

**Assessment of Life Skills Based Reproductive and Sexual Health
Interventions on Sexual Health of Adolescent Girls in Selected
Elementary Schools in Addis Ababa, Ethiopia**

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May 2013

Addis Ababa, Ethiopia

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DECLARATION

I hereby declare that the dissertation entitled ‘Assessment of Life Skills Based Reproductive and Sexual Health Interventions on Sexual Health of Adolescent Girls in Selected Elementary Schools in Addis Ababa, Ethiopia’ submitted by me for the partial fulfilment of MSW to Indira Gandhi National Open University (IGNOU), New Delhi is my own original work and has not been presented earlier, either to IGNOU or to any other institution for the fulfilment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by others. All pieces of information taken from others are duly acknowledged.

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ACKNOWLEDGEMENT

This study becomes fruitful since a number of people have participated in the process of the research undertaking. I would like to express my great appreciation to these individuals. First of all, I would like to express my heartfelt appreciation to the entire staff of IGNOU and my project supervisor Mr. Sebsib Belay for their intellectual and professional supports. In addition, I would like to forward my acknowledgments to the Management and Staff of URC who had first granted me a study leave and support during the entire study period.

I would also like to extend my appreciation to my field assistants Mr. Genene and Mr. Sisay for conducting interviews with the girl students at the three selected schools in Addis Ababa. Moreover, I want to forward my appreciation to the staff members of Kolfe Project Office of the Mary Joy Non-governmental Organization who have hosted me at their Offices while I am writing-up the MSW thesis. Special thanks also go to Mr. Haile Wolde Selassie, who is the Project Coordinator of Kolfe Branch Office under the auspices of Mary Joy Organization for being available and willing to answer my questions, as well as for his guidance and encouragement.

I am similarly grateful to the teachers and management of Medhanealem, Millennium and Efoyita Elementary and Junior High Schools for granting me permission to undertake the study in their respective schools. Finally, my appreciation and gratitude go to the girl pupils in those schools who have been willing to respond to all items in the questionnaires and to interview questions.

ACCRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CSW	Commercial Sex Workers
DCH	Department of Community Health
EDHS	Ethiopia Demographic Health Survey
HIV	Human Immunodeficiency Virus
MJATD	Mary Joy Aid through Development
MOH	Ministry of Health
NGOs	Non-governmental Organizations
RH	Reproductive Health
RSH	Reproductive and Sexual Health
STD	Sexually Transmitted Disease
TSDA	Tesfa Social Development Association
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
YRSH	Youth Reproductive and Sexual Health

ABSTRACT

The purpose of this study was to assess effectiveness of life skills-based reproductive and sexual health education for adolescent girls in three selected primary schools in Addis Ababa. The study investigated whether a difference exist in reproductive health knowledge and behaviour of female pupils that have participated and those who have not participated in programmes on life skills-based reproductive and sexual health interventions in those primary schools in Addis Ababa. The study population was comprised of 60 girl pupils aged 14 to 17 years who had attended the school-based reproductive and sexual health education (ARSH) programmes and life skills peer learning sessions in the two Sub Cities of Addis Ababa. The data were coded and analyzed using the SPSS 19 software. During the data analysis, the researcher used descriptive statistics, like frequencies and percentages.

The results of the survey demonstrate that in general the RSH programs actually reduced sexual behaviour, either by significantly delaying the initiation of sex, reducing the frequency of sex, or reducing the number of sexual partners. There is a great lack of information and knowledge among non-RSH education participating girl school adolescents on sexuality, contraception, and HIV/AIDS and several misconceptions abound. In the light of the findings, useful suggestions and recommendations were made.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Problem

Puberty is accompanied by physical, psychological and emotional changes which need a positive outlook to ensure reproductive and parenting success. Moreover, puberty is mainly associated with brain maturation and physical growth. This process manifests a complex endocrinology changes that has led to sexual maturation and reproductive capacity. Puberty further triggers emotional, cognitive and behavioural change.

World health Organization (WHO) (2006:6): has defined adolescence as “the age of 10 to 19 years. It is characterized by physical, psychological and social change transformation and maturation that takes place during this period. It is also called as period of stress and storm, a period when society sends mixed signals to its youngsters which results in confusion, frustration, despair and risk taking behaviour.”

The period of adolescence is furthermore subdivided into three stages of Early (10-13 years), Middle (14-16 years) and Late (17-19 years) (26). The exact age ranges are arbitrary and approximate. These classifications are used to identify common tendencies among young people as they develop from childhood to adulthood and help design adequate and individualized health care to adolescents. At early stages of adolescence, young people develop primary and secondary sexual characteristics. They consider themselves as focus of other people’s attention and conclude that they are invulnerable to harm. The young people in middle stage of adolescence begin to develop their capacity for abstract thinking, while adolescents in the third or late stage are able to consider problems systematically and abstractly. As successful progression through

each of these developmental tasks of adolescence is necessary for healthy adulthood, one should recognize the individual needs of adolescents in these various phases of development (WHO 2006).

The majority of youth experience insufficient access to information on reproductive health and sexual rights and don't communicate with their parents or other adults on reproductive and sexual health issues. In many parts of the world, adolescents have been a neglected group largely because of cultural sensitivities and gender disparities regarding sexuality. Adolescents may be reluctant to ask for help from adults in their families, communities, or in professional settings. Girls, in particular, are often kept from learning about sexuality and health issues because of cultural and religious beliefs.

Furthermore, the current prevalence of HIV infection as per HAPCO (2011) in Ethiopia was estimated to be 2.1% with a higher level of infection among females. Young people aged between 15 and 24 years had the highest rate of HIV infection in Ethiopia. With regard to the level of infection by risk factors, the rate of infection was 12.3 % among females with high risk behaviour, while it was 1.3 % in the same population with lower risk sexual behaviour.

Given this evidence for increasing sexual activity among young people and the current concern about HIV transmission, how should sexual health be promoted among the young in different settings or contexts? Schools are settings that prioritize learning and reach almost all young people. As such, schools are 'a vital resource for providing children, adolescents and young adults with the knowledge and skills they need to make and act upon decisions that promote sexual health' (McKay 2000). After the family, school-based sex education programmes are the main method by which adolescents receive information about sex related issues (Sexuality Information and Education of the United States (SIECUS : 1999). Moreover, girls in Ethiopia are

confronted with many problems and challenges, including gender inequity and reproductive health (RH) problems, such as early and unwanted pregnancy, unsafe abortion and sexual abuse.

The current cohort of Ethiopian youth is the largest ever accounting over one-fifth of the population (World Bank 2007). To contribute their full social and economic potential, young people need the knowledge and skills to make the right choices about when to have sex and how to protect themselves from HIV infection and unintended pregnancies. The reproductive health challenges Ethiopian youth face are similar to those of young people in many other African countries: high rates of teen pregnancy, high and rising rates of HIV infection, early marriage for young girls, malnutrition, and harmful traditional practices such as female genital cutting. Increasingly, policymakers are acknowledging the link between better youth reproductive health (YRH) and other aspects of healthy youth development including livelihoods, mental health, and road safety (FHI : 2005).

To that end, these adolescents need education on life skills which may provide them with the knowledge and skills to make the right choices about when to have sex and how to protect themselves from HIV infection and unintended pregnancy. Life skills, according to the Islamic Medical Association of Uganda (2003), are the strategies or abilities one uses to get along with one's own personality, one's friends, family, the society and the environment as a whole. These strategies empower the young person to interact with the society in which they live as effectively as possible.

The same source also indicates that the objectives of Life skills are to promote one's abilities in the adolescents from both sexes, such as taking positive health choices; making informed decisions; practicing healthy behaviour; and recognizing and avoiding situations and behavior

that are likely to pose risks to health. The goals (outcomes) for learning life skills may, on the other hand include: personal development; social development; feeling of fulfillment; empowerment; ability to make a meaningful contribution in life for themselves, their families, group and country; informed choices; healthy behaviour; prevention of drug abuse, violence, suicide, irresponsible sexual behavior; and new skills.

Therefore, some international and indigenous non-governmental organizations, in recent years, have been implementing life skills education as a strategy for preventing HIV infection and promoting sexual health in various contexts in a sporadic manner. There is no as such well-grounded evidence as to the effective contributions of school-based life skills education to create awareness of reproductive and sexual health, as well as to promote sexual health outcomes in targeted primary schools. However, there have not yet been consensus on these issues in schools which are being run in various socio-cultural, economic and political contexts so far. Thus, it becomes imperative to undertake an assessment study on what the adolescent girls have been gaining from education on life skills in general and school-based reproductive and sexual health education in particular in order to bring about effective outcomes on the part of these sections of the population in Addis Ababa, Ethiopia.

1.2 Problem Statement

The purpose of this study was to assess effectiveness of life skills-based reproductive and sexual health education for adolescent girls in three selected primary schools in Addis Ababa. Information on HIV/AIDS and life-skills education can be provided to young people in a number of ways, including through peer education or counselling, community activities that include

parents, and through the mass media and school-based education programmes. Often, these interventions are dispersed across many organizations and community-based groups and their effects are difficult to measure and to evaluate consistently. However, schools are a key setting for providing information and teaching adolescents the life skills necessary to prevent HIV/AIDS and unwanted pregnancy.

However, there are little or no concrete data on the effectiveness of such adolescent-focused reproductive and sexual health programmes in school settings not only because no quantitative survey has been designed and conducted with the aim of measuring and analyzing it with the practices and behaviours it entails but also because those few existing studies lack methodological foundations and social work perspective that can lead to testable hypotheses. Thus, the impact of those programmes with respect to healthy sexual behaviours deserves a close investigation and update of the existing empirical evidence in various socio-cultural, economic and political settings.

Studies conducted on how puberty impacts adolescent or young girls who are transiting to puberty age and their education confirms that it is a great concern mainly to the developing countries. No major differences exist at the preschool and early primary school levels between boys' and girls' enrolments. However, UNICEF' Report (2006) proves that, as children progress through primary school, differences begin to emerge, especially in rural areas of the developing countries. In sub-Saharan Africa, adolescent girls' participation in school is generally poor

Even in contexts where gender parity is achieved in the early grades, by late primary school (Grade 5 or 6), the numbers of girls in school has dropped significantly. In close scrutiny and review education data, enrolment rates are important. Yet, retention and successful completion

rates provide a stronger test of Education for All (EFA) achievements and more particularly of achievement of the Millennium Development Goal Number 21.

In an International Rescue Committee, Rhodes, Walker, & Martor (1998) argue that a study conducted on primary schools in Guinea shows (although girls represented almost 50.0% of pupils in early grades) they made up only 34.0% of those who had completed the cycle at Grade six. Similarly, as found out by UNICEF/AET (2002) in Southern Sudan, enrolment rates of girls in Grade 1 were found to be already very low (an average of only 26.0% of total enrolment rate) with a drop rate to 21.0% at Grade 8 (an absolute drop rate of more than 20,000 girls).

In the reconstruction and development of the Somali Educational System, gender related disparities are a key concern; only 35.0% of the pupils enrolled in Grade 1 are mostly girls. Thus, this proportion declines with girls making up only 29.0% of pupils in Grade 8 as per UNICEF's study (2002). Such drops in girls' participation can be attributed to multiple factors, sexual maturation, and the subsequent impact on their educational access and experience.

UNFPA, UNICEF and WHO (2003) report that parental fears about sexual abuse can mean that for unmarried girls movement is often restricted after menarche; a reality which can also interfere with schooling. In rural Peru, a girl who has begun to menstruate is perceived to be different by the community. Girls' self-perception changes dramatically after menarche. They see themselves as women rather than girls. Attitudes intensify adolescent girls' feelings of exclusion and inadequacy and lessen their desire to attend school. This strongly suggests that Menarche changes a girl's self-perception and the way she is perceived by her family and the community.

Many teachers (especially male teachers) are not sensitive to the special needs of girls during puberty. Therefore, the teachers are unprepared or choose not to provide the support and guidance girls need.

Parents send conflicting messages to their daughters. On one hand, they believe girls should adhere to gender-specific roles and begin to focus more attention on domestic tasks traditionally assigned to women. They reaffirm existing perceptions that girls don't need to continue their studies. In another study done in Tanzania indicated that a gender gap in girls' education at all levels of the school system continues to exist in Tanzania and across sub-Saharan Africa.

One unexplored aspect of this gender inequity is how the onset of puberty may be impacting on girls' attendance, participation, and completion of schooling. The social and cultural pressures in society which have arisen on the part of a girl may influence her as she becomes a young woman within the local society. These have implications of womanhood for a young woman's sexual health, well-being, and continued academic focus. Foundation, the Forum of African Women Educationalists, Uganda (FAWEU) pragmatic and thoughtful proposal for improving the lives of girls maturing after them, represents the power and importance of the findings. Equally valuable was the effort to place these young women's experiences within the social, economic, and political context of a globalizing world. The study underscores that there have been public health and education interventions that could be implemented now to improve young women's chances of remaining in school, and their overall health and well-being (Columbia University, 1997).

In a comparative assessment study on subjects' knowledge, attitude and practice, concerning puberty health programs done in Iran (MOH, 2006) again underscored that an appropriate health education concerning their periodic development had been of importance in community health

services. The study confirmed that discussion panels had been more effective in puberty health education for Iranian teenage girls than other method.

In Ethiopia, a large number of 10-14 year-old girls who had been drawn from poor families and communities were forced to transition very quickly from being “children” to taking on more adult roles (such as caregiver, spouse, bread winner and parent). These rapid transitions to new social roles can confer increased risks and vulnerabilities that many young people aged 10-14 may not be equipped to manage. According the Ethiopian Ministry of Health (2006), premature school-leaving increased the need for contribution to family economy, such as unpaid domestic labour, paid labour, migration to seek economic opportunity, social isolation, Female Genital Cutting (FGC) and early marriage.

School dropout in Ethiopia is caused by poverty and food insecurity which, in turn, are linked to a large family size. Parents with large families do not send all their children to schools. If girls are sent, they are often pulled out of schools for different reasons, such as having to help with household chores or work to provide supplemental income. Indirectly, girls may miss schools because of inadequate school facilities, such as gender differentiated toilets. Early marriage, abduction, gender-based violence and minimal community support are other factors contributing to girls to become dropout of schools. Schools may also lack designated staff to counsel and advise girls on how to address or overcome these types of issues (World Bank 2002).

The emergent issues for girls by aged 12 include: sexual maturation; consolidation of gender norms; disproportionate care (concern) on domestic work burden; withdrawal from and/or lack of safety in public space; school leaving and school safety; loss of peers; migration for work; and pressure for marriage (World Bank : 2002).

Despite the fact that their emergent vulnerabilities, girls aged 10-14 year olds are frequently neglected in research, policies and programs - they slip through the cracks - no longer eligible for child health programs and not considered by conventional youth, maternal and reproductive health programs. Early intervention may also create new opportunities for effective programming. It may also be easier to reach 10-14 year old girls – before they leave school, while they live in their home communities and before they migrate. Limited programming experience indicates that 10-14 year olds may be more open, flexible and creative – they are easier to work with before the onset of puberty.

In addition, it is reasonable to hypothesize that it may be easier to promote the development of positive behaviours rather than change stubborn and entrenched negative ones. To promote continued education, the following are recommended interventions: social and peer support and protection; safe places to meet learn and recreate; personal assets/life skills provision; positive health habits/information/services; and opportunities for personal and professional development close to home (WHO ; 2000).

Another big gap seen at the onset of puberty is that girls are left to cope with psychological and physical effects of sexual maturation on their own as parents, teachers and the community as a whole do not give them support during this time of change. Teachers are overwhelmed with a massive workload and feel too burdened to take on the task of empowering the girls while male teachers have the added obstacle of feeling that it is a role that females only should play. Parents, as a whole feel that they are incapable of teaching the girls about sexual maturation, fathers because they feel it is a female task and mothers because they feel shy about approaching the topic, preferring to leave it to teachers. While everybody “passes the buck” to someone else, the girl is left to collect scanty information on her own and basically guide herself into womanhood.

Different organizations have been implementing projects to scale up life skills-based reproductive and sexual health education for youth and young adults. Reports from Mary Joy through Development and TSDA which are indigenous non-governmental organizations indicate that more than 9,300 students have been trained for the past three years. The aims of most of such programmes revolve around building respondents' confidence in their own ability to protect themselves from HIV and reduce their risks, minimizing multiple sexual partners and staying faithful to one sexual partner. The projects were implemented in partnership with schools, faith-based and other community-based organizations through mobilization of CBOs strategies such as local anti-HIV/AIDS clubs, Parent-Teacher Associations (PTAs) and PLHIV Associations for persons living with HIV. Through a variety of activities, the projects sought to stimulate broad community discourses on healthy norms and risky behaviour so as to create an enabling environment for behaviour change and communications.

Generally, this study is inductive by its nature which is not well-informed about specific theories, approaches or models in a given field of specialization. However, the study mainly gets framed to generate empirical observations in the school settings and then to look for relevant social work perspective after the data have been analyzed and contextualized in the study areas.

1.3 Research Hypothesis

Sexual health education programmes in the three selected schools have improved the sexual wellbeing of adolescent girls. In other words, there is a significant difference in sexual wellbeing of adolescent girls between those who have attended life skills-based reproductive and sexual health programmes and those who have never attended the programmes.

1.4 Objectives of the Study

The overall objective of this study was to assess the effectiveness of life skills-based reproductive and sex education programs in enabling sexual behaviour of school girls 14-16 years of age in grade 6 to 8 in adopting healthy sexual behaviours and avoiding bad consequences. Specifically, the study intended:

- To identify difference in reproductive health knowledge and behaviour of female pupils that have participated and those who have not participated in programmes on life skills-based reproductive and sexual health interventions in those primary schools in Addis Ababa;
- To assess difference in risks between those girl pupils RSH have been participating and non-participating in programmes on sexual health, pregnancy and contraceptives, STIs and HIV/AIDS; and
- To identify and describe socio-cultural factors influencing reproductive and sexual health needs of girl adolescents in those three selected schools in the city.

1.5 Significance/Justification of the Study

Girls in Ethiopia are impeded from having the same learning opportunities as boys due to a variety of factors. Gender preference and inequalities in access to education and the sexual maturation and a myriad of factors related with sexuality and gender are considered to be an obstacle. Like the other factors, the sexual health amongst girls is a factor that greatly impacts the education of the girl child in Ethiopia affecting her quality in performance, subsequent rate of transfer to the next level of education and number of years of study.

Most schools in Addis Ababa have some form of sex education ranging from reproductive biology classes to comprehensive sex education programs that encompass reproductive health

and development, STIs, sexual behaviour, gender issues, and interpersonal relationships. The programs can be pragmatic and focus upon preventing STIs, HIV and unwanted pregnancy, or morally-based, where most young people are encouraged to abstain from sex until married (Stevens-Simon & Kaplan 1998; Lindberg et al. 2000; Clymer 2002). However, little is known on whether these sex education programmes have helped the girl pupils in the schools on the above-mentioned sexual health outcomes. Therefore, this study will help social/health policy makers, practitioners, programme developers in improving strategies of addressing the sexual and reproductive health needs of young girls, as well as it will contribute to existing knowledge reservoir in the area.

1.6 Operational Definition of Concepts

In order to measure those variables in the study, they have to be operationally defined. Those key concepts in the study are defined as follows:

- **Puberty:** World health Organization (WHO:2006) has defined puberty as the age of 10 to 19 years. It is characterized by physical, psychological and social change transformation and maturation that takes place during this period.
- **Reproductive and Sexual Health Education:** Sexuality education is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy (Douglas, 2006).
- **Risky sexual behaviour:** is defined as a sexual relationship with a non regular partner or had never used condom or exposed to sexual violence and rape or involvement in transactional sex on a casual basis (World Bank:2006b).

- **Sexual health outcomes:** for young people, sexual health outcome refers to including age at first intercourse rates of pregnancy and abortion, proportion of young people using contraceptive methods other than abortion, and the incidence and prevalence of STIs and HIV intimacy (WHO:2006:3).

1.7 Limitations of the Study

The study was conducted among 60 girl pupils in the three selected schools in Addis Ababa. Therefore, these results cannot be generalized to the elementary schools in the Kolfe Keranyo Sub City or the NGOs involved. An extensive study covering a longer period and bigger sample sizes need to be carried out for the results to be generalized.

The pupils were sometimes unable to recall their perceptions and experiences before they had joined Project during its life cycle period. Hence, recall bias was experienced. To address this, the pupils were probed to explain in detail what had happened or asked to refer to another pupil(s) to discuss the topics presented or give their opinions on these topics under investigation. The interviews conducted with key informants and FGD held were hand written during the actual sessions, which could have affected the quality of data.

1.8 Chapterization of the Thesis

This MSW thesis is organized into five chapters. The First Chapter introduces the background of the problem, problem statement, research hypothesis, objectives of the study, operational definitions of key concepts in the study, significance/justification of the study, limitations of the study, and Chapterization of the thesis.

Chapter Two presents a review of related literature. It also highlights literature on sexuality and adolescents, reproductive and sexuality education, objectives of reproductive and sexual education programmes, history of school-based RSH programmes, the role of schools, and common characteristics of those effective RSH programmes.

The Third Chapter describes the study areas and schools, study design and methods, including the universe of the study, sampling method, data collection tools and procedures, data processing and analysis, and ethical considerations. Chapter four presents data analysis, interpretation and discussion of major findings. Finally, the thesis draws conclusions from those major findings which are based on empirical observations and then recommends suggestions for action to be implemented by social work practising schools and other concerned stakeholders.

LITERATURE REVIEW

2.1 Introduction

This chapter describes literature related to the study objectives. It synthesizes studies related to the topics under review to identify gaps in knowledge, methods and findings. The review of the related literature is guided by the objectives of the study.

2.2 Models and Theories of Health Behaviour

There are well-known health behaviour related models and theories. Among them, the Health Belief Model, the Theory of Planned Behaviour, the Attitude-Social Influence-Efficacy Model, and selected aspects of the Social Cognitive Theory are most widely used approaches applied in health behaviour research (Aaro, Schaalmas, & Astrom 2005). However, the Social Cognition Models and Theories are widely used in research on health related behaviours.

The first research-based social cognition models which are relevant to the study of health behaviour were proposed in the 1950s, and a number of new models have been developed since then. One of them is the “Social Cognitive Theory” which was primarily called “Social Learning Theory”.

2.3 Sexuality and Adolescents

To perceive young people as sexual beings seems to be one of the hardest things to accept in most societies. However, sexuality is a pivotal component of adolescent development and the hallmark achievement of adolescent sexuality is the establishment of intimacy with another human being (Hofman 1989). No matter how much adults might like to ignore it, sex has great meaning in the lives of youth, whether they have had any sexual experience or not. Adolescents are becoming sexually active at increasingly earlier ages. It has been extensively documented that premarital sexual intercourse is relatively common in many industrialized nations, with the majority experiencing their sexual debut during their teen years. In United States, for example,

approximately 70% of women have had sexual intercourses by the age of 18 years (Susan 1993, p. 1213). In another study in the same country, 18% of 15 years old, 28% 16-year-old females are sexually active, representing increases of 24% and 34% respectively from the early 1970s (Brenda 1997).

A general overview shows that the circumstances of adolescents in developing countries with respect to sexual behaviour vary tremendously both across and within regions (Hughes 1998, p. 29). Adolescents aged 15 -19 years who had practiced sexual intercourse in Latin America varies from 18.4% in Peru to 30.1% in Paraguay. Similarly, in Sub Saharan Africa, this ranges from 14.2% in Rwanda to 68.5% in Cameroon. In Guinea, overall, 50% of female and 76% male participants of 15 – 24 years were sexually experienced (Elster 1994). In same country, it was found that female pupils had had fewer partners than their out of school counterparts, however, among young men the reverse was true. Moreover, out of school males reported fewer sexual encounters in the previous month than did those in schools, but the opposite were the case among women.

2.4 Reproductive and Sexuality Education

‘Sexuality education is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education thus addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality’ of adolescents (CEDPA 1998, pp. 37).

2.5 Objectives of Reproductive and Sexuality Education Programmes

Like other Youth Reproductive Health (YRH) Programmes, sexuality education aims to achieve a range of outcomes, some of which apply to sexually active youth and some to those not yet having sex. These objectives as elaborated by CEDPA include:

...reduced sexual activity (including postponing age at first intercourse and promoting abstinence); reduced number of sexual partners; increased contraceptive use, especially use of condoms among youth who are sexually active for both pregnancy prevention and prevention of HIV/AIDS and other sexually transmitted infections (STIs); lower rates of child marriage; lower rates of early, unwanted pregnancy and resulting abortions; lower rates of infection of HIV/AIDS and other STIs; and improved nutritional status. (CEDPA 1998, pp. 7-12).

Sexuality Education Programmes are part of a suite of proven interventions (see Table 1 below) that include activities, such as peer education, mass media, social marketing, youth-friendly services, and policy dialogue and advocacy. School and livelihood opportunities complement and reinforce these approaches

Table 1: Knowledge of HIV/AIDS and sexual behaviour among young men and women aged 15–24 years for selected countries, 1999–2003. (Values are percentages) Eastern and Southern Africa

	Country	Botswana	Ethiopia	Kenya	Malawi	Mozambique	Namibia	Rwanda	Uganda	Zambia	Zimbabwe
Females	Know that a healthy looking person can have AIDS	81	39	83	84	65	82	64	76	74	74
	Comprehensive correct knowledge about AIDS	40	NA	34	34	20	31	23	28	31	NA
	Sex before age 15	NA	14	15	17	NA	10	3	14	18	3
	Higher risk sex in the last year	NA	7	30	17	37	80	10	22	30	20
	Condom used at last higher risk sex	75	17	25	32	29	48	23	44	33	42
Males	Know that a healthy looking person can have AIDS	79	54	86	89	82	87	69	83	73	83
	Comprehensive correct knowledge about AIDS	33	NA	47	41	33	41	20	40	33	NA
	Sex before age 15	NA	5	31	29	NA	31	NA	16	27	6
	Higher risk sex in the last year	NA	64	84	71	83	85	42	59	86	82
	Condom used at last higher risk sex	88	30	47	38	33	69	55	62	42	69

Source: WHO (2006:34)

2.6 History of School-Based RSH Programmes

First established on a national scale in Europe in the 1960s, developing countries introduced school-based sexuality education in the 1980s. The emergence of HIV/AIDS gave many governments the impetus to strengthen and expand sexuality education efforts. Currently, more than 100 countries have such programs, including almost every country in sub-Saharan Africa (McCauley & Salter 1995; Rosen & Conly 1998; Smith, Kippax, & Aggleton 2000). Those United Nations' organizations, such as UNFPA, UNESCO, and UNICEF have traditionally been the leading international supporters of sexuality education. The World Bank, through its intensified efforts to help the countries in the world fight HIV/AIDS, has also become a major funding organization (World Bank 2002b). Many other bilateral donors and private foundations and organizations support and promote sexuality education worldwide.

2.7 School-Based RSH Programme Components

This Programme has three major components – curricula and training; health services; and school environment. The first component of the Programme includes such activities as information content; clarification of values; life building skills; age and developmental appropriateness; curriculum selection or development; classroom teaching methods; placement of RSH in school curriculum; selection of instructors/teachers; pre-service teacher preparation; in-service training for teachers; content and design of training programmes; training for educators; training for administrators; ongoing training and support; and training materials. The health services component of the Programme, on the other hand, is composed of school nurses; counselling services; nutrition services; contraceptive services; and linkages to community-based health services (Birdthistle & Vince-Whitman 2008).

2.8 The Role of Schools

In Ethiopia, as elsewhere in Africa and the developing world, schools play a key role in imparting important information on health and human relations. Although some Ethiopian youth still lack access to secondary or even primary education, for those young people who do attend school, the school setting provides an important venue to transmit information and skills that can protect youth against risky behaviours.

School-based sexuality and reproductive health education is one of the most important and widespread ways to help young people to improve their reproductive health. Countries in every region have organized sexuality education programs of one type or another. Such programs, if thoughtfully designed and well implemented, can provide young people with a solid foundation of knowledge and skills (Zadeh 2002).

2.9 Common Characteristics of Effective RSH Programs

A large majority of the effective programs share most of the 17 characteristics described below. These 17 characteristics can logically be divided into three categories, namely, those describing: (1) the development of the curriculum; (2) the overall design and teaching strategies of the curriculum itself; and (3) the implementation of the curriculum.

Characteristics describing the Development of the Curriculum

There are five common characteristics of effective curriculum development teams and their efforts to develop effective curricula. These teams are summarized below as presented in the sexuality education curriculum of the University of South Africa: (Department of Education 2002).

a) Included multiple individuals (and sometimes groups) with expertise in different areas in the design of the curriculum.

They often included people with different Sex and HIV Education Programs (Kirby et al. 2006). These include backgrounds and expertise especially in the areas of theory of health behaviour, research on adolescent sexual behaviour and risk and protective factors affecting that behaviour, theory of instructional design (how to change each risk and protective factor), elements of good curriculum design, specific activities used to teach youth about sexual topics, cultural knowledge, and evaluation.

b) Assessed the relevant needs and assets of the young people they were targeting.

The curriculum developers typically reviewed quantitative data on HIV, other STD or pregnancy rates, as well as any survey data on young adult sexual behaviour. They, to the extent feasible, reviewed these data for their targeted population.

c) Used a logic model approach to develop the curriculum

In public health, a logic model may specify how interventions can affect behaviour and achieve a health goal. Curriculum developers may or may not have consciously developed a formal logic model. However, their discussion of the development of the curriculum, their use of theory, and their measurement of both sexual and contraceptive behaviours and the mediating factors affecting those behaviours all suggest that they completed the following four steps, although not necessarily in the following order and not necessarily so logically.

d) Designed activities consistent with community values and available resources (staff time, staff skills, facility space and supplies).

In communities that greatly valued abstinence among young people, for example, abstinence was emphasized as the safest or best approach for young people. In schools with teachers inexperienced in using role plays, less or no emphasis was placed on students practicing role plays. In communities that lacked video equipment, videos and films were not incorporated. In schools that lacked paper and pencils, individual worksheets were not used.

While this characteristic may seem obvious, there are numerous anecdotal (and even reported) stories of people who developed curricula that could not or were not fully implemented because they were not consistent with community values and resources, and consequently they were not effective. Thus, even though this characteristic may be obvious to some people, it remains important to recognize.

e) Pilot-tested the program:

Many of the curriculum developers pilot-tested some or all of the activities and then made modifications in the activities before implementing the version that was actually evaluated.

b. Characteristics describing the contents of the curriculum itself

The eight characteristics describe the curriculum goals and objectives, activities, and teaching methods. More specifically, effective curricula:

f) Focused on at least one of three health goals: The prevention of HIV, other STDs and/or unintended pregnancy:

Effective curricula typically focused on young people's susceptibility to HIV, other STDs and/or pregnancy and the negative consequences of contracting HIV and other STDs or becoming pregnant.

g) Focused narrowly on specific behaviours leading to these health goals, gave clear messages about these behaviours, and addressed situations that might lead to them and how to avoid them:

The curricula designed to prevent HIV and other STDs focused on abstinence and frequency of sex, number of sexual partners (less commonly), and condom use. Curricula designed to prevent pregnancy focused on abstinence, frequency of sex (less commonly) and contraceptive use. Effective curricula focused on these behaviours in a variety of ways.

Although most programs emphasized abstinence and/or condom/contraceptive use, a few programs recognized that condoms do not provide complete protection against STD transmission and thus encouraged youth to limit their sexual partners, especially older male partners. Programs in some developing countries, especially Africa, emphasized the dangers of "Sugar Daddies" – older men who offer gifts or treats, but later want sex in return.

h) Focused on specific sexual psychosocial factors that affect the specified behaviours, and changed some of those factors:

Programs designed to reduce sexual activity either by delaying the initiation of sex, reducing the frequency of sex (or increasing the return to abstinence), or reducing the number of sexual partners focused on one set of factors, while programs designed to increase condom or contraceptive use tended to focus on another different but overlapping set of factors.

It is also true that a large majority of these factors were significantly improved by a majority of the studies that measured them and changed the associated behaviour and all of these factors were significantly improved by at least one-third of the studies that measured them and changed the associated behaviour (CRS 2009).

i) Attempted to create a safe environment for youth to participate.

Virtually all of the effective programs started by creating a set of ground rules for class involvement including rules such as not expressing put-downs, not asking personal questions, respecting the right to refrain from answering questions, recognizing that all questions are legitimate questions, not interrupting others, respecting the opinions of others, and maintaining the confidentiality of views expressed. Consistent with this characteristic, to help make youth more comfortable talking about sexual topics, some curricula encouraged educators to give positive recognition and positive reinforcement. In addition to establishing ground rules, some programs tried to create a safe environment by separating the class into same-sex groups for certain topics, or occasionally limiting the entire course to only one sex (CRS 2009).

j) Included multiple instructionally sound activities designed to change each of the targeted risk and protective factors.

In order to meet the needs of the targeted young people and to change the selected risk and protective factors, effective programs incorporated multiple activities to change these factors. Often individual activities were linked to specific factors; others times they addressed multiple factors.

In summary, like other human beings, adolescents have sexuality. It is a pivotal component of adolescent development. Sex has a great meaning in the lives of adolescents and youth. Generally, in developing countries and their sub divisions, the existing situations show the presence of great variations in terms of sexual behaviour. Those sections of the society need sexuality education, among other things, includes reproductive health.

In this regard, there are reproductive and sexual health programmes which are being run in various contexts. One of these contexts is school-based reproductive and sexual health (RSH) programmes. Therefore, United Nations' Organizations, particularly the World Bank help the developing countries, including Ethiopia to fight HIV/AIDS by funding the Programmes.

Schools in the developing countries, including Ethiopia play a significant role in imparting pieces of information on RSH issues. Thus, school-based RSH interventions are useful for improving the adolescents' awareness and knowledge of reproductive and sexual health. In order to assess and evaluate whether RSH Programmes are effective or not, there are common characteristics for this purpose, such as the development of the curriculum, the overall design and teaching strategies, the curriculum itself, and the implementation of the curriculum.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.0 Introduction

This chapter describes the site and setting, the study design, methods, universe of the study, sampling techniques, data collection tools and procedures, data quality control, as well as data processing analysis. In addition, ethical considerations in the study are briefly described.

3.1 Description of Study Site and Setting

The study was conducted at Medhanealem, Millennium and Efoyita Junior High Schools which are situated in Gulele and Kolfe-Keranyo Sub Cities of Addis Ababa respectively. The schools relatively have the same numbers of pupils ranging from 3200 to 4000, of whom girls being the majority in terms of the number of pupils who are currently attending in these schools. All the three schools are government-owned and -run schools. Most of the pupils who are attending in the three schools are mostly from the lower class of the society who live in the old parts of the city and the peripheries of Addis Ababa.

There are different ways of reviewing the evidence in relation to the UNGASS goals and targets for young people and HIV/AIDS, to assess whether or not interventions are effective in terms of increasing young people's access to information, skills and services, decreasing their vulnerability to HIV and decreasing HIV prevalence. In some settings, the outcome that has been the focus of the studies reviewed has been more limited. For example, the UNGASS's goal on providing access to services for the health services setting. And in some cases, behavioural outcomes, such as delaying sexual debut, decreasing the number of sexual partners, and increasing the consistent and correct use of condoms, has been used as proxy indicators for decreased prevalence. The assumption is that all of these behaviours are important in preventing

the spread of HIV and that the balance between them is likely to vary depending on the specific groups of young people under consideration and the contexts in which they live. In this paper, the researcher aimed to describe the relationship between sexual health education and reproductive health or sexual wellbeing of young people aged 14 to 16 years in the selected Efoyita, Millennium and Medhanealem Junior High Schools.

3.2 Study Design and Methods

The researcher employed non-experimental design. In addition, both quantitative and qualitative research approaches. Quantitatively, the researcher used descriptive sample survey to generate primary data from sample pupil respondents who were pursuing their schooling on those three Junior High Schools. Qualitative research methods, such as semi-structured interviews with key informants composed of teachers and pupils who were selected from those Schools, focus group discussions and documentary analysis were employed to collect pertinent qualitative primary data. Generally, this study was a cross-sectional study which applied quantitative and qualitative methods.

3.3 Universe of the Study

The study population was comprised of 60 girl pupils aged 14 to 17 years who had attended the school-based reproductive and sexual health education programmes and life skills peer learning sessions in the two Sub Cities of Addis Ababa. The community development workers of two indigenous NGOs, namely, Mary Joy Aid Through Development (MJATD) and Tesfa Social Development Association (TSDA), and teachers in the above-mentioned two schools who had been providing the girls with reproductive health education in the same period were interviewed.

The pupils were selected randomly from a list of programme participants by their respective school provided by MJATD and TSDA.

The teachers who were trained in providing reproductive and sexual health services and consented to participate were interviewed. Most of the interviewed teachers had been leaders of the reproductive health club and girls club in the three schools. In addition, those pupils aged 15 to 17 years who had attended the reproductive and sexual health education sessions were included in the study. To compare results, equal numbers of adolescents of the same age, same school but did not attend the RSH sessions who had given a written consent were interviewed. In contrast, those pupils who did not consent to the interviews were not interviewed. In general, the sample size was determined by the researcher to be 60 girl pupils who had participated in the research. Out of the total 276 girl pupils who had been participating in the Reproductive and Sexual Health Programme, only 60 of them approached and selected as survey respondents due to limited resources, such as financial, human, material and time resources.

3.4 Sampling Methods

In the study, the researcher employed purposive and convenient sampling techniques of the non-probability sampling technique. The former technique was used to select pupil respondents, while the latter was employed to select and to interview those pupils and teachers in the three schools. The latter technique employed for selecting cases or units of observation as they were available to the researcher. Only those teachers who were easily and conveniently available and accessible were interviewed.

3.5 Data Collection: Tools and Procedures

Interview schedules with closed-ended questions were presented and answered by 60 sample pupils to express their knowledge, attitude and experiences. The research instrument was mostly adapted from the Behavioural Surveillance Survey (BSS) questionnaire. Here, the focus of this study was to analyze a number of specific questions asked to girls who had been in the age group 13 to 16; about their most recent knowledge, attitude, practice and experience in their sex education and if there is any correlations with increased sexual wellbeing. The quantitative instrument attempted to address socio-demographic characteristics, sexual behaviour, knowledge and practice of condom use, alcohol and drug use, knowledge, attitude and practice of HIV, sexually transmitted infections, availability and access to HIV testing, etc. A group of children who had participated in sex education and another group of the same age group never exposed to any form of sex education would fill the same interview schedule.

Regarding reliability and validity of the research instruments the interview schedules and interview guides, the researcher conducted pre-testing and pilot study. Both instruments were pretested with 5 pupils to find out points of possible confusion and ease of use and adjustments were made accordingly.

Qualitative data was collected using interview guide through note taking. The interviews were carried out in Amharic. All responses between the researcher and the respondent were verbal.

Three Focus Group Discussions were conducted with five teachers, 16 students, five (5) community development workers of Mary Joy and TSDA, the Mary Joy Kolfe project coordinator, along with the observations of various Anti-AIDS and peer group records are reported. FGD information on the parent and teacher knowledge, attitude and support on puberty and sexuality issues and results of a key informant interview with girls' club leaders in school

levels of the study area was collected in the three sites. This method was useful to elicit students' perceptions and to explain quantitative results. This method also enabled participants to relax and talk freely and express their opinion (Rice & Ezzy 1999). Study participants were selected based on mothers' and infants' age.

Two key informant interviews were held with teachers from the three schools. An interview guide was developed to facilitate the discussions. These interviews allowed probing issues in detail and encouraged respondents to express their views to explore the existence of any sex network, guideline in the school system, which assist girl students to minimize vulnerability absenteeism and girls school dropouts.

3.6 Data Processing and Analysis

In order to process and analyze the quantitative data, the interview schedules were checked and missed questions amended in the field and at a central collection place. Data entry was validated by checking samples of the schedules to identify data entry errors. The data were coded and analyzed using the SPSS software. During the data analysis, the researcher used descriptive statistics, like frequencies, percentages, measures of central tendency and measures of dispersion. Moreover, bivariate data analysis techniques were used. In order to assess whether or not there are statistical differences between the subject and the reference group, the researcher used using Chi-Square tests (dichotomous variables). A value of $p < 0.05$ was considered as statistically significant.

Thematic analysis was applied to analyze written transcripts of qualitative data and then to identify emerging themes. The researcher reviewed the transcripts to develop a code list for the research objectives. Codes were applied manually to the transcripts by the researcher. No

software was used for the qualitative data analysis. Those texts pertaining to the codes in the qualitative data analysis was organized in a matrix to describe essential themes.

3.7 Ethical considerations

First of all, the researcher obtained a written informed consent from the study participants and emphasis is placed on the principles of privacy and confidentiality. The researcher explained the objectives of the study and guaranteed participants that all contributions would remain anonymous. Participants were encouraged to use local language and terms to describe practices pertaining to sexuality. Generally, the researcher took care not to encroach upon the psycho-social privacy of the pupils, teachers and other stakeholders who had participated in the study.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.0 Introduction

This section presents results and discussion from a sample of 60 girl students aged 14 to 16 in the three schools where the program has been operational. It included results of one Focus Group Discussion with mothers and two KIs with health workers.

A. RESULTS

4.1 Background characteristics of respondents

This chapter has three sections and in each section findings of various questionnaires presented to various groups of respondents were addressed. Written replies of sixty (60) students were gathered through a semi-structured questionnaire and explained in the first section of this chapter. We found a response rate of 100 % before we excluded cases of missing data. It became 80% when cases were excluded using criteria mentioned below. There were 64 participants in the three schools. The respondents were all girls in the age group of 14 to 16 years with a mean age of 15.07.

4.1 Socio Demographic Profile

Table 1 details selected socio-demographics of the women interviewed. The combined mean age of respondents was 15.07 years. The comparative age between the respondents in both those exposed to the reproductive and sexual health education and those not participated was relatively similar.

Table 2: Frequency and Percentage Distribution of respondents by RSH Exposure

Age	No. of RSH Participant Respondents	%	No. RSH Non-participant Respondents	%
14	8	26.67	9	30.00
15	12	40.00	12	40.00
16	10	33.33	9	30.00
Total	30	100	30	100.00

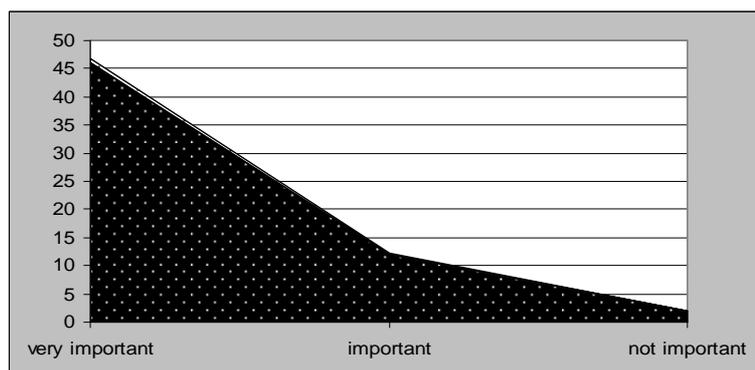
Religion: In this sample survey, all three major religions in Ethiopia were significantly represented by at least a quarter of the respondents: Orthodox (48.33%), Protestants (18.33%), and Islam (30.0%). The documented distribution of the respondents' religion in this survey is pertinent to the researched schools areas and do not necessarily reflect the prevailing religion composition in the general population. Thus, caution should be made while interpreting this data.

Table 3: Frequency and Percentage Distribution of respondents by Religion

Religion	No	Percentage
Orthodox	29	48.33
Muslim	18	30.00
Protestant	11	18.33
Catholic	2	3.34
Total	60	100

It is widely agreed that religiosity, though difficult to measure, may act as a more powerful influence on behaviour than formal religious affiliation. Accordingly, the data collected shows that majority of the students said they see religion as the very important characteristics that regulate behaviour.

Chart 1: Importance of Religion on Sexual behaviour



4.2 Awareness about changes during adolescence:

The comparative study included a few questions on topics to help us understand how conscious are the youth of the changes taking place in them and how aware they are about sexual and reproductive health issues. Out of the 30 respondents in the ARSH participating group, 28 of them identified the changes related to adolescence correctly, including mood swings where as only 19 correctly mentioned the changes in the non-participating group. 87% in the exposed and 64% in the non-exposed group were aware that sperm production begins in adolescence. This once again highlights the lack of enough understanding of the reproductive processes among the youth.

Table 4: Awareness about changes during adolescence

	YES		No		Don't know		Total	
	No.	%	No.	%	No.	%		
Girls start menstruating	52	87%	4	6%	4	7%	60	100%
Lack of concentration, moodiness	54	88%	5	8%	1	4%	60	100%
Physical growth, increase in height, development of muscles in boys	47	78%	7	11%	6	11%	60	100%
Roughness of voice in boys	42	71%	9	14%	9	15%	60	100%
Production of sperm begins	34	57%	6	9%	20	34%	60	100%
Breast development in girls	45	74%	6	9%	9	17%	60	100%
Growth of hair around private parts	46	77%	8	12%	6	11%	60	100%

4.3 Knowledge on Reproductive and Sexual Health

Out of the study participants, only 80 (8.0%) of them answered that a woman is most likely to become pregnant halfway between two periods, of which the majority, 80% were from the female group who participate in RYH program (Table 2). The proportion of non-exposed and exposed adolescents who replied correctly to this question was 8.3% and 11.3% respectively. Out of the total study subjects, 78.3% of them had reported that they know at least one means of avoiding pregnancy. Knowledge of sexual health trained girl students was three times higher than the non-participating ones. Oral pills, Injectables, and condoms were the most recognized contraceptive methods that were reported by 93% and 79% respectively. Moreover, a sizable proportion, 17.6% of the participants agreed douching to be one of the alternative methods of contraception and only 46% of the non-exposed known that a girl could get pregnant the first time she had sex. Fifty nine (98.3%) of the participants knew diseases that a person can acquire through sexual intercourse. Knowledge of adolescents on this question was found to be about four times higher for participating adolescents.

Among the 50 respondents who know at least one of the diseases that can be transmitted through sexual intercourse, the majority, 56 (93.33%) of them mentioned AIDS and 45.3% mentioned gonorrhoea and almost an equal proportion of them stated syphilis. Whereas, only 19% and 17% of them mentioned diseases like lymphogranulom venereum and chancroid respectively. It is interesting to state that 29 and 5 of the participants mentioned tuberculosis and haemorrhoids to be STDs respectively.

Out of 60 participants who mentioned there is means of preventing STDs and AIDS, most, 79% mentioned abstinence, 43% to use condom, 29% to remain faithful to a partner and 11% to avoid

sex with Commercial Sex Workers (CSW) to be ways that a person should follow to avoid getting these diseases. Out of the sixty (92%) of the respondents who had reported that they have heard about HIV/AIDS, 89% stated unsafe sex, 53% sharing syringes and needles, 22% transfusion of infected blood and 2.3% vertically from mother to child to be the major means of HIV transmission. Only 53% of the non-exposed group know that a healthy looking person can have HIV. The proportion of participants who agreed that a person can get HIV the first time he or she had sex was found to be very small, only 40% for non-exposed and 87% for exposed.

4.4 Source of Information on Reproductive Health

Parents (48%), peers (26%), health workers (11%) and media (10%) were mentioned to be the common source of information on sexual maturation in that order of importance. The respondents had reported that they prefer parents (52%), health workers (34%), peers (18%) and partner (13%) to discuss with to get more information about pregnancy respectively. More exposed adolescents want to discuss the issue with health professionals and peers whereas most rural adolescents prefer it to be with parents and partner. Media (37%), peers (35%), parents (31%); neighbour (28%) and health workers (21%) were reported to be the major source of information on STDs/AIDS. Out 99 respondents who stated media to be their source of information on sexual maturation, only 13% of them were from non-exposed group.

Table 5: Comparison of reproductive health knowledge of in-school Adolescent girls between RSH participants and non-participant girls

Variables	RSH Exposed Group (n=30)		Not exposed (n=30)	
	No	%	No	%
Knowledge of the likelihood occurrence pregnancy during menstrual cycle				
In the middle of her cycle	4	13.1	16	3.1
During her period	3	10.4	57	11.2*
Right after period is ended	12	40.0	12	37.6*
Just before her period begins	9	14.7	47	9.2*
The same throughout	0	0	7	1.4
Don' know	2	6.67	12	37.6*
Know means of avoiding pregnancy				
Yes	26	87.6	21	69.5
No	4	12.4	9	30.5
Know diseases that can be transmitted through sexual intercourse				
Yes	28	92.9	22	74.8*
No	2	7.1	8	25.2
Know means of STD and HIV/AIDS prevention				
Yes	27	87.3	21	69.1*
No	3	12.7	9	30.9
Have heard about HIV/AIDS				
Yes	29	6.3	26	88.1
No	1	3.9	4	11.9
Know what safe sex mean				
Abstinence	13	43.0	7	16.8
Using condom during every sex	4	8.6	2	2.3
Avoiding multiple sex partners	7	18.2	7	16.8
Avoiding sex with prostitutes	1	0.8	2	3.3*
Having sex with a faithful partner	4	96	4	10.0*
Do not know	1	0.4	1	1.

N.B. - * refers to significant difference

The above table shows that there is a significant difference in knowledge about HIV/AIDS and means of HIV transmission between groups involved in school based RSH programs and non

participating programs. Therefore, the girl students have better information or knowledge on basic prevention methods than students not participating in the program.

4.5 Reproductive and Sexual Health Behaviours

Out of the 60 participants, 45% have reported to be sexually active at least once before the time of the study, out of which 21(35%) were non RSH participants. The mean (\pm SD) age of sexually active participants at sexual onset was 13.6 (\pm 2.7) years. Non participating girl adolescents had earlier sexual onset compared to the RSH exposed ones. The mean (\pm SD) lifetime number of sexual partner per sexually active participants was 3.1 (\pm 14.4). After controlling for possible confounding variables sexual activity was found to be significantly associated with many of the independent variables. The older the age has almost five times risk to be engaged in sex. The number of sexual partners was higher for non participating females.

Among the reasons for engaging in sexual debut the first time, have desire to do so by 11%, fall in love by 20%, want to get married by 9%, and to get gifts by 4% to be the major reasons. However, 7 (11.6%) of the respondents mentioned that they were forced to do so.

Modern contraceptive use was found to be very low among the study subjects. Only 21% of the sexually active had ever used modern contraceptives. Only 4(6.6%) of the sexually active had used contraceptive during their first sexual engagement. Only 9 (15%), 2% of the non-exposed sexually active and 35% of RSH exposed sexually active, had ever used condom. The proportion of adolescents who have used condom during the most recent sexual intercourse was found to be as low as ever users. Only forty-eight, 11% of the sexually active had used condom during their most recent sexual début, of which 92% of them were from RSH participant group.

4.6 Knowledge about Transmission of Infection

A complete understanding of the modes of transmission is essential to promote safe behaviour among the youth. It may be noted that while around 55-60% of the respondents answered correctly to the questions regarding means of transmission, through blood and unprotected sex, only 31% said that HIV spreads through semen and vaginal fluids. 22% have also said it does not spread through semen and vaginal fluids. This indicates a clear gap in understanding the factors involved in sexual transmission of the disease.

Only 53% of the respondents felt that HIV/AIDS has no cure. Around 28% felt that it is curable while 19% were not sure. In short it shows that 47% of the respondents were not aware of the gravity of the HIV infection and may be indulging in risk behaviour. Use of sterilized needles and razors as well as condom use are identified as practices that prevent spread of HIV by 49% and 59% respondents respectively. It is important to note that 18% of respondents have said use of condom does not prevent HIV/AIDS. 37% said sterilized needles/razors do not protect from contracting HIV/AIDS.

Table 6: Response on Prevention knowledge of HIV/AIDS

Statement	Incorrect		Correct		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%
There is no cure for AIDS	13	21.66%	47	78.33%	0	0%	60	100%
Use of sterilized needles, razors etc will prevent HIV Transmission	0	0%	60	100%	0	0%	60	100%
Proper use of condom will prevent the spread of HIV	12	20%	46	76.66%	2	3.33%	60	100%

Symptoms of HIV/AIDS

HIV has a long gestation/incubation period when the patient does not exhibit any external symptoms. Only 44% of the respondents were aware of this. In contrast 20-25% respondents felt that they do have external symptoms and can be recognized by their appearance. 30-35% was totally ignorant about it.

Source, Knowledge and misconception about HIV/AIDS

Most of the FGD participants and interviews cited peer leaders, teachers, MJATD trainings and meetings, mass media and newsletters as major source of HIV/AIDS information and knowledge in the school community. Some of the respondents indicated that the source of HIV related information for them is mainly electronic and printed media.

Almost all respondents indicated that Peer group discussions are the forums for HIV/AIDS information exchange. Most of the beneficiaries of the project mentioned that they spent 30-60 minutes of their time per week. The more we go higher up to the anti-AIDS club members; more time spent for HIV/AIDS prevention activities. In the peer structure, not only HIV but also social issues are discussed during the peer learning process.

Majority of the respondents mentioned that with regard to the issues being discussed among the peer group includes modes of transmission, VCT, condom, misconceptions, peer influence, alcohol and chat chewing. Such discussions are lead by peer leaders and difficult questions might be referred to the next higher levels in the structure which sometimes goes to the level of an outreach worker.

4.7 Perceptions of Teachers and Staff On Changes in RSH Knowledge and Practices of Students

a) Basic information about risks of having sex and methods of avoiding sex or using protection:

To increase knowledge, the curricula focusing on HIV/STD prevention most commonly covered the following topics: the most common modes of HIV and other STD transmission, symptoms of STDs, inability to assess the existence of STDs from a healthy appearance, susceptibility to STDs, consequences of STD/HIV (e.g., pain, sterility, ectopic pregnancy, possible death, and effects on newborn infants), methods of preventing STDs, common local myths about pregnancy and STDs, effectiveness of abstinence and condoms, correct use of condoms, and more generally, overall knowledge of HIV/STD. Some effective curricula covered testing and treatment of HIV and other STDs.

As noted above, relatively few effective curricula covered pregnancy prevention, but appropriately, of those that did, the majority covered the causes of pregnancy, chances of becoming pregnant if sexually active, consequences of pregnancy, methods of preventing pregnancy (abstinence and contraception), sources of contraception including community reproductive health resources, teens' legal rights to contraception, how different methods work, effectiveness of different contraceptive methods, and myths and facts about pregnancy and contraception.

Although a few curricula included a couple of errors or some information that was slightly outdated, nearly all curricula included medically accurate information about methods of avoiding pregnancy or sexually transmitted disease. A variety of activities were used to convey and help personalize this information. The most common types of activities included short lectures, class discussions, competitive games in which teams win by correctly answering questions, simulations (discussed below), statistics on prevalence, skits, videos, flip charts or pamphlets with information about different STDs or contraceptives. Notably, many of these activities required that the students obtain and share their information rather than passively listen to the educators.

b) Perceptions of risk especially susceptibility:

Virtually all of the effective curricula focused in both susceptibility and severity of HIV, other STDs or pregnancy respectively. To increase feelings of susceptibility, curricula commonly provided data on the incidence or prevalence of HIV, other STDs or pregnancy in their countries or in their communities, and when possible among youth roughly their age. They also used class discussions, videos with true stories of young people having HIV or stories of young people becoming pregnant, handouts with scenarios involving risk, etc.

c) Personal values about having sex or premarital sex and perception of peer norms about having sex.

Programs for younger youth were more likely to address values about sex than were programs for older youth. Many programs, especially those for younger youth, promoted abstinence values by repeatedly emphasizing that abstaining from sex was the safest method of avoiding HIV, other STDs and pregnancy. Several programs included group discussions in which students

discussed the advantages and disadvantages of engaging in sex, and the educators both emphasized that abstinence was the only 100 percent effective method of avoiding pregnancy, STDs, and other negative outcomes and guided the discussion so that avoiding sex was viewed as the best choice by youth. A few curricula discussed methods of showing you care about someone without engaging in sex.

d) Individual attitudes and peer norms toward condoms and contraception.

Effective curricula gave a clear message about using condoms and contraception if sexually active. Typically, they discussed the effectiveness of condoms and contraception, often stating that they did not provide complete protection against STD or pregnancy, but were much safer than unprotected sex and those condoms provided the only significant protection against STD during sexual activity. Some effective curricula included survey data from large samples of either youth or from the students in each classroom showing that students believed that young people should use condoms or contraception if they do have sex.

Effective curricula addressed a variety of attitudes towards condoms and contraception and perceived barriers to using condoms, e.g., perceived effectiveness in preventing STD and pregnancy, difficulties obtaining and carrying condoms, embarrassment asking one's partner to use a condom, the hassle of using a condom, and the loss of sensation while using a condom. These were addressed by lectures and class discussions that talked about condoms and described their effectiveness if used properly, by discussions about where to obtain condoms with little embarrassment, by visits to drug stores to assess the characteristics of the condoms sold there, by fact sheets about condoms, and by practicing role plays in which each partner insisted on using condoms. A few programs included class discussions of how using condoms could increase

sexual enjoyment rather than decrease it by using lubricated or different kinds of condoms or by having the female partner put on the condom as part of sexual foreplay.

e) Communication with parents or other adults:

To increase parent/child communication, some programs provided homework assignments to discuss selected topics with their parents or other adults. Sometimes these assignments started with easier topics and moved toward topics that are more sensitive. Sometimes the programs provided the parents with information about HIV, other STDs and pregnancy, information about adolescent sexual behaviour, and various skills to talk more comfortably with their own children about sex. A few programs described a variety of values widely held in the communities that parents might wish to emphasize to their children. Because parents knew that their children were going to have these homework assignments, they could be better prepared and could understand why their children were asking questions about sex.

f) Employed activities, instructional methods and behavioural messages that were appropriate to the youths' culture, developmental age, and sexual experience:

Some curricula were designed for specific racial or ethnic groups and emphasized the high rates of HIV, other STDs or pregnancy among those groups and the need for young people to be responsible not only to themselves, but also to their communities, by avoiding unprotected sex. Other curricula were designed specifically for young women and emphasized that young women can be powerful and can be in control in sexual situations.

Most curricula were consistent with the developmental age and sexual experience of the students. Activities for younger youth sometimes included information that is more basic, less advanced cognitive tasks, and less difficult activities, while those for older youth did the reverse. For example, role-playing without scripts was more commonly implemented among older youth than among younger youth. As described above, for younger less sexually experienced youth, programs focused more on abstinence, while for older more sexually experienced youth, programs focused more on condoms.

g) Covered topics in a logical sequence:

In many, but not all, of the curricula, the risk and protective factors and the activities addressing them were presented in an internally logical sequence. Often the curricula first enhanced the motivation to avoid HIV, other STDs and pregnancy by emphasizing susceptibility and severity of these events and then addressed the knowledge, attitudes and skills needed to avoid them. For example, their sequence of activities included:

1. Basic information about HIV, other STDs or pregnancy, including susceptibility and severity of HIV, other STDs and pregnancy,
2. Discussion of behaviours to reduce vulnerability,
3. Knowledge, values, attitudes and barriers related.

B. DISCUSSION

This study has revealed the reproductive health differences between adolescents who participated in reproductive and sexual health programs and those who do not in terms of adequate

information, sexual initiation, and the existents of high-risk sexual and RH behaviours and patterns of health service utilization.

An important measure of sexual activity is timing of initiation of sex. The study demonstrates that RSH programs in general do not hasten the initiation of sex and rather delay the initiation of sex. The review studies that measured impact on the initiation of sex throughout the world, 22 (or 42 percent) found that the programs significantly delayed the initiation of sex among one or more population sub-groups for at least six months, 29 (or 55 percent) found no significant impact, and only 1 or 2 Sex and HIV Education Programs.

A second measure of sexual activity is the frequency of sex during a specified period (e.g. three or six months prior to the survey). This measure includes whether or not respondents had sex at all during that period. Sometimes people label this “being abstinent.” This measure is important for both pregnancy and STD prevention. The results indicate that in general programs do not increase frequency of sex and rather reduced the frequency. Programs in school with females of all age groups were found to be effective.

A third common measure of sexual activity is number of sexual partners during a specified period prior to the survey. This measure is especially important for STD transmission. Once again, results indicated that, in general, programs did not increase the number of sexual partners and some decreased the number. The study measured program impact on condom use and increase in condom use among the entire sample or one or more population sub-groups was seen in the studied group exposed to RSH education. Increased knowledge and contraceptive use was also registered better with the exposed group.

Studies recognized that STD/HIV transmission and pregnancy can be reduced either by reducing sexual activity or by increasing condom or contraceptive use and accordingly they developed composite measures of sexual activity and condom use, such as “frequency of unprotected sex” or “number of unprotected sexual partners.” These measures are strongly related to STD/HIV transmission and pregnancy. The school based programs significantly reduced sexual risk-taking.

CHAPTER FIVE

CONCLUSIONS AND SUGGESTIONS

5.1 Conclusions

The results of the survey demonstrate that in general the RSH programs actually reduced sexual behaviour, either by significantly delaying the initiation of sex, reducing the frequency of sex, or reducing the number of sexual partners. There is a great lack of information and knowledge among non-RSH education participating girl school adolescents on sexuality, contraception, and HIV/AIDS and several misconceptions abound.

Though some participants found to be involved in risky sexual behaviours, the great majority of them considered themselves low risk for HIV. There is no single dominant source of information for adolescents on selected sexual and reproductive health issues and mass media as source of reproductive health information was found to serve the larger number of adolescents.

A substantial number of adolescents were found to be sexually active. The majority had involved in risky sexual behaviours, like early sexual engagement, having multiple sexual partners and very low level of condom and contraceptive use. The number of adolescents utilizing health services including modern contraceptives is very low.

5.2 Suggestions

There is a need to design school-based reproductive and sexual health programs that comprise both promotional activities and feasible sexual and RH services that could serve adolescent girls.

The RSH programs should focus on improving the following eight factors:

1. Knowledge, including knowledge of sexual issues, HIV, other STIs, and pregnancy (including methods of prevention)
2. Perception of HIV risk
3. Personal values about sex and abstinence
4. Attitudes toward condoms (including perceived barriers to their use)
5. Perception of peer norms and behaviour about sex
6. Self-efficacy to refuse sex and to use condoms
7. Intention to abstain from sex or to restrict sex or partners
8. Communication with parents or other adults about sex, condoms, or contraception

In addition, programs that *reduce sexual activity* focused on and improved an additional two factors:

9. Self-efficacy to avoid STI/HIV risk and risk behaviours
10. Actual avoidance of places and situations that might lead to sex
11. Intention to use a condom

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	3. Catholic
	4. Muslim
	5. Other (Specify) _____
To which ethnic group do you belong to?	1. Amhara
	2. Oromo
	3. Tigraie
	4. Afar
	5. Others (specify) _____
What is your current marital status?	1. Single (never married)
	2. Live with regular partner, but not married
	3. Currently married
	4. Separated
	5. Divorced
	6. Widowed
Which Grade are you currently attending?	# Years completed [][]
	Year level _____
PART II Sexual behaviors of Adolescents and youth	
What are the RH problems that youth at your age (adolescent) faces? (more than one answer is possible)	1. Untimely sexual practice
	2. Unplanned pregnancy
	3. Abortion
	4. STIs
	5. Others specify _____
Of the problems that you mentioned on Q202, which one do you think is the biggest Problem for youth in your area?	1. Untimely sexual practice
	2. Unplanned pregnancy
	3. Abortion
	4. STIs
	98. Others specify _____
In your opinion, what is the ideal age for a girl to start sexual intercourse?years = 1 88.Don't known
In your opinion what is the ideal age for a boy to start sexual intercourse?years = 1 88.Don't known
Have you ever had sexual intercourse?	1. Yes
	2. No
How were you exposed to 1st sexual intercourse?	1. By my interest
	2. Forced by a friend
	3. I was raped
	4. On my marriage

	5. I drank alcohol
	6. Other specify _____
	99 No response
Did your first sexual intercourse was protected (were used condom)	1. Yes
	2. No
Which of the following consequence you faced from your first sexual exposure?	
	1. Pregnancy
	2. STIs
	3. School dropout
	4. Nothing was happened
	5. Other specify
	99 No response
Have you ever used any method of family planning? (Ask sexually active)	1. Yes
	2. No
Which method of family planning have you used? (More than one answer is possible)	
1. Female Sterilization/Tubal ligation	1. Yes 2. No
3. Pills	1. Yes 2. No
4. Injectable /Depo-Provera	1. Yes 2. No
5. IUCD	1. Yes 2. No
6. Implant	1. Yes 2. No
7. Condoms	1. Yes 2. No
8. Diaphragm/Foam/Jelly	1. Yes 2. No
9. Standard days method	1. Yes 2. No
10. Lactation amen. method	1. Yes 2. No
11. Rhythm method	1. Yes 2. No
12. Withdrawal method	1. Yes 2. No
Are you currently using any family planning method?	1. Yes
	2. No
Which family planning methods are you currently using? (More than one answer is possible)	
1. Female Sterilization/Tubal ligation	1. Yes 2. No
3. Pills	1. Yes 2. No
4. Injectable /Depo-Provera	1. Yes 2. No
5. IUCD	1. Yes 2. No
6. Implant	1. Yes 2. No
7. Condoms	1. Yes 2. No

8. Diaphragm/Foam/Jelly	1. Yes	2. No
9. Standard days method	1. Yes	2. No
10. Lactation amen. method	1. Yes	2. No
11. Rhythm method	1. Yes	2. No
12. Withdrawal method	1. Yes	2. No
Where did you get /obtain the current family planning methods you are using?		
Government health facilities		
1. Government hospital	1. Yes	2. No
2. Government health centre	1. Yes	2. No
3. Government health post/HEW	1. Yes	2. No
4. Government health station/clinic	1. Yes	2. No
5. Government pharmacy	1. Yes	2. No
6. Government drug vendor	1. Yes	2. No
Non Governmental Organization (NGO)		
1. NGO health facility	1. Yes	2. No
2. CBD/CBRHA/VCHW	1. Yes	2. No
3. Others (specify)_____	1. Yes	2. No
Private Health Facilities		
1. Private Hospital	1. Yes	2. No
2. Private clinic	1. Yes	2. No
3. Private pharmacy	1. Yes	2. No
4. Private drug vendor	1. Yes	2. No
Other sources		
1. Shop	1. Yes	2. No
2. Friend/relative	1. Yes	2. No
Who decides to use family planning in the relationship?	1. partner	
	2. Myself	
	3. Both	
Did you get the family planning method you are using free of charge?	1. Yes	
	2. No	
What are the reasons for not using family planning methods?		
Did your partner ever became pregnant by you?	1. Yes	
	2. No	
Did you ever became pregnant by your Partner?	1. Yes	
	2. No	

Appendix 2: NGOs Profile

i. Tesfa Social and development association (TSDA)

Tesfa Social and development association (TSDA) is a federation of 68 iddirs established in 2000. Many of its member iddirs have sustained for the last 50 years. The oldest and the first iddir in the country, nearly 100 years of age named NEBAR KOLFE is also the member of TSDA; assisting individual members during death calamities and funeral services was their standing points. Having established itself on a solid social base with a high degree of credibility within the community, TSDA has undertaken basic economic and social activities in the community by coordinating and mobilizing the efforts of member iddirs in an organized manner. One of the areas TSDA is focusing on is HIV and AIDS prevention and support to orphans and vulnerable children, senior citizens and PLHIV and other members of the community. A system is established whereby each individual community member regularly participates in the efforts of the federation through his/her iddir not only in raising money, but also participating in decision making process and taking part in the implementation of different projects. Presently, TSDA is providing home based care, educational psychological support and economical support to orphan and vulnerable children and PLHIV and orphan who are burdened with the responsibility caring for their grand parents due to the death of their own parents as a result of HIV and AIDS. TSDA is also striving to create a positive attitude in the community towards PLWHA and those affected by the epidemic and bring behavioral change to intensify the fight against the prevalence through organized communal and household actions.

TSDA has a management board elected by the general assembly to provide policy guidance, approve annual budget, and oversee the implementation of the objectives of the federation and

from time to time review strategic directions. The council of whom the management board is accountable constitutes the chairpersons, the secretaries and auditors of all member iddirs and meet every six month to discuss on the progress of the federation and make better decisions and provide guidance for the future. The general assembly constitutes all members of the executive bodies of each member iddirs. TSDA has also Executive committee that manages the day to day activities of the federation according to the approved plan and budgets. The Executive committee has a chair person, assistant , finance and property section, plan and program sections, social and development sections and administration office service each handed by the member of the Executive committee. The federation has a modest office provided by the local administration. There is a transparent communication structure lay down through which each member iddirs is informed of what the Executive committee does and interns provide feedback to the Executive committee every month. Standard financial management, procurement and property management, records management systems and procedures are in place and trainings are provided for the relevant staffs of the federation to make the system functional.

TSDA is re- registered by Charities and Societies Agency of the Ministry of Justice of the Federal Democratic Republic of Ethiopia to operate as a legal entity in its operational area.

VISION

Tesfa Social and Development Association aspires to see economically and socially dignified communities where each person has equal voice in creating a better and just life for every one.

Mission:

TSDA has the mission of serving individuals and families in its operational area to overcome poverty and become self-reliant through empowering mechanism.

Main objective of TSDA:

To provide community based care and support to vulnerable social groups such as elderly and orphans and vulnerable children who lost their parents due to HIV and AIDS and other causes.

To develop knowledge, skills and other resources to empower the target communities and initiate plan, implement and manage community led development intervention.

To assist vulnerable community groups such as women and unemployed youth to be engaged in small scale economic activities to improve their livelihoods.

ii. Mary Joy Aid through Development (MJATD):

Mary Joy is a local non-governmental organization legally registered by the Country's Ministry of Justice. It is governed by General Assembly with the member of over 30 people. There are five elected board of directors and has secretariat. The Board of Directors, which is accountable for the General Assembly, directs the organization through the development of policies and strategies for the organization.

Mary Joy envisions seeing *healthy, poverty free and empowered society*. Its core values and principles include: transparency, accountability, equity and equality. As an urban based organization, Mary Joy currently implements its Integrated Urban Development Programs in Addis Ababa and Awassa Town. In Addis Ababa, it operates in sub cities of Yeka, Kolfe –

Keranio and Gullele. In Awasa Town, it operates in all kebeles including Sub urban areas like Tulla, Gemeto and Datto. The primary direct targets of the organization includes: orphan and vulnerable children, HIV/AIDS victim citizens, unemployed youth, low income and destitute older persons and destitute women and families and the community at large. Currently the organization is implementing its second strategic plan document which was started in January 2010/11 and will continue for five years all the way through the end of 2015/16. The fundamental thematic program areas included in to the Strategic plan document are: Livelihood Enhancement; HIV/AIDS prevention care and Support; Capacity building for CBOs and institution and Private-Community-Public-Partnership.