Original article

Assessment of the levels of communication between youth, parents, peers and teachers about reproductive health issues and HIV/AIDS in Nekemte Town, West Ethiopia

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Abstract

Background: The youth is vulnerable to risky sexual and reproductive health behaviors such as unprotected sexual intercourse and not using family planning that could lead to unfavorable health outcomes. Youth communication can be one of the most effective strategies in reducing risky sexual and reproductive health behaviors.

Objective: To assess levels of communication between the youth and their parents, peers and teachers about reproductive health issues and HIV/AIDS in Nekemte town.

Methods: A cross-sectional community-based study was conducted using both quantitative and qualitative research methods. Four hundred twenty youngsters aged 15-24 years were selected from three sub-cities of Nekemte using simple random sampling procedures. In addition, 12 focus group discussions targeting the youth, parents, governmental and non-governmental employees, religious and elderly people took place in order to complement the quantitative findings.

Results: Overall, 61% of the youth scored the mean and above in four-point scale and considered to have good level of communication on reproductive health (RH) and HIV/AIDS. In the multivariate analysis, age, place of residence, education and income were significantly associated with youth communication.

Conclusion: A good level of communication about reproductive health and HIV/AIDS issue was documented in this study. However, emerging program interventions on reproductive health and HIV/AIDS by various stakeholders need to take into consideration those who have poor level of communication. [*Ethiop. J. Health Dev.* 2012;26(2):86-92]

Introduction

The youth are vulnerable to risky types of sexual and reproductive behaviors such as early initiation or unprotected sexual intercourse, not using family planning that can lead to unfavorable health outcomes like unintended pregnancy, sexually transmitted infections (STIs) and HIV/AIDS because of changing sexual and reproductive health behaviors and exposure to rapidly changing social environments. Communication about reproductive health (RH) issues and HIV/AIDS is one of the strategies used as an effective way to reduce risky sexual behavior and HIV infection among the youth (1-4). The World Health Organization (WHO) defines youth (15-24 years) as the time of development of adult mental process and identity, and transition from total socioeconomic dependence to relative independence (5). Globally, nearly half of all people are under 25 years of age and over a billion are between the ages of 15 to 24 years. Their decisions about education, marriage, sexual relationships and childbirth will have an enormous impact on their lives and, in turn, on their communities and nations (6).

Early sexual initiation and lack of communication with parents about their sexuality may predispose young people to HIV as their chances of having several partners before marriage increases. Young people are particularly vulnerable to HIV infection. The United Nations estimated that about half of new HIV infections worldwide occur among young people ages 15– 24 years (7). Moreover, more than 14 million young women give birth each year, and a large proportion of these pregnancies are unwanted forcing countless girls to drop out of school each day (8-10). Indeed, it has already been documented that the youth are at high risk of HIV infection in Ethiopia (10- 13).

Some studies have indicated that most of the youth get limited information from their parents, peers, and teachers. Basically, girls are more likely than boys to receive advice or be counseled (8-11). However, communication by the youth about their sexuality and HIV/AIDS were associated with low probability for the initiation of early sexual practices and its consequences (1, 3, 4). This indicates that the youth have to learn about family life education (FLE) to be prepared for adult life. As part of family life education, sexuality and HIV/AIDS, education can be approached through parental counseling, peer education, school based programs, and through community-based agents (12, 14-16).

Another study from Ethiopia indicated that parents were unaware of reproductive health issues. For instance, 57% and 40% of parents did not know the correct age range for puberty in males and females, respectively. The same study showed that 74% of parents did not know the safe and unsafe period in the menstrual cycle to prevent unwanted pregnancy. Among all reproductive health issues examined, the highest proportion of parents, who said that they ever communicated with their children, was only 20% (13).

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Several approaches have been employed to provide the youth with communication that helps them develop knowledge, positive attitude and skills to prevent early sexual practices and its consequences including HIV infection (3, 4). However, the level of communication between parents and their children about reproductive health and HIV/AIDS is not well explored in many developing countries like Ethiopia and this study was aimed to fill the gap.

More importantly, the study took place in Nekemte where the youth are at risk of HIV infection as the town is the route of traveler from different directions. Additionally, the prevalence of HIV/AIDS among antenatal care attendants in the town is increasing from time to time (9.1% in 2001 and 13% in 2003 (17).

Methods

The study was conducted in Nekemte, East Wollega Zone of Oromiya Region. The town is located 331 kilometers away from Addis Ababa to the west. The town is a transit hub for travelers from Benishangul-Gumuze region to Addis Ababa, Jimma to Bahir Dar the capital of the Amhara region. The town is administratively divided into 6 sub-cities and had an estimated total population of 93,007 at the time of the survey. The youth number constituted 28,832 based on the assumption that 31 % of the total populations are youth (18).

A community-based cross-sectional study involving both quantitative and qualitative methods was undertaken from April- June 2008. The quantitative data were used to assess the levels of communication of the youth about sexuality and HIV/AIDS. Focus group discussions (FGD) were used to elicit the qualitative data in order to complement the data that were generated by the quantitative survey and to elaborate issues that were not clearly reflected by the quantitative data. All the members of the youth (males and females) aged 15- 24 years residing in all the six-sub-cities of Nekemte were considered as the source population. The study populations in particular were youth living in three randomly selected sub-cities for a minimum of six months prior to the survey.

For the quantitative method, the sample size was determined using single proportion sample size calculation formula. The assumptions for the sample size calculation were: proportion of youth (P) who had good communication level about sexual matters with their parents 50% (because of lack of related study in the study area), 95% CI, and margin of error of 5%. This would give a sample size of 384. Adding 15% non-response rate, the total sample size was calculated to be 442 individuals.

Three sub-cities from the total six were randomly selected using EPI- Table calculator of EPI- Info version 6.04. All households in the selected sub-cities were registered through a house-to-house survey. Households with at least one young member aged 15-24 years old, who lived for the preceding six or above months in the town prior to enumeration were selected for inclusion into the sampling frame and probability proportionate to size was employed to allocate households to the three sub-cities. Every 4th households was visited to select the eligible youngster and in cases where there were more than one eligible in the household, only one was selected using a lottery method. Three attempts at different days were done to find eligible youth from the selected household before going to take from the adjacent households in case of absents.

Young people, who had completed high school, collected the quantitative data using structured questionnaire administered by an interviewer. The questionnaire was adapted from WHO standard questionnaires (19). The English version of the questionnaire was translated into *Afan Oromo* and back translation was done to insure consistency. The questionnaire was pre-tested and appropriate modifications were made. Informed verbal consent was obtained from each individual respondent before the interview.

Twelve focus group discussions were conducted after purposively selecting the participants from the study area. The FGD participants were both female and male youth, elderly, religious people from government and non-government employees in the town who directly or indirectly had communication with the youth. Each group consisted of six to ten participants and the discussions lasted from 1.30 to 2.00 hours. The total number of persons that participated in the discussions was 96. Trained female social workers and high school teachers in the town moderated the female group while trained male social workers with the principal investigator facilitated the male FGDs.

The quantitative data were entered and analyzed using SPSS for Windows version 15. Level of communication was measured between the youth and their parents, peers, brothers/sisters and teachers using five communication-related closed ended questions. The questions focused on puberty, methods of contraception, pregnancy, HIV/AIDS and other sexually transmitted infections using a four-point scale as: 1= never 2= sometimes 3= usually and 4= always. Mean score was computed and the level of communication were dichotomized into good and poor. Those respondents, who scored the mean and above were considered to have good level of communication. In this study, communication refers to the exchange and sharing of information, attitudes, and ideas among youth and with their parents, peers, and teachers regarding reproductive health issues and HIV/AIDS.

Significance level of association was assessed using chi-square test and 95% confidence level. Those variables that showed significant association at bivariate analysis

($P< 0.05$) were selected and entered one at a time into the model for further binary logistic regression analysis. Odds Ratio was used to explain the unadjusted and adjusted effects of predictor variables. The assumptions of logistic regression were checked to be satisfied.

Qualitative study was analyzed using thematic approach. Themes arising from the summary were used to write the text and were used complement the quantitative results and discussions.

Ethical clearance was obtained from the ethical committee of the Faculty of Health Science, Wollega University. Formal permission and consent was also obtained from the Nekemte town local government and the respective sub-city officials. The participants were informed that participation was voluntary. Strict confidentiality was assured through anonymous recording and coding of questionnaires and placing them in a secure place. Copies of the study report were given to Wollega University and to different levels of local government in the study area.

Results

A total of 420 male and female members of the youth aged 15– 24 years old participated in the study giving a response rate of 95.0%.

Socio-demographic Characteristics

Over half, 229 (54.5%) of the respondents were in the adolescent age range of 15– 19 years. The mean age of the respondents was 19.2 years (± 2.7 SD). Three hundred sixty six (87.1%) were never married and the majority, 240 (57.1%) were female. More than half, 221 (52.7%) had attended secondary level of education while those who had no formal education constitutes 24 (5.7%). School attendant at the time of the survey was 337 (80.2%). About half, 217 (51.7%) of the participants all reside had all their life in Nekemte while others had migrated to the town from other places (Table 1).

Two hundred forty four (58.1%) of the respondents were currently living with their parents. The median family (own) monthly income was calculated to be ETB 915 and 279 (66.4%) of the study participants family were earning income level below the median. Furthermore, 283 (67.4%) of the respondents family were perceived to have an average income comparable to their neighbors in the village (Table 2).

Level of Communication of Respondents about Reproductive Health and HIV/ADS

Respondents were asked whether they had ever discussed reproductive health and HIV/AIDS with their families, peers and teachers. More than 80% of the respondents had discussed signs of puberty, contraceptive methods, pregnancy, and STIs / HIV/AIDS. As indicated in Table 3, the majority, 191 (46%) and 292 (70%) of the respondents reported having discussed the afore-mentioned RH issues and HIV/AIDS with their teachers in school and peers, respectively. While less than a fifth, 78 (19%) had communicated with their parents either mother or fathers. However, more than three in four of the youth who had never discussed RH and HIV/AIDS with anybody reported that they felt shy to do so (Fig 1). This is supported by the results from focus group discussions which indicated that the majority of the youth discussed RH and HIV/AIDS with their teachers and peers than their families. Few of them mentioned that it was not culturally accepted to discuss RH and sexuality with their biological mothers and fathers, but few mentioned that their parents indirectly communicated messages by using some sayings and proverbs. For example:

"*take care of yourself, otherwise no one will care for you*". (a 23 year old married woman)

Another 18-year old unmarried young lady mentioned her mother's saying to her: "*when honey is kept for a long period of time it will be good*" to stress the mportance of premarital abstinence for her daughter.

Few discussants from the youth groups also mentioned the reason, for not communicating with their parents and community elders about reproductive health specifically sexually transmitted infections including HIV/AIDS was that they considered it as wrong. Instead they prefer to discuss with their friends and peers of the same ages. For example:

A 20 years old unmarried young man said: "*it is good to discuss with peers of the same age*" and stress the selection of friends because they feel ashamed to discuss with adults as it is considered a sin and a wrong deed by their parents.

However, the majority of discussants mentioned the youth learn bad behavior from bad friends and stressed the importance to this is the selection of friends.

Nevertheless, the majority of discussants of parents mentioned to having communication with their children about HIV/AIDS than about RH issues, because they had been hearing and learning about HIV/AIDS from different sources. Some parents mentioned that they participated in the trainings and meetings about reproductive health including HIV/AIDS. For example, a 49 years old male discussant mentioned that he was always discussing HIV/AIDS with his family and peoples in his village as he was working as a focal person in home based care with Organization for Social Services for AIDS (OSSA) a non-governmental organization working in the area. He mentioned that he always transmitted information about HIV/AIDS saying "*people face a problem when they have no knowledge of it*". This was to expresses the importance of raising the awareness of the family about reproductive health and HIV/AIDS.

The level of the communication score of the respondents on signs of puberty, contraceptive methods, pregnancy, HIV/AIDS and other sexually transmitted infections was computed and showed, that the majority, 254 (60.5%), scored the average and above and considered to have a good level of communication about reproductive health and HIV/AIDS. Whereas, 166 (39.5%) of the respondents scored below the mean and seen as having a poor level of communication about RH and HIV/AIDS (see Table 3).

Table 1: **Distribution of socio–demographic characteristics of Respondents (n= 420), Nekemte Town, April- June 2008**

Variables(N=420)	Response category	Number	Percent
Age	15 – 19 yrs	229	54.5
	20 – 24 yrs	191	45.5
Sex	Male	128	42.9
	Female	240	57.1
Place of grownup	Nekemte town	217	51.7
	Other urban town	155	36.9
	Rural	48	11.4
Marital status	Never married	366	87.1
	Married	45	10.7
	Others†	9	1.5
Religion	Protestant	166	39.5
	Orthodox	165	40.0
	Muslim	59	14.0
	Others*	27	6.5
Ethnicity	Oromo	355	84.5
	Amara	45	11.7
	Others	20	4.5
Current occupation	Student	337	80.2
	No work	30	7.1
	Private business	23	5.5
	Others (government employee, house maid)	30	7.1
Grade level	No education	17	4.0
	Read & write	7	1.7
	Primary (1 - 8)	82	19.5
	Secondary (9 – 12)	221	52.7
	College and above	93	22.1

N.B- Others include † divorce, widowed, separated, * *Catholic, Wakefata, Adventist,* ** Gurage, Tigre, Kambata

Table 2: **Distribution of living arrangement and income of youth in Nekemte Town, April- June 2008**

Variables (n=420)	**Response category**	**Number**	**Percent**
Currently living with	Both parents	168	40.0
	One parent only	76	18.1
	Relatives	58	13.8
	Spouse	118	28
Family or own monthly income (Birr)	300	114	27.1
	301 – 600	85	20.2
	601 – 1200	127	30.2
	> 1200	94	22.4
Perception of family economic status compared to their neighbor	Very poor	21	5.0
	Poor	81	19.3
	Medium	283	67.4
	Rich	27	6.4
	Very rich	5	1.2
	Do not know	3	0.7

Table 3: **Distribution of communication, person communicated and level of communication of respondents about R/H and HIV/AIDS with family, peers and teachers, Nekemte Town, April- June 2008**

Variables	Response category	Frequency	Percent
Ever communicated about contraception (n=418)	Yes	333	79.3
	No	85	20.2
The person ever communicate about contraception (n=333)	Parents(father/mother)	78	23.4
	Sister/brother	84	25.2
	Teachers	191	57.4
	Peers/friends	292	87.7
	Others*	16	4.8
Ever communicated about changes in menstruation/ wet-dream during puberty (n=420)	Yes	336	80.0
	No	84	20.2
The person communicated about Puberty (n=336)	Parents(father/mother)	58	17.3
	Sister/brother	87	25.9
	Teachers	130	38.7
	Peers/friends	285	84.8
	Others*	3	0.9
Ever communicated about pregnancy (n=420)	Yes	341	81.2
	No	79	18.8
The person communicated about pregnancy (n=341)	Parents(father/mother)	64	18.8
	Sister/brother	69	20.3
	Teachers	164	48.1
	Peers/friends	287	84.2
	Others*	8	2.3
Ever communicated about HIV/AIDS (n=420)	Yes	397	94.5
	No	23	5.4
The person communicated about HIV/AIDS (n=397)	Parents(father/mother)	189	47.6
	Sister/brother	131	33.0
	Teachers	276	69.5
	Peers/friends	371	93.5
	Others*	7	1.8
Ever communicated about STIs (n=418)	Yes	375	89.7
	No	43	10.3
The person communicated about STIs (n=375)	Parents(father/mother)	35	9.3
	Sister/brother	72	19.2
	Teachers	228	60.8
	Peers/friends	319	85.1
	Others*	7	1.9
Level of Communication of RH/HIV/AIDS (n=420)	Good communication	254	60.5
	Poor communication	166	39.5

NB: Others* include: Stranger, relatives

Factors Affecting the Level of Communication of RH including HIV and AIDS

Compared with youth aged 15-19 years of age, those aged 20- 24 years had reported significantly increased likelihood of having good communication [AOR (95% CI): 1.5 (1.2, 1.7)]. Moreover, of the youth brought up in Nekemte had an increased likelihood of having good communication [AOR (95% CI): 1.7 (1.6, 1.8)] than those who came from rural areas. In addition, compared to the uneducated respondents, those who attended grades 11 to 12 and college or above were nearly two times [AOR (95% CI): 1.7 (1.0, 1.9) and OR (95% CI):1.7 (1.6, 2.0)] more likely to communicate about RH/HIV and AIDS. Again the level of communication increased with monthly family or own income. Families or respondents earning monthly an income of ETB 301-600 [AOR (95% CI): 1.5 (1.4, 1.8)] and 601- 1200 were [AOR (95% CI): 1.7 (1.3, 1.8)] more likely to communicate about RH/HIV/AIDS than respondents whose families or own monthly income was less than ETB 300.

Table 4: **Factors associated with level of communication among youth in Nekemte Town, April - June 2008**

Variables	Level of communication		COR (95% CI)	AOR[A] (95% CI)
	Poor (%)	Good (%)		
Age group				
15- 19 years				
20- 24 years	113(49.3)	116(50.7)	1.00	1.00
	53 (27.7)	138(72.3)	**1.62 (1.42, 1.75)****	**1.49(1.19, 1. 69)***
Place of growing-up				
Nekemte town	92(42.4)	125(57.6)	**1.43 (1.14, 1.64)***	**1.67 (1.56, 1.79)***
Other towns	45(29.0)	110(71.0)	**1.69 (1.38, 1.85)****	1.58(0.77, 3.24)
Rural area	29(60.4)	19(39.6)	1.00	1.00
Education				
No education	11(64.7)	6(35.3)	1.00	1.00
Read and write	5(71.4)	2(28.6)	1.36 (0.20, 9.28)	1.84 (0.25, 13.38)
Primary (1-8)	45(54.9)	37(45.1)	1.44 (0.22, 1.97)	1.33(0.73, 2.68)
Grade 9^{th} -10^{th}	68(44.2)	86(55.8)	1.61 (0.15, 1.72)	1.42(0.81, 2.11)
Grade 11^{th} -12^{th})	17(25.4)	50(74.6)	**1.82(1.42, 1.94)***	**1.71(1.01, 1.91)***
College and above	20(21.5)	73(78.5)	**1.85 (1.49, 1.99)****	**1.72 (1.55, 1.91)***
Perception of wealth				
Poor	57(55.9)	45 (44.1)	1.00	1.00
In between	97(34.3)	186 (65.7)	**1.59(1.35, 1.64)****	1.23 (0.62, 1.46)
Rich	9 (28.1)	23 (71.9)	**1.69 (1.27, 1.87)***	1.65 (0.82, 1.76)
Income				
Less than 300	66(57.9)	48(42.1)	**1.00**	**1.00**
301- 600	24(28.2)	61(71.8)	**1.71 (1.48, 1.84)****	**1.51 (1.45, 1.75)***
601- 1200	45(35.4)	82(64.6)	**1.60 (1.33, 1.76)***	**1.66 (1.31, 1.83)***
> 1200	31(33.0)	63(67.0)	**1.64 (1.37, 1.80)****	1.35(0.81,1.83)

NB- COR-Crude Odds Ratio, AOR- Adjusted Odds Ratio; [A]djusted for the variables in the table
* P- Value <0.05, ** P- Value <0.001

Discussion

This community based study used a representative sample of male and female youngsters 15- 24 years of age in Nekemte to estimate the level of communications of RH and HIV/AIDS with their families, peers, and teachers and the factors affecting such communication. Nearly 61% of them in the study community had a good level of communication and about 80% communicated at least about one of the five RH/HIV/AIDS topics.

The majority of them communicated or discussed about the use of family planning with their peers and teachers in school. However, only 23.4% of the respondents had ever communicated with their parents, i.e., mother or father. This is consistent with the findings of Taffa N et al., in Ziway, where 20% of the parents said that they did communicate with their youth offspring's only (13). This was in agreement also with the study from South Africa and Zambia, which revealed that the youth couldn't easily share their feelings with their parents because they feel uncomfortable when talking about reproductive health issues (14, 15).

Overall, the quantitative findings of this study were in line with the findings from the focus group discussions for which the majority of discussants from the family group mentioned having discussions with their children about reproductive health and focusing more on HIV/AIDS. This is because nowadays they are hearing from different sources and some have also participated in the trainings and meetings on this issue. But this did not agree with the study in Bergen in which the young people trusted their parents for more reliable reproductive health information than their peers (16).

Most of the respondents preferred peers and teachers to their families for information about reproductive health. The most cited reasons for not communicating with anybody were being shy. This implies that there may be poor relationship or not a conducive environment in the family because of cultural influences. Other study findings in Ethiopia have indicated that parents were ignorant of reproductive health issues and did not know the correct age range for puberty. Moreover, in the same study, 74% of parents did not know the safe period and unsafe period of the menstrual cycle (13). The role of age and education in promoting youth communication about reproductive health and HIV/AIDS is supplemented by the results from FGDs where the majority of adults and elderly discussants mentioned that as the age and level of education of the youth increased they did not hesitate to talk about reproductive health and HIV/AIDS especially with their parents.

In conclusion, this study clearly indicates that three out of every five members of youth had a good level of communication about reproductive health and HIV/AIDS with most of them preferring to communicate with their peers and teachers than their parents. The age of the young, people places of residence, education, and income were factors significantly associated with level of communication of the youth about reproductive health

and HIV/AIDS. This emerging program interventions of reproductive health and HIV/AIDS prevention need to take into consideration this in order to address effectively the full context of the life of the youth including factors associated to these issues. Moreover, system design, a coherent strategy and program for youth-friendly services need to help improve the level of communication about reproductive health and HIV/AIDS.

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