UNIVERSITY OF CAPE COAST

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION AMONG RURAL FAMILIES IN GHANA: A STUDY IN ADAKLU, VOLTA REGION

ANTHONY SENANU AGBEVE

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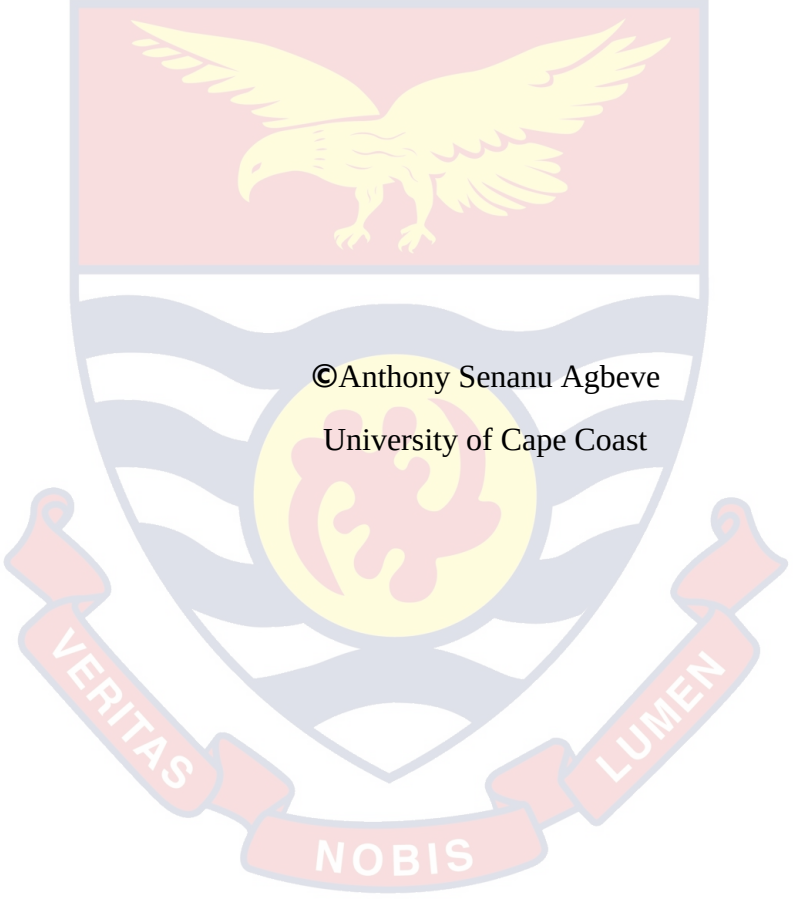

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BY

ANTHONY SENANU AGBEVE

Thesis submitted to the Department of Sociology and Anthropology of the Faculty of Social Sciences, College of Humanities and Legal Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Philosophy Degree in Sociology

AUGUST 2020

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: Anthony Senanu Agbeve

Supervisor's Declaration

I 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.

Supervisor's Signature: ..... Date: .....

Name: Dr. Daniel Yaw Fiaveh

ABSTRACT

Although sexual and reproductive health education contributes to the development of adolescents and young people, it remains a challenge among rural families in Ghana. Even in societies where young people have access to sexual and reproductive health information, discourse on sexual matters remains generally repressive due to socio-cultural norms and mis/conceptions. These influence the sort of issues that are discussed at home with young people within the context of their age and gender thereby making some have low knowledge and uninformed about SRH issues and marginalised. Using qualitative in-depth interviews and group discussions of purposively sampled households in Adaklu, the study investigated sexual and reproductive health discussions among families and how such discussions have empowered young people aged 16-19 years. The findings showed that access to sources of SRH information impacts young people's sexual attitudes and behaviours. Sexual and reproductive health discussions among families were not comprehensive and limited to areas some parents considered as non-sensitive issues while neglecting areas (such as contraception, dating, and relationships). Gendered socialisation scripted on cultural norms/values was found to be key in the entire sexuality education process and this hindered young people's access to sexual and reproductive health information. Based on the findings, it will be useful for stakeholders (e.g., parents/guardians, community, state, and non-state actors, and other gatekeepers) to think of innovative and adolescent-friendly SRH education ideas/strategies, for young people to acquire the essential knowledge, skills, and efficacy to make informed decisions about their sexuality.

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DEDICATION

To my mother, siblings, my late father, and step mother.

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LIST OF ABBREVIATIONS

ASRHE	Adolescent Sexual and Reproductive Health Education
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CPD	Conference on Population and Development
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, Gay, Bisexual, and Transgender
NPC	National Population Council
O^3	Our Rights, Our Lives, Our Future
SDG	Sustainable Development Goals
SHEP	School Education Programme
SRH	Sexual and Reproductive Health
SRHE	Sexual and Reproductive Health Education
SRHR	Sexual and Reproductive Health Rights
STDs	Sexually Transmitted Diseases

UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background of the Study

The study was about sexual and reproductive health education (SRHE) among families in rural Ghana. It focused on exploring the influence of SRHE on young people's sexual attitudes and behaviour in Adaklu of the Volta region of Ghana.

My interest in sexual and reproductive health education was heightened after I engaged with the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) on a project captioned "a baseline study for empowering adolescent girls through improved access to comprehensive sexuality education and rights". As a research assistant on the project, one thing I observed was that young people for fear of being misconstrued as engaging in early sexual activities were unable to approach and discuss SRH issues with their parents. This development gave me some renewed interest in the field of SRHE. My interest was further aroused when stakeholders (such as opinion leaders/traditional rulers, religious groups, and anti-lesbians, gay, bisexual, and transgender [LGBT] movements) protested against the introduction of comprehensive sexuality education (CSE) in Ghana. These scenarios further aroused my interest in the field of SRHE. My initial thought was why matters related to sexual and reproductive health education call for resistance although overwhelming evidence from the Ghana Demographic and Health Surveys (GDHS, 2014) points to increased sexual activity among young people in Ghana.

Sexual and reproductive health (SRH) education is considered key to the prevention of the spread of sexually transmitted diseases (STDs) and pregnancy among young people (UNESCO, 2009). The introduction and adoption of various policy programmes such as the International Conference on Population and Development (ICPD), ICPD Plus Five, International Planned Parenthood Federation (IPPF) and Committee of the Convention on the Rights of the Child (CRC), Sustainable Development Goals (SGD 3), and the African Union's Agenda 2063 have seen the support of stakeholders and civil society groups for adolescent sexual and reproductive health education (ASRHE). Sexual and reproductive health education constitutes the well-being of individuals to develop into sexually responsible beings and being able to enjoy their sexual and reproductive health rights (WHO, 2010). SRHE also helps inform young people about their reproductive health so they can avoid challenges associated with their sexual growth and development (UNESCO, 2009). Similarly, SRHE also helps young people develop their skills and enable them to make significant contributions to the development of their nation (UNFPA, 2014). In light of this, various intervention programmes (e.g., by the ICPD, IPPF, and UNESCO) have been made although not comprehensive due to cultural norms, apprehension, and mis/information.

Like many other cultures, in Ghana, sexual matters are generally sensitive and not openly discussed due to cultural norms and religious inhibitions often situated within the mis/information that educating young people about sex will make them curious and predispose them to experiment same (Awusabo-Asare, et al., 2017). This perception inhibits the sort of issues that are discussed at home with young people thereby making them sometimes uninformed about their sexuality.

About 22 percent of Ghana's population are young people between the ages of 10-19 years (GSS, 2013). These people face challenges associated with their sexual growth and development. For instance, the onset of puberty among boys and girls can be extremely challenging for them which might contribute to their early involvement in risky sexual behaviours. Ghana's Ministry of Education together with other agencies such as the Planned Parenthood Association of Ghana, International Marie Stopes Ghana, and the National Population Council of Ghana have developed programmes geared towards promoting the SRHE of young people. Despite these efforts, little impact is felt based on reported incidences of early adolescent pregnancy and marriage and relationship challenges particularly in deprived areas of Ghana.

Using data from rural Ghana, this study explores sexual and reproductive health education among some rural Ghanaian families and how such education empowers young people. This study is useful for specific fields in the discipline of sociology and anthropology namely: sociology of gender and sexuality, sex education, adolescent sexuality, population studies, and family violence. It is also useful to stakeholders and policymakers interested in understanding sexual and reproductive health education among Ghanaian families.

Statement of the Problem

Although sexual and reproductive health education (SRHE) contributes to the development of young people and for advancing the sustainable development goals (e.g., goals, 3-good health and well-being), SRHE remains a challenge among families in Ghana as young people are at disproportionate risk of HIV and other

sexually transmitted infections, early and unintended pregnancy, gender-based violence, and child marriage (Manu, Mba, Asare, Odoi-Agyarko, & Asante, 2015; UNESCO, 2019). Even in societies where young people have access to SRHE, they know little about sex. Young people are marginalized and discussions of sex remains generally repressive (Awusabo-Asare et al., 2017) due to cultural norms and perceptions which inhibit the content and the issues that are discussed and at what age with a particular gender including mis/conceptions that portray SRH discussions with young people as predisposing them to engage in early sexual activities (Awusabo-Asare et al., 2017; Baku et al., 2018).

SRHE in whatever form it takes, reduces inequalities, can break the cycle of poverty, foster tolerance, reach gender equality, and empower young people to live more healthy lives and attain more productive livelihoods (Awusabo-Asare et al., 2006; Fiaveh, 2018; UNICEF Ghana, 2016). Despite its relevance, discussions of sex are still considered sensitive and not comprehensive in Ghana (Manu et al., 2015). This makes young people unable to access credible information about their sexual and reproductive health wellbeing (Biddlecom, Awusabo-Asare & Bankole, 2009).

Using qualitative in-depth interviews and group discussions of purposively sampled households in Adaklu, a suburb of the Adaklu district in the Volta region of Ghana, I investigate SRH discussions among families and how such discussions have empowered young people. What are the perceptions, knowledge, and attitudes of parents and their wards on SRHE? What are the SRH issues discussed among parents and their wards? How does SRHE empower young people? What are the

gender differences and barriers to SRHE? These are some of the issues I interrogated in examining SRHE among some rural families in Adaklu.

Study Objectives

The main objective of the study was to investigate sexual and reproductive health discussions among parents and their wards (adolescents) and how such discussions have empowered the latter using Adaklu in the Volta Region of Ghana as a point of reference. Specifically, the study sought to:

1. find out the knowledge, perceptions, and attitudes (KAP) of parents and adolescents about SRH education;
2. examine the content of SRH discussions between parents and adolescents;
3. discuss the consequences of SRH education on or for young people; and
4. interrogate the gender disparities and barriers of SRHE among parents and adolescents.

Significance of the Study

The study investigates the discussions of SRH among young people and their parents in rural Ghana and provides insights on an in-depth understanding of the dynamics of sexual and reproductive health education in marginalised parts of Ghana. The findings are useful in shaping public opinion on the importance of sexuality education and in interrogating misinformation and myths that undergirds the discourse on Comprehensive Sexuality Education (CSE) of young people in Ghana. To a great extent, the findings are also useful in suggesting ways SRH

education can be used as a tool to empower young people with skills and knowledge relevant to their age and gender-specific needs.

The analytical approach of the study contributes to the conceptual knowledge of sexual and reproductive health education. In this regard, the study adds to the literature on sociology of sex and gender, population and health, anthropology of sex and culture. The findings also speak to policy planning and implementation of appropriate SRH programmes in Ghana. Stakeholders and policymakers interested in comprehensive sexuality education may find the discussion useful.

In terms of methodological contribution, the innovative techniques employed (i.e., data collection techniques and procedure) and analysis can serve as useful guides to subsequent efforts in the field, particularly in future studies that attempt to replicate the same from an urban perspective. The codebook developed from an interpretivist's perspective can also inform the development of a larger study from a positivist paradigm, e.g., using a survey.

Conceptual Clarifications

i. **Education:** an enlightening process of acquiring knowledge, skills, moral beliefs, and habits.

ii. **Empowerment:** the process by which an individual is given the authority to make informed choices to make them represent their interests in a responsible and self-determined manner.

iii. **Gender:** the social construct that specifies ideas about behaviours, actions, and roles expected of an individual in a given social and cultural context based on one's sex.

iv. **Habitus:** encompasses socially ingrained habits, skills, and dispositions that determine how individuals and groups act and define the social world around them.

v. **Household Heads:** individuals who have an economic and social responsibility towards a household.

vi. **Risky Sexual Behaviour:** sexual acts and behaviours that increase an individual's probability of exposure to negative outcomes.

vii. **Sex:** the biological characteristics that define an individual as either male or female. Sex, as used in the study could also mean any sexual activity that an individual engages in to satisfy their sexual desires.

viii. **Sexual Activities:** the ways and manner through which individuals express their sexuality.

ix. **Sexual and Reproductive Health (SRH):** the complete state of the physical, social, mental, and physical well-being of individuals in all matters relating to their reproductive health.

x. **Sexual and Reproductive Health Education (SRHE):** the education of individuals on their physical, social, mental, and physical well-being in all matters relating to their sexual and reproductive health.

xi. **Sexual and Reproductive Health and Rights (SRHR):** the concept of human rights applied to the sexual and reproduction health of individuals.

xii. **Adolescent Sexual and Reproductive Health Education (ASRHE):** the education that targets adolescents in all matters relating to their sexual and reproductive health to include their physical, social, mental, and physical well-being.

xiii. **Sexuality:** includes sex, gender identities, and roles, sexual orientation, pleasure, and intimacy that is either experienced or expressed in thoughts, beliefs, attitudes, desires, values, and behaviours.

xiv. **Young People and/ or Adolescents:** includes individuals within the ages of 16-19 years.

Organization of the Study

The study was organized into six chapters. The first chapter focused on the background of the study, statement of the problem, study objectives, the significance of the study, and conceptual definition of terms. The second chapter focused on the literature review. The first section presents the theoretical approaches employed in the study, i.e., cultural reproduction and social reproduction theory and black feminism, whereas the second section reviewed related literature. The reviews focused on the global perspective of SRHE, the roles of UNICEF, UNESCO, and other multi-national organizations. Other areas covered include: African discourse on SRHE, the Ghanaian perspectives on SRHE, and reviews of SRH policies in Ghana.

Chapter three focused on the methodological approaches and the techniques employed in the study. It provides details on the study area (i.e., Adaklu), the research design, the population of the study, the data collection techniques and procedure, data analysis, and a description of some ethical considerations of the

study. The fourth chapter deals with objectives one and two. Thus, it presents discussions on the sexual and reproductive health knowledge and content. The fifth chapter combines objectives three and five. It examines the consequences of sexual and reproductive health education and the dynamics (i.e., gender disparities, and barriers to SRH education). The last, chapter six provides the conclusions and some reflections from the study. It provides a summary of the main findings and the discussions and then suggested the ways forward.

Conclusion

This chapter discussed the motivation for the study and conceptualizes the problem. The chapter problematizes why the need for the study and presents the objectives. The chapter ends by giving conceptual clarifications of the terms used and an overview of how the various chapters of the study were organized.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter discusses the theoretical perspectives (i.e., cultural reproduction and social reproduction theory and black feminism) and reviews relevant literature on sexual and reproductive health education. The literature review focused on sexual and reproductive health education from the global perspective, on Africa and Ghana. It further reviewed sexual and reproductive policies in Ghana. The first sub-section begins with the theoretical underpinnings of the study.

Theoretical Perspectives

The theoretical perspectives underpinning the study explains the attitudes, perceptions, and behaviours that families and young people have regarding sexual and reproductive health education using two broad theories that fall within the constructionist paradigm, namely: cultural reproduction and social production theory by Pierre Bourdieu and black feminists thought drawing insights from Patricia Hill Collins. I begin with the Cultural Reproduction theory.

Cultural Reproduction and Social Reproduction Theory

Bourdieu (1973) described cultural reproduction and social reproduction theory as the process through which dominant social and cultural conditions are established and reproduced. The theory focused on education, social class

relationships, and the family. Bourdieu argues that education plays a key role in perpetuating social inequality and social exclusion. In the cycle of social reproduction, cultural capital assumes central importance as differences in cultural capital represents inequalities in the social class. Cultural capital for Bourdieu represents the transmissible parental cultural code and practices transmitted to children through the process of socialization, a term Bourdieu describes as the habitus. The habitus concept first defined and utilized by Pierre Bourdieu explains human behaviour by understanding how various social phenomenon impacts on individuals within the society.

According to Bourdieu, habitus operates at a subconscious level and defines how individuals and groups act and define their social world. For instance, from birth, we learn to behave and perceive things in a particular way. These behaviours and perceptions are incorporated into our daily lives and predispose us to think in a particular way. Bourdieu further describes the habitus as consisting of a system of embodied arrangements that generate practice in line with society's structural principles. These structural level principles are the informal and formal practices, norms, and values of society through relationships that create new types of meanings. This system of meanings is created and organized through the generative principle of dispositions that are resultant of an individual's material conditions of existence. For instance, a family's socioeconomic status and geographical locations can influence its members to act in certain ways. These factors shape the history of such families thereby creating an internalized structure of dispositions that inherently shapes the way such individuals think and feel about the social world around them.

The structure and nature of the dispositions have far-reaching implications on the attitudes and behaviours of individuals. According to Bourdieu, the habitus is reflexive of existing conditions (i.e., having similar structure/relation) within society. The greater the similarities of existing conditions, the greater the dispositions. Although behaviour is not determined by the social structures embodied in the habitus, the individual is predisposed to act according to the social structures that shape them. For example, gender identity is a habitus component of society that is inculcated into individuals from the moment of birth. These socially ascribed roles predispose individuals to act and behave in a manner based on either being male or female. According to Bourdieu (1973), through the society's institutions, which usually begin with the family, a sense of the habitus valued within society is conferred.

The application of the theory of cultural reproduction and social reproduction examines how the past experiences of families and individuals influence how they perceive sexual and reproductive health education among young people. There is an underlying notion that teaching young people sexually related issues will make them curious about sex. It can be hypothesized that the habitus of current generations on sexual and reproductive health education has been structured by these dispositions which have become the reality of how families view sexual and reproductive health education of young people. Habitus, therefore, can be said to be a part of the socialization process where our experiences are based on what we have experienced in the past and the series of events we go through whiles growing up. These experiences develop into a "matrix of perceptions" that informs how we view the social world. Individuals turn to internalize these

prevailing social and cultural ideas and the forms in which they are made available. Thus, individuals become subjects of specific types (i.e., race or gender) who in turn strengthen, reinforce, and reproduce these dominant ideas and socio-cultural ways of being.

The cultural reproduction and social reproduction theory engage debate about the appropriateness of parents discussing sexual issues with young people. Perceptions regarding sexuality discussions reinforce Bourdieu's idea of predispositions (i.e., socio-cultural factors/misconceptions) that underpin sexual and reproductive health education among families. The theory has its shortfalls; – for instance, the theory describes the relationship between the habitus (i.e., predispositions) and the individual as deterministic, however, some critics, as cited in Sulkunen (1982), believes this cannot be the case. The habitus for such critics is not deterministic or norms to which individuals are expected to conform but rather, the habitus provides individuals with strategies that are prescribed as appropriate ways of being that show conformity to existing socio-cultural norms and values. Also, the theory implicitly assumes that culture is repressive of the individual but critics like Patricia Hill Collins whose thoughts the study will engage in detail argue to the contrary. For Collins, even though society may portray some repressive tendencies towards the individual, knowledge can be empowering especially in the construction of agency for making self-reflecting choices (Collins, (2000).

Black Feminist Thought/Feminism

Feminist theorists try to analyse women's position in society and the causes of their subordination. Power according to feminists (such as Patricia Collins) is an

important characteristic of human relations in that, gender relations are socially constructed and differ between men and women. Feminism has various strands (such as radical feminism, liberal feminism, socialist feminism, separatist feminism, and black feminism). These various strands perceive power relations to be different among men and women and thus seek to promote gender equality. Generally, regardless of the strand, feminists believe women have control of their own lives, even when they do not have control over the factors and conditions surrounding them (Collins 2000).

Black feminists have established significant contributions among knowledge, consciousness, and empowerment of women. Empowerment here for feminists concerns the processes by which a person denied power acquires it to make informed choices. Drawing insights from the works of Patricia Collins (2000), *Black Feminist Thought*, Collins interrogates the relationship between knowledge, consciousness, and power and argues that knowledge can be power and subordinated people possess the power which is derived from their lived experiences. Based on the subjective meanings derived through the process of interaction, knowledge derived from these lived experiences influences one's beliefs and values (Collins, 2000). This Collins argues reshapes the cultural and societal scripts, beliefs, and behaviours of individuals.

Collins reveals that gender relations are reinforced by patriarchal institutions and agents of socialization such as the family, school, and the media. Thus, for Collins, this process constitutes the lived experiences from which power is derived to reshape cultural beliefs. For example, I can argue from a Collins lens that power relations between young people and the elderly differ and that the

imbalance in power relations makes young people unable to take full control of their lives especially when they are socialized to take up certain cultural scripts and beliefs. Thus, this creates the situation whereby certain sexual issues (i.e., contraceptive use, abortion, and sex) are not passed onto young people because they are considered not matured enough to know about these things.

Patricia Collins also presents an interesting perspective that empowering individuals and groups can give them the right to achieve their goals and reduce marginalization. For instance, educating young people on sexual and reproductive health issues could empower them to make informed choices about their sexual and reproductive health. Therefore, as young people become aware of their sexual and reproductive health and rights (SRHR), they could be empowered and can better deal with challenges associated with sexual and reproductive health. The outcome of such education could lead to improved sexual and reproductive health behaviours and informed decision-making among young people.

We can extrapolate from black feminist thought an insight into how various social actors (such as the family, media, school) can be both repressive and empowering. For instance, what are some of the factors that both encourages and discourages parents and their adolescents from discussing sex?

The theory of black feminism was useful for the study as it encouraged the inclusiveness of varied demography, i.e., parents and young people which is key in feminist discussions. The idea that knowledge can empower young people to take control of their sexuality is strong and was expanded in this work. Structuralists (such as Max Weber) are of the view that society exerts some form of control on the individual irrespective of the amount of power an individual possesses. Once

an individual is part of a system that is not open to change, they cannot influence it. Thus, for parents who are predisposed to cultural notions that inhibit the education of young people on sexual and reproductive health matters, they internalize and reproduce these notions.

Even though not all knowledge can be empowering and one can argue that the sort of knowledge and quality of the same matters for oppressed people, it is important to note that what constitutes empowerment can best be evaluated and constructed only by the individual in a given situation. Therefore, I still remain with Collins that knowledge is power however questionable knowledge itself may be.

Overall, the cultural reproduction and social reproduction theory and black feminism, have been valuable viewpoints for the study. Both theories argue about how culture and society can be repressive towards the individual, however, the point of departure for both theories is about structure versus agency. Whereas Bourdieu sees more of the influence of structure (society/culture), Collins feels agency is critical and can be empowering. Drawing on both theories, I argue that while structure (in this case cultural and religious beliefs) may be repressive of young people's sexuality, the agentic SRH education of young people empowers them to make informed choices about their sexuality with profound consequences for young people's sexual and reproductive health and rights (SRHR) in Ghana.

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Literature Review

Sexual and reproductive health education has become increasingly important as it ensures adolescents live a healthy sexual and reproductive life. Similarly, it also provides adolescents with the requisite information that helps

them develop positive attitudes and practical skills towards their sexuality thus, helping them to make informed decisions. This section reviews literature on sexual and reproductive health education. The reviews focused on the history of sexuality; global discourse on SHRE; sexual and reproductive health education in Africa; the socializing role of the family, perspectives on SRHE in Ghana, and SRH policies in Ghana.

History of Sexuality

Historically, discourse on sexuality has largely been repressive and Foucault (1979) was among those to argue that sexuality discourse since the eighteenth century was repressive, a term he describes as the "repressive hypothesis". The repressive hypothesis era defined outlets (i.e., psychiatry, prostitution) where inappropriate sexual feelings could be discussed freely. Sexuality discourse was therefore treated as a private affair that occurred only within the domain of marriage; between a husband and a wife (Foucault, 1979). Societies during this period began to take an interest in sexualities that did not fit within the marital bond (i.e., women and young people's sexualities). For Foucault, this was simply to make sex beyond the confines of marriage unthinkable and unspeakable.

Further, Foucault claims that issues of sexuality in the eighteenth century were concerned with regulating the "flesh" (i.e., the body), and thereby influencing the sexual desire and pleasure of individuals. According to Foucault, the construction of sexuality falls along three axes: knowledge of sexual behaviour; power systems that control the conduct of sexual acts; and ways by which

individuals see themselves as subjects of this sexuality. In discussing the sexualities of young people, Foucault argues that during the seventeenth century, there was a degree of freedom where adults and children were able to discuss sexual issues (a view concurred by anthropologists such as Margret Mead), but this was lost during the repressive era. This situation was in itself not just a simple implication of silence, but a new era that shaped the way sexuality discourses were conducted among the old and young.

The analysis of the situation manifested through power relations among the young and old and notions of controlling children's sexuality has led to adverse effects (such as deviant behaviours, sexual immorality, early initiation of sex as a result of curiosity). During the repressive years, Bourdieu (1973) as cited in Marcus (1964) in *The Other Victorians* also questioned the nature and repression of sexuality discourse within society. Marcus believed that the more repressive society was towards discourses on sexuality, the more people had to explore alternative ways to fulfil their sexual desires. Marcus further revealed that western religious repression that characterized the "Victorian era" also saw that sexuality discourse outside the domains of marriage was spoken in figurative terms.

That said, some critics such as conservatives and liberalists (feminists and gender advocates) consider sexuality as a social construct. Conservatives argue that sexuality discourse focuses on preparing young people to fit or follow the social, religious, or local community's norms and values. Conservative-based sexuality education is mainly undertaken to convey dominant sexualities oriented on either religious or secular sexuality interpretations (Jones, 2011). Such sexuality frameworks are dictated by external forces such as socio-cultural factors. Any

diversity outside the predetermined framework was rejected and declared a mistaken identity. However, liberalist, on the other hand, also believe young people's orientation to sexuality issues gives them the necessary knowledge and skills. This form of orientation allows for enabling choices for young people. Authority is vested in the individual who is influenced by the social institutions but still capable of making their own choices. Such diversities for the liberalist demonstrate the fluidity of sexuality (Jones, 2011).

Together, these historical viewpoints about sexuality point to the issue of sexual license i.e., socially accepted sexual norms. The argument here is that repressive sexuality can lead young people to find other alternative means to satisfy their sexual desires and pleasure. More importantly, these views illustrate and portray the history of sexuality discourses as largely repressive. This situation Bourdieu argues can be attributed to the predispositions and perceptions regarding young people's sexuality. Drawing insights from these arguments, the engagement of young people in risky sexual behaviours can be attributed to the repressive nature of society towards sexual and reproductive health education of young people. The failure of society and families to provide young people with such information can lead them to alternate sources (e.g., peers, media) which sometimes can provide misleading information and enhance young people's susceptibility to engage in sexual activities or risky sexual behaviours.

The Globality: Discourse on SRHE

Sexual and reproductive health education has become a public health concern because of the influence of globalization and the changing context in which

young people grow. This has made SRHE a health priority across the world as it has been identified as a key component of sexual health and wellbeing (UNFPA, 2014). International organizations over the periods through various programme implementations and policies have put in measures that seek to deal with adolescent sexual health. For instance, the International Conference on Population and Development (ICPD) ratified that information and services regarding sexual health should be made readily available to young people to help them understand their sexuality so they can make educated choices. Subsequent conferences such as ICPD Plus Five and Beijing Plus Five saw various governments renew their commitment to promoting SRHE among young people. The International Planned Parenthood Federation (IPPF) in various policy documents have outlined detailed guidelines to SRHE. Issues such as gender, sexual relationships, pleasure, and reproductive health issues have been considered as key to making young people make informed decisions about their sexual health.

More so, the United Nations General Assembly Special Session on Children also recognized the need to develop policies and programmes that seek to promote the health needs of young people. Similarly, the Committee of the Convention on the Rights of the Child (CRC), and the Sustainable Development Goals (SDG 3) are also policies aimed at reducing youth pregnancy rates, increasing awareness of HIV/AIDS, and making SRH information available to all. These commitments to SRHE have been adopted and inculcated in various regional conventions and treaties such as the African Union's Agenda 2063, Ghana's National Development Plan 2057, and the Ghana National Adolescent Reproductive Health Policy to provide sexual and reproductive health information for young people.

In 2019, UNESCO's launch of Our Rights, Our Lives, Our Future (O^3) programme aimed at targeting teenagers in sub-Saharan Africa to equip them with knowledge, skills, and values that allows them to take charge of their sexual and reproductive health needs. The O^3 programme further sought to deliver to young people comprehensive sexuality education that provides them with the needed skills, training, and exposure that can help them deal with sexual and reproductive health challenges (UNESCO, 2019). In achieving the Sustainable Development Goals (SDGs), the O^3 programme aims to contribute directly to achieving the SDGs that focus on education, health, and gender. Specifically, the O^3 initiative aimed at reducing early/unwanted pregnancy encouraging treatment and testing, and further promoting skills-based sexuality education. Similarly, the programme seeks to address factors that contribute to gender disparities that can help young people develop skills, attitudes, and values necessary for stable and inclusive societies that provide a model of respect for diversities, freedom, and equality.

Sexual and reproductive health education according to UNESCO (2009), can be provided through a range of modalities (such as SRH education, family education, sex and relationship services, life skills education, and dedicated SRH programmes). The United Nations Population Fund (UNFPA) also has four guiding principles concerning SRHE. These include: achieving social equity, protecting the rights of young people, maintaining cultural sensitivity, and affirming gender perspective whiles recognizing the rights of young boys and girls (UNFPA, 2014). Likewise, through its advisory bodies, CEDAW and the United Nations advocated for the incorporation of sexual and reproductive health awareness in educational programmes to increase young people's knowledge about SRH issues.

Having examined these various policy programmes aimed at promoting sexual and reproductive health education across the world, it is imperative to note that neglecting SRH education can have devastating effects on young people's sexual and reproductive health needs. For instance, young girls stand an early chance of becoming pregnant which can compromise their educational and economic potential. Young people also stand a chance of being exposed to sexually transmitted diseases and infections, sexual exploitation, and coercion, which can have significant impacts on their wellbeing. The sexual and reproductive health needs of young people can be linked to their social, cultural, and economic backgrounds. Other characteristics include gender, age, marital status, ethnic affiliation, sexual orientation, and socioeconomic status. It is therefore important that these policies and programmes take into account these contextual issues in their implementation process so that it benefits those they are intended for.

SRH Education in Africa

Across societies in sub-Saharan Africa, sexual and reproductive health education is ingrained in socio-cultural norms and values that influence decision-making skills (Darteh, Dickson & Doku, 2019). Sexual and reproductive health education across some societies through initiation rites is used as mechanisms to regulate sexual behaviour and brings cohesion and the codes of conduct regarding young people's sexual behaviour (Mudhovozi, Ramarumo, & Sodi, 2012). However, the decline in the performance of the initiation rites in contemporary times has made it lost its significance due to changing context through which socialization takes place among various families. Some critics argue that this

decline has implications on young people's sexual health as they lack the guidance previously provided by these rites (Dery, Fiaveh, & Apusigah, 2019).

The role of the family through the socialization process emphasizes their shared values, i.e., whether or not these values are shared by mainstream society. Through socialization, families transmit to their young ones' values and practices of the social group they belong to (Baferani, 2015). The transmission of these values and practices takes place through the process of interaction where individuals learn habits, attitudes, and values of the social group (Schneewind, 2001). The family plays a major role in the socialization process of young people. For instance, the family plays an important role in the formation of young people's personality such as providing them with values, norms, practices, and beliefs – that is usually a reflection of their own social status, socio-cultural norms, and beliefs regarding sexual and reproductive health education. This form of socialization may include views on sex as limited to marriage and a diverse viewpoint on the appropriateness of sexual and reproductive health education for young people.

SRH discussions across some cultures in sub-Saharan Africa are considered 'sacrosanct' and such discussions could only be carried out by elderly people (such as grandfather, grandmother, aunties, and uncles) within the family (Kajula, Sheon, De Vries, Kaaya, & Aaro, 2014). Attempts at discussing sexual issues remain an uneasy task, fraught with discomfort and misconceptions that educating young people on such matters will encourage them to engage in sex (Amuyunzu-Nyamongo et al., 2005). For fear of encouraging early sexual activities among young people, messages of fear and caution are issues that are passed onto young people. Families believe that by so doing, they are protecting young people from

information that may encourage them to experiment with sexual activities. Nevertheless, changing trends have enabled young people to access sexuality information especially with the proliferation of new/social media.

In sub-Saharan Africa, sexual and reproductive education has mostly focused on knowledge and awareness creation and in particular the potential dangers of sex. Abstinence messages are mostly stressed to prevent early sexual activities among young people. Despite these efforts, there have been limited behavioural changes among young people (Berglas, Constantine & Ozer, 2014). Interventions geared towards sexual and reproductive education are misaligned with reality (i.e., focusing on abstinence) and failing to address the socio-cultural factors that underpin sexual discussions among families. Another issue that comes up is the socialization role of parents. Through socialization, parents shape the attitude and behaviour of their wards by inculcating in them positive skills and values. That notwithstanding, many young people lack access to SRH information because they lack strong and positive relationships with their parents (Miller, Benson & Galbraith, 2001).

Studies have revealed that SRHE leads to increased awareness and reduction in risk-taking behaviour among young people. Despite the positive impact of SRHE, discussions on sexual-related issues among families are vague which leaves young people clueless and to conjecture (Awusabo-Asare et al., 2017). Parents fear that educating young people on sexuality issues will expose them to sexual immorality (Bhatasara et al., 2013). On the other hand, young people's difficulty in initiating sexuality discussions stems from the fear of being misinterpreted as their actual involvement in sexual activities (Amuyunzu-

Nyamongo et al., 2005). The problem, however, is not that young people are sexually active but rather they do not get the necessary information required to deal with the SRH challenges. Similarly, perceptions about SRH issues vary by culture, religion, and socio-economic factors which ultimately influence the content and approach to SRH discussions among families. As pointed out by Awusabo-Asare et al. (2017) socio-cultural norms and religious values are constraining factors to sexuality discussions among families.

Sexual and reproductive health education can be an efficient means through which young people's sexual and reproductive health can be enhanced. However, the controversies surrounding the discourse on SRH issues affect the kind of education and information passed on to young people. Largely, the contestation is not against sex education in general but rather the content of the education. Societies and families believe that in educating young people on matters of sexuality, issues such as sexual practices, sexual orientation, and contraceptive use should be avoided however, chastity and abstinence should be stressed. Together, these views from the African context exemplify Bourdieu's concept of the habitus where dominant socio-cultural norms inhibit the content and the sort of issues that can be discussed with young people. However, situating these views in the works of black feminists such as Collins (2000) brings to light the essence of empowering young people through sexual and reproductive health education. Young people's access to information regarding sexual and reproductive health issues can enlighten and empower them to make informed decisions about their sexual and reproductive health.

SRH Education in Ghana

Across many Ghanaian cultures, there are common features among the traditional rites and the socialization process of young people. Even though these rites of passage may differ across cultures, coming of age is characterized by initiation rites (Baku, Adanu, & Adatara, 2017). Traditionally, SRHE for young people was conducted through informal means and usually began at puberty—at menarche for girls and much later for boys (Fiaveh et al., 2015; Mpondo et al. 2018). For instance, among the Akans', this was called "bragro" whereas, among the Krobos', it was called "dipo". Such education was originally provided by traditional and community leaders before aspects of it were introduced into the formal education system. These rites constituted ways of regulating young people's sexuality, however, these customary passages of sex education, traditional practices, and social norms are fading due to changing lifestyles.

Recognized as a way of dealing with the sexual and reproductive health needs of young people, the inception of the school system saw the introduction of a structured curriculum to guide the teaching and learning of sexual and reproductive health education in Ghana. With the introduction of the formal school system, the emphasis was placed on reproductive physiology and abstinence from sex. While sexual and reproductive health education of the formal education system has been effective and widely accepted in Ghana, it has been received with mixed reactions in some societies partly because of socio-cultural beliefs and misconceptions that teaching young people sexual matters will make them curious and encourage them to have sex (Awusabo-Asare et al., 2017).

The influence of parents through the socialization process affects young people's sexuality. Factors such as supervision and monitoring and communication are associated with young people's sexual behaviour (Kumi-Kyereme et al., 2007). Some critics like Miller et al. (2001) argue on the contrary that several factors may underlie the relationship that exists among parents and their wards. Poor relationships, lack of discussions, and excessive control and supervision can enhance young people's susceptibility to engage in risky sexual behaviours. Similar studies by Adu-Mireku (2003) and Biddlecom et al. (2007) revealed that sexuality discussions can influence the behaviour of young people, however, the impact of such discussions depends on the openness of the communication, sexual issues discussed, family values, education level, economic status, sexual literacy, age and gender of adolescents. These factors influence the perceptions and behaviours of both parents and young people towards sexual and reproductive health issues.

Studies have revealed that young people's attitudes and behaviour towards SRH issues can be adduced to socio-economic and cultural factors. For instance, Fiaveh (2012) in a study revealed that misconceptions regarding condom use were widespread among young adolescent males. Popular misconceptions regarding condom use ranged from a reduction in sexual pleasure, loss of erection, and inferior sex. While these notions exist among young people, other scholars have identified contrary views of young people regarding sexual and reproductive health education. As demonstrated in Afenyadu and Goparagu (2003), it was revealed that factors such as peer influence, sexual pleasure, or sex for money affected young people's attitudes towards sexual and reproductive health issues. Socio-cultural perceptions also affected young people's attitudes toward sexual and reproductive

health issues. Young people in an attempt to access information regarding SRH issues (such as contraceptive services) are labelled as "bad" or deviant (Appiah-Agyekum & Kayi, 2013).

Cultural inhibitions, societal beliefs, and religious orientations continue to hamper the kind of SRH information passed onto young people. Misconceptions are rife among families who hold the belief that teaching young people about sexual and reproductive health issues would make them curious and encourage them to have sex (Amuyunzu-Nyamongo et al., 2005; Awusabo-Asare et al., 2006). Similarly, among some families, perceptions about SRHE disrupt open discussions on sexual matters. Shaped by religion, education, culture, and socio-economic status, sexual scripts among such families are connected to norms and values that create tension and uncertainties among its members (Dery, Fiaveh & Apusigah, 2019). Such disruptions are affected by heteronormative ideas and stereotypical perceptions regarding sexual and reproductive health education among young people. While there is a steady change from societal control to individual rights and needs, the longer such beliefs and perceptions remain, the more it distorts efforts towards effective sexual and reproductive health education among families.

Also, the perception that teaching young people issues (such as sex and contraceptive use) would make them practice sex are factors that underlie sexual and reproductive health education. According to Awusabo-Asare, et. al. (2017), this situation explains why some sexuality topics are "silent" and the curriculum-based instruction on SRH issues are fear-based. That fear-based view can be explained by historical justifications (i.e., norms and perceptions) that inhibit society from educating young people on sexuality issues. As demonstrated by scholars (such as

Awusabo-Asare et al. 2017; Fiaveh, 2012) the misconceptions and inappropriateness of SRH discussions can make young people rely on other sources (such as peers, and social media) which may sometimes provide inaccurate information that may not be beneficial to their sexual wellbeing.

Moreover, other studies have revealed that living arrangements between parents and their wards can also influence young people's sexual behaviour. As cited in Bleakley et al. (2009), young people are less likely to engage in sex when they reside with their parents. Other scholars argue on the contrary that the situation can be challenging as information provided by parents at the household level might not be sufficiently clear or ambiguous and may not cover a wide range of sexual issues. According to Bastien, Kajula, and Muhwezi (2011), parents' inability to discuss sexual issues with their wards are a result of their lack of adequate information and skills regarding SRHE. Young people's preferences for sexuality education, on the other hand, maybe based on their level of knowledge and perception of their sources' ability to maintain confidentiality (Amuyunzu-Nyamongo et al., 2005). This may either enhance or limit young people's access to SRH information.

Young People's SRH Issues in Ghana

Sexual and reproductive health education and its associated discussions remain a sensitive issue across many societies in Ghana (Awusabo-Asare, et. al., 2006). Sexual and reproductive health education among families is fear-based that seeks to make young people refrain from sex (Awusabo-Asare, et. al., 2017). Sexual issues are "revered" across many societies in Ghana, hence discussing such issues

among young people is limited to fewer sexual topics that are considered age-appropriate (Baku et al., 2017). Discussions on sexual issues mostly focus on personal hygiene, menstrual care, physical growth, and development (such as breast enlargement, and growth of pubic hair). Among the issues discussed, abstinence messages were stressed as a way of preventing young people from engaging in sex (Baku, et al., 2017). Even though SRHE is considered key to ensuring sexual well-being among young people, socio-cultural norms and misconceptions inhibit the sort of information that young people can access.

Studies have revealed the experiences of parents in discussing sexual and reproductive health issues with their wards. Among these studies, it was revealed that parents reported having discussed sexual issues (such as menstruation, peer pressure, premarital sex, personal hygiene, pregnancy, boy/girl relationships, and abortion). However, among these studies, abstinence messages were the most dominant issues discussed (Kumi-Kyereme et al., 2007; Manu et al., 2015). Other issues (such as sex, and contraceptive use) are silent during such discussions with young people. Critics like Bastien, Kajula, and Muhwezi (2011) reveal that the absence of contraceptive and sex issues during sexual discussions can be associated with the socio-cultural norms and perceptions of families towards young people's sexuality. According to Bastien et al. (2011), these norms and perceptions of families influence the sexual issues that can be discussed with young people.

Also, the religious virtue of chastity influences young people's access to sexual and reproductive health information (Anarfi & Owusu, 2011). Religious values admonish young people to abstain from sex hence, discussions on sexual issues that fall outside the scope of abstinence are perceived to be sexual

immorality. The gender and age of adolescents also influence the sort of sexuality issues they can access. Some sexual issues are perceived to be best discussed by mothers or fathers. For instance, menstrual issues and breast enlargement are perceived to be issues best discussed by mothers. This perception about sexual issues best discussed by mothers or fathers demonstrates the stereotypical role of gender in determining how sexual issues can be discussed among young people. As revealed by Baku, Agbemafle, Koton, and Adanu (2018), SRH discussions by mothers mostly focused on young adolescent girls because of their perceived vulnerability to getting pregnant. Mothers are more likely than fathers to discuss SRH issues with their daughters than they did with their adolescent boys. This, some critics argue that focusing more on adolescent girls at the expense of adolescent boys can hinder efforts towards effective sexual and reproductive health education among adolescent boys and girls (Biddlecom et al., 2007).

Another issue of importance is the nature and scope of sexual and reproductive health discussions among parents and young people. Some studies have revealed that parents' knowledge of sexual issues, level of education, economic status, and attitude towards SRH issues influence the nature and scope of such discussions with their wards. For instance, Baku et al. (2018) revealed that some parents only discuss sexual issues with their wards when they notice changes in their lifestyle or when they suspect them of engaging in deviant behaviours. Some scholars have also revealed that the attitude and behaviour of parents towards SRH issues influences young people's attitudes and behaviour. For example, parents who appear to be strict, harsh, and intolerant did not only limit young people's access to SRH information but also made it difficult for them to initiate or

discuss sexual issues (Kumi-Kyereme et al., 2007). However, elsewhere in advanced countries like the United States, Baku et al. (2017) cite Pluhar and Kuriloff (2004) to have revealed that positive parental attitudes towards SRH issues empower young people towards having sexual and reproductive health discussions with their parents.

Implications of SRH Education for Young People's Sexual Health in Ghana

SRH education has been proven to be an effective means of improving the sexual and reproductive health needs of young people (UNICEF, 2016). Various studies have shown that sexual and reproductive health education and awareness are key strategies to mitigating risky sexual behaviours such as teenage pregnancy and unhealthy sexual activities among young people (UNESCO, 2019). As cited in Kirby et al., (2007), even though abstinence message-only does not have a significant influence on young people's sexual behaviour, it sometimes accounts for the delay in early initiation into sexual activities among young people. Such information equips young people with the needed skills that can be used to make informed decisions about their sexual health.

Baku et al. (2018) also revealed in a study the essence of sexual and reproductive health education among parents and their children. Various reasons were attributed to such discussions among families however, the most important of it was attributed to making young people from engaging in pre-marital sex. This assertion supports earlier studies that have revealed that SRH discussions are associated with delayed engagement in sexual activities (Adanu et al., 2012). That being said, the impact of such education may be dependent on several factors such

as the timing and the nature of the discussion. In a similar study, Adanu, Seffah, Ananrfi, Lince, and Blanchard (2012), revealed that increased access to information and services regarding contraceptive use among young women leads to a reduction in unintended pregnancies and sexually transmitted infections (STIs).

Other studies have also identified a positive link between sexual and reproductive health education and safe sexual activities among young people. As revealed by Teye (2013) in a study, modern contraceptive use among young women may be explained by the fact that the more educated and knowledgeable they are in SRH issues, the more likely they become aware of the benefits of engaging in safe sexual practices. Similarly, as cited in Amuyunzu-Nyamongo et al. (2005), young people who receive adequate information regarding SRH are less likely to engage in risky sexual behaviours. The SRH information provides young people with the requisite information and skills needed to make informed choices and also deal with challenges that might arise. While sociocultural norms and misconceptions portray SRHE as a means of encouraging adolescents to engage in sexual activities, rather, evidence in the literature supports the claim that sexual and reproductive health education reduces young people's susceptibility to engage in early sexual activities and risky sexual behaviours (Adanu et al., 2012).

Similar studies in Ghana have revealed that practical information on how to prevent sexually transmitted infections (STIs), pregnancy, and negotiating within relationships were issues adolescents needed. However, it was revealed that about 23 percent of females and 27 percent of males interviewed respectively had engaged in sex before becoming aware of the knowledge and skills needed to practice safe sex. That said, about half of the students reported they would have

preferred to receive such information earlier (Awusabo-Asare et al., 2017). It is important and critical to note that providing sexual and reproductive health education can help empower young people to make informed decisions, improve their knowledge and confidence, change their attitudes and enhance their decision-making and communication skills, and overall, enhance their self-efficacy. To achieve this, young people must be given accurate information that will enable them to deal with sexual and reproductive health challenges. As Collins (2000) puts it, knowledge is power and that can be an effective means to empower people, thus, young people are likely to speak out if their sexual rights are violated.

Sexual and Reproductive Health Policies and Programmes in Ghana

Sexual and reproductive health policies and programmes influence and shape the behaviour of people towards sexual issues. This section does not seek to assess the successes and failures of these policies and programmes but rather review some of the policies and programmes whose activities have implications for shaping discourses on young people's sexual and reproductive health and wellbeing.

Sexual and reproductive health education in Ghana can be traced back to the 1950s. During this period, issues of hygiene and civic responsibilities were taught in schools as a way of educating young people on matters of reproductive health. The introduction of the policy on Population Planning for National Progress was introduced. This policy made Ghana one of the three countries in sub-Saharan Africa to have a national population policy. Improvements in the educational curricula saw the introduction of Life Skills, Environmental and Social Studies

which sought to concentrate on elements of abstinence, sexual and reproductive health, family life, fertility, sexuality, and HIV/AIDS.

In 1996, a Comprehensive Sexuality Education Programme was integrated into the educational curriculum for young people aged 15-24 years. The emphasis of this programme was improving the well-being of young people; preventing and responding to health problems, unprotected sex, teenage pregnancy, abuse of alcohol, poor nutrition, and infectious diseases (GHS Annual Report, 2010). The children's Act of 1998 was also introduced. The rationale for this policy was to raise awareness of the status and well-being of children. This policy spells out the responsibilities and obligations of both parents and the state to young people's well-being. For instance, it indicates the minimum age at which young people can marry and prohibits acts that can be harmful to the physical and mental well-being of children. Despite this policy, some children continue to face all forms of abuse (i.e., physical, mental, and sexual abuse) that are detrimental to their well-being.

Further, the National Youth Policy of 1999 was also introduced. Recognizing challenges faced by young people (i.e., teenage pregnancy, early marriage, drug/alcohol abuse), the policy sought to empower young people through national integration and cultural identity. Subsequently, the Adolescent Reproductive Health Policy was introduced. The initiative, first adopted in 2000, aimed at promoting a balanced policy framework that would allow young people to access information and services regarding their reproductive health rights. The policy further aimed at postponing the age at sexual debut, increase female enrolment in schools thereby decreasing early marriages, and sexually transmitted diseases among young people (National Population Council, 2000).

Other policies include the 2009-2015 Strategic Plan for Adolescent and Young People's Health and Development in Ghana. This policy framework aimed at providing a holistic perspective to support and meet young people's health needs. This policy was also introduced at the basic school level as the School Education Program (SHEP) to promote young people's health needs and promote awareness of HIV/AIDS among young people. While these policies and programmes are commendable, there has been opposition to the implementation of some of these policies. For example, while the right to information and services is clearly stated in the National Adolescent Reproductive Health Policy, condom demonstrations, and condom provisions in schools are not allowed by the Ghana Education Service. This situation turns to undermine efforts being made to make sexual and reproductive health education accessible to young people across the country.

Challenges and Barriers to Young people's SRHE in Ghana

Access to sexual and reproductive health information is vital for the psycho-social wellbeing of young people. Earlier studies have revealed that inadequate information about sexual and reproductive health can predispose young people to engage in risky sexual behaviours. This situation has prompted several countries including Ghana to put in place policies and programmes to deal with sexual and reproductive health challenges. That notwithstanding, many young people still face challenges that inhibit them from accessing sexual and reproductive health information. Discussions on SRH issues are mostly vague. Statements like "do not play with girls", "close your legs" are ideas that parents sometimes pass on to young people. According to Bastien, Kajula, and Muhwezi (2011), this sort of information

remains unclear and thus, leaves young people to speculate and interpret sexuality messages differently.

Further challenging to parents is the fear that discussing sexuality issues with their wards will make them curious and encourage them to have sex. Young people, on the other hand, are also unable to engage their parents in these discussions because they fear that will be misconstrued as their actual involvement in sex. A study among some Ghanaian parents revealed that cultural restrictions and norms are factors that prevent them from discussing sexual matters with their wards (Baku, Adanu & Adatara, 2017). For instance, it is a taboo among the Akans' to talk to a child about sexual issues because it's believed that doing that will make the child go wayward. In some cases, young people who wanted to know about sexual and reproductive issues are considered not matured enough to know about these issues.

Studies have also examined why young people do not get 'meaningful' sex education from their parents. For instance, studies in Ivory Coast, Kenya, Tanzania, and Ghana have established socio-cultural norms and religiosity as factors that prevent parents from discussing sexuality issues with young people. As cited in (Nundwe, 2012), parents revealed they were uncomfortable talking to their wards about sexual matters due to the sensitive nature of the subject. Even though this might appear to be the case, some critics argue on the contrary that lack of information and limited skills of discussion, fear, and shyness on the part of parents are contributing factors to their inability to discuss SRH issues with their wards. Also as revealed by Awusabo-Asare et al. (2006) young people prefer discussing SRH issues with their peers rather than their parents due to fear of being

misconstrued as engaging in sex. This misconception also tends to discourage and limit young people's access to sexual and reproductive health information (Awusabo-Asare et al., 2006).

Some other studies have also revealed that the sort of sexual and reproductive health issues passed on to young people also presents them with challenges that limit their access to the needed skills and information. Boamah et al. (2014) for instance, in a study, revealed that young people reported having discussed sexual issues with their parents, however, issues discussed were limited to fewer topics such as abstinence, menstruation, and personal hygiene. Issues of sex and contraception were lacking as a result of family religious values and norms. Similarly, curriculum-based instructions on sexual and reproductive health education also stressed abstinence messages and pay little or no attention to health behaviours such as contraceptive use and negotiation skills (NPC, 2000).

Gender disparities have also been identified in previous studies as barriers to effective sexual and reproductive health education. This disparity affects the kinds of sexual and reproductive discussions and messages passed on to the respective genders (i.e., boys and girls). As revealed by Manu et al. (2015), the sex of adolescents and that of parents affects the type of sexual issues discussed. For instance, fathers were more likely than mothers to discuss sexual issues with their sons and the reverse was also true for mothers. Young people also internalize and identify with the views of their same-sex parents. This meant that adolescent boys and girls adopt and internalize the attitude and characteristics of their parents as Freud, (1910) argues in the Oedipus complex. This in itself influenced the sort of SRH discussions that takes place among parents and their wards. Discussions

involving adolescent males mostly focused on abstinence messages whereas menarche and sexual self-restraint were the focus of adolescent female discussions. Girls are supervised and monitored more than boys because of their perceived vulnerability to getting pregnant (Baku et al., 2018).

Sexual and reproductive health education among families in the sub-region appears to be oppressive, unapproachable, inaccessible unidirectionally, and mostly characterized by ambiguous statements rather than direct and open discussions (Bastien, Kajula & Muhwezi, 2011). The parent-child relationship has been identified in previous studies as factors that hinder SRH discussions among parents and their wards. For example, parents who appeared to be authoritative and unapproachable limit young people's access to sexual information. This, some scholars argue denies young people from accessing adequate information regarding their sexual and reproductive health (Awusabo-Asare et al., 2006). Some critics also argue that barriers to open discussion on SRHE can be attributed to a lack of age-appropriate vocabulary, cultural norms, and misconceptions (Baku et al., 2018). The socio-cultural norms and misconceptions hinder young people from acquiring the needed information that can help them deal with sexual and reproductive health challenges.

While sexual and reproductive health education is an important step in identifying and learning approaches to young people's sexual and reproductive health needs, it is imperative to recognize that such discussions can also empower them to make informed choices. Outcomes of such engagements can lead to positive behavioural outcomes and improvement in decision-making skills. Similarly, SRHE can help young people develop good communication and

negotiation skills, thereby making them more confident in discourses related to their sexual health needs.

Conclusion

The reviews show that sexual and reproductive health education among various societies and families has numerous meanings and perceptions even though it is a major determinant of adolescent sexual behaviour. Studies from Ghana and some parts of Africa have provided support to the varying reasons why societies and families do not discuss or limit the sort of sexual matters that can be discussed with young people. Issues such as socio-cultural beliefs and religious practices frown on the education of young people on such sexual matters. Other factors include age, education, and socioeconomic status. Failure to educate young people on matters of sexuality rather makes them vulnerable and exposes them to risky sexual behaviours. Approaching sexual and reproductive health education in positive affirmative ways can equip young people with the skills needed to make healthy sexual choices. Once adolescents have open, supportive channels of communication with their parents, they can make informed decisions about their sexual health. Using the cultural reproduction and social reproduction theory and black feminism, I argue that even though SRHE among families is repressive of young people's sexuality, educating young people can empower them to make informed decisions about their sexual and reproductive health needs.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter provides a detailed description of the methodological approaches and the techniques that were employed in this study. It also provides details on the study area (i.e., Adaklu), the research design, the population of the study, the data collection techniques and procedure, data analyses, and a discussion of some ethical considerations of the study. The study was exploratory and a semi-structured interview guide was used as the instruments for data collection. The choice of Adaklu was based on convenience and empirical data from demographic and health surveys as further explained in sub-sections.

Research Design

The study design forms one of the essential parts of the research because it shows the direction the research took and the general strategy for addressing a research question. Thus, it forms the 'blueprint' of the study and controls the procedure used by the researcher to attain information for the research.

The exploratory qualitative approach was used in this study to investigate how sexual and reproductive health education takes place among families in Adaklu. This design did not provide conclusive evidence but rather helped to have a better understanding of the problem and explore the research topic with varying levels of depth. It also helped in the process and understanding of individuals' life

(i.e., participants) and the meanings they attributed to sexual and reproductive health education. The study was exploratory. Thus, using this approach was useful because it afforded me the laxity to explore the given phenomenon to gain an in-depth understanding of it. Further, using the explorative qualitative approach in the study presented me with a useful technique known as the use of probing questions to 'dig' further what I required from the participants.

The exploratory qualitative research design best fits the study as it emphasized an interpretive process of people creating meanings from their experiences with sexual and reproductive health issues. While the exploratory qualitative research design was useful, the challenge, posed by the design has to do with the generalizability of the findings. Some critics argue that this approach lacks statistical representativeness and can be limiting for the development of generalized knowledge. Even though the findings of the study are limited to narratives of some parents and their wards in Adaklu, this does not prevent me from making inferences and inductive reasoning to inform future studies or efforts in the field. Despite the challenges associated with this design, exploratory studies allow for flexibility during conducting studies of this nature. The design falls in line with the focus of the study and thus made it well suited and relevant to the study.

Study Area

The study was conducted in Adaklu, one of the 25 Administrative districts in the Volta region. Adaklu is about 802 square kilometers and shares boundaries with Ho Municipal to the North, Agortime-Ziope district to the East, Central Tongu district to the South, and Ho West district to the West. Carved out of the former

Adaklu-Anyigbe District now Agotime-Ziope District, Adaklu district now has Adaklu-Waya as its administrative capital which is geographically positioned in the centre of the District. Based on the 2010 Population and Housing Census, Adaklu district has a total projected population of 42,323 with an estimated growth rate of 2.5 percent per annum (GSS, 2014). The district features mountains, lowlands, and generally undulated landscapes. The Adaklu Mountain between Adaklu-Aboadi, Adaklu-Helekpe, and Adaklu-Tsrefe is a prominent feature in the district. Adaklu has three traditional divisions namely, Aboadi, Helepke, and Goefe with Aboadi serving as the paramountcy of the division.

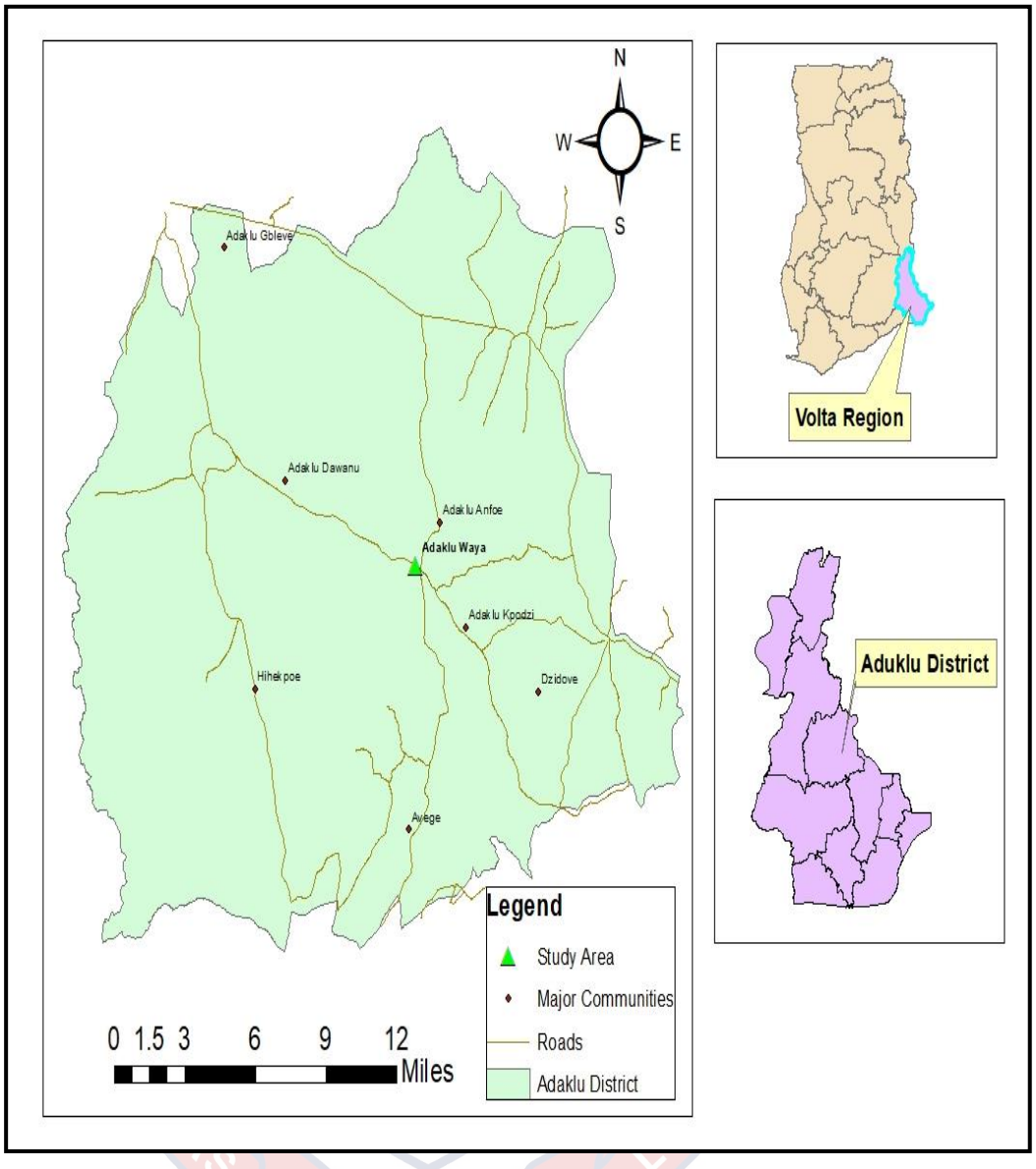
In the Adaklu district, young people aged 10-19 years constitute about 23 percent of the population. For young people aged 10-19 years, about 9 out of 10 are still in school (GSS, 2014). The proportion of people with a basic education in both men and women is higher across all marital status categories. For those never married, about 68 percent have achieved basic education, while about 18 percent had achieved High school education and less than 1 percent had received tertiary education. Categories of married men who have no form of education are about 21 percent less than the share of 29 percent of married women who have not been educated. The people of Adaklu are predominantly Christians who constitute about 85.4 percent, with a few traditional religious practitioners constituting about 2.5 percent and Moslems making up about 10.1 percent (GSS, 2014).

Adaklu is largely a rural area with agriculture as the most dominant economic activity in the district which employs about 78 percent of the labour force. The district is well known in the region for the production of cereals and legumes such as maize, cowpea, groundnut, rice, and tubers including cassava,

sweet potatoes, and vegetables (GSS, 2014). Livestock rearing plays an important role in the lives of the people as the district is endowed with large livestock populations of cattle, sheep, goats, poultry, and others. The local economy is also characterized by petty trading in household consumables. Traded products include food, clothes, and fuelwood. Although the population and housing census report (GSS, 2014) describes Adaklu as a rural area, access to light, water, improved telecommunication, media (i.e., television, and radio) were accessible within the community.

The choice of Adaklu was based on both convenience and empirical data from demographic and health surveys which points to increased risky sexual behaviour among young people within the district. Data from this region, generated by the Demographic and Health Surveys (DHS) points to increased risky sexual behaviours (such as teenage pregnancy and unsafe abortions) among adolescents in the Adaklu districts of the Volta Region of Ghana (GDHS, 2014). In 2014, about 81 teenage pregnancies representing 20 percent of antenatal registrants were recorded. Ensuing data from the District Directorate of Health shows an increase from 20 percent to 23 percent of teenage pregnancies recorded in 2016. For convenience, I am a native of Adaklu and have a fair idea about young people's sexuality and cultural upbringing in the area. However, I was cautious of my positionality (i.e., native of Adaklu) in order not to assume that “I know too much”. In that regard, I proceeded with my data collection drawing on both my strength as an “insider” (i.e., not seen as a stranger) and also guided by the fact that operating as an “outsider” (i.e., free of commitment to participants) offers some advantages as well.

Figure 1: Map of Adaklu District



Source: Remote Sensing and GIS Unit- University of Cape Coast

Population

The population of interest for the study included parents and young people within the Adaklu District. Participant recruitment for the study was through the purposive and snowball sampling technique. For parents (i.e., fathers/mothers), they were recruited for the study based on having young adolescents between the ages of 16-19 years. For adolescents, these were young people aged 16-19 years.

The choice of young people within this age cohort was based on empirical evidence from Demographic and Health Surveys (DHS) in Ghana. According to the DHS, age at first sex in Ghana begins among young people who fall within this age category.

Sampling Procedure and Sampling Size

Participants for the study were selected through purposive and snowball techniques. The purposive sampling technique was based on selecting a sample from which the most could be learned about. Participants were recruited using the purposive sampling technique because of the effectiveness of this technique in identifying potential interviewees (Bryman, 2008). For instance, using the purposive sampling technique enabled me to capture the experiences and perceptions of various individuals based on their demographic variables such as their age, gender, and their social status (i.e., being a parent/adolescent). This approach also allowed me to capture the experiences of such demographic groups on issues relating to sexual and reproductive health education.

To further enhance the heterogeneity of the sample, the snowballing technique was also employed in the study This technique was employed because it helped me in identifying participants who were willing to participate in the study. As a useful referral technique, the snowballing technique helped me to reach out to individuals who share or knew of others who possessed some of the characteristics that were of interest to the study. The snowballing approach also helped me to reach out to other possible participants that were willing to participate in the study. Although the snowballing method had its weakness for producing samples of the

same characteristics due to its reliance on networks of people with a similar background (Newman, 2011), it was useful because it helped me reach out to participants who were not known especially regarding their willingness and openness and depth of knowledge and experience to share given the sensitive nature of the study. This technique was also useful because it served as an entry point to persons that were otherwise difficult to reach.

In all, a total of 20 respondents participated in the study. This included 12 adolescents and 8 parents. Young people comprised of six (6) males and females respectively between the ages of 16-19 years whereas, parents also comprised of four (4) males and females each between the ages of 40-55 years. Most of the respondents were Christians except for one (1) who was a Muslim. All participants had attained some form of formal education (i.e., basic, secondary, and tertiary). In this study, there were no stringent rules for the determination of the sample size but rather, the number of participants employed was dependent on the questions asked, the data gathered, as well as the analysis to be used in supporting the research. The sample size (i.e., 20 participants) allowed me to comprehensively investigate the issues to be addressed based on the stated objectives of the research (Patton, 2002). Also, the essence of using this sample size was because it adequately and sufficiently provided facts that addressed the research questions (Creswell & Poth, 2016).

Data Collection Instruments

A semi-structured interview guide was used in collecting data for the study. The questions that guided the study were derived from the study objectives.

Separate interview guides were used for the various target groups (i.e., adolescents and parents) that were recruited for the study and composed of different sets of topics to effectively elicit information from them. The interview guides were structured into five sections. The first section captured the socio-demographic characteristics of the interviewees. The socio-demographic characteristics of the interviewees were captured as: could you please tell me something about yourself (with age, gender, religion, educational level, ethnicity, occupation as prompts)? The second section asked for information from interviewees on their knowledge, attitudes, and perceptions regarding sexual and reproductive health education. Some of the questions included: what do you know when we say sex? What about sexual and reproductive health education? What age do you think is appropriate for young people to know about this? How did you get to hear about it? These were a few but some of the topics examined in this section.

The third section focused on the sexual and reproductive health issues discussed. Some of the issues examined included: have you ever discussed sexuality issues with your parents or any person? Are there any programmes in the community targeted at educating young people on sexual and reproductive health issues? The fourth section also explored the impact of SRHE and how it has empowered the sexuality of young people. Issues discussed included: do you think sexual and reproductive health education with young people is useful? Are there any specific issues you think young people should know that can be useful for them? These were a few of the issues examined under these sections.

The final section also focused on gender disparities and barriers to sexual and reproductive health education. Issues explored under this section included the

dynamics with regards to how sexual and reproductive health discussions are carried out among parents and young people. Some of the questions included: do the specific issues discussed differ from what parents discuss with young people? How confident are young people in discussing sexual and reproductive health issues with their parents? What are some of the factors that prevent you from discussing sexual and reproductive health matters (religion, society, shyness, fear as prompts) formed part of this section?

Pretesting of Interview Instruments

Pretesting of interview instruments was conducted in Duakro, a suburb of Cape Coast in the Central region in December 2019. The choice of Duakro was because it is largely an "Ewe" dominated community. After all, I wanted to see how the translation of the research questions into the local dialect which is "Ewe" would look like. Also, the pretesting in Duakro helped me to sharpen my Ewe speaking skills since communicating in one's local dialect helps in rapport building (Fiaveh, 2019). A total of six (6) interviewees were engaged in the course of the pretesting. Interview sessions for all six interviewees took an average duration of one hour. These interviewees were identified through the purposive and snowballing sampling technique.

I also anticipated that all responses will be tape-recorded however, during the pre-test, I realized that some participants were not willing to be tape-recorded thus, this allowed me to improve my field note-taking skills. More so, the pre-test also allowed me to scrutinize and take out some irrelevant items in the initial interview guide thereby helping in restructuring the final version of the interview

guide. This helped in shaping some of the questions (possible validity) thereby reducing exaggeration. Overall, the pre-test was useful as it helped me foreground my interviewing and questioning skills during the actual data collection.

Data Collection Procedures

Data for the study was obtained through the use of in-depth interviews (IDIs) and group interviews (GIs).

The in-depth interview technique was employed in the study because it offered me an opportunity of using probing techniques so that insight into answers could be accomplished through exploration, as well as an explanation. In this study, using the in-depth interview approach helped me to get an in-depth understanding of what goes into sexual and reproductive health education. This technique also offered me the opportunity to explore additional views from parents and young people, in particular, the use of probing questions as a follow-up on what they said to make them 'open up' further on issues that were discussed. This technique also offered me the opportunity to gain a deeper insight into participants' experiences, feelings, and shared meanings they ascribed to sexual and reproductive health education. In all, a total of twelve (12) participants were involved in the one-on-one interview sessions.

Another technique that was employed for the study was the group interview. A total of four (4) group interviews were conducted and were made up of two (2) participants each (i.e., males and females). The composition of the group interviews was structured on the status of participants (i.e., parents and adolescents). In all, a total of 8 participants took part in the group interview. Each group consisted of two

(2) fathers, mothers, adolescent boys, and girls respectively (see Table 1). The group interview was useful as it helped me to quickly and conveniently elicit information from several interviewees simultaneously. This technique offered me an opportunity to tap into the collective opinions, feelings, and shared meanings and the underlying attitudes interviewees ascribed to sexual and reproductive health education. The group interview offered me the opportunity to observe non-verbal forms of communication including body gestures, facial grimaces, signs, and even some phonemic sounds such as tongue clicks, grunts, and sighs during the interview process. The group interview offered me the technique of observing how interviewees behaved and reacted whilst in the midst of others, in particular when discussing sensitive issues such as sexual issues.

Participation throughout the study was response-driven based on the willingness of participants to share their views and knowledge on sexual and reproductive health education. The semi-structured nature of the questions that guided the interviews made it such that, depending on the interviewee's answers, each interview took different twists and turns and followed its winding path – an important component that gave me the laxity to follow up on related issues raised by the interviewees themselves. Using this technique also made me become an active listener, thus encouraging interviewees to give their account and also reflecting on when it was appropriate – and not – to continue asking questions.

Table 1: ***Socio-demographics of participants involved in group interviews***

Group No.	Pseudo name	Gender	Age	Educational Level	Status
G I# 1	Inusah	Male	19	Secondary	Adolescent
	Emmanuel	Male	17	Secondary	Adolescent
G I# 2	Linda	Female	16	Secondary	Adolescent
	Dziedzorm	Female	17	Junior High	Adolescent
G I# 3	Enyonam	Female	39	Nursing Training	Parent
	Mawulorm	Female	37	Nursing Training	Parent
G I# 4	Ernest	Male	52	Middle school	Parent
	Kumah	Male	42	Primary	Parent

Source: Fieldwork, 2020

Interviews

In-depth interviews and group interviews were conducted for parents and young people between the periods from January to February 2020 in Adaklu, a community within the Volta region. Upon arriving in Adaklu, I made a tour of the community to familiarize myself with the terrain and also get to know certain areas within the community. I had a key informant within the Adaklu community whom I contacted upon arrival within the community. Through my key informant, I was able to meet some household heads (i.e., parents) and some community gatekeepers (i.e., elders) who were briefed on the purpose of my study and the essence of my visit to the community. After pleasantries were exchanged and the required approval granted, I proceeded with the data collection.

Participation in the study was response-driven based on the willingness of participants. In recruiting participants for the study, my key informant introduced

me to some potential participants who were parents and had adolescents between the ages of 16-19 years. I approached these potential participants and introduced myself. For young people, permission was sought from their parents before I interacted with them. Through informal conversations (such as whether they were in school, the programme they offered in school, and how they relate with their parents), I subtly introduced the topic to them. This technique helped me draw their attention to the subject matter. I then proceeded to engage them in the actual interview. What do you know about SRH? What do you think of the sexual and reproductive health education of young people? These are a few but some of the topics I engaged with my potential participants.

Rapport building was key to ensuring a successful interview with the participants. This technique played a key role in the successful recruitment of participants for the study especially for those whom I engaged in the group discussions. This approach gave me invaluable experience to participants" experiences with sexual and reproductive health discussions. In building rapport, for instance, I engaged in friendly conversations and discussions (i.e., football-related) with young boys who I met at a soccer viewing centre. Doing this helped me to establish some form of familiarity with them. This gave me the opportunity to introduce the topic to them and elicit their views on the matter. For young adolescent girls, I approached them politely and introduced myself to them. As a native speaker of the Ewe language, speaking Ewe with the adolescent girls made them identify me as one of them thereby deepening the sense of rapport between myself and the participants. My ability to speak the local language helped me in eliciting participants' confidence and trust as postulated by Fiaveh (2019). This

served as a means of allowing participants to freely discuss and open up to me on sexual and reproductive health issues.

Alternatively, the oral vignette was also employed as a way of starting the conversation with participants on issues to be discussed. For instance, some people say that young people should not learn about sexual and reproductive health issues until they are old. What do you think about what such people say? Do you agree with them? Why should young people like you know and at what age?". Also, in some instances, I had to share my youthful experiences with some adolescent boys and girls I engaged in the course of the study. In doing this, I shared an experience of how my father was strict with me and how he switched off or changed the channels anytime explicit scenes were shown in movies we were watching together. For parents within the community, I approached them and politely introduced myself to them. I explained the nature and purpose of the study to them and those who were willing to participate were interviewed. Some parents also referred me to other parents whom they believed will be of help. Through these referrals, I was able to reach out to other participants who were willing to participate.

Interested interviewees were all briefed about the nature and purpose of the study and were asked whether they were willing to participate in the study. Consent was sought from participants orally and was all captured on the tape recorder. For participants below the ages of 18 years, informed consent was sought from their parents. Participants were briefed on their rights as participants. For instance, participants were assured that their participation in the study would not bring any harm to them and they also reserved the right to refuse the audio recording and stop the interview session. Additionally, to ensure freedom of choice, participants were

assured of anonymity and confidentiality. In doing so, I assigned pseudo names to all interviewees to protect their identities. They were assigned codes and names other than their real names. Also, in ensuring the confidentiality of the data, information obtained from participants was not passed onto third parties who were not directly involved in this study.

Interviews were conducted in the English language. Even though the initial idea was to conduct the interviews in Ewe, upon reaching the field, I realised that there were variations in the Ewe language (i.e., Southern [Anlo] and Central [Hwedome]). Due to these variations in the Ewe dialect, and since most of the interviewees were fluent in English and were comfortable speaking it, interviews were conducted in English. It was therefore not surprising that all interviews were conducted in the English language. All interview sessions lasted between 30 to 60 minutes. Access to interviewees was in their homes, workplace, and community centres. All interviews were tape-recorded and took place at a convenient place chosen by interviewees such as under trees, their homes, and isolated places where no one could eavesdrop.

I went to each interviewee with an interview guide that had a list of topics I was interested in exploring. The interview guide was structured based on the objectives of the study, the purpose of which was to elicit in-depth information on SRHE among parents and their wards. Interviewees responded to the questions accordingly. During the first few interview sessions, I strictly followed the questions and the order in which it was outlined in my interview guide. The interviews were conducted in a semi-structured manner by allowing interviewees to freely express themselves on issues that were raised. Aside from the questions, I

had in the guide; other new issues also came up during the interview. Eventually, I improved on my probing skills thereby prompting interviewees to elaborate more on other issues that came up during the interview. This gave me an in-depth understanding of the issues raised by the interviewees as well as giving me the flexibility to explore specific issues that came up during the interview sessions.

Interviewees were cordial to me and willing to participate in the study after I had explained the nature and purpose of the study to them. Some interviewees especially adolescents, were a bit reluctant to open up on some of the issues that came up during the in-depth interview. For instance, when asked whether they have engaged in any form of sexual activity before, they were hesitant in responding however probing further, they opened up after I reassured them that whatever they said remains confidential. In some instances, I had to pause the recorder to allow them some time to put themselves together. Even though I had some degree of control during the interview, I allowed for some flexibility during the discussions, however, to ensure that the study objectives were being met, interviewees who digressed from the issues being discussed were brought on track so that they do not bring in issues that were not related to the issues that were being discussed.

Data Processing and Analysis

All taped recorded interviews were manually transcribed verbatim by me and all interviewees were assigned pseudo names. The names used reflected the ethnic origins of interviewees. This was to retain the originality of the transcript and for easy identification of what each interviewee said. All transcripts and interviews were treated confidentially. Transcripts were structured based on the

objectives of the study. Each interview was transcribed in a separate Microsoft Word document and contained pseudo names, date of interview, and duration of the interview. All transcriptions were done by me hence, this allowed me to have a fair idea of all that interviewees had to say. The transcripts were read about two (2) times to understand the data. Emerging patterns of themes, sub-themes, and codes were then identified based on the study objectives. Codes were then developed thus, enabling me to highlight the emerging themes using the thematic analysis approach (Bryman, 2008).

Based on the data, themes that were developed included knowledge, perceptions, and attitudes on SRHE, SRH issues discussed, impacts of SRHE, and gender disparities and barriers to SRHE (see Table 1). A coding frame/codebook was developed manually using Microsoft excel. Two separate worksheets in excel were created. The first worksheet captured the demographic characteristics of the interviewees using pseudo names and in the order in which the interviews were conducted. This included their age, gender, occupation, ethnicity, religion, and marital status. The second worksheet, the coding frame/codebook also captured the themes and sub-themes that were developed after the transcripts had been read. The codes/themes development was carried out simultaneously by me even though scholars such as Fiaveh (2019) postulate that codes should be developed before the themes are identified. Solely conducting the interviews and transcribing the same verbatim helped me to easily develop the themes and sub-themes simultaneously thereby helping me in identifying, analysing, and interpreting patterns of meaning (or themes) that emerged from the data as alluded to by some scholars including Fiaveh (2019).

The developed codes were based on the respective responses derived from participants. For instance, with sources of SRH knowledge, the intent was to know the various sources where each participant obtained information regarding SRH issues. Likewise, SRH issues discussed was another code that sought to identify the various issues participants discussed regarding SRH issues. Overall, the codes helped me to identify the various issues that were discussed with participants.

Table 2: ***Coding Frame for Sexual and Reproductive Health Education among Parents and their Wards***

'KAP' of SRHE	SRH Discussions	Impacts of SRHE	Gender Disparities/Barriers
Knowledge of SRHE	**SRH Discussions**	**SRHE Benefits**	**Variations in SRH Issues Discussed**
Knowledge about sex	Discussed SRH Issues	Usefulness of SRHE	SRH issues discussed by both parents
Definition of sex	Discussed SRH issues with both parents	**Effects of SRHE on Behaviour**	SRH issues discussed by father
Knowledge about sexuality	Discussed SRH issues with father	Positive effects	SRH issues discussed by mother
Definition of sexuality	Discussed SRH issues with mother	Negative effects	SRH issues discussed by friends
Knowledge about sexuality education	Discussed SRH issues with friends	**SRHE and Empowerment**	**Confidence in Discussing SRH Issues**
Definition of sexuality education	Discussed SRH issues with children	Empowerment	Confident discussing SRH issues
Knowledge about sex education	Discussed SRH issues with teachers	Useful SRH issues	Confident discussing with both parents
Definition of sex education	Age at discussing SRH issues	Preferred SRH Issues	Confident discussing with father
Knowledge about CSE	Reasons for discussing SRH issues	Appropriate age	Confident discussing with mother
Definition of CSE	**Not Discussed SRH Issues**		Confidence discussing with friends
Knowledge about SRHE	Not discussed SRH issues with children		Confidence differs with gender and age
Definition of SRH	Not discussed SRH issues with both parents		Not confident discussing SRH issues
Difference between sex and sexuality	Not discussed SRH issues with father		Not confident discussing with elderly people
Sources of knowledge	Not discussed SRH issues with mother		
SRH Issues discussed			
Perceptions about SRHE			
Parents discussing SRH issues with young people			
Perceptions about CSE			

Who Should teach young people SRH issues?
Young people should know SRH issues
Young people should not Know SRH issues
Appropriate age for SRH issues
SRH Issues

Attitudes of Adolescents
Engaged in sexual activity

Type of sexual activity
Sex
Kissing
Caressing/smooching
Others (pressing breast, butts)
Reasons for engaging in sexual activity
Age at first sexual activity
Reaction after engaging in sexual activity
Not engaged in sexual activity
Reasons for not engaging in sexual activity

Not discussed SRH issues with friends

SRH Discourse
SRH issues discussed
How often SRH discussions occurred
Who initiates SRH discussions?
Reaction towards SRH discussions
Feeling towards SRH discussion
Feel comfortable discussing SRH issues
Nature of SRH discussion

SRH Programmes
SRH Programmes

Type of Programme
School programme
Religious programme
Health programme
Community programme
SRH Issues discussed

Not confident discussing with father
Not confident discussing with mother
Initiating of SRH discussions
SRH Issues discussed

Barriers to SRH
Religious barriers
Cultural barriers
Societal barriers
Morality barriers
Fear/shyness/un-comfortability
Other barriers (time, busy schedules)
Experiences
Other issues

Source: Fieldwork, 2020

Validity

In qualitative research, validity is an equivalent concept of trustworthiness regarding the activities associated with the study data (Golafshani, 2003). In ensuring that the data obtained were trustworthy, I employed the member check approach to validate some of the responses I obtained from the participants. I called a few participants (i.e., adolescents) via phone calls to clarify some of the issues that emerged during the interview sessions. Additionally, emerging themes derived from the research objectives were discussed with my supervisor in an open process which helped me to revisit the categories of themes created and a consensus reached on the themes needed for the analysis of the data.

Positionality

Positionality is an important aspect of the research to ensure validity and eliminate all forms of personal biases. The position adopted by a researcher affects how the research problem is constructed, designed, and how participants are recruited. Positionality may include gender, age, religion, culture, ethnicity, and lived experiences (Brydon-Miller & Coghlan, 2014).

As a native speaker of the Ewe language, this could have influenced some of the participants' responses. The rapport-building process with participants through speaking of the local dialect and the data collection procedure could have also influenced the responses that were obtained. As a young man, my discussions with parents could have also been affected by the socio-cultural norms and underlining notions regarding young people discussing sexual issues with the elderly. My awareness of these values and interests made me cautious of the

research process to reduce the biases that are likely to come up in the analysis and interpretation of the data. Thus, a detailed interview guide was used to ensure that the data obtained were not intuitive.

Ethical Considerations

Research studies present some ethical and moral dilemmas which must be identified and addressed to protect the researcher and participants from potential harm and also ensure that the research is conducted professionally. The study conformed to the required ethical standards from the Institutional Review Board (IRB) of the University of Cape Coast. Ethical clearance was granted for the study (UCCIRB/CHLS/2019/38; Appendix 3). Participants engaged in the study were informed about the nature and purpose of the study and were only interviewed after they had consented to participate in the study. Consent was sought from them orally and captured on tape before the beginning of each interview session. Further, participants were also informed about their rights and ability to withdraw from the interview process when they so desired.

Interviewees were also assured of a high level of confidentiality due to the sensitive nature of some of the information. In ensuring this, information obtained from interviewees was kept safe and was not shared with third parties who were not directly involved in the study. The anonymity of interviewees was also ensured by assigning pseudo names instead of their real names. Thus, identifying details of interviewees was replaced with these pseudo names. The essence of this was to ensure that interviewees remain anonymous and narratives obtained could not be traced back to them.

Limitations of the Study

The samples that were employed in the study were drawn from the Adaklu community in the Volta region. The purposive and snowballing technique was used to reach these samples and data from the study were obtained qualitatively hence, findings from this study are not representative, thus, cannot be generalized for the entire population of the people of Adaklu. The study was limited to household heads (i.e., mothers/fathers) and young people aged 16-19 years within the Adaklu District of the Volta region, Therefore, caution is exercised when generalizing beyond this limited sample. Also, conducting the group interview was challenging especially with parents because of the time constraints bearing in the mind the respective schedule of each parent.

Conclusion

The chapter presented my methodological approach. I elaborated on the various issues and principles that were adopted in undertaking the study. The chapter further described the procedures used in sampling, data collection procedures, and how the data was analysed. The subsequent chapter presents the analyses and interpretations of the data obtained along with the themes identified.

CHAPTER FOUR

SEXUAL AND REPRODUCTIVE HEALTH KNOWLEDGE AND DISCUSSIONS

Introduction

Sexual and reproductive health education (SRHE) influences young people, including improving their knowledge, attitudes, and behaviours towards their sexual and reproductive health. Scholars (such as Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007) argue that even though SRHE is key to sustaining the sexual growth of young people, parental supervision, socio-cultural norms, and religious restrictions influence the sexual and reproductive health (SRH) issues discussed with young people. Based on in-depth and group interviews, I discuss the knowledge, perceptions, attitudes, and SRH behaviours of young people and their guardians and further examine the SRH issues discussed. The chapter is guided by black feminism with insight from the works of Collins (2000) and cultural reproduction and social reproduction theory as postulated by Pierre Bourdieu.

The chapter first explores the demographic characteristics of participants and then proceeds to discuss the first two objectives of the study, in two main sections. The first section discusses the first objective of the study (i.e., knowledge, attitudes and perceptions, [KAP] regarding sexual and reproductive health education, i.e., SRHE) and the subsequent section discusses the second specific objective (i.e., sexual and reproductive health issues parents and their wards often

talk about). Table two (2) presents a summary of the detailed themes that guided the chapter.

Table 3: ***Themes on sexual and reproductive health knowledge and discussions***

KAP of SRHE	SRH Issues Discussed
Knowledge of SRHE	**SRH Discussions**
Knowledge about sex	Discussed SRH Issues
Definition of sex	Discussed SRH issues with both parents
Knowledge about sexuality	Discussed SRH issues with father
Definition of sexuality	Discussed SRH issues with mother
Knowledge about sexuality education	Discussed SRH issues with friends
Definition of sexuality education	Discussed SRH issues with children
Knowledge about sex education	Discussed SRH issues with teachers
Definition of sex education	Age at discussing SRH issues
Knowledge about CSE	Reasons for discussing SRH issues
Definition of CSE	
Knowledge about SRHE	**Not Discussed SRH Issues**
Definition of SRH	Not discussed SRH issues with children
Difference between sex and sexuality	Not discussed SRH issues with both parents
Sources of knowledge	Not discussed SRH issues with father
SRH Issues discussed	Not discussed SRH issues with mother
	Not discussed SRH issues with friends
Perceptions about SRHE	
Parents discussing SRH issues with young people	**SRH Discourse**
Perceptions about CSE	SRH issues discussed
Who Should teach young people SRH issues?	How often SRH discussions occurred
Young people should know SRH issues	Who initiates SRH discussions?
Young people should not Know SRH issues	Reaction towards SRH discussions
Appropriate age for SRH issues	Feeling towards SRH discussion
SRH Issues	Feel comfortable discussing SRH issues
	Nature of SRH discussion
Attitudes of Adolescents	
Engaged in sexual activity	**SRH Programmes**
	SRH Programmes
Type of sexual activity	
Sex	**Type of Programme**
Kissing	School programme
Caressing/smooching	Religious programme
Others (pressing breast, butts)	Health programme
Reasons for engaging in sexual activity	Community programme
Age at first sexual activity	SRH Issues discussed
Reaction after engaging in sexual activity	
Not engaged in sexual activity	
Reasons for not engaging in sexual activity	

Source: Fieldwork, 2020

Socio-Demographic Characteristics of Participants

A total of twenty people participated in the study. This included twelve adolescents and eight parents. The gender composition for adolescents was six males and six females, and that of parents was also four males and females respectively (Table 3). Participants were reached through the purposive and snowballing techniques (as discussed in chapter three).

The age distribution of parents ranged from 40-52 years with a mean age of 44 years. The age of adolescents also ranged from 16-19 years with a mean age of 17 years. The participants reported being adherents of the Christian faith except for one Muslim. The main ethnicity was Ewe except three who reported being Ga, Akan, and Guan (Table 3). All these characteristics were due to the uniqueness of the study area, i.e., Adaklu is predominantly an "Ewe" community and the Church (Western Orthodox Christianity, i.e., Catholic and Protestants) has a significant influence on the lives of the people (GSS, 2010).

All participants (parents/adolescents) had attained some form of formal education. Out of a total of twelve adolescents, eleven were in secondary (senior high) school except for one who had completed her basic (junior high) education. Parents generally had attained some form of literacy/formal education. Out of the eight parents interviewed, six were married and two divorced. Each parent had at least one child with the average number of children per parent being two. Parents were engaged in occupations (such as teaching, health workers [i.e., nursing], driving, and dressmaking/fashion designing)

Table 4: ***Socio-Demographic Characteristics of Respondents***

R#	Pseudonym	Gender	Age	Educational Level	Religion	Ethnicity	Occupation	Status	Marital Status	No. of Children
1	Elikem	Male	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
2	Mawunyo	Male	17	Secondary	Christian	GA	Student	Adolescent	Single	
3	Elorm	Male	19	Secondary	Christian	Ewe	Student	Adolescent	Single	
4	Alorse	Male	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
5	Ablah	Female	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
6	Esi	Female	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
7	Esinam	Female	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
8	Xornam	Female	17	Secondary	Christian	Ewe	Student	Adolescent	Single	
9	Mrs. Sedem	Female	41	Tertiary	Christian	Ewe	Teacher	Parent	Married	1
10	Sagah	Male	52	Technical	Christian	Ewe	Driver	Parent	Divorced	4
11	Vincent	Male	42	Tertiary	Christian	Ewe	Govt. Worker	Parent	Married	2
12	Mrs.Eli	Female	50	Training College	Christian	Ewe	Teacher	Parent	Married	2
13	Inusah	Male	19	Secondary	Muslim	Guan	Student	Adolescent	Single	
14	Emmanuel	Male	17	Secondary	Christian	Akan	Student	Adolescent	Single	
15	Linda	Female	16	Secondary	Christian	Ewe	Student	Adolescent	Single	
16	Dziedzorm	Female	17	Junior High	Christian	Ewe	Student	Adolescent	Single	
17	Enyonam	Female	39	Nursing Training	Christian	Ewe	Nurse	Parent	Married	4
18	Mawulorm	Female	37	Nursing Training	Christian	Ewe	Nurse	Parent	Married	1
19	Ernest	Male	52	Middle school	Christian	Ewe	Driver	Parent	Married	3
20	Kumah	Male	42	Primary	Christian	Ewe	Driver	Parent	Divorced	1

Source: Fieldwork, 2020

Sexual and Reproductive Health Knowledge, Perceptions and Attitudes

This section discusses the knowledge, perceptions, and attitudes of parents and young people regarding sexual and reproductive health education. The issues discussed in this section emphasize three themes namely: sources of knowledge about SRHE, perceptions about SRHE, and young people's sexual experiences and attitudes towards SRH issues.

Sources of knowledge about SRHE: Young people and their guardians

The participants (i.e., parents and adolescents) cited the school, church, family (i.e., parents) peers, and the media (i.e., radio, television, internet) as various sources where they obtained knowledge about sexual and reproductive health issues. These sources form part of the socialization agents through which dominant societal norms and values including sexual and reproductive health knowledge are transmitted to parents and their wards.

Mainstream media (i.e., television and radio) was the main source of SRH knowledge among parents. In particular, parents indicated that they heard about SRHE through media reports when attempts were made by Ghana to introduce Comprehensive Sexuality Education (CSE) into the school curriculum. At the time, the discussion of CSE was met with resistance. Civil society groups, religious groups, and parents were of the view that CSE was a western concept and has the potential to "corrupt" the African cultural values (morals) although what constitutes "African morals" remains contested. Some felt that CSE is about promoting lesbian and gay (also LGBT) values. The controversies were widely circulated in the media (i.e., radio and television) including threats of voting against the government at the

time, i.e., the New Patriotic Party (NPP) should they continue with the introduction of CSE as planned.

The controversies surrounding sexuality education in Ghana (both in media and popular culture) points to the fact that parents largely have some knowledge about SRHE. Parents have a responsibility to educate their adolescents on SRH issues as one parent put it: "*I believe it's my job to educate my children"*. Another parent also said:

> Err… there was a debate in the public domain I think last year – somewhere last year about the government trying to introduce sexual comprehensive education. Personally, that was my first time err…getting to know much about that because I basically have little knowledge about that until their arguments came into the public domain. So, it was err… just talking much about how to introduce sexuality education in our basic education curriculum, or let's say introduce it into our schooling environment that's all. (R# 11: 42 years, male, Christian).

Just like parents, young people (i.e., boys and girls) also indicated the media as an important source of knowledge except that they emphasized the new/social media especially for those who had access to mobile phones. As expected, the school, the church, peers (i.e., schoolmates), and family upbringing also were sources of knowledge construction regarding sexuality. Given the proliferation of the media and the religiosity/spirituality of the African (Mbiti, 1990), this came as no surprise. Since young people were in school at the time, the school environment (peers and teachers) had a great influence on them. The young people indicated they obtained SRH knowledge from subjects (such as social studies, integrated

science, and religious and moral studies). Similarly, at church, religious texts, and messages were other sources they obtained SRH knowledge. However, unlike their peer groups and the school, their families were the less preferred sources they obtained sexual and reproductive health knowledge from. Highlighting the school as a source of their SRH knowledge, Linda and Dziedzorm, two young female students had this to say in a group interview:

> **Linda:** Social studies and then some integrated science. Well, it talks about reproduction so, the teacher taught us how to behave as ladies and then how to carry ourselves in public and how to conduct ourselves so that we don't do the wrong things and then they taught us the things we should do and things we should know so that we take the right decisions.
> **Dziedzorm:** Yes, like I said when I was in JSS they taught us in Social Studies and RME. There, the teachers taught us how to take care of ourselves and personal hygiene. (GI # 14: 17-year-olds, females, Christians).

Peers were other sources most young people obtained knowledge about sexual and reproductive health issues. From the discussions, it was evident that most young people obtained sexual and reproductive health information from peers because, peers were seen to be understanding, and ready to listen, unlike parents. This was pointed out by a young boy in a discussion:

> Oh…, for them, are like my age mates. These sexual issues for them even if they are negative, it is normal. My friends when it comes to these issues say a lot and you can feel free to also talk. Like boys-boys, we talk about anything we want but with your parents, they

> will have some suspicion; they will be thinking otherwise. Yeah, so for my friends I get all this information from them. (R# 4: 16 years, male, Christian).

The narratives show that sexual and reproductive health information is obtained from various sources (i.e., media, school, family, and the church). Among these sources, the media was the main source of SRH knowledge for parents. For young people, individuals outside the household (i.e., teachers and friends) were sources they obtained SRH knowledge however peers remained the dominant source. Boamah (2012) in a study among some Ghanaian adolescents revealed that teachers were the most preferred source of sexuality information among young people. Although this could be true, the findings do not support that assertion. Peers were the most preferred source of SRH knowledge for young people. This was as a result of the influence of friends through friendship bonds that make it acceptable for a wide array of behaviours. Similarly, young people identify and share common beliefs and values with their friends that made it easier for them to interact and share information related to SRH issues. Even though peers were a vital source of SRH knowledge, the downside of young people getting SRH knowledge from their peers was the possibility of getting misleading information.

Also, as established in previous studies (Bankole, Biddlecom, Guiella, Singh, & Zulu, 2007), young people indicated that parents were likely to provide them with accurate SRH information, however, misconceptions and fear of being misconstrued as engaging in sex limits their access to such information. These misconceptions and fear partly account for reasons why parents were the less preferred source of SRH knowledge among young people. These findings concur

with the assertions of Awusabo-Asare et al., 2006. They argued that sexuality discussions with young people are tabooed and remain a difficult task due to socio-cultural norms and restrictions. Although this has changed over time, some underlining notions continue to subtly limit young people's access to SRH information. Following Bourdieu's (1973) assertion of predisposed knowledge, the findings also show that the school, media, church, and the family constitute agents through which dominant ideas and knowledge about SRH issues are transmitted to parents and young people.

Perceptions about SRHE: Perspectives of parents and Adolescents

This section explores the perceptions of parents and young people towards sexual and reproductive health education. Studies (such as Bastien, Kajula, and Muhwezi, 2011) have revealed that perceptions regarding SRHE tend to either promote or hinder sexuality discussions among parents and their wards. Although perceptions (i.e., positive/negative) are important in examining notions regarding SRHE, growing evidence shows that positive perception leads to improvements in sexuality discussions among parents and their wards (Bastien et al., 2011). The key question is: how do perceptions about SRHE influence sexuality discussions among parents and their wards?

Perceptions of parents (i.e., positive/negative) towards sexual and reproductive health education tend to influence the sort of sexuality issues that are discussed with young people. Parents with positive perceptions towards sexual and reproductive health education revealed it enhances young people's access to sexual and reproductive health information. In particular, such parents perceived SRHE

provides young people with the necessary skills and training needed to make informed choices. Parents largely perceived sexual and reproductive health education as a positive step to preventing young people from engaging in early sexual activities and risky sexual behaviours (such as unprotected sex, teenage pregnancy, and abortion). Parents with such positive mindsets moved away from heteronormative ideals that shaped the popular discourse on sexuality matters with young people.

While most parents had positive perceptions regarding SRHE, a few had doubts, negative attitudes, and ethical dilemmas towards the sexual and reproductive health education of their wards. Underlining notions regarding the timing and age of young people influence the sort of SRH information passed on to young people. Some parents revealed that although sexual and reproductive health education is important for young people, they stressed the need for caution when having such discussions with young people. For them, age-specific issues (such as personal hygiene, menstrual hygiene, and puberty-related issues) must be introduced to young people at various stages in their life. Highlighting this assertion, Vincent, a 46-year-old father said:

> It's not a bad thing. It's all about you. I think it is all about you getting to know the time and the things you can discuss with them. Like the timing… yeah, when it should be done, and how it should be done effectively. Sometimes, you might be doing it at the wrong time because your child let's say is entering into err… adolescence. These are the things that should welcome them. These are the kind of education that should actually usher them into adolescence because within this err…growth stage, you know they become very

> vulnerable to a lot of things and so, it is good we have this kind of conversation with them.

Some parents were also opposed to the content of the sexual and reproductive health information that young people can access. Parents with this notion felt that the content of sexuality messages, for instance, CSE contents (such as relationships and understanding gender – feelings about biological sex) tend to expose young people to sexualities that are alien to societal norms and values (Baku et al., 2017). Some parents also felt that individuals (i.e., teachers) who could likely be members of LGBT movements could be used as tools to promote the CSE agenda in schools. This assertion resonated with a lot of parents who were of the view that sexual and reproductive health issues at best be discussed by parents due to their socialization role of the child which begins from home. Mrs. Eli, a 50-year-old mother pointed this out:

> I wasn't in support of it. The reason being that you don't know who the teacher is. You see we have homosexuals, so you don't know if the teacher is a homosexual who will go and work on the psyche of the children because you can change your gender too if you like. Yeah, so a teacher can come up with that but if parents can do that in the home with the religion that they belong to and train your child with it, I think that one will be better. So, by then, parents might have groomed their children or prepare their psyche about a lot of things before they go and listen to what the teacher has for them mmm…because children normally believe teachers than their parents… (R# 12: female, Christian).

Young people (i.e., boys and girls) on the other hand also perceived SRHE to be an important part of their development process and refuted popular assertions that SRHE is not appropriate for them. As ultimate beneficiaries of such education, young people revealed SRHE empowers them to make informed choices, take up positive attitudes and values, and also helps them to avoid risky sexual behaviours. Just like parents, the views expressed by young people resonated with those shared by parents who had positive attitudes towards SRHE. For young people, sexual and reproductive health education does not only empower them but also equips them with the requisite skills and training needed to develop into responsible adults. A young lady had expressed this notion about SRHE:

> To me, I will say young people should learn these things because when you know more about sex, no one can deceive you. Surely-surely, you cannot say [pause]… the way the world is now you will surely get to know something. If your parents are not the type that tells you more about sex education you will try indulging in it without you even knowing the consequences. So, to me, I think young people knowing about this is good. Is like knowing more about sex education will help us so that one day we won't get deceived or anything. (R# 8: 17 years, female, Christian).

The findings highlight parent's and young people's perceptions regarding sexual and reproductive health education. The narratives revealed that SRHE has positive influences on the sexual attitude and behaviours of young people as it impacts positive skills and values in them. Whiles, it appeared there was a consensus on the essence of sexual and reproductive health education, a few participants (i.e., parents) indicated that such education must take into account the

content of the information, timing, and age of young people. This assertion typifies the conservative and liberal stance of some families regarding SRHE among young people. Jones (2011) argues that the standpoints of families regarding sexuality education of young people can either promote or hinder such discussions among young people and their guardians. The findings support Jones's assertion as parents with conservative/liberalist viewpoints regarding SRHE appeared to either support/oppose heteronormative ideas that depict the kind of sexuality issues that were appropriate for young people.

The narratives of parents and young people also depict how socio-cultural norms influence the perceptions of families towards sexual and reproductive health education (Dery, Fiaveh & Apusigah, 2019). Although socio-cultural norms influenced the SRH discussions among parents and their wards, families with liberalist viewpoints regarding SRHE portray an attempt at disrupting the dominant socio-cultural ideas that portray sexuality discussions as inappropriate with young people. This viewpoint portrays a shift from Bourdieu's (1973) assertion that predisposed knowledge can make individuals become subjects who reinforce and reproduce dominant socio-cultural ideas and ways of being. Perhaps, liberalist ideas of parents regarding sexual and reproductive health education imply that culture can be dynamic and predisposed knowledge is not always deterministic of how families perceive SRHE. Other factors such as improvement in education and socioeconomic status (Dery, Fiaveh & Apusigah, 2019) can enhance changes in socio-cultural norms and values leading to improvements in predisposed knowledge and perceptions of people regarding heteronormative ideals on sexuality discussions among young people.

Young People's Sexual Experiences and Attitudes towards SRH Issues

This section discusses the sexual experiences and attitudes of young people towards their sexual and reproductive health.

For many young people, adolescence is a time that marks their youthful exuberance and exposure to diverse forms of sexuality such as sexual risk-taking. Early initiation into sexual activities by young people exposes them to risky sexual behaviours (such as unprotected sex, unwanted pregnancy, unsafe abortions, and sexually transmitted infections [STIs]). These behaviours pose serious health challenges to the sexual and reproductive wellbeing of young people (Mensch, Grant, & Blanc, 2006).

Young people (i.e., boys and girls) reported having frequently engaged in sexual activities (such as caressing, fondling of the breast, kissing, smooching, and sexual intercourse). The young people revealed initiation into such sexual activities were as a result of exposure to pornographic materials from the internet. The content of such erotic materials obtained from the internet enhanced young people's sexual drive by sending messages that stimulate their sexual desires to experiment with what they have seen. The impulsive nature of these materials enhanced young people's susceptibility to engage in early sexual activities (Carroll & Kirkpatrick, 2011). Sex for love, pleasure, and curiosity was also cited by young people (i.e., boys and girls) as reasons for engaging in sexual activities. These views were expressed by young people as trying out something they felt to be fun and nice.

Peer influence also emerged as a factor that encouraged young people to engage in sexual activities. The pressure to be seen by friends and wanting to fit in, or to be popular among their peers were motivating factors that encouraged young

people to engage in sexual activities. Peers remained the dominant source of sexual and reproductive health information for most young people. Sexual and reproductive health information obtained from peers was not entirely accurate and by extension led to unplanned outcomes of sexual activities including – but not limited to – unwanted "penetrative sex". Alorse, a 16-year-old adolescent boy had this to say about how friends influenced him to engage in sex:

> You know I have some friends that we do meet and talk about these things. When friends do it, they come and they are like oh!... they have done it before so you too you should try it and see whether it is exciting or not. They will say it and try to let you also do it. Some of them will be teasing and laughing at you when you can't talk to a girl. They will say you are a dull boy. So, some of them do it because they want to show that yeah… they are wild boys. I like this at first, I wasn't like that but my boys were saying it was nice so that is when I tried it with a girl in my area but I regretted it after doing it (R# 4: male, Christian).

Some young people on the other hand indicated their resilience to sexual activities. Religious values, societal norms, and admonishment from parents and teachers were cited as reasons for their non-involvement in sexual activities. For example, religious messages focused on admonishing young people to remain chaste and discouraged sex before marriage among young people. Such religious teachings played a key role in helping young people develop positive attitudes and behaviour towards their sexual and reproductive health. In particular, young people who participated in religious programmes (such as scripture union) delayed initiation into sexual activities.

Other reasons including fear of getting pregnant or getting a girl pregnant – for the boys, sexually transmitted infections (STIs), HIV/AIDS, the reaction of their parents, and securing an education were other reasons cited by young persons' for not engaging in sex. These factors in themselves served as social control measures that regulated young people's attitudes towards SRH issues. Some also revealed that monitoring and supervision by parents helped shape their attitudes and behaviours towards sexuality issues. Thus, effective parental supervision and monitoring were significant measures that reduced the susceptibility of young people to engage in early sexual activities unlike those with poor supervision (Kumi-Kyereme et al., 2007). Elikem, a 16-year-old student said this:

> Mostly because of advice from my parents about those pregnancies and those sexually related diseases. That is why I haven't engaged in it and how … [sighs], I was taught that if you engage in sex and all that, your concentration on studies and all that will decrease. They gave me advice that I should take care of my body and when the right time comes, I will get the right person so that I don't spoil my future and all those things (R# 1: female, Christian).

The narratives show that sexual experiences and attitudes of young people towards SRH issues are influenced by factors such as socio-cultural norms, religious values, parenting styles, and peer influence. Kumi-Kyereme et al. (2007) argue that parental supervision, monitoring, and connectedness influences young people's sexual attitudes and behaviours. The findings concur with Kumi-Kyereme et al.'s assertion as some young people revealed that parental admonishment and supervision were reasons for their non-engagement in sexual activities. For those engaged in sexual activities, Afenyadu and Goparagu (2003) argued that negative

peer influence was a motivating factor that encouraged such young people to engage in sexual activities. The findings support Afenyadu and Goparagu's assertion which revealed that young people engaged in early sexual activities were a result of negative peer influence.

Socio-cultural norms and the moral upbringing of young people influenced their attitude and behaviour towards sexual activities. These factors as revealed in the narratives show that the non-involvement of young people in early sexual activities could be a result of the cultural and moral restrictions on young people's sexuality. The young people were adherents of the Christian and Islamic faith which considered sex outside the confines of marriage a sin. Young people were admonished to remain chaste and abstain from sexual immorality. These religious virtues influenced the sexual socialization of young people and inhibited them from engaging in sexual activities (Anarfi & Owusu, 2011). While I acknowledge that cultural and moral upbringing are influencing factors on young people's sexuality, providing them with adequate information as revealed in previous studies (Adanu et al., 2012; Teye, 2013) can help reduce their susceptibility to engage in risky sexual behaviours. Critics like Collins (2000), also argued that adequate knowledge and information leads to improved awareness and consciousness. Thus, once young people have access to adequate information about SRH issues, this can empower them with the necessary skills needed to make informed choices about their sexual and reproductive health.

SRH Content among Parents and Adolescents

This section explores the content of sexual and reproductive health issues discussed and the nature of such discussions among parents and their wards.

Across societies in sub-Saharan Africa including Ghana, sexual issues are considered sacred and tabooed due to socio-cultural norms and misconceptions (Amuyunzu-Nyamongo et al., 2005). Discussions on SRH issues are perceived as introducing young people to sexual matters which is bad because educating them does not necessarily translate into practice. These misconceptions and restrictions limit the sort of SRH issues discussed with young people. Sexuality issues discussed are mostly cautionary or preventive and fear-based with the intent of making young people abstain from sex (Awusabo-Asare et al., 2017).

Most parents revealed they discussed menstruation, peer pressure, pre-marital sex, sexually transmitted infections (STIs), personal hygiene, abstinence, consequences of getting pregnant, abortion, and how their children can relate with the opposite sex. The rationale for discussing these issues was to transmit sexual norms and values, and information to young people to influence their attitudes and behaviours towards their sexual well-being. The SRH issues discussed were age-related and fit in the broader perspective of sexuality issues parents can discuss with their wards. Other issues discussed include physical growth, body changes, and how to say "no" to forced sex. Among these discussions, abstinence messages dominated the issues discussed. In a group interview with 47-year-old parents, Ernest and Kumah, this is what they said:

> **Ernest:** I do talk about pregnancy, personal hygiene, menstruation, focusing on their education, and staying away from bad behaviours

> that can lead to pregnancy and all that. Basically, these are the issues I discuss with them we meet and talk. I always tell them to abstain from these things because it is not good for them.
>
> **Kumah:** Oh, I tell him about pregnancy and how it can affect him if he gets someone pregnant. How to take care of himself while growing up and all that. So, I always tell him he shouldn't follow bad friends otherwise they will lead him to engage in bad behaviours (GI# 16: males, Christians)

Some parents also revealed the difficulties they have in discussing certain sexuality topics with their wards. These parents cited fear and the implications of exposing their children to sexual matters as factors that inhibit them from having such discussions with their wards. Others also revealed their inability to explain certain terminologies as inhibiting factors to SRH discussions. For example, contraceptive use and issues considered not suitable for young people were rarely discussed due to socio-cultural norms and religious restrictions. The notion was that introducing young people to contraceptives and sex-related matters will encourage them to engage in sexual activities.

Contrary to this view, some parents also revealed that young people should be introduced to all forms of SRH information irrespective of their age and gender. Parents with such views had higher educational attainment, unlike parents who stressed abstinence and fear-based messages. Even though as adherents of the Christian faith, they felt that educating their wards is key to ensuring they are well-positioned to deal with SRH challenges. They revealed that the youthful exuberance and assertiveness of young people makes them curious and susceptible to engage in sexual activities, hence it was important to open up to them. A 41-year-old mother, Mawulorm explains why young people must be educated on SRH issues:

> Yes, you know some children are sexually active. For those that are sexually active even if you tell them to abstain from sexual intercourse, they will still do it. So, for some of them, you have to introduce them to condoms and other contraceptives. Some cannot abstain so, you give them the contraceptives so that if it happens [sex], they can protect themselves. So, I think as a parent, we must educate our children on all these issues. Young people who come here I tell them everything about sex, and how they can take care of themselves. You have to give them options. You can't say this issue is not good because they are not old to hear. Children today hear a lot of things so it is better they hear it from you first. Tell them everything they need to know. Even when you do that, they trust you the parent. (R# 15: mother, Christian).

On the other hand, young people revealed that SRH issues discussed by parents were embedded in larger conversations related to hygiene, morality, education, puberty, and how to relate to the opposite sex. Such discussions come in the form of advice and caution which sometimes made it difficult for them to initiate sexual conversations with their parents in return. Expressing their inability to discuss SRH issues with their parents, young people cited socio-cultural norms and restrictions and the fear of being misconstrued as engaging in sex. This was not the case with their peers. Young people revealed they discuss SRH issues with their peers because they considered peers to be age-mates with whom they can freely discuss issues with. They described discussions with peers as interactive and interesting which focused on several issues (such as relationships and dating, contraceptives, use of aphrodisiac, how they have sex, and issues related to sex and intimacy) rarely discussed by parents. This is an extract of what a young man said:

> I discuss it with my friends when it comes to these things. I can't discuss with my parents some of this sexual matter because I don't want them to think negatively that am bad or anything. My boys, anytime we meet they talk about plenty of things. Err… sometimes too we discuss about trying to have a girl and all those things. They also influence me in such a way that they will be telling me that they have girlfriends so why am I not having one [laughs]… Some too will be saying how they have sex with their girls and all those things then we will be laughing. So, for my boys, they will tell you things and because we all are age-mates it is normal. Some too will tell you like different sex positions and all those things… hmm (R# 3: 19 years, Christian).

Another young adolescent also had this to say:

> Mmm… some of the issues my parents discuss include issues of menstruation. They also talk to me about how pregnancy at a young age can affect my education and personal life. They taught me that pregnancy at an early age can pose a lot of risk to my health. They sometimes say when you engage in these behaviours and it results in pregnancy, sometimes we might think of abortion which can result in death and all that. These are some of the issues they talk about (R# 4: 16 years, Christian).

The narratives show that SRH discussions among families focus on issues (such as menstruation, personal hygiene, pregnancy, avoiding sex, and how young people can relate to the opposite sex). Among these issues, abstinence messages dominated the discussions partly because of the notion that early sexual activities can have negative influences on the sexual health of young people. The findings support Baku et al.'s assertion. Baku et al. (2017) in a study among some Ghanaian

families revealed that parents stressed abstinence messages because they felt such messages can help young people abstain from sex. Parents in the study stressed abstinence messages as a way of curtailing young people from engaging in sex and other risky sexual behaviours.

Sexual scripts shaped by cultural norms also produced discursive notions about young people's sexuality and influenced the sought of issues parents discussed with their wards. Fear of being misconstrued as engaging in sex hindered young people's access to accurate sexuality information. This made young people relied on other sources (i.e., peers) which sometimes may provide inaccurate information. This finding concurs with Kiragu et al.'s, assertion. Kiragu et al. (2007) argued that socio-cultural norms and restrictions limit young people's access to SRH information. However, curbing such fear and misconceptions can be achieved by providing families with accurate SRH information. These critics like Collins (2000) argue can lead to awareness which in turn can lead to young people making informed sexual and reproductive health decisions.

Nature of SRH Discussions among Parents and Young People

This section discusses the nature of sexual and reproductive health issues discussed among parents and their wards.

Sexual and reproductive health discussions that took place among most families were usually initiated by parents and mainly focused on abstinence messages. Discussions between parents and their wards varied with tone and the seriousness of the issues being discussed. For example, some conversations were characterized by advice, caution, or threats of being sacked from the house when a

girl gets pregnant or a boy impregnates a girl. The forms through which such discussions occurred reflected the controversies surrounding young people's sexuality.

Some parents described discussions with their children as cordial and interactive. Parents felt that such discussions were responsibilities that were expected of them and especially when they have adolescent children. Parents indicated that the interactive and cordial nature of such discussions is to encourage their wards to open up and not get intimidated or fear when such issues are raised or being discussed. Despite this notion, parents appeared to be apprehensive and fear that over-exposing their children to SRH information could give them a false sense of protection or encourage them to practice. Also, the nature of sexuality discussions among parents and their wards appeared to be reinforced by the societal expectations of males and females. For example, fathers were drawn towards their sons than they did with their daughters during such SRH discussions. This was the same for mothers who also were drawn towards their daughters during such conversations. This disparity influenced how parents (i.e., fathers and mothers) interacted with their children. A father pointed this out:

> Oh very-very cordial and very friendly. I don't want to get them intimidated by my presence at home. Their mother as well you know. My son is just more or less daddy's boy and my daughter is also mummy's girl so, they have aligned themselves among us and we are doing our possible best to make sure they feel comfortable enough so they can come to any of us as and when there is the need for any discussion of such. But with my son, it is more interactive than my daughter you know. There are some issues I cannot discuss in detail with my daughter like the way her mother will do. Some

> issues are best discussed by women. When it's like that the girl will feel comfortable than when am the one doing it…[laughs] (R# 11: 42 years, Christian).

Other parents revealed that while seated with their children, they shared their personal life experiences on how they abstained from sexual activities. Such discussions were intended to draw their wards closer to them and encourage them to behave in affirmative ways. This made sexual and reproductive health discussions between parents and their wards interactive due to the bond that exists amongst them. In a narrative expression, Mrs. Eli, a mother shared this view:

> I feel comfortable discussing such issues with them and they also feel the same when it comes to discussing these issues. This is because I have drawn them closer to me like friends. I want them to open up and discuss such issues with me ahaa… so, I feel comfortable discussing it with them and I do it in such a way that I make them feel comfortable so, they can ask me questions. I am doing that for a purpose not that I just want to talk. I make it flexible so they can come and ask questions and all that. (R# 12: 50 years, female, Christian).

Young people also revealed contentment, confidence, and hope of discussing sexual and reproductive health issues with their parents. A number of them revealed that they were able to initiate such discussions with their parents however, this was dependent on the relationship they had with their parents. Adolescents who had positive relationships with their parents revealed such discussions to be cordial and interactive. These were exceptions and only a few adolescents expressed this opinion. However, most young people indicated that fear, timidity, embarrassment, and reluctance were factors that characterized sexual

discussions with their parents. For instance, some adolescents (i.e., boys and girls) revealed they are comfortable discussing certain issues with one parent than the other. Girls preferred to discuss menstrual issues and body changes with their mothers because of similarities in physiological characteristics and the notion that mothers were best suited for such discussions. Others also perceived parents to be strict, harsh, and unapproachable. This made it difficult for young people to initiate or discuss such issues with their parents. Rather, this prompted them to discuss SRH issues with their peers. An adolescent said this in a narrative expression:

> When it comes to my friends we talk and discuss all these issues freely. Because they are very close to me and we are my age mates. We are able to share our secrets and everything but for my parents, hmm… their reaction and their way of talking will be a little harsh – that is my mum. She will be very aggressive and react strangely which will prevent me from discussing any other issue with her. Because of this, I like to discuss this kind of issue with my friends because they will understand you well. The elderly people like parents they will think we are learning bad things so sometimes if you want to go to them 'koraaa'… you are afraid. (R# 2: 17 years, Christian).

Parents and their wads also indicated such discussions occurred when the need arises. Due to work and time constraints, parents indicated their inability to frequently have sexual conversations with their wards. Despite these constraints, parents felt the need to discuss such issues with their wards. Some common triggers for sexuality discussions include the onset of menstruation among girls, disobedience on the part of adolescents, and the development of secondary sexual features (such as pubic hair, enlarged breasts, and widened hips in females). Parents

also revealed such discussions occurred when young people in the community at a comparable age with their wards got pregnant. Parents in such instances used such opportunities to advise their wards. Other triggers for such discussions by parents was the realization that their wards were beginning to associate with the opposite sex or when their children come home late. Some parents had this to say in a group discussion:

> **Enyonam:** It's any moment. I don't have days or minutes I tell them this so far as I am in the house and anything concerning this comes, I discuss it with them. You know because of my work so I can't be doing this all the time but once I get the chance, I make sure I talk to them about it. One thing too you have to know is that the more you talk about this sometimes it becomes irritating to them so you have to balance it from time to time.
>
> **Mawulorm:** It's not very often but any time I see something or I hear that she is playing stubborn, then I call her and discuss it with her. Mostly am the one who starts the conversation. I remind her about this so that she knows about it. Once in a while I sit her down and advise her. Sometimes when I deal with cases of teenage pregnancies, I use that and advise her about it. (GI# 15: 41-year-olds, nurses, married, Christians).

The study examined the nature of sexual and reproductive health discussions and how such discussions influence the sexual attitude and behaviours of young people. The findings showed that positive and cordial relationships among parents and their wards enhance young people's confidence and their ability to initiate sexual conversations. This enhanced the tendency of parents and their wards to discuss such issues openly and freely. Nevertheless, some adolescents indicated

their inability to discuss such issues due to the strict and harsh nature of their parents. Sexual and reproductive health discussions appeared to be gendered with more emphasis on the adolescent girl (Kumi-Kyereme et al., 2007). Gender differences and cultural reasons influenced the sought of issues parents were able to discuss with their wards. Unlike mothers, fathers were unable to discuss puberty issues with their adolescent girls because of the notion that such issues are reserved in the social spaces of women. Mothers were close to their adolescent girls than their sons due to the perceived vulnerability of their daughters getting pregnant and the double standards regarding boys' and girls' sexuality (Biddlecom et al., 2007).

The findings also exemplify how socio-cultural norms influence sexuality discussions among parents and wards. These norms and values create tensions and disrupt discussions that focus on the sexualities of young people. Young people for fear of being misconstrued were unable to initiate or freely discuss such issues with their parents. Narratives of some parents revealed they only embarked on such discussions with their wards when the need arises. This gives credence to the popularly held notion that frequently discussing such issues with young people will draw their minds to sexual matters (Kiragu et al., 2007). By and large, parents embarked on such discussion with their wards due to body changes (i.e., puberty development) or when they notice strange behaviours. Consistent with previous studies, parents' socioeconomic status also influenced the frequency of sexual discussions that occurred (Dery, Fiaveh & Apusigah, 2019). The inability of parents to frequently carry out such discussions was due to the time constraints and nature of their work. Given the relatively low levels of sexuality discussions among families as highlighted in previous studies (Amuyunzu-Nyamongo et al., 2005)

there is a need for improvements in such conversations to enhance young people's knowledge and attitudes towards SRHE.

Conclusion

In this chapter, I presented the SRH knowledge, perceptions, attitudes/behaviours, and the content of SRH issues discussed among parents and their wards. The school, church, media (i.e., radio, television, and new media/social media), and family constituted mediums through which SRH knowledge was transmitted. These sources varied for parents and young people. Among these sources, the media constituted parents' source of SRH knowledge. For young people, peers were the dominant source where they obtained knowledge about SRH issues. Socio-cultural norms and restrictions influenced the sort of issues that were discussed among parents and their wards (Awusabo-Asare et al., 2006). Most parents restricted sexuality discussions and stressed abstinence and cautionary messages with the notion that will help young people abstain from sex. Young people, also due to these norms were unable to initiate or discuss SRH issues with their parents due to misconceptions and fear of being misconstrued as engaging in sex. These norms and restrictions also influence the nature of SRH discussions between parents and their wards, a situation that sometimes – left young people to conjecture and seek information from their peers. Parents indicated sexuality discussions with their wards did occur when they find the need to do so. Young people described parents as strict, harsh, and unapproachable due to restrictions on sexuality discussions with young people. Although this was the case for most young people, those who had close relationships with their parents were able to freely

discuss such issues with their parents. The findings revealed how dominant socio-cultural norms and ideas permeate SRH discourses, a term Bourdieu (1973) describes as predisposed knowledge. However, critics like Collins (2000) argue that empowerment, and in this case, providing parents and young people with the requisite information about SRHE can have cascading effects on the sexual attitude and behaviours of young people.

CHAPTER FIVE

CONSEQUENCES OF SRH EDUCATION AND THE DYNAMICS

Introduction

The previous chapter (i.e., chapter four) focused on the source of sexual and reproductive health (SRH) knowledge and issues discussed among parents and their wards. In this chapter, I explore the consequences of SRH education and the dynamics (i.e., gender disparities, and barriers of SRHE) among parents and adolescents. The chapter is guided by cultural reproduction and social reproduction theory by Pierre Bourdieu and black feminism with insight from the works of Patricia Hill Collins.

Studies have shown that sexual and reproductive health education influences the attitudes and behaviours of young people and is key to ensuring they abstain from risky sexual behaviours such as unwanted pregnancy and unprotected sex (Adanu et al., 2012; Kirby et al., 2007). However, socio-cultural norms and restrictions influence sexual and reproductive health issues discussed among parents and their wards. What are the impacts of SRHE on young people's behaviour? What are the gender disparities and barriers to SRHE? These are the issues to be interrogated in the chapter.

The first section of this chapter examines the consequences of sexual and reproductive health education for young people and how it empowers them. The second section also discusses gender disparities and barriers to sexual and

reproductive health education among young people and their guardians. Table 4 presents a summary of the themes that guided the chapter.

Table 5: ***Themes on the implications of SRHE and gender disparities/barriers***

Implications of SRHE	Gender Disparities/Barriers
SRHE Benefits	**Variations in SRH Issues Discussed**
Usefulness of SRHE	SRH issues discussed by both parents
	SRH issues discussed by father
Impact of SRHE on Behaviour	SRH issues discussed by mother
Positive effects	SRH issues discussed by friends
Negative effects	
	Confidence in Discussing SRH Issues
SRHE and Empowerment	Confident discussing SRH issues
Empowerment	Confident discussing with both parents
Important SRH issues	Confident discussing with father
Preferred SRH Issues	Confident discussing with mother
Appropriate age	Confidence discussing with friends
	Confidence differs with gender and age
	Not confident discussing SRH issues
	Not confident discussing with elderly people
	Not confident discussing with father
	Not confident discussing with mother
	Initiating of SRH discussions
	SRH Issues discussed
	Barriers to SRH
	Religious barriers
	Cultural barriers
	Societal barriers
	Morality barriers
	Fear/shyness/un-comfortability
	Other barriers (time, busy schedules)
	Experiences
	Other issues

Source: Fieldwork,2020

Consequences of SRH Education for Young People

This section deals with the consequences of sexual and reproductive health education for young people (i.e., views on the impacts of sexual and reproductive health education on young people's behaviour).

Parents overwhelmingly indicated that SRHE was good for young people even though a few had some reservations about the timing and content of the issues that should be discussed with young people. The parents I interacted with revealed that SRHE influenced the attitudes and behaviours of their wards towards sexual matters. For most parents, SRHE enhanced the awareness and impacted young people with positive values including messages that encouraged abstinence from early sexual activities and risky sexual behaviours. Even though SRHE among young people cannot be said to be a guarantee for their total abstinence from early sexual activities, parents indicated that it accounted for the reduction in teenage pregnancy, unintended abortion, and sexually transmitted diseases (STDs) among their children. Also, such education for them teaches young people about the consequences of engaging in early sexual activities.

Open discussions on sexual and reproductive health issues with young people were described by some parents as a way of opening up to their wards. For them, open discussions on sexual matters enhance the confidence of their wards and make it easier for young people to speak out and ask questions that border them. The parents felt that being open about SRH issues encourages and empowers their wards to approach them anytime they are faced with sexual and reproductive health challenges. Enyonam, and Mawulorm in a group interview said:

Enyonam: I open up and discuss with them so I believe it has helped them in many ways. If you teach them and open up to them very well, it positively affects them in a good way. If someone is trying to do anything bad to them, they will know and they can report it to you. When they know these things too it will help them avoid engaging in such things especially when friends can influence them and also because you have told them the consequences. Fine, some will still hide and do it because they are curious but, at least they will know the consequences.

Mawulorm: I will say positively such education has influenced them because it affected me positively when I was also growing up. When they are taught these things, it helps them to know what is good or bad. Also, they abstain from pre-marital sex and abortion. So, for me, I think the more I educate my children and other young people, the more it empowers them to do the right thing. At least I know it has helped them to do the right thing. (GI# 15: 38 years old, Christians).

Some other parents even though were abreast with the SRH issues and their impact on the life of adolescents, appeared to hold the popularly held notion that educating young people can lead them to practice what they are taught. These parents revealed that such education can negatively influence the attitude and behaviours of their wards. They felt that exposing their wards to sexual matters like the use of contraceptives can give them a false sense of protection and enhance their susceptibility to engage in risky sexual behaviours. Others also cited curiosity and the likelihood of children experimenting with what they are taught as negative consequences of SRHE. They revealed that instead, SRHE should be incremental (age-relevant). The parents revealed that as children grow, they can be introduced

to age-appropriate and content-specific messages at various stages in their life. Mrs. Sedem, a parent expressed this notion:

> Putting that in her mind alone can sometimes make her a bit inquisitive to try that for prevention and whatever. Maybe her peers might be telling her let's try this. Friends can tell her there is this drug okay, let's use that and do this. I think for now it is just okay that she knows the basis that prevention is better than cure. Let her stay in that but whiles she is growing gradually things will be setting in then I can be introducing her to other issues. That is what I think about sex education. I don't think by now I should teach her everything. (R# 9: 41 years, teacher, Christian).

Also, in a similar view regarding the negative impact of SRHE on young people's behaviour, some parents indicated that educating their wards on SRH issues would rather encourage them to engage in sexual activities. They felt that providing young people with sexual information can bolster their confidence and encourage them to engage in risky sexual behaviours. Highlighting this assertion, a parent said:

> Discussing sexual and other matters with them sometimes, they don't know much but might try to see how the whole thing about sex is like. As young as they are, they shouldn't be doing it but because they have the information related to this sex matters, and see the elderly people doing it, they will also think they know how to go about these things. Definitely, they will also want to try it [have sex] and see. You know children are curious so, we have to be careful with the things we tell them. That is the negative aspect of this sex education (R# 10: 52 years, father, Christian).

Adolescents also revealed the impact of sexual and reproductive health education on their sexual well-being. They indicated that SRHE impact positive values and attitudes including abstinence from sex, personal hygiene, and knowing the consequences of engaging in early sexual activities and risky sexual behaviours. Most young people revealed that SRHE has helped them to make informed decisions about their sexual and reproductive health. For instance, most young girls revealed that such education by parents (i.e., mothers) has helped them to resist negative peer influence and helped them to know how to relate to their male friends. Some of them also revealed that even though discussions with parents mostly focused on abstinence and preventive messages, it has helped them develop positive skills and shape their sexual attitudes and behaviours towards sexual matters. A 17-year-old girl pointed this out:

> It affects us positively. Some of my friends if you see them, you know their parents don't teach them these things. They don't know much about sex and that stuff. So, such people, they don't know how to behave but those of us that our parents educate us, we know how to behave and control our feelings and stuff. My mum always advises me that I shouldn't have sex otherwise I cannot continue my schooling when I become pregnant. For me, I don't do those things. Sometimes some of my friends will say let's go and do somethings but because of the kind of training my parents do give me, my conscience won't allow me to follow those kinds of friends… so to me, it's very good because it has helped me to abstain from certain things (R# 8: Christian).

Similarly, Elorm, an adolescent also said:

> Yes, I think it is useful because parents discussing such things with us. It has taught us to become aware of some of the side effects of certain behaviours. You know they will tell you don't go around chasing girls otherwise pregnancy issues and all that. So, we too listen to that advice so we don't fall on the wrong path. They as elderly people have passed through these things already. They know good things and those that are bad. So, in a way, they will teach us the right thing to do that will benefit us. So, sex education is good for us because it can help us to avoid pregnancy and diseases like HIV/AIDS. (R# 3: 19 years, Christian).

Some adolescents revealed that SRHE can be more empowering to them when a lot more sexuality issues are introduced during such discussions. For them, SRHE must go beyond abstinence messages to include issues of contraceptives, dealing with the opposite sex, relationship, and dating. The young people revealed such information when discussed by parents will complement the existing messages already been given by parents. They felt that if this is done, they will be better equipped with the requisite skills and information to deal with challenges or temptations that might arise during their adolescent stages. This is an extract of what a young lady said:

> Mmm… Yes, the major thing we should all know is the effect it will have on us when we go into those acts. We are growing, we are humans and we experience certain changes like emotional feelings and the urge to have sex. One of them is we get easily attracted to our opposite sex and such a thing can lead to relationships and dating, and even sex. So, if the education or the information we need

> to know about this is taught us, it will help us abstain. So, I think they should teach us about these relationship issues and how we can use contraceptives so that if the temptation comes and you can't resist, you know what to do. Some girls have stopped school because they are pregnant but, in my view, if they know this thing like that wouldn't happen… ahaaa (R# 5: 16 years, Christian).

The findings show that both parents and young people hold the view that SRHE has various implications on the sexual attitude and behaviour of young people. In particular, parents indicated that SRHE creates awareness, provides reliable information, and empowers young people to make informed decisions about their sexual and reproductive health. Parents who held this positive notion had positive perceptions regarding SRHE. As black feminist theorists such as Collins (2000) posits, knowledge can be power, hence, knowledgeable parents indicated such education can empower young people to make informed decisions. By so doing, parents who were knowledgeable reshaped cultural scripts regarding sexuality discussions with young people. Parents with much knowledge about SRH issues felt empowered to provide sexuality information to their wards. Such information empowered young people to take charge of their sexual health which in turn helped them abstain from risky sexual behaviours. This finding supports the assertion of Kirby et al, (2007) who argued that SRHE positively impacts the sexual wellbeing of young people and delayed their involvement in risky sexual behaviours.

While I acknowledge the views of Collins regarding knowledge and how it empowers people, it can also be inferred that individuals who lack knowledge are unempowered. The narratives of parents with low educational attainment show that

they did not appreciate the essence of SRHE. Following Bourdieu's (1973) argument of predisposed knowledge, parents who lacked adequate knowledge about SRHE reinforced popular misconceptions regarding sexuality education among young people. These misconceptions sometimes make young people unaware of and prone to engaging in risky sexual behaviours. While this assertion of young people engaging in sexual activities could be true, there is no clear evidence to support the validity of this assertion. Instead, evidence in the literature supports the claim that sexual and reproductive health education reduces young people's susceptibility to engage in early sexual activities (Adanu et al., 2012).

Gender Disparities to SRH Education

Gender disparities and barriers to SRHE influence young people's access to the SRH issues discussed by parents (Manu et al., 2015). Understanding the gender disparities and barriers to sexual and reproductive health education is key to addressing the SRH needs of young people. Specifically, this section discusses the gender dynamics and barriers to SRHE among parents and their wards.

Gender differences among parents and young people influenced the sort of sexuality issues discussed. Parents expressed varying reasons why sexuality issues discussed with their wards differed. For instance, parents cited differences in age and gender of their wards as factors that influenced the content and nature of sexuality issues discussed. For instance, mothers indicated that even though they assumed the responsibility of educating their wards (i.e., boys and girls), the focus of such discussions was towards the adolescent girl. They felt that girls needed

more of such discussions because of their vulnerability to getting pregnant. Hence, sexuality discussions with their wards were geared towards the adolescent girl.

Sexual scripts shaped by socio-cultural norms and ideals influenced the sort of sexuality issues parents discussed with their wards. Fathers described some sexuality issues as feminine subjects best discussed in the social spaces of women. The fathers felt that discussing sexuality issues (such as menstruation and breast development) will make their daughters feel uncomfortable and shy due to gender differences. Fathers relegated such sexuality topics they perceived as feminine subjects to the mothers. The mothers also revealed that they identify with the sexual needs of their daughters than they did with their sons. They indicated that the experiences of their daughters and the physiological changes (such as menstruation and breast development) account for the variations in SRH issues discussed among their sons and daughters. In a group discussion with some parents, this is what they said:

> **Enyonam:** Yes, it differs but for me, all my children are girls so I don't have any issue there. But for young people who come here [hospital], well sometimes it differs in a little way. But sometimes the same information I tell the girl is the same information I tell the boy. Maybe aside from menstruation and those issues that are only about girls, the rest is the same.
>
> **Mawulorm:** Yes, for me it differs small like menstruation and breast development. Boys don't develop breasts so those are the peculiar issues that make the difference. So, these are the only issues that I exclude from them but aside from these, the others such as abstaining from sex and all that, I discuss with both boys and girls. (GI# 15: 38-years-old, nurses, Christians).

Some parents however revealed that SRH discussions with their wards did not differ in any way. They felt that boys and girls need to have access to similar information regarding SRH issues so they can know how to relate with each other. For instance, divorced parents who had male and female adolescents revealed that irrespective of their wards gender, they assumed the responsibilities of ensuring that sexuality information was provided to them. Some other parents like Mrs. *Sedem,* who also doubled as a teacher revealed that both boys and girls need to learn about each other. For her, educating young people on sexuality issues irrespective of their gender has helped them to learn about their bodies and how they can deal with members of the opposite sex. This is what she said:

> No, whether boys or girls we discuss everything together because it's a learning process because boys are learning about girls and girls are learning about boys and of course when it comes to their exam and you don't know about the boys, how will you know it and write it. Yeah, it is something that has to go hand in hand with boys and girls. When boys and girls know about each other, it will help them to be careful. For instance, when boys know about menstruation, then they will know that they can get pregnant when they have sex with them and all that. (R# 9: 41 years, Christian).

Adolescents revealed that variations existed in the sexual and reproductive health issues discussed with their parents. The young people indicated that SRH discussions varied based on the gender of the parent discussing the issues. Adolescent boys indicated confidence with discussions held by their fathers because they identify with the views of their fathers than they did with their mothers. Young girls also indicated they feel comfortable discussing sexuality

issues (such as menstruation) with their mothers because of the physiological and biological similarities they share with their mothers. They revealed that they identify with the views of their mothers and that, discussions with their mothers were more detailed and covered broader sexuality issues than discussions by fathers. In a narrative expression, Esi, a 16-year-old girl said:

> Well, actually anything my dad says is reflected in what my mum says but it's just that my mum goes into detail. She talks about the activities of sex but that doesn't reflect what my dad says. My dad will just go straight to the point and say we should abstain from sex and all that. But my mother because I am a lady, she takes her time to educate me on all these issues. I think because I am a girl that is why she takes her time to do this with me. She sits me down and teaches me how to take care of myself during my menses and even how to use the pad and all that. She tells me that now am becoming a lady so I should be careful. I can get pregnant if I have sex. So, I will say when it comes to my mother, she discusses a lot about these sex education issues with me. (R# 6: Christian).

Some adolescents also revealed that sexuality discussions with their parents were dependent on the nature of the relationship they had with their parents. For instance, Abla, a 16-year-old girl revealed that she discusses SRH issues with her father because of the strict nature of her mother. She revealed that her mother is unapproachable and this makes sexuality discussions with her tense and not interactive like discussions with her father. For her, the receptive nature of her father makes her more comfortable during such discussions. Abla revealed that even though discussions on menstrual and personal hygiene are carried out by her

mother, she enjoys discussions on other sexuality issues with her father. She pointed this out:

> Hmm… okay, my mother, the way she takes the whole thing about this sex education just brings me down. She won't give you a face. Sometimes that is one major factor why I find it difficult approaching her to discuss certain issues with her. My dad is not like that. He will take his time to explain whatever you ask him. Maybe apart from menstruation issues that we don't discuss, he sometimes asks us about boys worrying us at school, then he will tell us what we should be careful and all that… ahaa. As for him, he will have time once you go to him but my mother ehh…she is a strict person. (R# 5: Christian).

The findings show that variations in the gender of participants (i.e., parents and young people) and underlining socio-cultural norms and beliefs influenced the SRH issues discussed among parents and their wards. The narratives of parents and young people provide insight into how SRHE is gendered. Sexual scripts portrayed some sexuality issues as feminine subjects best discussed by mothers. Fathers discuss SRH issues with their sons more than they did with their daughters. This was the same for mothers who mostly focused on sexuality discussions towards their adolescent girls. Parents acted in line with the existing socio-cultural norms that shaped sexuality discussions with young people. Socially ascribed roles through the socialization process made parents (i.e., mothers and fathers) act and think that certain sexuality issues are best discussed by mothers or fathers. For instance, fathers due to cultural reasons did not discuss puberty issues (such as menstruation) with their daughters because of the notion that such issues are best

discussed in the social spaces of women. The finding supports Bourdieu's (1973) assertion as cultural scripts based on predisposed knowledge influenced the sort of sexuality issues parents (i.e., mothers and fathers) discussed with their wards.

The findings also give a possible explanation of the reasons why young people (i.e., boys and girls) identify with the views of their fathers and mothers respectively. The finding supports the assertions of Freud (1910), who argued that boys and girls resolve the anxieties of the Oedipus/Electra complex by internalizing and identifying with the views of the same-sex parent. The resolution of these anxieties meant that adolescent boys and girls adopted and internalized the attitudes, values, and characteristics of their fathers and mothers respectively. The finding also supports the assertions of Manu et al. (2015) who argued that gender differences influence the sort of sexuality issues parents discussed with their wards.

Barriers to SRH Education

This section explores the barriers to sexual and reproductive health education among parents and their wards.

Parents expressed discomfort and difficulties discussing sexual issues with their wards. This difficulty was a result of gender roles that shaped sexual scripts and influenced the kind of SRH issues parents discussed with their wards. The gender disparities hindered the sort of issues fathers and mothers discussed with their sons and daughters respectively. For instance, fathers did not discuss certain sexuality topics with their daughters because they felt such issues were best discussed by mothers. Although mothers did discuss SRH issues with their wards

(i.e., boys and girls), they focused more on adolescent girls because of the perceived vulnerability of their daughters getting pregnant.

The educational level of parents was another factor that hindered parents from discussing SRH issues with their wards. Parents with higher educational levels (i.e., tertiary) appeared to be more knowledgeable in terms of SRHE. Parents with low educational attainment tend to fear and lacked accurate information about the essence of educating their wards on SRH issues. They had the misconception that educating their wards on such issues will rather encourage them to engage in early sexual activities. This perception influenced the sort of SRH issues they discussed with their wards and in particular, stressed abstinence messages. This also hindered them from opening up on broader SRH issues (such as contraceptive use and relationship with the opposite sex) with their wards. Mrs. Eli, a 50-year-old mother pointed this out:

> Some parents because their educational background is not that high so they see it as weird talking about it. They don't see the reason why they should discuss such issues with their children. They also sometimes see it as taboo talking about it. They think they are rather opening the child's eyes and minds about these things. So, sometimes they have to keep it as a secret until the child reaches some level before they come out with something but maybe it would have been too late. You see, I think because they have not gone to school that much so they don't see the importance of these things. Even those who do it is always caution and abstinence but children today know a lot. As a parent and teacher, I interact a lot with students and sometimes you can see clearly that at home they don't get such an education. So, I think these are some of the reasons why

> some parents are not able to do that with their children. (R# 12: teacher, Christian).

Socio-economic activities of parents were other limiting factors that prevented them from discussing SRH issues with their wards. Some parents revealed that the lack of time due to the nature of their work and their busy schedules were reasons they were unable to effectively discuss SRH issues with their wards. Others also cited the age of their children as an inhibiting factor in discussing sexuality issues with their wards. They felt that at such young ages, children should be taught abstinence messages only. A parent shared the following view:

> Err… challenges. One of the challenges I believe is like parents do not see the importance of it. It's a major challenge. We relegate such education to the background. We don't see it as something they need to know at this age. After all, we tell them to abstain so why the stress. Already, everyone is busy with work, and all those stuffs. Me like this, I am not at home always so, you can imagine. We don't get to talk about this every day because I am always busy. Once in a while, we do that. Also, because of their age, ermm… I try to get it to their level of understanding and in doing that a lot of information is censored because you don't want to make it look very 'raw' so, you end up covering up a few things. I think these are some of the challenges. (R# 11: 42 years, parent, Christian).

Adolescents also revealed socio-cultural norms and religious restrictions as factors that hindered them from accessing sexual and reproductive health information from parents. For fear of being misconstrued as already engaging in

sex, young people revealed they were unable to approach their parents with such sexual topics for discussion. The young people indicated that shyness, timidity, sense of morality due to religious restrictions on remaining chaste, fear of being labelled as deviants, and attitudes of parents towards such discussions were factors that hindered them from discussing such issues with their parents. Esi, an adolescent girl said:

> Well, our environment has shaped us to think in certain ways. Sometimes when I want to go to them and asked them some things, I think about the impression that they will have about me. Like I said earlier, my parents are strict so they will be like where am I hearing these things from. Then it will be like am becoming curious about things I don't have to be curious about. Sometimes too, they might think I am getting of age so I am trying to develop some bad habits and that is why I am asking those questions. Yes, so these things deter me from asking them. I don't want them to think I am becoming a bad girl. (R# 6: 16 years, student, Christian).

The findings show how socio-cultural norms prescribe and influence the kind of sexuality issues that can be discussed among parents and their wards. These cultural norms and misconceptions in line with Bourdieu's (1973) assertion are deeply rooted and develop into perceptions that inform how families view SRHE among young people. Parents turn to internalize these socio-cultural ideals which influence the sexuality discussions parents can have with their wards. These socio-cultural norms and ideals in themselves make young people hesitant and hinder them from accessing SRH issues or initiating such discussions with their parents. This finding supports the assertion that argued that fear of being punished or being

misconstrued as engaging in sex were factors that hindered young people from accessing SRH information (Bastien et al., 2011; Kumi-Kyereme et al., 2007).

The findings also depict how the socio-economic status of parents influenced young people's access to SRH issues. The nature of parents' work and time constraints were barrier factors that impacted the sexuality discussions parents had with their wards. The educational level of parents influenced the SRH discussions that occurred with their wards. Unlike parents with higher educational attainment (i.e., tertiary), parents with lower educational attainment exhibited a lower understanding of the essence of SRHE and reinforced underlining notions regarding SRHE with young people (Bourdieu, 1973). They felt that abstinence messages were enough and that young people should be restricted to heteronormative ideas regarding sexuality discussions. This finding also supports the assertion that argues that families with lower educational attainment were less likely to accept varied discourses on sexuality (Dery et al., 2019). Parents with lower educational attainment reproduced and reinforced the popularly held notion regarding the sort of sexuality issues parents could discuss with their wards in line with culture.

Conclusion

The chapter examined the consequences, gender disparities, and barriers to sexual and reproductive health education among young people and their parents. The parents indicated that SRHE has positive impacts on the sexual well-being of young people. They revealed such education inculcates in young people positive values such as chastity, abstinence, personal hygiene, and how to deal with SRH

challenges. For most parents, SRHE empowers young people to make informed decisions about their sexual health. Young people also revealed that SRHE provides them with useful sexuality information that shapes their sexual growth and wellbeing. The views of parents and young people concurred with the assertion of Collins (2000) who argued that knowledge derived from experiences influences one's beliefs. In this case, SRHE influenced young people's behaviour by empowering them with the requisite skills and information. Gender roles also shaped sexual scripts and influenced the sort of sexuality issues parents (i.e., fathers and mothers) discussed with their wards. Narratives of parents reinforced Bourdieu's (1973) idea of predispositions (i.e., socio-cultural norms and misconceptions) that underpins sexuality education. Families reinforced these dominant social-cultural norms regarding the sort of issues fathers and mothers could discuss with their wards. This hindered young people's access to SRH issues discussed by their respective parents. Although parents indicated they discuss SRH issues with their wards, underlining misconceptions and socio-cultural norms negatively influenced the sort of issues parents discussed with their wards (Awusabo-Asare et al., 2006).

CHAPTER SIX

CONCLUSIONS AND REFLECTIONS

Introduction

This chapter provides an overview of the study by highlighting the major research findings, conclusion, reflections, and policy implications. The conclusion of the study suggests that restrictive norms and negative perceptions/attitudes towards SRHE hinder young people's access to sexual information. The reflections also outline the limitations and challenges faced during the study and offer some policy alternatives and suggestions for future studies.

Focus of the Study

The study explored sexual and reproductive health education among some rural Ghanaian families and how such discussions have empowered the sexuality of young people in Adaklu, Volta Region, Ghana. Specifically, the study sought to find out the knowledge, perceptions, and attitudes of parents and their wards about SRHE, the content of SRH issues discussed, the consequences of SRHE and how it has empowered young people, and the gender disparities and barriers to SRHE among parents and adolescents.

Interviewees were recruited through purposive and snowballing sampling techniques. In all, a total of twenty participants took part in the study. The participants comprised twelve adolescents and eight parents. In-depth interview and group interview techniques were used to elicit information from participants. All

interviews were conducted in participants' preferred languages (Ewe and English). Informed consent was obtained from parents and informed assent on behalf of adolescents before commencing the interviews. The study conformed to the required ethical guidelines of the Institutional Review Board (IRB) of the University of Cape Coast. Thematic analysis was used to analyse the themes developed from the study. The findings were based on the developed themes of the study objectives. The themes included SRH knowledge and issues discussed with sub-themes including sources of knowledge about SRHE, perceptions about SRHE, young people's sexual experiences, SRH issues discussed, and the nature and frequency of SRH discussions. Additionally, there were themes on the implications of SRHE for young people and the gender disparities to SRHE with sub-themes including gendered SRHE and barriers to SRHE.

Main Research Findings

This section highlights the main findings of the study. The study examined aspects of SRHE among some rural Ghanaian families. The major findings are based on the objectives that specifically sought to explore how knowledge, perceptions, and attitudes of families regarding SRHE informed the SRH issues discussed and how that impacted the sexual attitude/behaviour of adolescents. The section ended by highlighting the gender disparities and barriers to SRHE. The major findings that emerged are discussed in the subsequent paragraphs.

The participants (i.e., parents and adolescents) had a fair knowledge of what SRHE entailed. The traditional media (i.e., radio and television) were dominant sources parents obtained knowledge about SRH issues. Most importantly, the radio

and television discourses on comprehensive sexuality education (CSE) heightened parents' knowledge/perceptions after attempts were made by the government at introducing CSE into the school curriculum. Personal experiences of parents growing up as adolescents (i.e., socialization) were other sources of their knowledge about SRH issues. For adolescents, individuals outside the household (i.e., teachers and peers) and social media were sources they obtained SRH knowledge. Among these sources, peers were their most dominant source of SRH knowledge/information. Several factors (such as comfort, friendliness, accessibility, openness, and cordiality) influenced young people's choice of peers as their preferred source of SRH information.

Also, the perceptions regarding SRHE varied among parents and were influenced by socio-cultural factors. While some parents stressed the essence of SRHE and its positive impact on adolescent sexual attitude and behaviour, a few parents also perceived it can expose adolescents to diverse sexuality issues that encourage them to engage in sexual activities. Socio-cultural norms and religious values especially those related to SRH issues influenced the sexual attitude and behaviour of young people. The restrictive nature of the societal norms and religious values made SRH discussions among families unattractive to adolescents. This hindered adolescents' access to SRH information and made them turn to alternate sources (such as peers and social media) where they obtained inaccurate SRH information which enhanced their susceptibility to engage in early sexual activities (such as kissing, sex, fondling).

The content of sexual and reproductive issues discussed by parents focused on issues related to puberty growth, personal hygiene, menstrual care, and the

consequences of engaging in risky sexual behaviours. The sexuality discussions were fear-based with cautionary messages that stressed abstinence. This was primarily to make adolescents oblivious of sexual-related issues that are perceived to encourage sexual practice among adolescents. This notion of abstinence message-only stems from the cultural, religious, and moral restrictions regarding young people's sexuality and the lack of open-mindedness of some parents regarding SRHE. For adolescents, SRH discussions with their peers focused on activities of sex, contraceptive use, relationships, and dating – issues not usually discussed by their parents. Socio-economic factors (such as the occupation of parents) impacted the frequency with which sexuality discussions occurred among families. Time constraints and the nature of parent's work influenced the number of times they discussed SRH issues with their wards. SRH discussions occurred when parents found the need to especially when they suspect their wards of engaging in deviant behaviours or the development of secondary sexual features (such as the growth of pubic hair, menstruation, and breast enlargement) among their wards.

The findings indicate that SRHE has positive impacts on the sexual attitudes and behaviour of young people. Most parents stressed that SRHE seeks to educate young people about SRH issues and impact in them skills that can help them abstain from early sexual activities and risky sexual behaviours. Even though SRH discussions among families stressed abstinence messages, it enhanced adolescent's sexual knowledge and awareness. The positive impact of SRHE was evident in the sexual attitudes of young people as it prevented them from engaging in risky sexual behaviours (such as unprotected penetrative sex, unwanted pregnancy, and

unintended abortion). Even though parents indicated SRHE was good for the sexual wellbeing of young people, a few had prior notions that coincided with popular misconceptions across some Ghanaian societies that educating young people on sexual matters encourages them to engage in sex.

Gender differences had implications on the sort of SRH issues discussed among parents and their wards. The gender differences emerged in terms of the strategies and approaches parents (i.e., fathers/mothers) used in discussing SRH issues with their wards. Gender-based perceptions regarding male and female sexuality informed the sort of issues parents discussed with their wards. Sexuality issues perceived to be feminine subjects were discussed by mothers whereas those considered to be masculine subjects were discussed by fathers. Adolescents, based on their gender were also drawn towards their same-sex parents for discussions on SRH issues. Although SRHE did occur among parents and their wards, socio-cultural norms/misconceptions, religious restrictions, gender differences, socio-economic factors (i.e., low educational attainment, occupation), fear, and shyness hindered efforts aimed at promoting SRHE among parents and their wards.

Conclusion

The study examined sexual and reproductive health education among some rural Ghanaian families and highlights the views of parents and adolescents. Even though parents recognized the essence of discussing SRH issues with young people, the findings of the study show that there is a gap between parents and their wards in terms of SRHE. Some parents were sources of SRH information for young people, however, socio-cultural norms and misconceptions among families created

tense atmospheres that made adolescents look elsewhere for SRH information. It was not surprising that adolescents' most preferred sources of SRH information were peers. This implies that the family systems (i.e., parents) should do more to create enabling environments and support for their wards in terms of discussions on SRH issues.

The SRHE seems to focus more on abstinence messages and the negative outcomes of young people engaging in sexual activities. Not much attention is paid to other equally important SRH issues (such as contraceptive use) that can help young people make informed choices about their sexual wellbeing. The general view is that abstinence is the best choice for young people as opening them up to diverse sexuality issues can encourage them to practice. This notion reflects the fear of parents introducing their wards to other diverse sexuality issues other than abstinence messages.

Socio-cultural norms and religious restrictions are influencing factors that determine the sort of sexuality issues parents discussed with their wards. The findings indicate that such norms and values impact young people's sexual attitudes and behaviour as they covertly obstructed their access to SRH information. The dominant view of most adolescents regarding the constraints posed by socio-cultural norms and restrictions towards SRHE with parents was the fear of being misconstrued as engaging in sex. Considering the cultural and social context through which SRHE takes place, the acceptability of SRHE among young people can be achieved by overcoming the socio-cultural norms and religious restrictions regarding young people's sexuality and the sort of issues that can be made available to them.

The narratives provide evidence to show that socio-cultural norms, religious restrictions, and gender differences impact the SRH issues discussed among parents and their wards. Hence, the claim by Bourdieu (1973) that predisposed knowledge has far-reaching implications on the attitude and behaviour of individuals (i.e., parents and adolescents) is supported by the findings. Although these dispositions impact on young people's sexual agency, feminist such as Collins (2000) argues that knowledge, consciousness, and power can help individuals (i.e., adolescents) make informed decisions. Therefore, empowering families with adequate knowledge about SRH issues and correcting misconceptions shaping the discourse on SRHE can help families (i.e., parents and adolescents) deal with SRH issues/challenges.

Reflections

Sexual and reproductive health education plays an important role in the sexual wellbeing of young people. The present study provides some understanding of how sexual and reproductive health education takes place among families in rural Ghana and the reasons why such discussions are limited to fewer sexual and reproductive health topics.

My emphasis on SRHE among parents and their wards was a result of some encounters I had with some adolescents on the difficulties they faced accessing/discussing SRH issues. The difficulty I encountered conceptualizing the study was the research design and the theoretical approach that could best address the research problem. Upon further reflection, I realized that the interpretive approach will help me focus on the meanings, interpretations, and experiences of

families regarding SRHE. The theory of cultural reproduction and social reproduction helped in understanding how socio-cultural norms and values influence the perceptions of families and predispose them to act in line with existing societal norms. The theory of black feminism with insight from the work of Collins (2000) explains how knowledge and consciousness can be empowering for individuals (e.g., adolescents and young people) and society (e.g., families) to overcome predisposed knowledge about SRHE.

While I am cautious not to oversimply sexual and reproductive health education in Ghana due to the design and sample (for example the study was conducted in rural Ghana using twenty participants), the findings can serve as a springboard for future research. The choice of Adaklu was based on both convenience and empirical data. By convenience I mean I know the Adaklu community and have an idea about the sexual and reproductive health issues within the area. Also, the empirical data (GDHS, 2014) points to increased teenage pregnancy among young adolescent females within the Adaklu District. Ensuing data from the District Directorate of Health shows an increase from 20 percent to 23 percent of teenage pregnancies within the Adaklu District. I also anticipated that all interviews will be conducted in the local language of the area (i.e., Ewe). However, upon reaching the field, variations in the 'Ewe' language made me to all interviews in the English language. Regardless of the challenges, the study has helped unravel some nuances about the sexual and reproductive health education of young people among rural families in Ghana.

The study shows that sexual and reproductive health education provides adolescents with knowledge, skills, and opportunities that can help them make

informed choices. Evidence from the findings (i.e., anecdotal and empirical) show that socio-cultural norms, religious values, and mis/conceptions regarding SRHE continue to limit young people's knowledge, perceptions, and access to SRH information. Despite the conservative religious and cultural polemics and sensitivities about sexuality and SRHE, there is a need for governments and civil society to engage SRH policies and to support the delivery of good quality sexuality education both in-school (e.g., syllabi, clubs, and theatre of development such as drama) and out of school (e.g., at home, church/mosque). Ultimately, this can help demystify misconceptions about the sexuality of young people which could afford them unhindered access to SRH information and to make informed choices about their sexuality. On that note, young adolescents living in Africa south of the Sahara, in particular, given their vulnerability, can have a better understanding of their bodies which could be empowering.

Based on the study findings and the conclusions, the following suggestions would be useful additions to expanding sexual and reproductive education among young people and their guardians in Ghana:

1. There is a need for intensive education of families through town hall meetings, advocacy dissemination workshops, and media (radio and TV) sensitization programmes to enable them to appreciate the usefulness of sexual and reproductive health education for young people. This could empower and motivate individual family members to be confident in discussing sexuality with young people. The sensitization efforts can also be useful for correcting misconceptions about CSE and SRH issues in general. When harnessed properly and timely (considering cultural

sensitivities about sex), this can help young people have unhindered access to SRH information and provide them with the needed knowledge, values, and skills essential for safer behaviours and to reduce adolescent/unplanned pregnancy, and gender equality.

2. Since the family (i.e., parents) interviewed in this study constituted one of the less preferred sources of sexual and reproductive health information and the majority of the adolescents still in school, it is recommended that the schools be given the necessary support in terms of informational materials that can help boost the knowledge and confidence of adolescents towards sexual and reproductive health issues. Parents should also endeavour to build trust and mutually respectful relationships that can enhance young people's access to SRH issues. Parents can do this by opening up to their wards concerning sexual and reproductive health issues.
3. Stakeholders (such as religious groups, traditional authorities, Ghana Health Service, National Youth Authority, civil society groups, and NGOs) through community intervention programmes (such as health talks, and outreaches programmes) develop strategies and unified approaches families can use in communicating SRH issues with adolescents. The sexuality issues should be about issues bordering on adolescent sexuality and must go beyond the abstinence messages to include sexuality issues (such as contraceptive use, relationships, and dating) as the abstinence approach has proven ineffective in improving adolescent sexual attitude/behaviour.
4. It would be needed for broader societal dialogue to demystify and correct mis/conceptions regarding the idea that adolescent sexuality is 'bad' and

'harmful' to culture. Families should also endeavour to discuss or educate adolescents (i.e., aged 16-19 years) on SRH issues (information and education aspects of the family and planning programme) as they become sexually active during this stage of their life. Educating them on SRH issues can prevent them from engaging in early sexual activities and risky sexual behaviours. It is also recommended that SRH discussions among families be carried out regularly and not a one-time event or as and when parents found the need to. This will help adolescents internalize the skills and attitudes towards SRH issues.

5. While acknowledging the critical role of socio-cultural norms and religious values in transmitting societal ideals including SRHE, it also restricts the sort of sexual and reproductive health issues parents discuss with their wards. In addressing this challenge, it is recommended that stakeholders and policymakers develop policies that target families and engage them as partners in programmes designed to improve sexual and reproductive health education at home. The interventions could afford families opportunities to address sexuality issues among young people and offer practical skills that promote healthy sexual and reproductive health discussions.

Future study

Based on the study's limitations, the following suggestions for further research can focus on:

1. expanding the scope of the current design for future work not only in terms of the participants but also the site particularly from an urban perspective

and comprehensive and holistic in nature and encompassed key areas to include stakeholders such as teachers, adolescent youth service providers, sex educators, traditional authorities, and policy actors.

2. future studies can focus on sexual and reproductive health education and its impact on adolescents in-school and out of school and age cohorts expanded to include young adolescents (i.e., 16-19 years) and older adolescents (i.e., 20-25years) to examine the dynamics of sexual and reproductive health education between these age categories.
3. a quantitative study to make up for the shortfalls in the qualitative approach utilised in terms of possible generalisation of the findings to sexual and reproductive health education among rural families in Ghana may come in handy which can be a useful basis for a global analysis of trends, especially on Africa.

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APPENDICES

Appendix 1: In-Depth Interview Guide (Parents/Community Leaders)

Introduction

Good morning/afternoon. I am a student at the Department of Sociology and Anthropology, University of Cape Coast. I would greatly appreciate your time in responding to some questions on the topic, "Sexual and Reproductive Health Education (SRHE) among Rural Families in Ghana." I assure you that any information given will be confidential. The discussion may last about 30-45 minutes. Are you willing to participate?

SECTION A: Socio-demographic Profile

1. Could you please tell me something about yourself (probes: age, level of education, religion, ethnicity, occupation, place of birth, marital status, number of children [if any], status in the community, i.e., parent, leader, health worker).

SECTION B: Knowledge, Perceptions, and Attitudes on SRHE

2. What do you know when we say sexuality education? What about Sexual and Reproductive Health education (probe for comprehensive sexuality education)?

3. What do you think about parents discussing sex or sexuality with young people? Do you think young people should know about sex and their sexuality (probe for reason and which aspects of their sexuality they should know and at what age)? What about comprehensive sexuality education? Do you think young people should know about it (probe for reasons)?

4. Who should teach young people about sex and sexuality (probes: parents, school, the church [applies to all faith], friends, media, social media)? What should they teach young people about sex and sexuality?

5. Do you see any difference between sex and sexuality (probe for reasons and specifics if any, biology and social differences)?

SECTION C: SRH Issues Discussed

6. Have you ever discussed sex or sexuality issues with young people? Why or Why not? (probes: gender of young person-male/female; at what age; how often; who initiated the conversation). What topics do/did you discuss with any young person (probe for common issues discussed)?

7. Follow-up: do you discuss issues about abstinence, puberty, menstruation, pregnancy, abortion, sexual intercourse, contraceptives, HIV/AIDS (probe for each item)?

8. Are there any programmes in the community educating young people about their sexuality? What about SRH issues (probe for each specifically mentioned programmes)? How often do these programmes take place (probe the means, e.g., during debars, festivals, town hall meetings, church services, community/youth activities)?

9. How do members of the community (parents/community leaders/health workers) feel when they want to discuss sexuality with young people (probe: culture/morality upbringing, fear, uncomfortable, anxiety, shyness)? What is your experience?

10. What is the nature of the discussion between adults and young people? Probe if it is liberal, repressive, interactive, and reasons.

SECTION D: SRH and Empowerment Issues

11. Do you think SRH or sexuality discussions with young people are useful? Probe for reasons? Can sexuality education affect young people's behaviour (probe for reasons and specifics)?

12. Those who champion SRH and sexuality education say that it is useful in informing young people about their bodies and to adopt a welcoming attitude towards others. What do you think?

13. Are there any specific issues you think young people should know that can be useful for them (probe for gender, relationships/dating, adolescence, sex, contraception, STIs, embodiment, and love, and specific age to know these)?

SECTION E: Gender Dynamics and Barriers to SRH Discussion/Education

14. Follow-up: do the specific issues discussed differ by gender, i.e., for boys and girls? Probe for specific issues by gender (e.g., puberty, dating, sexual maturity, sex, pregnancy, embodiment, and love), and why?

15. How confident are adults in discussing SRH issues with young people? Does the confidence differ by gender (probe for the gender of parents and young people)?

16. What do you see to be the challenges inhibiting the sexuality education of young people? Do you have any experience you want to share?

Appendix 2: In-Depth Interview Guide (Adolescents)

Introduction

Good morning/afternoon. I am a student at the Department of Sociology and Anthropology, University of Cape Coast. I would greatly appreciate your time in responding to some questions on the topic, "Sexual and Reproductive Health Education (SRHE) among Rural Families in Ghana." I assure you that any information given will be treated confidentially. The discussion may last about 30-45 minutes. Are you willing to participate?

SECTION A: Socio-demographic Profile

1. Could you please tell me something about yourself (probes: age, education, religion, ethnicity, place of birth)?

SECTION B: Knowledge, Perceptions, and Attitudes on SRHE

2. What do you know about sex? (probes: source and how)? Have you ever heard of sexuality? What do you know about it? What about sexuality education (probes: source and how and CSE)?

3. How did you learn about sexuality issues (probes: peers, parent, school, media/social media)?

4. Some say young people should not learn about sex until they are old? What do you think about this?

5. Have you ever had any sexual activity (probe for what kind, e.g., kissing, caressing, sex, smooching, etc.…)? Why did you or have you not engaged in any sexual activity (probe for reasons: curiosity, peer pressure, religious belief, parental advice)?

SECTION C: SRH Issues Discussed

6. Have you ever discussed sexuality issues with your parent or any person? Why or Why not?

7. Follow-up on some other specific SRH issues: did you discuss issues about abstinence, puberty, menstruation, pregnancy, abortion, sexual intercourse, contraceptives, HIV/AIDS (probe for each item)?

8. Who do you feel comfortable discussing sex or sexuality with (probe for parents, health workers, community/religious leaders)?

9. What is the nature of the discussion between young people and parents or elders (Probe hostile, liberal, interactive, friendly)?
10. Are there any programmes in this community that seeks to educate young people about sex and sexuality? What about health-related issues (probe for the "ABCD" model)? Why or why not?

11. How do young people feel when they want to discuss sex or sexuality with parents or adults (probe: fear, uncomfortable, shyness)?

SECTION D: SRH and Empowerment Issues

12. Do you think sex or sexuality discussions with parents or adults are useful? How? Does sex or sexuality education affect young people's behaviour (probe for reasons)?

13. Those who champion sexuality education say that it is extremely useful in informing young people about their bodies to enable them to adopt liberal attitudes towards other people. What do you think?

14. What information about sexuality would young people like to receive from adults (Probe for reasons and why)? Is it different from what you expect from peers?

15. Are there any specific issues you think young people should know about their sexuality? Why

SECTION E: Gender Dynamics and Barriers to SRH Discussion/Education

16. Do the specific issues differ by gender of the one teaching you, i.e., mother and father? Which issues differ by gender?

17. How confident are young people in discussing SRH issues with community members? Are young people's confidence levels affected by the gender of the person talking? Why or why not?

18. What are some of the factors that hinder young people from discussing sexual matters with parents or elders? What about health workers? Do you have any experience you would want to share?

Appendix 3: Ethical Clearance

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT
TEL: 0558093143 / 0508878309/ 0244207814
E-MAIL: irb@ucc.edu.gh
C/O Directorate of Research, Innovation and Consultancy

OUR REF: UCC/IRB/A/2016/682
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

8TH JUNE, 2020

Mr. Anthony Senanu Agbeve
Department of Sociology and Anthropology
University of Cape Coast

Dear Mr. Agbeve,

ETHICAL CLEARANCE – ID (UCCIRB/CHLS/2019/38)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Sexual and Reproduction Health Education among Rural Ghanaian Families: a Study in Adaklu, Volta Region, Ghana.** This approval is valid from 8th June, 2020 to 7th June, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

Appendix 4: Consent Form

Title: Sexual and Reproductive Health Education among Rural Families in Ghana: A Study in Adaklu, Volta Region
Principal Investigator: Anthony Senanu Agbeve
Address: University of Cape Coast, College of Humanities and Legal Studies, Faculty of Social Sciences, Department of Sociology and Anthropology

General Information about Research
I am an MPhil student at the University of Cape Coast. As part of my MPhil thesis, I am undertaking a research on Sexual and Reproductive Health Education among Rural Families in Ghana. I would wish to recruit you to participate in this study. With your help, the findings from this study will provide useful information for families, the general public, and policymakers interested in sexual and reproductive health education. I am conducting this interview among parents, opinion leaders, and young people living within the Adaklu District. I will ask you about your perspectives on sexual and reproductive health education. Thus, I will further ask you questions about your knowledge, perceptions, and attitudes regarding sexual and reproductive health education. These and some other questions are the issues to be engaged in our discourse.

Procedures
I invite you to take part in this research project. If you accept, you will be required to: either sign or thumbprint a form before the interview starts. In participating in this research, you will be asked questions relating to your background and your views regarding sexual and reproductive health education. This will entail your age, educational level, occupation, marital status, number of children, religion, and ethnicity. As part of our conversation, the interview session will be audio-taped. The expected duration of our interview should take us about 1 hour 30 minutes. You are at liberty to refuse the tape recording or ask to stop the tape at any time you so wish. If you do not wish to respond to any of the questions posed during the interview, you may say so and I will move on to the next question. The interview will take place at a convenient place chosen by you. The information recorded will be treated confidentially. If the questions I ask you are unclear and you have questions about the research, do not hesitate to ask me now. Please do well to answer all the questions as clearly as possible. We will only begin the interview only when you are clear of what we are about to do and you have fully consented to take part in the study.

Possible Risks and Discomforts
Your participation in this study will not cause any harm or risk, aside from being a little bit sensitive and personal on some issues that will be discussed. You may not

feel good about some of the questions I may ask you. If that happens, you can choose not to answer any of the questions I ask for any reason and at any time. You are free to turn down any question you deem so personal and uncomfortable with or may choose to stop the interview at any time.

Possible Benefits

Your participation in this study will help us understand how sexual and reproductive health education takes place amongst parents and their wards. The study will be useful to individuals and families as it will provide them with an in-depth understanding of the essence of sexual reproductive health education to help them develop positive attitudes and values including respect for self, open-mindedness, and a sense of responsibility concerning sexual and reproductive health issues. Also, the study will help shape the public's understanding of sexual and reproductive health education and dispel harmful myths that are currently shaping the discourse of sexual and reproductive health education in Ghana.

Confidentiality

The information you share with me in our conversation will be kept confidential; it will be used strictly for the research only. Third parties who are not directly involved in this research will not have access to the information that I will obtain from you. You will be assigned a unique code number or pseudonyms, that will be used on all forms/information you give me instead of your real name. If you choose to participate in this study, all information obtained from you will be protected to the best of my ability. You will not be named in any reports. I assure you that the information given will be treated as strictly confidential and is for purely academic purposes.

Compensation

You will not be given any financial reward for participating in this study. This study is for academic purposes only.

Voluntary Participation and Right to Leave the Research

Your participation in this research is completely voluntary. You have the right to refuse to take part in the research or withdraw at any point in time without any penalty and having to give any reasons. Refusal to take part will not attract any penalty. You have the right to withdraw from the research without any consequences.

Termination of Participation by the Researcher

This is to inform you that the researcher reserves the right to terminate or discontinue the interview with you if at a point during the interview the investigator

feels that you are not cooperating or suspects that you are providing wrong information which will not inure to the research findings.

Contacts for Additional Information

Just in case you need any clarification at a later date, you may contact the researcher, Anthony Senanu Agbeve on +233240217647, senantho@gmail.com.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of the University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant you can contact the Administrator at the IRB Office between the hours of 8:00 am and 4:30 p.m. through the phone lines 0558093143/0508878309/0244207814 or email address: irb@ucc.edu.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks, and procedures for the research title ***(Sexual and Reproductive Health Education among Rural Families in Ghana: A Study in Adaklu, Volta Region)*** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks, and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Date Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual

_____ _____

Date Name Signature of Person Who Obtained Consent

Appendix 5: Sample Interview Transcript

R# 6 (Esi)
Date: 24-01-2020
Time started: 11:23am
Time ended: 12:02pm
Conducted by: Anthony Senanu (Researcher))
Transcribed by: Anthony Senanu (Researcher)

Socio-demographic Profile
Interviewer: Alright, so like we have earlier discussed, I want to find out from you if you are willing to participate in this study?
Interviewee: Of course, I am.
Interviewer: Then we begin. I would like to know something about you so if you could please tell me something about yourself?
Interviewee: Okay, I am 16 years of age. I come from Battor in the Volta Region of Ghana so, am actually a Christian. Yes, and my basic education was held at Battor, Delali basic school… yes of course am here in Mawuli School for my secondary.
Interviewer: Form one?
Interviewee: Yes
Interviewer: So, do you live with your parents?
Interviewee: Yes, I live with both parents.
Interviewer: How close are you to them?
Interviewee: Ohh we are very close.
Interviewer: Is it both of them or you are closer to one of them than the other?
Interviewee: I will say am closer to mum than my dad?
Interviewer: Why is it so?
Interviewee: I don't know ooo… but maybe we gel well because maybe I don't know if we have the same gender or something but I don't know but there is some kind of connection there than my father.

Knowledge, Perceptions, and Attitudes on SRHE
Interviewer: What do you know when we say sex?
Interviewee: Well, I think when we talk about sex two things come involved; I mean sex can be reference to gender, and then we have sex as in activities between two people mainly a male and a female.
Interviewer: What sort of activity?
Interviewee: Is like sexual activity between two people.
Interviewer: What about sexuality, have you heard about it before?
Interviewee: Sexuality? Yes, I have heard about it but maybe in my perception, I think sexuality might have to do with sexual activities as such.
Interviewer: From where and how did you get to hear about these matters?
Interviewee: Well actually, it is from school. We were taught in various subjects such as R.M.E, social studies and science and sometimes the teachers come and talk about it openly irrespective of the subject, they give us something about it.

Interviewer: So, have you heard about sexuality education before and what have you heard about it?
Interviewee: Yes, I was listening to the news and I heard that the government is trying to introduce it in our various schools so yeah that's how I heard it.
Interviewer: What about comprehensive sexuality education sexuality education?
Interviewee: Actually, I didn't make much understanding about it but all the same I know that it has to do with sex, sexual activity, and sex education stuff.
Interviewer: Where did you about this also?
Interviewee: It was the news on TV.
Interviewer: How did you get to hear and learn about sexuality issues?
Interviewee: Well, I live in an environment such issues are not disclosed straight forward sometimes if you are with elders or your parents or something and they want to say anything concerning that, instead of saying the main they say other things. Per se excuse me to say something if they want to say the penis or the vagina, the penis they might say stick and the vagina they might say mortar or some kind of things but am not sure they know but at school, we are taught all that things and I come from an Ewe land and we study Ewe in school so we all know the kind of words to use so obviously if they are saying it, at least I get the concept of what they saying but they don't say it openly and they hide such words and those things.
Interviewer: Why do think they hide such matters from you?
Interviewee: I don't know but maybe they think we are not the age to hear it or maybe hearing about such things is very dangerous to us it might make us irresponsible or we might try to engage in such activities or develop an interest in such things so I think that is why they don't open up on such issues.
Interviewer: What about your peers and other sources, do you get such information from these?
Interviewee: Yes, as for my peers do, they say a lot and some of them too they know a lot but they don't like sharing but those that are bold enough as for some people they are very timid and they feel that opening up to it might give someone the perception that you are spoilt like you are uncultured so they try to talk about it but not that much.
Interviewer: So, what with your peers what do u discuss when you meet?
Interviewee: Well, in terms of these things we normally talk about boyfriend-girlfriend and some of them are firm enough to talk about sex and all those things and
Interviewer: Some people say young people should not know about sexual matters of issues, what do you think of what such people say?
Interviewee: Well in this life to me I think nothing has only positive sides to me sometimes there will be a little disadvantage accompanying it. I mean looking at everything Let's take it straight to the perceptions it is right but come to think of it there are also some disadvantages to it. People in the community say that we are not supposed to hear about it so, mostly because of our traditional concept or our culture doesn't permit such things they try to adopt some strategies to keep that information away from us so it has to do with maybe the high literacy rate because if you attend school you get to understand the fact that such things are quite very important but since maybe in one way or the other, they don't have access to this information so they turn to think it's a bad thing or not a good thing to hear about or maybe they think we might develop an interest in it.

Interviewer: So, when such people say that young people should not know about such a matter do you think they are right in saying that?
Interviewee: To me, I don't think they are right because as a person you need to acquire information about certain things as for issues on sex and sex-related issues, they have to let us know. People don't know about it. Mainly people think when it comes to sex education people think is only about sex, they only think about the activity but involves how to use protection to avoid diseases and pregnancy, how to take good care of yourself but people immediately they say sex education their mind doesn't go to other areas, all they think about is sex so I think people don't get the understanding of sex education.
Interviewer: So, at what age do you think it's appropriate for young people to know about sexuality matters, and what are the issues they should know at this stage?
Interviewee: Well for me I can't specify any age but all I will say is when as a parent you study your child and when you see that your child is of age or is getting aware of the environment or the way you see things the person is getting aware of these issues and information, then I think right from that point, you must start teaching the child about certain things because some people, it can do with age like say 13 but someone might be getting the information from 10 because the person is relating with the peers and might be knowing a lot and everybody's system differs. So, for me, there is no specific age, you just have to study your child and when you that the child is getting of age and those things, then you start.
Interviewer: What are some of the issues you think parents can start teaching their children when they realize their children are beginning to know the environment?
Interviewee: Well, I think we have both male and female and taking the females, I think the mums, since the child is developing, must teach her the dressing and everything. The child might experience menstruation so the mother has to teach her how to care for herself, dress, how to keep herself protected, and all those things and the mother have to tell the child that as you are experiencing this menstruation, there is a high possibility that you can get pregnant when you indulge in sexual activity and without protection, you might contract diseases not that the mother is trying in to tell the child to go for sex with protection but is just a says just in case. The boys should be taught how to take care of themselves, they must know the use of contraceptives and all those stuffs. Teaching them this is not to encourage them to engage in this but so they can know the side effects of all these things.
Interviewer: So, have you ever engaged in any form of sexual activity before?
Interviewee: No, please
Interviewer: Why haven't you engaged in any of these sexual activities?
Interviewee: Well first of all I come from a home of great discipline and maybe my spirit doesn't permit me to do that. Excuse me to say, am a type of person, I don't like to get intimate with people and I like to keep my distance and I know the home I come from, I know the rules, I know everything about the rules so I just don't have any reason to flout the rules and besides my parents advise me maybe that's why I don't engage in those things.

SRH Issues Discussed
Interviewer: Have you ever discussed sexuality issues with your parents or any other elderly person?

Interviewee: Yes.
Interviewer: What are some of the issues you discussed and why did you discuss such issues with them?
Interviewee: Well, I discuss it with my mum. So, first of all, I am not the person to start the conversation because I can't start anything so, sometimes when we are there then she will be like, oh Esi please, you are coming of age and you are aware of your environment and your peers. You see your peers pregnant meanwhile they are supposed to be in school. You have a bright future so, don't let anyone deceive you to do anything and you know who you are and you know where you are coming from so, please take good care of yourself. She tries to tell me about sexual issues and sometimes I don't know she gets the courage to tell me about it.
Interviewer: How old were you when she started having such conversations with you and how often do such conversations take place?
Interviewee: I can't quite remember the age but it started just off late and it's not that often. Like when we are discussing something and maybe it has something to relate with that, then it comes on board.
Interviewer: So, have you ever discussed issues such as abstinence, puberty development, menstruation, sexual intercourse, and contraceptive use with your parents before?
Interviewee: No. Although my mother tells me or advises me, she doesn't go there.
Interviewer: [interjects] she doesn't talk about contraceptives, menstruation, personal hygiene, or STIs.
Interviewee: Maybe the only thing she talks about is personal hygiene but as for the rest no.
Interviewer: What about puberty issues as you grow up and the changes that take place in your body?
Interviewee: No as for that one mainly maybe as in compliment like hey you are developing breast
Interviewer: [interjects] and how do you react to it?
Interviewee: Ohh I smile [smiles]
Interviewer: So, how do you feel anytime you want to discuss sexuality issues with your parents?
Interviewee: Well, I feel very uncomfortable
Interviewer: Why do you feel uncomfortable?
Interviewee: I don't know and I don't think there is any explanation I can give.
Interviewer: Or do you think they will say you want to engage in it or you are a spoilt girl that's why you feel uncomfortable?
Interviewee: Well, actually I don't have any explanation. I just feel uncomfortable.
Interviewer: So, who then do you comfortable discussing such issues with?
Interviewee: My mother. But I don't go forward to them unless they bring up.
Interviewer: Why your mother and not your father?
Interviewee: Well to me I think it has to do with gender. maybe my mum is a female and I am a female and I can't do that with my father because that connection is not there like with mum.
Interviewer: What is the nature of the discussion between you and your mother?
Interviewee: Well, it is interactive but is not like a continuous thing whereas she will be advising me. She will say something and say another thing as if she is talking to someone but all the same it's okay.

Interviewer: Are there any programmes being organized in this town to educate young people on matters of sexuality?
Interviewee: No, please.
Interviewer: What about the school and the church you attend?
Interviewee: No
Interviewer: Have you ever attended any such programme before?
Interviewee: No
Interviewer: What about health-related issues? For instance, health workers coming around to educate young people on such matters?
Interviewee: Yes, they come around sometimes but most of them don't touch on the main issue. They come around but they don't touch on the vital issues.
Interviewer: What are the issues they touch on?
Interviewee: They come and will be like take care of yourself, maintain personal hygiene and all those stuffs but like they don't talk about contraceptives. They just talk about personal hygiene
Interviewer: Why don't they talk about contraceptives?
Interviewee: Maybe they have the same perceptions as others who discourage sex education meanwhile, I think they should rather be encouraging us. I don't know whether they feel uncomfortable telling us or something so they just touch on personal hygiene.

SRH Discussions and Empowerment
Interviewer: Do you think sexuality discussions with your parents' sis useful for you?
Interviewee: Yes, because to me I treasure advice from my parents so as my mother gives me advice on how to take care of and how to position myself in society, feel that she has a certain trust in me that is why she was able to open up to me so, obviously I won't like to let her down so I think the information is useful because it deters me from engaging in such acts.
Interviewer: But do you think such education can affect your behaviour in any way?
Interviewee: Mmm… yes but it's not a bad thing though but maybe like you are taught the use of contraceptives to prevent pregnancy or sexually transmitted diseases so I can go about saying things. You know people naturally don't like to hear such things and when you acquire knowledge on these things, you know about these issues mainly it's like almost all the time you will like to be saying things about its people feel uncomfortable hearing such things so obviously you will also like to be saying it openly. In as much as it has positive effects, it affects your behaviour in society.
Interviewer: Some say sexuality education is useful for young people as it will help them know about their bodies and help them relate with other people. What do you think about it?
Interviewee: Well, I agree with them because sexual education like I said is not only about sex but it teaches you the various body parts and gives you more insight about your body and all that stuff. So yes, I agree with them.
Interviewer: What information about sexuality education will you like to receive from your parents?

Interviewee: Well, first of all, personal hygiene and the use of contraceptives to save you from the chances of not acquiring errr sexually transmitted diseases and save you from pregnancy. Ermm, tell me about how to relate with the opposite sex and gender relations but the gap should be maintained.
Interviewer: So, at what age should young people know about such issues as gender relations and dating?
Interviewee: Between the ages of 13 going.
Interviewer: Why this age?
Interviewee: [sighs] hmmm, because it can be 10 years alright but me, I will go with 13 because that is the teen ages. Those ages are the ages where mostly the adolescent female has the probability of menstruating and all those kinds of things so engaging in sexual activities can results in pregnancy so, I think they should be given the insight into all these things.

Gender Dynamics and Barriers
Interviewer: Do the specific issues discussed by you and your parents differ in any way with regards to their gender?
Interviewee: Well, kind of
Interviewer: How does it differ?
Interviewee: Well, my dad will just go straight to the point and say one thing but then my mother will like to say a lot of things. She will give me detail and all those stuffs, give me the necessary information in detail but my dad will not go into details as that of my mother's one.
Interviewer: So, what are the issues your mother talks about that your father does not talk about?
Interviewee: Well, actually anything my dad says is reflected in what my mum says but it's just that my mum goes into detail talks about the activities of sex but it doesn't reflect in what my dad says. My dad will just go straight to the point.
Interviewer: Why are your mum's own much detailed than that of your dad?
Interviewee: Well, like I said maybe because of the gender and maybe my dad is also not comfortable.
Interviewer: How confident are you in discussing sexuality issues with your parents or elderly people in your community?
Interviewee: Not as much but I think with my mother, I can say am getting there may be as time goes on, I will be conversant with things but as for now yes there is some kind of confidence but not to the extreme.
Interviewer: So, is your confidence affected by the person talking to you?
Interviewee: Yes, sometimes like with my mum the confidence is high because we can gel but with my dad, it is low because we can't gel because he is a male and am a female but with my mum, we are all the same gender so that's why.
Interviewer: So, what are some of the things that prevent you from discussing sexuality matters with your parents?
Interviewee: Well, our environment has shaped us in a way that we think certain ways. Sometimes we think that walking to them to discuss such things will give them the impression that I am hearing things and getting very curious about things I don't have to be curious about and maybe they think I am getting of age so am trying to develop some bad habits and that is why I am asking those questions. Yes, so it deters me from asking them. Also, culture and religion are like as for my

religion am a Christian so because of the godly ways some of them might think that saying these things is ungodly and our culture also cites some way with the religions. It doesn't allow our people to open up these things. They adapt to the method of them using other words to represent what they mean so I think culture and religion affect us.

Interviewer: What about fear and shyness.

Interviewee: Yes, they might also have a part to play

Interviewer: So, has there been any instance where you wanted to talk to your parents about sexuality issues but you couldn't.

Interviewee: Yes, so like I wanted to walk to her and ask her people say they experience menstruation and people to say they can be in the class or something and it will just come in an embarrassing moment like that but I couldn't ask her because I was shy.

Interviewer: Okay thank you very much for your time, am grateful.