



**ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCE
SCHOOL OF PUBLIC HEALTH**

**THE ASSESSMENT OF THE MAGNITUDE OF RISKY SEXUAL
BEHAVIOR AND ITS ASSOCIATION WITH SELF-ESTEEM AND
OTHER COVARIATES AMONG IN-SCHOOL ADOLESCENTS IN ADDIS
ABABA: AN EXPLANATORY MIXED-METHODS STUDY.**

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

SEPTEMBER, 2021

ADDIS ABABA, ETHIOPIA

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Full title of the research project	The assessment of the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis Ababa: an explanatory mixed-methods study.
Duration of project	December 2020 to October 2021
Study Area	Addis Ababa , Ethiopia
Total cost of the project	50173 birr
Source of budget	The investigator
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ACKNOWLEDGEMENT

I would like to express my sincere gratitude and special thanks to my advisor Dr. Wubegzier Mekonnen for his unreserved guidance and constructive comments and suggestions from the inception of the title selection up to this final thesis work without whose input this work would not have been materialized. I would also like to extend my great appreciation to sub-city and woreda administrators, school leaders and heads, the data collectors, and the study participants.

Finally, I would like to thank all those individuals who indirectly contributed to the preparation of this thesis.

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ACCRONOMYS/ ABRREVIATIONS

AAU	Addis Ababa University
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CI	Confidence Interval
CSW	Commercial Sex Worker
DC	Data Collector
EDHS	Ethiopian Demography and Health Survey
HBM	Health Belief Model
HIV	Human Immune Virus
ID	Identification Number
IEC	Information Education Communication
MoE	Ministry of Education
MoH	Ministry of Health
RSBs	Risky Sexual Behaviors
SPSS	Statistical Packages for Social Science
SSA	Sub Saharan Africa
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UN	United Nations
WHO	World Health Organization

ABSTRACT

Background: Most of the sexual initiation and sexual practice of adolescents begins at secondary school which is very risky. Low self-esteem may predispose adolescents to sexual risk through negative schemata and attributions. However, not enough was done to assess the effect of self-esteem development in reduction of risky sexual behaviors among Ethiopian adolescents.

Objective: The study aims to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis Ababa.

Methods: Facility-based explanatory sequential mixed methods design was employed during December 2020- February 2021. Self-administered questionnaire was used to collect quantitative data from 629 high school students selected using a multi-stage sampling method. Quantitative data was entered to Epi-data version 3.1 and exported to STATA version-15 for analysis. Frequency distributions of variables were tabulated. Bivariable and multivariable binary logistic regression analyses were performed and p-values less than 0.05 were considered to calibrate statistical significance. The views of 18 qualitative participants selected by maximum variation sampling procedure were explored using an in-depth interview. The qualitative data were coded and classified into themes and sub-themes and findings were represented by way of a narrative.

RESULTS: A total of 605 participated in the study (response rate of 96.2%). About 248(41%) of students reported that they ever had sexual intercourse. About 546(90.3%) of the students had high self-esteem. The overall prevalence of risky sexual behavior was 160(26.5%). Perception about the risk of STIs and pregnancy (AOR=2.34; 95% CI, 1.51-3.63), self-esteem (AOR=3.48; 95% CI, 1.88-6.42), and school type (AOR=2.08; 95% CI, 1.14-3.79) were independent predictors of risky sexual behaviors. The strong reasons for the practice of risky sexual behaviors among these adolescents were perception about sexual and reproductive health, low self-esteem, school type, peer influence, substance use, pornography viewing and social media activities.

CONCLUSIONS: Over one in four high-school students have risky sexual behavior. Risk perception, self-esteem and school type are significantly associated with risky sexual behavior. Sexual and reproductive health programs for in-school adolescents should be tailored to address their specific needs by building friendly public policies; creating a supportive environment, developing personal skills, and reorienting the health services that help develop self-esteem and change poor perceptions about STIs and pregnancy.

Key words: Risky Sexual Behavior, Self-esteem, Adolescents, Students, School

1. INTRODUCTION

1.1 BACKGROUND

The World Health Organization (WHO) defines adolescents as those between the ages of 10-19 years and youth as those between 15-24 years. The National Youth Policy of Ethiopia classifies youth as those between the ages of 15-29 years (1). Based on the WHO definition, there is currently 1.8 billion youth in the world, the largest number of youth ever to have existed (2).

Sub-Saharan African countries (SSA) have a proportionally large youth cohort. In 15 countries in SSA, half the population is under age 18 (2, 3). Of Ethiopia's population, estimated at 104 million, 41 percent is under the age of 15 and more than 28 percent is aged 15 to 29 (4). Due to changing conditions in civilization, urbanization, and life-style, the health of adolescents is increasingly at stake especially for Sexually Transmitted Infections(STIs), Human Immune Virus (HIV) and other reproductive health problems (5).

Self-esteem refers to self-judgments of personal worth and global feelings of competence and self-acceptance (6). High self-esteem is manifested by acceptance of responsibility for one's actions, self-motivation, willingness to take reasonable risk, and taking command and control of one's personal life including health and sexual behaviors but low self-esteem is manifested by a focus on trying to prove self to others, lack of confidence, doubt on self-worth and acceptability and blame others rather than take responsibility for one's health and sexual behaviors (7). Through negative schemata and attributions low self-esteem may predispose adolescents to sexual risk (8).

Globally, a number of policies and programs are attempting to help young people practice healthy sexual behaviors, improve reproductive health, and prevent sexually transmitted infections (STIs), including HIV (9). Global programs to improve adolescent sexual and reproductive health are grossly classified as: Abstinence-based education programs, Comprehensive sex-education programs, Clinic-based programs, Youth-development programs, Parent–youth relationship programs and Programs with impacts on key outcomes (10). There are many reproductive health programs targeting adolescents in Ethiopia, including programs run by NGOs, government agencies, and private commercial providers. These programs do not specifically focus on self-esteem building but help adolescents to think critically, make sound

decisions, and have good judgment. All of this together will help to increase young people's self-esteem, build their confidence, and elevate their self-efficacy (11).

1.2 STATEMENT OF THE PROBLEM

Unsafe sex is estimated by WHO to be the second most important global risk factor for health where adolescents and young people are especially vulnerable group (12). Worldwide, the highest reported rates of STIs are found among people between 15 and 24 years; up to 60% of the new infections and half of all people living with HIV globally are in this age group(13). Since 1993, the number of adolescents with HIV increased by 34%, making AIDS one of the leading causes of death among persons 15 to 24 years of age (14). Nearly 16 million women 15-19 year olds give birth each year, about 11% of all births worldwide. Ninety-five percent of these births occur in low-and middle-income countries. About 2.5 million adolescents have unsafe abortions every year. Fourteen percent of all unsafe abortions in low-and middle-income countries are among women aged 15–19 years (15).

Studies suggest 45 to 52 percent of SSA women had sexual intercourse by age 19 and 45 to 73 percent of SSA men by age 17(15). Recent surveys in several countries in SSA have detected decreases in condom use and/or an increase in the number of sexual partners. The overall proportion of condom use during youths' most recent higher-risk sexual encounter was 40% among 15 to 19 year olds (16). The UNAIDS report on the global AIDS epidemic showed that SSA accounts for 60% of all people living with HIV/AIDS (17). In Eastern and Southern African countries HIV prevalence among girls and women aged 15–24 is two to three times higher than it is for their male peers (18).

The government of Ethiopia has developed and implemented various strategies to promote sexual and reproductive health. Despite these interventions, different studies showed a high prevalence of risky sexual practices(19). In Ethiopia, a higher percentage of young people reported having sex before the age of 15 (18.3%). Higher percentage of women reported having sex before age 18 (40%) compared with men (12%)(20). Ethiopia is one of the developing countries where HIV/AIDS is fueling and striking its population of all age including adolescents (21). According to EDHS 2016, 0.2 percent of young women and men aged 15-24 are HIV-positive in Ethiopia (20).

There are different predictors of risky sexual behaviors among adolescents (21, 22). Individual factors like co-occurring sexual activity and substance use among adolescents is associated with greater risk for exposure to STIs (23). Alcohol consumption, chewing “khat” and substance use are among the major predictors of risky sexual behaviors among Ethiopian youths (16). Lack of accurate information about reproductive health and sexuality, lack of access to health services, lack of awareness about contraception, poor knowledge towards HIV/AIDS and vulnerability to sexual abuse put youth at highest risk (21, 22). Community factors like Peer pressure and watching pornographic materials are also the major predictors of risky sexual behaviors among adolescents (16). Other major predictors of risky sexual behavior among Ethiopian youths are factors related to family and living environment like poor living arrangement, educational status of parents and family connectedness (16).

Risky sexual behavior increases the probability of negative health consequences associated with sexual contact (24). Unintended pregnancy is both a possible effect of risky behaviors as well as a risk factor in itself which has been linked to higher rates of socio-emotional risks (25). Pregnancy and STDs pose risks in the short run, but also can have lifelong consequences. Given the potential effects of unintended pregnancy and STDs on health and the quality of life, however, understanding adolescent sexual behavior is a critical priority (26). Unsafe abortion is another serious risk to health that arises as a consequence of adolescent sexual activity, which directly causes the deaths of many adolescent girls and injures many more (18).

Self-esteem is a significant personality variable in determining human behavior (27). It was viewed as a vital component of an adolescent's healthy development and successful transition to adulthood. Studies have shown sometimes contradictory results when assessing the relationship between self-esteem and sexual behavior (6, 27). The literature on self-esteem and health-risk behaviors seems contradictory. Inconsistencies in results might reflect sampling characteristics. Studies that evaluate self-esteem and health risk behaviors have been conducted mostly in developed world populations (6). Therefore, it is important to explore the extent of risky sexual behavior and its relation with self-esteem and other covariates in a developing world sample like Ethiopia.

1.3 SIGNIFICANCE OF THE STUDY

Young people have limited access to reproductive health services that focus on the special needs of adolescents (28, 29). Factors like limited knowledge about adolescent sexual behavior, cultural influences, and the limited capacity of implementers hinder the provision of reproductive health education and services to young people (30). Focused policies and programs employing a multi-sector approach are essential if the existing adverse situation faced by young adults is to be reversed (9, 28, 31). Different health programs and policies should be geared toward educating health care providers to be more sensitive to the special needs of youth. Therefore, it is essential to have data on the extent of adolescent sexual activity and the factors that affect their sexual behaviors to have a clear understanding of the situation.

Ethiopia's first Adolescent and Youth Reproductive Health (AYRH) Strategy was developed in 2006 (1). The ministry of health directed the formation of a national adolescent reproductive health steering committee, instituted training on adolescent reproductive health management for health care providers, developed and distributed IEC materials, and conducted and participated in ARH workshops (30).

Schools are key settings for educating children about HIV/AIDS and for halting the further spread of the HIV infection (32). Integrated reproductive health education and services for young people in schools should include family planning information, and counseling on gender relations, STDs and HIV/AIDS, sexual abuse and reproductive health (33).

Self-esteem, the individuals' opinion of their self-worth, or their ability to feel positive about themselves has been identified as one of the factors that have the potential to influence health behaviors. The association between self-esteem and risky sexual behaviors (RSBs) among adolescents has not been given much attention in Ethiopia. Therefore, this study will add certain knowledge on extent of adolescent sexual activity and its association with self-esteem and other covariates among high school adolescents. The findings of this study will help the ministry of education and ministry of health for the development of effective health education and health promotion policies, programs, and practices targeted at young people.

2. LITERATURE REVIEW

2.1 THEORIES AND MODELS RELATED TO SELF-ESTEEM AND RISKY SEXUAL BEHAVIORS

Health behavior theories, including Social Cognitive Theory, the Theory of Planned Behavior, and Problem Behavior Theory, provide possible mechanisms by which self-esteem may affect sexual risk behavior (8).

The Health Belief Model (HBM) is a theory of behavioral change that can be used to understand how people act when faced with various health-related challenges and social cognitive theory is used to examine the association of sexual behaviors and sexual knowledge, self-esteem, and sexual attitudes (8, 34). The constructs of the HBM include perceived susceptibility, threat and severity, cues to action, modifying factors, perceived benefits and barriers, and self-efficacy. Taking action to change behavior entails examination of benefits and barriers as well as self-efficacy. For example, an individual would likely use condoms with non-marital, non-cohabiting sexual partners if the perceived benefits outweighed the negative effects of such an action; and this must be backed by one's self-confidence to use condoms (35).

Social Cognitive Theory suggests that people learn how to behave in social situations by paying attention to the environment around them and reacting or responding to the environment and its stimuli which implies that behaviors, including sexual, can be taught. Parents, peers, work units, schools, churches and community organizations are the socializing force most often indicated by adolescents as having largely influenced their knowledge, values, and attitudes about sex (34).

Psychological empowerment theory identifies three components that determine outcomes, namely, intrapersonal, interactional, and behavioral components. Applied to sexual risk behavior in the context of intimate relationships, sexual empowerment determinants included within the intrapersonal component are HIV knowledge, self-esteem, condom self-efficacy, attitudes toward condom use, and condom negotiation skills (36) .

These theories and models suggest that problem behaviors like substance use and sexual risk are determined by dynamic and reciprocal interactions with personality characteristics like depression and self-esteem, and environmental factors, such as societal expectations (8).

2.2 MAGNITUDE OF RISKY SEXUAL BEHAVIOR

Risky sexual behavior is a composite variable with main attributes that include; early sexual initiation, having more than one sexual partner, inconsistent/incorrect use of condoms and sex for exchange of money/item (16).

2.2.1 EARLY SEXUALITY

Globally, by age 20, more than 85 percent of young women are sexually active, and 30 percent of all births are to women aged 15 to 24 (28). A study among Malaysian adolescents showed that the mean age at first sexual intercourse for both genders was 14 years (37). A similar study among Thailand adolescents showed that among sexually active participants 3% reported as they initiated sexual intercourse at age of 11 years (37). According to the 3rd South African national youth risk behaviors survey, nationally, 36.3% of learners reported ever having had sex and 12.0% had their first sexual encounter before the age of 14 years (38).

Early sexual debut is also a common problem in Ethiopia. The median age at first sex for women is 16.4 years (1). In a study among high and preparatory school youth in East Wollega, the minimum and maximum age of sexual debut for males were 14 and 20 years and for that of females was 12 and 20 years (39). Different studies in different parts of the country prove this reality. In a cross-sectional study conducted among high school youth in Pawe Woreda, out of the study subjects; 24.1% of respondents were sexually active (21). Another cross-sectional study among Boditti secondary and preparatory school students showed that 29.1% are sexually active (22). Another cross-sectional study done among adolescent students in Gonder showed that 134 (84.3%) of sexually active youth were below 18 years at the time of sexual initiation (40). A study in east Gojjam showed that among 275 respondents, about 196 of them had a history of sexual contact with 119(60.7%) being males and 77(39.3%) females (41).

2.2.2 MULTIPLE/ CONCURRENT SEXUAL PARTENRS

Having multiple sexual partners is another risky sexual behavior common among adolescents. Malaysian National Health and Morbidity Survey 2017 showed that among those who ever had sex, 16.6% had multiple sexual partners (42). Adolescents may also have sex with a little-known person. For example, a study among middle- and high-school Latino students showed that 40.0% had sexual relations with a little- known person (43). The problem is more challenging in Africa.

According to the 3rd South African national youth risk behaviors survey, among learners who had ever had sex, almost half (47.4%) reported having had two or more sexual partners in their lifetime, 58.0% had one or more sexual partners in the three months preceding the survey (38). Findings from studies in Ethiopia showed that many adolescents have more than one sexual partner. A comparative study among male and female students in Jimma zone preparatory schools showed that 25.9% of male and 21.6% of female students had two or more sexual partners in the last six months of the survey (44). A similar finding was obtained from a cross-sectional study among Boditti secondary and preparatory school students where 20.5% are committed sex with more than one sexual partner (22). In another study conducted among high school youth in Pawe Woreda, out of the study subjects, 35.1% reported having more than two sexual partners (21). A similar study in East Gojjam showed that a high percentage of both sexes had experienced multiple sexual partners (52.2% for males and 64.4% for females) (41).

2.2.3 SEX FOR EXCHANGE OF MONEY/ITEMS

An emerging contributing factor to HIV/STIs among young people is a transactional sexual relationship. It involves socially recognized “exchange of material goods within sexual relationships, including food, cash, cosmetics, transport, mobile phone and items for children, school fees” (1). A meta-analysis study in India showed that the prevalence of HIV in males who had paid sex was found to be 0.55%, and in those who did not have paid sex, it was 0.30% (45). According to EDHS 2016 less than 1% of men aged 15-19 paid for sex in the last 12 months before the survey (46). The study in Boditti cited need for money to have influenced students’ sexual activities (22).

A qualitative study among high and preparatory school youth in East Wollega showed that risky sexual behaviors of some female high school students were related to finance. Some students were financially insecure and they need money/ other gifts from their sexual partner. As a result, during sexual intercourse they fail to negotiate with their partners to use condoms, thus they practice unsafe sex (39).

2.2.4 INCONSISTENT USE OF CONDOM

Another risky sexual behavior common among adolescents is inconsistent condom use during sexual inter course. For example, a study among middle- and high-school Latino students

showed that, 33.7% students informed inconsistent condom use (43). In another cross-sectional study among adolescent Thai vocational students, only 6.3% reported using condoms whenever having sex at the beginning of the relationship (47).

The problem is not different in Ethiopia. When we see the study among students in Jimma zone preparatory schools only 9.4% of the male and 8.6% of the female students used condoms consistently in the last six months before the survey(44). In another study conducted among high school youth in Pawe Woreda, among the sexually active students: only 41.1% reported ever use of condoms; consistent use of condom was reported only by 43.2% (21). Another cross-sectional study among Boditti secondary and preparatory school students showed that only 67.6 % used condoms (22).

2.3. FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

Adolescent sexual development is influenced by a range of factors namely the biological, socio-cultural, family, and individual factors. However, the sexual behaviors of adolescents are also influenced by the inconsistencies and contradictions in adult behaviors as viewed in life and through the media (38).

2.3.1 SOCIO-DEMOGRAPHIC FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

According to a study among adolescents receiving treatment for substance abuse problems, the path from co-occurring sex and alcohol use to unprotected intercourse was significantly stronger among adolescent girls, suggesting a mediation effect moderated by gender. The path from sexual sensation seeking to past year number of partners via co-occurring sex and alcohol was stronger among adolescent boys. However, this gender path difference was not statistically significant (23).

In sub-Saharan Africa, females 15 to 24 years old are twice as likely as young men to be living with HIV (48). A cross-sectional survey of 361 adolescents in nine secondary schools in Jos Plateau, Nigeria showed that the mean age at first sexual intercourse for male adolescents' was 16.12 (SD = 2.54) and female adolescents' was 14.94 (SD = 2.54), with no significant difference based on gender (7). According to a study to predict young Batswana males and

females intention to practice safe sex, boys reported seeing more sexual partners compared to girls. In this study, a one-way ANOVA comparison of the mean age at sexual debut between boys and girls showed a statistically significant difference ($p = 0.005$) (49).

In a study in east Gojjam among respondents with a history of sexual contact, more females (52.1%) were found to have experienced unprotected sexual intercourse (never used any contraceptive method or condom) than males (38.9%). In addition, more male respondents (59%) had history of multiple sexual partners than females (41).

A comparative study among male and female students in Jimma zone preparatory schools showed that the odds of risky sexual behavior among female students were 1.6 times more than male students (44). Another study among high school youth in Pawe Woreda showed being in 18-24 age group is associated with risky sexual behavior (21). A similar study in Boditti showed that the odds of risky sexual behavior increase with increasing age. The Boditti study also showed that the odds of risky sex were significantly lower among preparatory level students compared to those in secondary school level (grades nine and ten) (22). A comparative cross-sectional study in Addis-Ababa showed that the odds of risky sexual behavior among grade 11 and 12 students is less by 72 % compared to grades 9 and 10 students ($p < 0.05$). When controlled for school type (public vs. private) however, the difference is insignificant (50).

2.3.2 INDIVIDUAL FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

A study conducted in Dominican suggested that for girls, chronic alcohol use can interfere with relationships with their mothers, which, in turn, leads to lower self-esteem as girls lose the support and respect of their parents. This lower self-esteem then motivates girls to seek out sexual partnerships, perhaps as a compensatory mechanism to deal with lowered feelings of self-worth. Such dynamics were not evident in boys. According to this study, chronic alcohol use was associated with higher intentions to engage in sexual intercourse in the future (47). Another study among Middle- and High-School Latino Students showed that 18.4% reported sexual intercourse after alcohol consumption, 5.8% after illegal drugs consumption (40). A qualitative study among Malaysian adolescents showed that previous use of alcohol and illicit drugs was associated with initiation of sexual intercourse among participants. Factors such as deeming sex as an expression of love and the inability to control sex drive supplemented the individual

domain of the quantitative results (37). Drinking alcohol and using drugs before having sex is also a common problem among African adolescents. According to the 3rd South African National Youth Risk Behaviors Survey 17.5% used alcohol before having sex, 13.1% used drugs before having sex (39).

An institution-based cross-sectional study among preparatory school students in Arba Minch town showed, drinking alcohol and using hashish/shisha were significantly associated with risky sexual behaviors (16). A similar study among male and female students in Jimma zone preparatory schools showed female students who consumed alcohol were 7 times more likely to be at risk than those who did not consume alcohol. Male students who consumed alcohol were 2.8 times more likely to be at risk than those who did not consumed alcohol. Male students who chewed khat were 4.6 times more likely to be at risk than students who did not chew khat (41). Another study among high school youth in Pawe Woreda showed drinking alcohol was associated with risky sexual behavior (21).

Technology perpetuates risky sexual behavior from exposure to sexually explicit materials in movies and the internet (1). A qualitative study in Malaysia revealed that Pornography viewing causes adolescents to become stimulated and induces a sexual fantasy about a partner with whom they want to have sex, which in turn influences them to initiate sex when given the opportunity (37). An institution-based cross-sectional study among preparatory school students in Arba Minch town showed watching pornographic movies was significantly associated with risky sexual behaviors (16). In another cross-sectional study among students in Gondar, ever-watched pornographic film was significantly associated with risky sexual behavior. In this study, the odds of risky sexual behavior among those who ever-watched pornographic films were 2.2 times higher than their counter- part (12). A study in East Gojjam showed that both the knowledge and attitude of the respondents were not significant factors for sexual risk behaviors (41). A similar study in Boditti showed that knowledge on the risk of unsafe sex and getting monthly pocket money did not show a statistically significant association (22). Another study in Addis-Ababa showed that pocket money had no significant effect on risky sexual behavior among adolescents (50).

2.3.3 FAMILY ENVIRONMENTS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

A Study in Malawi showed that unmarried adult men in the rich and richest households, respectively, had significantly higher incidence risk ratios for a number of non-marital non-cohabiting sexual partners compared with those in the poorest households. Adult men in the rich and the richest household quintiles had significant incidence risk ratios for higher number of non-marital non-cohabiting sexual partners compared with the poorest group (35). A comparative study in Addis-Ababa showed that family monthly income had no significant effect on risky sexual behavior among adolescents (50). An institution-based cross-sectional study among preparatory school students in Arba-Minch town showed, marital status, education and occupational status of the father, occupation of the mother were significantly associated with risky sexual behaviors (16). A similar study among male and female students in Jimma zone preparatory schools showed living arrangements, educational status of parents, family connectedness were the major predictors of risky sexual behavior. In the Jimma study, female students living away from their parents were 3 times more likely to be at risk than students living with their parents (44). A cross-sectional study in East Gojjam Zone showed that Students who lived with a brother or sister or friend or alone were significantly more likely to engage in sexual risk behaviors than those who lived with parents. Similarly, students from uneducated parents were significantly more likely to engage in sexual risk behaviors (41). Another study in Gondar showed the odds of practicing risky sexual behavior among respondents who had no parental monitor were 12 times higher than respondents who had parental monitor. Besides the odds of risky sexual behavior among respondents who had no parental discussion regarding sexual and reproductive health issues were 2.6 times higher than their counterparts (12). A qualitative study among high and preparatory school youth in East Wollega showed that family connectedness was a protective factor for risky sexual behavior. The study showed that families who strictly monitor/follow their children, openly and freely communicate with their children on how to resist peer pressure influence on bad behaviors, and parents who show signs of love to their children helped to protect their children from negative peer influences (39).

2.3.4 INTER PERSONAL FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

Interpersonal factors like peer pressure may affect sexual behaviors of adolescents. Qualitative findings from a study in Malaysia revealed that one of the reasons for the initiation of sexual intercourse among these adolescents was partner influence (37). A cross-sectional study among students in Boditti cited peer pressure to have influenced students' sexual activities (22). In a similar study in Gondar, 13.1% of respondents had perceived they had peer pressure to have sex and 20.5% of respondents had sexually active peers (12). In another study in Gonder respondents who had experienced peer pressure to have sex were 2.5 times at higher risk to practice risky sexual behavior than their counterparts (40). A cross-sectional study among school children in Addis Ababa showed that risky sexual behavior is significantly and very strongly associated with perception of peers' involvement in sexual intercourse (51). A qualitative study in Malaysia revealed that adolescents who had been victims of child abuse responded that they initiated sex because of feelings of powerlessness, guilt, shame, stigmatization, and low self-esteem due to the loss of their virginity (37).

2.3.5 SCHOOL FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIORS

A comparative study in Addis-Ababa showed that among sexually active students, 2.9% of the private and 3.1% of the government students had sexual contact with a commercial sex worker, with no difference across these groups. This study also showed that 14.6% of the private and 15.6% of the government school students had also inconsistent condom use; moreover, 18.5% and 16.6% of the former and the latter group had also early sexual debut, respectively (50).

2.4 THE ASSOCIATION BETWEEN SELF-ESTEEM AND RISKY SEXUAL BEHAVIORS

Studies suggest that self-esteem can affect the initiation and frequency of sexual intercourse among adolescents. A study conducted in the USA to predict coitus initiation in a population of early adolescents suggests that self-esteem may differentially influence adolescent transition to non-virginity. According to this study girls who scored low on the self-esteem measure were 3 times more likely to subsequently initiate sexual intercourse. Conversely, boys who scored high on the self-esteem measure were 2.4 times more likely to initiate coitus during the subsequent 22

month period (10). In another study in USA among 155 sexually active adolescent females, aged 14–19 years, adolescents who had lower self-esteem at baseline reported initiating sex earlier and having had risky partners (52). According to another study among women in Atlanta, lower levels of self-esteem were associated with more oral sex ($p < 0.05$) (53). In another cross-sectional study of 169 male (46.8%) and 192 female (53.2%) Nigerian adolescents with a mean age of 16.9, adolescents with low self-esteem were 1.7 times more likely to be sexually active (7). From a study on self-efficacy, self-esteem, and the intention to practice safe sex among Botswana adolescents, the results showed a weak relationship though statistically significant between self-esteem and intention to abstain from sex (49).

Self-esteem can also affect the use of condoms among adolescents. According to a study among women at Atlanta, lower levels of self-esteem were associated with more negative attitudes toward using condoms ($p < 0.001$), and less condom use and self-efficacy ($p < 0.001$). According to this study for condom use self-efficacy and attitudes toward using condoms, self-esteem was a significant multivariate contributor (53). A weak relationship though statistically significant between self-esteem and intention to use condoms was obtained from a study among Botswana adolescents (49). But another study among young adult ecstasy users showed that self-esteem was not found to be related to condom use once the effects of race/ethnicity, marital/relationship status, sexual orientation, age, and gender were controlled (54).

Intention to limit sexual partners among adolescents may also be affected by self-esteem. A study among young adult ecstasy users showed that higher levels of self-esteem were associated with having had fewer sexual partners ($p < .05$) (54). A weak but statistically significant relationship between self-esteem and intention to limit partners was obtained from a study on self-efficacy, self-esteem and the intention to practice safe sex among Botswana adolescents. According to this study the Pearson correlation coefficient between self-esteem score and intention to limit partners was 0.316 ($p < 0.01$) (49). According to a study among women in Atlanta, lower levels of self-esteem were also associated with more sex with paying partners ($p < 0.05$) (53).

Some of the findings from these studies showed as there is a positive statistically significant relationship between risky sexual behaviors and self-esteem but others showed as there is negative statistically significant relationship between risky sexual behaviors and self-esteem.

Still, others showed as there is no relationship between self-esteem and risky sexual behaviors. Most of the studies were cross-sectional and quantitative which are unable to explain the findings using qualitative data. In addition, most are done in developed countries. Therefore, this mixed-method study will fill these gaps.

2.5 CONCEPTUAL FRAME WORK

The study will examine risky sexual behavior at four levels. Chosen from an array of possible socio-demographic and individual factors are sex, age, grade, knowledge, risk perception, monthly pocket money, relationship status and self-esteem. In the context of this study, self-esteem is thought to have an inverse association with engaging in risky sexual behaviors. Adolescents in female-headed households might behave differently from those in male-headed households because they would fear a male head more than a female head. Adolescents from wealthier households might be more likely to have multiple sexual partnerships than their poorer counterparts. Exposure to media is deemed to have a dual effect on whether adolescents with high exposure to media would be more likely to engage in risky sexual relationships as this might depend upon the type of information and messages received. Type of school is thought to exhibit a mixed influence on adolescents' high-risk sexual behavior, and the direction of influence is indeterminate. (Fig-1)

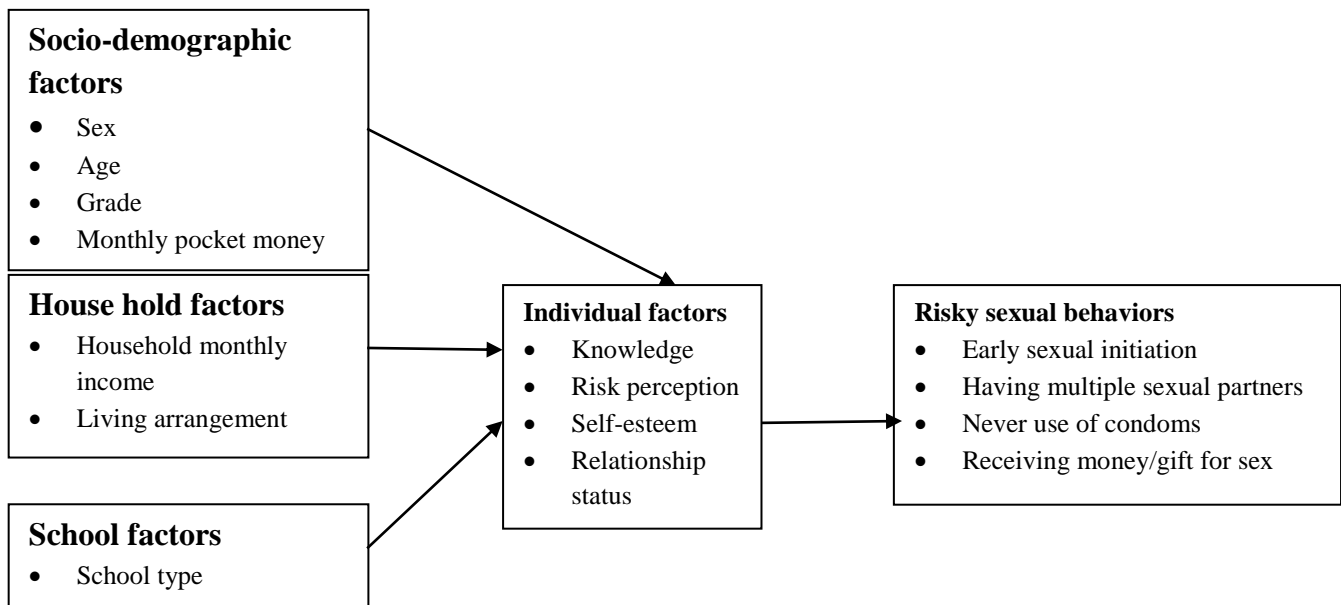


Figure 1: Conceptual framework adapted from different studies to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis Ababa, 2021(39).

3. OBJECTIVES OF THE STUDY

3.1 GENERAL OBJECTIVE

- To assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis-Ababa.

3.2 SPECIFIC OBJECTIVES

- To measure the magnitude of risky sexual behavior among in-school adolescents in Addis-Ababa.
- To calibrate the association of self-esteem and other covariates with risky sexual behavior among in-school adolescents in Addis-Ababa.
- Exploring the contribution of self-esteem in reduction of risky sexual behaviors.

4. METHODS

4.1 STUDY AREA

This study was conducted in Addis Ababa, the capital city of Ethiopia. The city is administratively divided into 11 sub-cities and 116 Woredas. The education system in the capital is a 6-2-4 education system. In such an education system, students go through six years of primary education, two years of junior school, and four years of high school. Of a total of 222 secondary schools, 146(66.7%) of the schools are owned by heterogeneous nongovernmental owners that included private, foreign community, religious community and other organizations. In the year 2020–2021, 2,711 schools were registered under Addis Ababa City Administration Education Bureau. Of these 2,711 schools, 222 are secondary schools. In the academic year, 70,211 males and 76,324 females were enrolled in secondary schools (55, 56).

4.2 STUDY DESIGN AND PERIOD

A facility-based explanatory sequential mixed methods design of quantitative and qualitative studies was conducted from December 2020 to February 2021. The cross-sectional quantitative study was used to measure the degree, direction, and significance of the association of risky sexual behavior with self-esteem and other covariates. In the first quantitative phase of the study, questionnaire was used to collect information from students at secondary schools [grade 9-12] in Addis Ababa. In the second qualitative phase, an in-depth interview was conducted among 18 selected participants from heads and leaders of the school system, counselors, youth club heads and youth club member adolescents to further explore the contribution of self-esteem in the reduction of risky sexual behaviors. The reason for the exploratory follow-up was to help explain or build upon initial quantitative results.

4.3 POPULATION

4.3.1 POPULATION FOR QUANTITATIVE STUDY

4.3.1.1 SOURCE POPULATION

All adolescent regular students in secondary schools [grade 9-12] in the age range of 10 and 19 years in Addis Ababa city during the study period.

4.3.1.2 STUDY POPULATION

The study population was adolescents who had a chance to attend regular secondary schools in the ten selected Woredas of Addis Ababa city administration during the 2020/2021 academic year.

4.3.1.3 INCLUSION AND EXCLUSION CRITERIA FOR QUANTITATIVE STUDY

All adolescents who attend regular secondary schools in Addis Ababa in the 2020/2021 academic year were included in the quantitative study. Whereas, evening and distance secondary school students, those who were severely sick and those who were unable to hear or speak were excluded from the study.

4.3.2 TRANSFERABILITY AND PARTICIPANTS FOR QUALITATIVE STUDY

4.3.2.1 TRANSFERABILITY

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents (57). The researcher facilitated the transferability judgment by a potential user through thick description and maximum variation sampling. This means that the researcher provided a detailed description of the inquiry and participants were selected using maximum variation sampling.

4.3.2.2 STUDY PARTICIPANTS

The study participants were 18 selected individuals from heads and leaders of the school system that includes Addis Ababa region education bureau, sub-city education department and woreda education office, counselors, youth club heads and youth club member adolescents in secondary schools in Addis Ababa city during the 2020/2021 academic year.

4.3.2.3. INCLUSION AND EXCLUSION CRITERIA FOR QUALITATIVE STUDY

In the qualitative study, 18 participants from heads and leadership of the school system that includes Addis Ababa region education bureau, sub-city education department and woreda education office, counselors, youth club heads and youth club member adolescents were

included. Whereas, those head, leaders, counselors, youth club heads and members who were severely sick were excluded from the study.

4.4. SAMPLE SIZE DETERMINATION AND SAMPLING PROCEDURE

4.4.1. SAMPLE SIZE DETERMINATION

4.4.1.1 SAMPLE SIZE FOR QUANTITATIVE STUDY

The sample size was calculated using the single population proportion formula.

A. Calculating the sample size using different attributes of risky sexual behavior

First, an attempt was made to calculate the sample size by considering the different attributes of risky sexual behavior separately and the largest value has been taken to increase the power of the study. The p-value was taken 45.6% for had sex with more than one sexual partner, 55.6% for didn't use condoms consistently and 20.6% for sex at the exchange of money from a previous study about the effect of peer influence on risky sexual behavior among students in the study area (51).

$$n = \frac{(Z_{\alpha/2})^2 (P) (1-P)}{d^2}$$

Z= the standard normal deviation at 95% confidence level=1.96

P= the proportion of study population with expected prevalence of risky sexual behavior

d = the desired precision (marginal error) = 5%

n_i = initial sample size

n_f = final sample size

N= total number of regular secondary school adolescents=146,535

The sample size for having sex with more than one sexual partner:

$$n_i = \frac{(1.96)^2 (0.456)(1-0.456)}{(0.05)^2} = 381$$

The sample size for did not use condoms consistently:

$$n_i = \frac{(1.96)^2 (0.556)(1-0.556)}{(0.05)^2} = 379$$

The sample size for sex at the exchange of money:

$$n_i = \frac{(1.96)^2 (0.206)(1-0.206)}{(0.05)^2} = 251$$

The sample size for risky sexual behavior as a composite score:

$$n_i = \frac{(1.96)^2 (0.361)(1-0.361)}{(0.05)^2} = 354$$

B. Calculating the sample size using different factors

Second an attempt was made to calculate the sample size by considering the different predictors of risky sexual behavior. The prevalence of risky sexual behavior among adolescents with median age of 14.8 is 36.1% (43) and the prevalence of did not use condoms consistently among adolescents with low self-esteem was taken as 41.9% (8). The prevalence of drinking alcohol before sex was taken as 17.9 % (38).

The sample size for sex at an early age:

$$n_i = \frac{(1.96)^2 (0.361)(1-0.361)}{(0.05)^2} = 354$$

The sample size for drinking alcohol before sex:

$$n_i = \frac{(1.96)^2 (0.179)(1-0.179)}{(0.05)^2} = 255$$

The sample size for did not use condom consistently among adolescents with low self-esteem:

$$n_i = \frac{(1.96)^2 (0.419)(1-0.419)}{(0.05)^2} = 374$$

The largest value that is 381 is taken as the initial sample size to increase the power of the study.

The n_i computed this way was adjusted using what is called 'Design Effect' (DE) of 1.5:

$$n_i' = 381 * 1.5 = 572$$

By considering a non-response rate of 10 % the final sample size was:

$$n_f = 572 + 10\% = 629$$

4.4.1.2 SAMPLE SIZE FOR QUALITATIVE STUDY

To gain detailed accounts of the responses and allow for large amounts of information to be analyzed, 18 participants from heads and leaders of the school system that includes Addis Ababa region education bureau; sub-city education department and woreda education office, counselors, youth club heads and youth club member adolescents were obtained using maximal variation sampling by describing the research and requesting participants to participate. Data were

collected from each participant using an in-depth interview. The sampling was continuing until the researcher did not get any new information or was no longer gaining new insights.

4.4.2. SAMPLING PROCEDURE

4.4.2.1 SAMPLING PROCEDURE FOR QUANTITATIVE STUDY

The study population was randomly selected using a multi-stage sampling method that aimed at selecting 629 eligible students from 10 secondary schools in Addis Ababa. In the first stage, five sub-cities namely (Akaki-Kaliti, Gullele, Kolfe-Keranio, Nefas Silk-Lafto, and Yeka) were randomly selected. In the next stage, two Woredas from each sub-city were randomly selected. In the third stage, one school was randomly selected from each selected Woreda. The selected woredas and schools were as follow:- Akaki-Kaliti Woreda-6(Bulbula secondary school), Akaki-Kaliti Woreda-8(Derartu Tulu secondary and preparatory school), Gullele Woreda-1(Entoto Ameba Secondary school), Gullele Woreda-7(Ethio-Parents school), Kolfe-Keranio Woreda-1(Beteseb Academy), Kolfe-Keranio Woreda-4(Yetwliid Tesfa secondary school), Nefsa Silk-Lafto Woreda-7(Frehiowt secondary and preparatory school), Nefas Silk-Lafto Woreda-12(Ginbot 20), Yeka Woreda-5(Kokebe Tsibeha secondary and preparatory school) and Yeka Woreda-9(Andenet International school). Then, sections were selected randomly from each grade level in the selected schools. Finally, students were selected from each section using a simple random sampling technique by using the class attendance sheet as a sampling frame. The total sample size was distributed to each school, grade, and section proportionate to their size. The list of schools in the city and the number of secondary school students in each sub-city and Woreda was identified by asking heads from the school system of the city and using Education Statistics Annual Abstract of City Government of Addis Ababa Education Bureau. The total number of secondary school adolescents in each school, grade, and respective section was identified by asking the school administrators of each selected school to draw the sample.

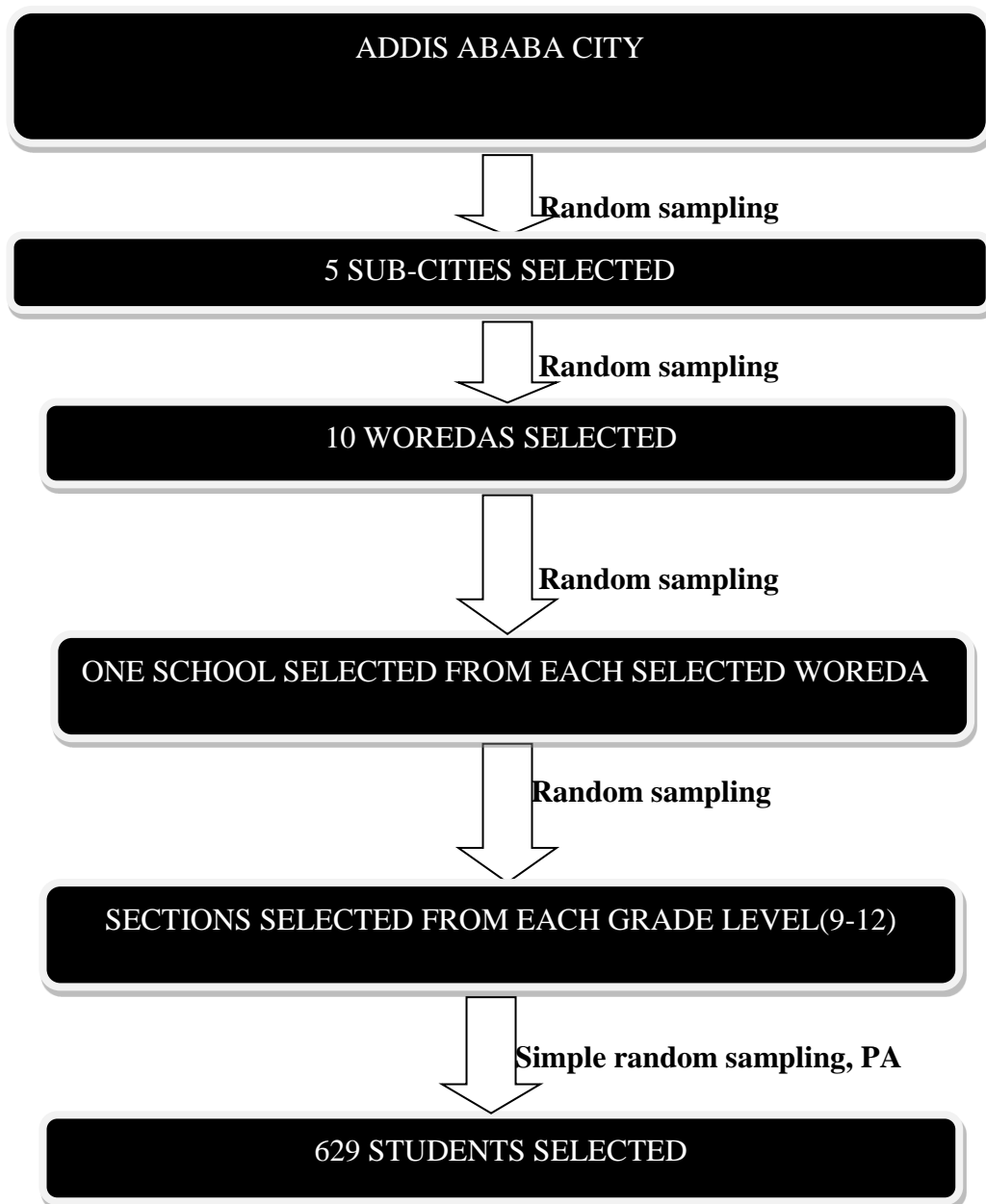


Figure 2: Schematic presentation of sampling for the study to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis Ababa, 2021

Table 1: Proportional allocation of respondents sample size to each selected school, 2021

School	Size of students in each school	Size selected from each school
Bulbula secondary and preparatory school	1951	82
Derartu Tulu secondary and preparatory school	2114	89
Entoto Amba secondary and preparatory school	2711	115
Ethio – parents school	280	12
Beteseb academy	534	23
Yetwliid –Tesfa secondary and preparatory school	741	32
Frehiowt secondary and preparatory school	1784	75
Ginbot -20 secondary and preparatory school	1616	68
Kokebe Tsibeha secondary and preparatory school	2912	122
Andenet international school	249	11

Table 2: Proportional allocation of respondents sample size to each grade level, 2021

School	Size of students in each grade level				Size selected from each grade			
	9	10	11	12	9	10	11	12
Bulbula secondary and preparatory	851	500	455	145	36	21	19	6
Derartu Tulu secondary and preparatory school	483	165	1005	461	20	8	42	19
Entoto amba secondary and preparatory school	1478	673	510	50	62	29	22	2
Ethio –parent school	77	79	71	53	4	3	3	2
Beteseb academy	176	118	128	112	8	5	5	5
Yetwliid –Tesfa secondary and preparatory	191	224	146	180	8	10	6	8
Frehiowt secondary and preparatory school	664	496	380	244	28	21	16	10
Ginbot -20 secondary and preparatory school	455	250	525	386	19	11	22	16
Kokebe Tsibeha secondary and preparatory	1042	740	674	456	44	31	28	19
Andenet international school	88	70	47	44	4	3	2	2

4.4.2.2 QUALITATIVE PARTICIPANTS AND RECRUITMENT

In the qualitative study 5 heads and leaders of the school system, 3 school vice directors, 5 school counselors, 4 school youth club leaders, and 1 school youth club member were recruited until saturation of ideas. Maximum variation qualitative sampling procedure was employed. This study intended to acquire a maximum variation sample by recruiting 18 participants from leaders of the school system that includes Addis Ababa region education bureau, sub-city education department and woreda education office, counselors, youth club members, and male and female adolescents. Each participant who agreed to interview was asked to read and sign an informed consent form before participating and promised their complete anonymity.

4.5. DATA COLLECTION METHOD

4.5.1 QUANTITATIVE DATA COLLECTION

A structured questionnaire was developed by reviewing different literature on risky sexual behaviors and its determinant factor the main one being self-esteem. The questionnaire included demographic information, other individual-level factors, household factors, school factors and the Rosenberg Self-esteem Scale to assess self-esteem. The questionnaire was first prepared in English language and translated to Amharic version and re-translated back to English to check its consistency. About 5% of the questionnaire was pre-tested in similar settings among school adolescents of other sub-cities not included in the study to alleviate problems related to understandability, simplicity, and for the sake of planning before the actual data collection. An appropriate modification was done before the questionnaire was used for the main study. The data was collected by using a self-administered questionnaire. Ten teachers who are working in the schools as counselors and youth club leaders from each school were trained intensively for two days for data collection. The collected data were checked for completeness and consistency on daily basis.

4.5.2 QUALITATIVE DATA COLLECTION

In the qualitative phase, open-ended, semi-structured, in-depth interviews were conducted. Open-ended interviews were designed as it allows participants to discuss their opinions, views and experiences fully in detail whereas perhaps a set interview with closed-ended questions may inhibit them to express their full opinions and feelings. Face-to-face interviews allowed the researcher to observe any non-verbal communication and allowed both the interviewer and

participant to seek any clarification necessary. It began with unstructured questions such as the following: "What do you think about risky sexual behaviors?". The interviews consisted of open-ended questions, uniquely developed by the researcher for the sole purpose of this study. The interviews lasted from 14 to 33 minutes. The interviews were audio-taped with permission from the participant to ascertain an accurate account of the interview which was replayed for analytic purposes and anonymity was assured during the recording. To ensure participants' anonymity and privacy during the interviews, access to a private room within the working area was arranged.

4.6. MEASUREMENT

4.6.1. VARIABLES

4.6.1.1 INDEPENDENT VARIABLES

Self-esteem was considered a major independent variable. Other variables like socio-demographic factors (age, sex, grade, current sexual relationship status and monthly pocket money), individual factors (knowledge and risk perception), house hold factors (living arrangement, average household monthly income.), and school factor (school type) were also observed.

4.6.1.2 DEPENDENT VARIABLES

Risky sexual behaviors [early sexual initiation, having multiple sexual partners, never use of condoms and receiving money or gift for sex].

4.6.2 DEFINITION OF TERMS

Risky sexual behavior: Nineteen items were used in general to assess sexual experience and risky sexual behavior is composite variable which was created from at least one of early sexual initiation, having multiple sexual partners, never use of condoms and receiving money/gift for sex.

Early sexual initiation: starting sex before 18 years old.

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

Self-esteem: is described as the evaluation one has of his/herself, how one feels about his/herself in almost any situation. To measure self-esteem, the study utilized the Rosenberg Self-Esteem Likert scale, comprising in total ten-item statements which enquired on whether the individual strongly agreed, agreed, disagreed, or strongly disagreed with the statements that enquired on their evaluations of themselves. In scoring the items, the positive

statements were given points as follows; Strongly Agree (SA) = 3, Agree (A) = 2, Disagree (D) = 1 and Strongly Disagree (SD) = 0 while the negative statements were reverse-scored as follows; SA = 0, A = 1, D = 2 and SD = 3 and finally summing the numbers to get the score for the overall self-esteem. The scores were interpreted to mean that the higher the sum number, the higher the individual's self-esteem.

Sex for exchange of money/items: getting money or any other form of material to have sexual intercourse with someone.

Knowledge: Two yes/no items and 4 multiple-choice items were used to assess knowledge about STIs including HIV/AIDS and unwanted pregnancy. Those students who scored at least 60% and above in knowledge questions were considered as having good comprehensive knowledge.

Perception: Ten yes/no items were used to assess perception about STIs including HIV/AIDS and unwanted pregnancy. Those students who scored at least 60% and above in perception questions were considered as having good perception.

4.7 DATA QUALITY CONTROL

4.7.1 QUANTITATIVE DATA QUALITY CONTROL

The quality of data was assured by giving appropriate training for data collectors on the research tools (questionnaires). Moreover, close supervision was done during data collection for its completeness and consistency. Pilot testing was done in 5% of the study participants in Addis-ketema sub-city which was not included in the actual study. The data was cleaned by running frequency for each categorical variable and cross-checking with the original questionnaire (hard copy). Data was entered, and coded by using EPI data and STATA version 15. Descriptive was analysis carried out to see outliers, missing values, and inconsistencies.

4.7.2 TRUSTWORTHINESS OF QUALITATIVE DATA

4.7.2.1 CREDIBILITY

Credibility refers to the degree to which the findings reflect the actual “lived experience” of the participants. To ensure credibility debriefing of the key findings from the qualitative data was done (58).

4.7.2.2 TRANSFERABILITY

Representative and information-rich samples were selected from the participants and the researcher provided thick descriptions that could be rich enough for other researchers to be able to make judgments about the transferability of the research findings to different contexts (59).

4.7.2.3 DEPENDABILITY

The dependability of this research finding was ensured through stepwise replication (inclusive of a thick or dense description of the methodology) and inquiry audit. Code-recode strategy was used (57).

4.7.2.4. CONFIRMABILITY

Confirmability of findings was tested by rereading the data to test for fit of the final themes by the researcher. Audit trail, reflexive journal (all events that happened in the field, personal reflections in about the study, such as the ‘ah’ phenomenon that arises during the investigation) were used (57, 58).

4.8. DATA PROCESSING AND ANALYSIS

4.8.1 QUANTITATIVE DATA ANALYSIS

The data was first entered into Epi data and later exported to and analyzed by using STATA version 15. A composite variable for measuring risky sexual behavior was computed by combining early sexual initiation (under the age of 18 years), having multiple sexual partners, inconsistent or incorrect use of condom, sex for exchange of money/item(for females only), and sexual activity with commercial sex workers (for males only) in the past 12 months from the study period. Frequencies for all variables were revealed using tables. Binary logistic regression model was used to determine the association between risky sexual behavior and different independent variables, the main one being self-esteem. Multi-collinearity was checked using the variance inflation factor, VIF. Furthermore, multivariable logistic regression analysis was used to see the net effects of each independent variable in explaining variation in the outcome variable. Odds ratio along with the 95% confidence interval was used to ascertain association, statistical significance, and direction of association between variables. Statistical significance was set at a P-value of <0.05.

4.8.2 QUALITATIVE DATA ANALYSIS

The researcher used inductive analysis for open-ended in-depth interview questions. In this regard, the researcher read the data looking for trends and patterns to identify themes to better understand the data within the confines of thematic analysis. Next, the researcher coded the data based on similar categories and topics that emerged from the data as they aligned with the research objectives. Each topic addressed in the data had a number assigned to it. After coding the data, the researcher spent some time describing the ten secondary-school settings, the participants who agreed to participate in the study, themes that emerged from qualitative data and categories that surfaced in the data analysis. Next, the researcher classified all data related to the thematic pattern and related sub-themes. Following the coding, descriptions, and categorizing, the researcher represented findings by way of a narrative. A narrative analysis of the data collected painted a portrait of the perceptions of the participants about the contribution of self-esteem in the reduction of risky sexual behaviors. This included direct citations from participants and a comparison of results from the study, literature review, and theories on this topic. Finally, the researcher derived thematic categories that emerged from the qualitative data, which were consistent with the literature review to describe the topic under study. These helped the researcher to explain the meaning of the information that was gathered to increase knowledge about the perceptions of participants concerning the contribution of self-esteem in the reduction of risky sexual behaviors. To assure the readers' understanding of the transferability of the results, thick description was also used in the data analysis.

4.9. ETHICAL CONSIDERATIONS

Ethical clearance and approval of the study protocols were obtained from the Ethical Review committee of School of Public Health in Addis Ababa University. Ethical clearance was obtained from Addis Ababa public health research and emergency management directorate. In addition, permission was sought from the respective heads of Addis Ababa City Administration health bureau and the respective schools. Prior to data collection, individuals were informed about the study and verbal consent was obtained from the study participants. Each respondent was informed about the objective of the study, procedures of selection and assurance of confidentiality. Participants were free to withdraw from the study at any time. Participants were not facing any harm nor receiving any monetary incentive for participating and it was solely

voluntary based. Confidentiality was kept at each step of the data collection and then after. To assure confidentiality no name or personal identifying information was written on the questionnaire and information was recorded anonymously. Once the data had been collected it was transferred onto a computer and immediately the data became confidential by using numbers to identify each individual, as well as all the documents being password protected.

5. RESULTS

5.1. QUANTITATIVE RESULTS

5.1. 1. SOCIO-DEMOGRAPHIC CHARACTERISTICS THE RESPONDENTS

From the total of 629 students who were identified for the study from ten high and preparatory schools of Addis-Ababa, 605 participated in the study making the response rate 96.2%. The widely held of the respondents were from grade nine 219(36.2%) followed by grade eleven 164 (27.1%). Five hundred twenty-five (86.8%) of the students were from public schools. Three hundred and eighty-five of the study participants were females (63.4%) and the majority 433(71.6%) were single in current relationship status. The majority of the respondents 589(97.4%) were in the age range of 15-19 years and the mean age of the respondents was 17.185(\pm 1.41).

Table 3: Frequency distribution of socio-demographic characteristics of the in-school adolescents in Addis- Ababa, Ethiopia, 2021

Variables	Frequency (N=605)	Percent
Sex		
Male	20	36.6
Female	385	63.4
Age		
10-14	16	2.6
15-19	589	97.4
Current attended grade level		
9	219	36.2
10	132	21.8
11	164	27.1
12	90	14.9
Current sexual relationship status		
In relationship	172	28.4
Single	433	71.6
School type		

Public	525	86.8
Private	80	13.2
Household average monthly income(ETB)		
≤1000	38	6.3
1001-3000	106	17.5
3001-5000	184	30.4
≥5001	277	45.8
Living arrangement		
With both parents	395	65.5
Father only	23	3.8
Mother only	102	16.9
Relatives	68	11.2
Under marital union	10	1.7
Alone	7	1.1
Average monthly pocket money		
≤100	381	63
101-300	133	22
301-500	72	11.9
≥501	19	3.1

5.1.2. KNOWLEDGE OF IN-SCHOOL ADOLESCENTS ABOUT STIs AND UNWANTED PREGNANCY

Around 528(87.3%) respondents reported as they were aware of sexually transmitted infections and the main information sources mentioned by students were mass-media 201(38%) and schools 193(36.5%). Around 510(96.6%) of the respondents knew the transmission methods of STIs including HIV/AIDS and the main transmission methods mentioned were blood contact 338(66.3%), mother to child 55(10.8%) and sharing sharp materials 38(7.5%). Besides, 369(72.4%) and 59(11.6%) students said abstinence from sex and condom utilization can reduce the risk of acquiring STIs including HIV/AIDS respectively. The students reported that abstinence from sex 286(47.8%) and using condoms 163(26.9%) during sexual intercourse were

the main prevention methods of unwanted pregnancy. Accordingly, of the total participants, 511(84.5%) had good comprehensive knowledge of STIs including HIV/AIDS and unwanted pregnancy.

Table 4: Knowledge of in-school adolescents about STIs and unwanted pregnancy in Addis-Ababa, Ethiopia, 2021

Variables	Response	Freq.	%
Heard about STIs including HIV/AIDS? (N=605)	Yes	528	87.3
	No	77	12.7
Sources of information (N=528)	Mass media	201	38
	Health professionals	96	18.2
	School	195	36.6
	Reading materials	38	7.2
Awareness about the transmission mechanisms of STIs, including HIV/AIDS (N=528)	Yes	510	96.6
	No	38	3.4
Transmission methods of STIs including HIV/AIDS(N=510)	Blood contact	338	66.3
	Physical contact	23	4.5
	Kissing	19	3.7
	Mother to child	55	10.8
	Sharing sharp materials	38	7.5
	Unprotected sex	37	7.3
Prevention methods of STIs including HIV/AIDS(N=510)	Abstinence from sex	369	72.4
	Being faithful to partner	42	8.2
	Using condom	59	11.6
	Avoid sharing sharp materials	40	7.8
Prevention methods of unwanted pregnancy(N=510)	Abstinence from sex	289	47.8
	Using condom	163	26.9
	Using other modern contraceptive methods	102	16.9

	I don't know	51	8.4
Comprehensive knowledge about STIs including HIV and pregnancy(N=605)	Good knowledge	511	84.5
	Poor knowledge	94	15.5

5.1.3. RISK PERCEPTION

The majority of the respondents 488(80.7%) thought that they were not at risk of getting HIV and 404(66.8%) thought they were not at risk of having unwanted pregnancy. About 317 (52.4%) of the adolescents perceived that alcohol consumption can predispose them to HIV infection. Of the total of 440 (66.8%) respondents who perceived that condom use is a practical option for the prevention of HIV/AIDS and 431(71.2%) perceived that the chance of getting unwanted pregnancy can be significantly reduced by using condoms. Similarly, 422(69.8%) of the respondents perceived that the chance of getting STIs can be significantly reduced by having sex only with one sexual partner. About 490(81%) of the respondents perceived that condom price was not too expensive but only 204(33.7%) thought they were confident enough to purchase and use condoms and almost half 292(48.2%) thought they can convince their partners to use condom during sexual intercourse. Accordingly, of the total participants, only 271 (44.8%) had good comprehensive perception of STIs including HIV/AIDS and unwanted pregnancy.

Table 5: Perception of in-school adolescents about STIs and unwanted pregnancy in Addis-Ababa, Ethiopia, 2021

Variables	Response	Freq.(N=605)	%
I believe I am at risk of getting HIV	Yes	117	19.3
	No	488	80.7
Alcohol consumption can predispose to HIV infection	Yes	317	52.4
	No	288	47.6
Believe at risk of having unwanted pregnancy	Yes	201	33.2
	No	404	66.8
Condom use is a practical protective option against HIV/AIDS	Yes	440	72.7
	No	165	27.3
Unwanted pregnancy can be significantly reduced	Yes	431	71.2

by using condom	No	174	28.8
The chances of contracting STIs can be significantly reduced by having sex with only one partner	Yes	422	69.8
	No	183	30.2
Condom price is too expensive	Yes	115	19
	No	490	81
I am confident to purchase and use condom	Yes	204	33.7
	No	401	66.3
I can convince my partner(s) to use condoms during sexual intercourse	Yes	292	48.3
	No	313	51.3
Comprehensive perception about STIs and pregnancy (N=605)	Good perception	271	48.3
	Poor perception	334	51.7

5.1.4. SELF-ESTEEM OF THE RESPONDENTS

The minimum Rosenberg self-esteem score of the respondents was zero and the maximum score was thirty. The mean Rosenberg self-esteem score was 19.4(\pm 4.89). Among the respondents the majority 546(90.3%) had high self-esteem levels.

Table 6: Self-esteem of in-school adolescents in Addis-Ababa, Ethiopia, 2021

Variables		Response			
		Strongly agree	Agree	Disagree	Strongly disagree
On the whole, I am satisfied with myself	Freq.(N=605)	457	105	18	25
	%	75.5	17.4	3	4.1
At times, I think I am no good at all.	Freq.(N=605)	134	152	172	146
	%	22.2	25.2	28.5	24.1
I feel that I have a number of good qualities	Freq.(N=605)	337	185	55	28
	%	55.7	30.6	9.1	4.6
I am able to do things as well as most other people	Freq.(N=605)	252	152	138	63
	%	41.7	25.1	22.8	10.4
I feel I do not have much to be proud of	Freq.(N=605)	122	88	245	150
	%	20.2	14.6	40.5	24.7
I certainly feel useless at times	Freq.(N=605)	105	77	228	195
	%	17.4	12.7	37.7	32
I feel that I'm a person of worth, at least on an equal plane with others.	Freq.(N=605)	319	151	77	58
	%	52.7	25	12.7	9.6

I wish I could have more respect for myself	Freq.(N=605)	352	122	57	74
	%	58.2	20.2	9.4	12.2
All in all, I am inclined to feel that I am a failure	Freq.(N=605)	104	84	236	181
	%	17.2	13.8	39	30
I take a positive attitude toward myself	Freq.(N=605)	404	135	24	42
	%	66.8	22.3	4	7
		High self-esteem		Low self-esteem	
Grand self-esteem level	Freq.(N=605)	546		59	
	%	90.3		9.7	
		Mean	Min	Max	
Total Rosenberg self-esteem score	19.4(±4.89)	0		30	

5.1.5. SEXUAL BEHAVIORS

About 248(41%) of students reported that they ever had sexual intercourse, of which 142(23.5%) and 106(17.5%) were females and males, respectively prior to the study. The minimum and maximum ages of sexual debut were 13 and 19 years respectively for both sexes. The mean age at first sexual intercourse was 17.153±1.359 years (17.14±1.442 for males and 17.16±1.297 for females). The median age of the students at first sexual intercourse was 17 years. One hundred sixteen (46.8%) of sexually active youth were below 18 years at the time of sexual initiation. Love and peer pressure were the most common reasons to start the first sexual intercourse reported by 75 (30.24%) and 56 (22.58%) of sexually active students respectively. Majority of sexually experienced respondents 225 (90.7%) were also sexually active within 12 months period before the study.

Forty-nine (21.8%) of sexually active respondents had had more than one sexual partner within twelve months period before the survey of which 25(51%) and 24(49%) were females and males respectively. The minimum and maximum numbers of concurrently owned sexual partners of males were 1 and 6 and for females 1 and 5 respectively in the last 12 months.

Of the sexually active students, 166(66.9%) ever used condom correctly, of which the majority 143(86%) always used condom each time they had sexual intercourse. To prevent pregnancy 86(47.3%) and to prevent STIs/HIV 78(52.1%) were the main reasons for use of condom. Nineteen (21.8%), 17(19.5%) and 15(17.24%) of respondents reported their main reason for non-use of condom was because they think condom decreases pleasure/satisfaction, partner refusal and being shy to buy condom respectively.

Of those male respondents who had sexual intercourse, 12 (11%) reported that they had sexual intercourse with commercial sex workers (CSWs) of which 10(83%) of them used condoms at all times they had encountered sex with CSWs. Of those female students who had sexual intercourse, 12(9.5%) reported that they received money/gift for sex in the past 12 months.

Table 7: Sexual history of in-school adolescents in Addis Ababa, Ethiopia, 2021

variables	Response	Freq.	%
Ever had sex (N=605)	Yes	248	41
	No	357	59
Time of initiation of sexual activity (N=248)	Age less than 18 years	116	46.8
	Age 18 years and above	132	53.2
Having sexual intercourse in the last 12 months (N=248)	Yes	225	90.7
	No	23	9.3
Number of sexual partners in the last 12 months(N=225)	One	176	78.2
	Two or more	49	21.8
Ever used condom(N=248)	Yes	166	66.9
	No	82	33.1
Frequency of condom use (N=248)	Sometimes	15	9
	Most of the time	8	5
	Always	143	86
Correct use of condom(N=166)	Yes	157	94.6
	No	9	5.4
Ever had sex with commercial sex workers-Males only (N=106)	Yes	12	11
	No	94	89
Ever used condom when having sex with CSWs-Males only (N=12)	Yes	10	63.3
	No	2	16.7
Frequency of condom use when having sex with CSWs-Males only (N=10)	Sometimes	3	30
	Most of the time	1	10
	Always	6	60
Ever received money /gift for sex in the	Yes	12	8.5

last 12 months-Females only (N=142)	No	130	91.5
Ever had pregnancy-Females only (142)	Yes	12	8.5
	No	130	91.5
Unwanted pregnancy-Females only (N=12)	Yes	11	91.7
	No	1	8.3
Ever had abortion-Females only (12)	Yes	11	91.7
	No	1	8.3
Number of abortions-Females only (N=11)	One	9	81.8
	Two or more	2	18.2
Place of last abortion-Females only (N=11)	Public health institution	6	54.6
	Private clinic	5	45.4

Overall, 160(26.5%) of the adolescents were involved in risky sexual behaviors prior to the study.

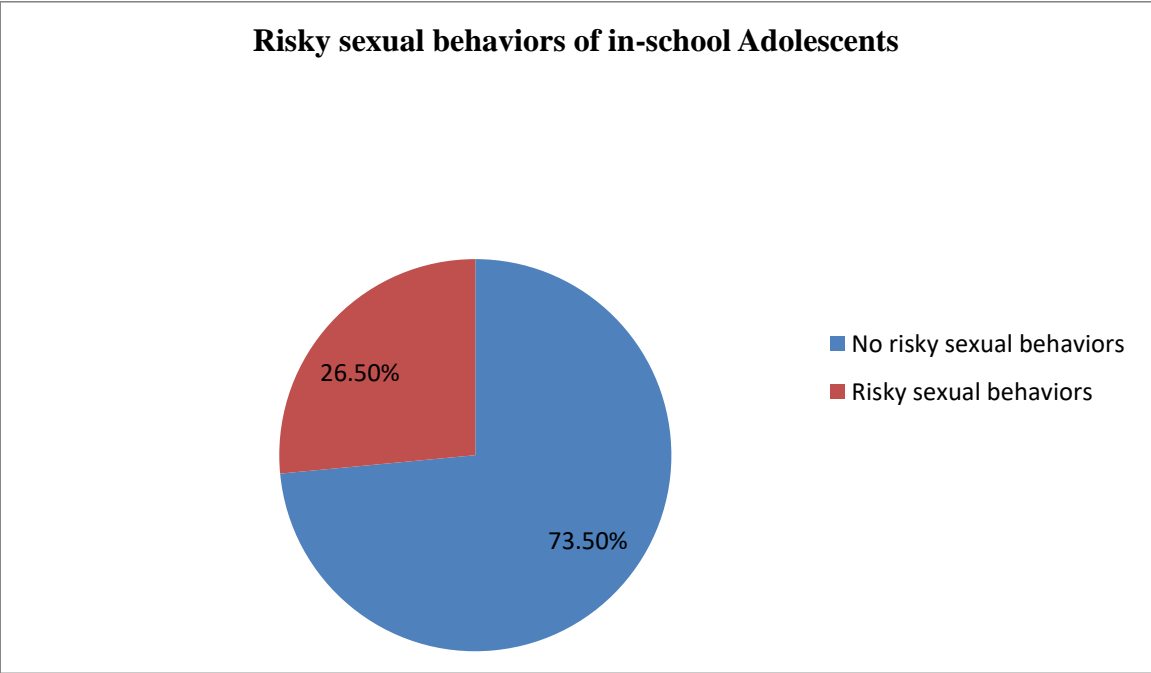


Figure 3: Risky sexual behaviors of in-school adolescents in Addis Ababa, Ethiopia, 2021

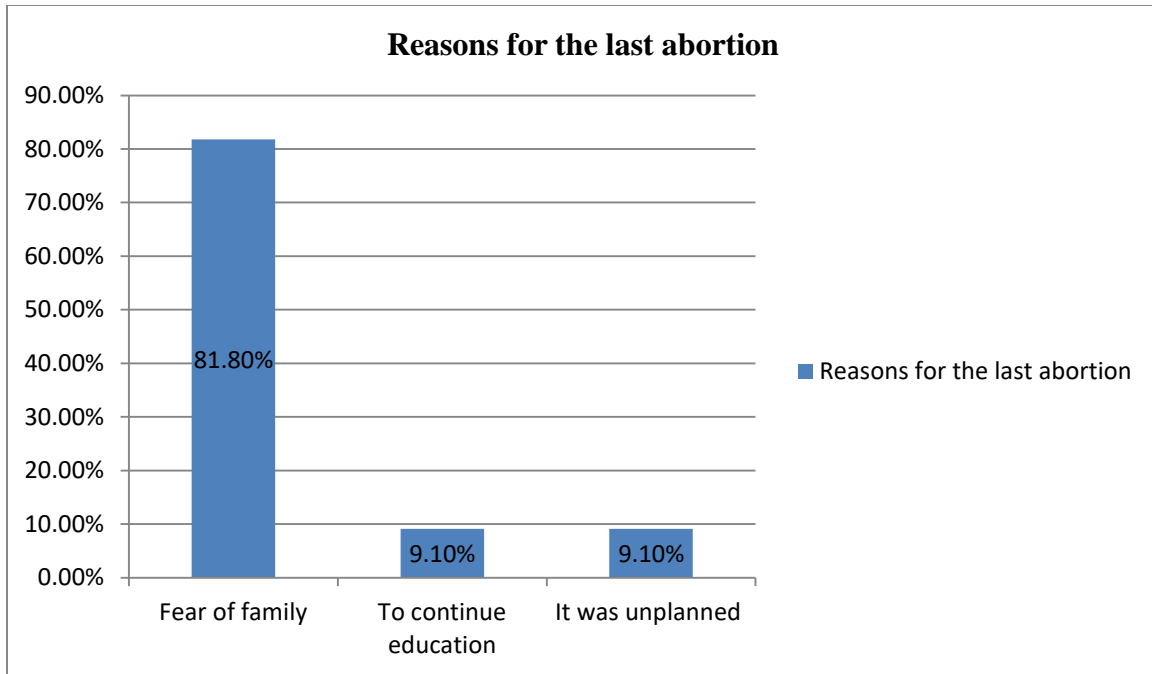


Figure 4: Reasons for abortion among female in-school adolescents in Addis Ababa, Ethiopia, 2021

5.1.6. FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOR

In multivariable logistic regression school type, living arrangement, average monthly pocket money, perception about risk of STIs and pregnancy, and self-esteem were factors significantly associated with risky sexual behavior.

The odds of risky sexual behavior among private school students were (AOR=2.08; 95% CI, 1.14-3.79) times higher than their public-school counterparts.

Students who lived alone were (AOR=8.4; 95% CI, 1.38-51.3) times more likely to exercise risky sexual behavior compared to students who lived with both parents, although the result should be cautiously interpreted for its wider confidence interval. There was no statistical difference between students who lived with both parents, with father only and with mother only.

Students who got average monthly pocket money of 301 to 500 ETB and who got more than 500 birr were (AOR=3.04; 95% CI, 1.66-5.65) and (AOR=5.02; 95% CI, 1.66-15.2) times more likely to exercise risky sexual behaviors compared with students who got less than 100 ETB respectively. There was no statistical difference between students who got less than 100 ETB and students who got between 101 and 300 ETB.

The odds of risky sexual behavior among in-school adolescents who had poor perception about the risk of STIs including HIV/AIDS and pregnancy were (AOR=2.34; 95% CI, 1.51-3.63) times higher compared with adolescents who had good perception.

On the other hand, the odds of risky sexual behavior among in-school adolescents who had low self-esteem were (AOR=3.48; 95% CI, 1.88-6.42) times higher compared with in-school adolescents who had high self-esteem.

Table 8: Bivariable and multivariable binary logistic regression analysis for risky sexual behavior among in-school adolescents in Addis Ababa, Ethiopia, 2021

Variable	Risky sexual behavior		COR (95%CI)	p-value	AOR(95%CI)	p-value
	Yes (%)	No (%)				
Sex						
Female	95(24.7)	290(75.3)	1.00		1.00	
Male	65(29.6)	155(70.4)	1.28 [0.88- 1.85]	0.192	1.03[0.67-1.60]	0.88
Age						
10-14	2(12.5)	14(87.5)	1.00		1.00	
15-19	158(26.8)	431(73.2)	2.57[.58- 11.42]	0.216	3.02[0.57-15.94]	0.193
Current attended grade level						
9	55(25)	164(75)	1.00		1.00	
10	36(27)	96(73)	1.12[.685-1.83]	0.655	0.84[0.49-1.44]	0.526
11	43(26)	121(74)	1.06[0.67-1.68]	0.806	0.73[0.43-1.24]	0.242
12	26(29)	64(71)	1.21[0.699-2.09]	0.493	0.76[0.40-1.42]	0.385
School type						
Public	128(24.4)	397(75.6)	1.00		1.00	
Private	32(40)	48(60)	2.07[1.27-3.37]*	0.004	2.08[1.14-3.79]**	0.017
Household average monthly income(ETB)						
≤1000	9(23.7)	29(76.3)	1.00		1.00	
1001-3000	27(25.5)	79(74.5)	1.10[0.46-2.62]	0.827	1.32[0.49-3.54]	0.576
3001-5000	42(22.8)	142(77.2)	0.95[.418-2.17]	0.909	1.06[0.41-2.72]	0.903
≥5001	82(29.6)	195(70.4)	1.35[0.614-2.98]	0.452	1.07[0.42-2.72]	0.881

Living arrangement						
With both parents	100(23.3)	295(74.7)	1.00		1.00	
Father only	5(21.7)	18(78.3)	0.82[0.296-2.26]	0.701	0.87[0.29-2.63]	0.803
Mother only	21(20.6)	81(79.4)	0.76[0.45-1.30]	0.322	0.79[0.45-1.41]	0.428
Relatives	22(32.4)	46(67.6)	1.41[0.81-2.46]	0.225	1.52[0.81-2.86]	0.190
Under marital union	7(70)	3(30)	6.9[1.75-27.13]*	0.006	4.75[1.01-22.4]**	0.049
Alone	5(71.4)	2(28.6)	7.4[1.41-38.61]*	0.018	8.4[1.38-51.3]**	0.021
Average monthly pocket money						
≤100	84(22)	297(78)	1.00		1.00	
101-300	35(26.3)	98(73.7)	1.26[0.80-1.99]	0.316	1.43[0.85-2.39]	0.176
301-500	29(40.3)	43(59.7)	2.38[1.40-4.05]*	0.001	3.04[1.66-5.65]**	<0.001
≥501	12(63.2)	7(36.8)	6.0[2.31-15.88]*	<0.001	5.02[1.66-15.2]**	0.004
Knowledge about risk of STIs and pregnancy						
Good	129(25.2)	382(74.8)	1.00		1.00	
Poor	31(32.9)	63(67.1)	1.46[0.907-2.34]	0.120	1.09[0.63-1.92]	0.742
Perception about risk of STIs and pregnancy						
Good	56(20.7)	215(79.3)	1.00		1.00	
Poor	104(31.3)	230(68.9)	1.74[1.19-2.52]*	0.004	2.34[1.51-3.63]**	<0.001
Grand self-esteem level						
High	130(23.8)	416(76.2)	1.00		1.00	
Low	30(50.8)	29(49.2)	3.31[1.92-5.72]*	<0.001	3.48[1.88-6.42]**	<0.001

N.B: * Significant for Crude Odds Ratio and ** significant for Adjusted Odds Ratio

5.2. QUALITATIVE RESULTS

5.2.1. CHARACTERISTICS OF THE PARTICIPANTS

A total of 18 participants participated in the qualitative component of the study. The majority of the participants 14(77.8%) are male participants. The age level was from 17 years to above 50 years of age. The median age of the participants was 35 Years (range 17-58 years). In terms educational status, six participants had second degrees, eleven had first degrees and one participant had secondary education. In terms of work experience, one of the participants was a school youth club member grade 11 student but the other participants had work experiences of 2-27 years. In terms of responsibility, five of the participants were heads of the school system that includes Addis Ababa region education bureau, sub-city education department and woreda education office, three were school vice directors, five were school counselors, four participants were school youth club leaders and one was a school youth club member.

Table 9: Characteristics of in-depth interview participants of the in-school adolescent study on risky sexual behavior in Addis Ababa, Ethiopia, 2021

Characteristics		Frequency(18)	Percentage
Sex	Male	14	77.8
	Female	3	22.2
Age	10-29	3	16.7
	30-35	7	38.9
	36-55	7	38.9
	>56	1	5.6
Responsibility	School system heads	5	27.8
	Vice directors	3	16.7
	School counselors	5	27.8
	Youth club leaders	4	22.2
	Youth club members	1	5.6
Educational status	Second degree	6	33.3
	First degree	11	61.1
	Student	1	5.6

5.2.2. CODING, CATEGORIZING AND THEMATIZING THE QUALITATIVE DATA

The qualitative data were coded, categorized, and thematized mainly by focusing on assessing common risky sexual behaviors, path-ways related to adolescents' risky sexual behaviors, consequences of risky sexual behaviors, and responsibilities to adolescent sexual and reproductive health in-school adolescents.

Table 10: Themes, sub-themes and number of coded responses of the qualitative data

Themes	Sub-themes	No of coded responses
Common risky sexual behaviors		
Early sexual initiation		8
Commercial sex work		7
Sex for exchange of money/gifts		4
Path-ways related to adolescents' risky sexual behaviors		
Individual circumstances	Sex of adolescents	12
	Age	8
	Grade level	7
	Relationship status	6
	Pornography viewing	9
	Substance use	12
	Perception about HIV/AIDS	16
	Pocket money	8
	Self-esteem	18
	Social media activity	9
Family circumstances	Living arrangement	8
	Family guidance and control	5
	Family economic status	5
Peer pressure		8
School type		7
Consequences of risky sexual behaviors		
HIV/AIDS and STIs		13
Unwanted pregnancy		10
Psychological problems		8
Responsibilities to adolescent sexual and reproductive health		
Parents' responsibility		15
Schools' responsibility		8
Government 's responsibility		10
Community's responsibility		8

5.2.3. COMMON RISKY SEXUAL BEHAVIORS.

The findings revealed that in-school adolescents were practicing different risky sexual behaviors. The analysis revealed three general thematic clusters that offer insight into the common risky sexual behaviors that were practiced among in-school adolescents. These themes were early sexual initiation, commercial sex work, and the sex for exchange of money or gifts.

5.2.3.1. Theme 1: Early sexual initiations

According to participants, risky sexual behavior is a common practice among in-school adolescents of grades 9 to 12 because adolescents at this level are at fire age. One participant suggested that:

“Adolescent students of grade 9 to 12 participate in risky sexual behaviors because they are at fire age. We cannot only say they are susceptible but it is a common experience in high schools. In our experience we know many students who engaged in risky sexual behaviors whose age ranges 18 to 20 years. Generally, high school adolescent students both males and females are susceptible to risky sexual behaviors and they need great attention, follow up and control. Parents, schools and teachers must work together very closely” (Male, 42).

Early sexual practice is having sexual intercourse before the age of 18 years. A number of respondents mentioned early sexual practice as the commonest risky sexual behavior practiced by adolescent students. One participant suggested that:

“...adolescents started sexual intercourse at early age. It is an unsafe sexual act that is not based on their conscious decision. It is sexual intercourse due to the influence of others. The other thing is students sometimes practice sexual intercourse with the same sex by simply watching videos released through the internet” (Male, 30).

Another participant noted that:

“Adolescents started sexual intercourse before the age of 18 years. Most of the time adolescent students start sexual intercourse due to the influence of their friends. If they saw their friends in risky sexual behaviors, they will also practice it. When a girl will be

in sexual relationship, all her friends will want to be like her. Some adolescent students are even in drug addiction like chewing Khat and smoking shisha” (Male, 39).

Another participant noted that:

“The most common risky sexual behavior among adolescents is early initiation of sexual intercourse due to peer pressures. Sexual intercourse at this early age is not in a safe way, it is in a way that creates different risks” (Female, 34).

5.2.3.2. Theme 2: Commercial sex work

Participants reported that female students could practice commercial sex work to support their life. Especially in-school adolescents whose mothers work as commercial sex workers might develop the habit and become commercial sex workers. One participant who is school guidance reported:

“I know and counsel students from a single mother who works at bars to support her mother and exposed to risky sexual behaviors. Some female students where their mothers are commercial sex workers will develop the habit and easily engage in risky sexual behaviors. Students who started commercial sex work at lower level came to us for counseling to be out from this behavior” (Male, 37).

Another participant noted that:

“There are girls who practice risky sexual behavior due to economic reasons. There are female students who work as commercial sex worker and learn and lead a family” (Male, 42).

5.2.3.3. Theme 3: Sex for the exchange of money/gifts

According to respondents adolescent female students could practice sexual intercourse with sugar daddies for the sake of money or gifts. To have clothes and shoes like their friends was the main reason to have sex with sugar daddies. One of an in-depth interview participant reported:

“Sometimes our students want to dress good and become stylish. But their parents may not fulfill their desire. As a result, they will become the victim of what we call them sugar

daddy. The sugar daddies are always chasing children from poor families. Is not it? There are adolescent students who do not want to see their families suffer. There are adolescents who scarify themselves for their parents. They know it is dangerous but they will engage in risky sexual behavior for their families. It is not all who engage in risky sexual behavior due to luxury .There are some who scarifies their life for their families” (Female, 43)

Another participant stated:

“...Female students who do not have families might practice sexual intercourse for exchange of money to support their life...” (Male, 17).

Another participant who is woreda education office head stated:

“Adolescent students are engaging in early sexual intercourse for the sake of money. They use this money to be like their friends by having the same shoes and clothing. They do not give the money they got to their families since families can raise questions about the source of the money” (Female, 37).

Another participant noted:

“There were some male adolescent students who worked as a broker between rich people and adolescent female students for the sake of money” (Male, 34).

5.2.4. PATHWAYS RELATED TO ADOLESCENTS’ RISKY SEXUAL PRACTICE

The findings revealed that to understand the reasons for adolescents’ risky sexual practice, the related and connected pathways must be understood. The analysis revealed four general thematic clusters that offer insight into the circumstances that indirectly influenced adolescents’ sexual behaviors. These themes were individual circumstances, family circumstances, peer pressure and school type.

5.2.4.1. THEME 1: INDIVIDUAL CIRCUMSTANCES

An individual circumstance is a concept that is related to the adolescent’s personal social life. Nine sub-themes emerged- sex, age, and grade level, relationship status, pornography viewing,

substance use, perception about HIV/AIDS, pocket money and self-esteem. These sub-themes were reported by participants as follows.

5.2.4.1.1. Sub-theme: Sex of adolescents

The respondents stated that adolescent girls practice risky sexual behaviors more than adolescent boys due to early maturity, economic and cultural reasons. One participant reported:

“Adolescent girls are engaging in risky sexual behaviors due to our countries economic status. They will practice risky sexual behaviors not due to their interest but due to the influence of their families. Female students who do not have families may practice sexual intercourse for exchange of money to support their life. There are many consequences of risky sexual behaviors among girls. Boys are also at risk but it is not comparable with girls” (Male, 17).

Another participant stated that:

“The males can practice risky sexual behaviors by their own interest but there are different factors that push adolescent girls to risky sexual behaviors. They may be raped by family members, neighbors and even in the straights by men who are drunk. Even biologically, female adolescents are more susceptible to risky sexual behaviors than male adolescents. When female adolescents committed suicide, they write notes that shows the reason behind it is rape by a family member” (Male, 39).

Another school guidance and counseling participant also stated:

“When we counsel in our office, the chance of exposer to risky sexual behaviors at early age is high among adolescent girls. They told us that they started sexual intercourse at grade 7 and grade 8 levels. But the males are starting sexual intercourse at a later age. Girls will start sexual intercourse early than boys because there are people who chase teenager girls for sexual intercourse. Generally, girls have a great chance to be exposed to risky sexual behaviors. The other thing that exposed girls to risky sexual behaviors is the lack of freedom at home. There is no free discussion regarding sexuality between girls and parents”.

5.2.4.1.2. Sub-theme: Age

According to the participants adolescent students in the age range 14 to 18 years are practicing risky sexual behaviors due to low capacity to judge situations. According to the participants adolescent students want to experiment everything. One participant stated that:

“Students from the age of 15 to 25 years are practicing risky sexual behaviors since they have low capacity to judge things. Adolescent students in this age category want to practice everything they saw” (Male, 35).

Another participant who is a school youth club leader noted:

“Most of the students that practice risky sexual behaviors are in the age range of 13 to 17 years who are very young. They will be lost in everything they got. This is may be the lack of training in self-discipline at the early stage. Those at this age category are easily susceptible to engage in risky sexual behaviors” (Female, 47).

Another participant noted:

“At the age of 17 years female adolescents become at risk. They want to touch and try everything. It is the same for adolescent boys. If they stay late, it is only until the age of 18 or 19 years” (Male, 17).

5.2.4.1.3. Sub-theme: Grade level

The participants reported that since adolescent students of grade 9 and 10 are less matured intellectually, the practice risky sexual behaviors than grade 11 and 12 students. One participant reported that:

“Risky sexual behavior is more common in grade 9 and 10. It starts in grade 9 or 10 but will be better in grade 12. Sometimes there are adolescents who had good discipline at lower classes but will engage in drug use and practicing risky sexual behaviors when they reached at grade 9 and 10” (Male, 17).

Another participant stated:

“Grade 9 and grade 10 students practice risky sexual behaviors most commonly. This is because of their age. They will come from grade 8 and when they meet students of higher age, they will be persuaded risky sexual behaviors as a sign of maturity and modernization. Since they are not matured enough, they will be easily pushed into risky sexual behavior” (Female, 47).

Another participant noted:

“Students in grade 9 and 10 are more exposed. Especially grade nine students are more exposed due to the physical change that occurred to them. Students in grade 11 and 12 have the capacity to judge things and cannot easily engage in risky sexual behaviors. So, grade 9 and 10 students are more exposed to risky sexual behaviors” (Male, 36).

Another participant stated:

“Students at lower level that is students in grade 9 and 10 are more at risky sexual behaviors because grade 11 and 12 students can manage themselves. Grade 11 and 12 students are more matured physically and intellectually and they understand the consequences of risky sexual behaviors and as a result they will not easily engage in risky sexual behaviors. But grade 9 and 10 students can easily be fooled if there will be a request for sexual intercourse” (Male, 58).

5.2.4.1.4. Sub-theme: Relationship status

According to the participants adolescent students who were in relationships practice risky sexual behaviors most of the time because most relationships at secondary school level are not stable.

One participant reported that:

“The studies showed that let alone at secondary school level, relationships at college level are not permanent. May be these students are in relationship not due to love. If they are not in love, they are easy to perform any activity. You will give care and support only to a person who is permanent. So, I think the ones in relationships are more susceptible to risky sexual behaviors. Let me tell you, if we look at our students, they will be with one partner this year then with another one in grade 10, with another in grade 11. They will change partners every year” (Female, 43).

Another participant who is a school guidance and counselor noted that:

“In secondary schools, students who are in relationship have risky sexual behaviors. Because when their first love life failed, they want to try another one. This becomes a habit and they continuously switched from one relation to another. For example one of our grade nine students committed suicide due to depression she got as a result of multiple sexual partnerships. When they are in relationships, they are one step closer to sexual practice which may not be safe. When one relationship is not successful, they move to another one. So, in the case of our school students who are in relationship engaged in risky sexual behaviors than students who are not in relationship” (Female, 27).

5.2.4.1.5. Sub-theme: Pornography viewing

Participants stated that watching movies and dramas that contain some pornographic contents is the major driving force among adolescent students. On line pornography is also another factor that pushes adolescents to RSBs. One participant stated:

“One of the driving forces to risky sexual behaviors is watching pornography through movies and dramas. No one blames the contents of movies and dramas. Nowadays the movies and dramas are the pushing factors to risky sexual behaviors rather than educating them” (Male, 58).

Another participant noted that:

“Adolescents have smart phones in their hands and these smart phones can bring everything from the western world without any restriction. They will be exposed to different sexual and pornography texts and videos which are not appropriate to their age. Online pornography is now commercialized and it is the main factor that pushes adolescents into risky sexual behaviors. Online sex and prostitution make our adolescents susceptible to risky sexual behaviors. So, parents should control the use of smart phones by their children. The parents may think they fulfill their children’s needs when they give them smart phones but they are spoiling the life of their children” (Male, 36).

5.2.4.1.6 Sub-theme: Substance use

A number of respondents mentioned as adolescent students used substances such as tobacco, illicit drugs like Khat, shisha, and alcohol. The inability of tobacco to provide sufficient satisfaction, coupled with pressure by their friends, led adolescent students to use other substances, such as alcohol and illicit drugs. One participant suggested that:

“Substance use pushed adolescents to risky sexual behaviors. There are many things under drugs. It is wide. There are “Khat”, Shisha, there is what they call it “Ganja”, Ecstasy, Everything! Now it is presented to the adolescents in the form of candy and cake. People who did this to children considered it as business. They are waiting the students at the entrance of schools and abuse them. So, in addition to the drug, we adult people are responsible for spoiling the life of the adolescents” (Female, 43).

Another participant noted:

“There are many things that we are hearing about students. For example, students are using drugs. In our case students are using a drink called “Korefe”, smoking, and khat chewing. There are students who are captured when they are smoking in the school compound. They drink alcohols especially ‘Areke’ during birthday parties” (Female, 27).

Another participant who was a school guidance and counselor noted:

“Most of the adolescents that practice risky sexual behaviors are the ones who use illicit drugs. It is more of related to drugs. Once they use drugs, they can easily rush into practicing risky sexual behaviors” (Female, 47).

5.2.4.1.7 Sub-theme : Perception about HIV/AIDS

The participants reported that adolescent students were practicing risky sexual behaviors not due to lack of Knowledge or awareness about sexual and reproductive health including HIV/AIDS and unwanted pregnancy. According to the participants adolescent student practiced risky sexual behaviors due to poor perception about sexual and reproductive health including HIV/AIDS and unwanted pregnancy. One participant reported:

“Now there is no problem of knowledge about HIV/AIDS. They considered HIV/AIDS as nothing different from chronic diseases. When they engaged in risky sexual behavior, what they fear most is pregnancy and abortion. What comes into their mind is only pregnancy. They did not worry about HIV/AIDS and other sexually transmitted diseases. In our school, there are many grade nine students who got birth and attending school by giving their children to their parents. This shows that students are engaged in risky sexual behaviors” (Female, 27).

Another participant noted:

“I do not think there is awareness problem. Adolescent students in cities can get information about reproductive and sexual health issues both in formal and informal ways. They know well about sexuality issues. The problem is there is external pressure from Medias and societies that push adolescents to risky sexual behaviors. Adolescents consider practicing sexual intercourse as a sign of modernization” (Female, 26).

5.2.4.1.7 Sub-theme: Pocket money

According to the participants adolescents who got extra pocket money were practicing risky sexual behaviors due to access to many luxurious materials. One participant noted:

“Adolescent students are not expected to have money rather to have pens, exercise books and Knowledge. If you gave them pocket money, that means you are allowing them to do extra things. If they have the money rather than eating, drinking and studying, they will try something extra. Not only are the adolescents, even you and me will try to practice something new if we have extra money. So, having a pocket money is one of the negative contributory factors to risky sexual behaviors” (Male, 35).

Another participant stated:

“Most of our students are from poor families. They help themselves economically by doing different works like webbing traditional clothes. They can get money by doing different works but they may not manage the money well at this young age. As a result, they will engage in the use of drugs and risky sexual behaviors. Since most of our students are from poor families, they will not get money from their parents. If you go to

private schools, they will get a lot of money from their parents and this push them to unwanted behaviors like risky sexual behavior and drug use. Students of private schools have the money freedom to buy and use anything they want like drugs. When they use drugs it will easily push them to risky sexual behaviors” (Male, 39).

5.2.4.1.8 Sub-theme: Self-esteem

According to participants self-esteem is the respect the adolescents give to themselves. When we say high self-esteem, it is selecting what is import to them and making the necessary decisions regarding every aspect of their life. Developing self-esteem starts from family and builds step by step. Self-esteem is not putting oneself into a risky situation and identifying the important from the non-important. An adolescent who had a high self-esteem could give value to the lives of others. If a person did not know and give value to himself/herself, then he/she could not care about the lives of others.

According to participants, in-school adolescents who have high self-esteem are protected from many harmful things. They are better students in their education. There are adolescents who lead a planned life by discussing with their parents. They know what to do at this young age. They did not initiate sexual intercourse at this young age if they have high self-esteem. But students with low self-esteem could engage very easily in risky sexual behaviors. One participant reported:

“I think self-esteem means the value that students give to themselves. Students with high self-esteem know who they are. If someone wants to have high self-esteem, he/she should have self-image. If students can identify their strengths and weaknesses, they will develop their self-esteem. So, self-esteem is very important in the life of adolescent students. Definitely students with high self- esteem had their own vision and goals. They know where to go in life. So, they will not practice risky sexual behaviors. But students with low self-esteem did not know where to go in life. They are like “I am on the way but I do not know where I am going.” Therefore, adolescent students with low self-esteem are more susceptible to risky sexual behaviors” (Male, 36).

Another participant noted:

“Self-esteem is about self-concept, knowing and being oneself. There are some students who have self-confidence and move by their own imagination and thinking. To be in a long- lasting relationship, it demands high self-esteem. It is the adolescent students who have low confidence and self-esteem who engaged in risky sexual behaviors. Students who had high self-esteem and high self-confidence either stay single or they would be in a one-to-one relationship” (Male, 34).

Another participant stated:

“Having high self-esteem is a very important thing. Students who give value to themselves would not participate at risky sexual behaviors. A Student who has value for himself/ herself would work only for the accomplishment of his/her goals. Students with low self-esteem and self-confidence would be the victim of risky sexual behaviors either by themselves or due to the influence of their peers” (Female, 34).

5.2.4.1.9 Sub-theme: Social media activity

According to participants, if we use it wisely the social- media is very important. But the media can also be harmful if not used in the right ways. There are some movies and music that are broadcasted through the social media that can easily have an influence on the sexual life of adolescent students. One participant stated:

“Social media has a lager effect since there may be pornography videos that are released by different plat forms. Social media has a larger effect on risky sexual behaviors of adolescents than the other Medias since it is easily available via smart phones that are available on the hands of the adolescents. At schools, students have the tendency of watching pornography movies in groups of males and females” (Male, 34).

Another participant noted:

“Social media like face book, YouTube and telegram had negative effect on the sexual and reproductive health of adolescents. Adolescent students are trying to explore more information from different sources. As a result, they would be exposed to many things

that could push them to risky sexual behaviors from social media. Parents should control the social media activities of their children” (Female, 26).

Another participant noted:

“There are many disadvantages of globalization on under-developing countries. The first one is the effect of technology like telegram, face book and Instagram. The contents broad casted by these social-medias are not all important, that is, they are not restricted” (Male, 30).

5.2.4.2 THEME 2: FAMILY CIRCUMSTANCES

Family circumstances were an important theme, and three sub-themes emerged as factors that indirectly influenced adolescents’ sexual behaviors. These sub-themes, as well as their illustrations, are presented below.

5.2.4.2.1. Sub-theme: Living arrangement

According to participants, adolescents who lived by their own and with other relatives might practice risky sexual behaviors due to disagreement, lack of family love, lack of family control and economic problems. One participant reported:

“The way parents handle children affects their sexual behavior. Students who were controlled and nurtured well by families would not engage in risky sexual behaviors. There was lack of control on students who lived with single parents or with other relatives. If there was no control, the adolescents would live as they want and may engage in risky sexual behaviors. Students who live with both parents will not engage in risky sexual behaviors due to strict control” (Male, 42).

Another participant reported:

“The degree of exposure among students who lived with their parents and those who lived with other parents was not the same. Adolescent students who lived with other relatives were more at risk. Even students who lived with only with a single parent were more susceptible to risky sexual behaviors than adolescent students who lived with both parents. Children who lived with both parents could get the necessary love, support and care than students who

lived with single parents and other families. Being a single parent had many burdens and made it difficult to give love and support to children. In case of adolescent students who lived with other families, there might be sexual harassment by some non-close relatives” (Female, 34).

Another participant noted:

“Students who lived with other relatives were at risk due to the sexual harassment they faced from these relatives. They were in a position where they do not defend themselves due to the economic dependence. Students who lived with single parents would have low self-esteem and could easily expose to risky sexual behaviors. I know and counseled students from a single mother who worked at bars to support her mother and exposed to risky sexual behaviors. When we counseled some students, we found that female students who were raised by single mothers were involving in risky sexual behaviors in order to get the love they missed from their fathers. They feel as if they missed the love of elder people and started sexual relationships with people older than them in order to get that love (Male, 36).

5.2.4.2.2. Sub-theme: Family guidance and control

According to the participants lack of guidance and proper discussion related to adolescent sexual reproductive health issues was one of the reasons that adolescent students practice risky sexual behaviors. One participant stated:

“There were some parents who did not want to discuss sexual issues with their children. This would expose adolescents to risky sexual behaviors. There should be open discussion between parents regarding when to start sex, effects of early sexual initiation and the consequences of risky sexual behaviors” (Male, 58).

Another participant noted:

“Lack of control and guidance by parents was one of the reasons to practice. There was desire to sexual relationship and if there was no control, the adolescents could easily practice risky sexual behaviors” (Male, 42).

5.2.4.2.3. Sub-theme: Family economic status

The participants noted that adolescent students from low economic status families could engage in risky sexual behaviors to fulfill the needs of themselves and their parents.

“Adolescents from low economic status were more at risk because people with money could easily persuade them to engage in risky sexual behaviors using money. I am not saying that adolescents from high economic status are safe , what I am saying is that due to lack of money the pressure on adolescents from poor families is very high. There were students who work as waitress at cafes and restaurants due to economic reasons which make them easily accessible and susceptible to risky sexual behaviors (Male, 58).

Another participant stated:

“Students from low economic status might practice risky sexual behaviors due to economic reasons and due to the environment, which they lived. There are parents who send their children to school by earning money as a commercial sex worker. Adolescents might also adapt these risky behaviors from their parents by considering it as normal” (Female, 34).

5.2.4.3. THEME 3: PEER PRESSURE

The participants reported that the adolescent students would seek support and counseling from their peers rather than from their families, teachers and guidance and counselors. But their friends did not have the right experience. They were not better than them. They advised them not from their experience. One participant stated:

“There were students who come for counseling. In our school, one boy loves a girl but the girl was not voluntary. One day her friends took her for a party to celebrate her birthday. At the birth day party the boy surprised her. Then her peers convinced her to stay the night with him and have sex with him. Starting from that day she did not know how to handle the case and seek counseling. The one who pushed her towards this risky sexual behavior was her best friend. So there is the effect of peer pressure to engage in risky sexual behaviors. If one would have a boyfriend/girlfriend, then the other will do so. As students told me, in our school, a student who has no boyfriend/girlfriend is considered as uncivilized, in their words

“fara”. A girl who was in risky sexual behavior wants her friends to do the same. There were group party and birthday celebrations” (Female, 27).

Another participant noted:

“At this age the students were more influenced by their peers than their family. Peer pressure might influence students to be sexually active. They might convince them by saying do not worry; we would taker and the like. They could make both females and males sexually active. They could influence them by saying, look at me I do have a sexual partner, why not you try it like me. But if the adolescents were strong enough, especially the girls, they could resist by considering the future consequences like pregnancy and HIV/AIDS” (Male, 58).

5.2.4.4. THEME 4: SCHOOL TYPE

According to the participants, adolescents from private schools were practicing risky sexual behaviors more than government school students due to poor family control and guidance, access to pornography videos, and drug use. One participant stated:

“I had the privilege to know both school types. Students from government schools, single parent and low economic status are more exposed to risky sexual behaviors. But majority of the students from private schools are more exposed to risky sexual behaviors due to poor family control and guidance. Students from private schools are very exposed to pornography videos. Students of private schools showed behaviors like smoking, chewing Khat and risky sexual behaviors. They did not fear anything. They always organize get-together and parties in the city” (Male, 36).

Another participant noted:

“Adolescent students who practiced risky sexual behaviors were those students who learn at private schools because in government schools once they entered into the school the chance of going out was very minimal but in private schools students could easily go out from the school by getting permission from their teachers. Students of private schools might even bring changing clothes and would be out by changing their uniform and no one asks them about this. Students from private schools were renting large houses and practicing risky

sexual behaviors at these houses with different rich people. There are students from private schools who practice sexual intercourse with the same sex” (Female, 37).

5.2.5. CONSEQUENCES OF RISKY SEXUAL BEHAVIORS.

The in-depth interview explored that Risky sexual behavior had many consequences. According to the participants adolescents’ life would not be the same once engaged in risky sexual behaviors. Adolescents who practice risky sexual behaviors could spoil the lives of other people besides themselves. It would have a big scare in their future lives. The analysis revealed three general thematic clusters that offer insight into the common consequences of risky sexual behaviors. These themes were HIV/AIDs and STIs, unwanted pregnancy and psychological problems.

5.2.5.1. Theme 1: HIV/AIDs and STIs

The participants noted risky sexual behaviors had an effect on the health of students. The students would be exposed to HIV/AIDS and other STIs. One participant noted:

“Risky sexual behavior has many consequences. Adolescent students who practice risky sexual behaviors could be susceptible to HIV/AIDS and other STIs” (Female, 47).

Another participant noted:

“Risky sexual behaviors had also an effect on the health of students. The students would be exposed to HIV/AIDS and other STIs. The final outcome would be death” (Male, 42).

5.2.5.2. Theme 2: Unwanted pregnancy

The participants noted unwanted pregnancy and related issues like abortion, school dropout and fistula as the consequences of risky sexual practices by adolescent students. One participant stated:

“Adolescent Female students could get unwanted pregnancy and as a result faced dropout of school and discrimination from their friends” (Male, 40).

Another participant noted:

“There might be unwanted pregnancy and unsafe abortion which might lead to loss of life. There might also be school dropout due to unwanted pregnancy and child birth” (Male, 39).

Another participant noted:

“Adolescent student who practice RSBs could be exposed to different health problems like unwanted pregnancy, abortion and fistful due to immaturity of the sex organs”(Male,36).

5.2.5.3. Theme 3: Psychological problems

According to the participants, adolescents who practiced risky sexual behaviors would be in loneliness, anxiety and depression. According to them there were adolescent students who committed suicide due to the effect of risky sexual behaviors. One participant stated:

“Adolescent students who practiced RSBs, especially girls, would be in depression and hopelessness. If they became hopeless, they would completely engage in risky sexual behaviors and this might lead female adolescents into prostitution. It might also lead adolescent boys into depression and stress which could lead to suicide. There were many students who committed suicide at schools due to the consequences of risky sexual behaviors. There might also be school dropout due to these risky sexual behaviors” (Male, 39).

Another participant reported:

“Risky sexual behavior itself is a disease and might lead to mental health problems. It would have psychological impact due to stigma and discrimination by the community. They would be marginalized and be in depression and commit suicide” (Male, 34).

5.2.6. RESPONSIBILITIES TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

The in-depth interview analysis showed that everybody has the responsibility to the sexual and reproductive health of adolescent students. Responsibility starts from home and went to neighbors, teachers at school, government and the community as the whole. According to the participants since these adolescents are the future of our country, we should give them the necessary advice and counseling. The analysis revealed four general thematic clusters that offer insight into the responsibilities to adolescent sexual and reproductive health. These themes were parent responsibility, school responsibility, government responsibility and community responsibility.

5.2.6.1. Theme 1: Parents' responsibility

The in-depth analysis showed that proper guidance, counseling and control by parents could prevent adolescents from practicing risky sexual behaviors. One participant reported:

“Parents should know the behavior of their children and make a strict control. Most parents tried to defend the behavior of their children which was unacceptable. They always said my child is innocent; he could not practice these types of behaviors. Parents should aware that students might have different behaviors at home and schools” (Male, 42).

Another participant noted:

“The most responsible bodies for adolescent students' sexual and reproductive health were parents. They should control their children. They should create a link with schools and followed every activity of their children” (Female, 37).

5.2.6.2. Theme 2: Schools' responsibility

The in-depth interview analysis showed that creating awareness to the adolescents about sexuality and reproductive health at the appropriate time would help them from practicing risky sexual behaviors. At schools, teachers should teach the students about gender and sexuality related issues using gender clubs. One participant stated:

“Sometimes schools were straggling in achieving the desired result regarding adolescent sexual and reproductive health because works were done using only campaigns. If schools worked continuously, I am sure the adolescents would be effective. For example, in our school when we gave the students the right sexual education and counseling, they would develop self-confidence and refrained from practicing risky sexual behaviors. This is because the brain would hold only the things that were told to it repeatedly. By creating awareness to the adolescents repeatedly using the life experience of other people, schools could inspire them. So, these students would set their own goals and worked day and night to achieve that goal” (Female, 43).

Another participant noted:

“Schools should create awareness about sexual and reproductive health using school clubs and normal classes. Counseling and other necessary supports should be given at schools to adolescent students who practiced risky sexual behaviors” (Female, 26).

5.2.6.3. Theme 3: Government responsibility

According to the participants the government should empower studies and implement the necessary policies, strategies, rules and regulations regarding sexual and reproductive health of adolescent students. The government should coordinate all. NGOs, schools and even the community would not act without the permission and coordination of the government. The analysis showed that ministry of health and ministry of education had the responsibility to design the right sexual and reproductive health education to adolescent students. One participant stated:

“Government laws related to adolescent sexual and reproductive health should be put in practice. Media which broadcast inappropriate contents should be punished by the government. Trade and industry minister should close pensions who rent rooms for adolescent students. License should not be given for pensions, khat houses and drink houses around schools. People who sell drinks for less than 18 years old adolescent students at the back of their drinking houses should be punished” (Male, 48).

Another participant noted:

“The government had a responsibility regarding adolescent sexual and reproductive health. The government should build Schools in areas that safe and free from drugs. Attention should be given to adolescent sexual and reproductive health education on the education curriculum. The government should create community awareness and mobilization regarding adolescent sexual and reproductive health” (Female, 26).

5.2.6.4. Theme 4: Community responsibility

The in-depth analysis showed that the whole community is responsible for the sexual and reproductive health of adolescent students. The analysis showed that since adolescents are the future of the country every community member had the responsibility to guide and counsel them.

One participant stated:

“People who convince adolescent students for sexual intercourse using money are living within the community as a result the community should take the responsibility for such things. People who have pensions, drinking houses and Khat houses should take the responsibility and treat the adolescents as their own children” (Male, 48).

Another participant noted:

“The problem in our country is the community did not control adolescent students as its on children. Community members did not say anything when they saw students at khat house, shisha house, drinking house and dance clubs wearing their school uniforms during school hours. Since these adolescents are the future of our country, every community member should give them the necessary advice and counseling” (Male, 39).

6. DISCUSSION

This study tried to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among in-school adolescents in Addis-Ababa. The finding of this study revealed that over one in four high-school students have risky sexual behavior. The common risk sexual behaviors include 46.8% had early sexual initiation (<18 years), 21.8% had more than one sexual partner, 33.1% of students never used condom during every sexual act and 8.5% of female students received money/gifts for sex. Nine in ten of in-school adolescents had high grand self-esteem.

Many literatures in Ethiopia showed that in-school adolescents are practicing risky sexual behaviors (39-41, 50). This study also found that 26.5% of the adolescent students were practiced risky sexual behaviors prior to the study. This study finding is much lower than a previous study done in Addis-Ababa(71.2%) among in-school adolescents (50). The lower result might be due to an improvement in knowledge about the risk of STIs and pregnancy among in-school adolescents. The implication for this finding is that more programs that targeted behavior change of in-school adolescents towards healthy sexual behaviors should be incorporated in the school curriculum.

This study revealed that 41% of the respondents ever had sexual intercourse. This implies that many in-school adolescents were sexually active before the study. This finding is much higher than previous studies conducted among in-school adolescents in Bodditi (29.1%) (22) and Gonder (23.6%) (12). This discrepancy of finding might be due to different sample sizes of study subjects, time variation and there might be under-reporting and over-reporting of responses, that is, there might be respondents that holdback the fact because they are shy and unable to disclose their sexual history. However, this finding is much lower than a study done among adolescent students (60.7%) in East Gojjam (41). Early marriage is very common in East Gojjam which is attributed to the early initiation of sex in the specific area.

The mean age at first sexual intercourse in this study was 17.153 ± 1.359 years (17.14 ± 1.442 for males and 17.16 ± 1.297 for females). This demonstrates that high and preparatory school students are sexually active at an early age which prolongs their exposure to STIs including HIV/AIDS. The finding was supported by the qualitative findings where some participants mentioned early

sexual initiation as the commonest risky sexual behavior practiced by adolescent students. The participants reported that, the most common risky sexual behavior among adolescents is early initiation of sexual intercourse due to peer pressure. They stated that Sexual intercourse at this early age is not in a safe way, it is in a way that creates different risks. This finding is almost similar to study done among high school students in Gondar City, Northwest Ethiopia, where the mean age of sexual commencement was 17.3 ± 1.6 years (12). This can be explained as a result of the two study areas being urban settings and majority of participants in both studies were in adolescent age category so that their sexual behavior will be closely related. However, this finding is higher than the findings of a study among high school youth in Pawe woreda Benishangul Gumuz, where the mean age at first sexual intercourse was $14.61 + 2.89$ SD for males and $15.74 + 2.165$ SD years for females (21). This is due to cultural differences between the study areas, as a result, the population attitude toward having sex and taking safety measures would be differently affected. The implication of the finding is the need for strengthening prevention strategies, effective interventions, and programs to reduce early sexual initiation among in-school adolescents with a collaboration effort of government policy makers, non-governmental organizations, program designers, religious institutions, and other stakeholders.

In this study, 22.58% of adolescent students reported peer pressure as a reason for the initiation of sexual intercourse. The finding was supported by the qualitative study where participants mentioned that at this age the students are more influenced by their peers than their family. Peer pressure is among the leading causes to be sexually active. This finding is higher than the findings of a study conducted in Pawe Woreda Benishangul Gumuz where peer pressure (16.2%) was the main reason for sexual initiation (21). The possible reason for this difference might be the difference in method and time of data collection. Therefore, launching and promoting peer education programs in schools to have positive peer pressure around school compounds is very crucial in changing the risky sexual behaviors of in-school adolescents in-order to have healthy future generations.

Among those who ever had sexual intercourse, 90.7% had sex in the last 12 months and among those who had sexual intercourse in the last 12 months, 21.8% had multiple sexual partners. This is similar to the study conducted in Addis-Ababa where (22%) among private and government

adolescent students in 2015 had multiple sexual partners. This indicates that despite five years of interventions, the behavior of adolescent students about having multiple sexual partners remains high. The reason for the result might be the notion that having multiple sexual partners is seen as a sign of modernizing. However, this finding is lower than the findings of study in Gonder where (51.6%) of sexually active respondents ever had more than one sexual partner (12). The possible explanation for this might be the study area is more urban than the previous study. In-school adolescents who had multiple sexual partners were at risk of contracting STIs including HIV/AIDS and these groups need immediate attention from responsible bodies.

Condom use is one of the strategies for preventing STIs including HIV. However, the prevalence of condom use among adolescent students is still low despite the efforts made so far to improve the utilization (39-41, 50). This study showed that 66.9% of sexually active students used condoms consistently with a non-regular partner prior to the study. This finding is similar to the findings of studies in Boditti high and preparatory schools (67.6%) (22) and Jimma university(69.1%) (60). The similarity in the findings showed that there might be knowledge gaps in utilizing condom in the study areas and the other reason might be the misperception of condom among adolescents and youths, that is, condom use decreases satisfaction during sexual intercourse. From this, we could see that significant sexually active in-school adolescents practiced unsafe sex which exposes them to risks. The reason that prevents them from using condoms was not persuasive enough and it is important to prevent themselves from the negative impact of risky sexual behaviors and subsequent consequences.

In this study, 11% of male adolescent students had sex with commercial sex workers in the past 12 months. This finding is comparable with a previous study done among East Wollega adolescent students(11.9%) (39)but a little lower than the previous study done among Gonder secondary school adolescent students(16.7%) (40). This study also showed that a significant amount of students who had sex with commercial sex workers did not use condoms consistently which might expose them to STIs including HIV/AIDS. Since adolescents have a responsibility and role in the growth and development of our country, the responsible body should tackle these problems immediately.

In this study, 8.5% of female in-school adolescents were receiving money or gift for the sake of sexual intercourse. This was supported by the qualitative study where participants mentioned adolescent female students could practice sexual intercourse with sugar daddies for the sake of money or gifts. To have clothes and shoes like their friends were the main reason to have sex with sugar daddies. This finding is similar to a qualitative study among high and preparatory school youth in East Wollega which showed that some students were financially insecure and they need money/ other gifts from their sexual partner. As a result, during sexual intercourse they fail to negotiate with their partners to use condoms, thus they practice unsafe sex (39).

In this study students who lived alone were 8.4 times more likely to exercise risky sexual behavior. This finding was supported by the qualitative finding where the participants stated adolescents who lived by their own and with other relatives might practice risky sexual behaviors due to disagreement, lack of family love, lack of family control and economic problems. This finding is similar to a study in Jimma where Female students living away from their parents were 3 times more likely to be at risk than students living with their parents (44). Numerous studies recommended family interventions to improve parent-child communication, supportive parenting, and parental monitoring. Therefore, effective parental monitoring of adolescents' behavior, attitude, and values have a significant role in reducing poor decision-making on sexual and reproductive life.

Students who got average monthly pocket money of 301 to 500 ETB were 3.04 times more likely to exercise risky sexual behavior and students who got more than 500 birr were 5.02 times more likely to exercise risky sexual behaviors compared to students who got less than 100 ETB. This was supported by findings from the qualitative study where participants noted adolescent students are not expected to have money rather have pens, exercise books, and knowledge. If you gave them pocket money, that means you are allowing them to do extra things. If they have the money rather than eating, drinking, and studying, they will try something extra like alcohol and drugs. This is different from a study among high and preparatory adolescents in Boditti and Gonder where there was no statistical association between pocket money and risky sexual behavior (12, 22). The difference might be due to the geographical and cultural differences between the study areas where students in Boditti and Gonder might not have the access to extra

things even if they had pocket money. Therefore, giving extra money to adolescent students might push them towards the use of alcohol and drugs, parents should only give a limited amount of money to their children. They should teach their children about the wise use of money.

In this study, the odds of risky sexual behavior among adolescents who had poor perception about the risk of STIs including HIV/AIDS and pregnancy were 2.34 times higher than adolescents who had good perception. This was supported by the in-depth interview analysis where participants reported that adolescent students were practicing risky sexual behaviors not due to lack of knowledge or awareness about sexual and reproductive health including HIV/AIDS and unwanted pregnancy. According to the participants, adolescent students practiced risky sexual behaviors due to poor perception about sexual and reproductive health including HIV/AIDS and unwanted pregnancy. This was similar to a study in Ghana where perception about the risk of STIs including HIV/AIDS and pregnancy were significantly associated with sexual activity (61). Efforts to reduce risky sexual behaviors among people in Ethiopia must be sustained as it holds the hope of HIV prevention in the country. The situation where adolescents generally perceived themselves to be at no risk of HIV infection despite their involvement in risky sexual behavior needs to be addressed. This calls for a focus on interventions that help adolescents to have a correct risk perception about STIs including HIV/AIDS and pregnancy of themselves.

In this study, the odds of risky sexual behavior among adolescents who attended private schools were 2.03 times higher than adolescents who attended government schools. This finding was supported by findings from the in-depth interview analysis where participants noted adolescents from private schools are practicing risky sexual behaviors more than government school students due to poor family control and guidance, access to pornography videos, and drug use. This is different from a comparative study in Addis-Ababa showed that among sexually active students, 2.9% of the private and 3.1% of the government students had sexual contact with a commercial sex worker, with no difference across these groups (50). The difference might be due to differences in sample size where the small size of students who started sex in the previous study made the sample size inadequate to assess factors. Government and non-government organizations and different school clubs such as Anti- AIDS clubs of the schools should further

work for reduction of risky sexual behavior. Sexuality education needs to be promoted in schools to help reduce the vulnerability of in-school adolescents.

In this study, adolescents who had low self-esteem were 3.48 more likely to engage in risky sexual behaviors compared to students who had high self-esteem. This finding was supported by findings of the qualitative study where participants noted that low self-esteem can be a predictor for having sex at an earlier age. According to the participants, adolescent students who have high self-esteem are protected from many harmful things. They are better students in their education. Some adolescents lead a planned life by discussing with their parents. They know what to do at this young age. They did not initiate sexual intercourse at this young age if they have high self-esteem. But students with low self-esteem could engage very easily in risky sexual behaviors. There is a similar study finding in Nigeria that showed adolescents with low self-esteem were more likely to be sexually active and to have higher mean RSB score ($t=2.2$, $p=0.3$, mean BHS score high self-esteem=1.3, mean BHS score low self-esteem=1.9) (7). This finding was also similar to another study among young adult ecstasy users in Atlanta which showed that higher levels of self-esteem were associated with fewer sexual partners ($p < .05$) (54). This finding might be due to the use of the same scale for measuring global self-esteem among adolescent students. From this, we could observe that adolescents who have a strong sense of themselves and self-respect might not be immune from sexual urges, but having good self-esteem might help them to handle relationships in more mature ways. Adolescents who are struggling with their sense of self-worth might be the most prone to unwise decisions about sex. A parent or caregiver should help foster healthy self-esteem in their children as well as a supportive and caring relationship with them, which can encourage their children to make healthy choices in all aspects of their life, including their relationships and sexuality. Sexually active adolescents will also need non-judgmental education about the risks and responsibilities of sex, including proper medical care where appropriate.

7. STRENGTHS AND LIMITATIONS OF THE STUDY

7.1. STUDY STRENGTHS

There are several strengths to this study. Most previous reviews and studies in Addis-Ababa have not documented the use of mixed methods techniques to assess the association between self-esteem and risky sexual behaviors among adolescent students. Thus, this is the first study of its kind. The limited data, as well as the sensitive topic, have made it difficult for other researchers to gain information from previous studies. Thus, the in-depth results from this study have provided significant data to document adolescents' risky sexual behaviors that put them at risk of STIs, HIV, and unwanted pregnancies. This study will assist researchers, health educators and professionals, as well as policy-makers, in conducting further studies, formulating sexual and reproductive health programs and improving current adolescent health policies.

The mixed-methods approach has specific strengths that should be considered. Firstly, the study had utilized a two-phase sequential design in which the phase one results were used to develop and inform the purpose and design of the following phase. Secondly, it was decided to complement the other method by using both quantitative and qualitative methods. Thirdly, the study design provided a stronger evidence for a conclusion through methodological triangulation. Finally, the qualitative component has added further insights and understanding that might be missed during the quantitative phase. This produces more complete knowledge necessary to inform theory and practice.

7.2. STUDY LIMITATION

Cross-sectional studies are not adequate for measuring the directionality of associations found, and this study may be subject to several unmeasured, potential confounders. Like in most studies on adolescent sexuality, this study relied on the respondents' self-reports of their sexual behaviors, and hence information bias may result due to either under/or over-reporting of their true risk behaviors. Since the study used single proportion formula, the small sample size might affect the findings as it was seen in some findings with wide confidence intervals. The other limitation of this study is that, students might not be the appropriate respondents for monthly household income.

8. CONCLUSION AND RECOMMENDATIONS

8.1. CONCLUSION

Based on the findings, the majority of in-school adolescents were sexually active before the age eighteen and over one in four of sexually active high-school students have risky sexual behavior. Nine in ten of them have high self-esteem. Risk perception, self-esteem, and school type are significantly associated with risky sexual behavior. Low self-esteem, peer influence, lack of family guidance and control, substance use, and pornography viewing were the major reasons to practice risky sexual behaviors.

Sexual and reproductive health programs for in-school adolescents should be tailored to address their specific needs by building friendly public policies, creating a supportive environment, strengthening community action, developing personal skills, and reorienting the health services that help develop self-esteem and change poor perceptions about STIs and pregnancy.

8.2. RECOMMENDATIONS

8.2.1 FOR THE GENERAL POPULATION

The population should be aware of the disadvantage of giving excess pocket money to adolescents since having excess money is associated with engaging in risky sexual behavior. The public should inform adolescents about the risks of early sexual initiation via open communication.

Parents should know the behavior of their children and make a strict control. They should give proper guidance, counseling and control to prevent adolescents from practicing risky sexual behaviors.

8.2.2. FOR HEALTH CARE PROVIDERS

Behavioral change communication (BCC) and information, education and communication (IEC) programs should be designed by giving great emphasis to adolescent sexuality. Especial emphasis should be given to changing the poor perception regarding the risk of STIs including HIV/AIDS and pregnancy. The School-based health education should be given at both public and private schools. Interventions should focus on building healthy public policies, creating a supportive environment; strengthening community action, developing personal skills, and

reorienting the health services that help develop self-esteem and change poor perceptions about STIs and pregnancy.

8.2.3. FOR PROGRAMMERS AND POLICY-MAKERS

When health programs and policies are designed, they should take the sexual and reproductive health needs of adolescents at the center. Policies and programs should incorporate every factor that can affect the sexual and reproductive health of adolescents. Ministry of Education in collaboration with the Federal Ministry of Health should work hard on strengthening Sexual Health Education in Schools. School based health programs should focus on self-esteem development and changing poor perceptions regarding STIs and unwanted pregnancy using life skill trainings in school youth clubs.

8.2.4 FOR RESEARCHERS

Further research is needed to develop effective interventions for this population to reduce sexual risk behaviors, which may have a huge benefit to the control of HIV and STI.

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ANNEXES

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

Questionnaire for a study on the assessment of the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescents in Addis Ababa.

Annex 1: Study Information Sheet

My name is _____. I belong to the research team studying the assessment of the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescent students. The study is being conducted by a graduate student of Public Health (**Shimeles Zewdie**) at the School of Public Health in Addis Ababa University. The objective of this study is to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescents in Addis-Ababa. I kindly ask you to participate in this study and give me genuine answers for my questions. Your participation in this study is greatly helpful in identifying problems related to sexual reproductive health among adolescents and the effect of developing self-esteem in reducing risky sexual behaviors. The interview will take about 30 minutes. Your name will not be written in this form and will never be used mentioned in the report either. You will not get payment because of your participation in this study and will not lose any service rendered by the youth center or similar health service providers. All information given by you will be kept confidential and no one except the research team members will have access to the information. Your participation is completely voluntary and you are not obligated to answer any question you are not willing to respond. If you feel any discomfort with the question, it is your right to drop it at any time you want. You may even decide not to engage in this study from the very beginning. I hope I have clarified the purposes of the study. If you have any question you can ask me now or you may ask the principal investigator, Shimeles Zewdie, whose telephone is **+251913075507** or email: **shimeles.zewdie@yahoo.com/beke.emere@gmail.com.**

Annex 2. Consent Form

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

Are you willing to participate in this study?

- 1. Yes..... Continue to the next page
- 2. No..... Skip to the next participant

Signature of interviewer-----

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

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

Annex 3. Sexual Behaviors and Self-esteem Related English Version Questionnaire

Addis Ababa University, College of Health Sciences, School of Public Health Questionnaire to determine the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescents in Addis-Ababa,2020.

001 Questionnaire ID_____

002 Addresses: sub-city_____ Woreda_____ house No _____

Phone number_____

003 Name of school_____

004 School type: Public-----1

Private-----2

Part I. Socio-demographic characteristics of adolescent students in Addis Ababa, 2020 <i>(please tick in the space provided)</i>				
No	Questions	Responses	Code	Skip to Q
101	Sex of respondent	<input type="checkbox"/> Female	1	
		<input type="checkbox"/> Male	2	
102	How old are you in your last birthday?	-----		
103	What is your current sexual relationship status?	<input type="checkbox"/> In relationship	1	
		<input type="checkbox"/> Single	2	
104	What is your current attended grade level?	<input type="checkbox"/> 9	1	
		<input type="checkbox"/> 10	2	
		<input type="checkbox"/> 11	3	
		<input type="checkbox"/> 12	4	
105	With whom are you currently living?	<input type="checkbox"/> with both parents	1	
		<input type="checkbox"/> with father only	2	
		<input type="checkbox"/> with mother only	3	
		<input type="checkbox"/> with relatives	4	
		<input type="checkbox"/> under marital union	5	
		<input type="checkbox"/> alone	6	
106	What is your households' expected average monthly income?	-----birr		
107	How much monthly pocket			

	money do you get?	-----birr		
Part II. Knowledge of school adolescents about STIs and unwanted pregnancy <i>(please tick in the space provided)</i>				
No	Questions	Responses	Code	Skip to Q
201	Are you aware about Sexually transmitted infections?	<input type="checkbox"/> Yes	1	
		<input type="checkbox"/> No	0 →	206
202	What were your sources of information? (multiple response possible)	<input type="checkbox"/> mass media	1	
		<input type="checkbox"/> health professionals	2	
		<input type="checkbox"/> school	3	
		<input type="checkbox"/> reading materials	4	
203	Are you aware about the transmission mechanisms of sexually transmitted infections, including HIV/AIDS?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	206
204	Which transmission method do you know? (multiple response possible)	<input type="checkbox"/> Blood contact	1	
		<input type="checkbox"/> Physical contact	2	
		<input type="checkbox"/> Kissing	3	
		<input type="checkbox"/> Mother to child	4	
		<input type="checkbox"/> Sharing sharp materials	5	
		<input type="checkbox"/> Unprotected sex	6	
205	How do you prevent sexually transmitted infections including HIV/AIDS? <i>(multiple response possible)</i>	<input type="checkbox"/> Abstained from sex	1	
		<input type="checkbox"/> Being faithful for boy/girlfriend	2	
		<input type="checkbox"/> By using condom	3	
		<input type="checkbox"/> Avoid sharing sharp materials	4	
206	How do you prevent unwanted pregnancy? <i>(more than one response possible)</i>	<input type="checkbox"/> Abstained from sex	1	
		<input type="checkbox"/> By using condom	2	
		<input type="checkbox"/> By using other modern contraceptive methods	3	
		<input type="checkbox"/> I don't know	4	
Part III. Sexual behaviors and related practices of school adolescents in Addis Ababa,2020 <i>(please tick in the space provided)</i>				
No	Questions	Responses	Code	Skip to Q
301	Have you ever had sexual intercourse?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	401
302	At what age did you first have sexual intercourse?	----- <i>(age in completed years)</i>		

303	Why did you decide to have sexual intercourse for the first time?	<input type="checkbox"/> Attending night clubs	1	
		<input type="checkbox"/> Chewing khat	2	
		<input type="checkbox"/> Forced	3	
		<input type="checkbox"/> I got married	4	
		<input type="checkbox"/> I was drunk	5	
		<input type="checkbox"/> Love	6	
		<input type="checkbox"/> Peer pressure	7	
		<input type="checkbox"/> Personal desire	8	
		<input type="checkbox"/> To get money	9	
		<input type="checkbox"/> Watching porn video	10	
304	How many people in total have you ever had sexual intercourse in the past 12 months?	-----		
305	How many people in total have you ever had sexual intercourse in the past one month?	-----		
306	Have you ever used condom correctly each time you have sex?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	311
307	How often did you use Condom?	<input type="checkbox"/> Sometimes	1	
		<input type="checkbox"/> Most of the time	2	
		<input type="checkbox"/> Always	3	
308	Have you ever used condom correctly each time you have sex?	<input type="checkbox"/> yes	1 →	310
		<input type="checkbox"/> no	0	
309	Which problem had been encountered during condom use?	<input type="checkbox"/> Condom tear off during sexual intercourse	1	
		<input type="checkbox"/> Inappropriate insertion of condom	2	
		<input type="checkbox"/> Inappropriate removal of condom	3	
		<input type="checkbox"/> Other (specify)	99	
310	Why have you used condom? <i>(more than one response possible)</i>	<input type="checkbox"/> To prevent STIs/HIV	1	
		<input type="checkbox"/> To prevent pregnancy	2	
		<input type="checkbox"/> Other (specify)	99	
311	If you have not used condom at all, or have not used it	<input type="checkbox"/> Ashamed to buy	1	
		<input type="checkbox"/> Decreases satisfaction/pleasure	2	

	consistently what was the reason? (<i>multiple response possible</i>)	<input type="checkbox"/> I trust my partner	3	
		<input type="checkbox"/> I was drunk	4	
		<input type="checkbox"/> My religion prohibits	5	
		<input type="checkbox"/> Not available	6	
		<input type="checkbox"/> Partner refusal	7	
		<input type="checkbox"/> Too expensive	8	
		<input type="checkbox"/> others(specify)	99	
312	(Question 312-314 for male respondents only) Have you ever had sexual intercourse with commercial sex workers?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	401
313	Have you ever used a Condom when having sexual intercourse with commercial sex workers during the last 12 months?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	401
314	How often did you use Condom when having sexual intercourse with commercial sex workers?	<input type="checkbox"/> sometimes	1	
		<input type="checkbox"/> most of the time	2	
		<input type="checkbox"/> always	3	
315	(Question 315-322 for female respondents) Have you ever received money/gift for sex in the last one year?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
316	Have you ever become pregnant?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	401
317	How old were you when you were first become pregnant?	-----years		
318	Did you ever have unplanned pregnancies?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	

319	Have you ever aborted or stopped a pregnancy?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0 →	401
320	How many times did you have abortions?	-----		
321	Why did you abort or terminate the last pregnancy? (<i>multiple response possible</i>)	<input type="checkbox"/> Fear of my family	1	
		<input type="checkbox"/> To continue my education	2	
		<input type="checkbox"/> It was unplanned	3	
		<input type="checkbox"/> It had been outside marriage	4	
		<input type="checkbox"/> Economical problems	5	
		<input type="checkbox"/> Others (specify)	99	
322	Where did you the last abortion have?	<input type="checkbox"/> At public health institution	1	
		<input type="checkbox"/> At private clinic	2	
		<input type="checkbox"/> At abortionist house	3	
		<input type="checkbox"/> Others (specify)	99	

Part IV: Risk perception of adolescent students in Addis Ababa, 2020(*please tick in the space provided*)

No	Questions	Responses	Code	Skip to Q
401	Do you believe you are at risk of getting HIV virus?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
402	Do you perceive that alcohol consumption can predispose to HIV acquisition?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
403	Do you believe that you will get unwanted pregnancy?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
404	Do you think that unwanted pregnancy can be significantly reduced by using condom?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
405	Do you believe that condom use is a practical protective option against AIDS?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
406	Do you think that the chances	<input type="checkbox"/> yes	1	

	of contracting STIs can be significantly reduced by having sex with only one partner?	<input type="checkbox"/> no	0	
407	Do you believe that using a condom reduce sexual satisfaction?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
408	Do you believe that condom is too expensive?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
409	Are you confident to purchase and use condom?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	
410	Can you convince your partner(s) to use condoms during sexual intercourse?	<input type="checkbox"/> yes	1	
		<input type="checkbox"/> no	0	

Part V: Self-Esteem Related Questions (Rosenberg scale) (please tick in the space provided)

No	Questions	Responses	Code	Skip to Q
501	On the whole, I am satisfied with myself.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
502	At times, I think I am no good at all.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
503	I feel that I have a number of good qualities.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
504	I am able to do things as well as most other people.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
505	I feel I do not have much to be proud of.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
506	I certainly feel useless at times.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	

507	I feel that I'm a person of worth, at least on an equal plane with others.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
508	I wish I could have more respect for myself.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
509	All in all, I am inclined to feel that I am a failure.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	
510	I take a positive attitude toward myself.	<input type="checkbox"/> strongly agree	1	
		<input type="checkbox"/> agree	2	
		<input type="checkbox"/> disagree	3	
		<input type="checkbox"/> strongly disagree	4	

Thank you very much!

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

An interview guide to a study on the assessment of the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescents in Addis-Ababa.

Annex 4: Study Information Sheet for an in-depth interview

My name is _____. I belong to the research team studying the assessment of the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescent students. The study is being conducted by a graduate student of Public Health (**Shimeles Zewdie**) at the School of Public Health in Addis Ababa University. The objective of this study is to assess the magnitude of risky sexual behavior and its association with self-esteem and other covariates among adolescents in Addis-Ababa. I kindly ask you to participate in this study and give me genuine answers for my questions. Your participation in this study is greatly helpful in identifying problems related to sexual reproductive health among adolescents and the effect of developing self-esteem in reducing risky sexual behaviors. The interview will take about 30 minutes. Your name will not be written in this form and will never be used mentioned in the report either. You will not get payment because of your participation in this study and will not lose any service rendered by the youth center or similar health service providers. All information given by you will be kept confidential and no one except the research team members will have access to the information. Your participation is completely voluntary and you are not obligated to answer any question you are not willing to respond. If you feel any discomfort with the question, it is your right to drop it at any time you want. You may even decide not to engage in this study from the very beginning. I hope I have clarified the purposes of the study. If you have any question you can ask me now or you may ask the principal investigator, Shimeles Zewdie, whose telephone is **+251913075507** or email: **shimeles.zewdie@yahoo.com/beke.emere@gmail.com.**

Annex 5. Consent Form for in-depth interview

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

Are you willing to participate in this study?

- 1. Yes..... Continue to the next page
- 2. No..... Skip to the next participant

Signature of interviewer-----

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

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

Annex 6: Interview Guide

Questions for heads and leaders

1. How does self-esteem affect the sexual behaviors of adolescents?
2. Whom do you think engaged in risky sexual behaviors? Adolescents with high self-esteem or adolescents with low self-esteem, why? What must be done to improve adolescents' self-esteem?
3. Who do you think is responsible about the sexual and reproductive health of adolescents? Why? Tell me more about it?

Questions for media club heads

1. In your own words describe your perceptions of risky sexual behavior and the factors that drive adolescents to risky sexual behaviors.
2. What is the influence of mass-media on the sexual behavior of students?

Questions for counselors

1. Do you think that peer influence have an effect on the sexual behavior of students? How?
2. What about pocket money?
3. What must be done to prevent adolescents from engaging in risky sexual behaviors? Do you think this strategy is effective? Do you think this could be improved?

Questions for students

1. What is risky sexual behavior? Tell about the main attributes of risky sexual behavior.
2. Can you tell me in your own words your experience of self-esteem? What does this mean for you?
3. What is the driving force for you first sex?
4. Have you ever felt you engaged in risky sexual behaviors? Tell me what you experience?
5. What challenges do you face in your sexual life? In your opinion can this challenges be overcome?

Annex-7: Proportional allocation of respondents sample size to each selected school, 2020

School	Size of students in each school	Size selected from each school
Bulbula secondary and preparatory school	1951	82
Derartu Tulu secondary and preparatory school	2114	89
Entoto amba secondary and preparatory school	2711	115
Ethio –parent school	280	12
Beteseb academy	534	23
Yetwliid –Tesfa secondary and preparatory school	741	32
Frehiowt secondary and preparatory school	1784	75
Ginbot -20 secondary and preparatory school	1616	68
Kokebe Tsibeha secondary and preparatory school	2912	122
Andenet international school	249	11

Annex-8: Proportional allocation of respondents sample size to each grade level, 2020

School	Size of students in each grade level				Size selected from each grade			
	9	10	11	12	9	10	11	12
Bulbula secondary and preparatory	851	500	455	145	36	21	19	6
Derartu Tulu secondary and preparatory school	483	165	1005	461	20	8	42	19
Entoto amba secondary and preparatory school	1478	673	510	50	62	29	22	2
Ethio –parent school	77	79	71	53	4	3	3	2
Beteseb academy	176	118	128	112	8	5	5	5
Yetwliid –Tesfa secondary and preparatory	191	224	146	180	8	10	6	8
Frehiowt secondary and preparatory school	664	496	380	244	28	21	16	10
Ginbot -20 secondary and preparatory school	455	250	525	386	19	11	22	16
Kokebe Tsibeha secondary and preparatory	1042	740	674	456	44	31	28	19
Andenet international school	88	70	47	44	4	3	2	2

አባሪዎች

አዲስ አበባ ዩኒቨርሲቲ

የጤና ሳይንስ ኮሌጅ

የህብረተሰብ ጤና ትምህርት ክፍል

በአዲስ አበባ ከተማ የሚገኙ አፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለውን ቁርኝት ለማጥናት የተዘጋጀ የአማርኛ መጠይቅ፤

አባሪ 1: የጥናቱ መረጃ ቅጽ፤

ጤና ይስጥልኝ፤

ስሜ _____ እባላለሁ። የአፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለውን ቁርኝት ከሚያጠኑት አካላት አንዱ/ዷ ነኝ። ጥናቱ የሚካሄደው በአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና ትምህርት ቤት የህብረተሰብ ጤና የድህረ-ምረቃ ተማሪ በሆነው በሽመልስ ዘውዴነው። የጥናቱ ዋና ዓላማ የአፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለው ቁርኝት ምን ይመስላል የሚለውን ለማጥናት ነው። አንተን/አንችን የምጠይቅህ/ሽ በዚህ ጥናት ላይ እንድትሳተፍ/ሪ እና ለጥያቄዎቹ ትክክለኛ ምላሽ እንድትሰጡኝ/እንድትሰጩኝ ነው። ያንተ/ቺ በዚህ ጥናት ላይ መሳተፍ ከጸታዊና የስነ ተዋልዶ ጤና ጋር ተያይዘው የሚከሰቱ ችግሮችን በመለየት የአፍላ ወጣት ተማሪዎችን የራስ ዎጋ መስጠትን ማሳደግ የወጣቶችን አደገኛ ወሲባዊ ተግባራት ከመቀነስ አንጻር ያለው ተፅዕኖ ምን እንደሚመስል ለመለየት ይጠቅማል። ቃለ-መጠይቁ 30 ደቂቃዎችን ሊወስድ ይችላል። በዚህ ቅጽ ላይ ስምህ/ሽ አይጻፍም እንዲሁም በሪፖርቱ ላይ አይጠቀስም። በዚህ ጥናት ላይ በመሳተፍህ/ሽ ምንም አይነት ክፍያ የለውም ። ሁሉም የምትሰጡው/ጭው መረጃ ምስጢራዊነቱ የተጠበቀ ነው። ከጥናት ቡድኑ በስተቀር ማንም ሊያገኘው አይችልም፤ ያንተ/ቺ ተሳትፎ ፍጹም በፈቃደኝነት ላይ የተመሰረተ ነው። ፈቃደኛ ያልሆንክበትን/ያልሆንሽበትን ጥያቄ እንድትመልስ/ሽ ማንም ሊያስገድድህ/ሽ አይችልም። በሚጠየቁ ጥያቄዎች ምችት ካልተሰማህ/ሽ በማንኛውም ጊዜ ቃለ መጠይቁን የማቋረጥ መብትህ/ሽ የተጠበቀ ነው። ከዚህም ባለፈ ከመጀመሪያውም በዚህ ጥናት ላይ ያለመሳተፍ መብት አለህ/ሽ። ስለ ጥናቱ ዓላማ በሚገባ አብራራቸልሃለሁ/አብራራቸልሻለሁ የሚል ተስፋ አለኝ። ጥያቄ ካለህ/ሽ አሁኑኑ መጠየቅ ትችላለህ/ትችያለሽ ወይም ዋና አጥኝውን ሽመልስ ዘውዴን በሚከተለው አድራሻ መጠየቅ ይቻላል። ስልክ ቁጥር +251913075507 ወይም ኢ-ሜይል: shimeles.zewdie@yahoo.com/beke.emere@gmail.com

አባሪ 2: የተሳታፊዎች ፈቃደኝነት ቅጽ

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

በጥናቱ ለመሳተፍ ፈቃደኛ ነህ/ሽ?

- 1. አዎ _____ ወደ ሚቀጥለው ገጽ ሂድ/ጅ
- 2. አይ _____ ወደ ሚቀጥለው ተሳታፊ ሂድ/ጅ

ቃለ-መጠይቁን ያካሄደው መረጃ ሰብሳቢ ፊርማ _____

መረጃው የተሰበሰበበት ቀን-----/-----/-----

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

አባሪ 3: የአፍላ ወጣቶችን የወሲብ ፣ ስነ-ተዋልዶ ሂወት እና ለራስ ዋጋ መስጠትን ለመዳሰስ የተዘጋጁ የአማረኛ ጥያቄዎች

001 የመጠይቁ መለያ ቁጥር-----

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

003 የትምህርት ቤት ስም-----

004 የምትማርበት/ሪበት የትምህርት ቤት አይነት፤ 1. የመንግስት

2. የግል

ክፍል አንድ: መሰረታዊ የግል መረጃዎች(መልሱን በክፍት ቦታው መላይ)				
ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	መለያ	ዕለፍ
101	ጾታ	<input type="checkbox"/> ሴት	1	
		<input type="checkbox"/> ወንድ	2	
102	እድሜህ/ሽ በሙሉ ዓመት ስንት ነው?	-----		
103	አሁን ያለህ/ሺ የፍቅር ግንኙነት ምን ይመስላል?	<input type="checkbox"/> የፍቅር ዳደኛ አለኝ	1	
		<input type="checkbox"/> የፍቅር ዳደኛ የለኝም	2	
104	የክፍል ደረጃ ህ/ሽ?	<input type="checkbox"/> 9	1	
		<input type="checkbox"/> 10	2	
		<input type="checkbox"/> 11	3	
		<input type="checkbox"/> 12	4	
105	አሁን ከማን ጋር ነው የምትኖረው/ረው?	<input type="checkbox"/> ከሁለቱም ወላጆቼ ጋር	1	
		<input type="checkbox"/> ከአባቴ ጋር	2	
		<input type="checkbox"/> ከእናቴ ጋር	3	
		<input type="checkbox"/> ከዘመድ ጋር	4	
		<input type="checkbox"/> ከፍቅር አጋሬ ጋር	5	
106	በአማካኝ የቤተሰብህ/ሽ የወር ገቢ ስንት ነው?	-----ብር		
		-----ብር		
107	በወር ውስጥ ምን ያክል የኪስ ገንዘብ ይሰጥሃል/ሻል?	-----ብር		
ክፍል ሁለት: የአዲስ አበባ አፍላ ወጣት ተማሪዎች በአባላዘር በሽታዎች እና የአልተፈለገ እርግዝና ዙሪያ ያላቸውን እውቀት ለመዳሰስ የተዘጋጀ መጠይቅ(መልሱን በክፍት ቦታው መላይ)				
ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	መለያ	ዕለፍ
201	ስለ አባላዘር በሽታዎች ሰምተህ/ሽ ታውቃለህ/ሽ?	<input type="checkbox"/> አዎ	1	
		<input type="checkbox"/> የለም	0 → 206	
202	መረጃውን ያገኘሁ/ሽው ከየት ነው? (ከአንድ በላይ መምረጥ ይቻላል)	<input type="checkbox"/> ከብዙሃን መገናኛ	1	
		<input type="checkbox"/> ከጤና ባለሙያዎች	2	
		<input type="checkbox"/> ከትምህርት ቤት	3	
		<input type="checkbox"/> የተለያዩ ነገሮችን በማንበብ	4	

203	ስለ አባላዘር በሽታዎች ኤች.አይ.ቪ/ኤድስን ጨምሮ መተላለፊያ መንገዶችን ታውቃለህ/ቂያሽ?	<input type="checkbox"/> አዎ	1	
		<input type="checkbox"/> የለም	0 →	206
204	የትኛውን መተላለፊያ መንገድ ታውቃለህ/ቂያሽ? (ከአንድ በላይ መምረጥ ይቻላል)	<input type="checkbox"/> ደም ንክኪ	1	
		<input type="checkbox"/> በአካላዊ ንክኪ	2	
		<input type="checkbox"/> በመሳሳም	3	
		<input type="checkbox"/> ከእናት ወደ ልጅ	4	
		<input type="checkbox"/> ስለታማ ነገሮችን በጋራ መጠቀም	5	
		<input type="checkbox"/> ልቅ በሆነ የግብረ-ስጋ ግንኙነት	6	
205	የአባላዘር በሽታዎችን ኤች.አይ.ቪ/ኤድስን ጨምሮ እንዴት መከላከል ይቻላል? (ከአንድ በላይ መምረጥ ይቻላል)	<input type="checkbox"/> በመቆጠብ	1	
		<input type="checkbox"/> ለጓደኛ በመታመን	2	
		<input type="checkbox"/> ከንዶምን በመጠቀም	3	
		<input type="checkbox"/> ስለታም ነገሮችን በጋራ ባለመጠቀም	4	
206	ያልተፈለገ እርግዝናን እንዴት መከላከል ይቻላል? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<input type="checkbox"/> በመታቀብ	1	
		<input type="checkbox"/> ከንዶም በመጠቀም	2	
		<input type="checkbox"/> ሌሎች ዘመናዊ የወሊድ መከላከያዎችን በመጠቀም	3	
		<input type="checkbox"/> አላውቅም	4	

ክፍል ሦስት: የአዲስ አበባ አፍላ ወጣቶች ወሲባዊ እና ተያያዥ ተግባራትን በተመለከተ ለመዳሰስ የተዘጋጀ መጠይቅ (መልሱን በክፍት ቦታው ሙሉ/ይ)

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	መለያ	ዕለፍ
301	የግብረ-ስጋ ግንኙነት አድርገህ/ሽ ታውቂያለህ/ሽ?	<input type="checkbox"/> አዎ	1	
		<input type="checkbox"/> የለም	0 →	401
302	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት ስታደርግ/ጊ ስንት ዓመትህ/ሽ ነበር?	-----ዓመት		
303	ለመጀመሪያ ጊዜ የግብረ-ስጋ ግንኙነት ለማድረግ የወሰንከው/ሽው ለምንድን ነው?	<input type="checkbox"/> የምሽት ክለብ ስለተከታተልኩ	1	
		<input type="checkbox"/> ጫት ስለቃምኩ	2	
		<input type="checkbox"/> ተገድጄ	3	
		<input type="checkbox"/> አግብቼ	4	
		<input type="checkbox"/> ጠጥቼ ስለነበረ	5	
		<input type="checkbox"/> ፍቅር ይዘኝ	6	
		<input type="checkbox"/> በጓደኛ ግፊት	7	
		<input type="checkbox"/> የግል ፍላጎቴ ስለተነሳሰ	8	
		<input type="checkbox"/> ገንዘብ ለማግኘት	9	
		<input type="checkbox"/> የወሲብ ቪዲዮ ስለተመለከትኩ	10	

304	ባለፉት 12 ወራት ለምን ያህል ሰው ጋር የግብረ-ስጋ ግንኙነት አደረግህ/ሽ?	-----		
305	ባለፈው 1 ወር ለምን ያህል ሰው ጋር የግብረ-ስጋ ግንኙነት አደረግህ/ሽ?	-----		
306	የግብረ-ስጋ ግንኙነት ባደረግህበት /ሽበት ጊዜ ኮንዶም ተጠቅመሃል/ሻል?	<input type="checkbox"/> አዎ	1	
		<input type="checkbox"/> የለም	0 →	311
307	ኮንዶም በምን ያህል ድግግሞሽ ትጠቀማለህ/ትጠቀሚያለሽ?	<input type="checkbox"/> አንዳንድ ጊዜ	1	
		<input type="checkbox"/> አብዛኛውን ጊዜ	2	
		<input type="checkbox"/> ሁልጊዜ	3	
308	ኮንዶምን በአግባቡ ተጠቅመሃል/ሻል?	<input type="checkbox"/> አዎ	1 →	310
		<input type="checkbox"/> የለም	0	
309	ኮንዶምን በአግባቡ ካልጠቀምክ/ሽ ምን ዓይነት ችግር አጋጥሞህ/ሽ ነበር?	<input type="checkbox"/> የኮንዶም መቀደድ	1	
		<input type="checkbox"/> ኮንዶምን በአግባቡ አለማጥለቅ	2	
		<input type="checkbox"/> የተጠቀሙበትን ኮንዶም በአግባቡ አለማስወገድ	3	
		<input type="checkbox"/> ሌላ (ይገለጽ)	99	
310	ለምንድን ነው ኮንዶም የተጠቀምከው/ሽው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<input type="checkbox"/> የአባላዘር በሽታዎችን/ኤች.አይ.ቪን ለመከላከል	1	
		<input type="checkbox"/> ያልተፈለገ እርግዝናን ለመከላከል	2	
		<input type="checkbox"/> ሌላ (ይገለጽ)	99	
311	ሁልጊዜ ኮንዶም የማትጠቀምበት/ሚበት ምክንያት ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	<input type="checkbox"/> ለመግዛት አፍሬ	1	
		<input type="checkbox"/> እርካታ ስለሚቀንስብኝ	2	
		<input type="checkbox"/> ጓደኛዬን ስለማምናት / ስለማምነው	3	
		<input type="checkbox"/> ጠጥቶ ስለነበር	4	
		<input type="checkbox"/> ሀይማኖቴ ስለማይፈቅድ	5	
		<input type="checkbox"/> ኮንዶም ስላላገኘሁ	6	
		<input type="checkbox"/> ጓገኛዬ ስለተቃወመኝ/ችኝ	7	
		<input type="checkbox"/> በጣም ውድ ስለሆነ	8	
		<input type="checkbox"/> ሌላ (ይገለጽ)	99	
312	(ከ 312-314 ያሉ ጥያቄዎች	<input type="checkbox"/> አዎ	1	

	ለወንዶች ብቻ) ባለፈው አንድ አመት ውስጥ ከሴተኛ አዳሪ ጋር የግብረ ስጋ ግንኙነት አድርገህ ታውቃለህ?	[] የለም	0 →	401
313	ከሴተኛ አዳሪ ጋር የግብረ ስጋ ግንኙነት ስታደርግ ኮንዶም ተጠቅመሃል?	[] አዎ	1	
		[] የለም	0 →	401
314	በምን ያህል ጊዜ ውስጥ ኮንዶም ትጠቀማለህ?	[] አንዳንድ ጊዜ	1	
		[] አብዛኛውን ጊዜ	2	
		[] ሁልጊዜ	3	
315	(ከ 315-322 ያሉ ጥያቄዎች ለሴቶች ብቻ) በአለፈው አንድ አመት ውስጥ የግብረ-ስጋ ግንኙነት ለመፈጸም ገንዘብ /ስጦታ ተቀብለሽ ታውቂለሽ?	[] አዎ	1	
		[] የለም	0	
316	አርግዘሽ ታውቂያለሽ?	[] አዎ	1	
		[] የለም	0 →	401
317	ለመጀመሪያ ጊዜ ስታረግዥ እድሜሽ ስንት ነበር?	-----ዓመት		
318	ያልተፈለገ እርግዝና አጋጥሞሽ ያውቃል?	[] አዎ	1	
		[] የለም	0	
319	የጽንሰ ማቋረጥ/ማስወረድ አድርገሽ ታውቂያለሽ?	[] አዎ	1	
		[] የለም	0 →	401
320	ስንት ጊዜ አስወረድሽ/ውርጃ ገጠመሽ?	-----		
321	የመጨረሻው ጽንሰ እንዲቋረጥ/እንዲወርድ ያደረግሽው ለምንድን ነው?	[] ቤተሰቦቼን ፈርቼ	1	
		[] ትምህርቴን ለመቀጠል	2	
		[] ያልታቀደ ስለነበር	3	
		[] ከጋብቻ ውጭ በመሆኑ	4	
		[] ማሳደግ ስለማልችል/ የኢኮኖሚ ችግር	5	
		[] ሌላ (ይገለጽ)	99	
322	የመጨረሻውን የጽንሰ ማቋረጥ የት	[] የመንግስት የጤና ተቋም	1	

	ቦታ ነበር ያደረግሽው?	[] ከግል ኪሊኒክ	2	
		[] ሰፈር ውስጥ	3	
		[] ሌላ (ይገለጽ)	99	
ክፍል አራት፡ በአዲስ አበባ ትምህርት ቤቶች የሚማሩ አፍላ ወጣቶች አደገኛ ወሲብን በተመለከተ ያላቸው አስተሳሰብ(መልሱን በክፍት ቦታው ሙሉ/ይ)				
ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	መለያ	ዕለፍ
401	እስከአሁን ባለው ጊዜ ለኤች.አይ.ቪ ተጋልጬለሁ ብለህ/ሽ ታስባለህ/ቢያለሽ?	[] አዎ	1	
		[] የለም	0	
402	አልኮል መጠጦችን መጠጣት ለኤድስ በሽታ ያጋልጣሉ ብለህ/ሽ ታምናለህ/ኛለሽ?	[] አዎ	1	
		[] የለም	0	
403	ያልተፈለገ እርግዝና ሊያጋጥመኝ ይችላል ብለህ/ሽ አስበህ/ሽታውቃለህ/ቂያለሽ?	[] አዎ	1	
		[] የለም	0	
404	ያልተፈለገ እርግዝናን ኮንዶም በመጠቀም መቀነስ ይቻላል ብለህ/ሽ ታስባለህ/ቢያለሽ?	[] አዎ	1	
		[] የለም	0	
405	በኮንዶም መጠቀም ለኤድስ በሽታ መከላከያ ዘዴ ነው ብለው ያምናሉ?	[] አዎ	1	
		[] የለም	0	
406	አንድ የፍቅር ጓደኛ ብቻ እንዲኖር በማድረግ በአባላዘር በሽታዎች የመያዝ እድልን መቀነስ ይቻላል ብለህ/ሽ ታስባለህ/ቢያለሽ?	[] አዎ	1	
		[] የለም	0	
407	ኮንዶም መጠቀም እርካታን ይቀንሳል ብለህ/ሽ ታምናለህ/ሽ?	[] አዎ	1	
		[] የለም	0	
408	የኮንዶም ዋጋ በጣም ውድ ነው ብለህ/ሽ ታምናለህ/ኚያለሽ?	[] አዎ	1	
		[] የለም	0	
409	ኮንዶምን ገዝተህ/ሽ መጠቀም	[] አዎ	1	

	ትችላለህ/ያለሽ?	[] የለም	0	
410	በግብረ-ስጋ ግንኙነት ጊዜ ኮንዶም ለመጠቀም ዳደኛህን/ሽን ማሳመን ትችላለህ/ያለሽ?	[] አዎ	1	
		[] የለም	0	

ክፍል አምስት: ለራስ ዋጋ መስጠትን የተመለከቱ ጥያቄዎች (መልሱን በክፍት ቦታው ሙሉ/ይ)

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	መለያ	ዕለፍ
501	በአጠቃላይ በራሴ በጣም ድስተኛ ነኝ።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
502	ሁሌም ጥሩ እንዳልሆንኩ አንዳንዴ አስባለሁ።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
503	በርካታ ጥሩ ነገሮች እንዳለኝ ይሰማኛል።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
504	ሌሎች እንደሚያደርጉት ሁሉ እኔም ማድረግ እችላለሁ።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
505	ብዙ የሚያከሩ ነገሮች እንደሌሎች ይሰማኛል።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
506	አንዳንዴ ጥቅም እንደሌለኝ በርግጠኝነት ይሰማኛል።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
507	ዋጋ እንዳለው ስው ይሰማኛል፤ ቢያንስ እንኳ ከሌሎች እኩል እንደሆንኩ ይሰማኛል።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	
508	ለራሴ ትልቅ ዋጋ እንዲኖረኝ እመኛለሁ።	[] በጣም እስማማለሁ	1	
		[] እስማማለሁ	2	
		[] አልስማማም	3	
		[] በጣም አልስማማም	4	

509	በአጠቃላይ ስሜቴ የሚያዘነብለው እንዳልተሳካልኝ ነው።	<input type="checkbox"/> በጣም እስማማለሁ	1	
		<input type="checkbox"/> እስማማለሁ	2	
		<input type="checkbox"/> አልስማማም	3	
		<input type="checkbox"/> በጣም አልስማማም	4	
510	ለራሴ ቀና የሆነ አመለካከት ይኖረኛል።	<input type="checkbox"/> በጣም እስማማለሁ	1	
		<input type="checkbox"/> እስማማለሁ	2	
		<input type="checkbox"/> አልስማማም	3	
		<input type="checkbox"/> በጣም አልስማማም	4	

ስለተሳተፉ በጣም አመሰግናለሁ!!!

አዲስ አበባ ዩኒቨርሲቲ
የጤና ሳይንስ ኮሌጅ

የህብረተሰብ ጤና ትምህርት ክፍል

በአዲስ አበባ ከተማ የሚገኙ አፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለውን ቁርኝት ለማጥናት የተዘጋጀ የአማርኛ መጠይቅ፤

አባሪ 4: የጥናቱ መረጃ ቅጽ፤

ጤና ይስጥልኝ፤

ስሜ _____ እባላለሁ። የአፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለውን ቁርኝት ከሚያጠኑት አካላት አንዱ/ዷ ነኝ። ጥናቱ የሚካሄደው በአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና ትምህርት ቤት የህብረተሰብ ጤና የድህረ-ምረቃ ተማሪ በሆነው በሽመልስ ዘውዴ ነው። የጥናቱ ዋና ዓላማ የአፍላ ወጣት ተማሪዎችን የወሲብ ባህሪ እና ለራስ ዎጋ መስጠትን ማሳደግ አደገኛ ወሲባዊ ተግባራትን ከመቀነስ አንጻር ያለው ቁርኝት ምን ይመስላል የሚለውን ለማጥናት ነው። አንተን/አንችን የምጠይቅህ/ሽ በዚህ ጥናት ላይ እንድትሳተፍ/ፈ እና ለጥያቄዎቹ ትክክለኛ ምላሽ እንድትሰጡኝ/እንድትሰጩኝ ነው። ያንተ/ኛ በዚህ ጥናት ላይ መሳተፍ ከጾታዊና የስነ ተዋልዶ ጤና ጋር ተያይዘው የሚከሰቱ ችግሮችን በመለየት የአፍላ ወጣት ተማሪዎችን የራስ ዎጋ መስጠትን ማሳደግ የወጣቶችን አደገኛ ወሲባዊ ተግባራት ከመቀነስ አንጻር ያለው ተፅዕኖ ምን እንደሚመስል ለመለየት ይጠቅማል። ቃለ-መጠይቁ 30 ደቂቃዎችን ሊወስድ ይችላል። በዚህ ቅጽ ላይ ስምህ/ሽ አይጻፍም እንዲሁም በሪፖርቱ ላይ አይጠቀስም። በዚህ ጥናት ላይ በመሳተፍህ/ሽ ምንም አይነት ክፍያ የለውም ። ሁሉም የምትሰጡው/ጭው መረጃ ምስጢራዊነቱ የተጠበቀ ነው። ከጥናት ቡድኑ በስተቀር ማንም ሊያገኘው አይችልም፤ ያንተ/ኛ ተሳትፎ ፍጹም በፈቃደኝነት ላይ የተመሰረተ ነው። ፈቃደኛ ያልሆንክበትን/ያልሆንሽበትን ጥያቄ እንድትመልስ/ሽ ማንም ሊያስገድድህ/ሽ አይችልም። በሚጠየቁ ጥያቄዎች ምችት ካልተሰማህ/ሽ በማንኛውም ጊዜ ቃለ መጠይቁን የማቋረጥ መብትህ/ሽ የተጠበቀ ነው። ከዚህም ባለፈ ከመጀመሪያውም በዚህ ጥናት ላይ ያለመሳተፍ መብት አለህ/ሽ። ስለ ጥናቱ ዓላማ በሚገባ አብራርቻልሃለሁ/አብራርቻልሻለሁ የሚል ተስፋ አለኝ። ጥያቄ ካለህ/ሽ አሁኑኑ መጠየቅ ትችላለህ/ትችያለሽ ወይም ዋና አጥኝውን ሽመልስ ዘውዴን በሚከተለው አድራሻ መጠየቅ ይቻላል። ስልክ ቁጥር +251913075507 ወይም ኢ-ሜይል: shimeles.zewdie@yahoo.com/beke.emere@gmail.com

አባሪ 5: የተሳታፊዎች ፈቃደኝነት ቅጽ

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

በጥናቱ ለመሳተፍ ፈቃደኛ ነህ/ሽ?

3. አዎ _____ ወደ ሚቀጥለው ገጽ ሂድ/ጅ

4. አይ _____ ወደ ሚቀጥለው ተሳታፊ ሂድ/ጅ

ቃለ-መጠይቁን ያካሄደው መረጃ ሰብሳቢ ፊርማ _____

መረጃው የተሰበሰበበት ቀን-----/-----/-----

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

አባሪ 6 :የቃለ-መጠየቅ መመሪያ

ለትምህርት ጽ/ቤት እና ትምህርት ቤ/ት አመራሮች የተዘጋጀ ጥያቄ

1. ለራስ ትልቅ ግንዛቤ /አመለካከት / መስጠት ስንል ምን ማለታችን ነው? ለራስ ትልቅ አመለካከት መኖር ከአደገኛ ወሲብ ጋር ምን አይነት ቁርኝት አለው ብለህ/ሽ ታስቢያለሽ ?
2. ለአደገኛ ወሲብ የሚጋለጠው ከፍተኛ የራስ አመለካከት ያለው አፍላ ወጣት ነው ወይንስ ዝቅተኛ የራስ አመለካከት ያለው? ለምን ? ይህን ችግር ለመቅረፍ ምን መደረግ አለበት?
3. የአፍላ ወጣቶችን የመራቢያና የወሲብ ጤና በተመለከተ አለፈነት ያለበት ማን ነው ብለህ/ሽ ታምናለህ/ኛለሽ? ለምን ? እስኪ በደንብ አብራርተህ/ሽ ንገረኝ/ሪኝ።

ለክበባት ተጠሪዎች የተዘጋጀ ጥያቄ

1. በአንተ/ቺ አረዳድ እስኪ አደገኛ ወሲብን ግለ ጽ/ጭልኝ። አፍላ ወጣቶችን ለአደገኛ ወሲብ የሚያጋልጡ ምክንያቶች ምን ምን ናቸው? ይህ ለአንተ/ቺ ምን ማለት ነው?
2. የመገናኛ ብዙሃን ለወጣቶች አደገኛ የወሲብ ብሃሪ ምን አይነት አስተዋጾ አላቸው?

ለትምህርት ቤት አማካሪዎች የተዘጋጀ ጥያቄ

1. አፍላ ወጣቶች ወደ አደገኛ ወሲብ እንዳይገቡ ምን መደረግ አለበት ብለህ/ሽ ታስብለህ/ቢለሽ? ይህ ዘዴ ውጤታማ ነው ብለህ/ሽ ታስብለህ/ቢለሽ? ይህ ዘዴ መሻሻል አለበት ታስብለህ/ቢለሽ?
2. የአቻ ግፊት ለወጣቶች የወሲብ ሂደት ምን አይነት ተጽኖ አለው ? ወራዊ የኪስ ገንዘብስ?

ለተማሪዎች የተዘጋጀ ጥያቄ

1. አደገኛ /ልቅ ወሲብ ማለት ምን ማለት ነው? የአደገኛ ወሲብ መገለጫዎች ምን ምን እንደሆኑ ልትነግረኝ/ሪኝ ትችላለህ/ሽ?
2. ለአደገኛ ወስብ ተጋልጬ አውቃለህ ብለህ/ሽ ታስብለህ/ባለሽ? እስኪ ስለተሞክሮህ/ሽ በደንብ ንገረኝ/ሪኝ።
3. የወሲብ ሂደትህን/ሽን በተመለከተ ምን ፈተናዎች አገጥመውህ/ሽ ያውቃል? ይህን ፈተና ማለፍ ይቻላል ብለህ/ሽ ታምናለህ/ሽ? እስኪ ተሞክሮህን/ሽን ንገረኝ/ሪኝ።
4. ለመጀመሪያ ጊዜ ወሲብ እንድታደርገ/ግ ያስገደደህ ምንድን ነው?

ለትብብርህ/ሽ አመሰግናለሁ!!!