COMMUNICATION SELF-EFFICACY AND CONTRACEPTIVE USE AT SEXUAL DEBUT AMONG RURAL ADOLESCENT GIRLS IN ETHIOPIA

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ABSTRACT

INTRODUCTION: Girls with early sexual debuts are exposed to risky sexual behaviours, such as unintended pregnancy and contracting sexually transmitted infections. Communication self-efficacy is vital for protecting girls from unwanted pregnancy by educating them about the use of contraceptives. This study aimed to investigate the relationship between communication self-efficacy and contraceptive use at sexual debut in a rural Ethiopian setting.

METHODS: A cross sectional study design was employed to study communication self-efficacy at sexual debut in West Hararghe rural zone, Oromia region of Ethiopia. Adolescent girls between the ages of 13 – 17 were selected with simple random sampling technique and out of these a total of 394 girls who self-reported their sexual debut, were included in the analysis. Data were collected with an electronic data collection system through one to one interviews. Communication self-efficacy was measured using two items: adolescents who discussed contraceptives with their partners, and adolescents who discussed contraceptives with other people. The association between contraceptive use at sexual debut and communication self-efficacy was examined using a multivariable logistic regression model that accounted for a complex sample survey design.

RESULTS: The mean age of sexual debut was 14.5 years (95% CI 14.38, 14.69) and the proportion of contraceptive use at sexual debut was 17.37% (95% CI 12.75, 22.95). Contraceptive use at sexual debut was higher among girls who talked to their partner about contraceptives (adjusted odds ratio (AOR) = 1.94, 95% CI [0.98 - 3.8]) and those who discussed contraceptives with others (AOR = 2.45, 95% CI [1.56 - 5.55].

CONCLUSIONS: Contraceptive use at sexual debut was low among young rural adolescent girls. Adolescent girls who had communication self-efficacy were likely to use contraceptives at sexual debut. Life skills interventions that improve communication and negotiation are recommended to enhance contraceptive use.

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INTRODUCTION

Adolescent girls who make their sexual debut without protection or using contraceptives face the risk of contracting various sexually transmitted diseases and having a pregnancy at an early age.[1, 2] Studies have shown that early childbearing can compromise the physical, mental and social wellbeing of girls[3] and can limit them from achieving greater life goals such as education and independence.[4] Some adolescent girls make sexual debuts without much preparation. Some engage in these behaviours whether by curiosity, sexual attraction, manipulation or coercion.[5, 6] A synthesis of nationally representative data of 33 Sub-Saharan countries showed that lack of contraceptives was a prominent challenge that girls faced, which prevented them from having safer and protected sex.[7] This challenge is greater in rural settings where social norms and patriarchal dominance are prominent.[8, 9] These contextual factors have a strong influence on young adolescent girls[10] as they suffer more from negative sexual and reproductive health consequences.[11]

Enhancing adolescent girls' agency is critical in defining their sexual and reproductive health goals that affect and influence their lives.[12, 13] Using the extended Bandura's self-efficacy theory, DiClemente argues that people must alter their risky habits and believe in their ability or efficacy to exercise personal control to achieve self-directed change.[14] The concept of self-efficacy, which is defined as an individual's capacity to achieve control over one's behaviour,[15] has different components, which explain why individuals are compelled to act beyond their ability. Communicating ideas effectively and discussing a particular matter, such as contraceptives, is an essential component that requires taking necessary actions.[16] Communication and negotiation are at the heart of self-efficacy that facilitate the use of contraceptives. Adolescents with high self-efficacy to communicate and negotiate have better chances of using contraceptives and making favourable decisions towards their sexual health.[17] However, there is scant evidence on whether communication self-efficacy is associated with the use of contraceptives at first sexual intercourse among young adolescent girls in low-income settings. The present study aims to examine the association between the use of contraceptives at sexual debut and communication self-efficacy.

The theoretical foundation for this study is conceived from the Yeboah and Appai, 2015 conceptual framework and modified to fit the purpose of the study.[18] In the modified framework, contraceptive use at sexual debut is influenced by sociodemographic factors (including religion, literacy, mother's education, having own income and household food security), awareness factors (awareness and prevention of sexually transmitted infections (STIs) and pregnancy), and self-efficacy factors (ability to refuse nonconsensual sex, talking to a partner about contraception, discussing contraception with anyone and ability to refuse to unprotected sex). This study chooses to focus on self-efficacy to communicate and negotiate contraceptive use while acknowledging that the background and external factors, such as social norms and economy, may influence contraceptive use at sexual debut. The focus on self-efficacy emanated from a keenness to learn about the drive behind young rural adolescent girls' behaviour to use contraceptives at sexual debut. The individual and household factors have been controlled because all girls are drawn from the community that more or less follows similar social norms and from similar socio-economic backgrounds. Thus, we believed those would be reasonably self-controlled.

METHODS

Context

The study was conducted in four rural districts of West Hararghe Zone in Oromia regional state, Ethiopia. The West Hararghe Zone has an estimated population of 1.9 million. Women and girls account for 48.8% of the total population. The majority of the population is rural residents (91.4%),

speak Afaan Oromo language (89.47%) and follow Islamic religion (88.05%). Agriculture and related activities are the mainstays of approximately 85% of the population.[19]

Study design, participants and data collection

This paper drew data from the baseline study of a larger study, which was a cross-sectional study conducted to evaluate the effect of interventions in improving the sexual and reproductive outcomes of young adolescent girls.

Data were mainly collected from the Adolescent girl questionnaire which was administered to girls aged 13-17 years for households selected for the survey. Information was collected on various variables including sociodemographic status, education and school attendance, girls' empowerment and decision making, and adolescent reproductive health and sexuality. The socio-economic (household income) and food security profile of the households were collected using the Household questionnaire for which head of the household was the respondent. A set of questions were used to construct household food security and income variables.

The sample size for the baseline survey was calculated assuming a reduction of early marriage from 22% to 15%, a 5 percent level of significance, 90 percent power, average cluster size of 30, a design effect of 1.5 and 10% non-response rate. Accordingly, a total of 1140 households were needed for three arms, as per the research and integration objectives. Thirty households with eligible adolescent girls in 38 clusters were selected in each arm, resulting in a total of 3420 (1140*3) households in each arm. The source population for this study was adolescent girls between the age of 10-19 years. The study samples were adolescent girls who self-reported sexual debut. A structured questionnaire was designed to capture the socio-demographic, social, and sexual and reproductive health information of participants. Data were collected face-to-face by trained data collectors at the residence of the adolescent girls. The details of the parent project methodology are discussed elsewhere.20 Out of the 3150 girls interviewed (aged 13-17 years), 394 adolescent girls who self-reported sexual debut were included for this analysis.

Measurement and Analysis

We used STATA version 14 statistical software for the data analysis. A complex survey data analysis was adopted by applying sampling weights and the "svy" command in the analysis. "Contraceptive use at sexual debut" was the outcome variable of the study, measured if the girls reported using any contraceptives at first sexual intercourse, if "Yes" coded as "1" and if "No" coded as "0". We define contraceptive rate as the percentage of girls who/ whose partners use any form of contraceptive at first sexual intercourse. This was the ratio of the weighted number of girls who used contraceptives at sexual debut to the weighted number of all sexually debuted girls.

All study participants have been sexually initiated. To understand sexual debut experience a bit further, four questions that explored sexual debut were used: *respondent's age at the time of debut, person (relationship) with whom she was sexually debuted, use of any contraceptives during first sex and use of condom during first sex. Ever having heard about contraceptives and ever having heard about STIs* were two variables used to assess the girl's awareness on contraceptives, which were similarly coded "1" if they said "Yes" and "0" if they said "No".

Four variables that assess self-efficacy to contraceptives were chosen from the questionnaire to explore the relationship between the girls' self-efficacy and their use of contraceptives at sexual debut. The variables are "having talked to a partner about contraceptives", "having discussed contraceptives with anyone", "being able to object to unprotected sex" and "being able to say no to non-consensual sex". Frequency distribution tables have been used to summarize the demographic data. The first two components of self-efficacy that revolved around communication were to identify how communication self-efficacy was associated with contraceptive use at first sex. To examine the association between "contraceptive use at sexual

debut" and "communication self-efficacy", two items (Having talked to a partner about contraceptives AND Having discussed contraceptives with anyone) were each re-coded as "1" if the girls answered "Yes" and "0" if they said "No" or "Don't know".

In bivariate analysis, after significant association is obtained (p-value of 0.25 and less), the self-efficacy for communication factors were taken to multivariable analysis along with other background factors, including individual and household factors. Then, these factors were adjusted in the multivariable logistic regression based on the theoretical criteria listed in the conceptual framework. Statistical significance was declared at $P < 0.05$.

RESULTS

Background characteristics

A total of 394 self-reported sexually debuted adolescent girls between the ages of 13 and 17 were included in the analysis. About 356 (88.76%) of the participants, which accounts of the large majority, were Muslims. About 229, nearly 60% of the girls could not read and write; although 255 (65.7%) reported ever attending school. Those whose mothers have ever attended school were 63 (15.66%). About one-third of the girls reported having their own source of income. However, 280 (71.6%) of the girls were from food-insecure households (Table 1).

Table 1. Background characteristics of study characteristics of study participants (sexually debuted girls) (N = 394)

Characteristics	Number	Percentage
Age		
13	1	0.19
14	15	4.96
15	74	19.17
16	93	24.78
17	211	50.9
Religion		
Muslim	356	88.76
Christian	38	11.24
Ever attended school		
Yes	255	65.7
Never	139	34.3
Can you read and write?		
Yes	165	40.76
No	229	59.24
Mother ever attended school		
Yes	63	15.66
No	331	84.34
Household wealth quintile		
Lowest	69	22.08
Second	63	19.85
Middle	54	21.2
Fourth	55	18.09
Highest	54	18.77
Household food security		
Secure	102	28.38
Insecure	280	71.62

Girls' contraceptive use at sexual debut

Although the study was conducted among girls between the ages 13 and 17. The reported age at first sex ranged from 10 to 17 years. The peak age for the sexual debut was between ages 14 and 15, accounting for 67.31%. The mean age of adolescent girls at sexual debut was 14.5 years (+ 1.31). The majority of the girls, 88.44%, reported having initiated sexual intercourse with a husband or a steady partner. Four out of five (82.63%) of the sexually debuted girls revealed neither themselves nor their partners used any contraceptives at first sex. By the time of the survey, 51.4% of the girls had a pregnancy history (Table 2). However, 41% of them are already mothers (data not presented).

Table 2. Sexual experience and contraceptive use in young adolescent girls at sexual debut

	Number	Percentage
How old were you when your first had sexual intercourse?		
10-13	56	15.48
14-15	262	67.31
16-17	76	17.21
With whom did you have sexual intercourse for the first time?		
Husband/Partner	347	88.44
Boyfriend	42	10.19
Casual person	5	1.37
Did you/partner use any contraceptives during your first sexual intercourse?		
Yes	62	17.37
No	332	82.63
Did you/your partner use a condom at first sex?		
Yes	5	1.14
No	389	98.8

Self-efficacy and contraceptive use at sexual debut

Three out of the four studied self-efficacy factors were observed to have a significant association with contraceptive use at sexual debut. Approximately half of all sexually debuted girls (49.76%) neither talked to their partners about contraceptives nor used any at sexual debut. Talking about contraceptives with a partner was significantly associated with using them at first sex. Similarly, girls who reported never discussing contraceptives with anyone (53.39%) also never used it at first sex; this too was significantly associated. A higher percentage of girls (80.65%) who could not object to sex when their partner refused to use condoms did not use any contraceptives at sexual debut. Being able to object to unprotected sex was significantly associated with contraceptive use at sexual debut. Accordingly, the majority of the girls (54.49%) who had sex without contraceptives were not able to say no to non-consensual sex at their sexual debut. However, saying no to non-consensual sex did not have a significant association with the sexual debut (Table 3).

Table 3. Percentage distribution of self-efficacy factors and contraceptive use at sexual debut (n=394)

	Used contraceptive at sexual debut	Not used contraceptives at sexual debut	Chi-square value	P-value
Talked to a partner about contraceptives				
Talked	11.59	32.98	17.06	0.001
Not talked	5.67	49.76		
Discussed contraceptives with anyone				
Discussed	11.17	29.35	20.11	0.00
Not discussed	6.09	53.39		
Objected to unprotected sex				
Objected	1.39	2.08	5.17	0.02
Not objected	15.87	80.65		
Able to say no to non-consensual sex				
Able	6.78	27.97	0.57	0.4
Not able	10.75	54.49		

Contraceptive use at sexual debut and associated factors

Different factors were tested in bivariate logistic regression to evaluate their association with contraceptive use at sexual debut. In background characteristics factors, we observed an association between contraceptives at sexual debut and religion, own income, household food security, mothers' education and literacy, which was at P-value < 0.25 in the binary logistic regression. Similarly, in bivariate analysis, there is an association between awareness about sexually transmitted diseases and awareness about contraceptives (awareness factors). After adjusting the background and the awareness factors, talking about contraceptives with a partner and discussing contraceptives with anyone, the self-efficacy for contraceptives communication showed a statistically significant association with

contraceptive use at the sexual debut of the adolescent girls at p-value < 0.05.

Girls who reported having the experience of talking to their partners about contraceptives were almost two times of using one at sexual debut. Girls who perceived themselves to have self-awareness in discussing contraceptives with anyone were again at least two times more likely to report using some form of contraceptives at sexual debut, compared to their counterparts (Table 4).

Table 4. Factors associated with contraceptive use at sexual debut among rural young adolescent girls in West Hararghe, Ethiopia

	Contraceptive use at sexual debut		COR (95% C/I)	AOR(95% C/I)
	Yes (%)	No(%)		
Background factors				
Religion				
Muslim	13.03	75.8	.38*(0.11 – 0.71)	.29**[0.09 - 1.01]
Christian	4.23	6.93		
Own income				
Have own income	7.31	22.61	2.02*(1.02 – 3.71)	2.03*[0.87 – 4.35]
Don't have	9.95	60.13		
Household food security				
Secure	7.323	20.88	2.22**(1.28 – 4.40)	2.01**[1.07 - 3.78]
Insecure	9.232	62.57		
Mothers' Education				
Attended school	4.43	11.36	1.83*(1.12 – 4.19)	1.4[0.66 - 2.97]
Never attended	12.83	71.38		
Literacy				
Literate	10.95	29.93	2.28**(1.46 – 6.86)	2.17**[0.98 - 4.07]
Not literate	6.31	52.81		
Awareness factors				
Ever heard of STIs				
Have heard	14.86	56.46	1.66*(0.16 – 1.09)	1.10[0.3 - 3.98]
Never heard	2.40	26.28		
Ever heard of contraceptives				
Yes	11.33	44.13	2.01*(0.82 – 10.0)	1.50[0.62 - 11.48]
No	5.936	38.61		
Self-efficacy factors				
Talk contraceptives with partner				
Yes	11.59	32.98	3.08**(1.50 – 6.29)	1.94**[0.98 - 3.8]
No	5.676	49.76		
Discuss contraceptives with anyone				
Yes	29.35	29.35		2.45**[1.56 - 5.55]
No	6.09	53.39		
Objected unprotected sex				
Yes	1.391	2.086		2.68[0.62 - 11.48]
No	15.87	80.65		

*p < 0.05 **p < 0.001

DISCUSSION

Four out of five of the sexually debuted girls revealed neither themselves nor their partners used any contraceptives at first sex. This study showed that the rural adolescent girls who were sexually debuted at 10-17 years of age were mostly from poor and food-insecure households, and their families were mostly uneducated. They were mostly below the expected literacy and educational level. In other words, they were below the appropriate school grades for their age. We found that the age for the sexual debut was 14-15 years. Most of the girls reported having their sexual debut with their husbands/partners. Most of the girls did not use any form of contraceptives at sexual debut. While girls who were Muslims were less likely to use contraceptives at sexual debut, being from a food secure household and being literate were found to be protective factors.

We found that two "self-efficacy for communication factors": *Having talked to a partner about contraceptives and Having discussed contraceptives with anyone* were positively and significantly associated with contraceptive use at sexual debut. Girls who talked and negotiated about contraceptives also have used contraceptives at first sex. This could be because discussing contraceptives made them assertive and gave them the confidence to use one when they started having sexual intercourse. Studies show that verbal persuasion is one source of self-efficacy, which explains that talking about and deliberating on matters ahead of time makes them take action when the need arises.[21]

The girls who used any contraceptives at sexual debut had different stances from the majority of those who did not use one. Early marriage is a social norm in the rural Ethiopian community, which predictably leads to an early sexual debut.[22] This early marriage norm takes a unique shape in the Hararghe context that allows elopement with a chosen partner in the name of marriage.[23] This in turn has paved the unfortunate way of early sexual initiation among girls as young as 10 years old. The age of sexual debut was between 14 and 15 years, which explains that these debuts are mostly happening under the cover of marriage as the ideal age for marriage aligns with it.22 For this reason, it is not surprising when the majority of the girls did not use any contraceptives during their sexual debut.[24] Adolescents, particularly those less than the age of 16, do not have a track record of using contraceptives at sexual debut whether under marriage or not.[25, 26] Lack of education, lack of exposure to information and being young to comprehend possible consequences are likely to be the major reasons for the lack of using contraceptives.[27] Majority of rural adolescent girls do not use any form of contraceptives at sexual debut because of reasons such as non-accessibility, social norms and non-prior preparedness. Thus, unprotected sexual debut places girls' reproductive health and wellbeing at high risk.

One might not expect the girls in such communities to use contraceptives at sexual debut because of the norms and customs. However, those who communicated about contraceptives were exceptions because they took the desired measure towards safe sex. Behavioural theories show that self-efficacy is needed to initiate change. Moreover, the person's evaluation of the outcomes will lead to positive results.[28] Thus, individuals who cannot convey results do not even attempt to use contraceptives. Therefore, girls who were able to communicate with partners and others had the self-efficacy to make the decision and to use contraceptives. Expressing their ideas and getting support empowers girls to take favorable measures regarding their sexual and reproductive life.[29]

Limitations: Our study focused only on communication self-efficacy; the dataset we obtained for analysis did not contain information on attitude and knowledge/awareness, which were components of a general self-efficacy measure. As Levinson argued that communication self-efficacy is critical to the adoption of contraceptive behaviour.[29] In this sense, this study provides useful information regarding the interventions in enhancing the use of contraceptives at sexual debut among young adolescent girls.

CONCLUSION

This study showed that the use of contraceptives at sexual debut among rural adolescent girls was very low. Only one in six uses any form of contraceptives. Adolescent girls who had communication self-efficacy were more likely to use contraceptives at sexual debut. Life skills interventions that improve communication self-efficacy are recommended to enhance contraceptive use at sexual debut.

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