

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
DEPARTMENT OF NURSING AND MIDWIFERY

**ASSESSMENT OF ATTITUDE TOWARDS RISKY SEXUAL BEHAVIOR AND
SEXUAL PRACTICE AMONG ADAMA UNIVERSITY UNDER GRADUATE
STUDENTS, ADAMA, ETHIOPIA**

By:

MESERET TSIKE

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Addis Ababa, Ethiopia

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By:

Meseret Tsige (BSc MW)

Advisor:

S/r Yezabnesh kebe (MSC)

June, 2012

Addis Ababa, Ethiopia

Approval by the Board of Examiners

This thesis by ----- is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of Masters of Science in Maternal and Reproductive Health Nursing.

Internal examiner:

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Full name	Rank	Date

Research Advisor/Supervisor:

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Full name	Rank	Date

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ACRONYMS

AAU	Addis Ababa University
AIDS	Acquired Immuno Deficiency Syndrome
AOR	Adjusted Odds Ratio
CI	Confidence Interval
COR	Crudes Odds Ratio
CSW	Commercial Sex Worker
EDHS	Ethiopian Demography and Health Survey
EMOH	Ethiopian Ministry of Health
FGD	Focus Group Discussion
HIV	Human Immunodeficiency virus
HPV	Human Papilloma Virus
IT	Information Technologies
IRB	Institutional Review Board
KAP	Knowledge, Attitude, Practice
KAPB	Knowledge, Attitude, Practice and Behavior
MSM	Men Sex with Men
OR	Odds Ratio
PI	Principal Investigator
PPS	Probability Proportionate to Size
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
SRS	Simple Random Sampling

STDs	Sexual Transmitted Disease
STIs	Sexual Transmitted Infections
U.S.A	United State of America
WHO	World Health Organization

ABSTRACT

Background

Healthy adolescents and youth are the base of future generation. However, globally adolescents and youth are most frequently affected by STIs/ AIDS as the result of risky sexual behavior. In developing countries including Ethiopia the problem was found more serious and many young people engage in risky sexual behavior. Most of them were aware of the risk even though they failed to change their behavior.

Objective: To assess attitude towards risky sexual behavior and sexual practice among Adama University under graduate students, Ethiopia.

Method: institution based a cross sectional descriptive study was conducted between September, 2011 and February, 2012 G.C. A total of 563 students were assessed for their attitude towards risky sexual behavior and sexual practice in Adama University, Ethiopia. Multi stage and simple random sampling technique was used to select the school and participants. Data were collected using semi-structured self-administered questionnaire. A pre-test was conducted on 5% of comparable group other than the study population before actual data collection. Data were analyzed using EPI INFO and SPSS version 16.

Result: Majority of the respondents (81.5%) was males and the mean age of the participant's was 21.45 years. Thirty percent of the study subjects currently chewing khat. Two-third (68.9%) of the participants had favorable attitude toward risky sexual behavior. Thirty four percent of respondents had sexual experience. Among sexual active respondents in the past one year 31.2% of them had not used condoms.

In addition, 18.1% of the respondents practices homosexuality and significantly associated with current chewing khat (AOR 0.115) and drug intake (AOR 0.071).

Conclusion: The attitude towards risky sexual behavior was favorable among Adama University under graduate regular students. However, the prevalence of premarital sex is high and sexual active respondents were engage in some risky sexual behavior like unprotected sex, sex with commercial sex worker and homosexuality. This indicates that the university students are exposed to health hazards through their risky sexual behavior. Therefore sexual and reproductive health issues should be included in the curriculum of both high schools and universities education to prevent risky sexual behavior and render sexual intercourse safe.

Keywords: Risky sexual behavior, Attitude, Practice

CHAPTER ONE

Introduction

1.1: Back ground

Risky sexual behaviors place individuals at risk of encounter many health, developmental and social problems. Globally in relation to risky sexual behavior an estimated of 333 million new sexual transmitted infections (STIs) occur every year. Of these 111 million occur in young people under 25 years of age. STIs are among the most common causes of illness in the world and have far-reaching health, social and economic consequences. In addition to their sheer magnitude, sexual transmitted infections are a major public health problem for two reasons: serious consequences, and the fact they facilitate transmission of HIV (1).

A person with untreated STIs resulted to an acute illness, infertility, long term disability and death, with severe medical and psychological consequences for millions men, women and infants (2). The presence of sexual transmitted infections means that there is a more chance of broken skin or membranes allowing the HIV to enter or leave the body (3). Furthermore youth and adolescents, who are sexually active face specific reproductive health concerns that, if not addressed, critically increase their exposure to serious health risks, with HIV/AIDS infection above all (4).

In 2010, around 34 million people globally were estimated to be living with HIV. Of which about 2.7 million people are newly infected and around 1.8million lost their lives due to AIDS in the same year. In fact, Sub-Saharan Africa accounts for 22.4 million (20.8-24.1 million) infections, which is about 67% of the total HIV burden.

The number of people estimated to acquire new infections is around 1.9 million accounting for 69 % of the total number of new infections. This was noted as a significant reduction in the number of new cases since 2001. On the other hand, it was also reported that HIV/AIDS has become the leading cause of death in the region (5, 6).

Ethiopia is one of the Sub-Saharan African countries most severely affected by the HIV/AIDS pandemic. Currently, the national adult prevalence rate is estimated at 2.3 percent and an estimated number of 1.2 million people are living with HIV/AIDS (6) and an estimated of 18,073 died due to AIDS at the end of 2007 (7).

According to World Health Organization (WHO) fact sheet, new HIV infections in the younger age group continues to rise as overall proportion of people living with HIV/AIDS falls (1). At present, almost one third of the estimated 33.4 million people living with HIV/AIDS worldwide are under age 25 and represent more than half of new HIV infections each year. The devastating impact of HIV/AIDS on young people (6,000 infections daily or 5 every minute) is evident not only through high prevalence rates, especially in Southern Africa (4).

Risky sexual behaviors are also associated with unwanted pregnancies, unsafe abortions and death among young women and girls partly stemming from their ignorance about the risks involved in being sexually active at a young age. One in every ten births worldwide happens to a teenage mother. Value placed on fertility and children also puts young women at risk of having many children at an early age.

In Africa, one in five births is to a female under 20 years of age, placing the region among countries with the highest ratio of childbearing adolescents. The incidence of unwanted pregnancies in this group is very high. According to some estimates, unsafe abortions contribute to 13 percent of all maternal deaths or 68,000 per year. In Africa, the chances of death related to pregnancy or delivery is as high 1 in 16, reflecting both high incidence of pregnancy and greater risks associated with pregnancy (4, 8). In conclusion risky sexual behavior (unprotected sex) without using any contraceptive method; it resulted to unwanted pregnancy, unsafe abortion and its complications that lead to maternal death.

Generally, a young person because of their age, desire to experience new events and feeling of being less susceptible to adverse outcome associated with risk behavior place them at greater risk for HIV/AIDS, other curable sexual transmitted infections and unwanted pregnancy and its consequences. Furthermore, high risk behaviors established in younger age often extended into adult hood (9).

Concerning attitude towards risky sexual behavior and sexual practice, a study done on knowledge, attitude and practice on HIV/AIDS among high school students in Gondar, Northwest Ethiopia showed that their perception of risk of acquisition of HIV/AIDS and practice of protected sex is low (9). Another study conducted in South Africa revealed that on average, 97.4% women indicated that they were aware of HIV/AIDS, of which 95.6% were knowledgeable about the sexual transmission routes of the HIV.

Of those women who were aware of HIV/AIDS and knowledgeable about the sexual transmission routes of the virus, only 2.8% had had last sex with a casual acquaintance, someone they have just met, or a commercial sex worker. Yet, 80.8% of these women who had last sex with a casual acquaintance were engaged in risky sex, i.e. did not use a condom during last sex (10). Similar study done in Gondar, Northwest Ethiopia among College of Medical Science students on high-risk sexual behavior and pattern of condom utilization revealed that highest proportion of health officer students (60.3%) have had contact with commercial sex workers, which indicates that there is unsafe sexual practice (11). In addition, a study done in Gambella town on knowledge, attitude and practice on HIV/AIDS prevention and transmission revealed that safe sex practices are less practiced (12).

In general, studies of college students indicate that they have a relatively high level of knowledge, including general knowledge, knowledge about HIV/AIDS transmission and prevention. Most of the studies, however, report some caveats in knowledge which lead to significant misconceptions and risky behavior (13).

1.2: Statement of the problem

Sexuality is a universal phenomenon in all young people. Psychologically, adolescents become sexually active at earlier age due to peer pressure, avoidance and resistance to behavior changes through various forms of denial and rationalism (14, 15). Initiating sexual activity is a natural transition made by nearly all humans. Nevertheless, it is not the occurrence of this transition, but the timing and the circumstances under which it occurs that has significant implication (16,).

In the last two decades sexual behavior exhibited by school adolescents and youth between 19 to 24 years has led to the emergence of several health and developmental problems among students.

Among the key issues associated with these problems were unprotected sex and undesirable sexual behavior, teenage pregnancy, sexual harassment and increasing cases of prostitution (16). Globally, unprotected sexual intercourse between man and woman is the predominant mode of transmission of the HIV virus and other sexual transmitted infection (17). Young people in both developing and developed countries begin sexual activity relatively early. The lowest median at first sexual contact in Nigeria is 15 years for men (18).

The study conducted on high-risk sexual behavior among youth in Tanzania revealed that (0.3%) girls and (3.2%) boys had their first sexual debut by the age of 9 years and 10% by the age of 13years. The largest group, 55% of girls and 45% boys had their first sexual intercourse experience between the age of 14 to 17years(14,19). Another study in Tanzania revealed that 30% of respondent were sexually experienced, the average age at first intercourse in this group being 12.7years (20).

The sexuality situation in Ethiopia is the same as in other African countries. A study conducted on the determinant of high risk sexual behavior for HIV/AIDS among out-of school youth in Addis Ababa showed that 52.1% of boys and 47.8% of the girls have had sexual experience, their mean age of sexual commencement being 17years(14, 20).

Another study conducted by the family guidance association of Ethiopia on adolescent's sexuality revealed that 71.9% of boys and 71.4% of girls have had their first sexual contact in the age range 15-17 years (14). In Ethiopia, higher risk sex (sex without adequate protection) among both women and men are most prevalent among those living in urban areas. The study among secondary school students in Ethiopia showed that one third (33.3%) of the youth reported to have had sexual intercourse and the mean age of sexual initiation was 15.3years (14, 15).

According to 2006, EDHS report the prevalence of higher risk sex is also notably high among men in Gambela, Dire-Dawa, Harare, Tigray and Afar (16).

A study conducted among high school students in Gondar revealed that 11.9% of the sexually active respondents had sex with commercial sex workers and 10.7% had contracted STIs. The findings show that over a fourth of the sexually active respondents had multiple sexual partners including CSWs indicate that such risky behavior can predispose the students to acquisition of STIs including HIV. Furthermore, condoms were used only some times by about a third of those who were practicing sexual intercourse (9). Similarly, the study conducted among Addis Ababa university students revealed that 37.5% of sexually active respondents had more than one sexual partner and 28.5% of sexually active respondents reported that they had not used condoms in the past 6 months of sexual encounter.

This indicates that some of the respondents were still at high risk of contracting HIV/AIDS and other sexually transmitted infection due to unsafe sexual practice (15). Even if some studies demonstrate that adolescents and youth are exercising risky sexual behaviors, it requires further study to identify magnitudes of the problem among students of higher education institution. Adama University is one of the higher education institutions and found in Adama town. Adama is the biggest town and business center in Ethiopia. It has the highway to Djibouti, Harar, and Sodere and found near to Mojo dry port. A lot of passengers pass through it. Many people including those who come from abroad prefer it for recreation. So that Adama university students are more vulnerable to have risk sexual behavior. Thus, the aim of this study is to assess the level of knowledge, attitude and practice on risky sexual behavior among the higher education institute students at Adama University.

1.3: Significance of the study

The expected results from this study are stated here under.

For the nursing and midwifery profession and professionals:

It will increase knowledge to the profession and help to carried out evidence based practice. In addition it will enhance awareness about the gap in sexuality and reproductive health services among the professionals and aid to act promptly upon it.

For the community, institution and policy makers:

It also increase awareness on risky sexual behavior among the students, young adults and community at large and help to bring behavioral changes. Additionally it provide base line information to the institute and help to establish or strengthen sexual and reproductive health service in the university. Furthermore it helps policymakers to understand the concrete situation of adolescents and youth and guide them in developing appropriate policy.

CHAPTER TWO

Literature review

2.1. Factors put youth at greater risk

Risky sexual behavior in adolescence is a behavioral pattern that increase risk for serious adolescent health problem (26). About seven of every ten sexual transmitted infections (STIs) occur among individuals ages 15-24. Sexually active, unmarried adolescents and youths are at high risk for STIs not only for psychological and behavioral reasons but also for biological and social reasons (27).

Psychological factors that put many adolescents at increased risk for STIs include a general sense of invulnerability and the desire to try new sexual and substance (drug) experimentations. Also the willingness to take risks, including changing sexual partners often or having a partner who has multiple partners makes them at increased risk of encounter STIs/HIV/AIDS. In addition, many adolescents and youths lack knowledge of STIs that contributes to risk-taking behaviors, find it difficult to use condoms consistently and correctly, or lack communication and negotiation skills, making condom use difficult (27). As well, adolescents are probably more biologically susceptible to STIs than older women because of a condition called cervical ectopy. This is a normal condition that is present in most female adolescents and becomes less common with age. Cervical ectopy develops when the cells that line the inside of the cervical canal extend onto the outer surface of the cervix.

These cells are more vulnerable to infections such as chlamydia and gonorrhea. In addition, the risk of acquiring trichomoniasis, chlamydia, herpes and human papilloma virus (HPV) is possibly greatest at first exposure to the STIs.

First exposure often occurs during adolescence; both male and female adolescents are particularly vulnerable to sexual transmitted infections. Getting one STI makes it more likely that an adolescent may acquire other STIs (4). On the other hand, Social-cultural norms that reinforce gender inequalities and make young women and girls also economically inferior to men allow for age-mixing and sexual networking as a coping strategy for young women and girls (4). Many young girls have their first sexual experience with older men. Older men are “high risk partners”, as they are more sexually experienced and thus more likely to be infected (4, 27).

Social factors include adolescents' relative lack of power in relationships with adults and others, who may be their partners. Some adolescent's experience nonconsensual sexual relationships with older, more powerful partners with whom they may feel unable to negotiate safer sex practices (27)

In addition, programmatic factors can also increase risks associated with STIs. Programmatic factors include limited access to family planning or STI services; inconvenient clinic hours or locations; cost prohibiting purchases of condoms from pharmacies, other shops, or clinics; lack of confidentiality, trained clinic staff or staff members with negative attitudes about adolescent and youth sexual activity and contraceptive use, and legal restrictions (4, 27).

Worldwide, the highest reported rates of STIs are found among young people aged 15-19 and 20-24. In the developed world, two-thirds of all reported STIs infections occur among men and women under the age of 25. In developing countries the proportion is even higher (30).

Generally, early sex among young person's can have negative consequences like pregnancy and STIs, including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), result in high social, economic, and health costs for affected persons, their children,

and society (28). For instance early acquisition of STIs increases the probability of recurrent infections because of longer exposure time and the likelihood of a greater number of partners (28, 29). Recurrence can exacerbate the health consequences. For example, repeated chlamydial infection is more likely than primary infection to be associated with fallopian tube damage (30, 31, 32).

2.2. Adolescent sexual activity

A study done among USA high school students in 2009 revealed that 46% of the respondents were sexually active (34). Another study conducted among Chinese university students 17.6% of males and 8.6% females were sexually active. The mean age of first sexual experience was 19.4 (SD = 1.8) and 19.7 (SD = 1.6) for males and females respectively (35). A survey done among Vocational Students in Northern Thailand shows 43% of females and 48% of males were sexually active. Among those with any sexual experience, the mean ages at first sexual contact and first intercourse were significantly earlier for males (16.0 and 16.7, respectively) than for females (17.2 and 17.7, respectively) (36). The study conducted on high-risk sexual behavior among youth in Tanzania revealed that (0.3%) girls and (3.2%) boys had their first sexual debut by the age of 9 years and 10% by the age of 13 years.

The largest group, 55% of girls and 45% boys had their first sexual intercourse experience between the age of 14 to 17 years (14,19). Another study in Tanzania revealed that 30% of respondent were sexually experienced, the average age at first intercourse in this group being 12.7 years (19). Similarly, the study conducted in Tanzania among students in secondary school and college shows 54% of the students were sexually active and the average age of sexual debut was 15.5 years for boys and 15.8 years for girls (37).

Ethiopian according to the second round HIV/AIDS Behavioral Surveillance Survey, it was found out that around 9.9 percent of the in-school youth (14.6 % of males and 5.3 % of females) had sexual experience. The mean and medium age of sexual debut among youth was 16 years (15, 38). In general adolescents and youth in developed and developing countries were experiencing their sexual or coital debut at younger age as stated above.

Regarding factors related to initiation of sexual practice, a study done in Nekemte town school students, the main reasons of sexual intercourse were fell in love which accounted for 49(38.8%), desire to practice sexual intercourse 44(33.3%), and peer pressure in 25(17.2%) (44). Another study among preparatory students in Alata Wondo, according to FGD participants, there were sexual practice among the students and the main reasons for early sex were peer pressure, economic problems, being away from family, lack of adequate education on STIs and HIV/AIDS and reproductive health in the school. Even though it is not much common among students, alcohol and khat consumption were also mentioned (45).

2.3. Adolescent and youth risky sexual behavior

Sexual risk behaviors place adolescents and youths at risk for HIV infection, other STIs, and unintended pregnancy. A study done among USA high school students in 2009 has shown that 14% had had sex with four or more people during their life (34). Similarly, a study conducted in Colombia, among Antioquia University student's shows of 793 sexually active participants 10.9% (17.2% of men and 3.3% of women) said they had contracting some type of sexual transmitted infections. The risk of contracting STIs was 3.4 times in those with four or more sexual partner as compared with students not practicing such behavior (40).

A study done among Chinese University students revealed that, among those who had been sexually active males were significantly more likely to have had non-regular partners, including casual partner and commercial partners ($\chi^2 = 40.80$, $P < 0.001$) than were females. Males were also significantly more likely to have had multiple sexual partner than were females ($\chi^2 = 10.21$, $P = 0.001$) (35). Similarly, a study done in Tanzania among college students, a total of 403 students (39%), reported that they had regular sexual relationship at the time of study. Among them 78 students (7%), 13% of boys and 4% of girls, had multiple partner (37).

Another study conducted in Nigeria among tertiary education students, in Lagos, 39.9% (94) of sexually active respondents have had two to three sexual partner in their life. Notably, about one-tenth (10) had more than ten life time sexual partners in the year preceding the study (41). In Ethiopian situation, the studies conducted among Addis Ababa University students and high School students in Gondar also shows significant number of students had had multiple sexual partner (9, 15). In conclusion having multiple sexual partners among college and university students found common sexual and reproductive health problem and place them at risk of contracting STIs/HIV/AIDS.

Risky sexual behavior includes participation in casual sex, often changing sexual partners, having multiple sexual partners and the failure to use condom. The most efficient and recommended means to reduce the chance of contracting STIs/HIV/AIDS is condom use (37).

Many young people engage in sexual risk behavior that can result in unintended health outcome. A study in USA among high school students showed 39% of students who were sexually active did not use condom the last time they had sex (34).

Another study done in Thailand among vocational students revealed that from 43% of female and 48% of male who had had sexual intercourse only one quarter of the participants had used a condom at first sexual intercourse(36). The same study done among Chinese University students showed prevalent unsafe sexual practice among respondents; 35% respondents from both gender reported never/rarely using condom in the previous year (35).

In Africa, some surveys revealed that the ratio of unmarried, sexually active females aged 15-19 who use condoms is low, ranging from 2 to 18 percent. Among adolescent males, the prevalence of condom use is also much lower compared to adult males. Similarly, inconsistency of condom use is reported to be very high among both young males and females (4).

A study done in Dar-Es-Salam, Tanzania showed that among 219 female respondents, 57% had engaged in sex with a 'sugar daddy'. Of these only 2% of them always used condom and the decision during sex with a sugar daddy were predominately made by the male partner (37). Similar study done in Lagos, Nigeria among tertiary education students, revealed that the use of condom was low 68(36.4%) at first sexual experience. Out of 187 respondents who have had sex before one-fifth of them never had used a condom (41).

In Ethiopian context, a study conducted among Agaro (Southwest Ethiopia) high school students showed that 25% students had a history of sexual intercourse. Among who had previous exposure, 54.4% used condom at least once. Of these, only 46 (9%) were using condoms always. In similar study done in the Gondar (Northern Ethiopia) college of medical science, students showed that 56% were sexually active. Among sexually active students, only 37% reported ever using condom. Consistent condom use was reported only by 6.4% (14).

Similar study done among Addis Ababa University students showed that out of sexually active respondents, 41(28.5%) respondents, 15.3 % males and 13.2% females reported that they had not used condoms in the past 6 months of sexual encounter (15). In general, several studies showed that condom-use behavior is low among college and university students.

Substance use increases the probability that an adolescent will initiate sexual activity, and relatedly, sexually experienced adolescents are more likely to initiate substance use. Alcohol and drug use by young people may lead to earlier sexual initiation, unprotected sexual intercourse, and multiple partners as well as putting young people at risk for STIs, unintended pregnancy, and sexual violence (47).

A study done in USA among African American adolescent girls revealed that high rates of substance use and it was a significant predictor of teens' risky sexual behavior. Sixty-nine percent of teens (109 of 158) reported having used alcohol in the past, and 40% (63 of 158) reported drinking alcohol one or more times in the past month. Forty-four percent of adolescents (70 of 158) endorsed at least one instance of marijuana use in the past, and 26% (41 of 158) reported using marijuana one or more times in the past month before the study conducted (46).

Similar study done on Khat, alcohol use and risky sex behavior among in-school and out-of-school youth in Ethiopia showed that Khat use was strongly associated with initiation of sexual activity with four-fold increased odds in both daily and weekly users. The odds ratios for daily use were: adj. OR (95% CI) = 4.13 (3.26, 5.23); and for weekly Khat use: 4.18 (3.50, 4.99).

Alcohol use was strongly and linearly associated with initiation of sexual activity, those using alcohol having a four-fold increase, and daily users having six-fold increased odds of sex initiation (P for trend < 0.001). Use of substances other than Khat was also strongly associated with sex initiation: adj. OR (95% CI) = 2.54 (1.84, 3.51) (48). In conclusion, substances like alcohol and khat have a power to initiate sexual activity as stated above.

Homosexuality and Lesbian; the term homosexual is relating to, or characterized by a tendency to direct sexual desire toward another of the same sex or involving sexual intercourse between persons of the same sex (51). Lesbian is female homosexuality and is less risky than male homosexuality. Although it is true that men who have had sex with men (MSM) experience significantly more physical health risks than women who only have sex with women (49). Estimates of the frequency of homosexual activity also vary from one country to another.

A 1992 study reported that 6.1% of males in Britain had had a homosexual experience, while in France the number was 4.1%. According to a 2003 [survey](#), 12% of [Norwegians](#) have had homosexual sex. In [New Zealand](#), a 2006 study suggested that 20% of the population anonymously reported some homosexual feelings, few of them identifying as homosexual. Percentage of persons identifying homosexual was 2–3%. According to a 2008 poll, while only 6% of Britons define their sexual orientation as homosexual or bisexual, more than twice that number (13%) of Britons has had some form of sexual contact with someone of the same sex (50). “ men who have had sex with men since 1977 have HIV prevalence 60 times higher than the general population, 800 times higher than first time blood donors, and 8000 times higher than repeat blood donors.”

MSM also have an increased risk of having other infections that can be transmitted to others by blood transfusion. For example, infection with the Hepatitis B virus is about five to six times more common and Hepatitis C virus infections are about two times more common in men who have sex with men than in the general population (49). Homosexuality is also associated with a higher number of lifetime sexual partners, which puts both men and women at an increased risk of health problems such as bleeding, lacerations, and perforations of the rectum and/or anal sphincter muscles. Once this damage occurs, open sores, hemorrhoids, and anal warts can result and also Homosexual men are also at an increased risk for anal cancer (49).

2.4. Adolescents and youth attitude towards risky sexual behavior and its out come

A study conducted on perception of the risks of sexual activities among out-of-school adolescents in northern part of Ethiopia (in southern Gondar) showed that participants' attitude towards HIV risk perception were (5.3) of the rural and 11.2% of the urban (19). Even if there is general assumption of that students, who have a high level of education, should be well informed concerning AIDS and STIs and should therefore have positive attitudes and responsible sexual behavior. Nevertheless, practical observation and existing research findings show that for many campus students the opposite appears to be the case (15)

2.5. Conceptual frame work

This conceptual frame work is adopted and modified from ecological frame work (52).

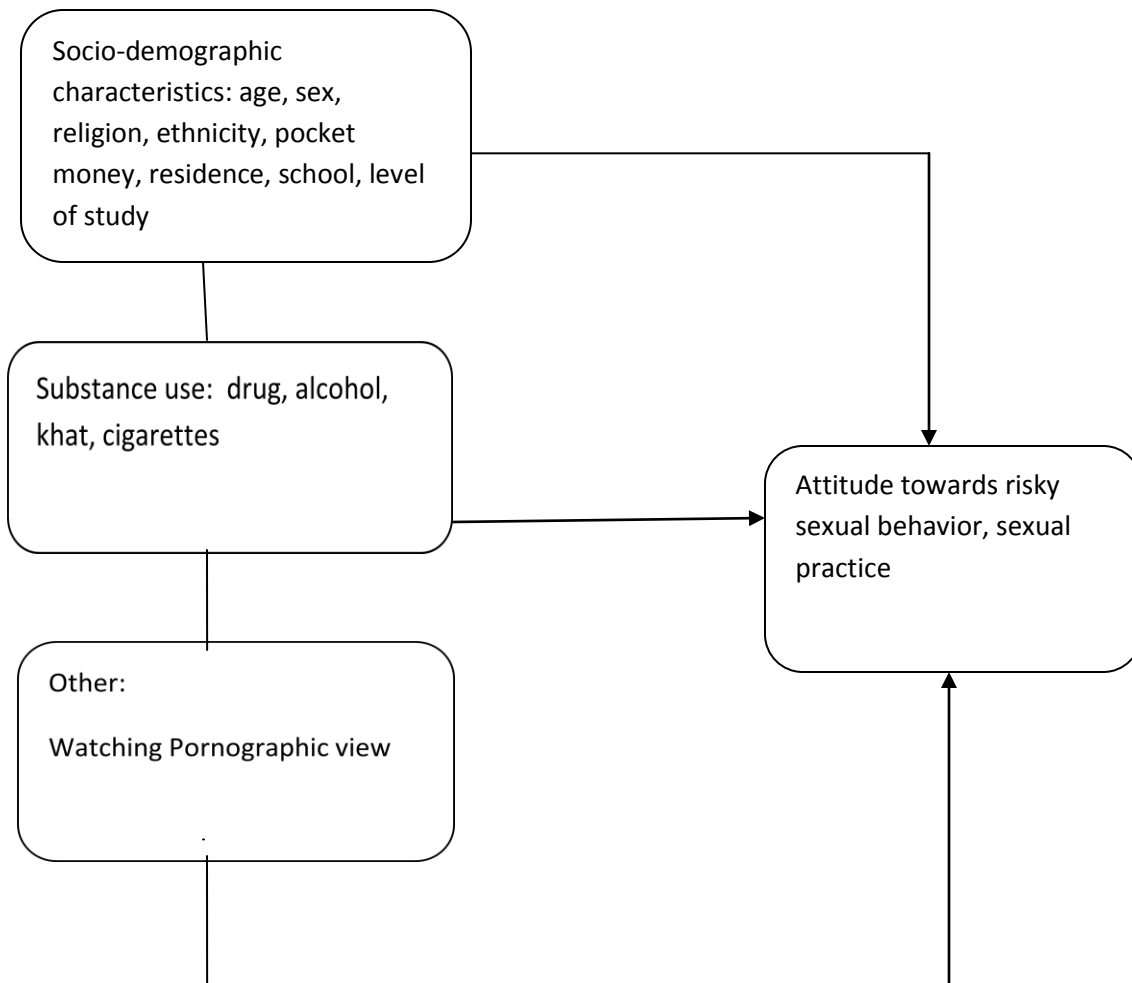


Figure 2 Conceptual frame work of Risky sexual behavior.

As shown in figure-1 several factors influence the attitude towards risky sexual behavior and sexual practice. In this study socio demographic characteristics, substance use like drug, alcohol, khat and cigarettes and other factors will be considered.

CHAPTER THREE

Objectives of the study

3.1. General objective

To assess attitude towards risky sexual behavior and sexual practice among Adama University students, Adama, Ethiopia

3.2. Specific objectives

To identify the level of attitude of the students towards risky sexual behavior.

To assess practice of the students on risky sexual behavior.

To determine factors associated with attitude towards risky sexual behavior and sexual practice.

CHAPTER FOUR

Methodology

4.1. Study area

The study was conducted at Adama Science and Technology University the former Nazareth Technical College, which is found in Adama town, Oromia regional state, Ethiopia. Adama town is located in the East Shewa Zone, at 8° 33'N at an elevation of 1712 meters and 99 km southeast of Addis Ababa.

Adama University has four branches (i.e Adama, Asella, Debrezeit and Addis Ababa(Wenget) having a total of 9214 regular undergraduate students who are registered as second-semester enrolment of 2011 /12 academic year according to the registrar office. Of this 1286 of them are females. First year undergraduate students for 2011/12 academic year not yet registered

4.2. Study period

The study was conducted from September 2011 to February, 2012 G.C.

4.3. Study Design

Institution based cross-sectional descriptive study was conducted to assess attitude towards risky sexual behavior and sexual practice of students at Adama university.

4.4. Source Population

The source populations were all Adama university students registered for second semester of 2011/12 academic year.

4.5. Study Population

The study populations were all undergraduate regular students of Adama University.

4.5.1. Inclusion and Exclusion Criteria for the Study Population

4.5.1.1. Inclusion Criteria

- i. All second year and above under graduate regular students registered for second semester 2011/12 academic year.
- ii. Both in campus and outside campus students.

4.5.1.2. Exclusion Criteria

- i. Students attending in non-regular program (evening and distance).
- ii. Students attending post graduate program.
- iii. First year students.
- iv. Students who were not registered for second semester.

4.6. Sample size determination

The sample size was computed based on the formula proposed by Hollander (1999) for single population proportion. The value of P was taken as 57% of consistent condom used based on a previous KAPB study conducted among AAU students. A Z value of 1.96 was used at 95% CI and margin of error is 5%. Accordingly, the sample size (n) of the study was calculated as follows and none-response rate of 10% contingency and correction for Multi-stage sampling design effect (multiply by 1.5) were considered.

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

Where

n= the required sample size

$Z_{\alpha/2}$ = Critical value = 1.96

P = the prevalence of risky sexual behavior.

D = marginal error between the sample and the population (0.05).

$$n = \frac{(1.96)^2 \times 0.57 \times (0.43)}{(0.05)^2} = 377$$

Hence, the calculated sample size is 377 and the population is less than 10,000 correction formulas were used.

$$nf = \frac{ni}{N} = \frac{377}{9214} = 362$$

$$\left[\frac{1+ni}{N} \right] \quad \left[\frac{1+377}{9214} \right]$$

= 362 plus 10% contingency for non- response and the total sample size were

$$= 362 + 36 = 398$$

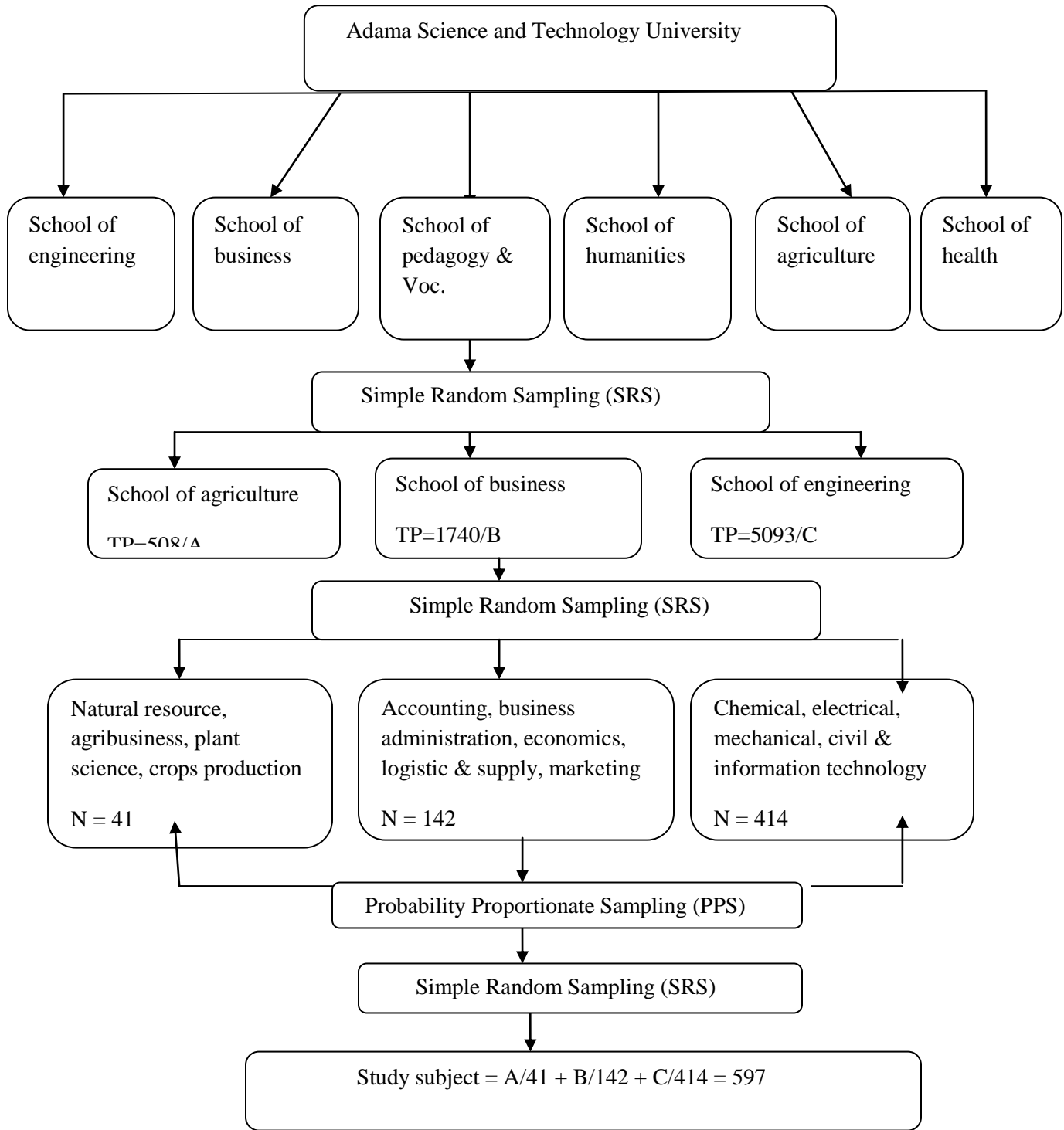
$$= 1.5 \text{ design effect } 398 \times 1.5 = 597$$

4.7. Sampling technique

In order to obtain the required number of sample population a multi-stage sampling method was employed.

First a random sampling method was used to select three schools out of six schools of Adama University. Then the calculated sample size (597) was distributed to each of the recruited school using probability proportional to their size (PPS). Secondly, five departments from school of engineering and information technology (Chemical engineering, Civil engineering, Electrical engineering, Mechanical engineering and Information technology);

Five departments from school of Business (Accounting, Business Administration, Economics, Logistics & Supply Chain Management and Marketing & International Trade) and four departments from School of Agriculture (Natural Resource Management, Agribusiness Management, Plant Science and Crop Production) randomly selected. Then, the sample size allocated to each School was distributed to randomly selected department proportional to their size. Eventually, the required number of respondents selected from each year of study again distributed proportional to their size from the randomly selected departments and students from the selected department were chosen randomly (see figure 2 below). Finally, the questionnaire was distributed to randomly selected respondents.



TP- total population; N- sample population

Figure 2: schematic Presentation of sampling technique

4.8. Data collection and Measurements

4.8.1. Data collection Instrument

Based on the review of relevant literature, the questionnaire assessing attitude and practice were adopted from WHO AIDS questionnaire (WHO 1990) and possible modification was carried out.

Semi-structured self-administered questionnaire was written in English and translated to Amharic and then back to English to ensure consistency of translations. The questionnaire was organized into three sections. The first section is aimed at collecting Socio-demographic information (e.g., Sex, Age, religion, ethnicity, residence, level of study, monthly income...) that are believed related to attitude and practices of respondents' on risky sexual behavior.

The second section was set to assemble information on the subjects' attitude towards risk sexual behavior and the third section produces data on respondents' sexual practice.

4.8.2. Data collection method and procedure

Data were collected from February 15 to 20, 2012 after getting access to the students through heads of schools or departments; they were informed about the purpose of the proposed study. Two data collectors and supervisors were used for data collection. Prior to data collection, the investigator and data collectors were discussed the information on the information sheet briefly in order to ensure comprehension the information by the participants. Then, they were offered the questionnaire and a letter to participants. Up on completion, they were asked to put the questionnaire in the envelope and return to data collectors.

4.8.3. Quality control measures

Four Adama University School of health academic staffs were recruited for data collection and supervision. Appropriate training on research instruments and data collection procedure was given to the data collectors and supervisors. A pre-test study was employed two weeks prior to actual data collection on 5% of the sample on similar population who are not part of the actual sample to test the instruments for clarity, understandability and the study strategies. Some questions were rephrased, revised and the final questionnaire was prepared.

The data was checked for completeness during and at the end of data collection by the supervisors and investigator. The principal investigator was facilitated and supervises the overall data collection process.

4.8.4. Variables

4.8.4.1. Dependent variables towards risky sexual behavior

Attitude, Practice

4.8.4.2. Independent variables

Socio-demographic: - age, sex, religion, ethnicity, current residence, pocket money, level of study.

Substance use: - current drug intake, cigarette smoking, chewing khat, current alcohol intake

Other: -Watching pornographic view

4.9. Operational definitions

Risky sexual behavior - having had last sex with casual acquaintance, someone they have just met, or a commercial sex workers and not having protected themselves, homosexuality, and early initiation of sexual intercourse or marriage and having multiple sexual partners.

Attitude – Opinion, way of thinking: behavior reflecting about risky sexual behavior

A Likert scale was used to rank the participant`s response and each statement is assigned a numerical score ranging from 1 to 4.

In this study there are 12 attitude measuring items equally categorized in positive and negative items and four Likert scaling was used. These are strongly agree = 4, agree = 3, disagree = 2, strongly disagree = 1

- . Positive questions were summed from the lowest, 1 score (strongly disagree) to the Highest, 4 score (strongly agree) and
- . Negative questions were summed from the lowest, 1 score (strongly agree) to the Highest, 4 score (strongly disagree)
- Each degree of agreement (item response) was computed by summing these scores.
- The total score of respondent reveals the particular opinion of a person.
- The range of scores went from 27 to 48 out of 48 (Scoring $\geq 27/48$ or $\geq 56\%$) favorable and $< 27/48$ or $< 56\%$ unfavorable.

Practice – to carry out or engaging in activity or process related to risky sexual behavior. It was categorized as follows:

Good practice – students exercise a safe sex practice.

Poor practice – students practice at least one risky sexual behavior among practice measuring questions.

4.10. Data Analysis and Interpretation

The collected data was entered into Epi Info version 3.5.1 and then exported for analysis to SPSS version 16.0. The data was cleaned for inconsistencies and missing values. Simple frequencies were run to see the overall distribution of the study subject with the variables under study. Bivariate analysis was used to determine the association between different factors and the outcome variable.

4.11. Ethical consideration

The data collection was carried out after getting approval for the project proposal from Addis Ababa University School of Medicine College of Health Science Department of Nursing and Midwifery Institutional Review Board (IRB). Furthermore, permission to conduct the research in the proposed setting was obtained from the official of the study area. In order to ensure the participants right to self-determination and privacy, they were informed both verbally and in writing about the study. The investigator was clearly informing them that they have the right to decide voluntarily whether to participate in the study and right to refuse participation.

Voluntary consent was obtained after essential information had given about the study and has shown comprehension of the information.

The participants' right to privacy was protected throughout the study through anonymity. The study was anonymous and the questionnaire was administered in a class room with adequate space between each participants. The information gained during data collection was kept confidential.

4.12. Dissemination of the result

The result of the study will be disseminated to organization that have helped the project to be carried out, which includes Addis Ababa University Faculty of medicine School of Nursing and Midwifery, Adama University, other concerned body and NGOs who are working on adolescents and youth reproductive health. Furthermore, the result from the study will be tried to publish in different journals to be read by different professional, officials and other interested group and will be presented in different sexual and reproductive health conference's and meetings in higher education institution for improvement of risky sexual behavior among the students.

4.13. Strengths and Limitations of the study

4.13.1. Strengths

- i) Standardized data collection instrument – The adopted and modified according to the aim of the study and a prepared English questionnaire then translated to Amharic language was used to all participants.
- ii) Questionnaires were pre-tested and data collectors were trained to maintain the quality of data.

4.12.2: Limitations

- i) The study was conducted in one university involving 563 students, which might undermine generalizing the result to the general population.
- ii) Since sexual behavior and practice are sensitive topics that many young people are reluctant to talk about. As such, there could be some bias in the reported sexual practice.

CHAPTER FIVE

Result

The subjects of the study were 597 under graduate regular students at Adama University, Ethiopia. Of which, 563 of them responded and gives a response rate of 94.13%. Thirty four respondent do not filled the questionnaire completely and it contributes for 5.87% non-response rate.

5.1: Socio-demographic Characteristics

As described in Table one below, 459 (81.5%) and 104 (18.5%) of the respondents were male and female students respectively. Their mean age was 21.45 years (SD \pm 1.4). The survey revealed that the age of respondents were in the range of 18-30 years. The lowest age was 18 years while the highest was 30 years. The highest frequency was 21years old. Regarding ethnic composition of the students more than half 294 (52.2%) were Oromo. One hundred and sixty five (29.3%), 50(8.9%), 35 (6.2%) and 19 (3.4%) were Amhara, Tigre, Gurage and other respectively. Regarding their religion, 279 (49.6%) of them belonged to Orthodox Christian. One hundred and fifty three (27.2%), 65 (11.5%) and 38 (6.7%) were Muslims, Protestant and Catholic Christian respectively. Other constituted 28 (5%). All of the respondents live in the campus and most of the participants 400 (71%) were from School of Engineering and more than half 236 (59%) of them were third year students.

The majority of the participants 500 (88.8%) have pocket money and they obtain from their parents. Of which, 240 (42.6%) of them earned less than 200 bir per month.

Table 1: Socio-demographic characteristics of the study subjects in Adama University, Ethiopia, February, 2012.

variables	Frequency (N=563)	Percentage
Sex		
Male	459	81.5
Female	104	18.5
Age in year		
15-19	32	5.7
20-24	525	93.3
>24	6	1.1
Religion		
Orthodox	279	49.6
Muslim	153	27.2
Protestant	65	11.5
Catholic	38	6.7
Other*	28	5
Ethnicity		
Oromo	294	52.2
Amhara	165	29.3
Tigre	50	8.9
Gurage	35	6.2
Other**	19	3.4
Residence		
In campus	563	100

<hr/>		
Pocket money	N=500	
<200bir	240	42.6
201-250birr	131	23.3
251-300birr	52	9.2
≥ 301birr	140	24.9
School		
Engineering	400	71
Business	121	21.5
Agriculture	42	7.5
Level of study		
Year-2	235	41.7
Year-3	236	41.9
Year-4	83	14.7
Year-5	9	1.6

“* Only Jesus and Jehovah witness believers

““** Somale, Harari, Hadya

5.2: Other factors influencing risky sexual behavior

Of the total number (563) of participants, one hundred and forty four (25.6%) of them used alcohol. Of which, 74 (51.4%) of respondents use alcohol sometimes and 70(48.6%) regularly. Regarding chewing khat, 169 (30%) of the study subjects chewing khat. Among them, 155(91.7%) and 14 (8.3%) were chewing khat regularly and sometimes respectively. About drug use, only 11 (2.0%) of the respondents took drugs and 6 (54.5%) and 5(45.5%) of them use drugs regularly and sometimes respectively. Regarding cigarette smoking, 20 (3.6%) of the participants were smoke cigarettes. Of which 13 (65%) and 7 (35%) of them were smoke cigarettes regularly and sometimes respectively. More than half of the participants, 336 (59.7%) were watching pornographic view. Of which 210(62.5%) of them watch pornographic view regularly while, 26(37.5%) of the respondents watch sometimes.

Table 2: Distribution of study subjects and factors influencing risky sexual behavior, Adama University, Ethiopia, February, 2012.

Variable	Frequency(N=563)	Percentage
Alcohol intake		
Yes	144	25.6
No	419	74.4
If yes, how often	N=144	
Regularly	70	48.6
Sometimes	74	51.4
Chewing khat		
Yes	169	30
No	394	70
If yes, how often	N=169	
Regularly	155	91.7
Sometimes	14	8.3
Drug use		
Yes	11	2
No	552	98
If yes, how often	N=11	
Regularly	6	54.5
Sometimes	5	45.5
Cigarette smoking		
Yes	20	3.6
No	543	96.4
If yes, how often	N=20	
Regularly	13	65
Sometimes	7	35
Watching pornographic view		
Yes	336	59.7
No	227	40.3

5.3: Attitude on risky sexual behavior among Adama university students

As indicated in table 7 below, the participants reported their agreement and disagreement on different attitude indicators ranging from 'strongly agree to strongly disagree'. It demonstrates that certain questions were answered better than others. Majority of the participants 499 (88.6%) and 505 (89.7%) were disagreed and 64 (11.4%) and 58 (10.3%) agreed about having sexual intercourse with commercial sex workers and multiple sexual partners respectively. Regarding avoiding premarital sex 276 (49%) were agreed and 287 (51%) were disagree respectively. About condom utilization, almost half of the participants 282 (50.1%) were agreed that condom use reduces sexual pleasure. Most of the participants 453(80.5%) were agreed that homosexuality is immoral. Five hundred and thirteen (91.1%) and 354 (62.9%) were agreed and 50 (8.9%) and 209 (37.1%) were disagreed to limit with single sexual partner and consistently to use condom respectively. As summarized in figure 3 below, 388 (68.9%) of the respondents had favorable attitude on risky sexual behavior while 175 (31.1%) of them had unfavorable attitude.

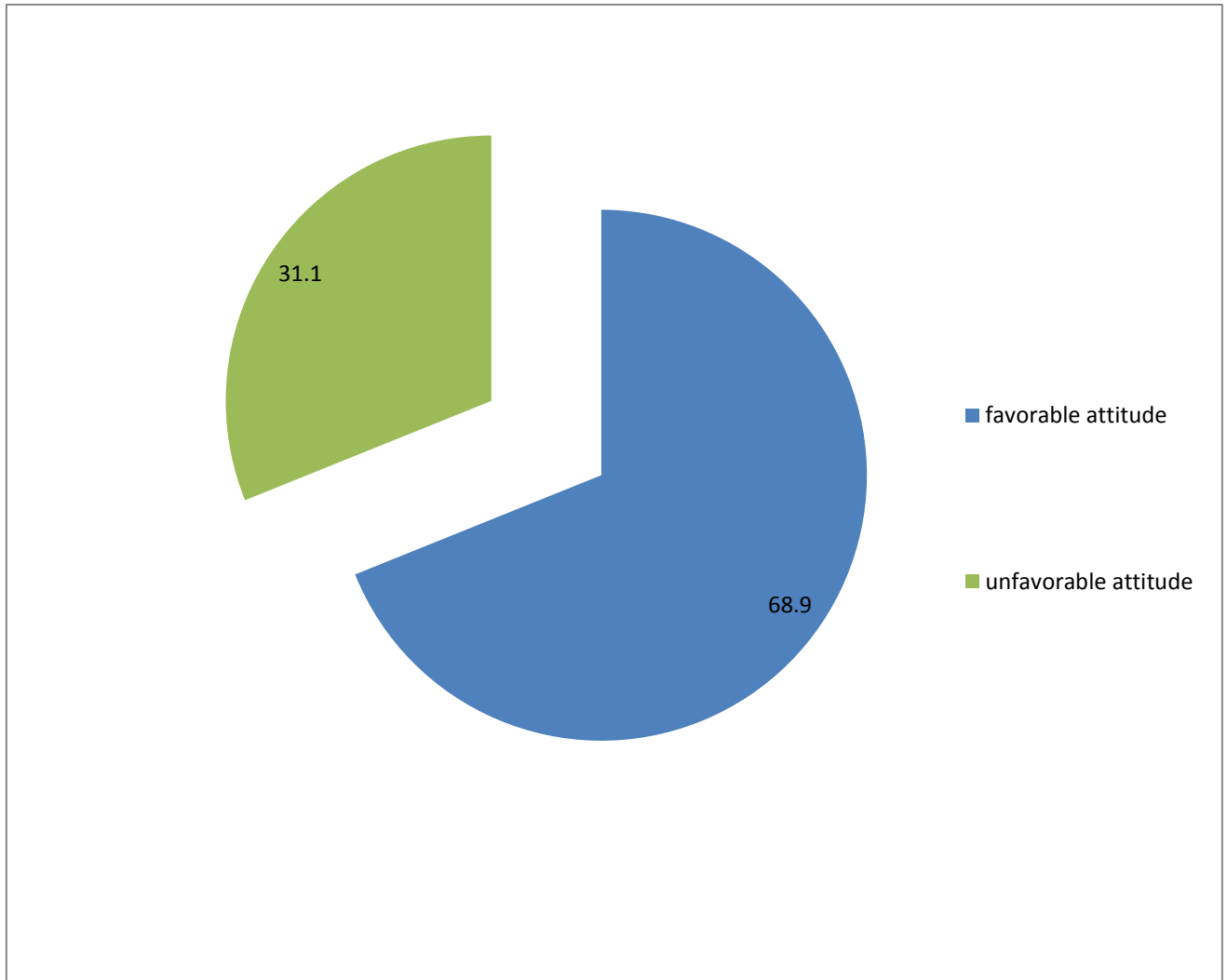


Figure 3: Respondents reported level of Attitudes by percentage towards Risky Sexual Behavior, Adama University, Ethiopia, February, 2012 (N=563).

Table 3: Distributions of Respondents' by Reported Attitude on risky sexual behavior,
Adama University, Ethiopia, February, 2012.

Variable	Participants response			
	N=563			
Attitude questions	Strongly disagree	Disagree	Agree	Strongly agree
	Freq. (%)	Freq. (%)	Freq. (%)	Freq.(%)
In my opinion it does not matter having sexual intercourse with commercial sex workers	367(65.2)	132(23.4)	46 (8.2)	18(3.2)
In my opinion having multiple sexual partners enables me to choose the best one	352 (62.5)	153 (27.2)	36 (6.4)	22 (3.9)
having single sexual partner is a safe sex practice	45 (8)	74 (13.1)	186(33)	258(45)
Having sexual intercourse with a previously experienced person is most useful to satisfy sexual desire	162 (28.8)	217 (38.5)	91(16.2)	93(16.5)
Condom use creates confidence between partner	129 (22.9)	177 (31.3)	138(24.5)	119(21.1)
Avoiding sex other than my sexual partner makes me faithful to my partner	60 (10.7)	63 (11.2)	159(28.2)	281(49.9)
My partner usually does not accept the idea of avoiding premarital sex	133 (23.6)	143 (25.4)	138(24.5)	149 (26.5)
Condoms reduce my sexual pleasure	114 (20.2)	167 (29.7)	171(30.4)	111 (19.7)
I may lose my partner if I say no to sex	125 (22.2)	160 (28.4)	160(28.4)	118 (21)
Having sexual intercourse with same sex is immoral	61 (10.8)	49 (8.7)	6(10.7)	393 (69.8)
From now I have it in mind to limit my sexual contact with one partner	28 (5)	22 (3.9)	121(21.5)	392 (69.6)
From now I intend to use condom	90 (16)	119 (21.1)	165(29.3)	189(33.6)

5.4: Factors influencing Attitude on risky sexual behavior

Binary logistic regression was used to see the association between levels of attitude on having sexual intercourse with a previously experienced person is most useful to satisfy sexual desire and some Socio-demographic factors, substance use and other factors influencing risky sexual behaviors. A p-value of less than 0.001 was considered statistically significant. In order to employ the model, dependent variable was dichotomized and coded as 0 (unfavorable attitude) and 1 (favorable attitude). Categorical independent variables were meaningfully grouped. The selected variables included in the model were: sex, age, level of study, Pocket money, Pornographic film show, currently Alcohol intake, currently Khat chewing, current drug intake and, currently cigarette smoking. As displayed in table 8 current chewing khat and watching pornographic view were found significant association with level of attitude { $P < 0.000$, AOR 2.499, 95% CI: 1.485-4.207 and $P < 0.000$, AOR 2.268, 95% CI: 1.495-3.441 respectively}.

Table 4: Bivariate and multivariate logistic regression analysis of the association of selected Socio-demographic characteristics and factors influencing risky sexual behavior with level of attitude on selected risky sexual behaviors, Adama University, Ethiopia, February, 2012.

N=563

Variable	Having sexual intercourse with a person who had sexual practice is most useful for sexual satisfaction		P-value	Crude OR (CI 95%)	Adjusted OR (CI 95%)
	Unfavorable attitude	Favorable attitude			
Sex					
Male	160(28.4%)	299(53.1%)		1.00	
Female	24(4.3%)	80(14.2)		1.784(1.087,2.926)	0.957(0.536, 1.706)
Age in year					
15-19	6(1.1%)	26(4.6%)		2.185(0.833,5.406)	2.065(0.759, 5.618)
≥ 20	178(31.6%)	353(62.7%)		1.00	
Level of study					
Year-2	68(12.1%)	167(29.7%)		1.344(0.936,1.929)	1.074(0.717, 1.609)
Year-3 & above	116(20.6%)	212(37.6%)		1.00	
Pocket money/month					
<200bir	75(13.3%)	165(29.3%)		1.188(0.654,2.159)	1.002(0.526, 1.911)
201-250bir	33(5.9%)	98(17.4%)		1.856(0.937,3.678)	1.581(0.754, 3.316)
≥251bir	20(3.6%)	32(5.7%)		1.00	

Alcohol intake					
Yes	74(13.1%)	70(12.4%)		2.970(2.005, 4.398)	1.440(0.854, 2.427)
No	110(19.5%)	309(54.9%)		1.00	
Chewing khat					
Yes	88(15.6%)	81(14.9%)	0.000	3.372(2.3084.929)	2.499(1.485-4.207)*
No	96(17.1%)	298(52.9%)		1.00	
Drug use					
Yes	7(1.2%)	4(0.7%)		3.708(1.071,12.830)	1.852(0.471, 7.282)
No	177(31.4%)	375(66.6%)		1.00	
Smoking cigarette					
Yes	10(1.8%)	10(1.8%)		2.121(0.867, 5.189)	0.857(0.319, 2.307)
No	174(30.9%)	369(65.5%)		1.00	
Watching pornographic view					
Yes	137(24.3%)	199(35.3%)	0.000	2.637(1.789-3.886)	2.268(1.495-3.441)*
No	47(8.3%)	180(32.0)		1.00	

*** P value < 0.001

5.5: Practice of the students on risky sexual behavior

Among all respondents 191(34%) reported to have had previous history of sexual experience. Of these, 168 (88%) and 23 (12%) were male and female respectively. majority of the participants 147 (77%) had started sexual intercourse at the age of 17- 21years, 34 (17.8%) at the age of 12-16 years, and 10 (5.2%) had started at the age of ≥ 22 years old. The mean and median age at first sexual contact was 18.4 and 18 years (SD ± 2.0) for male and 18.2 and 18.2(SD ± 1.9) for female. The minimum age of sexual initiation was 12 and 13 years for male and female respectively. The range went 12 to 24 years. The respondents were asked about their sexual partner during the first sexual act, 122 (63.9%) were responded that they had have first sexual contact with their boy/girlfriends while 34 (17.8%), 23 (12%) and 12 (6.3%) had have their first sexual contact with casual acquaintance, somebody just met and commercial sex workers respectively. Regarding condom use during their first sexual contact, more than half of sexually active respondents 113 (59.2%) did not use condoms. About sexual contact with commercial sex worker, 42 (22 %) of sexual active male respondents reported that they had sexual contact with commercial sex worker. Concerning sexual partner, currently 220 (39.1%) of the respondents had sexual partner. In relation to number of sexual partner, 183 (83.2%) of the participants had single sexual partner while 19 (8.6%), 11 (5%) and 7 (3.2%) had two, three and more than three sexual partner respectively. Regarding sexual practice, 144 (75%) of sexual active respondents had sexual practice in the past one year prior to this study. Of these, 126 (87.5%) were males and 18 (12.5%) were females. About route of sexual contact, 128(88.9%) of sexual active respondents were used normal (genital) route of sexual contact. Eleven (7.6%) and 5 (3.5%) were used anal and oral route of sexual contact. Out of sexually active respondents, 99 (68.8%) used condoms.

Of those who used condoms, 85 (85.9%) were males and the rest 14 (14.1%) were females. About frequency of condoms use, 48 (48.5%), 14(14.1%) and 37 (37.4%) of the participants had used condoms always, usually and sometimes respectively. However, 45 (31.3%) of respondents reported that they had not used condoms in the past one year of sexual contact. Regarding reasons not to use condoms, participants reported that: 8 (17.8%) it reduces sexual pleasure,16(35.6%) partner disagreement, 3(6.7%) condoms unavailability, 10 (22.2%) lack of knowledge and confidence 11 (24.4%).

In relation to homosexuality and lesbian, 26 (18%) of sexually active respondents in the past one year reported that they had sexual contact with the same sex. Of these, 24 (92.3%) and 2 (7.7%) were male and female respectively.

Table 5: Percentage Distributions of Respondents by Sex and Reported Sexual Practice among Adama University students, Ethiopia, February, 2012.

Variables	Sex		Total
	Male	Female	
Have you ever had sexual intercourse?	N=563		
Yes	168(29.8%)	23(4.1%)	191(34%)
No	291(51.7%)	81(14.4%)	372 (66%)
If yes, at what age?	N=191		
12-16	31(16.2%)	3(1.6%)	34(17.8%)
17-21	127(66.5%)	15(7.9%)	147(77%)
≥22	10(5.2%)	5(2.6%)	10(5.2%)
If yes, with who?	N=191		
Boy/girl friends	103(53.9%)	19(9.4%)	122(63.9%)
casual acquaintance	33(17.3%)	1(0.5%)	34(13.8%)
Somebody just met	20(10.5%)	3(1.6%)	23 (12%)
Commercial sex worker	12(6.3%)	0	12 (6.3%)
Had you ever used condom during your first sexual act?	N=191		
Yes	71(37.2%)	7(3.7%)	78(40.8%)
No	97(50.9%)	16(8.4%)	113(59.2%)
Have you ever had sexual contact with commercial sex worker?	N=191		
Yes	42(22%)	0	42(22%)
No	126(66%)	23(12%)	149(78%)
Had have sexual partner currently?	N=191		
Yes	171(34.8%)	49(8.7%)	220(39.15)
No	288(51.2%)	55(9.8%)	343(60.9%)
If yes, how many?	N=220		
One	138(62.7%)	45(20.5%)	183(83.2%)
Two	17(7.2%)	2(0.9%)	19 (8.6%)

Three	10(4.5%)	1(0.5%)	11(5%)
More than three	6(2.7%)	1(0.5%)	7(3.2%)
Have had sexual intercourse for the last one year			
Yes	126(87.5%)	18(12.5%)	144(75%)
No	333(59.1%)	86(15.8%)	419(74.2%)
If yes, what routes do you used?	N=144		
Genital	111(77.1%)	17(11.8%)	128(88.9%)
Anal	10(6.9%)	1(0.7%)	11(7.6%)
Oral	5(3.5%)	0	5(3.5%)
If yes, have you ever used condom?	N=144		
Yes	85(59.0%)	14(9.7%)	99(68.8%)
No	41(28.5%)	4(2.8%)	45(31.2%)
If yes, how often?	N=99		
Always	43(43.4%)	5(5.1%)	48(48.5%)
Usually	11(11.1%)	3(3.0%)	14(14.1%)
Sometimes	31(31.3%)	6(6.1%)	37(37.4%)
If no, what was your reason?	N=45*		
It reduce sexual pleasure	8(17.8%)	0	8(17.8%)
Partner disagreement	13(28.9%)	3(6.7%)	16(35.6%)
Condom unavailability	3(6.7%)	0	3(6.7%)
Lack of knowledge	10(22.2%)	1(2.2%)	11(24.4%)
Confidence	11(24.4%)	0	11(24.4%)
Have you ever had sexual intercourse with the same sex	N=144		
Yes	24(16.7%)	2(1.4%)	26(18.1%)
No	102(70.8%)	16(11.1%)	118(81.9%)

“*“Multiple responses were possible and don’t give the exact figure.

5.6: Factors influencing homosexuality

Binary logistic regression was used to see the association between homosexuality/lesbianism and some Socio demographic factors, substance use and other factors influencing risky sexual behaviors. A p-value of less than 0.001 and less than 0.01 was considered statistically significant. In order to employ the model, dependent variable was dichotomized and coded as 0 (not homosexual) and 1 (homosexual). Categorical independent variables were meaningfully grouped. The selected variables included in the model were: sex, age, level of study, Pocket money, Pornographic film show, currently Alcohol intake, currently Khat chewing, currently drug intake and, currently cigarette smoking. As showed in table 10 current chewing khat {P <0.000, AOR 0.115, 95% CI 0.037-0.360} and drug intake {P <0.004, AOR 0.071, 95% CI 0.012-0.419} were found significant association with homosexuality.

Table 6: Association between Socio demographic characteristics and some other related factors with homosexuality among Adama University students, Adama, Ethiopia, February, 2012.

Variables	Have you ever had sexual intercourse with the same sex		P-value	Crude OR (CI 95%)	Adjusted OR (CI 95%)
	Yes	No			
Sex					
Male	24(24.3%)	435(77.3%)		0.560(0.120, 2.606)	1.632(0.269, 9.983)
Female	2(0.4%)	102(18.1%)		1.00	
Age in year					
15-19	2(0.4%)	30(5.3%)		2.500(0.432, 14.465)	3.591(0.387, 33.328)
≥20	24(4.3%)	507(90.1%)		1.00	
Pocket money/month					
<200bir	22(3.9%)	358(63.6%)		0.685(0.276, 1.702)	0.590(0.178, 1.953)
201-250bir	2(0.4%)	129(22.9%)		0.503(0.102, 2.482)	0.419(0.057, 3.068)
≥251bir	2(0.4%)	50(8.9%)		1.00	
Level of study					
Year-2	11(2.0)	224(39.8%)		0.592(0.242, 1.444)	0.383(0.114, 1.280)
Year-3 & above	15(2.7%)	313(55.6%)		1.00	
Alcohol intake					
Yes	8(1.4%)	136(24.2%)		1.202(0.479, 3.016)	3.647(0.997, 13.340)
No	18(3.2%)	401(71.2%)		1.00	

Chewing khat					
Yes	15(2.7%)	154(27.6%)	0.000	0.119(0.046 -0.308)	0.115(0.037 -0.360)*
No	11(2.0%)	383(68.0%)		1.00	
Drug use					
Yes	6(1.1%)	5(0.9%)	0.004	0.113(0.032-0.394)	0.071(0.012-0.419)**
No	20(3.6%)	532(94.5%)		1.00	
Cigarette smoking					
Yes	2(0.6%)	18(3.2%)		0.297(0.047, 1.881)	1.328(0.102, 17.318)
No	24(4.3%)	519(92.2%)		1.00	
Watching pornographic View					
Yes	21(3.7%)	315(56.0%)		1.250(0.450,3.471)	0.937(0.251, 3.496)
No	5(0.9%)	222(39.4%)		1.00	

***P value < 0.001

***P value < 0.01

CHAPTER SIX

DISCUSSION

A descriptive cross sectional study was conducted to assess the level of attitude towards risky sexual behavior and sexual practice among Adama University under graduate regular students. The study showed that the majority of the participants 459(81.5%) were male. More than half of the respondents 294 (52.2%) were Oromo and 279 (49.6%) were Orthodox Christians. Twenty five point six percent and 30% of the respondents reported that they currently take alcohol and chew khat respectively. Among the respondents who chew khat, they were further inquired for their chewing condition. The responses indicate that majority of them (91.7%) used to chew regularly and 6.3% of them chew sometimes. This result was higher than the findings by Nigatu (2012) which showed the current prevalence rate of khat using among Addis Ababa University students were 16.8%. This may be due to environmental influences (15).

6.1: Attitude on risky sexual behavior

Almost more than two-third (68.9%) of the participants had a favorable attitude towards risky sexual behavior while 31.1% of them unfavorable attitude. This is nearly similar to a study done among AAU university students, 65.5% of respondents had positive attitude on the prevention of risky of sexual behavior (15). Majority of the participants (89.7%) were disagreeing in having multiple sexual partners. This is favorable attitude and it should be encouraged as a way in reduction of risky sexual behavior and important element of behavioral change. About two-third (67.3%) of participants were disagree with the idea of having sexual intercourse with a previously experienced person is most useful to satisfy sexual desire. Current chewing khat and watching pornographic view were found significant association with level of attitude { $P < 0.000$, AOR 2.499, 95% CI: 1.485-4.207 and $P < 0.000$, AOR 2.268, 95% CI: 1.495-3.441 respectively}.

Khat chewer and pornographic film viewers are 2.499 and 2.268 times more likely to have favorable attitude than their counterpart on the idea of having sexual intercourse with a person have sexual practice. This result reflects that currently khat chewers and pornographic viewers are more imaginative to think about the risky sexual behaviors that affecting the health of individuals than non-chewers and viewers. Also it may be due to chewing khat and watching pornographic views in group it gives an opportunity to discuss about the impact of risky sexual behaviors. However, this result violates the hypothesis that “Adama University students who are currently chewing khat and watching pornographic views have unfavorable attitude on risky sexual behavior”.

In short, the logistic regression result identified currently chewing Khat, and currently watching pornographic views as positively affecting respondents’ attitude on risky sexual behavior when compared to their counterparts. However, this does not mean that respondents who do not watching pornographic view and consume khat had no favorable attitude. Similarly, having favorable attitude by consuming Khat and watching pornographic movies is not advisable due to their risk factor. According to Assefa et al (2005) those who drink alcohol, chew khat and smoke cigarette are at a higher risk of being infected by HIV/ AIDS virus and other sexual transmitted infection due to having of risky sexual behavior (60). Similarly study done on Khat, alcohol use and risky sex behavior among in-school and out-of-school youth in Ethiopia showed that Khat use was strongly associated with initiation of sexual activity with four-fold increased odds in both daily and weekly users. The odds ratios for daily use were: adj. OR (95% CI) = 4.13 (3.26, 5.23); and for weekly Khat use: adj.OR (95% CI) = 4.18 (3.50, 4.99) (48).

Almost half of the respondents (51%) were agree with having premarital sexual intercourse. The figures highlight a significant difference between the expectation of avoiding premarital sexual intercourse and the real situation. Many studies have reported that good knowledge on prevention of risky sexual behavior but negative attitude is still prevalent (53). This indicates that the university students are exposed to health problems through their unfavorable attitudes towards risky sexual behavior.

6.2: Sexual practice

The finding of this study indicates that a third (34%) of the respondents reported to have had sexual intercourse. More male participants had ever sex compared to female (OR 2.033, 95% CI 1.233-3.354, $P < 0.005$). This finding is consistent with previous study at Addis Ababa University where 34.2% of students had had sexual experience (15). In contrast, this result is higher than that reported in a study done among Haramaya University students in which 28% were found to have had sexual experience (55).

In addition, a greater proportion of Adama University students are sexually active compared to the 8% who had ever had sex among students from Wuhan University in China (58). But much lower than 76.8% report among undergraduate students in Nepal (57). Such a variation of findings among studies conducted in different areas may be due to utilization of different intervention strategies in addressing the problem such as use of health education on sexuality and reproductive issues. Cultural expectation may be another factor. However, the figures highlight an important discrepancy between the expectation of preventing premarital sexual intercourse and the fact in the ground. The mean and median age at first sexual act was 18.4 and 18 years ($SD \pm 2.0$) for male and 18.2 and 18.2 years ($SD \pm 1.9$) for females.

This finding almost comparable with other studies conducted in AAU and Haramya University where the mean and median age at first sexual intercourse was 17.8 and 18.0 years respectively (55,15). However, the median age at first sexual intercourse of this study greater almost by two years than the national survey result of EDHS (2005) which is 16.1 years.

The study also revealed that risky sexual behavior is common among the participants. Among the male students that ever had sexual practice, 42 (22%) had sexual intercourse with commercial sex workers. This is very high when we compare it with undergraduate students from the University of Gondar in Northwest Ethiopia in which only 7.1% of the students had sexual contact with commercial sex workers (11). In contrast, this figure is much lower when we compare it with the study done among Haramaya University students (52.7%) (55). Among participants that ever had sex in the past one year before the study period, 68.8% of them had used condom. Of which only 48.5% of the students had used condom consistently. This finding is better than the study done among Haramya University students where condom utilization and consistent use of condom during sexual intercourse were 64.1% and 20.4% respectively (55).

The overall prevalence of ever use condom in sexual intercourse among Adama University undergraduate students was 68.8%. The finding differed from national behavioral surveillances survey and EDHS 2005 were 43.1% and 45.9% of sexual active youth samples reported ever used condom (16, 38). Furthermore, 31.2% of the participants, 91.1% male and 8.8% females reported that they had not used condoms. This is higher than a study done among AAU students where non-utilization of condom was 28.5% (15).

This indicates that some of the respondents were still at high risk of contracting HIV/AIDS and other STIs and unwanted pregnancy due to unsafe sexual practice and calls for strengthen sexual and reproductive health services and awareness creation campaigns in the higher education institutes.

Homosexual sex is considered a taboo and illegal in Ethiopia like many other African countries.

This study revealed that 26 (18 %) of the sexually active students in the past one year reported to have practiced homosexual and lesbian sex. Current chewing khat {P <0.000, AOR 0.115, 95% CI 0.037-0.360} and drug intake {P <0.004, AOR 0.071, 95% CI 0.012-0.419} were found significant association with homosexuality. Kaht chewers and drug users are more likely to practice homosexuality and lesbianism than non- chewers and non-drug users. This figure is much higher than the 6.4 percent reported in a study done among students of Haramaya University, Ethiopia (55). This indicates that despite the cultural taboo and illegality of homosexuality in Ethiopia and other African countries, there are sections of youth practicing it. It is clear that this group is at a disadvantage when it comes to reducing risks due to the sensitive nature of their act and the possibility of promiscuity. For instance the study among Dire Dawa University students found a high risk of HIV infection among this group compared to heterosexuals (OR 10.5; 95% CI 1.9 - 56.4) (55) .

6.3: CONCLUSION

The result of this study revealed that, most of respondents (68.9%) looked more have favorable attitude towards risky sexual behavior. On the other hand, the study showed that 34% of the participants had had sexual practice which indicates the prevalence of premarital sex is high among Adama university undergraduate students.

Furthermore, the study revealed that sexual active respondents were engage in different risky sexual behaviors like having sexual intercourse with commercial sex worker, multiple sexual partner, unprotected sex and homosexuality and lesbianism. In general the finding shown that there is a discrepancy between the level of attitude towards risky sexual behavior and sexual practice. Therefore, this result is alarming the concerned body in reacting promptly to bring behavioral change among higher education institutes students.

6.4: RECOMMENDATION

Based on the findings of this study the following recommendations are proposed:-

1. The level of attitude should be maintained through continuous sensitization program on risky sexual behavior by using mini-media.
2. Sexual and reproductive health services should be integrated with other health care services delivered in the University clinics.
3. Establish or strengthen different clubs that address sexual and reproductive health needs and facilitate behavioral changes among students.
4. Universities higher officials should be participate in easing sexual and reproductive health issues.
5. Parents should be involved in education of risky sexual behavior.
6. Finally, it is highly recommended that related studies be conducted in other colleges, particularly in newly established regional universities.

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ANNEXES

ANNEX-1

Subject information sheet and consent form (English version)

Addis Ababa University, school of medicine and college of health sciences, Department of nursing and midwifery consent form for assessment of knowledge, attitude and practice on risky sexual behavior among Adama University students. East Shewa Zone, Ethiopia.

Greeting!!

Introduction

My name is _____. I am working in the research team of Addis Ababa University, school of medicine and college of health sciences, Department of nursing and midwifery. With a research entitled, Assessment of knowledge, attitude and practice on risky sexual behavior among Adama University students. You have been selected to participate in this study. The finding of the study will be used for better planning & intervention of risky sexual behavior in Ethiopia. Therefore, I am requesting you to fill this questionnaire by yourself. There are no rights or wrong answers. The question includes very personal questions and difficult to talk about, but you have found it useful to have the opportunity to talk. Your response is completely confidential. You do not need to write your name and will never be used in connection with any of the information you give me. You are kindly requested to answer every question and you may stop filling the form at any time you want to. However, your honest answers to these questions will help us better understand about risky sexual behavior of the students. According to the questions it is allowed to have more than one answer.

We would greatly appreciate your help in responding to these questions. The survey will take about for twenty minutes to fill this questionnaire.

Would you be willing to participate? [X]

Yes -----

No -----

If you are willing after responding to the questionnaire return the questionnaire to the data collector.

If you have any query, contact principal investigator.

Address: cell phone – 0911-79- 60-27

: E.mail – tsigemeseret35@yahoo.com

ANNEX- II

Questionnaire (English Version)

Self-administered Questionnaire

A questionnaire prepared to assess knowledge, attitude and practice about risky sexual behavior among Adama university students.

Direction: For multiple choice questions circle the answer in front, for short answers write on the space provided, thanks for your cooperation

Part I. Socio-demographic data

No.	Questions	Coding category	Skip to
Q101	How old are you?	/-----/years	
Q102	What is your sex?	1. Male 2. Female	
Q103	Religion	1.OrthodoxChristian 2.Muslims 3.Protestant 4.Catholic 5.Other/specify	
Q104	Ethnicity	1.Oromo 2.Amhara 3.Tigre 4.Gurage 5.Other/specify	
Q105	Where do you live?	1.In campus 2.Out side campus	

Q106	Do you have pocket money?	1.Yes 2.No If your response is No →	Q108
Q107	From where you get your pocket money?	1.Parents 2.Brother/sister 3.Boyfriend/girlfriend 4.Cost sharing Other/ Specify.....	

Part I Socio-demography Cont.....

Q108	How much money in Birr was sent to you per month?	1.< 100 Birr 2.100 – 250 Birr 3.251– 500 Birr 4.> 500 Birr	
Q109	Do you think it was enough?	1. Yes 2. No	
Q110-a	In which school are you learning?	
Q110-b	In which department are you learning	
Q111	In which academic year are you now?	1. 2 nd yr, 2. 3 rd yr, 1. 4 th yr, 4. 5 th yr	

Q112	Have you ever used substance like?	Usually		Some time	
	1. Alcohol	Yes	No	Yes	No
	2. Chat	1	2	1	2
	3. Drug like cannabis	1	2	1	2
	4. cigarettes	1	2	1	2
	5. Other specify.....	1	2	1	2
113	Have you ever viewed pornography film?	1.yes		2.no	

Part II. Attitude assessing questions towards risky sexual behavior

No	Questions	Coding categories	Skip to
Q201	In my opinion it does not matter having sexual intercourse with commercial sex workers	1. Strongly disagree 2.Disagree 3.Agree 4. Strongly agree	
Q202	In my opinion having multiple sexual partners enables me to choose the best one	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	
Q203	having single sexual partner is a safe sex practice	1. Strongly disagree 2. Disagree 3.Agree 4. Strongly agree	
Q204	Having sexual intercourse with a previously experienced person is most useful to satisfy sexual desire	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	

Q205	Condom use creates confidence between partner	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	
Q206	Avoiding sex other than my sexual partner makes me faithful to my partner	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	
Q207	My partner usually does not accept the idea of avoiding premarital sex	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	
Q208	Condoms reduce my sexual pleasure	1. Strongly disagree 2. Disagree 3. Agree 4. Strongly agree	

PartII attitude assessment cont.....

Q209	I may lose my partner if I say no to sex	1. Strongly disagree 2. disagree 3. Agree 4. Strongly agree	
Q210	Having sexual intercourse with same sex is immoral	1. Strongly disagree 2. disagree 3. Agree 4. Strongly agree	
Q211	From now I have it in mind to limit my sexual contact with one partner	1. Strongly disagree 2. disagree 3. Agree 4. Strongly agree	
Q212	From now I intend to use condom	1. Strongly disagree 2. disagree 3. Agree 4. Strongly agree	

Part III. Sexual practice assessing questions on risky sexual behavior

No	Questions	Coding categories	Skip to
Q301	Have you ever had sex?	1. Yes 2. No	
Q302	If yes, at what age was your first sexual contact?	/...../year	
Q303	With who do you had your first sexual contact?	1.with boyfriend/girl friend 2. casual acquaintances 3. somebody just met 4. commercial sex worker	
Q304	Had you ever used condom during your first sexual contact	1. Yes 2. No	
Q305	Have you ever had sex with commercial sex worker	1. Yes 2. No	
Q306	Have had sexual partner currently	1. Yes 2. No	
Q307	How many sexual partner do you have had for the last one year	1. one 2. Two 3. three 4. more than three	

Part III. Practice assessment conti.....

Q308	Have had sexual practice for the last one year?	1. Yes 2.No	
Q309	If your answer is yes for Q408, which route of sexual contact have you ever used?	1. Genital 2. Anal 3. Oral	
Q310	If your answer is yes for Q408, have you ever used condom	1. Yes 2.No	
Q311	If your answer is yes for Q410, how often(circle one)	1. Always 2. Most of the time 3. Some times	
Q312	If your answer is no for Q410, what is your reason (thick all that apply)	___it reduce sexual excitement ___Partner disagreement ___unavailability of condom ___lack of knowledge ___other/specify.....	
Q313	Have you ever had sexual intercourse with same sex?	1.Yes 2.No	

ANNEX- III

Subject Information Sheet and Consent Forum (Amharic Version)

በአዲስ አበባ ዩኒቨርሲቲ በሕክምና ጤና ሳይንስ ኮሌጅ የነርቭና የሚድዋይፈር ትምህርት ክፍል ለሥነ ተዋልዶ የጤና ችግር የሚያጋልጡ ባህሪያት ላይ የአዳማ ዩኒቨርሲቲ ተማሪዎች ያላቸውን እውቀት ዝንባሌና ልምምድን በተመለከተ በሚደረግ ጥናት ላይ የጥናቱን ተሳታፊዎች ፍቃድ መጠየቂያ ፎርም

ሠላምታ!!

መግቢያ:-

እኔ ስሜ _____ ሲሆን የምሠራው በአ.አ.ዩኒቨርሲቲ በሕክምናና ጤና ሳይንስ ኮሌጅ የነርቭና የሚድዋይፈር ትምህርት ጥናትና ምርምር አድራጊ ቡድን ውስጥ ነው።

የጥናቱም ርዕስና አላማ ለሥነ ተዋልዶ የጤና ችግር የሚያጋልጡ ባህሪያት ላይ የአዳማ ዩኒቨርሲቲ ተማሪዎች ያላቸውን እውቀት ዝንባሌና ልምምድ ለማጥናት ነው።

የዚህ ጥናት ውጤትም በከፍተኛ ትምህርት ተቋማት ውስጥ ለሥነ ተዋልዶ የጤና ችግር በሚያጋልጡ ባህሪያት ላይ ተገቢውን የመከላከል ዘዴን ለመንደፍና ለመተግበር ይረዳል ብለን እናምናለን።

ስለሆነም እርሶም የዚህ ጥናት ተሳታፊ እንዲሆኑና አስፈላጊውን መረጃ እንዲሰጡን በትህትና እንጠይቃለን። በዚህ ጥናት ላይ መሳተፍዎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሠረተ ሲሆን ላለመሳተፍም ሆነ መረጃ መስጠትዎን በማንኛውም ሰዓት የማቋረጥ መብትዎ የተጠበቀ ነው።

የጥናቱ መጠይቆች ሙሉ በሙሉ በራስዎ የሚሞላ ሲሆን መጠይቆቹ ትክክልና ትክክል ያልሆነ መልስ የላቸውም። መጠይቆቹ ግላዊና ለመናገር የሚከብዱ ቢሆኑም ይህንን መግለፅ በመቻልዎ እንደ ጥሩ አጋጣሚ ይቆጠሩት።

በዚህ ጥናት ሲሳተፉ ስምዎን መጻፍ አስፈላጊ አይደለም። የሚሰጡንንም መረጃዎች በሙሉ በሚስጥር እንደሚያዙና ለጥናቱ ዓላማ ብቻ እንደሚውል እያረጋገጥንልዎ የሚሰጡን ተዓማኒነት ያላቸው መረጃዎች ተማሪዎች ለሥነ ተዋልዶ የጤና ችግር የሚያጋልጣቸውን ተግባራት እንድንገነዘብ ይረዳናል።

መጠይቆቹ ከአንድ በላይ ምላሽ ሊኖራቸው ይችላል። መጠይቆቹን ለመሙላት የተሰጠው ሃያ ደቂቃ ብቻ ነው።

በዚህ ጥናት ለመሳተፍ ፍቃደኛ ነዎት (x)

አዎን _____

አይደለም _____

ፈቃደኛ ከሆኑ መጠይቆቹን ሞልተው ከጨረሱ በኋላ በፖስታው ውስጥ ከተው ለመረጃ ሰብሳቢው ይመልሱ።

ያልተረዱት ነገር ካለ ጥናት አድራጊውን አግኝተው ያነጋግሩ።

አድራሻ፡- ሞባይል 0911 79 60 27

E-mail: tsigemeseret35@yahoo.com

ANNEX-IV

Questionnaires (Amharic version)

ቅፅ አንድ

በግል የሚሞሉ መጠይቆች

ይህ መጠይቅ የተዘጋጀው የአዳማ ዩንቨርሲቲ ተማሪዎች ለስነ ተዋልዶ የጤና ችግር ስለሚያጋልጡ ባህሪያት ላይ ያላቸውን እውቀት


ዝንባሌና ልምምድ ለማጥናት ነው።

መመሪያ፡- ለምርጫ ጥያቄዎች መልሱን እንዲያከብሩና አጫጭር መልስ ላላቸው በተሰጠው ክፍት ቦታ ላይ እንዲሞሉ ይጠየቃሉ።

ስለትብብርዎት እናመሰግናለን።

ክፍል-አንድ- ማህበራዊና ስነ ህእባዊ ሁኔታን የሚያመለክቱ መጠይቆች

ተ.ቁ	መጠይቅ	የመለያ ደረጃ	ወደ ሚቀጥለው ይሂዱ
101	እድሜ	-----አመት	
102	ፆታ	1-ወንድ 2-ሴት	
103	ሀይማኖት	1-አርቶዶክስ 2-ሙስሊም 3-ፕሮቴስታንት 4-ካቶሊክ 5-ሌላ ካለ ይገለፅ	
104	ብሔር	1-አርሞ 2-አማራ 3-ትግሬ 4-ጉራጌ 5-ሌላ ካለ ይገለፅ	

105	መኖሪያ ቦታ	1-ግቢ ውስጥ	2-ከግቢ ውጪ	
106	የኪስ ገንዘብ አለህ/ሽ?	1-አዎን	2-የለም	ወደ 108 ይሄዱ
		መልሱ የለም ከሆነ 		
107	መልሱ አዎን ከሆነ ከየት ነው የምታገኘው/ኛው?	1-ከቤተሰብ	2- ከወንድም/እህት	
		3- ከወንድ/ሴት ገደኛ	4- ወጪ መጋራት	
		5-ሌሎች ካሉ ይግለጹ		
108	በወር ምን ያህል ገንዘብ ይላክልሃል/ሻል?	1-ከመቶ ብር በታች	2-ከ100-250 ብር	
		3-ከ251-500 ብር	4-ከ500 ብር በላይ	
109	በቂ ነው ብለህ ታስባለህ/ሽ?	1-አዎን	2-አይደለም	
110	የትኛው ት/ቤትና ዲፓርትመንት ተማሪ ነህ/ሽ?	1-ት/ቤት-----		
		2-ዲፓርትመንት-----		
111	የስንተኛ አመት ተማሪ ነህ/ሽ?	1-2ኛ	2-3ኛ	
		3-4ኛ	4-5ኛ	
112	ከዚህ በታች የተዘረዘሩትን ይጠቀማሉ?	ሁልጊዜ		አልፎ አልፎ
	1-አልኮል መጠጥ	1-አዎ	2- አይደለም	1-አዎ 2- አይደለም
	2-ጫት	1-አዎ	2- አይደለም	1-አዎ 2- አይደለም
	3-አደንዛኸር ዕፅ	1-አዎ	2- አይደለም	1-አዎ 2- አይደለም
	4-ሲጋራ	1-አዎ	2- አይደለም	1-አዎ 2- አይደለም
	5-ሌላ ካለ ግለፁ	1-አዎ	2- አይደለም	1-አዎ 2- አይደለም

113	ለወሲብ የሚያነሳሱ ፊልሞችን ታያለህ/ሽ?	ሁልጊዜ	አልፎ አልፎ
		1-አዎ 2- አይደለም	1-አዎ 2- አይደለም

ክፍል ሁለት- ለስነ ተዋልዶ የጤና ችግር የሚያጋልጡ ባህሪያት ላይ ተማሪዎች ያላቸውን ዝንባሌ የሚያመላክቱ መጠይቆች

ተ.ቁ	መጠይቅ	የመለያ ደረጃ	ወደ ሚቀጥለው ይሂዱ
201	በእኔ አመለካከት ከሴተኛ ኢዳሪዎች ጋር ወሲብ መፈጸም ምንም ማለት አይደለም	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
202	በኔ አመለካከት ከአንድ በላይ ወሲብ ጋደኛ መያዙ የተሻለውን ለመምረጥ ያስችላል	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
203	ከአንድ የወሲብ ጋደኛ ጋር መወሰን ለስነ ተዋልዶ ጤና ችግር ላለመጋለጥ አስተማማኝ ነው	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
204	የወሲብ ግንኙነት ልምምድ ካለው ሰው ጋር ወሲብ መፈጸም የወሲብ ፍላጎትን ያረካል	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
205	ኮንዶም መጠቀም በጾታ ጋደኞች መካከል መተማመንን ይፈጥራል	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
206	ከወሲብ ጋደኛዬ ውጪ ወሲብን አለመፈጸም ለጋደኛዬ ታማኝ መሆኔን ያመለክታል	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ
207	ጋደኛዬ ባብዛኛው ቅድመ ጋብቻ የወሲብ ግንኙነት አለማድረግን ይቃወማል/ትቃወማለች	1-በጣምአልስማማም 3-እስማማለሁ	2-አልስማማም 4-በጣም እስማማለሁ

208	ኮንደም መጠቀም የጾታ እርካታን ቀንሳል	1-በጣምአልሰማም 3-እስማማለሁ	2-አልሰማም 4-በጣም እስማማለሁ	
209	ወሲብ አላደርግም ብል ጋደኛዬ ሊተወኝ ይችላል/ትችላለች	1-በጣምአልሰማም 3-እስማማለሁ	2-አልሰማም 4-በጣም እስማማለሁ	
210	ከተመሳሳይ ጾታ ጋር ወሲብ መፈጸም ስነ ምግባር የጎደለው ልምምድ ነው	1-በጣምአልሰማም 3-እስማማለሁ	2-አልሰማም 4-በጣም እስማማለሁ	
211	ከአሁን በሃላ በአንድ የወሲብ ጋደኛ እወሰናለሁ	1-በጣምአልሰማም 3-እስማማለሁ	2-አልሰማም 4-በጣም እስማማለሁ	
212	ከዚህ በሃላ ሁልጊዜ ኮንዶም እጠቀማለሁ	1-በጣምአልሰማም 3-እስማማለሁ	2-አልሰማም 4-በጣም እስማማለሁ	

ክፍል ሶስት- ለስነ ተዋልዶ የጤና ችግር የሚያጋልጡ ባህሪያት ላይ ተማሪዎች ያላቸውን ልምምድ የሚያመለክቱ መጠይቆች

ተ.ቁ	መጠይቅ	የመለያ ደረጃ	ወደ ሚቀጥለው ይሂዱ
301	የወሲብ ግንኙነት አድርገህ/ሽ ታወቃለህ/ሽ?	1-አዎን 2-አላውቅም መልስህ/ሽ አላውቅም ከሆነ	406
302	ለተ.ቁ 401 መልስህ/ሽ አዎን ከሆነ በስንት ዓመተህ/ሽ ነበር የመጀመሪያ ግንኙነት ያደረግኸው?	-----ዓመት	
303	ለተ.ቁ 401 መልስህ/ሽ አዎን ከሆነ ከማን ጋር ነበር የመጀመሪያ ግንኙነት የፈጸምከው/ሽው?	1-ከወንድ/ከሴት ጋደኛ 3-ባጋጣሚ ካገኙት ሰው ጋር	2-ከድንገተኛ ጋደኛ 4-ከሴተኛ አዳሪ ጋር

304	በመጀመሪያ ግንኙነት/ሽ ኮንዶም ተጠቅመህ/ሽ ነበር?	1-አዎን	2-አልተጠቀምኩም	
305	ከሴተኛ አዳሪ ጋር ወሲብ ፈጽመህ ታውቃለህ/ሽ?	1-አዎን	2-አላውቅም	
306	አሁን የወሲብ ጋደኛ ለህ/ሽ?	1-አዎን	2-የለኝም	
307	ለተ.ቁ 406 መልስህ/ሽ ዎን ከሆነ ስንት የወሲብ ጋደኛ አለህ/ሽ?	1-አንድ 3-ሦስት	2-ሁለት 4- ከ ሦስት በላይ	
308	ባለፈው አንድ ዓመት ውስጥ ወሲብ ፈጽመህ/ሽ ታውቃለህ/ሽ?	1-አዎን	2-አላውቅም	
309	ለተ.ቁ408 መልስ አዎን ከሆነ የነበረህ/ሽ ግንኙነት በምን ነበር?	1-በብልት 3-በአፍ	2-በፊንጢጣ	
310	ለተ.ቁ 408 መልስህ/ሽአዎን ከሆነ ኮንዶም ተጠቅመህ/ሽ ታውቃለህ/ሽ?	1-አዎን	2-አላውቅም	
311	ለተ.ቁ 410 መልስህ/ሽ አዎን ከሆነ አጠቃቀምህ/ሽ አንዴት ነበር?	1-ሁልጊዜ 3-አልፎ አልፎ	2- ባብዛኛው	
312	ለተ.ቁ 410 መልስህ/ሽ አላውቅም ከሆነ ምክንያቱ ምን ነበር(ተሰማሚ የሆኑትን ሁሉ መመለስ ይቻላል)?	1-የጾታ ፍላጎት ስለሚቀንስ 3- የኮንዶም አጥረት 5-ሌላ ካለ ይገለጽ	2-የጋደኛ ለመስማማት 4-የአውቀት ማነስ	
313	ከተመሳሳይ ጾታ ጋር ወሲብ ፈጽመህ/ሽ ታውቃለህ/ሽ?	1-አዎን	2-አላውቅም	

ANNEX -V

Declaration

This thesis my original work, has not been presented for a degree in only other University and that all sources of material used for the thesis have been duly acknowledged.

Principal investigator

Name ----- Signature -----Date-----

Advisor

Name -----Signature-----Date-----