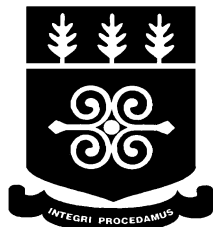


**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**PARENT-ADOLESCENT COMMUNICATION ABOUT SEXUAL AND
REPRODUCTIVE HEALTH: A CASE STUDY OF THE ASHIEDU
KETEKE SUB-METRO, ACCRA**

BY

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AWARD OF MASTER OF PUBLIC HEALTH (MPH) DEGREE**

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DECLARATION

I, Felicia Aperkor, declare that apart from specific references which have duly been acknowledged, this work is the result of my own original research, conducted under supervision. I affirm this dissertation has not been presented either in whole or in part elsewhere for another degree.



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.....

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DATE

DEDICATION

This work is dedicated to the Almighty God, my husband, Dr. Nicholas Aperkor and my children, Dede Drom Aperkor-Bah and Koryo Djorm Aperkor-Bah for their immense support, contribution and understanding.



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ABSTRACT

Background: Globally, adolescent period is a critical developmental phase where many preventable health problems are acquired. However, studies have shown that parent adolescent sexual communication is protective against risky sexual behaviours. Nationally, parent adolescent communication on Sexual Reproductive Health (SRH) rarely occurs. Furthermore, anecdotal evidence along the coastal towns/suburbs shows a high prevalence of risky sexual behaviours and its associated consequences.

Objectives: This study aimed at exploring the patterns of parent-adolescent sexual communication in the Ashiedu-Keteke sub-metro of Accra.

Methods: This was a cross-sectional study conducted within the Ashiedu-Keteke sub metro. Data were qualitatively collected using Focus Group Discussions with adolescents, and In-depth Interviews with parents. Convenience sampling method was used to select participants for the study. All interviews were audio-recorded and were transcribed verbatim. Data were analyzed thematically after the transcripts were read several times to identify appropriate themes per the objectives.

Results: The study found that parents communicated more with adolescents on general issues but less on SRH. Also, the media as well as unacceptable events that occurred in the community served as triggers for initiating communication. Parents reportedly lacked fine details of SRH issues to equip the adolescents in making the right decisions and choices. The study identified teenage pregnancy, abortion, rape, lesbianism/ homosexuality as the most commonly discussed sexual health topics among parents and their adolescents. However, adolescents' reports revealed that they lacked detailed information about these topics and how to prevent the occurrence of some of these risky sexual behaviours. Additionally, the study found that parents feared that their children may become promiscuous if they discussed sexuality issues with them; while the adolescents were also concerned that parents may brand them as spoilt if they asked questions about sexuality.

Conclusion: Parent-adolescent sexual communication has not been effectively handled in the Ashiedu-Keteke sub metro even though it is one of the best ways of curbing incidence of risky sexual behaviour. Additionally, lack of trust prevents adolescents from seeking out parents to discuss SRH issues.

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LIST OF ABBREVIATIONS

AIDS -	Acquire Immune Deficiency Syndrome
FGD -	Focus Group Discussion
GHS -	Ghana Health Service
GPS -	Global Position System
GSS -	Ghana Statistical Service
HIV -	Human Immunodeficiency Virus
IDI -	In Depth Interview
PAC -	Parent-Adolescent Communication
RH -	Reproductive Health
SHS -	Senior High School
SRH -	Sexual and Reproductive Health
STI/STD -	Sexually Transmitted Infection/Disease
UNFPA -	United Nations Fund for Population Activities
USA -	United States of America
WHO -	World Health Organization

DEFINITION OF TERMS

Adolescent- A person between the ages 10years and 19years.

Parent- The person with the legal responsibility for a minor. S/he may be the biological parent or guardian who assumes the legal responsibility for the minor.

Sexual communication- The sharing of ideas or knowledge, verbal or non-verbal, relating to sexual and reproductive health issues



CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Adolescence is described by the World Health Organization (WHO) as the period in human growth and development that occurs after childhood and before adulthood, and ranges from ages 10 to 19 years (WHO, 2015). It is a critical period in life marked with a remarkable pace in physical, emotional, psychosocial and cognitive growth (Brand & Kirov, 2011). Adolescence is also the period that physical and sexual maturation occur.

Globally, adolescents are about one billion, with 70% living in developing nations (Ayalew, Mengistie, & Semahegn, 2014). It has been estimated that young people, including adolescents, make up 33% of sub-Saharan Africa's 973.4 million population. However, that population is expected to continue to increase over the next 35 years (Kabiru, Izugbara, & Beguy, 2013; World Bank, 2015). In Ghana, adolescents are said to constitute about 22% (5.5 million) of the total national population (Ghana Statistical Service (GSS), 2012).

A key aspect of adolescent growth is sexual development. Adolescents are typically associated with behaviours that influence their sexual development (Crockett, Raffaelli, & Moilanen, 2003). These behaviours include high levels of risk-taking, exploration, novelty and sensation seeking, impulsive decision-making, and other behaviours that may put them at avoidable risks. Consequently, developing interventions that target their sexual behaviours is imperative for them to grow up into healthy adults (Crews, He, & Hodge, 2007; Gutiérrez-Martínez, Bermúdez, Teva, & Buéla-Casal, 2007; Kelley, Schochet, & Landry, 2004). Furthermore, these interventions will help reduce their

propensity to have unprotected sex, casual sex with multiple partners, sex while on alcohol or regulated drugs, inter-generational and transactional sex which results in dire outcomes that will severely affect their growth negatively (Meyersfeld & Vujovic, 2012).

The International Conference on Population and Development (ICPD) held in 1994 and the Fourth International Conference on Women held in 1995 endorsed the rights of adolescent to have access to sexual and reproductive health information (UNFPA, 2004). Despite this global consensus, reproductive health information and services remain largely inadequate in sub-Saharan Africa because of uncertainty on whose role it is to provide such an information (Hensel & Fortenberry, 2013). Many stakeholders have in the past advocated for intervention that will enable adolescents have access to information on sexual and reproductive health and the role parents should play in achieving this goal (Guilamo-Ramos et al., 2008; Hensel & Fortenberry, 2013). In developing such interventions, it is very important to recognize the family (especially the parents), as a critical factor that influences the life of an adolescent. This is because studies have documented that parents have an influence on the cognitive, social and emotional development of a child. (Luster & Okagaki, 2008; Moretti & Peled, 2004). Moreover, parents tremendously influence their children through sexual socialization. Parent-adolescent communication is vital in educating the child on values, expectations and norms on sexual health. It can also protect adolescents from being involved in risky sexual activities, inform parents as to the sexual and reproductive health challenges the child faces, socially and physically (Dessie et al., 2015).

However, parent-child communication regarding sex appears complicated, as it is governed by the type of relationship between the parent-child dyads (such as parental warmth versus coldness, acceptance versus rejection, autonomy and permissiveness versus control and strictness, involvement versus detachment or neglect) (Newman et al., 2008). Principally, adolescents have to build trust in their parent to share with them on personal matters as intimate as their sexuality. Parents would also have to be non-judging and flexible to be able to impact on the adolescent (Kajula et al., 2014).

In sub-Saharan Africa, where a fourth of all adolescents are said to have some sexual experience, parent-adolescent communication, while still low, is on the increase (Ayalew et al., 2014). This increase has been explained as contributing to the delay in sexual intercourse, reduction of teenage pregnancy and sexual transmitted infections. The utilisation of this important strategy in Ghana has the potential to facilitate healthier sexual behaviour among adolescents.

1.2 Problem Statement

According to the 2008 Ghana Demographic and Health Survey, 37.3% of females and 21.9% of males aged 15-19 years were sexually active (Ghana Statistical Service [GSS] & Macro, 2009). Nonetheless, these sexually active teenagers have a low rate of contraceptive use. For example, the rate of contraceptive use among sexually active adolescent girls aged 15-19 years was as low as 8.1% (GSS et al., 2009). Consequently, teenage pregnancy rate among that age group has been consistently high (13% in 2008 to 14% in 2014). The United Nations reported 62 births per 1000 live births as the adolescent childbearing rate in Ghana (United Nations Population Fund - [UNFPA] & Population Reference Bureau [PRB], 2012).

Murray et al. (2014) found that adolescents are likely to delay initiation of sexual intercourse. In their study, children were more likely to communicate with their sex partners about sexual risk, and less likely to have unprotected sex if they enjoy strong communication with their parents on sexual health within a period of 30 days. It is therefore imperative to examine how this seemingly significant parental influence can be explored to assure the sexual health of adolescents in Ghana.

In Ghana, there is a gaping lack of in-depth research into parent–adolescent sexual communication. To date, very few adolescent health studies have examined on parent-adolescent sexual communication (Manu et al., 2015).

Studies into patterns of communication between adolescent and parents, especially those bothering on sexual issues would elucidate factors that mediate this communication and how these factors can be used to influence or manipulate adolescent sexual behaviour for better outcomes in their sexual and reproductive health. These include prevention of STIs, teenage/unwanted pregnancies and improved uptake of contraception. It is imperative to fill the yawning gap of knowledge on parent-adolescent sexual communication to facilitate policies and reproductive health programmes that focus on adolescents.

Thus the need to examine the patterns of parent-adolescent sexual communication from the adolescent’s perspective to help provide a comprehensive picture on how best to improve parent-adolescent communication and its outcomes. This study provides evidence on the patterns of sexuality communication between parents and adolescents. It

provides the basis for further studies on what factors can be used to influence adolescent sexuality through communication with parents.

1.3 Theoretical Framework

The Theory of Planned Behaviour (TPB) was adopted for this study. The theory was propounded in 1985 by Ajzen. The theory proposed that intentions are the hallmark of behaviour, propelled by the individual's attitude, subjective norms and perceived behavioural control. The purpose of these prepositions are to predict the occurrence of a behaviour that is of intent (Ajzen, 1991). In the view of Ajzen, an individual's attitude towards behaviour depends on the individual's behavioural beliefs and outcome evaluation. Therefore an individual's evaluation of a particular behaviour determines his/her attitudes. Thus, the outcome of the evaluation whether positive or negative will determine attitude. Another predictor, according to this model, is the subjective norms about the behaviour. This involves normative beliefs and motivation to comply. This is how the individual acknowledges the societal pressures in enacting a particular behaviour. Ajzen (1991) further explained that subjective norms show how beliefs about a phenomenon influence the required behaviour as well as the individual's motivation. The final construct in the theory of planned behaviour is perceived behavioural control. Perceived behavioural control is the ability of the individual to exhibit the required behaviour. Perceived behavioural control depends on the beliefs about that behaviour and inner drive to appreciate that behaviour which can be situational.

Figure 1 illustrates the theory of planned behaviour and how it is used to determine an individual's behaviour.

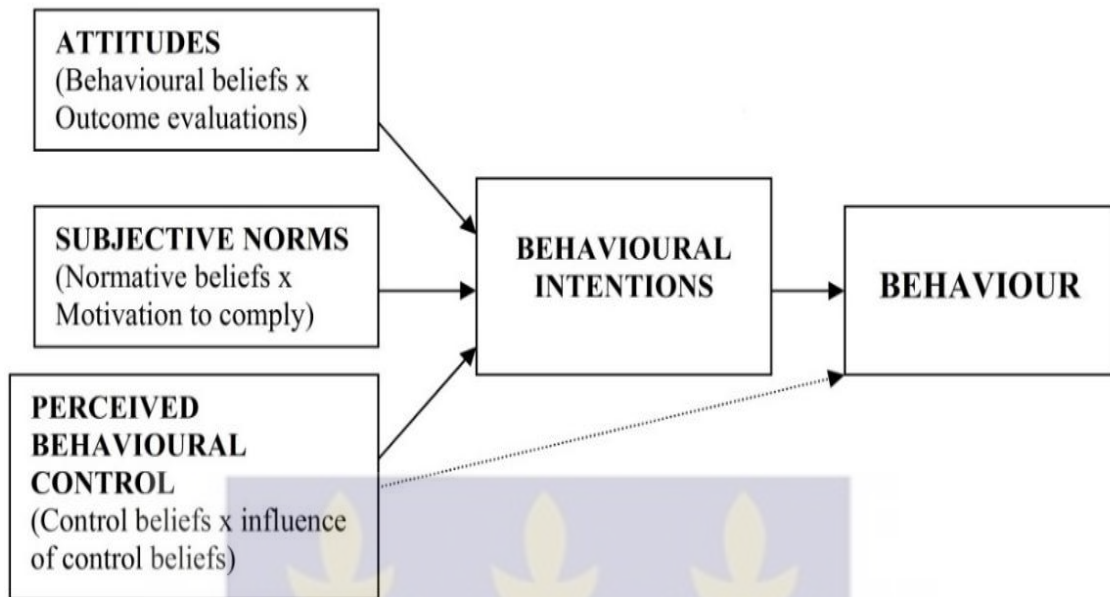


Figure 1. The Theory of Planned Behaviour (Ajzen, 1991)

Figure 1: The Theory of Planned Behaviour (Ajzen, 1991)

The theory of planned behaviour as applied to this study is based on the premise that parents who have the intention to communicate with their adolescents will be motivated to do so upon appraisal of their attitude towards sexual health communication, the prevailing norms in the society they live and their ability to initiate such as communication. The interplay of these factors will either motivate or inhibit a parent from initiate parent-adolescent sexual education. Parents who perceive sexual education to be important and appropriate for a parent to have such communications with their adolescent will have a positive intention and are likely to initiate such a communication provided societal norm permits. However, parents with negative attitude towards parent-adolescent sex education may refrain from initiating such a communication. Nonetheless, a parent’s ability to communicate with their adolescents will also be facilitated by their possession of the right knowledge/information (behavioural control). However, perceived behavioural controls and factors indirectly related mediate the full

attainment of an intended communication with the adolescent. Factors such as parent-adolescent relationship/trust, parent or adolescent discomfort about sexual communication and perceived generational gap were investigated to determine the extent to which they influence parent-adolescent sexual communication.

1.4 Justification for the study

Parent-adolescent communication is very key due to sexual activities beginning at early age for several adolescents. Nevertheless, limited studies have been conducted on communication between parents and adolescents concerning sexual and reproductive health issues. A unique distinguishing factor per this study looked at conversations on sexuality between parents and their adolescents in sub-Saharan Africa which were constrained by certain factors. These communication are reported to be mediated by power dynamics imposed by the cultural expectations of deference and respect (Wamoyi et al., 2015). There is also the culture of silence at the heart of African belief about adolescent sexuality (Ogunsanmi et al., 2014).

This study sought to inform policy-makers, program managers and service providers on the efficacy of parent-adolescent communication on sexual issues in managing adolescent sexual health. Furthermore, the study provided information on knowledge and attitudes towards adolescent sexuality by both parents and adolescents. This gives an opportunity for holistic solutions to guide policy planning and the design of appropriate reproductive health programmes for adolescents and their parents. Moreover, improving parental-adolescent communication could provide adolescents the knowledge and skills to avoid pregnancy and STIs and also enhance long-term reproductive and physical health.

1.5 Objectives

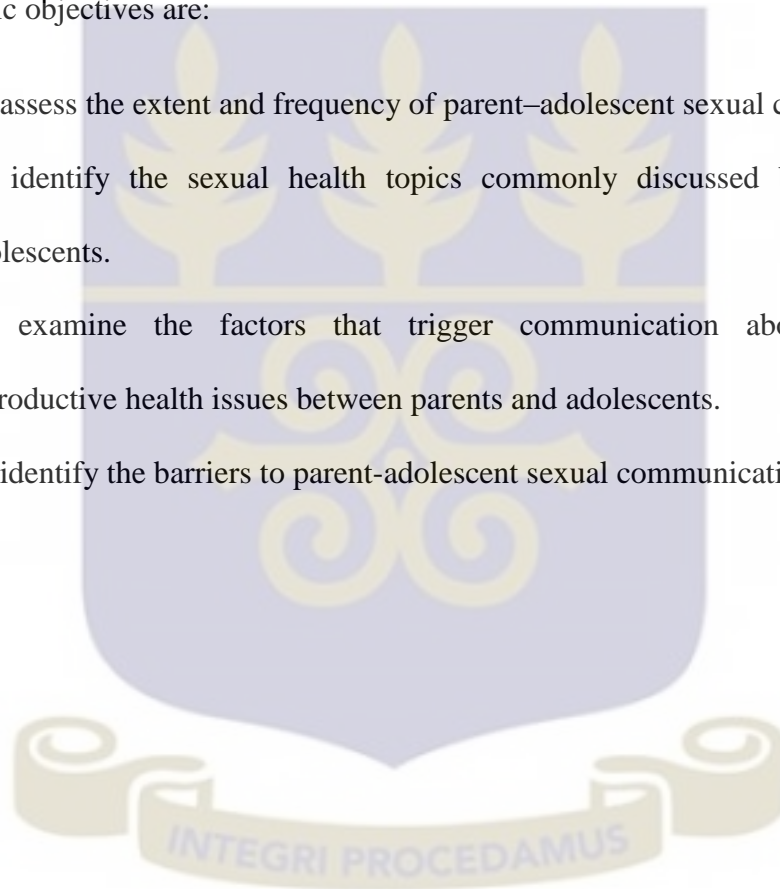
1.5.1 General objective

To explore the patterns of parent–adolescent sexual communication in Ashiedu-Keteke sub-metro of Accra.

1.5.2 Specific Objectives

The specific objectives are:

1. To assess the extent and frequency of parent–adolescent sexual communication.
2. To identify the sexual health topics commonly discussed by parents with adolescents.
3. To examine the factors that trigger communication about sexual and reproductive health issues between parents and adolescents.
4. To identify the barriers to parent-adolescent sexual communication.



CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviewed literature on ‘Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke Sub-Metropolitan Area of Accra’. The literature was organized based on; adolescence, adolescent sexual behaviour; importance/consequences, perceptions, health promotion, and sexual communication; the role of parents, its prevalence and frequency, who communicates with who, advantages of communication, the content of sexual communication, the timing of the communication, parental marital status/family status and adolescent-parent relationship/trust.

2.2 Concept of Adolescence

Adolescence is a developmental stage occurring in the second decade of life which is characterized by many changes, including sexual development (McNeely & Blanchard, 2009). During this period, most adolescents’ complete puberty, explore their independence, autonomy, and sexual identities, develop cognitively and emotionally, and also experiment with romantic and sexual expression (Facing Facts, 1995; Parents’ Sex Ed Center, 2008). Hence, to understand adolescent uniqueness and complexity, it is important to appreciate these facts (Tolman et al., 2003). However studies affirm that parents have a role to filter societal morals and information as well as shape the sexual identity of adolescents (Biddlecom et al., 2009).

Globally, adolescents are about one billion, with 70% living in developing nations (Ayalew et al., 2014). It has been estimated that young people, including adolescents,

make up 33% of sub-Saharan Africa's 973.4 million population. However, that population is expected to continue to increase over the next 35 years (Kabiru et al., 2013; World Bank, 2015). In Ghana, adolescents are said to constitute about 22% (5.5 million) of the total national population (Ghana Statistical Service (GSS), 2012).

2.2.1 Adolescents and sexual behaviour

Adolescence is an important period of human sexuality and development. Given that it is normally the stage at which most individuals get sexually initiated, it has a molding impact on life-long sexuality (Bearinger et al., 2007). However, global inclination towards marriage at later ages has resulted in an increased prevalence of premarital sex, which begins in adolescence (Wellings et al., 2006).

A significant proportion of adolescents in sub-Saharan Africa have been observed to be sexually active by their mid-teens (Bhatasara et al., 2013). The age of sexual initiation has been observed to be gradually decreasing. Also the age of initiation varies by sex, thus girls are initiated at a younger age than boys. In 2004, the mean age range of sexual initiation in Ghana was between 15-19 whereas girls were being initiated earlier than boys (Awusabo-Asare et al., 2004).

Further, adolescents who engage in early sexual activity, especially in sub-Saharan Africa end up contracted STIs including HIV. This is due to the low prevalence of the use of contraception as well as a lack of education (WHO, 2014). Hence adolescents need to be coached especially on areas relating to their sexual behaviour for a positive outcome.

2.2.2 Consequences of adolescent sexual behaviour

Adolescent engaging in sexual practice comes challenges that if poorly managed, would lead to problems such as pregnancy and STDs, particularly HIV, whose effects would persist throughout an individual's life (Forhan et al., 2009; Manu et al., 2015). Also, this could have an impact on the life expectancy and quality of life. Such problems stem from risky behaviours such as having unprotected sex (including oral and anal sex), multiple casual partners and having transactional (often intergenerational) sex (Lindberg et al., 2008; Madiseal et al., 2007). A recent study also showed that among adolescent, early initiators had an increased likelihood of having had multiple sex partners, getting pregnant and having experienced forced sex or forced a partner to have sex, had frequent intercourse and had sex while drunk or high (O'Donnell, O'Donnell, & Stueve, 2015).

Groce-Galis' (2004), study revealed that 16% of women and 11% of men aged 12-24 years who ever had sex reported being involved in terminating a pregnancy. However, about 30% of women and 39% of men of the same age group mentioned that the last abortion they were involved in were unsafe ones that occurred at home (Croce-Galis, 2004). The prevalence of STIs among adolescents in Ghana is very high. Several studies report an HIV/AIDs prevalence 3.4% among those aged 15-24 years and 90% prevalence in young people (15-24years) with new HIV infections (Ganle et al., 2012; Odonkor et al., 2012). Furthermore, 1.7 million of 2.1 million adolescents infected with HIV in 2012 were located in sub-Saharan Africa (Idele et al., 2014). Also, 250,000 of the 2 million new HIV infections recorded in 2013 were among adolescents aged 15-19 with 64% of these infections occurring in girls. As AIDS has been tagged the biggest cause of deaths among adolescent in sub-Saharan Africa (UNICEF., 2014), it is crucial

to pursue an increased investment in protecting the sexual and reproductive health (SRH) of adolescents.

Apart from the physical and psychological consequences of adolescents sexual behaviour discussed above, unplanned pregnancies that occur during adolescent have found to have intergenerational effects. It has been found in a longitudinal study that children that are born from such unplanned pregnancy by adolescents also have a higher likelihood of experiences similar faith in future. This implies that female children born from unplanned pregnancy are more likely to become adolescent mothers in future whilst their sons have a significant probability of incarceration as adults (Walker & Navarro Paniagua, 2012).

2.2.3 Perceptions on adolescent sexuality

Perceptions on adolescent sexuality vary by culture, geography and socio-economic status. Parents view adolescent sexuality warily, and blame media exposure for the source of sexual promiscuity (Werner-Wilson et. al., 2004). In sub-Saharan Africa, adolescents are regarded by society as children and ignorant on sexual matters. As such, sexual knowledge by adolescents is regarded as dangerous because it suggests the erosion of virtue (Bhatasara et al., 2013). This perception was observed in a mixed-method study in Nigeria where uneducated parents opined that sexuality issues should not be discussed with children as it may unnecessarily expose them to sex or make them curious about sex (Ojo et al., 2011). Meanwhile, Partington (2013) asserts that this viewpoint is also popular with adolescent sexuality conversation rife with abstinence-only messages (Partington, 2013).

However, research shows that adolescents perceive their own sexuality differently, with indications that sexuality is important within the cultural and religious view of African adolescents, despite adult denials (Bhana & Epstein, 2007). Among adolescents, sexuality was viewed as simply a means to an end of money, academic success, sexual pleasure and satisfying peer pressure (Afenyadu & Goparaju, 2003). Adolescents' sexuality is also perceived differently by adolescents based on residence (urban being more liberal than rural), gender (sexual violence, male promiscuity as related to female chastity) and education (Bhatasara et al., 2013; Peltzer, 2006).

Some parents silently support adolescent sexuality based on a social context of poverty, lack of opportunities for education, and unemployment for adolescents. Religion has also been perceived by parents to play double-edged role of restraining adolescents from risky sexual behaviours; while disparaging the existing traditional measures that regulated sexuality (Osafo et al., 2014).

2.2.4 Health promotion

Promoting healthy sexual behaviours such as delayed sexual debut, condom use by sexually experienced adolescents are key components that assure the health of adolescents (Bearinger et al., 2007). There is evidence that condom use at last sex has marginally increased among adolescents in sub-Saharan Africa (Hindin & Fatusi, 2009). However, these are not effectively curtailing the spread of HIV/AIDS among the adolescents (Hindin & Fatusi, 2009).

Studies have noted that sex education and family planning initiatives, promotion of responsible sexual behaviours, encouraging abstinence, increased use of contraceptives,

training of health professionals, promotion of RH policies and many others as key in the promotion of adolescent reproductive health (Ramella, 2002).

The promotion of these sexual behaviours is contingent upon tackling the widespread lack of adequate and accurate knowledge about sexual matters among adolescents. This can be done by opening up the opportunities inherent in family (parental) discussion on reproductive health (RH) issues which often leads to increased awareness on RH matters and reduces risky behaviours among adolescents (Yadeta et al., 2014).

2.3 Sexual communication

Sexual communication is very critical since adolescents are affected with the burden of unwanted pregnancy and its complication, HIV/AIDS/STI, as well as other sexual and reproductive ill-health.

Some studies have proven that young people prefer receiving sexual information from their parents (Clawson & Reese-Weber, 2003). Meanwhile very few adolescents get information from their parents (Babalola, Tambashe & Vondrasek, 2005; Somers & Paulson, 2000). Sexuality communication could be a very valuable intervention that have the potential to boost sexual responsibility among adolescents if the message is appropriately and comprehensively delivered (Undie, Crichton & Zulu, 2007).

However, communication on sexuality in many African cultures has been seen as a taboo, thus allowing only ceremonial rites or authorised persons such as grandparents, paternal aunts and uncles to discuss the subject with young people (Kajula et al., 2014). Research suggests that sexuality communication can be a very useful intervention that

encourages sexual responsibility among adolescents when the message is properly and comprehensively delivered (Manu et. al., 2015).

2.3.1 Role of Parents in Sexual Communication

Parents' role in the life and decision-making processes of adolescents is often underestimated (Schear, 2013). Historically, Rollins and Thomas (1979) posited that parents' influence was in two ways – the power of compliance they wield over children and the control attempts they made over the behaviour of their children.

The control attempts could be coercive and forceful, or inductive and reasoning. Thus they concluded that parental coercion would be most effective in obtaining the adolescent's compliance in the short term. Nonetheless, inductive controls would most likely result in the children's internalizing parental standards or requests and acting accordingly in the future. Assessing the influence of parenting on adolescent health, especially those led by the WHO have brought the importance of parental involvement into sharper focus.

Parents are thus able to coerce their children to avoid sexual intercourse and sexually explicit behaviour, but this is likely to last only short term and likely to be complied with only in their presence. Among their peers, they are likely to display behaviour that may be a variance to that instructed by their parents. The inductive approach by parents in inculcating appropriate sexual behaviour is more likely to be long term.

2.3.2 Prevalence and frequency of communication

Parental communication on sexual issues is perceived as the principal method through which sexual knowledge and attitudes are transmitted (Davis & Friel, 2001). However, prevalence of this parent-adolescent communication is low. A study in two Ghanaian communities, asserted that parents accepted sex talk with adolescents as their responsibility but said they rarely engaged in it (Asampong et. al., 2013). An earlier study among adolescents in Central Region of Ghana by Owusu et al. (2011) showed that the major sources of information on sexual and reproductive health available to adolescents were their friends (30%), radio/television (26%) and parents (13%) emerged as the least source of communication on sexual and reproductive health. This also conforms with a study in Nigeria where only 5% of sexually active students reported communication with parents about sex and 27% had had such communication about AIDS (Mathew, Shugaba, & Ogala, 2006). This is in direct contrast the findings of a study in US showed that the majority (75%) of adolescents had received parental sexual and reproductive health communication (Hall, Moreau, & Trussell, 2012).

In Accra, 73.6% of Senior High Schools (SHS) students talked about HIV/AIDS with parents or other family members (Adu-Mireku, 2003). He also found that communication about HIV/AIDS between students and parents or other family members increased the odds of using a condom at last sexual intercourse (Adu-Mireku, 2003). This is consistent with a study in Nigeria among Christian women where 65% of parents reported having discussed sexuality topics with their children, but contrasted with a study in Kenya where 40% of parents in Kenya had never talked to their child about HIV/AIDS (Opara, Eke, & Akani, 2010; Poulsen et al., 2010). Manu et al. (2015) also noted that while 82.3% of parents said they had at some point in time discussed sexual

and reproductive health issues with their adolescents, adolescents reported that only 78.8% of mothers and 53.5% of fathers had.

2.3.3 Who communicates with whom?

Studies on sexual communication have shown that generally, mothers discuss sexuality with adolescent more often than fathers (Manu et al., 2015; Bostein, 2011; Kumi-Kyereme et al., 2007). However, this parental gender difference is often affected by the gender of the adolescent: Mothers communicate more often with their daughters than with their sons, while fathers rarely communicate with their daughters about sex; however, mothers and fathers discuss sex with their sons at approximately equal rates (Miller et al, 1998).

Moreover, a study revealed that mothers communicated about sexuality more frequently than fathers (41% vs. 17%), (Amoran et al., 2003). Also, female adolescents communicated more with their parents than their male counterparts (Schear, 2013). Another study in Ghana showed that both male and female adolescents reported more sexuality communication with mothers than fathers (Kumi-Kyereme et al., 2007). The attendant consequence of a gender discordance was found to be that discussing with fathers has a negative association with sexual activity for males whilst it is positive for females (Kumi-Kyereme et al., 2007). As a group, mothers reported better communication with their children than did fathers.

Also in their study, Teitelman et al., showed that mothers consistently reported more positive communication with their adolescents than fathers did (Teitelman, Ratcliffe, & Cederbaum, 2008). This difference was attributable to higher levels of openness

reported by mothers in their parent- child interactions. The teens reported about equal levels of problems in trying to communicate with each of their parents. Compared to the adolescent reports, both parents reported significantly more openness and fewer problems in communicating with their children. Clearly adolescents viewed their intra-family communication with greater negativism, with this especially true for adoptive families (Rueter et al., 2009).

A greater proportion of adolescents (55%) who received sexuality information from peers were sexually experienced compared with 34% who sought information from parents and other sources (Amoran et al, 2005).

2.3.4 Advantages of communication

Parent-adolescent sexual communication has been found by different studies as beneficial. The ability of male and female adolescents' to discuss sex with their parents leads to a lower likelihood of early sexual debut and safer sexual practices like contraceptive use and single sexual partnerships (Aspy et al., 2007; Schuster et al., 2008). A review by De Vore & Ginsburg (2005) revealed that parental monitoring, open parent-child communication, supervision, and high quality of the parent-child relationship deter involvement in high-risk behaviour (DeVore & Ginsburg, 2005). However, there is also evidence that the more parents talked to their female adolescents about sex, the less likely they were to have multiple partners (Joffe & Franca-Koh, 2001).

In Ghana, female adolescents who live in two-parent homes are likely to delay sexual debut, implying contact driven attitudinal transfer (Kumi-Kyereme et. al., 2007).

However, some data revealed substantial generational differences in communication quality and frequency (Musa et al., 2008). Although these gender differences exist in parent-adolescent communication, both parents may influence adolescents' sexual risk-taking behaviours (Stanton et al., 2004).

2.3.5 Content of sexual communication

Adolescents tend to discuss different topics with their parents on STIs, HIV and condom use but they avoid certain topics of conversation such as dating experiences (Yang & Wu, 2013). Female adolescents tended to talk about the menstrual cycle with their mothers, sexual abstinence with their fathers and sexual intercourse with their friends (DiIorio et al., 1999). Eisenberg et al, (2006), reported that young women discussed relationships, facts and values with their mothers more often than did young men, who in turn discussed protection like birth control, and prevention of sexually transmitted infections with their fathers more often than did young women.

In Nigeria, 98% of students reported discussing about condoms with a 'family member'. (Musa et al. 2008). Also in their study, 34% of respondents reported discussing about premarital sex with a family member. Although the study specified that the member of the family most often involved in sexuality discussions was the mother (44%), the study did not make clear which family member was involved in discussions for each topic investigated.

In Ghana, Karim et al, (2003), assessed whether or not communication about avoiding or delaying sex took place and found that communication about these topics was low. A study conducted in Burkina Faso, Ghana, Malawi and Uganda also observed that only

few adolescents reported having discussed sex-related matters and contraceptives (with the exception of females in Uganda) (Biddlecom et al, 2009).

2.3.6 Timing of communication

Many parents do not discuss with their child until they discover their adolescents have already made difficult sexually related decisions. By this time, an adolescent has probably already engaged in sexual activity, communication becomes ineffective. Because the child was not encouraged to discuss sexually related issues from an early age; the teen will feel uncomfortable with the subject matter at this point in time. As a result the teen might lie or tell the parents what they want to hear in order to avoid an awkward situation. Parents may also feel uncomfortable discussing the subject matter with their child and will have difficulty initiating such a conversation (Bastien et al., 2011). Moreover, parents and adolescents are often uncomfortable when discussing issues of sexuality as sex appears to be linked to responsible sexual behaviours among adolescents (Burgess et al., 2005).

2.3.7 Parental marital status/family status

Wang's (2000) study determined the relationship between parent-adolescent communication and sexual risk-taking behaviours of adolescents. In that study, the type and nature of parent marital status, level of parent-adolescence communication among the married, divorced, mother remarried, father remarried, mother deceased, father deceased and parents who did not marry were considered. The study also noted that adolescents whose father was deceased reported more parent-adolescent communication about sexual issues than those whose parents were married, divorced but both still single, or mothers who had remarried. However, it appears that the main differences in

communication about sex in the family were found between adolescents whose father was deceased and those whose parents were divorced (both parents single). It is also reported that adolescents whose mothers remarried reported more sexual risk-taking behaviours than those whose parents were married, divorced but both still single, or where the fathers were deceased. Moreover, adolescents who lived with sibling(s) reported a higher degree of openness of their communication with their parent(s), while those who did not live with sibling(s) (Pearson, Muller, & Frisco, 2006).

2.3.8 Adolescent-parent relationship/trust

The occurrence and effectiveness of sexual communication is dependent on the relationship between the parent and adolescent. Research evidence strongly affirms that parent-child relationships significantly decrease the odds of early sexual debut, especially among female adolescents (Pearson et al., 2006). Besides, parents do not verbally discuss sexual issues with their children, but adolescents still pick up cues and hints from them through non-verbal, behavioural means, and act according to such unacknowledged information transfer (Socha & Stamp, 2013). However, adolescents tend to have stronger faith in their parents as sources of sexual information, but found their parents not easily accessible, hence rely exclusively on nonverbal cues to get the much needed sexual knowledge (Joffe & Franca-Koh, 2001). However, due to the methodological problems associated with studying non-verbal communications, this study focused solely on verbal communication.

CHAPTER THREE

3.0 METHODOLOGY

This chapter describes the study area, study design, target population, source of data, sampling technique and sample size, methods for data collection, analysis and ethical considerations.

3.1 Study Design

A descriptive cross-sectional study was conducted using parent-child dyads including parents and their adolescents aged 10-19 years. Qualitative method of data collection comprising Focused Group Discussions (FGDs) and In-Depth Interviews (IDIs) were employed in this study.

3.2 Study Area

The study was conducted in Ashiedu-Keteke sub-metro of the Accra Metropolitan Area. There are four main communities in Ashiedu-Keteke namely: James Town Community, Accra Central Community, Ussher Town Community and the Korle Dudor Community. It is the smallest and yet the most densely populated sub-metro of the 10 sub-metros in the Accra Metropolis. Ashiedu-Keteke sub-metro is the centre of Accra for all economic activities. It shares boundary with Obetsebi Lamptey circle, the Graphic Road and Kimbu Traffic Light in the north, Korle Lagoon and Mortuary road in the west, Barnes Road to Kwame Nkrumah Mausoleum in the east and by the Gulf of Guinea in the South. Ashiedu-Keteke sub-metro has a population of about 129,566 people (GSS 2012). Anecdotal evidence shows that most of the inhabitants are semi-literates, school drop outs and illiterates, .

Though, the inhabitants are aware of health problems and issues affecting their welfare, they have other values and beliefs which affects their behaviour. The main health care facility is the Ussher polyclinic which comprises the James Town maternity home. Out of the four communities within the sub-metro, the James Town and the Ussher Town Communities were purposively selected as the study sites due to the urban location, as well as the mix nature of the population which is somewhat representative of the whole Ghana. These communities are areas of dense mixture of commercial and residential use. Residents of both communities are largely indigenous Ga people who are mainly fishermen and fishmongers.

Furthermore, anecdotal evidence shows high incidence of risky sexual behaviour with its resultant consequences. Such evidence suggest that young people, especially girls are ridiculed as being barren if they were not parents or at least not been pregnant before by a certain age. This systematically encouraged young girls to get pregnant to prove their fertility and thus increasing risky behaviour. Hence choosing James Town and Ussher community was ideal.

3.3 Study Population

The study population constituted adolescents aged 10 to 19 years and parents/caregivers of adolescents who resided in either James Town or Ussher Town community in the Ashiedu-Keteke sub-metro of Accra. For the purposes of this study, parents include biological parents and legal guardians.

3.3.1 Inclusion criteria

Participant included in the study were:

- Adolescents between the ages of 10 and 19 years.
- Parents/parents-figure must have been living with adolescents.
- Individuals must be residents of either James Town or Ussher community.

3.3.2 Exclusion Criteria

Participant who were excluded from the study were:

- Adolescents aged 10 to 19years as well as parent/parent-figure who do not live in James Town and Ussher community
- Adolescents between the ages of 10 to 19years who did not affirm participation or whose parents did not give their consent to participate.

3.4 Sampling

The Ashiedu-Keteke sub-metro consists of four major communities namely: Jamestown, Korle-Dudor, Ussher and the Accra Central communities. The two study communities; Jamestown and Ussher Communities were randomly selected out of the four by ballot. These communities give a balanced representation of the characteristics of the poor urban settlements in Accra.

Convenient sampling method was used to select participants. This method was used due to the difficulty in recruiting parent-adolescent dyads, which was a necessary requirement for the study. Thus during the data collection period, the study team recruited parent-adolescent dyads who were readily available for participation. The team thus moved from one house to the other until the required sample size was obtained.

Parents and adolescents were selected irrespective of their gender. Two Focus group discussions were conducted with eligible adolescents whose parents were one in each community. Each Focus Group Discussion comprised of 7 adolescents for each study community. In addition, 14 In-depth interviews were conducted for the parents of the adolescents, in their homes.

3.5 Data collection

Data for the study were collected from both parents and adolescents in April 2016.

3.5.1 Data Collection Techniques

In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs) were used to collect data from participants. The principal researcher together with an experienced research assistant with qualitative interview experience conducted the FGDs and IDIs. Data collection was done using two data collection tools – FGD guide for adolescents and an IDI guide for the parents. Open ended questions were used to probe the subject of discussion. Both FGD and IDI guides (see Appendices A and B) covered thematic areas such as type of conversations parents have with adolescent children, nature of the communication, parents view on the knowledge level of their child regarding sexual and reproductive health and importance of having sexual and reproductive health communication with their adolescent children.

3.5.2 Data collection procedure

Both FGDs and the IDIs participants were recorded on audio tapes as well as notes taken by the research assistant. Interviews were conducted in English and/or the local languages of Twi & Ga.

In all, two FGDs (of 7 participants each) and 14 IDIs were conducted. The location of each FGD was at a central point in each community. Each FGD lasted about 45minutes whilst each IDI lasted for about 1 hour. During FGDs, all participants were given the opportunity to freely speak to any question posed before proceeding to the next question.

3.6 Training of Research Assistance

A day training was conducted for the research assistants. The trainees were taken through:

- The objective of the study,
- Definition of key concept such as adolescent, parents as well as parent-figure
- The study procedure/methods
- Review of the study instruments and interview techniques. Demonstrations were performed using sample study technique.
- Parent-adolescent sexual communication, cultural sensitivities in talking about sexuality across sexes

3.7 Pre-testing

Before the main study, one FGD was conducted in Korle Gonno (a neraby community) among 4 adolescents aged 10-19 years from selected households. Furthermore, IDIs were also conducted for 4 parents from the same selected household. These were done for the purpose of pretesting and improving the FGD and IDI guides. These participants did not partake in the main study. The pretesting was done to validate the questionnaire and also detect any likely problems before commencing the study.

3.8 Data processing/analysis

3.8.1 Data processing

Both the FGDs and IDI were transcribed verbatim into Microsoft Word by the investigator. Interviews that were conducted in the local language were translated into English language during the transcription process. However, local language terminologies were not translated into English so as to preserve their informative meanings.

3.8.2 Data Analysis

After transcription, the transcripts were reviewed by another independent person. The review process involved listening to the voice recordings and comparing it with the transcripts that were produced from these voice recordings. Samples of the transcripts were again reviewed and a codebook developed from them. The codebook contained the codes to be used in coding the data, their definition, instances to use that codes and examples. The codebook covered the main themes and sub-themes that emerged from the data. Thematic content analysis involves four interrelated steps consisting of reading through textual data, identifying themes in the data, coding those themes, and then interpreting the structure and content of the themes (Guest et al. 2012).

The background characteristics of the respondents were entered and analyzed using SPSS version 2.0.

3.9 Ethical Considerations

The following measures were taken to ensure that study participants' safety and rights were guaranteed and protected:

- Ethical approval was obtained from the Ghana Health Service Ethical Review Committee protocol identification number GHS-ERC 22/3/09 (Appendix G).
- Permission and approval were also obtained from the Ashiedu-Keteke sub-metro before embarking on the study.
- Parents of adolescents were informed to give consent for adolescents who were below 18 years of age and their wards (the adolescents). Affirmations (assent) were obtained from adolescents aged below 18 years before participation in the study.
- Study rights were also explained to participants accordingly and this included rights to privacy, confidentiality and anonymity. The participants were assured of a high level of privacy and confidentiality. Furthermore, participants were informed that their participation was solely voluntary and their refusal or decision to quit the interview would not warrant any penalty. All interviews were conducted in secluded but secure places as agreed by the participant and the interviewer. Focus Group Discussions were conducted in central locations in each community.

3.10 Quality control

The following quality control measures were taken to ensure quality data:

- Two research assistance who have completed tertiary education were recruited and trained accordingly
- Interviews were audio recorded to maintain its authenticity.
- Furthermore, the tools/interview guides were translated into Twi and Ga to ensure uniformity, validity and accuracy of the dialogues.

CHAPTER FOUR

4.0 RESULTS

4.1 Socio-demographic characteristics of participants

This study explored the patterns of parent–adolescent sexual communication in the Ashiedu-Keteke sub-metro area of the Accra Metropolitan Area. Table 4.1 presents information on the socio-demographic characteristics of the participants. Overall, 28 individuals participated in the study, comprising 14 adolescents and 14 parents. Whereas adolescents were involved in focus group discussions, parents participated in-depth interviews.

The participants in the study were parents and adolescents of both sexes aged between 28-52 years (median age 37) and 12 to 19years (median age 15) respectively.

The parents had children of the adolescent age range. Fifty percent were married whilst 14% were co-habiting. A majority (86%) had had some form of formal education. For most of the parents, the main means of livelihood was fishing or fish mongering. A few were engaged in other income earning activities such as petty trade, dress making and commercial motor biking.

Majority of adolescents, (62%) were in school whilst 15% were school dropouts engaged in menial activities such as ‘driver’s mates’ (commercial bus conductors), petty trading or unemployed. The remaining 23% had completed basic or secondary education but wereunemployed. Most of them were single, 7% were co-habiting and none was married. Below is a tabular representation of the socio-demographic information of participants.

Table 4.1: Socio-demographic characteristics of parents and adolescents

Characteristics	Parents		Adolescents	
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)
Community				
Ussher	7	50	7	50
Jamestown	7	50	7	50
Educational Background				
No Education	2	14.3	-	-
Basic	7	50	5	35.7
Secondary	5	35.7	9	64.3
Religious Affiliation				
Christians	9	64.3	12	85.8
Muslims	2	14.3	1	7.1
Traditionalist	2	14.3	-	-
No Religion	1	7.1	1	7.1
Ethnicity				
Ga	9	64.3	9	64.3
Akan	4	28.6	4	28.6
Hausa	1	7.1	1	7.1
Marital Status				
Single	5	35.7	13	92.9
Married	7	50	-	-
Co-habiting	2	14.3	1	7.1
Occupation				
Employed	13	92.9	2	15.3
Unemployed	1	7.1	3	23.1
Students	-	-	8	61.6

4.2 Results presented according to Objectives

The results have been presented by themes in accordance with the study objectives.

Within each theme, results have been categorized into key topics.

4.3 Extent and frequency of parent–adolescent sexual communication

4.3.1 General things parents discuss with their adolescents

Parents generally had some form of communication with their adolescent children.

Parent-participants mentioned that they generally advise their adolescents on issues of general living like taking their education seriously and being of good behaviour. Both

men and women interviewed explained that though some of the adolescents were disrespectful, they advise them to beware of bad company, live a meaningful life and be respectful. Also, hard work and emphasis on spirituality were some of the general issues parents reported that they discuss with their adolescent children. The following quotes throws more light on some of the general issues parents discuss with their children.

“As for my kids, I talk to them to beware of bad company. Some of the children here (in this community) are very bad and I am always worried, because my son is always seen with some of those boys. When you talk to them, they don’t listen, but I will always keep talking. Also, I have talked to the girls that if they don’t take what they are doing seriously, it will affect them in future.” (IDI8, mother 35 years, Jamestown)

“We talk about how they should live a good life so that God would bless them. We also talk about any issues prevailing. They should respect people because for children of this age, most of them are disrespectful. We also talk about their education” (IDI1, mother 35 years, Ussher).

“I always advise them to take their studies seriously so that they can become somebody in future. I also advise them not to get involved with bad company. When anything happens in the community and it’s worth discussing, we do. My main problem with them is the kind of company they find themselves in.” (IDI4, Father 40 years, Ussher).

However, when adolescents were asked of the general things they discuss with their parents, they reported that they only had discussions with their parents when they needed things like school fees, money for food, etc. They further indicated that they are very uncomfortable discussing their private issues bordering on sexual and reproductive health with their parents. Some of the adolescents also complained that their mothers did not provide confidentiality for the issues they discussed with them. Thus they had to be circumspect with respect to when and how they initiated any discussions with their parents. Some prefer discussing some personal issues with other relatives like aunties and siblings or their friends and contemporaries. They felt much comfortable with the above people because they trust them.

“I don’t discuss any issues with my mother. When I get the chance to talk to her, it is solely about money. I don’t discuss my personal life with her. It’s my aunty and sister I sometimes discuss certain issues with. This is because my mother doesn’t care about me.” (FGD5, adolescent male 19 years, Ussher).

“I don’t discuss any issues with anyone. I only communicate with my little boy. This is because he is the one who listens to me and does not discuss my issues with anyone” (FGD7, adolescent female 18 years, Ussher).

4.3.2 Frequency of parent interaction with adolescent

Some of the parents conceded to infrequent interactions with their adolescent children with respect to sexual and reproductive health. The narratives from the transcripts indicated that their inability to consistently interact with their adolescents were due to time constraints, work-related issues, apathy and parents’ beliefs of not being responsible for such communication.

“I think having enough time for them is a problem. But if you are not careful, peer influence might change them negatively. I nearly lost my first girl in such a circumstance when she was not discussing sensitive issues with me but with her friends.”(IDI1, Mother 35 years, Jamestown)

“Not frequent. We need to work to take care of them. Time is a factor. Most of the time when I get time and come home they will be sleeping.” (IDI5, Mother 48, Ussher)

When the adolescents were asked about the frequency of interactions with their parents, they reported that interactions with their parents were infrequent with respect to communication. However, they blamed lack of knowledge and apathy for the poor frequency in communication. Priority was placed on ways of making money rather than communication.

“Our parents do not have much knowledge on some of these issues as well as the time. Even if they did, they prefer making their money.” (FGD7, adolescent male 15 years, Jamestown)

4.3.3 Depth of parent-adolescent communication on sexual issues

The study revealed that parental communication about SRH issues lacked salient details. Adolescents who reported that their parents have ever talked to them about SRH issues stated that their parents used folklores and proverbs in communicating with them. These usually lacked clearly defined details. They however felt that if communication was clearer and more understandable, some of them might not have fallen victim to some of these SRH issues.

A narrative from an 18year old adolescent with a child said:

“My mother just told me to be careful with men; if I get close to men or was touched by a man, I would get pregnant.” (FGD10 Adolescent female, 18 years, Jamestown)

They further narrated that their parents needed more education on the issues they discussed bordering on sexual communication.

“My mother does not know much about these things so how can she teach me.” (FGD6 Adolescent female, 12 years, Jamestown)

Parents on the contrary felt that giving too much information to the adolescents would spoil them hence were cautious in discussing such matters.

“When you discuss those issues with them, it means that you are pushing them into it, you are rather exposing them.” (IDI6, 36 years, mother, Jamestown).

4.3.4 Nature of parent-adolescent communication

Evidence gathered on the field with respect to the adolescent on the nature of parent-adolescent communication was mixed. Adolescent perspective differs from that of their parents. When the adolescents were asked to describe the nature and the extent of communication with their parents during the FDG, about half used expressions such as, ‘extremely poor’, ‘not effective’, ‘not peaceful’ and even ‘no communication at all.’

Furthermore, they mentioned that parents insult and shut them up anytime they wanted to discuss certain private issues with them.

“As for me, communicating with my parents is not effective; it is extremely poor.” (FGD4, adolescent male 18 years, Jamestown).

“In my situation, we get more attached to our friends than our parents because they insult and shut me up anytime we want to talk about such issues.”(FGD2, adolescent female 12 years, Jamestown).

Further probe on the contrary revealed lack of cordiality between parent and adolescent in the course of discussions. Parents, especially feel that instilling fear in adolescent will put them on track. The quote below from a 14 year old adolescent illustrates this view.

“It is not peaceful, we don’t discuss anything at all. Discussions always end up with shouting at me so there is no cordial discussion”. (FGD7, adolescent male 14 years, Ussher).

Although parents believed that, establishing a cordial relationship with their children was the best way to communicate with their adolescent, they also believed that they needed to put some fear in them to best achieve this. The transcripts buttresses this assertion. Furthermore, the nature of the discussion also varied with respect to the parent involved. The interview revealed that mothers rather had a more cordial relationship with their adolescents compared to fathers.

“Madam, these days, when you talk to them and threaten them or do not establish a cordial relationship, they will seek the information elsewhere hence you need to persuade and convince them. So as for me, I don’t block them. I allow them to free their mind. However, they fear their father and so they mostly do not discuss any issues with him.” (IDI1, Mother 35 years, Jamestown)

Parents also believed the ‘spare the rod and spoil the child concept of training a child’ expression hence to them, putting fear in them was the ideal way in communicating with their adolescents.

“I allow them to talk but if you issue is not sound I will beat you. You have to put some fear in them, you know; so that they could be responsible in future, I believe you understand me.” (IDI4, Father 40 years, Ussher).

4.3.5 Importance of sexual and reproductive health education

The study revealed that both parents and adolescents considered parent-child discussions on sexual and reproductive health issues important. They believed that such discussions will enable the adolescents to make the right choices as well as avoiding certain dangers or behaviours that might predispose them to various risks. They emphasized that some of these issues, such as teenage pregnancy and early childbearing were unheard of during their adolescent days. Also, homosexuality and lesbianism were only heard of from folklor

es and tales from foreign lands but these days, these sexual practices are common in their communities. Almost all participants supported the need for educating children on sexual and reproductive health issues. The following quotes illustrate some of the views articulated by both parents and adolescents:

“Due to where this world is moving to today, unlike our time, I think it’s very important they know about such issues.” (IDI1, Mother 35 years, Jamestown)

“Yes, I think adolescents should know about sexual matters...they say education is the key to success, the more you know something, the more careful you are.” (FDG2, adolescent female, Jamestown)

Only a few believed that such exposures would spoil their adolescents rather than benefitting them.

“No no no! I don’t support that idea at all. You are rather exposing them.”
(IDI6, Mother 36 years, Ussher).

Most parents conceded that contemporary issues which were happening were non-existent during their adolescent years. They further alluded to the fact that their adolescent prefer to seek information from some of these sources than them.

“Because they are exposed to so many things on social media ie. WhatsApp, Facebook etc. unlike in the olden days, they tend to seek the information from these sources.” (IDI3, Mother, 35 years, Ussher).

4.3.6 Parents-adolescent discussions about sexual issues

Interview narratives revealed that an overwhelming majority of all discussions on sensitive sexual issues were attributed to events which had occurred on the electronic media such as during radio or television programs, or while watching a movie. However, others also based their discussions on issues which had occurred in their community. Some parents thought that initiating discussions with their adolescents on sensitive issues would spoil them, hence they wait till an incidence or a television program triggers such discussions.

However, a few stated that communications were self-initiated. Some of the sensitive issues commonly discussed among parents and adolescents ranged from rape, teenage pregnancy, abortions, to lesbianism and homosexuality. In totality, parents only comfortably initiated communication based on someone’s issues rather their personal experiences or knowledge.

“I don’t start it, but you know that in James Town, lesbianism and homosexuality come with money hence when we see those people, based on that we give the necessary advice. If I start discussing such things with my children, it can spoil them because it will let them know too much.” (IDI4, Father 40 years, Ussher)

“Sometimes when we are watching TV and some of these issues crop up, we all discuss them. I advise them myself but mostly when an incident happens, I also emphasize that and also advise them.” (IDI7, Father 32 years, Ussher)

“....if you start it, you can spoil your children because you will let them know too much.” (IDI4, Mother, 32years, Ussher).

Adolescents expressed frustration as well as apathy on the part of their parents. They felt their parents lack interest in initiating communication with regards to sensitive sexual issues. Some of these issues discussed included gonorrhoea, syphilis, teenage pregnancy, HIV/AIDS, abortion, rape, homosexual and lesbianism. Further probe on the part of the adolescent revealed parent interest in discussing issues which were none of their business (gossiping). Moreover, stigmatisation, criticisms and lack of confidentiality and privacy from parents prevented adolescents from effectively communicating with their parents. Parents’ judgemental attitudes prevented smooth discussions on sensitive sexual issues.

“One day, I had problems with my menses, when I told my mum she started shouting and saying ‘hey are you pregnant?’ From that day I swore not to discuss issues with her again.” (FDG2, adolescent female, Jamestown)

“A friend was raped so I wanted to find out what happened afterwards. My parents rather blamed my friend that she does not dress well that was why it happened to her....So I share my problems rather with my friends than my parents.” (FDG3, adolescent female 15, Ussher)

“If it is gossiping, about someone’s issues, then fine but for them to discuss some of these issues in the form of advice, it never happens.” (FDG4, adolescent female 18 years, Jamestown).

4.3.7 Process of Communication

4.3.7.1 Parents comfort in discussing sexual issues with adolescents

Most parents felt comfortable mentioning the names of the private parts freely whilst a few expressed shyness. During the in-depth interview a participant stated that mentioning names of the private parts was a norm in their communities. Those who

were not able to do so expressed resentment in discussing very detailed sexual issues with adolescents.

“Here the vagina and the penis is never an issue for us at all. Your armpit is grown, ‘go and remove that smelly grown armpit hair’, and when your breast is not properly in the brassieres, we ask you to put the breast into the brassieres well. Over here it is quite normal to say things as they are.” (IDI4, Father 40 years, Jamestown)

“Me, I use “taflatse otherwise when you mention it raw, you will spoil them. But even if you don’t mention it, they already know” (IDI1, Mother, 35 years, Ussher)

Parents fear that their children will become promiscuous when they discuss sexuality issues with them. As a result parents who engage in sexual discussions are cautious.

“Oh not often, hahaha. When I am talking with them (adolescents) and I mention the private parts in our local language, they laugh and sometimes tell me that I’m spoilt so it does not make me feel comfortable using the local language.”(IDI3, Mother 41 years, Ussher)

“.....if you start it, you can spoil your children because you will let them know too much.”(IDI4, Mother, 32years, Ussher)

4.3.7.2 Adolescent’s comfort in discussing sexual issues with parents?

Majority of the adolescents mentioned that it was difficult discussing sexual issues with their parents because their parents may perceive them as spoilt children. However, such fears were absent when discussing such issues with their peers. They felt comfortable and safe.

“No! Those of us who have delivered before, they don’t want to listen to any submission from us because they see us as failures. Therefore I am not able to express myself freely.”(FGD5, Adolescent female 17 years, Ussher)

“No, no, no, if you are not careful, they might even stop paying your school fees. How dare you mention sexual issues freely to your mum, hmmm. She will say I am spoilt to my dad and even beat me up.” (FGD2, Adolescent female 12 years, Jamestown)

4.3.8 Barriers to communication with your adolescents

Parents mostly attributed the barriers to sexual communication to peer influence, social media, time constraint and fear of over exposing them to sexual reproductive health issues. They further stated that their wards view their advice as colloquial and outmoded hence preferred to listen to their peers rather than them. Further inquiries revealed lack of privacy and confidentiality leading to the barrier to communication.

“Here time is a problem, our children also see us as old-fashioned and peer pressure is also another issue. They listen to their friends more than to me.” (IDI2, Mother 48 years, Ussher)

“They like watching TV and doing Facebook and WhatsApp than listening to advice. Also I don’t have time due to funerals that I have to attend.” (IDI7, Mother 52 years, Jamestown)

Nonetheless, the adolescents ascribed the barriers to communication to a lack of privacy and stigmatisation. Upon probing further, it was also detected that factors such as fear and parents discussing personal issues with friends (lack of confidentiality) acted as barriers to adolescents discussing such issues. Thus the parents lose the trust of their adolescents hence they are not able to discuss sensitive sexual issues with them.

“It is not easy at all because when you want to confide in them, the behaviour they put up will put some fear in you such that you can’t attempt it again.”(FGD1, Adolescent female 17 years, Ussher)

“There is no privacy, when you want to discuss something intimate with them other people could hear what you are discussing with them. I also feel shy of my mum so I can’t discuss certain intimate issues with her” (FGD2, Adolescent female 15 years, Ussher)

“I think our parents do not have time for us. They feel that their work is more important to them than any other thing in this world.”(FGD3, Ussher & FGD7, Jamestown).

4.4 Sexual health topics commonly discussed by parents with adolescents

4.4.1 Parent-adolescent knowledge on sexual and reproductive topics

Parents and adolescent were asked about some sexual topics that they commonly discussed in their communication. It was evident from the discussions that participants knew about gonorrhoea, HIV/AIDs, syphilis, genital infections, genital warts and many more as these were some of the topics that they stated that they discussed. Adolescents however had a deeper meaning and understanding to these topics due to their educational level. Parents and adolescents mentioned that some non-governmental agencies (NGOs) also periodically educated them on some of these topics as part of their community studies/research and social responsibility. Healthcare students and researchers, in the course of doing studies in the communities, educated them on some of these topics.

“Here HIV/AIDs, gonorrhoea (‘babaso’), syphilis, and candidiasis (white) are common here so I know some.”(FGD1, Adolescent female 17 years, Ussher)

Some adolescents further reiterated that such knowledge was acquired from school, television as well as friends.

“Through child welfare clinics, NGOs, on TV and some friends. Some medical students and nurses from Korle-Bu come here to interview and educate us.”(FGD7, Adolescent male 15 years, Jamestown)

Most parents expressed diverse ways by which they acquired their knowledge on sexual health topics. Diverse channels such as electronic media like television and radio; women fellowships, child-welfare clinics and books were cited. Some also learnt from their children who in turn learn these from school.

“Through radio, sometimes health promotion programs. Sometimes they learn from school so they teach me and I also read from books.”(IDI3, Mother 35 years, Jamestown)

“I have once worked as a volunteer for UNICEF where they taught us a whole lot of things, women meeting discussions too help and I also listen to some from radio and TV too.”(IDI5, mother 38 years, Ussher)

4.4.2 Ideal age for sexual communication

4.4.2.1 Parents Perspective

Most parents advised that ideally sexual communication should be done by age 12 years.

However, others recommended that sexual communication should be done starting from ages ranging up to 18 years.

“12 years. Even in the older days, 20 years and above...’ Also, I think from when they menstruate because if any man sleeps with them around that time, they would get pregnant.” (IDI1, Mother 35 years, Ussher)

“This one, if you see that the child is developing breast and the boy too is making moves on women then you talk to them...I think 14yrs is okay.” (IDI4, Mother 32 years, Jamestown)

Parents who preferred older ages compared their time (the past) to these present generation. Further, they felt lack of understanding on some of these issues with their adolescents. Additionally, they argued that when discussions starts earlier it will spoil them.

“When they grow up. I think 18 years onwards is ideal, because by then, they would have grown up to understand and even practice sexual issues.” (IDI6, Mother 39 years, Jamestown).

4.4.2.2 Adolescent Perspective

The adolescents expressed mixed opinions on the ideal age for sexual communication.

The various ages reported range between 8 and 18 years. They further justified why they specified those ages as the appropriate ages for communication about sexual and reproductive health.

“12 years because a friend told me that those changes into adolescence begin around that age.” (FDG3, Ussher & FDG4, Jamestown)

“18 years. We should be grown before being exposed to some of these things.” (FGD4, Adolescent male 14 years, Ussher)

“8 years. Parents always say we are not grown, however we are menstruating from age 8. What happens if we get pregnant? Are they going to say that you are not grown?” (FDG2, Adolescent female 12 years, Jamestown).

4.4.3 Sensitive issues on reproductive health discussed between parents and adolescents

Most parents mentioned sensitive issues such as teenage pregnancy, abortion, lesbianism, homosexuality and rape. However majority of the parents admitted that they lacked detailed knowledge on these topics as opposed to the adolescent who had enough knowledge.

“They always discuss rape, lesbianism, teenage pregnancy on TV and radio so they know.” (IDI7, Mother 52 years, Jamestown)

“I talk about teenage pregnancy because most of their friends are pregnant. I don’t want anybody to put my girl in the family way since it can spoil their life and you have to start school all over again.” (IDI1, Mother 35 years, Ussher)

The adolescents mentioned that they acquired such information from school and friends who had fallen prey to these predicaments. They attested to the fact that they know some of their friends who indulge in some of these acts.

“Mostly they talk to us about teenage pregnancy, syphilis and gonorrhoea.” (FGD3 & FGD4, Ussher and FGD6, Jamestown)

“Me too, same as teenage pregnancy. Me, I have gotten pregnant before so they keep on reminding me of that. Always, the only conversation is ‘look after yourself well.’ That is all.” (FGD4, Adolescent female 18 years, Jamestown)

4.4.4 Importance of parent-adolescents discussing sexual health topics

Nearly all respondents expressed the need to discuss sexual health issues amongst themselves. Field interactions on the part of adolescent showed the zeal as to why they should discuss such issues. The adolescent felt they were the final recipient of any form of predicament that might happen to them hence they must know. Nonetheless, a few of the parents felt that too much discussions on these topics could spoil their adolescents.

“Because these are issues which generally affect us. It is very important that you know when to use condom, for instance, to avoid teenage pregnancy.”(FGD1, Adolescent female 17 years, Ussher)

“I also think these are issues which are common in James Town, Chorkor and other community and a lot of people and NGOs come here to work in these areas hence it is important. And most of our friends are no more in school due to such issues.”(FGD6, Adolescent female 15 years, Jamestown)

“I think they should know, as for that one, you are not lying. Now the children, at 12 and 13yrs, take seed so I think we should talk to them. Sometimes a child of 22yrs could have a child and a grandchild so it is a problem. I think the government should do something about it.”(IDI4, Father 40 years, Jamestown)

“I think is important. They need to know how to protect themselves so that they don’t fall prey to any of these. Because if you go to this spot (name withheld) there you will see men sleeping with men and vice versa. Illicit drug use such as alcohol, weed etc.”(IDI7, Father 32 years, Ussher).

4.5 Triggers of Parent-Adolescent communication about sexual and reproductive health issues

During the interviews, most parents revealed that 60% of the triggers of parent-adolescent communication arose after watching or listening to television and radio programs. But other triggers were also from issues that occurred in the community such as teenage pregnancy, abortion, rape etc.

“Our conversations are mainly based on incidents which happened in the community. Because, as for here, there is a lot of teenage pregnancies, criminal

abortions, lesbianism, homosexual and many more.”(IDI3, Mother 41 years, Ussher)

“I don’t wait for an incident to happen. Once a while I call them and we talk. Mostly we get a lot of topics for discussion from radio and from the films we watch on TV.” (IDI5, Mother 31 years, Jamestown).

Moreover, the adolescents mentioned that communication with their parents on such issues were normally initiated when an incidence occurs or when watching television or when their parents were in a good mood.

“Mostly when we are watching TV and an incidence happens then they take the opportunity to advise you on that but my father or mother will never call you that come I want to talk to you.”(FGD2, Adolescent female 15 years, Jamestown)

Besides, these adolescents expressed fear in initiating such communication with their parents. In probing further, such fears hindered the initiation of any form of communication with their parents. Furthermore, stigmatisation as well as being branded as spoilt, hindered them from doing so.

“My father is really strict. So I don’t even want to have any form of discussions with him. I avoid it always. Nothing triggers communication between us. Because if you are not careful, he will slap you for you to lose your teeth.” (FGD2, Adolescent female 12 years, Ussher).



CHAPTER FIVE

5.0 DISCUSSION

This chapter discusses the results of the study. The discussion is structured along the four objectives of the study and the theoretical framework that was used for the study. This study adopted the theory of planned behaviour. This theory predicts an individual's behaviour as a function of three interrelated constructs; attitude, perceived behavioural control and subjective norms. Therefore the discussion takes into consideration these determinants in relation to the parent-adolescents sexual and reproductive communication.

5.1 Extent and frequency of parent–adolescent sexual communication

Parents generally had some form of communication with their adolescent. Parent-participants mentioned that they generally advised their adolescents on issues of general living such as taking their education seriously and being of good behaviour. Adolescents on the other hand indicated that they often discussed finance-related issues such as their school fees, money for food and money for their general upkeep with their parents. The study found that the adolescents find it very uncomfortable to discuss sexual and reproductive health issues with their parents, similar to findings of Svodziwa et al. (2016) in Zimbabwe. They found that parents did not communicate effectively with their adolescents due to certain barriers. Some of the adolescents also complained that their mothers did not provide confidentiality for the issues they discussed with them. Thus they had to be circumspect with respect to when and how they initiated such discussions with their parents. Some preferred discussing some personal issues with other relatives like aunts and siblings or their friends and contemporaries. In Asia, it was found that

many adolescent also engaged in general discussion with their parent whilst only few adolescents (22%) reported regularly discussing sex with parents (Chung et al. 2007).

Both parents and adolescents expressed the importance of the need to discuss issues pertaining to sexual and reproductive health for informed decisions and making the right choices. However when adolescents do not receive the right information from the correct source they may fall prey to misinformation from other sources. With the advent of electronic and social media and with the current ease of access to those media, adolescents who do not receive the right information may rely on these media which may expose them to unreliable and unverifiable information that may rather lead to unsafe sexual practices (Anton, 2016). Clearly, from the study, adolescents were more knowledgeable than their parents regarding sexual and reproductive health issues from various sources such as schools and media.

As observed by Montemurro (2003), adolescents live and are functioning within a complex environment, which exposes them to many things and ideas; some of which may have negative consequences on them. The electronic media and online sexual activities are very common and adolescent who have access to this information stand the risk of being lured into these online sexual platforms (Montemurro 2003). In their study among unmarried youth in Bolgatanga in the Upper East Region of Ghana, Geugten et al., (2013) found that sexually active adolescents see premarital sexual relationships as normal and their opinion was attributed to increased access to a host of media. This therefore calls for the need for adolescents to receive the right information on sexual and reproductive health issues from parents and other expert at the early stage of their life in order to prevent them falling prey to uncensored information that has the potential of leading them to early and unsafe sexual practices. In this study, parents indicated that

they only heard of homosexuality and lesbianism from folklores and tales from foreign movies in their days. Nonetheless, it is common among adolescents in their use of social media and internet in contemporary times (McGrath, 2012). Further, this buttresses the point that adolescents in this study were already relying on the media for information on sexual and reproductive health which may not be censored. Also, an overwhelming majority of participants supported the need for education on sexual and reproductive health issues. Communication on sexual and reproductive health before the initiation of sex has been found to be associated with condom use at first intercourse when provided by parents (Atienzo et al. 2009). Another study among adolescents in the United States showed that adolescents who received comprehensive sex education in school were significantly less likely to report teen pregnancy than those who received no formal sex education (Kohler et al. 2008). This further reinforces the need to educate adolescents on sexual and reproductive health.

Some of the parents conceded to infrequent interactions with their adolescent children with respect to sexual and reproductive health. However, frequent interaction with parents was required to create good rapport with adolescents such that they can feel comfortable to discuss sexual and reproductive health issues with them. The findings of this study is different from an earlier study which was conducted in the Netherlands that showed parent have frequent interaction with their adolescent children on sexual and reproductive health issues with about 75% of parents reported having had discussions with adolescents on at least one topic on multiple occasions (De Looze et al. 2014).

The study showed that though parents could freely mention sexual body parts such as vagina and penis, it was viewed as inappropriate for a parent to initiate and discuss

sexual and reproductive health-related matters with their children. Parent believed this could rather lead them into promiscuous lifestyles. Nonetheless, both adolescents and parent believed it was important for adolescents to receive education on these matters. In their study Jerman and colleagues found that more than two-thirds of the parents reported experiencing some type of sexual communication difficulty, such as developmental concerns and embarrassment (Jerman & Constantine 2010). But ignorance about sexuality and reproduction health among adolescents has been reported to increase the early initiation of coital relations and of unwanted pregnancies (Minnick & Shandler 2012).

Majority of the adolescents interviewed mentioned that it was difficult discussing sexual issues with their parents as their parents may perceive them as spoilt children. However, such fears were absent when discussing such issues with their peers. This notwithstanding, an earlier study had showed that adolescents who have sexual communication with their parents felt closer to their parents and felt more able to communicate with their parents in general. Therefore adolescents could also use this strategy to get closer to their parents (Martino et al. 2008).

Depth of communication was shallow as revealed by the narratives from the adolescents. They stated that their parents lacked fine details as to the communication which ensued. One adolescent corroborated this by stating that...*“my parent do not know much hence how can she teach her”*.

5.2 Sexual health topics commonly discussed by parents with adolescents

The findings of this study showed that common sexual and reproductive health topics discussed between parents and adolescents were HIV/AIDS and other sexually transmitted infections such as gonorrhoea, syphilis, and genital warts. Menstruation, abortion, lesbianism, homosexuality candidiasis and rape were also some of the sexual health issues commonly discuss by participant. However, majority of the parents admitted that they lacked detailed knowledge on these topics as opposed to the adolescent who had enough knowledge. For adolescents this information were mostly acquired from school whilst parents were educated through the activities of some non-governmental agencies (NGOs). Generally, some earlier studies in Ghana showed that adolescent knowledge on sexual and reproductive health has been low. Awusabo-Asare and colleagues in study among Ghanaian adolescents observed that majority of female and less than half of older male adolescents are aware there are certain days a woman was more likely to get pregnant. However, knowledge of the specific time that a female could get pregnant among the 15-19 years was low, as only 26% among the females and 14% among the males were aware of fertile periods for females. In like manner, fewer younger adolescents (12-14years) were aware of the fertile period (34% females and 18% males), (Awusabo-asare et al. 2006). The low knowledge has implication on safe sexual practices as female adolescents could be engage in unprotected sex during their fertile period which could result in conception.

An earlier longitudinal study of 12–14-year-old virgins in Tanzania showed that 27% reported talking to their parents about sex and HIV, but that these discussions were not associated with the timing of sexual initiation (Kawai et al. 2008). In Nigeria and Uganda, it was also found that parents emerged as the most important sources of

information on sexual and reproductive health as they had discussed issues relating to safe sexual practices, HIV and AIDS with their adolescents children (Ybarra et al. 2008; Nwagwu 2007; Nwalo & Anasi 2012).

In providing adolescents with information about sexual and reproductive health, it is important to also highlight safe sex practices including the use of condom. In Ghana, it has been found that abstinence till marriage is a cultural requirement and a vision among Christian and Islamic religions in Ghana (Geugten et al. 2013). Therefore, many parents in providing information of sexual practices tend to only focus on abstinence. Nonetheless, a study in USA has showed that education to adolescents that emphasize abstinence only does not lead to reduction in the likelihood of unplanned pregnancy (Kohler et al. 2008). Drawing from the findings of this study in the USA, it would be important for any discussion and education to adolescents on sexual and reproductive health to go beyond promoting abstinence only to making it possible for adolescents to access services that can ensure that adolescents who wish to engage in sex do that with protection against pregnancy and STIs.

It has also been reported that adolescents who exhibit delinquent behaviours, used alcohol and marijuana, are more likely than their counterparts who do not practice these vices to engage in vaginal sex without using a condom (Thompson & Auslander 2011). Based on this observation, it would be important for parents to also incorporate discussions on use of alcohol and drugs to the health education they provide to their children because of the close association between the use of such substances and unsafe sexual practices.

However, when the discussion turned to the ideal age to discuss the topic, there were varying views between parent and adolescents regarding the ideal age for initiating parent-adolescent communication. Many parents believed sexual and reproductive education should commence by age 12 years, whilst other parents believed 12 years might be too young and believed it should be done after age 18 years. Adolescents however were of the view that sexual and reproductive health education was important and expressed mixed opinions on the ideal age for sexual communication. The various ages reported by adolescents range between 8 and 18 years. The Ghana Demographic and Health Survey showed that the percentage of girls who have begun childbearing increases from less than 1% among 15 year olds, to 29 % among 19 year-olds (Ghana Statistical Service et al. 2009). As alluded to by some of the adolescents, evidence shows that the age at which girls attain menarche has consistently been declining. This has been attributed to overall improvement in nutrition. This carries with it the increased risk of pregnancy if they engaged in unprotected sexual intercourse. Hence initiation of sexual education should be such that it would minimize adolescents' risk-taking behaviour from such periods to prevent pregnancy. Also, given the fact that the risk of sexual behaviour increases with increasing age of the adolescent, it would be important for such education to be a continuous process.

5.3 Triggers of Parent-Adolescent communication about sexual and reproductive health issues

During the interviews, most parents revealed that more than half of the triggers of parent-adolescent communication were events encountered whilst watching or listening to television and radio programs. But other triggers were also issues that occurred in the community such as teenage pregnancy, abortion, rape. From all indication, adolescents

were not comfortable initiating communication and social norms inhibit parents from also initiating such a conversation. Furthermore, stigmatisation as well as being branded as spoilt, hindered them from doing so. Household communication on sexual and reproductive health issues during adolescent years appears to be very key (Kennedy et al., 2014). Adolescence is a developmental period marked by sexual discovery with a lot of sexual risks. A predominant means for transmitting sexual values, beliefs, expectation, and knowledge between parents and their adolescents is through discussion (Ayalew et al., 2014). Earlier studies document that any interventions that are targeted at reducing risky sexual behaviour among adolescents may not be successful where parent-adolescent is not taken into consideration (Wang et al. 2014).

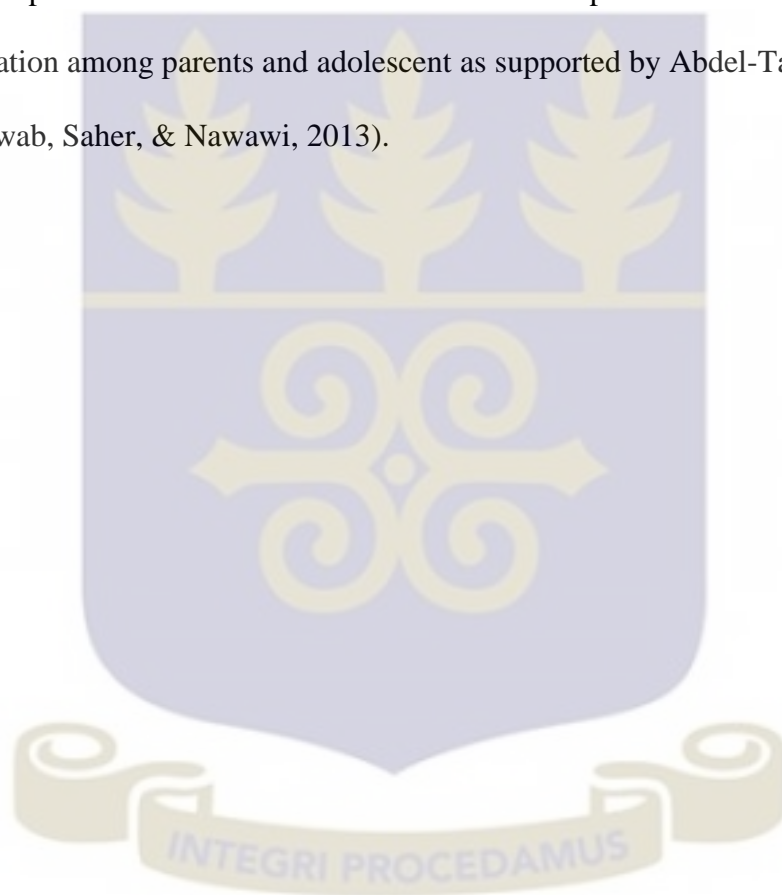
5.4 Barriers to Parents-Adolescent communication about Sexual and Reproductive Health issues

The study revealed lack of trust on the part of adolescent as a hindering factor to communication. They reiterated that discussions on matters with parents ends up in the opening by their parents' friends. A study by Bastein et al., (2011) confirmed this assertion.

On the contrary, parents said that their adolescent viewed their advice and contributions as colloquial and old fashioned hence turned to listen to their contemporaries than them. Parents further stated that peer pressure served as a great barrier to some of these communication.

As adolescence is a developmental phase, characterised with identification of peers, parents therefore need to understand this phenomenon to enhance an effective and harmonious discussion.

Lack of privacy in discussing confidential issues with parents was not conducive due to the settlement nature of their community. Furthermore parents not knowing much about sexual and reproductive issues as well as time constraint prevented smooth communication among parents and adolescent as supported by Abdel-Tawab et al (Abdel-Tawab, Saher, & Nawawi, 2013).



CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The following conclusions were made based on the findings of the study.

- Both parents and adolescents were uncomfortable initiating communications about Sexual and Reproductive Health issues.
- Parents generally assumed that the media, churches and events in the community adequately equipped their adolescents on sexual and reproductive health issues.
- The most common sexual health topics discussed were abortion, lesbianism, homosexuality, rape and prevention of sexually transmitted infections such as gonorrhoea, HIV/AIDs, syphilis, and genital warts.
- Factors such as events encountered whilst watching TV and listening to radio programs, and issues that occur in the community such as teenage pregnancy, abortion, rape triggered communication on sexual health issues.
- Parental barriers to communications were lack of fine details on sexual and reproductive health issues as well as lack of trust of their adolescent.
- Stigmatisation, lack of privacy and confidentiality in discussing sexual issues with parents as well as adolescent viewing parental advice as colloquial and old fashioned are some of the barriers to adolescent communication

6.2 Recommendations

Based on the study conclusion, the following recommendations are made:

- Parents should build trust and mutually respectful relationships with adolescents to enhance free communication.

- Communication about sexual and reproductive health issues should be inculcated into daily household activities and not to be initiated by events.
- Parents should be educated periodically by the Ministry of Gender, Children and Social Protection to enhance effective parent-adolescent communication.
- Parents should be educated/oriented to avoid stigmatization and labelling adolescents who express their views or ask questions about SRH issues.



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APPENDICES

APPENDIX A: FOCUS GROUP DISCUSSION INTERVIEW GUIDE

Participant number	Age	Education	Occupation	Religion	Marital status	Ethnicity
1						
2						
3						
4						
5						
6						
7						

1. What kind of personal things do you talk about with your parents?
2. How do you consider the communication between you and your parents? Probe: Do you discuss issues openly or is the communication threatening, mutually interactive, beneficial etc?
3. Do you think adolescents need to know about sexual and reproductive health issues? Why your answer? In your opinion, what is the appropriate age to talk/know about sexuality?
4. Have you ever discussed sensitive issues such as sexual matters with your parents? Probe: which of your parents did you discuss with? Why that parent?
5. How important do you think it is to discuss sexuality with your parents?
 - a. How do you communicate with your parents on sexual and reproductive health issues? Probe: Ask for examples of what sexual topics and reproductive health issues were discussed. Prompt: puberty, menstruation, STDs, HIV/AIDS, sexual intercourse, pregnancy, abortion, reproduction, consequences of premarital sex, sexual pressures, etc. Why did you talk about these things?
 - b. How did the communication happen?
 - c. What usually triggers communication about sex? Probe: Is it a disagreement, an occurrence of a peer being pregnant, a movie/TV show, a religious event etc.
 - d. During communication about sexual issues, do you think you can freely express your views?
 - e. Do your parents tolerate your views on sexual and reproductive health issues?
6. How difficult or easy is it for you to discuss sexual issues with your parents? Probe for barriers and facilitators.
7. How confident are you in discussing sexual issues with your parents? Do you feel comfortable? Probe: does your confidence in discussing sexual issues differ for your father and mother?
8. How well do you know these topics you have mentioned?

APPENDIX B: IN-DEPTH INTERVIEW GUIDE

Participant number	Age	Education	Occupation	Religion	Marital status	Ethnicity
1						
2						
3						
4						
5						
6						
7						

1. What kind of personal things do you talk about with your child?
2. What is the nature of the communication between you and your child? Probe: Is it threatening, mutually interactive, beneficial etc?
3. Do you think your child needs to know about sexual and reproductive health issues? Why? In your opinion, what is the appropriate age to talk/know about sexuality?
4. Have you ever discussed any sensitive issues such as sexual matters with your child? Probe
5. How important is it to discuss sexuality with your child?
 - a. How do you communicate with your child on sexual and reproductive health issues? Probe: Ask for examples of sexual topics and reproductive health issues. Prompt: puberty, menstruation, STDs, HIV/AIDS, sexual intercourse, pregnancy, abortion, reproduction, consequences of premarital sex, sexual pressures, etc. Why did you talk about these things?
 - b. How did the communication happen?
 - c. What usually triggers communication about sex? Probe.
 - d. During communication about sexual issues, is he/she free to express his/her views?
 - e. If he/she does, do you tolerate his/her?
6. Personally, how difficult or easy is it for you to discuss sexual issues? Probe for barriers and facilitators.
7. How confident are you in discussing sexual issues with your child? Do you feel comfortable? Probe: does your confidence in discussing sexual issues differ for boys and girls?
8. How well do you know these topics you have mentioned?

APPENDIX C: PARENTAL CONSENT FORM FOR ADOLESCENT PARTICIPATION

Title: Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke sub-metro of Accra.

Principal Investigator: Felicia Aperkor

Phone and e-mail address: 0243283110, faperkor@gmail.com

Address: University of Ghana, School of Public Health, P.O. Box 43, Legon

Dear Parent,

Your child is invited to participate in a research title stated above. You are entreated to read the information below very careful before you agree to allow your child to take part in the research.

General Information about Research

The purpose of the study is to explore the patterns of parent–adolescent sexual communication and its influence on the sexual behaviour of adolescents in Ashiedu-Keteke sub-metro of Accra.

The study will address the three objectives to:

1. To explore the extent and frequency of parent–adolescent sexual communication
2. To identify the sexual health topics commonly discussed by parents with adolescents, and perspective of parents on such topics
3. To describe sexual behaviour of adolescents, comparing for parent–adolescent sexual communication characteristics.

Your child will be required to participate in a focus group discussion which will take 45 to 60 minutes and will hold at the auditorium of the Ghana National Fire Service Training School, Jamestown. Your daughter/son will take part in a discussion with 7 other teenagers from the community. The girls and boys will be in separate groups. This discussion will be guided by me. This discussion will be audio recorded with your child's permission and field notes will be taken on event that cannot be record. The recordings will be transcribed in exactly the same words as all participants in the discussion, including your child used them and then analysed. The findings will be discussed by comparing it to other related researches and conclusion drawn. The report will be shared with the University of Ghana, as well as the Ministries of Health & Youth and Sports, who deal with adolescent's health issues.

Possible Risks and Discomforts

Your child will not be exposed to any risk or discomfort in this research.

Possible Benefits

Your child will not receive any direct benefit for participating but the findings of the study will be used to counsel adolescents and their parents on how to better communicate and improve the sexual health of the adolescent. It will also inform health providers especially on designing effective interventions for healthier sexual practices by adolescents.

Confidentiality

All the information that your child will provide will be known exclusively to the researcher and her supervisors. Your child's name will not be included in any of the information your child will give me except the agreement form. The information your child provides will be kept under lock for five years and if the need to use it again arises permission will be sought from you and your child.

Compensation

Your child will be given refreshments after the discussion. Apart from this no other compensation will be given to the child.

Voluntary Participation and Right to Leave the Research

Please be assured that your child's participation in this study is entirely voluntary. Your child has the right to participate or refuse to participate and this will not result in any penalty to your child. Your child has the right to drop out of the research at any time he/she desires.

Contacts for Additional Information

If you or your child has any questions now or at any point during the course of the study, please feel free to ask. For further information please contact the principal investigator, Felicia Aperkor, School of Public Health, University of Ghana, Legon. Telephone: 0243283110 or email: faperkor@gmail.com. Contact can also be made with the supervising lecturer, Dr Abubakar Manu. If you have any questions about your child's rights as a research participant you can contact the Ghana Ethical Review Board Office via Hannah Frimpong 0243235225 or 0507041223.

APPENDIX D: PARENTAL AGREEMENT

The above document describing the benefits, risks and procedures for the research titled “Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke Sub-Metro of Accra” has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction.

By ticking this box, I agree that my child should participate in the research.

Date

Signature or thumbprint of parent or guardian

If parent or guardian cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the child’s parent or guardian. All questions were answered and the child’s parent/guardian has agreed that his or her child should take part in the research.

Date

Signature or thumbprint of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual

Date
Consent

Name & Signature of Person Who Obtained



APPENDIX E: CHILD ASSENT FORM

My name is Felicia Aperkor and I am from the School of Public Health at the University of Ghana. I am conducting a research study titled “Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke sub-metro of Accra”. I am asking you to take part in this research because I am trying to learn more about how parents can influence the sexual behaviour of adolescents. It will take you 45 to 60 minutes to participate.

If you agree to be in this study, you will be asked to participate in a focus group discussion with seven (7) other adolescents about your communication with your parent/guardian about sexual matters and also your own sexual behaviour, and it will be audio taped with your permission.

Your participation in this study will not result in a direct benefit to you but the findings will be used to improve adolescent health services. However, there are no risks associated to this research.

You can stop participating at any time if you feel uncomfortable. No one will be angry with you if you do not want to participate. There will also be no punishment or any negative consequence to you not participating.

Your information will be kept confidential and apart from those who are in the discussion with you, your information will be known to the researcher alone.

You may ask me any questions about this study. You can call me at any time on 050-5353-662 or talk to me the next time you see me.

Please talk about this study with your parents/guardians before you decide whether or not to participate. I will also ask permission from your parents before you are enrolled into the study. Even if your parents say “yes” you can still decide not to participate.

By signing below, it means that you understand and know the issues concerning this research study. If you do not want to participate in this study, please do not sign this assent form. You and your parents will be given a copy of this form after you have signed it.

This assent form which describes the benefits, risks and procedures for the research titled “Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke sub-metro of Accra” has been read and or explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate.

Researcher’s Name: _____

Researcher’s Signature: _____ Date: _____

Child’s Signature/ Thumbprint: _____ Date: _____

APPENDIX F: PARENT CONSENT FORM

Title: Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu Keteke sub-metro of Accra.

Principal Investigator: Felicia Aperkor

Address: University of Ghana, School of Public Health, P.O. Box 43, Legon.

Dear Respondent,

You are invited to participate in a research title stated above. You are entreated to read the information below very careful before you agree to take part.

General Information about Research

The purpose of the study is to explore the patterns of parent–adolescent sexual communication and its influence on the sexual behaviour of adolescents in Ashiedu-Keteke sub-metro of Accra.

The study will address the four objectives to:

1. To explore the extent and frequency of parent–adolescent sexual communication
2. To identify the sexual health topics commonly discussed by parents with adolescents, and perspective of parents on such topics
3. To describe sexual behaviour of adolescents, comparing for parent–adolescent sexual communication characteristics.

You will be required to answer interview questions which will take you 45 to 60 minutes to go through the interview at a convent place of your choice. This will be audio recorded with your permission and field notes will be taken on event that cannot be record. The recordings will be transcribed in exactly the same words as you used them and then analysed. The findings will be discussed by comparing it to other related researches and conclusion drawn.

Possible Risks and Discomforts

You will not be exposed to any risk during the research.

Possible Benefits

You will not receive any direct benefit for participating but the findings of the study will be used to counsel other parents on communicating on sexual issues with their adolescents. It will also inform health providers especially on designing effective interventions for healthier sexual practices by adolescents.

Confidentiality

All the information you will provide will be known exclusively to the researcher and her supervisors. Your name will not be included in any of the information you give me. The interview will be done at place where nobody will be able to identify you. The

information you provide will be kept under lock for five years and if the need to use it again arise permission will be sought from you.

Compensation

You will be given refreshments after the interview.

Voluntary Participation and Right to Leave the Research

Please be assured that your participation in this study is solely voluntary. You have the right to participate or refuse to participate and this will not result in any penalty in the service you are entitled to. You have the right to drop out of the research at any time you desire.

Contacts for Additional Information

If you or your child has any questions now or at any point during the course of the study, please feel free to ask. For further information please contact the principal investigator, Felicia Aperkor, School of Public Health, University of Ghana, Legon. Telephone: 024-3283-110 or email: faperkor@gmail.com Contact can also be made with the supervising lecturer, Dr Abubakar Manu on 024-423-6598

Participant Agreement

The above document describing the benefits, risks and procedures for the research titled “Parent–adolescent communication about sexual and reproductive health: a case study of the Ashiedu-Keteke sub-metro of Accra” has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction.

By ticking this box, I voluntarily agree to participate in the research.

Date Signature or thumbprint of parent or guardian

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date Signature or thumbprint of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual

Date Name & Signature of Person Who Obtained Consent

APPENDIX: ETHICAL CLEARANCE

