COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF REPRODUCTIVE, FAMILY AND POPULATION HEALTH

THE CONTRIBUTION OF SOCIAL MEDIA USE ON SEXUAL AND REPORDUCTIVE HEALTH LITERACY AMONG IN-SCHOOL ADOLESCENT GIRLS IN ADDIS ABABA, ETHIOPIA

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ADDIS ABABA, ETHIOPIA

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Full title of the research project	The Contribution of social media use on Sexual and Reporductive Health Literacy among in-school adolescent Girls in Addis Ababa, Ethiopia
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Acronyms

ASRH	Adolescent Sexual and Reproductive Health**.**
HIV	Human Immunodeficiency Virus
HLS-EU	European Health Literacy Scale
SDG	Sustainable Development Goals
SMUIS	Social Media Use Integration Scale
SPSS	Statistical Package for the Social Sciences
SRH	Sexual And Reproductive Health
SRHL	Sexual and Reproductive Health Literacy
STIs	Sexually Transmitted Infections
WHO	World Health Organization
FMOH	Federal Ministry Of Health

Abstract

Background: Sexual and reproductive health (SRH) literacy plays a crucial role in adolescent health, yet many adolescents lack adequate knowledge and access to quality sexual and reproductive health services. Though social media spread misinformation and unverified content, adolescents are increasingly turning to social media access SRH information. Assessing the contribution of social media use on sexual and reproductive healthis essential for improving adolescents' sexual and reproductive health literacy.

Objective: To assess the contribution of social media use on sexual and reproductive health literacy among in-school adolescent girls in Addis Ababa

Methods: A school-based cross-sectional study was conducted among secondary school girls using structured, self-administered questionnaires on Social Media Use and sexual and reproductive health literacy Integration Scale. Data were collected by trained data collectors using a standardized tool that measured with a validated scale .The sample size was determined using Epi Info and data were entered, cleaned, and analyzed using SPSS version 25**.** binary and Multivariable logistic regression analysis was applied to identify siginficant factors

Result: Total of 648 adolescent girls participated in the study, yielding a 95% response rate with 48% having optimal sexual and reproductive health literacy. While the use of social media as a source of sexual and reproductive health information was low in 23.6%, moderate in 59.9%, and high in 16.5%. Girls aged 15–17 years (AOR = 5.47; 95% CI: 3.01–9.95), fathers in the private sector (AOR = 4.49; 95% CI: 1.54–13.07), and mothers owning a business (AOR = 5.81; 95% CI: 1.51–22.36) or in government (AOR = 8.85; 95% CI: 2.28–34.22) had higher odds sexual reproductive health optimal literacy, while migration from rural areas (AOR = 0.34; 95% CI: 0.14–0.86), rare/once-per-week phone use (AOR = 0.72; 95% CI: 0.26–1.98; AOR = (0.23), and moderate social media integration (AOR = 0.34)reduced the odds of sexual reproductive health optimal literacy .

Conclusion: Sexual and reproductive health literacy among adolescent girls in Addis Ababa is shaped by socio-demographic factors and digital engagement. Targeted interventions are needed for adolescents with limited digital engagement to support informed decision-making.

Keywords: Sexual and reproductive health literacy, Social media, Adolescent

1. Introduction

1.1 Background of the study

According to the World Health Organization (WHO), sexual and reproductive health (SRH) is essential for achieving the Sustainable Development Goals (SDGs), particularly in promoting gender equality and supporting girls to remain in school (SDG 5). It also aligns with SDG 3, Target 3.7, which calls for universal access to sexual and reproductive health information, education, and services (1). Achieving these goals requires adequate sexual and reproductive health literacy (SRHL). SRHL refers to the ability to access, understand, and use SRH information to make informed decisions (2). It includes four core components: access, which is the ability to obtain relevant SRH information; understanding, which involves comprehending the information; appraisal, which refers to evaluating its quality and relevance; and application, which involves using the information to make appropriate decisions and guide behavior (2,3,4).

Despite its importance, many adolescents face challenges during the transition to adulthood due to low levels of SRHL. They also encounter barriers in accessing quality SRH services, including social stigma, limited agency, and inadequate youth-friendly service provision (5). In Ethiopia, similar barriers persist, and access to adolescent SRH (ASRH) services remains limited, contributing to high levels of unintended pregnancy and sexually transmitted infections (STIs) among young people (1,6).

Recent evidence shows a shift in how adolescents obtain SRH information. Instead of relying on traditional media such as newspapers, radio, and television, many adolescents increasingly access information through social media platforms (7). Globally, platforms such as Facebook, YouTube, Instagram, WhatsApp, TikTok, Telegram, and Snapchat have become major tools for communication, learning, and social interaction (8). These platforms provide adolescent girls with spaces to explore SRH topics, including contraception, menstrual health, STIs, healthy relationships, sexual experiences, abortion, and physical changes during adolescence (9). While social media can promote SRH awareness and improve access to information, it also poses risks, such as exposure to misinformation and reliance on unverified sources (10).

In addition to social media use, SRHL among adolescent girls is influenced by personal, household, and technological factors. Personal factors include age, educational level, and place of residence, which affect access to and understanding of SRH information (11,12). Household factors, such as parental education, family income, and parents' occupation, shape adolescents' exposure to health resources (13,14). Marital status and school type further influence opportunities for guidance on SRH topics. Technological factors, including internet availability, mobile phone access, and type of devices used, determine how adolescents engage with digital sources of SRH information (12,13). Studies in Ethiopia and sub-Saharan Africa show that these factors significantly predict SRH knowledge and literacy (11–15).

As of 2024, more than 5.17 billion people worldwide use social media (11). In Ethiopia, there were 24.83 million internet users and 7.05 million active social media users in 2024 (12,13). Despite this growth, adolescent girls in Ethiopia continue to face challenges in accessing comprehensive and accurate SRH education, mainly due to limited school-based instruction and restricted access to reliable SRH content (14,15).

Therefore, this study aims to assess the level of sexual and reproductive health literacy (SRHL) among adolescent girls in Addis Ababa secondary schools and examine how it is influenced by various independent factors, including social media use and socio-demographic characteristics. By focusing on SRHL as the single outcome, the study seeks to identify the key factors associated with adolescents' knowledge and understanding of sexual and reproductive health.

1.2 Statement of the problem

In sub-Saharan Africa, particularly in Ethiopia, social media has become an important platform for adolescents seeking sexual and reproductive health (SRH) information, as traditional sources are often limited or stigmatized (15). Although it improves access to information, the quality and accuracy of content are frequently questionable, which can expose adolescents to misinformation (16). This dual influence both positive and negative highlights the need for reliable, accurate resources to support youth health literacy and ensure that adolescents benefit safely from social media as an information source (12,16)

In sub-Saharan Africa, particularly in Ethiopia, social media has become an important platform for adolescents seeking sexual and reproductive health (SRH) information, as traditional sources are often limited or stigmatized. While it provides access to information, social media can also expose adolescents to misinformation, making careful and responsible use essential. (15). Adolescents increasingly rely on social media for health information; however, the quality and accuracy of content are frequently questionable (16). This raises concerns about misinformation, which can influence adolescent behavior both positively and negatively, highlighting the need for reliable resources to support youth health literacy (12,16).

Despite the potential of social media to enhance SRH knowledge, many adolescent girls lack the critical SRH literacy skills needed to evaluate the reliability of the information they encounter, increasing the risk of harmful or inappropriate behaviors (17,18). Moreover, SRH literacy is influenced by personal, household, and environmental factors. Age, educational level, and place of residence can affect adolescents' access to and understanding of SRH information (11,12). Family-related factors, including parental education, family income, and parents' occupation, shape exposure to health resources (13,14). Marital status and school type further influence opportunities for guidance on SRH topics, while technological factors such as internet availability, mobile phone access, and type of devices used determine engagement with digital sources of information (12,13,15).

The consequences of inadequate SRH literacy among adolescents are severe. According to the UNFPA report from 2024, among every 1,000 Ethiopian girls aged 15–19, 72 are expected to give birth, indicating a high adolescent birth rate (19). Early childbearing can significantly impact education, health, and economic opportunities. Additionally, a 2016 WHO report shows that 17% of Ethiopian girls aged 15–19 are married, with 6% married by age 15. Among this age group, 12.5% have given birth, and 2.4% are pregnant with their first child. Despite these early life transitions, only 32% of girls aged 15–19 use contraceptives. Comprehensive knowledge of HIV/STIs is low at 24% for girls compared to 37.6% for boys, and condom use in premarital sex is limited, with only 18.6% of girls using condoms versus 53.4% of boys (20).

These statistics highlight the urgent need to improve SRH literacy among adolescent girls in Ethiopia. While social media has the potential to increase access to health information, there is

limited evidence on how it interacts with personal, household, and technological factors to influence SRH literacy. Understanding these relationships is crucial for identifying gaps, informing educational interventions, and supporting adolescent girls to make informed decisions about their sexual and reproductive health (12,15–20).

1.3 Rationale of the study

This study is important because it explores how social media use relates to sexual and reproductive health (SRH) literacy among adolescent girls in secondary schools in Addis Ababa. Many adolescents in Ethiopia have limited knowledge about SRH, which can negatively affect their health, wellbeing, and ability to make informed decisions. Understanding this relationship can help highlight gaps in knowledge and identify the factors that influence SRH literacy among adolescent girls in these schools. Additionally, the findings can inform national-level strategies and policies aimed at improving adolescent SRH education and promoting safe practices.This study is important because it explores how social media use relates to sexual and reproductive health (SRH) literacy among adolescent girls in Addis Ababa secondary schools. Many adolescents have limited knowledge about SRH, which can affect their health and wellbeing.

By exploring strategies to improve SRH literacy through social media, the study aims to empower girls to adopt safer health practices and make informed decisions about their sexual and reproductive health independently. Furthermore, the findings will be valuable for academic institutions such as Addis Ababa University College of Health Sciences, providing insights for researchers and educators to design interventions and integrate digital health education into school curricula.

Ultimately, this research will contribute to a better understanding of how social media can support adolescent girls in accessing accurate sexual and reproductive health (SRH) information, fostering healthier behaviors, and improving overall well-being among secondary school students in Addis Ababa. In addition, the findings can serve as a reference for fellow researchers, providing insights and guidance for future studies on SRH literacy and the role of digital platforms among adolescents.

2. Literature Review

2.1. Introduction

This literature review examines how social media use affects sexual and reproductive health (SRH) literacy among adolescent girls in Addis Ababa secondary schools, using the Social Cognitive Theory (SCT). SCT explains how learning occurs through observation, self-regulation, and social influences, all of which are common on social media platforms. Social media has the potential to serve as an accessible and engaging channel for adolescents to gain knowledge and develop positive health behaviors. The review aims to understand how social media can improve SRH knowledge and behaviors among young people. However, most existing research on SRH literacy does not focus specifically on social media or the factors associated with it, and there is a scarcity of studies examining these aspects among adolescent girls in this context, highlighting the need for targeted research.

2.2 Prevalence of SRHL

Sexual and reproductive health literacy (SRHL) is critical for enabling adolescents to make informed decisions about their sexual and reproductive health (22). It involves the ability to access, understand, appraise, and apply information related to SRH, including contraception, prevention of sexually transmitted infections (STIs), and healthy sexual behaviors (22,23). Adolescents with higher SRHL are better equipped to adopt safe practices, seek appropriate health services, and avoid risky behaviors.(24,25).

The countries of Bangladesh, Burkina Faso, El Salvador, Ethiopia, Lao PDR, Nepal, Nicaragua, Niger, and Nigeria were selected for a study on adolescent sexual and reproductive health (ASRH) challenges within the context of Universal Health Coverage (UHC). These countries were chosen due to their high ASRH burden (26).

In an Iranian study, 20.5% of participants had limited sexual health literacy (27). Similarly, a study in Nigeria revealed a low sexual and reproductive health (SRH) literacy rate of 22.27% these findings highlight the need for improved SRH education in both countries (28).

Despite progress in adolescent health initiatives, studies reveal significant knowledge gaps. In Ethiopia, only a minority of adolescent girls have comprehensive knowledge of contraception and HIV prevention, and awareness of emergency contraception remains low. While urban adolescents are more informed, rural adolescents continue to face barriers in accessing SRH information (24,25).

The study conducted in the Boke district revealed that 47.4% of the adolescents exhibited limited sexual and reproductive health literacy (SRHL) (29). In Contrast, a separate study conducted in the Oromia region district of Boke revealed that the overall prevalence of adequate reproductive health literacy among adolescents was 18.4%, with a 95% confidence interval (30).

2.3 Social Media in SRH Literacy

Social media has emerged as a primary source of SRH information for adolescents. Globally, adolescents engage with platforms such as Instagram, TikTok, YouTube, WhatsApp, Snapchat, and Telegram for social interaction, learning, and entertainment (22,23). In Ethiopia, urban adolescents are more likely to use social media, with platforms like Facebook, Telegram, WhatsApp, and YouTube being especially popular among young girls for both social and educational purposes (12,13). While social media presents opportunities to improve SRHL, it also carries risks, including exposure to misinformation and unverified content (10,16).

In Ghana, social media has become a significant source of sexual and reproductive health information for adolescents. Due to cultural taboos surrounding discussions of these topics within families, adolescents often find it safer and more convenient to turn to social media platforms for guidance. The lack of access to sexual and reproductive health information in a safe, friendly, and culturally sensitive manner within traditional settings has led to a heavy reliance on social media among adolescents seeking information (31).

A Kenyan study found that social media is increasingly popular among youth, with Google, WhatsApp, YouTube, and Facebook being the most used platforms, while Telegram was the least popular. Social media showed significant potential for accessing SRH information, particularly on family planning. User engagement was highest on WhatsApp, Google, TikTok, and Instagram, highlighting these platforms as key for effective SRH outreach (32).

In Harar, sources like healthcare workers, books, and the internet are significantly associated with SRH knowledge. This finding highlights the importance of incorporating SRH education into the medias can help (17). In Uganda, similar challenges were identified, with limited SRH knowledge and poor access to comprehensive SRH education among adolescents (33).

2.4 Factors affecting SRH Literacy

Socio-demographic factors play a crucial role in shaping adolescents' sexual and reproductive health (SRH) literacy. Variables such as age, gender, education level, and socioeconomic status significantly influence access to and understanding of SRH information.

In Sri Lanka, rural adolescents had significantly higher levels of limited sexual and reproductive health literacy (SRHL) compared to urban adolescents (29). In Tasmania, significant predictors of SRHL among adolescents included female sex, older age, and sexual experience. These factors highlight key areas for targeted interventions to improve SRHL (34).

In Vanuatu, socio-cultural norms and taboos around adolescent sexual behavior were found to be the most significant barriers preventing adolescents from accessing services. These barriers contributed to fear and shame among adolescents, as well as judgmental attitudes from service providers, parents, and community gatekeepers (35).

A Nigerian study identified several barriers to social media use for accessing SRH information. These include high data costs, poor publicity, and network issues. Other factors are concerns about anonymity and societal expectations of young girls (36).

In kenyan study the role of social media barriers to accessing AYSRH identified in the study are individual factors (feelings of shame, lack of information, and fear of being judged parental factors, healthcare worker and health institution factors, teacher/educators factors, and broader contextual factors such as culture, religion, poverty, and illiteracy (37).

In Kenya, barriers to getting sexual and reproductive health services include bad attitudes from health workers, long distances to health facilities, high costs, and cultural beliefs that affect privacy and confidentiality. Other barriers include feeling ashamed, not having enough information, and fears of being judged are linked to the SRH literacy (38).

In meta-analyses done in sub-Saharan Africa, influencing factors included family influence, economic status, power differentials between males and females, sex, age, grade/education level, access to health facilities (39). In Arba Minch, limited SRH literacy was significantly associated with mother's occupation (17).

Recent studies from Southern Ethiopia highlight substantial barriers to adolescent sexual and reproductive health (ASRH) is influenced by geographic location, economic status, and educational attainment, with half of adolescents lacking a comprehensive understanding of sexual and reproductive health and rights (SRHR) (40).

2.5 Conceptual framework

The framework designed using SCT to show how socio-demographic factors like age, education, and family income affect social media use and access to information. These factors influence how adolescents learn about SRH through observational learning and self-efficacy. Social media provides SRH information, and access to technology helps adolescents engage with it. All these factors work together to shape sexual and reproductive health literacy(3).

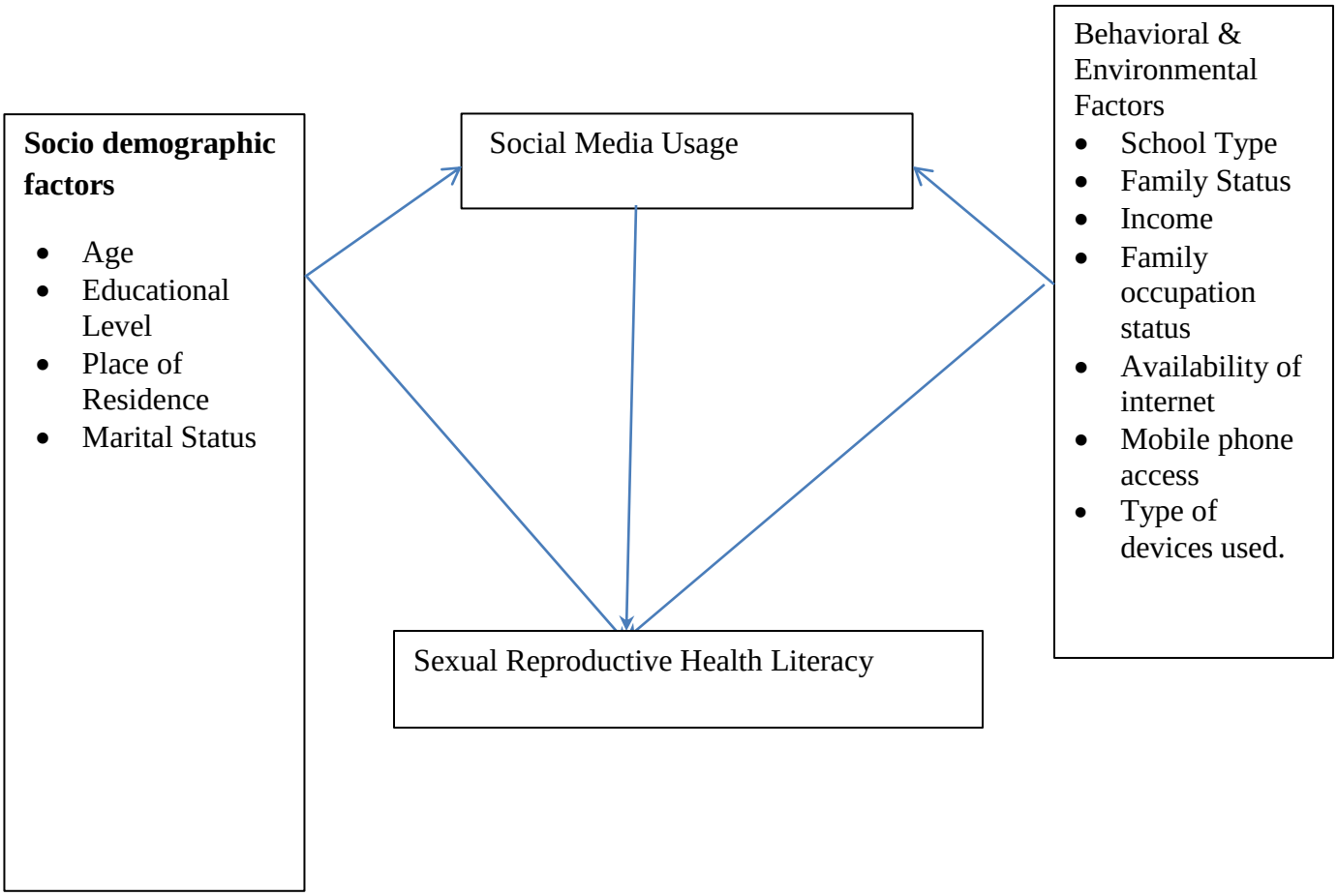

Figure 1: Conceptual framework on the assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools (3)

3. Objectives of the Study

3.1 General objective

- To assess the contribuion of social media use on sexual and reproductive health literacy among school adolescent girls in Addis Ababa.

3.2 Specific objectives

- To assess the level of sexual and reproductive health literacy among in-school adolescent girls in Addis Ababa
- To determine the frequency of social media use among in-school adolescent girls in Addis Ababa.
- To identify factors, including social media use, associated with sexual and reproductive health literacy among in-school adolescent girls in Addis Ababa.

4. Methods

4.1 Study Area and Period

The study was conducted in Addis Ababa, the largest historical and capital city of Ethiopia, which lies at 9°1′48″N latitude and 38°44′24″E longitude with a total area of 540 km². The city had a complex mix of highland climate zones, with average temperature differences of up to 12.2°C, depending on elevation and prevailing wind patterns, and its time zone was categorized as East Africa Time (UTC+3). Based on information from the Addis Ababa City Education Bureau, the city had 158 private schools and 80 government schools. The study focused on private and public secondary schools in Addis Ababa found in three subcities. The study period was from September 2024 to November 2025.

4.2 Study Design

A descriptive facility-based cross-sectional study design was used.

4.3 Population

4.3.1 Source Population

The source population was all adolescent girls who were attending high schools in Addis Ababa city in 2024/2025.

4.3.2 Study Population

The study population consisted of adolescent girls selected through random sampling from the chosen schools.

4.4 Eligibility Criteria

4.4.1 Inclusion Criteria

The study included adolescent girls aged 15–19 years who were enrolled in secondary schools in Addis Ababa, were active on at least one social media platform, and were available during the study period.

4.4.2 Exclusion Criteria

The study excluded girls who had never used social media, those with cognitive or health impairments that would prevent participation, and students withnight shifts. Additionally, adolescents who were unable to provide assent or did not have parental consent were also excluded.

4.5 Sample Size Determination and Sampling Technique

The required sample size for the study was computed by using the single population proportion formula with the following assumption: Prevalence of SRH literacy in Harar (41) P=0.255, level of confidence of 95% =1.96, 0.05% margin of error, design effect=2

$$n = \frac{Z_{\frac{\alpha}{2}}^{2} \quad p\,(1-p)}{d^2}$$

(n) = (1.96^2 *0.255) * (1-0.255)/0.05^2)*2

= (3.8416 * 0.255 * 0.745)/ 0.0025) *2

(n)= 584 with 10% non-response rate

(n) = 643

By adding a 10% non-response rate, the final sample size was 643.

For social media use, a prevalence of 28% among adolescents in India was assumed. The confidence level was set at 95%, and the margin of error (d) was 5%.

$$n = \frac{Z_{\frac{\alpha}{2}}^{2} \quad p\,(1-p)}{d^2}$$

$$n= \frac{(1.96)^2\ 0.28\ (1-0.28)}{0.05^2} =310$$

Considering the design effect, the sample size was multiplied by two (310 × 2 = 620). Adding a 10% non-response rate, the final sample size was 682. Since the largest sample size was taken, the final sample size for this study was 682.

For the third objective, to identify factors, including social media use, associated with sexual and reproductive health literacy among in-school adolescent girls, the sample size was calculated using Epi Info version 7 .Family monthly income was significantly associated with SRH literacy, with approximately 40% of adolescents from higher-income families and 25% from lower-income families having adequate literacy. Using a 95% confidence level and 80% power, the initial sample size was estimated at 298 participants. To account for the clustered nature of school-based sampling, a design effect of 2 was applied, increasing the sample size to 596, and after adjusting for a 10% non-response rate, the final total sample size was 662 adolescent girls.

4.5.1 Sampling Technique

According to the Addis Ababa City Education Bureau, the city has 158 private schools and 80 government schools. This study focused on secondary schools within three sub-cities: Gullele, Nifas Silk, and Akaki Kality, which were selected using a lottery method to ensure fairness and randomness. The study employed a three-stage sampling procedure. In the first stage, three sub-cities (Gullele, Nifas Silk, and Akaki Kality) were randomly selected as primary sampling units. This approach was used because the sub-cities of Addis Ababa are relatively homogeneous in terms of school structure, curriculum, and adolescent characteristics, while being heterogeneous with respect to socio-economic and geographic features. Random selection of sub-cities therefore ensured representativeness of the study population while maintaining feasibility. .

In the second stage, schools within each selected sub-city were stratified into two categories: government and private. This stratification ensured a balanced representation of school types. In the third stage, one school from each category was randomly selected within the selected sub-cities. Specifically, in Nifas Silk sub-city, Fitawrari Lak. Adgh Secondary School (government) and Future Generation School and Abune Gorgorios School (private) were selected. In Gullele sub-city, Delber Secondary School (government) and Sumeya School and E.P.S School (private) were chosen. For Akaki Kality sub-city, Magala Secondary School (government) and Akaki Adventist School and School of Indiana (private) were selected.

Following school selection, the total student population across these schools was 4,064 students**.** The total study sample was 682 students, allocated proportionally to each school using the formula:

$$ni=N/Ni\times n$$

- ni: sample size for the iii-th school.
- Ni: Total number of students in the iii-th school.
- N: Total number of students in all selected schools combined.
- n: Total sample size for the study.

The proportional allocation resulted in Delber Secondary School, E.P.S School, and Sumeya School in Gullele sub-city having 180, 35, and 45 students**,** respectively. In Nifas Silk sub-city**,** Fitawrari Lak. Adgh Secondary School, Future Generation School, and Abune Gorgorios School had 95, 40, and 50 students**,** respectively. Similarly, in Akaki Kality sub-city, Magala Secondary School, the School of Indiana, and Akaki Adventist School were allocated 55, 85, and 97 students, respectively.

The sample sizes for each school in the study were allocated proportionally across grades 9 to 12 to ensure adequate representation. The calculation for the grade-specific sample size was based on the formula:

Grade-specific Sample = (Number of Students in the Grade ÷ Total Number of Students in the School) × Total Sample Size.

The grade-wise sample allocation across the selected schools was carried out to ensure proportional representation of students from grades 9 to 12. In Gullele sub-city**,** Delber Secondary School included 52 students from Grade 9, 44 from Grade 10, 44 from Grade 11, and 40 from Grade 12**,** while E.P.S School included 9 students from Grade 9, 9 from Grade 10, 9 from Grade 11, and 8 from Grade 12**,** and Sumeya School had 13 students from Grade 9, 11 from Grade 10, 10 from Grade 11, and 11 from Grade 12**.** In Nifas Silk sub-city, Fitawrari Lak. Adgh Secondary School comprised 19 students from Grade 9, 18 from Grade 10, 29 from Grade 11, and 29 from Grade 12**,** Future Generation School had 10 students from each grade**,** and Abune Gorgorios School included 13 students from Grade 9, 12 from Grade 10, 12 from Grade

11, and 13 from Grade 12**.** In Akaki Kality sub-city**,** Magala Secondary School included 14 students from Grade 9, 13 from Grade 10, 14 from Grade 11, and 14 from Grade 12**,** the School of Indiana had 24 students from Grade 9, 21 from Grade 10, 20 from Grade 11, and 20 from Grade 12**,** and Akaki Adventist School comprised 25 students from Grade 9, 24 from Grade 10, 24 from Grade 11, and 24 from Grade 12**.**

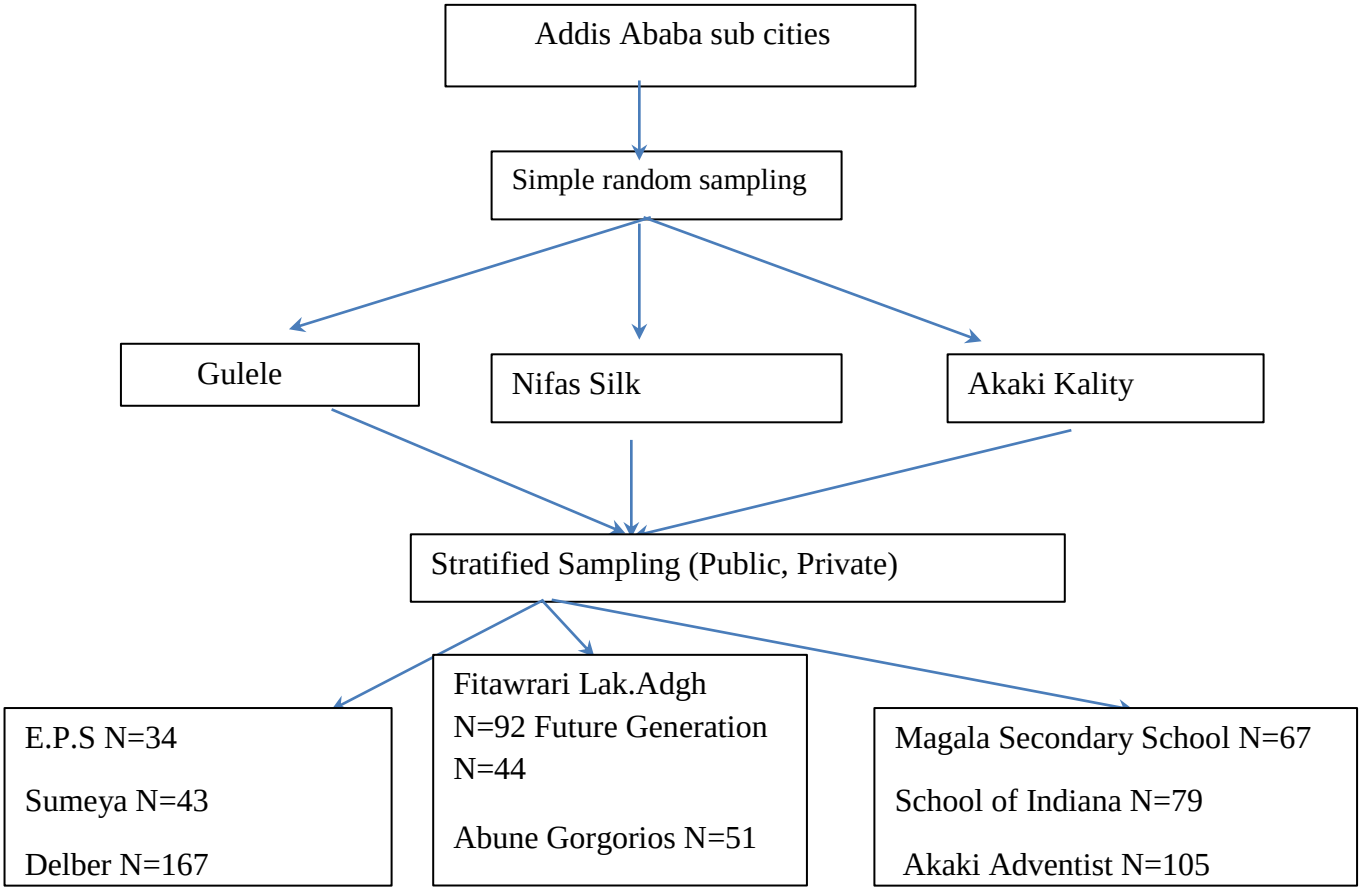

Figure 2: Schematic presentation sample size of assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools

4.6.1 Dependent Variables

- Sexual and Reproductive Health Literacy (Categorical)

4.6.2 Independent Variables

- Social Media Usage
- Age, Educational Level, Place of Residence

- Religion
- Family Educational Level
- School Type, Family Income, Family Occupation Status
- Availability of Internet
- Access to Mobile Phone
- Type of Devices Used

4.7 Operational Definitions

- SRH literacy : Sexual and reproductive health literacy refers to the ability of adolescents to access, understand, appraise, and apply information related to sexual and reproductive health in order to make informed decisions concerning their sexual and reproductive well-being(41)
- **SRH Literacy Levels:** Scores in the range of 0–50 were considered inadequate SRHL, 50.1–66 slightly adequate SRHL, 66.1–84 adequate SRHL, and 84.1–100 excellent SRH. Inadequate and slightly adequate were considered limited SRHL, while adequate and excellent were considered optimum SRHL. Literacy status was then determined by two categories: limited and optimal SRH (41)
- **Social media:** Social media refers to digital online platforms accessed via mobile phones **or** computers that allow adolescents to communicate, interact, and obtain information, including sexual and reproductive health–related content.
- **Standard SMUIS Items:** measures how much adolescents use and rely on social media in their daily lives. Their use is categorized as low, moderate, or high based on how often and how much they use social media for communication, entertainment, and information. Low integration: 10–23, Moderate: 24–36, High: 37–50.(25)

4.8 Data Collection Tools, Methods, and Procedures

- The data collection tool was developed by integrating the European Health Literacy Survey Questionnaire (HLS-EU-Q47).(41) [Citation] and the Social Media Use Integration Scale (SMUIS) .(25) standardized scales. Additionally, a systematic literature review was conducted to identify other relevant variables, including socio-demographic factors, to ensure comprehensive data collection. A structured, interviewer-administered questionnaire

was designed to assess social media use, socio-demographic characteristics, and sexual and reproductive health literacy among adolescent girls.

Four trained nurses collected the data for this study. The nurses conducted data collection during regular school hours in a private and quiet space within the school premises. Data were collected using an interviewer-administered questionnaire, with the nurses clarifying any questions participants had. The process ensured that all data were collected systematically and efficiently.

First, the research team obtained a list of all the selected schools and contacted the school administrators to explain the study's purpose and request permission to conduct the research. On the day of data collection, the team gathered a list of eligible students aged 15–19 from the school administration, ensuring all students in this age group were accounted for.

Next, the data collectors screened the students to confirm they met the inclusion criteria and to ensure there were no exclusion factors such as existing medical conditions. From the eligible students, a random sampling method was used to select participants. Once selected, the students and their guardians (if the students were under 18) were contacted, informed about the study's purpose, and asked to provide consent. Participants received a verbal consent form explaining the study procedures, risks, and benefits, and verbal consent was obtained from both the participants and their parents before data collection began.

4.9 Data Quality Management

Before data collection, the data collectors and supervisor received training led by the principal investigator, covering the objectives of the study and proper procedures for conducting the interviewer-administered questionnaire. The questionnaire was pre-tested during a pilot study to ensure clarity, consistency, and reliability. During data collection, interviewers checked each completed questionnaire on the spot to ensure all responses were complete and accurate, correcting any issues immediately. Participants who did not respond were contacted up to two additional times. To ensure accuracy, the data were double-entered by the principal investigator, and the reliability of the questionnaire was confirmed during the pilot stage.

4.10 Data Processing and Analysis Procedures

After data collection, the data were entered into EpiData version 3.1 for accurate entry and validation, then exported to SPSS version 25 for analysis. Descriptive statistics were computed, with continuous variables summarized using means, medians, and standard deviations and categorical variables using frequencies and percentages. Bar charts and tables were used to illustrate the distribution of sexual and reproductive health literacy (HL) levels, social media use (SMUIS), and other socio-demographic characteristics.

To identify factors associated with HL, binary logistic regression was performed, treating HL as the dependent variable and social media use along with socio-demographic factors such as age, education, and income as independent variables. Variables with $p < 0.25$ in bivariate analysis were included in the multivariable logistic regression model. The Hosmer–Lemeshow goodness-of-fit test was used to assess the fit of the logistic regression model. Multi-collinearity was assessed using the Variance Inflation Factor (VIF). Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were reported, and statistical significance was set at $p < 0.05$.

4.11 Ethical Considerations

Formal ethical approval for this study was obtained from the Institutional Review Board (IRB) of the Addis Ababa University College of Health Sciences. Permission to conduct the research was additionally secured from the Addis Ababa City Education Bureau, the selected schools, the Consortium of Reproductive Health Associations, and the Addis Ababa Regional Health Bureau.

Written informed consent was obtained from the parents or legal guardians of all participants under 18 years of age after a clear explanation of the purpose, procedures, potential benefits, and possible risks of the study. In addition, verbal and written assent was obtained from each adolescent participant, using age-appropriate language to explain the study, its benefits, potential harms, and the voluntary nature of participation.

4.12 Dissemination of Results

As partial fulfillment of a master's degree in Public Health, the results of this study were defended at Addis Ababa University, College of Health Sciences, Department of Public Health. Efforts will also be made to share the findings with relevant stakeholders, including the Addis Ababa City Education Bureau and the selected schools, to inform policy and program decisions. Furthermore, attempts will be done to publish the findings in reputable peer-reviewed journals and present them at national and international conferences to reach a wider audience.

5. Results

5.1 Socio demographic characteristics

Out of 682 planned participants, 648 adolescents completed the study (95% response rate). Over half were aged 15–17 years (71.6%), and most were Orthodox Christians (73.6%). Nearly all were native residents of Addis Ababa (95.2%). Regarding grade level, 33.5% were in Grade 11, and almost all participants were unmarried (98.5%). Concerning school type, 47.7% were from public schools and 52.3% from private schools.

Parental education was moderate to high: 38.6% of fathers and 30.1% of mothers completed secondary education, while 25.6% of fathers and 27.5% of mothers held bachelor's degrees. Fathers mainly worked in the private sector (35.2%) or owned a business (30.6%). Most mothers also owned a business (37.7%). Over half of households (61.9%) earned 0–25,000 ETB monthly. The largest share of students was from Delber School (24.5%) (Table 1).

Table 1: ***Socio demographic characteristics assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools***

Variable		Frequency	Percentage
Age	15-17	464	71.6
	>=18	184	28.4
Religion	Orthodox	477	73.6
	Muslim	89	13.7
	Catholic	28	4.3
	Protestant	54	8.3
Migration status	Rural to Addis Ababa	31	4.8
	Native resident of Addis Ababa	617	95.2
Grade level	Grade 9	199	30.7
	Grade 10	142	21.9
	Grade 11	217	33.5

	Grade 12	90	13.9
Marital status	Married	10	1.5
	Unmarried	138	98.5
School Type	Private	339	52.3
	Public	309	47.7
Paternal educational level	Can't read and write	21	3.2
	Grade 1 - 8	119	18.4
	Grade 9 - 12	250	38.6
	Bachelor degree	166	25.6
	Masters and above	91	14.2
Maternal educational level	Can't read and write	49	7.8
	Grade 1 - 8	148	22.8
	Grade 9 - 12	195	30.1
	Bachelor degree	178	27.5
	Masters and above	78	12
Paternal occupational status	Unemployed	14	2.2
	Own Business	198	30.6
	Government Employee	182	28.1
	Private Sector Employee	228	35.2
	Retired	26	4
Maternal occupational status	Unemployed	110	17
	Own Business	244	37.7
	Government Employee	154	23.8
	Private Sector Employee	22	18.8
	Retired	18	2.8
School	E.P School	31	4.8
	Sumeya School	40	6.2
	Delber School	159	24.5

	Fitawrari Lak.Adgh School	89	13.7
	Future Generation School	41	6.3
	School of Indiana	74	11.4
	Magala Secondary School	64	9.9
	Akaki Adventist	99	15.3
	Abune Gorgorios School	51	7.9
Income	0-25,000 ETB	401	61.9
	25,000-50,000 ETB	109	16.8
	50,000-75,000 ETB	61	9.4
	75000-100,000 ETB	40	6.2
	>100,00 ETB	37	5.7

5.2 Access to Internet and Mobile Phones, and Purpose of Use

Most adolescents had internet access at home (83.6%), and nearly two-thirds used the internet daily (64.8%). Mobile data (48.5%) and home Wi-Fi (46.8%) were the main sources of connection. Mobile phone ownership was also high (82.9%), with more than half using their phones every day. Social media was the primary purpose of phone use (61.7%), followed by general communication. Smartphones were the main device for obtaining SRH information (82.1%).(Table 2)

*Table 2: **Access to internet and mobile phones, and purpose of use on assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools***

Variable		Frequency	Percentage
Access to the internet at home	Yes	542	83.6
	No	106	16.4
How often do you use the internet	Daily	420	64.8
	Several times a week	63	9.7
	Once a week	40	6.2
	Rarely	121	18.7

	Never	4	0.6
primary source of internet access	Mobile data	314	48.5
	Wi-Fi at home	303	46.8
	Public Wi-Fi (e.g., cafes, libraries)	23	3.5
	School/Institution internet	8	1.2
Own a mobile phone	Yes	537	82.9
	No	111	17.1
How often do you use your mobile?	Daily	382	59
	Several times a week	53	8.2
	Once a week	67	10.3
	Rarely	103	15.9
	Never	43	6.6
Mainly use your mobile phone for	Social media	400	61.7
	Browsing the web	5	0.8
	Communication	68	10.5
	All of the three	175	27
Devices used to access SRH-related information	Smart phone	532	82.1
	Tablet	31	4.8
	Laptop	42	6.5
	Either one of them	43	6.6

5. 3. Sexual and reproductive health literacy

The mean sexual and reproductive health literacy (SRHL) score among the participants was 65.97, with scores ranging from 34.4 to 100. SRHL was measured using the standardized HLS-EU-Q47 questionnaire, and each participant's total score was calculated by summing their responses across all items and converting it to a scale of 0–100. Based on this scoring system, SRHL was categorized into four levels: inadequate (0–50), slightly adequate (50.1–66), adequate (66.1–84), and excellent (84.1–100). Among the participants, 71 (10.8%) had inadequate literacy, 266(41.2%) had slightly adequate literacy, 243(37.6%) had adequate literacy, and only 68(10.4%) achieved excellent SRHL (Figure 3).

According to the final SRH measurements, 52% participants had limited SRHL and only 48% had optimal SRHL(Figure 4)

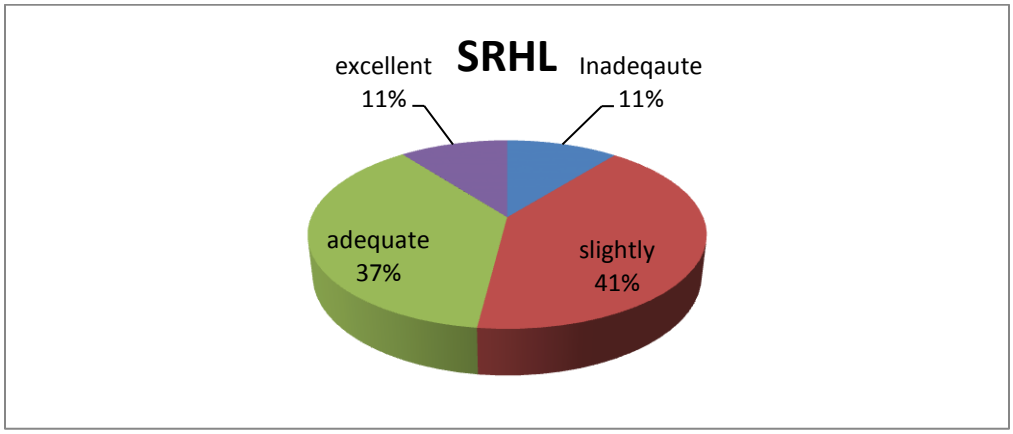

Figure 3: ***Sexual and reproductive health literacy on assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools***

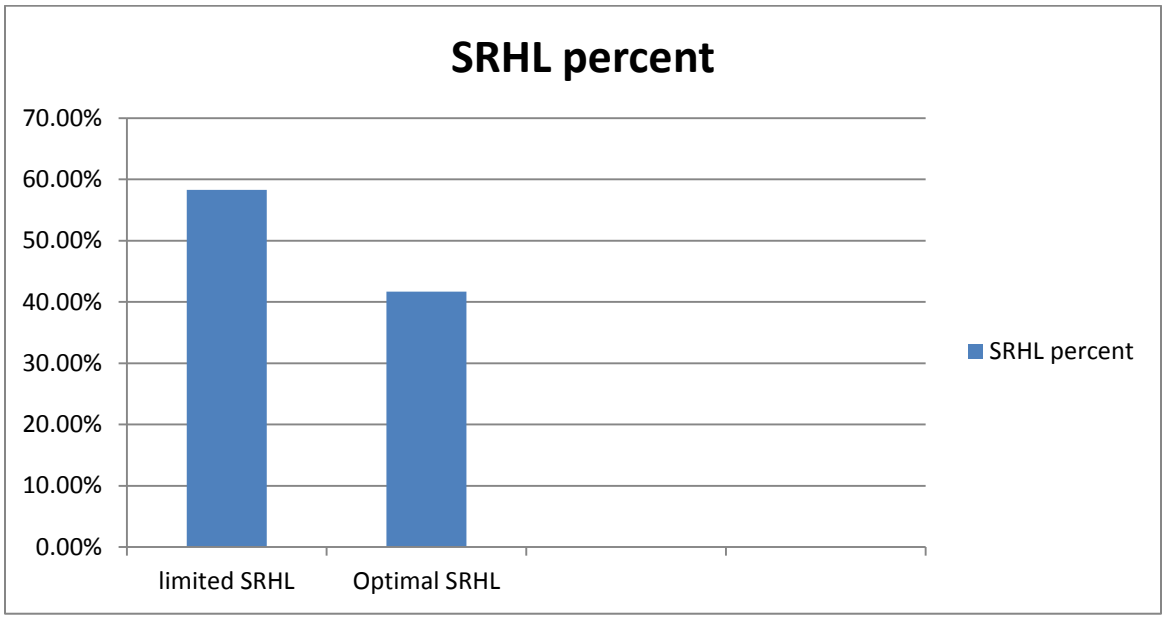

Figure 4: ***Final adjustment Sexual and reproductive health literacy on assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools***

5.4 Social Media Use Integration Scale (SMUIS)

Social media use was measured using the Social Media Use Integration Scale (SMUIS), a standardized tool consisting of 10 items that assess how social media is integrated into daily life, including emotional connection and routine use. Each participant's responses were summed to generate a total score, which was then used to categorize social media integration into five levels**.** these categories were combined into three groups: low, moderate, and high integration. Out of the total participants, 155 (23.6%) were classified as having low integration, 388 (59.9%) had moderate integration, and 107 (16.5%) had high integration of social media use (Figure 5).

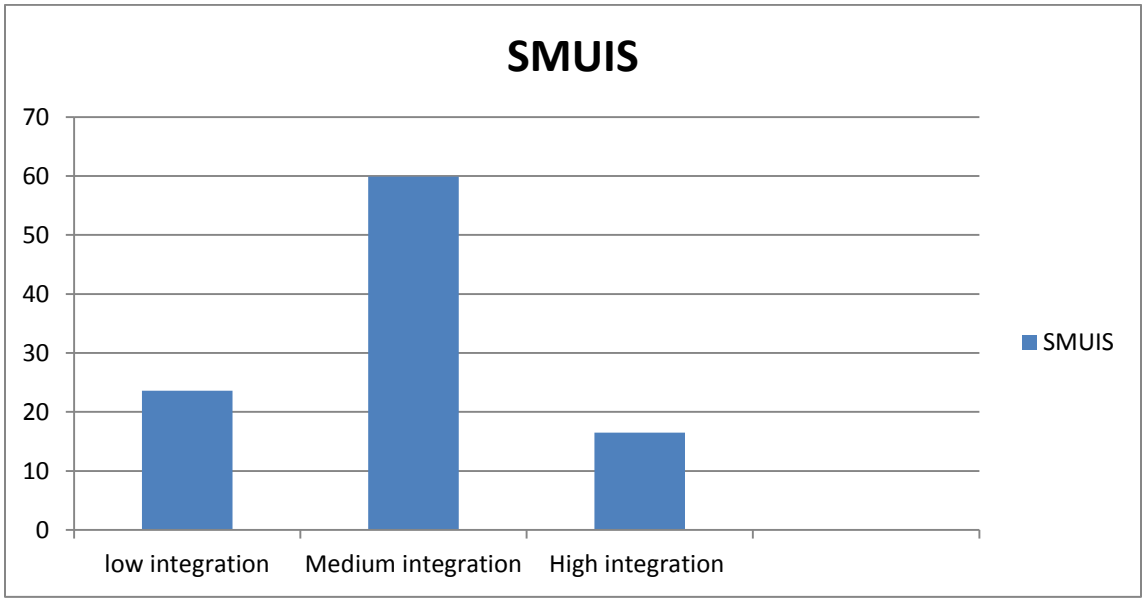

*Figure 5: **Social Media Use Integration Scale on assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools.***

5.5 Factors associated with Sexual and Reproductive Health Literacy

In the bivariable logistic regression analysis, several factors showed a significant association with sexual and reproductive health (SRH) literacy among adolescent girls, including age, migration status, parental occupation, phone use frequency, and social media integration. All variables with p-values less than 0.25 in the bi variable logistic regression analysis were entered into the multivariable logistic regression model. The logistic regression model demonstrated a

good fit, as indicated by the Hosmer-Lemeshow test (p = 0.27), suggesting no evidence of poor fit. Additionally, multi-collinearity among the independent variables was low, with the highest Variance Inflation Factor (VIF = 4.454) (Table 3).

Table 3: ***Multivariable logistic regression** on **assessment of the relationship between sexual and reproductive health literacy and social media use among adolescent girls in Addis Ababa secondary schools***

Variables	Category	Limited	Optimum	COR	AOR	P Value
Age	15-17	209	256	2.686(1.870-3.860)	5.474 (3.011-9.950)	<0.001**
	>=18	126	59	1	1	
Migration status	Rural to Addis Ababa	22	9	0.424(0.192-0.936)	0.341(0.136-0.859)	0.022*
	Native Resident Of Addis Ababa	313	304	1	1	
Class	Grade 9	91	107	3.057(1.783-5.243)	1.127(0.493-2.579)	0.777
	Grade 10	75	67	2.323(1.318-4.094)	0.434(0.180-1.048)	0.063
	Grade 11	104	112	2.800(1.643-4.771)	1.925(0.999-3.708)	0.05*
	Grade 12	65	27	1	1	
School Type	Private	185	154	0.684(0.461-1.017)	0.716(0.432-1.187)	0.798
	Public	153	158	1	1	
Paternal occupational status	Unemployed	7	7	3.33(0.831- 13.372)	1.858(0.342-10.092)	0.473
	Own Business	113	85	2.507(0.965-6.514)	1.262(0.405-3.930)	0.688
	Government Employee	96	85	2.951(1.132-7.692)	1.931(0.649-5.746)	0.237
	Private Sector Employee	99	128	4.310(1.668-11.13)	4.493(1.544-13.072)	0.006**
	Retired	20	8	1	1	
Maternal occupational status	Unemployed	72	37	1.336(0.443-4.034)	2.686(0.631-11.432)	0.181
	Own Business	118	126	2.776(0.960-8.026)	5.805(1.487-22.664)	0.011**
	Government Employee	54	99	4.767(1.613-14.084)	8.849(2.230-35.109)	0.002**

	Private Sector Employee	78	44	1.467(0.490-4.387)	1.889(0.467-7.645)	0.372
	Retired	13	5	1	1	
Do you have a phone	Yes	271	264	1.327(0.878-2.005)	1.603(0.829-3.100)	0.161
	No	64	47	1	1	
How often do you use your mobile ?	Never	23	6	1.284(0.683-2.416)	1.153(0.438-3.036)	0.772
	Rarely	51	52	0.591(0.259-1.351)	0.715(0.258-1.984)	0.041**
	Once a week	46	20	0.500(0.225-1.109)	0.234(0.080-0.686)	0.008*
	Several times a week	35	18	1.173(0.575-2.392)	0.316(0.104-0.954)	0.520
	Daily	180	201	1	1	
SMUIS	Low integration	64	88	0.902(0.544-1.495)	0.701(0.359-1.370)	0.299
	Medium integration	229	159	0.456(0.294-0.707)	0.341(0.197-0.590)	0.000**
	High integration	42	64	1	1	

In the multivariable logistic regression analysis, several factors remained significantly associated with optimum SRH literacy among adolescent girls. Adolescents aged 15–17 years had significantly higher odds of having optimum SRH literacy compared to those aged 18 years and above (AOR = 5.47; 95% CI: 3.01–9.95; $p < 0.001$). Migration status also showed a significant association: girls who migrated from rural areas to Addis Ababa had 66% lower odds of optimum SRH literacy compared to native residents (AOR = 0.34; 95% CI: 0.14–0.86; $p = 0.022$).Regarding grade level, being in Grade 11 was marginally significant, with students showing nearly twice the odds of optimum SRH literacy compared to Grade 12 (AOR = 1.93; 95% CI: 1.00–3.71; $p = 0.050$).

Parental occupation also demonstrated strong associations. Adolescents whose fathers worked in the private sector were about 4.5 times more likely to have optimum SRH literacy compared to those whose fathers were retired (AOR = 4.49; 95% CI: 1.54–13.07; $p = 0.006$).Similarly, mother's occupation played a significant role: girls whose mothers owned a business had higher odds of optimum SRH literacy (AOR = 5.81; 95% CI: 1.51–22.36; $p = 0.011$), and those whose

mothers were government employees also showed significantly increased odds (AOR = 8.85; 95% CI: 2.28–34.22; p = 0.002), compared to adolescents whose mothers were retired.

Mobile phone usage frequency was also significant. Compared to daily users, adolescents who used their mobile phone rarely had 28.5% lower odds of optimum SRH literacy (AOR = 0.715; 95% CI: 0.258–1.984; p = 0.041), and those who used their phone once per week had 76.6% lower odds (AOR = 0.234; 95% CI: 0.080–0.686; p = 0.008).

Finally, social media integration (SMUIS) was a strong predictor. Adolescents with medium social media integration had 66% lower odds of optimum SRH literacy compared to those with high integration (AOR = 0.34; 95% CI: 0.20–0.59; p < 0.001).

Overall, the analysis indicates that being aged 15–17 years, having parents employed in the private sector, owning a business, or working in government**,** and high social media integration were positively associated with optimum SRH literacy among adolescent girls. Conversely, migration from rural areas to Addis Ababa and infrequent mobile phone use (rarely or once per week) were associated with reduced odds of having optimum SRH literacy.

6. Discussion

This study assessed sexual and reproductive health literacy (SRHL) and social media integration among adolescent girls in Addis Ababa secondary schools. The findings revealed that 52% of participants had limited SRHL, whereas 48% exhibited optimum SRHL. This aligns with previous research in Ethiopia, which has consistently reported low SRHL among adolescents. For instance, a study in the Boke district found that 47.4% of adolescents had limited SRHL, while another study in Oromia reported that only 18.4% had adequate SRHL (29,30). These findings indicate persistent gaps in adolescent SRH knowledge, even in urban contexts where access to information is generally higher. The limited SRHL observed highlights the need for targeted interventions aimed at enhancing adolescents' ability to access, understand, evaluate, and apply SRH information effectively (22–25).

Social media has emerged as a significant platform for SRH information among adolescents. In the current study, 16.5% of participants reported high social media use, 59.9% moderate use, and 23.6% low integration. These patterns are consistent with findings from Ethiopia and other African countries, where urban adolescents, especially girls, frequently use Facebook, WhatsApp, Telegram, and YouTube for both social and educational purposes (12,13). Globally, platforms such as Instagram, TikTok, and Snapchat are popular among adolescents seeking health-related information (22,23). The high prevalence of moderate to high social media use suggests that digital platforms are accessible and potentially effective mediums for delivering SRH information, although the risks of misinformation necessitate careful monitoring of content quality (10,16).

Multivariable analysis revealed a strong positive association between high social media integration and optimum SRHL. Adolescents with medium social media use had 66% lower odds of achieving optimum SRHL compared to those with high use (AOR = 0.34; 95% CI: 0.20–0.59; $p < 0.001$). This finding supports the potential role of social media in improving SRH literacy, consistent with the Social Cognitive Theory, which emphasizes learning through observation and social interactions (22,23). Similar studies in Ghana and Kenya highlight social media as a crucial source of SRH information, particularly in contexts where cultural taboos limit traditional communication channels (31,32). These results suggest that appropriately

tailored social media interventions could promote positive health behaviors and SRH knowledge among adolescent girls.

Overall, the results highlight that while urban adolescents have better access to SRH information; gaps in literacy persist and are influenced by social, demographic, and digital factors. The study reinforces the potential of social media as a complementary tool for SRH education and calls for targeted interventions that consider age, parental occupation, mobile phone access, and social media engagement to enhance adolescent SRHL.

7. Strength and Limitations

7.1 Strength

- The study assessed both social media use and SRH literacy, giving useful information on their relationship.
- Data were collected directly ensuring relevant and real-time information.
- The study used standardized tools to measure social media integration and sexual and reproductive health literacy, allowing for consistent and reliable data collection.

7.2 Limitations

- The study only included schools in Addis Ababa, so findings may not reflect adolescents in rural areas.
- This study relied on self-reported data from adolescents, which may be subject to recall bias.

8. Conclusion

This study found that 52% of adolescent girls in Addis Ababa had limited sexual and reproductive health literacy, showing knowledge gaps even in urban settings.Social media integration and frequent mobile phone use were strongly associated with optimum SRHL, showing the potential of digital platforms as accessible and effective channels for delivering accurate, culturally appropriate sexual and reproductive health information.

These findings show that using social media and mobile technologies and family support and school-based programs, could effectively increase SRHL also adolescent girls make informed sexual and reproductive health decisions. Other factors influencing SRHL included age, grade level, and parental occupation, which were associated with higher literacy, whereas rural to urban migration, medium or low social media use, and infrequent mobile phone access were linked to lower literacy.

9. Recommendations

For Schools:

- They should combine social media based sexual and reproductive health (SRH) education into the curriculum to reach students where they are.
- They should consult and give guidance on responsible use of social media to access reliable and truthful SRH information.

For Health Organizations and Providers:

- They should give age appropriate SRH content on mostly social media platforms used by adolescents.
- They should help them have online campaigns, virtual workshops, or social media challenges to engage adolescents with social media integration and improve their SRHL.

For Parents:

- They should help adolescents to use social media responsibly for learning about SRH.
- They should help them figure out adolescents toward trustworthy digital sources, helping them distinguish accurate SRH information

For Policymakers:

- They should help programs that increase digital access and connectivity for adolescents.
- They should increase initiatives that strengthen digital literacy in schools, enabling them to improve SRHL.

For Adolescents:

- They should actively use social media to seek accurate SRH information.
- They should engage with high quality digital content to increase SRHL and make informed decisions about sexual and reproductive health.

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Annexes

Annex 1: Information sheet and Assent (English version)

Hello, my name is ———————————————— I am here on behalf of Afomiya Zewdu, a student college of health science of Addis Ababa department of reproductive health and family and population health. She is conducting research on "the assessment of the relation between social media and sexual and reproductive health literacy among adolescent girls in Addis Ababa secondary schools"

If you agree to participate in the study, you can stop at any time if you don't feel comfortable during an interview and measurement process. Filling the questionnaire will take about 30 minutes.

The study could provide baseline data for policy makers and relevant stakeholders for designing and implementing effective control programs and strategies. It could also give insight on the role of social media use in sexual and reproductive health literacy among adolescent girls and what major factors could be associated. The information that you provide will be kept confidential by using only code numbers and locking the data. Your name will not be written on the questionnaire. No one will have access to the non-coded data except the principal investigator and the data will not be used for purposes other than the study. Your willingness and active participation is very important for the success of this study. For further explanation use the Principal Investigator's Address; Name: Afomiya Zewdu

Email: fomizabate@gmail.com Cell phone: 0912726903

Based on the information, are you willing to participate in this study? A) Yes B) No

If yes, I will continue and If no, I will skip to next participant after writing the reasons of refusal:

Interviewee Name_____ Signature_____

Questionnaires ID number_____

Date of interview_____ Starting time_____ Completed_____

Result of interview A) Completed B) Not completed C) Partially completed D) Refused

Annex II: English Version Questionnaire

Section 1: Socio demographic characteristics

Question	Response
Age	_____
Religion	1. Orthodox 2. Muslim 3. Catholic 4. Protestant 5. Others
Migration status	1. Rural to Addis Ababa 2. Native resident of Addis Ababa
Grade level	1. Grade 9 2.Grade 10 3.Grade 11 4. Grade 12
Marital status	1.Married 2.Unmarried
School Type	1.Private 2.Public
Father educational level	1. Can't read and write 2. Grade 1 - 8 3. Grade 9 - 12 4. Bachelor degree 5. Masters 6. Professor

Mother educational level	1. Can't read and write 2. Grade 1 - 8 3. Grade 9 - 12 4. Bachelor degree 5. Masters 6. Professor
Fathers occupational status	1. Unemployed 2.Own Business 3.Goverment Employee 4.Private Sector Employee 5.Retired 6.Other Please Specify _____
Mothers occupational status	1. Unemployed 2.Own Business 3.Goverment Employee 4.Private Sector Employee 5.Retired 6.Other Please Specify_____
Type of school	1. E.P School 2. Sumeya School 3. Delber School 4. Fitawrari Lak. Adgh School 5. Future Generation School 6. School of Indiana 7. Magala Secondary School 8. Akaki Adventist 9. Abune Gorgorios School

Family income	_____

Access To information

Question	Response
Do you have access to the internet at home	1.Yes 2.No
How often do you use the internet	1. Daily 2.Several times a week 3.Once a week 4.Rarely 5. Never
What is your primary source of internet access	1.Mobile data 2.Wi-Fi at home 3.Public Wi-Fi (e.g., cafes, libraries) 4.School/Institution internet 5.Other (please specify): _____
Do you own a mobile phone	1.Yes 2.No
If yes, how often do you use your mobile phone for accessing the internet?	1. Daily 2.Several times a week 3.Once a week 4.Rarely 5. Never
What do you mainly use your mobile phone for? (Select all that apply)	1.Social media 2.Browsing the web 3.Communication (calls, texts) 4.Other (please specify): _____

Which of the following devices do you have access to SRH-related information? (Select all that apply)	1.Smart phone 2. Tablet 3.Laptop 4.Other (please specify): _____

Section II: sexual and reproductive health literacy

Questions	Very difficult	Difficult	Don't know	Easy	Very easy
Find information about symptoms of sexual and reproductive health issues that concern you as an adolescent, such as irregular periods, sexually transmitted infections (STIs), or concerns about puberty and sexual development?					
Find information about treatments for sexual and reproductive health issues that concern you, such as irregular periods, STIs, or contraception options?					
Find out what to do in case of a sexual and reproductive health emergency, such as a sexually transmitted infection (STI), unexpected pregnancy, or menstrual health issues?					
Find out where to get professional help for sexual and reproductive health issues when you're feeling unwell, such as for STIs, menstrual irregularities, unexpected pregnancy or sexual health concerns?					
Understand what your doctor says about sexual and reproductive health issues, such as contraceptive methods, STI prevention, or menstrual health?					
Understand the information in the leaflets that come with medications related to sexual and reproductive health, such as contraceptives or treatments for STIs?					
Understand what to do in a sexual and reproductive health emergency, such as in the case of an STI, pregnancy-related issue, or severe menstrual pain?					

Understand your doctor's or pharmacist's instructions on how to take prescribed medications for sexual and reproductive health issues, such as contraceptives, antibiotics for STIs, or menstrual-related medications?					
Judge how the information your doctor provides about sexual and reproductive health applies to your personal situation, such as advice on contraception, STI prevention, or menstrual health?					
Judge the advantages and disadvantages of different treatment options for sexual and reproductive health issues, such as treatments for STIs, menstrual disorders, or other reproductive health conditions?					

Questions	Very difficult	Difficult	Don't know	Easy	Very easy
Judge when you may need to get a second opinion from another doctor regarding your sexual and reproductive health, such as concerns about contraception, STIs, or menstrual health issues?					
Judge if the information about sexual and reproductive health issues in the media, such as contraception, STIs, or menstrual health, is reliable?					
Use the information your doctor gives you to make decisions about your sexual and reproductive health, such as choosing contraception, managing menstrual health, or addressing sexual health concerns?					
Follow the instructions on medication related to your sexual and reproductive health, such as contraception, treatments for STIs, or menstrual health medications?					
Call an ambulance in a sexual and reproductive health emergency, such as severe menstrual pain, complications during pregnancy, or an STI-related					

emergency?					
Follow the instructions from your doctor or pharmacist regarding sexual and reproductive health, such as taking contraceptives, following STI treatment, or managing menstrual health					
Find information on managing unhealthy behaviors related to sexual and reproductive health, such as unsafe sexual practices, irregular menstrual cycles, or unhealthy relationships?					
Find information on managing sexual and reproductive health issues, such as irregular menstrual cycles, contraceptive use, or sexually transmitted infections (STIs)?					
Find information about HPV vaccinations or sexual health screenings, such as STI or cervical cancer tests, which you should have?					
Find information on how to prevent or manage sexual and reproductive health conditions, such as sexually transmitted infections, unwanted pregnancy or menstrual health issues?					

Questions	Very difficult	Difficult	Don't know	Easy	Very easy
Understand health warnings about behaviors such as unsafe sex, lack of contraception use, or multiple sexual partners?					
Understand why you need vaccinations, such as the HPV vaccine, for sexual and reproductive health?					
Understand why you need health screenings, such as STI tests or cervical cancer screenings,					

for sexual and reproductive health?					
Find health warnings related to sexual and reproductive health, such as information about contraception, pregnancy, sexually transmitted infections (STIs), or menstrual health?					
Judge when you need to see a doctor for a sexual and reproductive health check-up?					
Judge which sexual and reproductive health-related vaccinations you may need, such as the HPV vaccine or other relevant immunizations?					
Judge which sexual and reproductive health screenings you should have, such as screenings for STIs, cervical cancer, or breast health?					
Judge if the information on sexual and reproductive health risks in social media is reliable?					
Decide if you should receive a sexual and reproductive health-related vaccination, such as the HPV vaccine or other immunizations relevant to SRH?					
Decide how to protect yourself from sexual and reproductive health risks based on advice from family and friends?					

Questions	Very difficult	Difficult	Don't know	Easy	Very easy
Decide how to protect yourself from sexual and reproductive health risks based on information in the social media?					
Find information on healthy sexual and reproductive health practices, such as					

contraception, STI prevention, or menstrual health?					
Find information about activities that are good for your sexual and reproductive health well-being, such as practices for healthy relationships, sexual health care, or menstrual health?					
Find information on how your neighborhood could be more sexually and reproductive health-friendly, such as access to healthcare services, sexual education, or safe spaces for young people?					
Find out about political changes that may affect sexual and reproductive health, such as changes in laws related to contraception, early pregnancy, abortion, or sexual health education?					
Find out about efforts to promote sexual and reproductive health in your school, such as access to sexual health education, contraception, or menstrual health?					
Understand advice on sexual and reproductive health from family members or friends, such as guidance on contraception, menstruation, or healthy relationships?					
Understand information on food packaging related to sexual and reproductive health, such as nutrients that support menstrual health or overall reproductive well-being?					
Understand information in the media on how to improve your sexual and reproductive health, such as advice on contraception, STI prevention, or menstrual health?					
Understand information on how to keep your sexual and reproductive health in good					

condition, such as guidance on menstrual health, sexual well-being, or reproductive care?					
Judge where your lifestyle affects your sexual and reproductive health and well-being, such as factors like sexual behavior, contraception use, or menstrual health?					
Judge how your housing conditions contribute to your sexual and reproductive health, such as access to privacy, hygiene facilities, or a safe environment for sexual health practices and well-being?					
Judge which everyday behaviors are related to your sexual and reproductive health, such as practices around contraception use, menstrual hygiene, sexual activity, or maintaining overall reproductive well-being?					
Make decisions to improve your sexual and reproductive health, such as choosing contraceptive methods, managing menstrual health, or seeking sexual health care when needed?					
join a gender club or a club focused on sexual and reproductive health if you want to					
Influence your living conditions in ways that affect your sexual and reproductive health and well-being, such as ensuring privacy, access to hygiene facilities, and a safe environment for sexual health practices?					
Take part in activities at school that aim to improve sexual and reproductive health and well-being, such as SRH education programs, awareness campaigns, or peer support groups?					

Section III: Social Media Use Integration Scale (SMUIS) for SRH Literacy

Questions	Stron	Disa	Neu	agr	Stron

	gly Disagree	gree	tral	ee	gly agree
I feel disconnected from friends when I have not logged into social media to discuss sexual and reproductive health topics.					
Social media plays an important role in my understanding of sexual and reproductive health.					
Using social media helps me feel emotionally connected to others when discussing sexual and reproductive health.					
I enjoy connecting with people on social media to talk about sexual and reproductive health issues.					
Social media allows me to stay informed about sexual and reproductive health topics that are important to me.					
I feel that social media helps me stay connected to people who share information on sexual and reproductive health.					
Using social media to learn about sexual and reproductive health is a part of my everyday routine.					
I often check social media for updates on sexual and reproductive health topics without thinking about it.					
I use social media regularly throughout the day to learn about sexual and reproductive health.					
It feels strange to not check social media for sexual and reproductive health information for an extended period of time.					

Annex III: Amharic information sheet

ጤና ይስጥልኝ ስሜ_____ በአዲስ አበባ የስነ ተዋልዶ ጤና እና ቤተሰብ እና ህዝብ ጤና ክፍል ጤና ሳይንስ ኮሌጅ ተማሪ የሆነችውን አፎሚያ ዘውዱን ወክዬ መጥቻለሁ። "በአዲስ አበባ 2ኛ ደረጃ ት/ቤት በጉርምስና ዕድሜ ላይ የሚገኙ ልጃገረዶች በጾታዊ እና ስነ ተዋልዶ ጤና እውቀት ላይ የማህበራዊ ሚዲያ አጠቃቀም ሚና" በሚል ርዕስ ጥናት እያካሄደች ነው::

በጥናቱ ላይ ለመሳተፍ ከተስማሙ በቃለ መጠይቅ እና በመለኪያ ሂደት ውስጥ ምቾት የማይሰማዎት ከሆነ በማንኛውም ጊዜ ማቆም ይችላሉ። መጠይቁን መሙላት 30 ደቂቃ ያህል ይወስዳል። ጥናቱ ውጤታማ የቁጥጥር ፕሮግራሞችን እና ስትራቴጂዎችን ለመንደፍ እና ለመተግበር ለፖሊሲ አውጪዎች እና ለሚመለከታቸው ባለድርሻ አካላት የመነሻ መረጃን ሊያቀርብ ይችላል። እንዲሁም በጉርምስና ዕድሜ ላይ ባሉ ልጃገረዶች ላይ የማህበራዊ ሚዲያ አጠቃቀም በወሲባዊ እና በሥነ ተዋልዶ ጤና እውቀት ላይ ያለውን ሚና እና ዋና ዋና ጉዳዮችን በተመለከተ ግንዛቤን ሊሰጥ ይችላል። ያቀረቡት መረጃ ኮድ ቁጥሮችን ብቻ በመጠቀም እና ውሂቡን በመቆለፍ በሚስጥር ይጠበቃል። ስም በመጠይቁ ላይ አይጻፍም። ከዋናው ተመራማሪ በስተቀር ማንም ሰው ኮድ ያልሆነውን መረጃ ማግኘት አይችልም እና ውሂቡ ከጥናቱ ውጭ ለሌላ ዓላማዎች ጥቅም ላይ አይውልም።

ለዚህ ጥናት ስኬት የእርስዎ ፍላጎት እና ንቁ ተሳትፎ በጣም አስፈላጊ ነው። ለበለጠ ማብራሪያ የዋናውን ተመራማሪ አድራሻ ይጠቀሙ;

ስም፡ አፎሚያ ዘውዱ ኢሜል፡ fomizabate@gmail.com

ስልክ፡ 0912726903

በመረጃው መሰረት፣

በዚህ ጥናት ለመሳተፍ ፈቃደኛ ኖት? ሀ) አዎ ለ) አይደለም አዎ ከሆነ፣ እቀጥላለሁ እና አይደለም ከሆነ፣ የእንቢታ ምክንያቶችን ከጻፍኩ በኋላ ወደ ቀጣዩ ተሳታፊ እዘልላለሁ፡-

ስም _____

ፊርማ_____

መጠይቆች መታወቂያ ቁጥር _____

የቃለ መጠይቁ ቀን _____

የመነሻ ሰዓቱ _____ ተጠናቀቀ_____ የቃለ መጠይቁ ውጤት ሀ) የተጠናቀቀ ለ) ያልተጠናቀቀ ሐ) በከፊል የተጠናቀቀ መ) እምቢተኝነት

Annex IV: Amahric version questionnaire

ክፍል1፡ የስነ ሕዝብ አወቃቀር ባህሪያት የጥያቄ ምላሽ

ጥያቄ	ምላሽ
ዕድሜ	_____
እምነት	1ኦርቶዶክስ 2.ሙስሊም 3.ካቶሊክ 4.ፕሮቴስታንት 5.ሌላ
የመኖሪያ ቦታ	1. ገጠር 2. አዲስ አበባ
የት / ቤት ዓይነት	1. የግል 2. መንግስት
ክፍል	1. 9ኛ ክፍል 2. 10ኛ ክፍል 3 .11ኛ ክፍል 4. 12ኛ ክፍል
የጋብቻ ሁኔታ	1. ያገባ 2. ያላገባ
ትምህርት ቤት	ነ.ኢትዮ ፓረንትስ ት/ቤት 2.ሱመያ ት/ቤት 3.ድልበር ት/ቤት 4.ፊታውራሪ ላቀ ኣንዳር ት 5.ፊውቸር ጀነሽን ት/ቤት 6.ስኩል ኦፍ ኢንዲያና

	7.መጋላ ሁለተኛ ት/ቤት 8.ኣቃቂ ኣድንቲስት ት/ቤት 9.ኣቡነ ጎርጎርዮስ ት/ቤት
የኣባት የትምህርት ደረጃ	1 .ማንበብ እና መጻፍ የማይችል 2.1-8 ኛ ክፍል 3.9-12 ኛ ክፍል 4.የ መጀመሪያ ዲግሪ 5.ማስተርስ 6ፕሮፌሰር
የእናትየትምህርት ደረጃ	1 .ማንበብ እና መጻፍ የማይችል 2.1-8 ኛ ክፍል 3.9-12 ኛ ክፍል 4.የ መጀመሪያ ዲግሪ 5.ማስተርስ 6ፕሮፌሰር
የኣባት የሥራ ደረጃ	1. ሥራ አጥነት 2.የራስ ንግድ 3.የመንግስት ሰራተኛ 4.የግል ዘርፍ ሰራተኛ 5. ጡረታ ወጥቷል 6. ሌላ እባክዎን _____ ይግለጹ
የእናት የሥራ ደረጃ	1. ሥራ አጥነት 2.የራስ ንግድ 3.የመንግስት ሰራተኛ

	4.የግል ዘርፍ ሰራተኛ 5. ጡረታ ወጥቷል 6. ሌላ እባክዎን _____ ይግለጹ
የቤተሰብ ገቢ	_____

ቤት ውስጥ የበይነመረብ መዳረሻ አለ?	1. አዎ 2.አይ
በየስንት ጊዜ ኢንተርኔት ትጠቀማለህ	1. በየቀኑ 2.በሳምንት ብዙ ጊዜ 3. በሳምንት አንድ ጊዜ 4. አልፎ አልፎ 5. በጭራሽ
የበይነመረብ መዳረሻዎ ዋና ምንጭ ምንድን ነው?	1.የተንቀሳቃሽ ስልክ ውሂብ 2.በቤት ውስጥ ዋይ-ፋይ 3.ይፋዊ ዋይ ፋይ (ለምሳሌ፡ ካፌዎች፣ ቤተ መጻሕፍት) 4.ትምህርት ቤት/ተቋም ኢንተርኔት 5. ሌላ (እባክዎ ይግለጹ): _____
የሞባይል ስልክ ባለቤት ነዎት?	1. አዎ 2.አይ
አዎ ከሆነ፣ ኢንተርኔት ለማግኘት የሞባይል ስልክዎን ምን ያህል ጊዜ ይጠቀማሉ?	1. በየቀኑ 2.በሳምንት ብዙ ጊዜ 3. በሳምንት አንድ ጊዜ 4. አልፎ አልፎ 5. በጭራሽ

በዋናነት የሞባይል ስልካቸሁን ለምን ትጠቀማላችሁ? (የሚመለከተውን ሁሉ ይምረጡ)	1. ማህበራዊ ሚዲያ 2. ድሩን ማሰስ 3. ግንኙነት (ጥሪዎች፣ ጽሑፎች) 4.ሌላ (እባክዎ ይግለጹ):_____
ከኤስአርኤች ጋር የተገናኘ መረጃን ለማግኘት የተጠቀሙት ከሚከተሉት መሳሪያዎች ውስጥ የትኛው ነው? (የሚመለከተውን ሁሉ ይምረጡ)	1. ስማርት ስልክ 2. ታብሌት 3. ላፕቶፕ 4.ሌላ (እባክዎ ይግለጹ): _____

ክፍል II: የ እና የስነጾታዊ ተዋልዶ ጤና እውቀት

ጥያቄዎች	በጣም ከባድ	አስቸጋሪ	አላው ቅም	ቀላል	በጣም ቀላል
በጉርምስና ወቅት እርስዎን የሚያሳስቡ የጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ምልክቶችን መረጃ , እንደ መደበኛ ያልሆነ የወር አበባ፣ በግብረ ሥጋ ግንኙነት የሚተላለፉ ኢንፌክሽኖች ፣ ወይም ስለ ጉርምስና እና ስለ ወሲባዊ እድገት ያሉ ስጋቶችመረጃ ያገኛሉ?					
እንደ መደበኛ ያልሆነ የወር አበባ፣ የአባላዘር በሽታዎች፣ ወይም የእርግዝና መከላከያ አማራጮች ያሉ እርስዎን የሚያሳስቡ ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ህክምናዎች መረጃ ያገኛሉ?					
በግብረ ሥጋ ግንኙነት የሚተላለፉ ኢንፌክሽኖች ፣ ያልተጠበቀ እርግዝና ወይም የወር አበባ ጤና ጉዳዮች ያሉ የጾታዊ እና የስነ ተዋልዶ ጤና ድንገተኛ ሁኔታ ሲያጋጥም ምን ማድረግ እንዳለቦት መረጃ ያገኛሉ?					
እንደ የአባላዘር በሽታዎች፣ የወር አበባ መዛባት፣ ያልተጠበቀ እርግዝና ወይም የጾታዊ ጤና ስጋቶች ሲያጋጥምዎ ለጾታዊ እና ስነ ተዋልዶ ጤና ጉዳዮች የባለሙያ እርዳታ የት እንደሚያገኙ ያገኛሉ ?					
እንደ የወሊድ መከላከያ ዘዴዎች፣ የአባላዘር በሽታዎች መከላከል ወይም የወር አበባ ጤንነትን የመሳሰሉ ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ዶክተርዎ ምን እንደሚል ይረዳሉ?					
ከጾታዊ እና ከሥነ ተዋልዶ ጤና ጋር በተያያዙ መድኃኒቶች፣ እንደ የወሊድ መከላከያ ወይም የአባላዘር በሽታዎች ሕክምናዎች ጋር አብረው የሚመጡትን በራሪ ወረቀቶች ውስጥ ያሉትን መረጃዎች ይረዳሉ?					

በጾታዊ እና በስነ-ተዋልዶ ጤና ድንገተኛ ሁኔታ ምን ማድረግ እንዳለቦት፣ ለምሳሌ እንደ የአባላዘር በሽታዎች ፣ ከእርግዝና ጋር የተያያዘ ጉዳይ ወይም ከባድ የወር አበባ ህመም ሲያጋጥም ምን ማድረግ እንዳለቦትይረዳሉ?					
እንደ የወሊድ መከላከያ፣ የአባላዘር በሽታ አንቲባዮቲክስ ወይም ከወር አበባ ጋር የተያያዙ መድኃኒቶችን ለጾታዊ እና ተዋልዶ ጤና ጉዳዮች የታዘዙ መድሃኒቶችን እንዴት እንደሚወስዱ የዶክተርዎን ወይም የፋርማሲስት መመሪያዎችን ይረዳሉ?					
እንደ የወሊድ መከላከያ፣ የአባላዘር በሽታ መከላከያ ወይም የወር አበባ ጤንነትን የመሳሰሉ ምክሮችን በተመለከተ ዶክተርዎ ስለ ጾታዊ እና ስነ ተዋልዶ ጤና የሚሰጡት መረጃ በግል ሁኔታዎ ላይ እንዴት እንደሚተገበር ይገመግማሉ?					
እንደ የአባላዘር በሽታዎች፣ የወር አበባ መታወክ ወይም ሌሎች የስነ ተዋልዶ ጤና ሁኔታዎች ያሉ ለጾታዊ እና ተዋልዶ ጤና ጉዳዮች የተለያዩ የሕክምና አማራጮች ጥቅሙንና ጉዳቱን ይገመግማሉ?					

ጥያቄዎች	በጣም ከባድ	አስቸጋሪ	አላውቅም	ቀላል	በጣም ቀላል
እንደ የወሊድ መከላከያ፣ የአባላዘር በሽታዎች ወይም የወር አበባ ጤና ጉዳዮች ያሉ የወሲብ እና የስነ ተዋልዶ ጤናዎን በተመለከተ ከሌላ ዶክተር ሁለተኛ አስተያየት ማግኘት ሲያስፈልግዎ ይገመግማሉ?					
እንደ የወሊድ መከላከያ፣ የአባላዘር በሽታዎች ወይም የወር አበባ ጤና ያሉ በመገናኛ ብዙኃን ላይ ስለ ወሲባዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ያለው መረጃ አስተማማኝ ከሆነ ይገመግማሉ?					
የወሊድ መከላከያ መምረጥ፣ የወር አበባን ጤና መቆጣጠር ወይም የወሲብ ጤና ጉዳዮችን በተመለከተ ውሳኔ ለማድረግ ዶክተርዎ የሰጠዎትን መረጃ ይጠቀማሉ?					
እንደ የወሊድ መከላከያ፣ የአባላዘር በሽታዎች ወይም የወር አበባ ጤና መድሐኒቶች ካሉ ከጾታዊ እና ከሥነ ተዋልዶ ጤናዎ ጋር በተያያዙ መድሃኒቶች ላይ ያሉትን መመሪያዎች ይከተላሉ?					
በወሲባዊ እና በስነ-ተዋልዶ ጤና ድንገተኛ አደጋ እንደ ከባድ የወር አበባ ህመም፣ በእርግዝና ወቅት የሚፈጠሩ ችግሮች፣ ወይም ከአባላዘር በሽታ ጋር የተያያዘ ድንገተኛ አደጋለ አምቡላንስ ይደውላሉ?					
የወሊድ መከላከያ መውሰድ፣ የአባላዘር በሽታ ሕክምናን መከተል ወይም የወር አበባን ጤንነት መቆጣጠርን የመሳሰሉ የወሲብ እና የስነ ተዋልዶ ጤናን በሚመለከት ከዶክተርዎ ወይም ከፋርማሲስትዎ የሚሰጠውን መመሪያ ይከተላሉ?					
ከጾታዊ እና ከሥነ ተዋልዶ ጤና ጋር የተዛመዱ ጤናማ ያልሆኑ ባህሪያትን እንደ ጤናማ ያልሆነ የግብረ-ሥጋ ግንኙነት፣ መደበኛ ያልሆነ የወር አበባ ዑደቶች ወይም					

ጤናማ ያልሆኑ ግንኙነቶችን ስለመቆጣጠር መረጃ ያገኛሉ?					
መደበኛ ያልሆነ የወር አበባ ዑደት፣ የወሊድ መከላከያ አጠቃቀም፣ ወይም በግብረ ሥጋ ግንኙነት የሚተላለፉ ኢንፌክሽኖችን (STIs) ያሉ የወሲብ እና የመራቢያ ጤና ጉዳዮችን ስለመቆጣጠር መረጃ ያገኛሉ?					
ስለ HPV ክትባቶች ወይም ስለ ወሲባዊ ጤና ምርመራዎች፣ እንደ STI ወይም የማህፀን በር ካንሰር ምርመራዎች ያሉ መረጃዎችን ያገኛሉ?					
በግብረ ሥጋ ግንኙነት የሚተላለፉ ኢንፌክሽኖች፣ ያልተፈለገ እርግዝና ወይም የወር አበባ ጤና ጉዳዮችን እንዴት መከላከል ወይም መቆጣጠር ወይም መገልገል እንደሚችሉ መረጃ ያገኛሉ?					

ጥያቄዎች	በጣም ከባድ	አስቸጋሪ	አላው ቅም	ቀላል	በጣም ቀላል
ጤናማ ያልሆነ የግብረ ሥጋ ግንኙነት፣ የእርግዝና መከላከያ አለመጠቀምወይም በርካታ የግብረ ሥጋ ግንኙነት አጋሮች ያሉ የጤና ማስጠንቀቂያዎችን ይረዳሉ ?					
ለምን HPV ክትባት፣ ለጾታዊ እና የስነ ተዋልዶ ጤና ክትባቶች እንደሚያስፈልግ ይረዳሉ?					
ለጾታዊ እና ስነ ተዋልዶ ጤና እንደ የአባላዘር በሽታዎች ወይም የማህፀን በር ካንሰር ምርመራዎች ያሉ የጤና ምርመራዎች ለምን እንደሚያስፈልግዎ ይረዳሉ?					
የወሊድ መከላከያ፣ እርግዝና፣ በግብረ ሥጋ ግንኙነት የሚተላለፉ ኢንፌክሽኖች (STIs)፣ ወይም የወር አበባ ጤንነትን የመሳሰሉ ከጾታዊ እና ከተዋልዶ ጤና ጋር የተያያዙ የጤና ማስጠንቀቂያዎችን ያገኛሉ ?					
ለወሲብ እና የስነ ተዋልዶ ጤና ምርመራ ዶክተር ማየት ሲያስፈልግዎ ይገመግማሉ ?					
የHPV ክትባት ወይም ሌሎች ከጾታዊ እና ስነ ተዋልዶ ጤና ጋርተዛማጅ ክትባቶችን ይገመግማሉ?					
የአባላዘር በሽታ፣ የማኅጸን በር ካንሰር ወይም የጡት ጤናን የመሳሰሉ የወሲብ እና የስነ ተዋልዶ ጤና ምርመራዎች ማድረግ እንዳለቦት ይገመግማሉ?					
በማህበራዊ ድህረ-ገፆች ላይ በጾታዊ እና በተዋልዶ ጤና አደጋዎች ላይ ያለው መረጃ አስተማማኝ መሆኑን ይገመግማሉ?					
ስለ HPV ክትባት ወይም ከበጾታዊ እና በተዋልዶ ጤና ጋር ተዛማጅነት ያላቸው ሌሎች ክትባቶችን ከጾታዊ እና ከተዋልዶ ጤና ጋር የተገናኘ					

ክትባት መውሰድ እንዳለቦት ይወስናሉ?					
ከቤተሰብ እና ከጓደኞች ምክር በመነሳት እራስዎን ከጾታዊ እና የስነ ተዋልዶ ጤና አደጋዎች እንዴት እንደሚከላከሉ ይወስናሉ?					

ጥያቄዎች	በጣም ከባድ	አስቸጋሪ	አላው ቅም	ቀላል	በጣም ቀላል
በማህበራዊ ድህረ ገጽ ላይ ባሉ መረጃዎች ላይ በመመስረት እራስዎን ከ እና ከ ጾታዊ እናተዋልዶ ጤና አደጋዎች እንዴት እንደሚከላከሉ ይወስናሉ?					
የወሊድ መከላከያ፣ የአባላዘር በሽታ መከላከያ ፣ የወር አበባ ጤና ወይም ጤናማ የወሲብ እና የስነ ተዋልዶ ጤና ልምዶች ላይ መረጃ ያገኛሉ?					
ለጾታዊ እና ስነ-ተዋልዶ ጤና ደህንነትዎ ጠቃሚ የሆኑ ተግባራትን ለምሳሌ ለጤናማ ግንኙነት፣ ለጾታዊ ጤና አጠባበቅ ወይም የወር አበባ ጤና ያሉ ተግባራትን በተመለከተ መረጃ ያገኛሉ?					
የጤና እንክብካቤ አገልግሎቶች፣ የጾታ ትምህርት ወይም ለወጣቶች ደህንነቱ የተጠበቀ ቦታዎች እንዴት ለጾታ እና ሥነ ተዋልዶ ጤና ተስማሚ ሊሆን እንደሚችል መረጃ ያገኛሉ?					
እንደ የወሊድ መከላከያ፣ ቅድመ እርግዝና፣ ፅንስ ማስወረድ፣ ወይም የጾታዊ ጤና ትምህርትን የመሳሰሉ ሕጎች ላይ ለውጦችን በጾታዊ እና በሥነ ተዋልዶ ጤና ላይ ተጽእኖ ስለሚያሳድሩ ፖለቲካዊ ለውጦች መረጃ ያገኛሉ ?					
በትምህርት ቤትዎ ውስጥ የጾታ እና የስነ ተዋልዶ ጤናን ለማበረታታት ስለሚደረጉ ጥረቶች፣ እንደ የወሲብ ጤና ትምህርት፣ የወሊድ መከላከያ ወይም የወር አበባ ጤንነትን የመሳሰለ መረጃ ያገኛሉ ?					
ስለ የወሊድ መከላከያ፣ የወር አበባ ወይም ጤናማ ግንኙነት ያሉ ከቤተሰብ አባላት ወይም ከጓደኞች ስለ ጾታ እና የስነ ተዋልዶ ጤና ምክር ይረዳሉ?					
ከጾታዊ እና ከሥነ ተዋልዶ ጤና ጋር በተዛመደ የምግብ ማሸጊያዎች ላይ መረጃን ይረዳሉ፣ ለምሳሌ የወር አበባን ጤንነት የሚደግፉ አልሚ ምግቦች ወይም አጠቃላይ የስነ ተዋልዶ ጤና ይረዳሉ?					
የጾታዊ እና የስነ ተዋልዶ ጤናዎን እንዴት ማሻሻል እንደሚችሉ በመገናኛ ብዙኃን ላይ መረጃን ለምሳሌ ስለ የወሊድ መከላከያ፣ የአባላዘር በሽታ መከላከያ ወይም የወር አበባ ጤና ያሉ ምክሮች ይረዳሉ?					
የጾታዊ እና የስነ ተዋልዶ ጤናዎን በጥሩ ሁኔታ እንዴት ማቆየት እንደሚችሉ መረጃ ለምሳሌ የወር አበባ ጤና፣ የወሲብ ደህንነት ወይም					

የስነ ተዋልዶ እንክብካቤ ይረዳሉ?					
እንደ ወሲባዊ ባህሪ፣ የወሊድ መከላከያ አጠቃቀም ወይም የወር አበባ ጤና ያሉ የአኗኗር ዘይቤዎ የጾታ እና የስነ ተዋልዶ ጤናዎን እና ደህንነትዎ ላይ ተጽዕኖ እንደሚያሳድር ይገመግማሉ?					
የመኖሪያ ቤትዎ ሁኔታ ለጾታዊ እና ስነ-ተዋልዶ ጤናዎ፣ እንደ ግላዊነት፣ ንፅህና አጠባበቅ ተቋማት፣ ወይም ለጾታዊ ጤና ተግባራት እና ደህንነት ደህንነቱ የተጠበቀ አካባቢን እንዴት እንደሚያበረክቱ ይገመግማሉ?					
የወሊድ መከላከያ አጠቃቀም፣ የወር አበባ ንፅህና፣ የጾታዊ ተግባር ወይም አጠቃላይ የስነ ተዋልዶን ደህንነትን መጠበቅን የመሳሰሉ ከጾታዊ እና ስነ ተዋልዶ ጤናዎ ጋር ምን አይነት የእለት ተእለት ባህርዮት ጋር እንደሚዛመዱ ይገመግማሉ?					
የወሊድ መከላከያ ዘዴዎችን መምረጥ፣ የወር አበባን ጤንነት መቆጣጠር ወይም አስፈላጊ ሆኖ ሲገኝ የግብረ-ሥጋ ግንኙነትን መፈለግን የመሳሰሉ የጾታዊ እና የስነ ተዋልዶ ጤናን ለማሻሻል ውሳኔዎችን ያደርጋሉ?					
ከፈለጉ የስርዓተ-ፆታ ክበብ ወይም በወሲብ እና በስነ-ተዋልዶ ጤና ላይ ያተኮረ ክለብ ይቀላቀላሉ?					
ስለ ግላዊነት፣ የንፅህና መጠበቂያ ተቋማት ተደራሽነት እና ለጾታዊ ጤና ተግባራት ደህንነቱ የተጠበቀ አካባቢን በመሳሰሉ የፆታዊ እና የስነ ተዋልዶ ጤና እና ደህንነት ላይ ተፅእኖ በሚፈጥሩ መንገዶች የኑሮ ሁኔታዎ ላይ ተጽእኖ ያደርጋሉ?					
እንደ SRH የትምህርት ፕሮግራሞች፣ የግንዛቤ ማስጨበጫ ዘመቻዎች፣ ወይም የአቻ ድጋፍ ቡድኖችን በመሳሰሉ የጾታዊ እና የስነ ተዋልዶ ጤና እና ደህንነትን ለማሻሻል በሚታሰቡ በትምህርት ቤት እንቅስቃሴዎች ውስጥ ይሳተፋሉ?					

ክፍል **III:** የሶሻል ሚዲያ የውህደት መለኪያ **(SMUIS)**

ጥያቄዎች	በጣም አልስማማም	አልስማማም	ገለልተኛ	እስማማለሁ	በጣም እስማማለሁ
በጾታዊ እና ስነ ተዋልዶ ጤና ጉዳዮች ላይ ለመወያየት ወደ ማህበራዊ ሚዲያ ውስጥ ሳልገባ ስቀር ከጓደኞቼ ጋር ያለኝን ግንኙነት እንደተቋረጠ ይሰማኛል።					
ስለ ጾታዊ እና ስነ-ተዋልዶ ጤና ግንዛቤ ውስጥ ማህበራዊ ሚዲያ ትልቅ ሚና ይጫወታል					
ማህበራዊ ሚዲያን መጠቀም ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ስወያይ ከሌሎች ጋር በስሜት እንድገናኝ ይረዳኛል።					
ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ለመነጋገር በማህበራዊ ሚዲያ ላይ ከሰዎች ጋር መገናኘት ያስደስተኛል.					
ማህበራዊ ሚዲያ ለእኔ ጠቃሚ ስለሆኑት የጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች መረጃ እንዳገኝ ይፈቅድልኛል					
ማህበራዊ ሚዲያ ስለ ጾታዊ እና ስነ ተዋልዶ ጤና መረጃን ከሚጋሩ ሰዎች ጋር እንድገናኝ እንደሚረዳኝ ይሰማኛል					
ስለ ጾታዊ እና ስነ ተዋልዶ ጤና ለማወቅ ማህበራዊ ሚዲያን መጠቀም የእለት ተእለት ተግባሬ አካል ነው።					
ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ጉዳዮች ብዙ ጊዜ ሳስብ ማህበራዊ ሚዲያዎች ላይ አረጋግጣለሁ።					
ስለ ጾታዊ እና የስነ ተዋልዶ ጤና ለማወቅ ቀኑን ሙሉ በመደበኛነት ማህበራዊ ሚዲያዎችን እጠቀማለሁ።					
ለረጅም ጊዜ የጾታዊ እና የስነ ተዋልዶ ጤና መረጃን ለማግኘት ማህበራዊ ሚዲያን አለማጣራት እንግዳ ነገር ነው					