PATTERNS OF MOTHERS COMMUNICATION ON HIV/AIDS WITH THEIR ADOLESCENT CHILDREN IN IBADAN METROPOLIS

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DEDICATION

This work is dedicated to the Family - the foundation of our behavioural tendencies.

ABSTRACT

Young people aged 15-24 years have the highest prevalence rate of HIV infection. The key to prevention is providing this group with correct information and education on HIV/AIDS, especially, through the parents. Armed with correct information about HIV/AIDS from home, adolescents can make informed decisions about their sexual behaviours without a negative peer influence. Only few studies had explored the extent to which mothers discuss HIV/AIDS issues with their adolescent children. The objective of the study was to describe the patterns of mothers' communication on HIV/AIDS issues with their adolescents in Ibadan metropolis.

This descriptive cross-sectional study was conducted in Ibadan metropolis using a multi stage sampling technique. One hundred and twenty five mothers were randomly selected from each of the three geographical locations in the city – inner-core (125), transitional (125), and peripheral (125). Semi-structured questionnaire and Focus Group Discussions (FGD) were used for data collection. Eight focus group discussions were carried out while the questionnaire was used to interview 375 mothers who had adolescent students.

Respondents' mean age was 40 years (SD ± 14.3). Sixty six percent were traders, and 85.5% were of Yoruba ethnic group. Eighty nine percent were married, and 41.3% had secondary school education. More respondents (67.5%) had adolescent daughters than sons (66.2%). Almost all the respondents (98.4%) had heard about HIV/AIDS, but 41.5% believed mosquito bites could transmit HIV infection. There was a significant difference between respondents who perceived adolescents to be at risk of HIV infection than who do not ($p=<0.05$). A greater number of respondents (37.1%) believed that boys were more vulnerable to HIV infection than girls ($p=<0.05$). Virtually all respondents (97.2%) had discussed HIV/AIDS issues with their adolescent children. Slightly more respondents (97.9%) had discussed HIV/AIDS issues with adolescent sons than daughters (96.4%). Almost all the respondents (96.2%) cited the mass media as the major influencing factor for discussing HIV/AIDS with adolescents. Vulnerability of daughters and outset of menstruation were major factors influencing discussion with daughters. Some of the issues discussed with both sons and daughters were educational success, peer influence, decent dressing to avoid early exposure to sex, condom use, and avoiding sex with multiple partners. However, findings from the FGD showed that a two-way flow of communication was not common amongst the respondents. Most of the discussions were in the forms of advice,

caution and counselling. Time constraints, immaturity of adolescents, and lack of knowledge on HIV/AIDS issues were hindrances to mothers initiating HIV/AIDS discussions with adolescents.

These findings suggest that mothers communicate HIV/AIDS with adolescents. However, the communication was more of comments than interactive discussions. There is a strong need to organise awareness campaign for mothers that will effectively equip them with adequate parent-adolescent communication skills.

Keywords: HIV/AIDS, Mothers, Communication, Adolescents.

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CERTIFICATION

I certify that Osoghe Osanyintolu in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria carried out this work.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

GLOSSARY OF ABBREVIATIONS

AHI	Action Health Incorporation
AIDS	Acquired Immune Deficiency Syndrome
CDC	Center for Disease Control
FGD	Focus Group Discussion
FGN	Federal Government of Nigeria
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IIEP	International Institute for Educational Planning
INA	Inner Core Area
LGA	Local Government Area
NARHS	National HIV/AIDS and Reproductive Health Survey
NHPP	National Health Promotion Policy
NRHPS	National Reproductive Health Policy and Strategy
PA	Peripheral Area
PHC	Primary Health Care
SIP	Sustainable Ibadan Project
STD	Sexual Transmitted Diseases
SRH	Sexual Reproductive Health
TA	Transitional Area
UCH	University College Hospital
UNAIDS	United Nations Joint Programme on HIV/Aids
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the study

Adolescence, age 10 and 19 years, is a very tender stage in human growth and development. This is a period of psychosocial development beginning in the preteen years, through puberty onset till the individual assumes adult role in the society (Adolescent sexual behaviour, 2002.). At this stage, when most youths are entering secondary school a profound change in physical appearance is experienced, menstruation begins for the girl-child while production of sperm and other manhood features begins for the male-child. Adolescents experience increased mobility and independence with less adult presence and protection, thus the tendency to experiment risky behaviours, which may have harmful consequences (Adolescent sexual behaviour, 2002).

With the advent, and subsequent prevalence of the HIV/AIDS in sub-Saharan Africa, and its debilitating effect, especially, on the productive segment of the population, prevention of the infection has become a priority with a focus on the adolescents who are most vulnerable.
In the African tradition, parents play a significant role in moulding the characters and behaviour of their children. When parents affirm the value of their children, young people more often, develop positive and healthy attitudes about themselves (Lagina 2002). Norms, values, and beliefs are passed from one generation to another. Mothers, particularly, serve as role models in shaping adolescents' perception of gender roles, reproductive health, and sexual behaviours (Focus on Young Adult 1998). In the traditional Ugandan setting, for instance, the father is the traditional channel for socialising the adolescent girls into sex and marriage (Mayinda, Nakuya, Whitworth and Pool 2004). However, in many other traditional settings in Africa, particularly in Nigeria, parents were not expected to educate their adolescent children on sexuality; appointed guardians for these roles were often available especially during initiation ceremonies to adulthood (Kinagu, Obwaka, Odallo and Hulzen 1996). These days, however, parents tend to divide among themselves, sexuality-education communication with their children, based on gender. Fathers find it easier to communicate with the son on such issues, while mothers communicate better with the daughter (Noller and Callan 1990). Studies show that adolescents practice less risky behaviours when there is a sense of connectedness to their parents (Slap, Huang, Danivam, Zink, and Succop 2002)

It has been estimated that about 11.8 million young people aged between 15 and 24 are infected with the virus that causes AIDS; and more than half of all new adult infection, estimated at 6000 daily, occur among this age group (UNAIDS 2002). In 2005, the prevalent rate of HIV infection in Nigeria was put at 4.4%, a reduction from the previous 5.8%. The age group 10 to 24 accounts for >60% of the infected. Apparently HIV is not abating; the reduction is insignificant when compared to the actual figures of those infected. More effort is, therefore, required in the drive to preventing more people from being infected. It is a known fact that as much as 67 percent of new infections are transmitted by people who are unaware of their HIV infection (CDC, 2002). This underscores the importance of implementing prevention programs long before sexual activity begins since many young people are unaware of the threat posed by HIV (UNAIDS, 2002). Early parental guidance and communication on HIV/AIDS is a strong tool for Aids prevention among adolescents.

Problem statement

In many African societies, it is common to promote sexual ignorance among adolescents (Kebaabetwe and Norr 2002). In Nigeria, it has been reported that about 16% of girls age 15 to19 have had sex before their 15th birthday while about 8% of boys also had sex before their 15th birthday (UNICEF, 2001). Moreover, in Nigeria only 23% of adolescents know how to get contraceptive and about 36% know how conception takes place (Rodnick, 2000). Studies also show that many young people do not connect knowledge and risk perception with behaviour (UNAIDS, 2002). They may have a high level of knowledge about HIV/AIDS but do not use condom. Many adolescents see HIV/AIDS as a distance phenomenon that does not in anyway affect them and believe they are not at risk of contracting the infection.

Arrays of socio-environmental and personal factors have been attributed to the sexual risky behaviour of adolescents (Sieving, McNeely, and Blum 2000). Among the most powerful sources of social influence in descending order are: parents, siblings, sexual partners, and friends (Kirby 1997, Miller 1998). Evidence has shown that adolescents living in stable family environments and are close to their parents are more likely to practice abstinence, delay sex, have fewer partners and use contraceptives (UNFPA, 1993). In contrast, young people living in households that experience disrupted household events were less likely to practice safe sex (UNAIDS, 2002). Many Nigerian studies have shown that parents play a

little role in information dissemination on sexuality to their adolescent children (Okonkwo and Ilika, 2003).

It has been documented that open and frequent communication about sex is associated with adolescents not having sex or postponing sexual debut (Jaccard, 1996; Casper, 1990). Positive communication between parents and adolescents helps to establish individual values and healthy sexual behaviour among adolescents (Lagina, 2002). Talking about sexuality issues with children is generally viewed as an abomination in Nigeria. This could have stemmed from the fact that most parents do not have enough knowledge of sexuality issues and lack skills required to communicate effectively with adolescents. Again, since discussion of reproductive health issues between patents and adolescents is a recent strategy employed to reduce adolescents' susceptibility to HIV/AIDS infection, parents need time to get used to the idea.

In general, mothers find it difficult to talk to adolescents on sexual health issues because they do not want to expose their ignorance (Okonkwo et al, 2003). Studies also show that parents worry that discussing sex with adolescents will encourage experimentation. Mothers are expected to be the first to teach their children sex education, and should be interested in knowing what their children already know and practice (Moronkola, Osowole, and Olubola 2002). When mothers fail to discuss sex with adolescents, or communicate about it in a diachronic manner, a gap, filled with distrust, will be created. Adolescents will shy away from discussing personal sexual issues with their mothers. Studies show that mothers' hostility towards communicating sexuality issues with adolescents was significantly correlated with adolescents' distrusts for their mothers while perceiving little maternal support (Paley, Conger, and Harold 2000).

The future course of the pandemic depends on preventing HIV/AIDS infection among adolescents immediately. Involving parents and other adults is a basic strategy in prevention of HIV/AIDS among adolescents (UNAIDS, 2002). A positive pattern of mother-child communication will influence the behaviour of adolescents in the context of HIV/AIDS prevention. The role of mother-child communication on HIV/AIDS, content of communication, process, as well as timing are important in the prevention of HIV/AIDS among adolescents. It is expected that mothers initiate discussion on HIV/AIDS with adolescents. However, attempts by parents to introduce sexuality education to adolescents are

usually a "top-down" communication approach. This denies adolescents the opportunity to express themselves and make decisions about their reproductive health (Yowell, 1997). In a study conducted in Nigeria, out of 127 pregnant adolescents sampled, none of the girls ever communicated with their mothers on human sexuality (Oladepo, 1994).

Maternal communication on sex in an urban African-American environment was often restricted and moralistic; it deters daughters from confiding in their mothers (O'Sullivan, Meyer-Bahlburg, and Watkins, 2001). This should be avoided since mothers being the primary caregivers are better placed to effectively educate adolescents on HIV/AIDS prevention. Studies conducted in Nigeria show that although mothers wish to discuss sex-based issues with adolescents, many lack the knowledge, information, and skills to do so. They, therefore, encourage their children to get needed information from schools (Okonkwo et al. 2003).

Justification of the study

Many studies have proposed and validated the need for parents to adequately communicate sexuality issues with their adolescents' children. It is believed that adolescents empowered with correct information from the parents are more likely to make right decisions as regards their sexual health (Pick and Polos 1995). This is more pertinent because of strong peer influence experienced at adolescence. There have been several studies on parents' adolescents' sexuality communication however, only few had ever explored the extent to which mothers discuss HIV/AIDS with their adolescents.

HIV/AIDS though being a sexuality issue is peculiar because of its high impact effect. Moreover, HIV, apart from being a sexually transmitted infection, has no cure or vaccine. Adolescence is also a period where sexual needs and urges is most emphasized, hence, tendencies to be sexually reckless abound. Therefore, it behoove on the parents to properly educate their children on the risk of getting HIV infected and its resultant effect.

Mothers have been selected for this study because they are more likely to discuss sexuality issues with their adolescents irrespective of the gender (Miller, Kotchick, Dorsy, Forehand and Ham, 1998). Adolescents also tend to discuss more openly sexuality issues with their mothers than their fathers (Hacker, Amare, Strunk and Horst, 2000).

Operational Definition

Patterns of Communication:

Frequency, timing, manner and styles mothers adopt in discussing HIV/AIDS issues with adolescents children.

Research Questions

- What is the mother's level of knowledge on HIV/AIDS?
- How often do mothers discuss HIV/AIDS with their adolescent?
- When do mothers start to discuss HIV/AIDS with their adolescent?
- How do mothers discuss HIV/AIDS with their adolescent?
- What factors hinder or promote discussion on HIV/AIDS between mothers and their adolescent?

General Objective

The general objective of this study was to identify mothers' pattern of communication on HIV/AIDS with their in-school adolescent children in Ibadan metropolis.

Specific Objectives

The specific objectives of this study were:

- To assess the level of mother's knowledge about HIV/AIDS.
- To document maternal perceived threat of HIV/AIDS to their adolescents.
- To identify the specific communication methods used by mothers to discuss HIV/AIDS with their in-school adolescents.
- To identify when mothers initiate HIV/AIDS discussions with their adolescents.

Hypothesis

The following null hypotheses were formulated:

- There is no association between mothers' level of knowledge on HIV/AIDS and the pattern of HIV/AIDS communication with their in-school adolescent children.
- There is no association between the level of closeness that exist between mother and adolescent children and the pattern of communication on HIV/AIDS between mothers and adolescent children.
- There is no association between the age of adolescent and the inception of HIV/AIDS communication between mothers and their in-school adolescent children.

Limitations of the Study

Only respondents residing in Ibadan metropolis were involved in this study. Due to limited literature on the extent of mothers' communication on HIV/AIDS with adolescent children, this study focused only on the mothers. Also, because of the difficulty in tracking families of out-of-school adolescents, this study had as respondents' mothers of in-school adolescents.

CHAPTER TWO

LITERATURE REVIEW

Adolescents and HIV/AIDS

In the last few years, the momentum has increased for the need to reduce HIV/AIDS transmission through prevention of new infections. The government, civil societies, media, and communities have all agreed to tackle HIV/ AIDS by all means. UN General Assembly Special Session on HIV/AIDS in June 2001 declared that by 2005, a wide range of prevention programmes be made available in all countries (UNAIDS, 2002). It also declared among others that by 2005, 90% of young people of ages 15 to 24 must have access to information, education, and services necessary to reduce their vulnerability to HIV/AIDS, and that this should be raised to 95% by 2010. The United Nations also declared the reduction by 25%, the rate of infection among young people aged 15 to 24 in most affected countries by 2005, and globally by 2010 (UNAIDS, 2002). WHO estimates that worldwide, 1 out of 20 adolescents' contacts sexually transmitted infection each year, while one-fifth of the world's population infected with HIV/AIDS are in their 20s. This is an indication that they probably got infected at adolescence but it is now being manifested in their 20s because of the long latency period of HIV/AIDS (Action Health Incorporated, 1996).

Adolescents are particularly vulnerable to HIV/AIDS infection because of risky behaviour and lack of access to correct and adequate HIV/AIDS information and prevention services (UNAIDS 2002). In Nigeria, the correct and adequate knowledge of HIV/AIDS transmission among young people still remains low; many adolescents have misconceptions about HIV/AIDS, falsely believing they are at little or no risk to HIV/AIDS. In the National HIV/AIDS and Reproductive Health Survey (NARHS) done in Nigeria in 2003, 74% of 1791 adolescents said that they were at no risk of contacting HIV/AIDS, yet about 60% of them had had unprotected sex within the last 12 months. Many adolescents are unaware of the threat posed to them by HIV/AIDS. A large proportion of them are affected by HIV/AIDS daily, and yet they have a misguided knowledge on prevention methods. In the NARHS, 51.4% of 2145 adolescents had incomplete knowledge on HIV/AIDS prevention methods, while 58.3% of 1791 had misconceptions about HIV/AIDS (NARHS). In River state of

Nigeria, 35 of 90 adolescent respondents said they were not worried about contacting HIV/AIDS, 30% said a healthy looking person could not be infected with HIV, 32% agreed that mosquitoes could transmit HIV/AIDS while 60% of respondents said that their friends do not use condom in sexual encounters (Wodi, 2005).

In 1999, in USA, 3.9% of reported cases of HIV/AIDS were among 13-24 years; in 2003 the percentage rose to 4.7% and 237 died of AIDS (CDC, 2004). Also in the United States nearly four million youths under 20 experience sexually transmitted infection including herpes, human papillomavirus (HPV), chalamydia, gonorrhoea and HIV. In Plateau state of Nigeria, Slap et al in (2002) reported that 57.1% of male and 48.3% of female in-school adolescents had more than one sexual partner, 30.5% and 38.4% had been treated for STDs while 22.7% and 24.5% were infected with HIV/AIDS.

It has been noted that adolescence contributes to the incidence and clinical features of STDs in young people. During this stage, genital maturation increases and the internal genital tract are more susceptible to infections especial in females. During adolescence, the female columnar epithelium is located on the exposed vaginal surface of the cervix making it easy for infections such as HIV, and gonorrhoea (Adolescent sexual behaviour, 2002). Female adolescents are increasingly at risk of HIV infection through heterosexual contact because of their biological vulnerability, lack of recognition of their partner's risk factors and having sex with older men who are more likely to be infected with HIV (TheBody.com, 2006)

Characteristics of Adolescence

Adolescence is a phase of life that begins from the age of 11- 19 years; it is a period in life in which a person's biological, cognitive, psychological, and social characteristics are changing from what is typically considered child-like to what is considered adult like (Lerner and Spanier, 1980). This is a period requiring adjustment to change in the self, in the family and in the peer group; adolescents are usually faced with a difficult challenge which must be overcome, with help from parents and older family members, institutions, and the society. Apart from the physical changes, most times adolescents are also undergoing institutional changes, there is change in school setting for young adolescents as they transit from elementary school to secondary schools, for older adolescents, this is the period they transit to tertiary institutions (Lerner R, Brennan A. Noh Ree and Wilson C, 1998).

Adolescence usually occurs in stages, staring with:

Early Adolescence

Early Adolescence starts at ages 10 to 15 years; this is the period where they are entering secondary school. Adolescents also begin to undergo puberty at this stage, physical changes begins in the body. A lot of the adolescent concern at this stage bothers on physical changes and symptoms (www.sidservices.on.net, 2002). Early adolescents begin to separate from childhood and their parents though they still vacillate between adult-like and child-like behaviours. They have rapid wide mood swings, easily become upset and emotional and alternate between extreme resistance and extreme cooperation to adult guidance. Sexually, as puberty begins, early adolescents may masturbate and perform other self-stimulation. Socially, early adolescents tend to form close friendship with same-gender peers and may experiment sexually with them usually to satisfy curiosity.

Middle Adolescence

Middle Adolescence begins from ages 14-18 years; most adolescents at this stage have either finished/continuing education or seeking employment. Puberty is usually complete, adult – size is approaching and fertility often a reality. These adolescents struggle the most with the development of self-identity, and autonomy. They have increased mobility and independence hence, less adult presence and protection. Risk-taking behaviour is usually most pronounced in middle adolescence - Drunken driving, substance use and/or sexual activity may have unanticipated harmful consequences which these adolescents are unable to effectively prevent. Sexual experimentation seem to be a normal even necessary part of adolescents development, at this stage half of all adolescents have had sexual experiences which ranges from oral-genital to anal sex. Many have heterosexual relationships, while some have also experimented with homosexual intimacy (www.sidservices.on.net, 2002).

Late Adolescence

Late adolescence refers to the years past secondary school, usual from ages 17 to 18 into early twenties. At this stage adolescents are physically adults and accepted as adults in the society. They are self supposing or pursuing educational or vocational training to become able to support self and a family. Their self identity is consistent with the realities of their societal limits and expectations. Late adolescents have a well-established sexual pattern and they ability to have intimate relationships that satisfy emotional and sexual needs. Some of these adolescents have children of their own and married or unmarried; while some are divorced or separated. At this stage most of these adolescents have not reached the level of psychosocial maturity that would facilitate a healthy family life (www.stdservices.on.net, 2002).

Adolescent Sexuality, Contraceptive use and Abortion seeking behaviour

Most adolescents have heterosexual relationships; other sexual activities they engage in include oral, genital, anal sex and homosexual intimacy. The frequency of sexual intercourse increases with age, while male adolescents experience sex at an earlier age than female, girls engage in sex more often than boys (Parera and Suris, 1997).

Studies show that by age 17, approximately half of all adolescents have experienced sexual intercourse either before puberty or at age 15 or 16 (Adolescent sexual behaviour, 2002). However, Oladepo and Brieger (2000) reported that the mean age at first sexual intercourse of male secondary school students in Oyo state Nigeria was 13.5 year.

Studies have shown that many Nigerian adolescents experience early sexual debut, they become sexually active before the age of 15. Lack of parental communication on sexuality and conflicting information, and ideals on sexual values and behaviour are some reasons given for adolescents' early sexual debut. Studies have repeatedly shown that the earlier an adolescent becomes sexually active, the more likely they are to have more sexual partners resulting in greater chances of being HIV/AIDS infected. Adolescents' sexual practices usually do not include use of condoms (WHO 2000). In a study done in Nigeria, only 21.2% of 810 of 15 to 19 years had ever used condom, while 29.4% of the same group have had multiple sexual partners in the last 12 months (NARHS 2003). In respect of gender disparities: Young women are more at risk of HIV/AIDS infection because the most common mode of transmission in Nigeria is heterosexual sex. The biological vulnerability of

adolescent girls put them at higher risk than boys of the same age. Also, cross-generational sexual activities expose young girls to these risks. Girls tend to date older men who probably would have had many more sexual partners (Luke and Kurz 2002). Likewise, boys are encouraged to have early sexual debut to prove their masculinity while having multiple sexual partners is seen as the accepted norm.

Adolescents are unlikely to use contraceptives or preventive methods when engaging in sex and are more likely to deny symptoms of STD infections In a survey of 2460 secondary school students in eastern Nigeria, 17.0% agreed to have ever used a contraceptive method (Amazigo et al, 1997). This age group also make STD control frustrating because of practice of partial treatment with self-prescribed antibiotics obtained from friends (Adolescent sexual behaviour, 2002).

The high incident rate of induced abortion among unmarried adolescent girls is also an indication of unprotected sexual activities. Premarital childbearing, especially among teenagers attending school is highly frowned at in Nigeria because it is perceived as the end of education for the girl-child, signifying the end of a worthy life. This among other reasons is why adolescents resort to illegal induced abortion, which at times results in complications. Adolescents constitute the majority of cases of abortion related complications admitted in Nigerian hospitals (NARHS 2003). The rate of sexually transmitted infection and high school dropout of adolescents is also on the increase in Nigeria, especially, in regions where early marriage is practiced.

Social and cultural practices in Nigeria and other African countries, most times permit adolescents and young people to feign ignorance or acknowledge their personal risk to HIV/AIDS infection. Seventy four percent of 1791 of 15 to 19 years interviewed believed they were not at risk. Lack of open discussions on high-risk behaviour, reluctance to learn or disclose HIV status, and familial concealment of HIV status all contribute to failure to recognise personal risk (Kebaabetwe and Norr 2002). Parents and adolescents hardly ever have open discussions on sexuality in the African setting because it is socially discouraged. This makes it almost impossible for parents to educate their children about the risk of HIV/AIDS. More so that parents, themselves, did not grow up discussing sexuality issues with their own parents. Traditional rites of passage conducted by non-parental adults were some of the ways most parents learnt about sex (Kimani et al 1996).

Socialization during adolescence

Ross Parke and John Buriel (1998) described socialization as the process whereby an individual's standards, skills, motives, attitudes, and behaviour change to conform to those regarded as desirable and appropriate for his or her present and future role in any particular society. Though the agents or forces of socialization are many, including the parents, teachers, media, institutions, peers and the society, however, the parents, peers and teachers are the three main agents of socialization for adolescents. Socialization is also important in the process of personality formation, the process moulds personality in the particular directions by encouraging specific beliefs and attitudes as well as selectively providing experiences (O'Neil D, 2006).

Though early childhood is the period of the most intense and crucial socialization, however, at adolescence a new statue is reached and there is a need to learn the appropriate roles. Most of this socialization is done informally under the supervision of mothers and female relatives (O'Neil D, 2006). The family is the first point of contact for the child; hence socialization begins from the home. Adolescent socialization within the home setting most times might be gender bias. Father emphasized instrumental behaviours while mothers emphasized expressive behaviours in child socialization (Bakans, 1966). Mother-daughter relationships are more intense than father-daughter relationships (Steinberg, 1987). There is the tendency to be more protective of females and more permissive of males. Daughters are usual socialized towards dependency while sons are socialized toward independence. Several social, psychological and cultural considerations all play an important part in this socialization. Parents especially during adolescence want to teach their children gender appropriate chores and family roles (Hall, 1978). It has also been noted that gender differences peaks during adolescence, adolescents' males usually obtain employment outside the home at an earlier age than females, which contributes to male independence (Peter, 1987). However, despite this independence, male totally depend upon women for food preparation and housekeeping, this means that the independence is selective. Mother's employment has also been noted to have an effect in family structure and socialization. Girls self concept were generally affected positively in the house with a working mother. Daughters of gainfully employed mother view their mothers as having a greater degree of competence than daughter with non- employed mothers (Fox and Hesse-Biber 1984). Also, homes where both parents have full time employment children tend to do more house hold

chores, they were also the most traditional in designation of teenager chores, girls did more than the boys and it was distinguished along gender lines.

Parents feel that adolescents should participate in household tasks to learn responsibilities and share in family duties (Peter, 2004). Children learn gender role behaviour largely from their parents through socialization (Hoffman and Nye 1984). It is evident that the gender of the child is a very important criterion in determining the tasks assigned in the housework. Gender socialization in the home is affected by the variable of adolescents' age and gender, number and gender of siblings, age of parents, ethnic identity, social class, employment of mother and parenting style adopted in the home. However, adolescents' gender behaviour is generally derived from their interactions with the various agents of socialization. Benin and Edwards (1990) researched that the socialization of gender-roles in household tasks is critical in adolescence than at any other period. Mothers may differ from the father regarding children's gender specific behaviours. The father may encourage traditional values in some areas (more sport for sons than daughters) and the mother in other areas (more housework for daughters than sons) (Peter 1994). Women are more affective than men and this will be evident in parent-teenage relationships, men are less apt to discuss or empathize with changing attitudes towards gender roles (Steinberg 1987). It is the parent-adolescent relationship that forms the bases for most of the socialization in the home. A positive parent-adolescent relationship results in smooth transition to responsible adulthood for the adolescent. Parents that enjoy positive relationship with their adolescent children tend to have less emotional problems (Compas, Howell, Phares and Williams, 1989).

Parenting Adolescents

For parents as well as the adolescents this is a period of great anxiety, discovery and bewilderment. Roles changes and adjustment are made to the parent-child relationship. Parenting is not only a biological process but also a complex social process (Lerner, Castelliono, Terry, Villarruel and McKinney, 1995). Parenting involves bidirectional relationships between members of two (or more) generations; can extend through all or major parts of the respective life spans of these groups; may engage all institutions within a culture and it is embedded in the history of a people (Ford and Lerner, 1992). The key function of a parent is to raise the adolescent in as healthy a manner as possible, to provide a safe, secured, nurturant, loving, and supportive environment, which allows the adolescent to have a happy and healthy youth, the atmosphere that will permit the adolescent to develop the knowledge,

values, attitudes, and behaviours necessary to become an adult making a productive contribution to self, family, community, and society (Lerner et al, 1995). Depending on period of adolescence, and the parenting style adopted, there is diversity in the nature and implications of parents-child relations during adolescence.

A positive parent adolescent relationship includes warm parental interactions involving supportive behaviour and positive emotions, these is associated with effective problem solving ability in the adolescent. However, hostile interactions are associated with destructive adolescent problem solving behaviours (Ge, Best, Conger and Simons, 1996). Parents who are attuned to their adolescents' development and support their autonomy in decision making, have adolescent who is better adjusted and gains greater peer popularity (Bronstein, Fitgerald, Briones and Pieniadz, 1993). It should also be noted that parental religiousity, cohesive family relationship and low interpersonal conflict are associated with low levels of problem behaviour and with self regulation among adolescents (Brody, Stoneman and Flor, 1996).

Conflicts usually occur in parent-adolescent relationship when there is a perceived threat or lack of emotional support. Many adolescents perceive their parents as being unable to understand their feelings or that parental expectation are too high. Fisher and Johnson (1990), study revealed that adolescent complained that conflicts happen when parents are not providing emotional support they want, or because there is a lack of consensus on societal values. When conflict is not properly handled by parents it could degenerate and may lead to the adolescent thinking negatively about him/her (Shagle and Barber, 1993). Unresolved conflict in parent-adolescent relationship results in problems in youth development (Rubenstein and Feldman, 1993). This may in turn (adolescent problems) increase parent-adolescent conflict, resulting in a vicious cycle (Maggs and Galmbos, 1993).

However, it should be noted that there are different family structures each having unique features which have varied influences on parents-child relationship. Parents also have different parenting styles of raising their children, namely: authoritative, authoritarian and permissive (Baumrind, 1971). Behavioural variation by use of any parental styles is associated with differences in adolescents' behaviour and development (Lamborn, Mants, steinberg and Dornbush, 1991). The behavioural variation of individual parent is associated with differences in contextual factors relating to parental education, family social support,

parental mental health, family stability and poverty (Lerner, and Brennan, 1998). However, there are different family structures each having unique features which have varied influences on parents-child relationship. Parents also have different parenting styles of raising their children, namely: authoritative, authoritarian and permissive (Baumrind, 1971). Behavioural variation by use of any of the parental styles is associated with differences in adolescents' behaviour and development (Lamborn, Mants, steinberg and Dornbush, 1991).

Family communication patterns

Communication within the family is believed to be one of the major elements of family interaction. One of the three major dimension of any human adjustment problem is the degree or extent or nature of the communication between or among the parties involved (Bernard, 1964). Communication can be viewed as the index of the family operations and the means where by the family transacts the business of life (Scherz, 1967). It provides the blueprint by which the child grows from infancy to maturity (Satir, 1964). Communication is especially important during adolescence, when old patterns of communication must be altered to fit the growing needs and capabilities of adolescent (Sachs, 2001). During adolescence, the child is striving to gain independence, yet retain close ties with families. The family communication can contribute to the general atmosphere of the family's day –to- day interactions. A positive parents-adolescent communication pattern has several adjustment outcome for the adolescent, self-esteem, academic achievement, and total well-being. Research has linked adolescent adjustment with a balance of positive and negative discussions with parents (Sachs, 2001).

Human communication is described in behavioural sciences as any message(s) passing between the members of a group of two or more. It is the vehicle for social interaction- the process of transmitting feelings, attitudes, facts, beliefs and ideas between living beings (Bienvenu M, 1969). Language, however, is the primary means of communication, though not the only means. Non-verbal communication encompasses listening, facial expressions, silences, gestures, touch, hearing, vision and all other nonlanguage symbols and clues used by persons in giving and receiving meaning. Interpersonal communication may include all the means by which individuals influence and understands one another (Ruesch, 1963). It may take many forms and is transacted on the conscious, preconscious, and unconscious level. Most of the communication within the family is interpersonal, it is one of the paramount experiences tending to solidify the internal operations of the family (Cervantes, 1966).

Communication within the context of the family appears to be particularly important during adolescence. Family communication affects adolescent identity formation and role-taking ability (Cooper, Grotevant, Moore and Condon, 1982). Adolescents who experience the support of their families may feel freer to explore identity issues (Cooper et al., 1982) Stanley (1978), found that discussions between parents and children significantly facilitated the development of higher levels of moral reasoning in adolescents. Another study by Grotevant and Cooper (1983) studied the role of communication in the process of adolescent individuality from the family. It noted the importance of communication to helping family members strike a balance between separateness from and connectedness to each other. Adolescents whose parents are warm and uncritical usually develops a pattern of resilience, parents who communicates clear expectation of behaviours, clear values and expectation for educational standards and goals are likely to have adolescent capable of making right decisions in their everyday lives (Hawkins and Catalano, 1992). Conversely, parents who communicate in a harsh, overly authoritarian or overly permissive manner are at risk of having irresponsible adolescents. Parents who have unclear expectations for behaviour, inconsistent or harsh discipline are likely to have adolescent more likely to engage in risk behaviours. In homes where there is lack of bonding and caring, conflict between parents and low expectation for adolescent success contributes to adolescent risk of risky behaviour (Wilson and Herrnstein, 1985).

Communicating HIV/AIDS with adolescents

Adolescent also need accurate and age appropriate information about HIV/AIDS, how to talk to their parents or trusted adult about HIV/AIDS and how to reduce and eliminate risk among other things (TheBody.com, 2006). Though peer influence may be significant at this stage, many adolescents still prefer to seek directions and guidance from their parents (Hacker et al 2000). In a study conducted by Player and Frank (1994), it was reported that there is a strong deficiency in the frequency of parent-child communication on HIV/AIDS. Education on HIV/AIDS prevention should therefore, begin at an early age, before children and young people are exposed to risks, and should be sustained over time (IIEP/UNESCO 2004).

Clear parent-child communication on values and behaviour about sex is an important step in helping adolescent delay sexual initiation and make responsible decisions about sexual behaviours later in life. Parents have unique opportunities to discuss HIV/AIDS, STD and

teenage pregnancy prevention with adolescent on regular and timely bases (Dittus, Miller, Kotchick, and Forehand, 2004). Adolescents often cite their parents as their preferred source of education about sex (Alexander, 1984); however, many studies have shown that parents find it difficult to talk with their children about menstruation, contraception and pregnancy (Liskin 1985). Generally, mothers have been found to discuss sexuality with adolescents more than fathers, this parental gender difference is often affected by gender of the adolescent (Miller, Kotchick, Dorsy, Forehand and Ham 1998).

Lagina (2002) noted that older people expects the youth to know about abstinence, contraceptives, and other means of preventing HIV/AIDS infection. The media however, has been noted to be a main source of information to adolescents about sex. In Nigeria, the most common sources of information on sexuality among secondary school students were the television, radio, health workers and newspaper in that order, parents ranked fifth (Oladepo and Brieger 1997). Studies also revealed that adolescents were more comfortable discussing sexually related issues with older sisters, brothers, mothers, and fathers in that order. About 30.3% of 2145 adolescents felt comfortable discussing with older sisters, 21.4% with older brothers, and 19.8% with mothers while only 8.7% felt all right discussing HIV/AIDS and related issues with fathers. The study revealed that many parents and adolescents alike find it difficult discussing sexual matters; parents did not communicate much on sex with adolescents though more information was given to daughters than sons (NARHS 2003).

Some studies have shown that adolescents not only look up to their parents for guidance and direction on life skills but also on sexual reproductive matters (Amazigho, Silva, Kaufman and Obikeze 1997). More studies also showed that adolescent girls find it easier to discuss sex and reproductive health issues with their mothers (Griffin-Carlson and Schwanenflugel, 1998). Many girls in Pakistan also reported their mothers and older female siblings or relatives as their sources of information on reproductive health issues (Haque and Fatzunnisa 2003).

Unlike what many parents believe, adolescents prefer their parents to peers as sources of information on sexuality and reproductive health matters (Mturi, 2000). Studies in many countries including Nigeria have found that parents are influential sources of information and advice for children (John Hopkins Centre for Communication Programs, 1995). Adolescent girls in a study done in USA reported feeling freer to talk about sex and birth control with

their mothers than with any other person (Griffen et al 1998). In a similar study done in the same country, 50% of the adolescents consulted at least a parent about contraceptive use (Pistella et al 1998).

Howard (1988) in his study of poor parent-child sexuality communication found that parents experience new feelings and attitudes when their children begin to develop sexual features in puberty. It becomes more difficult for parents to talk freely with children, they find it difficult to answer questions as carefully and honestly as they used to do when the children were younger. As adolescents begin to have more interest in the opposite gender, parents' anxieties grow stronger and they become more protective. This is made worse because sexuality is a forbidden subject of discussion between parents and children especially in the African setting. Some parents, who initiate sexuality discussions with adolescents, instil fear and communicate in authoritative one-way flow that leaves the adolescent more confused (Akin-Otiko 1999).

Parents who communicate on sexuality education with their adolescents are more comfortable discussing about STDs and HIV/AIDS with their children (Brock and Beazley 1995). Studies in Nigeria and Kenya however, showed that young people believe that it was impossible or uncomfortable for them to talk with their parents on sexuality (Barker and Rich 1992). This may however be due to the facts that adolescent perceive hostility in the attitude of parents to such discussions. Parents need to adopt an open and receptive approach when initiating conversation or responding to adolescent's questions. Parents also need to have adequate knowledge, willingness to listen, talk openly and freely, and understanding the feelings behind questions posed by adolescents (Miller et al, 1998).

Open, honest, and frequent parent-adolescent communication about sex and related issues guide adolescents in making healthy decisions about sexual relationship. Similarly, Jaccard in a study (1996) associated frequent parent-adolescent communication on sex, with adolescents not having sex or delay of sexual debut. It is said that knowledge is power. An adolescent that is armed with correct information on HIV/AIDS particularly coming from the parents will be empowered to protect him/herself from getting infected. Most parents do not know how to communicate their concerns freely to adolescents in ways that will be helpful to the young person (AkinOtiko 1998), despite the fact that they know that older adolescents do engage in sexual activities. Further more, some mothers that are aware of their adolescents' sexual

activities often find it difficult to discuss openly with them on such matters. Mothers usually wait for the adolescent to initiate the discussion (Mturi, 2001). However, in a research in Lesotho, parents in the urban areas accepted that it was okay for their older adolescents' children to be sexually active before marriage (Mturi, 2001). This emphasises the fact that parents wrongly believe that adolescents are knowledgeable and matured to engage in sexual activities; although in reality this may not so. Rodnick in (2000) reported that adolescents have little knowledge about sexuality. In Nigeria only 23%, of adolescents know how to get contraceptives and only 16% know how conception takes place.

The role of parents to SRH, HIV/AIDS communication

Parental care for children starts early in life and runs through a lifetime, however, care is most needed in adolescence. In the face of the threat posed by the advent of HIV/AIDS to adolescents, it has been observed that sexual education should begin early as part of a lifelong process of acquiring information and forming attitudes, beliefs, values and behaviour. The sexual foundation built within the family through verbal and nonverbal communication plays an important role in fostering a sexually healthy adolescent (CDC, 1998).

Most parents do not admit that their adolescents are sexually active because they cannot know unless they ask their children directly. Since sexual activities among adolescents are usually hidden practices, parents have a hard time second-guessing. However, some parents admitted they knew unmarried adolescents do get involve in sexual activities (Mturi 2001). Many reasons have been adduced for the increase in sexual activities among adolescents while numerous surveys has also shown that there is an increase in sexual experimentation by increasing number of adolescents at younger ages (Adolescent Sexual Behaviour, 2002). Otoide, Oronsaye, and Okonofua, reported in 2001 that with the current level of deterioration in social norms and values coupled with influx of the western culture in Nigeria, more teenagers are engaging in premarital sex. Similarly, Ajuwon, Osungbade, Fawole, Lurie and Hearst (1998), in a study of adolescent female hawker that frequent bus and truck parks, revealed that most were sexual active, 57.0% had first sexual experience with an older partner while 87.0% had last sex act with an older partner.

Most sexually active adolescents living with their parents usually do not want their parents to know of their sexual activities. This is worse where parents do not communicate on sexual issues with children or where the adolescent cannot discuss such issues with parents. Some

mothers opined that adolescents of ages 10 to 13 are too young to have sexual knowledge or be involved in sexual activities. However, it has been noted that boys and girls experience puberty at younger ages compared to previous generations (Akin-Otiko, 1998), many of them reach sexual maturity before they attain emotional or social maturity.

Many studies done on adolescents' health-seeking behaviour had recommended parents' involvement in preventing adolescents' risky behaviours since research has shown that a lot of adolescents do not care about becoming infected with HIV (National Survey of Teens on HIV/AIDS, USA, 2000). A stable family home and parental guidance has a positive effect on adolescents' health-seeking and prevention behaviours (Astou, 2002). The importance of active parental involvement in achieving success in adolescent awareness, prevention and educative programs on sexual reproductive health and HIV/AIDS is gradually becoming more and more emphasised (Bowler, Sheon, D'Angelo, and Vermund 1992).

The NARHS done in Nigeria in 2003 revealed that of the 2477 parents interviewed, only 45.2% talked or ever talked to their adolescent sons on HIV/AIDS while 47.4% of 2205 had talked about HIV/AIDS to their adolescent daughters. In the findings, parents and guardians who had higher level of education were more likely to have ever discussed with adolescents on HIV/AIDS and related reproductive health issues. On the whole, mothers discussed with daughters as well as sons and a lower percentage of fathers discuss with their female adolescents.

Maternal Communication Patterns

Mother appears to more critical than fathers in communicating with adolescents, fathers were thought to be less trusting than mother (Bienvenu, 1969). More adolescent reported discussing personal problems with mothers. Mothers reported better communications with adolescents than fathers, there was higher level of openness in mother-adolescent communication (Barnes and Olson, 1985). This study also showed that the gender of the adolescent had no effect in mothers' pattern of communication with the adolescent.

In general, mothers have been found to discuss sexuality with adolescent more than fathers (Miller et al 1998). Mothers communicate more often with their daughter than with their sons; HIV/AIDS or STDs were the most commonly discussed topics, followed by condoms, reproduction, pressures to have sex, when to start having sex and choosing sex partners.

Mothers are still the primary communicator with adolescents regarding sexual behaviour and related topics, regardless of the adolescents' gender.

Maternal communication on SRH and HIV/AIDS to adolescent

In many households in Nigeria, mothers are mainly responsible for passing information on sexuality and reproductive health to their children. Shulman and Klein, in (1993) reported that compared to mothers, fathers spend less time discussing personal and family matters with adolescents. Moreover, adolescents tend to have more formal communication with their fathers and more open communication with their mothers and siblings (Cooper, 1993). Mothers are perceived to be in the best position to provide continuous guidance on HIV/AIDS prevention to their adolescents and can more effectively channel information adolescents are exposed to in the home. In a study in Delta State, Nigeria, 70% of 300 mothers set rules on what their young people watch or read in the home (Okonkwo et al 2003). From pervious studies, it was concluded that mothers are still the primary communicators with adolescents regarding sexual behaviour and related topic, regardless of adolescent's gender (Miller et al 1998). Furthermore, in the traditional and modern Yoruba society, mothers are expected to impart sex education which is mostly concentrated on family values (Demehin, 1984).

Mothers communicate more often with their daughters than with their sons, while fathers rarely communicate with their daughters about sex; however, mothers and fathers discuss with their sons at approximately equal rates (Nolin and Petersen 1992). Interestingly, topics such as HIV/AIDS or choosing a sexual partner were more discussed between mother and son pair than topics such as birth control, reproduction and physical and sexual pressures, which are more discussed between same gender pair (Miller et al 1998). The prominence of mothers' role cannot be ignored in educational programs, however, fathers appears to communicate with adolescents on certain sexual topics particularly with sons on condom use and STDs. Mothers who are skilled communicators on sex- related topics were more likely to discuss a broad range of sex-related topics with adolescent, and adolescents are more likely to listen (Miller et al 1998). Adolescents between the ages of 13 to 15 years were more likely to ask sex-related questions with mothers than friends or fathers (Diiorio Kelly and Hockenberry-Eaton 1999).

Negative sexual behaviour and practices during adolescence, especially in relation to HIV/AIDS infection and STDs, leaves an impact on how the adolescent live out their lives as adults (Mensch, Bruce and Greenee 1998). HIV/AIDS being a sex-related issue require more awareness and education now more than ever because of its high prevalence. In sub-Saharan Africa, the main mode of transmission among young people still remains heterosexual intercourse (UNAIDS. 2004). It, therefore, becomes, imperative for parents to make sure that transition to adulthood takes place under favourable conditions. The way and manner in which mothers communicate HIV/AIDS to adolescents goes a long way in having an effective positive behavioural change. Studies over time have shown that mother's level of knowledge, and educational attainments affect her self-efficacy in communicating such messages to adolescents. Mothers that have a firm grasps of the issues involved in HIV/AIDS are better at passing on the required and correct information to their adolescents, likewise, mothers that know little or nothing about the issue shy away from discussing such with adolescents (Okonkwo et al 2003).

Some mothers discuss HIV/AIDS and other sex related topics using moralistic religious standard. In some cases, the bible is used as a yardstick for all discussions on such topics. A mother, in a focus group discussion study in Botswana, said she sometimes quotes the bible to drive home her points. In the same study, some parents said they only discuss sex related issues with adolescents when there is an example of unmarried adolescents with problems in the neighbourhood, which resulted from sexual relationships (Mturi, 2001). Parents that are shy in discussing sex related issues with adolescents often wait for an opportunity to present itself, for instance, discussion could emanate from a HIV/AIDS programmes in the media.

It is interesting to note that many mothers advocate that reproductive health information be provided for young people in schools, this is an indication that mothers are aware that adolescents could be sexually active; thus, they need the correct and appropriate information in order to make right choices. Okonkwo et al in 2003 reported that 85% of 300 mothers believed that reproductive health information should be provided in schools because lack of such information have resulted in high incidence of unintended pregnancies and sexually transmitted infections including HIV/AIDS. Most of the mothers supported the use of contraceptives and encouraged access to condom among adolescents (Okonkwo et al 2003).

Why mothers need to communicate HIV/AIDS with adolescent

The role of mothers in modifying the sexual behaviour adopted by adolescents cannot be over emphasised. It is a known fact that young people in the age range of 15 and 24 years account for half of all the new cases of HIV/AIDS (UNAIDS, 2004) the infection must have occur during early adolescence. This is a vulnerable stage, where parental skill is most needed in communicating HIV/AIDS to adolescents. To successfully combat the HIV/AIDS epidemic among adolescents, information, education, and health services must be available to them, especially, through those who influence them. Mothers that regularly converse with adolescents about HIV/AIDS have more opportunities of reducing the chances of adolescents engaging in risky sexual behaviour that may lead to HIV/AIDS infection. Many adolescents engage in risky behaviour because they lack knowledge and correct information on the consequences of their actions; they end up bearing the negative consequences alone and regretting their actions when it is too late.

UNAIDS (2004) among others has recommended that all efforts should be geared at preventing the future generations from getting infected as they are also the greatest hope for changing the tide of the HIV/AIDS epidemic. Provision of a supportive environment where adolescents can obtain adequate and correct HIV/AIDS and reproductive health information, education, and services is one of the tools recommended. Importantly, parents, extended families, and other strong influences are also encouraged to act as positive mentors to youths in influencing their behaviours. Mothers have an important role to play in these preventive efforts because they can pass on more comprehensive information on sexuality and HIV/AIDS to adolescent regularly and timely.

National Reproductive Health Policy and Strategy

The national reproductive health policy in Nigeria was initiated in 2001, it emerged as a result of Nigeria's participation in the International Conference on Population and Development (ICPD) in 1994. Each nation had to operationalise the reproductive health concept and promote quality reproductive health services in the interest of the well-being of the people, enhance social life of the community, national development and the future of the human society (NRHPS, 2001). Adolescent and Maternal reproductive health are incorporated into this policy, almost all aspect of reproductive health of an individual, family and community was address in this policy.

The reproductive health status of the Nigerian adolescent is poor, first sexual intercourse among adolescents is usually unprotected and it occurs most times in earl adolescence (14-16 years) (NRHPS, 2001). Young people are also mostly affected by the HIV/AIDS epidemics, and suffer disproportionately from other sexually transmitted diseases. Recurrent or prolong sexually transmitted infections constitute a high risk for subsequent development of cervical cancer, HIV/AIDS and other harmful infections. The high rate of teenage pregnancy also constitute to high rate of induced abortion mainly done by quacks in unsafe environment all contributes to a poor status of adolescent reproductive rights in Nigeria. The policy aims to address among other issues, the increasing high-risk behaviour of adolescents leading to premarital sexual encounter, early marriage, unintended pregnancies, unsafe abortions and social consequences such as school dropout with subsequent negatives intergenerational effects.

One of the guiding principles, declaration and framework of this policy is to make information on health available and disseminated to all person and communities to enable them to have greater responsibility for their health. It also states that emphasis shall be placed on prevention and promotive measures which shall be integrated with treatment and rehabilitation in multi-disciplinary and multi-sectoral way. To ensure access of the public to scientifically proven preventive and curative reproductive health conditions including HIV/AIDS, the policy further declared that all forms of barriers that limit access to comprehensive, integrated and qualitative reproductive health care shall be removed. Among other declaration was to develop appropriate, culture-and gender sensitive information education and communication materials on reproductive health to enhance the adoption of reproductive health behaviour and lifestyles. While for adolescent, a declaration was made to ensure that young people have the information, skills and means to prevent unwanted pregnancies, HIV/AIDS and other sexually transmitted infections (NRHPS, 2001).

Amongst the objectives and targets of the policy is to reduce unwanted pregnancies among adolescents by 50%, also to increase the proportion of people, including adolescents who have access to accurate and comprehensive reproductive health information and services by 50%. Another major objective is to increase knowledge of reproductive biology and promote responsible behaviour of adolescents regarding prevention of unwanted pregnancy and sexually transmitted infections. The targets stated for this objective includes: increase access to appropriate reproductive health information to all in-school and out-school adolescents.

To further achieve these target and objective, family and community member. ~~especially~~ mothers must be empowered to communicate effectively on HIV/AIDS and other reproductive health issues with their adolescents. They would also make referrals to adolescents' friendly health centres. Previous studies had reported that adolescents prefer to discuss sexuality and reproductive health problems with their mothers than fathers. Mothers would have adequate information and knowledge on HIV/AIDS and SRH issues are also known to be effective communicators, they not only serve their families but are useful to the community and state at large.

Conceptual Framework

Circumplex Model: Parent-Adolescent Communication (Barnes and Olson, 1985)

The circumplex model comprises of three dimensions –

Family cohesion – this is the emotional bonding between family members; it could also mean the emotional bonding between mother and adolescent child (ren). Some of the variables that can be used to measure family cohesion dimension are: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interest and recreation (Olson 1999.) For instance, how much quality time do mother and adolescent spend together? Do mother open up and share time with the adolescents, do them have same interest?

Family adaptability – this means the ability of the family to change and adjust in response to situation and developmental stresses (Barnes and Olson 1985), basically this means the ability of family members to change to suit prevailing circumstances. This could be explained to mean the ability of the mother and adolescent to change, adapt, and acquire more or new skills in response to situation and developmental issues. For instance, the mother may need to sharpen her communication skills in the face of discussing HIV/AIDS and related issues with adolescent children. Also parents may need to change the way they relate and communicate with their children when they reach adolescence

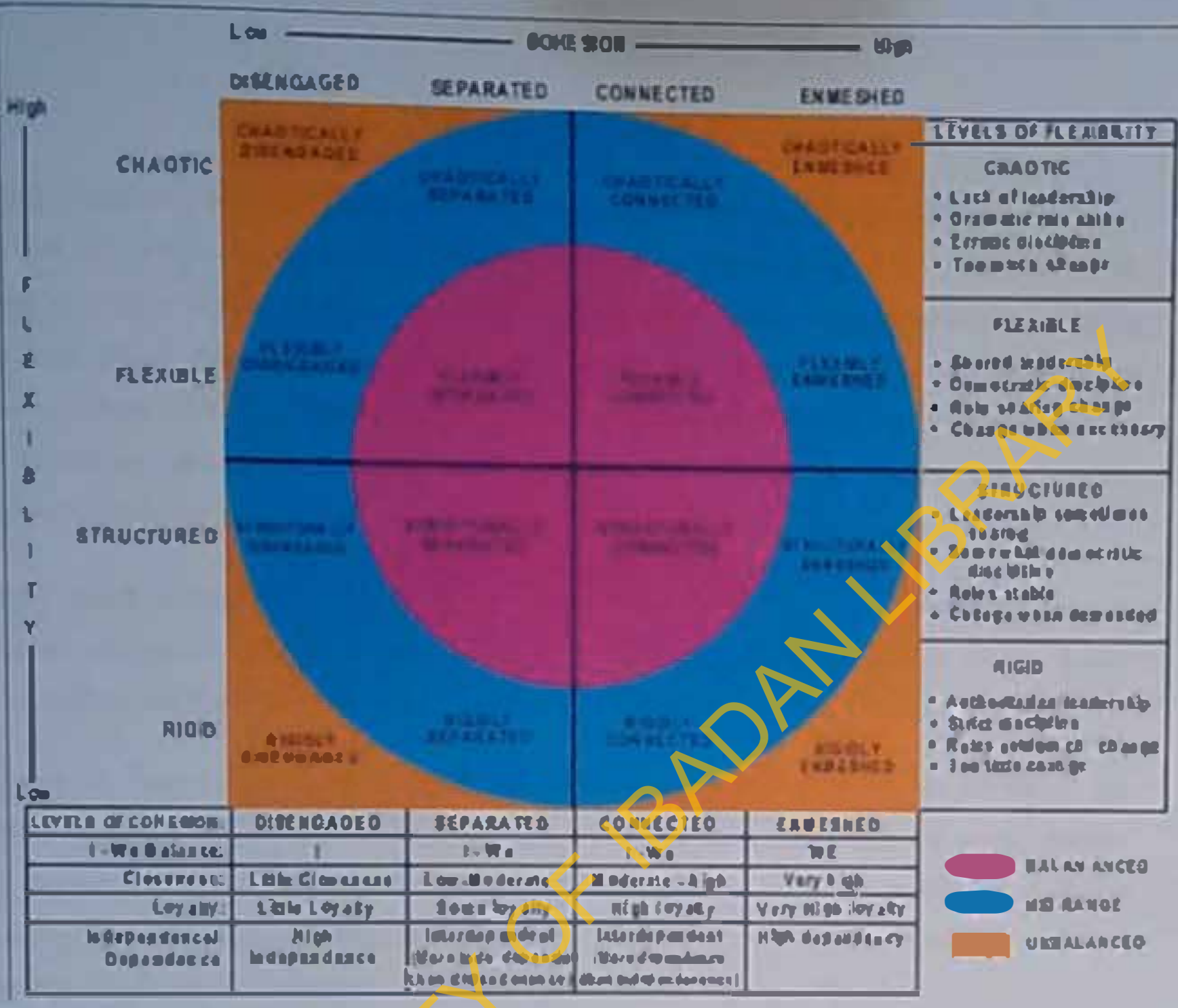
The model has four levels of cohesion ranging from disengaged (very low) to separated (low to moderate) to connected (moderate to high) to enmeshed (very high). The central or balanced levels of cohesion, that is, separated and connected makes for optimal family functioning. The extreme or unbalanced levels are generally seen as problematic for parent-adolescent relationships. The four levels of adaptability range from rigid (very low) to structured (low to moderate) to flexible (moderate to high) to chaotic (very high). As with cohesion it is believed that central or balanced levels of adaptability (structured and flexible) are more conducive to good parent-adolescent functioning. These four levels in cohesion and adaptability make it possible to identify sixteen types of family systems and relationships; the optimal family functioning is characterized by a balance on both cohesion and adaptability.

Family communication – The authors of the circumplex model maintain that communication is the mechanism families utilise to express their levels of cohesion and levels of

adaptabilities. Communication is viewed as the facilitating dimension of the circumplex model hence, not represented graphically in this model. This dynamic component is critical in aiding the movement of families on the other dimensions of cohesion and adaptability. While positive communication promotes stronger levels of family cohesion and adaptability, lack of communication skills or negative communication within the family structure will inhibit the family system. Communication within the family is measured in terms of listening skills, speaking skills, self-disclosure, clarity, continuity tracking, and respect and regard (Olson 1999). Speaking skills include speaking of oneself while self disclosure relates to sharing feelings about self and the relationship. Tracking is staying focused on topic and respect and regard relate to the affective aspects of the communication and problem solving skills. Effective communication on HIV/AIDS between mother and adolescent will include but not limited to mother's ability to effectively track issues, this means she must stay focused on the HIV/AIDS and related issues she is discussing, while being open in discussing her experiences. At the same time mothers must have respect and regard to their adolescents by listening and understanding adolescents' views on HIV/AIDS issues. Parents must also allow adolescents to express themselves through self-disclosure and speaking about themselves.

Application of model to study

This model by its nature gives room for varied types of relationships to exist between mother and adolescents. However, when communication is effective – an optimal, positive and health relationship will exit, this in turn will promote positive communication on issues including HIV/AIDS.



LEVELS OF COHESION	DISENGAGED	SEPARATED	CONNECTED	ENMESHED
I-We Balance:	I	I-We	I-We	WE
Closeness:	Little Closeness	Low-Moderate	Moderate-High	Very High
Loyalty:	Little Loyalty	Some loyalty	High loyalty	Very High loyalty
Independence/ Dependence	High Independence	Interdependent (Some independence, some dependence)	Interdependent (More dependence than independence)	High dependency

Figure 1: Circumplex Model

When mothers and adolescents share effective communication on HIV/AIDS and related issues, they are more likely to enjoy optimal/balanced relationship, where role sharing and adaptation to change occurs. Information sharing and processing will lead to mutual understanding, mutual agreement, and collective action.

CHAPTER THREE

METHODOLOGY

Study Design: This was a descriptive and cross sectional study. The focus of the study was to identify factors that promote or hinder mothers in communicating HIV/AIDS issues with their secondary school adolescent children. It further examined the communication patterns mothers adopt when discussing HIV/AIDS issues with their secondary school children between ages 10 and19. The study population were mothers with secondary school children in randomly selected communities within Ibadan metropolis: all the children were between ages 10- 19 years.

Description of study site: The study was conducted in the five local government areas in Ibadan metropolis namely: Ibadan South East, Ibadan South West, Ibadan North, Ibadan North East, and Ibadan North West.

Ibadan, the largest city in West Africa and the second largest in Africa is the capital of Oyo State, Nigeria. The city was founded in 1829 at Oja Oba near Mapo Hill. The name 'Ibadan' is derived form Eba-Odan which means 'beside grassland'. In 2002, population of Ibadan metropolis was 1,835,300 (FMOH, 2002), but the conservative estimate is over two million. Ibadan metropolis is drained by two major rivers namely: Ogunpa, and Ona.

Ibadan metropolis, a predominantly Yoruba settlement, has a representation of all the major ethnic groups in Nigeria. The total landmass is 3,123.0km^2 with 15% within the urban area while 85% is in the rural area (Sustainable Ibadan Project, 1996).

Ibadan metropolis is divided into the urban, rural, and inner core communities. These areas are usually described, along three distinct zones based on historical progression.

The traditional or inner core is made up of slums. It is usually rowdy and unplanned. Ibadan metropolis originated from here. It is a highly dense populated area. The settlement is in clusters of tightly built buildings. Some of the communities are Bere, Mapo and Agbeni.

The transitional area is more spacious than the inner core. It is an admixture of indigenes and non-indigenes. Buildings in this settlement are well demarcated. Houses are detached, and walls separate the houses. Some of the locations in this area are Mokola, Agodi and Dugbe.

The suburban peripheral is a newly built and more developed area. It is well laid-out, and occupied by urbane residents. Ikolaba, Ashi and Felele are examples of locations within this area.

Over three-quarters of Ibadan metropolis fall within inner core and transitional areas. Residential buildings are basically mud houses with the more developed areas having modern buildings. Most of the inner-core residents use pit latrine for their sewage disposal. Portable water, borehole, well and streams are sources of water supply in Ibadan metropolis. There is also access to electricity (Sustainable Ibadan Project, 1996).

A General Hospital, the University College Hospital (UCH), two state hospitals, and about forty Primary Health Care (PHC) centers are health facilities. Other health facilities include private clinics and hospitals, and maternity homes.

With over 200 primary and secondary schools, one government technical college, a state polytechnic, and the University of Ibadan, the city boasts of adequate educational institutions.

Sample size Determination: The formula below was used to calculate the sample size.

$$n = \frac{z^2 pq}{d^2}$$

(Araoye 2003)

Where:

n = the desired sample size (when population is greater than 10,000)

z = the standard normal deviate, usually set at 1.96 (or more simply at 2.0), which corresponds to the 95 percent confidence level

p = proportional evidence in previous studies which form the above study = 38% (0.38).

q = 1.0 – p

d = degree of accuracy desired, usually set at 0.05 or occasionally at 0.02

$$n = \frac{(1.96)^2 \times 0.38 \times 0.62}{0.05^2}$$

Therefore:

$$= \frac{0.9050}{0.0025}$$

$$= 362.03$$

Thus:

Sample size = 360 approximately.

Sample size was increased to 375 respondents with consideration for attrition.

Sampling procedure: A multistage sampling technique was used. This process involved many stages. In the first stage, lists of all wards in all the five local government areas in Ibadan metropolis namely: Ibadan southeast, Ibadan southwest, Ibadan north, Ibadan northeast and Ibadan northwest were obtained from respective town planning departments of the LGA.

At the second stage, all the wards in each of the five local government areas were listed. Each ward was then stratified into any of the three main zones in Ibadan metropolis namely: the inner core area (INA), transitional area (TA) and peripheral area (PA).

Three wards per local government representing INA, TA and PA were randomly selected by balloting. At the end of the balloting, 15 areas evolved from the five LGAs consisting of five INAs, five TAs and five PAs.

In the third stage, eligible mothers with secondary school children were selected by purposive sampling. Interested participants were enlisted in the markets, shops and at their homes to take part in the study. Twenty five mothers were enlisted per zone that is INA, TA and PA in each LGA. In all a sample size of 375 mothers were interviewed in Ibadan metropolis.

Table 1: Showing selected locations where the study was conducted

	Inner Core Area (INA)		Transitional Area (TA)		Peripheral Area (PA)	
LGA	Selected areas	Sample size	Selected area	Sample size	Selected area	Sample size
Ibadan South East	Isale-Ijebu/ Elekuro	25	Orita Aperin	25	Felele	25
Ibadan North West	Ayeye/ Oke padre	25	Ekoledo/ Dugbe	25	Benjamin	25
Ibadan North	Yemetu	25	Mokola	25	Ashi	25
Ibadan North East	Itabale/ Olugbode	25	Idi Obi/Yidi	25	Loyola	25
Ibadan South West	Agbokojo	25	Odo ona	25	Challenge	25
Total		125		125		125

Instrument development

Two major methods for data collection were utilised:

1 Qualitative (Focus Group Discussion)

2 Quantitative (Questionnaire)

Focus Group Discussion Guide: Focus group discussions are designed to be group discussions where people with similar interest and characteristic are brought together to discuss a topic of interest. A Focus Group Discussion (FGD) guide was developed in consultation with the researcher's supervisor. The guide was made up of three parts: introduction, discussion topics, and conclusion. It was designed to elicit responses about HIV/AIDS awareness and knowledge from respondents. Discussions revolved around HIV/AIDS issues that mothers discuss with adolescents in respect to gender of adolescent, factors promoting or hindering such discussions, the influence of the media on the discussions, and what should be done to improve on present situation.

The Questionnaire: This was the second instrument used to collect information. It was developed based on responses from FGD participants.

The questionnaire consisted of an introductory part in which the interviewer explained the purpose of the research and solicited the consent of the respondent.

The other questions in the instruments were categorized into four sections. The first section had the demographic data responses on independent variables collected. Information on HIV/AIDS awareness and knowledge were collected in the second section. Mother-adolescent communication on HIV/AIDS was the responses collated in section three, while mother-adolescent relationship was the focus of the data got from section four.

Validity of Instrument

A total of 36 questionnaires were pre tested on mothers of in-school adolescents at Akinyele local government area of Oyo state. The pre-test was specifically done at Moniya, an inner core area (INA); Odogbo/Barracks, a transitional area (TA), and Ojoo, a peripheral area (PA). Twelve questionnaires were successfully administered in each area on mothers with in-school adolescent, this represented 10% of the actual sample size for this study. These three communities purposefully picked within Akinyele LGA, had similar characteristics to the study sites. Content validity of the questionnaire was also ensured through the FGD sessions. Similarly, a pre-test of the FGD guides was also done on two groups of mothers with in-school adolescents in Lagelu LGA an inner core area (INA) and Moniya in Akinyele LGA, a transitional area (TA). Extensive literature review was also done to strengthen the validity of these instruments.

Reliability of Instrument

To ensure reliability of the study instruments experienced female research assistants who had participated on FGD and questionnaire administration were employed. Female research assistants who spoke and read Yoruba language very well were used because of the target population being mothers in Ibadan metropolis, a Yoruba speaking community. The pre-test of the instruments helped to eliminate questions which were ambiguous and to modify unclear questions. It also strengthened the reliability of the instrument by ensuring that the questions elicited accurate responses and minimized information bias.

FGD Guides: The focus group discussion guides were developed in English language and translated to Yoruba the local language of the target population by a Yoruba language expert. Another language expert translated it back to English language: this was done to ensure reliability and content validity. The guides were pretested on two groups of mothers with in-school adolescents in Lagelu LGA an inner core area (INA) and Moniya in Akinyele LGA, a transitional area (TA). These areas had characteristics similar to the study area. Corrections were made to the final guides from responses got during the pretest. It was observed that some questions like Q6 and Q8b were very similar in nature as similar responses were given. It was also noted that time management had to be improved as some of the mothers were talking out of point.

Questionnaire: This instrument was developed in English language but since it was going to be interviewer administered, research assistants were trained on method of approach and use of language. A total of 36 draft questionnaires were pre-tested on mothers of in-school adolescents at Moniya, an inner core area (INA); Odogbo/Barracks, a transitional area (TA); and Ojoo, a peripheral area (PA). These three communities had similar characteristics to the study sites. Results obtained from this exercise were used to modify the actual questionnaires. For clarity, conciseness, the researcher's supervisory suggested that questions 7,8 and 9 which were questions about number of children male and female be made as one question with sections a and b. Questions with between two to four options were also put in table format while questions with options for sons and daughters were tabulated for example Q27. Ability to understand the questions were ensured by changing the wordings of some questions and by adding options, examples are Q36 and Q43.

DataCollection

Focus Group Discussion: A total of eight Focus Group Discussions held in July 2005 for four days were conducted across the five local government areas with mothers of in-school adolescents. Two were held in the inner core areas (INA) in the morning, most of the mothers were traders, and the discussion held at shops of a selected member. Three in transitional area (TA) were held in the late afternoon as some of the mothers were civil servants and just returned home from work. The three FGDs held in peripheral areas (PA) were conducted on Saturdays. Each focus group session, which lasted for almost one hour involved between 8 and 10 mothers under the guidance of a moderator, an observer, and a recorder. The language of communication throughout the discussions was Yoruba; all the discussions were tape-recorded and also hand written.

Questionnaires

The five trained female research assistants administered the questionnaires over a period of eight days in August 2005. They worked together in each LGA because three locations had to be covered within a LGA. Each interview lasted for about 45 minutes though some were self-administered where the mother was literate and proficient in the English language. The researcher monitored the progress of the interviews while daily review meetings were held. Daily challenges encountered by the research assistants were dealt with and ways to make the job easier were discussed at the meeting. For, example one questionnaire had to be discarded because the interviewee refused to continue the interview half way because she felt the questions were too personal. Some interviewees also felt that the researchers were just wasting their time and that they had nothing to gain for the interview. Some respondents also asked for incentives. It was decided that the issues be properly explained to the mothers in a loving manner before interviews proceeded and when mothers insisted on incentives, interviews must be stopped.

Data Processing and Analysis

The questionnaires after collection were processed using the following steps:

- Sifting of questionnaires to identify and remove incomplete and un-correctly filled questionnaires. Two questionnaires were cancelled because they were incomplete as respondents declined to continue the interview because they felt the questions were too personal.
- Developing the coding guide for responses in the questionnaire
- Coding of questionnaires
- Feeding the data codes into the computer
- Analysis of the data

Data Analysis

The tape-recorded responses from FGDs were transcribed and used to update recorder's reports. The responses were analysed through identification of related phrases and key words followed by generation of themes, which were then used to and to validate the quantitative data.

A coding guide was developed for the questionnaires after collection and collations. Responses were assigned codes from the coding guide. The data was analysed using Statistical Package for Social Science (SPSS). Frequencies were generated and cross-tabulations of some variables were done.

Ethical Consideration

This study was conducted with utmost consideration for the dignity and respect of all respondents. The participants of this study were randomly selected from the five study sites. The respondents were adequately informed on the purpose of the study, the types of questions expected to be answered and duration of the interviews. Their names were not written out on the questionnaire administered to them neither was it tape recorded during the FGD, this was done to ensure confidentiality. Voluntary consents of respondents were sought before interviews began, they were assured that they could terminate the interview at any point they felt uncomfortable with it. Light refreshment was served at the end of each Focus Group Discussions to compensate for the use of respondents' time.

CHAPTER FOUR

RESULTS

Demographic characteristics of respondents

Respondents' age

The mean age of the respondents was 40.4 years (S D ± 0.74). A hundred and seventy one (47%) of the respondents were between ages 24 and 40 years; 162 (22.5%) were between 41 and 50 years; and 31(8.3%) were above 50 years. The youngest of the respondents was 24 years while the oldest was 70 years. All adolescents, both male and female, were between ages 10 and 19 years.

Respondent's parity

A total of 366 of the 375 respondents in this study answered questions about the number of children they had. The numbers of children per respondent ranged from one to eleven, respondents with four children each were the highest at 106 (29%). Closely followed were 90 (25%) respondents each with 5 children while 69 (19%) of the respondents each had three children. Few respondents had large number of children, 13 (3.5%) respondents had seven children each, three respondents each having eight (0.3%), nine (0.3%), and 11 (0.3%) number of children. On the low side were respondents with less than three children, 34 (9.2%) respondents had 2 children each while a total of 12 (3.2%) respondents had one child each. In respect of the number of adolescent children per respondent, over 80.0% of the respondents had one or two adolescent children at the time of this study, only 3.5% had four adolescent children at once, while 15% of the respondents had 3 adolescent children.

Religion, marital status and household living arrangements

(a) Religion. Most respondents 247 (66.2%) were Christians followed by 125 (33.5%) Muslims. Only one (0.3%) of the respondents practiced traditional religion. The pattern was the same for adolescents' religious preferences. Two hundred and forty (64.3%) of the adolescents were Christians while 13 (35.7%) were Muslims.

(b) Marital Status. Virtually all the respondents 332 (89%) were married. Twenty-two (5.9%) were widows. Fifteen (4%) respondents were separated, one (0.8%) was divorced.

while 3 (0.8%) had never been married. For those married, 74 (22.2%) had husbands married to other women. Thirty- four (45.9%) of those in polygamous relationships lived in the same households with the other wives.

(c) Household and Living Arrangement: Over three quarters of the mothers 363 (97.8%) live in the same house with their adolescents.

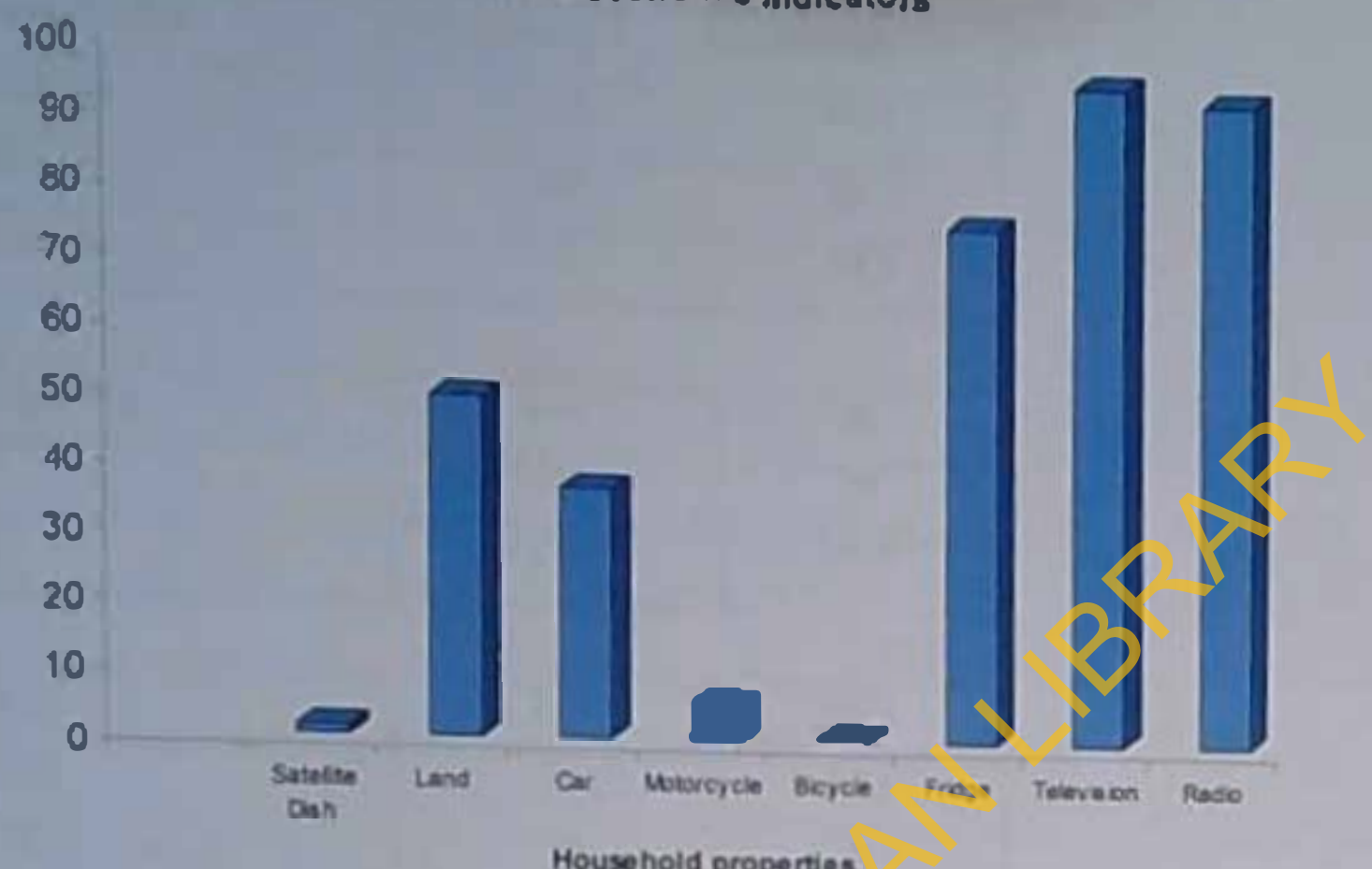
Respondents' educational qualifications and occupation

Almost half of the respondents 154 (41.3%) had secondary education, next were 58 (15.5%) who had primary school education. Forty-eight (12.9%) had no formal education, while 41 (11%) had vocational training. Others were 39 (10.5%) with diploma, 17 (4.6%) had less than primary education and 16 (4.3%) had university education. However, the educational level of the mother was not statistically significant to the level of communication of HIV/AIDS with their adolescent children (p=0.1035). All adolescents, both male and female, were in secondary school.

About two-thirds of the respondents 246 (66%) were traders, 58 (15.5%) were artisans. Twenty-nine (7.8%) had paid employment as teachers and 23 (6.2%) were civil servants. Ten (2.7%) of the respondents were medical workers, while 7 (1.9%) were housewives.

Household economic indicators

Five (1.3%) of the respondents had satellite dish in their houses. A hundred and eighty five (50%) owned plots of land while 141 (37%), 22 (5.8%) and 3 (0.8%) had cars, motorcycle, and bicycle respectively. Two hundred and eighty six (76.7%) of the households boast of refrigerators. Almost all the respondents, 351 (97.8%) had television; and radio, 356 (95.4%). See figure 2 below for illustration.



Mothers' knowledge level on HIV/AIDS issues

HIV/AIDS Awareness

High level of awareness on HIV/AIDS was reported among the respondents. All respondents had heard of an illness called HIV/AIDS and 370 (99%) believed that HIV/AIDS exists (p=0.0001). This result correlates with the findings of FGD in which all respondents were aware of HIV/AIDS and agreed that it exists.

Knowledge of causation and misconceptions on HIV/AIDS

Knowledge on modes of transmission of HIV was equally high. Over three quarters of respondents 368 (98.6%) knew that HIV could be contacted through sexual intercourse. Other modes reported by respondents were through mother to child at birth. However, misconceptions on modes of transmission of HIV were high among respondents. Two hundred and fifteen (41.5%) reported infection with HIV through mosquitoes or insects bites. (See table 2).

Table 2. Knowledge on modes of transmission

Modes of transmission	Frequency	Percentage
Sexual intercourse	368	98.6
Sharp object	360	96.5
Blood transfusion	354	94.9
Through pregnancy	310	83
At birth	320	85
Breast milk	282	75.6
Mosquito bite	215	41.5
Casual contact	96	25.7
Sharing of food / cutlery	136	36.4

- Responses on this table were mutually exclusive (N = 373)

This finding agrees with what obtained at the FGD where majority of the mothers were of the opinion that AIDS is got from having sexual intercourse with one or more partner. "It is a disease that is caused from sexual intercourse between a man and a woman and it has no cure." replied a respondent from Ibadan South West. Using infected sharp objects like blade, nail file, clippers and cutting combs were also mentioned as mode of transmission. The mothers are aware that AIDS is a disease that can be transmitted through infected blood. However, none of the respondents mentioned mother to child transmission.

Knowledge on Latency of HIV

One hundred and thirty six respondents (36.9%) did not know how long it took to get sick with Aids once infected with HIV. The answers given were: 3 to 5 years by 90 (24.4%) respondents; one to two years - 35 (9.5%), a few months. 32 (8.7%) while 7 (1.9%) respondents reported a few weeks of latency. However, 69 (18.7%) reported that it took about ten years.

Knowledge on HIV/AIDS prevention

Respondents' knowledge on prevention of HIV/AIDS infection is high. Three hundred and forty eight (96.4%) knew that an individual can do something to prevent HIV infection. Various categories of answers were given on what can be done by a person to prevent HIV/AIDS infection. Three hundred and five (83%) agreed on complete abstinence from sex, while 362 (98%) favoured faithfulness to partner. Three hundred and sixty seven (99%) preferred to encourage a partner to stay faithful. Three hundred and fifty three (95%) cited avoiding unscreened blood while 294 (79%) opted for condom use. Prevention of HIV/AIDS for 359 (97%) of respondents meant avoiding sharing needles or sharp objects. Three hundred and fifty one (94.8%) would rather avoid commercial sex workers while 291 (78.6%) would avoid casual sex. Also on the list were 335 (90.5%) who would avoid circumcision at unauthorized places.

This result also corroborates with findings in the FGD, most respondents mentioned condom use, abstinence, avoidance of sharing sharp objects and avoiding sex with many partners as ways of preventing HIV/AIDS. Respondents from Ibadan South East said that "condom could be used to prevent infection of HIV/AIDS," another respondent stressed that "I normally tell my girl to go with her combs to the hair saloon because I don't want her to share sharp objects." A respondent from Ibadan North LGA said she tells her children to avoid sharing sharp object with others and to avoid having multiple sexual partners, so that they won't contract HIV/AIDS.

Maternal Perception on Threat of HIV/AIDS to Adolescents

A little more than half of the respondents 316 (65.6%) perceived that adolescents were not at risk. However, there was a significant difference ($p=0.01$) between respondents who thought sons 86 (37.1%) are at greater risk of HIV infection than daughters 79 (31.7%). Twenty five (11%) respondents with sons and daughters 24 (9.7%) reported that adolescents were at risk because they engage in risky sexual behaviours. Results from the FGD showed that most of the mothers were concerned about their adolescent children getting infected with HIV/AIDS; many of the mothers admit that their adolescent children are at risk of the infection. According to a respondent, "We cannot vouch for these our adolescents as we don't know where they may go to and what they are up to, also youths of these days no longer have patience, so because of this, I tell them about AIDS and advise they to use condom." Some of the respondents also believed that adolescents are not being monitored as they should, "this gives the children the opportunity to be promiscuous, which can then lead to AIDS."

Mothers' opinion on adolescent's sexual relationships

Majority of the respondents believed sexual relationships should not occur at adolescence 86.9% for sons and 93.4% for daughter. The average age for daughters to have sex was put at 23 years and 25 years for sons. Maturity and marriage were accepted as reasons for sexual relationships.

Mother-adolescent communication pattern on HIV/AIDS.

Perceived importance of HIV/AIDS discussion with adolescent

Most of the respondents, irrespective of gender of adolescent, believed it is important to discuss HIV/AIDS issues with daughters 243 (97.2%), and sons 220 (96.1%). However, more respondents with daughters 114 (45.6%) than sons 97 (44.9%) placed great importance on the discussion because of the need for daughters to avoid HIV/AIDS. Other reasons given are shown on Table 3.

Findings from the focus group discussion showed that educational success, peer influence, condom use and avoiding sex with multiple partners were issues equally discussed with adolescent sons and daughters. A respondent put it this way "I usually advise my son not to join any bad gang... and that he should face his studies." However, vulnerability of girls and decent dressing to avoid early exposure to sex were emphasised with daughters by FGD participants. The respondents were of the view that girls are more vulnerable than boys thus; more reproductive health issues should be discussed with the female than male. The mothers said they don't want their female children to destroy their lives by getting pregnant while their sons are advised not to impregnate any girl. According to respondents, "girls wear indecent clothes that reveal areas of the body that should be covered...children that dress like these are wayward and promiscuous."

Table 3. Perceived importance of discussing HIV/AIDS with adolescent

Importance of discussion	Son		Daughter	
	Frequency	Percent	Frequency	Percent
To avoid contacting HIV	97	36.7	114	45.6
For Awareness/Education	54	20.5	69	27.6
Not to bring disgrace	51	19.3	.	.
Disease is incurable	28	10.6	17	6.8
To take care of self	13	4.9	22	8.8
To avoid peer pressure	10	3.8	7	2.8
To give safe and secure future	8	3	13	5.2
Because she is female	.	.	5	2
Not to get involved in sexual practices	3	1.1	3	1.2

Mothers' perceived ability to discuss HIV/AIDS issues with their adolescent

Most respondents with daughters (78.5%), and sons (78%) felt that they had enough knowledge to enable them discuss HIV/AIDS with adolescents. One hundred and two (27.3%) respondents believed that they do not have enough knowledge to discuss HIV/AIDS issues with adolescents. Causes, prevention and symptoms of HIV/AIDS are some areas where respondents require more knowledge. See Table 4 for more details.

Table 4. Respondents' knowledge need on HIV/AIDS

Aspects of HIV/AIDS	Frequency	Percent
Causes/ways of contacting	18	39.1
Signs and symptoms	12	26.1
Drugs/ treatment	5	10.9
Modes of transmission	4	8.7
Prevention	4	8.7
HIV Virus	2	4.3
Communication tools	1	2.2

Results from the FGD showed that majority of the mothers were of the view that no topic was too difficult to talk about on HIV/AIDS. To them it is better to discuss the issues now than to face the consequences in future, "the disease is too deadly and it has no cure..." explained a respondent from Ibadan North West. However one of the mothers said it was not easy talking about sex especially with her daughter.

Most of the mothers said it was easier to talk about prevention of HIV/AIDS; prevention is better than cure they reasoned. The mothers from Ibadan South East all agreed that "since it's incurable what else can we say but for them to avoid getting it? We advise them to use condom." However a respondent from Ibadan North said. "As a Christian, I don't agree with the use of condom, abstinence is the best way for females as for male. let them and the lady they want to marry go for test."

Maternal-adolescent discussion on HIV/AIDS

Two hundred and forty-two (96.4%) respondents reported discussing HIV/AIDS issues with their daughters while. 231(97.9%) have discussed with sons. More respondents with daughters 84 (34.9%) discussed HIV/AIDS with their adolescents the preceding week to this interview than with sons 68(29.8%). More mothers with sons 25(11%) than daughters 21(8.7%) could not remember the last time they discussed. Others are shown on Table 5.

Table 5. Last discussions held between mothers and adolescents on HIV/AIDS

When last discussions held	Son		Daughter	
	Frequency	Percent	Frequency	Percent
Can't remember	25	11	21	8.7
Last month	34	14.9	38	15.8
Last week	68	29.8	84	34.9
Others	45	19.7	45	18.7
Today	33	14.5	28	11.6
Two weeks ago	23	10.1	25	10.4

Others: Irregularities - anytime, any moment e.t.c.

However, findings from focus group discussion showed that most mothers did not initiate a two-way flow of communication with their adolescent children; most of the discussions were in the forms of advice, caution and counsel. One of the respondent replied that "mothers should always talk to their children about HIV/AIDS. we should not put a time for the talk, and we must not be tired of talking to our children." Many of the FGD respondents also believed that the discussion could take place at any place and time, "it could be any where inside the house, market place, bedroom etc."

Age of adolescents at inception of discussion

Three hundred and twenty-two (92%) mothers reported initiated HIV/AIDS discussions with their adolescent sons and daughters. Thirteen years was the average age of adolescents (sons and daughters) at inception of discussions. Puberty and fear of sexual relationships made respondents commence discussion with sons 95 (37.7%) than daughters 68 (28.6%). On set of menstruation, however, made 44 (18.5%) respondents to commence the discussions with daughters. Only 42 (17.6%) of respondents started discussions with daughters as soon as they (respondents) became aware of the HIV/AIDS. Forty-three (17.1%) did same with sons. This is closely related to age 12 which majority of mothers at FGD gave as age HIV/AIDS discussion commenced with their adolescent daughters "they would have reached puberty

and have started menstruation." This they believe make the female child vulnerable to sexual exploits, which could lead to contracting sexually transmitted infection, unintended pregnancy and HIV/AIDS. Age 13-15 was however, proposed for the male child

Frequency of discussion

Findings on frequency of discussions between respondents and adolescents revealed that more respondents with sons 91 (39.1%) than daughters 84 (33.9%) had no fixed time for discussions. Conversely, more respondents with daughters 81(32.7%) than sons 63(27%) had a weekly routine for discussions. Once a month, 39 (15.7%) discussed with daughters and 39 (16.7%) with sons. Closely followed were respondents that discussed twice a month with daughters 29 (11.7%) and sons 29 (12.4%). Surprisingly, respondents with daughters 15 (6%) than sons 11 (4.7%) had never had HIV/AIDS discussions. For the FGD respondents, HIV/AIDS discussion should be as often as possible especially "when something related to HIV/AIDS happens or we hear or watch it on television." One of the mothers from Ibadan South East opined "it is necessary to talk all the times about HIV/AIDS, so that they will listen and take it seriously." However, one respondent from Ibadan South East said, "I only talk to them about HIV/AIDS once in awhile when I have the opportunity to sit and talk with them."

Timing of discussion

Most respondents do not have a specific period or time set aside for regular discussions on HIV/AIDS with adolescents. Seventy-nine (32.3%) respondents with daughters and 70 (31.1%) with sons only discuss when HIV/AIDS issues come up in the media. More respondents with sons 57 (25.3%) than daughters 55 (22.8%) discuss at weekends. Others are shown on Table 6

Table 6. Period of discussion on HIV/AIDS between mother and adolescent

Period of discussion	Son		Daughter	
	Frequency	Percent	Frequency	Percent
After school	41	18.2	48	19.9
At weekend	57	25.3	55	22.8
Others	28	12.4	31	12.9
When asked related questions	9	4	17	7.1
When issues are seen on media	70	31.1	79	32.8
When with friends	20	8.9	11	4.6

In FGD, most participants did not have a regular time or routine for discussions on HIV/AIDS with adolescents. They believed that discussions should be anytime adolescents are going out or coming in, they must be reminded about HIV/AIDS. Some respondents were of the view that no one should wait for a situation to arise or right time before having HIV/AIDS discussion with adolescent daughter/son. Others respondents however said, "We hear it on radio and television jingles all the time, we read in the newspapers and see real life experiences." She also said that she's motivated to discuss with her female child because they are so vulnerable to the deceit of men who entice them with money. Another respondent explained that mothers have to be vigilant about their adolescent children, when you notice that he/she has adopted some bad new behaviour, it should motivate one to talk about the issue.

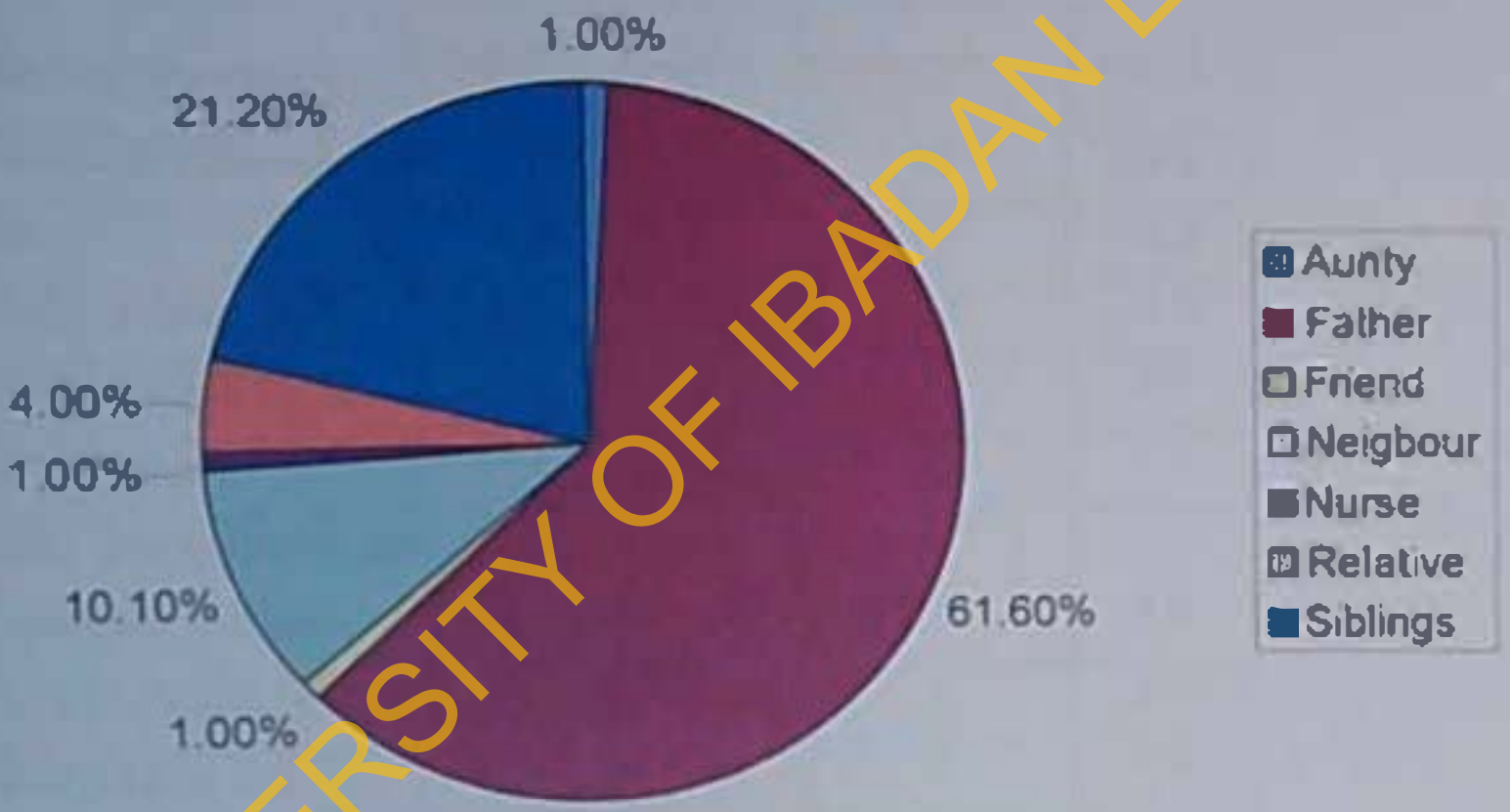
Involvement of others in discussions

Involving others during HIV/AIDS discussions with daughters 68 (28.2%) and sons 62 (28.1%) was similar regardless of adolescents' gender. Fathers 61 (61.6%) came tops in the people usually involved by respondents in HIV/AIDS discussions with adolescents. Others are illustrated in Figure 3.

Respondents seeking more advice and information on HIV/AIDS issues involved others while discussing with sons 33 (47.1%) than daughters 24 (46.2%). A few siblings were

involved in discussions with daughters 8 (11.4%) than sons five (9.6%) so that they can learn. These findings corroborate the results of FGD in which majority of participants do not involve others. However when probed, they admitted that fathers are involved in discussions, especially, with the male child, so that the father can instil fear and make them do what they are advised to do. A respondent explained that "the children fear their father more than me, so they always have it as the back of their mind to do as what he wants."

Figure 2. Persons involved in discussing HIV/AIDS with adolescent



Level of comfort experienced during mother-adolescent HIV/AIDS discussion

Most respondents reported not experiencing any discomfort when discussing HIV/AIDS with adolescent daughters 226 (95%) or sons 212 (94.5%). More respondents with daughters 52 (21.8%), than sons 44 (20%) attributed their (respondents) confidence to the attentiveness of adolescents during discussion. Existence of a good relationship between respondents and adolescent daughters 17 (7.1%), and sons 12 (5.5%) enhanced good level of comfort. Other reasons are shown on Table 7 below.

Table 7. Reasons for level of comfort discussing HIV/AIDS with adolescents.

Comfort during discussion	Son		Daughter	
	Frequency	Percent	Frequency	Percent
Attentiveness of adolescent	44	20	52	21.8
Owns child	42	19.1	41	17.2
For knowledge/awareness	25	11.4	28	11.8
Maturity of adolescent	24	10.9	14	5.9
Good relationship exist	12	5.5	17	7.1
Do not want adolescent to get involved in sexual practices	5	2.3	9	3.8
Sexual issues involved	5	2.3	4	1.7
Do not know what to say	3	1.4	2	0.8
Peace of mind	.	.	1	0.4
Adolescent is aware of sexual issues	2	0.9	2	0.8
I am a teacher	2	0.9	.	.

Some views expressed above agreed with the results of the FGD conducted. Many respondents agreed that a close relationship between mothers and adolescents fosters better discussions; they however said that they felt closer to their daughters than their sons. According to a respondent in Ibadan South East, "it's better for the mother to pick an ideal time when the child likewise the mother will be relaxed." The mothers in Ibadan North West also agreed that mothers should not be harsh but should try to be approachable. In general,

many of the mothers testified that their girl child is usually more relaxed during the discussion. 'My daughter listens more carefully and follows my advise, my son just says he has heard," responded a mother from Ibadan South West. She further said that it's easier for a daughter to relax and ask questions during the discussion than her son who prefers to discuss with his father.

Maternal perception on adolescents' response to HIV/AIDS discussion

More respondents with daughters 199 (86.6%) than sons 172 (79.3%) are of the opinion that adolescents' participated very well to HIV/AIDS discussions. Daughters 92 (39%) were perceived as participating better in HIV/AIDS discussions than sons 78 (35.3%). Others responses are shown in Table 8.

The finding corroborates FGD result in which respondents reported daughters participated in HIV/AIDS discussions better than sons. The respondents said that daughters are usually more relaxed and receptive to the discussions than the sons. According to a respondent, "the male children are not comfortable with the discussion they are always in a hurry to leave but we normally insist. The female children are more comfortable and listen better especially the ones that are not yet sexually active." Another respondent said that her boys were usually more lackadaisical about the HIV/AIDS discussion than her daughters "my daughter listens more carefully and follow the advise, my son just says he has heard, boys generally even as toddlers have this lackadaisical attitude"

Table 8 Mothers' perception of adolescent response to HIV/AIDS discussion

	Son		Daughter	
Responses	Frequency	Percent	Frequency	Percent
INDIFFERENT	7	3.2	3	1.3
NO RESPONSE	2	0.9	1	0.4
VERY WELL	172	79.3	199	86.9
WELL	36	16.6	26	11.4

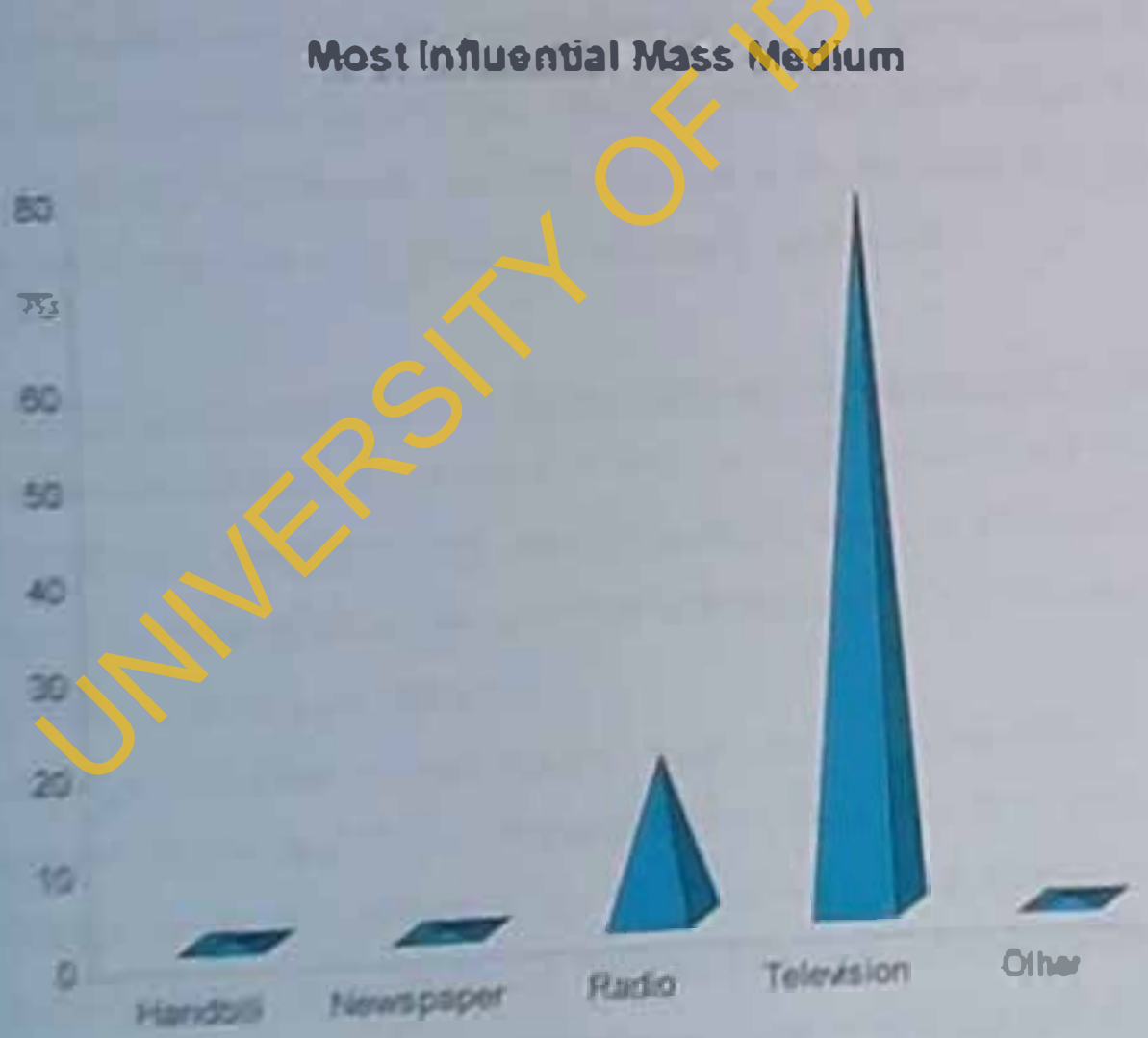
Attentiveness during discussions by daughters 92 (53.8%), and sons 110 (52.2%) gave respondents reasons to believe that adolescents approve of the discussions. More daughters 41 (24%) than sons 48 (22.7%) reportedly asked questions during discussions. According to a

respondent in the FGD. "my daughter is usually very curious and asks about how Aids is contracted" Some of the respondents however believe that their adolescent children responded very well to the discussion because they already have sufficient knowledge and awareness about HIV/AIDS. "My children usually lecture me about HIV/AIDS ..." said a respondent.

Factors promoting HIV/AIDS discussions between mother and adolescent

The mass media was reported as a major factor in promoting HIV/AIDS discussions between respondents and adolescents. One hundred and nineteen (52%) respondents with daughters and sons 104 (49.1%) attested to this. The media have reportedly highly influenced 358 (96.2%) mothers in discussing HIV/AIDS issues with adolescents. The television was said to exert most influence on 288 (77.2%) respondents closely followed by radio 61 (17.3%). Other sources of influence are illustrated in Figure 3.

Figure 3. Most influential medium for mothers



Others: Billboards, Magazines.

For a few respondents, the environment and life experiences were factors that promoted discussions with sons 30 (14.2%) and daughters 30 (13.1%). The fear of HIV infection and its consequences promoted discussions for more respondents with sons 20 (9.4%) than daughters 10 (7%). Onset of menstruation 6 (2.6%) and vulnerability of girl-child 3 (1.3%) were promoting factors for respondents with daughters. These findings are related to what was obtained at FGD where all the mothers said that HIV/AIDS educative programs heard and seen in the mass media served as stimulant and created opportunities to open up HIV/AIDS discussions with adolescents. All respondents across the five local government areas mentioned Abule Oloke Merin – a weekly HIV/AIDS Yoruba radio programme as a good example. Real life events and programmes on radio and television were mentioned by all the mothers as situations that motivate HIV/AIDS discussion with their adolescents. The mothers claim that when they see or hear of people within the community infected with HIV, they are motivated to have HIV/AIDS discussion with their children. "If my children are not around to watch or listen to the news or programmes on HIV/AIDS, I always tell them about what I have heard or seen." said a respondent form Ibadan South East. Other situations mentioned by some mothers were if they notice that the child is keeping late nights or behaving in a manner displeasing to the mother. this situation they said makes them call the child for discussion. Also mentioned, was the fact that a lot has been said about HIV/AIDS in the media, this disease the mothers fear is too deadly and is real.

Factors that hinder HIV/AIDS discussions between mother and adolescent

Many hindrances were mentioned. A few respondents (2%) and (0.9%) could not discuss HIV/AIDS with daughters and sons respectively because of sexual topics involved. Time constraints equally hindered respondents with daughters 12 (4.9%) and sons 12 (5.3%). Other hindrances are shown on Table 9.

Most of these hindrances corresponded with what many respondents reported in the FGD, a respondent replied that "older mothers don't believe that HIV/AIDS is real... they have no knowledge about the disease." The busy schedule of a mother was also reported as a hindrance. Another respondent said "talking about sex could be difficult, some people think it is like teaching children to be promiscuous... but in this age and time... we have no choice but to enlighten them about sex and its implications." Many more of the respondents reasoned that it is only a wayward mother that will have reasons that will hinder her from discussing HIV/AIDS with her children. "If a mother is promiscuous she won't be able to correct her children..." explained a respondent from Ibadan North West. A respondent from

Ibadan North however, said that there could be hindrance in HIV/AIDS discussion between mother and adolescent because, "some mothers have no knowledge about AIDS moreover, they believe that AIDS is not real." The mothers further said that some children are so stubborn and disobedient, "they don't listen to their mothers ... these type of children only learn from experience and by then it will be too late." Another mother from Ibadan South West said that when she calls the attention of her children to programmes or jingles on television showing infected people the normally reply 'that's their luck'. Apparently the young people believe they are smarter and not at risk of getting infected.

Table 9: Hindrances to HIV/AIDS discussion between mother and adolescent

Hindrance	Son		Daughter	
	Frequency	Percent	Frequency	Percent
Lack of knowledge on HIV/AIDS	17	7.6	13	5.3
Time constraints	12	5.3	12	4.9
Too young	8	3.6	9	3.7
Death	16	7.1	9	3.7
Sexual topics	2	0.9	5	2
Ignorance	2	0.9	3	1.2
My mind does not tell me to talk			2	0.8
Irresponsible mothers	3	1.3	1	0.4
I am harsh	1	0.4		

CHAPTER FIVE

DISCUSSION

Respondent's perception of HIV/AIDS Threat to Adolescent

This study showed that 65.6% of respondents' perceived adolescent not to be at risk of HIV/AIDS, this corroborates with finding from many similar studies in Nigeria. Moreover, most adolescents do not perceive themselves at being at risk of HIV infection. Wodi in 2005 revealed that 67% of adolescents in his study of HIV/AIDS knowledge, attitudes and opinion were not worried about contacting HIV. Wodi also indicated that over half of the youth do not use condom and felt little or no threat to HIV/AIDS infection. However, most respondents in this study perceived males to be at higher risk of HIV/AIDS infection than females. This is not surprising as males tend to take more sexual risk than females; also males have more sexual freedom than females. For example, in this study, more respondents will allow their sons (13.0%) to have sexual relations than their daughters (6.6%). Studies on sexual behaviour of adolescents reported that boys age 14 or younger are slightly more likely to have had intercourse than girls of the same age; however, Oladepo and Brieger (2000) reported that the mean age at first sexual intercourse of male secondary school students in Oyo state Nigeria was 13.5 year. In a related study conducted in the USA among 1829 participates aged 10-18, more than 90% of the males were sexually active; 61% had more than one sexual partner in the last three months (Teplin, Mericle, McClelland and Abram 2003). In Nigeria, Slap et al in (2002) reported that 57.1% of male and 48.3% of female in-school adolescents had more than one sexual partner, while a study conducted in the USA reported that among secondary school students 48.5% of males and 42.9% of females reported having sexual intercourse, 17.2% of the males reported having more than four sexual partners compared to 11.4% of females.

It is also generally believed that the more sexual conquests a man have the better prove of a virile manhood hence, men tend to have more sexual partners simultaneously than females. In a WHO publication (2001), it reported that it is more acceptable for males to have premarital sex than females. furthermore, both females and males consider premarital sex to be more acceptable for males than females. A case study in Argentina reported the wide spread belief that males sexual urges are uncontrollable and consequently explain the greater 'need' that

males have for sexual relationships. To also prove that sexual activity for adolescent male is seen as a conquest, Pantelides, (1991), reported that males reported a sense of satisfaction and winning after sexual relationship while females had a sense of sharing. Mendez Ribas et al (1995), also reported that reasons commonly given by adolescent males for having sex included curiosity, "physical need" and peer pressure while for females, desire to express or prove love, and need to strengthen relationships were mostly given.

Respondents' HIV/AIDS Awareness

In this study, the level of education of mothers had no effect on their awareness on HIV/AIDS, or frequency of communication of HIV/AIDS issues with their adolescent children. This study agreed with the null hypothesis that there was no association between mother's level of knowledge on HIV/AIDS and pattern of HIV/AIDS communication with their in-school adolescent children. All respondents (100%), irrespective of their educational background or socio-economic class had heard and were aware of HIV/AIDS as a deadly disease with no cure. This might have occurred because the study was conducted in urban areas where media and awareness campaigns on HIV/AIDS are more intense compared to rural areas. Nearly all the respondents (81.60%) had television sets in their homes: they all affirmed that the media had a high influence in their HIV/AIDS awareness.

Past studies have shown that mothers with higher education have higher awareness and knowledge on HIV/AIDS issues (Okonkwo et al 2003). Results from previous study on father-adolescent sexuality communication also showed that educated fathers were more involved in sexuality communication with adolescent children than the uneducated (Aigbefor, 2001). However, this study did not show any association between education and knowledge on HIV/AIDS. This suggests the need to examine more carefully the role of formal education in influencing disease knowledge especially those that have been widely disseminated in the media, for example HIV/AIDS. Occupation however, affected the frequency of HIV/AIDS discussions between mothers and adolescents as most respondents reported discussing HIV/AIDS issues with adolescents at weekend (24.5%) this might be as a result of being pre-occupied with their jobs during the week.

The level of awareness on HIV/AIDS, knowledge on modes of transmission and prevention of HIV/AIDS were quite high among the respondents, again there was not association between this knowledge and respondents' educational level. However, misconceptions in

respect to food or toilet seats sharing, and mosquito/insect bites were equally high among all respondents irrespective of educational attainment, while there was little or no knowledge on latency of HIV. Cultural values and societal beliefs on sexual relations contribute to these misconceptions about HIV/AIDS (Udonsi, Omilaju and Chibock, 2004). Also because there are still debates on the origin and cause of Aids; confusion, controversy and denial fuel the misconceptions (Duesberg, 1988). In days past, persons with infectious disease was ostracized and regarded as unclean. As such, when a person in unclean any item used or worn by such a person can not be touched or handled by an uninfected person for fear of contamination. In this study a respondent state during the FGD that "when on is infected with HIV/AIDS the person becomes an outcasic, we can't shake hands with them, can't eat or sleep on the same bed with the person, their garment or sweat must not touch us." This reflect what many of the respondents believed that HIV/AIDS is a deadly disease with no cure, it is assumed that anybody infected with the virus is contagious. This suggests the need to adopt strategies grounded on innovation, community participation and action in tackling HIV/AIDS (Udonsi et al 2006).

Conversely, these beliefs and misconceptions could encourage risk behaviors. For example people believe that a healthy looking person can not be HIV infected (Wodi 2005). In Nigeria where for religious and cultural reason sex is hardly ever discussed openly, a lot of myth and misconception about sex and it consequences abound (Pennington 2006), such as the belief that STIs can be prevented by good personal hygiene or that a woman cannot be pregnant at first intercourse (WHO series 2001). Myth and misconception about HIV/AIDS also fuelled the increased in rape of younger girls in South Africa, where it was believed that having sex with a virgin can cure HIV/AIDS (Science in Africa, 2001). Lack of adequate information on sexuality health information and educauon also contributes to the widespread of these misconceptions.

Mother-adolescent communication on HIV/AIDS

This study showed that most of the respondents had one time or the other talked or 'discussed' HIV/AIDS or related issues with their adolescents regardless of the level of closeness that exist between mother and adolescent. Contrary to what some study had reported on inability of parents to hold sexuality discussions with their adolescent children (Okonkwo et al 2003), almost all the respondents in this study felt it was important to have HIV/AIDS discussion with their adolescent children whom they perceived to be at risk of HIV infection. This might have resulted from HIV/AIDS been seen as an incurable disease that eventually leads to death, as well as the stigma associated to the infected which might have a motivating factor to discussing these issues with adolescents. Though most of the respondents reported feeling closer and sharing better with their adolescent daughters than sons, however, a few of the respondents felt easier discussing sex and related issues with their sons.

However, what many respondents termed as having discussion with adolescent were more of counsel, caution, advice or out right castigation especially when a child is seen as being wayward or promiscuous. This sort of 'discussion' gave no room for questions, feed backs or clarifications. In other words, this was not a two-way flow communication. For the mothers, as long as they have advised or talked about HIV/AIDS (in what ever way) with their adolescents, they (respondents) have done their duties. Moreover, most of the respondents, will rather discuss HIV/AIDS issues with their children in middle adolescence; they believed that children age 10-14 were still too young for such discussion. Though middle adolescence is the stage where adolescents face most struggles with independence and identity, it also the period where HIV/AIDS discussions and issues will have most meaningful impact (www.sidservices.on.net, 2002). During this period, adolescents tend to be more influenced by peers than parents while sexual experimentation is at it heights. Apparently, the older the adolescent the more comfortable the mothers felt in discussing this issues, this refutes the hypothesis that the age of the adolescent does not affect the pattern of HIV/AIDS discussion.

This study further shows that there is no consistent pattern of initiating discussion on HIV/AIDS with adolescents. Some respondents only discuss when a situation occurs in the neighborhood involving adolescent misconduct; others however, wait for an appropriate media program to stimulate discussion on HIV/AIDS. In addition, majority do not have a fixed time for discussion. The aspect of the media prompting is expected since all the

respondents mentioned at least one medium of mass communication as having a strong influence on the HIV/AIDS discussion with their adolescent children The television (77.2%) was also picked as the most influential means of mass media. Most media houses are also located in the urban areas and reports a lot of news and feature stories which makes it easier for the respondents to relate with such issues. Most HIV/AIDS campaigns and outreach programs are done in the urban areas and are usually publicized by the media. This corroborates with wodi's study (2005) of HIV/AIDS knowledge, attitudes and opinion of adolescents in the River states of Nigeria, where most common source of information on HIV/AIDS were television, radio and school, in that order

Holistic approach to HIV/AIDS Prevention

Most of the respondents felt inadequate discussing HIV/AIDS prevention with their adolescents alone, believing that schools should be involved. This feeling may have arisen because parents see school as a second home for secondary school students as in-school adolescents spend most part of the day in school during session. Teachers are ranked very high by many of the respondents, according to a respondent in the FGD conducted, "students lend to listen to their teachers better... we can only reinforce what they have been taught at school when they get home". It might also relate to parents believing that teachers are the most equipped to educate and set standard for their students. This finding corroborates with the literature review in which Okonkwo et al in (2003) reported that 85% of 300 mothers believed that reproductive health information should be provided in schools. Teachers can also act as the catalyst in promoting a better parent-adolescent relationship by teaching family living issues in schools. Teaching instruments and materials should be developed to assist teachers in promoting stimulating discussion among adolescents on family communication. This will also help in giving the teachers a deeper understanding of students' relationship with their parents. Fathers also appears to be a very important stakeholder in HIV/AIDS prevention program for adolescent as many of the respondents (61.9%) reported that they needed fathers to be involved in the HIV/AIDS discussion with adolescents. Fathers are perceived to be firmer and stemer with children than mothers hence, there is a higher tendency for adolescent to take them more seriously (Aigbefor, 2001). This may also agree with what Miller et al (1998) reported that it was easier for fathers to initiate HIV/AIDS or sexual education with their adolescent daughters than their sons

Health Education Implications of Study

Findings from this study on patterns of mothers' communication on HIV/AIDS with their secondary school adolescent children showed that mothers had a generally high awareness of HIV/AIDS and fairly good knowledge on prevention. However, the level of misconceptions on HIV/AIDS needs to be addressed. Many of the respondents perceived adolescents sons than daughters to be at risk of HIV/AIDS infection hence, great importance was placed on the need to discuss HIV/AIDS issues with adolescents. However, a lot of irregularities featured in the patterns of discussions. The age of the adolescents, timing of discussion and the media were also factors that affected the discussion. It must be noted that discussion by the mothers' standard was not a two-way flow of communication where answers and feedbacks are exchanged. The gap between intention and actual practice in discussing with adolescent is also obvious. There is therefore a need to adopt holistic approach to improving mother-adolescent HIV/AIDS communication. It has become imperative to have all stakeholder involved.

There is a major need for orientation and reorientation training for mothers on HIV/AIDS prevention among adolescents. It is only when parents are properly trained in HIV/AIDS and other reproductive health issues that their adolescents will become more empowered to make right decision and choices that affects their sexuality. Mothers need to be trained on how to discuss sexuality issues with adolescent without being moralistic, they particularly need further education on HIV/AIDS especially on aspect of latency of HIV virus, misconceptions, care and support, prevention strategies. Consequently, these findings suggest that a more intensive interpersonal communication should be employed to further educate and empower mothers on HIV/AIDS. This will further empower them in their discussions with adolescents. Emphasis should be placed on educating and enlightening mothers to remove misconceptions on modes of transmission, and latency of HIV virus. Since many mothers have no ideal of the incubation period of the virus. They, require knowledge in this direction, so that adolescents can be educated early before risky behaviours commence. More effort should also be directed towards educating mothers to adapt good attitudes towards people living with HIV.

Mothers lack the basic communication skills needed to communicate effectively with adolescents. Training and retraining are required in order to build mothers' confidence; skill and capacity to communicate effectively on HIV/AIDS and sexually related issues with their children from childhood through adolescence. The content and mode of sexual

communication with children must be emphasized. mothers need to be made aware of the important elements of dialogue with their adolescents and help to implement this in their relationship with them. The community including teachers, parents, community based organizations (CBO), religious bodies, and government must need to establish a center where family values would be upheld and reinforced. Family members would be encouraged to interact openly on issues that might cause conflicts in the home. Counselors and health workers will also be employed to tackle family living issues with family members while open communication would be encouraged and practiced.

National Health Promotion Policy

The Federal Government of Nigeria (FGN) saw the need of incorporating health promotion for the overall improvement of human health. Studies had provided convincing evidences of the effectiveness of health promotion strategies in modifying risk factors and offer practical approaches to pursuing equity in health. Poor communication skills had also been identified as a major weakness in limiting the capacity of the Nigerian health system to effectively carry out health promotion. The Health Promotion Policy is formulated to expand and elaborate on the health promotion component of the National Health Policy. It contains guidelines to assist in creating positive outcomes such as empowerment for health action and increased community/family involvement (NHPP, 2006). One of the major thrust developed by the Federal Ministry of Health in implementing a health sector reform is improving consumers' awareness and community/family involvement.

In order to achieve its aim of increased communities and family involvement in health promotions, strong communication skills must be developed among all stakeholders in the communities. This goes further to emphasis the need to improve communication skills between parents especially mothers and adolescents, mothers that are effective communicators stand a better chance of acting as change agents within the community. When mothers can discuss HIV/AIDS and other sexual reproductive health issues with their adolescents, they help in creating awareness about this health issues; they also provide adolescents with needed information to make positive reproductive and sexually health decision that would affect their future. Family and community communication

Consumer Rights and Health

People (communities and families) have both the rights and responsibilities for their health; they have the responsibility to take the best possible action to ensure their health, and that of their families. In return, they also have the right to expect the health system to provide the services and enabling environment that will allow them to take these actions. Invariably, women play an important role in the provision of basic services to their families, especially to children (NHPP, 2006). The National Health Policy, states that consumers health knowledge, comprising information, education and communication and their level of awareness of their rights to quality health care are low; so also is awareness of health obligations. When empowered with reliable information, women are likely to contribute to improved health outcomes with improved management ands prevention of diseases.

The consumer's right to good health will not be realised until greater effort is put on creating more awareness through information, education and communication on their right to good quality health. Knowledge and practice on utilizing the available information will only be attainable when the government, community based organisation, non-governmental organisations put in place structures and policies that promote optimal health care services. Communication at the lowest level in the community is needed to educate consumers on their rights and obligations, expectations from Government and what is expected of them to achieve and promote good health. Mothers within the family and community levels are usually the ones that take responsibility of for the health of family members; hence, women must be targeted and trained to serve as influential points of contact in health information dissemination. Mothers that are equipped with the right and useful information on public health issues would be able to help in the prevention of disease thus improving the quality of life within the family and community. Mothers need to be trained on HIV/AIDS and other reproductive health issues, they must also be trained on how to effective communication to adolescents.

Recommendations

Based on the findings of this study the following recommendations are made:

(a) Involving fathers:

The need to involve fathers in the prevention of HIV/AIDS infection in adolescents cannot be over emphasised. Many studies have reported that sexuality discussion is usually divided along gender line in the home. Fathers need to contribute their own quota in discussions with adolescents, especially, with daughters on HIV/AIDS, choice of sexual partner and other sexual topics. studies show that fathers find it easier to communicate on such topics with daughters than sons (Miller et al 1998). In other words, a holistic approach, involving all family members should be employed in HIV/AIDS prevention programs for adolescents.

(b). Involving schools: Most of the respondents recommended that schools and teacher should be involved in HIV/AIDS education for adolescents. Parents generally believe that it is easier for teacher to discuss sexuality, as adolescents are prone to practice what they study in school. There is also need to introduce more family oriented issues in the school curriculum; teaching should be involved in teaching effective parent-adolescent communication to their studies. Tools for promoting family relationship and communication can be developed to assist students have a better family live.

(c). Media Programs:

More media programs on HIV/AIDS should be designed to promote family unity and discussions while meeting the needs of each family member. HIV/AIDS educational programs should also be family oriented.

Suggestions for Future Research

There is a need to conduct intervention research to test the effectiveness of training mothers on HIV/AIDS prevention communication is suggested in the future.

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Appendix i

MATERNAL PATTERN OF COMMUNICATION ON HIV/AIDS WITH IN-SCHOOL ADOLESCENT IN IBADAN, OYO STATE.

A Focus Group Discussion Guide For Mothers of In-School Adolescents.

A. INTRODUCTION

Greetings. My name is _____ and my colleagues' names are _____ we are from the University of Ibadan. We invite you to come and share your views with us on issues relating to maternal pattern of communication on HIV/AIDS with in-school adolescents.

In this discussion there are no right or wrong answers, all we need are your honest views and perceptions about the issues that will be raised for discussions. Please do make your contribution brief since we would not want to take too much of your time. There is no order of speaking, each person should feel free to speak whenever she has something to say.

We request your permission to write and tape-record the discussion so that we can always remember the views you will share with us today. Do you agree, please?

We assure you that whatever you tell us will be made confidential and will only be used to design educational programmes relating to maternal pattern of communication on HIV/AIDS with in-school adolescents. So, feel free to air all your views. For avoidance of doubts your names will not be written down or tape- recorded.

Thank you.

B. *PARTICIPANTS' INTRODUCTION*

Now, we will like to give you to introduce yourselves. Please, tell us your name and where you live; what you do for a living and any other information that you want others to know about you.

C. *DISCUSSION POINTS*

S/N	QUESTIONS
1.	What problems do adolescent daughter/son have in this community?
2.	What is HIV/AIDS?
3.	What type of issues do mothers discuss with adolescent daughter/son? (What are your views on discussing HIV/AIDS withadolescent daughter/son?) (What makes you think so) (At what age do you think is right to start HIV/AIDS discussions with adolescent daughter/son) (Why?)

4 How often should mothers discuss HIV/AIDS with adolescent daughter/son?
(Why is this so?)

5. Who do mothers involve in the HIV/AIDS discussions with adolescent daughter/son?
(Why do they involve those mentioned?)
(When do they bring those mentioned into the discussion?)

6. What situation motivates the discussion?
(when is that?)
(who starts the discussion)
(where does the discussion take place and how does it proceed?)

7. What topics on HIV/AIDS are mothers

(a) comfortable about discussing with adolescent daughter/son?
(why is this so?)

(b) uncomfortable about discussing with adolescent daughter/son?
(why is this so?)

8. What factors hinders mothers from discussing HIV/AIDS with adolescent daughter/son?
(How has these mentioned factors affected the discussion?)

8b. What are the things that encourages mothers to discuss HIV/AIDS with their adolescent son/daughter?

9. In what way has the media influence mother's discussion on HIV/AIDS with adolescent daughter/son?
(What other thing influences mothers in discussing HIV/AIDS with adolescent daughter/son?)

10. How comfortable are adolescent daughter/son during discussion on HIV/AIDS with mother?
(What issues are raised by adolescent daughter/son during the discussion?)

11. How close are mothers as regards interpersonal relationship/communication with adolescent daughter/son?
(Why do you think so?)

11b. In what way does this relationship affect the discussion on HIV/AIDS with adolescent daughter/son?

12. What is the outcome of such HIV/AIDS discussion on the adolescent daughter/son?

13. What can be done to improve maternal communication on HIV/AIDS with adolescent daughter/son?

D. *CLOSURE*

We thank you very much for contributions, (summarize, highlighting areas of difference and similarities without being judgemental)... "If any one wishes to add any view, please feel free to do so..."

Once again we thank you for your precious time and views shared with us. We wish you the very best in all your endeavours. Amen

Appendix ii

MATERNAL PATTERN OF COMMUNICATION ON HIV/AIDS WITH IN-SCHOOL ADOLESCENT IN IBADAN, OYO STATE.

Atosa Ijiroro fun awon Iya ti omo won je odo ti won si wa ni ile-iwe

Aki yin.

Oruko mi ni _____, oruko awon ekegbe nii yio ku na si ni _____. A wa lati Ile iwe nla ti o wa ni Ibadan (University of Ibadan).

Anpe yin lati ba yin jiroro lori ona ti e ngba lati ba awon odo ti oje omo yin ti o wa ni ile iwe soro lori arun ti ko gbogun anpe ni HIV/AIDS.

Nmi ijiroro yi ko si idahun kan ti ko dara, nkan ti o se pataki ni oye ati imi yin lori koko oro ti a gbe wa. Inu wa yio dun bi e ba le se awon alaye yin ni soki-soki nitori ako fe gba yin ni akoko ju bi o se ye lo.

Emi keni lo ni anfani lati koko soro ko si pe a o yan eni kan ni o gbenu so.

A ro yin lati gba wa ni aye lati lo eto igbohun sile eleyi yio je ki a ma ranti gbogbo ohun ti e ba wa so. Nje e fi ara mo eleyi bi?

Ni ipari , anfi dayin loju pe ni asiri ni gbogbo ohun ti e ba ba wa so yio wa. ise iwadi wa ni lati ri a o si lo won fun papa fun idani leko awon odo ti o wa ni ile eko eleyi to yio ma fi bi iba ara eni se wa larin iya ati omo lori oro arun aiko gbo gun (HIV/AIDS). Ki o le da yin loju pe ni asiri ni gbogbo ohun ti e ba wa so yio wa. a o ni bere oruko yin bemi ako ni gba sile ma eto igbohun sile.

E se pupo.

B Idanii mo awon odo olukopa

Ni ba yin a fe lati mo eyin na. Ejowo e so oruko yin fun wa. ibi ti e ngbe ise ti ense

jowo ati gbogbo awon nkan gbogbo miran ti e fe ki a mo nipa yin.

C. Awon Ibere fun Ijiroro

To pin pin lati ri idi oko doro oro

1. Iran aso eni isoro wo nio adoju ko awon odoktanrin/odo binrin ni awujo yi?

2. Kini ampe ni HIV/AIDS

3. Iru awon nkan wo ni awon iya mo ba awon omo won ti nje odo kunrin/odo binrin jiroro le lori?
(Kini ero yin lori ki a ma jiroro lori oro arun ti ko gbogun HIV/AIDS pelu awon odo kunrin/odo binrin)
(Kini idi ti e se ro be)
(Bi omo odun melo ni ero wipe o ye ki ati bere si ni mo ba awon odo jiroro lori oro arun ti ko gbogun)
(Ki ni idi ti e se so be)

4. Bawo ni o se ye ki o sun mo ara won to ti o ye ki awon iya ki o mo ba awon odo kunrin/odo binrin jiroro lori oro arun ti ko gbogun
(ki ni idi ti o fi ye be)

5. Iru awon wo ni awon iya maa nge si ijiro won pelu awon odo nigba ti won ba fe soro lori arun ti ko gbogun
(Ki ni o ma sele ti won a fi pe awon ti e nsu eru kan yi)
(Kini idi ti won fi ma nge iru fe awon eni ti a nsu eru kan yi

6. Kini nkan ti o ma nse okunnfa iru ijiroro yi
(Ni gba wo ni)

7. Ki ni awon akole lori arun ti ko gbogun ti o ma nte awon iya lorun lati mo ba awo odo kunrin/ odo binrin soro lori arun ti ko gbogun
(Kini idi ti eleyi fi ri be)

7b. Ki ni awon akole lori arun ti ko gbogun ti ko kin nte awon iya lorun lati mo ba awon odo kunrin/ odo binrin soro lori arun ti ko gbogun
(Kini idi ti eleyi fi ri be)

8. Kini awon nkan ti o nfa gi dina ero ngba awon iya lati ma ba awon odokunrin ati odobinrin jiroro lori oro arun ti ko gbogun
(bawo ni awon nkan ti awi won yi se nfa gi dina ijiroro)

9. Awon eka wo ni eto ileewe, redio, telefisan, iwe iroyin ngba lati se iranwo fun awon iya lori ijiroro won pelu awon odo kunrin/odobinrin lori oro arun ti ko gbogun
(Kini awon nkan miran ti o tun nse iranwo fun awon iya lori ijiroro won gbogun pelu awon omo won ni odo kunrin ati obinrin)

10. Bawo ni ara awon odo kunrin/odo binrin se bale si ni gbati awon iya ba nba won jiroro lori oro arun ti ko gbogun
(Iru awon bere wo ni awon odo mo bere ni akoko ti aba nse ijiroro pelu won?)

11. Bawo ni awon iya se sun mo awon omo to je odo okunrin /odo binrin ti o ba di oro ki a mo ba ara eni soro
(Kini idi to e se so be)
(Bije won ma dahun si ijiroro yi)

(b) Ore wo ni o ro wipe ajo se po yi se ran iru ijiroro ti a nwi lori oro arun ti ko gbogbo n (HIV/AIDS) yi lowo pelu awon odo kunrin/odo binrin
(Kini idi re)

12. Kini o ma nje abajade iru awon ijiroro yi pelu awon odo kunrin/odo binrin

13. Kini a le se lati tun mu iba ran eni soro larin iya ati awon odo jagere si lori oro arun ti ko gbogun (HIV/AIDS) pelu awon awon odo binrin ati okunrin

D. A dupe pupo lowo yin fun awon ipa ti e ko (se akojo po gbogbo nkan ti a ti so ni soki. se alaye awon apa ibi ti iyato wa ati awon ibi ti gbogbo nkan ti ba ara won mu lai fi igba kan bo nkan ninu

Appendix III

MATERNAL PATTERN OF COMMUNICATION ON HIV/AIDS WITH IN-SCHOOL ADOLESCENT IN IBADAN, OYO STATE.

Mothers of in-school Adolescents **Questionnaires**

INTRODUCTION

Greetings. My name is _____and I am a student of the University of Ibadan. This questionnaire is designed to study maternal pattern of communicating HIV/AIDS with in-school adolescents. Your honest responses to the issues raised in the questionnaire are important for the success of the programme and they shall be treated with confidentiality. Your names are not requires, please.
Thank you.

SECTION A: DEMOGRAPHIC INFORMATION

1. Occupation.....

2. Ethnic group
   1. Yoruba
   2. Ibo
   3. Hausa
   4. Others (specify).....

3. Religion
   1. Christianity
   2. Islam
   3. Traditional
   4. Others (specify).....

4. Age.....

5. Adolescent's religion
   1. Christianity
   2. Islam
   3. Traditional
   4. Others (specify).....

6. How many children do you have.....
   (a) Males..... (b) Females.....

7. How many children do you have between the ages of 10-19 years?.....
   (b) How many are boys..... (c) How many are girls.....

8. Are you? (If answer is not A, skip to question 13)
   (a) Married (b) Widowed (c) Never married (d) Divorced (e) Separated

9. How long have you been married?.....

10. Do you live with your husband and children in the same house?
    (a) Yes (b) No

11. Is your husband married to other wives? (a) Yes (b) No

12. Do you all live together? (a) Yes (b) No

13. What is your highest level of education?
1 No education
2 Less than primary
3 Primary
4 Secondary
5 Vocational/technical
6. Diploma
7 University

14. Which of the following does your household have? (Circle all applicable)

1. Plot of land	2. Radio
3. Television	4. Refrigerator
5. Car	6. Motorcycle
7. Satellite dish	8. Bicycle

15. Does your adolescent children live in the same house with you?
a. Yes b. No

16a. Do you belong to any club /society/association
a. Yes b. No

16b. Yes, specify.....

SECTION B: HIV/AIDS AND REPRODUCTIVE HEALTH ISSUES

17. Have you ever heard of an illness called HIV/AIDS? (a) Yes (b) No

18. Do you believe that HIV/AIDS exists? (a) Yes (b) No

19 Do you know the full meaning of HIV or AIDS? (a) Yes (b) No

20 What is it .....

21 Please mention all the ways in which you believe a person can get HIV/AIDS ((Probe by asking, "is that all?" and circle all that apply.)

	Without prompting		With prompting		
	Yes	No	Yes	No	D/K
	a	b	a	b	c
Sexual intercourse	a	b	a	b	c
Sharing sharp object	a	b	a	b	c
Blood transfusions	a	b	a	b	c
During pregnancy	a	b	a	b	c
Mother to child during birth	a	b	a	b	c
Through breast milk	a	b	a	b	c
Mosquito or other insect bites	a	b	a	b	c

Casual contact with infected person (Sharing food, cup, or handshake) a b a b c

Sharing same toilet, cough or sneeze a b a b c

Others (specify): _____ Don't Know

22. Is there anything a person can do to avoid getting HIV/AIDS?

Yes	No	Don't Know
a	b	c

23 What can a person do? (Probe by asking, "is that all?" and circle all that apply.)

	Without prompting		With prompting		
	Yes	No	Yes	No	D/K
Avoid sex completely/abstinence	a	b	a	b	c
Stay faithful to partner	a	b	a	b	c
Encourage partner to stay faithful	a	b	a	b	c
Avoid contaminated blood	a	b	a	b	c
Use condom at every sex	a	b	a	b	c
Avoid sharing needles	a	b	a	b	c
Avoid commercial sex workers	a	b	a	b	c
Avoid casual sex	a	b	a	b	c
Avoid circumcision at unauthorised places	a	b	a	b	c

Others _____

24 How long does it usually take somebody to get sick with AIDS after being infected with HIV (the virus that causes AIDS)?

1 A few weeks
2 A few months
3 One or two years
4 Several years
5 Others (specify) _____
6 Don't know

25. Have you heard of VCT? (a) Yes (b) No

26. What is VCT? _____

27. Will you encourage your adolescent children to do VCT

	Yes	No
Daughter(s)		
Son(s)		

SECTION C: MOTHER AND IN-SCHOOL ADOLESCENT COMMUNICATION ON HIV/AIDS

29 Have you ever discussed HIV/AIDS issues with your adolescent

	Yes	No
Daughter(s)		
Son(s)		

29 When was the last time you discussed HIV/AIDS with your adolescent

	Today	Last week	Two weeks ago	Last Month	Others (Specify)	Can't remember
Daughter(s)						
Son(s)						

30 How often do you discuss HIV/AIDS issues with your adolescent

	Once a week	2-3 times a month	Once a month	Others (Specify)	Haven't talked
Daughter(s)					
Son(s)					

31. Who starts HIV/AIDS discussion with your adolescent children?

1 You
2 Your adolescent children

32. At what age do you start such discussion with your adolescents?

Daughter(s)..... Why .....

Son(s)..... Why .....

33a Do you involve other people in discussing HIV/AIDS with your adolescent

	Yes	No
Daughter(s)		
Son(s)		

33b Can you mention who (probe for father or siblings) .....

33c Why do you involve this person during the discussion with

Daughter(s)	
Son(s)	

34a Do you think your adolescent children are at risk of getting HIV/AIDS

Daughter(s)? 1 Yes 2 No

Why .....

Son(s)? 1. Yes 2 No

Why .....

34b Do you think it is important to discuss HIV/AIDS issues with you adolescent children?

Daughter(s)? 1.Yes 2.No
Why.....

Son(s)? 1.Yes 2.No
Why.....

35.When do you discuss HIV/AIDS with them?

	After school	At the weekend	When with friends	When asked related questions	When issues about HIV/AIDS comes up in the media	Others (Specify)
Daughter(s)						
Son(s)						

36. Do you feel comfortable discussing HIV/AIDS issues with your adolescent children?
Daughter(s)? 1.Yes 2. No
Why.....

Son(s)? 1.Yes 2. No
Why.....

37. Do you believe you have enough knowledge to discuss HIV/AIDS issues with your adolescent?

	Yes	No
Daughter(s)		
Son(s)		

37b If not, what aspect will you like to receive more information?
.....

38.Does your adolescent children open up or ask questions during the HIV/AIDS discussions?
Daughter(s)? 1.Yes 2. No
If Yes, In what situation.....

Son(s)? 1.Yes 2. No
If Yes, In what situation.....

39.Do you think your adolescent children like or approves of the HIV/AIDS discussion?
Daughter(s)? 1.Yes 2.No
Why.....

Son(s)? 1.Yes 2.No
Why.....

40 How does your adolescent respond to the HIV/AIDS discussion?

	Very well	Well	Indifferent	No response
Daughter(s)				
Son(s)				

41a. What are the factors that promote HIV/AIDS discussion with your adolescent

Daughter(s).....

Son(s).....

41b What are the factors that hinder HIV/AIDS discussion with your adolescent Daughter(s).....

Son(s).....

42a Has the media in any way influence your HIV/AIDS discussion with your adolescent children
1. Yes
2. No

42b If yes, which of the medium?
1. Television
2. Radio
3. Newspaper
4. Handbills Posters
5. Others

SECTION D: MOTHER AND IN-SCHOOL ADOLESCENT RELATIONSHIP

43 How important is it that your adolescent children complete secondary school?

	Not important at all	Not very important	Somewhat important	Very important	Definitely important
Daughter(s)					
Son(s)					

44. Do you believe your adolescent children trust you?
Daughter(s)? 1. Yes 2. No
Why.....
Son(s)? 1. Yes 2. No
Why.....

45. Do you encourage your adolescent children to have girlfriend/boyfriend?
Daughter(s)? 1. Yes 2. No
Why.....

Son(s)? 1. Yes 2. No
Why.....

46. Do you encourage your adolescent children to bring their friends home?
Daughter(s)? 1. Yes 2. No
Why.....

Son(s)? 1. Yes 2. No
Why.....

47 Should adolescents have sex before marriage?

	Agree	Disagree	Don't know
Daughter			
Son			

48 At what age should adolescent start having sex?

Girls..... Why.....

Boys..... Why.....