Dynamics of Parent-Adolescent Communication on Sexual and Reproductive Health in Sub-Sahara: A Focus on Barriers and Policy Implications

Authors:
Douglas Nyathi, School of Social Sciences, University of KwaZulu Natal, Howard College, Durban, Republic of South Africa,
Joram Ndlovu, School of Social Sciences, University of KwaZulu Natal, Howard College, Durban, Republic of South Africa,
Keith Phiri, Department of Sociology and Anthropology, Faculty of Social Sciences and Humanities, University of Fort Hare, 50 Church Street, East London, Republic of South Africa,
Mxolisi Sibanda, Department of Development Studies, Lupane State University, Bulawayo, Zimbabwe.

Address for Correspondence
Douglas Nyathi,
School of Social Sciences
Howard College
University of KwaZulu Natal
Durban, Republic of South Africa.
E-mail: douglasnuyathi08@gmail.com.

Citation

Submitted: May 14, 2019; Revised: Mar 3, 2020; Accepted: Oct 15, 2020; Published: Dec 20, 2020

Abstract: Communication of sexual matters between the parents and adolescents has been seen as one of the strategies that could play a cardinal role in encouraging adolescents to be responsible and delay sexual debut or avoid unprotected sexual intercourse. The increasing rate of teenage pregnancies and new HIV/AIDS infections among adolescents in Sub-Saharan Africa makes the phenomenon worth analysis. The purpose of this paper is to interrogate the dynamics of parent-adolescent communication on sexual and reproductive health in Sub-Sahara. Specifically, the paper focuses on barriers to communication between parents and adolescents on sexual and reproductive health and its policy implications. It emanates from the paper that communication on sexual and reproductive health at household level is triggered by death of a relative from a sexual related illness, suspicion on sexual activity, radio programmes and in some instances, fliers. Literature engagement reveals that communication between parents and adolescents on sexual and reproductive health is made difficult by economic factors (poverty, lack of privacy and low self-esteem), household demographics (age, sex, class, death), socio-cultural factors (beliefs and religious values) as well as social media. We argue that there is need to use broadcast media to come up with radio and television programmes that create family environments in which sexual and reproductive health issues are discussed. We also recommend that government departments and Non-Governmental Organisations concerned with sexual issues need to undertake studies that can help dismantle taboos, prejudices and stereotypes that impede sexual and reproductive health communication between parents and adolescents.

Key Words: Parent-adolescent, Communication, Sexual and reproductive health, Barriers, Sub-Sahara

Introduction:
Sexual and reproductive health is an important aspect of normal adolescent growth and development that encompasses biological, sex, gender roles and identity, sexual orientation, sexual behaviour, and reproduction (1). Achieving healthy adolescent sexual development involves managing the many physical, social, and emotional changes experienced during adolescence (2). For Bastien et al (3) improving the sexual and reproductive health of young people is a global priority as it aims to promote healthy sexual behaviour characterised by delayed sexual debut, decreased number of sexual partners as well as increased use of condoms. Sexual Transmitted Infections (STIs) and other sexual related health issues like unplanned pregnancies continue to rise world-wide (4-6). These problems have been noted to affect mostly adolescents living with parents and those living with guardians. According to United Nations Economic Social Council (5), HIV/AIDS has in the past twenty-five years particularly afflicted young people (those aged 15–24) hard, especially those living in Sub-Saharan Africa and females in particular. In 2005, this age group from sub-Saharan Africa had the highest prevalence rates worldwide with 4.3% of young women and 1.5% of young men estimated to be living with HIV (7). In low and middle income countries, where most unwanted pregnancies, unsafe abortions, maternal deaths and STIs occur, investment in positive youth development to promote sexual and reproductive health (SRH) is increasing (8). It is also stated by Igrasa et al (8) that information from lower-and middle-income countries on the SRH knowledge, attitudes and behaviours of younger adolescents is scant. Resnick et al (9) reveals that most studies in the developed and developing world including Africa, have shown that parents who transmit clear messages about sexual conduct, the value of school and adverse consequences of risk taking sexual behaviours have teenagers who describe themselves as low frequency participants in risky behaviours. These risk reduction behaviours are said to include delayed sexual debut, consistent condom use, ability to discuss HIV and AIDS in sexual.
relationships and the ability to communicate with parents when faced with problems regarding SRH and others (10). The heightened HIV prevalence rate in statistics on Sexual and Reproductive Health related problems in Sub-Saharan raise a concern revolving around the role of parents in communicating and educating their adolescents on Sexual and Reproductive Health matters (5). While programmes and the literature on parent-adolescent sexuality communication in developing countries and Sub-Saharan Africa are limited, Bastain et al. (3) posit that parent-child sexuality communication has been identified as a protective factor for adolescent sexual and reproductive health, including HIV infection. According to Tesso et al (10) family communication affects adolescent identity formation and role-taking ability. The scholars further argue that adolescents who receive family support may feel freer to explore identity issues. Identity formation and role-taking ability play a key role in Sexual and Reproductive Health because they determine whether an adolescent will engage in risky sexual behaviour or not (1). It is therefore essential to study the stumbling blocks to this important communication between parents and adolescents on Sexual and Reproductive Health so that measures are taken to counter them with the belief that improvement in this communication will lead to the reduction of many Sexual and Reproductive Health problems faced by adolescents in rural and urban areas. The purpose of this paper therefore is to explore dynamics of parent-adolescent communication on Sexual and Reproductive Health (SRH) with a particular focus on the barriers and policy implications. The paper uses Sub-Saharan Africa as a unit of analysis. The last part of the paper dwells on policy implications and way forward with respect to addressing the barriers to communication between parents and adolescents on sexual and reproductive health issues.

**Sexual and Reproductive Health: A theoretical conjecture**

Sexual and reproductive health is viewed by the Department for International Development (4) as an essential element of good health and human development. The UNFPA (12) posit that reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes. Therefore, people are able to have a satisfying and safe sex life and have the capability to reproduce and the freedom to decide if, when and how often to do so (4). According to Glasier et al (4), sexual health and reproductive health is also about guiding people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion, exploitation, and gender-based violence. In explaining the concept of sexual reproductive health, some scholars argue that it is a state of physical, emotional, mental, and social well-being in relation to sexuality (13-15).There are five components of sexual and reproductive health care and these are said to include improvement of antenatal, perinatal, postpartum, and new-born care; provision of high-quality services for family planning including infertility services; elimination of unsafe abortions; prevention and treatment of sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promotion of healthy sexuality (4,11,13). This is also supported by Collumbien et al (16) who also outline the main domains of sexual and reproductive health to include bearing children safely, avoiding unwanted births, respect of rights, safe and pleasurable sexual life as well as maintaining a healthy reproductive system. Wahba and Roudi-Fahimi (15), international consensus affirms that adolescents need and have a right to sexual and reproductive health (SRH) information and services. Bloom et al (17) postulates that sexual and reproductive health is also important as an issue in itself. People have the right to make their own choices and decisions based to a large extent on information. The scholars further argue that improving sexual and reproductive health is among the most cost-effective of all development investments, reaping personal, social and economic benefits and has the potential to save and improve lives, slow the spread of HIV and AIDS and encourage gender equality (17). DFID (11) notes that sexual and reproductive ill health includes death and disability related to pregnancy and childbirth, sexually-transmitted infections, HIV and AIDS, and reproductive tract cancers. It is also noted that sexual and reproductive ill health accounts for at least 20 per cent of the burden of global ill health for women of reproductive age (15-44 years) and 14 per cent for men (11). UNDP (14) asserts that poor sexual and reproductive health accounts for an estimated one third of the global burden of illness and early deaths among women of reproductive age. SRH problems do not only affect the elderly but also adolescents given that women and adolescent girls continue to die and suffer from disabilities during pregnancy and childbirth (12). Glasier et al (13) argue that sexually transmitted diseases are extensively infections of the young, mainly because their sexual relations are often unplanned, sometimes a result of pressure or force, and typically happen before they have the experience and skills to protect themselves.

**The Health Belief Model and Sexual and Reproduction Health**

The Health Belief Model (HBM) is by far the most commonly used theory in health education and health promotion (18,19). It was developed in the 1950s as a way to explain why medical screening offered by the United States Public Health Service, particularly for Tuberculosis were not successful (20). The Health Belief Model is a psychological model that attempts to explain and predict health behaviours of individuals by focusing on attitudes and beliefs of individuals (18,21). The model has since been used to explore a variety of health behaviours including sexual risks behaviours and HIV and AIDS as well as the influence of parents on the sexual behaviour of adolescents (22). Maleta (22) notes that conducive factors to behaviour change in the model are referred to as cues to action and catalysts. Cues to action bring in realities of the severity of potential illnesses and catalysts promote the feasibility of implementing the new behaviour (17). From a Health Belief Model perspective, sexually transmitted infections including HIV, unwanted abortions, child sex education; fear of being misinterpreted to promote promiscuous behaviour, and uncertainty that adolescents can co-operate with their parents on sexual and reproductive decisions based on sound information. The perceived pressing forces for parents to consider communicating with their children matters on sexual reproductive health also include their assessment of susceptibility of their children as shown in Fig 1. Since change is not something that comes easily to most people, one of the construct of the Health Belief Model are the perceived barriers (20). Perceived barriers to parent adolescent communication may emanate from the attitude of the parent towards cultural protocol for parent-child sex education; fear of being misinterpreted to promote promiscuous behaviour, and uncertainty that adolescents can co-operate with their parents on transmitted infections active health (22). The underlying concept of the Health Belief Model as indicated in Fig 1, is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (20). The ability of a parent to understand the importance of communicating with adolescence on sexual reproductive health and the ability to overcome barriers to such an engagement system. According to the engagement model will large extent determine whether or not a parent communicates with his or her child on the matter.
Motivations for parent-child sexual communication
Studies have unveiled a number of triggers for parent-child sexual communication. According to Hyde et al (23) one factor that has been found to increase the likelihood of parents discussing sexuality with their children is the presence of triggers to help stimulate discussion. Studies have found that when children ask about their origins from parents, it triggers parent-child sexual communication. In the case of young children, Frankham (24), whose work is based on semi-structural interviews with 50 parents and case studies in which all members of ten families were interviewed, asserts that crucial to the relative ease parents feel about engaging in the process of sex education is that children ask questions about their origins and this is then taken as a prompt to begin talking about sex (23). It has also emanated from various studies that portrayals of risky sexual behaviours can stimulate conversations between parents and teenagers (25, 26). Hyde et al (23) also note that parental beliefs about teenagers’ behaviour can also serve as a prompt to engage in communication about sex and gives an example of the study by Eisenberg where parents who believed that their teenagers were romantically involved were up to 2.5 times more likely to have talked to them about a wider range of sexual matters. According to a study by Walker (27), for mothers of sons the increased provision of sex education resources, specifically those written from a male perspective, was viewed as a particularly beneficial trigger to parent-child sexual communication.

Barriers to communication between parents and adolescents on Sexual and Reproductive Health
Economic factors and communication between parents and adolescents on SRH
Studies conducted on barriers to communication between adolescents and parents on SRH have revealed that economic
factors play a cardinal role in determining communication between the two. A study in Tanzania by Nundwe (29) underscores that the occupation in which parents are engaged in can be a barrier for parents to discuss with their children issues of reproductive health as they have little time to be with them. Some of the respondents stated that their jobs keep them busy as they keep travelling and as a result had inadequate time to discuss SRH issues with their adolescents. This challenge is manifest in border towns in Zimbabwe for example in Plunket where people engage in migratory labour because of limited employment opportunities at home (30). They may return home once per year thus providing limited time to discuss SRH issues with their adolescents. Household income has also been discovered to be having a bearing on parent-adolescent communication on sexual reproductive health issues (29,31). A study by Bushaija et al (31) in Rwanda that aimed at establishing the nexus of parent/guardian income and communication practices showed that respondents that depended on farming and remittances were less likely to discuss sexual matters than the salaried and self-employed. The study also indicates that 264 respondents attributed their low socio-economic status as a factor that inhibited them from discussing sexual matters with adolescents, citing lack of time due to busy work schedule (70%) as a major hindrance. Other impediments included lack of radio or television sets (22%) at home for sexuality information. Homelessness, lack of descent accommodation and lack of privacy (4%) where discussions with children could be conducted were some of the barriers highlighted. The lack of privacy may be a factor since poor families may find it difficult to have their own houses and share accommodation where they live in numbers and in such circumstances, discussing SRH issues would attract an unintended audience (29,32,33).

Dindili (33) substantiate the above argument as he alludes that poverty and lack of accommodation are barriers to parent-adolescent engagement on sexual reproductive health. In one study the scholar (33) found that the majority of female respondents (mothers) were living in overcrowded homes (shacks, hostels) where lack of privacy limits conversations with daughters on sexuality issues. One of the respondents is quoted to have expressed that “It is difficult to talk because my neighbours will hear the conversation. I do not have privacy in my shack”. It can be noted that with the African perception of secrecy on sexual issues, the issue of privacy becomes a barrier as it is generally believed that such issues cannot be discussed in public. There is no Sub-Saharan communities appears to be a critical factor in limiting SRH communication between parents and children in certain circumstances. However, it can be noted that some studies like Nundwe’s (30) in Tanzania found that household wealth and income do not significantly influence SRH communication in any way. They noted that owning many properties and other wealth indicators does not hinder parent-adolescent engagement on SRH. In relation to income, the study discovered that SRH issues are discussed regardless of income because STIs do not affect people according to their economic status.

**Household demographics and communication between parents and adolescents**

Jerman and Constantine (34) posit that demographic characteristics of parents and children can influence parent-child sexual communication. Studies have found that some household demographics that include births, deaths, wealth, disease, age, sex, class and size of the family have some influences when it comes to communication between adolescents and parents on SRH. According to Ojo et al (35), there is a significant different in reproductive health communication between adolescent boys and girls with their mothers; girls are more likely to talk with mothers than boys. The researchers observed that it is possible that girls are likely to ask their mothers about menstruation since female family members traditionally teach daughters about this monthly cycle when they reach puberty. The study by Ojo et al (35) in Nigeria found that males were two times more likely than females to discuss reproductive health issues with their children. The age of the child also has been found to influence sexual communication, with less frequent and extensive communication occurring with younger children and it is also suggested that children’s age, and children’s gender interacting with parents and gender, determine sexual communication (34). Studies have found that African mothers report greater comfort and self-efficacy in communicating about sexuality with their 6 to 12-year-old children and reported more frequent sexual communication with them (30,34). It can be noted from such findings that some households have difficulties in communicating with the younger children on SRH issues as they believe that it will trigger the child’s desire to experiment on sexual practices whilst other households see communicating SRH issues with children as easier than doing so with adolescents (31).

**Socio-cultural factors**

Studies have unveiled that there are social and cultural factors that deter communication between adolescents and parents on sexual and reproductive health. According to Nyarko et al (25), in Ghana sexual health is an important determinant of productivity and national development, yet the mere mention of ‘sex’ seems to evoke itchy feelings among both the young and old. In a study conducted by Bushaija et al (31) in Rwanda, one of the factors found to be a cause for apathy in discussing SRH matters is religious affiliation. The Rwanda study established that 12% of the respondents that did not discuss sexual matters with adolescents attributed it to their religious belief as a major factor as one of the discussant expressed that as Christians, they could not advise their adolescent children to use condoms which they believed was immoral. This is validated by Athar (36) who notes that the church often gives “moral education” and not sex education and to Muslim parents, sex is a taboo subject (19). The study by Bushaija et al (17) also revealed that cultural factors such as beliefs and taboos also hindered parents/guardians from discussing sexual matters with adolescents and of the 314 parents/guardians that did not discuss sexual matters with adolescents, 39% found it difficult to mention sexual terms in Kinyarwanda while others either had prohibitive beliefs or considered it the role of aunts and uncles to provide SRH education. A study by Bushaija et al (17) found that poverty in Sub-Saharan communities appears to be a critical factor in limiting SRH communication between parents and children in certain circumstances. However, it can be noted that some studies like Nundwe’s (30) in Tanzania found that household wealth and income do not significantly influence SRH communication in any way. They noted that owning many properties and other wealth indicators does not hinder parent-adolescent engagement on SRH. In relation to income, the study discovered that SRH issues are discussed regardless of income because STIs do not affect people according to their economic status.

One of the social factors hindering parent-adolescent communication found in Nundwe’s (29) study in Tanzania was that it was seen as shameful for both the parent and adolescent to discuss sexual matters. Men and women interviewed explained that it was shameful for them to discuss with their children the opposite sex issues of STIs, condom use, HIV/AIDS and physical development. Cultural norms have also been fingered as a communication barrier between adolescents and parents on SRH. In Nundwe’s...
study, the interviewed participants explained that cultural norms and tradition deterred them from discussing issues of puberty with their children as sexuality discussion were not discussed with children. Participants in the Tanzanian study believed that they were not the right people to talk with their children about these issues as their cultural norms allow this activity to be handled by seniors or elders like grandfathers, grandmothers, aunts and uncles. It can be noted that the hindrances especially the ones relying on elders to communicate with adolescents on SRH issues place adolescents at the risk of getting outdated information as the elderly may not be abreast with current issues on SRH. Gender and social stratification have also been noted as some of the socio-cultural factors deterring parent-adolescent engagement. Nundwe’s study revealed that gender is one of the barriers to effective communication between parents and adolescents concerning reproductive health issues. It is revealed that parents fail to communicate with their children of the opposite sex on issues based on sexuality like physical development, STIs, puberty and condom use. It also emanated that in most cases this kind of communication tended to be gender biased as parents preferred to speak or discuss with children of the same gender. Tesso et al (10) found that in Ethiopia some participants (parents) expected their children to get SRH information from school and believe that reproductive health (RH) is not an agenda for discussion in the family. Thus, in some societies, sexual and reproductive health issues are not discussed in households as the topic is treated as a foreign.

The influence of social media
Mass media has been noted to play a centrifugal role in the spreading of SRH information. However, this role, though significant, becomes a barrier to parent-child communication on SRH issues. According to Scheck (26), the media plays an extremely influential role in the sexual socialization process of adolescents by providing them with a source for making meaning in their lives. The Society for Adolescent Health and Medicine allude that teens learn sexual messages and obtain ideas about sex from music videos, billboards, magazines, movies, the Internet, and video games (37,2). Studies have shown that adolescents tend to rely more on media for sexual information than on their parents, thereby discouraging engagement between the two parties on SRH issues. A study conducted by The National Campaign to Prevent Teen Pregnancy reported that 61 percent of the 501 adolescents surveyed identified that the media provided them with advice and information about sex (26).

A study conducted by Asampong et al (37) on adolescents and parents’ perceptions of best time for sex and sexual communications in the Eastern and Volta Regions of Ghana found that adolescents’ unhindered access to technology denies parents the chance to do sex talks. One female parent in their study indicated that, “When you think this child is now of age so I can advise her concerning sex, by that time, he/she already knows about it in a movie and has seen all the act on TV and even on radio stations. So when you call them to advise them they don’t take it.” The scholars also observed that parents view the electronic media as channels through which adolescents learn about sexual activities thus making parents’ role of providing sex education redundant (39,40,41). They concluded that the challenge for adolescents is rooted in the early exposure to what they perceive as volatile information to children without caution and in that sense, parents viewed the child as armed with information that could expose parent’s ignorance when they attempt to educate them about sex (38).

Policy interventions on improving parent-child Sexual and Reproductive Health communication
The following are the interventions that can help dismantle the communication barriers that impede effective SRH communication between parents and adolescents thereby improving it.

1. The broadcast media can be used to come up with radio and television programmes that create family environments in which SRH issues are discussed. These programmes should reflect practical challenges captured in this research such as age discrepancies, embarrassment, diverse economic backgrounds, cultural taboos and religious obstacles. These programmes should preferably be aired during the prime time viewing slot or incorporated into the scripts of popular soaps or programs that are followed. This will provide a good contextual situation for parents and children to learn from the broadcasted programmes and also make it easier for them to conquer their shyness and discuss SRH issues as they will learn from the characters in the soap or programme strategies for doing this.

2. Since the extended family constituting of grandparents, aunts and uncles has been affected by the exigencies of urbanisation and modernity the broadcast media can create programmes featuring experts who will be aunts, uncles and grandparents who can discuss these issues and respond to the concerns of adolescents. Questions can be communicated through social media platforms and studio calls as the programme is being broadcasted. Parents can be incorporated into the shows by giving them the platform to educate through the same channels. This will encourage them to learn how to use information technology to educate adolescents on SRH issues.

3. The government departments and NGOs concerned with SRH issues need to undertake studies that can help dismantle taboos, prejudices and stereotypes that impede SRH communication between parents and adolescents. They must also hold workshops, road shows and community outreach programmes to educate parents and adolescents on the need for both to engage in SRH communication.

4. Opinion leaders such as councillors, politicians, musicians, prominent businessmen and church leaders should be approached and convinced to work together with other advocates and stakeholders concerned with dismantling the socio-cultural barriers that impede effective SRH communication between parents and adolescents.

5. Economic policies and programmes that encourage entrepreneurship should be supported, especially those that support community and family businesses that will see parents and children working together. This will create a conducive environment for them to spend more time together and bond, making it easier ultimately for the two parties to communicate on SRH issues.

Conclusion
Communication between parents and adolescents on sexual and reproductive health has a potential to contribute to reduction of teenage pregnancies, illegal and unsafe abortions and new STIs. Communication between a parent and his or her child is one of the most important practices in parenting, though not an easy one. It requires continuous attention and time. However, there are barriers that deter effective communication between parents and adolescents on SRH. As a result of those different and diverse factors, parents do not talk to their children about sex, they do not want their children to do anything sexual and they avoid confronting or advising their children on what they are doing or should do concerning sexuality. The findings in this paper are important for learning processes as well as for action purposes. Interested parties and institutions working towards ensuring health for all can use them and come up with programs to counter these barriers.
References


22. Maleta TM. Parent and Child communication on sexual and reproductive health matters in Malawi. College of Medicine, University of Malawi, 2006.


33. Dindili, N. Communication barriers around Sexual Reproductive Health (SRH) within families that lead to increase in teenage pregnancy and vulnerability to HIV/AIDS. Assignment presented in fulfilment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) in the Faculty of Economic and Management Science at Stellenbosch University. Stellenbosch University, 2014.


