

# FACTORS AFFECTING ATTITUDE TOWARD SAFE SEX AND REPRODUCTIVE HEALTH AMONG SHIRAZ CITY YOUTH

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**ABSTRACT** *Young people are the most vulnerable to reproductive and sex issues than the others. Iranian youth like many other counterparts throughout the world encounter social, cultural and economic barriers to the information and health services they need to protect themselves against sexual and reproductive diseases.*

*The purpose of this study was to examine the relationship between some demographic, socio-economic, and cultural factors affecting the attitude toward safe sex and reproductive health among Shiraz city youth. A cross-sectional quantitative survey was conducted in Shiraz city with a final sample of 384 youth in fall 2004. The data collection was done by use of a self-administered questionnaire. The data was coded and analyzed by the use of SPSS 11.5. Results are presented in both descriptive and inferential statistic tables.*

*The multivariate analysis showed that six of fourteen studied independent variables have effect on youth attitude toward safe sex and reproductive health in Shiraz city; interpersonal communications, father's education, access to modern applicants and facilities, awareness about safe sex and reproductive health, non-printed mass media habits, and printed mass media habits.*

**KEYWORDS** *Safe sex, Reproductive health, Youth, Attitude, Sexually transmitted diseases.*

## INTRODUCTION

Many young people face the risk of Sexually Transmitted Infections (STIs), HIV, physical abuse and sexual violence, female genital mutilation, unintended pregnancy, and emotional, cultural and social problems related to their sexual and reproductive health. "More than 100 million sexually transmitted infections, not including Human Immunodeficiency Virus (HIV), occur every year around the world among people under age 25." (UNAIDS, 2002). However, many infections go unnoticed. For

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biological reasons, women and girls may show no symptoms or the signs may be so mild that they are unrecognizable. In addition, young people have serious misconceptions about HIV and other Sexually Transmitted Infections (STIs). "Of the estimated 40 million people living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) worldwide, nearly one-third is between the ages of 15 and 24 years." (UNICEF-UNAIDS-WHO, 2002). "This group accounted for two-thirds of newly infected individuals in developing countries in 2003." (UNAIDS, 2004). Existing HIV prevalence combined with disproportionately young population results in a concentration of new infections among young people. Given that the burden of new HIV infections in developing countries is concentrated among the youth and females, there is emerging awareness that even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people, especially females (UNAIDS, 2004).

Iranian youth, like many others throughout the world, encounter social, cultural and economic barriers to the information and health services they need to protect themselves against sexually transmitted infections (STIs) and other threats to their sexual and reproductive health. Youth are the most vulnerable to HIV and other STIs.

Due to social and cultural taboos and inhibitions, sexual health research in Iran remains restricted to a few number of studies for youth, especially those who are unmarried. Social and cultural norms impose barriers to the transfer of sexual health information. As this group requires having proper guidance regarding their health, which can make them beneficial for community and nation and so, they can play an innovative role for welfare and advancement of the country.

Understanding how factors such as one's demographic, socioeconomic and cultural status confer vulnerability to unsafe sexual attitude and behaviors among youth is important for development policies and programs. Helping young people to develop healthy behaviors and providing them with appropriate information and care are key investments in their future.

Today, youth and adolescent reproductive health is increasingly becoming a government priority. This study hopes to help professionals and policy makers to understand how promote sexual and reproductive health behavior among young people. Not only youth soon bear the new generation, but also they can play an innovative role for welfare and advancement of the country, so improving their attitude by regarding their health is an important task for the country.

We want to have a clear idea of young adult's attitude toward reproductive health, safe sex, and STDs. Youth's attitude toward reproductive health and safe sex is an interesting topic that has attracted our attention. The main reason for this is that it focuses on youth in particular rather than the public. Youth are faced with numerous problems, which are sometimes beyond their comprehension. To achieve sustainable change, however, it is necessary to focus on young people before they become sexually active and before myths become deep rooted and unsafe patterns of sexual behavior are established (D. Kirby, 2001, A. Grunseit, 1997).

The broad aim of the study is to determine some factors affecting attitudes towards reproductive health and safe sex among youth in Shiraz city.

A survey like this increases our knowledge on how youth think about sex and reproductive health. It increases our knowledge around sex that influences young person's behavior on sexual arena. It would also help professionals and policy makers to understand how one should proceed in doing this in order to promote a sexual behavior among young people.

## **METHODS**

***Type of the Study*** This is a cross-sectional quantitative study, conducted in fall 2004. The study is based on the survey method.

***Target Population*** The target population of this study is all 15 to 29 years old men and women living in Shiraz city. Male and female, both sexes will be given equal chances to be chosen. We have chosen our sample age groups according to demographic statistic categories (15 to 19), (20 to 24), (25 to 29) years old and youths situation in Iran. Many Iranian youth at (25 to 29) years age group have few sexual experiences while their counterparts in other parts of the world may be well experienced.

***Sampling Method and Sample Size*** The sampling method, here, will be simple random multi-stage sampling. According to Statistical Center of Iran data, Shiraz City is divided into 9 regions including 150 districts (hozeh). Each district has some blocks and each block consist of some households. Through simple random multi-stage sampling, we will choose sample regions, hozeh, blocks, households, and individuals randomly. The sample size of this study will be drawn from Cochran formula. The sample size is 384 persons in the age group of 15 to 29 years old.

**Data Collection Method** The technique used for gathering data and information in this study is a self-administrated questionnaire. Considering the sensitive nature of the study, participants will be assured that all data and responses will remain confidential and anonymous. Questionnaires were distributed among the sample elements and time was given to complete and return the questionnaire.

**Questionnaire Design** The used questionnaire is a structured questionnaire with tow kinds of questions: multiple choice and numeric open-end. The designed 95-item questionnaire consists of two main parts, one part deals with the dependent variables and the other one with the independent variables.

The 39 statements investigate the respondents' attitudes towards safe sex and reproductive health issues using a 5-point Likert scale ranging from strongly agree to strongly disagree ( $\alpha = 0.76$ ).

The rest 56 statements and questions are trying to find out the factors which affect the mentioned attitudes including demographic variables (age, sex, and marital status), socio-economic status variables (parents' education, person's education, and family income, access to modern goods and facilities, social class), cultural variables (awareness, religiosity, interpersonal communications, and mass media habits).

**Validity and Reliability** The face-validity was done to test the validity of the questionnaire. Several drafts of the questionnaire were developed and reviewed by experts in demography, social science, psychology, and health science to establish the validation. The agreement of the judges and the thoroughness and comprehensiveness of the item analysis approved internal consistency of the scale.

The reliability of questionnaire was tested by Cronach alpha coefficient. It was 0.76 for attitude, 0.90 for religiosity, 0.81 for interpersonal communications, and 0.68 for mass media habits.

**Pre-Testing the Questionnaire** The questionnaire was tested on a small sample of target population (58 youth, chosen randomly). Then the collected data was analyzed with the planned statistical methods before the survey was conducted on a large scale. The rationale behind this was to identify the problems as early as possible to prevent from wasting time and money. This kind of test run can reveal unanticipated problems with question wording, instructions to skip questions, etc. It can help see if the respondents understand your questions and giving useful answers. The pretests also aimed at determining whether the questions on safe sex and reproductive health were

acceptable to the youths. Then the necessary changes were incorporated in the final questionnaire. After revision, they were printed for data collection. The completed questionnaires were coded in preparation for data entry. Coding and analysis were carried out using the SPSS (version 11.5) computer software.

## **RESULTS**

### **Descriptive Statistics**

We had 384 respondents which 45.6% of them were male and 54.5% of them were female. Mean age of this sample is 21.7 years old. 80% of them were single and 20% were married. One of them did not state his/her marital status and none of them were divorced or widow/er.

The lowest level of education of respondents was Guidance school. The majority of them (35.6%) had high school diploma. After that we had B.A. /B.Sc., post diploma, high school, M.A. /M.Sc., Guidance, and Ph.D. respondents, respectively. 83.9% of fathers and 93.7% of mothers had high school diploma or less education. The rest of both groups had post diploma or more. Totally level of mothers' education was less than fathers' education.

81.7% of the respondents stated that they belong to good social class or low and 18.2 percent of them thought that they were in very good or excellent class. The majority (49.5%) thought that they were in the middle, good class.

### **Bivariate Analysis**

The bivariate results show that youth attitude toward safe sex and reproductive health is mainly influenced by sex, person's education, father's education, access to modern applicants and facilities, awareness about safe sex and reproductive health, religiosity, interpersonal communications, and non-printed mass media habits. Results of statistical tests are shown in table 1.

Females have a higher attitude score than males. Those who are more educated have more positive attitude toward safe sex and reproductive health. Father's education has an effect on youth attitude. But their mothers' does not have. Correlation analysis shows that there is a positive relationship between access to modern home applicants and facilities and youth attitude. Youth who have more sexual knowledge and information have more positive attitude toward safe sex and reproductive health. Youth who have more strong religion believes have more

positive attitude toward safe sex and reproductive health. Youth who have more strong communications, have more positive attitude toward safe sex and reproductive health. Pearson's correlation analysis shows that there is a negative relationship between attitude and non-printed mass media habits, but there is not any relationship between youth attitude and their printed mass media habits.

**Table1- Biivariate Analysis (Relationships between Independent Variables and Dependent Variable)**

Independent Variable	Relationship with Dependent Variable	Results of Statistical Test
Sex	*	t = 2.507 P= 0.011
Age	-	r = 0.065 P = 0.261
Marital Status	-	F = 0.079 P = 0.779
Person's Education	*	F = 3.680 P = 0.002
Father's Education	*	F = 3.355 P = 0.001
Mother's Education	-	F = 1.501 P = 0.166
Family Income	-	F = 2.122 P = 0.078
Social Class	-	F = 0.571 P = 0.684
Access to Modern applicants & Facilities	*	r = 0.114 P = 0.049
Awareness about Safe Sex & Reproductive Health	*	r = 0.111 P = 0.050
Religiosity	*	r = 0.170 P = 0.002
Interpersonal Communications	*	r = 0.272 P = 0.000
Non-printed Mass Media Habits	*	r = -0.104 P = 0.045
Printed Mass Media Habits	-	r = 0.099 P = 0.086

\*: there is a relationship between this variable and dependent variable.

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### **Multivariate analysis**

Multiple regressions analysis was used to predict the impact of independent variables on dependent ones in this study. In order to force ordinal variables into the regression equation, we had made dummy variables from our ordinal variables; sex, marital status, and education.

Out of independent variables which were forced into the regression equation, 6 variables (Interpersonal communications, Father education, Access to modern applicants and facilities, Awareness about safe sex and reproductive health, Non-printed mass media habits, and printed mass media habits) were included in the equation based on the magnitude of beta weight and the level of significance ( $P < 0.05$ ). Results are shown in table 2.

The beta column states that 30 percent of changes in attitude are explained by interpersonal communications. Those who have better communication with their parents and friends, have more positive attitude toward safe sex and reproductive health. The second variable is father's education. 26 percent of changes in attitude are explained by father's education. Those who have better communication with their parents and friends, have more positive attitude toward safe sex and reproductive health. In other words, the more educated the father is, the more positive attitude toward safe sex and reproductive health the respondent has. The third variable is access to modern applicants and facilities. 20 percent of one unit variation in dependent variable is explained by this variable. Those who have more access to modern applicants and facilities have more positive attitude toward safe sex and reproductive health. The fourth variable is non-printed mass media habits. 18 percent of changes in attitude are explained by respondents' non-printed mass media habits. The negative sign next to the coefficient shows that there is a negative relationship between non-printed mass media habits and attitude toward safe sex and reproductive health. Those who use more non-printed media have more negative attitude toward safe sex and reproductive health. The fifth variable is awareness about safe sex and reproductive health. 16 percent of changes in attitude are explained by respondents' awareness. Those who have more knowledge about sex and reproductive health have more positive attitude toward it. The sixth variable is printed media habits. 12 percent of changes in attitude are explained by one's printed media habits. Those who are more educated, have more positive attitude toward safe sex and reproductive health.

The calculation of F ratio is useful as a test of statistical significance for the equation as a whole. The value of F ( $F = 11.55$ ) and the significance level ( $P = 0.000$ ) for the computed equation reveals that there is a significant relationship between the youth attitude and the remaining independent variable in the regression equation.

**Table 2- Multiple Regressions for Predicting the Impact of Independent Variables on Dependent Variable**

Independent Variable	Unstandardized Coefficients Standardized		Standardized Coefficients	t	Level of Sig.
	B	Std. Error	Beta		
Constant	123.69	7.49	-	19.52	0.000
Interpersonal Communication	0.70	0.15	0.30	4.82	0.000
Father's Education	6.51	1.58	0.26	4.11	0.000
Access to Modern Applicants and Facilities	0.20	0.07	0.20	2.89	0.004
Non-printed Mass Media Habits	-0.61	0.22	-0.18	-2.83	0.005
Awareness about S.S. & R.H.	1.10	0.42	0.16	2.67	0.008
Printed Media Habits	0.62	0.31	0.12	2.00	0.047
F = 11.55                      sig. = 0.000                      R= 0.46                      R <sup>2</sup> = 0.21					

## Conclusion

Non-printed mass media habits have an indirect relation with youth attitude. Those who are at greater exposure to these media have more negative attitude toward safe sex and reproductive health. Media are an important part of modern society and our lives. Youth are at exposure of full range of western type media. Unfortunately, these media implicitly or explicitly encourage sexual freedom without putting much weight on responsibility for sexual behaviour.

Youth receive few, if any, positive models for healthy sexual behaviour. Modelling positive and healthy sexuality-related behaviour to youth is extremely important. Because sexual behaviours often happen in private settings, much of what youth observe modelled about sex takes place on TV and in movies, and popular music. The majority of this modelled behaviour - early sexual activity, violence combined with sex, no mention of protection, no discussions about risks - is counter to what family life educators are trying to teach youth. Mass Media should be encouraged to disseminate information regarding reproductive health and safe sex issue.

Looking back to theories we see that social learning theory (SLT) is a particularly good fit for reproductive health and safe sex programs because sexual behaviour is



influenced by personal knowledge (awareness about safe sex and reproductive health), skills, attitudes, interpersonal relationships, and environmental influences (non-printed mass media habits). All of these factors are addressed in SLT.

The theory of reasoned action asserts that beliefs about the consequences of sexual and reproductive health behaviours and perceptions of social support for performing such behaviours are fundamental psychological underpinnings of attitudes and social norms regarding performance of these actions. Systematic identification of modal beliefs about the consequences of sexual and reproductive health behaviours and modal referents that support or oppose sexual and reproductive health behaviours can be accomplished in the context of elicitation research within a population of interest. Based upon this information, empirically targeted interventions can be crafted to change attitudes and social norms by strengthening favourable beliefs and perceptions of referent support and weakening or offsetting unfavourable beliefs and perceptions of referent support concerning the performance of specific sexual and reproductive health behaviours.

It is concluded that further research into the community's attitude, knowledge and motivation regarding sexuality and AIDS is crucial for optimizing the effectiveness of community-based intervention strategies for young people. Since the non- printed mass media habits had an indirect effect on youth's attitude toward safe sex and reproductive health; it seems that this should be studied more specifically in future. And also is an alert for policy makers to use these media in their proper way and for the health of the society not in the opposite side.

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