IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 17, Issue 4 Ver. 6 (April. 2018), PP 06-14
www.iosrjournals.org

The Impact of Parent Adolescent Communication on Sexuality on Sexual Debut and Related Risk Behaviors among In School Adolescents in Benin City.

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Abstract: Background*: adolescent sexual practice is increasing worldwide with serious health and social consequences. Parent adolescent communication on sexuality (PACS) despite being rare has been found to have positive impact on delaying sexual debut among adolescents but receives little attention in strategies targeting improved adolescent sexual outcome. There is need to explore the prevalence and content of PACS, the adolescent's perception thereof and the mode of impact on their sexual practice in our environment.* ***Aim and Objectives****: To determine the pattern and content of parent adolescent communication on sexuality, the adolescent's perception of the discussion and impact on their sexual practice.* ***Methodology****: Over 400 senior secondary school students from 2 mixed day schools were recruited by random sampling. Only 336 customised self administered questionnaires were adequate for analysis. P value was set at 0.05.* ***Results****: The prevalence of sexual debut was 10.1 %. PACS was provided mostly by mothers at a prevalence of 46.7% with a significant relationship with sexual debut, other risk behaviours, female gender and maternal education. PACS was mostly perceived as educative but with low coverage of sexual health issues and impacted sexual debut via moral persuasion.*
Conclusion*: Parent adolescent communication on sexuality positively impacts adolescent sexual debut and other risk behaviours via moral persuasion. Strategies to improve adolescent sexual outcome should target parental practice and capacity for PACS.*

Date of Submission: 29-03-2018 Date of acceptance: 14-04-2018

I. Introduction

The world is currently having the largest population of adolescents ever. At over 1.8 billion adolescents and youth in the world,[1] 70% of them living in the developing nations and about 37.8 million adolescents in Nigeria (22.3% of the total population),[2] this demographic subset demands focused attention. The adolescent is that individual aged 10 -19 years who is transiting from childhood to adulthood.[2] The transition involves rapid changes in physical, psychological, sexual and mental domains posing a great challenge for the youth.

Sexuality is a central aspect of being human and beyond sex, includes gender identity and roles, sexual orientation, eroticism, intimacy and reproduction. It is experienced and expressed in thoughts beliefs, fantasies, desires, values, attitudes, behaviours, roles and relationships. It is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.[3] The home is the central milieu in which sexuality is developed and through which all these factors impact on the individual and the major mediating factor is parenting. Sexuality development occurs right from birth as the child is nurtured along gender specific trajectories dictated by societal norms. The adolescent stage is of particular importance because biological factors in puberty drive the increase in sexual feelings and interest in the child. The need for accurate information and support from parents becomes urgent to enable them understand and manage themselves effectively.

Worldwide, adolescent sexual activity is increasing with attendant adverse consequences on pattern of sexually transmitted infections including HIV/AIDS, teenage pregnancy, abortion related morbidities and mortality, interrupted education[4] and teenage motherhood with a resultant vicious cycle of maternal poverty.

Factors like gender, child personality, educational status, socioeconomic status, religion and culture, family structure, functioning and ecology,[5,6] and neighbourhood characteristics[7]etc influence sexual decisions and practice among adolescents. Sexual health issues of concern include early sexual debut, poor condom use, multiple partners, transactional motivation,[8] sexually transmitted infections and pregnancy.

In Nigeria, prevalence of sexual activity among in school adolescents in Ilorin (north central) was found to be 28.2% [9] and in a similar population in Ibadan (south west) it was 28.3%.[10]Another study in south west Nigeria confirmed that parental influence deters sexual indulgence.[11] While a study in the south south

region found that factors that influenced sexual practice include: pornography, peer pressure, parental indifference.[12]

The major public health tool for combating the problem of adolescent sexuality is school sex education with very little attention given to parental sex education[4,13] Sexuality education is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.[14]

All over the world there is varying degrees of resistance to specific training on sexuality in the homes ,schools and religious settings thereby leaving the youth unprepared to appropriately manage the challenges of their sexual health.[15] This is attributed to many factors principal of which is the discomfort of the adult in discussing sex with the child and the fear that knowledge will encourage indulgence in sex.[16,17]

Parent Adolescent Communication on Sexuality (PACS) is uncommon especially in Nigeria. A study in Akoko Edo, Edo State found that only 8.2% of parents had communication on sexuality with their children and only 23.8% supported school sex education.[18] Many studies have shown that parental sex education is an important factor in determining sexual behavior in the adolescent.[19,20] The variables found to mediate this effect include: the frequency and specificity of Parent–adolescent communications,[21,22,23,] the quality and nature of exchanges,[19] parental knowledge, beliefs[24] and comfort with the subject matter; and the content[20,25] and timing of communications.[25] Generational differences are also at play as most parents did not receive such training and so find it difficult to give it.[26,27]

Existing literature has demonstrated that PACS where it occurs, has positive influence on delayed sexual debut despite the observed inadequacies. There is need to explore the content of the discussion, the adolescent's perception thereof and the mode of impact on their sexual practice. This will provide valuable knowledge in planning intervention to strengthen PACS in our locale as done in developed nations as additional means of controlling adverse adolescent sexual outcome.[16,28] The Family Physician has a responsibility to provide adolescent health care and can effectively improve the awareness, capacity and willingness of parents to undertake PACS and therefore bridge this gap[29]

Justification: Parental sex education has been shown to be strongly related to sexual practice among adolescents. In our environment, the pattern of this communication, it's content and the adolescent's perception and impact on their sexual practice is unknown. This study was done to provide this knowledge to facilitate strategies to strengthen PACS and improve adolescent sexual outcome.

Aim and Objectives: This study seeks to determine the pattern and content of parent adolescent communication on sexuality, the adolescent's perception of the discussion and impact on their sexual practice.

II. Materials and Method.

Study Design: The study was a cross sectional descriptive design.

Study Area: Secondary schools in Benin City, the capital of Edo State Nigeria. There are both private and public schools in the city. The low to middle class citizens generally attend the public schools while the private ones are attended by children from the middle to upper class homes. The secondary schools are divided into junior and senior schools of three years each.

Study population: the adolescents in senior secondary schools in Benin City. The adolescent population in Edo state is estimated at 344, 024.[2] The prevalence of adolescent sex in Nigeria is between 8% [6] and 28% [9,10] with an average of 18%.

Selection criteria:

Inclusion: All senior secondary students within age 10-19 who consented to participate.

Exclusion: All students in senior class who were below 10years or above 19years or refused to consent.

Sampling method: Random sampling by balloting was used to select two mixed non boarding schools, one private and one public. Non boarding mixed schools were chosen because there is expected to be some important contextual differences between these schools and single sex schools, boarding schools (mixed or single sex), faith based schools and secular schools. Non Boarding schools also have the additional advantage of having children who are in constant contact with their parents, the school and the society. They offer the highest likelihood of adolescents in their natural milieu.

Calculated sample size was 267. Over Four hundred students were recruited from the two schools.

Ethical consideration: Ethical approval was obtained from the Ethics and Research Committee of University of Benin Teaching Hospital. Certificate No ADM/E 22/A/VOL.VII/1349. In the schools, permission was obtained from the Principals in writing and informed consent obtained from the students.

Method of Data collection:

The study instrument was a customized self administered questionnaire which was distributed to the students after permission and consent had been obtained. The filled questionnaires were retrieved same day at break time.

Study Duration: Data collection was done over about 4weeks.
Data Management:
Data was collated using the excel spread sheet and analysed using the SPSS version 21. P value was set at 0.05.

III. Results

Only three hundred and thirty six questionnaires were found adequate for analysis.

Table 1: Distribution of Demographic variables among the Respondents.

Demographic variable	Response	Frequency	Percentage
Age :	**Range: 11-19years**		
	Mean= 15.39 years.		
	SD= +/- 1.454years		
Adolescent phase:	**Early adolescence (11-13yrs)**	**28**	**8.3**
	Middle adolescence (14-16yrs)	236	70.3
	Late adolescence (17-19Yrs)	72	21.4
Sex	**Male**	**168**	**50**
	Female	168	50
Religion	**Christianity**	**327**	**97.3**
	Islam	8	2.4
	African traditional religion.	1	0.3
Father's educational status	**None**	**14**	**4.2**
	Primary	11	3.3
	Secondary	76	22.6
	Tertiary	235	69.9

Distribution of demographic variables (contd)

Variable	Response	Frequency	Percentage
Mother's educational status	**None**	**16**	**4.8**
	Primary	22	6.5
	Secondary	101	30.1
Family Type	Tertiary	197	58.6
	Monogamous	**290**	**86.3**
Family cycle stage	polygamous	46	13.7
	Stage 4	**245**	**72.9**
Living conditions	Stage 5	91	27.1
	Living with both parents	**243**	**72.3**
Parental separation type	Living with separated parent	93	27.7
	Divorce	**27**	**29.0**
	Work	31	33.3
Distribution of Risk behavior	Death	35	37.7
	Yes	**86**	**25.6**
	No	250	74.4

Most of respondents (70.3%) were in the middle phase of adolescence with a mean age of 15.39yrs. Sex distribution was equal. Majority of the respondents were Christians (97.3%). More than 88% of their mothers and fathers had secondary education or more. Majority of them were from monogamous families (86.3%) in which they lived with both parents (72.3%). Of the 27.7% who had separated parents, cause of separation was evenly spread between divorce, work and widowhood. Most of the families (72.9%) were in the fourth stage of the family life cycle. Majority (74.4%) of the respondents did not engage in any risk behaviour (Table 1).

Table 2: Prevalence of Sexual Debut among the Respondents.

Sex debut	Frequency	Percentage
Yes	34	10.1
No	302	89.9
Total	**336**	**100**

Majority of the respondents had not initiated sexual activity. The prevalence of sexual debut among the respondents was 10.1%.

Table 3: Pattern of Parent Adolescent Communication on Sexuality (PACS) among the Respondents.

Variable	Response	Frequency	Percentage
Prevalence of PACS among the respondents.	Yes	157	46.7
	No	179	53.3
Sex distribution of Respondents that had PACS.	**Male**	**110**	**70.1**
	Female	47	29.9
Distribution of Parent who gave PACS.	**Mother**	**128**	**81.5**
	Father	23	14.6
	Both	6	3.8
Sex distribution of those who had PACS from their Father.	**Female**	**2**	**8.7**
	male	21	91`.3
Sex distribution of those who had PACS from both parents.	**Female**	**1**	**16.3**
	Male	5	83.3

Majority of the respondents did not have any discussion on sexuality with their parents. The prevalence of parent adolescent communication on sexuality was 46.7%. Seventy percent of the respondents who had PACS were female. The mother was the source of PACS (81.6%) for most of the respondents. The father was the source for only 14.6% and both parents for 3.8% of the respondents. Majority of the respondents who got PACS from their father (91.3%) or from both parents (83.3%) were males.

Table 4: Relationship between PACS and Sexual debut among the Respondents.

Parental sex education	Sex debut (No)	Sex debut (Yes)	Total
Yes	148	9	157 (100)
No	154	25	179 (100)
Total	**302 (100)**	**34(100)**	**336 (100)**

The relationship between Parent adolescent communication on sexuality and Sexual debut is significant. Calculated Chi square= 6.235 at df 1 p value= 0.013.

Table 5: Relationship between Sex of Respondent and PACS

Sex	PACS (Yes)	PACS (No)	Total
Female	110 (65.5)	58 (34.5)	**168**
Male	47 (28.0)	121 (72.0)	**168**
Total	**157**	**179**	**336**

The relationship between sex of respondents and PACS is statistically significant. Calculated chi square = 47.453 at df=1 . p value =000 (Table 5).

Table 6: Relationship between Educational Status of Respondent's Mother and PACS.

Mother's Educational Status	PACS (Yes)	PACS(No)	Total
None	7(43.8)	9 (56.2)	**16**
Primary	3 (13.6)	19 (86.4)	**22**
Secondary	39 (38.6)	62 (61.4)	**101**
Tertiary	108 (54.8)	89 (45.2)	**197**
Total	**157**	**179**	**336**

A significant relationship was found between PACS and Educational status of Respondent's Mother. Calculated chi square is 17.591 at df=3. p value=0.

Table 7: Relationship between Educational Status of Respondent's Father and PACS.

Father's educational status	PACS (Yes) Frequency (%)	PACS (No) Frequency (%)	Total
None	7 (50)	7 ?(50)	**14**
Primary	4 (36.4)	7 (63.6)	**11**
Secondary	33 (43.4)	43 (56.6)	**76**
Tertiary	113 (48.1)	122 (51.9)	**235**
TOTAL	**157**	**179**	**336**

The relationship between PACS and educational status of respondent's Father is not significant. Calculated chi square is 1.043 at df =3. P value =0.791.

Table 8: The Relationship between PACS and Risk Behaviour among the respondents

PACS	Risk behaviour (Yes)	Risk behaviour(No)	Total
Yes	**22**	**135**	**157**
No	**64**	**115**	**179**
Total	**86**	**250**	**336**

PACS was found to be protective against risky behavior. A significant relationship was established between risky behavior and PACS. Chi square = 20.760 at df 1.p value= 0.000.

Table 9: The Relationship between the PACS and Moral Decision Factor for Sexual Debut.

PACS	Moral factor	Non Moral factor	Total
Yes	121	36	**157**
No	116	63	**179**
Total	**237**	**99**	**336**

The impact of the moral decision factor was established in a significant relationship between PACS and the moral factor. Chi square =6.055.at df 1. P value= 0.014

Table 10: Pattern of coverage of content of PACS among the respondents who had PACS. Fourteen items were explored and have been classified into four categories:

Table 10a: Content related to self efficacy in relationships.

S/N	Content Item	Response	Frequency	Percentage
1	**How to choose your friends and maintain good friendships.**	**Yes**	**148**	**94.3**
		No	9	5.7
2	**How to avoid being influenced by others to engage in sexual activities**	**Yes**	**144**	**91.7**
	How to value and respect the rights and dignity of the other person in a	No	13	8.3
3	**relationship with you.**	**Yes**	**131**	**83.4**
		No	26	16.6
4	**Avoid sexually suggestive misuse of the internet and social media**	**Yes**	**131**	**83.4**
		No	26	16.6
5	**The link between other risky behaviours and unplanned sexual activity.**	**Yes**	**131**	**83.4**
		No	26	16.6

Most of the respondents (mean 87.2%) reported coverage of the items in the subset relating to self efficacy in relationships.

Table 10b: Content related to Avoiding Intimacy.

S/N	Content item	Response	Frequency	Percentage
1	**How to handle your relationship with the opposite sex**	**Yes**	**136**	**86.6**
		No	21	13.4
2	**How to avoid unwanted sexual advances.**	**Yes**	**143**	**91.1**
		No	14	8.9
3	**Explain other kinds of touching that can be regarded as sexual**	**Yes**	**132**	**84.1**
	Sexually suggestive behaviours and how to avoid them.	No	25	15.9
4		**Yes**	**134**	**85.4**
	The advantages of abstinence	No	23	14.6
5		**Yes**	**146**	**93.0**
		No	11	7.0

Most of the respondents, mean 86.8% reported coverage of the items relating to avoiding intimacy.

Table 10c: Content related to maintaining Sexual Health in intimacy

S/N	Content item	Response	Frequency	Percentage
1	**Explain the act of sex?**	**Yes**	**94**	**60.0**
		No	63	40.0
2	**How to prevent pregnancy or sex transmitted infection like**	**Yes**	**104**	**66.2**
	HIV if you have sex	No	53	33.8
		Yes	**111**	**70.7**
3	**How to deal with your personal sexual feelings**	No	46	29.3

Most of the respondents mean 65.6% reported coverage of items relating to maintaining sexual health in intimacy.

Table 10d: Content related to Parental Support.

S/N	Content item	Response	Frequency	Percentage
1	Assure you have their support in any problem related to sex /relationship.	Yes No	127 30	80.9 19.1

Majority of the Respondents, mean 83% reported being assured of parental support in matters relating to sexuality and relationships.

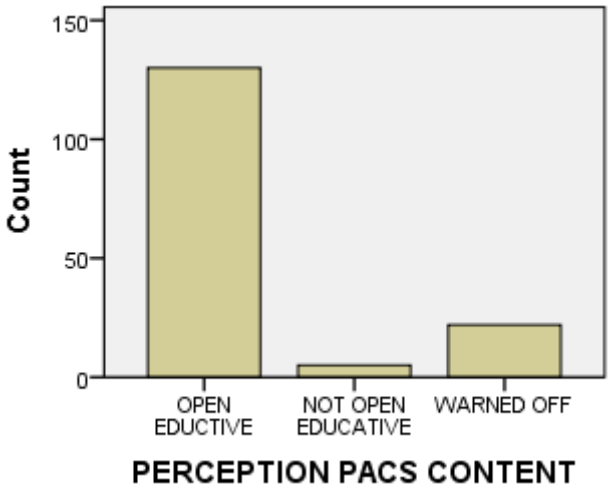

Figure 1: Pattern of Respondent Perception of the content of PACS

Among those who had PACS, majority felt their parents educated them on sexuality (82.8%), the rest felt they were warned off sex or not educated at all (Figure 1)

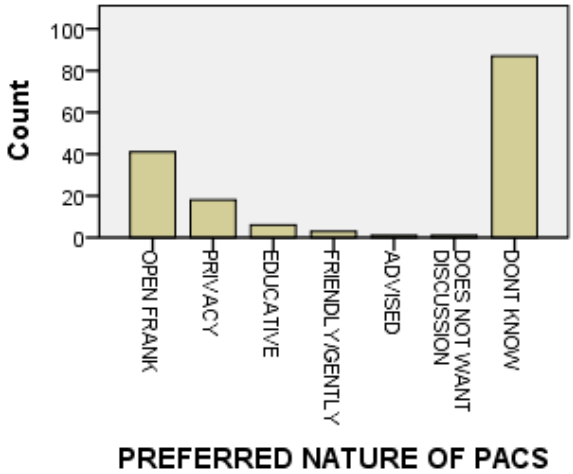

Figure 2: Distribution of respondent's opinion on their preferred nature of PACS.

Most of the respondents (55.4%) had no opinion as to their preference on the nature of the communication on sexuality, 26.1% wanted an open and frank discussion. The rest wanted privacy and gentleness as necessary conditions. One respondent did not want any discussion on the issue (Figure 2).

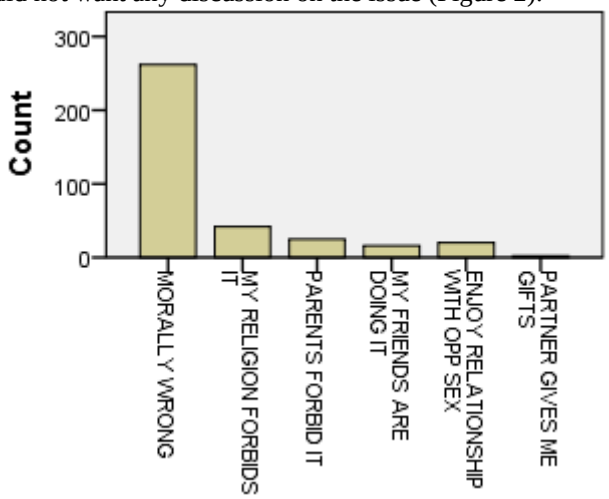

Figure 3: Distribution of Respondent's reasons for decision on sexual debut.

The distribution of the respondent's reason for decision on making sexual debut showed majority of them chose morality (70.5%) followed by religion and parental disapproval as determinants of their decision on making sexual debut.

IV. Discussion

A significant majority of the respondents in this study had not made sexual debut. The prevalence of sexual debut in this sample population was much lower than in the study on in school adolescents in Ibadan [9]and Ilorin[10] both in Nigeria. The sample populations were similar in educational engagement of the adolescents and educational status of their parents, but significantly different in the older age range of the respondents, a higher proportion of Muslims, polygamous family structure and ethnicity. Also the pattern of parent adolescent communication on sexuality was not explored and this along with the observed cultural factors need to be studied to determine if they are accountable for this difference.

PACS was reported in a minority of the respondents in this study but was still found to have a significant relationship with sexual debut demonstrating the vital role PACS plays in determining the sexual practice of adolescents. The prevalence of PACS in this study is higher than that found in Akoko edo, a rural setting in the same state [18]. The difference is attributable to the educational attainment of the parents. Maternal education was found to have a significant relationship with PACS. This is in keeping with the global positive impact of female education on the welfare of children and family. As regards PACS, education enables the mother to appreciate the risk associated with the massive exposure to sexual material the adolescents have access to through various media, understand their response, and articulate the best approach and information needed to deliver PACS. This was also evident as the majority of the respondents considered the discussion to be educative.

The mothers are generally responsible for nurturing and monitoring of the children and share a more empathic relationship with them. They are therefore naturally the more common source of PACS for majority of respondents as found in this study and supported by literature [21,22,27.] Studies have demonstrated that PACS is best provided in the setting of such a relationship and that a higher frequency of this communication strengthens parent adolescent bonding in addition to improving sexuality outcome[23]. However, adolescents have also expressed the need for a parent of same sex to deliver PACS to enable them ask questions and get adequate responses to gender sensitive issues.[30] Boys have been shown to be more interested in intimacy and how to manage their desires whereas girls are more interested in developmental changes and sexual health. Fathers are generally more distant from their children and do not engage in PACS. When they do they can only teach their sons as also evident in this study[21,22 27.] This has serious negative implications for the coaching of boys to develop healthy sexual practice and reduce the negative issues surrounding sexual health, violence and culture.

PACS was also shown to be targeted more at the girls with a significant relationship between PACS and sex of respondent. This usually happens because PACS is purposed to prevent unwanted pregnancy[30].Frequent mother-daughter communication on sex influences delayed initiation for the girls and this in turn is enhanced if the girls view their mother as a positive role model.[21,22,27]Family Physicians need to help parents understand that PACS is an obligation in responsible parenting and beyond sex and pregnancy helps to prepare and support their child to develop healthy sexual moral values, attitudes and practice in adulthood.[16]

The coverage of the content of PACS was remarkably high generally and is attributed to maternal education. The emphasis was largely on parental support, self efficacy in relationships, refusing sex and avoiding peer influence and other circumstances or risk behaviours predisposing to sexual indulgence. This was evidenced by the significant relationship between PACS and other risk behaviours. The positive impact of PACS on non sexual risk behaviours makes it an important tool for facilitating healthy adolescent outcome. It is well known and obviously harnessed by the parents in this study sample that these risk behaviours co exist and increase the risk of adverse sexual events.[26]

Content coverage was significantly lower for items related to maintaining sexual health as seen in literature.[16,31] This is attributed to parental inhibitions, fear of encouraging sexual indulgence and because mothers generally under estimate their children's sexual practice often resulting in adverse events occurring before the need to deliver PACS is recognised [27]. Shyness on the part of the adolescent is also a factor in this as demonstrated by the fact that majority of the respondents did not know their preference on how they would like PACS to be delivered and supported by literature.[17,32] Whereas this works for majority who decide to be abstinent, those who are sexually active critically need accurate information to maintain their health and prevent adverse outcome. The fundamental parameters in this situation include adolescent self disclosure and parental acceptance and surmounting of the inhibition to provide this knowledge. These dynamics are heavily dependent on other factors including the family structure, functioning and parent adolescent relationship. However as maturity develops, frequent communication and a realistic approach facilitates the accrual in depth of content ensuring the adolescent is armed with necessary information when needed[32]. Majority of respondents who had

an opinion as to their preference on the nature of PACS wanted open, frank, and educative discussion on the subject demonstrating their strong desire to get honest answers from their parents.

The impact of PACS on sexual debut was seen to operate via moral values as it was shown to be the strongest determinant of decision to delay sexual debut with a significant relationship established between moral factor and PACS. Most of the respondents who chose non moral factor as determinant for their decision on sexual debut were those that did not receive PACS. This finding is strongly supported by Kirby et al. who found that the strongest protective factor against sexual indulgence in adolescents is their personal values, belief and attitudes.[33] It contradicts other authors and anecdotal reports suggesting that moral persuasion has no impact on today's adolescents.[17] It is also very important for parents as it provides encouragement and a framework for delivering PACS. The significant relationship between PACS and other risk behaviour probably also derives from this.

Limitations: This study was unable to elicit the communication style and interactivity employed in delivering PACS. Also the frequency of the communication and the conducive nature of timing and circumstances for the discussions were not explored. These limitations provide the questions for further studies.

Recommendations: programmes targeted at improving adolescent sexual outcome should include strategies to improve parental capacity for PACS.
Family Physicians should include in their adolescent care package, strategies to increase parental awareness and capacity for PACS.

V. Conclusion

This study has achieved its aim of determining the pattern and impact of PACS on sexual debut among in school adolescents using a customised self report instrument. Low prevalence of sexual debut and other risk behaviours significantly associated with parent adolescent communication on sexuality operating via strong moral persuasion was found. Strategies to strengthen parenting in this regard and improve adolescent outcomes can confidently be based on these findings.

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Dr Vivien O. Abah "The Impact of Parent Adolescent Communication on Sexuality on Sexual Debut and Related Risk Behaviors among In School Adolescents in Benin City.."IOSR Journal of Dental and Medical Sciences (IOSR-JDMS), vol. 17, no. 4, 2018, pp 06-14.