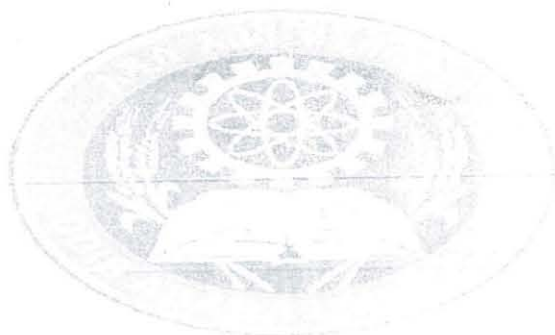


ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTES OF POPULATION STUDIES



GENDER DIFFERENTIALS IN YOUTH SEXUAL BEHAVIOR
AND VULNERABILITY TO HIV INFECTION IN BURAYU ZONE
OROMIA REGION

BY: SADIK ALEWI



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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES ADDIS
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THE DEGREE OF MASTER OF SCIENCE IN POPULATION STUDIES

ADVISOR: Dr. MICHAEL DEJENE

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JUNE 2010
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**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES**


***Gender Differentials in Youth Sexual Behavior and Vulnerability
to HIV Infection in Burayu Zone Oromia Region***

By
Sadik Alewi Mohammed

**Institute of Population Studies
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Approved by the Examining Board

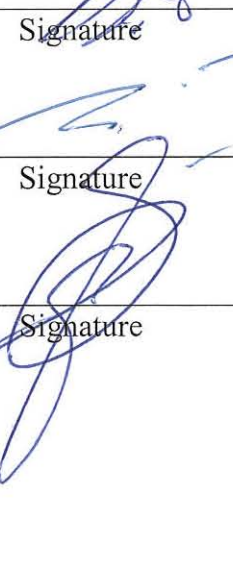
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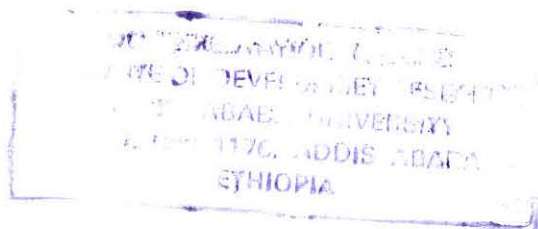

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CSA	Central Statistical Agency
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic and Health Survey
FGD	Focus Group Discussion
FHI	Family Health International
HAPCO	HIV/AIDS Prevention & Control Office
HIV	Human Immune Deficiency Virus
MOH	Ministry of Health
PRB	Population Reference Bureau
RH	Reproductive Health
SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nation Program on AIDS
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
WHO	World Health Organization

ABSTRACT

Ethiopia is a developing country with a demographic profile dominated by a young population. Due to biological, socio-cultural, economic and gender inequality young people, particularly those aged 15-24 years, are generally at a high risk of contracting STDs including HIV/AIDS. This study is intended to examine gender differentials in youth sexual behavior and vulnerability to HIV infection in Burayu zone of Oromia Regional State. A cross-sectional, study was conducted in both urban and rural areas of the Zone. Both quantitative and qualitative data collection methods were used to gather the required information for the study. For quantitative part of the study, a total of 723 youth (367 males and 356 female youth), in the age group 15-24 years, living in a randomly selected urban and rural kebeles of the zone were interviewed. Four focus-group discussions, each with a total of 10 participants, were conducted with male and female youth to supplement the findings in quantitative part. Descriptive statistics and logistic regression analysis were used to examine the influence of the explanatory variable on the dependent variables using the SPSS software 16. The major finding of the study shows that sexual initiation which typically occurs at an early age for both sex. However, females are more likely to start sex before reaching the exact age 15 and 18. It is also found that the mean age at sexual debut was 17.2 for male and 16.5 for female. Although most youths have used condoms, its consistent use was remained low. Considerable proportion of the youth in the area exhibited high risk sexual behavior including multiple sexual partnership, early sexual activity and inconsistent or non use of condoms that predisposed them to Sexually Transmitted Diseases including HIV infection. This implies that HIV/AIDS prevention and other reproductive health programmes need to target youths when they are very young, particularly for females in the study area.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The HIV/AIDS epidemic remains one of the leading public health problem and obstacles for development of poor countries. Currently large numbers of people are infected and affected by HIV. There were a total of 33.4 million people estimated to be living with HIV globally in 2008, of which 2.7 million people became newly infected and 2 million people died of AIDS in the same year. Sub-Saharan Africa accounts for 22.4 million infections, which is about 67% of the total HIV burden. The number of people estimated to acquire new infections in the region was 1.9 million accounting for 68% of the total number of new infections and 1.4 million people was died with AIDS related disease in the same year (UNAIDS, 2009).

Young people aged 15 to 24 accounts for an estimated 45% of all new HIV infection worldwide and more than 50 percent in Sub Saharan Africa with girls being particularly affected. One-third of all women living with HIV are between the ages of 15 to 24 are in Sub-Saharan Africa and over three-quarters (76%) of young people in the same age bracket living with HIV are female (UNAIDS, 2008). Although HIV prevalence rates are higher among young women, high-risk sexual behavior is much more common among young men, especially those in urban areas. Young men are much more likely to have multiple sexual partnerships and engage in higher-risk sex than young women (UNICEF, 2008).

Young male and female have different interests, motivations and strategies for engaging in premarital sexual relationships. Young female in Sub Saharan African countries for example enter into sexual relationships for various reasons such as enhancement of their marriage prospects (Calves, 1996), proving their fertility to their future husbands (Meekers, 1994) and for financial benefits (Akuffo, 1997). Male on the other hand are more likely to engage in sexual relationships before marriage for sexual

experience and sexual satisfaction and also having multiple partners is often a means for a young male to gain social status and respect among his peers (Calves, 1996).

It is becoming increasingly evident that premarital sexual activity and multiple partnerships among young African male and female are associated with an increased risk of sexually transmitted diseases (STDs) including HIV/AIDS. Data from Cameroon, Swaziland, Uganda, Tanzania, and Zimbabwe showed that young female in particular with multiple sexual partners and with older partners were more likely to be infected with HIV (UNICEF, 2008).

The current prevalence of HIV/AIDS among young people ages 15 to 24 is estimated to be 0.4 percent for male and 0.6 percent for female worldwide, however in Sub-Saharan Africa young female are still disproportionately affected by HIV, where 1.1 percent male and 3 percent of female are expected to live with HIV (PRB, 2009). According to UNICEF, in some African countries young female are almost two to five times more likely to be infected with HIV than young male in some countries. In Swaziland, for example, 6 percent of young male and 23 percent of young female were living with HIV at the end of 2007 (UNICEF, 2008).

Ethiopia takes a big share in the number of HIV/AIDS cases at global as well as regional levels in the Sub Saharan African countries. The 2005 Demographic and Health Survey (DHS) result however indicates that the epidemic may be less severe, less generalized and more heterogeneous than previously believed. The national HIV prevalence was estimated to be 2.4 percent, 1.9 percent for males and 2.9 percent for females in 2010. Of the estimated 1.22 million people living with HIV/AIDS in 2010 about 717,669 (59 percent) are females. In the same year the total number of annual death was estimated at 28,073 among this 12,024 are male and the remaining 16,049 are females (MOH, 2007; 2).

A careful assessment of data gathered over the last four years suggests that the epidemic has relatively stabilized, with adult HIV prevalence estimated at 2.1% in 2006 and has reached 2.4% in 2010 (MOH, 2007: 2). The rural epidemic appears to be relatively widespread but heterogeneous, with most regions having a relatively low

prevalence of HIV and in general, HIV incidence is leveling off after declining over the 1996-2001 (MOH, 2008).

In particular the prevalence of HIV among youth aged 15 to 24 in Ethiopia were 0.5 and 1.5 for youth male and female respectively (UNAIDS 2008). It was further shown that about 221,400 female and 68,200 male youths were living with HIV/AIDS in 2005, which means one male for every 3 female. (HAPCO, 2006).

1.2 Statements of the Problem

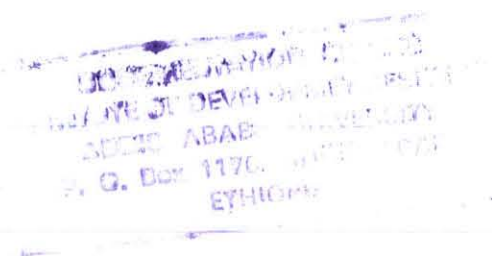
Worldwide there are about 1.2 billion people within the age of 15 to 24 year, which means one in five people living in the world are youth, and among this 1.1 billion of them are living in less developed countries (PRB, 2009). Young people in Ethiopia also accounts for about one-fifth of the total population. (CSA, 2007). Young people undergo a period of development in terms of biological, physical, cognitive, and social traits and hence mature from childhood to adulthood. During this stage, the challenges that youth face and the decisions they make can have a tremendous impact on the quality and length of their lives. Many important life events and health damaging behaviors start during this youth years and they are vulnerable to many HIV related problem (DHS, 2008). Young people are particularly vulnerable to HIV infection for social, political, cultural, biological, and economic reasons (UNAIDS, 2006).

Young people are at the centre of the global AIDS epidemic because, according to UNICEF among 1.7 billion young people worldwide, 5.4 million are estimated to be living with HIV at the end of 2007 accounting for 45 percent of new HIV infections worldwide. Youth in 15-24 age group also has the highest rates (over 500,000 infections daily) of sexually transmitted infections excluding HIV (UNICEF, 2008). Although HIV prevalence among young people is declining in many countries, in some of them it continues to affect girls and young women disproportionately. Of the 5.5 million young people aged 15 to 24 living with HIV in developing countries about 62 percent were female at the end of 2007 (UNICEF, 2008).

While HIV/AIDS is mainly a health problem, the epidemic is more of a gender issue. Statistics prove that both the spread and impact of HIV and AIDS is not random. Gender inequality together with age is particularly pronounced in Sub Saharan Africa and indeed, the epidemic is clearly gendered. For example in Cote d'Ivoire and Kenya, for every infected young man there are five infected young women. The corresponding ratios are also one to three in Botswana, Namibia, South Africa, and Zambia (UNAIDS, 2006). Zimbabwe has been particularly hard hit by the HIV epidemic. According to the 2005/2006 Zimbabwe Demographic and Health Survey HIV prevalence among those 15–19 years old was 6.2% for females versus 3.1% for males and among those 20–24 the prevalence was 16.3% for females and 5.8% for males and gender differentials are quite apparent.

In Ethiopia, as in most of the Sub Saharan African countries female are at higher risk of HIV infection than that of male. Results from the 2005 Ethiopian Demographic and Health Survey (EDHS, 2005) indicate that 1.4 percent of Ethiopian adults age 15-49 are infected with HIV. The age patterns suggest that young females are particularly vulnerable to HIV infection compared with young males. The prevalence of HIV among female age 15 to 19 is 0.7 percent compared with 0.1 percent of male age 15 to 19 and similarly the HIV prevalence among female 20 to 24 is over three times higher than that of male in the same age group that is 1.7 percent for female and 0.4 percent for male respectively. This discrepancy is attributed to the earlier age at marriage among women and sexual intercourse between young women and older men (CSA and ORC Macro, 2006).

The recent HIV prevalence among young pregnant women, 15-24 years, attending 82 ANC sites throughout the country was more than four times the national average, 9.1% in urban and 2.4% rural. In young males, prevalence rates are lower than 1% in both urban and rural areas. These data suggest that still high burden of new HIV infections concentrated among young female, especially those sexually active, never married, both in the urban and rural areas of the country. In contrast, the high infection pattern among young female does not hold for male, with the younger male exhibiting lower risk of HIV compared to their older counterparts both in the urban and rural areas. The



observed age pattern of HIV infection between males and females signals the fact that gender affects not only the general level of HIV prevalence, but also the shape of the prevalence curve as a function of age (Yemane B. et al, 2007).

Regional single point HIV prevalence estimation in Oromia shows that the adult HIV/AIDS prevalence in 2010 was 1.6 percent among this 1.3 percent for male and 1.9 percent for female. From the total 287,301 people living with HIV/AIDS in 2010 in the region, which is 23.6 percent of the national HIV/AIDS cases, about 118,228 (41.1 percent) are males and the remaining 169,011(58.9 percent) are female. In the same year the total number of estimated annual death in the region was about 6,854 among this 2,918 are male and the remaining 3,939 are females (MOH, 2007: 2).

1.3 Significance of the Study

Young people, especially never married sexually active females carry the greatest risk of HIV infection in Ethiopia, with prevalence rates much higher than the average for both urban and rural areas or for all women of reproductive age. This is associated with an early age of sexual debut and sexual mixing with high risk older men, on top of their biological and gender related vulnerability (HAPCO, 2006). Prevention and mitigation programs need to be established in order to reduce the epidemic potential in this population group.

Youth remain at the centre of the epidemic in terms of transmission, vulnerability, impact, and potential for change. To reach the global targets set forth in international agreements to reduce HIV/AIDS prevalence, urgent action must be made in HIV prevention specifically for young people by taking gender differentials into consideration. Gender differentials among youth sexual behavior is of particular interest because the period between sexual initiation and experimentation is different for both young male and female and that may involve high-risk behaviors and are vulnerable to HIV infection differently (Calves, 1996). There was also no in-depth study done that indicate the gender differentials in youth sexual behavior and vulnerable to HIV infection in Burayu zone even if it is among the fastest economically growing town in

Oromia regional state due to its geographical location near to Addis Ababa and important area for residence and investment.

Thus the present study will be conducted to generate both quantitative and qualitative information that are relevant to improve our understanding of gender differentials in youth sexual behavior and vulnerability to HIV/AIDS infection in the area of study. This helps to fill gap in the design of prevention programmes that can effectively manages the role of gender in relation to the spread of HIV/AIDS in youth and for the researcher that wants to work further on it in the specified area.

1.4 Objective of the Study

1.4.1 General Objective

To examine gender differentials in youth sexual behavior and vulnerability to HIV infection among male and female youth age 15 to 24 living in Burayu town of Oromia region.

1.4.2 Specific Objectives

1. To examine the socio-economic and demographic characteristic of youth in the study area that influence male and female sexual behavior and vulnerability to HIV infection and exposure to sexually transmitted illnesses.
2. To assess gender differentials in early sexual initiation, number of sexual partners and consistent condom use among youths.
3. To evaluate the consequence of youth risk sexual behavior among male and female based on the symptom of sexually transmitted diseases (STDs).

1.5 Research Hypotheses

1. Young males are more likely to have multiple sexual partners and engage in higher-risk sex than young females.
2. Females start sex in their earlier age and are less likely to use condom consistently than young males.

3. Females are more vulnerable to contract sexually transmitted diseases (STDs) and HIV/AIDS than males.

1.6 Operational Definitions

For purposes of the present study, the following definitions are adopted:

Youth: All people aged 15 - 24 (WHO, 1998)

Risky Sexual Behavior: Is sexual intercourse with irregular sexual partner and without the use of condom (EDHS, 2005).

Multiple partners: Person having two or more than two sexual partners in the last 12 months before the survey date (EDHS, 2005).

Sexual initiation: Refer to the age at first sexual intercourse of the person.

Consistent condom use: Use of a condom during in each and every sexual encounter.

Regular Sexual partner: includes spouse or a sex partner who has cohabited (lived-in) for twelve months or longer (EDHS, 2005).

Causal partner: includes two groups of non-commercial partnership:

- (a) Sexual partnership where partners are not married, either never cohabited or cohabited for less than twelve months;
- (b) Sexual partnership for longer than twelve months but where partners never married or lived together.

Vulnerability to HIV infection: Youth who are sexually active and fail to use condom consistently in each and every sexual intercourse.

1.7 Limitations of the study

The first limitation of the study was the use of cross sectional study design as cross sectional study was one shot or one contact study it cannot measure changes and the other limitation was due to budget, time and other facility constraints, the study was restricted to four kebeles of Burayu town as a representative sample to address issues of the whole youth in the zone. Finally due to the fact that this study deals with very personal and sensitive issues about youth sexual behavior and vulnerability to HIV/AIDS infection, sometimes obtaining frank response from the youth was believed to be difficult and it make the study susceptible to social desirability bias.

CHAPTER TWO

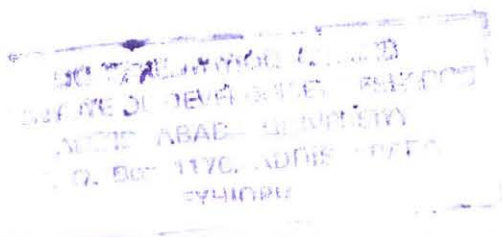
REVIEWS OF RELATED LITERATURE

2.1 Theoretical Framework

The sexuality versus gender relationship framework propounded by Dixon Mueller provides a useful theoretical orientation for the analysis of the effect of gender issues and sexuality in the prevention and control of HIV/AIDS. She identified four dimensions of sexuality gender framework, namely, sexual behavior, nature of sexual acts, social construction of sexuality, and nature of sexual drives and enjoyment (Nkoli N. Ezumah, 2003).

The first dimension focuses on sexual behaviour and deals with the issue of timing, duration, number, choice and identity of sexual partners. The conditions that influence the initiation of sexual activities have important influence on peoples' subsequent attitudes and behaviour. In some societies, a double standard of morality exists with respect to gender differences in sexual behaviour. It has been pointed out that sexual relationships between older men and younger women are acceptable in many societies (Aral S, 1992). Extramarital relationships by married men are also tolerated in Nigerian communities. Similarly, the practice of patronising commercial sex workers by married men is often pervasive (Havanon N, 1996).

The second aspect focuses on sexual acts and it include the nature, frequency and conditions of choice of sexual partners as well as the types of sexual practices individuals engage in. Dixon Mueller argues that because heterosexual practices tend to be more dominant in societies, the existence of homosexual practices might appear invisible in apparently heterosexual populations. Moreover she raises the issue of certain sexual practices such as oral and anal sex, masturbation, use of devices to enhance sexual pleasure that may have implications for disease transmission and prevention. This dimension also addresses the implications of gender based violence and coercive sex for disease transmission and unwanted pregnancies (Nkoli N. Ezumah, 2003).



The third dimension focuses on the social construction of sexuality and it deals with the cultural interpretations and meanings that are ascribed to sexual thoughts and behaviours. These reflect the beliefs and ideas people have about "the nature of the body". Cultural taboos and sanctions are established to control undesirable sexual behaviours of males and females. However, it has been observed that due to cultural inhibitions, the "culture of silence" in sexuality has persisted in some societies among couples and between parents and children. In particular, women's compliance with their expected norms in sexual relationships is often responsible for their inability to participate in meaningful communication about sexuality. Consequently, some women dwell on misinformation and ignorance about the sexual behaviour of their partners and the likely consequences of such actions. Concomitantly, they are not able to protect themselves from infection especially if their partners indulge in multiple sexual networking (Gammage S, 1997).

The fourth dimension refers to sexual drives and pleasures. It deals with how individuals perceive their sex drives and the meanings they attribute to sexual pleasure. The perception that sexual pleasure is desirable for males predisposes them to early involvement in sexual experience. This often starts during adolescence. In the case of women, the expression of sexual pleasure is hardly thought of (Nkoli N. Ezumah, 2003).

Due to the interrelationship between genders, sexual behaviours and practices that enhance the transmission of STIs and HIV/AIDS as demonstrated in this theoretical orientation, one joins in the call for a better understanding of sexual behaviour as well as its determinants in different cultural settings. Such information would be indispensable in ensuring that culturally specific and appropriate programmes are instituted to bring about desired positive changes in sexual behaviour as a measure towards prevention and control of STIs and HIV/AIDS in a society as a whole and among youth in particular (Nkoli N. Ezumah, 2003).

2.2 Youth, Gender and Vulnerability to HIV Infection

In many of the heavily affected countries, young people represent the most rapidly growing component of new HIV/AIDS infections, with girls outnumbering boys by a substantial factor. The reasons for this vulnerability include factors relating to poverty, lack of information, lack of economic and social empowerment, and lack of availability of protective methods and gender inequality (WHO, 2003).

HIV/AIDS prevalence among young pregnant women in Ethiopia (age 15-24 years) attending 82 ANC sites throughout the country shows that more than four times the national average (9.1% in urban and 2.4% rural) (HAPCO, 2006). In young males, prevalence rates are lower than 1% in both urban and rural areas. These data suggest there high burden of new HIV infections concentrated among young women, especially those sexually active, never married, both in the urban and rural areas of the country. In contrast, the high infection pattern among young women does not hold for men, with the younger men exhibiting lower risk of HIV compared to their older counterparts both in the urban and rural areas. The observed age pattern of HIV infection between males and females signals the fact that gender affects not only the general level of HIV prevalence, but also the shape of the prevalence curve as a function of age (Yemane B et al, 2007).

As youth is a time of choices, it involves gaining autonomy, assuming responsibility, and making choice about health, family, career, peer, and school. The ability to confront these decisions effectively is important to the wellbeing of youth. However, since youth are more mature physically than mentally or emotionally, they are often fail to make the serious decisions they face. During this stage, the challenges that youth face and the decisions they make can have a tremendous impact on the quality and length of their lives (DHS, 2008). Many important life events and health-damaging behaviors start during this youth years. Youth are vulnerable to many reproductive and particularly to HIV related problem and they are frequently being influenced to participate in behaviors that place their health at risk or impair their social competence, often called risk-taking behaviors. These risk taking behaviors include early and unsafe

2.3 Age at First Sexual Intercourse among Youth

The age at which young persons have sex is crucial as it marks the onset of exposure to the risks of contracting HIV and other STI infections. Initiation of sexual intercourse at an early age contributes to vulnerability to HIV infection by exposing adolescents to more sexual partners and a longer period of sexual activity before they form long-term monogamous relationships (Bongaarts, 2007). Studies in Kenya and Uganda suggest that early initiators are less likely to know how to prevent STIs, including HIV, or to be able to negotiate condom use than are those who delay sexual intercourse (Zulu et al, 2002 and Hilton et al, 2002). For young females, early initiation poses additional risks because of their physiological immaturity and the power differentials between them and older male partners (Ajuwon, 2002).

Increase in urbanization, modernization and education together with exposure to western media appear to have led to a decline in traditional values and in particular to have reduce the importance of virginity at marriage. In addition parental control and authority over young people decline and adolescent are no longer willing or required to be accounted to the societal structure that formerly controlled and informed their sexual behavior (Letamo G. and Bainame K, 1997)

Sub-Saharan African countries, young women start having sex earlier than young men, except in Kenya, Lesotho, and Senegal. In contrast, young women start having sex later than young men in Latin American and Caribbean countries and in Moldova (DHS, 2008). In Ethiopia data from the 2000 and 2005 DHS confirm the widely held belief that girls start having sex earlier than boys. The proportions that initiate sex before age 15 and age 18 are significantly higher in females than males. Sixteen percent of young women and 2 % of young men had sex by age 15, while 35 % of young women and 9 % of young men had sex by age 18.

2.4 Multiple Sexual Partners among Youth

The percentage of young women reporting multiple sexual partners ranges from less than 1 percent in Armenia and Vietnam to 13 percent in Congo. More than 5 percent of

young women in Cameroon, Lesotho, Mozambique, and Colombia report having more than one sexual partner in the past 12 months. Among young men who had sex in the past 12 months, those age 20-24 years are more likely to have multiple partnerships than those age 15-19 years in most sub-Saharan African countries. Reported levels of multiple partnerships in the past 12 months are much higher among young men than young women, ranging from 2 percent in Vietnam to 41 percent in Cameroon (DHS, 2008). In Ethiopia in contrast to the other Sub Saharan African countries young women in the age group 15-19 are more likely to have multiple sexual partners than in the age group 20-24, 1.4 % compare with 0.7 % (MOH, 2008).

2.5 Sexually Transmitted Diseases (STDs)

Unsafe sexual practice among youth results to high risk of contracting STIs and HIV, mostly because there are high rates of unprotected sex with multiple partners among the young people. So far the number of cases of STIs is considerably high, according to World Health Organization in 2004, out of the expected 333 million new cases of STIs excluding HIV, that occur in the world every year. at least over 100 million occur among young people less than 25 years of age. Adolescents typically engage in short-lived relationships which make them more likely than adults to have sex with multiple partners; this places them at greater risk for contracting STDs (WHO, 2004; 2).

Worldwide, 8 million cases of STDs are reported each year for individuals under the age of 25 and the highest rates of Gonorrhoea, Syphilis and Chlamydia are found among teens aged 15-19 years. STDs have particularly large impact on young women who are more easily infected than older women and when we compared to men, they are more frequently asymptomatic, more difficult to diagnose and suffer more serious and long-term complications (WHO, 2004; 2).

In Ethiopia Sexually active girls ages 15-19 are three times (1.4%) more likely to report an STI than sexually active boys in the same age group (0.5%). Thus young girls are at increased risks of contacting STI, as they probably engage in unprotected sex due to the limited control they may have over their sexual lives (MOH, 2006). Knowledge of STIs is also much more limited than that of HIV. Only about half of the adolescents ages 15-19

had some knowledge of STIs and their symptoms. An STI is a useful marker for unprotected sex and also as a co-factor for HIV transmission.

2.6 Condom Use among Youth

Although the majority of youth have heard of AIDS, many do not know how HIV is spread and do not believe that they are at risk. Those young people who do know something about HIV often do not protect themselves because they lack the skills, the support or the means to adopt safe behavior. Young girls and women are regularly and repeatedly denied information about and access to condoms. Often they do not have the power to negotiate the use of condoms (WHO, 2002).

Recent analysis of the AIDS epidemic in Uganda has confirmed that increased condom use, in conjunction with delay in age of first sexual intercourse and reduction in sexual partners, were important factors in the decline of HIV prevalence in the 1990s. Thailand's efforts to de-stigmatize condom use and its targeted condom promotion for sex workers and their clients dramatically reduced HIV infection. A similar policy in Brazil's early and vigorous condom promotion among the general population and vulnerable groups has successfully contributed to sustained control of the epidemic (UNAIDS, 2004).

A perception of low risk and a sense of complacency can lead to unprotected sex through reduced or non-consistent condom use. Fidelity and/or safer sex practice emanating from the societal cultural norm based on the one-to- one sexual relationship in marriage bond, and proper distributions of condoms through all possible outlets at affordable prices on a continuous basis are the strategies of the HIV/AIDS policy (MOH, 1998).

A review of school based HIV/AIDS risk reduction programmes for youth in Africa showed that 10 of the 11 studies that assessed knowledge reported significant improvements. All seven that assessed attitudes reported some degree of change toward an increase in attitudes favorable to risk reduction. In one of the three studies that targeted sexual behaviors, sexual debut was delayed, and the numbers of sexual



partners decreased. In one of the two studies that targeted condom use, condom use behaviors were improved (Melanie G, et al, 2004). Data analysis highlighted six factors hindering condom use: lack of perceived risk, peer norms, condom availability, adult attitudes to condoms and sex, gendered power relations and the economic context of adolescent sexuality (Frehiwot A, 2006).

Study conducted on high-risk sexual behavior among youth in Tanzania revealed that 49% of the youths reported to have used condoms (Ikamba L. et al, 2003). A similar study conducted in Tanzania showed that 54% of students were sexually active, 39% had a regular sexual partner and 13% had multiple partners in the previous year. However, 30% of sexually active respondents did not always use condoms and 35% of those with multiple partners in the previous year did not always use condoms (Masulanya E. et al, 1996). According to the National Survey conducted in Tanzania 4.1% of women and 15.2% of men used condoms during their last sexual encounter. Men aged 20- 24 years and women aged 15-19 years reported the highest rate of condom use. In both men and women, condom use increased with increasing levels of education. Among both women and men, residents of large urban centers were more likely to have used condoms. Condom use was significantly increased among women and men who were never married and in those who had ever been tested for HIV (DHS, 2000).

Study conducted in Ethiopia among Agaro, (Southwest Ethiopia) high school students showed that 25% of students had a history of sexual intercourse (Tadesse E. et al 1996). Among those who had previous sexual exposure, 54.4% used condoms at least once. Of those, only 9% were using condoms always. In a similar study done in the Gondar (Northern Ethiopia) College of Medical Sciences (GCMS), students showed that 56.1% were sexually active and among this, only 37.1% reported ever using condom and only 6.4 percent use condom consistently. Sexual contact with commercial sex workers was also reported by 7.8% of sexually active students (Fitaw Y. et al, 2002). Another study in Gondar indicated that 49% were engaged in sexual intercourse and only a third used condoms, despite their improved knowledge and beliefs on condoms (Teka T., 1997). Another study conducted in Ethiopia. South Gondar showed that 42% of the

respondents were sexually active; 23.3% of the sexually active claimed to have more than one sexual partner (Dawud A., 2002).

A study conducted in Addis Ababa revealed that only 43.2% of the sexually active students knew about condoms on their first coital encounter. Among this 82 percent of those did not use condoms on their first sexual encounter and only 27.7% of the sexually active students claimed that they had continuously used condoms (Eshetu F. et al, 1997). Another study done on college students revealed that only 17.9% of the sexually active respondents reported that they always used condoms, whereas the highest proportion 66% reported that they did not use condoms at all (Petros B. et al, 1997). A study conducted on patterns and correlates of sexual initiation, sexual risk behaviors, and condom use among secondary school students in Ethiopia showed two-third of sexual initiations was unprotected and some occurred with higher risk groups. The most commonly reported lifetime risk behaviors included much older (15.5%) or casual/commercial sex partners (9.1%), multi-partner sex (52.7%) and sex with casual (30.4%) or commercial (25.3%) partners. Although 56.7% of the youth ever used condoms, only less than half of these used them regularly (Adamu R. et al, 2003).

2.7 Factors Contributing to Youth Vulnerability to HIV/AIDS Infections

Young people constitute a rapidly growing and the largest segment of population in the human history. More than half of the world's population is below the age of 25, and four out of five young people live in developing countries (UNFPA, 2004). In Ethiopia also 46 percent of all populations are younger than 15 year and 30 percent are 15 to 24 years and totally over 65 percent of its population is under 25 years of age (FHI, 2004). Nevertheless, presently the lives of millions of young people worldwide are at higher risk from broad range of health problems. Above and beyond swift increment in number, the young people found in every country, more particularly those found in the developing countries are vulnerable to various health risks (WHO, 2004: 2). Some of the factors that have contributed to youth vulnerability to HIV/AIDS are the following.

2.7.1 Lack of Sexual and Reproductive Health Information

In fact, in the past adolescents and youth are considered, by most societies, as risk free or have no any health problems and have been neglected for many years (WHO, 2002). Health services often regard them as a healthy group who do not need priority action and so provide a minimum subset of health services with no adjustments for their special needs (WHO, 2004). Particularly at the adolescence period, they face and disproportionately distressed by multidimensional health problems that are mainly related to sexuality and reproductive health (Friedman, 2002). Most of all, because they engaged in unsafe sexual intercourse at an early teenage, they are vulnerable to STIs including HIV infection, which predominantly affects adolescents at this time (WHO, 2002).

Youth period is a time when young people face many new situations and the challenges of the second decade of life. At this stage they are curious and receptive to information about themselves and their bodies and they begin to take an active part in decision-making. Because this period presents not only opportunities for progress but also risks to health and well being of the young people, they need correct information and proper guidance about their sexuality and reproductive health. With out appropriate information and guidance they will be at higher risks of various SRH problems. Hence, a little help that is provided at this time can go a long way in channeling their behavior towards positive and productive paths (UNFPA, 2002).

In most cases teenage sexuality is characterized over all by lack of information and guidance, by low and inconsistent contraceptive use at first sexual intercourse (UNFPA, 2004). Studies from across the globe have indicated that vast majority of adolescents are vulnerable to SRH and HIV/AIDS problems these days, due to, predominantly, lack of basic information and comprehensive knowledge about SRH and its problems such as risk of STI and HIV/AIDS (UNFPA, 2002).

In Ethiopia also same facts observed, adolescent and youth lack of appropriate information communication and guidance in SRH matters (Berhane F, 2000). Most Ethiopian parents do not discuss issues of SRH with young people, reluctant to openly

inform and communicate with their children about sexual matters. Due to this most youth prefer to discuss with peer friends, for instance, in study conducted in Gonder (Seifu, 2001), it was indicated that about 75 percent of adolescents preferred to discuss about body changes that occurred during adolescence with peers of the same age rather than elders. Apart from this, adequate systems are not yet in place to reach all of the young people needs of information and appropriate guidance and counseling services in the country.

2.7.2 Socio- Economic, Demographic and Cultural Factors

Along with other problems, demographic, socio-economic and cultural factors also the main barriers on adolescent and youth sexual and reproductive health information and services needs. For instance, in many countries, cultural expectations encourage men to express their masculinity by initiating sexual activity at younger age, having multiple partners or visiting commercial sex workers (WHO, 2002). On the other hand, due to gender difference, norms and expectations young females are more at risk to being forced into sexual relationship and sexual abuse, lack of skills or power to negotiate abstinence or condom use, or refuse in case of unsafe sexual intercourse (UNFPA, 2002).

Adolescent and youth sexuality is closely linked to gender issues that root up from the family and societal values and perception. A girl child in almost all society is less likely to be offered a schooling opportunity compared to boys. Of the 130 million children of primary school age not in school, 70 percent are girls. Despite progress in raising educational enrolment rates in the past three decades, gender inequalities persist due to cultural factors, household responsibilities, early marriage and pregnancy (UNICEF, 2004).

Youth, particularly women, are also more susceptible to coercive sexual relationships. There are reports of “sugar daddy” phenomena, which refer to sexual relations between young women and older and wealthier men; young women have sexual intercourse with the older men in exchange for economic gains. In addition to coercion based on the economic power of men, young women have been forced to have sexual

intercourse by a person with authority over them (Upchurch and Kusunoki, 2004). In the Republic of Korea, 9 percent of female factory workers surveyed had been forced to have their first sexual intercourse with factory supervisors or colleagues (Brown et al, 2001). Moreover, even in the context of dating, young women tend to be coerced to have sexual intercourse with their boyfriends. One fourth of young Thai women had their first sexual intercourse because they could not resist pressure from their boyfriends. These women accepted sexual demands of their boyfriends to please them and to sustain the relationship. Young women in Bangkok also admitted the weak bargaining power of women over the issue of sexual intercourse (Isarabhakdi, 2000).

It is the interplay of biological, cultural and economic factors that make young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV; including their own biological vulnerability to infection, if they start having sex very young (UNAIDS, 2004).

Girls are also far more likely than boys to be coerced, raped or enticed into sex by someone older, stronger or richer. Sometimes, the power held over them is mainly that of greater physical strength and social pressure to accept the elders. In the era of AIDS, the consequences of the young girls can be disastrous, male migrants tend to engage in unsafe sexual practices when they are away from the family and young women migrants, on the other hand, may be forced to work as sexual workers as a means of survival (UN, 2001).

There are large differences in the trends and impacts of reproductive and sexual behavior between young men and young women. Many analyses on the role of gender in early initiation of reproductive activities have commented on the differences in societal expectations and norms for females and males (Singh et al, 2000). In most African societies, women get married at a younger age than men and, in some; premarital sexual activity is common and even favored. An early birth is seen to secure marriage for a woman because it demonstrates her fecundity to the man's family and

increases her social standing. Adolescents' contextual surroundings can profoundly affect their reproductive and sexual attitudes and practices (Meeker, 1994).

Poverty may be considered a root cause (Singh et al, 2000), it has further been suggested that economic transactions following intercourse are frequent among both adolescent boys and girls in many countries of Sub-Saharan Africa, and are not necessarily perceived as a source of social condemnation (Calves, 1996 and Meeker, 1994). Reciprocity of the giving and receiving between girls and boys is common, and characterize a majority of early sexual encounters in some areas. Teenagers whose sexual activities are often accompanied by financial rewards exhibit behaviors that put them at greater risk of HIV/AIDS infection (Meeker, 1994).

In Ethiopia some studies reported that there is lack of discussion and communication between parents and young people on matters of sexuality and reproductive health because of hampering socio-cultural norms and taboos of the society. Nevertheless, attitudes and perceptions of parents and communities have not intensively investigated and documented so far (Eshetu, 1997).

As it is true in the case of theoretical literature, most empirical studies also show that there is positive and significant relationship between youth background characteristics and reproductive health problems. Demographic factors (age, sex), socio-economic status and geographic location many of which are not amenable to programmatic interventions were the most commonly analyzed factors, and youths who perceive their friends or peers to be sexually active are significantly more likely to engage in sex themselves, as well as have multiple sexual partners.

Different studies indicate that Demographic and Socio-economic variables have influence youth sexual activity and reproductive health. These are described by various studies as follows.

School enrollment: Youths who are in school tend to have greater opportunities to interact with others and may get information on sexuality and reproductive health behavior and less likely to involve in sex (Meeker, 1994).

Discussion on sexual issues: With parents, peers and other relatives affect youth reproductive behavior. Because access to condoms and one's ability to negotiate condom use are likely to affect condom use and communication with parents and other family members concerning sex and reproduction is protective against sexual risk-taking behaviors (Holtzman and Rubinson, 1995). Studies in Ethiopia indicate that those adolescents and youth who mostly discussed with their parents were not involved in sexual practice as compared to their counterparts who did not (MOH, 2006).

Living arrangement: Studies show that youth from intact families are consistently less likely to report sexual intercourse (Sunmola et al, 2003).

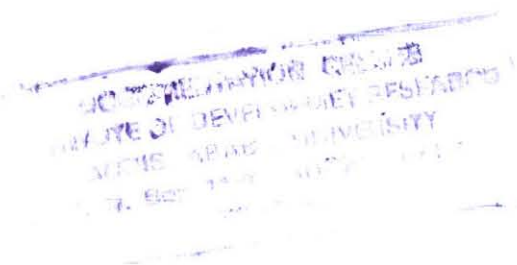
Marital status: In societies where marriage is early, marriage itself can expose very young adolescents to reproductive health risks. Yet at the same time marriage may reduce one's reproductive health risks, because married persons tend to have one or fewer sexual partners than unmarried persons (Meeker, 1994).

Household economic status: Prior literature highlights the association of household or family economic status with a range of risky behaviors and adverse reproductive health outcomes. The study conducted in Nigeria revealed that, youth who reported to have low parental income were more sexually active than those who reported to have high or medium parental income (Odimegmu et al. 2002).

Peer behaviors and influence: Adolescents and youths are susceptible to influence by peers, and reviews of the research indicate that peer behaviors can have both positive and negative influences (Calves, 1997).

Media exposure: Exposure to mass media provides the opportunity to be acquainted with new ideas and knowledge that is useful in preventing HIV/AIDS (EDHS, 2005).

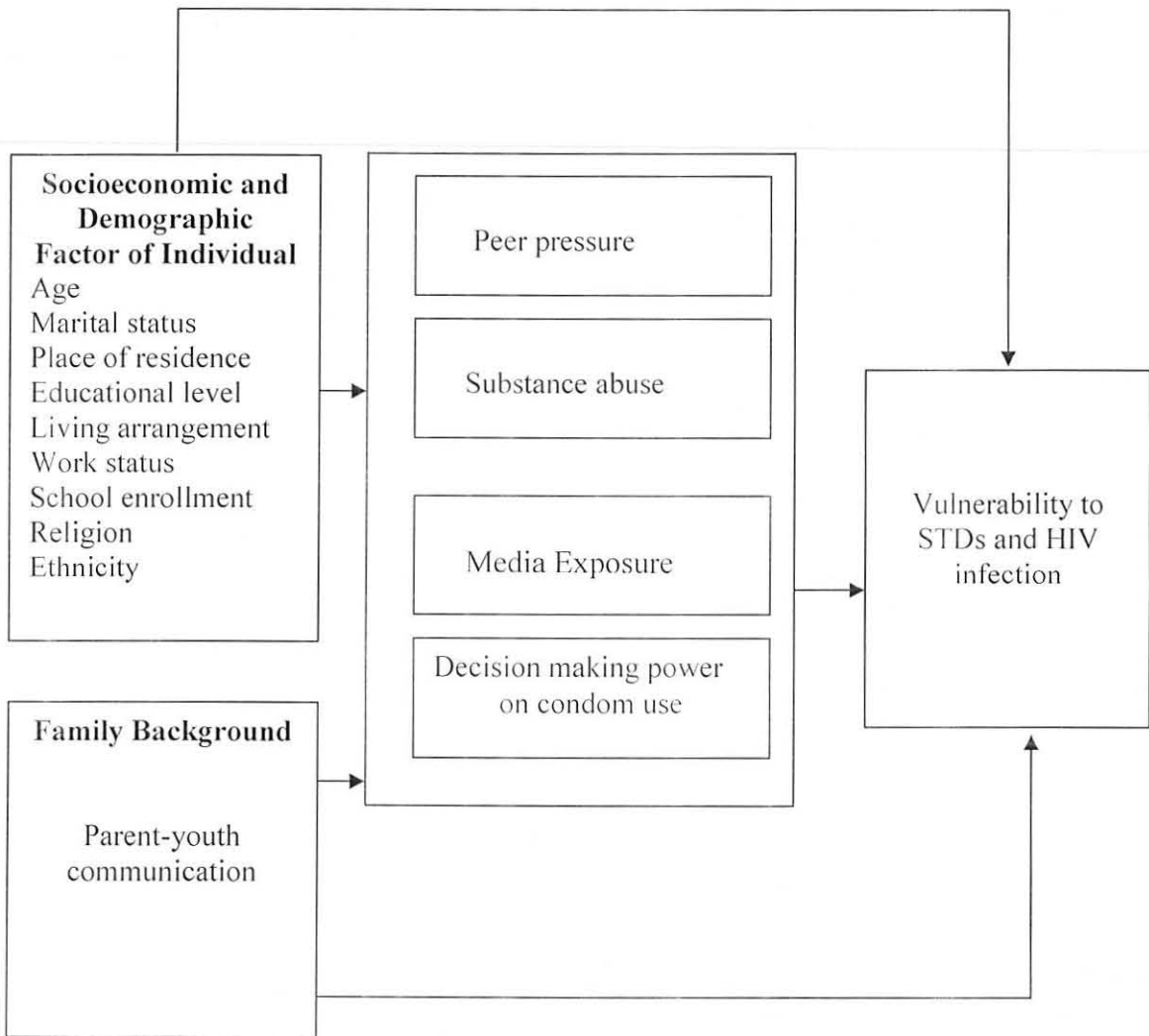
Educational level: Educational level is also affects youth reproductive health. The median age at first intercourse for women with no education is three years earlier than women with at least a secondary school education (EDHS, 2000).



Substance Use: Alcohol makes it difficult for the dependent user to judge what is right or wrong, what is good or bad, and what is moral or immoral. Therefore, it undermines judgment and reduces people's ability not to indulge in unsafe and risky sexual practices that facilitate the transmission and spread of HIV/AIDS (Josef et al, 1989). Other studies have also reported that substance abuse increases the sexual desire of users and that condoms often do not get used when people are drinking or using drugs with resulting weakening of ego controls and eliciting behaviors likely to increase the probability of exposure to HIV (Henry, 2002).

In an earlier study in Addis Ababa, Ethiopia, frequent drinking of alcohol and use of drugs, including *khat*-chewing, were positively and significantly associated with having sex with a commercial sex partner and with HIV seropositivity (Seme et al, 2005). In Tanzania, Kenya, and the USA, the frequent uses of alcohol, tobacco, and drugs were the most important predictors of multipartner sexual activity among adolescents and youths (Lake G. and Girmson R, 1996).

2.9 Conceptual Framework of the Study



Source: Developed by the Author

CHAPTER THREE

DATA SOURCE AND METHODOLOGY

3.1 Profile of Study Area

The study was conducted in Burayu Zone of the Oromia regional state. The zone is located some 10 km West of Addis Ababa town. Burayu zone covers a total area of 90,000 hectares and is bordered by Alem Gena from South, Sululta from North, Welmera from West and Addis Ababa from East. Administratively the zone is divided into six kebeles. The Zone has a total population of 63,873 and out of which about one-fifth are in age group 15 to 24 (CSA, 2007).

There is only one health center and about five private clinics in the town. The health service coverage of the area is estimated at about 38.8 percent (Yared S, 2007). Though there are large number of youth living in the zone there is only one youth center which provides services on basic outdoor recreational activities and information on Sexual and Reproductive Health including HIV/AIDS for limited number of youth living in the area.

3.2 Study Design, Sources of Data and Population

The study follows a cross sectional descriptive survey design and uses both qualitative and quantitative methods for data collection. A structured questionnaire was used to gather the quantitative data while focus group discussions (FGD) and in-depth interview were used to gather qualitative information. Male and female youth in aged group 15 to 24 who live in Burayu zone at the time of the survey were the source population for the study.

Four FGDs were conducted with the same sex discussant each attended by about ten participants. Ten in-depth interviews were conducted with five female and five male youths living in the study area. Each focus-group discussion session takes about one to one and half hours.

3.3 Sample Size Determination

Early initiation of sexual intercourse among youth is associated with increasing risk behaviors, such as more frequent intercourse, having multiple sexual partners and lower probability of consistent use of condom and hence make youth to be more vulnerable to STDs including HIV/AIDS infection (DHS, 2005).

Assumption used to calculate the sample size (n) is maximum tolerable error e in estimating the parameter (proportion of youth who are vulnerable to HIV/AIDS infection) with 95% confidence was 5% and the proportion of youth who were sexually experienced and failed to use condom consistently (vulnerable youth) was taken as 64% from the previous study (Fikadu M. et al, 2009). In short

The following formula and assumptions are used to calculate the sample size:

$$n = \frac{Z^2_{a/2} * P(1 - P)}{e^2}$$

Where n- Sample size

Z- Values of standard variant at 95% confidence interval (Z=1.96)

P- Estimated proportion of youth which are not use condom consistently

e- Standard error

$$\begin{aligned} \text{So, } n &= \frac{Z^2_{a/2} * P(1 - P)}{e^2} \\ &= \frac{(1.96)^2 * 0.64(1 - 0.64)}{(0.05)^2} \\ &= 354 \end{aligned}$$

To minimize bias due to non-response, additional 10% and a design effect of 2 for the multistage nature of sampling technique are added to have the appropriate sample size; hence we have a total of $[354 + (354 * 0.10)] * 2 = 778$ youth respondent.

3.4 Sampling Procedure

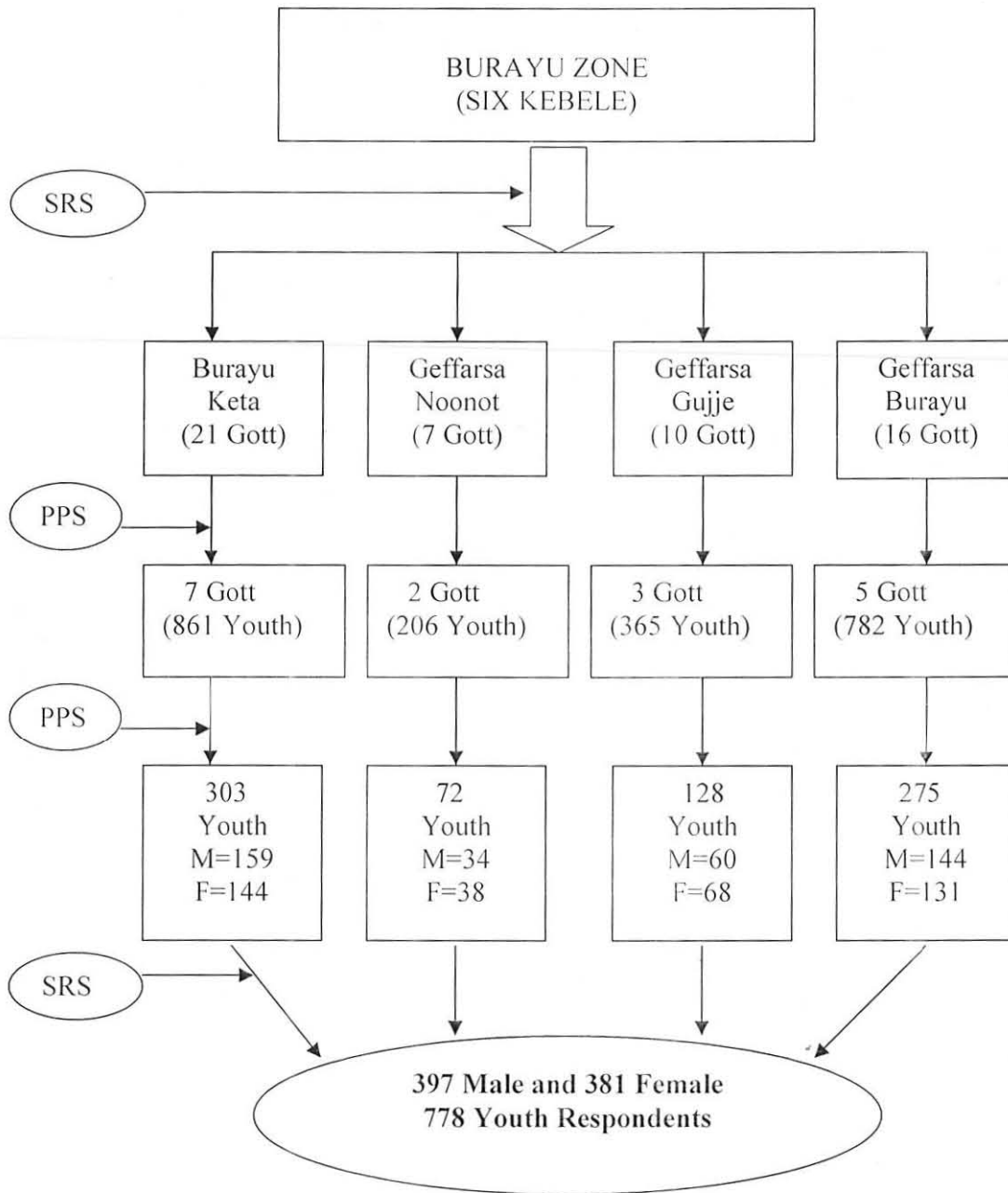
The study subjects were selected from the source population through a multi-stage sampling technique. In the first stage of the sampling process, four kebeles were randomly selected (using lottery method) from all the six kebeles located in the zone. Similarly, 17 gotts¹ were selected from the total of 54 gotts located in the randomly selected four kebeles taking proportional to the number of gotts available in the four kebeles. Finally the study groups (male and female youth in the aged group 15-24) were selected from each gotts proportional to the number of youth living in the gotts. Here the sample frame was prepared by listing all youths age 15 to 24 from a recently updated family roster available with the kebele administrations. During the final selection process, the first youth within the gotts was selected randomly and the consecutive youth included in the sample were selected systematically by adding 'n' to the one previously selected (here 'n' being the sampling interval and calculated from number of youth in the gotts divided by the required number of youth from that particular gotts). When the selected youth was not available at home during data collection, the interviewers revisit his/her home three times at different time intervals. After the three visits, when interviewers failed to get that specific youth, it was excluded from the survey and the interviewers go to the adjacent household with eligible respondents and randomly pick a respondent among eligible youth living in the household.

¹ Gott is division of population under kebele which may contain about 300 households.

Table 3:1 Number of Gotts and Youth in the Selected four Kebele of Burayu Zone, Oromia Region State 2010.

Selected Kebele	Number of gotts in the kebele	Number of selected gotts	Number of youth in the selected gotts	Number of sample youth
Burayu Keta	21	7	861	303
Geffarsa Noonot	7	2	206	72
Geffarsa Gujje	10	3	365	128
Geffarsa Buray	16	5	782	275
Total	54	17	2214	778

3.5 Schematic presentation of the sampling procedure



3.6 Recruitment and Training

A team of six female and six male researches assistant and two supervisors were hired for data collection. Young, high school students and experienced interviewers were hired for the field work in order to obtain respondents confidence and obatine free and frank response. A one day intensive training was given on sampling procedures, administration of individual questionnaire and conduct of in-depth interviews.

3.7 Pre-test

As a part of training, the Amharic and Affa-Oromiffaa version of the questionnaires were pre-tested on 20 young people who are living in the gotts which were not taken as the sample in the study area. The pretest result was used to make the necessary correction of the questionnaire and to estimate the actual time required to fill the questionnaire.

3.8 Field Work

The field survey for the present research was conducted during the period February to April 2010. A close and harmonious relationship with town administration and respondents was first established. This was feasible because of frequent visits to the field, acquaintances with the respondents and controlling contact with them. This helps the investigator in obtaining fairly reliable and valid information from the respondents. Even though researchers faced typical problems in data collection process in the field work, ultimately however we were able to pick up the respondents according to the sampling framework.

3.9 Data Analysis

Responses given to open ended questions were coded after the completion of the field work. After manual edition the data were entered into the computer using SPSS software version 16. Data cleaning was done case by case and variable by variable. Descriptive statistics and multivariate logistic regression were used for the analyses.



Descriptive analysis: The study findings are presented in a form of percentages, means and cross tabulations.

Binary logistic regression model: It was used to see how much the independent variables affect the dependent variable. The model is used when the dependent variable is a dichotomy and it also applies the maximum likelihood estimation after transforming the dependent variable into a logit variable (the natural log of the odds of the dependent occurring or not).

The logistic regression function is explained by the following model:

$$P = \frac{1}{1 + e^{-(a+bx)}} \text{ where } a = \text{is an intercept}$$

b = slope/logit parameters

P = probability that youth uses condom consistently

$1-P$ = the probability that youth not use condom consistently

$$1-P = \frac{e^{-(a+bx)}}{1 - e^{-(a+bx)}}$$

The odd ratio which is the ratio of the probability that youth who uses condom consistently in the last 12 month to the probability of not uses consistently is $P/1-P$, were denoted by

$$\frac{P}{1-P} = e^{-(a+bx)} \text{ and}$$

$$\ln \frac{P}{1-P} = -(a+b_1x_1 + b_2x_2 + \dots + b_kx_k)$$

The results of the logistic regression models were expressed as odds ratios representing the effect of a one-unit change in the explanatory variables. Odds ratios larger than one

indicate a likelihood greater than that of the reference category; odds ratios smaller than one indicate a smaller likelihood as compared with the reference category. All the analyses were estimate separately for male and female respondents.

3.10 Description of Variables

3.10.1 Dependent Variable

A dummy variable which indicates youth who are sexually active in the last 12 months and use or do not use condom consistently was used as dependent variable so as to measure their vulnerability to HIV infection and other sexually transmitted diseases (STDs). Here a code “1” is given for those youths who consistently used condom in the last 12 months where as “0” is given for those youths who reported not using condom consistently in the last 12 months.

3.10.2 Independent Variable

The followings are the main explanatory variables that are included in the study so as to analyses the dependent variable with their respective reference category.

1. Age group: 15-19 versus 20-24 (Reference category).
2. Place of resident: Urban versus Rural (Reference category).
3. Living arrangements: Parents versus Others (Reference category).
4. Educational level: Illiterate, Primary versus Secondary and above (Reference category).
5. School enrollment: Student versus Non-student (Reference category).
6. Work status: Yes versus No (Reference category).
7. Marital status: Ever married versus No (Reference category)
8. Religion: Orthodox verses Others (Reference category).
9. Ethnicity: Oromo verses Others (Reference category).
10. Parent and youth communication; Yes versus No (Reference category).

3.11 Ethical Consideration

Ethical clearance for the study was obtained from the Department of Population Studies Addis Ababa University. During the study, full information was given to the study participants on the purpose and nature of the research and only those youth who gave their consent to participate in the study were enrolled as the respondents of the study. Confidentiality of the information obtained from the participant will be maintained strictly.

CHAPTER FOUR

BACKGROUND CHARACTERISTICS

4.1 Socio-Economic and Demographic Characteristics of Youth

A total of 723 males and females youth living in Burayu Zone participated in the study, giving a response rate of 93.0%. Females account for 356(49.8%) of the respondents while the remaining i.e. 367(50.2%) are male. About 77.2 percent of the females and 80.7 percent of the males live in urban areas and the remaining live in the rural areas of the Zone.

The age and sex differentials of the respondents showed that 190(53.4%) of the females and 155(42.2%) of the males were in the age group 15-19 years. While, 212(57.8%) of the males and 166(46.6%) of the females were in the age group 20-24 years. The mean age of respondents was also found to be 19.3 for females and 19.7 for male youth.

About 58 percent of the respondents belong to the Oromo ethnic group followed by Amhara, 20.7 percent and Gurage 10.6 percent. It was further found out that the majority, 57.9 percent of the female and 51.5 percent of the male respondents are followers of Orthodox Christianity while Muslims account for 27.8 percent of the females and 25.1 percent of the males respondents. The great majority i.e.92.7% of the female and 94.0% of the male respondents are literate. About a third i.e. 36.2% of the females and 26.7% of the males had elementary level education and higher proportion i.e. 42.7% of the females and 41.1% of the males had a secondary school level education.

The living arrangement of the respondents showed that the majority of youth, that is 64.9% of the females 54.0% of the males, were currently livings with their parents. Only 16.9% of the females and 10.1% of the males reported ever married. The details of the basic socio demographic characteristic of the respondents are outlined in Table 4.1 below.

Table 4:1 Percentage distribution of youth by socio-economic and demographic characteristics, Burayu Zone, Oromia Region 2010.

Socio-Economic and Demographic Variables	Female			Male		
	Total	Number	Percent	Total	Number	Percent
Age group	356			367		
15-19		190	53.4		155	42.2
20-24		166	46.6		212	57.8
Educational level	356			367		
Illiterate		26	7.3		22	6.0
Primary		129	36.2		98	26.7
Secondary		152	42.7		151	41.1
Above secondary		49	13.8		96	26.1
Marital Status	356			367		
Ever married		51	14.3		47	12.8
Never Married		305	85.7		320	87.2
Work Status	356			367		
Yes		122	34.3		162	44.1
No		234	65.7		205	55.9
Religion	356			367		
Orthodox		206	57.9		189	51.1
Muslim		99	27.8		92	25.1
Protestant		39	11.0		73	19.9
Catholic		5	1.4		5	1.4
Others		7	2.0		8	2.2
Ethnicity	356			367		
Oromo		205	57.6		214	58.3
Amhara		77	21.6		73	19.9
Tigre		6	1.7		9	2.5
Gurage		35	9.8		42	11.4
Others		33	9.3		29	7.9
Place of residence	356			367		
Urban		275	77.2		296	80.7
Rural		81	22.8		71	19.3
Currently living with	356			367		
Mother and Father		144	40.4		128	34.9
Mother Only		59	16.6		59	16.1
Father Only		28	7.9		11	3.0
Brother/Sister		22	6.2		48	13.1
Relatives		22	6.2		35	9.5
Alone		30	8.4		53	14.4
Spouse		51	14.3		33	9.0

4.2 Background Characteristics of youth's parents

Table 4.2 outlines the basic background characteristic of the parent's of the youth respondents. Accordingly, the father's of about a third i.e. 34.8% of the female and 31.1% of the males reported to have secondary level education where as about 23.0% of the female and 21.0% of the male respondents' reported that their father have primary level education.

Table 4:2 Background Characteristics of Youth's Parents, Burayu Zone, Oromia Region 2010.

Variable	Female			Male		
	Total	Number	Percent	Total	Number	Percent
Father educational level	286			296		
Illiterate		34	9.6		35	9.5
Grade 1 - 8		82	23.0		77	21.0
Grade 9 - 12		124	34.8		114	31.1
Above Secondary		46	13.0		70	19.1
Father occupation	286			296		
No occupation		7	2.4		13	4.4
Daily laborer		11	3.8		15	5.1
Civil servant		98	34.3		112	37.8
Farmer		42	14.7		27	9.1
Employed in private sector		30	10.5		46	15.5
Others		98	34.3		83	28.0
Mother educational level	282			306		
Illiterate		115	32.3		101	27.5
Grade 1 - 8		91	25.6		101	27.5
Grade 9-12		51	14.3		79	21.5
Above Secondary		25	7.0		25	6.8
Mother occupation	282			306		
House wife		165	58.5		171	55.9
Daily laborer		10	3.5		10	3.3
Home servant		4	1.4		12	3.9
Civil servant		33	11.7		39	12.7
Employed in private sector		43	15.2		41	13.4
Others		27	9.6		33	10.8

Almost a quarter (25.6% of the female and 27.5 male) of the respondents reported that their mother's have primary level education. And, about 14.3% of the female and 21.5% of the males respondents' reported that their mother have attended secondary level education.

Nearly a third (34.3 percent of the females and 37.8 percent of the males) reported that their father's are civil servants while very few (2.4% of the females and 4.4% of the males) of the respondents reported that their father's were unemployed. Over half of, (58.5% of the female and 55.9%) of the male respondents' reported as their mother are housewives.

4.3 Sexual Initiation among Youth

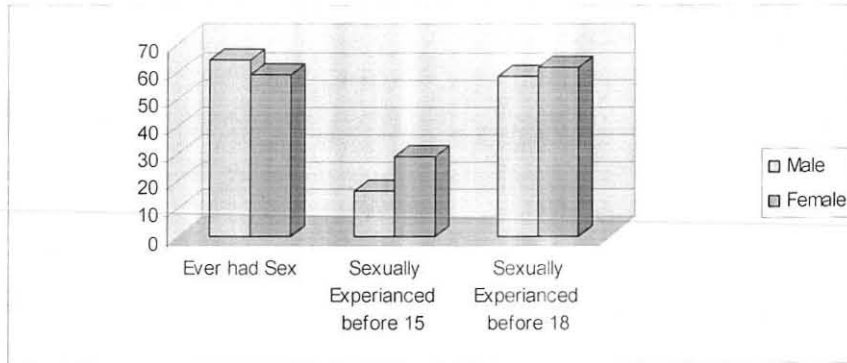
This section describes differences in the timing of sexual initiation among male and female youth. Figure 4:1 shows the percentage of males and females youth who ever had sex and the time of their sexual debut. Accordingly, the result shows that 448(61.9%) of all youths have had sexual experience. Slightly higher proportion of males reported having sexual experience (63.8% males' vs. 60% of the females)

Out of the sexually experienced youths, about a third (29 percent) of the females and 16.3% of the males reported starting to have sex before reaching the age of 15 years. While the proportion of respondents who reported starting to have sex before reaching the age of 18 has raised to 61.5 percent for the females 58.1 for the males. The mean age at sexual debut is 17.2 and 16.5 years for males and females respectively. The above figures showed that sexual initiation typically occurs at an early age for both sex, however as compared to males, females are more likely to start sex before reaching the age of 15 and 18.

The further assessment made on the main reasons for starting sexual intercourse among youth show that also about 146(62.4%) of the males and 72(33.6%) of the females started sex for enjoyment and pleasure. While about 52(22.2%) of the males and 59(27.6%) of the females reported to have started sex due to peer pressure. Very few i.e. 1(0.4%) of the male and 7(3.3%) of the female respondents reported to have started

sex for the sake of money. This indicates that among the study group peer pressures plays considerable role for the youth to start having sex.

Figure 4:1 Percentage distribution of youth who were sexually experienced before age 15 and 18, Burayu Zone, Oromia Region 2010.

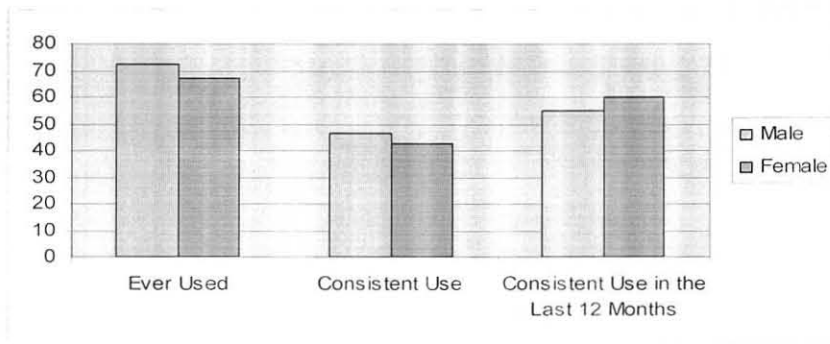


4.4 Condom Use among youth

Out of the 214 female and 234 of the male sexually experienced youth about 67.3% of the females and 72.2% of the males have used condom at least once in their sexual life. Though a relatively larger proportion of sexually active youths reported ever using condom, the practice of consistent condom use was found to be relatively low, as only 91(42.5%) of the females and 108(46.2%) of the males reported using condom consistently. The fact that relatively large proportion of youth are not consistently using condom showed that this behavior could increase their risk of exposure to different STDs including HIV/AIDS.

Assessment made on the current sexual practice of youth showed that, 118(55.1%) of the females and 186(79.5%) of the males who reported ever having sex also reported they were sexually active within twelve months prior to the survey date. Out of the latter group, about 71(60.2%) of the females and 102(54.8%) of the males reported consistently using condom during every act of sexual intercourse. This shows that, there is a relative increase in the proportion of sexually active youth with a consistent condom use among those who reported having sex in the last twelve months.

Figure 4:2 Percentage distribution of condom use among youth, Burayu Zone, Oromia Region 2010.



4.4.1 Age Disaggregate on Condom Use

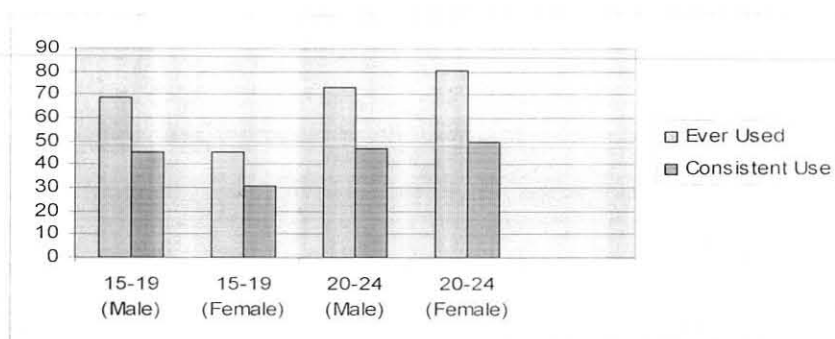
The age differentials in ever use and consistent use of condom show that as the age of youth increases their probability of using condom and its consistent use increases. In this regard the results of the study showed that, out of sexually experienced 64 males and 81 females in the age group 15 to 19 about 44 (68.8%) of the males and 37(45.7%) of the females use condom at least ones in their sexual life. While, about 29(45.3%) of the males and 25(30.9%) of the females consistently use condom within this age group.

Out of sexually active 170 males and 133 females youth in the age group 20-24, about 125(73.5%) of the males and 107(72.6%) of the females were ever use condom. Concerning consistent use of condom about 79(46.5%) of the males and 66(49.6%) of the females use condom consistently in every sexual intercourses within this age group. Females in this age group are more likely to use condom and also have a relatively high proportion of consistent use of condom than male.

Findings also showed that among male respondents as age increases change is observed in proportion who reported ever and consistent use of condom. In this regard, about 44(68.8%) of the males in the age group 15-19 and 125(73.5%) of those in the age group 20-24 reported ever use of condom. Similarly, 29(45.3%) of males in the age group 15-19 and 79(46.5%) of those in the age group 20-24 reported consistently use of condom. It was also shown that among females the proportion of both ever and

consistent use of condom increases as the age of the respondents increases. Out of the sexually active females, about 37(45.7%) in the age group 15-19 and 107(80.5%) of those in the age group 20-24 reported ever use of condom. While, 25(30.9%) of the female in the age group 15-19 and 66(49.6%) of the females in the age group 20-24 reported consistently used condom.

Figure 4:3 Percentage distribution of condom use by age and sex, Burayu Zone, Oromia Region 2010.



Out of sexually experienced youth about 126(53.8%) of the males and 123(57.5%) of the females reported either not using condom at all or failed to consistently use condom during every sexual intercourse. Findings on the main reasons why youth fail to use condom or unable to use it consistently showed that 35(9.5%) of the males and 41(11.5%) of the females reported that they do not think of using condom. About 29(7.9%) of the males and 33(9.3%) of the females youth also reported that they did not use condom because they trust their partners. Only 5(1.4%) of the males and about 18(5.1%) of the females fail to use condom because their partner refuse to do so. In addition about 5(4.0%) of the males and 9(7.3%) of the females reported that they are fail to use condom because it is not available at that time.

4.5 Multiple Sexual Partners and Risky Sexual Practices among Youth

4.5.1 Number of Life Time Sexual Partners

Information on the number of lifetime sexual partners and the number of partners during the past 12 month prior to the survey date was collected from sexually active

female and male youth. Accordingly, out of 214 of the females and 234 of the males who were sexually experienced, about 147(62.8%) of the males and 71(33.2%) of the females reported as they have had two or more lifetime sexual partners. Here the proportion of male who reported life time sexual partners is found to be almost twice that of the females. Age differentials also shows that males and females in the age group 20-24 are more likely to report having multiple sexual partners than those in age a group 15-19. In this regard about 34(23.1%) of the males and 29(40.8%) of the females in the age group 15 to 19 have reported having two or more sexual partners, while the proportion of sexually active youth in the age group 20-24 and who reported having multiple sexual partners is 113(76.9%) for the males and 42(59.2%) for the females.

Out of sexually active youth 186(79.5%) of the males and 118(55.1%) of the females have reported having sex within 12 months prior to the survey date. Among these 15(12.7%) of the females and 36(19.4%) of the males reported having sex with two or more sexual partners during the same period.

4.5.2 Age of Sexual Partner at the First Sex

About 28(7.9%) of the female and 6(1.6%) of the male sexually active youth have their first sex with a person who is 10 years and above older than them. Similarly, about 100(28.1%) of the females and 42(11.4%) of the males reported having their first sex with a person who is 5 to 10 years older. Assessment of the behavior of youth in condom use during their first sexual intercourse showed that about 144(67.3%) of the sexually active females and 169(72.2%) of the sexually active males used condom during their first sexual intercourse.

4.5.3 Sex with Commercial Sex Worker:

A total of 14(6.0%) of sexually active males reported ever having sexual intercourse with commercial sex workers. Out of them, 12(85.7%) reported consistently using condom every time they had sex with CSW and the remaining 2(14.3%) reported not consistently using condom while having sex with them.

Table 4:3 Percentage Distributions of Youth by Sexual Behavior, Burayu Zone, Oromia Region 2010.

Variables	Female			Male		
	Total	Number	Percent	Total	Number	Percent
Ever had sex	356			367		
Yes		214	60.1		234	63.8
No		143	39.9		133	36.2
Age at first sexual intercourse	214			233		
Under 15		62	29.0		38	16.3
15-18		88	41.1		121	51.9
19-24		64	29.9		74	31.8
Partner's age in the first sex	214			234		
Older than 10 yrs		28	7.9		6	1.6
Older than 5-10 yrs		100	28.1		42	11.4
Younger than me		10	2.8		58	15.8
Age Like me		65	18.3		124	33.8
Do not know		11	3.1		4	1.1
Life time sexual partners	214			234		
One		143	66.8		87	37.2
Two or More		71	33.2		147	62.8
Ever had sex in the last 12 months	214			234		
Yes		118	55.1		186	79.5
No		96	44.9		48	20.5
Partners in the last 12 month	118			186		
One		103	87.3		150	80.6
Two or More		15	12.7		36	19.4
Consistent condom use in the last 12 months	118			186		
Yes		71	60.2		102	54.8
No		47	39.8		84	45.2
Ever develop the symptom of STDs	214			234		
Yes		21	9.8		36	15.4
Not		193	90.2		198	84.6

4.6 Youth Exposure to Sexually Transmitted Diseases (STDs)

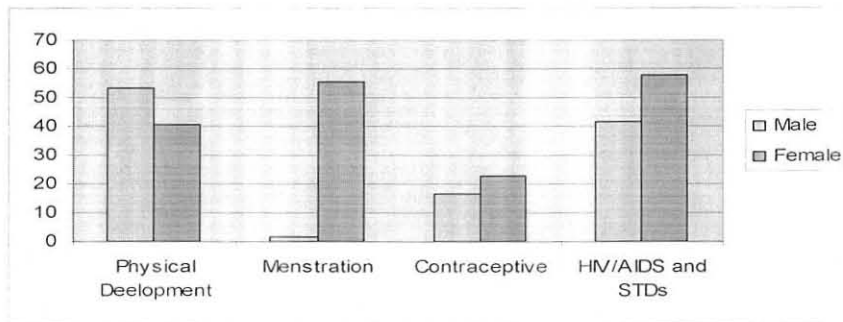
The assessment on youth exposure to sexually transmitted disease show that out of sexually experienced youth, about 36(15.4%) of the males and 21(9.8%) of the females youth reported as they have ever developed a symptom of sexually transmitted disease (STDs), at least ones in their life time.

In addition the data shows that males and females youth are vulnerable to STDs differently in different age group. Out of the youth who ever develop the symptom of STDs, about 14(38.9%) of the males and 14(66.7%) of the females developed the symptom of STDs belong to the age group 15-19, while 22(61.1%) of the males and 7(33.3%) of the females who develop the STD symptoms are in the age group 20-24 years. This result reflects that females in the age group 15 to 19 are more likely to expose to the risk of HIV/AIDS and STD infection.

4.7 Discussion about Sexual and Reproductive Health Issues with Parents

Assessments made on behavior of youth discussing reproductive health issues with parents showed that about 197(55.3%) of the females and 110(30.0%) of the male respondents discussed about certain sexual and reproductive health issues with their parents. Out of the total of youth who reported ever discussing RH issues with parents about 59(53.6%) of the males and 80(40.6%) of the females discuss about their physical change during adolescent. Only 18(16.4%) of the males and 45(22.8%) of the females youth discuss about contraceptive issue with their parents. It was also found that 46(41.9%) of the males and 114(57.9%) of the females discuss either about HIV/AIDS or other STDs with their parents. Here we can see that female are some how tends to discuss with their parents regarding their sexuality and reproductive health issues than male.

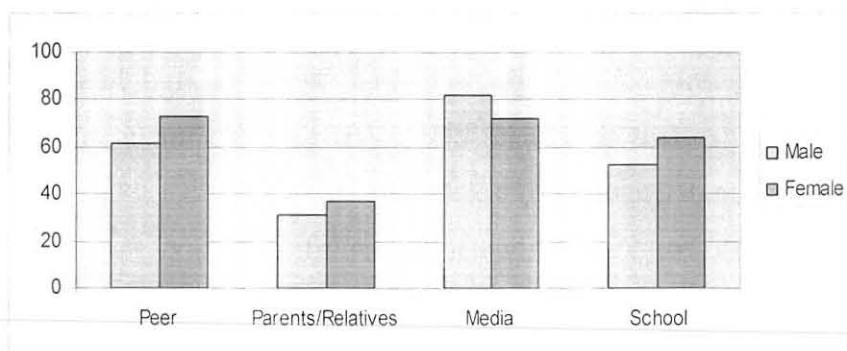
Figure 4:4 Percentage distributions of youth who discuss RH issues with parents, Burayu Zone, Oromia Region 2010.



4.8 Sources of Information about HIV/AIDS among Youth

The assessment of sources of information regarding HIV/AIDS and related issues among youth was shown in the figure below. Out of the total 367 males and 356 females about 297(81.6%) of the males and 254(72.0%) of the females obtain HIV/AIDS related information from Radio and/or television (media), while 131(37.1%) of the females and 114(31.3%) of the males respondents reported that parents and/or relatives were the main source of HIV/AIDS related information. Further 258(73.1%) of the females and 192(52.7%) of the males respondents reported as they obtain information about HIV /AIDS from school and also 224(61.3%) of the males and 227(64.4%) of the females reported as they are getting HIV/AIDS related information from their peer groups.

Figure 4:5 Percentage distributions of sources of information about HIV/AIDS among youth, Burayu Zone, Oromia Region 2010.

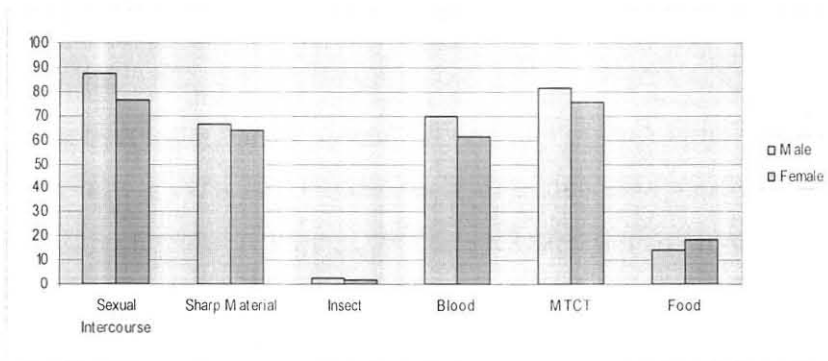


4.9 Knowledge about HIV/AIDS Transmission among Youth

Most of the youth in the study area have the basic knowledge about the mode of HIV/AIDS transmission. The multiple response result shows that out of the total youth participated in the study about 271(76.8%) of the females and 317(87.1%) of the males knows that unprotected sexual intercourse is the main transmission of the virus. The other 225(63.7%) of the females and 241(66.2%) of the males reported that the virus can transmits through Sharing of sharp materials with HIV infected person and about 298(81.9%) of the males and 267(75.6%) of the females respondents reported that HIV/AIDS can also transmitted from infected mother to the unborn children.

The results also indicate that many youth in the study area have adequate knowledge about the ways in which the HIV/AIDS virus can and cannot be transmitted. Though 8(2.2%) of the females and 7(2.0%) of the males from the total youth erroneously believed that HIV/AIDS can be transmitted by mosquito bites, the majority reject this common misconception. Larger proportions of males and females also believed that HIV/AIDS is not a curse of God, which is about 330(90.7%) of the males and 313(88.7%) of the female. Although about 291(81.6%) of the females and 316(86.0%) of the males knows that HIV/AIDS virus is not transmitted by sharing food with a person who is infected with HIV/AIDS virus.

Figure 4:6 Knowledge about mode of transmission of HIV/AIDS among youth, Burayu Zone, Oromia Region 2010.

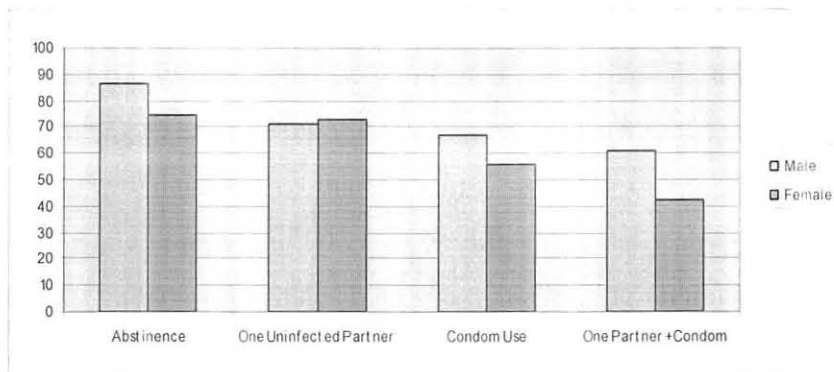


4.10 Knowledge of Ways to Reduce HIV/AIDS Transmission among Youth

The assessment on the knowledge of youth whether they can reduce the chances of getting HIV/AIDS virus by having just one faithful sexual partner, using a condom in every sexual encounter, and abstaining from sex show that about 257(72.8%) of the female and 260(71.4%) of the male youth aware that the chances of getting the HIV/AIDS virus can be reduced by limiting sex to one uninfected partner and also 266(74.7%) of the females and 316(86.8%) of males the reported that abstaining from sexual intercourse also reduces the chances of getting HIV/AIDS virus.

Around six in ten females and seven in ten males are aware that using a condom consistently during sexual intercourse can reduce HIV/AIDS transmission. In addition about 151(42.7%) of the males and 222(60.9%) of the females have an awareness about using condoms and limiting sex to one uninfected partner can reduce the risk of getting HIV/AIDS virus. It was also reported that about 315(89.2%) of the females and 348(95.6%) of the males believe that avoiding sex with casual partners reduces the chance of getting and contracting HIV/AIDS virus and finally about 278(78.8%) of the females and 311(85.4%) of the males believed that avoiding premarital sex also reduces the chance of getting and contracting of HIV/AIDS virus.

Figure 4:7 Percentage distributions of youth by knowledge to reduce HIV/AIDS transmission, Burayu Zone, Oromia Region 2010



CHAPTER FIVE

LOGISTIC REGRESSION ANALYSIS

5.1 Binary Logistic Regression Analysis

For behavioral as well as physiological reasons, early sexual debut increases young peoples' risk for infection with HIV and other STDs. Youths who begin sexual activity early are more likely to have high-risk sex or multiple sexual partners and are less likely to use condoms and they are vulnerable to HIV infection (DHS, 2005). Hence youth who are initiated sex and fail to use condom consistently are more vulnerable to HIV infection than the other group. Youths who are sexually active in the last 12 months and use condom consistently or not used as a dependent variable to measure their vulnerability to HIV and other STDs. Here condom use behavior in the last 12 month was selected as a dependent variable because youth can easily recall it and give correct information.

5.2 Consistent condom use among youth in the last twelve months

This section describes the result of the logistic regression model estimating the effect of various independent variable on the likelihood that a respondent who are sexually active in the last 12 months and able to use condom consistently or not. The variable is labeled as a dummy variable where one, was coded for the respondent, who use condom consistently in the last 12 month while zero was code for a respondent who do not use condom consistently.

The results from the binary logistic regression analysis indicated that both male and female youth in the age group 15 to 19 are 22.0 percent and 27.5 percent lower to use condom consistently in the last twelve month than the other age group respectively, indicating that young male and female are more vulnerable to HIV infection than the older group. The other finding is that youth males and females who are living with their parents at the time of the survey are 23.5 and 9.1 times more likely to use condom in their each and every sexual intercourse respectively and they are less vulnerable to HIV

than other group and the effect is more significant for male. From the odd ratio of educational level of respondent we have that illiterate male (by 98.3 percent) and female (by 95.0 percent) lower to use condom consistently in their sexual intercourse in the last 12 month than those youth whose educational level is secondary and above but having elementary level educational status has not significantly affects consistent condom use.

The other determinant factor is youth discussion about reproductive health issue with parents. Though most youth are not prefer to discuss about reproductive health issues with their parents, the result shows that youth males and females who are used to discuss about a certain reproductive health issue with their parents are 8.8 and 6.8 times more likely to use condom consistently and are less vulnerable to HIV/AIDS infection than the other group in the last 12 moths respectively. School enrollment was also found as an important determinant factor in the behavior of consistent condom use, the result show that youth males and females who are enrolled in school are 9.6 and 14.2 times more likely to use condom consistently than out school youth respectively, indicating that in school youth have more awareness about HIV/AIDS and condom than the out school youth. The result also shows that place of residence of male and female has an impact on consistent use of condom in their sexual intercourse in the past 12 months. Youth males and females who are living in urban area are 6.4 and 11.2 times more likely to use condom consistently than rural dweller respectively, indicating that youth in urban area have more awareness and facility of condom and are less vulnerable to HIV/AIDS than the rural youths.

The other independent variables are work status of respondents and economic status of parents. The result show that youth males and females who have work are 8.9 and 13.6 times more likely to use condom consistently than the other groups respectively, showing that youths when ever they have job or work it increases their confidence on condom negotiation and can avoid risk factor that predispose then to contract STDs and HIV/AIDS in particular.

Table 5:1 Relative Odds of youth who are sexually active in the last twelve months and able to use condom consistently by Sex and Socio Demographic Characteristics, Burayu Zone, Oromia Region 2010.

Independent Variables	Sex					
	Male			Female		
	B	S.E	ExpB	B	S.E	ExpB
Age group						
15-19	-0.248	0.675	0.780*	-0.321	1.450	0.725*
20-24			1.000			1.000
Living with						
Parents	3.158	1.036	23.531**	2.206	1.427	9.080*
Other			1.000			1.000
Educational level of respondent						
Illiterate	-4.088	1.232	0.017**	-2.901	1.464	0.050*
Primary	-0.963	0.891	0.382	1.386	1.307	3.998
Secondary and above			1.000			1.000
Discuss RH issues with parents						
Yes	2.178	0.894	8.832*	1.922	0.957	6.834*
Not			1.000			1.000
Marital status of respondent						
Ever Married	-1.540	0.908	0.214	0.650	0.773	1.916
Not			1.000			1.000
School enrollment						
Yes	2.268	0.832	9.662**	2.665	1.319	14.172*
No			1.000			1.000
Place of residence						
Urban	1.857	0.772	6.406*	2.413	1.003	11.172*
Rural			1.000			1.000
Religion						
Orthodox	-0.012	0.667	0.988*	-0.008	0.764	0.992*
Others			1.000			1.000
Ethnicity						
Oromo	-1.132	0.854	0.322*	-1.210	0.543	0.298**
Others			1.000			1.000
Work status of respondent						
Yes	2.187	0.863	8.909*	2.613	1.140	13.644*
Not			1.000			1.000
Constant	-1.524	0.847	0.218*	-1.540	1.787	0.214*

1. *P<0.05 and **P<0.01. N_F=118 and N_M= 186

2. 86.3 % and 76.8% of the dependent variable is explained by these independent variables for the respective male and female respondents.

Consistent condom use among youth is not differ by religion, it is the same for Orthodox religion followers and for the other religion followers where as ethnicity significantly affect the behavior of youth on consistent use of condom in the last 12 months, for example male from Oromo ethnic group are 67.8 percent and female also in the same ethnic group are 70.2 percent lower to use condom consistently in the last 12 months than the other ethnic groups.

5.3 Result of Focus Group Discussion among Youth in Burayu Town

All participants of the focus-group discussions and in-depth interviews agreed that the pattern of the HIV/AIDS epidemic was getting worse over time, as they are observing the disease seriously affecting the young and productive population groups in the zone.

Males FGD discussants agreed that males often start sex latter than females of the same age. When justify this, females are continuously asked for sexual relationship by a number of males ones they reached puberty. Similarly the female group also emphasized that females have a higher chances to starts sex early than boys because they were constantly coerced by matured and older men and some times may be cheated to have sex early. Peer pressure from the same sex usually pressurizes the younger one to commence sex. Both group further reported that male youths found at the center of Burayu town makes money in their early age because they works in Burayu Slaughter in the morning (even parallel to learning in the regular school programmes) and having money creates a chance to introduce themselves with girls and to start sex earlier than youth living in the other kebeles.

Regarding condom use some of the group participants said that condom is not a good option as a prevention method. The other also believed that condom is useful only for sex workers and those people who have multiple sexual partners. They also believe that condom encourages youth to start sex at early age. The focus group discussant noted that most youths in the area don't use condom in every act of sexual intercourse particularly at first sexual intercourse and also youths do not have the confidence to purchase condom from shop or Pharmacy when they needed. The female group said the reason for low condom use especially during first sex is that males usually not expect

any disease from the girls, especially who hadn't sex before, and also have not willing to taken the virgin with condoms. The male group also said that we are not ready during first sex and this is because most of the time first sex occurs accidentally.

The FGD discussants also noted that since it is embarrassing to discuss about sex within the family, mostly the youth don't get information about reproductive health issues starting from early age. They also discussed on the source of sexual and reproductive health information and they reported that getting it from mass media and informally from peers.

It was also reported that there was a trend among youths male for taking too much alcohol after chewing *khat* to break *mirkana* and alcohol makes it difficult for the dependent user to judge what is right or wrong, what is good or bad, and what is moral or immoral. Therefore, it undermines judgment and reduces people's ability not to indulge in unsafe and risky sexual practices that facilitate the transmission and spread of HIV/AIDS.

In conclusion, the findings of this study have shown that youths in the study area practice multiple sexual partner and other risky sexual activity without consistent condom use and in particular female group indicated that males are the one that involve in having multiple sexual partners, because they consider rejecting of the pervious and having other sexual partner as fame in addition to the money they have, therefore, they are at a risk of HIV/AIDS and other sexually transmitted infections. Finally many youths reported the habit of substance abuse in terms of drinking alcohol and chewing *khat* which were significantly associated with risky sexual practices.



CHAPTER SIX

DISCUSSION, CONCLUSION AND RECOMMENDATION

6.1 Discussion

This study has described gender differentials in youth sexual behavior and vulnerability to HIV/AIDS in Burayu zone, and has examined the extent to which male and female youth are exposed to the risk of HIV/AIDS by the same factors. Several important findings emerged from this study. Results showed that about 61.9 percent of youths (that is 63.8 percent of males and 60.1 percent of females) are sexually active. This finding is consistent with the result of a similar study conducted in Bahir Dar where about 64.2 percent of out of school youth are reported to be sexually experienced (Hibret A et al, 2003) while the figure is a little higher than the result found among youths in North East Ethiopia which shows that 51.3 of the youth respondents were sexually active (Fikadu M. et al, 2009).

Out of the sexually experienced youths, about a third (29 percent) of the females and 16.3 percent of the males reported starting to have sex before reaching the age of 15 years. While the proportion of respondents who reported starting to have sex before reaching the age of 18 has raised to 61.5 percent for the females 58.1 for the males. The above figures showed that sexual initiation typically occurs at an early age for both sex, however as compared to males, females are more likely to start sex before reaching the age of 15 and 18. This figure is greater than the findings in the 2005 DHS where about 11.5 percent and 31.6 percent of female youth living in Oromia region had sex before reaching the exact age 15 and 18 respectively. But , only 1.4 percent and 9.8 percent of the male from the same region have started sex before the exact age 15 and 18 years respectively. Though the result of the other study is not disaggregated by sex, the finding of this study was consistent with the findings of another study MOH (2003), where 33 percent of the out school youth and 25 percent of the in school youth started to have sex before reaching the exact age 15. The result of the study less than the result obtained by a study conducted by the Family Guidance Association of Ethiopia

(FGAE) which reported that about 71.9 percent of male and 71.4 percent of female youth have their first sex in the age group 15 to 17 (FGAE, 2003).

The study indicates that the mean age at first sexual commencement was 16.9 (17.2 for male and 16.5 for female). A study conducted on the determinants of high risk sexual behavior for HIV/AIDS among out-of school youth in Addis Ababa showed that 52.2 percent of the boys and 47.8 percent of the girls have had sexual experience with mean age of sexual commencement being 17 years (Abate S, 1999). Similarly, a study conducted on school anti-AIDS club members and non-members in Agaro and Jima areas showed that about one- third of the club members and a quarter of non-club members admitted to have sex with the mean age at sexual debut of 16.8 years (Yazachew M, 2003).

In this study findings showed that it is very common for youth especially; older males and females in the age group 20-24 to have multiple sexual partners, it was further shown that six out of every ten male and three out of every ten female had two or more sexual partners during their sexual life. The data clearly show that even though both males and females tend to be sexually active before reaching the exact age 18, higher proportion of youth in the age group 20-24 are found involved in risky sexual practices.

The study also indicates that among the youth who reported ever having sex, 79.5 percent of male and 55.1 percent of female youth had sex within 12 months preceding the survey date and among this about 12.7 percent of female and 19.4 percent of men reported as having had two or more sexual partners during same period. This finding is inconsistent with the result of the study conducted among out-of-school anti-AIDS club members and non-member youths, in Jima and Agaro towns, which showed that of the sexually active respondents, 30.3 percent of club members and 16.4 percent of the non-club members reported having had two or more sexual partners in the last one year (Yazachew M, 2003).

This study finds out that though a relatively large number of youths used condom the practice of consistent use is low as only about 42.5 percent of female and 46.2 percent of male reported consistently using condom in their sexual life. However, the recent

behavior of youth toward condom use further shows that among youth who reported being sexually active during the last 12 months about 54.8 percent of the males and 60.2 percent of female reported consistent condom use i.e. used condom during every act of sexual intercourse. This shows that there is a relative increases in the proportion of youth reporting consistent condom use in the recent time. The Behavioral Surveillance Survey conducted five years ago in Ethiopia showed that although condoms were readily accessible, only 50 percent of sexually active in-school and out-of-school youth had ever used them with non-commercial partners. Similarly, in the same study consistent condom use in the past 12 months with non-commercial partners was reported to be 39 percent for out- of- school youth and 73.6 percent for the in-school youth (MOH, 2007; 1). Another study conducted among high school students in Agaro town showed that among 25 percent of students who had a history of sexual intercourse about 54.4 percent used condoms at least once but only 9 percent were using condoms always (Girma B. et al, 2002). A similar study conducted among students of Gondar College of Medical Sciences (GCMS), showed that 56.1 percent of the respondents were sexually active and among them, only 37.1 percent reported ever using condom and much lesser proportion i.e 6.4 percent reported consistent condom use(Fitaw Y. et al, 2002).

In the current study the gender and age disaggregated data for condom use showed that as the age of the respondent increases the probability of using condom and its consistency increases. Out of 41.3 percent of male and 42.6 percent of females who were sexually active in the age group 15-19, about 68.8 percent and 45.7 percent reported ever using condom respectively. While, about 45.3 percent and 30.9 percent of them used condom consistently respectively within this age group.

Differences are also observed among male and female sexually active youth in the age group 20-24. Females in this age group are more likely to use condom and also have a relatively high percentage of consistent use than males. Out of 62.1 percent of males and 72.6 percent of females who were sexually experienced in this age group, about 73.5 percent of the males and 80.5 percent of the females were ever used condom.

While, about 46.5 percent of the males and 49.6 percent of the females consistently use condom within this age group.

As could be anticipated, these high rates of youth sexual activity, combined with low and inconsistent use of the condom, lead to fairly high prevalence of sexually transmitted diseases and contracting HIV/AIDS. In the study population, males aged 20-24 years have the highest incidence of sexually transmitted diseases but it is evident that female also face considerable high sexual and reproductive health risks, even at a very young age, 15.4 percent of male and 9.8 percent of female, the result was less than the finding in similar study in Bahir Dar, where about 55 percent of male and 45 percent of female reported symptom of STDs (Hibret A et al, 2003). The results from this study highlight the need for additional and better programmes specifically designed to address the sexual and reproductive health risks of youth in the area.

In this study it is also shown that peer pressure encourages early sexual initiation among both males (22.2 percent) and females (27.6 percent). This result is less than the finding obtained among adolescents in Addis Ababa, where is 35.2 percent of sexually active youth have their first sex due to peer pressure (Eshetu F. et al, 1997)

From the logistic regression result among the main explanatory variables: living with parents, living in urban area, school enrollment, discussing reproductive health issues with parents and having job or work are positively associated with consistent condom use in the last 12 months and implying youths in this categories are less vulnerable to HIV and other STDs. Female in the age group 15 to19 found to be less likely to use condom consistently than those in the older group and illiterate male and female youth are also less likely to use condom consistently than youths whose educational level are secondary and above. Marital status is found to have no significant effect on youth consistent condom use in the last 12 month. Finally male from poor parent economic status are less likely to use condom consistently than the other group but this variable has no effect on female group.

6.2 Conclusion

This study was conducted among youth in Burayu zone to explore factors influencing sexual activity among male and female youth separately; hence on the basis of the results of the study the following conclusions are drawn:

Considerable proportion of the youth in the area exhibited high risk sexual behavior that predisposed them to HIV infection. The risk behavior includes multiple sexual partners, early sexual activity and inconsistent or non use of condoms. Young male and female are found to be more at risk to contract STDs and HIV/AIDS due to unprotected sex.

Females were relatively more exposed to risky sexual behavior as compared to males in the same age group due to early sexual initiation and inconsistent condom use. Sexually active youth who are living with their relatives or alone are less likely to use condom consistently than youth in the other age group and are at a higher risk of contracting STDs and HIV/AIDS.

Open and free communications and discussion between parents and youth on matters of sexual issue was very low. So youth preferred to discuss with their peers that encourages early sexual initiation than postpone to marriage.

Young male are much more likely to have multiple sexual partners and engaged in higher risk sexual behavior than females in the same age group. Sexual initiation typically occurs at an early age for both sex, however females are more likely to start sex before reaching the age of 15 and 18. It was also found that also mean age at sexual debut is low for male and female, which are 17.2 and 16.5 respectively in the study.

A significant number of sexually active youth reported ever experiencing symptom of STIs, which is the major indication for the youth as they are vulnerable to HIV and this may aggravate the problem in controlling and preventing the diseases.

6.3 Recommendation

Although it needs more detailed and frequent study, on the basis of the present findings it is reasonable to recommend the following points.

1. The finding that sexual initiation typically occurs at an early age in the study area implies that HIV/AIDS prevention and other reproductive health programs need to target youths when they are very young, particularly for females.
2. Youth who regularly discusses about sexual and reproductive health issues with their parents are more likely to use condom consistently during sexual intercourse than the others. This finding suggests that parents are an effective source of family life education, hence community based training is important so as to encourage parents in the study area to discuss on reproductive health issues including HIV/AIDS with their children.
3. Risk and vulnerability to HIV/AIDS are substantially different for male and for female and this has implications in order to have appropriately designed strategies in the study area that takes gender differences in to consideration so as to reduce overall prevalence of HIV/AIDS and STIs.
4. Youths who are in- school and out-of-school; rural and urban; the employed and the unemployed are differently vulnerable to HIV/AIDS and STDs so that programmes for youth also need to recognize this diversity to reduce the prevalence among youth population in the area.
5. Finally, having been said, one comes from this research with a sense that there is not one factor that explains most youth sexuality and vulnerability to HIV infection in the study area. The factors that put young people at risk for health compromising sexual behaviors are multifaceted. So, too, the factors that protect young people from harm are equally complex. This paper should give programmes planners and policy makers in regional level and to Burayu zone HIV/AIDS prevention control office in particular some clues of where the evidence lays as to what influences sexual and reproductive health outcomes among youth.

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ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTES OF POPULATION STUDIES

Confidentiality and Consent

Dear respondent,

My name is _____.

Currently, I am a graduate student at the Institute of Population Studies, College of Development Studies in Addis Ababa University. This survey is conducted to know gender differentials in youth sexual behavior and vulnerability to HIV infection in Burayu Zone, Oromia Region. The research will be helpful in preventing HIV infection in youth aged from 15-24 through bringing behavioral change and also will help us to develop services and educational programs so as to mitigate the problem in the zone. There fore, your honest and genuine participation and response to the question help for a better understanding of the factors that affects youth sexual behavior and vulnerability to HIV/AIDS infection in the study area.

All the information you give me will be kept private and your name is not put any where on this questionnaire. Moreover, any one of your response will not be given to any one at any time. If you decided not to participate in the survey, you can refuse and you may also stop filling the questionnaire at any time. This interview will take an average of 30 to 45 minutes to complete the questionnaire.

Are you interested to participate in this study!

Yes No

If the response is no, say thank you and go to the next interviewer. If the response is yes, continue the interview and say thank you in advance for taking your response at the end of the interview.

IDENTIFICATION FORM

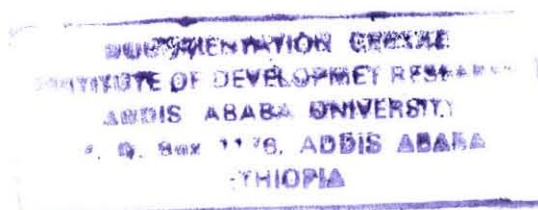
No	Identification	Name	Code
1	Region	Oromia	01
2	Zone	Burayu	02
3	Kebele		_____
4	Identification Number of the Questionnaire		_____
5	Date of Interview _____ / _____ / 2010		
	Starting time of the Interview _____		
	Ending time of the Interview _____		
6	Results of Interview A. Completed B. Partially completed C. Refused D. Other (please specify) _____		
7	Interviewer Name and Signature _____		
8	Supervisor Name and Signature _____		

PART I: Socio-Economic and Demographic Characteristics of Respondent

Item	Questions	Coding Categories	Skip to
101	Sex of respondent	1. Male 2. female	
102	How old are you? (In complete years)		
103	Can You Read and Write?	1. Yes, I can Read 2. Yes I can Read and Write 3. No	If no skip to Q. 107
104	Have you ever attended any formal education?	1. Yes 2. No	If no skip to Q. 107
105	What is the highest level of education you completed?		
106	Are you attending any education at the moment?	1. Yes 2. No	
107	What is your ethnic group?	1. Oromo 2. Amhara 3. Tigirie 4. Gurage 5. Other (specify) _____	
108	What is your current marital status?	1. Unmarried 2. Married 3. Divorced 4. Widowed 5. Separated	
109	What is your religion?	1. Orthodox 2. Protestant 3. Catholic 4. Islam 5. Other(specify) _____	
110	Place of Residence		
111	With whom are you living now?	1. Both parents 2. Mother only 3. Father only 4. Brother/sister 5. Relative 6. Alone 7. Spouse 8. Other(specify) _____	
112	Do you have any work currently, in which you get money?	1. Yes 2. No	If no skip to part II
113	What is your major occupation?	1. Daily laborer 2. Home servant 3. Private business 4. Civil Servant 5. Private Organization 6. Other(specify) _____	
114	How much birr do you earn per month?	Birr	

PART II: Respondent Parent's Background and Characteristics

Item	Question	Coding Categories	Skip to
201	Is your father alive?	1. Yes 2. No	If no skip to 206
202	Can Your father Read and Write?	1. Yes, he can Read 2. Yes he can Read and Write 3. No	If no skip to 206
203	Did your father attend any formal education?	1. Yes 2. No	
204	What is the highest level of education your father completed?		
205	What is your father occupation?	1. No occupation 2. Daily laborer 3. Civil servant 4. Farmer 5. Employed in private sector 6. Has private business 7. Other(specify)	
206	Is your mother alive?	1. Yes 2. No	If no skip to 211
207	Can Your mother Read and Write?	1. Yes, she can Read 2. Yes she can Read and Write 3. No	If no skip to 211
208	Did your mother attend any formal education?	1. Yes 2. No	
209	What is the highest level of education your mother completed?		
210	What is your mother occupation?	1. Housewife 2. Daily laborer 3. Home servant 4. Civil Servant 5. Employed in private sector. 6. Has private business 7. Other(specify)	
211	In your opinion which of the following shows your families' economic status?	1. Poor 2. Medium 3. Rich	



PART III: Substance Use and Communication About Sexual Issue

Item	Question	Coding Categories	Skip
301	Have you ever drunk alcohol like Tella, Tej, Beer, Areki etc?	1. Yes 2. No	If no skip to Q. 303
302	How frequently do you take alcohol?	1. Daily 2. Once a weak 3. Occasionally 4. More than once a weak 5. Other(Specify) _____	
303	Do you smoke Cigarette?	1. Have never smoked 2. I have tried once or twice 3. Occasionally 4. I smoke daily 5. Other(Specify) _____	
304	Do you chew 'chat'?	1. Have never chewed 2. I have tried once or twice 3. Occasionally 4. I chew daily 5. Other(Specify) _____	
305	Have you ever watched pornographic films or read Magazines that focused on sex?	1. Yes 2. No	If no skip to Q. 307
306	How frequently did you watched Pornographic films or magazines that focused on sex?	1. Most often 2. Occasionally 3. Always 4. Other(Specify) _____	
307	Have you ever discussed with your parents about sexual matters?	1. Yes 2. No	If no skip to Q. 309
308	On what topic do you usually discuss? (Multiple responses are possible)	1. Body change(physical; development) 2. Menstrual cycle 3. Method of contraceptive 4. HIV/AIDS 5. STDs 6. Other(specify) _____	
309	What is the main reason for not discussing sexual issues with your parents?	1. Afraid to talk with them about these issues 2. Prefer to talk with some one else 3. Not interested in discussing these issues. 4. This topic upsets them 5. Other(specify) _____	
310	Who is your important source of information about sexual matters? (Multiple responses are possible)	1. Father 2. Mother 3. Relative 4. Health professional 5. Boy/Girl friend 6. Causal partner 7. Books/Films 8. Radio 9. Television 10. Other(specify) _____	

PART V: Knowledge about HIV/AIDS and STDs

Item	Question	Coding Categories	Skip to
401	Have you ever heard about HIV/AIDS?	1. Yes 2. No	If no skip to Q. 405
402	What is the source of your information? (Multiple responses are possible)	1. Friends/Peers 2. Parents/relatives 3. Boy/girl friend 4. Health institutions 5. Radio/TV(Media) 6. News papers, posters or Pamphlets 7. School 8. Other(specify)	
403	What are the ways of transmission for HIV/AIDS? (Multiple responses are possible)	1. By sexual intercourse 2. Sharing Sharp Material 3. Mosquito/ insect bite 4. Blood transfusion 5. From mother to unborn child 6. Sharing food with HIV ⁺ Person 7. A curse from God 8. Sharing toilet with HIV ⁺ person 9. Others(specify)	
404	Can AIDS be cured?	1. Yes 2. No	
405	Do you know any sexually Transmitted disease?	1. Yes 2. No	If no skip to Q. 407
406	Which STDs do you know? (Multiple responses are possible)	1. Syphilis 2. Gonorrhea 3. Cancroids 4. Trichominas 5. Other(specify)	
407	Have you ever had symptoms of STIs, such as genital ulcer, abnormal genital discharge, pain during urination or genital swelling?	1. Yes 2. No	If no skip to Q. 410
408	With whom you did first discuss the issue?	1. Partner (husband/wife) 2. My friends/peers 3. My boy/girl friend 4. My parents 5. Health workers 6. Traditional healers 7.Others(specify)	
409	Where did you go for the treatment? (More than one answers are possible)	1.Traditional healer 2. Public health institution 3. Local injector 4. Private clinics 5. Private health institution 6. Others specify	
410	Is there any means a person can do avoid getting STIs and HIV/AIDS? (Multiple responses are possible)	1. Sexual abstinence 2. Remain faithful to a partner 3. Use condoms in every act of sexual intercourse 4. Avoid casual sex	

		5. Avoid sex with commercial sex worker 6. Avoid premarital sex 7. Other(specify)	
411	Do you think that getting infected with STDs could increase the chance of acquiring HIV/AIDS?	1. Yes 2. No 3. I don't know	
412	Do you believe having multiple sexual contact leads to HIV acquisition?	1. Yes 2. No 3. I don't know	
413	Do you believe alcohol consumption and drug use can predispose to HIV acquisition?	1. Yes 2. No 3. I don't know	
414	Do you believe you are at risk of getting HIV virus?	1. Yes 2. No	If no skip to Q. 416
415	If yes, why at risk? (Multiple response is possible)	1. More than one sexual partners 2. Mistrust 3. Have had sex without condom 4. Have had sexual intercourse with CSWs 5. Past history 6. Injuries with contaminated sharps 7. Blood transfusion 8. Others (specify)	
416	If no, why not at risk? (Multiple response possible)	1. Have never made sexual intercourse 2. I have abstained from sex 3. Faithful 4. One partner 5. Protected sex 6. I did not share injection 7. I always use condom 8. Others, specify	
417	What is your chance of acquiring HIV/AIDS?	1. None 2. Small 3. Medium 4. High 5. I don't know	
418	Have you ever heard about voluntary counseling and testing for HIV?	1. Yes 2. No	
419	Did you ever under go HIV test?	1. Yes 2. No	If no skip to Q. 421
420	I will not going to ask you the result, but have you heard it for yourself?	1. Yes 2. No	
421	Are you volunteers to under go voluntary counseling and testing for HIV now?	1. Yes 2. No	

PART IV: Sexual Behavior and Practice of Respondent

Item	Questions	Coding Categories	Skip to
501	Do you have boy or girl friend	1. Yes 2. No	
502	Have you practiced sexual intercourse?	1. Yes 2. No	If no skip to 504
503	If you never had sexual intercourse in your life time, what is the main reason for you not to have had sexual intercourse?	1. Fear of STDs and HIV/AIDS 2. Fear of parents 3. Wish to wait virgin until marriage 4. Fear of pregnancy 5. For religious reason 6. Other(specify) _____	
504	Is there pressure from your friends for you to have sexual intercourse?	1. No pressure at all 2. A little pressure 3. A lot of pressure	
505	How old were you when you had first sexual intercourse?		
506	What was your relation with your partner the first time you had sexual intercourse?	1. Boy/girl friend 2. Casual partner 3. Commercial Sex worker 4. Husband/wife 5. Relative 6. Other(specify) _____	
507	What is your main reason for sexual intercourse the first time you had it?	1. Enjoyment/pleasure 2. Fell in love 3. To get boy friend/girlfriend 4. In marriage 5. Was drunk or stoned 6. Needed money/material 7. Peer Pressure 8. Other(specify) _____	
508	How older or younger was the person with whom you had your first sexual experience?	1. More than 10 years older 2. 5-10 years older 3. Younger than me 4. Almost age like me 5. Don't know	
509	For women , Have you ever face rape?	1. Yes 2. No	
510	Have you ever used a condom in the sexual intercourse?	1. Yes 2. No	If no skip to Q. 514
511	Did you use condom in the first sexual intercourse?	1. Yes 2. No	
512	Did you use condom in the last sexual intercourse?	1. Yes 2. No	
513	For males , Are you all right if female initiate condom use in time of sexual intercourse?	1. Yes 2. No	

514	Can you be able to refuse sex if your partner does not want to use condom?	1. Definitely could not 2. Probably could not 3. Probably could 4. Definitely could 5. I Don't know	
515	Have you used condom consistently in each and every sexual intercourse?	1. Yes 2. No	If yes skip to Q. 517
516	If no, What was your main reason for not using condom consistently?	1. It was not available 2. I do not think of it 3. I am not sure to protect me from STDs and HIV/AIDS 4. I believe that it had a bad effect on my sexual pleasure 5. I trust my partner 6. I was drunk and stoned 7. I didn't know how to use it 8. Ashamed to buy 9. My partner refuse to use 10. Other(specify)_____	
517	How many different sexual partners have you ever had in your life time?	_____	
518	During the past 12 months have you had sexual intercourse?	1. Yes 2. No	If no skip to Q. 521
519	How many partners have you had sexual intercourse during the last 12 months?	_____	
520	How often did you use condom in the last 12 months?	1. Always 2. Most of the time 3. Sometimes 4. Never used 5. Other(specify)_____	
521	For males, Have you ever had sexual intercourse with commercial sex workers?	1. Yes 2. No	
522	For males, Have you ever used a condom when making sexual intercourse with commercial sex workers?	1. Yes 2. No	
523	For males, How often did you use condom when making sexual intercourse with Commercial Sex worker?	1. Always 2. Some times 3. Not at all 4. Other(Specify)	

THANKS

Questions for Focus Group Discussion (FGDs)

1. What type of problems are youth facing at present related with HIV in this area?
2. Who do you think that premarital sexual activity is more common-male or female?
3. At what age do male and female youth generally start sexual intercourse?
4. What do you think that the reason for having sex at earlier age?
5. Is it usual among youth to have sex with more than one partner?
6. Is it usual among youth to use condom consistently during sexual intercourse?
What were the reasons for not using condom, if they did not use?
7. Is it common among youth to use substances like chat, cigarette, and alcoholic drinks?
8. How do you evaluate the behavior of those youth that take such substances, in terms of sexual activity?
9. Are your parents encouraging you to discuss about sexual issues with them? If not what are the reasons?

Declaration

The thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been duly acknowledged.

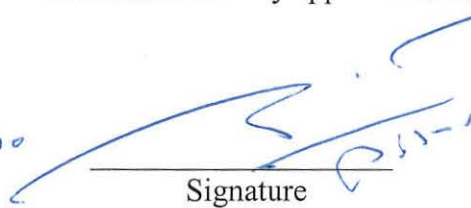
Sadik Aleni
Student


Signature

June 30, 2010
Date

I confirm that this thesis has been submitted with my approval as the supervisor of the same.

Dr Michael Dejeno
Advisor


Signature

June 30, 2010
Date

