TECHNIUM
SOCIAL SCIENCES JOURNAL

Vol. 9, 2020

A new decade for social changes

www.techniumscience.com

ISSN 2668-7798

Technium Social Sciences Journal
Vol. 9, 195-210, July 2020
ISSN: 2668-7798
www.techniumscience.com

Family Communication Patterns and Adolescent Sexual and Reproductive Health: Experiences from Coastal Communities in Ghana

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Abstract. A good understanding of human growth and development helps in the smooth transition of an individual from one stage to another. One of such stages is adolescence, which presents a lot of challenges as well as opportunities. There are differences in the extent to which families encourage conversation, the extent to which they demand conformity to family values as well as the extent to which families pass down strongly held family values from one generation to another, regarding changes that occur during adolescence. The study examines Parent-Child Communication Patterns between parents and adolescents in coastal communities in Ghana. Also, the study explored the effects of parent-child communication related to sexual and reproductive health in improving adolescent sexual reproductive health practices in Ghana. Data was collected from 300 adolescents in selected coastal communities within the Cape Coast Metropolis in Ghana. We found that many parents in the coastal communities within the Cape Coast Metropolis are unable to transmit SRH information to their children. The findings also revealed that level of formal education influenced parents' ability to transmit SRH information to adolescents and exposes poor parent-adolescent relationship regarding SRH information in the communities studied. Aside from contributing to literature and informing policy directions on family communication patterns regarding adolescent SRH, the study brings more insight on how parents and their adolescents along coastal communities in Cape Coast, Ghana communicate SRH issues. Implications for counselling are outlined.

Keywords. Parent-child communication patterns, adolescence, sexual and reproductive health, family communications patterns, Ghana.

1. Introduction

Family communication behavior and family beliefs regarding the way members of a family should communicate with one another are intimately associated, aggregating to create family

Technium Social Sciences Journal
Vol. 9, 195-210, July 2020
ISSN: 2668-7798
www.techniumscience.com

communication patterns (Koerner & Mary Anne, 2002). Every stage in the developmental life of humans comes with its peculiar issues. Effective sexual reproductive health communication between parents and adolescents would most likely promote healthy sexual development and minimize risks associated with adolescence. People have ways of dealing with these human development issues as they come. However, when an individual has a good understanding of the stages of human growth and development, and he/she is clothed with the capacity to manage the challenges associated with each stage, largely, it helps to transition smoothly. One of such stages of human development is adolescence, which presents a lot of challenges as well as opportunities. The World Health Organization (W.H.O) defines adolescence as the second decade of life which is a period in which an individual undergoes major physical and psychological changes (W.H.O, 2009). Adolescence is characterized by a lot of changes – social, emotional, physical and biological. Due to these changes, adolescents need a lot of information that they can rely on. Information may come from several sources and through different means. Awusabo-Asare and Abane (2004) assert that lack of adequate knowledge renders adolescents vulnerable and exposes them to unplanned teenage pregnancies and sexually transmitted infections (STIs).

There are differences in the extent to which families encourage conversation, the extent to which they demand conformity to family values as well as the extent to which families pass down strongly held family values from one generation to another, with regards to changes that occur during adolescence. Effective sexual reproductive health communication between parents and teenagers will most likely promote healthy sexual development and minimize risks associated with adolescence. Communication is a key means for parents to convey sexual values, beliefs, expectations and knowledge to their offspring, especially adolescents. Adolescents in the coastal communities appear to lack the needed sexual and reproductive health information necessary to aid their smooth transition from adolescence to adulthood (Regmi, Simkhada, & Van Teijlingen, 2008). They assert that most parents in such communities lack the needed SRH information, hence; are unable to pass same to their young ones.

Meanwhile, the needs of adolescents especially, regarding SRH is a collaborative responsibility of health care systems, families of adolescents and the communities within which adolescents live (Cherry & Dillon, 2014). Yesus and Fantahun (2010) conclude that parent-adolescent communication is important for fruitful adolescence. However, in 2016, the Cape Coast Metropolis recorded high rates of teenage pregnancy, HIV/AIDs and other Sexually Transmitted Infections (STIs) (Ghana Health Service Report, 2016). Due to how vital issues concerning adolescence and adolescents is, it has attracted the attention of researchers, especially in developed countries, hence, several studies have been conducted in the area. Despite the extant literature on adolescence and Sexual and Reproductive Health (henceforth, SRH), especially in developed countries, the extent to which family communication patterns affect how SRH information is handed down to adolescents has not received much empirical attention in a developing country like Ghana. For instance Aperkor (2016) reports that sexual communication between parents and adolescents in the Ashiedu-Keteke sub-metro in the Greater Accra region of Ghana is not effectively done. She found that adolescents in the sub-metro do not approach their parents for SRH information/education for lack of trust. More worrying is the fact that recent report from the Ghana Health Service indicate that teenage pregnancy, HIV/AIDs and STIs are on the increase in Ghana (Ghana Health Service, 2017).

It is, therefore, very prudent to find out if there exist any parent-adolescent SRH communication among parents and adolescents in the Cape Coast Metropolis.

The main objective of the study was to examine Parent Child Communication Patterns regarding adolescent SRH in coastal communities in the Cape Coast Metropolis of Ghana. The

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Vol. 9, 195-210, July 2020
ISSN: 2668-7798
www.techniumscience.com

specific objectives were: to analyze the ability of parents to transmit SRH information to their children; to examine the differences in communicating sexual and reproductive health issues among male and female adolescents; to explore the mode of communicating sexual and reproductive health information and its effects on improving adolescent sexual reproductive health practices in the Cape Coast Metropolis of Ghana.

We assessed the level of SRH communication between parents and their adolescents in these communities. Three research questions were formulated to direct the study:

1. To what extent are parents in the coastal communities within Cape Coast Metropolis able to transmit sexual and reproductive health information to their adolescents?
2. How do parents' educational levels influence their ability to transmit sexual and reproductive health information to their adolescents?
3. What are the gender differences regarding SRH communication between adolescents and their parents?
4. What is the effect of family communication pattern on adolescents' sexual reproductive health behavior?

The following hypotheses were tested:

H1. There is statistically significant relationship between parents' mode of communicating SRH and the effect of communication on the wards.
H2. There are significant differences in the family communication patterns among male and female adolescents.

2. Literature review

Adolescent SRH issues are crucial to every nation's development, and as such many countries pay a great deal of attention to issues regarding adolescence and adolescents. Literature has been reviewed to capture prior studies in the area relevant to our study under the following headings: parent-child communication patterns among adolescents and their parents; Differences in gender regarding SRH communication between adolescents and parents; Influence of parents' educational background on parent-child communication regarding SRH; Relationship between Family Communications Patterns and communication traits of parents and adolescents; and Barriers to communicating SRH.

2.1. Parent-child communication patterns among adolescents and their parents

To be able to share information effectively, there must be a common ground which facilitates assimilation of whichever information is shared. Undoubtedly, parents have a great influence on the SRH of their children. Uniquely, parents have an opportunity to transmit SRH knowledge to their adolescents (Evans et al., 2019). There exist patterns of communication at most levels. Tesso, Fantahun, and Enquselassie (2012) are of the view that one of the main avenues of channeling sexual values, beliefs and expectations is through sexual communication among parents and their wards. In Ethiopia, communication between parent and their wards regarding SRH is inglorious (Taffa et al., 2002). Jejeebhoy, Santhya, and Council (2011) report that there are variations in the communication patterns among parents and their children in India, and these variations are largely dependent on the sensitivity or otherwise of the topic/subject discussed. Relatedly, Biddlecom, Awusabo-Asare and Bankole (2009) report that adolescents who are not married experience low levels of parent-child communication regarding sexual issues. According to Jang and Kim (2012) parent-child communication patterns that are open in nature have minimal influence on children's assimilation of information passed down to them

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Vol. 9, 195-210, July 2020
ISSN: 2668-7798
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by their parents. Howell (2001) avers that SRH communication is more habitual between parents and their daughters than it is with sons (see Feldman & Rosenthal, 2000; Russo, 1992; Baldwin & Baranoski, 1990).

2.2. Differences in gender regarding SRH communication between adolescents and parents

Discourse on SRH among family, peers definitely has positive effect on adolescents' sexual behavior (Melaku et al., 2014). Evans et al. (2019) report that parents communicate risks associated with sexual issues as compared with communication about sex-positive issues. They further state that regarding gender, there is less SRH communication between fathers and their daughters. Taffa, Haimanot, Desalegn, and Tesfaye (2017) report that adolescents in Ethiopia exchange SRH information with their peers, mostly, of same sex. This, they say is largely, due to the perception of SRH issues as matters of taboo. In Nigeria, Iliyasu, Aliyu, Abubakar, and Galadanci (2012) aver that mothers often discuss reproductive health matters with their daughters, even though most mothers do not have adequate SRH knowledge. In the Brong Ahafo region of Ghana, a study by Manu, Mba, Asare, Odoi-Agyarko, and Asante (2015) find that, as compared to fathers, mothers talk to their daughters more about SRH issues. Shams, Parhizkar, Mousavizadeh, and Majdpour (2017) are of the view that mothers must be empowered with SRH knowledge because they (mothers) are in the best position to educate their adolescent girls on SRH. Wilson and Koo (2010) report gender differences in parent-child communication regarding SRH, where fathers, compared with mothers were found to communicate minimally about SRH to their adolescents, and conclude that in order to subdue communication barriers, especially regarding SRH, fathers need to be supported.

Also, Kapungu, Baptiste, Holmbeck, McBride, Robinson-Brown, Sturdivant, and Paikoff (2010;251) find that mothers talk habitually about SRH with their adolescent daughters than they do with their adolescent sons, however "parental messages" for adolescent daughters are often shielded, and this is corroborated by Pick, Susan and Palos, (1995). In a related study, Nwoga (2000) find that African-American mothers transmit SRH information to adolescent girls through storytelling, mostly, stories based on personal experiences. In East Africa, Abdallah, Magata, and Sylvester (2017) report that mothers are comfortable communicating SRH information to their adolescent daughters than to their male (adolescent) counterparts, and fathers also communicate more with their sons (adolescents) about SRH because most parents feel shy doing so with opposite sex (see also, Murphy, Rotheram-Borus, & Reid, 1998). However, Harris, Sutherland, and Hutchinson (2013) found that adolescent males discussed SRH issues with their mothers often, compared to frequency of discussions between adolescent daughters and their mothers. In Mexico, Atienzo, Walker, Campero, Lamadrid-Figueroa, and Gutirrez (2009) found that majority of adolescents (male and female) communicate with their parents about sex, and they do so mostly with their mothers. However, Busse, Fishbein, Bleakley, and Hennessy (2010) found no gender differences regarding SRH communication among adolescents.

In reviewing literature on parent-child communication studies regarding sexuality and HIV/AIDS in sub-Saharan Africa, Bastien, Kajula, and Muhwezi (2011;17) reported that, generally, discussions on SRH, instead of being open and direct, are often "authoritarian and unidirectional" in nature, usually, characterized by vain threats. Muhwezi et al. (2015) found that, the perception of adolescents tended to point to more open and frequent communication with mothers than fathers and to cordial relationships with mothers. Fathers were perceived by adolescents to be strict, intimidating, unapproachable and unavailable. While adolescents tended to generally discuss sexual issues with mothers, male adolescents communicated less with anyone on sex, relationships and condoms. Much of the parent-adolescent communication

Technium Social Sciences Journal
Vol. 9, 195-210, July 2020
ISSN: 2668-7798
www.techniumscience.com

was perceived to focus on sexually transmitted infections and body changes (Muhwezi et al., 2015).

2.3. Influence of parents' educational background on parent-child communication regarding SRH

Communicating SRH information could involve several factors such as the educational level/background of parents of adolescents. Ryan, Franzetta, Manlove, and Schelar (2008) report that one factor that prevents parents from communicating SRH information to their adolescents is low educational background of parents. Ayehu, Kassaw, and Hailu (2016) state that, parents with low educational backgrounds mostly decline to talk about sex with their adolescents largely, because they feel ashamed. Trinh, Steckler, Ngo, and Ratliff (2009) found that low parental educational level prevents parents from discussing issues concerning sex with their children. Taffa et al. (2017) found that parent's level of education to a large extent impact the frequency and depth of sexual communication with their adolescents. They further noted that parents with high educational backgrounds communicate frequently about SRH with their adolescents in Ethiopia. Mbugua (2007) indicates that, in Kenya, highly educated parents, especially, mothers are able to transfer information regarding infectious diseases such as influenza, but are unable to do same for STIs such as HIV/AIDS largely due to certain forbidden factors relating to socio-culture and religion.

2.4. Relationship between Family Communications Patterns and communication traits of parents and adolescents

Communication in families can be largely affected by individual traits, and this can be annihilative or formative in nature. The family, to a large extent is the fundamental communication environment available to children. Some people perceive the family as a unit that enhances propels and promotes the cultivation and maintenance of healthy relationships, while others think the family is a unit that remind them about awful events. According to Bate (1992), cited in Booth-Butterfield and Sidelinger (1997) communication that is destructive in nature is viewed as asocial, and this establishes roadblocks among family members, leading to unpleasant relational effects. On the other hand, constructive family communication, which is also referred to as concept-oriented family communication is deemed pro social which produces a family communication atmosphere that is open in nature thereby increasing relationships in the family. Research has proven that parents do have some control over their adolescents if the pattern of communication is not inimical to openness (Ritchie & Fitzpatrick, 2013; Wilks, 1986).

Koerner and Mary Anne (2002) aver that families that possess high conversation orientation encourage free interaction among members of the family, whereas families which have low conversation orientation inhibit free interaction among members of the family. In her book, Baumrind (2005:62) identified three parenting constellations—'authoritative, authoritarian, permissive' as empirical descriptions of how parents of adolescents, differed on various variables. She found in a further study that adolescents who had authoritative parents were the most competent and least maladjusted. However, those whose parents were only moderate, that is concept-oriented and non-authoritarian-directive, were almost as competent and well adjusted.

2.5. Barriers to communicating SRH matters

It is unacceptable culturally, to talk to one's children about sex in Northwest Ethiopia (Ayehu et al., 2016). In Thailand, Sridawruang, Pfeil, and Crozier (2010) found that core cultural values prevent parents from discussing SRH issues with their children. From their findings, they

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Vol. 9, 195-210, July 2020
ISSN: 2668-7798
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further state that education regarding SRH is not considered a duty for parents. Trinh, Steckler, Ngo, and Ratliff (2009) found restrictions in the forms of low parental confidence and knowledge level, lack of good communication skills and feeling of embarrassment with regard to discussing SRH with adolescents in Vietnam. Mbugua (2007) attributes parents' inability to discuss SRH issues with their adolescents in Kenya as they do with diseases such as influenza, to socio-cultural and religious factors. Baku, Adanu, and Adatara (2017) found that parents' cultural beliefs prevent them from discussing SRH issues with their adolescents. As cited in Baku, Adanu, and Adatara (2017), Izugbara (2008) reports that, in Nigeria, parents shelve issues regarding condoms and contraceptives in the course of educating their adolescents on sexuality because to them, this may spur promiscuity among adolescents. Baku et al. further state that should a child seek knowledge about sex, parents declined to provide such knowledge since they (parents) felt the child was not mature enough to know. They also found that it is a taboo to mention certain parts of the human body openly.

3. Methodology

We adopted the descriptive research design. The sample consisted of 300 adolescents aged between 13 and 19 years. The simple random sampling technique was employed in selecting the adolescents from some selected Junior High Schools in Coastal Communities in the Cape Coast Metropolis.

The research instrument used was the Family Communication Inventory which has components adapted from the Family Communication Patterns (FCP) instrument developed by Ritchie and Fitzpatrick, (1990). The instrument was pilot tested on 30 adolescents from coastal communities in Accra Metropolis. A Cronbach Alpha reliability estimate of 0.78 was achieved form the Pilot test. The information gathered from the data collected was analyzed using descriptive and inferential statistics. Any item with a mean score less than 2.0 means the respondents agreed to the item and any item with a mean more than 2.0 meant respondents did not agree to the item.

3. Results

Research Question One: To what extent are parents in the coastal communities within Cape Coast Metropolis able to transmit sexual and reproductive health information to their adolescents?

To answer this research question, respondents responded to fourteen items on parents' ability to discuss SRH issues with their children. Table 1 displays the results.

Table 1. Means and Standard Deviation on Parents' Ability to discuss SRH issues

No.	Statement	Mean	S.D
1	My parents provide me with prompt information on Sexual and Reproductive Health (SRH) issues	2.42	.872
2	My parents do not create a friendly environment to discuss SRH issues	1.72	.923
3	My parents insult me when I ask for SRH education	1.64	.898
4	My parents do not give me SRH information because they think it would make me sexually promiscuous	1.65	.903
5	My parents use other people's situations as opportunity to talk to me about SRH issues	1.69	.884
6	I first learnt about changes during adolescence from my parents	2.25	.943

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7	My parents taught me about changes during puberty and taught me personal hygiene associated with puberty	2.21	.979
8	My parents talk to me about STIs from time to time	2.29	.954
9	My parents encourage me to share my experiences regarding SRH issues with them	2.17	.849
10	I think my parents are not comfortable with discussing SRH issues with me	1.54	.851
11	My parents easily discuss issues on SRH with me	2.05	.765
12	My parents tell me to ask my teachers about SRH issues whenever I ask them SRH-related questions	1.76	.945
13	My parents only started talking to me about changes during puberty when I started experiencing them	1.89	.970
14	Growing up, I never heard my parents mention the real names of the sexual organs.	1.33	.709
	Overall	2.30	.423

Table 1 shows the means and standard deviations of adolescents' perception of their parents' ability to communicate SRH information to them. Notably, a mean less than 2 shows that majority of the respondents agreed with the item and vice versa. The lower the mean the more agreeable respondents were to the item. It can be seen that the adolescents agreed with eight out of the 14 items. Interestingly, these items are quite negative. Implying that, parents to a large extent are not able to transmit SRH well enough to the expectation of adolescents. The overall mean also confirms the inability of parents to transmit SRH information to adolescents.

We consider these findings quite worrying as it suggests that adolescents would lose out on getting useful SRH information from their parents. In support of this, (Taffa et al., 2002) found that in Ethiopia, communication between parents and their wards regarding SRH is inglorious. Relatedly, Biddlecom, Awusabo-Asare and Bankole (2009) have reported that adolescents who are not married (such as the respondents in this study) experience low levels of parent-child communication regarding sexual issues. Also, Adzovie and Adzovie (2020) in another study on social media and adolescent SRH found that adolescents rather pick more SRH information from their peers and social media. Their finding may be due to the fact that adolescents ask their parents for SRH information, but do not receive the answers they need, which leaves them with the option of peers. This, to the researchers, is not good enough.

Research Question Two: How do parents' educational levels influence their ability to transmit sexual and reproductive health information to their adolescents?

This research question sought to investigate how parents' educational levels could influence their ability to communicate SRH information to adolescents. Educational level was considered at four levels namely; Tertiary (56), Senior High (112), Basic (84) and None (48). Tables 2 and 3 show the results. Table 2 presents the ANOVA results while Table 3 displays post hoc results

Table 2. ANOVA on Parents' Educational Level and Ability to Share SRH Information

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	16.197	3	5.399	42.730	.000
Within Groups	37.400	296	.126		
Total	53.597	299			

$p < 0.05$

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Results in Table 2 show there were statistically significant differences in the ability of parents with different educational backgrounds to share or communicate SRH information to adolescents.
To find where the significant differences were, a Tukey HSD post hoc was done. Table 3 displays the results.

Table 3. Tukey HSD on Educational Levels and Parents' Ability

Dependent Variable	(I) Educational Level	(J) Educational Level	Mean Difference (I-J)	Sig.
Parents' Ability	Tertiary	Senior High	-.50191*	.000
		Basic	-.58844*	.000
		None	-.69324*	.000
	Senior High	Tertiary	.50191*	.000
		Basic	-.08652	.351
		None	-.19133*	.013
	Basic	Tertiary	.58844*	.000
		Senior High	.08652	.351
		None	-.10480	.383
	None	Tertiary	.69324*	.000
		Senior High	.19133*	.013
		Basic	.10480	.383

* The mean difference is significant at 0.05 level

From Table 3, it is clear that the difference is between the tertiary educational level and the others. Notably their means were as follows: Tertiary - 1.83, Senior High - 2.33, Basic level - 2.42, None - 2.52. This implies that parents with tertiary educational level are able to transmit more SRH information to their adolescents while those with lower educational levels find it quite difficult.
Supporting the finding that parents with tertiary education level were better able to transmit SRH information to their children, Taffa et al. (2017) found that parents with high educational backgrounds communicate frequently about SRH with their adolescents in Ethiopia. Perhaps tertiary level education provides more exposure and knowledge to recipients and this makes it easier for them to transmit SRH information. It is possible that those with lower and no educational backgrounds were not able to transmit SRH information because they may not have the facts and may therefore feel embarrassed to display their lack of knowledge to their children. In relation to this, Ayehu, Kassaw, and Hailu (2016) state that, parents with low educational backgrounds mostly decline to talk about sex with their adolescents largely, because they feel ashamed. Trinh et al. (2009) and Ryan, et al. (2008) also found that low parental educational level prevents parents from discussing issues concerning sex with their children.

Research Question Three: What are the gender differences regarding SRH communication between adolescents and their parents?
Research question three investigated gender differences among adolescents with regard to which parent communicated SRH information to them. Table 4 presents the results based on an independent samples t-test.

Table 4. t-test on Gender Differences in Communicating SRH Information

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Which Parents?	Gender	N	Mean	S.D.	T	Df	Sig.
Only Mother	Male	144	1.76	.430	10.318	298	.000
	Female	156	1.24	.431			
Only Father	Male	144	1.83	.374	-5.225	298	.000
	Female	156	1.99	.080			
Both	Male	144	1.71	.456	3.523	298	.000
	Female	156	1.51	.501			
None	Male	144	1.46	.500	-.388	298	.698
	Female	156	1.48	.501			

$p < 0.05$

From the Table 4, there were significant differences among males and females with regard to receiving SRH information from parents. It can be observed that both males and females received more SRH information from their mothers more than their fathers. Looking at the means, though both sexes received from their mothers more than their fathers, the females received more from each of them as well as from both parents more than their fathers.
In support of these findings, Evans et al. (2019) report that regarding gender, there is less SRH communication between fathers and their daughters. Similarly, Iliyasu, Aliyu, Abubakar, and Galadanci (2012) aver that in Nigeria mothers often discuss reproductive health matters with their daughters, even though most mothers do not have adequate SRH knowledge. In Ghana, Manu et al (2015); Wilson and Koo (2010) found that, as compared to fathers, mothers talk to their daughters more about SRH issues. Perhaps mothers are generally more approachable and less-feared so adolescents were able to get more information form their mothers. In support of this, Muhwezi et al. (2015) found that perceptions of adolescents tended to point to more open and frequent communication with mothers than fathers and to cordial relationships with mothers. Fathers were perceived by adolescents to be strict, intimidating, unapproachable and unavailable.
Perhaps fathers felt more comfortable to provide SRH information to their sons than to their daughters because they are shy to do so or not well-versed in SRH information about the opposite sex. In support of this, Abdallah, Magata, and Sylvester (2017) report that fathers communicate more with their sons (adolescents) about SRH because most parents feel shy doing so with opposite sex.

Research Question Four: What is the effect of family communication pattern on adolescents' sexual reproductive health behavior?

This question sought to find out the effect of the family communication pattern (FCP) on adolescents' sexual and reproductive health behavior. There are two main family communication patterns looked at in this study namely socio-oriented and concept-oriented (Ritchie, 1991). Table 5 shows the results based on a Pearson Product Moment correlation.

Table 5. Correlation (Pearson) of Family Communication Pattern and the Effect on Adolescents' Sexual and Reproductive Health Behaviour

		Effect	Socio-oriented FCP	Concept-oriented FCP
Effect	Pearson Correlation	1	-.093	.251**

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	Sig. (2-tailed)		.109	.000
	N	300	300	300
Socio-oriented FCP	Pearson Correlation	-.093	1	.046
	Sig. (2-tailed)	.109		.426
	N	300	300	300
Concept-oriented FCP	Pearson Correlation	.251**	.046	1
	Sig. (2-tailed)	.000	.426	
	N	300	300	300

** p < 0.01(2-tailed)

As shown in Table 5, the Pearson's Product Moment correlation (r) was run to determine the relationship between Socio-oriented FCP and the effect on adolescents SRH behaviors as well as that of the Concept-oriented FCP. The results in the Table show a very weak statistically insignificant inverse relationship between socio-oriented FCP and its effect on adolescents' SRH behaviors (r = -0.093; n = 300; p> 0.109). This implies that there is no statistically significant relationship between socio-oriented FCP and the effect of SRH communication on the adolescents. The inverse correlation implies that a change (increase) in socio-oriented FCP will lead to a decrease in the effect. The coefficient of determination (r2) is 0.00. This means that socio-oriented FCP explains 0.0% of variation in the effect of FCP on adolescents on their wards. Therefore, the variations may result from other unknown factors. Hust, Wong & Chen (2011) opined that socio-oriented family communication tend to in a way suppress children's ability to express their feelings, since they are thought to obey norms strictly, and to at all times endeavor to avoid conflicts. This, they aver that socio-oriented parents achieve through some of control as well as conformity to family values (See Austin, 1993).

Similarly, the Pearson's Product Moment correlation (r) was run to determine the relationship between concept-oriented FCP and its effect on adolescents' SRH behaviors. The results in the Table show a weak statistically insignificant inverse relationship between concept-oriented FCP and its effect on adolescents' SRH behaviors (r = 0.251; n = 300; p>0.000). This implies that there is statistically significant relationship between concept-oriented FCP and its effect on adolescents' SRH behaviors. The direct correlation implies that a change (increase) in concept-oriented FCP will lead to an increase in the effect on adolescents' SRH behaviors. The coefficient of determination (r2) is 0.06. This means that concept-oriented FCP explains 6.0% of variation in effect on their wards. Therefore, the variations may result from other unknown factors.

Hypothesis One

H1: There is statistically significant relationship between parents' mode of communicating SRH and the effect of communication on the wards.

In an attempt to answer the research hypothesis stated for this study, the Pearson's Product Moment correlation coefficient was used to test if there is a statistically significant relationship between parents' mode of communicating SRH and the effect of communication on the wards. The directions and degrees of relationship were also indicated. Both variables were continuous and therefore the assumptions of the statistical tool adopted was not violated. Results are displayed in Table 6.

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Table 6. Correlation (Pearson) of Parents' Mode of Communicating SRH and the Effect of Communication on Wards

		Mode	Effect
Mode	Pearson Correlation	1	.073**
	Sig. (2-tailed)		.206
	N	300	300
Effect	Pearson Correlation	.073**	1
	Sig. (2-tailed)	.206	
	N	300	300

** $p < 0.01$(2-tailed). R^2=.01 (1%).

As shown in Table 6, the Pearson's Product Moment correlation (r) was run to determine the relationship between parents' mode of communicating SRH and the effect of communication on the wards. The results show a weak statistically insignificant positive relationship between parents' mode of communicating SRH and the effect of communication on the wards ($r = 0.073$; $n = 300$; $p > 0.206$). Therefore, the hypothesis (H1) was rejected. This implies that there is a statistically insignificant positive relationship between parents' mode of communicating SRH and the effect of communication on the wards. The positive correlation implies that a change (increase) in mode of communicating SRH by parents will lead to an increase in the effect of the communication. The coefficient of determination (r2) is 0.01. This means that parents' mode of communicating SRH information explains 1.0% of variation in effect on their wards. Therefore, the remaining 99.0% of the variations may result from other unknown factors.
Notably 47% of the respondents reported that their parents communicate SRH information to them by providing books on the subject, 34% received insults from parents and 19% received SRH information through storytelling. In support of this, Bastien, Kajula, and Muhwezi (2011) report that, generally, discussions on SRH, instead of being open and direct, are often authoritarian and unidirectional in nature, usually, characterized by vain threats. In a related study, Nwoga (2000) find that African-American mothers transmit SRH information to adolescent girls through storytelling, mostly, stories based on personal experiences.

Hypothesis Two
There are significant differences in the family communication patterns among male and female adolescents.
Hypothesis two sought to test the gender differences in the family communication patterns (FCP) of adolescents in coastal communities in the Cape Coast metropolis. There are two main family communication patterns looked at in this study namely socio-oriented and concept-oriented (Ritchie, 1991). Table 7 presents the t-test results for the hypothesis.

Table 7. t-test on Gender Differences in Family Communication Patterns (FCP)

FCP	Gender	N	Mean	S.D.	t	df	Sig.
Socio-Oriented FCP	Male	144	1.58	.709	-1.302	298	.194
	Female	156	1.69	.760			
Concept-Oriented FCP	Male	144	2.14	.539	2.688	298	.008
	Female	156	1.98	.523			

$p < 0.05$

Technium Social Sciences Journal
Vol. 9, 195-210, July 2020
ISSN: 2668-7798
www.techniumscience.com

An independent samples t-test was conducted to compare the gender differences of adolescents with regard to their family communication patterns. There was a statistically significant difference (t (298) = 2.688, p =.008) between males (M=2.14) and females (M=1.98) on the concept-orientation family communication pattern. The means in the Table imply that both males and females experience socio-oriented family communication pattern as their means were less than 2; however, the difference was not statistically significant. Although there was no significant difference among males and females with the socio-oriented family communication pattern, the means showed that males agreed more to it than the females.

4. Conclusions and recommendations

This study investigated the experiences of adolescents regarding family communication patterns and their sexual and reproductive health behaviours. The findings have shown that many parents are unable to transmit SRH information to their children. Parents with tertiary level education background found it easier to communicate SRH information to adolescents more than those with lower or no formal education background. Also both males and females received more SRH information from their mothers than their fathers. Our findings have indicated that the socio-oriented FCP is most prevalent in coastal communities in the Cape Coast Metropolis. These findings point to the existence of poor parent-child communication about sexual and reproductive health issues. We conclude that parent-child communication regarding SRH information sharing is crucial to the wellbeing of adolescents in coastal communities in the Cape Coast Metropolis. We also conclude that appreciable levels of formal education directly and indirectly impact how parents influence their adolescents with respect to SRH information, since lack of same is a barrier to SRH information communication among parents.

We recommend that:

1. Parents check the timing for communicating SRH information to their children as respondents reported their parents only used other people's experiences as opportunities to educate them on SRH. Parents do not need to wait for signs that a child is sexually active before they educating them on the consequences.
2. There should be a more cordial way for parents to communicate SRH information to their children other than insults as this will deter adolescents from getting close to their parents for the right SRH information.
3. Mothers need to be empowered with rich SRH knowledge or information because they (mothers) are in the good position to educate their children on SRH issues.

5. Implications for counselling

1. Counsellors should provide more education in SRH through written sources that can be accessed by parents to give to their children since many of the parents provided books on SRH to their children as their mode of communication.
2. Guidance programs to empower mothers (women) with rich SRH knowledge should be organized while fathers are encouraged to get more involved in educating children especially, their adolescents on SRH issues.

6. Acknowledgements

This study has been supported by the Faculty of Multimedia Communications of Tomas Bata University in Zlin, Czech Republic. Our sincere gratitude goes to the Dean, all Vice-Deans and all staff of the Faculty, for the invaluable assistance. We also acknowledge the contributions of the respondents for the study.

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