

**BEHAVIOR CHANGE COMMUNICATION (BCC) AND THE
RESPONSE OF YOUNG ADULTS: THE CASE OF ETHIOPIA**



Save Lives Ethiopia (SaLE) Relief & Development Organization

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ii. Executive Summary

The spread of the HIV/AIDS pandemic in Ethiopia threatens the social and economic well being of the nation. The high level of HIV/AIDS awareness, however, is not accompanied by a corresponding knowledge of specific behaviors to prevent infections. Although significant progress has been achieved in some areas (government response, implementation arrangement, increase in NGO involvement, etc) during the past decade, surveys suggest that despite the fact that the majority of young people have heard of AIDS, many still do not know how to prevent transmission.

Providing access to youth-friendly health services is an integral part of the national prevention policy/program. The main services necessary to prevent HIV and other STIs include providing access to information, condoms, voluntary counseling & testing (VCT) treatment, and care for STIs and HIV/AIDS. Access to services remains insufficient in all settings. The number of condoms available has increased. However, the availability of condoms does not ensure that condoms are used. In addition, the proportions of young people using condoms is still very low, even when they have sex with non-regular partners.

Change in risk behavior is believed to play a key role in reducing HIV/AIDS infection. Countries like Uganda have managed to substantially bring down prevalence rate over about a decade (1992-2000, USAID (2002). Thus experience teaches us that a well designed and contextualized behavior change communication is an effective strategy in reducing HIV/AIDS infection.

Efforts should therefore be made in the area of public policy and type and level of intervention to change the level of knowledge and attitude concerning HIV/AIDS prevention practices and should reduce the risk behaviors.

Strategies need to be designed for identifying the appropriate target groups such as high-risk groups, in order to address the desired knowledge through intensive and comprehensive training that would results on transforming on the current state of behaviors. This suggests the need for farther research study to development and designing appropriate and relevant information, education and communication messages to address the knowledge gap in the community.

CHAPTER ONE

1.1 Introduction & Background

Ethiopia is one of the world's oldest continuous civilizations, with a history dating back more than 2000 years. . The total population is estimated at about 73 million, and it is expected to grow by over 2 percent annually through 2025.

Ethiopia's population is young, with 44% under the age of 15 years and a median age of 16.9 years (1). Eighty-five percent of the population is rural.

Ethiopia is among the hardest hit nations of the world by the pandemic of HIV/AIDS. HIV/AIDS remains a real threat to the life of the people and the social and economic well being of the nation. Currently, the official figure for infection rate stands at 4.4% of the adult population or 1.5 million people. In terms of age group, the young and productive population (in the age range of 15 to 49 years) is most affected. The greatest mode of transmission in the country is heterosexual intercourse (above 85%), mother to child transmission, and a small number of transmissions through medical procedures. In effect, it is widely accepted that if heterosexual risk behaviors that lead to infection are changed, the epidemic will be controlled better.

To combat the spread of the disease, the government of Ethiopia has developed a strategy for the nation, which includes capacity building of some important sectors, community mobilization and empowerment, integration with health programs, leadership and mainstreaming, coordination and networking and targeted response. Behavior Change Communication (BCC) as a strategy is

widely adopted by the government, international and local NGOs and community based organizations (CBOs), with particular emphasis on changing risk behaviors that expose people to HIV infection. However, the policy makers, practitioners in the field, and the mass media consistently bring to the surface that change in risk behaviors, particularly among the young adults, is very low, as compared to the efforts made and the level of awareness of the society. Despite the effort that have been taken by different parties, the epidemic still continues to grow steadily both in urban and rural settings, claiming the lives of the most productive segment of the society. HIV/AIDS has become one of the major challenges to the socio-economic development of the country.

1.2 HIV/AIDS Prevention and Control Efforts in Ethiopia

The AIDS pandemic has taken the attention of the world since its emergence in the early eighties. The numbers infected with the virus to date are ever greater than were predicted at that time. In the year 2005, estimates showed that 40 million people globally were living with HIV/AIDS. More than 10 million of them are young people aged 15-24 years. Half of the 4.2 million of new infections in adults in 2005 occurred in this age group. Sub –Saharan Africa contains almost two thirds of all young people living with HIV or AIDS (6.2 million)(4).

HIV was first detected in Ethiopia in stored sera collected in 1984, and the first two AIDS cases were reported in 1985. Soon after the first laboratory report confirmed HIV and AIDS cases, the government initiated a response. The initial

response was the establishment of the National HIV/AIDS taskforce in 1985, which focused on analyzing the situation, developing operational guidelines for prevention and assessing the capacity required to arrest the spread of HIV infection. (5)

In 1987, the AIDS Control Program (ACP) was established at a department level in the Ministry of Health (MOH), with the responsibility of coordinating the national prevention and control program. HIV/AIDS surveillance activity began in 1989. Subsequently the Short and Midterm Plans for Prevention & Control were designed and implemented, in 1987 and 1989, respectively. In the year 1998 the national HIV/AIDS policy was issued, followed by the development of a strategic framework for the national response in 1999. Both of these created an enabling environment for HIV/AIDS prevention and control (6). The policy had many parts: education and training policy calling for a multisectoral response; guaranteeing rights for PLWHA; and facilitating the development of policies, e.g. on the supply and use of antiretroviral (ARV) drugs, among other things.

The HIV/AIDS Prevention and Control Office (HAPCO) was established in 2002 after two years of functioning as the National HIV/AIDS Council Secretariat (NACS). It had developed and implemented a five year (2000 to 2004) national strategic framework as part of the national response to HIV/AIDS. Several priority interventions were implemented and several targets were achieved in this period. However, it was found that the national response and intervention were still far from adequate. considering the magnitude of the problem.

Hence, the strategic plan for the succeeding four years (2005 -2008) learned from the gaps as well as built on the achievements, focusing on provision of preventive care, support and treatment services and stipulating ambitious targets. According to the plan, the implementation of all the programs were to be based on the principles and approaches of multi–sectoralism, decentralization, community mobilization, ownership & partnership. Based on these principles, restructuring of the implementation and coordination mechanisms was done, whereby the MOH has started to spearhead the implementation and coordination of the national programs. Encouraging achievements were seen with in the first one and half years of the implementation of the five-year strategic plan. These include: training and deployment of health extension workers who are implementing the health extension package, the construction and furnishing of various health institution especially in rural areas, and the massive scale up of ART, HCT &PMTCT services. A number of non–governmental organizations (NGOs) and community based organizations (CBOs) have also been working in partnership with the donors to engage and foster civic participation in the fight against the pandemic. Even though a 2006 report from HIV/AIDS Surveillance estimates gave some signs that the epidemic is stabilizing, still, the observed changes are not significant compared to the desired goals of the response against the epidemic.

1.3 Preventing HIV Infection through Sexual Behavior Change

There is no cure or vaccine to this deadly virus so far. Moreover, the available life prolonging treatments with antiretroviral therapy for PLWHA are expensive, difficult to administer and have severe side effects (5,6). Therefore, primary prevention through Behavioral Change Communication (BCC)/IEC still remains a top public health intervention. In regard to this, the prevention intervention guideline “Guideline for the national HIV/AIDS Communication Framework“ was developed. It was based on the earlier “National HIV/AIDS Communication Framework,” in collaboration with UNAIDS and Penn State University in the United States, and it was adopted by the country. The communication framework focuses on contextual areas for bringing individual and social changes. The focus areas include policy, socio-economic, gender, culture, and spirituality.

The main purpose of the guidelines are to serve communication as a tool for responding to the questions what, who, how and when while undertaking Information, Education and Communication(IEC)/ Behavior Change Communication (BCC) and advocacy communication intervention for HIV/AIDS prevention, care and support. The guidelines also include the communication process, monitoring and evaluation.

Based on the guidelines, government line ministries, international & local NGOs, FBOs, CBOs and youth groups are highly involved in the prevention intervention activities, efforts aimed at young people to provide them with basic information on how to protect themselves and their partners from acquiring the

virus. HIV/AIDS information and life skills education are provided to young people in a number of ways, including peer education, counseling, community activities that include parents, and through the mass media and school-based education programs. Often these interventions are dispersed across many organizations and community groups, and compared to the prevalence rate, it is not enough. Therefore their effects are difficult to measure and evaluate consistently. Most of the programs focus on providing education about HIV transmission, disease consequences, and prevention strategies.

Providing access to youth-friendly health services is an integral part of the national prevention policy/program. The main services necessary to prevent HIV and other STIs include providing access to information, condoms, voluntary counseling & testing (VCT) treatment, and care for STIs and HIV/AIDS. Access to services remains insufficient in all settings. The number of condoms available has increased (6). However, the availability of condoms does not ensure that condoms are used. In addition, the proportions of young people using condoms is still very low, even when they have sex with non-regular partners.

Although significant progress has been achieved in some areas (government response, implementation arrangement, increase in NGO involvement, etc) during the past decade, surveys suggest that despite the fact that the majority of young people have heard of AIDS, many still do not know how to prevent transmission. Furthermore, misconceptions about HIV and AIDS are widespread.

1.4 Problem Statement

Ethiopia is one of the poorest countries in the world with a per capita income of only 100 USD per year. Though health status is a resultant outcome of a multitude of factors, poverty and ill health tend to occur together. So the health status of the population is very low compared with most countries in sub-Saharan Africa, and reproductive health represents one of the major problems of the country. The underlying causes include low income, low levels of education, and poor access to services.

Some Basic Health Indicators (%)

Indicator	1999	2000	2001	2002	2003
Total population	63,495,000	65,344,000	67,220,000	69,127,021	71,066,000
Potential Health service coverage	57.3	59.1	61.0	61.3	64.0
Health service utilization	0.27	0.27	NA	0.29	0.36
Antenatal coverage	29.1	34.7	34.1	27.4	40.8

Source: Ministry of Health 2004, Health and Health Related Indicators

Since its evidence in the country in 1984, HIV/AIDS has claimed the lives of millions people. According to HAPCO (2005), out of the currently 1.5 million people reported to be living with HIV/AIDS in the country, 96,000 are children. New infection was estimated at 197,000, and it is projected that this rate will increase over the coming decade, particularly among the rural communities where over 85% of the population resides.

Estimated and projected adult Prevalence (%) by Sex and Setting, Selected Years, 1982 – 2008

Description	1982	1985	1990	1995	2000	2001	2002	2003	2008
National	0.0	0.2	1.6	3.2	3.9	4.1	4.2	4.4	5.0
Male	0.0	0.2	1.5	2.8	3.4	3.5	3.7	3.8	4.4
Female	0.0	0.2	1.7	3.6	4.4	4.8	4.8	5.0	5.7
Urban	0.0	0.7	7.0	13.4	13.0	12.8	12.7	12.6	12.6
Rural	0.0	0.1	0.3	0.8	1.9	2.1	2.4	2.6	3.4

Source: HAPCO, 2004

As reported by HAPCO (2005), the predominant mode of HIV/AIDS transmission is unprotected sex, and the high risk group is young adults in the age range 24 to 49 years (they represent 90% of the total infected population). Regarding gender, the prevalence rate is high among female (5%) as compared to their male counterparts (3.8%). The high rate among females is attributed to several socio-cultural and economic factors.(7)

In the HAPCO 2nd behavioral surveillance survey (7), the preliminary results indicated that though knowledge of at least one preventive method is high across all target groups, there is still low comprehensive knowledge and there are persistent common misconceptions. One or more stigmatizing attitudes prevailed in almost all target groups. The indications of Knowledge, Attitude and Practice surveys carried out in various parts of the country show the same outcome of disparity between knowledge, attitude and practices.

Change in risk behavior is believed to play a key role in reducing HIV/AIDS infection. Countries like Uganda have managed to substantially bring down prevalence rate over about a decade, from 1992-2000, according to a report from USAID (2002) (8). The same report confirms that, by and large, the fall in prevalence rate is attributed to changes in risk behaviors. Experience teaches us that a well designed and contextualized Behavior Change Communication is an effective strategy in reducing HIV/AIDS infection.

In Ethiopia, Behavior Change Communication (BCC) is the main strategy for changing risk behaviors that expose vulnerable people to HIV infection, and the strategy has been widely adopted by every stakeholder who is involved in HIV/AIDS prevention. Despite all the interventions taken to prevent risk behaviors, the actors have noted the gap between knowledge, attitude and practice.

Knowledge and practice surveys carried out in various parts of the country showed the same reality. This has created great concern both to the policy

makers and practitioners. However, no assessment and/or research has been conducted on investigating why behavior change hasn't been achieved.

Generally the risk heterosexual behaviors that expose people to infection by HIV/AIDS include:

Multiple partners

Sex at early age.

Unprotected sex

Harmful traditional practices like rape, female genital mutilation and sharing blade.

This paper reviews data on the situation of young people and HIV/AIDS. It assesses the level of existing information and service related to HIV prevention and response of the young people, it gives some recommendations and also takes the initiative for an in- depth study of the problem and set methodology. The sample for the ongoing project is from where Save Lives Ethiopia works. The goal is to assess the behavioral change of youth 10 to 24, as well as adults 25 to 49 . The outcome of this study will be to help design appropriate strategies on risk reduction method and promotion of other youth friendly activities.

1.5 Research Question

The main research question is: what are the barriers to risk behavior change by young adults in response to Behavior Change Communication programs launched in Addis Ababa ? More specific questions include:

What individual, social, environmental, cultural and economic factors influence change in risk behaviors?

Which particular modes and components of the BCC programs are successful and which ones are not?

Given these factors, what BCC strategies can promote consistent and sustained risk reduction behavior change?

The research focuses on the most vulnerable groups: youth aged 10 to 24 and adults aged 25 to 49 years.

1.6 Objectives

Save Lives Ethiopia (SaLE) is an indigenous NGO, founded in March 2002, that exists to empower those who are needy, oppressed and uncared for, through giving love, taking care of, and partnering with them to address their physical, social and spiritual needs. There is much focus on children and youth (as the future generation) to “Regenerate hope and self-esteem.”

SaLE is dedicated to a quest for excellence in all its undertakings. We are committed to quality and adding value in every aspect of our work. Based on the organization’s vision, mission and values, the main goal of the study is to use the

opportunity for further in-depth study on HIV/AIDS prevention as a bridge while searching for more appropriate and effective HIV prevention strategies and interventions. SaLE hopes to transform adolescents and youth from their current state of confusion, stagnation and hopelessness towards HIV/AIDS-free dynamic and visionary citizens, enabling them to be active participants in the overall affairs of the country.

Apart from using the study for the long term goal fulfillment, the **short term objectives** are:

- ❖ to use as a means to communicate the findings, thereby influencing government policies and strategies and assisting other stakeholders in reviewing and updating their strategies.
- ❖ Save Lives Ethiopia BCC strategies will be updated per the findings and recommendations of the research.
- ❖ to describe factors that characterize the sexual behavior of youth and young adults in Addis Ababa, more specifically in Save Lives Ethiopia project areas.

1.7 Method

This study tries to assess youth perception of HIV risk and examines how this translates to prevention strategies and different intervention activities. The outcome of this study will help to design appropriate strategies for risk reduction methods and promotion of effective and efficient prevention strategies and

activities among youth in the country and more specifically for Save Lives Ethiopia project areas.

Thus, this research work has two phases. The first phase, which is covered in this paper, reviews data and information on the situation of young people and their response to HIV/AIDS. The data reviewed on knowledge, behavior, life skills, access to service and HIV prevalence among young people comes from nationally representative surveys, antenatal care surveillance, behavioral surveillance survey and other studies.

Data on vulnerable groups with high risk behavior comes mainly from behavioral surveillance surveys and other studies. Information on access to service come from a 2003 coverage survey implemented by the policy project (1). HIV prevalence data are principally based on information from country surveillance reports and the epidemiological fact sheets available from UNAIDS, WHO and UNICEF. In addition, information was used from different knowledge and practice surveys, done by different development practitioners.

The second phase, which will take place in Ethiopia, is an in-depth KPC survey of the on going prevention activities as whole, and a critical assessment of the ABY (Abstinence, Be faithful and Condom use) strategic approach as BCC. It will also evaluate other strategic approaches used in HIV/AIDS prevention programs and projects (education, contents, techniques and strategy) in the country. For that study, the statistical procedures and the sample size is indicated below the formulated questionnaire(see in annex 1).

1.8 Sample Size Requirements

Study design

A sample will be selected randomly from all 13,467 unmarried 1st cohort intervention participants. A separate sample of married participants will be drawn by going to the household neighboring the home of each of a random sample of unmarried participants.

Respondents will complete interviews at baseline and after 12 months. The analysis will compare the proportion of respondents reporting specific behaviors at baseline and at 12 months.

Outcomes of interest

Outcome 1: What proportion of non-sexually active participants will report an intention to remain sexually abstinent until marriage after one year?

Outcome 2: What proportion of sexually active participants will report consistent condom use (use of condoms in 100% of sexual encounters in the past year) after one year?

Outcome 3: What proportion of all participants will report having used voluntary counseling and testing services in the past year?

Outcome 4: What proportion of married respondents will report having had no extramarital sexual relations in the past year?

Assumptions at baseline:

50% of non-sexually active unmarried participants will report an intention to remain abstinent until marriage.

40% of sexually active unmarried participants will report consistent condom use in the past year.

20% of unmarried participants will report using VCT services in the past year.

80% of married participants will report no extramarital partners in the past year.

A 10 percentage point increase in each outcome between baseline and follow-up is worth detecting.

30% of unmarried participants will be sexually active at baseline and 70% will be not sexually active (NSA).

All calculations are based on a Type I error rate (alpha) of 0.05.

Calculations are presented to achieve both 80% and 90% power.

Sample size requirements, unmarried sample

For adequate (80%) power to detect a 10 percentage point increase, the study will require:

194 NSA youth to address outcome 1 (meaning 277 youth overall expecting 70% to be NSA);

191 sexually active youth to address outcome 2 (meaning 637 youth overall expecting 30% to be sexually active);

137 youth overall to address outcome 3.

For strong (90%) power to detect a 10 percentage point increase, the study will require:

259 NSA youth to address outcome 1 (meaning 370 youth overall expecting 70% to be NSA);

256 sexually active youth to address outcome 2 (meaning 853 youth overall expecting 30% to be sexually active);

188 youth overall to address outcome 3.

Sample size requirements, married sample

For adequate (80%) power to detect a 10 percentage point increase for outcome 4, the study will require 107 married participants.

For strong (90%) power to detect a 10 percentage point increase for outcome 4, the study will require 137 married participants.

Summary

To address all 3 outcomes with $\geq 80\%$ power will require a sample of 637 unmarried youth and 107 married youth.

To address all 3 outcomes with $\geq 90\%$ power will require a sample of 853 unmarried youth and 137 married youth.

Sample size calculation formula

The following notation is used:

α = Type I error rate (set at 0.05)

β = Type II error rate ($1 - \beta$ = power)

$z_{\alpha/2}$ and z_{β} = the cut point values corresponding to an area of $\alpha/2$ and β , respectively, in the upper tail of the standard normal distribution

P_0 = the hypothesized baseline value of the outcome of interest ($Q_0 = 1 - P_0$)

P_1 = the value of the outcome of interest that we wish to be able to detect at follow-up as different from P_0 ($Q_1 = 1 - P_1$)

N = the required sample size to reject the null hypothesis that the observed outcome proportion P_1 differs from the hypothesized baseline value of P_0 with power $1 - \beta$ and a Type I error rate of α .

Then the required sample size N may be calculated as:

$$N = \frac{(z_{\alpha/2}\sqrt{P_0Q_0} + z_{\beta}\sqrt{P_1Q_1})^2}{(P_0 - P_1)^2}$$

Appropriate questionnaires are developed (see in appendix 1) and will be administered to samples selected at random from six groups of two sub cities (from Nefas-Silk Lafto and Akaki Kality sub-cities) of Addis Ababa. The six groups are teenage children (10 to 15 years male, female), unmarried young adults (male, female) and married young adults (male, female). A pre-determined number of samples will be drawn at random by using a simple random sample from each group. Questionnaires will be completed using enumerators/staff of SaLE.

The collected data will be entered into a computer and analyzed using appropriate database. The data will be cleaned and analyzed using statistical

software. In addition to the primary, secondary data will be collected from government, NGOs and CBO/FBOs. These data will be used to complement and triangulate with the primary and enrich the findings. Finally, the findings will be interpreted and final research document will be written.

CHAPTER TWO

2.1 HIV/AIDS & YOUNG PEOPLE

The highest prevalence of HIV infection rate is in the age of 15 to 34 years, followed by 35 to 49 age. This prevalence is sometimes used as a proxy for recent infections.

Unadjusted HIV Prevalence by Age Group and Site Setting, 2003 (%)

Age group (years)/ setting	15-24	25-34	35-49
National	8.6	8.1	6.3
Urban	11.9	12.5	10.3
Rural	4.3	3.9	3.6

Source: Federal Ministry of Health, June 2005

Vulnerability of Ethiopian youth to HIV infection is attributed to early sexual maturation preceding social maturity coupled with lack of information (7, 8). They lack the family life education from primary and secondary socializing agents and institutions (7, 8). Thus, youth mostly learn all the good and evils of life by trial and error. Generally, one or a combination of these factors may predispose young people to health hazards, including HIV/AIDS.

2.2 Indicative Information of HIV/AIDS Knowledge & Response

Age at first sex

Attitudes towards particular aspects of sexuality are always changing. Masturbation and premarital sex have become more accepted in recent years. There is greater openness about sexual orientations, alternative behavior, and gender identities, although there is a significant degree of debate about their acceptability (9).

Children move from a generalized awareness of their sexual natures to more specific experiences of sexual feelings. Adolescents explore their sexuality through relationships with others and there is evidence that they have become sexually active at increasingly younger ages (9).

Sexuality is a universal phenomenon in all young people. Psychologically, adolescents become sexually active at earlier age due to peer pressure, avoidance and resistance to behavior changes through various forms of denial and rationalism (10). Initiating sexual activity is a natural transition made by nearly all humans. Nevertheless, it is not the occurrence of this transition, but the timing and the circumstances under which it occurs, that has significant implications (11).

Globally, unprotected sexual intercourse between men and women is the predominant mode of transmission of the HIV virus (12). Young people in both developing and developed countries begin sexual activity relatively early. The lowest median age at first sexual contact in Nigeria is 15 years for men (10).

The study conducted on high-risk sexual behavior among youth in Tanzania revealed that (0.3%) girls and (3.2 %) boys had their first sexual debut by the age of 9 years and 10% by the age of 13 years. The largest group, 55% of girls and 45% boys, had their first sexual intercourse experience between the ages of 14 to 17 years (13). Another study in Tanzania revealed that 30% of respondents were sexually experienced, the average age at first intercourse in this group being 12.7 years (14).

The sexuality situation in Ethiopia is the same as in other African countries. 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% of the boys and 47.8% of the girls have had sexual experience, their mean age of sexual commencement being 17 years (15).

Another study conducted by the Family Guidance Association of Ethiopia on adolescent sexuality revealed that 71.9% of boys and 71.4% of girls have had their first sexual contact in the age range of 15-17 years (10). The 2000 Ethiopian DHS also found out that the median age for first sexual intercourse was 16.3 years (15). The respondents initiated sex as early as 11 years (21). Some of the reasons for sexual debut were identified, such as maintaining relations with male partners (51%), for the sake of passionate love (45.8%), and to overcome loneliness (40%) (21).

A study among secondary school students in Ethiopia showed that one third (33.3%) of the youth reported to have had sexual intercourse. Mean age of sexual initiation was 15.3 years (22). A study indicates that the mean number of

sexual partners within six months was around two to ten (9.3%) had sex with commercial sex workers within that period of the months (23). Similarly, a study on school anti-AIDS club members and non-members showed that about one-third of the club members and a quarter of non-club members admitted to having practiced sexual activity with the mean age at sexual debut of 16.8 years, respectively (24).

Risk perception of HIV/AIDS and STIs

Literature on health related behavior emphasizes the perception of being at risk of infection as being one of the necessary conditions for behavioral change (25). Moreover, the degree of the perceived risk seems to affect individual actual control in adopting preventive measures. Individual risk perception is dependent on the perception held by other members of her/his personal network. Individual risk perception, as well as individual knowledge, is likely to be subjected to social environment influences, as long as social interaction allows information exchange, facilitates common evaluation and definition of the meaning and of its validity.

Risk perception depends on the individual perceived control of her/his capability to take preventive measures against the infection. Risk perception is dependent on the capability to assess the relationship between behavior and the mode of transmission of the virus (25).

Poverty, underdevelopment, lack of choices and the inability to determine one's own destiny fuel the epidemic (26). Vulnerability to HIV is a measure of an individual's or community's inability to control their perception of risk. In both low

and high endemic settings, reducing the vulnerability of young people to HIV infection is the principal defense against the epidemics of the future (26).

A requirement for translating knowledge into behavior change is a feeling of personal vulnerability to HIV infection. HIV has been characterized as a disease of 'others' from the earliest reports of infection. Perception of personal risk or susceptibility appears to be the most difficult to change. Both of the evaluations that measured these found no change. However, a study conducted in Uganda on risk perception and condom use revealed that HIV risk perception was found to be associated with condom use, religion, educational attainment, marital status, residence, number of sexual partners and having contracted an STD (28). Another study conducted on high-risk sexual behavior among youth in Tanzania revealed that 11.7% of the participants felt that they were at a high risk of getting HIV/AIDS and STDS, 25% felt that they had a very low risk, while 53.1% felt that they were not at risk at all (13).

A similar study conducted on knowledge, risk perception of AIDS and reported sexual behavior among students in secondary schools and colleges in Tanzania showed that students engaging in risky sexual behavior were aware of the risk, even though they failed to change their behavior (30). Only 25% of students felt that they themselves were personally at risk of acquiring HIV and 41% thought that friends were at greater risk than themselves. Sixty-six percent were prepared to take an HIV test. Students seemed to have a good understanding of AIDS as a social problem, but not as an issue in their personal lives (30).

Another study showed that accurate assessment of potential partners' risk for HIV or other STDS may assist individuals in making the decision to avoid sexual contact, or to adopt protective behaviors within the partnership (for example condom use). However, methods of assessing the validity and reliability of self reported behavior or perceived risk behavior of sex partners have not been standardized (31). A similar study on young Zambian males revealed that their risk perception of sexually transmitted infections (STIs) and HIV/AIDS was low due to misconceptions, folk beliefs and denial (32).

A study conducted on perception of the risks of sexual activities among out-of-school adolescents in northern part of the country (in south Gondar) showed that participants' attitude towards HIV risk perception were (5.3%) of the rural and (11.2%) of the urban (11, 33). Adolescents are engaged early to practice sex, exposed to high-risk sexual behavior and the perception of risk acquisition is weak. Another study conducted in southwest of the country (in Jima) revealed that 6.7% of female students and 11.2% of male students were found to have been involved in unprotected sexual activity. (34).

Focus group discussions conducted in Uganda revealed that one of the factors facilitating the spread of AIDS in African societies is having multiple sexual partners (35). Different reasons were given for having many sexual partners in the era of AIDS. Peer pressure, a lot of sexual urge, and attraction to beauty, prestige and experimentation were the reasons for many sexual partners reported by adolescents, including street children. The responses on risk perception of

HIV revealed that participants in all groups perceived people with multiple sexual partners as being highly at risk of contracting HIV/AIDS (35).

Condom use

Although the majority of people 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 (36).

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. 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 Cambodia has helped stabilize national prevalence, while substantially decreasing prevalence among sex workers. In addition, Brazil's early and vigorous condom promotion among the general population and vulnerable groups has successfully contributed to sustained control of the epidemic (5).

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 (37).

A study conducted in Uganda on risk perception and condom use revealed that was at 46% among males and 27% among females (28). 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 (27). A focus group study on condom use among adolescents and young people in a South African township revealed that community and social factors hinder condom use amongst youth (29).

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. Another study conducted on high-risk sexual behavior among youth in Tanzania revealed that 49% of the youths reported to have used condoms (13). 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 (30). 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 (30). According to the National Survey conducted in Tanzania (Tanzania Demographic and Health Survey), 4.1% of women and 15.2% of men used condoms during their last sexual encounter (6). 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 (6).

The Behavioral Surveillance Survey conducted three years ago in Ethiopia tried to compare knowledge about preventive measures and practices exposing in-school and out- of- school youths to HIV/ AIDS (4). It showed that although condoms were readily accessible, only 50% of sexually active in-school and out-of-school youth had ever used them with non-commercial partners. Consistent condom use in the past 12 months with non-commercial partners was 39% for out- of- school youth and 73.6% for the in-school youth (4).

Another study conducted among Agaro, (Southwest Ethiopia) high school students showed that 25% of students had a history of sexual intercourse (19, 38). Among those who had previous sexual exposure, 54.4% used condoms at least once. Of those, only 46 (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 (39). Among the sexually active

students, only 37.1% reported ever using condom. Consistent condom use was reported only by 6.4%. Sexual contact with commercial sex workers was also reported by 7.8% of them (39). 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 (40).

Another study conducted in Ethiopia, South Gondar showed that 42% of the respondents were sexually active; 76 (23.3%) of the sexually active claimed to have more than one sexual partner (11). About 25% of sexually active male adolescents visited female commercial sex workers, of which only 36% reported ever using condoms and none of them reported consistent condom use during commercial sex (19, 41). A similar study conducted in Addis Ababa revealed that only 43.2% of the sexually active students knew about condoms on their first coital encounter (18). Eighty two percent of those did not use condoms on their first sexual encounter. Only 27.7% of the sexually active students claimed that they had continuously used condoms (18).

Another study done on college students revealed that only 217(17.9%) of the sexually active respondents reported that they always used condoms, whereas the highest proportion-- 802 (66%)-- reported that they did not use condoms at all (41). A study conducted on patterns and correlates of sexual initiation, sexual risk behaviors, and condom use among secondary school students in Ethiopia showed that two-thirds of the sexual initiations were 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 (22). Another study conducted on the assessment of sexual risk behavior for HIV infection between out-of-school anti-AIDS club members and non-members, among youth in Jima and Agaro, showed that of the sexually active respondents, 30.3% of club members and 16.4% of the non-club members reported having had two or more non-commercial sex partners in the last one year, while only 46% and 39.3% (respectively) used condoms consistently (24).

The role of non-sexual risk behaviors for HIV infection

Having used alcohol and drugs was a risk factor for having had sex, having more sexual partners over a lifetime, and having more than one partner during the last three months (10, 42). In Ethiopia, alcohol and drugs like Khat are commonly consumed in both urban and rural areas. Among the youth 14 who reported having had risky sex in the previous 12 months, 44% used alcohol and Chat regularly (4).

A study conducted on casual sex-debuts among female adolescents in Addis Ababa showed that alcohol and Khat use have strong links with the incidence of rape as a factor contributing to early sex initiation (21). As in many societies, there is a feeling of cultural clash between the society and youth that have been exposed to and influenced by modernization. Chat chewing and alcohol consumption, often in combination, enhance engagement in sex. These practices were reported to be common among groups of young people who call

themselves 'modernized' (43). In a study conducted on school anti-AIDS club members and non members, youth in Jima and Agaro showed that alcohol and Khat consumption had a significant effect for risky sexual practice (24).

Peer influence in sexual behavior

Having sexually experienced friends was associated with a higher probability of ever having had sex and having more lifetime sexual partners (42). Youth who engaged in high-risk activities (attending parties, going to discos, drinking alcohol) were more likely to ever have had sex, had a higher number of sexual partners over their lifetimes and were less likely to have used condoms (42).

A study conducted on the attitudes of students, parents and teachers towards the promotion and provision of condoms for adolescents in Addis Ababa revealed that peer pressure was a frequently reported factor that led to the first sexual encounter (accounting for 35.2% of the sexually active respondents) followed by being forced (21.6%), alcohol (11.5%) and drugs(10.3%) (18). Another study done in Addis Ababa showed that young people were faced with enormous pressure to engage in sex, especially from peers, exposure to unlicensed erotic videos and the desire for economic gain(43). Love relationships lacked an adequate romantic period for partners to learn more about each other and negotiate condom use (43).

Cultural shaping of young people's sexuality gave privileges for males to be sexually active, be in control of sexual relationships and be less responsible for taking precautions to prevent HIV/AIDS. The youth in general sensed their

excessive vulnerability to HIV/AIDS, but lacked individual motivation and skills to practice safe sex behavior (43).

CHAPTER THREE

Conclusion & Recommendations

3.1 Conclusion

The following conclusions are drawn from the review of BCC intervention and the response of youth:

Generally, the HIV/AIDS epidemic continues to pose a threat to the development of the country as a whole, where in 2005 1.5 million people were living with the virus, 744,100 were orphaned due to AIDS, and 277,800 were in need of ART. AIDS accounted for an estimated 34% of all young adults' deaths aged 15 to 49 in Ethiopia and 66.3% of all young adults' deaths aged 15 to 49 in urban settings such as Addis Ababa. All of the existing information shows that youth 15 to 24 as well as young adults 25 to 49 are at the center of the AIDS epidemic, both in terms of new infections and opportunities for halting the transmission of HIV.

Because of its intensity in young people aged 15 to 24, these people are potentially the greatest force for change-- if they can be reached with the appropriate interventions. It is generally believed that IEC/BCC intervention on HIV/AIDS can bring about significant levels of behavior changes in the community. However, the assessed information indicates that while knowledge of prevention methods in urban setting like Addis Ababa was reasonably good, comprehensive knowledge was very low and misconceptions about prevention methods existed among the young people. .

Risky sexual practices such as premarital sex, having more than one partner, unprotected sex, having causal sexual intercourse, and cross-generation sexual relations are common. Most of youth are highly involved in sexual practices, and some of the reasons for that are peer pressure, exposure to unlicensed erotic videos, alcohol and drugs, desire for economic gain, love relationships lacking an adequate romantic period for partners to learn more about each other, cultural shaping of young people's sexuality giving privileges for males be in control of sexual relationships and be less responsible for taking precautions to prevent HIV/AIDS, unwanted pregnancy etc., and lacking the individual motivation and skills to practice safe sex behavior.

The level of self-risk perception for HIV infection was very low. Even sexually active youth did not perceive themselves to be at risk for HIV infection. It is generally agreed that IEC/BCC interventions are still the main tool to curb the spread of HIV and mitigate its socio-economic impact. Exposure to IEC/BCC intervention, especially to mass media messages, was relatively high.

In some schools HIV/AIDS club members are more involved in risk sex than nonmembers. This indicates that BCC intervention, particularly in these schools and in some other areas, was not able to provide adequate, consistent, need based, and clear messages to equip youths with the necessary knowledge and skills to bring the desired behavior changes.

Almost all interventions as well as surveys of young people are targeted at those aged 15 years and older. However, in many situations a significant proportion of 15 years olds have already begun to have sex or are involved in

other risky behaviors. In general, it is recognized that the best time for prevention is early in the life span, before behavior patterns are established. There is a need to start the intervention and to collect systematically more data from younger adolescents aged 10 to 14.

There are some conditions (rather than personal risk behavior) which encourage risk sex beyond the control of individual. These factors are: poverty, discrimination, lack of educational opportunities and subordination of women. Still, the prevention strategy, intervention, and the youth perception and other necessary situations need further research and analysis. Lack of resources exists as a great bottleneck (limits the establishment and expansion of health and other services which would be highly useful for prevention of HIV prevalence) in government as well as the NGO level.

3.2 Recommendations

For Policy Makers

- ❖ Young people account for a substantial proportion of the groups who are at particularly high risk of acquiring HIV, so there is a clear need to focus prevention activities on those behaviors and systems which have strong bonds with young people, like schools, other youth centered institutions and parties that engage in them (parents and other key actors in the life of children and youth) so that they are involved in HIV/AIDS prevention activities.

- ❖ **Public policy intervention is very important:** (1) Critical monitoring and evaluation of existing public health and other related services; (2) An enabling environment or environmental intervention such as control of illegal video houses, khat, and shisha is required; (3) improve professional skills in sexual health promotion; (4) develop and expand an infrastructure for STD, VCT and ensuring access to quality of clinical services; (5) supporting sexual –health research; (6) creating a conducive environment and building the capacity of NGOs and grassroots community organizations; (7) protective policy intervention for people infected with and affected by HIV/AIDS; (8) catalyzing change through mass media messages & giving great attention for the quality of the messages by focusing on the areas which have misconceptions; (9) intensifying school based interventions and building human and material capacity of schools.

For Planners and Implementers

The existing prevention strategies and interventions need to be critically evaluated to ensure that those interventions for which there is strong evidence of effectiveness are rapidly and intensively scaled up.

- ❖ Non-government and other humanitarian organizations/institutions need to plan and promote efforts to increase young people’s knowledge, life skills and access to services and implement services in innovative ways (establish and run of youth friendly reproductive health services, VCT in schools and youth centers, safe educational & recreational facilities,

- libraries, information and documentation centers etc..). These efforts must consider the different needs of gender and age groups.
- ❖ Promotion of primary and secondary abstinence among the youth should be given priority. In addition, promotion of correct and regular condom use should continue for all individuals who are sexually active.
 - ❖ Mass media and other IEC/BCC activities should address the existing widespread misconceptions to enhance behavioral change.
 - ❖ Giving attention to youth clubs (HIV/AIDS or others), building their capacity and providing comprehensive, accurate and timely information to members and peer educators. This way, they can accomplish their objectives, be good models for others and encourage other youth to be members and benefit from the services.
 - ❖ Life skills programs for young people have to concentrate on promoting safe behavior. and it should be started from age 10..

For Researchers

HIV/AIDS has a profound impact on the health sector as well as the socio-economic development of the country in general, and it is becoming a life costing challenge for the young adults and young people, so to prevent and control its effects it is very important and essential to assess the policy, strategy and methodology which are used for BCC on changing risk behaviors that expose people to HIV infection and barriers for risk behavior changes. A research and

study process must consider the different needs of gender and age group (including teenagers) in the HIV/AIDS issue.

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