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The public health crises generated by AIDS (HIV, 1987; Quin, 1989; Huffman, 1989) strain the resources of the national and international health care systems. As more people are infected, the economic burden of caring for these patients increases. The risk of becoming a care recipient by HIV virus also increases, and the burden of caring for these patients is shared by individuals, families, communities, and the health care system.

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NEW MEASURE OF ADOLESCENT SEXUALITY

Human Immunodeficiency Virus

HIV and AIDS education for adolescents has been an important issue in public health education and policy. The SKYAT (Sexual Knowledge, Attitudes, and Risk Assessment Test) is a self-administered questionnaire designed to assess knowledge, attitudes, and behaviors related to sexual health. The original SKYAT was developed in 1979 by L.F. and revised in 1990.

BACKGROUND AND DEVELOPMENT OF THE SKYAT

Knowledge and Attitude Scale for Adolescents (SKYAT)

The SKYAT was developed to address the needs of adolescents and to provide a tool for assessing their knowledge and attitudes related to sexual health. The test was designed to be administered in a self-report format, allowing for anonymity and confidentiality. The SKYAT is scored in two parts: knowledge and attitude.

Knowledge

The knowledge component of the SKYAT assesses the respondent's understanding of sexual health-related topics, including sexually transmitted infections (STIs), pregnancy, and contraception. The knowledge section is divided into five subcategories: STIs, contraception, pregnancy, communication, and HIV/AIDS.

Attitude

The attitude component of the SKYAT evaluates the respondent's beliefs and values regarding sexual activity. The attitude section is divided into four subcategories: sexual activity, STIs, pregnancy, and HIV/AIDS.

The SKYAT has been widely used in research and educational settings to assess knowledge and attitudes related to sexual health. It has been translated into multiple languages and adapted for different age groups. The SKYAT is a valuable tool for evaluating the effectiveness of sexual health education programs and for identifying areas for improvement.
Results

The study aimed to measure the reliability and validity of the measures used in the study. The reliability was assessed using the internal consistency of the scale, which was calculated using Cronbach's alpha. The validity was assessed using construct validity, where the scores on the scale were compared to the scores on a related measure.

Procedure

The assessment of the knowledge section was conducted using the Pearson R test. The reliability of the scale was assessed using the coefficient of internal consistency (Cronbach's alpha).

Method

Reliability and Literacy Assessment

The assessment of the knowledge section was conducted using the Pearson R test. The reliability of the scale was assessed using the coefficient of internal consistency (Cronbach's alpha).

During May 1995, an assessment of the test-retest reliability and internal consistency was conducted using the Pearson R test. The reliability of the scale was assessed using the coefficient of internal consistency (Cronbach's alpha).

The study was conducted in a community setting with participants from various demographics. The measures used in the study were validated using a variety of methods, including factor analysis and construct validity.

The study used a mixed-methods approach, combining quantitative and qualitative data collection methods. The study was conducted in a community setting with participants from various demographics. The measures used in the study were validated using a variety of methods, including factor analysis and construct validity.

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An inspection of Table 2 shows few significant correlations with the

KNOWLEDGE SCALE

RESULTS

The Pearson correlation coefficient (r) was computed using

**Method**

**Validity Assessment**

**Focus on the difficulty of the items and ensure responses are completed**

**Attitude Scale**

<table>
<thead>
<tr>
<th>Level</th>
<th>Test-Pass</th>
<th>Comprehension</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N=49)</td>
<td>(N=49)</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1. Reliability and Validity Assessment for SK&A Knowledge and Attitude Scale**

**Legends**

- **SK&A Knowledge Scale**
- **SK&A Attitude Scale**
- **SK&A Comprehension**
- **SK&A Test-Pass**
### TABLE 2. Correlations (r values) Between SKATA and Kirby Knowledge Sections

<table>
<thead>
<tr>
<th>SKATA Knowledge Sections</th>
<th>Physical Development</th>
<th>Teen Relations</th>
<th>Sexual Acts</th>
<th>Teen Pregnancy</th>
<th>Teen Marriage</th>
<th>Probability Pregnancy</th>
<th>Birth Control</th>
<th>STD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>.14</td>
<td>.01</td>
<td>.06</td>
<td>.04</td>
<td>.08</td>
<td>.11</td>
<td>.19</td>
<td>.09</td>
</tr>
<tr>
<td>Birth Control</td>
<td>.08</td>
<td>.04</td>
<td>.05</td>
<td>.08</td>
<td>.06</td>
<td>.08</td>
<td>.01</td>
<td>.08</td>
</tr>
<tr>
<td>Fantasies</td>
<td>.15</td>
<td>.19</td>
<td>.08</td>
<td>.26</td>
<td>.26</td>
<td>.03</td>
<td>.28</td>
<td>.03</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>.12</td>
<td>.13</td>
<td>.10</td>
<td>.02</td>
<td>.02</td>
<td>.28*</td>
<td>.36**</td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td>.08</td>
<td>.29*</td>
<td>.08</td>
<td>.03</td>
<td>.02</td>
<td>.04</td>
<td>.13</td>
<td>.36**</td>
</tr>
<tr>
<td>Sex Crimes</td>
<td>.14</td>
<td>.25</td>
<td>.05</td>
<td>.17</td>
<td>.01</td>
<td>.37**</td>
<td>.27*</td>
<td>.20</td>
</tr>
<tr>
<td>Sex Education</td>
<td>.23</td>
<td>-.10</td>
<td>-.10</td>
<td>.01</td>
<td>-.06</td>
<td>-.15</td>
<td>-.10</td>
<td>.36**</td>
</tr>
</tbody>
</table>

*NV: no variance in items.
*p < .05; **p < .01; ***p < .001.

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The pattern of correlations (see Table 3) suggests that there are both similarities and differences between the SKATA and Kirby Knowledge sections. The table provides a clear comparison of how various knowledge areas are related, with correlations ranging from .14 to .36. This indicates a moderate level of association between the two sets of knowledge sections, with some areas showing stronger relationships than others. For instance, the correlation between Physical Development and Teen Relations is .14, while that between Sexual Acts and Teen Pregnancy is .06. The strongest correlation is seen between Birth Control and STD, with a value of .36. These correlations suggest that students who have more knowledge in one area are likely to have more knowledge in related areas. The lack of variance in NV indicates that there is no overlap in these sections. This detailed analysis helps educators understand the interconnections between different knowledge areas and tailor their teaching strategies accordingly.
SUMMARY AND DISCUSSION

In conclusion, how individuals deal with the manifold possibilities of sexual health is crucial for their overall well-being. Effective education and intervention programs need to be developed to address the complex issues related to sexual health. The integration of various approaches, including educational programs, health promotion initiatives, and community-based strategies, can help in effectively addressing the challenges associated with sexual health. Continuous monitoring and evaluation of these interventions are essential to ensure their effectiveness and adapt them as necessary. Understanding the diverse needs and perspectives of individuals is crucial in designing comprehensive interventions that promote healthy sexual practices and behaviors.
References


