THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

Knowledge on HIV/AIDS and Perception of Sexual Behavior among Return and Non Return Migrant Youths in Selected Rural Areas of Ethiopia

Dr. Sellakumar G. K.
Assistant Professor, Department of Psychology,
Faculty of Social Sciences and Humanities, University of Gondar, Gondar, Ethiopia
Samuel Menelik
Post Graduate Student, Department of Psychology,
Faculty of Social Sciences and Humanities, University of Gondar, Gondar, Ethiopia

Abstract:
The prevalence of HIV/AIDS is most common among the migrants population. Ethiopia is one of the worst-affected countries in Sub Sahara having the third largest HIV-positive population in the world. Specifically, rural migrant workers are prone to get infected by HIV/AIDS. The study tends to yield the knowledge and perception of risk sexual behavior among migrant and return migrant youth community. Cross-sectional comparative research design was employed and 265 return migrant and 498 non migrant youth were selected by employing multi stage sampling technique. A questionnaire was adopted from behavioural studies on HIV/AIDS was administered to assess the knowledge, perception and sexual behavior of the participants. The result shows that sociodemographic characteristics of return migrants in rural areas had higher levels of sexual risk than non-migrants, including unprotected sex. Among return migrants, sexual risk behaviors were associated with age, gender, marital status, and number of sexual partners. The finding reveals that there is a chance of high risk for HIV infection among both migrants and return migrants. Hence, HIV/AIDS education and prevention efforts should be targeted towards these populations, both in urban and rural areas will facilitate in alleviating the risky sexual behavior among migrant workers.

Keywords: *HIV/AIDS prevention, return migrant, Non- migrants, Sexual risk behavior*

1. Introduction

On its third decade of the epidemics, HIV/AIDS is still imposing an irrefutable threat to the contemporary world. The fast spread of the disease makes its impact much more pronounced. According to the UNAIDS estimate, 34 million people were living with HIV/AIDS. In 2011 there were 2.5 million new infections and 1.7 million deaths globally in the same year. More than half of those newly infected cases are between 15 to 24 years old (UNAIDS, 2012). Since the beginning of HIV in the early 80s, Sub-Saharan Africa remains the hardest hit region; currently shelter 23.5 million people, nearly 69% of the world's population living with the virus. Ten million of these are young people between the ages of 15 to 24. Young girls aged 15 to 24 are especially vulnerable to HIV infection. In 2011, an estimated 3.1% of young women aged 15–24 were living with HIV/AIDS in sub Saharan Africa, compared to 1.3% of young men in the same age group. This makes young people an essential focus group of any HIV prevention endeavor (UNAIDS, 2012).

Ethiopia is one of the worst- affected countries in Sub Sahara having the third largest HIV-positive population in the world (UNAIDS, 2012) and 90% of the AIDS cases are due to heterosexual transmission (Eshete & Sehlu,1996).

The present study was conducted in a rural area which is surrounded by small towns and the people from the study area have frequent contact with the town for temporary jobs (Berhane et al. 2008). This type of migration is denoted as seasonal migration and these migrants are called as "bridge population" who contribute for the HIV epidemic in these rural areas (Coast, 2005). These seasonal migrants are mostly farmers who return home during agricultural activities and slack seasons. This seasonal migration is considered of the factors causing HIV epidemic (Decosas, 1997; Mabey and Mayaud, 1997; Sambrook, 2008). The majority of this group is from rural areas visit their residence at different occasions and stay for a short duration with their family and return to their respective work place. These groups share a higher risk of HIV infection that differs from the general population and categorized as mobile populations, others fall into economically poor groups who are likely to engage in high risk of unprotected sexual practices. There is a correlation exists between migration experience and increased sexual risk behaviors (Brocherhoff & Biddlecom, 2008) and also this sexual risk behavior is potentially contributed by a number of social and cultural activities. Even now the spreading of STIs and HIV infections due to sociocultural factors is complex and not well understood.

Mekonnen (2009) pointed out the risk populations of HIV, including migrants in hot spot areas in the region ranges from 11.6% to 37%, which is five –fold higher than the national urban adult population 7.7%. The high prevalence is attributed to sexual partner change, multiple sexual partnership, high exposure to STIs, and low and inconsistent condom use (FHPCO, 2010).

2. Migration and HIV/AIDS

People who are migrating from one place to another, usually for employment and reside there for short or long duration within the nation or across the nation are referred as migrants. Migration is one of the major hidden social factors that cause HIV infection. Since migrants stay away from their place of origin, less contact and separation from their regular sexual partner or spouse is one of the major factors pave way to having extramarital sex, approaching commercial sex workers, multiple sexual partners eventually causes HIV transmission (Wilson, 1972; Nyanzi et al., 2004). Hunt (1989) argues that migrants are all over the world are highly vulnerable and at higher risk of acquiring HIV. This vulnerability among the migrants is not the direct result of their mobility whereas the high risk of HIV infection is caused due to the circumstances and events related to the mobility process they encounter. UNAIDS (2008) reported that migration alone is not the only risk factor for HIV/AIDS rather situation and behviours of migrants increases the risk and vulnerability.

Despite, other reasons also causes this behavior. Migrants from rural to urban areas and vice-versa are often called as "bridging populations" who are caused to transmit HIV between these two areas (Morris, 1997; Nyanzi, Nyanzia & Kalina, 2003), and these communities are mentioned as disease carriers (Castle, 2004; Ososanya & Briger, 1994).

Compared to stable residents, people frequently and recently changed their residence and mobile populations tend to be at higher risk for HIV and other sexually transmitted infections (STIs) (Arnafi, 1993; Prson, et. al. 2007; Pison et al., 1993; Brockerhoff and Biddlecom, 1999; Lurie et al., 2003; Nyanzi et al., 2004; Mbizvo et al 1996; Brewer et al 1998; Nunn et al 1995). A widespread of sexual networking in Ghana caused due to migration, many migrants have regular sexual partners, but there was a decline in recent periods due to AIDS campaign and substantial number of encounters with casual partners. Furthermore, the risk of HIV infection is increased with international migrants (Anarfi, 1993).

There was a rise identified in the amount of HIV infected individuals in rural areas due to return migrants who lived and worked previously away from their place of origin (Topouzis & du Guerney, 1999). Another factor noted by Nishigaya (2002) was poor socio-economic status of rural-urban migrants might also lead to direct involvement in high risk sexual behaviour. Similarly, California AIDS data indicate that from the year 1995 to 2000, the percentage of Mexican or Mexican American resident was increased from 36.5% to 47.7% (Solorio, Currier, and Cunningham, 2004). IOM (2005) reported that there are reciprocal connection between population mobility and HIV infection.

There is an intimate relationship between mobility and vulnerability among rural Mozambique and Switzerland migrants. And also there is a close relationship between the causes and consequences of vulnerability of migrants and their partners (Crush, Raimundo, Simelane, Cau and Dorey, 2010).

A survey in India reported that more HIV-positive men were identified as migrants than HIV-negative populations, significantly more HIV-positive than HIV-negative women had migrant husbands, higher proportion of migrant than non-migrant men reported having ever had extramarital sex or having had extramarital sex in the past 12 months and considerable proportion of women also engaged in extramarital sex. Moreover, condom use during the last extramarital sex act was also low among both men and women in these areas (NACO, 2011).

Another survey conducted by International Organization of Migration (2011) reported that female migrant workers in Bangladesh were forced to engage in prostitution and they are extremely vulnerable to abusive practices such as trafficking, sexual violence, exploitation either by the employer or by the mediators engage in migration process.

Kimuna & Djamba (2012) identified migrants are significantly more likely to exhibit fear of HIV infection than non-migrants. The perception of risky sexual behavior is significantly correlated with non-use of condoms for migrants than for non-migrants. Migrants who perceive themselves as being at risk of HIV infection are less likely to use a condom at their last non-marital sexual encounter. Also, migration is significantly correlated with multiple sexual partners.

These studies indicate that the risk of engaging in risky sexual activities increases even for married persons when they are away from their spouses. Hence, the present study was conducted to investigate the other underlying factors and its association in relation to risky sexual behaviour among rural return migrants and non migrant youths in the selected study area.

3. Method

3.1. Research Design

Cross-sectional comparative research design was followed to describe and compare sexual behavior among return- migrants and non migrants.

3.2. Data Source

3.2.1. Location and the Study Area

The study was carried out in misha wordas (Village) rural kebele (sub district) which is found in SNNP region at Hadiya zone. The rationale to choose this area for study was familiarity with the study site and convenience of the researcher. Moreover, the residents from this study site migrate for job nearby towns where hydroelectric power projects are functioning.

3.2.2. Population

The populations of this study were both return migrants and non-migrants who live in misha woreda (Village) in 23 kebele (sub-district). According to 2007 national census 151,000 people are live in the woreda, among them 68,800 are male and 83,000 are female. From the total population 47% are youth (Age 15 to 24).

3.2.3. Sampling

Multi-stage sampling technique was used. From all the 23 sub-districts (Kebeles), 9 were selected by random sampling technique. Individual Kebele households were selected using a systematic sampling technique and the numbers of households sampled from the selected Kebeles were determined using proportionate-to-population size. One individual aged 15-24 years in the selected household was further selected and interviewed. For households with more than one individual aged 15-24 years in one household, only one person was selected using lottery method. When the selected House Hold (HH) was closed during data collection, but it is known that there are persons aged 15-24 years the interviewers revisited the HH three times at different time intervals and when interviewers failed to get that HH, the household was excluded from the survey. When the person in the specified age group from the selected household was not available during the data collection the next nearest household (HH) was included in the survey.

The sample size was calculated based on the following assumption:-

Prevalence of non migrants who feel that they are not at risk, having reported unprotected sex (P1=86%). Since there is no study on risk perception of return migrant a difference of 10% was considered between the two groups (P2=96%)

Level of confidence =95% (α=.05)

Power=80%

Return migrants to non migrant allocation ratio = 1:2

15% non response rate

Design effects =2 (since the sampling procedure involves more than one stage)

With the above assumption, the sample size was calculated using the STATISTICAL program of EPI6 Computer software statistical package and the overall sample size was found to be 801 (n1=267; and n2=534)

3.2.4. Measures

A questioner was adopted from behavioral studies on HIV/STIs was used to assess the knowledge, perception, and sexual behavior of return migrants and non migrants towards HIV practice of AIDS. The questionnaire was initially prepared in English and it was translated to Amharic (National Language of Ethiopia) and it was also translated back from Amharic to English.

3.2.5. Experience of Rural-to-Urban Migrant

Participants were asked whether they have ever migrated to cities for temporary jobs in the past. Based on their responses to this question, participants were considered as either a return migrant (i.e. those who had previously migrated to a city for employment), or non-migrants (i.e. those who had never migrated to a city).

3.2.6. Demographic Characteristics

All participants were instructed to mention their age, level of formal schooling, and marital status. The response to the schooling question was grouped into three categories: no more than primary school or below (i.e., less than or equal 6 years of formal education); middle school (7–9 years of schooling); or at least high school (at least 10 years of formal schooling). Marital status was grouped into never married or ever married, divorced and widowed

3.2.7. Family Socioeconomic Status (SES)

To obtain a comprehensive measure of the overall family SES, an index score was constructed based on three questions: (1) self perception of relative standing of family economic condition in comparison with neighbors in the village (top half or bottom half); (2) participants' average monthly income (in Ethiopia currency birr; Approximate 18.00 birr= US $1.00 during the time of this study); (3) type of dwelling. The respondents were instructed to divide their total estimate annual income by 12 as an estimate of their approximate monthly income. The responses to each of the three variables was dichotomized as to whether their family economic condition is in the top half in the village (yes=1, no=0), whether the participants' monthly income is more than the 50^{th} percentile among the sample (yes=1, no=0), whether they have their own house (yes=1, no=0), A composite index, ranging from 0 to 3, was derived by summing the dichotomous responses to the three items, with a higher score indicating a higher family socioeconomic status

3.2.8. Sexual Risk Behaviors

At last section, sexual risk behaviors was measured using five items, it included number of sexual partners in their sex life, number of sexual partners in the previous month, commercial sex (selling or buying sex), overall frequency of condom use, and the number of times using a condom during the three most recent sexual intercourses. The responses to each of the five items are dichotomized as to whether the participants have lifetime multiple sexual partners (yes=1, no=0), whether they have multiple sexual partners in the previous month (yes=1, no=0), whether they have engage in commercial sex in the previous 12 months (yes=1, no=0), whether they have unprotected sex (e.g., do not always use a condom) in the past (yes=1, no=0), or whether they have unprotected sex during the previous three episodes of sexual intercourse (yes=1, no=0).

3.2.9. Data Collection Procedures

Data was collected using a structured questionnaire for the quantitative method. Ten data collectors, who completed grade 12 and can speak Amarice & Hdiyessa Language and are familiar with local customs were recruited. Two supervisors were selected who were qualified diploma in nursing. The enumerators and the supervisors were trained for three days about the procedures and techniques of data collection. The questionnaires were initially prepared in English and then translated into Amharic. The Amharic version was again translated back to English to check for any inconsistencies or distortions in the meaning of words and concepts.

The questionnaires were pre tested prior to the actual data collection in kebele three of the Shashego woreda district among 20 respondents who were excluded from the main study. The result of the pre test was discussed, and necessary corrections and changes were made on the questionnaires. Due care was taken during the data collection to obtain accurate information regarding demographic characteristics, sexual behavior, STI and condom use.

3.3. Data Analysis

Data was analyzed using SPSS version 20 for descriptive and inferential analyses. Statistics is presented in percentages and Chi-square test was performed on some selected variables. Odds ratios were calculated to determine the strength of association of selected variables. Logistic regression analyses were done to control the effect of each explanatory variable on the outcome variables.

4. Results

Variables	Non migrant (N=498)		Return migrant (N=265)		Total (N=763)	
	N	%	N	%	N	%
Gender						
Male	209	42.0	155	8.5	364	47.70
Female	289	58.0	110	41.5	399	52.29
1Age						
10-14	165	33.1	32	12.1	197	25.81
15-19	333	66.9	233	87.9	566	74.18
Religion						
Protestants	497	99.8	254	92.5	751	98.42
Other	01	0.2	20	07.5	21	02.8
Ethnic Group						
Hadiya	498	100.0	265	99. 2	763	100.0
Marital Status						
Never Married	303	60.8	35	13.2	520	68.2
Recently Married	180	36.1	17	13.2	215	28.2
Divorced / Separated	15	03.1	13	04.9	28	03.7
Educational Status						
Illiterate	275	55.2	39	14.1	314	41.2
Read & Write	59	11.8	33	12.5	92	12.1
Primary	122	4.5	40	15.1	162	21.2
Secondary	42	8.4	153	57.7	195	25.6
Occupation						
Daily laborer	22	4.4	20	07.5	42	5.5
Private employee	15	03.0	46	17.4	61	08.0
Other	88	17.7	52	19.6	140	18.3
Nothing	373	74.9	147	55.5	520	68.2
Monthly income						
≤ 15	34	30.9	17	15.6	51	23.3
16-29	23	20.9	28	25.7	51	23.3
30-69	27	24.5	34	31.2	61	27.9
≥70	26	23.6	30	27.5	56	25.6
Perceived family economic status (N=384)						
Poor	193	55	54	40.9	193	50.3
Medium	99	39.3	76	55.3	172	44.8
High	14	5.6	32	24.3	19	04.9

Table 1: Socio Demographic Characteristics of Return Migrants & Non Migrants

Totally, 801 sample respondents interviewed, but only 763 provided valid responses to the question of migration experience. Among them 498 (65.3%) identified as migrated at least for temporary period and 265 (34.7%) were never migrated. The age of return migrants (M = 21.3) years and non migrants (M=19.3) years. More males reported a history of rural-to-urban migration than females (58% Vs 42%) compared with non-migrants, fewer; return migrants, had completed high school or more education (57.7% Vs 89%); non –migrants had a higher family socio economic status than return migrants.

More non migrants were married than return – migrants (81.7% Vs 36.1 %) the main reasons cited for returning home from city were, bad personal experience in cities (26%); difficulty in finding a jobs or earn money in cities (29.1%); family needs for labor at home (27.5%): or coming home to get married (11.1%).

Variables	Non Migrant		Migrant		χ^2
	N	%	N	%	
Ever had sexual intercourse (n=763)	209	42.0	116	43.8	
Yes	289	58.0	149	56.2	0.16
No	209	42	65		
Life time number of sexual partner					
One	171	81.8	76	67.3	7.91 *
>two	38	18.2	37	32.7	
Ever used modern contraceptives (n=250)					
Yes	54	32.7	55	64.7	22.05*
No	111	67.3	30	35.3	
Had ever been pregnant (n=250)					
Yes	114	69.1	35	41.2	17.01*
No	51	30.9	50	58.8	
Risk perception to contract HIV/AIDS (n=325)					
Yes	11	5.3	13	11.2	3.03
No	51	30.9	103	88.	
Sex with female commercial sex workers (n=77)					
Yes	8	18.6	11	32.	1.26
No	35	81.4	23	67.	
Condom use during last sexual Intercourse with FCSW (n=31)					
Yes	7	70.0	12	57.1	0.09
No	35	30.0	9	42.9	
Ever had STIs (n=325)					
Yes	7	3.3	9	7.8	2.22
No	202	96.2	107	92.2	
Ever abort (149)					
Yes	2	1.8	6	17.1	9.64*
No	112	96.7	29	82.9	

Table 2: Comparison of Sexual and Reproductive Health Behaviors and Practices of Youth by Their Experience of Residence
**Significant At 0.05 Level*

4.1. Sexual History of Survey Respondents

Out of all respondents 325 (42.6%) were sexually active. Almost one – third of the sexually active respondents (104) were never married. Among return migrants 116 (43.8%) had experienced sexual intercourse while 209 (42.0%) of non migrants reported to be sexually active. Over all, the proportion of sexually active is female youth than of males 74 (23.2%). For return migrants males, the median age at first sexual intercourse was 16.00 (mean=16 1$\pm$ 1.583) and female was 15.00 (mean = 14.987 $\pm$ 1.916), on the other hand, the median age at first sexual intercourse for non migrant male and female youth was 17.00 (mean 16.1$\pm$ 36.6) and 14.00 (mean =13.721$\pm$ 1.734) respectively. Of those sexually active, 169 (80.9%), non migrants and 41 (35.3%) return migrants had their first sexual experience only after marriage.

According to return migrants the main reason for first sexual encounter including sexual desire 12 (10.5%), to obtain gifts 8 (69%) and romantic love 42 (36.2%) for non-migrant the main reasons given for first sexual encounter included sexual desire 17 (8.9%), rape 12 (5.7%) and romantic love 50 (15.4%). Alcohol was cited as a predominant driving force by 7% of male respondents of those who are sexually active 37 (32.7%) non-migrant. And 38 (18.2%) return migrant reported that they had sexual intercourse with two or more partners. The mean number of sexual partners for return migrant is 1.629$\pm$ 1.1 3850 (median 1.00) and that of non –migrant is 1.292 $\pm$ 0.704 (median= 1.00) out of those sexually active respondents.

A total of 19 (25.7%) male youth reported experiencing commercial sex in the past 12 months; the proportion was higher (33.3%) for return migrant than (18.6%) non migrant. Although 36% of them reported occasional condom used none of the 19 youth reported

consistent condom use during commercial sex. About 7.8% of the sexually active return migrants and 3.35% of the sexually active non migrants reported history of signs of STIs.

The proportion of reported STIs was higher in males (9.5%) than females (3.0) of those sexual active females, 69.1% of non migrant and 41.2% of return migrant have got pregnant at least once prior to this study, out of which 1.8% of non-migrant and 17.1% of return migrant reported history of including abortion at least once.

Generally, history of ever sex, sex with female commercial sex worker, proportion of STIs, risk perception to contract HIV, and condom use during last inter course did not show statistically significant difference ($p>0.05$) between return migrant and non migrant whereas, ever use of modern contraceptives, and rate of abortion were significantly higher ($P<0.05$) in return migrant than non migrant and history of ever pregnancy was significantly higher in rural resident than return migrant.

Variables	**Experience of Residence**				
	Non Migrant (N=498)		**Migrant (N=265)**		**χ^2**
Ever had sexual intercourse (n=763)	**N**	**%**	**N**	**%**	
Correct	41	8.2	65	24.5	37.4*
Incorrect	457	91.8	200	**75.**5	
Know means of avoiding pregnancy					
Yes	280	56.2	211	79.6	40.26*
No	218	43.8	54	20.4	
Know diseases that can be transmitted through sexual intercourse knowledgeable					
Knowledgeable	159	31.9	184	69.4	96.82*
Not Knowledgeable	339	68.1	81	30.6	
Know means of STD and HIV/ AIDS Prevention					
Yes	33	6.6	75	28.3	65.1*
No	465	93.4	190	71.7	
Have heard about HIV/AIDS					
Yes	457	91.8	261	98.5	12.9*
No	41	8.2	4	1.5	
Using condom is a sign of not trusting your partner					
Disagree	141	28.3	108	40.8	11.62*
Agree/ Not sure	116	23.3	55	20.8	
A boy should have sex before he gets married					
Disagree	382	76.7	210	79.2	0.503
Agree/ Not sure	116	23.3	55	20.8	
Discussing condom or contraceptive with young people promotes promiscuity					
Disagree	204	68.5	188	70.9	61.03*
Agree/ Not sure	294	31.5	77	29.1	
Believe that they have done something that put at risk of getting AIDS					
Yes	12	2.4	16	6.0	5.45*
No	486	97.6	249	94.0	

Table 3: Reproductive Health Knowledge and Attitude of Non Migrant & Return Migrant

Out of all study subjects only 41(8.0%) non migrant and 65 (24.5%) return migrant responded that a woman is most likely to become pregnant halfway between two periods. Over all more, return migrants (79.6%) appear to know at least one modern contraceptive than non-migrants (56.2%). Oral contraceptive pills were the most frequently cited contraception known by 189 (71.3%) of return migrants and 254 (51.0%) non migrants. One hundred fifty six (58.9%) and 109 (41.1%) of return migrants mentioned injectables and condom

as second and third familiar methods, respectively. On the other hand, only (7.4%) and 15 (3.0%) of non migrants mentioned condom and injectables as second and third familiar method, respectively.

The majority (94.1%) of the study populations were aware of HIV/AIDS. The proportion of knowledge on HIV is higher in non migrants 41 (9.1%) than return migrants 4 (1.5%). However, only 343 (45.0%) respondents recognized diseases other than HIV/ AIDS that can be transmitted through sexual intercourse among them 184 (69.4%) were return migrants and 159 (31.9%) were non migrants. Among respondents who know disease that can be transmitted through sexual intercourse other than AIDS, 316 (92.1%). 311 (90.7%). 115 (33.5%) and 92 (26.9%) mentioned gonorrhea, syphilis, lymphogranulom, venerum, and chancroid, respectively, moreover, only 33 (8.3%) of non migrants and 75 (28.3%) of return migrants mentioned all the three possible methods of HIV-STIs prevention (abstinence, be faithful to one sexual partner, and condom use). Out of 645 participants who mentioned at least one means of preventing STDs and AIDS, 517 (67.8%), mentioned abstaining. 305 (40.1%) remaining faithful to sex partner, 234 (30.7%) using condom, and 89 (11.7) avoiding sex with female commercial sex workers (FCSW). Only 46% of the participants agreed that a girl could get pregnant first time she had sex. Slightly more than half (53%) of them mentioned that a healthy looking person could have HIV.

Generally, there was statistically difference ($P<0.05$) between the return migrant and non migrant groups in terms of their Knowledge about basic human reproduction and HIV/STIs, their attitude towards condom use, and their self-risk perception of acquiring HIV.

As far as the source of information concerned, Radio (44.4%), family members/parents (44.7%) newsletters/ pamphlets (19.1%) peers (18.9%), heath workers (16.8%) and religious leaders (14.0%) were mentioned as common sources of information about HIV/AIDS. Surprisingly, only 33.4% of youth reported that they had source of information about sexual and development changes during adolescence.

Variable	Yes	No	Crude Odd Ratio	Adjusted Odd Ratio (95% CI)
Experience of residence				
Migrant	28 (24.1)	88 (75.9)	5.22 (2.43,11.76)	1.112(0.375, 3.302)
Non - Migrant	12 (5.7)	197 94.3)	1.00	
Sex				
Female	23(9.20	228(90.8)	0.34 (16,0.76)	0.635(0.255,1581)
Male	17(23.0)	57(77.0)	1.00	1.00
Age				
10-17	11(11.00)	89.00	0.84(0.36,1.82	0.966 (0.347,2.692)
18-19	29(12.9)	196(87.1)	1.00	1.00
Marital status				
Currently married	5(26.7)	189(97.4)	0.07(0.02, 0.20)	0.184 (0.059, 0.573)*
Currently not married	35(26.7)	96(73.3)	1.00	1.00
Number of sexual partners				
One	12(4.9)	235(95.1)	0.10(0.04, 0.22)	0.112(0.044, 0.289)*
≥ Two	26(44.0)	49(56.0)	1.00	
Educational level				
Illiterate	6(4.6)	125(95.4)	0.11(0.04, 0.29)	0.350(0.093, 1.333)
Primary	5(5.1)	94(94.9)	0.12(0.04, 0.34)	0.108(0.026, 0.447)*
Secondary	29(30.5)	66(69.5)	1.00	1.00
Risk Perception				
Yes	9(37.5)	15(42.5)	5.23(1.84, 13.93)	1.365 (0.405, 4.597)
No	31(10.3)	270(89.7)	1.00	1.00
Knowledge of HIV Prevention				
Knowledgeable	17(34.0)	33(66.0)	5.64(2.53, 12.29)	2.268(0.865, 964)
Not Knowledgeable	23(8.4)	252(91.6)	1.00	1.00
Alcohol				
Yes	30(11.4)	233(88.6)	0.67(0.30,1.64)	0.531(0.194,1.459)
No	10(16.1)	52(83.9)	1.00	1.00

Table 4: Condom Use by the Migrants and Return Migrants

The reported figures are adjusted odds ratios (AOR), with their confidence intervals (CI) given in parentheses at different probability levels (P). Only 12.3% of the sexually active youth reported ever condom use was associated with marital status, educational status and number of sexual partners. Those who were currently married use condom less frequently than those who were not [AOR=0.184 (0.59. 0.73), those with primary education [AOR= 0.108(0.026, 0.447] and those who reported a single sexual partner [AOR=0.112 (0.044, 0.285] also use condom less frequently than those who had secondary education and those who had two or more sex partners respectively.

Variables	Yes	No	Crude Odd Ratio	Adjusted Odd Ratio (95% CI)
Experience of residence				
Return Migrant	16(6.0)	249(6.0)	2.60(.13, 6.12)	3.577(1.028, 12.449)*
Non – Migrant	12(2.4)	486(97.6)	1.00	1.00
Sex				
Female	13(2.9)	431(97.1)	1.00	1.00
Male	15(4.7)	304(95.3)	1.64(0.71,3.79)	1.635(0.587,4.559)
Age				
10-17	7(1.6)	426(98.4)	1.00	1.00
18-19	21(6.4)	309(95.6)	4.14(1.66,11.64)	1.110 (0.340,3.626)
Marital status				
Currently married	4(1.9)	211(98.1)	1.00	1.00
Currently not married	24(4.4)	524(95.6)	2.24.(0.28, 9.69)	5.071(1.307,19.677) *
Number of sexual partners				
One	8(3.2)	239(95.7)	1.00	1.00
≥ Two	16(21.3)	59(78.7)	8.10(3.07, 22.27)	0.678 (0.102, 4.523)
Educational level				
Illiterate	3(1.0)	311(99.0)	1.00	1.00
Primary	3(1.2)	251(98.8)	1.24(0.16, 9.33)	0.678 (0.102, 4.523)
Secondary	22(11.9)	173(88.1)	13.86(3.86, 9.45)	9.721(1.903, 45.176)*
Agree to VCT				
Yes	16(4.3)	360(95.7)	1.39(061, 3.26	1.424 (0.475, 4.226)
No	12(2.9)	375(96.9)	1.00	1.00
Knowledge of HIV Prevention				
Knowledgeable	9(8.3)	99(91.7)	3.04(41.18, 7.28)	1.240 (0.475, 4.226)
Not Knowledgeable	19(2.9)	636(97.1)	1.00	1.00
Alcohol				
Yes	22(4.3)	493(95.7)	1.80(0.70, 5.94)	1.296 (0.390, 4.3080)
No	6(2.4)	242(97.6	1.00	1.00

Table 5: Comparison of Selected Socio Demographic and Sexual Behavior of Non Migrant & Return Migrant's Risk Perception

Participant's attitude towards perceiving themselves as susceptible to HIV infection was stated and the result indicated that only 12 (2.4%) of non migrant and 16 (6.0%) of migrant were about of being engaged in high-risk, 64% reported no condom use, 25% reported multi sexual partner, and no condom use with female commercial sex works. The most frequently (52%) cited reason, by those who did not perceive themselves at risk, was that they did not have any sexual contact followed by faithful to one sex partner (25.5%) and other factors that includes, experience of residence, marital status, educational status and numbers of sexual partners have shown significant association with self risk perception.

Variable	Yes	No	Crude Odd Ratio	Adjusted Odd Ratio (95% CI)
Experience of residence				
Return Migrant	182(68.7)	83(31.3)	3.44(2.48, 4.78)	1.735(0.908, 3.3118)
Non – Migrant	194(39.0)	304(61.0)	1.00	1.00
Sex				
Female	192(43.2)	252(56.8)	1.00	1.00
Male	184(57.7)	135(42.3)	1.79(1.39, 2.42)	2.912(1.591, 5.329) *
Age				
10-17	184(42.5)	249(57.5)	1.00	1.00
18-19	192(58.2)	138(41.8)	1.88(1.39, 2.54)	1.248(0.741, 2.13)
Marital status				
Currently married	90(41.9)	125(58.1)	1.00	1.00
Currently not married	286(52.2)	262(47.8)	1.52(1.09, 2.11)	1.108(0.682, 1.956)
Number of sexual partners				
One	123(49.8)	124(50.2)	1.26(0.73, 2.20)	1.869(1.027, 3.402) *
≥ Two	33(44.0)	42(56.0)	1.00	1.00
Educational level				
Illiterate	121(38.5)	193(61.5)	1.00	1.00
Primary	116(45.7)	138(54.3)	1.34(0.95, 1.90)	1.441(0.682, 3.044)
Secondary	139(71.3)	56(28.7)	1.00	1.00
Risk Perception				
Yes	16(57.1)	12 (42.9)	1.39(61, 3.26)	1.315(0.503, 3.436)
No	360(49.0	375(51.0)	1.00	1.00
Knowledge of HIV Prevention				
Knowledgeable	71(65.7)	37(34.3)	2.20(1.41, 3.47)	1.075(0.517, 2.095)
Not Knowledgeable	305(46.6)	350(53.4)	1.00	1.00
Alcohol				
Yes	261(50.7)	254(49.3)	1.19(0.87, 1.63)	1.148 (0.629,2.095)
No	115(46.4)	133(53.6)	1.00	1.00

Table 6: Comparison of Non Migrant & Return Migrant Willingness for Voluntary Counseling and Testing (VCT)

The majority (68.7 %) of the return migrants, and about 39% of the non migrants expressed their willingness to undergo VCT for HIV if the service made readily available in the area. Sex of respondents and number of sexual partners were significantly associated with willingness to VCT. Male were almost three times more willing [AOR= 2,912 (1.59, 5.322)] than females, and those who reported single sexual partner were almost two times more willing, [AOR= 1.869 (1.027. 3.402)] than those who reported two or more sexual partner to undergo VCT.

5. Discussion

In this study, return migrants in rural areas had a higher level of sexual risk than non- migrants. This study has assessed the perception of risks of sexual activity among return migrants and non- migrants who live in one of the surrounded by different region/zonal part of the country. The study has also assessed and identified some of the socio-economic and cultural factors that related to migration influence on sexual behavior and practices among these youth population.

5.1. Knowledge

The study shows that more than 90% of the non-migrants and return migrants youths are aware that unprotected sex can expose to HIV/AIDS, and about 45% of them understand the risks of acquiring other STIs. This result is consistent with the finding of Negeri (2012) whereas this finding is contrast to the finding by Tamiru et al. (2012). General knowledge of HIV/AIDS among mineworkers is good in South Africa (Brummer, 2002). Knowledge among urban rural migrants on HIV/AIDS in Tanzania is 98% (Coast, 2005). The findings generally suggest that the sexual behavior of youth in the study area is highly influenced by socio- economic and cultural factors than by their knowledge.

5.2. Preventive Methods

It is also found out that HIV/AIDS and illegal abortion performed by local abortionists are the common problem of youths in the area. Although, most of the respondents did not name all the three preventive methods, about 68%, 40% and 31% of the respondents said that one could avoid HIV by abstaining, being faithful to a single partner and using contraceptives. However, the practices of preventive methods among youth were generally very low despite their significant involvement in high-risk sexual practices.

5.3. Socio and economic Factors

About 41% and 47% of the respondents were illiterate and school dropouts respectively. Most subjects (67.2%) were jobless. The quantitative data indicated that, early marriage, forced sex, peer pressure, practice of sex at earlier age for economic reasons, disapproval of youth sexuality, lack of convenient services, and negative attitude towards modern contraceptives are some of the important factors that molded their sexual practices. These facts clearly indicate the influence of social and economic factors that affect the sexual life of youth in the study area. But, Contrary to this findings, income and marital status not independent affect in risky sexual behavior such as consistent condom use (Gupta, Rudhra & Saggurti, 2008).

5.4. Sexually Active

In this study, about 43.8% of return migrants and 42% of non-migrants youth have reported that they are sexually active. This finding is relatively low when compared to a similar study conducted by Dawude (2003) in North Gonder, in India Saggruti (2011), rural (30%) and urban (33%) currently married migrants reported of having extra marital sex in the past 12 months (Coast, 2005) which slightly lesser than the present findings. In several previous studies the proportion of sexually active males was persistently higher, ranging from 49.2% to 83.8% compared to that of females, 13.5% to 47.8% (Meswanya. et al., 2007). Opposed to this fact, the proportion of sexually active female adolescents in our study was much higher (56.5%) than male adolescents (23.3%). This can be attributable to the common societal practice of early marriage in rural areas of Ethiopia. The practice of sex at earlier age for economic reasons, and forced sex that was significantly reported by female respondents of this study is another possible explanation.

But, similar finding was reported by a recent study that compared the reproductive health needs of non- migrants and migrants youth in South Africa. Urbanization and being migrant to urban stimulates premarital sex, while early marriage is common in rural areas. Therefore, the difference between these two findings could be attributed to differences in the study settings as well as to compositions of subjects in terms of their marital status. The mean age at first sexual intercourse in this study was 14.67; this is relatively low compared to several previous studies in Ethiopia in which it ranges from 15 to 17.2 years (HAPCO, 2012). But this one is relatively high when compared to the recent study report that assessed the reproductive health needs of rural and urban adolescents is attributed to the involvement of rural adolescents who reported early marriage. The finding of our study can also prove these facts, in that the proportion of married non- migrant female youths was far greater (49.8%) than the male group (14.8).

The existence of risky sexual practice including premarital sex, unprotected sex with non marital partners and sex with female commercial sex workers are reported by both return migrant and non- migrants youths. A study by Tamiru et al (2012) also indicates that the proportions of premarital sex (20.8%) and multiple sexual partnerships (MSP) (31.40%) were significantly higher among migrants than non-migrants (7.4% and 14.2% respectively). Among those who had multiple sexual partners, only 12.7% of migrants and 9.8% of non-migrants reported consistent condom use with their sexual partners.

Although vast majority of sexually active non migrants (18.8%) and (67.3%) return migrants reported that they are limited to one sexual partner, still considerable proportions of return migrants (32.9%) and non-migrants (18.2%) youths have reported to have two or more sexual partners. The mean number of sexual partner for return migrant youths is still found high (1.63+1.14) compared to that of the non-migrants groups (1.29+0.70). Among sexually active male youths, 27% reported experiencing commercial sex in the previous 12 months, which is much higher than in previous studies. The proportion of reported exposure to commercial sex in our study is very high (34.4%) for return migrant male youths compared to the non- migrants (19.0%).

A survey in Kenya reported that consistent condom use during commercial sex practice among migrant & non-migrant youth was only 58% (Decosas et al, 1995). The alarming of this study is that only 36% of those who reported experiencing commercial sex used condom just occasionally and none of them reported consistent condom use. Most unmarried rural and urban migrants never use condom (Coast, 2005); less likely use condom in the last non marital sexual encounter (Kimuna & Djamba, 2012); both men and women never use condom (NACO, 2011).

Studies conducted in some parts of the country among youths revealed that the prevalence of self reported STDs were 6.5%, 4% and 6% in Bahirdar, Awasa, and Addis Ababa respectively (Taffe, 2009). In our study a self reported sign (symptoms) of STIs among sexually active youth was 4.9%, which is almost similar. However, the actual number may be higher, as people may not be so open in discussing such as issues because of related stigma. The symptoms of STDs are more easily identified in males than in females (MOH, 2008). Therefore, this might also have made the overall reported figure lower, as the proportion of females who reported STDs in this study is much higher than males (3.6% vs. 9.5%). Half of those who reported history of STDs first consulted peers and a considerable proportion (44%) got treatment ether form local injectors or from private pharmacy, while they could have been better treated in fair cost in government health institutes. Effectiveness of the treatment and obtaining confidential service were the two main concerns for preferring the visited service areas. Peers may not have accurate knowledge about STDs; however, the observed peer consultation can encourage interventions that consider peer involvement as a strategy to disseminate accurate information in such sensitive and personal issues.

Considering girl's sexual behavior, the study result indicated that a substantial proportion of both non-migrants and return migrants' female youths are practicing unprotected sex. Almost 70% of the sexually active non-migrant and more than 40% of the sexually active return migrant youth have reported that they got pregnant at least once prior to this study, out of which 1.8% of non- migrant and 17.1% of return migrant youths reported history of induced abortion at least once. In this study, only one out of the total of 8 reported abortions was induced by a health professional, while untrained local abortionists induced the majority (88.2%) of cases, under hazardous conditions.

Ever use of modern contraceptives among sexually active female youths in this study was high (43.6%) compared to some of the previous reports that range between 22% and 30%. However, there was great discrepancy between this knowledge and practice (86.7% vs. 43.6%).

The same fact is observed in our study, since 58.6% of the single youths had reported having used modern contraceptive as compared to only 35.6% of the currently married ones. This may be due to the fact that married youths, but to bear a child as immediately, and negative attitude to modern contraception are some of the possible barriers for low utilization of the available services.

Young people knowledged very little about reproductive health and their own biology and are often victims of their own misconception about the risks and dangers of unsafe sexual relations. This study has also revealed the same fact. Only 13.9% of the non- migrants and 24.5% of the return migrants study subjects, correctly identified a woman is most likely to become pregnant half way between two periods, which is lower than findings from Harar and Addis Ababa (Abate, 2007). However, when only female youths are considered, the result is relatively higher than that of demographic and health survey (DHS) of Ethiopia. In our study 17.8% of female youths correctly replied to this question compared to 12.2% of all women of participants DHS. The majority (94.1%) of the study population reported being aware of HIV/AIDS. The proportion of those who have never heard about the epidemic is higher in non-migrants 41 (9.1%) than in return migrants 4 (1.5%) youths. This finding is similar to most of recent findings in the country. However, only 33 (8.3%) of non-migrants and 75 (28.3%) of return migrant youths mentioned all the three possible methods of HIV-STIs prevention (abstinence, being faithful to one sexual partner, and condom use). Additionally, only 343(45.0%) of the respondents were aware of disease other than HIV/AIDS that can be transmitted through sexual intercourse. Thus, there is a big gap between level of awareness, and knowledge of prevention methods as well as the link between HIV and other STIs.

Out of 645(80%) participants who mentioned at least one means of preventing HIV/AIDS, 67.8% and 40.1% of respondents said one could avoid the infection by abstaining and remaining faithful to sex partner respectively, while only 234 (30.7%) mentioned condom use.

5.5. Conclusions

About more than 90% of the study population is aware of HIV /AIDS, its risk factors and unprotected sex. However, both the return migrant & non-migrant youth in the study area generally start sexual intercourse very early and are involved with high- risk sexual practice, including multi-sexual partner & sex with female commercial sex worker. Additionally, a remarkable number of sexually active youth had a history of sexually transmitted diseases and vast majority are practicing unprotected sex. In spite of these facts, majority of both non-migrant & return migrant had a low individual risk perception.

While it is true that sex is not talked about openly in the community and access to accurate information is denied to both non- migrants and return migrants youth, the major problem that influence sexual behavior of the study subject are still linked to their socioeconomic and cultural environment. Absence of social support being the major reason, limited accesses to social services like education and health, and lack of job (Forced idleness) lack of support from family, cultural factors like early marriage and teen age pregnancy are some of the major environmental factors that influences the study population to exercise unsafe sexual practice though awareness exist among them.

6. References

i. Anarfi, J. K. (1993a). Sexuality, migration and AIDS in Ghana: A Socio-Behavioural Study. Health Transition Review, 3, 45-67.
ii. Anarfi, J. K. (1993b) Sexuality, migration and AIDS in Ghana - A socio-behavioural study, Health Transition Review, 3, 1-22.
iii. Birhane, Y., Mekonnen, E., Seyoum, D., Wilson,, L., Gelmot. (2008). HIV/ AIDS in Ethiopia- An Epidemiological Synthesis World Bank Global AIDS Program.
iv. Brummer, D. (2002). Labour Migration and HIV/AIDS in Southern Africa. International organization of migration.
v. Brockerhoff, M., & Biddlecom, A.E. (2008). Migration, secual behavior and Risk of HIV in Kenya, International Migration Review, 33, 833-856.
vi. Brockerhoff, M. & Biddlecom, A. E. (1999). Migration, Sexual behavior and risk of HIV in Kenya. International Migration Review, 33, 833-856. DOI: 10.2307/2547354.
vii. Castle, S. (2004). Rural children's attitudes to people with HIV/AIDS in Mali: the causes of stigma Culture, Health and sexuality, 6 (1), 1-18.
viii. Crush, Raimundo, Simelane, Cau & Dorey. (2010). Migration-Induced HIV and AIDS in Rural Mozambique and Swaziland Southern African Migration Programme (SAMP), International Organization for Migration (IOM), Published by Idasa, 6 Spin Street, Church Square, Cape Town, 8001, and Southern African Research Centre, Queen's University, Canada.
ix. Coast, E. (2005). Sexual behavior and perceptions of risk: male rural-urban migrants in Tanzania. Paper presented at International Union for the Scientific Study of Population XXV International Population Conference, Tours, France.
x. Decosas, J. F. Kane, J. K. Anarfi, K.D.R. Sodji, H.U. Wagner. (1995). Migration and AIDS. The Lancet, 346, 826-8.
xi. Dawude, A. (2003). Perception of the Risks of Sexual Activities among Out of School Adolescents in South Gondar Administrative zone, Amhara region. M.A Thesis: Addis Ababa.
xii. Eshete, H., & Sahlu, T. (1996). The Progression of HIV/ AIDS in Ethiopia. Ethiopian Journal of Health Development, 10 (3), 179-190.

xiii. Federal Democratic Republic of Ethiopia and Federal HIV/AIDS Prevention and Control Office (2010). Report on Progress towards implementation of the UN declaration of Commitment on HIV/AIDS.

xiv. Hunt, C. W. (1989). Migration labouor and sexually transmitted Disease: AIDS in Africa. Journal of Health Social Behaviour, 30, 353-373.

xv. International organization of migration (2005). HIV/AIDS, Population Mobility and Migration in Southern Africa Defining a Research and Policy Agenda, 1-82.

xvi. International Organization of Migration (2011). HIV and Bangladeshi Women migrant Workers, An Assessment and Vulnerabilities and gaps in services.

xvii. Kimunal, R. S., Djamba, K. Y. (2012). Migration, Sexual Behaviour and Perceptions of Risk: Is the place of origin a factor in HIV infection?, Advances in Applied Sociology, 2, 3, 167-178. DOI: 10.4236/ aasoci2012.23023.

xviii. Lurie, M., Harrison, A., Wilkinson, D., KArim, S., Setel, P., Chirwa, W., & Abdool Karim, S. (2004). Circular Migration and Sexual networking in rural KwaZulu/ Natal: implications for the spread of HIV and other Sexually transmitted diseases. Health Transition Review, 19, 17-27.

xix. Maswanya, E. S., Moji, K., Horiguchi, I Nagata, K., Aoyagi, K., Hondal, S.,& Takemoto, T. (2007). Knowledge, Risk perception of AIDS and reported sexual behavior among students in secondary Schools and Colleges in Tanzania. Health Education Research, 14, 185-96.

xx. Mekonnen, Y. Daniel. G., Mekonnen, A., Degefu, A., & Tegbaru, B. (2009). Magnitude of a Risk Factors for HIV Infectionamong Most at Risk Populations (MARPs) in Amhara Region: Ethiopian Public Health Association, Amhara Region HPCO, CDC.

xxi. Morris, M. (1997). Sexual networks and HIV/AIDS 11(Suppl. A) S209-S216.

xxii. Ministry of Health (MOH) and federal HIV/ AIDS Prevention and Control Office (FHAPCO). AIDS in Ethiopia 6th Report. (2006).

xxiii. Ethiopian Demographic Health Survey (EDHS). Central Statistical Authority (CSA), 2005.

xxiv. Ministry of Health (MoH) and Federal HIV/AIDS Prevention and Control Office (FHAPCO). AIDS in Ethiopia, 2005.

xxv. National AIDS control Organization (2011). Migration and HIV in India: Study of Selected Districts Population Council, United Nations Development Program.

xxvi. Negari, E. L. (2012). Assessment of Sexual Behaviour, Attitude and Risk Perception about HIV/ AIDS among out of School Youths, Ilu –Ababa- Bora Zone, Western Ethiopia. Science, Technology & Arts Research, 1(2), 18-30.

xxvii. Nyanzai, S. Nyanzia, B. & Kalina, B. (2003). Urban husbands with rural wives: migration, employment and sexual health in a high HIV risk areas in Uganda. Urban Health and Development Bulletin, 6(1-2), 79-86.

xxviii. Nishigaya, K. (2002). Female garment factory workers in Cambodia: migration, sex work and HIV/AIDS, Women and health, 35(4), 27-42.

xxix. Nyanzi, S., Nyanzi, B., Kalina, B., & Pool, R. (2004). Mobility, sexual networks and exchange among bodaboda men in southwest Uganda. Culture, Health & Sexuality, 6, 239-254. DOI: 10.1080/13691050310001658208.

xxx. Ososanya, O. O. &. Brieger W. R. (1994). Rural-urban mobility in south-western Nigeria: implications for HIV/AIDS transmission from urban to rural communities. Health Education Research, 9 (4), 507-518.

xxxi. Pison, G., Le Guenno, B., Lagards, E., Enel, C. & Seck, C. (1993). Seasonal migration: a risk factor for HIV infection in rural Senegal. In: Journal of Acquired Immune Deficiency Syndromes, 6, 2, 196-200.

xxxii. Prson, G., Le Guenno, b., Lagards, E., Enel, C., & Seck, C. (2007). Seasonal Migration: A risk factor for HIV infection in rural Senegal. Journal of Acquired Immune Deficiency Syndromes, 25, 196-200.

xxxiii. Sambrook, B. C. (2008). Dynamics of the HIV/ AIDS epidemic in value chain development in rural Ethiopia and responses through market led agricultural initiatives. IPMS (Improving Productivity and Market Success) of Ethiopian Formers Project Woking Paper, 1, ILRI (International livestock Research Institute), Nairobi, Kenya, P.84.

xxxiv. Solorio, M. R., Currier, J., & Cunningham, W. (2004). HIV Health Care Services For Mexican Migrants, Journal of Acquired Immune Deficiency Syndrome , 37, 4, 1, 240-250.

xxxv. Topouzis, D.. J., & Guemey, D.U. (1999). Sustainable Agriculture: Rural Development and vulnerability to the AIDS epidemic, UN- AIDS Best Practice Collection. Geneva: UNAIDS & FAO.

xxxvi. Tamiru, M., Hailemariam, D., & Mitike, G.(2012). HIV-Related Sexual Behaviors and Leisure Activities among Rural to Urban Migrants and Non-migrants in Bure Wreda, Amhara Region, Ethiopia. Online Journal of Medicine and Medical Science Research, 1, 1, 5-17.

xxxvii. UNAIDS. (2008a). Migrant's Rights to health. Geneva.

xxxviii. UNAIDS. (2008b). Population Mobility and AIDS-Technical update. Geneva.

xxxix. UNAIDS. (2012). Global AIDS Epidemic.

xl. Wilson, F. (1972). Migration labour in South Africa, Johannesburg, South Africa.

xli. Adih, W. K., & Alexander, C.S. (2008). Determinants of Condom Use to prevent HIV infection among Youth in Ghana. Journal of Adolescent Health, 12, 63-72.

xlii. Bisrat, F., & Pickering, J. (1994). High School Student's Knowledge, Attitude and Practice of Contraception in Harar Town, Eastern Ethiopia. Ethiopian Medical Journal, 32, 151-159.

xliii. Bolland, J. M. (2003). Hopelessness and Risk Behaviour among Adolescents Living in High Poverty Inner City Neighborhood. Journal of Adolescence, 26, 145-158.

xliv. Brewer, T., Hasbun, J., Ryan, C., Hawes, S., Martinez, S., Sanchez, J., butler de Lister, M., Constanzo, J., Lopez, J., Holmes, K. (2005). Migration, Ethnicity and environment: HIV risk factors for women on the sugar cane Plantations of the Dominican Republic. AIDS report, 12, 1879-1887.

xlv. Campbell, C. (2008). Going underground and Going after Women: Masculinity and HIV Transmission amongst black workers on the gold mines. In R. Morrell, Ed., Changing men in southern Africa. Pietermaritzburg and London: University of Natal Press and Zed Books.

xlvi. Dalene, G., G.Wheeler, J., & Grosskurth, H. (2004). Adolescent Reproductive Health and Awareness of HIV among rural High School Students, North Western Ethiopia, AIDS care, 20 16 (1), 57-68.

xlvii. Decosas, J. (1999). Mobility and sexuality: The policy Dimension. Paper presented at the Conference on AIDS, Livelihood and Social Change in Africa, Wageningen.

xlviii. Decosas, J., & Adrien, A. (1997). Migration and HIV/ AIDS.

xlix. Desmond, N., C. F. Allen, S. Clift, B. Justine, J. Mzugu, M.L. Plummer, D. Watson-Jones, D. & Ross, A. (2005). A typology of the groups at risk of HIV/STI in a gold mining town in north-western Tanzania: Social Science and Medicine, (60), 1739-1749.

l. Eaton, L., Flisher, A. J., & Aaro, L. E. (2003).Unsafe Sexual behavior in South African Youth. Social Science & Medicine, 56, 149-165.

li. Erulkar, A. S., Mekbib, T. A., Simie, N. & Gulema, T. (2006). Migration and Vulnerability among Adolescents in Slum Areas of Addis Ababa, Ethiopia. Journal of Youth Studies, 9 (3), 361-374.

lii. Evian, C. (2006). The Socio economic Determinants of AIDS Epidemic in South Africa. South African Medical Journal, 121 (29), 635-636.

liii. Freidman, H. L. (2004). Changing Patterns of Adolescent Sexual Behaviour: Consequences for Health and Development. Journal of Adolescent Health, 13 (5), 345-50.

liv. Gilgen, D., Williams B. G., MacPhail, C., Van Dam, C. J., Campbell, C. et al. (2001). The natural History of HIV/AIDS in a major goldmining centre in South Africa: results of a biomedical and social survey. South African Journal of Science, 97 (10), 387-392.

lv. Govindasamy, Pav, Aklilu, K., & Hailon, B. (2006). Youth Reproductive Health in Ethiopia, Journal of medicine and Science, 89 (21), 63-72.

lvi. Gupta, I., Rudhra, S., & Saggurti, N. (2008). Determinants of demand for safe sexual among male migrants in India.

lvii. Henderson, M., Wight, D., Raab, G., Abraham, C., Buston, K., Hart, G., & Scott, S. (2010). Heterosexual risk Behaviour among Youth Teenagers in Scotland. Journal of Adolescence, 25, 483-494.

lviii. Kapiga, S.H., & Lugalla, J. L. P. (2009). Sexual behavior Patterns and Condom use in Tanzania: Results from the 2008 Demographic and Health Survy. AIDS Care, 14 (40), 455-469.

lix. Korra, A., and Haile, M. (1999). Sexual Behaviour and Level of Awareness on Reproductive Health among Youths: Evidence from Harar, Eastern Ethiopia. Ethiopian Journal of Health Development, 13 (2), 107-113.

lx. Kotchick, B. E., Shaffer, A., Miller, K. S., & Forehand, R. (2008). Adolescent Risk Sexual Behaviour: A Multi System Perspective, Social Science and Medicine, 21, 493-519.

lxi. Laga Marie. (2004). Epidemiology and Control of Sexually Transmitted Diseases in Developing Countries. Paper Presented at the 21st International Meeting of the International Society for STD Research, Helsinki Finland.

lxii. Larson, C., Assafa, M., Aboud, F., & Shiferaw, T. (1991). Risk Behaviours for HIV infection: their Occurrence and Determinants in Jimma Town, SouthWestern Ethiopia. Ethiopian Medical Journal 29 (3) 127-136.

lxiii. Lurie, M., Williams, B., Zuma, K., Mkaya-Mwamburi, D., Garnett, G., Sturm, A. W., Sweat, M. D., Gittelsohn, J., & Karim, S. S. (2003). The impact of migration on HIV transmission in South Africa: A study of migrant and non-migrant men and their partners. Sexually Transmitted Diseases, 30, 149-156.

lxiv. MOH (2008). AIDS in Ethiopia, Addis Ababa.

lxv. Meschke, L. L., Bartholomae, S., & Zentall, S. R.(2006). Adolescent Sexuality and Parent Adolescent Process: Promoting Healthy Teen Choices. Journal of Adolescent Health, 31, 264-179.

lxvi. Mill, J. E., Anarfi, J. K. (2009). HIV Risk Environment for Ghanian Women: Challenges to Prevention. Social Science and Medicine, 54, 325-337.

lxvii. Mundani, C., Cissers, D., Voeten, h., Habbema, D., & Gregson, S. (2006). No Difference in HIV incidence and sexual Behaviour between out migrants and residents in rural Manicaland, Zimbawe. Tropical Med. Int. Health, 11(5), 705-711.

lxviii. Negeri, E. L. (2012). Assessment of Sexual Behaviour, Attitude and Risk Perception about HIV/AIDS among Out-of School youths, Ilu-Abba-Bora Zone, Western Ethiopia, Science, Technology & Arts Research , 1(2), 18-30.

lxix. Ntozi, J. P., Najjumba, I. M., Ahimbisibwe, F., Ayiga, N., Odewee, J. (2007). Has the HIV/ AIDS epidemic changed sexual behavior of high risk groups in Uganda?. Africa Health Science, 3, 107-116.

lxx. Parroda, e., Flippen, C., & McQuiston, C. (2004). Use of commercial Sex Workers Hispanic Migrants in North Carolina: Implications for the Spread of HIV. Perspectives in Sex reproductive Health, 36 (4), 150-156.

lxxi. Smith, C. (2005). Socio Geography of sexually transmitted diseases in China: Exploring the role of Migration and urbanization. Asia Pacific Viewpoint, 46 (1), 65-80.

lxxii. Sonja, F., & Katie, K. (2009). Maastricht Graduate School of Governance Migration in Ethiopia: History, Current Trends and Future Prospects.
lxxiii. Soskolene, V., & Shtarkshall, R. A. (2010). Migration and HIV Prevention Programs: Linking Structural Factors, Culture and Individual Behaviour –an Israeli Experience. Social Science & Medicine, 55, 123 -130.
lxxiv. Saggurti1, N., Mahapatra, B., Swain, S.N., Jain, A. K. (2011). Male migration and risky sexual behavior in rural India: is the place of origin critical for HIV prevention programs? BMC Public Health, 11(Suppl 6):S6.
lxxv. Swart-Kruger, J., & Richter, L. M. (2004). AIDS Related Knowledge, Attitude and Behaviour among South African Street Youth: Reflections on Power, Sexuality and Autonomous Self. Social Science and Medicine, 45 (96) 957-66.
lxxvi. Taffa, N. (2002). Sexual and Reproductive Health Status of Youth in urban Ethiopia (Unpublished).
lxxvii. Taffa, N., Klepp, K. I., Sundby, J., & Bjune, G. (2005). Psycho Social Determinants of Sexual Activity and Condom use intention among Youth in Addis Ababa, Ethiopia. STD AIDS, 13(10),714-9.
lxxviii. Taffa, N., Sundby, J., Bjune, G. (2007). Reproductive Health Perceptions, Beliefs and Sexual Risk Taking among Youth in Addis Ababa, Ethiopia. Patient Education and Counselling, 49 (2), 165-169.
lxxix. Tarantola, D. (2009). Impact of Travel and Migration on the Spread of HIV: Risk, Vulnerability and Mobility. Paper Presented at the 12th Conference of the International Society of Travel Medicine, June 6-10, Montreal.
lxxx. UNAIDS. (2010). Young People and HIV/AIDS: Opportunity in Crisis.
lxxxi. UNAIDS. (2011). AIDS Epidemic Update. Geneva.
lxxxii. Yang, X. (2005). Temporary Migration and the Spread of STDs/ HIV in China. Migration Review, 38 (1), 212-235.
lxxxiii. Yaukey, D. & Anderton, D. L. (2001). Demography. 2nd Ed. Illonois. Waveland Press. Inc.,
lxxxiv. Zelher, S. L. (2007). Condom Use and the Accuracy of AIDS knowledge in Cot dIvoire. International Family Planning Perspective, 29, 41- 47.
lxxxv. Zulu, E., Doodoo, F.N. & Ezeh, A.C. (2004). Urbanization, Poverty and Sex: Roots of Risky Sexual Behaviours in Slum Settlements in Nairobi, Kenya in HIV and AIDS in Africa: Beyond epidemiology (pp.174-176) Eds. Kalipeni, E. Cgraddock, S. Oppong, J. R. Ghosh, J. Blackwell Publishing: Mass.
lxxxvi. Ministry of Health (MoH) [Ethiopia]. November 2010. Health Sector Development Programme IV, 2010/11-2014/15. Addis Ababa, Ethiopia: Ministry of Health.