

MASTERS THESIS

**KAP STUDY IN HARAR TOWN
HIGH SCHOOL STUDENTS
ON FAMILY PLANNING**

BY

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KAP STUDY IN HARAR TOWN HIGH SCHOOL
STUDENTS ON FAMILY PLANNING

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ABBREVIATIONS

- DNK - Do Not Know
- CM - Contraceptives Method
- FGAE - Family Guidance Association of Ethiopia
- FP - Family Planning
- HIV - Human Immunodeficiency Virus
- IPPI - International Planned Parenthood Federation
- KAP - Knowledge, Attitude and Practice
- STD - Sexually Transmitted Disease
- SD - Standard Deviation
- WHO - World Health Organization
- X² - Chi Square

ABSTRACT

In Ethiopia, there is no reliable information about sexual behaviours and contraception usage of adolescent students. The incidence of morbidity and mortality of young female students due to induced abortion of unwanted pregnancy is increasing. This is a cross sectional study which was conducted to assess the knowledge, attitude, and practice of high school students in Harar town toward family planning. A total of 1674 students from 11th and 12th grades aged between 15 and 26 years were interviewed by means of self administered anonymous questionnaires. The respondents were 887(52.9%) males and 787 (47.1%) females.

The major finding of the study were that 20% of females and 65% of the males admitted to having had sexual intercourse. The average score of knowledge and attitude items about FP was 8.3 out of 13 and 7.3 points out of 10 respectively. Among those who had sexual intercourse, 60.3% of the females and 67.1% of the males reported that they knew at least one type of contraceptive methods. Of the sexually active females, 59.6% were using one of the contraceptive methods. However, the majority (76.3%) were using the calender method and only 19.4% said they used birth control pills or condoms. One fifth of the male respondents (20.0%) used condoms. A total of 21.8% of females who are sexually experienced have been pregnant, and 55.9% of them have terminated the pregnancy by means of induced abortion.

The main source of CM information was mass media (31.3%) followed by school (24.2%). More than half of the respondents (53.3%) have an intention to use contraceptive methods in the future. The majority (93.7%) of the respondents approved the provision of information in school about contraception and STDs.

In our findings the knowledge of the students was modest and the practice of contraceptive utilization was low. This information can be used in planning family life education programs.

INTRODUCTION

In developing countries the size of the adolescent population has increased rapidly. More than half the world's population is currently under the age of 25 (1). Because of their numbers in the community and vulnerability their health problems are of high priority.

There is evidence to suggest that sexual activity among adolescents is on the increase in both developed and developing countries. The sexual behaviour and fertility of young people will have a significant impact on present and future family structures and on the development of communities and countries.

Traditionally, in most parts of Ethiopia, sex before marriage among females has been completely forbidden. Virginity is of high value to the girl and her family. However, premarital intercourse is increasing because of urbanization, increasing years of education and improved economic status among other factors. Hence, premarital sex is becoming much more common among the urban population of Ethiopia. Although data on premarital sexual activity in adolescents is lacking, the evidence available from a survey conducted in Addis Ababa senior high school by Gebre in 1990 indicates that 38% of adolescents had had heterosexual experience (2).

Adolescent pregnancy is a great concern today, both in developed and developing countries. Unwanted pregnancy often leads to an induced abortion or mistreated or abandoned children. The

mother may be forced to drop out of school early or leave her family. Prostitution may result among these who are unable to find work.

The incidence of abortion, its consequences, and complications represent public health problems of major dimension in a large number of towns in Ethiopia. Abortion was one of the top ten causes of hospital admission in Harar Zuria Awraja in 1987 (3) and 1990 (4). Precise abortion figures by age group in the Awraja are lacking. Health personnel are of the opinion that the majority are adolescents. Abortion has been shown to be a major cause of maternal mortality in Addis Ababa which is likely to be the case in other urban centres of Ethiopia.

A first step to addressing the issue of increasing sexual activity and pregnancies among young people is to ensure that they have a good understanding of their own sexuality and contraception methods. School health program in Ethiopia are inadequate in this area. Information about sexuality and family planning in schools is weak although it is covered to a variable extent in biology classes. There is still resistance to the implementation of sex education programs in schools because of the opposition of large parts of the society, particularly the religious leaders and parents. They are concerned that such education will encourage sexual activity among the students.

It is important that health workers enhance the awareness of policy-makers, community leaders, religious leaders, teachers and the community at large of the fertility related needs of young

people and to increase knowledge of reproductive and contraceptive methods among our youth.

Few studies have been done in Ethiopia regarding sexual behaviour and contraceptive methods in high school students and these mostly came from Addis Ababa. Students from Addis Ababa may be quite different from students in other parts of the country. It is necessary to further our understanding of the knowledge, attitudes, and practices related to contraceptive methods and sexual practice of students outside as well as in Addis Ababa in order to plan appropriate preventive measures.

This study aimed to provide data concerning adolescent students' knowledge, attitudes, and practice regarding sexual behaviours and family planning methods. It is hoped that these data will help us to take more appropriate intervention strategies to promote effective family life education for the students in school.

OBJECTIVES OF THE STUDY**GENERAL OBJECTIVE**

To describe the knowledge, attitude, and practice of high school students regarding sexual behaviours and family planning methods.

Relevance of the Study

1. To heighten awareness of the needs of high school students with respect to health education about sexual behaviours and family planning among parents and teachers of high school students.
2. To facilitate the introduction of appropriate sex education in schools.

LITERATURE REVIEWAdolescent Reproductive Behaviour

Adolescence is a period of transition from childhood to adulthood. The beginning of this period is more or less dictated by the onset of biological maturation (1,5,6). This age group constitutes a large proportion of the world's population. In many countries they form 20-25 % of the population (1). In Ethiopia 10-19 year old are estimated to be 21.2% of the total population (7).

Friedman and Edstron (8) have stated in their study on adolescent reproductive health that "it should also be borne in mind that adolescence is a period of great change, growth, development and maturation which often proceeds unevenly with respect to physical, social and psychological aspects. These differ in males and females, vary from culture to culture and display great variation from individual to individual within such groups. Since some grouping is necessary, however, the chronological age range of 10 - 19 years has been utilized as a rough indicator of that period between childhood and adulthood called adolescence". Generally it is recognized as a significant point in the life cycle of the individual (9).

Adolescence is very much a social phenomenon, requiring society to invest time, thought and resources in programmes designed to involve and educate its youth as a valued member of the community (5). Especially, parents have a prime responsibility in the preparation of the young for responsible parenthood (10).

Today, one of the great health problems of adolescents, world wide is early pregnancy. The reason for this is that in many countries young people are engaging in sexual activity at an early age without any form of protection. In developing countries this frequently arises from early marriage (1,9,11,12,). The problems presented to society by adolescent pregnancy are important, not merely in physical terms, but also for social reasons (5).

Various studies have confirmed that sexual activity among adolescents is relatively common in many countries. In the United States of America a 1987 study showed that 45% of women age 15-17 had had sexual intercourse (13). In New Zealand two different studies in different high schools students reported 29% (14) and 39% (15) had experienced coitus. In Nigeria one study indicated 34% of the study population of students had sexual intercourse before age 16 (16).

A study from Nairobi, Kenya, in 1986 revealed that among adolescent secondary school girls aged between 12 and 19 years 23.8% had been or were sexually active (17). In Ethiopia adequate data on premarital sexual activity of adolescents is lacking. A 1990 survey conducted in Addis Ababa senior high school, 9-12 grade students (age range from 13 to 19 years) indicated that 38% of adolescents have had sexual experience. Of the respondents, 53% and 24% of the total male and female respondents respectively admitted to being sexually experienced(2).

Data and evidence based on the above studies indicate that young people are becoming increasingly at risk of early sex. So,

education and counselling should be provided for the young of both sexes and the physical, social, psychological and emotional consequences of early sexual involvement need to be carefully explained (10).

Adolescent Pregnancy and Abortion

Every year, an estimated half a million women die of causes related to pregnancy and child birth (1,18). Frequent and close spaced pregnancies and pregnancies very early or very late in life increase the risks for both mother and child (11).

In the developed world, there are only 5-30 maternal deaths per 100,000 live births. In developing countries the figures range from 50 to 800 or more. Women in developing countries run 100 to 200 times the risk of dying in pregnancy and childbirth than do women in affluent countries (18,19). Teenagers run an excess risk of death compared with women age 20-24 years (12).

Immediate causes of maternal deaths are obstructed labour, eclampsia, toxæmia, infection and complications for both spontaneous and induced abortions (1,11,12,19). Young girls have higher rates of death from all these causes. (1,12). Hence, adolescent pregnancy is of great concern today (1,20). It is estimated that every year more than one million United State teenagers become pregnant, and 30,000 of them are below 15 years of age (21). One study in Peru showed that among women age 11-19 who took part in the study, 25% had been pregnant at least once, and at least half of these pregnancies had occurred before the girls' 18th birthday (22).

Illegal abortion is a common solution for a woman with an unwanted pregnancy in countries where safe abortion is either not available or legally restricted (18). Illegal abortion from unwanted pregnancies causes some 25-50% of maternal deaths (19). Most unwanted pregnancies among adolescent girls ended up in illegal abortion according to a community based study in Addis Ababa in 1983 (23).

Reports from many developing countries cite abortion as one of the main underlying causes of maternal death, if not the main one. For example, reports from Colombia, Jamaica and Nigeria have given figures of 29%, 33% and 35% of maternal deaths as occurring from abortions (12) and a survey of maternal deaths in Addis Ababa between 1981 and 1983 found that 54% were due to complication of illegal abortion (23).

A study in Nairobi, Kenya, suggests that the incidence of abortion is high with 60% of the acute gynaecological beds being occupied by abortion patients. 62.3% of these patients are induced or likely to have been induced, 43% were adolescent girls and 79% unmarried, 60% of these patients are school girls or un employed (24). Another study in Benin city, Nigeria showed 60.8% of the patients in the gynaecology ward were adolescent girls and 53.7% of them had had septic abortions (25). In Ethiopia, it is difficult to obtain statistical evidence, but the health profile of Harar Zuria Awraja done by Bantirgu 1988 (3) and by Bisrat 1991 (4) showed that abortion was one of the top ten cause of hospital admission in Harar Zuria Awraja. In these years there were

abortions which account for 5.4% and 11.2 of hospital admissions respectively. Although age specific data is not available, personal communication with hospital staff showed that the majority are adolescent females.

Sexually Transmitted Disease

One of the most serious health hazards associated with sexual activity among young people is the risk of sexually transmitted disease (20). A survey was conducted in Monrovia, Liberia in 1984 among never married adolescents aged 14 - 21, and the extent of STD was alarming. Among adolescents women who have had sexual relations, from 10 to 15% of those aged 14 - 17 and 20% of those aged 18 - 21 had had an STD. Among male adolescents, 29 to 41% of those aged 18 -21 reported that they have suffered from an STD on one or more occasions (26).

The recent wide spread and rapid dissemination of the disease AIDS spread mainly by sexually activity is one of the worst epidemics the human race has encountered.

Gebre's study in Addis Ababa senior high school 9 - 12 grade students in 1990 indicated that on the average, the students have modest knowledge of AIDS, but a low level of knowledge on other STDs. The results show that over a third of the students have experienced sex and 48% of them never use any protective means to avoid STDs (2).

Adolescents need to be made aware of the dangers of STD, how they are prevented, spread, and how to recognize symptoms, in order

that they may be prevented and/or treated properly and rapidly (5). Some contraceptives such as condoms have the potential to prevent not only pregnancy, but also the acquisition of sexually transmitted disease, including AIDS (14).

Contraceptive Knowledge and Use

Throughout the world, experts and government agree that population growth is one of the serious issues confronting mankind at present. Various studies in many countries demonstrated that family planning has played an important role in reducing fertility (1). Contraception is the keystone of any rational approach for dealing with the sexually active adolescent (6). If a boy and girl start having sexual relations they should know that an unwanted pregnancy can happen unless contraception protection is used every time they have sex (10).

Family planning services at this time have the highest likelihood of reducing the rate of early childbearing. In the 1970s FP services in USA expanded substantially, serving increasingly large numbers of teenage women. During the same period, rates of contraceptive use increased, and the rates of pregnancy declined (27,28).

In some countries contraception is considered acceptable for adolescents, but the distribution of contraception is only to married couples - for example in China and Indonesia (6). However, a study in urban Nigeria showed that the use of contraception among women having premarital sexual relations has increased considerably (29).

Various studies in high school students indicate that the use of modern contraception is variable. In Kenya, in 1986 one study showed 95% of the sexually active girls age between 12 and 19 were not using any contraceptive method(17). On the other hand in a 1984 study in Liberia among adolescents aged 14 - 21 among sexually active students respondents 51% of females and 28% of males use a contraceptive method (26). In the study in Nigeria secondary school girls, among sexual active girls 44% had never used any contraceptive method (29).

In the study conducted in New Zealand, North Island region among high school students aged 16 to 19, 20% of coital experienced students reported they had never used contraception; 5% reported they occasionally used contraception; 32% reported they some times used contraception and the remaining 41% reported always using contraception (15).

Gebre's study in Addis Ababa senior high school students revealed among sexually active students about 48% of the respondents (56% and 28% of the boys and girls respectively) never used protection against pregnancy (2).

Knowledge of contraception among adolescent varies markedly among countries. The study in Kenya (17) demonstrated that among female students the pill, coil and natural method were known . Pills and condom were equally well known among Liberian adolescents(26). The three most common methods of contraception that have used by respondents among New Zealand students were: condom, pill and withdrawal(14).

Attitude Toward Sexual Behaviour and Contraception Use

According to Douglas study (26) in Liberia few adolescent respondents approved of premarital sex without restrictions. It was more acceptable if the couples were engaged to be married. In general, males are more likely than females to approve premarital sex.

In Ibadan city Nigeria among high school students 33% of the males and 19% of the female student respondents approved premarital sex (30). The majority of the students sampled (67%) in the study in New Zealand high school students, reported that they approved of premarital coitus (15).

In general, approval of contraceptive in those who have had sexual relations is high among students in different countries (15, 17, 26, 30). In Kenya 48% of high school female students approve that all women regardless of whether they married or not, should be given contraception on request to protect themselves from unwanted pregnancies (17). Similarly, in Nigeria secondary school students, 68% and 72% of males and females respectively (30), and in Liberia the majority of respondents agreed that unmarried adolescents should be practising contraception if they are having sexual relation (26).

In another study in high school students in New Zealand 67% and 93% of students reported that contraception was a joint male and female responsibility in casual coital and steady coital relationship respectively (15).

Sex Education and Counselling

The United Nations international conference on population held in Mexico city in August 1984 sought to define the rights of adolescents in this area. Recommendation 29 of the report of the conference stated, " Governments are urged to ensure that adolescents, both boys and girls receive adequate education, including family life and sex education with due consideration given to the role, right and obligations of government and changing individual and cultural values. Suitable family planning information and services should be made available to adolescents within the changing socio-cultural framework of each country" (1).

Focus group studies were conducted in five awrajas of Ethiopia, in 1991 and the study revealed that old women suggested the younger women should take contraceptives to avoid unwanted pregnancy which is now becoming a cause of death as a result of abortion. The younger women also proposed that health education should be given to avoid unnecessary rumours, so that they can use contraceptive methods without any fear. Hence, it is necessary to explore the younger generations knowledge, attitude and practice. This would enable appropriate intervention to be designed which might reduce problems related with contraception (31).

The panel on adolescent pregnancy and childbearing of the National Academy of Sciences in U.S.A 1987 concluded that priority must be given to efforts at primary prevention - delaying early sexual activity and improving contraceptive use among sexually

activity teens. These primary prevention programs have typically taken three tasks: (a) educating teens about sexually and contraception; (b) changing attitudes about early sexual involvement, that is, saying no to early sex, and (c) providing contraception and family planning services (28).

In one intervention study conducted in the USA, the effect of combined sex education, counselling and contraceptive services in a school program were evaluated. After 28 months of operation, when the program was evaluated pregnancy rates had decreased more than 30% in the program schools, while they had increased almost 60% in the control schools (13).

Schools have the opportunity to inform a large number of young adolescents about contraception. They should provide population family life and sex education including family planning and reproductive health management (10).

MATERIALS AND METHODS**STUDY DESIGN**

This is a descriptive study which was conducted by means of a self-administered anonymous questionnaire in the two high schools located in Harar town, East Hararghe Administrative Region, Ethiopia.

POPULATIONSource Population

In Harar Zuria Awraja there are 102 elementary, 17 junior secondary and 3 high schools with a total of 39,078 students. Of these students, 61.5% are male and 38.5% are female (32). The high school students (9-12 grade) constitute 17.5% of the total students (10.2% are male and 7.3 are female students). Out of three high schools two are in Harar-town with a total of 5,315 students. In these two high schools 2,229 students are in 11th and 12th grade; 1,223 are male and 1,006 are female.

Study Population

The study population consisted of all students in 11th and 12th grade in the two high schools in Harar town who were attending school on the day of the survey. No sampling was carried out, to avoid the problem of those who were sampled thinking they had been selected for a particular reason.

ETHICAL CONSIDERATIONS

The Regional and the Awraja Education Department heads, the school directors, and the staff in each school were informed of the study. All students voluntarily agreed to participate in the study. No students were involved in the study against their will. Approximately 20 students declined to fill the questionnaire. Before the questionnaire was administered, an explanation was given by trained health workers on the value of the study, how to complete the questionnaires. Anonymity was guaranteed. It was also stated in writing at the top of the questionnaire that the students could leave blank any or all of the questions. Confidentiality was maximized by the use of anonymous questionnaires and by prior training of the health workers involved in the survey.

MEASUREMENT

A structured questionnaire was constructed for this study which consisted of 50 questions. Twenty eight questions were common for both sexes. Twelve female and 10 male questions were presented separately. The questionnaire assessed knowledge, attitudes, and practices related to sexual behaviours and contraception. A copy is found in Appendix I.

Outcome

The principal outcomes are:

1. The students' knowledge, attitudes, and practices related to sexual behaviours.

2. The students knowledge, attitudes and practices regarding contraception.

Determinants

This study is largely descriptive. However, the KAP of the students was analyzed with respect to age, sex, and religion. Where relevant, with specific knowledge, attitude and practice items. Ethnicity was not asked about as the political climate at the time made this a sensitive area.

The questionnaire was prepared in English and translated into Amharic, since the students speak and write Amharic well. All questions were answered by putting an "X" mark in the box corresponding to the question except question number 7 which was open ended and required writing.

DATA COLLECTION AND MANAGEMENT

Translation of the Questionnaire

A structured questionnaire was prepared in English by the investigator. Translation of the questionnaire from English to Amharic was done by three individuals who are able to speak and write English and Amharic. Of these three individuals two of them are medical doctors. After translating individually, all questions were then discussed together with all three translators and a consensus was reached. Then both the English and Amharic versions were given to another medical doctor who has experience in translation of questionnaires, to give his final comments on the questionnaire.

Training

The Awraja Health Team as well as selected health personnel from the Regional Health Department and Hospitals were given one day of training by the principal investigator. During the training they were briefed on the objectives and importance of the study. The content and intent of each question in the questionnaire was then reviewed. Emphasis was placed on the importance of privacy and confidentiality of the information obtained.

Pilot Study

The pretest was conducted in Jijiga High School within the same grades, one class from each grade. Jijiga is one of the Awrajas of Eastern Hararghe Administrative Region which is more or less similar to the study population.

The objective and purpose of the pretest survey was explained to the Awraja Education Department, school director and teachers. The objectives of the pretest study were:

1. To improve the structure and content of the questionnaire
2. To evaluate the student reaction
3. To improve the approach to the students, by the health workers administering the questionnaire
4. To determine the time required for students to complete the questionnaire.

After pretesting, problematic questions were discussed, some questions were rewritten, and certain procedures were modified.

Data Collection

The objectives and purpose of the survey were explained to the Regional and Awraja Education Department, school directors and teachers. Discussions were conducted by the principal investigator with the above officials to determine the day of the survey, to close the classes of the other grades, to bring the different shifts in at one time and to assign a coordinator who would arrange the students in each classroom.

On the day of the survey, the students were arranged so that the sexes were in different classrooms. Individuals were seated separately, each one having their own chair and table so they would not be able to see one another's questionnaire. After that, the teachers left the classroom.

The trained health workers took their place in the classroom and explained the purpose of the study, how to fill out the questionnaire, and reassured the students about confidentiality. This took 5-10 minutes. Then, the trained health workers distributed the questionnaire in the classroom. At the top of the structured questionnaire the instructions, purpose of the study, and a reassurance of confidentiality were clearly stated. The students were reminded verbally that they did not have to respond to questions which they didn't wish to. After finishing, the questionnaires were collected by putting them on a table at the same time from all students.

The survey was carried out on December 20th, 1991 within one day, during the same hours in two schools. The questions took 40

minutes on average. All the questionnaires were collected immediately from each trained health worker. Due to a high absentee rate the survey was repeated on the following day, with the identical procedures.

Data Analysis

The principal investigator and the three trained health workers reviewed all questionnaires for errors and inappropriate coding. There were very few errors. The data were entered, then data were cleaned and all the necessary corrections on data entry were done by using the frequency distribution printout. Recording of knowledge and attitude variables were done. The data were edited and analyzed using the EPI-INFO Version 5 statistical package (33).

Frequencies for all variables and the appropriate knowledge and attitude scores were calculated. To determine the knowledge of the respondents on FP and STD, scores between 0 and 2 were given for five knowledge questions, which were questions number 16, 17, 18, 19, and 20. This knowledge score reflects the over all knowledge of the respondents. The respondents were given 2 points if they answered a question correctly, 0 if wrongly and 1 point if they answered "don't know". A score of 0 to 3 was given to the knowledge of different types of contraceptive methods. Three points were given for those who knew 3 or more contraceptive methods, 2 points for those who knew 2 contraceptive methods, 1 point for those who knew 1 contraceptive method and 0 points for those who

didn't know any contraceptive method. These two different knowledge scores were combined and analyzed together. The maximum score was 13 points.

The general attitude of respondents about family planning and abortion was assessed by another five questions, which were question number 9, 10, 11, 15 and 24. 2 points were given to those who reported positive or "liberal" attitudes to these questions; i.e. they were in favour of contraception, legalized abortion, and sex education in schools, and did not think that sex education would increase sexual activity or that only bad girls go for abortion. 1 point was given when the answer was "don't know" or "not sure". 0 points when the answer was negative or "conservative". The maximum score was 10 points. These scores were cross tabulated with selected variables to determine if any association existed. Mean scores were calculated for knowledge and attitude items.

RESULTS

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF STUDENTS RESPONDENTS

Questionnaires completed by a total of 1,674 students were analyzed. This represents 75% of the total 11th and 12th grade population. Eight hundred eighty seven (52.9%) of the students were male while the remaining 787 (47.1%) were female. The ages ranged from 15 to 26 years with a mean of 17.4 and standard deviation of 1.44 years (Figure 1). One thousand two hundred seventeen students completed the questionnaire on the first day, and 457 on the second day.

Orthodox Christianity was the most prevalent religious group (75.6%). This is followed by Islam (17.0%), Catholic (3.7) and Protestant (2.0%) and other religious groups comprising 1.7%. The majority (96.4%) of students in the study group had never married.

KNOWLEDGE OF CONTRACEPTIVE METHODS

All students were asked the types of contraceptive methods they knew. 53.6% reported that they knew at least one type of contraceptive method. Regarding gender distribution, 42.2% of females and 63.8% of males reported that they were familiar with one or more contraceptive method. The three most common methods of contraception known by respondents were: the condom (87.2%), pills 80.7%, and the calendar method in 63.1% (Table 1).

The sources of knowledge on contraceptive methods are detailed in Table 2. The three most common sources of information were mass

media in 281 (31.3%), school for 219 (24.2%), and health institutions in 206 (22.9%).

The students preferred source of information on contraception is seen in Table 3. The majority of the students (53.0%) preferred to learn from health workers in school. The second most common (28.9%) preference was to learn from health workers in health institutions, followed by teachers in school (7.5%).

The three most common preferred source to get contraceptive methods were from Health institutions (55.3%), from pharmacy (20.5%) and from school (11.8%).

All students asked different type of question to judge the knowledge which are detail stated in (Table 4).

ATTITUDE TOWARD CONTRACEPTIVE METHOD AND SEXUAL BEHAVIOUR

All students were asked whether they intend to use contraceptive methods or not in the future. A positive response was given by 926 (55.3%) (Table 5).

Almost all responding students, 1,569 (93.7%), gave their approval to information in school about contraception and STD. 11.4% felt that this would encourage students to have sexual intercourse (Table 5).

Students of both sexes were asked various types of questions about sex related behaviours. Only 201 (12.0%) agreed on premarital sex for girls while 423 (25.3%) agreed for boys (Table 5).

Most, 1,036 (61.9%), disagreed that induced abortion should be made legal (Table 5). To the question: "If a high school girl gets

pregnant without intending to, what should she do?", 57.8% said that she should deliver. In response to the question. "Who should take the responsibility of making sure not to have pregnancy occur?", 1,239 (74.0%) reported that the responsibility should be taken by both sexes and 19.4% gave the responsibility to girls. Almost none wanted to make the boys solely responsible.

The two most important health problem mentioned by the students were; STD and pregnancy was 53.2% (female 53.7% and male 52.6%) and secondly lack of proper Nutrition 15.5%

SEXUAL BEHAVIOUR

One hundred fifty six (19.8%) of the females and 577 (65.1%) of the males in the study population admitted to having had sexual intercourse (Table 6). The mean age at first intercourse was 16.2 years for females and 15.3 years for male students. The proportion of females who had ever had intercourse by age 14 years was 1.2%, by age 16 11.2%, and 17% by age 18. Among males 17% that reported that intercourse by age 14. This figure increased to 46.4% by age 16 and 57.3% by age 18. Of sexually experienced males 1.7% said that they first had intercourse before age 12 (Figure 2).

More than half of the females who had had intercourse (52.6%) reported that their first intercourse had occurred due to a love affair and the second most common reason was being forced (14.7%). For male respondents major reasons for the occurrence of their first intercourse were physical pleasure in 44.9% and love affair in 29.1% (Table 7). The majority (82.5%) of the young males had had

their first sexual experience with female students. The second most common was with a prostitute 7.6%. Among those who had had intercourse, 71 (45.5%) of the females and 221 (38.3%) of the males reported that they had had intercourse at least once in the three months preceding the survey.

Reasons students gave for never having had sexual intercourse are seen in Table 8. Among female students, the most frequently cited reasons for not having had sexual intercourse were; want to wait until marriage (42.6%), followed by no desire to have sexual intercourse (17.7%), and considering sexual intercourse as wrong for them (13.0%). When we come to the males the main reasons for not having sexual intercourse were: considering sexual intercourse as wrong for them (20.3%), wanting to wait until married (15.5%), having no desire (14.2%), lack of opportunity (13.9%) and 16.1% said other reasons such as religious constraints or wanting to wait until finishing school. Among the respondents, 31.0% of boys and 32.0% of girls reported they had currently a regular boy/girl friend.

CONTRACEPTIVE METHODS USED AND REASON FOR NOT USING BY THE SEXUALLY ACTIVE STUDENTS

Among sexually active respondents, 93 females (59.6%) were using one of the contraceptive methods to avoid pregnancy. The calender method (76.3%) was by far the most commonly used method among female students. Other methods reported were: birth control pills(10.8), condom (6.5%), and very few said they had been using other modern methods (Table 9).

SEXUALLY TRANSMITTED DISEASES

Among female students who have had sexual relations, only (3.8%) admitted that they have suffered from a sexually transmitted disease on one or more occasions. For male students the proportion was higher 76 (13.2%).

Figure 1. Age of Respondants

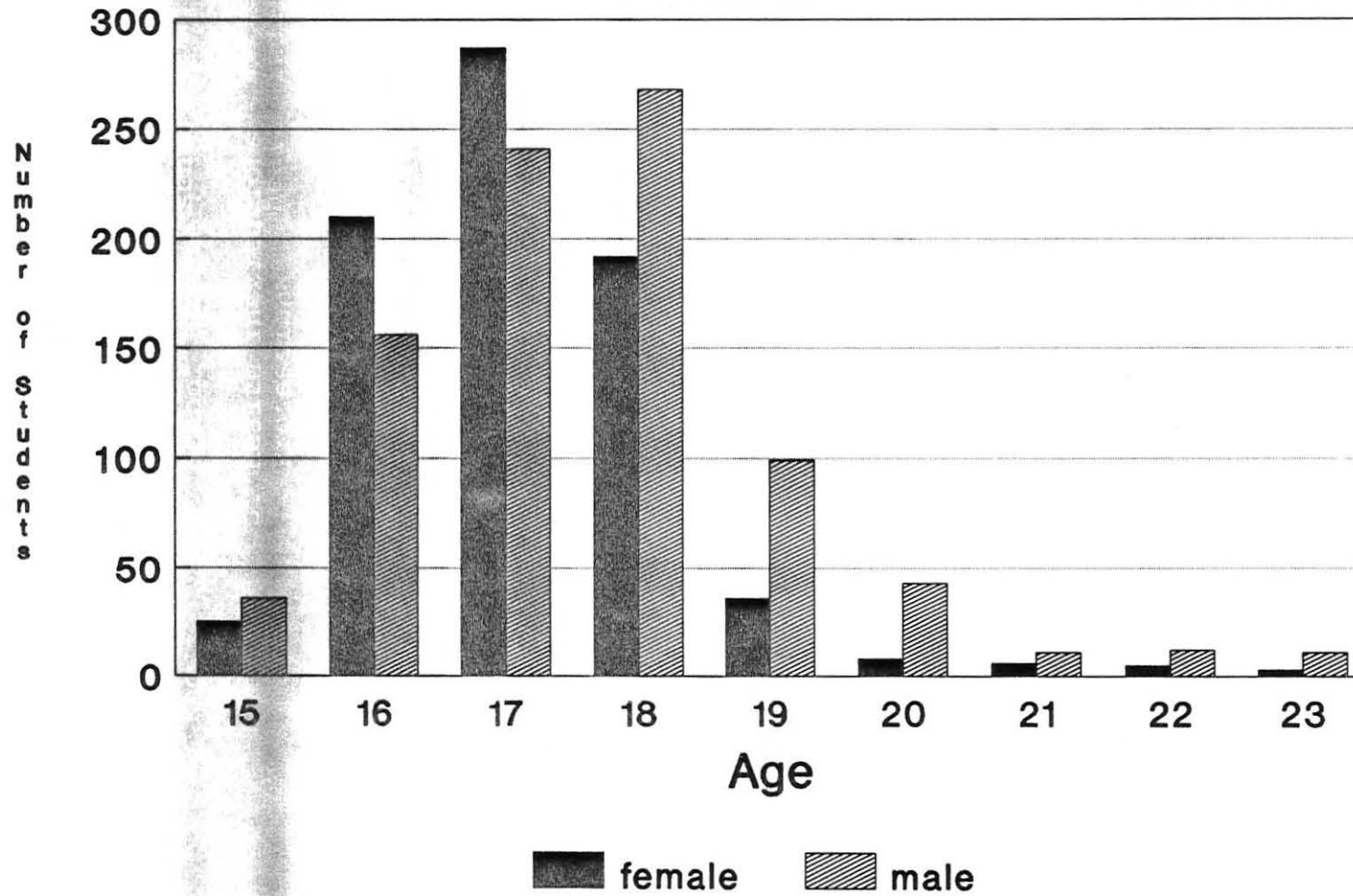


Table 1. Knowledge of Types of Contraceptive Methods. Harar Town, 1991.

Variables	Female		Male		Total	
	No.	%	No.	%	No.	%
One or more CM Known						
Yes	332	42.2	556	63.8	898	53.6
No	449	57.0	318	35.9	767	45.8
Non Response	6	0.8	3	0.3	9	0.6
Total	787	100.0	877	100.0	1674	100.0
Type of CM Known						
Condom	279	84.0	504	89.0	783	87.2
Birth Control Pills	288	86.7	437	77.2	725	80.8
Calender Method	229	69.0	338	59.7	567	63.1
Loop	122	36.7	206	36.4	328	36.4
Diaphragm	43	13.0	73	12.9	116	12.9
Other	15	4.5	75	13.3	90	10.0

Table 2. Main Source of Contraceptive Methods Information.
Harar Town, 1991

Source of Information	Female	%	Male	%	No.	%
1. Mass media (TV. Radio Magazine)	104	31.3	177	31.3	281	31.3
2. School (Teachers)	74	22.3	143	25.3	217	24.2
3. Health institutions/ Professional	79	23.8	127	22.4	206	22.9
4. Friends	23	6.9	25	4.4	48	5.3
5. Parents or other family members	9	2.7	9	1.6	18	2.0
6. Non Response	43	13.0	85	15.0	128	14.3
Total	332	100.0	566	100.0	898	100.0

Table 3. Preferred Source to Learn about Contraception and STD. Harar Town, 1991

Source of Information	Female	%	Male	%	No.	%
1. Health workers in school	403	51.2	485	54.7	888	53.0
2. Health workers in health institutions	276	35.1	207	23.3	483	28.9
3. Teachers in school	41	5.2	85	9.6	126	7.5
4. Well informed friends	28	3.5	46	5.2	74	4.4
5. Parents or other family members	14	1.8	11	1.2	25	1.5
6. Non Response	25	3.2	53	6.0	78	4.7
Total	787	100.0	887	100.0	1,674	100.0

Table 4. Students Knowledge Toward Various Statement.
Harar Town, 1991

Statement	Female		Male		Total	
	No.	%	No.	%	No.	%
1. After SI taking one BCP immediately will prevent pregnancy						
Yes	80	10.2	157	17.7	237	14.2
No	270	34.3	487	54.9	757	45.2
Don't Know	430	54.6	233	26.3	663	39.6
Non Response	7	0.9	10	1.1	17	1.0
Total	787	100.0	887	100.0	1674	100.0
2. A girl is most likely to get pregnant if she has sex about 2 weeks after her last period.						
Yes	281	35.7	364	41.0	645	38.5
No	129	16.4	265	29.9	394	23.6
Don't Know	365	46.4	250	28.2	615	36.7
Non Response	12	1.5	8	0.9	20	1.2
Total	787	100.0	887	100.0	1674	100.0
3. Ampicillin will cause a girl to abort, if she is pregnant.						
Yes	108	13.7	167	18.8	275	16.4
No	228	29.0	359	40.5	587	35.1
Don't Know	440	55.9	349	39.3	789	47.1
Non Response	11	1.4	12	1.4	23	1.4
Total	787	100.0	887	100.0	1674	100.0
4. Males who Urinate facing the moon get gonorrhoea.						
Yes	58	7.4	57	6.4	115	6.9
No	432	54.9	690	77.8	1122	67.0
Don't Know	285	36.2	135	15.2	420	25.1
Non Response	12	1.5	5	0.6	17	1.0
Total	787	100.0	887	100.0	1674	100.0
5. Use of Condom prevent pregnancy						
Yes	563	71.6	796	89.7	1359	81.2
No	75	9.5	46	5.2	121	7.2
Don't Know	138	17.5	37	4.2	175	10.5
Non Response	11	1.4	8	0.9	19	1.1
Total	787	100.0	887	100.0	1674	100

Table 5. Students Attitudes towards Various Statement. Harar Town, 1991

Statement	Female		Male		Total	
	No.	%	No.	%	No.	%
1. Want to use contraception in the future						
Yes	352	44.7	574	64.7	926	55.3
No	85	10.8	62	7.0	147	8.8
DNK	78	9.9	68	7.7	146	8.7
Non Response	272	34.6	183	20.6	455	27.2
2. Approve of information in school about contraception and STD						
Yes	737	93.6	832	93.8	1569	93.7
No	18	2.3	41	4.6	59	3.5
DNK	26	3.3	8	0.9	34	2.0
Non Response	6	0.8	6	0.7	12	0.7
3. Teaching students about contraception and STD will encourage them to have sexual intercourse						
Yes	48	6.1	143	16.1	191	11.4
No	653	83.0	629	70.9	1282	76.5
DNK	80	10.1	105	11.8	185	11.1
Non Response	6	0.8	10	1.1	16	1.0
4. Females should have sex at least once before married						
Yes	41	5.2	160	18.0	201	12.0
No	463	58.8	386	43.5	849	50.7
DNK	277	35.2	326	36.8	603	36.0
Non Response	6	0.8	15	1.7	21	1.3
5. Boy should have sex at least once before married						
Yes	107	13.6	316	35.6	423	25.3
No	274	34.8	290	32.7	564	33.7
DNK	392	49.8	265	29.9	657	39.2
Non Response	14	1.8	16	1.8	30	1.8
6. Only bad girls go for abortion						
Yes	111	14.1	136	15.3	247	14.8
No	396	50.3	550	62.0	946	56.5
DNK	272	34.6	196	22.1	468	27.9
Non Response	8	1.0	5	0.6	13	0.8
7. Induced abortion should be made legal						
Yes	131	16.7	209	23.6	340	20.3
No	136	17.3	536	60.4	1036	61.9
DNK	500	63.5	128	14.4	264	15.8
Non Response	20	2.5	14	1.6	34	2.0

Table 6. Reported History of Sexual Intercourse Among Students.
Harar Town, 1991.

Sexual Intercourse	Female		Male		Total	
	No.	%	No.	%	No	%
Yes	156	19.8	577	65.1	733	43.8
No	631	80.2	310	34.9	941	56.2
Total	787	100.0	887	100.0	1674	100.0

Figure 2. Age at First Intercourse

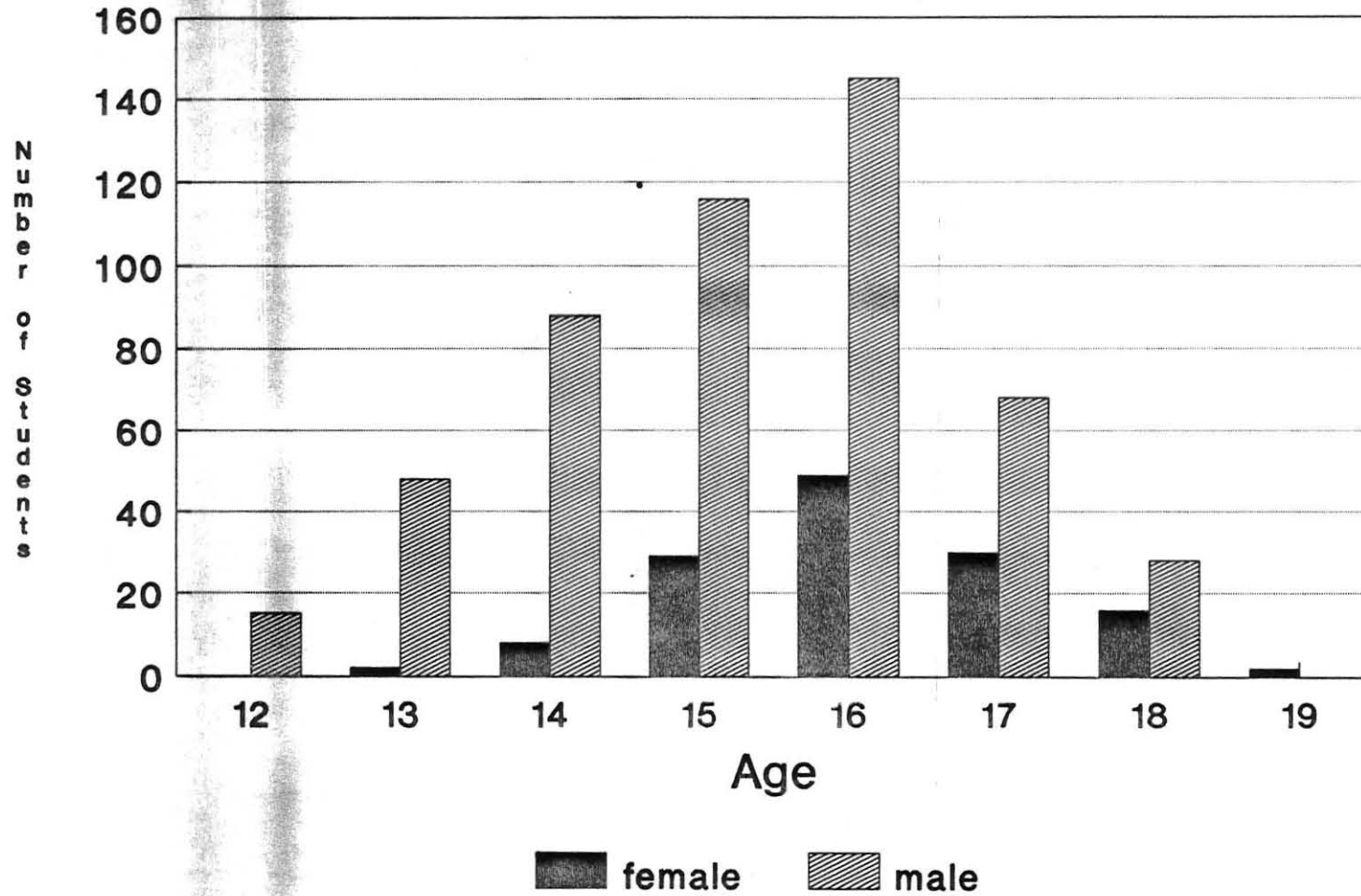


Table 7. Reason for First Episode of Sexual Intercourse.
Harar Town, 1991

Reason	Female		Male	
	No.	%	No.	%
1. Physical				
Pleasure	6	3.8	259	44.9
2. Love Affairs	82	52.6	168	29.1
3. Because all my Friends are doing	4	2.6	41	7.1
4. I was forced	23	14.7	-	-
5. To get Money	1	0.6	-	-
6. To keep my boy/girl friend	6	3.9	7	1.2
7. Got Married	17	10.9	-	-
8. Don't Know	11	7.1	51	8.9
9. Other	1	0.6	15	2.6
10. Non Response	5	3.2	36	6.2
Total	156	100.0	577	100.0

Table 8. Reason Given for not Having Sexual Intercourse.
Harar Town, 1991

Reason	Female		Male	
	No.	%	No.	%
1. Fear of STD / AIDS	34	5.4	35	11.3
2. Fear of Parents	16	2.6	6	1.9
3. Want to wait until married	269	42.6	48	15.5
4. Think it is wrong for me	82	13.0	63	20.3
5. No desire	112	17.7	44	14.2
6. No opportunity	1	0.2	43	13.9
7. Fear of pregnancy	23	3.6	-	-
8. Others	29	4.6	50	16.1
9. Non Response	65	10.3	21	6.8
Total	631	100.0	310	100.0

Table 9. Contraceptive Methods Used by the Sexually Active Females. Harar Town, 1991

Method used	Number	%
Calender method	71	76.3
Birth control pills	10	10.8
Condom	6	6.5
Others	2	2.1
Non Response	4	4.3
Total	93	100.0

Table 10. Reasons for not Using Contraception in Sexually Active Females. Harar Town, 1991

Reason	Number	%
1. I don't know of any method	14	22.2
2. I don't think I will become pregnant	11	17.5
3. I am shy to use a method	10	15.9
4. I want to become pregnant	5	7.9
5. Others	8	12.7
6. Non Response	15	23.8
Total	63	100.0

Table 11. Reasons Given for not Using a Condom Among Male Students. Harar Town, 1991

Reason	Number	%
1. It decreases sexual satisfaction	104	18.0
2. Partner unwilling to use	58	10.1
3. My partner is using contraception	42	7.3
4. I don't know about condoms	39	6.7
5. Not easily available	35	6.1
6. Expensive	5	0.9
7. Others	47	8.1
8. Non Response	247	42.8
Total	577	100.0

Table 12. Pregnancy Outcomes. Harar Town, 1991

Outcome	Number	%
1. Delivered	11	32.4
2. Abortion induced by self or someone else	19	55.9
3. Aborted spontaneously	1	2.9
4. Non Response	3	8.8
Total	34	100.0

BIVARIATE ANALYSIS

Knowledge of Family Planning

The mean knowledge score was 8.3 with SD 2.5 for both sexes. There was a statistically significant association with knowledge found for age, sex and sexual activity of both sexes. A summary of these analyses is presented in Table 13.

There was statistically significant association between knowledge and age (F-stat = 3.1 , $P < 0.001$). The mean score of the knowledge increases as the age becomes older.

A statistically significant difference is observed between male and female students in their knowledge score (F - stat = 90.6, $P < 0.0001$). The mean knowledge score of male students is higher (M = 8.8, SD = 2.4) than of female students (M = 7.7, SD = 2.4).

There was no statistically significant association between knowledge and religion (F-stat = 2.1, $P > 0.05$).

Again, a statistically significantly different score was obtained when the knowledge of both sexes who had had sexual intercourse was compared to those who hadn't had. Those who had had sexual intercourse had a higher mean knowledge score than those who hadn't had in both sexes.

A statistically significant association was observed among sexually active female students, in knowledge score between those who were using contraceptive methods and not using. (F-Stat = 36.1, $P < 0.0001$). Those who were using had a higher mean knowledge score than those who were not using it.

Among males who have had sexual intercourse, those who use condoms had a higher mean knowledge score than those who did not use them. (F-stat = 7.2, $P < 0.01$).

2. Attitude of FP

the mean attitude score was 7.3, SD 1.6. A summary table presented in Table 14.

The mean score of attitude toward FP and abortion with different variables was calculated (ie, age, sex, religion and sexual activity in both sexes). There was a statistically significant association observed in all variables.

There was a statistically significant association seen between female and male. (F-stat = 5, $P < 0.05$). Females had higher mean attitude score than male students.

Those who were sexually active had a statistically significantly higher attitude score than those who were not. This was true for both sexes.

3. Knowledge of Different Types of Contraceptive Method by Sex and Sexual Activity

An analysis was made of students' knowledge of the different types of contraceptive methods by sex (Table 15).

The following items showed statistically significant differences- Condoms, Birth control pills, Calender method and others. Male students were more likely to know about condoms than female students while the female students were more likely to know Birth control pills and the calender method than the male students.

When a comparison was made between sexually active and not active female students knowledge about different types of contraceptive methods we got a statistically significant association for the following methods = Calender method OR=1.83, 95% CI=1.02 to 3.31, $P < 0.01$ and diaphragm OR=0.37, 95% CI = 0.14 to 0.96, $P < 0.01$. Sexually experienced female students were more likely to know about calender method than not, while not sexually active female students more likely to know about the diaphragm. No statistically significant association was observed with the following methods birth control pills, condom, loop and others.

Ever having had sexual intercourse did not to appear to affect boy's knowledge of specific contraceptive methods except that boys who had had sexual intercourse were more likely to know about the Birth control pills. OR = 1.70 95% CI = 1.11 to 2.62, $P < 0.01$.

4. Attitude of Both Sexes by Different Items

More male students (81.5%) approved the use of contraception in the future as compared to the female students (68.3), (OR = 2.24, 95% CI 1.55 to 3.23, $P < 0.0001$).

Female students approved sex education in school about contraception and STD more than male students OR = 0.50, CI = 0.27 to 0.90, $P < 0.05$. Ninety three point six of the females approved of education in the school while 93.8% of the males did the same.

There were separate questions which tried to assess the attitude of the students toward premarital sex, The result obtained from these questions showed a statistically significant difference between male and female.

Both males and females thought it was more acceptable for males to have premarital sex than females. Thirty six point three percent of males and 13.8% of females thought it was good for boys to have sex at least once before they were married, whereas only 5.2% of males and 18.3% of females felt that it was good for females to have sex at least once before they were married.

Table 13. Distribution of Mean Knowledge Score About FP by Age, Sex, Religion, and sexual activity. Harar town,

1 9 9 1

Variable	No.	Mean	SD	F-Stat	p.Value
1. Age					
15-16	427		7.8	2.5	
17-18	988		8.4	2.5	
19-20	186		8.7	2.4	
21+	48	9.2	2.6	3.1	<0.001
2. Sex					
Male	887	8.8	2.4		
Female	787	7.7	2.4	90.6	<0.0001
3. Religion					
Muslim	282	7.9	2.6		
Orthodox	1258	8.4	2.5		
Catholic	62	8.0	2.6		
Protestant	33	8.4	2.4		
Others	28	8.0	1.9	2.1	ns
4. Females:History of intercourse					
Yes	156	8.3	1.6		
No	631	7.5	1.7	11.8	<0.001
5. Males:History of intercourse					
yes	577	8.9	2.3		
No	310	8.6	2.5	4.0	<0.05

Table 14. Distribution of Mean Attitude Score about FP by Sex, Religion, and Sexual Activity. Harar Town, 1991

	No.	Mean	SD	F.Stat	p.Value
1. age					
15-16	427	6.6	1.6		
17-18	988	6.9	1.8		
19-20	186	6.6	1.6		
20+	48	7.3	0.5	5.1	<0.01
2. Sex					
Male	887	6.8	1.9		
Female	78	7.0	1.2	5.1	<0.05
3. Religion					
Muslim	282	6.9	1.9		
Orthodox	1258	6.9	1.6		
Catholic	33	6.0	0.0		
Protestant	62	5.7	2.9		
Others	28	8.0	0.0	9.8	<0.001
4. Females History of intercourse					
yes	156	7.5	1.7		
No	631	6.8	1.0	18.4	<0.0001
5. Males History of intercourse					
Yes	577	7.1	1.8		
No	310	6.2	1.8	58.9	<0.0001

Table 15. Knowledge Toward Different Types of Contraceptive Methods by Sex. Harar Town, 1991

Variable	Female (%)	Male (%)	p.value	OR	95 % CI
Know about CM					
Yes	332 (42.5)	566 (64)	<0.0001	2.41	(1.97, 2.95)
No	449 (57.5)	318 (36)			
Condom					
Yes	279 (84)	504 (89)	<0.05	1.54	(1.02, 2.33)
No	53 (16)	62 (11)			
Pills					
Yes	288 (86.7)	437 (77.2)	<0.001	0.52	(0.35, 0.77)
No	44 (13.3)	129 (22.8)			
Calender Method					
Yes	229 (69)	338 (59.7)	<0.001	0.67	(0.49, 0.90)
No	103 (31)	228 (40.3)			
Loop					
Yes	122 (36.7)	206 (36.4)	ns	0.98	(0.74, 1.32)
No	210 (63.3)	360 (63.6)			
Diaphragm					
Yes	43 (13)	73 (12.9)	ns	1.0	(0.65, 1.52)
No	289 (87)	493 (87.1)			
Others					
Yes	15 (4.5)	75 (13.3)	<0.000	3.23	(1.77, 5.97)
No	317 (95.5)	491 (86.7)			

DISCUSSION

The information collected in this survey provides an opportunity to examine the knowledge, attitude, sexual experience and contraceptive practices of adolescent students.

We tested the level of knowledge by asking the students to name different types of contraceptive methods. We found that more than half of the students (53.6) know at least one method. In knowledge score the students scored more than 8 points out of 13. This two factors indicates the students on the average have a modest knowledge of FP.

More than half of the respondents (55.3%) have shown a positive attitude to the use of contraceptive methods in the future. The average score of all the students for general attitude toward FP and abortion was 7.3 point (out of 10) This result seems to be positive.

Twenty percent of the females and 65% of the males had already had sexual experience at the time of the study. This is comparable to a 1990 study conducted in Addis Ababa senior high schools in grade 9 - 12 students, with age range of 13 to 19 years, (2), in which the findings showed that 24% of the female and 53% of the male respondents admitted to having had sexual intercourse at least once.

The majority of male students (82.5%) said that their first sexual experience was with female students. But, the finding showed that the number of female students who admitted to having

had sexual intercourse were less, when compared with the male students experience. This might be because of the girls shyness to tell the truth, or due to some female students who are very active.

A total of 45.5% of the females and 38.3% of the males reported that they had had intercourse at least once during the three months preceding the survey.

The second most common reason for female student first sexual intercourse was being forced by some one. A relatively high percentage of sexual abuse/rape as a cause of first sexual intercourse is a cause for concern and further investigation.

The survey showed that both sexes believed that it was more acceptable for male adolescents to have premarital sexual experience than for females. In general, males are more likely to approve of premarital sex than females. The study by Nichols et al (26) ascertain the same fact. This study also showed that a much larger proportion of the males had sexual intercourse than the female students.

A total of 59.6 of the female students who had had sexual intercourse had been using one of the contraceptive methods to avoid pregnancy. However, the majority (76.3%) were using an unreliable method i.e, the calendar method. The other different modern contraceptive methods they used less commonly.

Among sexually experienced female respondents 60.3% knew at least one type of contraceptive methods (notably the birth control pills and condom). Knowledge about these two types was widespread, particularly among those respondents who were sexually experienced

while use of different modern contraceptive methods was only 19.4%. Oyeka (34) 1984 in his study of FP among Nigerian post secondary female students found that about 60.1% of sample expressed knowledge of family planning techniques but only 23.3% had ever practised it. This means that knowledge of FP is not changing the behaviour. This unsatisfactory usage of contraceptive and the risky methods, therefore, exposes them to the risk of unwanted or unplanned pregnancy. Other studies have shown the same low contraceptive use by sexually active adolescents (14,16,17,30,35).

In this study, among adolescent male students who had had sexual intercourse 79% did not use condoms. This shows that the majority of the students are exposed to the risk of adolescent pregnancy and STD including AIDS.

In this study (3.8% of sexually active females and 13.2% of sexually active males) contracted at least one STD in the past. For male adolescents the proportion is high. The Monrovia study also indicated that the extent of STD among adolescents is alarming and higher in males (26). Walter (36) stated that these findings indicate unsafe sexual practices and suggests that the development of effective preventions designed to curtail involvement in these behaviours is an urgent public health priority, particularly for students.

The main reasons given by the male students for not using condoms were: the fear of the decrease of sexual satisfaction and unwillingness of a female partner. Having unprotected sexual intercourse may lead to the risk of unwanted pregnancy and STD/HIV

infection. This should be corrected by providing the appropriate training and health education.

Among sexually active respondents 19.9% of the girls had become pregnant. Of these individuals, over half (55.9%) terminated their pregnancy by means of induced abortion. Other research workers have also found a high prevalence of induced abortion among students (16,25,26,35). This study confirms that adolescent students have a low rate of use of contraceptive methods, and use infective or risky methods, therefore, exposing themselves to the risk of unwanted, and unplanned pregnancy, which often lead to induced abortion.

Most 1,036(61.9) disagreed that induced abortion should be legal. When analyzed by sex 60.4% of males and 17.3% of females disagreed, while on the other hand 63.5% of females and 14.4% of males gave their response don't know. This show that the majority of the male students oppose the legalization of abortion while the majority of females are not sure. This reflects that the male students stick to the principle of religion and influence of traditional customs. The majority of female students were not sure, possibly because of the fear of consequences of unplanned pregnancy which may be tackled by legalization of abortion.

The need for FP information and sex education programme is underlined by the finding. Knowledge, as measured in this study was significantly associated with sexual activity. There was also statistically significant association in mean knowledge score between those who were using contraceptive methods and those who were not. The former had higher a mean knowledge score. A limitation of a study such as this is that although association can be seen, the temporal sequence is not clear. That is, is it use that follows knowledge, or knowledge that follows use? The majority (93.3%) of the respondents approved the importance of provision of information in school about contraception and STDs. The respondents expressed their preference to get their information from health workers in school. This emphasizes the importance of the health workers in the sex education of adolescent students.

Hatcher (13) and Rubin (37) emphasised providing information about pregnancy and birth control through formal sex education programmes increases knowledge of human reproduction and methods of contraception. Integrating sex education programme to students with a contraceptive service, would increase contraceptive utilization and reduce the level of unprotected sexual intercourse and consequently unwanted pregnancy among the adolescent population.

In a study such as this, it is always difficult to be sure of the validity of the students responses. In spite of intensive efforts to reassure the students of confidentiality, there may have been a desirability bias in their response. There may also have

been some contamination due to repeating the survey on the next day. The repetition was done because due to a misunderstanding of the schedule, a significant number of students did not appear on the first day. It was felt that it was preferable to get students who were missed, than to avoid the problem of contamination.

The results of this study are likely to be valid for other towns in Ethiopia with a similar ethnic composition.

CONCLUSION

This study finds that a significant proportion of the young adolescent students in Harar are sexually active with a low level of contraceptive protection, that a large proportion of adolescent girls who are sexually active have been pregnant, and that half of them have terminated the pregnancy by means of induced abortion. Many male students had had an STD.

In our finding the knowledge of the students is acceptable but the practice of contraceptive utilization was very low. This might reflect that acceptable knowledge is not a guarantee for acceptable practice. Any intervention planned for young people should take this into account.

It is essential to disseminate information in these areas to the adolescent. The evidence in this study has revealed that the role of the school has been weak so far, even though it is the preferred source by the students. We hope that these findings will enable the community to realize the importance of the subject matter discussed. Co-operation with teachers of high school will give a great advantage to pass information to students about FP. It is also clear that unless important institutions such as family, religious and policy makers give the necessary support, the program will not be practical.

RECOMMENDATIONS

1. Discussion should be begun in the community about the problem and how to solve it.
2. Discussions between the Awraja health Office and schools should occur concerning how the health sector can be involved in health education in schools.
3. Programs that emphasize behavioral change, rather than simply importing facts should be used.

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QUESTIONNAIRE

This questionnaire is to help us know the needs of high schools students about family life education. Please help us by being as honest as possible. If you don't want to answer a question, leave it blank. Remember YOUR NAME IS NOT RECORDED. We will never be able to find out who filled this questionnaire.

Please give only one answer to each question by putting "X" mark. Only for question No. 7 give your answer by writing down. Thank you.

1. Age _____
2. Sex
 1. _____ Male
 2. _____ Female
3. What is your religion?
 1. _____ Muslim
 2. _____ Orthodox christian
 3. _____ Catholic "
 4. _____ Protestant "
 5. _____ Others specify _____
4. Have you ever been married?
 1. _____ Yes
 2. _____ No
5. Are you presently married?
 1. _____ Yes
 2. _____ No
6. Do you know about contraception methods?
 1. _____ Yes
 2. _____ No

If the answer is "NO", do not answer question 7 and 8 go to question 9.

7. If the answer is yes write the types you know
1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
8. From whom/ where did you get most of your information about contraceptive methods.
1. _____ Family
 2. _____ School (Teachers)
 3. _____ Health institutions/ professional
 4. _____ Friends
 5. _____ Mass media (Tv, Radio, Magazine)
9. Do you want to use contraception in the future?
1. _____ Yes
 2. _____ No
 3. _____ Don't know
10. Do you approve of information in school about contraception and STD?
1. _____ Yes
 2. _____ No
 3. _____ don't know
11. Do you think that teaching students about contraception and STD will encourage them to have sexual intercourse?
1. _____ Yes
 2. _____ No
 3. _____ Don't know
12. How would you prefer to learn about contraception and STDs?
1. _____ From my parents or other family member
 2. _____ From teachers, in school
 3. _____ From health workers, in a health institution
 4. _____ From health workers in school
 5. _____ From well informed friends
13. Do you think that a girl should have sex at least once before she gets married?
1. _____ Agree
 2. _____ Not sure
 3. _____ Disagree
14. Do you think that a boy should have sex at least once before he gets married
1. _____ Agree
 2. _____ Not sure
 3. _____ Disagree

15. Do you agree that only bad girls go for abortion?
1. Agree
2. Not sure
3. Disagree
16. DO you think that after sexual intercourse taking one birth control pill immediately will prevent pregnancy?
1. Yes
2. No
3. Don't know
17. DO you think that a girl is most likely to get pregnant if she has sex about 2 weeks after her last period?
1. Yes
2. No
3. Don't know
18. Do you think that Ampicillin will cause a girl to abort, if she is pregnant?
1. Yes
2. No
3. Don't know
19. Do you agree that males who urinate facing the moon get gonorrhoea?
1. Yes
2. No
3. Don't know
20. Do you think that the use of condoms prevents pregnancy?
1. Yes
2. No
3. Don't know
21. If a high school student needed contraception where would she prefer to get it?
1. School
2. Health institution
3. Pharmacy
4. Health post
5. Through peer groups
6. Other specify _____
22. Do you presently have a regular boyfriend/ girlfriend?
1. Yes
2. No

G I R L S

29. Have you ever had sexual intercourse?

1. Yes
2. No

If the answer is "No" go directly to question 40.

30. If the answer is yes at what age did you first have intercourse? _____

31. What was your main reason for sexual intercourse the first time you had it?

1. Physical pleasure
2. Love affairs
3. Because all my friends are doing it
4. I was forced
5. To get money
6. To keep my boy friend
7. Got married
8. Don't know
9. Other, specify _____

32. Have you had sexual intercourse in the last 3 months?

1. Yes
2. No

33. Do you do anything to avoid becoming pregnant?

1. Yes
2. No

If the answer is "No" go to question 35.

34. If yes, what?

1. Calender method
2. Pills
3. Condoms
4. Other, specify _____

35. If no, why not?

1. I don't think I will get pregnant
2. I want to get pregnant
3. I am shy to use for a method
4. I don't know any method
5. Others, specify _____

36. Have you ever been pregnant?

1. Yes
2. No

If the answer is "NO" go to question 39.

37. If the answer is yes what was the result?
1. Delivered
 2. Aborted Spontaneously
 3. Abortion induced by self or some one else
 4. Others, specify _____
38. If the answer was abortion induced, What was your most important reason for having an abortion?
1. Fear of parents and family
 2. Fear of discontinuing school
 3. Economic problems
 4. Others, specify _____
39. Have you ever had a STD?
1. Yes
 2. No
 3. Don't know
40. Answer only if you have never had sexual intercourse.
What is the main reason you have never had sexual intercourse?
1. Fear of STD/AIDS
 2. Fear of parents
 3. Want to wait until married
 4. Think it is wrong for me
 5. No desire
 6. No opportunity
 7. Fear of pregnancy
 8. Others, specify _____

B O Y S

41. Have you ever had sexual intercourse?
 1. Yes
 2. No
 If the answer is "No" go to question 50.
42. If the answer is yes at what age did you first have sexual intercourse? _____
43. What was your main reason for sexual intercourse the first time you had it?
 1. Physical pleasure
 2. Love affairs
 3. Because all my friends are doing it
 4. To keep my girl friends
 5. Got married
 6. Don't know
 7. Others, specify _____
44. With whom was first sexual intercourse?
 1. Prostitute
 2. Students
 3. House-made
 4. Other Specify _____
45. Have you had sexual intercourse in the last 3 months?
 1. Yes
 2. No
46. Do you usually using a condom during sexual intercourse?
 1. Yes
 2. No
 3. Don't know
 If the answer is "YES" go to question 48.
47. If not use condom, reason not using.
 1. I don't know about condom
 2. Not easily available
 3. It decreases sexual satisfaction
 4. Partner unwilling to use
 5. Expensive
 6. My partner using contraception
 7. If any other, specify _____
48. Are you usually embarrassed to use condoms when having sex?
 1. Yes
 2. No
 3. Don't know

49. Have you ever had a STD?

1. Yes
2. No
3. Don't know

50. Answer only if you have never had sexual intercourse. What is the main reason you have never had sexual intercourse?

1. Fear of STD/AIDS
2. Fear of parents
3. Want to wait until married
4. Think it is wrong for me
5. No desire
6. No opportunity
7. Others, specify _____

ሰላ ስታ ንግሥርት መሰጠት ክስፈላጊነት

ግጥምን መጠይቅን

ይህ መጠይቅ ለሁለተኛ ደረጃ ተግባራዊ ሰላ ስታ ንግሥርት መሰጠት ክስፈላጊነት ለግጥም ዓገፈባ ነው። ስለሆነም በተቻለ መጠን ጥያቄዎችን በገልጽነት ክንዲትመልሱ ለቅን ክብርን ያጠይቃሉ። ስትመልሱ ለ ዓገፈባው ለግጥም ጥያቄ ካለ ክላረው/ፊት መጠይቅ ግጥምን ክንዲት መሰጠት ክስፈላጊነት። ስለዚህ መጠይቅን ግን ክንዲት ለግጥም በፍጹም ክደቻሉ።

ለክፍሉ ጥያቄ ክንዲት መልስ ስጥ " x " መልስ በመጠቀም ስጥ / ስጥ ለ ጥያቄ ግጥም መልስ ስጥ በግጥም መልስ መልስ። ስለዚህ መልስ።

ይህ ስታ ክደቻሉ

1. ዕድሜ _____

2. ስታ

1. _____ ወገድ

2. _____ ስታ

3. ግጥም ተለቀ / ግጥም ተጠቅሞ ሃይማኖት

1. _____ ክስፈላጊነት

2. _____ ስርዓት

3. _____ ክፍለ

4. _____ ፕሮጀክት

5. _____ ስላ ክሆነ ይጠቀስ _____

4. ክንዲት ስጥ ተጠቅሞ ተጠቅሞ / ?

1. _____ ክፍ

2. _____ ክላገጥም

5. በክሆነ ወቅት ክፍ ስለሆነ ስለሆነ ?

1. _____ ክፍ

2. _____ ዓለግ

11. ስለ ጭላቋ ቀጥጥርና ስለሌባለዘር በሽታዎች ንጋሪት መሰጠት ተግባራትን ገብረ ሥጋ ገንቢነት አንዲያደርጉ ይገፋፋቸዋል ብለህ ሽታስቢያለሽ ?

- 1. — አያ
- 2. — አላስብም
- 3. — አላውቅም

12. ስለጭላቋ መኖሪያና ስለሌባለዘር በሽታዎች በየትኛው ዓይነት መንገድ መጣርን ክርክርለህ /ክርክርግላለህ ?

- 1. — ከጭላቋ ወይንም ከሌላ ጭላቋ
- 2. — ከጭላቋዎች በንጋሪት ቤት
- 3. — ከጭላቋ ባለጭላቋዎች በጭላቋ ተጋዳሪዎች
- 4. — ከጭላቋ ባለጭላቋዎች በት/ቤት
- 5. — ስለ ጭላቋ ፊትነት ክርክር ማድረግ

13. ስት ለጭላቋ ክፍፍላቸው በፊት ቢያንስ አንድ ጊዜ የገብረ ሥጋ ገንቢነት ግዴረገ አለባት ብለህ ሽታስቢያለህ /ታስቢያለሽ ?

- 1. — አስባግለሁ
- 2. — አይባሉም
- 3. — አያውቃለሁ

14. ጭላቋ ለጭላቋ ክፍፍላቸው በፊት ቢያንስ አንድ ጊዜ የገብረ ሥጋ ገንቢነት ግዴረገ አለባት ብለህ ሽታስቢያለህ /ታስቢያለሽ ?

- 1. — አስባግለሁ
- 2. — አይባሉም
- 3. — አያውቃለሁ

15. የሽታስቢያለሽ ጭላቋ የሚያደርጉት መገኛ ቤቶች ብቻ ናቸው በግልጽ ማሳወቅ ስትችሉ /ትችሉ ?

- 1. — አስባግለሁ
- 2. — አይባሉም
- 3. — አያውቃለሁ

16. የገብረ ሥጋ ገንቢነት ይተደረግ በታላቅ ወይንም አንድ የጭላቋ መኖሪያ አንድነት ለሆነ /መሰረት አይገኝም ይከለከላል ብለህ ሽታስቢያለህ /ታስቢያለሽ ?

- 1. — አያ
- 2. — አላስብም
- 3. — አላውቅም

29. የገቢዎች ስርዓት ለማሻሻል ለማድረግ ምን ዓይነት ስራዎች ይኖራሉ ?

- 1. — አያ
- 2. — አላረጋገጠም

ጠቅላይ አላረጋገጠም ከሆነ በየጥቂት 40ኛው ደረጃ ተሸጋገሪ

30. ጠቅላይ አያ ከሆነ በገንዘብ ዓይነት ላይ የሚከተሉትን ገቢዎች ማረጋገጥ ይቻላል ምን ገንዘብ ይረጋገጣል? _____

31. የሚከተሉትን የገቢዎች ስርዓት ማሻሻል ለማድረግ የገቢዎች ስርዓት ማሻሻል ስራዎች ምን ዓይነት ናቸው ?

- 1. — ስራዎች አሰጣጥ ለማድረግ
- 2. — ፍቅር
- 3. — ገቢዎች በሙሉ ስለማረጋገጥ
- 4. — ተገቢዎች
- 5. — ገንዘብ ለማድረግ
- 6. — የገቢዎች ፍቅርና አገልግሎት ስራ
- 7. — በገንዘብ ዓይነት
- 8. — አላረጋገጠም
- 9. — ሌላ ስራ ይጠቀስ — —

32. ገቢዎች ስርዓት ማሻሻል ስራዎች ምን ዓይነት ናቸው ?

- 1. — አያ
- 2. — የሌላ

33. አሰጣጥ ስራዎች ለማሻሻል የሚከተሉትን ዘዴዎች አሉ ?

- 1. — አያ
- 2. — የሌላ

ጠቅላይ የሌላ ከሆነ ከ 35 ተሸጋገሪ

34. ጠቅላይ አያ ከሆነ ምን ዓይነት ስራዎች ?

- 1. — በገንዘብ ዓይነት / በገንዘብ / ወይም በሌላ ዓይነት ዘዴ
- 2. — የአሰጣጥ ስራዎች ስራ / ስራ /
- 3. — ሌላ
- 4. — ሌላ ከሆነ ይጠቀስ _____

35. ጠቅላይ የሌላ ከሆነ ስራዎች ?

- 1. — የሚከተሉትን ስራዎች
- 2. — ሌላ ስራዎች
- 3. — ሌላ ስራዎች ለማሻሻል ስራዎች