



School Adolescents' Risky Sexual Practice and Associated Factors in Nekemte Town, West Ethiopia, 2017

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Abstract: Introduction: World Health Organization (WHO) defines adolescent as person between 10 and 19 years of age. Adolescents' sexual behavior threatens the physical, psychological and social health and wellbeing of this group and takes their life. Objective: So, the aim of this study was to assess in school adolescents' Risky sexual practice and associated factors in Nekemte Town. Methodology: School based cross sectional survey was carried out on 576 students in March 2015 involving quantitative and qualitative method. The qualitative part involved 12 focus group discussions. The data was collected using pre-tested self-administered questioners and analyzed using SPSS V.20. Multi-variate logistic regression was used to see association between independent and outcome variables. Result: 568 of respondents completed the questioners, making the response rate (98.6%). 105 (18.5%) of study subjects were sexually active and among them 59 (59.6%) and 25 (28.7%) have not used condom on their first sexual encounter and never used condom at any time of their sexual episode, respectively. Considerable proportion of sexually active students had more than one sexual partner 50 (50.5%). Over all 95 (16.5%) of respondents have been engaged in risky sexual practice. Being male (AOR (95% CI) of 5.73 (2.33, 14.08), Perceived poor academic performance (AOR (95% CI) of 17.59 (3.61, 85.55)), pornographic watch (AOR (95% CI) of 3.31 (1.79, 6.14)) and perceived moderate to high HIV risk perception (AOR (95% CI) of 5.89 (2.43, 14.27)) were positively associated with risk sexual practice. Conclusion and Recommendation: School adolescent have risk taking behaviors. Students get information about HIV/AIDS from their school mini media and some voluntary HIV positive person in an occasional and limited way. So that, it is recommended that adolescent should be equipped with comprehensive sexual education, including condom use and understand the consequence of their sexual practice.

Keywords: Adolescents, Risky Sexual Practice, Predisposing Factors, HIV/AIDS

1. Introduction

Adolescence is a period of transition from childhood to adulthood. World Health Organization (WHO) defines adolescent as person between 10 and 19 years of age and around 1 in 6 persons in the world is an adolescent; that is 1.2 billion people aged 10 to 19. Adolescents' sexual behavior threatens the physical, psychological and social health and wellbeing of this group and takes their life. Therefore, risky sexual practice is an essential indicator to assess the trend of Human Immune Virus /Acquired Immune Deficiency Syndrome (HIV/AIDS) among this vulnerable group and to take an action in its prevention and control [1].

School adolescences are assets of the society and change agents in filling the gap in the past and on whom the future generation is based. It is also clear that this group is on the way of transforming to adulthood, filled with ambition and building their future academic and social career. Neglecting their sexual and reproductive health can lead to high social and economic costs; both immediately and in the years ahead [2].

Ethiopia is a developing country with a demographic profile dominated by young population within the ages of 15–24, constituting one third of the total population. Even

though the number of school going adolescents is continuously mounting in Ethiopia, studies rarely assessed adequately their sexual behavior and the context in which the behavior occurs; the studies were done on limited samples of students and schools [3, 4]. Despite their numbers, adolescents have not traditionally been considered a health priority since they have lower morbidity and mortality than older and younger age groups. Nonetheless, in some areas such as mental and sexual health, adolescents suffer disproportionately [5].

Since the initial case of Acquired Immune Deficiency Syndrome was recognized in 1981, in United State America, the disease has spread wide and became a serious health, economic and social problem of the world than any other health problem a human being currently faced. In 2011, Even though, UNAIDS released its 'Getting to Zero' campaign with a vision that entails a future generation with 'zero new HIV infections, zero discrimination and zero AIDS-related deaths' [6, 7]. The prevalence of AIDS cases due to HIV continues to rise worldwide [8] Young people were at the heart of HIV/AIDS pandemic; globally in 2010, out of estimated 2.7 million people newly infected with the virus 41% were young people. The future of the HIV epidemic lies in the hands of young people. The behaviors they adapt now and those they maintain throughout their sexual lives will determine the course of epidemic for decades to come. Young people will continue to learn from one another, but their behavior will depend largely on the information, skills and services that the current generations of adults choose to equip their children with. HIV spreads faster and faster in a lack of information condition in which many young people live [9, 10].

As to the setting, Beside the variety of problems Sub-Saharan Africa carries, the burden that HIV/AIDS brings to the socio economic development of this region is higher than any part of the world., according to the 2012 UNAIDS Global report, Sub-Saharan Africa remains the most severely affected, faces the worst prospects, nearly one in every 20 adults (4.9%) are living with HIV, which accounts for 69% of the people living with HIV worldwide. Although just 10% of the world's adolescent live in Sub-Saharan Africa, nearly 80% of all new infection lives in Sub-Saharan Africa and the health threats that this disease puts on young people especially in Sub-Saharan Africa are so significant [11, 12]. Of the estimated 333 million new STDs that occur in the world every year, at least 111 million occur in young people under 25 and Rates of premarital pregnancy and STDs among adolescents provide indications of the extent of unprotected sexual activity among young people and their vulnerability to HIV/AIDS [12, 13].

Since adolescents' social, emotional, psychological and physical maturity development is incomplete and they tend to experiment risky behavior and their reproductive organs could not easily afford coital act and the consequences following it, thereby making them biologically vulnerable to sexually transmitted diseases including HIV/AIDS. Adolescent are much more

vulnerable to HIV/AIDS than older people are. Adolescents often are not able to comprehend fully the extent of their exposure to risk. [14].

Societies often compound young peoples' risk by making it difficult for them to learn about HIV/AIDS and reproductive health. Moreover, many youths are socially inexperienced and Peer pressures easily influence them often in ways that can increase their risk of exposure to the disease [14, 15]. The environment in which young people are making decisions related to sexual and reproductive health is also rapidly evolving. Rates of sexual initiation during young adulthood are rising or remaining unchanged in many developing countries. [15, 16].

HIV/AIDS have been a threat to Ethiopia since the mid-1980s [17]. Ethiopian HIV Behavioral Surveillance Survey (BSS) also indicates, having multiple sexual partners and non-condom use among in school Adolescents was significant which increases their exposure to HIV/AIDS infection [18]. In Ethiopia Demographic and Health Survey, 2011, male adolescents were more likely to have reported STD or associated symptoms [19]. These groups of population in the country may face the increased risks of HIV by virtue of their social position, unequal life chances, rigid and stereotypical gender roles and poor access to education and friendly health services. They also have limited access to reproductive health services that focus on the special needs of adolescents. Inadequate knowledge about adolescents' sexual behavior by the society, cultural influences and the limited capacity of implementing reproductive health services hinders the provision of reproductive health education and services to the young group [20].

The Ethiopian policy on HIV/AIDS of 1998 also emphasized on the prevention programmers for young people in school since they are essential components of any national HIV prevention efforts. Moreover, it clarifies that preventive health education should be comprehensive, providing an age appropriate balance of life skills development, reproduction and sexual health information, and discussion of attitudes and values. Furthermore, Ministry of Health has taken the mandate to provide technical assistance to Ministry of Education to ensure that appropriate curriculum and teaching materials shall be developed and implemented for HIV/AIDS/STDs in school health education at all levels. [21]

Understanding in school adolescents' risky sexual practice and associated factors among the adolescent will help in addressing practical and strategic need of adolescent sexual health program in Ethiopia. Studies in this respect seem to be limited in this country which resulted in information gap among practitioners, researchers and policy makers. Among the exiting literatures few studies were dedicated to assess only magnitude and associated factors of premarital sex and use of condom which is only part of risky sexual practice. Therefore, the main purpose of this research was to asses in school adolescents' (10-19 years) sexual practice and factors influencing them to have

risky sexual practice in Nekemte Town, East Wollega, Ethiopia, March, 2015.

2. Methods and Materials

2.1. Study Area

This study was conducted in Nekemte Town of Oromia Regional State located in the western part of Ethiopia. From 2007 National census, Nekemte has a projected to have population of 100,596 in year 2014 with 1.1 to 1 female to male ratio; the Town has six sub cities as to information from municipality. Based on the information from the Town Educational Bureau, The Town has six high schools of 9-10 grades in which four of them are governmental and the other two of them are private schools, four preparatory (11 &12) and also there are eight schools consisting of elementary School, which consists 11,847 adolescent students (55.7% Females and 44.3% males). There are also two functional youth centers in Town that is established for young people to spend their leisure time.

2.2. Study Design and Period

School-based Cross-Sectional Survey supplemented by qualitative study was carried out in Nekemte Town, West Ethiopia from March 1- 15/2015.

2.3. Populations

2.3.1. Source Population

The source population for this study was all adolescents in Nekemte Town attending their high School (9-10) and Preparatory schools (11-12) in 2014/2015 academic year.

2.3.2. Study Population

Selected school adolescents aged between 10 and 19 years in Nekemte Town.

2.4. Inclusion Criteria

All regular students, those aged 10 to 19 years, and attending their regular education at the time of data collection were included. Those students who were not available during data collection time were excluded.

2.5. Sample Size Determination

2.5.1. Quantitative Method

The sample size for quantitative method was determined using a formula for estimation of single population proportion with the assumption of 95% confidence interval, a margin of error of 5% and by using an assumption of the proportion of the prevalence of risky sexual behavior 14% and this was taken as $P= 0.14$ (29) and design effect of 2 was used. Based on this assumption, the actual sample size for the study was as indicated below.

Sample size was calculated using single proportion

formula.

$n = (Z \alpha/2)^2 \cdot P (1-p) = 288$, using design effect=2 and considering 10% none response rate and calculated sample size was= 576

2.5.2. Qualitative Method

The quantitative method was supplemented with focus group discussion, which have been guided by discussion guide and this focus group discussion were conducted in all selected schools (six) separately for male and female for privacy, which yields 12 FGD in which eight purposively selected discussants from those who participated in the survey were used in each FGD and discussion sustained till level of saturation is attained.

2.6. Sampling Procedure

A multi stage stratified sampling procedure was employed. First schools were clustered by academic level (high school or preparatory level education). Then they were stratified by Ownership (Whether they are owned by Government or Private). The schools are the Primary Sampling Units (PSU), four schools were selected by lottery method from the high schools (9-10) in which two of them represents Governmental schools and the other two from the private. Two preparatory schools were also drawn by the same method, one from governmental owned and the other from Private. And generally, six schools have been drawn of which four are from high schools and two of them are from preparatory Schools. The sample size was distributed proportionally to each selected school based on the student population they have. Study subject selection is Secondary Sampling Unit (SSU). Using students list (sampling frame), respondents were selected by systematic random sampling. Different sampling interval were used for different schools by dividing the total number of that schools of student for their sample share. In case of index sample or first sample which is also differs among selected schools and selected randomly between one and sampling interval and in case of absenteeism the next number of the list was included in the study.

2.7. Data Collection Tools and Procedures

A questionnaire was prepared in English then translated to Region official language (Afan Oromo) and then retranslated to English language to check for consistency during translation and data were collected by self-administered structured questionnaire which was adapted from HIV Behavioral Surveillance Survey 2005 and after reviewing different literatures. Two facilitators who have completed grade twelve and a Nurse Supervisors were recruited to assist the data collection process. Facilitators and the Supervisor have been trained on the objectives of the study, the questionnaire, checking completeness of questionnaire and the way to keep respondents privacy. The facilitators were responsible in arranging the seating of the respondents, giving clarifications on how to fill the questionnaire, distributing questionnaires to the respondents and assisting

the students on difficulties they had during filling the questionnaires. Privacy was maintained by making different sexes to respond in different rooms, reminding students not to write their names and put questionnaire in a box after they completed. To make them to respond freely, the school community members were not allowed to come to the hall.

The questionnaires were Pre-tested 10 days before the actual data collection on 5% of respondents; in a Bekenisa Kese high school that contains Grade 9-10 level which found in the same town and necessary amendment, specially, on the sequential flow of questions, have been done by taking respondents question and comment in to consideration.

In order to prevent discussion among the students, questionnaire filling by the respondents was completed in both morning and afternoon shifts within the same day in the respective schools, on the fourth period of the morning and first period of the second shift.

The focus group discussions were tape-recorded and the facilitators take notes. In order to keep privacy, discussion of different sexes held in two different rooms.

2.8. Data Quality Management

Data quality was managed by training and appropriate supervision of data collectors. Overall supervision was made by the principal investigator. Each question was explained in the language the participants understand and questionnaire was filled on the spot so as to get unbiased remarks.

2.9. Data Processing and Analysis

The filled questionnaires were checked for completeness and entered in to EPI data statistical software and then transferred to SPSS windows version 20 for analysis. Frequencies and cross tabulations were used to summarize descriptive statistics of the data and tables and graphs were used for data presentation. Bivariate analysis was used primarily to check which variables have association with the dependent variable individually. Variables with $p < 0.1$ were entered in to Multiple Logistic regression for controlling the possible effect of confounders. Multi-collinearity between exposure variables was checked with VIF. Hosmer and Lemeshow goodness of fit of test was used to assess the model fitness assumption. Finally, the variables which have p -value < 0.05 were considered statistically significant. The strength of association between independent and dependent variable was assessed using odds ratio with 95% confidence interval.

2.10. Ethical Considerations

Ethical clearance was obtained from the Research Ethics Review Committee of Wollega University. Communication with the different town and sub-cities administrators were

made through formal letter obtained from Wollega University. Officials in Nekemte Town Administration and Educational office were contacted and permission was secured. The necessary explanation about the purpose of the study and its procedure, benefit and harms, assurance of confidentiality, the right not to participate on the study without any consequences were done for respondents and a written consent from respondents age above 18 years and assent and consent of willingness were obtained from the students and family or care giver of students whom aged less than 18 years by sending ethical letter to family or care giver through selected students one day prior to data collection date. Participants were also informed that participation is on voluntary basis and they can withdraw from the study at any time if they are not comfortable about the questionnaire. In order to keep confidentiality of any information provided by study subjects, the data collection procedure was anonymous. Information sheet and consent form were also attached to each questioner.

3. Result

Among total sampled 576 students, 568 of them have respond to the questionnaire, with response rate of 98.6%. Among study participant's females were 320 (56.3%) and males were 248 (43.7%). Of the study subject 309 (54.9%) were in age group of 12-17 years, with mean age of 17.26 ± 2.23 (17.5 ± 1.29 for males and 17.09 ± 1.18 for that of females). Among subjects Participated in the study 565 (99.5%) were single in marital status, the ethnic and religious composition of the students reported that 544 (98.5%) and 379 (66.7%) were Oromo and protestant respectively. Five hundred thirty-eight (94.7%) study participant report that they do attends their religion, and three hundred six (56.1%) of them attends once a week. As to their parents living condition 453 (80.3%) of their parents live together. Concerning respondents living condition 396 (61.3%) of them are currently living with both parents. Three hundred ninety-six (69.7%) lives in town whereas, the rest come from rural area and lives in rented houses.

Perceived family economic status relative to their neighbor shows 240 (42.5%) of study population were from families better of their neighbors. For 184 (32.6%) respondents pocket money was being allocated of which 89 (49.2%), 44 (24.3%) and 48 (26.5) of them will earn $< 100, 100-200$ and greater 200 ETB/Month respectively. As to student academic performance self-perceptions, three hundred seventy-three (67.8%) of them evaluate oneself as medium level performing students, while more than one out of four 151 (27.5%) self-perceived as good performer and 26 (4.7%) as having poor performance. (Table-1 below)

Table 1. Socio demographic status of in school adolescents, Nekemte, March 2015.

CHARACTERISTICS		Number	%
SEX	Male	248	43.7
	Female	320	56.3
Age of participants	14-17	313	55.1

CHARACTERISTICS		Number	%
Academic level	≥18	254	44.9
	9 th	116	20.4
	10 th	173	30.5
	11 th	127	22.4
	12 th	152	26.8
School type	Private	77	13.6
	Governmental	491	86.4
Ethnicity	Oromo	544	95.8
	Amhara	12	2.1
	Others	9	1.6
Respondents marital status	Single	565	99.5
	Not single	3	0.5
Religion	Muslim	26	4.6
	Orthodox	133	23.4
	Protestant	379	66.7
	Catholic	16	2.8
With whom does respondent live	Other	14	2.5**
	Both parent	347	61.3
	Singleparent	219	38.7
Residence situation	Live in town	396	69.7
	Come from rural	171	30.1
Pocket money allocated	Yes	184	32.6
	No	381	67.4
Amount per month, if allocated.	<100	89	49.2
	100-200	44	24.3
	>200	48	26.5
Perceived academic performance	Good	151	27.5
	Medium	373	67.8
	Poor	26	4.7

**Others are Wakefana and other traditional religion.

Concerning parents, 453 (80.3%) of students' report that both of their parents live together, the wealth of 240 (42.5%) participants parent is economically better of their neighbor relatively, while 132 (23.4%) of respondents' family are in the same economic level or similar in wealth to their neighbor. Table-2 below.

Table 2. Parent characteristics of adolescent's, Nekemte, March 2015.

Variables (568)		Number	%
Parent marriage	Parents lives together	453	80.3
	Not live together	111	19.7
Father's education	Unable to read and write	46	8.4
	Elementary	251	46.1
	Secondary	248	45.5
Mother's education	Unable to read and write	133	23.9
	Elementary	251	45.1
	Secondary	173	31.1

Sexual behavior of the study subject

Sexual History

In this study, 105 (18.5%), of the respondents reported that, they had ever practice sexual intercourse. Among those who had ever practice sexual intercourse 70 (77.8%) were between the age of 18-19 years and the mean age of first sexual intercourse was 15.96 ± 1.75 . (mean \pm SD). The reason, reported for early initiation of first sexual encounter for those who ever practiced sexual intercourses, 58 (57.1%) was due to personal desire and 36 (35.6%) of them were due to peer pressure. Of those students who have been reported to have sexual intercourse, 57 (59.7%) were engaged in sex in last 12 months before data collection period.

Risky sexual behavior

Among sexually active students 59 (59.6%) have not used condom in their first sexual encounter and 50 (50.5%) of

them reported to have more than one sexual partner in the past. Among those who reported sexual relation with more than one partners 24 (48%) of them mentioned that the main reason to have a sex with them was trusting their partner because they are health looking. Thirty-four (53%) of those who commenced sexual intercourse in past one year practiced sexual act with casual partner and also 18 (28.6%) and 10 (15.9%) with Regular partner and Partner who have multiple sexual partners respectively.

Twenty (21.5%) of them respond that they had given or received money, gift or favor in return to sex from their sexual partners and six (8.6%) of students reported to have sexual intercourse with commercial sex worker and the mean age to go to commercial sex worker was 16.16 ± 1.16 years and 4 (66.7%) of them reported that their peers insisted them to practice sexual relation with CSW. But, only 3 (50%) of

them uses condom on sex with CSW.

In their sexual intercourse episodes 25 (28.7%) have never used condom at any of their sexual episode while only 16 (18.4%) of them used condom consistently and among those who had sex with regular partner 17 (42.7%) did not use condom; the main reason for not using were unavailability and being not comfortable in arousal in which each of them

holds the same proportion 10 (19.6%) and also among students who have practiced sexual intercourse 7 (7.4%) of them had encountered rape. Ninety-five (16.7%) of study subjects have developed risky sexual behaviors. Pertaining to STDs 36 (6.8%), 23 (4.3%) of respondents had genital discharge and genital ulcer /sore in last twelve months respectively. (Table-3 below)

Table 3. Sexual behavior characteristics of in school Adolescents, Nekemte, March 2015.

Variables		Frequency	%
Ever had sex (568)	Yes	105	18.5
	No	463	81.5
Age of the first sexual initiation (95)	11-17	8	8.2
	18-19	34	34.7
	Do not know/Remember	53	57.1
Reason for initiating sex (105)	Personal desire	60	57.1
	Peer pressure	38	35.2
	Influence of alcohol	2	2.0
	Coercion	4	4.0
Engaged in the sex in last 12 month (96)	Economic problem	1	1.0
	Yes	57	59.4
	No	39	40.6
Age of the first sexual partner (98)	Younger	8	8.2
	The same age	34	34.7
	Less than 5 years older	16	16.3
	5-10 years older	14	14.3
Condom used during the first sex (99)	More than 10 years older.	15	15.3
	Do not know /Remember	11	11.2
	Yes	36	36.4
	No	59	59.6
Attitude towards condom use (532)	Do not know/remember	4	4.0
	Positive	418	78.6
No of sexual partners (95)	Negative	114	21.4
	1	45	49.5
Reason for having multiple sexual partners (50)	>1	50	50.5
	Not to reduce sexual pleasure	17	34
	Not to be sexually weak	9	18
Frequency of condom use at each sexual episode (87)	Trusting all my partners	24	48
	I have never used	25	28.7
	Some times	28	32.2
	Most of the time	14	16.1
	Always	16	18.4
Currently with regular partner (532)	Do not remember/know	4	4.6
	Yes	151	28.4
Have a sex with regular partner (154)	No	381	71.
	Yes	38	24.7
Ever have a sex with CSW (70)	No	116	75.3
	Yes	6	8.6
Condom use in sex with CSW (6)	No	64	91.4
	Yes	3	50.0
Reason for not using condom with CSW (5)	No	3	50.0
	Not available	4	80
Received gift or money in return for sex (93)	Do not think of its necessity	1	20
	Yes	20	21.5
Coerced sex (94)	No	70	75.3
	Do not remember	3	3.2
Genital discharge in last 12 month (94)	Yes	7	7.4
	No	87	92.6
Genital ulcer in last 12 month (97)	Yes	17	18.1
	No	77	81.9
Risky sexual behaviours	Yes	10	10.3
	No	87	89.7
	Yes	95	16.7
	No	473	83.3

Among the study subjects 166 (31%), 33 (6.1%), 98 (18.1%) and 22 (3.9) were looking pornography film, chewing khat, Using alcohol and shisha respectively. (Table 4 below)

Table 4. Magnitude of substance use among school adolescents, Nekemte, March 2015.

Characteristics		Number	%
Drink alcohol (542)	Never used	444	81.9
	Used	98	18.1
Chewed khat (543)	Never used	508	93.9
	Used	33	6.1
Watched pornography (525)	Never seen	369	69.0
	Seen	166	31.0
Used shisha (542)	Never used	520	91.5
	Used	22	3.9
Drug use	Yes	117	21.4
	No	429	78.6

Knowledge on HIV/AIDS

Half of the respondents (50.1%) are knowledgeable on HIV/AIDS and the main mode of HIV transmission known by students where unprotected sexual intercourse/un safe sex/ 459 (83.9%), Un screened blood transfusion 304 (55.6%) and from mother to child 283 (51.7%), while 162 (29.9%) of respondents has one or both misconception on HIV/AIDS, Specifically, Mosquito bite 101 (18.8%) and Chicken swallow used condom 90 (16.7%). Four hundred fifteen (83.4%) and 436 (83.4%) of the student mentioned that they do not know whether HIV is transmitted by chicken that swallowed used condom and mosquito bite or not respectively. In the same way 117 (22.7%) mentioned that they do not know that person who looks health can be infected by HIV. 171 (33.5%) of the respondent do not know that whether person with virus but looks health can transmit virus or not.

Two hundred ten (39.3%) of the study subjects reported that sexual abstinence protects from HIV, while a considerable proportion of students 324 (60.6%) do not know whether abstinence prevents people from being infected or not. Additionally, 201 (37.3%) of the students do not know that having one uninfected faithful sexual partner protects people from HIV infection.

Risk Perception

On personal risk perception more than half 48 (55.1%) and 26 (29.8%) of sexually active students report that they do not have the chance or low chance and moderate to high chance of being infected by the virus respectively. Sixty-seven (27.7%) of respondents does not know their chance of being infected by the virus. The reason listed out by the students as

no or low chance were never having sexual contact 337 (83%), trusting their sexual partner and abstaining from sexual intercourse has both 22 (5.4%) each. The main reason listed by the student why they have categorized themselves as a moderate to high risk were having sexual contact without condoms 14 (35%), having more than one sexual partner 8 (20%).

Most of the respondents, 310 (61.5%) thought that a person can avoid AIDS by changing his/her behaviors. Among sexual active students 77 (81.9%) intended to make a change in their behaviors that could exposes them to HIV/AIDS while 17 (18.1%) reported that they do not have any intention to make change in their sexual behavior in the future. Among changes mentioned by the students in their future plan to prevents themselves from HIV/AIDS infections, the majors were getting great care in choosing partner 196 (45.1%), Sexual abstainace 154 (35.4%), avoid sex with stranger 140 (31.9%) and Avoid unclean needles 124 (30.8%).

Comparison of Risky sexual behaviors by Socio demographic factors.

To examine the effect of some explanatory variables by controlling the effect of confounders on risk behaviors exposing adolescents to HIV/AIDS, Regression analysis was carried out. Sex, perceived academic performance, misconception on condom, self-risk perception and Pornography watch shown to have statistically significant association with risky sexual behaviors.

Males are 5.73 times more likely to be engaged in risky sexual behavior as compared to that of females (AOR=5.73, 95% CI: 2.33, 14.08), Students perceive them self as performing at medium are 3.1 more likely to participate in risky sexual behavior than those student perceived them self as good academic performer (AOR=3.07, 95% CI: 1.18, 7.96) and by similar fashion those respondents perceived oneself as having poor academic performance has more than 17.59 more likely to get involved to risky sexual behavior (AOR =17.59, 95% CI, 3.61, 85.55), As to the association with self-risk perception, moderate to high level self-risk perception of HIV infection has 5.89 times less likely to Participate in risky sexual behaviors (AOR 5.89 at 95% CI (2.43, 14.27)) as compared to respondent whose self-risk perception to HIV infection is no to low chance of infection.

School adolescent watching porno are 3.31 times more likely to practice in risky sexual behavior as compared to those never watched pornographic film (AOR =3.31, 95% CI:1.79, 6.14) and risky sexual behaviors has also shown significant association with misconception on condom. Students free of misconception on condom were 55% less likely to be engaged in risky sexual behaviors (AOR =0.55, 95% CI, 0.31, 0.96). Table 4 below

Table 4. Comparison of school adolescent's socio demographic characteristics with risk to HIV, Nekemte, March 2015.

Variables	Risk sexual behaviors		COR	AOR	
	Yes n (%)	No n (%)	95% CI	95% CI	
SEX	Male	63 (25.40)	185 (74.60)	3.06 (1.93, 4.87)	5.73 (2.33, 14.08)**
	Female	32 (10)	288 (90)	1	1
Age of participant	<18	36 (11.65)	273 (88.34)	1	1
	≥18	59 (22.77)	200 (77.22)	2.23 (1.42, 3.51)	2.09 (0.89, 4.53)
Marital status	Single	93 (16.46)	472 (83.54)	10.15 (0.91, 113.09)	
	M/W/D	2 (66.67)	1 (33.33)	1	1
Parent marital status	Live together	297 (85.59)	50 (14.41)	1	1
	Not live together	43 (19.63)	176 (80.37)	1.59 (0.95, 2.66)	1.92 (0.70, 5.24)
Perceived academic performance	Good	19 (12.6)	132 (87.4)	1	1
	Mid	55 (14.7)	318 (85)	1.20 (0.68, 2.10)	3.07 (1.18, 7.96)**
	Poor	19 (73.1)	7 (26.9)	18.85 (6.99, 50.80)	17.59 (3.61, 85.55)**

** P Value <0.05.

4. Discussion

This study revealed that, school adolescents commence sexual practice at early age. The reported mean age of first sexual practice for the students was 15.96 ± 1.75 (15.96 ± 1.98 males and 16 ± 1.15 for females). Male students were found to start sexual intercourse earlier than female students and this may be due to fear that females' shoulders most of the consequence related to early sexual initiation like teen age pregnancy, unacceptability and discrimination in social life. By similar fashion, males were found to be more exposed to risky sexual behavior. This may suggest that adolescents begin sex too early, which could as a result expose them to develop risky sexual behavior and its consequences. As compared to the study in Gondar town that showed the mean age of sexual first commencement for females and males was 17.1 and 17.3 respectively. This difference is one of indication for the age of first sexual commencement is falling in town recently and may be also due to cultural and tradition difference among study areas. [25]

Different factors may insist school adolescents to engage in a premarital sexual practice due to an inherent risk in being an adolescent and the need to experiment different things by this group. In the present study among the reasons reported by the students for the initiation of sexual act for the first time, personal desire 58 (57.4%) and peer pressure 36 (35.6%) were the leading factors. Similarly, a study in 2008, in Bale, Ethiopia found that in school adolescents have had sexual experience, personal desire (39.1%) and peer pressure (23.3%) was the most important factor that precipitates the first sexual encounter which is much lower than the finding of the current study and this may be due to cultural and religious difference. [27]

Among study participants, 105 (18.5%) of them reported that they have ever had sexual intercourse. Even though, this figure is comparatively low as compared to study conducted in 2009 in Jimma University, 26.9% of University students were ever had sexual intercourse and this may be related to age and academic level difference among the study population. But this result is extremely high when compared to high school students in china, in which only 4.8% of them

had experienced sexual intercourse and this might be related to difference in Socio-economic and cultural factors. [23]

In this study a significant proportion of sexually active students (50.5%) reported to have sexual intercourse with more than one partner in their lifetime. This may indicate that the risk taking behavior among school adolescents is high. Similarly, a study conducted in Addis Ababa and Gondar shows 54% and 40% of sexually active adolescence have experienced sex with more than one partner including CSW respectively, the finding from this study was higher as compared to that of Gondar and a bit lower than study in Addis Ababa and this may be related to Socio cultural difference. [24, 25]

In the current study, 28.7% of sexually active respondents have never used condom during any sexual episode and only 18.4% of them used condom consistently. This signifies that the extent of exposure of school adolescents to HIV and other STDs was high due to their engagement in unprotected sexual practice. In line with this finding previous study in Ethiopia have also shown 58.1% have not used condom during any episode sexual intercourse. [25]

The current study has revealed that the magnitude of STDs among sexually active students in that 18.1% students reported to have genital discharge and 10.3% of them had genital sore in the last 12 months. Whereas study in Jamaica, claim that 57% and 39.5% of sexually active Jamaican adolescence had genital discharge and genital sore in last 12 months before the survey respectively. [27]

Current study revealed that 7.4% of the students had encountered coerced sex which is very low as compared to finding in Bale that shows (15.9%), which signifies that such an issue has been legal concern in recent years and could be also due to cultural difference. [26]

A transactional sex, which involves change of gift or money in return for sexual favor among school adolescents and old aged partner, serves as one means for the dissemination of HIV/AIDS among this vulnerable group. In the present study 15.3% had the first sexual encounter with a partner 10 years older than them, while that was 7.3% in EDHS 2011 and this is indicating that the issue of getting in sexual relation with older persons is increasing or the need of older partner for selection of younger partner is high in this

study area. Moreover, 21.5% of sexually active study in this study had received different supplies in return to sex. Towards the reason of sexual contact with older people, in the FGD, economic supply in terms of money and /or gift where the main one. This indicates the sexual relation with the older partner due to economic support is becoming common which fuels further expansion of the disease to the younger population since the older people had had sexual experience with different partners. [6, 19]

Sexual activity and substance use are common among adolescents today. The more substances that school adolescents and young adults ever tried, the more likely they are exposed to risky practices as a consequence contract HIV and other STDs. In this study among the reported substance used by study subjects 18.1% of them have used alcohol, 6.1% khat, and 3.9% Shisha. The FGD also depicted that substance use like alcohol, khat and shisha where among factors that pushed school adolescents to sexual debut in an early age. This increased rate of substance use in town may indicate that the unavailability of places for adolescents to spend time out of school, there by involve themselves to risky sexual behavior. Other study in western part of Ethiopian also revealed that 20.3% of the in school youth chewed khat at least once in their life time and this can be due to religious and cultural difference among eastern and western part of the country. [28]

Even though, most of the students know more than one mode of transmissions and preventive methods, still they have a misconception, which leads to the limitation of their knowledge. In our study 18% had reported that mosquito bite, 15.4% eating uncooked chicken that had swallowed used condom could transmit the virus. Ethiopian behavioral surveillance survey also yield almost the same proportion of respondent reported mosquito bite can transmit HIV, whereas 22.5% of respondents claim that the virus can be transmitted by eating uncooked chicken that has swallowed used condom, and the finding of this study area is much lower compared to 2005, Ethiopian BSS, which might be the indication of progress in reducing misconception since BSS in 2005.

A feeling of perceived risk of HIV infection is one of the important prerequisites for translating HIV knowledge in to behavioral change. The present study found that 55.1% of students who have practiced sexual intercourse perceived that they do not have chance or low chance of being infected by the virus and only 29.8% of them perceived that they have moderate to high chance of being infected by the virus. In Behavioral Surveillance Survey (2005) done in Ethiopia, most of respondents (87.5%) of sexually active in school youth perceived the likelihood that they would become HIV infected is null or low. Even though, the finding of this study is lower than EBSS 2005, which might be indicative of change in self-perception, However, this signifies that still an adolescent self-risk perception to HIV/AIDS was not sensed, as they are vulnerable and does not go with actual practice they have. [6]

As to the factors associated with risky sexual practice of

the current study, being male is found to be a factors by AOR (95% CI) of 5.73 (2.33, 14.08) and 0.55 (0.31, 0.96) respectively. Study conducted in Bale and Jimma are also in the same line with this report, in that being male is 1.81 and 2.65 more likely to be engaged with risky sexual behavior respectively. [23, 27]

Studies in Bale also reported that respondents who has negative attitude towards condom use are 4.18 more likely to be engaged in risky sexual practice. This result is also found in the same direction with the current study that shows misconceptions free respondents are 55% less likely to be engaged with risky sexual practice as compared with those who have misconception. [27]

5. Conclusions and Recommendations

5.1. Conclusion

School adolescents are practicing high-risk behavior that can expose them to HIV/AIDS. The risk behaviors are early sexual debut, sex with risky groups, having multiple sexual partners, committing sexual intercourse with casual partner and commercial sex workers and un protected sex. School adolescents are also engaged in sexual practice with older person that favors the dissemination of HIV/AIDS and STDs in this vulnerable group. Pornography watch significantly insisted school adolescents' sexual behavior and Perceiving oneself as good academic performance is found to be protective against risky sexual practice. Considerable proportions of sexually active adolescents were suffering from STDs (genital discharge and genital ulcer) in the last 12 months. Knowledge on HIV/AIDS is better, though comprehensive knowledge is minimal, misconception on HIV and condom use exists. Self-risk perception to HIV infection among sexually active the students is found to be low.

5.2. Recommendations

Policy makers or the concerned governmental officials are recommended that, reproductive health services (condom provision, treatment on sexually Transmitted Disease and VCT) should be made available to nearby or in schools, with special emphasis on sexuality, including HIV/AIDS prevention and control that have incorporated in the school curriculum should be practical beginning from the primary level. Governmental officials should develop a controlling mechanism on cinema house showing pornography films.

Health institutions, voluntary HIV positive persons, Opinion leaders, religious leaders and school anti AIDS club members should provide IEC in a regular basis to enhance school adolescence knowledge, reduce misconceptions and increase HIV risk perception. The government and NGOs should also strengthen the capacity of school anti AIDS clubs in terms of material and training. Parents and teachers of student at this age category should stand beside them, to ignite their academic performance, since academically good performing student are more protected from engagement of risky sexual practice.

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