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Health and psychosocial problems of school adolescents in Jimma Zone, South West Ethiopia

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Abstact

Background: Currently, both at national and regional levels, there is very little data-based information available on adolescents' health to guide planners, decision makers and service providers to successfully organize and/or provide adolescent health service. Therefore the present study was to assess the health, social, and psychological concerns and problems among adolescents in Jimma Zone.

Method: The study was conducted in the year 1998. The study employed a cross sectional school based survey on a sample of 1840 students, selected proportionally to size from a source population of 11048 in eight Junior and senior high schools. A pre-tested self-administered questionnaire was used to collect data and analyzed using SPSS/PC soft ware.

Result: Eight hundred fifty six (48.0%) and 752(42.0%) reported to have had one or more emotional concern and currently experiencing emotional problems respectively. One thousand five hundred eighty seven (89.0%) and 1327(75.0%) reported one or more health problem concerns such as skin, dental, STD. Having a health problem showed a statistically significant association (P<0.001) with age, grade of the students and educational status of parents. Four hundred fifty eight (26.0%) and 267(14.0%) had one or more sexually related concern and problems. One thousand seventy eight (61.0%) and 933(53.0%) have social related concerns and problems. Age and sex showed a statistically significant (P<0.001) association with social related problems. Three hundred one (18.0%) and 267(16.0%) had one or more substance use concern and substance use problem which showed a statistically significant association (P<0.000) with age, sex, grade residence and education of both parents.

Conclusion: Adolescent concerns about their emotional, sexual, social outlook and substance uses are substantiative. These concerns should be used as an early entry stage to promote and design relevant strategies such as special adolescent/youth health services to address the adolescent needs. [*Ethiop. J. Health Dev.* 2001;15(2):97-107]

Introduction

Adolescence is a period in human development characterized by rapid physical, social and psychosexual changes. Adolescents (10-19 years) in Ethiopia are estimated to be 19.3% of the total population (1). Even though they comprise a large segment of the population, there exists very little information on their health, social and emotional issues. As WHO noted, these young people ae of

crucial importance for strategies to achieve the targeted goal of health for all because they are the parents of the future (2) Adolescence is a time when sexual exploration, intimacy and feelings of independence begin to have prime importance despite a hostile and unwelcoming physical and social environment. As a result, they tend to become involved in high-risk, health compromising behaviors and yet feel invincible to the negative consequences of their actions.

The curiosity of adolescents about the world in general and sexuality in particular is intense (5), and they are receptive to discussions about premature sexuality, pregnancy, STDs, and abortion (6, 7). In many developed countries there is open discussion on sexuality between parents and their adolescent offspring, while it is the reverse in developing countries (3, 4).

Adolescents are subject to early marriage and childbirth (5, 7-8). They constitute a risk group in pregnancy (9, 10), with increased incidence of pre-term birth, pre-eclampsia and obstructed labor. Early marriage, pregnancy and childbirth result in dropouts from schools and single-lone mothers without social support (10-13).

Among the high risk behaviors of adolescents are unprotected sex, alcohol, smoking, use of drugs, and disregard to the expectations and rules of the family, school and society. The consequences of these actions are many and sometimes extremely detrimental to the adolescent's future health (9, 10). The major health problems of adolescents that emanate from the aforementioned risky behaviors include STDs, mental illnesses, crime and violence. The most important factors contributing to these problems are teenage pregnancy, substance-use, physical abuse, psychological disorders, violence and trauma (9, 11, 14).

Sexual victimization is often a risk factor for acquiring STDs. STDs are acquired as a direct consequence of victimization, and also as a result of later behaviors such as promiscuity or prostitution, which place the victim at risk (6, 13, 14). The risk of exposure to STDs and other diseases is determined by socio-demographic, environmental, psychosocial, behavioral and biologic factors. Many of the psychological problems begin to appear during adolescence (7, 12, 15-17). A considerable proportion of adolescents fail to adjust to the various demands of life and reveal their frustrations through conflicts with families, involvement in crime, suicide attempts, and dropping out of school.

Social maladjustment and mental ill health conditions are the outcome of delinquency, school withdrawals and threatened suicide. These signs and symptoms of emotional disturbance in adolescents could represent deviations from the normal and cause limitations to healthy development. Rig and Fisher reported psychological symptoms such as parent child conflict, academic failure, chronic depressive reaction, acute adjustment reaction, acute anxiety reaction and tension headaches to be prevalent among adolescents (19, 20).

According to the little literature available, adolescents are exposed to mental health conditions and often suffer from a range of physical, social, educational and emotional problems. The impact of mental problems on the social, physical and emotional health of many adolescents is obvious. From what we know, however, no survey has been undertaken in Ethiopia in general and Jimma Zone in particular on adolescents' views about the state of their health, and their social and emotional problems and concern. Hence, this study focuses on an exploration and identification of what health, age, sex and socio-cultural related problems prevail among adolescents and the psychological worries and concerns that emanate out of their perceptions of these problems. The overall aims of this

undertaking is to assess the health, social, sexual and emotional concerns that develop among adolescents due to problems and challenges deriving out of health complications, age and sexual factors and socio-economic state of parents and themselves. Currently there is very little data-based information available on adolescents' health, both at national and regional levels in Ethiopia. Such study is a tool to guide planners, decision-makers and service providers to successfully organize and/or provide adolescent health services. Accordingly, the study aims at the following specific objectives:

1. To determine the perceived health, social, emotional needs, problems and concerns among adolescents.

2. To determine perceived risk conditions of adolescents such as alcohol consumption, Drug, tobacco use/abuse, and sexually transmitted diseases.

3. To generate a baseline data on health and health related problems and concerns among adolescents.

Methods

Study area: The study was conducted in seven of the 13 woredas of Jimma Zone, Oromiya Regional State, southwest Ethiopia. According to the zone planning and development office, there were 27 Junior secondary schools with 7799 students and eight secondary schools with 8939 students in the Zone, at the time of the survey (1998).

Design and Population: The study employed a cross-sectional design. According to the WHO definition adolescence is defined as the age between 10 to 19 years (2). Therefore, the source population were all adolescents in Junior and senior Secondary schools (N=11,048) in 13 Woredas of Jimma Zone. The study population were students selected from seven Woredas of the Jimma Zone where both junior and senior secondary schools were available. Junior and senior high schools were targeted as these could serve an appropriate source to cover the age range of 10-19 years.

Sample Size and Sampling Procedure: In order to determine the sample size, the schools were first stratified into three strata: grades 7 and 8; 9 and 10, 11 and 12. Then, allocation of the study subjects was made proportional to the size of the classes. The students in grades seven to twelve responded to the questionnaire administered.

Data Collection and Management: A pre-tested self-administered questionnaire was used to collect the data. The variables collected include socio-demographic characteristics and adolescent risk behaviours such as, alcohol consumption, use of drugs, tobacco smoking and sexually transmitted diseases, and injuries. The questionnaire was first prepared in English and then translated into Amharic. Seven trained research assistants were assigned one to each Woreda to administer the questionnaires and collecte data. The data collectors' task was to ascertain the quality and completeness of the data during the stage of data collection. A one-day orientation program to data collectors was undertaken. Throughout data collection time the accuracy and completeness of the questionnaire was checked by supervisors. Finally, the collected data were coded and entered into an SPSS/PC computer statistical software package.

Data Analysis: The data were analyzed by the SPSS/PC computer statistical package. A small sample of data was analyzed to check completeness, internal consistency and type of information on different variables. Then, Frequencies, rates and other applicable tests of significance were applied.

Results

1. Socio-demographic characteristics of he study population:

1768 (96.1%) adolescent students completed the questionnaire. The majority of the male students' lie in the age group of 17-19 years (53.5%) and were in the grade stratum of 9-10 (22.4). Most of the female students were in the age range of 14-16 years (55.1%) and were in the same grade stratum of 9-10 (20.5%). Over three-quarters (78.7%) of the total respondents currently live with their parents while the rest (21.3%) live alone and /or with other people. The majority of the parents of the respondents (56.3%) were illiterate, with no monthly income (75%) and 63.3% of mothers were housewives. The fathers were more literate (61.4%) and farmers by occupation (38.1%).

2. **Adolescents' problems and concern**

Adolescents experience physical health, sex, age and social related problems and they suffer from concerns and worries, as a result in this study, the adolescents undergoing through either of these ailing experiences and/or the prevalence of any perception held against these ailments is considered

as a problem. On the other hand, states of emotional feelings that arise out of these experiences and perceptions are regarded as concern. In other words, problems are the source and the primary factors and concern, feelings and worries are derivatives of the former. Behavioral manifestations of one kind or another are the ultimate result of problems and concerns either actual or perceived.

2.1 **Emotional problems and concern**: anxiety, anger, depression and worries about career were grouped as emotional problems and/or resulting concerns. Out of the total sample respondents, 856(48.4%) have stated one or more emotional problems as their source of concern. The results showed that male students (56%), in the age group of 17-19 (57.8%) in grade 7-10 (35.6%), With an illiterate father (57.6%) and mother (59.9%) did have more emotional problems and concerns than those in similar categories. The age, sex and grade of students, and the level of literacy of both parents have statistically significant association (P= 0.000) with the subjects' emotional problems and concerns. Over 42% reported to currently experience one or more emotional problem (Table 1).

2.2 **Health problems and Concerns:** Being too fat or too thin, having skin diseases, and dental problems, and contracting sexually transmitted diseases were grouped as health problems and concerns. Among the sample population those who had one or more type of health problems and concerns accounted for 1587 (89.7%). Those who reported to suffer from such health problems and concerns were male students (50.8%) years, aged 14-16 (48.5%), in grades 9-10 (44.1%), had an illiterate father (63.1%) and mother (54.6%), and resided with parents (78.7%). At the time of the survey, 1327 (75.1%) of the total sample reported to have one or more health problem, among others, skin and dental diseases, sexually transmitted diseases, and either underweight or overweight as a health problem. Of those who were concerned about their health, 564(31.9%) have one or more of the health problems stated. Having health problems showed a statistically significant association (p=0.000) when cross tabulated with age and grade of students and educational status of the father and mother (Table 2).

2.3 **Sexuality Related Problems and concerns:** Three variable were considered as sexually related problems and/or concerns. These were access to/getting birth control, pressure to have sexual intercourse and beingsexually abused. The analysis showed that only (26.5%) of the sample have experienced one or more of the stated problems and uphold concerns. Age, grade and living with parents and literacy status of both parents were strongly associated with sexuality related problems and concerns (p=0.000). Only 247 (20.4%) of those who indicated to have concerns stated they have experienced sexually related problems (Table 3)

2.4 **Social Related Problems and Concerns:** problems and conflicts with family; conflicts and physical fights with peers; lack of social support, and lack of life satisfaction with day to day life were taken as social related problems and/or concerns. Out of the total sample 1078 (61.0%) reported to hold such concerns. In this case too, male students (58%) in the age group 14-16 (72.4%), grade level 9-10 (43.8%) with an illiterate father (61.9%) and mother (56.8%) living with parents (72.0%) had more social related problems and concerns. Among the variables tested for association only parents educational status did not have a significant statistical association. Nine hundred thirty three (52.8%) reported to currently have one or more social problems. Age and sex of the students have a statistically significant association with experienced social problems and felt concerns (Table 4).

Discussion

2.5 **Substance use/Abuse problems and Concerns:** Drinking alcohol, cigarette smoking, khat chewing and use of other drugs were categorized under problems of substance use and related concerns. Stated concern for one or more of these unhealthy practices accounted for only 301 (17%) of the total sample population. When these concerns were cross tabulated, male students (67.1%) in the age group of 14-16 (66.4%), grade level 11-12 (65.8%) with an illiterate father (64.1) and mother (61.5%) and residing with parents (69.5%), had more substance use concerns than others. Two hundred sixty seven (15.1%) reported to have experienced one or more of the substance use/abuse problems. The problems and concerns were found to be statistically associated with age, sex and grade level of students, the educational status of parents and the adolescents residing with parents (Table 5).

A lot of health problems and needs of adolescents in developed society have been well reported while the same have not been well studied in developing countries (3,5,14,16,23-26). Few studies in Ethiopia indicate that alcohol consumption, sexual intercourse, cigarette smoking, chewing khat and use of drugs are increasing among adolescents, possibly accompanied with health and health related problems such as STD/AIDS (23-24,40).
In the USA, adolescents aged 12-17 years use alcohol (48%), smoke cigarettes (40%) and 23% use illicit drugs (24). These USA findings support the results in this study and other similar studies previously conducted in Agaro and Butajira (38,39). In USA youths drink while driving motor vehicles which tremendously adds to the adolescent's high delinquency and mortality rates. However, drunkenness and motor vehicle driving is not an issue among adolescents in Ethiopia. With this in view we have to deliberate upon the major components that help reduce problems and concerns of adolescents. Along with public Health and Medicine, educational programs that involve parents, schools, communities and the adolescents themselves must be sought among the remedies. Even though health, sexual, social related and, substance use related problems and/or were regarded not common among adolescents in

this country, Yohannes (1997) reported the prevalence of depression (7.3%), skin problems (6.1%) unwanted sexual activity (3.8%) and substance use (3.4%) among school children in Ethiopia . Yohannes had also reported that dental problems were common and that supports our finding too. This could be explained by the effect of the environments in which they are brought up which harbor such incidences. These illnesses could have a serious impact on the school performance of the already disadvantaged adolescents as observed in this study. One has also to worry for those who live alone (13.8%) and those residing with other people (7.5%) for they might get exposed to STD's HIV or other health problems.

Some of the study subjects use alcohol and khat (8.9%) and about 12% are sexually active. More than two thirds have visited a health institution during the previous year. This suggests an important role for health professionals as a source of information and positive role models for these adolescents (38). Out of the total sampled students, about half the subjects had reported to have had emotional problems and concerns and yet the majority did not seek help. The explanation could be that the adolescents have no assurance of confidentiality in health facilities (35,36). In one study it was reported that assurance of confidentiality increased the number of adolescents willing to disclose sensitive information about sexuality, substance use, and mental health to health instructions (26). The association of emotional problems/concerns with parental education and income levels in this study could be that parents are not knowledgeable about problems that affect adolescents traditional health care, and work options. Also the general care parents extend to their children may vary. For example, females are perceived less valuable than boys in some area (26-28). Emotional care and health lessons given to female children by parents are on family care, body pride, worried about school, particularly worries or concerns about violence. Such unwanted care and lessons may contribute to reluctance to report about emotional and other health problems disturbing them. Health problems and concerns reported in this study are similar with other studies in which most of the health problems of the respondents were acute and biological (29-32). Parents serve their children as the primary educators on health issues, but they may have no accurate information. In this case, a comprehensive school-home partnership is the key to promoting the health of adolescents. Comprehensive adolescent health programs and integrated services are necessary to support parent and community efforts to promoted adolescent health issues such as environmental, family life education, STD/HIV prevention, nutrition, and dental care for most of those engaged in self care practices (33,34).

Many adolescents did not report their sexual problems and concerns as we had expected. This could be because of pressure from taboos and cultural factors in the society. In this study, only 26% reported to have had sexual related problems. Although there are no studies regarding the level of sexual violence in this region, there is indirect evidence that indicates the presence of the problem. Some students in this study have reported to have experienced pressure to have sex and had met sexual abuse. Studies among high school students in Harar and Addis Ababa had reported that forced sexual intercourse was desired to initiate the sexual capabilities of adolescents and rape was a cause of conception (35,36). These studies clearly indicate that there is a need to fill the gap in knowledge regarding sexual violence and sexual related problems among adolescents in the country in general, and Jimma Zone in particular. It also needs further study to ascertain. The sexually related problems/concerns associated with parental education and residence could be explained by the inability of most parents to understand the problem of their adolescent offspring's and the consequent fate awaiting victims of sexual abuse with consequences of pre-marital pregnancy and HIV/AIDS. The fact that male adolescents are not worried about such consequences of sexual abuse is also a serious concern. Almost one fifth had problems/concerns related to addiction. They are currently experiencing problems such as drinking alcohol, cigarette smoking, chewing khat and use of other drugs. This could lead them to risk behavior illness, disability and committing crime. These risk factors reported in this study were similarly reported in other studies in this country (37-40). This indicates substance use/abuse problems are spreading widely in the country. These could be due to loose family bonds imitated from the west. It is therefore time to initiate more studies towards this growing adolescent problem, identify the magnitude and design appropriate preventive measures.

The high morbidity and mortality rates associated with adolescence can be reduced by the provision of health services that are particularly designed to meet the needs of adolescents. It is also time and important to ascertain which features or components of the problems need to be addressed as priorities. As very well stressed in the health and population guidelines, the identification and early prevention of the physical health, social and behavioral problems of adolescents should be given the attention it deserves (17,19-22).

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Tables

Table 1: Number and percentage distribution of emotional concerns and problems reported by adolescent students, Jimma Zone, southwest Ethiopia, 1998.

	Concern[1]		Problem[2]		Statistics	
	No (n=912)	Yes (n=856)	No (n=1016)	Yes (n=752)	^{2}	P-value
Age:						
11-13	105(11.5)	32(3.7)	117(11.5)	20(2.7)	[1]128.68	0.000
14-16	513(53.3)	329(38.4)	572(56.3)	270(35.9)	[2]164.34	0.000
17-19	294(32.2)	495(57.8)	327(32.2)	462(61.4)		
Grade:						
7-8	375(41.1)	320(37.4)	374(36.8)	321(42.7)	[1]87.37	0.000
9-10	448(49.1)	310(36.2)	447(44.0)	311(41.3)	[2]7.04	0.020
11-12	89(9.8)	226(26.4)	195(19.2)	120(16.0)		
Literacy: Father:						
Illiterate	189(20.7)	493(57.6)	302(29.7)	380(50.5)	[1]251.77	0.001
Literate	723(79.3)	363(42.4)	714(70.3)	372(49.5)	[2]8.09	0.000
Literacy: Mother:						
Illiterate	482(52.9)	513(59.9)	559(54.0)	446(59.3)	[1]8.54	0.003
Literate	430(46.5)	344(40.1)	467(46.0)	306(40.7)	[2]3.92	0.047
Sex:						
Male	424(46.5)	479(56.0)	83(47.5)	420(55.9)	[1]15.46	0.000
Female	488(53.5)	377(44.0)	33(52.5)	332(44.1)	[2]11.62	0.006
Residence:						

				[1]17.13 [2]51.23	0.000 0.000	
448(33.8) 879(66.2)	681(51.3) 646(48.7)	224(50.8) 144(32.7) 73(11.5)			92(20.9) 349(79.1)	234(53.1) 207(46.9)
					94(7.1) 620(46.7) 613(46.2)	471(35.5) 614(46.3) 242(18.2)
Alone With parents With other	123(13.5) 719(78.8) 70(7.7)	121(14.1) 673(78.6) 62(7.2)	32(13.0) 802(78.9) 82(8.1)	112(14.9) 590(78.5) 50(6.6)	[1]0.25 [2]2.32	NS NS

NS = Not significant ( ) = percentage

Table 2: **Number and percentage distribution of health concerns and problem reported by adolescent students, Jimma Zone, southwest Ethiopia, 1998.**

		No (n=441)	**Yes (n=1327)**		
Age: 11-13	116(7.3) 770(48.5)	21(11.6) 72(39.8)	43(9.8) 222(50.3)	[1]7.19 [2]6.88	0.027 0.032

14-16		701(44.2)	88(48.6)	176(39.9)		
17-19						
			Concern[1]			
			No (n=181)	**Yes (n=1587)**		
					Problem[2] Statistics	
					[2]	**P-value**
Grade:						
7-8			603(38.0)	92(50.8)	[1]12.01	0.002
9-10			699(44.1)	59(32.6)	[2]34.55	0.000
11-12			288(17.9)	30(16.6)		
Literacy: Father:						
Illiterate				96(53.0)	586(36.9)	
Literate			867(54.6)	85(47.0)	1001(63.1)	
Literacy: Mother:						
Illiterate					128(70.7)	
Literate			720(45.4)		53(29.3)	
	0.000	225(51.0)	**Sex:**			
	0.000	216(49.0)	Male	31(17.1)	872(54.9)	
			Female	150(82.9)	715(45.1)	
				[1]91.49	[1]123.55	0.000
				[2]0.00	[2]51.76	0.977
Residence:						

Alone	25(13.8)	219(13.8)	61(13.9)	184(13.9)	[1]0.02	0.988
With parents	43(79.0)	1249(78.7)	344(78.4)	1037(78.4)	[2]0.00	0.999
With other	13(7.2)	119(7.5)	34(7.7)	102(8.7)		

Table 3: **Number and percentage distribution of sexual related health concern and problems reported by adolescent students, Jimma Zone, southwest Ethiopia, 1998.**

Sex:						
Male	617(47.5)	286(61.1)	656(43.1)	39(15.8)	[1]196.75	[1]10.30
Female	683(52.5)	182(38.9)	587(38.6)	171(69.2)	[2]86.07	[2]39.02
Age:						
11-13	85(6.5)	52(11.1)	94(6.2)		**Problem[2]**	
14-16	625(48.1)	217(46.4)	728(47.9)	**Yes (n=247)**		0.006
17-19	590(45.4)	199(42.5)	699(45.9)			0.000
Grade:					**Concern[1]**	
					No (n=1300)	**Yes (n=468)**
7-8	640(49.2)	55(11.8)				
9-10	429(33.0)	329(70.3)		**Statistics[2]**	**P-value**	
11-12	231(17.8)	84(17.9)				
Literacy: Father:						
Illiterate	434(33.4)	248(53.0)	656(43.1)	39(15.8)	43(17.4)	
Literate	866(66.6)	220(47.0)	587(38.6)	171(69.2)	114(46.2)	
Literacy: Mother:			278(18.3)	37(15.0)	90(36.4)	
Illiterate	478(36.8)	295(63.0)				
Literate	822(63.2)	173(37.0)		0.000	531(34.9)	
				0.000	990(65.1)	

						628(41.3) 893(58.3)			
					[1]55.11 [2]65.63	0.000 0.000	151(61.1) 96(38.9)		
		[1]95.41 [2]25.45	0.000 0.000					145(58.7) 102(41.3)	
	[1]25.11 [2]32.19			168(68.0) 79(32.0)	735(48.3) 786(51.7)		0.000 0.000		
	[1]16.18	0.000					195(12.8)	49(19.8)	
Residence:			155(11.9)	89(1.9)					

	1052(80.9)	340(72.6)	1212(79.7)	180(72.9)	[2]8.85	0.012
Alone	93(7.2)	39(8.3)	114(7.5)	18(7.3)		
With parents						
With other						

Table 4: **Number and percentage distribution of social related health concerns and problems reported by adolescent students, Jimma Zone, southwest Ethiopia, 1998.**

	No (n=690)	**Yes (n=1078)**	**No (n=835)**	**Yes (n=933)**	**Concern[1] Statistics**	
				Problem[2]	**[2]**	**P-value**
Age:						
11-13	40(5.8)	97(9.0)	45(5.5)	92(9.9)	[1]778.12	0.000
14-16	62(9.0)	780(72.4)	196(23.5)	646(69.2)	[2]454.36	0.000
17-19	588(85.2)	201(18.6)	594(71.1)	195(20.9)		
Grade:						
7-8	333(48.3)	362(33.6)	277(33.2)	418(44.8)	[1]59.58	0.000
9-10	286(41.4)	472(43.8)	443(53.1	315(33.8)	[2]67.93	0.000
11-12	71(10.3)	244(22.6)	115(13.7)	200(21.4)		
Literacy: Father:						
Illiterate	419(60.7)	667(61.9)	493(59.0)	593(63.6)	[1]0.19	0.664
Literate	271(39.3)	411(38.1)	342(41.0)	340(36.4)	[2]3.61	0.057
Literacy: Mother:						

Illiterate	383(55.5)	612(56.8)	464(55.6)	531(56.9)	[1]0.22	0.635
Literate	307(44.5)	466(43.2)	371(44.4)	402(43.1)	[2]0.27	0.602
Sex:						
Male	272(39.4)	631(58.5)	329(39.4)	574(61.5)	[1]60.75	0.000
Female	418(60.6)	447(41.5)	506(60.6)	359(38.5)	[2]85.40	0.000
Residence:						
Alone	47(6.8)	197(18.3)	111(13.3)	133(14.3)	[1]11.83	0.000
With parents	616(89.3)	776(72.0)	664(79.5)	728(78.0)	[2]0.59	0.745
With other	27(3.9)	105(9.7)	60(7.2)	72(7.7)		

Table 5: **Number and percentage distribution of substance use/abuse health concerns and problems reported by adolescent students, Jimma Zone, southwest Ethiopia, 1998.**

	Concern[1]		**Problem[2]**		**Statistics**	
	No (n=1467)	**Yes (n=301)**	**No (n=1501)**	**Yes (n=267)**	**^{2}**	**P-value**
Age:						
11-13	66(4.5)	71(23.6)	71(4.7)	66(24.7)	[1]242.08	0.000
14-16	642(43.8)	200(66.4)	665(44.3)	177(66.3)	[2]229.40	0.000
17-19	759(51.7)	30(10.0)	765(51.0)	24(9.0)		
Grade:						

		24(8.0)		18(6.8)	[1]582.42	0.000
7-8	671(45.7)	79(26.2)	677(45.1)	69(25.8)	[2]540.38	0.000
9-10	679(46.3)		689(45.9)			
11-12	117(8.0)	198(65.8)	135(9.0)	180(67.4)		
Literacy: Father:						
Illiterate	489(33.3)	193(64.1)	517(34.4)	165(61.8)	[1]98.61	0.003
Literate	978(66.7)	108(35.9)	984(65.6)	102(38.2)	[2]70.43	0.001
Literacy: Mother:						
Illiterate	588(40.1)	185(61.5)	608(40.5)	165(61.8)	[1]45.53	0.000
Literate	879(59.9)	116(38.5)	893(59.5)	102(38.2)	[2]40.90	0.000
Sex:						
Male	701(47.8)					
Female	766(52.2)					