ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

THE EFFECT OF YOUTH CENTERS ON REDUCTION OF RISKY SEXUAL BEHAVIORS AMONG YOUTH IN ADDIS ABABA, 2016

BY: - NIGUSIE FETENE (B.Sc)

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES ADDIS ABABA UNIVERSITY FOR THE PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC HEALTH IN THE SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES OF ADDIS ABABA UNIVERSITY

JUNE, 2016

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ACRONYMS

AAU _____ Addis Ababa University

AOR _____ Adjusted Odds Ratio

AIDS _____ Acquired Immuno Deficiency Syndrome

COR _____ Crude Odds Ratio

CSA _____ Central Statistical Agency

CSW _____ Commercial Sex Worker

EDHS _____ Ethiopian Demographic and Health Survey

ETB _____ Ethiopian Birr

FP _____ Family Planning

HBM _____ Health Belief Model

HIV _____ Human Immunodeficiency Virus

MOH _____ Ministry of Health

RH _____ Reproductive Health

SD _____ Standard Deviation

STDs _____ Sexually Transmitted Diseases

STIs _____ Sexually Transmitted Infections

SPSS _____ Statistical Packages for Social Science

SSA _____ Sub Saharan Africa

UN _____United Nations

UNAIDS _____Joint United Nations Program on HIV/AIDS

UNICEF _____United Nation Children's Fund

US _____United States

VCT _____Voluntary Counseling and Testing

WHO _____World Health Organization

YC _____Youth Center

ABSTRACT

Introduction: Risky sexual behaviors negatively affect the health of adolescents and young adults putting them at high risk of sexually transmitted infections and unwanted pregnancy for females, which may cause serious health consequences, social and economic problems. In addition, unwanted pregnancies may lead to school dropout and end up with unsafe abortion. No attempt was done to assess the effect of youth centers in reduction of risky sexual behaviors. Therefore, this study was designed to assess the difference in engagement of risky sexual behaviors between users and non-users of youth centers among youth in Addis Ababa.

METHODS: A comparative cross-sectional study design was employed among 524 youth in Addis Ababa from September, 2015 to June, 2016. Multi-stage sampling was used to select youths from randomly selected sub cities. The data was cleaned, entered and analyzed through EPI-INFO 7 and SPSS version 16.0. First distribution of variables was presented by using tables and descriptive statistics to calculate some statistical datas and then logstic regressin model were used to measure magnitude of risky sexual behaviors among users and non-users.

Results: Nearly half 254 (48%) of the respondents ever had sexual intercourse. The mean age of first sexual initiation was 18.56 (±3.019) years and about 37% of those who ever had sexual intercourse started it before the age of 18 years. Among those who ever had sex 47% of them never used condom. The over all prevalence of risky sexual behavior was 43.1% and the prevalence of risky sexual behavior among users and non-users were 38.5% and 47.7% respectively (P-value = 0.042). Utilization sataus of the youth center and age of the respondents were significantly associated with risky sexual behavior. Non-users of the youth center RH clinic were 1.570 times more likely to engage in risky sexual behavior compared to users of the youth

center (AOR= 1.570; 95%CI = 1.056, 2.333). Youth aged 15-19 years were 92.1% less likely to practice risky sexual behavior compared to youth aged 25-29 years old (AOR = 0.079; 95%CI = 0.041, 0.376).

Conclusion: A significant number of youths had risky sexual behavior that might lead them to different reproductive health risks. Non-users of the youth center were at a significantly higher risk of sexual behaviors than users.
Keywords: Youth, Risky sexual behavior, Youth center, Addis Ababa, Ethiopia

1. INTRODUCTION

1.1. Background

The United Nation secretariat uses the term youth and young people interchangeable to mean age 15-24 years with understanding that member states and other entities use different definitions. The African Youth Charter categorize youth as the age range of 15-35 years. In the Ethiopian context the youth are persons in the age range 15 and 29 years (1-3).

UN estimate that around 1.2 billion portion of the population are youth (15-24 years) in the world which accounts 17.6% of the total population and more than 80% of them living in developing countries and in 2006 Ethiopia accounts approximately 22% of the total population which is around 17.6 million (4).

Risky sexual behaviors negatively affect the health of adolescents and young adults putting them at high risk of STIs and unwanted pregnancy for females, which may cause serious health consequences, social and economic problems. In addition, unwanted pregnancies may lead to school dropout and end up with unsafe abortion. Globally as well as in the developing world unintended pregnancies are among the major health problems (5, 6).

STIs refer to a variety of clinical syndromes caused by more than 30 different pathogens that can be acquired and transmitted through sexual activity and they are the causes of morbidity and mortality among adolescents with multiple consequences (7-9).

STIs are a major global cause of acute illness, infertility, long-term disability and death, with severe medical and psychological consequences for millions of men, women and infants. The impact of these diseases is magnified by their potential to facilitate the spread of HIV infection. STI surveillance data should actively be used to improve the quality and effectiveness of STI and HIV prevention programs (10).

There are currently more than 700 youth centres run by the government.These youth centres provide several services including recreation facilities (indoor and outdoor games), library services, ICT, VCT and RH services(11). Youth centers assist adolescents to protect themselves from sexually transmitted diseases, including HIV/AIDS and from unwanted pregnancy, high risk abortion, and other reproductive health related problems. The health providers in the youth

centers guide and motivate adolescent to utilize available family planning and other reproductive health services including risk reduction counseling (12).

1.2. Statement of the problem

A teen engaging in risky sexual activities has a 90% chance of having a pregnancy within a year and around 48% of sexually transmitted diseases diagnosed every year involve the youth. HIV prevalence among youth in Africa is higher than all other major world regions (13). A study conducted in 2014 in United States showed that nearly half (47%) of high school students report ever had sexual intercourse. One every ten female teens and one every six male teens had more than four sexual partners in their lives. Eighty two percent of teen pregnancies are unplanned and it comprises one every six of total unintended pregnancies annually in the U.S and 36% of this unintended pregnancies end in abortion. About 18% of women having abortion are teens and 33% are in the age range of 20 and 24. Over 34,000 young people (13-24) were estimated to be living with HIV/AIDS were infected through sexual contact (14).

Many adolescents engage in risky behavior, develop unhealthful habits, and experience physical and mental health conditions that can jeopardize their immediate health and contribute to poor health in adulthood (15).Thirty-nine percent of all sexually active U.S. high school students did not use a condom at last intercourse. Six percent of all U.S. high school students had sexual intercourse before the age of 13 and almost 14 percent of all U.S. high school students have had sexual intercourse with 4 or more partners over their lifetimes (16).

One every two young women and one every three young men are sexually active and worldwide more than 4.4million young people (15-19) have abortion every year and 40% of which is unsafe. Each day half a million youth are infected with STIs and only 17% of sexually active youth use a contraceptive. The reproductive health situation of youth is a major concern. The prevalence of sexually transmitted diseases (STDs) like HIV/AIDS is relatively high among young people in Ethiopia. According to the HIV sentinel surveillance of mothers seeking antenatal care, HIV/AIDS prevalence is 11 percent among women aged 15-19 and 15 percent among those aged 20-24 years (17).

Worldwide 38% of pregnancies are unintended. Ten million young people, most of them in Africa and Asia are currently living with HIV/AIDS. The epidemic has had a devastating impact on the

sexual and reproductive health of young people, as they are particularly vulnerable to different infections (18).

In the developing world, 13 million adolescent girls and women younger than the age 20 years have unintended births each year, and significant unmet need for contraceptives exists among both unmarried and married adolescents. Forty one percent of unsafe abortions in developing regions take place among young women aged 15–24 years; fifteen percent are among those aged 15– 19 years. The highest rates of curable STIs occur among young people aged 15–24 years (19). Majority of SSA youth have multiple sexual partners in their lives which put them at risk for STIs and unintended pregnancies (20) and young people especially young women are more vulnerable to HIV than adults (21).

Many new cases of HIV worldwide involve young people aged 15–24 years and it is also true for Africa. HIV/AIDS is the leading cause of death for both young males and females in the continent. Sub-Saharan Africa continues to bear the main source of the HIV/AIDS pandemic. The region accounted for 72% of all new infections, and for 68% of the global number of people living with HIV (22).

The incidence and prevalence of STIs among youths are higher than adults. This is probably because of their sexual activeness and tendency to frequently engage in unsafe sexual practices. A study conducted by Demeke showed that 52% of female and 39% of male respondents had unprotected sexual intercourse and 59% of male and 47% of female respondents had history of multiple sexual partners. In addition to this majority of the respondents (97.4% of males and 90.4% of females) had early age of sexual initiation (23).

Condom is important in SSA for protection because HIV transmission is through sexual intercourse. But still it is the most difficult issue to address in the designing of programs to reduce sexual transmission of HIV in Africa and it is due to negative attitudes towards condom utilization (24).

The Ministry of Health (MOH) reports indicate that the number of youth dying from unsafe abortions is very high. Around 70 percent of women who seek medical attention for incomplete abortions are less than 24 years of age. As one of the leading causes of maternal mortality in Ethiopia, abortion causes 56 percent of fatalities, 13 percent of whom are adolescent girls. Death

from abortion, especially among the youth, is due to lack of health facilities that provide adequate preventive and post-abortion services (25).

The relationship between individuals' perception of their risk for acquiring STIs and their use of condoms is poorly understood. Even with high levels of perceived risk, condom use among young women in Sub-Saharan Africa might remain low. The link between perceived risk and sexual behaviors highlights how behavior is influenced by the extent to which an individual feels personally at risk of contracting a disease. Risk perception is associated with sexual debut and sexual behavior (26, 27).

Globally, young people aged 15-24 years accounted for 42% of new HIV infections and nearly 80% of this lives in Sub-Saharan Africa. Unless appropriate age and institution targeted intervention exist, certain behaviors can place youth at greater risk of HIV infection. Groups of people who engage in these high-risk sexual behaviors are considered vulnerable to HIV infection and need to be watched cautiously in order to control the epidemic (28).

In Ethiopia limited access to targeted RH care and services for young people contributes to many of the RH problems. Over a quarter of all pregnant youth and adolescents feel that their pregnancies are mistimed, reflecting this population's limited access to FP and RH services. These unwanted pregnancies entail significant risks for maternal health, including high rates of delivery-related complications and high abortion rates. Unwanted pregnancy is one of the major RH challenges faced by adolescents in Ethiopia. About 54% of pregnancies to girls under the age of 15 years were unwanted compared to 37% for those ages 20-24 years. This indicates the need to refocus programs and prioritize interventions tailored to adolescents less than 15 years. Abortion places many young women at risk as the termination of pregnancy is usually conducted under unsafe conditions. Girls under the age of 15 years are three times more likely to end their pregnancies in abortion compared to those aged 20-24 years. Abortion accounts for nearly 60% of gynecological and almost 30% of all obstetric and gynecological admissions in Ethiopia (4).

1.3. Rationale of the study

Youth friendly services and the successful RH strategies can only become realities if there is a commitment from all partners to implement in an accelerated, flexible and participatory manner. The Ethiopian Government's vision is to provide youth reproductive health services through the health service extension package at the community level and through youth centers. Youth centers have a significant role in decreasing risky sexual behaviors of youths. Health professionals in the youth center provide appropriate information and skills to strengthen youth to protect themselves from STIs and unwanted pregnancies. This means health providers provide counseling services about STIs and unwanted pregnancies reduction, engage youth in evaluating their own risk perceptions and address their misconceptions, facilitating youth dialogues, condom distribution, providing emergency contraceptive, counseling on how to reduce number of sexual partners, dual protection of condom utilization, strengthening Anti-AIDS and RH clubs, VCT (4).

The reproductive health clinics of youth centers provide different kinds of service for youth the major ones are Voluntary Counseling and Testing (VCT), Family Planning, Reproductive Health Counseling and condom distribution, further more they facilitate peer education, prepare training on reproductive health matters and first aid service (29).

Providing voluntary counseling and testing (VCT), condom distribution, access different family planning methods and pregnancy test are the major services in the youth centers. Therefore, assessing the effectiveness of those youth centers provide appropriate clues to design another intervention strategy for policy makers as well as for the beneficiaries to get appropriate reproductive health services in the youth centers. So assess the effect of youth centers on reduction of risky sexual behaviors can assist strategic planning of the country in expanding youth friendly services.

2. LITERATURE REVIEW

2.1. Magnitude of risky sexual behaviors among youth

Globally, it is estimated that 5.4 million young people aged 15 to 24 are living with HIV; 3.2 million reside in sub-Saharan Africa (SSA). In fact, in SSA the youth lack access to HIV prevention education programs, with only 8 per cent of out-of school youth having access such programs. This indicates that out-of-school youth are more at risk of getting HIV infection due to lack of access to HIV prevention programs (30).

A study conducted in Tanzania among out of school youths showed that most participants perceived to be highly susceptible to HIV infection. It was common for respondents to mention risky sexual behaviors such as: multiple sexual partners and inconsistent condom use as predisposing factors for HIV infection. Several participants perceived HIV infection to be deadly and a severe disease. Participants expressed fear of death and/or sexual disorders as serious outcomes following STI, including HIV (30).

More than 340 million new cases of STIs occur worldwide every year. About half of all new infections are among the youth. Today's young people are the AIDS generation. Young women are several times more likely to get infected than young men. In China, the incidence of STIs, especially HIV/AIDS has rapidly increased. In developing nations, the spread of STIs/HIV infection continues to affect millions of young and productive population (31).

Unwanted pregnancies in youths and complications of induced abortions are an important health problem in the world. Each year, approximately 20 million abortions are performed worldwide, 95% of them in developing countries (32).

A study conducted among South African University students showed that one-third of the respondents never used condom during the past three months of the survey. In addition, perceived susceptibility to HIV/AIDS and self-efficacy of condom use or the confidence of the respondents to utilize condom during sexual intercourse was associated with past condom use which is those who had a high perceived susceptibility and self-efficacy can use condom than those respondents with low perceived susceptibility and self-efficacy, but there was no association between self-efficacy and sex (33).

Another study conducted on high-risk sexual behavior among youth in Tanzania reported that 11.7% of the participants felt that they were at a high risk or high perceived susceptibility of getting HIV/AIDS and STDs, 25% felt that they had a very low risk, while 53.1% felt that they were not at risk at all (34).

Among the study participants who had sexual intercourse 84.4% started sexual intercourse below the age of 18years, 45.6% of them having two and more than two sexual partners and 58.9% of them never used condom during sexual intercourse due to trust on sexual partner and the mean age at first sexual intercourse was 14.61±2.89 SD for male and 15.74±2.165 SD years for females (35).

A study conducted among Mizan-Tepi university students in 2015, showed that more than one-third of the respondents ever had sex, of which 42.1% had multiple sexual partners and 69.4% of them whoever had multiple sexual partners never used condom. This showed that having multiple sexual partners reduced the probability of using condom. In addition, among the respondents who had a high perceived risk of acquiring STIs including HIV reduced the likelihood to have multiple sexual partners (36).

A study conducted among high school students in Gurage zone Agena woreda showed that 70.5% of the respondents out of those who had sexual experience had two and more than two sexual partners in the past one year of the survey and the mean age of sexual initiation was 16.2 years which is a risk for STIs, unwanted pregnancies and other reproductive health related complications. Of those who had sex in the past one year of the survey 37% of them never used condom during sexual intercourse (37).

The reproductive health behavior of street youth and associated factors were studied in Gondar. Among sexually active study participants, 65.9% started sexual intercourse earlier than 18 years of age. Of youth who had been sexually active, 62.4% had more than one lifetime sexual partner and the mean number of sexual partners for them were 3.15 ± 4.5 and out of sexually active females, 37.5% had a history of unintended pregnancy(38).

2.2. Factors associated with risky sexual behaviors

Globally, it is estimated that around one-third (38%) of all pregnancies are unintended and studies have indicated that risk factors for unintended pregnancy in Arab countries include early marriage, low socioeconomic status, low education and certain local socio-cultural factors. Furthermore, unintended pregnancies in the Middle East and North Africa countries were estimated between 15% and 58%, either mistimed when occur or unwanted at all (39).

Perceived susceptibility to HIV/AIDS and Perceived severity of HIV/AIDS of the respondents was quite high. The perceived effectiveness of using condoms to prevent HIV/AIDS was relatively high. Majority of the respondents 77.6% agreed that correct and consistent use of condoms during sexual intercourse can prevent HIV/AIDS. Relatively fewer respondents perceived some barriers to condom use. It will land up in their stomach, latex condoms can cause itching and 39.2% of them agreed that they feel embarrassed to ask their partners to use condoms. For perceived self-efficacy for condom use, about 75% of the respondents agreed that they have the confidence that they could refuse sex with their partners if they refuse to use condoms, while 67.7% agreed that they felt confident that they can convince their sexual partner(s) to use condoms during sexual intercourse (40).

A study conducted among in-school youths of shendi town in west Gojjam showed that almost half of youths claimed that the main reason for initiation of first sexual intercourse was falling in love. In addition to this most of them didn't use or use condom inconsistently due to trusting partner, a shamed to ask partner to use, fear to buy from shops or pharmacies and reduce sexual pleasure. It was supported qualitatively that majority of the focus group discussants didn't consider the use of condom as an acceptable means of prevention because of perceived reduction in sexual pleasure (41).

Higher risk sexual behavior was strongly associated with youths' level of education and economic status. There is a significant association between higher educational attainment and higher risk sexual behavior. Youth who had higher risky sexual behavior were likely to be characterized by the middle to highest wealth index in the majority of the countries studied. The total odds ratio suggests that, across countries, male youth in the middle to highest wealth index were 2.2 times more likely than low-wealth youth to report higher risky sexual behaviors (42).

A study conducted among university students in Kenya showed that socio-economic factors, negative beliefs towards condom use, inadequate information about risk reduction, condom inaccessibility and perceived benefit of condom use were the determinant factors for risky sexual behaviors (43).

The main reasons for early sexual initiation among youth were sexual desire and boy/girlfriends pressure. On the other hand youth free from family control, substance use, peer pressure and existence of night clubs and video houses were the determinant factors for having risky sexual behaviors. In addition to this current substance users were about 3 times more likely to ever had sexual intercourse as compared to non-users (OR=3.03; 95% CI: 2.00, 4.59) (44).

A study conducted among female youth in Tiss Abay showed that respondents had risky sexual behavior such as having sex without using condom. Refusal of sexual partners to use condom, low perceived benefit of using condom by the respondents, inaccessibility and cost of condoms were the main reasons for this risky sexual behaviors (45).

Peer pressure is the prime driver of risky sexual behaviors among school adolescents in Addis Ababa. Respondents were likely to experience risky sexual behavior if they had low knowledge of STIs and/ or unwanted pregnancy, reported low self esteem and manifested low perceived efficacy to use condom. Parental control was significantly associated with risky sexual behavior. Restrictive parental norms towards sex were a protective from risky sexual behavior [AOR = 0.77 (95%CI: 0.61 - 0.99)] (46).

Increased use of *Khat* among youth is associated with unprotected sex. A majority of the key informants interviewed expressed concern regarding the increased use of *Khat* by young people. In particular, they talked about the chain of events that commonly accompanies use of the drug. Adults and youth alike mentioned that frequent *Khat* -chewing often leads to increased alcohol use, which ultimately leads to young people having unprotected sex. Many informants recommended that youth centers and youth-focused programs need to better address this problem by teaching young people about the consequences and dangers of drug and alcohol use and their effects on the lives of young men and women (47).

2.3. Study frame work

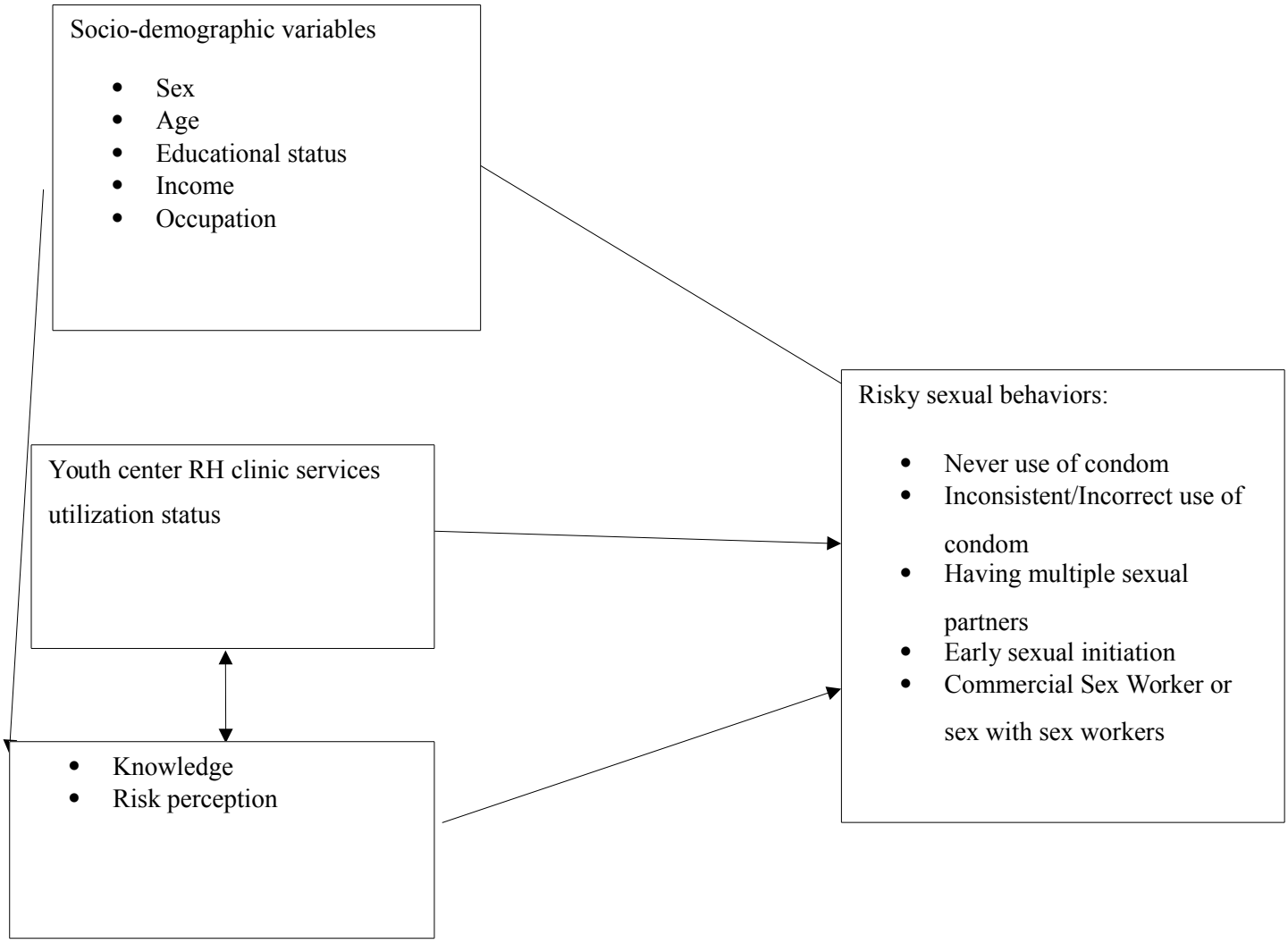


Figure 1: Conceptual framework to assess the effect of youth centers on reduction of risky sexual behaviors among youth of Addis Ababa, 2016

3. OBJECTIVES OF THE STUDY

3.1. General objective

3.1.1. To assess the difference in risky sexual behaviors between youth center utilizers and non-utilizers in Addis Ababa in 2016.

3.2. Specific objectives

The specific objectives of this study are the following:

3.2.1. To measure the magnitude of risky sexual behaviors among the youth who are youth center users and non-users in Addis Ababa, 2016.

3.2.2. To assess the association of utilization of youth center reproductive health clinics and engagement in risky sexual behaviors among the youth of Addis Ababa, 2016.

3.2.3. To assess factors associated with risky sexual behaviors among youth of Addis Ababa, 2016.

4. METHODS

4.1. Study area

The study was conducted in Addis Ababa, the capital city of Ethiopia. Addis Ababa is administratively divided in to 10 sub cities and 116 Woredas. The projected total population on July, 2015 by Central Statistics Agency of Ethiopia for Addis Ababa was 3,273,000 (48). In Addis Ababa there are a total of 106 youth centers, of which 84 are functional (49) and which provide

services such as library for reading different type of books , internet, cafeteria, Digital Satellite Television, sport games ,different type of trainings, hall renting service ,shower rooms to be used by youth, reproductive health services like Voluntary Counseling and Testing of HIV/AIDS, condom distribution, providing of contraceptives, information on reproductive health, peer education by assigned health provider. Those youth centers were established five years ago.

4.2. Study design and period

The study was conducted from March to April, 2016. The study design for this particular research was comparative cross-sectional study design. In this study, the comparative groups are the youth who uses reproductive health clinic in the youth center and youth who didn't use the reproductive health clinic in the youth center. And the ratio of the comparative group was considered to be 1:1.

4.3. Population

4.3.1. Source population

All youth in the age range of 15 and 29 years residing in Addis Ababa city during the study period.

4.3.2. Study population

The study populations were youth who are usual residents of Addis Ababa who had a chance to use the youth center RH clinics in the ten woredas of Addis Ababa city administration.

4.3.3. Inclusion and Exclusion criteria

Resident youth of the city who lived in it for at least 6 months (the youth might be user of youth center or non-user of youth center). Whereas the youth who were severely sick and suspected of mental health problem and those who were unable to hear or speak, involuntary to participate and those who did not have friend in either of the study arm were excluded from the study.

4.4. Sample size and procedure

4.4.1. Sample size determination

The sample size was determined by using the two population proportion formula. First an attempt was made to calculate the sample size by considering the different attributes of risky sexual behavior separately and the largest value has been taken to increase the power of the study. Youth center RH clinic users and non-users were considered as main factor for risky sexual behavior and used for sample size determination considering the following assumptions (level of confidence of 95% with a standard score of = 1.96), proportion of youth with risky sexual behaviors specifically considering having multiple sexual partners among non-users of the youth center in the RH clinic

from the previous study was found to be 45.6% (46) and it was assumed that having multiple sexual partners was 15% lower among youth center RH clinic users which resulted in 30.6%. A power of 80% to detect the above difference and 15% non response rate was also assumed. Moreover, a design effect of 1.5 was considered to control clustering effect due to the varying nature of the youth in socio-economic status and we are also using multistage sampling technique.

Based on this assumption, the sample size for the study was calculated by using Epi-Info version 7 and it become **570,** of which 285 were youth center RH clinic users and 285 were non-users of the youth center RH clinic.

$$n1=n2=\frac{(Z\alpha/2*\sqrt{2\acute{P}*(1-\acute{P})}+Z\beta\sqrt{p1*q1+p2*q2})^2}{(P1-P2)^2}$$

Where, $\acute{P}=\frac{p1+p2}{2}$ and q1=1-p1, q2= 1-p2

This is the sample size formula for comparison for two population proportion for equal sizes of the comparative groups.

Where, $n1=n2$ = minimum sample size required from each group

$Z_{\alpha}/_2$= confidence level =1.96 (95% CI)

P1= proportion of youth (Non-users of the youth center RH clinic) with multiple sexual partners = 45.6%

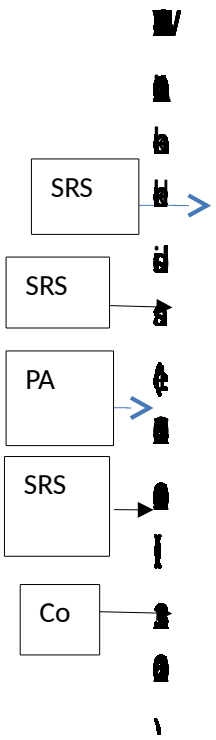
P2 = proportion of users of the youth center RH clinic with multiple sexual partners = 30.6%

Z_{β}= power with 80% = 0.84.

4.4.2. Sampling procedure

Multi-stage sampling was used to select youths. Five sub cities namely (Akake-Kality, Arada, Bole, Kirkos and Yeka were randomly selected). In the next step two Woredas which are functional and having registration book for users were randomly selected from each of the selected sub cities. The total number of youth aged 15-29 living in each woreda were identified by

asking woreda administrators and youth center managers to draw the sample. But they didn't know the exact number of youth rather through estimation by using population projection. The estimated youth in each selected woreda was as follows; Akaki-kality woreda 1=5600, Akake-Kality woreda 8=6820, Arada woreda 4=7466, Arada woreda 10=2380, Bole woreda 3=8000, Bole woreda 4=12000, Kirkos woreda 2=9000, Kirkos woreda 10=5000, Yeka woreda 6=7920 and Yeka woreda 7=6160. Among those youth living in each woreda users of the youth center RH clinic and non-users were identified by taking the data from the health care providers / clinical nurses in the youth center RH clinic and then the sample size was determined by proportional allocation based on the number of users from each woreda. Therefore from Akake Kality sub-city woreda 1 (44 samples) and woreda 8 (56 samples); Arada sub-city woreda 4 (50 samples) and woreda 10 (30 samples); Bole sub-city woreda 3 (62 samples) and woreda 4(70 samples); Kirkos sub-city woreda 2 (62 samples) and woreda 10 (50 samples); Yeka sub-city woreda 6 (40 samples) and woreda 7(60 samples) were selected by using simple random sampling technique. The registration book in the youth centers RH clinic used as a sampling frame for youth center RH clinic users and equal number of intervention and control groups were taken from each woreda. If the selected study subject do not have comparative group or inaccessible then the next subject was considered. The control groups were selected through convenience sampling who satisfied the inclusion criterias. As much as possible matching by sex and age had been performed.



AA= Addis Ababa

SRS=Simple Random Sampling

PA= proportional Allocation

Co= Convenience sampling

Figure 2: Schematic presentation of sampling for the study to assess the effect of youth centers on reduction of risky sexual behavior among youth of Addis Ababa, 2016

4.5. Data collection method

Structured questionnaire was developed by reviewing different literatures on risky sexual behaviors. The questionnaire was first prepared in English language and translated to Amharic version and re-translated back to English to check its consistency. About 5% of the questionnaire was pre tested in similar settings among youth of other sub-cities not included for the study to alleviate problems related to understandability, simplicity and for the sake of planning before the actual data collection. An appropriate modification was done before the questionnaire is used for the main study. The data was collected by using interviewer-administered questionnaire or face-to-face interview by adopting from similar studies (33) and EDHS standards and modifying it to align with the study objective. Ten clinical nurses who are working in the youth center RH clinic from each woreda were trained intensively for two days for data collection. The collected data was checked for its completeness and consistency on daily base.

4.6. Measurement

4.6.1. Variables

4.6.1.1. Independent variables:

Socio-demographic characteristics (age, sex, income, educational status, occupation), Youth center RH clinic services utilization status, knowledge, risk perception.

4.6.1.2. Dependent variables:

Risky sexual behaviors in this study when a respondent reported either of: - never using a condom or inconsistent or incorrect use of condom during sexual intercourse or having multiple sexual partners, starting sex before 18 years or commercial sex worker and having sex with commertial sex workers.

4.6.1.3. Operational definitions

Risky sexual behavior - In this study it is defined as one of the following: never use of condom (inconsistent or incorrect use of condom), having more than one sexual partner, and starting sex before age 18 years or commercial sex worker/having sex with sex workers.

Early sexual initiation: starting sex before 18 years old.

Consistent condom use: use of a condom during every sexual act.

Users: youth who get either VCT, family planning counseling, contraception, training related to RH issues, RH counseling etc.

4.7. Data quality control

The quality of data was assured by giving appropriate training for data collectors on the research tools (questionnaires). Moreover, close supervision were also done during data collection for its completeness and consistency. Pilot testing was also done in 5% of the study participants in Nefas silk lafto sub-citiy which is not included in the actual study. The data was cleaned by running frequency for each categorical variable and cross-cheking with the original questionnaire (hard copy). Data were entered, and coded by using EPI-Ifo version 7 and SPSS version16.0. Double data entry was done on 5% of the collected data to compare the quality of data and the finding showed that the data has been entered properly and consistent.

4.8. Data analysis

The data was first entered into Epi Info version 7 and later exported to and analyzed by using SPSS version 16.0**.** First composite score were calculated for the main outcome variable which is risky sexual behavior. Then, descriptive statistics such as proportion was computed and the distributions of study participants by various socio-demographic variables were presented for users and non-users of youth center RH clinic. Moreover knowledge of the respondents about STIs and unwanted pregnancy and distribution of sexual behavior and risk perception of the respondents were presented using tables. Binary logestic regression model was employed to determine the association between dependent variable and independent variables. Odds ratio along with the 95% confidence interval was used to ascertain association. Moreover, multivariate logstic regression was applied to control the effect of confounders with 95% confidence interval and adjusted odds ratios were used to measure the strength of association. Statistical significance was set at a P value of <0.05.

4.9. Ethical consideration

Ethical clearance was obtained from the Research Ethics Committee of the school of Public Health in Addis Ababa University. Based on the ethical clearance, official permission has been obtained from Addis Ababa City Administration health office and the respected subcities and woredas. The respondents were informed about the objective of the study and oral consent has been obtained from each respondent. Confidentiality issue was assured and the data was collected anonymously.

5. RESULTS

Socio-demographic characterstics of the respondents

The socio-demographic characterstics of the study subjects are shown in Table 1. Out of the 570 youths, a total of 524 youths participated in the study making the response rate 92%. Nearly one-third 185 (35%) of them were females. Among the total respondents 209 (40%) of youths were between the age ranges of 15 to 19 years, 219 (42%) of them were between 20 to 24 years and the mean age of youths were 21 (±3.49) years. About 195 (37%) of the respondents were Amhara and nearly two-third, 319 (61%) were Orthodox chrstian by religion. Regarding to respondents marital status 481 (92%) of them were not in union and 241(46 %) of them were living with both parents. Of the total respondents 434 (83%) of them were secondary and above by their educational status. There was no any significant diferrence between reproductive health clinic users and non-users in terms of sex, age, ethnicity, marital status, educational status and household average monthly income other than their utilization status of the reproductive health clinic. The distribution indicated that the study population does not significantly vary across the different categories of the variables considered for the study.

Table 1: The distribution of study participants by socio-demographic characteristics in Addis Ababa, Ethiopia, 2016.

Characteristics	Category	Number (Percentage)		P-value
		RH clinic Users (n=262)	RH clinic Non-users (n=262)	
Sex	Female	89 (34%)	96 (37%)	0.583
	Male	173 (66%)	166 (63%)	
Age	15-19	110 (42%)	99 (38%)	0.162
	20-24	99 (38%)	120 (46%)	
	25-29	53 (20%)	43 (16%)	
Ethnicity	Amhara	106 (40%)	89 (34%)	0.683
	Guragie	24 (9%)	30 (11%)	
	Oromo	62 (24%)	66 (25%)	
	Tigrie	32 (12%)	37 (14%)	
	Wolaiyta	17 (7%)	15 (6%)	
	Others*	21 (8%)	25 (10%)	
Marital status	Currently married	22 (8%)	21(8%)	1.000
	Not in union	240 (92%)	241(92)	
Educational status	No formal education	14 (5%)	20 (7%)	0.458
	Primary	25 (10%)	31 (12%)	
	Secondary	172 (66%)	169 (65%)	
	Above 12th	51 (19%)	42 (16%)	
Household avegare monthly income	≤1000	29 (11%)	24 (9%)	0.390
	1001-3000	124 (47%)	125 (48%)	
	3001-5000	81 (31%)	73 (28%)	
	≥5001	28 (11%)	40 (15%)	

* **= Afar, Gamo, Sidamo, Siltie**

Knowledge of youth about STIs and Unwanted pregnancy

Among the total respondents about 505 (95%) of youths heard about sexually transmitted infections and the main source of information were mass-media 374 (75%) and school 273 (55%). Almost all 496 (99.6%) of the respondents knew about STIs transmission mechanism and 446 (90%) of them reported unprotected sex as the major transmission mechanism followed by blood contact 389 (78%). The respondents revealed that the main prevention method for both STIs and unwanted pregnancies were correct and consistent use of condom. But there was no significant difference between reproductive health clinic users and non users (COR= 0.748 (0.466, 1.201 and 0.699 (0.412, 1.185))) respectively.

Table 2: Knowledge of youth about STIs and Unwanted pregnancy in Addis Ababa, 2016

Variables	Category	Number (Percentage)		
		RH clinic Users (n=262)	RH clinic Non-users (n=262)	Total
Heard about STIs (n=524)	Yes	252 (48%)	246 (47%)	498 (95%)
	No	10 (2%)	16 (3%)	26 (5%)
Source of information (n=498)	Mass-media	173 (35%)	201 (40%)	374 (75%)
	Health personnel	127 (26%)	102 (20%)	229 (46%)
	School	130 (26%)	143 (29%)	273 (55%)
	Reading materials	81 (16%)	72 (15%)	153 (31%)
Knowledge of modes of transmission of STIs including HIV/AIDS (n=496)	Blood contact	211 (43%)	178 (35%)	389 (78%)
	Physical Contact	59 (12%)	31 (6%)	90 (18%)
	Kissing	64 (13%)	38 (8%)	102 (21%)
	Mother-to-child	172 (35%)	141 (28%)	313 (63%)
	Sharing sharp materials	181 (36%)	161 (33%)	342 (69%)
	Unprotected sex	230 (46%)	216 (44%)	446 (90%)
Knowledge of Prevention methods of STIs including HIV/AIDS (n=496)	Abstained from sex	204 (41%)	202 (41%)	406 (82%)
	Being faithful for boy/girl friend	169 (34%)	156 (32%)	325 (66%)
	By using condom	214 (43%)	199 (40%)	413 (83%)
	Avoid sharing sharp materials	160 (32%)	128 (26%)	288 (58%)
Knowledge of Prevention methods for unwanted pregnancy (n=524)	Abstained from sex	200 (38%)	216 (41%)	416 (79%)
	By using condom	235 (45%)	225 (43%)	460 (88%)
	Prevent by other modern contraceptive method	46 (9%)	29 (5%)	75 (14%)
	I don't know	5 (1%)	5 (1%)	10 (2%)

Percent in some case is above 100% because of multiple answers by participants

Sexual behavior of youth in Addis Ababa

Among the total respondents 254 (48%) of them ever had sexual intercourse. Of which 115 (45%) of them were youth center reproductive health clinic users. The over all prevalence of risky sexual

behavior was 226 (43%) and the prevalence of risky sexual behavior among youth center reproductive health clinic users were 101 (38%) and among non-users were 125 (48%). The diference is statistically significant at 95% confidence level with (P-value = 0.042).

The mean age of first sexual initiation was 18.56 (±3.019) years and about 94 (37%) of those who ever had sexual intercourse were initiated sex before the age of 18 years, of which 34 (36%) of them were users of reproductive health clinic and 60 (64%) of them were non-users. There is a significant differenece between users and non-users with (P-value= 0.035) interms of their age at the time of first sexual initiation.

About 107 (42%) of the respondents were had two and more sexual partners in the past 12 months. Among users who ever had sexual intercourse 44 (38%) of them had two and more sexual partners and 64 (56%) of them had only one sexual partner in the past 12 months. Whereas 63 (45%) of non-users of the reproductive health clinic had two and more sexual partner and 64 (46%) of them had only one sexual partner in the past 12 months. But the diference between users and non-users was not statistically significant indicating no siginifcant variation between intervention and control groups across different attributes of the study population.

On the other hand, 119 (47%) of the respondents never used condom during sexual intercourse. Among users of the youth center and who ever had sexual intercourse 48 (42%) of them never used condom and among non-users had sexual intercourse 71 (51%) of them did not use condom but the diferrence between users and non-users were not statistically significant.

Among males who ever had sexual intercourse 28 (17%) of them had sex with commercial sex workers in the past 12 months and 7 (8%) of female respondents were commercial sex workers themselves. There was no statistical significant diferrence between users and non-users youth centers clinics interms of having sex with CSW and working as a commercial sex worker. The prevalence of pregnancy from those who had sex were 26 (29%) and 9 (35%) of first pregnancies occurred before the age of 18 years. Of those pregnancies 15 (58%) were unplanned and ended up with abortion due to fear of families.

Table 3: Sexual behavior of youth in Addis Ababa, 2016

Variables	Utilization status number (Percentage)		P-value
	RH clinic Users	RH clinic Non-users	

Ever had sexual intercourse (n=524)	Yes No	115 (44%) 147 (56%)	139 (53%) 123 (47%)	**0.044**
Risky sexual behavior (n= 226)	Yes No	101 (38%) 161 (62%)	125 (48%) 137 (52%)	**0.042**
Age at first sexual intercourse (n=254)	<18 ≥18 **Mean±SD**	34 (30%) 81 (70%) **18.70±2.947**	60 (43%) 79 (57%) **18.45±3.084**	**0.035**
Number of sexual partners in the past 12 months (n=254)	None One Two and more	7 (6%) 64 (56%) 44 (38%)	12 (9%) 64 (46%) 63 (45%)	0.295
Ever used condom (n=254)	Yes No	67 (58%) 48 (42%)	68 (49)% 71 (51%)	0.174
Frequency of condom use (n=135)	Sometimes Most of the time Always	11 (16%) 14 (21%) 42 (63%)	12 (18%) 9 (13%) 47 (69%)	0.496
Correct use of condom (n=135)	Yes No	52 (78%) 15 (22%)	53 (78%) 15 (22%)	1.000
Ever had sex with CSW in the past 12 months (n=163)	Yes No	12 (15%) 65 (85%)	16 (19%) 70 (81%)	0.762
Ever been a CSW (n=91)	Yes No	4 (11%) 34 (89%)	3 (6%) 50 (94%)	0.645
Ever become pregnant (n=91)	Yes No	11 (29%) 27 (71%)	15 (28%) 38 (72%)	1.000
Unplanned pregnancies (n=26)	Yes No	6 (55%) 5 (45%)	9 (60%) 6 (40%)	1.000

Reason of sexual initiation

The overall prevalence of risky sexual behavior as mentioned above was 226 (43%). The main reason of having sex for the first time were falling in love 72 (28%), personal desire 70 (27%), peer pressure 43 (17%), got married 19 (8%), getting drunk 13 (5%), forced 12 (5%), attending night clubs 10 (4%), followed by watching pornographic videos 3 (3%) for both groups. But there

is no significant diference between users and non-users with regards to the risky behaviors mentioned above.

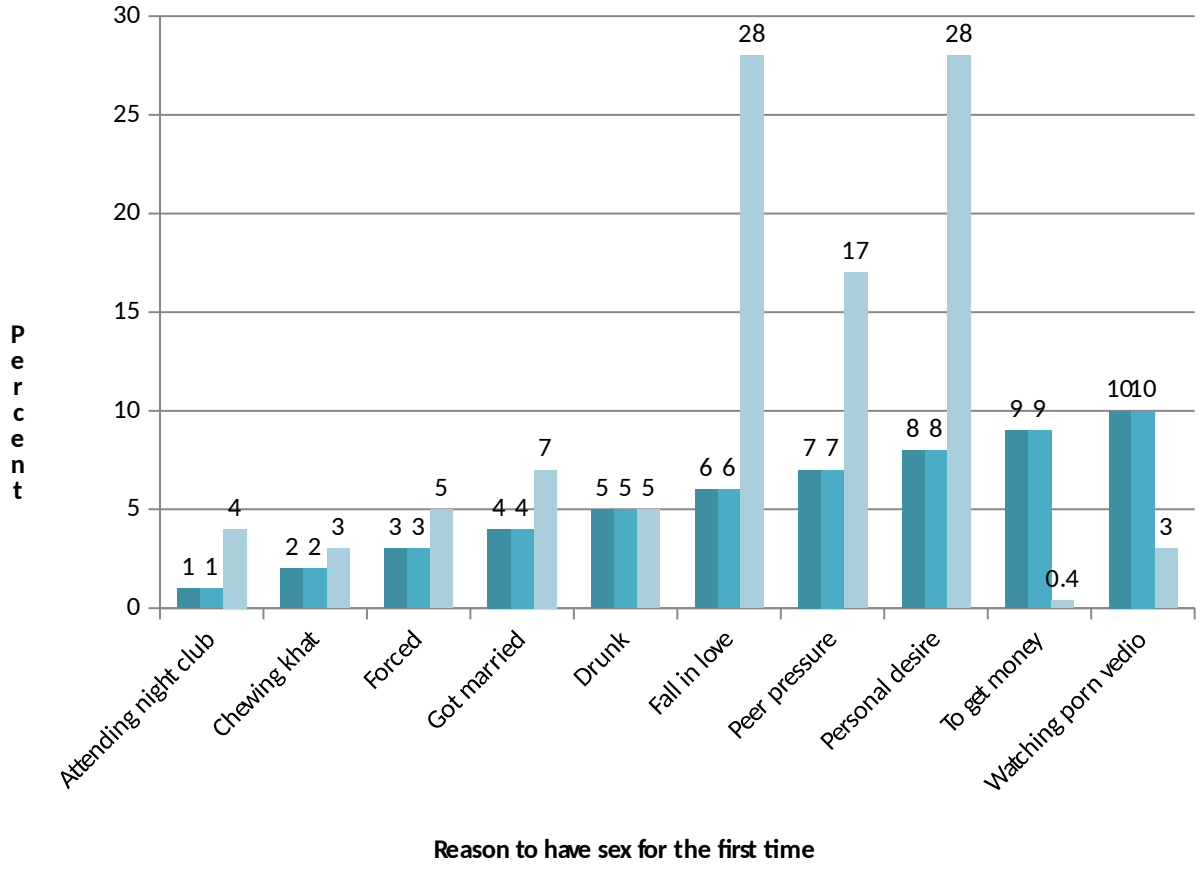


Figure 3: Reasons to have sex for the first time in youth in Addis Ababa.

Reasons for not using condom

Of those who ever had sexual intercourse 119 (47%) of them did not use condom due to the belief of condom decreasing sexual satisfaction 60 (36%), trust on sexual partner 48 (29%), ashamed to

buy condoms 25 (15%), partner refusal 24 (15%), drunk alcohol 13 (8%), followed by condom inavailability 10 (6%) and there is no statistical significant diferrence between users and non-users with regards to the different attributes related to rejection of condom use.

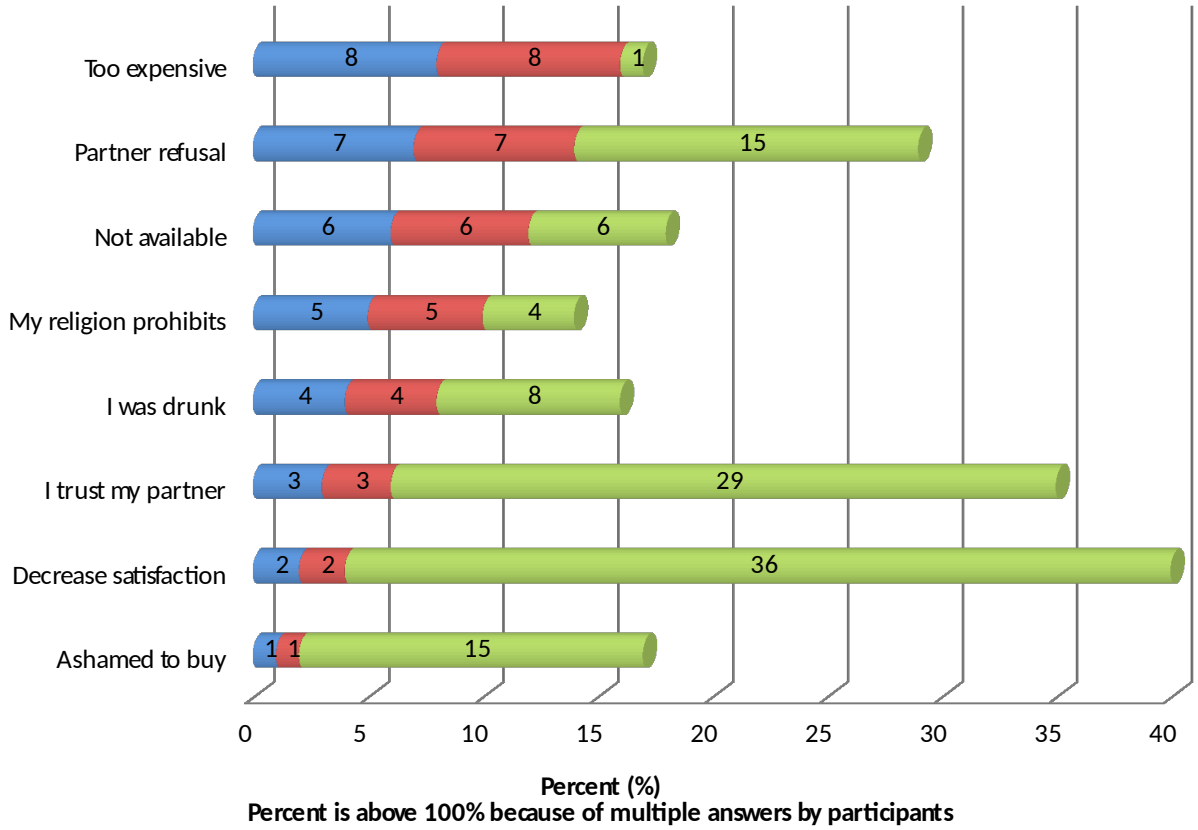


Figure 4: Reasons for not using condom during sexual intercourse youths of Addis Ababa.

The main reason for abortion was fear of family to undergo abortion 9 (60%), the pregnancy was unplanned 8 (53%) and it was outside marriage 8 (53%). There is no any significant diferrence between users and non-users interms of reason for abortion.

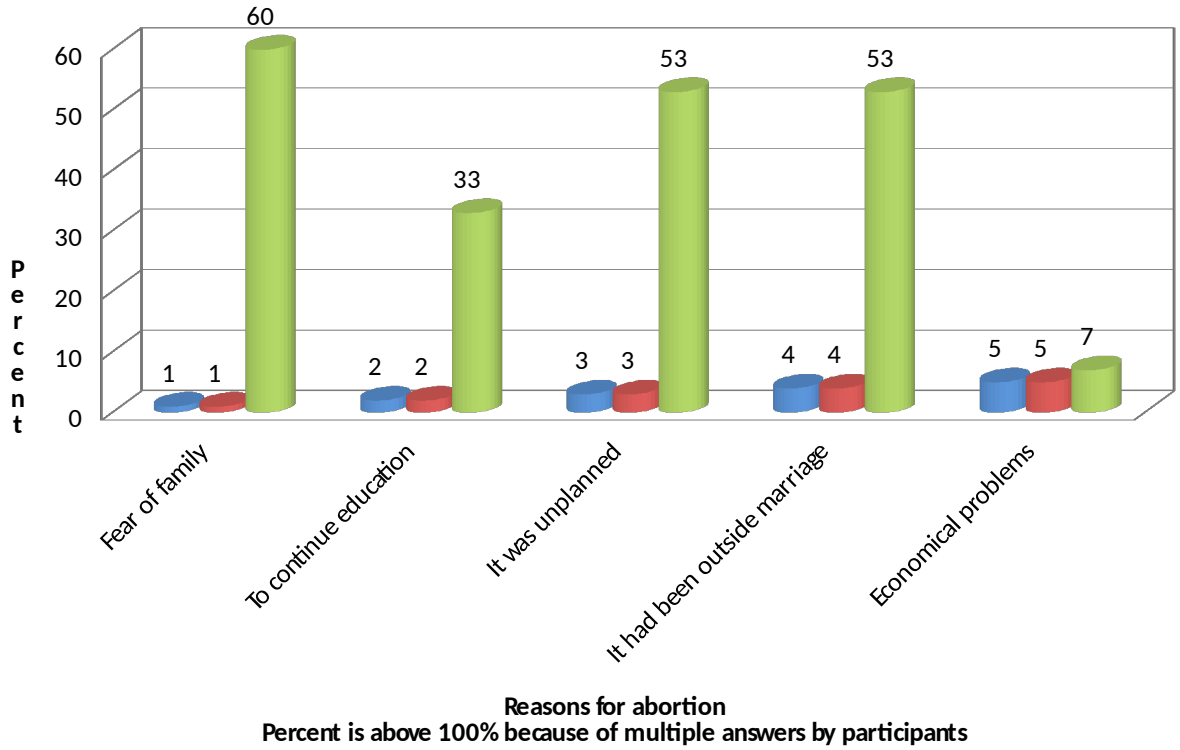


Figure 5: Reasons for abortion among female youth in Addis Ababa.

Risk perception of the respondents

About 41 (16%) of youth center reproductive health clinic users and 63 (24%) of non-users thought that they were at risk of getting HIV virus. About 245 (94%) reproductive health clinic

user and 231 (88%) of non-users perceived that condom use is a practical protective option against AIDS, 249 (96%) users and 230 (88%) non-users perceived that that the chances of contracting STIs can be significantly reduced by having sex with only one sexual partner. Therefore, there was a significant diferrence between users and non-users (P-value = 0.049 & and 0.005 respectively).

Among youth center reproductive health clinic users 242 (92%) and 221 (84%) of non-users were perceived that condom is not too expensive. In this regard there was a significant diference between users and no-users (P-value = 0.006 and Chi-square test = 7.421). About 165 (62%) of youth center reproductive health clinic users and 128 (48%) of non-users perceived that they can purchase and use condom confidently and there was a statistical significant diference between users and non-users with (P-value = 0.002 and Chi-square test = 10.034). One hundred seventy (64%) of users and 132 (50%) non-users perceived that they can convince their sexual partner(s) to use during sexual intercourse and it was also a statistical significant diference between users and non-users (P-value = 0.001 and Chi-square test = 10.700). Other perception items were not statistically significant among users and non-users as shown Table 4.

Table 4: Risk perception of youth in Addis Ababa, 2016

Variables	Category	Number (Percentage)		
		RH clinic Users (n=262)	RH clinic Non-	P-value

			users (n=262)	
I am at risk of getting HIV virus	Yes No	41 (16%) 221 (84%)	63 (24%) 199 (76%)	**0.021**
Alcohol consumption can predispose to HIV acquisition	Yes No	224 (85%) 38 (15%)	217 (83%) 45 (17%)	0.473
Belief of getting unwanted pregnancy	Yes No	73 (28%) 189 (72%)	59 (23%) 203 (77%)	0.191
Unwanted pregnancy can be significantly reduced by using condom	Yes No	240 (92%) 22 (8%)	226 (86%) 36 (14%)	0.070
Condom use is a practical protective option against AIDS	Yes No	245 (94%) 17 (6%)	231 (88%) 31 (12%)	**0.049**
The chances of contracting STIs can be significantly reduced by having sex with only one partner	Yes No	249 (96%) 13 (4%)	230 (88%) 32 (12%)	**0.005**
Using a condom reduce sexual satisfaction	Yes No	138 (52%) 124 (48%)	150 (57%) 112 (43%)	0.334
Condom is too expensive	Yes No	20 (8%) 242 (92%)	41 (16%) 221 (84%)	**0.006**
Confident to purchase and use condom	Yes No	165 (62%) 97 (38%)	128 (48%) 134 (52%)	**0.002**
Convince your partner(s) to use condoms during sexual intercourse	Yes No	170 (64%) 92 (36%)	132 (50%) 130 (50%)	**0.001**

Factors associated with risky sexual behavior

There was a negative association between youth center reproductive health clinic utilization status and risky sexual behavior. Non-users of the youth center reproductive health clinic were 1.570 times more likely to engage in risky sexual behavior compared to users of the youth center reproductive health clinic (AOR= 1.570; 95%CI = 1.056, 2.333) when age, educational status, knowledge about STIs, knowledge about condom use for prevention method of unwanted

pregnancy and perception of youth about decresing sexual pleasure by using condom are controlled. Youth aged 15-19 years were 92.1% less likely to practice risky sexual behavior compared to youth aged 25-29 years old (AOR = 0.079; 95%CI = 0.041, 0.150) and youth aged 20-24 years were 79.3% less likely to engage in risky sexual behavior compared with their elders (AOR = 0.207; 95%CI = 0.114, 0.376). Youth who had no formal education were 2.945 times more likely to exercise risky sexual behavior than those youth who were above 12th grade (AOR= 2.945; 95%CI= 1.069, 8.116) and there is no statistical significant diferrence on primary and secondary levels. On the other hand youth who knew about condom use as a prevention method for unwanted pregnancy were 2.593 times more likely to engage in risky sexual behavior compared to those youth who didn't knew about condom use as a prevention method for unwanted pregnancy (AOR = 2.593; 95%CI= 1.307, 5.143). Youth who perceived that condom utilization during sexual intercourse reduce sexual satisfaction were 1.673 times more likely to engage in risky sexual behavior than those who perceived condom utilization didn't reduce sexual satisfaction (AOR = 1.673;95%CI= 1.124, 2.491). Risky sexual behavior was not statistically significantly associated with sex, ethnicity, religion, occupation, primary and secondary level of education.

Table 5: Association of utilization status of youth centers, socio-demographic characterstics and knowledge of the respondents with risky sexual behavior in Addis Ababa, 2016.

Variables	**Risky sexual behavior**			
	Yes	No	COR (95%CI)	AOR (95%CI)
Utilization status				
Non-user	125 (48%)	137 (52%)	1.454 (1.028, 2.059)*	1.570 (1.056, 2.333)**
User	101 (39%)	161 (61%)	1.00	1.00

Age				
15-19	48 (23%)	161 (77%)	0.078 (0.044,0.141)*	0.079 (0.041, 0.150)**
20-24	102 (47%)	117 (53%)	0.229 (0.131,0.401)*	0.207 (0.114, 0.376)**
25-29	76 (79%)	20 (21%)	1.00	1.00
Educational status				
No formal education	26 (76%)	8 (24%)	2.676 (1.097, 6.527)*	2.945 (1.069, 8.116)**
Primary	21 (38%)	35 (62%)	0.494 (0.251, 0.973)*	1.168 (0.511, 2.672)
Secondary	128 (38%)	213 (62%)	0.495 (0.311, 0.787)*	1.060 (0.616, 1.824)
Above 12th	51 (55%)	42 (45%)	1.00	1.00
Heard about STIs				
No	18 (69%)	8 (31%)	3.137 (1.339,7.353)*	2.524 (0.871, 7.316)
Yes	208 (42%)	290 (58%)	1.00	1.00
Prevent unwanted pregnancy by using condom				
No	18 (28%)	46 (72%)	1.00	1.00
Yes	208 (45%)	252 (55%)	2.109 (1.187, 3.749)*	2.593 (1.307, 5.143)**
Using a condom reduce sexual satisfaction				
No	82 (35%)	154 (65%)	1.00	1.00
Yes	144 (50%)	144 (50%)	1.878 (1.318,2.675)*	1.673 (1.124, 2.491)**

NB *Significant for Crude OR & **Significant for Adjusted OR.

6. DISCUSSION

The magnitude of risky sexual behavior among users and non-users of the youth center reproductive health clinics were statistically significantly different with 39% and 48% respectively. The youth who didn't utilize youth centers reproductive health clinic were more likely to engage in risky sexual behavior compared with users of the youth centers and there was a significant difference between users and non-users.

Over one third of youth center users and half of non-users reported unprotected sex. This study was comparable to a study conducted in Western Ethiopia among in-school and out-of-school youths. On the other hand more than one third of users of the youth center and 45% of non-users reported to have two and more sexual parteners in the past 12 months. This finding was slightly

higher that the above study (50). The diferrence might be due to environmental influence and exposure status to diferrent events.

About 42% of the respondents were reported that had two and more sexual partner(s) in the last 12 months with confidence interval (37.8% to 46.2%) at 95%. This was higher than a study conducted among Jimma University students (44). The diferrence might be due to educational as well as environmental influences.

The overall prevalence of risky sexual behavior in this study was 43% with (95%CI = 39% to 47%). It was higher than the findings of a study conducted among high school students in Addis Ababa (46). The diferrence might be due to the time laps and the awareness level of the youth.

The primary objective of Ethiopian national youth policy was create favorable conditions for the youth to have proper access to information, education, counseling and leadership services in the areas of reproductive health issues (51). Inorder to implement this policy the country develop a strategy and programs like health extension program; which includes adolescent reproductive health as one package. Accessibility and availability of health services for youth through youth centers was another program. Therefore, this study particularly implied that risky sexual behaviors of youth might be decreased through strengthening and launching diferrent youth reproductive health programs in the country.

Almost half, 48% (with 95%CI = 44% to 52%) of the respondents ever had sexual intercourse in this study. It was similar to the study conducted among youth in Addis Ababa. However, it is higher than the finding from Bahir dar University students which was 36.4% and Agena preparatory school students in Guragie zone which was 27.1% (29, 37, 52). This might be due to the difference in educational status of youth and exposure status of youth to diferrent things due to globalization effect.

The mean age of the respondents having sexual intercourse for the first time were 18.56 years and it was comparable to the study conducted among Haromaya University students and greater by almost two years than the study conducted among preparatory students in Guragie zone which was 16.2 years. The difference might be due to intervention effect of the youth centers and awareness level of youth to delay sexual initiation (37, 52). Moreover, in this study 37% of the respondents had started sexual intercourse before the age of 18 years with 95%CI of (33% to

41%) and it is less than studies conducted in Benshangul Gumuz region, Gondar town and West Gojjam zone (35, 38, 41). It implies that the mean age at the time of first sexual intercourse might not detect youth risky sexual behavior but the median age tells us about the magnitude of risky sexual behavior of youth. Because age of the respondents at the time of first sexual initiation was not normally distributed so it is better to use median rather than mean age to assess risky sexual behavior.

Another indicator for risky sexual behavior is having sexual intercourse with multiple sexual partners. In this study about 42% of the respondents had two and more sexual partners in the past 12 months. It is similar to the study conducted among Mizan Tepi university students and less than that of Agena, Guragie zone and Pawe, Benshangul Gumuz zone (35-37). The discrepancy might be due to their residence and family control. In the rural part youth may perceive having more than one sexual partner as a fashion due to lack of awareness and most of the time youth may live alone without family control. The implication of this finding is that even though the youth had a good knowledge about transmission and prevention methods of STIs and unwanted pregnancies still they could be exposed to high risky sexual behavior.

Condom utilization is an important intervention strategy for STIs, including HIV/AIDS and/or unwanted pregnancy prevention method. But in this study of those who ever had sexual intercourse almost half, 47% of the respondents had never used condom with (95%CI = 43% to 51%) and it was highr than the study conducted in Addis Ababa youth center reproductive health clinics which was 25.5% of the respondents were never used condom during their sexual intercourse, Guragie zone which was 37% and South Africa University students (35%) (29, 33, 37). The diference might be due to the time laps. So it implied that the risk of youths had been increased in general even though youth centers were effective on reduction of risky sexual behavior.

The main reasons for not using condom in this study were respondents thought that using condom reduce sexual satisfaction, they trust their sexual partner(s) and refusal of sexual partners to use condom. It was consistent with other studies conducted in Shendi and Tiss Abay (41, 45).

On the other hand the main reasons for having sexual intercourse for the first time were falling in love, personal sexual desire and peer pressure. It is similar to a study conducted in Shendi town, West Gojjam zone and Jimma university students (41, 44).

According to this study, 17% of the sexually active youth ever had sexual intercourse with commercial sex workers. It was similar to the study conducted among Haromaya University students (52). But higher than the study conducted in Benshangul gumuz region which was 5.5% of them reported having sexual contact with commercial sex workers (35).

Perceived susceptibility of youth to HIV/AIDs was high. Non-users of the reproductive health clinics were more likely to feel that they are at risk of getting HIV virus compared to users and it was statistically significantly diferrent. This was similar to the study conducted in Cameron and Tanzania (30, 40).

There was a negative association between utilization of youth center reproductive health clinics and risky sexual behavior. Youth center reproductive health clinics users were statistically significantly at reduced risky sexual behaviors than non-users. This has been the target of the youth center reproductive health clinics as revealed in the youth development program evaluation that was conducted in 2012. Youth centers are expected to provide information about young people's sexual health behaviors and reduce their risk (11). Therefore, increased participation of the youth in the activities of youth centres is essential and youth centres should expand their services, and youth centers should be established in areas where they do not exist and equipping them with more facilities so that young people can be attracted to youth centres and spend more time in and around them thereby their engagement in risky sexual behaviors could be reduced.

7. STRENGTHS AND LIMITATIONS

7.1. Strengths of the study

This study could be considered as a baseline study to assess the association between utilization of youth reproductive health services and risky sexual behavior.

7.2. Limitations of the study

- The study design was cross-sectional, which implies that the direction of causal relationships cannot be determined.
- Face-to-face interview was used which may not be convenient to study sexuality in a conservative societies like ours.
- Data collectors were nurses who are working at the youth center RH clinics; so there might be professional bias.

- Since this study touches very sensitive and very personal issue; social desirability responding cannot be ruled out.

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

The magnitude of risky sexual behaviors was statistically significantly higher among non-users of the youth center reproductive health clinic than users. This study has shown that a substantial proportion of youth engaged in different risky sexual behaviors that are evidenced by the existence of multiple sexual partners, none use of condom, inconsistent use of condom, incorrect use of condom, early sexual initiation and having sex with CSW and being a CSW that predispose youth to STIs including HIV infection and unwanted pregnancy. The study also revealed a negative association between utilization of youth center and risky sexual behaviors. Besides, age and risky sexual behavior were found to be statistically significantly to one another.

8.2. Recommendations

8.2.1. For general population

- Early sexual initiation was one indicator of risky sexual behavior and large proportion of youth had early sexual initiation. Therefore, the wider public should be aware on the disadvantages of early sexual debut.

8.2.2. For health care providers

- Information, education and communication (IEC) programs should be established and emphasis should be put on reproductive health in order to encourage the youths to delay sex, negotiate to use condom and to be faithful for their sexual partner.

8.2.3. For programmers/policy makers

- Large proportion of youth had risky sexual behaviors and the proportion was higher among non-users of the youth center. Therefore, emphasis should be given for youth who are non-users of the youth center through social and behavioral change communication (SBCC) and launching other youth-friendly services.
- Moreover the youth center reproductive health clinics have to be scaled-up in areas where they are not available.

8.2.4. For researchers

- Further study needs specifically qualitative study to be conducted to explore the reasons why youth are involved in risky sexual behaviors and to see the wider social norms that may encourage risky sexual behaviors among urban youth.

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10. ANNEXES

Addis Ababa University

College of Health Science

School of Public Health

Questionnaire for a study on assessment of the effect of youth centers on reduction of risky sexual behaviors among youth in Addis Ababa city

10.1.1. Study information sheet

My name is_____. I belong to the research team studying the effect of youth centers on reduction of risky sexual behaviors among young people. The study is being conducted by a graduate student of Public Health (Nigusie Fetene) at the School of Public Health in Addis Ababa University. The objective of this study is to assess effect of

youth centers on reduction of risky sexual behaviors among young persons aged 15 to 29 years in Addis Ababa. I kindly ask you to participate in this study and give me genuine answers for my queries. Your participation in this study is greatly helpful in identifying problems related to sexual reproductive health among the use and the effect of youth centers in reducing risky sexual behaviors. The interview will take about 30 minutes. Your name will not be written in this form and will never be used mentioned in the report either. You will not get payment because of your participation in this study and will not lose any service rendered by the youth center or similar health service providers. All information given by you will be kept confidential and no one except the research team members will have access to the information. Your participation is completely voluntary and you are not obligated to answer any question you are not willing to respond. If you feel any discomfort with the question, it is your right to drop it at any time you want. You may even decide not to engage in this study from the very beginning. I hope I have clarified the purposes of the study. If you have any question you can ask me now or you may ask the principal investigator, Nigussie Fetene, whose telephone is 0910364142 or email:nigusiefetene2006@gmail.com.

10.1.2. Consent Form

I have understood the verbal explanation of the information sheet concerning this study and I understood what will be required of me and what will happen to me if I take part in it. I also understand that any time I may withdraw from this study without giving a reason and without me or my families' routine service utilization being affected for my refusal.

Are you willing to participate in this study?

1. Yes…….. Continue to the next page

2. No…… Skip to the next participant

Signature of interviewer----------

Date of data collection--------/--------/----------

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

10.1.3. English version Questionnaire

Addis Ababa University, College of Health Sciences, School of Public Health Questionnaire to assess the effect of youth centers on reduction of risky sexual behavior among Youth of Addis Ababa city, 2016.

001 Questionnaire ID----------

002 Addresses: Sub city----------woreda----------House No.----------

Phone number----------

003 Category 1. Youth center RH clinic user [2] 2. Youth Center RH clinic Non-user [ ]

Part I. Socio-demographic characteristics of youth in Addis Ababa, 2016			
No	**Questions**	**Responses and coding**	**Skip to**
101	Sex of the respondent	Female----------1 Male----------2	
102	How old are you in your last birthday?	----------	
103	What is your Ethnicity?	Amhara----------1 Guragie----------2 Orormo----------3 Silti----------4 Tigre----------5 Wolayita----------6 Others (Specify)----------99	
104	What is your religion?	Catholic----------1 Muslim----------2 Orthodox----------3 Protestant----------4 Other (specify)----------99	
105	What is your current marital status?	Divorced----------1 Married----------2 Separated----------3 Single----------4 Widowed----------5	

106	Can you read and write in any language you are speaking with?	Yes----------1 No----------0 →	108
107	What is your attained grade?	Grade---------- Informal ☐	
108	With whom are you currently living?	With both parents ----------1 With father only ----------2 With mother only ----------3 With relatives ----------4 Under marital union ----------5 Alone ----------6	
109	What is your main occupation?	Government employed ----------1 House wife ----------2 Merchant ----------3 Privately employed ----------4 Student ----------5 Unemployed ----------6	
110	What is your households' average monthly income?	----------Birr	
Part II. Knowledge of respondents about STIs and unwanted pregnancy			
201	Did you heard about Sexually transmitted infections?	Yes----------1 No----------0 →	206
202	What was the source of information? **(multiple response possible)**	Mass media----------1 Health professionals----------2 School----------3 Reading materials----------4	
203	Do you know about the transmission mechanisms of sexually transmitted infections, including HIV/AIDS?	Yes----------1 No----------0 →	206
204	Which transmission method do you know? **(multiple response possible)**	Blood contact----------1 Physical Contact ----------2 Kissing ----------3	

		Mother-to-child----------4 Sharing sharp materials----------5 Unprotected sex----------6	
205	How do we prevent Sexually transmitted infections, including HIV/AIDS? **(multiple response possible)**	Abstained from sex----------1 Being faithful for boy/girl friend----------2 By using condom ----------3 Avoid sharing sharp materials----------4	
206	How do we prevent unwanted pregnancy? **(more than one response possible)**	Abstained from sex----------1 By using condom----------2 By using other modern contraceptive methods ----------3 I don't know----------4	
Part III. Sexual behavior and related practices of youth in Addis Ababa, 2016			
301	Have you ever had sexual intercourse?	Yes----------1 No----------0 →	401
302	At what age did you first have sexual intercourse?	----------Age in completed years	
303	Why did you decide to have sexual intercourse for the first time?	Attending night clubs----------1 Chewing khat----------2 Forced----------3 I got married----------4 I was drunk----------5 Love----------6 Peer pressure----------7 Personal desire----------8 To get money----------9 Watching porn video----------10	
304	How many people in total have you ever had sexual intercourse in the past 12 months?	----------	
305	How many people in total have you ever had sexual	----------	

	intercourse in the past 1 month?		
306	Have you ever used condom during your sexual intercourse?	Yes----------1 No----------0 →	311
307	How often did you use Condom?	Sometimes----------1 Most of the time----------2 Always----------3	
308	Have you ever use condom correctly?	Yes ----------1 → No ----------0	310
309	Which problem had been encountered?	Condom tear off during sexual intercourse----1 Inappropriate insertion of condom----------2 Inappropriate removal of condom----------3 Other (specify)---------- 99	
310	Why have you used condom? **(more than one response possible)**	To prevent STIs/HIV----------1 To prevent pregnancy ----------2 Other (specify)----------99	
311	If you have not used condom at all, or have not used it consistently what was the reason? **(multiple response possible)**	Ashamed to buy----------1 Decreases satisfaction/pleasure---------2 I trust my partner----------3 I was drunk ----------4 My religion prohibits----------5 Not available----------6 Partner refusal----------7 Too expensive----------8 others, specify----------99	
312	**(Question 312-314 for male respondents only)** Have you ever had sexual intercourse with commercial sex workers during the last 12 months?	Yes ----------1 No ----------0 →	401

313	Have you ever used a Condom when having sexual intercourse with commercial sex workers during the last 12 months?	Yes ----------1 No ----------0	401 →
314	How often did you use Condom when having sexual intercourse with commercial sex workers?	Sometimes----------1 Most of the time----------2 Always----------3	
315	**(Question 315-322 for female respondents)** Have you ever commertial sex worker in the last 1 year?	Yes ----------1 No ----------0	
316	Have you ever become pregnant?	Yes ----------1 No ----------0 →	401
317	How old were you when you were first become pregnant?	Age----------years	
318	Did you ever have unplanned pregnancies?	Yes ----------1 No ----------0	
319	Have you ever aborted or stopped a pregnancy?	Yes ----------1 No ----------0 →	401
320	How many times did you have abortions?	----------	
321	Why did you abort or terminate the last pregnancy? **(multiple response possible)**	Fear of my family----------1 To continue my education ----------2 It was unplanned----------3 It had been outside marriage----------4 Economical problems----------5 Others (specify)----------99	
322	Where did you the last abortion have?	At public health institution----------1 At private clinic----------2 At abortionist house----------3 Others, specify----------99	
Part IV. Risk perception of youth in Addis Ababa, 2016			

401	Do you believe you are at risk of getting HIV virus?	Yes ----------1 No ----------0	
402	Do you perceive that alcohol consumption can predispose to HIV acquisition?	Yes ----------1 No ----------0	
403	Do you believe that you will get unwanted pregnancy?	Yes ----------1 No ----------0	
404	Do you think that unwanted pregnancy can be significantly reduced by using condom?	Yes ----------1 No ----------0	
405	Do you believe that condom use is a practical protective option against AIDS?	Yes ----------1 No ----------0	
406	Do you think that the chances of contracting STIs can be significantly reduced by having sex with only one partner?	Yes ----------1 No ----------0	
407	Do you believe that using a condom reduce sexual satisfaction?	Yes ----------1 No ----------0	
408	Do you believe that condom is too expensive?	Yes ----------1 No ----------0	
409	Are you confident to purchase and use condom?	Yes ----------1 No ----------0	
410	Can you convince your partner(s) to use condoms during sexual intercourse?	Yes ----------1 No ----------0	

Thank you very much!

አዲስ አበባ ዩኒቨርሲቲ

የጤና ሳይንስ ኮሌጅ

የህበረተሰብ ጤና ትምህርት ክፍል

በአዲስ አበባ ከተማ የሚገኙ ወጣት ማዕከላት የወጣቶችን አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያላቸውን ውጤታማነት ለማጥናት የተዘጋጀ የአማርኛ መጠይቅ

የጥናቱ መረጃ ቅጽ፤

ጤና ይስጥልኝ፤

ስሜ_____እባላለሁ:: የወጣት ማዕከላት የወጣቶችን አደገኛ ወሲባዊ ተግባራት ከመቀነስ አንጻር ያላቸውን ውጤታማነት ከሚያጠኑት አካላት አንዱ/ዷ ነኝ። ጥናቱ የሚካሄደው በአዲስ አበባ ዩኒቨርሲቲ የህበረተሰብ ጤና ትምህርት ቤት የህበረተሰብ ጤና የድህረ-ምረቃ ተማሪ በሆነው በንጉሴ ፈጠነ ነው። የጥናቱ ዋና ዓላማ ወጣት ማዕከላት የወጣቶችን (ከ 15-29 ዓመት) አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያላቸው ውጤታማነት ምን ይመስላል የሚለውን ለማጥናት ነው። እንተን/አንችን የምጠይቅህ/ሽ በዚህ ጥናት ላይ እንድትሳተፍ/ፊ እና ለጥያቄዎቹ ትክክለኛ ምላሽ እንድትሰጠኝ/እንድትሰጭኝ ነው። ያንተ/ቺ በዚህ ጥናት ላይ መሳተፍ ከጾታዊና የስነ ተዋልዶ ጤና ጋር ተያይዘው የሚከሰቱ ችግሮችን በመለየት የወጣት ማዕከላት የወጣቶችን አደገኛ ወሲባዊ ተግባራት ከመቀነስ አንጻር ያላቸው ተፅዕኖ ምን እንደሚመስል

ለመለየት ይጠቅማል።ቃለ-መጠይቁ 30 ደቂቃዎችን ሊወስድ ይችላል። በዚህ ቅጽ ላይ ስምህ/ሽ አይጻፍም እንዲሁም በሪፖርቱ ላይ አይጠቀስም። በዚህ ጥናት ላይ በመሳተፍህ/ሽ ምንም አይነት ክፍያ የለውም፤ እንዲሁም በወጣት ማዕከላት ወይም በተመሳሳይ የጤና ባለሙያዎች ከሚሰጡ አገልግሎቶች የምታጣው/የምታጭው ነገር አይኖርም። ሁሉም የምትሰጠው/ጭው መረጃ ምስጢራዊነቱ የተጠበቀ ነው። ከጥናት ቡድኑ በስተቀር ማንም ሊያገኘው አይችልም፤ ያንተ/ቺ ተሳትፎ ፍፁም በፈቃደኝነት ላይ የተመሰረተ ነው። ፈቃደኛ ያልሆንክበትን/ያልሆንሽበትን ጥያቄ እንድትመልስ/ሽ ማንም ሊያስገድድህ/ሽ አይችልም። በሚጠየቁ ጥያቄዎች ምቾት ካልተሰማህ/ሽ በማንኛውም ጊዜ ቃለ መጠይቁን የማቋረጥ መብትህ/ሽ የተጠበቀ ነው። ከዚህም ባለፈ ከመጀመሪያውም በዚህ ጥናት ላይ ያለመሳተፍ መብት አለህ/ሽ። ስለ ጥናቱ ዓላማ በሚገባ አብራርቸልሃለሁ/አብራርቸልሻለሁ የሚል ተስፋ አለኝ። ጥያቄ ካለህ/ሽ አሁኑኑ መጠየቅ ትችላለህ/ትችያለሽ ወይም ዋና ተመራማሪውን ንጉሴ ፈጠነን በሚከተለው አድራሻ መጠየቅ ይቻላል። ስልክ ቁጥር 0910364142 ወይም ኢ-ሜይል፡ nigusiefetene2006@gmail.com.

<u>የተሳታፊዎች ፈቃደኝነት ቅጽ</u>

ስለ ጥናቱ በቃል የተደረገልኝ ማብራሪያ እና ከእኔ ምን እንደሚጠበቅ በሚገባ ተረድቻለሁ።እንዲሁም በማንኛውም ጊዜ ምክንያቱን የማሳወቅ ግዴታ ሳይኖርብኝ ከቃለ መጠይቁ መውጣት እንደምችልና ከቃለ መጠይቁ በመውጣቴ እኔም ሆንኩ ቤተሰቦቼ የተለመደው/መደበኛው አገልግሎት ላይ ምንም አይነት ተፅዕኖ እንደማይደረግብኝ ተረድቻለሁ።

በጥናቱ ለመሳተፍ ፈቃደኛ ነህ/ሽ?

1. አዎ…….. ወደ ሚቀጥለው ገጽ ሂድ/ጅ

2. አይ…… ወደ ሚቀጥለው ተሳታፊ ሂድ/ጅ

ቃለ-መጠይቁን ያካሄደው መረጃ ሰብሳቢ ፊርማ----------

መረጃው የተሰበሰበበት ቀን--------/--------/----------

(ቃለ-መጠይቁን ያካሄደው መረጃ ሰብሳቢ ፊርማ የሚያረጋግጠው ተሳታፊው ፈቃደኝነቱን መስጠቱን ነው)

001 የመጠይቁ መለያ ቁጥር----------

002 አድራሻ: ክ/ከተማ----------ወረዳ----------የቤት ቁጥር.----------

ሞባይል----------

003 ምድቡ፡ 1. የወጣት ማዕከሉ ተጠቃሚ 2. የወጣት ማዕከሉ ተጠቃሚ ያልሆኑ

ክፍል አንድ፡ መሰረታዊ የግል መረጃዎች			
ተ.ቁ	ጥያቄዎች	አማራጭ መልሶችና መለያ አሰጣጥ	እለፍ
101	ጾታ	ሴት----------1 ወንድ----------2	
102	እድሜህ/ሽ በሙሉ ዓመት ስንት ነው?	----------	
103	የየትኛው ብሄር ተወላጅ ነህ/ሽ?	አማራ----------1 ጉራጌ----------2 ኦሮሞ----------3 ስልጤ----------4 ትግሬ----------5 ወላይታ----------6 ሌላ (ይገለጽ)----------99	
104	የየትኛው ሀይማኖት ተከታይ ነህ/ሽ?	ካቶሊክ----------1 ሙስሊም----------2 ኦርቶዶክስ ክርስቲያን----------3 ፕሮቴስታንት ክርስቲያን----------4 ሌላ (ይገለጽ)----------99	
105	የጋብቻ ሁኔታ	ተፋትቻለሁ----------1 ያገባ/ች----------2 ተለያይቻለሁ----------3 ያላገባ/ች----------4 ባል/ሚስት የሞተባት----------5	
106	ማንበብና መጻፍ	አዎ----------1	

	ትችላለህ/ትችያለሽ?	የለም----------0 →	108
107	የክፍል ደረጃህ/ሽ?	ክፍል ---------- መደበኛ ያልሆነ ☐	
108	አሁን ከማን ጋር ነው የምትኖረው/ሪው?	ከሁለቱም ወላጆቹ ጋር----------1 ከአባቱ ጋር----------2 ከእናቱ ጋር----------3 ከዘመድ ጋር----------4 ከፍቅር አጋሬ ጋር----------5 ብቻዬን ----------6	
109	ዋናው ስራህ/ሽ ምንድን ነው?	የመንግስት ሰራተኛ ----------1 የቤት እመቤት----------2 ነጋዴ----------3 የግል ስራ ተቀጣሪ----------4 ተማሪ----------5 ስራ የለኝም----------6	
110	በአማካኝ የቤሰሰባችሁ የወር ገቢ ስንት ነው?	----------ብር	
ክፍል ሁለት፡ የአዲስ አበባ ወጣቶች በአባላዘር በሽታዎች እና ያልተፈለገ እርግዝና ዙሪያ ያላቸውን እውቀት ለመዳሰስ የተዘጋጀ መጠይቅ			
201	ስለ አባላዘር በሽታዎች ሰምተህ/ሽታውቃለህ/ሽ	አዎ----------1 የለም----------0 →	206
202	መረጃውን ያገኘሽው/ሽው ከየት ነው (ከአንድ በላይ መምረጥ ይቻላል)	ከብዙሃን መገናኛ----------1 ከጤና ባለሙያዎች----------2 ከትምህርት ቤት----------3 የተለያዩ ነገሮችን በማንበብ----------4	
203	ስለ አባላዘር በሽታዎች ኤች.አይ.ቪ/ኤድስን ጨምሮ መተላለፊያ መንገዶችን ታውቃለህ/ቂያሽ	አዎ----------1 የለም----------0 →	206
204	የትኛውን መተላለፊያ መንገድ ታውቃለህ/ቂያለሽ (ከአንድ በላይ መምረጥ ይቻላል)	በደም ንክኪ----------1 በአካላዊ ንክኪ ----------2 በመሳሳም----------3 ከእናት ወደ ልጅ----------4 ስለታማ ነገሮችን በጋራ መጠቀም---------5	

		ልቅ በሆነ የግብረ-ስጋ ግንኙነት----------6	
205	የአባላዘር በሽታዎችን ኤች.አይ.ቪ/ኤድስን ጨምሮ እንዴት መከላከል ይቻላል? (ከአንድ በላይ መምረጥ ይቻላል)	በመቆጠብ----------1 ለጓደኛ በመታመን----------2 ኮንዶምን በመጠቀም----------3 ስለታም ነገሮችን በጋራ ባለመጠቀም-------4	
206	ያልተፈለገ እርግዝናን እንዴት መከላከል ይቻላል? (ከአንድ በላይ መልስ መስጠት ይቻላል)	በመታቀብ----------1 ኮንዶም በመጠቀም----------2 ሌሎች ዘመናዊ የወሊድ መከላከያን በመጠቀም ----------3 አላውቅም----------4	
ክፍል ሦስት፡ የአዲስ አበባ ወጣቶች ወሲባዊ እና ተያያዥ ተግባራትን በተመለከተ ለመዳሰስ የተዘጋጀ መጠይቅ			
301	የግብረ-ስጋ ግንኙነት አድርገህ/ሽ ታውቂያለህ/ሽ?	አዎ----------1 የለም----------0 →	401
302	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት ስታደርግ/ጊ ስንት ዓመትህ/ሽ ነበር?	----------ዓመት	
303	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት ለማድረግ የወሰንከው/ሽው ለምንድን ነው?	የምሽት ክለብ ስለተከታተልኩ----------1 ጫት ስለቃምኩ----------2 ተገድጄ ----------3 አግብቼ----------4 ጠጥቼ ስለነበረ----------5 ፍቅር ይዞኝ----------6 በጓደኛ ግፊት----------7 የግል ፍላጎቱ ስለተነሳሳ----------8 ገንዘብ ለማግኘት----------9 የወሲብ ቪዲዮ ስለተመለከትኩ----------10	
304	ባለፉት 12 ወራቶች ከምን ያህል ሰው ጋር የግብረ-ስጋ ግንኙነት አደረግህ/ሽ?	----------	
305	ባለፈው 1 ወር ከምን ያህል ሰው ጋር የግብረ-ስጋ ግንኙነት አደረግህ/ሽ?	----------	
306	የግብረ-ስጋ ግንኙነት	አዎ----------1	

	ባደረግህበት/ሽበት ጊዜ ኮንዶም ተጠቅመሃል/ሻል?	የለም----------0 →	311
307	ኮንዶም በምን ያህል ድግግሞሽ ትጠቀማለህ/ትጠቀሚያለሽ?	አንዳንድ ጊዜ ----------1 አብዛኛውን ጊዜ----------2 ሁልጊዜ----------3	
308	ኮንዶምን በአግባቡ ተጠቅመሃል/ሻል?	አዎ ----------1 →	310
		የለም ----------0	
309	ኮንዶንም በአግባቡ ካልጠቀምክ/ሽ ምን አይነት ችግር አጋጥሞህ/ሽ ነበር?	የኮንዶም መቀደድ----------1 ኮንዶምን በአግባቡ አለማጥለቅ----------2 የተጠቀሙበትን ኮንዶም በአግባቡ አለማስወገድ----------3 ሌላ (ይገለጽ)----------99	
310	ለምንድን ነው ኮንዶም የተጠቀምከው/ሽው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	የአባላዘር በሽታዎችን/ኤች.አይ.ቪን ለመከላከል----------1 ያልተፈለገ እርግዝናን ለመከላከል --------2 ሌላ (ይገለጽ)----------99	
311	ሁልጊዜ ኮንዶም የማትጠቀምበት/ሚበት ምክንያት ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	ለመግዛት አፍሬ----------1 እርካታ ስለሚቀንስብኝ----------2 ጓደኛየን ስለማምናት/ስለማምነው----------3 ጠጥቸ ስለነበር ----------4 ሀይማኖቴ ስለማይፈቅድ----------5 ኮንዶም ስላላገኘሁ----------6 ጓገኛዬ ስለተቃወመኝ/ችኝ----------7 በጣም ውድ ስለሆነ----------8	
312	(ከ **312-314** ያሉ ጥያቄዎች ለወንዶች ብቻ) ባለፈው አንድ አመት ውስጥ ከሴተኛ አዳሪ ጋር የግብረ ስጋ ግንኙነት አድርገህ ታውቃለህ?	አዎ----------1 የለም----------0 →	401
313	ከሴተኛ አዳሪ ጋር የግብረ ስጋ ግንኙነት ስታደርግ ኮንዶም ተጠቅመሃል?	አዎ----------1 የለም----------0 →	401
314	በምን ያህል ጊዜ ውስጥ ኮንዶም ትጠቀማለህ?	አንዳንድ ጊዜ ----------1 አብዛኛውን ጊዜ----------2	

		ሁልጊዜ----------3	
315	(ከ **315-322** ያሉ ጥያቄዎች ለሴቶች ብቻ) ባለፈው 1 ዓመት ውስጥ ሴተኛ አዳሪ ሆነሽ ሰርተሽ ታውቂያለሽ?	አዎ ----------1 አይ ----------0	
316	አርግዘሽ ታውቂያለሽ?	አዎ----------1 የለም ----------0 →	401
317	ለመጀመሪያ ጊዜ ስታረግዥ እድሜሽ ስንት ነበር?	----------ዓመት	
318	ያልተፈለገ እርግዝና አጋጥሞሽ ያውቃል?	አዎ ----------1 የለም ----------0	
319	የጽንስ ማቋረጥ/ማስወረድ አድርገሽ ታውቂያለሽ?	አዎ----------1 የለም----------0 →	401
320	ስንት ጊዜ አስወረድሽ/ውርጃ ገጠመሽ?	----------	
321	የመጨረሻው ጽንስ እንዲቋረጥ/እንዲወርድ ያደረግሽው ለምንድን ነው?	ቤተሰቦቼን ፈርቼ----------1 ትምህርቴን ለመቀጠል----------2 ያልታቀደ ስለነበር----------3 ከጋብቻ ውጭ በመሆኑ----------4 ማሳደግ ስለማልችል/ የኢኮኖሚ ችግር-----5 ሌላ (ይገለጽ)----------99	
322	የመጨረሻውን የጽንስ ማቋረጥ የት ቦታ ነበር ያደረግሽው?	የመንግስት የጤና ተቋም----------1 ከግል ኪሊኒክ----------2 ሰፈር ውስጥ----------3 ሌላ (ይገለጽ)----------99	
ክፍል አራት፡ የአዲስ አበባ ወጣቶች አደገኛ ወሲብን በተመለከተ ያላቸው አስተሳሰብ			
401	እስከአሁን ባለው ጊዜ ለኤች.አይ.ቪ ተጋልጫለሁ ብለህ/ሽ ታስባለህ/ቢያለሽ?	አዎ ----------1 የለም ----------0	
402	አልኮል መጠጦችን መጠጣት ለኤድስ በሽታ ያጋልጣሉ ብለህ/ሽ ታምናለህ/ኛለሽ?	አዎ ----------1 የለም ----------0	
403	ያልተፈለገ እርግዝና ሊያጋጥመኝ ይችላል ብለህ/ሽ አስበህ/ሽ	አዎ ----------1 የለም ----------0	

	ታውቃለህ/ቂያለሽ?		
404	ያልተፈለገ እርግዝናን ኮንዶም በመጠቀም መቀነስ ይቻላልብለህ/ሽ ታስባለህ/ቢያለሽ?	አዎ ----------1 የለም ----------0	
405	በኮንዶም መጠቀም ለኤድስ በሽታ መከላከያ ዘዴ ነው ብለው ያምናሉ?	አዎ ----------1 የለም ----------0	
406	አንድ የፍቅር ጓደኛ ብቻ እንዲኖር በማድረግ በአባላዘር በሽታዎች የመያዝ እድልን መቀነስ ይቻላል ብለህ/ሽ ታስባለህ/ቢያለሽ?	አዎ ----------1 የለም ----------0	
407	ኮንዶም መጠቀም እርካታን ይቀንሳል ብለህ/ሽ ታምናለህ/ሽ?	አዎ ----------1 የለም ----------0	
408	የኮንዶም ዋጋ በጣም ውድ ነው ብለህ/ሽ ታምናለህ/ኚያለሽ?	አዎ ----------1 የለም ----------0	
409	ኮንዶምን ገዝተህ/ሽ መጠቀም ትችላለህ/ያለሽ?	አዎ ----------1 የለም ----------0	
410	በግብረ-ስጋ ግንኙነት ጊዜ ኮንዶምን ለመጠቀም ጓደኛህን/ሽን ማሳመን ትችላለህ/ያለሽ?	አዎ ----------1 የለም ----------0	

በጣም አመሰግናለሁ!!!