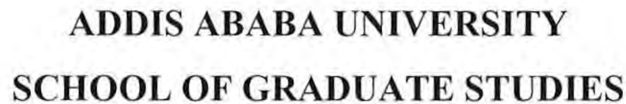

ADOLESCENT PERCEPTIONS ON SEXUAL HEALTH ISSUES:

A CASE STUDY OF STUDENTS OF HIGH SCHOOL IN ADDIS ABABA

A Thesis Submitted to the School of Graduate Studies

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By

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LIST OF ACRONYMS

AIDS: Acquired Immune Deficiency Syndrome

FHI: Family Health International

HIV: Human Immune Deficiency Virus

ICDR: Institute of Curriculum Development and Research

ICPD: International Conference on Population and Development

IEC: Information, Education and Communication

MCH: Mother Child Health

MOE Ministry of Education

MOH: Ministry of Health

NGO: Non- Governmental organization

OSSA: organization for social services for AIDS

PAI: Program for Action International

STDs: sexually Transmitted Diseases

STI: Sexually Transmitted Infections

SIECUS: Sexuality Information Education Council of United State

UNAIDS: United Nations Joint Program on HIV/AIDS

UNDP United Nations Development Program

UNESCO: United Nations Educational Scientific and Cultural organization

UNFPA: United Nations population Fund

UNICEF: United Nations Children's Fund

WHO: world Health Organization

ABSTRACT

The concept of Adolescent reproductive Health (ARH) has gained attention following the international conference (ICPD) held in September 1994 in Cairo, Egypt. Reproductive health problems associated with the risk behaviour and vulnerability of adolescents, especially in relation to early and unwanted pregnancy, unsafe abortion, sexually transmitted infection and HIV/AIDS. Therefore, addressing risk behaviour is certainly important, considering that many adolescents have insufficient factual knowledge of sexual and reproductive health. Also they have in adequate guidance from adults and limited access to health care services, of course sexual intercourse is an inevitable precondition for the generational continuation of human existence. In the current conditions of HIV/AIDS as a new global risk, however, sex has become a possible threat to existence of people in all societies.

In this study, an attempt has been made to investigate the issues of sexual health among the school adolescents in Addis Ababa High School. Risks of sexual behavior cannot be predicted in the current circumstances in which especially adolescent meet many risky challenges that drive their behavior and even their intimacy. When the world around them is rapidly changing young people face threatening syndromes like HIV/AIDS, which cause ontological uncertainty because of their unknown character.

Adults impose their sexual worries on to children and young adults in ways, which are relatively inaccessible and bounded by what cannot be said aloud or clearly seen because of the taboo character of sex. Taboo makes the issue of sex extremely difficult to discuss with young people, the exact risks, however, being warned about.

Most of these risks are preventable but many parents, opinion leaders and policy makers are afraid to act. They do not want to inform young people about sex and its consequences because they believe this will lead to teenage promiscuity and immorality. Parents might be embarrassed to bring up reproductive health with their children, opinion leaders may not speak out because they wish to avoid controversy. As a consequence, our societies face unnecessary human and social costs.

The purpose of the study is to investigate the status of reproductive health among adolescents in Addis Ababa High Schools, by using primary and secondary sources of information. Its main objectives are 1) to assess the knowledge, attitude, beliefs and perceptions of reproductive health practices of high school students in Addis Ababa, and 2) to map out their sources of information and 3) to assesses attitude of adolescent towards sex education.

This study was carried out in Addis Ababa High School students. At the time of data collection, there were 70 High Schools and a total of 96,571 students all in all in the city. Out of these 10 schools randomly selected and 600 students were sampled from each grade and gender (314 males and 286 females). The study was conducted in March 2005.

The major findings of the study showed that age of adolescents determine their sexual behaviour; their knowledge on aspects of their own sexually is seen incomplete and not enough to minimize risk-taking behavior. Younger adolescents shown more open attitudes toward sexual issues than the older adolescents do. The knowledge about sexual health issues comes from health professionals and teachers as well as some patchy information is received from peers of the same sex who may themselves be too little informed or misinformed.

Based on the out comes of the study, seeking of general information on how to behave in the sexual life sphere was positively perceived, as claimed by both male and female adolescents. Yet more than half of all adolescents believe that it is unacceptable to discuss these matters openly with their parents or adults.

It is also found from the analysis that a greater number of male than female respondents know more about the top two contraceptive methods namely condom and pills. Most part, more than (81.8%) of all adolescents, indicate their interest to use contraceptive methods in the future.

The study indicates that quite large portion of male (44.3%) and females (39.5%) among the population under the study were sexually active, more than half of them (67.5%) reported to have had unprotected sexual intercourse. While the rest tell that they used contraception (condom) in the past. The general attitude is that the act of premarital intercourse is not supported in this survey. Based on the finding, some suggestions are forwarded for future needs to initiate sex education in the school curriculum emphasizing the community-based efforts, as recommended. Furthermore, for practical reasons, community based preventive interventions sites need to be established by enabling the existing networks: health facilities, religious organizations, school teachers and peer educators.The use of trained peers as educators could be a part of the school curriculum and an increase of the responsibility of parents in matters concerning sexuality of adolescents might ease the workload on health professionals and teachers.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Reproductive health diseases have become rampant phenomena in Ethiopia. Governments, when approving international treaties like the convention on Child Rights, as well as when participating in international conferences on population and development, held in Cairo in 1994, have recognized the need to protect adolescents' sexual health (UN, ICPD, 1994). It has been widely acknowledged that the concern connected to young people health cannot be separated from cultural attitudes and practices that influence young people's vulnerability. Also socio- economic situations that affect their access to reproductive health information and services must be taken into consideration (UN, ICPD, 1994; Gardiner et al., 1998). Therefore, cultural attitudes and social practices as well as other socio-economic dimensions, which may affect the well being of young people, need a thorough investigation.

Most of the problems among adolescents in Ethiopia are associated with reproductive health practices such as high fertility rate (7) and early child bearing (60% of women under 20 years are mother). Furthermore, pregnant women receiving prenatal care are estimated to be only 20%. Deliveries assisted by a skilled birth attendant in the health facilities are reported to be about 8% indicating critical problems in the country (MOH, 2000:4; Mengistu et al., 1999: 23). The low use of contraception (10%) and the average life expectancy for female and male 50 and 47 years, respectively are among the lowest in the world, with current HIV/AIDS endemic it may even decrease to 44 and 43 (Nega, 2001:33; MOH, 2000:27). In 1998, the adolescent fertility rate was 154 births per 1000 for women aged 15-19 (MOH, 2001). There is high number of unwanted pregnancies and school dropouts. Death of young girls, caused by illicit abortion is rampant. Recent estimates in Ethiopia place the rate of maternal mortality due to illegal unsafe abortion at about 200 deaths per 100,000 live births (Debel and Eshetu, 1998: 332-334). In general, the maternal mortality rate is estimated to 560-850 per 100,000 live births in Ethiopia (Health indicator, 1999; Berhane, 2000; cf. Sedman et al., 1994). The numbers are even bigger in the age group of 15 to 19; there are about 1,270 maternal deaths per 100,000

live births. This number is approximately three times higher than for women in the age from 20 to 34 years (Noble. et al., 1996:56-74). Currently, above 17% of the population in Addis Ababa said to be infected by the HIV corresponding to a ratio of two out of every twelve persons on the street of the capital city (Hirut 2002:10-12). Life expectancy in Ethiopia is about 50 years, with the pandemic of AIDS it is predicted to lower to 42 in the near future (Nega, 2001:33; MOH, 2000:27). Access to services like treatment of sexually transmitted diseases, abortion facilities and center for counseling is limited, as they are mostly located in the capital and other big cities. This situation places especially young people (pregnant adolescents) among the least privileged citizens in the world-level (WHO/UNICEF, 1996: 16-24; Ahmed et al., 2000: 10; The Pai report card, 2001).

A risk assessment report indicates that Ethiopia is among the 10 worst affected countries in Sub-Saharan Africa by reproductive health problems and especially with AIDS (Solomon, 2001). According to Solomon's statements, " AIDS means a war against humanity." AIDS is killing more people than were killed by all the past wars and natural disasters" (Solomon, 2001:37). Most of the deaths in Ethiopia are among young people between 15-34 years of age. About 13% of the students in Addis Ababa high schools are reported to be HIV positive (Bekel, 2001:37), what does this situation mean? Does it mean lack of information on the availability of health services in the country? Is the shortage of services the physical reason for this situation or the lack of access to the means of prevention? Or is it a result for this societal connotation embarrassing young people to use contraception? The reasons could be combinations of these factors and other issues unmentioned here, which need a thorough investigation. However, education for behavioral change is necessary among the young people at individual and group level.

In Ethiopia, access to qualified reproductive health services is hampered due to a limited health infrastructure and poorly trained human personnel in this field. It is coupled with a low level of awareness and underdeveloped practice of family planning. This problem demands that all possible systems, including the services that are community based, are utilized in the delivery of health services (MOH, 2000: Mengistu et al., 1999). Mengistu and others have stated that community based approach to health services is a new phenomenon in Ethiopia. It means that

local people are trained to assist in health needs of the society, especially of mothers and children and pregnant women. Experiences of community based delivery services have gained recognition only recently in Ethiopia and put in practice on a limited scale in government institutions. However, with regard the perspective of the quality a few non-governmental organizations (NGO's) have experience, in carrying out community-based programs. Thus, one can hardly find widely integrated and consistent community based reproductive health services in Ethiopia (Hailemariam et al., 1998).

Ethiopia is among the least developed countries in the world in terms of health care facilities, economic development and living standard of its people. The fundamental cause for this situation is the backward socio-economic system that has prevailed for centuries. As recently indicated, the HIV/AIDS pandemic syndrome is killing mostly young adults in all economically productive age groups (Nega, 2001). This reduction from the ranks of economically productive young adults has enormous impact to reverse Ethiopia's uncontrolled population growth. It imposes also a great pressure on the limited health resources and services in the country.

Power balance as measured according to gender, conventional social norms, harmful traditional practices such as female circumcision or female genitalia mutilation as well as different skin piercing like tattooing were also reported to have contributed to fast spread of HIV/AIDS in Ethiopia (Gebreselase et al., 1985: 223-228; Nigussie, 1998: 53). According to Konjit (1998: 225), approximately (90%) of girls and women in Ethiopia undergo female genitalia mutilation. The discrepancy in gender lower results in lack of awareness fosters ignorance and leads to a low status of women. The subordinate status of women means a limitation to their right to decide on their own reproduction, which causes greater health risk. Thus, well established family planning programs and other reproductive health services like early diagnosing of sexually transmitted disease and treatment, and voluntary HIV tests, have a significant share in reducing maternal mortality and morbidity as well as infant mortality and morbidity rates (Ahmed et al., 2000: 10; The Pai Report card, 2001: 15-27).

The low coverage of health services results in very rampant communicable disease like acute respiratory diseases malaria, and diarrhea that cause a heavy toll of deaths and burden of disease. Malnutrition and anemia as well as intestinal parasites are also among the major killer in Ethiopia. These health problems have been made worse with the emergence of HIV /AIDS, as it has spread fast in the last two decades. Currently HIV has already infected as many as 12% of Ethiopian women in reproductive age and (7%) less than 19 years of age are HIV positive (Ahmed et al., 2000:14).

The health situation of women in Ethiopia could be summed up by what Fathalla (1993:4-6) has said, that there is no other area of health in which inequality is as striking as in reproductive health. The author demonstrated how mortality differentials in the world have increases in the past two decades. He justifies this by giving statistically evidences on the crude death rate for the population in the less developed countries in the East Africa including Ethiopia. The death rate is about ten percent more than in the more developed regions. This difference of situations marks the reproductive health risks more than any other areas of human life influencing especially the life of women and children.

1.2 STATEMENT OF THE PROBLEM

Adolescent people physically mature faster and become sexually more active today than earlier. They are facing serious health risks especially with the emerging issues of unplanned and unwanted pregnancy of adolescent's girls and the HIV/AIDS problem. Most of them face these risks with too little or no factual information (WHO, 1994; UNICEF, 1994). In other words, they are not informed enough and lack of guidance and easy access to health services. The result is that they are unable to take responsibility on their sexuality and more general on their health and life expectancy.

Sexual and reproductive health issues of adolescents, including unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDS, are addressed through education to promote reproductive health and sexual behavior (WHO, 1994).

However, adolescents have wider ranges of sexual and reproductive health problems. It is being opioned that the main causes are unprotected adolescents' sexuality and their early sexual initiation. It is really surprising that the trends in early sexual activity of adolescents is increasing in the world, but more so in developing countries. Surveys conducted on premarital sexual activities through Africa indicated that Africa have wide variations, ranging from 4% in Burundi to over 75% in Botswana and Liberia (Nere. et al., 1997:42-69)

Young people in many parts of the third world, particularly in Ethiopia, experience ever-greater confusion in the area of sex. Parents and elders are reserved and hesitate to talk about it because of the cultural taboo around sex. On the other hand peers, seem to talk about it in a very special way having their own coded terminology when discussing the issue of sex. While being embarrassed even among themselves, they may not be able to pass around correct and complete information. This is unfortunate, because young people often receive the education in sexual matters from their peers. In urban settings, sex and love among young people are projected as interchangeable and portrayed as normal way of life on TV and radio. In urban societies where parents are working full time away from home, there is a lot less supervision of young people, and this allow them the freedom to experiment with sex much earlier than it used to be the case (Eshetu and Tadese, 1998: 70).

In many developing countries aspects of education on sexuality are incorporated in to various types of programs, called family life skills or family life education or sometimes shortened simply to sex education.

With the emergency of HIV/AIDS it has become a very crucial issues to open up matters of sexuality for discussion in all spheres of the society. That is why this study focuses on adolescence perceptions on sexual health issues in Addis Ababa high school students.

1.3 OBJECTIVES OF THE STUDY

1.3.1. Major Objective

The general objective of the study is to investigate the perception of adolescents on sexual health issues, to shed light on the problems adolescent face in the field of sexuality among students in Addis Ababa high schools.

1.3.2. Specific Objectives are:

1. To asses knowledge and attitude of adolescents in Addis Ababa high schools, regarding sexual health issues like STI, HIV/AIDS and contraceptives.
2. To identify major sources of information from where the adolescents receive on sexual health and contraceptive use.
3. To identify the attitude of students towards the provision of sex education in the school curriculum.
4. To assess the perception of adolescent students on the sexual practice.
5. To identify the major social, economic and demographic correlates of sexual activities of high school adolescents of Addis Ababa.

1.4. RESEACH QUESTIONS

The present study investigates the level of knowledge about reproductive health among adolescents in Addis Ababa high schools. By adolescent in Ethiopia, researcher refers empirically to the young people of Addis Ababa high schools. They supposed to answer to a questionnaire, which dealt with their knowledge, attitude and perceptions of adolescents on reproductive health issues. To proceed with this study, the following basic questions need to be formulated:

1). What knowledge and attitude do students in Addis Ababa high schools have about sexual health and contraceptive methods?

2). What are the major sources of information about reproductive health for these students?

3). What are the attitudes of students towards the provision of sex education in the school curriculum?

4). What are factors affecting the sexual health of adolescent?

The researcher tries to answer these questions in the study.

1.5. SCOPE OF THE STUDY

The study attempts to investigate the status of knowledge, attitude, perceptions and beliefs concerning sexual health and contraception among adolescents of Addis Ababa high school students. The scope of empirical study is limited because it covers only students in Addis Ababa Government high schools. This is due to limited resources (financial and time). Researcher strongly wish to encourage the various sectoral organizations to collect their power together to work for the well being of the young people, and try to break the existing barriers of sexuality education.

1.6 RATIONALES AND JUSTIFICATION OF THE STUDY

There are over one billion young people between the ages of 15 and 24 worldwide. The reproductive and sexual health decisions of these young people, which they make today, will affect the health and well being of their countries and of their world for decades to come. (http://www.advocates for youth on line)

The concern for research on adolescent is related to reproductive health behavior that leads young people to risk ill health and death as burning issues in the area of the risk (MCH issues, 2000: 22). Young people are prone to sexual and reproductive problems such as early and unwanted pregnancies, septic abortion, sexual violence as well as sexually transmitted disease including HIV/AIDS in the past two decades has been increasingly affected the young people in Ethiopia. As young age group and those between 15-19 years has the relatively highest frequencies of contracting HIV infection especially females (MOH, 2000: 11) as compared to the other groups calculated in the age period of five years.

In particular, two international issues have profound impact on young people's lives: family planning and HIV/AIDS. Women in less development countries are 30 times more likely to die from reproductive health related causes than women in industrialized countries. And, teenage women are twice as likely to die from pregnancy related health complications, as are women in their twenties. HIV/AIDS indicate that one-half of all new HIV infections worldwide occur among young people age 15 to 24. Every minute, five young people worldwide become infected with HIV/AIDS, and over to 7,000 young people die each day. The socioeconomic and political consequences of the HIV epidemic place these youth at further risk as the infrastructure in their countries comes under enormous strain (http://www.advocates for youth on line)

Sexually active youth in developing countries need access to confidential, low- cost, and youth friendly contraceptive services to delay too- early child bearing and protect themselves from sexually transmitted diseases, including HIV infection.

The medical and public health field has dominated research on sexual health issues in developing countries over the past decade. To some extent, this focuses was predictable and understandable since study of this topic was in its infancy, following the identification of the HIV virus that causes AIDS. Initial concerns focused on the extent and rapidity of spread of HIV infection and on the natural history of HIV infection, and subsequent development of AIDS.

However, in recent years, this situation has changed. The major modes of transmission have been identified and it has become clear that, in many societies the general population (not only those with identified high risk behavior) is at significant risk of HIV infection. Thus, studies of the perception of sexual health patterns of the general population are relevant to the study of the potential for future spread of HIV. In this regard, since little research has been done before, this study could generate useful information concerning what young people at high school level know, think and do in the face of ground danger of AIDS. Moreover, it attempts to fill the gap in information and to suggest ideas for policy implications, which could enables the establishment and strengthening of programs to combat the spreads of AIDS. The result of this

study is also believed to have a significant importance in designing different strategies for changing young people's sexual behaviors with a view to creating sexual values that reduce the risk of AIDS and other STI.

1.7. DEFINITION OF TERMS (OPERATIONAL DEFINITION)

Adolescence: is stage of maturation between childhood and adulthood. The term denotes the period from the beginning of puberty to maturity; it usually starts at about age 14 in males and age 12 in females. The transition to adulthood varies among cultures, but it is generally defined as the time when individuals begin to function independently of their parents (Encarta 2002). There is no universally accepted definition of adolescent. According to WHO adolescent is defined as the period during which the individual progress from a point of initial appearance of sex characteristics to that of sexual maturity and the individuals psychological progress and pattern of identification developed from those of a child to those of an adult. In this study for practical purpose the age limits of 14-24 years will be used to define adolescents.

Attitude:- The perception of adolescents about premarital sex and contraceptive use (Encyclopedia of Britannica, 1982).

Knowledge:- Awareness of young people on the contraception risk factors or HIV/AIDS (Encyclopedia of Britannica, 1982).

Sexual behaviour:-is any activity between two persons(heterosexual or in a group that includes sexual arousal (Encyclopedia of Britannica, 1982).

Sexuality:- Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concern (SIECUS, 1999).

Sexual Health:-The World Health Organization defines sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love...every person has a right to receive sexual information and to consider sexual relationships for pleasure as well as for procreation." (SIECUS, 1999).

Sexual health issue in this regard is that are related to sexual matter such as sexual education, premarital sexual experiences, protected sex, unwanted pregnancy, abortion and infection of STI/AIDS.

Sexual Rights: -The rights of individuals to have the information, education, skills, support and services they need to make responsible decisions about their sexuality consistent with their own values. These include the right to bodily integrity, voluntary sexual relationships, a full range of voluntary accessible sexual and reproductive health services, and the ability to express one's sexual orientations without violence or discrimination (SIECUS, 1999)

Sexuality Education: -is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality (SIECUS, 1999).

Teenager:- a young person between 13 and 19 years old (Encyclopedia of Britannica, 1982).

1.8 ORGANIZATION OF THE STUDY

This thesis contains six chapters. Chapter one deals with the general overview of adolescents' perception on sexual health issues. In this part the background of the study, the statement of the problem, objective of the study, the research questions, the scope of the study, rationale and justification of the study, definition of terms and organization of the study are included. The second chapter deals with the theoretical framework and review of related literature. It includes: the concept of adolescent sexuality, sexual risk behavior of adolescents, adolescent knowledge and practice of contraception, adolescent pregnancy, abortion, knowledge of STDs and HIV/AIDS, HIV/AIDS syndrome in the modernizing culture, the need for information on sexuality among adolescents, sexuality education of adolescents in Ethiopia, and factor influencing individual behaviour towards reproductive health. The third chapter deals with the methodology of the research. It includes the target population, sampling techniques and sample size determination, study design, source of data, data collection instruments, and data processing & method of analysis. The forth chapter deals with various aspects of sexual behavior and contraceptive use: on sexual and contraceptive knowledge and attitude as well knowledge of STD & HIV/AIDS. The fifth chapter deals with the socio-economic and demographic correlates of sexual intercourse and contraceptive use using bivariate and multivariate logistic analysis. Chapter six finally summarizes the finding of the study, conclusions and forwards recommendations.

CHAPTER TWO

REVIEW OF RELATED LITERATURES

2.1The Concept of Adolescence Sexuality

The beginning of adolescence period is more or less dictated by onset of biological maturation, i.e. puberty. Puberty, in all societies, is a significant milestone in the transition from child hood to adulthood. It is often marked by religious rates and changes in what is permitted and expected from boys and girls (Friedman et al., 1995). This sexual maturation is often accompanied by anxieties about development of secondary sexual characteristics. Particularly when the young adolescent is ignorant of their meaning or is not expecting them. The adolescent is drawn into activities associated with the opposite sex by the excitement and stimulations initiated by the glandular changes of puberty (Malm et al., 1952). Between the ages of 16-20 the adolescent reaches the peak of his/her sexual capacity (Kingslay, 1968). That is s/he will be very much interested in the opposite sex.

Thus, adolescents' problems focus on newly aroused sexual needs. During adolescence period many rapid bio-psychological changes take place making the adolescents vulnerable to physical and psychological environment (Cernada, 1986). So, adolescents are characterized by undeveloped decision making, experimentation and subjection to peer influence. Many mature boys or girls attempts to solve personal problems by means of trial and error procedures. Such practices naturally result in changes in behavior and conduct (Ayo, 1991).

Moreover, sexuality is an important aspect of human existence for it enables the human race to continue to exist (Fogel, 1990). Sexuality is a phenomenon that spans the entire lifecycle. What is unique to adolescent is that complex cognitive and psychological changes affect how sexuality is expressed (Grant, 1988).

Furthermore, Kaymond and Alan (1996) mention two prominent interpretations, taking opposite points of view in describing the causes of sexual behavior of adolescents: - One is that of Freud, the other is that of Simon and J.H. Gagnon. The Freudians argues that adolescents'

sexual behaviors are the result of increasingly strong inner drives into yet channeled and controlled. These drives are postulated to be stronger in males than females. Simon and Gagnon argue that sexuality is not a response to inner drives but rather a learned response to cultural expectations. Consequent each sex follows a cultural script and learns the behaviors expected by their culture. Similarly, Andargachew (1994) states that adolescents' sexuality is dependent on socio economic relationship and cultural practices of the country. Adolescent sexuality is not without health and social consequences. In some societies sexual gratification is postponed until the day of marriage. However, schooling brings adolescents together and this often assists in breaking the taboo. Contrary to the above notions, Jeppesson (1995) states that adolescent sexual maturity develops before social, psychological and physical maturing. As a result adolescents who engage in sexual activity at their very early age end up with many physiological and social problems. Sexual intercourse may have undesirable consequences such as the contraction of STDs, unwanted pregnancies and formed marriages.

Thus, today morbidity and mortality among adolescents be increasingly becoming a focus of research. The problems of teenagers including unprotected sexual activity, low contraceptive use, rising pregnancy rate and reliance on clandestine abortion are becoming reading apparent (Uche et al., 1997).

Similarly, the recent widespread and rapid dissemination of the AIDS disease mainly by sexual activity is one of the worst epidemic the human race has encountered. So, with prevention riding above all a behavioral change, AIDS made it legitimate to study sexuality and sexual behavior. Hence, sexual behavior is considerably more diverse than was imagined before. Despite the worldwide campaign against AIDS and other STI, adolescents are still engaged in risky sexual activities, which put them at special risk of AIDS (WHO, 1992). The rise in the rate of AIDS and other STDs among adolescents support this fact. In fact based on this more effective interventions can be planned.

Many studies have been conducted all over the world to assess the sexual behaviors of adolescents. Hatcher (1990) in a study conducted in USA showed that (45%) women age 15-17 had sexual intercourse. Nickerson (1990) in his survey of Indianapolis found that (46%) of all

adolescents have had sexual experience. Grant et al (1988) reviewed several studies conducted in USA and reported them as follows: in 1979 Sorenson from a national sample of 411 adolescents found (58%) of male and (39%) of female adolescents to be sexually active. Moreover a survey was also conducted on reproductive health between 1986-1989 in Jamaica, Costa Rica and 10 cites in five other countries, namely Brazil, Guatemala, Mexico, Chile and Ecuador. In this study, it was found that the sexual activity pattern ranged from males from (42%) in Mexico to (78%) in Jamaica for females from (12%) in Guatemala to (55%) in Jamaica (Population Report 1992).

In addition, Douglas et al (1986) in Ibadan, Nigeria found that the sexual behaviors of adolescents reached 76%. WHO (1991) in a study conducted in Sub-Saharan Africa showed that half of the teenage girls have had sexual intercourse at least once?

For instance, in Ethiopia, Levine (1965) mentions that premarital sexual experimentation for a boy is acceptable. However, this has to be carried out quietly and with discretion.

> *If a boy is still virgin by the end of teens he may be referred to by one of his peers with the insult terms as " silb " (castrated one). The unwed girl must remain virgin at all costs. A girl who is found not to be virgin on her wedding night will be beaten by her husband and possibly sent to her parents (p.99).*

Now a day the trend about sexual behavior is changing in that adolescents are becoming sexually active at younger age Levine (1965) mentions that:

> *In Ethiopian's modernizing sector, however, society and the individual have been affected by numerous changes all at once. Adult standards have become confused, available rules have multiplied beyond comprehension; new agents and techniques of seconding socialization have supplemented the old. Over night adolescent have become both a category and a challenge. With regard to premarital preparation for adult sexual functions, however, double standards, does exist. Although public norms require boys to be virgin at marriage, and one bears it said that "in the old days" this norms was strictly enforced (pp. 96-99).*

Some recent studies show different patterns: - Solomon (1990) study in Addis Ababa Senior high school (9-12 grade students) indicated that 53% of the boys and 25% of the girls were

sexually active. 74% of these had their first sexual encounter when their ages were between 14-16 years old. Asnake et al (1993) in a survey conducted on northwestern Ethiopia adolescents found that the majority of them had their first sexual encounter before the age of 16. CYAD (1995) in a survey of adolescent sexual behavior in urban Ethiopia indicted that 50.2% of males and 21.2% females in the 15-29 years age category-experienced sexual intercourse. Tilahun's (1993) survey results reveal that 40% of the students had experienced sexual intercourse.

In sum, all the above studies, without exception claim that adolescents are in fact sexually active. Due to all these, adolescent sexuality is not an issue to be ignored.

2.2 Sexual Risky Behavior of Adolescents

The question of human sexuality is an issue concerning of who has the right to decide on matters of everyday life meaning economic and social rights (Gammge, 1995). These matters are determined by the status a person has in the society. It is also the question of human rights; therefore it is the question of socioeconomic and political power rocking the status quo. Human sexuality is also affected by male biased societal value systems that subscribe the ideal behaviors for men and women to take roles in their spheres of everyday life as well as determining their status and identities (Elson, 1995). Gender inequalities have serious consequences for adolescent sexual health. In many part of the world, women and girls are economically dependent on men, may face domestic violence and non-consensual sex, and are encouraged to remain ignorant and passive. So long as women and girls are denied access to information and education, economic resources and health services, they will continue to face increased risks of HIV infection (FHI, 2002). Program planners have relatively ignored the health needs of young people until recently and such issue has negative consequences on the health of both young men and women. It is unlikely therefore that young people will be able to possibly maximize the knowledge of gender sexual health. Major changes are demanded to improve the issues of gender relation and inequalities, which facilitate the transmission of HIV. Those concerned with the prevention of HIV and promoting adolescent health must seek to

influence public policy agendas to lay the foundations of greater equity and equality between genders in the future (Hartigan, 1998).

Before every thing else, it must be remembered how important it is fight against the prevalent ideologies of traditional masculinity and traditional femininity, which prescribe women's 'invisibility, subjugation' and facilitating the exclusion of young women and young men as dominant and sexually outgoing. Furthermore, the ideology of traditional masculinity and traditional femininity places men as the main stream of social economical and political decision making while alienating women (Morgan, 1992; Scharf and Toole, 1992: 15-34). These ideologies need to be challenged by policy action at micro and macro levels. Policy has an implication to make young people visible in all spheres to develop confidence and self-esteem.

Stereo type gender roles place young women and to a lesser extent also young men, at a heightened risk of HIV infection. Young women in many parts of the developing world have little control over how, when and where sex takes place (Gupta and Weiss, 1995). Generally, women find it very hard to negotiate for their reproductive rights. There is a strong pressure on young unmarried women to retain their virginity (Petchesky and Judd, 1998). However, the social pressure to remain virgin can contribute in a number of ways as being risks of sexually transmitted diseases and HIV, which young women face in specific contexts. Young women may engage in risky sexual practices, for instance in more developed countries, anal sex was been reported as means for protecting their virginity, while oral sex was reported to be the case in the less developed countries (Gupta and Weiss, 1995).

The high social value placed on virginity in the case of unmarried girls may pressure parents and communities to ensure that young women are kept ignorant about sexual matters. Female ignorance of sexual matter is often viewed as a sign of purity and innocence, while having 'too much' knowledge about sex is a sign of 'easy virtue', meaning that girls become cheap and get spoiled if they know too much about sexual life (ibid). This emphasis on 'innocence' prevents young women from seeking health care. Sexually active young women are also discouraged from discussing sex too openly with their own partners, since women are encouraged to be

ignorant and inexperienced. This means that young women are unlikely to be able to communicate their needs for safer sex with their partners.

Oladepo and Brieger (1994) in a study at Ibadan, Nigeria reported that 48% of the students who are sexually active have multiple sex partners.

In Ethiopia in light of these views, Giel (1968) briefly mentions sex problems of Ethiopian boys as follows:

> *Visits to prostitutes are considered without feelings of guilt. However this attitude seems to be changing in the students. Some thought in a moral and were troubled by their sexual desired. They assumed from their fantasies that they were "over sexed" masturbation was considered harmful affecting potency in later life (P. 3).*

Similarly, Solomon (1990) found that 7.1% of the girls and 34.4% of the boys had had sex with eight or more persons. The majority of the boys (76.7%) and girls (92.9%) never used condoms for prevention of STI in during AIDS.

Moreover, Tesfaye et al (1993) in their survey in Jimma town reported that 40% had had unprotected sexual activity, and the prevalence of high risk sexual encounter who high. Asnake et al (1993) indicated that the mean number of sexual partners of sexually active adolescents was three. Tilahun (1993) found that 19.6% of Gonder College in coming students had had sexual contact with definite high-risk persons (prostitute) and 27.3% with a casual individual. Filimona and Joyce (1994) found that 83% of the sexually experienced males reported that their first intercourse had been with a female student. Only 8% said it was with a prostitute. Furthermore, Tilahun (1993) reported that the majority of the students who practice sex do not use condoms. Generally all surveys conducted up to now have demonstrated beyond doubt that most sexually active adolescents do not practice safer sex.

2.3. Adolescents' Knowledge and Practice of Contraceptive

Sexuality is a taboo subject in most societies. Young adolescents frequently have little knowledge about contraception or the basic fact of contraception. They are naturally impulsive,

less likely to plan than adults, and so the act of intercourse may lead to unwanted pregnancy. Hence, if a boy and a girl start having sexual relations they should know that an unwanted pregnancy could happen unless contraception is used every time they have sex. For instance, in countries like USA, Germany, and Mexico 50-60% of both sexes did not use any fertility regulating method at their first sex (Liskin 1985). Most surveys revealed that fewer than half of the sexually active youth ever used fertility regulating method (Ibid).

Some studies revealed that students in Kenya and Nigeria had heard about contraceptives but in correctly cited dangerous side effects (Population Report, 1995). Accordingly, one study in 1986 showed that 85% of the sexually active sorts aged between 12 and 19 were not using any contraceptive method (Lema, 1990). In a study conducted in Dakar, Senegal condoms were the most widely known methods with nearly all the men and the majority of the women mentioning them. In addition, pills were the next most commonly named method though older women were more likely to mention them than the 15-19 years olds (Christine, 1996). Obviously it is well understood that the perhaps the only technology aside from education that is effective and can be introduced immediately to reduce the risk of sexual transmission of HIV is condom (WHO, 1992). Mesganaw et al (1995). In their studying high school students in North Gonder reveled that 75.7%of high school female students have knowledge of contraceptive. In their study knowledge of pills and positive attitude to contraception were significantly associated with modern contraceptive use? Filimona and Joyce (1994) have also mentioned that 54% of the high school students had contraceptive knowledge.

Onset of menstruation is one of the earliest signs of puberty in females. Some teens know little about this important change. Levine (1965) reported that the onset of menstruation is kept secret, since menstruation is seen as a shameful event for the unmarried women. Gebeyehu (1970) indicated that the majority of the girls do not know when to do with their menstruation. However, fertility awareness methods are highly dependent in under studying of the menstrual cycle and the time of evolution (May, 1990).

2.4. Adolescence Pregnancy

In fact, we all want our children will grow in to responsible adults. We also want them to develop positive attitude towards sexual activities. This is largely a question of our own value. But teenagers or young people get involved in sexual activities, thus often acquired grave health and social consequences. So the problems presented to society by adolescent pregnancy are important not merely in physical terms, but for social reasons also (Senanayalce, 1984).

In this respect Broadribb (1983), Eyob et al (1996) have mentioned that decrease of family traditional control together with low (quality) education, poor socio economic status, peer group influence and taking of stimulate expose adolescents to sexual activity and unwanted pregnancy. May et al (1990) pointed out that concern about confidentiality clearly contributes to adolescents' reluctance to seek essential survival. Furthermore, Friedman (1993) reported that in Africa pregnancy between the ages of 15-19 years is common. Surveys showed that in Mali (45%), in Liberia (37%), in Uganda (30%), and in Senegal (26%) of teenage women have given births. Ojwang and Maggwa (1991) reported that in Kenya adolescent girls contributes up to 30% of the total pregnancies. Moreover, in many Ethiopian societies out of wedlock pregnancy is poorly tolerated (Jeppesson 1995). If pregnancy happens, the blame is usually put on girls. She is regarded as a disgrace to the family, and her later chances of finding a husband is reduced. For instance, Eyob et al (1996) confirms that two thirds of adolescents become mothers before they reach the age of 20. Mesganaw et al (1995) found that among sexually active senior high school students aged 15-17 years, 30.1% reported having been pregnant. In sum, the prevention of unwanted teenage pregnancy and related problems are urgent challenges in Ethiopia. So teenage pregnancy, be it martial or extra-marital has complications that threaten the life of mother. However, in a study of Venice vaginal fistula in northeastern Ethiopia, the mean age of marriage was found to be 11.5 years with parental pre-arranged marriage often as young as 5 years (Seyoum and Getahun, 1988).

2.5. Abortion

Societal concern with adolescents' pregnancy in the United States increased in the past 20 to 30 years as studies began to document a risk in teenage sexual activity (Hillings & Felice,

1996). After liberalized abortion laws, it was observed that one third of all abortions were being performed on teens, nearly half million per years in 1983. Tiefze and Henshaw (1986) indicated that abortions on young women account for more than 10% of all abortions performed in most countries and they exceeded by 25% in several other countries. Pregnancy and child bearing among adolescents can have grave health and societal risks like obstructed labor, infertility, school dropouts and septic abortion.

As sex associated problems of unwanted pregnancy has become the major concern for both developed and developing countries. An unwanted pregnancy may lead to induced abortion, which in the case of an experienced or ashamed adolescent, & likely to take place later in pregnancy. It involves greater risk of life, health and future fertility. If the procedure is illegal it probably be performed under unsafe conditions, increasing the risk even more. Most unwanted pregnancies among adolescent girls end up in illegal abortion according to a community based study in Addis Ababa in 1983 (Kwast et al., 1986). About (54%) of the maternal deaths in Addis Ababa between 1981 and 1983 were due to complications of illegal abortion.

Thus, sexual activity among youth in Ethiopia, particularly in urban areas results in a large number of unwanted pregnancies and abortions. Eyob et al (1996) found that in Ethiopia from 351 sexually active adolescents, 136 were pregnant while they were under the age of 20. Out of 136 pregnancies, 83% include live births, 2.9% stillbirth, and 7.4% miscarriage and 6.6% induced abortion. Kool and Ahmed (1993) stated that abortion has become the single most important cause of maternal mortality in Addis Ababa. Induced abortion is most frequent among students. Moreover, Kool and Ahmed (1993) reported that in Gonder town and its surrounding 14% of abortions occurred among adolescent students. Filimona and Joyce (1994) reveled 20% of 1674 students of Harar high school encountered unwanted pregnancies and 15% of them have induced abortion. Teweldebrahn (1996) mentioned in his community and hospital based studies in Addis Ababa that about 25% of the deaths that occurred to teenage girls were due to abortion.

2.6. Knowledge of STDs and HIV/AIDS.

The spread of HIV/AIDS among adolescent is a more recent phenomena. In the light of this view, Mengistu (1990) based on a few sero surveys in the Ethiopia observed that the younger age groups of the population are affected by HIV/AIDS. The highest prevalence rate of HIV (20.8%) was recorded between the 15-19 ages.

Furthermore, FGAE (1998) in adolescence survey conducted in Jimma youth cited that the level of knowledge about HIV/AIDS increases with age. The proportion of knowledge of HIV/AIDS was also high among sexually active adolescents. There are also some other research reports revealed a high knowledge of HIV/AIDS than the other STDs among young people in both the developing and developed countries (Solomon1990). General knowledge pertaining of AIDS has no relation to sex, sexual experience or type of department the student was entering. Tilahun (1993) indicated that the knowledge of AIDS among the students of Gonder Medical College was adequate and comparable with the other students of colleges and high schools. Beyene et al. (1997) found that although college students in general are well informed about AIDS, there are gaps in their knowledge of some vital information. A relatively low level of awareness about some vital information of the risk factors and the model of transmission of AIDS was revealed by the study. Accordingly, it will be helpful to know the level of awarness about AIDS among high school students as these are the most affected group.

2.7 HIV/AIDS-SYNDROME IN THE MODERNIZING CULTURE

From the viewpoint of modernizing theory urbanization is understood as a process of change, which carries risks with its good and bad in all walks of life. Especially issues concerning sexual behavior are now taken in to consideration (Douglas, 1992). The cultural crisis of the modern world means destabilizing all aspect of life in economic, social –cultural and political affairs. The crisis is related to the whole system of representations in all societies and even more seriously in the developing countries and undergoing an over-all crisis in front of economic and technological developments. A rapid flow of information as a result of mechanized information technology is an important aspect of globalizations a driver toward

cultural uniformity (Giddens, 1990: 77; Beck et al., 1994:59). As it is often stated, modern cultural uniformity, which is implicitly included in the commercialization of cultural values, leads to a gradual disappearance of culture diversity based on local traditions. The disappearance of local tradition and emergence of global knowledge to control the risks characterizes young people and remains a challenge to the risk for society. This situation is explained more by Giddens (1990:37) as disembodying and breaking down of the local culture because indigenous social values and systems that sustain traditional communities are no longer valued. The cultural crisis of modernism is reflected in both at the generals' level and at the level of individual, societal and sectarian factors affecting highly specific issues such as the HIV/AIDS pandemics syndrome. In this respect, the fundamental reasons for people refute or reservations against the apparently efficient and rational prevention and care system of HIV/AIDS are also cultural and deeply linked to their deepest convictions. In search of better future, modern mobility may result in the following manifestations among other indicators of the crises:

- Migration of young people for socio- economic reasons or violent conflict situations like war, as was the case of Ethiopia, break down people's cultural identity. Like with original family –relation are tending to be broken, resulting in situations of economic, social intellectual and cultural distress.
- Worsening conditions of young women in reproductive age, entailing impoverishment, impossibility to take care of themselves, and their children and being forced in to prostitution (Walakira, 2002).
- Family crisis: divorcer other kinds of separation of spouses, leading to abandonment of young people.
- Loss of moral values,
- Weakening of extended families as source of solidarity systems (Walakira, 2002).

As a common feature, it has been emphasized in many countries' assessments that a complexity of reproductive health problems and particularly the HIV/AIDS issue is beyond its purely epidemiological reality.

This is because HIV/AIDS affects socio- economic and societal systems and cultural phenomena, crippling the development process and causing it to fail from achieving its

intended goals (Panos, 1992). This phenomenon is related to the accelerated disintegration and erosion of people's specific societal embedded ness and resource systems. It seems extremely difficult in many cases to provide reliable opportunities for new socio-economic and societal systems to emerge that allow young people to think and behave in ways that change their life toward sustainable and human oriented goal. Difficulties can be noticed frequently in contexts where the way of life is transforming from rural, traditional, non market- oriented as well as towards industry- oriented global life. Thus the crisis linked to the reproductive health problems including HIV/AIDS syndrome among young people is at the same time a determinant and an effect of the overall economic, societal and cultural crisis at local and global level (Panos, 1992). Another common trend is the insufficient relevance of the current prevention and care system, interfaced with societal/cultural systems and there narrowly designed rational that do not cover all risk area of urban young people migrate to cities, they face multiple difficulties in which they have to adapt to urban life style for survival reasons that HIV prevention intervention may not take in to consideration.

Urban patterns of life for young girl with no financial support may mean increased promiscuity, unwanted pregnancies and sexually transmitted infection including HIV/AIDS as well as uncontrolled population explosion. Another situation is lack of housing in urban area, which means that young people have to live in slums under no hygienic conditions resulting in health hazards. As Claude and Fischer (1982) say, for young people, whether in slums or on the streets, large cities are viewed as the places for getting opportunities especially in matters of education, employment and status of adult life.

Lisa (1995) indicates that governments and organizations in many developing countries including Ethiopia, design actions and programmes for prevention/ interventions which are meant to reduce the incidence of sexually transmitted diseases and provision of treatment to avoid the complications such as infertility but these efforts have not been very efficient. As Lisa (1995) comments, inadequate in planning and in the implementation of the programmes to prevent unwanted pregnancy, sexually transmitted infections and HIV/AIDS has been part of the failure. Furthermore, Lisa (1995) stated that programmes have not been able to provide special training to all health care providers in the prevention, detection and counseling on

sexually transmitted infection especially among women and youth as early as possible. As a result, making use of information, counseling for responsible sexual behavior and effective prevention of sexually transmitted diseases and HIV/AIDS that are integral components of all reproductive and sexual health services have lagged behind. As Niguse et al. (2001) pointed out, prevention programmes fail due to economic reasons, conservative culture and policies in these circumstances which do not allow the promotion and distribution of high quality condoms which should, however be integral components of reproductive health care services. Therefore the endemic of HIV/AIDS remain an unchallenged dilemma in many developing countries as well as in Ethiopia. Thus the idea of safe sex and safe motherhood for young women becomes nearly a dream (Niguse et al., 2001).

According to Doyal (1995:84) the reasons for practicing unprotected sex are:(1) conception cannot combine with safe sex, (2) most Africans want to have large families. Not only the joy of having children is enough as a reason to disregard the advice of using Condoms but there are other cultural and economic factors as well. In a culture that places a high value on family life, and where family size is an issue of gaining status and respect in the community, it may be futile to urge married couples to use condoms. The rejection of using condoms is in the interest of women as well as this behavior is preferred by men because " in many societies, motherhood represents the only route to status, identity and personhood, ultimately security and support in old age" (Doyal, 1995:84). Even if a woman suspects of her husband's infidelity and HIV- positive status, it may still remain in her silenced cultural experiences that she does not request a condom. This is how Doyal put it "unless fidelity is certain, conception cannot be mixed with HIV prevention" (Doyal, 1995:84). Sex is often referred to as a private issue. Counting on a partner's fidelity means that a trust relationship is expected between partners and by trusting the other one takes a health risk. Such kind of risks is invisible in the sense that HIV takes many years after unprotected sex to develop in to AIDS (Beck, 1992:28; Adam et al., 2000:16).

In many societies including Ethiopia, motherhood represents the only way to have a better status and security and support as well as the way to keep a husband or partner from looking for another wife who can give him children. This holds true in Ethiopia even at present. How

can a woman be safe about her own health if she wants to have children to get a status as a wife? According to Bruyn (1992:255) a woman cannot be safe if a man does not agree to use a condom or to have not penetrative sex. As a result, many women feel forced to choose between motherhood and unsafe sex, putting their life at risk. It remains an unresolved paradox in the life of Ethiopian women under age of 20 years. They are facing mortality, as the maternal mortality rates are still as high as 270 to 1400 per 100,000 live births, approximately three to four times higher than for women above the age of 20 (Noble et al., 1996:235).

Furthermore, safe motherhood hampered by complications related to abortion of unwanted pregnancy and childbirth resulting in death account for half a million deaths every year, 99% of them in developing countries (Doyal, 1995:119; WHO, 1994). There are several reasons that contribute to these facts: -1) the age at which women begin or stop childbearing, 2) the interval between each birth, 3) the total number of lifetime pregnancies, 4) illicit abortion due to socio-cultural and economic circumstances in which women live. All these reasons influence the maternal morbidity and mortality (WHO, 1994). According to UN (1997) report, approximately 90% of all countries in the world have policies that permit abortion under varying legal conditions but mostly as based only on the idea to save the life of the mother. In Ethiopia, too, abortion is banned unless it is for medical matter of saving the mother's life. This reasons has also to be determined by the board consisting of three doctors (Assefa, 1992). As a result, significant proportions of abortions are carried out illicitly, sometimes as self- induced or otherwise unsafely done by someone else under unsanitary conditions, leading to a large fraction of pregnant injury or maternal deaths of women.

2.8. THE NEED FOR INFORMATION ON SEXUALITY AMONG ADOLESCENTS

One of the most important reasons why young people are denied adequate access to information, sexual health services and protective resources such as condoms originates from stereotypical and often contradictory ways in which they are viewed as a risk group. It is popularly believed that all young people are risk- taking pleasure seekers who live only for the present. Such views tend to be reinforced by uncritical use of the term adolescent having connotations of "storms and stress" in the specialist psychological and public health literature.

This term tends to homogenize and pathologies our understanding of young people as possessing a series of "gaps"(in knowledge, attitudes and skills, which need to be remedied by adults' interventions (Aggleton and Warwick, 1997:55-67).

Hoffman and Futterman have commented that adults often hold ambivalent attitudes towards young people, viewing them simultaneously as '…small adults and as immature, inexperienced and untrustworthy children' (Hoffman and Futterman, 1996:42-63). Many adults also have difficulties in acknowledging adolescents as sexual beings, and therefore adolescents' sexuality is viewed as something, which must be controlled and restrained. These stereotypes have also influenced much HIV related research and practice with young people.

Warwick and Aggleton (1990:82-122) for example, have described the central images on young people and AIDS to be found in sexual health related literature. These images include the "unknowledgeable or ill informed adolescents", the " high-risk adolescent", the "adolescent who is unduly conforming to peer pressures", and " the tragic innocent adolescent" who inadvertently becomes infected by HIV. All these images describe young people in a negative way. Some adults perceive young people as problematic and believe that they are by their nature sexually promiscuous and that giving them information about sex will make young people even more sexually active (Friedman, 1993:4). As a result, sex education in schools either does not take place or promotes only certain risk reduction measures (most usually abstinence). Yet there is now clear evidence from the western countries, especially in Scandinavia that well designed programmes of sex education, which include messages about safer sex as well as steady sexual partners, have resulted in the decrease in sexually transmitted disease and an increase of contraceptive use among those who are already sexually active (Papp, 1999; Kontula, 2000; Kosunen, 1996). More over, there is evidence to suggest that young who openly communicate about sexual matters with their parents, especially with their mothers, are less likely to be sexually active or (if girls) become pregnant before marriage (Gupta and Weiss, 1995). The truth is that adolescents need appropriate information and services to become responsible citizens. Moreover adults also need information and education to understand the process of changes in adolescence as a normal part of life and be helpful to deal with the changing bodies and mental status of their children.

There are a number of structural and individual factors, which may heighten young people vulnerability to HIV and AIDS. Young people living in developing countries of Asia, Africa and Southern and Central America vary in terms of culture, religion and socio-economic factors, while sharing a number of experiences, which render them particularly vulnerable to HIV infection. Access to education and information is often limited, a level of literacy is low and poverty is prevalent.

Young people living in poverty, or facing the treat of poverty, may be particularly vulnerable to sexual exportation through the need to trade or sell sex in order to survive (WHO, 1998). Young people express the views that sex education begins too late, and there is too little of it (Measor, 2000:123). For example through informal discussion it was learned that many young people in Ethiopia start receiving sex education too late and there is too little of it. They have already informed on sexual matters through peers while some receive information mostly through media and third group have been counseled by parents to be cautions in their sexual relations (Papp, 1999; Kontula, 2000; Kosunen, 1996). They seemed confident in their knowledge and had been co-habiting or had a steady sex partner from their mid teen-age.

On the contrary, from informal discussion with young people in Ethiopia, it was disheartening to hear them express their fear and hopelessness of probable HIV positiveness because they did not get explicit information to take caution and yet they were sexually active at their teen-age. When asked their plan for next ten years they answered by speculating that who will live ten years or more? Thus it is important to note that sex education may be required prior to secondary schooling. Most importantly, by reviewing a number of programmes of sex education for young people, Grunseit (1997) has noted that sex education programs have greatest impact if undertaken prior to the onset of sexually active. What is sexuality education more specifically, as included in family planning and what should the contents of it include? In the following section the review of literature on sexuality education of adolescents in Ethiopia is presented.

2.9. SEXUALITY EDUCATION OF ADOLESCENTS IN ETHIOPIA

The promotion of reproductive health issues has a positive impact on sexual behavior of adolescent in any society, particularly in the literacy program in Ethiopia. Although the consideration of sexual health issues in the school curriculum requires further scrutiny, has been a prevailing reality. Accordingly, when the program was started in the 1980s the idea was attached to population and family life education reproductive health being an implicit part of it. The program was tried out in few secondary schools, and finally it was transformed in to another program to be integrated in all subjects rather than to be given as a specific subject only at this level (Solomon, 1990).

It has often been stated that school programmes about sexuality education and contraceptive in Ethiopia are inadequate. Family life education has been the only wide spread program of adolescents in school. The aim of that program has been to give knowledge and information with out training skills and to advocate abstinence from premarital sex (Solomon, 1990; WHO, 1994). It is also reported that a large number of adolescents have incorrect information about fertility, contraception and sexually transmitted diseases. The lack of clear guidance on how to include sexuality education in the curriculum is a serious problem with a tendency to ignore the topic of sexual education or leaving it at only a nominal level. Appropriate sex education is hardly given or gender stereotypes are used to portray only biased messages (FGA, 1995).

Humm (1989) call this phenomenon the "hidden" curriculum with the meaning that it transmitted to girls a collection of message reinforcing sexual stereotyping and sustaining a sexual division of labor in the social process of schooling. This is further confirmed by feminist theories on a cultural power ideology dealing with symbolic violence, which also includes educational curriculum concerns, and only clearly defined subjects but also hidden agendas. As a result, adolescent people are not able to get correct information and as they mature and become sexually active, especially girls face serious health risks with out having access to health services. As a result they are unable to take responsibility over their own sexuality (WHO, 1990/1994;UNICEF, 1994).

The traditional practice of initiation rites as the way to learn sexuality is now eroding as a result of urbanization in Ethiopia. Youth culture is changing so rapidly that parents are unable to equip their children with proper information. In the 1980s sexuality education in school curriculum seemed unclear because it was given as a component of other subjects such as social or natural science. For example Derebssa points out the importance of sexual health education at school particularly for female pupils. He stated that it has not achieved the goal of reducing the high birth rate and the high number of unwanted pregnancies. He suggested further to make a deliberate effort to include reproductive health and population control education in the curriculum along with HIV prevention, in order to reduce the steadily rising fertility rate and AIDS prevalence in Ethiopia (Derebssa, 1999: 129).

The demand for sexuality education in modernizing urban societies have become crucial everywhere. The demand for action to promote healthy development of young people has never been for urgent than today's urbanizing risk society (Friedman, 1993). Educating young people with essential life skills that enable them to negotiate to make rational and responsible choices to avoid risks sexual behavior remains essential to having a healthy future generation. Furthermore formal education is a basis for reproductive education and health for society.

Generally speaking, no human society is developed with out a formal education system. The role of education has been widely stressed by many researchers. For instance, in generating and transmitting knowledge on worth while values and enhancing the culture to promote labor productivity and the development of human resources, or eventually improving the kind of technology which facilitates reproductive health services for young people and the public at large (Phillips, 1975; Forojalla, 1993). Education has been particularly significant as an instrument of social policy, not only in the sense of policies for welfare but also as policies intended to deal with the changes in the structure of the society. The aim of education is the intellectual development of young people that serves the individual person's capability to achieve her/his fullest potential, including reproductive health. Education is also a method of transmission of social norm and values to young people concerning sexuality and their intimate life. Education serves the industrial process and the economy by producing trained people for the active workforce, and by providing proper sexual education, care and services to children

as well as to old people like in the modern west. By and large, it is considered as a means to bring about the social change hoped for working with parents, teachers, and other in a community to create a more supportive environment for young people who want to change their behavior remains crucial. Expert knowledge, counselors, guidance, and health professionals are the most important actors and aspects for the education of young people. This requires in an adaptation of the African proverb: it takes a village to raise a child." This proverb reflects a conviction that youth need to hear consistent message for all the people who play a role in their socialization.

2.10. FACTORS INFLUCING INDIVIDUAL BEHAVIOUR TOWARDS REPRODUCTIVE HEALTH PROBLEMS

The process of changing behavior and attitudes is not a direct journey. Most people move back and forth, between steps forwards and backwards, some times skipping steps before achieving success toward safe behavior. For instance the use of contraception, and the way people respond to different methods of intervention at different rates is a continuous process (Ragers, 1983). Even when an individual or group adopts new behaviors, they may at times revert to the old habits under certain circumstances like peer pressure. That explains the process involved in to developing a new behavior pattern of using the contraceptive methods in prevention of unwanted pregnancies and sexually transmitted diseases. Thus a person is characterized as: 1) unaware of risks and pre-contemplating, 2) aware having knowledge but contemplating, 3) concerned, 4) knowledgeable and using preventive methods, 5) motivated to change and trying to practice the new behavior and 6) actively practicing the new behavior in a sustained way (Prochaska et al., 1992: 1102-1114).

According to this perspective, factors that are effective for prevention efforts including the development of strategies that require effective communication in vulnerable communities creating enabling environment, policies of community values, modifying the norms, and human rights of young people. Furthermore, youth friendly accessible services and mobilization of community institutions as well as the peer network support positive changes in behavior (Kelly, 1995). A greater interest in the context surrounding individual behavior leads

to an increase in the number of effective education interventions. But the aspect of gender is also important when prevention of unwanted pregnancies and HIV/AIDS is discussed.

Situation of young people are different in urban and rural areas. Males and females behave differently. Some people are physically and mentally challenged. The absence or presence of reproductive health education affects the circumstances and conditions of young people, and in line with this, their facilities are also different. Adolescents from the poor and well to do families may face different challenges and health risks (CEDPA and UNFPA, 1997:11). Some young people have a great deal of sexual experiences while others have none. Adolescents' experiences and problems are influenced by their life situations. Teenagers' concerns are also related to their age. Young men and women just reaching puberty may especially want to learn about menstruation, reproduction, masturbation, wet dreams and sexual orientation. Older adolescents may be more interested in partner relationships and sexual practices. What shape most adolescents regardless of their particular circumstances in the impact of their societies gender- based expectations on their particular circumstances. Estimated values about characteristics, abilities and behavior which are considered ' proper' and 'typical' for women and men, are widely shared (Gilbert and Chomba, 1999). Different institutions like families, schools, religion, the media, advertising, and entertainment carry these values and spell them out. Young men often learn that it is considered masculine to be strong and dominating, not to show emotions, and to exercise authority over women's sexual choices. Young women may learn that females are regarded as more polite and introvert and then expected to be submissive to men in their decision- making (WHO, 1996:6). Culturally, women are considered adults and are expected to take responsibility mainly, if they are married while men can resume adult responsibility even before marriage concerning sexuality.

Because of a pressing need of preventing sexually transmitted diseases including HIV/AIDS epidemic, the Ethiopia government has established in 1987 a national HIV/AIDS control program integrated in the sexually transmitted disease prevention under the ministry of health (MOH, 2000). The governments and NGOs, especially once connected to religious organizations and others international partners, have undertaken several intervention activities. Until July 14,1998 the control program for sexually transmitted disease and HIV/AIDS was

carried out with out policy guidance. The presence of an AIDS policy is believed to create conducive environment for the control and prevention of sexually transmitted diseases and HIV/AIDS (MOH, 2000). It was also reported that the HIV/AIDS control program does not have a well established monitoring and evaluation system or methodology (MOH, 1998). Efforts being undertaken to mitigate the problems are reported to be uncoordinated and poorly targeted (Lisa, 1995). These problems are further compounded by the level of awareness about sexually transmitted infections and HIV/AIDS that is prevalent in a certain community before they can have their desired impact in changing risky sexual behaviors and unsafe health practices. The health care services organized to provide out patients and inpatients' care for the diagnosis and management of sexually transmitted disease including HIV/AIDS must include psychological support for people already infected. Follow up programmes and home cares were founded seriously stretched both in quantity and quality. Thus the health care institutions were reported to overwhelmed by this fast spreading silent AIDS epidemic (Mehret, 1995).

Voluntary HIV counseling and testing were included in the interventions aimed at reducing and controlling the frequency of sexually transmitted infections among the high-risk groups, mainly commercial sex workers and long distance truck drivers including military troops. Other target groups were young people out of schools, people living with HIV/AIDS and migrant male workers. Furthermore, mobilization of internal and external resources and collaboration with international agencies were the main activities of the intervention programmes (MOH, 2000). It can be observed that the objectives have not targeted to deal with young people specifically. Moreover, the program was decentralized to regions during 1993/94 to be more effective. With decentralization the size of the central staff was drastically reduced and weakened. Regions are the implementers of the different activities. Because of the shortage of personnel, some regions lack a local person for preventing HIV/AIDS or the region is too vast for the personnel assigned to it to coordinate all activities (MOH, 2000).

Investment in essential reproductive and sexual health care remains insufficient in Ethiopia and many other developing countries. The absence of a holistic approach to reproductive health issues and missing of such health care for young people especially women and girls, has been observed, the demand being based on human rights. Moreover, women's right to enjoy the

highest attainable standards of physical, social, sexual and mental health throughout the life cycle progress of their sexual health has been constrained (Cleves, 1993). Many poor women encounter barriers to their rights to enjoy good health. The predominant focus of health care systems on treating illness rather than maintaining optimal health also hinders prevention intervention by means of a holistic approach (Panos, 1992; Doyal, 1995).

In some countries, insufficient attention is paid to the social and economic resource to facilitate preventive health (Lisa, 1995). A lack of access to gender- specific health research, and insufficient gender sensitivity in the provision of health information and health services are related to problems of behavioral change affecting the life of young people in Ethiopia (Lisa, 1995). Poverty and underdevelopment continue to affect the capacity of Ethiopia and many developing countries to provide and expand the quality of healthy care. A shortage of financial and human resources, in developing countries is an every day phenomenon. Restructuring of the health sector and/or the increasing trend to privatization of health care systems in some cases has resulted in poor quality and insufficient health-care services. Thus, these issues lead to neglecting the health needs of the most vulnerable groups like young people (Lisa, 1995; Rweyemanu, 1999).

Lack of communication as well as insufficient understanding between young women and men on women health issues makes women's health risky (Rweyemanu, 1999). From my own observation, women who are recipients of health care are frequently not treated with respect; nor their privacy or confidentiality is guaranteed, and they do not receive full information about options and services available. In some cases, workers in health services do not confirm human rights in ethically, professional and gender sensitive ways in the delivery of women's health services .Nor do these professionals ensure voluntary and informed consent to enable their young clients to take responsibility (Doyal, 1995).

Furthermore, sufficient attention is not paid to maternal and emergency obstetric care. There is lack of prevention, screening and treatment for breast cancer or cervical and ovarian cancers for most women in developing countries including Ethiopia (Fathalla, 1992;Doyal, 1995). For actions regarding the health impact on unsafe abortions and the need to have access to

resources to abortion services have not been fully implemented in Ethiopia. This is so because Ethiopia is following a law against abortion unless it is carried out for some medical reasons (Cook and Maine, 1987:339-44). These and other unmentioned factors exacerbate the reproductive health problems, including the AIDS syndrome, among the young people in Ethiopia.

A program for preventing sexually transmitted diseases especially HIV/AIDS can hardly be successful without the participation of community representatives. Furthermore, religious organizations, and other relevant agents should be involved in developing policies for health education to prevent unwanted pregnancies, sexually transmitted diseases and the spread of AIDS. Moreover, school boards, parents, school administrators, teachers, and department heads as well as those working in school heath services, and at the local health department of broadly based community expertise enhances the coordination of various activities with in the compressive school health program (Rweyemanu, 1999). Thus, one can ask why reproductive health problems and particularly HIV/AIDS do; continue to affect the life of young people in Ethiopia.

2.11. CONCEPTUAL FRAMEWORK

In general the sexual health issue is very crucial factor for the adolescents. It may be affected by family background, Parents Attitude towards adolescents' discussion on premarital sexual experience, Parents Occupational Structure, Individual characteristics of adolescents and Institutional factors. All these factors will affect directly and indirectly on the sexual behavior of adolescent. This conceptual framework is adopted from the study of Djamba (1997) on Africa. This frame is adopted in this study in such away that to include some new variables from empirical findings and theories available on the sexual and reproductive health of young people. Based on this conceptual framework, we found that there are many factors that associated with sexual behaviour of adolescents. Hence, sexual experience and contraceptive use are dependent variables in this study. Among various factors influencing dependent variables, only individual level socio economic characteristics, family related variables, peer influence, exposure factors and intermediate variables are considered. Factors like institutional are not considered and treated so that extra efforts should be made to explore the influence of

these factors on sexual behaviour of adolescents. The following description gives detailed relationship towards sexual health issues among adolescents.

Individual Factor
Age, education,
sex, religiosity
Income, living condition

Family Factor
Education
Income
Family size
Parental attitude
Premarital sex
Parent ado disuson

Knowledge About
STDs/HIV/AIDS
Contraception
Attitude toward
Pre marital sex unwanted preg, abortion

Sexual health out comes
Sexual experience
Contraceptive use

Institutional Factor
School
Health institute
Religious organization

Exposure
Substance use
TV/radio
Video/Sex film
News paper/books
Peer influence

Source: Modified from Djamba,K.Yenji(1997)

VARIABLE SPECIFICATION

The variable in the model are :

Dependent variable (Y):-the sexual health out comes such as sexual experience, and contraceptive use

Independent variables: The following variables are specified for as independent variable s under different categories:

Individual factors: Age of individual, sex, religion, religiosity, education, income

Family background: - Parent's education, income, living arrangement, family size, and attitude towards premarital sex and parent adolescent discussion on sexual activity.

Institutional factor: - school curriculum, guidance and counseling services, health institution providing services and religious institution.

Intermediate variable: - knowledge on contraception, HIV/AIDS, Attitude towards premarital sex, exposure to media TV/Radio

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 THE TARGET POPULATION

Based on the nature and purpose of the research problem there is need to define the target population. The target population of this research is the students of high schools in Addis Ababa City.

3.2 SAMPLING TECHNIQUES AND SAMPLE SIZE DETERMINATION

The study used random sampling technique for the selection of sample. There were a total of 70 secondary schools in the city, which are distributed into ten kifeleketemas (sub-cities) according to their geographic location. From each kifeleketema (sub-city), one school selected randomly. The samples of students from the selected schools are taken on the basis of probability proportional to the size of students. The sample thus selected from each grade and gender. Then the total number of sample students determined on the basis of proportionate adolescent students having of premarital sexual experience of adolescents in the city, which was 40%(Eyob et al, 1996).

Thus, sample size $(n) = \frac{Z^2_{\alpha/2} . P . Q}{d^2}$, where P=0.4, Q= (1- 0.4) =0.6

$$n = \frac{(1.96)^2 \times 0.4 \times 0.6}{(0.04)^2} = 576$$

Where $Z^2_{\alpha/2}$ **:** standard normal deviate at the confidence of 95 percent with value 1.96

P: prevalence of sexual activity among adolescents

Q: 1-p

d: degree of precision desired (at 4%)

Thus, the sample size = 576 + 10% of 576 = 634.

Therefore, the approximate sample size is fixed as 600.

3.3 STUDY DESIGN

There were total of 96,571 high school students' in 2003/2004, in the Addis Ababa city. However, the total sample is used about 600 obtained from the method of sample size determination. Then the sample size of each selected school distributed equally to each grade (9-12). The selection of sections in each grade done randomly on the basis of probability proportional to their size, size being the number of section in each selected high schools. Finally the students in selected section are taken randomly. The sample schools are Addis ketema, Dereartutulu, Dagmawmenilik, Bole, Yekatit12, Abyot kirs, Kolfe, Africa kokeb, Ginbot 20, and Wonderad secondary school. Table 1 presents the selected schools, the total student's population in each school and the sample size taken from each of these schools.

Table 1 Name of the sample school with proportional sample size:

No	Name of school's	Kefeleketema (Sub city)	N	%	n
1	Addis ketema Secondary school	Addis ketema	5263	13.0	78
2	Derartu Tulu Secondary school	Akaki Kalit	4121	9.9	60
3	Dagmawi menilk Secondary school	Arada	5777	13.9	83
4	Bole Secondary school	Bole	5475	13.2	79
5	Yekatit 12 Secondary school	Gullelie	4935	11.9	71
6	Abyot Kirse Secondary school	Kirkos	5535	13.3	80
7	Kolfe Secondary school	Kolfe keranio	4991	12.0	72
8	Africa kokeb Secondary school	Lideta	158	0.3	2
9	Ginbot 20 Secondary school	Nefas silk-Lafto	1721	4.1	25
10	Wonderad Secondary school	Yeka	3491	8.4	50
	Total		41,467	100	600

3.4 SOURCE OF DATA

The major source of data was collected from primary and secondary sources. The primary data collected from survey of students in Addis Ababa high school through questionnaire.

3.5 DATA COLLECTION INSTRUMENT (QUESTIONNAIRE)

The major data collection instrument, which used to collect primary data, is questionnaire. When planning the questionnaire, the book of Krista Papp (1997) "knowledge of sexual health issues, moral beliefs, and sexual experiences among adolescents in Estonia and Finland" used

as a model. The questionnaire plans was prepared in English and translated in to Amharic. The translation from English to Amharic necessary to make respondents understood and helped to respond easier. Before printing the final copy of the questionnaire pre-testing arranged in Dagmaw Menilk high school with 30 students. In the pre-test, respondents were asked to complete the questionnaire and identifying questions and difficult questions. Particular attention focuses on the instruction and discussion of the meaning of the answers. The pre-test help in identified question that respondents misunderstand or misinterpret as well as format and design problems of the questions. Based on the pre- test results, some questions that overlook amended and those that redundant and/ or inapplicable to the study area are deleted. Also in some cases check questions are also included to verifying the consistency and reliability of the data and the information.

The questionnaire prepared for the sample students able to explain the purpose of the study to the respondents explicitly enough as well informed about the importance of the study. The respondents persuade to the questionnaire honestly. Confidentiality reaffirm further by having self-filled questionnaire and informing the staff to assist only practically in how to fill the procedures. The questionnaire distributed to the respondents in different class rooms at the school building where each students made to sit separately to fill in order to give his/ her view and to respond or not. These operations support to increase the degree of confidentially and feeling of security about what was answer not exposed to the others.

3.6. DATA PROCESSING AND ANALYSIS

3.6.1 Data entry, cleaning and editing

Data processing is an important part of the whole survey operation. It includes manual editing, coding, data entry, data cleaning and consistency checking. After being collected the answer to the questions are coded as categorized according to predetermined format, of course this process carried through the help of assisting group. In order to make questionnaires suitable for coding and analyzing processes, these again in English the coded data entered in to computer soft ware using SPSS program for analysis. Once the entry is accomplished, cleaning of data and editing employed for checking of whether the assigned value in each case is legitimate,

and logically consistent frequencies of all variables calculated and cross-tabulated between both sexes and different age group by using relevant differentiation like percentages.

3.6.2 Method of Analysis

The appropriate method of data analysis was descriptive statistics (cross tabulation, frequency table, and averages) to describe, the socio economic and demographic characteristics of the respondents and intermediate variable with the dependent variable, chi square test and odds ratio based on bivariate distribution was used to examine the relationship between dependent with selected predictors. In addition the relative risk among response variables with respect to predictors are also used to some unadjusted effects.

The multivariate logistic regression also used to measure the net effects of each predictor after controlling for all other factors. Thus, two multiple regression logistic models are run to analyses the net effect of each predictors entered into model on the dependent variables.

The unit of analysis for logistic regression is these adolescents having sexual experience ever or not. The probability of experiencing sexual intercourse is dictomous (with live out comes) in nature is dependable.

Based on Retherford and Minize. Chaoe (1997) the logistic distribution function for the involvement of adolescents in sexual experience or contraceptive use at the time of sex can be presented as such;

$$P_i = \frac{1}{1+e^{Zzi}} = \frac{e^{Zi}}{\left(1+e^{Zz}\right)} \qquad (1)$$

Where, $\mathbf{P_i}$: is the probability of having sexual intercourse by the respondents and its value lies between 0 and 1.

Z_i is function of (linear combination of explanatory /independent variables, which is expressed by

$$Z_i = \beta_0 + \beta_1 X_{1i} + \beta_{2i} + \ldots + \beta_{n}.X_n \qquad (2)$$

Where $X_1, X_2 \ldots X_n$ are explanatory variables β_0 is intercept and β_i (i =1,2...n) are regression coefficient, is slope which is used in odds ratio to describe the relative change in dependent variable. It is easy to verify that as n ranges from -ω to ω, pi ranges between 0 and 1; and pi is non-linearly related to the explanatory variables, Thus pi is probability of having sexual intercourse and 1-pi is the probability of not having sexual intercourse, and

$$1 - P_i = \frac{1}{1 + e^{Zi}} \qquad (3)$$

$$\text{Therefore, the odds} = \frac{P_i}{1 - P_i} = \frac{1 + e^{Zi}}{1 + e^{-Z}} = e^{Zi} \quad or$$

$$\log_n \left(\frac{P_i}{1 - P_i} \right) = \beta_0 + \beta_1 X_{1i} + \beta_2 X \beta_{2i} + \beta_k \times X_k$$

Now pi/1-pi is the odds of probability that adolescents having sexual intercourse relative to the probability that adolescents would not ever had sexual intercourse.

In terms of odds ratio (exp (β)) is the factor by which the odds of having ever had sex increased/decrease when nth independent variable changed by unit.

In the case of the contraceptive use, the unit of analysis for logistic regression is the using and not using contraceptive methods at the time of sexual intercourse. Thus, the probability of contraceptive use at sexual activity is dictomous (1 if contraceptive used, 0 otherwise). In general, the procedure and formula used for logistic regression of contraceptive uses are similar to the model developed for the sexual intercourse of adolescents.

CHAPTER FOUR

SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE AND PRACTICES

4.1 SOCIO DEMOGRAPHIC DESCRIPTION OF THE RESPONDENTS AND THEIR PARENTS

The empirical analysis is mainly based on the answers to the questionnaires, which were completed by 600 respondents, who represent the three age groups between 14 and 24 years. In over all sample, there were slightly more males (52.3%) than females (47.7%) who participated in the study.

The questionnaire consisted of five main parts which are: -a) the socioeconomic and demographic characteristics of adolescents, b) sexual behavior and practices c) contraceptive knowledge and practices d) sex education and hetro-sexual adjustment, and finally e) knowledge about STD/HIV/AIDS.

The socio demographic characteristics are considered as yardsticks through which this study tries to explain how adolescent perceptions and practice on sexual health issues are understood among the respondents. Accordingly, age, sex, religion, ethnic background, marital status, living condition, family educational level and family income are considered (see Table 4.1).

Table4.1: Proportion of School Adolescents by Major Socio-Economic and Demographic Characteristics, Addis Ababa 2005 (N=600)

Characteristics		Sex					
		Male		Female		Total	
		Count	%	Count	%	Count	%
Sex		314	52.3	286	47.7	600	100
Age	14-16	113	36.0	144	50.3	257	42.8
	17-19	180	57.3	137	47.9	317	52.8
	20-24	21	6.3	5	1.7	24	4.3
	Total	314	100	286	100	600	100
Grade	9th	94	29.9	78	27.3	172	28.7
	10th	87	27.7	91	31.8	178	29.7
	11th	69	21.9	64	22.4	133	22.2
	12th	64	20.3	53	16.5	117	19.5
	Total	314	100	286	100	600	100
Religion	Orthodox	208	66.2	228	79.7	436	72.7
	Muslim	53	16.9	26	9.1	79	13.2
	Protestant	48	15.3	23	8.0	71	11.8
	Catholic	2	.6	3	1.0	5	.8
	Others	3	.9	6	2.1	9	1.5
	Total	314	100	286	100	600	100
Ethnicity	Amhara	153	48.7	159	55.6	312	52.0
	Oromo	49	15.6	39	13.6	88	14.7
	Gurage	76	24.2	46	16.1	122	20.3
	Tigre	22	7.0	30	10.5	52	8.7
	Others	14	4.5	12	4.2	26	4.3
	Total	314	100	286	100	600	100
Martial Status	Unmarried	292	93.0	253	88.5	545	90.8
	Married	7	2.2	11	3.8	18	3.0
	Divorced	3	1.0	9	3.1	12	2.0
	Separated	8	2.5	8	2.8	16	2.7
	Others	4	1.3	5	1.7	9	1.5
	Total	314	100	286	100	600	100
Family Monthly Income	<300	61	19.4	72	25.2	133	22.2
	300-500	85	27.1	98	34.2	183	30.5
	501-1000	84	26.8	55	19.2	139	23.2
	1001-1500	39	12.4	25	8.7	64	10.7
	>1500	45	14.3	36	12.6	81	13.5
	Total	314	100	286	100	600	100
Business Activity	Yes	111	35.4	72	24.8	182	30.3
	No	196	62.4	207	72.7	404	67.3
	Nresponse	7	2.2	7	2.4	14	2.3
	Total	314	100	286	100	600	100

Living arrangement	Motheronly	52	16.6	56	19.6	108	18.0
	Father only	17	5.4	9	3.1	26	4.3
	Mother & Father	130	41.4	146	51.0	276	46.0
	Mother & Step father	5	1.6	11	3.8	16	2.7
	Father & Step Mother	20	6.4	10	3.5	30	5.0
	Relatives	43	13.7	30	10.5	73	12.2
	Guardian	47	14.9	24	8.3	71	11.8
	Total	314	100	286	100	600	100
Father's Education	Illiterate	33	10.5	23	8.0	56	9.3
	Reading & Writing	53	16.9	59	20.6	112	18.7
	Grad 3 – 6	27	8.6	37	12.9	64	10.7
	Grad 7 – 8	39	12.4	31	10.8	70	11.7
	Grad 9 – 12	52	16.6	45	15.7	97	16.2
	12 – Diploma	74	23.6	54	18.9	128	21.3
	Degree & Above	36	11.4	37	11.7	73	12.2
	Total	314	100	286	100	600	100
Mother's Education	Illiterate	66	21.0	67	23.4	133	22.2
	Reading & Writing	59	18.8	53	18.5	112	18.7
	Grad 3 – 6	53	16.9	46	16.1	99	16.5
	Grad 7 – 8	32	10.2	21	7.3	53	8.8
	Grad 9 – 12	54	17.2	44	15.4	98	16.3
	12 – Diploma	38	12.1	47	16.4	85	14.2
	Degree & Above	12	3.8	8	2.5	20	3.3
	Total	314	100	286	100	600	100
Migration Status	Non Migrant	171	54.5	191	66.8	362	60.3
	Migrant	143	45.5	95	32.2	238	39.7
	Total	314	100	286	100	600	100
Continuous Living in Addis	1 – 4Year	19	6.1	14	4.9	33	5.5
	5 – 9 Year	126	40.1	81	28.3	209	34.5
	10+ Year	169	53.8	191	66.8	360	60.0
	Total	314	100	286	100	600	100

4.1. BACKGROUND CHARATERSTICS OF THE STUDY POPULATION

In this section of the study, the socio economic and demographic characteristics of 600 adolescent are prescribed. Further more, adolescents' sexual attitude, belief and experience of sex are discussed.

Table 4.1, shows the major socio-economic and demographic characteristics of the respondents. Approximately 43% of the respondents belong to age group14-16 years, while remaining 52.8% are found in the 17-19-age group and 4.3% in the20-24 age group. Age distribution of adolescents by sex reveals a different trend; about one half of female adolescents are in the prior age group 14-16years. The similar trends, in the percentage were seem for as of all the adolescents. However, a high percentage of female adolescents in the age group 14-16 compared to other ages are observed. Adolescents in the age category of 17-19 years account 57.3% and 47.9% of male and female respectively. About 36% of male and 50.3% of female adolescents are in the age group of 14-16. The remaining 6.3 % of male and 1.7% of female adolescents belong to the age group of 20-24 years. The mean age of the respondents was 17 years. Age can be expected to be very crucial indicator to assess the level of knowledge, attitude and practice about sexuality and use of contraception.

The major religious dominations of the respondents were orthodox, Muslim, and Protestant constituting (72.7%), (13.2%) and (11.8%) in that respective order. About 2.3% were also catholic and others. According to the information of religion, majority of the respondents are orthodox Christians, this group contains 66.2% of males and 79.7% of female respondents, respectively. The second most dominant religion was Islam (13.2%), which constitutes 16.9% of males and 9.1% of females; and fifteen percent of the males and 8.0% of female students are Protestants. Religion can be thought to have an impact on the attitudes concerning sexual behavior. Religious background of the respondents can be hypothesized that in religious community, prevalent values have clear influence on the promotion of sexual health education. In principle, religious background is often assumed as one of the most important factors, when dealing with moral values within which can also be included sexual behaviour. Thus, it could be considered that religion is one of the elements, which forms a strong bond in cultural and moral codes for young people as well as for most adults in any society. It may also influence the attitudes towards sexual behaviour, and sex education of young people in a positive or

negative way. This depends on religious leaders' portrayal of sexual relations as a healthy and natural part of life and educating young people on how to be in safe intimate relations. However, for some religious leaders, educating unmarried young people on how to have safe sexual relations by using condoms may be considered unhealthy, and a way of tempting as well as encouraging them to commit sin safely. Thus it could be a challenge to know how to approach that of benefits that condemn the acts of informing unmarried young people on developing healthy relationships and proceeding towards sexual health in order to prepare them to take responsibility in their future relationships.

Ethnic background can also be expected to have an impact on reproductive health. In the light of ethnic differences, the respondents were asked to identify their ethnic background. In this survey, the majority of the respondents, 48.7% of males and 55.6% of females represent the Amhara ethnic group. The next largest group, (24.2% of males and 16.1% of females), comes from the Gurage ethnic group, while 15.6% of males and 13.6% of females are from the Oromo ethnic group. Seven percent of males and 10.5% of females are from the Tigre ethnic group. 4.5% of males and 4.2% of female respondents represent other ethnic groups. Altogether the Amhara ethnic groups were 52.0% followed by the Gurage ethnic group (20.3%) and the Oromo ethnic group (14.7%). It is often discussed that ethnicity has much less impact on the life of modern people in today's global village than this aspect used to have. However, for people living in developing countries the issue of ethnicity still remains remarkable, and can be even more serious when some conflicting practices and benefits are encouraged around sexuality. In our society, ethnicity is an important factor in determining the different kinds of rituals that take place in everyday life. This aspect becomes especially important as far as the transition from child hood to adult hood is concerned. Sex before marriage is not generally accepted among most ethnic groups. In this case, among those representing Amhara, Gurage, Oromo and Tigre ethnic groups, information about sex is secret. Education on sexuality to the young unmarried boys and girls is not accepted as given by responsible adults like parents.

Regarding the sample of students selected from each grade, 28.7% of students were ninth graders, 29.7% of them were tenth, 22.2% of them were eleventh and 19.5% were from twelfth graders.

The survey included marital status of respondents. At the time of survey it is observed that, only 3% of all, 2.2% of males and 3.8%of females were married. The majority of respondents, 93.0% of males and 88.5% of female respondents reported to be unmarried all in all 90.8%. It is also noted in the above table that 41.4% of males and 51.0% of females live with both parents. Those who live with single parent 22.3% of the total respondents, which constitutes 22.0% of males and 22.7% of females respondents. About 12.2% of the all the respondents consisting of (13.7% of males and 10.5%of female) and 11.8% of total respondents with (14.9% of males and 8.3% of females) were living with others relatives and guardians, respectively.

As regards their parents educational level, 23.6% of male respondents reported their fathers have from twelve grade up to diploma level education, followed by 16.9% who can only read and write; on the other hand, 20.6% of female respondents reported their father can only read and write, followed by 18.9%who responded that their fathers attained from twelve grade up to diploma level of education. Furthermore, 21.0% of male respondents told that their mothers were illiterate and 18.8% said they can only read and write. Similarly 23.4% of female respondents reported their mothers were illiterate, while 18.5% reported that their mothers can only read and write.

Regarding migration status, 54.5% of male respondents and 66.8% of female respondents were non-migrants and the remaining, 45.5% of males and 32.2% of female respondents were migrants from different parts of the country in Addis Ababa. Like wise, staying in the city 53.8% of males and 66.8% of females lived more than ten years in the city, while 40.1%of males and 28.3% of females lived since five to nine years, the remaining 6.1% of males and 4.9% of females were living from one up to four years in the city.

The socio economic and demographic characteristics of parents revealed that 22.2% of all adolescents which constitutes 19.4% of males and 25.2% of female respondents were from those parents who earn less than 300 Ethiopian birr per month, while 27.1% of male 34.2% of female respondents reported their parents earn from 300 to 500 Ethiopian birr per month. The distribution of respondents by activity states shows that 30.3% of all of them (35.4% and 24.8% of females) contributed some type of activity to get some sort of pocket money and more than two third of them, 67.3% (62.4% of males and 77.7% of females) had not (any means of income) engaged in any income generating activity.

4.2. ATTITUDE TOWARDS AND PRACTICE OF SEXUAL ACTIVITIES

Table 4.2.1 Proportion of School Adolescents Perception of Premarital sex by Gender Addis Ababa, 2005.

		Male Count	%	Female Count	%	Total Count	%
Opinion of premarital sex	Agree	65	20.7	17	5.9	103	17.2
	Disagree	242	77.1	267	93.3	509	84.8
	No response	7	2.2	2	.7	9	1.5
Premarital sex help for Marriage Settlement	Agree	38	12.1	18	6.3	56	9.3
	Disagree	271	86.3	262	91.6	533	88.8
	No response	5	1.6	6	2.1	11	1.8

Adolescent' perception on premarital sex will encourage adolescent to involve in sexual activity. It is being argued that traditional family and community support is no longer available or has been unable to cope up with rapidly changing realities in many parts of the world in relation to young adolescents' sexuality (UNFPA, 1998). However there have been endeavors to alleviate the young peoples' problem in the world. Of course, a few years before 1998, school and community based devices and information, education and communication for adolescents were given all over the world including Ethiopia (Nugussie, 1998). Thus, the pattern and level of sexual behaviour and reproductive health information among adolescents, the respondents were asked for their attitude, belief and practice of sexuality. Regarding the opinion of premarital sex adolescents were asked about it the above table reveals that 77.1% of male and 93.3% of female adolescents do not agree of premarital sex. About one fifth of

adolescent male and female however express their agreement for the same subject. Further, adolescents were questioned to understand whether premarital sex help for marriage settlement. It can be seen in table that more than to four fifth of adolescents (86.3%) of male and 91.6 % of female disagree for this. About one tenth of adolescents agreed that premarital sex help for marriage settlement.

Table 4.2.2 Adolescents Perception Towards Family allow for premarital sex by gender Addis Ababa, 2005

		Sex					
		Male Count	%	Female Count	%	Total Count	%
Perception toward their mother allow for premarital sex	Agree	5	1.6	4	1.4	9	1.5
	Disagree	297	94.6	276	96.5	573	95.5
	No response	12	3.8	6	2.1	18	3.0
	Total	314	100	286	100	600	100
Perception toward their Father allow for premarital sex	Agree	7	2.2	14	4.9	21	3.5
	Disagree	286	91.1	264	92.3	550	91.7
	No response	21	6.7	8	2.8	29	4.8
	Total	314	100	286	100	600	100

As can be seen in table 4.2.2, the students were asked about family perception toward their premarital sex. Almost all (95.5%) of respondents reported that their mother did not allow to premarital sex and 91.7% of all respondents gave their disagreement towards the perception of father towards their premarital sex. A sex wise break of respondents on the subject showed that 94.6% of the males and 96.5% of the females and 91.1%of males and 92.3% of females respondents reported to disagreement of premarital sex by their mother and father respectively. Only, 1.5% of which (1.6% of males and 1.4% of females) and 3.5% of which (2.2% of males and 4.9 % of females) of respondents reported their parents having positive attitude towards premarital sex to their children and the rest 3.0% and 4.8% of respondents do not want to respond to the questions. The result indicates that families do not accept premarital sex for their children.

Table 4.2.3 Proportion of School Adolescent attitude, beliefs and behavior towards sexuality Addis Ababa2005

	Attitude toward	Sex				Total	
		Male		Female			
		Count	%	Count		Count	%
	Want to use contraception in the future						
	Yes	268	84.4	226	79.0	491	81.8
	No	17	5.4	27	9.4	44	7.3
	No response	32	10.2	33	11.5	65	10.8
	Total	314	100	286	100	600	100
	Girls should have sex at Least once before marriage						
	Yes	202	64.3	141	49.3	343	57.2
	No	74	23.6	89	31.1	163	27.2
	No response	38	12.1	56	19.6	94	15.7
	Total	314	100	286	100	600	100
	Boys should have sex at least once before marriage						
	Yes	213	67.8	181	63.3	394	65.7
	No	65	20.7	48	16.8	113	18.8
	No response	36	11.5	57	19.9	93	15.5
	Total	314	100	286	100	600	100
	Only bad girls go for abortion						
	Yes	74	23.6	68	23.8	142	23.7
	No	210	66.9	193	67.5	403	67.2
	No response	30	9.6	25	8.7	55	9.2
	Total	314	100	286	100	600	100
	Induce abortion should be made legal						
	Yes	149	47.5	159	55.6	308	51.3
	No	154	49.0	117	40.9	271	45.2
	No response	11	3.5	10	3.5	21	3.5
	Total	314	100	286	100	600	100

Table 4.2.3, shows that the perception of respondents according to the willingness to use contraception in the future or not and this has been cross tabulated between males and females. The results show that 84.4% of the males and 79.0% of the females had positive attitude towards using contraceptive in the future. Altogether, 81.8% of the respondents expressed their interest in using contraception in the future. Male respondents seem to show slightly more positive attitude than females toward the future use of contraception.

Once again, we have to speculate that the result also tells about openness of each gender towards discussing sexual matters.

With respect to the belief that boys/girls should have sex at least once before marriage, has also been examined in this research. There are various beliefs in many countries concerning premarital sexual intercourse. Premarital sexual intercourse for boys is accepted in many traditional cultures though there are some societies, which disapprove sex before marriage both for boys and girls. Hence, beliefs about premarital sexual intercourse were asked in this investigation. The responses are described below. It can be noted that 67.8% of the males and 63.3% of females opted for premarital sex for boys. On the other hand, 20.7% of males and 16.8% of females rejected the usefulness of premarital sex for boys. Altogether 18.8% of the respondents did not accept the idea of premarital sex for boys .It is also remarkable that 15.5% of all respondents did not want to respond as to whether boys should have sex before marriage or not.

A similar question was also asked to assess the views of the respondents on girls' premarital sexual intercourses. Accordingly, 64.3% of males supported premarital sexual intercourse for girls. While almost half 49.3%of females support premarital sexual intercourse for girls. On the other hand, a little less of one third of females 31.1% of females and 23.6% of males opted against premarital sexual practice for girls. Among all respondents, 27.2% of them opted against sexual practice before marriage for both male and female.

The respondents know that abortion is legally and religiously unaccepted in this society, and children are considered ideally as blessings to their parents. Once they become pregnant, they have to born and accept a child as a grace for their family. Breaking taboos means that things are brought in to realistic and clam perspective. Rationality allows an objective way of thinking to increase. Global choices, which are based on this kind of rationality; things are made be reasoning in way that can be applied in all cultures (Mulugata, 2002). To discuss more on abortion as a method of 'contraception' is an ethical issue that this practice may violet or prevent the fetus's right to born alive. On the other hand, abortion is violation of human rights that also include women's rights to decide on their own bodies. Women must allow taking their

own action on such matters that are decisive to their life. It is important to bear in mind that after being raped, many women were reported to be suffering physically, mentally and emotionally, and therefore often asking for justified abortion. Also many feminists have been arguing to liberalize abortion as a women's right, especially in the case of rape. This argument has been taken in to attention in many countries but it is still under a hot debate in most developing countries including Ethiopia. Again, it is an ethical question whether one violates human rights more when aborting a pregnancy resulting from rape or full sex. If a woman has to keep that kind of pregnancy, and the baby is born, it can be expected that the child can have a good life, for instance, through adoption to other parents or with her or his own mother as life can change for the better (Harman1987; Jacobson 19990; 1991).

Mulugata (2002) states that abortion is one of the possible solutions for preventing unwanted children from being born, this solution is not considered ethical either from religious or cultural grounds in most of the religious and ethnic communities in Ethiopia. This is particularly true in the largest religious groups, Christianity and Islam. In this regard, Mulugeta emphasizes the importance of programs that will create a forum to openly discuss how to break the silence on abortion as a solution to unwanted pregnancies.

To elaborate this, the students were asked to show their views on abortion seeking behavior of girls. 23.6% of males and 23.8% of females believed the statements that only bad girls go for abortion. On the other hand, 67.5% of females and little less 66.9% of males' believed that not bad girls go for abortion. While 9.2% of all respondents, which constitutes 9.6% of males and 9.7% of females, said they did not respond to the statements. The result indicates that the belief about "induce abortion should be made legal" was supported by half 51.3% of all respondents. It can be seen that opinions were quite different when seen according to the sex of the respondents. While, 47.4% of males defended this statement, more than half 55.5% of females said yes. Furthermore, 49.0% of males and 40.9% of females who answered "no" defended the opposite opinion. This means that the idea of legalizing the termination of pregnancy was not accepted by 45.2% of the respondents. It can be seen in table that 3.5% of the total respondents did not want to respond whether abortion should be made legal or not.

4.3. PRACTICE OF SEXUAL ACTIVITIES

Table 4.3.1 Proportions of School Adolescents who had experience of sexual intercourse by gender Addis Ababa, 2005

	Sex	Yes Count	%	No Count	%	Total Count	%
Ever had sexual intercourse	Male	139	44.3	175	55.7	314	100
	Female	113	39.5	173	60.5	286	100
	Total	252	42.0	348	58.0	600	100

It was expected in this survey that the respondents are confident to tell the truth when asked about their experience of sexual intercourse. The respondents were further asked to respond to whether they have been engaged in sexual intercourse or not. According to the above table a total of 42.0% adolescents, which constitutes 44.3% of the males and 39.5% of the females respondents admitted in their answers that they have had sexual intercourse. Few more than half of total respondents 55.7% of males and 60.5% of female reported that they had not yet had sexual intercourse. In this study, the starting age for sexual intercourse was also asked; then it was indicated that young people get sexual initiation around the age of 15 for males and 16 for females and fewer girls than boys were also sexually active. Why do girls in lesser numbers report to have been engaged in sexual practice? Ivorsson and Tesfay (1997) give three possible reasons1) girls are shy to admit because of cultural expectation that they are "bad" if sexually active; 2) they fear getting pregnant and dropping out of school; 3) the average age of girls sexual debut is one year later than that of boys. However, it is a demanding issue for those who have already been engaged in sexual intercourse to tell openly in an investigation, even with out a possibility for personal identification, whether they had an intercourse and whether they used contraception or not during the intercourse. Because condom is the most reliable method in avoiding an infection related to sexual intercourse.

Table 4.3.2 Proportion of Adolescent by Reasons for Involving sexual activities by sex Addis Ababa, 2005

	Sex					
	Male		Female		Both sex	
	Count	%	Count	%	Count	%
Reasons for having sex						
Physical pressure	40	28.8	14	12.4	54	21.4
Love Affaire	24	17.3	33	29.2	45	22.6
Keep friends	21	15.1	30	26.5	48	20.2
Forced	-	-	1	.9	1	.4
Got Money	27	19.4	17	15.0	44	17.5
All friends have done	20	14.4	17	15.0	37	14.7
Got married	7	2.2	1	.3	8	3.2
No response	6	1.9	1	.3	7	2.8
Total	139	100	113	100	252	100

As can be seen from Table 4.3.2, the major reason for having sexual experience was love affaire 29.2% for females while physical pressure 28.8% was for male respondents. This is followed by keeping boy friend 26.5% for female and got money 19.4% for males of sexually active respondents. The other reasons to make sexual relation showed equal percentage of respondents 15.0% of females and of male said all friends have done, and 15% of female respondents reported to, get money. There appear different reasons between the two sexes for first sexual contacts.

Table 4.3.3 Proportion of Adolescent by sexual Partner by sex Addis Ababa, 2005

	Sex				Both sex	
	Male		Female		Count %	
	Count	%	Count	%		
Sexual partners						
Boy/girl friend	111	79.9	103	91.1	214	84.9
Causal person	2	1.4	1	.9	3	1.2
Commercial sex worker	6	4.3			6	2.3
Married person	1	.7	5	4.4	6	2.4
Maid servant	4	2.9	2	1.8	6	2.4
Forceful done	2	1.4	1	.9	3	1.2
Others	13	9.4	2	1.8	15	6.0
Total	139	100	113	100	252	100

As shown in table 4.3.3, the sexually active respondents were asked who their first sexual partners were. Accordingly 84.9% of all the respondents, which constitutes 79.9% of males and 83.2% of females reported that they had it with their girl/boy friends. More over, 4.3% of sexually active males admitted having sex with commercial sex workers.

Table 4.3.4 Proportion of school adolescents' by number of sexual partners by gender, Addis Ababa, 2005

Number of Sexual partners	Sex					
	Male		Female		Total	
	Count	%	Count	%	Count	%
Only one	112	80.6	107	94.7	219	86.9
Two to three	13	9.4	4	3.5	17	6.7
Four to five	10	7.2	-	-	10	4.0
Six to seven	1	.7	-	-	1	.4
Above seven	2	1.4	2	1.8	4	1.6
No response	1	.7	-	-	1	.4
Total	139	100	113	100	252	100

As shown in table 4.3.4, the sexually active respondents were asked about the number of sexual partners they had sex with at the time of the study. Accordingly, 86.9% of the respondents (80.6% of males and 94.7% of females) never changed sexual partner since their first encounter, followed by 6.7% (9.4% of males and 3.5% of females) who have two to three sexual partners and 7.2 % of boys respondents have four to five sexual partners. Two of males and females respondents have above seven sexual partners.

Many students acknowledged having concurrent sexual relationship with more than one partner. Male students were more likely than female counterparts to report multiple relationships. That is there is a high statistical significant difference between male and females with regard to the number of sexual partners they had sex with till the time of study

Table 4.3.5 Proportion of School Adolescents by reason for not involved in sexual activity By sex Addis Ababa, 2005

Reason for not having Sexual intercourse	Sex					
	Male		Female		Both sex	
	Count	%	Count	%	Count	%
Religion	10	5.7	3	1.7	13	3.7
Fear of STD/ AIDS	31	17.8	19	10.9	50	14.4
Fear of Parents	2	1.1	2	1.1	4	1.1
Think it is wrong for me	33	19.0	30	17.2	63	18.1
Want wait until married	38	21.8	79	45.4	11	33.6
No desire	21	12.1	17	9.8	38	10.9
No opportunity to get	24	13.8	17	9.8	41	11.8
Others	2	1.1	1	.6	3	.9
No response	13	7.5	6	3.4	19	5.4
Total	174	100	174	100	348	100

The result in table 4.3.5, shows that the major reasons for not having sexual intercourse was a respondent wanted to wait until marriage 33.6% of the total respondents, which constitutes (21.8% of males and 45.4% of females) respondents. About 18.1% of all adolescents claimed, that it is wrong to do. A sex wise break for the same reasons that 17.2% of female and 19.0% of male respondents gave same answer and 14.4% of all respondents reported that by fear of STD/AIDS, which constitutes (17.8%) of males and (10.9%) of female respondents respectively.

4.4.CONTRACEPTIVE USES AND THE RISK OF SEXUAL BEHAVIOR

Table 4.4.1 Proportion of School Adolescent use of condom during first sexual intercourse

	Sex	Yes Count	%	No Count	%	Total Count	%
Use of condom during first sexual Intercourse.	Male	53	37.8	87	62.1	140	55.5
	Female	29	25.8	83	74.1	112	44.5
	Total	82	32.5	170	67.4	252	100

When we examine the patterns and differentials of contraceptive use, males were the most contraceptive users as compared to females at the time of sexual intercourse. The association between sex of adolescents and contraceptive use are statistically significant (p<. 03). Age wise, older adolescents (≥18 years) reported to have used more as compared to those found in early ages (<18 years) with the proportion of 9.8% for less than 18years

old and 90.2% for 18 years and above adolescents, at the time of sexual practice (Table 4.4.2).

In the same table, the trends of contraceptive use rise up for those found living in Addis less than 10 years compared to those living 10 years and more. The association is not statistically significant. Like wise family income has shown insignificant association with contraceptive use. Religious distributions of adolescents have shown significant differentials of contraceptive use, ($p<.02$). Another variable that was found to be significant in chi-square test is the money-spent experience of adolescent. A high proportion of adolescents (66.7%) have spent money for enjoyment and some time they have used contraceptives. The association is statistically significant.

The chi square test depicts that association between discussions of sexual matters with close friends, whether sex films, and having sexual experienced with intimate friends, and contraceptive uses are statistically significant. The rest of predictors have not found association with contraceptive use.

Respondents were asked whether they used of condom during their first sexual intercourse. It was reported by only one third (32.5%) of all the sexually active adolescents (37.8% of males and 25.8% of females) that they had used condom during the first intercourse, while two from three (67.4%) of all the respondents which constitute 62.1% of males and 74.1% of female respondents reported that they have had sexual intercourse and further told that they practiced unprotected sex during their first sexual encounter. This indicates clearly that most of them practiced high-risk sexual behavior endangering both their own life and the life of their partners. It can be expected that in reality the situation was even worse; for instance we can speculate whether they had learnt well enough how to use the condom in proper way. Therefore, it is also interesting to see how the respondents gave reasons about that kind of risky behavior by asking why they did not use contraceptive during their first sexual intercourse. In the following table the reasons given by the respondents for not using condoms are classified.

Table 4.4.2. Chi-square test results of the association between current contraceptive Use at the time of intercourse and some socio-demographic and economic factors of the adolescents, Addis Ababa, 2005.

	Contraceptive Use at the Time of Sexual Intercourse					
Independent Variables	**Yes Count**	**%**	**No Count**	**%**	**χ^2**	**P value**
Sex						
Male	53	64.6	87	51.2	4.057	0.030**
Female	29	35.4	83	48.2		
Age						
<18	74	90.2	158	92.9	.551	.305
≥18	8	9.8	12	7.2		
Living in Addis						
<10 years	42	51.2	71	41.8	1.999	.101
≥10 years	40	48.8	99	58.2		
Living arrangement						
Only one parent	32	48.5	66	50.8	.091	.440
Both parents	34	51.5	64	49.2		
Family income						
<300	17	26.2	45	18.7	.144	.419
≥300	48	73.8	112	71.3		
Religion						
Orthodox	62	75.6	131	77.1	10.078	0.018**
Muslim	8	9.8	28	16.5		
Protestant	12	14.6	8	4.7		
Others	-	-	-	-		
Ethnicity						
Amhara	40	48.8	86	50.6	3.834	.429
Oromo	12	14.6	22	12.9		
Gurage	23	28.0	35	20.6		
Tigre	5	6.1	17	10.0		
Others	2	2.4	10	5.9		
Money spent						
Enjoyment	40	66.7	107	83.6	6.913	.032**
Hand over to parent	13	21.7	130	10.2		
Others	7	11.7	8	6.3		
Discussion of sexual matter with Close fined						
Yes	69	87.3	117	71.3	7.602	0.004***
No	10	65.0	47	28.7		
Going to fun place						
Yes	28	35.0	50	29.4	.791	.228
No	52	65.0	120	70.6		
Have seen sex film						
Yes	70	85.4	163	95.9	8.776	.004***
No	12	14.6	7	4.1		
Intimate fiend who have experience of sex						
Yes	48	59.3	127	74.3	6.200	.010**
No	33	40.7	43	25.3		

Table 4.4.3. Proportion of School Adolescent not using condom during first sexual intercourse by reason and sex, Addis Ababa,2005

Reason not using Condom during first Intercourse	Sex				Total	
	Male		Female			
	Count	%	Count	%	Count	%
Not available	42	48.3	33	39.7	75	44.1
Did not think of it	23	26.4	24	28.9	47	27.6
Not sure to protect STD/AIDS	5	5.7	-	-	5	2.9
Reduce sexual satisfaction	13	14.9	16	19.3	29	17.1
Opposition from partners	1	1.1	8	9.6	9	5.3
Other	3	3.4	2	2.4	5	2.9
Total	87	100	83	100	170	100

The respondents gave many different reasons why they did not use condoms in their first intercourse. It can be observed how 48.3% of males and 39.7% of females reported that "not available" to the time of sex. Furthermore, 27.6% of all the respondents, which constitutes 26.4% of males and 28.9% of female respondents, reported that they did not think of the use of condom at the time of intercourse. Moreover, 14.9% of males and 19.3 % of female respondents reported that the reason for not using condom was their expectation that condom reduces sexual satisfaction. Other reasons not strictly mentioned, were reported by 2.9% of those answering the questions reported due to opposition from sexual partners. Sexual intercourse with out using contraceptive/condom may have the risky results of unintended pregnancy and infections.

4.5.Perceptions about sex education and heterosexual adjustment

Table 4.5.1 Proportion of school adolescents' perception towards sex education introduction, by different opinions and sex, Addis Ababa 2005.

		Sex				Total	
		Male		Female			
		Count	%	Count	%	Count	%
	Approve of Sex education in school curriculum						
	Yes	284	90.4	268	93.7	552	92.0
	No	27	8.6	16	5.6	43	7.2
	No response	3	1.0	2	.7	5	.8
	Total	314	100	286	100	600	100

The significance of sex education in the school curriculum was asked and cross-tabulated between sexes. Almost all of respondents, which constitute 90.4% of males and 93.7% of females, opted for the inclusion of sex education in the school curriculum. All in all, 92.0% of the respondents agreed to the inclusion of sex education (contraceptive information) in the school curriculum and 7.2% of respondents disagreed .The reason may be that they do not want to show their willingness to learn about sexual health so openly because it is against their values and norms that they already have. Clearly such reasons need further elaboration.

Table 4.5.2 Proportion Of School Adolescents' Perception Towards Teaching Sex Education(contraceptive & STDs) by Sex, Addis Ababa 2005.

	Sex				Total Count %	
	Male Count %		Female Count %			
Teaching students about Sex education (contraceptive &STDs) will encourage early sexual intercourse. Yes	57	18.2	47	16.4	104	17.3
No	248	79.0	235	82.2	483	80.5
No response	9	2.9	4	1.4	13	2.2
Total	314	100	286	100	600	100

With regard to the issues of perception about teaching contraceptive method and STDs in sex education as encouraging early sexual practice, respondents had also given different statements related to their perception, attitude, belief and practices of contraception and about whether sexual education will encourage early sexual intercourse; 79.0% of males 82.2% of females, altogether 80.7% respondents responded against the statements; only 17.3% which constitutes 18.2% of male and 16.4%of female respondents reported teaching adolescent about contraceptive /sex education encourages early sexual intercourse

Table 4.5.3. Proportion Of School Adolescents' Perceptions Toward Sex Education And Different Topics included in school curriculum By Sex, Addis Ababa 2005.

Different Topic included in sex education		Male		Female		Both sex	
		Count	%	Count	%	Count	%
Menstruation and ovulation	Important	259	82.5	259	90.6	512	86.3
	Not important	55	17.5	27	9.4	82	13.7
Use of Contraceptive method	Important	241	76.8	205	71.7	446	74.3
	Not important	73	23.2	81	28.3	154	25.7
Unplanned pregnancy	Important	288	91.7	261	91.3	549	91.5
	Not important	26	8.3	25	8.7	51	8.5
Preventive of illegal abortion & rape	Important	269	85.7	253	88.5	522	87.0
	Not important	45	14.3	33	11.5	78	13.0
Sexual transmitted disease including AIDS	Important	287	91.4	264	92.3	551	91.8
	Not important	27	8.6	22	7.7	49	8.2
Developmental psychology	Important	277	88.2	245	85.7	522	87.0
	Not important	37	11.8	41	14.3	78	13.0

Important topics that need to be included in the sex education were asked to respondents. The respondents reported that menstruation and ovulation, use of contraceptive methods, unplanned pregnancy, prevention of illegal abortion and rape, sexually transmitted diseases including HIV/AIDS and developmental psychology are important topic to be included in the sex education of school curriculum. These found to be ranked the percentage point of 86.3%, 74.3%, 91.5%, 87.0%, 91.5%, 87.0%, respectively. Few respondents (13.7%, 25.7%, 8.5%, 13%, 8.2%, 13%)in their respective order reported that such topics are not important and

should not be included in the school curriculum. The respondent may oppose due to their religious background.

4.6.SOURCE OF HIV/AIDS INFORMATION AND PROTECTION MECHANISM

Table 4.6.1.Proportion of School Adolescent About Source of Information on HIV/AIDS by Sex Addis Ababa, 2005

Source of HIV/AIDS information	Sex				Total	
	Male		Female			
	Count	%	Count	%	Count	%
Friends/Peers						
Yes	201	64.1	183	63.9	384	64
No	113	35.9	103	36.1	216	36.0
Family/Relatives						
Yes	135	49.2	152	53.1	287	47.8
No	179	57.1	134	46.8	313	52.2
Mass media						
Yes	294	93.6	273	95.4	567	94.5
No	20	6.4	13	4.6	33	5.5
School AIDS club/teacher						
Yes	182	57.9	180	62.9	362	60.5
No	132	42.1	106	37.1	238	39.6
Health institution						
Yes	225	71.6	238	83.2	463	77.2
No	89	28.3	48	16.7	137	22.8
Religious institution						
Yes	140	44.5	151	52.7	291	48.5
No	174	54.6	135	47.2	309	51.5

As shown in table 4.6.1, the respondents were asked about the source of information on HIV/AIDS to them. The results are cross- tabulated between sexes. The results are as follows: The dominant sources of information on HIV/AIDS for 94.5%, of the respondents which constituted 93.6%of males and 95.4%of females were indicated to be the mass media. Health institution is the second most dominant source of information on HIV/AIDS reported by 71.6% of the males and 83.2% of the females in the study.

While 64.0%of all respondents (64.0% of males and 63.9% of females) reported that they heard about it from their friends. And 60.5% of both sexes got information from their

school AIDS club/teacher. Almost equal percent of respondents have shown family and religious institutions were the source of information on HIV/AIDS. This accounts for 47.8%and 48.5% respectively. This indicates, that there is little discussion between parents and their children regarding sexual matters. This may be because of cultural taboos.

Table 4.6.2.Proportion of school adolescent perception toward preferred source of sexual information by sex, Addis Ababa 2005

Preferred source of Information on HIV/AIDS	Sex					
	Male Count	%	Female Count	%	Total Count	%
Mass media	64	20.3	44	14.0	108	18.0
Family/ parents	49	15.6	63	20.0	112	18.7
Religion institution	34	10.8	20	6.4	54	9.0
School/teacher	60	19.1	56	17.8	116	19.3
Health institution	81	25.7	74	23.5	155	25.8
FGA	13	4.1	18	5.7	31	5.2
Friends	10	3.2	6	1.9	16	2.6
No response	3	.9	5	1.5	8	1.3
Total	314	100	286	100	600	100

Respondents were also asked on their preferred sources of information. The result indicates that the most preferred source of sexual information by both sexes were through health personnel and health institutions, this was from one fourth of respondents. The second most preferred source was the mass media; 20.3% of males, while 20.0% of females preferred the media to their family. While the next preferred source of HIV/AIDS information was from school/ teachers 19.1% of males and 17.8% of females. All in all 25.8% of respondents preferred health institution as source of information. The next preferred source was 19.3% of respondents from schoolteachers and the third preferred source 18.7% of respondents from family. Through health personnel and health institutions were implicated as major preference of sexual information to the students and favored by the majority of the respondents, the practicality of disseminating such information through health institution is questionable, because of the heavy workload on the health staff. The health units are responsible for the provision of various preventive and curative health services; obviously they may not be able to

spend much of their already limited time for young people's reproductive information needs and to ensure the availability and accessibility of contraceptive methods to young people.

Once again, the health institutions are not able to carry the burden of distributing contraceptives and the transmission of information on sexuality to young people with out involving other possible distributors. As a result, young people need also more information on the fact that the official health system cannot afford to carry the burden of reproductive health problems, and especially HIV prevention, in preferred ways. Therefore, to solve the problem of resources, it has been suggested that empowering education and practical training have to be given to voluntary youth leaders for them to help other young people so that they are able to go forward and fight for their life

Table 4.6.3. Proportion of school Adolescents' knowledge of HIV/AIDS and protection mechanism by sex, Addis Ababa 2005.

Protection with HIV/AIDS	Sex								Total			
	Male				Female							
	Yes		No		Yes		No		Yes		No	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
1.Abstinence	251	79.9	63	20.1	237	82.8	49	17.1	488	81.3	112	18.7
2.Use condom	144	45.8	170	54.2	86	30.1	200	69.9	230	38.3	370	61.6
3.Avoid sex with commercial sex worker	132	42.0	182	57.7	89	31.1	197	68.8	221	36.8	379	63.2
4.Avoid blood transfusion	51	16.2	263	83.7	36	12.6	250	87.4	87	14.5	513	85.5
5.Avoid Kissing	56	17.8	258	82.2	48	16.7	238	83.2	104	17.3	496	82.6
6.Avoid mosquitoes	65	20.7	249	79.2	60	20.7	226	79.1	125	20.8	475	79.1
7.Avoid using in common sharp edged materials	242	77.0	72	22.9	235	82.2	51	17.8	477	79.5	123	20.5

As shown in the table 4.6.3, those schools adolescent were asked to describe ways of protection mechanisms not to be infected by HIV/AIDS. The analysis revealed that more than three fourth of respondents 81.3% responded using Abstinence method, which constitutes 79.9% of males and 82.8% of females and the next method which was followed was to avoid

using sharp edged materials in common. The sex wise distribution of responses for that was 77.0% of males and 82.2 % of female respondents. The rate of the use of condom as protection mechanism was higher for males than females, which was 45.8% and 30.1% respectively. This implies that the majority of respondents know the way of avoiding the transmission of the virus.

4.7. CONSEQUENCE OF SEXUAL INTERCOURSE

Table4.7.1. Proportion of school Adolescent Experience of having Impregnated or ever been pregnant and the Results by sex, Addis Ababa, 2005.

No	Adolescent pregnancy	Sex				Total	
		Male		Female			
		Count	%	Count	%	Count	%
	Have you impregnated your partner or Ever been pregnant						
	Yes	10	7.2	19	16.8	29	11.5
	No	119	85.6	86	76.1	205	81.3
	No response	10	7.2	8	7.0	18	7.1
	Total	139	100	113	100	252	100
	The result of pregnancy						
	Normal delivery	-		6	31.6	6	20.7
	Induce abortion	8	80.0	12	63.2	20	69.0
	Spontaneous abortion	1	10.0	-		1	10.0
	Tried to abort but not succeed	1	10.0	1	10.0	2	5.3
	Total	10	100	19	100	29	100

As can been seen in the table 4.7.1, the respondents were asked to respond to the question, have you impregnated your sexual partner or ever been pregnant during first sexual intercourse or not. A total of 11.5% of the respondents, which constituted 7.2% of males and 17.6% of females, reported that they had been pregnant, and 86.2% of males and 79.6% of females reported that they did not face pregnancy during their first sexual intercourse. On the other

hand, 7.1% of sexually active respondents reserved to respond as to whether happen of pregnancy in their first sexual intercourse or not.

The other question raised to respondents was what was the result of pregnancy? 69.0% the respondents, which constituted 80.0% of males 63.2% of females, reported to have terminated the pregnancy through induce abortion. Generally, since abortion is illegal in Ethiopia, except under the most restricted conditions, many young people seem not to have access to terminate an unwanted pregnancy on the safe way. Furthermore, six respondents of females (20.7%) who reported to have been pregnant had normal delivery. While two had tried to abort but they did not succeed and one had spontaneous abortion. This is quite alarming situation in the sense that an urgent response is demanded to know how to proceed to deal with this problem. It seems important to take sexuality education as a compulsory element of the prevention efforts. This situation is also threatening in conditions that expose young people to a high risk of getting HIV/AIDS: a problem which has now become morally, economically, politically and operationally enormous in increasing uncertainty, both in global and local terms. This risk has become a big human challenge. No matter what cultural traditions have to say, whether there are resources or not; empowering young people through early sexuality education at school is a crucial issue in order to have a healthier society at least as far as the result of this study can be relied upon.

4.8 AWARENESS OF STDs OTHER THAN AIDS

Table 4.8.1. Proportion of school adolescent's awareness of STDs by selected characteristics, sign & symptom of STDs by sex Addis Ababa, 2005

No	Awareness of STDs other than AIDS	Sex				Total	
		Male		Female			
		Count	%	Count	%	Count	%
	Have you been infected with STDs other than AIDS? Yes	49	35.5	43	38.0	92	36.5
	No	90	64.7	70	61.9	160	63.5
	Total	139	100	113	100	252	100
	What sign and symptom STDs?						
	Abdominal Pain	1	2.0	1	2.2	2	2.2
	Genital discharge	12	24.5	10	23.3	22	23.3
	Foul smelling	2	4.1	2	4.7	4	4.3
	Burning pain	3	6.1	8	18.6	11	12.0
	Urination	4	8.2	8	18.6	12	13.0
	Genital sores/wars	18	36.7	7	16.3	25	27.2
	Blood in urine	1	2.0	-	-	1	1.1
	No response	8	16.3	7	16.3	15	16.3
	Total	49	100	43	100	92	100

In this survey, respondents were asked about STDs other than HIV/AIDS as a consequence of early sexual intercourse. In this survey, it was also found as a consequences of early sexual intercourses one of the question that was raised to know the prevalence of sexually associated problems was whether they acquired STDs other than AIDS and its symptoms. As observed from table 4.8.1, out of sexually active respondents, 35.5% of males and 38.0% of females reported that they had acquired STDs. All together 36.5% of respondents acquired STDs. The remaining 63.4% respondents, which constitute, 64.7% of males and 61.9% of females reported that they were not infected by STDs during their first sexual intercourse.

Regarding the prevalence of the symptoms for STDs. A total of 27.2% of adolescents, which constituted 36.7% of males and 16.3% of females, reported genital sores/wars as the most commonly encountered symptom and the next common symptom was genital discharge.

Furthermore, out of 23.9% of adolescents, of which 24.5% of males and 23.3% of them are females, reported that they were infected by genital discharge.

Table 4.8.2. Proportion of school adolescent's Treatment of STDs by sex Addis Ababa, 2005

No	Treatment of STDs other than AIDS	Sex				Total	
		Male Count	%	Female Count	%	Count	%
	Did you get treatment?						
	Yes	30	61.2	28	65.1	58	63.0
	No	10	20.4	6	14.0	16	17.4
	No response	9	18.4	9	20.9	18	19.0
	Total	49	100	43	100	92	100
	Where do you go for treatment?						
	Used medication at home	19	38.8	10	20.9	27	30.4
	Pharmacy	2	4.1	5	18.6	15	10.9
	Hospital/clinics	11	22.4	10	34.9	25	28.3
	Traditional healer	4	8.2	1	4.7	6	6.5
	Others	3	6.1	4	-	6	3.3
	No response	10	20.4	13	20.9	13	20.7
	Total	49	100	43	100	92	100

The other question, raised was to know whether the infected adolescent got treatment or not and where to go for a treatment. The results indicated that 61.2 % of males and 65.1% of females got treatment and 20.4% of males and 14.0% of females were not treated at all, the rest 18.4% of males and 20.9% of females did not respond. The majority of infected adolescents 30.4 %, among them 38.8 % males and 20.9 % of females treated themselves by taking medicine at home and few more than a quarter of adolescents went to hospital/clinic for treatment.

CHAPTER FIVE

ANALYSIS AND DISCUSSION OF THE RESULTS

This study attempts to investigate the status of knowledge, attitude, perceptions and beliefs concerning reproductive health and contraception among adolescents studying in Addis Ababa High schools. The framework of study was constructed to cover the problems, which are facing them as they seek information and services on reproductive health. My endeavor was to seek the view of adolescents when solving the problems of prevailing situation. The findings of this research indicate that adolescents in the research area have little knowledge about reproductive health and sexuality because they have limited access to sexual health education and services. The study suggests, parents, teachers and peers need to mobilize themselves to carry out the preventive interventions concerning the reproductive health of their youth. It implies that there is need for further studies for developing effective policy strategies, including improvements in curriculum design.

Altogether, 92.0% of all respondents support the use of contraception and sexuality information to be given at school. On the other hand, few students, (7.2%) respondents were against the use of contraception and sexuality education in the school curriculum. Among the participants in the survey, almost 17.3% of the respondents believed that more information in the school curriculum on contraception and sexuality would encourage adolescents to have early sexual intercourse.

5.1.BIVARIATE STATISTICAL ANALYSIS

5.1.1 Patterns or Differentials in Sexual Experience:- Since adolescent people have diverse group based on their socio economic and demographic characteristics, their sex experience also varied accordingly. Therefore, analysis is performed on the patterns or differentials of sexual experience of adolescent by gender using chi-square tests and odd ratios analysis.

For conducting analysis the dependent variables were sexual experience of adolescents and use of contraceptive during first sexual intercourse, and the explanatory variables are adolescents'

age, their involvement in business activities, family income, continuous living in Addis, and the set of intermediate variables including alcohol taking experience, habit of narcotic, exposure of fun places (such as cinema, bar, night club picnic and restaurants) with close friends, frequent going of fun places, , perception of adolescent to their father towards premarital sex, having close friends who have sexual experiences, discussion of sexual matter with close friends, have boy/girl friend, experience of sex by kissing hugging, touching of sex organ, exposure to film focused with sex, opinion of boys and girls toward sex once before marriage.

The bivariate analysis is used to measure the association between the independent variables and dependent variables. In addition, the risk ratios of predictors on dependent variable with 95% confidence interval are also examined.

Table 5.2.1 shows the differentials in sexual experience by socio-economic and demographic characteristics of adolescents from males and females separately. The livelihoods of sexual practices of adolescents and age of adolescents have positive relations. It was an increase with the increase age of males and girls. It constituted (42.3% Vs 71.4%) for males and (38.4%Vs 100%) of females for ages, < 18 years to 18 years and above. Almost all of female adolescents, practice sex at an older age than male. This may be because of fear of pregnancies and fear of the society's culture (Ivorsson Tesfay, 1997). The chi square test reveals that sexual experience of males or females was highly statistically significance by age. The association is significant at p<. 000

The living conditions of adolescents' have significant association with sexual experience, 58.5% of males who are living with one of their parents and 36.9% of males living with both parents have experience of sex. Similarly 51.2% of females who live with one of their parents have sexual experience compared with 33.6% of them living with both parents who have experience of sex. The associations of living arrangement (conditions) in case of both the males and females have significant associations with sexual experience (p<. 000; males or p<. 01 females). The results show that the close supervision of both parents is an important factor for adolescents to have delayed in early sexual intercourse. The unadjusted odd ratios for boys

who were living with either of the parents was 2.4 times higher compared to those living with both parents. However the odds was 2.0 times higher in case of female adolescents for the similar conditions of living as of males.

Employment or income generating activities is also assumed to have an effect on the sexual activity of school adolescents. For our study group, the pattern seems that those who had been engaged with some business activity prior to survey dates were more likely involved in sexual intercourse (premarital sex) than those who did not become employed. The results show that 68.5%employed Vs 32.1% unemployed among males and 44.6%employed Vs 39.2%unemployed among females were engaged in sexual activity. These differentials by activity states of males and females have significant association with their proportionality to get involved in sexual intercourse activity at $p<.000$ and $P<.05$ respectively.

The unadjusted odd ratios show that 4.6 times higher for involvement of those males in to sexual activities who were doing business activity compared to those males not doing any business activity. Like wise odds ratio is 2.3 times higher for females doing business activity as compared to their counterpart. The results indicate as males involve in business activity, could get money to have for sexual intercourse with commercial sex workers or with his girl friends.

The family income was also found to have positive association with sexual practice of males and females; however, the relation is only statistically significant for girls ($p<.05$). The odd ratios show 2.3 times higher risk of females engaging in sexual activity; those females have higher family income compared to females belonging to lower family income.

One of the variables that is continuous living in Addis Ababa was also significantly associated with sexual experience of males. A high percentage of adolescents involved in sexual activity indicate for those who were continuously living in Addis less than ten years. Those who was born and lived in Addis were more exposed to sexual practices than those living in Addis for more than ten years. It may be the case that those who are found living for few years may be migrant from other places and living with their relatives.

Furthermore, analysis is extended separately to examine the association between the set of intermediate variables and sexual experience of males and females.

Table 5.2.1 Percentage of school adolescents ever had sexual intercourse, and odd ratios (and 95% confidence interval) by selected characteristics by gender Addis Ababa, 2005

Characteristics		Ever had Sexual Intercourse											
		Male						Female					
		Yes %		95% Confidence		$\chi2$	P	Yes %		95% Confidence		$\chi2$	P
				Odd ratios	Lower-upper					Odd ratios	Lower-upper		
Age	<18years	42.3	293	.293	.111-.778	6.729	0.009***	38.4	281	.384	.331-.446	7.791	0.009**
	18+ years	71.4	21	1.00				100	5	1.000			
Living condition	Only one parent	58.5	130	2.409	1.399-4.148	10.235	0.001***	51.2	146	2.074	1.203-3.576	6.981	0.01**
	Both parent	36.9	94	1.00				33.6	86	1.00			
Family average monthly income	<300 Birr	37.7	61	.693	.386-1.243	1.522	.038*	44.6	72	2.339	1.339-4.085	9.116	0.02**
	>300 Birr	46.6	208	1.00				39.2	178	1.00			
Involve in business activity	Yes	68.5	196	4.584	2.780-7.559	37.742	0.000***	44.6	208	2.339	1.339-4.085	9.116	0.02**
	No	32.1	111	1.00				39.2	71	1.00			
Continuous living in Addis	<10 years	51.0	169	1.668	1.064-2.614	5.00	0.017**	42.1	191	1.176	.712-1.940	.401	.306
	10+years	38.5	145	1.00				38.2	95	1.00			

*: <. 05, * *:< .01, * * *:< .0000

Table 5.2.2 Percentage of School Adolescents Ever had sexual intercourse, and odd ratios (and 95% confidence interval) by intermediate and other related factors by gender Addis Ababa, 2005

Variables		Ever had Sexual Intercourse (N=252)											
		Male						Female					
		Yes %	N	95% Confidence Odd ratios	95% Confidence Lower-upper	$\chi2$	P	Yes	N	95% Confidence Odd ratios	95% Confidence Lower-upper	$\chi2$	P
Alcohol drunk	Yes	79.7	64	7.04	3.632-13.66	36.600	0.000***	79.2	48	8.02	3.786-16.974	36.373	0.000***
	No	35.8	246	1.00				32.2	227	1.00			
Habit of narcotic	Yes	93.3	60	28.17	9.87-80.4	70.349	0.000***	100	39	3.35	2.75-4.08	68.377	0.000***
	No	33.2	244	1.00				29.9	231	1.00			
Exposure to fun place	Yes	80.4	107	11.43	6.46-20.24	82.245	0.000***	85.3	102	36.98	18.42-74.2	138.997	0.000***
	No	26.4	201	1.00				13.6	177	1.00			
How frequently go fun place	Few day per week	82.0	89	2.81	0.99-7.89	4.031	0.048**	86.4	81	1.49	.425-5.285	.397	.371
	Frequently	61.9	21	1.00				81.0	21	1.00			
Opinion of sex before marriage	Agree	87.7	65	14.43	6.568-31.69	61.891	0.000***	82.4	17	8.05	2.257-28.70	13.944	0.000***
	Disagree	33.1	245	1.00				36.7	269	1.00			
Perception of adolescent towards father opinion for premarital sex	Agree	85.7	7	7.84	.93-65.95	4.967	0.031**	78.6	14	6.01	1.64-22.08	9.178	.003**
	Disagree	43.4	286	1.00				37.9	264	1.00			
Had sexual experiences of peers	Yes	65.7	143	5.32	3.265-8.66	47.833	0.000***	65.1	126	7.58	4.43-12.96	59.894	0.000***
	No	26.5	166	1.00				19.7	157	1.00			
Have boy /girl friend	Yes	78.6	154	28.52	15.285-53.211	142.475	0.000***	75.7	140	71.71	29.04-177.08	152.143	0.000***
	No	11.4	158	1.00				4.2	144	1.00			

Variables		Ever had Sexual Intercourse (N=252)											
		Male						Female					
		Yes %	N	95% Confidence Odd ratios	95% Confidence Lower-upper	χ2	P	Yes	N	95% Confidence Odd ratios	95% Confidence Lower-upper	χ2	P
Experience of kissing hugging touched opposite sex organ	Yes	92.0	150	0.080	0.046-0.138	244.75	0.000***	99.1	114	0.009	0.001-0.062	255.966	0.000***
	No	-	139	1.00				-	146				
Expose to sex film	Yes	53.1	241	6.337	3.089-12.999	30.18	0.000***	51.2	203	8.64	4.102-18.188	40.209	0.000***
	No	15.2	66	1.000				10.8	83	1.00			
Taking drug during first intercourse	Alcohol/Chat	94.3	35	.532	0.085-3.327	.468	.404	86.7	30	.867	.753-.997	10.261	0.006**
	Did not take	96.9	96	1.00				74.0	74	1.00			
Boy should have sex before marriage	Yes	51.6	213	2.238	1.246-4.017	7.472	0.004***	53.2	181	2.61	1.490-4.568	7.493	0.004***
	No	32.3	65	1.00				30.3	48	1.00			
Girls should have sex before marriage	Yes	51.5	202	2.211	1.264-3.869	7.906	0.004***	53.2	141	2.61	1.490-4.568	11.547	0.001***
	No	32.4	74	1.00				30.3	89	1.00			
Discussion sexual matter with close friend	Yes	51.9	206	2.350	1.336-4.132	9.045	0.002***	45.7	175	1.12	.654-1.928	1.76	.389
	No	31.5	73	1.00				42.9	77	1.00			

: <. 05, * *:< .01, * * *:<.0000

Table5.2.2 shows the bivariate results of dependent variable and a set of intermediate variables. The analyses have indicated a statistically significant relation ship between the dependent variable and 12 of 13 intermediate variables employed for study. For example, almost about equal percent of adolescents 79% who have experienced of alcohol have positive relations with their experience of sexual intercourse The associations are highly statistically significant (p<. 000) for both males and females.

For many adolescents, experimenting with drug, chat, narcotic, and alcohol are highly exposed to unprotected sex. It is being argued that propensity to take risk applied to all sorts of risks and risk behavior is also linked to each other (population Report, 2001). As far as our study population is concerned, those adolescent who had the habit of taking alcoholic drinks were more involved in sexual intercourse activity than their counterparts who had not taken any alcoholic drinks. It was 79.7% of males who took drinks Vs 35.8% of those who did not take. The corresponding percentage for female adolescents was 79.2%Vs 32.2%, respectively. The chi-square statistic revealed that the association between the habit of taking alcohols and involvement in sexual intercourse are highly significant for each sex separately at p< .000 (see table5.2.2). The risk of sexual intercourse experience increases by 7.04 times for those males who experienced drinking than the odds of male adolescents who did not engage in such kind of behavior. Like wise, almost all the other behavior or attitudinal variables have shown significant association (for both sexes) with the experience of sexual activities. The odds of sexual intercourse among male adolescents are higher for those who reported to have had habit of narcotic than those having not habit of narcotic. It was 28 times higher for males and only 3.4 times for females.

The exposure to fun places is also highly statistically significant for males and females sexual experience. For instance, 80.4% of males and 85.3% of females who had exposure to fun places also have experience of sexual intercourse. The odds of risk of sexual intercourse increases by 36.9 and 11.4 times for females and males who had expose to fun places than that of those who had not.

The positive attitude towards premarital sex has also positive impact on the exercise of sexual intercourse for males and females. There are 87.7% of males and 82.4% of females who agreed to premarital sex and have experience of sexual intercourse. The odds results indicate that there is 14.4 times higher risk for males and 8.0 times higher risk for females with positive opinion of sex before marriage as compared to their counterparts.

Similarly, adolescents who have friend of the experience of sexual intercourse are highly significant association for females and males to have sex for them. There were 65.7% of males and 65.1% of females friends to have had experienced of sex have also made sexual relation to them. The odd results show that there is 5.3 times higher risk for males and 7.5 times higher for females compared to those peers with out sex experience. This indicates that there is a high peer influence to motivate and to make sexual intercourse. As the odds results have shown higher risk among males than females may be because of societal bondage for females, and that cultural taboo may be prevailed among males so males discuss sexual matter among their friends freely than that of females.

By and large, the analysis revealed a highly significant association between sexual experience of males and females and most of the intermediate variables showed strong risk. The unadjusted odd ratios have also represented the high and significant risk for the adolescents of both sexes. As the results revealed based on bivariate analysis, and odd ratios shown here give first hand unadjusted risk results, which may not be used for decision-making inferences. Therefore to examine the individual impact of several selected predictors, multivariate logistic regression is used for the purpose to find the individual impact, controlling for the effects of other factors.

5.1.2.Patterns and Differentials in Contraceptive Use: - while looking in to the patterns and differentials of contraceptive use, males were the largest users of contraceptives in the 18 years and above age group as compared to male users of the below 18 years age group. Nearly equal proportions of females (25%) irrespective of their age have used contraception, which also seems to be very low when seen in light of risky sexual behaviour.

Another variable that came out significant in chi square test for males is the discussion of sexual matters with their close friends. The adolescent males who had discussed sexual matters with their close friends were two times significant users of contraceptives compared to their counterparts. Also, the odds ratios is 2.8 for those males who had discussed sexual matters and used contraceptive compared to those males who had not any discussion. The association and risk ratio are found to be statistically significant (p<. 04, see table5.2. 3).

The chi-square tests depict that female adolescent's contraceptive use are significantly associated in the case of money spent for enjoyment and having of exposure to sex film as compared to the their respective counterparts. The associations are significant at p <. 000. Further the analysis was carried out to examine the associations of some of selected variables related to sex attitudes and beliefs with the contraceptive use of all the adolescents.

Opinion of sex before marriage have brought out variations among adolescents in contraceptive use at p<. 000. The unadjusted odds ratios is 7.9 times higher for adolescents who agreed in opinion of having sex before marriage and contraceptive use than those who did not agree for the same.

Perception of adolescent about their fathers' attitudes to allow premarital sex and contraceptive has also significant association between them. For instance, The chi-square test reveals that the association between drinking habit of alcohol intake chat chewing and contraceptive use are further statistically significant (p<. 05); the question regarding the permissive attitude of sex, whether males should have sex at least once before marriage or not was found to be statistically significant with their use experience of contraception at (p<. 00) .The odds ratio analysis also has revealed that males who should have sex at least once before marriage their contraceptive use is found 2.8 times higher than that of males who should not have this type of sex experience.

The significant differentials have also existed in case of female adolescent with contraceptive use and attitude of sex should be at least once or not. The patterns of differentials and their association are statistically significant at p<. 000. Of course, female adolescent students have

used contraception 5.5 times more who had in opinion of sex experience should at least once before marriage compared to those who were not.

Adolescents who had some discussion on sexual matter with their friend have shown strong significant associations with contraceptive use at p<. 000. For adolescents who discussed sexual matters with friends, the odds of using contraceptives is 3.8 times higher than that of their counterparts.

Literacy status of the fathers of adolescent students have brought significant differences among adolescents for using contraceptive at p<. 000.

Table 5.2.3 Percentage of school adolescents' contraceptive use during first sexual intercourse, and odd ratios (and 95% confidence interval) by selected characteristics by gender Addis Ababa, 2005

Variables		Contraceptive use during first Sexual Intercourse											
		Male						Female					
		% Yes	N	95% Confidence Odd ratios	95% Confidence Lower-upper	χ2	P	% Yes	N	95% Confidence Odd ratios	95% Confidence Lower-upper	χ2	P
Age	<18years	35.6	262	.221	0.41-1.184	3.643	0.068	25.9	248	1.050	.105-10.512	0.002	0.725
	18+ years	71.4	20	1.00				25.0	5	1.00			
Ado. Involvement in business activity	Yes	31.2	103	.531	.266-1.060	3.254	0.052	23.4	66	.781	.328-1.860	.313	.369
	No	46.0	174	1.00				28.1	181	1.00			
Money spent	Enjoyment	34.1	126	.613	.243-1.543	1.090	.210	18.5	97	.201	0.064-0.629	8.409	0.006
	Others	45.8	57	1.00				52.9	58	1.00			
Exposure to sex film	Yes	36.0	26	.378	.101-1.406	2.244	.124	22.3	76	.144	0.33-.620	8.479	0.009
	No	60.0	168	1.00				66.7	168				
Discussion sexual matter with close friend	Yes	42.1	199	2.758	.958-7.939	3.741	0.041*:	30.4	162	2.444	0.842-7.092	2.813	0.072
	No	20.8	62	1.00				15.2	71	1.00			
Knowledge of contraceptive method	Yes	38.0	266	1.072	.298-3.85	.011	.594	24.1	240	0.106	0.11-1.060	5.213	0.053
	No	36.4	15	1.00				75.0	13	1.00			
Family average monthly income	<300 Birr	35.7	53	.833	.421-1.651	.273	.364	20.8	64	4.89	.206-1.159	2.689	0.080
	≥300 Birr	40.0	190	1.00				35.0	159	1.00			

*: <. 05, * *:< .01, * * *: <.000

Table 5.2.4 Percentage of school adolescents' contraceptive use, and odd ratios (and 95% confidence interval) by selected characteristics Addis Ababa, 2005

Variables		Contraceptive use					
		Yes %	N	Odd ratios	95% Confidence Lower- upper	$\chi 2$	P
Opinion of sex before marriage	Agree	98.7	79	7.86	1.065-57.970	5.694	.007* * *
	Disagree	90.8	448	1.00			
Adolescent perception towards father views their premarital sex	Agree	55.0	20	.086	.033-.222	38.367	.000* * *
	Disagree	93.5	489	1.00			
Taking drug at first sex	Alcohol/chat	83.9	62	.37	.150-.931	4.738	.031*
	Did not take any	93.5	164	1.00			
Boy should have sex at least once before marriage	Yes	93.6	376	2.785	1.397-5.55	9.059	.004*:*:*
	No	84.0	94	1.00			
Girl should have sex at least once before marriage	Yes	96.7	361	5.509	2.737-11.087	27.286	.000* * *
	No	81.4	140	1.00			
Discussion sexual Matter with friend	Yes	94.7	361	3.764	1.976-7.170	18.082	.000* * *
	No	82.7	133	1.00			
Father literacy	Illiterate	78.8	52	.273	.129-.581	12.757	.002* * *
	Literate	81.4	483	1.00			

*: <. 05, * *: <. 01, * * *: <. 000

5.2.FACTORS DETERMINING THE RISK OF SEXUAL BEHAVIOUR: RESULTS OF MULTIVARIATE ANALYSIS.

As discussed in the previous chapter, a preliminary assessment using cross- tab, odds ratio based on cross tab and chi-square test were performed to determine factors, which are significantly associated with sexual behaviour namely, sexual intercourse and contraceptive (condom) use during first sexual intercourse. However, such simple cross- tabulation may not show the exact association between the dependent and independent variables because the influence of additional variables were not controlled while looking the net effect of independent variable. Therefore, to measure the independent effect of each predictor on dependent variable, a multivariate logistic regression is used for the purpose.

The multivariate analyses are based on two sets of logistic regressions. The regression analyses in the first examine the effects of each predictor separately, which we refer to them as adjusted effect. It is obtained when only considered predictor and dependent variable for entered rule the model. The regression in the second set estimates the effects of predictors on dependent variables controlling the socio economic, demographic and intermediate variables.

Based on the bivariate results, variables that show significant differences in the dependent variables were selected for further analysis. Thus, the subsequent explanations of findings are based on the multivariate results.

5.2.1 FACTORS ASSOCIATED WITH SEXUAL INTERCOURSE/ SEXUAL ACTIVITIES

As can be seen from the chi square test, age of adolescents has significant associations with their sexual intercourse experience. The logistic model reveals the adjusted effect of selected predictors on the sexual intercourse of adolescent (see table 5.5). The results showed that the adjusted effects of all the considered predictors on the sexual intercourse of adolescents are statistically significant at the minimum of $p<.05$. The multiplicative estimates of age suggest variations in the odds of sexual experience for the adolescents in ages less than 18 and 18 years old and above. Accordingly, controlling for the effects of other predictors used in model, the

odds ratio of sexual experience among younger adolescents ages less than 18 years declines to 80% than for the adolescents aged 18 years above.

The business activity status of adolescents is another important variable that was found to be highly significant ($p < .000$) for all the aggregate data. Further, the same table provides the effects of involvement of adolescents in business activity on their involvement of sexual activity. The table indicates that for the adolescents who are involved in any business activity, the odds ratio of their sexual activity is increased by 4.7 times than for those that of not doing any business activity ($e\beta=4.7$). It is one of the out comes of the research question that set out to address the relationship between employment and sexual debut of adolescents.

For the adolescents whose mothers are illiterate, their involvement in sexual activity is significant at level of $p < .027$. The likelihood ratio of sexual involvement is increased by 54% ($e\beta=1.54$) than those adolescents whose mothers are literate.

The income of family is another predictor variable that explains variations in the likelihood of sexual involvement among adolescents. Hence, the multivariate analysis indicates that the odds of sexual intercourse increases by a factor of 1.25 ($e\beta=1.25$) for the adolescent whose family income is less than 300 Ethiopian birr per month compared to other group of adolescents belonging to income group more than 300 birr per month. The level of significance is $p < .05$ for those adolescents whose family income is greater than 300 Ethiopian birr.

Living arrangements of adolescents is one of the social factors, which have made unique contributions towards the involvement of adolescents in to sexual activity. For the purpose, the variable is categorized in to two categories, those who live with both parents and those who live with single parent.

The likelihood of the involvement of adolescents in to sexual activity who live with single parents is increased by 12%($e\beta= 1.12$) than the adolescents living with both the parents and the effect is statistically significant ($p < .05$).

Attitude of adolescents towards premarital sex is another important predictor that explains the variation in the likelihood of sexual involvement among adolescents. Thus, the opinion of adolescents for premarital sex revealed that the adjusted effect of this predictor, i.e. for those adolescents who had permissive attitude towards premarital sex, the likelihood risk of the involvement in to sexual activity is 12 times higher as compared to those adolescent who had less permissive attitude or do not ($e^{\beta} = 11.99$, $p < .000$). It is one of the out comes of research question that set out to address the relationship between attitude toward premarital sex and sexual debut of adolescents.

Having the opinion of boy/girl friends on having sex at least once before marriage is another important predictor that explains the variation in the likelihood of sexual intercourse among adolescents in this study. Multivariate analysis of sexuality of adolescents indicated that the odds of sexual intercourse of adolescents increases by a factor of 2.37 times for those adolescents who have the opinion of boy/girl should have sex at least once before marriage than their counter parts. It is observed that the effects are highly significant (at $P < .000$) after controlling for the effects of other variables. This is an indication of the fact that adolescents who have the opinion of sex at least once before marriage have a high risk of involvement in to sexual behavior and related activities.

The odds of sexual experience among adolescents are significantly associated with the sexual experience of peers (intimate friends) in the study. The multiplicative coefficients of sexual experience for those adolescents who reported to have had sexually experienced intimates is higher by a factor of 6.25 than the odds of those adolescents who reported not to have had sexually active peers (intimates).

The result of multivariate logistic regression assumes that exposure to sex films have significant effect on the risk of involvement into sexual intercourse at $p < .000$. The odds of sexual activity shows that the adolescents who had seen film focused on sex in the past increases by 7.47 times than the odds of their counterparts who had not seen such films, after controlling the effects for other predictors

For both sexes altogether, the risk of sexual intercourse of adolescents increased by a factor 51.23 times for those adolescents who had the habit of narcotic /drinks than of adolescents who did not engage in such type of behavior and the effect is highly significant (p<. 000).

Those young adolescents (both sexes altogether) who reported to have visited fun places had shown adjusted high risk of involvement in sexual activity than their counterparts. The level of significance is at p< .000. The likelihood ratio increased by 18.78 times higher than those adolescents who did not go to the fun places.

Adolescents who have not the awareness of STDs have high risk of sexual involvement than those who have the awareness of STDs. The level of significance is at p<. 01. The odds of sexual involvement of such adolescents is comparatively higher by a factor 1.03 compared to their counterparts.

5.2.3.CURRENT CONTRACEPTIVE USE

Besides to chi square test results, multivariate logistic regression analysis is employed to examine the net effects of the independent variables on the contraceptive use of adolescents at the time of sexual intercourse.

Table 5.2.6 presents the result of multivariate logistic for the contraceptive use of adolescents. The likelihood of contraceptive use was higher among adolescents, who have positive opinion of premarital sex, as compared to their counterparts. The likelihood of contraceptive use was correlated with adolescents' perception towards fathers view for their premarital sex. Adolescents who discuss sexual matters with close friends are more likely to use contraceptives as compared with those adolescents who did not discuses sexual matter with close friend; those adolescents who have the opinion of boy/girls should have sex at least once before marriage are more likely to use contraceptives than those adolescents who did not have such opinion. Adolescents who did not take drug during intercourse have a greater likelihood of using contraceptives as compared to those adolescent who take drug during intercourse.

As can be seen from table 5.2.6, the results of multivariate for those who used contraception. The logistic regression reveals the adjusted effect of selected predictors on contraceptive use. The results showed that the adjusted effects of all considered predictors are statistically significant. For instance, opinion towards premarital sex is statistically significant with the contraceptive use of adolescents at $p < .05$. The odds ratio of contraceptive use among adolescents who had permissive attitude toward premarital sex were found to be 7.78 times higher as compared to the adolescents who were against premarital sex.

Another variable that found significant in multivariate regression the adolescent perception toward father view for their premarital sex. It is also an important predictor that explains the variation in the likelihood of using contraceptive among adolescents whose perception is positive. The odd of contraceptive use of such adolescents is found to be declined by a factor .08 times compared to their counterparts.

Those adolescents whose perception towards boy/girl should having sex at least once before marriage is another important predictor of the effective use of contraceptives. The likelihood odds ratio of contraceptive use was 5.51 times higher for adolescents who have the opinion that girls should have sex before marriage than those who do not have such opinion. The multiplicative coefficient is highly significant ($p<. 000$).

The adjusted effect of contraceptive use by adolescents who have discussed sexual matter with their close friends increased by 3.76 times higher than the adolescents who did not discuss sex matter with their friends. At the same time, the existing effect is highly significant ($p<. 000$).

Those adolescents who reported to have drug before sexual intercourse, had less likely to use contraception than their counterpart in the study. Accordingly, the risk of using contraception decreases by 62.6% for those who took drug at the time of sexual intercourse than their counterpart. The odds ratio is significant at less than 5 percent level ($p<. 035$) (see table5.6).

In general, when other factors are kept constant in multivariate logistic analysis, exposure to sex films, education of parents, business activity of adolescents, income of family and some others, which have associations with current contraceptive use in chi-square test have lost their significance at below 5% significance level in multivariate analysis.

Table 5.2.5. Logistic Regression Result of sexual experience with the socio economic demographic and intermediate Variable

Variable	Adjusted effect			
	β	S.E	Sig	Exp (β)
Age of adolescent				
<18 years	-1.588	.473	.000***	.204
≥ 18 years ^{RC}				
Mother education				
Illiterate	.437	.198	.027*	1.547
Literate ^{RC}				
Family income				
<300 birr	.224	.101	.027*	1.251
≥ 300 birr ^{RC}				
Adolescent involvement in business activity				
Yes	1.54	.192	.000***	4.663
No ^{RC}				
Living arrangement				
One parent	.109	.048	.022**	1.115
Both parent ^{RC}				
Opinion of premarital sex				
Agree	2.484	.337	.000***	11.992
Disagree ^{RC}				
Intimate friend who had sexual experience				
Yes	1.834	.184	.000***	6.258
No ^{RC}				
Habit of narcotic				
Yes	3.936	.519	.000***	51.23
No ^{RC}				
Boy/girl should have sex at least once				
Yes	.863	.229	.000***	2.370
No ^{RC}				
Going to fun place				
Yes	2.933	.223	.000***	18.78
No ^{RC}				
Seen film focused on sex				
yes	2.012	.263	.000***	7.47
No ^{RC}				
Awareness on STDs				
yes ^{RC}				
No	.032	.014	.019**	1.033

5.2.6.Logistic Regression Result of Contraception use With Independent Variable

Variable	Adjusted effect			
	β	S.E	Sig	Exp (β)
Opinion premarital sex				
Agree	2.052	1.015	.043*	7.780
Disagree [RC]				
Adolescent perception toward father view their premarital sex				
Agree	-2.458	.485	.000***	.086
Disagree [RC]				
Taking drug				
Yes	-.984	.465	.035*	.374
No [RC]				
Girls should have sex at least once before marriage				
Yes	1.706	.357	.000***	5.509
No [RC]				
Discussion with sexual matter with close friend				
Yes	1.325	.329	.000***	3.764
No [RC]				

Variable entered in the logistic regression model: opinion of premarital sex, adolescents perception towards fathers view of their premarital sex, taking drug , opinion of boy/girls should have sex at least once before marriage, and discussion of sexual matter with close friends

β= Regression coefficient

S.E= standered error

R.C =reference category

Sig. T =Significance at P≤. 05*, ≤ .01, ≤ .000*****

Exp(β)=exponent of β(0dds ratio)

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this chapter summary and conclusions of the study and relevant recommendations have been presented.

6.1 SUMMARY

In this study, efforts have been made to assess adolescent perceptions on sexual health issues. The purpose of this study is to point out the magnitude of problems and to recommend ways of providing solutions. In order to realize the aim of the study and clearly answer the basic questions, the descriptive survey method was used. Accordingly, to effectively use this method, questionnaires for students were used. To establish the problem well, a variety of related literatures were reviewed. The objective of study is to investigate the perception of adolescents on sexual health issues, to shed light on the problems adolescent face in the field of sexuality among students in Addis Ababa high schools. According to conceptual framework modified from Djamba, K.Yenji socio demographic, knowledge, belief, and attitude of adolescents towards sexual behaviour have relationship with adolescents' practice of sexual contact. Hence, based on conceptual framework and relevant review of literature, possible research questions were designed. In this study, two dependent variables namely, sexual intercourse and use of condom at the time of sex have been considered dependent variables, which are dictomus. Similarly, independent variables are also used in categorical form.

Based on the objectives of the study, attempts were made to answer the basic questions. The outcomes are limited to the sample and population under consideration in this study. Therefore, on the basis of the analysis of the data obtained through the instruments, most important findings of the study are summarized in the following section.

To analyze data, univarate, bivariate (cross tabulation, chi-square, odd ratio) based on cross tabulation and multivariate analysis were applied. To test the out comes of results to research questions, show logistic results of adjusted from have been used.

The results show that almost half of the students (42.3%) have experienced sexual intercourse. When looking at the age of the group of the participants 92.0% of whom are <18 years, the finding is rather high and worrisome. On top of that, the possibility of under reporting should not be forgotten.

Age of sexual commencement of Addis Ababa high school students was lower than many other studies. This early commencement of sex may lead to high rates of unwanted pregnancies and their complications. Since the participants of the survey are at their adolescence, it might be difficult for some to suppress their physiological sexual feeling. This is also supported by the study findings that "natural feeling" and to express love" were the most frequently mentioned reasons for first sexual intercourse.

One third of sexually active adolescents have been pregnant during their first sexual intercourse and almost one third of them have terminated the pregnancy by means of induced abortion. This is alarming because of multiplicity of problems related to pregnancies and infections.

The attitudes can, however, reveal a significant aspect on how their behavior is reasoned. Nearly 94 % of the respondents know one or more method of contraception. However, their knowledge seems very modest when it comes to profound understanding of prevention of unwanted pregnancies and sexually transmitted diseases including HIV/AIDS. Though they are sexually active, their use of contraception seems to be at low level. However, more than half of the respondents have shown interest in the use of contraception and the practicing of safer sex in their future life. It is therefore important to try and convince those responsible for sexual health education that educational programs are meaningful for improving the practical knowledge of young people on how to behave.

Condom and pills appear to be the most commonly used methods among young people Condom was more prevalent among sexually active males, while most females reported using pills and calendar method. And most of the respondents are found to be engaged in unprotected sexual intercourse. The major reason for not using contraceptive/condom during first sexual

intercourse was that it was not available at time of intercourse (44.1%) and the next reason from all respondents (27.6%) was that they did not think of using them. This may be lead to practice of sexual intercourse among most adolescents immediately with out readiness.

The most crucial findings of the study are the prevalence of the practice of high-risk behavior among high school students. In sum, of all the respondents a large proportions of them are sexually active, and 12.7% of them also reported experienced multiple sexual partners, which is the major risk factor for acquiring AIDS in this population.

The survey indicates that the number of female students who have admitted sexual experience is smaller than the number of their male counterparts; this might be explained by different reasons. First, the average age of females may be one year later than that of males, i.e. 16 years, was for males and 17 for females, between the respondent and the female sexual debut. Second, females are probably shy to admit their careless sexual practices. Also, the prevailing moral norms prohibit them from expressing loud that they were as active as the boys in this respect. Third, males at this age are probably more promised to engage in active sexual practice than girls or they may be exaggerating their activity.

According to the results of this study, neither females nor males approve premarital sexual intercourse. Nevertheless, more boys than girls seem to have shown positive attitudes towards having experiences of sexual intercourse before marriage. A total of 42.0% of adolescents had sexual experience. A large number of males has engaged in sexual intercourse than females (44.3% Vs 39.5%) but only 37.8% of males and 25.8 % of females used some type of contraceptive methods during their first sexual intercourse, the one mainly used being the condom. On the other hand, 62.1% of males and 74.1% of females did not use condom during their first sexual intercourse. This evidence indicates that this kind of careless sexual activity without adequate knowledge of contraceptive method can be a dangerous risk, both because of the risk of unwanted pregnancies and also because of contracting sexually transmitted diseases including HIV/AIDS.

In this study, the risk of sexual intercourse of adolescents increased by a factor 51.23 times for those adolescents who had the habit of narcotic /drinks than of adolescents who did not engage in such type of behavior

Adolescents who have exposure to sex films have significant effect on the risk of involvement into sexual intercourse. The adolescents who had seen film focused on sex in the past increases by 7.47 times than the odds of their counterparts who had not seen such films.

Therefore, high school students in Addis Ababa have indicated that risks concerning reproduction health problems including HIV infection and unwanted pregnancies are real. The findings of the current study are comparable to an earlier study. It is evident that students expose to narcotic, alcohol, drug and sex films start to practice sex early and in an unprotected way. As a result, subsequent sexual behavior is characterized by high risks especially when sex is practiced with several partners and condoms are not used or they are used inconsistently.

6.2 CONCLUSION

It is to be assumed that this study suffers from the limitations that are symptomatic of all self-administered questionnaires. In particular because of the fact that the subject matter of investigation, sexuality, and its associated problems are highly sensitive, the social desirability factor is likely to influence such information withdrawal behavior; with an appreciation of this limitation, the results of this study can be concluded with the following points.

1. Study found that young adolescent students in Addis Ababa high schools are sexually active. The proportion of sexually active students was low when compared with the results of studies made in other parts and even in the city. Love affair and physical pleasure were the important factors that precipitated the first sexual encounter. The highest proportion of partnership for the sex performed willingly were students i.e. their boy/girl friend (81.3%) followed by commercial sex workers.

2. In this study, the presence of high risk factors for acquisition of STD/AIDS among adolescents in evident; these factors are having multiple sexual partners, sex with commercial sex workers and failure to have protective sex.

3. The most common source of information on AIDS/STD and contraception are mass media and health institutions. The role of family and school in providing information is limited; even though it is the preferred source by students, an overwhelming majority of students supported the idea of immediate commencement of sex education in the school curriculum.

4. From the results of this study, it can be concluded that adolescents have an incomplete understanding of comprehensive reproductive health knowledge concerning the use of contraception and prevention of sexually transmitted diseases and unwanted pregnancies.

5. Discussion on sexual matters continues to be a cultural taboo for both the adolescents and their parents.

6. The adolescents in this study preferred health professionals and teachers as the primary source of information while according to some other former studies in Addis Ababa, Harar and Jimma town youth prefer peers of the same sex to be the primary source of information on matters of reproductive health. Peers can, however, be seen as an uncertain source because information given by them is not always valid. Attitudes and belief of the youth in this study indicate the town sides of this complicated problem sphere.

7. Disapproval of premarital sexual is an ideal while quite a large number of the respondents admit that they have been engaged in unprotected sexual practices. Among the sexually active young people only few are knowledgeable enough of the means for safe sex.

8. In this study, the risk of sexual intercourse of adolescents increased by a factor 51.23 times for those adolescents who had the habit of narcotic /drinks than of adolescents who did not engage in such type of behavior.

9. Adolescents who have exposure to sex films have significant effect on the risk of involvement into sexual intercourse. The adolescents who had seen film focused on sex in the past increases by 7.47 times than the odds of their counterparts who had not seen such films.

Therefore, the overall conclusion is that the population in general and policy makers and school communities in particular, could no longer continue to ignore the issues of steadily growing and alarming sexual risks facing adolescents. This, therefore, calls for an urgent implementation of prevention programs.

6.3 RECOMMENDATIONS

Based on results and conclusions of this study, and in light of research questions designed, the following recommendations are forwarded.

There is an enormous communication job for health workers to empower adolescents and their parents by equipping them with relevant knowledge through educational information. Not only parents and their children but also religious leaders, representatives of NGOs and community members at large need to develop positive attitudes to acknowledge that adolescents are sexual beings. Adolescents are entitled to have access to education and services and this entitlement is a part of the basic human right to enjoy full health, in both emotional and physical aspects of sexuality. By this way, we can form strategies towards improving sexual health in adolescence. The network of parents, community leaders and professionals such as teacher and health staff could all together enable the youth to charge their risky attitude and practices during adolescence towards a more safe direction. It has already been recommended that culturally appropriate and comparative family life education be initiated for students. Further, it is worth suggested that this kind of education should start during the early year in child's life. Parents,

teachers, religious leaders and heath professionals can play a crucial role at home, in the school, in church/mosques, and in health facilities. This network should cover all Ethiopia and build a sense of responsibility between all partners in this endeavor. This effort should put into practice by all parties (the family, the school system, health workers, and young people themselves) faithfully and responsibly

Immediate and strong efforts should be made by education and policy makers to the institute and integrate sex education into regular teaching learning process. Social institutions such as family, youth clubs and mass media have a supporting role in this regard. The strategies of changing young peoples' sexual behaviors with view of creating sexual values that reduce the risk of AIDS should not be limited to conveying relevant information through the mass media. So the dissemination should be expanded by dramas, cartoons and by distributing pamphlets.

The observed early sexual practices of students could be attributed to their day-to-day interactions among themselves leading to initiation to sexual affairs with their peers. Thus, these students who are at risk with regard to unintended pregnancy and other STI including HIV/AIDS should get information and services by forming family life education clubs with in schools.

High school students are exposed to health hazards through their unprotected sexual behavior and therefore, timely gender specific sexuality education must be made available.

The content of sexual education should include discussion of sexuality, reproduction, menstruation and ovulation, decision making, delaying first intercourse, abstinence, method of contraception, preventing of illegal abortion and its sequel, unwanted pregnancy, and rape. Further more, both female and male students need more lessons about menstrual cycle on the assumption that infrequent intercourse combined with sound awareness of fertile and infertile days factor pregnancies prevention.

Open discussion between parents and their children has to be encouraged. Religious institutions where the moral values are installed in general population have a significant role in

changing the sexual behavior of young people and hence religious leaders should be informed and trained on how to disseminate information on sexuality.

The study suggests that health professionals, teachers, parents and peers need to mobilize themselves to carry out the preventive interventions concerning the reproductive health of their youth. It implies that there is need for further studies for developing effective policy strategies, including improvements in curriculum design.

The government should design ways of controlling production and distribution of pornographic materials and films.

The government seeks the ways of discouraging the use of narcotic and drugs.

Future research would have to investigate longitudinally the problem by considering wide and heterogeneous groups.

List of References

Adam, B. et al (eds)(2000). The risk society and beyond: Critical Issues for Social Theory. Sage, London.

Aggleton, P.(1991). When will they ever learn? Young people. Health promotion and HIV/AIDS social research AIDS care, 3 (3), 259-264.

Ahmed, O.B. et al (2000). The decline in child mortality: a reappraisal. Bulletin of the World Health Organization, 78,10 Geneva.

Andargachew, T. (1994). "Current Situation of Adolescents (Youth) in Ethiopia" paper prepared for the workshop in preparation of National; plan for action for the adolescent health program. A.A. Unpublished Manuscript.

Ary, D. Jacobs, L. and Razavieh. A (1996). Introduction to research in education (5th ed) fort Worth.IX: Harcourt Brace college publishers.

Asnake H. et al (1993). Knowledge, Attitude and practice on HIV/AIDS among pupils of a rural high school in northwestern Ethiopia. A.A

Assefa H (1992) " An overview of the determinants of high fertility in Ethiopia", in Journal of Development Research 14(2),1-30, Ethiopia.

Ayo, A. et al (1991). Adolescent Sexuality and Fertility in Kenya, a survey of Knowledge, Perception and practice studies in Family planning July-Aug 22(4), 205-216.

Beyene. P. et al., (1997). "AIDS and college students in Addis Ababa: A study of knowledge Attitude and Behaviors." Ethiopian Journal of Health Development,11(2), 115-124.

Broadribb,V. (1983). Introductory pediatrics Nursing, 3rd ed. USA, J.P. Lippincott company.

CEDPA/UNFPA .(1997). Assessment of Adolescent Reproductive Health in Ethiopian. Adolescent and Gender project for Sub Saharan Africa ,A.A.

Cernada, G.P. et al (1986). Implication for Adolescents sex Education in Taiwan, Studies in Family planning, 17(4), 181-187.

Chreyl , R.(1990) Parental Responses to Extra Familiar/child sexual Assault, Child Abuse and Neglect,113-120.

Christine, N. (1996). Measuring Access to family Planning Education and service for

young Adults in Dakar, Senegal. Family Health International Dakar, Senegal.

Claude and Fischer (1982). To Dwell Among Friends. Berkeley: university of California Press, USA.

Cleves, M.J (1993) Half the world Half a chance, Oxfam Oxford.

Cook and Maine (1987) 'spousal veto over family planning services'America Journal of public Health, 77 (3), 339-44.

CYAO (1995). Ethiopian youth Basic challenges and Prospects. A.A MOLSA.

David, F. and Chin, F. (1998). Economic and psychological influence of family planning on the lives of women in western Visayas. Final report on women's studies project. Research Triangle Park. Family health International. North Carolina.

Derbessa Dufera (1999). "Population Growth as an Impediments to the realization of universal primary education in Ethiopia." The Ethiopian Journal of Education. Institute of Educational Research, Addis Ababa University.

Debel, s and Eshetu, M. (1998). Reproductive Health and Family planning Needs in hand book on population and family life education for secondary school teachers in Ethiopia. ICDR, DTRC and IDR. Addis Ababa University.

DiClement, R. J and Peterson, J. L. (1994). Preventing AIDS: theories and methods of behavioural interventions, evaluation studies, Journal of Adolescent Health.

DiClemente, R. J., et al (1990). College students' knowledge and attitudes about AIDS and changes in sexual behaviour. Journal of Adolescents Health 12, 232-236.

Diclemente, R. and Wingood, G. (1995). A randomized controlled trial of HIV sexual risk-reduction interventions for Young African- American women. Journal of the American Medical Association, 274 (16), 1271-1276.

Dixon-Mueller, R (1993). The Sexuality Connection in reproductive health studies in Family planning 24(5), 269-282.

Djambo, K.Y.(1997) "Theoretical perspectives of Female sexual Behavior in Africa A review of conceptual model", Journal of African Reproductive Health, Population Research Center 1(2): 67-78.

Dougulas M. (1992) Risk and Blame Essays in cultural Theory. Routiledge, London, New York.

Douglas, G.P. et al (1986). Sexual Behavior Contraceptive Practice and Reproductive

Health Among Nigerian Adolescents: Studies in Family planning, 17(2), pp 100-106.

Dougulas,M. and Wildavisky,A.(1982) Risk and culture, An Essays on the selection of Technological and environmental dangers. Berkeley University, California Press. Doyal, Lesley. (1995). What makes women Sick? Gender and Political Economy of Health. Macmillan Press Ltd London UK.

Encarta (2002) Microsoft Encarta Encyclopedia Standard.

Encyclopedia of Britannica (1982). H. Hemingway Beuton, Fifteenth edition.

Erimias M. (1996) Prevalence and Attitude and Factors Related to sexual Violence Among High school students. Unpublished, MD thesis, AAU. A.A

Elson D. (1995). " Male bias in the development process: an over View' in D. Elson (2nd eds), Manchester University press.

Eshetu, E. and Tadesse, A. (1998). Adolescent Reproductive Health and other Issues in Ethiopia Institute of Curriculum and Development Research. Addis Ababa.

Eshetu, F. et al. (1997). "The Attitude of students, parents and teachers towards the promotion and provision of condoms for adolescents in Addis Ababa," Ethiopian Journal of Health Development, 11 (1), pp 7-16.

Eyob et al, (1996) " A survey of adolescent reproductive health in the city of Addis Ababa" Ethiopian Journal of health development 10 (1) pp 35-40

Fathalla,M.F (1993). The tragedy of maternal mortality in developing countries: A health problem or a human right issue? New on health care in developing countries, 17,4-6

FGAE (1996). A base line survey Report on Knowledge, Attitude and practice of sexuality and Reproductive Health Among Jimma youth Research and Evaluation unit, A.A.

FHI (2002). Women's Voices women's lives the impact of family planning. Family Health.

Filimona Bisrat and Joyce Pickering (1994). "High school students Knowledge Attitude And Practice of contraception in Harar Town." Ethiopian Medical Journal, 32, pp 151-160.

Fishbein M. and Middlestadt, S. J. (1989). Using the theory of reasoned action as a

framework for understanding and changing AIDS- related behaviours. In: Mays et al editors 1992 primary prevention of AIDS: psychological approaches Newbury Park (CA): sage publication.

Forojalla, S.B (1993). Educational Planning for Development, London: St. Martin's Press, SNC.

Fogel, C.N (1990). "Human sexuality and Health care, W.B. Saunders Company, Philadelphia.

Friedman H.L (1993). Overcoming Obstacles to Good Adolescent Health .FHI Network.14 (2), .4. Geneva.

Friedman, H. B. and Ferguson, B. (1995). Adolescent Health: The Need for action, Health care of women and children in developing countries, Wallac, M. Hellen et al (eds), Third party Publishing Company, California.

Fluglesang, M. (1997). ''Lessons for life past and present modes of Sexuality education, in Tanzanian Society.'' Social Science and Medicine, 44(8), 1245-1254.

Gammagew (1995). Women's role in house holds decision-making: a case study in Nigeria, Washington Dc, International Center for Research on women.

Gardiner,C. et al (1998). The sexual and reproductive health of adolescents: A Review of UNFPA program experiences, Technical Report 43, UNFPA New York

Gebeyehu, D. (1970) Survey of problems of Adolescents in Teferi mekonnen Empress, Menen and Menilik High school and the role of Guidance services in this schools HSIU, unpublished senior Essay.

Gebre, S. et al, (1985). Harmful Traditional Practice affecting the health of women and children in Ethiopia, UNICEF/ MOH, Addis Ababa.

Gebreselase. et al, (1985). Harmful Traditional Practice Affecting the health of women and children in Ethiopia, UNICEF/Moe, Addis Ababa.

Giddens, A. (1990). The Consequences of Modernity. Stanford, California: Stanford University Press, UK.

Grant, L.M. and Demetron,E (1988). "Adolescent sexuality". The pediatric clinics of North America. 35 (6), 1271-1287.

Gupta G.R.and Weisse E. (1995). Women's lives and sex: Implications for AIDS

prevention.In parker R.G. and Gagon J.H.(eds) conceiving sexuality: Approaches to sex research in a post modern world, 259-270 Routledge, New York.

Hailemariam, et al. (1998). Reproductive health and family planning in underserved communities in the SNNP regional state of Ethiopia: findings from baseline survey.

Hartigan Pamela (1998):" Gender and health equality" The working Paper in series during two workshops prepared under the Global Health equity Initiative project. Geneva, Switzerland, Also in health series 22 (1) 73-88.

Hatcher, R.A et al (1990). Contraceptive Technology. Adolescent Pregnancy New York, 1990-1992. 15th Revised Edition, 513-544.

Heise L. (1993) violence against women: the missing agenda. In Koblinsky M. Timyan J. ed. The health of women: A global perspective. Boulder. CO: West view Press.

Heise, et al (1994) violence against women: the hidden health burden. World Bank Discussion paper No 255, IBRD/World Bank. Washington DC.

Hilling, W.D and Felice M. (1996). Teenage pregnancy: A Multiracial Sociologic Problem. American Journal of Obstetric Gynee, 155, pp 741-746.

Hirut A. (2000). AIDS: the wild Assailant. Journal of women to women. 5 (3), 22. The British Council Addis Ababa, Ethiopia.

Hoffman, N.D and Futterman,M.D(1996). Youth and HIV/AIDS in J.mann and D. Tarantola (eds) AIDS in the world II: Global dimensions, social Roots and Responses. New York: oxford University Press.

ICPD(1994). Program of Action for International conference on Population and Development, Adolescents, Basis for Action No 7.41,7.43, UN, New York.

Jeppesson, A. (1995). Manual of Maternal and Child Health Care A.A. MOH Artistic Printers.

Jemmott III.J.B., et al. (1992).Predicting intentions to use condoms among African American Adolescents: the theory of planned behaviour. American Journal of Public Health, 280 (19), 1529-1536.

Kelly J.A. (1992) AIDS prevention: strategies that work. The Aids Reader 135-141

Kingslay, D. (1968). The Sociology of Parent-Youth Conflict, American Sociological Review Vol. 5, New York, Johnson Reprint Corporation.

Konjit,K.(1998). Gender Violence in Ethiopia. Human Rights perspective of the practice of female Genital mutilation: paper prepared for the fifth postgraduate courses on right of women, Kampala, Uganda.

Kontula, O. (2000). The Media as sex educator. New Views on Sexual Health. The case of Finland, Lottes. The population Institute. The Family federation of Finland. Publication of the population Research Institute series D 37,2000.

Kools H. and Ahmed Z. (1993). The Ecology of Health and Diseases in Ethiopia 1st Edition Sanfrancisco West view Press.

Kosunen, E.(1996). Adolescent Reproductive Health in Finland: Oral Contraceptives, Pregnancies and Abortions from 1980sto 1990s. Academic Dissertation. University of Tampere. Acta universities Tamperensis set Vol. 486.

Kurth,A. (1993) 'Introduction: an overview of women and HIV disease', in Kurth, A. eds until the cure: caring for women with HIV, New Heaven, Yale university, London

Kwast, B. E. Rochat, R.W, Wudad K.M (1986). Maternal Mortality in Addis Ababa. Ethiopia. Studies in Family Planning, 17, pp 288-301.

Lema U. (1990). "Sexual Behaviour contraceptive practice and Knowledge of Reproductive Biology Among Adolescent Secondary school Girls in Nairobi Kenya." East African Medical Journal, 67, pp 86-94.

Levin, D.N. (1965). Wax and Gold Chicago; the university of Chicago press.

Lewis,H. (1987). Young Women's Reproductive Health survey. New Zealand Medical Journal, 100, pp 490-492.

Lisa, B. (1995) Adolescents Reproductive Health in Ethiopia: An Investigation of Needs, Current policies and Programmes Un published Documents.

Liskin,L. (1985) Health problems of young people: Accidents, Alcohol, Tobacco and Drugs. Population Report Series M. No 9 pp 369-378.

Lotters,I. And Kontula, O.(2000).New views on sexual health, the case of Finland Population Research Institute, Helsinki. Publication of Population Research Institute, Series D37/2000.

Malm, L. (1952). Adolescence. New York; McGram Hill book company.

May, Akathoryn, et al. (1990). Comprehensive Maternity Nursing 2nd edition J.P. Lippincott Company, USA.

Measoe et al.(2000) Young people's Views on sex education Attitude and Behaviour.Routiledge Falmer London.

Meheret et al. (1995). Establishing of the base line survey for the Evaluation of the Ethiopian AIDS control Forecasting, Global program on AIDS, Geneva.

Mengistu, et al. (1999). Follow-up Evaluation of effects of the Ethiopian Evangelical church Mekane Yesus Community Based Reproductive Health Project in Hadiya and KAT zones of SNNPR.Ethiopia

Mesganaw F. Fekadu C. Mesfin L. (1995). "Knowledge, Attitude and Practice of Family Planning Among senior High school students in Northern Gonder" Ethiopian Medical Journal, 33(1) pp 21-29.

Morgan,D.(1992). Discovering men. Routiledge London.

Mother and child health issues (2000). Health and Health Indicator. Ministry of Health Report. Addis Ababa.

MOH (2000). AIDS in Ethiopia. Disease prevention and control department.3rd (eds) Nov-2000,11. Addis Ababa

Molineux Bailey (2003) Sex and the high school student. On line : solveyourproblem.com.19-03-03.

Morris et al. (1999). Social and Sexual Networks: their role in the spread of HIV/AIDS: AIDS education and prevention among Young people,7 (5), 24-25.

Muusa, R. (1996) Theories of adolescents, six edition, McGraw-Hill Companies. New York.

Nega, Berehanue (2001). Economic holocaust. The Impact of HIV/AIDS on Economic sector in Ethiopia. On line http://www.addistribune.com

Nickerson, A. E. C (1990). "Comments on Sexually Active Adolescents and Condoms," American Journal of Public Health, 80(10), pp 1174-1181.

Nigussie, T et al (1999) "Do parents and young people communicate on sexual a matters? The situation of Family life Education in a rural area of Ethiopia." Ethiopia Journal of Health Development, 13 (3), 205-210.

Nigussie, B. (1988). Traditional wisdom and Modern Development Institute of International Education, University of Stockholm No 13.

Ntukula, M. (1997). ' The initiation rite in Z. Tumbo-Masabo and R.Liljestrom eds,

chelewa, The dilemma of teenage Girls, The Scandinavian Institute of African Studies, Uppsala

Nugussie.T(1998). "Sexual activity of out school youths and their knowledge and attitude about STD/HIV/AIDS" in southern Ethiopia

Noble,J. et al(1996) The world's youth population reference Bureau .Washington DC.

Ojwang,S.B.O and Maggwa, A.B.N. (1991). "Adolescents sexuality in Kenya." East African Medical Journal, 68, pp 74-80.

Oladepo,D. Brieger W.K. (1994). "AIDS Knowledge, Attitude and Behavior Patterns Among University students in Ibadan, Nigeria." Africa Journal of Medical Sciences, 23 (2), pp 119-125.

Papp, K. (1997) "Knowledge of sexual issues, moral beliefs, and sexual experiences among adolescents in Estonia and Finland." University of Helsinki Department of public Health, University of Turku, Department of Obstetrics and Gynecology.

STAKES, National Research and Development Center for Welfare and Health Research reports 82. Gumemrus Printing Press.

Panos Institute (1992) The Hidden cost of HIV/AIDS, The challenges of HIV to Department, Panos Institute, London UK.

Petchesky,R. and Judd K. eds. (1998). Negotiating Reproductive Rights: Women's perspectives Across Countries and Cultures, International Reproductive Rights Action group. London: Zed Press.

Phillips, H.M (1975) Basic Education: A World Challenges: Measures and Innovations for Children and Youth in Developing countries, John-Wiley & Sons, London. Pollack, S. (1993). " Masculinity Ideology: Its Impact on Adolescents Males' Heterosexual Relationship." Journal of Social Issues,49 (3), 11-29.

Population Report (1985). Volume XXIII No, 3, series (No 41).

Population Report (2001). Youth and HIV/ AIDS, Can we Avoid Catastrophe, Vol. XXIV, No 3, series (No.12).

Quadrel, M. J. et al. (1993) "Adolescent (In) vulnerability." American Journal of Psychology, 48(2),102-116. Quarterly, 19 (1), 25-40. Quarterly, 63(2), 187-197

Raymond, J and Alan J. (1996). Concise Encyclopedia of Psychology. second edition, John Wiley and sons.

Rehn, E. and Johnson,S.E (2002). Women, war and peace: the Independent Experts' Assessment on the impact of Armed Conflict on women and women's Role in peace- building UN/FEM.

Retherford, R.D., and M.K. Choe (1993). Statistical model for causal analysis, New York: Jone wiley and Sons, Inc.

Rogers,E.M (1981) Diffusion of Innovation, 3rd edition . The Free Press, New York.

Rosenstock, I. M. et al. (1994) the health belief model and HIV risk behaviour change: in Diclemente R.J. and peterston J.L., editors (19994) preventing AIDS theories and Methods of behavioural interventions. Plenum Press. New York.

Rweyemamu, C. (1999) " Sexual Behavior in Tanzania" , In M. Foreman eds AIDS and Men, taking risks or taking responsibility? Panose/ZED, London.

Salttery, H. (2002). HIV/AIDS a call to action, responding as Christians, paulines Publications Kenya.

Scharf and Toole (1992). HIV/ AIDS, the Invisibility of women, Is there a need to redefine AIDS? Feminist Review Journal 42 (3),15-34.

Schwart I.L. (1991). "Sexual Violence Against Women." American Journal of Preventive Medicine, Nov-Dec Vol. 7, Issue 6, pp 363-373.

Seidman,S.N.et.al(1994)."Predictors of high Risks Behavior in unmarried American women: Adolescent Environment as Risk factors", Journal of Adolescent Health 15(2), 126-132.

Senanayake,P.(1984). "Problems of Adolescents' Sex." International Journal of Gynecology Obstet, 22, pp 457-461.

Seyoum Y. and Getahun K. (1988). A six-year Review of Maternal Mortality in Teaching Hospital in A.A, Ethiopian Medical Journal, 26; pp115-120.

SIECUS (1999) Public support for sexuality Educational Researches Highest level: press release on line http://www..siecus.org.

Solomon G. (1990). "Sexual Behavior and Knowledge of Aids and other STDS": A survey of senior high school students." Ethiopian Journal of Health Development. 4 (2) pp 123-131.

Stehr, N.and Ericson, R. eds (1992). The Culture and power of Knowledge. Inquiries in to Contemporary Societies, Walter de Gruyter, Berline.

Olomon, B. (2001). Addis Ababa and the spread of AIDS messages by actual and perceived risk. AIDS Education and prevention, 4(2), 259-269.

Tesfaye S. Sileshi D. and Meseret S. (1993). Contraceptive Demographic and sexual Behaviour of High school students in Jimma, South Western Ethiopia. Jimma. Unpublished Manuscript.

Tewelde Birhan G. (1996). Risk Factors for Adolescent premarital Pregnancy in Awassa, Unpublished Master Thesis AAU. A.A.

The Pai Report Card (2001). A World of Difference Sexual and Reproductive Health and Risks, Population Action International. Washington Dc.

Tietze, C and Henshaw S.K. (1986). Induced Abortion Award Review, 6th (ed). New York, Alan Guthmaner Institute

Tilahun, T. (1993). "College students Attitude and Knowledge of AIDS." Ethiopian Medical Journal, 31(4) pp233-237.

Tsoukas,H. (1992) Postmodernism, Reflexive Rationalism and organizational Studies: A Replay to Martin Parker. Organization studies, 13 (4), 643-649.

Uche, A. et al (1997) "Sexual Activities and Contraceptive Knowledge and use among school Adolescents in Nigeria." International Family Planning Perspective, 23 (10), pp 28-33.

UNFPA (1998). The status of world population. The Right to Choose: Reproductive Right and Reproductive Health. UNFPA, New York.

United Nations (1994). International Conference on Population and Development Chapter VII, Reproductive Rights and Reproductive Health, Cairo.

United Nations (1997) The Right to choose: Reproductive rights and reproductive health. UN Population Fund, New York.

UNAIDS (2000). Sexual Health Education does lead to safer sexual behaviour. Geneva. UNAIDS (2000 b). Report on Global HIV/AIDS epidemic Geneva.

Vance, C. eds (1984) Pleasure and Danger: Exploring female Sexuality, London, Routldege.

Walakira, E.J. (2002) An investigation into commercial sex Exploitation of Children in Mawazo. The Journal of the faculties of Arts & social sciences. Vol.8.No.1 June 2002 Mekerere University Uganda

Whelen, D. (1999). Gender and HIV/AIDS: taking stock of research and Programmes, text written by D. Whelan, UNAIDS best practice collection (UNAIDS/9916E) online. http://www.unaids. Org.

Werner-Wilson (1998) Gender differences in adolescent sexual attitudes: The influence of individual and family factors. Adolescence, 33,519-531

WHO (1992). School Health Education to prevent AIDS and STDs. Geneva.

WHO (1997). Young People and sexually Transmitted Disease. Fact Sheets No, 186, Geneva Switzerland on line: www.undp.org/hiv.

WHO (1996). Female Reproductive Health coverage of maternity care: A listening of available Information. WHO, Geneva.

WHO/ UNICEF (1996). Estimate of Maternal Mortality: A survey Approach by WHO and UNICEF, Geneva.

World Bank. (1993). World Development Report Investment in Health. Oxford University Press New York.

www. Advocates for youth. On line

Zeidenstein, S. and Moore, K. (ed)(1996). Learning about sexuality: Practical Beginning. The population Council, New York.

Appendix – 1
Addis Ababa University
Graduate Studies
Department of Demographic Training and Research Center

The aim of this questionnaire is to gather information on Adolescent perception on sexual health issue among Addis Ababa high school students. In fact, I should make it clear that the questionnaire explores a lot of very personal areas but at the same time I should note that the information planned obtained from you through this questionnaire is very essential to the successful completion of the study. I, therefore, request you to kindly fill in this questionnaire as accurately and carefully as possible.

Regarding confidentially, the whole process of questionnaire administration is set up in such away that utmost secrecy is maintained. To assure this you are not expected to write your name in any of the questionnaire pages. To indicate your response please encircle or put "√ " mark or write your answer on the space provided for the questions that require to give written responses.

Organization of the Questionnaire

This questionnaire has five parts. Part one consists of questions on your background information. The second part deals with sexual behavior. The third part deals with contraceptive knowledge and practices. The fourth part deals with sex education and heterosexual adjustment. The last part deals with knowledge of STDs and HIV/ AIDS.

Thank you in advance.

Part I General Information

101. What is name of your school? ______________________________

102. What is your present Grade? ______________________________

103. Sex Male=1 Female=2

104. How old are you? (Age in completed ________________ years)

105. What is you current Religion?

    Orthodox=1 Catholic=4

    Muslim=2 Others, specify ________=5

    Protestant=3

106. What is you ethnic group

    Amhara =1 Tigre=4

    Oromo=2 Others, specify =5

    Guragie=3

107. What is your Martial Status

    Unmarried=1 Separated=4

    Married=2 Others, specify ____=5

    Divorced=3

108. What is Average monthly income of your family?

    Less than 100 birr =1 1001-1500 birr=4

    100-500 birr=2 More than 1500 birr=5

    501-1000 birr=3

109. Have you attend any business activities to earn your income (pocket money generating parents/others)

    Yes =1 No=2 No response=99

110. If your response in (No109 is yes) in what business activities

    1. Selling cigarettes and chewing gum=1
    2. Parking=2
    3. Polish of shoes=3
    4. Others, specify----------=4

111. Mostly, what do you do with your money?

    Enjoyment of personal affair=1 Other (specify)=3

    Handed over to parents=2 No response=99

112. Mostly, with whom do you live?

    Mother only=1 Mother and step father=5

    Father only=2 Father and step mother=6

    Mother and father =3 Guardian =7

    Relatives=4 Others, specify------=8

    No response=99

113. If do not live with your father or mother what was major reason-------------

114. What is the educational level of your parents?

    12.1Fathers educational level

    Illiterate=1 Grade 9-12=5

    Reading and writing=2 above grade 12 – Diploma=6

    Grade 3-6 =3 Degree and above=7

    Grade 7-8=4

12.2 Mothers educational level

Illiterate=1	Grade 9-12=5
Reading and writing=2	Above grade 12 – Diploma =6
Grade 3-6 =3	Degree and above=7
Grade 7-8=4	

115. Were you born in Addis Ababa?
Yes =1 No=2 No response=99
116. If No., where you born?
In rural area =1
In a small town (Population < 10,000)=2
In medium town (Population > 10,000)=3
In large town (Population > 50,000)=4
117. How long have you been living continuously in Addis? -------------------Years?
118. Did you take any alcohol drinks in the last 4 weeks?
Yes=1, No=2, No response=99
119. If yes how frequently you take alcohol?
Daily =1, A day per week=2, more than a day per week=3
Other=4, No response=99
120. Did you have a habit of taking any "Narcotics?"
Yes=1, No=2, No response=99
121. If yes, mention the name of them?

	Yes	No	No Response
Chat	1	2	99
Cigarette	1	2	99
Pipa/ 'Shisha'	1	2	99
Others	1	2	99

122. Did you go with your friends (both sexes) to cinema, picnics, restaurants, video parlors; bars and discotheques?
Yes=1, No=2, No Response=99
123. If yes, how often did you go any of these places in the past?
One to four times per months=1 Others, (specify) =4
More than four times per months=2 No Response =99
A few day per year=3

Part II Sexual Behavior

201. In your opinion school adolescent students should not have sex before marriage
Agree=1, Disagree=2, No response=99
202. In your opinion premarital sex is all right for adolescents planning to get married
Agree=1, Disagree=2, No response=99
203. In your opinion what do your mother feel about young adolescents having sex before marriage
Agree=1, Disagree=2, No response=99
204. In your opinion what do your father feel about young adolescents having sex before marriage
Agree=1, Disagree=2, No response=99

205. Did you have intimate friend who has/have started sexual intercourse?
Yes=1, No =2, No response=99

206. Did you have boy/girl friends?
Yes=1, No =2, No response=99

207. If yes, have you experienced kissing, hugging touching or being touched sex organs of opposite sex
Yes=1, No =2, No response=99

208. If yes, how old were you when you had any of these experience?______________

209. Have you ever had sexual intercourse?
Yes =1, No=2, No Response=99

210. How old was your first sexual intercourse partner?__________________

210. What was the highest grade when started sexual intercourse=__________________ grade

211. If yes age of your first sexual contact __________________

212. Who was your first sexual partner?
Finance/steady boy/girlfriends=1, uMaid servant=5,
Causal person=2, Forceful done=6,
Commercial sex worker=3, Others(specify)=7,
Married person=4 , No response=99

214 What was your main reason for sexual intercourse the first time you had it?
Physical pleasure=1 To get money=5
Love affairs=2 Because of all friends were doing it=6
To keep my boy friends/girl friend =3 Got married=8
It was forced=4 Others, specify=_____________
No response=99

213. How many different partners have you ever had intercourse with your life?
Only one=1, two to three=2, four to five=4,
six to seven=5, above seven=6, I couldn't remember=88,
No response=99

214. Have you seen or saw any films or magazine that focused on sex?
Yes=1, No=2, No response=99

215. If yes, explain them

	Yes	**No**
Romance books/magazines	1	2
Video parlors/cinema	1	2
Pornography	1	2
Love affairs transmitted on Radio/TV	1	2
Others (specify)	1	2
No Response	99	-

216. Did you use the following drugs during your first sexual contact?
I used only alcohol =1 I didn't use any drug =4
I used only chat=2 Others, specify _____=5
I used both alcohol and chat= 3 No response=99

217. Have you impregnated your sexual partner or ever been pregnant?
Yes=1, No=2, No response=99

218. If yes, what was the result of your pregnancy?
Gave birth to a baby=1 Tried to above but not succeeded=4
Induced abortion =2 Gave birth to a dead baby (still birth)=5
Had spontaneous abortion =3 Others, specify _____________=6
No response=99

219. If it was unwanted, what happened to you as a result of it.
Left school =1 Separated from the family=5
Quarreled with parents=2 Got marred=6
Was ashamed of it=3 Others, specify _______=7
Attempted suicide=4 No response=99

220. Boys should have sex at least once before marriage
Yes =1 No=2 No response=99

221. Girls should have sex at least once before marriage
Yes =1 No=2 No response=99

224. Only bad girls to for abortion
Yes =1 No=2 No response=99

225. Induced abortion should be make legal
Yes =1 No=2 No response=99

226. Are you interested to use contraception in the future?
Yes=1 No=2 No response=99

227. Do you ever discuss sexual relation with your close friends?
Yes =1 No=2 No response=99

228. Did you use any means of protection to avoid unwanted pregnancy when you first entered into sexual union.
Yes =1 No=2 No response=99

229. If you use (see no 51 above) what kind of method
Condom=1 Both of the above=3
Sex with only one partner=2 Others, specify ____=4
No response=99

230. Do you know about any contraceptive method?
Yes =1 No=2 No response=99

231. What is your attitude towards premarital sex
It is good=1
It is good if the couple plan to many=2
It is good whether the couple plan to marry or not=3
It is not good=5
Others, specify ____=6
No response=99

232. Have you never had sexual intercourse, so what is the main reason for you not to have had sexual intercourse

Fear of STD/AIDS=1
Fear of parents =2
Want to wait until married=3
Think it is wrong for me=4
No desire=5
No opportunity to get afraid who fits me=6
For religious reason=7
Other, specify _________ =8
No response=99

233. Point out the sources of sexuality information
Mass media=1
Family or parents=2
Religious institution=3
School/teacher =4
Friends/peers =5
Health institutions=6
Familyguidance ass.=7
Others, specify _____ =8
No response=99

234. Number the sources of sexuality information according to your preferences
Mass media=1
Family or parents=2
Religious institution=3
School/teacher =4
Friends/peers =5
Health institutions=6
Familyguidance ass.=7
Others,specify _____ =8
No response=99

Part III Contraceptive Knowledge and Practices

301. What types of contraceptive methods do you know? /NB number the following in the order known to you
1.Condom ____________________
2.Pills ______________________
3.Loop ______________________
4.Sterilization _________________
5.Calendar ___________________
6.Other, specify ________________

302. Point out contraceptive delivery points/you know
Mass media=1
Family or parents =2
Religious institution =3
School/teacher =4
Friends/peers =5
Health institution=6
Family guidance ass.=7
Others, specify _____ =8
No response==99

303. Number the contraceptive delivery points/you know according to your preferences
Mass media=1
Family or parents =2
Religious institution =3
School/teacher=4
Friends/peers=5
Health institution=6
Family guidance ass.=7
Others, specify ____ =8
No response=99

304. Did you use condom during your first sexual contact?
Yes=1, No=2, No response=99

305. If No (see no 304) why?
It was not available =1
Did not think of it=2
Your are not sure of its protection against AIDS and other STDs and pregnancy=3
Bad effect on your sexual behavior=4
My partner did not want me to use it =5
Other, specify _________________ =6
No response=99

Part IV Sex education and Heterosexual adjustment

401. If sex education is to be provided at school, would you approve of it?
Yes=1, No=2 , No response=99

402. Teaching adolescents about contraception can encourage early sexual intercourse
Yes=1 No=2 No response=99

403. What is your opinion about the following topic being induced in the school curriculum regarding adolescent sexuality?

		Important	Not
403.1	Menstruation and ovulation	______	______
403.2	Unplanned pregnancy	______	______
403.3	Use of contraceptive method	______	______
403.4	Sexual transmitted disease including AIDS	______	______
403.5	Prevention of abortion and rape	______	______
403.6	Developmental psychology	______	______

Part V Knowledge about STDs and HIV/AIDS

501. Have you ever heard the existence of HIV/AIDS?
Yes=1, No=2, No response=99

502. What were the sources of your information on HIV/AIDS?

	Yes	No
Friends	1	2
Parents	1	2
Relatives	1	2
School AIDS club	1	2
Radio/TV	1	2
Written material	1	2
Drama/Theatre	1	2
Church/Mosque	1	2
Others	1	2
No response=	99	

503. What kind of care should be taken so as not to be infected/contacted with HIV/AIDS?

	Yes	No
Abstinence	1	2
Use condom	1	2
Avoid sex with commercial sex worker	1	2
Avoid blood transfusion	1	2
Avoid Kissing	1	2
Avoid mosquitoes	1	2
Avoid using in common sharp edged materials	1	2
No response	==99	

504. How often do you use any protection to avoid catching AIDS and other STDs?
Never=1 Sometimes=2 Mostly=3 Always=4

505. If you did not use contraceptives at your first sexual relation, what was the major reason?
Not available=1 want to be pregnant=4
Did not think of it =2 Religious reason=5
Partner opposition=3 did not know how to use=6
Concerned about safety contraceptives=7
No response=99

506. Questions assessing the students' awareness of AIDS in relation to sexual behavior about your knowledge of the different risk factors for acquiring (AIDS)

	High risk factor	Yes	No.
506.1	Either sexes with multiple partner	1	2
506.2	Sexual relation with sex worker	1	2
506.3	Sexual relation with casual person	1	2
506.4	Premarital sexual	1	2
506.5	Sexual relation with out condom	1	2
506.6	Drug usage for sexual episodes	1	2
506.7	History of sexual transmitted disease	1	2

507. Do you know STDs other than AIDS?
Yes=1, No=2, No response=99

508. What sign and symptoms would lead you think that has such an infection?
Abdominal Pain=A Genital sores/ wars=F
Genital discharge=B Swelling genital area=G
Foul smelling =C Blood in Urine=H
Burning Pain =D Others=I
Urination =E No response=J

509. Have you seen any of the above-mentioned symptoms of infection on your self?
Yes=1, No=2, No response=99

510. If you have been infected ever, did you get treatment?
Yes=1 No=2, No response=99

511. Where do you go for treatment for this disease?
Used medication at home=1 Traditional healer=4
Pharmacy=2 Other (specify)------=5
Hospital/Clinic/health institution =3 No response=99

512. If not taken treatment specify the reasons for that not taking treatment
____

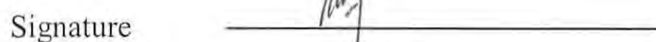
513. Please specify STD commonly known other than AIDS
____
____

Thank you again

Declaration

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university, and all the sources of materials used for the thesis work has been duly acknowledged.

Name WOSSEN- YIMER



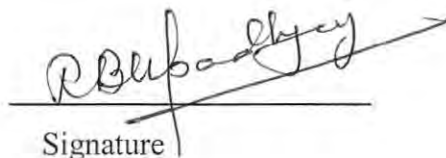
Signature

Place Addis Ababa

Date of submission July 15/2005

This thesis has been submitted for publication with my confirmation as a university Advisor.

Dr.R.B Upadhyay
Name of Advisor



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