BEYOND KNOWLEDGE: PATTERNS OF SEXUALITY AND CORRELATES OF HIGH-RISK BEHAVIOUR AMONG URBAN YOUTH IN ADDIS ABABA, ETHIOPIA

YORDANOS MEQUANINT TIRUNEH

March 2004

DEPARTMENT OF INTERNATIONAL COMMUNITY HEALTH
UNIVERSITY OF OSLO

BEYOND KNOWLEDGE: PATTERNS OF SEXUALITY AND CORRELATES OF HIGH-RISK BEHAVIOUR AMONG URBAN YOUTH IN ADDIS ABABA, ETHIOPIA

YORDANOS MEQUANINT TIRUNEH

THESIS PRESENTED TO THE DEPARTMENT OF INTERNATIONAL COMMUNITY HEALTH, FACULTY OF MEDICINE, UNIVERSITY OF OSLO

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PHILOSOPHY IN INTERNATIONAL COMMUNITY HEALTH

MARCH 2004

OSLO, NORWAY

UNIVERSITY OF OSLO

Beyond Knowledge: Patterns of Sexuality and Correlates of High Risk Behaviour among Urban Youth in Addis Ababa, Ethiopia

By

Yordanos Mequanint Tiruneh

International Community Health

Faculty of Medicine, University of Oslo

Approved by the Examining Board

_____ _____

Chairman, Department

_____ _____

Advisor

_____ _____

Examiner

_____ _____

Examiner

TABLE OF CONTENTS

Page

Acknowledgements

I am deeply indebted to the institutions and people who in their various capacities contribute to the successful completion of this study. I would like to thank the Christian Michelsen Institute (CMI), Norway and the Department of Sociology and Social Anthropology at the Addis Ababa University (AAU), Ethiopia for the financial support offered for this research. I am also grateful for the grant obtained from GLOBINF and Helle's Legat for the successful completion of my study.

I am greatly indebted to my primary advisor Prof. Johanne Sundby, whose dedication and insightful advice has inspired me through out my study. It was a great pleasure to work with her. Special thank you goes to my local advisor Prof. Yemane Berhane, who despite his extremely tight schedule afforded me every available opportunity to benefit from his supervision. I sincerely appreciate his resourceful, unreserved support and exemplary work ethics. My deepest gratitude goes to my advisor Dr. Alula Pankhurst who has always wholeheartedly given me a constructive advice and encouragement.

I thank Lord the creator who has blessed the path I walked. My heart-felt thanks goes to my parents whose tremendous love, encouragement and unwavering support led me to success through out my work. My sincere gratitude goes to my family members, for their constant support and confidence in me.

I owe a special thanks to my dear friends and colleagues, who contributed to this work by giving me feedback and advice in all the phases of my research. I was fortunate in receiving substantial comments and help with training, editing, and references. I appreciate your loyal support and assistance. I wish to recognize the support, which I received from the department of International Community Health at the University of Oslo during my studies. The staff and faculty members were unfailingly supportive.

Last but not least, I owe an enormous debt of gratitude to all of the young people who participated in my study and shared their personal experiences with me. Thanks are also in order for all the incumbents at the different administrative offices in Addis Ababa. Many people helped me to realize the goal of this research; I wish to express my thanks to all of them.

List of Tables

List of Figures

Page

List of Appendices

LIST OF ABBREVIATIONS

AIDS:	Acquired Immune-Deficiency Syndrome.
CSA:	Central Statistics Authority
FGD:	Focus Group Discussion
HIV:	Human Immuno-deficiency Virus
MOH:	Ministry of Health
NAC:	National AIDS Council
NGO:	Non-Governmental Organization
PLWHA:	People Leaving With HIV/AIDS
STI:	Sexually Transmitted Infection
STD:	Sexually Transmitted Disease
UNFPA:	United Nations Population Fund
UNAIDS:	United Nations Program on AIDS
UNICEF:	United Nation Children Fund
WHO:	World Health Organization
AA:	Addis Ababa
OSY:	Out -of -School Youth
ISY:	In- School Youth
CSW:	Commercial Sex Worker
IEC:	Information, Education, and Communication
FHI:	Family Health International
DHS:	Demographic and Health Survey

GLOSSARY

Arada: Refers to a person who is "smart" and has the propensity to experiment things.

Asko, Arat-killo, kassanchis : Names of places in Addis Ababa.

Bewotatinetih tetekemibet : Do what ever you want while still young.

Benkifatim yimotal : People may even die of simple stumbles let alone....

Birr : The Ethiopian currency bill equivalent to almost one eighth of a dollar.

Borko : A slang that refers to a person living on the street.

Duriye : One who is a loiter and is often seen doing culturally unacceptable deeds.

DC sefer : A poor neighborhood, characterized by rows of small shanty houses rented by young girls for the purpose of commercial sex work.

Eski wota bel : Do not just sit here ! Go and explore the world outside the house.

Fa' ra: The opposit of 'Arada', referring to person's backwardness.

Findata : A new community catchword with a negative connotation referring to adolescents and youth with overt behavioral expression befitting their age.

Gibir : A rule of the street subculture demanding taxation of girls for independence from guardianship by male partners acting as husbands. The tax is paid to the host lady (a senior street dweller) who protects the street girl from sexual abuse.

Gondar, Jimma, Bahir Dar, Harar , ***Butajira, Mekele***: Names of cities and towns in Ethiopia.

Khat : A local chewed stimulant herb (fresh leaves of Catha Edulis) with amphetamine like effect containing cathine. It is mostly used in Ethiopia for social purposes, excitement and dismissing fatigue.

Khat bet: A house where *khat* is sold and often is used also for a makeshift *khat* chewing ceremony.

Kebele : The smallest administrative unit in a urban settings of Ethiopia defined by its own borders.

Kifle ketema : Group of *kebeles* under the same administrative office. A *kifle ketema* may include 17-25 kebeles.

Kissana : A slang that refers to a ceremony of kissing competition by youth at special parties.

Mekdim-Ethiopia : A local NGO working with People Living With HIV/ AIDS (PLWHA).

Mesberia: This refers to a ritual of drinking alcohol following *khat* chewing ceremony with the intention of breaking the effect of *khat*.

Shisha : Is fresh tobacco leaves mixed with fruit shavings and flavored molasses, specially blended for use with a hookah (social smoke). It is inhaled in an oriental tobacco pipe with a long flexible tube connected to a cold water container.

Shisha bet : A place/house where *shisha* is served.

Tella bet: An Amharic word for Ale house. It is a place where a local drink called *Tella* (a kind of local beer with alcohol content comparable to an average factory beer or even more) is sold.

Video bet: A house where video shows, both normal and adult movies are featured without sensor regardless of age and sex.

Wonda-wond : Male like woman, one whose attitude and deeds is expected of a man.

Yager lij: A person from the same locality of birth as another.

Yebet lijoch : This refers to properly brought up children with strict observation to the local norm and culture.

ABSTRACT

A community based cross-sectional study inquiring into determinants and correlates of sexual risk taking was conducted from June to December 2003. The objective of the study was describing sexual behavior and assessing socio-economic and cultural correlates of high-risk sexual behavior among urban youth in Addis Ababa. A multi-systemic perspective, an approach that focuses on the reciprocal relations among the personal, family, and extra family systems on sexual behavior was employed. Data were collected using anonymous questionnaire based interview, seven focus group discussions and four case studies of PLWHA.

A total of 925 youth aged 15 to 24 from inner and outer Addis Ababa participated in the survey. Females make 53.3% and mean age was 18.8 years. Over 60% of the respondents were in school and one third was employed in the labor force. Nearly a third (28.1%) were sexually active, 66.2% of them being males. Close to half (46.5%) of the sexually active youth had history of multiple sexual partners and 2.3% had history of STD. Condom usage at debut was 36.5% with 30.8% regular usage rate. One fifth (20.3%) of the sexually active males admitted having had sex with CSWs and same proportion of girls had been pregnant. Out of 12 HIV knowledge related questions, almost 75% scored 10-12 (adequate knowledge). Only 5.3% perceive personal risk and 3.8% were found to have favorable self-protective attitude.

From the self system, being a male, age 20-24, taking part in the labor force, watching pornography, alcohol consumption, *khat* use and having taken the HIV test kept on having statistically significant association with potential sexual risk-taking behavior. Youth with strong parental monitoring and who discuss sexual matter with parents demonstrated less indulgence in sexual activity. Living in the inner city, and having sexually active friends and involvement with delinquent peers were correlates of sexual risk taking with in the extra-familial system. The FGDs and the cases also confirmed the survey findings and further revealed that socially disadvantaged youth such as CSWs and street youth were more at risk than others whereby the influence of familial and extra familial systems predominate.

CONCLUSION: Many young people are engaged in sexual behavior that is considerably risky for HIV/AIDS. There is neither a single explanation for sexual risk taking among youth nor is there a single intervention to curb the problem of HIV/AIDS. There is a need to consider the entirety of personal, familial and extra familial factors as co-determinants of high-risk sexual behavior.

I.Background

On its third decade of the epidemics, HIV/AIDS is still imposing an irrefutable threat to contemporary world. The swift spread of the disease makes its impact much more pronounced. According to the UNAIDS estimate, 40 million people were living with HIV/AIDS by the end of 2003; the figure rose by 7 million in five years. There were 5 million new infections and 3 million deaths globally in the same year. More than half of those newly infected cases are between 15 to 24 years old (1-3, 24).

The peril of HIV epidemic is worse in developing countries, where other socio-economic predicaments are coupled with the pandemic. Since the advent of HIV in the early 80s, Sub-Saharan Africa remains the hardest hit region; currently sheltering 28.2 million people, nearly 70 % of the world's population living with the virus. Ten million of these are young people between the age of 15 and 24. Young girls aged 15 to 24 are especially vulnerable to HIV infection. In 2002, an estimated 6–11% of young women aged 15–24 were living with HIV/AIDS in sub Saharan Africa, compared to 3–6% of young men in the same age group. This makes young people an essential focus group of any HIV prevention endeavor (1, 4).

Ethiopia is one of the worst- affected countries in Sub Sahara having the third largest HIV-positive population in the world (3) and 90% of the AIDS cases are due to heterosexual transmission (23). Currently, an estimated 6.6% of the adult population (over 2.2 million) lives with the virus. Around 91 percent of HIV infections occur among economically functional adults between 15 and 49 years. Although the prevalence of HIV is highest among people within the age range of 20-49 years, current trends as measured by HIV annual incidence reveal that the number of new infections is highest among youth aged 15 to 24. As with other sub Saharan African Countries, adolescent girls between 15 and 19 years are infected at a

higher rate than males in the same age group. It is projected that the cumulative number of deaths from AIDS will increase to between 4 and 7 million over the next 12 years, with 260,000 new cases each year. Apart from its economic impact, social and psychological consequences of the epidemic are somber for poor countries like Ethiopia aggravating the levels of poverty (3, 5).

The HIV prevalence rate in Ethiopia is higher in urban areas (13.7%) while the rate for rural areas remains as low as 3.7% (5). In Addis Ababa (the study area for this research) HIV prevalence is about 15.6 percent; an estimated one out of every 6 adults is infected (5). Although a decline in HIV prevalence from 24.2% in 1995 to 15.1% in 2001 has been detected among young inner-city women aged 15–24 attending antenatal clinics in Addis Ababa, we cannot take a decreasing trend for granted as similar trends were not evident in outlying areas of the city and there is no evidence of them occurring elsewhere in the country (3).

The speedy progression of the HIV/AIDS pandemic has challenged Ethiopia's severely constrained health sector by increasing the workload of already overburdened health personnel and further congesting health facilities. AIDS patients occupy nearly half of the available hospital beds in Ethiopia (7). Treating opportunistic infections requires expensive drugs and supplies over long periods of chronic illness, further draining resources from individuals, families and the health systems (5). In view of all these adverse effects of the HIV/ AIDS pandemic, irreversible and unsought alteration and damage would be inevitable if left without intervention.

Since the advent of the first sero-positive case in 1984 and the first AIDS cases in 1986, the spread of the disease has been increasing progressively. In response to the identification of the

disease, a National Task Force for AIDS was established in 1985 and an office for the coordination of AIDS intervention activities was recognized in 1987 under the Ministry of Health. A surveillance system on AIDS was launched in 1989 and a collaborative effort of government and NGOs was initiated on the basis of the motto of Fighting AIDS Together as of 1990 (23). Furthermore, Ethiopia adopted a comprehensive HIV/AIDS policy in 1998 to emphasize prevention, care and support, and target vulnerable groups. The National AIDS Council was also established in April 2000, which includes nongovernmental organizations (NGOs), government, and religious bodies (5).

In spite of the concerted efforts to combat the HIV/AIDS pandemic, satisfactory results are not seen in decreasing HIV prevalence so far. Unsafe sexual behavior is rampant and so is the number of people dying from the disease. All the same, the fact that there is no cure or effective vaccine for HIV/AIDS so far made prevention pivotal and the lone option at hand. As sexual routes are responsible for the dominant share of the infection in the country under study, understanding sexual behavior and its determinants is crucial to come up with effective intervention of the HIV pandemic in the contemporary world (5).

Different theories of behavior have been employed to understand how HIV risk is related to sexual behaviors. Nevertheless, inherent to most of the studies is the attempt to find a single explanation for the phenomena under study and emphasis on personal and interpersonal factors. A number of factors are responsible for shaping trends of sexuality. It is imperative to examine the various factors and their relationships in order to obtain an accurate and comprehensive understanding of sexual behavior. Thus, due emphasis should be given to realize how factors from multiple systems interrelate and link with one another in shaping sexual behavior (9).

This research, therefore, focused both on factors internal as well as external to the individual that negatively affect safe sexual practices at three different systems namely the self, the family and the extra familial. This is a multi system perspective, an approach guided by Ecological systems theory that focuses on the reciprocal relations among multiple systems of influence on personal behavior (9). The role of individual knowledge about HIV/AIDS, risk perception, family structure, neighborhood, peer groups, socioeconomic status, social norms, visions about the future, and the physical environment in shaping sexual behavior of young people were investigated. It shows the synergism among the potential correlates of sexual behavior.

The fact that young people are primal sufferers of the HIV pandemic; and the fact that they are the resources of the next generation, has called global attention and focus on youth health (10, 11). A slight change on sexual behavior of young people significantly alters the loss from the epidemic. Eventually, sexual health of young people has become a priority public health issue and researchers have lately showed interest in adolescent sexual behavior and risk prevention (13). Nevertheless, not much literature is available on young peoples' sexuality in Ethiopia to date. Youth below the age of 24 being a high priority group for HIV/AIDS intervention, this study tried to fill the knowledge gap on sexual behavior among young people in urban Ethiopia.

Addis Ababa, the study area of this research, has a high prevalence of HIV, shelters people from heterogeneous backgrounds with prominent socioeconomic differences, and is home to all kinds of evil that come with urbanization. The study has assessed if high poverty urban neighborhoods are especially vulnerable to the adverse effects of risky sexual behavior (14, 15).

II. Literature Review

2.1 Young People

Contemporary world has encountered a remarkable increase in the number of young people. About 1.5 billion young people are living in the world today, of which 85% live in developing countries. In Ethiopia, over 33% of the total population falls with in this age range. As per the convention passed by WHO, UNFPA and UNICEF, the term young people refers to those between the ages of 10 - 24. This group is further categorized as adolescents and youth to refer to people in the age group of 10 -19 and 15 - 24 respectively (18). In Ethiopia the proportion of young people who are in their teens exceeds that of the youth in their twenties (19). The transition from childhood to adulthood is infused by risky behaviors that endanger adolescent health in general. The youth is negatively affected by the outcomes of these risky behavioral patterns (20).

2.2 Magnitude of HIV/AIDS on Young People

The declining age at puberty and entry to institutionalized unions in later ages presents young people with a relatively longer period of possible sexual practice without marital ties. Eventually, they suffer from the unwanted consequences of by and large their reckless practices (9). Sexually Transmitted Infections are major public health threat now worsened by the advent of AIDS (21). The diffusive effect of risk taking behavior, the latter a harbinger of STIs and HIV/AIDS especially among those living in high poverty urban situations is well-evidenced (23,72).

The magnitude of HIV is highly pronounced among the youth in Ethiopia, which is mostly attributed to their sexual behavior aggravated by peer pressure, low sense of vulnerability, and

propensity to risk taking (23). The extreme level of poverty in the country has aggravated the reproductive health problems faced by its young people. Eventually they are the hardest hit group of the HIV pandemic in the country (19).

At present, nearly 12 million young people between the ages of 15 and 24 are living with HIV/AIDS globally and close to 6,000 new infections occur in the same age group everyday. In Sub Saharan Africa, where the epidemic remains severe, women between 15 –24 years of age are 2.5 times more likely to be infected by HIV than men. In Ethiopia, the estimated HIV prevalence among youth in 1999 was on average 11.9 and 7.5 for females and males respectively (24).

2.3 Youth Sexuality

Young people face many significant life challenges during adolescence as they pass on to their adult roles. Sexual initiation is one of the experiences during this period. The changing patterns of adolescent sexual behavior fells a prey to the plethora of youth living in unstructured and impoverished living conditions mostly in developing countries, the communication explosion across cultural boundaries and the increase in travel, tourism and migration. There are models, pressures and opportunities for sexual contact. Nuclear families, single-parent families, and no families are replacing the extended multigenerational families of traditional societies. The foregone traditional patterns of marriage are contrasted with the evolving western youth with unparalleled freedom to make decisions. The pressures of early premarital intercourse are reflected in unwanted pregnancies, abortions, sexually transmitted diseases, and HIV/AIDS (53).

People embark on their sexual lives at their teens. Fifty percent of the adolescents in South Africa are sexually active by the age of 16 (8). Eighteen percent of the boys and 15% of the

girls of 14- year- olds in Scotland and 12.1% of males and 3% of females of 12 year-olds in the USA reported sexual activity (13, 71). Self reported sexual activity rose to 54% (75% of boys and 40% of girls) of high school students in Dar-es Salaam, Tanzania (27). Many studies conducted in Ethiopia revealed that significant amount of young people are engaged in early sexual practices. Sexually experienced adolescents in North Gondar were about 44% in urban areas and 42% among the rural counterparts (28).

The proportion of sexually active males tends to be higher than those of the female adolescents in many studies conducted. A study done in Harar, a traditional Muslim population dominated Eastern Ethiopian town, showed that half of the men in the age group of 14-29 were sexually active as compared to one fifth of their female compatriots (29). Likewise, a study among high school students in the same town (Harar) revealed that 20% of females and 65% of the males have experienced sexual intercourse (30). On the contrary, a Demographic and Health Survey (DHS) survey in Ethiopia was analyzed and the report revealed that young women between the age range of 15 and 24 have more sexual engagement than their male counterpart (19). In the same line, a recently conducted study in Ethiopia came up with higher level of sexually active females than males; 56.5%: 23.2% (28).

Age at first sexual practice varies with sex and place of residence. The median age of sexual debut for women between 25 and 49 years of age in Ethiopia is 15 while the median age of debut for men between 25 and 59 years of age is 20.3 (19). The mean ages at debut were reported to be 16.1 and 15 for urban males and females in North Gondor respectively (28).

High-risk sexual behavior is characterized by different combination of behaviors, which include being sexually active as opposed to abstinence, multi-partner sexual contact (concurrent or serial monogamy), practice of unprotected sex (non-use or inconsistent use of

condom), and history of STI. Some studies have considered the use of mood-altering substances such as alcohol and drugs, history of coercive sex (rape) and having casual partner. But not all these indicators were used with equal emphasis. A DHS in Tanzania revealed that 29% of the men and 8% of the women were found to have high-risk sexual behavior as measured by non-regular and multiple sexual partners. The same study revealed that women with increased education and those who perceived increased risk of HIV were having high-risk sexual behavior (25). Being a female, age group of 20 – 24 years and being out of school significantly increased the likelihood of belonging to the most vulnerable category of the high-risk group (51). In the same manner being out of school, male, age 20 – 24years, alcohol use and *khat* chewing predicted the likelihood of engagement in sexual intercourse in Ethiopia. The same study depicted that a third of the youth had sexual experience and of these only 50% used condoms (52).

A community-based study on youth in Ghana showed that about 65% of the sexually active males had used condom at least once in their sexual lives while only 25 % reported condom use at the last intercourse (31). A DHS in Tanzania depicted that only 4% of the women and 15% of the men used condom at their last practice and surprisingly a positive statistical association between condom use and high-risk sexual behavior was observed (25). Occasional condom use was reported by 36% of the sexually active adolescents in North Gondor of Ethiopia (28).

Several high-risk sexual behaviors were found to be prevalent in Jimma Town, southwestern Ethiopia; 47% reported having sex with prostitutes (32). In North Gondor, history of sexually transmitted diseases was reported by 7.8% and 41.2% of the female adolescents have been

pregnant. Induced abortion was reported by 17.1% (28). Among high school students in Harar, 20% had been pregnant and 75% of the latter had induced abortion (30).

2.4 Correlates of High Risk Sexual Behavior

Common global understanding has been reached on preventive strategies to minimize the spread of HIV/AIDS through the understanding of the responsible factors since there is no cure or vaccine for HIV/AIDS (23). A growing body of evidence points to the complexity of sexual behaviour. Risky sexual behaviour is influenced by factors at three levels: with in the person, with in the proximal context (interpersonal relationships and physical and organizational environment) and with in the distal context (cultural and structural factors) (8). For the most part health researches on young people tend to be limited to descriptive, cross sectional studies focusing on KAP and condom use (18). In Ethiopia, different literatures have tried to address various factors that are directly or indirectly correlated to high-risk sexual behaviour and the risks of HIV/AIDS. Many of them have identified biological, social and behavioural factors independently (23). Oftentimes, the available literatures on Ethiopia are done on easily accessible target groups/youth such as high school or college students. KAP studies predominate all other types of studies. Most studies focused more on specific sexual practices and patterns such as age at first coitus, frequency, number of partner, knowledge of HIV transmission, issues of vulnerability, and condom use (18, 23, 32, 36 -38). These are however more useful to describe the gravity of the problem than for intervention purposes. Factors influencing sexual behaviour are addressed individually as if they are not interacting and influencing with another factors in the social environment. Social and cultural conditions of risk taking beyond the individual and the socially and culturally conceptualised picture of sexuality are not given much emphasis. How ever, lately some transfer in interest is being seen. (8, 9)

2.4.1 Knowledge and Beliefs

Studies show that awareness about HIV, its transmission, prevention, nature of the disease and similar knowledge is existent in many of the studies especially those who covered urban areas (28,33). However, correct knowledge of the virus and its modes of transmission were limited to 44% of the boys and 41% of the girls. More boys (82%) than girls (37%) know about sexually transmitted infection and 20% had first hand personal history of STI among the sexually active (34). Knowledge scores were compared between urban and rural areas from Gondar; Ethiopia, which revealed that more than 90% of the adolescents are aware of HIV/AIDS (28). In a near by locality in rural Gondor, 74.2% confessed having heard about HIV but at the same time 89.9% did not know any thing about condom (38).

Knowledge about prevention options was found to be misty by some studies. Serious misconceptions and mythical disadvantages on condom use were also reported. The level of accuracy of AIDS knowledge however did not predict the likelihood of recent condom use (35). There is no consensus between accurate knowledge of sexuality and risky practice either. Some say that they are not associated while others say that more accurate knowledge is associated with safe sexual behavior. Yet, others say that knowledge alone does not relate to behavioral change. Case in point is a study among junior college students in Gondar, Ethiopia; which concluded that there is no association between AIDS knowledge and condom use (36). A similar study done among out of school youth in Bahir Dar failed to show any significant association between knowledge scores with attitude and practice scores (37). Some researchers say that there is a mediating variable in the translation of knowledge to practice. An investigation in to the knowledge, self-efficacy and behavioral intent towards AIDS prevention behaviors among culturally diverse secondary school pupils in South Africa asserted the

existence of adequate level of knowledge about HIV, with considerable inaccuracy about its means of transmission. They felt most self-efficacious regarding how to protect themselves from being infected and least self-efficacious on knowing where to go for information on HIV/AIDS. Culturally diverse knowledge, self-efficacy and behavioral intent towards AIDS prevention was found among white, black and Asian pupils (56).

2.4.2 Perception of Personal Risk

In most of the studies, personal risk perception is amazingly low. People believe that HIV exists and that people of their age are at risk but they do not at the same time accept that they are personally at risk. A study that assessed risk perception disclosed that only 6% of the urban adolescents in North Gondor are aware of their engagement in high-risk sexual practices (28). Another study among the rural Dembia, near Gondor revealed that 60% of the study subjects were wary/ afraid of HIV (38).

The Social Cognitive Learning Theory and the Health Belief Model propose the importance of perception about seriousness, perception about one's risk and perceived ability to reduce risk as key determinants of sexual behavior. But controversial ideas exist on the relation between perceived vulnerability and sexual risk taking. Some say that there is a direct relation while others say that they are inversely related and yet another group claims that they have no association. It is also difficult to know the direction of association between the two variables. "Is it indulgence in high risk behavior that increases perception or is it people who are engaged in risky behavior do so because they do not perceive risk?"(8). A study which questioned whether the HIV epidemic has changed the sexual behavior of high risk groups like prostitutes, long distance truck drivers, bar maids, and street children concluded that little if at all has changed in the way of the sexual behavior of these groups in Uganda (39).

2.4.3 Psychological /Psychosocial Factors

Different theories of behavior are used to predict sexual risk taking. Some of the major theories include Theories of Reasoned Action (TRA), Social Cognitive Theory (SCT), and the Health Belief Model (HBM). TRA holds the idea that individual's behavior is determined by one's intention to engage in a certain behavior whereby intentions are predicted by attitudes and norms of the society. According to the Social Cognitive Theory, however, the interaction between personal and environmental factors determines behavior. On the other hand, the HBM claims that health-related behavior is based on the belief one has about the behavior and its consequences (40).

Intention to use preventive methods was related to high use of the prevention method such as condom. In the theories of planned behavior and theory of reasoned action intention is claimed to affect behavior. Positive attitude to risk reduction strategies are associated with their use. An inquiry in to the risk and protective factors of youth behavior made in Zambia, showed that among many, only school attendance and knowledge of AIDS were found to be associated with both lower levels of sexual activity and consistent condom use (41).

2.4.4 Substance Use and Deviance/Delinquency

According to the problem behavior theory, high risk sexual behavior co-occurs with other deviant behaviors such as substance use and delinquency (fighting, school suspense, expulsion, drug and alcohol use) (9). Though reliable data on the rate and amount of alcohol consumption is not readily available, alcohol is identified as one of the major factors for HIV infection in Ethiopia (23). A case control study conducted in Addis Ababa revealed that alcohol consumption was associated with high serum HIV positivity (42). A study conducted in Hong

Kong on adolescents also showed that cigarette smoking was significantly correlated with sexual activity (43).

The wide use of *Khat* in Ethiopia is often related to high-risk sexual behavior. *Khat* was found to be prevalent in as much as 31.7% of the population with more Muslims than Christians, more men than women and in the age group of 15 to 34 years. *Khat* was found to have a significant effect on family functioning, however it showed no significant correlation with social functioning and economic well being. The effects of *khat* were found to be significantly pronounced on under nutrition, injuries and mental disorders (44). Sexual initiation combined with drug usage was found to be indicative of high- risk sexual behavior than sexual activity alone as a study made among urban low income African-Americans concluded (44). Substance use is directly related with peer and family member use of such substances. Individual protective factors from substance use are mediated by family and school connectedness (60).

2.4.5 Peer Influence

In adolescence, the most influential point of reference is the social environment and more specifically peers. Adolescents whose peers are sexually active are likely to be active too and protected sex was correlated to partner's positive attitude towards it. Affiliation with deviant peer group is an easy way to sexual risk (9). A study examining the effect of peer influence among 13 to 15 year old adolescents in the US showed that adolescents who were less likely to believe that their friends favored intercourse and who held more favorable attitudes about the personal benefits of abstaining from sex were less likely to have initiated sexual intercourse (61). Peer influence extends and has far reaching implications in both sexual as well as non-sexual behavioral patterns. The youth were found to engage in a wide range of folk practices and do-it-yourself procedures to maintain personal hygiene, prevention and treatment of STDs

as well as prevention and termination of pregnancy. These practices are learnt from and passed on through peers. The learnt practices are considered more confidential and even preferred to the reproductive health services provided by health institutions (62).

2.4.6 Inter-personal Communication Skills

People opt for risky behavior when they cannot communicate with their partners. Many of the studies show that introducing condom is perceived to break intimacy in relationships. Once they have started not having condom, introduction in the middle of their relationship questions loyalty (8). Among the sexually active, those who expressed confidence in putting on a condom, and in being able to refuse sex with a sexual partner, and who expressed more favorable outcome expectancies associated with using a condom were more likely to use condom consistently (61). A study in condom use among commercial sex workers in Nigeria showed that 69.5% of the women would refuse sex without condom, 16.6% would do nothing and have sex without condom whilst 4.4% would charge extra money for sex without condom (46). A qualitative study on the pre-marital sexual behavior of out of school adolescents in Tanzania presented the differential perception of the genders on the basis of sexual relations. Males think that females engage in sex largely for material gain, which the females perceive as expressions of a partner's love or commitment. This disparity calls for interventions in order to empower sexual negotiation skills among adolescents and address the issue of gender in expectations and interpretations of sexual relationships (63).

2.4.7 Family Situation

Familial influence on sexual behavior could be seen from two categories; family structure and family process. Family structure refers to parental education, single parenting, living with a biological parent and SES of family which are often related to risky sexual behaviors.

Especially in urban poor areas, poor SES coupled with poor academic performance is associated with indulgence in unsafe sex (9).A study conducted among secondary school students in Nigeria discovered that, of the 34% of sexually active students, 42% came from a polygamous family in comparison to 28% from monogamous family. The same study found out that such variables as male sex, older age, lower sense of connectedness with parents, having a dead parent, family polygamy, lower sense of connectedness with school and lower educational level of parents were independently connected (54). A study conducted among US adolescents inquiring a possible association between sexual behavior versus socioeconomic status, family structure and race / ethnicity concluded that the differences in adolescent sexual behavior by race and SES were not large enough to fully explain differences in rates of pregnancy and STD infection. This suggests that other factors, including access to health services and community prevalence of STDs, may be important mediating variables between SES and STD transmission (55).

With regard to family process, socialization and monitoring play a pivotal role in shaping sexual behaviour. Both supervision and non-supervision by parents could lead to risky sexual behaviour. Parent-adolescent relationship and communication are found to be considerable determinants of high-risk sexual behaviour. An open communication on difficult issues facilitates self-respect and control. Parental support indirectly increases safe sex. Parental norms and deeds are also vital in shaping the behaviour of the youth (8). Discussion about sexual issues is a taboo in most of the Ethiopian society (23). A study of parental characteristics and adolescent sexual behaviour in Nigeria showed that adolescents with whom parents had discussed family life issues were less likely to be sexually active than those with whom parents had never discussed such issues (47).

The influence of parental monitoring, and effect of negotiated unsupervised time allowances and parental trust study in Cleveland, US showed that for both sexes increased negotiated unsupervised time was strongly associated with increased risky behavioural development along with substance use but also with sex-related protective actions. In males, high degree of parental monitoring was associated with less alcohol use and consistent condom use while it had no effect on female behaviour. Perceived parental trust served as a protective factor against sexual activity, tobacco, and marijuana use in females, and alcohol use in males (64). Street life is devoid of parental either structure or process. The absence of family nurture exposes the street youth to high-risk sexual behaviour (48).

2.4.8 Neighborhood Situations

Neighborhood or community affects sexual behavior. There is a strong hunch that in urban slums where future opportunities are low, insufficient monitoring of adolescent behavior, socio-economic disadvantages (low SES of the neighborhood) and instability (where by parents are not in a position to fulfill the needs of their children or at times benefit from their children's activities) are homes for high risk sexual practices. The problem of housing in Urban Ethiopia is assumed to be responsible for delayed age at marriage in spite of early biological maturation (23).

Young people living on the street are lately distinguished as a group at high risk for HIV infection. Street children become sexually active at an earlier age, are exposed to have multiple partner and sexual coercion, less protective of themselves and cut off from sources of information due to their social disadvantage. HIV prevalence was found to be 10 to 25 times higher than other youth groups in South Africa. Rape, prostitution, sexual bartering and exchanges, and casual sex are common in the street life. Fear of HIV infection, in spite of their passable knowledge about the

disease, seems to be the least of their worries as they are occupied by their day to day survival concerns of food, money and clothing as exposed by one study in South Africa (48). Not much has been done on these issues in Ethiopia.

2.4.9 Lack of Access to Services

In many developing countries, reproductive services that teach skill of safe sexual life for adolescents are either scarce or unfriendly to youth. Access to free condom is also limited (clinic staff attitude or out of stock). A study in family planning practices in Butajira, Ethiopia showed that the reasons for not using protections among many was embarrassment to buy, lack of knowledge, partner refusal and diminished pleasure. Lack of access to knowledge and effective services is also evident (49).

Sex is seen as leisure time activity for adolescents who are unemployed and have nowhere else to go. Social services being unavailable or unaffordable for many of the people who are by and large poor, people resort to local bars and Hotels during their leisure time (23).

2.4.10 Socio-cultural Factors

A cross sectional comparative study conducted on out-of-school and rural adolescents in Ethiopia revealed that cultural environment influences sexual behavior and showed that adolescents engage in high-risk sexual behavior in spite of their knowledge about the risks of unsafe sex (28). Most African countries are patriarchal and often oppress women. This culturally approved gender inequity in many African countries increases the risk of HIV. The sexual norm in most Ethiopian culture justifies the upper hand of men in deciding sexual issues and often, sexual negotiation is not the case. Having multiple sexual partners is one of the ways to express masculinity in Ethiopian societies (23). A cultural belief that says sexual desire should not be suppressed, a social norm endorsing men's right for sexual relation with in

romance, if needed by force and women's subordinate position in society, a social norm which supports violence and coercion as signs of passion in relationships are responsible for indulgence in unsafe sexual behavior (8). Gender role differentiation and imbalance in exercising sexual rights lead to coercion and sexual violence-often associated with low SES of women. Sexual coercion is expressed by adolescents in Ibadan, Nigeria to include verbal threats, unwanted touch, unwanted kiss, assault, deception, drugging, attempted rape and rape. The reported rate of such coercions was 55%; the commonest being unwanted touches and kisses (50). Socio cultural factors influencing the sexual attitude of adolescents were studied between two communities in Ghana. The focus group discussions held pointed to some of the ways adolescents recognize sex role disparities in their own socialization and that of other young people. The two communities reflect two lineage types, one patrilineal and the other matrilineal. With few exceptions patriarchal attitudes essentially prevail across age sex and lineage types (65).

Beyond the individual, socio cultural factors studied under a situation of communal displacement and adjustment in a new country was found to have its effect on risky sexual behavior. This was demonstrated in a study among the Jewish immigrants of Ethiopian and former Soviet Union in Israel. Migration with its entailed structural macro factors like low socio-economic status and limited power in the new society; intermediate structural factors like limited social capital and bi-directional interaction of cultural norms; and the individual level factors of stressors unique to the migration context, depleted psychosocial resources, loss of cultural beliefs and low use of health facilities all were found to interrelate and affect risky sexual behavioral development and transmission of HIV/AIDS (66).

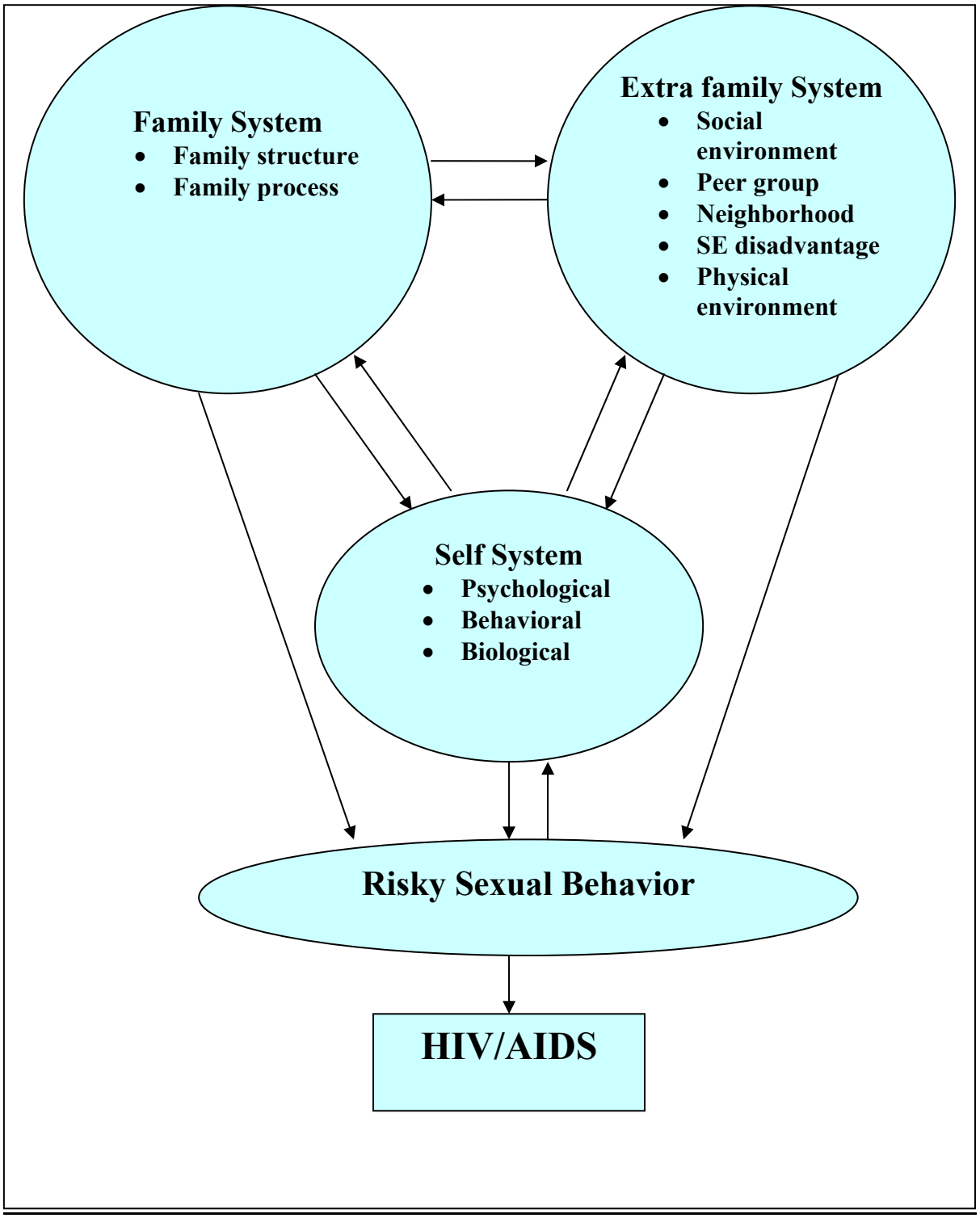
2.4.11 Poverty

Unemployment, hopelessness, indifference, overcrowding, and low educational levels are associated with high risk of exposure to HIV/AIDS among the youth. Commodification of sex (prostitution/sugar daddies) for financial reasons exposes young people to untoward reproductive ill health. Further, girls from low socioeconomic status are more exposed to rape and abuse and eventually are exposed to HIV/AIDS (8, 23). Poverty along with other factors resulted in unequal distribution of sexual power.

In developing countries, extreme poverty in rural areas gave rise to overburdened urban environment due to rural-urban migration. Different group of youth, who are dislocated from their communities and their families, tend to live on the street of inner cities (48). Homelessness exposes many adolescents to high-risk sexual behavior. The ever-accelerating number of street children in urban areas of Ethiopia (especially Addis Ababa) is another major social problem, which aggravates the dissemination of HIV (19). Adolescents living in high poverty inner city neighborhood were found to react to their uncertain future by abandoning hope, leading them to engage in high level of risky behavior. Nearly 50% of the males and 25% of the females had moderate to severe feelings of hopelessness (67).

We can further categorize factors related to high-risk sexual behavior as immediate factors, and distal factors on the basis of their direct influence on behavior and possibility to address them easily. The factors seem to be interwoven and interrelated that we cannot keep them as such separate. They affect one another and the synergistic effect (the interaction between the factors) better displays correlates of high-risk sexual behavior (8).

Figure 1: Conceptual Framework[1]



[1] Adopted from the multi-systems model (9).

III. Objectives of the Study

General Objective

The general objective of this study is to describe sexuality patterns and assess socio-economic and cultural correlates of high-risk sexual behavior among urban youth in Addis Ababa.

Specific Objectives

- To describe sexual behaviors of young people in Addis Ababa.
- To identify the knowledge attitude and practice gap towards HIV/AIDS among young adults in Addis Ababa.
- To determine differences in risk perception of young adults towards HIV/AIDS by selected factors.
- To identify socio- economic and cultural correlates that affect youth sexual behavior in an urban setting at the individual, familial and extra familial levels.

IV. Research Methodology

4.1 Study Design

A community based cross sectional survey was conducted where a house-to-house interview was carried out. Case studies and focus group discussions (FGDs) were used to collect qualitative data with four individuals and seven different groups respectively.

4.2 Study Area

This study was conducted in the capital city of Ethiopia, Addis Ababa, which is divided into ten sub cities called *kifle ketemas*. According to the 1994 Housing and Population survey, the total population in the city is estimated to be 2,112,737 with a sex ratio of 1 male to 1.06 female. About 29% of the population is in the age group 15-24 while females account for around 56% of those in the mentioned age group (17).

The area is selected:

1. For its peculiar urban characteristic influenced by western civilization and globalization. It is a city with all vices of poverty and remnants of traditional cultural practices with flourishing cultural importation and diffusion especially among the youth who have less cultural investment and superficial ties with the accepted traditional practices.
2. Addis Ababa accommodates people with different cultural backgrounds, norms, and values with a considerable diversity of socio-economic statuses.

4.3 Study Population

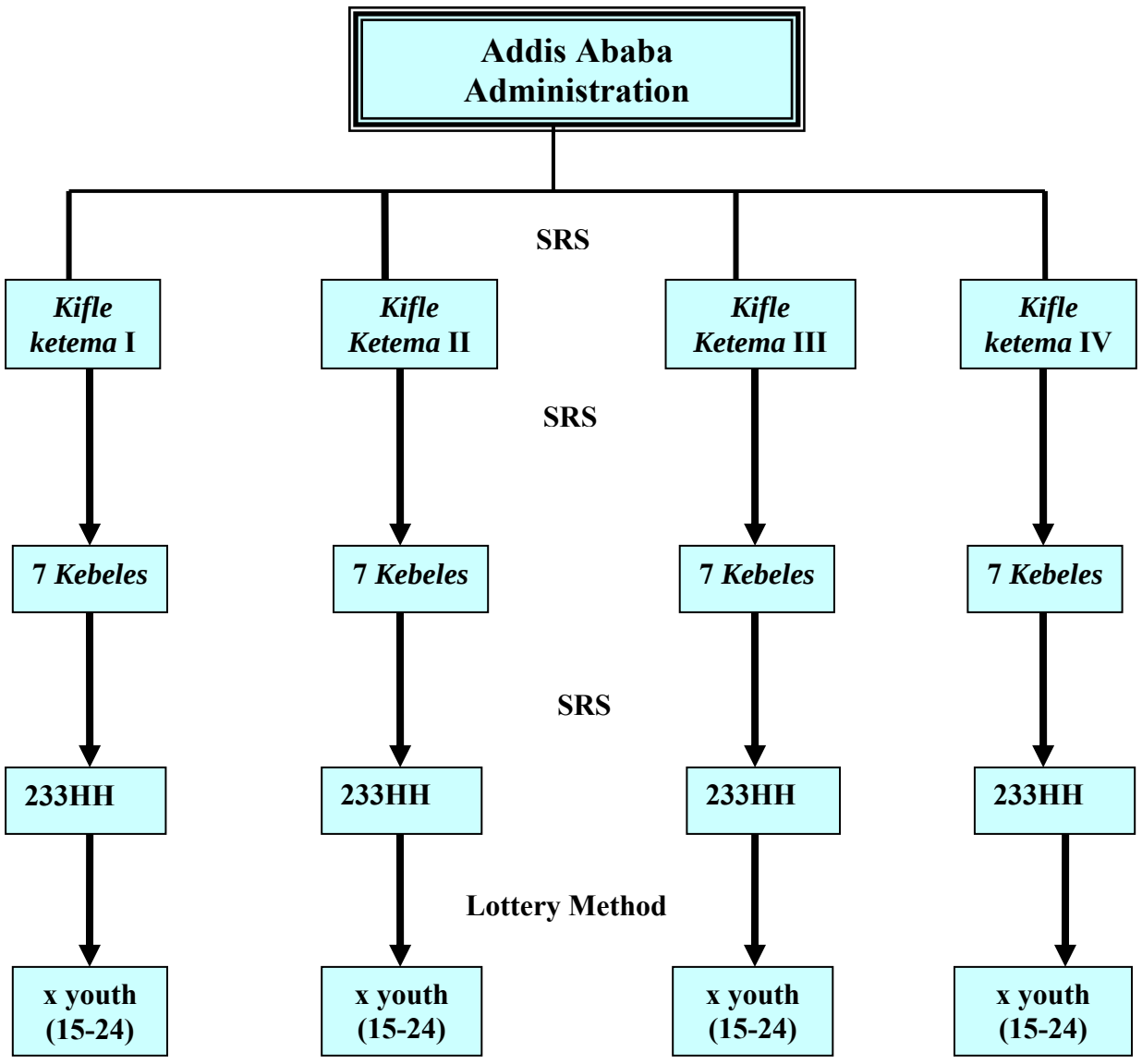
The source population was young people with in the age group of 15-24 in Addis Ababa, both school going and out-of-school. All youth residing in the selected lowest administrative unit in the country called *kebele* at the time of the survey were the target population for the study.

4.4 Sample Size Determination

Sample size was calculated using Epi Info version 6.04 statistical package with the following assumptions: 40% expected prevalence of sexuality (estimated proportion of sexually active youth, based on previous studies) among young people, 95% confidence level, desired precision level of 5%, and a design effect of 2.5. Accordingly, the required sample size was 922.

A total of seven groups (two from street youth, one from HIV positive youth, one from female commercial sex workers, and three from in-school and out-of-school youth), each group having six to eight members were recruited for the Focus Group Discussions. Four HIV positive cases were purposefully chosen and interviewed.

Figure 2: Schematic Presentation of the Procedure Used to Select Study Participants (Study Architecture)



For the qualitative study, individual HIV positive youth were contacted through their organization and a snowball technique was employed. Participants for FGD with street youth, in-school youth, out-of-school youth and commercial sex workers in the same age group were selected from the same study area.

4.5 Sampling Procedure

Multi stage sampling technique was used.

First stage: Of the ten *Kifle Ketemas*, four of them are geographically at the center and thus are considered as inner city. The remaining six *kifle ketemas*, surrounding the four inner *Kifle Ketemas*, are considered as outer city. Two *kifle ketemas* were randomly selected from each cluster using a simple random method.

Second stage: In the second stage seven *kebeles* were randomly chosen from each of the four *Kifle ketemas.*

Third stage: Using the *Kebele* Administration office as a common landmark, every three household to the right of the *Kebele* office were selected until a sample of 33 eligible subjects is obtained from each *Kebele*.

Fourth stage: Within a household all young people in the specified age group and fulfilling the inclusion criteria were eligible for the study. However, only one eligible person was allowed to enter to the study. If there were more than one eligible subject in a household, one was selected by a simple lottery method.

Entry/ Exclusion criteria.

- A permanent resident of the locality. i.e A person who lived at least for six months in the locality.
- Full consent to participate in the study.

- Both males and females between the age of 15 and 24.
- Unmarried

4.6 Data Collection and Management

Quantitative Data

Twenty-four interviewers (twelve male and twelve female) second year and above University students were recruited and trained for four days. The content of the questionnaire, basic skills of interviewing and filling out the questionnaire and identifying appropriate individuals for case studies if they came across them were some of the issues addressed during the training. Following the training, the questionnaire was pre-tested on 35 youth outside of the study area and it was standardized and pre-coded before the administration of actual data collection. Participants of the focus group discussion were not encompassed in the survey. Male interviewers interviewed male respondents, while female interviewers interviewed female respondents when required.

Qualitative Data

a) Focus group discussion is a useful tool for evoking discourses on social behavior and is proved to be efficient in areas of reproductive health (70). Maximum effort was made to make the discussants as homogeneous as possible. Two members of the research team (one facilitating and the other tape-recording the discussion) facilitated each focus group discussion. The focus group discussions aimed at exploring factors that are responsible for the existing high-risk taking and low personal risk perception towards HIV in spite of the magnitude of the problem. The discussions were tape recorded with full consent of the participants.

b) Case studies: the life histories of four HIV positive youth were reconstructed. The cases retrospectively narrated their lives to enable the researcher to map the precursor personal,

familial, extra familial and structural factors that have exposed them to the infection. Interviews with the cases were recorded with full consent of the people.

Instrument of data collection

Questionnaire

An anonymous, interviewer-administered structured questionnaire was used to get high response rate. A standardized questionnaire format of Family Health International (FHI) was adopted and custom tailored for the purpose of this study (69). A total of 83 questions were prepared for the survey that took 15 to 20 minutes to be completed on average. The questionnaire was prepared in English and translated into Amharic (the local language which is used by all in the study area). The questionnaire addressed variables related to HIV risk perception, sexual behaviour, and socio-cultural and economic factors influencing sexual behaviour in addition to the demographic and socio-economic variables.

Discussion Guide

Discussion guides were prepared for the FGDs to gather detailed qualitative information on main factors that determine sexual behaviour, current trends of sexual behaviour among the youth and the exposing and protective factors to HIV/AIDS.

Ensuring Data Quality

Four supervisors and the principal investigator closely followed the day-to-day data collection process to monitor and ensure quality of the data, correctness and completeness of information. In all the qualitative procedures, the principal investigator took the major role.

4.7 Data Processing and Analysis

Quantitative data: Data was entered and stored in a computer, and SPSS Version 10.0 statistical package was applied for analysis. Knowledge about HIV/AIDS was measured by 12-item HIV related questions about modes of transmission and methods of prevention. A value of 0 and 1 was given for each question. Scores were computed by simple summation whereby a high score indicated greater knowledge. Variables like parental monitoring, peer involvement, attachment to family and attitude towards self-protection from HIV were measured by using Likert scale out of a range of four to five statements assessing each variable.

Qualitative Data: Gathered qualitative information in chronological steps, which involve interviewing, writing field notes, and expanding them into fair notes. The information gathered was analysed and interpreted to create a conceptual map of the correlates of sexual behaviour that exposes and already exposed (in the cases of PLWHA) young people to HIV/AIDS.

4.8 Ethical Considerations

Ethical clearance was obtained from the Regional Committee for Medical Research Ethics in Western Norway (Regional Komite for Medisinisk forskiningsetikk Vest-Norge (REK Vest)). Furthermore the proposal was presented to the Department of Sociology and Social Anthropology; Addis Ababa University and was approved to be ethically sound.

Individuals were enrolled into the study after obtaining informed consent. The written consent form, which contains information on the objective of the study and the relevance of their response, was clearly read out to them. Interviewers further explained other inquiries if there was a need and continued to interview the subject after obtaining a full consent. Interviews were held in relatively quite places where interviewer and the interviewee can freely discuss the questions. At times, interviewers had to take the interviewees out of the compound to

ensure more privacy for the subjects. Names were totally omitted on the questionnaire to ensure confidentiality of information. For the qualitative part, pseudonyms were used to ensure anonymity.

4.9 Operational Definitions

Commercial sex workers: People who are engaged in sexual relationship for pay on a regular basis. In this study it refers to women only.

Drugs: refer to any kind of mood altering substances other than alcohol. It could be *Khat*, *shisha*, marijuana, cocaine, and benzene but not generic medical drugs prescribed by physicians.

Multiple sexual partners: A person having more than one sexual partner either serially or concurrently is considered to have multi partner sexual contact.

Potentially High Risk Sexual Behavior: Refers to being sexually active outside marriage regardless of the circumstances.

Out-of-School Youth: young people who have completed their secondary education or who dropped out of school or who have never been to school in their lives.

In-School Youth: refers to young people who are currently attending any type of school.

V. Results

5.1 Quantitative Data

5.1.1. Socio-Demographic Variables

A total of 925 youth responded to the interviews with 100% response rate. As it is depicted on Table 1, more than half 493 (53.3%) were females and the majority 592 (64%) were with in the age group of 15-19 years. Four hundred and sixty one (49.8%) were residing in areas operationalized as inner city in this study. The mean age of the study subjects was 18.8 (S.D±2.53). Over 70% of the subjects have lived in the study area with in their respective reference city location for more than 10 years. Seven hundred and ninety nine (86.5%) were Christians, of which 747(80.8%) were followers of Orthodox Christianity.

Those who live with their both biological parents make up 510 (55.1%) of the subjects while 172 (18.6%) were living with one biological parent (4.3% with their father only and 14.3% with their mothers only). The remaining 204 (22.1%) were living with their siblings, relatives, employers or friends. In comparison with other households in the neighborhood, 599 (64.8%) believe their families are on average economic stances while 214 (23.1%) felt that they are very low in the economic ladder of their neighborhood.

Over 60% of the respondents were attending school at the time of the study. The majority 256 (44.6) of them were in high school. Those who were attending post secondary schools comprised 13.4 percent. Family members and relatives in 80.3% (458/574) of the cases covered expenses for school and school supplies. Three hundred twenty five out of the 351 of the out of school youth (92.6%) used to go to school previously, out of whom 197 (61%) have completed 9 to 12 school years.

About a third 299 (32.3%) of the respondents participate in the labor force to generate their own income. Enrollment in the labor force was statistically significant (P<0.001) with age. Youth in the age group of 20 -24 were more active in the labor force than those between 15 and 19 (44.4%Vs25.5%). The same fact holds true for sex whereby 24.1% of the females were working (largely in the informal sectors) as compared to 41.7% of the males (P<0.001). Working youth were more in the inner city than the periphery (34.9% as compares to 21.7 %). Only 10.4% (31/299) of the working group were engaged in the formal sector. The considerable majority 268(90.6%) of the working group is engaged in informal jobs such as construction work, small-scale trade, shoe shining, taxi assistance, housemaid, broker, shop keeping, catering and even commercial sex. Of this working group, 135 (45.2%) have the responsibility of supporting other family members beside themselves, of which the majority are in the inner city. On the other hand, 223 (35.6%) of the young people reported that they could not get jobs even if they wanted to work.

Table 1: Socio Demographic Characteristics of Urban Youth in Addis Ababa, 2004

Characteristic	Inner City		Outer City		Total	
	No.	%	No.	%	No.	%
Demography						
Sex						
Male	217	47.1	215	46.3	432	46.7
Female	244	52.9	249	53.7	493	53.3
Age						
15-19	288	62.5	304	65.5	592	64
20-24	173	37.5	160	34.5	333	36
Religion						
Orthodox Christian	343	74.4	404	87.1	747	80.8
Catholic Christian	7	1.5	1	.2	8	0.9
Protestants	24	5.3	20	4.3	44	4.8
Muslim	84	18.2	35	7.5	119	12.9
No religion	2	.4	1	.2	3	0.3
Others	1	.2	3	.6	4	0.4
Family Background						
Currently Living with						
Alone	16	3.5	21	4.5	37	4
Both biological parents	247	53.6	263	56.7	510	55.1
Single biological parent	92	20	80	17.2	172	18.6
With siblings and relatives	86	18.7	83	17.9	169	18.3
With employers/friends/ peers and others	20	4.3	17	3.7	37	4
Perceived family economic status i relation to their neighborhood						
Very poor	98	21.3	116	25	214	23.1
Average	302	65.5	297	64	599	64.8
Moderately good	48	10.4	44	9.5	92	9.9
Rich	9	2	5	1.1	14	1.5
Do not know	4	.9	2	.4	6	0.6
School Enrollment Status						
Current school enrollment status						
In- School-Youth	277	60.1	297	64	574	62.1
Out-of- School- Youth	184	39.9	167	36	351	37.9
Completed school years (ISY)					N= 574	
1-4	17	6.1	16	5.4	33	5.7
5-8	97	35	111	37.4	208	36.2
9-10	81	29.2	102	34.3	183	31.9
11-12	36	13	37	12.5	73	12.7
Above 12	46	16.6	31	10.4	77	13.4
Ever attended school (OSY)					N= 351	
Yes	167	90.8	158	94.6	325	92.6
No	14	7.6	9	5.4	23	6.6
No response	3	1.6	-	-	3	.9
Completed school years (OSY)					N=351	
0-4	10	5.5	17	10.1	25	7.7
5-8	44	24.2	43	25.4	87	26.9
9-12	105	57.7	92	54.4	197	61.0
Above 12	7	3.8	4	2.4	11	3.4
No response	16	8.8	13	7.7	3	.9
Labor Force Status						
Work to earn money						
Yes	161	34.9	138	21.7	299	32.3
No	300	65.1	326	70.3	626	67.7
In which sector are you engaged in?					N=299	
Formal	15	9.3	16	11.6	31	10.4
Informal	146	90.7	122	88.4	268	90.6
Supporting families					N=299	
Yes	78	48.4	57	41.3	135	45.2
No	81	50.3	78	56.5	159	53.2
No response	2	1.2	3	2.2	5	1.7

5.1.2 Immediate Environment

In an attempt to consider the social environment of the respondents in the analysis of sexual behavior, a few questions were asked about neighborhood situations. Accordingly, 480 (51.9%) of the subjects said that only a few household heads in the neighborhood have jobs and 467 (50.5%) affirmed that most of the people in the neighborhood are engaged in the informal sector. With regard to young people in their communities, the popular characterizing feature of the youth was unemployment followed by doing whatever jobs they can get to make a living. Joining higher education and being engaged in illegal activities were mentioned by a small number of respondents. Six hundred and forty four (69.6%) of the youth affirmed the absence of recreational places in their neighborhood where people of their ages can spend their leisure time.

5.1.3 Peer Situation

One hundred and forty four (15.6%) admitted that they have friends who have been accused of delinquency (Table 2). Two hundred eighty eight (31.1%) of the youth claimed that their friends have had no sex while 70 (7.6%), 116 (12.5%), 274 (29.6%) reported that all, many and some of their friends are sexually active respectively. A considerable number of the youth 159 (17.2%) did not know the sexual activity of their friends. Of the respondents who have sexually active friends, 10.6% (49/460), reported that their friends had a history of STD. Attachment to peer/ friends, as measured by a Likert scale revealed that, 362 (39.1%) of the young people had a strong peer involvement while 358 (38.7%) were found to have a moderate attachment.

Table 2: Peer Norms and Peer Involvement of Urban Youth in Addis Ababa, 2004

Characteristic	Inner City		Outer City		Total	
	No	%	No.	%	Number	Percent
Number of friends who are sexually active						
All	38	7.8	34	7.3	70	7.6
Many	56	12.1	60	12.9	116	12.5
Some	142	30.8	132	28.4	274	29.6
None	137	29.7	151	32.5	288	31.1
Do not know	77	16.7	82	17.7	159	17.2
Missing	13	2.8	5	1.1	18	1.9
Number of friends who have had STDs						
Most	2	0.9	5	2.2	7	1.5
Some	23	9.9	19	8.4	42	9.1
None	168	72.1	171	75.3	339	73.7
Do not know	40	17.2	32	14.1	72	15.7
Total =460						
Have you a friend ever been accused of delinquency?						
Yes	61	13.2	83	17.9	144	15.6
No	382	82.9	365	78.7	747	80.8
Do not know	4	0.9	12	2.6	16	1.7
Missing	14	3	4	0.9	18	1.9
Peer involvement/attachment						
Strong	170	36.9	192	41.4	362	39.1
Moderate	194	42.9	159	34.3	358	38.7
Weak	77	16.7	103	22.2	180	19.5
Missing	15	3.3	10	2.2	25	2.7

Common points of discussion in the youth subculture were assessed. Academic matters and youths' futures were found to be the popular issues reported by 53.1% and 36.6% of the entire respondents respectively. Three hundred and sixteen (34.2%) of them also mentioned that relationship issues are often discussed among peers, followed by family issues, sexual issues, sport and spiritual matters in decreasing frequency. Discussion about academic matters had a statistically significant association with age and sex at $P<0.001$ and $P<0.005$ respectively whereby 15-19 and girls tend to discuss it more. Future plan as a point of discussion had a statistical significance with age at $P<0.001$ and discussions of family and sport were associated with sex (females discuss more about their families and males discuss more about sport) at $P<0.001$.

5.1.4 Social Behavior

Table 3 depicts the social behaviors of the survey participants. Nearly two thirds, 608 (65.7%) of the respondents, watch western video films and music, and 340 (36.7%) have watched pornographic films at least once. Forty-five (4.8%) of the young people reported that they smoke cigarettes currently or used to smoke before. Only 87(9.4%) of the respondents admitted that they have been accused of delinquency of any sort.

Among the in-school-youth, 260(45.3%) have failed their exams before and 193 (33.6%) admitted truancy. Inner city youth reported a slightly more truancy while failure in exams was admitted more by the outer city dwellers. Majority, 797(86.1%) of the study subjects, reported frequent and regular church/mosque attendance.

Table 3: Social Behavior of Urban Youth in Addis Ababa, 2004

Characteristics	Inner city		Outer city		Total	
	No	%	No	%	Number	Percent
Do you watch western video films?						
Yes	319	69.2	289	62.3	608	65.7
No	142	30.8	175	37.7	317	34.3
How many times have you watched pornographic films?						
Never	274	60.1	303	65.7	577	62.9
Once in life tine	16	3.5	26	5.6	42	4.6
Few times	130	28.5	106	23	236	25.7
Many times	36	7.9	26	5.6	62	6.8
Do you participate in any anti-AIDS clubs?						
Yes	101	22	104	22.5	207	22.2
No	358	78	359	77.5	717	77.8
How often do you smoke cigarette?						
Never	439	95.4	439	94.8	878	95.1
I used to but quit	5	1.1	8	1.7	13	1.4
Sometimes	10	2.2	7	1.5	17	1.8
Many times	6	1.3	9	1.9	15	1.6
Have you ever been accused of any delinquent behavior?						
Yes	34	7.5	53	11.5	87	9.5
No	421	92.5	409	88.5	830	90.5
Have you ever failed an exam?					N=574	
Yes	117	42.2	143	48.1	260	45.3
No	160	57.8	154	51.9	314	54.7
Have you ever missed a class and spent your school time somewhere else?					N=574	
Yes	102	37	91	30.7	193	33.7
No	174	63	205	69.3	379	66.3
How often do you usually attend religious services?						
Daily	114	24.8	98	21.2	212	23
Twice or three times a week	99	21.5	99	21.4	198	21.5
Once a week	126	27.4	146	31.5	272	29.5
Once a month	60	13	58	12.5	118	12.8
Once a year	10	2.2	17	3.7	27	2.9
Not at all	44	9.6	39	8.4	83	9
Others	7	1.5	6	1.3	13	1.4

As it is shown in Table 4, a total of 274 (29.6%) of the respondents admitted that they consume alcohol or have experienced alcohol consumption. Alcohol consumption was found to have a strong statistical association with sex, age, and school enrollment status at $P<0.001$ whereby males between the age of 20-24 and out-of-schools tend to be higher in number. The same fact is true for *khat*, which was reported to be used by 130 (14.1%) of the entire study population. Use of *shisha* was not statistically significant with sex but an association was observed with residential location at $P<0.005$, whereby youth in the inner city tend to use it more. *Shisha* use also had a statistical significance with age and school enrollment status. Although people who reported using hashish are few in number, more males, between the ages of 20 and 24 and who are out-of-school dominate over the others. More than one tenth 95 (10.3%) of the young people reported the use of at least one type of drug while a greater majority 790(85.5%) denied the use of any mood-altering drug at all.

Table 4: Substance Uses of Urban Youth in Addis Ababa, 2004

Characteristics	Sex				Age				School Enrollment Status				Residence Location				Total	
	Male		Female		15-19		20-24		ISY		OSY		Inner City		Outer City			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Have had drunk alcohol	180	41.7	94	19.1	*137	23.1	137	41.1	*141	24.6	133	37.9	139	30.2	135	29.1	274	29.6
Chew *khat*	*100	23.2	30	6.1	*50	8.5	80	24	*44	7.7	86	24.5	67	14.6	63	13.6	130	14.1
Use *Shisha*	26	6	16	3.2	*14	2.4	28	8.4	*14	2.4	28	8	**30	6.5	12	2.6	42	4.5
Use hashish	*** 7	1.6	1	0.2	*** 2	0.3	6	1.8	1	0.2	*** 7	2	6	1.3	2	0.4	8	0.9
Drug use	*				*				*				***					
Non use of drug	331	76.8	459	93.1	540	91.4	250	75.1	528	92.1	262	74.6	390	84.8	400	86.2	790	85.5
Use at least one drug	73	16.9	22	23.2	38	6.4	57	17.1	32	5.6	63	17.9	42	9.1	53	11.4	95	10.3
Multiple drug use	27	6.3	12	2.4	12	2.2	26	7.8	13	2.3	26	7.4	28	6.1	11	2.4	39	4.2

NB: Test statistics: Chi-square. * P<0.001, ** P<0.005, ***P<0.05

5.1.5 Family Situation

A Likert scale used to assess parental monitoring and parent-child bond revealed that, strong parental monitoring and family attachment was measured among 415 (46.8%) and 662 (73.4%) respectively (Table 5). Attachment to the family was statistically significant with sex and school enrollment status ($P<0.05$) but not with age (in-school-youth and females tend to be more attached to their families). On the other hand, parental monitoring was found to have a significant association with sex, age and school enrollment status ($P<0.001$), whereby girls, in-school- youth and those in the age range of 15-19 reported stronger parental supervision than their older counterparts. One hundred and sixty five (17.8%) declared that they discuss sexual issues with their parents and less than half 418 (45.2%) claimed that they discuss such issues with other members of the family (Table 5). Reasons mentioned for not discussing sexual issues with parents include cultural factors and the accompanying discomfort in discussing such issues.

Table 5: Parental Monitoring and Attachment to Family of Urban Youth in Addis Ababa, 2004

Characteristics	Number	Percent
Parental monitoring		
Strong	415	46.8
Moderate	317	35.7
Weak	155	17.5
Attachment to the family		
Strong	662	73.4
Moderate	176	19.5
Weak	64	7.1
Discuss sexual issues with parents		
Yes	165	17.8
No	699	75.6
Missing	61	6.6
Discuss sexual issues with other members of the family		
Yes	418	45.2
No	466	50.4
Missing	41	4.4

5.1.6 Sexual Behavior

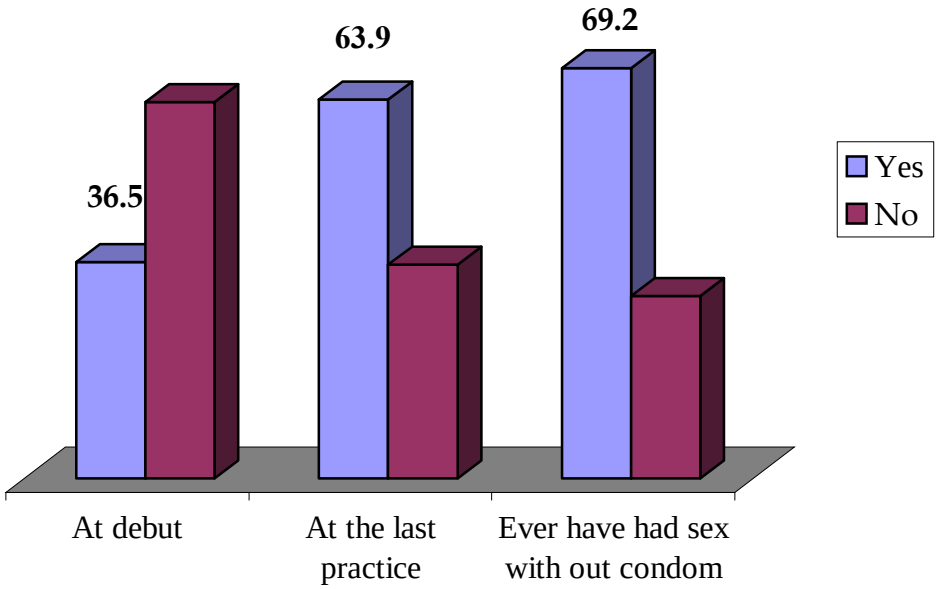
Two hundred and sixty (28.1%) of the study subjects (40% of the male subjects and 18% of the females) admitted having had sexual experience (Table 6). The mean age of menarche was found to be 14.3(SD±1.35) the lowest being 9 and the highest 18. The average age for sexual initiation was 17.5(SD±2.26) (17.3 for females and 17.5 for males), the lowest age of sexual initiation reported by the girls was 8 and the figure rose up to 10 for males. The highest age to break celibacy for the sexually active group was 23 for both sexes. One hundred and sixty three (62.7%) of the sexually active youth were in the age range of 20 to 24 and 169 (65%) of them were out of school youth. Age, sex, and school enrollment status were found to have statistical significance with sexual activity at $P<0.001$.

Over two thirds, 175 (67.3%) of the sexually active claimed that they had their first coitus with their steady friends while only a negligible 9 (3.5%) of the sexually active boys admitted that their first sexual partners were CSWs. Nearly three fourths 188 (72.3%) did it on their own free will, while 52 (20%) claimed that they were inspired to have sex by their peers. Only 5 (1.9%) did it forced by other people without their consent. One hundred twenty one (46.5%) of the sexually active youth admitted having multiple sexual partners. The average number of sexual partners for those who have practiced sexual intercourse was 1.5 (S.D±0.5), while some have reported as high as nine partners.

Ninety five (36.5%) claimed the use of condom at debut. Of the young people who were sexually active in the last six months, 94 (63.9%) claimed that they used condom in their last sexual practice. Eighty (30.8%) of the respondents claimed regular use of condom by denying ever having sex without a condom (Figure 3). Of the subjects who use alcohol and *khat*, 34.9% (51 out of 146) and 24.3% (25 out of 103) acknowledged that they had inconsistent and

incorrect use of condom after the use of substance respectively. Thirty (20.5%) and 26 (25.2%) of the alcohol and drug users claimed that they do not have any sexual desire after the use of the aforementioned substances respectively.

Figure 3: Percent Distribution of Condom Use Trend by Urban Youth in Addis Ababa



As can be seen from Table 6, out of the 172 sexually active males, only 35 (20.3%) admitted having had sex with CSW. Twelve (4.6%) of the sexually active respondents (equal number of males and females) claimed that they were forced by their partners to have sex without their will in the last six months. About 40 (15.4%) of the sexually active respondents reported ever having had sex with a casual partner whereby the number of males was three times that of the females. A significant minority 6 (2.3%) of the cases admitted that they have had a sexually transmitted disease in the past. Of these, 4 were males and in the age group of 15 to 19. Of the sexually active girls, 18(20.5%) reported that they had ever been pregnant whereby

5(27.7%) of the pregnancies ended in abortion. There was no difference in sexual behavior of youth living in the inner city and in the outer city that can be proven statistically.

High risk sexual behavior was computed out of eight questions assessing risky sexual behavioral patterns but the differences in scores were too subtle to categorize people in different groups as high risk and low risk. Therefore we considered all the sexually active youth as having potentially high risk sexual behavior.

Table 6: Sexual Behavior of Young People in Urban Addis Ababa, 2004

Characteristics	Inner City		Outer City		Total	
	No	%	No	%	Number	Percent
Have you ever had sexual intercourse?						
Yes	142	30.8	118	25.4	260	28.1
No	319	69.2	346	74.6	665	71.9
Use of condom at first practice						
Yes	55	38.7	40	33.9	95	36.5
No	87	61.3	78	66.1	165	63.5
Condom use in the last practice					N=147	
Yes	86	60.6	66	55.9	94	63.9
No	56	39.4	52	44.1	53	36.1
Ever have had sex with out condom						
Yes	92	64.8	88	74.6	180	69.2
No	50	35.2	30	25.4	80	30.8
Ever have sex with CSW					N=172	
Yes	21	22.3	14	17.9	35	20.3
No	73	77.7	64	82.1	137	39.7
Number of partners reported						
Only one	76	53.5	63	53.4	139	53.5
More than one	66	46.5	55	46.6	121	46.5
Have you had genital ulcer in the last six month?						
Yes	2	1.4	1	0.8	3	1.2
No	140	98.6	117	99.2	257	98.8
Have you had genital discharge in the last six month?						
Yes	2	1.4	1	0.8	3	1.2
No	140	98.6	117	99.2	257	98.8
Have you ever been pregnant?					N=88	
Yes	12	25	6	15	18	20.5
No	36	75	33	82.5	69	78.4
No response	-	-	1	2.5	1	1.1
Have you given birth?					N=18	
Yes	9	75	4	66.7	13	72.2
No	3	25	2	33.3	5	27.8

5.1.7 Knowledge about and Attitude towards HIV/AIDS

All but one, 924 (99.9%) reported that they have heard about HIV/AIDS. Of these, 493 (53.3%) of them had a close relative, or neighbor or a close friend who has died of HIV/AIDS and 335 (36.2%) know a person living with the virus presently. Seventy nine (8.5%) admitted that they have taken care of a person who suffered from the virus.

Figure 4 depicts a knowledge score, which was calculated out of 12 questions assessing awareness about HIV transmission and prevention. Accordingly, only 16 (1.7%) of the respondents were found to have scores 0 to 6 (inadequate knowledge) while 226 (24.4%) scored 7 to 9 (moderately adequate knowledge) and the remaining majorities scored 10 to 12 (adequate knowledge) about HIV/AIDS.

Figure 4: Knowledge about HIV/AIDS

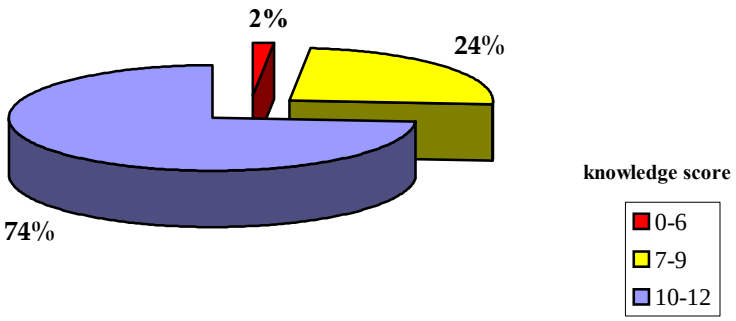
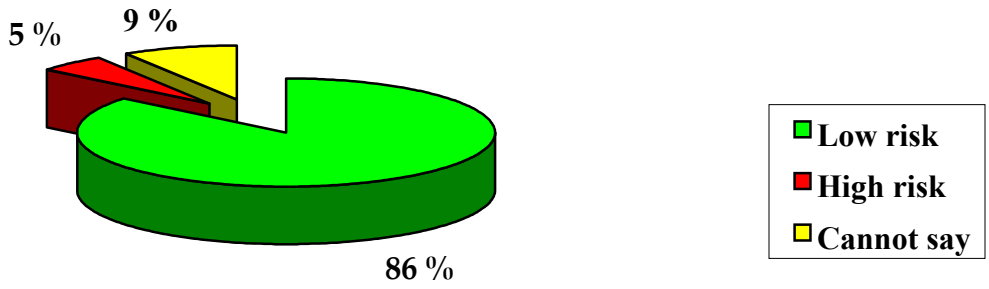


Table 7 depicts the attitude of young people towards HIV/AIDS. Eight hundred ninety six (97%) of the youth believe in the gravity of the HIV pandemic and think that it is a multidimensional problem. Three hundred and fifty-six (38.5%) admit the fact that young people of their age are especially vulnerable to the disease. The fact that young people are

engaged in unsafe sex even if they know about AIDS, multiple determinant factors of sexual behavior, difficulty in changing youth behavior and the inadequacy of knowledge about the disease were reported as reasons for vulnerability of young people in decreasing frequency by 95.2, 75.8, 44.7 and 30.9 percents of respondents respectively. The respondents believed that sexual behaviors that expose to HIV are the resultant effects of many factors, of which upbringing, knowledge about AIDS, parental guidance and supervision, and neighborhood situations were the most frequently stated factors by over sixty percent of the study participants.

When it comes to personal susceptibility, hardly any 49 (5.3%) of them declared that they have high chances of getting HIV while the great majority claimed that they have no or low chances of getting it (Figure 5). The respondents mentioned being sexually inactive, trusting partners, using safe sharp instruments, use of condom as major argument for their low/no risk of contacting HIV/AIDS.

Figure 5: Perceived Chances of Contracting HIV



As Table 7 shows, attitude towards self-protection from HIV/AIDS measured by Likert scale revealed that only 35 (3.8%) of the study population have favorable attitude towards protecting themselves from HIV and 591 (64%) of the study subjects had unfavorable attitudes towards self-protection. An encouraging number 841 (91%) of the youth conceive the idea that VCT would help prevent the further spread of HIV/AIDS. Four hundred and thirty-five (47%) of them reported that VCT services in their communities are unavailable and inaccessible. One hundred sixty one (17.4%) of the youth had an HIV screening test, of which 97 (60.2%) did it on their own initiative to know their status while the remaining did it on requirement by different processes. An optimistic number of respondents 846 (91.6%) expressed their willingness to use VCT services if the service is available.

Table 7: Attitudes of Urban Youth towards HIV and HIV Testing, 2004

Characteristics	Number	Percent
Do you think that HIV is a multi-dimensional problem?		
Yes	896	97
No	25	2.7
Do not know	3	0.3
Do you think that people of your age are vulnerable to HIV/AIDS?		
Yes	356	38.5
No	446	48.3
Do not know	122	13.2
Do you believe that voluntary testing and counseling services would help to control the spread of HIV?		
Yes	841	91
No	78	8.4
Do not know	5	0.5
Have you ever had an HIV test?		
Yes	161	17.4
No	763	82.6
Will be using VCT services if available?		
Yes	846	91.6
No	68	7.4
Do not know	10	1.1

N.B: N was 924 excluding one subject who has never heard about HIV.

Bivariate and multivariate analyses were conducted between sexual behavior and some variables that measure the self, the familial and extra familial situations. Most of the variables related to the self-system appeared to be associated with risky sexual behavior. However, only few of them kept on having statistically significant association with sexual behavior after adjustment.

Table 8 depicts that males and those youth who are generating their own income were almost twice more likely to have potentially high risk sexual behavior OR= 2.35(1.11-4.97) and 2.11(1.13-3.94) respectively. Young people aged 15-19 and who were going to school were less indulgent in sexual practices (OR=0.37(0.20, 0.70)). *Khat* users were found to have 4 times more risk to sexual indulgence at OR= 3.84(1.40-10.49). Academic performance as measured by the experience of failure and truancy revealed that poor academic performance was not associated with sexual behavior. Likewise involvement in Anti-AIDS clubs and the knowledge one has about HIV/AIDS were found to be insignificant to determine sexual behavior of the individual.

Young people who have high-risk perception were found to indulge in high-risk sexual behavior 5 times more than those who have low risk perception and do not know their degrees of vulnerabilities (OR= 5.49(1.69-17.82)). However, it is not possible to tell from this data set if high personal risk perception towards HIV is due to indulgence in risky sexual behavior. People who have undergone HIV test were three times more active sexually than those who did not know their HIV status OR=2.52(1.17-5.41)

Table 8: Sexual Behavior of Young People and Variables Related to the Self-System, 2004

Variables associated to the self system	Sexually Inactive No.	%	Sexually Active No	%	Crude OR	Adjusted OR
Sex						
Males	260	39.1	172	66.2	3.04(2.25-4.11)	2.35(1.11-4.97)
Females	405	60.9	88	33.8	1.0	1.0
Age						
15-19	495	74.4	97	37.3	0.20(0.15-0.28)	0.37(0.20-0.70)
20-24	170	25.6	163	62.7	1.0	1.0
School enrollment status						
In School youth	483	72.6	91	35	0.20(0.15-0.28)	-Had linear effect
Out of School Youth	182	27.1	169	65	1.0	with age
Admitted truancy at school (ISY N=572)						
Yes	134	27.9	59	64.8	4.77(2.97-7.67)	1.90(0.99-3. 66)
No	347	72.1	32	35.2	1.0	1.0
Self evaluation of academic performance						
Top student	103	21.4	10	11	0.45(0.23-0.91)	0.74(0.30-1.81)
Average and Weak student	378	78.6	81	89	1.0	1.0
Have you failed an exam?						
Yes	207	42.9	53	58.2	1.86(1.18-2.93)	1.61(0.85-3.02)
No	276	57.1	38	41.8	1.0	1.0
Have been accused of delinquent behavior?						
Yes	32	4.9	55	21.1	5.27(3.32-8.38)	2.13(0.80-5.67)
No	626	95.1	204	78.8	1.0	1.0
Have you ever smoked cigarette?						
Never	654	98.6	224	86.2	0.09(0.04-0.18)	0.44(0.08-2.54)
Yes /I used to	9	1.4	36	13.8	1.0	1.0
Do you work to earn money?						
Yes	163	24.5	136	52.3	3.38(2.50-4.56)	2.11(1.13-3.94)
No	502	75.5	124	47.7	1.0	1.0
Watch western video and films?						
Yes	408	61.4	200	76.9	2.10(1.51-2.92)	1.38(0.58-3.28)
No	257	38.6	60	23.1	1.0	1.0
Have you ever watched Pornography?						
Never	479	72.8	96	37.8	0.23(0.17-0.31)	0.44(0.23-0.86)
At least once	179	27.2	161	62.2	1.0	1.0
Do you participate in Anti AIDS clubs?						
Yes	158	23.9	47	18.1	0.70(0.49-1.01)	0.76(0.39-1.47)
No	504	76.1	213	81.9	1.0	1.0

Drunk Alcohol						
Yes	122	18.3	152	58.5	6.26(4.57-8.58)	2.08(1.10-3.92)
No	543	81.7	108	41.5	1.0	1.0
Use *Khat*						
Yes	30	4.5	100	38.5	13.21(8.48-20.58)	3.84(1.40-10.49)
No	634	95.5	160	61.5	1.0	1.0
Use *Shisha*						
Yes	7	1.1	35	13.5	14.6(6.40-33.33)	1.26(0.26-6.18)
No	657	98.9	225	86.5	1.0	1.0
Perceived chances of getting HIV						
High chance	16	2.4	33	12.7	5.88(3.18-10.88)	5.49(1.69-17.82)
Low chance and could not tell their chance	647	97.6	227	87.3	1.0	1.0
Have you undergone an HIV test?						
Yes	83	12.5	78	30	3.0 (2.11-4.26)	2.52(1.17-5.41)
No	581	87.5	182	70	1.0	1.0
Do you have a close relative, neighbor or friend who has died of HIV?						
Yes	328	49.5	165	63.7	1.79(1.33-2.40)	1.06(0.53-2.12)
No	334	50.5	94	36.3	1.0	1.0
Do you have a close relative, neighbor or friend who is infected by HIV?						
Yes	220	33.5	113	43.6	1.53(1.14-2.06)	1.13(0.57-2.25)
No	440	63.5	146	56.4	1.0	1.0
Current living arrangement						
With both biological parents	364	54.7	146	56.2	1.05(0.79-1.41)	1.09(0.59-2.03)
Other arrangements	301	45.3	114	43.8	1.0	1.0
Knowledge score on HIV/AIDS						
0-6	10	1.5	6	2.3	1.55(0.56-4.30)	2.59(0.08-86.60)
7-12	654	98.5	254	97.7	1.0	1.0

NB: Reference was the last category all the times, CI=95%, Irregular N due to valid missing and missing.

Perceived socio economic status of the family turned out to have no statistically significant associations with sexual behavior (Table 9). Strong attachment to the family, and discussion of sexual matter with parents were not also found to be protective of risky sexual indulgence. Strong parental monitoring promoted less sexual indulgence among youth (OR=0.21(0.13-0.33)). When the reference group in the regression model is changed, young people with weak parental monitoring were 6 times more indulgent in sexual activities compared to the ones with strong parental monitoring. On the contrary, youth who discuss about sexuality with any other member of the family were twice more likely to be sexually active OR=1.91(1.35.2.71) after adjustment.

Table 9: Sexual Behavior of Young People and Some Selected Variables Related to the Family System, 2004

	Sexually Inactive		Sexually Active		Crude OR	Adjusted OR
Variables associated to the family system	**No.**	**%**	**No**	**%**		
Parental monitoring (N=887)						
Strong	346	54.5	69	27.4	0.16(0.10-.0.24)	0.21(0.13-0.33)
Moderate	221	34.8	96	38.1	0.34(0.23-0.51)	0.40(0.26-0.64)
Weak	68	10.7	87	34.5	1.0	1.00
Attachment to family						
Strong	508	78.3	154	60.9	0.26(0.17-0.48)	0.59(0.30-1.16)
Moderate	110	16.9	66	26.1	0.56(0.32-1.00)	0.95(0.47-1.90)
Weak	31	4.8	33	13	1.0	1.0
Do you discuss sexual issues with your parents?(N=864)						
Yes	131	20.8	34	14.5	0.65(0.43-0.98)	0.66(0.42-1.05)
No	499	79.2	200	85.5	1.0	1.0
Do you discuss sexual issues with other members of your family?						
Yes	293	45.1	125	53.2	1.38(1.02-1.86)	1.91(1.35-2.71)
No	356	54.9	110	46.8	1.0	1.0
Socio-economic status of the family						
Very poor	145	22	69	26.6	2.85(0.62-13.10)	2.36(0.49-11.28)
Average	431	65.3	168	64.9	2.34(0.52-10.55)	2.11(0.45-9.85)
Moderate	72	10.9	20	7.7	1.67(0.34-8.06)	1.75(0.35-8.91)
Good economy	12	1.8	2	0.8	1.0	1.0

NB: Reference was the last category all the times, CI=95%, Irregular N due to valid missing and missing values.

As can be seen on Table 10, engagement with delinquent peers was found to be directly related with indulgence in high-risk sexual behavior as those who have delinquent peers were twice more likely to be sexually active OR=1.75(1.16-2.65). Young people whose friends are sexually active tend to be five times more likely to indulge sexually 4.77(2.84-8.03). Statistical significance was not evidenced between sexual behavior and neighborhood economic situation. Keeping all other extra familial variables in the regression model constant, inner city youth were slightly more likely to be potential high-risk groups (OR=1.48 (1.06-2.08)).

Table 10: Sexual Behavior of Young People and Some Selected Variables Related to Extra-familial System, 2004

Variables associated to the extra family system	Sexually Inactive No.	%	Sexually Active No	%	Crude OR	Adjusted OR
Peer Involvement						
Strong	259	40.1	103	40.6	1.03(0.69-1.54)	0.99(0.61-1.59)
Moderate	257	39.8	101	39.8	1.02(0.69-1.52)	0.99(0.61-1.60)
Weak	130	20.1	50	19.7	1.0	1.0
How many of your friends are sexually active?						
At least some	244	37.5	216	84.4	4.74(2.98-7.55)	4.77(2.84-8.03)
None	273	41.9	15	5.9	0.30(0.15-0.58)	0.30(0.14-0.63)
Do not know their sexual life	134	20.6	25	9.8	1.0	1.0
Residential area						
Inner city	319	48	142	54.6	1.31(0.98-1.74)	1.48(1.06-2.08)
Outer city	346	52	118	45.4	1.0	1.0
How many of the household heads have jobs in your neighborhood?						
Most	286	45.2	108	43.7	0.94(0.70-1.27)	0.90(0.64-1.27)
Few or none	347	54.8	139	56.3	1.0	1.0
Have any of your friends being accused of delinquency?						
Yes	75	11.5	69	27	2.71(1.29-5.71)	1.75(1.16-2.65)
No and do not know about them	576	88.5	187	73	1.0	1.0

NB: Reference was the last category all the time, CI=95%, Irregular N due to valid missing and missing.

Risk perception towards HIV as measured by perceived chances of contracting the virus was tested for association with a number of variables. Though it has been a determinant variable in most of the analysis in this study and other studies as well, sex was found to have no significant association with risk perception. Knowledge about HIV was associated with risk perception at $P<0.05$. Sexual activity, school enrollment status and parental monitoring have significant association with risk perception at $P<0.001$.

Table 11: HIV/AIDS Risk Perception of Youth by Some Selected Variables, 2004

	Low Risk Perception		High risk Perception		Do not know about their risk level		P value
Variables associated to Risk Perception	**No**	**%**	**No**	**%**	**No**	**%**	
Sexual behavior							
Sexually inactive	600	90.5	16	2.4	17	7.1	P<0.001
Sexually active	191	73.5	33	12.7	36	13.8	
Sex							
Male	367	85.2	28	6.5	36	8.4	
Female	424	86.2	21	4.3	47	9.6	Not significant
School Enrollment Status							
In school	511	89.3	21	3.7	40	7	P<0.001
Out of school	280	79.8	28	8	43	12.3	
Parental monitoring							
Strong	379	91.5	12	2.9	23	5.6	
Moderate	262	82.9	18	5.7	36	11.4	P<0.001
Weak	126	81.3	17	11	12	7.7	
Drug use							
None use of drug	694	88.1	26	3.3	68	8.6	
Use of at least one type of drug	69	72.6	16	16.8	10	10.5	P<0.001
Multiple drug use	27	69.2	7	17.9	5	12.8	
Sexually active friends							
At least some	375	81.5	42	9.1	43	9.3	
None	268	93.7	3	1	15	5.2	P<0.001
Do not know	137	86.2	2	1.3	20	12.6	
Score of knowledge related to HIV							
0-6	10	62.5	-	-	6	37.5	
7-9	191	84.5	13	5.8	22	9.7	P<0.005
10-12	590	86.6	36	5.3	55	8.1	

5.2 Qualitative Data

Seven groups of youth discussions were convened on the issues of youth sexuality in relation to HIV/AIDS. The participants were recruited from five different sections of youth in the society; PLWHA, CSW, OSY, ISY, and street youth. Altogether 52 youths were involved in the study, 21 were males and 31 females. The age range of the participants was 16-24 except for the group of PLWHA whose age range was raised to 24-29. The slight increment in the age range of the latter group was due to the difficulty of getting many young people who accepted their status and were able to reflect on their present situation as victims of HIV.

FGD Attendants	Males	Females	Age Range	Total
PLWHA	2	5	24-29	7
In -School-Youth	8	7	16-24	15
Out -of - School-Youth	4	4	17-21	8
Street Youth	7	8	17-24	15
Commercial Sex Workers	0	7	18-24	7
TOTAL	21	31		52

5.2.1 People Living with HIV/AIDS (PLWHA)

The discussion was held with people living with HIV/AIDS; all members of Mekdim-Ethiopia. They were raised or had single parent/ guardian except for one who was raised by both biological parents, but then she was married off at an early age. The disruption of the family structure was one of the confounding elements responsible for the development of a behavioral pattern that led them to their present HIV status.

Poverty and unemployment feeding each other were mentioned as the roots and stems, from which the HIV/AIDS pandemic along with its multiple medical and social ill-effects offshoot. The idle and poverty stricken youth have plenty of time to just spend. Lack of healthy recreational facilities drives them to get together and chew *khat*. The ceremonial *khat* chewing

party includes smoking cigarettes and *shisha*, and it is followed as a matter of course by drinking alcohol in the evening, the latter believed to soothe one's high from the *khat*. It is called *Mesberia* in the local slang. Alcohol they believed facilitates the eventuality of high-risk sexual practice. As a result, the boys become regular customers of commercial sex workers and the girls resort to prostitution in order to generate their own income. One of the participants retrospectively narrated this itinerary as customary deed for him and his friends. He believes that this is true for most youth in Addis Ababa today.

The situation is not different for the seemingly employed youth. One of the case studies reinforces the fact that the imbalance between the societal expectation and one's income leads to risky sexual behavior. When one's income is not enough to establish one's own family, not to mention the problem of housing and other vises of marriage and family life, people stay unmarried and yet will have irresponsible behavioral patterns.

An epic story of a girl in the group reveals the multivariate cause of high-risk sexual behavior development, which took its roots from her family and socio-cultural environment. She was exposed to an early marriage as per the custom of the rural area she used to live in. She then had her first misfortune in getting a vesico- vaginal fistula out of her first teen age pregnancy and home delivery. This mishap was the reason for her eventual divorce from her husband and alienation from the society. She then had to immigrate to Addis Ababa, seeking medical treatment. She was treated at the Fistula hospital and ultimately cured, but then she had nowhere to go and had nobody to support her. She sought an employment as a housemaid, but this work she did not like. A local broker came in with the work he said that suited her. "Waitress, a disguise for regular prostitution" as she discovered later. Waitress in a bar is a double job with prostitution in most of the cases though not the rule. She eventually wanted to

go abroad and had to have her HIV status checked as a requirement for visa processing; it was time for her to discover that she was a victim of HIV.

The way to commercial sex workers for boys and being one for girls seems to have many routes. The physical environment the youth live in, like the many illegal video houses that feature pornographic films, and prostitutes' streets or the *DC sefer* (the Amharic equivalent for dirty corner neighborhood, which is characterized by rows of small rooms rented by young girls where one can spend a night or part of a day with the accompanying sex worker for a very cheap price) present the youth with a ready choice to spend time in. The neighboring commercial sex workers facilitate sexual experimentation after the pornographic shows. In-school and out -of -school boys naivety in the ways of courtship leads them to an easier negotiation with commercial sex workers.

Girls' victimization into unwanted sex by luring and persuasion into marriage or rape by men who know themselves as HIV positive was discussed as a strange and dangerous incident by the group. The culprits of this act are men with HIV who deliberately want to spread the virus out of vengeance and scorn for the society. It was not possible to know if this is a myth or a reality as nobody in the group has experienced it or know a person who was a victim.

There is an increased tendency of belittling the problem of HIV /AIDS by some people, in spite of adequate self-preserving knowledge about the disease. People do embellish and support their argument with local catch phrases like, '*beinkifatim yimmotal*' translated as "people may die of even simple stumbles let alone…" This gives a boost to the notion "what is a big deal of dying of HIV?"

Pursuant to their high-risk sexual behavioural patterns, or accidental exposure to the virus and/or their indifference in spite of knowledge, the discussants came to know about their HIV status not

because they developed a positive reversal of behaviour or assertion. Half of the discussants had to be tested for the reason of processing a visa and the rest were incurably ill, and none of them were willing to have a voluntary counselling and testing as befitting one with conscious and self preserving behaviour.

The development of a different behavioural pattern came over the discussants after they all knew about the disease; following a series of counselling services attended at the organization they joined. This, however, they confessed was a behavioural change they would regret not to have acquired before they got the disease.

Teaching the society about the HIV/AIDS presently, the discussants encounter people with different views of the disease. The fact that death from HIV is not prompt made people so reluctant to protect themselves from contracting the virus. Several people say that; "We can live up to 10 years even with HIV. Do we have any guarantee to live more than that without it?" School children are often misled by the physical appearance of HIV positive people who dress up very well and seem physically healthy.

Neither the short segment TV commercials, nor other IEC channels they believed could lead to the expected behavioral change in the society. People tend to forget/ deny fast about the disease even after attending the burial ceremony of one victimized by HIV/AIDS. They tend to sympathize when someone dies and they will forget it the same evening when they are out. Acknowledgment of the problem of HIV/AIDS eludes both the individual as well as the society. Only three of the discussants disclosed their HIV status to their family, while the rest kept it secret not to hurt family members and in fear of the stigma. They emphasized the fact that stigma is the precipitating factor for revenge. “People should be afraid of the virus, not the people who are living with the virus.”

5.2.2 Street Youth

Two discussion sessions were held among street youth; female and male attendants on separate venues were compared and analyzed. These youth live and work in the streets of Addis Ababa. Two of the girls were born and bred in the street and the rest of the girls lived from one year to ten years on the street. Only one girl out of both groups still attends school the rest being dropouts.

Family disorganization, poverty and economic insecurity, orphanage, parental or guardian abuse were among the push factors whereas such causes as peer influence, substance use and addiction and the options of freedom in the street are some of the beacons of the street life.

Life in the street for the youth in general is about minimal daily subsistence, securing meals and whiling away time. They do not have jobs; hence they get no regular income and do not aspire to get one. They pick on garbage cans and hotel leftovers. Begging and menial labor when available are two of their means of subsistence, but at times they indulge in small robbery and the girls do commercial sex work at night.

They lead a very competitive and conflicting life amongst themselves in order to secure their daily survival. The girls particularly get most of the abuses of the street life. The critical time for females living on the street is the night. Their own friends rape them when they are too tired to defend themselves after the day's hunting for food. Five to six men may rape a girl overnight.

The street youth perceive themselves as socially alienated, stigmatized, discriminated against and above all degraded. They see that the society considers them to be robbers, thieves and useless. And too often they find themselves playing out these roles. They feel that the government remembers them only in time of war for levy. They also claim that police and even

religious leaders do not treat them well. Since neither the organized social institutions nor the general society takes notice of them they walk on like shadows. Consequently, the majority of the street youth succumb to addiction in order to forget their stressful life. Indulgence in drugs seems to be a requirement of the street sub-culture.

Most street youth smoke cigarettes, chew *khat*, smell benzene from gas stations, the latter helps them warm up in time of cold seasons and for its stimulating effect. All of them agree that 90% of street adolescents use substance. The male street adolescents customarily use substances like benzene and other drugs considered being very dangerous.

The family institution in the street subculture dictates the importance of male guardianship in addition to addiction. It comprises an inconsistent guardian male and the girls who pose as wives to the former. The guardianship rule states that no woman shall live on the street without a guardian alias a husband of her choice. If a female street dweller did not choose one of them, she will be subject to all kinds of sexual abuse by all street residents, in their terms called *Borko*. This means that she has no right to resist anyone who wants her sexually in the street subculture. If a girl chooses not to have a guardian, then she will be liable to the rule of *Gibir*, a kind of monetary taxation to a senior street dweller for protection. Only one girl among the discussants doesn't have a guardian, and she claims to be chaste to this day. She is the same girl who still attends school. Four out of the eight girls have given birth, two of whom lost their kids to illnesses.

The protectorate guardians pimp for their 'wives' and use them for income generation. Their clients usually are from the middle to high class of the society. The latter feign and disguise it as aid extended on their part. According to the discussants, the truth is that most of their clients believe they are healthier than prostitutes and hence safer to have sex with.

According to the discussants, some members of the high to middle class society are often engaged in irresponsible acts of sexual exploitation of the street youth. The discussion with the male group revealed that people with socially unapproved sexual orientations at times visit the street youth. Sexual experimentation after watching pornography, sex without condoms as well as sex with disabled clients accrue large sums of money ranging from 200 to 300 birr, which is equivalent to 25 to 38 US dollars.

Having no nuclear family structure, being immune to the society's cultural and religious influences and having developed a peculiar street subculture of their own, the street youth are compelled to nurture a high risk behavioral pattern with respect to sexual matters. High-risk sexual life in the street as dictated by the sub-culture includes guardian or husband exchanges, multi partner sexual contact, and failure to use condom and as a result unintended pregnancy, birth and or abortion. Most of the street youth perceive that they are involved in high-risk sexual behavior.

Knowledge of HIV/AIDS varies among the group. Some are informed and others do not know about the disease. The issue of protection and the importance of self-preserving behavioral tendency don't seem to weigh much in their mind. Denial of the existence of HIV/AIDS is reflected among the group. They say "It is hard to believe that HIV is a reality if we are alive". Apart from the denial of HIV/AIDS, indifference to the hazards of the epidemic seems to be the norm of the street subculture. They are indifferent since HIV is not a priority for them. They say that whoever wants to ask us about HIV is teasing us. Most would prefer to die of HIV than to live on the street. The only pleasure the youth on the street get is having sex without reservation since they have no hope and are frustrated in life. The day-to-day aim of

the male youth is to secure 2 to 3 birr (a local currency which is equivalent to 40 cents in US currency) necessary to sleep over with prostitutes in the *DC sefer*.

5.2.3 Commercial Sex Workers

Commercial sex workers operating in Addis Ababa took part in this focus group discussion. They were all high school graduates. They came from economically disadvantaged and illiterate families. Four had been raised by single mothers and live with siblings; one with her single father and siblings, one was orphaned at the age of ten and the last lives with both biological parents. One of them has two daughters. All but one have the responsibility of income generation for the family. Even though they had the benefit of at least high school education, it was not qualifying enough to get them work. They believed that they became prostitutes for many reasons. Two of them mentioned poor parental guidance about sexual matters and excessive or poor supervision. One mentioned peer influence and the pressure of pimps who work for sugar daddies. Another felt the street and neighborhood where she was selling things in childhood had contributed to her present status as a full-fledged prostitute.

They operate in six distinct and at times blending modus operandi of prostitution.

Street – work, these prostitutes work mainly in the evening and their clients are men who have cars.

Bar prostitution, these prostitutes are employed or help out as waitresses in the various bars and restaurants in the town.

Rented prostitutes, this group of prostitutes rent a room along *DC sefers* for the express purpose of prostitution. A number of girls stand by the gate and solicit clients. They charge three or four birr (half a dollar) and average 3 to 4 clients per day.

Home prostitution, the prostitutes in this line of work have regular home and lead their other wise normal lives. Clients pick them up from home after telephone negotiation with pimps. The clients for these prostitutes are usually foreigners and separated or married men.

Nightclub prostitutes, girls often pay their entrance fee to nightclubs and look for potential clients.

The influence of Sugar daddies and pimps has been discussed by the group as a serious cause of child and school prostitution. They often operate around high schools. Sugar daddies are mostly married men who persuade girls with entertainments and gifts, but if they like the student, they may have her as a "putting". Sugar daddies often meet their girls by the means of the pimps who are mostly boy students or people outside the school community.

Apart from having unrestricted sexual partners, the life of sex workers is characterized by drinking alcohol, smoking cigarettes and using drugs. One of the participants said," We are human beings but our deeds are close to animals. When our human nature clicks our minds, we want to forget our situation. We therefore hide ourselves in alcohol and drugs." They also claimed that some customers urge them to drink much alcohol especially if they want some privilege like having sex without condom or want to have sex in different positions. Some customers often would propose sexual experimentation with pornography on.

Commercial sex work confounds all sorts of high-risk sexual behavioral practices most of which comes in as the side effects of the work; an occupational hazard. Most of the customers do not want to use condoms and seem to have a strong hatred for it and they are often heard saying: "using a condom is just like trying to eat a banana without pealing the skin or it is just trying to eat honey from a bottle container without opening it". The use of condoms as a protection for commercial sex workers is not that reliable. In the first place many people do not

like to use it. Secondly, even if persuaded to, they may pull it out in the middle of the intercourse. The only way to ensure its best use is to adapt it as a female condom. However, no prostitute uses it for it is very expensive in spite of their desire to use it. One female condom costs about eight birr (nearly a dollar).

Commenting on the present footings of the TV and other media concerning HIV/AIDS and condom promotion, the discussants summed it up as failure. It has rather the opposite effect in that it has changed people's perception of HIV in a way that presumes a person living with the virus capable of leading exactly the same life as others. This idea has increased reluctance to use condoms among members of the society. The advertisement on condoms has never been effective in increasing its use.

Generally speaking, the society's knowledge of HIV/AIDS is not that shallow. However, some misconceptions are apparent. There are people who say that they could never contract HIV, as "their immunity to STDs" is high. The group perceives risk of sexually transmitted illnesses including HIV/AIDS, unwanted pregnancy and abortion. Two of the participants gave birth and a few others had history of abortion. They have had histories of STI.

For all their ready risk perception the group had its own dichotomized idea of rehabilitation to other means of living. Half of them claimed that they want to get out of this life while the remaining half said that nobody wants to get out of it once immersed. The latter group supports their argument by saying that by prostitution, one can get money though the life is awful. One girl said, "If I am employed in a restaurant or pastry shop as a waitress, I will get 80 *birr* per month (nearly 10 US dollars). I can get that money or even more per day in prostitution." It is difficult for them to be engaged in so-called "menial work". A participant said, "I can not be engaged in small scale trade or other low class jobs. I would rather continue in my career and

will accept the consequences". The other discussant added "Even if we are engaged in such low class jobs, the money is never enough. There are many things that got into our system as a prostitute such as *Khat*, coffee, fashion, etc. Obviously it is difficult to satisfy those needs by working low class jobs. I myself started to do a manual work but the money was never enough so that I came back to prostitution." The discussants agreed that 50 to 75 percent of the prostitute might like to lead a safe life and get out of commercial sex.

They do not have any vision since opportunities are limited and they are not sure of their HIV status. Most are hopeless and careless about tomorrow. The stigma and discrimination from the society makes life even worse. One of the discussant said, "We are always in disagreement with our consciousness. Even if we do not like what we are doing, we are into it. There is no rule governing in our life."

The participants said that CSWs are not deviants and useless. "It is simply lack of options that led us to such a life despite our education." In the old days, prostitution used to be a very shameful career to have. But these days it is just another way of life. It is all a manifestation of poverty.

The participants are very pessimistic about behavioral change in the society. They say that the slightest hope is on children. The society has to do its best to prevent young children who are increasingly joining the profession. Behavioral change should start from the officials. Those who are broadcasting about behavioral change day and night do not have exemplary behaviors. A lot has to be done. The discussants asserted that they would like the society to be aware that HIV is not a disease of CSW. It could affect anyone. "We are doing it to live, although we know the bad effects of HIV. Let others who have other means of living protect themselves."

5.2.4 Out-of- School Youth

The discussion with the out of school youth was aimed at pointing out the correlates of sexual behavior. Family guidance was considered to be determinant of sexual lives in general terms. The present day family control of children they believed is too coercive and doesn't allow free discussion between parents and children. The discussants asserted that families for cultural reasons consider discussion of sexual content a taboo with in the family.

The influence of friends and peer groups is emphasized because the youth spend more time with their peer group than the family. The youth mostly get their theoretical or practical experience of sexual matters from their peers. Discussions of such issues are sought after and are followed with keener interest than any other topic. A friend can influence them both positively and negatively. On the contrary, a few of them said that peer influence does not affect behavior if there is no inclination from the person. This group said that all that matters is one's strength and self-efficacy in sticking to one's own behavior.

The neighborhood situation influences one's upbringing and behavior. If an individual's surrounding is not good, then the child grows up internalizing those values that are not socially approved. Behavior is relative to the area one lives. If one spends his/her time around places where there are facilities of sport and recreation, like YMCA (Young Men Christians Association) they are going to develop athletic, competitive behavior and will not be exposed to high-risk sexual behavior. On the contrary, if he/she grows up in an area where there are so many bars and *khat bets* and *video bets*, he/she is more likely to develop risky sexual behavior.

The group discussed gender blames for initiation of unintended sexual intercourse. Some of the male discussants believe the way women dress themselves up to be provocative. And this is considered to result in the indulgence in unintended sex by both sex. The majority, surprisingly

more female participants agreed that it is often the girls who initiate and lead the males to risky sexual behavior.

The prevalence of substance use, including addictive ones has increased among the present day youth. They often go to *khat bet*, and *shisha bet*. Cigarette smoking and alcohol consumption is also widely practiced. The males together with their girl friends come to *khat bet*, *shishsa bet* and to the neighboring *video bet*. These days, students often have parties where the use of hashish and alcohol is significantly high. They do have all sorts of competitions at such events that include dancing and kissing; the latter is called *kissana*. The kissing competition is assigned randomly so that the couples often do not know each other before and the couple that stays longest will be the winner. The process is that the students stand in a row and they use a coke bottle to point out one male and one female at random. Such a practice usually ends up in casual sex because the kissing continues longer and deeper. The discussants also mentioned that there are also certain nightclubs, which facilitate such competitions.

The discussants reached a consensus that over 80% of the adolescents are aware of the risks of HIV. Their knowledge, however, is not powerful enough to bring about attitudinal and eventually behavioral changes favoring safe sex. For many of the youth whether to use condoms with a certain partner is decided by his/her physique and appearance. It is wrong to say that adolescents don't have basic knowledge about HIV/AIDS, however, their emotions, sexual desires and other factors rather than rational decision-making guide them when it comes to their sexual lives. Even young people who are trained in anti AIDS clubs can be equally exposed to HIV regardless of the rich information they have about HIV/AIDS.

The participants asserted that behavioral change cannot be attained without a multidimensional effort to change the other problems as well. For instance, if unemployed young people gain

behavioral change education, they will go back to their neighborhood without any other change in their practical lives. They have got no work to do, and they will keep on engaging themselves in their previous activities. So in this case it may not be effective.

Speaking of advertisements, most advertisements are not found to be proper to bring about behavioral change by the participants. Some even make them undermine the problem. They mentioned a current advertisement on ETV (the national Tele Vision station) as an example, which makes HIV a minor stuff. It says, "*Demo le AIDS*" (which has a notion of “so what is the big deal with HIV?” It undermines HIV’s deadly capacity and motivates the youth not to be careful. On the contrary, some of the things presented about HIV portray it as fearsome phenomena. The participants feel that the media aggravates the stigma and discrimination on HIV/AIDS. Another misconception the media creates in viewers is that it is only the males who are portrayed as naughty and the causes of HIV. Advertisements should be well thought of before presentation on the media.

The discussants could not reach a consensus about the local video houses. Some say that it is illegal and it should be closed while others say that they should not be banned, as they are functional for young people. The latter group expressed their anguish by saying; "We cannot stand by the road as we will be labeled as *duriye*, burglar, pick pocket… we do not have anything to do. We just finished high school and could not join College. We do not have any other places to spend our time. We need those places to hide ourselves as long as the films are decent."

Cultural values and sayings, which could possibly indulge young people in high-risk sexual behavior, were also discussed with this group. Discussants came up with different sayings that promote unsafe sexual practices. If a man is privileged to take the virginity of a girl, his peers

consider him as brave. If a guy chases girls, chews *khat* and smoke cigarette (generally use substance), he is considered as *arada* on the contrary those guys who usually are around their homes are considered as *fara*. If a guy is seen around many girls, he is considered as smart and brave. The school culture encourages males to have a girl friend. If a boy is seen with a girl, then he is considered as her boyfriend. The guy eventually thinks that way due to peer pressure. Likewise, if a girl is seen with a boy, she will be considered as socially bad. *Duriye*. This label will lead her to socialize herself as people who are considered *duriye*.

The recommendation of the group on how to achieve a sustainable behavioral change is summarized as follows. Avoid bad company and unhealthy atmosphere. Behavioral change is unthinkable if one is used to spending time in areas that precipitate unsafe sexual practices. Productive places need to be created for the youth. Expansion of recreational facilities like sport centers, public places for games, and properly censored cinemas for the youth were felt to be useful by the discussants. The recreational centers often need to be youth-centered. They should be able to meet their needs and choices and should not be costly as most young people are unemployed. There is a great need to promote discussion about sexual issues among family members and friends. They asserted that, instead of blaming the youth, the family should have behavior changing education and then it should extend to the youth. Peer education is also mentioned as an effective method to achieve behavioral change. Education geared to change behavior should be given in a local context and style (indigenous way), not with “western” style.

The out-of-school youth also mentioned the need to have well-trained counselors who can give advice concerning relationships and courtship for boys and girls during adolescence. They

have also raised their concern about the strict control on drugs. They aired their worries about the possibility of controlling for drugs while people are given legal permits to sell *khat*.

Generally they have suggested that the control measures on HIV/AIDS should not necessarily focus only on the subject of HIV/AIDS per se. Since the problem is a vicious circle, one has to look for a hole in the circle. Measures need to be taken on decreasing the problem of unemployment, reducing substance use, creating healthy physical environment and the like. Otherwise, saying this and that about AIDS without doing the groundwork is ineffective and inefficient. “Clear the vices of poverty first, and then the problem of HIV will be controlled.”

5.2.5 In –School- Youth

The participants in both discussion groups were in junior high school. The reasons the present day youth is exposed to the dangers of HIV/AIDS, according to the participants, were many. Poverty was mentioned as the main reason girls go out with men for the purpose of getting money in return for sexual favors. Those who follow current fashions or ones with an influential friend will seek ways of getting money in order to meet such demands, lest she feels inferior. Another reason mentioned blames the family process. The family values taboo free discussion of sexual nature with offspring. Girls who raise such issues are considered spoiled, so they refrain from the subject. The use of addictive and habit forming substances like drugs, *khat* and alcohol were another reason why the youth is exposed to unsafe sex practices. Lack of recreational and sports facilities within their surroundings usually lead young people to go to *tella bet*, *Khat bet* and *video bet* to watch sex films accompanied by sexual experimentation and indulgence in unsafe sex. The male group discussants agree on all of the above arguments with additional emphasis on such issues as the way girls dress up in a provocative manner to entice boys into sexual conjugation.

Consensus could not be reached on knowledge the youth have on HIV/AIDS. Some believe that most of the youth know about HIV but this knowledge fails to bring about the expected behavioral change. Some others argue that what people know is too superficial and should not be considered as knowledge, why else would we hear them saying that "there is no AIDS after 10:00 pm"? They also commented about the mass media information and educational broadcasts, which couldn't bring about any change. The information has no substance and is not well structured with respect to, for instance age of the audience or viewers.

Considering the family structure and function; the economical status, educational level and the degree of the control towards their children were among the points emphasized. The degree of leniency and allowances for free discussion within a family was mentioned more often as the core of sexual expression in children and the youth. The curiosity of the youth to try out everything should be based on a foundation of free discussion within the family or else it will lead them to learning by trial and error and the latter may sometimes prove to be a fatal one. The family has to learn to trust their youth, and stop considering them suspiciously. Control is good but some allowances have to be made.

Since most parents are illiterate they don't know the importance of free discussion in shaping the sexual lives of their children. Particularly in the case of girls, parents do not want their daughters to talk or hear issues related to sexuality. The youth tend to rely on friends for consultations and discussion on sexual issues. The youth may go with a grave problem out of the league of the friend counselor and advisor; before that, friends take precedence over the family in the day-to-day experience sharing and development of personality.

Environment has a great impact on a child's behavior. A child follows what s/he considers a role model from their immediate surroundings. If a certain girl always observes the life and

style of a commercial sex worker, she just wants to be like her. The characters that dominate in the social environment influence the future behavior of a child. A single girl persistently argued that it is friends and families that determine one's behavior rather than the social environment.

The school environment as different from the immediate environs of upbringing plays a peculiar role, which is entwined with peer group influence and the exemplary figures of teachers who may assume the place of guardians or family within the school compound. The school environ is described in consideration of the many *tella bet*, *khat bet* and clubs in place of which public libraries and healthy recreational centers should have been built.

Teachers these days are negligent and have no feelings of responsibility to their students especially after the introduction of teachers' evaluations by students. At times, controlling the behavior of the students would go beyond their capacity. Sometimes teachers themselves do not demonstrate good exemplary behavior towards their students. If a student observes his teacher smoking, he might consider smoking as socially acceptable behavior and the same is true for other behaviors. Behavioral change should start from the so-called “role models”.

The ISY raised some of the normative issues that may be responsible for development of high-risk sexual behavior. Family gives more freedom of choice to boys than girls. The unequal treatment of boys and girls at home is reflected in society making girls more submissive and not assertive of their rights. Boys who may be decent, or pass their time in the house are considered as *fara* and they will be compelled to go out “*eski wota bel*” an Amharic equivalent to just go out and explore the world, on the other hand if a girl participates in public activities like in anti-AIDS clubs or have many friends she will be considered as *wonda-wonde* (an Amharic equivalent for male-like) or *duriye*.

The youth came up with such sayings, as "*bewotatinetih tetekemibet*" meaning "do what ever you want to do while you are still young". Catch phrases like "*kebelu tibis kenedu DX kemotu be AIDS*" (an amharic equivalent of "if you are to eat go for grilled meat, if you are to drive go for Toyota DX and if you have to die, die of AIDS"), and "There is no AIDS after 6:00 pm" are common among the youngsters. Most young people say, "Life is in high school" with the idea imparted here being having boy/girl friend and *khat* chewing and smoking etc. A boy is expected to get or have a girl friend, if he doesn't he is nudged *yaz enji* (an equivalent of what are you waiting for, catch one).

VI. Discussion

Most people are sensitive to questions related to sexuality. Although the questionnaire based interview was a most efficient way of minimizing non-response rate and maximizing completeness of a questionnaire, it has its own limitations. One of the main limitations is the social desirability bias. A maximum effort was done to convince study subjects to tell us the truth by explaining the objectives of the study. To ensure reliability of information on this sensitive issue, young interviewers of their ages were recruited and interviewer of the same sex was used as much as possible. The wording and phrasing was corrected for appropriateness after pre-test and intonations and approach while asking sensitive questions were well covered during the training of the data collectors. Privacy of the subjects was highly maintained by avoiding questions referring to identity including names. To minimize dissemination of information about the survey and avoid prior preparedness by the respondents, all interviewers collected information from the same *kebele* in a short period of time mostly a day.

Method triangulation was employed both to supplement the survey by maximizing clarity of information collected and complement the study by addressing the hard to reach youth groups such as the CSWs, PLWHA and the street youth. The retrospective information obtained from PLWHA was very instrumental to clarify and interpret ideas that have been controversial or unclear in the quantitative part.

The sample taken for the survey represents proportional number of index cases with respect to age and sex. The age distribution depicted slightly more teenagers in their late adolescence than youth above 20 years. This matches the findings for demographic data from the general Ethiopian population statistics and others (19, 22). Thus, it is reasonable to claim that the findings are relatively generalizable.

With respect to dwelling places, the sample group was taken in proportional figures from both the inner city and from the periphery of the city limits. The basic assumption for this was that people living in inner cities may have a higher exposure to vices of urban poverty and eventually to risky sexual behavioral patterns. The sex ratio 1:1.4 in favor of females gives an acceptable representation of both sexes. The same goes for the focus group discussion attendants with a slightly higher number of female attendants than males.

The religious constituency of the sample group shows a predominance of orthodox Christianity (80%). Proportionally Christianity balances the Muslim population in Ethiopia. The discrepancy of the sample group with respect to religion may be explained by the characteristic dwelling system of the Muslim population in Addis Ababa. Muslims tend to dwell in close clusters; hence the random sampling technique used to choose the areas might have left such places underrepresented. This discrepancy with respect to religion was also seen on the sample group in other studies (22, 33).

The proportion of youth living with their both biological parents was only 50%. This conforms to the prediction on the changing patterns of adolescent sexual behavior being a prey of, among many factors, the changing situation of present day and future trend of family structures (22).

The perception of the study subjects about the socio-economic status of their parents was used to assess parental economic stand as opposed to annual earnings. This was because of the fact that many people find it difficult to explicitly tell the income of their parents or it is difficult to know because of its irregularity. The majority (90%) in our sample perceives their economical background to be that of very poor or average with only 10% reporting liberation from the ill effects of economic disadvantage. This finding goes along with other study conducted on

school going adolescents where only 12% of them perceived themselves to be from rich families (33).

More than ninety percent of the sampled youth have been enrolled in school, and two third of them are currently attending school in junior and high school grades. Regardless of their educational level, only a third (33%) are employed, largely in the informal sectors. Nearly half of the respondents have the responsibility of supporting their families economically. Most young people are desperate about the severe unemployment that exists in the country. This was also seen on the CSWs and the PLWHA in the FGDs and most of the cases.

Both qualitative and quantitative data revealed, for the most part, a picture of poor socioeconomic status. Nearly 70% of the neighborhoods have no recreational facilities appropriate for the youth. The unhealthy physical set up that exists in most neighborhoods is responsible for the development of risky behavioral patterns.

Sexual Behaviour and Condom Use

A little over a quarter (28%) of the youth in this study is sexually active. Our finding is low compared to most other studies in the country, 42 % in rural Gondor (28), 50% in Harar (29) to 59.3% in Bahir Dar (22). The rate of sexual activity in this study is almost half of the one reported in Dar-es-salaam (55%) (27), but higher than the finding in Scotland (18%) (13). More males were sexually active than females (40%: 18%). This trend for any given age is similar with most studies reported (8, 13, 27, 29, 23, 29, 30, 52, 54). However, recent studies (19, 28) in Ethiopia reported higher percentage of girls being sexually active. Sexual initiation among females is relatively earlier than males in our study, which was seen in previous studies too (23, 54). Nearly two third of the sexually active youth were with in the age range of 20 to 24 years and were out of

school. Likewise, Taffa has reported that out of school, male, age 20 – 24years, predicted the likelihood of engagement in sexual intercourse (52).

Over two third of the sexually active had their first coitus with their steady friends compared to a study conducted in Jimma, Ethiopia that revealed 47% of the youth had their first practice with prostitutes (32). If underreporting has not masked the reality, the higher inclination of the youth to have their first sex with steady friends is something that needs to be encouraged. In this study, partners forced in only 1.9% of those who had sexual practices, a very low figure as compared to 45% of the females and 32% of the male high school students who reported sexual coercion in Nigeria (54). The lower proportion of forced sex in our survey may be attributed to underreporting, relatively less possibility of the act in an urban setting or the absence of significantly exposed groups such as street youth in the survey.

Condom use seems to have improved from 36.5% at debut to 63.9% with in the last 6 months of sexual activity reported. Condom use on subsequent practice is higher in our study as opposed to 25 % in Ghana and 4% and 15% among women and men in Tanzania respectively (25, 31). Regular usage of condom is claimed by only a third (30.8%) of the sexually active youth in our study, which is slightly higher than 22.6% on previous study among OSY in Ethiopia (37). Contrary to ones expectations, only 34.9% of those who drink alcohol and 24.3% of those who take drugs before sex confessed to have used condom incorrectly or inconsistently. However, almost all the focus group discussions and the case studies (see appendix) blamed alcohol and drug use for incorrect and inconsistent use of condom. The CSWs expressed their extreme desire to use condom, had it not been for their clients who prefer to have flesh –to-flesh contact during intercourse. Their desire to use a female condom is hampered by the high cost of female condoms in the market, which calls for an intervention.

Few (2.3%) of the sexually active subjects confessed ever having sexually transmitted infections (genital ulcers and/or discharges); which is lower than 7.8% in Gondar, Ethiopia (28). Given the poor condom usage rate by the various study subjects and high rate of multi-partner sexual contact, one would rather have expected higher rates of reported STI.

In this study 20.5% had history of pregnancy and 27.7% abortions. Similarly, out of 41.2% pregnancies reported by the study in Gondar, 17.1% ended up in induced abortions (28). A higher abortion rate was seen to have leaped up to 75% among high school students in Harar, where 20% had been pregnant (30). Knowing that illegitimate children are highly uninvited, the amount of pregnancy and childbirth reported is a huge burden for unmarried youth in Ethiopia.

Youth and Family

All the discussants in each focus group agreed that parental monitoring is important but should not be either too strong or too lenient. Both supervision and lack of supervision from parents could contribute to unsafe sexual behavior (8). However, strong parental supervision was found to be protective from sexual indulgence in our survey. Parental monitoring had no effect on female sexual behavior but boosts self-preserving behavior among the males (64). The observed significant relationship of parental monitoring with risky sexual behavior calls for an investigation of the nature of monitoring.

Considering the degree of family and sibling attachment in the study group, three quarter boasted strong family attachment. This degree of attachment, however, doesn't seem to allow for free discussion on sexual issues. Three quarters of the youth do not discuss sexual matters with their parents. The same was true in our focus group result in that the youth do not discuss these issues for cultural reasons; they believed that most parents were too traditional and consider discussion of sexual nature is a taboo in Ethiopia (23). Adolescents with whom

parents had discussed family life issues were less likely to be sexually active than those with whom parents had never discussed such issues (47); nevertheless, this was not the case in our study. Nearly half of the youth claimed discussion of sexual issues with other members of family. However, it was not found to be protective of high-risk sexual behavior. The situation of the street youth exemplifies the no family scenario without parental monitoring or free discussion (48).

The silence about sexuality extends to the extent that people hide their HIV status to their parents, which is often related to sexual behavior. Most of the youth living with the virus in our focus group discussions and the case studies did not disclose their HIV status for their families in fear of stigma.

Regarding family structure, all but one of the HIV victims in our study were raised up by a single parent or relatives. Even if the survey result does not show statistical relation between family socio-economic situation and indulgence in sexual activity, the FGD with all groups emphasized the association of sexual behaviour with socio-economic situations of the family. The victims of HIV in the case studies and in the discussion groups were all from very poor families during their formative periods. Similarly, all the CSWs and the street youth are from unstable and very poor mostly single-headed families.

Peer Influence

The influence of peers on the sexual behavior of the youth is a well-established fact as confirmed by previous researchers (61, 62). Peer pressure was expressed as a very strong if not the strongest factor that influences adolescent sexual behavior in comparison with family by both the in school and out of school focus group attendants. The youth often share their problems to their friends than to their family members. The effect of peer influence is the rule

in case of street youth who don't have any other alternatives. Youth whose peers favor abstinence were found to be less likely to have initiated sexual intercourse (61). Likewise, the association of having sexually active peers and being sexually active was statistically evidenced in this study. Peers could also have a positive influence as was raised in the discussion with OSY.

According to the problem behaviour theory, risky sexual behaviour co-occurs with other problem behaviours such as substance use and delinquency (9). In line with the problem behavior theory, young people who were accused of a delinquent act were indulgent in high-risk sexual behaviour in this study. Concordant outcome was observed in other studies in that affiliation with deviant peer group is an easy way to sexual risk (9).

Peer group discussion provides a free and easy venue for sensitive issues concerning sexual matters. The diffusion theory of epidemics was likened to the diffusion of sexual behavior among peer group as well (22). Given the high, nearly (80%) of strong to moderate degree of attachment with peer groups as reported by the participants of the survey, one can infer how much diffusion of sexual behaviors goes around the youth.

Social Life and Context

Various aspects of the social behavioural patterns of youth, as to how, where and with whom the youth spend their time is believed to influence sexual behaviour. Irrespective of the location of their place of residence with in the city limits, two third of the study subjects watch western video films and a third watched adult movies more than once. On the same issue of video shows the various focus group discussants expressed the need for and against video shows. In our survey, young people who have never seen pornographic films were less indulgent in sexual acts. Most of the discussion on the pornographic films condemned the shows as the very sources of sexual

experimentation and especially of hitherto unknown types of sexual conjugations, which are highly risky. The youth turns to these pastimes for lack of appropriate recreational facilities with in their premises and also for lack of information on sexuality. Participation of the study subjects in Anti-AIDS clubs seems to be very low. These seemingly specialized clubs are believed to offer information and peer educational venues on HIV/AIDS, although the survey did not witness a benefit of joining such clubs on sexual behaviour.

School performance as probed from the youth by missing classes and failing exams was not found to be statistically associated with sexual behaviour. However, the FGDs and the cases affirmed the fact that many young people who are truants are engaged in high risk behaviours. The reasons behind skipping school as explained by attendants of the focus group discussants is the various beacons around school compounds namely *tella bet*, *video bets* and *khat bets*. These school neighborhoods present the youth oriented to delinquency and class skipping with the physical ground conducive of high-risk sexual behavior development.

Unlike the expectation of many of us, sexual indulgence was seen twice more on youth who are active in the labor force. This could be attributed to the frustration faced by working youth who often fail to satisfy their needs as per the norms and expectations of the society due to very low earnings. This fact was evidenced by one of the cases who indulged himself in high-risk sexual behavior when he failed to fill the gap between his income and societal expectation. Sex is seen as leisure time activity for adolescents who are unemployed and have nowhere else to go. Social services being unavailable or unaffordable for many of the people who are by and large poor, people resort to local bars and hotels during their leisure time (23). Street youth particularly get the worst of the lot, in that they loiter around getting the experiences rather the bad influences of low socioeconomic situations. The contribution of healthy neighborhoods

with public libraries and alternative recreational centers like YMCA were noted to promote healthy behaviors.

Normative sayings and community proverbs which encourage the youth to experiment sexual practices "*bewotatinetih tetekemibet*" "*yaz enji*" and those which undermine the gravity of HIV "*demo le AIDS*' from which the youth learn and try to justify its behavior like "*kebelu tibis kenedu DX kemotu be AIDS*", and "There is no AIDS after 6:00 pm" play major roles in the development of high risk sexual behavior.

Substance Abuse

The percentage of ever use of alcohol (30%) was almost an average to another study on ISY in Ethiopia that ranged from 17.9% in public to 57.8% in private high schools (68). Our finding is less compared to 69% of adolescents in the US (73). *Khat* use was admitted by 14% in our study while it was reported by 22% of high school students on average (68). We found low use of hashish, almost no use of hard drugs. Five percent of the youth admitted ever use of cigarette in the survey, which was also the case in other drug study (68). Smoking cigarettes was claimed to be a prerequisite for *khat* chewing by the various focus group discussants. Most of the reported drugs are relatively mild in effect. However, the use of unregulated mild illicit drugs will eventually graduate to the use of hard drugs. The street youth confessed that the proportion of substance use is very high. The same goes for commercial sex workers. Excessive use of alcohol and drugs were retrospectively blamed as correlates of high risk sexual behaviour by PLWHA in the FGD and the cases.

Awareness of Dangers like HIV

All but a single respondent, who recently came to Addis and engaged in domestic work, heard and are aware of HIV/AIDS in this study, a high figure when compared to any other studies in

Ethiopia (23, 37). This should not be a surprise, given the increasing death toll of HIV everyday and the high IEC effort in urban settings. A knowledge score of (95.4 %) was reported in Gondar (37) and 91.9 % in Nigeria (68). Personal first hand experience of the disease as learnt from having a close relative or friend with the illness in half of the cases and from acquaintance of a person with the illness for a third of our study subjects may explain the better knowledge score recorded. All the focus group discussants, like wise, have the awareness of the disease but the heated debate on the sessions highlighted the fact that the issue of "knowledge" is certainly controversial. PLWHA believe that people do have the knowledge now than previously while some other groups mentioned the superficial nature of it. Given the level of knowledge of HIV/AIDS, with high acknowledgement of its global nature and multidimensionality of the pandemic's threat, the respondents' perceived vulnerability is low in our study. A remarkable minority of (5.3%) declared personal susceptibility. This figure contrasts with what Ismael reported from Gondar, where 60.7% perceived risk of getting the disease (38). The great majority of our survey subjects seem to be eluded by a false sense of security. In light of the considerable sexual activity, the presence of multi-partner sexual contact, and minimal regular condom usage habit, it is easy to surmise that they got a false sense of security. On the other hand, high sense of vulnerability was noted among the CSWs and the street youth, unlike the risk perception reported among South African street youth (48). Their high risk perception may be the result of their indulgence in high risk behavior.

The FGD with the street youth and CSWs confirms that, there are sections of the youth whose voices are unheard. People do have the knowledge and they have the intention to protect themselves. Unlike the explanations given by theory of reasoned action, which proposes that behavior is determined by the individual's intention to perform or not to perform the behavior,

these socially disadvantaged groups of the society have no power to protect themselves from HIV. Similarly, other behavioral models like the Social Cognitive Theory, the HBM, and the KAP model, fail to fully explain behaviors of individuals who are in different social milieus. Thus, the notion of knowledge and intention often remains to be unsolved. Obviously the great majority who know about the disease, with their corresponding attitudes, fail to practice self-preserving methods against high-risk sex. This fact is supported with other studies from Ethiopia (23, 36, 37) and South Africa (48, 56). This would lead us to say that knowledge is not a sufficient but a necessary factor to bring about behavioral change (8). Another study in Ethiopia also reported an inverse relation between knowledge and high-risk sexual behavior (17).

All this argument is not to undermine the importance of knowledge in the promotion of safe sexual behavior. From the focus group discussions, it was possible to understand that different points should be emphasized for different groups of the society. In other words, the type of information that needs to be reinforced for street youth is different from the one for CSWs, ISY or OSY. This is because they are living in a totally different social context. The problem of contextualizing the problem is visible. The content and context of providing information should be well attended to bring about effective preventive interventions. This issue was also emphasized by Eshete (23). The FDG with ISY and OSY found the spots and captions of HIV information on Medias at times misleading.

Gender Issues

Most studies seem to agree on the gender susceptibility with respect to females to be the most vulnerable group. This fact was supported in our qualitative study as well. Female street youth are more vulnerable to sexual abuse and exploitation than males. Female sex workers are not in

a position to bargain with their clients on equal footings. The same fact was supported by female victims of HIV whereby most of the participants in the FGD and the cases were exposed to HIV due to their culturally approved gender role differentiation and power of social and economic origin. We can infer that there is an apparent gender differences in HIV risk behavior and their correlates. Thus it is more likely that interventions that are custom-tailored specifically to either sex should be more successful than a general approach.

Social Disadvantage

The street sub culture which dictates high risk sexual behavior by way of multi - partner sex (side business prostitution, forced sex, casual sex, and partner exchange) and no option of using condom, exposes street youth to HIV more than other youth groups. Street youth are often cut off sources of information (do not attend school, have no access to media) to reinforce the information they have about the disease, have a very poor living situation even to sustain life for the day, perceive themselves as useless and hated by the society. The issue of HIV was not a priority at all for street youth in our study. Similarly, fear of AIDS and efforts to protect themselves from it was not also found to be a main concern for youth living on the street (48).

Selling sex turned out to be lucrative for both male and female street youth. Often their clients are those people who would like to have socially unapproved types of sexual practices. High uses of alcohol and drugs, not to mention alcoholism and addiction as social ills, definitely expose them to high indulgence in risky behaviors. This practice endangers the public at large.

Stressful and socially impoverished living condition, sense of powerlessness to protect their health and wellbeing, the ever-present sense of insecurity and vulnerability coupled with unforeseen chances of changing the situations led street youth to develop careless and

impulsive sexual behavior they have now. People who are socially disadvantaged believe that they are unable to control their lives and to make things better (75). The interaction of all these factors would not allow them neither to protect themselves nor even to care about it. The ever-increasing death toll from HIV, eventually increase the number of AIDS orphans who probably would soon join the street youth. This leaves the problem in a vicious circle.

The analysis of the discussion with CSWs revealed that the decision to use condom is not something that takes place between two equally consenting adults. Their capacity to promote protective measures is very limited and their bargaining power is apparently low. Here again the behavioral theories and KAP models which spin around decision making and an individual's health related knowledge and attitude to explain behavior hardly work. This fact was raised by a previous study conducted on South African youth (48). Being poor does not allow one to have an option. The same thing was reported by sex workers in Ghana (72). The problem of unemployment and the pervasive poverty that urges them to support themselves and their families is manifested by the fact that high school graduates had no chance of paid employment but sex work. Prostitution is likely to flourish in the future, given the high rate of unemployment in the country. The monetary incentives offered by the clients to make different types of sex facilitate the transmission of the disease.

These two socially disadvantaged groups are more vulnerable to HIV than any other youth groups. As Farmer argued (74), we have to look for the differential effects of social forces on unequally positioned individuals in the society.

The Multi-Systems Model

The web nature of high risk sexual behavioral correlates need to be spun in to a thread line for one to be able to figure which one or another is significant enough for one to design a possible interventional scheme.

With in the self system, age, sex, labor force status, watching pornography, alcohol consumption, *khat* use and having taken the HIV test showed significant relationship with high- risk sexual behavior. Other studies also found different combinations of these variables as predictors of high risk sexual practice (12, 51, 52, 33, 42). With in the family system, parental supervision protected young people from sexual risk taking. This fact was augmented by the FGDs and the cases as well. The qualitative data also reflected a view that parent-child communication about sexual matters is crucial in promoting safe sexual behavior. Although statistical significance was not evidenced between sexual behavior and the family structure in our survey, all the victims of HIV in the cases and FGD were suffering from family disorganization.

As far as the extra family system is concerned, unhealthy social environment in the neighborhood such as the *khat bets, tella bets, video bets,* coupled with the rampant unemployment led young people to indulgence in other delinquent behaviors including substance abuse. The focus group discussion with the various attendants and the cases furnished an elaborate description of the neighborhood effect on adolescent sexual behavior. Such neighborhoods are fertile grounds for the production of hopeless, delinquent youth who have reckless, impulsive sexual behaviors. Association with such peers further opens the door for others to adopt the behavior. When such practices are repeated, they will have their own pattern and eventually graduate to communally held ideas and believes. At this point, many

normative sayings and catch phrases came into picture in order to justify actions. What has been a saying for one generation will be a norm for the coming one. Therefore, a factor in the self system affects other factors in the family or extra family system which further affects sexual behavior.

Sexual behavior is the result of the inter-relation between the systems. Drawing the organic analogy, in order to keep the entire system well functioning, addressing all factors and the relation with each another is mandatory. Thus to bring about behavioral change, simultaneous multi-dimensional intervention is more gainful.

VII. Conclusions

- Sexual behavioral development and high-risk sexual practice evolve out of the chemistry of personal, familial and extra familial factors. The various factors give conclusive evidence of concurrent action in shaping up youth sexuality and development of high-risk sexual behavior.
- Sexual practices of young people in urban Addis Ababa are by and large associated with high risk of acquiring HIV infection.
- Males, aged 20-24, who are actively engaged in the labor force, who consume alcohol, chew *khat*, who watch pornography and who have undergone an HIV test were more indulgent in sexual risk taking.
- Parental monitoring is found to be protective of sexual indulgence.
- HIV-risk behaviour does not occur in a vacuum. Association with delinquent peers and having sexually active friends were correlated with risky sexual behavior.
- Inner city poor neighborhoods with no healthy recreational facilities for youth were highly related with substance abuse (alcohol consumption, *khat* use), watching pornographic video and delinquency and eventually high risk sexual behavior.
- Parent-child communication about sexual issues is a taboo while it proved to be protective factor of high-risk sexual behavior. The evident high degree familial attachment and monitoring especially with females and the in school youth could be used to facilitate free discussion on sexual issues.
- The risk of HIV/AIDS is more pronounced on socially disadvantaged groups such as the street youth and Commercial Sex Workers due to the low social power they have. Special attention prompt intervention should be made for these vulnerable groups.

- Although the general trend of condom use among the youth is unsatisfactory, CSWs were found to have the desire to use female condom had it not been for its high cost.
- Knowledge about HIV/AIDS is adequate but it cannot be translated it into self-preserving attitude and eventually to the development of safe sexual behavioural patterns due to other factors beyond the individual.
- Failure to bring about behavioural change is engrained in the larger structure of poverty.

VIII. Recommendations

- HIV preventive efforts should take consideration of the various factors that determine youth sexuality. Interventions should aim at altering the broader social and material conditions, which encourage high-risk sexual behavior. Thus, there is a need to firmly integrate the issue of HIV prevention with the larger poverty reduction strategy.
- Proper drug policy that regulates the use of illicit habit forming and mood altering drugs need to be considered by the government.
- Sensitize the community about the normative sayings, which eventually lead a person to risky sexual practices. There is a great need to promote free discussion about sexual issues between parents and children.
- The issue of sexual behavior should be contextualized with in the larger structural framework; including all social, cultural, economic, political components. Thus further study is needed to come up with an all-inclusive model to explain behavior.
- Family life education is more appropriate for pre-teen youth in order to improve courtship skills through the youth counseling services or the school system.
- Expansion of healthy recreational facilities like sport centers, public places for games, and properly censored cinemas for the youth need to be considered. Strict control on illegal video houses that show pornography and extra ordinary clubs is necessary.
- The content of information and the context in which health educations are given should be given due emphasis before presented to the public. Close monitoring of the media advertisements is needed. Correcting cultural sayings, which promote high-risk behavior, is mandatory. Health education should be custom-tailored to the different groups of the society; gender sensitive approaches are indispensable.

- The government, social institutions and mutual help associations should address the social problem of homelessness and prevent factors that lead children to go out to the streets.
- Further study is needed to understand the correlates of risky sexual behavior among socially disadvantaged group such as street youth and CSWs. Different intervention is needed for groups in totally different social contexts.
- Expansion of VCT centers with well-trained counselors in order to promote safe sexual behavior.
- The problem of HIV/AIDS is beyond the scope of public health that multi-disciplinary team is better equipped to study the socio-cultural aspects of sexual behavior.
- Promotion of female condoms and improving its availability and accessibility seems to be a better option for Commercial Sex Workers.

References

1. UNAIDS/WHO. "AIDS Epidemic Update." Geneva. December 1998
2. UNAIDS/WHO. "AIDS Epidemic Update." Geneva. December 2000
3. UNAIDS/WHO. "AIDS Epidemic Update." Geneva. December 2002
4. UNAIDS. "Young People and HIV/AIDS: Opportunity in Crisis."2002
5. MOH. "AIDS in Ethiopia." Addis Ababa:2002
6. NACS. "National AIDS Council Secretariat. Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2001-2002)", 2000. Addis Ababa. Ethiopia
7. MOH. "AIDS in Ethiopia". Addis Ababa:2002
8. Eaton L, Flisher Flisher A.J., Aarø L.E. "Unsafe Sexual behavior in South African Youth." *Social science & Medicine.* 2003 March 56(1):149-165
9. Kotchick BE, Shaffer A, Miller K.S, Forehand R. "Adolescent Risk Sexual Behavior: a Multi system Perspective "*Social Science & Medicine* 2001 June 21(4):493-519
10. UNAIDS. "Sex and Youth: Contextual Factors Affecting Risk for HIV/AIDS".Geneva:1999
11. WHO. "Sexual Relation among Young People in Developing Countries: Evidence from WHO Case Studies". Geneva. 2001
12. Bachanas PJ. Morris MK. Lewis-Gess JK. Sarett EJ. Sirl K: Ries JK. et al. "Predictors of Risky Sexual Behavior in African American Adolescent Girls: Implications for Prevention Interventions." *Journal of Pediatric Psychology* 2002 27(6):519-530
13. Henderson M, Wight D, Raab G, Abraham C, Buston K, Hart G, Scott S. "Hetrosexual Risk Behavior among Youth Teenagers in Scotland." *Journal of Adolescence* 2002 25: 483-494
14. Latkin CA, Forman V, Knowlton A, Sherman S. "Norms, Social Network, and HIV- Related Risk Behaviors among Urban Disadvantaged Drug Users" *Social Science & Medicine* 2003 56:465-476
15. Price N. Hawkins K. "Researching Sexual and Reproductive Behavior: a Peer Ethnographic Approach." *Social Science & medicine* 2002 October 55(8):1325-1336

16. Varkevisser C M. Pathmanathan I. Brownnlee A. “Designing and Conducting Health system Research Projects: Proposal Development and Fieldwork” International Research Development Center. Ontario. Canada. 1991

17. CSA. ”The 1994 Population and Housing Census of Ethiopia, Results for Addis Ababa” 1999. Vol. II. Analytical Report. Addis Ababa

18. Taffa N. "Sexual and Reproductive Health Status of Youth in Urban Ethiopia". (Unpublished); 2002.

19. Govindasamy, Pav, Aklilu K., Hailom B. "Youth Reproductive Health in Ethiopia" Calverton, Maryland. ORC Macro. 2002

20. Abdurehman A, Enqouselassie F. “Demographic impact of HIV/AIDS in Addis Ababa. “ *Ethiop Med J*. 2001 March; 39(1): 9 – 22.

21. Laga Marie. "Epidemiology and Control of Sexually Transmitted Diseases in Developing countries." Paper presented at the tenth International Meeting of the International Society for STD Research", Helsinki, Finland, August 29 to September 1, 1993, Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerpen, Belgium.

22. Romer D, Stanton BF. “Feelings about Risk and the Epidemic Diffusion of Adolescent Sexual Behavior. “ *Prevention Science* 2003 March 4(1): 39-53

23. Eshete H. sahlu T. "The Progression of HIV/AIDS in Ethiopia" *Ethiopian Journal of Health Development*. 1996 10(3):179-190

24. UNAIDS/WHO. "AIDS Epidemic Update." Geneva. December 2003

25. Kapiga SH, Lugalla JLP. “Sexual Behavior Patterns and Condom Use in Tanzania: Results from the 1996 Demographic and Health Survey.” *AIDS Care.* 2002 14(4):455-469.

26. Mekbib TA. “Reproductive health: conceptual and operationalization challenges.” *Ethiop Med J*. 2001 March; 39(1): 61 – 73.

27. Maswanya E S., Moji K., Horiguchi I., Nagata K., Aoyagi K., Honda1 S., Takemoto T. "Knowledge, risk perception of AIDS and reported sexual behavior among students in secondary schools and colleges in Tanzania” *Health Education Research*. 1999 April 14(2):185-96.

28. Dawud A. “Perception of the Risks of Sexual Activities among Out-of-School Adolescents in South Gondor Administartive zone, Amhara Region.” Thesis submitted to A.A.U, School of Public Health.2003

29. Korra A and Haile M. "Sexual Behaviour and Level of Awareness on Reproductive Health among Youths: Evidence from Harar, Eastern Ethiopia" *Ethiopian Journal of Health Development*, 1999; 13(2):107-113

30. Bisrat F, Pickering J. "High School Students' Knowledge, Attitude and Practice of Contraception in Harar town, eastern Ethiopia." *Ethiopian Medical Journal*. 1994 Jul; 32(3): 151 – 9.

31. Adih WK. Alexander CS. "Determinants of Condom Use to Prevent HIV Infection among Youth in Ghana." *Journal of Adolescent Health.* 1999 March 24 (1):63-72

32. Larson C, Assafa M, Aboud F, Shiferaw T. "Risk behaviors for HIV Infection: their Occurrence and Determinants in Jimma – Town, Southwestern Ethiopia." *Ethiop Med J*. 1991 Jul; 29(3): 127 – 36.

33. Berhane F. "Health Problems and Service Preferences of School Adolescents in Addis Ababa: With Emphasis on Reproductive Health." Thesis submitted to A.A.U, School of Public Health.2002

34. D Alene G, G Wheeler J, Grosskurth H. "Adolescent reproductive health and awareness of HIV among rural high school students, North Western Ethiopia." *AIDS Care*. 2004 Feb; 16(1): 57 – 68.

35. Zellner SL. "Condom use and the accuracy of AIDS knowledge in Cot d' Ivoire." *International Family Planning Perspective*. 2003 Mar; 29(1): 41 – 7.

36. Teka T. "AIDS related knowledge and behaviors among college students, Gondar, Ethiopia: a comparative study." *Ethiopian Medical Journal*. 1997 Jul; 35(3): 185 – 90

37. Fantahun M, Chala F. "Sexual Behavior, and Knowledge and Attitude towards HIV/AIDS among Out of School Youth in Bahir Dar Town, Northwest Ethiopia." *Ethiopian Medical Journal*. 1996 Oct;34(4): 233 - 42

38. Ismael S, H/Georgis F, Legesse D, Alemu E, Regassa K, Abdella M, Shibeshi M. "knowledge, attitude and practice on high risk factors pertaining to HIV/AIDS in a rural community." *Ethiopian Medical Journal*. 1995 March; 33(1): 1 – 6.

39. Ntozi JP, Najjumba IM, Ahimbisibwe F, Ayiga N, Odwee J. "Has the HIV/AIDS epidemic changed sexual behavior of high risk groups in Uganda?" *Africa Health Sci.* 2003 Dec; 3(3): 107 – 16.

40. Basen- Engquist K, Masse LC, Coyle K, Kirby D, Parcel GS, Banspach S, Nodora J. "Validity of Scales Measuring the Psychosocial Determinants of HIV/STD-

Related Risk Behavior in Adolescents." *Health Education Research.* 1999 14(1): 25-38.

41. Magnani RJ, Karim AM, Weiss LA, Bond KC, Lemba M, Morgan GT. "Reproductive Health Risk and Protective Factors among Youth in Lusaka, Zambia." *Journal of Adolescent Health.* 2002 March 30(1): 76-86

42. Seme A. "The Association between Substance Abuse and HIV infection among People Visiting HIV Testing and Counseling Centers in Addis Ababa, Ethiopia." Thesis submitted to A.A.U, School of Public Health.2002

43. Lam T. H.,Stewart S. M, Ho L.M; Youth Sexuality Study Task force 1996, The Family Planning Association of Hong Kong. "Prevalence and Correlates of Smoking and Sexual Activity among Hong Kong Adolescents." *Journal of Adolescent Health*. November 2001. Vol 29, Issue 5, pp 352-358

44. Belew M, Kebede D, Kassaye M, Enquoselassie F. "The magnitude of Khat use and its association with health, nutrition and socio – economic status." *Ethiopian Medical Journal*. 2000 March; 38(1): 11 – 26.

45. Li X. Stanton B. Cottrell L. Burns J. Pack R. Kaljee L. "Patterns of Initiation of Sex and drug Related Activities among Urban Low Income Africa-American Adolescents." *Journal of Adolescent Health.* 2001 March 28(1):46-54

46. Umar US, Adekunle AO, Bakare RA. "Pattern of condom use among commercial sex workers in Ibadan, Nigeria." *Afr J Med Sci.* 2001 Dec; 30(4): 285 – 90.

47. Odimegwu CO, Solanke LB, Adedokun A. "Parental characteristics and adolescent sexual behavior in Bida Local Government Area of Niger State, Nigeria." *Afr J Reprod Health*. 2002 Apr; 6(1): 95 – 106.

48. Swart – Kruger J, Richter LM. "AIDS – Related Knowledge, Attitude and Behavior among South African Street Youth: Reflections on Power, Sexuality and the Autonomous Self." *Social Science and Medicine*. 1997 Sep; 45(6): 957 – 66.

49. Versnel M, Berhane Y, Wendte JF. "Sexuality and contraception among never married high school students in Butajira, Ethiopia." *Ethiop Med J.* 2002 March; 40(1): 41 – 51.

50. Ajuwon AJ, Olley BO, Akin-Jimbo J, Akintola O. "Experience of Sexual Coercion among Adolescents in Ibadan, Nigeria." *African Journal of Reproductive Health.* 2001 Dec 5(3):120-131.

51. Taffa N, Sundby J, Bjune G. "Reproductive Health Perceptions, Beliefs and Sexual Risk Taking among Youth in Addis Ababa, Ethiopia." *Patient Education and Counseling*. 2002 Feb 49(2): 165-169.

52. Taffa N. Klepp KI, Sundby J, Bjune G. "Psycho-social Determinants of Sexual Activity and Condom Use Intention among Youth in Addis Ababa, Ethiopia." *Int. J STD AIDS*. 2002 Oct; 13(10): 714 – 9.

53. Friedman HL. "Changing Patterns of Adolescent Sexual Behavior: Consequences for Health and Development." *Journal of Adolescent Health*. 1992 JU; 13(5): 345-50)

54. Slap GB, Lot L, Huang B, Daniyam CA, Zink TM, Succop PA. "Sexual Behavior of Adolescents in Nigeria: Cross sectional survey of Secondary School Students." *BMJ* 2003 March Vol. 326

55. Santelli JS, Lowry R, Brener ND, Robin L. "The Association of Sexual Behaviors with Socio-economic Status, Family Structure, and Race/Ethnicity among US Adolescents." *American Journal of Public Health* 2000 Oct 90(10):1582-1588

56. Peltzer K, Cherian L, Cherian VI. "Knowledge, Self efficacy and Behavioral intent towards AIDS Prevention Behaviors among Culturally Diverse Secondary School Pupils in South Africa." *East Africa Medical Journal*. 2000 May; 77(5): 279 – 82

57. Yeh Chao-Hsing. "Sexual Risk Taking among Taiwanese Youth" *Public Health Nursing* 2002 19(1): 68-75.

58. Whaley A. "Preventing the High –Risk Sexual Behavior of Adolescents: Focus on HIV/AIDS Transmission, Unintended Pregnancy, or Both?" *Journal of Adolescent Health* 1999 June 24(6):376-382

59. Coyle K, Basen-Engquist K, Kirby D, Parcel G, Banspach S, Collins J, Baumler E, Carvajal S et al. "Safer Choices: Reducing Teen Pregnancy, HIV, and STDs." *Public Health Reports* 2001 Supp.1(16): 82-93.

60. Sale E, Sambrano S, Springer JF, Turner CW. "Risk, Protection, and Substance Use in Adolescents: A Multi-site Model." *Journal of Drug Educ*. 2003; 33(1): 91-105)

61. DiLorio C, Dudely WN, Kelly M, Soet JE, Mbwara J, Potter JS. "Social Cognitive Correlates of Sexual Experience and condom Use Among 13- Through 15- Years – Old Adolescents." *Journal of Adolescent Health.* 2001 29:208-216.

62. Alubo O. "Adolescent reproductive Health Practices in Nigeria." *African Journal of Reproductive Health.* 2001 Dec 5(3):109-119.

63. Nuko S, Chiduo B, Mwaluko G, Urassa M. “Pre-Marital sexual Behavior among Out-of-School Adolescents: Motives, Patterns and Meaning Attributed to Sexual Partneship in Rural Tanzania.” *African Journal of Reproductive Health.* 2001 Dec 5(3):162-174.

64. Borawski EA, Lievers-Landis CE, Lovegreen LD, Trapl ES. “Parental Monitoring, Negotiated Unsupervised Time, and Parental Trust: The Role of Perceived Parenting Practices in Adolescent Health Risk Behaviors.” *Journal of Adolescent Health.* 2003 Aug; 33(2): 60-70)

65. Ampofo AA. “When Men Speak Women Listen”: Gender Socialization and Young Adolescents’ to sexual and Reproductive Issues.” *Journal of Reproductive Health*. 2001 Dec 5(3):196-212.

66. Soskolene V, Shtarkshall RA. “Migration and HIV Prevention Programmes: Linking Structural Factors, Culture, and Individual Behavior-an Israeli Experience.” *Social Science & Medicine* 2002 55: 1297-1307

67. Bolland JM. “Hopelessness and Risk behavior among Adolescents Living in High-Poverty Inner-city Neighborhood.” *Journal of Adolescence* 2003 26(2003):145-158

68. Kassaye, M. Taha Sherif, H Fissehaye, G. Teklu T ““Drug” Use among High School Students in Addis Ababa and Butajira” *Ethiopian Journal of Health Development* 1999. 13(2):101-106

69. FHI “Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk” 2000

70. Price N., Hawkins k. "Researching Sexual and Reproductive Behavior: A Peer Ethnographic Approach" *Social Science and Medicine* 2002. 55(8)1325-1336

71. Meschke L.L, Bartholomae S., Zentall S.R "Adolescent Sexuality and Parent-Adolescent Process:Promoting Healthy Teen Choices" *Journal of Adolescent Health* 2002 31(6 Supp 1)264-179

72. Mill J. E., Anarfi J. K. “HIV Risk Environment for Ghanian Women: Challenges to Prevention” *Social Science and Medicine* 2002. 54(3)325-337

73. Bachanas P J, Morris M K, Lewis-Gess J K, Sarett-Cuasay E J, Sirl K, Ries j K, Sawyer M K " Predictors of Risky Sexual Behavior in African American Adolescent Girls: Implications for Prevention Intervention" *Journal of Pediatric Psychology* 2002. 27(6)519-530

74. Farmer, P. “Infections and Inequalities: The Modern Plagues, Updated Edition with a New Preface”. The University of California Press, 1999.

75. Bolland J. M. “Hopelessness and Risk Behavior among Adolescents Living in High-Poverty Inner-city Neighborhoods” *Journal of Adolescence* 2003 26:145-158

Appendix A: Case Studies

Case 1- Female

My name is Alem and I am 27-Years old. I was born and brought up in Harar. My father died before my fifth birthday, my mom brought me up alone with my six siblings. We did not have any other income other than my father's pension. I used to be an average student in elementary school. My academic performance and interest decreased in high school and I was expelled from school at 11th grade since I failed repeatedly. Then I started to live with my grandmother and started to sell things to make a living. I did not find it that lucrative and I left it.

I met a man when I was 18 and I started to go out with him. He was 37 then. He was a merchant. Then I became pregnant and gave birth to my son 8 years ago. He used to have a lot of partners and often goes to prostitutes. He was highly promiscuous. I was waiting for his marriage proposal but the guy had no plan of marriage. I realized that he is not at all marriage substance and then I stopped our relationship. Then I met another man who was a pensioned soldier in 2000. He was 40 when we met. I thought our relation might graduate to marriage and I was committed to him. He was deceiving me by saying that he will take me abroad and I wanted to realize my dream of going abroad with him. After a while I got pregnant and told him the news. I have never seen him after that day onwards. I knew that I cannot support another child and I aborted it. Later on, I learnt that he has two wives and children in Mekele. In the meantime I got a job in a factory and started to support myself. Going abroad and making money has always been my dream. Somebody promised me to facilitate this process and I was required to undergo HIV screening. It was how I came to know that I have HIV infection. I did not expect to be positive. One thing that deceived me was that I was allowed to donate blood twice not long ago before I knew my test results.

I think I was exposed to the virus mainly due to the low socio-economic status of my family. I was forced to leave the house and look for someone who can help me. I did it in search of better life. I thought it was a way out from the financial constraint I was in. My poor performance in my education has also a significant contribution to the problem I am in right now. Had we been in a better situation economically, I could have gone to private or night school when I was expelled from the State schools. The fact that I was left free when I moved to my grandmother as opposed to a strict supervision that I had while I was with my mom created a big space in my life. I was not even aware of the disease at that time.

These days I have a lot of things to worry about. When I think of my illness, what comes to my mind first is my death. It is a pity that I never helped my Mom. My dream was to let her live a better life. I would like to say something. “Whoever she/he is, we have to make sure of the serological status and the degree of commitment one has when we are thinking of a relationship."

Case 2- Male

Girma is a 30-year-old man who was born and grew up in Addis, at the center of the city. He has three sisters and 5 brothers.

> I am the first child of my family. My father died while I was a child. We did not have any income so that my Mom had to sell *tella* (A local drink prepared at home) to sustain such a large family. When I completed high school, I was able to join College and got my diploma in forestry. Then I got a job in Afar, a desert where you can get nothing. My dream was to stay in Addis, help my mother, and pursue my study and be someone. I did not have an option though. My salary was not enough for me let alone helping my family as much as I intended to. I have stayed there alone for a number of

holidays since I could not even cover the cost of transportation. I was not economically sound to have a settled life; like marriage, hence establishing my own family was not an agenda for me.

Life in Afar was like a soldier. I used to drink alcohol to elude my frustration and chew *khat*. I was only 20 at that time. Being young and having my own money coupled with being far from my family synergistically led me to where I am now. I had my first practice with a casual partner at 20, a time when I did not have good knowledge about relationships and even have no know-how of a courtship. Then the door was open. I had countless partners after that. I used to have casual partners and often visited commercial sex workers. My condom use pattern was so irregular that I often forgot to use it in my practices after alcohol.

Eventually my health situation started to deteriorate and I suspected that it could be HIV since I knew my sexual behavior. Then I took the initiative to test my blood for HIV. My test result turned out to be positive three years ago while I was attending further education. I was not fortunate enough to get a good counseling at that time. None of my family members but two of my friends knows about my HIV status. I will not tell them till I die because they are expecting all the positive things from me not a positive result from my HIV test. I should have been a role model for my younger siblings.

He was filled with anguish and hopelessness all of a sudden.

Girma heard about HIV before he got it but he did not have adequate information. He has never seen a person living with the virus before that. He used to believe that there is no HIV.

He said it never seemed real until one gets it or witnesses somebody's illness. More priority is given for the thing at hand, which is immediate sexual gratification.

Young people are exposing themselves to HIV these days due to uncensored video films, which are displayed in the neighborhood. Indulgence in addiction forming substances like *khat* and the use of alcohol eventually exposes one to high-risk sexual behavior. The bottom line for all, Girma emphasized, is hopelessness of the young generation about the future. There is no job; there is no access to education, no bright future, no vision at all. Young people are walking in the dark. Everything is tied up with poverty. When a person cannot see himself/herself in a better situation after few years, hopelessness is inevitable. Today everyone needs to be happy for the day. Nobody cares about tomorrow. Last but not least, there are some normative practices that encourage young people to indulge in risky behavior. For instance, a guy who goes out with many girls is accorded high prestige from his peers. Having multiple partners is a positive compliment for a person rather than being untoward. “I would also like to add that lack of knowledge about courtship compels young people to unsafe sexual practices.”

Case 3- Female

Helen, a 22 years old youth, was born and grew up in Addis Ababa. She does not know her biological father. Her mother lives with her new husband and her other three kids (1 boy and 2 girls). Helen grew up with her grandmother till the age of 16 and then went to her mother for a year when she started to see a man in the army. Presently, Helen lives with her grand mother and she visits her mother, stepfather and half sisters and brother occasionally. Helen and her grandmother have hardly subsistence income, which they get from renting their small rooms in their compound. They are often reliant on financial assistance from their relatives. Helen has

graduated from high school and attends a training in computer basics that is sponsored by a college instructor.

"…. As I was 16, I told my grandmother that I wanted to go to my mother and I moved there. I started seeing a man who used to serve the army. After a year, I had a disagreement with my mother and moved in with my boy friend. I lived with him for 6 years without being legally married. Seventeen was my age of debut. His parents did not favor me, as I am not from the ethnic group they want to be related with. Then, his families interfered and wanted him to marry a girl from his region. "*yager lij yagiba*". Unfortunately, by then, I was 7 months pregnant. Nevertheless, I was forced to leave him for he can't take me as a wife anymore. I came back to my grandmother and spent the rest of my time there. I gave birth to a son who died on the 3rd month. I have had some illness experience few years ago while I was living with my former boyfriend. This illness of mine persisted and I got an offer from my relative to see a doctor. It was then that I knew I had the HIV virus in my blood."

Helen has a strong hunch that she contracted HIV from her former partner. She said, " I think I caught it from my ex boy friend because he was the first man in my sexual life. Moreover, I did not know anything about his background experience. However, I think it's difficult to judge people because many unknowingly and carelessly infect others just like what happened to me, and one should not necessarily be *duriye* (a local slang that refers to being ignorant, careless, indulgent in many illicit activities) in order to be infected by the virus. As to me, I say any sexual experience; even the first intercourse could lead one to contract HIV. It is all a matter of chance. I did not share any sharp object with others nor did I have any other sexual partner.

Before being infected by the virus, Helen had blurred information about the disease; rather she used to imagine it as a ghost. She said, "I can say that I knew about HIV after I contracted it ". I learned about it the hardest way, on myself.

Living with the virus, Helen faced no ostracism in her community, as she has not disclosed her HIV status to the public except for few of her relatives. Even my former boyfriend doesn't know about my HIV status. She knows that her friend is being discriminated against for living with HIV, even by family members. Her friend is deprived of her former smooth communication; is isolated in a room with no electricity and could not get water any time she wants. Her family discriminates against her friends as well thinking that they are all carriers of HIV virus.

Helen describes sexual behavior of people of her age as unsafe regardless of their knowledge about HIV /AIDS. "Nowadays many people, including small children, know about HIV but the problem is rooted in being reckless about one's life. Young people, especially the males, do not realize the consequences of unsafe sex. They rush into sex, they are not faithful to a single partner, do not tend to have safe sex, thus are vulnerable to contract the disease. I say people should know about their own and others' serological status before indulging into sex. A change in the teaching methods on HIV/ AIDS might improve the situation."

For Helen, socio-cultural and environmental factors influence one's behavior. She said, "For instance, I was born and grew up around *Asko*, which is a residential quite area. Whenever I went to *Arat killo* and *Kazanchis*, where there are lots of bars and lots of commercial sex workers, I used to love spending my time there. Besides, if one is raised where there are no exemplary relationships among men and women, one will grow up with the image he/she used to see in the surroundings and the greater will be the indulgence in unsafe sex.

Economic status is another influential factor. In this case, if one is poor, she/ he needs a way out of the financial problem they have. Women in particular think of relationship with the other sex and/or marriage as an outlet, which usually is not the solution. Furthermore, imposition of household chores on children by family or even worse, being raised by relatives usually lead adolescents to develop bitterness about life. If there is no love and good relationship among family members, young people often need a way out, to work as waitresses and at the worst as prostitutes."

Currently Helen is relatively stable and sees a sparkle of hope at the far end of her life. After knowing her HIV status, she was informed to go to MMM (an NGO working on HIV/AIDS and assists people affected and infected by HIV). Then she joined *Mekdem*- Ethiopia (an NGO established by PLWHA for PLWHA). After she joined *Mekdem*, she completed home care and counseling training, which she said, has given her psychological support and increased her awareness about HIV/AIDS. Eventually, she is protecting herself from factors that precipitate the course of the illness. In the future, she would like to work using her computer skills or home care and counseling with any woman's department in *Mekdem* where she believes could assist people living with HIV/AIDS, who really need such a service.

Case 4- Male

Kebede is a 27-year-old man, who is living with HIV. He is single and is currently working as a social worker in *Mekdem*-Ethiopia. Kebede has completed 12th grade and further attended college for a year. He was born and grew up in the countryside. His parents are farmers; he has four sisters and five brothers. When he describes his family he said, " We grew up loving one another and respecting our parents". Kebede joined the Dergue army (the army of the previous

government) when he was 16 years old and served the army for 4 years until the present government took the position.

The neighborhood he grew up is a rural area where there is not much choice of recreational and other facilities. So, Kebede and his friends used to go out to a nearby town in order to entertain themselves. However, what the town could provide them was *Khat bet*, drinking places like small bars, which to the best of Kebede's knowledge, were basic push factors for them to indulge in unsafe sexual behaviors.

Going back in time to recall his past sexual life, he said," …me and my friends used to spend our time together by going to *Khat bet* chewing *khat*, visiting bars, smoking cigarettes and sleeping with innumerable girls whom we didn't know much and even without any protection. We did not have permanent girl friends at all and our practices were totally unsafe. After I contracted the virus, I can say that my sexual behavior is completely changed due to the repeated counseling which I used to get from health care center and *Mekdem*. Nevertheless, it does not help. Too late!!

When I was 17, I was seriously ill and thought it was Tuberculosis until I went to a hospital and was told that I have HIV in my blood. Although I heard about HIV in the mass media, my knowledge about it was so superficial, in fact not more than the name. Initially, my reaction to the test result was neutral for I did not have adequate awareness about HIV. I even thought that it would be cured. It is only after repeated counseling services I received in the health centers and at *Mekdem*-Ethiopia that I understood I should take pretty good care of myself even to live a bit longer.

Even thought I knew that I am a person living with HIV/ AIDS, I continued serving the army until the downfall of the Dergue. After EPRDF took position, I rented a house with a foreigner

friend and started living on my own. Then I joined college and attended for about a year. I also started computer training for few months, unluckily I couldn't accomplish it.

Kebede bitterly recalls about the stigma attached to HIV/AIDS in the society. He said, 'I remember a friend avoided sharing cups and plates with me for I am a PLWHA, which was so heart breaking. My other sad experience happened in my computer-training center. I told a friend that I have HIV in my blood and asked him to tell no one. However, the news spread so fast and everyone started discriminating and avoiding me. This time it was too much for me to bear and as a result I quit the computer class.

In contrast to the past few years, stigma attached to HIV is relatively reduced these days. Not so long ago, people used to think (actually some people still do) that the virus could be transmitted through skin contact and breathing.

"Presently, I work with people like me (HIV carriers) as a social worker in *Mekdem*-Ethiopia, which gives me awareness about the virus." Kebede strongly infers that the main factor that exposes young people to unsafe sexual behavior is substance use; drugs and alcohol. These days, the majority knows about HIV but the knowledge is not adequate to bring about real behavioral change. In reality, people do not practice what they know accordingly. The knowledge clicks their minds when they are into the problem, after it is too late. I can say that many people are exposed and are at risk to HIV especially what we commonly call *yebet ljoch* (a local phrase that refers to properly socialized kids who went through a proper parental guidance and support). They are easily attracted to financial and material possession of males and often take the risk of sleeping with a person whom they don't know. The other at risk groups includes soldiers and truck drivers because they are exposed for multiple sexual encounters. My final message for the youth is that, before they go out and sleep with a person,

they should know about his /her back ground sexual behavior. Especially female adolescents who are labeled as *findata* (a local slang that refers to the prominent characteristics and styles of early puberty/ early adolescent youth) should keep themselves from indulging in sex with a person they barely know.

Appendix B: Questionnaire

University of Oslo, Faculty of Medicine, Department of International Community Health
A study on Sexuality and Correlates of High –risk Sexual Behavior among Urban Youth in Ethiopia.
Questionnaire Prepared for Unmarried Youth between the age of 15 and 24
Addis Ababa, Ethiopia, 2003

Questionnaire Number _____

Greetings! I'm working with a study team from the University of Oslo, Norway. We are interviewing young people of your age in order to find out about peoples' sexual behavior, HIV/AIDS related knowledge, attitude, risky sexual behavior and practice in an urban setting.
The purpose of the study is to generate knowledge about the patterns of sexual behaviors that are associated with the HIV pandemic, to assess social and environmental correlates of high risk sexual behavior and eventually to recommend appropriate interventions promoting safe sexual behavior and preventing the spread of HIV/AIDS. Therefore your honest and genuine participation by responding to the questions is highly appreciated.

Consent

I'm going to ask you some personal questions, which some people might find them difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may quit this interview at any time you want to. Your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about 30-40 minutes.

Would you be willing to participate in this study?"
If yes, proceed.
If no, thank the person and leave the household.

_____

Name of the interviewer_____

Name of the supervisor_____

Date of interview: _____

CHECKED BY SUPERVISOR: Signature _____ Date _____

Section 1: Background Information

No.	Questions and filters	Coding categories	Skip to
	Address of the respondent	Kebele: [_____] Kifle Ketema:_____ House Number: [_____]	
101	Sex of the respondent	Male 1 Female 2	
102	How old are you? (age in years)	[_____]	
103	What religion are you following? **(Read the options)**	Orthodox 1 Catholic 2 Protestant 3 Muslim 4 No Religion 5 Others _____6 No Response 99	
104	How long have you lived in this Kebele?	Number Of Years [____] Don't Remember /Don't Know 88 No Response 99 Less than one year 00	
105	Whom do you live with presently? Alone? With both Parents? With father only? With mother only? With siblings? With family (relative)? With employer? With peers/friends/coworkers/ Students? On the streets? **(Read the options)**	Alone 1 With both biological Parents 2 With biological father only 3 With biological mother only 4 With siblings 5 With family (relatives) 6 With employer 7 With peers/friends/coworker /students 8 Other_____ 9 No Response 99	
106	In relation to other families in your neighborhood, what would you say about your family?	We are very poor.1 We are average.2 We are of moderate economy.3 We have good economy.4 _____Others.5 Do not know.88 No response.99	
107	Do you go to school now?	Yes.1 No.2 No response.99	→ **Q110**

108	What is the highest level of grade you completed? (Number of school years completed)	Read and write. 1 Grade 1-4. 2 Grade 5-8. 3 Grade 9-10. 4 Grade 11-12 .5 Above grade 12. 6 No Response. 99	
109	Who pays your school fees and supplies?	Mother 1 Father 2 Both Mother And Father 3 Relatives 4 Sex Partner 5 Gov't/ NGO Support 6 Myself. 7 Other_____..8 No Response 99	Q113
110	Have you ever attended school before?	Yes.1 No.2 No response.99	→**Q113**
111	How many total years of education have you completed up to now?	# Years Completed [_____] Don't Know 88 No Response 99 Less than one year 00	
112	Why did you dropout of school? (If the respondent has not taken grade 10 or 12 school leaving examination)	Do not have any supporting family.1 Could not afford to go to school.2 I do not see any point of learning.3 I could not get a place in school.4 I have repeatedly failed.5 Other _____.6 Do not know.88 No response.99	
113	Do you work to earn money for yourself?	Yes 1 No 2 No response 99	→**Q116**

114	What do you do to earn money? **(Multiple answer possible)**	Government employee.1 Employee of NGO.2 Construction work(Labor work).3 Hair dresser or barber.4 Broker.5 Shoe Shining.6 Taxi assistant.7 Domestic worker .8 Shop worker /Tea /Pastry.9 Commercial sex work.10 Small scale trade.11 Buy and sell.12 Other _____.13 No Response.99	
115	Are you supporting any one (Children, parents or others) by the money you get now?	Yes 1 No 2 No Response 99	
116	Why do not you work? (For respondents who are not currently working)	Could not get job.1 Did not want to work.2 I am a student.3 Other _____.4 Do not know 88 No response 99	

Section 2: Information on family, peers, neighborhood and school situation

No.	Questions and filters	Coding categories	Skip to
201	How many of the household heads in your neighborhood have jobs?	Many.1 Some.2 Partly.3 All.4 None.5 Do not know.88 No response.99	→**Q203**
202	In which sector are **most** of them involved?	Formal sector.1 Informal sector.2 Do not know.88 No response.99	
203	What do most of the young people who have completed their high school in your area do? (Multiple response is possible)	Join higher education.1 Do whatever jobs they get.2 (Unemployed)Do nothing.3 Are involved in illegal activities to earn a living.4 Others _____.5 Do not know.88 No response.99	
204	When you think about your family, would you say that: 1. I feel attached to my family 2. My family values my opinion 3. I mean a lot to my family 4. I can count on my family when I need a help 1. CA= Completely Agree 2. PA= Partly Agree 3. PD=Partly Disagree 4. CD=Completely Disagree 99. No response	**CA PA PD CD NR** 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99	
205	What kind of relationship do you have with your parents? 1. My parents know where I am and what I am doing at the weekdays. 2. My parents know where I am and what I am doing at the week ends. 3. My parents know who I ma together with in my spare time. 4. My parents like the friends I am together with in my spare time. 5. I ask permission from my parent to spend some time with my friends.	**CA PA PD CD NR** **1** 2 3 4 99 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99	

206	Do you perceive that your parents are strict to allow you do things without their knowledge?	Yes, my father is very strice.1 Yes, my mother is very strict.2 Yes, both are strict.3 No, no one is strict.4 My siblings are strict .5 Other member of my family is strict on me.6 Neither my mother nor my father is strice.7 Other_____.8 No response.99	
207	Do you discuss sexual issues with your mother/father? (Do no ask respondents who are living alone or with friends)	Yes, with my mother.1 Yes, with my father.2 Yes, with both.3 No, I do not discuss with both.4 Do not know.88 No response.99	**→Q209** **→Q209** **→Q209**
208	What is the reason for not discussing sexual issues with your mother/father/both?	It is culturally wrong to talk about sex with parents.1 My parents have never given me the chance to talk about sex.2 My parents will suspect that I am sexually active if I ask them about sex.3 I feel that they will not tell me all the information I want.4 I do not feel comfortable.5 Other_____.6 Do not know.88 No response.99	
209	Do you discuss about sexual issues with other member of your family? (Do no ask respondents who are living alone or with friends)	Yes.1 No.2 No response.99	
210	When you think about your friends, would you say that : 1. I feel closely attached to my friends 2. My friends value my opinion 3. I can help/support my friends 4. I can count on my friends when I need a help	CA PA PD CD NR 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99 1 2 3 4 99	

211	How many of your friends are sexually active?	All.1 Many.2 Some.3 None.4 Other_____.5 Do not know.88 No response.99	 **→Q213** **→Q213**
212	How many of your friends you know have had STD(s)?	Many.1 Some.2 None.3 All.4 Other_____.5 Do not know.88 No response.99	
213	Have any of your friends been accused of delinquency?	Yes.1 No.2 Do not know.88 No response.99	
214	What issues do you most often discuss with your friends at school?	About sexual issues.1 About academic issues.2 About relationships.3 About future plans.4 About families.5 About politics.6 Spiritual things.7 About sport.8 Other_____.9 Do not know.88 No response.99	
215	Do you watch western video films and music?	Yes.1 No.2 No response.99	 **→Q217**
216	Where do you watch such films? (Multiple answer possible)	At home.1 At a video house nearby.2 At Cinemas.3 At a friend's house.4 Others_____.5 No response.99	
217	How many times have you seen pornographic films?	Once in my lifetime.1 Many times.2 Some times.3 Never.4 Other _____.5 Do not remember/ Do not know.88 No response.99	
218	Do you participate in any anti AIDS clubs or activities?	Yes 1 No 2 No Response 99	
219	Where do you spend you leisure time?	YES NO NR	

		I go to stadium.1 I go to the cinema.2 I meet friends and chew chat.3 I go to the bars and have some drink.4 I read fictions.5 I will meet my partner.6 I watch films in local video houses.7 I do not know how I spend my time.8 Other_____.9 No response.99	1 2 99 1 2 99 1 2 99 1 2 99 1 2 99 1 2 99 1 2 99 1 2 99	
220	In your neighborhood, are there recreational places where young people of your age can spend their time?	Yes.1 No.2 Do not know.88 No response.99		

Section3: Non- Sexual (Social) Behaviors

No.	Questions	Coding categories	Skip to
301	Have you ever drunk alcohol?	Yes.1 No.2 No respone.99	→**Q303**
302	During the last 6 months how often have you had drinks containing alcohol? (**List out)**	Every day 1 At least once a week 2 More than once a week 3 Never 4 Some times.5 Others_____.6 Don't remember 88 No response 99	
303	Which of the following have you used/tried? **(Read the options)**	Yes No DK NR 1.Khat 1 2 88 99 2.Hashish 1 2 88 99 3.Benzene 1 2 88 99 4.Shisha 1 2 88 99 5.Cocaine 1 2 88 99 6.IV drugs 1 2 88 99 Others_____ 1 2 88 99	If the answer is 2 or 99 for all, skip to Q308
304	During the last 6 months how often have you used drugs? 1=Every day 2=Once/Week 3=Less than once a week 4=Never 88=Don't Know 99=No Response	1.Khat 1 2 3 4 88 99 2.Shisha 1 2 3 4 88 99 3.Benzen 1 2 3 4 88 99 4.Hashish 1 2 3 4 88 99 5.Cocaine 1 2 3 4 88 99 6. IV drugs 1 2 3 4 88 99 Others_____ 1 2 3 4 88 99	
305	What is your reason of using those drugs?	For entertainment .1 To avoid stress in life .2 To get excited and stay alert .3 To pass some time together with friends.4 Others_____.5 Do not know .88 No response .99	
306	Where do you use these mood altering substances?	At home.1 At school.2 At friend's house.3 Other_____.4 No response.99	
307	After the use of one or more of the above drugs, does your sexual behavior change? (Do not ask respondents who do not use any type of drug)	Yes, I have more sexual desire .1 No, I will have less sexual desire .2 It has no impact on my sexual desire .3 Do not know .88 No response .99	

308	How often do you smoke cigarette?	Never .1 I used to but I quitted .2 Sometimes .3 Many times.4 Other_____.5 No response .99	
309	How often do you usually attend religious services in church/Mosque or other meetings in your moral community?	Once a month .1 Once a week .2 Two to three times a week .3 Daily .4 Once a year .5 Not at all.6 Other _____ .7 Do not know .88 No response .99	
310	Have you ever been accused of any delinquent behavior? (Explain: Homicide, misbehavior of any sort which may have led to school suspension ,expulsion or police intervention)	Yes .1 No. 2 Do not know/Do not remember .88 No response .99	
311	Have you ever failed an exam? (Have you ever repeated a class?)	Yes .1 No. 2 No response .99	
312	In relation to your classmates, how do you evaluate your school performance?	I am a clever student.1 I am an average student.2 I am a bit weak academically .3 Other_____.4 Do not know.88 No response.99	
313	Have you ever missed a class and spent your school time somewhere else? (Truancy)	Yes .1 No. 2 No response .99	
314	What future plans and vision do you have? (Multiple answer possible)	I will join higher education.1 I will find job.2 I will have a better life in any way.3 I do not have any bright future.4 I do not have vision at all.5 Others_____.6 Do not know.88 No response.99	

Section4: Sexual Behaviour: Numbers and types of partners, condom use, history of STD

I am going to ask you personal questions about sex. Would you please answer the following questions honestly? Remember, your name is not written on this questionnaire.

No.	Questions	Coding categories	Skip to
401	What was your age at your first menstruation? (For females only)	Age in years_____	
402	Have you ever had sexual intercourse?	Yes 1 No 2 No Response 99	→**Sec. 5**
403	What was your age at your first sexual intercourse?	Age in Years [____] Don't remember /Don't know 88 No Response 99	
404	What type of sexual partner did you have first?	Steady friend.1 Commercial sex workers.2 Casual partner.3 Stranger.4 Other_____.5 Do not know.88 No response.99	
405	What was your reason for first initiation of sex?	Personal desire.1 Peer pressure.2 Influence of alcohol or drug.3 Forceful sex/Coercion.4 To get money.5 Pornographic film.6 Other----------.7 Don't Remember /Don't Know.88 No response.99	
406	Have you used condom during the first time you had sex? (Includes both male and female condom)	Yes 1 No 2 Don't Remember /Don't Know 88 No Response 99	
407	Could you remember how many sexual partners have you had after your first partner?	No one.1 Two to four.2 Five to eight.3 More than nine.4 Other_____.5 Don't remember.88 No response.99	
408	Have you had sexual intercourse in the last 6 months?	Yes 1 No 2 No Response 99	
409	The last time you had sex did you and your partner use a condom? (includes both male and female condom)	Yes.1 No.2 Don't Remember /Don't Know.3 No Response.4	→**Q411**

410	Why didn't you and your partner use a condom that time?	Not available.1 Not comfortable.2 Too expensive.3 Partner objected.4 Embarrassed to buy or ask for.5 I do not believe that it will prevent HIV.6 Didn't think of it /forget.7 I trust my partner.8 It reduces my sexual pleasure.9 Frustrated with frequent breakage.10 Do not know how to use it .11 I was drunk.12 Other _____.13 Do not remember.88 No response.99	
411	Have you ever had sex with commercial sex worker? **For males only**	Yes.1 No.2 Don't know / Don't remember. 88 No response. 99	**→Q413** **→Q413**
412	Have you used condom the last time you had sex with commercial sex worker?	Yes.1 No.2 Don't know / Don't remember. 88 No response. 99	
413	Have you ever had sex with out condom?	Yes.1 No.2 Don't remember. 88 No response. 99	
414	Did any of your sexual partner(s) force you to have sex with them with out your will during the last 6 months?	Yes 1 No 2 No Response 99	
415	Have you ever been forced to have sex with a casual partner?	Yes 1 No 2 No Response 99	
416	In a sexual relation you have after consumption of alcohol, do you use condom correctly?	Yes, I use condom always.1 No, I do not use it always.2 I use condom but I am not sure if it is correctly.3 Other_____.4 Do not know.88 No response.99	
417	In a sexual relation you have after use of drugs, do you use condom correctly?	Yes, I use condom always.1 No, I do not use it always.2 I use condom but I am not sure if it is correctly.3 Other_____.4 Do not know.88 No response.99	

418	Have you ever heard of diseases that can be transmitted through sexual intercourse?	Yes 1 No 2 No Response 99	
419	Have you ever had a genital discharge during the last 6 months?	Yes 1 No 2 Don't Remember /Don't Know 88 No Response 99	
420	Have you had a genital ulcer during the last 6 months?	Yes 1 No 2 Don't Remember /Don't Know 88 No Response 99	
421	Have you ever been pregnant? (Females only)	Yes 1 No 2 No Response 99	→**Q422**
422	Have you ever given birth? (Females only)	Yes 1 No 2 No Response 99	

Section 5 : Knowledge, Opinions, and Attitudes about HIV/AIDS

No.	Questions	Coding categories	Skip to
501	Have you ever heard of HIV or the disease called AIDS?	Yes 1 No 2 No Response 99	→**The end**
502	Do you have a close relative, neighbor or close friend who has died of AIDS?	Yes 1 No.2 No response.3	
503	Do you have a close relative, neighbor or close friend who is infected with HIV?	Yes 1 No 2 No Response 99	→**Q505**
504	Have you ever taken care of a close relative, neighbor or close friend who is infected with HIV?	Yes 1 No 2 No Response 99	
505	What do you know about HIV/AIDS? (Read out the list)	Yes No DK NR	
	1. Can a person get HIV through a blood transfusion?	1 2 88 99	
	2. Can a child get HIV in the process of child birth?	1 2 88 99	
	3. Can a child get HIV during pregnancy?	1 2 88 99	
	4. Can a child get HIV through breast feeding?		
	5. Can a person get HIV if he has many partner one after the other?(Serial monogamy)	1 2 88 99	
	6. Can a person get HIV by having more than one sexual partner at a time?	1 2 88 99	
	7. Can people protect themselves from HIV by using new or properly boiled piercing instruments?	1 2 88 99	
	8. Can people protect themselves from HIV by abstaining from sexual intercourse?	1 2 88 99	
	9. Can a person get HIV by getting injections with a needle that was already used by someone else?	1 2 88 99	
	10. Can a person get HIV by sharing a meal with an infected person?	1 2 88 99	
	11. Can a person get the HIV virus from mosquito bites?	1 2 88 99	
	12. Can people protect themselves from HIV by drinking hard alcohol and eating pepper?	1 2 88 99	
		1 2 88 99	
506	Do you think that HIV/AIDS is a serious multidimensional problem?	Yes.1 No.2 Do not know.88 No response.99	

507	Do you think that people of your age in your area are vulnerable to HIV/AIDS?	Yes.1 No.2 Don't know.88 No response.99	→**Q509** →**Q509** →**Q509**
508	If Yes to Q 507, why do you think that they are vulnerable? (Read out the list) 1. I know that many young people are engaged in unsafe sexual practices even if they know about HIV/AIDS 2. I do not think that many people have adequate information about HIV/AIDS 3.I think there are many factors that influence sexual behavior 4. I believe that it is impossible for young people to change their sexual behavior 5._____Other	Yes No No Response 1 2 99 1 2 99 1 2 99 1 2 99 1 2 99	
509	What factors do you think influence sexual behavior of people of your age? (Read out the list) 1.Family structure (single parent) 2. Socioeconomic status of families 3. Upbringing 4. Parental supervision and guidance 5. Neighborhood situation 6. Academic performance 7. Knowledge about HIV 8. Opportunity of income generation for self 9. Gender role in society 10. Financial problems 11. Social norms 12. _____other **(Probe)**	Yes No Don't know NR 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99 1 2 88 99	
510	What are your chances of getting infected with HIV? **READ OUT**	No chance 1 Low chance 2 High 3 Don't Know 88 No Response 99	**Q512**

511	If you perceive that you do have no or low chance of getting HIV, why is that? **Multiple answer is possible** Encourage to speak out.	1. Had no sexual contact 2. Abstained from sex 3.I trust my partner(s) 4.No injection with un sterile needles 5. I had no tooth extraction 6.I always use condom 7.I had no contact with person with HIV 8. HIV is a disease of CSW, drivers, soldeirs… 9. _____ Other 99. No Response	
512	What do you think about protecting yourself from HIV/AIDS? 1. I believe that I use effective precaution to avoid HIV/AIDS. 2. I do not believe that condom use is a good risk reduction strategy. 3. I believe that I have adequate knowledge to enable me lead safe sexual life. 4. I can communicate with my partner frankly and clearly about sexual matters with no reservations at all. Coding: 1. Strongly agree 2. agree 3. disagree 4. strongly disagree 88. Do not know 99. No response	SA A D SD DK NR 1 2 3 4 88 99 1 2 3 4 88 99 1 2 3 4 88 99 1 2 3 4 88 99	
513	Do you believe that testing for HIV voluntarily and getting advises would help to control the HIV spread?	Yes.1 No.2 Do not know.88 No response.99	
514	Are there possibilities for someone to know if he/she is infected by HIV confidentially?	Yes 1 No 2 Don't Know 88 No Response 99	

515	Have you ever had an HIV test? **(I am not going to ask you the result)**	Yes 1 No 2 Don't Know. 88 No Response 99	**→Q517**
516	Why did you have the test?	I want to know my status 1 The test was required 2 No Response 99	
517	If a Voluntary Counseling and Testing service is available in your community or school will you be willing to use the service?	Yes 1 No 2 Don't Know 88 No Response 99	

Thank you very much for taking your precious time to participate in this study. I appreciate your help.