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Parents-adolescents Communication and HIV/AIDS in Jos North Local Government Area, Plateau State, Nigeria

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A cross sectional descriptive study of four hundred and fifty-nine early adolescent secondary school students aged between ten and fourteen years in Jos North Local Government Area of Plateau State, Nigeria was conducted to assess parent-adolescent communication on HIV/AIDS. The study revealed that only 27.2% of the respondents communicate with their parents on sexual issues, even though they confided in their mothers more with obvious communication barrier due largely to inadequate knowledge on the part of the parents. It is therefore recommended that parent-child communication about HIV/AIDS should start early. Advocacy and education of political, religious, community leaders and parents through civil society and community based programmes are important in redefining social norms. Family Life Education (FLE) should appropriately be made mandatory in secondary schools with legislation to enforce it.

Key words: Parents, adolescents, communication, HIV/AIDS

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INTRODUCTION

Adolescence is the period of transition from childhood to adulthood. According to WHO definition, it spans the ages of 10 to 19 and is sub-divided into two periods-early adolescence (10-14 years) and late adolescence (15-19 years) (CP, 2000). Youth is defined as a person between the age 14 and 20 years while a young person is between 15 and 24 years (CP, 2000).

It is estimated that young people between ages 13 and 25 contract HIV at the rate of two per hour (THE WHITE HOUSE, 2000). Approximately half of the HIV-infected population in 2002 was between the ages of 15-24 years (Unaids, 2002). In Sub Saharan Africa during the year 2001, estimated 6-11% young women aged 15-24 years were living with HIV/AIDS (Unaids, 2002). In countries with generalized epidemics in Africa, up to 50% of women aged 15-24 years have been shown to lack knowledge about HIV/AIDS (Unaids, 2002).

Current research shows that communication about sexuality is time and energy well spent. Ongoing communication with teens is important and may serve as a buffer against their participation in risk taking behaviour (CDC, 1999). Many adolescents want to talk to their parents about HIV infection and taking sexual risks but find it difficult to communicate these sensitive topics. Hence infection with the acquired immune deficiency syndrome is an urgent problem with several implications. The societal and economic impacts of HIV/AIDS are becoming issues of great concern as the pandemic continues to spread.

Population and family life education including sexuality education is not taught in most schools despite the fact that a relevant curriculum has been designed and approved for Nigerian secondary schools (Kola and Idris, 2002).

There is often debate and discussion about the role of parents and schools in relation to the education of children about HIV/AIDS. There is only sparse research on parent-child relationship and communication. This is the first study carried out to assess the knowledge, behavior and parent-adolescent communication among early Nigerian adolescents in Plateau State targeting junior secondary school students in Jos North Local Government Area, Plateau State.

According to a University of California study, good parent-child communication on topics such as sex and HIV could greatly enhance the value of prevention messages to youth and the study pointed out the great need to design more programs to involve parents in their teens' education (Machel, 2001).

Ninety-two percent of parents now say they believe that they should play a significant role in informing young

people about sex and relationships (CDC, 2000). A further two-thirds mentioned teachers as important sources of information. This contrasts sharply with a 1994 study that showed parents found it difficult to discuss sex with their children-only half of the parents interviewed said they broached the subject with their own offspring. Some people believe talking to your children about sex encourages early sexual activity. However, all evidence points to the fact that when children are given good sex education and informed choices, they tend to delay actual sexual activity as seen in a study done among young girls of average age fourteen years in Hertfordshire and in West County, United States of America. It was also shown that it is equally important education starts before children notice changes, both anatomically and emotionally, in him or her (Azuzu, 1994).

When young people feel unconnected to home, family and school, they may become involved in activities that put their health at risk. However, when parents affirm the value of their children, young people often develop positive, healthy attitudes about themselves (Ryst-Van-Der and Joubert, 2001). In many African societies, socio-cultural norms define sexuality as taboo, allowing only ceremonial rites or authorized persons such as aunts or uncles to approach the subject with young people. Now with urbanization and modernization, traditional approaches are compromised. The role played by community appointed teachers must now be assumed in part by family and in particular by parents (Kola and Idris, 2002).

A multi-year study assessing the effectiveness of a parent based HIV risk reduction programme targeting pre-adolescent children.

Looking at 375 parent-child pairs it was found that even though only parents received training, positive outcomes were seen in children in terms of functional HIV knowledge and understanding, unrealistic HIV worry, comfort in interacting with HIV patients and risk reduction avoidance interventions (Godfrey and Krauss, 2003).

Among women surveyed in America, nearly half reported feeling somewhat or very uncomfortable discussing sexuality with their parents. However the same young women reported wishing their mothers (97%) and fathers (87%) had shared more information with them about sexuality (Hutchison and Cooney, 1998).

Another study on 907 adolescent (aged 14-17)-mother pairs recruited from public high schools in San Juan, Puerto Rico; Montgomery, Alabama and the Bronx, New York showed mothers who were skilled communicators about sex-related topics were more likely to discuss a broad range of sex-related topics with their adolescents and were more likely to be heard by their adolescent during those discussions (CDC, 1998).

Talking to teens about physical, biological and sexual changes and their impact is uncomfortable but the issue of sex should be a part of the infamous talk during adolescence. Increased and improved communication between adults and teens about sexuality has been linked to delay timing of first intercourse and increased likelihood of adolescent contraceptives (Miller, 1998).

A study done in November 2001 among 1425 adolescent youths in South Africa, parents reported higher levels of communication than teenagers (56% compared to 45%) (Manzini *et al.*, 2004). Among 57% parents that agreed open communication reduces HIV, 39% had not talked to their children. Like other studies, findings showed parent-teen communication on sexual issues reduce risk-taking behaviour (Manzini *et al.*, 2004). The Health Belief Model (Becker and Maiman, 1975), an extensively studied model of health behavior change, points that individuals must perceive themselves to be at risk of the health threat before they will take actions to reduce risky behaviors or to engage in healthy alternative behaviors. The role of perceived susceptibility when high has indicated such individuals practice safer sexual behaviors (Villarruel and Jemmot, 1998). This must be coupled with accurate knowledge in order to bring about behavioral change. Another factor of the Health Belief Model is the role of self-efficacy of which an element-confidence is one of them-that is confidence in practicing safe sex (Villarruel and Jemmot, 1998).

In Nigeria, Information, Education, Communication [IEC] on sexual health issues including HIV has many hindrances like religion and culture that makes the war against HIV more difficult. There is an assumption on the part of parents that their adolescent children have sexual health education maybe from schools. Teachers however do not have the information and skills to provide the information and education adolescents require on HIV. Few students get information from their schools. This is rampant all over Africa (Kasule and Mbizuo, 1997). In a study done in Lagos state where a significant number of students were involved (20.6% of total number of respondents), only 4.5% of students got their information from their schools (Kasule and Mbizuo, 1997). In a study in Kenya over three-quarters of parents of children of ages 10 to 14 said that adolescents should be taught in school about HIV/AIDS and other STI's (Reaching out, 2004).

A paper that reviewed existing forms of parent-child communication concluded that apart from involving religious groups, community leaders, school guidance counselors parent- child communication on sexual health issues is an important vehicle through which IEC on HIV/AIDS can be effectively provided to prevent further

spread of infection among children and adolescents because of the cultural and religious setting in Nigeria (www.ias.sc/bangkok/admin/images/upload/428.pdf).

In Lome, Togo, a descriptive larger population based cross-sectional study that assessed attitudes, behaviors of adolescents aged 10-24 years showed that adolescents who communicated with either parent specifically about STIs/HIV are more likely to use contraception particularly condoms than adolescents who communicate about other reproductive health issues (Machel, 2001).

African American female adolescents reported more discussions about sex-related topics with their mothers than did male adolescents (Ryst-van-der and Joubert, 2001). This is consistent with research done in Kuwait where mothers of black adolescents are the primary parental communicators about sexual topics (AL-Owaish and Moussa, 1990).

Jos North Local Government in Plateau state was chosen as the LGA as it constitutes about one-fifth of the population of the state and is the most densely populated LGA having a high prevalence rate of AIDS of 6.3% (2003 National HIV Sero-prevalence Sentinel Survey).

The objective of this research was to generally assess parent- adolescent communication and HIV/AIDS and specifically to determine factors that influence communication between parents and adolescents on HIV/AIDS IN Jos North Local Government Area of Plateau State.

MATERIALS AND METHODS

This study was carried out between April, 2004 and July, 2004 in Jos North local government area, one of the 17 Local Government Areas (LGA) of Plateau state of Nigeria. It was created in 1991 as a result of the split of the former Jos Local Government Area into two namely Jos North and Jos South (Jos North Local Government, 2001).

Located in the middle belt (North Central) region of Nigeria, Jos North Local Government Area is bounded in the East by Jos East Local Government Area; to the South by Jos South Local Government Area; to the West by Bassa Local Government Area and to the North by Bauchi State (Jos North Local Government, 2001). It is strategically located by nature on the high altitude of the Plateau covering 285 square kilometers of land (Jos North Local Government, 2001).

Jos North Local Government Area has a cool temperate climate between 81.7 degree Fahrenheit maximum and 51.7 degree Fahrenheit minimum. It has a mean annual rainfall of between 131.75 and 146.0 cm, mostly in the months of May-August. This climate has attracted a lot of visitors from all areas of Nigeria, as well

as foreign investors hence the state has been coined home of peace and tourism (Jos North Local Government, 2001).

Secondary schools: Majority of the secondary schools in Plateau state are located in Jos North Local Government Area. Out of a total of 94 secondary schools, 68 are private-owned and 26 are government schools. Out of this 26 government schools, 3 are boarding schools. Of the 23 government (state owned) day schools, three are Senior Secondary schools only. The remaining 20 government day schools are both Junior and Senior Secondary schools and all the schools are mixed (both boys and girls).

Study design: It is a descriptive cross-sectional study of State-owned Day Junior Secondary Schools (JSS 1 and JSS 2) Students (Ercr, 2004) in Jos North Local Government Area of Plateau State.

Study population: Comprised of all JSS 1 and JSS 2 (state owned) Day Junior Secondary School students chosen by the inclusion criteria of students in the early adolescent age group of 10-14 years and living with either one or both parents in Jos North Local Government Area of Plateau State. A pilot study conducted prior to this indicated that majority of the students of ages 10-14 years fell into the class bracket of Junior Secondary School classes, JSS 1-2. This comprised of 20 state owned day secondary schools each of which fell into the four health districts (clusters) (Ercr, 2004).

Each JSS 1 and JSS 2 class in each school had an average of approximately 60 students, giving a total study population of roughly 2500 students.

Sample size calculation: As the definite population size of the study population is not known the finite correction was not made use of in the calculation of the sample size.

As the population of the study population was less than 10,000, we had to find the desired sample size when the population is more than 10,000 (n) first before calculating the final sample estimate (nf) (Araoye, 2003).

$$n = \frac{z^2 pq}{d^2}$$

Where,

n = sample size

p = Proportion of students aware of HIV/AIDS. 50% (that is 0.50)

q = Proportion of students unaware of HIV/AIDS = 1 - p = 50% = 0.50.

z = Standard normal deviation = 1.96 but if we approximate the z statistic to the nearest whole number for convenience it is 2.0,

d = Degree of accuracy desired and was taken as 5% = 0.05

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$n = \frac{3.8416 \times 0.5 \times 0.5}{0.0025} = 384 \cong 400$$

For populations <10,000

$$nf = \frac{n}{1 + \frac{n}{N}}$$

Where,

nf = The desired sample size when the population is less than 10,000.

n = The desired sample size when the population is more than 10,000.

N = The estimate of the population size.

$$nf = \frac{400}{1 + \frac{400}{2500}} = \frac{400}{1.16} = 345$$

Adding 40% to correct for attrition, 345 + 135 = 480.

Sampling technique: The sample contained sample units drawn from all 4 clusters (health districts) of Day Junior Secondary Schools in Jos North Local Government Area of Plateau State. The sample was drawn using the 3-stage cluster sampling technique. The primary sampling units were the Day Junior Secondary Schools; the secondary sampling units were the Junior Secondary 1 and Junior Secondary 2 classes in the selected secondary schools while the tertiary sampling units were the individual students in the selected classes.

1st stage: Three schools by simple balloting were selected from each of the four clusters (health districts) viz.,

Township district

- Government Secondary School Township (GSS Township)
- Government Junior Secondary School Gangare (GJSS Gangare)
- Government Junior Secondary School Laranto (GJSS Laranto)

Naraguta district

- Government Secondary School Babale (GSS Babale)
- Government Secondary School Naraguta (GSS Naraguta)
- Government Secondary School Yelwa Zangam (GSS Yelwa Zangam)

Nasarawa district

- Government Secondary School Lamingo (GSS Lamingo)
- Government Secondary School Jos Jarawa (GSS Jos Jarawa)
- Government Secondary School Rikkos (GSS Rikkos)

Tudun Wada District

- Government Secondary School Kabong (GSS Kabong)
- Government Secondary School Utan (GSS Utan)
- Government Junior Secondary School TudunWada (GJSS TudunWada)

2nd stage: Junior Secondary 1 and 2 classes. Where there were more than one stream per class, simple balloting was done to choose one stream.

3rd stage: Twenty students were to be taken from each junior secondary one and two class by simple random sampling (using the random table of numbers) Every student was given a number starting from 01 to the last number depending on the number of students in the class. Using the table and starting from the 6th row, 1st column, the number 16 was taken (1st student who had that number) and then the 2nd child with the number 17. This was continued going horizontally along the table till 20 children were picked.

Data collection technique: This was done by the administration of self-administered questionnaires containing closed and open-ended questions (Appendix II). Questions on parent/adolescent communication followed the Millers (1998) and the answers of the Likert scale type. Questionnaires were structured to assess knowledge, behaviour and parents-adolescent communication in the junior secondary classes. With the assistance of health workers (interviewers), respondents were given uniform instructions.

Data analysis: This was done with the aid of SPSS computer statistical software package and Microsoft excel

® computer software to facilitate graphical and pictorial representation of observations. Tables and graphs were drawn where applicable and appropriate. Statistical tests such as χ^2 were used to test the existence of a relationship between two variables. A p-value of < 0.05 was accepted as significant.

Ethical considerations

- Consent was sought from Local Government Area and school authorities and a detailed explanation of study given to them (Appendix III).
- Consent was also sought from individual students involved in the study.
- Individuals offered choice of opting out of the study at any point in time.
- Confidentiality of respondents was strictly ensured (as indicated on top of the questionnaire).

RESULTS

Personal data: Table 1 shows of a total of 459 students, 54.7% were males and 45.3% were females. Majority of respondents were of 14 years of age (54.9%).

Majority (30.1%) of the respondents were Hausas followed by the Biroms (18.3%). The Afizere constituted 7.4% while the Irigwe were the least in number. Majority (22.8%) of the respondents were Hausa Muslims followed by Berom Christians (13.9%) (Table 2).

Majority of the respondents live with both parents (87.4%), while 3.5% live with only their father and majority of the respondents (89.3%) were staying with their parents since birth; a minority (1.2%) stayed with their parents for less than 5 years (Table 3).

Parents-adolescent communication: Sex (21.2%) was the least of the issues talked to respondents by their parents (Table 4).

Of those who had engaged in sex, 27.0% only had been talked to by their parents about HIV/AIDS and 5.4% about sex (Table 4). There is a significant difference between sexual exposure and if children were talked to by parents (Table 5). There was one non-response.

Family interaction: Fifty six point two percent agreed that schools should play a role (Table 6).

Forty-two point seven percent of respondents thought group discussions between school and parents desirable (Table 7).

Forty-two point one percent 42.1% of respondents confided in their mothers and then their teachers (38.1%) (Table 8).

Table 1: Age and sex distribution of respondents

Age	Sex		Total (%)
	Male (%)	Female (%)	
10 years	10(4.0)	4(1.9)	14(3.1)
11 years	31(12.4)	21(10.1)	52(11.3)
12 years	22(8.8)	29(13.9)	51(11.1)
13 years	45(18.0)	45(21.5)	90(19.6)
14 years	142(56.8)	110(52.6)	252(54.9)
Total	250(100.0)	209(100.0)	459

Table 2: Distribution of respondents by tribe and religion

Tribe	Frequency			Total	(%)
	Muslim	Christian			
Hausa	105	33		138	30.1
Berom	20	64		84	18.3
Anaguta	4	48		52	11.3
Yoruba	19	31		50	10.9
Igbo	8	41		49	10.7
Afizere	5	29		34	7.4
Others	12	18		30	6.5
Irigwe	2	20		22	4.8
Total	175	284		459	100.0

Table 3: Distribution of respondents according to whom they have been living with and for how long

Time	Frequency			Total	(%)
	Since birth	5-10 yrs	<5 yrs		
Both	400	1	-	401	87.4
Mother only	9	30	3	42	9.1
Father only	1	13	2	16	3.5
Total	410	44	5	459	100.0

Table 4: Response of sexually active respondents to the issue of AIDS been talked with them by parents

Issue	Have you ever had sex		Total	(%)
	Yes (%)	No (%)		
Not talked to about AIDS	108(73.0)	225(73.0)	333	72.7
Talked to about AIDS	40(27.0)	85(27.0)	125	27.3
Total	148(100.0)	310(100.0)	458	100.0

$\chi^2 = 7.1$ $p < 0.05$ $df = 1$

Table 5: Response of sexually active respondents to the issue of sex been talked with them by parents

Issue	Have you ever had sex		Total	(%)
	Yes (%)	No (%)		
Not talked to about sex	140(94.6)	226(72.9)	366	79.9
Talked to about sex	8(5.4)	84(27.1)	92	20.1
Total	148 100.0	310 100.0	458	100.0

$\chi^2 = 0.008$ $p < 0.05$ $df = 1$

Table 6: Perception of respondents on whether school authority can influence communication between parent and adolescents

Opinion	Frequency (%)
Strong disagree	69(15.0)
Disagree	34(7.4)
Neutral	31(6.8)
Agree	258(56.2)
Strong agree	67(14.6)
Total	459(100.0)

Most respondents agreed mothers and fathers hold back information and would not be honest with them (Table 9).

Table 7: Perception of respondents on best approach to influence parents involvement in communicating sex with adolescents

Method	Frequency (%)
Group discussions between parents and school	196(42.7)
Media	80(17.4)
Others	79(17.2)
Run programs	62(13.5)
Face to face between parents and school	42(9.2)
Total	459(100.0)

Table 8: Person whom respondent confided in

Person	Frequency (%)
Mother	193(42.1)
Teachers/school	175(38.1)
Father	51(11.1)
Friends	40(8.7)
Total	459(100.0)

Table 9: Response of respondents on the opinion father/mother holds back information/would not be honest with me

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	27(5.9)	8(1.7)
Disagree	56(12.2)	48(10.5)
Neutral	1(0.2)	3(0.7)
Agree	315(68.6)	304(66.2)
Strongly agree	60(13.1)	96(20.9)
Total	459(100.0)	459(100.0)

Table 10: Response of respondents on the opinion father/mother understand and care about my feelings

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	1(0.2)	52(11.3)
Disagree	53(11.5)	48(10.5)
Neutral	4(0.9)	2(0.0)
Agree	320(69.7)	293(63.8)
Strongly agree	81(17.7)	64(13.9)
Total	459(100.0)	459(100.0)

Table 11: Response of respondents on the opinion mother/father just too preoccupied to talk to me about sex

Responses	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	49 (10.7)	138 (30.1)
Disagree	62(13.5)	86 (18.7)
Neutral	62 (13.5)	17 (3.7)
Agree	274 (59.7)	126 (27.5)
Strongly agree	12 (2.6)	92 (20.0)
Total	459 (100.0)	459 (100.0)

Majority of respondents agreed mothers (69.7%) and fathers (63.8%) understand and care about their feelings (Table 10).

Thirty point one percent strongly disagree fathers are too preoccupied to talk to them about sex but agree (59.7%) that mothers are too preoccupied with work to talk to them about sex (Table 11).

Table 12: Response of respondents on the opinion mother/father would argue if I were to talk about sex

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	82(17.9)	56(12.2)
Disagree	51(11.1)	95(20.7)
Neutral	57(12.4)	35(7.6)
Agree	191(41.6)	273(59.5)
Strongly agree	78(17.0)	-
Total	459(100.0)	459(100.0)

Table 13: Response of respondents on the opinion my mother/father doesn't know enough for me talk about sex

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	43(9.4)	12(2.6)
Disagree	64(13.9)	3(0.7)
Neutral	58(12.6)	47(10.2)
Agree	207(45.1)	299(65.1)
Strongly agree	87(19.0)	98(21.4)
Total	459(100.0)	459(100.0)

Table 14: Response of respondents on the opinion if I talk about sex, he/she will think I might be interested in experimenting with sex

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	42(9.2)	3(0.7)
Disagree	26(5.7)	1(0.2)
Neutral	254(55.3)	138(30.1)
Agree	82(17.9)	120(26.1)
Strongly agree	55(11.9)	197(42.9)
Total	459(100.0)	459(100.0)

Table 15: Response of respondents on the opinion I really don't want to talk to my mother/father about sex: I know what I need to know

Response	Parent	
	Mother	Father
	Frequency (%)	Frequency (%)
Strongly disagree	38(8.3)	48(10.4)
Disagree	48(10.4)	3(0.7)
Neutral	11(2.4)	50(10.9)
Agree	294(64.1)	240(52.3)
Strongly agree	68(14.8)	118(25.7)
Total	459(100.0)	459(100.0)

Respondents agreed that their mother/father would argue if they talked about sex (Table 12).

Respondents agreed mother (45.1%) and father (65.1%) don't know enough for them to talk about sex (Table 13).

Respondents were neutral on the above issue (Table 14).

Respondents agreed that they don't want to talk to mother (64.1%) and father (52.3%) as they already know what they need to know (Table 15).

DISCUSSION

This cross sectional descriptive study of four hundred and fifty nine early adolescent secondary school students between ten and fourteen years was conducted in Jos North Local Government Area of Plateau State to assess parent adolescent communication and HIV/AIDS.

Data collected in this research showed that of the total 459 respondents aged 10-14 years (majority of whom were of 14 years of age), 96.7 % of them had heard of HIV/AIDS.

A percentage of 27.5 respondents got information of HIV/AIDS from teachers in schools. This is similar to studies conducted elsewhere in Nigeria (Ayankugbe *et al.*, 2003).

Majority (72.7%) of the four hundred and fifty-nine respondents had not been talked to about HIV/AIDS by their parents but the national average is about 53% (Unaid, 2002). A study in Kenya showed that less than half of the parents of teenage children had discussed HIV/AIDS with them in the preceding year (Reaching out, 2004) but in Ghana a study done found 73.6% had talked HIV/AIDS with parents (Adu-Mireku, 2005).

In many cultures parents traditionally do not discuss sex with their children. Of the four hundred and fifty-nine respondents in this study, 79.9% had not been talked to about sex by their parents. Among issues talked of with parents, sex education was last on the list (21.2%). The breakdown of traditional cultures has left many parents with the challenge of talking to their children about HIV/AIDS as well as sex and many are ill-prepared (Reaching out, 2004). This is true as shown in Table 11 where most of the respondents felt their parents didn't know enough for them to talk about sex.

Just less than half of the respondents confided in their mothers and their teachers while they confided in their friends least of all (8.7 %). In a study done in Kuwait mothers of black adolescents were the main primary communicators about sex (AL-Owaish and Moussa, 1990). Majority agreed mothers and fathers hold back information and would not be honest with them though they agreed their parents understand and care about their feelings. Studies show that young people with a stable, positive and supportive family environment engage in less risk-taking (Reaching out, 2004). Parental affection

helps deter adolescent behavior problems and more likely to delay sex than those who are emotionally detached (Cohen and Trussel, 1996).

Respondents strongly disagreed that fathers are too busy to talk to them about sex but instead agreed that mothers are too busy to talk to them. Majority of respondents strongly agreed that both mothers and fathers would argue if they were to talk to them about sex. In Mexico, young people in a study there cited such communication barriers as lack of time, not getting along with their parents and lack of trust in their parents' advice (Reaching out, 2004).

CONCLUSIONS

This study showed positive parental affection and a very low level of interaction between parents and early adolescents (even though most of them were brought up with their parents) on HIV/AIDS. One important factor noted for the communication barrier between these two groups was the inadequacy of knowledge on the part of the parents.

RECOMMENDATIONS

Based on the findings of this study, we recommend that:

- Sex education should be made mandatory in secondary schools and enforced by legislation as early adolescents not only want education HIV/AIDS but are already engaged in safe sex practices. Majority of campaigns on HIV/AIDS concentrate on older age groups as prevalence studies show a higher rate among the 15-24 age groups. It is high time to focus on the early adolescents as this study has shown a high rate of sexual activity among this age group. Participatory teaching methods should be encouraged so that the adolescents can be empowered to voice out their opinions and doubts.
- Group discussions moderated by school authorities should be encouraged so that parents will realize their deficiencies and shortcomings, communication barriers noted, solved and accurate knowledge got.
- Delivery of accurate knowledge by supportive supervision and monitoring providers.

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