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A Better Fate for Young People:

Challenges to Behaviour Change in Ethiopia and Their Implications for HIV Prevention

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Young people aged 15–24 years are among their own worst enemies – and best hope as change agents – according to this project implemented by AMREF in two districts (Kifle and Ketemas) in Addis Ababa the capital city of Ethiopia, and three other sites outside the capital. The FATE project – Fighting AIDS Together in Ethiopia – uses behaviour change communication as its main strategy to reduce HIV transmission.

As this Technical Briefing Paper describes, the project targets youth and involves them in identifying problem areas and articulating opportunities for change. The study concludes that targeted, youth friendly services and information campaigns are needed to stem HIV transmission.

Background

Akaki and Kaliti are roadside industrial towns along the Ethiopia - Djibouti highway, approximately 25 kilometres from central Addis Ababa. The towns and surrounding farming areas have a population of about 100,000. Poverty is pervasive and youth unemployment runs as high as 60%. The truckstops along the highway and the many places of entertainment provide a meeting ground for the variety of populations living in the area, the factory employees, transportation workers, commercial sex workers, farmers who come to sell their produce, internally displaced people and the youth.

Youth in the 15 - 24year age bracket have the highest HIV/AIDS prevalence in Ethiopia.

An AMREF youth centre established in June 2002 serves about 10,000 young people. HIV transmission is high in Addis Ababa, with a prevalence of 15%, and is likely to be higher in this area with intense commercial sex work. Youth in the 15 - 24year age bracket have the highest HIV/AIDS prevalence in Ethiopia (12.1%). Most are not married, and many have multiple sex partners.

Objectives

Experience across Africa indicates that half of all the new HIV infections occurred among the youth ages 15 - 24. Reaching the youth is therefore the essential element in stemming the spread of the pandemic. AMREF carried out an assessment of behaviour related to HIV transmission among youth to gauge whether the intervention programme was appropriate for the target group. The assessment intended:

- To explore risky sexual behaviours among the youth.
- To identify specific challenges in communicating with the youth about safer sex practices.
- To determine possible strategies for dealing with risky behaviours for more effective HIV prevention in future.

Methodology

The study was carried out in two phases. It first reviewed the knowledge, attitudes and practices of the youth in eight kebeles (smallest administrative unit) and farmer associations. Second, it conducted six focus group discussions at the youth centre with 101 discussants, plus key informant interviews in four kebeles and two farmer associations. This phase explored the risky sexual behaviours of the youth identified in phase 1 and assessed behaviour that promotes HIV transmission.

Key Findings

It turns out that there are several interlinked sex networks in Kaliti and Akaki that contribute to HIV transmission in adolescents. Knowing how they operate is essential to designing workable interventions for young people. The networks include:

- Young male students making their sexual debut with commercial sex workers, especially young ones.
- School pupils with other pupils or sometimes teachers in dark corners near schools.
- Young people frequenting cheap, illegal movie houses

called dirty corners where they drink alcohol and watch pornographic films. Group sex allegedly occurs in such places.

- Farmers, male and female, who frequent bars and brothels when they come to town to market their produce.
- Truck and taxi drivers, who frequent the brothels and give girl students lifts in exchange for sex.

Attitudes and Practices. A prevailing misconception among young people is that sex is safe as long as they stick with their peer group. Safer sex generally meant using condoms. Most believed condoms could prevent pregnancy but were unsure about protection against HIV/AIDS. Young people were quite open in discussing sex, and wished their parents and religious leaders would discuss sexual issues with them.

Several interlinked sex networks contribute to HIV transmission in adolescents.

They readily identified poverty's role in spreading HIV/AIDS, and recognized that it drove girls and women to commercial sex work. They also acknowledged that in most families, girls were treated as inferior, had less opportunity for education and were often pushed into early marriage. Homosexuality, said to be increasing, was associated with the illegal movie houses, dirty corners and pornographic films. The practice is taboo; homophobic parents consider it to be caused by evil spirits that can only be cleansed by baptism and isolation in monasteries.

Sources of Information. Where do young people learn about reproductive health and sexuality? Almost all discussants said that the media - TV, newspapers, magazines, books and especially radio - were their chief sources of information. Next were friends and peers, including peer educators trained by AMREF and the Family Guidance Association of Ethiopia. School Anti-AIDS clubs and teachers were also named. Young people liked to talk with friends about problems, because of the immediacy of feedback.

Parents still hold a strong taboo against talking about sexual matters with their children.

Parents still hold a strong taboo against talking about sexual matters with their children. Religious leaders also tend to talk about HIV/AIDS as retribution for sin rather than as a health and social matter that everyone faces. The stigma religious leaders place on HIV/AIDS effectively blocks communication with young people. Not surprisingly, parents and religious leaders were the least important sources of information. Studies have shown that in places where religious leaders engage in the life situation of people with HIV, almost inevitably, perspective shifts and the community tends to accept people living with HIV/AIDS (PLWHAs).

Access to Services. The focus groups cited a number of deterrents to condom use:

- Only five reproductive health and family planning services are located in the area, and only two of these are youth friendly, that is, they have specially trained service providers, privacy and confidentiality, and accessibility.
- No condom dispensers are found in the area. Many kiosks carry condoms, but youth are reluctant to purchase them in their own neighbourhoods for fear of being labelled promiscuous.
- Kiosks are few in rural areas, meaning that a would-be purchaser must travel far to buy condoms.

Despite these drawbacks, according to an earlier study, youth feel that condom use has increased by about 25%. Sexually transmitted infections (STIs) are common but access to treatment is poor.

Young people wished their parents and religious leaders would discuss sexual issues with them

The discussants said that youth prefer to go to private clinics but getting the money to do so from their parents is a problem, especially as they feel they cannot openly discuss their infections. The attitude towards voluntary counselling and testing (VCT) was positive, but the service is not yet available locally.

Lessons Learned

- Knowledge alone does not necessarily translate into behaviour change among young people, and the practice of having multiple sex partners is rampant. A recent survey indicated that 9.4% of respondents had too many sex partners to remember and 27% had more than three partners. Identifying the sexual networks in the area provides an opportunity to improve HIV interventions.
- Intervention planning needs to be upgraded regularly using information from surveys like this one; interventions may not address the real problems if based only on generic approaches.
- Focus group discussions are efficient means for assessing knowledge and practices among target groups for the purpose of modifying and targeting interventions. Although the youth are the most affected by the HIV/AIDS epidemic, they are also the most willing to speak out and actively want solutions.
- More outreach programmes are needed to place services where youth will have easy access to them. This includes improved access to condoms and treatment for STIs, as part of any youth-targeted programme of HIV prevention.
- The negative attitude of religious leaders has maintained or even increased the stigma and discrimination attached to HIV infection.

- Parents need to be sensitized on how to give youth the help and information they need. At present, cultural taboos prevent parents from talking with their children about sexual matters.
- Integrated approaches are needed to reach parents, religious leaders, bar and video housekeepers, farmers and their families, and commercial sex workers to complement interventions targeted at youth.
- Key partnerships are probably the only way a project like FATE can achieve such comprehensive coverage. Active partnerships including service delivery and sharing of information should be initiated to serve the youth more effectively.

Recommendations

- The FATE project needs to collaborate with schools to introduce a workable sex education programme in schools. The Anti-AIDS clubs are well modelled on the successful USA DARE programme against drugs, but teachers need training and school support.
- Both girls and boys should be given vocational training, but programmes are specifically needed for girls and young women to counteract the oppressing poverty that channels them into commercial sex work.
- The FATE project should collaborate with local elementary and secondary schools to disseminate the findings of this study and to open discussions, particularly on gender-related issues, as the community unduly marginalizes women.
- Radio as a source of information has much potential especially if interactive techniques are used. Television and videotapes are also popular and effective, but their reach is limited because of the higher cost of receivers. They should be investigated from the perspective of the community centre and mobile shows in Kaliti and Akaki.

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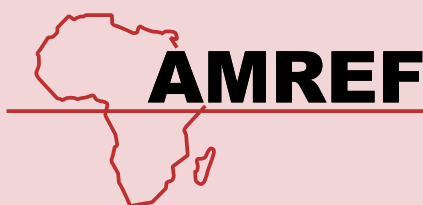
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Its mission is to improve the health of disadvantaged people in Africa as a means for them to escape poverty and improve the quality of their lives.

AMREF defines the disadvantaged as people who suffer a high prevalence and impact of major health problems and challenges including malaria, HIV/AIDS, STI and TB, adolescent and reproductive health problems, low access to water and basic sanitation, and who have poor access to health care.

AMREF headquarters has been in Nairobi, Kenya, since it was founded in 1957. It has country programmes in Kenya, Ethiopia, Uganda, Tanzania and South Africa, and major projects in southern Sudan and Somalia.

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