Original article

Sexual activity of out-of-school youth, and their knowledge and attitude about STDs and HIV/AIDS in Southern Ethiopia

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Abstract: A cross-sectional survey on sexual activity of out-of-school youth (15-24 years), and their knowledge and attitude towards STDs and HIV/AIDS was done in Awassa in June 1995. Most (94.4%) study subjects knew about HIV/AIDS, whereas, a lesser proportion of them knew the common STDs other than HIV/AIDS. Few of them were aware that the two are inter-related, one facilitating the transmission of the other. Forty-nine percent of the respondents (mean age 17$\pm$2 years) claimed to have started sex before the study date. Of these, 27.6% reported condom use during their most recent coitus. Thirty-six percent of the sexually active subjects admitted to have had more than one sex partner during the past 6 months (mean = 2.9$\pm$2). Lack of adequate knowledge, being careless often times, fear that condom will reduce sexual excitement, and pressure from sex partners appeared to be the common reasons for less use of condom during sex. The majority (91.0%) agreed that sex education and family life education for young people should be started early in life; in fact a quarter of them suggested as early as 10-12 years. It was concluded that out-of-school youth are sexually active; a considerable number of the sexually active are not practicing safe sex; and even if they have information about HIV/AIDS and STDs, it was not strong enough to bring about any significant behavioral change. This warrants the need for a continued expansion of Information, Education and Communication (IEC) linked with services to the youth, particularly the out-of-school youth which are at a higher risk. [*Ethiop. J. Health Dev.* 1998;12(1):17-22]

Introduction

Adolescents in most developing countries constitute about a quarter of the population. Demographic health surveys (DHS) in many of these countries have shown that, today, boys and girls experience puberty at younger ages than the previous generations. Most of these changes are attributed to better health and nutrition (7,10,11). As a result, they are involved in early initiation of sexual activity, most of it being unsafe and exposing them to problems such as unwanted pregnancy, abortion and sexually transmitted diseases (2,5,7,10,13). The underlying lack of access to information and services has led to the health, social and economic consequences of adolescent sexuality that most developing countries are facing now (3,6-8,11,13). To site an example, of the total cases reported to the National AIDS Control Programme, up to July 1995, 48.7% were in the age range of 15 to 29 years and those aged 15-19 years constituted 5.06% (8).

In many parts of the world, traditional family and community support is no longer available or has been unable to cope with rapidly changing realities. In the 1960s, development planners in Europe and America started to inform adolescents about rapid population growth and family planning under the name "Family Life Education" (FLE), mostly in school setup. In the 1980s,

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educators began AIDS prevention programmes. Currently, school and community-based clinics for adolescents are beginning to have much influence in most parts of the world (7).

Pocket studies on sexuality, awareness and attitude of adolescents on reproductive health issues in Ethiopia have very much limited themselves to the most confined and accessible adolescents in

school. Intervention attempts directed towards these problems were also emphasizing the school community. Evidences, on the other hand, show that out-of-school youth comprise a majority of youth at large and most of the at risk group as far as sexual activity and its consequence is concerned (6,7,11). This study is thus intended to provide an insight in to the reproductive health problems of out-of-school youth in Awassa town.

Methods

This cross-sectional survey on sexual behaviour of out-of-school youth and their knowledge and attitude about HIV/AIDS and STDs was carried out in Awassa Town in June 1995. Awassa, the capital of the Southern Ethiopia Nations, Nationalities and Peoples' Southern Ethiopia Nations, Nationalities and Peoples' Regional State (SNNPRS) has a population of 66,911 according to a health profile done in 1994 (Solomon M., unpublished data). Adolescents aged 15-24 years were 21,379 (32.4%). Out of school youth according to this survey, are those aged 15-24 years and currently not attending schools during the daytime. Those who have completed their secondary education but have not yet engaged in any formal employment, and school dropouts currently engaged in short-term technical training were some of them. Out of school youth who are engaged in formal commercial sex work were not included in this study.

An estimate of 50% prevalence of sexual activity in this group with a 95% confidence limit, 5% marginal error and a power of 80% gave us a sample size of 384. A list of job-less out-of-school youth was obtained from the Sidama Zone Ministry of Labour and Social Affairs (MOLSA). Another list of girls attending typing and secretarial training and seamstress schools was collected from these centers. Same was done for male youth practising in garages, involved in fishery and those working in metal workshops. The number of individuals to be sampled from the above groups was determined using proportionate-to-population size (PPS). Systematic sampling was employed to get a person for an interview. Interviews took place at home, workplace or training schools, by trained interviewers stratified by gender after obtaining an informed consent. Repeated visits (2-3) were made in cases of unavailability of a person. Lastly, interviewers went to the main centres of the city and systematically sampled youth in the streets using peer guiders. Data were entered, cleaned and analyzed using EPI-Info Version 5 computer package.

Results

A total of 375 subjects were studied; ten people refused to participate, making the response rate to be 97.4%. One hundred ninety (50.7%) were males and the rest, 185 (49.3%), were females. The mean age of the

Table 1: **Socio-demographic characteristics of the study group, Awassa, June 1995**

Variables	Frequency n= 375	Percent
Age (yrs)		
15 -17	72	19.2
18 -20	179	47.7
21 -24	124	33.1
Educational status		
No education	21	5.6
1^0 School*	50	13.3
2^0 School	263	70.1
12^+ grade	41	10.9
Religion		
Orthodox Christian	234	62.4
Protestant Christian	95	25.3
Catholic	23	6.1
Muslim	20	5.3

Others	3	0.8
Ethnicity		
Amhara	126	33.6
Wolayta	59	15.7
Sidama	48	12.8
Oromo	47	12.5
Kembata	28	7.5
Others**	67	17.9
Marital status		
Single	317	84.5
Married	58	15.5

***** - Includes 5 individuals who under -went literacy campaign education for 3 years and completed their education.

****** - Included here are Tigre, Gurage, Hadiya, etc in respective order of occurrence

study subjects was 19.6± 2.4 years. Other socio-demographic characteristics of the study subjects are presented in Tables 1 and 2.

Twenty-one (5.6%) of the study subjects have never heard of HIV/AIDS. Current occupational status did not influence knowledge about HIV/AIDS. The association between age and educational status with knowledge about HIV/AIDS is shown in Table 3. Gender difference did not influence knowledge status about the disease. Three-hundred thirty-two (93.8%) of those who responded to have heard about HIV/AIDS remembered upto three modes of disease transmission. Among these, some had wrong conceptions and speculations about HIV/AIDS transmission, such as kissing, and saliva by 19(5.3%), body contact by 16(4.8%), and air droplets by five(1.5%) people. The three major risk factors perceived to expose a person for HIV infection were sexual promiscuity, taking injections using unsterile needles and frequent sexual contact with commercial sex workers, in that respective order.

Table 2: **Current occupation of the studied out-of-school youth, Awassa, June 1995.**

Type of Occupation	Frequency	Percent
Jobless	188	31.5
Daily labourers	66	17.6
Private Business	58	15.5
Temporary employment in private sector (company)	58	15.5
Student in Technical training school (*)	56	14.9
Fishermen	19	5.1
Total	375	100.00

* - These are youth who are currently attending secretarial and typing schools, wood and metal workshops, and seamstress training, etc.

Nineteen (5.4%) of the study subjects believed that there could be a cure for HIV/AIDS. Fifteen (4.2%) were not sure if there could be any. Of the commonly known sexually transmitted diseases, gonorrhoea was known to 268 (71.5%), syphilis to 161 (69.6%), chancroid to 160 (42.9%) and lymphogranuloma venereum to 73 (19.5%) subjects, respectively.

Fifteen (4.0%) of the respondents gave history of pussy urethral discharge and/or genital lesion following sexual intercourse in the past 6 months. About two-thirds of these visited government or private health facilities. The remaining one third consulted friends/relatives, used left-over drugs, visited traditional healers or did not do anything about it at all.

Table 3: **Influence of age and educational status on knowledge about HIV/AIDS in out-of-school youth, Awassa, June 1995.**

Variables	Know about HIV/AIDS		OR	P-value
	Yes	No		
Age (years)				
15-17	15	6	1.0	
18-20	45	5	3.6	
21-24	294	10	11.76	< 0.0001*
Educational status				
Illiterate	65	7	1.0	
Primary school	168	11	1.64	
Secondary & above	121	3	4.34	< 0.05**

* Chi-square for linear trend = 23.7 **

Chi-square for linear trend = 4.7

One hundred fifty eight (42.1%) of the study subjects did not know any problem associated with repeated sexually transmitted disease infection. Among the perceived complications of STDs by the rest of the study group were, infertility 76 (35%), male urethral stricture 61 (28.1%), exposure to HIV infection 44 (20.2%), congenital anomalies in the newborn 48 (22.1%), and lastly 82 (37.8%) of them mentioned things like chronic cachexia and death. (multiple answers were possible). Hundred eighty five (49.3%) of the respondents admitted to have had sexual intercourse some time in the past (Table not shown). Mean age of starting sex for study subjects was 17 ± 2 years, (16.7 ± 2.3 years for males and 17 ± 1.8 years for females). Eighty four percent of them started sex between the age of 15 and 19 years. Males were more likely to be sexually active compared to their female counterparts (OR = 2.3, 95% CI 1.49-3.56, P<0.0001).

Reported condom use rate during the first sexual intercourse was 13.5%, while it was 27.6% during their most recent one (Table not shown). There was a significant change in the rate of condom use (X^2 (df=1) = 11.2, P<0.0001), even though the time gap is not specified between the first and most recent coitus. Reported condom use rate was significantly higher for males than for females during the recent sexual intercourse (OR=1.98, 95% CI, 0.93-4.27, P<0.05).

Table 4: **Perceived HIV prevention methods (behaviours, practices) by out-of -school youth. Awassa, June 1995.**

Prevention methods	Frequency n = 354	Percent*
Sex with single trusted partner	223	59.5
Use condom during sex with- non-familiar people	191	50.9
Don't share blades, tooth brushes and other body piercing utensils	79	21.0
Avoid sex with prostitutes	61	16.3
Pre-marital sexual abstinence	48	12.8
Use HIV screened blood only	28	7.5
Avoid traditional practices- involving blood contaminations	18	4.8
Do not know	14	3.7

* - Multiple responses possible

General reasons sited for low condom use rate by the youth are whown in table 5, while reactions while reactions towards a partner who refuses condom use during sexual intercourse are in Table 6. There was no significant gender difference in the tendency to negotiate or accept sex proposals without condom. Of those youth who claimed to have started sex, 140 (75.7%) said that they have got a fixed sexual partner. However, 51 (36.4%) of them responded that they have also had sex with

other people in the last six months. The mean number of partners for these individuals during the last 6 months was 2.9±2.

Two-thirds of the study subjects thought that any youth of their age would have enough knowledge about the use and importance of condom. The remaining third were either unaware or could not be sure if youth would have knowledge about condom or not.

Different routes of condom promotion for the youth were suggested. The following were included according to their order of importance: making condoms available in

Table 5: **Reasons for low condom use rate as was perceived by out-of-school youth, Awassa, June 1995.**

Reasons	Frequency	Percent(*)n = 375
Lack of Knowledge about its importance	143	38.1
Carelessness	114	30.4
Fear of reduced sexual pleasure & excitement	109	29.1
Do not know	84	22.4
Pressure from sex partner	41	10.9

***** - Multiple answers possible

shops and bars 185 (49.3%), in pharmacies and health facilities 62 (16.5%), use of Family Guidance Association clinics 25 (6.7%) and use of trained youth condom promoters 17 (4.5%). Sixty-eight (18.1%) of them were not sure of the places/methods that may be appropriate to distribute condoms for the youth. When asked about who should participate in educating the youth about sex and family life, 205 (54.7%) said schools, 241 (64.3%) said health professionals, 34 (9.0%) said peer educators, 33(8.8%) said the community, and few others mentioned families and religious organizations (multiple responses were possible).

Table 6: **Reaction towards partners who refused condom use by sexually active respondents, Awassa, June 1995.**

Type of reaction	Frequency	Percent
Try to negotiate as much as possible	60	32.4
Agree to have sex without condom	38	20.5
Refuse having sex	33	17.8
Difficult to predict what I would do	39	21.2
Others	15	8.1
Total	185	100.00

The optimal age for initiation of Family Life Education to an adolescent was suggested to be 1314 years by 119 (31.7%), 15-16 years by 116 (30.9%) and 10-12 years by 96 (25.6%). The remaining 32 (8.5%) said that it should be given after 17 years and 2 (0.5%) did not even agree with the idea that adolescents should be
educated on sex and family life. Ten (2.7%) did not know the right age when teaching adolescents about sex should begin (Table not shown).

Discussion

Despite its shortcomings on sampling technique and absence of a similar study for comparison, this study has provided an insight in to the reproductive health problems of the out-of-school youth. Most of the study subjects were either school dropouts or have completed secondary education and were waiting for job opportunities. Being a school dropout or jobless would put young people at an increased risk for exposure to early sexual activity and its serious consequences. In fact, there might

be some who could be secretly engaged in commercial sex work as a result of disappointment and financial strain.

HIV/AIDS was known by more than 90% of the respondents. However, when it comes to practice, only few of those who were sexually active did use condom. This commonly found reality (1-3,5,6) indicates that behavioral changes may not soon follow awareness, particularly in this age group. It may be because of the incomplete information received by the youth from different sources. For instance, in the current study, we see that quite a number of youth do not have enough knowledge regarding routes of HIV transmission. Certainly, this may be the reason why the youth (or even others) still continue to practice unsafe sex.

It is interesting to note that the knowledge for HIV/AIDS is greater than the knowledge for STDs. Although our finding is not different from what has been observed by many other investigators, it generally appears that the youth have not understood adequately the interrelationship of HIV/AIDS and STDs, one leading to the other or one facilitating the transmission of the other.

Even though prevalence figures of specific STDs in the community are often lacking or unreliable, STDs ranked 6th among 15 frequently reported diseases from health facilities under the MOH, making 4.7% of all cases of communicable diseases seen (MOH, 1986-87). Another study in adult population reported 2.5% two weeks prevalence of STD symptoms in rural Ethiopia (9). Compared to these figures, the prevalence rate in this study population is fairly high. If this magnitude is coupled with the current practice of STD treatment and its association with HIV, future economic and social implications could be foreseen to be severe.

Engagement in sexual activity in our study group is relatively lower than groups in most studies conducted locally (2-5). Gender difference in being sexually active (ie- 59.4% vs 38.9%) was not as pronounced as it was in some studies (1,2,4). The mean age at first coitus was also relatively later than most of the above study findings. Mean number of sex partners for those who admitted multipartner contacts was comparable to some of them (3,6). In general, although it appears that there are some differences among youth in the country, most of them run more or less equal risk as far as the outcome is concerned.

There is quite a significant variation in the practice of condom use among Ethiopian youth in different places, study groups and study time (1,2,4-6). It indicates the status of health information dissemination in the country, its effect in behaviour modification and, thus, its variation in the risk of acquiring the consequences of adolescent sexuality.

Interestingly, lack of knowledge and fear that condom decreases sexual pleasure and excitement are, like those cited by lots of other investigators, the common reasons cited for less use of condoms. The traditional belief that educating the youth on sex and family life in earlier ages will encourage sexuality was found not to be true in this study. This may be the reason why about a quarter of the study subjects suggested initiation of sex education to be as early as 10 -12 years of eye.

This study has demonstrated that most adolescents are sexually active, and a substantial majority of them are not using condom. Even if information about HIV/AIDS and STDs is made available, it was not strong enough to bring about a significant change in adolescent behaviour. The need for further expansion and strengthening of information and services to adolescents, particularly for the less accessible out-of-school ones, can not be over-emphasised. Government must assume the leadership in coordinating the efforts of many NGOs in the country and in making the family to take part in the multi-faceted effort.

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