

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



**PARENT-CHILD COMMUNICATION AND ADOLESCENT SEXUAL BEHAVIOUR IN  
THE EJISU JUABEN MUNICIPALITY**

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## DECLARATION

I, Bismark Bisala Lambongang hereby declare that apart from the references made to other people's work which have been duly acknowledged, this work is the result of my own research work done under supervision and that this work has neither in whole nor part been presented to the University or elsewhere for another degree.

.....

Date.....

Bismark Bisala Lambongang

(Student)

.....

Date.....

Dr. Abubakar Manu

(Supervisor)



## **DEDICATION**

I dedicate this work to God Almighty for his love and kindness and for bringing me this far, then to my wife and lovely son.



### **Acknowledgement**

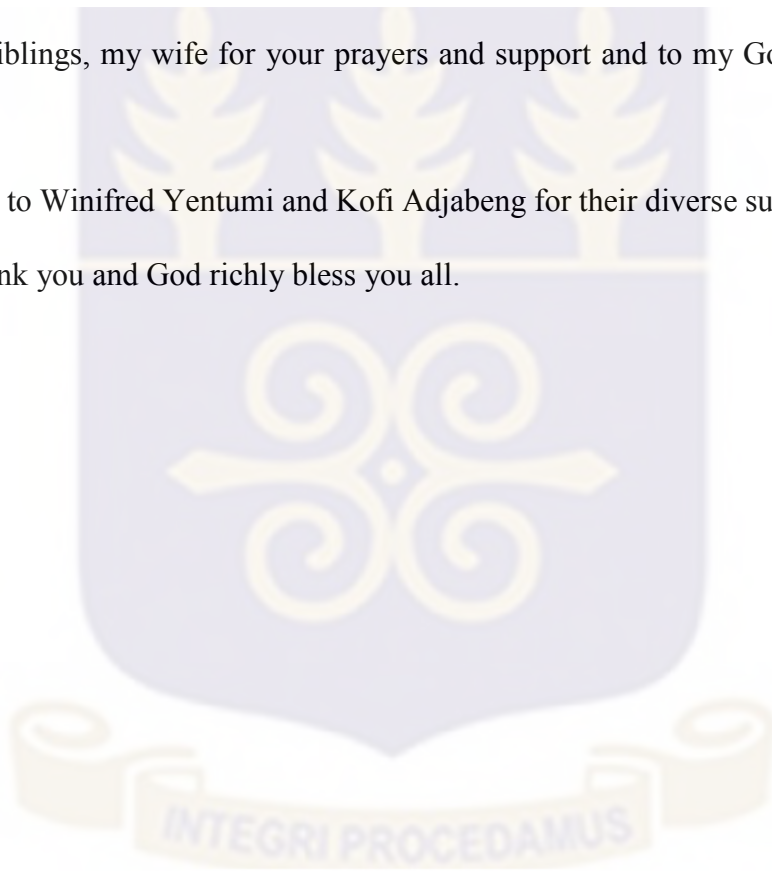
My sincere thanks goes to God Almighty for seeing me through this programme successfully.

I wish to express my heart felt gratitude to my academic supervisor Dr. Abubakar Manu for his immense guidance, support and encouragements throughout the research period.

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## ABSTRACT

**Background:** Parent-child communication regarding sexual and reproductive health has the potential to reduce adolescent sexual risk-taking behaviours; yet parents find it difficult to discuss sexual issues with their children. In particular, parents fail to communicate with their adolescent children on sensitive issues of sexuality, like sexual intercourse, condom use, puberty, STIs, and physical development, but rather do so on less sensitive ones such as the effects of HIV. Communication between parents and adolescents about reproductive health issues, however, is difficult for parents.

**Objective:** To determine the barriers to parent-adolescent communication on sexuality and reproductive health issues.

**Methods:** The study was a community based cross-sectional study. A simple random sampling was used to select 422 young people of age 10-19 together with their parents in communities near Ejisu. Data were analyzed using SATA 14. Odds ratios and their 95 percent confident interval were used to assess the strengths of association. In all statistical analysis, P value of 0.05 was used to determine the statistical significance.

**Conclusion:** The objectives of the studies were achieved by identifying the factors that had impacts on communication between parents and their adolescents, it was identified in this study that the major barriers inhibiting parent-adolescent communication on sexual and reproductive health matters include the, the religious and cultural beliefs of the parents, low level of education of the parents, age (younger age of child) and the lack of connectedness of adolescents to their parents.

### **Definition of Terms.**

**Sexuality:** Sexuality in this study refers to the broader context of adolescent reproductive health encompassing puberty, emotional maturity, gender roles and sexual health.

**Adolescence:** According to the World Health Organization, adolescence is the age bracket between 10-19 years. For purposes of this study, adolescents will refer to persons aged 10-19 years which also corresponds to the Ghana educational system age categorization from primary (elementary) school to senior secondary.

**Communication:** Communication in this study refers to the exchange and sharing of information, attitudes, and ideas among parents and their adolescent children regarding sexuality.

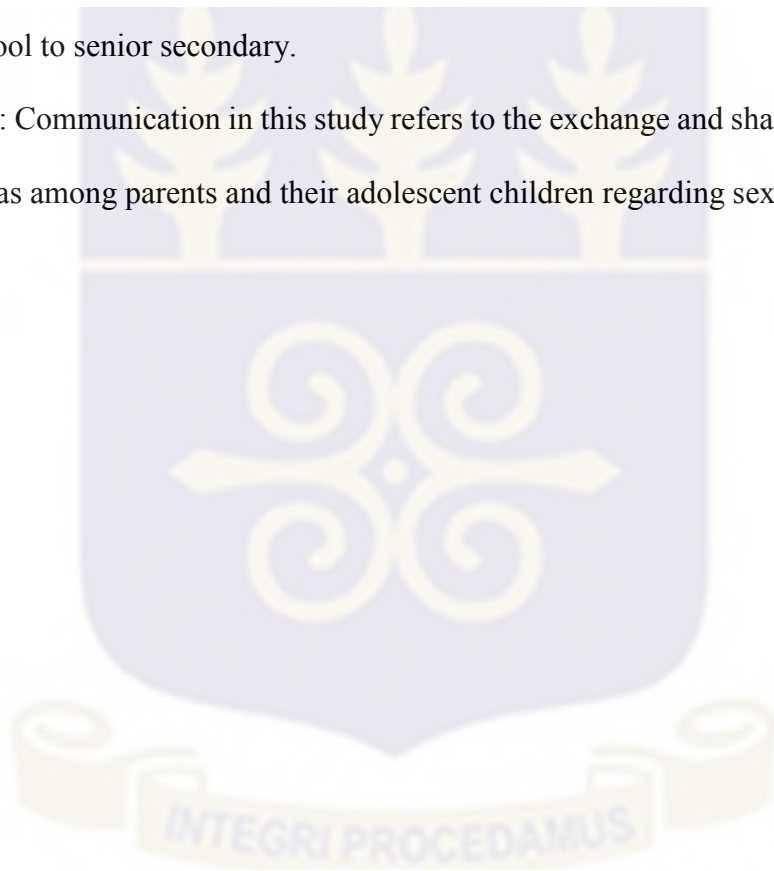


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## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background

Parent- child sexual communication is still a challenge in the world (Manu, Mba, Asare, Odoi-Agyarko, & Asante, 2015). Literature from the developed world has revealed that parent-child communication is protective against many sexual risky conducts (Manu et al). In spite of the possible benefits of parent-child communication, many parents across the globe are said to be uncomfortable discussing sexuality issues, especially with their children (Conklin, 2012). In sub-Saharan Africa generally, parent-child communications on sexuality are determined by socio-cultural factors (Jejeebhoy, Santhya, & Council, 2011).

Adolescence is an era of change from childhood to adulthood. It is when several biological, social, and emotional growth and changes are taking place. Sexual and reproductive growth and development are areas of the notable changes during this period. Parents are expected to engage their children on sexuality communication (Jejeebhoy, Santhya, & Council, 2011).The communication about sexual issues helps to transmit values, beliefs and expectations about sexuality issues to their adolescents. Evidence has shown that communication on sexuality safeguards the young from indulging in risky sexual practices and its associated adverse health consequences (Yohannes & Tsegaye, 2015).

Studies in Ghana have established that before the age of 15 years, 12 percent of girls and 9 percent of boys have had sexual intercourse and by the age of 18-19 years, 58 percent of girls and 37 percent of boys have had sexual intercourse (Ghana Demographic Health Survey, 2015).

Adolescent sexual and reproductive health issues are a test case to parents, teachers, healthcare providers and adolescents themselves (Baku, 2014). A study by Boamah, (2012), acknowledged that inadequate knowledge about sexual and reproductive health can be attributed to a number of social and cultural factors such as religious beliefs, individual factors and gender. While the value of sexuality education is acknowledged by some, it is also opposed in many societies in Ghana, particularly due to the believe that early exposure to knowledge about sexuality and reproductive health could do more harm to adolescents than help them to overcome problems they encounter while growing up. They believe it will rather make them try or go into sexual behaviours they had no knowledge of.

A study has demonstrated that adolescents are mostly influenced by their teachers and the media on their sexual and reproductive health issues, but rarely by their parents (Baku, 2014). Due to lack of effective parent adolescent communication many adolescents rely on friends for information about sexual and reproductive health issues that may also be inaccurate. Adolescents need the facts and correct information on their sexual and reproductive health to make informed decisions. Parents as the primary educators, or primary means of communication could be the key in decreasing adolescents' sexual-risk (Manu, Mba, Asare, & Odoi-agyarko, 2015). A study on Adolescents reproductive health education and its effects on in-school adolescents in the Ejisu Juaben Municipality of the Ashanti Region of Ghana showed that there was lack of communication between parents and their adolescent children on sexual reproductive health (Akakpo, 2008 ). The

study therefore recommended that parents should be empowered with the necessary skills to talk to their children about sexual and reproductive health issues. It is against this background that this study is being conducted to explore parent-adolescent communication including barriers and enablers to communication in order to gain better understanding that will help improve sexual and reproductive health of adolescents in Ejisu.

## **1.2. Statement of the Problem**

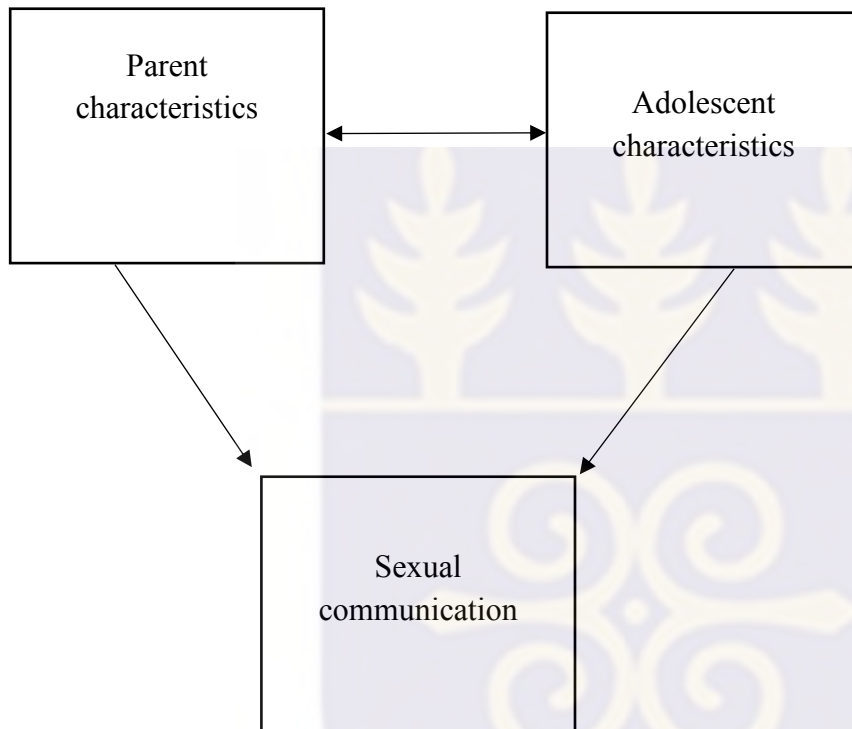
Poor knowledge on sex education has contributed to the increased unintended adolescent pregnancies, abortions and sexually transmitted infections including HIV/AIDS (Loftin, 2015). In the Ashanti Region of Ghana, 14, 139 teenage girls aged between 10 and 19 years became pregnant in 2008, while 2,280 attempted abortion and ended up at various health facilities with complications (Aklorbortu, 2008). Out of this number, 3540 representing 25 percent came from the Ejisu Juaben Municipality with Ejisu recording the highest within the municipality. Records from the “No Yawa Adolescent Reproductive Health Youth friendly Centre” at Ejisu over the past year show that over three thousand (3000) walk in clients made up of adolescents between 13 and 19 years of age visited the facility for different adolescent health services. Out of the total number, more than half the number came with unwanted pregnancies and had made failed attempts to abort before finally calling on them for help. The rest made enquiries on safe sex, contraceptive use, issues on puberty and menstruation and many other issues. This coupled with other adolescent risky sexual behaviours clearly shows that there is a huge gap in terms of parent-child communication on sexuality related issues in Ejisu and therefore the need for the study there to find out why it so. Lack of parental knowledge on sexuality and exactly what to say to their children makes it very difficult for parents to discuss sex issues with their children. (Manu,et al.,

2015). According to Svodziwa, Kurete, & Ndlovu, (2016), simply knowing what to discuss with the adolescents may not be sufficient, but parental openness, skill and level of comfort are factors that can facilitate the effectiveness of parent-child communication on sexuality and many parents living within the Ejisu municipality lack these qualities. Many young people from the ages of 10-24 years that form one-third of the Ghanaian populace are sexually active and are at high risk of adverse health effects due to insufficient sexual and reproductive health information (GSS, 2012).

Unsafe sexual conducts such as inconsistent condom use and sexual intercourse with numerous partners are comparatively common among adolescents and youth in the Ejisu Juaben municipality. This conduct tend to intensify the danger of unintended pregnancies and the infections of sexually transmitted diseases and particularly HIV/AIDS (Lin & Scott, 2012). The lack of adequate sex education has also added to the escalation in adolescent's undesirable pregnancies, abortions and STI's in Ghana with Ejisu Juaben municipality being one of the affected areas (Conklin, 2012). Traditional norms and unacceptability of dialogues on sexual and reproductive health associated matters have considerably contributed to a high level of undesirable pregnancies among adolescents (Jejeebhoy et al., 2011). The fear that dialogues on sexual and reproductive health matters will make adolescents go wayward, have also been reported by most parents. Uneasiness and other form of barriers that may impact parents in educating their adolescents about sexually related issues pre-supposes that adolescents may stand the risk of getting unintended pregnancies and STI's (Jejeebhoy et al., 2011). Other studies have been done on parent- adolescent communication on sexual and reproductive health in Ghana (Manu, 2011). Nevertheless, most of the researches focused primarily on restricted topics. This has created a theory gap and hence the need for additional research to fill the knowledge gap.

**Figure 1.2.1**

**Conceptual framework**



Parent-child sexual communication has been widely studied, mainly in the developed countries without an approved well-ordered framework for understanding how parents affect their children in a communication setting. Generally, communication among people can run in a way such that the message can come from any one of the parties (Jaccard et al., 2002); or in a straightforward way- from one party to another. This study ponders a communication practice in which parents takes the initiative to transfer information about sexuality issues to their children. The importance

of this nature of communication is to touch young people's knowledge, values, attitudes, objectives, thoughts and behaviour in general (Jaccard et al., 2002).

The framework presented above indicates a parent –child communication setting that includes some key components which interrelate in numerous ways to result in sexual communication. The components are: Parent/family characteristics (family structure, religion, family link up and family openness). (Parents age, sex, educational level, religious background, parents' level of sexual understanding and accessibility).

Adolescent characteristics (age, sex, educational level, religious background, place of residence.

Parent-child communication (procedure {easy and opened}, content, frequency and timing of communication

Sexual Communication.

For clarity or ease of understanding, this framework is restricted to a two-fold interaction between one parent and one child, where the parent is the (source of the information) and transfers a sexual message to the child (recipient) with the hope of enticing the child's sexual deciders such as knowledge, values, attitudes and behaviour.

A parent may on his /her own will, start sexual communication with his/her child based on the characteristics like age and sex. Such an individual mostly measures the benefits of talking to the child against the harm of not talking to the child about sex (Manu, 2011)

Parental sexual communication may also come up upon a hint of the adolescent's association in sexual activity or in response to a risky sexual activity involving the children and their peers in the vicinity. Such activities include an evidence of sexual initiation, pregnancy and abortion. This will

then afford parents the opportunity to dialogue with their children about vital issues including sexuality (Guilarmo-Ramos et al., 2006).

Finally, adolescents' sexual behaviour possibly will rise from the child's own uniqueness. (Huang et al., 2010). The uniqueness of the child can have a straight forward and divided influence on the child's attitude and sexual behaviour. This may notably be strengthened by peer pressure and sexual information young people receive from sources such as friends, teachers and other family members etc. These reasons disturb adolescent sexual orientation and thus affect their overall sexual behaviour.

#### **1.4 Justification and Significance of Study**

Reinforcing sexual and reproductive health among parents and adolescents is essential. This will go a long way to help prevent unwanted pregnancies and sexually transmitted infections among adolescents. The outcomes of the study will add up to the information base urgently needed to forge an approach to refining dialogues on sexuality between parents and their adolescent children. It will also help to pinpoint other likely research areas for further studies related to parent-adolescent sexual communication in the study area. This research was needed to provide ample data and information on the barriers that impacts the decision of parents or their unwillingness to discuss issues related to sexual reproductive and health to their adolescents. These will provide some extra guidelines regarding the need for parents to continuously monitor their children and to create awareness and services that will considerably improve their reproductive health.

## 1.5 Objectives

### 1.5.1 General objective

To determine the barriers to parent-adolescent communication on sexuality and reproductive health issues in Ejisu in the Ejisu Juaben municipality.

### 1.5.2 Specific Objectives

- To identify the adolescent factors that influence parents to communicate with their children
- To identify the parents factors that influence parents to communicate with their children on sexuality issues.
- To examine parents knowledge about adolescent sexual and reproductive health matters.

### 1.5.3. Research questions

To be able to address the objectives of the study, the following questions were posed:

- What are parents' factors that limit communication between parents and their adolescents?
- What are the adolescent factors that limit communication between parents and their adolescents on sexual and reproductive health matters?
- What kind of sexual topics are parents likely to discuss with their children in sexual communication engagements
- What proportion of parents engaged in sexuality communication over the past twelve months?

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 Introduction

Parent-adolescent communication on sexuality issues in several African cultures is forbidden or not acceptable, allowing only ceremonial rites or making the young ones to discuss the subject with suitable people such as paternal aunts and uncles (Sedge et al., 2007; Baku, 2014). Nevertheless, these accustomed ways of communicating sexual matters between groups have been destroyed due to lifestyle modifications in many countries (Aninanya et al., 2015).

Further Studies by (Wang, 2009) recommended that female youths be educated by aunts according to tradition about how to perform sexually in marriage, but aunts no more do that. A study carried out in Kenya indicated that it is rare for discussions on sexuality matters to take place among most cultures (Conklin, 2012).

The situation is even more challenging at the family level but at the same time, parents are obliged to provide this information to their children. A study conducted in Tanzania found that parents do agree to the idea of passing on sexuality knowledge to their young ones (Nundwe, 2012). Another study in Ghana found that, 82.3 percent of mothers surveyed testified to have been talking to their daughters about sexuality but was restricted to a small number of topics. The study of Manu, et al., (2015) showed that mothers are more likely to involve in conversations about sex and birth control mechanisms with their children than fathers. Adu-gyamfi, (2014) ascribed these gender differences to the fact that mothers are relatively closer and generally better at communicating because they are agents of affection and can also handle these sexual stuffs more securely than fathers. However, Conklin (2012) pointed out that even though dialogues of that sort were

commonly introduced at the puberty stage where menstruation had even started, some mothers still felt reluctant to talk to their daughters.

## **2.2 Information Communicated Between Parents and Adolescents**

A study in Uganda discovered that, communication on sexuality issues are mostly vague at the family level anytime it takes place (Bastien, Kajula, & Muhwezi, 2011). For example, statements such as ‘do not play with boys’ are given by mothers cautioning their teenage girls on sexuality. Messages like that are given without clarity leaving the recipient to conjecture. A study in Ghana showed that more mothers reported to have communicated with their daughters more often than what their daughters also reported (Manu et al., 2015). This was attributed to the ambiguity of the messages, which the daughters didn’t consider to be sex education. This indicates that one needs to appreciate not only how adolescents interpret sexuality but also how they understand sex education in general.

Factors that influence parent-adolescent communication on sexuality, according to Wamoyi, Fenwick, Urassa, Zaba, and Stones, (2010), are that more sex topics are discussed only when mothers (parents) are transparent and interested in dialogues about sex with their adolescents. However, the procedure might be adversely influenced by fear especially in the African setting where discussions on sex are perceived as forbidden. A study in Uganda also revealed that young people fear their parents would interpret as actual evidence of sexual involvement if they come up with sexual topics for discussion (Population Reference Bureau, 2014). On the contrary, parents also feared that if they talked about sex their children may indulge in and experiment it.

Studies have shown that the quality of parent-child relationships, parenting style in general and communication about sex and sexuality appear to be strong determinants of adolescent sexual

behaviour (Seif & Kohi, 2014). Evans, Davis, Umanzor, Patel, and Khan (2011) reckon that parents are in a unique position to help socialize adolescents into healthy sexual adults by providing exact information about sex and by nurturing accountable sexual decision-making skills. Parents can shape the presentation of information to be in consonance with their own values and applicable to the life situations (social and familial context) of the adolescent. This is buttressed by clarifications made that when parents approach their role as sex educators in positive, affirmative ways, young people are better able to make healthy sexual choices and to build affectionate relationships (Seif & Kohi, 2014). Conversely, the customary passages of sex education, traditional practices and social norms that have been hailed for molding adolescent sexual comportment are fading due to changing lifestyles (Aninanya et al., 2015). Considering the susceptibility of the youths particularly to HIV infection, and the role of communication in encouraging healthy behaviour, there is a need to understand the factors and procedures that restrain and/or enhance communication and discussions on sexuality among young people and their parents in a developing world context. It is based on this idea that this small scale study tried to know the procedure, perceptions and opinions of a sample of both parents and their adolescent children in the Ejisu municipality regarding sexuality.

### **2.3 Barriers to Parent-Child Communication on Sexuality.**

Studies in 2011 and 2012 in India and Tanzania respectively examined the full picture why daughters don't get 'meaningful' sex education from their mothers who are educated. These studies identified a number of socio-cultural and religious obstacles to communication on sex issues. Specifically, reasons that obstruct a clear form of communication are discussed, comprising: 1) traditional obstructions, 2) embarrassments due to modern Christianity or religion, 3) dependence on school teachers and books for sex education. Most of the mothers surveyed in

the study disclosed that they were shy in providing sex education to their own daughters due to traditional barriers. They went further to say that they themselves never received any form of sex education from their parents therefore felt uncomfortable and tend to evade communication on sexuality (Nundwe, 2012).

In a research by Bogale and Seme (2014), the findings showed that 38 percent of parents were of the view that discussions about sexuality with their children will inspire them to experiment sex. The study's hypothesized that the attitudes of parents in this respect would impact communication was not accepted. Other studies have accepted the view or idea that educating children on sex will lead them to premature sexual initiation. Additionally, 61 percent of parents of children of age 10-12 years old in Kenya assumed that educating them on sex at that age was rather early and not appropriate. These outcomes focus on a variety of obstacles supposed by both parents and young people to discussions on sex and its associated topics.

Focus group data from Ghana by Awusabo-asare, Biddlecom, Kumi-Kyereme, & Patterson, (2006) showed that young people choose or are unwilling to talk about sex issues with their parents. They rather tend to prefer discussing such topics with their friends rather than their parents, because of shyness and also for fear that they may be penalized for talking about it. This notion of corporal punishment or blame existed and tends to discourage adolescents on discussions with parents on sex and initiation of sex.

#### **2.4 Gender Differences in Parent-Adolescent Communication.**

Major differences exist between sexes in the form of reproductive health communication. A study by (Manu et al.,2015) found that both male and female adolescents were more likely to choose to discuss sexual topics with their mothers than their fathers. The study further stated that the sex of

the adolescent also affects the sex of the parent as well with whom dialogues are held. That is, fathers are most likely to dialogue with their sons and least with their daughters while mothers would also choose to dialogue most with their daughters than with their sons. Wang (2009), also established that, daughters were not likely to receive sex education from their mothers because their mothers felt uncomfortable to discuss it with them. The study reiterated that even though these differences in sex exist in parent-child communication, both parents could impact adolescents' sexual adventurous conducts. Also adolescents tend to discuss different topics with their parents. Discussions involving male adolescents with both parents were fairly constant on STD's, HIV/AIDS and condom use were commonly discussed. Females mostly discussed sexual intercourse with friends, menarche with their mothers and sexual self-restraint with their fathers.

### **2.5 Nature of Families and Parent-Adolescent Communication.**

The setting of a family tends to aid in having smooth dialogues on sexuality issues. Lin and Scott (2012) revealed that young people who live with their grandparent(s) had less dialogues on sexuality issues, where as those who don't live with their grandparent(s) had more dialogues on sexuality issues. Additionally, those who had siblings and lived with them had a greater level of sincerity of their communication with their parents; whereas for those who did not live with siblings, the opposite was true. Joh, Kim, Park, (2013) researched into the association between parent- adolescent communication and the Circumplex Model of Marital and Family Structures. Their exploration of the Parent-Adolescent Communication Scale data discovered significant generational differences. As a group, mothers reported having had enhanced dialogues with their children than fathers did. Adolescents expressed having challenges interacting with both parents. At the collective level, the opinions were generally mixed among parents and adolescents which specifies a lack of communication challenges. The results showed no sex variations among males

and female adolescents in terms of how they supposed their communication with their parents, or how parents of either sex, perceived their interaction with either a male or a female adolescent.

## **2.6 Frequency and content of discussion.**

Majority of parents don't chat with their children until they realize that they have taken some incorrect sexually linked decisions. By this time they have possibly been involved in sexual activity already, dialogues with them then becomes unproductive. The child was not cultured or encouraged to talk about sex and its related issues from the very basis, the adolescent will tend to feel uncomfortable discussing it at this point in time. Consequently, the adolescent might tell the parents the truth or will perhaps tell them anything to please them in order to avoid being in an uncomfortable state. The parents might also not be comfortable communicating on the topic with their child and will tend to be in a state of discomfort introducing this topic (Desalegn Gebre Yesus<sup>1</sup>, 2010). Parents and their children are mostly not comfortable when chatting on subjects related to sex as it seems to be associated to adolescents with very good sexual conduct (Burges et al., 2005). Even with the backing for more dialogues on sex between parents and their children, most of them still don't feel comfortable approaching the topic. Results from scholarly work that dealt with the frequency and content of discussions established that adolescents mostly favor dialogues with parent of the same sex on sex related issues.

Another study on in-and out-of-school female adolescents, found that mothers were the primary choice by both groups, with 44 percent and 37 percent of females reporting mothers as the desired partner for sex dialogues, respectively. From the views of parents, a study of Nigerian parents found that, they also desired same sex discussions with their children (Izugbara, Egesa, & Okelo, 2015). A study in Nigeria by (Berg et al., 2012) reported that, 98 percent of respondents had

discussions about condom use with a 'family member'. This study further established that 34 percent of respondents testified discussing premarital sex with a relative. The research further stated that the person who frequently did that was the mother (44 percent) as compared to the father of (29 percent), but did not make clear which person or relative was involved in each discussion examined.

One more study by Awusabo-Asare et al., (2006) established that 33 percent of females and 16 percent of male adolescents reported having conversations with the mothers on sex-related matters while 13 percent of females and 12 percent of males reported having conversations with their fathers. A research in Ghana by Boamah (2012) evaluated whether communication about avoiding or postponing sex took place or not and found that dialogues on these topics was small. Other studies in Burkina Faso, Ghana, Malawi and Uganda established that the percentage of teenagers reporting to have conversed on sex-related issues and contraceptives was very low with only 10 percent reporting such discussions (except teenage girls in Uganda) (Biddlecom, Awusabo-Asare, & Bankole, 2009). Lastly, a cross-sectional study from Nigeria came out that 30 percent of teenagers reported looking for sex information from their parents. The research also established that there was an important association between sexual involvement and the source of information. For instance a high percentage of teenagers (55 percent) who got sexuality information from friends had sexual experience more than the 34 percent of those who pursued for information from their parents(Ajayi & Ajuwon, 2015).

## **2.7 Triggers for parent-child sexuality communication**

A review of studies on parent- adolescence communication focusing on the factors that trigger discussions about HIV/AIDS showed that parents regularly used examples of relatives and friends

who died of AIDS to start a conversation and to restate the severity of the disease. Other forms of triggers for conversation stated by parents in this research includes radio programs, flyers, parental opinions of risky sexual behaviour, or someone they assumed was HIV positive, for instance due to thinness (Bastien et al., 2011).

## **2.8 Knowledge on Sexual and Reproductive Health, Sources of Information and Desired Sources of Information.**

In Ghana, premarital sex is not socially accepted. The religious views and socialization structures in Ghana have made it very challenging for adolescents to have discussions on sexually related issues particularly with adults because it is regarded as a preserve of only married adults (Biddlecom et al., 2009; Bogale & Seme, 2014). Most parents have the notion that when children are educated on sexual and reproductive health issues their desire to have sex is intensified (Awusabo-Asare et al., 2006; Jejeebhoy et al., 2011) but there is no scientific proof for this belief. According to the results of a cross sectional study on sexual behaviours and contraceptive usage in Kintampo in the Brong Ahafo Region of Ghana, awareness on pregnancy related issues was not encouraging. As many as 59 percent of males and 66.2 percent of females in that study answered that they will not get pregnant during their first sexual intercourse (Boamah, 2012).

Another study by (Biddlecom et al., 2009) established similar statistics from the outcome of their study which disclosed that only 53 percent and 60 percent of males and females respectively knew that a girl can become pregnant at her first sexual intercourse. They also found out that 56 percent of teenagers didn't know that a female can get pregnant if she had an unprotected sex and washed

herself afterwards. Studies by (Dangat & Njau, 2013) also established that although most adolescents know about “safe period” in the life of a woman, they didn’t know precisely what it meant. Knowledge is thus a very essential factor in decision making. It gives the holder enough possibility to survey the positives and negatives or advantages and disadvantages of a given preference and hence places the individual in an enhanced position to take an informed decision.

### **2.8.1 Sexual behaviour of adolescents.**

In a study by Ganle, Obeng, Yeboah, Tagoe-darko, & Charlotte (2016), virtually all the 95.2 percent of adolescents interviewed who agreed that they were in relationships also agreed that they had had sexual intercourse either once or more. But among all teenagers, only 24.6 percent of the males and 55.4 percent of the females had had sex.

Another study by Biddlecom et al. (2009) among four African countries -- Ghana, Burkina Faso, Malawi and Uganda -- showed that 37 percent females and 60 percent males among teenagers interviewed from Malawi had had sex. Forty-eight percent (48 percent) females and 49 percent males from Uganda had also had sex. The difference is high in percentage between the outcome of this study and what Ganle et al (2016) found. This might be so because it involved samples of both adolescents who have been to school and those who have not. The sample for the study did not adequately provide for that. Likewise with the research from the other African countries, the people were much younger (12-19). In most cases, the proportion of females who have had sex is mostly higher than males. This might be ascribed to the fact that girls typically get into sexual affairs much earlier and also tend to have boyfriends or partners who are older than them, while some of them also get raped. Although some boys are also raped, it is the females who are mostly the victims especially at this stage. It then means that, more young females than males are exposed to all the harmful consequences of unsafe sex.

### **2.8.2 Adolescent's perceptions and sexual activity.**

Adolescents' views about sex and when it must occur can impact their sexual behaviour. They perceive that a relationship cannot be called so if it is without sex. Adolescents who decide not to have sex are seen as timid, primitive and out of fashion (Asonye, 2014; Bastien et al., 2011; Moitra & Mukherjee, 2012).

### **2.8.3 Factors associated with sexuality communication.**

A different research found out that, adolescents living in rural areas testified that they had regular communication about HIV/AIDS with both parents than those in the urban areas. Additionally, being educated and being in an upper socioeconomic status were established to be linked with regular dialogues with parents ((Mmbaga et al., 2012). A multi-site research done in South Africa and Tanzania showed that higher socio-economic status was in the same way found to be considerably related with regular dialogues with parents in both of the South African sites, but not in Tanzania (Mmbaga et al., 2012).

In summary, sex education is supposed to be treated with importance and must be engaged by all and sundry especially parents and their adolescents. But rather, the very opposite of this situation is what is seen between parents and their children.

The literature reviewed from the various research studies sought to identify and close the gap pertaining to communication on sexuality between the older generation (parents, teachers, heads

of institution, religious leaders, etc) and the younger generation (children and adolescents), yet no substantial amount of progress has been made in closing the gap.

In view of this, this study seeks to identify the barriers responsible for the inactive or restrictive dissemination of information from parents to their adolescents on sexuality and sexual matters and also come up with recommendations to help bridge the gap.



## CHAPTER THREE

### 3.0 METHODOLOGY

#### 3.1 Introduction

Based on the review of literature and the objectives of the study, the chapter discusses the various procedures and methods that were employed in the study. It looks at the study design, study population, study location, sampling technique and procedure, data collection and analysis and ethical issues.

##### 3.1.1 Study design

This study adopted the descriptive cross-sectional design. It was also quantitative in nature and this influenced the way the research tools were developed and data collected to respond to the research questions.

##### 3.1.2 Study population

The population for this study consisted of parents and their adolescent children aged between 10 and 19 years.

#### 3.2.0 Study Location

3.2.1 The study was conducted in the Ejisu- Juaben Municipal area as shown in the figure.

The Ejisu-Juaben Municipality lies within Latitudes  $1^{\circ} 15' N$  and  $1^{\circ} 45' N$  and Longitude  $6^{\circ} 15' W$  and  $7^{\circ} 00' W$ , occupying a land area of 582.5 km<sup>2</sup>. The capital is Ejisu and can be found in the central part of the Ashanti Region. It shares boundaries with the Sekyere East and Afigya Kwabre to the Northeast and North-West respectively; the Bosomtwi and Asante Akim South Districts to the South; the Asante Akim North to the East and the Kumasi Metropolis to the West.

### DISTRICT MAP OF EJISU / JUABEN



According to the 2010 Population and Housing Census, the total population of the area was 143,762 representing 3.0 percent of the region's total population. Out of that, 68,648 (47.8 percent) were males while 75,114 (52.2 percent) were females. The population is predominantly rural accounting for 72.5 percent of the total population. The Municipality has a sex ratio of 91.4 and it falls below the regional average of 94. A total of 50.7 percent of the populace are youth depicting a broad base population pyramid which tapers off with a small number of elderly persons of (5.1 percent) (Ghana Statistical Service, 2014).

### **3.2.1 Inclusion criteria**

A parent was eligible if he/she had an adolescent between the ages of 10 to 19 years and accepted to be interviewed. Parents and adolescents must also be residing within Ejisu. The criteria for inclusion in the study was that participants and their parents preferably should be living in the same household. Both the adolescents and their parents should to be willing to participate in the study. The preference for matching parents and their adolescents was to gain insight into shared meanings and contrasting perspectives within the same family and across families who participated in the study.

### **3.2.2 Exclusion criteria**

An adolescent was excluded from the study if the parent refused to give consent to participate in the study. Parents and adolescents living outside the selected study area were also excluded from the study.

### 3.2.3 Sample size determination

The sample size was calculated using a single population proportion formula provided by Cochran (1977):  $n = z^2p(1-p)/d^2$ ;

Where  $n$ = desired sample size

$z$ = standard normal deviate at 95% confidence level usually set at 1.96

$p$ = the estimated proportion of adolescents aged 10 to 19 years.

As a rule of thumb, 50% (0.5) assumption was used since the estimated proportion was unknown,

$d$ =degree of precision, 0.05 probability level

The 10% non-response was adopted to ensure that the sample size determined provided the required level of accuracy in the occurrence of no-response or withdrawal of participants. Using the formula above a total sample size of 422 participants was used for the study comprising of 211 parents and 211 adolescents as well. An adolescent who fell within the age category together with the parent qualified to take part in each household survey. Both closed and open-ended questions were used to collect the data.

### 3.2.4 Sampling Technique

Adolescents were the key respondents; and were used as leads for choosing parents. After determining a random starting point, simple random sampling technique was used to select young

people aged 10–19 years together with their parents. In each house, only one household, that is, parent–child pair was suitable for the interview. Consequently, all carefully chosen single-household houses with eligible adolescents were automatically eligible for the interview. However, in compound houses where there were multiple households, one household was randomly selected for the interview.

### **3.3 Selection of Mothers and Fathers**

Both mothers and fathers were involved in the study but in each household, only one of them was interviewed. In general, the sex of parents was selected consecutively from one household to the other regardless of the sex of the child. In addition, in houses with multiple households, one was randomly selected. Also, in instances where there were more than one parent and child pair, one (1) eligible pair was randomly selected using the ballot approach. Any parent and child who picks a ballot with the label “Y” was interviewed while those who picked “N” were exempted. Nevertheless, in situations where I met only one parent and child pair, they were automatically interviewed.

### **3.4. Sampling procedure**

The study was done in the Ejisu town and communities nearby. Since Ejisu is the district capital, the study was limited to nearby communities. Ejisu has 29 communities and 10 of the communities that are not more than 5 km away including Tikrom, Atia, Akyawkrom, Ejisu Zongo, Krapa, Fumesua, Adako Jachie, Besease, Asotwi and Adadientem were selected with each of them used as a cluster. From each cluster, (42) respondents were selected except Fumesua where (44) respondents were selected in order to get the required sample size for the study. In houses with

more than one qualified participant, a simple random sampling was used to select one of them. Also an adjacent house with a qualified participant was used to replace houses without qualified participants or with a participant who declines participation in the study. In the households, questionnaires were administered to both parent and adolescents to seek their views on sexual and reproductive health issues.

### **3.4.2 Data collection technique and tools**

Structured questionnaires were done in both closed and open ended format. The knowledge of parents about adolescent sexual and reproductive health matters was scored and their frequencies determined. The cumulative scores were converted into percentages and original Bloom's cut off points was used to categorize level of knowledge as follows: 80 - 100% interpreted as Good Knowledge; 60-79% as Moderate Knowledge and <60% as Poor Knowledge. Responses to attitude questions were scored as agree (score 0), uncertain (score 1) and disagree (score 2). Total scores were converted into percentages and classified as lower attitude (<50%) or higher attitude ( $\geq 50\%$ ). The questionnaires were pretested with 25 parents and adolescents each from a community that was not selected for the study before actual data collection was done. To obtain the quantitative data from the selected participants, the researcher then administered the questionnaire to them one at a time, face to face and in their preferred language. This happened only after the participants had given their consent to participate in the survey. The questionnaire was used to seek relevant information to address the specific objectives of the study.

### 3.5 Variable

#### 3.5.1 Outcome variable

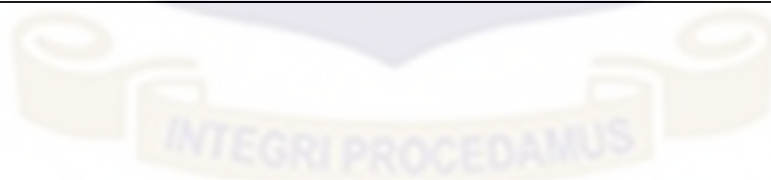
The outcome variable was parent-adolescent communication. From literature (Manu et. al, 2015) Parents are more likely to discuss topics on abstinence more than any other topic. Therefore, communication on abstinence was used as a proxy to represent sexuality communication between parents and adolescents. This was measured directly with a Yes/No response. The adolescents perspectives of responses were used because they are at the receiving end and can also give much reliable information for the study.

#### 3.5.2 Independent variables

##### Independent variables

**Table 3.5.3: Independent Variables**

<b>Adolescent factors</b>	<b>Parent factors</b>
-Age	-Religion
-Education	-Education
- Sex	-Age
-Closeness to parent	-Knowledge on sexuality



**Table 3.5.4a: Operational Definitions of the Adolescent’s factors**

Variable	Operational Definition	Scale of Measurement	Source of data
Age	Adolescent’s age at last birthday	Continuous-discrete (years)	Interview
Sex	Sex of Adolescent	Binary Male Female	Interview
Educational level	Adolescent’s Highest formal education attained	Ordinal None Primary Secondary/Vocational Tertiary	Interview
Closeness to parent	Adolescent’s closeness to parent	Binary Yes No	Interview
Abstinence	Communication on abstinence	Binary Yes No	Interview

**Table 3.5.4.b: Operational Definitions of the Parent’s factors**

Variable	Operational Definition	Scale of Measurement	Source of data
Age	Parent’s age at last birthday	Continuous-discrete (years)	Interview
Sex	Sex of Parent	Binary Male Female	Interview
Educational level	Parent’s Highest formal education attained	Ordinal None Primary Secondary/Vocational Tertiary	Interview
Religion	Parents Religion	Nominal Catholic Anglican Methodist Pentecost/Charismatic Other Christians Moslem Traditional	Interview

### **3.6 Data processing and Analysis**

Raw data collected was entered into Microsoft Office Excel spreadsheet (2010) and finally exported onto STATA software version 14 for statistical analysis. Descriptive statistics such as means  $\pm$  SD, cross-tabulations, tables, frequency and percentages were used to describe demographic characteristics of the study population. The Chi-square test statistics was used to determine association between demographic characteristics and knowledge and attitude of parents on adolescent's reproductive health. Binary logistic regression was used to determine the relationship between descriptive variables (parent adolescent sexual communication) and outcome (Abstinence). Variables with significant association in the bivariate analysis were entered into multivariate logistic regression analysis to define the independent associated factors of adolescent parent communication on sexual and reproductive health. Odds ratios (OR) and their 95% confidence interval (CI) were used to assess the strengths of association. In all statistical analysis, the p value of 0.05 was used to determine statistical significance.

#### **3.5.4 Pretesting**

Pretesting of the questionnaire was carried in Kwamo near Ejisu and errors detected in the questionnaires rectified before actual data collection. Data was not collected in the area where the pretest was done.

### **3.6. Quality control mechanisms**

Accurate quality guarantee measures and protections were built into the study to assure the validity of the data. The researcher selected research assistants that have public health background and gave them adequate training. The content of the training involved; the purpose and objectives of

the study, data collection techniques, community entry guidelines, translation of questionnaires into various local languages, data collection ethical guidelines. The principal researcher was part of the team during the interviews to ensure that information collected was in line with the objectives of the study. The questionnaires were checked for errors and completeness before final entry into the appropriate software for statistical analysis. Errors detected were discussed with the respective assistants and asked to go back and make the necessary corrections.

### **3.7. Ethical considerations**

- Ethical approval was got from the Ghana Health Service's Institutional Review Board.
- Consent was sought from all the study participants. Potential study participants were made to understand that participation in the study was entirely voluntary. Their decision not to enter the study, failure to answer any question or termination of the interview was respected and duly considered by the principal investigator.
- Permission was sought from the Ejisu Juaben Municipal Assembly and the Municipal Health Directorate.

Confidentiality and anonymity were taken into consideration. To provide further protection to participants, there were no identifiers linked to the information provided during the study. All information was not linked in any way to respondents. Additionally, confidentiality and obscurity was improved by substituting names and other information with encoded identifiers, with the encoded key kept in a different safe place. Ultimately, people who comprised of the research group were fully trained on the procedures to protect the data so that access to it is limited. Data was collected in the quietest corner of participant's house or a serene place where was no noise or disturbance.

**Possible Risk and Discomforts**

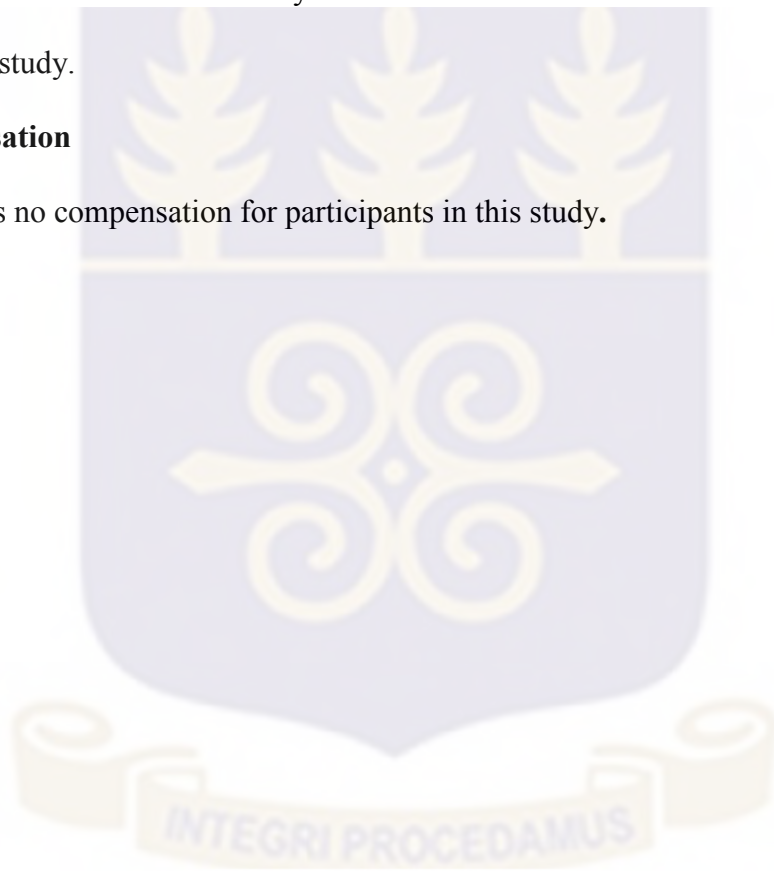
- There was no possible risk associated with this study but we anticipated some discomfort during the interview process given the sensitive nature of some of the questions.

**Possible Benefits**

- There was no direct benefit to the participants of this study. However, the information provided might contribute to the overall knowledge on the factors associated with parent-child communication on sexuality and adolescent sexual behaviour that will be generated from this study.

**Compensation**

- There was no compensation for participants in this study.



## CHAPTER FOUR

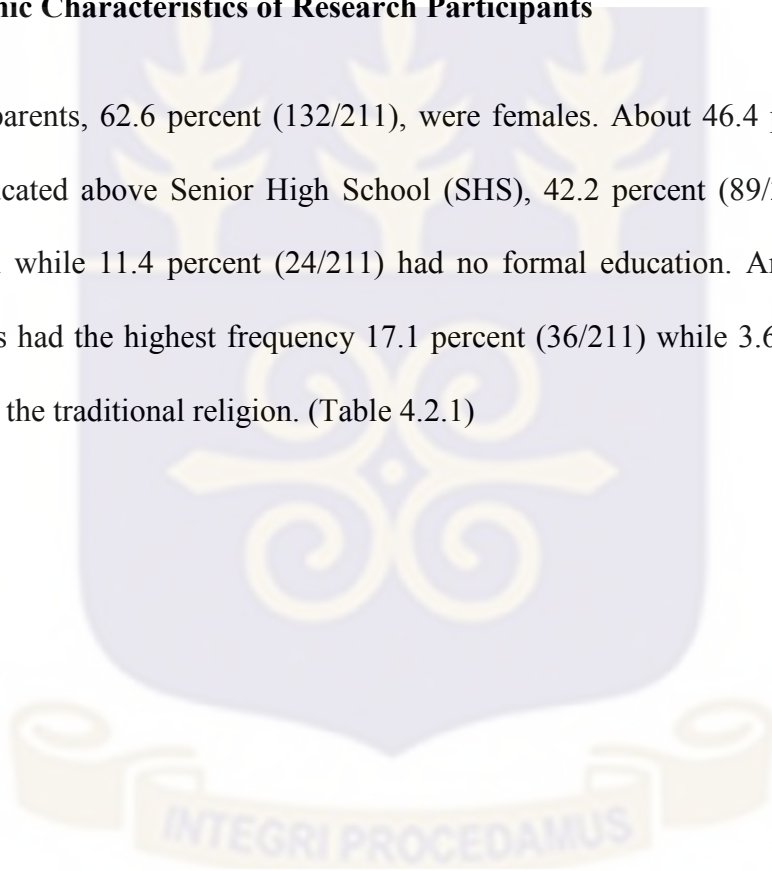
### 4.0 RESULTS

#### 4.1 Introduction

The chapter talks about the results and analysis of the study. It looks at the socio demographic characteristics of the respondents, frequencies, bivariate, multivariate of the factors studied on

#### 4.2.0 Demographic Characteristics of Research Participants

Majority of the parents, 62.6 percent (132/211), were females. About 46.4 percent (98/211) of parents were educated above Senior High School (SHS), 42.2 percent (89/211) had education below SHS level while 11.4 percent (24/211) had no formal education. Among the Christian parents, Catholics had the highest frequency 17.1 percent (36/211) while 3.6 percent (8/211) of them belonged to the traditional religion. (Table 4.2.1)



**Table 4.2.1: Parents' characteristics**

Characteristic	Frequency	%
<b>Sex</b>		
Male	79	37.4
Female	132	62.6
<b>Educational status</b>		
No Formal education	24	11.4
< SHS	89	42.2
≥ SHS	98	46.4
<b>Religion</b>		
Catholic	36	17.1
Anglican	25	11.8
Presbyterian	25	11.8
Methodist	32	15.2
Pentecost/Charismatic	32	15.2
Other Christian	15	7.1
Moslem	38	18.0
Traditional	8	3.6

Majority of the adolescents 82% (173/211) were between the ages of 15-19 years (late adolescents). About 57.3% (121/211) of caregivers were females, 40% (84/211) had SHS education while 3.3% (7/211) had no formal education (Table 4.2.1).

**Table 4.2.2 Frequency table for sexuality topics**

Topic	Parent (%)	Adolescent (%)
Abstinence	146 (69.52)	111 (52.6)
Condom use	35(16.58)	41 (19.43)
Other contraceptive use	12(5.68)	15(7.1)
Allow to engage in pre-marital sex	0(0)	8(3.79)
Engaged in pre-marital sex	13 (6.16)	89(42.1)
Been Pregnant or made someone pregnant	14(6.66)	42(19.90)

Six sexual topics were used to measure abstinence. From the table, 146 parents (69.2) reported to have given education on sexuality focusing on abstinence while 111(52.6) of adolescents also reported receiving education from their parents on abstinence. 35(16.58) responded that they would allow their children to use condoms if found to be sexually active while 41(19.43) reported to have being educated by parents to use condoms if they could not abstain. 12 (5.68) of parents responded that they will not allow their children to use other forms of contraceptives if found to be sexually active while 15(7.1) of the children also responded that indeed their parents will not allow them to engage in pre-marital sex. However, 0(0) no parent responded to want to allow the child to engage in pre-marital sex while 8 (3.79) adolescents responded that their parents will allow them to engage in pre -marital sex. Finally, 14(6.66) of adolescents stated that their children

have been pregnant or impregnated someone while 42 (19.90) adolescents also responded to have been pregnant or made someone pregnant.

**Table 4.2.3: Adolescent demographic characteristics**

Characteristic	Frequency	%
<b>Age</b>		
10-14	38	18
15-19	173	82
<b>Sex</b>		
Male	90	42.7
Female	121	57.3
<b>Education</b>		
No education	7	3.3
Primary	47	22.2
JHS	40	18.9
SHS	84	40.0
Tertiary	33	15.6

### **4.3 Bivariate analysis of Sexuality Communication and Parent and Adolescent characteristics.**

The adolescent factors that were found to be significantly associated with adolescent parents' sexuality communication were: Sex ( $p=0.013$ ), Age ( $p=0.001$ ) and closeness to the parents ( $p<0.001$ ). The results of the bivariate analysis showed that 44.6 % (29/65) adolescents who were males received communication on sexuality while 63.0% (92/146) adolescents who were females received communication on sexuality. Adolescents who were males had 0.47 times odds of receiving sexuality communication than females (cOR=0.47, 95% CI 0.25-0.89)

The results also showed that 69.2% (45/65) adolescents who were between 10-14 years (early adolescents) received communication on sexuality while 87.7% (128/146) adolescents who were 15-19 years (late adolescents) received communication on sexuality. The early adolescents (10-14 years) had 68% times less of receiving sexuality communication compared to those in the late adolescents' stage (15-19 years) (cOR=0.32, 95% CI 0.14-0.69) (Table: 4.3.1).

With regards to closeness or connectedness of adolescents to their parents, the results showed that 40% (26/65) adolescents who reported not to be close to their parents received communication on sexuality while 66.4% (97/146) adolescents who reported to be close to their parents received communication on sexuality.

Adolescents who were not close to their parents had 66% times less of receiving sexuality communication compared to those who were close to their parents (cOR=0.34, 95% CI 0.18-0.64).

**Table 4.3.1: Bivariate analysis of Sexuality Communication and Adolescent characteristics.**

	Abstinence talk		COR	P value
	Yes	No		
<b>Sex</b>				<b>0.013</b>
Male	29 (44.6)	36 (55.4)	<b>0.47 (0.25-0.89)</b>	
Female	92 (63.0)	54 (37.0)	1.0	
<b>Age</b>				<b>0.001</b>
10-14	45 (69.2)	20 (30.8)	0.32(0.144-0.695)	
15-19	128 (87.7)	18 (12.3)	1.0	
<b>Close to parents</b>				<b>0.001</b>
No	26(40.0)	39 (60.0)	0.34 (0.18-0.64)	
Yes	97 (66.4)	49 (33.6)	1.0	
<b>Education</b>				<b>0.719</b>
SHS	47 (72.3)	18 (27.7)	1.13 (0.56-2.30)	
SHS	102 (69.9)	44 (30.1)	1.0	

**4.4 Bivariate analysis of Sexuality Communication and Adolescent characteristics.**

The only significant parent factors at bivariate level ( $p=0.007$ ) (Table 4.4.1) were religion ( $p=0.007$ ) and parents education. The results also showed that 83.9 % (52/65) parents who were Muslims communicated to their children on sexuality while 95.1% (136/143) Christian parents communicated to their children on sexuality. Parents who were Muslims had 74% times less of

giving sexuality communication to their children than those who were Christians (COR=0.26, 95% CI 0.08-0.83).

Further, the results showed that 56.9 % (37/65) parents who were less than 40 years communicated to their children on sexuality while 59.6% (87/146) parents who were 40 years and above communicated to their children on sexuality (Table: 4). Parents who were less than 40 years had 0.90 times odds of giving sexuality communication to their children than those who were 40 years and above (COR=0.48, 95% CI 0.25-1.70).

With parents' education, the results showed that 16.1 % (10/52) parents who had less than SHS education communicated to their children on sexuality while 40.7% (59/146) parents who had SHS and above education communicated to their children on sexuality (Table: 4.4.1).

With regards to closeness or connected to their parents, children who were not close to their parents had 66% times less of receiving sexuality communication compared to those who were close to their parents (cOR=0.34, 95% CI 0.18-0.64) (Table: 4.4.1).

Parents who had less than Senior High School (SHS) education had 72% times less of giving sexuality communication to their children than those who had Senior High School (SHS) and above education (cOR=0.12, 95% CI 0.12-0.62). Parents age ( $p=0.716$ ) and knowledge on sexuality topics (0.774) did not prove statistically significant.

**Table 4.4.1: Bivariate of Parent Characteristics and Parent Adolescent Sexuality Communication.**

	Abstinence talk		COR	P value
	Yes	No		
<b>Parents Religion</b>				<b>0.007</b>
Muslim	52(83.9)	10 (16.1)	<b>0.26(0.08-0.83)</b>	
Christian	136 (95.1)	7 (4.9)	1.0	
<b>Parents Education</b>				<b>0.001</b>
<SHS	10 (16.1)	52 (83.9)	<b>0.28(0.11-0.62)</b>	
≥SHS	59(40.7)	86 (59.3)	1.0	
Parent years				0.716
<40 years	37 (56.9)	28(43.1)	0.90 (0.48-1.70)	
≥40 years	87 (59.6)	59(40.4)	1.0	
Sexuality Knowledge				0.774
Poor	28 (43.8)	36 (56.2)	0.92 (0.49-1.73)	
Good	67 (45.8)	79 (54.2)	1.0	

**4.5 Multivariate Analysis of Sexuality Communication and Parents’ Characteristics.**

In a multivariate analysis, adolescents age ( $p>0.001$ ), and their closeness to their parents ( $<0.001$ ) were the adolescent factors that were significantly associated with adolescent parent sexuality communication. Parent education ( $p=0.001$ ) was the only significant factor that was associated with adolescent parent sexuality communication at multivariate level. Table 4.4.1

Adolescent closeness to their parents ( $p < 0.001$ ), age of adolescents ( $p = 0.03$ ), sex of adolescents ( $p = < 0.001$ ) parent's religion ( $p = 0.03$ ), parent's educations were significant factors at multivariate level.

Adolescents reported to be close to their parents had 0.29 times odds of receiving adolescent parent sexuality communication compared to those who reported not to be close to their parents (aOR=0.28, 95% CI, 0.12-0.64,  $p = 0.03$ )

Further multivariate analysis showed that male adolescents were 42% less likely to receiving adolescent parent sexuality communication compared to those who were females (aOR=0.58, 95% CI 0.30 -1.12). Adolescents who were aged 10-14 years(early adolescents) had 72% times less of receiving adolescent parent sexuality communication compared to those who were 15-19 (late adolescents) (aOR=0.28, 95% CI 0.21-0.85).

With regards to the parent factors, parents who were Muslims were 71% less likely to communicating sexuality issues with their children compared to those who were Christians (aOR=0.29, 95% CI 0.09-0.91).

Parents who had lower than SHS education were 74 % less of communicating sexuality issues with their children compared to those who had above SHS (aOR=0.26, 95% CI 0.12-0.57).

**Table 4.5.1: Multivariate Analysis of Sexuality Communication and Parents' and Adolescents' Characteristics.**

Variable	Abstinence talk		Unadjusted Odd ratio		Adjusted Odd ratio	
	Yes	No	(95% CI)	P value	(95%CI)	P value
<b>Sex</b>				0.013		0.013
Male	29 (44.6)	36 (55.4)	0.47 (0.25-0.89)		0.58 (0.30-1.12)	
Female	92 (63.0)	54 (37.0)	1.0		1.0	
<b>Age</b>						
10-14	45 (69.2)	20 (30.8)	0.32(0.144-0.695)	0.001	0.28(0.21-0.85)	0.03
15-19	128 (87.7)	18 (12.3)	1.0		1.0	
<b>Close to parents</b>				0.001		<0.01
No	26(40.0)	39 (60.0)	0.34 (0.18-0.04)		0.29(0.15-0.58)	
Yes	97 (66.4)	49 (33.6)	1.0			
<b>Parents Religion</b>				0.007		0.03
Muslim	52(83.9)	10 (16.1)	0.26(0.08-0.83)		0.29(0.09-0.91)	
Christian	136 (95.1)	7 (4.9)	1.0			
<b>Parents Education</b>				0.001		0.001
SHS	10 (16.1)	52 (83.9)	0.28(0.11-0.62)		0.26(0.12-0.57)	
SHS	59(40.7)	86 (59.3)	1.0		1.0	

## CHAPTER FIVE

### 5.0 DISCUSSION

#### 5.1 Introduction

The purpose of this research was to provide data and information on the barriers that impact the decision of parents or their willingness to discuss issues related to sexual and reproductive health with adolescents. The most important barriers that were identified included, the religious and cultural beliefs of the parents, level of education of the parents, age (early adolescents) and connectedness of the adolescent to their parents.

#### 5.2 Barriers to parent adolescent communication on sexuality and reproductive health

Religion plays a major role in withholding communication between parents and adolescents on sexual and reproductive health matters. Based on the findings of this study, results showed that 83.9 % (52/65) parents who were Muslims communicated to their children on sexuality. Parents who were Muslims were 74% times less of giving sexuality communication to their children than those who were Christians (cOR=0.26, 95% CI 0.08-0.83).

Some parents from some religious sect, for example, Catholics find it not only difficult to recommend the use of contraceptives to their adolescents but also impossible to encourage their wards to engage in protected premarital sex as it is totally at odds with religious values as reported in other studies (Gullamo-Ramos, Bouris, 2008; Nundwe, 2012).

### **5.3 Adolescents' factors that influenced parent adolescent communication on sexuality**

One common barrier that was found to impact parent-adolescent communication on sexual and reproductive health matters is age. Based on findings from this study, approximately 90% of adolescents in the late phase had sexuality matters discussed with parents while adolescents in the early phase accounted for only 65% approximately with a 68% less of discussing sexual and reproductive health matters with parents. It is found that parents felt comfortable to talk with older adolescents (15-19) than with younger adolescents (10-14) on sexual and reproductive health matters. The findings were similar to those in a previous study which highlighted that parents spoke less to younger adolescents about sexuality issues because they were of the belief that it was inappropriate to discuss such sensitive issues to them at that age (Viner, Ozer et al, 1 2012).

One study suggested that it was possible parents only initiated communication as a means of protection once they discovered the teenager to be sexually active (Romo, Lefkowitz et al, 2002).

It was also found that parents communicated more on sexual and reproductive health matters with adolescents who were very close to them ( $p < 0.001$ ) regardless of their age. Parents feel more comfortable discussing such sensitive issues with these adolescents than with those adolescents who seemed rather distant in terms of parent-child relationship.

Based on the results, adolescents who were very close to their parents had 72% chance of receiving information on sexuality matters from their parents. Similar findings in other studies show that parents interacted more with adolescents who shared similar views with parents on most issues and were considered favorites of such parents (Yadeta et al, 2014).

#### **5.4 Parents factors that influenced parent-adolescent communication on sexuality**

It is identified that parents who had formal education up to SHS had in-depth knowledge about sexual and reproductive health matters and freely shared this knowledge with adolescents ( $p=0.001$ ) than parents who received little to no amount of formal education. Based on findings, parents who had higher level of education had 0.12 odds of communicating with adolescents on sexuality issues. They rather kept to cultural beliefs that suggest that discussion of such sensitive matters with adolescents was unheard of. Cultural beliefs and taboos about sexuality are deeply rooted in parents' lives and hinder communication as reported in previous studies (Sedge et al, 2007; Gullamo-Ramos, Bouris, 2008; Baku, 2014).

On the basis of gender, more adolescent boys received information on sexual and reproductive health matters from their parents than their female counterparts had. Based on findings, adolescents who were males had 42% times chance of receiving adolescent parent sexuality communication compared to those who were females (aOR=0.58, 95% CI 0.30 -1.12) confirming the study of (Wang, 2009). However, mothers tend to give out information to adolescents on sexual and reproductive health matters than fathers did. Similar findings were reported in other studies because male adolescents were seemed as more matured than their female adolescents when sexuality issues were raised (Nathanson, 2002; Joh et al. 2013)

The role of parents and adolescents in the society resulted in them having different views when sexual and reproductive health matters are made mentioned. Hence the undisputable blockage in the flow of information freely from parents to adolescents on such sensitive issues with parents remaining strongly attached to cultural beliefs which inhibits discussions on sexual and

reproductive health matters. These findings concur with previous studies where parents were conserved to give sex education to adolescents (Jaccard, 2010)

### **5.5 Implication of the Findings**

Adolescents and youth accounts for more than 20 percent of the global population. Young people mainly face a lot of reproductive problems which have been masked by different cultural and religious factors that limits for open discussion on their reproductive health issues. Access to sexual and reproductive health services has a potential of contributing to achieve Sustainable Development Goals (SDG) 3, 4, 5 and 6. The multidimensional nature of sexual and reproductive health can have negative outcomes among young people such as unwanted pregnancy; HIV/AIDS, unsafe abortion and school dropout etc. Most of sexual and reproductive health problems are easily avoidable through positive communication between parents and adolescents. Therefore, assessing parent-adolescent communication on sexual and reproductive health issues and associated factors helps for policy makers, health care providers and any other concerned bodies to design appropriate intervention strategies to tackle reproductive health problems for the young generation. Information obtained here can be used for planning of intervention programs in different parts of the country.

## 5.6 Strengths and Limitations of the Study

The strength of this study lies in that the richness of its findings and its potential contribution to studies of a similar nature. The study would have been more beneficial if some qualitative questions were asked to provide a deeper understanding of the phenomenon investigated. However, this was not possible due to time constraints. This was one of the study's major limitation.



## CHAPTER SIX

### 6.0 CONCLUSION AND RECOMMENDATIONS

#### 6.1 Conclusion

The chapter presents the concluding remarks of the study based on the results and the findings. The study was done to determine the barriers that prevent or limit parent-child communication on sexuality, and both the adolescent and the parent factors influence communication between parents and their adolescents. These objectives were achieved by identifying the factors that had impacts on communication between parents and their adolescents and the barriers that limits it as well. From the study results and findings, it was concluded that the barriers on sexuality communication includes the following:

- The religious and cultural beliefs of the parents, level of education of the parents, age and close of the adolescent to their parents also had a negative impact on sexuality communication between parents and their adolescents.
- The age of adolescents (young age or early adolescents) also influenced the way parents communicated with their adolescent as they felt they are too young at that age to be engaged in such discussions. However, on the part of the older adolescents, even though communication mostly took place at that stage, it focused mainly on abstinence restricting the adolescents to only that sexuality choice.
- The study also revealed that sexuality communication between parents and adolescents was tilted or biased towards the females as parents tend to educate the females more than the males on sexuality issues. Based on the findings and the conclusions, the study came out with the following recommendations:

## 6.2 Recommendations

- For these reasons above, further research is needed to tailor interventions to contain ideologies from both school of thoughts and find a neutral ground by considering the roles of parents and adolescents as well as promoting cultural integration of traditional and western norms as a means of creating an enabling environment for effective parent-adolescent communication on sexual and reproductive health matters. Therefore organizations like Plan, World Vision, Right to Play and others that have their work focus on children should take the lead in that research.
- It would help to improve parent-adolescent communication on sexual and reproductive health matters, if parents are sensitized on the importance of sharing such information to encourage open discussion among family members in general and between parents and adolescent in early age. It is important to encourage and empower parents to start to communicate with their adolescent on sexual matters while the adolescents are still in late childhood or early teenage years, before they become sexually active.
- Health extension workers should come in to help by teaching parents on how to communicate or dialogue effectively with their adolescent.
- There is the need for more NGO's to take up programmes on adolescent sexual education to complement the efforts of the few existing ones and parents in educating adolescents.
- Further qualitative and analytical study design is recommended on adolescents and parents communication.

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## **APPENDIX I: INFORMED CONSENT (PARENTS)**

**Project Title:** Parent-child communication and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality.

**Principal Investigator:** BISMARCK BISALA LAMBONGANG,  
P.O.BOX UP 863, KNUST, KUMASI.  
**TEL:** 0243664381.  
**EMAIL:** bblambongang@st.ug.edu.gh

### **General Information about the Study**

This is a research study being undertaken by Bismark Bisala Lambongang a student of the School of Public Health, University of Ghana, Legon; in order to examine issues that affect Parent-adolescent communication on sexuality and reproductive health in Ejisu in the Ejisu Juaben municipality.

### **Purpose of the Study**

The purpose of this research is to examine the barriers associated with Parent-child communication on sexuality and adolescent sexual behaviour among adolescents (10-19 years) in Ejisu, their knowledge in sexual and behaviour with regards to sexual and reproductive health.

Findings from this study will strengthen sexual and reproductive health communication among parents and adolescents. This will help prevent unwanted pregnancies and sexually transmitted infections among adolescents. The findings will contribute towards the information base urgently needed to forge a strategy of improving dialogue on sexuality between parents and their adolescent children. It will also help to identify other possible research areas for further study related to parent-adolescent sexual communication in the study area

### **Procedures**

Randomly selected parents who have adolescents aged 10-19 years living in Ejisu will be included in the study.

If you are eligible and agree to participate in the study, you will be required to complete an interviewer-administrated questionnaire. We will ask you questions about your background, knowledge about Sexual and Reproductive Health (SRH) and on sexuality behaviour.

The interview is expected to last for an average of 30 minutes.

### **Possible Risk and Discomforts**

There is no possible risk associated with this study but we anticipate some discomfort during the interview process given the sensitivity of some of the questions. You may feel uncomfortable answering those questions or you may not know the answer to a particular question. You are free to skip any questions you are not comfortable answering.

### **Possible Benefits**

There is no direct benefit to the participants of this study. However, the information you will provide will contribute to the overall knowledge on the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour that will be generated from this study. The research will provide adequate data and information on the barriers that influence the decision of patience or unwillingness to discuss issues related to sexual reproductive and health to their adolescents. These will provide additional guidelines regarding the need for parents to continuously monitor their children and create awareness and services that will significantly improve their reproductive health.

### **Voluntary Participation and Right to Refuse**

Your participation in this study is absolutely voluntary. During the interview, you can choose not to answer any question that you feel you do not want to answer. Additionally, you are at liberty to withdraw from the study or stop the interview at any time. However, we will encourage you to participate and complete the questions since your options are very important in helping us to understand the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour.

### **Confidentiality**

We would like to assure you that whatever information you provide will be handled with strict confidentiality, it will be used solely for research purpose and will never be used against you. Data analysis will be done at an aggregate level to ensure anonymity. Your name or personal information will not be published in any report. Some members of the research team (principle researcher and research supervisors) may sometimes review the research records, but no unauthorised individual(s) will be able to access the information.

### **Compensation**

There is no compensation for participants in this study.

### **Contact for Additional Information**

If you have any questions about the study later, you may contact: (Bismark Bisala Lambongang  
Tel: 0243664381 Email: [bblambongang@st.ug.edu.gh](mailto:bblambongang@st.ug.edu.gh)

### **Your Right as a Participant**

If you have any questions about your rights as a research participant, you can contact the Ghana Health Service Ethical Review Committee at the following address:

Hannah Frimpong  
GHS-ERC Administrator  
GHS-Ethical Review Committee  
Research and Development Division  
Ghana Health Service  
P. O. Box MB 190  
Accra-Ghana  
Office: 233(0)243235225 / 0507041223  
Email: [Hannah.Frimpong@ghsmail.org](mailto:Hannah.Frimpong@ghsmail.org)



## **VOLUNTARY CONSENT**

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I hereby declare that the above document describing the purpose, procedure as well as risks and benefits of the research titled “*Parent –child communication on sexuality and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality*” has been thoroughly explained to me in English/Twi language. I have been given the opportunity to ask any question about the research which has been answered to my satisfaction. I hereby voluntary agree to participate as a subject in this study.



\_\_\_\_\_  
(Participant's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

Or Thumbprint)

If the participant cannot read the form themselves, a witness must sign here.

I, \_\_\_\_\_ was present while the purpose, procedures as well as the risks and benefits were read to the participant. All questions were answered and the participant has voluntarily agreed to participate as a subject in this study.

\_\_\_\_\_  
(Witness Signature  
Or Thumbprint)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

**Interviewer's Statement and Signature**

I, \_\_\_\_\_ certify that the purpose, procedures as well as the risks and benefits associated with participating in this study have been explained to the above individual in the English /Twi language. The individual has freely agreed to participate in the study.

\_\_\_\_\_  
(Signature of person  
who obtained consent)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**APPENDIX II: QUESTIONNAIRE (PARENTS)**

**QUESTIONNAIRE ON PARENT-CHILD COMMUNICATION ON SEXUALITY AND ADOLESCENT SEXUALITY BEHAVIOUR IN EJISU IN THE EJISU MUNICIPALITY**

QN. NO.	QUESTIONS	Response/CODING
		Respondent ID:  __ __ __
<b>SECTION A</b>	<b>SOCIO-DEMOGRAPHIC INFORMATION</b>	<b>CIRCLE OR WRITE WHERE APPROPRIATE</b>
A1	What is your Sex?	1. Male 2. Female
A2	How old were you at your last birthday?	__ __  years
A3	What is your religious affiliation?	1. Catholic 2. Anglican 3. Presbyterian 4. Methodist 5. Pentecostal/ Charismatic 6. Other christian 7. Moslem
A4	What is your highest level of education?	8. Traditional 9. No Religion  1. No education 2. Primary
A5	How are close are you to your child?	3. Secondary 4. Tertiary  1. Very Close 2. Close 3. Not so close 4. Not close

SECTION	PARENT-CHILD COMMUNICATION	
B		
B1	What is your opinion about pre-marital sex	1.its bad 2.it should not be encouraged 3.it is dangerous
B2	What kind of personal things do you discuss with your child?	1.Puberty2.sex3.STI/HIV/AIDS 4.Menstruation 5.Abstinence
B3	Do you discuss abstinence with your child?	1. Yes 2. No
B4	If yes, how do u do it, and if no, why?	-----
B5	Does your child freely express his/her views?	1. Yes 2. No
B6	How confident are you when discussing sexual issues with your child?	1. Very confident 2Confident 3.Not so confident 4.Not confident.
B7	Do you feel comfortable?	1. Yes 2. No
B8	Does your religious belief allow you to discuss sexual issues with your child?	1. Yes 2. No
B9	Does your family and friends agree that you discuss sexuality issues with your child?	1. Yes 2.No
B10	What kind of sexual matters have you discussed with your child?	1.Puberty2.sex3.STI/HIV/AIDS 4.Menstruation 5.Abstinence
B11	Why do you discuss or talk about these topics?	-----
B12	In what ways does communication on these topics with girls differ from boys?	-----
B13	How well do you know about these topics?	1. Very well 2.well3. Not so well 4
B14	Have you discussed sexuality with your child in the past twelve months?	1. Yes 2. No
B15	In your opinion, what is the appropriate age to talk to your child about asexuality and why?	(1).5-10. (2)11-15. (3)16-19.----- -----1.Child

<p>B14</p> <p>B15</p> <p>SECT. C</p>	<p>What is the importance of discussing sexuality with your child</p> <p>SEXUALITY</p>	<p>remains chaste 2.</p> <p>Protected from sexual immorality</p> <p>3 Informed on sexuality issues.</p>
<p>C1</p> <p>C2</p> <p>C3</p> <p>C4</p> <p>C5</p> <p>C6</p> <p>C7</p> <p>C8</p> <p>C10</p>	<p>Do you know whether your child has ever had sexual intercourse with a boy or girl?</p> <p>How do you know?</p> <p>If you find out that your child is sexually active, what will you do?</p> <p>Do you think sexual communication with your child can influence his/her sexual behaviour?</p> <p>Explain your answer above.</p> <p>Have you talked to your child about contraceptive choices before?</p> <p>Have you talked to your child about contraceptive choices in the last twelve months?</p> <p>Will you allow your child to use condoms if found to be sexually active?</p> <p>Will you allow your child to use other forms of contraceptives if found to be sexually active?</p> <p>Has your child being pregnant or made someone pregnant before?</p>	<p><b>1. Yes 2. No</b></p> <p>1. Confessed 2. Always with the opposite sex 3. Suspects initiation of sex due to lifestyle</p> <p>1. Continue advising her 2. Disappointed 3. Punish her 4. Throw her out of my house</p> <p>1. Yes 2. No</p> <p>-----</p> <p>1. Yes 2. No</p> <p>1. Yes 2. No</p> <p>1. Yes 2. No</p> <p>1. Yes 2. No</p> <p>1. Yes 2. No</p>



### **APPENDIX III: INFORMED CONSENT (ADOLESCENTS AGED 18-19)**

**Project Title:** Parent-child communication and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality.

**Principal Investigator:** BISMARCK BISALA LAMBONGANG,  
P.O.BOX UP 863, KNUST, KUMASI.  
**TEL:** 0243664381.  
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Findings from this study will strengthen sexual and reproductive health communication among parents and adolescents. This will help prevent unwanted pregnancies and sexually transmitted infections among adolescents. The findings will contribute towards the information base urgently needed to forge a strategy of improving dialogue on sexuality between parents and their adolescent children. It will also help to identify other possible research areas for further study related to parent-adolescent sexual communication in the study area

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The interview is expected to last for an average of 30 minutes.

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There is no possible risk associated with this study but we anticipate some discomfort during the interview process given the sensitivity of some of the questions. You may feel uncomfortable answering those questions or you may not know the answer to a particular question. You are free to skip any questions you are not comfortable answering.

### **Possible Benefits**

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### **Voluntary Participation and Right to Refuse**

Your participation in this study is absolutely voluntary. During the interview, you can choose not to answer any question that you feel you do not want to answer. Additionally, you are at liberty to withdraw from the study or stop the interview at any time. However, we will encourage you to participate and complete the questions since your options are very important in helping us to understand the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour.

### **Confidentiality**

We would like to assure you that whatever information you provide will be handled with strict confidentiality, it will be used solely for research purpose and will never be used against you. Data analysis will be done at an aggregate level to ensure anonymity. Your name or personal information will not be published in any report. Some members of the research team (principle researcher and research supervisors) may sometimes review the research records, but no unauthorised individual(s) will be able to access the information.

### **Compensation**

There is no compensation for participants in this study.

**Contact for Additional Information**

If you have any questions about the study later, you may contact: (Bismark Bisala Lambongang  
Tel: 0243664381 Email: [bblambongang@st.ug.edu.gh](mailto:bblambongang@st.ug.edu.gh))

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GHS-Ethical Review Committee  
Research and Development Division  
Ghana Health Service  
P. O. Box MB 190  
Accra-Ghana  
Office: 233(0)243235225 / 0507041223  
Email: [Hannah.Frimpong@ghsmail.org](mailto:Hannah.Frimpong@ghsmail.org)

**VOLUNTARY CONSENT**

---

I hereby declare that the above document describing the purpose, procedure as well as risks and benefits of the research titled “*Parent –child communication on sexuality and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality*” has been thoroughly explained to me in English/Twi language. I have been given the opportunity to ask any question about the research which has been answered to my satisfaction. I hereby voluntary agree to participate as a subject in this study.

\_\_\_\_\_  
(Participant’s Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

Or Thumbprint)

If the participant cannot read the form themselves, a witness must sign here.

I, \_\_\_\_\_ was present while the purpose, procedures as well as the risks and benefits were read to the participant. All questions were answered and the participant has voluntarily agreed to participate as a subject in this study.

\_\_\_\_\_  
(Witness Signature  
Or Thumbprint)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

**Interviewer's Statement and Signature** I, \_\_\_\_\_ certify that the purpose, procedures as well as the risks and benefits associated with participating in this study have been explained to the above individual in the English /Twi language. The individual has freely agreed to participate in the study

\_\_\_\_\_  
(Signature of person  
who obtained consent)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## **APPENDIX IV: ASSENT FORM: PARENTS WITH ADOLESCENTS AGED 10-17 YEARS**

**Research Title:** Parent-child communication and adolescent sexual behaviour in Ejisu in the Ejisu Juaben municipality

**Principal Investigator:** Bismark Bisala Lambongang,  
P.O. Box U.P863, KNUST, Kumasi.  
**Tel:** 0243664381  
**Email:** bblambongang@st.ug.edu.gh

### **Purpose of the Study**

The purpose of this research is to examine the barriers associated with Parent-child communication on sexuality and adolescent sexual behaviour among adolescents (10-19 years) in Ejisu, their knowledge in sexual and behaviour with regards to sexual and reproductive health.

Findings from this study will strengthen sexual and reproductive health communication among parents and adolescents. This will help prevent unwanted pregnancies and sexually transmitted infections among adolescents. The findings will contribute towards the information base urgently needed to forge a strategy of improving dialogue on sexuality between parents and their adolescent children. It will also help to identify other possible research areas for further study related to parent-adolescent sexual communication in the study area

### **Procedures**

Randomly selected parents who have adolescents aged 10-19 years living in Ejisu will be included in the study.

If you are eligible and agree to participate in the study, you will be required to complete an interviewer-administrated questionnaire. We will ask you questions about your background, knowledge about Sexual and Reproductive Health (SRH) and on sexuality behaviour.

The interview is expected to last for an average of 30 minutes.

### **Possible Risk and Discomforts**

There is no possible risk associated with this study but we anticipate some discomfort during the interview process given the sensitivity of some of the questions. You may feel uncomfortable answering those questions or you may not know the answer to a particular question. You are free to skip any questions you are not comfortable answering.

### **Possible Benefits**

There is no direct benefit to the participants of this study. However, the information you will provide will contribute to the overall knowledge on the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour that will be generated from this study. The research will provide adequate data and information on the barriers that influence the decision of patience or unwillingness to discuss issues related to sexual reproductive and health to their adolescents. These will provide additional guidelines regarding the need for parents to continuously monitor their children and create awareness and services that will significantly improve their reproductive health.

### **Voluntary Participation and Right to Refuse**

Your participation in this study is absolutely voluntary. During the interview, you can choose not to answer any question that you feel you do not want to answer. Additionally, you are at liberty to withdraw from the study or stop the interview at any time. However, we will encourage you to participate and complete the questions since your options are very important in helping us to understand the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour.

### **Confidentiality**

We would like to assure you that whatever information you provide will be handled with strict confidentiality, it will be used solely for research purpose and will never be used against you. Data analysis will be done at an aggregate level to ensure anonymity. Your name or personal information will not be published in any report. Some members of the research team (principle researcher and research supervisors) may sometimes review the research records, but no unauthorised individual(s) will be able to access the information.

### **Compensation**

There is no compensation for participants in this study.

### **Contact for Additional Information**

If you have any questions about the study later, you may contact: (Bismark Bisala Lambongang  
Tel: 0243664381 Email: [bblambongang@st.ug.edu.gh](mailto:bblambongang@st.ug.edu.gh))

### **Your Right as a Participant**

If you have any questions about your rights as a research participant, you can contact the Ghana Health Service Ethical Review Committee at the following address:

Hannah Frimpong  
GHS-ERC Administrator  
GHS-Ethical Review Committee  
Research and Development Division  
Ghana Health Service  
P. O. Box MB 190  
Accra-Ghana  
Office: 233(0)243235225 / 0507041223  
Email: [Hannah.Frimpong@ghsmaail.org](mailto:Hannah.Frimpong@ghsmaail.org)

### **VOLUNTARY CONSENT**

I hereby declare that the above document describing the purpose, procedure as well as risks and benefits of the research titled “*Parent –child communication on sexuality and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality*” has been thoroughly explained to me in English/Twi language. I have been given the opportunity to ask any question about the research which has been answered to my satisfaction. I hereby voluntary agree to participate as a subject in this study.

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Participant's Signature  
Or Thumbprint)

(Date)

If the participant cannot read the form themselves, a witness must sign here.

I, \_\_\_\_\_ was present while the purpose, procedures as well as the risks and benefits were read to the participant. All questions were answered and the participant has voluntarily agreed to participate as a subject in this study.

\_\_\_\_\_  
(Witness Signature  
Or Thumbprint)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

**Interviewer's Statement and Signature**

I, \_\_\_\_\_ certify that the purpose, procedures as well as the risks and benefits associated with participating in this study have been explained to the above individual in the English /Twi language. The individual has freely agreed to participate in the study.

\_\_\_\_\_  
(Signature of person  
who obtained consent)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

## **APPENDIX V: ASSENT FORM (ADOLESCENTS AGED 10-17 YEARS)**

**Research Title:** Parent-child communication and adolescent sexual behaviour in Ejisu in the Ejisu Juaben municipality

**Principal Investigator:** Bismark Bisala Lambongang,  
P.O. Box U.P863, KNUST, Kumasi.  
**Tel:** 0243664381  
**Email:** bblambongang@st.ug.edu.gh

### **Purpose of the Study**

The purpose of this research is to examine the barriers associated with Parent-child communication on sexuality and adolescent sexual behaviour among adolescents (10-19 years) in Ejisu, their knowledge in sexual and behaviour with regards to sexual and reproductive health.

Findings from this study will strengthen sexual and reproductive health communication among parents and adolescents. This will help prevent unwanted pregnancies and sexually transmitted infections among adolescents. The findings will contribute towards the information base urgently needed to forge a strategy of improving dialogue on sexuality between parents and their adolescent children. It will also help to identify other possible research areas for further study related to parent-adolescent sexual communication in the study area

### **Procedures**

Randomly selected parents who have adolescents aged 10-19 years living in Ejisu will be included in the study.

If you are eligible and agree to participate in the study, you will be required to complete an interviewer-administrated questionnaire. We will ask you questions about your background, knowledge about Sexual and Reproductive Health (SRH) and on sexuality behaviour.

The interview is expected to last for an average of 30 minutes.

### **Possible Risk and Discomforts**

There is no possible risk associated with this study but we anticipate some discomfort during the interview process given the sensitivity of some of the questions. You may feel uncomfortable answering those questions or you may not know the answer to a particular question. You are free to skip any questions you are not comfortable answering.

### **Possible Benefits**

There is no direct benefit to the participants of this study. However, the information you will provide will contribute to the overall knowledge on the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour that will be generated from this study. The research will provide adequate data and information on the barriers that influence the decision of patience or unwillingness to discuss issues related to sexual reproductive and health to their adolescents. These will provide additional guidelines regarding the need for parents to continuously monitor their children and create awareness and services that will significantly improve their reproductive health.

### **Voluntary Participation and Right to Refuse**

Your participation in this study is absolutely voluntary. During the interview, you can choose not to answer any question that you feel you do not want to answer. Additionally, you are at liberty to withdraw from the study or stop the interview at any time. However, we will encourage you to participate and complete the questions since your options are very important in helping us to understand the factors associated with Parent-child communication on sexuality and adolescent sexual behaviour.

### **Confidentiality**

We would like to assure you that whatever information you provide will be handled with strict confidentiality, it will be used solely for research purpose and will never be used against you. Data analysis will be done at an aggregate level to ensure anonymity. Your name or personal information will not be published in any report. Some members of the research team (principle researcher and research supervisors) may sometimes review the research records, but no unauthorised individual(s) will be able to access the information.

### **Compensation**

There is no compensation for participants in this study.

### **Contact for Additional Information**

If you have any questions about the study later, you may contact: (Bismark Bisala Lambongang  
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### **VOLUNTARY ASSENT**

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I hereby declare that the above document describing the purpose, procedure as well as risks and benefits of the research titled “*Parent –child communication on sexuality and adolescent sexual behaviour in Ejisu in the Ejisu Juaben Municipality*” has been thoroughly explained to me in English/Twi language. I have been given the opportunity to ask any question about the research which has been answered to my satisfaction. I hereby voluntary agree to participate as a subject in this study.

\_\_\_\_\_  
(Participant's Signature

Or Thumbprint)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

If the participant cannot read the form themselves, a witness must sign here.

I, \_\_\_\_\_ was present while the purpose, procedures as well as the risks and benefits were read to the participant. All questions were answered and the participant has voluntarily agreed to participate as a subject in this study.

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**Interviewer's Statement and Signature**

I, \_\_\_\_\_ certify that the purpose, procedures as well as the risks and benefits associated with participating in this study have been explained to the above individual in the English /Twi language. The individual has freely agreed to participate in the study.

\_\_\_\_\_  
(Signature of person  
who obtained Assent)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**APPENDIX V: QUESTIONNAIRE (ADOLESCENTS)**

**QUESTIONNAIRE ON PARENT-CHILD COMMUNICATION ON SEXUALITY AND ADOLESCENT SEXUALITY BEHAVIOUR IN EJISU IN THE EJISU MUNICIPALITY**

QN. NO.	QUESTIONS	Response/CODING
Respondent ID:  __ __ __		
<b>SECTION A</b>	<b>SOCIO-DEMOGRAPHIC INFORMATION</b>	<b>CIRCLE OR WRITE WHERE APPROPRIATE</b>
A1	What is your Sex?	2. Male 2. Female
A2	How old were you at your last birthday?	__ __  years
A3	What is your religious affiliation?	2. Catholic 2. Charismatic 3. Other -----
A4	What is your highest level of education?	5. No education 6. Primary 7. Secondary 8. Tertiary 1. Close 2. Not close
A5	How close are you to your parent or guardian?	1. Yes 2. No
A6	Do you have the freedom to go anywhere at anytime?	1. Yes 2. No

A7	Will your parents or guardian allow you to engage in pre-marital sex?	
SECTION	PARENT-CHILD COMMUNICATION	
B		
B1	Are your parents able to talk to you about things that are important to you	<b>1. Yes 2. No</b>
B2	Have they discussed sexual topics with you before?	1. Yes 2. No
B3	If yes, precisely what did they discuss with you?	-----
B4	Who mostly does it, father or mother	1. Father 2. Mother
B5	Do you feel comfortable when you discuss it?	1. Yes 2. No-
B6	Apart from your parents who else discusses sexual issues with you?	1. Very confident
B7	How would you rate their level of confidence?	2. Not confident.
B8	Are your parents well informed on sexual and reproductive health issues?	1. Yes 2. No
B9	Do you trust what they tell you?	1. Yes 2. No
B10	What kind of sexual matters do they discuss with you? Probe(puberty, sex, menstruation, Hiv/Aids etc)	-----
B11	What sexual topics do you think are important for your parents to discuss with you and why?	1. Yes 2. No
B12	Have they discussed sexual topics with you within the last twelve months?	-----

B13	What did they discuss with you?	-----
B14	Have you discussed sexuality with your child in the past twelve months?	-----
	How would you rate the frequency of communication between you and your parents?	
SECT. C	SEXUAL BEHAVIOUR	
C1	Why do you think young people go into sexual relationships?	-----
C2	What forces young people to have sex especially unprotected sex?	--
C3	Have you ever had sexual intercourse with a boy or girl?	-----
C4	If yes, are you currently in a relationship?	<b>1. Yes 2. No</b>
C5	How many sex partners have you had so far?	<b>1. Yes. 2. No</b>
C6	Can you share with me how and why they came into your life?	1. Yes 2. No
C7	During your first sexual intercourse, did you protect yourself?	-----
C8	What are the various ways that one can protect him/herself from unwanted pregnancies, STI's HIV/Aids	1. Yes 2. No
C9	In your opinion, what prevents young people from using contraceptives?	-----
C10	Have you ever been pregnant or made someone pregnant? Did you intend to?	-----
C11	What happened to the pregnancy?	1. Yes 2. No

<p>C12</p> <p>C13</p>	<p>Do you feel pressured to have sex?</p>	<p>-----</p> <p>1. Yes 2. NO</p>																				
	<table border="1"> <tr> <td data-bbox="383 674 578 751"></td> <td data-bbox="578 674 1036 751"></td> </tr> <tr> <td data-bbox="383 751 578 932"><b>SECTION D</b></td> <td data-bbox="578 751 1036 932"> <p><b>KNOWLEDGE ON SEXUAL AND REPRO HEALTH *</b>  <i>(D1- D7 are some statements about P  tell me whether you think the stateme  False or whether you don't know)</i></p> </td> </tr> <tr> <td data-bbox="383 932 578 968">D1</td> <td data-bbox="578 932 1036 968">Pubic hair grow during puberty</td> </tr> <tr> <td data-bbox="383 968 578 1003">D2</td> <td data-bbox="578 968 1036 1003">Breasts enlarge during puberty</td> </tr> <tr> <td data-bbox="383 1003 578 1039">D3</td> <td data-bbox="578 1003 1036 1039">Boys develop broader shoulders in pu</td> </tr> <tr> <td data-bbox="383 1039 578 1117">D4</td> <td data-bbox="578 1039 1036 1117">A girl can get pregnant the very first t sexual intercourse/sex.</td> </tr> <tr> <td data-bbox="383 1117 578 1194">D5</td> <td data-bbox="578 1117 1036 1194">A woman stops growing after she has intercourse for the first time.</td> </tr> <tr> <td data-bbox="383 1194 578 1230">D6</td> <td data-bbox="578 1194 1036 1230">Masturbation causes serious damage</td> </tr> <tr> <td data-bbox="383 1230 578 1308">D7</td> <td data-bbox="578 1230 1036 1308">A woman is most likely to get pregnat sexual intercourse half way between</td> </tr> <tr> <td data-bbox="383 1308 578 1579">D8</td> <td data-bbox="578 1308 1036 1579"> <p>Which method do you think is most s young people?</p> <p><b>CIRCLE ONE ANSWER</b></p> <p>INTEGRITY PROCEDAMUS</p> </td> </tr> </table>			<b>SECTION D</b>	<p><b>KNOWLEDGE ON SEXUAL AND REPRO HEALTH *</b>  <i>(D1- D7 are some statements about P  tell me whether you think the stateme  False or whether you don't know)</i></p>	D1	Pubic hair grow during puberty	D2	Breasts enlarge during puberty	D3	Boys develop broader shoulders in pu	D4	A girl can get pregnant the very first t sexual intercourse/sex.	D5	A woman stops growing after she has intercourse for the first time.	D6	Masturbation causes serious damage	D7	A woman is most likely to get pregnat sexual intercourse half way between	D8	<p>Which method do you think is most s young people?</p> <p><b>CIRCLE ONE ANSWER</b></p> <p>INTEGRITY PROCEDAMUS</p>	
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**GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE**

*In case of reply the  
number and date of this  
Letter should be quoted.*



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Ghana Health Service  
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Your Ref. No.

615

Lambongang Bismark Bisala  
University of Ghana  
School of Public Health  
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 119/02/17
Project Title	Parent-Child Communication and Adolescent Sexual Behaviour in Ejisu in the Ejisu Juaben Municipality
Approval Date	13 <sup>th</sup> June, 2017
Expiry Date	12 <sup>th</sup> June, 2018
GHS-ERC Decision	<b>Approved</b>

**This approval requires the following from the Principal Investigator**

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....  
DR. CYNTHIA BANNERMAN  
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

