PARENTS' KNOWLEDGE ON SEXUALITY AND PERCEPTIONS TOWARDS DISCUSSING SEXUALITY WITH THEIR ADOLESCENT CHILDREN
(A COMPARATIVE STUDY OF RURAL AND URBAN COMMUNITIES)

BY

Mwinga N. Tolosi Bsc Nursing, RM, RN.

A dissertation submitted to the University of Zambia in partial fulfilment of the requirement for the Masters' degree in Public Health (MPH).

(School of Medicine)
THE UNIVERSITY OF ZAMBIA
LUSAKA

2002

STATEMENT

This dissertation is a genuine work of Namasiku Mwinga Tolosi, carried out in woodlands residential area in Lusaka City and Ndanda, a rural area in Mongu District.

Prof K. S. Baboo, MBBS, MED, FRSH, DABTM.
Supervisor
MPH Co-ordinator

Dr C. C. Michelo, MBcHB, MPH
Lecturer
Department of Community Medicine

DEDICATION

This study is dedicated to my late father Mr Luka Mwinga and mother Namangolwa Mbaala for contributing to my upbringing and education which has culminated into this paper. To you both I say thank you.

DECLARATION

I here by declare that the work presented in this dissertation for the Master's degree in Public Health (MPH) is my own work and has not been previously submitted for a degree at the University of Zambia or any other University.

Namasiku Mwinga Tolosi
(Candidate)

Date 19/07/12

APPROVAL

This dissertation of Namasiku Mwinga Tolosi is approved in partial fulfillment of the requirement for the award of a Master's degree in Public Health (MPH) by the University of Zambia.

Examiner	Examiner	Examiner
Date: 19/07/22	Date:	Date:

Abstract

Adolescence is a critical phase in human development. It is a period during which young people experience great and rapid changes in their bodies and is often associated with risk taking behavior and experimentation resulting from peer pressures. To over come such, parents need to talk to their children about growing up and measures needed to overcome pressures.

The study sought to determine rural and urban parents' knowledge on sexuality and their perceptions towards discussing sexuality with their adolescent children. Their knowledge and perceptions were then compared for similarities and/ or differences.

A cross-sectional comparative study design was carried out in Ndanda rural area in Mongu District of Western Province and Woodlands low density residential compound in Lusaka.

A total sample of 236 parents (118 from each area) was randomly selected from parents who were keeping adolescent children aged between 10 and 19 years. Systematic sampling method was employed in selecting them.

A semi – structured questionnaire consisting of pre-coded and open - ended questions was used for data collection. Focus group discussions were also held with rural parents who were not part of the interviews.

The study revealed that there was no significance difference in rural and urban parents' level of knowledge on sexuality ($P = 0.446$).

Education of parents was found not influencing their level of knowledge on sexuality. According to the findings, 85 (72.0%) of urban parents with college

level of education and 75 (63.6%) rural parents with primary level of education had knowledge on sexuality.

Parents source of information on sexuality differed. According to the findings, 87.8% of urban parents obtained information through the media while 61.6% of parents in the rural area received advise from family members. These results demonstrated that environment in which parents live determined their source of information on sexuality.

Communication between parents and children on issues pertaining to sexuality existed in both areas. The results revealed that 107 (90.7%) of rural and 103 (87.3%) of urban parents had started discussing sexuality with their children. However, 15 (12.7%) of urban and 11 (9.3%) of rural parents had not started discussing sexuality with their children.

The age at which discussions were started was also established. Findings show that 58 (54.2%) parents from the rural area and 47 (45.6%) from the urban initiated the discussions when their children were between 10 and 14 years.

The type of information parents found easy to discuss with children differed in the two areas. Those in the rural area found it easy to advise their children on manual work (65.4%) while those in the urban (54.4%) advised their children to refrain from promiscuous activities. The study further established that little was said about the changes in sexual characteristics of the adolescents, despite it being an important topic.

In conclusion parents in both areas were knowledgeable about sexuality and their levels of knowledge were not significantly different.

Communication between parents and children on sexuality existed in both areas with majority of them having initiated the discussion on sexuality when their children were between 10 and 14 years.

The type of information parents discussed with their children was different in the two areas.

In accordance with these findings, it is therefore recommended that reproductive health educators educate parents on the importance of initiating sexuality discussions early in adolescent's life. Furthermore a qualitative study should be carried out to explore the information parents discuss with their children.

ACKNOWLEDGEMENTS

I wish to express my special thanks to my academic supervisors **Professor K. S. Baboo and Dr C. C. Michelo** for their massive guidance and valuable suggestions made to this study. I thank the Ministry of Health for granting me permission to undertake the studies at the University of Zambia that enabled me to study for the Master's degree in Public Health.

Many thanks go to the Government of Zambia through Central Board of Health and the Danish Government for awarding me a scholarship that enabled me to study for this degree. I would also like to acknowledge with thanks Institutional Collaboration through General Nursing Council (GNC) and Sweden International Development Aid (SIDA) for partially financing this study.

I'm indebted to Mr Philemon Ndubani for his advice especially in analysis of qualitative data and my husband Mr Martin Tolosi for the assistance rendered in data processing and analysis.

My sincere thanks go to Mongu Municipal council, the Chief and Headmen for Ndanda rural area, the respondents from both areas for allowing me to collect data. Lastly, I thank all the people who assisted in every way to make the study a success.

TABLE OF CONTENTS

CHAPTER THREE: METHODOLOGY

CHAPTER FOUR: RESULTS

CHAPTER FIVE: DISCUSSION OF FINDINGS:

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background information

Adolescence is a period between onset of puberty and adulthood (Webb *etal* 1996). It is a period of physical, psychological and social maturity. The World Health Organization (WHO) in 1994 defined adolescence as the period during which an individual progresses from the period of initial appearance of secondary sexual characteristics to that of maturity. WHO further stated that during adolescence, the individual's psychological process and patterns of identification develop. Adolescence is a critical phase in human development because of the significant biological and psychological changes which occur to which a child has to adjust to. It is the time during which young people experience great and rapid changes in their bodies, in their concerns, relationships and roles in society (Banda and Makono, 1995). According to Ministry of health in 1984, an adolescent is a young person aged between 10 and 20 years.

Sexuality on the other hand describes the total behaviour of a person in relation to feelings, thoughts, emotions, attitude, values, gender roles, gender identity and sexual behaviour (Khetsiwe, 1995). Khetsiwe further added that sexuality is experienced in different ways like walking and dressing, which are influenced by the environment under which one lives.

Adolescence is often associated with risk taking behaviour and experimentation. During this period, adolescents start to develop self-esteem and exert independence from the parental generation. In addition, friends become more important. They learn a lot of new information, form values and attitudes about who they are. If not properly guided, they can easily adopt undesirable values and behaviours. Adolescents need guidance during this phase of development from parents and guardians to shape them into responsible adults.

Historically, in many cultures, the period of adolescence was short. Children were recognized as adults soon after they had gone through an initiation ritual at puberty which consisted of lessons on intimate relations and responsibilities (Minou, 1988). Minou further states that lessons were conducted by specially assigned persons close to the family like a grandparent, aunt or uncle, a scenario found in Zambia. To day this is not the case due to social changes. The period of adolescence has lengthened in most societies due to early menarche, late marriages and the many years spent in schools (Khetsiwe, 1995). The socio - economic changes have to a large extent eroded the traditional guidance system. Most relatives no longer play the same roles in guiding and controlling their adolescent children as was the case in the past. This is attributed to rural - urban migration and changing family patterns. In modern family set up, the extended family members are no longer easily accessible. With these changes, parents are expected to take up this role.

Education of an adolescent should be started early enough before they are sexually active. Researches have shown that many adolescents become sexually active at an early age. Tamara *etal* (1995), said that most Zambian adolescents are sexually active by their mid teens. More young people are being sexually active without proper access to sexual reproductive health information.

Sexual activity is known to be the most common cause of sexually transmitted diseases (STDs), Human Immuno Deficiency Virus (HIV) / Acquired Immuno Deficiency Syndrome (AIDS) and unplanned pregnancies. Most adolescents have little knowledge about sexuality and reproduction. They receive little guidance about rights and responsibilities and how they can protect themselves against unwanted pregnancies, STDs and HIV/AIDS.

The Ministry of Health (MOH) through Central Board of Health (CBOH) is striving to address adolescent reproductive health problems by coming up with guidelines on prevention and treatment of these problems. To address these issues, a national adolescent reproductive health policy is being formulated. This indicates therefore that the Ministry of Health has no specific policy at the moment for adolescent reproductive health. Lack of a written policy should not be used as a stumbling block to the development of initiatives and activities targeting young people (Webb *etal,* 1996). Parents need to realise that educating adolescents on sexuality helps them to attain a level of maturity for responsible decisions about their sexual life. In case of a girl child, this information will help her to understand

her sexuality and protect herself from unwanted pregnancies, STDs and HIV/AIDS. Young men will have respect for women's self determination, hence share responsibly in matters of sexuality and reproduction (Mwale, 1998).

1.2 Statement of the problem

Traditionally, sexuality and reproduction were issues that were addressed by a member of the extended family like an aunt, uncle, grand - parent or cousin. Over the past few decades, there has been a rise in urbanization and this has weakened the traditional family structure. In addition, the life expectancy for Zambians has reduced to 42 years (CSO, 1990), meaning that most grand parents die before their grand children reach stages for initiation. This change in family pattern has eroded the traditional way children got facts. Families and relatives do not play the similar roles as they used to. Ajai *et al* (1991) states that the decline of traditional controls on sexual activity among adolescents is attributed to the process of social change.

Young people today are often more influenced by the external world than by their parents. Some of them are intensely exposed to the mass media images of casual sex, romance and violence. This view is supported by Tamara *et al* (1995) in a study conducted in Lusaka in which they found that most of the knowledge acquired by adolescents is from the media, verbal information from friends and their practical experiences. Information from such sources could be misleading. Chikotola *et al* (1996) found that the information adolescents gathered from television, video films and friends had gaps or misinformation. Such information may lead to undesirable behaviour, which exposes them to reproductive health problems of unplanned pregnancies, STDS and HIV/AIDS.

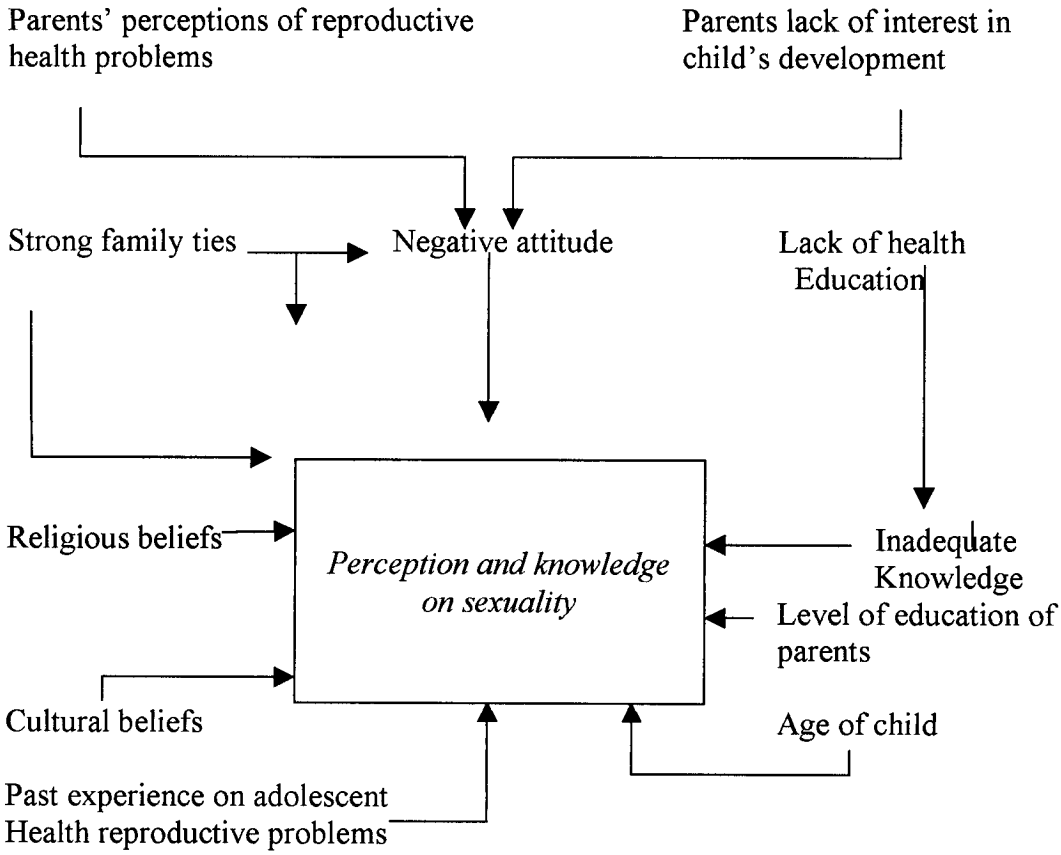
Parents, who went through the traditional ways of socialization, may still expect their children to be socialized in the same way even where such family ties do not exist. The way parents learnt about sex influences their attitudes about sex and this may, affect their feelings as they talk to their children. This is in line with Chikotola *et al* (1996) who stated that many parents find it embarrassing and hard to talk about sex with their children mainly because their parents did not talk to them about sex. With the changes in family structure and the increasing risk of reproductive health problems adolescents are exposed to, parents are expected to discuss sexuality with their children. This new role conflicts with their culture and beliefs. The questions to be asked include; Are parents willing to discuss sexuality? What are their views concerning this role?

1.3 Rationale

Although many studies have been done on adolescent sexual and reproductive health, little is known about Parents' perception and views on the subject. In view of the above, a study of this nature was under taken to establish and compare rural and urban parents' perceptions towards discussing sexuality with their adolescent children. The study also aimed at establishing and comparing rural and urban parents knowledge on sexuality in order to determine their level of understanding and involvement. The question asked was "how comfortable were parents in discussing sexuality with their adolescent children? For those who were not, what factors contributed to this?" This information may be helpful to policy makers and planners of adolescent reproductive health services. The information may assist them to formulate policies and come up with strategies aimed at changing parents'

attitude towards discussing adolescent sexuality. Health providers may also use the information in creating awareness to parents on sexuality.

Problem analysis



1.4 Objectives

1.4.1 General objective

To determine and compare rural and urban parents' knowledge on sexuality and perceptions regarding discussing sexuality with their children.

1.4.2 Specific objectives

1. To determine and compare rural and urban parents' level of knowledge on sexuality.

2. To establish whether there is any communication between (rural and urban) parents and children regarding sexuality.

3 To establish and compare rural and urban parents' perceptions towards discussing sexuality with their children.

4. To determine and compare some of the factors that enable and inhibit rural and urban parents from discussing sexuality with their children.

5. To determine and compare the age at which rural and urban parents begin discussing sexuality with their children.

6. To establish and compare the type of information rural and urban parents discuss with their children.

7. To establish and compare rural and urban parents' source of information on sexuality.

8 To make recommendations to policy makers and planners of Adolescent reproductive health.

1.5 Hypothesis

1. Parents who attain high level of formal education are more likely to discuss sexuality with their adolescent children than parents with no or low educational level.

1.6 Operational definitions

For the purposes of this study, the following terms were defined as

1. Adolescent – A child aged 10 – 19 years.

2. Parent – Biological mother, father, guardian (A person who has kept an adolescent for more than one year.

3. Attitude – Is the feeling or thinking towards discussing sexuality with adolescents.

4. Sexuality – Gender roles, gender identity, sexual matters and feelings towards sex.

5. High educational level - Secondary and above formal education qualification.

6. Low educational - Only attained primary education.

7. No education – Never been to school.

8. High social status – being easily accessible to basic services of safe clean water, health facility, education facility and communication facility.

9. Low social status – being inaccessible to basic services of safe clean water, health facility, education facility and communication facility.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

Adolescence as a concept and a period has not always been recognized due to early marriages. In many cultures, children were recognized as adults and ready for marriage after initiation ritual at puberty (Minou, 1988). To day the period has lengthened due to late marriages, more years of education and early menarche. Likwa (1994) stated that age at menarche is falling below the age of 14 indicating an increase in adolescent period. Gumugaba (1995) supported this by stating that girls' age at first menarche varied from 10 to 19 years with average age recorded at 14 years. This indicates that some girls have their first menarche very early in their adolescence.

The adolescents of today are the parents of tomorrow. The skills, ideas or facts imparted in them during adolescence period, has bearing in their parenthood. To develop their full potential they need to be nurtured in an enabling environment where all their needs including good health and protection are met. Adolescents have been recognized as a high - risk group in relation to a variety of sexual and reproductive health problems. Zambia recognizes adolescents to be a major concern because of its increased youth population of 3.4 million (CSO, 1990). Youth sexuality has emerged into serious consequences of reproductive health problems requiring interventions (Likwa, 1994). The social and health problems adolescents face are enormous which requires parents intervention. The current

surge in interest in the area of adolescent sexual and reproductive health is the threat posed by the HIV/AIDS pandemic. For instance, out of the 36,984 ARC/AIDS cases reported to Ministry of Health in Zambia in 1996, 1,584 cases were associated to the 15 - 19 age group (Webb *etal*, 1996). These figures are likely to increase if left unchecked by concerned parties such as parents.

One of the strategies for over coming these problems and improving the sexual and reproductive health for adolescents is to increase their access to comprehensive package of basic services including information and counselling on sexuality.

2.2 Adolescents sexual behaviour and health

Adolescent's health is a primary element in the development of any country and should be promoted. Most studies done on adolescent sexuality indicate that the risk taking behaviours adolescents take affect their health. Webb *etal* (1996) agreed to this by saying that the nature of reproductive health of the adolescent is related to the sexual activities. Prevalence of sexual activity among the adolescents is high with first sexual act beginning in early stages of life. Results of a study on psychological and health consequences of girls in Kenya revealed that girls became sexually active very early in their adolescence with age range of 5 – 19 years (Gumugaba, 1995).

In a study conducted by Chikotola *etal* (1996) in seven (7) Lusaka peri-urban compounds, it was found that some of the adolescents had their sexual experience between 6 - 16 years. CSO (1999) stated that the mean age at first sex being about 16.3 years. Pillai and Yates (1993) stated in their study on teenage sexual activity that most adolescents enter into close relationship with a high proportion engaging in sexual intercourse.

2.3 Adolescent source of information

Literature reviewed show that adolescents get most of the information on sexuality from other sources other than parents. A study on knowledge, attitudes and practices of girl child regarding physiological changes by Mwale (1997) revealed that 58 percent of the girls interviewed obtained information on sexuality from teachers and the media. The study further revealed that only 10 percent received information from parents. Parents therefore are not viewed as sources of information on sexual and reproductive health. Chikotola *etal* (1996) stated that information from parents mainly comprise of warnings about being careful or do's and don'ts of life without any explanation. She further said adolescents common source of information is the media, friends, grand parents, experience and that information from these sources sometimes has gaps and misleading. Studies have shown that parents rarely discuss issues of sexuality with their children. Khetsiwe (1995) acknowledges this fact by saying that children are not encouraged to talk about sex.

2.4 Parents attitude towards sexuality

Parents are influential sources of knowledge, beliefs, attitudes and values for children. They are often role models who shape young peoples' perceptions of gender roles and influence the choices youths make about their sexual behaviour (Barnett, 1994). Parents have powers to guide their children's development toward health sexuality and can help them develop and practice responsible sexual behaviour and personal decision- making (Alter *etal,* 1984). Parents need to have positive views towards discussing sexuality with children. They need to spent some time and discuss these important issues with children. This may make change in adolescents' lives. Teens who live in stable family environments and close to their parents are more likely to remain sexually abstinent and post pone intercourse (Brent, 1998).

The role of parents in promotion of sexuality education to their children remains a contentious issue in our society. Many parents in traditional society believe that it is the grand parent's or respected elderly people's responsibility. It is often regarded as taboo for parents to discuss sexuality with their children. In Zambia, several appeals have been made to parents on the need to discuss sexuality with their children. This appeal comes after studies revealed that some parents do not talk to their children about sexuality and reproduction. Although policy makers and Programme managers agree that parents are the preferred providers of sex

education to children, few parents do so (Okumu *etal*, 1994) despite the high risk of reproductive health problems.

Mohammed (1996) stated that institutional barriers continue to obstruct the provision of effective programmes that could not only prevent the rising incidence of adolescent reproductive health problems, but also help young ones to realize their sexuality in a positive and responsible manner. Khetsiwe (1995) stated that traditional beliefs, taboos and religious restrictions work against talking openly about sexuality. She added on to say that the way parents learnt about sex influences their attitude and this affect their feelings as they talk to their children.

Although issues of sexuality are regarded as the role of grand parents and other members of the extended family, it is clear that increasing urbanization and fragmentation of the extended family is making the reliance on distant relatives less and less viable and the taboos on parental involvement less practical (WHO 1995). Grandparents and other extended members of the family are less available to provide sex education to adolescents, making traditional way of providing instructions on sex none existent (Mafuba, 1995). Parents should break the cycle of shame and silence and start discussing sexuality with their children.

Some parents feel that imparting knowledge to adolescents on sexuality and reproduction would promote early sexual activity and promiscuity. Contrary to this, studies have shown that adolescents have become sexually active even before traditional initiation on sexual matters are done.

Mohammed (1996) stated that adolescents will continue to explore and seek to understand their sexuality independent of deliberations. This was supported by Khetsiwe (1996), by stating that sexual feelings do not magically develop when children reach puberty but are born with. This implies that even if parents do not

talk to their children about sex, they will still have the desire and consequently have sex.

2.5 Communication between parents and children

The attitude parents have towards issues of sexuality could be barriers to sexuality education. Literature reviewed show that parents rarely discuss sexuality with their children. Chikotola *etal* (1996) supported this by saying that parents feel embarrassed and hard to discuss sexuality with their children. Children are not encouraged to talk about sexuality and yet they may have a lot of un answered questions. Such children may end up consulting their peers who may not give them correct information. Khetsiwe (1995) found out that children who had questions ended up asking friends who probably ended up with wrong information. Young people are more tempted to experiment with sex if they do not have the facts and guidance they need from parents.

Communication increases children's self esteem which is considered necessary towards assertive decision - making (Common Wealth Youth Programme 1993). Parents therefore need to talk to their children about growing up and share with them facts and values that are important for their development.

2.6 `Indicators and cut off points for variables

Variable	*Indicator and cut off points*
Parent's knowledge on sexuality	1. Not knowledgeable (where parents gave incorrect answer or did not mention any)
	2. Knowledgeable – (where parents mentioned at least one correct meaning of sexuality).
Education level	1. Never been to school
	2. Primary
	3 Secondary
	4. College/ UNZA

CHAPTER THREE
METHODOLOGY

3.1 Study design

A descriptive cross sectional and comparative study design was used to describe parents' knowledge on sexuality and perceptions towards discussing sexuality with their adolescent children. The knowledge and perceptions of both urban and rural parents were compared in order to come up with some similarities and/or differences.

3.2 Variables

The dependent variable in this study was the parents' knowledge on sexuality and perceptions towards discussing sexuality with their children while parents' education, inadequate knowledge on sexuality, child's age, religious beliefs, parents' attitudes and strong family ties were the independent variables.

3.3 Research setting

This study was conducted in a rural and urban setting. This enabled the researcher compare the knowledge and perceptions of parents from the two areas. These two areas were Ndanda, a rural area in Mongu District of Western province and Woodlands residential area in Lusaka.

Ndanda rural area is situated 103 kilometres on the eastern part of Mongu District and has a total population of 2,295 (CSO, 1990). The inhabitants of the area are mostly subsistence farmers with low education and social status. The other area Woodlands, is a low density residential area in Lusaka City with a population of 6,690. The people in Woodlands attained high education and are in formal employment. These two areas were chosen because the people found in these areas differ socially and economically, as such their knowledge and perception were expected to be different. The areas were also chosen because of easy accessibility.

3.4 Study population

The study sought to compare the knowledge and perceptions of urban and rural parents. For this reason, the study population consisted mainly of parents from rural and urban areas. The urban parents were selected from Woodlands, one of the low density residential areas in Lusaka City while those from rural were from Ndanda, a rural area in Mongu District. The parents recruited for the study included those in marriage and those who were not.

3.5 Sample size

Information was collected from a total sample size of 236 parents. This sample comprised of 118 rural and 118 urban parents (59 fathers and 59 mothers) selected from a total population of 6,690 for Woodlands residential area and 2,295 for Ndanda rural area. Only parents or guardians living with children aged 10 to 19

years were included in the study. On the other hand parents who were not citizens of Zambia were excluded from the study as their opinions were expected to be different from Zambians. To arrive at the above sample size, a formula that gave difference between proportions was used. This formula enabled the researcher come up with two proportions. Calculations were as follows;

$$N = \underline{[(U + V)^2[p_1(100 - p_1)] + P_2 (100 - P_2)] / (p_1-p_2)}$$

Where V = SD (95% CI) or 1.96 and U = Power 80 % = 0.84

P_1 = 30 % (proportion of urban parents willing to discuss with their children

P_2 = 15 % (proportion of rural parents willing to discuss with their children

$= [(0.84 + 1.96)^2 30(100-30) + 15 (100 - 15)] / (30 -15)^2$

$= [(2.8)^2 (2100 + 1275) / 225]$

$= 7.84 X 3375 / 225$

= 118 in each area

3.6 Sample selection

Convenient sampling method was used to select the two Districts. This was because the languages spoken in both areas were well understood and spoken fluently by the researcher. Hence translation and communication was very easy. The areas were also conveniently selected because they were easily accessible to the researcher as the road network was good.

Before data collection, all parents in households in the two areas were listed in order to identify households with adolescent children. The listing also enabled the

stratification of eligible population into fathers and mothers. These were given a serial number from one (N_{11}) up to the last number (N_{1n}). In the rural area N_{1n} = 750 while in urban area N_{1n} = 1,010. In cases where there were more than one parent in a household, both of them were listed and given equal chance of being selected into the sample. The list that was compiled served as a sampling frame from which the sample for the area was drawn.

A sample size of n_1 (parents) was then selected proportionally using systematic sampling design.

1. $K = N_{1n}/n_1$ where K was the sampling intervals.
   i. Rural area K = 750/118 = 6
   ii. Urban area K = 1010/118 = 9
2. Choose a random start R_1 between one (1) and N_{1n} (750 for rural and 1,010 for urban area).
3. Started with the random start proceed as follows:
   1, R_1, R_1+K_1, $R_1 +2K_1$, $R_1 + 3K_1$,. ..... $[R_1 + (n_1 - 1) K_1 = n_1]^{th}$ respondent

3.7 Data collection

Data collection was carried out over a period of two months and 15 days starting from third week of February to end of April 2000. A structured interview schedule with both open and closed ended questions was used. Focus group discussions with parents were held in Ndanda to validate data from the interviews. Combining different techniques according to Achola (1988) maximizes the quality of data

collection and reduces the chances of bias. Two [2] qualified nurses were used as research assistants [one for each area]. The research assistant for the rural area was selected from the rural health centre staff in the area while the one for the urban was identified in Lusaka. Training for the research assistants was conducted separately. This was done to reduce on travel and accommodation expenses.

3.8 Ethical consideration

Ethical approval was sought from the University of Zambia (UNZA) Research Ethics Committee. Permission to conduct the study was obtained from Mongu Municipal council and the area councillors. A letter of introduction was sought from the Department of Community Medicine. Consent from respondents was obtained before the interviews and confidentiality assured.

3.9 Pre testing

Pre testing of the instruments was done before the main study. This was done to test the data collection tool to ensure that questions were clear, concise and consistent. There after appropriate changes were done. The pilot was done in first week of January 2000 in Rhodes Park, an urban residential area in Lusaka city different from the residential area where the main study was carried out.

3.10 Quality control checks

Care was taken to maintain uniformity of information collected. At the end of each day, all the questionnaires were checked for any incomplete or missing information. A completed questionnaire ensures consistency and quality of information. It also increases the statistical power of the data when analysed.

3.11 Data processing and analysis

Before data entry, Open - ended questions were coded. Analysis was done using SPSS software. Frequencies and cross tabulations were used. Chi square statistical tests were carried out to compare proportions.

3.12 Limitation

Focus group discussions with urban parents were not held. This was because parents could not agree to move from their homes to another place for the discussion.

CHAPTER FOUR

RESULTS

4.0 Description of the sample

4.1 Sample size, age and sex distribution

A total of two hundred and thirty six (236) parents (118 males and 118 females) were recruited for the study from Ndanda rural area and Woodlands compound. This sample comprised of 118 rural and 118 urban parents (59 males and 59 females) giving a 100 percent response rate. Parents' age ranged from 24 to 80 for rural parents while their urban counter parts was from 24 to 62. Their mean ages were 43.02 for rural and 43.88 for urban parents with standard deviations of 8.82 and 7.48 respectively.

4.2 Educational level of parents

According to results in table 4.3.1, the educational level of parents in the two areas differed. In the rural area, 91 (77.1%) parents attained primary education while 90 (76.3%) of their urban counterparts went as far as college. Absolute figures only were used in some tables with cells having denominators less than 30.

4.3 Background information

TABLE 4.3.1: PARENTS' LEVEL OF EDUCATION BY AREA

Education	Rural		Urban	
	Frequency	Percent	Frequency	Percent
None	17	14.4	0	0
Primary	91	77.1	7	5.9
Secondary	10	8.5	21	17.8
College and above	0	0	90	76.3
Total	118	100.0	118	100.0

TABLE 4.3.2: PARENTS' OCCUPATION BY AREA

Occupation	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Self employed	0	0	26	22.0
Formal employment	0	0	67	56.8
Farmer	118	100	4	3.4
Other	0	0	21	17.8
Total	118	100.0	118	100.0

While all parents in the rural area were farmers, most parents in the urban were either in formal employment (56.8 %) or self employed (22.0 %) as shown in table 4.3.2.

TABLE 4.3.3: PARENTS' RELIGION BY AREA

Religion	Rural		Urban	
	Number	Percent	Number	Percent
Catholic	0	0	46	39.0
SDA	1	0.8	15	12.7
JW	6	5.1	7	5.9
NAC	53	44.9	6	5.1
Pentacostal	21	17.8	4	3.4
ECZ	15	12.7	0	0
UCZ	3	2.5	18	15.3
None	17	14.4	1	0.8
Other	2	1.7	21	17.8
Total	118	100.0	118	100.0

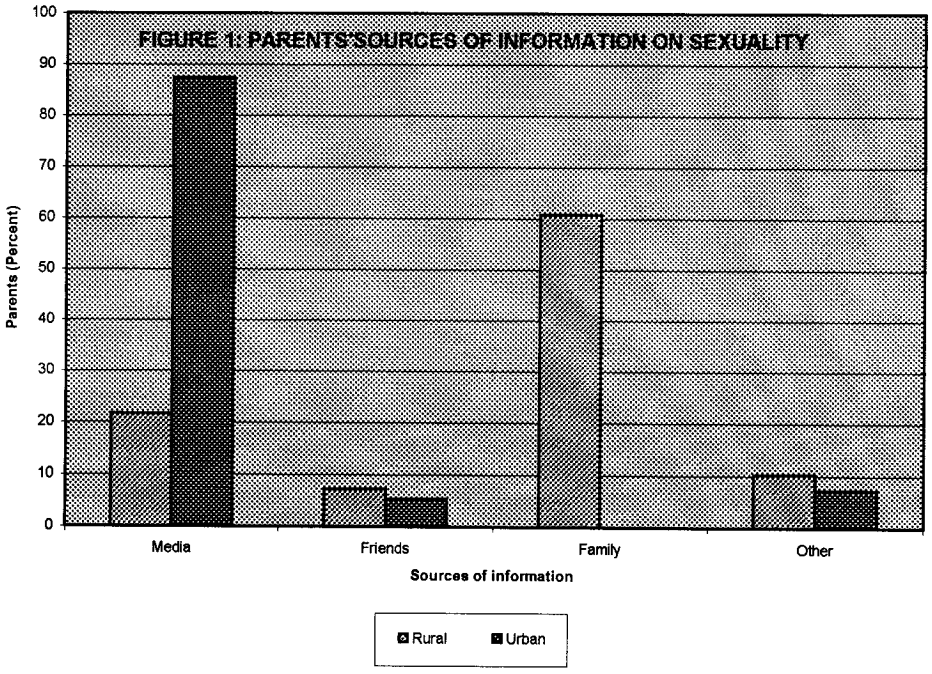
Table 4.3.3 shows that majority of parents from the rural area belonged to New Apostolic church (44.9 %) where as those in the urban area were Roman Catholic (39.0%).

4.4 Parents' knowledge on sexuality

TABLE 4.4.1: PARENTS' KNOWLEDGE ON SEXUALITY

Knowledge	Rural		Urban	
	Frequency	Percent	Frequency	Percent
No knowledge	2	1.7	5	4.2
Knowledgeable	116	98.3	113	95.8
Total	118	100.0	118	100.0

Table 4.4.1 shows that majority of parents from both urban (95.8%) and rural (98.3%) were knowledgeable on sexuality. These levels of knowledge were not significantly different (Fishers exact test P value = 0.446).



Out of 118 parents interviewed in the urban area, 87.8% obtained information from the media compared to 21.2% of their rural counterparts. On the other hand 61.6% of rural parents received information from family members. None of the urban parents received information from family members (figure 1).

TABLE 4.4.2: SEX BY AREA DISTRIBUTION OF PARENTS WHO HAD KNOWLEDGE ON SEXUALITY

Sex	Rural		Urban	
	Number	Percent	Number	Percent
Male	58	50.0	57	50.4
Female	58	50.0	56	49.6
Total	116	100.0	113	100.0

About half of rural parents (50.0%) and urban (50.4%) who were knowledgeable about sexuality were males. (Table 4.4.2).

FIGURE 2: RELIGION OF PARENTS WITH KNOWLEDGE ON SEXUALITY

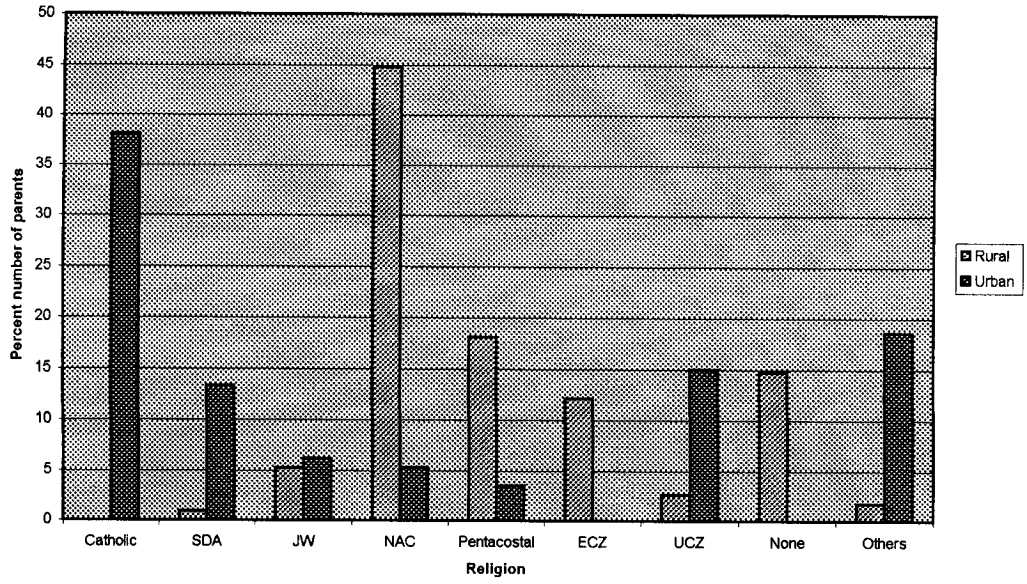


Figure 2 illustrates that 44.8% of parents from the rural area with knowledge on sexuality belonged to the New Apostolic Church. 38.1% of those in urban area were from Roman Catholic. The distribution of parents' religion between rural and urban was significantly different ($x^2 = 159.85$, df =8, $P < 0.001$).

4.5 Communication

TABLE 4.5.1: PARENTS STARTED DISCUSSING SEXUALITY WITH THEIR ADOLESCENT CHILDREN

Response	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Yes	107	90.7	103	87.3
No	11	9.3	15	12.7
Total	118	100.0	118	100.0

Table 4.5.1 shows that 107 (90.7 %) parents from the rural area and 103 (87.3 %) from the urban had started discussing sexuality with their children at the time of interviews.

TABLE 4.5.2: AGE OF CHILD AT WHICH PARENTS STARTED DISCUSSING SEXUALITY

Age group	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Below 10	36	33.6	37	35.9
10 – 14	58	54.2	47	45.6
15 and above	13	12.1	19	18.5
Total	107	100.0	103	100.0

Table 4.5.2 shows a distribution of parents by age group of their children at which they started discussing sexuality. In both the rural (54.2%) and urban (45.6%) areas, most parents started discussing sexuality with their children when they were between the age group 10 and 14 years. In addition, 37 (35.9%) urban and 36 (33.6%) rural parents started the discussions when their children were below 10 years.

TABLE 4.5.3a: RURAL PARENTS' EDUCATIONAL LEVEL BY CHILDS AGE AT WHICH DISCUSSION ON SEXUALITY IS STARTED

Education	Age group of urban children		
	< 10	10–14	15 and above
	No	No (%)	No
None	2	12 (19.7)	4
Primary	25	45 (73.8)	9
Secondary	7	4 (6.6)	0
Total	34	61 (100.0)	13

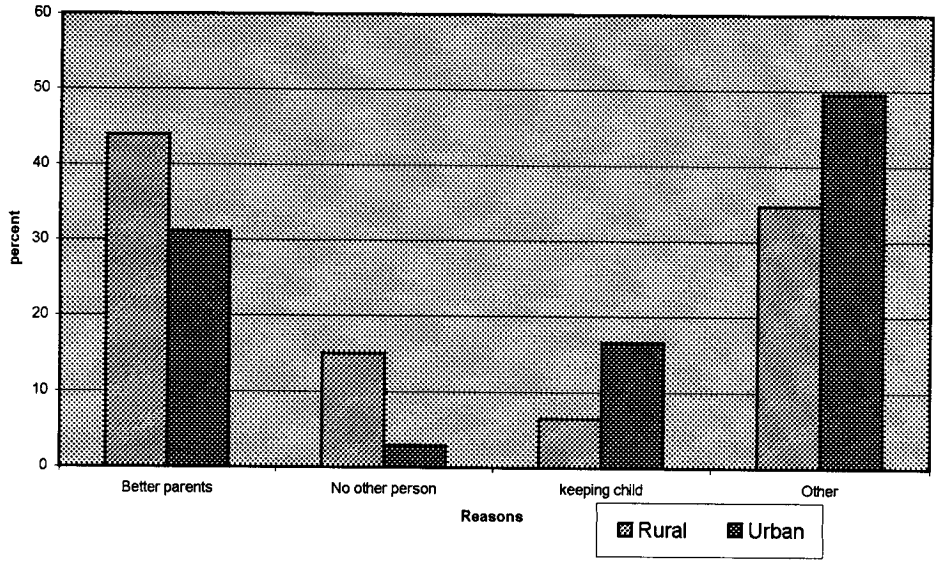
Out of the 34 rural parents who started discussing sexuality with children aged below 10 years, 25 attained primary education. Similarly 45 (73.8%) of 61 parents who had started discussing with children of 10 to 14 years, were of primary education. In the urban area, most parents who started discussing sexuality with children of 10 to 14 years (76.5%) and those aged 15 and above were of college or higher education (Tables 4.5.3a and 4.5.3b).

TABLE 4.5.3b: RURAL PARENTS' EDUCATION LEVEL BY CHILDS AGE AT WHICH DISCUSSION ON SEXUALITY IS STARTED

Education	Age group of urban children		
	< 10	10–14	15 and above
	No	No (%)	No
None	2	2 (3.9)	2
Primary	3	10 (19.6)	8
Secondary	10	39 (76.5)	24
Total	15	51 (100.0)	34

4.6 Parents' views

FIGURE 3: PARENTS' REASONS FOR BEING RIGHT PEOPLE TO DISCUSS SEXUALITY WITH THEIR CHILDREN



Parents differed over the reasons given for being right people to discuss sexuality with their children. In figure 3, majority (49.5%) of urban parents cited other reasons like escalation of HIV/AIDS while (43.9%) of those in the rural areas said

that by virtue of being parents, they automatically became the right persons to discuss sexuality with their children as it is an obligation. Some parents (15 %) in the rural area said since there is no other person to talk to the children, parents become the right people to discuss the subject. Those in the urban (16.5%) said as people keeping the children, they were the right people to discuss sexuality.

TABLE 4.6.1: RIGHT PERSON TO DISCUSS SEXUALITY BY PARENTS' SEX

Sex	Rural – Yes		Urban - Yes	
	Number	Percent	Number	Percent
Male	56	56.0	43	45.3
Female	44	44.0	52	54.7
Total	100	100.0	95	100.0

Majority of rural (100) and urban (95) parents interviewed said that they were the right people to discuss sexuality with their children. There was no significant association between sex and area (x^2 =2.25, df = 1, p =0.134) as shown in table 4.6.1

TABLE 4.6.2: RIGHT PERSON TO DISCUSS SEXUALITY BY EDUCATIONAL LEVEL

Education	Rural		Urban	
	Yes (%)	No	Yes (%)	No
None	13 (13.0)	2	0	0
Primary	78 (78.0)	5	6 (6.3)	1
Secondary	9 (9.0)	0	17(17.9)	7
College	0	0	72 (75.8)	0
Total	100 (100.0)	7	95(100.0)	8

Although parents from both areas appeared to have similar opinions over right person to discuss sexuality with children, their educational background differed. According to table 4.6.2, 78 (78.0%) rural parents with primary education and 72 (75.8%) urban parents with college and above educational level said were the right people to discuss sexuality. Both parents with low and high education status felt that they were the right people to discuss sexuality with their children.

TABLE 4.6.3: PARENTS' RELIGION BY FREEDOM ON DISCUSSING SEXUALITY

Religion	Rural			Urban		
	YES		NO	YES		NO
	No	(%)	No	No	(%)	No
Catholic	0	0	0	35	38.0	4
SDA	0	0	1	8	8.7	3
JW	5	5.3	1	8	8.7	1
NAC	47	49.5	1	3	3.3	1
Pentacostal	18	18.9	1	3	3.3	1
ECZ	9	9.5	5	0	0	0
UCZ	2	2.1	0	16	17.4	2
None	12	12.6	3	1	1.1	0
Other	2	2.1	0	18	19.5	1
Total	95	100.0	12	92	100.0	13

Table 4.6.3: illustrates that majority of rural parents (49.5%) belonging to New Apostolic church said were free to discuss sexuality with their children while those in the urban area with similar opinion were from Roman Catholic (38.0%).

TABLE 4.6.4: PARENTS WHO WERE FREE TO DISCUSS SEXUALITY BY SEX

Sex	Rural		Urban	
	Number	Percent	Number	Percent
Male	53	55.8	39	43.3
Female	42	44.2	51	56.7
Total	95	100.0	90	100.0

Table 4.6.4 shows that 95 rural and 90 urban parents indicated that they had the freedom of discussing sexuality with their adolescent children. Out of those in the rural area, 55.8% were males while 56.7% of those in the urban were females. There was no significant association between sex and area ($x^2 = 2.87$, df = 1, p =0.090).

4.7 Information discussed

TABLE 4.7.1: INFORMATION PARENTS FIND EASY TO DISCUSS WITH CHILDREN

Type of information	Rural		Urban	
	Frequency	Percent	Frequency	Percent
No promiscuity	24	22.4	56	54.4
Manual work	70	65.4	8	7.7
Other	13	12.2	39	37.9
Total	107	100.0	103	100.0

The information parents found easy to discuss with children was different in the two areas as shown in table 4.7.1. Most respondents in the rural area (65.4%) advised their children to concentrate on manual work, while the urban parents (54.5%) discussed avoidance of promiscuity more than any other topic.

TABLE 4.7.2: INFORMATION PARENTS FIND DIFFICULT TO DISCUSS WITH CHILDREN

Type of information	Rural		Urban	
	Frequency	Percent	Frequency	Percent
Sex with opposite	31	29.0	31	30.1
Nothing	70	65.4	44	42.7
Other	6	5.6	28	27.2
Total	107	100.0	103	100.0

Though most parents in the rural (65.4%) and urban (42.7%) areas did not find any difficulties in discussing sexuality with their children, 31 (29.0%) rural and 31

(30.1%) urban parents found difficulties in discussing sexual issues with children of opposite sex (Table 4.7.2).

TABLE 4.7.3a: RURAL PARENTS' EDUCATIONAL LEVEL BY TYPE OF INFORMATION DISCUSSED

Education	Topic Discussed			
	Avoid opposite sex N	Abstain from sex N (%)	Sexual characteristics N	Other N
None	1	11 (18.6)	1	2
Primary	22	43 (72.9)	4	14
Secondary	1	5 (8.5)	0	3
Total	24	59 (100.0)	5	19

Table 4.7.3a shows that most parents in the rural area who discussed abstinence from sex were of primary education (72.9%). In the urban area, 53 (79.1%) of the 67 parents who discussed avoiding opposite sex were of college education (Table 4.7.3b).

TABLE 4.7.3b: URBAN PARENTS' EDUCATIONAL LEVEL BY TOPIC DISCUSSED

Education	Topic Discussed		
	Avoid opposite sex N (%)	Abstain from sex N	Sexual characteristics N
None	0 0	0	0
Primary	3 (4.5)	3	0
Secondary	11 (16.4)	4	1
College	53 (79.1)	18	4
Total	67 (100.0)	25	5

TABLE 4.7.4a: RURAL PARENTS' SEX AND INFORMATION DISCUSSED

Topic	Male		Female	
	Number	Percent	Number	Percent
Avoid opposite sex	13	22.8	11	22.0
Abstain from sex	36	63.2	23	46.0
Sexual characteristics	1	1.8	3	6.0
Other	7	12.3	12	24.0
Total	57	100.0	50	100.0

Tables 4.7.4a and 4.7.4b show that majority of men in both rural (63.2%) and urban (83.3%) discussed abstinence and avoidance of opposite sex respectively. Women who discussed similar topics with children accounted for 46.0% for rural and 49.1% for urban. The tables also show that sexual characteristic is rarely discussed (1.8% rural men, 6.0% rural women and 9.1% urban women).

TABLE 4.7.4b: URBAN PARENTS' SEX AND TYPE OF INFORMATION DISCUSSED

Information	Male		Female	
	Number	Percent	Number	Percent
Avoid opposite sex	40	83.3	27	49.1
Abstain from sex	6	12.5	21	38.2
Sexual characteristics	0	0	5	9.1
Other	2	4.2	2	3.6
Total	48	100.0	55	100.0

4.8 Focus group discussion matrix

Focus group discussion number	Topic	
	Meaning of sexuality	**Remember discussing sexuality**
1 (Mothers)	As the child grows things happen like appearance of breasts for girls, pimples and deepening of voice	Remembered discussing avoiding prostitution, not to play with opposite sex to avoid a pregnancy
2 (Fathers)	Performance of adult roles, looking for sexual partners	Remembered being told to respect adults, avoid prostitution and how to stay in a home
3 (Mothers)	Performing adult roles, appearance of secondary sexual characteristics.	Agreed being told to avoid prostitution for parents benefit.
4 (Mothers)	Child refusing to be sent or becoming rude,	Remembered being advised on good behaviour, avoid prostitution to prevent unwanted pregnancies, concentrate on education, performing house duties.
5 (Fathers)	Looking for sexual partners, identification of sex, maintaining cleanliness.	Remembered being advised on respecting elders, avoid prostitution to prevent sexual transmitted diseases and not to drink deer.
6 (Fathers)	Appearance of secondary sexual characteristics, promiscuity.	Remembered being told to avoid stealing, performing housework.
Focus group discussion number	Topic	
	Source of information for parents	**Whether good or bad source**
1(Mothers)	Parents	Good because what was being said was happening
2 (Fathers)	Parents of same sex with child	Good as those who followed the advice grew up into responsible people
3 (Mothers)	Grandparents	Good advice because we became better people
4 (Mothers)	Parents of same sex with child	Good as we grew up into better people

5 (Fathers)	Parents	Good as those who followed it never had problems
6 (Fathers)	Parents	Good because with their advise we have become responsible persons

Focus group discussion number	Topic	
	Age of participants at which sexuality discussions are initiated	**Whether good or bad age to start discussions**
1 (Mothers)	Before puberty at 10 years	Good as we were big
2 (Fathers)	At 7 years	Good, better to start when child is young
3 (Mothers)	Between 10 and 14 years	Good because we were big to understand
4 (Mothers)	At 10 years	Good as we were big
5 (Fathers)	At 5 years	Good to start early. If started late, child becomes difficult.
6 (Fathers)	At 10 years	Good as we were big

Focus group discussion number	Topic	
	Information parents discussed	Need to discuss with adolescents
1 (Mothers)	Avoid promiscuity, not to play with opposite sex to prevent un wanted pregnancies and sexually transmitted diseases	There is need so that they know the consequences of promiscuity
2 (Fathers)	To respect elders, avoid promiscuity, how to live with others, concentrating on house work	There is need for them to grow into responsible people, should avoid promiscuity for fear of AIDS
3 (Mothers)	Avoid promiscuity, maintain cleanliness	Children need the advice we received of avoiding promiscuity to prevent reproductive health problems
4 (Mothers)	Good behaviour, avoid promiscuity to prevent unwanted pregnancies, concentrate on education and house work	There is need to discuss sexuality with adolescents so that they do not misbehave. Should be advised to concentrate on house work, education and avoid promiscuity.

5 (Fathers)	Respecting elders, avoid promiscuity to prevent sexually transmitted diseases, not to drink beer	There is need to advise the children so that they do not misbehave
6 (Fathers)	Not stealing, perform house work	There is need to advise children to concentrate on education, house and not to smoke

Focus group discussion number	Topic	
	Childs age at which discussion is started	**Whether both girls and boys need same information**
1 (Mothers)	When child turns 12 years because he/she is big enough	Both need same information as they are at risk
2 (Fathers)	Between 5 and 6 years so that child is equipped with knowledge at early age	Both should receive same information because they both make same offences
3 (Mothers)	When child turns 10 years as he is big enough	Both need same information as they both make mistakes
4 (Mothers)	When child reaches 10 years as he is big. If started early child would not follow advise	Both need the information because both are at risk
5 (Fathers)	As early as 5 years so that child acquires knowledge much early	Both need same information to help them make informed decisions
6 (Fathers)	When child turns 9 years when he is still to follow advice	Both need the information as they are at risk of contracting sexually transmitted diseases
Focus group discussion number	Topic	
	Right person to discuss sexuality with children	
1 (Mothers)	For girls, mothers are the right people. Boys would not listen if advised by mothers	
2 (Fathers)	Parents are the right people as children get information which parents want their child to know	

3 (Mothers)	Parents of the same sex with the child are the right people	
4 (Mothers)	Parents have the right to discuss with their, because if they don't then nobody will do it for them	
5 (Fathers)	Girl child is advised by the mother while the boy is advised by his father	
6 (Fathers)	Mother suppose to advise a girl child while a father advises the boy	

4.8.1 FOCUS GROUP DISCUSSION FINDINGS

Six (6) focus group discussions were held with parents in the rural area who were not included in the interview. To allow for free expression of opinion, the participants were grouped according to age and sex.

Results from the focus group discussion show that participants defined sexuality as sexual behaviour and development of secondary sexual characteristics. This was said by three groups.

The results further show that participants discussed sexuality with their children and that most of them initiated the discussions when their children were aged between 10 and 14 years. These findings are similar to those from interviewers.

Concerning the information parents discussed with children, the results show that majority of them advised their children to refrain from promiscuous activities. This was said by 5 groups. This finding is similar to the findings from interviews with the urban parents but different from the results obtained from the rural parents.

Regarding their opinion on who could be the right person to discuss sexuality with children, all six (6) groups expressed that parents with the same sex with the children were the right people.

CHAPTER FIVE
DISCUSSION

5.0 Introduction

The study sought to determine rural and urban parents' knowledge on sexuality and their perceptions towards discussing sexuality with their adolescent children. The knowledge and perceptions were compared for any similarities and / or differences.

The discussion of the results is presented in four sections outlined as:

1. Parents' level of knowledge on sexuality.
2. Communication between parents and children.
3. Views towards discussing sexuality with adolescent children.
4. Type of information discussed.

5.1 Parents' knowledge

Results of this study showed no significant difference in rural and urban parents' level of knowledge on sexuality as most of the parents from both areas were found to be knowledgeable about sexuality.

The study also showed that the sex of parents who had knowledge on sexuality was not related to residence. This is shown in the study where 58(50.0%) rural males, 58(50.0%) rural females, 57(50.4%) urban males and 56(49.6%) urban

females were knowledgeable. The level of knowledge for both fathers and mothers in the two areas was the same. This reflects the fact that sexuality issues are discussed with all people requiring the information.

Source of information for parents on sexuality differed in both areas. Results showed that 87.8% of urban parents obtained information mostly through media while 61.6% of their rural counterparts received the information through family members. These results were similar with those from focus group discussions with rural parents where participants said received information on sexuality from either parents or grandparents. These results indicate that the environment under which a person is, does determine his source of information on sexuality. The differences in availability of social services and family set up in the two areas may also have contributed to this scenario. In the rural areas Ndanda inclusive, electronic and print media facilities rarely exist, a situation different in Woodlands. The availability of such services in the urban area exposes the urban parent to the service.

On the other hand the extended family structure in the rural area is still in existence. This makes the rural communities adhere to the traditional values of seeking help from family members. This set up does rarely exist in urban areas due to migration and urbanisation. This is in line with what is reported in Ministry of Health (MOH) and World Health Organisation (WHO) report of 1995 where it was stated that increasing urbanization and fragmentation of the extended family is

making reliance on distant relatives less and less viable. People migrating to urban areas leave their family members in the villages and such people turn to other sources like media and friends for information on sexuality.

Parents' religion was significantly different. In the rural area, most parents who were knowledgeable about sexuality belonged to New Apostolic Church while those in the urban area were from Roman Catholic Church.

5.2 Communication between parents and children

Dialogue between parents and children on issues of sexuality is important for adolescents' good reproductive health. This is more important in the current environment where adolescents are at greater risk of reproductive health problems.

In a society like Zambia where reliance on extended families especially in urban areas is becoming less viable, parents remain the first and most important persons in socialisation of their children in all aspects of life including sexuality. In this study, results revealed that most parents in both areas, 107 (90.7%) rural and 103 (87.3%) urban parents discussed sexuality with their children at the time of fieldwork. More of these discussions took place in the rural area. The need to discuss sexuality was also expressed in all the focus group discussions held with rural parents. The reasons given by most of them for starting the discussions were the fear for HIV/AIDS. They said with the escalating infections, parents should take the initiatives of educating their children on the dangers of HIV/AIDS. This

information can help adolescents make responsible decisions over their sexual behaviour. These results are contrary to Coletta who stated in 1992 that adult family members tended to shy away from actively educating youth about issues of sexuality.

However 15 (12.7%) urban and 11 (9.3%) rural parents had not initiated sexuality discussions with their children at the time this study was being undertaken. Even though the number seems small, the effects of ignorance on their children may be enormous. These ignorant children may indulge in unprotected sex, which would lead them into a lot of reproductive health problems of HIV/AIDS, STI and unwanted pregnancies. On the other hand these children might pass on wrong information to other children. They may also turn to their peers for information. Cross in 1991 stated that when young people fail to get information at home, they seek answers else where from peers, media or even their observations of other adults. This can lead to misinformation and the persistence of damaging myths (Calderone M. S and Ramey 1983).

The age of children at which sexuality discussions were initiated was established. The results showed that 58 (54.2%) rural and 47 (45.6%) urban parents initiated the discussions when their children were between 10 and 14 years of age. This was also mentioned by 4 groups of parents during focus group discussions in the rural area. When asked why they started discussions at that age, they said by then, the children were mature enough to assimilate what they were told. While it may be

good to discuss such issues with a person who is able to understand and comprehend, sometimes it can be too late. For some children, discussions initiated at that age may be started when they are already sexually active.

Some studies have shown that some children engage in sexual activities at a much early age. In a study of maternal deliveries in Kenya, a 10 years and 3 months girl was found to have delivered a full term baby, suggesting that she conceived when she was about 9 years (Okumu *etal* 1994). Results of another study in Ethiopia of 181 teenagers revealed that 40% of the teenagers became sexually active before menarche (Duncan *etal 1994*). Siziya *etal* in a study of adolescent pregnancy in Zimbabwe (1998) said that adolescent's chances of being pregnant doubled as they got older from 15 – 19 years. They further suggested for interventions to curtail adolescent pregnancy much early before girls reach 15 years of age. This would mean that the girl engaged in sexual intercourse at a very early age. Sexuality discussions should therefore be started before children become sexually active in order to impart knowledge required for forming acceptable values and attitude. Molefe in 1999 stated that knowledge and attitude for children are often formed before the age of 12 years.

However 37 (35.9%) urban and 36 (33.6%) rural parents started the discussions before their children reached 10 years. When this group of parents were asked why they started the discussions at that age, they said children who receive sexuality education at an early age were easy to control. This was also expressed by two groups of parents during focus. These findings disputes the perception by most

people that sex education or any talk on sexuality should be given when teenagers are adults as it is rendered old fashioned by the realities of our times (UNFPA 1996). This is because by the time young people are provided with the information, they are already sexually active.

A small proportion of parents (18.5% of urban and 12.1% of rural) initiated discussions on sexuality when their children were in the 15 and 19 years age group. As already stated in this study, sexuality discussions started at that age have little help on the children.

The study further revealed that formal education had no influence over the period parents started discussing sexuality with their children. In this study, 73.8% rural parents with primary education started sexuality discussions when their children were 10 to 14 years compared to 76.5% urban parents with college education. These findings may indicate that age of children did determine the time sexuality discussions were started. This is so because most of them cited growing up as the reason for starting discussing sexuality with children.

5.3 Parents views over discussing sexuality with children

In the Zambian society, the subject of sexuality is not openly discussed. It is considered taboo hence not right for parents to discuss such issues with their children. It is also believed that giving young people information about sex

encourages promiscuity (Banda and Makono 1995). People are taught to think that sex is something private, secret and shameful (UNFPA 1996).

Contrary to these beliefs, results of this study revealed that parents from both rural and urban areas were willing to discuss sexuality with their children. As stated in the study, majority of parents had started discussing sexuality with their children. A number of reasons were given for this scenario. Some of the reasons were that advice is better given by a parent (43.9% for rural and 31.1% for urban) as it is an obligation for them. Respondents said as biological parents, it was their obligation to instil some sense of responsibility in children. Other reasons given were the fear for HIV/AIDS. Parents said as people who would not like to loose their children from the deadly infection (HIV/AIDS), it was better they talked to them as they were to loose if the children died. This view was also expressed during the focus group discussions with rural parents.

Another factor found not significant was sex of parents. The results showed that most fathers in the rural area and mothers in the urban said were the right people to discuss sexuality with the children. In the study, 56.0% of fathers and 44.0% of mothers from the rural area said were the right people to discuss sexuality with children compared to 54.7% of mothers and 45.3% of fathers from the urban. These results could be due to the different roles parents play in the two areas. In the rural area women are taught to be submissive to their husbands in all areas. They are taught to adopt a second position in a home. They rarely make decisions

concerning the up bringing of the children on their own. This may make them think that they are not the right people to discuss sexuality with children. This scenario is different in the urban area due to the economic and social status of women especially in communities of high social and economic status like those in Woodlands. At the same time fathers in the urban area including Woodlands rarely stay with children for longer time. The same view was expressed over their freedom to discuss sexuality with children. Most fathers 53 (55.8%) from the rural and 51 (56.7%) mothers from the urban areas said were free to discuss sexuality with the children. These results mean that the environment under which parents live may influence their opinions.

The religious affiliation of parents in the two areas differed. Most of those in the rural area belonged to New Apostolic Church while those in the urban area were from Roman Catholic. Despite this difference, this study has revealed that parents from both areas were knowledgeable and that they discuss sexuality with their children.

The study further showed no association between parents' education and discussing sexuality. Parents' education did not influence their decision to discuss sexuality with children in both areas. These results rejected the hypothesis that parents with high education discuss sexuality more than those with low education.

These results showed that parents' education did not influence their opinion concerning the right person to discuss sexuality with children as more (78.0%) of

rural parents with primary education said were the right people to discuss sexuality with their children compared to 75.8% of their urban counterparts with college education.

5.4 Type of information discussed

Parents from the two areas differed on the type of information they discussed with children. Results showed that majority (65.4%) of parents from the rural area advised children on manual work such as housework and cultivating while those in the urban (54.4%) talked about refraining from promiscuity. The environment under which parents live may influence the type of information discussed with children. Those in the rural area mostly adhere to the traditional and cultural norms where issues of sexuality are only discussed secretly and by authorised members of the family. In rural areas, parents prefer teaching children manual work more than any other topic as they prepare them for adulthood. Sexual issues are only taught when a child is marrying. On the other hand urban parents tend to follow the western culture that advocates for open dialogue on issues of sexuality. However, 31 (29%) parents from each area still found it difficult to discuss sexual issues with children of opposite sex. This was also expressed by two (2) groups of parents during focus. In a situation where children are raised by one parent, those of opposite sex would be deprived of the most needed information.

Education of parents was found not influencing the type of information discussed with children. The results showed that 43 (72.9%) rural parents with primary

education discussed abstinence compared to 3 (12.0%) urban parents with same level of education. As regards to the topic on avoidance of opposite sex, 53 (79.1%) urban parents with college education advised their children on avoiding playing with people of opposite sex compared to 22 of their rural counterparts. These results indicate that parents from both areas advised children on not engaging in premarital sex despite of the differences in education.

Parents' sex was found to influence the type of information discussed with children. Results of the study showed that most males from both areas discussed abstinence (63.2% for rural) and avoidance of opposite sex (83.3% for urban) more than women did (49.1% for urban and 46.0% for rural). This could be as a result of the different roles men and women play in society. Naturally men being the heads of households, their roles among others are those of disciplining family members while women concentrate on domestic chores. This may make the mothers think that discussing sexuality is not their role.

Sex of parents was found influencing type of information discussed with children. Men in both areas discussed abstinence and avoiding playing with children of opposite sex than women did. The results also revealed that little attention was paid to the changes taking place in children's sexual characteristics.

6.2 Recommendations

Based on the findings of the study, the following recommendations have been made:

1. There is need for Adolescent Reproductive Health educators to educate parents on the need to start discussing sexuality with their adolescent children early. This should be done much early before the adolescents are sexually active.

2. Educators of adolescent reproductive health need to sensitise mothers on the importance of discussing sexuality with their children.

3. Another study should be carried out on a larger scale on the same subject in order to enable generalisation of results.

4. There is need to conduct a qualitative study to explore the information parents discuss with their children in detail.

5. Educators of adolescent reproductive health should educate parents on the need to discuss with their children the changes in sexual characteristics of adolescents.

Sex of parents was found influencing type of information discussed with children. Men in both areas discussed abstinence and avoiding playing with children of opposite sex than women did. The results also revealed that little attention was paid to the changes taking place in children's sexual characteristics.

6.2 Recommendations

Based on the findings of the study, the following recommendations have been made:

1. There is need for Adolescent Reproductive Health educators to educate parents on the need to start discussing sexuality with their adolescent children early. This should be done much early before the adolescents are sexually active.

2. Educators of adolescent reproductive health need to sensitise mothers on the importance of discussing sexuality with their children.

3. Another study should be carried out on a larger scale on the same subject in order to enable generalisation of results.

4. There is need to conduct a qualitative study to explore the information parents discuss with their children in detail.

5. Educators of adolescent reproductive health should educate parents on the need to discuss with their children the changes in sexual characteristics of adolescents.

6. The Ministry of Health through Central board of Health should develop a policy on adolescent reproductive health. The policy will provide guidance to health educators as they develop strategies aimed at encouraging parents to dialogue with their children on issues of sexuality.

Annexes 1 REFERENCES

1. Achola A., and Bless C. (1998). Fundamentals of social research methods, pp 27.

2. Ajayi A. A., Miller M J. and Paxman J. M. (1991). Adolescent sexuality and fertility in Kenya: A survey of knowledge, perceptions and practices, Fam plan 22 (4), pp 205 – 216.

3. Alter J. S. etal. (1984). Teaching parents to be the primary sexuality educators of their children, Bethesda Mathlech Inc.

4. Banda F. P. and Makono S. (1995). Adolescent and Youth reproductive health, A paper presented at inter agency Technical committee on Population, Fair mount Hotel, Zambia, pp 2.

5. Barnet B. (1997). Gender norms affect adolescents, Network, 17:3.

6. Calderone M. S. and Ramey J. W. (1983). Talking with your child about sex, New York, Random House.

7. Central Statistical Office. (1999). Zambia's Sexual behavior survey 1998 with selected findings from the quality of STD services assessment, pp 7.

8. Central Statistical Office. (1990), Census of population and housing, pp 18

9. Chikotola B. et al. (1996). Summary report on adolescent sexual and reproductive Health for seven (7) Lusaka Peri Urban compounds, Care (Z) International PALS, Lusaka ,pp 8 - 12.

10. Coletta N. D. (1992). Communicating with parents first, Develop communication report, Number 78, USAID Bureau for science and technology, Office of education, Clearing House on Development communication, Washington D.C.

11. Common Wealth Youth Programme, Africa Centre, Positive living network, Workshop Report, 1993, pp 15 – 18.

12. Corlien M., Pathmanathan V.I. and Brownlee A. (1993). Part 1: Proporsal Development and Fieldwork, International Development Research Centre, Ottawa. Pp 215

13 Cross R. J. (1991). Helping Adolescents learn about sexuality, SIECUS Report, April/may report.

14. Duncan M. E. et al. Teenage Obstetrics and Gynacological problems in an African city, Central African Journal of Medicine, . (1994), 40 (9): 234 – 44, Department of Medical Microbiology, University of Edinburgh, Scotland, U.K.

15. Douglas W., Bull N. and Becci M. (1996). The emergency of adolescent in Zambia, the Policy Response Change, UNICEF pp 7. - 468.

16 Feedman D.A., O'hara P., Baboo K.S., Chilatu N.W. and Ying Lu. HIV Prevention among Zambia adolescents, Developing a Value Utilization Social Science Medical Journal, (1997). Volume 44, Number 4, PP 455.

17. Khetsiwe D. (1995). Talking Together, A hand book for parents and their teens, The Family Life Association, Swaziland, pp 9.

18. Likwa R. N. (1994). Youth Sexuality: A Situation Analysis of Reproductive Behavior and Health Status in Zambia, Paper presented at the District Capacity Building, Ministry of Health, Lusaka, pp 6.

19 Mafuba C. (1995), Sex education, whose duty should it be, The Herald, pp 11.

20 Mariella B., Peter A. and Gary S. (1993). Sex Education does not lead to earlier or increased sexual activity in youth, World Health Organisation (WHO) Global Programme on AIDS, Geneva, Switzerland.

21 Brent M c. (1998). Families matter: A research synthesis of family influences on adolescent pregnancy, Washington D. C, The Urban Institute.

22 Ministry of Health. (1984), Statistics Bulletin, Zambia.

23 Minou F. (1998). Issue Paper : Adolescent Sexuality Education, Counselling and Services, Swedish International Development Co-operation Agency.

24. Mohammed S. (1996). A paper on Youth Friendly Services, Lilongwe, Malawi, 7-12.

25. Molefe J. (1999). Young Adult reproductive health, Harnessing the power of media for health and development, Focus on Young Adult Magazine, Pathfinder International.

26 Mwale G. A. (1997). A Study to Determine Knowledge Attitudes and Practice of the Girl Child regarding her Physiological Changes of the Reproduction System, pp 43. **Unpublished.**

27. Okumu M. T., Chege N., Yonn P. and Orega H. (1994), Female Adolescent health and sexuality in Kenya Secondary Schools. A survey report, African Medical Research Foundation.

28. Pillai V.K. and Yates D.C. (1993). Teenage Sexual Activity in Zambia,the need for a sex education policy, Journal of Biosocial Science, pp 280.

29. Siziya S., Rusakaniko S. Masafu T., Mudyarabikwa O. and Gwanzura L Adolescent Pregnancy in Zimbabwe, distribution by socio- demographic factors, Africa Journal of Health Sciences. (1998), Volume 5 number 3 – 4.

30. Tamara F., Mupela E. and Rutenberg N. (1995), Youth Talk about Sexuality, A Participatory Assessment of Adolescents Sexual and Reproductive Health in Lusaka, Zambia pp 18 - 19.

31. United Nations Fund for Population Activities (UNFPA). (1996). International Youth Essay contest, Promoting responsible reproductive health behaviour, The youth perspectives, pp 68.

32. World Health Organization. (1995). Expanding Family Planning Options, an assessment of the need for Contraceptive Introduction in Zambia, Geneva, Switzerland, pp 11.

33. World Health Organization (1994). The Health of the Youth, Geneva, Switzerland.

Questionnaire no.... **Confidential**

QUESTIONNAIRE FOR PARENTS ON ADOLESCENT SEXUALITY: PARENTS' KNOWLEDGE ON SEXUALITY AND PERCEPTIONS TOWARDS DISCUSSING SEXUALITY. (A comparative study of rural and urban communities)

AREA CODE:..... DISTRICT CODE:..... DATE:.....

NAME OF INTERVIEWER:.....

INSTRUCTIONS TO RESEARCH ASSISTANTS

1. Always introduce your self before interview.
2. Explain the purpose of the study and ask for permission to do the interview.
3. Make the respondent sign the consent before you start.
4. Assure confidentiality.
5. Do not force a respondent to participate, pull out politely where respondent is reluctant or unwilling to take part.
6. Do not write the name of respondent on the questionnaire.
7. Write the appropriate response in the box provided.

SECTION A: DEMOGRAPHIC CHARACTERISTICS

1. Relationship to the child

1.Biological mother 2. Father
3.Guardian 4. Grandparent

2. Age: .....

3. Sex: 1. Male 2. Female

4. School grade completed

1. None
2. Primary
3.Secondary
4.College and above

5. Occupation

1. Self- employed
2. Employed
3. Farmer
4. Other (Specify).....

6. Marital Status:
1. Never married
2. Married
3. Divorced
4. Separated
5 Widow/Widower

7. Religion:
1. Roman Catholic
2. SDA
3. Jehovah's Witness
4. New Appostolic
5. Pentacostal
6. Evangelical Church of Zambia
7. United church of Zambia
8. None
9. Other

8. How many children do you have?

1. None
2. 1 - 3
3. 4 - 6
4. 7 and above

9. Do you keep any relative aged 10 - 19 years

1. Yes
2. No **Go to Section B**

10. For how many years have you kept the child?

1. 1 - 2
2. 3 - 4
3. 5 - 6
4. 7 and above

SECTION B: KNOWLEDGE ON SEXUALITY

11. In your understanding what does sexuality mean?

.....
.....
.....

12. Do you remember discussing sexuality in your childhood?

1. Yes
2. No **Go to Q14**

13. What information was being discussed most?

1. Avoid opposite sex
2. Abstain from sex
3. Changes in sexual characteristics
4. Other (Specify)

14 Why did you never used to discuss sexuality?

.....
.....
.....

15. What was your main source of information?

1. Parents
2. Relative
3. Friends
4. Other (specify)..... .....

SECTION C: PARENTS PERCEPTION ON SEXUALITY

26. Have you started discussing sex with your child/children?

1. Yes
2. No **Go to Q 30**

27. How old was the child when you started?

1. Below 10 years
2. 10 - 14 years
3. 15 - 19 years
4. 20 years and above

28. Was that a good age to start discussing sexuality?
1. Yes
2. No

29. Explain

.....

.....

Go to Q 31

30. Why have you not started discussing sexuality?

1. Not biological child
2. Child well behaved
3. Taboo
4. Other (specify).....

31. Are you the right person to discuss sexuality?

1. Yes
2. No

32. Explain

.....

.....

33. What information do you discuss with your child most?

1. Avoid opposite sex
2. Abstain from sex
3. Changes in sexual characteristics
4. Other (Specify)

34. Are you free to discuss sexuality with your child?

1. Yes
2. No

35. Explain

.....
.....

36. What is the right time to start discussing sexuality with children?

1. When get married
2. During initiation at puberty
3. Before puberty
4. Other (Specify).....

37 What do adolescents need to know about sexuality?

1. Risk of contracting STD and HIV/AIDS
2. Abstain from sex
3. Changes in sexual characteristics
4. Other (Specify).....

38. Why should they know about such information?

.....
.....
.....

39. Has any of your adolescent ever been pregnant before marriage (Legal or Traditional Marriage)?

1 Yes
2 No **Go to Q 46**

40. How did you feel?

1. Disappointed
2. Happy
3. Upset
4. Other (Specify).....

41. Was that a good age to start having children?

1 Yes
2 No

42. Explain

.....

.....

43.Did you use this experience to talk to the other children about sexuality?

1 Yes
2 No **Go to Q 45**

44. What did you tell them?

1. Abstain from sex
2. To have protected sex
3. To use contraceptives
4. Other (Specify) .....

GO TO QUESTION 46

45. Why did you not use the experience?

.....

.....

46. Has any of your children ever suffered from STD or AIDS

1 Yes
2 No **Go to end**

47. How did you feel?

.....

.....

48. Did you use this experience to educate your other children?

1 Yes
2 No **Go to Q 50**

49. What did you tell them?

1. Abstain from sex
2. To have protected sex
3. To go to a health institution when sick
4. Other (Specify) .....

GO TO THE END

50. Why did you not use this experience to talk to the other children?

1. Not my responsibility
2. Had no time
3. Children well behaved
4. Other (Specify).....

END OF INTERVIEW

THANK THE RESPONDENT