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Sex and sexually transmitted infections including HIV/AIDS among street youth in Indonesia A research proposal

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Background

Young people who spend a considerable time on the street, often referred to as 'street youth' are increasingly present all over the world. The exact number of street youth is difficult to estimate. They are a transient and difficult to reach population, often fleeing from their families, social service agencies, or the police. It is estimated that there are between 10 to 100 millions street children (aged 24 years or less) all over the world (1). Most are found in large, urban areas of developing countries. In Bangalore, India, their number is estimated at between 85,000 and 100,000 (2). A study done in 1995 in Jakarta, Indonesia, estimated the number of street children (aged 18 or less) ranged between 4,000 and 20,000, and it is believed that this number rose after the economic crisis in 1997. In recent years the problem of street youth has worsened across the world because of economic problems, political changes, civil unrest, increasing family separations and conflicts, the epidemic spread of diseases and natural disasters.

Young people, especially street youth, both in developed and developing countries have been identified as the group suffering most from STDs including HIV/AIDS. A review of literature on HIV/AIDS risk behaviour among street youth in the United State suggested that runaway youth are 2-10 times more likely to become infected with HIV than other youth (3). The United States national estimate of HIV seropositivity conservatively estimated at 5 percent and range to a high of 17 per cent among street youth in San Francisco (3). Data from developing countries are limited, but considering that treatment is less accessible, the prevalence in developing countries may be higher. A study in Brazil reported some subgroups of street youth having HIV prevalence rate of 35 per cent (4). In Indonesia, the prevalence rates of STDs and HIV/AIDS infection among street youth are unknown. Nevertheless, it is estimated that in Jakarta, one in every seven street children had a history of STIs (5).

Previous studies in many countries have indicated that street youth are particularly vulnerable of STDs and HIV infections because: most are sexually active (6; 7), have multiple sex partners, including prostitutes (8), engage in homosexual activity (6), provide sex in exchange for money without protection (8; 9), are sexually abused (10), rarely or inconsistently use condoms despite being aware of AIDS (11; 12), are ignorant of other sexually transmitted diseases (STDs) against which they tend to self-medicate (7) and use illicit drug, including intravenous drug (8; 13).

Moreover, street youth often do not receive appropriate medical care due to numerous individual and systems barriers impeding health care access in this population. In addition to the barriers experienced by the adult homeless population, homeless adolescents confront further hurdles stemming from their age and developmental stage. Some of these impediments include a lack of knowledge of clinic sites, fear of not being taken seriously, concerns about confidentiality, and fears of police or social services involvement (14; 15).

The significance of the study

Despite the recent growing awareness of the risks of STDs and HIV/AIDS among street youth in Indonesia, few studies have been done to understand the context in which sexual decision-making is undertaken. Program targeting street youth in Indonesia mostly are conducted by NGOs and only few of them cover sexual and reproductive health issues. In Medan, for example, in 1999, there were at least three NGOs interested in street kids but none of them covering reproductive health issues. At the same time the NGOs interested in adolescent reproductive health did not cover those out of school (16). Some NGOs in Jakarta opposed condom promotion, favouring moral education, while some groups believed that other issues were more important than HIV/AIDS in improving the children's lives (10).

In addition, the provision of access to and information about sexual and reproductive health services for single people remains controversial in Indonesia. The Programme of Action of the 1994 ICPD in Cairo and the Platform of the Fourth International Conference on Women in Beijing suggested that governments should "protect and promote the rights of adolescents to sexual and reproductive health information and services they need". Nevertheless these suggestions meet many obstacles to implementation. Because of socio-cultural, religious and political reason, the Indonesian government only encourages the availability of adolescent reproductive education, but not services. Providing family planning services to single people is still considered illegal. According to the Indonesian "Family Welfare" law (UUD No. 10/1992), family planning programs are only available to married couples or families.

Furthermore, the availability of data that can be used to design efficient and effective programs for street youth in Indonesia is not sufficient. Results of searching of literature in electronic database 'PubMed' in March 2005 (key words "Sexually transmitted diseases in Indonesia") show that most studies and programs on STDs and HIV/AIDS focussed on female commercial sex workers or male transgender. Given these facts research is urgently needed on issues related to street youth and sexually transmitted diseases covering both socio-cultural and bio-medical aspects in Indonesia.

Objectives

This study aims to explore sexual lives and risk of sexually transmitted infections including HIV infection among street youth in three largest cities of Indonesia; Jakarta, Surabaya and Medan. The study specific objectives are:

1. to describe the patterns and level of knowledge about STDs and HIV infection among street youth.
2. to describe the sexual behaviour, including the attitudes about condom use among street youth.
3. to identify socio-cultural and demographic factors that may contribute to the risk of street youth contracting STIs including HIV/ AIDS.

The proposed study

The Setting

The study will be carried out in the three largest city of Indonesia: Jakarta, Surabaya and Medan. These cities have their own unique characteristics. With the population of 10 million people, in 2000, Jakarta is known as the largest city in Indonesia. Jakarta is unique with its status as the capital city of the country and the centre of the city administration. Jakarta is also the centre of social, cultural and health activities.

Surabaya is the capital city of East Java Province. The total population of the city was approximately 3 million, in 2000, in which one forth is seasonal migrants. The people of Surabaya are heterogeneous, but the majority of them are Javanese.

Medan is the capital city of North Sumatra Province. With the population of 2 million in 2000, it is the third largest city in Indonesia and the largest city outside Java. This city has become a major destination for migrants from around the region since the Dutch colonial government introduced various plantations to the area in the nineteenth century.

The study population

The subjects of this study are street youth aged 15-24 who have lived in the city being studied for at least six months. The definition of street youth in this study is modified from WHO's training module on Substance use, sexual and reproductive health including HIV/AIDS and STDs (17). Street youth are defined as young people

- who are 'of the street', having no home but the streets. Their family may have abandoned them or they may have no family member left alive. Such youth have to struggle for survival and might move from friend to friend, or live in shelter such as abandoned buildings.
- who are 'on the street', those who visit their family regularly. They might even return every night to sleep at home, but spends most days and some nights on the street because of poverty, overcrowding, sexual or physical abuse at home.
- who are 'a part of the street family'. Those who live on the sidewalks or city squares with the rest of their family. Family displaced due to poverty or natural disaster may be forced to live on the street.
- who are in institutional care, having come from a situation of homelessness and at risk of returning to a homeless existence.

Research Methods

To meet the objectives of the study, both quantitative and qualitative approach will be applied. Information obtained from each approach will be used as complementary to the other. The quantitative approach provides numerical results that can be used to see the pattern of issues being studied. On the other hand, the qualitative approach using selective informants allows the researcher to probe into sensitive issues as well as attitudes, values and beliefs (18) and the collection of information on issues that are difficult to obtain from a quantitative survey.

- **The quantitative approach**

The number of sample: a total of 300 street youth both males and females (100 in each city) will be recruited.

The recruitment of the sample: participants will be recruited through "drop-in centers" and from street-based locations such as bus stations, traffic lights, food stalls, malls and parking areas. Considering random sampling procedures will be difficult to implement, these methods will strengthen the representative of the sample.

The interview:

- To prevent the respondents getting tired or bored when interviewed, the questionnaire will be constructed as short as possible**.** The questionnaires will be designed for self-administered, but participant will be offered to choose to be interviewed by researcher or to complete the questionnaires by themselves. To ensure confidentiality, the respondent's name will not be asked. To identify the cases, all the questionnaires will be numbered, but the numbered.
- The questions will be classified into six categories:
    - Socio-economic and demographic backgrounds (age, sex, religion, ethnicity, education completed, occupation, living arrangement, relationship with parents and peers).
    - Knowledge and attitudes regarding STDs including HIV/AIDS (symptoms, preventions and myths)
    - Current sexual practices (sexual partners and condom use)
    - Sexual and STDs history
    - Alcohol/drug use

- **The qualitative approach**

The qualitative data collection will involve in-depth interview and focus group discussions. In-depth interviews elicit information that people can consider as too private to talk about in a group (19), while focus groups are a suitable approach for getting people to express a range of different opinion about an issue (20). For this study, the combination of both methods is particularly good because it allows the researcher to obtain information on group norms as well as information about the more private aspects of sexual, STDs and HIV/AIDS infections.

Recruitment of respondents for in-depth interviews and focus group discussions will be done in various ways: recommendations of other respondents (snowballing), interviewers, local researchers and NGOs.

In-depth interviews with selected street youth will be carried out. The selection will be based on gender, age, sexual experiences, living arrangement, experience of STDs/HIV infection and other aspect that might be raised in the field.

In-dept interviews also will be conducted with several key informants including, representatives of NGOs, local researcher, local staff of government's institute in-charge of street youth (Ministry of Health and Ministry of Social Welfare), community leaders and others that may provide relevant information for the issues being studied.

Three focus group discussions in each city will be conducted; two groups of males (aged 15-19 years, males aged 20-24 years) and one group of females (it is assumed that the number of street youth females is smaller than males). Each group will consist of 5-8 people.

Data processing and analysis

- The quantitative data will be entered and analysed using SPSS for Windows. The analysis will employ descriptive statistics, including frequencies and percentage distribution, bivariate analysis, including cross-tabulations and the chi-square test. The bivariate analysis will be used to examine the relation between independent and dependent variables individually.

Socio-economic and demographic variables will be treated as independent variables while attitudes and knowledges will be treated as both independent and dependent variables. Sexual practices and experience of STDs and HIV/AIDS will be treated as dependents variables.

- The qualitative data will be analysed through 'descriptive thematic analyses'. It is aimed primarily at identifying and describing the themes that are contained in the transcripts. These include:

1. transcription
2. developing and applying codes
3. selective text retrieval
4. constructing an overview grid to summarize points
5. re-organizing points into more general themes
6. re-reading relevant segments and memos
7. reporting: describing findings, selecting quotes/describing illustrative cases, interpreting and discussing results

Informed consent

Considering the culture and characteristics of street youth in Indonesia, it is less likely that the respondents will agree to sign an informed consent. Nevertheless, before the interview, respondents will be asked to read all the questions briefly, and asked whether they are willing to participate. Informed consent will be given orally.

Outcome

The study will produce publications in peer-reviewed journals. The findings of the study will enter the policy arena in Indonesia through conferences and the preparation of policy-oriented papers.

References

1. World Health Organization (WHO), 2000. *Working with street children: A Training Package on Use, sexual and reproductive health including HIV/AIDS and STDs (Introduction),* WHO: Geneva
2. Ramakrishna Y, Karott M, Murthy RS, 2003. Experiences of sexual coercion among street boy in Bangalore India, in S Bott, S Jejeebhoy, I Shah , C Puri (eds.), *Towards adulthood: exploring the sexual and reproductive health of adolescents in South Asia*, World Health Organization (RHR): Geneva. (Full text)
3. Walters AS. HIV prevention in street youth. J Adolesc Health. 1999 Sep;25(3):187-98. Review. Erratum in: J Adolesc Health 1999 Dec;25(6):414. (PubMed)
4. Rotheram-Borus MJ, Song J, Gwadz M, Lee M, Van Rossem R, Koopman C. Reductions in HIV risk among runaway youth. Prev Sci. 2003 Sep;4(3):173-87. (PubMed)
5. Population Report, 2001. Volume XXIX No. 3 Seri L number 13. *Reaching Youth at Special Risk.*
6. Lockhart C. Kunyenga, "real sex," and survival: assessing the risk of HIV infection among urban street boys in Tanzania. Med Anthropol Q. 2002 Sep;16(3):294-311. (PubMed)
7. Anarfi JK. Vulnerability to sexually transmitted disease: street children in Accra. Health Transit Rev. 1997;7 Suppl:281-306. (PubMed)
8. Haley N, Roy E, Leclerc P, Lambert G, Boivin JF, Cedras L, Vincelette J. Risk behaviours and prevalence of Chlamydia trachomatis and Neisseria gonorrhoeae genital infections among Montreal street youth. Int J STD AIDS. 2002 Apr;13(4):238-45. (PubMed)
9. Swart-Kruger J, Richter LM. AIDS-related knowledge, attitudes and behaviour among South African street youth: reflections on power, sexuality and the autonomous self. Soc Sci Med. 1997 Sep;45(6):957-66. (PubMed)
10. Black B, Farrington AP, 2004. *Preventing HIVAIDS by promoting life for Indonesian Street Children.* (full text)
11. Snell CL. Help-seeking and risk-taking behavior among Black street youth: implications for HIV/AIDS prevention and social policy. J Health Soc Policy. 2002;16(1-2):21-32. (PubMed)
12. Liverpool J, McGhee M, Lollis C, Beckford M, Levine D. Knowledge, attitudes, and behavior of homeless African-American adolescents: implications for HIV/AIDS prevention. J Natl Med Assoc. 2002 Apr;94(4):257-63.(PubMed)
13. Gleghorn AA, Marx R, Vittinghoff E, Katz MH. Association between drug use patterns and HIV risks among homeless, runaway, and street youth in northern California. Drug Alcohol Depend. 1998 Aug 1;51(3):219-27. (PubMed)
14. Feldmann J, Middleman AB. Homeless adolescents: common clinical concerns. Semin Pediatr Infect Dis. 2003 Jan;14(1):6-11. (PubMed)
15. Rew L, Chambers KB, Kulkarni S. Planning a sexual health promotion intervention with homeless adolescents. Nurs Res. 2002 May-Jun;51(3):168-74. (PubMed)
16. Situmorang A, 2001. Adolescent Reproductive Health and Pre-marital sex in Medan, The Australian National University: Canberra (Unpublished PhD. thesis)
17. World Health Organization (WHO), 2000. *Working with street children: A Training Package on Use, sexual and reproductive health including HIV/AIDS*

and STDs (Module 1), WHO: Geneva
18. Scrimshaw SCM, 1991. Combining quantitative and qualitative methods in the study of intrahousehold resource allocation. In *Health Transition: Methods and Measures*, Canberra: Australian National University, pp. 237-250.
19. Bernard R, 1988. Unstructured and semi-structured interviewing. In *Research Methods in Cultural Antrophology*. Beverly Hills: Sage Publications, pp. 203-223.
20. Murphy B, Cockburn J, Murphy M. Focus groups in health research. Health Promotion Journal of Australia 1992; 2 (2):37-40.