UNIVERSITY OF CAPE COAST

PARENTS' PERCEPTIONS AND INTENTIONS ON PROVISION OF CONDOM EDUCATION FOR ADOLESCENTS IN THE CAPE COAST METROPOLIS

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature ……. Date …….

Name: Nana Akua Bema Gyasi-Duku

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

This study focused on parents' perceptions and intentions to provide condom education for adolescents. A descriptive cross-sectional quantitative study was employed using self-administered questionnaire. A total of 398 parents from rural and urban communities in Cape Coast Metropolis completed the questionnaire. The study discovered that though some adolescents have knowledge on condom use, parental contribution to such knowledge was very minimal because they do not feel comfortable discussing such topics with their adolescent children, and cited media advertisement (billboards & radio) and friends as major sources of adolescents' condom education. Parents perceive that condom education must take place in the school setting at the JHS level with female teachers handling such education. The study also found that the perception that condom education for the adolescent will have an effect such as initiating them into sexual experimentation influences their readiness or intention to provide their adolescent children with condom education. In view of this, it is recommended that public health education programs should target parents to sensitize them on the essence to communicate and educate their adolescent children on condom use in order to curb misinformation and misuse about condom usage by adolescents to help improve their sexual health now and in adulthood.

KEYWORDS

Adolescents

Condom education

Early sexual experimentation

Intention

Parents

Perception

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DEDICATION

To my parents, Rev. & Mrs. Augustus Harry Awortwi and my husband, Kwaku Tieku Gyasi-Duku

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ACRONYMS

ABC	Abstinence, Be faithful, Condom use
AIDS	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control
FCSW	Female Commercial Sex Worker
FSWs	Female Sex Workers
GAC	Ghana AIDS Commission
GDHS	Ghana Demographic Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus
IM	Integrative Model
PHC	Population and Housing Census
PLWHA	People Living With HIV/AIDS
RAA	Reasoned Action Approach
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
UNAIDS	United Nations program on HIV and AIDS
UNICEF	United Nations Children's' Emergency Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

In the Ghanaian society, parents and adults in general refrain from discussing condom and other sexual matters with the adolescent (Osei, 2009). It is perceived that providing education on condom to adolescents will initiate them into early sexual experimentation as indicated by adults surveyed in the 2008 Ghana Demographic and Health Survey (GDHS). Parents' perceptions, attitudes and their intention to provide condom education for their adolescent children are vital in the development of adolescents' sexual health now and into adulthood. The main focus of previous studies on condom education has been on adolescents avoiding parents who are the custodians of these adolescents. There is, therefore, the need to find out about parents' perception and their intention to give condom education since children attain the first experience from the family especially parents and they influence their children's outcome (Hoover-Dempsey & Sandler, 1995).

Condom is an important tool used to fight against Acquired Immune Deficiency Syndrome (AIDS) and other sexually transmitted diseases, with the campaign for its usage, launched to all groups in the society (Solomon & Dejong, 1989). Condom education involves creating the awareness of its existence, teaching how it is used, when it is used, it's efficacy when used, its advantages and disadvantages over other contraceptives.

Condom is a latex barrier device which is worn by both sexes to prevent pregnancy and sexually transmitted diseases (STDs) including HIV/AIDS. There

are the male and the female condom which are worn by each sex. The latex prevents semen from entering the female reproductive organ and prevents fluids from contacting the male reproductive organ. This process protects both organs from directly getting in touch thereby preventing fluid exchange which could either lead to pregnancy or contraction of STDs including HIV/AIDS. Several laboratory tests conducted on condom confirm it as the most effective method to prevent the Human Immunodeficiency Virus (HIV) and other pathogens as it provides an essentially impermeable barrier making infection unlikely to occur (Carey, Herman & Retta, 1992; Lytle & Routson, 1997). The incidence and spread of HIV/AIDS and its effects are a public health and social challenge (Boutayeb, 2009; Mbulo, Ian & Newman, 2007) hence, the education on condom usage is therefore very essential.

United Nations Children's Emergency Fund (UNICEF) and United Nations Program on HIV and AIDS (UNAIDS) estimated that 2.6 million out of the 36.9 million people living with HIV (PLWHIV) worldwide in 2014 were children under 15 years. They indicated that 80 percent of adolescents aged 10-19 living with HIV are within the Sub-Saharan African Region.

Over the years several strategies have been initiated to help alleviate the spread of HIV of which condom education has been a key tool in all HIV control programs. However, low patronage and inconsistency of condom usage (Bankole, Ahmed, Neema, Ouedrago & Konyani, 2007; Darteh, 2012; DiClemente, Durbin, Siegel, Krasnonsky, Lazarus & Comacho, 1992; Exavery, Mubyazi, Rugemalila, Mushi, Massaga, Malebo, Ogondiek & Malecela, 2012; Njau, Mtweve, Barongo,

Lekule & Jalipa, 2007;) among young people are being explained by the high social risks such as the family and neighbours associated with condom usage (Freedman, Salazar, Crosby & DiClemente, 2005) rather than the availability of the condom.

Adolescents are highly sexually active (Awusabo-Asare, Abane & Kumi-Kyereme, 2004) and may learn more about condom usage as well as other issues relating to sexuality and they can experiment what they learnt (Halpern & Reznick, 2009) and so for that reason, parents who are legally responsible for adolescents and first educators have the duties and responsibilities to provide education on condom and other sexual health education for them (ICPD, 1994). Adolescents are at a higher risk of transactional sex (GSS, 2009) and engage in risky sexual behaviours such as inconsistent condom use and sex with multiple partners (Nundwe, 2012) as a result; perception of parents about educating adolescents on condom is vital.

Despite the essence of condom education for the adolescents, controversy surround adults' support of educating the youth on condom usage to prevent HIV infection because parents perceive that it will initiate them into early sexual experimentation, they will indulge in multiple sex partners and likely practice promiscuity (GSS, 2009). This notion makes adults shun discussions on sexual matters especially condom education in the Ghanaian society with adolescents (Osei, 2009). The perception parents have about condom and their readiness to provide condom education can positively influence adolescents' sexual health now and into adulthood, therefore, condom education is essential to adolescents to

help them build a healthy relationship in a positive way. High-quality information and condom education can equip adolescents with knowledge, skills, and attitudes which will help them make informed choices now and into adulthood (Boonstra, 2011). In Ghana, contraceptive services provided is targeted at the adult population thereby putting the adolescents at a disadvantage and reducing their confidence in the use of a condom (Adih & Alexandros, 1999). These situations do not provide a favorable environment for the Ghanaian adolescent to freely purchase or inquire about condoms.

According to Roosem and Meekers (2011), perceived approval of condom education and usage facilitates the use of condoms by adolescents. The study indicated that perceived support for condom education from a most valued person has a positive influence on condom usage. The youth studied indicated that the support of condom use by parents and other relatives had some effect on their usage. This implies parental influence can play a significant role in shaping adolescents sexual life. Brooks-Gunn and Paikoff (1991) have shown in a study that parents who communicated their perceptions, attitudes, beliefs and values about sexual activity to their adolescent children influence their sexual risk behaviours. Also as parents provide condom education and sex education to their adolescent children, adolescents are able to delay their involvement in early sexual intercourse (Fasula & Miller, 2006; Pearson, Muller & Frisco, 2006).

Although parents' view that adolescents must receive condom education from their parents in other to avoid the consequences of negative sexual behaviours, few parents are directly able to explicitly provide condom education because they

feel uncomfortable (Hu, Wong, Prema, Fong, Tsai & Vijaya, 2012; Ramarumo, Mudhovozi & Sodi, 2011) and for fear of initiating them into early sexual experimentation (GSS, 2009). In Ecuador it is reported that parents have a restrictive view of sex education as well as condom education however, they expressed willingness to make available good sex education. The restrictiveness of parents being unable to discuss sexual matters with their adolescent children emanates from strict traditional and cultural beliefs of parents on sex and its related issues being dangerous grounds for the adolescent. Parents, educators, and some health providers feel uncomfortable or unwilling to discuss sexual health issues with the adolescent. They incorrectly believe that sexuality education leads to increased or earlier onset of sexual activity (Baldo, 1993; GSS, 2009).

It has been identified that mothers are more positive towards condom education and have a greater intention to provide such education better than fathers (Brown, Rosnick, Webb-Bradley & Kirner, 2014; Hutchinson & Montgomery, 2007; Liying, Xiaoming, Shah, Baldwin & Santon, 2007; Sneed, 2008; Tsvakayi, Baptiste, Holmberk, McBride, Robin-Brown, Sturdivant & Paikoff, 2010). Socio-economic characteristics of parents play a role in parents' perception and readiness to provide condom education for adolescents. Parents with a high level of education and income or wealth are able to educate their adolescents while those with low-level education and income or wealth show little interest in communicating on condom issues (Guilamo-Ramos, Jaccard, Goldberg, Dittus, & Bouris, 2006; Liu, Van, Edwards, & Russell, 2011).

Statement of the Problem

Parents in Ghana are not ready to provide condom education for adolescents though these adolescents are sexually active and therefore Cape Coast Metropolis with high HIV/AIDS prevalence rate (9.6) and teenage pregnancy (14.4%) is of concern (GAC, 2012; GHS, 2015). Parents play a critical role in the development of adolescents such as their physical, emotional and sexual growth by providing education, however, the education from them are insufficient especially on condom education for adolescents' healthy sexual life (Boonstra, 2011). In our Ghanaian society, parents and adults in general shun and refrain from open discussions with adolescents on condom and other sexuality issues (Osei, 2009) with the perception that it will initiate them into early sexual experimentation (GSS, 2009).

Parental perception and social support on condom education and usage (Albarracin, Kumkale & Johnson, 2001) are essential as effective measures in the prevention of STIs including HIV/AIDS infection and unwanted or teen pregnancy. Such education helps adolescents acquire adequate knowledge and well-informed perceptions about sex. Parents, however, do not feel comfortable educating adolescents on condom, they do not want adolescents to do anything relating to sex and they avoid discussing condom and other sexuality issues with them.

Previous research has indicated that sexual activity among adolescents is high in Ghana (Awusabo-Asare, Biddlecom, Kumi-Kyereme, & Patterson, 2006); Central region has 14.4 percent teenage pregnancy rate and about 21.3 percent of

15-19 year adolescents have begun motherhood (GHS, 2015); and HIV prevalence rate of 9.6 in Cape Coast. To improve prevention of HIV infections as well as other sexually transmitted infections (STIs), and teenage pregnancy in Cape Coast and its environs, effective preventive measures such as condom education is critical. Though studies have identified that parents play a vital role in influencing the sexual behaviour of adolescents (Harris, Sutherland & Hutchinson, 2013; Koesten, Miller, & Humert, 2002; Wang, Stanton, Li, Cottrell, Deveaux, & Kaljee, 2013), Ghanaian parents refrain from providing adolescents with education on condom.

Studies on condom education and usage have failed to indicate the extent to which the adults who are custodians of the adolescents positively or negatively influence adolescents' usage of condom in sexual encounters. Adults' controversy in the discussion on sexual matters with adolescents makes the provision of education on condom for adolescents unpopular among Ghanaians. As indicated in 'the 2008 GDHS', the reason for adults not supporting condom education for adolescents is their perception that it promotes early sexual experimentation thereby this study sought to ascertain the perceptions of parents and their intention to provide adolescents with condom education.

Objectives of the study

The main objective of the study is to assess parents' perceptions on condom education for adolescents and their intentions to provide such education to enhance adolescents' sexual health.

Specifically, the research objectives sought to;

1. Investigate parents' views on adolescents source of information on condom

2. Examine parents' place of residence and their intention to communicate and provide condom education

3. Ascertain the influence of parents' perception on their intention to provide condom education for adolescents

Research Questions

1. What in parents' view provide information on condom education for adolescents?

2. Do parents' places of residence influence their communication and intention to provide condom education for adolescents?

3. What are parents' perceptions towards condom education for adolescents, and do they influence their intention in providing condom education?

Hypotheses of the Study

H_0 : There is no significant relationship between parents' education and their knowledge on source of adolescent's information on condom.

H_0 : There is no significant relationship between place of residence of parents and intention to provide adolescents' condom education.

H_0 : There is no significant relationship between parents' perception towards condom education for adolescents and their intention to provide such education.

Significance of the Study

There have been numerous researches on parent-adolescent communication on sexual issues and the influence on adolescents' sexual and reproductive health (Brooks-Gunn & Paikoff, 1991; Fasula & Miller, 2006; Pearson, Muller & Frisco, 2006), yet Ghanaian parents do not feel comfortable educating their adolescent children on condom. The studies conducted on condom in Ghana have been on knowledge and inconsistency in use (Adih & Alexandros, 1999; Awusabo-Asare et al, 2004). Though adolescents are at a higher risk of transactional sex and engage in risky sexual activities, parents shun open discussions on sexual matters with them (GSS, 2009; Osei, 2009). The influence of parents in adolescents' acquisition of knowledge on condom and its usage has not been critically examined. The background characteristics of parents will be assessed to ascertain whether it influences their perceptions about condom education for adolescents as well as their intention to contribute to such education.

This study is significant in that it will bring out the perceptions parents have about adolescents and condom, and the reasons for their intention to provide or not to provide such education. The study will help parents to realize that their role in the provision of condom education for the adolescent is vital to their sexual health development. The results could be of benefit to policy makers and reproductive health providers in drawing policies and programs concerning adolescent reproductive health by placing parents at the fore.

Delimitations

The study was delimited to parents' perception and their intention on educating adolescents on condom and not the parental provision of condom education because the researcher was curious with the topic and wanted to know how parents' perceive the idea of educating adolescents on condom and not how or why they provide condom education.

The parents in Adisadel and Nkanfoa are also delimited as well as their socio-demographic characteristics. The results of this study will be generalized to the parents used for the study and the findings may or may not be applicable to all parents in the Cape Coast Metropolis or the Central Region.

Limitations

The study was limited in not using qualitative method or a mixed method but a quantitative method, the closed-ended questions were found to be limited therefore a qualitative method of data collection such as in-depth interview and/ or focus group discussions could have been more powerful as complexities of parents' perception on condom education would have been explored in the results.

The study was also limited to parents in Cape Coast Metropolis with varying socio-demographic backgrounds.

Definition of Terms

Adolescence – a critical transition period of an individual's life which prepares him or her for adulthood, it spans from ages 10 to 19.

Adolescent – an individual who is within the adolescence period of ages 10 to 19.

Higher-risk sex – sex with multiple partners

Transactional sex – exchange of sex for money, favours, or gifts

Organization of the Study

The study is organized into five chapters. Chapter One is the introductory chapter comprising the background to the study, problem statement, purpose of the study, research objectives, research questions, hypotheses, the significance of the study, delimitations, limitations, definition of terms, and organization of the study.

Chapter Two discusses related literature to the study such as condom education in Ghana, sources of condom knowledge, parent-adolescent communication on sexual health, the concept of perception and intention, perceptions about condom education, and parental intentions to provide condom education. The Chapter also presents the conceptual framework for the study.

Chapter Three describes the study area, the data and methods used. It outlines the research design, study area in respect to its location and size, physical and demographic characteristics, and socio-cultural background. It also entails the target population, sampling procedures, sample size, data and sources, data collection instrument, data collection procedure, data processing and analysis, limitations of the study and ethical consideration.

Chapter Four presents and discusses the results of the study covering all the objectives of the study. Finally, Chapter Five comprises a summary of main findings, conclusions, recommendations and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The study on parental perception and intention to provide condom education for adolescents is essential since parents are the custodians of these adolescents who are sexually active and stand the risk of engaging in risky sexual behaviours. This chapter reviews related literature in relation to the study. It covers the adolescent, condom studies in Ghana, parents' communication and influence on adolescents, parents' role in condom education, parental issues about the provision of condom education, rationale for providing condom education for adolescents, concept of perception and intention, perceptions about condom education, influence of background characteristics of individuals on perception and the Health Belief Model (HBM). It also discusses theoretical issues and the proposed conceptual framework on which the study is based.

The Adolescent

World Health Organization (WHO) identifies adolescence period as a critical transition period of an individual's life which prepares him or her for adulthood. It spans from ages 10 to 19 and is marked by rigorous growth spurts and changes in development (WHO, 2004). The major developmental change within this period is the biological developmental process with the onset of puberty which marks the passage from childhood to adolescence. A study by Hurlock (1967) points out that the adolescence period is more than physical spurts of growth, but involves the development of new interests and attitudes as well as learning of new

patterns of behaviors. This period is characterized by lots of changes in the adolescent thus hormonal, physiological, psychological and emotional (Awortwi & Awortwi, 2004), where boys show interest in girls in a sexual way and girls also show interest in boys in a romantic way (Adegoke, 2013).

The development of adolescent sexuality includes cognitive, emotional, social and moral development. These developments introduce the adolescent to sexual thoughts, sexual feelings, and sexual choices. The adolescent thus begins to show interest in sexual images such as movies, photographs of naked people and other pornographic materials especially in the media (Gruber & Grube, 2000). The adolescent begins to learn more about sexuality and may even experiment what is learned (Halpern & Reznik, 2009). Some adolescents may choose to remain entirely abstinent from sexual activity while others may actively engage in sexual activity. Adolescents who are sexually active may get concerned about consequences of their sexual activities and may begin researching into issues about pregnancy, STIs, and contraceptives. However, those who will remain chaste will still experience sexual thoughts and feelings. The sexual decisions and behaviors of individuals formed from the adolescence period are vital and this will depend on how the adults help them during this developmental period to make informed choices.

The adolescent's physical growth and sexual maturation give rise to intimate relationships (Jha et al, 2010); these developments make the adolescent prey to higher-risk sex and transactional sex (GSS, 2009). A National Adolescent Survey conducted in Ghana in 2004 reports of age 12 – 14 years of both sexes

having heard of sexual intercourse, kissing and fondling with a few (less than 10% of those surveyed) having experienced sex, kissing and fondling (Awusabo-Asare et al, 2004). Adolescents, therefore, need accurate and comprehensive education about sexuality to enable them to practice healthy sexual behavior now and in adulthood. It is known that if adolescents assume obstacles in having condom education, they are likely to encounter negative outcomes to sexual activity (Felice & Feinstein, 1999). Adolescents who are aware and knowledgeable about their reproductive health tend to have a positive attitude towards the use of condom as they perceive it to protect them from STIs including HIV/AIDS and pregnancy. Therefore the education and use of condoms is very essential for the adolescent since they engage in risky sexual behaviors (Rock, Ireland, Resnick & McNeely, 2005) as well as sexual experimentation (Halpern & Reznik, 2009). The adolescent is thus put at higher risk of contracting STIs including HIV/AIDS. 1998, 2003 and 2008 GDHS all indicate the awareness and knowledge of condom use as an effective tool in the prevention of HIV infection as well as other STIs. Advertisements on condom through the media and advertising billboards are not uncommon yet according to the GDHS 2008; condom use at first sex is not common in Ghana.

Though condom knowledge and use among adolescents is widespread (Weinman, Small, Buzi & Smith, 2008), it is still quite low in sub-Sahara Africa (Bankole et al, 2007; Exavery et al, 2012; & Njau, Mtweve, Barongo, Lekule & Jalipa, 2007). Among the adolescents, male's knowledge and use of condom supersedes that of the females (GDHS 2003 & 2008). The 2008 GDHS shows

82.5% of males and 74.9% of females surveyed had knowledge of condom use and 77.6% of males and 76.4% of females had knowledge in the 2003 GDHS. Bankole (2009) and others study on knowledge of condom use in four African countries (Burkina Faso, Ghana, Malawi & Uganda) affirmed that adolescents have ample knowledge on condom use with about 50% to 68% of adolescents responding positively to the knowledge of condom use. The study also indicated that male adolescents demonstrated having better knowledge on condom use.

Adolescents in a fresh relationship find themselves at high risk, therefore, will use a condom at first sexual intercourse but as the relationship progresses the high-risk fear fade and condom use becomes inconsistent or ignored. Adolescents engage in a high-risk sexual activity yet condom use is not consistent among them (Darteh & Nnurom, 2012; & DiClemente, Durbin, Siegel, Krasnovsky, Lazarus & Comacho, 1992). The inconsistent use of condom tends to increase with the length of the relationship (Exavery et al, 2012, 2011; Kayiki & Forste, 2011; Mendes, Nèia, Valenti, Sugishita & Abreu, 2012; & Weinman et al, 2008) and misconceptions on the use of condom (Crosby & Yarber, 2000). Negligibility of condom use exist among young ones in spite of their risky sexual behavior however studies have shown the intention to use (Bauman, Karasz & Hamilton, 2007). According to research, adolescents have ample knowledge about condom and STIs including HIV/AIDS yet it does not reflect in their condom usage (Weinman et al, 2008). Also, younger adolescents (10-14 years) tend to have less knowledge on condom than older adolescents (15-19 years) (Marinho, Souza, Ferreira, Fernandes & Cabral-Filho 2012; Mendes, Schor, Vlenti, Sugishita, Yuri

& Abreu, 2012 & Exavery et al 2011). Adolescent's knowledge and use of condom are determined by the educational level and skills acquisition (Bankole et al, 2007; Anderson & Beutel, 2007), parental communication, peer influence and positive attitude towards condom (Weinman et al, 2008 & Small et al, 2009).

The literature did not indicate the role of parents in adolescents' knowledge and decision on condom usage. Early exposure to sex education or condom education has not been linked to adolescents' increased sexual activity, earlier age of first intercourse or multiple sexual partners.

Condom Education

Condom is the most effective method of HIV/AIDS and STIs preventive method other than abstinence (Kayiki & Forste, 2001) and therefore education on its use and effectiveness is vital across all sectors of the population. Condom education involves teaching the effectiveness, importance and the correct way to use condom. A study on parents via telephone on the provision of condom education for adolescents in schools showed their support (Eisenberg, Bernat, Bearinger & Resnick, 2009). The parents came out that adolescents need condom education but it should be provided in the school setting in the higher levels of education. In the study, parents were of the view that they should be consulted and included as stakeholders in developing school-based programs and education regarding condoms. The study, however, did not find out the perception of the parents in providing condom education to their adolescent children themselves.

Kohler, Manhart and Lafferty (2008) research on sex, contraceptive and condom education indicated that teaching about the condom is not associated with

adolescent early sexual activity. They found out that condom education decreases unwanted pregnancy lower than providing education on abstinence-only or no education at all.

Another research indicated adolescents as being sexually active (Awusabo-Asare et al., 2004; Bankole et al, 2007; Weinman et al, 2008; Darteh & Nnurom, 2012) with their period being associated with unwanted pregnancies and STIs including HIV/AIDS therefore condom education among this group must be encouraged in order to decrease these negative outcomes (Kaplan, Feinstein, Fisher, & Klein, 2001). In their work they hammered on condom education involving its effectiveness, consistent and proper use and that pediatrician and schools must be the channels of education. The study only recommended that parents' awareness of such education must be raised but did not find out parents perceptions of adolescent condom education of which this current study sought to find.

On the other hand, the educational system policy maker, Ministry of Education, do not encourage exclusive condom education and its distribution in basic and second cycle institutions in its policy ("GES to review condom education,"2013)

The forgoing studies on condom education is commendable however they did not involve studies on parents' influence in the provision of condom education to the adolescents though parents are first educators in an individual's life.

Condom Studies in Ghana

The ABC concept is the widely communicated preventive method of HIV (Mugoyela & Charles, 2009; Teye, 2005). The A represents abstinence; B stands for being faithful to ones' partner and the C for condom use in sexual activities. Other research has also come out with behavioral change (Faria, 2008; Antwi & Oppong, 2003), safer sex, food security, and HIV/AIDS prevention education as being KEY in preventing HIV infection among the population. A study by Weller and Davis shows that consistent condom use during sexual intercourse can reduce HIV incidence by 80% (Weller & Davis, 2002).

There has been numerous studies on condom usage in Ghana among which include the use of condom among female commercial sex workers (Adu-Oppong, Grimes, Ross, Risser, & Kessie 2007), superstition associated with the use of condom (Tenkorang, Gyimah, Maticka-Tyndale; Adjei 2011), condom use among People Living With HIV/AIDS - PWLHA (Ncube, Akunna, Babatunde, Nyarko, Yatich, Ellis, Turpin, & Jolly, 2012; Teye, 2005), use of condom among adolescents (Darteh & Nnorom, 2012) and condom use among married women (Tenkorang, 2012).

A study by Adu-Oppong (2007) and others on condom usage by female commercial sex workers (FCSW) in Ghana shows that sex workers insist that their customers or clients use condom before services are rendered in order to protect them from STIs including HIV/AIDS (Adu-Oppong et al, 2007). The study used 450 street commercial sex workers in Accra, Kumasi, and Techiman. It indicated that the level of condom education was low (14%) among the sex

workers however consistent use with clients was relatively high (49.6%). These workers, the study indicated, can deny their clients services if condom use is not adhered to. It identified that age and education of FCSW has a great influence on acceptability and value placed on condom use, showing that FCSW who are 24 years and younger (Nobelius, Kalina, Pool, Whitworth, Chesters & Power, 2012) placed more value on customers using condom as well as those who have had some level of education as compared to the older ones and those with no education.

Another study on commercial sex workers in Greater Accra Region indicated that about 94.8% of the 400 female sex workers (FSWs) studied had knowledge of condom use as a way of preventing STIs including HIV (Amenudzi-Darku, 2013). The study again recorded only 11.7% of the FSWs used condom frequently during sexual intercourse, 76.8% occasionally used and 9.7% used condom on clients they are not familiar with.

A research by James & Wells (2002) showed superstitious belief influences the tendency of individuals to use condom in sexual intercourse in Ghana. The notion is that witches and some supernatural forces somewhere are the causes of most diseases especially HIV/AIDS instead of germs or virus (Tenkorang, Gyimah, Maticko-Tyndale & Adjei (2011). In the study, both men and women who believed that HIV/AIDS can be spread through witchcraft and other supernatural beings were less likely to use condom yet they engage in sexual intercourse. The belief is more pronounced in the Akan-speaking regions of the country namely Ashanti, Brong-Ahafo, Central, Eastern and Western where witches are believed

to be the cause of most illness. The study indicates that this belief has impacted HIV prevention behaviors such as condom use. The Akan ethnic group in Ghana reported lower condom use since they are the most superstitious group in the country (Tenkorang et al, 2011).

Studies show that sexual activity among adolescents in Ghana is high (Awusabo-Asare et al, 2006; GSS, 2009) yet their sexual debut and subsequent encounters are devoid of condom use thereby exposing them to HIV infection (Awusabo-Asare et al, 2004; Darteh & Nnorom, 2012; Mendes et al, 2012; Nobelius et al, 2012). A study in Ghana in 2004 showed that by age 20, about 83% of women and 56% of men have had sex however condom use at last intercourse among those who had sex in the last twelve months recorded 16% among females and 28% among males (Awusabo-Asare at al, 2004).

Darteh and Nnorom (2012) study on sexual activity among urban adolescents identifies the need for enlightenment on adolescents' reproductive health issues so as to improve acceptance and usage of condom in their sexual encounters. In their study, it came out that though a greater percentage of the adolescents' first sexual encounter is planned (68% of females and 62% for males), condom use was not consistent showing that about 37 percent of the adolescents who had sexual intercourse seldom used condom.

A study on young Ghanaian females showed that most sexually experienced adolescent females do not know where to get condoms and this poses as a risk factor for STIs including HIV infections. They were also not discussing contraceptives with their partners (Ohene & Akoto, 2008).

A study in Yilo-Krobo district in the Eastern region among males aged 15 to 24 who had ever had sexual intercourse indicated that only 21% of them ever used a condom at the last sexual intercourse signifying a greater percentage of 79% not using condom in their sexual encounters (Adih, & Alexandros, 1999). In another study of 12 to 24-year-olds in three Ghanaian towns showed that premarital sexual activity is common but condom use is minimal although the level of awareness is high. The study found that about 65% of the respondents thought it appropriate for males to carry condoms with 78% indicating that it is inappropriate for females to carry condoms (Glover, Bannerman, Pence, Jones, Miller, Weiss, & Nerquaye-Tetteh, 2003).

A research on sexual risk behavior of People Living with HIV/AIDS (PLWHA) indicated that condom use was high but quite a number still have unprotected sexual intercourse (Ncube, Akunna, Babatunde, Nyarko, Yatich, Ellis, Turpin, & Jolly, 2012). Ncube and others study showed a strong association between one's disclosure of HIV status and protective patterns of condom use. Another study on PWLHA and condom use shows that individuals who are willing to have children will not use condom irrespective of their partners HIV status (Teye, 2005). Therefore PWLHA individuals who want to reproduce will less likely use condom in their sexual encounters.

Also, Tenkorang's (2012) study on married women and condom use indicated that married women are less likely to negotiate for safe sex than non-married women as condom use is largely restricted to sexual encounters outside of marriage (Bauni & Jarabi, 2003). Females with high educational attainment and

wealth can also negotiate with their partners on condom use to ensure safer sex than those who are less wealthy and have high education.

Other studies considered the barriers that influence adolescents decision in using condom; such as confidence in using condom, social support of condom use (Albarracin, 2004), alcohol use (Sarkar , 2008; Tung, Farmer, Ding, Tung & Hsu, 2009) and misconception of reduced sexual pleasure.

Studies in Ghana on condom have mainly focused on knowledge, consistency and correct use without delving into how parents' perceive condom education and their intention to provide such education for the adolescent child.

Parents' Communication and Influence on Adolescents

The family is widely known to be the most prominent and continuing influence in an individual's life, though this phenomenon is quite complex, it is taken that since a child attains the first experience from the family, especially the parents for that matter their influence cannot be ignored in an individual's behavior. Parental communication according to Epstein (1986) is vital in parental involvement in adolescents' development. As a result, over the years, parents' involvement is of major concern for policymakers, educators, and researchers (Lopez, 2001; Henderson & Mapp, 2002).

Parental communication in a positive way has been found through research to influence condom use among adolescents (Dilorio, Pluhar, & Belcher, 2003). A study on Bahamian students indicated that parents who were identified with problematic parent-adolescent communication had their adolescents being associated with risky behaviors such as substance use, delinquency, and sexual

activities. Parents who had knowledge and control of their early adolescent children were able to reduce their risky behaviors in middle adolescent years (Koesten, Miller & Hummert , 2002; Wang et al, 2013).

Several studies and researches have shown that parents exert a greater influence on their children and for that matter individual's behavior and life in areas of development and decision making. A study by Harris, Sutherland, and Hutchinson (2013) has identified that parent-child relationship and parent-child communication between parents and children can help in reducing their sexual risk behavior. In their study, they sought to find out parental influences of sexual risk among male African American adolescents and they came to the conclusion that parents who are closely related to their adolescent children are able to communicate well on sexual behaviors and that influence their decision in matters relating to sexual activities. They found out that parents who communicated well with their children produced adolescents who had less permissive attitudes towards sex, who had more positive attitudes towards condoms and had the greater intention of using condoms. Their study also showed that mothers were more likely to communicate on sexual topics than fathers to the young ones and thus exerts a greater influence (Hutchinson & Montgomery, 2007; Liying et al, 2007; Sneed, 2008; Tsvakayi et al, 2010; Harris et al, 2013).

This supports a study by Calhoun & Friel (2001) that mothers play a significant role in preventing teen pregnancy and that the impact of adolescent sexual behavior is mostly influenced by the level of parent- adolescent closeness. Other researches show that mothers can penetrate into adolescents and make them

feel at ease in discussing issues relating to their reproductive health and as a result adolescents feel more comfortable and relaxed to approach their mothers on condom education discussions and other contraceptive issues (Commendador, 2010; Fox, 1980). The study supported that maternal influence and communication significantly determines adolescent's sexual activeness and effective use of contraceptive among adolescent girls.

However a study by Ramarumo, Mudhovozi and Sodi (2011) showed difficulty mothers encounter in discussing issues pertaining to adolescent sexuality with them especially concerning the use of condom to prevent pregnancy and STDs including HIV infection nevertheless the mothers came out with the fact that knowing about sexual issues and facing the adolescent with the facts is the best way in helping them develop healthy sexual life. They were of the view that children must receive sex education as well as condom education from their parents in other to avoid the consequences associated with negative sexual behaviors such as HIV infection and teen pregnancy.

Barnett (1997) in a study on gender norms affecting adolescent indicated that in some cultures, parents and family members such as aunts, uncles, and elder sisters are influential sources of knowledge, beliefs, attitudes and values for children and youth. Their role the study showed is vital in the adolescent development as they are role models who shape adolescents' perception of gender roles and influences the choices the adolescent make about their sexual behavior. These adults can help their adolescent relations to develop and practice responsible sexual behavior and personal decision-making. According to Barnett,

adolescents who live in a stable family environment and stay close to their parents are likely to remain sexually abstinent, postpone intercourse, have fewer partners and use condom.

Another study shows that parental influences and communication can play a significant role in reducing sexual risk behaviors. It indicated that parents who communicate their perceptions, attitudes, beliefs and values about sexual activity can affect their children's attitudes and beliefs about sexual activity and thus positively influence their sexual risk behaviors (Brooks-Gunn & Paikoff, 1991). Moore and Chase-Landale (2001) also indicated in their research that adolescents who feel positive about their parents will listen and absorb their parent's values and beliefs. As parents discuss issues on sexual issues with their adolescent children, it is able to delay their involvement in early sexual intercourse (Fasula &Miller, 2006; Pearson, Muller &Frisco, 2006).

A research on parents-adolescent communication and Hispanic youth showed that open parent-adolescent communication about sex and condom use greatly affects an individual's condom use behaviors (Ebersole, Miller-Day & Raup, 2014; Malcolm, Huang, Cordova, Freitas, Arzon, Jimenez, Pantin, & Prado, 2014;). It showed that omission of parent-child relationship can jeopardize efforts to improve adolescent health.

Parents and adults play a significant role in behaviors of young people's risk taking behavior. That is if parents monitor adolescents, their involvement in sexual activity and risk of unprotected sex is greatly minimized. A study by Biddlecom and others in 2009 in four African countries on parental monitoring

and adolescents strongly showed that parental monitoring had a significant impact on adolescent sexual activity and contraceptive use. The study showed that across all four countries, parental monitoring was strongly associated with reduced adolescent sexual activity.

The family's involvement in communication with their adolescent children on sexual issues such as responsible sexual life, education on STDs and contraception has a positive influence on adolescent's contraceptive decision making (Aspy, Vesely, Oman, Rodine, Marshall, & McLeroy, 2007). Adolescents who received education from home on delayed sexual activities and contraception are likely to use contraceptives in their sexual activities (Romer, Stanton, Galbraith, Feigelman, Black & Li, 1999; Casper, 1990) and that it plays a role in adolescent's use of a specific contraceptive type (Frisco, 2005). The influence of parents cuts across all sectors of adolescent development. A study by Ornelas, Perreira & Ayala in 2007 on parental influences on adolescent physical activity showed that parents play an important role in the development of children's lifestyle. Parent-child communication and parental engagement in their children's life strongly influence their participation in planned programs for them.

Research has noted that gender and cultural norms play a significant role in determining parents' communication on sexual issues. In Ghana, cultural norms and family living situations pose as a limitation to parent-child sexual communication (Kumi-Kyereme, Awusabo-Asare, Biddlecom, & Tanle, 2007).

These studies have identified the merits of parental involvement in parent-adolescent communication on the development in all areas of the adolescent

including reproductive health. They however did not critically indicate the effects the absence of parent involvement in issues concerning the reproductive health of the adolescent such as providing condom education will have on adolescents.

Parents' Role in Condom Education

Parents are seen as primary sexual educators (PSEs) and they are expected to be 'open and frank' to talk about condoms to be able to provide the necessary education needed by the adolescent. Parents as PSEs increase parent-child communication about sexuality which includes condom and other contraceptives education (Klein, Sabaratnam, Pazos, Auerbach, Havens, & Brach, 2005).

A study showed parental involvement and influence to impart positive attitudes in the adolescent towards sexual activity by delaying sexual initiation (Biddlecom, Awusabo-Asare & Bankole, 2009; Shtarkshall, Santelli & Hirsch, 2007). But in their study, the parent was perceived to support the schools in providing condom and sex education but not put at the fore of the education which this current study aims at finding. A research by Dyson (2010) also indicated that parents play a role as passive educators by supporting condom and sex education in schooling, and ensuring that the contents and educators have the skills and qualification to provide such education. Planned Parenthood of Massachusetts has come out with benefits of parents playing a role in the education on sex, contraceptives, and condoms. Such benefits include; interpretation and correcting information got from peers, adolescents able to avoid negative peer pressure and sexual exploitations, and postponement of sexual activity.

From the fore going, parents' role in the education on condoms for the adolescent cannot be overruled therefore their perceptions and intention on the provision of such education ought to be assessed.

Parental Concerns about their Provision of Condom Education

A study on how parents communicated about contraceptive and condom usage with their adolescent and pre- adolescent children indicated that though a greater number of parents professed to be open about sex and its related issues only a few really directly were able to explicitly discuss with their children matters on their sexuality. Some parents in the study expressed the fear of initiating their children into sexual activity with such discussions thus supporting the concern raised in the 2008 GDHS survey. The parents assumed such discussions must take place in the school setting. A study conducted in Singapore indicated that parents saw the need for parent-child communication on sexual issues such as condom education but felt uncomfortable to initiate such communication. The study showed that just about half of the parents studied were able to initiate a conversation about sex with their children (Hu, Wong, Prema, Fong, Tsai, & Vijaya, 2012). Though parents are aware of their children's sexuality many do not discuss issues surrounding their sexuality or condom usage with them before the onset of their sexual debut (Beckett, Elliot, Martino, Kanouse, Corona, Klein & Schuster, 2010).

A study in China on parent- adolescent communication on issues about sex showed that adolescents are more likely and feel relaxed in discussing matters of their sexuality with their mothers more than their fathers (Liying et al, 2007;

Pluhar, Dilorio & McCartey, 2008). Mothers who are more comfortable and have greater self-efficacy for talking about sexuality with children are able to frequently communicate about condom education with their adolescent children (Diiorio, Resnicow, Dudly, Thomas, Wang, Van, Manteuffel & Lipana, 2000). A study by Sneed (2008) also came out that the adolescents studied reported being more comfortable to discuss issues about their sexuality with their mothers in comparison to their fathers.

Sexuality and its related issues appear to be a concern between parents and adolescents in communication. It has however been identified through research that mothers can penetrate into adolescents and make them feel at ease in discussing issues relating to the topic. Such is seen in the research conducted on Latino mothers and their adolescent children. In the study, the mothers expressed difficulty in discussing issues pertaining to adolescent sexuality with them especially concerning the use of contraceptives such as condom to prevent pregnancy and STDs including HIV infection. But the mothers came out with the fact that knowing about sexual issues and facing the adolescent with the facts is the best way in helping them develop healthy sexual life. In a similar study, mothers were of the view that children must receive sex and condom education from their parents in order to avoid the consequences associated with negative sexual behaviors (Ramarumo et al, 2011) such as HIV infection and teen pregnancy.

Research has also shown that socioeconomic characteristics of parents play a role in ensuring parent-adolescent communication on sexual issues such as

condom usage. Parents with a high level of education and income or wealth are able to communicate well with their adolescents while those with low-level education and income or wealth show little interest in communicating on such matters (Guilamo-Ramos et al, 2006; Liu, Van, Edwards, & Russell, 2011).

A study on sex education in Ecuador reported parents having a restrictive view on sex and condom education though they expressed willingness to make available good sex education. The restrictiveness of parents being unable to discuss sexual matters with their adolescent children emanates from strict traditional and cultural beliefs of parents on sex and its related issues being dangerous grounds for the adolescent. Parents, educators, and some health providers feel uncomfortable or unwilling to discuss sexual health issues including condom education with adolescents. They incorrectly believe that sexuality education leads to increased or earlier onset of sexual activity (Baldo, 1993; & GSS, 2009).

Studies have shown that parents are concerned with adolescents' knowledge about their reproductive health issues such as condom education. On the other hand, these studies did not identify if parents are willing or have the intention to provide such knowledge to adolescents of which this study seeks to identify.

Rationale for Providing Condom Education for Adolescents

The provision of condom education for adolescents is vital considering factors such as their nature, subject to peer influence, engaging in the risky sexual behaviour, being at high risk of transactional sex, eroding sexual immorality in

our society, increasing HIV/AIDS infections and for sexual health enhancement in adulthood.

The nature of the adolescent required the provision of condom education for them (Akpama, 2013). United Nations Children's Emergency Fund (UNICEF) describes the adolescence period as being filled with curiosity about their body and exploration of the world. This period is characterized by lots of changes in the adolescent thus hormonal, physiological, psychological and emotional (Awortwi & Awortwi, 2004), where boys show interest in girls in a sexual way and girls also show interest in boys in a romantic way (Adegoke, 2013). The adolescent begins to learn more about sexuality and may even experiment what is learned (Halpern & Reznik, 2009).

Adolescents are more exposed to peer influence which has negative consequences on them. Peer influence involving peer pressure and peer norm exposes adolescent to sexual activity and teen pregnancy as quite a number of adolescents of both sexes engage in sex before they are actually ready due to this influence (Allen & Antonishak, 2008). The physical growth and sexual maturation give rise to intimate relationships (Jha et al, 2010); these developments make the adolescents prey to higher-risk sex and transactional sex (GSS, 2009).

Modernity today has exposed the adolescent to much about sexuality. Sexuality is available everywhere on television, paper prints, cinemas, billboards and radios (Bose, 2008; Akpama, 2013). These medium expose the adolescent to sexual sceneries which they may want to experiment. The increasing eroding sexual morality that has engulfed our society (Akpama, 2013) with its high HIV

infection prevalence rates (1.3%), STDs and teen pregnancies, adolescents need condom education. The knowledge of condom and its importance will help them build a healthy sexual life in adulthood.

Concept of Perception and Intention

Perception is the process of recognizing and interpreting sensory stimuli. That is the way one thinks about or understands someone or something. Perceptions of objects and knowledge or belief about something emanates from an individual's mind. Protagoras, 450 B.C. stated that 'Man is nothing more than a bundle of sensations'. The constructivist theories see perception as the result of the interactions between stimulus and internal hypotheses, expectations, and knowledge of the individual with motivations and emotions playing a vital role (Eysenck & Keane, 2008; Démuth, 2013). A constructivist, Gregory (1970) in his top-down theory indicates that perception is a constructive process in which our perception of reality or issues is actively constructed based on our past experiences from the environment and stored knowledge or information. Individual's perception is based on their perceived view of what really is and not on what reality actually is. Perception is dynamic in according to how one views reality within his or her environment in the wider world. People's perception can be influenced by their experience, expectations, social setting, and other background variables (Thu Ha, & Ayda, 2014).

Intention is a mental state that represents an individual's commitment to perform an action. It is considered as a mental construct of an ordered series of action considered to complete the desired outcome (Kuhlmann & Kristin, 2009).

Mental state includes capturing an individual's assessment of whether an issue or object holds fact or not (Shoham, 2009).

The Theory of Reasoned Action predicts that perception of how importance behaviour is to individuals determines their intention to perform that behaviour (Fishbein & Ajzen, 1975, 1980). Thus the perceived quality, value or risk a product or behaviour is influenced by people's intention to perform such behaviour or accept such a product (Asshidin, Abidin, & Borhan, 2016).

Perceptions about Condom Education

A study has shown that adolescents' adoption of a given behaviour hinges on social approval and support like that of a parent (Rossem & Meekers, 2011; Tarkang, 2014). If parents negatively disapprove of condom, providing education for the adolescent will be difficult. A study by Crosby et al (2013) indicated some negative perceptions adults have about condom. They perceive it to reduce pleasure during sex and breed mistrust or distrust when a partner uses it. Another showed adults dislike of condom due to their low perception of risk and vulnerability to STDs and HIV/AIDS infections (Hall, 2015). Studies show the positive perception of condom when there is parental and social approval of condom education and usage for the adolescent.

Studies have shown positive perceptions towards condom and sex education for adolescents but the parents see it as a responsibility of the school (Dyson, 2010; Henderson & Mapp, 2002; Lopez, 2001; Shtarkshall et al, 2009). Parents are also concerned about the contents of the condom and sex education provided (Dailard, 2001).

Influence of Background Characteristics of Individuals on Perception

Several studies have indicated that the background characteristics of individuals influence their perceptions about issues. Such was the study by Essendi and Madise (2014) who showed that background characteristics such as age, gender, education and income level of individuals influence their perception about development. Chow and Bai (2010) also indicated in their study on Chinese elders that socio-demographic characteristics of people influence perception. They came out that age, place of residence; marital status and employment status have an effect on the elders' perception of the image of aging. A study identified socio-demographic characteristics such as age, sex, education, employment and residence to influence individuals' perception of the environment. They accessed these variables with perception about environmental quality.

The fore going studies have identified that background characteristics of individuals influence perceptions about issues but did not show if the perceptions developed has any influence on an individual's intention about the issues.

The Health Belief Model

The Health Belief Model (HBM) by social psychologists Rosenstock, Hochbaum, Kegeles and Leventhal in the 1950s explained and predicted health behaviours such as condom education.

The HBM identified perceived susceptibility, perceived severity, perceived benefits, perceived barriers and self-efficacy as accounting for peoples' readiness or intention to act. In the model, how serious one sees a condition and its consequences, ones' belief in its efficacy, ones' psychological cost and one's

confidence in the ability to perform the act influences their readiness or intention to perform the act. The theory as used by Glanz and others in 2002 indicated that socio-demographic variables such as age, sex and education modify the perceptions of individuals in their likelihood to perform an action.

Theoretical framework: Fishbein & Ajzen's Reasoned Action Approach (1980)

The theoretical framework of this study is centered on the theory of reasoned action approach (RAA) by Fishbein & Ajzen (1980). Ajzen states that "attitudes towards a behavior, perceived norms, and perceived behavioral control determine people's intentions". And that a person's attitude toward a behavior consists of a belief that that particular behavior leads to a certain outcome and an evaluation of the outcome of that behavior. The theory of Reasoned Action Approach is based on the presumption that human beings are reasonable and pragmatic such that when making decisions or taking an action will systematically use the information available to them to make logical and desired action. This action is based on the individual's perceptions and attitudes (positive or negative feelings) towards that behavior and their subjective norms. An individual's behavior is predicted by attitudes towards that behavior and the perceptions on how other people would view their behavior.

Perception is the result of the interactions between stimulus and internal hypotheses, expectations, and knowledge of the individual with motivations and emotions playing a vital role (Eysenck & Keane, 2008; & Démuth, 2013). Wood, Zeffane, Fromholtz and Fitzgerald (2006) define attitude as "a predisposition to

respond in a positive or negative way to someone or something in our environment". Simonson and Moushak (2001) explains attitudes as relating to how people perceive situations in which they found themselves as in the direction (positive or negative), in degree and in the intensity (the amount of commitment which a position is held). Intention is a mental construct of an ordered series of action considered to complete the desired outcome (Kuhlmann, 2009).

As a person forms beliefs about an object, he automatically and simultaneously acquires a perception towards that object. Each belief formed links the object to some attributes. Perception is usually acquired towards some object when there is the realization or an expectation of an association with other objects, attributes, qualities or actions by which one already has a perception towards within the environment (Eysenck & Keane, 2008; & Démuth, 2013). These attitudes are functions of beliefs linking the attribute to other characteristics and evaluations of those characteristics. Perceptions tend to be positive towards things deem 'good' and negative towards 'bad' things. A person's life experiences lead to the formation of many different perceptions about various objects, actions, and events. A person is viewed as processing the information he/she has about an object in arriving at his evaluation of the object. Meaning human beings evaluate their perceptions and attitudes and make attributions based on what they believe might have caused them. As Protagoras, 450 B.C. stated that 'Man is nothing more than a bundle of sensations'. That is individual's perception towards condom education may be due to the individual's knowledge that adolescent condom education must take place in the school setting (Lopez, 2001; Henderson & Mapp,

2002; Shtarkshall et al, 2009; & Dyson, 2010) and or educating the adolescent on condom in that early life may lead them to experiment sex early as indicated in the 2008 GDHS.

The Reason Action Approach indicates that the willingness of an individual to perform a behavior is predicted by that individual's intention to perform that behavior. Intentions are thus conceptualized as the readiness to engage in a particular behavior by a person (Roberto, Krieger, Katz, Goei & Jain, 2011). Fishbein and Ajzen's Reasoned Action Approach is diagrammatically shown in figure 1.

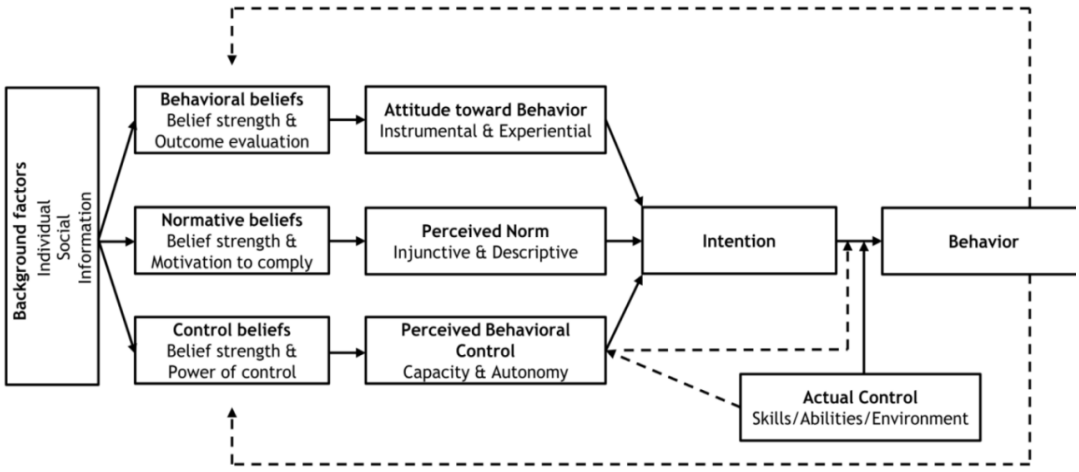

Figure 1: Fishbein and Ajzen's (1980) Reasoned Action Approach

Definition of concepts in the theory

- Behaviour: this comprises the action performed, the target at which the action is directed, the context in which the behaviour is performed, and the time at which it is performed

- Intention: this is an individual's perceived probability or likelihood of performing a given behaviour
- Perceived behavioural control: it encompasses individual's perceptions of the degree of which they are capable of, or have control over performing a given behaviour. This comprises the capability to perform the behaviour, and autonomy being the perceived degree of control over performing the behaviour
- Perceived norm: this is the perceived social pressure to perform or not to perform a given behaviour
- Attitude: is a predisposition to respond to an object in a consistently favourable or unfavourable manner. It comprises instrumental aspect which is an individual's anticipated positive or negative consequence, and experimental aspect which is the perceived positive or negative experience.

The Reasoned Action Approach as a theoretical framework backing this study is necessitated as the perception and intention of parents to provide condom education is under study in this work. The approach posits that perceptions and attitudes inform intentions of an individual which further predicts the individuals' performance of the behaviour. The background factors such as the parents individual values and traits; social life comprising education, age/gender, religion; and information in the form of knowledge (Fishbein & Ajzen, 2010 &1980) on the object when delved into will bring out their perceptions and intentions in accepting or not accepting that they have to provide condom education for

adolescents. The study will be explored using the Integrative Model of Behavior Prediction (IM) as the conceptual framework. The IM as a conceptual framework was founded on the theoretical framework of the Theory of Reasoned Action Approach by Fishbein and Ajzen.

Conceptual Framework

The Integrative Model of Behavior Prediction used by Marco Yzer (2012) as a tool for designing health messages which was capped from Fishbein's Reasoned Action Approach is the conceptual framework guiding the study. The Integrative Model was first introduced by Fishbein in his address delivered to the 4th AIDS Impact Conference in1999 and stressed that Integrative model (IM) is a tool for designing and evaluating health behavior change and intervention. IM is the latest model by Fishbein which represents the Reasoned Action Approach (RAA) to understanding behavior whereby only a few of the numerous variables need to be considered in the prediction or reinforcement or change in certain behavior in populations.

According to Fishbein (2008), the IM is a model formulated to help improve public health in the areas of decision making and preventive health actions on certain health issues by members of the public. The model postulates that irrespective of how a particular behavior or action is defined, the RAA suggests that the best predictor of whether one will perform a behavior or not is the person's intention to perform that behavior.

Integrative model (IM) hinges on the fact that though a number of variables may in a way influence behavior, just a few of these variables needs to be

considered in predicting or explaining the behavior of a targeted population in any situation (Fishbein & Ajzen, 2008, 2010). Al-Rafee and Cronan (2006) came up with six variables that affect an individual's attitude in how he/she behaves and makes decisions. These variables they indicated are individual's sex (gender), age, cognitive beliefs, affective beliefs, perceived importance and subjective norms. The Integrative Model is shown in Figure 2.

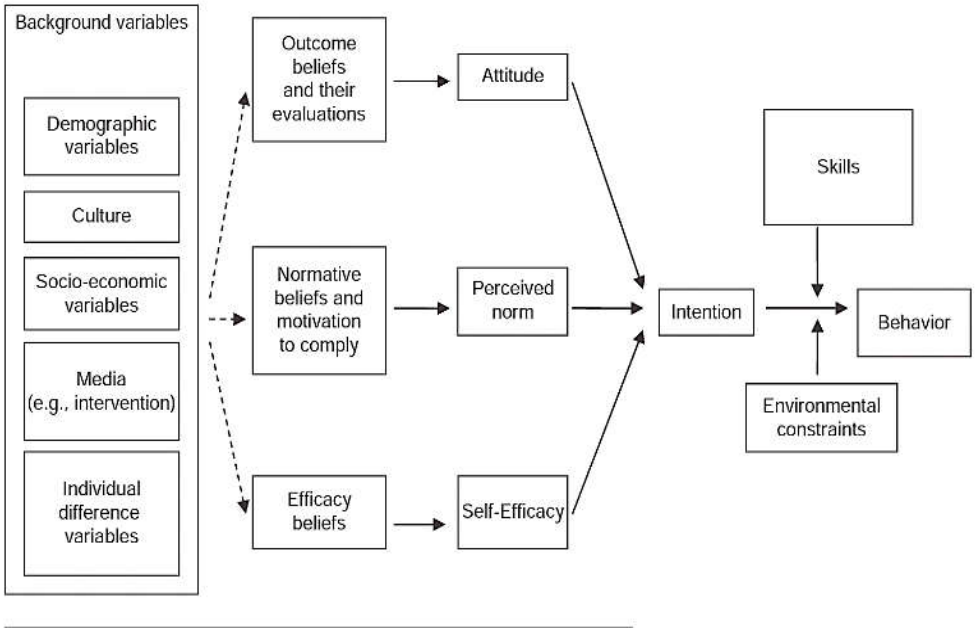

Figure 2: The Integrative Model of Behavioral Prediction

Source: Yzer (2012.

Integrative Model (IM) posits that an individual's intention to perform a behavior emanates reasonably from some specific beliefs that individual have about a behaviour. That is if people believe performing a behaviour is a good thing, they are more inclined towards performing that behaviour. The IM predicts that people act on their intention based on the perceptions, self-efficacy, the

necessary skills they have and the environmental factors that do not impose behavioral performance. It generally accepts intentions to be a function of three types of perceptions; which are attitudes, perceived norm and self-efficacy. Attitudes, perceived norm, and self-efficacy shine an individual's perception of a behavior (action) and determine an individual's intention to perform a behavior or action. These determinants are explained by the model as follows:

Attitude - a person's evaluation of how favorable or unfavorable his/her performance of a particular behavior would be.

Perceived norm - the social pressure an individual expects upon performing a particular behavior. There are two aspects of perceived norm, injunctive norm, and descriptive norm. Injunctive norm is how important social networks support the individual's performance. Descriptive norm is the extent to which other members of the network perform the behavior themselves.

Self-efficacy - the extent to which a person feels capable of effectively performing the behavior.

In the case of condom education for the adolescent, parents' perceptions are their evaluation of how good or bad (pleasant or unpleasant) education of condom for the adolescent is to them. The injunctive norm indicates how significant people such as religious group members and family members will support them in accepting condom education for their adolescent children. The descriptive norm is the parents' perception of how other parents support and educate their adolescent children on condom use. Self-efficacy is the extent to which the

parents themselves feel comfortable and capable in wanting to support the education and how effectively they can hold such support.

According to the model, the attitude, perceived norm, and self-efficacy are determined by an individual's background factors. These factors immediately determine the perceptions of an individual which influences the intentions and whether the behavior will be performed or not. These determinants are demographic variables (sex), socioeconomic variables (education, occupation), and individual difference variables.

Parents' locality of stay, gender, the level of education, occupation, and religion in Ghana plays a major role in the acceptance of any form of education concerning the adolescent in their development including their sexual health issues. Parental involvement in children's education significantly aid in their academic and social performance (Hoover-Dempsey & Sandler 1995; Jeynes, 2003).

The immediate determinants of behavioral intentions such as one's locality of stay, education, gender, occupation and the religious affiliation greatly influence any form of communication or education on the sexuality of their adolescent children including condom. The immediate antecedent of a decision by a parent to agree or disagree to educate the adolescent on condom use is essential in this study since parental perceptions and intentions are the key concepts under study in this work. These intentions backed by the skills that parents have (personal knowledge and the importance of condom) and the environmental constraints

influence the willingness or readiness of parents' to provide condom education for adolescents.

Parents' readiness to communicate about condom and its usage with their adolescent children can even open conversations relating to other problematic sexuality issues confronting the adolescent. All of the variables in the immediate determinants of behaviors intention play a role in how and why parents are essential in the education of their adolescent children on condom. The need to analyze parents' perceptions on providing education on condom will shed light on parents' intention to engage in communication on the issues about condom. Parents' perception about condom education for adolescents, the social norms they perceive related to adolescent knowing about condom, their beliefs and expectations of such conversations, their self-concept and how it relates to their awareness of adolescent knowledge about condom, as well as parental emotions or feelings and the self-efficacy in carrying out communication with their children will all contribute to parents' intention to provide condom education.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter describes the research design, study area, target population, data collection instruments, data and source, sample size, sampling procedure, data collection procedures, data processing and analysis, limitations of the study and ethical consideration.

Research Design

Research design refers to the way in which a research idea is transformed into a research project that can be carried out in practice by a researcher (Cheeks, 2008). The study adopted the quantitative research methodology in the collection of data and analyzing the data. This conforms to the positivists' position derived from the natural science which adheres to objectivity, reality, and truths. The positivists perceive human beings to be rational individuals who are shaped by their social world but are subject to fixed patterns of life in which truths can be gathered by observation, experience and measured empirically using the quantitative methods such as surveys, questionnaires and statistical or numerical analysis (Sarantakos, 2005; Babbie, 2010).

This study was conducted using the survey design. The descriptive research design was used to enable the researcher survey parents' perceptions on condom education for adolescents. Descriptive design provides a meaningful picture of events and a clear explanation of items which are not clear in responses to the follow-up questions usually provided (Manion & Cohen, 1994). This study design

was ideal as perception and intention of parents were under study. Human beings are rational individuals who are shaped by their social world in which their experiences and expectations of the reality of the world are vital in their predictions of occurrences and outcomes (Sarantakos, 2005). The descriptive design focuses on answering the 'what' and 'why' questions. It made use of questionnaires to collect information from the respondents who were chosen at random. Descriptive design makes statistical analysis possible in which significant relationships and correlations between variables can be accessed making it probable for generalizations about a population from the sample. Thus, the researcher is able to generalize findings and make inferences about respondents' characteristics, perceptions and intentions by using the descriptive research design.

Due to the nature and length of the study, observation, focus group discussion, and personal interviews would not have provided the honesty needed and would have added bias and inconsistency in the administration of the survey instrument. It would not have provided the concrete data needed for statistical analysis.

This research design was useful as the study aimed at looking out for the relationship between variables and also to test hypotheses.

The Study Area

Location and size

The study area is the Cape Coast Metropolis in the Central Region of Ghana. It lies within latitudes 5º.07' to 5º.20' north of the equator and between longitudes 1º.11' to 1º.41' west of the Greenwich Meridian. It is located on the

west of Accra, the capital of Ghana. It is bounded on the north by Twifu-Heman Lower Denkyira district, on the south by the Gulf of Guinea, on the west by Komenda/Edina/Eguafo/Abrem district and on the east by Abura/Asebu/ Kwamankese district. The Metropolis covers an area of 122 sq. km (12,200 ha). It is the smallest metropolis in the country with Cape Coast as its administrative capital. It comprises 19 communities namely; Akotokyere, Ekon, UCC, OLA, Pedu, Abora, Adisadel, Nyinasin, Nkanfoa, Kakomdo, Effutu, Duakor, Amama, Amisano, Ankaful village, Essuekyir, and Kokoado.

Demographic characteristics

The total population of the Metropolis from the 2010 population and housing census is 169,894 of which 82,810 (48%) are males and 87,084 (52%) are females (GSS, 2012) with a sex ratio of 95 males per 100 females and an annual growth rate of 3.1%. The Metropolis has 76.7% of its inhabitants living in the urban area and 23.3% in the rural area. The average household size is 3.5 persons per household. About 24.8% of the household population live in a nuclear setting of father, mother, and children, while 12.9% are in single parent nuclear families with few households (2.2%) having any children. About 31.2% of the population comprises adolescents.

Socio-cultural background

The inhabitants of Cape Coast are known as Fantes and the dialect spoken is Fante. However, the numerous institutions have brought in varied ethnic groups all over the country and beyond to the metropolis.

The metropolis served as a center for the early Christian missionaries and therefore the dominant religion is Christianity (85.1%) with about 9.7% Muslims and 0.3% traditionalist (GSS, 2012). The Christian bodies comprise Catholic, Anglican, Methodist, Presbyterian, Lutheran, Pentecostal and Charismatic groups.

Main economic activities

The main economic activities are fishing and farming. Most of the indigenes are fishermen and fish mongers. The farmers cultivate trees crops such as oil palm, citrus, and coconut; crops such as maize, cassava, pepper, cabbage, lettuce, carrots and the rearing of livestock. Some inhabitants are found within the service industry such as banking, teaching, health, trading and many others.

The Metropolis is endowed with infrastructural facilities such as roads, educational institutions, and health facilities. The compact nature and spatial limitation of the Metropolis have made it possible for all parts to be interconnected by roads.

Almost all communities have access to basic educational facilities but second cycle and tertiary institutions are concentrated in the southern part of the Metropolis. There are 18 secondary and 4 tertiary institutions in the south with only one in the north at Efutu. The Metropolis has 18 health institutions which fall under both government and private.

The characteristics of the population were significant in that it gave the researcher a fair idea of the population under study since their background characteristics were being used to access their perception and intention to provide condom education for adolescents.

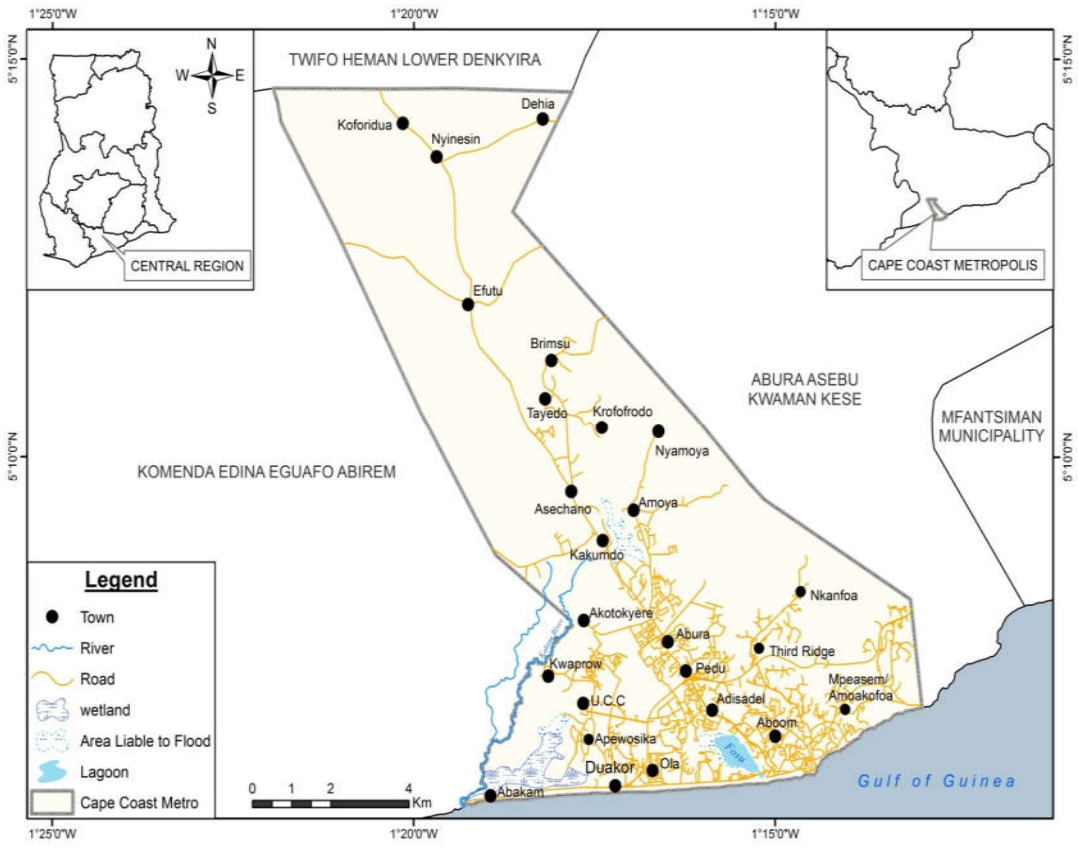

Figure 3: Map of Cape Coast Metropolis

Source: GIS Unit, UCC, 2014

Target Population

Population in a research according to Ross (2005) is a finite population that consists of elements or persons who conform to some designated set of specifications. The population for this study was parents of both sexes aged 18 years and above. This age bracket was taken because it contains adults who may be parents and it is parents' perception under study.

Sample Size

A sample is a representative selection of a population in a research (Kadam & Bhalerao, 2010; Sarantakos, 2005). Frey, Botan & Kreps (2000) defined a sample as a subgroup of a population.

A sample size is the number of participants in a sample (Kadam & Bhalerao, 2010). Determining a sample size in research is necessary because it is usually impossible, not natural or not practical to have a complete coverage of an entire population (Sarantakos, 2005; Kadam & Bhalerao, 2010). A sample size is needed since it makes research more efficient, economical and enables the researcher to get more detailed information (Sarantakos, 2005).

In calculating the sample size for this study, Yamane's (1967) simplified formula will be used. The mathematically derived Yamane formula is below:

$$n = \frac{N}{1+N(e)^2}$$

Where **n** is the sample size (required responses), **N** is the population and **e** is the level of significance which is the acceptable sampling error.

From the 2010 census, the population of the persons aged 18 years and above in the Cape Coast Metropolis was 110333. Using this figure, the sample size will be 398. The calculation in getting the sample size was done using Yamane's sample size mathematical formula as follows: **N** = 110333**. e** = 0.05.

$$n = \frac{N}{1+N(e)^2}$$

$$n = \frac{110333}{1+(110333)x(0.05x0.05)}$$

$$n = \frac{110333}{1+(110333)x(0.0025)}$$

$$n = \frac{110333}{276.9826}$$

n = 398

Sampling Procedures

Stratified sampling, random sampling and purposive sampling procedures were used to pick the sample for the study. The stratified method was used by putting the population into strata of rural and urban groups. According to the 2010 Population and Housing Census (PHC), urban locality comprises an area with a population of more than 5000 inhabitants and a rural area is an area of a population of fewer than 5000 inhabitants. The communities in the Metropolis comprised 15 urban and 4 rural areas.

A simple random sample (lottery method) was used to select a community from each stratum or group. Quota was allocated to the two communities based on the percentage of rural and urban population in the Metropolis to derive the sample frame for each locality. Adisadel community was selected as the urban locality among the 15 urban localities described in the 2010 PHC and Nkanfoa (3,680 inhabitants) as a rural locality. The population of urban dwellers in the metropolis according to the 2010 PHC is 130,348 making up about 77 percent while the rural dwellers have a population of 39,546 giving 23 percent. Then households of adults who are parents were purposively selected for the study. A total of 398 parents were selected using Yamane's formula for deriving a sample from the population. The allocated quota for the two communities is shown in Table 1.

Table 1-*Sample distribution*

Type of community	Name of community	Population size of 18 years and above	Sample quota
Urban population	Adisadel	84,625	305
Rural population	Nkanfoa	25,708	93
Total		110,332	398

Source: Field survey, (2015)

Data and Sources

The data for this study were mainly primary. The primary data consisted of socio-demographic characteristics of respondents, respondents' knowledge on condom, and communication with adolescent children on condom.

Information from secondary sources was obtained from textbooks, journals, the 2008 Ghana Demographic Health Survey (GDHS), 2011 HIV sentinel survey report and the internet.

Data Collection Instruments

A questionnaire was used as the instrument for the collection of data. The questionnaire consisted of open-ended, Likert scale and close-ended questions. With respect to questions that required a 'Yes' and 'No' responses, the instrument provided an opportunity for respondents to explain their choice of response. The questionnaire was divided into five sections for easy comprehension. The first part was made up of the socio-demographic characteristics of parents, the second part comprised parents' knowledge on adolescents' source of condom education, the third part was made up of parent-adolescent communication on condom

education, and the fourth was on parents' perceptions on condom education for adolescents, and the fifth was on parents' intention on the provision of condom education.

Data Collection Methods and Procedures

The data were collected in 2015 between May and June. A total of three weeks were used in the collection. Two assistants administered the questionnaire and collected the responses. The method of collecting data was the survey type in which questionnaires were used. A random parent among those present at the time of visit to households were administered questionnaires. A household with both parents (mother & father) present at the time of visit was given one questionnaire to be respondent by either and not both. Parents in multi-family households of less than five households were all administered questionnaires and in multi-family households of more than five households, four parents were randomly selected and administered questionnaires. The communities were made up of varied ethnic groups so the instrument had to be interpreted into the local language for those who could not understand the language used in the instrument. This extended the duration stipulated for the data collection by seven days.

Data Processing and Analysis

Data analysis is the process of extracting, compiling and interpreting raw data for drawing conclusions and predicting outcomes in social settings. It is a way of drawing inductive inferences from data and distinguishing the phenomenon of interest from the statistical fluctuations present in the data (Shamoo & Resnik, 2003). The data were examined and edited to ensure consistency of responses.

The SPSS version 20 was used to analyze the responses from the questionnaire. The data entered were analyzed using frequencies and percentages which were presented in tables as well as graphs. The relationship between background variables of respondents and issues centered around perception on condom education for adolescents was explored using Person's Chi-square, Kolmogorov-Smirnov test and correlation analyses.

Challenges encountered on the field

The main limitation was limited time on the part of both field workers and respondents during the administration of the questionnaire. The language used in the questionnaire had to be translated into the local language for some of the respondents to understand and comprehend therefore requiring more time spent on a respondent.

Some respondents refused to respond to some of the questions based on religious grounds. Other respondents also avoided some open-ended questions which were an explanation for their choice of a 'yes' or 'no' to questions provided.

Ethical Issues

According to Polit, Beck, and Hungler (2001), any piece of research should take into consideration basic principles of beneficence, respect for human dignity and consent from participants. The researcher, therefore, has the responsibility to ensure that ethical standards are adhered to. Respondents' consent was sought verbally before enrolling them into the study. The purpose and intention of the study were made known to respondents before the questionnaire was

administered. Participation was voluntary and information obtained from respondents was kept confidential.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and discussion of the data collected from the field. It covered socio-demographic characteristics of respondents, parents' knowledge on adolescents' source of condom education, parent-adolescent communication on condom education, parents' perception on condom education for adolescents and parents' intention on the provision of condom education for adolescents.

Background Characteristics of Respondents

Background characteristics of parents have been examined in this section. According to the Integrated Model (IM) used for the conceptual framework, background characteristics of individuals influence perception and intention to perform an action (Yzer, 2012). Some of the background characteristics covered in the study were: locality type, age, sex, the level of education, occupation and religious affiliation.

Table 2 depicts that the study was carried out in two different locality types. Some of the respondents lived in the urban locality while others lived in the rural locality. Table 2 indicates that 76.6 percent of the respondents lived in an urban area while 23.4 percent lived in a rural area. The ages of the respondents were grouped into six categories to make it convenient for data to be analysed.

Table 2 - *Background Characteristics of Respondents*

Socio-demographic variable	Category	Frequency	Percentage
Locality type			
	Urban	305	76.6
	Rural	93	23.4
Total		398	100
Age distribution			
	less than 20	1	0.3
	20-29	64	16.1
	30-39	110	27.6
	40-49	110	27.6
	50-59	69	17.3
	60 and above	44	11.1
Total		398	100
Sex			
	Male	185	46.5
	Female	213	53.5
Total		398	100
Level of education			
	No education	80	20.1
	Basic education	105	26.4
	Secondary	109	27.5
	Tertiary	104	26.1

Total		398	100

Table 2, continued

Occupation			
	Fisherman	11	2.8
	Fishmonger	13	3.3
	Farmer	11	2.8
	Trader/Business	174	43.7
	Teacher	48	12.1
	Health worker	27	6.8
	Civil servant	68	17.1
	Artisan	24	6
	Unemployed	68	17.1
Total		398	100
Religious affiliation			
	Christian	303	76
	Islam	93	23.4
	Traditional	1	0.3
	Hindu	1	0.3
Total		398	100

Source: Field survey, (2015)

Table 2 also depicts that 53.5 percent of the respondents were females with 46.5 percent being males. The sex of the respondents was essential for the study since parenthood is not restricted to one sex but both sexes and to explore what

other researchers have indicated; that mothers communicated well on sexuality issues with adolescent children than fathers (Hutchinson & Montgomery, 2007; Liying et al, 2007; Tsvakayi et al, 2010; Ramarumo et al, 2011; & Harris et al, 2013).

About 20.1 percent of the respondents had no education with 79.9 being educated. The respondents with the highest educational level at the basic made up 26.4 percent, the secondary was 27.4 percent while the tertiary was 26.1 percent indicating that majority of the respondents were educated. The table also showed that 17.1 percent of the respondents were unemployed with 82.9 percent being employed. Education and employment are perceived to equip individuals with skills therefore as variables they were essential in the study as shown in the conceptual framework (Yzer, 2012).

Table 2 also shows that 76.1% of the respondents were Christians, and those who professed the Islamic faith made up of 23.4 percent. There was one African Traditionalist respondent representing 0.3 percent and one Hindu representing 0.3 percent.

Parents' Knowledge about Condom

Parents' knowledge on condom and their awareness of their children's knowledge on condom use was assessed. Ramarumo et al (2011) came out with the findings that knowledge about sexual issues and facing the adolescent with the facts about sexual issues can help in the development of a healthy sexual life for the adolescent. The Reasoned Action Approach theory from which the IM framework emanates posits that the information in the form of knowledge that a

parent possesses coupled with other variables when delved into concerning an object or topic will bring out the beliefs they have on the topic or object (Fishbein & Ajzen, 1980 & 2010). Such beliefs will inform the attitude and perception of parents as well as their intention to carry out a behaviour or action.

It is perceived that if parents and adults have some knowledge of reproductive issues including condom usage, their perception towards adolescent knowledge on condom usage will be positive (Temin et al, 1999). Table 3 shows that 98.4 percent of parents in the urban area responded positively to having knowledge on condom. Parents in the rural area who indicated they have no knowledge on condom use were 3.2 percent compared to the 1.6 percent of urban parents who do not know about condom use. Thus more parents in rural localities have no knowledge regarding condom issues.

More males comprising 98.4 percent in the study had knowledge on condom use than females (97.7%) while more females (2.3%) responded negatively to having knowledge on condom use than males (1.6%). This result agrees with Glover and others (2003), that condom knowledge is higher among males than females and that it is appropriate for males to carry condoms and inappropriate for females to carry condoms. Also, it agrees with Holland and others (1991), and Tenkorang (2012), who researched and came out with the findings that females are less likely to negotiate for safer sex because knowledge on condom use, is not high among them.

Table 3 - *Parental background characteristics and knowledge on condom usage*

Background characteristics	Category	Yes (98%)	No (2%)	Total
Locality type	Urban	299(98.4%)	5(1.6%)	304
	Rural	90(96.8%)	3(3.2%)	93
Total		389	8	397
Sex				
	Male	181(98.4%)	3(1.6%)	184
	Female	208(97.7%)	5(2.3%)	213
Total		389	8	397
Level of education				
	No education	77(97.5%	2(2.5%)	79
	Basic	101(96.2%)	4(3.8%)	105
	Secondary	108(99%)	1(1%)	109
	Tertiary	103(99%)	1(1%)	104
Total		389	8	397
Religious affiliation				
	Christian	298(98.3%)	5(1.7%)	303
	Islam	89(96.7%)	3(3.3)	92
	Traditional	1(100%)	0(0%)	1
	Hindu	1(100%)	0(0%)	1
Total		389	8	397

Source: Field survey, (2015)

Educational level determines condom knowledge (Anderson & Beutel, 2007; Bankole et al. 2007) as a result; knowledge about its availability, accessibility,

and correct use is influenced by one's level of educational attainment. The result from this study on the educational level of parents and their knowledge on condom use agrees with the findings of Anderson and Beutel, and Bankole and others. Table 3 indicates higher knowledge on condom use by parents with higher educational levels, secondary (99%) and tertiary (99%). Parents with lower educational attainment (basic) and no formal education were the most in having no knowledge of condom use (basic education, 3.8% and no education, 2.5%) compared to 1 percent each for parents with secondary and tertiary education.

Parents in all religious groups responded positively to having knowledge on condom use. However, more Christian parents (98.3%) had knowledge than Islamic parents (96.7%) and one Islamic parent refused to respond thereby giving a total of 397 respondents instead of 398 as shown in table 3. Though 100 percent of Hindu and African Traditional parents responded knowing about condom, their total number is less than 1 percent of the total sample population.

Parental Views on Adolescent Knowledge on Condom Usage

Table 4 indicates that parents in the urban areas (69.7%) are aware that adolescents know about condom use compared to only 50 percent of parents in the rural areas. More parents are not aware of adolescents' knowledge in the rural areas (50%) with only 30.3 percent of parents in the urban area not being aware.

Table 4 - *Parents' background characteristics and their views on adolescents' knowledge about condom*

Background characteristics	Category	Yes (65%)	No (35%)	Total
Locality type				
	Urban	212(69.7%)	92(30.3%)	304
	Rural	46(50%)	46(50%)	92
Total		258	138	396
Level of education				
	No formal education	63(79.7%)	16(20.3%)	79
	Basic	61(58.7%)	43(41.3%)	104
	Secondary	72(66.1%)	37(33.1%)	109
	Tertiary	62(59.6%)	42(40.4%)	104
Total		258	138	396
Religious affiliation				
	Christianity	203(67%)	100(33%)	303
	Islam	53(58.2%)	38(41.8%)	91
	Traditional	1(100%)	0(0%)	1
	Hindu	1(100%)	0(0%)	1
Total		258	138	396

Source: Field survey, (2015)

Table 4 showed that 79.7 percent of parents with no formal education were aware that adolescents know about condom use while 58.7 percent of parents with basic education, 66.1 of parents with secondary education and 59.7 percent of parents with a tertiary education knew about adolescents' knowledge on condom usage. Parents with basic education as their highest level of educational attainment (41.3%) were the largest group with no awareness about adolescents' knowledge on condom. All the two Traditional religious believer and Hindu parents as well as 67 percent Christian parents and 58.2 Islamic parents had the awareness on adolescents having condom knowledge. Two Islamic parents did not respond to this question.

The study showed that parents, in general, have some awareness about adolescents' knowledge on condom usage.

Parental Knowledge of Adolescent's Source of Information about Condom

Adolescents' source of information about condom was vital in investigating parents view on how they perceive condom education for adolescents. The sources provided by parents were radio, billboards, television, Non-governmental Organizations (NGOs), friends and parents. Table 5 depicts parents' response to adolescents' source of information on condom.

Table 5 - *Adolescents source of information about condom*

Source of information	Frequency	Percentage
Radio	47	11.9
Billboards	293	74
Television	3	0.7
NGOs	2	0.5
Friends	31	7.8
Parents	20	5.1
Total	396	100

Source: Field survey, (2015)

Parents indicated that the major source of information about condom for the adolescent was billboards taking 74 percent of the responses, followed by radio (11.9), friends (7.8 %), parents (5.1%), television (0.7%) and NGOs (0.5%). The table showed that parents form 5 percent in providing information about condom to the adolescent. Thus, though parents are aware of their adolescent children having knowledge about condom use from Table 3, they form only 5 percent in the provision of this knowledge. The results show that parents are aware of adolescents' knowledge about condom; however, their role in imparting that knowledge is minimal (5%). The other sources outside the home provide about 95 percent of condom knowledge for the adolescents. This agrees with the findings by Yadeta, Bedane and Tura (2014) that silence exist between a number of parents and their adolescent children on reproductive health issues including condom.

The study further analysed the relationship between parents' locality of stay, educational level and their knowledge on adolescents' source of information on condom using the Chi-square test. The results showed a p-value of 0.000 for parents' locality of stay and 0.010 for educational level. This indicates that there is a significant relationship between parents' locality of stay, their educational level and their knowledge on the source of adolescents' condom information. Therefore the null hypothesis was rejected.

Background Characteristics of Parents and their Communication on Condom Usage with Adolescents

The study sought to explore whether background characteristics influences parents communication on condom with adolescents. According to Harris et al., (2013), parent-child communication on sexual behaviours such as condom use reduces adolescents' sexual risky behaviours. Parents were therefore assessed on whether they have ever talked to their adolescent child or children about condom and if a child or children have ever asked them questions about condom.

According to Jerman and Constantine (2010), parents' socio-demographic factors such as age, gender, education, ethnicity and religion influence parent-adolescent sexual communication. The main socio-demographic factors considered in the study were: locality type of residence, sex, the level of education and religious affiliation

Table 6 - *Parents ever talked to their child/children about condom by background characteristics*

Background characteristics	Category	Yes (%)	No (%)	X^2	Degree of freedom	P-value
Total (%)		15.6	84.4			
Locality type				7.742	1	0.005
	Urban	15.6	81.4			
	Rural	6.5	93.5			
Sex				0.819	1	0.365
	Male	17.4	82.6			
	Female	14.1	85.9			
Level of education				19.791	3	0.000
	No formal education	8.9	91.1			
	Basic	9.5	90.5			
	Secondary	13.7	86.3			
	Tertiary	28.8	71.2			
Religious affiliation				5.665	3	0.129
	Christianity	15.2	84.8			
	Islam	16.3	83.7			
	Traditional	100	0			
	Hindu	0	100			

Source: Field survey, (2015)

The results in Table 6 indicated that 84.4 percent of the parents responded negatively to ever talking to their adolescents about condom with 15.6 percent responding positively to ever talking to their children about condom issues supporting the findings of Yadeta et al (2014) on silence existing between parent-adolescent reproductive health communications. The table showed that 93.5 percent of parents residing in the rural area never talked about issues on condom with their children as against 81.4 percent of urban parents.

Though research indicates that mothers have greater self-efficacy and are more likely to communicate on sexual issues with their adolescents than fathers (Diiorio et al., 2000), the study showed more male parents (17.4%) ever talked to their children on condom than females (14.1%). However, the Chi-square test did not show any significant difference between sex (X^2 =0.819, df=1, p-value=0.365), and their ability of ever talked to the adolescent on condom use.

Parents with high level of education are able to communicate well with adolescents on condom while those with low level of education show little interest in such discussions (Guilamos-Ramos et al., 2006; Lius et al., 2011). This conforms to the result of the study showing more parents with secondary (17.4%) and tertiary (28.8%) education ever talking on condom issues with their adolescent children compared to parents with basic education who covered 8.6 percent as well as parents without any formal education forming 8.9 percent.

Table 6 showed all Traditional religion believer (100%) and Islamic parents (17.4%) ever talking to children on condom while only 15.8 percent of Christian parents and the Hindu parent have not ever talked on the issue.

A Chi-square test of the results showed a significant relationship between parents' place of residence and their level of education in ever talking to their children on condom. The results showed $X^2 = 7.742$, df =1, p-value=0.008 for parents' locality type and X^2=19.791, df =3, p-value =0.000 for parents' level of education. These results agree with the conceptual framework that background characteristics of individuals such as the place of residence and level of education of parents influence their ability to communicate with adolescent about condom use. Thus the more developed the area, the likelihood that a parent will discuss condom issues with a child and the higher the level of education of the parent, the likelihood that such a parent will talk about condom issues with the adolescent.

Parents' response to their comfortability in ever discussing condom issues with their adolescents is shown in Figure 4.

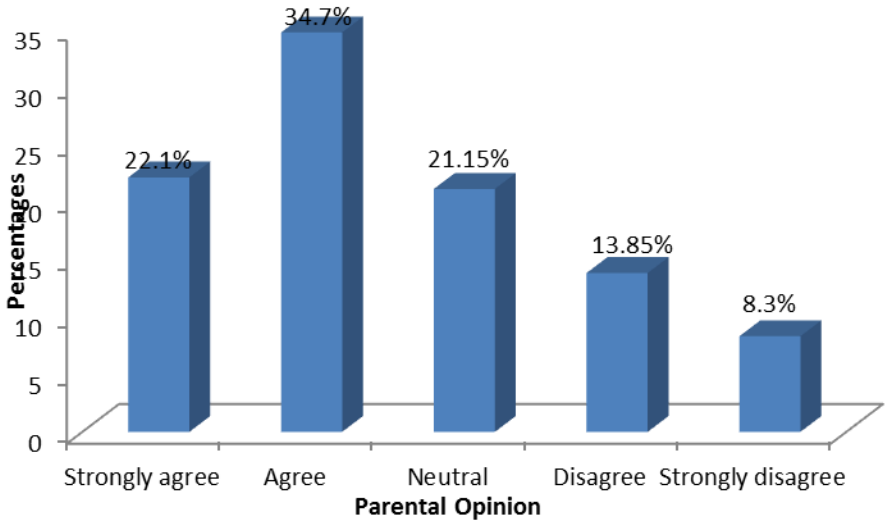

Figure 4: Parental opinion on their discomfort in talking about condom to adolescents

Source: Field survey, (2015)

About 56.8 percent of the parents agreed that they do not feel comfortable in discussing issues about condom with their adolescent children. Parents who felt comfortable to talk on condom issues with their adolescent children formed 22.15 percent. This could explain the low percentages shown in Table 6 on parents ever talking to their adolescent children on condom issues and the reason parents shun open discussions on condom issues and other sexuality matters (Osei, 2009).

Parents being ever asked Questions on Condom use by Adolescents

Table 7 provides the relationship between parents' socio-demographic variables and their adolescent children ever asking them questions pertaining to condom use. The results in the table showed a significant difference of parents' place of residence (X^2 = 6.941, df = 1, p-value =0.008), level of education (X^2=19.830, df =3, p-value = 0.000) and their adolescents asking them questions on condom. Thus parents' area of stay and educational level attained play a role in adolescents' willingness to initiate communication on condoms with the parents. However, Table 7 showed that more parents in the urban areas (19.1%) had their children asking them questions on condom use than parents residing in the rural areas (7.5%). Thus adolescents in developed areas were able to communicate more on condom issues with their parents than those from less developed areas. The table also showed that the higher a parent's educational level, the likelihood that an adolescent will ask them questions on condom use. Parents with tertiary educational attainment had 28.8 percent (though a small figure but the highest among the other educational levels) of them answering positive to a child ever asking them questions on condom use, secondary educated parents had 17.4

percent while basic and those with no formal education covered 8.6 percent and 8.9 percent respectively

Table 7 - *Parents whose adolescent children have ever asked them questions on condom*

Background characteristics	Category	Yes (%)	No (%)	X^2	Degree of freedom	P-value
Total (%)		16.4	83.6			
Locality type				6.941	1	0.008
	Urban	19.1	80.9			
	Rural	7.5	92.5			
Sex				0.26	1	0.610
	Male	17.4	82.6			
	Female	15.5	84.5			
Level of education				19.83	3	0.000
	No formal education	8.9	91.1			
	Basic education	8.6	91.4			
	Secondary education	17.4	82.6			
	Tertiary	28.8	71.2			

Table 7, continued

Religious affiliation				5.436	3	0.143
	Christianity	15.8	81.2			
	Islam	17.4	82.6			
	Traditional	100	0			
	Hindu	0	100			

Source: Field survey, (2015)

Though parental sex was not significant (p-value, 0.610) in influencing adolescents to ask parents questions on condom use, Table 7 indicated that adolescents communicated more with fathers (17.4%) about condom while only 15.5 percent of mothers were engaged in such communication thus contradicting the findings by Liying and others (2007) that adolescents are more likely and more comfortable in communicating on issues about sexuality with their mothers more than their fathers. Parent's religious affiliation was not influential in either parents initiating communication (p-value, 0.129) or adolescent initiating communication (p-value, 0.143) on condom use.

The results from Tables 6 and 7 on parent-adolescent communication by background characteristics indicate a significant difference between parents' background characteristics and parent-adolescent communication about condom education. This posits that some background characteristics of parents influence the possibility of communication between parents and adolescents on condom education. However, their communication on such issue is minimal looking at the low percentage of parents agreeing with Osei (2009) that sex and its related issues are unspoken words in the typical Ghanaian home.

Background Characteristics of Parents and their Perception on Condom Education for Adolescents

In the conceptual framework, perceptions (attitudes, perceived norm and self-efficacy), that is a person's evaluation of how favourable or unfavourable a performance will be to him or her influences their intention and performance of that behaviour or action (Yzer, 2012). In the study parent's views on whether the provision of condom education will have an effect on the adolescent were assessed.

As shown in Table 8, 65.7 percent of parents responded positively to the notion that offering education on condom to the adolescent can have an effect on him or her while 34.3 percent differed in that view.

Table *8 - Effect of condom education on the adolescent by parents' background characteristics*

Background characteristic	Category	Yes (%)	No (%)	χ^2	Degree of freedom	P-value
Total		65.7	34.3			
Locality type				7.352	1	0.007
	Urban	62.2	37.8			
	Rural	77.4	22.6			
Sex				0.708	1	0.4
	Male	63.6	36.4			
	Female	67.6	32.4			

Table 8, continued

Level of Education				28.778	3	0.000
	No formal education	45.6	54.4			
	Basic	60	40			
	Secondary	70.6	29.4			
	Tertiary	81.7	18.3			
Religious affiliation				17.446	3	0.001
	Christianity	60.7	39.3			
	Islam	82.6	17.4			
	Traditional	0	100			
	Hindu	100	0			

Source: Field survey, (2015)

The table showed 77.4 percent of parents in the rural area indicated that providing condom education for the adolescent will have an effect on him/her with 62.2 percent of urban parents also responding positively. More mothers (67.6%) saw condom education as having an effect on the adolescent than fathers (63.6%). This provides reasons to why in Table 5 more fathers do discuss issues about condom use with their adolescent children than mothers in this study area. The results showed that parental perception on condom education having an effect on adolescent increases with one's educational level. Parents with no formal education had 45.6 percent of them agreeing to the notion, 60 percent of parents

with basic education, 70.6 percent of parents with secondary education and 81.7 percent of parents with tertiary education. Most Islamic parents (82.6%) responded that condom education has effects with 60.7 Christian parents agreeing to the notion as well as the Hindu parent while the traditional believer responded that there is no effect.

The Chi-square test indicated that there was a significant relationship between parents place of residence (p-value= 0.007), level of education (p-value= 0.000), religious affiliation (p-value= 0.001) and their view that condom education has effect on the adolescent. Indicating that no matter the area of residence, the level of education or the religious affiliation of a parent, they are of the view that educating the adolescent will have some effect on the adolescent. However, the test showed that the gender (p-value= 0.400) of parents do not significantly influence their perception on the effect of condom education. The effect could be positive or negative which may influence parents' intention and willingness to provide adolescents with condom education.

Condom Education can lead to Early Sexual Experimentation

Table 9 shows results of parent's responses to whether educating adolescents on condom use can lead to sexual experimentation. The results indicated that only 38 percent of parents in the study responded positively to condom education leading to sexual experimentation. Sixty-two percent of the parents responded in the negative. This contradicts the results in the 2008 GDHS of which indicated that parents thought that the provision of condom for the adolescents, can lead to early sexual experimentation.

In the results, more parents residing in the rural area (40.9%) responded positively to condom leading to early sexual experimentation with 37.2 percent of urban parents responding positively. Parents without any form of formal education responded lowest (21.5%) in accepting that condom education can lead to early sex with parents with some form of formal education responding positively to the notion (Basic education, 40%, Secondary education, 54.1% and Tertiary education, 34.6%).

Table 9 - *Condom education can lead to sexual experimentation by parent's background characteristics.*

Background characteristic	Category	Yes (%)	No (%)	χ^2	Degree of freedom	P-value
Total		38	62			
Locality type				0.411	1	0.521
	Urban	37.2	62.8			
	Rural	40.9	59.1			
Sex				1.081	1	0.298
	Male	40.8	59.2			
	Female	35.7	64.3			
Level of education				26.498	3	0
	No formal education	21.5	78.5			
	Basic	40	60			
	Secondary	54.1	45.9			

Table 9, continued

	Tertiary	34.6	65.4			
Religious affiliation				51.413	3	0
	Christianity	28.4	71.6			
	Islam	68.5	31.5			
	Traditional	100	0			
	Hindu	100	0			

Source: Field survey, (2015)

The Traditional religion believer and Hindu parents indicated that condom education can lead to sexual experimentation. The table also displayed more Islamic parents (68.5%) perceiving condom education as leading to early sexual experimentation while 28.4 percent of Christian parents agreed to this notion. The level of education (p-value =0.000) and religious affiliation of parents significantly influenced their perception that condom education can lead to early sexual experimentation.

The results from Tables 8 and 9 posit that some background characteristics of parents influence their view that condom education for the adolescent can have an effect on them. These effects include influencing their decision to use condom in marriage, making rightful sexual health decisions, knowing the dangers of unprotective sex, prevention of STDs and unwanted pregnancy, increasing fornication/ promiscuity and early sexual experimentation.

Provision of Condom Education for Adolescents by Parents

In the conceptual framework, perceived norms determine an individual's intention to perform a behaviour therefore parents' acceptance of condom education was assessed to ascertain their stake in accepting or not accepting condom education for the adolescent.

Table 10 shows that more than half of the parents (61.2%) in the study accept that condom education is provided for the adolescent. The framework also supports that background characteristics influence parent's intention to partake in a behaviour or action. As shown in table 10, more parents in the urban area (69.1%) accept to provide condom education for the adolescents as compared to 35.5 percent for the rural area. More males (65.8%) than females (57.3%) in the study area were in support of the education contrary to the findings that more mothers are interested in adolescent sexual topics than fathers (Sneed, 2008; Tsvakayi et al, 2010 & Harris et al, 2013).

Table 10 - *Acceptance of provision of condom education for the adolescents by parent's background characteristics*

Background characteristics	Category	Yes (%)	No (%)	x2	Df	Sig.≤ 0.05
Total		61.2	38.8			
Locality type				33.851	1	0
	Urban	69.1	30.9			
	Rural	35.5	64.5			
Sex				2.993	1	0.084
	Male	65.8	34.2			
	Female	57.3	42.7			

Table 10, continued

Highest level of education				9.335	3	0.025
	No formal education	63.3	36.7			
	Basic	52.4	47.6			
	Secondary	57.8	42.2			
	Tertiary	72.1	27.8			
Religious affiliation				9.92	3	0.019
	Christianity	65	35			
	Islam	48.9	51.1			
	Traditional	100	`0			
	Hindu	0	100			

Source: Field survey, (2015)

The conceptual framework supports that level of education which is a background characteristic influences a behaviour. Table 10 depicts that acceptance to provide condom education is influenced by parent's level of education. Parents with tertiary education (72.1%) accept to provide condom education for adolescents conforming to the findings of Guilamo-Ramos and others 2006 that parents with high level of education show interest in adolescent sexual matters. More Christian parents (65%) than Islamic parents (48.9%) responded positively to wanting to provide condom education for the adolescent. The Traditional religion believer responded positively to wanting to provide condom education for the adolescent while the Hindu parent did not accept that adolescents be given condom education.

The Chi-square test results indicated that place of residence of parents (p-value=0.000), educational level (p-value=0.025) and religious affiliation (p-value=0.019) is significant with parents wanting to provide condom education. The results showed that irrespective of parents' area of stay, the level of education and religious affiliation, they accept to provide condom education for adolescents.

Locality Type and Parental Provision of Condom Education for Adolescents

Table 10 results indicated that irrespective of a parent's area of stay, condom education for the adolescent was accepted with the p-value of 0.000. Therefore, the study further sought to find out if the parents of the two communities agree to provide education on condom use to the adolescents by themselves. The results in Table 11 showed that majority of parents in the urban area (77.3% comprising parents who strongly agreed, 36.5% and those who agreed, 40.8%) agreed to provide condom education for their adolescent children while 52.7 percent (16.1% of strongly agreed parents and 36.6% of agreed parents) of the parents living in the rural area agreed to give condom education themselves. Thus more than half of parents from both urban and rural areas agree that parents must provide condom education.

Table 11 - *Parents' intending to provide condom education for adolescents by locality type*

Locality type	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
Urban	111(36.5%)	124(40.8%)	3(1.0%)	29(9.5%)	37(12.2%)	304
Rural	15(16.1%)	34(36.6%)	3(3.2%)	29(31.2%)	12(12.9%)	93
Total	126	158	6	58	49	397

(KS Test = 0.246145, D Statistic@0.05 = 0.161159)

Source: Field survey, (2015)

Further comparison between the opinion of parents in the urban and rural areas was explored. A Kolmogorov-Smirnov test was conducted on the two communities to assess their opinion since the variable in question, locality type involved two unequal sample sizes from the same population and the data were ordinal scale data. The test showed that there is no significant relationship between parents of urban and rural areas; and their intention/willingness to provide condom education for their adolescent children. The D Statistic value (p-value) of 0.161159 was greater than the significant level @ 0.05 and the KS Table value 0.246145 was also greater than the D Statistic (0.161159) therefore the null hypotheses was not rejected. The test results agree with the table results that parents of urban and rural areas see the essence in their provision of condom education for their adolescent children. They provided reasons such as parents educating them will prevent them from misinformation from peers, get the adolescent ready for life and prevention of unwanted pregnancies and STDs including HIV/AIDS. Their view conforms to the numerous findings that the

provision of condom education and other related sexuality issues by parents for adolescents is essential since they are the primary educators and can influence their sexual health decision making (Aspy et al, 2007; Ebersole et al, 2014; Malcolm et al, 2013).

Parents as First Educators on Condom for Adolescents

Parents are known to be the first educators in a child's life for development, therefore, parents were asked if they agree to be the first educators of condom education for their adolescent children. Table 12 shows parents' responses.

Table 12 - *Parents as first condom educators for adolescents*

Parents Opinion	Frequency	Percentage
Strongly Agree	105	21.4
Agree	150	37.2
Neutral	78	21.1
Disagree	45	13.6
Strongly Disagree	20	6.8
Total	398	100

Source: Field survey, (2015)

Fifty-eight percent of parents supported the idea that parents must be first condom educators for the adolescent, however, they refrain from open discussion on condom issues as indicated by Osei (2009) in his essay.

Parents' response to the parent best fit to provide condom education is shown in Figures 5 and 6. Figure 5 indicates that less than half of the parents in the study area (42.1%) agreed to fathers providing condom education though Brown,

Rosnick, Webb-Bradley and Kirner (2014), came out with the findings that fathers who were able to discuss condom issues with their adolescents daughters built confidence in them which enabled them to discuss safer sex and preference of condom use in their marriage life.

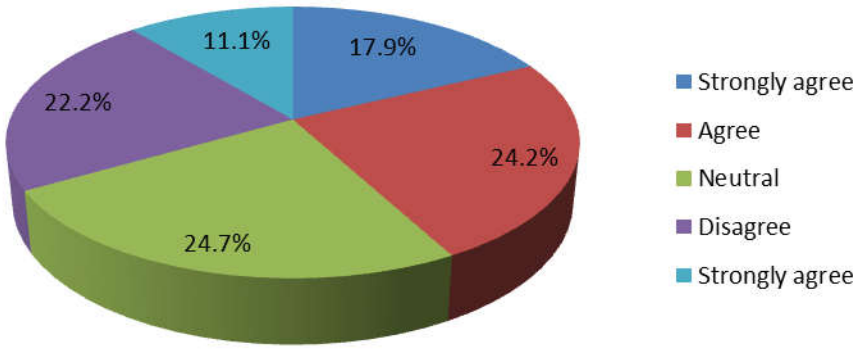

Figure 5: Agreement to fathers' provision of condom education

Source: Field survey, (2015)

Figure 6 shows responses of parents to the support of mothers providing condom education instead of fathers.

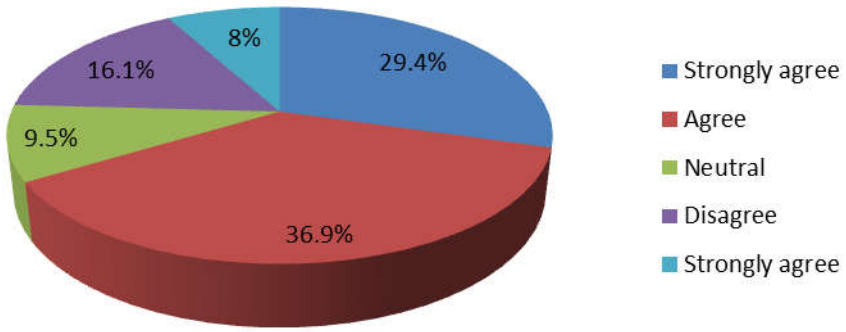

Figure 6: Support for mothers to give condom education

Source: Fieldwork, 2015

About 66.3 percent of parents indicated their support in the view that mothers must give condom education to the adolescent instead of fathers. This is in conformity to the findings that mothers are appropriate in the discussion of sexuality issues and provision of condom education for the adolescents as they feel more relaxed in such discussions (Diiorio et al, 2000; Liying et al, 2007; Pluhar et al, 2007; & Sneed, 2008).

Condom Education must occur in the School Setting

Studies have shown that parents perceive condom education must take place in the school environment (Biddlecom et al, 2009; Dyson, 2010; & Shtarkshall, 2007). Parents' view of this assertion was sought and it agrees with previous studies that condom education must be provided in the school setting and figure 8 shows their response.

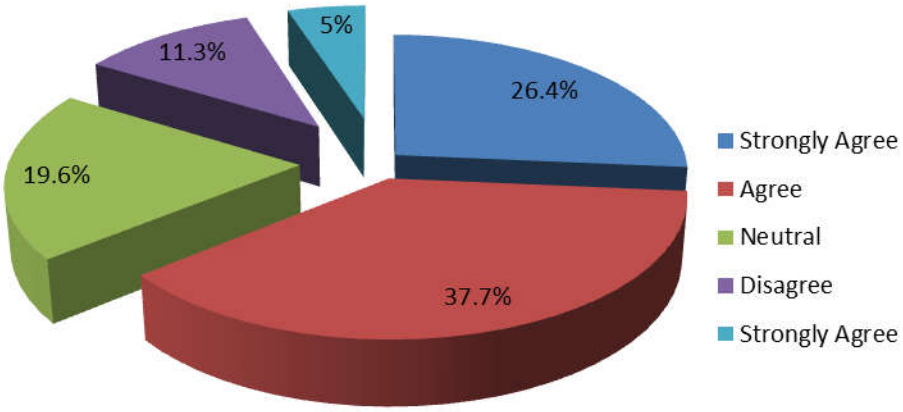

Figure 7: Parents opinion on condom education in the school setting

Source: Field survey, (2015)

A total of 64.1 percent of the parents surveyed indicated their agreement to the support of condom education in the school setting. They prefer the school rather than themselves proving education on condom for the adolescent.

Preferred Level to Provide Condom Education for Adolescent

Parents indicated that they prefer the adolescent child to receive condom education at the Junior High School level. The data showed 46 percent of parents agreeing to the JHS level being the most preferred level with 25.6 percent for primary level, 19.1 percent at Senior High School level and 9.3 percent suggesting that the adolescent is given condom education at the tertiary level. Figure 8 shows parent views in percentage.

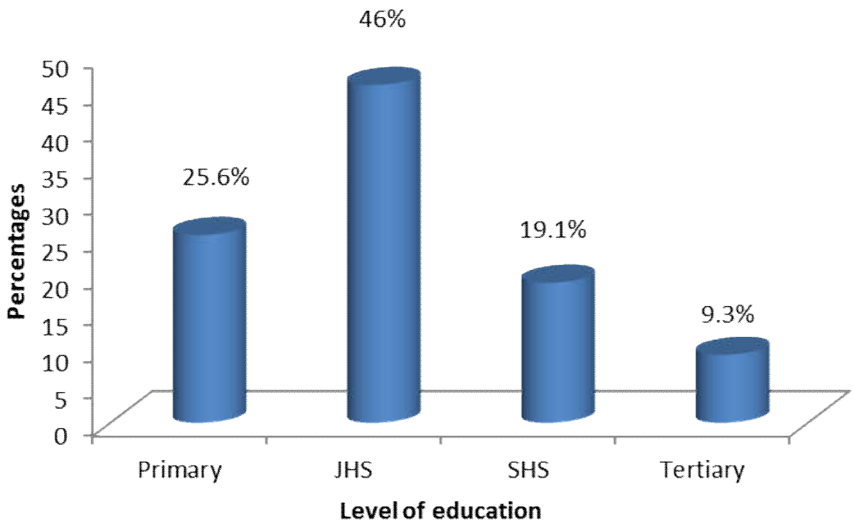

Figure 8: Preferred level to educate adolescent on condom

Source: Field survey, 2015

Preference of condom educator in schools

Respondents were asked about the preferred sex of teacher they would want to teach on condom issues in schools. Out of the 398 respondents, 269 representing

61.3 percent indicated their choice of female teachers to educate adolescents on condom. 14.3 percent of the respondents want male teachers to teach the topic with 18.1 percent preferring both sexes to teach it. Figure 9 shows parents' preference of the sex of the teacher to teach their adolescent children issues regarding condom.

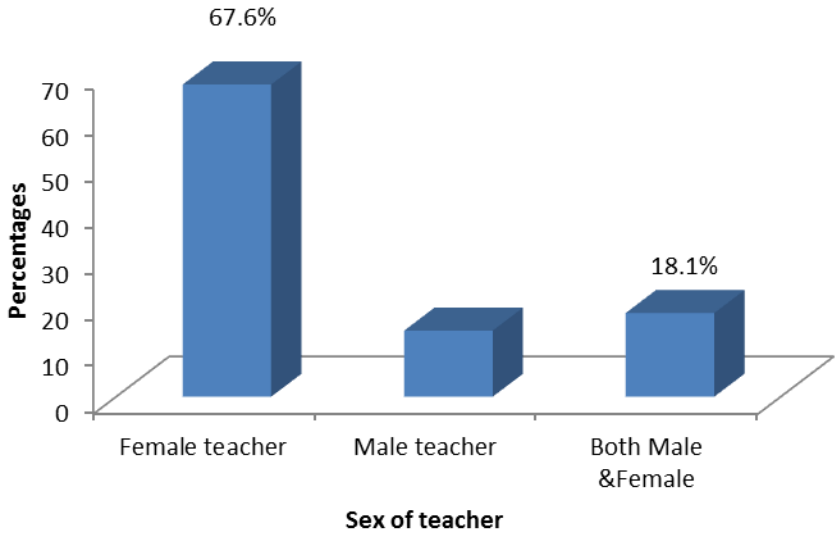

Figure 9: Sex of teacher to provide condom education

Source: Field survey, 2015

Correlation between background variables (locality type, education, sex and religious affiliation) and perception on condom education for adolescents

Table 13 shows correlation analyses of the relationship between the background variables (locality type, education, sex and religious affiliation) of parents and their perceptions on condom education for the adolescent. The independent variables considered are locality type (L), education (E), sex (S), religious affiliation (R). The dependent variables are communication on condom with adolescent (C1), parental acceptance to provide of condom education for the

adolescent (C2), parents' belief that condom education have effect on adolescents (C3), belief that condom education will lead to early sex (C4) and provision of condom education in school setting (C5).

The results show that correlation is significant at a 0.05 alpha level among all the variables with the relationship being either negative or positive. The table depicts a weak positive linear relationship between a parent's locality of stay which was significant at the assumed error of 0.05 (p-value) and communication with adolescents, acceptance of condom education and acceptance that condom education must occur in the school setting. Thus the more developed the place of stay of parents the higher the acceptance and intention to educate adolescents on condom.

From the table, a p-value (0.000, 0.000 and 0.011) less than the assumed error for parents' education and communication on condom as well as the perception that condom education will have an effect on the adolescent such as indulging in early sex showed a weak negative linear relationship. That is the higher a parents' educational level, the lower their perception that condom education for the adolescent will result in any effect or early sex experimentation and accept that the adolescent must be educated on condom.

Table 13 - *Correlation between background variables (locality type, education, sex and religious affiliation) and perception on condom education for the adolescent*

Background		C1	C2	C3	C4	C5
L	Correlation coefficient	0.140	0.292	-0.136	-0.032*	0.283
	Sig. (2-tailed)	0.005	0.000	0.007	0.523	0.000
E	Correlation coefficient	-0.198	-0.083*	-0.269	-0.127*	0.043*
	Sig. (2-tailed)	0.000	0.098	0.000	0.011	0.391
S	Correlation coefficient	0.045*	0.087*	-0.042*	0.052*	-0.059*
	Sig. (2-tailed)	0.367	0.084	0.401	0.300	0.239
R	Correlation coefficient	-0.028*	0.141	-0.179	-0.357	0.268
	Sig. (2-tailed)	0.573	0.005	0.000	0.000	0.000

*Correlation is significant at the 0.05 level (2-tailed)

A coefficient (0.141 and 0.268) and a p-value (0.005 and 0.000) indicated a positive linear association between a parent's religious affiliation and acceptance of condom education though the relationship was weak. Implying that the more religious a parent is the more willing he/she will accept the need to educate adolescents on condom. P-values (0.000 and 0.000) and coefficients (-0.179 and -

0.357) between a parent's religion and the perception that condom education have an effect on adolescents showed a weak negative linear relationship.

Parental Intention to Provide Condom Education

The study sought to explore parents' intention to offer condom education to their adolescent children. Table 14 shows parents' background characteristics and their intention to give condom education and the responses of the parent show that more parents in the urban area (80.9%) intend to give condom education while 51.6 percent of parents in the rural area support the idea. Thus the place of resident of a parent determines one's intention to provide condom education.

Table 14 - *Parental intention to provide condom education*

Background characteristics	Category	Yes (64.8%)	No (35.2%)	Total
Locality type				
	Urban	245(80.9%)	58(19.1%)	303
	Rural	48(51.6%)	45(48.4%)	93
Total		293	103	396
Sex				
	Male	131(71.2%)	53(28.8)	184
	Female	162(76.4%)	50(23.6%)	212
Total		293	103	396

Table 14, continued

Level of education				
	No formal education	64(81%)	15(19%)	79
	Basic	72(69.2%)	32(30.8%)	104
	Secondary	82(75.2%)	27(24.8%)	109
	Tertiary	75(72.1%)	29(27.9%)	104
Total		293	103	396
Religious affiliation				
	Christianity	246(81.2%)	57(18.8%)	303
	Islam	45(49.5%)	46(50.5%)	91
	Traditional	1(100%)	0(0%)	1
	Hindu	1(100%)	0(0%)	1
Total		293	103	396

Source: Field survey, (2015)

More mothers (76.4%) responded positively to their intention in the provision of condom education than fathers (71.25%). In the study, more parents across all the educational levels have the intention of providing condom education. Indicating that irrespective of a parent's educational background there is an intention to provide condom education for adolescents. All the Traditional believing and Hindu parents showed their intention to provide the education well as 81.2 percent of Christian parents. Less than half of Islamic parents (49.5%) showed an intention to give the education with two Islamic parents not responding

to the question about their intention to provide condom education for their adolescent children.

Influence of parental perception on their intention to provide condom education for adolescents

In the conceptual framework, a person's perception of an action influences the intention and performance of the action therefore parents' attitude about condom education and their willingness to support or provide such education was examined. Though the preceding results depict parents' acceptance to provide condom education their perception about condom education and how it influences their acceptance to provide the education was examined. Table 15 gives the results of the survey on the perception of parents on condom education and its influence on their intention to provide condom education.

Table 15 - *Parental perception on their intention towards the provision of condom education for the adolescent*

Attitude towards CE	Intend to provide CE (%)	Do not intend to provide CE (%)	X^2	Degree of freedom	P-value
Effect of CE on adolescent			11.693	1	0.001
CE has effect on adolescent	59.2	76			
CE has no effect on adolescent	40.8	24			
Early sexual experimentation			36.371	1	0.000

Table 15, continued

CE leads to early sex	26.3	56.5
CE do not lead to early sex	73.7	43.5

Correlation@0.001 (2tailed) = 0.001 and coefficient = -0.172

Source: Field survey, (2015)

The results show that there is a significant relationship between the perception parents have about condom education and their intention to provide such education for the adolescent. The null hypothesis that there is no significant relationship between parent's perception towards condom education for adolescents and their intention to provide condom education was rejected. The correlation analysed showed a weak negative linear relationship implying the greater the perception that condom education has an effect on the adolescent, or will lead to sexual experimentation, the lower the intention of parents to provide condom education. Seventy percent of parents who responded negatively to the acceptance of condom education believe it can have an effect on the adolescents. On the other hand, only 26.3 percent of parents who accepts condom education for the adolescent perceive it will lead them to early sexual experimentation. Implying though they accept that the adolescent needs the education, their perception that educating the adolescent on condom will have some effect on the child including early sexual experimentation make them unwilling to provide condom education for their adolescent children.

The results show that there is a significant relationship between the perception parents have about condom education and their readiness to provide such education for the adolescent. This conforms to the conceptual framework that

individual's perceived norm, self-efficacy and attitudes influences the intention to perform behaviour or action.

Parents' religion and approval of condom education for adolescents

Parents' were examined on the approval of their religion in providing condom education for the adolescent since most religions view condom education among youth will lead to early sexual debut (Kavinya, 2009). The results in Table 16 showed that about half of parents indicated their religions' approval to condom education for adolescents. More Christians (58.4%) approve of the provision of condom education than Moslems (26.1%).

Table 16 - *Religious approval of condom education for adolescents*

Background characteristics	Category	Yes (%)	No (%)	X^2	DOF	P-value
Religious affiliation		50.6	49.4	31.57	3	0.000
	Christianity	58.4	41.6			
	Islam	26.1	73.9			
	Traditional	0	100			
	Hindu	0	100			

Source: Field survey, (2015)

The table also shows that Traditional religion believers and Hindus also do not approve that the adolescent is given condom education. A Chi-square test conducted on the religious opinion on condom education for the adolescent showed a significant relationship between religion and the approval of adolescent condom education. Implying the religious groups do not, in reality, approve that

the adolescent is given condom education. Though more Christians indicated their approval, majority of the religious groups studied (Moslems, Traditionalist and Hindus) showed their disapproval, implying the slightly more than half Christians figure (58.4%) from the table is statistically insignificant in relation to the general opinion from the other three religions. The general reasons provided for the religious approval for condom education to be provided for the adolescent were to protect them against unwanted pregnancies, against STDs, and as a birth control measure. On the other hand, parents indicated why their religion is not in support of parents providing condom education for adolescents such as it is not holy, it will lead them to practice sex early, lead to promiscuity, it is not biblical, religion is against premarital sex and religious leaders do not teach about it so they too cannot teach their children.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter gives an overview of the entire study. It covers a summary of the objectives, findings outlined in the previous chapter, conclusions from the findings, and recommendations. The chapter ends with areas suggested for further research, and the contribution of the study to knowledge.

Summary of main findings

The purpose of the study was to assess parents' perception and their intention to provide condom education for adolescents. Marco Yzer's Integrative Model of Behaviour Prediction was adopted as the conceptual framework. The study area was the Cape Coast Metropolis from which two communities (one urban, one rural) were randomly selected for the study. Quantitative research methods were used in selecting the units of study while questionnaires were used as the research instruments in collecting data. Parents from both communities summing up to 398 were randomly identified for the study. The data collected were analysed using frequencies, percentages, bar charts and pie charts. Chi-square statistic and Kolmogorov-Smirnov statistic tests were used to test the hypotheses.

The study examined some background characteristics of parents and how they influenced their perception on condom education and their intention to provide such education for their children. The main background characteristics used were locality type, sex, education and religious affiliations of parents.

The study found that majority of the parents, being more than 95 percent of those examined had knowledge on condom and were also aware of the adolescent's knowledge about condom by which they provided the various sources of information the adolescents get their knowledge. The parents showed that they contribute only 5.1 percent to the source of adolescent condom knowledge. The major sources of adolescents' condom knowledge were billboards (74%), radio (11.9%) and friends (7.8%). The study found a significant relationship between a parent's place of residence and level of education in their communication on condom education thus rejecting the null hypotheses of no significant relationship between parents' education and condom education communication with adolescents.

Though it was found that majority of the parents did not feel comfortable engaging their adolescents in condom communication, place of residence and level of education of parents influenced such communications. There is a positive linear relationship between parents' locality and communication with their adolescent children on condom issues. Parents living in urban areas communicated more about condom to their adolescent children than those in the rural areas. And the higher the level of education of the parents, the higher the likelihood that such a conversation will occur. In the same way adolescents in urban areas were able to initiate condom discussions with their parents than those in rural areas and the higher the level of education of the parent, the easier it was for adolescents to initiate such conversations.

The study also showed that there was no significance relationship between parent's place of residence or stay and their willingness to provide condom education for adolescents. Parents from both rural and urban settlements see the importance of parents providing condom education for their adolescent children.

Since perception of a person towards an action influences the intention to perform and the actual performance (Fishbein & Ajzen, 1980; Yzer, 2012), parents' perception of the effect of condom education for the adolescent was considered and examined. The results showed that there was a significant relationship which was negative between parent's area of residence, the level of education and religious affiliation and the view or perception that condom education for the adolescent will have an effect on him or her. Parents indicated that the effect could be negative or positive. But parent's educational level and religious affiliation showed a strong relationship to the view that condom education will lead the adolescent to early sexual experimentation conforming to parents' view in the GDHS survey of 2008 but contradicting a study by Guttmacher, Lieberman, and Ward (1997) as well as Kaplan and others (2001) that there is no evidence that condom education contributes to early or increased sexual activity among adolescents.

Parents generally accepted that condom education for the adolescent was necessary (61.2%). The results showed statistically that irrespective of the locality of stay of a parent, no matter the level of education or the religious faith of the parent they all believe the adolescent must have some education on condom. The null hypothesis which states that there is no significant relationship between

parents in urban and rural areas on their opinion in their willingness to provide adolescent with condom education was thus not rejected. The findings agree with numerous studies like Aspy et al., 2007 and Biddlecom et al., 2009 that parents have to contribute immensely to the provision of condom education for the adolescent. The results also showed a statistical significance difference between the perception parents have and their intention to provide the adolescent with education on condom. Thus, though their intention to provide the education is positive, their perception on the outcomes of such education can influence their willingness to provide the education. However, they believe mothers should spearhead such education in the home confirming with previous studies like Diiorio et al. (2000) and Sneed (2008).

Another core objective of the study was to ascertain the influence of parents' perception on their intention to provide condom education for adolescents. Individuals' perception about an act is believed to account for their readiness or intention to perform that act. The study revealed that parents' perception about condom education for adolescents' accounts for their readiness to provide such education for their adolescent children. The null hypothesis which states that there is no significant relationship between parents' perception and intention towards condom education for adolescents was rejected. Implying the effect parents perceive the provision of condom education will have on the adolescent influences their readiness to accept to provide condom education for their adolescent children.

Parents view adolescents' main source of condom education is the billboard advertisement and that their contribution to their knowledge on condom is minimal, though they see the essence in their contribution to adolescents' condom education.

Conclusions

Based on the findings from the study it can be concluded that some background characteristics such as locality/place of stay, education and religious affiliation of parents influence their perceptions, beliefs, and self-efficacy on their intention to the provision of condom education as depicted by the conceptual framework. For instance, parents with higher than basic education had a positive perception on adolescents-condom education and intended to provide such education.

There is a lapse in parents' communication on condom issues with adolescents. Parents do not feel comfortable to discuss issues relating to condom with their adolescent children. Parents indicated that the adolescents' main source of condom information is through billboards advertisement.

Parents' residing in urban localities showed willingness to support and partake in providing condom education for the adolescent. Also parents who perceive that condom education will lead to sexual promiscuity, increased sexual activity or lead them into early sexual experimentation are less likely to support condom education.

Parents view that condom education should be provided in the school setting and that it should be introduced at the Junior High School (JHS) level since at that level they have just entered into adolescence.

Recommendations

Based on the findings and conclusions of the study, the following recommendations have been submitted as the way forward to enhance positive perception by parents on the provision of condom education for adolescents so as to approve of such education to ensure the sexual health of adolescents in Cape Coast.

1. The Public Health Department of the Ghana Health Service, NGOs and Social Marketing Agencies should launch an educational program to sensitize parents and the general public especially those in rural areas on the essence of parent-adolescent communication on condom education. Parents must be made aware that they have the responsibility of providing education on condom usage instead of other external sources to curb misinformation. It is established that some adolescents know about condom use and are sexually active therefore providing the rightful information from an appropriate source is essential.
2. Public Health educators must intensify education in rural areas on parent-adolescent condom education. The education must disabuse the negative perceptions parents have concerning adolescent condom education.
3. Mothers and female teachers were identified as the best condom education providers for adolescents, confirming most studies. Therefore programs

organized by all stakeholders involved with adolescent reproductive health must include more females and they must be equipped with the necessary skills to provide condom education.

Suggestions for further research

Based on the findings of this study it is being suggested that further qualitative research should be undertaken on parents' perceptions and views on the sex of parent and teacher to provide adolescent with condom education.

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APPENDIX A

QUESTIONNAIRE

INFORMED CONSENT

Dear Madam/Sir,

My name is _____, a student of the Department of Population and Health, University of Cape Coast, Ghana. I am conducting a study on parents' perceptions on condom education for the adolescents in the Cape Coast Metropolis. I would appreciate your participation in this study. The information you provide is important to this study and will be used for only academic purpose. Whatever information you provide will be kept strictly confidential. Respond to each question by ticking the appropriate responses and/or provide own response where necessary.

Signature of respondent: .....Date: .....

Name of Field assistant: .....

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARENTS

1. Locality type; Urban [ ] Rural [ ]
2. Age of respondents ……
3. Sex of respondents;

   Female [ ] Male [ ]

4. What is your highest level of education?

No education [ ] Basic (Primary-JHS) [ ] Secondary [ ]

Tertiary [ ]

5. What is your main occupation?.....

6. What is your religious affiliation?

Christianity [ ] Islam [ ] Traditional [ ] Other specify [ ]

7. How many adolescent children do you have? ……..

8 What are the ages of your children? ……

9. What are the sexes of your children?.....

SECTION B: PARENTS' KNOWLEDGE ON ADOLESCENTS' SOURCE OF CONDOM EDUCATION

10. Do you know about condoms? Yes [ ] No [ ]

11. If yes, where did you hear about condom?

Radio and television Advertisements [ ]

Billboard advertisements [ ]

Clinic [ ]

Health education [ ]

NGOs [ ]

12. Do your child or any of your children know an\bout condom? Yes [ ]

No [ ]

13. Where did he/she first hear about condom?

.....

14. Where in your opinion is the main source of information on condoms for adolescents?

Radio [ ]

Television [ ]

Billboards [ ]

NGOs [ ]

Friends [ ]

Parents [ ]

SECTION C: PARENT-ADOLESCENT COMMUNICATION ON CONDOM EDUCATION

15. Have you ever talked to your child about condoms?

Yes [ ] No [ ]

16. If Yes for what reason?.....

17. If No why not? ……

18. Have your child or children ever asked you questions on condom?

Yes [ ] No [ ]

19. Do you want to provide condom education for your adolescent child?

Yes [ ] No [ ]

20. If yes, for what reasons? .....

21. If no, why not? ……

22. Does condom education have an effect on the adolescent?

Yes [ ] No [ ]

23. If yes, how does it affect the adolescent?

……

24. If no, why not? ……..

25. Will a provision of condom education lead the adolescent into sexual experimentation?

Yes [ ] No [ ]

26. Give one main reason for your answer to question 25…….

27. Do you agree that parents must give condom education to their adolescent children?

Strongly Agree [ ]

Agree [ ]

Strongly Disagree [ ]

Disagree [ ]

28. Give one main reason for your response to the answer given in question 27.....

29. Does your religion approve of providing information on condom use to adolescents?

Yes [ ] No [ ]

30. If yes for what reasons? .....

31. If no why not? .....

SECTION D: PARENTS' PERCEPTION ON CONDOM EDUCTION FOR ADOLESCENTS

Indicate your agreement or disagreement to the following statements

SA = Strongly Agree A = Agree N = Neutral D = Disagree SD = Strongly Disagree

No.	STATEMENT	SA	A	N	D	SD
32.	I do not feel comfortable talking about condom to my adolescent					
33.	Parents must be first educators on condom for adolescents					
34.	Fathers should educate their children on condom					
35.	Mothers should educate their children on condom					
36.	Condom education must take place in the school setting					
37.	Female teachers must educate adolescents on condom					
38.	Male teachers must educate adolescents on condom					
39.	Educating adolescents on condom will have an effect on them					
40.	Condom education initiates adolescents into early sex					

SECTION E: PARENT'S INTENTION ON THE PROVISION OF CONDOM EDUCATION FOR ADOLESCENTS

41. Do you intend proving condom education for your adolescent child?

Yes [ ] No [ ]

42. If Yes, give one main reason.....

43. If No, give one main reason ……

44. At what level of the adolescent will you want condom education to be introduced?

Primary school [ ]

J.H.S. [ ]

S.H.S. [ ]

Tertiary level [ ]

45. Give one main reason for your response in question 44……..

46. Who would you prefer to give condom education in the school setting?

Female teachers [ ]

Male teachers [ ]

Both male and female teachers [ ]

47. Give one main reason for your answer above…….……