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# PARENT-ADOLESCENT COMMUNICATION ON SEXUAL AND REPRODUCTIVE HEALTH: PERCEPTIONS AND EXPERIENCES OF OUT-OF-SCHOOL ADOLESCENT MOTHERS IN THE EAST GONJA MUNICIPALITY, GHANA

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**ABSTRACT:** Social institutions such as family have an important role to play in shaping adolescent sexual behaviour, and parents remain central to this responsibility. Available evidence suggests that adolescent girls who are engaged in a healthy parent-child communications on sexual and reproductive health (SRH) (e.g. sex, contraception, and sexually transmitted infections (STIs) prevention) at an early age are more likely to learn or adopt safe sexual behaviors. This qualitative study explored the perceptions and experiences of out-of-school adolescent mothers on parent-child SRH communications. Sixty-four (64) participants were recruited from the antenatal care (ANC) unit of the East Gonja Municipal Hospital in Salaga, Ghana, through purposive sampling technique. Data were collected from six focus group discussions (FGDs) and thematic analyses were conducted using ATLAS.ti version 9. The results of the FGDs were presented using illuminating verbatim quotations. In all the FGDs, parents were cited as an important source of SRH information. Parent-adolescent conversations on SRH were often initiated by the female parent and this often took the form of case-base discussion. However, most participants indicated were unsatisfied with the topics discussed and the context in which parent-adolescent SRH communications were conducted. Lack of trust, perceived authoritative and insensitive nature of male parents to the needs and plights of adolescent girls, and socio-cultural norms restricting/prohibiting open discussions on SRH, especially those concerning sexuality and contraception, were mentioned as barriers to effective parent-adolescent SRH communications. Parent-adolescent SRH communications were lately initiated, infrequent, and often did not address the most important aspects of adolescent SRH.

**Keywords:** Parent, Adolescent, Perception, Experience, Sexual and Reproductive Health

## 1. INTRODUCTION

Adolescence is a special developmental period often associated with diverse sexual and reproductive health (SRH) risks (Pichon *et al*., 2022). The World Health Organization (WHO) defines an adolescent as an individual aged 10 to 19 years (Bekele *et al*., 2022), and describes this period as a rapid and formative phase of human development (Malango *et al*., 2022). While transitioning from childhood to adulthood, adolescents undergo distinctive physical, cognitive, emotional, and sexual developmental changes which require special attention and consideration in both local and national policy and programme development (Malango *et al*., 2022). Coupled with their curiosity, young people, especially those between 10 and 19 years of age, have relatively immature physical and mental strength which makes them highly vulnerable to distinctive sexual adventures (Asamoah & Agardh, 2018). Adolescents aged 15-19 years, particularly, have an increased risk for early sexual intercourse, unsafe sexual practices and other high-risk sexual behaviours (Kothari *et al*., 2012).

In recent year years, globally, exposure to sexual activities tends to begin at early ages and this pattern of behaviour has increased in proportion over the past decades (Asamoah & Agardh, 2018). Literature has shown that many sexually active adolescents and youth in Ghana began sexual intercourse and sex-related activities before their 15th birthday (Ghana Health Service [GHS], 2016), relative to what was known previously (Awusabo-Asare *et al*., 2004). Reports from the 2015 Ghana Demographic and Health Survey (GDMH) showed that sexual intercourse before 15 years among adolescents aged 15-19 years increased by 61.6% between 1998 and 2014, from 7.3% to 11.8% (Ghana Statistical Service [GSS], GHS, & Inter City Fund [ICF] International, 2015). However, modern contraceptive use in Ghana has only increased steadily since 1998 and the progress, very uneven. Consequently, the incidence of adolescent pregnancy and sexually transmitted infections (STIs) among young people remains considerably high in Ghana (GSS *et al*., 2015). Recognizing and responding to these problems, the GHS (2016) launched the "Adolescent Health Service Policy And Strategy (2016-2020)" which sought to improve availability and accessibility to SRH services among adolescents, especially those in underserved areas. One of the key strategies the GHS sought to use was parent-adolescent communication on SRH to bridge the significant gap between need for and accessibility to accurate SRH information adolescents (GHS, 2016).

Social institutions such as family have an important role to play in adolescent SRH, and parents remain central to this responsibility (Manu *et al*., 2015). A growing body of evidence shows that adolescents, particularly girls who are engage in a healthy parent-child communications on SRH (e.g. sex, sexuality, contraception, and sexually transmitted infections (STIs)) at an early age are more likely to learn or adopt safe sexual behaviors, including abstinence and protective behaviors that prevent pregnancy and STIs (Bekele *et al*., 2022). In a recent study, good parent–adolescent SRH communication was found to have a positive correlation with good adolescent mental health, educational, and developmental outcomes (Pichon *et al*., 2022). However, in many homes and community settings in Ghana, parents still overlook this important social responsibility. In the Adaklu district in Volta region of Ghana, Klu *et al*. (2022) reported that only 11.3% of adolescents were engaged in SRH communications by their parents.

Barriers to effective parent-adolescent SRH communications are diverse and complex. In Ghana, adolescent girls particularly face several challenges in accessing SRH services (Yeboah *et al*., 2022). Consequently, about 50% of adolescents in Ghana are still unable to received accurate SRH information that will enable them make the right decisions and choices about their SRH (WHO, 2020). A recent systematic review based on 15 outcome studies reported that lack of parent self-

efficacy and stringent socio-cultural norms restricting/prohibiting open discussions on sex and sexuality are factors hindering parent-adolescent SRH communications in Africa (Usonwu *et al*., 2021). Other factors affecting parent-adolescent communications on SRH include parents' beliefs, attitude and knowledge on SRH, communication skills, social system and culture (Seif *et al*., 2019). This, combined with the breakdown of the extended family systematic as an important social institution, could have contributed to the recent paradigm shift in the information-seeking behavior of adolescents in developing countries, where they seem to develop love for information available in the traditional and social media including television, radio, Facebook and WhatsApp (Pradesh *et al*., 2022). Despite serving as important sources of SRH information, there is significant evidence that some SRH information available on media are inaccurate and misleading for adolescents (Adzovie & Adzovie, 2020).

The recent efforts at benchmarking adolescent SRH services and policies (GHS, 2016) in Ghana identified gaps in parent-adolescent SRH communications, especially in rural communities where there are still stringent socio-cultural norms restrict/prohibits open discussions (parent-adolescent) on SRH. This study explored the perceptions and experiences of out-of-school adolescent mothers in the East Gonja Municipality on parent-adolescent SRH communications.

## 2. MATERIALS AND METHODS

### Study Approach

This study adopted a qualitative approach to explore out-of-school adolescent mothers' perceptions and experiences of adolescent-parent SRH communication. The selection of this study approach was informed by the following considerations; (1) the paucity of empirical data on the topic, particularly, on the social and individual-level aspects of parent-child SRH communication, and (2) the prior experiences of the target population regarding sexuality, pregnancy and motherhood which were relevant for a focus group discussion (FGD). Adopting this method provided an in-depth understanding of parent-adolescent SRH communication and how it played a role in adolescent sexual behaviours.

### Study Area

The East Gonja Municipality (Figure 1) is one of the seven districts/municipalities in the Savannah Region of Ghana, located in the eastern part of the region. It shares boundaries with North East-Gonja District to the North, Central Gonja District to the West, Nanumba-North, Nanumba-South and Kpandai Districts to the East, and the Bono-East Region to the South. The municipality is divided into seven sub-municipals – Kafaba, Kayereso, Makango, Salaga North, Salaga South, Aboromase, and Buma. According to the 2021 Ghana Population and Housing Census, population of the East Gonja Municipality is 117,755; the third highest in the Savannah Region (GSS, 2021a). More than half of the population is males (51.1%). Most of the residents of the municipality live in rural communities (72.4%), and about 77.3% of the working population is employed in skilled agriculture, forestry and fishery (77.3%). The majority (59.2%) of the East Gonja Municipality population has never attended school and only about one-third (32.7%) of persons aged 11 years and older in the municipality are literate in any language. More females are non-literate (52.1%) than males (47.9%) (GSS, 2021b). The recent Multidimensional Poverty Index Study (GSS, 2020) in Ghana revealed that the Savannah Region has the highest level of multidimensional poverty index (0.403%), poverty incidence (70.9%) and intensity (56.8%).

The East Gonja Municipal Hospital is the largest secondary-level healthcare facility in the East Gonja Municipality. Located in the administrative capital "Salaga", the hospital provides general and specialist healthcare services (including surgical services) to

residents of the municipality and neighboring districts. The hospital's antenatal care (ANC) unit runs from Monday through to Friday. Routine services provided at the unit include but not limited to assessment of mother's general health status, folic acid and iron supplementation, education and counselling on maternal nutrition, monitoring of foetal conditions, provision of insecticide treated net and malaria preventive therapy, counselling on family planning, and treatment of minor obstetric conditions.

**Participants and Sampling Technique**

Sixty four (64) out-of-school adolescent mothers attending the ANC clinic of the East Gonja Municipal Hospital were purposively selected for the study. The selection of this population was based on the following considerations; (i) The rising incidence of adolescent pregnancy in the Savannah Region of Ghana despite a reduction at the national level, (ii) the researcher's response to calls articulated in global and national public health resolutions, guidelines and framework to tackle adolescent pregnancies, and (iii) the paucity of accurate data on parent-adolescent SRH communication and how it played a role in adolescent pregnancies. This study was relevant to the local context, and there was evidence of policy-maker interest. Participants were sampled from the seven sub-municipals and major ethnic groups in the East Gonja municipality to maximize heterogeneity. Criteria for inclusion in the study were; (i) sex – female, (ii) age – 10-19 years, (iii) residence – East Gonja Municipality, (iv) currently pregnant, confirmed by ultrasound scan, (v) not enrolled in any formal education, (vi) attending the ANC clinic of the East Gonja Municipal Hospital, (vii) generally stable, and (viii) able to give assent/consent for the study.

**Data Collection Procedure**

Six FGD were conducted in March 2022, at the ANC unit of the East Gonja Municipal Hospital. Each FGD was made up of 10-12 participants, and was facilitated by two sex-matched research assistants with at least five years' experience in maternal health care; one moderated the discussion, and one took short notes on the discussion. Research assistants were recruited from the maternal and child health unit of the East Gonja Municipal Hospital. The already established rapport between the research assistants and the clients enhanced the FGD. Before the data collection, the facilitators of the FGDs informed the participants of the purpose of the study and those who showed interest in the study were taking through the consent process. Only those who consented were recruited for the FGD. The length of each FGD ranged from 50 to 60 minutes. The facilitators jointly selected the venue for the data collection with the participants to ensure privacy, convenience, and safety. Given the low literary rate of the participants in the English language and the multi-cultural characteristics of the East Gonja Municipality, the FGD were conducted in four common local languages (Hausa, Gonja, Konkomba, and Asanti Twi). Participants were assigned to one of the six FGD depending on the language they could proficiently communicate with.

At the FGDs, the facilitators first introduced the topic (SRH) and allowed for opened discussions. Data were collected and analyzed to a point where no more new information to enrich theme identification was forthcoming (Muhwezi *et al*., 2015). Theme identification started during the literature review (Aventin *et al*., 2020; Muhwezi *et al*., 2015; Nurachmah *et al*., 2019; Tesso *et al*., 2012; Usonwu *et al*., 2021) and continued as long as patterns that captured interesting issues were emerging. As presented in Table 1, the topic guides covered; (1) Prior awareness of SRH and parent-adolescent SRH communications, (2) source of information on SRH, (3) facilitators and barriers to effective parent-adolescent SRH communications, and (4) strategies to improve parent-adolescent SRH communications. Participants were served water. None was given monetary compensation since they were there to access routine ANC services.

**Table 1** Questions used for the focused group discussions

| | Questions in the FGD |
|---|---|
| 1 | Did you ever hear about sexual and reproductive health (SRH)? (Probe: what it is, how important it is to the adolescent). |
| 2 | Where do receive SRH information from? (Probe: primary sources; most trusted sources; most preferred sources). |
| 3 | Did your parents ever discuss with you issues related to SRH? (If a person answers 'Yes', probe: at what age; which parent; how often; person initiating the conversation; topic discussed). |
| 4 | For participants who have never had SRH communications with their parents, probe the reasons. |
| 5 | How do your parents communicate SRH information to you? Do they come as cautions, threats, or friendly discussions? |
| 6 | What is your level of satisfaction with these communications? (Probe: topics discussed, context, length of time for such discussions, etc.) |
| 7 | What challenges do you face in discussing SRH with your parents? |
| 8 | How do you think parent –adolescent SRH communications can be improved? (Probe: perceived appropriate age to start these conversations, topics to discuss, how structural barriers can be addressed etc.) |
| 9 | Do you have other comments or suggestions or issues you would want to be addressed to improve parent-adolescent SRH communications? |

**Quality Assurance**

The entire research, more especially the data collection, went through a rigorous quality assurance process. Prior to the data collection, the principal investigator provided a 4-day practice-based training on how to conduct FGD for the research assistants. The training covered various aspects of the research process, including facilitating and note taking in FGD. The research assistants were also oriented to the inclusion criteria and ethical considerations of the study. In all the FGDs, the principal investigator was around to supervise the process and ensure that the procedures for the FGD were followed as much as possible.

**Data Analysis**

Following the FGD, the audio recordings were translated, and transcribed verbatim into English language by four language experts. The primary data were analyzed using ATLAS.ti Win (Version 9.1.20) and followed an inductive approach. First, the principal investigator examined all the transcripts and identified emerging quotations about parent-adolescent SRH communication, which were then labelled with a code. The codes were reviewed to identify and resolve coding discrepancies. Where necessary, and upon consultation with relevant experts, codes were merged or separated. Finally, codes were categorized into themes and subthemes. Using the developed codebook, a second level of coding was conducted. Thematic analysis was used to analyze the data, where first, the primary data was triangulated. Differences with themes and sub-themes were discussed with experts in the subject area. The results of the study has been organized in such a way that they summarize participants' perceptions and experiences of parent-adolescent communications, including general views, communication approaches, facilitators, and barriers to parent-adolescent SRH communications. A range of relevant quotes had been included in the results section to expound on each theme.

### Ethical Consideration

The study approval was granted by the East Gonja Municipal Health Directorate (Ref # GHS/SR/EGMHD/HIS/9). Verbal consent was obtained from the participants. Participation in the study was voluntary.

## 3. RESULTS

### Socio-demographic Characteristics of Participants

As presented in Table 1, a total of 64 out-of-school adolescent mothers participated in the study. Individuals from the indigenous tribe, Gonja, constituted 17.2% of the sample. Most of the participants were residents of rural communities (76.6%). Regarding religious affiliations, the largest proportion of the sample were Muslims (71.9%). More than half of the respondents had no formal education (57.8%) and 56.3% were married. The majority of the participants were employed (65.6%), with farming being the most predominant occupation (57.1%). Most of the respondents' first pregnancy occurred when they were between 16 and 19 years of age. First time mothers constituted 79.7% of the total study sample.

**Table 2** Socio-demographic characteristics of participants

| Variable | Frequency (n) | Percent (%) |
|---|---|---|
| Age | | |
| 10-15 years | 7 | 10.9 |
| 16-19 years | 57 | 89.1 |
| Tribe | | |
| Gonja | 11 | 17.2 |
| Dagomba | 9 | 14.1 |
| Fulani | 13 | 20.3 |
| Konkomba | 10 | 15.6 |
| Others | 21 | 32.8 |
| Community of residence | | |
| Rural | 49 | 76.6 |
| Urban | 15 | 23.4 |
| Religion | | |
| Islam | 46 | 71.9 |
| Christianity | 12 | 18.8 |
| Others | 6 | 9.4 |
| Highest level of education | | |
| No formal education | 37 | 57.8 |
| Elementary school | 19 | 29.7 |
| SHS | 8 | 12.5 |
| Marital status | | |
| Single | 10 | 15.6 |
| Married | 36 | 56.3 |
| Co-habiting | 18 | 28.1 |
| Employment status | | |

| Variable | Frequency (n) | Percent (%) |
|---|---|---|
| Employed | 42 | 65.6 |
| Unemployed | 22 | 34.3 |
| Current occupation† | | |
| Farming | 24 | 57.1 |
| Trading | 6 | 14.3 |
| Apprenticeship | 4 | 9.5 |
| Others | 8 | 19.0 |
| Age at first pregnancy | | |
| 10-15 years | 16 | 25.0 |
| 16-19 years | 48 | 75.0 |
| Number of childbirths | | |
| 1 | 51 | 79.7 |
| 2 | 13 | 20.3 |

Note. N = 68. †N = 42. SHS = Senior High School.

**Parent-adolescent Communications on SRH**

**Primary source of information on SRH**

Most participants indicated were familiar with SRH. In all the FGD, peers were cited as the main source of information on SRH.

*I was 12 years when I first heard about menstruation, but it did not come from my parents. A friend who had menstruated earlier before me shared her experience with me. But how she described it made it seem frightening until I started menstruating and realized it wasn't so* (Out-of-school adolescent mother, FGD 1).

Adolescent mothers who had ever enrolled in a formal education also cited school as an important source of information on SRH.

*While I was still in SHS [senior high school], we used to have some health workers from the district hospital come to educate us on menstruation, contraception and other stuff. It was really interesting to have experts speak to you on such matters. Most of us didn't have any knowledge on them until our encounter with the health experts* (Out-of-school adolescent mother, FGD 2).

Although peers served as an important source of SRH information for adolescents, some information the participants received from their colleagues were misleading. Read what one participant said in the FGD:

*A friend told me that using contraceptive would make me become infertile and when I wanted to confirm that from my elder sister, she also said using contraceptive would make me stop menstruating and would not be able to give birth to a child* (Out-of-school adolescent mother, FGD 3).

Some adolescent mothers admitted had ever received SRH information from their parents. Compared to males, female parents were cited as an important and most preferred source of information on SRH.

*When you have a mother or a family member who is familiar and interested in these things [SRH communications], they will help you know about it. During my first menstruation [menarche], the advice my mother gave me was that I would become pregnant if I slept [had sexual intercourse] with a man* (Out-of-school adolescent mother, FGD 4).

**Initiating parent-child SRH communication**

Parent-adolescent conversations on SRH were often initiated by the parent or the adult member of the family and this was often in a form of case-base discussion. Most of the adolescent mothers stated that when a girl of a comparable age from their neighbourhood or

community became pregnant, their parents, particularly mothers, would react to the situation sounding as though they were disappointed in that particular adolescent and in doing so, would start a conversation on SRH.

*I remember when one of my age mates and friends became pregnant; my mother advised me almost every passing day and night against intimate relationship. She would always emphasize that I did go to school or leave her house if I became pregnant. Unfortunately, the latter happened. But the sad thing is that in sounding those cautions, she failed to teach me other possible ways in which I could have avoided this pregnancy* (Out-of-school adolescent mother, FGD 6).

### Mode of communication

Often, SRH information came in a form of advice and sometimes as an unplanned SRH conversation.

*My mother occasionally used storytelling to advise me and my sisters on pre-marital sexual intercourse. She would often use her experiences to advise us against sexual intercourse with a man. She said we would also become pregnant like she did if we slept [engage in sexual intercourse] with a man* (Out-of-school adolescent mother, FGD 5).

*In some instances, the conversation [on SRH] was unplanned. It just happened because we were discussing other [social] topics that concerned young girls* (Out-of-school adolescent mother, FGD 4).

### Topics often discussed in parent-child SRH communication

Topics that were often discussed in parent-adolescent SRH communications were those relating to menstruation and pregnancy.

*... for once I thought the topic would change but it never did. It was always on menstruation or pregnancy, thus if a girl of a comparable age in my community became pregnant. I remember after my first sexual intercourse which I did without family planning [contraceptive], I wanted to learn about how to prevent pregnancy because I was afraid I could become pregnant, but all the discussions my mother brought up during that period were related to menstruation* (Out-of-school adolescent mother, FGD 1).

Occasionally, issues concerning contraception and family planning were discussed also.

*Since I started menstruating, it was only on one or two occasions my mother told me about contraceptives. Even with that, it was just a passing comment. She did not provide any in-depth explanation on that. Maybe she didn't also know much about it or perhaps she was afraid if I knew about it I might start using it* (Out-of-school adolescent mother, FGD 5).

### Comfort with parent-child communications on SRH

Most of the participants mentioned that they felt comfortable discussing SRH issues with their mothers who were often accommodating and friendly, compared to their fathers who they perceived to be fearsome, harsh and authoritarian.

*Unlike my father, my mother experienced the same pubertal changes I am going through and so I feel comfortable discussion my [pubertal] experiences with her* (Out-of-school adolescent mother, FGD 3).

Others also mentioned that discussing SRH with their mother made them felt tensed or uncomfortable.

*I always felt tensed when my mother was talking to me SRH or asked me questions about my menstruations and issues concerning intimate relationship. I had a sexual partner at a very young age and I loved him. So, whenever my mother talked to me about the consequences of early sexual intercourse, I felt very uncomfortable, perhaps because of the fear of what was just about to happen [referring to her pregnancy]* (Out-of-school adolescent mother, FGD 2).

### Level of satisfaction with parent-child SRH communications

Many adolescent mothers indicated were not very satisfied with the kind of parent-adolescent SRH communications they were exposed to or the context in which it was conducted. Some also indicated the SRH information they received prior to becoming pregnant was just not adequate for them.

*… it was once in a while we did hear about SRH from my mother and I think that was just not enough. If it was, perhaps this [the pregnancy] wouldn't have happened* (Out-of-school adolescent mother, FGD 5).

*… many a time the issues my mother discussed with us were not on how to prevent pregnancy. She always sounded as though she is cautioning us against pregnancy but she would hardly tell you the tricks about this sex thing [she giggled]* (Out-of-school adolescent mother, FGD 6).

### Barriers to effective parent-adolescent SRH communications

Major barriers to effective parent-adolescent SRH communications mentioned in the FGD were lack of trust in some parents, perceived authoritative and insensitive nature of male parents to the needs and plights of adolescents, and the socio-cultural norms restricting or prohibiting open discussions on SRH, especially those concerning sexuality and contraception.

*When you have a mother who cannot keep secret, and would tell your father anything you discuss with her because she also fears him as you do, it becomes very difficult to confide in her and share sensitive information such as those relating to sexual practices. This is especially so for some of us whose fathers would not care to chase you away from the house if he sees or hears that you have a boyfriend* (Out-of-school adolescent mother, FGD 4).

*In our community, you hardly hear adults discussing issues related to sex or sexuality in the open. I don't know how they communicate with each other on such matters but I hardly see or hear them do that. This is something we have grown to meet, and so it becomes difficult to do the unusual, the society would be mad at you, especially when you are a female. This is not helping the young girls in our communities. Maybe if I knew about contraception properly, I could have prevented this pregnancy* (Out-of-school adolescent mother, FGD 2).

*My mother is a single parent, trader and often she is away from home. When she is around we don't get to discuss some of these issues [SRH] with her because she is attending to other things. Moreover, she doesn't even initiate conversations on those issues [SRH] and I think that was where she left me. It really did me no good* (Out-of-school adolescent mother, FGD 3).

### Strategies to improve parent-adolescent SRH communications

Many adolescent mothers mentioned that addressing the socio-cultural barriers that restrict or prohibits open discussions on SRH could help improve parent-adolescent SRH communications.

*Considering how the world is changing, I think there should be more effective measures to remove the barriers to accessing SRH information from parents and adult members of the family. If this is done, it will enhance the SRH communication between parents and their children and this will help to reduce the number of pregnancies in our communities* (Out-of-school adolescent mother, FGD 1).

Some participants also urged parents to set aside adequate time for parent-adolescent SRH communications and create good parent-adolescent relationship/rapport to enhance these communications.

*Parents need to make enough time for their kids to discuss important issues concerning their SRH. This can also help to prevent adolescent pregnancies in our communities. But is it important that they have good relationship with their children. In that case the children will feel comfortable to tell them [SRH] issues that bother them* (Out-of-school adolescent mother, FGD 2).

Several others participants expressed concerns on the topics often discussed during parent-adolescent SRH communications, emphasizing the need for parents to select and discuss age-appropriate, gender-sensitive topics, including those related to sex, sexuality, family planning and contraception.

*If the topics parents discuss with their children are not sensitive to their needs, then it will not make any positive impact on the adolescent. So it is important that our parents choose topics that will benefit us, like how to avoid pregnancies you don't want to have* (Out-of-school adolescent mother, FGD 3).

## 4. DISCUSSION

Adopting a qualitative approach, this study explored the perceptions and experiences of

out-of-school adolescent mothers in the East Gonja Municipality on parent-adolescent SRH communications.

The results of this study show that parents were an important source of information on SRH for adolescent girls. Often, parent-adolescent SRH communications were initiated by the female parent. This finding is consistent with observations from studies in Ghana (Klu *et al*., 2022) and Uganda (Ayalew *et al*., 2014; Muhwezi *et al*., 2015) where adolescents often relied on mothers rather than fathers for SRH information. The reason for this, as has been extensively reported in literature (Ayalew *et al*., 2014; Klu *et al*., 2022; Usonwu *et al*., 2021; Wudineh *et al*., 2021), was that most participants in the current study perceived their male parents to be authoritative and insensitive to the needs and plights of the adolescent girl. While it is important to encourage mother-child communications on SRH, the lack of fathers' involvement in SRH discussions could mean that male parents do not support such communications, especially in a setting like the East Gonja Municipality where there are still significant socio-cultural norms prohibiting open discussions on SRH with children.

Consistent with earlier observations (Ayalew *et al*., 2014; Muhwezi *et al*., 2015), the current study found that parent-adolescent conversations on SRH were often initiated by the parent or the adult member of the family and this was often in a form of a case-base discussion. This was due to lack of confidence on the part of the adolescent to bring up such conversations. Similar observations were made in studies in SSA; Ethiopia (Bekele *et al*., 2022; Wudineh *et al*., 2021), and rural Tanzania (Wamoyi *et al*., 2010), and reflects the traditional norms in Africa which tend to prevent adolescents from engaging in such conversations perceived to be meant for adults, and branding adolescents who tend to show interest in these conversations as lacking good moral values or not properly brought up by their parents.

Often, SRH information was delivered to adolescents as an advice and sometimes as cautions, especially when an adolescent girl of a comparable age became pregnant in their community or neighbourhood. Muhwezi *et al*. (2015) in a study among secondary school students in rural and urban Uganda reported that most parent-adolescent SRH discussions, especially those involving adolescent girls tend to be delivered to them in a similar form. Also, in a systematic review of 15 outcome studies, Usonwu *et al*. (2021) noted that parents often used negative tones including threats, warnings and misinformation to deliver SRH information to adolescents. Although these approaches (cautioning) adopted for parent-adolescent SRH communications may help to instill some fear and discipline in the adolescent girl, it has the potency to further dampen adolescents' confidence in sharing important SRH information with their parents and the effect can be very detrimental to their health (Pichon *et al*., 2022).

Topics often discussed in parent-adolescent SRH communications were those related to menstruation and pregnancy, and occasionally, issues on contraception and family planning. In a study in Uganda, Muhwezi *et al*. (2015) reported that the content of parent-adolescent communications on SRH usually focused on abstinence, self-control, and STIs prevention. While these topics might be important for the girl child, many participants in the current study indicated were unsatisfied with the topics discussed and the context in which parent-adolescent SRH communications were conducted. Some also indicated the SRH information they received prior to becoming pregnant was just not adequate for them. In Muhwezi *et al*. (2015) study, adolescents from rural-based schools expressed some level of dissatisfaction with the content of parent-child SRH communications. Parents' failure to teach "sex positive" behaviours and condom negotiation skills (Pichon *et al*., 2022) could have contributed to the pregnancies noticed among adolescents in the current study and has an important implications for SRH policy development in the near future.

As extensively reported in literature (Klu *et al*., 2022; Manu *et al*., 2015; Muhwezi *et al*., 2015; Pichon *et al*., 2022), lack of trust, perceived authoritative and insensitive nature of male parents to the needs and plights of adolescent girls, and socio-cultural norms restricting or prohibiting open discussions on SRH, especially those concerning sexuality and contraception, were stated as barriers to parent-adolescent SRH communications. These barriers, which had perhaps remained with the study participants for several years, could have contributed to the high incidence of adolescent pregnancies in the East Gonja Municipality.

Strategies for improving parent-adolescent SRH communications suggested by the participants were; (1) addressing the socio-cultural barriers that restricts open discussions on SRH, (2) selection and discussion of age-appropriate, gender-sensitive topics, including those related to sex, sexuality, family planning and contraception, (3) improved parent-child relationship, and (4) allocation of adequate time by parents for SRH discussions with their children.

## 5. CONCLUSION

In all the FGDs, parents were cited as an important source of SRH information. Parent-adolescent conversations on SRH were usually initiated by the female parent, in a form of a case-base discussion. However, most participants indicated were unsatisfied with the topics discussed or the context in which parent-adolescent SRH communications were conducted. Factors affecting parent-adolescent SRH communications were lack of trust, perceived authoritative and insensitive nature of male parents to the needs and plights of adolescent girls, and socio-cultural norms restricting or prohibiting open discussions on SRH, especially those concerning sexuality and contraception. Overall, there were major deficiencies in parent-adolescent SRH communications; these communications were lately initiated, infrequent, and often did not address the most important aspects of adolescent SRH. Having identified these challenges, it is important that the East Gonja Municipal Health Directorate engage relevant institutions (e.g. GHS, traditional authorities and opinion leaders in the East Gonja Municipality) to focus actions and resources to respond appropriately.

In the quest to address adolescent pregnancies in the East Gonja municipality, it is important that intervention programmes on parent-adolescent SRH communications should focus on improving parental knowledge and skills to deliver comprehensive sexuality education which is of high quality and age-appropriate, and teaches condom negotiation skills. Parental approaches to discussing SRH with the adolescent girl could also be improved by encouraging and promoting questions and open dialog between parents and adolescents.

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### Conflict of Interest

None declared

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