ST. MARY'S UNIVERSITY

SCHOOL OF GRADUATE STUDIES INSTITUTE OF AGRICULTURE AND DEVLOPMENT STUDIES,

DEPARTMENT OF SOCIOLOGY.

ASSESMENT OF YOUTH SEXUALITY AND ASSOCIATED HEALTH RISKS FACTORES THE CASE OF ST. MARY'S UNIVERSITY UNDERGRADUATE STUDENTS.

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By Enawgaw Alemayehu

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RESEARCH TITLE

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ABBREVIATIONS AND ACRONYMS

AIDS -Acquired Immune Deficiency Syndrome

AYFHS- Adolescent and Youth Friendly Health Service

AYH -Adolescent and Youth Health

AYRH- Adolescent and Youth Reproductive Health

CSA -Central Statistics Agency

CSO -Civil Society Organization

EDHS -Ethiopian Demographic Health Survey

FBO -Faith-Based Organization

FGM- Female Genital Mutilation

FMOH -Federal Ministry of Health

FP -Family Planning

GYSI -Girls, Youth, and Social Inclusion

HIT- Health Information Technology

HIV- Human Immune Virus

HSTP -Health Sector Transformation Plan

HTP -Harmful Traditional Practice

MNCH- Maternal Newborn and Child Health

NCDs -Non-Communicable Diseases

NGO- Non-Governmental Organization

SBCC -Social and Behavioral Change Communication

SDG -Sustainable Development Goal SGBV -Sexual and Gender-Based Violence

SRH -Sexual and Reproductive Health

STI -Sexually Transmitted Infection

WHO -World Health Organization

Abstract:

This study aimed to assessment of youth sexuality and associated health risk factors the case of St. Mary's university undergraduate students." Students of private higher learning institutions are with multiple health risks in the life at younger age.

***Methods**: A cross-sectional study was conducted among 200 randomly selected undergraduate students from st marry universities from December 2022 to April 2024. Study participants were selected using random sampling technique Interviewers and structured questionnaire was used to collect the data.*

***Findings** include a predominantly female population 62.9 with a significant portion in the 18-20 age group 70.4. of youth sexuality and associated health risks reveal notable rates of alcohol consumption 41.2 and khat chewing 26.3 while smoking prevalence is relatively low 10.3 Sexual activity is reported by 13.5 of respondents, with condom use at 45.5 among sexually active individuals.*

***Conclusion**. the finding of this study identified that significant numbers of students engaged in health risky sexual factors in their lifetime. Regarding the university's role in addressing youth sexuality and related health risks, the study indicated that the university has not ever done its homework in this regard and the student don't have access to information about youth sexuality to make informed decisions and make a health transit. Therefore, understanding the factors with sexuality and associated health risk factors is important for implementing comprehensive interventions and prevent multiple risk factors among private university students.*

CHAPTER ONE

BACKGROUND OF THE STUDY

1. Introduction

In this chapter, issues related to the background of the study, statements of the problem, research questions, general and specific objectives of the study, scope of the study, significance of the study and organization of the research report are discussed thoroughly. Besides, limitations of the study are briefly included in this chapter.

1.1 Background of the study

A youth refers to the time of life when one is young. It encompasses the period between childhood and adulthood, but it can also denote one's peak in terms of health or the phase known as being a young adult. Adolescents experience significant physiological, and social changes following puberty. They are also vulnerable to many health problems. Young people aged 15-24 constitutes more than one billion of the world population, with four out of five living in the developing countries About 20 percent of the sub- Saharan African people are youth (WHO, 2015). In Ethiopia, adolescents and youth aged10 to 24 make up 33 percent of the total population, with over three-quarters of them residing in rural areas.

According to the 2007 Ethiopia population census, there are more than 15.2 million populations are constituting 20.6% youth of whole population. In Ethiopia, according to the Ministry of Health youth represent a significant proportion of the society. Currently, it is estimated that young people between ages 10-24 constitute more than one third of the total population, which is more than 21 million.

In Africa, 32% of the population belongs to the age group of 10-24 years. As the single largest and yet dynamic section of the population, adolescents and youth have the potential to contribute to growth and development. Young people are being referred to as the "torchbearers" of the 2030 SDG agenda The African Union's Agenda 2063 has a pivotal role to play both as beneficiaries of actions and policies a collective partner. Indeed, the 2030 agenda calls for the development and activation of sound, evidence-based youth policies and actions to ensure its full realization.

According to EDHS 2016 Report Ethiopia people were asked how old they were when they first had sexual intercourse. Among women aged 25-49 yrs., 29% first had sexual intercourse before

age 15 ,62% first had sexual intercourse before age 18 indicating that nine out of ten married women had their first sex during adolescence. Most young people are exposed to risky behavioral practices in their teens. Moreover, because they practice risky behaviors without precautions, they are exposed to various SRH problems including unwanted pregnancy, unsafe abortion, HIV/AIDS and sexually transmitted diseases (STD); STDs are major public health problems.

To address these key adolescent and youth health issues, the government of Ethiopia has taken several measures through its youth policy, the Health Sector Development Program I-IV, the Health sector transformation plan I-II, Federal Ministry of Health. National Adolescent and Youth Health Strategy (2021-2025). However, adolescents and youth are still facing multiple challenges starting from the emerging health threats, preventable causes of morbidity and mortality. WHO. Regional Atlas on Adolescent and youth 2017 report monitor the health status and trend of Adolescents and Youth in Africa.

The African we want. 2015 Effective prevention that enables to adapt safer behavior requires not only just knowing who is at risk, but also understanding why they engage in risky behavior, motivating them to reduce their risk; developing their knowledge and skills; improving their access to means of prevention in ways that are appropriate to them, and providing a supportive social and policy environment for behavioral change need to be considered.

Taking this into consideration, this study will assess the magnitude of youth sexuality and associated health risks factors at Addis Ababa. In the case Undergraduate program at St. Mary's University

1.2 Statement of the Problem

Adolescent reproductive health is important for the healthy development Adolescents, and it has immense contribution to who they become when they mature into adulthood. It is related consequences like HIV/AIDS, STDs, unwanted pregnancies, abortion, school dropout and early marriage. Adolescents lack adequate information and proper guidance, which may lead them to unrealistic decision and often become sexually active without consciously deciding. They are without question, highly exposed to all sorts of problems. One in every five people in the world is an adolescent, defined by World Health Organization as a person between 10 to 19 years of age. Unsafe sex is a major threat to the health and survival of millions of adolescents. Each year, one in 20 adolescents worldwide contracts STI including HIV. Every day, over 7000 young people

aged from 10 to 24 years become infected with HIV. Globally more than half of all new HIV infections are among 15 to 24 years old. WHO 2022 report Several studies shown that young people are engaged several associated health risk factors. Adolescents in Ethiopia are also exposed to various risks such as unprotected sex, early marriage, early pregnancy, sexually transmitted infections (STIs) and HIV/AIDS, unemployment, drug abuse and crime. To tackle these problems, adolescents should learn to develop the life skill they need to survive in their environment. Life skill-based education enables them to develop an ability in critical thinking, problem solving, Self-management and interpersonal communication skill to adopt a health behavior. When sexuality is discussed openly and when young people learn more about their bodies and their emotions, they are better able to cope with sexual maturations. Schools are the ideal places where adequate and accurate information be provided along with their formal education. Moreover, peer groups in school play a great role in information dissemination and help students internalize the facts that lead to behavioral change. The intensity of involvement in risky associated health risk factors from no sexual relationship to unprotected sexual relationship with multiple partner and prostitution. Sexually active youth who exhibits few positive or pre-socially behaviors such as involvement in organized action at universities are at high risk for outcomes such as early sexual activity and pregnancy during their teenage years and unwanted life disorders of the future.

In this regard, very few research has been done in risky sexual behaviors of regular private universities in Ethiopia where more students are potentially joined. Since the problem is serious among private regular university students in Addis Ababa, Ethiopia; therefore, this research is envisioned to fill the gap by expanding available research finding to assess risky sexual behavior of private regular university students in Addis Ababa. Accordingly, the researcher undertakes this study to fill the knowledge gap in the area According to EDHS 2016, report Ethiopia women and men were asked how old they were when they first had sexual intercourse. Most young people are exposed to risky behavioral practices in their teens.

However, in Ethiopia few research done in this topic, it is imperative to study the magnitude of unsafe sex and contributing factors among adolescent students to inform planners to develop appropriate and timely intervention programs to prevent unsafe sexual practices and associated health risk factors in these populations. Finally, the country loses educated man powers via risky sexual behaviors and health factors.

Hence, this study focuses on university students. This group of adolescents is chosen because many of themcome from rural areas and move to urban centers for their education, where they encounter diverseand sometimes conflicting cultural values and norms. They frequently interact with peers of similar age both within and outside university, exposing them to significant peer pressure. Additionally, theylead relatively independent lives with minimal direct supervision from adults, family, or community members, which can influence the development of both healthy and risky behaviors. This population is pivotal as they are in a transitional phase; as current university students, they willsoon move into public service roles, making their behaviors and health status crucial for both present and future generations. Considering these dynamics, the study aims to explore youth sexuality within the prevailing social and cultural context and investigate health issues such as HIV risk behaviors and related concerns in relation to their sexual behavior. to this end the study is a indicate to answering the following research questions.

1.3 Research Questions

1. What are the factors leading the university students to youth sexuality?
2. How informed are the students about the socio-cultural determinants of youth sexuality HIV/AIDS, STI and other health risk factors?
3. What is the conceptualization of students towards determinants of youth sexuality?
4. How is youth sexuality and associated health risks treated in the university?

1.4 Objective of the Study

1.4.1 General Objectives

The overall objective of the study is to evaluate the youth sexuality and related health problems among young university students at St. Mary University undergraduate program.

1.4.2 Specific objectives:

- To identify the factors leading students at the university to youth sexuality
- To assess the extent to which students are vulnerable to youth sexuality and related health risks in their stay at the university.
- To assess how the university treats youth sexuality and associated health risks.
- To assess youth sexuality and associated health risks at private university.

1.5 Significance of Study

In Ethiopia, it has been pointed out that managing the health issues and inevitably of youth has been an issue in health policy, and that the Ministry of Health is taking many initiatives. However, practical activities in the field of public health service delivery are still not visible.

Given the evidence to date and the scale of the problem, the researcher believe it is necessary to reduce the number of people endangered by HIV/AIDS, STI and other aftereffects of youth sexual behavior. Therefore, the purpose of this study is to identify health risk and protective factors. In this regard, this study is significant for policy makers, scholars in the field and future researchers around the study.

1.6 Scope of the Study

The thematic scope of the study is youth sexuality and related health risks especially among university students. More specifically, the study focuses on the undergraduate regular students at St. Mary University whose age range is below 24 years. And the study has employed a descriptive research method to demonstrate how they understand, and practice sexuality and their vulnerability to associated health risks.

1.7 Limitation of the study

In performing this study existing some limitation that highly affects the effectiveness of the study The respondents were not willing to give their respective detailed response or information about their operation. This is also one of the major problems in conduction the research. In addition to the general objective, this research could address other issues related to sexual practices among youths. However, being focused only on youth sexuality associated health risk factors issues couldn't imply all the problems related to sexual risks and this is the limitation of the study.

1.8 Operational Definitions of Key Terms

Drugs: In this study, drugs refer to any type of stimulant that alters the physiology of the body.Examples: alcohol, khat, shisha, hashish.

Early sexual initiation*:* Penetrative intercourse that occurs before the age of sexual maturity (18 years).

High-risk sex: History of sexual intercourse with multiple sexual partners and/or no use of condoms and affect changes in sexual partners.

Non-Commercial Sex Partner: A partner other than a commercial partner.

Parental Monitoring*:* is defined as a parent's knowledge of who their child is with and where they are spending their time.

Premarital sex: Heterosexual vaginal intercourse before formal marriage.

Risky behavior: This includes behaviors such as changing sexual partners frequently, using condoms inconsistently, having sex with sugar daddies.

Safe sex: Students who have sexual intercourse but regularly use condoms, whose only partner is whose partner and girlfriend have taken a VCT test, whose partner and girlfriend are 18 years ofage or older There is open communication between them.

Unsafe sex*:* For the purposes of this study, unsafe sex is defined as initiating sex without coherent condom use, without VET testing between better half, and with little or no communication about safe sex. Refers to the acts of young, unmarried youth 18 years or older, has a sexual partner, or has had multiple sexual partners.

Youth: Youth is considered a youth from the age of 15 to the age of 24.

Sexual Engagement*:* Student who had sexual intercourse with her at least once before the study.

Shisha: A mixture containing tobacco, hashish, and spices. Smoked from an Asian tobacco pipe.
Drug abuse*:* people chew khat, consume hashish, smoke cigarettes, smoke shisha, people drink alcohol.

1.9. Organization of the Thesis

This research report is structured into five chapters. The first chapter encompasses the background of the study, statement of the problem, study objectives, fundamental research questions, significance, scope of the study and operational definitions of key terms in the study. Meanwhile, the second chapter focuses on the review of related literature, including conceptual, theoretical, and empirical reviews.

In the third chapter, the study methodology is outlined, including the target population, sample size, sampling techniques, data collection tools, data analysis methods, validation and reliability of the data collection tools, and ethical considerations.

The fourth chapter presents the study's findings and analyzes them considering the reviewed literature. Subsequently, the fifth chapter outlines the conclusions drawn from the study and provides recommendations based on these findings. Additionally, references, and data collection instruments are included as annexes at the end of this research report.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This part of the thesis presents relevant related literature review in connection with the study topic. It comprises concepts and definition of terms, theoretical as well as empirical literature review considered as useful to conduct the study.

2.1 Concepts, Definition of Terms related to Youth.

The World Health Organization (WHO) (2007) defined youth as individuals aged between 15 and 24 years. Youth is considered a youth from the age of 15 to the age of 24. In Africa between 15-35 age are youth. In Ethiopia, the proportion of those aged 18 to 29 accounts for about a quarter of the total population of the country.

Adolescence: Adolescence is the time of transition from childhood to adulthood. Adolescents experience significant physiological, psychological, and social changes following puberty. They are also vulnerable to many health problems. Young people aged 15-24 constitutes more than one billion of the world population, with four out of five living in the developing countries About 20 percent of the sub- Saharan African people are youth.

Adolescents and youth constitute 42% of the population in Ethiopia (Central Statistics Agency, July 2013). However, about 20% of adolescent girls aged 15-19 years are anemic and underweight. Most young people in Ethiopia lack comprehensive knowledge on sexual and reproductive health (SRH), often engaging in risky behavior. Urban-rural disparities in comprehensive knowledge about HIV and HIV testing persist. About 37% of girls and 43% of boys aged 15-19 year consume alcohol. About 57% of boys also chew Khat. Despite high prevalence of health problems and risk factors among adolescents and youth, access to and utilization of health services is limited; and health education and life skills trainings for youth are often fragmented. Wide HSTP II | 2020/21-2024/25 2013 EFY - 2017 EFY 25 ministry of health strategy plan. Ethiopia.

2.2 Theoretical Framework of the Study

It is appropriate to use social–ecological model as a theoretical framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behavior. According to social–ecological model, a single factor cannot explain why some people or groups are more likely than others to engage in certain behaviors, because behavior can be influenced by

factors at several levels: the individual, relationship, community, organizational and societal levels. While the individual is responsible for engaging in a healthy lifestyle, the social environment (e.g. community norms, values, regulations, and policies) greatly impacts individual behavior.

The social–ecological model recognizes the relationships between the individual and his or her social and physical environment and that these relationships underlie health outcomes. This makes the model a suitable framework for inquiries of sexual behaviors among young people (DiClemente et al., 2005). Norms and traditions are very important for the SRH of adolescents. For instance, sexual harassment is probably explained related to ideology and male dominance in society. According to a study done in Fiche North Shewa zone, Ethiopia indicated, youth with social connectedness such as family, school and religion were found with increased condom use, decreased number of sexual partners, and reduced risky sexual behaviors. However, a high score of peer and social media connectedness was correlated with an increased number of sexual partners (Handebo, 2018). Religion is an important factor, which can significantly influence the sexual behaviors of adolescents by delaying their sexual debut. The only way to guarantee the health care system's capability, legislation, workforce, funding, infrastructure and data revolution for evidence-based decision, transparency and accountability is through government leadership, such as politicians, civil servants, and lawmakers (WHO, 2015).

Resource constraints in the healthcare organization, knowledge, skill and attitude gap of health professionals, age difference and fear of confidentiality breach hinder adolescents to utilize and have basic knowledge and skill regarding SRH and access services. In addition to this, poor involvement of the school in SRH, poor control and supervision of students in school predispose adolescents to experience romantic sexual relationships and practice in the school compound and school environment. Poor law enforcement was found especially among private business organizations like bars, hotels, shisha houses, illegal houses, and private pharmacies. Adolescents have easy access to substances at any age and this excessive use of substances encourages them to engage in risky sexual behaviors.

Neighborhood and environmental factors, socially related factors and financially related factors are listed at the community level. The living environment of adolescents such as expansion of nightclubs and bars, shish houses and traditional alcohol sellers around the living environment of adolescents, changing the living environment from rural to urban compound or environment led adolescents to risky sexual behaviors. The community has a conservative attitude on early

initiation either with single or with multiple sexual partners that also impacts negatively on condom use (Handebo et al., 2018).

Stakeholders should introduce socially and culturally acceptable comprehensive sexual education curricula for adolescents. Training should be given to health professionals working with adolescents to provide equitable and comprehensive services for adolescents. To overcome social and cultural hurdles affecting teenagers' sexual behavior and health, there should be guidelines or techniques on capacity building for families, youth, educators, and community members. The regulatory bodies under the health bureau should re-enforce and promote the available laws, policies and regulations that are to minimize the exposure of adolescents to risky sexual behaviors for the sake of saving adolescents. Responsible bodies should consider ensuring an adequate and continuous supply of medical equipment, commodities and diagnostic materials to adolescents and youth (Some fun, 2019).

2.3 Empirical Literature Review

Some scholars also appear to believe that (Donenfeld, et al, 2017) and the number of people in this age group is projected to rise significantly soon. Ethiopia is demographically a country of young people, and it needs to do justice mainstreaming its developmental agenda along the needs of its young citizens Youth constitute the period in the life span characterized in terms of transition from childhood to adulthood (Steinberg, 2014). They are, on the one hand, replete with potentials such as vigor, optimism, and optimal physical functioning for high level productivity, community agency for development and positive socialization of the self (Azeez & Augustine, 2013).

On the other hand, strategic support facilitates access to needed resources and information (Pittman et al., 2003). Studies including (Benson, 2003) & (Benson, Scales, & Sivertsen, 2011) indicated that young people are more likely to refrain from problem behaviors and demonstrate healthy growth when they are nurtured with essential developmental nutrients of services, opportunities, and support. International Planned Parenthood Federation (IPPF) 2006 state that Youth centers are developmental settings in which services, opportunities, and supports are provided to young persons in an integrated and sustained manner. Youth centers are "adolescent friendly contexts where young people can access information and services which address their needs and wants, including sexual and reproductive health needs as well as other needs, such as life skills and recreational activities."

Youth centers have been a popular approach for engaging youth, particularly in urban contexts. They are considered as useful settings for enhancing young people's participation and empowerment and offering training in vocational and life skills. Youth centers have also been promoted as a means of bringing sexual and reproductive health (SRH) services to youth and providing safe places for youth to interact. The design and types of services to be provided would depend on the specific realties of communities as well as the specific needs of the young people.

2.4 HIV/AIDS and STIs

According to the Ethiopian Demographic and Health Survey (EDHS) of 2016, report there is a significant disparity in comprehensive HIV knowledge among adolescents and youth, particularly noticeable among rural females. The survey indicates that in rural areas, only 16% of females and 38% of males possess comprehensive knowledge about HIV, compared to 39% of females and 48% of males in urban settings. Additionally, the report reveals that 5.4% of sexually active urban females and 3.2% of sexually active rural females reported having a sexually transmitted infection (STI) within the past year.

Globally, approximately half of the new human immunodeficiency virus (HIV) infections occur in the age group 15 to 24 years 11 and account for 22% of 50% are female) total population. In sub–Saharan Africa, adolescent girls and young women account for 25% new HIV infection among adults. 2016 WHO HIV/AIDS report, adolescent and young people aged 15-24 years are at particular high risk of HIV infection, accounting for 34% and in Sub-Saharan Africa 37% of new HIV infection among adults 22. On its third decade of the epidemics, HIV/AIDS is still imposing an irrefutable threat to contemporary world. The swift spread of the disease makes its impact much more pronounced. According to the UNAIDS estimate, 40 million people were living with HIV/AIDS by the end of 2003; the figure rose by 7 million in five years. There were 5 million new infections and 3 million deaths globally in the same year. More than half of those newly infected cases are between 15 to 24 years old 21. Addis Ababa, the study area of this research, has a high prevalence of HIV, shelters people from heterogeneous backgrounds with prominent socioeconomic differences, and is home to all kinds of evil that come with urbanization (21).

In 2010 about70% of new HIV infections and 68% of all people living with the virus resided in sub–Saharan Africa region. Besides, concurrent sexual partnerships were suggested as a possible

explanation for why HIV epidemics are so much more severe in sub-Saharan Africa than elsewhere in the world (23).

HIV prevalence is notably significant among young people in Ethiopia, largely due to their sexual behavior influenced by factors such as peer pressure, a diminished sense of vulnerability, and a tendency towards risk-taking. The pervasive poverty in the country exacerbates reproductive health challenges among its youth, making them the most severely affected demographic by the HIV epidemic in Ethiopia.

Currently, approximately 12 million young individuals aged 15 to 24 are living with HIV/AIDS worldwide, with nearly 6,000 new infections occurring daily within the same age bracket. In Sub-Saharan Africa, where the epidemic persists, women aged 15 to 24 are 2.5 times more likely to be infected with HIV compared to men. In Ethiopia, the estimated HIV prevalence among youth in 1999 was around 11.9 for females and 7.5 for males on average (WHO, 2007).

2.5 Substance Use and Mental Health

The most common addictive substances used by adolescents and youth in Ethiopia are cigarettes, alcohol, and Khat. According to the EDHS 2016 report, 36.8 % of adolescent girls and 43.3 % of adolescent boys aged 15-19 years consume alcohol. The national prevalence of Khat consumption among adolescents and youth is 51%; higher among males 56.5% than females 36.6%.

In connection to such substance use, mental illness is the leading non-communicable disorder among adolescents and youth in Ethiopia. With the prevalence ranging from 12-25%, mental illnesses make the highest burden of non-communicable disorders in the health sector. Cyber addiction is also currently evolving as a main public health problem, particularly among adolescents and youth due to the rapid advancement of information technology and the Internet becoming public health concern. Evidence indicates that about 75% of mental disorders in adulthood have their onset in adolescent and youth, particularly among those 12 – 24 years of age. In Ethiopia, mental illness in children and adolescents is estimated to be between 17% and 23%, with lower prevalence in rural settings. Studies indicate that substance use among Ethiopian adolescents and youth are considerably rising. Of the young segment of the Ethiopian population, college and university students are at the highest risk of substance use. Joining university often leads to new opportunities, independence from family control, self-decision making, and peer pressures to use alcohol or other drugs14. Studies done in different universities and colleges in the

country show that Khat chewing ranges between 14.1% in Addis Ababa University to 33.1% in Jimma University. Alcohol drinking and cigarette smoking are the cases where a third of university students from Axum, Debre Markos, Addis Ababa, and Jimma universities.

2.6 Non-Communicable Diseases and Injuries

Studies indicate that NCDs is an emerging epidemic in Ethiopia and other low and middle-income countries because of the increasing urbanization and the related changes in lifestyle and dietary habits. In Ethiopia, Non-communicable diseases (NCDs) are recognized as emerging public health problems which accounts for 30% of deaths in 2014. In a study conducted among working adults in Addis Ababa, the prevalence of diabetes mellitus was 6.5% and the prevalence of hypertension was 19.1% with a higher proportion among males 22%. Injuries are among the leading causes of death and disability among adolescents and youth with unintentional injuries such as road traffic injuries, physical fight, and burns-being the most common.

As per the national AYH baseline statistic report, road traffic injuries account for a prevalence rate of 31.5% among all trauma patients in Ethiopia, which is also estimated to reach 58.3% in southern nations, nationalities, and peoples SNNPR regions. Physical fight, often associated with substance use and other behaviors, is common among younger adolescents, and more among boys than girls leading to severe injuries. In Ethiopia, injuries due to Road Traffic Accidents RTA account for 22.9% of the mortality or injury among adolescents and youth 15-29, the prevalence of RTAs is 2.7% (3.2% male and 2% female) and that of non-RTAs is 2.4% (3% male and 1.6% female)

2.7 Gender-Based Violence and Harmful Traditional Practices

Evidence reveals that GBV is an outstanding problem in Ethiopia. Studies conducted in northwestern Ethiopia indicated that the prevalence of GBV (physical and/or sexual) among high school girls is 57.3%. GBV is so common that 60.3% of married young women believe that a husband is justified for beating his Federal Democratic Republic of Ethiopia, Ministry of Health, December 2021. There is poor awareness about the existing legal framework. More than half (53%) of married adolescent women aged 15-19 do not know the existence of a law that protects women from GBV in Ethiopia, similar for the older age groups (EDHS, 2005, 2011). Due to socio-cultural and economic factors, women have limited space for decision-making autonomy, lack of control over resources, have limited participation in socio-economic practices, and experience

child and early forced marriage, and this poor service utilization has exposed them to poor sexual and reproductive health outcomes. Young girls with disabilities are also suffering from GBV, including sexual violence as they are viewed as "defenseless and live under poor protection" (Samrawit7 et al., 2019). Hence, disability and poverty can also exacerbate vulnerability to GBV. Similarly, the prevalence of FGM in Somali and Afar is almost universal 91% & 99%, giving the national prevalence rate of 65% among women of 15-49 years16. The promising part is that the national prevalence of FGM in children aged 0-14 years has declined to 16%, but far from ending. The prevalence of FGM in aged 15-19 years has also declined from 71% in 2000 to 47% in 2016. The practice is likely to persist unless new approaches to intervention are implemented. It is recommended that a comprehensive response that couples community empowerment with strong enforcement of legislation is administered to effectively end FGM in Ethiopia by 2025, in alignment with the national plan against Harmful Traditional Practices.

2.8 Health Risky Sexual Behavior of Students in Ethiopia

Ethiopia is one of the sub-Saharan African countries severely by HIV pandemic. About 42% of the urban population in Ethiopia, age 15-34 years is at great risk of HIV infection. According to the national statistical agency report in 2012, HIV prevalence was the second highest in Addis Ababa reaching 5.2%, which is next to the 6.5% prevalence recorded in Gamble region. In Addis Ababa, comprehensive knowledge about HIV/AIDS is very low (31.8% in females and 43.7% in males). Comprehensive knowledge is defined as 1) knowing that both condom use and limiting the number of sex partner to one uninfected partner are HIV prevention methods; being aware that a healthy-looking person can have HIV; and rejecting the two most common local misconceptions-that HIV/AIDS can be transmitted through mosquito bites and by sharing food He national survey also showed among all participants aged 15-24 years, more males were observed to have multiple sex partnerships than females. Among those reported to have multiple sex partnerships, nearly 47% used a condom at their last sex during the interview.

In public universities, HIV Initiatives ("Modeling and Reinforcement to Combat HIV/AIDS, MARCH project in Addis Ababa University") exist to prevent and control the spread of HIV infection among students. Students in private universities are so far not privileged to take part in similar programs. Such disadvantages may put them at great risk of unsafe sexual practices. Therefore, this study attempts to consider other issues beyond risky sexual practices and associated

predisposing factors such as socioecological factors including the impacts of norms and traditions on SRH among private university students. Since there is limited data, effort will be made to fill the gap. Besides, policymakers may use the study findings for addressing the prevailing factors towards HIV prevention and control programs.

2.9 Conceptual Framework of the Study

In Ethiopia and Nigeria, high-risk sex was observed in studies among undergraduate students living campus. Some of the students rent and live alone in a single room. His might give them freedom from parental supervision. In the youth age group, poor parental supervision was significantly\ associated with risky sexual practices in eight African countries.

Private university students are mostly under twenty-one and may be easily influenced by their peers. As they are likely to be from a high-income family, they may be capable of buying and using substances. Studies indicated this age group is easily influenced by peer pressure- to experience risky health behaviors (unprotected/unsafe sex, alcohol or khat or tobacco use). Unlike students in public universities, private university students need to pay tuition fees and associated expenses.

Here fore, some may have financial problems and may try to solve these by partaking in transactional sex. For instance, in Ethiopia and Nigeria, studies reported university students engaging in unprotected sex for the benefit of money (Desalegn & Netsanet, 2019).

HIV prevalence increased in accordance with the number of lifetime sex partners. For instance, females with 5-9 partners encountered 8.7% prevalence. Similarly, males with more than 10 partners encountered 6.8% HIV prevalence. High prevalence of HIV was also observed in people with secondary education and higher income. University students are young and part of the educated society. Unless they get youth-friendly reproductive health services, they are at risk of STI/HIV infection, unplanned pregnancies, and associated complications. the risks may be worsened if they use substances. Substance use in general, Khat and alcohol use by the Ethiopian youth, ages between 15-24 years were significantly associated with unprotected sex. His was found to be a challenge in the national prevention of HIV. Despite the continuous of the Ethiopian government and donor agencies, the incidence of new HIV infections is still increasing though at a slower pace. Some studies in Ethiopia also indicated the presence of high-risk sexual behavior among students in public universities (ibid).

As far as this study is concerned, there were no available studies investigating the patterns of risky sexual behavior as well as socio-ecological factors (norms & traditions) affecting youth sexuality in private universities in Ethiopia. No information is available about the prevalence of sexual debut, multiple sex partnership, condom use, or other risky sexual behavior. Majority of undergraduate students are youth. This fact, by itself, may put them at risk of unsafe sexual practices. He\she is part of the educated society and so could have a high level of knowledge-about STI/HIV. In Nigeria and Uganda, studies among university students indicated that this knowledge might not be followed by the appropriate risk perception and safe sexual practices. In Ethiopia, students in private higher institutions make use of campus facilities-without school regulations. This may give them the freedom to partake in risky behaviors.

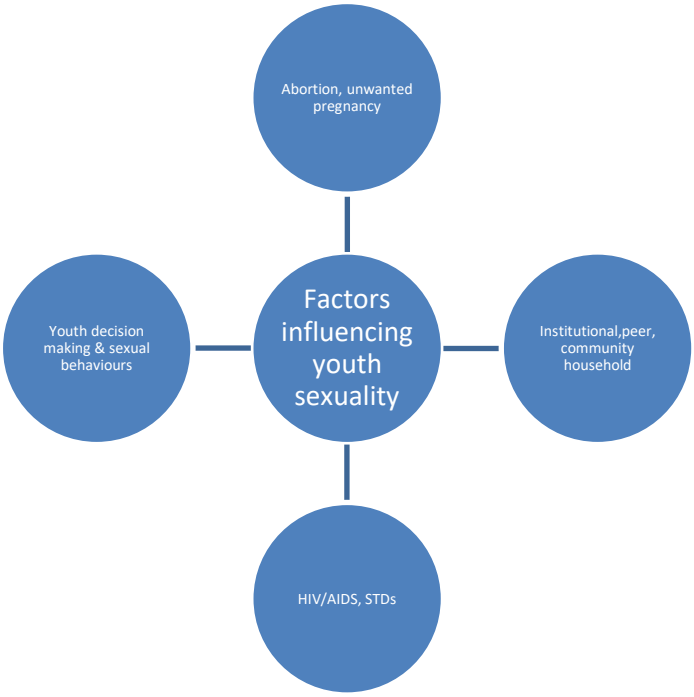

Fig 2.1: **Done by using the national statistical agency report 2012.**

CHAPTER THREE

METHODOLY

3. Introduction

In this section, the methodology, sampling techniques, data analysis techniques, data gathering instruments and the ethical standards are going to be explained in detail. More specifically, the choice of each have been demonstrated based on the specific objectives of the study. Besides, the chapter discussed about the reliability and validity of the data gathering instrument.

3.1 Research Design

This research was a procedure for collating information by asking some members of the target population a set of questions and then recording the responses. The cross-sectional survey was suitable design since the research concentrated on studying a cross section of the target population by administering the survey instrument once to a representative sample of the population, yielding data on the measured characteristics as they existed at the time of the data collection. This design was appropriate because it was not possible to assess and measure the entire mentioned population on the variables of interest in the study.

In other words, as the research title clearly indicated, the aim was to assess the of youth sexuality and associated health risk factors at St. Marry University amongst undergraduate students. And this design is chosen for its ability to include both quantitative and qualitative data taken in cross-sectional way.

3.2 Sampling Design

The research total sample size 200 undergraduate student's age from 18-24 year by using simple random sample method of them are taken from st marry university.

3.2.1 Sample Size Determination

In this study a simplified formula for Proportions developed by Yamane (1967) is used. Accordingly, it is written as follows.

$n = N/1+N(e)^2$

Where; - n is the sample size, N stands for the population size, and e is the level of precision. According to the st marry university the total numbers of under graduated student's participants are 200. By taking 95% precision level (e=0.05) and inserting in the above formula gives 200 and by rounding sample size was be taken (n=200) i.e. =200

N=200/1+200(.05)

3.2.2 Sampling techniques

In this study the researcher has used quantitative and qualitative technique to select from undergraduate program from the university. Consequently, the business and economics department has been selected in the random sampling technique. based on the random sampling around 200 students at different level such as freshman, second year and above. on the other hand, purposive sampling technique was used to select academically active students for an interview.

3.2.3 Target Population

The researcher focuses on St. Mary University undergraduate students. Of the total 3,253 studentsat St. Mary University, 2001 were undergraduate students and 1252 were graduate students. St. Mary's University has a total enrolment of 3,253 with a gender distribution of 41.53% male (1,351 students) and 58.47% female (1,902 students). There are 796 male and 1,205 female students in undergraduate school and 555 male, and 697 female students are attending graduate school at St. Mary's University. The university deliver above ten fields of study in the undergraduate program. Among these fields of study using a random sampling technique as the size of the whole target population were not manageable in such a limited time and resources of the researcher.

3.3 Sampling Survey

The primary method that was used by the research to get quantitative data from respondents was a sample survey. The researcher was distributing the self-administered questionnaire, which consists of closed- open and broad questionnaires. The researcher assisted in completing the questionnaire respondents on their own.

The study participants were young, skilled university students, so it was easy for them to understand the questions and give their answers. The questionnaire was prepared English to enable this cooperation with research participants.

3.4 Source of Data

To conduct this study primary source of data has been used to achieve the objective of the study. Primary source of data has been collected through structured questionnaire from the undergraduate students who were selected for the study and observation checklist is used to assess the services rendered in the university campus.

3.5.1 Primary data

Primary data to be originally collect while in case of secondary data the nature of data collection work primary data while doing experiments in experimental research but in case we do research of the descriptive type & perform surveys whether sample surveys or census surveys then we can obtain primary data either through observation or through direct communication with respondents in one form or another through interviews.

3.5.2 Secondary Data

Secondary data are those which have already collected by same one else, and which have already passed through statistical process the method of collecting primary data & secondary data difference:

3.6. Data Gathering Instruments

The researcher has used, questionnaire and interview checklist to collect primary data. More specifically, the primary data has been collected through questionnaires and checklist. Both has been administered by the researcher himself at the university campus carrying a support letter from the university graduate program coordination office.

3.6.1 Interview

In this method the researcher has prepared an interview guide to assess the understanding of youth sexuality and associated health risks, the services available in the university campus and students practice of sexuality from a selected group of students who are selected purposively based on their academic achievement. Interview was conducted with principal respondents from the university compound. The very first respondents for the necessary preliminary information about situations involving love were the campus guidance and counseling. Data on health problems due to sexuality among classmates. To determine what they are doing, how the students are participating, and the perceived needs of the students brought to them, some heads of HIV and gender alcohol

consumption's chewing khat, substance and associated health risk factors participate in the in-depth interview. To handle the withdrawal and other relevant student documents, the college registrar's office was also asked to interview.

3.6.2 Questionnaire

In this study prepared 200 questionnaires had been distributed to the sampled population. The questioners have been adopted from previous similar research (Hadas, 2019; Yordanos, 2004 & Tolossa 2013). The questionnaire has got five parts, the first part was having demographic status of respondents, the second part was about the substance use of respondents, the third part was about the sexual experience of respondents and the fifth part was about the associated health risk factors exposure.

3.5 Data Analysis Technique

Descriptive statistics in the form of frequencies, and percentage are computed to describe what is going on with the data. It involves the transformation of the raw data into some processed form to facilitate analysis. Highlight the important characteristics of the data, facilitates comparisons, and render it suitable for further statistical analysis and interpretations. In this section, the raw data to be collected has been checked and adjusted to identify omissions, eligibility, consistency, completeness, uniformity, and accuracy of the responses given by the respondents. Editing has been done both at housing and in the field to check completeness, consistency and questions answered out of order by respondents.

Finally, descriptive data analysis method was applied in this study. After data has been collected the researcher was organize, arrange, analyze, and interpret making use of frequency tables, and percentages as need be. Besides, the data collected through observation has been used to elaborate the discussion of major findings.

3.6 Validity and Reliability of the Instrument

3.8.1 Validity of the Instrument

The validity of the instrument relates with the relevance of the contents with that of the study questions and the areas of the study. In this regard, the validity has been checked by my advisor

and by those who has been involved in the pilot test from other departments of the university. According to the comments given some items were omitted and some are modified. Moreover, in this study, the researcher secured validity by precisely defining major concepts, clear instructions, matching the items to the research questions, clarity of wording, visual layout and format, readability, accuracy of the elicited information were seriously considered, and key terms were operationally defined. All questionnaires were completed and distributed to respondents by the researcher personally. This was done to prevent respondents from giving questionnaires to other people to complete on their behalf.

3.8.2 Reliability of the Instrument

A questionnaire is said to be reliable if we get same/similar answers repeatedly. This has been done by Test-retest reliability - whether repeating the test/questionnaire under the same conditions produces the same results have been done.

Reliability was done to ensure that same results are obtained when used consecutively. This was established following pre-test procedure before they are used for actual respondents. This was done by minimizing sources of measurement error like data collector bias by the researcher's being the only one to administer the questionnaires, exhibiting similar personal attributes to all respondents, e.g., friendliness and support. Respondents were requested not to write their names on the questionnaires to ensure confidentiality. In addition to this, the researcher was tried to put clear instructions at the beginning and be sure that all questions were answered based on proper understanding of respondents. Thus, by asking different questions or statements using different rating scales (e.g. agreement/disagreement) respondents can measure the same characteristic or satisfaction.

Since n had to be greater than 30 and the total target population at the marketing department was not more than 200. The researcher took 30 students from the accounting department randomly to conduct the pilot study. Once the data has been collected, it has been encoded into the SPSS software and Cronbach alpha was calculated for each part. Consequently, a Cronbach alpha coefficient of 0.74 is obtained for Part II, 0.77 for Part III, 0.72 for Part IV and 0.76 for Part V has been obtained. And this indicates the reliability of the instrument. Moreover, the larger portion of the instrument is adapted from previous similar research in which case its reliability and validity has been demonstrated for the most part.

3.7 Ethical Consideration

The researcher has been able to maintain all ethical code of conduct while collecting and analyzing data. Informed consents of the participants required level of anonymity, and equal consideration of collected responses have been maintained throughout the process regardless of the opinion of the researcher so that participants would feel free and safe to express their ideas.

In the study, the researcher has maintained objectivity, courtesy and high professional standards through scientific process and no falsification, alteration, or misrepresentation of data for biased or other purposes.

The study was conducted by considering ethical responsibility. This includes providing information to the respondents about the purpose of the study and the use of the information as well. Information obtained has been held in strict confidentiality by the researcher. Besides, the study has acknowledged all resources from where ideas were taken.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4. Introduction

In this chapter the demographic characteristics of respondents and the data collected through questionnaires is presented making use of frequency and percentage tables. Of the total 200 respondents sampled in the study only 186 respondents have returned the questionnaire and considered in this presentation. And this makes the return rate to be 93% which is quite enough to a descriptive study such as this one. Besides, an interview has been conducted with some selected students who were selected purposively based on their academic achievements and the data obtained from them has been used to elaborate the quantitative data presented using tables, frequency count and percentage. Focus group discussion has been planned as another data collecting tool for the study, however due to time constraint and lack of resources it cannot be conducted, and the findings are solely made using the questionnaires and the interview data presented in this chapter. Finally, a discussion of major findings of the study are included in this chapter to summarize the overall factors for youth sexuality and associated health risks at the university.

On the other hand, data has been collected from among five academically active students through an interview session which lasts on average for 30 minutes. Be that as it may, this data is not presented alone but rather used to elaborate the results obtained from questionnaires and in the discussion of major findings.

4.1 Socio-Demographic Profiles of the participants

the demographic characteristic of respondents, their family other important data is presented using frequency count and percentage.

Table 1. Socio-Demographic Profiles of the Respondents

No	Items/Variables	Frequency	Percentage
1	What is you gender?		
	A. Male	69	37.10%
	B. Female	117	62.90%

	C. Total	186	100%
2	To which age group do you belong?		
	A. 18-20	131	70.40%
	B. 21-24	49	26.30%
	C. Above 24	6	3.20%
	D. Don't know	0	0
	E. Total	186	100%
3	With whom you are living now		
	A. With mother	18	9.80%
	B. With brother	8	4.40%
	C. With father	9	4.90%
	D. With sister	3	1.60%
	E. With friends	9	4.90%
	F. With family both mother & father	123	67.20%
	G. Others	13	7.10%
	H. Total	183	98.39%
4	Where do you live by now?		
	A. Urban	186	100%
	B. Rural	0	0%
	C. Total	186	100%
5	What is your religion?		
	A. Orthodox	129	69%
	B. Muslim	42	23%
	C. Protestant	9	5%
	D. Catholic	0	0%
	E. Others	3	2%
	F. Total	183	98%
6	What is your marital status?		
	A. Unmarried	159	85.48%
	B. Married	9	4.84%

	C. Friends	6	3.23%
	D. Alone	0	0.00%
	E. Relatives	5	2.69%
	F. Total	174	93.55%
7	Do you work to earn money in your spare time?		
	A. Yes	12	6.45%
	B. No	172	92.47%
	C. Total	184	98.92%
8	Which batch are you at St. Mary University?		
	A. First year	60	32.60%
	B. Second year	28	15.20%
	C. Third year	75	40.80%
	D. Fourth year	23	12.50%
	E. Total	184	99%
9	What is your ethnicity?		
	A. Amhara	72	39%
	B. Oromo	19	10%
	C. Gurage	30	16%
	D. Tigray	19	10%
	E. Others	45	24%
	F. Total	184	99%

the above Table 1 respondents are from the total sampled students the predominantly consists of the 37.1% male respondents and 62.9% respondents are female When it comes to their age most of the respondents fall within 18-20 age 70.4%, followed by 26.3% and only a few respondents are above 24 ages.

In relation to living arrangements, most respondents live with both parents in urban areas. On the other hand, those who live with their mother are 9.8% with brother 4.4% with father 4.9% living with sister 1.6% with friends 4.9% with family are 67.2% living with other which is the highest and with others 7.1% and in relation to marital status, the majority respondents are unmarried.

More specifically Unmarried respondents are 91.4% and 5.2% respondents are married on the other hand Friends3.4% respondents are friendly used Most respondents are not currently employed Yes 6.5% No 93.5% the educational states of the respondents the highest number of participants are in the First year 32.6% Second year: 15.2% Third year 40.8% Fourth year students are 12.5% regarding ethnic distribution, Amhara respondents 36%, Oromo respondents 9.5%; Gurage respondents 15% Tigray respondents 9.5% and other respondents are 22.5%.

4.2 Alcohol Drink Intake Respondents

In this section the alcohol related experiences of respondents are presented and discussed.

Table 2 . Alcohol intake experience of respondents

No	Item	Frequency	Percentage
1	Have you ever drunk alcohol?		
	A. Yes	75	40.32%
	B. No	117	62.90%
	C. Total	182	97.85%
2	Which one of the following drinks have youhad in the past 12 months?		
	A. Tella	33	17.74%
	B. Beer	18	9.68%
	C. Wine	48	25.81%
	D. Arki	6	3.23%
	E. Others	9	4.84%
	F. Total	114	61.29%
3	In what frequency do you drink alcohol?		
	A. Per day	18	9.68%
	B. 1-3 time per day	0	0.00%
	C. Sometimes	87	46.77%
	D. Total	105	56.45%
4	Which age group did you belong when youfirst drink alcohol?		

	A. 10-15 years	21	11.29%
	B. 16-18 years	24	12.90%
	C. Above 19- years	36	19.35%
	D. Total	79	42.47%
5	Do you think that drinking alcohol increases sexual desire?		
	A. Yes	12	6.45%
	B. No	39	20.97%
	C. Don't know	135	72.58%
	C. Total	186	100.00%

As can be seen from the above Table 2 mentioned that, from the total sampled students the sample predominantly consists sampled students of a significant portion of respondents drink alcohol. Among those who drink, wine is the most popular choice. Alcohol Consumption respondents are 41.2% participants are du you have used a drink alcohol and the do not drink alcohol respondents are 58.8%. some respondents are 37.5% used alcohol and 28.9% respondents are used tell, Beer used respondents 15.8% on the other hand 42.1% respondents are drink wine, on the other hand Arki used respondents are 5.3% and other respondents are 7.9%. When it comes to frequency of alcohol consumption, among the total 17.1% respondents per day and Sometimes 82.9% respondents of the total respondents concerning First Time exposure to Drinking Alcohol respondents 26.6% respondents 30.4% and Above respondents 45.6%. Of the total respondents asked whether there isa relationship between Alcohol and Sexual Desire from total participates 23.5% yes and 76.5% respondents say no. In relation to alcohol consumption in the last 12 months of the total respondents say yes 9.8% and the majority participants 90.2% say no.

4.3 . Substance Usage of Respondents

In this section the exposure of respondent students to substances available locally is assessed andpresented.

Table 3: Substance Usage of Respondents

	Items	Frequency	Percentage
1	Have you ever used any substance for any purpose? Which one did you use?		
	A. Shisha	3	1.61%
	B. Marijuana	6	3.23%
	C. Prescriptions	7	3.76%
	D. Medicines		0.00%
	E. Others	6	3.23%
	F. Total	22	11.83%
2	Do you currently smoke cigarettes?		
	A. Yes	18	9.68%
	B. No	157	84.41%
	C. Total	175	94.09%
3	How often do you smoke in the last 12 months?		
	A. Daily	6	3.23%
	B. Sometimes	6	3.23%
	C. Usually,	6	3.23%
	D. Total	18	9.68%
3	Have you ever chewed Khat?		
	A. Yes	54	29.03%
	B. No	130	69.89%
	C. Total	184	98.92%
4	How often did you chew Khat in the last 12 months?		
	C. Everyday	6	3.23%
	D. 2-3 per day	6	3.23%
	E. 2-3 per week		0.00%
	F. Once a month	5	2.69%
	G. occasionally	24	12.90%
	H. Total	41	22.04%

Based on the above data presented in table 3 out of the total respondents are they have many types of substances Shisha used respondents 13.6% Marijuana used respondents 27.3% Prescriptions used respondents are 31.8% and other respondents are 27.3%. On the other hand, the minority of respondent's currently smoking cigarettes. From the total sampled students 10.3% are not currently smoking cigarettes: 89.7%. When it comes to other Substances such asKhat chewing is relatively common among respondents use.

4.4 Sexuality and Related Health Risk Factors

In this section, Table 4: Sexuality and Related Health Risk Factors

No	Items	Frequency	Percentage
1	Have you ever had sexual intercourse		
	A. Yes	24	12.90%
	B. No	154	82.80%
	C. Total	178	95.70%
2	What was your age group during first sexual intercourse?		
	A. 10-15	9	27.27%
	B. 16-18	9	27.27%
	C. Above 18	24	72.73%
	D. total	33	100.00%
3	Was your first sexual intercourse planned?		
	A. Yes	15	8.06%
	B. No	18	9.68%
	C. Total	33	17.74%
4	What was the reason for your first sexual intercourse?		
	A. Marriage	3	9.09%
	B. Rape	6	18.18%
	C. Love	12	36.36%
	D. Others	12	36.36%
	E. Total	33	100.00%

5	How many sexual partners have you ever had?		
	A. Don't have one ever	153	82%
	A. With one person	18	10%
	B. With two persons	6	3%
	C. With three persons	0	0%
	D. With four and more persons	9	5%
	E. Total	186	100%
6	Have you ever used condom?		
	A. Yes	85	45.70%
	B. No	101	54.30%
	C. Total	186	100.00%
7	Have you ever had pregnancy?		
	A. Yes	2	1.71%
	B. No	115	98.29%
	C. Total	117	100.00%
8	Have you ever seen pornography?		
	A. Yes	26	14%
	B. No	6	3%
	C. Total	32	17%
9	Have you ever faced any violence in the last 12 months?		
	A. Sexual	3	1.61%
	B. Physical	9	4.84%
	C. Psychological	15	8.06%
	D. Any other	0	0.00%
	E. Total	27	14.52%

Based on the above data presented in Table 4 the above the total sampled students of youth sexual activity a minority of respondents have engaged in sexual intercourse 13.5% and 86.5% Condom Use: from the above participates a small percentage reported consistent condom use: 45.5% and

do not use a condom respond antes are 54.5% and 86.5% respondents Age Group at First Sexual Experience Not specified: 16–18 respondents 27.3% and above 1 respondent 72.7%.

When it comes to making plans at first sexual experience of the Decisions and Planning During the First Sexes respondents 55.6%, on the other hand 44.4% respondents Reasons for First Sexual Intercourse respondents are 33.3% Love respondents 66.7% are Others, 54.5% respondents Number of Sexual Partners respondents with two people respondents are 18.2%. With three people More than 27.3% Total respondents Use of Condoms and 45.5% respondents say to No. on the other hand 54.5% respondents Ever Paid Money for the Respondents 25% says to No and respondents, have reported to 75% Total respondents Pregnancy are Yes and 1.1% of respondents have No Total Ever Seen Pornography respondents, 50% are yes and 50% respondents no Violence Within the Last Months Sexual respondents 11.1% of physical respondents are 33.3% Psychological respondents 55.6% Any other respondents.

Table 5: Understanding of respondents about Socio-cultural determinants of youth sexuality.

No	Question	Frequency	Percentage
1	Do you know that hormonal changes during puberty drive sexual development and behaviour?	157	84.41
2	Do you know that personal attitudes towards sex, self-esteem, and mental health influence sexual behaviour?	74	39.78
3	Do you know that sexual education can empower youth with the knowledge to make informed decisions about their sexual health?	102	54.84
4	Do you know that parental attitudes, communication about sex, and supervision significantly impact youth sexuality?	69	37.10
5	Do you know that peer norms and behaviours strongly influence youth decisions about sex?	133	71.51
6	Do you know that dynamics within romantic relationships, including power imbalances and partner attitudes, can affect sexual decision-making and behaviours?	98	52.69

7	Do you know that societal attitudes towards sex, gender roles and sexuality significantly impact youth behaviour?	75	40.32
8	Do you know that socioeconomic status influences access to education and health services, with disadvantaged youth at higher risk of negative sexual health outcomes?	145	77.96
9	Do you know that laws and policies regarding sexual education, age of consent, and access to reproductive health services play a critical role in shaping sexual health outcomes?	72	38.71

Based on the above data presented in Table 5 above, many respondents which are 84.41 percent know that hormonal changes during puberty drive sexual development and behaviour while small number of the respondents which are 15.59 percent says no. In this regard, the students seem to have a good understanding to the effect of hormonal changes in relation to youth sexuality which is a good thing if it influences their sexual behaviour and enable them to a smooth sexual transition to adult life. As studies show this is considered as biological determinant of sexuality.

When it comes to psychological youth sexuality which are personal attitudes towards sex, self-esteem, and mental health, most respondents seem to have a very low understanding as 60.22 percent of them says no to this determinant and yet, 39.78 percent of the respondents seems to have a very good awareness and understanding towards this determinant. Previous studies have also revealed that this determinant is quite important for youth sexual wellbeing and the transition they make.

When it comes to the ability of sexual education to empower youth with the knowledge to make informed decisions about their sexual health, 54.84 percent of the respondents says yes while the remaining 45.16 percent says no. In this regard, the later amount is shocking in the sense that a significant number of students still don't believe that sexual education is not that important to make informed decisions about their sexual health. And this may be since conversations about sex and sexual education is considered as a taboo in our society as the interview data revealed the same due to social and cultural orientations, we Ethiopians have. Similarly, most respondents, 62.9 percent of them, do not admit the need for parental attitudes, communication about sex, and supervision significantly impact their sexuality. And in this case, one can infer that there is no

open communication and discussion in the households of these respondents. On the other hand, 31.1 percent of the respondents acknowledge its importance to impact their sexuality positively.

When the respondents were asked about peer norms and behaviours in having a strong influence youth decision about sex, the majority 71.1% acknowledged it which is a good sign according to the findings of previous similar studies as it has a great impact, and most respondents admit its effect. Of the total respondents, 52.69 percent of the respondents also know that dynamics within romantic relationships, including power imbalances and partner attitudes, can affect sexual decision-making and behaviours which is also another good understanding that the respondents demonstrate.

In relation to the impact of societal attitudes towards sex, gender roles and sexuality towards youth behaviour, most respondents, 58.68 percent, says no whereas 40.32 says yes. In this regard, the interview data revealed that college students believe that sexuality is something personal and no societal attitude would affect their sexuality as it is done behind closed doors. And yet, this is not the right understanding according to the findings of previous researchers for youth sexuality wellbeing and the transition they make in this regard. Regarding the knowledge of the respondents about the effect of socioeconomic status in influencing access to education and health services, with disadvantaged youth at higher risk of negative sexual health outcomes, most respondents seem to have a good understanding, as 77.96 percent of the respondents acknowledged it and only 22.04 percent says no to it. When it comes to the necessity of laws and policies regarding sexual education, age of consent, and access to reproductive health services in playing a critical role in shaping sexual health outcomes, 61.29 percent of the respondents, which is a great majority, seems to have no good understanding whereas 38.71 percent of the respondents says yes and seems to have a good understanding about it.

4.5 Major Findings

The study was conducted among 200 regular undergraduate St. Marry University students in Addis Ababa using structured questionnaire to assess the youth sexuality and associated health risk factors among them.

More specifically, Age, gender, socioeconomic status, and cultural background significantly shape youth sexual behavior. Understanding these influences helps tailor interventions to

differentdemographic groups effectively. Besides, students living address, their family situations, and educational background have had immense contribution to their sexuality and vulnerability to associated health risk factors.

Role of Education and Awareness is also vital for a healthy sexual transition among college students. Comprehensive sexual education is crucial in equipping young people with the knowledge to make informed decisions about their sexual health. Discussions often focus on the effectiveness of different educational programs and the need for accurate, age-appropriate information. However, St. Mary University do not have that kind of service to the students. The university only got two first aid providers and a guidance office which literally dedicated to academic support. In this regard, the students have no access to information when it comes to youth sexuality and associated health risk factors.

Impact of Substance use has also been as one of the contributing factors for youth sexuality and vulnerability of associated health risks. In other words, the use of alcohol, drugs, and other substances like Khat is linked to higher rates of risky sexual behavior among youth. This relationship is an important point of discussion for developing preventive strategies and support systems. And again, St. Mary University do not well communicate this issue with its students as it has no platform dedicated for things like this. Not only that the university do not work in alliance with other governmental and non-governmental institutions for the best of its students.

Media and Technology Influence is also another determinant factor for youth sexuality and vulnerability to associated health risk factors as significant number of the students are exposed to social media and pornographic contents these days. More specifically, the proliferation of pornography and sexual content in media and online platforms influence youth perceptions and behaviors. Discussions focus on the need for digital literacy and the role of media in shaping sexual norms and expectations.

Parental and Family Dynamics is also an important factor for a healthy transition of university students to youth sexuality and associated health risk factors. In this regard, the study indicated that the majority live with their both parents and still significant others live with a single parent or relative. In relation to this, family environment and parental supervision play a significant role in shaping youth sexual behavior. Open communication between parents and children about sexual matters is crucial for promoting safe practices. Family disorganization and lack of

supervision are often linked to higher risks. However, this is not that well practiced in our context as discussions about sext with children is considered a taboo in our culture.

Access to Health Services is another important factor for students to transcend university with healthy experiences of sexuality and associated health risk factors. In this regard, availability, find accessibility of youth-friendly health services, including sexual and reproductive health services, are critical. Discussions often address barriers to access, such as stigma, confidentiality concerns, and lack of tailored services for young people. Be that as it may, St. Mary University do not have organized such center yet. And this research input might wakeup the management to think of one in the upcoming years.

Mental Health and Sexual Behavior is a highly linked concept with youth sexuality and associated health risk factors. More specifically, the relationship between mental health issues and sexual behavior is an emerging area of concern. Addressing the mental health needs of young people can be an integral part of reducing risky sexual practices.

Peer Influence and Social Networks is also another detrimental factor for youth sexuality and associated health risk factors. To explain it more, the role of peers and social networks in shaping sexual behavior is significant. Peer education programs and positive role models can be effective in promoting healthy sexual behaviors. However, study found out that the university has no such. peer support clubs and groups that consult and discuss with students about sexuality and associated health risk.

Policy and Advocacy is also an important element in supporting youth sexuality and associated health risks for college students. This includes advocating for comprehensive sexual education, access to health services, and supportive environments. In relation to this, the preliminary assessment made by the research in the planning of this study, the university has no policy and advocacy strategy to mitigate and prevent youth sexuality and associated health risks in the campus. Cultural and Religious Factors matter as much as the other discussed above in determining the sexuality of the youth and associated health risks. More specifically, cultural, and religious beliefs significantly impact youth sexuality and health behaviors. Discussions often focus on balancing respect for cultural values with the need for effective health interventions. By addressing these discussion points, St. Mary University and other stakeholders can develop comprehensive strategies to promote healthy sexual behavior and improve the overall well-being of young people.

CHAPTER FIVE

5. SUMMARY, CONCLUSION ARECOMMENDATION

5.1 Summary of Findings

The purpose of this study is to assess youth sexuality and associated health risks among St. Mary University undergraduate students. To this end, the study employed a descriptive cross-sectional study design to undertake the research. And this method has been chosen because the study attempted to collect both quantitative and qualitative data. The sampling technique used was random sampling. Firstly, the one department has been chosen from among eleven department found in the undergraduate program of the university. And next, a census method has been used to incorporate all students of the undergraduate program as their number was found to be manageable to conduct the study. In this regard, 200 students of the department have been involved in this study, especially those who are regular students at the university. In other words, the undergraduate students in the extension program are not included in the study as the age of significant number of students are not considered to be eligible to the study and they don't spend much of their time in the university campus and they are most probably daytime employees unlike the regular students.

Accordingly, most of the respondents were found to have a good understanding about sexuality while still significant number of the respondents don't have a clear and good understanding about sexuality.

When it understands of the undergraduate students towards determinants of youth sexuality, many of the students were found to have good understanding about most factors and yet, still significant number of them were found to have a poor understanding about some of the determinant factors.

5.2 Conclusions

Conclusively, youth sexuality is a multifaceted aspect influenced by various factors including societal norms, cultural beliefs, peer interactions, education, and access to resources. St. Mary's University students navigate a crucial period in their sexual development, often encountering new experiences and challenges. While exploring their sexuality, they may face several health

risks, including sexually transmitted infections (STIs), unintended pregnancies, andmental health issues.

Addressing youth sexuality and related health risks requires a comprehensive approach that includes.

- Comprehensive Sexual Health Education: Providing accurate, inclusive, and age-appropriate sexual health education programs that cover topics such as STIs, contraception, consent, and healthy relationships.
- Access to Resources: Ensuring easy access to sexual health resources including condoms, STI testing, contraception, and counselling services, either on campus or through community partnerships.
- Supportive Environment: Creating a supportive campus environment that promotes open dialogue, destigmatizes sexual health issues, and encourages help-seeking behavior.
- Peer Education and Support: Utilizing peer-led initiatives to disseminate information, foster discussions, and provide support on sexual health matters.
- Substance Use Prevention: Implementing strategies to address substance use and its impact on sexual decision-making, including education, prevention programs, and support services.
- Consent Education: Prioritizing education and awareness about consent to prevent sexual violence and promote healthy and respectful relationships.
- Cultural Competence: Recognizing and respecting the diversity of student populations by employing culturally competent approaches to sexual health promotion.
- Research and Evaluation: Continuously evaluating the effectiveness of sexual health programs and interventions to ensure they meet the evolving needs of college students.

The data underscores the importance of targeted interventions aimed at promoting safer sexual practices, preventing substance abuse, and increasing awareness about STIs and HIV/AIDS. Strategies should be tailored to address the specific needs of different demographic groups, considering factors such as gender, age, religion,and educational status.

Efforts should focus on improving access to healthcare services, implementing comprehensive sex education programs, and fostering community-based initiatives to support positive health outcomes among them. Collaboration of St. Mary University with health care providers, educators, policymakers, and community organizations is essential for the successful

implementation of interventions aimed at addressing students' sexuality and associated health risks.

5.3 Recommendations

To address youth sexuality and related health risks among undergraduate students at St. Mary University, several recommendations can be made. Of the possible recommendations exist in the literature the findings of this study recommend the following ones: Based on the findings, the following recommendations are forwarded to be implemented by concerned officials.

For Ministry of Education: •

- Sexual and reproductive health education should be incorporated into the school curriculum.

For Ministry of Health: •

- Health professionals should counsel university students on consistent condom use to prevent the outcomes of youth sexuality andassociated health risks.

For Health programmers/policy maker •

- school based sexual and reproductive health intervention programs like condom distribution and education at private u university's must be organized, strengthened, effectively implemented, and monitored to reduce youth sexuality andassociated health risks.

For researchers

- Qualitative study needs to be conducted to explore the reasons why students who attended their high school education at private school involve in risky sexual behavior. By implementing these recommendations, St. Mary University can create an environment that support the sexual health and well-being of its student populations, ultimately reducing the prevalence of sexual health risks among students.

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APPENDIXS

Appendix I: Data gathering instruments.

Dear/sir all

My name is Enawgaw Alemayehu I am postgraduate student at st Mary university post graduate programdepartment of sociology on the title the assessment of youth sexuality and associated health risk factors in Addis Ababa in the case of st marry university under graduated program the information you provide is meant for purpose only academic In this section you are kindly expected to fillout socio demographic, potential associated health risky and sexual factors and prevalence in higher learning institution.

The choice of individuals will be done randomly using systematical approach. This question will involve various personal and sexual issues of individual. Hence, it is your full right to refuse or participate in this study. Moreover, I assure you that your responsesare completely confidential and private. You do not also need of writing or mention your name, mobile andemail address on these survey papers.

However, to attain its goal, I kindly request for your willful participation in the survey and provide me yourgenuine response.

I thank you in advance for taking some minutes to respond to the questions. If you have any question, youcan contact the principal investigator Mrs. Enawgaw Alemayehu using his cell phone 0910602033& E- mail: enawgawalemayhu2013@gmail.com

Would you like to participate?

1. Agree to participate! ☐
2. disagree to participate (stop here) ☐

Part I/ Socio Demographics Characteristics of Respondents.

Instruction/ Give your answer by encircling the choice that best describes your situation.

Variable	Questions	response	
1.Age	How old are you?	A. 18-21 B. 22-24 C. Above 24 years D. Don't know year	
2.sex	Record sex of the respondent?	a. Male b. Female	
	With whom you are living now?	A. With Mather B. With father C. With brother D. With sister E. With friends F. Others specify----	
3.residency	Where are you living know?	a. urban b. rural	
4.religion	What is your religion?	a. Orthodox b. Muslim c. Protestant d. Others e. Catholic f. (specify)-	
5.marital status	What is your marital status?	A. Unmarred B. married C. others (specify)-----	
6. Educational status	What is your educational status	A. 1-8 primary B. 9-12 secondary C. 12+ D. others specify	

	What is your educational status at st marry university?	A. First year B. Second year C. Third year D. Fourth year	
7.Ethiniic	To which ethnic group do you belong?	A. Amhara B. Oromo C. Gurage D. Tigray E. Others specify	
8.occupation	Currently do you have? employment?	A. Yes B. no	
Family Status			
12.finance	1. Do you have permanent money?	A. Yes B. no	
	2. How much pocket moneydo you get from your parents' or relative per month?	A. 500 B. 600-1000 C. 1100-2000 D. Above 2000	

Part II/ socio cultural determinants of Alcohol Usage of Respondents.

Instruction/ Give your answer by encircling the choice that best describes your situation. And youcould give more than one answer when necessary.

Variable	Questions	Answer	
1. Alcohol	1. 1. Have you ever consumed an alcoholic drink & frequency and doze and the type of alcohol of intake not aboutusing alcohol?	A. Tella B. Beer C. Wine D. Arki E. Others specify.	
	2. Frequency of alcohol drink?	A. Per day B. 1-3 times per day C. Sometimes	
	3. How old were you when you had your first drink of alcohol?	A. 10-15 years old B. 16-18 years old C. Above 19 years	
	4. Does your alcohol drink increase youth sexual desire arose after taking alcohol?	A. Yes B. no	
	5. During the last 12 month, did you drink alcohol?	A. Yes B. no	
1. History of Smoking	1. Do your currently smoke cigarette?	2. Yes 3. no	
	2. How often do you smoke?	A. Daily B. Sometimes C. usually,	
3. Khat Related	1. Have you ever chewed khat?	A. Yes B. no	
	2. How often did you chew khat in the least 12 months?	A. Everyday B. 2-3 per day C. 2-3 a week	

		D. Once a month E. occasionally	
3. Substances Rlated	1. Have you often used a substance in the last 12 month?	A. Everyday B. 2-3 per day C. 2-3 a week D. Once a month E. occasionally	
	2. What types of substance used?	A. Alcohol B. Marijuana C. Prescriptions medicines, such as pain pills, stimuluses' D. Others specify	

Part III/ Youth Sexuality and Experience of Respondents

Instruction/ Give your answer by encircling the choice that best describes your situation.

Variables	**Questions**	**Answers**	**Remark**
1.sexual related	1. Have you ever had sexual intercourse?	A. Yes B. No	
	2. At what age did you first sexualinter course?	A. Age 10-15 B. 16-18 C. Above 18---	
	3. What reason for first sexualintercourse?	A. Marriage B. Rape C. Love D. Others ----	
	4. Why did you have decided and planed during first sex?	A. Yes B. no	

	5. How many sexual partners haveyou had so far?	A. With one person B. With two persons C. With three persons D. More than four	
	6. Have you ever used condom during intercourse?	A. Yes B. No	
	7. Have you Ever paid money for sex (only for male)	A. Yes B. No	
	8. What is your history of pregnancyyour status (only for female)?	A. Yes B. No	
	9. Have you ever seen pornography?	A. Yes B. No	
	10. Violence within 12 months?	A. Sexual B. Physical C. Psychological D. Any other (specify)----	

Part III / socio cultural determinants of Youth sexuality Associated with health risk factors.

Variable	Questions	Yes	No
	1. Do you know that hormonal changes during puberty drive sexual development and behaviour?		
	2. Do you know that personal attitudes towards sex, self-esteem, and mental health influence sexual behaviour?		
	3. Do you know that sexual education can empower youth with the knowledge to make informed decisions about their sexual health?		

	4. Do you know that parental attitudes, communication about sex, and supervision significantly impact youth sexuality?		
	5. Do you know that peer norms and behaviours strongly influence youth decisions about sex?		
	6. Do you know that dynamics within romantic relationships, including power imbalances and partner attitudes, can affect sexual decision-making and behaviours?		
	7. Do you know that availability of and access to youth-friendly health services, including contraception and STI testing, are crucial for sexual health?		
	8. Do you know that universities which provide comprehensive sex education and promote a supportive environment can positively influence sexual health outcomes?		
	9. Do you know that societal attitudes towards sex, gender roles and sexuality significantly impact youth behaviour?		
	10. Do you know that socioeconomic status influences access to education and health services, with disadvantaged youth at higher risk of negative sexual health outcomes?		
	11. Do you know that laws and policies regarding sexual education, age of consent, and access to reproductive health services play a critical role in shaping health outcomes?		

Thank you for your time and energy!