested that TV/ radio was their major sources of information followed by Anti-AIDS clubs.

### **2.3 Adolescents' sexual risk-taking behaviors**

The fact that the consequence of a certain sexual activity is risky or safe depends on the degree to which a person involves in risky actions. Risk for HIV/AIDS, for instance, is not a matter of "who the person is" but "what a person does" (Kalichman, cited in Perloff, 2001).

The kind of partner with whom a person makes sex ( i.e. casual or regular partner), the number of partners he/she has, and the frequency/ consistency of his/her contraceptive usage determine the degree to which his/her behavior is risky. Thus, some sexually active adolescents are at low risk. Still there are some adolescents who are at the highest risks of STDS and AIDS or pregnancy (Zastrow and Ashman, 1997). The only risk- free behavior is abstaining from sex (Perloff, 2001).

A sexually active adolescent who uses condoms for all sexual penetration, limits the number of his/her sexual partners & avoids sexual contact with someone who is suspected to have many partners is at the lower risks (Zastrow and Ashman, 1997).

Thus, someone who is heterosexually active is at the lower risk but considerable potential risk. Someone who is faithful to one regular partner and at the same time uses contraceptives is at the lower risk. Young people's risk level rises if they have sex with several and high risk partners such as homeless or runaway youths (Perloff, 2001). Adolescents who are in the highest risk category are those who started sexual activity early, who have multiple sexual partners and who do not use contraceptives and who have inadequate information or wrong information (Papalia, 2001; Zastrow and Ashman, 1997).

Adolescents' involvement in sexual activity in general and risk-taking behaviors in particular can be attributed to many factors. Some adolescents are forced to involve in sexual activities. In one survey it was found that social pressure was the chief reason given by 73% of girls and 50% of boys when asked why they engaged in sexual activity (Louis Harris & Associates cited Papalia, 2001). Another survey showed that about 16% of women whose first intercourse took place before ages 16 and 22% of those whose first experience was before age 15 reported that it was not voluntary (Abameta, cited in Papalia, 2001).

Another variable associated with the initiation is sexual behavior and the form it takes and the beliefs about sexual activity in one's peer group. i.e. perceived level of sexual activity of their friends is the strongest predictor of adolescents sexual activity (Kinsman, et al., cited in Papalia, 2001; and Furstenerg, et. al., cited in Unger and Crawford, 2000).

In addition, those adolescents who have low academic scores, those who are frequent drinkers, have little parental supervision and have history of being abused involve in risky sexual activities (Luster and Small, cited in Papalia, 2001).

In Ethiopia, risky sexual behavior resulting in unplanned pregnancy, STDs and AIDS are the results of lack of proper information, poor economic base, the social and cultural backgrounds of the family and the like (CYAO, 1995).

## **2.4 Adolescents' contraceptive usage**

### **2.4.1 Factors affecting adolescents' contraceptive usage**

Many surveys showed that adolescents often fail to use contraceptives or use them inconsistently or inappropriately and involve in risk sexual activities. Such risk-taking activity can be attributed to many variables some of which are discussed as follows.

#### **(1) Lack of knowledge**

Because of lack of sufficient knowledge many adolescents fail to use contraceptive methods. Zastrow and Ashman (1997), for instance, stated that lack of accurate information can be one of the major reasons for the adolescent's failure to use contraceptives. Many teen girls, for instance, inaccurately believe that they are not old enough to conceive, that they have to have sexual intercourse much more often than they do in order to conceive, that it is perfectly safe to have sex during certain times of the month, that withdrawal before ejaculation is an effective birth control method. Similarly, Zelink & Kanter (cited in Laurence, 1993) stated that many adolescents do not understand that the likelihood of pregnancy varies over the course a woman's menstrual cycle & more than half mistakenly believe that it is during menstruation that the risk of pregnancy is greater. At the time of the first intercourse about one-thirds of all teenagers who do not use contraceptives fail to do so because they don't know about contraceptives (Hayes, cited in Laurence, 1993).

In most African countries where people consider sex as a taboo subject for discussion within society, and specially within the family, adolescents are deprived of information. A survey conducted by UNIADS (1997), for instance, showed that attempts in a number of African countries to introduce sexuality education into schools have been thwarted by conservative opposition. Consequently, adolescents are deprived of accurate information on what contraceptives are, from where one can get them and how they are used.

In Ethiopia, parents are often evasive and information concerning sex is not readily available to young people. Consequently, young people lack adequate and pertinent information, education

and guidance on matters of sexuality and reproductive health which results in ineffective use of contraceptive methods (Ethiopian Public Health Association, 2005).

## **(2) Lack of access to contraception**

Some adolescents make sex without using contraceptive methods simply because they never get them. Hayes (cited in Laurence, 1993 ) indicated that in a survey about 15% of adolescent girls and 25% of boys reported that they didn't use contraceptives when they had sex for the first time because they couldn't get them.

## **(3) Gender inequality and sexual double standard**

The inequality of power between heterosexual partners is a variable affecting their use of contraceptive methods. Especially, teen girls are often coerced to comply with their partners' decisions. Most adolescent girls and few adolescent boys often feel under pressure to engage in sexual activities they are not ready for (Louise Harris & Associates, cited in Papalia, 2001).

According to the sexual double standard, males may often believe that the "real" parent and the one responsible for contraception is the female. But teen girls may be reluctant to antagonize a partner who is unenthusiastic about contraception (Lamanna & Riedman, 1985). Thus, fear of being considered too sexually active if she prepares herself for sex (i.e. if she purchases condoms ) before hand in one way (Lamanna & Riedman, 1985) ; and lack of power within heterosexual relationships to convince her partner in bringing and using condoms in the other way results in failure to use them (Unger & Crawford, 2000).

## **(4) Age factors**

It was found, in many surveys, that age is one of the factors determining adolescents' contraceptive decisions. Older adolescents are more likely to use contraceptives than the younger ones Hayes, cited in Laurence, (1993)). Early sexual initiation which increases the likelihood of having multiple high risk partners and inconsistent use of contraceptive methods increase the chance of infection among the younger teenagers (Papalia, 2001). This fact is true in the Ethiopian case too. Surveys conducted by the Family Guidance Association of Ethiopia (1997 and 1998) in Harer and Jimma towns showed that proportion of youth who know at least one

contraceptive method varied with age. The knowledge and usage was found to be greater among the older youth than the younger ones.

Failure or inconsistency in contraceptive usage among the younger adolescents can be attributed to lack of experience in sex, lack of sufficient knowledge, and feeling of shame and so forth ( Louise Small, Miller & Moore, cited in Papalia, 2001).

### **(5) An unanticipated intercourse**

Especially during the first sexual intercourse, since sex is often unanticipated, teenagers fail to use contraceptive methods. In addition, the social attitudes combined with perceptions that planning for sex spoils romance, which may not stop sexual activity, inhibited contraceptive usage among teenagers Johns, et. al., (1986).

In addition contraceptive usage is influenced by drugs and alcohols. i.e. adolescents who take drugs, alcohols or any kind of substance are less likely to use contraceptives effectively and consistently. A survey conducted by UNICEF (2002) in the United Republic of Tanzania suggested that young people aged 16-24 who smoke and drink alcohol were four times more likely than their peers to have multiple sexual partners; and in USA college students who have sex under the influences of drugs and alcohol are 2.5 times more likely not to use protections.

## **2.5 Adolescents' risk perceptions**

### **2.5.1 Risk perception as a predictor of sexual behavior**

A number of survey reports showed that adolescents' sexual behaviors are influenced by the ways they perceive their vulnerability to risks associated with their activities. i.e. adolescents who perceive invulnerability to risks are more likely to involve in risky sexual activities (UNICEF, 2002). Most adolescents, even when they have information, engage in unprotected sex. Their involvement in such risk behaviors can be attributed to their perception of individual risks as low in addition to lack of skills to negotiate abstinence or condom use, and being fearful to talk with their partners (Unger & Crawford, 2000). In a survey conducted in Nigeria, it was found that about 95% of sexually active girls aged 15-19 perceived their risks of getting AIDS to

be minimal or non-existent; and in Haiti the figure for all adolescents runs as high as 93% (UNICEF, 2002).

### **2.5.2 Adolescents' reasons for not at-risk**

Most adolescents, though they involve in risky sexual activities, perceive their vulnerability to risks as low because of many factors. With regard to this, it was found, in a study that college students underestimate their AIDS risks because they use personal decision rules that are inaccurate (Malloy et al cited in Unger & Crawford, 2000). Many of them, for instance, believe that it doesn't matter to have unprotected sex with someone they know well & like (Williams et al cited in Unger & Crawford, 2000). Some of them misperceive that they are risk-free because their partners look good (Hammer, et. al., cited in Unger & Crawford, 2000). In a study conducted in Malawi, most girls perceived little risk in having sexual relations with a boy whose mother know their family (UNICEF, 2002). There are still some adolescents who perceive invulnerability because they trust their partners .They perceive they are safe because they are monogamous. But they may be serially monogamous. i.e., they may have sex with only one partner at a time, but one monogamous relationship is followed by another (Thompson, et. al., cited in Perloff, 2001).

The other cause of adolescents' perception of invulnerability is their egocentric thinking associated with heir developmental stage. Especially younger adolescents perceive that they are risk-free and will not encounter any kind of risk for the future too (Cobb, 2001). This is mainly because they have imaginary audiences. i.e. they perceive that other people are aware of what they are thinking and doing. Consequently, they tend to deny their feelings of risks and continue to involve in risky sexual activities (Elkind, et. al., cited in Kimmel and Weiner, 1985).

## CHAPTER THREE

### METHOD OF THE STUDY

#### 3.1 Selection of the Study Areas

Taking many factors into account the investigator selected Adama and Shashamene as the areas of the study. Some of the rationales behind the selection of these towns are explained as follows.

- 1) **Accessibility:** the two towns are relatively accessible to Addis Ababa where the researcher lives.
- 2) **Frequency of previous research:** the researcher, through informal assessment and looking at different research papers, understood that several similar studies were conducted in Addis Ababa than at the sites selected. Actually, this might have happened because of the fact that Addis Ababa is a big city where everything goes smoothly for the researchers. Thus, the researcher felt that there was no agency to conduct such a research in Adama and Shashamane.
- 3) **Prevalence of the problem:** especially, Adama is one of the biggest towns in Ethiopia where some problems associated with the study are highly prevalent. For instance, Adama is one of the top ranked towns in Ethiopia in HIV/AIDS epidemic. Similarly, it was informally assessed that similar situation prevails in Shashemene.
- 4) **Cooperation & support:** school directors, teachers and students in Adama and Shashamene schools were found to be more willing to cooperate with the researcher than those schools who got fedup working with researchers.
- 5) **Ease of follow-up research for the future:** because of its accessibility to Addis Ababa, further follow-up study can be conducted on the problem in the future.

#### 3.2 The study population and sampling procedure

##### 3.2.1 The study population

The population of this study was students attending their education in the year 2006/2007 in Adama and Shashemene high schools. This included students in grade 9 & 10, through both grades of the preparatory program (i.e. 11<sup>th</sup> & 12<sup>th</sup>). Thus, it was from this population that the required samples were chosen using stratified random sampling.

### 3.2.2 Sampling procedure

The population is a combination of heterogeneous strata. i.e., it consisted of individuals of different genders and grade levels. Thus, stratified random sampling technique was believed to be appropriate to select representative participants.

From the lists of high schools in Adama and Shashemene towns 4 high schools (2 from Adama and 2 from Shashemene) were randomly selected using lottery method. In these selected high schools there were a total of 7008 student out of which 1276 were from Adama high schools and 5732 from the two Shashemene schools. From the total number of the selected high schools in Adama 657 of them were from St.Joseph school and 619 from Naf-yad school; and from the total number of selected schools in Shashamanne 965 of them were from Shashamanne preparatory school and 5732 were from Shashemene high school.

With regard to the sample size, 400 students were selected based on the following statistical formula in order to keep the representativeness of the sample.

$$n = \frac{(Z)^2(N)(P)(q)}{e^2(N-1) + (Z^2)(p)(q)}, \text{ where :-}$$

N = the size of the population (7008)

n = sample size

Z = standard variety at a given confidence level (At confidence level=0.05,  
Z=1.96)

e = acceptable error or error tolerance (0.05)

p = proportion of population (0.5)

q = 1-P.

Source : Kothari,C.R. (2004, Pp.175-180)

So, after deciding the number of participants from each grade level, 3 sections were selected from all the selected schools and stratification was made on the bases of gender and grade levels of the participants. Accordingly, in each gender and grade level strata, the number of students selected was determined using equal allocation method. Finally, using class rosters,

the desired number of sample (consisting equal number of males and females from each grade level) were selected.

Thus, using equal allocation method, a total number of 400 participants of which 200 males and 200 females were selected.

From each grade level 100 students were selected to participate in the study. Even though the total number of students in grades 11 & 12 were very much less than the total number of students in grades 9 & 10 the participants were selected using non-proportional (equal allocation) technique. Because it was felt that sufficient information would be obtained from the more mature (11<sup>th</sup> and 12<sup>th</sup> graders) adolescents. For the final data analysis only 360 participants were considered, while questionnaires of 40 participants were disregarded because of either attrition or other limitations.

### **3.3 The study variables**

#### **3.3.1 Independent variables**

**Family factors:** - refers to variables such as parental economic level, their educational backgrounds, the degrees of parent-adolescent communication & family structure. In this study, parental economic level was categorized into three levels (high, medium & low). Their educational backgrounds were categorized into three (high school complete or more, elementary education attended and formal education never attended), degree of communication on sexuality in to three (always, sometimes & never) and family structure in to categories like single, both parents, step parents & in-law parents.

**Peer groups:** - refers to the degree & nature of communication between the adolescents and their peer groups.

**School programs/clubs:-** refers to the extent to which the school adolescents are involved in programs conveying information about sexuality & HIV/AIDS.

#### **3.3.2 Dependent variables**

**Sexual behavior:-** include sexual activity (being sexually active/not active), number of sexual partners, contraceptive usage (usage with regular partner or casual partner, usage at

first intercourse or at the last intercourse, knowledge & confidence in usage), sexual history (sex with prostitute, sexual abuse and experience of risks) and so on.

**Risk perception:** - refers to the degree to which sexually active adolescents perceive vulnerability to risks like STDs, unplanned pregnancy & the like

### **3.4 Data Collecting Tools**

Data collection was performed using both quantitative and qualitative techniques, through questionnaires and Focus Group Discussion (FGDs). For both close ended questionnaire and Focus Group Discussion items were taken from different sources including published and unpublished materials. Some of them were adopted from published books such as Kimmel and Weiner (1985); Johns, et.al., (1986); Perloff,(2001), and Ethiopian Public Health Association (2005). Other items were borrowed from unpublished master's thesis. Some of these sources were: Feben Demissie (2005); Solomon (2004); Fetsum Idiris (2006); and Family Guidance Association of Ethiopia (1995). However, through critical reading and analysis of literature, the investigator developed few additional items. The data collecting tools were, first, prepared in English language and, latter, translated into Amharic version by the language professionals for the participants to understand easily.

The questionnaire has different parts including the socio-demographic characteristics, adolescents' sexual behaviors (number of partners, contraceptive behavior and the like), adolescent-parent and adolescent-peer relationships, school clubs situation, adolescents' general level of understanding on sexuality & their risk perceptions.

To complement the data collected by the questionnaire, 8 FGDS were conducted in which 5-10 students participated in each group. The FGDs were moderator led discussions in which the investigator was involved to help the discussants understand some issues clearly.

### **3.5 Reliability and Validity of the data collecting tools**

#### **3.5.1 Content Validity**

To measure the content validity of the tools, the questionnaire was checked by different professionals. It was checked by two medical doctors & two master's degree graduate

experts. In this respect, the title of the study, the major research question & the objectives of the study were clearly written and given to the experts with the questionnaire. This was done for the ease of testing the degree to which the tools can measure what they were intended to measure. Finally, based on the comments of the experts, improvements were made. In addition to the experts' comments, the fact that most of the items were borrowed from different sources could add a bit to the researcher's confidence with their being valid.

### **3.5 2 Reliability**

To test the reliability of the data collecting tools pilot test was conducted on 60 randomly selected students from grades 9 to 12 in Yekatet 12 secondary school in Addis Ababa. For the purpose of test-retest, the questionnaires were administered two times to the same participants with the time difference of 15 days.

On the bases of the nature of the items in each section of the questionnaire, different techniques were employed for item analysis and to test the reliability. Applications of all the statistical techniques were preformed using SPSS. (a) For the items whose scores can not be added together, test-retest item correlation and average correlation (using Z-transformation) were computed. (b) For the items whose scores could be added together item total correlation and Chrobach Alpha were computed.

Accordingly, for the items on sexual behavior (part II-2.1), parent/peer & adolescent communication (part-III), school clubs (Part -IV) and adolescents' risk perception (Part-VI) test-retest item correlation were computed; and items having  $< 0.75$  correlation coefficients were rejected. Thus 3 items from part-II (2.1), 4 items from part III, 3 items from part IV, and 1item from part-V, a total of 11 items were discarded.

For items on the trends in condom usage, since the total scores of individual respondent could be added together, item total correlation & Crombach Alpha were employed . Items found to have  $>0.75$  correlation were accepted & for the remaining items reliability was computed.

For the knowledge test, the difficulty index and discrimination power of each item was computed; and items having a difficulty index of **0.4 to 0.7** and discrimination power of  $\geq 0.3$  were accepted. So, 3 items were discarded. The discrimination power & the difficulty index were computed to be as follows.

Items	Difficulty index	Discrimination power
40	0.41	0.380
41	0.506	0.775
42	0.563	0.875
43	0.70	0.563
44	0.594	0.813
45	0.66	0.680
46	0.69	0.630
47	0.49	0.401

Reliabilities of various scales are presented using the following table.

Sections (parts)	Titles of sections	Items	Total no of items	Test-retest reliability	Alpha reliability	
II	2.1	Sexual behavior	1-20	20	0.96	-
	2.2	Condom use self-efficacy	21-26	6	-	0.825
III	Parent & peer – adolescent communication	27-35	9	0.83	-	
IV	School Clubs	36-39	4	0.83	-	
V	Level of knowledge	40-47	8	-	0.774	
VI	Risk perception	48-54	7	0.75	-	

### 3.6 Data collecting procedures

After the questionnaire was ready, it was administered by the researcher and some cooperating school teachers who were given short training. The focus group discussions were also led by the researcher and some cooperating school teachers. In doing that, the following ethical issues were taken into account.

#### 3.6.1 Ethical considerations

We are familiar with that many people do not openly respond to question on sexual issues because of cultural, religious or other factors. Especially this is true in the case of conservative societies. Thus, in order to treat the participants in the ways they could feel free,

and in order to get their genuine responses, it was felt that possible emphasis must be given to the ethical issues. Accordingly, participation was made voluntary; measures were taken in keeping their respect, dignity & freedom of each participant. For example, participants were not made to sacrifice their lunch time or after school time, but their cooperation was asked during their regular class time. Information on the purposes and procedures of the study was given verbally to them. Participants were assured of complete confidentiality of their information.

### **3.7 Data analysis**

After the data collection, the data were edited and questionnaires that were not appropriately and completely filled were identified and excluded. Then all the items were coded for computerization. Finally, the quantitative data collected by the questionnaire were analyzed using SPSS. In this respect, techniques like percentage distribution, Spearman's Rank Order Correlation, Pearson Product Moment Correlation Coefficient and Chi-square analysis were used. To complement the data collected by the questionnaire, the data collected through focus group discussions (FGDs) that were recorded on tape recorder were transcribed and translated into English language & described qualitatively, and the most important findings were incorporated into the research findings.

## CHAPTER FOUR

### RESULTS

In this chapter the research results are presented in tables. The chapter begins with the description of the participants' demographic characteristics.

#### 4.1 Demographic characteristics

In this part, as can be seen in table 1, distribution of the participants of this study by gender, grade level, religion and church/mosque attendance, parental education and economic background and family structure are presented

**Table 1. Distribution of respondents by demographic characteristics**

Variables	Male (n,%)	Female (n,%)	Total (N, %)
Age			
• 14-17	86 (46.7)	115(65.3)	201(55.80)
• 18-21	98 (53.3)	61(34.7)	159 (44.2)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360(100)</b>
School of attendance			
• School A	45(26.6)	43 (24.4)	88 (24.4)
• School B	47(25.5)	45 (25.6)	92(25.6)
• School C	44 (23.9)	44 (25.0)	88 (24.4)
• School D	48 (26.1)	44 (25.0)	92 (25.6)
<b>Total</b>	<b>184 (100)</b>	<b>176(100)</b>	<b>360 (100)</b>
Grade Level			
• 9 <sup>th</sup>	49(26.6)	47(26.7)	96(26.7)
• 10 <sup>th</sup>	48 (23.4)	41(23.3)	84(23.3)
• 11 <sup>th</sup>	48 (26.3)	44(25.00)	92(25.6)
• 12 <sup>th</sup>	44 (23.9)	44(25.00)	88 (24.4)
<b>Total</b>	<b>184 (100)</b>	<b>176(100)</b>	<b>360(100)</b>
Place of residence			
• Urban	145(78.8)	152(86.4)	297 (82.5)
• Rural	39 (21.2)	24 (13.6)	63 (17.5)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>

Variables	Male (n,%)	Female (n,%)	Total (N,%)
Brought up by:	6 (3.3)	8 (4.5)	14(3.9)
• Father only	9 (4.9)	9 (5.1)	18 (5.0)
• Mother only	164 (89.1)	151 (85.8)	315 (87.5)
• Both father and mother	2 (1.1)	4 (2.3)	6 (1.7)
• father / mother with step parent	3 (1.6)	4 (2.3)	7 (1.9)
• relatives			
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>
Reason for not reared by the father and mother	3 (15)	4 (16)	7 (15.6)
• lost both by death	5 (25)	7 (28)	12 (26.7)
• lost one by death	12 (60)	14 (56)	26 (57.7)
• divorced	20 (100)	25 (100)	45 (100)
<b>Total</b>			
Currently living with:			
• Father only	5 (2.7)	7 (4.0)	12 (3.3)
• Mother only	8 (4.3)	10 (5.7)	18 (5.0)
• Both father and mother	135 (73.4)	136 (77.3)	271 (75.3)
• Friends	17 (9.2)	9 (5.1)	26 (7.2)
• Relatives			
• Brother / sister	18 (9.8)	13 (7.4)	31 (22.8)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>
Religion			
• Orthodox	83 (45.1)	91(51.7)	174 (48.3)
• Muslim	70 (38.0)	48 (27.3)	118 (32.8)
• Protestant	31 (16.8)	37 (21.0)	68 (18.9)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>
Frequency of church/ mosque attendance			
• Always	42 (22.8)	53 (30.1)	95 (26.4)
• Sometime	51 (27.7)	73 (41.5)	124 (34.4)
• Rarely	59 (32.1)	22 (1.5)	81 (22.5)
• Never	32 (17.4)	28 (15.9)	60 (16.7)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>

Variables	Male (n, %)	Female (n, %)	Total (N, %)
Father's education level			
• High school complete or more	92(50)	106(60.2)	198(55)
• primary education	49(26.6)	29(16.5)	78(21.7)
• Not educated	23(12.5)	16(9.1)	39(10.8)
• other	20(10.9)	25(14.2)	45(12.5)
<b>Total</b>	<b>184(100)</b>	<b>176(100)</b>	<b>360(100)</b>
Mother's education level			
• High school complete or more	69 (37.5)	74 (42)	143 (39.7)
• primary education	38 (20.7)	39 (22.2)	77 (21.4)
• Not educated	57 (31.0)	38 (21.6)	95 (26.4)
• other	20(10.90)	25 (4.2)	45 (12.5)
<b>Total</b>	<b>184 (100)</b>	<b>176 (100)</b>	<b>360 (100)</b>
Family economic level			
• High	19(10.3)	28(15.9)	47(13.1)
• Medium	107(58.2)	113(64.2)	220(61.1)
• Low	59(32)	35(19.9)	94(26.1)
<b>Total</b>	<b>184(100)</b>	<b>176(100)</b>	<b>360(100)</b>

Table 1 above shows that the number of the male participants (51.1%) is slightly higher than the females (48.9%). Age wise, the number of adolescents whose ages ranging from 14 – 17 (55.8%) exceeds that of the 18-21(44.2), whereas the number of students from each of the selected school were nearly equal. Since this study was conducted in towns, only few (17.5%) students were from rural residences. Adolescents who were living in towns were 82.5 %.

With regard to the family structures most adolescents (87.5%) were reported to be raised by both parents. The other few adolescents were raised by single parents (8.9%) by mother or father. Among the respondents who were not raised by both parents the proportion of the respondents who lost both parents by death, one parent by death and whose parents were divorced were 15.6%, 26.7% and 57.7%, respectively. Some adolescents reported that they were not living with the individuals who raised them. For instance, only 75.3% and 8.3% of

them were living with both parents and with father/mother only. Others were living with friends (7.2%), relatives (8.6%) and brother/ sister (0.6%).

The proportion of participants from Orthodox, Muslim and Protestant were 48.3%, 32.8% and 18.9%, respectively. Even though there were some adolescents (26.4%) who reported to be frequent attendants of their religious institutions (Church or Mosque), the remaining were attending their religious institutions either sometimes (34.4), very rarely (22.5%) or never (16.7%).

The above table, with regard to father educational background, shows that 58.3%, 23.7% and 16.9% of the respondents reported that their fathers' education was post high school, elementary school, and not educated, respectively. 40.3% of the respondents reported that their mothers were high school complete and 24.1% elementary complete. 3.6% of them reported their mothers being not educated.

#### 4.2 Adolescents' sexual activity

The following table indicates the distribution of adolescents by sexual activity, gender, and ages. It presents the frequencies of the sexually active and non-active adolescents against their ages and genders.

Table 2 Distribution of adolescents on sexual experience by ages and gender

Variables	Ever had intercourse		Total (N,%)	$\chi^2$ -value
	Yes (n,%)	No (n,%)		
Gender				
• Male	77(41.8)	107(58.2)	184(100)	10.28** p<0.01
• Female	44(25.0)	132(75.0)	176(100)	
<b>Total</b>	<b>121(33.6)</b>	<b>239(66.4)</b>	<b>360(100)</b>	
Age				
• 14-17	31(15.5)	170(84.5)	201(100)	67.44** p<0.01
• 18-21	90(56.7)	69(43.3)	159(100)	
<b>Total</b>	<b>121(33.6)</b>	<b>239(66.4)</b>	<b>360(100)</b>	

As shown in the above table, nearly one-thirds (33.6%) of all respondents reported that they have sexual experience. The number of male respondents who reported that they have sexual experience (63.6%) exceeds that of female respondents (36.4%). The chi-square analysis

also indicated that there is statistically significant differences in the number of adolescent boys who reported to have sexual experience and that of the adolescent girls ( $\chi^2 = 10.28$ ,  $p < 0.01$ ). In addition, differences were seen between adolescents in different age categories with regard to their sexual experiences. Thus, the proportion of adolescents in the age category of 14-17 (25.6%) was very much less than those who were in the age category of 18-21 (74.4%) in their sexual experience; and the difference is statistically significant ( $\chi^2 = 67.44$ ,  $p < 0.01$ ).

#### 4.3 Sexually active adolescents by sexual histories

The table below clearly indicates the sexual history of the sexually active adolescents like age at which they had intercourse for the first time, their reasons for engagement in sexual activity, their history of intercourse with regular and casual partners, their experience of intercourse without their willingness, sex with payment, and their histories of sexuality-related risks are presented.

← Table 3. Gender-wise distribution of the sexually active adolescents by sexual histories

Variable	Male (n,%)	Female (n,%)	Total (n, %)	$\chi^2$ - value
Age at first intercourse				2.991 $p > 0.05$
• 10-13	8(10.4)	2(4.5)	10(8.3)	
• 14-17	54(70.1)	37(84)	91(75.2)	
• <del>18-21</del>	15(19.5)	5(11.4)	20(16.5)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Reasons for engagement in sex				40.965** $P < 0.01$
• Fall in love	38(49.4)	6(13.6)	43(35.5)	
• Forced	1(1.3)	11(25)	12(9.9)	
• To get money & other privileges	3(3.9)	13(29.6)	16(13.2)	
• Others are having sex	36(46.8)	14(31.8)	50(41.3)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Having regular partner				1.830 $P > 0.05$
• Yes	16(20.7)	14(31.9)	30(24.8)	
• No	61(79.3)	30(68.1)	91(75.2)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Experience of sex with casual partner				2.191 $P > 0.05$
• Yes	54(70.2)	25(56.8)	79(65.9)	
• No	23(29.8)	19(43.1)	42(34.1)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	

Contd....

Table 3. contd...

Variable	Male (n,%)	Female (n,%)	Total (N,%)	$\chi^2$ -value
Experience of sex with out ones willing				31.116* P<0.05
• Yes	4(5.2)	17(38.6)	21(17.4)	
• No	73(94.8)	27(61.4)	100(82.6)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Experience of sex with payment				0.448 p>0.05
• Yes	22(28.5)	15(34)	36(29.8)	
• No	55(71.5)	29(66)	85(70.2)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Experience of risks				28.929** P<0.01
• Yes	19(24.6)	33(75)	52(43)	
• No	58(75.4)	11(25)	69(57)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Kinds of risks encountered				40.822** P<0.01
• Pregnancy	0(0)	16(48.4)	16(30.8)	
• Abortion	0(0)	8(24.3)	8(15.4)	
• Childbirth	0(0)	6(18.1)	6(11.5)	
• STDs	19(100)	3(9.1)	22(42.3)	
<b>Total</b>	<b>19(100)</b>	<b>33(100)</b>	<b>52(100)</b>	

#### *Age at the first intercourse*

Table 3 above, generally, shows that most of the sexually active adolescents began intercourse in the age category of 14-17(75.2%). In this the proportion of male was less (70.3%) than that of female (84.0%). There were also some respondents (i.e. about 19.4% of the sexually active boys and 11.4% of the sexually active females respondents) engaged in sexual activity in the age category of 18-21years.

Adolescents who had had sex for the first time in the age category of 10-13 years old accounted for about 8.30% of the whole sexually active groups. Gender wise, about 10.4% of the male respondents and 4.5% of the females were reported that they began intercourse in this age category. Although a slight difference is observed in the frequency and percentage of male and female respondents in different age category in which they had intercourse for the first time, the difference is not statistically significant ( $\chi^2 = 2.991$ ,  $P > 0.05$ ). In addition, the mean age at the first intercourse was 15.34 years (with standard deviation = 1.03) for males and 15.87 years (with standard deviation = 0.94) for females.

### *Reasons for engagement in intercourse*

The respondents gave different reasons when asked what made them engage in sexual activity. For example, perceiving their peer groups as sexually active (41.3%) and falling in love with some one (35.5%) were the major reasons that made them engage in sexual activity. Receiving money and other privileges (13.2%), and being coerced by their partner (9.92%) were also reported as the reasons which made them engage in sexual activity. While falling in love (49.4%) and perceived peer group sexual activity (46.8%) were reported as the major reason by the sexually active males, perceived peer group sexual activity (31.8%) and receiving money and other privileges (29.6%) were reported as major reasons by the female respondents. Being coerced to engage in sexual activity was reported by one fourth (25%) of the whole sexually active females and by a single (1.3%) male respondent. As less number of males received money (3.9%), relatively less proportion of females reported falling in love as the reason why they engaged in intercourse than the male respondents (13.6%). The chi-square analysis also showed that there was statistically significant differences in the reasons given for the respondents' engagement in sexual intercourse as the function of the differences in their genders ( $\chi^2 = 40.965$ ,  $P < 0.01$ ). That is, significantly different reasons were given by different proportion of males and females.

### *Sexual partners (regular/ casual)*

Most of the sexually active adolescents, as indicated in the above table, did not have regular sexual partners (75.2%). Only 24.8% of the respondents reported to have a regular partner. About 65.9% of them experienced intercourse with casual partners.

While experience of sex with a single regular partner was reported by more females (31.9%) than males (20.7%), intercourse with casual partners was more prevalent among the males (70.2%) than the females (43.1%). However, the chi-square analysis showed no significant differences in both experiences in intercourse with casual ( $\chi^2 = 1.830$ ,  $P > 0.05$ ) and regular partners ( $\chi^2 = 2.191$ ,  $p > 0.05$ ) by the function of gender.

### *Experience of intercourse without ones willingness*

Experience of intercourse without ones willingness was reported by 17.4% of the whole sexually active respondents. And this was reported by much more proportion of females

(17.4%) than the males (5.2%). That is, experience of intercourse was more prevalent among the females than the male respondents. In this regard, difference between the male and the female respondents was found to be statistically significant ( $\chi^2=31.116$ ,  $p<0.01$ ). A history of either receiving or paying money for sex was reported by 29.75% of the whole respondents. Even though this experience was reported by 22 males (28.5% of all the sexually active males) and 15 females (34.5% of the whole sexually active females), the statistical test showed no significant difference ( $\chi^2 = 0.448$ ,  $p>0.05$ ).

#### *History of sexual activity related risks*

Risks associated with sexual activities were reported by 43% of the whole sexually active respondents. In this case, about three-fourth (75%) of the females and nearly one-fourth (24.6%) of the sexually active males reported their experiences of risks associated with sexual activity. The chi-square analysis, in this case, showed statistically significant difference ( $\chi^2=28.929$ ,  $p<0.01$ ) by gender.

Pregnancy (30.8%), abortion (15.4%), child birth (11.5%) / by females only/ and STDs (42.3%) by both males and females were reported. Statistically significant difference was also observed in the prevalence of the risks reported ( $\chi^2 = 40.822$ ,  $P< 0.01$ ).

#### **4.4 Adolescents' condom use**

This sub-part focuses on the presentation of adolescents' experiences in condom use at first and last intercourse, condom use with regular and casual partners, and their attribution of responsibility for the decisions on condom use. It, clearly, compares barriers to condom use during the first intercourse and last intercourse, and degrees of condom use with regular and casual partners. Thus, the findings are presented using the following table.

**Table 4. Gender- wise distribution of sexually active adolescents on condom use**

Statements	Male (n,%)	Female (n,%)	Total (N, %)	$\chi^2$ -value
Condom use during the first intercourse				
• No	58(75.4)	38(86.4)	96(79.3)	$\chi^2=41.611$ p<000
• Yes	19(24.6)	6(13.6)	25(20.7)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Condom use during the last intercourse				
• No	37(48.1)	33(75)	70(57.85)	$\chi^2=171.162$ p<000
• Yes	40(51.9)	11(25)	51(42.15)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	
Condom use with Regular partner				
• Always	1(3.8)	3(13.6)	4(8.33)	$\chi^2=10.35^{**}$ p<0.01
• Some times	6(23.1)	3(13.6)	9(18.75)	
• Never	19(73.1)	16(72.7)	35(72.92)	
<b>Total</b>	<b>26(100)</b>	<b>24(100)</b>	<b>48(100)</b>	
Condom use with casual partner				
• Always	14(26.9)	1(3.2)	15(18.07)	$\chi^2=16.20^{**}$ p<0.00
• Some times	27(52.0)	14(45.2)	41(49.39)	
• Never	11(21.2)	16(51.6)	27(32.5)	
<b>Total</b>	<b>52(100)</b>	<b>31(100)</b>	<b>83(100)</b>	
A person to whom brining condom is attributed during intercourse				
• I my self	16(20.7)	10(20.8)	26(21.49)	$\chi^2=16.625^{**}$ p<0.00
• My partner	22(30.1)	13(27)	35(28.93)	
• Both of us	39(50.6)	21(47.7)	60(49.59)	
<b>Total</b>	<b>77(100)</b>	<b>44(100)</b>	<b>121(100)</b>	

The data in the above table, generally, indicate that there were variations in the extents and frequencies of condom use as the function of the time of intercourse and the nature of the partner with whom individuals had intercourse.

***Condom use during the first and the last intercourse***

While only 20.7% of the sexually active adolescents reported condom use during their first intercourse, about 42.15% of them reported condom use during the last sexual intercourse. Inconsistent or failure to use condoms with regular partner were reported by higher

proportion of the respondents (72.92%); whereas inconsistent or failure to with casual partners was reported by lower proportion of the respondents (32.5%).

Gender wise, differences were seen between the males and female respondents in condom use. About 75.4% of the sexually active adolescent males and 86.4% of the females reported not using condoms during their first sexual intercourse; and 48.1% of the sexually active males and 75.0% of the females reported non- condom use during the last time they had intercourse.

#### *Condom Use with Regular and Casual Partners*

Non- condom use with regular partners was reported by 73.1% of males and 72.7% of the females, whereas non-use with casual partners was reported by 21.2% of male and 51.6% of the female respondents.

#### *Attribution of Condom Use responsibility*

Most of the sexually active respondents reported that both they and their sexual partners were equally responsible in bringing condoms during intercourse (49.59%). Some of them reported that they themselves are responsible in bringing condoms during intercourse (21.49%). The others (28.93%) limited the responsibilities of using condom to their partners. Concerning this, the number of males and females who attributed the responsibility to themselves were 21.9% and 20.8%, respectively. About 30.1% of the sexually active males and 27.0% of the sexually active adolescent girls reported that it is the responsibility of their sexual partners to bring condoms during sexual intercourse. The other 50.6% of the females attributed condom use responsibility to both themselves and their partners. This is also indicated by the chi-square test which clearly pointed out the statistically significant differences in the patterns of attribution of responsibility between the male and the female adolescents ( $\chi^2 = 16.625$ ,  $P < 0.01$ ). Similarly, in the focus group discussion, though many of their discussion indicated that both males and females were responsible to bring and use condoms, ideas given by many discussants showed that contraceptive responsibility is limited to males. Those who limited the responsibility of condom use to males gave reasons like purchasing condoms are not embarrassing for males, strict controls from the sides of parents on girls may create shortage of time for girls to visit shops or clinics to buy condoms, and girls' bringing condoms during intercourse can spoil their romance than boys' bringing condoms.

#### 4.5 Reasons for not using condoms

The following table indicates the reasons reported by both the male and the female adolescents. The comparative analysis of the reasons for not using condoms during the first and the last intercourse is presented in the table.

**Table 5. Gender- wise distribution of adolescents by the reasons for not using condoms**

Reasons	Non using at The 1 <sup>st</sup> intercourse			$\chi^2$ value	Non using at the last intercourse			$\chi^2$ value
	Male (n,%)	Female (n,%)	Total (N,%)		Male (n,%)	Female (n,%)	Total (N,%)	
Lack of money to buy	1(19.0)	3(7.9)	14(14.6)	23.430*, p<0.05	4 (108)	1 (3.0)	5 (7.1)	19.526*, P<0.05
Inaccessibility of condoms.	4 (6.9)	2 (5.3)	6 (6.3)		-	2(6.1)	2(2.9)	
Fear of public opinion to buy ✓	8(21.1)	7 (18.4)	20(20.8)		2(5.4)	5(15.2)	7(10)	
Partner's resistance	3 (5.2)	4 (10.6)	7(7.3)		11(29.8)	6(18.1)	17(24.3)	
Trusting ones partner ✓	2(3.4)	1(2.6)	3(3.1)		5(13.5)	10(30.3)	14(21.4)	
Lack of knowledge on how to use	15(25.9)	6(15.8)	21(21.9)		1(2.7)	2(6.1)	3(4.3)	
It reduces pleasure ✓	3(5.2)	3(2.6)	4(4.2)		8(21.6)	4(12.1)	12(17.1)	
The intercourse was unanticipated ✓	3(5.2)	9(23.6)	12(12.5)		2(5.4)	2(6.1)	4(5.7)	
Lack of information how to get	4(6.9)	3(7.9)	7(7.3)		1(2.7)	1(3.0)	2 (2.9)	
Took alcohol	1(1.7)	1(2.6)	2(2.0)		3(8.1)	-	3(4.3)	
<b>Total</b>	<b>58(100)</b>	<b>38(100)</b>	<b>96(100)</b>			<b>37(100)</b>	<b>33(100)</b>	

As we have seen in table 4, most adolescents reported that they inconsistently or never used condoms during intercourse. Differences were also indicated in the number of condom users across the times of intercourse (i.e. their first and last intercourse). In addition, the above table (table 5) shows that the major reasons reported by the respondents as barriers to their being consistent in using condoms. Lack of skills on how to use condoms (21.9%), fear of public criticism to purchase condoms (20.8%), lack of money to purchase them (14.6%) and the fact that the intercourse was an unanticipated (12.5%) were the major barriers that hindered them from using condoms during the first intercourse. Resistance from the sides of their partners (7.3%), lack of information from where to get condoms (7.3%), inaccessibility

of condoms in their surrounding (6.3%), fear of reduction in their sexual pleasure (4.2%) trusting ones own sexual partner (3.1%) and intercourse under the influence of alcohol (2%) were also reported. However, resistance from the side of their sexual partners (24.3%), trusting ones own partner (21.4%), and perceiving that condoms reduce sexual pleasure (17.1%) were reported as barriers to condom use during their last intercourse. Slight gender differences were also indicated in their reasons. While an unanticipated intercourse (23.6%), fear of public criticism (18.4%), lack of knowledge on how to use condoms (15.8%) and lack of money to buy (7.9%) were reported as the major barriers for girls (in their first intercourse), lack of knowledge (25.9%), fear of public criticism (20.6%) and lack of money to purchase (19.0%) were reported by adolescent boys. During their last intercourse resistance from the side of partners (29.8%) and the need for free sexual pleasure (21.6%) were the major factors by which the adolescent males were hindered from using condoms at their last intercourse.; and trusting ones own partner (30.3%) and resistance from the sides of partners (18.10%) influenced the girls during their last intercourse.

#### 4.5 Adolescents' sexual risk-taking behaviors

As it is indicated in the following table, adolescents are categorized on the bases of the degree to which they involve in risky sexual behaviors. Those adolescents who reported no condom use with many casual partners were categorized as high risk group. Those who reported their experience of intercourse with considerably many partners, but consistently used condoms were categorized as at- risk group and those who reported their sexual experience with a single faithful partner were categorized as minimum risk group. These sexual behaviors, there fore, were seen across the different age and gender categories.

Table 6. Distribution of the sexually active Adolescent by age and gender versus risk sexual behaviors

Variable	High risk (n,%)	At-risk (n,%)	Minimum risk (n,%)	Total (N,%)	$\chi^2$ -value
Age					
• 14-17	3(9.7)	11(35.5)	17(54.8)	31(100)	8.810*
• 18 -21	23(25.6)	43(47.8)	24(26.7)	90(100)	
<b>Total</b>	<b>26(21.5)</b>	<b>54(44.6)</b>	<b>41(36.4)</b>	<b>121(100)</b>	
Gender					
• Male	12(15.6)	38(49.4)	27(35.1)	77(100)	4.540
• Female	14(31.8)	16(36.4)	14(31.8)	44(100)	
<b>Total</b>	<b>26(21.5)</b>	<b>54(44.6)</b>	<b>41(36.4)</b>	<b>121(100)</b>	

Table 6 shows three major categories of the sexually active adolescents. These are the high risk category which accounted for 21.5%, the at-risk category which accounted for 44.6% and the minimum risk category which accounted for 36.4% of the total sexually active population. Proportion of the respondents in the age category of 18-21 years old was 25.6%, in at-risk category, 47.8% in at risk group and 26.7% in the minimum risk category. Whereas, most individuals in the age category 14-17 years old were found to be in the minimum risk group (54.8%) followed by at-risk group (35.5 %) and high risk category (9.7%). Chi-square analysis also indicated that there was statistically significant differences in the risk sexual behavior as the function of ages ( $\chi^2 = 8.810, P < 0.05$ ). That is, the degree of risks differ one age category to the other. For example, high risk behaviors like intercourse with multiple sexual partners were reported by higher proportion of the higher age category than the younger ones.

When this risk sexual behavior was seen gender wise, most adolescents of both gender, males (49.4%) and females (36.4%) were found to be in the at risk category. Even though differences could be observed in that more females are in the higher risk category (31.8%) than males (15.6%) and more males were in the minimum category (35.1%) than females in that category (31.8%), the differences were statistically not significant ( $\chi^2 = 4.540, P > 0.05$ ).

#### **4.6 The relationships between adolescents' risky sexual behavior and**

##### **Family structure and economic background**

The following table presents the relationships between risk sexual behavior and family structure and parental economic backgrounds. It presents whether or not there is gender difference in risk behaviors as the function of the family variables.

**Table 7. Risk sexual behavior across family structure and economic level**

Variables	High risk		At-risk		Minimum risk	
	Male (n,%)	Female (n,%)	Male (n,%)	Female (n,%)	Male (n,%)	Female (n,%)
Brought up by						
• Father only	0(0)	1(7.1)	1(2.6)	1(6.3)	1(3.7)	2(14.3)
• Mother only	1(8.3)	3(21.4)	3(7.9)	1(6.3)	2(7.4)	0(0)
• Both father and mother	9(75)	9(64.3)	33(86.8)	14(87.5)	23(85.2)	11(78.6)
• Father/Mother with step parent	1(8.3)	0(0)	1(2.6)	0(0)	0(0)	1(7.7)
• Relatives	1(8.3)	1(7.1)	0(0)	0(0)	1(3.7)	0(0)
<b>Total</b>	<b>12(100)</b>	<b>14(100)</b>	<b>38(100)</b>	<b>16(100)</b>	<b>27(100)</b>	<b>14(100)</b>
Family economic status						
• High	4(33.3)	2(14.3)	1(2.6)	1(6.3)	1(3.7)	4(28.6)
• Medium	3(25)	3(21.4)	29(76.3)	9(56.3)	17(63)	6(42.9)
• Low	5(41.7)	9(64.3)	8(21.1)	6(37.5)	9(33.3)	4(28.6)
<b>Total</b>	<b>12(100)</b>	<b>14(100)</b>	<b>38(100)</b>	<b>16(100)</b>	<b>27(100)</b>	<b>14(100)</b>

### Family Structure versus Risk Sexual Behavior

As it is shown in the above table about 75% of males and 64.3% of the female in high risk behaviors were reported that they were brought up by both parents. 21.4% of females and 8.3% of males reported that they were brought up by mother only. While no one from males in high risk category reported to be brought up by father only, about 7.1% of females in high risk category were brought up by father only. 8.3% of males and no female in the high risk category reported that they were living with either father or mother with a step parent, and 8.3% of males & 7.1% of females were brought up by relatives. About equal proportion of males (86.7%) and females (86.8%) in at risk category were brought up by both parents. But more proportion of females (6.3%) than males (2.6%) was brought up by father only. More proportion of males (7.9%) than females (6.3%) in at- risk category was brought up by mother only. In this category, no one reported his/her being brought up by relatives.

More proportion of males ( 85.2%) brought up by both parents were in minimum risk category than females (78.6%) 14.3% of the females in minimum risk and 3.7% of the males were brought up by father only. About 7.4% of males and no female brought up by mother only were in the minimum risk category. And 7.1% of the females and no male brought up by father/mother with step parents were in the minimum risk group. About 3.7% of the males in minimum risk category and 0% of females were brought up with relatives.

### **Family economic level & risk sexual behavior**

About 33.3% of the males in high risk category and 14.3% of the females were from high economic level; 25% of males & 21.4% females were from medium, and 41.7% males in high risk category & 64.3% of the females were from poor families. 37.5% of females and 21.1% of the males in the medium risk group were from the well to do families. 56.3% of females and 76.3% of the males in the category were from medium economic level; and about 6.3% of females and 2.6% of the males in the at-risk groups reported that they were from the well-to-do families. The proportion of males in minimum risk category who were brought up in the well to do families (3.7%) exceeds the proportion of females (28.6%). About 42.1% of females in the minimum risk category and 63% of the males were from the medium economic background, & 28.6% of the females in the category & 33.3% of males were from poor families.

The above table indicates that generally more proportion of girls in the high risk category was brought up with single parents than the proportion of males in the category. And the proportion of males were in the high risk category who were brought up with both parents, father/mother with step parents and relatives than the proportion of females. In addition the table shows that higher economic background was associated with higher risk sexual behaviors among males. But, the reverse was true for the females.

### **4.7 Reasons for sexual abstinence**

The reasons reported by those respondents who haven't ever had intercourse in their life are presented using the following table. The reasons are compared across gender to test whether or not differences are observed.

✓  
**Table 8. Gender wise distribution by reasons for sexual abstinence**

Reasons Reported	Male (n, %)	Female (n, %)	Total (N, %)	$\chi^2$ -value
• Fear of public opinion	8(7.5)	15	23(9.6)	38.405**,  P< 0.01
• Lack of opportunity	29(27.2)	(11.36)	43(17.99)	
• Fear of STDS and AIDS	10(9.3)	14 (10.6)	17(7.1)	
• Fear of parental measures	9(8.4)	7(5.3)	31(12.9)	
• It's inappropriateness be fore marriage	28(26.2)	22(16.7)	66(27.6)	
• Religious prohibition	18(16.8)	38(28.7)	52(21.8)	
• Lack of desire for sex	6(5.6)	34 (25.8)	8(3.3)	
		2 (1.5)		
<b>Total</b>	<b>107(100)</b>	<b>132(100)</b>	<b>239(100)</b>	

Varieties of reasons, as indicated in table 8, were given by respondents who were not sexually active for their being abstainers. The inappropriateness of premarital intercourse (27.6%), religious prohibitions (21.8%) and lack of the opportunity for intercourse (14.89%) were generally reported as the major reasons for not having intercourse. There were also some adolescents who reported fear of public criticism (9.6%), fear of parental measures (12.9%), and fear of STDs and AIDS (7.1%) lack of desire for sex as their reasons for not having sex. While considering premarital intercourse as in appropriate was reported by both male and female respondents (26.7% and 28.7%) at their major reason for abstaining, lack of opportunity (for male adolescents, 27.2%) and religious prohibition (for females, 25.8%) were the second major variables that hindered them from having intercourse. Lack of desire for sex was the reason list reported by both sexes (i.e, 5.6% of males and 3.5% of females).

#### 4.8 Relationships between sexual experience and age, grade level and parental economic level

**Table 9. Correlations between sexual experiences and selected variable**

Variables	Sexual Activity
	Correlation
• Age	.350**
• Grade level	.241**
• parental economic level	.242**

\*\* Correlation is significant at 0.01

As the above table shows, adolescents' age ( $r = 0.35^{**}$ ), their grade levels ( $r = 0.241^{**}$ ) and their parental economic level were tested to be correlates of adolescents' sexual activity. i.e. they were related to their being sexually active or not.

#### 4.9 The relationships between level of knowledge and sexual experience

The following table presents coefficient of correlation computed to test the degree to which adolescents' sexual experience is related to their level of knowledge on sexual issues.

**Table 10. Relationships between level of knowledge & sexual experience**

Knowledge	correlation	Ever having intercourse or not
	Pearson r	-.019
Sig.	.750	
N	360	

As indicated above, that the relationships between sexual experience and level of knowledge was statistically not significant.

#### 4.10 Level of knowledge and condom use

To measure their general levels of knowledge adolescents were asked a series of items on sexual issues like pregnancy, and transmission and prevention of risks like STDs and AIDS. Using Pearson Product Moment Correlation the respondents' total scores on the knowledge versus their self-efficacy on using condoms were computed. The coefficient of correlation is the presented in the following table.

**Table 11. Relationship between knowledge and condom use**

Knowledge		Condom use
Pearson r		.0449
Sig.		.099
N		121

The above summary table shows that there is no significant relationships between the adolescents' general level of understanding above sexuality and STDs and their perceived self - efficacy about using condoms (Pearson  $r = 0.0449$ ).

#### 4.11 Adolescent-parent communication

The following table, generally, indicates the frequency distribution of adolescents by the degree of communication they make with their parents on sexual issues. The table presents

the presence or absence of communication, the family member with whom they often communicate and perceived responses for sexuality-related questions from the different family members.

**Table 12. Adolescent -family communication on sexuality and HIV/AIDS**

Statements	Freq	%	$\chi^2$ -value
Discussion on sexuality and HIV/AIDS in family <ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> <li>• Other</li> </ul> <b>Total</b>	277 55 28 360	76.9 15.2 7.8 100	327.33 **   p< 0.000
Individual with whom sexual issues are discussed <ul style="list-style-type: none"> <li>• With sister(s)</li> <li>• With bather(s)</li> <li>• With mother</li> <li>• With father</li> </ul> <b>Total</b>	5 6 26 18 55	9.1 10.9 47.3 32.7 100	22.15**   p<0.01
Perceived response form fathers on sexual issues. <ul style="list-style-type: none"> <li>• Respond me helpfully</li> <li>• Scold me</li> <li>• Not competent to respond</li> <li>• Other</li> </ul> <b>Total</b>	84 178 80 18 360	23.4 49.4 22.2 5.0 360	145.15**   p<0.01
Perceive response from mothers on sexual issues <ul style="list-style-type: none"> <li>• Respond me help[fully</li> <li>• Scold me</li> <li>• Not competent to respond</li> <li>• Other</li> </ul> <b>Total</b>	96 120 112 32 360	26.7 33.3 31.1 8.9 100	53.18**   p<0.01
Perceived response from brother(s) on sexuality and STDS - related questions <ul style="list-style-type: none"> <li>• Respond me helpfully</li> <li>• Scold me</li> <li>• Not competent to respond</li> <li>• Other</li> </ul> <b>Total</b>	69 82 86 123 360	19.2 22.7 23.8 34.2 100	17.89**   p< 0.01
Perceived response from sisters on sexuality and STDS-related questions <ul style="list-style-type: none"> <li>• Respond me help[fully</li> <li>• Scold me</li> <li>• Not competent to respond</li> <li>• Other</li> </ul> <b>Total</b>	65 82 101 121 360	18.1 22.8 28.1 33.6 100	19.66**   p<0.01

As it is indicated in the above table, the presence or absence of communication on sexual issues, a family member with whom the adolescents are more likely to discuss, and their perceived responses from the different members of their family are presented. So, the percentage of respondents who reported the absence of discussion in their family on sexuality and related issues accounted for 76.9%. Only few respondents (15.2%) reported the presence of discussion on the issue with in the family. The other 7.8% never responded to the item probably because of the absence of father or mother in the family. Among those who reported the presence of discussion on sexuality discussion with mothers (47.3%) was reported by many of them followed by discussion with their fathers (32.7%). Discussion with their sisters and brothers were reported by 10.9% and 9.1% of them respectively.

With regard to the perceived responses from their fathers on question related to sexuality and HIV/AIDS, most respondents (49.4%) perceived their fathers scolded them if asked about sexuality. About 22.2% of the respondents reported their fathers' incompetence to respond to their questions. Only some (23.4%) of the respondents perceived their fathers to respond to their questions positively. Probably because of the absence of father in their family the other 5% didn't respond to these items. In the case of their mothers, while about 26.7% of respondents perceived their mothers to respond to their questions positively, others perceived their mothers to either scold them (33.3%) or not competent to respond to their questions (31.1%). The other 8.9% never responded to this item probably because of the absence of mothers in the family.

Positive responses from their brothers and sisters were reported by 19.2% and 18.1% of the respondents. About 22.7% and 23.8% of the respondents reported negative responses and incompetence of their brothers. Negative response or incompetence of their sisters was reported by 22.8% and 28.1% of the respondents respectively.

From the focus group discussion, it was also understood that discussion within the family on sexual issues was very uncommon.

#### **4.12 Gender-wise distribution of adolescents on communication with parents**

The following table presents whether or not a difference was observed in the degree of communication on sexual issues and related risks as the function of gender difference.

**Table 13. Gender-wise distribution by adolescents-parents communication**

Variable	Discussion in family on sexuality and STDs				$\chi^2$ -value
	Yes (n,%)	No (n,%)	Others (n,%)	Total (N,%)	
Gender					0.875
• Male	31(16.8)	137(74.5)	16(8.7)	184(100)	P>0.05
• Female	24(13.6)	140(79.5)	12(6.8)	176(100)	
<b>Total</b>	<b>55(15.3)</b>	<b>277(76.9)</b>	<b>28(7.8)</b>	<b>360(100)</b>	

The above table showed the presence or absence of communication on sexuality and related issues across the genders of the respondents. Thus, the percentage of respondents who reported the presence of communications and discussion on the issue was 15.5%. This constitutes about 16.8% of the whole males and 13.6% of the female respondents. But the chi-square analysis was tested to be insignificant.

#### 4.13 Adolescent-peer communication

The proportion of adolescents who often share their experiences on sexual issues and related risks are presented using the following table.

**Table 14. Adolescent -peer communication on sexuality and HIV/AIDS**

	Freq.	%	$\chi^2$ -value
Sharing ideas on sexual issues with peers.			
• No	107	29.7	59.2**
• Yes	253	70.3	
<b>Total</b>	<b>360</b>	<b>100</b>	<b>P&lt;0.01</b>

As it is shown in the above table, most of the respondents (70.3%) reported that they share their feelings and experiences with their peer groups. Only 29.7 % of them reported the absence of discussion on the issues. This differences in the distribution of the frequency of the respondents on sharing their experiences with their peers is tested to be statistically significant ( $\chi^2 = 59.2$ ,  $P<0.01$ ). That is, there was significant difference in the proportion of the respondents who share their ideas with their friends and those who don't share their ideas whereby higher proportion of them reported that they share their ideas with their peers.

In the focus group discussion, it was also indicated that most of the respondents openly discuss on the sexual issues with their peers.

#### 4.14 Sources of information on sexuality and STDs / AIDS

Distribution of the adolescents by their sources of information is presented in the following table to identify their major sources of information on sexuality and HIV/AIDS.

**Table15. Sources of information on sexuality and HIV/AIDS**

Sources of information	Number of respondents	%
Family members		
• Father	13	3.6
• Mother	19	5.3
• Brother(s)	12	3.3
• Sister(s)	18	5.0
peers	112	31.1
school teachers	26	7.2
School clubs/ programs	52	14.4
Medias (TV/ radio)	87	24.2
Religious leaders	6	1.7
Health professionals	15	4.2
<b>Total</b>	<b>360</b>	<b>100</b>

As we have seen in table 10, most adolescents do not feel embarrassed talking about sexuality with their peer groups. Similarly, when the respondents asked their major sources of information on sexual issues, most of them (31.1%) reported their peers followed by medias-TV/radio (24.2) and school clubs /programs (14.4%). Some respondents reported their teachers (7.2%) and health professionals (4.2%). Different family members were reported as sources of information by insignificant number of respondent's. i.e., mothers (5.3%), sisters (5.0%), fathers (3.6%) and brothers (3.3%). Very much negligible proportion (1.7%) of the respondents reported religious people as their sources of information. The discussants of the FGDs also indicated that their major source of information were their friends, media and schools in general. They also pointed out that they never or rarely heard about sexual issues from their parents and religious people.

#### 4.15 School clubs-availability, attitudes and frequency of attendance

In this sub-part an assessment of the presence or absence of clubs providing information on sexuality and HIV/AIDS, the students' interests to attend and their degree of attendance and reasons reported by none attendants are presented using the following table.

**Table 16. School clubs- availability, attitudes and frequency of attendance**

Items	Freq	%	$\chi^2$ - value
Availability of clubs providing information on sexuality			
• Yes available	250	69.4	237.405** p<0.01
• Not available	95	26.4	
• Don't know	15	4.2	
<b>Total</b>	<b>360</b>	<b>100</b>	
Interests to involve in clubs providing information sexual issues			
• Yes interested	200	55.6	80.26** p<0.01
• No, never like	84	23.3	
• Others	76	21.1	
<b>Total</b>	<b>360</b>	<b>100</b>	
Frequency of attending in clubs programs			
• Always	88	24.4	80.26** p<0.01
• Some times	70	19.9	
• Rarely	23	6.4	
• Never	116	32.2	
• Other	63	17.5	
<b>Total</b>	<b>179</b>	<b>100</b>	
Reasons for not attending clubs providing information on sexual issues			
• perceiving the clubs will initiate sexual activities	29	16.21	43.6** p<0.01
• Religious prohibition			
• Parental prohibition	40	22.3	
• Lack of expectation of sufficient information	21	11.8	
• Perceiving them as unnecessary time wastage	11	6.1	
• Perceiving then as supplementing work load	5	2.8	
• Other	10	5.6	
<b>Total</b>	<b>63</b>	<b>35.2</b>	
	<b>179</b>	<b>100</b>	

As the distribution of the respondents on school clubs (programs) which, specifically, work on HIV/AIDS and other related issues, most respondents reported the presence of such clubs in their schools (69.4%). Others reported the absence of well developed programs on the issue (26.4%). Still there were some few individuals who, even, never know whether or not there were such clubs (programs) in there school (4.2%) most respondents reported that they had interests to involve in school clubs (55.6%), though some of them never like such

programs (23.3%). With regard to the frequencies of attendance in school clubs attending always was reported by 24.4%, some times 19.4%, rarely 6.4% and never by 32.2%.

The major reasons reported by the non-attendant categories were religious prohibitions (22.3%), perceiving such programs, even, initiate sexual activities (16.2%) parental prohibitions of involvement in such programs (11.8%). Lack of good expectation to obtain sufficient /new information form the clubs (6.1%), considering such programs unnecessary work load (5.6%) and wastage of time (2.8%) were also reported. Similarly, in the focus group discussion participants raised many ideas in relation to school clubs. The major problems were the absence of trained club leaders and absence of novel ideas from the clubs' lessons.

#### 4.16 Adolescents' risk perception

The ways adolescent perceive the risks associated with their sexual activities are presented in the following table. In this part the extent to which they feel the risks of contracting STDs and AIDS or dying from AIDS in the future, getting pregnant, and their self-efficacy towards HIV/AIDS test are presented. With regard to these all, whether or not there are gender and age differences was also tested.

Table 17. Adolescents' risk perception by gender

Statements	Male (n,%)	Female (n,%)	Total (n,%)	$\chi^2$ -value
Frequency of feeling risks of contracting STDS and AIDS.				223.2***, p<0.00
• Always	7 (9.1)	1(2.27)	8 (6.6)	
• Some times	9(11.6)	5(11.4)	14(11.6)	
• Rarely	21(28.2)	7(15.9)	28(23.1)	
• Never	40(52.0)	31(70.5)	71(58.6)	
<b>Total</b>	<b>77.(100)</b>	<b>44(100)</b>	<b>121(100)</b>	

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• Never	40(52.0)	31(70.5)	71(58.6)	
<b>Total</b>	<b>77.(100)</b>	<b>44(100)</b>	<b>121(100)</b>	

Statements	Male (n,%)	Female (n,%)	Total (n,%)	$\chi^2$ -value
Reasons given for feeling at-risks <ul style="list-style-type: none"> <li>• Sexual contact with infected person</li> <li>• Intercourse with out condom Sex with multi partners</li> <li>• mistrust ones own partner</li> <li>• Gave care for an infected person</li> <li>• Sex with commercial sex workers</li> <li>• Had an injection whose sterility is not known</li> </ul> <p style="text-align: right;"><b>Total</b></p>	4(10.8) 12(32.4) 8(21.6) 5(13.5) 2 (5.4) 3 (8.1) 3 (8.1)	0(0) 4(30.8) 3(23) 3(23) 1(7.7) 0(0) 2(15.3)	4(8) 16(31) 11(22) 8(16) 3(6) 3(6) 5(10)	21.14**, P=0.01
Reasons given for feeling risk-free. <ul style="list-style-type: none"> <li>• Truest ones own partner</li> <li>• Used condom effectively</li> <li>• Feel health</li> <li>• Never had intercourse with infected person</li> <li>• Tested negative</li> </ul> <p style="text-align: right;"><b>Total</b></p>	16(40) 2 (5) 13 (32.5) 5 (12.5) 4 (10)	17(54.8) 1 (3.2) 8 (25.) 3 (9.7) 2 (6.5)	33 (46.4) 3 (4.2) 21 (29.5) 8 (11.3) 6 (8.5)	1.31, P>0.05
Attitudes towards HIV/AIDS & expectation <ul style="list-style-type: none"> <li>• Willing to be tested &amp; expect AIDS-free result</li> <li>• Not willing to be tested but feel AIDS-free</li> <li>• Willing to be tested, but never expect AIDS-free result</li> <li>• Never willing to be tested because of feeling of being infected by AIDS</li> </ul> <p style="text-align: right;"><b>Total</b></p>	67(97.0) 7(9.1) 1(1.3) 2(2.6)	39(88.6) 4(9.1) 1(2.3) 0(0)	106(87.6) 11(9.1) 2(1.7) 2(1.7)	21.356*, P<0.05
Feeling of dying from AIDS in the future <ul style="list-style-type: none"> <li>• Always</li> <li>• Some times</li> <li>• Rarely</li> <li>• Never</li> </ul> <p style="text-align: right;"><b>Total</b></p>	1 (1.3) 3 (3.9) 25(32.5) 48(62.3)	1(2.8) 2(4.5) 13(21.6) 28(63.6)	2 (1.7) 5 (4.5) 38(31.4) 76 (62.8)	7.938, P>0.05

### *Perception of the risk of contracting STDs and AIDS by gender*

Most sexually active adolescents, as indicated in the above table reported that they never felt any risk of contracting STDS or AIDS (58.6%). About 23.7 % of them rarely feel risks and 11.6% some times perceived the risks. Only 6.6% of the sexually active respondents perceive their risks of contracting STDS and AIDS. Gender wise, about 70.5% of the sexually adolescent females and 52.0% of the males reported their risk-free perceptions; about 27.2% of the sexually active males and 15.9% of the females rarely perceive risks, and 11.6% of the males and 11.4% of the females felt some times the risk of vulnerability. Only 9.1% of males and 2.27% of the females perceived the risks of contracting STDS and AIDS. In addition to the differences in this percentage distribution chi-square analysis also indicated statistically significant differences in their risk perceptions.

### *Reasons for not feeling at-risk by gender*

The table also shows the reasons given by those who reported risk perception. About 32% the respondents who at least rarely perceive vulnerability reported their history of intercourse without condoms followed by intercourse with multiple partners which was reported by 22% of them. Mistrusting ones own sexual partner and sexual contact with infected individuals were reported by 8% and 4% of the respondents respectively. About 10% of the respondents perceive their vulnerability to any kind of risk because they had an injection whose sterility is not known. Sex with commercial sex workers (6%) and giving care for infected individuals (6%) were also reported as reasons for their feeling at risks. Intercourse with out condoms was reported both the male respondents (32.4%) and the females (30.8%) as the first major reason followed by sex with multiple partners (by 21.6% of the males and 23% of the sexually active females). While some sexual contact with infected persons and sex with commercial sex workers were reported by 10.8% and 8.1 % of males, the two reasons were not reported by any female respondent. Much more females reported mistrusting their partner (23%) than the males (13.5%). With regard to the reasons given for feeling at risks of contracting STDs and AIDS, the chi-square test indicated statistically significant differences as the function of the differences in the genders of the respondent.

### *Reasons for feeling at-risk by gender*

Respondents who reported risk-free perceptions gave different reasons for their perceiving invulnerability. Trusting one's own sexual partner was reported by about 46.4% of the whole respondents followed by feeling healthy (29.5%) for their perception of invulnerability. Having no intercourse with infected individuals (11.3%) tested to be risk-free (8.5%) and effective use of condom (4.2%) were also reported by those who perceived they were risk-free. Trusting one's own sexual partner (by 54.8% of the sexually active females and 40.0% of the males) followed by feeling healthy (25.8% of the females and 32.5% of the males) were reported as the major reasons for feeling risk-free. Having never had intercourse was reported by 72.5% of the sexually active male and 9.7% of the females respectively. Effective use of condom was reported by few respondents by 5% of the whole males and 3.2% of the females. However, these differences in the reasons across sexes were statistically tested to be very insignificant ( $\chi^2=1.31$ ,  $P>0.05$ ).

### *Attitude towards HIV/AIDS test*

Concerning the respondents' attitudes and expectations of HIV/AIDS-test result about 87.6% of the whole respondents reported to be willing to be tested and expect an AIDS-free result. Some of them were reported that they were unwilling to be tested, but if forced to be tested they report that they expect an AIDS-free result (9.1%). Others reported that they were willing to be tested but never expect an AIDS-free result (1.7%), and still some of the respondents (1.7%) reported to be unwilling and never expect an AIDS-free result. The chance of dying from AIDS in the future was felt always by few respondents. i.e. it was reported only by 1.7% of the female respondents and 1.3% of the males. And it was never felt by many of the females (63.6%) and the males (62.3%). Much more proportion of males (32.5%) felt rarely than the females (21.6%). About 4.5% of the females & 3.9% of the males felt the chance of dying from AIDS in the future.

**Table 18. Distribution of the sexually active adolescents by risk perception**

Statements	14-17 (n,%)	18-21 (n,%)	Total (N,%)
Reasons given for feeling to be at risk			
Intercourse with an infected person			
• Intercourse with out condoms	1(11.1)	3(9.7)	4(10)
• Intercourse with multiple partners	6(66.7)	9(29.0)	15(37.5)
• Mistrust ones own partner	1(11.1)	8(25.9)	9(22.5)
• Gave care for an infected person	0 (0)	5(16.1)	5(12.5)
• Sex with commercial sex workers	0 (0)	2(6.5)	2(5.0)
• Had and injection whose Sterility is not known	0(0)	2(6.5)	2(5.0)
	1(11.1)	2(6.5)	3(7.5)
<b>Total</b>	<b>9(100)</b>	<b>31(100)</b>	<b>40(100)</b>
Reasons given for feeling to be risk-free			
• Trust once own partner	9(41.0)	23(46.9)	32(45.1)
• Used condoms effectively	1( 4.5)	2(4.1)	3(4.2)
• Feel health	11(50)	11(22.5)	22(31)
• Never had intercourse with an infected person	1(4.5)	7(14.2)	8(11.3)
• Tested negative	-	6(12.2)	6(8.5)
<b>Total</b>	<b>22(100)</b>	<b>49(100)</b>	<b>71(100)</b>
Attitudes toward HIV/AIDS test.			
• Willing to be tested and expect AIDS-free result	25(80.7)	81(90)	106(87.6)
• Not willing to be tested, but feel being free from AIDS.	4 (13)	7(7.8)	11 (9.1)
• Willing to be tested but never expect AIDS-free result	1 (3.2)	1(1.1)	2 (1.7)
• Never willing to be tested because of felling of being infected by AIDS.	1 (3.2)	1 (1.1)	2 (1.7)
<b>Total</b>	<b>31(100)</b>	<b>90(100)</b>	<b>121(100)</b>
Feeling of dying from AIDS in the future			
• Always	1 ( 3.2)	1 (1.1)	2 (1.7)
• Sometimes	1 (3.2)	4 (4.4)	5 (4.1)
• Rarely	8(25.9)	20(22.2)	38(31.4)
• Never	21(67.8)	55(61.1)	76(62.8)
<b>Total</b>	<b>31(100)</b>	<b>90(100)</b>	<b>121(100)</b>

Age wise, more proportion of the older age category (18-21) felt the risk of vulnerability (7.8%) than the younger ones (14-17) /3.2%). And risk-free perception was reported by more

number (67.8%) of the younger age category (14-17) than the 18 to 21 age category (55.6%). Intercourse without condom was reported as the major reason for feeling at risk among both the younger age category (66.7%) and older respondents (29.0%). Intercourse with an infected person, intercourse with multiple partners, and an injection whose sterility was not known (each of them) were reported by 11.1% of the younger respondents (14-17). Intercourse with multiple partner and mistrusting ones own partners were reported by 25.9% and 16.1% of the older adolescents respectively. No one reported mistrusting his/her partner, giving care for an infected individual and intercourse with commercial sex worker' from the younger age category while feeling health was reported as their major reasons for feeling risk-free among them (50%), trusting their partners was reported as the major reason for feeling risk-free among the older age groups (46.9%). No one reported to be tested negative from the younger respondents; where as about 14.2% of the older respondents reported to be tested negative. In both age categories, most of them reported that they were willing to be tested and expect HIV/AIDS-negative result, though a little bit higher number of the older adolescents (90%) was observed than the younger age groups (80.7%). Dying from AIDS was never felt by 67.8% of the younger category & 61.1% of he older age category.

**Table 19. Distribution of adolescent girls by risk perception**

Statements	14-17 (n,%)	18-21 (n,%)	Total (N,%)	$\chi^2$ -value
Feeling of risks of un wanted pregnancy in the near future				
• Yes	2(15.3)	7(22.6)	9(20.5)	8.810* P<0.05
• No	11(84.6)	24(77.4)	35(79.5)	
<b>Total</b>	<b>13(100)</b>	<b>31(100)</b>	<b>44(100)</b>	
Reasons for not feeling to be at risk of unwanted pregnancy				
• Consistent in using condoms	2(18.1)	20(83.3)	22(62.9)	4.540 P>0.05
• Abstain	1 (9.1)	2 (8.3)	3(8.6)	
• Not mature enough to conceive	8(72.8)	2(8.3)	10(28.5)	
<b>Total</b>	<b>11(100)</b>	<b>24 (100)</b>	<b>34 (100)</b>	

Among the sexually active females about 79.5% (constituted by 84.6% of the 14-17 age category & 77.4% of the 18-21 age category never perceived the risks of getting pregnant in the future. Most (about 83.3%) of the older age category reported to use condoms effectively. Whereas most (72.8) of the younger age category reported that they were not mature enough

to conceive. And that was the reason why the never expect the risk in the future. Still there were others who perceived them selves to be immature to get pregnant (28.5%) and who plan to abstain (8.6%).

#### 4.17 The relationships between risk sexual behaviors and selected variables

The following correlation matrix indicates the degree and direction of the relationships between sexual risk taking behaviors and other variables such as frequency of involvement in school clubs/programs, degree of parent- adolescent communication on sexual issues, risk perception, adolescent – peer communication, and father’s and mother’s educational back grounds.

**Key:** X<sub>1</sub>= Risk sexual behavior

X<sub>2</sub>= Involvement in school clubs/programs

X<sub>3</sub>= Parent – adolescent communication

X<sub>4</sub>= Risk perception

X<sub>5</sub>= Adolescent–peer communication

X<sub>6</sub>= Father’s education

X<sub>7</sub>= Mother’s education

Variables	X <sub>1</sub>	X <sub>2</sub>	X <sub>3</sub>	X <sub>4</sub>	X <sub>5</sub>	X <sub>6</sub>	X <sub>7</sub>
X <sub>1</sub>	1.0						
X <sub>2</sub>	-.147	1.0					
X <sub>3</sub>	-.175	.144	1.0				
X <sub>4</sub>	-.160	.192*	.221*	1.0			
X <sub>5</sub>	-.019	.271**	.212*	.115	1.0		
X <sub>6</sub>	-.195*	.042	.214*	.134	.124	1.0	
X <sub>7</sub>	-.260*	.129	.260**	.198**	.128	.208*	1.0

\*\* Correlation is significant at P<0.01

\* Correlation is significant at P<0.05

The above Pearson correlation matrix clearly indicates the degree of relationship between each of the variables. Therefore, it is shown that risk sexual behavior has a statistically significant negative correlation with mother educational level ( $r=0.260$ ,  $p<0.01$ ) and father education ( $r=0.195$ ,  $p<0.05$ ). But the strength of its relationship with mother’s education is slightly higher. Though not statistically significant, it has also negative correlation with

parent- adolescent–communication and degree of risk perception. In addition, it was clearly observed, in this study that risk sexual behaviors were negatively related with involvement in school clubs and adolescent peer communication.

In this study, as indicated above, it was found that involvement in school clubs/programs has significant positive relationship with risk perception ( $r = 0.192$ ,  $p < 0.05$ ) and adolescent peer communication ( $r = 0.271$ ,  $p < 0.01$ ). But, it has no significant relationship with parent–adolescent communication, fathers' education and mothers' education.

Parent–adolescent communication was computed to have significant positive correlation with risk perception ( $r = 0.221$ ,  $p < 0.05$ ), adolescent–peer communication ( $r = 0.272$ ,  $p < 0.05$ ), father education ( $r = 0.214$ ,  $p < 0.05$ ) and mother education ( $r = 0.26$ ,  $P < 0.01$ ). Parent–adolescent communication has slightly stronger relationship with mother education than father education.

Risk perception was found to have statistically significant positive correlation with mother education ( $r = 0.198$ ,  $p < 0.05$ ). It has also positive, but weaker (not significant) correlation with adolescent–peer communication & father education.

The correlation matrix above also shown that adolescent – peer communication has positive, but not significant correlation with father & mother education. Father education has significantly correlated with mother education ( $r = 0.208$ ,  $P < 0.05$ ), which might imply that the educational backgrounds of each couple was more or less similar.

## CHAPTER FIVE

### DISCUSSION

#### *Sexual activity across gender*

In this study it was found that only one-third of the school adolescents reported that they have ever had sexual intercourse and some two-thirds reported that they never had intercourse in their life. Adolescent males accounted for a much more proportion (63.6%) in reporting that they have ever had intercourse than the female respondents which accounted for only 36.4% of the sexually active category. The fact that most of the adolescents in general and the female respondents in particular never reported their sexual history was attributed to different variables in previous findings. Papalia (2001), for instance, stated that most individuals are unwilling to report their sexual history. Moreover, most of the time those individuals who are willing to answer questions about sexuality are not genuine in giving their responses. i.e. discrepancies are often recognized between what they say and whom they are or what they do. Gender wise, variations were observed among male and the female participants in admitting whether or not they were sexually active or not. The traditional view of masculinity and sexual double standard could encourage males in sexual activities than females (Unger & Crawford, 2000). On the other hand, the view could either hinder adolescent girls from premarital intercourse or make them hide their sexual histories.

#### *Sexual activity across age*

Even though, in this research, the younger age category (14-17 years ages) accounted for more proportion than the older adolescents (18-21 years ages), they constitute only one-fourth of the sexually active adolescents. i.e. nearly three-fourth of the sexually active adolescents were the older age categories. A similar survey conducted by Ethiopian Public Health Association (2005) indicated that the proportion of adolescents who were sexually active rose with age.

It was found, in this study, that most adolescents had intercourse for the first time during the middle adolescent (14-17 years old). There were also adolescents who began intercourse in the age category of 18-21 years. Some few respondents reported that they began sexual

intercourse in the age category of 10-13 years. A research conducted on adolescent reproductive health by FGAE (2005) also revealed that most adolescents (71.9% of males and 71.4% of females) have had intercourse within the age range of 15-17. It indicated that only 13% of them began within the age range of 10-14. . A survey conducted by MOLSA (1991) also showed that most adolescents (about 50.2% of males and 21.1% of females) experienced intercourse within the age range of 15-18 years. A little difference was observed in that more proportion of males began intercourse in the early age and late age category than the females, and more proportion of the females in the middle age category than the male respondents (see table 3). It was also found, in this study, that the mean age at the first intercourse were 15.34 (SD= 1.09) for male and 15.87 (SD= .94) for the females. However, unlike the finding of this research, a survey conducted by EPHA (2005) showed that the mean age at first intercourse was a little bit greater for males (15.57 with SD= 0.96) than that of females (15.46 with SD= 0.98).

#### *Variables initiating engagement in sexual activity ?*

Different reasons were given by the adolescents for their engagement in intercourse. Some fall in love, others were coerced to begin intercourse, or deceived by money and other privileges and other adolescents began intercourse perceiving that their peers were doing that. Though the proportion varied, perception of their peer group as sexually active was reported as the major reason by both males & females. Similarly, Unger & Crawford (2000) and Papalia (2001, p.456) pointed out that one of the major variable to which early sexual initiation is attributed is perceived sexual practices of ones peer groups. Some adolescents, especially girls, began intercourse by being coerced by males or deceived by some kinds of privilege. With regard to this, for instance, Papilla (2001), said that “teenage girls (and to a lesser extent boys) often feel under pressure to engage in activities they do not feel ready for”. Similarly, the traditional images of masculinity, as suggested by UNAIDS (1995), mostly encourage men to force unwilling female partners to engage in intercourse. This problem was prevalent mainly among the females from the low economics levels. A Report of a National Conference on Adolescent Reproductive Health (2000), generally, indicated that peer pressure, pornographic influences, personal drive, alcohol and drug and material

and financial interests are the major variables that initiated the Ethiopian adolescents to involve in sexual activity.

### *Adolescents' sexual experiences (histories)*

It was found, in this study, that most of the sexually active (nearly three-fourth) of them never had regular sexual partners. Only about one fourth of them (24.7% the males & 31.9% of female respondents) reported to have regular sexual partners. Most of them (nearly 70.2% of the male respondents & 56.8% of the females) experienced intercourse with casual partner at least once in their life (table 3). Very insignificant proportion of respondents neither reported to have their own regular partner nor to have a history of intercourse with casual partners. They probably had regular partner once upon a time in the past. Even though statistically significant differences were not observed in the patterns of sexual relationships across the genders of the adolescents, the proportion of males who had experiences with casual sexual partners exceed that of the female adolescents (table 3). Varieties of justifications were given, for these differences, by many other researchers who studied similar issues. Wilson and Eshleman (1995), for instance, presented that a research conducted on a university adolescents in America indicated that males reported twice as many sexual partners as did females. Similarly, UNAIDS (2001), pointed out that, even all over the world, men often are under pressure to conform to ideologies that emphasize sexual prowess and encourage them to have multiple sexual partners and exercise authority over women.

In this study, about 5.2% of the sexually active males and 38.6% of the females reported that they had a history of intercourse without their willingness. Experiences of sexual intercourse by either giving or receiving money were reported by 29.75% (nearly 28.5% of the males and 34.0% of the females) respondents. However, this slight variation in the adolescents experiences of intercourse with payment across gender didn't show statistically significant value ( $\chi^2=0.448$ ,  $P>0.05$ ). Similarly, many other studies revealed that most of both the males & the female adolescents experience intercourse as the expense of payment whereby males often pay money for sex with commercial sex workers & adolescent girls (especially those who were from the poor families) receive money from males. A survey conducted by UNICEF (2002), for instance, indicated the prevalence of both intercourse without ones

willing and intercourse by receiving money as the expense of other privileges among poor girls. The survey indicated that young girls in poverty are often enticed or coerced into having sex with some one older, wealthier or in a position of authority, such as an employer, school teacher or older sugar "daddy" in order to support themselves & their families. It was found out in a survey conducted in Botswana, for example, that about one-fifth of school adolescent girls reported that it is difficult to refuse intercourse when money & gifts are offered. The Ethiopian Case is also not different from the other African countries. Thus, in Ethiopia, lack of economic opportunity makes the girls to search for money or other gifts as the expense of sex and increased the prevalence of prostitution. In addition the number of young men who visit commercial sex worker is becoming higher (CYAO, 1995). Similarly, in a survey conducted by EPHA (2005) in selected towns of Ethiopia, significant proportion of males admitted that they had had intercourse with commercial sex workers at least once in their life.

Coming to the histories of risks associated with sexual activities, many adolescents (29.75% about one-fourth of the males and three-fourth of the females) admitted that they encountered any of the risks associated with sexual activity at least once in their life. Among those who reported risks, females were much more victims than the males. Thus, risks like unplanned pregnancy (30.3%), unsafe abortion (21.2%) and child birth ( 15.2%) were reported by female adolescents any of the STDs was the only risk reported by the males ( 100%) which was reported by 33.3% of the females ( table 3). This research result (that females are much more vulnerable than males) is confirmed by a number of surveys. A survey conducted by UNAIDS (1995) in the different parts of Africa indicated that, because of both biological and social factors, girls were more vulnerable than males.

According to a survey in Tanzania, for example, it was found that about 17% of young women aged between 15 to 24 and only 5% of the young males were HIV- positive. This, as suggested by UNAIDS (1997), was not because more young women involved in high risk behavior, rather it is the combined effect of biological and social variables. The risk of getting infected by any kind of STDs and AIDS because of the nature of their sex organs, the presence of gender inequality in sexual decisions and the variation in their ages and their

sexual partners increase the chances of being vulnerable to different risks among the women & girls (UNICEF, 2002).

### *Condom use*

The existing practices on condom use among adolescents indicates that the practice varied across genders, at the time of intercourse, the nature of a sexual partner with whom an individual had intercourse. In addition, attribution of contraceptive responsibility to either partner as a barrier to condom use was assessed to be a major problem.

### *Condom use at first and last intercourse*

The proportion of adolescents who used condom during their first intercourse was less than their proportion in the last intercourse. For example, while 79.3% of the sexually active adolescents admitted their failure to use condom at the first intercourse. It was only 57.85% of them who reported their experience of intercourse with out condoms during the last intercourse (table 5). The male and female respondents, in this research, varied in that more proportion of females (86.4%) didn't use condoms than the proportion of males (75.4%) at their first intercourse and at the last intercourse too (75% females & 48.1% of males). This variation in condom use during both times was also tested to be statistically significant across both sexes (i.e.  $\chi^2=41.661$ ,  $p<0.01$ ) at first intercourse and ( $\chi^2 = 171.162$ ,  $P< 0.000$ ) the last intercourse). Similarly, Weiner & Kimmel (1985) pointed out that age is one the major variables hindering adolescents from using condoms during the first intercourse. They indicated, for instance, that in a survey conducted on a group of teenagers, it was found that very few of them who are under 17 years old used condoms during their first intercourse. And with ages, adolescents become familiar with how to get and use condoms.

### *Condom use with regular and casual partners*

Failure to use condoms with regular partner (72.92%) was reported by many respondents than its uses with casual partners (32.5%). Reluctance in condom use with regular partners was reported by nearly equal proportion of males & females (73% and 72.8%). Whereas, much more proportion of females (51.1%) admitted non condom use with casual partners compared to the proportion of males (21.1%). This situation in which condom use was higher with casual partners than with regular partners was justified by many researches. Similarly, as Hammer et al., (1996); Kalichaman, (1989); Reisen and Popen, (1995), cited in Perloff,

(2001), indicated one factor that has an especially strong impact on condom communication is the phase of the romantic relationship. Some college students talk more about condom use in casual relationships-one night stands. Condom use is more likely to occur in casual than serious relationships. Once a relationship gets serious, condom use seems to drop-off and perhaps so too does communication about safer sex. Young people incorrectly believe that a monogamous relationship is a safe and are concerned that initiating safer sex behavior might threaten trust or intimacy.

Supporting what Perloff has pointed out above, Wilson and Eshleman (1995) also found out that defining their current relationships as monogamous with promises to be long term is one of the major factors hindering regular sexual partners from using condoms. In addition, the study result on attribution of responsibility to either partner in using condoms is also conformed by Wilson and Eshleman (1995).

#### *Factors affecting condom use*

Variations were observed variables influencing adolescents' condom use during the first intercourse and the last intercourse. Fear of Public criticism (20.8%), lack of skills on how to use condoms (21.9%) are failure to plan for intercourse (12.5%) were the major variables reported to cause non- using at the first intercourse. Whereas, resistance from the sides of ones partner (24.3%), trusting ones own partner (21.4%) and the need for sexual pleasure with out condoms (17.1%) were reported at the last intercourse. While lack of knowledge (25.9%) and fear of public criticism(20.6%) were reported by the male respondents as the major barrier at first intercourse, failure to plan for inter course (23.6%) and lack of knowledge on how to use (15.8%) and fear of public criticism to buy condoms was reported by (21.1%) of the females. Resistance from the side of partner (29.8) and the need to enjoy intercourse with out condoms (21.6%) were reported as the major variables at the last intercourse by males. Whereas, trusting ones own partner (30.3%) and resistance from partner were reported by (18.1%) of the females.

#### *Risk sexual behaviors*

Coming to the risk taking sexual behavior, statistically significant difference was observed between the younger and the older age categories ( $\chi^2 = 8.810$ ,  $p < 0.05$ ). That is, high risk behaviors (intercourse with out condoms & with many causal partners) were admitted by

nearly one fourth of the older adolescents (18-21), and only 9.1% of the younger age category (14-17) reported high risk behaviors. Whereas about 26.7% of the older adolescents and 54.8% of the younger ones reported minimum risk behavior such as intercourse with single partner and consistent use of condoms. However, the proportion of the older adolescents who reported to be at average risk (consistent condom use with many partners) 47.8%) greater than the proportion of the younger adolescents (35.5%). Unlike many other similar studies, this study shows that involvement of females in high risk behavior (31.8%) than the males, though the statistical analysis indicated insignificant differences in risk behaviors across sexes ( $\chi^2=4.540$ ,  $p>0.05$ ). minimum risk behaviors were reported by 35.1% of males & 31.8% of the females. Contrary to this study, a survey conducted by the Ethiopian Public Health Association (2005) in selected towns of Ethiopia indicated that high risk behaviors were reported by much more proportion of males than females. A survey conducted by FGAE (2001) in Jimma town also showed that 31.0% of males of 11% of the females reported their histories of intercourse with multiple partners. This research shows mixed result in that higher proportion of males (49.4%) reported consistent condom use with multiple partners (at-risk behavior) than the proportion of females (36.4%).

#### *Reasons for sexual abstinence ✓*

Different reasons were given by those who were not sexually active for not having intercourse. The inappropriateness of premarital intercourse (27.6% by 28.7% of the females & 26.6 % of the males), followed by religious prohibition (21.8%) by 25.8% of females and 16.8% of males), and lack of the opportunity for intercourse ( 17.99%/ by 27.2 % the males & 10.6% of the females) were reported as the major reasons. Other reasons were also given by some proportion of the respondents. These were fear of public criticism (11.36% of females & 7.5% of males) fear of STDs (9.3% of males & 5.3% of females), fear of parental measures (16.7% of females & 3.4% of males) and lack of desire (5.6% of males and 1.5% of the females (see table 8 in chapter 4).

This situation in which more proportion of males abstained was simply because of lack of the opportunity, fear of STDs or lack of desire and more females abstained because of fear of public opinion, fear of parental measures, religious prohibition and considering premarital intercourse as inappropriate was, directly or indirectly, indicated in similar studies. Social

variables like public critics parental or religious prohibition unlike females, ever bother males to have intercourse because of the sexual double standard which gives males more sexual freedom than females (papilla, 2001; Unger & Crawford, 2000).

### *Sexual activity across age and economic background*

The parametric test, in table 9, indicates that ages ( $r=0.350$ ,  $p<0.01$ ) and grade level ( $r=0.241$ ,  $P<0.01$ ) predict adolescents' sexual activities. i.e. the older an individual adolescent and the more he/she is from the poor family, the more likely he/she is sexually active and vice versa. A survey conducted by FGAE (2001) on Jijjiga-Ethiopia town indicated, for instance, that much more proportion of the sexually active adolescents were from the older age categories. The survey by EPHA (2005) which indicated the higher proportion of sexually active adolescents were from the poor families & vice versa can also confirms this study. Since grade level is directly related to the age levels, the justification given concerning the relationships between age & sexual activity may work with that of grade levels.

### *Knowledge and Perceived Condom Use Self-efficacy*

With regard to the relationships between the respondents general level of knowledge and perceived self-efficacy about using condoms, in this study, was not significant. Similarly, many surveys indicated that adolescents' levels of knowledge couldn't predicate their practices. For example, different surveys conducted in different countries of Africa (Nigeria, Malawi) by UNICEF (2002) that there were discrepancies between what adolescents know and what they practiced with regard to sexual activities. In line with this, surveys conducted by FGAE in the different town of Ethiopia revealed that there were inconsistency between adolescents' knowledge of contraception's and their condom usages. FGAE (1995), for instance, found out that adolescents had better levels of knowledge on sexuality & related issues, but reported to act in a different manner. Similarly, in this research, it was found out that there was no significant relationships between the general levels of knowledge and their perceived self-efficacy in using condoms. In addition, the relationship between their level of knowledge and their being sexually active or non-active was very much less or insignificant (Pearson  $r= 0.019$ ). Thus, this study, in this respect, is confirmed by different surveys we have been citing in this study in that it implies abstinence doesn't necessarily implies higher level of knowledge.

### *Sexual behavior and parent-adolescent communication*

With regard to parent-adolescent communication, in general, it was found that very much insignificant number of respondents reported that there were discussions on sexual issues & related risks in the family. This finding is highly consistent with the previous findings of many other researchers' we have been presenting in this study. For example, similar findings were presented by Feben Derisse (2005), EPHA (2005) and FGAE (1997). Among few proportions of the respondents who discuss the issue with parents, relatively larger proportion of them reported to discuss with their mothers than their fathers. Being scolded was perceived response from fathers and mothers reported by 49.4% and 33.3% of the adolescents respectively. Some respondents underestimated the level of their fathers' (22.2%) and mothers' knowledge (31.1%) questions in relation to sexual issues. Generally, perceived positive response from fathers, mothers, brothers and sisters was reported by 23.4%, 26.7%, 19.2% and 18.1% of the respondents respectively. Family members are embarrassed when a sexual subject comes up in family, where some do not have necessary information. Still there are some parents who keep waiting for their children to ask questions, but the children are either embarrassed to ask or perceive negative response (Kelly, 1998). Parent-adolescent communication, when seen gender wise, very little variation was observed in that 16.8% of males & 13.6% of the females reported the presence of communication in the family. That means, regardless of gender differences, the absence of communication is prevalent in different families ( $\chi^2 = 0.87, p > 0.05$ ). However, the insignificant variation in communication across genders could be attributed to the social view that gives better freedom for boys than girls on sexual issues (Unger & Crawford, 2000). Therefore, most respondents reported the different family members (fathers, mothers, brothers & sisters) as one of the least source of information on sexual issues. Where as, most of them reported their peers as their major source of information followed by media (24.2%) and school programs (14.4%). Hence, this study is confirmed by surveys conducted by FGAE (1997) UNICEF (2002), Perloff (2001) & UNAIDS (1997). With regard to school clubs/ programs focusing on sexuality and HIV/AIDS, most school adolescents reported that they were aware of the presence of the programs in their school. However, they were other students who reported that such programs/ clubs were absent in their school. Still others didn't know whether or not the programs exist in their schools. Half of the students reported to have strong interests to

involve in such clubs/ programs. While nearly one- fourth of the students reported to attend to the clubs, always, 19.9 % some times, 6.4% rarely. There were also other students who never attend to such clubs (32.2%). Those who reported to have less/no interest to involve in such programs gave reasons like religious prohibitions (22.3%) perceived negative out comes of involving in such clubs (16.21%) parental prohibition (11.8%) perceived insufficiency of the information obtained from the clubs (6.1%) perceived unnecessary work load (5.6%) & perceived unnecessary time wastage (2.8%).

### *Adolescents' risk perception*

An assessment of risk perception, in this study, indicated that most adolescents perceived their individual risks as low or non- existent. Nearly three fifth of the sexually active adolescents (67.8% of the 14-17 years age category & 55.6% of the 18-21 years age category) never perceived their chance of contracting STDs and AIDS. They reported that they were risk free because some of them trusted their sexual partners (41.0% of the younger adolescents & 46.9% of the older ones), others felt health (50%of the younger & 22.5% of the older), and still others reported to had no intercourse with an infected individuals (4.5% of the 14-17 ages and 14.2% of the 18-21). None of the younger age category & 12.2 % of the older ones reported that they were tested negative.

Many other similar studies also revealed that, regardless of their involvement in risk sexual activities, adolescents have low risk perceptions. Zastrow and Ashman (1997), for instance, clearly stated that adolescents (especially the younger ones) feel risk- free. Similarly, a survey conducted in selected regions of Ethiopia by EPHA (2005) indicated that most respondents reported their individual risks as low or non existent because they had had no injection with unsterile needles or cut from other sharp objects, had sexual contact with only a single partner whom they trust. Few respondents who perceive a risk of contrasting STDs and HIV/ADS, gave reasons like intercourse without condoms, intercourse with multiple partner, intercourse with suspected persons, gave care for an infected person, mistrust their partners and so on. In this study, most of the respondents were willing to make HIV test and expect AIDS- free result; and reported to perceive their chance of dying from AIDS in the future as very low.

Risk perception was very low among the females than the male respondents. And this finding is confirmed by the 2005 EPHAS' survey in which risk perception was slightly higher among the males than the females. In addition, risk perception was very low among the younger girls than the older ones.

### ***Adolescent sexual behavior and parents' educational background***

Generally, in this research, it was found that adolescents' sexual behaviors were predicted by variables such as mother's and father's educational background, adolescent-family communication, involvement in the school clubs, adolescent-peer communication and risk perception. With regard to father's and mother's educational background, it was found that risk sexual behavior has a negative relationship with both father's and mother's education. i.e. the higher the parents educational status the better the degree of openness in discussing on sexual matters and the less the degree of involvement in risk sexual behavior would be on the sides of adolescents (the correlation matrix on page 60). This finding is confirmed by many of the previous findings. Feben Demisse, (2005) and UNICEF (2005), for instance, justified that parents education predicts communication which predicts sexual behaviors. Similarly, a research conducted by Zubedia (1992) showed that there is an inverse relationship between parental education and sexual behavior of young women. Solomon (2004) also suggested that adolescents from illiterate family are more likely to be sexually active earlier. This study, specifically, showed that mothers' education slightly stronger predictor of sexual behaviors than father's education. In addition, mother's education was a stronger predictor of parent-adolescent communication than father's education. i.e. the better the mother's education the better the degree of communication the family and the less the chance of involving in risk sexual behavior from the sides of adolescents. This, to some extent, can be consistent with the research findings of Kahn and others cited in Crawford and Unger (2000), which indicated that mother's communication was associated with late or safer sexual activities than father's communication. With regard to the relationships between family economic backgrounds, this study showed that lower economic background is associated with risk behavior for girls than for boys, and higher economic background is associated with risk sexual behaviors for boys. However, many previous studies seem to generalize the effect of economic level as similar for both boys and girls. A study conducted

by Feben Demisse (2006),fore instance, showed that the higher the families economic level of the more likely their children would postpone their sexual activities. A research conducted by Tewoldeberhan (1996) in Awasa also indicated that lower economic level the family was associated with risk sexual behaviors among adolescents. However, this study to some extent confirmed by the study on Zelink and Others (1981) cited in Crawford and Unger (2000) which indicated, specifically for girls, low economic status was associated with early sexual initiation.

#### *Adolescents' sexual behaviors across family structure and economic levels*

With regard to the relationship between family structure and sexual behavior, this study indicated that girls from single parent (especially mother only) were involved in risk sexual behaviors than boys from single parents. In this respect, this research is consistent with what Laurence (1993) indicated. i.e. growing up in a single parent home affects girls' sexual behavior than boys because of some reasons. Boy's parents, fore instance, may not attempt to exert great control over their sexual activity regardless of whether the household has one parent or two. Consequently, boys from one and two parent homes may be equally sexually active. The sexual behaviors of girls, in contrast, may be more subjected to parents' control. In addition, single parent mothers, as justified by Laurence, are more likely to be dating than married mothers and in so doing, may inadvertently be role models of sexual activity to their daughters.

#### *Risk perception as predictor of sexual behavior*

Risk sexual behaviors were negatively correlated with risk perception and degree of involvement in school clubs. i.e. the higher the risk perception and the degree of involvement in the school clubs the lower the degree of the risks in which the adolescents were involved. Similarly, it was showed in a survey conducted by UNICEF (2002) that adolescents who perceived their individual risks as low or non-existent were more likely to involve in risk sexual behaviors. The survey also showed that different programs provided in schools could help adolescents delay from being sexually active, and when they start having intercourse they become more likely to protect themselves against the risks like unwanted pregnancy, STDs and AIDS.

## CHAPTER SIX

### CONCLUSSIONS AND RECOMMENDATION

Adolescence is the period when sexual activity comes with the onset of puberty. Most people begin sexual activity during this period. Most research studies, therefore, justify that individuals in this age category are most probably sexually active. However, since many adolescents under report their sexual histories, researchers often encounter problems in addressing the exact proportions of the sexually active adolescents and the prevalence of premarital intercourse in different parts of the world & regions of different countries. This might also be the reason why only about one- thirds of the participants of this study reported their being sexually actives.

Among those who admitted that they were sexually active, in this study, the proportion of males exceeds that of females. In addition, the proportion of adolescents in the older age category (18-21) exceeds that of the younger age category (14-17). The majority of the sexually active adolescents began intercourse between ages 14-17 years. The mean age at the first intercourse was a little bit greater for females.

Most respondents of this study reported that they engaged in sexual intercourse because they perceived their friends were doing that. Some of them fall in love, and others were coerced to engage in intercourse by partners. There were still adolescents, especially a large proportion of females (and some insignificant proportion of males), engaged in sexual activity by being induced with money and other material supports.

Intercourse with a single faithful partner was not common practices among most of the participants; and most of the school adolescents experienced intercourse with causal partners at least once in their life. In addition it was found out that sexual debut with out their willingness & intercourse at the expense of paying or being paid was reported. Some of the sexually active adolescents encountered risks like STDs, unanticipated pregnancies, abortion or childbirth in their life whereby significant proportions of the victims were females.

Most of the adolescents never used condom during intercourse. Especially, condom use during the first intercourse and with regular partners was lower than during the last intercourse and with casual partners. In addition, many adolescents limited the responsibilities of coming with condoms for intercourse to their partners only. And this can be one of the barriers to condom use among adolescents.

It was found that many factors hindered adolescents from using condoms. In addition, variations were seen in the reasons for their condom use at the first intercourse and across gender. For instance, while lack of knowledge on how to use condoms, fear of public criticism to buy condoms and lack of money to buy were the major barriers during the first intercourse, resistance from the sides of ones sexual partner, trusting ones partner and the need for enjoyment with intercourse with out condoms were the major barriers at the last intercourse. In addition, making an unanticipated intercourse, lack of information from where to get condoms and intercourse under the influences of drugs & alcohols were also reported as barriers to condom use during both the first and the last intercourse, by different proportions of respondents.

Risk sexual behaviors were prevalent among the older age category (18-21) than the younger ones (14-17) and slightly higher among females than the males.

Sexual abstainers gave different reasons for their abstaining, and variations were observed between the males and the females in their reasons. For instance, while perceived in appropriateness of premarital intercourse was reported by both males and females' lack of opportunity for intercourse was reported by larger proportion of males. Whereas, religious prohibition was the reason given by larger proportion of females. In addition, fear of STDs, public criticism, or parents were also the reasons given by different proportions of males & females.

In this research, a discrepancy between the adolescents' level of knowledge & their sexual activities were observed.

Most families were reported to be very conservative in discussing sexual matters with their children. Children were also embarrassed to ask any questions related to the issue because of the perceived negative responses of parents. However, adolescent peer communication was very common, but might not help them make responsible decisions. Therefore, peers media TV/radio, and schools were the major sources of information on sexual matters for the adolescents. Whereas, little or no information could be obtained from parents & religious people. In addition, family structure & parental economic background could predict adolescents' sexual behaviors. Thus, it was found that girls from single parents were involved in risk behaviors than, boys. Girls from lower, economic background & boys from higher economic family were in higher risks. School clubs were important and most students enjoy with them. But, there are some barriers which hinder the adolescents' involvement in the programs. For example, religious prohibitions, parental prohibitions, lack of information on their importance & the like. In addition, it seems that the school clubs were not well developed to attract the majority's attention. No matter how problems are there with school clubs, participation in them, in this research, found to have negative relationships with risk sexual behaviors. i.e. the higher the degree of participation, the lower the risk sexual behavior were found to be.

Even though adolescents were involved in risk sexual activities, they perceived their individual risks associated with their activities as very low or non-existent. Adolescents gave different baseless reasons for their not perceiving risks. That was, probably, the reason why their risk perception had negative relationship with their sexual risk taking behaviors

Generally, this study and many other previous studies indicate that there are varieties of challenges adolescents encounter in relation to sexual activity. The decline in the age of pubertal changes that come up with sexual feelings on the one hand, and dalliance in the age at marriage, on the other hands, tempted adolescents to have premarital intercourse. Adolescents do not get any information and guidance from their parents and other members of the community because of some misunderstandings and the existing conservative view. Consequently, adolescents are often make uninformed or misinformed sexual decisions which, unquestionably, threaten their future life. Therefore, the researcher, critically

analyzing these and many other problems related to adolescent sexuality, addressed the following points as recommendations.

- ↓ The government should increase community awareness and actions on adolescent health problems, including the establishment of a policy that will effectively address the adolescent health issues.
- ↓ The planning and implementation of young people's reproductive health interventions must target parents. In this respect, sufficient awareness must be given to parents so that they can avoid their conservative view and understand the importance of their communication and guidance on sexual issues with their children in predicting risk-free decisions.
- ① In awareness creation, the Ministry of Education must work in collaboration with the ministry of health. In this respect, they have to increase the number of programs providing reproductive health and life enhancing opportunities for the school adolescents. The schools must, some times, arrange programs to invite health professionals to visit the schools and provide their professional guidance & information for the school adolescents.
- ↓ Peers were reported as the major and even the only source of information for the adolescents on sexual issues. However, Communication with peers never indicates, in this study, strong positive impact on the sexual behavior of adolescents. This happened, probably, as the result of the limited & similar levels of knowledge and skills they have in shaping each other. Consequently, they could misinform, or even initiate each other to involve in unsafe sexual activities. So, efforts must be made to train selected students so that they teach their friends practical skills. This is because information and opinions can often be shared more easily in a clear, friendly and objective way by friends trained as educators than parents or other adults who are quite naturally and properly involved with the young people.
- ② This study indicated that gender inequality in sexual decisions is one of the major barriers hindering girls' contraceptive usage. Therefore, awareness on gender issues, together with reproductive health education, must be given.
- ↓ This study indicates that there is discrepancy between the adolescents' levels of knowledge on sexual issues and related risks and their practices. That means, the factual knowledge they are provided with can't predict risk-free sexual behavior. So, to reduce

their misunderstandings & wrong perceptions which lead them to take high risk path, regardless of the levels of their factual knowledge, they must be helped to internalize important values and skills, increase their motivation to reduce their own risks, and they must be taught specific skills and behaviors including practices in talking about condoms with a partner, avoiding drinking or drug use before intercourse and learning to purchase and use condoms.

- ✦ Emphasis must be given to sports, recreations and cultural pursuits to shift the attentions of adolescents and youth from unsafe sexual activities. These can provide them opportunities for the development of self-confidence and self-expression minimizing the existing stereotypes & sexual double standard against girls.
- ✦ Governmental and non governmental organizations must invest sufficient budget in conducting a more detail survey so that the problems of Ethiopian adolescents & youth are well addressed and practical problem-solving strategies are designed.

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# APPENDICES

**Appendix-I**  
**Addis Ababa University**  
**School of Graduate Studies**  
**Department of psychology**

**Questionnaire**

Dear respondents, this questionnaire is prepared to assess/ understand the influences of family, peers and school clubs on the sexual behavior of adolescents and their perceptions of risks associated with sexual activity. It is simply used to conduct a research which is used for the requirement of Master's Degree in Developmental Psychology at Addis Ababa University .

Having this general purpose in mind you are kindly requested to give your genuine responses for the given items.

The researcher would like to inform you that there is no right or wrong response. In addition be sure that the researcher offers no objection to any type of your behavior or activity in which you could possibly involve .

Your responses will be kept very confidential and used only for the research purpose.

Please, give your responses based on the directions given to each part of the questionnaire.

**Thank you for your cooperation!**

**Part – I**

**Demographic Characteristics**

Followings are lists of questions asking about you and your family. Please, give your responses by putting a tick “✓” mark in one of the boxes of the alternative responses listed against each of the items, or writer what you are asked to write in the boxes.

No	Items /questions	Responses/options
1	Age (please, write in the box)	<input type="text"/>
2	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
3	Name of your school(Please, write in the box)	<input type="text"/>
4	Grade level	<input type="checkbox"/> 9 <sup>th</sup> <input type="checkbox"/> 10 <sup>th</sup> <input type="checkbox"/> 11 <sup>th</sup> <input type="checkbox"/> 12 <sup>th</sup>
5	Where were you brought up/lived much in your life?	<input type="checkbox"/> Urban <input type="checkbox"/> Rural
6	Who raised you?	<input type="checkbox"/> Father only <input type="checkbox"/> Mother only <input type="checkbox"/> Father/mother with other person <input type="checkbox"/> Both father and mother <input type="checkbox"/> My sister/brother <input type="checkbox"/> Other relatives <input type="checkbox"/> Other specify _____
7	If you are the one who was not raised by both father and mother together, what was the reason ?	<input type="checkbox"/> Lost both by death <input type="checkbox"/> Lost one of them because of divorce <input type="checkbox"/> Lost one of them because of death <input type="checkbox"/> Other reason, if any _____
8	With whom are you living now?	<input type="checkbox"/> Father only <input type="checkbox"/> Friends <input type="checkbox"/> Mother only <input type="checkbox"/> Relatives <input type="checkbox"/> Both father and mother <input type="checkbox"/> Sister/brother <input type="checkbox"/> My fiancé      Other, if any _____
9	What is your religion?	<input type="checkbox"/> Orthodox <input type="checkbox"/> Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Other, if any _____
10	How often do you attend religious institution?	<input type="checkbox"/> Always <input type="checkbox"/> Rarely <input type="checkbox"/> Some times <input type="checkbox"/> Never
11	What is the educational level of your father?	<input type="checkbox"/> High school complete or more <input type="checkbox"/> Elementary education attended <input type="checkbox"/> No formal education attended Others, if any _____
12	What is the educational level of your mother?	<input type="checkbox"/> High school complete or more <input type="checkbox"/> Elementary education attended <input type="checkbox"/> No formal education attended Others, if any _____
13	How do you rate the relative economic status of your family?	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low

## Part- II

### 2. Sexual Behavior

Dear respondents! the following items are selective/alternative response types asking information about you. Please, give your response by putting a tick “✓” mark in one of the boxes of the alternatives listed against each of the items.

#### 2.1 Sexual Activity

No	Items/statements	Alternatives/options
✓1.	Have you ever had intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If your response for question number 1 is 'Yes,' please, respond to questions 2-19, if not, skip to questions 19&20	
2 ✓	Do you have a regular sexual partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 ✓	If your response for question number 2 is yes, how often do you use condoms with your regular partner?	<input type="checkbox"/> Always/consistently <input type="checkbox"/> Sometimes/inconsistently <input type="checkbox"/> Never use it
4 ✓	Have you ever had sex with a casual sexual partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 ✓	If your response for question number 4 is yes, with how many casual partners have you had sex in your life?	<input type="checkbox"/> One <input type="checkbox"/> two <input type="checkbox"/> three <input type="checkbox"/> four or more
6 ✓	If your response for question number 4 is yes, how often do you use condoms with your casual partner?	<input type="checkbox"/> Always/consistently <input type="checkbox"/> Sometimes/inconsistently <input type="checkbox"/> Never use it
7 ✓	At what age category have you started sex for the first time?	<input type="checkbox"/> 10-13 <input type="checkbox"/> 18-21 <input type="checkbox"/> 14-17 <input type="checkbox"/> Other _____
8 ✓	What made you engage in sex?	<input type="checkbox"/> I fall in love <input type="checkbox"/> I was forced <input type="checkbox"/> I was made to generate income/material support with intercourse <input type="checkbox"/> I felt most of my friends practice it <input type="checkbox"/> I got married <input type="checkbox"/> Other, if any _____
9 ✓	Did you use condoms the first time you had sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10	If your response for question number 9 is 'No', what was the reason?	<input type="checkbox"/> It was expensive <input type="checkbox"/> It was not available <input type="checkbox"/> I was afraid/ashamed of my partner <input type="checkbox"/> I trusted my partner <input type="checkbox"/> I didn't know how to use it <input type="checkbox"/> I was refuted by my partner <input type="checkbox"/> I was afraid of public criticism to buy condoms <input type="checkbox"/> I got drunk <input type="checkbox"/> It reduces pleasure <input type="checkbox"/> <i>The intercourse was unanticipated</i> <input type="checkbox"/> Didn't know where to get <input type="checkbox"/> Other, if any _____
11	Did you use condoms the last time you had sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12	If your response for question number 11 is 'No', what was the reason?	<input type="checkbox"/> It was expensive <input type="checkbox"/> It was not available <input type="checkbox"/> I was afraid/ashamed of my partner <input type="checkbox"/> I trusted my partner <input type="checkbox"/> I didn't know how to use it <input type="checkbox"/> I was refuted by my partner <input type="checkbox"/> I was afraid of public opinion to buy <input type="checkbox"/> In got drunk <input type="checkbox"/> It reduces pleasure <input type="checkbox"/> <i>The intercourse was unanticipated</i> <input type="checkbox"/> Didn't know where to get <input type="checkbox"/> Other, if any _____
13	Whom do you think is more responsible in bringing and using condoms?	<input type="checkbox"/> My partner <input type="checkbox"/> I my self <input type="checkbox"/> Equally, both of us
14	Have you ever been forced to have sex against your will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15	Have you ever paid/received money for sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Have you ever faced any kind of risk associated with sexual activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17	If your response for question number 16 is 'Yes', which of the following risks have you ever faced in your life?	<input type="checkbox"/> Unwanted pregnancy(for girls) <input type="checkbox"/> STDs <input type="checkbox"/> childbirth (for girls) <input type="checkbox"/> Abortion(for girls) <input type="checkbox"/> Other, if any _____

18	Whom did you contact when you encountered the risk?	<input type="checkbox"/> My mother <input type="checkbox"/> My sister <input type="checkbox"/> My father <input type="checkbox"/> My brother <input type="checkbox"/> A health professional <input type="checkbox"/> A teacher <input type="checkbox"/> A religious people <input type="checkbox"/> A local medicine man/woman <input type="checkbox"/> Consulted no one <input type="checkbox"/> Other, if any _____
19	Do you think premarital intercourse is important?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes, if marriage is planned <input type="checkbox"/> No
20	If your response for question number 1 is NO, what is your reason?	<input type="checkbox"/> Fear of public criticism <input type="checkbox"/> Lack of the opportunity <input type="checkbox"/> Fear of my parents measures <input type="checkbox"/> Its being inappropriate <input type="checkbox"/> Fear of STDs <input type="checkbox"/> Religious prohibition <input type="checkbox"/> Lack sexual desire <input type="checkbox"/> Other, if any _____

### 2.2 Trends in condom Use

21	I feel confident I could purchase condoms with out feeling embarrassment.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
22	I would feel comfortable discussing condom use with a potential sexual partner before we ever engaged in intercourse.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
23	If I were to suggest using a condom to a partner, I would feel afraid that he/she would reject me.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
24	I would not feel confident suggesting using condoms with a new partner because I would be afraid he/ she would think I had a sexually transmitted disease.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
25	I feel confident that I would remember to use a condom even after I have been drinking.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
26	I feel confident I could not stop to put a condom on my self or my partner even in the heart of passion.	<input type="checkbox"/> Disagree <input type="checkbox"/> Can't say <input type="checkbox"/> Agree

**Part-III**

**Adolescents' Communication/Relationships With their parents and Peers**

27	Do you share any idea on sexual issues and related risks like STDs, unwanted pregnancy and the like with your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28	If your response for question number 27 is 'Yes', with whom do you relatively communicate on the issue very often?	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other ,if any_____
29	If you ask your father about sexual issues what do you think would be his response?	<input type="checkbox"/> Would answer helpfully <input type="checkbox"/> Would scold me <input type="checkbox"/> Would turn me away <input type="checkbox"/> Not competent to respond <input type="checkbox"/> Other, if any_____
30	If you ask your mother about sexual issues what do you think would be her response?	<input type="checkbox"/> Would answer helpfully <input type="checkbox"/> Would scold me <input type="checkbox"/> Would turn me away <input type="checkbox"/> Not competent <input type="checkbox"/> Other, if any _____
31	If you ask your brother about sexual issues what do you think would be his response?	<input type="checkbox"/> Answer help fully <input type="checkbox"/> Scold me <input type="checkbox"/> Turn me away <input type="checkbox"/> Not competent to respond <input type="checkbox"/> Other, if any_____
32	If you ask your sister about sexual issues what would be her response?	<input type="checkbox"/> Answer help fully <input type="checkbox"/> Scold me <input type="checkbox"/> Turn me away <input type="checkbox"/> Not competent to respond <input type="checkbox"/> Other, if any_____
✓ 33	Do you share your personal experiences on sexual issues with your friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✓ 34	If you encounter any problem /question related to sexuality (pregnancy, STDs and so on), to whom do you tell first?	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Friends <input type="checkbox"/> Sexual partner Other, _____
✓ 35	In general, who is your major source of information on sexual issues and related risks like HIV/AIDS? (please, rank them according to their importance to you)	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Religious people <input type="checkbox"/> Friends <input type="checkbox"/> Sex Partner <input type="checkbox"/> teachers <input type="checkbox"/> Media <input type="checkbox"/> Health Professionals <input type="checkbox"/> School based clubs <input type="checkbox"/> Other, specify

**Part – IV**  
**School Based Clubs' situations**

36	Is there any school based club which provides information on sexual issues and the associated risks like HIV/AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> Don't know <input type="checkbox"/> No
37	How often do the program/club inform you about risk taking sexual behavior?	<input type="checkbox"/> Always <input type="checkbox"/> Rarely <input type="checkbox"/> Some times <input type="checkbox"/> Never
38	Do you enjoy participating in any of the school based program/club which provides information/education on sexual issues and related risks like AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> Can't decide <input type="checkbox"/> No
39	If your response for the item number 49 is 'No', what is your reason?	<input type="checkbox"/> I believe such programs can even initiate me try risk sexual practices <input type="checkbox"/> My religion prohibits <input type="checkbox"/> My parents prohibit <input type="checkbox"/> I believe it is unnecessary time wastage <input type="checkbox"/> It over burdens me <input type="checkbox"/> Don't provide sufficient information and services Other, if any

**Part – V**

**General Level of Understanding on Sexual issues**

40	Oral contraceptives like birth control pills can also protect STDs	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
✓41	Some one who haven't had sex in his/her life is unquestionably free of HIV/AIDS.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
✓42	A girl can not get pregnant with the first time she has sex.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
43	A person looking health may have HIV/AIDS.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
✓44	The probability of getting STDS or AIDS is greater for males than for females	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
45	Coughing and sneezing do not spread AIDS.	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
46	An HIV/AIDS- free child in no way can be born to an infected mother	<input type="checkbox"/> Agree <input type="checkbox"/> Can't say <input type="checkbox"/> Disagree
✓47	Which one do you think is the best technique of preventing HIV/AIDS?	<input type="checkbox"/> Being faith full <input type="checkbox"/> Using condoms <input type="checkbox"/> Abstinence

**Part-VI**  
**Risk-perception**

48	How often do you feel you did some thing that might put you at risks of getting any of the STDs or AIDS?	<input type="checkbox"/> Always <input type="checkbox"/> Some times <input type="checkbox"/> Rarely <input type="checkbox"/> Never at all
49	If you feel you are at risks, what is your reason?	<input type="checkbox"/> Had sexual contact with infected person <input type="checkbox"/> Had sex with out condom <input type="checkbox"/> Have more than one partner <input type="checkbox"/> Don't believe my partner <input type="checkbox"/> Gave care for an infected person <input type="checkbox"/> Had sex with commercial sex worker carelessly <input type="checkbox"/> Had an injection whose sterility is not known <input type="checkbox"/> Other, specify _____
50	If you feel you are a risk-free, what is your reason?	<input type="checkbox"/> Never had sexual contact <input type="checkbox"/> Trust my partner <input type="checkbox"/> Used contraceptives consistently <input type="checkbox"/> I feel healthy <input type="checkbox"/> Never had sex with infected person <input type="checkbox"/> Tested negative <input type="checkbox"/> Other, specify _____
51	Do you feel you will be at risk of unwanted pregnancy once up on a time in the near future?(for girls only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
52	If your response for question number 75 is 'No', why?	<input type="checkbox"/> I am consistent in using contraceptives <input type="checkbox"/> I will abstain from sex <input type="checkbox"/> I think I will not be mature enough to get pregnant in the near future <input type="checkbox"/> Other, specify _____
53	With regard to HIV/AIDS test, which statement fits with your feeling /decision?	<input type="checkbox"/> I am willing to be tested and expect risk free result <input type="checkbox"/> I am not willing to be tested, but if you are forced to do so you expect risk free result <input type="checkbox"/> I am willing to be tested and expect risk result <input type="checkbox"/> I am not willing to be tested, and if you are forced to do so you expect risk result
54	How often do the thought of getting STDs or dying from AIDS in the future comes to your mind?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never at all

## QUESTIONS FOR THE FOCUS GROUP DISCUSSIONS (FDGs)

**Direction:** When discussing on the following points, share your own experiences( **give some examples from what you observe, know, feel** )

1. What factors initiate adolescents to engage in sex?
2. To what extent do you think most adolescents use condoms? What barriers do you think hinder adolescents from using condoms? Do you think some of the barriers are gender related?
3. Who is more responsible to bring and use condoms? (**the male or the female partner?**)
4. Whom do you think can adolescents contact when they encounter any question or risk associated with sexual activity? Why?
5. What trends are there in different families with regard to communication on sexual issues? (**Please, share your own experience.**)
6. Who is your major source of information on sexuality and related issues?
7. What kind of clubs are there in your school? How do you evaluate the effectiveness of clubs in your school in providing information and guidance on sexual issues for the school adolescents? Why?
8. What information do you have about human sexuality?
9. What are the causes, types and preventive techniques of STDs and AIDS?
10. How can a person with HIV/AIDS identified? What are the major symptoms?

Appendix II

አዲስ አበባ ዩኒቨርሲቲ  
የድህረ- ምረቃ ፕሮግራም  
የሳይኮሎጂ ትምህርት ክፍል

የተከበራችሁ ተጠያቂዎች ይህ መጠይቅ የተዘጋጀው የቤተሰብ፣ የጋደኞችና የትምህርት ቤት ክበቦች በወጣቶች ወሲባዊ ባህርያትና ተያያዥነት ያለቸው ችግሮችን በተመለከተ በሚኖራቸው አመለካከት ላይ የሚያደርሰውን ተፅዕኖ ለማጥናት ነው። ይህም ደግሞ በአዲስ አበባ ዩኒቨርሲቲ በሳይኮሎጂ ትምህርት ለ2ኛ ድግሪ ማሟያነት ሲባል የሚያስፈልገው ምርመር ለማካሄድ የሚረዳ ነው።

ይህንን አጠቃላይ ዓላማ ግንዛቤ ወስጥ በማስገባት ለቀረቡት ጥያቄዎች የየራሳችሁን ትክክለኛ መልሶች እንድትሰጡ በትህትና ትጠየቃለችሁ።

የጥናቱ ባለቤት ሊያሳስባችዎ የሚፈልገው ነገር ቢኖር ትክክለኛ ወይንም የተሳሳተ መልስ አለመኖሩን ነው። በተጨማሪም ደግሞ የጥናቱ ባለቤት እናንተ በነበራችሁት በማንኛውም የግል ተሞክሮ ወይንም ወሲባዊ ባህሪ ላይ ምንም ዓይነት ሂስ እንዳማይሰጥ እርግጠኛ እንድትሆኑ ይፈልጋል።

የእያንዳንዳችዎ መልስ በማንኛውም አካል እንዳይታይ ተደርገው በምስጢር በጥንቃቄ የሚቀመጥና ለምርምሩ ዓላማ ብቻ የሚውል ይሆናል።

ለእያንዳንዱ የመጠይቁ ክፍል በተሰጠው መመሪያ መሰረት መልሶቻችዎን እንድትሰጡ በትህትና ትጠየቃለችሁ።

ለሚደርግልኝ ትብብር በቅድሚያ  
አመሰግናለሁ!!

**ክፍል 1**

**የግል ሁኔታዎች መረጃ**

የሚከተሉትን ጥያቄዎች ስለራስህ (ሽ) ና ስለቤተሰቦችህ (ሽ) የሚጠይቁህ (ሽ) ናቸው። መልሶችህን ( ሽን) ይህችን ምልክት «✓» ከተዘረዘሩት ሳጥኖች በምትመርጠው (ጨጨ) ሃሳብ ጉን በተቀመጠው ሳጥን ውስጥ በማስቀመጥ ወይም ደግሞ የተጠየከው(ሽውን) ነገር ከፊት ለፊት በተቀመጠው ሳጥን ውስጥ በመጻፍ ስጥ( ጨ)

1. ዕድሜ ( በተሰጠው ሳጥን ውስጥ 9ፍ(ሬ)
2. የታ  ወንድ  ሴት
3. የትምህርት ቤትህ ( ሽ) ስም \_\_\_\_\_
4. የትምህርት ደረጃ  9ኛ  10 ኛ  11ኛ  12 ኛ
5. የእድገትህ (ሽ) ቦታ ወይም በብዛት የኖርክበት (ሽበት) አካባቢ ምን ዓይነት ነበር?  ከተማ  ገጠር
6. ማን ነበር ያሳደገህ (ሽ) ?  
 አባቱ ብቻ  አባቱ / እናቱ ከሌላ ሰው ጋር  
 እናቱ ብቻ  ወንድሜ /እህቴ  
 አባቱና እናቱ  ሌሎች ዘመዶች ሌላም ካለ \_\_\_\_\_
7. አባትህ ( ሽ) እና እናትሽ ሁለቱም በአንድ ላይ ያሳደጉህ ( ሽ) ከሆነ ምክንያቱ ምን ነበር?  
 ሁለቱንም በሞት ምክንያት ስላጣሁ  
 አንዳቸውን በሞት ምክንያት ስላጣሁ  
 አንዳቸውን በትዳር መፍረስ ምክንያት ስላጣሁ  
 ሌላ ምክንያት ካለ ይገለጽ \_\_\_\_\_
8. በአሁኑ ጊዜ ከማን ጋር እየኖርክ (ሽ) ነው?  
 አባቱ ብቻ  ጋደኞቹ  ፍቅረኛዬ  
 እናቱ ብቻ  ዘመዶቹ ሌላም ካለ ይገለጽ \_\_\_\_\_  
 አባቱና እናቱ  ወንድሜ /እህቴ
9. የየትኛው ሐይማኖት ተከታይ ነህ (ሽ) ?  
 ኦርቶዶክስ  ሙስሊም  ፕሮቴስታንት ሌላም ካለ \_\_\_\_\_
10. የራስህን (ሽን) የሐይማኖት ፀሎት ቤቶችን ምን ያህል ተከታተላለህ (ሽ)?  
 ሁል ጊዜ  አንዳንድ ጊዜ  
 አልፎ አልፎ  አልተከታተለም
11. የአባትህ (ሽ) የትምህርት ደረጃ ምንድን ነው?  
 የሁለተኛ ደረጃ ትምህርትን ያጠናቀቀ /ከዚያ በላይ  
 የአንደኛ ደረጃ ትምህርትን የተከታተለ  
 ምንም ዓይነት መደበኛ ትምህርት ያልተማረ  
 ሌላም ካለ ይገለጽ \_\_\_\_\_
12. የእንትህ (ሽ) የትምህርት ደረጃ ምንድን ነው?  
 የሁለተኛ ደረጃ ትምህርትን ያጠናቀቀች /ከዚያ በላይ  
 የአንደኛ ደረጃ ትምህርትን የተከታተለች  
 ምንም ዓይነት መደበኛ ትምህርት ያልተማረች  
 ሌላም ካለ ይገለጽ \_\_\_\_\_
13. በአንጻራዊ ሁኔታ ሲታይ የቤተሰቦችህ (ሽን) የኖሩ ደረጃ እንዴት ትገልጻለህ (ሽ)?  ከፍተኛ  መካከለኛ  ዝቅተኛ

**ክፍል 2**

**2. ወሲባዊ ባህርያት**

የሚከተሉት ጥያቄዎች ወሲባዊ ሁኔታዎችን በተመለከተ ስለራስህ ( ሽ) የሚጠይቁህ ( ሽ) የምርጫ ጥያቄዎች ናቸው። መልሶችህን (ሽን) ይህንን ምልክት «✓» ከእያንዳንዱ ምርጫ በፊት ከተቀመጡት ሳጥኖች በምትመርጠው( ጨጨ) ሃሳብ አጠገብ ባለው ሳጥን ውስጥ መልስህን (ሽ) አስቀምጥ/ ስጥ።

2.1 ወሲባዊ ድርጊቶች

1. የግብረ-ሥጋ ግንኙነት አድርገህ (ሽ) ታወቃለህ(ሽ)?
  - አዎን       አይደለም
  - ለአንደኛ ጥያቄ መልስህ (ሽ) «አዎን» የሚል ከሆነ ከጥያቄ ቁጥር ከ 2-19 ላሉት ጥያቄዎች መልስህ (ሽ) ስጥ (ጭ)፤ መልስሽ «አይደለም» የሚል ከሆነ ግን በቀጥታ ወደ ጥያቄ ቁጥር 19 እና 20 ሂድ(ጂ)።
2. ቋሚ የፍቅር ጓደኛ አለህ (ሽ)?     አዎን       አይደለም
3. ለጥያቄ ቁጥር 2 መልስህ (ሽ) «አዎን» የሚል ከሆነ ከቋሚ የፍቅር ጓደኛህ (ሽ) ጋር ከንደምን ምን ያህል ተጠቀመላህ(ሽ)?
  - ሁል ጊዜ       አንዳንድ ጊዜ       አልጠቀምም
4. ቋሚ የፍቅር ጓደኛህ (ሽ) ካልሆነ ሰዉ ጋር የግብረ-ሥጋ ግንኙነትን አደርገህ(ሽ) ታወቃለህ(ሽ)?     አዎን       አይደለም
5. ለጥያቄ ቁጥር 4 መልስህ (ሽ) «አዎን» የሚል ከሆነ ከስንት ቋሚ የፍቅር ጓደኛህ(ሽ) ካልሆነ ሰዎች ጋር በሕይወትህ (ሽ) የግብረ-ሥጋ ግንኙነት አርገሃል(ሻል)?  አንዳንድ ጊዜ     ሁለቱም     ሰባት     አራትና ከዚያም በላይ
6. ቋሚ የፍቅር ጓደኛህ (ሽ) ካልሆነ ሰዎች ጋር የግብረ-ሥጋ ግንኙነት ስታደርግ (ጊ) ከንደምን ምን ያህል ተጠቅመህ (ሽ) ተወቃለህ (ሽ) )?
  - ሁልጊዜ       አንዳንድ ጊዜ       አልተጠቀምኩም
7. ለመጀመሪያ ጊዜ የግብረ-ሥጋ ግንኙነትን በየትኛው የዕድሜ ክልል ውስጥ ነበር ያደረግከዉ(ሽዉ) ?     10-13     14-17     18-21     ሌላም ካለ-----
8. የግብረ-ሥጋ ግንኙነትን እንዴት ጀመርክ (ሽ) )?
  - በፍቅር ምክንያት       ብዙዎች ጓደኞቼ ስለሚያደርጉ
  - ተገድጄ ነበር       በጋብቻ ምክንያት
  - ገንዘብ ወይም ሌላ ጥቅም ስላገኘሁበት ሌላም ካለ -----
9. ለመጀመሪያ ጊዜ የግብረ-ሥጋ ግንኙነት ስታደርግ (ጊ) ከንደምን ተጠቅመሃል(ሻል) ?     አዎን       አይደለም
10. ለጥያቄ ቁጥር 9 መልስህ (ሽ) «አይደለም» የሚል ከሆነ ምክንያቱ ምን ነበር?
  - ለመግዛት ገንዘብ ስላልነበረኝ       ለመግዛት የሕብረተሰቡን ይሉኝታ ስለፈራሁ
  - በአካባቢዉ አለመገኘቱ       አልኮል ስለወሰድኩ
  - ፍቅረኛዬን ፈራሁ/አፈርኩ       ጓደኛዬ ስለተቃወመኝ
  - ፍቅረኛዬን ስላመንኩ       እርካታ ስለሚቀንስ
  - አጠቃቀሙን ስላላወኩ      ሌላም ካለ -----
11. ለመጨረሻ ጊዜ የግብረ-ሥጋ ግንኙነት ስታደርግ(ጊ) ከንደም ተጠቅመሃል(ሻል) ?
  - አዎን       አይደለም
12. ለጥያቄ ቁጥር 11 መልስህ (ሽ) «አይደለም» የሚል ከሆነ ምን ነበር ምክንያቱ?
  - ለመግዛት ገንዘብ ስላልነበረኝ       ለመግዛት የሕብረተሰቡን ይሉኝታ ስለፈራሁ
  - በአካባቢዉ አለመገኘቱ       አልኮል ስለወሰድኩ
  - ፍቅረኛዬን ፈራሁ/አፈርኩ       ጓደኛዬ ስለተቃወመኝ
  - ፍቅረኛዬን ስላመንኩ       እርካታ ስለሚቀንስ
  - አጠቃቀሙን ስላላወኩ      ሌላም ካለ -----
13. ከንደምን አምጥቶ በመጠቀም የበለጠ ኃላፊነት ያለበት ማን ይመስልሃል(ሻል)?
  - ፍቅረኛዬ       እኔዉ እራሴ       ሁለታችንም እኩል ኃላፊነት አለብን
14. በሕይወትህ(ሽ) ዉስት ከፍላጎትህ(ሽ) ዉጪ የግብረ-ሥጋ ግንኙነት አርገህ (ሽ) ታወቃለህ(ሽ)?     አዎን       አይደለም
15. በሕይወትህ(ሽ) ዉስጥ ለግብረ-ሥጋ ግንኙነት ገንዘብ ከፍለህ(ሽ) ወይም ተቀብለህ(ሽ) ታወቃለህ(ሽ)?     አዎን       አይደለም
16. በሕይወትህ (ሽ) ዉስጥ ከወሲባዊ ጉዳዮች ጋር ተያያዥነት ያለዉ ችግር ደርሶብህል(ሻል)?     አዎን       አይደለም
17. ለጥያቄ ቁጥር 16 መልስህ (ሽ) አዎን የሚል ከሆነ ምን ዓይነት ችግር ነበር የደረሰብህ (ሽ)? ( ያጋጠመህን (ሽን) በሙሉ ለይተህ(ሽ) አሳይ(ዩ)
  - አላስፈላጊ የልሆነ እርግዝና ( ለሱቶች ብቻ)     ያለ ዕቅድ መወለድ ( ለሱቶች ብቻ)
  - ጽንሰ ማስወረጃ ( ለሱቶች ብቻ)
  - በግብረ-ሥጋ ግንኙነት በሚተላለፍ በሽታ መያዝ      ሌላም ካለ-----

18. ከወሲብ ጋር ተያያዥነት ያለው ችግር ደርሶብህ(ሽ) ከሆነ በወቅቱ ለችግሩ ማንን ነበር ያማከርከው.(ሽጩ)?

- አባቴን  እናቴን  እህቴን  ወንድሜን  አስተማሪዬን
- የጤና ባለሙያን  የሐይማኖት ሰው  ባህላዊ ሐኪም ( አዋቂ)
- ማንንም አላማከርከም ሌላም ካለ ይገለጽ\_\_\_\_\_

19. ከጋብቻ በፊት የግብረ-ሥጋ ግንኙነትን ማድረግ አግባብ ነው ብለህ(ሽ) ታስባለህ (ሽ)?  አዎን  አዎን ግን ለጋብቻ ዕቅድ ካለ  አይደለም

20. ለጥያቄ ቁጥር 1 መልስህ/ሽ/ አይደለም የሚል ከሆነ ምንድነው ምክንያትህ/ሽ/?

- ይሉኝታን ስለፈረሁ  ሐይማኖተ ስለሚከለክለኝ
- አጋጠሚውን ስለጠው  ፍላጎት ስለጠሁ
- የቤተሰቦቼን ቅጠት ስላፈራራሁ  ሌላም ካለ \_\_\_\_\_
- ከጋብቻ በፍት አግባብ ባለመሆኑ
- በግብረ-ሥጋ ግንኙነት የሚተላለፉ በሽታችን ስለፈራሁ

**2.2 የኮንዶም አጠቃቀም ተሞክሮ**

21. ያለምንም መጨናነቅ ኮንዶምን መግዛት እችላለሁ::

- እስማማለሁ  መወሰን አልችልም  አልስማማም

22. ወደ ግብረ-ሥጋ ግንኙነት ከመግባታችን በፊት ለወደፊት ከእኔ ጋር የግብረ-ሥጋ ግንኙነት የማድረግ አዝማሚያ ካለው ሰው ጋር ስለኮንዶም ማወራት አይከብደኝም:

- እስማማለሁ  መወሰን አልችልም  አልስማማም

23. ኮንዶም እንድጠቀም ለፍቅረኛዬ ከተናገረኩ የሚጠላኝ(የምትጠላኝ) ይመስለኛል::

- እስማማሁ  መወሰን አልችልም  አልስማማም

24. ከአዲስ ፍቅረኛዬ ጋር ስለኮንዶም ለማወራት አልደፍርም :: ምክንያቱም በግብረ-ሥጋ ግንኙነት በሚተላለፈው በሽታ ተይዟል (ለች) በሚል ይጠረጥረኛል (ለች) የሚል ፍረሃት ስለሚፈጥርብኝ ነው::

- እስማማለሁ  መወሰን አልችልም  አልስማማም

25. መጠጥ ከወሰድኩ በኋላ እንኳን ብሆን ምንጊዜም ኮንዶምን መጠቀም አልዘነጋም::

- እስማማለሁ  መወሰን አልችልም  አልስማማም

26. በማንኛውም ዓይነት የፍቅር ስሜት ወስጥ እንኳን ብገባ ለራሴ ወይም ለጓደኛዬ ኮንዶምን ማድረግ አልዘነጋም::  እስማማለሁ  መወሰን አልችልም  አልስማማም

**ክፍል 3**

ወጣቶች ከቤተሰቦቻቸውና ከጓደኞቻቸው ጋር ያላቸው ግንኙነት

27. ስለወሲባዊ ጉዳዮችና ተያያዥነት ያለቸው ችግሮች (ለምሳሌ በግብረ-ሥጋ ግንኙነት የሚተላለፉ በሽታዎች ፣ አላስፈላጊ የሆነ እርግዝና እና የመሳሰሉት) ላይ ከቤተሰቦችህ (ሽ) ጋር ሐሳቦቻችሁን ትጋራላችሁ?  አዎን  አይደለም

28. ለጥያቄ ቁጥር 27 መልስህ(ሽ) «አዎን» የሚል ከሆነ ብዙውን ጊዜ ከማን ጋር ታወራለህ(ሽ)?  አባቴ  እናቴ  ወንድሜ  እህቴ ሌላም ካለ\_\_\_\_\_

29. ስለወሲባዊ ጉዳዮች አባትህን(ሽ) ጥያቄ ብትጠይቀው(ቂው) መልሱ ምንድን ነው የሚሆነው?

- በትህትና ይመልስልኛል  በቂ መልስ ለመስጠት ዕውቀቱ የለውም
- ይቆጣኛል  ከቤት ያስወጣኛል ሌላም ካለ\_\_\_\_\_

30. ስለ ወሲባዊ ጉዳዮች እናትህን (ሽን) ጥያቄ ብትጠይቃት መልሷ ምንድን ነው የሚሆነው?

- በትህትና ትመልስልኛለች  በቂ መልስ ለመስጠት ዕውቀቱ የላትም
- ትቆጣኛለች  ከቤት ታስወጣኛለች ሌላም ካለ\_\_\_\_\_

31. ስለ ወሲባዊ ጉዳዮች ወንድምህን(ሽን) ጥያቄ ብትጠይቀው (ቂው) መልሱ ምን ይሆናል?
- በትህትና ይመልስልኛል  በቂ መልስ ለመስጠት ዕውቀቱ የለውም  
 ይቆጣኛል  ከቤት ያስወጣኛል ሌላም ካለ\_\_\_\_\_
32. ስለ ወሲባዊ ጉዳዮች እህትህን(ሽ) ብጠይቃት (ቂያት) መልሷ ምንድን ነው የሚሆነው?
- በትህትና ትመልስልኛለች  በቂ መልስ ለመስጠት ዕውቀቱ የላትም  
 ትቆጣኛለች  ከቤት ታስወጣኛለች ሌላም ካለ\_\_\_\_\_
33. ወሲባዊ ጉዳዮችን በተመለከተ የግል ተሞክሮዎቻቸውን ከጓደኞችህ (ሽ) ጋር ትካፈላላችሁ?  አዎን  አይደለም

34. በወሲባዊ ጉዳዮች ላይ የሆነ ችግር ቢያጋጥምህ(ሽ) ቅድሚያ ማንን ታማክራለህ(ሽ)?
- አባቴን  እናቴን  ወንድሜን  እህቴን  
 ፍቅርኛዬን  ጓደኞቼን ሌላም ካለ\_\_\_\_\_

35. በአጠቃላይ በወሲባዊ ጉዳዮችና ተያያዥነት ባላቸው እንደ ኤች.አይ.ቪ/ኤድስ ባሉት ጉዳዮች ላይ ዋነው የመረጃ ምንጭህ (ሽ) ማን ነው? (እንደአስፈላጊነታቸው በቅደም ተከተል አስቀምጥ( ጨ.)
- አባቴ  ጓደኞቼ  ፍቅረኛዬ  እህቴ  ወንድሜ  እናቴ  የሐይማኖት ሰዎች  
 የትምህርት ቤት መምህራኖቼ  የሕዝብ ግንኙነት  
 የትምህርት ቤት ክለሶች  የጤና ባለሙያዎች  ሌላም ካለ \_\_\_\_\_

ክፍል 4 X

- ስለ ትምህርት ቤት ክበቦች ሁኔታ
36. በት/ቤትህ(ሽ) ውስጥ በወሲባዊ ጉዳዮችና ተያያዥነት ያላቸው እንደ ኤድስ ባሉት ችግሮች ላይ ለተማሪዎች መረጃን የሚሰጡ ክበቦች አሉ?
- አዎን  አለውቂም  አይደለም
37. ክበቦቹ በመጥፎ የወሲባዊ በሕርያት ላይ ለትምህርት ቤቱ ተማሪዎች አስፈላጊውን መረጃ ምን ያህል ጊዜ ይሰጣሉ?  ሁልጊዜ  አንዳንድ ጊዜ  አልፎ አልፎ  ምንም
38. በወሲባዊ ጉዳዮችና ተያያዥነት ያለቸው እንደ ኤድስ ባሉት ችግሮች ላይ መረጃን /ትምህርትን የሚሰጡ ፕሮግራሞች /ክበቦች ውስጥ መካፈል ያስደስተሃል(ሽል)?
- አዎን  መወሰን አልችልም  አይደለም
39. ለጥያቄ ቁጥር 37 መልስህ (ሽ) «አይደለም» የሚል ከሆነ ምንድን ነው ምክንያትህ(ሽ)?
- እንደዚህ ዓይነቱ ፕሮግራም ጭራሽ ወደ ወሲባዊ ተግባር የሚገፋፋኝ ይመስለኛል  
 ሐይማኖቱ አይፈቅዱልኝም  
 ጊዜን አላግባብ ማባከን ይመስለኛል  
 ቤተሰቦቼ አይፈቅዱልኝም  
 ተጨማሪ የሥራ ሽክም ይመስለኛል  
 በቂ መረጃና አገልግሎት ስለማላገኝበት
- ሌላም ካለ ይግለጹ \_\_\_\_\_

ክፍል 5

- በወሲባዊ ጉዳዮች ላይ ያለው አጠቃላይ ግንዛቤ
40. የሚዋጡ የወሲድ መከላከያ መድኃኒቶች (ፐልሶች) በግብረ-ሥጋ ግንኙነት የሚተላለፉ በሽታዎችንም ይከላከላሉ::  እስማማለሁ  መወሰን አልችልም  አልስማማም
41. የግብረ-ሥጋ ግንኙነት አደርገው የማያወቅ ሰው ከኤች/አይ/ቪ ኤድስ ነጻ መሆኑ አያጠያይቅም::  እስማማለሁ  መወሰን አልችልም  አልስማማም
42. አንዲት ሴት ልጅ ለመጀመሪያ ጊዜ በምታደርገው የግብረ-ሥጋ ግንኙነት ማርገዝ አትችልም?  እስማማለሁ  መወሰን አልችልም  አልስማማም

43. ጤነኛ የሚመስል ሰው ራሱ ኤድስ ሊኖርነት ይችላል?  
 እስማማለሁ  መወሰን አልችልም  አልስማማም
44. ከሱቶች ይልቅ ወንዶች በግብረ-ሥጋ ግንኙነት ጊዜ በኤድስ የመያዝ ዕድላቸው ከፍተኛ ነው?  
 እስማማለሁ  መወሰን አልችልም  አልስማማም
45. ኤድስ በሳልና በማስነጠስ አይተላለፍም?  
 እስማማለሁ  መወሰን አልችልም  አልስማማም
46. ኤች.አይ.ቪ/ኤድስ ያለባት እናት በምንም ዓይነት መልኩ ከቫይረሱ ነጻ የሆነ ሕጻን መውለድ አትችልም?  
 እስማማለሁ  መወሰን አልችልም  አልስማማም
47. ኤች አይ ቫ/ኤድስን ለመከላከል ከሁሉም የተሻለ ዘዴ የትኛው ነው?  
 አንድ ለአንድ መወሰን  ኮንዶምን መጠቀም  መታቀብ

**ክፍል 6**

ከወሲባዊ ድርጊቶች ጋር ተያያዥነት ላላቸው ችግሮች በመጋለጥ ሁኔታ ላይ ያለው ል አመለካከት

48. በግብረ-ሥጋ ግንኙነት ለሚተላለፉ በሽታዎችና ለኤድስን ሊያጋልጠኝ የሚችል ነገር አድርጌአለሁ ብለህ (ሽ) ምን ያህል ታስባለህ(ሽ)?  
 ሁልጊዜ  አንዳንድ ጊዜ  አልፎ አልፎ  በፍፁም አላሰብም
49. የችግሮቹ ለሰባ ነኝ ብለህ(ሽ) የምታስብ(ቢ) ከሆንክ(ሽ) ምንድን ነው ምክንያታህ(ሽ)?  
 በበሽታው ከተያዘ ሰው ጋር የግብረ-ሥጋ ግንኙነት ስላደረኩ  
 ያለኮንዶም ወሲብን ስለፈጸምኩ  
 ከአንድ በላይ ፍቅረኛ ስለነበረኝ  
 ፍቅረኛዬን ስለማላምነው(ናት)  
 በበሽታው ለተያዘ ሰው እንክብካቤ ስሰጥ ስለነበርኩ  
 ከቡና ቤት ሠራተኞች ጋር ወሲብን ስለፈጸምኩ  
 ዕዳቱ በማይታወቅ መርፌ ስለተወጋሁ  
 ሌላም ለ ይግለጹ \_\_\_\_\_
50. ከችግሮቹ ነፃ እንደሆንክ(ሽ) የሚሰማህ(ሽ) ከሆነ ደግሞ ምንድን ነው ምክንያታህ(ሽ)?  
 የግብረ-ሥራ ግንኙነት አድርጌ ስለማለውቅ  
 ፍቅረኛዬን ስለማምነው(ናት)  
 ሁልጊዜ ኮንዶምን ስለምጠቀም  
 ጤንነት ስለሚሰማኝ  
 ከበሽታው ተጠቂ ጋር ወሲብን ስላልፈፀምኩ  
 በምርመራ ነፃ መሆኔን ስለወቅኩ ሌላም ካለ ይግለጹ \_\_\_\_\_
51. ወደፊት በአንድ ወቅት ለማያስፈልገው እርግዝና ልጋለጥ እችል ይሆናል ብለሽ ታስቢያሽ? ( ለሱቶች ልጆች ብቻ)  አዎን  አይደለም
52. ለጥያቄ ቁጥር 51 መልስሽ «አይደለም» የሚል ከሆነ ለምን?  
 የወሊድ መከላከያን በአግባቡ ስለምጠቀም  
 ስለምታቀብ  
 በቅርብ ጊዜ ለማርገዝ ዕድሜዬ ለጋ ይመስለኛል  
 ሌላም ካለ ይግለጹ \_\_\_\_\_
53. የኤች አይ ቫ / ኤድስ ምርመራን በተመለከተ ከስሜትህ (ሽ) ጋር የትኛው ዓረፍተ ነገር ነው የሚጣጣመው?  
 ለመመርመር ፈቃደኛ ነኝ፤ ከኤድስ ነጻ የሆነ ወጤት እጠብቃለሁ።  
 ለመመርመር አልፈልገም እንደመረመር ከተገደድኩም ከኤድስ ነጻ የሆነ ወጤት እጠብቃለሁ።  
 ለመመርመር ፍቃደኛ ነኝ፤ ነገር ግን ጥሩ ወጤት አልጠብቅም።  
 ለመመርመር ፍቃደኛ አይደለሁም ብመረመርም ከኤድስ ነጻ ወጤት አልጠብቅም።
54. ለወደፊት በኤድስ ልምት እችላለሁ የሚል ስሜት ምን ያህል ጊዜ ይመጣብሃል(ሻል) ?  
 ሁልጊዜ  አንዳንድ ጊዜ  አልፎ አልፎ  በጭራህ አስቤወ አላውቅም

ለቡድን ውይይት የቀረቡ ጥያቄዎች

መመሪያ:- በሚከተሉት ጥያቄዎች ላይ ስትወያዩ የየረሳችውን ተሞክሮች እንድትለወጡ ትጠያቃላችው። / ከዚህ በፊት ያጋጠማችውን ወይንም የሚታውቁትን ወይንም የሚሳማችውን በምሳሌነት አቅርቡ።/

1. ወጣቶችን ወዳ ግብረ ሥጋ ግንኙነት ድርጊቶች እንድንገቡ የሚገፈፋቸው ምክንያቶች ምንድነቸው?
2. ወጣቶች ኮንዶም ምን ያህል እጠቀማሉ? ወጣቶች ኮንዶምን በአግባቡ እንዳይጠቀሙ የሚያደርጋቸው እንቅፋቶች ምንድናቸው? እናዚህ እንቅፋቶች ከፆታ ፆታ የሚለያዩ ይመስሉሃል/ሻል/?
3. በግብረ ሥጋ ግንኙነት ጊዜ ከወንድና ከሴት የፍቅር ጓዳኛሞች ኮንዶም አምጥቶ በመጠቀም ረጋድ የበለጠ ኅላፍነት ያለበት ማን ይመስልሃል/ሻል/? ለምን?
4. ወጣቶች በለሲባዊ ድርጊቶችና ተያያዥነት በላቸው ችግሮች ላይ የሆነ ችግር ወይንም ጥያቄ ቢያገጥማቸው በቀላሉ ማማከር የሚችሉት ማንን ነው?
5. በወሲባዊ ጉዳዮች በመወያየት ረጋድ በተለያዩ የቤተሰብ አባላት መካከል ያለው ተሞክሮ ምን ይመስላል? የቤተሰቦችህን /ሽን/ ተሞክሮ ለተወያዩቹ አከፍል/ይ/።
6. በወሲባዊ ጉዳዮች ላይ ዋናኞቹ የመረጃ ምንጮችህ/ሽ/ ምንድናቸው?
7. በትምህርት ቤታቸው ውስጥ ምን ዓይነት ክበቦች አሉ? ክበቦቹ ለትምህርት ቤቱ ተማሪዎች በወሲባዊ ርጊቶች ላይ መረጃና ምክርን በመስጠት ረገ ምን ያህል ስኬታማ ናቸው ብለህ/ሽ ታስባለህ/ቢያለሽ? ለምን?
8. የሰው ልጆች ወሲባዊ ሁኔታዎችን በተመለከተ ምን ዓይነት መረጃ አለህ/ሽ?
9. በግብረ ሥጋ ግንኙነት የሚተላለፉ በሽታዎች ምን ምን ናቸው? እንዴትስ ልንከላከላቸው እንችላለን?
10. ኤች አይ ቪ/ኤስ ያለበት ሰው እንዴት ለይተን ልናውቅ እንችላለን? ምልክቶቹ ምን ናቸው?

