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Research Article

KNOWLEDGE AND BELIEFS REGARDING CONTRACEPTION, HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS AMONG YOUNG ADULTS ATTENDING COLLEGE IN A PERI-URBAN AREA OF BANGALORE

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ABSTRACT

Introduction: Sexually transmitted Infections (STI) including HIV/AIDS mainly affect sexually active people, most of whom are young adults. STIs are associated devastating sequelae like pelvic inflammatory disease, infertility and poor perinatal outcomes. In India, the RMNCH+A programme focusses on prevention and control of STIs, contraception and health education. This study was conducted to document the knowledge and beliefs regarding contraception, HIV/AIDS and STIs among young adults attending college in a peri-urban area of Bangalore. **Methods:** Data was collected using a face-validated questionnaire which recorded socio-demographic data, and knowledge and beliefs regarding contraception and STIs and HIV/AIDS. To assess knowledge, correct answers were given a score of 1. Students were categorised as having good, moderate or poor knowledge based on tertiles. **Results:** 420 students in the age group of 18-25 years were included in the study. 40% students had poor knowledge of contraception and 35% students had poor knowledge of STIs and HIV. Only 35.7% of students were aware of emergency contraceptive pills and 55% knew that condoms could prevent pregnancy as well as STIs/HIV. Very few students knew where STIs were treated (20.7%) or where to obtain condoms and oral pills to prevent pregnancy (27.1%). Result of Multinomial Logistics Regression analysis showed that female gender [OR 11.78] and poor educational status of the mother [OR 2.49] were significantly associated with poor knowledge. **Conclusion:** Erroneous beliefs and poor knowledge regarding contraception and STIs/HIV among these young adults, indicate a need to focus on this important issue in the context of a college environment.

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INTRODUCTION

Sexually transmitted Infections (STI) including HIV (Human Immunodeficiency Virus) mainly affects sexually active people, most of whom are young adults¹. As of 2014, approximately 37 million people are living with HIV worldwide, with about 2 million new cases adding to the global pandemic.² 35% of all HIV / AIDS infections in India occur amongst young people in the age group of 15 – 24 yrs of age.³ With increasing independence and sexual liberation, young adults become invariably vulnerable to HIV and STDs. Easy access to mobile phones, internet and social media increase the vulnerability of youth to behaviours that are linked with STI/HIV.⁴ STIs encompass a wide range of infections contracted mainly through sexual intercourse, like Gonorrhoea, Syphilis and Chlamydia HIV, Herpes Simplex, Human

Papilloma Virus (HPV) and Hepatitis B Infection.⁵ All STIs are associated with complications like infertility and chronic renal disease, however females suffer from devastating sequelae like pelvic inflammatory disease, dyspareunia, infertility, chronic pelvic pain, increase risk of ectopic pregnancies, and poor fetal outcomes like abortions, still births, prenatal and neonatal morbidities.⁶

In India, STIs are widely associated with social stigma, embarrassment and denial. Sexuality and sexually transmitted diseases are major taboos, especially in young adults. Youth are at a greater health risk as most of them become sexually active in adolescent period. Physiologically, young people are more vulnerable to STIs than adults; girls more than boys. Gender imbalances, societal norms and economic dependence contribute to this risk. Lack of access to correct information, tendency to experiment and an environment which makes

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discussing issues around sexuality taboo, adds to their vulnerability.⁶ The RMNCH+A programme focusses on prevention and control of STIs, contraception and health education, with the guideline that health education interventions should serve as a platform to counsel and educate adolescents and young adults on risk behaviour modifications.⁷

With this background, this study was conducted to document the knowledge and beliefs regarding contraception, HIV/AIDS and STIs among young adults attending college in a peri-urban area of Bangalore. This study would help in identifying gaps in their knowledge regarding contraception, HIV/AIDS and STIs, which could then be incorporated into the learning curriculum for young adults in educational institutions.

MATERIALS & METHODS

The study design was a cross-sectional study. The study group included students of a college in peri-urban area of Bangalore Urban district. Ethical approval was obtained before the commencement of the study (IEC Study Ref.No 164/2017). Prior written permission from the college principal was also obtained. Using data from NFHS 3, where the knowledge regarding prevention of HIV/AIDS⁸ was 53% as an estimate of prevalence, at relative precision of 10%, a confidence interval of 5% and assuming a 10% non-response rate the sample size was estimated to be 374. All students above the age of 18 years, both males and females, enrolled in various general degree courses in the college were invited to participate in the study. Students who were absent on the day of the study were excluded. Only students, who gave written informed consent were included in the study. A face-validated questionnaire was administered to the students. The questionnaire recorded socio-demographic data, and knowledge and beliefs regarding contraception (14 items), STIs and HIV/AIDS (23 items). Each correct answer was given a score of one. Thus, the maximum possible score was 14 for knowledge on contraception and 23 for STI and HIV/AIDS. The knowledge scores were divided into good, moderate and poor knowledge based on tertiles. Students then participated in an interactive discussion and health education session on contraception, STIs and HIV/AIDS.

Data collected were entered into a Microsoft Excel sheet and analysed using Statistical Package for Social Sciences (SPSS) version 16.0. Descriptive statistics such as frequency, mean and standard deviation were used for describing the socio-demographic data and knowledge scores. Associations between knowledge scores and sociodemographic factors were looked at using Chi Square test and Fischer's exact test as applicable. Variables which were significantly associated with knowledge scores were then computed into a logistic regression model for further analysis. Statistical significance was taken as a p value of 0.05 or less.

RESULTS

The results of our study have been presented under the following headings:

- Sociodemographic details of the study population
- Knowledge of contraception and STI/HIV/AIDS
- Factors associated with knowledge levels

- Erroneous beliefs and misconceptions
- Sources of information

Sociodemographic details of the study population

A total of 420 subjects were included in the study. The study subjects belonged to the age group of 18-25 with a mean age of 20 years (± 1.031). There were more females (58.4%) than males. Majority of the population were of Hindu religion (65.2%). Most of them belonged to the class II socio-economic status (31.9%) according to modified BG Prasad classification.⁹

Knowledge of contraception and STI/HIV/AIDS

Most of the students (40.7%) had poor knowledge of contraception. Regarding knowledge on STDs and HIV/AIDS, a third of the students had good knowledge, a third had moderate knowledge and a third had poor knowledge. The overall knowledge regarding STDs and HIV/AIDS was better as compared to that of contraception. (see table 1).

Only 150 (35.7%) students were aware of emergency contraceptive pills. Only 55% knew that condoms could prevent pregnancy as well as STDs, including HIV and AIDS. Just 44.3% knew that oral contraceptive pills (OCPs) could prevent pregnancy. 141 (33.6%) were aware of higher modalities of contraception such as depot injection every 2 or three months, yet only 74 (17.6%) of the participants have heard of intra uterine contraceptive devices. More participants knew about tubectomy (65.5%) as compared to vasectomy (44.8%).

Very few students were aware that ulcer on the genitals (13.6%) and discharge from the genitals (19.5%) could indicate sexually transmitted disease. Most students were aware about the common modes of transmission of HIV, that is sexual intercourse (93%), blood transfusion (82.9%), infected needles (66.9%), from a pregnant woman to her unborn child (65.7%). However only 87 (20.7%) of students knew of any place where they could see a doctor and be treated for sexually transmitted diseases and only 114 (27.1%) knew where to obtain condoms and oral pills to prevent pregnancy.

Many students (71.4%) knew that a simple blood test could diagnose HIV whereas only 41.2% knew that apart from HIV/AIDS other diseases could be acquired by sexual intercourse. In addition, 64% knew that they need to visit a doctor for treatment of a sexually transmitted disease. One fourth of the participants knew that anal intercourse increases risks of HIV and 44.5% knew that having another STD also increases HIV risk. 25.2% knew that some STDs could also cause cancer.

Factors associated with knowledge levels

It was found that males had a better knowledge of contraception compared to females across all three categories of knowledge levels ($p < 0.001$). It was seen that religion also played a role in the knowledge of contraception with the Christian community having a higher percentage of participants with good knowledge (40%) followed by Muslim community who had moderate knowledge and Hindu community with poor knowledge ($p = 0.006$). Those students that belonged to Upper class of the Socio-economic status according to Modified B G Prasad classification were found to have better knowledge compared to those that belonged to Lower class ($p = 0.001$).

Students whose father had attained graduation showed better knowledge as compared to those whose father had education of primary / middle school (p=0.075), although this was not statistically significant. Students, whose mother's education status was that of a graduate was found to have better knowledge as compared to those whose mothers had education of primary / middle school (p=0.002).

With respect of knowledge of STI/ HIV/AIDS and its relationships to socio demographic variables, it was seen that gender did play a role. Males were found to have a marginally better knowledge compared to females (p value 0.058). Religion did not play a role when it came to the knowledge of HIV / AIDS. Socio-economic status of upper class according to modified B G Prasad classification was found to have good knowledge compared to other classes which was statistically significant (p value = 0.033). In terms of knowledge of HIV/AIDS, it was seen that both father's and mother's education status of graduate level was significantly associated with better knowledge as compared to those whose father and mother had education of primary / middle school (p=0.001 and p=0.021 respectively).

Multinomial Logistics Regression results showed that gender is a significant factor for knowledge regarding contraception (p<0.001). Female students had 11.8 times greater chance of having poor knowledge of contraception as compared to male students. (Adjusted OR:11.78;95% CI:-6.4-21.5). Regression analysis also showed that the educational status of the students' mother was a significant factor for knowledge regarding STDs and HIV/AIDS (p<0.05). Subjects whose mother studied upto high school had 2.5 times greater chance of having poor knowledge compared to those whose mothers were college graduates. (Adjusted OR 2.495;95% CI:- 1.074-5.799)

Erroneous beliefs and misconceptions

The young adults in this study had some erroneous beliefs with regards to contraception. Many students (69.1%) believed that a condom can be used more than once. Other erroneous beliefs among the students included ones like "condoms can slip of the man and disappear inside the woman's body" (84.3%) and "OCPs can prevent both pregnancy as well as sexually

Table 1 Knowledge on contraception and STDs and HIV/AIDS and associated factors

Variables	Total N=420 n(%)	Knowledge on contraception			p value	Knowledge on STDs and HIV/AIDS			p value	
		Good 113(26.9)	Moderate 136 (32.4)	Poor 171 (40.7)		Good 139 (33.1)	Moderate 135 (32.1)	Poor 146 (34.8)		
Gender	Male	175 (100)	81 (46.3)	64 (36.6)	30 (17.1)	<0.001* ^a	67 (38.3)	46 (26.3)	62 (35.4)	0.058 * ^a
	Female	245(100)	32 (13.1)	72 (29.4)	141 (57.5)		72 (29.4)	89 (36.3)	84 (34.3)	
	Hindu	274(100)	59 (21.5)	87 (31.8)	128 (46.7)		86 (31.4)	94 (34.3)	94 (34.3)	
Religion	Muslim	11(100)	4 (36.4)	4 (36.4)	3 (27.3)	0.006* ^b	3 (27.2)	4 (36.4)	4 (36.4)	0.838* ^b
	Christian	110(100)	44 (40)	34 (30.9)	32 (29.1)		41 (37.2)	29 (26.4)	40 (36.4)	
	Others	25(100)	6 (24)	11 (44)	8 (32)		9 (36)	8 (32)	8 (32)	
Socio-economic Status (Modified BG Prasad Classification)	Upper Class	109 (100)	50 (45.9)	27 (24.8)	32 (29.4)	0.001 * ^b	44 (40.4)	28 (25.7)	37 (33.9)	0.033 * ^b
	Upper middle class	134 (100)	29 (21.6)	47 (35.1)	58 (43.3)		48 (35.8)	44 (32.8)	42 (31.4)	
	Middle class	118 (100)	23 (19.5)	43 (36.4)	52 (44.1)		33 (28)	46 (39)	39 (33)	
Father's Education	Lower middle class	48 (100)	9 (18.8)	16 (33.3)	23 (47.9)	0.075 * ^a	11 (22.9)	11 (22.9)	26 (54.2)	0.001 * ^a
	Lower class	11 (100)	2 (18.2)	3 (27.3)	6 (54.5)		3 (27.3)	6 (54.5)	2 (18.2)	
	Primary/Middle School	102 (100)	20 (19.6)	32 (31.4)	50 (49)		23 (22.5)	35 (34.3)	44 (43.1)	
Mother's Education	High school/ Pre-University	205 (100)	54 (26.3)	66 (32.2)	85 (41.5)	0.002 * ^a	64 (31.2)	76 (37.1)	65 (31.7)	0.021 * ^a
	Graduate	113 (100)	39 (34.5)	38 (33.6)	36 (31.9)		52 (46.1)	24 (21.2)	37 (32.7)	
	Primary/Middle School	108 (100)	22 (20.4)	42 (38.9)	44 (40.7)		30 (27.8)	36 (33.3)	42 (38.9)	
Mother's Education	High School/ Pre-University	235 (100)	57 (24.3)	72 (30.6)	106 (45.1)	0.002 * ^a	74 (31.5)	85 (36.2)	76 (32.3)	0.021 * ^a
	Graduate	77 (100)	34 (44.2)	22 (28.6)	21 (27.3)		35 (45.5)	14 (18.2)	28 (36.4)	

Table 2 Multinomial Logistic Regression: adjusted risk factor for knowledge about contraception.

Factor	Adjusted OR	95%CI for OR	P Value
Female (reference category: male)	11.78	6.4-21.5	<0.001
Poor knowledge	2.7	1.5-4.7	<0.001
Moderate knowledge			

Reference category: Good knowledge

Table 3 Multinomial Logistic Regression: adjusted risk factor for knowledge about HIV / AIDS.

Factor	Adjusted OR	95% CI for OR	P Value
Mothers educational status (reference category: Graduate)	2.495	2.4-1.07	<0.05
Primary school	2.427	1.159-5.082	<0.05
High school			

Reference: Good knowledge

transmitted diseases" (88.8%). A large majority (88.6%) of the students felt that condom use would result in reduction of sexual pleasure during coitus.

With respect to beliefs regarding STDs, HIV/AIDS, around half (51.8%) students believed that HIV could be cured completely. Three fourth of the students believed that HIV can be transmitted by touching an infected person, also through mosquito bites (38%) and public toilets (42.1%) Other erroneous beliefs included "once a person has sexually transmitted disease he or she will not suffer from the same disease again" (32.9%), "a person with HIV always looks sick or unhealthy" (69.3%), "person would develop open sources on their genitals soon after HIV infections (61.1%).

Many students believed (75%) believed that all STDs were caused by the same organism and only 8.3% believed that STDs can lead to serious health problems.

Sources of information

The students obtained information on contraception and STDs/HIV from various sources. The most common source of information was from friends accounting for 41% for knowledge on contraception and 32% for STD and HIV/AIDS respectively. Internet (36.4% and 34.5%), films (30.7% and 22.6%), textbooks (29.8% and 36.2%), teachers (24.8% and 40%) and magazines (22.1% and 16.9%) were the commonest sources of information for the students.

DISCUSSION

The present study aimed to study the knowledge and beliefs regarding contraception and STI/HIV/AIDS among young adults studying in a degree college, located in a peri-urban area of Bangalore Urban District. The study intended to determine the possible gaps in knowledge and document wrong beliefs that could be a barrier in reducing morbidity and mortality from STIs, HIV and AIDS.

The overall knowledge of contraception and STI/ HIV/AIDS was poor as seen in our results. The results of a descriptive study done in Southwestern Nigeria among 550 adolescents showed that only 6.9% had good knowledge of STIs and the rest had fair and poor knowledge whereas in our study 33.1% had good knowledge of STIs and the remaining had moderate to poor knowledge.¹⁰ A Malaysian study conducted among 1139 students between the age group of 15 – 20 years concluded that majority of the students had moderate knowledge on STIs while about a third of the students had moderate knowledge of STIs in our study.¹¹ The different levels of knowledge in the above settings probably point towards differences in the epidemiology of the problem at the local level and the initiatives for awareness regarding the same.

An Ethiopian study with 3543 participants who responded to a self-administered questionnaire similar to our study reported that only 634 (17.9%) of adolescents had knowledge of symptoms of STIs and that they had a poor information about STIs which is lower in comparison to our study where a good percentage of the participants had knowledge of symptoms of STIs.¹² The Ethiopian study also showed that the students know more about HIV/AIDS than other STIs. This finding was similar to a study done in Mumbai among 279 college students¹³ which showed that moderate knowledge was present with regard to STIs and good knowledge was present when it came to HIV/AIDS. Our study mirrored the findings of these two studies. Considering the fact that a sizeable chunk of information regarding STIs, HIV/AIDS came from teachers, as reported in our study, it is possible that teachers themselves reduce information about other STIs and give more emphasis to HIV/AIDS. The Ethiopian students also reported that they did not know where to go if they had an STI (70%), similar to the students in our study.

Regarding knowledge of modes of transmission and prevention of HIV/AIDS, a study among students in Iraq¹⁴ found that most students were that HIV/AIDS could be transmitted through sexual intercourse (94.3%), blood transfusions (83.5%), shared needles (73.7%) and from mother to child (75.3%). This was similarly reported by our study. A comparative study in a rural and urban setting in Sri Lanka on 294 students showed that

only half of the students that participated in the study knew that condom use prevents HIV transmission, which was a similar finding in our study.¹⁵ A study among school-going adolescents in Wardha, Maharashtra stated that symptoms of genital discharge possibly indicating STI was known by 45.8%. This proportion was however much higher than that among the college students in our study (19.5%).¹⁶ This finding points to a possible difference in the educational curriculum content between the two states.

When it came to misconceptions, the youth in our study believed that HIV can be transmitted by touching or hugging, just like the youth in a nation-wide Malaysian survey.¹⁷ A study done in South Delhi among female students reported that almost 30% of the participants believed that HIV /AIDS could be cured,¹⁸ whereas in the present study, 51.8% believed that AIDS was completely curable. In our study, 88.8% of the participants erroneously believed that OCPs could prevent both pregnancy and STI/HIV, which was much higher than the South Delhi study (41%) as well as the earlier Mumbai study¹⁴. The better knowledge among the Delhi and Mumbai students could be attributed to the fact that those students were from a core urban area, whereas the students in our study were from a peri-urban area, where cultural norms often dictate the taboos attached to STIs and contraception.

In a study done among 3563 African American high school students in the United States,¹⁹ regression analysis showed that knowledge score for STIs was significantly associated with female gender ($p < 0.001$) which was similar to the Iraqi study¹⁵ as well as our study which showed that female students were more likely to have poor knowledge of contraception and STIs as compared to male students. The lower levels of knowledge among females could indicate the barriers perceived by females to seek knowledge on these topics. These barriers may include social taboos on females openly discussing matters related to sexuality. The fact that a similar study done in Kerala 17 years ago,²⁰ showed the same gender disparity, is an indication that points towards designing interventional packages specifically targeted at increasing knowledge levels among females.

Our study indicated that students of higher socioeconomic status had better knowledge levels regarding HIV/AIDS, this was similarly found in the study in Iraq¹⁵ and Malaysia¹². Our study also showed that higher parental education was associated with better knowledge scores. The youth, whose mothers had low educational status were found to have 2.4 times the chance of having poor and moderate knowledge in comparison to those whose mother had a graduate degree. A similar study in Nigeria²¹, substantiated these results.

In our study, friends were the commonest source of knowledge regarding contraception. It was also interesting to know that family support in respect to this regard was low, probably because students felt uncomfortable in discussing contraception and their sexuality with their family members. The college where they studied did not provide a platform for clarifications of doubts on this topic. The societal taboo to speak of contraception at public forums like educational institutions may also have contributed to this. On the other hand, the same pattern of results did not apply when it came to the knowledge of HIV/AIDS. Our results show that teachers were the main source of information, followed by textbooks. This could be

explained by the fact that the alarming burden of HIV/AIDS has resulted in wide spread dissemination of HIV-related information as well as inclusion into education curriculum. The internet and films were also a common source of information for the youth, similarly described in a Nigerian study¹¹.

CONCLUSION

The overall knowledge of contraception and STIs and HIV/AIDS were poor as seen in our results. Female gender was associated with significantly lower levels of knowledge regarding contraception, while lower socioeconomic status and lower education status of the mother was associated with lower levels of knowledge of STIs and HIV/AIDS. Majority of the students had good knowledge about the modes of transmission of STIs and HIV/AIDS but had misconceptions and erroneous beliefs with regard to prevention of STIs and contraception. From this study we can infer that gaps in knowledge are present among college-going youth, with regards to knowledge of contraception, STIs and HIV/AIDS. Therefore, it is important that health professionals take cognizance of these gaps and design interventional programs to address them. Knowledge dissemination strategies should take into account the familiarity and comfort of today's youth with electronic media and develop strategies focussed on their optimal use.

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