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Basic knowledge of Adolescents on Sex, Sexuality, Sexual and Reproductive Health: The Case of Burayu Preparatory School

A Thesis Submitted to the Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirement for the Degree of Masters of Science in Biology

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List of Abbreviations

AIDS: - Acquired Immune Deficiency Syndrome

CSE: - Comprehensive Sexuality Education

ESA: - Eastern and Southern Africa

FMoH: - Federal Ministry of Health

HIV: - Human Immunodeficiency Virus

HTPs: - Harmful Traditional Practices

ICDR: - Institute for Curriculum Development and Research

MoWCYA: - Ministry of Women, Children and Youth Affair

NGOs: - Non-governmental organizations

RH: - Reproductive Health

SRH: - Sexual and Reproductive Health

STDs: - Sexually Transmitted Diseases

STIs: - Sexually Transmitted Infections

UNESCO: - United Nations Educational, Scientific and Cultural Organization

WHO: - World Health Organization

Abstract

Adolescents and young people represent the future of every society. In order to enable the young to be responsible and productive citizen, it is essential to cultivate with better education including information on sex, sexuality and sexual and reproductive health issues to equip them with better life skills and attitudes for their adult life.

A study was conducted to assess the knowledge and attitude level of students on Sex, Sexuality and Sexual and Reproductive Health (SRH) in Burayu preparatory school, Oromia National Regional State. Five basic questions established and a research methodology suitable to the basic questions has been designed and informants were identified. Instruments including questionnaire and desk interview items developed and pilot tested before distributed to informants. The knowledge and attitude of students, attitude and readiness of school teachers as well as the opinion of principals and the town educational office personnel has been gathered, organized and analyzed.

The findings of the study in relations to the basic questions shown that over 80% of the students have basic orientation on sex, sexuality and sexual and reproductive health. However, student's practical application in avoiding problems related to SRH was found to be insufficient. The study also disclosed low level of readiness among teachers to help students on SRH related contents. Furthermore, about 40% of school teachers are not confident enough on their SRH knowledge to teach students; indicating the need to provide SRH related contents in teacher's training colleges and universities.

Students and other informants preferred body in informing SRH issues are parents, health professionals and school teachers. Significant proportion of students are also strongly considered parents are the most

appropriate ones to assist them when problems related to SRH has occurred. Health professionals and school teachers took the next rank.

The current Ethiopian school curriculum does not sufficiently treat SRH contents. Hence, students cannot acquire essential knowledge, attitude and skill required for future life. It is of a great value if the Ministry of Education incorporate SRH related contents in the curriculum both in depth and scope.

The school under study did not establish SRH club in this and the previous academic years. Hence, the students cannot get assembled under the umbrella of the club and become equipped with informed decision-making practices for their future life. Services on SRH issues like counseling and guidance, safest corner for girls to keep personal hygiene during menstruation including the necessary materials at the school compound are not prepared. The in availability of such facilities obliged girls to stay at home due to fear of the improperly managed discharge. The researcher would like to remind the school principals and other concerned bodies to prepare such facilities in the school compound.

The existing students basic orientation on SRH related issues need to be supported and improved through school-based interventions, parents' involvement and the joint actions of other concerned bodies.

KEYWORDS: - Burayu preparatory school, Sex, Sexuality, Sexual and Reproductive Health, Teenage Pregnancy.

1. Introduction

1.1- Background of the Study

Adolescent and young people represent the future of every society. Better education and public health measures can be hugely beneficial to their health and development. For most adolescent and young people, this period of their lives is a time of enormous vibrancy, discovery, innovation and hope. Adolescence is also the time when puberty takes place, when many young people initiate their first romantic and sexual relationships, when risk-taking is heightened and 'fitting in' with peers becomes very important. It can also be a challenge time for young people, who are becoming aware of their sexual and reproductive rights and needs, and who rely on their families, peers, schools and health service provider for affirmation, advice, information and the skills to navigate the sometimes difficult transition to adulthood. This transition may catalyze a range of challenge including HIV infection, other sexually transmitted infections (STIs), unwanted pregnancy, low education attainment or dropping out of education and training (UNESCO, 2013).

In any nation including Ethiopia, the education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities. Currently there are 650 million primary school-age young people in the world. Considering that 57 million of them do not attend school, this leaves 593 million who can be reached through school-based programs, making schools the ideal location to reach a large proportion of learners before puberty (UNESCO, 2014 c).

According to UNSCO (2016), poor access to quality health care is one of the greatest barriers to the realization of young people sexual and reproductive health (SRH) right in Eastern and southern Africa (ESA). Of particular importance is the access to SRH care which includes supports

related to sexual development, reproductive health, relationships, intimacy and gender-related issues. All young people, regardless of gender, sexual orientation, marital status, age, disability, religious or political beliefs should have the right to access these services. However , access to SRH services are prevented by stigma; judgmental health providers; confidentiality; lack of knowledge; and in many cases, legal and policy constraints related to age of consent, gender roles and marital status.

In Ethiopia, adolescents and young people comprise over 45% of the total population. Currently the education system is hosting over 22 million learners nationally. This appears at the same time to have an implication on the demand for the right to health information and services. It is also imperative to deliver quality education that includes the practical knowledge, values and attitudes about sexuality and reproductive health issues, so that learners can exercise informed decisions and actions in life (UNESCO, 2014 a).

According to UNESCO (2009), effective sexuality education can provide young people with age appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values and to practice the decision-making and other life skills they will need to be able to make informed choices about their sexual lives.

1.2- Justification of the study

The sexual development of a person is a process that comprises physical, psychological, emotional, social and cultural dimensions. In many countries, young people are exposed to several sources of information and values e.g. from parents, teachers, media and peers).These often present them with alternative or even conflicting values about gender, gender equality and sexuality. Furthermore,

parents are often reluctant to engage in discussion of sexual matters with children because of cultural norms, their own ignorance or discomfort (UNESCO, 2009).

Ethiopia is a youth dominated population, nearly 45% of the total population constitute between 10-29 age. On the other hand nearly 22 million students who estimated ¼ the total population are in the education system. As a result of diverse social background and learning needs the school system is characterized by both challenges and opportunities. Lack of age appropriate, culturally sound and accurate information and vulnerability to sexual problems is a top challenge in secondary schools. In Ethiopia, while family discussion with children on issues like body changes, sexual relation etc. is still a taboo in most cultures of the country, technology is penetrating in its bad shape and effect in each home. The globalization dynamic social and economic changes all around are becoming eminent. Technology has now two forged sharp sword and multiple effects on the life of children, youth and adults. However, all information is not good and constructive. As a result children are exposed to such technologies series educational and human resource wastages are observable which are characterized by unsafe sex, unwanted pregnancy, unintended abortion that leads to threatening conditions including school dropout, run away from home, migration, internal displacement, unwanted street life and death of girls and young boys.

The education system, despite its sound achievements in increasing enrollment, is gradually facing multiple and interrelated social, sexual 0and reproductive health problems to which students are exposed. Ever increasing unsafe sexual experiences, including in upper primary grades, high levels of teenage pregnancy, unsafe abortions, sexually transmitted infections (STIs) and HIV/AIDS are among the sexual and reproductive health problems faced by many young Ethiopians. These are further

complicated by limited opportunities and accesses to SRH information and the poor quality of adolescent and youth friendly sexual and reproductive health information and services available inside and outside the school.

The existing complicated problems on adolescent girls are also related to limited knowledge of school teachers in teaching and addressing sexuality education.-

The current Ethiopian school curriculum hardly addresses such topics except in few chapters in subjects like biology, civics and ethical education, and geography. Even in this case it is subjected to the interest of the teacher. Furthermore there are no club activities that help young girls who are exposed to newly urban life. If this challenge is not tackled through the school system, then the educational wastage increases and girls learning achievement will be in danger.

This study will contribute to the improvement of the mechanisms to address the challenges of unsafe sex and related complications through formal academic and co -curricular activities in schools so that adolescents get equipped with responsible decision –making skills and practices they will need to make informed choices about their sexual lives.

2. Literature Review

2.1 Adolescent and Adolescence

2.1.1 Adolescent

The World Health Organization (WHO) defines adolescent as an individual in the 10-19 years. Young people refer to those between the ages 10-24 years. The two overlapping age groups combined in the age category "young people" covering the age range 10-24 years (FMOH, 2008).

Young people aged 10-24 years constitute 1.8 billion and represent 27 percent of the world population (Kasiye et al., 2014). Adolescent and young people aged 10-24 make up an estimated 33 % of the population in Eastern and Southern Africa, this population of 158 million is expected to grow to 281 million by 2050 (UNESCO, 2013).

The population of Ethiopia is estimated to be 88.4 million, of which 45% (39.8 million) are adolescents and youth with age range of 10-24 years (MoWCYA, 2014). In developing countries including Ethiopia, most of the adolescents are sexually active. Sexual activity at an early age is also defined as being associated with several serious risks and health complications (ICDR, 1998). Many adolescents approach adulthood faced with conflicting and confusing messages about sexuality and gender. This is often exacerbated by embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers, at a very time when it is most needed. A growing number of countries have implemented or are scaling up sexuality education program. Effective sexuality education is important because of the impact of cultural values and religious beliefs on all individuals, and especially on young people, in their understanding of these issues and in managing relationships with their parents, teachers, peers and the community (UNESCO, 2009).

2.1.2. Adolescence

Is a special time, a time of transition from child- hood to adult - hood. During this transition to adulthood, adolescents develop biologically and psychologically and move towards independence (FMOH, 2008).

Adolescence is an exciting time of life, a period when individuals become interested in sex and become biologically capable of having children. It is an era when young people begin to think they are wiser, more sophisticated, and better able to handle things by themselves (ICDR, 1998).

According to Samkange – Zeeb (2013), it is also a stage during which young people take risks to test and define themselves. The risk taking behavior is described as a normal and necessary part of adolescence which help them to discover themselves and the larger world. It can have positive outcomes such as learning new skills and experiences which can prepare young people for the future, while on the other hand making them vulnerable. Adolescence is a time when many young people experience critical and life-defining challenges such as their first sexual experiences, marriage, pregnancy and parenthood. Adolescent sexual behavior is important not only because of the possible reproductive outcomes, but because risky sexual behavior is associated with unintended pregnancy, early marriage, sexually transmitted infections such as HIV/AIDS (Govindasamy et al. 2002).

Curiosity, sexual maturity, a natural inclination toward experimentation, and peer pressure lead adolescents to risky behaviors such as unprotected sex, substance use, reckless driving, and dangerous recreational activities (FMOH, 2008).

Adolescent years are composed of a series of phases rather than one homogenous stage. Accordingly, distinctions are made as follows.

2.1.2.1. Early Adolescence

This age category, corresponds to the age 10-13 and is characterized by a spurt of growth and the beginning of sexual maturation. It is the stage in which young people start to think abstractly (ICDR, 1998).

Early adolescence is a key stage in the life cycle and in terms of the entry point for education that will make a difference to key health and social outcomes. In education terms, this highlights three issues:

1) The necessity of sexuality education at upper primary school level.
2) The importance of reaching adolescents before and during puberty; and
3) Before they leave the education system all together. Successful intervention at this stage have the potential to impact positively on social norms (e.g. gender equality) as well as sexual decision-making (if and when to become sexually active or refusing sex), the skill to protect themselves against HIV transmission or other STIs and prevent unintended pregnancy. (UNESCO, 2013).

2.1.2.2. Mid Adolescence and Before Sexual Debut (Age 14-15)

It is a time when the physical changes are completed, while the individual develops stronger sense of identity and relates more strongly to his/her peer group (ICDR, 1988). It is the key age to the formation and adoption of healthy behavior and the skills to manage relationships of all forms. Some young people will also need to be reached with services; it is also critical to develop a safe environment, free from gender violence or

rights violations. In this regard families support in helping adolescents to be on the right track usually remains important (UNESCO, 2013).

2.1.2.3. Late Adolescence (age 16-19)

The body fills out and take its adult form, while individual now has a distinct identity and more settled ideas and opinions (ICDR, 1988). Ongoing skill and behavioral-based education should be connected closely to appropriate services. Services for specific vulnerable group will be required e.g. young married women, sexually exploited women, young men who have sex with men) (UNESCO, 2013).

2.2. Puberty and its Effects on Adolescents

Puberty is a key process of human development into adulthood, involving the most rapid physical growth the human undergoes except for pre-natal and neonatal growth. Hormonal changes lead girls to experience their first menstruation (menarche), while boys will have their first ejaculation (semenarche). The physical growth of puberty is accompanied by new and complex emotions, including sexual desire and gender identity. These changes are also associated with peer pressure to behave in a certain way (UNESCO, 2014 c). Stimulated in late childhood by a "cascade of endocrine changes" the processes of bodily growth and sexual and reproductive maturation associated with puberty are accompanied by series of emotional, cognitive and behavioral transition that make the period of early puberty (WHO, 2011). The differences between boys and girls become more pronounced. An important dimension of puberty is that young adolescents be able to integrate bodily changes into their self-identity, and to incorporate others responses to these changes in to that self-identity. Same sex peers become important during the early stages of puberty as someone to talk to, and bonding between peers increases to the possible detriment of the relationship with parents (UNESCO, 2014 c). Before puberty all young

people should learn about puberty, sex and sexual health and the skills needed to negotiate their emerging sexuality, while increasing awareness of gender violence and rights (UNESCO, 2013).

According to WHO (2011), the onset of puberty in girls begins about two years before menarche, with the gradual build-up of estrogens and progesterone released from the adrenal cortex. The normal timing of first menses along healthy girls extends from about 11 years to 14-15 years. Mean age of 14 or 15 years are not unusual among rural girls or urban girls in low-income urban households. In addition, evidences of protein or vitamin deficiencies or iron-deficiency anemia would help to establish the relationship between nutrition and individual and group variations in the timing of menarche in diverse population.

Ovulation, the release of an ovum from an ovary, occurs about midway through the menstrual cycle (13-15 days before a woman's next period). The few days surrounding ovulation (from approximately days 10-18 of a 28 days cycle) constitute the most fertile phase. A woman can get pregnant if she has sexual intercourse with a man about half way between her periods, although this varies (ICDR, 1998).

According to UNESCO (2014 c), for girls, puberty means the onset of menstruation. In many contexts menstruation is considered a private issue, making it difficult to speak about it in public, for instance in a classroom. Many girls are not properly prepared: Numerous studies, particularly from low-income countries, show that a very high number of girls start menstruating without having any idea what is happening to them and why. Girls report experiencing stress, shame, embarrassment, confusion and fear due to lack of knowledge and inability to manage their menstruation. The absence of knowledge transfer from older women, parents and teachers to young girls is caused by such factors as cultural taboos, discomfort in discussing the topic and lack of information.

The first sign of pubertal changes in boys occur at the beginning of the growth spurt in height and weight, when the testes and scrotum begin to change visibly, followed 1-2 years later by lengthening and broadening of the penis. Peak bone mass is achieved by the early 20s. Male adolescents typically reach adult sexual development at about 16-17 years, although some late maturating boys do not complete the process before the age of 20 years (WHO, 2011).

According to UNESCO (2014 c), male puberty, is exemplified as the onset of sexual desire and 'power' that boys can enjoy. Erections and wet dreams, while also potentially embarrassing occurrences, are not usually embedded the same narrative of shame that girls experience. The transition from boyhood to manhood is presented as exciting, and puberty for boys is much more explicitly linked to sexual fillings in a positive way. Complex discussions of masculinity have been absent in many puberty education programs because they are perceived as unproblematic. Studies reviled that boys typically look to quite different sources of information (and of stimulation) than girls do, for example, often relying on friends and on sexually explicit magazines, movies or internet sites rather than on parents, teachers and other legitimate sources (WHO, 2011).

As noted above, a large number of girls do not know what menstruation is and how to manage it at menarche, demonstrating the need to start puberty education at an early age (from 5-8 years old) and to continue providing it until 15-18 years old. Puberty education must be adapted to the target age group to ensure optimal learning. Concepts and skills for younger children should be more basic, and with each new age group, concepts and skills should build upon what has already been taught. This building-block approach to learning ensures that key concepts and skills are integrated effectively (UNESCO, 2014 c).

Effective sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values, and to practice the decision- making and other life skills they will need to be able to make informed choices about their sexual lives (UNESCO, 2009).

2.3. Sex, Sexuality and Sexual Reproductive Health

2.3.1. Sex

People use the term 'sex' to differentiate two divisions of organs formed on the distinction of male sex or female sex. As it is applied to the differences between male and female, sex is a biological term. People are either male or female depending on their sex organs and genes. The term sex is also used to mean sexual intercourse. Which refer to the insertion of penis into the vagina (ICDR, 1998).

2.3.2. Sexuality

Is the desire of intimacy and communication, both emotionally and physically. It is the physiological and psychological grouping of our capacity to love. We express our sexuality through a variety of behaviors. These include actions that quickly come to mind when we think about sexuality, such as touching, holding hands, caressing, kissing, hugging and sexual intercourse. However, they also include a variety of more subtle behaviors such as the way we walk, talk, and dress (ICDR, 1988).

According to UNESCO (2014 b), developing comfort and confidence about sexuality is a part of growing up. Such comfort is also influenced by individual, family, and social factors and experiences. Sexuality - expressed alone or in a mutual consensual and respectful situation with a partner - can be source of pleasure and meaning in life. It can enhance happiness, well-being, health, and the quality of life. It can also foster

intimacy and trust between partners. In many settings, one of the best things adolescents can do to protect their sexual and reproductive health is to stay in school. An increasing number of schools are trying to provide meaningful sexuality education to enable their students to have safe and responsible sex lives. Sexuality education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. Sexuality education provides opportunities to explore one's own-values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality (UNESCO, 2009).

2.3.3. Sexual and Reproductive Health

Is a state of physical, emotional and social well-beings. It is not merely the absence of disease, dysfunction or infirmity, in all matter related to the reproductive system and its functions and processes. It also includes sexual health, the purpose of which is the enhancement of life and personal relations (FMOH, 2008). Sexual and reproductive health, therefore, implies that people are able to have the capacity to reproduce and the freedom to decide if, when and how often to do so (ICDR, 1998).

Sexual and reproductive health services offer a range of health, social and economic benefits for young people. Scarce knowledge or lack of awareness in SRH enhance the chance of vulnerability for adolescents to engage in unintended pregnancies, maternal mortality, unsafe abortions and STIs including HIV/AIDS (UNESCO, 2013).

According to UNESCO (2016), poor access to quality health care is one of the greatest barriers to the realization of young people's sexual and reproductive health rights. Of particular importance is the access to SRH care which includes supports related to sexual development, reproductive health, relationships, intimacy, and gender related issues.

All young people, regardless of gender, sexual orientation, marital status, age, disability, religious or political beliefs should have the right to access these services. However, access to SRH services are prevented by stigma, judgmental health providers, confidentiality, lack of knowledge, and in many cases legal and policy constraints related to age of consent, gender roles and marital status.

Combining comprehensive sexuality education and access to health services in a way that is age -appropriate and within a supportive environment can make a positive impact on adolescents and young people when they need it most. Furthermore, this needs to be understood as part of the life cycle of children and young adults as they move from dependence to full autonomy (UNESCO, 2013).

2.4. Challenges that Adolescent Face on SRH Issues

According to UNESCO (2013), the type of relationship that adolescents and young people are engaged have an important impact on their sexual and reproductive health. Multiple and concurrent partnerships are both recognized as drivers of the problem that adolescents faced. Women most at risk of engaging in inter- generational sex are young women of school-going age. Transactional relationship (for money, gift such as school provisions or shelter and protection) are also common and further disempower the receiving partner, usually girls or young women. Studies have found that, the greater the economic gift or transfer, the less likely it is for safe sex to be practiced.

2.4.1. Early Sexual Debut

In Ethiopia, sexual experience begins early. Early initiation of sex poses risk for both women and men. Most young adults who enter into a sexual relationship for the first time do not use any form of contraception, leaving them vulnerable to unintended pregnancies and unplanned

parenthood (Govindasamy et al. 2002). Early sexual debut and limited use of contraceptive methods have been associated with increased risks of unwanted pregnancy, STIs/HIV infection, and maternal health mortality and morbidity. Women with at least primary education initiate sexual activity five years later than girls in the same age group with no education (FMOH, 2007).

2.4.2. Age at First Marriage

The median age of marriage for women age 15-19 in Ethiopia is 16.1 years, indicating that for most girls, marriage drives sexual debut (FMOH, 2007). Men tend to enter marriage later in life, with almost eight years later than women. These large age differences between men and women limit the young girls' autonomy and control of their reproductive life. Child brides often experience psychosocial problems and constraints related to their loss of mobility, lack of a supportive environment and an inability to persuade their education. As a result, almost half of these early marriages end in divorce or separation and the newly single young women often migrate to urban centers in search of work (FMOH, 2007).

2.4.3. Teenage Pregnancy

Complications from pregnancy and childbirth are among the leading causes of death of girls aged 15-19 globally (UNESCO, 2013). Teenage pregnancy is higher among rural than urban women. Education influences pregnancy and childbirth at an early age. Three in four sexually experienced women with little or no education are mother or pregnant with their first child at a young age compared with two in three women with secondary education or higher (Govindasamy et al. 2002).

Limited knowledge of sexual physiology, early marriage, and limited use of contraceptives, limited access to reproductive health information and education, and girls' limited agency over their sex lives all contribute to the high rate of unwanted pregnancies (FMOH, 2007).

2.4.4. Early Childbearing

Worldwide, more than 10% of all birth are to women 15-19, and in the least developed countries teen pregnancy accounts for 17% of all births (FMOH, 2008). In the context of Ethiopia, young adolescent mothers are likely to suffer from severe complications during delivery that result in high morbidity and mortality of both the mother and child. Girls, age 15-19 years, are twice as likely to experience obstetric fistula compared to other women of reproductive age (FMOH, 2007).

2.4.5. Unsafe Abortion

In the case of Ethiopia abortion is considered to have two aspects. Induced abortions which are legal only under extenuating circumstances are done upon the legal court or authorized permissions. As discussed by (Govindasamy et al. 2002), however, most young women who do not want to carry the pregnancy to its full term resort to unsafe abortions. Hence, due to lack of facilities and conducive environments, most unsafe abortions are illegal. With this understanding, as majority of the studies indicate, girls under age 15 are three times more likely to end their pregnancies in un-induced abortion account for nearly 60% of gynecological and almost 30% of all obstetric and gynecological admissions (FMOH, 2007).

Adolescents in their teen age are encountered with many challenges concerning their sexual and reproductive issues among which few of them are mentioned above. These teenagers are also engaged in a variety of relationships and are sexually active, both within and before marriage. Regardless of marital status, it is essential that this population has access to the education, services and commodities they need in order to prepare for responsible adulthood life and to maintain their sexual and reproductive health (UNESCO, 2013).

2.5. Adolescents' Source of Information on Sex, Sexuality and SRH Issues

According to ICDR (1998), adolescent and young people are interested in finding out about sexual intercourse, birth control, pregnancy, STIs including HIV/AIDS and other related issues. The common sources of information vary from issue to issue. But on sex, books and journals, peers, mass media, teachers and the parents are the main sources of information.

2.5.1. The Role of Parents and Family Members

Parents and families play a key role in shaping attitudes, norms and value related to gender roles, sexuality and the status of adolescents and young people in the community (UNESCO, 20016). Children tend to accept and respect the information provided by their parents. But unfortunately Ethiopian parents do not provide their children, information pertaining to sexual behavior due to cultural taboos. In most parts of Ethiopia parents place more restriction on their teenage daughters than on their teenage boys; they worry more about their daughters' safety and especially about their sexual activity and the risk of pregnancy (ICDR, 1998).

Poor parental involvement in preparing young people for safe sexual life and good reproductive health was part of the blame for the lack of skills on sexual decision- making. Life skills enable individuals to translate knowledge, attitudes and values in to actual abilities i.e. "what to do and how to do it" (Kasiye et al. 2014). It is important for the parents to try to talk to their children about sexuality before the age in which the children will learn from peers. If children learn about sexuality from their parents, they receive much more positive views of sexuality (ICDR, 1998). As adolescent do not have access to proper information from their parents, they seek it from their peers and other sources.

2.5.2. The role of schools

Schools are important for providing sexual and reproductive health education because they reach a large number of children and adolescents (Ann et al. 2001). Education has the responsibility, authority and ability to reach every adolescent and young person with a minimum package of good quality HIV and sexuality education that can make a difference to knowledge and skill levels and the uptake of service (UNESCO, 2013). In Ethiopian school sex-related education is given as part of different courses. It is integrated and offered in course like environmental science at primary schools; biology, civics and ethical education, geography and physical educations at junior and secondary schools. The topics most often covered are sexual physiology, STIs including HIV/ADIS and pregnancy / contraceptive methods (ICDR, 1998). Education programs should be relevant for the needs of today's adolescent and young people. They should prepare young people for a sustainable and independent life after schooling has ended. Sex education, which focuses on adolescents sexual needs, reproductive health, sexuality and family planning need to be incorporated into the existing school curriculum (Govindasamy et al. 2002).

Numerous studies have shown that investment in education, particularly for women, lead to better child birth, lower fertility rate and reduced maternal mortality (FMOH, 2006). In many settings, one of the best thing girls can do to protect their sexual and reproductive health is to stay in schools. An increasing number of schools are trying to provide meaningful education to enable their students to have safe and responsible sex lives and to avoid HIV infection (UNESCO, 2014 b). The longer a girl stays in school, the greater the chance she will delay sexual debut, reduce unintended pregnancy as well as reduce exposure to STIs and gender-based violence (UNESCO, 2016).

Studies have shown that education regarding sexual and reproductive health does not increase sexual activities. Instead, it may help to delay the first sexual intercourse, thus reducing the frequency of sexual activity, pregnancy, abortion and unwanted birth rates. It may also increase condom use among sexually active adolescents and young people, protecting them from STIs including HIV and pregnancy. Monitoring school effort has shown that teachers either shy away from the subject or do not have the skill to teach the subject (Azrian et al. 2011). Quality education and outcomes which can be achieved through CSE require us to invest in teachers to ensure that they are well trained, resourced and supported to deliver programs in and out of schools (UNESCO, 2016).

2.5.3. The role of peers

According to Kasiye et al. (2014), because of cultural taboos adolescents in many developing countries rarely discuss sexual matter explicitly with their parents. Most information of their patchy knowledge comes from peers of the same sex who may themselves lack adequate information or are incorrectly informed. Through close friendships, adolescents learn a great deal about sex and about ways of dealing with members of the opposite sex - lessons that are less likely to be learned from parents or other adult members of the society. Adolescents are thought to become interested in sex in part because of increases in sex hormones at puberty and in part because sexual activity becomes accepted or even encouraged in their peer groups. It is advisable to supplement the information obtained by other more reliable sources such as teachers, books and health services (ICDR, 1998).

2.5.4. Mass Media and other Sources of Information

Many studies have shown that adolescents and young people are affected by the media and the book and journals they read, the radio and television programs they listen to or watch. Adolescents are interested in games, conversations, sports, movies, parties, travelling and reading. The message these activities and channels carry to the adolescents and youth affect their general and sexual behavior (ICDR, 1998). Media content need to be sensitive and relevant to adolescents and young people to be successful in encouraging them to adopt or modify behaviors. A well thought out media program can affect major changes in attitudes and behavior. Therefore, programs geared toward addressing youth reproductive health should consider media exposure a crucial component of success (Govindasamy et al. 2002).

As a matter of fact, the pornographic films one sees affect his/her attitude, values and behaviors. Videos and clandestine written materials which are too pornographic are to be discouraged / regulated (ICDR, 1998).

Faith and faith based organizations and community meetings are another important ways to promote critical information in Ethiopia, and this strategy needs to be exploited to the fullest.

2.6. Contraceptive usage among adolescents

Family planning refers to the use of various method of fertility control that will help individuals (men and women) or couples to have the number of children they want and when they want them in order to assure the wellbeing of children and parents (Bahirdar university, 2013).

In Ethiopia, about 20% (over 2,500) of maternal death could be averted each year by using family planning. Pregnancy related ill-health will also be avoided in thousands of women. Family planning methods vary

widely, and can be divided into several categories. These include: I) terminal methods, II) barrier methods, III) intra uterine devices (ICUDs), IV) hormonal methods and V) natural methods (ICDR, 1998). Targeted family planning services can prevent high risk and unwanted pregnancies and have the potential to significantly reduce maternal and children mortality (Govindasamy et al. 2002).

Most of the fertility problems affecting adolescents come about because of the absence of family life education both at home and school (Bahirdar University, 2013).

Adolescents and young people have limited knowledge about effective use of contraception, the negative effects of early marriage and childbearing on the health of young mothers, or the effects of having many children on the quality of life (Govindasamy et al. 2002)

According to ICDR (1998), most of the adolescents who are virgins find themselves unprepared for contraception when they engage in sexual activities. Lack of such preparation appears to place them at greater risk of pregnancy. Furthermore, adolescents are more likely to use contraception when they plan in advance to have sex than when intercourse is unplanned. It might be due to such spontaneous sexual exposure that unplanned and unwanted pregnancies occur. Over a quarter of all pregnant youth and adolescents, fill that their pregnancies are mistimed, reflecting this population's limited access to family planning RH services (FMOH, 2007). Adolescent pregnancy often brings detrimental social and economic consequences for a girl, her family and the broader community, especially if it leads to a girls' dropping out of school. The health risks of adolescents are also greater, with higher risks of complications and maternal mortality (UNESCO, 2013)

2.7. Significance of the stud

This study is important to help both the schools and young girls and boys who wish to improve their lives through informed decision making on sex, sexuality and sexual reproductive health. The researcher believes the study will contribute a great deal on the roles that the school and other responsible bodies can play to improve adolescents' sexual and reproductive health related problems and ensure adolescents stay in schools particularly young girls who are primarily vulnerable to unsafe sex related complications. In addition it will serve as a spring board for other similar studies and researchers who would like to take up the subject in depth.

2.8. Objectives of the Study

2.8.1. General Objectives

The general objective of the study is to assess the knowledge level of adolescents on sex, sexuality and sexual and reproductive health issues with special references to Burayu preparatory school students in Oromia National Regional State; Burayu special zone.

2.8.2. Specific Objectives

The specific objectives of the study are:

- To assess the knowledge level of high school students on sex, sexuality and reproductive health.
- To survey the attitude of school teachers on sexuality education and their readiness to help the students.
- To identify mechanisms applied when problems on unsafe sex are observed among girls.

- To check the availability of contents related to sexuality education in selected subjects particularly biology and civics in which Ministry of Education claims to have included.
- To suggest feasible mechanisms to address the problem related to the knowledge and attitudes of sexuality and sexual reproductive health issues in preparatory school

2.9. Basic Questions of the Study

In line to the specific objectives of the study, the following basic questions will be addressed in this study.

- Do preparatory school students have basic orientation on sex, sexuality and sexual and reproductive health?
- What is the level of knowledge and attitude of school teachers on sexuality education and their readiness to help their students?
- What mechanisms do preparatory school students apply when they face problems related to sex, sexuality and SRH?
- Are there subjects, contents, learning activities that help students to prepare themselves on problems related to SRH?
- What feasible responses are needed in formal and co-curricular learning areas to enable students make informed decisions on SRH?

2.10 Delimitation of the Study

This study is delimited to Burayu preparatory school students in Oromia National Regional State. Due to resource issues the study particularly emphasized at Burayou preparatory school class room and co -curricular activities. The study will help the researcher to obtain information easily and communicate the informants regularly as he too is staff member.

3. Materials and Methods

3.1. The Study Area

The study was conducted in Burayu special zone (Burayu town); Oromia National Regional State in 2008 E.C. Burayu is a town located 12 Kms west of Addis Ababa. According to the information obtained from the town health office, which is based on the central statistics agency report, the current (2008 E.C.) total population of the town is 91,089 with sex distribution of 51 percent (46455) males and 49 percent (44634) females.

In the town there is only one governmental preparatory school which in compass a total population of 542 (260 male and 282 female) students.

3.2. Sources of Information

The source of information mainly focuses on the informants. Accordingly, preparatory school girls and boys are the primary sources of data and information. Equally school teachers, principals, the town educational office supervisor and authorized personnel's were also included as sources of information. This helped the researcher to cross check data / information and reach sound conclusion.

3.3. Population Sample

3.3.1. Student Sample Population

Burayu preparatory school has a total population of 542 (male 260, female 282) students attending in grade 11 and 12 In 2008 E.C. academic year. Out of the total population 162 students (Male 78, Female 84) were included in the study through the simple random sampling technique. The detail population sample size in terms of grade, sex and academic stream is indicated in Table 1.

Table1. Number of student population used for the study (30% of the total population size)

Grades	Stream	M		F		Total	
		No	%	No	%	No	%
11	Natural Science	27	34.6	27	32.14	54	33.33
	Social Science	14	17.9	15	17.85	29	17.9
12	Natural Science	29	37.2	22	26.2	51	31.48
	Social Science	8	10.3	20	23.8	28	17.28
	Total	78	100	84	100	162	100

The technique of selecting the sample population for the study was simple random sampling, using a lottery method. Hence, all members of the population had an equal chance of being chosen in the sample.

The knowledge and attitude of the school teachers together with their readiness and willingness to help their students on issues related to SRH has also been addressed. Accordingly, the researcher has distributed a self-administered questionnaire to 23 teachers (male 16 and female 7) which is the total teaching staff of the school and gathered information on SRH. Questionnaire and desk interview has also conducted with the school director, vice director, preparatory school supervisor and educational office authorized personnel's which contain a total of 5 workers, (male 3 and female 2).

3.3.2. School Teachers who are Engaged in the Study

The teaching staff of Burayu preparatory school contains 23 teachers of which 16 are males and 7 are females. Because of the manageable size/number of the teachers, the researcher preferred to take the whole

number of teacher's idea and opinion concerning sex, sexuality and SRH issues.

3.3.3. Principals and Authorized personnel who are Incorporated in the study

The school principals, the town educational office supervisor and authorized personnel's have also been the source of information during the study. Their number is 5 with 2 school principals, 1 preparatory school supervisor and 2 educational office authorized personnel.

3.4. Data organization

The researcher conducted a questionnaire-based cross-sectional study to assess the knowledge, attitude and skills on SRH among adolescents attending in Burayu Preparatory School. A structured and self-administered questionnaire with both close and open ended questions which contains 20 items has been prepared to collect data and information from the respondents. The questions was prepared in English and then translated to Afan Oromo language for its appropriateness and easiness. The translated questionnaire was checked by Afan Oromo language experts for its perfection. The questions before filled by the informants, were pilot tested and assessed for ambiguity, clarity and comprehensibility. Then based on the feedbacks the question items were corrected, modified and enriched.

The questionnaire has been distributed with a short orientation session on how to respond. The researcher and some subject teachers supervised the completion of the questionnaire which took about two periods (one and half hours). There was strict examination condition so that the students can provide their own opinion without making any discussion with each other. Responses were collected within that day ensuring the return back of the whole questionnaires.

A questionnaire containing 13 items with both open and close ended items were also distributed to the school teachers so that they can provide their suggestions regarding SRH status of their students. Questionnaire with 10 items has also been distributed to the school principals, supervisor and educational office personnel. Desk interview were also conducted with the school principal.

Finally, responses from all respondents were collected, organized in tables and then analyzed using percentage.

4. Result

4.1. Knowledge of Students on Menarche, Pregnancy and Condom Usage

The knowledge of student on some basic issues concerning SRH like that of menarche, pregnancy, the abstinence method of birth control and the effectiveness of condom usage in preventing pregnancy has been shown in Table 2.

One hundred forty two (87.6%) of them have responded with the chance of getting pregnant, if a woman who has reached menarche involved in an unprotected sexual intercourse.

Twelve (7.4%) disagree (negatively responded) and 8 (4.9%) of them do not know about the issue. One hundred forty four (88.9%) of the respondents knew that abstinence is the best method of preventing unwanted pregnancy. Fifteen (9.2%) disagree and 3(1.9%) of them do not know.

One hundred thirty eight (85.2%) correctly pointed out as STIs including HIV/AIDS and unintended pregnancies can be prevented by effective usage of condom. Nine (5.6%) disagree and 15 (9.2%) of them do not know.

Table2:- Students basic knowledge on menarche, pregnancy, abstinence method of birth control and condom usage to avoid STI/HIV/ADIS in percentage

No	Items	Options							
		Agree		Disagree		I don't know/not sure		Total	
		No	%	No	%	No	%	No	%
2.1.	Females who have reach menarche can become pregnant if they have un protected sexual intercourse.	142	87.6	12	74.4	8	4.9	162	99.9
2.2.	Sexual abstinence is the best method to prevent unwanted pregnancy.	144	88.9	15	9.2	3	1.9	162	100
2.3.	Pregnancy and sexually transmitted infections including HIV/ADIS can be prevented by using condoms during sexual intercourse.	138	85.2	9	5.6	15	9.2	162	100

4.2. Knowledge on the Fertile Day of a Woman

The knowledge on the fertile day of a woman shows that, 82 (57.7%) of the respondents can not indicate the fertile day of a woman in between two menstrual cycles.

Forty two (21.8%) know as it can occur at the end of one month and the beginning of the next month, 31 (21.8%) replied as they did not know and 9 (6.3%) said that pregnancy could possibly occur at any time within a month.

It is only 60 (42.3%) students who have correctly replied that pregnancy could possibly occur at around half way between a woman's menstrual cycles as indicated in Table 3.

Table 3: - Students basic knowledge on the fertile day of a woman.

No	**Item**	**Options**									
		A		B		C		D		Total	
2.4.	If your answer to q 2.1 is agree, when do you think pregnancy could possibly occur? A. At any time of the month B. About half way b/n her menstrual cycle. C. At the end of one month and beginning of the other. D. I don't know.	No	%	No	%	No	%	No	%	No	%
		9	6.3	60	42.3	42	29.6	31	21.8	142	100

4.3. Grade Levels in which Students First Learn about SRH Content

The grade level in which students first encountered with SRH content has been requested and responses were given. Accordingly, 117 (72.2%) have witnessed that they have started to learn at primary school during their study in grades 5-6. Reproductive organs (male and female), STIs including HIV/AIDS and abstinence from sexual intercourse are some of the key concepts that students can remember from their studies in these grades. Forty one (25.3%) of the respondents indicated that as they have learned in upper primary school (grade 7-8) and the key concepts they can remember are human reproductive organs, changes at puberty, menstrual cycle, contraceptive usage and STIs including HIV/AIDS. Very few respondents 4 (2.5%) said that they have started in grades 9-10 and none of the respondents took the issue to grade 11 & 12 as tabulated in Table 4.

Table 4:- Grade levels in which students first learn about SRH

No	Item	Grades (options)									
		5-6		7-8		9-10		11-12		Total	
		No	%	No	%	No	%	No	%	No	%
2.5.	In which grade did you learn about sexual reproductive health for the first time? And key topics you remember.	117	72.2	41	25.3	4	2.5	-	-	162	100

4.4. Students' Understanding about SRH

Students' understanding about SRH issues has been responded by informants as follow. Fifty two (32.1%) of them responded as it is the right to choose when and with whom to deal in sexual matters and 49 (30.2%) of them replied as it is access to health information and services. Forty four (22.7%) of them witnessed as it is concerned with sexually transmitted infections including HIV/AIDS as indicated in Table 5.

Table 5: - students' understanding about SRH

No	Items	Options									
		Family planning		Access to health information and services		The right to choose when and with whom to have sex		STIs/HIV/ ADIS		Total	
		No	%	No	%	No	%	No	%	No	%
2.6.	In your understanding, what is sexual reproductive health all about?	17	10.5	49	30.2	52	32.1	44	27.2	162	100

4.5. Preference of Adolescents from whom to learn about SRH

Item 2.7 which deals with preference of adolescents in learning about SRH has been responded differently. Some respondents restrict their choice to 3-5 most appropriate alternatives while others have ranked from 1-7 as required by the researcher. Despite this, the alternatives (a - g) have been responded by different number of informants.

Seventy four (49.7%) choose parents as the first most appropriate body while 32 (21.4) considered parents as the second most appropriate alternative. Health professionals are preferred by 55 (35.9%) respondents in the first place and by 32 (20.9%) in the second.

School teachers are preferred to be the responsible groups by 50 (34.2%) and43 (29.5%) respondents next to the parents and health professionals as discussed in the above paragraph. On the other side, the table shown that religious leaders are placed to be the fifth appropriate alternative and are preferred by 39 (29.5%).

Forty five (30%) of the informants preferred peers in the fourth most appropriate place and 31 (20.8%) selected them in the second place. Social networks and mass media are preferred in the 6th and 7th levels by 54 (38.3%) and 53 (37.9%) of the respondents respectively as shown in Table 6.

Table 6: - Opinion of adolescents in informing about SRH during their developmental ages

In your opinion, among the following who do you think is the most appropriate in teaching adolescents about sexual reproductive health? (Please rank in terms of your opinion).	1st most		2nd most		3rd most		4th most		5th most		6th most		7th most		total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
a) Parents	74	49.7	32	21.4	18	12.1	8	5.4	12	8.1	2	1.3	3	2	149	100
b) Health professional	55	35.9	30	19.6	32	20.9	17	11.1	9	5.9	5	3.3	5	3.3	153	100
c) School teachers	14	9.6	43	29.5	50	34.2	24	16.4	8	5.5	6	4.1	1	0.7	146	100
d) Religious leaders	3	2.3	10	7.9	13	9.8	22	16.7	39	29.5	20	15.1	25	18.9	132	99.9
e) Peers	6	4	31	20.8	22	14.8	45	30	25	16.8	13	8.7	7	4.7	149	99.8
f) Social network	6	4.3	1	0.7	5	3.5	12	8.5	26	18.4	54	38.3	37	26.2	141	99.9
g) Mass media	1	0.7	8	5.7	9	6.4	18	12.9	20	14.3	31	22.1	53	37.9	140	100

4.6. Students' Opinion on the Correct Age to Inform to Children about SRH

Fifty seven (35.2%) of the respondents have chosen 10 – 12 age category and almost equal number of respondents, 53 (32.7%) preferred age 13 -15 years. Eighteen (11.1%) and 28 (17.3%) have responded as the 16 – 17 years and the 18^{+} years are the correct age to reach adolescents respectively.

Opinion of informants on the correct age to discuss and tell about SRH to children is shown in Table 7.

Table 7: - Students' opinion on the correct age to inform to children about SRH

No	Items	Options for Correct age											
		7-9 years		10-12 years		13-15 years		16-17 years		18+ years		Total	
		No	%	No	%	No	%	No	%	No	%	No	%
2.8.	What do you think is the correct age to inform to children about SRH?	6	3.7	57	35.2	53	32.7	18	11.1	28	17.3	162	100

4.7. Attitude of Students on Sexual Intercourse and Condom Usage

Table 8 shows attitudes of adolescents on sexual practices and condom usage during their first sexual intercourse.

One hundred twenty four (76.5%) of the informants have responded as they never had sexual practice. Twenty three (14.2%) have witnessed that they have practiced it and 15 (9.3%) are the non-respondent group.

Among the respondents who have experienced sex i.e. 23; 15 (65.2%) of them did not use condom during their first sexual intercourse while only 7 (30.4%) have used. One (4.3%) respondent did not respond to this item.

Table 8: - Attitude of students on sexual intercourse and condom usage during their first intercourse

No	Items	Options							
		Yes		No		No response		Total	
		N	%	N	%	N	%	N	%
3.1.	Have you ever had sexual intercourse?	23	14.2	124	76.5	15	9.3	162	100
3.2.	If yes, did you use condom for the first time you had sexual intercourse?	7	30.4	15	65.2	1	4.3	23	99.9

4.8. Frequency of Condom Usage at Sexual Intercourse

Ten of the informants have witnessed as they use condom during sexual intercourse. Out of this, it is only 3 (30%) who used it always. Five (50%) used most of the time and 2 (20%) used some times. The rate at which adolescents use condom has been tabulated in Table9.

Table9: Adolescents' frequency of condom usage at sexual intercourse

No	Item	Option									
		Always		Most of the time		Sometimes		Not at all		Total	
		No	%	No	%	No	%	No	%	No	%
3.3.	How often did you use condom during Intercourse?	3	30	5	50	2	20	-	-	10	100

4.9. Adolescents' / partners contraceptive usage

Table 10 shows the contraceptive usage practices among adolescent or her /his partner. Thirty seven (22.9%) of the respondents either themselves or their partner are clients of family planning services. One hundred five (64.8%) of respondents have confirmed that they did not use contraceptives at all and 20 (12.3%) are not sure.

Table 10:- Adolescents / partner contraceptive usage.

No	Items	Options							
		Yes		No		Not sure		Total	
		No	%	No	%	No	%	No	%
3.4.	Did you/your partner ever used contraceptive?	37	22.9	105	64.8	20	12.3	162	100

4.10. Adolescents' Attitude to Solve Unintended Pregnancy

Item 3.5 of the questionnaire intended to investigate adolescents' most preferred advice to a friend in case she faced unintended pregnancy. In order to get this response as shown in Table 11, seven options were listed and the students were asked to prefer one or more in terms of their preferences. Accordingly a good majority of the respondents have limited their preferred solution to 3-5 alternatives while others listed all the preferences or alternatives listed in the questionnaire. From the responses it was observed that majority of the students have more than one choice or preferences. In addition, the preferences vary from informant to informants

based on their background information and exposure they made to each one of the preferences.

Fifty four (37.5%) and 53 (36.8%) respondents suggested to inform the case to parents in the 2nd and 1st places respectively. Sixty three (42.3%) of the respondents suggested their advice to visit a clinic prior to all. Forty one (34.7%) and 37 (31.6%) informants gave their advice to discuss the condition with a concerned person in the 3rd and 4th places respectively.

Thirty six (35%) and 30 (29%) informants advised to take medicines to solve the problem as the 4th and 5th alternatives. Another 24 (29.3%) and 22 (26.8%) advice providers suggested to drop out of school in the 6th and 7th ranks. Abortion as a solution is the least choice as it is suggested by 22 (26.8%) and 20 (24.4%) in the 6th and 7th places as indicated in Table 11.

Table 11: - Students Attitude to Solve Unintended Pregnancy Problem

No	Item	I will advise her to...															
		1st best advice		2nd best advice		3rd best advise		4th best advice		5th best advice		6th best advice		7th best advice		Total	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
3.5	What do you do if one of your friends faced unintended pregnancy problem?																
	a) inform to parents	53	36.8	54	37.5	25	17.4	4	2.8	3	2.1	2	1.4	3	2.1	144	100
	b) visit clinic	63	42.3	49	32.9	29	19.5	4	2.7	1	0.7	1	0.7	2	1.3	149	100
	c) visit traditional healer	5	6	10	11.9	13	15.5	25	29.8	9	10.7	14	16.7	8	9.5	84	99.9
	d) take medicine	1	1	13	12.6	6	5.8	36	35	30	29	14	13.6	3	2.9	103	99.9
	e) drop out of school	1	1.2	2	2.4	4	4.9	12	14.6	17	20.7	24	29.3	22	26.8	82	100
	f) abort it	4	4.9	3	3.7	6	7.3	10	12.2	17	20.7	22	26.8	20	24.4	82	100
	g) Discuss with the concerned person.	37	31.6	13	11	41	34.7	11	9.3	7	5.9	4	3.4	5	4.2	118	100

4.11. School SRH Club Participation

One hundred seventeen (72.2%) of the informants confirmed that they did not participate in school SRH club. Forty one (25.3%) of them said that they participate and 4 (2.5%) are not sure.

The reasons behind their not participation have been asked and replied as:-

Ninety two (78.6%) of them have verified as there is not SRH club in their school. Fifteen (12.8%) have no interest in SRH club and 10 (8.5%) are due to inconvenience of club activity time.

Adolescent's school SRH club participation is indicated in Table 12.

Table 12:- Adolescents' school SRH club participation and their reasons why they do not participate

No	Items	Options															
		Yes		No		Not sure		No club activity		Not interested		Inconvenience of time		Other		Total	
		No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
3.6	Do you participate in SRH club activities in your school?	41	25.3	117	72.2	4	2.5									162	100
3.7	If your answer to Q 3.6 is no, why you don't participate?							92	78.6	15	12.8	10	8.5	1	1	117	99.9

4.12. SRH Contents in Tests and Exams

One hundred eighteen (72.8%) of the student informants verified as the issue is not treated in their group assignments while 34 (21%) said it does and 10 (6.2%) of them are not sure.

Ninety (55.6%) have also witnessed as the content is not treated in their tests and exams. Fifty two (32.1%) of them said that it does and 20 (12.3%) are not sure.

The inclusion of SRH contents in the school formal education including group assignments, tests and final exam is indicated in Table 13.

Table 13: - Responses of adolescents on the incorporation of SRH issues in their test and exam

No	Items	Options							
		Yes		No		Not sure		Total	
		No	%	No	%	No	%	No	%
3.8.	Do you take group assignments to discuss on sexual reproductive health issues?	34	21	118	72.8	10	6.2	162	100
3.9.	Is sexual reproductive health issue included in your mid-exam and final exam?	52	32.1	90	55.6	20	12.3	162	100

4.13. Knowledge and Attitude of School Teachers on SRH

Fourteen (60.9%) of teachers strongly agree and 7 (30.4%) agree with the role that family background and environment can play in affecting children SRH knowledge and attitude. One (4.3%) disagree and another 1 (4.3%) not sure.

The contribution of diet of children and exposure to movies that focus on sexuality in aggravating early puberty have been supported by 10 (43.5%) strongly agree and 9 (39.2%) agree respondents. Three (13%) disagree and 1 (4.3%) not sure.

Eight (34.8%) strongly agree and 12 (52.2%) agree with the contribution of mass media and social net works in offering correct information on SRH related issues to adolescents. One (4.3%) disagree and 2 (8.7%) not sure on the roles of mass media and social networks.

Only 9 (39.1%) of the respondent agree and 5 (21%) strongly agree that they are knowledgeable and ready to teach their students on SRH contents. 8 (34.8%) disagree and 1 (4.3%) of them are not sure about their SRH knowledge.

Almost half of the respondents, 11 (47.8%) have witnessed their students do not have basic knowledge attitude and skills on SRH. Three (13%) strongly agree and 7 (30.4%) agree that their students are knowledgeable while 2 (8.7%) of them are not sure.

The school teacher's knowledge and their readiness to help students on SRH topics have been given in Table 14.

Table 14:- The knowledge and attitude of school teachers to help their students on SRH.

No.	Item	Options									
		Strongly agree		Agree		Disagree		Not sure		Total	
		No	%	No	%	No	%	No	%	No	%
2.1	Family background and the environment in which adolescents grow will affect their knowledge about SRH.	14	60.9	7	30.4	1	4.3	1	4.3	23	99.9
2.2	Mass media and social networks can offer correct information on SRH to adolescents	8	34.8	12	52.2	1	4.3	2	8.7	23	100
2.3	Diet of children and exposure to movies that focus on sexuality can aggravate the occurrence of early puberty.	10	43.5	9	39.2	3	13	1	4.3	23	100
2.4	As a trained teacher, you are knowledgeable on SRH and teach your students concerning SRH contents effectively.	5	21.7	9	39.1	8	34.8	1	4.3	23	99.9
2.5	Students in your school have basic knowledge, attitude and skill on SRH.	3	13	7	30.4	11	47.8	2	8.7	23	99.9

4.14 Teachers' opinion on most appropriate body in teaching adolescents about SRH

School teachers are included to respond to the list of alternatives so that they choose most appropriate and comfortable body in teaching SRH to students. In this regard, teachers are invited to respond by selecting different options listed under.

Accordingly, 13 (56.5%) and 4 (17.4%) of the informants placed parents in the first and second level respectively. Five (21.7%) have considered that health professionals to be the right groups to teach adolescents on issues related to SRH in the third and fourth places equally. Six (26.1%) and 5 (21.7%) respondents preferred school teachers in the fifth and third places while 4 (17.4%) preferred them in the first and second place equally.

In the table, among the alternatives, "Peers" has been ranked as the third most appropriate body by 6 (26.1) and as the second and fifth by equal number of informants i.e. 4 (17.4%). Religious leaders are preferred by 7 (30.4%) of the informants in the 8th rank. Four (17.4%) and 5 (21.7%) informants preferred religious leaders in the 6th and 7th places respectively.

Mass media and social net works preferred by 7 (30.4%) and 11 (47.8%) in the 6th and 8th ranks respectively. Four (17.4%) select mass media in the second and third places equally while 5 (21.7%) and 3 (13%) have preferred social networks in the 4th and 5th ranks in order.

School club has been chosen by 6 (26.1%) in the fifth place. Four (17.4%) and 3 (13%) have also ranked school club in the second and sixth places. Preferred opinion of school teachers on the most appropriate group in teaching adolescents on SRH issues is tabulated in Table 15.

Table 15:- Teachers' opinion on the most appropriate body in teaching adolescents about SRH

No.	Item	Options																	
		1st most appropriate		2nd most appropriate		3rd most appropriate		4th most appropriate		5th most appropriate		6th most appropriate		7th most appropriate		8th most appropriate		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2.6	In your opinion, among the following groups who do you think is/are the most appropriate and comfortable in teaching adolescents about SRH?																		
	a) Parents	13	56.5	4	17.4	2	8.7	-	-	1	4.3	2	8.7	-	-	1	4.3	23	99.9
	b) Health professionals	3	13	2	8.7	5	21.7	5	21.7	-	-	3	13	3	13	2	8.7	23	99.8
	c) School teachers	4	17.4	4	17.4	5	21.7	3	13	6	26.1	-	-	1	4.3	-	-	23	100
	d) Peers	3	13	4	17.4	6	26.1	1	4.3	4	17.4	2	8.7	3	13	-	-	23	99.9
	e) Religious leader	1	4.3	-	-	2	8.7	3	13	1	4.3	4	17.4	5	21.7	7	30.4	23	100
	f) Mass media	-		4	17.4	4	17.4	1	4.3	3	313	7	30.4	4	17	-	-	23	99.9
	g) Social network	-	-	1	4.3	-	-	5	21.7	3	13	3	13	-	-	11	47.8	23	99.9
	h) School clubs	-	-	4	17.4	2	8.7	4	17.4	6	26.1	3	13	3	13	1	4.3	23	99.9

4.15. Preferred Advice of School Teachers in Case Unwanted Pregnancy has happened

Table 16 of the study discusses the different options that intend to solve unwanted pregnancy problem of school- going girls by teachers. Accordingly, list of alternatives have been responded by different number of the informants.

Fourteen (60.9%) and 7 (30.4%) of them gave their advice to inform the problem to parents as the second and the first solution respectively. Seven (43.6%) and 4 (25%) of the respondents suggest to visit health institutions in the third and second places. Another 13 (56.5%), 4 (17.4%) and 3 (13%) of the informants gave their advice to discuss with the concerned friend / person in the first, second and third places in order.

Among the list of alternatives, dropping out of school, abortion or visit traditional healers have been responded by insignificant number of respondents i.e. maximal by two (22.2%) is placed as the seventh alternative .

Table:- 16 Preferred advice of school teachers to a student who has faced unintended pregnancy

No.	Item	1st best advice		2nd best advice		3rd best advice		4th best advice		5th best advice		6th best advice		7th best advice		8th best advice		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2.7	What do you if one of your students faced unintended pregnancy problem? I will advice her to																		
	a) Inform to parent	7	30.4	14	60.9	1	4.3	-	-	-	-	-	-	-	-	1	4.3	23	99.9
	b) Visit clinic	1	6.3	4	25	7	43.6	1	6.3	2	12.5	-	-	1	6.3	-	-	16	100
	c) Visit traditional healer	-	-	1	11.1	2	22.2	1	11.3	2	22.2	1	11.3	2	22.2	-	-	9	100
	d) take medicine	1	12.5	-	-	1	12.5	2	25	1	12.5	1	12.5	2	25	-	-	8	100
	e) Drop out of school	1	16.7	1	16.7	-	-	-	-	1	16.7	1	16.7	2	33.3	-	-	6	100
	f) Abort it	-		4	17.4	4	17.4	1	4.3	3	13	7	30.4	4	17	-	-	23	99.9
	g) discuss with the concerned friend or person.	13	56.5	4	17.4	3	13	2	8.7	-	-	1	4.3	-	-	-	-	23	99.9

4.16. Appropriate Age to Discuss SRH Issues to Daughters

Nine (39.1%) and 8 (34.8%) of the informants pointed out as the 13-15 years and 10-12 years of age category are the correct time to discuss on SRH with their daughters. Two (8.7%) preferred 7-9 years and 1 (4.3%) took the issue to 16-17 years. Three (13%) of them preferred the 18+ age category.

School teacher's opinion on the correct age to inform SRH issues to her/his daughter is tabulated in Table 17.

Table 17:- Teacher's opinion on the appropriate age to inform to his/her daughter about SRH

No.	Item	Options											
		7-9 years old		10-12 years old		13-15 years old		16-17 years old		18+ years old		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
2.8	Suppose you do have a daughter, at what age do you think is appropriate to inform her about SRH?	2	8.7	8	34.8	9	39.1	1	4.3	3	13	23	99.9

4.17. Availability of SRH Related Contents in the School Curriculum

Seventeen (73.9%) teachers responded as SRH related topics are not incorporated in the subject they are teaching. It is only 5 (21.7%) who have witnessed incorporation of the content in their subject. One (4.3%) teacher is not sure.

Response of school teachers on the availability of SRH related contents in the subject area they teach is indicated in Table 18.

Table18. Teachers' response on the availability of SRH related content in the subject area they teach

No.	Item	Options							
		Yes		No		Not sure		Total	
		No.	%	No.	%	No.	%	No.	%
2.9	Is there any unit or topic(s) in your subject area that deals with puberty, sexuality and sexual reproductive health?	5	21.7	17	73.9	1	4.3	23	99.9

Items 2.12 and 2.13 of teachers' questionnaire seek to gather information about the role that schools can play to avoid unwanted pregnancy among adolescents and how to equip them with the informed decision making techniques on SRH. Almost all respondents have emphasized on the need

to incorporated SRH contents in a formal school curriculum and the establishment of strong SRH club in the school.

The opinion of school principals, preparatory school supervisor and educational office authorized personnel on the sexual and reproductive health issues at the school level has been requested and the responses were analyzed based on the type of items provided.

Almost all of the respondents, 5 (100%) have agreed as educating adolescents on SRH topic is the priority of schools.

4.18 Opinion of School Principals and Authorized Personnel in Teaching Adolescents on SRH

Four (80%) of the respondents preferred parents in the first place and 1 (20%) put parents in the second place.

Three (60%) preferred health professionals as the third most appropriate alternative and school teachers are preferred equally by 2 (40%) in the first and second most appropriate position.

The roles that peers can play have been placed in the fourth and seventh places by 2 (40%) of the respondents equally. Religious leaders took the fifth rank by 2 (40%) and mass media and social networks are preferred in the seventh and sixth places by 2 (40%) and 3 (60%) of the informants respectively.

Responses of school principals and educational office personnel in teaching adolescents about SRH content is indicate in Table 19.

Table 19 :- Opinion of school principals and educational office authorized personnel in teaching adolescents about SRH

No.	Item	1st most appropriate		2nd most appropriate		3rd most appropriate		4th most appropriate		5th most appropriate		6th most appropriate		7th most appropriate		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1.1	In your opinion, among the following groups whom do you think is/are the most appropriate and comfortable in teaching adolescents about SRH?																
	a) Parents	4	80	1	20	-	-	-	-	-	-	-	-	-	-	5	100
	b) Health professionals	-	-	1	20	3	60	1	20	-	-	-	-	-	-	5	100
	c) School teachers	2	40	2	40	-	-	-	-	-	-	1	20	-	-	5	100
	d) Peers	-	-	-	-	-	-	2	40	1	20	-		2	40	5	100
	e) Religious leader	-	-	-	-	1	20	1	20	2	40	1	20	-		5	10
	f) Mass media	-	1	-	20	1	20	1	20	-	-	-	-	2	40	5	10
	g) Social network	-	-	-	-	-	-	-	-	2	40	3	60	-	-	5	100

4.19. Opinion of principals on the basic knowledge of students and teaching staffs about SRH

Item 2 and 3 of school principals and authorized personnel questionnaire seek to gather information on the basic knowledge of adolescents, teachers and administrative staffs.

The informants reacted that as the students under study do not have the required basic knowledge, skill and attitudes on SRH. As to the principals and authorized personnel opinion the school teachers and administrative staffs have some basic knowledge on SRH issues.

4.20. Responses of principals and authorized personnel on the availability of subjects that treat SRH

About 3 (60%) of the school principals and personnel from educational office responded as there is no subject that treat SRH to students while 2(40%) of them have witnessed as SRH content is treated in biology, civics and ethical education and English texts although it lacks depth and scop to raise up their knowledge level as needed.

They all agreed on the incorporation of SRH contents as a stand alone subject in the curriculum or treating it by integrating in other subjects in more detail.

4.21. Availability of Facilities and Services

All informants have reached consensus on the need of facilities and services such as guidance and counseling on life skills, safest area for girls to keep personal hygiene during menstruation and supply of items related to menses at school level.

4.22. Situation of Co-curricular Learning Activities on SRH

Concerning co-curricular activities to promote sexual reproductive health in the school context, informants mentioned as there is no club and club activities in the school under study. They all have agreed on the essentiality of co-curricular activities.

4.23. Correct Age Category to Tell about SRH to Children

Table 20 shows the correct age category to inform about SRH to children as forwarded by school principals and educational office authorized personnel.

Four (80%) of the respondents preferred the 10-12 years age category while 1 (20%) preferred the 13 -15 years age group.

Table 20:- Appropriate age category to inform about SRH to children's as preferred by school principals and educational office authorized personnel.

No.	Item	7-9 years old		10-12 years old		13-15 years old		16-17 years old		18+ years old		Total	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
7	Suppose you do have a daughter, which age do you think is appropriate to inform her about SRH?	-	-	4	80	1	20	-	-	-	-	5	100

4.24. Number of Girls who have dropped out of School due to Unintended Pregnancy

Item 9 of the questionnaire intended to collect information on the consequences of unintended pregnancy among school going girls during the investigation academic year.

Most of the respondents can not tell as what has happened to girls due to unsafe sex during their stay around the school.

The school principal has witnessed as there are two girls who quit their education due to unintended pregnancy in this academic year.

Item 10 of the questionnaire focused on the mechanisms the school need to apply at school level to reach adolescents before problems concerning SRH will occur.

The item were addressed by 4 (80%) of the respondents and they all pointed out on the need for the inclusion of SRH related contents in all subjects as much as possible.

Establishing SRH club and working with the concerned bodies is another key measure to be taken. To recruit trained person and provide guidance and counseling service at the school compound has also been mentioned.

5. Discussion

Knowledge of students on menarche, pregnancy, sexual abstinence and the importance of condom is good. The majority of respondents, more than 87%, have basic orientation on these important issues and seem to protect themselves from SRH related complexes. As to Azrian et al. (2011) the majority of the students (79.8%) knew sexual abstinence is the best method to prevent pregnancy. Adolescents should be educated abstinence from sexual intercourse is the most effective method to prevent pregnancy and STIs including HIV/AIDS. Although students knew the role of condom in preventing unintended pregnancy, consistent usage of it during sexual intercourse is not satisfactory. Adolescents who have basic orientation about menarche, pregnancy and condom usage seem more communicative and also seem to have the better solution at their capacities. Such knowledge should be encouraged and need to be scaled up through school based interventions. From the study, the other few percent seem to have devoid of this information. This group, although their number seems small, as the problem is grave to young lives and leads to life complications, need to be addressed with SRH related education as it is the base for healthy and safest way of life.

Students under investigation have indicated as they have first learned about SRH in primary school i.e. grade 5-6. They have also mentioned some key concepts that they can remember from these grades. A review of curriculum also indicates that, SRH related contents start to be given from grade 5 on wards as part of subjects like environmental science (e.g. Body parts), civic and ethical education (e.g. family) and in biology in upper primary grades up to grade 8 (e.g. HTPs, Human Reproductive organs, HIV/AIDS, STIs etc.) (UNESCO, 2014 a). In all grade levels the content of SRH is introduced as part of related chapters like human reproduction, contraceptive methods, STIs including HIV/AIDS and the like. Adolescents preferred to be informed SRH concerns primarily by their

parents, health professionals and school teachers than any other bodies. This result is in line with other reports in which adolescents asked from whom they would prefer getting information, and their most frequently named sources were parents (34%) and physicians (33%) (Romero de Castilla Gil et al. 2001). In another similar study, the preferred sources of information about sexuality especially among young females is the parents, particularly mothers. However, parents may assume their children are unlikely to engage sexual relations or are not mature enough to be educated regarding this subject (Ann et al. 2001). Apart from this finding, the study conducted by Kasiye et al. (2014), showed TV and the school are the primarily sources of information which are account for 48.3% and 42.6% respectively. Only 28.8%and 24.3% of the respondents witnessed friends and mothers were their SRH issue information sources respectively. The gap of knowledge that cannot be obtained from these preferred bodies may lead adolescents to seek it from peers, faith and faith – based institutions and the media which they do not prioritize.

Students' opinion on the correct age to inform SRH issues to children is good. Early age category i.e. 10 – 12 and 13 – 15 years have been preferred as the correct time to give information and create awareness among adolescents on SRH. This age groups is also taken as the right time by the school teachers, school principals and educational office authorized personnel. As to the study conducted by Azrian et al. (2011), on Malaysian adolescents, early exposure to sexual and reproductive health information may provide students with better information to make choice since the age of first sexual intercourse for both male and female Malaysian adolescents has been reported to be as young as nine years old. This supports the need to begin sexual and reproductive health education earlier in many schools (WHO, 2005). The researcher too believes as early age category is correct to reach adolescents just before and around the onset of puberty. The 18+ year category respondents are too late to reach adolescents on SRH issues because adolescents at this age group have already exposed to

different environmental and social pressures. Therefore, it needs to give special emphasis to those who have preferred this age category.

Over 76% of the students under study did not involve in sexual activities; which is a good practice for adolescents to keep themselves away from the consequences of early sexual debut and stay in school. The non condom users among those who have involved in sexual activity are too high denoting that their chance of exposure to unsafe sex related consequences such as unintended pregnancy, unsafe abortion, STIs including HIV/AIDS, dropping out of school and other personal and social evils are significant. Therefore, awareness creation education on condom usage and its role in preventing unsafe sex related consequences need to be addressed on time.

Condom usage frequency among adolescents is inconsistent. About 30% of the informants used it always, 50% most of the times and 20% sometimes. On the other hand, the finding from other study shown that 26.7% used it always, 21.6% occasionally and 51% used rarely during sexual intercourse (Soboka and Kejella, 2015). The inconsistent usage of condom during sexual contacts is a sign of danger, warning that most of the adolescents are in a great risk of health problems associated with that of early and unprotected sexual behavior.

The contraceptive knowledge of adolescents is very good as they can mention the requested three types of contraceptive methods under the open ended item 3.10. Almost all informants can mentioned the different types of contraceptive techniques by emphasizing on abstinence method, condom, oral contraceptives, calendar or rhythm method etc. The majority of respondents 105 (64.8%) did not use contraceptive at all. This is may be due to their not engagement in sexual activities as indicated in Table 8 item 3.1.

Adolescents preferred their parents prior to all to solve unintended pregnancy problem. Although the roles that parents can play in solving

their children's problems are crucial, most Ethiopian parents hardly discuss SRH related issues with their children due to cultural taboos. The adolescents' need and cultural taboos create a significant gap between parents and children which could be a hindrance for adolescents to acquire the required knowledge and life skills.

Tendencies of adolescents to visit clinics and get advice from health professionals are also very good. But it needs a genuine response and good hospitality from the service providers. Discussing about the problem and seeking solution with a concerned person/friend, which is placed in the 3rd and 4th most appropriate rank, is also good. But most concerned individuals fail to accept themselves as part of the problem and turn their face away from the condition.

The number of respondents who rely on abortion, dropping out of school and taking medicines is very few (see Table 11). This is an acceptable or correct attitude to keep adolescents away from risk taking practices. Although their number is few, it signifies the need to address adolescents with SRH education through curricular and co-curricular activities to equip them with essential life skill techniques for their future life.

Over 78% of informants have witnessed as there is no SRH club in the school under study. The researcher, being a staff member of the school, can also forward his witness words as there has been no SRH club in this and the previous academic years. He also wants to suggest his opinion for the establishment of SRH club in the school. Services provided through SRH club are of a significant importance for adolescents particularly for girls who might quit their education due to SRH related complications.

Over 72.8% of the informants have witnessed as SRH related contents are not incorporated in group assignment, tests and exams while 21% of them have confirmed its inclusion. The opinion inconsistence among respondents might arise due to the incorporation of certain topics like that of reproductive organs, STIs including HIV/AIDS, contraceptive methods

and the likes under some subjects like that of biology, civics and geography. Although about 87% of the school teachers agreed on the correctness of information obtained from mass media and social network, they preferred it in the sixth and seventh ranks in teaching adolescents concerning SRH which is also underlined at about the same rank by the adolescents themselves.

From the study that addressed the issue of teachers' role in the subject knowledge has indicated that significant proportion (60.1%) responded that they have sufficient knowledge and skills to integrate SRH contents into their subjects and help students fully. On the other hand nearly one-third of the teachers have witnessed that their knowledge and skills is not sufficient to help their students. According to Samkange – Zeeb (2013), sexuality education is embedded in biology lessons and hence provided by teachers who are not necessarily trained to discuss sexual issues with adolescents. Sexuality educators have to be able and be prepared to discuss intimate issues with pupils, while remaining neutral and objectives. Results of a survey conducted among teachers in Minnesota showed that a large majority of teachers teaching sexuality education had not received any training on how to teach the subject and were not prepared on how to deal with the controversial nature of the topic (Eisenberg & Madsen 2010). The finding of this study and others indicate that it needs more efforts to cope up the knowledge level of school teachers during their stay in teacher's training colleges and universities by offering SRH related courses. Efforts should also need to be done by the Ministry of Education, Oromia Education Bureau and NGOs who work on SRH to raise up the awareness level of teachers through in - service seminars and work shops.

Almost around half of the school teachers believed that as their students do not have basic knowledge, attitude and skills on SRH. This judgment

indicates as adolescents need to be addressed before they leave or dropped out of school.

School teachers preferred advice in case unwanted pregnancy has happened to a school going girl is emphasized in discussing and seeking solutions with the concerned person / friend. Parents and health professionals are considered to be the next problem solvers. Other options like that of abortion, dropping out of school and visiting traditional healers are given less attention.

The availability of SRH related content in the school curriculum has been verified by 5(21.7%) of teachers. Among the 5 respondents 2 who are language teachers (English and Afan Oromo) have witnessed as the content is treated sufficiently. The content mentioned by the Afan Oromo teacher is 'reproductive organs' while the English teacher told that it is 'the supplementary material on life skill' distributed by USAID. Three of the respondents who are biology teachers approved as the subject matter is not sufficiently treated.

Considering that the content in the English text book is supplementary material to create awareness on HIV/AIDS and the insufficiently treated content in biology texts, we can deduce that the subject matter is not well treated in the current school curriculum. Therefore, the Ministry of education, curriculum development department needs to give due attention for the incorporation of SRH related issues into related subjects in depth and scope. The need for the incorporation of SRH related content into the school curriculum has also been emphasized by almost all teachers. They have also underlined the establishment of strong SRH club which rely on inter-club activities and interactions within the school and other concerned bodies outside the school compound. Pamphlets and posters could also help to raise the awareness level of students if they are placed in the library so that adolescents can find them easily.

The responses obtained from school principals and educational office authorized personnel on the preferred body to teach adolescents about SRH issues has revolved around the roles that parents, health professionals and school teachers can play is crucial.

The school principals have pointed out that as the students under investigation do not have the required basic knowledge, skill and attitude on SRH. They have also mentioned the need for the strengthening of contents given in some subjects so that students can develop essential life skills and attitudes in their future life.

As to school principals and authorized personnel opinion, school teachers have some basic knowledge on SRH issues which is not enough to pass it to their students.

The inadequacy of teacher's SRH knowledge has also been pointed out by the teachers themselves (Table 14; item 2.4). Therefore much effort is needed from the concerned bodies to equip school teachers with SRH related knowledge, attitude and skills so that they can develop confidence to help students.

The need for the availability of services and facilities like that of guidance and counseling, safest area for girls to keep personal hygiene during menstruation and supply of items related to menses at school have been strictly underlined by the school principals and authorized personnel. Although the essentialities of such facilities are believed, none of them are available in the school under study.

The absence of safe area and essential material to manage personal hygiene during menstrual cycle forced girls to stay at home due to fear of the improperly managed discharge. This will increase the girls' absenteeism rate from school which will directly affect their educational achievement. Hence, it will be of a great benefit if the school facilitates such services in the school compound by allocating budget and co-operating with NGOs who work on SRH.

As stressed by the school principal and authorized personnel, there is no club and co-curricular activities to promote sexual and reproductive health in the school context. They all have agreed on the essentiality of co-curricular activities that practice interclub relations and interactions with other clubs particularly to that of girls club which is currently functioning in the school compound. It is also valuable if the SRH club works in collaboration with that of the mini-media club so that it can reach adolescents effectively.

The evil effect of unsafe sex and its consequences like that of unintended pregnancy has been stressed by the school director indicating that as two girls were forced to quit their education during this academic year. It needs a detail and careful study in order to reach a sound conclusion on the exact number of unsafe sex victims.

In general, the researcher would like to indicate the essentiality of the integration of SRH related issues in the current school curriculum in depth and scope so that it can equip adolescents with the required knowledge, skills and attitude for their adult life. Teachers and school principals particularly have great responsibilities in educating their students through curricular and co-curricular activities.

6. Conclusion and Recommendation

6.1 Conclusion

From the obtained results it is possible to conclude that:-

i. The students under investigation have basic orientation on some basic concepts concerning SRH related issues. Such orientation is good and need to be encouraged and scaled up through school-based intervention.

ii. Many informants fail to address the fertile day of a woman in between her menstrual cycle which could possibly expose them for unintended pregnancy and related consequences.

iii. Attitude of informants on condom usage at first sexual intercourse is very poor. Consistent usage of condom among adolescents under investigation is also very low, revealing their high chance of exposure to unsafe sex related negative consequences.

iv. Adolescents need to be informed SRH related issues primarily by their parents and they also consider their parents as the major solver of problems that may occur due to unsafe sex.

v. School teachers are not properly prepared in giving education concerning SRH issues to their students.

vi. The existing school curriculum does not contain sufficient information on SRH matters.

vii. Co-curricular activities concerning SRH are totally absent in the school under investigation.

viii. The school does not prepare safe environment and materials for girls to manage personal hygiene during menstruation.

6.2. Recommendation

Based on the results of the study, the researcher suggests the following recommendations. The researcher strongly considers that this recommendation will be given due attention by the concerned bodies and be used to improve the knowledge and attitude of adolescents so that they can acquire responsible and safest life skill.

a) It is highly advisable to improve knowledge of adolescents on sexual and reproductive health, particularly in relation to early sexual debut, unsafe sexual practices and its consequences.

b) With the context of school – parent relations, it is recommendable to engage parents in supporting their children on SRH related issues. In order to do this, emphasis need to be given to educate parents by providing seminars and conducting discussion forums so that cultural taboos are challenged and free communication between parents and children will be promoted.

c) Providing SRH related courses at teacher's training colleges and universities can help teachers to develop full confidence and address the subject. Teacher training programs both at the pre-service and in-service programs need to include all the relevant contents.

d) It is also advisable to develop curriculum on SRH contents and provide the necessary education at different grade levels in depth and scope; both in the horizontal and vertical dimensions.

e) Counseling and guidance services by allocating trained person is of a great importance and need to be given due attention.

f) The establishment of SRH club at the school level together with its interclub relations and interactions are significantly important to equip adolescents with SRH related skills for their adult life.

g) The accessibility and quality of SRH services at school level like that of preparing safe corner and essential materials for girls to manage personal hygiene during menstrual cycle is crucial to reduce girl's absenteeism from school.

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Definition of Terms

Adolescence: - a time of growing up-an intermediate point between the immaturity of childhood and the maturity of adulthood. It is a phase rather than a fixed time period in an individual's life.

Adolescent: - the world Health organization defines adolescent as an individual in the 10-19 years age group.

Comprehensive Sexuality Education: - an age – appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non – judgmental information.

Counseling: - to discuss reproductive health issues and choices, guiding the clients to make informed decision regarding his/her reproductive life while respecting confidentiality and privacy.

Gender: - differences in the social roles that societies and families expect from males and females. It is socially or culturally defined ideas about masculinity (male roles, attributes and behaviors and femininity (female roles, attributes and behaviors).

Gender Equality: - this ensures that women and men enjoy the same status and have an equal opportunity to exercise their human fights and realize their full potential to contribute towards political, economic, social and cultural development and to benefit from the result.

Gender Equity: - refers to fairness in the treatment of both males and females in all aspects of life while recognizing differences between them.

Gender Roles: - the social roles assigned to males or females by the society or family in which they live. Such roles include, for example, how they should behave or what jobs they should have.

Peer: - children or adolescent who are of about the same age or maturity.

Reproductive Health: - a state of physical, mental and social well – being, not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes.

Reproductive Rights: - are those rights specific to personal decision – making and behavior in the reproductive sphere, including access to reproductive health information, guidance from a trained professional, and reproductive health services.

Rights: - Something that an individual or a population deserves, which they can legally and justly claim.

Rights on Sexual and Reproductive Health: - these are rights specific to personal decision making and behavior on reproduction including access to reproductive health (RH) information, privacy, guidance from trained personnel, obtaining RH services free from discrimination, and no coercion or violence in one's sexual life.

Sex: - is the difference in biological characteristics of males and females, determined by a person's genes.

Sexual Coercion: - forced sex. Studies have linked sexual coercion during childhood to increased consensual, unsafe sexual activity during adolescence and also increased likelihood of multiple partner, and increased risks of unintended pregnancy, sexually transmitted infections (STIs), abortion and mental health problems.

Sexuality: - encompassed gender identity, male and female roles, eroticism, sexual orientation, pleasure, intimacy and reproduction.

Sexuality Education: - teaching and learning on issues relating to human sexuality. It encompassed education about all aspects of sexuality, including information about family planning, reproduction (fertilization, conception and development of the embryo and fetus

through to child birth) plus information about all aspects of one's sexuality including body image, sexual orientation, sexual pressure, values, decision – making, communication, dating, relationships, STIs and how to avoid them and birth control methods.

Sexually Transmitted Diseases (STDs): - diseases that are transmitted primarily through sexual contact. The contact is not limited to vaginal inter course but includes oral-genital contact as well.

Youth: - the time of life when one is young, but often means the time between childhood and adulthood (maturity). Youth is an alternative word for the scientifically oriented adolescent and the common term teen and teenager.

Young People: - refers to those between the ages of 10-24 as defined by the WHO.

Value: - reflect a persons sense of right and wrong or what "ought" to be "equal rights for all", "excellence deserves admiration", and "people should be treated with respect and dignity" are representative of values.