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**SEX EDUCATION IN GHANA: THE PERSPECTIVES OF
ADOLESCENTS AND PARENTS**

BY

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DECLARATION

This is to certify that this thesis is the result of research carried out by **JESSICA OSEI OWUSU** towards the award of the MPhil Counselling Psychology Degree in the Department of Psychology, University of Ghana.



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DEDICATION

First and foremost, I thank the Almighty God for providing me with the strength, understanding, and wisdom to complete this thesis.

I also dedicate this thesis to my family, especially my mother, Ms. Jocelyne Chidiac, and brother, Mr. Joel Osei Owusu for their unwavering support and contributions to my personal and academic development.



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ABSTRACT

The extant literature has explored sex education from the perspectives of adolescents, but the views of parents are largely neglected. The few studies that have examined the views of both parents and children are selective in scope, coverage, and assessment. Thus, there is a dearth of data on the type of topics discussed and the frequency of parent-child sexual communication. The present study sought to explore adolescents' and parents' perspectives on sex education. To achieve this aim, a qualitative research design with a semi-structured interview was employed. Thirty parents and adolescents were conveniently sampled from Ablekuma South Metropolis, in the Greater Accra Region. Interpretative Phenomenological Analysis (IPA) was used in analysing the data. Three superordinate themes were extracted from the data. Participants' responses generally clustered around parent-child sex communication, perception of sex education, and impact of sex education. It was recommended that stakeholders ought to institutionalize diverse behaviour change interventions such as interpersonal communication and adult role modeling (in which adults share their experiences of navigating adolescence, with a focus on sexual abstinence). The Ghana Health Service must collaborate with the Ghana Psychological Association to organize training programs aimed at empowering youth to develop and acquire personal skills such as assertiveness training, refusal skills, and goal setting.



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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Adolescence is a stage of development that comes with sexual discovery, exploration, and risk-taking behaviours (Forhan et al., 2009). Most adolescents during this stage go through a series of changes and transition from childhood life to adulthood life (World Health Organization, [WHO], 2020). Most adolescents experience growth in height and overall body changes such as the growth of pubic hair, the development of breasts among girls, and the development of muscles and a deep voice among boys (Sawyer, et al., 2012). Biological changes in male and female sexual characteristics come along with various problems (Kar et al., 2015). They are sometimes confused about the transition in their lives. Hence, their confused state serves as a driving force to propel them to fetch for information to understand their current development (Casey et al., 2010). In their quest to understand their transition period, some of these youths are sometimes misinformed, thereby raising their concerns about the possibility of contracting various forms of diseases. Others also see this transition as an opportunity to explore by engaging in varying kinds of sexual activities (WHO, 2020). Adolescents' quest to satisfy their sexual needs through numerous sexual escapades has resulted in a high birth rate.

WHO (2011) highlights that each year, about 16 million females, aged 15 to 19 years give birth and this as such constitute about 11% of all birth worldwide. Interestingly, about 95% of these births happen in middle- and low-income countries. Additionally, the prevalence rate of births in China is known to be about 2%, 18% in Latin America and the Caribbean, and more than 50% in sub-Saharan Africa (WHO, 2011). In Ghana, about 43% of females and 27% of

males between the ages of 15 to 19 years have engaged in sexual intercourse and are currently sexually active (Ghana Statistical Service, GSS, 2015). Hence, the median age at first sexual intercourse for females is 18 years while that of males is 20 years. Awusabo-Asare et al. (2017) further highlight that the proportion of adolescent females who had engaged in sexual intercourse before age 15 in Brong Ahafo is 21% whereas that of Greater Accra is 5% and 8% for Northern Region. Concerning males, 23% of them had engaged in sexual intercourse in Greater Accra, 7% in Brong Ahafo, and 3% in the Northern Region (Awusabo-Asare et al., 2017). The prevalence rates of sexual behaviours highlighted attest to the fact that there has been an increase in sexual behaviours among adolescents worldwide.

Sexual behaviour is related to a variety of activities individuals involve themselves in to express their sexuality (Crooks & Baur, 2008). These diverse activities include masturbation, oral sex, vaginal sex, kissing and touching, and others (Brown, 2013). This increase in sexual activity could be due to economic and social changes in terms of urbanization, modernization, and improvements in health and nutritional status. It has, therefore, led to a reduction in the age of sexual debut (Sawyer et al., 2012).

This course of sexual discovery and exploration does not start from a blank slate. Thus, these adolescents happen to use signals from their previous experiences to develop sexual scripts as a guide for future sexual behaviour (Simon & Daneback, 2013). Sex education, therefore, provides a benchmark for adolescents to explore their sexuality. Sex education is structured to help adolescents gain detailed information, skills, and motivation about a broad variety of topics related to sex and sexuality, to help them make better decisions (Planned Parenthood, 2020). According to Magoon (2010), there are three types of sex education: abstinence-only sex education, health, and safety-oriented sex education, and comprehensive sex education.

Abstinence-only-sex education focuses on teaching adolescents to wait or abstain from sex until they are married or are adults (United Nations Population Fund, UNFPA, 2016). It solely emphasizes the mechanics of sex without incorporating information about birth control or disease prevention techniques. Health and safety-oriented sex education, on the other hand, teaches young adolescents the mechanics of sex as well as information about birth control or disease prevention techniques. This form of sex education primarily emphasizes the physical well-being of adolescents. Thus, there is little emphasis on the emotional implications associated with sexual relationships (Magoon, 2010). Though Ghana Education Service has included sex education topics such as abstinence, reproductive physiology, and sexual and reproductive rights in their curriculum, there is little emphasis on gender equity, contraceptive use, and sexually transmitted infection services (Awusabo-Asare et al., 2017). Due to these lapses, several studies recommend the use of comprehensive sexuality education (Awusabo-Asare, et al., 2017; Eisenberg et al., 2008).

Comprehensive sexuality education programs recognize the fact that sexual activity could happen during the adolescent period. Comprehensive sexuality education is delivered in formal and non-formal settings to provide scientific and accurate information about human development, anatomy, and reproductive health, and information about contraception, childbirth, and sexually transmitted diseases (UNFPA, 2016). Hence, United Nations Educational, Scientific and Cultural Organization (UNESCO, 2018), defines comprehensive sexuality education as a curriculum-based process concerned with enlightening children about certain aspects of their sexuality such as cognitive, physical, emotional, and social development. Hence, the ultimate goal of comprehensive sex education is to help adolescents delay sex until they are older, use condoms and contraceptives in case they are sexually active, and reduce the frequency of sex as

well as the number of sexual partners (Planned Parenthood, 2020). Comprehensive sexuality education highlights a range of topics that are related to human development, relationships with family, friends, and romantic partners, sexual behaviour specifically abstinence and sexuality, sexual health (sexually transmitted diseases, the use of contraception, and avoidance of pregnancy) and personal skills on communication and decision making (Planned Parenthood, 2020).

Comprehensive sexuality education utilizes the learner-centered approach in the delivery process. That is, this form of sex education allows learners to construct their understanding of the information and material by critically engaging with personal experiences. Although there is little evidence concerning the impact of the learner-centered approach on comprehensive sexuality education, research by Kontula (2010) highlights the fact that there is a positive effect on sexuality education whenever participatory teaching techniques are employed. Children spend long hours in school, thus agents in the school have vital roles to play in comprehensive sex education. (UNESCO, 2008)

Apart from teachers and other stakeholders in the educational sector delivering sex education, parents also matter when it comes to talking about sex with their children. Several studies have found that parent communication about sexually transmitted diseases, birth control methods, and other sexual-related topics have a significant association with delayed sexual initiation and increased birth control methods and condom use among adolescents (Manu et al., 2015; Rogers, 2017). Also, non-formal settings such as community centres, faith-based organizations, health facilities, vocational facilities, and others, play a crucial role in delivering sex education. Non-formal education is primarily delivered in the non-formal setting because we live in a world where 263 million children between the ages of 6 to 15 years do not attend a

school or have dropped out of school (UNESCO, 2016). In some parts of the world, it is unacceptable for teachers to conduct condom demonstrations in class (UNESCO, 2018). As such, comprehensive sexuality education offered within the non-formal and community settings provides a platform to sensitize, adolescents, parents, and community leaders.

The comprehensive sexuality education programs, therefore, seek to ensure the safety of sexual activity among adolescents and also equip these adolescents with the knowledge and ability to make informed choices (Awusabo-Asare et al., 2017). The ultimate goal of comprehensive sexual education is to equip the child with knowledge, skills, attitudes, and values to empower the child to improve their health, well-being, and dignity (UNESCO, 2018). Thus, exposure to information about contraceptives and sexually transmitted diseases increases the likelihood of the child protecting him/herself when engaging in sexual behaviour (Simon & Daneback, 2013). This to a large extent indicates that comprehensive sexuality education programs primarily increase the reproductive health of adolescents. Thus, comprehensive sexuality education represents the extent to which individuals can have a satisfying and safe sex life (WHO, 2018). Through comprehensive sexuality education programs, most of these adolescents might end up ensuring that they have delayed sexual initiation, increased birth control methods, and condom use among adolescents (Manu et al., 2015; Rogers, 2017).

Sex education in the Ghanaian context

In Ghana, the discussion of sexual and reproductive issues among adolescents has remained taboo (Baku et al., 2018). The convergence of cultural, religious, and geographic factors creates an environment in which individuals find it difficult to express their views on sexuality. Thus, the mere mention of “sex” evokes an itchy feeling among both Ghanaian youth and the old (Abaka, 2015). Consequently, adolescents become afraid of asking questions about

their sexuality since they will be regarded as disrespectful and disobedient (Nyarko et al., 2014). In effect, individuals perceive sexual issues as topics solely for adult discussions within the Ghanaian context. Among Akans for instance, it is considered taboo to talk about sex with an adolescent since it is believed the child could go wayward. The Ghanaian culture considers sexuality sacred and for that matter teaching sex education to children is perceived as introducing them to early sexual intercourse and subsequently teenage pregnancy (Baku et al., 2017). As such, it is considered taboo in Akan society to mention the private part of the body in the presence of a child and also in public (Baku et al., 2018).

Some sexual discussions by Ghanaian parents only took place with the girl after menarche whereas, with boys, no sex education is provided to them (Baku et al., 2017). Most of the sex education discussions with the girls centers on topics related to body changes, menstruation, personal hygiene, abstinence from sex, and the consequences of getting pregnant (Baku et al., 2018). There is therefore little emphasis on contraceptive use and services that renders sexually transmitted infections. Aside from these, there are strict parental rules on what adolescents should read or watch. A study by Esantsi et al. (2015) among 1303 adolescents and 626 parents or guardians in the Greater Accra Region indicates that about 57% of parents or guardians set rules about what their child ought to read or watch. About 31% of the parents prohibited adult films and movies with sex scenes, 31% permitted only educational programmes, and 11% prohibited non-educational magazines.

In most schools, the Ghana Education Service has approved a curriculum method where related topics on sexual and reproductive health have been included in subjects such as social studies, integrated science, biology, and management in living (Awesabo-Asare et al., 2017). Other sex education programs (i.e. The School Health Education Programme [SHEP] and

Human Immunodeficiency Virus [HIV] alert program) are generally offered to students outside of the regular curriculum. The ultimate aim of SHEP is to help adolescents acquire knowledge, skills, and attitudes on sex and sexuality to achieve lifelong health. The HIV alert programme, on the other hand, focuses on the prevention of HIV infection and other related topics such as chastity and abstinence (Awesabo-Asare et al., 2017).

Also, most religious centres in Ghana provide moral education to the youth rather than sex education. Thus, our society repeatedly believes delivering sex education to children is a form of encouraging immorality. Religious teaching from the three major religious groups in Ghana (i.e. Christianity, Islam, and Traditional religion) abhors sex outside marriage and regards it as a sin. Religion as such has a significant effect on sexual socialization in Ghana. When parents and caregivers have difficulties adopting means to regulate their child's sexual behaviours, they tend to switch to religion for help. Parents perceive religion to play two positive roles in regulating their child's sexual behaviours (Anarfi & Owusu, 2011). The first role has to do with the inhibition role where religious values are considered to discourage the child from engaging in immoral behaviours such as sex. Moreover, religion is considered to play a facilitative role by instilling religious values, principles, and ideals in the child to opt for better choices. This role is normally instigated by religious leaders who end up becoming counselors for these adolescents (Osafo et al., 2014). In all, the religious view on sex education has been on the fact that it could influence those who are not sexually active to start sexual experimentation (Francoeur, 2001). Unsurprisingly, there is little evidence to back the assertion made by these religious bodies. The evidence known is that teenagers with little or no exposure to sex education, are more likely to experience teenage pregnancy (Kantor et al., 2020; Ochiogu et al., 2011).

1.2 Statement of the Problem

Adolescents are increasingly using the Internet to learn about, explore, and develop their sexuality (Cookingham & Ryan, 2015). Indeed, for many, it is their first encounter with sexual images and behaviors. Although the Internet can provide positive experiences and health information, parents and health professionals are increasingly concerned about the impact that sex-related Internet use may have on adolescents' well-being. One common concern is that one-sided, glamorized depictions of sexuality on the internet will negatively influence adolescents' perceptions of their bodies and sexual lives (Owens et al., 2012). Low physical self-esteem, high body surveillance (monitoring one's appearance), and dissatisfaction with one's sexual experience are all symptoms of the negative body and sexual self-perceptions (Vandenbosch & Eggermont, 2013). Because these self-perceptions have been linked to serious physical and mental health issues such as eating disorders, low self-esteem, and depression, it is critical to investigate their possible antecedents (Vanwesenbeeck et al., 2014).

The evidence further indicates that there is little parental supervision to examine the appropriate information adolescents are supposed to be exposed to on various media platforms. Poor parental supervision would not only lead to sexual experimentation and other sexual escapades, but also externalization behaviors such as substance abuse and aggression (Chou & Edge, 2012).

Interestingly, the majority of the formal sex education done by African parents are largely narrowed toward abstinence-only education program (UNFPA, 2016). This form of sex education has been shown to have little impact on the improvement of adolescents' sexual and reproductive health (Kirby, 2008; Underhill et al., 2007). Based on these lapses in the

abstinence-only education program, several researchers suggest a comprehensive sexuality education program (Awusabo-Asare et al., 2017; Eisenberg et al., 2008).

Also, in Ghana, there is a general misconception about sex education and there is a scarcity of research on the extent to which sex education has a significant influence on the reproductive health and sexual behaviours of adolescents. The majority of the research works in Ghana have focused on the impact of sex education on teenage pregnancy (Donkor, 2017; Donkor & Lariba, 2017). Others, on the other hand, attend to the knowledge, perceptions, and attitude toward sexuality education (Sumankuuro et al., 2020). Also, there is a paucity of research on how Ghanaian parents conduct sex education and the extent to which these adolescents experience the process. The majority of the studies in Ghana sought information from the perspective of adolescents. (Boamah et al., 2014; Donkor & Lariba, 2017). As such, the views of the parents are mostly neglected. The few studies that attend to the views of both parents and children are selective in scope, coverage, and assessment. For instance, Adu-Mireku (2003) only explored family communication about HIV/AIDS whereas Kumi-Kyeremeh and his colleagues (2007) operationalized communication on sexual behaviour as an instance whereby an individual discusses sex-related matters with an adolescent. This, therefore, implies that there is a dearth of data on the type of topics discussed and the frequency of parent-child sexual communication. It is therefore essential for researchers to project their lenses to fill these gaps.

1.3 Objectives of the Study

The main objective of this study is to explore adolescents' and parents' perspectives on sex education. Specifically, the following objectives are proposed, to explore:

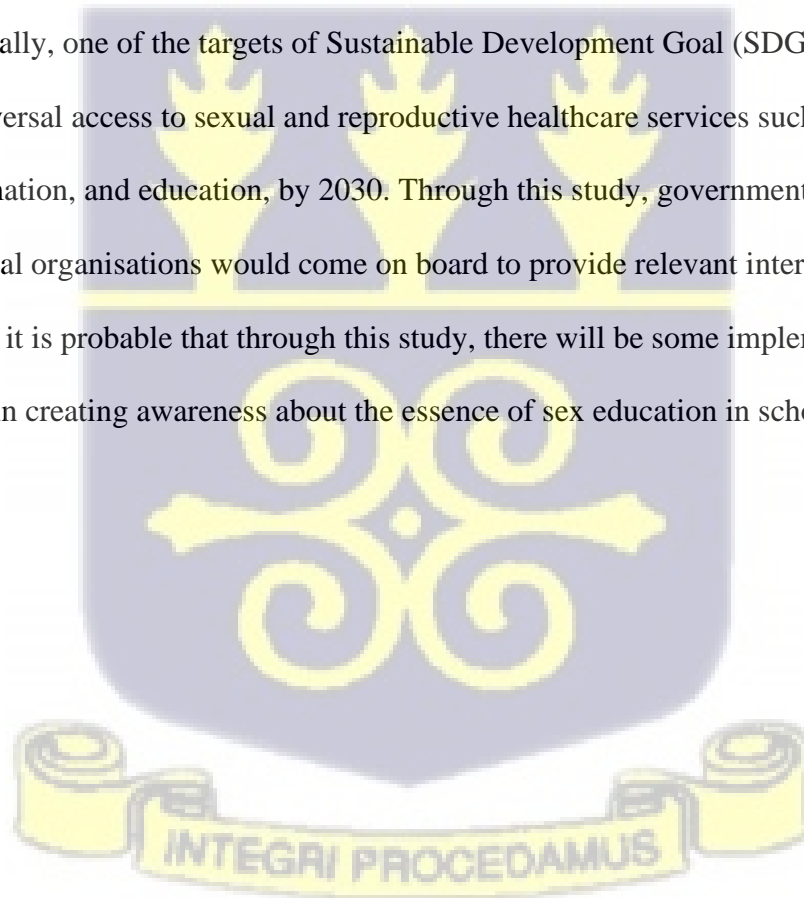
1. Adolescents' perception of sex education.
2. Parent's perception of sex education

3. The impact of sex education on adolescents' reproductive health.
4. The impact of sex education on adolescents' sexual behaviours

1.4 Relevance of the study

This study would inform both theoretical and practical decisions. Empirically, the findings of this study would add to the existing body of knowledge on the general subject of sex education and its impact on sexual behaviours and reproductive health in Ghana. Even though globally there have been some studies on sex education, understanding the lived experiences of comprehensive sex education and its impact on the sexual behaviours and reproductive health of adolescents would be part of the few studies within the Ghanaian context.

Additionally, one of the targets of Sustainable Development Goal (SDG) 3, is to ensure that there is universal access to sexual and reproductive healthcare services such as family planning, information, and education, by 2030. Through this study, governmental agencies and non-governmental organisations would come on board to provide relevant intervention programs. Thus, it is probable that through this study, there will be some implementation of key policies to help in creating awareness about the essence of sex education in schools and other sectors.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter focuses on four major issues. It begins by outlining the theoretical foundations of the research. The theory of planned behaviour and social cognitive theory are both explained. This is followed by a review of related studies, from which the study's rationale is derived and the research questions are stated.

2.2 Theoretical Framework

Different theorists have attempted to explain the impact of sex education on individuals' sexual and reproductive health. The current study was guided by the theory of planned behaviour as well as the social cognitive theory.

2.2.1 Theory of Planned Behaviour (Ajzen, 1991)

The theory of planned behaviour is based on the assumption that people make logical and reasoned decisions to execute a particular behaviour by evaluating the kind of information available to them. According to Ajzen (1991) behavioural achievement is based on the person's intentions to engage in the behaviour. These intentions are typically influenced by the value the person places on the behaviour, the ease at which the person can perform the behaviour, and the views of significant others. More so, the person's perception of the fact that the behaviour is within his/her control fuels the tendency to execute the behaviour. As such according to Ajzen (1985), an individual's behavioural intentions and behaviour are influenced by the person's attitude toward the behaviour, subjective norms, and perceived behavioural control. Attitude in this context refers to the person's evaluation of the extent to which the behaviour is favorable or unfavorable. Subjective norms, on the other hand, have to do with how significant others

approve or disapprove of the behaviour. It primarily refers to a person's beliefs about whether peers and significant others believe that he/she should engage in the behaviour. Perceived behavioural control also refers to a person's perception of how easy or difficult it is to perform the desired behaviour. The resources and opportunities which are at the mercy of the individual determine the likelihood of the person achieving the desired behaviour. Perceived behavioural control differs across situations and actions, resulting in a person's perception of behavioural control changing depending on the situation (Ajzen, 1985).

The theory of planned behaviour is important in sex education because parents with favorable attitudes and subjective norms towards sex education as well as greater perceived behavioural control are more likely to have stronger intentions to teach their children about their sexuality. For example, when parents believe sex education is strategically designed to help their children make informed decisions and have significant others who agree that sex education is important, as well as the necessary resources and capabilities to teach their children, they are more likely to perform the act.

Adolescents who have positive attitudes and subjective norms toward sex education as well as greater perceived behavioural control are more likely to have stronger intentions and are more to be receptive and practice sex education. For instance, an adolescent who believes abstinence is the best approach and has significant others who agree that abstinence is important, as well as with the necessary resources (e.g., high assertiveness training) to abstain from sex, is more likely to perform the act.

2.2.2 Social Cognitive Theory (SCT, Bandura, 1986, 2002b)

SCT highlights a triadic relationship between the person, the environment, and the person's behaviour (Bandura, 1986, 2002b). The personal consideration of this model includes

factors related to cognitive, affective, and biological factors. The social environment component on the other hand centers on surrounding factors such as cultural and political factors whereas personal behaviours involve the extent to which individuals respond to an event or circumstance. Bandura (2002a) further emphasized people's behaviours are driven by purposes and goals that are fueled by their personal beliefs of self-efficacy and goal expectations from their behaviours in a specific social environment. Self-efficacy which is one of the cardinal factors Bandura identified, primarily influences individuals' self-regulation and expected outcomes. Thus, when an individual has a high belief in having the required capability of executing a behaviour successfully, there is a high likelihood the individual will be goal-directed.

In the field of health education, the social cognitive theory has been employed to understand behaviours associated with substance use and sexual and reproductive behaviours. Factors such as personal characteristics, family relationships (siblings and parents), cultural background, and religious concepts have been found to have a significant influence on adolescents' sexual and reproductive health. That is, adolescents are more likely to observe the actions of significant others such as parents, siblings, and peers, and develop rules to guide their sexual and reproductive health. The sexual and reproductive actions of adolescents could also be better explained using Bandura's triadic reciprocity. When adolescents have positive beliefs and abilities about contraceptives, and the social environment is supportive of contraceptives, there is a high likelihood that the adolescent will use contraceptives when necessary.

2.3 Review of related studies

The subject of how parents conduct sex education has been of interest to many researchers over the years. Some researchers argue that most parents end up resorting to fear-arousing tales to prevent their children from engaging in any sexual behaviours (Baku et al.,

2017; Izugbara, 2008). Parents usually prefer to discuss sexual risk prevention and developmental topics rather than experiential sex (Manu et al., 2015). Adolescents perceive sex and reproductive health education from significant others, to help reduce the tension and shocks associated with the transition from childhood to adolescents (Kapinga et al., 2015). However, factors such as religion, culture, the attitude of health workers, myths, and conception about sex education prohibit adolescents from learning about their sexual and reproductive health (Anarfi & Owusu, 2011; Ezenwaka et al., 2020; Koo & Martyn, 2016).

2.3.1 Parent-Child communication about sex education

Within the African context, the convergence of cultural, religious, and geographic factors leads to an environment that inhibits adolescents' expression of their opinions about sex. Nyarko et al. (2014) asserted sexual issues in Africa are perceived as topics solely for adult discussions. Parents end up having hard time talking about sexual issues with their children. Izugbara (2008) for instance emphasized that only a few parents make time to have discussions with their children about sex. Most parents fear that having discussions about sex especially at an early age, with their children would evoke sexual imagination among them (Baku et al., 2017). As such, most parents delay sexual education until their child reaches puberty stage or had begun engaging in sex (Izugbara, 2008). Some parents, on the other hand, filter sexual information depending on the age of their child. Pop and Rusu (2019) for instance opined that the anatomic and physiological aspects of development are normally filtered by the parents depending on the child's cognitive development phase.

Also, diverse forms of sexual topics are discussed during parent-child dyads. Parents primarily resort to the use of fear-arousing information to prevent their children from engaging in any form of sexual activity (Izugbara, 2008). Manu et al. (2015) found that these fear-evoking

topics given by parents focus on the consequences of premarital sex (teenage pregnancy, and sexually transmitted diseases among others). Other parents go to the extent of presenting scary stories to reinforce chastity and abstinence in their children. Izugbara (2008) highlighted parents present scary stories on the basis that their children will become mad, ostracized, poor, and hopeless when they engage in premarital sex. Other sexual-related topics discussed by parents were the male (wet dreams, masturbation) and female physical development (menstruation and females' bodies) (Beckett et al., 2010). Parental communication, thus, is directed toward a few topics (Manu et al., 2015).

Interestingly, parents hardly talk about contraceptive use and experiential sex topics with their children (Manu et al., 2015). The use of condoms, abortions, and contraceptives are rarely discussed during parent-child sexual communication (Wyckoff, 2008). Wamoyi et al. (2010) opined that parents exclude discussions on condom use because they feel doing that could encourage the child to engage in sex which therefore would contradict the message of abstinence. Beckett et al. (2010) further highlight that some sex-related topics parents decide not to discuss with their children include birth control efficacy, how to refuse sex, prevention of sexually transmitted infections, and choosing a birth control method. Two-thirds of the sons, thus, indicated they never received any discussions from their parents about how to use a condom (Beckett et al., 2010). Stone et al. (2013) opined that topics related to the act of intercourse and question that centers on how babies are made seem challenging for parents to discuss with their children. Also, parents rarely use exact words to describe sexual parts of the body during sexuality discussions with their children (Wamoyi et al., 2010). Izugbara (2008) points out that in Nigeria, words used to describe the vagina were *women's thing* or *women's body* whereas the penis is described as *men's thing* or *men's body*. Parents generally assume that

their children understand what they mean when they use these descriptions. Some reasons parents described the sexual part indirectly before their children include not corrupting them, not sounding vulgar, and feeling it is the best thing to do (Izugbara, 2008).

Communications on sexuality between parents and children to a large extent are dependent on gender. Generally, mothers have sexual discussions with their children a lot more than fathers (Padilla-Walker, 2018). Most parents preferred to communicate with young females with the notion that their girls are prone to deception and are likely to make mistakes if not well educated on their sexuality (Tessa et al., 2012; Wyckoff, 2008). Often, parents depict boys' engagement in sexual behaviours as risk-taking, adventure, and discovery. Parents feel comfortable having discussions about sexuality when it involves same-sex (Kunnuji, 2012; Tessa et al., 2012). For instance, in Izugbara (2008) study, the majority of the male parents indicated that it is inappropriate for them to discuss issues about sex with their daughters. Hence, they believe it is the responsibility of the mother to educate the daughter about sex. However, in Opare et al. (2010) study, the majority of the female parents emphasized that it is the responsibility of both parents to educate their girl child about their sexuality. Interestingly, male adolescents prefer discussing the risk of sexual activities with their mothers whereas issues of prevention are normally discussed with their fathers (Atienzo et al., 2009). Also, female adolescents feel more comfortable having discussions about the biological aspects of reproduction with their mothers compared to their fathers (Atienzo et al., 2009). Wyckoff (2008) for instance emphasized that topics related to menstruation were only discussed when only mother and daughter constitute the discussion.

Moreover, parents largely initiate and dominate home-based sexuality discussions (Wamoyi et al., 2010). Children turn out to offer little input when it comes to sexuality

discussions. Parents primarily determine what their child needs to know and hear (Tesso et al., 2012). Most parents are dispirited when their children begin the discussion or show to have a lot of information about the issues at hand. Izugbara (2008) asserted when children initiate sexuality discussions, it signals to the parent that the child is either engaging in sex or intends to do so. Adolescents as such, are hesitant to share their opinions and experience during discussions of sex with their parents.

Parents end up using myriads of timing tactics and approaches to discussing issues of sexuality with their children. Some parents ardently believe that the puberty stage is the appropriate period to set the stage for sex education (Izugbara, 2008). Their justification for using this period has to do with the fact that, at puberty, the child has immense cognitive development to understand issues about sex (Izugbara, 2008; Pop & Rusu, 2019). Hence, until puberty, parents delay issues of sexuality since they believe before puberty, the child is sexually innocent (Stone et al., 2013). In other instances, parents withhold some sexual matters from the child with the notion that the child's innocence will be corrupted or destroyed. Even at puberty, some parents express fears of potentially losing their child's innocent minds and as such, they make efforts to shield their children from crossing over into the world of grown-ups (Stone et al., 2013). Wamoyi et al. (2010) on the other hand assert parent-child dyad about sex is often spontaneous and is triggered by several factors. Some of these factors include listening to the radio and watching television programmes about sex with the child, the child is seen in the company of opposite sexes, the child being found with love letters and other erotic materials such as pornographic films, books, or magazines (Baku, 2018; Izugbara, 2008; Wamoyi et al., 2010). Parent use periods whereby their children engage in risky behaviours (i.e., engaging in sexual activity, sneaking outside, and coming home late), as an opportune moment to talk to

them about sex. Some parents wait for clues about the fact that the child has started engaging in sex before initiating sex education. Parents thus, utilize monitoring techniques by inspecting especially their daughters' private parts to confirm whether the child has engaged in any sexual activity (Wamoyi et al., 2010). That is, parents, combine physical inspection with discussions about sex only when they have heard, suspected, or have received reports from significant others about their child's involvement in sexual behaviours (Izugbara, 2008).

Furthermore, certain factors are likely to create a barrier when it comes to parent-child dyads on sexual and reproductive health topics. Tesso et al. (2012) postulate that culture is one of the major challenges hindering parents' communication about sexual and reproductive health matters. Most young people believe that discussing sexual and reproductive health topics with their parents is difficult and as such, they are less likely to discuss such matters with their parents. The reasons given for not discussing sex-related matters with their parents have to do with the fact that they feel embarrassed to discuss such matters with their parents (Tesso et al., 2012). Also, parents' lack of interest to discuss such matters with them could shy away adolescents from not discussing sex-related matters with their parents. Also, the taboo attached to sex and parents' failure to give them a listening ear to a large extent could be considered as one of the major hindrances of parent-child dyad on sexual and reproductive health topics (Tesso et al., 2012). Asampong et al. (2013) further point out that some factors such as poor role models, taboos on sex, fear, and exposure to technology could serve as a barrier to sex talks among parents and adolescents. Womoyi et al. (2010) also point out that a lack of practical solutions from the parent could discourage the child from subsequently confiding in the parent when encountering sexual health problems. Also, some parents lack the right parental skills and knowledge to speak effectively with their child about sexual-related matters (Stone et al., 2013).

Lack of such knowledge and strategies on the part of the parent could hinder effective sexual communication. Furthermore, religious, and political beliefs among parents have a strong influence on the content and type of approach to adopt in sexuality education (Iyer et al., 2014). In most religious faith, premarital sex is forbidden, and this as such makes it difficult for parents with a strong religious background to discuss issues about contraceptives and safe sex with their children (Gesser-Edelsburg & Arabia, 2018).

Generally, some major factors have been found by several researchers to have a significant influence on the child's sexuality. Pluhar et al. (2008) assert the child's problem behaviour and gender, the mother's self-efficacy, and comfort is predictive of sex education. That is, there is a significant positive relationship between a mother's self-efficacy, comfort, and sexual communication. Pop and Rusu (2019) also highlight that to facilitate communication with children on issues about their sexuality, parents must be properly informed and trained and there should be a societal and individual change in attitudes about sexuality. Hence, parents' educational level is positively associated with the parent-child dyad in sex education (Stidham-Hall et al., 2012). It has also been found that some characteristics of the child could influence his or her willingness to engage in sexual education with the parents. Young people who happen to have higher education or are at the tertiary level are more likely to have discussions about their sexuality with their parents than those at the lower level (Tesso, et al., 2012; Wamoyi et al., 2010). Also, young adults who perceive their parents give them less time to discuss issues about sex were less likely to have discussions with their parents (Tesso et al., 2012).

2.3.2 Adolescents' Perception and experience of sex education

Myriads of factors have been found to shape adolescents' views and perspectives about sexual and reproductive health. Adolescents tend to have less favorable views of sex education

when it is solely about abstinence only (Barlow et al., 2016). Hence, comprehensive sexual education on related topics such as reproduction and birth, puberty and physical development, pleasure and enjoyment, and sexual decision-making in relationships, are more preferred by adolescents (Byer et al., 2017; Gardner, 2015). In Byer et al.'s (2017) study, for instance, the majority of Canadian adolescents had more favorable views on topics that comprehensively cover communication skills, sexual decision-making, masturbation, and health normative sexual behaviours than programmes that solely comment on puberty and sexual health consequences. Also, sexual and reproductive health programs that use the correct names of genitalia and discuss emotions of relationships are deemed to be important among adolescents (Byers, 2017; 2013).

Apart from the content of sexual health education, adolescents perceive the timing and environment in the sexual and reproductive health education conducted as important. In terms of the environment, adolescents perceive the environment as safe when the sex education talks create an opportunity for them to ask questions (Barbagallo & Boon, 2012). They further perceive the environment as safe and comfortable when sex education is solely done for their same-sex counterparts (Kimmel et al., 2013). With the timing of sex education, most adolescents' sex education is more effective when it is done in the 5th and 6th grades (Helmer et al., 2015). In the 5th to 6th grades, these adolescents believe sex education should center on an introduction to human anatomy and puberty (Lloyd et al., 2012). From their perspective, starting at an early age (5th and 6th grade) could be used as a foundation to discuss more complex sexual and reproductive health topics at older ages (Gardner, 2015). In the Ghanaian context, most adolescents believe the best time for an individual to have sex is when the person is economically independent (Asampong et al., 2013).

In terms of advice on the use of contraception and sexual health, most adolescent females believe they do not receive good advice from significant others. Most adolescents in Adidome and Somanya in the Volta Region of Ghana, believe their parents and significant others do not serve as good role models due to the sexual impropriety of the significant others (Asampong et al., 2013). Hence, the majority of these adolescents heavily rely on their friends for information about their sexual and reproductive health issues and this explains why they fall into the trap of bad advice (Siva et al., 2021). Apart from their friends, the next source of information about their sexual and reproductive health they rely on is media sources such as television, radio, magazines/books, the internet, and cinema. Obtaining information about their sexual and reproductive health from their parents and other healthcare providers normally becomes the last option they resort to. The source of information from significant others is often gendered. Female adolescents normally prefer to have discussions about their sexual and reproductive health with their parents and family members. Male adolescents, on the other hand, prefer to have such discussions with their peers or friends. Most adolescents who heavily rely on their friends end up being conscientized to believe that “it is cool to have sex at adolescent age” (Siva et al., 2021). It is no surprise why Siva et al. (2021) opined that there is an increased level of risky sexual behaviours among adolescents who frequently rely on their friends for information about their sexual and reproductive health.

Moreover, some general perception about contraceptive use decreases adolescents’ usage of it. There is a general perception that the usage of contraceptives could cause infertility and sterility (Coles et al., 2011). Other factors such as stigma, fear of parents, and lack of confidence in the health care worker hinder patronage of contraceptives among adolescents (Arisukwu, 2019). Cultural and religious norms play a significant impact in contraceptive use. In most

African settings, adolescents who patronize contraceptives are considered to be wayward (Appiah-Agyekum & Kayi, 2013). On religious grounds, the view of pre-marital sex as immoral forces adolescents to go into hiding for fear of being recognized when seeking information about contraceptives (Ezenwaka et al., 2020). Additionally, adolescents' fear of side effects related to contraceptive use serves as a barrier to utilizing contraceptives. The side effects often reported by adolescents as contributing factors that hinder their patronage of contraceptives are prolonged or irregular menstrual cycle and weight gain or loss (Appiah-Agyekum & Kayi, 2013; Ezenwaka et al., 2020).

Aside from the side effects, some attitudes of healthcare workers have been found to decrease the utilization of contraceptives uses. These perceptions and attitudes about contraceptives have a huge impact on their sexual behaviours. Most adolescents perceive some healthcare workers as unfriendly and judgmental whenever they seek their services on contraceptive use. These judgmental looks and behaviours, discourage adolescents from seeking healthcare services (Ezenwaka et al., 2020; Lesedi et al., 2011). Adolescents who have perceived sterility and subfertility, partner pressure, and decreased access to contraceptives experience an increased risk of mistimed and unwanted birth (Arisukwu, 2019; Potter, 2014).

Adolescents' perception of parental expectations has a significant influence on their sexual behaviours. Adolescents who perceive their parents as conservative and disapproving tend to have delayed onset of sex and reduced multiple partners (Koo & Martyn, 2016). These parental expectations are heavily influenced by parents' views of religious values and culturally appropriate gender roles. Most adolescents, thus, perceive their parents to be more protective toward their daughters including strict curfews and increased monitoring (Koo & Martyn, 2016). The family's religious beliefs and activities significantly influence the sexual behaviours of

adolescents. Adolescents with strong family religious beliefs lead high regard for abstinence until marriage (Anarfi & Owusu, 2011). Interestingly, the majority of the youth especially Asian Americans are more likely to perceive parental sexual expectation of “abstinence until marriage” as conservative (Koo & Martyn, 2016). Additionally, adolescents are more likely to perceive parental attitudes about sexual timing about sex as acceptable when it centers on “abstinence until marriage” or “it is okay as long as they are being safe” (Koo & Martyn, 2016, p.8). More so, adolescents most often learn these parental expectations via non-verbal cues (Guo & Nathanson, 2011). Majority of the adolescents especially Asian Americans, thus, prefer to use non-verbal cues since sex is perceived as a taboo in their culture (Koo & Martyn, 2016, p.8).

2.3.3 Consequences of Sex Education

Sex education has been found to have a significant influence on individuals’ sexual behaviours and reproductive health. When individuals are exposed to myriads topics related to sex education, they tend to have positive attitudes toward their sexuality (de Castro et al., 2018). It is also quite evident that comprehensive sex education allows individuals who are sexually active to engage in safer sex (Padilla-Walker, 2018). Comprehensive sex education, thus, increases adolescents’ knowledge of sexually transmitted diseases, pregnancy prevention, and other sexual and reproductive health issues (Rashid, & Mwale, 2016).

Similarly, Atienzo et al. (2009) opined that sexual communication about risk and prevention is strongly associated with the use of condoms. When people are exposed to comprehensive sex education, they make conscious efforts to engage in safe sexual behaviours. de Castro et al. (2018) for instance intimate that when students are exposed to comprehensive sexual education, they are four times more likely to understand effective contraceptives as well as have positive attitudes toward condom use, and understand that condoms can only be used

once. Also, Reis et al. (2011) emphasize that students who have been exposed to sex education often engage in fewer sexual risk behaviours. Most of these students tend to have fewer occasional partners, less sex-related alcohol use and drugs, unwanted pregnancies, and abortions (Reis et al., 2011). Thus, most students are more likely to use pills and condoms in their first sexual intercourse when educated about sex-related matters. In line with Reis al. assertion, Li et al. (2017) highlight that sexual reproductive health education reduces students' chances of engaging in sexual intercourse without using any contraceptive. Students who are sexually educated do not only use contraceptives for themselves, they can also convince their partners to also use contraceptives (de Castro et al., 2018). As such, there is a negative association between sexual reproductive health education and a partner's experience of pregnancy (Li et al., 2017).

Moreover, most researchers agree on the basis that exposing adolescents to sex-related topics to a large extent delays their engagement in sexual activity. Lindberg and Maddow-Zimet (2012) for instance assert that either abstinence-only or comprehensive sex education significantly delays the adolescent child's transition into first vaginal sex. Similarly, Erkut et al. (2012) suggest that an early-stage introduction to sex education could reduce sex initiation among adolescents. Their findings, thus, revealed that students who received sex education were about 30% more likely to initiate sex than those being exposed to it in the sixth grade (Erkut et al., 2012). Furthermore, Tortolero et al. (2010) point out that exposing students to sex education before the ninth grade engenders positive beliefs about abstinence before marriage, increased knowledge about sexually transmitted diseases, and confidence in refusing sex. However, Koo et al. (2011) reported that at the end of their sex education intervention on sex delay, a higher percentage of grade six girls in the intervention group had anticipated sexual intercourse and had engaged in sexual intercourse than the controls. The intervention, interestingly, had no

statistically significant effect on the rate of increase in sexual activities among boys (Koo et al., 2011). Markham et al. (2012) postulate that risk avoidance (abstinence-only) has no significant effect on sex delay types such as delayed initiation of oral, vaginal, or anal sex. Grossman et al. (2013) also propose that teaching positive attitudes to encourage self-efficacy in sex education would help adolescents have intentions to delay sex. Also, apart from adolescents having positive attitudes, exposure to comprehensive sexual education on matters concerning sexual rights and citizenship help them to attend sexual and reproductive health counseling (de Castro et al., 2018).

Concerning abstinence-only education, there have been divergent results about the extent to which influences adolescents' sexual and reproductive health. Others are of the view that the use of abstinence-only has a detrimental effect on adolescents' sexual and reproductive health. Stanger-Hall and Hall (2011) intimate that there is a positive relationship between abstinence education and teenage pregnancy. Significant individuals who indulge in abstinence-only sex education tend to engage in unprotected vaginal sex and have a significantly less favorable attitude toward sex (Shepherd et al., 2017). Kohler et al. (2008) also point out that abstinence-only has no significant effect in causing a delay in terms of initiation of sexual activity or reducing the risk of teenage pregnancy and sexually transmitted diseases. Adolescents who were exposed to comprehensive sexual education were at lower risk of teenage pregnancy than those who did not receive any sex education. More so, neither comprehensive sex education nor abstinence was significantly related to the risk of sexually transmitted diseases when compared with no sex education (Kohler et al., 2008). Jemmott et al.'s (2010) finding contradicts Stanger-Hall's (2011) finding that abstinence-only sex education primarily leads to a surge in teenage pregnancy. In Jemmott et al.'s (2010) study, they found that abstinence-only sex education rather

reduces adolescents' sexual initiation and recent sexual intercourse. It also observed that majority of the participants in the control group had engaged in sexual intercourse. Furthermore, adolescents in the comprehensive sex education and safer sex group did not differ from the control group when it comes to sexual initiation (Jemmott et al., 2010). Markham et al. (2012) further found that females who engage in risk avoidance (abstinence), were less likely to indulge in oral or vaginal sex compared to the controls.

Sex education is considered to have a significant influence on the psychosocial outcomes of individuals. Abstinence-only or comprehensive sex education has been found to create positive beliefs about waiting and abstinence before marriage decreased risky behaviours, and greater condom use self-efficacy and intentions (Markham et al., 2012). However, Shepherd et al. (2017) emphasize that comprehensive sexual education increases condom self-efficacy more than abstinence-only education among adolescents. Sex education to a large extent increases the level of sexual satisfaction in terms of the emotional, physical and sexual well-being of the individual (Wylie, 2010). Jayne et al. (2020) also highlight the fact that little family sex communication and a high emphasis on religious values about sex during childhood create sex anxiety among individuals.

2.4 The rationale of the study

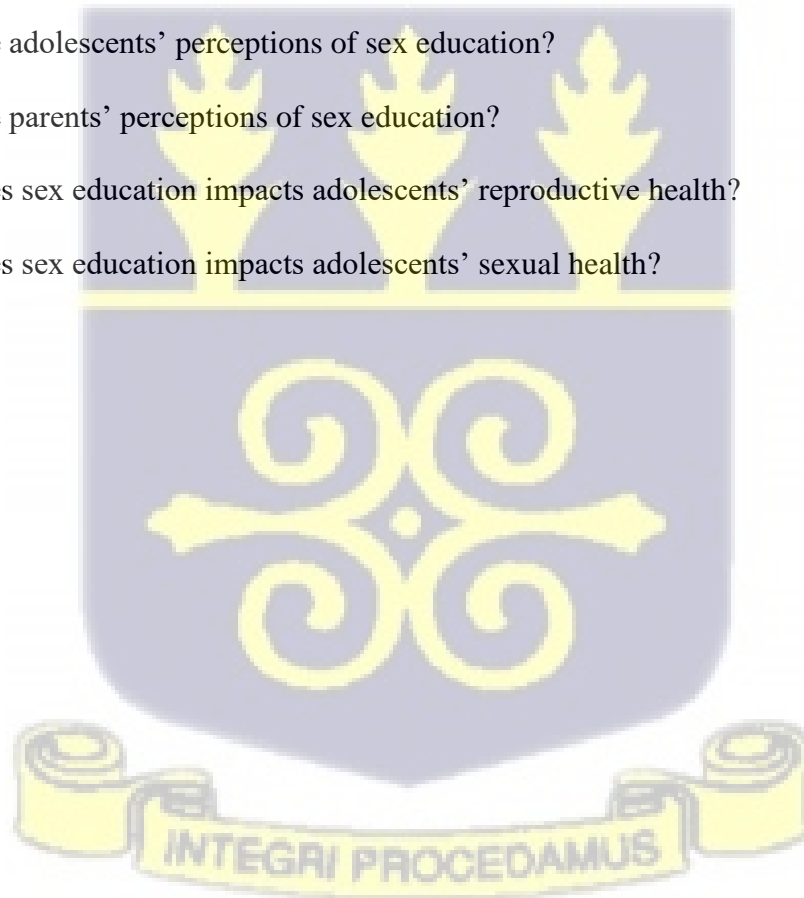
Most studies on the perceptions and consequences of sexual and reproductive health are done in the USA and European countries (Byer et al., 2013; 2017; Gardner, 2015; Stanger-Hall & Hall, 2011). Though some studies have been done in other African countries (e.g., Wamoyi et al., 2010; Ezenwaka et al., 2020) and in Ghana (e.g., Anarfi & Owusu, 2011; Manu et al., 2015), the question remains on how parents conduct sex education among adolescents. Most of the studies in Ghana, thus, sought information from the perspective of adolescents (Boamah et al.,

2014; Donkor & Lariba, 2017). As such, the views of the parents are mostly neglected. The few studies that attend to the views of both parents and children are selective in scope, coverage, and assessment.

The extent to which parents conduct sex education has a significant influence on the sexual behaviours of adolescents as suggested by previous studies (Lindberg & Maddow-Zimet, 2012; Padilla-Walker, 2018). As such exploring the lived experiences of parent-child communication will be an added advantage by providing detailed information in a Ghanaian context.

2.5 Research questions

1. What are adolescents' perceptions of sex education?
2. What are parents' perceptions of sex education?
3. How does sex education impacts adolescents' reproductive health?
4. How does sex education impacts adolescents' sexual health?



CHAPTER THREE

METHODOLOGY

3.1 Introduction

The chapter begins with a discussion of the research design that was used. This is followed by the study's setting, sampling strategy, and interview guide. The instrument used is also described, and the data collection procedure is clearly outlined. Furthermore, the chapter goes on to show how ethical protocols were considered as well as how reflexivity and trustworthiness were ensured. The chapter concludes with the data analysis of the study.

3.2 Research Design

A qualitative research design was used in this study. Qualitative research helps us to gain an in-depth understanding of an individual's subjective experiences (Creswell, 2014). Brannen (2005) highlights that the type of research design adopted must satisfy the methodological, practical, and theoretical goals by aiming to address the research questions of the study. The research questions in the current study sought to explore the experiences of adolescents and parents concerning sexual and reproductive health without the imposition of the researcher's perceived ideas. Given this, a qualitative research design with semi-structured interviews was used. The use of a semi-structured interview guide allows flexibility in how questions should be posed (Turner, 2010) as well as resonates with the theoretical underpinnings of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009).

IPA is “concerned with the detailed examination of personal lived experiences, the meaning of experience to participants, and how participants make sense of that experience” (Smith, 2011, p.9). IPA consists of three theoretical underpinnings. First, IPA is considered to be phenomenological since it takes into account the participants' perspectives on their experiences.

In this case, the phenomenon is sexual and reproductive health. According to Flick (2006), participants have a complex repertoire of subjective knowledge of issues within their context. When put into context, parents and adolescents have a wealth of knowledge about their sexual and reproductive health that deserves to be explored. The phenomenological component of the IPA explores what sex education means for individuals in their context to adequately explain it from the participants' perspectives (Lavery, 2003). This was accomplished by interacting deeply with the participants during the interview to learn more about their life world (Smith et al., 2009). As such, several efforts were made to establish rapport with the participants and make them comfortable in sharing their experiences on sexual and reproductive health.

Moreover, IPA also places much emphasis on the idiographic level of analysis where the meaning of an experience and its significance to a specific participant is recognized. There is a strong preference for the value of the particular rather than the general (Larkin & Thompson, 2012). Idiography which emphasizes the particular operates at two levels. The first is that one must become deeply involved with the specific phenomenon (for instance sex education) to allow for in-depth analysis (Smith et al., 2009). In addition, much effort is devoted to investigating how a phenomenon such as sex education is understood from the perspective of specific individuals in a specific context (Smith et al., 2009).

Lastly, IPA is considered to be interpretative rather than descriptive (Smith et al., 2009). From the IPA's perspective, the meanings provided by the individual on an account of an event are critical. As a result, the researcher can improve an individual's interpretation of an event or experience through interpretation (Smith et al., 2009). Smith et al. (2009) opined that there are two types of interpretations. One such interpretation is participants' views about the phenomenon represented one level of their interpretation of what the experience entailed. At another level, the

researcher derives meaning from the interpretations of the participants. This is what Smith et al. (2009) termed double hermeneutics.

3.3 Research Setting

The study was conducted in Ablekuma South Metropolis. The Ablekuma sub-Metropolis was selected for this study because it is saddled with myriads of social issues including high population growth, and high rates of unemployment among others (Accra Metropolitan Assembly; AMA, 2021). Anecdotal evidence suggests that the district has a high prevalence of unintended pregnancies due to low contraceptive use and thus a high prevalence of unsafe abortions. This Metropolis is one of the three Sub Metropolitan District Councils of the Accra Metropolitan Assembly (AMA). The Sub Metro is considered to be the largest in the Metropolis and shares boundaries with Ablekuma Central, Ablekuma North Municipal Assembly, and Ashiedu Keteke Sub Metropolitan District Council. It has a land area of 15.1 square kilometers.

According to the 2010 housing Census, the Sub Metro has a population of 257,543, with 22,751 houses and 69,401 households (Ghana Statistical Survey, 2012). The population of Ablekuma South is expected to be 315,051 in 2018, based on the Greater Accra Growth Rate of 3.1 percent. The Ablekuma South Sub Metro area has made significant contributions to Accra's economic development. Because the majority of the Sub-communities Metro's are located along the coast, fishing and fish-mongering activities are the dominant economic activity within the Sub-Metro. It also houses some commercial establishments such as supermarkets, banks, gas stations, educational institutions, and hotels. The sub-metro has five electoral areas, namely; Korle Gonno, Korlebu, Chorkor, Mamprobi, and New Mamprobi (AMA, 2021). The sub-metropolitan district stretches to towns such as Laterbiokorshie, Dansoman, Otordjor, Opetekwei, Shaibu, Gbegbeyise among others.

3.4 Sample Size and Sampling Technique

A total of 15 parents and 15 adolescents were selected for the study. This sample size was adequate since Guest et al. (2006) suggest that within interview sessions saturation usually occurs around 12 participants in a homogeneous group. The sample size determination for the qualitative study was further addressed using Malterud et al.'s (2016) recommendation for information power. Given the study's goal, sample specificity, guided theory, quality of dialogue, and analysis strategy, this number was deemed appropriate. Malterud et al. (2016) referred to this as the concept of "information power," and recommended using it instead of the concept of saturation to determine the sample size for qualitative studies.

Convenience sampling was employed to select parents and adolescents who were readily available. In each of the electoral areas parents and adolescents who were readily available and agreed to be part of the study were used for the study. The interviews were conducted in the evenings or on weekends when both parents and adolescents were at home.

3.5 Interview Guide

In collaboration with supervisors, an interview guide with key questions and probes was created and used to collect data. Before the actual interviews, the researcher conducted a pilot interview with one of the parents and adolescents to ensure that the interview guide elicited the necessary responses that could help address the study's research questions. Some of the questions in the interview guide are, "when is it appropriate to discuss sex with your child?", "Which of the genders do you prefer to talk about sex with?", "What worries might you have about your child using contraceptives?", "what are some of the barriers to sex education?", and "at what point do you perceive the environment as safe for sex education?"

3.6 Inclusion Criteria

Adolescents between the ages of 13 to 19 years. Parents of the adolescents.

3.7 Exclusion Criteria

Adolescents below 13 years. Parent of a child above 19 years.

3.8 Procedure

The researcher began the study by obtaining ethical approval from the Departmental Research and Ethics Committee (DREC). Following approval from DREC, an introductory letter together with the DREC was sent to the District Chief Executive of the Ablekuma South Metropolis where the research was conducted. The researcher then went to the towns to begin collecting data.

The data collection process began with obtaining written or oral consent from both parents and adolescents. Respondents in this study were allowed to carefully read the informed consent letter and disagree or agree formally by appending their signature to a column provided for such purpose. Also, consent was sought from parents of adolescents below 18 years. Translations were done orally in a local dialect (Twi) to respondents who had difficulty reading the written English informed consent. They were also informed of their freedom to withdraw from the study if they so desire to discontinue the process even after they have given their initial consent. Afterward, oral consent was sort from parents and adolescents to use audio recorders to record information on their responses based on the qualitative interview guide. After dealing with the ethical issues, data was collected from the parents and the adolescents. Parents and adolescents were first interviewed together to gain an accurate picture of their sexuality communication. The interview lasted 1 hour 6 minutes to 1 hour 24 minutes, with an average time of an hour. The individual interviews followed the same interview guide, to allow

individuals to share information they might not have felt comfortable sharing during the joint interview. However, these parents and adolescents were very open with each other and thus, there was little new information they shared in the individual interviews. The interviews lasted between 15 and 50 minutes, with a 35-minute average. Throughout the interviewing process, the participant's emotional state was taken into account. A total of 2 participants were referred to see a licensed clinical psychologist from Tema International School. This was done to ensure that participants were not subjected to any psychological harm during the data collection process.

3.9 Ethical Consideration

Following the American Psychological Association's (2002) Ethical Code, this study was guided by certain ethical principles in the use of humans as participants for research. The ethical considerations that were highlighted in this are informed consent, freedom to withdraw, confidentiality, and anonymity/privacy. All participants were provided with the right and relevant information regarding the study. This was the purpose of the study for which their help or assistance was requested.

Informed consent and assent form were given to each participant to complete. However, signing the form was not used to coerce participants to complete the research if along the line they realize they could not continue the study. As a result, they were free to leave their study at any time.

Another critical issue raised in the study in terms of ethics was the confidentiality and anonymity of participants' identities as well as their responses. Participants were given complete assurance that any information they provided to the researcher and his team would be kept completely confidential. As a result, participants were not required to provide their names but

were required to provide other forms of identification, which were not shared with a third party. Furthermore, when reporting participant reports, pseudonyms were heavily relied on.

3.10 Reflexivity

In reflexivity, the researcher considers how his or her biases, values, and personal background (gender, culture, history, and socioeconomic status) may have influenced their interpretations of the study (Creswell, 2014). Barry et al. (1999) point out that the researcher's relationship with the participants could easily influence the study. In this regard, the researcher decides what to investigate, how to formulate research questions, what questions to ask, and how to probe.

With the aforementioned issues, it was necessary to conduct an introspection to identify subjective beliefs, opinions, and personal backgrounds that could potentially affect the study's outcome. Frequent contact with teenagers as a Christian youth educator, as well as media reports of teenage pregnancy, where the researcher resides, piqued the researcher's interest in the subject of study.

As a Christian Youth Educator who works with adolescents, the researcher observed how adolescents' well-being was jeopardized as a result of a lack of proper sex education. Because of the close contact with the adolescents, the researcher acknowledged how easy it was to provide cues, empathy, and take sides with the adolescents whereas my reaction to the parents could be biased and negative. The decision to use a research diary was therefore influenced by awareness of these predispositions. Nadin and Cassell (2006) opined that a research diary is the best tool for improving reflective practice in a qualitative study. That is, when researchers record their thoughts, emotions, and behaviour after an interview with participants, it allows them to become conscious of their state (Nadin & Cassell, 2006). Because of the researcher's Christian faith, she

had thoughts of passing judgment on adolescents for some sexual misbehaviour they had engaged in. As a result, there were times when the researcher expressed disappointment in both the adolescents and their parents. To a large extent, diary writing served as a cathartic tool, allowing the researcher to channel her disappointment in both parents and adolescents, as well as other negative emotions to an external source. The researcher's approach echoes Browne's (2013) assertion that diary writing can be cathartic because it allows the researcher's deepest frustrations, fears, and anxieties to be channeled from the internal to the external via writing.

Furthermore, because the researcher lived in the research setting, she assumed she was an insider for both parents and adolescents. Parents, however, perceived the researcher as an outsider because she was young, single, and had no children. The gender of the researcher (female) to some extent also had a potential effect on the study. That is, since the research is culturally sensitive, adolescents in particular might feel uncomfortable discussing their sexual exploits with an interviewer of the opposite sex.

Being an insider proved to be both beneficial and detrimental to the study. To begin, in terms of how detrimental it was, some participants (both adolescents and parents) expressed reluctance to participate in the study for fear of exposing their private lives to the researcher, who is well known to them. On the other hand, being an insider was advantageous because it allowed some participants to freely elicit their experiences without hesitation. As a result, they saw the interview as an opportunity to vent their frustrations to someone they knew and could confide in.

For being an outsider, the researcher read enough literature to stay up to date on parents' experiences to avoid appearing ignorant. Parents who assumed the researcher was young and

believed certain issues would be difficult to understand had their responses probed to obtain detailed descriptions of experiences.

Steps were also taken to avoid the challenge posed by the researcher's gender. The female researcher attended to the female participants, while the male research assistant attended to the male participants. This allowed the adolescent boys and girls to express themselves as clearly as possible.

3.11 Trustworthiness

Keeping the end goal of ensuring the trustworthiness of the qualitative results in mind, Shenton's (2004) recommended procedures were followed. According to Shenton (2004), the credibility, transferability, dependability, and confirmability of the qualitative study are critical. Certain procedures were documented to ensure the study's credibility. The interview was recorded using a high-quality voice recorder. Probes were used to elicit more information from the participants. Participants were interviewed in serene settings free from the hearing of others. Participants were then encouraged to be as frank as possible and to remember that there were no right or wrong answers to the questions that would be asked. Frequent debriefing sessions were made between the researcher and the supervisor to generate ideas for the study. In addition, the researcher and the supervisor engaged in back-and-forth communication until the data was thoroughly analyzed. During this process, the supervisor read through the researcher's codes, themes, and subthemes to assess the level of agreement and disagreement on the analysis and interpretations. Some changes were made to the codes, themes, and subthemes on which there was disagreement. Opportunities were also created for some of the researcher's colleagues to provide feedback on the qualitative work. Pseudonyms were also employed in the research report to conceal the identities of participants.

To ensure transferability, interviews were audio-recorded, transcribed, and read over several times. As a result, the researcher was able to become acquainted with the data and obtain a detailed description of the phenomenon. Confirmability was ensured by involving supervisors and colleagues in the analysis, which reduced the possibility of a single person's viewpoint dominating the interpretation of participants' responses. Furthermore, dependability was addressed by assessing the efficacy of the processes used in the study. This was accomplished by inviting a person who was not a participant in the study to conduct an inquiry audit on the research study. The raw data were compared to the findings by the external auditor to ensure that they were consistent.

3.12 Data Analysis

Interpretative Phenomenological Analysis (IPA) was used to make sense of Ghanaian parents' and adolescents' lived experiences with sexual exploration and reproductive health (Reid et al., 2005). IPA was utilized by following steps such as transcribing, bracketing, and phenomenological reduction, listening to the interviews, describing units of general meaning, and describing units of meaning relevant to the research questions.

Based on the steps opined by Pietkiewicz and Smith (2012), the researcher attempted to understand the participants' experiences from their point of view. The data were analyzed through a psychological lens, and interpretations were made using psychological theories and concepts relevant to the research problems.

The transcript was initially read several times. The primary investigator and research assistant immersed themselves in the data by listening to the audio recording several times while remembering the atmosphere and setting of the interviews. Following that, the principal investigator took note of emerging themes and established connections or associations between

them by clustering them based on conceptual similarities. These clusters were then labeled descriptively. Finally, the themes were written up with exemplification quotes from the interviews, followed by analytic comments from the principal investigator.



CHAPTER FOUR

RESULTS

4.1 Introduction

The chapter begins with a presentation of the demographic characteristics of the participants. Characteristics such as age, religion, and educational background are clearly outlined. Following that, is a tabular and diagrammatic presentation of the study's key findings, which are organized into superordinate and subordinate themes. They are explained further using quotes from participants' experiences.

4.2 Demographic Characteristics of Participants

Participants were made up of adolescents ($n=15$) and parents ($n=15$). The majority of these participants ($n= 21$) were Christians. Moreover, most of them ($n=20$) had attained secondary education. In terms of gender, the majority of them were female ($n=19$).

Table 1: Demographic characteristics of adolescents

Variables	Frequency	Percent (%)
Family Position		
• Son	7	23.3
• Daughter	8	26.7
Educational Status		
• Secondary	12	80
• Tertiary	3	20
Religion		
• Christian	11	73.3
• Muslim	4	26.7

Table 2: Demographic characteristics of parents

Variables	Frequency	Percent (%)
Family Position		
• Father	6	40
• Mother	9	60
Educational Status		
• Basic	3	20
• Secondary	8	53.3
• Tertiary	4	26.7
Religion		
• Christian	21	70
• Muslim	9	30

4.3 Findings

Three (3) superordinate themes were extracted from the data: *parent-child sex communication*, *perceptions of sex education*, and *impacts of sex education*. Parent-child sex communication had two subordinate themes: *commonly discussed sexual topics* (themes: abstinence, consequences of premarital sex, and puberty discussions) and *less discussed sexual topics* (themes: contraceptive use and experiential sex topics). Perception of sex education had two subordinates: *negative perception* (themes: infertility and sterility, and sexual experimentation) and *positive perception* (themes: prevention of sexually transmitted disease, and pregnancy). Furthermore, the response following the impact of sex education had two subordinate themes: *positive impact* (themes: psychological wellbeing, prevention of unintended pregnancy and sexually transmitted diseases) and *negative impact* (themes: anxiety and early sexual initiation). These themes are presented in table 2.



Table 3: Superordinate and subordinate themes

Superordinate theme	Subordinate theme	N
Parent-child sex Communication	Commonly discussed sexual topics:	28
	<i>Abstinence</i>	19
	<i>Consequences of premarital sex</i>	20
	<i>Puberty Discussions</i>	11
	Less discussed sexual topics:	
	<i>Contraceptive use</i>	17
	<i>Experiential sex topics</i>	22
Perception of sex education	Negative Perception:	10
	<i>Infertility and sterility</i>	
	<i>Sexual experimentation</i>	
	Positive Perception:	24
	<i>Sexually transmitted disease prevention</i>	
	<i>Pregnancy prevention</i>	
Impact of sex education	Positive impact:	21
	<i>Psychological wellbeing</i>	
	<i>Unintended pregnancy prevention</i>	
	<i>Sexually transmitted disease prevention</i>	
	Negative impact:	9
	<i>Early sexual initiation</i>	
	<i>Anxiety</i>	

4.3.1 Parent-child sex communication

A wide range of sexuality issues is discussed during home-based sexuality education. Both parents and adolescents admitted that specific topics such as abstinence, physical development, and the consequences of premarital sex are often discussed. The majority of the adolescents, however, stated that their parents frequently use fear-inducing stories during these discussions. Parents, on the other hand, stated that they use specific times to discuss sexuality with their children. Furthermore, both parents and adolescents agreed that contraception and experiential sex topics are rarely discussed during home-based sex education. The majority of parents believe that experiential sex matters are inappropriate in the public or child's domain and should thus be

kept private. Despite parents' efforts to keep such information private, most adolescents stated that they obtain it from their friends and the internet.

Commonly discussed topics

Both parents and adolescents (n = 28) revealed that common sex-related topics are usually discussed during parent-child communication. Adolescents are typically advised by their parents to abstain from having sex until marriage. Additionally, most parents end up discussing sex-related topics such as puberty and the consequences of premarital sex with their children.

Abstinence: This theme explains how adolescents are advised to abstain from sexual behaviours. Most of these adolescents were advised to live chastely and to keep their virginity until marriage. Parents usually preach abstinence until marriage because most parents with strong religious beliefs believe sex unites two people and completes the marriage bond. In the excerpt below, this participant strongly advocates for abstinence until marriage because of her religious faith. She understands that sex is the final rite of passage in marriage. As such, it should only be performed by married couples to spiritually unite them as one. This type of religious orientation influences how she raises her children concerning sex. One can thus, deduce that most of the discussions she has with her children highly center on abstinence until marriage because of her strong religious orientation.

“I believe abstinence is the key to a good life. I always tell my children to refrain from bad company and remain chaste since our Catholic faith tells us sex is solely for married people. To me having sex is a spiritual affair and that is why it is consummated in marriage rites. It unites people spiritually and therefore young people who are not married should make efforts not engage in sex” (Jane, Mother, 46 years, Christian)

Likewise, majority of adolescents pointed out that they are usually advised by their parents to refrain from having sex until marriage because sex is considered sacred. According to these adolescents, some of their parents who led chaste lives before marriage tend to educate them to follow in their footsteps to live a good life.

They tell us to abstain from sex till we get married. My mother is very particular about it and says sex is a spiritual affair because it binds two together. She usually uses herself as an example since she remained a virgin till, she got married to Dad (Mansa, Daughter, 19 years, Christian).

Consequences of premarital sex: This theme depicts how parents create an avenue to discuss issues related to pregnancy and sexually transmitted diseases with their children during home-based sexuality education. Parents often emphasize the negative repercussions of premarital sex to prevent their children from engaging in it. In their quest for this feat, the majority of the parents rely on fear-evoking tales. Discussions about sexuality education highly centers on the consequences of sex education in the teenager's home environment. The majority of the adolescents highlighted that their parents frequently employ strategies to instill fear in them to reduce their proclivity to engage in any form of sexual behaviour;

My parents are very strict when it comes to issues about sex. They frequently tell us to refrain from sex so that we don't get pregnant... so I am very careful. My mother has already told me to refrain from bad company and focus on my education because if I get pregnant, she will make sure I stop school and use the money to cater for the baby (Amina, Daughter, 18 years, Muslim).

Like the 18-year-old, this 16-year-old acknowledges that his parent usually induces fear in him to make him remain chaste. These fear-arousing stories include tales about individuals who have gone to jail and messed up their future goals owing to premarital sex.

I remember my father told me to abstain from sex because he doesn't want me to end up like a guy who some time ago went to prison for engaging in sex. He said a lot of police officers came to the area to arrest that guy and his life was never the same after he was released (Kelvin, Son, 16 years, Christian).

Some adolescents acknowledged that during home-based sexuality education, their parents usually comment on how premarital sex can lead to sexually transmitted infections.

This sixteen-year-old viewpoint is supported by a nineteen-year-old who admits that her parents usually choose a specific period to educate her on how premarital sex can lead to sexually transmitted diseases.

Mansa narrates how her parent usually employs some timing and tactics to educate her on the consequences of premarital sex. She recounts how her mother usually adopts the vicarious learning approach (learning as a result of the experience of others) to educate her on the negative repercussions of premarital sex.

My mother often talks about how sex can end me up pregnant and I can contract some diseases such as HIV/AIDs, syphilis, and gonorrhoea. One thing I have studied about her is she usually talks about these things when we are watching local movies where, a young teenage person became pregnant or was infected with HIV/AIDs (Mansa, Daughter, 19 years, Christian).

In the same way, most parents emphasized that they educate their children about how sex could lead to sexually transmitted diseases. In doing so, they heavily employ some timing and tactics.

From their perspective, home-based sexuality education is usually discussed when they find any sexual escapades on the part of the adolescent.

This 42-year-old mother highlighted that she relies on specific cues to talk to her child about her sexual behaviours. She employed the tactic of going through her daughter's WhatsApp messages to find any sexual escapades. Following the discovery of such an incident, this parent initiated open discussions about sex with the child;

I went through my daughter's phone some time ago and I was surprised to find she was sharing WhatsApp love messages with a guy. I felt disappointed in her. I sat her down and discussed with her how early sex could lead to unintended pregnancies and other diseases. Till now, I have been educating her about it. (Maame, Mother, 42 years, Christian).

This 56-year-old parent narrated that it was not until his son began watching erotic movies that he started educating him about sex. Like many African parents, he scolded his child's behaviour before having sexual discussions with the child;

I started having sexual discussions with him when I once caught him red-handed watching blue films (pornographic movies). I scolded him and later made him understand why it is unnecessary to watch such movies and the consequences of such acts on his life (Solomon, Father, 56 years, Christian).

Most of these parents stated also that they make effort to educate their children so that society does not label them as bad parents. The society in which they find themselves serves as a watchdog over how parents raise their children. The narrative by this parent supports this assertion;

As a parent, the shame and blame will be on you when there is unintended pregnancy. People will say you didn't train the child well in the house. I try to educate her to abstain from sex and also shy away from people that will influence her to wear skimpy dresses and others to attract men (Jane, Mother, 46 years, Christian).

Puberty Discussions: both parents and adolescents also admitted that puberty topics are typically discussed during home-based sexuality education. Puberty discussions usually occur during the onset of menstruation in girls. Parents usually take the opportune moment to educate their child about personal hygiene and physical changes such as breast development, and growth of pubic hairs among other things. However, there are sometimes concerns about the use of euphemisms such as sticks, melons, and others during sexual discussions with the child. Adolescents especially were concerned that using euphemisms makes it hard to have open discussions about sexuality.

In the case of this 18-year-old, her mother explained why there were drastic changes in her body shortly after she began menstruating. The onset of menstruation serves as a symbol for parents of their daughters' potential fertility and sexual development. Hence, parents go out of their way to teach their daughters to be extra cautious with their male counterparts to avoid unintended pregnancy;

My parents started talking to me about sex and why my breasts are becoming large during my first menstruation. For me, I believe the menstruation period is the right time to talk to a child about sex. My mother made me aware that I am mature now and that I am more susceptible to temptations from boys. I should therefore be very careful so that I don't get pregnant (Amina, Daughter, 18 years, Muslim).

The narrative from a 19-year-old explains that these adolescents are concerned that using euphemisms sends the message to them that these parts are embarrassing, secret, or shameful. Using common names for these parts makes it easier for them to talk about how to keep the parts healthy, clean, and safe. Additionally, speaking openly about these topics from an early age will help children express future concerns about health, illness, relationships, sex, shaming, exploitation, or abuse.

The adolescent narrated;

They do their best to teach you some sexually related matters. But sometimes they are not blunt, especially when discussing the male and female anatomy. They use words like “stick”, “melons” and others to replace the real thing. This usually makes things awkward for us. My little suggestion is that they should try and be more direct with us so that we can feel free to express our opinions on such matters (Michael, Son, 19 years, Christian).

The majority of the parents also admitted that they usually use euphemisms when especially mentioning sexual organs. They pointed out that they sometimes feel embarrassed when teaching their children anatomically the correct name.

The narrative by this 41-year-old parent buttresses this assertion;

This is difficult. It’s not right to just tell the child everything. Sometimes you feel uncomfortable when the child asks you where a baby comes from. Just coming down to their level and using names like melons, and secret sticks make things easier (Kukuaa, Mother, 41 years, Christian).

Less discussed sexual topics: Although the majority of participants agree that some topics are always covered during home-based sex education, only a few believe that related topics such as

contraceptive use and experiential sex are covered. Most of these parents are hesitant to discuss experiential sex topics such as contraception and condom demonstrations. Parents expressed feelings of embarrassment and shame to discussing contraceptive use and experiential sex topics with their children.

Experiential sex topics: The theme seeks to illustrate how topics related to experiential sex are rarely discussed in the home-based sexuality setting. Most parents perceive demonstrations of these sex-related topics, especially in the presence of their child as inappropriate.

According to one of the parents, he hardly discusses experiential sex topics such as condom demonstrations with his child. From his narration, one can easily deduce that experiential sex matters are off-limits because they are perceived to be private and should be kept private. It is no surprise, then, that the father ardently recounts how humiliating it is to perform a condom demonstration in front of his child.

The parent ardently stated;

I don't think that will be possible. Where and how will I start? Demonstrating this condom thing to them is not the best. It would sound and look very weird and awkward to demonstrate its use to them. Our people frown upon it. (Francis, Father, 46 years, Christian).

This adolescent's report corroborates his father's claim that experiential topics are rarely discussed during home-based sexuality education. He goes on to explain that his parents' aversion to discussing sex issues stems from their introverted personalities. That is, this adolescent believes that his parent's introverted personality makes him feel very shy and embarrassed to engage in open sexual discussions and demonstrations.

Never!!! I don't remember the last time they did that. They hardly ever talk to us about issues related to sexual anatomies, let alone demonstrations on contraceptive use...My parents especially my father are very reserved and conservative. I suspect it's hard for them to share such things with us because they are very shy (Isaac, Son, 17 years, Christian).

Contraceptive use topics: This theme highlight how contraceptive use topics are hardly discussed during home-based sexuality education. The majority of both parents and adolescents pointed out that topics on contraceptives are rarely discussed in home-based sexuality education. Society believes that teaching children about the use of condoms and pills, among other things, may influence their decision to begin experimenting. Interestingly, despite parents' efforts to keep contraceptive information from their children, some children obtain detailed information about their use by relying on friends and the internet.

The narration of this adolescent confirms the majority of the issues raised;

No parent will talk about contraceptives with you. To them, it's a no-go area. You know there is a general perception that teaching such stuff to the child might make him bad. In my case for instance I got to know about condom use from friends and the internet (Michael, Son, 19 years, Christian).

Like the adolescent, this father asserted that topics about condom use are hardly discussed during home-based sexuality education. He ardently believes having discussions with children about condom use might influence their decisions to use it without relying on abstinence from sex.

No way. I will never teach them how to use condoms. They have to be taught to abstain at all costs. If you preach to them about alternatives, then whatever you say about refraining from sex is nothing. You know they are young and always want to have their

way around things. So it's not best at all to talk about condom usage (John, Father, 51 years, Christian).

4.3.2 Perception of sex education

Participants had either positive or negative perceptions of sex education. With regard to the negative perceptions of home-based sex education, both parents and adolescents postulated that some topics of sexuality education such as contraception violated societal moral values and could lead to sexual experimentation among adolescents. Additionally, both parents and adolescents perceived contraceptives use as a means of causing infertility and sterility. On the part of parents, they see contraception as a subtle way for white men to exterminate the black race. The majority of adolescents, on the other hand, regard infertility as a normal side effect of long-term contraceptive use that any race may experience. It was further observed that both parents and adolescents had some positive perceptions of sex education. Both opined that discussions on sexuality could promote adolescents' sexual and reproductive health. They both agreed that sex education promotes adolescent abstinence, which serves as a mechanism for improving sexual and reproductive health.

Negative Perception: Both parents and adolescents highlighted some negative repercussions of sex education. According to these participants, sex education could engender sterility and infertility as well as sexual experimentation.

Infertility and Sterility: This theme describes how participants believe that contraceptive use could lead to infertility and sterility. Their reason for this perception has to do with the fact that there are strong conspiracies from the white to sterilize the blacks via the means of emergency pills and Intrauterine devices (IUDs). The majority of the parents had the idea that contraceptive use is Westerners' plot to sterilize the black community.

Narration from this parent corroborates some of these perceptions;

Contraception is not something I believe in. It has been suggested that it may affect your womb because long-term use may make it difficult to conceive... I read some articles about how these Whites are brainwashing us to use various contraceptives to make us produce less so that our numbers will decrease in the world. (Maame, Mother, 42 years, Christian).

Although some adolescents claimed that contraceptive use could result in sterility, they believe it is one of the common symptoms that anyone, regardless of race, experiences. From their perspective, it alters the menstrual cycle which over time results in infertility.

This 19-year-old asserted;

Yes!!! It is likely to cause complications. I have heard when one often uses emergency pills, for instance, it can cause infertility among women. You know it changes your menstrual cycle so with time you become infertile. Which could then affect your sexual life and marriage (Mansa, Daughter, 19 years, Christian).

Sexual Experimentation: This theme aims to explain how parents and adolescents perceive comprehensive sex education as a conduit for people's sexual gratification, potentially leading to sexual behaviours such as masturbation, sex, and others. As a result, they consider it highly unacceptable and inappropriate to include some sexuality topics, such as contraception, in home-based sexuality discussions.

From the excerpt below, this parent claims that some sexuality topics, particularly contraception, should not be taught to children because it may encourage adolescents to engage in sexual behaviours. He goes on to argue that because most adolescents mimic what they see in their

surroundings, teaching them how to use condoms signals to them that you have permitted them to engage in sex at their age.

Some content need not be taught to these children. You know they are still young and they always want to practice what you preach. When you educate them on how to use a condom, you are signaling to them that you have given them the green light or passport to engage in sex. With time you will see them experimenting with all kinds of sexual fantasies, which might be out of control (Francis, Father, 46 years, Christian).

Some adolescents agree with their parents that exposure to condom use could influence their decisions to sate their sexual conquests. As such, sexuality education should be devoid of teaching adolescents about contraceptive use.

It needs not be taught to us. We are still young and we usually want to practice some new things that come to our minds. Teaching us condoms, and contraceptives in schools and the house, imprints in our minds that it is normal to use them so we would use them (Dora, Daughter, 16 years, Christian).

Another reason why comprehensive sex education should not be provided, according to parents, is that adolescents may end up watching pornographic materials and masturbating. Furthermore, parents with strong religious backgrounds assert that masturbation and pornographic viewing are incompatible with their Christian faith and thus, will not permit their child to perceive such acts as a natural transition.

The assertion by this parent below is a true reflection of some of the claims raised:

At their age, it's not right to provide the full details about sex. They can easily be influenced by that. When they get too much information from this, you will see them watching pornographic movies, masturbating, and engaging in other immoral

behaviours... Yes, and you and I know that masturbating is against the Christian faith. So why should I tell my child that touching yourself is a normal phenomenon at your age, So keep on doing that? It's uncalled for (Kukuaa, Mother, 41 years, Christian).

In a similar vein, this parent ardently believes contraception should not be part of home-based sexuality education as it increases adolescents' tendencies of engaging in sexual behaviours.

According to the participant, teaching adolescents about contraception will encourage them to question their parents' cultural and religious values about early sex.

Teaching them condom use is a no-go area. If care is not taken, children might begin to even question their parents' cultural and religious faith about sex. They might think abstinence is archaic and therefore early sex is the current trend that needs to be copied (Jane, Mother, 46 years, Christian).

Positive Perception: Participants had a favourable opinion of sex education. They believed that sex education is important since it plays a role in the prevention of sexually transmitted diseases and teenage pregnancy.

Sexually transmitted disease prevention: Some participants believe that sex education is important since it protects one from sexually transmitted diseases. They often postulate that through sex education adolescents tend to abstain from sex and those who are sexually active make a conscious effort to use condoms to protect themselves.

The quote below depicts how, as a result of the health risks associated with sex, most adolescents are extremely cautious about their health. They usually make efforts to abstain from sex and those who are sexually active try to make use of condoms before engaging in any sexual intercourse.

Sex education is very essential to us. Because it makes us aware of the dangers associated with sex, especially HIV/AIDs. Due to this most of us try to abstain from sex and those who can't restrain themselves from sex are educated to understand to use condoms before having sex (Mansa, Daughter, 19 years, Christian).

Along the same lines, the majority of parents emphasized the importance of home-based sexuality education as a means of preventing sexually transmitted diseases. Being sexually active, in their opinion, predisposes one to all types of sexually transmitted diseases. As a result, when adolescents practice abstinence, they are primarily saving themselves from all forms of sexually transmitted diseases.

The narration of this parent confirms the majority of the issues raised;

Children who engage in sex are the ones who usually get some of these sexually transmitted diseases. That's why we normally tell them to always abstain so that all these HIV/AIDs, and others will not be a portion of them (Maame, Mother, 42 years, Christian).

Pregnancy Prevention: This theme describes how adolescents perceive information gained through home-based sexuality education helps to avoid teenage pregnancy. They believe that the majority of home-based sexuality education between parents and adolescents focuses on abstinence by instilling fear in the adolescent to restrain their sexual desires.

This participant described how, during parent-child conversations about sex education, parents frequently use fear-arousing stories to keep their children from becoming pregnant. The participant goes on to say that this type of sex education strategy has been extremely effective in preventing teenage pregnancy.

You know African parents. They will try to say all kinds of tales to make you have some form of fear. I believe this has worked over the years to prevent us from any form of teenage pregnancy (David, Son, 19 years Christian).

Also, the majority of parents agree that early home-based sexuality education engenders abstinence which in effect reduces teenage pregnancy. They thus, emphasized that early sexuality education brings the child closer to the parent, and as a result, the parent can detect any sexual advances made to their children on time. Most adolescents refrain from having sex until they reach the age of marriage as a result of such discussions.

It's really good especially when the children are taught to abstain from sex at an early age. They easily listen to their parent's advice and make sure that they report anyone who makes advances toward them to their parent. Through this, engaging in sex and pregnancy at an early, is not an option for them (Kukuaa, Mother, 41 years, Christian).

4.3.3 Impact of sex education

Sex education was discovered to have a significant positive or negative impact on the lives of adolescents. Both parents and adolescents reported that sex education had a significant positive impact on some aspects of adolescents' psychological and sexual health. It was discovered that sex education had resulted in a significant increase in adolescents' self-efficacy. It has also contributed to the prevention of teenage pregnancy and sexually transmitted diseases.

Interestingly, sex education was also reported to have negative impacts in some areas of adolescents' lives. Although both parents and adolescents agreed that some topics discussed during home-based sex education had a significant influence on early sexual initiation, their explanations differed. As a result, the majority of parents believe that contraception and experiential sex topics are more likely to elicit early sexual initiation. Some adolescents, on the

other hand, argue that the fear-inducing stories used in home-based sex education encourage them to engage in sex at an early age whereas others expressed concern that the fear-inducing stories make them nervous and anxious.

Positive Impact: Sex education was found to have a significant positive impact on the mental health of adolescents. The participants emphasized that sex education has helped them to have control over their sexual urges. Additionally, sex education has had a significant impact on the prevention of teenage pregnancy and sexually transmitted diseases.

Psychological wellbeing: This theme describes how participants pointed out that sex education affected their psychological wellbeing. Psychological wellbeing took the form of a sense of autonomy, personal growth, and competence.

From the narration below, this 18-year-old Muslim emphasized that sex education has primarily increased her self-efficacy and competency level. She currently possesses the knowledge, skills, and attitudes required to control any sexual urges or demands from others. In general, sex education has made her more assertive, preferring to say, "No to Sex."

"I believe my knowledge of sexuality has helped me to have control over certain situations. I am a girl and sometimes guys want to have their way out because you are beautiful and have all the supposed qualities, they sexually desire. I am mostly assertive and say "no to sex" to them. I tell them the consequences of their sexual actions and they never come back or make such advances again" (Rashida, Daughter, 18 years Muslim).

Almost corroborating the view of the 18-year-old daughter is a parent who highlights that, through sex education, her daughter has learned to be assertive enough to allow others to understand her boundaries. This Christian parent acknowledges that sex education has created some sense of autonomy and competency in her daughter to be assertive around her male

counterparts. According to her, due to her daughter's friendly nature, some male friends tend to make sexual advances toward her. Her daughter thus relies on her religious values or preferences and inner goals to negotiate and draw sexual boundaries with such male friends.

My daughter has a lot of male friends because she is easygoing and approachable. Sometimes when you are very friendly to boys, they misinterpret your actions. She has learned to always hold unto her religious faith about remaining chaste until marriage... She tries to draw boundaries and let them know they can only be friends and nothing else whenever they make attempts of any sexual advances.” (Catherine, Mother, 49 years, Christian).

Sexually transmitted disease prevention: Some participants benefited from sex education to protect themselves against sexually transmitted diseases. Sex education was beneficial in that those who were sexually active were better informed about the importance of using condoms or insisting that their partners use condoms before engaging in sexual activity.

In the case of this adolescent, he learned how to use condoms from friends and social media. Even though he is sexually active, he believes that sex education has influenced his decision to always use condoms before having sex.

Yeah, it has helped me, you know. Because frankly speaking I am not a virgin and through some education from friends and social media about HIV/AIDs, syphilis, and co, I do make sure that I always wear condoms before having sexual intercourse with any girl (Michael, Son, 19 years, Christian).

The majority of the parents also pointed out that their children and people they know have significantly benefitted from sex education. From the parents' perspective, most adolescents who

receive home-based sex education are much more careful in their dealings with any sexual escapades in order not to be infected by any form of sexually transmitted disease.

The narration by this 42-year-old mother captures most of these assertions highlighted.

It has helped a lot. I have seen some improvement in my son when I started talking to him about sex. Now he is quite careful about girls because he doesn't want to get any AIDs and other diseases (Maame, Mother, 42 years, Christian).

Pregnancy Prevention: Some adolescents believed that sex education had helped them avoid pregnancy. These adolescents primarily learn to listen to home-based sexuality education through the consequences of other people's behaviours to avoid pregnancy.

This 17-year-old for instance asserts that through vicarious learning, she has learned to listen to home-based sexuality education to avoid becoming pregnant. As a result, she believes that at her age, her only priority is her studies.

"Me it has influenced my decisions a lot. You, I have a neighbour who is the same age as me and she is pregnant. I have learned to always listen to my parents' advise about sex so that I don't fall into the trap of that girl. I am very cautious now because, at my age, I don't want to be pregnant with any guy. Focusing on my studies is my major aim now."
(Harriet, Daughter, 17 years, Christian)

This parent's report corroborates her daughter's claim that through vicarious learning, she has learned to listen to home-based sexuality education to avoid becoming pregnant. She goes on to point out that her daughter has made a solemn promise to remain chaste till marriage.

My daughter has grown a lot. She has a friend who lives close by and is currently pregnant due to bad choices she made. Currently, the girl's education has come to an end since she ought to cater to the child. I believe she has learned from the girl's mistake

and keeps mentioning why it is essential to maintain her virginity till after marriage

(Maame, Mother, 42 years, Christian).

Negative Impact: The adolescents demonstrated how sex education had a negative influence on some parts of their lives. Some participants opined that the home-based sexuality education they receive has caused them a great deal of anxiety. They stated once more that home-based sex education influenced their decision to initiate sex at an early age.

Early Sex Initiation: This theme depicts how some home-based sex education topics influenced adolescents' decisions to have sex at a tender age. Most home-based sex education which focuses on inducing fear influences adolescents' sexual imaginations to engage in sexual experimentation.

From the narration below, this adolescent believes the fear arousal stories that are typically infused in home-based sexuality education do not affect his decision to abstain from sex. It, on the other hand, fuelled his sexual curiosity and forced him to satiate his sexual desires by sexually experimenting.

Sometimes I don't understand why our parents are not straight with us about sex and put us in fear. To me, it doesn't work. When I was very young my parents, especially my mum used to tell me not to expose my private part to girls or else they will vanish. I think that challenged me growing up to try sex for the first time if that is possible (Michael, Son, 19 years, Christian).

In a similar vein, most parents agree that some content in comprehensive sexual education increases adolescents' desire to sexually experiment. From their perspective, home-based discussions on contraceptive use and demonstration are one major means which lead to sexual experimentation among adolescents.

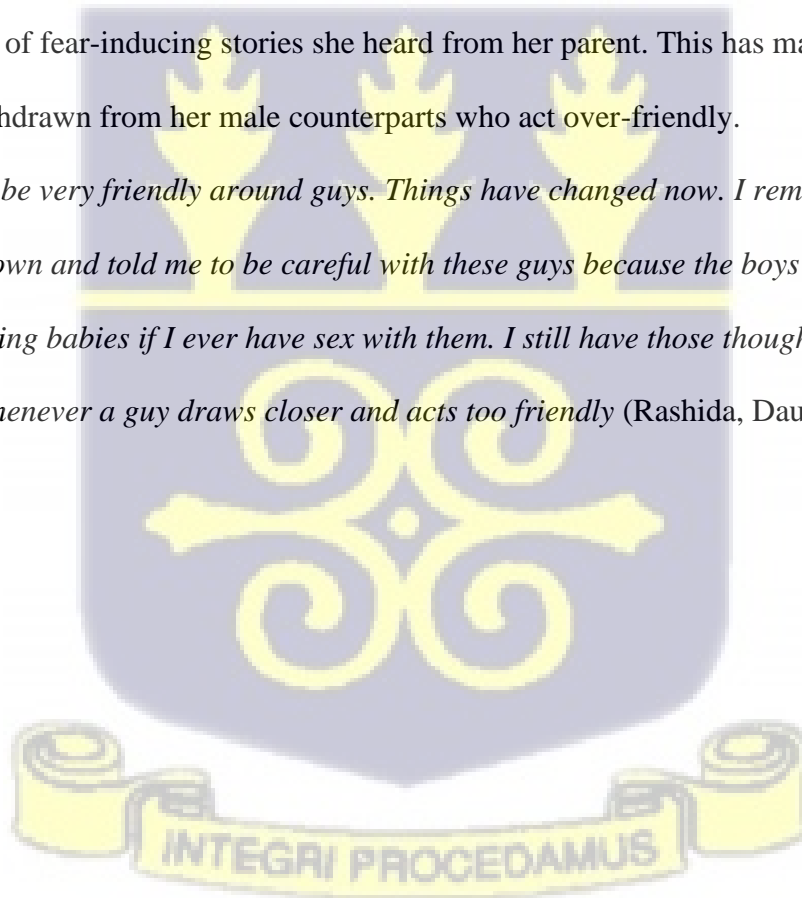
The narration from this parent confirms the issues highlighted;

I have witnessed cases whereby parents thought it is okay to teach their children how to use condoms and others. But things didn't end well the way they were expecting. They felt doing this might prevent their children from getting pregnant or impregnating others. That's not true. At the moment some of these children are pregnant at a younger age (John, Father, 51 years, Christian).

Anxiety: This theme seeks to explain that some participants believe some aspects of home-based sex education usually evoke anxiety.

In this participant's case, she is always nervous around male counterparts who usually act friendly because of fear-inducing stories she heard from her parent. This has made her significantly withdrawn from her male counterparts who act over-friendly.

I used to be very friendly around guys. Things have changed now. I remember my mother sat me down and told me to be careful with these guys because the boys will destroy me from having babies if I ever have sex with them. I still have those thoughts and become afraid whenever a guy draws closer and acts too friendly (Rashida, Daughter, 18 years Muslim).



CHAPTER FIVE

DISCUSSION

5.1 Introduction

This study aimed to explore parents' and adolescents' perspectives on sex education in Ghana. In light of the above aim, the findings of the study are discussed below. The findings of the data analysis are discussed in relation to cultural norms, theories, and related research. The findings on adolescents are discussed first in the presentation, followed by the findings on parents. The findings are then integrated to discuss the implications for practice and future research. This chapter also discusses the limitations of the study as well as future research recommendations. The chapter then concludes with highlights from the research.

5.2 Discussion of findings (Adolescents)

Three main themes emerged from the data analysed and these were guided by research questions; At what point do your parents discuss issues about sex with you? What topics do you think should constitute sex education? What worries might you have about using contraceptives? To what extent has sex education impacted your life?

The main themes were organized into parent-child communication, perception of sex education, and the impact of sex education. These themes answer the research questions highlighted.

5.2.1 Parent-child sex communication

The findings revealed that common and/or rare topics were discussed among parents and adolescents during home-based sexuality education. In terms of the commonly discussed topics, the majority of the adolescents referred to the fact that home-based sexuality education centers on topics such as abstinence, puberty, and the consequences of sex education. This aligns with

existing literature that has found that parental communication is directed towards a few topics such as abstinence, male (wet dreams, masturbation) and female physical development (menstruation and females' bodies), and consequences of premarital sex (teenage pregnancy, sexually transmitted diseases among others) (Beckett et al., 2010; Manu et al., 2015).

The finding of abstinence as one of the most commonly discussed topics in home-based sexuality education reported by adolescents reflects the adolescent's exposure to strict African cultural norms. In most African cultures which Ghana is inclusive, sex is considered to be sacred and thus, must solely be shared between married couples (Baku et al., 2017). In adolescents' quest to have a positive image in society, they are constantly taught by significant others to live a chaste life until marriage. Topics on abstinence may also be motivated by reasons such as a desire to live a "Christian life" and live according to Bible principles, avoiding negative consequences and trouble, and an attempt to distinguish oneself from other people who have promiscuous sexuality. These reasons echo the findings of a large number of studies that show that sexual abstinence is primarily determined by religious beliefs and personal values (Gardner, 2011; Gesser-Edelsburg & Arabia, 2018; Landor & Simons, 2014).

Additionally, during puberty discussions, the majority of the adolescents reported their parents used euphemisms when describing male sexual organs to them. This finding reflects the Ghanaian cultural perception of sexual issues as solely the domain of adults. In many African settings, there is a consensus that having sexual discussions with children can lead to early sexual initiation (Baku et al., 2017). As a result, it is considered taboo in Akan society to discuss the private parts of the body in the presence of a child, as well as in public (Baku et al., 2018).

Moreover, these adolescents reported that the majority of their sexuality education focuses on the consequences of premarital sex. Parents, according to the adolescents, usually use

specific timing and tactics to educate them about the consequences of premarital sex. That is, most parents have sexual discussions with their children when for instance, a child in a movie becomes pregnant or is infected with sexually transmitted diseases. This type of timing and tactics used by parents can be explained using the social learning theory by Bandura (1986). In the field of health education, the social cognitive theory has been employed to understand behaviours associated with substance use and sexual and reproductive behaviours. Factors such as personal characteristics, family relationships (siblings and parents), cultural background, and religious concepts all have a significant impact on adolescents' sexual and reproductive health. That is, parents, happen to employ these tactics since they believe that when adolescents observe the actions of significant others such as parents, siblings, and peers, they are more likely to develop rules to guide their sexual and reproductive health.

In addition, the adolescents reported that some sexuality topics such as contraception and experiential sex were rarely communicated by parents during home-based sexuality education. Most of the adolescents asserted that their parents' aversion to discussing these sex issues stems from their cultural background and their introverted personalities. Our cultural dimension allows parents to make an effort to keep sexual issues private (Baku et al., 2018; Izugbara, 2008), and thus discussing sex-related topics, particularly experiential sex topics, with the child usually appears awkward on the parents' part. This awkwardness usually breeds shyness and embarrassment between parents and adolescents whenever attempts are made to demonstrate for instance experiential sex topics to the child (Tesso et al., 2012). Most of these parents' aversion to discussing contraception and experiential sex is exacerbated when their introverted personalities interact with African cultural sex ideology (Iyer et al., 2014).

5.2.2 Perception of sex education

It was found that adolescents had both negative and positive perceptions of sex education. From their perspective, sex education leads to sterility and infertility, as well as sexual experimentation. The findings that adolescents perceive sterility and infertility as one of the major side effects of contraception echo a recent study of black American adolescents who reported sterility as one of the reasons for not using contraceptives (Coles et al., 2011). Also, ambivalence toward pregnancy has long been identified as a risk factor for ineffective contraception, pregnancy, and childbearing during adolescence (Bruckner et al., 2004). The majority of adolescents are probably less informed of the possible side effects of contraceptives. This lack of information influences how these adolescents respond to the side effects, and it may also contribute to a family's decision to avoid health facilities or to rely on inaccurate information circulating in their communities (Chebet et al., 2015). Lack of knowledge and the perception of invincibility have been identified as major factors that contribute to false perceptions and, as a result, unintended pregnancies among teenagers (Coles et al., 2011).

Concerning adolescents' perception of sex education leading to sexual experimentation, it is consistent with Francoeur (2001) who opined that sex education could influence those who are not sexually active to start sexual experimentation. The majority of these adolescents' perceptions are shaped by their religious beliefs. Contraception is seen as morally wrong in the majority of Christian households. Significant others teach adolescents to be mindful of some sex education topics from the time they are born so they do not stray from their religious faith. This finding has been reported in previous research (Anarfi & Owusu, 2011; Osafo et al., 2014) where most religious centers have been found to provide moral education to the youth rather than sex

education. Thus, religious society repeatedly believes delivering sex education to children is a form of encouraging immorality.

Adolescents also expressed positive perceptions toward certain aspects of sex education. Sexuality discussions, according to these adolescents, promote sexual and reproductive health significantly. That is, in their opinion, home-based sexuality education promotes the prevention of adolescent pregnancy and sexually transmitted infections. Because they are frequently exposed to fear-inducing stories during home-based sexuality education, most of these adolescents believed sex education significantly reduced teenage pregnancy and sexually transmitted diseases. Parents, thus, go to the extent of presenting scary stories to reinforce chastity and abstinence in their children (Beckett et al., 2010; Izugbara, 2008; Manu et al., 2015).

5.2.3 Impact of sex education

It was discovered that sex education had a significant positive or negative impact on the lives of adolescents. These adolescents reported that sex education had a significant positive impact on some aspects of adolescents' psychological and sexual health (psychological health and prevention of teenage pregnancy and sexually transmitted diseases). The finding that sex education improves adolescents' sexual health is consistent with the findings of Reis et al (2011), who found that individuals exposed to sex education often engage in fewer sexual behaviours, such as fewer occasional partners, fewer sex-related alcohol, and drugs, and prevention of pregnancies and sexually transmitted diseases. Sex education was found to have had a positive impact on adolescents' sexual health because the home-based sexuality education received by these adolescents improved their knowledge of sexually transmitted diseases, pregnancy prevention, and other sexual and reproductive health issues (Rashid, & Mwale, 2016). Also, the finding that home-based sexuality education improved the psychological health of adolescents

echoes Wylie's (2010) finding that sex education increases the level of satisfaction in terms of the emotional, physical and sexual well-being of individuals.

With the negative impacts of sex education, a significant number of adolescents indicated that home-based sex education influence early sexual initiation and also induces anxiety. From the perspectives of adolescents, the fear-inducing stories used by parents during home-based sex education discussions encourage them to engage in sex at an early age or engender nervousness. The findings that home-based sex education led to early sex initiation are in sharp contrast with existing studies' findings that an early-stage introduction of sex education reduces sex initiation among adolescents (Erkut et al., 2012; Lindberg & Maddow-Zimet, 2012; Tortolero et al., 2010). Most of the home-based sex education in the African context centers on risk avoidance (abstinence-only and fear-arousing tales). Risk-avoidance sexuality topics have been found to have a significant effect on fueling adolescents' sexual curiosity, thereby forcing them to satiate their sexual desires (Shepherd et al., 2017; Stanger-Hall & Hall, 2011).

Moreover, the majority of the adolescents pointed out that home-based sex education induces fear in them. This finding is in line with Jayne et al. (2020) who highlighted that little family sex communication and high emphasis on religious values about sex during childhood creates sex anxiety among individuals. That is, parents with strong religious backgrounds are fond of emphasizing risk-avoiding sexual topics to ensure their children tune in line with Christian moral values. The high expectations put on these adolescents sometimes create a toll on them and make them extra cautious in their dealings with peers and significant others to not disappoint their parents.

5.3 Discussion of findings (Parents)

Similar to the adolescents, three main themes emerged from the data analysed and these were guided by research questions; At what point do you discuss issues about sex with your child? How do you feel when discussing issues about sex with your child? What are the key things you discuss with your child about sex? To what extent has sex education impacted your child's life? The main themes were organized into parent-child communication, perception of sex education, and the impact of sex education. These themes answer the research questions highlighted.

5.3.1 Parent-child communication

Parents also reported some common and rare sex topics that are discussed during home-based sex education. With the common topics, the majority of the parents asserted abstinence, consequences of premarital sex, and puberty topics are usually discussed during parent-child communication about sex. This finding echoes a study by Manu et al (2015) that parental communication about sex is directed towards a few topics such as teenage pregnancy, abstinence, and sexually transmitted disease prevention. In most African settings, parents determine what their children need to know and hear (Tesso et al., 2012). Most parents are thus dismayed when their children begin the discussion or demonstrate a wealth of knowledge about the issues at hand. As a result, communication focuses solely on areas that the parents believe are appropriate for the child. Also, religious beliefs among parents have a strong influence on the content and type of approach to adopt in sexuality education (Iyer et al., 2014). In most religious faith, premarital sex is forbidden, and thus, parents are oriented to teach their children to practice abstinence before marriage (Gesser-Edelsburg & Arabia, 2018).

Moreso, it was discovered that the majority of parents prefer to use fear-arousing tales during home-based sex education to deter their children from engaging in any form of sexual behaviour. The finding resonates with Ajzen (1985) theory of planned behaviour. According to the theory of planned behaviour, parents with favorable attitudes and subjective norms towards sex education as well as greater perceived behavioural control are more likely to have stronger intentions to teach their children about their sexuality. This implies that when parents believe fear-arousing tales are strategically designed to reduce adolescents' sexual escapades and have significant others who also agree with this assertion, as well as have the necessary resources and capabilities to teach their children, they are more likely to present fear-evoking tales during home-based sex education.

It was also noted that parents wait till the puberty stage to discuss issues about sex with their children. This stage agrees with Izugbara (2008) finding that African parents strongly hold onto the fact that the puberty stage is the best time to introduce sex education. Their justification for using this period is that during puberty, the child has enormous cognitive development to understand sex issues (Izugbara, 2008; Pop & Rusu, 2019). As a result, until puberty, parents postpone sexuality issues because they believe the child is sexually innocent before puberty (Stone et al., 2013). In other cases, parents withhold certain sexual matters from their children out of fear that the child's innocence will be tainted or destroyed. Even during puberty, some parents express concerns about their children losing their innocence, and as a result, they make efforts to keep their children from entering the world of grown-ups (Stone et al., 2013).

Additionally, it was found that some sex education topics were rarely discussed. Some of the rarely discussed topics found were contraceptive use and experiential sex topics. These topics are rarely discussed in most African home-based sex education programs because there is a fear

that exposing children to experiential sex topics, for example, will corrupt their minds, leading to sexual experimentation. Most African settings also perceive adolescents who patronize contraceptives as wayward (Appiah-Agyekum & Kayi, 2013). Most parents, therefore, make a conscious effort not to teach contraception to their children to maintain the image of the household.

Some factors such as poor role models, taboos on sex, fear, and exposure to technology could serve as a barrier to sex talks among parents and adolescents (Asampong et al., 2013). Some parents also lack the necessary parental skills and knowledge to effectively communicate with their children about sexual issues (Stone et al., 2013). A parent's lack of such knowledge and strategies may impede effective sexual communication. Parental religious beliefs have a strong influence on the content and approach used in sexuality education (Iyer et al., 2014). Premarital sex is prohibited in most religious faiths, making it difficult for parents with a strong religious background to discuss contraception and safe sex with their children (Gesser-Edelsburg & Arabia, 2018).

5.3.2 Perception of sex education

Similarly, parents had both positive and negative perceptions of sex education. In terms of negative perceptions of home-based sex education, the majority of parents believe that some related sex topics violate moral values and may lead to sexual experimentation. Families with strong religious beliefs have high regard for abstinence until marriage (Anarfi & Owusu, 2011). They are more likely to view contraception as a means of exposing their children to premarital sex and, as a result, will make every effort not to educate their children about contraception during home-based sex education. The majority of parents also fear that having experiential sex discussions with a child at an early age would evoke their sexual imaginations (Baku et al., 2017)

and as such, they make effort to filter the sexual information given to the child. Pop and Rusu (2019) for instance opined that the anatomic and physiological aspects of development are normally filtered by the parents depending on the child's cognitive development phase. It is no surprise why the majority of the parents in this study pointed out that they usually use euphemisms when highlighting the male and female anatomical structures.

The parents also asserted that the use of contraceptives could lead to infertility and sterility. These parents perceived contraception as a subtle way used by white men to exterminate the black race. This could be explained on the basis that some parents lack the right parental skills and knowledge to speak effectively with their child about sexual-related matters (Stone et al., 2013). Lack of such knowledge and strategies on the part of the parent could hinder effective sexual communication.

5.3.3 Impact of sex education

Parents also asserted that sex education to a large extent has had a significant positive and negative influence on adolescents. From the perspectives of the parents, home-based sex education has improved the psychological and physical well-being of adolescents. That is, the majority of the parents opined that home-based sex education has increased the sexual assertiveness of adolescents. This finding echoes Kim and Choi's (2016) study that sexual knowledge significantly increases sexual assertiveness. Michalos (2014) defines sexual assertiveness as the voluntary ability to initiate or reject unwanted sexual activities and to also negotiate the use of contraceptive/barrier methods to perform sexual behaviors most healthily and satisfyingly. Individuals with high sexual assertiveness can easily handle and control their sexual matters by rejecting unwanted sexual situations (Park, 2010).

The majority of the parents also postulated that home-based sex education has led to pregnancy and sexually transmitted disease prevention in most adolescents. Sex education to a large extent increases adolescents' knowledge of sexually transmitted diseases, pregnancy prevention, and other sexual and reproductive health issues (Rashid, & Mwale, 2016). High knowledge of some of these areas could lead to fewer sexual risk behaviours in terms of fewer occasional partners, less sex-related alcohol use and drugs, unwanted pregnancies, and abortions (Reis et al., 2011).

The parents further reported that some of the home-based sex education topics led to early sex initiation among adolescents. From the parents' perspective, home-based discussions on contraception and sexual demonstrations are the main means which engender sexual experimentation among adolescents. This finding is consistent with Francoeur (2001) who opined that sex education could influence those who are not sexually active to start sexual experimentation.

5.4 Integration of findings (Parents and Adolescents)

The nature of commonly discussed sex topics asserted by both parties were abstinence, physical development, and consequences of premarital sex. This finding confirms Manu et al (2015) argument that parental communication is directed toward a few topics. Most sexual discussions are devoid of condom use, abortions, and contraceptives (Wamoyi et al., 2010; Wyckoff, 2008). Most parents exclude discussions on condom use because they believe doing that could encourage the child to engage in sex which therefore would contradict the message of abstinence (Wamoyi et al., 2010). Both parties additionally commented that fear-evoking tales are usually used by parents during home-based sex education. Fear-evoking stories are

frequently used by parents to reduce their child's proclivity to engage in any form of sexual behaviour (Baku et al., 2017; Manu et al., 2015).

Again, both parents and adolescents postulated that some topics of sexuality education violated societal moral values and could lead to sexual experimentation. This finding echoes Francoeur (2001) study that sex education has the potential to persuade those who are not sexually active to begin sexual experimentation. Individuals with strong religious beliefs are more likely to perceive some sexuality topics (contraception and experiential sex topics) as morally wrong (Tesso et al., 2012). Additionally, sexual discussions in African settings are considered to be done in private for only adults. Hence, exposing adolescents to especially experiential sex topics is considered to be taboo (Baku et al., 2018). In terms of the positive light, both parents and adolescents asserted that home-based sex education leads to the prevention of teenage pregnancy and sexually transmitted diseases. Most individuals with strong religious backgrounds are oriented to perceive that sex before marriage is a sin against God (Anarfi & Owusu, 2011). As a result, the majority of the parents and adolescents likely had strong religious backgrounds that led them to believe that high abstinence leads to the prevention of adolescent pregnancy and sexually transmitted diseases.

Again, both parties reported a positive and negative impact of sex education. With the positive impact, they both pointed out that home-based sex education increases the psychological and sexual health of adolescents. From the psychological point of view, they opined that home-based sex education significantly improves the self-efficacy and assertiveness level of adolescents. This is in line with Markham et al. (2012) assertion that sex education increases condom self-efficacy and assertiveness. They both agree with the fact that home-based sex education has improved adolescents' confidence to say "No" to any unwanted sexual contact and

demands. They both further agree that home-based sex education has significantly improved the sexual health of adolescents. From the perspective of the two parties, home-based sex education has led to the prevention of teenage pregnancy and sexually transmitted infections among adolescents. With the negative impact of home-based sex education, both parents and adolescents postulated that some aspect of home-based sex education influences their decision to initiate sex at an early age.

5.5 Implications of the study

Comprehensive sexuality education programs that promote abstinence and other preventive strategies like mutual fidelity and contraceptive use should be developed and implemented in home-based sexuality discussions.

The necessary stakeholders should raise awareness about the importance of educating adolescents on topics such as contraception and experiential sex. The electronic (radio and television) and print media (cartoons, youth-focused magazines, posters, stickers, and handbills) can be used as primary platforms to communicate some of these sexual education topics to youth and parents to dispel some of the myths surrounding contraception and other sex topics.

The Ghana Health Service must collaborate with the Ghana Psychological Association to organize training programs aimed at empowering youth to develop and acquire personal skills necessary for abstinence. The training program will not only focus on the cognitive aspect of learning, but will also aim to boost the youth's confidence and improve their skills in areas related to abstinence and self-efficacy, such as assertiveness, refusal skills, and goal setting.

Diverse behavior change intervention strategies that foster a positive attitude toward the practice of the behavior, promote abstinence values, and instill the necessary skills to adopt abstinence are required. These include, but are not limited to, interpersonal communication and

adult role modeling (in which adults share their experiences of navigating adolescence, with a focus on sexual abstinence). Furthermore, well-known actors, athletes, and musicians can serve as positive role models. All of these have the potential to boost young people's confidence while also teaching them the necessary abstinence skills.

5.6 Limitations and recommendations for future studies

There were some limitations to this study. First of all, adolescents and parents were only involved in one metropolis in the Greater Accra Region of Ghana, which was a relatively small portion of the entire region. As a result, future studies should consider exploring families across the entire region, if not nationwide.

This study centered on a sensitive topic because there are a lot of stigmas attached to premarital sex among young individuals in Ghana. Assessment of sexual behaviours in Ghana thus, are prone to recall biases, confidentiality concerns, and stigmatization of the behaviour in question. Although these might affect the credibility and generalizability of the findings, efforts were made to mitigate the effects of these by assuring participants of full confidentiality.

5.7 Conclusion

The study has identified factors that tend to protect young adolescents from premarital sex and those that put them at risk. Given that the sexual behaviours of adolescents are influenced by several factors, it is therefore imperative that an integrated multi-sectoral approach involving all stakeholders in providing comprehensive sexuality education to adolescents is institutionalized. In other words, sex education should not be the sole responsibility of a single organization. The main actors in sexuality education (parents, teachers, health counselors, and religious bodies) must work together to supplement each other's shortcomings.

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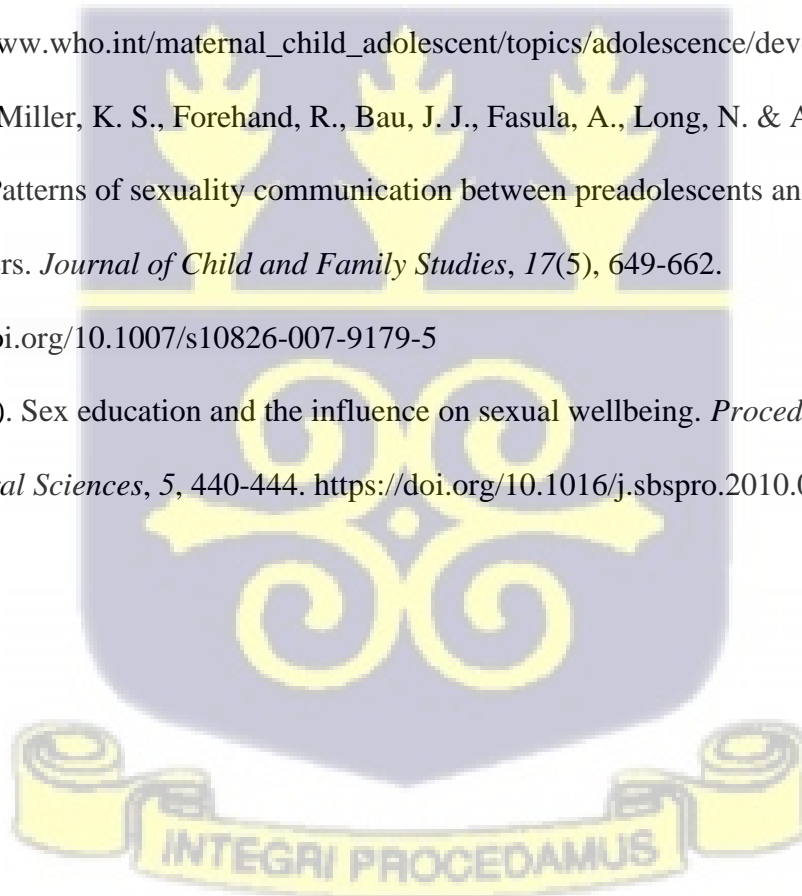
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APPENDICES

Interview Discussion Guide

Introduction:

1. Welcome

Introduce yourself, and send the Sign-In Sheet with a few quick demographic questions (age, religion, region, educational background)

Step II: Introduce Procedures of the Interview

Greet participants as they arrive. Create a friendly tone. Ask participants to sit wherever they feel comfortable.

Open the session. I will introduce myself, my role, and my purpose. I would indicate that I'm an MPhil student who is working on experiences and perceptions of sex education. I will also add the reasons for my concern about sex education and share a story or statistics about sex education to break the ice.

Introductions. Ask the parent or adolescent to make a brief introduction with his/her age, and anything they'd like to say.

Introduce note taker. Introduce the note taker and his role.

Explain the meeting's purpose. Briefly describe your agenda and purpose of the interview. Emphasize that you want to hear his views and concerns about sex education.

Emphasize confidentiality. Stress that his/her name will be kept anonymous. It sometimes helps to allow the participant to sit close to the note taker to check for no name. The parent or adolescent would more likely open up knowing you are serious about confidentiality.

Set clear meeting rules: Emphasize that his/her opinions count. There are no "right" or "wrong" ideas. Explain that he/she is there to represent his/her ideas as well as what feel is his/her peers' point of view.

Turn on Tape Recorder

Ask the parent/adolescent if there are any questions before you get started, and address those questions.

The discussion begins, make sure to give the parent/adolescent time to think before answering the questions, and don't move too quickly. Use the probes to make sure that all issues are addressed, but move on when you feel you are starting to hear repetitive information.

Questions to Parents

Section A: Demographic information

How old are you?

Mother or Father

Educational background

Religion

Section B: Parent-Child communication about sex

What is the relevance of sex education?

At what point do you discuss issues about sex with your child?

When is it appropriate to discuss sex with your child?

Can you further explain your response?

Please describe how you communicate to your child about sex. (probe further on the response)

Which of the genders do you prefer to talk about sex with? Why?

How do you feel when discussing issues about sex with your child?

Why do you feel the way you do when talking about sex with your child?

What would make it easier for you to talk to your child about sexuality?

What are the key things you discuss with your child about sex? Any fear arousing tales? (probe further on responses)

Section C: Perception of Sex Education

At what point do you perceive the environment as safe to talk about sex education?

Have you heard about contraceptives, condoms, and IUDs?

Do you provide any information on contraceptive use to your child when discussing sex?

Discussion on condoms/abortion; birth control?

Why do/don't you?

What do you think are some of the good things about using contraceptives, condoms, and IUDs?

What worries might you have about your child using contraceptives, condoms, and IUDs?

Impact of Sex Education

To what extent has sex education impacted your child's life?

Can you describe how sex education has influenced your child's abstinence level?

Can you describe how sex education has influenced your child's use of contraceptives?

Can you describe how sex education has influenced your child's reproductive health? (STIs, pregnancy prevention)

That concludes our interview. Thank you so much for coming and sharing your thoughts and opinions with us. If you have additional information that you did not get to say in the interview, please feel free to write it on this form (separate form).

Questions to Adolescents

Section A: Demographic information

How old are you?

Grade

Educational background

Religion

Section B: Parent-Child communication about sex

What do you think about sex education?

When did you receive any sex education?

Where do you receive information about sex?

At what point do your parents discuss issues about sex with you?

What are the key things your parents discuss with you about sex? Any fear arousing tales? Any information on contraceptive use? Discussion on condoms/abortion; birth control?

Which of your parent, do you prefer to talk about sex with? Why?

At what age did this happen?

Section C: Perception of Sex Education

By what age should an adolescent first have sex? Why?

Are you sexually active? Do you use condoms when having sex? Why?

What topics do you think should constitute sex education?

At what point do you perceive the environment as safe for sex education?

What are some of the barriers to having discussions with your parents on sex education?

Have you heard about contraceptives, condoms, and IUDs?

What have you heard about these?

What do you think are some of the good things about using contraceptives, condoms, and IUDs?

What worries might you have about using contraceptives, condoms, and IUDs?

What does your boyfriend/girlfriend think about IUDs?

If you decide that you wanted to use contraceptives, condoms, and IUDs, where would you get them?

If you wanted contraceptives, condoms, and IUDs, what might make it hard for you to get them?

Impact of Sex Education

To what extent has sex education impacted your life?

Can you describe how sex education has influenced your abstinence level?

Can you describe how sex education has influenced your use of contraceptives?

Can you describe how sex education has influenced your reproductive health? (STIs, pregnancy prevention)

That concludes our interview. Thank you so much for coming and sharing your thoughts and opinions with us. If you have additional information that you did not get to say in the interview, please feel free to write it on this form (separate form).

Materials and supplies for the interview

Sign-in sheet

Consent forms (one copy for participants, one copy for the researcher)

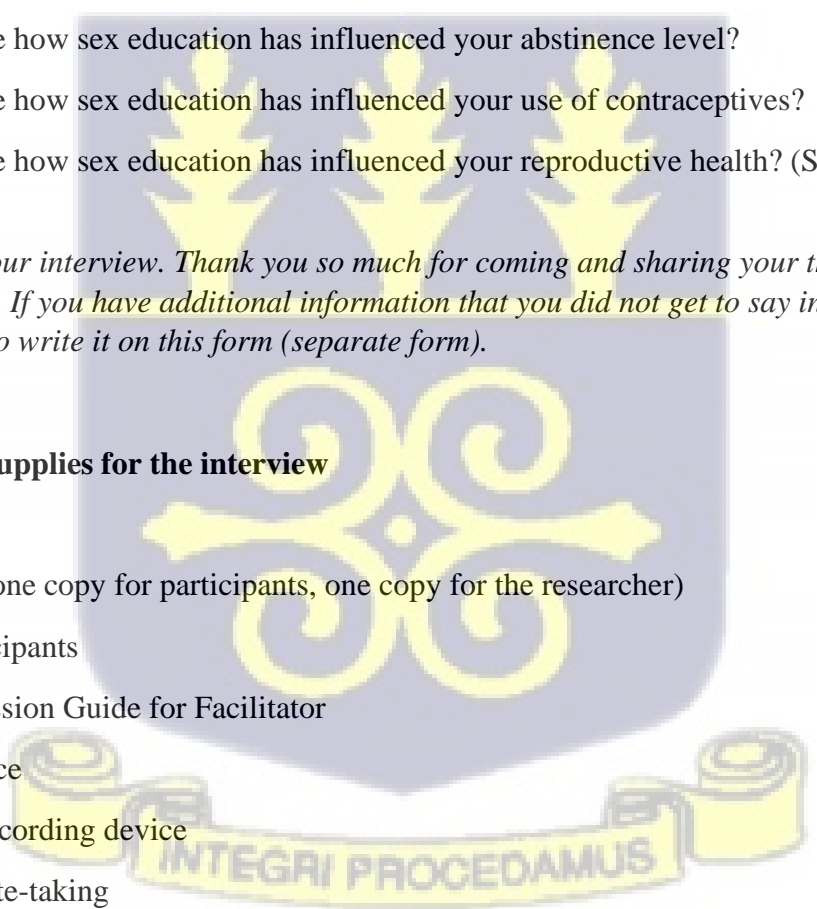
Pencils for participants

Interview Discussion Guide for Facilitator

1 recording device

Batteries for a recording device

Notebook for note-taking



Letter from Departmental Research and Ethics Committee (DREC)

DEPARTMENT OF PSYCHOLOGY
SCHOOL OF SOCIAL SCIENCES
UNIVERSITY OF GHANA



DEPARTMENTAL RESEARCH & ETHICS COMMITTEE (DREC)



31 August, 2021

Jessica Osei Owusu
Department of Psychology
University of Ghana, Legon
Ghana

Dear Ms. Osei Owusu

Protocol number: DREC/016/20-21

Project title: Sex Education in Ghana: The Perspectives of Adolescents and Parents in Ghana

Full Approval-Committee Reviewed Protocol

In response to your application received on July 21, 2021, the Departmental Research & Ethics Committee of the Department of Psychology, University of Ghana has considered the above mentioned application and the protocol has been granted **Full Approval**

Any significant alteration(s) to the approved research protocol (i.e. the Questionnaire/Semi-structured interviews, Informed Consent Form, Title of the Project, Research Approach and Methods) must be submitted for review and approval prior to implementation. In case you have further queries, please quote the above reference number.

Note: Research data should be securely stored at an appropriate location and should only be destroyed after 5 years.

This ethical clearance certificate is valid for only 12 months from the date of issue. Thereafter, re-certification must be applied for on annual basis.

We take this opportunity to wish the very best in your research.

Yours faithfully,

A handwritten signature in red ink, appearing to read "Annabella Osei-Tutu".

Annabella Osei-Tutu, Ph.D.
Chair, Departmental Research & Ethics Committee (DREC)

A yellow banner with the Latin motto "INTEGRA PROCEDAMUS" in blue capital letters.

Cc: Prof. Joseph Osafo, Head, Department of Psychology, University of Ghana