FACTORS AFFECTING DISSEMINATION OF FAMILY LIFE EDUCATION TO ADOLESCENTS IN APATA COMMUNITY BY THEIR PARENTS

by

Moridiyat Omolara Adeyinka ADEYEMO

B.Sc. Hons. (Nursing) Ibadan

A dissertation in the

Department of Preventive and Social Medicine.

Submitted to the Faculty of Clinical Sciences and Dentistry, College of Medicine, in partial fulfillment of the requirements for the degree of

MASTER OF PUBLIC HEALTH (Health Education)

of the

UNIVERSITY OF IBADAN, NIGERIA

February, 1995

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

DEDICATION

With gratitude to Almighty Allah, the Source of knowledge and wisdom, this dissertation is dedicated to my children, Mubarak, Ashraff and Hikmat. and my husband who assisted and encouraged me to pursue and finish this study.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

ACKNOWLEDGEMENTS

Praise be to Almighty God who has made it possible for me to pursue this course.

I wish to express my sincere gratitude to my principal supervisor, Dr. William Brieger, who guided and assisted me in making this study a reality, especially during the difficult phases.

I appreciate the encouragement and assistance I received from Professor C. Udoh, in the College of Education of the University of Ibadan, and Messrs. Sunday Aloo, Ademola Ajuwon and Hammed Adotunji. I also thank Dr. (Mrs.) M. Onadeko for her encouragement during the initial stage of this research.

My thanks and appreciation also go to my loving husband, Muhammed Tiamiyu Olatunji Adeyemo, for his spiritual, financial and physical support throughout the period of this course. I also say a big thank you to my parents and grandmother for their support.

I thank the community leaders of Apata, the study area, for their cooperation. My profound gratitude goes to Mr. Adeleke, a post-graduate student in the Department of Linguistics, University of Ibadan, who translated my questionnaire into Yoruba. I also wish to thank my uncle, Architect Mufutau Kudayisi and all other people who have contributed to the success of this study.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

ABSTRACT

Family life education is a process of imparting factual knowledge on developmental characteristics, relationships with the opposite sex, preparation for parenthood and prevention of unwanted pregnancies and sexually transmitted diseases. In traditional African homes, parents impart knowledge on relationships with the opposite sex to their children, but with urbanisation, and the subsequent reduction in effectiveness of traditional social restraints, most adolescents are exposed to the risks of unwanted, premarital pregnancy, abortion and its complications, and sexually transmitted diseases because there is minimal or even no parent-child communication on sexual matters. This study intended to find out factors that affect dissemination of family life education to adolescents of the Apata community in the city of Ibadan by their parents.

Apata is a suburban community with an estimated population of 43,600 inhabitants. Three hundred parents with adolescent children were chosen for interview from 300 of the approximately 1,900 residential houses in Apata using a systematic sample of every sixth house. In houses where there was more than one family with an adolescent, interviewees were chosen by balloting. Interviewing took place between August and September, 1991 with the aid of structured questionnaires which had been pre-tested in another, similar section of Ibadan. A final sample of 253 parents

UNIVERSITY OF IBADAN LIBRARY

were interviewed. Although there was a high refusal rate, those who refused differed from the responders on only one demographic characteristic; they were older.

A twelve-point Family Life Communication Score (FLCS) was constructed based on parents' reports of discussing the following six topics: growth and development, pregnancy and reproduction, abortion, sexually transmitted diseases, preparation for parenthood and contraceptives. The most commonly discussed topics were growth and development (83%), pregnancy (69%) and abortion (59%). Mothers most often initiated these discussions. Mean FLCS was significantly higher in families where the father was 60 years old or older, but mothers' age did not make a difference. No significant difference was discerned concerning family religion, type of marriage or tribe.

In homes where the father had more formal education, mean FLCS was significantly higher. The same trend was visible for mothers. While mothers' occupation was not associated with mean FLCS, homes where fathers were retired, civil servants or professionals, has significantly higher mean scores.

The study has shown that while most parents discuss with their adolescents on family life and sexuality, the level of communication could be improved. Recommendations are made to provide support and encouragement to Parents in their educational roles.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CERTIFICATION

I certify that this work was carried out by Mrs. Moridiyat Omolara Adeyinka ADEYEMO in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.

SUPERVISOR

William R. Brieger,
B.A., M.P.H. (Health Education) Chapel Hill,
C.H.E.S. (USA), Dr.P.H. (Johns Hopkins), U.S.A.
READER in the Department of Preventive and Social Medicine, College of Medicine, University of Ibadan, Ibadan, Nigeria.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CONTENTS

Page

Title i

Dedication ii

Acknowledgements iii

Abstract iv

Certification vi

Contents vii

List of Figures ix

List of Tables x

CHAPTER ONE

INTRODUCTION 1

CHAPTER TWO

LITERATURE REVIEW 7

Human Sexuality 7

Adolescence and Sexuality 11

Health Problems Related to Adolescent Sexuality 18

Communication Between Parents and Adolescents 20

CHAPTER THREE

METHODOLOGY 23

Purpose and Objectives 23

Variables and Hypotheses 24

Study Population and Sample 25

Data Collection Procedures 28

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Page

Analysis of Results 30
Limitations 31
CHAPTER FOUR
RESULTS 33
Demographic Characteristics 33
FAMILY LIFE COMMUNICATION TOPICS 41
FAMILY LIFE COMMUNICATION SCORES 49
OPINIONS ON FAMILY LIFE EDUCATION PROCESSES 59
CHAPTER FIVE
DISCUSSION 69
REFERENCES 77
APPENDICES 84

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Page

Analysis of Results 30

Limitations 31

CHAPTER FOUR

RESULTS 33

Demographic Characteristics 33

FAMILY LIFE COMMUNICATION TOPICS 41

FAMILY LIFE COMMUNICATION SCORES 49

OPINIONS ON FAMILY LIFE EDUCATION PROCESSES 59

CHAPTER FIVE

DISCUSSION 69

REFERENCES 77

APPENDICES 84

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

LIST OF TABLES

Number | Page

1. Comparison of Responders and Refusers 42
2. Initiators of Discussion on the Various Family Life Education Topics 45
3. Comparison of Fathers' Ages and Family Life Communication Score 51
4. Comparison of Mothers' Ages and Family Life Communication Score 52
5. Comparison of Families' Religion and Family Life Communication Score 54
6. Comparison of Type of Family and Family Life Communication Score 55
7. Comparison of Fathers' Education and Family Life Communication Score 56
8. Comparison of Mothers' Education and Family Life Communication Score 57
9. Comparison of Tribe and Family Life Communication Score 58
10. Comparison of Fathers' Occupation and Family Life Communication Score 60
11. Comparison of Mothers' Occupation and Family Life Communication Score 61
12. Opinions on Who Makes the Best Family Life Educators . . 62

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Number		Page
13.	Parents' Perception that Their Religion Guides Them Concerning Family Life Education	67
14.	Presence of Cultural Rites Concerning Adolescent Sexuality	68

UNIVERSITY OF IBADAN LIBRARY

CHAPTER 1

INTRODUCTION

The period of adolescence has been regarded as a tumultuous and stressful time [Asuzu, Odor, Asuzu and Oyejide, 1989]. Adolescence may be defined as, "The developmental period that begins with puberty and ends with marriage or economic independence from the family" [Gowdow, 1982]. It is a transition between childhood and adulthood, and also a developmental period where an individual experiences physical, psychological and social changes. It has its own subculture that differs from other developmental periods and is characterised by plenty of energy and drive, a desire for change and newness and a high sense of idealism, which when coupled with a lack of experience and wisdom, is also characterised by mistakes and frustrations [Asuzu, 1992].

Development of sexual organs takes place during this period of life, and adolescents become sexually mature. Psychologically the individual's patterns of identification develop from those of a child to those of an adult. A general age range has been set between 12 and 18 years, but may vary from eight to 21 years [Hunt, 1976].

The problems associated with adolescent sexuality and fertility have received inadequate attention in many developing

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

countries, Nigeria included [Hunt, 1976]. This is because in most cultures the period of adolescence is not distinctly recognized apart from childhood and adulthood. Thus children in many countries are considered to have become adults immediately they reach puberty.

Trends have changed, and adolescents now spend more years in schools and looking for employment before settling down for marriage. The effect of urbanization and modern life styles provide more opportunities for sexual relationships and reduce the effectiveness of traditional social restraints. This increases the gap between sexual and social adulthood and subsequently exposes youth to risks of venereal diseases, unwanted, pre-marital pregnancies and consequent emotional stress [Hunt, 1976].

Adolescents are usually regarded as future leaders of a community, who should be well groomed to face future challenges. Instead, they now face many sex related disorders as mentioned above because they are ignorant of normal sexual behaviour. This also subjects them to educational and economic setbacks in the short term, and later in life they pay dearly for these mistakes made while still young [Liskin, 1985].

Several surveys focussing on young unmarried adolescents of reproductive age yield valuable insights on the problem. For instance, in Ibadan between 1981 and 1982, 49% of sixteen year old boys reported pre-marital intercourse, compared with 28% of girls

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

of the same age [Liskin, 1985]. This results in unwanted pregnancy and illegal abortion, leading to major social and health problems, which arise because adolescents are exposed to low quality information on reproductive health [Nichols, Oladipo, Paxman and Otolorin, 1986]. The information they receive is often half-truths and distorted facts, derived from pornographic publications, corrupt peers and unfortunate personal experiences.

Many people agree that parents should talk to their children about human reproduction and moral standards for sexual behaviour [Greaves, 1965; Sol, 1978; Yaber, 1979; Ajala, 1987; Liskin, 1985], yet many parents do not practise this because they may be embarrassed or find it difficult to put their thoughts into words [Liskin, 1985]. For some parents, discussion of sexual matters with their children is taboo, or they feel that sexual matters should be kept private to the individuals concerned [Dimehin, 1983].

To compound the problem, today, most parents run after worldly gain and do not stay home to see to the welfare of their children. Children are left to the mercy of house maids. When these children observe developmental changes in themselves, they want to find out the cause. They turn to their peers for discussions that yield some of the problems outlined earlier [Dimehin, 1983].

Home is the first school for children, and parents are the

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

first teachers who directly or indirectly teach children everything about life. Unfortunately in the area of sexual matters, parent-child communication is often minimal or non-existent [Liskin, 1985]. In Grenada, it has been reported that mothers do not even tell their daughters about menstruation. In the Ivory Coast, a survey found that only 10% of 700 young people talked with their parents about human sexuality and contraception. A similar survey in Nigeria showed that not one of 127 pregnant girls interviewed had ever talked to her parents about human sexuality [Liskin, 1985].

To date, most Nigerian studies have looked at the issue of family life education from the perspective of school teachers [Akintayo, 1987] or the adolescents themselves [Asuzu et al, 1989]. More needs to be known about the perspectives, beliefs and capabilities of parents for communicating about sexuality and preparation for family life. Much of the parent-child communication that has been documented has been negative in nature, e.g. avoid moving with members of the opposite sex [Liskin, 1985]. With the inquisitive nature of children today, such injunctions may likely have the opposite effect.

A major recommendation from all the above studies is that adolescents need to be guided by family life education. For the purpose of this study, family life education has been defined as the process of imparting factual knowledge on developmental

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

characteristics, relationships with members of the opposite sex, preparation for parenthood and sexual health, including the avoidance of unwanted pregnancies and sexually transmitted diseases [Greaves, 1965; Sol, 1978; Yaber, 1979]. Most studies also advocate that parents must not only be involved in, but also be a major source of family life education [Barrett, 1979; Yaber, 1979; Watson, 1980]. This study therefore was designed to learn how parents themselves view and practise this challenging role of providing family life education.

Presentation of the research and its findings has been organized into the five chapters of this text. This first chapter has introduced the topic and defined the basic terms, adolescence and family life education. Chapter Two reviews literature on human sexuality, family life education, theories of adolescent sexuality, characteristics of the developmental stage of adolescence, and factors affecting tho communication of family life information with adolescents.

Chapter Three outlines the survey methodology used in the study as well as the objectives, study variables, instrument development processes and limitations of tho study. The area used for the research, the suburban community of Apata in Ibadan, the capital of Oyo State, Nigeria, is described. Chaptor Four contains the results of the research. The main dependent variable, the Family Life Communication Score, is explained and

UNIVERSITY OF IBADAN LIBRARY

compared with various family demographic characteristics to test the study's hypotheses. Implications of these findings are discussed in Chapter Five, which ends with major conclusions and recommendations.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER TWO

LITERATURE REVIEW

Family life education takes place within the context of community values and biological realities about human sexuality. This chapter reviews literature as a foundation for understanding this context. The concept of human sexuality is explored. Special problems facing adolescents and their sexual development are described. The formal and informal processea of learning about sexuality are outlined, with special attention to the nature of communication between parents and adolescents. Findings from related studies are presented and analysed as a means for showing a need for better understanding of the role and opinions of parents concerning family life education in Nigeria.

Human Sexuality

Human sexuality has been described in many ways depending on the author's beliefs and biases, but one common thing is that sexuality is an "intrinsic part of human being." It has also been described as "most intimate feelings and deepest longings of the human heart to find meaningful relationship." (Brower, 1967). Sexuality also includes biological, social, cultural, psychological and ethical components of sexual behaviour.

Sexuality may be used or abused in the society. It may

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

bring happiness or despair, pleasure or pain. "Sexuality is the expression of two individual personalities and their merging in both symbolic and physical feelings of tenderness, respect and concern for each other and their pleasure" [Hohmann, 1972].

The biological aspect of sexuality, according to Hogan [1985], includes the anatomic and physiologic organs and processes, i.e. sex organs, hormones, nerves and brain centres, including the larger reproductive instinct to procreate. The psychological aspect involves both gender and sexual image or self-concept. He classified the socio-cultural aspects as gender and sexual identity, which describes one's internal sense of masculinity or femininity, i.e. the awareness of "I am male," or "I am female." Hogan [1985] defined gender or sexual role behaviour as all we do to disclose ourselves as male or female to others. This role is not established at birth, but is built up cumulatively through experience, planned or unplanned, and through explicit, but more frequently implicit instructions.

Two main sources of information have been identified for learning about the sexual role [Hogan, 1985]. First, parents and schools, referred to as the formal source, encourage the child to learn his/her sexual role, especially the sexual value system of the family and the community. The second source of learning is regarded as informal, where the effect of peer group is felt. This is the most pervasive type of sexual learning.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Barrett [1979] noticed that most teenagers do not know anything about family life education and that they received the bulk of their information on sexual matters from their peer groups and the mass media. She observed that the situation was due to the fact that the society, especially the parents, have failed the young ones in guiding then in this most important developmental phase of life. In studies conducted by Ramsey [1942] and Gebhard [1965], peers were found to be the primary source of sexual knowledge.

The ideal forum for learning about sexuality has been debated heatedly. Some conservative individuals and groups in society have been actively opposed to formal sex education courses in schools, and argue that this instruction should be a private matter, provided by the parents [Hogan, 1985]. Other people argue that parents have little or no knowledge of what to say, and are, at times, embarrassed to talk about sexuality, thus making a case for sex education in schools. In Nigeria the Planned Parenthood Federation of Nigeria (PPFN) is in full support of formal sex education [PPFN, undated].

Advocacy for school-based sex education by no means precludes the need for home-based learning about sexuality. Most experts agree that parents greatly influence their children and that sex education should ideally start in the family setting [Ajala, 1987; Barrett, 1979; Kapp, Taylor and Edward, 1980].

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Various means have been suggested to encourage parent-teenager communication on sexuality. Films, discussion sessions, radio and television programmes have been used to show parents how to be more approachable or to discourage teenagers from engaging in early sexual behaviour [Harris et al, 1983].

Since sexuality has been described as basic to human existence, its relationship with other needs must be considered. Sex is one of those basic physiological needs that must be satisfied by people in order to attain and maintain health. According to Maslow's Theory of Human Motivation, sex is one of those needs that must be met for the survival of the human species [Maslow, 1943]. Sexuality is still part of other needs like security/safety, love/belonging, self-esteem and self-actualisation [Hogan, 1985]. Sexual behaviour is multi-determined, not only by the sexual needs, but also by other needs in which love and affection are chief concerns.

It must be understood that the child's early experiences are everlasting and have influence on the conduct of sexual life in future [Hogan, 1985]. Parents should develop positive attitudes towards sexuality so as to transfer such to their children [Ajala, 1987]. This implies that sex instruction should be provided in a normal, natural atmosphere. Sexual learning of children starts right from birth. Immediately that parents know the sex of their child, their attitudes toward the child are influenced by whether

UNIVERSITY OF IBADAN LIBRARY

the child is a boy or girl.

Children learn what love and affection means by watching their parents care for each other [Hogan, 1985]. For instance, the child who is in an unhappy home will never know what happiness in life means. Parents can negatively affect the sexual learning of their children depending on their own reaction to the sexual behaviour of the children. Misleading and inconsistent information about sexual behaviours may lead, for example, to confusion between aggression and sexuality [Hogan, 1985].

Parents have been found to give little or no information about sexuality to their children or wards [Barrott, 1979; Liakin, 1985]. Gebhard [1965] found that approximately three-quarters of parents of both sexes failed to give any sexual information to their children. When mothers gave any information, it was primarily on facts about menstruation and pregnancy. Discussion between fathers and sons was also minimal, and in fact mothers were often a greater source of sexual information for their sons. Most information is passed on in secret, therefore loading children to keep sexuality a secret, even from those they love.

Adolescence and Sexuality

Puberty is the period of physiological development during which children become capable of reproduction [Godow, 1982]. The period is characterised by rapid growth and development that spans the teenage years and ends at a culturally established date of

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

maturity. The period is also characterised by development of social relationships, the culmination of educational efforts and the achievement of life experience [Kuczynski, 1988].

The earliest sign of male puberty is the growth of the testicles shortly after the time at which the pituitary gland has begun to act on them. This is followed by changes in the larynx, the skin and the distribution of hair on the body [Sinclair, 1973]. The growth of the penis is subject to wide variations as is the timing for the spurt in height. By the time some boys are 14 year old, they are sexually mature. There could be some degree of temporary mammary development in adolescent boys and will have disappeared by the age of 21 years [Godow, 1982].

According to Sinclair [1973], the first sign of puberty in females is the increase in size of the ovaries. This is not visible physically. Therefore the first external sign is the enlargement of the breasts. About the same time the growth of the uterus and vagina accelerates, and the pubic hair appears. Onset of menstruation is easily recognisable, and it is an event well remembered by the girls.

Apart from biological maturation in adolescents, there are crucial developmental tasks which are psychological in nature. These tasks are never accomplished quickly, smoothly or completely by everyone. Labarre [1969, as quoted by Kuczynski, 1988] identified the following as the crucial developmental tasks:

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

1. The task of searching for self-identity. Adolescents constantly are asking, "Who am I? What am I to become?"
2. The task of development of the adolescent's sexual identity. This includes the task of learning to be a man or a woman and liking it.
3. The task of developing an independence and separation from one's parents, that is becoming emotionally independent of parents without rejecting them.
4. The task of development of a moral value system - the establishment of principles by which one is going to live and relate to others.
5. The task of choosing life's vocation.
6. The task of developing the capacity for a lasting relationship of a heterosexual nature.

Adolescence is also characterised by extremes of behaviour including periods of rebellion and experimentation, followed by quiescent periods that may even seem regressive [Kuczynski, 1988].

Various theories of adolescent development exist that emphasise the biological, socio-cultural and developmental factors that influence adolescent behaviour. Hall [1904] was the first pioneer to do major work on adolescent development. He took a biological perspective and believed that adolescent development is due to genetically determined physiological factors. Perhaps his

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

most popular concept was that adolescence is a period of storm and stress [Godow, 1982]. This has not been documented by research, but is still believed by many people.

Godow [1982] mentioned another theory which was propounded by Sigmund Freud. This theory is based on biological factors and focused on psychosexual stages of development, especially in childhood. Freud proposed that libido or sexual energy was the central drive of the human organism.

Freud's daughter, Anna, also attempted to formulate a theory of adolescence. Her central hypothesis was that the biological changes that occur during puberty produce a new surge of sexual drive and interest in adolescents [Godow, 1982]. This new surge of sexual drive causes anxiety especially since it re-awakens the hypothetical Oedipus or Electra Complex. Therefore a major task of adolescence is learning to manage this new sexual urge in ways that are socially acceptable.

Godow [1982] went further to mention Freud's suggestion as to ways of dealing with the above mentioned problems of adolescents. One is by a defense mechanism such as sublimation, for example by re-directing the libidinal energy toward the goal of becoming a successful athlete.

Another group of theorists were the socio-culturalists [Godow, 1982]. They pointed out that in some cultures the period of adolescence does not exist [Hunt, 1976; Godow, 1982]. Although

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

the socio-cultural theorists accept the physical factors, they believe that culture has the major influence of development of the adult personality. One of these theorists, the anthropologist, Margaret Mead, believed that if the roles of childhood and adulthood are similar in the society, less strain will be produced in adolescence [Godow, 1982]. Mead observed that there is a difficult adolescent period in Western cultures because there are differences between child and adult roles. She proposed that religious, social and economic institutions of any given culture are the keys to personality and development.

According to Godow [1982], there are still current theories apart from the afore mentioned. These combined biological and socio-cultural factors. One of those theorists was Erickson [1963], who made an attempt to modify Freud's idea and developed another complex theory of adolescence. He acknowledged the biological factor, but put much emphasis on cultural factors. Erickson's central concept is development of ego identity, which is supposed to be an ongoing process throughout life, but most importantly during adolescence.

Erickson [1963] identified two important developmental tasks, which if not achieved, may cause continual problems throughout adulthood. The first task is the integration of elements of childhood in order to develop a positive self-concept. The second is dealing successfully with the transition from the

UNIVERSITY OF IBADAN LIBRARY

family as the central unit of life to society as a whole. Development of mature sexual behaviour and new skills in interpersonal relationships are essential to the transfer from childhood to adulthood [Godow, 1982]. Erickson [1963] viewed the capacity for sexual and personal closeness with other individuals as a major developmental goal of mature adults.

All the theorists agreed that social development is an important aspect of the personality and that sexuality is a central dimension of social development during adolescence [Godow, 1982], but sexuality may pose problems to adolescents. Adolescents are normally considered a healthy segment of the population, but the process of adolescence, including the component of sexuality, may be tumultuous and stressful, especially when there is poor family background and an inadequate social support system [Asuzu et al, 1989].

Ajala [1987] suggested that children should understand the physiological aspects of the human body and reproduction by the time they reach age 11 or 12 years. After this point, they should know more about meaningful human relationships, the concept of marriage and the family, and the impact and control of human feelings. Concepts like pre-marital sexual relations, abortion, venereal diseases, adultery and illegitimacy should be explained to them. When this does not happen as a planned process by parents and educators, children become conscious of these issues

UNIVERSITY OF IBADAN LIBRARY

by other means, leading to experimentation, stress and other problems highlighted above.

The lack of intentional parental transmission of knowledge on sexual matters to their children can be blamed in part of inadequate knowledge, but the problems has been exacerbated by industrialisation, which has increased the parent-child generation and communication gap further. This destablises the family resulting in psycho-sexual problems [Asuzu et al, 1989].

The views of the socio-culturalists noted previously may explain why the problems of adolescent sexuality and fertility have received little attention in developing countries, Nigeria inclusive. The period of adolescence is still a new cultural concept. The familiar stages of childhood and adulthood were traditionally and rather quickly bridged when the child reached puberty and initiation rites, marking the passage to adulthood, were carried out [Hunt, 1976].

Adolescents in many areas are sexually mature and capable of reproduction at a younger age that their parents were. Sexual maturation now takes place earlier, but age at marriage is increasing because adolescents spend more years in school, look for employment and make sure they get what they need for a living before Marriage [Hunt, 1976]. This increases the gap between sexual and social adulthood and subsequently exposes adolescents to the risks of unwanted and premarital pregnancy, abortion and

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

venereal diseases.

However in many countries, including Nigeria, the new methods of coping with developmental changes in adolescent sexual physiology such as sex education or family life education are meeting resistance [Scales, 1980; Dimebin, 1983]. This is due to taboos, customary laws, beliefs of certain religious groups, parental fears of promoting promiscuity, and even resistance by some school authorities [Hunt, 1976].

Health Problems Related to Adolescent Sexuality

The ignorance of adolescents about normal sexual behaviour has subjected them to sex-related disorders including unwanted and premarital teenage pregnancy, venereal diseases, abortion and premature death [Liskin, 1985]. Early childbirth restricts educational and career opportunities and contributes to low economic status, forced marriages and even legal discrimination [Hunt, 1976]. A connection exists between poverty, racial/ethnic discrimination and teenage pregnancy [Sol, 1978].

Risks of mortality and morbidity are high in adolescent mothers and their children. The pregnant adolescent has a higher incidence of anaemia, genital infections, poor nutrition and adverse habits such as smoking and substance abuse [Morris, 1991]. The problems are not only physical but also emotional [Reid, 1982]. Intercourse and pregnancy at a very young age has been associated with increased risk of cervical cancer [Hunt, 1976].

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Strong social discrimination against out-of-wedlock pregnancy may lead to abusive forced marriages, illegal abortion, death, suicide, or diminished chances of future marriage. The child born to an adolescent runs the risk of economic hardship in life and delinquency [Hunt, 1976]. In fact the adolescent herself who becomes pregnant is likely to have been a victim of child abuse, alcoholism and depression, and these problems resurface in the next generation [Sol, 1978].

Hospital records show that the problem of sexually transmitted diseases is very common among adolescents [Liskin, 1985]. To worsen the situation, the victims often do not seek medical attention in time until serious complications such as urinary retention and infertility develop.

The absolute number as well as the proportion of abortions performed on adolescent girls has increased in most countries. Unwanted pregnancy and illegal abortion among young unmarried people is a major social and health problem in Nigeria [Nichols, Ladipo, Paxman and Otolorin, 1986]. A five-year review of women treated for abortion in Nigeria found that over 90% of patients were single adolescent girls [Hunt, 1976]. These adolescents do not seek abortion until the pregnancy is well advanced, thereby resulting in more complications. This delay may be due to inexperience, denial of the problem, ignorance of sources of help, hesitation to confide in adults, lack of economic resources to pay

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

for the service, and laws that do not permit adolescents to seek medical services without parental consent [Hunt, 1976].

Communication Between Parents and Adolescents

The health problems mentioned above are usually the result of a lack of accurate information on human sexuality [Hale and Philliber, 1978]. Another of the reasons given for increase in adolescent sexuality problems is reduction in the effectiveness of traditional social restrains [Hunt, 1976]. This occurs most especially where rapid urbanization and modernization are occurring and young people are breaking away from constraints applied by their families and communities [Liskin, 1985]. These are problems of parent-child communication.

Most people agree that parents should be greatly involved in reducing the problem through counseling at home [Barrett, 1979; Yarber, 1979; Watson, 1980; Kapp, Taylor and Edwards, 1980; Harris, Baird, Clybus and Mara, 1983; Udoh, 1983; Liskin, 1985; Ajala, 1987]. Many parents feel that they should be solely responsible for their children's sex education, and they are worried that the sexual values of outsiders, who might provide sex education, may not be compatible with the family's beliefs [Hale and Philliber, 1978; Harris et al, 1983].

While most experts agree that the home is the basic school for sex instruction, they also observe that parents do not always know this nor how to teach it [Block, 1974; Charthan, 1973; Ajala,

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

1981; Udoh, 1983]. Reasons for this inability have been highlighted by parents themselves. Some are embarrassed to talk about masturbation and intercourse, or even do not know what to say [Harris et al, 1983; Hogan, 1985]. Others expressed misgivings about their abilities to provide sex instruction, even though they see this as an important parental function [Hale and Philliber, 1978]. Some simply feel that they do not know much about sex themselves [Liskin, 1985].

The communication problem can occur from both sides. Liskin [1985] stated that adolescents are also reluctant to discuss sexuality with their parents. They too may feel embarrassed or afraid of their parents' disapproval.

Many programmes designed to address the lack of sex and family life education are aimed at the schools, and a few even through the mass media [Barrett, 1979; Harris et al, 1983]. This is often done with the realisation that schools may not be the ideal place for the transmission of family life and sex education, but where the family or religious institutions do not provide such information, the schools may represent the only opportunity for a young person to learn about sexuality [Kapp et al, 1980].

Two approaches have been reported that try to bridge the gap between the family and the school. Harris et al [1983] described one school health programme that tried to consider the beliefs and values of the community. Surveys and focus group discussions of

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

both parents and young people were employed. In addition to gathering information to develop the programme, the group interviews stimulated adolescents and parents to examine their own lack of communication at home. The adolescents noted that their parents rarely or never spoke about sex. The parents expressed a feeling of responsibility for the sex education of their children, but frankly admitted that they had not spoken to their own children yet. This led to educational materials such as films that modeled the "approachable parent," who could communicate with his/her child about sexual matters.

A second approach developed educational classes for both parents and students [Barrett, 1979]. Prior to teaching the students about family life education, the views and opinions of parents were gathered through special meetings organized just for them. Topics were presented and films were shown, and parents were encouraged to discuss what they heard and saw. Some parents, especially mothers, said they learned a great deal. For example many did not know about wet dreams and had no ideas that their sons may be having difficulties in this area.

It is in the spirit of learning from and involving parents that this present study about family life communication has been designed. The next chapter describes the methods by which the study was developed and implemented.

UNIVERSITY OF IBADAN LIBRARY

CHAPTER THREE

METHODOLOGY

This is an exploratory study that was designed to examine various factors affecting dissemination of family life education to adolescents by their parents in the Apata community of Ibadan, through the use of cross-sectional survey research methods. The selected respondents provided information on family demographic characteristics, the nature and content of communication between children and parents on sexual matters, and the relationship between religion, culture and sexual behaviour.

In scope, the study focused on parents as potential and actual providers of education about family life matters that included the following: 1) human growth and development, 2) pregnancy, 3) preparation for parenthood, 4) venereal diseases, 5) contraception, and 6) abortion. These topics were derived from a review of literature on family life and sex education curricula and programmes for adolescents.

Purpose and Objectives

The overall purpose of the study was to examine the nature and extent of family life communication between parents and adolescents in Ibadan, a major Nigerian metropolitan area, and to determine factors affecting the level of this communication. The

UNIVERSITY OF IBADAN LIBRARY

following specific objectives were formulated to achieve this aim:

1. To document parents' knowledge of the nature of family life education.
2. To determine the content and level of communication between parents and their adolescents on family life matters.
3. To identify family demographic and other factors that may influence the level of family life communication between parents and their adolescents.
4. To explore parents' attitudes toward their own role as educators on sexual and family life matters as well as their opinions about other sources of family life information in the community.
5. To use the findings to recommend appropriate health education strategies to involve parents more fully in their roles as family life educators.

Variables and Hypotheses

The major dependent variable under study was the communication of family life information between parents and their adolescent children. In order to measure this practice, a family life communication score was developed through review of literature. Six major content areas/topic areas were chosen as listed above. A scoring system was developed that awarded two

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

points, if a topic was reported to have been discussed at the initiation of the parent, since the focus of the study is on the willingness of parents to undertake the role of family life educator. If the topic was discussed, but at the initiation of the child or another person (teacher, relative), one point was given. No points were assigned when a topic was not discussed in a particular family. A Family Life Communication Score (FLCS) was thereby calculated that could range, for the six items, from zero to twelve points and that served as an indicator of the level and extent of family life communication within a home.

Data were gathered on several independent variables. Parents' ages were one of the family demographic factors considered. Others included family religion, type (monogamous or polygamous), parents' levels of education, ethnic group, and parents' occupations.

The basic associations that were tested in the study could be summarized in the null hypothesis that family life communication score is not related to family and parents' demographic characteristics.

Study Population and Sample

The subjects of this study were parents of adolescent children in the Agata community of Ibadan. Adolescents were defined as children between ages 12 and 18 years. Ibadan itself is considered to be the largest indigenous African city south of

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

the Sahara [Mabogunje, 1968]. At present the metropolitan area is divided into six local governments. Apata is a suburban area located at Ibadan Southwest Local Government and is situated west of the city on the Abeokuta Road as seen in Figure 2.

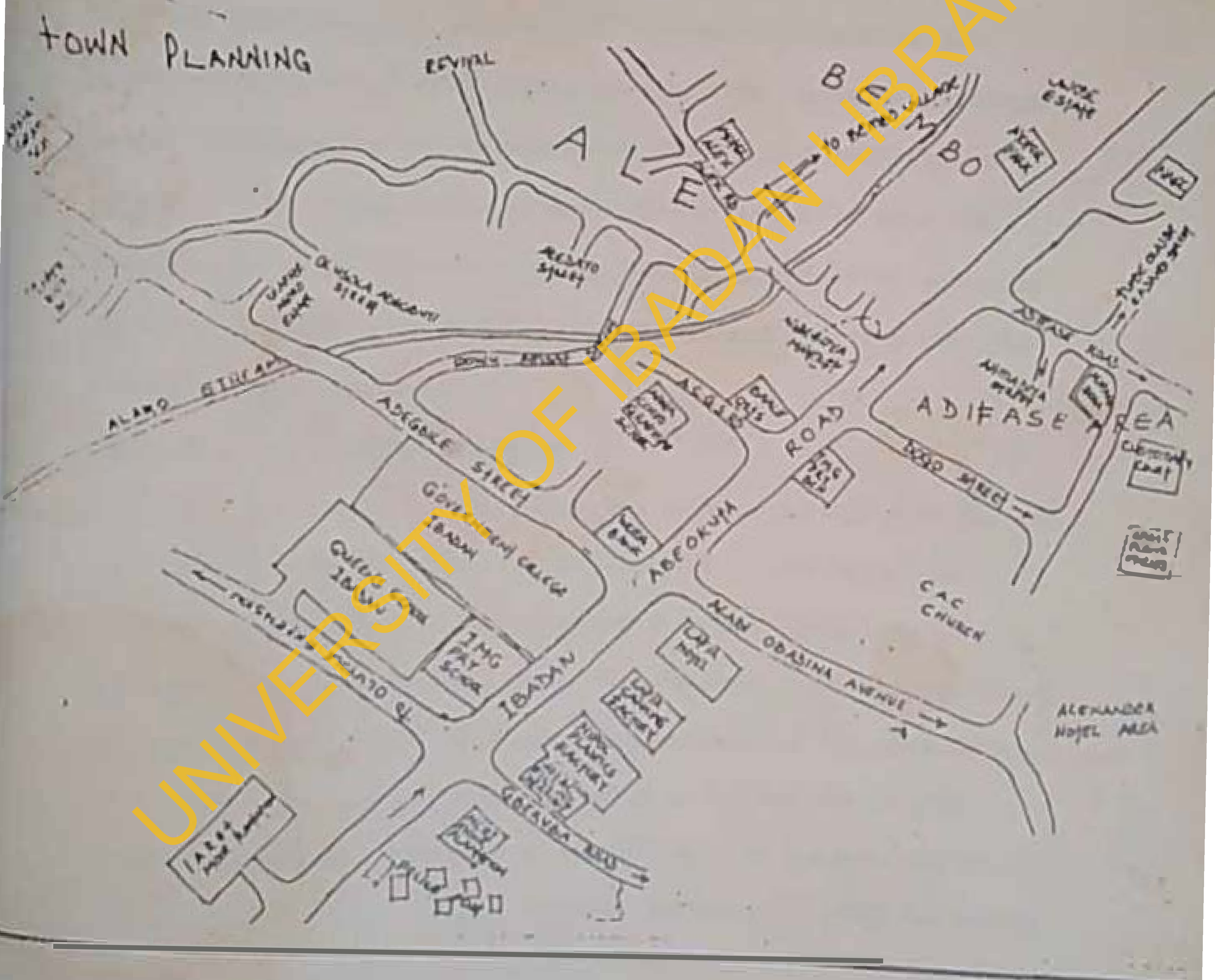
Apata was the site of the author's concurrent field practice during her Master of Public Health studies at the African Regional Health Education, University of Ibadan. Apata Ganga, as the area is formally known, is bordered on the east by the Moor Plantation agricultural research station, and in the west by the Owode low cost government housing estate. Its northern boundary is the railway line, and the Ibadan Town Planning Authority is a landmark for the southern extent of the community.

There is a major taxi/bus stop and market in the centre of the community. Being a suburban settlement, the streets in Apata are fairly well laid out, and the houses are numbered by the local government authority. Apata Ganga is a predominantly Yoruba speaking community, but a sizeable Igbo and Ebira population has settled in the area. Residents are primarily civil servants and business people working in Ibadan.

No accurate information is available on the exact number of residents in Apata, but the 1991 provisional census results indicate that the whole of Ibadan Southwest contains 274,028 residents. Preliminary house counting by the author found over 1,900 residential buildings in the community, averaging four

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT



SKETCH DRAWING OF AFARA COMMUNITY SHOWING THE MAJOR STREETS

FIGURE 1: SKETCH MAP OF STUDY AREA

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

families each. Initial investigations, with the aid of the Town Planning Authority, yielded an estimated average of six members per family. Based on this, one could determine a potential population of 45,600 for the community.

A goal of 300 families was set as an adequate sample size to test the hypotheses of this study. Systematic sampling was conducted with every sixth house chosen. The relatively orderly street arrangements in the community facilitated this type of sampling. If in the selected house there were more than one family with an adolescent child, balloting was done to select one of them. If none of the residents had an adolescent child, the next house was chosen.

Data Collection Procedures

All data required for the study were collected with the aid of a questionnaire. Prior to construction of the questionnaire, relevant literature was reviewed and informal interviews with parents from all walks of life were conducted. These two sources yielded information to help frame the content of the questions.

The first set of questions obtains information on the demographic characteristics of the family, the parents and the adolescents in that family. This is followed by questions asking whether each of the six previously outlined family life education topics was discussed between parents and adolescents, who initiated the discussion and what specifically was discussed.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Questions were largely open-ended. The study is exploratory, and therefore interviewers needed to encourage respondents to share their views on this potentially sensitive subject as fully as possible.

The final part of the instrument looks at other aspects of the process of family life communication both within the family and community. These including 1) perceived age by which family life education should begin with a child, b) opinions on the appropriateness of various sources of information (parents, teachers, the media, peers, etc.) on family life and sexuality, and c) religious and cultural issues that guide the family in communicating with their adolescents.

The questions were initially constructed in English and then translated into the Yoruba language. Back-translation into English was performed to ensure accuracy of meaning. The final questionnaire contained both the English and Yoruba versions side-by-side, since Apata is a multi-ethnic community. Interviews were conducted in the language preferred by the family.

The questionnaire was pretested in the Mokola community of Ibadan to ensure reliability and validity of the questions and the interviewing process. Ambiguous and sensitive questions were eliminated or reconstructed as appropriate. The pretesting also helped determine that 35 minutes would be needed for each interview.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Two interviewers were hired and trained. They were both mature people who could speak both English and Yoruba fluently. The use of mature adult interviewers was predicated on the need for guaranteeing comfort in the communication between them and the parents. The interviewer training consisted of a thorough reading of the questions with brief explanations on the nature and importance of each question and the study overall. The importance of approach, including proper greetings and self-introductions, was emphasized. Proper recording of responses was demonstrated. Field experience was gained through participation in the pretesting of the instrument at Mokola.

The questionnaires were administered between August and September 1991. The researcher supervised the interviewers in the field. Visits to homes took place in the evenings so that more people would be found at home. Parents were interviewed as a pair, if both were found at home. Otherwise the interview proceeded with whichever parent was available. All results were reviewed at the end of the day, and necessary corrections made before continuing the next day's set of interviews.

Analysis of Results

All questionnaires were reviewed by the researcher to learn the range of responses for each question. From this information, a coding guide was developed for both the closed (demographic) and open-ended questions. The researcher herself performed the

UNIVERSITY OF IBADAN LIBRARY

coding. She also summarized manually the frequency results for the more detailed, open-ended responses that focused on the content and reasons for family discussion about the different components of family life education.

The Epi-Info computer software programme of the U.S. Centers for Disease Control and Prevention was used to analyze the data. Association between the FLCS, the main dependent variable, and the various family demographic variables was tested using Analysis of Variance (ANOVA or F Test). The five percent level of probability was chosen as the cut-off point for determining statistical significance, although in the text the exact p values found are reported in the interest of scientific accuracy.

Limitations

Since no pre-existing map of the study community could be found, the researcher, with the assistance of a surveyor, had to sketch one. It is therefore possible that some areas of the community may have been overlooked.

The nature of the subject matter under study, i.e. human sexuality, was sensitive. The choice of mature interviewers, the emphasis on choosing a language the family was comfortable with and the process of pretesting to improve the acceptability of the questions, were major steps taken to encourage respondents to participate fully. Even with these precautions, respondents were observed to be hesitant at times.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FOUR

RESULTS

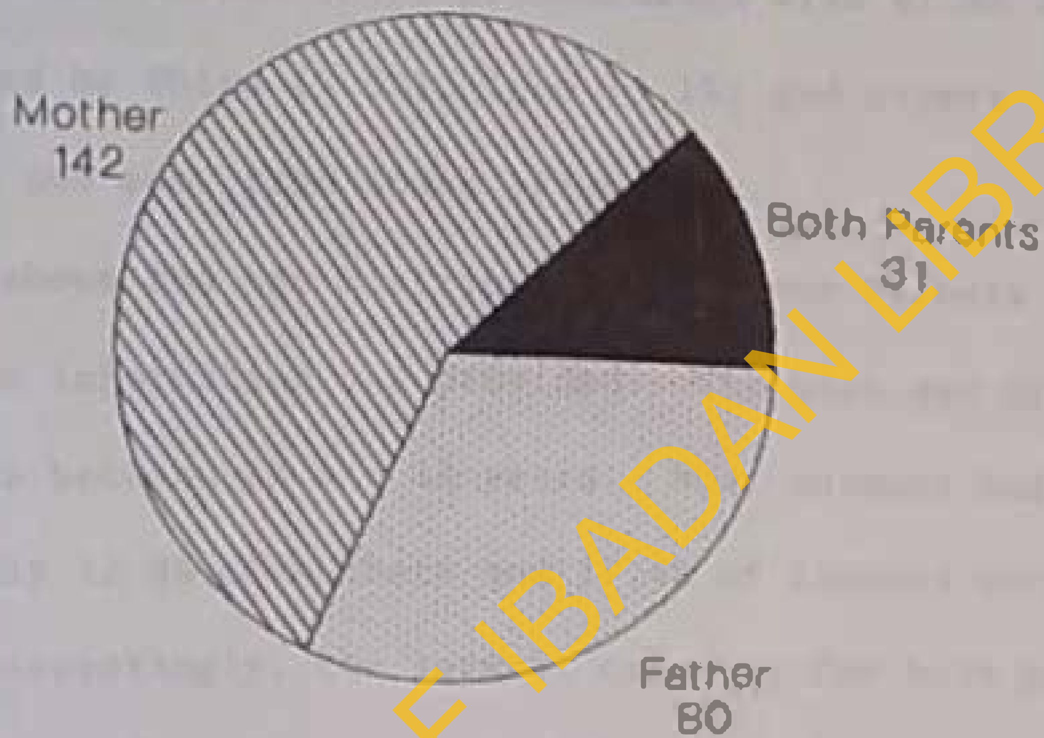
The results of the study, as presented in this chapter, are organized into three major sections. The demographic data about the families and their members are presented first. This is followed by information on the six family life education topics that comprise the Family Life Communication Score (FLCS) are discussed and factors associated with FLCS are examined. The third section presents opinions on the appropriate timing and conditions under which family life education should take place.

The target number of 300 families were visited. As noted in the previous chapter, twenty respondents refused outright to be interviewed. An additional 27 stopped responding after the demographic data were obtained. Thus 253 completed questionnaires were analyzed.

Demographic Characteristics

Whoever was present at home during the visit of the interviewer was chosen as respondent. More than half of the 253 respondents (56.1%) were mothers. Nearly one-third (31.6%) were fathers. In 12.3% of the visits both parents were home and responded together as seen in Figure 2.

UNIVERSITY OF IBADAN LIBRARY



N - 253

FIGURE 2: RESPONDENTS FOUND AT HOME

UNIVERSITY OF IBADAN LIBRARY

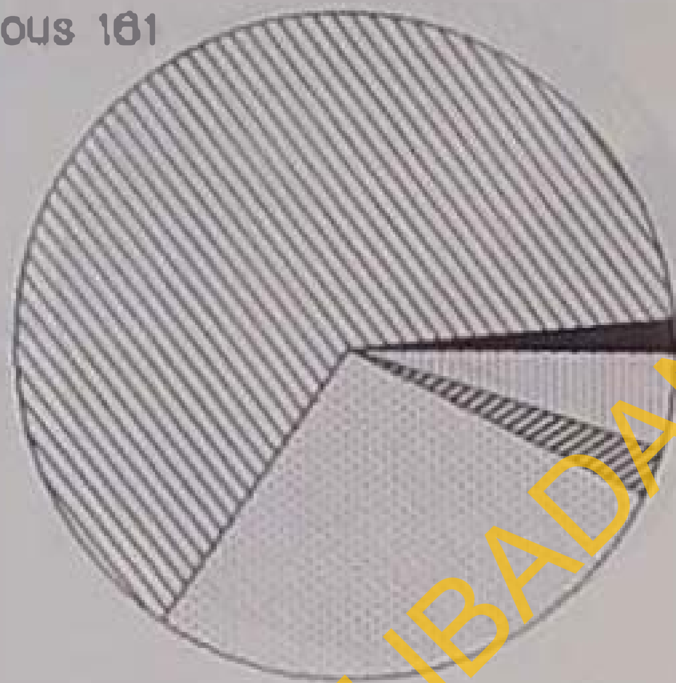
The 253 families consisted of 231 (91.3%) who were married, and of these 161 were in monogamous relationships. Among the rest were four single mothers, three widows and three widowers, seven separated or divorced women and five separated or divorced men (see Figure 3). The Yoruba tribe predominated with 82.6% of families followed by Ebira (9.5%), Igbo (5.1%) and others including Hausa and some from Ghana (Figure 4).

Figure 5 shows the age distribution of those fathers and mothers for whom information was provided. The peak age group for both parents was between 40 and 44 years. Most parents had some education as only 22.9% of mothers and 17.4% of fathers were illiterate. Interestingly, the largest category for both parents was post-secondary education, which had been received by 32.0% of mothers and 40.7% of fathers (Figure 6).

The most common occupation reported for fathers was civil servant (35.2%), and for mothers it was trader (41.1%). The reverse was true for the second most common occupation for each as seen in Figure 7. The suburban nature of the community is reflected in the fact that five mothers and 29 fathers were farmers.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

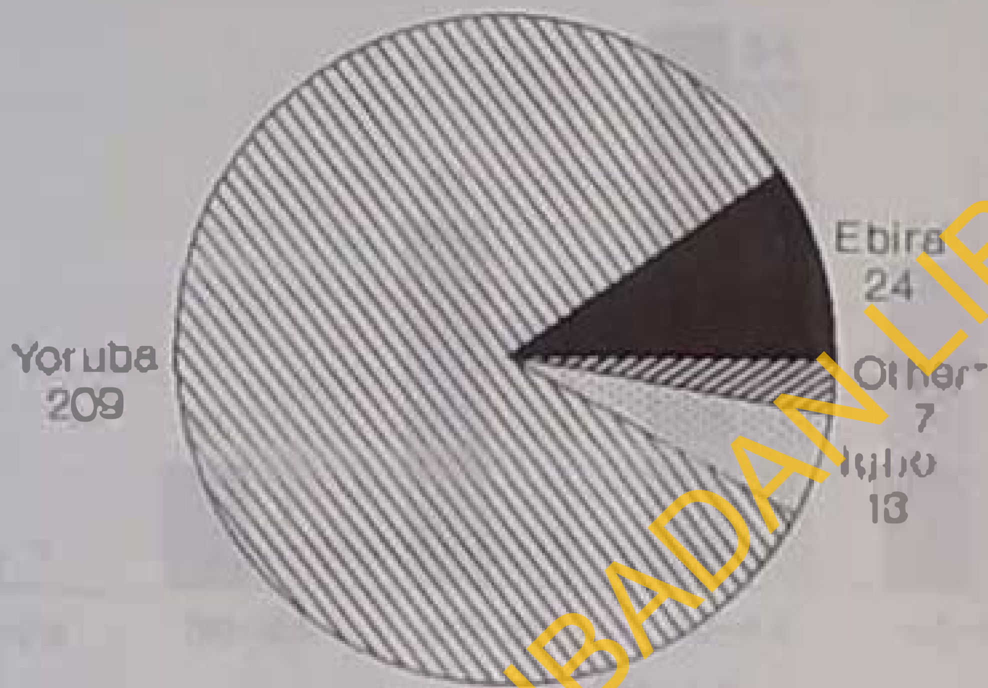


N = 253

FIGURE 3: MARITAL STATUS OF RESPONDENTS

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT



*Hausa, Ghanaian; N = 253

FIGURE 4: DISTRIBUTION OF RESPONDENTS BY TRIBE

UNIVERSITY OF IBADAN LIBRARY

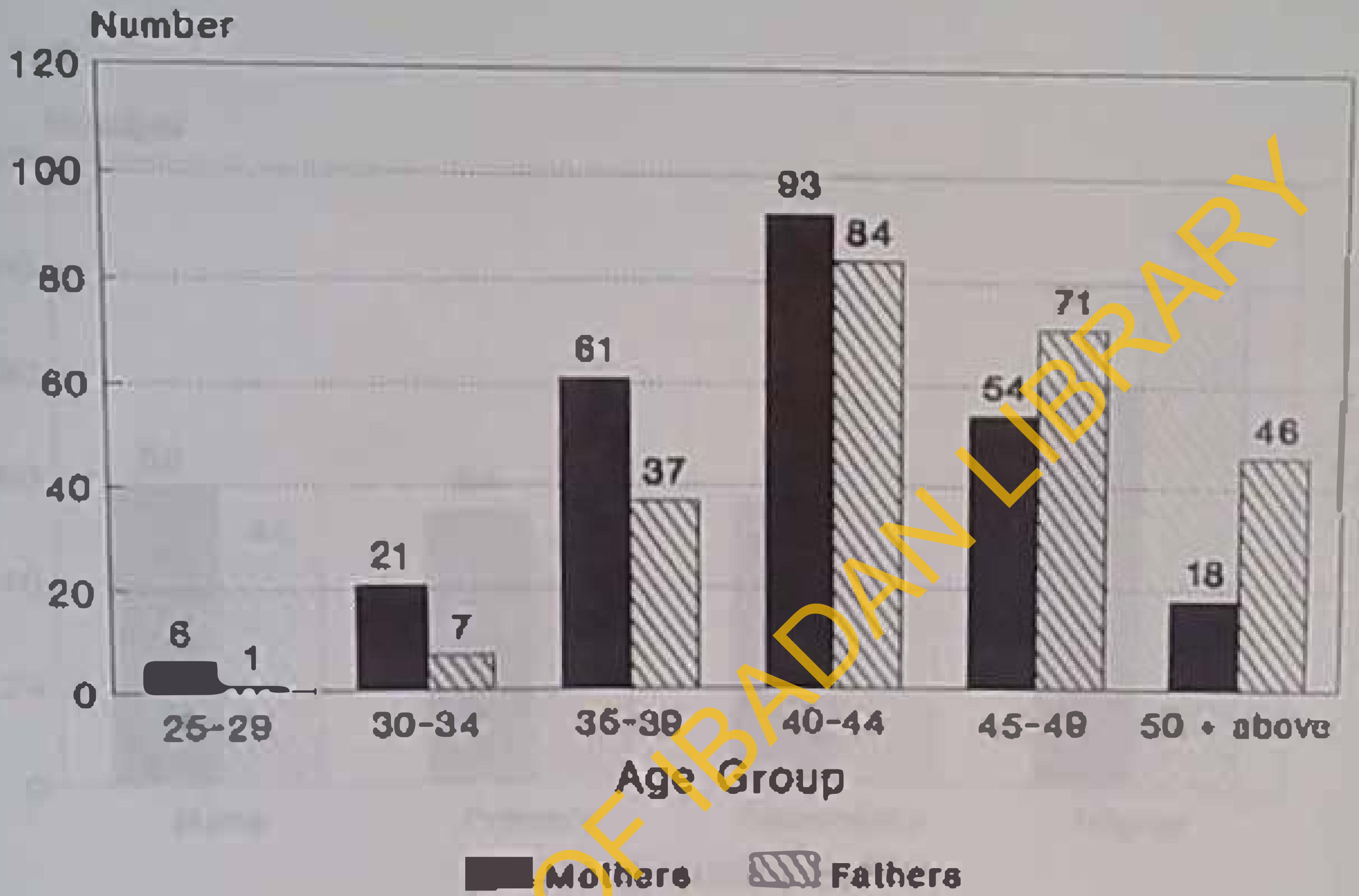
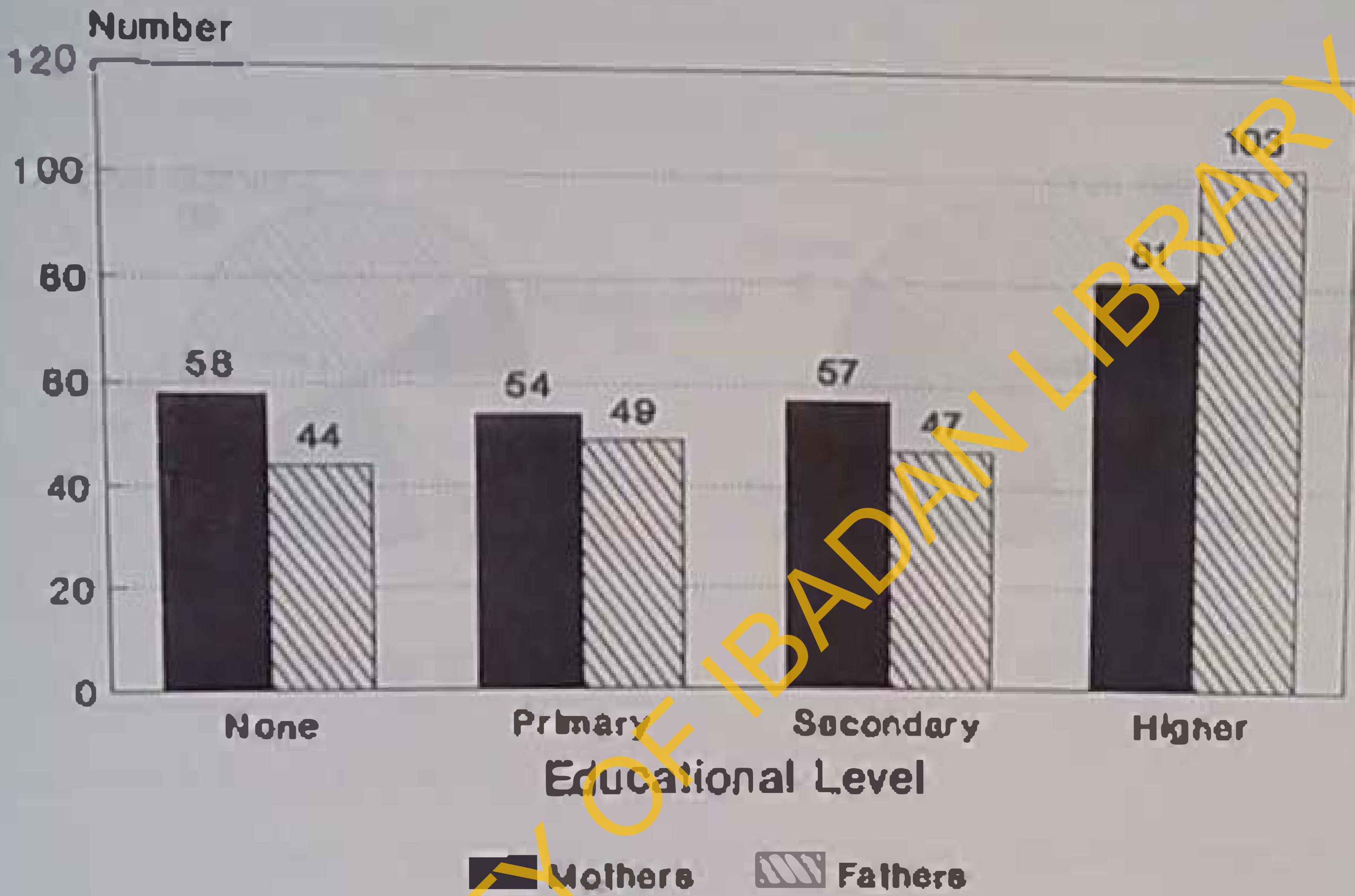


FIGURE 5: AGE DISTRIBUTION OF MOTHERS AND FATHERS

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

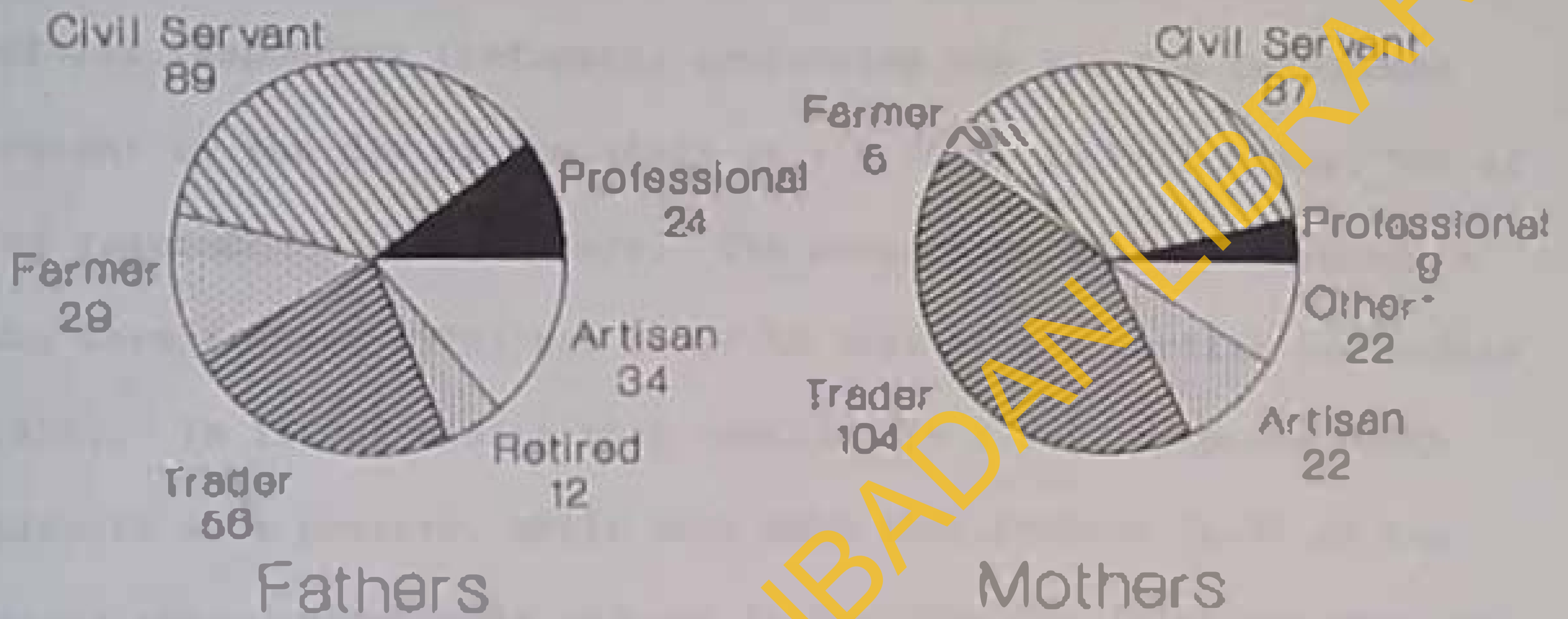


not indicated for 3 mothers & 10 fathers

FIGURE 6: EDUCATIONAL LEVEL OF MOTHERS AND FATHERS

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT



Fathers- 244, Mothers - 249
*Housewife - 20, Retired - 2

FIGURE 7: OCCUPATION OF MOTHERS AND FATHERS

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

In order to consider whether the non-responders were different from the responders, the demographic data for the 27 families who refused to answer once the family life education topics were introduced was compared with the 253 full respondents. Table 1 shows no significant difference between the full and partial responders (refusers) concerning who was the respondent present on the day of the visit ($p > 0.70$). In both cases, 56% of the respondents were mothers. The proportion of full responders who were fathers (32%) was close to that of the partial responders (37%). In 12% of visits that resulted in a full response, both parents were present, while both were also present in 7% of the cases where respondents refused to continue the interview when the family life education topics were introduced.

Similarly, the responders and 27 refusers did not differ significantly by tribe, religion and educational status (Table 1). The only point of difference was age. While 26.6% of the 253 responders were under 35 years old, all of those who refused to answer the family life communication questions were over 35 years.

FAMILY LIFE COMMUNICATION TOPICS

Six topics were included in the Family Life Communication Score (FLCS) as described earlier. Not every topic was discussed in all families as can be seen in Figure 8. Human growth and development was the topic most frequently discussed (83%) in the 253 families. The second most common subject to

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 1

COMPARISON OF RESPONDERS AND REFUSERS

	Respondent (%)	Refuser (%)	Total
FAMILY MEMBER AT HOME:[1]			
Mother	142 (56.1)	15 (55.6)	157
Father	80 (31.6)	10 (37.0)	90
Both Parents	31 (12.3)	2 (7.4)	33
TRIBE:[2]			
Yoruba	209 (82.6)	24 (92.3)	233
Other	44 (17.4)	2 (7.7)	46
RELIGION:[3]			
Islam	103 (40.9)	9 (33.3)	112
Christian	149 (59.1)	17 (66.7)	166
EDUCATION:[4]			
Illiterate	49 (19.4)	8 (29.6)	57
Primary	53 (20.9)	4 (14.8)	57
Secondary	57 (22.5)	6 (22.2)	63
Higher	94 (37.2)	9 (33.4)	103
AGE OF RESPONDENT:[5]			
Under 35	67 (26.6)	0	67
35 & Above	185 (73.4)	27 (100.0)	212
TOTAL	253	27	280

[1] $\chi^2 = 0.710$; d.f. = 2; $p > 0.70$

[2] $\chi^2_{Yates} = 0.98$, d.f. = 1, $p > 0.27$. One no response excluded.

[3] $\chi^2_{Yates} = 0.17$, d.f. = 1, $p > 0.68$. One no response excluded.

[4] $\chi^2 = 1.81$, D.F. = 3, $P > 0.61$

[5] $\chi^2_{Yates} = 8.05$, d.f. = 1, $p < 0.005$. One no response excluded.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

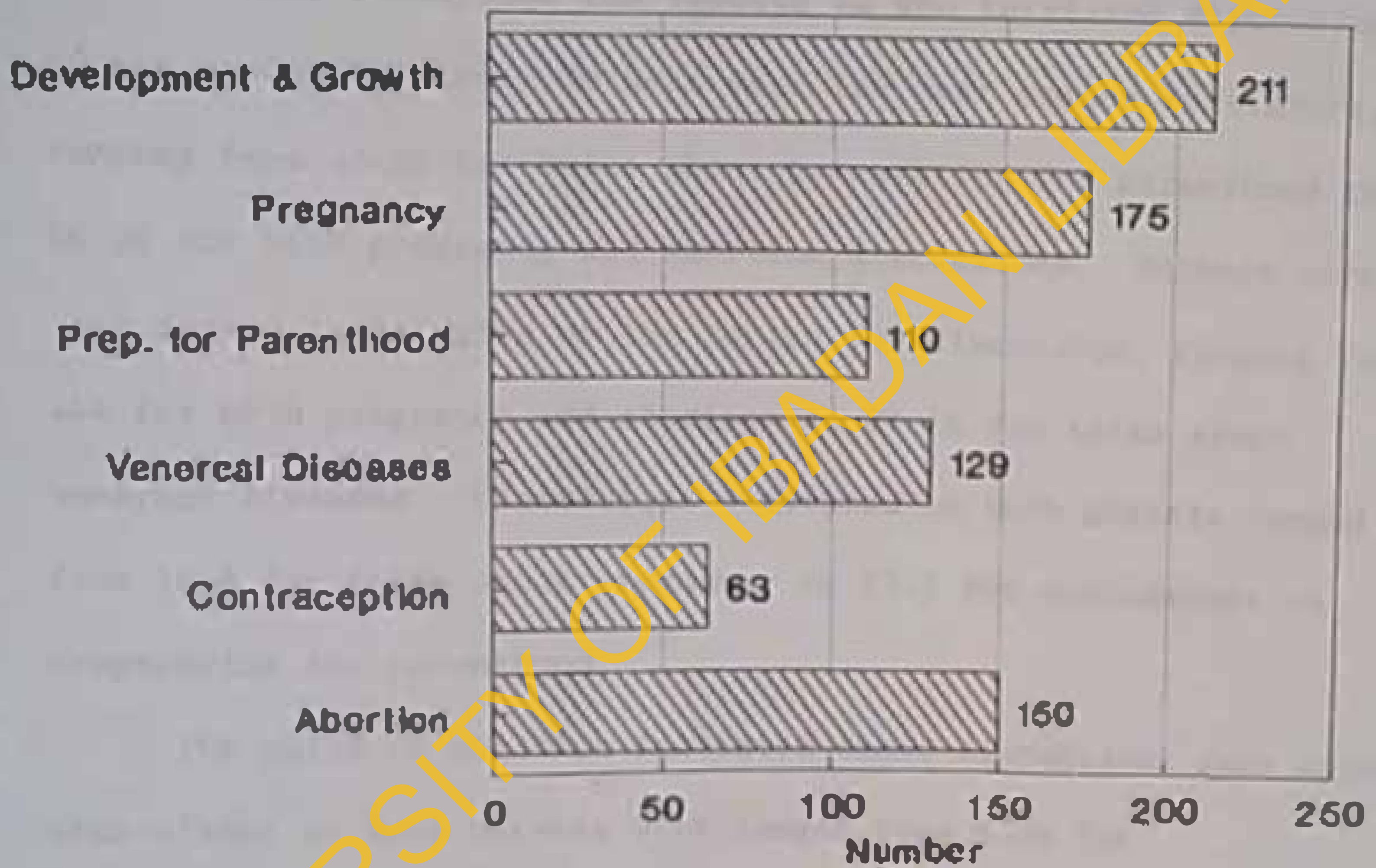


FIGURE 8: FAMILY LIFE EDUCATION TOPICS DISCUSSED

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

be discussed was pregnancy (69%). Abortion ranked third, with 59% of families having discussed that issue. Venereal diseases were discussed in 51% of families, and preparation for parenthood was discussed by 44%. The least discussed topic was contraceptives where only 25% of families raised the issue.

Table 2 summarises the reports on who initiated discussion on the various topics. Mothers were the most common initiators, ranging from 45.5% for talks about preparation for parenthood to 56.0% for both pregnancy and abortion discussions. Fathers were less active in bringing up the topics for discussion, ranging from 16% for both pregnancy and abortion to 27.1% for talks about venereal diseases. Discussions initiated by both parents ranged from 16.6 for talks about pregnancy to 22.7 for discussions on preparation for parenthood.

The child in question initiated these discussions less often than either or both parents with ranges from 8.0% for conversations about abortion to 19% for discussions about contraceptives. In only a few cases did the stimulus for conversation come from outside the family, e.g. teachers.

Open-ended questions sought details on the issues parents discussed about each topic, or reasons why the topic had not been discussed. The major points are summarised next. The most common issue discussed concerning development and growth was changes that occur in the body during adolescence such as menstruation,

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 2

INITIATORS OF DISCUSSIONS ON THE VARIOUS FAMILY LIFE EDUCATION TOPICS

Initiator	TOPICS (%)					
	Development & Growth	Pregnancy	Preparation for Parenthood	Venereal Diseases	Contraceptives	Abortion
Both Parents	19.0	16.6	22.7	17.8	19.0	18.0
Father	22.7	16.0	20.9	27.1	14.3	16.0
Mother	46.9	56.0	45.5	45.7	46.0	56.0
Child	10.9	10.3	10.0	8.5	19.0	8.0
Others*	0.5	1.1	0.9	0.8	1.6	2.0
Number who Discussed the Topic	211	175	110	129	63	150

*e.g. teachers

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

deepening of the voice in boys, and growth of pubic, axillae and chest hair. Others discussed the role of food and nutrition in growth, care of the body and personal hygiene. When asked why they discussed the topic, a few said the issue arose from questions by the children like why does daddy have a beard.

The main reason given for not discussing growth and development issues was that those parents did not know what to discuss. In fact, one parent said that it was the questionnaire that made him realise the importance of such discussions.

The most common topic discussed concerning pregnancy was causes and outcomes. In particular, parents stressed that it was dangerous to get pregnant (or make someone pregnant) when one is still young. Parents warned their children not to have relations with the opposite sex so as to avoid teenage pregnancy. The main reason why these discussions took place was to guide the children and to prevent unwanted pregnancies. Some said that the onset of features like menses made them initiate the discussion.

The main reason for not discussing pregnancy is that those parents thought the children were still too young for such discussion since they were not yet married. One parent said there was no time for these discussions.

Preparation for parenthood, as seen above was discussed by fewer parents. The main issue raised was the need to study hard, get a good job and allow God to control their lives so that they

UNIVERSITY OF IBADAN LIBRARY

would be ready to raise their own children. A few said that involvement of their adolescent children in the care of their younger siblings was a way to prepare them for parenthood.

The main reason for not discussing this topic was that some parents believed their children could not understand and/or were not mature enough yet. A few said they did not know what to discuss about this topic.

Those who discussed venereal diseases with their adolescents mentioned the cause and outcome with particular emphasis on the avoidance of indiscriminate sexual intercourse which could lead to infertility or even killer diseases like AIDS. Others emphasised the need to avoid immoral behaviours and to keep to one sexual partner. The types of diseases and the need for prompt medical treatment were discussed by a few.

These discussions were prompted by parental desires to prevent their children from becoming infected and becoming infertile. The main reason for not talking about venereal diseases was that some parents said they had not thought about it, i.e. that it had not occurred to them to do so. Again a fair number said they did not know what to discuss, while a few were satisfied that their children would have heard about this topic on radio, television or in school.

When parents talked with their children about contraceptives, they did indicate that these were meant for child

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

spacing and prevention of unwanted pregnancies, but they added that contraceptives were meant to be used by married people only. Some talked about the advantages and disadvantages of contraceptives. A few told the child to seek medical advice before using contraceptives. These discussions were often prompted by parental desires that children not misuse the drugs to the extent of causing infertility in the future. A few were stimulated to talk about contraceptives after seeing a condom advertisement on the electronic media.

The major reason for not discussing this topic was fear of corrupting the children by exposing them to the idea. As before, another common reason was not knowing what to say. Two said that the children were already knowledgeable, so there was no need for parents to discuss this topic with them.

The main focus on discussion about abortions was that it is akin to murder and that it is sinful and punishable by God. A few discussed the possible outcomes of induced abortion. Most brought up the topic to prevent the problem.

Reasons for not discussing abortion included the perception that the child was still too young. A few said there was no need to discuss this issue, because their children were brought up well and would never do such a thing. One thought that mere discussion about this issue would corrupt the child. This was the only topic where no parent said he/she did not know what to talk about.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

FAMILY LIFE COMMUNICATION SCORES

As described in Chapter Three, the FLCS serves as an indicator of the communication level about family life matters in the home. The potential score could range from 0-12 points based on a maximum of two points for each of six family life topics. No points were given if an item was not discussed. One point was awarded if the topic had been discussed, but conversation had not been initiated by the parents. Finally two points were scored when parents raised and discussed an issue with their adolescent.

Actual scores did range from 0-12, with a mean of 6.2 points. Figure 9 shows a major peak in the 7-8 point range (19.3%), with zero points receiving the lowest frequency (8.7%). The latter had discussed none of the topics. On average only two different topics were discussed at all among the families surveyed. Only 15.8% of families reported discussing all six topics.

Analysis was undertaken to determine associations between family characteristics and the FLCS. Table 3 shows that father's age was significantly associated with the FLCS with the highest mean score (7.8) occurring in families with the oldest fathers (60 years and above). Families with fathers in the next youngest age set had the lowest average score (4.9). No clear pattern emerges in mean scores compared to mothers' ages (Table 4), and the differences were not significant.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

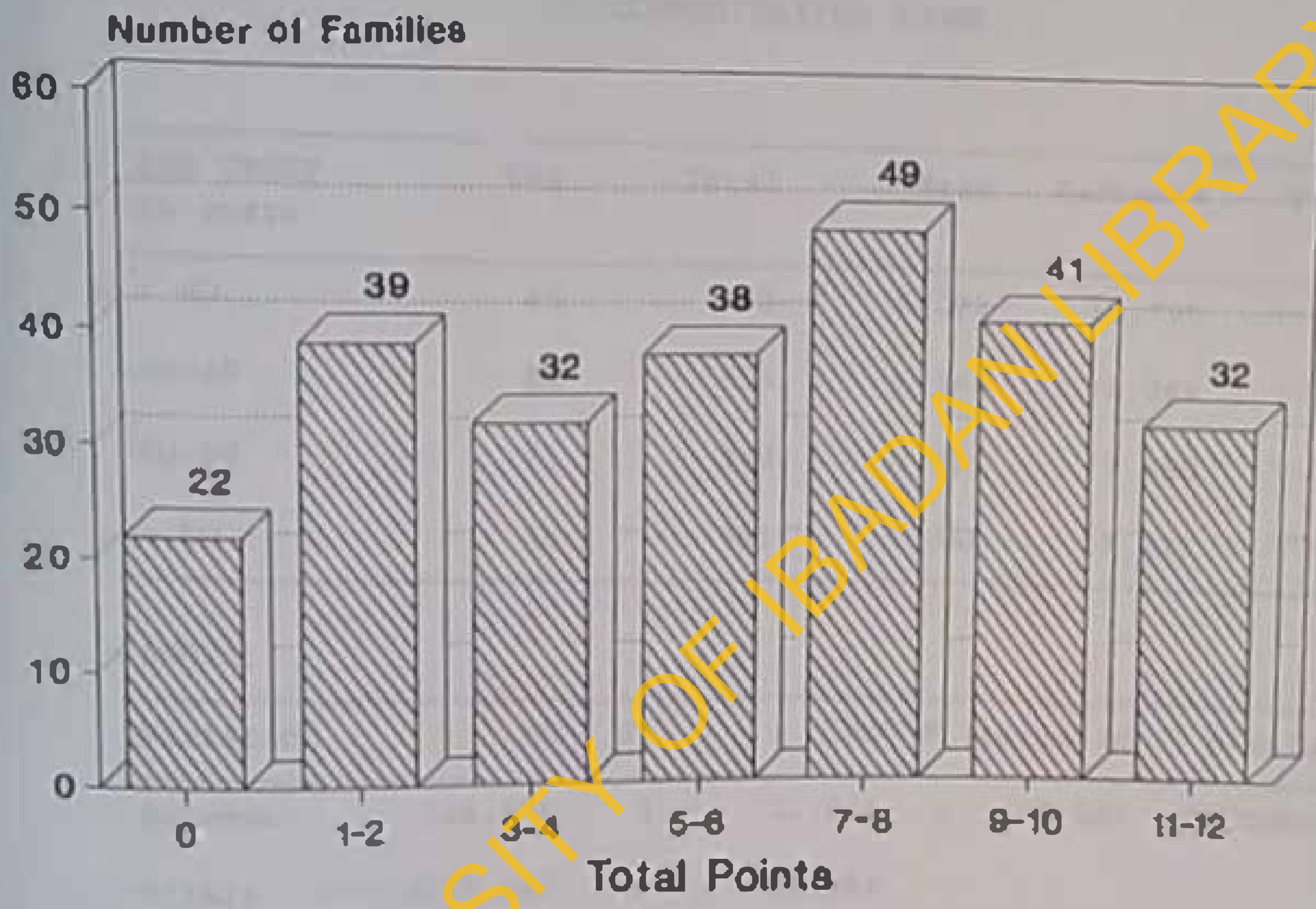


FIGURE 9: DISTRIBUTION OF FAMILY LIFE COMMUNICATION SCORES

UNIVERSITY OF IBADAN LIBRARY

TABLE 3

COMPARISON OF FATHERS' AGES AND FAMILY LIFE COMMUNICATION SCORE

AGE GROUP in years	Obs	Total	Mean	Variance	Std Dev
< 40	45	271	6.022	16.795	4.098
40-49	84	535	6.369	14.284	3.779
50-59	71	349	4.915	9.450	3.074
≥ 60	46	361	7.848	11.821	3.438

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	245.531	3	81.844	6.352	0.000618
Within	3117.965	242	12.884		
Total	3363.496	245			

UNIVERSITY OF IBADAN LIBRARY

TABLE 4

COMPARISON OF MOTHERS' AGES AND FAMILY LIFE COMMUNICATION SCORE

AGE GROUP in years	Obs	Total	Mean	Variance	Std Dev
< 30	21	125	5.952	14.648	3.827
30-39	61	376	6.164	15.839	3.980
40-49	93	543	5.839	12.767	3.573
≥ 50	72	497	6.903	12.314	3.509

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	48.694	3	16.231	1.198	0.310679
Within	3292.213	243	13.548		
Total	3340.907	246			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Family religion was compared with FLCS in Table 5. The 149 Christians had a slightly higher mean score (6.4) than the 103 Moslems (6.0), but the difference was not significant. One family that professed an indigenous religion was not included in the analysis. Although a lower mean FLCS was found for polygamous families (5.9) compared to either single parent (6.3) or monogamous homes (6.4), these differences were also not significant (Table 6).

FLCS rose steadily with fathers' education. The lowest mean score (4.9) was recorded where fathers had no formal education. It increased from primary education (5.4) to secondary (7.1), and then dropped slightly among those with post-secondary education (6.6). Table 7 shows that there is a significant association between FLCS and fathers' education.

The pattern with FLCS and mothers' education was similar, rising from a mean of 5.2 in families where the mother had no formal education to 6.2 for primary and 7.0 for secondary. Again, as seen in Table 8, there is a slight drop to 6.4 for homes where the mother had post-secondary education. The association in this case showed only borderline significance (p = 0.052)

Although Yoruba families scored a higher mean FLCS of 6.4, Table 9 shows that this was not significantly different from the mean score of 5.6 among families of other tribes.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 5

COMPARISON OF FAMILIES' RELIGION* AND FAMILY LIFE COMMUNICATION SCORE

RELIGION	Obs	Total	Mean	Variance	Std Dev
Moslem	103	619	6.010	12.108	3.480
Christian	149	952	6.389	14.753	3.841
Difference			-0.380		

ANOVA: The p value is equivalent to that for the Student's T Test, since there are only 2 samples.

Variation	SS	df	MS	F statistic	p-value
Between	8.773	1	8.773	0.642	0.570416
Within	3418.413	250	13.674		
Total	3427.187	251			

*one with indigenous religion not included in analysis

TABLE 6

COMPARISON OF TYPE OF FAMILY AND

FAMILY LIFE COMMUNICATION SCORE

FAMILY TYPE	Obs	Total	Mean	Variance	Std Dev
Monogamous	161	1029	6.391	14.040	3.747
Polygamous	70	412	5.886	13.842	3.720
Single Parent	22	138	6.273	10.303	3.210

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	12.495	2	6.248	0.457	0.639658
Within	3417.797	250	13.671		
Total	3430.292	252			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 7

COMPARISON OF FATHERS' EDUCATION

AND FAMILY LIFE COMMUNICATION SCORE

FATHERS' EDUCATION LEVEL	Obs	Total	Mean	Variance	Std Dev
None	44	215	4.886	12.289	3.506
Primary	49	263	5.367	13.654	3.695
Secondary	47	334	7.106	13.662	3.696
Post Secondary	103	682	6.621	13.512	3.676

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	166.146	3	55.382	4.149	0.007114
Within	3190.521	239	13.349		
Total	3356.667	242			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 8

COMPARISON OF MOTHERS' EDUCATION AND FAMILY LIFE COMMUNICATION SCORE

MOTHERS' EDUCATION LEVEL	Obs	Total	Mean	Variance	Std Dev
None	58	300	5.172	12.496	3.535
Primary	54	336	6.222	13.723	3.704
Secondary	57	400	7.018	14.303	3.782
Post Secondary	81	523	6.457	13.351	3.654

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	104.386	3	34.795	2.587	0.052578
Within	3308.690	246	13.450		
Total	3413.076	249			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 9

COMPARISON OF TRIBE AND FAMILY LIFE

COMMUNICATION SCORE

TRIBE	Obs	Total	Mean	Variance	Std Dev
Yoruba	209	1332	6.373	13.850	3.722
Others*	44	247	5.614	12.289	3.506
Difference			0.759		

ANOVA: The p value is equivalent to that for the Student's T Test, since there are only 2 samples.

Variation	SS	df	MS	F statistic	p-value
Between	20.971	1	20.971	1.544	0.212613
Within	3409.322	251	13.583		
Total	3430.292	252			

*Igbo, Ebira

UNIVERSITY OF IBADAN LIBRARY

Table 10 compares fathers' occupations and the FLCS. Families where the fathers were artisans and farmers had the lowest mean scores (4.8 and 5.1 respectively). The middle range of mean scores was occupied by traders (5.7), professionals (6.5) and civil servants (6.6). The highest mean score was obtained by the smallest group, the families of retired people (10.2). These differences were significant.

The range of mean scores according to mothers' occupations was not as wide. Where the mother was a civil servant, the mean was highest (6.7). The lowest average of 5.0 was obtained by a small group of others including farmers, professionals and retired persons. Table 11 shows that these differences were not significant.

OPINIONS ON FAMILY LIFE EDUCATION PROCESSES

The interview contained several opinion questions about the family life education process. Table 12 shows whom respondents thought make the best family life educators. Mothers top the list (54..2%), followed by both parents (20.5%). Health workers come third (11.2%). Fathers and religious leaders were mentioned by 5.5% each. Only five people (2.0%) mentioned teachers. Two people listed all of the above, while one person did not respond.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 10

COMPARISON OF FATHERS' OCCUPATION

AND FAMILY LIFE COMMUNICATION SCORE

FATHERS' OCCUPATION	Obs	Total	Mean	Variance	Std Dev
Civil Servant	89	591	6.640	13.847	3.721
Trader	56	320	5.714	11.481	3.388
Professional	24	157	6.542	14.868	3.856
Farmer	29	147	5.069	14.067	3.751
Retired	12	123	10.250	2.205	1.485
Artisan	34	164	4.824	12.695	3.563

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	331.147	5	66.229	5.204	0.000307
Within	3028.935	238	12.727		
Total	3360.082	243			

UNIVERSITY OF IBADAN LIBRARY

TABLE 11

COMPARISON OF MOTHERS' OCCUPATION AND FAMILY LIFE COMMUNICATION SCORE

MOTHERS' OCCUPATION	Obs	Total	Mean	Variance	Std Dev
Civil Servant	87	578	6.644	14.209	3.769
Trader	104	644	6.192	13.089	3.618
Housewife	20	120	6.000	10.947	3.309
Artisan	22	127	5.773	16.470	4.058
Other	16	80	5.000	15.333	3.916

ANOVA:

Variation	SS	df	MS	F statistic	p-value
Between	44.880	4	11.220	0.816	0.517866
Within	3353.972	244	13.746		
Total	3398.851	248			

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 12

OPINIONS ON WHO MAKES THE BEST FAMILY LIFE EDUCATORS

Best Educator	Frequency	Percent
Mothers	137	54.2
Both Parents	52	20.5
Health Workers	28	11.1
Fathers	14	5.5
Religious Leaders	14	5.5
School Teachers	5	2.0
All of the Above	2	0.7
No Response	1	0.4
Number	253	

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Reasons were elicited for the choice in best family life educator. Those who picked mothers said that children always feel free to discuss with their mothers, and that they feel closer to their mothers. Those mentioning fathers did so because they believe fathers are firm with their children. Some who mentioned both parents did so in the belief that fathers should educate sons and mothers teach daughters, while others said the collective effort of both parents is necessary to reinforce learning and values.

Those who suggested religious leaders did so because they thought these people could transmit valuable lessons from the holy books. The few who mentioned school teachers did so because they thought schools are a good source of education. Health workers were suggested because of their relevant scientific knowledge.

In the sections above, one of the reasons given why parents had not discussed a particular family life education topic with their child was that the child was not mature enough. The question was posed directly concerning how old a child should be to begin these discussions. Figure 10 shows that most parents would begin family life education when the child reaches somewhere between 11 and 16 years, with a peak in the 11-13 age group (35.6). A few (6.7%) would start at 10 years or younger, while a few would delay until the child reached 20 (7.5%). Only one person gave no response.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

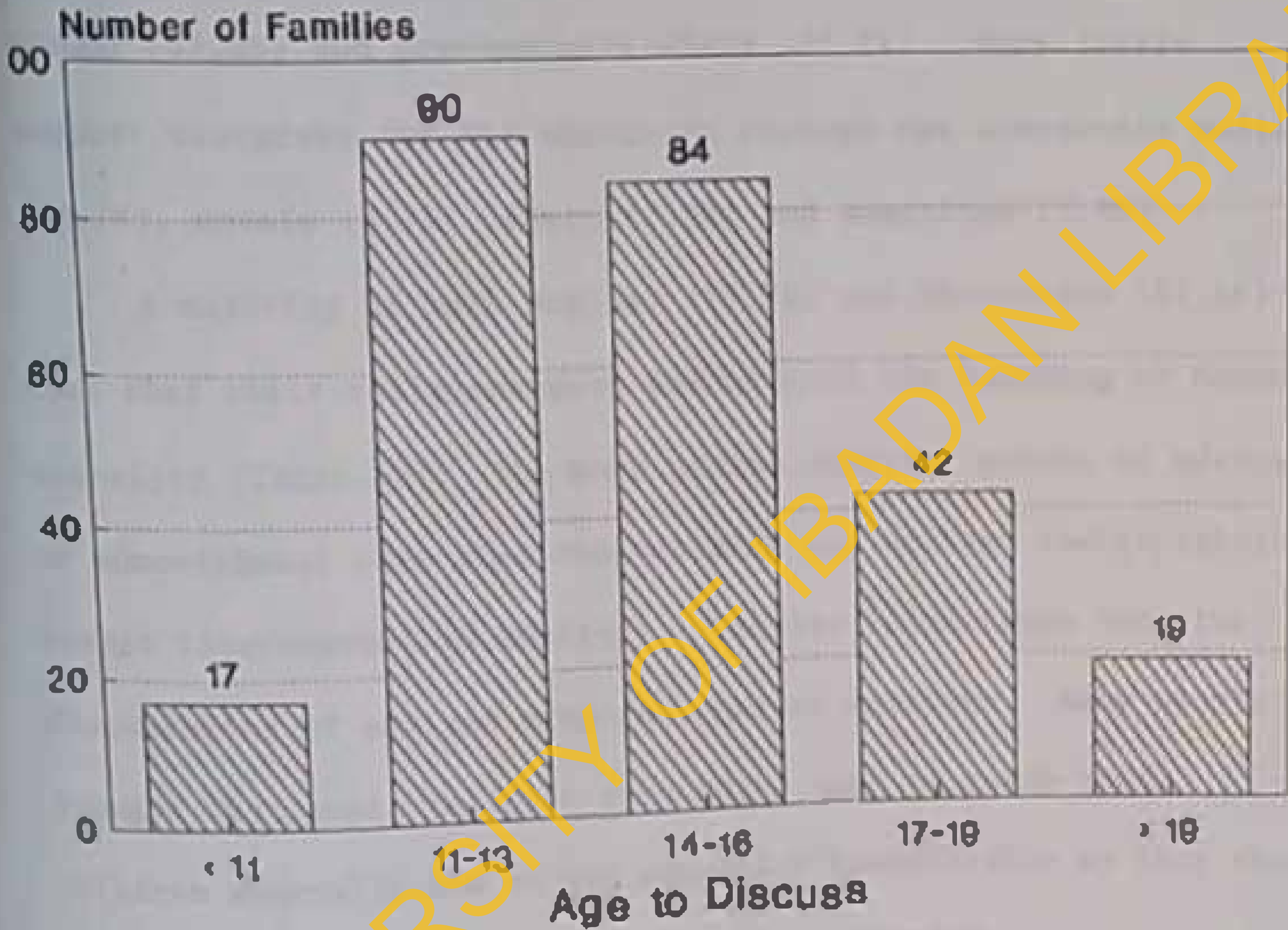


FIGURE 10: AGE PARENTS BELIEVE CHILDREN ARE MATURE ENOUGH TO BEGIN FAMILY LIFE EDUCATION

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Respondents were asked to indicate the sources of sex education for adolescents that they considered to be good. Seven potential sources were posed. Figure 11 shows that parents received the highest positive vote (79.4%). Schools were rated second (43.5%) and grandparents third (25.7%). Very little support was given for sex education through the electronic media (10.7%), novels (4.7%), peers (4.3%) and magazines (2.8%).

A majority of both Moslems (77.7%) and Christians (82.4%) felt that their religions gave guidance on the teaching of human sexuality (Table 13). The most common specific pieces of advice or admonishment were that the religion was against indiscriminate sexual intercourse and adultery. Similar injunctions were the discouraging of sex and pregnancy before marriage. Many people thought that their religion encouraged them to teach their children generally and on sex education specifically so that they will grow up to be good and God fearing citizens.

Finally parents were asked to comment on any particular rites in their culture that related to adolescents and sexuality. Table 14 shows that only 12.2% thought there were such rites. Most (80.2%) said no, while six said that they did not know, and thirteen did not respond. Although a higher proportion of Yoruba households mentioned such rites (13.8%) than did others (4.5%) the difference was not significant.

UNIVERSITY OF IBADAN LIBRARY

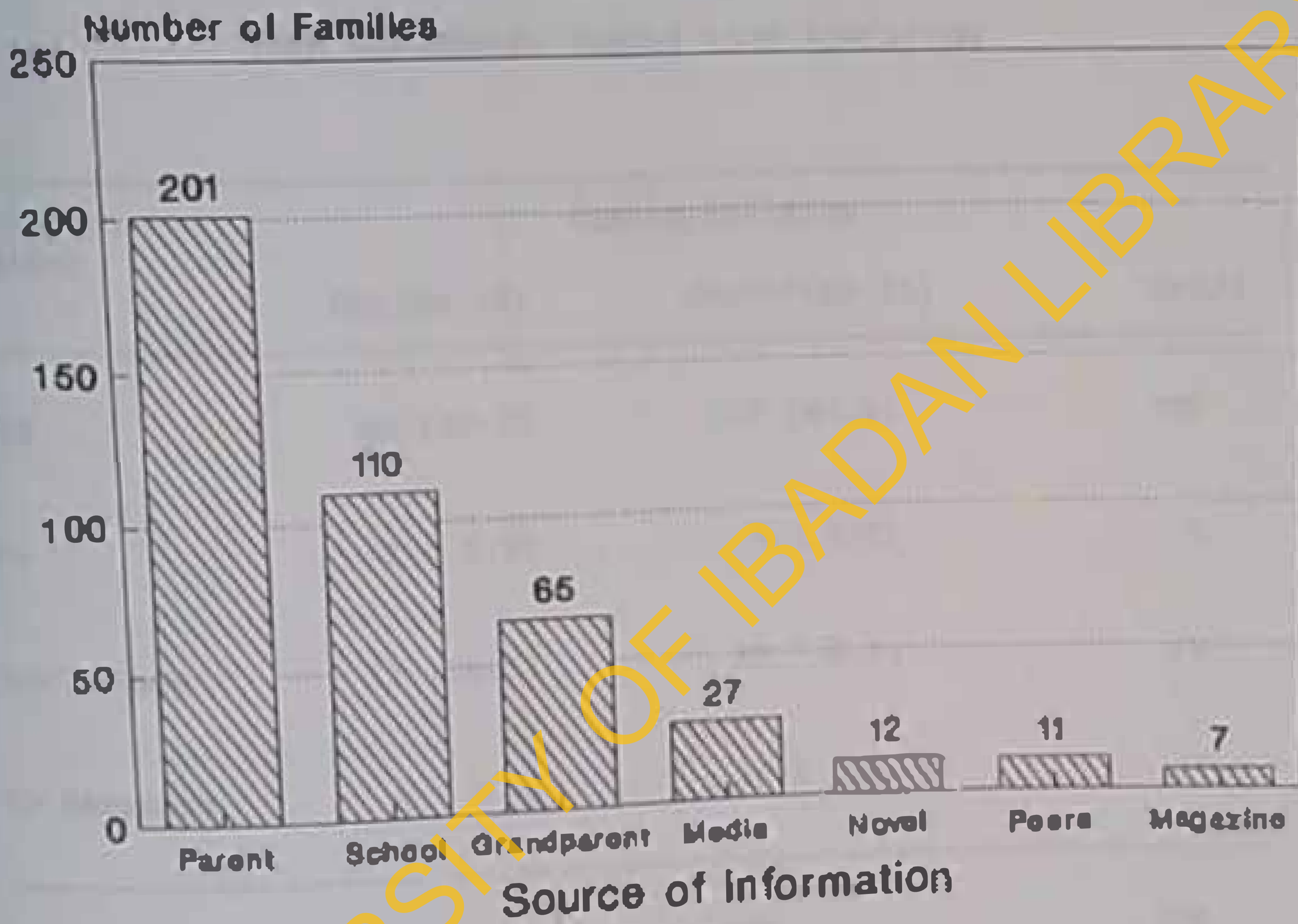


FIGURE 11: PERCEIVED GOOD SOURSES OF FAMILY LIFE EDUCATION

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 13

PARENTS' PERCEPTION THAT THEIR RELIGION GUIDES THEM CONCERNING FAMILY LIFE EDUCATION

Religion Guides	Family Religion		
	Moslem (%)	Christian (%)	Total
YES	80 (77.7)	122 (82.4)	202
NO	2 (1.9)	4 (2.7)	6
Don't Know	17 (16.5)	12 (8.1)	29
No Response	4 (3.9)	10 (6.8)	14
Total	103	148	253

$X^2_{Yates} = 0.60$, d.f. = 1, $p > 0.43$
(Comparing Yes versus other responses)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

TABLE 14

PRESENCE OF CULTURAL RITES CONCERNING ADOLESCENT SEXUALITY

Rites Exist	Tribe		
	Yoruba (%)	Others (%)	Total
YES	29 (13.8)	2 (4.6)	31
NO	171 (81.8)	32 (72.7)	203
Don't Know	2 (1.0)	4 (9.1)	6
No Response	7 (3.4)	6 (13.6)	13
Total	209	44	253

$X^2_{Yates} = 2.14$, d.f. = 1, p > 0.14
(Comparing Yes versus other responses)

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

CHAPTER FIVE

DISCUSSION

Family life education does take place in the homes of Apata community in Ibadan. This study has shown that the range of topics discussed, on average, is somewhat limited. The actual communication contains a strong moral or value component. As noted in previous studies, parents in Apata also often feel less than knowledgeable when it comes to dispensing factual information about sexuality and family life [Charthon, 1973; Block, 1974; Halc and Philliber, 1978; Ajala, 1983; Udoh, 1983; Liskin, 1985; Asuzu et al, 1989].

The situation in Apata also conforms to other findings that mothers are the primary source of home-based education on sexual matters [Gebhard, 1963; Hogan, 1985]. In practical terms, the interviewers were more likely to find mothers at home in the late afternoons and evenings (i.e. in 88% of homes). Furthermore, Table 2 showed that for all six family life education topics, mothers were mentioned by the largest number of respondents as the person who actually initiated discussion. This is reconfirmed in Table 12 when a majority of respondents said that the mother makes the best family life educator.

Concerning the latter point, very few respondents suggested

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

teachers as "best" family life educators, or for that matter, and person outside the home. It is not uncommon that parents should feel that "outsiders" should not be involved as they may convey sexual values and information that is not compatible with the family's values and beliefs [Hale and Philliber, 1978; Harris et al, 1983]. There is the irony, found in other studies, that while Apata residents believe parents are the best family life educators, they ultimately see the school as a good source of information (Figure 11). This may relate to their own fears that they may not know what to teach their children or are embarrassed to talk about the issues [Hunt, 1976; Harris et al, 1983; Hogan, 1985; Liskin, 1985].

The role of fathers in family life education appears, from these findings, to be influenced by his education and occupation. Families with retired fathers had the highest mean score, implying that possibly these fathers had more time to communicate with their children. Higher education levels of fathers were also associated with a higher mean FLCS. Such fathers may not only be more knowledgeable, but also more open to communicating with their children about potentially sensitive matters. The link between education and occupation is evident as civil servants and Professionals also had higher mean FLCS than farmers and artisans.

The association between fathers' age and FLCS may be explained in two ways. Older fathers, as noted above with retired

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

fathers, may have more time at home to communicate with their children. The younger fathers may tend to be better educated. Overall, though, it would appear that fathers' education may be the most important of these factors.

Of all the six family life issues presented in the Questionnaire, contraceptives received the least attention during discussions at home between parents and adolescents. It is important to examine this topic along with parents' concerns about pregnancy, abortion and sexually transmitted diseases. Apata parents for the most part did not discuss contraception because they believe it is an issue for married couples only. They may assume that the issue will not arise if children heed their admonishments to avoid "indiscriminate" sex and thus prevent pregnancy.

Another theme may be running through their minds. A major reason for concern about abortion and sexually transmitted diseases is fear that these may lead to infertility. They also have said that abortion kills foetuses. Thus there is a pro-natalist attitude generally among the parents, and contraceptive use would be antithetical to this view.

Under the topic, preparation for parenthood, most of the issues raised were actually advice such as "study hard," or "get a good job," in order to support a family in future. Important issues such as relations between spouses and care and guidance of

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

their own children were not addressed directly. A few even thought that there was no point in talking about these issues until near time of marriage. This area needs strengthening in home-based family life education, and demonstrates the concern of many that they do not know what to talk about.

It was interesting though that some parents felt that allowing older children to take care of their younger siblings, they were providing a sort of apprenticeship for parenting. With increased urbanisation pulling families in different directions, the opportunities for such practical learning are decreasing [Liskin, 1985, Asuzu et al 1989].

A common reason for not discussiog family life topics with children was immaturity. Figure 10 shows that many parents would wait to talk about these subjects until the child was in his or her late teenage years or even later. This contrasts to the recommendation of Ajala [1987] who believes that, at minimum, discussion of the physiological aspects of human development and reproduction should begin by the age of 11 years, when changes of puberty raise many questions in the child's mind.

Again, this reluctance to begin discussion at an early age may be attributed to feelings of inadequacy to present the facts and embarrassment, as documented in other studies [Halo and Philliber, 1978; Barrott, 1979; Harris et al, 1983; and Hogan, 1985]. This is unfortunate because during the delay, children are

UNIVERSITY OF IBADAN LIBRARY

bound to learn many ideas from peers and print media, sources which the parents of Apata agree in large majority, are inappropriate for the purposes of family life education.

Parents in this community ascribed much significance to their religion (Islam and Christianity) in guiding family life education, but underplayed any cultural rites that may have traditionally played a role in the transition from childhood to adulthood. This is in keeping with the modernisation and urbanisation processes going on in this large community (Liskin, 1985, Aauzu et al 1989). Neither family religion or tribe showed a significant association with FLCS. The two common modern religions share similar values concerning adolescent or pre-marital sexual behaviour. This combined with the fact that members of the sample are relatively highly educated, points to reasons why tribal issues may have fallen into the background.

CONCLUSIONS

This exploratory study has documented that parents in a peri-urban community of Ibadan, the capital of Oyo State, Nigeria, do initiate family life education with their adolescent children in their homes. On average, only three of six potential topics is discussed, and much of the content of discussion is moral rather than informative. Mothers are not only viewed as the best family life educator, but in reality were found to have initiated

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

discussions with their children more often than anyone else.

This strong maternal influence may be responsible for the fact that no maternal demographic characteristics were found to influence significantly the mean family life communication score. In contrast, fathers' education, age and occupation were associated with mean FLCS. Older and retired fathers who spend more time at home were thought to have more time to communicate with their children about family life matters. Fathers with higher education were believed to be more knowledgeable and open minded in discussing these topics with their adolescents.

Other family characteristics such as tribe, religion and type of marriage were not associated with FLCS. The modernising influences of urbanisation, higher education and similar value systems in cosmopolitan religions were seen as factors that reduced the potential impact of these family attributes.

RECOMMENDATIONS

Several recommendations are offered below to aid parents in gaining a better understanding of human sexuality and encouraging them to be open to their roles as educators of their children.

1. Meetings should be organized for parents in the community to educate them of the topics of family life education. Community input into the choice of topics should be gained. Possible venues for these meetings could be at the clinics,

UNIVERSITY OF IBADAN LIBRARY

churches, mosques and schools (during parent-teacher association meetings). Health educators and teachers could guide the discussion at these meetings. Patience and sensitivity will be needed by the group facilitators because of parental feelings of embarrassment. Separate meetings for mothers and fathers may be needed as appropriate. During such meetings, parents should also be encouraged to start family life education early in their children's lives or as early as children start asking questions on human sexuality.

2. Many parents in Apata still see a role for the schools in family life education. Teachers should plan appropriate lectures in consultation with parents and adoleecents in order to meet both their needs for information and maintain an acceptable level of moral probity. The Parent-Teacher Association would be an appropriate venue for this planning. Teachers may need in-service training themselves on matters of human sexuality and on supportive methods for working with and helping parents.

3. Peer education sessions could also be organised. Young people who have experienced problems related to adolescent sexuality and have been able to change to healthier behaviour can be asked to speak to groups of young people on how they could prevent such problems for themselves.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

4. Finally parents should support the formation and joining of youth clubs for their adolescents (e.g. Boy Scouts, Girl Guides, Red Cross, religious groups). Parents should volunteer to serve as group leaders and use this forum to provide family life education. At the same time they can use these organizations to provide healthy alternative recreational and service activities for the young people to prevent recourse to dangerous sexual practises.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

REFERENCES

Ademuwagun, Z.A. (1981) Healthy family living and sex education: an overview. Nigerian School Health Journal, 3(1): 12-14.

Ademuwagun, Z.A. (1984) Family life and sex education taboos and superstitions. unpublished document in the African Regional Health Education Centre, College of Medicine, University of Ibadan, Nigeria.

Ademuwagun, Z.A. (1986) Charactoristics and dynamics of functional group/organization activities with emphasis on effective communication. a paper presented at the WHO AFRO professional seminar, Brazzaville, 12 February 1986.

Ajala, J.A. (1981) Teaching family life and sex education in the schools. Nigerian School Health Journal, 3(1): 69-75.

Ajala, J.A. (1987) Essential guiding principles in dealing with sex education for parents of teenagers and young adults. The Nigerian Nurse, 7(1): 24-28.

Akintayo, D. (1987) An Assessment of Secondary School Teachers' Knowledge, Attitudes and Perceptions of Sex Education. a dissertation in the Department of Preventive and Social Medicine, University of Ibadan, Nigeria.

Asuzu, M.C., Odor, O.E., Asuzu, C.C. and Oyejide, C.O. (1989) Health education needs assessment and curriculum development

UNIVERSITY OF IBADAN LIBRARY

for formal adolescent education in human sexuality and family life. Journal of Community Medicine and Primary Care, 2: 72-80.

Asuzu, M.C. (1991) Adolescent youth health and family life. lectures given at the Annual Pro-Life Adolescent Youth Congress on Health, Human Love, Sexuality and Stable Family Life, Ibadan.

Barrett, J.E. (1979) Family life education: parental involvement. The Journal of School Health, 49(1): 15-19.

Block, W.A. (1974) What Your Child Roally Wants to Know About Sex - and Why. New York: Fawcett World Library.

Brieger, W.R. (1978) Parents involvement to improve school health. Nigerian School Health Journal, 1(2): 100-104.

Brower, L. (1967) Character education: a guideline for discussion of sexual behavior. Journal of School Health, 39: 715-722.

Bunting, A. (1984) Sex education for pupils from Asian ethnic minority groups. Health Education Journal, 43(4): 100-101.

Chan Ho, S.S.Y. (1984) Teenage child boaring, family size and birth interval: a study in Singapore public health. The Journal of the Society of Community Medicine, 98(6): 336-343.

Chartham, R. (1973) You, Your Children and Sex. London: Leslie Frewin, Limited.

Clarke, L. (1982) Teenage views of sex education. Health Education

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Journal, 41(2): 47-51.

Demehin, A.O. (1983) Sex education in Nigeria, problems and proposals. The Journal of the Society of Community Medicine, 97(4): 228-239.

Fawole, J.O. (1981) Pregnancies in out secondary schools: a task for educators. Nigerian School Health JOurnal, 3(1): 15-17.

Erickson, E.H. (1963) Childhood and Society, 2nd ed., New York: W.W. Norton and Company, Inc.

Gebhard, P.H. (1966) Factors in marital organism. Journal of Social Issues, 22(2): 88-95.

Godow, A.G. (1982) Adolescent Sexuality, Human Sexuality. The C.V. Mosby Company. pp. 291-327.

Greaves, N.J. (1965) Sex education in colleges and departments of education. The Health Education Journal, 24(4): 171-177.

Hale, C. and Philliber S.G. (1978) The subtle points of controversy: a case study in implementing sex education. Journal of School Health, 48(10): 586-591.

Hall, G.S. (1904) Adolescence (2 volumes). New York: Appleton.

Harris, D.G., Baird, S.A., Clyburn, and Mars, J.R. (1983) Developing a teenage pregnancy program the community will accept. Health Education Journal, 1983 (May/June): 17-20.

Hawley, L.E., Shear, C.L., Starck, A.M. and Goodman, P.R. (1984) Resident and parental perceptions of adolescent problems and family communications in a low-economic population. The

UNIVERSITY OF IBADAN LIBRARY

Journal of Family Practice, 19(5): 652-655.

Hite, S. (1978) The Hite Report. The Journal of School Health, 49(5): 251-254.

Hofman, A.D. (1984) Contraception in adolescence: a review, psycho-social aspects. Bulletin of the WHO, 62(1): 151-162.

Hogan, R. (1985) Human sexuality: an overview. in Human Sexuality: a Nursing Perspective, 2nd ed. Norwalk, Connecticut: Appleton-Century Crofts, pp. 3-8.

Hohmann, G.W. (1992) Considerations in management of psychosexual readjustment in the cord injured male. Rehabilitation Psychology, 19: 50-58.

Hunt, W.B. (1976) Adolescent fertility risk and consequences. Population Reports, Series J, 10: 157-172.

Jekel, J.F. (1977) Primary and secondary prevention of adolescent pregnancies? The Journal of School Health, 47(8): 457-461.

Johnson, W.R. and Belzer, E.G. (1973) Sexual Behavior and Sex Education, 3rd ed. Philadelphia: Lea and Febiger, pp. 225-264.

Kapp, L., Taylor, B.A., and Edwards, L.E. (1980) Teaching human sexuality in junior high school: an interdisciplinary approach. Journal of School Health, 50(2): 80-83.

Kegeles, S.S. (1963) Why people seek dental care: a test of a conceptual formulation. Journal of Health and Human Behavior, 4: 166.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

Kitson, G.C., Graham, A.V., and Schmidt, D.D. (1983) Troubled marriages and divorce: a prospective suburban study. The Journal of Family Practice, 17(2): 249-258.

Kuczynski, H.J. (1988) An approach to preventing adolescent pregnancy. Midwives Chronicle, 101: 234-237.

Labarre, M. (1969) The Triple Crisis - Adolescence, Early Marriage and Parenthood. New York: National Council of Illegitimacy, p. 15.

Liskin, L. (1985) Special topics on youth in the 1980s: social and health concerns. Population Reports, Series M, 9: 350-368.

Mabogunje, A.L. (1963) Urbanization in Nigeria. London: University of London Press.

Maslow, A.H. (1943) A theory of human motivation. Psychological Review, 50: 4.

Morris, M. (1991) Adolescent pregnancy. Journal of the Society of Obstetricians and Gynaecologists of Canada, 13(3): 15-20.

Nichols, D.A., Ladipo, O., Paxman, J.M. and Otolorin, E.O. (1986) Sexual behavior, contraceptive practice and reproductive health among Nigerian adolescents. Studies in Family Planning, 17(2): 100-105.

Oikeh, A.J. (1981): The place of sex education in secondary schools in Nigeria. Nigerian School Health Journal, 3(1): 17-35.

PPFN (undated) Profile of Planned Parenthood Federation of

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

UNIVERSITY OF IBADAN LIBRARY

Nigeria, Lagos: PPFN, 14 pp.

Ramsey, C.V. (1943) The sexual development of boys. American Journal of Psychiatry, 56: 217-234.

Reid, D. (1982) School sex education and the causes of unintended teenage pregnancies - a review. Health Education Journal, 41(1): 4-10.

Scales, P. (1980) Barriers to sex education. Journal of School Health, 50(6): 337-341.

Sinclair, D. (1973) Human Growth After Birth. 2nd ed. Southamptom: Camelot Press, Limited, pp. 90-93.

Sol, C. (1978) coming to terms with your own sexuality first. The Journal of School Health, May: 241-250.

Steel, A. (1987) Attitudes of paronts and teachers to sex education. Health Education Journal, 46(1): 29-30.

Vacalis, T.D., Hill, E. and Gray, J. (1979) The effect of two methods of teaching sex education on the behaviour of students. The Journal of School Health, 49(7): 404-409.

Watson, C. (1980) Sexual instruction for mildly retarded and normal adolescents: a comparison of educational approaches; parental expectation and pupils' knowledge and attitude. The Health Education Journal, 39(1): 88-95.

Wolff, L, Weitzel, M.H. and Fuerst, E.V. (1979) Fundamentals of Nursing. 6th ed. Philadelphia: J.B. Lippincott Company. p. 88.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

WHO (1975) Pregnancy and Abortion in Adolescence. Technical Report Series, No. 583, p. 27.

Yarber, W.L. (1979) Instructional emphasis ion family life and sex education: view points of students, parents, teachers and principals at four grade levels. The Journal of School Health, May: 263-265.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX 1

QUESTIONNAIRE ON FACTORS AFFECTING DISSEMINATION OF FAMILY LIFE EDUCATION TO ADOLESCENTS BY THEIR PARENTS.

The purpose of this study is to find out from parents whether they disseminate information on family life to their adolescent children or not. Also to examine various factors that prevent or encourage them to perform this important role.
Names are not required on the questionnaire, but kindly answer the questions as honestly as possible. All information given by you will be strictly confidential and will be used mainly for this reasearch. Your coorperation will be appreciated. Thank you.

[Interviewers, please tick (✓) the appropriate boxes and fill in the gabs where applicable.]

Pataki ise iwadi yi ni lati se ibeere lodo awon obi boya won ti e n da awon odo langba won l'eko lori oro ti o je mo ibalopo okunrin ati obinrin tabi won ko se e. Bakanna ni n maa se ayewo awon idi ti o le de'na tabi ran awon obi l'owo lati se ise pataki yii.
E ma sopo lati ko oruko yin si ori iwe yi i, sugbon mo ro yin lati dahun awon ibeere won yi pelu otito. Mo nfi dayin l'oju wipe eyikeyi idahun yin ninu iwadi yi i yoo je bonkele ti yoo si je lilo fun ise iwadi yi nikan. Inu mi yoo dun lopolopo ti e ba f'owo so wopo pelu mi. E se pupo.

[E jowo fi ami (✓) sinu awon iho ki e si di awon alafo ni ibi ti o ba ye.]

PART A : DEMOGRAPHIC DATA

1. Respondent: ☐ mother ☐ father ☐ both

2. Age/ojo ori :

Father	Mother	Age Group
		25_29 years
		30_34 years
		35_39 years
		40_44 years
		45_49 years

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

3. Marital Status/ Ipo Lokolaya

☐ Married/ Abileko ☐ Single Parent/ Alailoko to bi omo ☐ Divorced/ Kora Sile

☐ Separated/ Delemosu ☐ Widow/Widower/ Opo

4. Religion/Esin

☐ Islam/ Musulumi

☐ Christian Igbagbo Denomination (specify)/Ijo (so pato) ________

☐ Others (specify) Omiran (so pato) ________

5. Educational Level/Adeduro Imo Eko

Mother/Iya	Father/Baba	Education
		Illiterate/Purutu
		Primary School/ Ile Iwe Alakobere
		Secondary School/ Ile Iwe Sekondiri
		Post Secondary/ Ile Iwe Giga

6. Occupation/Ise

Mother/Iya	Father/Baba	Education
		Civil Servant/Osisi Ijoba
		Trader/Onisowo
		Professional/Ise Ayanlaayo
		Farmer/Agbe
		Pensioner/Eniti oti Pehinti lenu ise
		Housewife/Iyawo ile
		Artisan/Onise owo peepe

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

7. Tribe/Eya tabi iran ______________________

8. Number of children/Iye Omo

Female/Abo	Male/Ako	Number
		1-2
		3-4
		5-6
		6 and above

9. Type of Family/Iru Ebi

☐ monogamy/Oko kan, Iyawo kan

☐ Polygamy/ Oko kan, Iyawo pupo

10. When usually at home/Igbati a maa n saba wa n'ile

Father/Baba	Mother/Iya	Child/Omo	Time at Home
			Weekdays/Aarin ose.
			Day time/Ojumomo
			Evening/Irole
			Night/Ale
			Weekend/Ipari ose.
			Day Time/Ojumomo
			Evening/Irole
			Night/Ale

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

PART B: Growth and development involve all physical, psychological and social changes that occur in human beings.

Idagba soke ati ilosiwaju je mo ayipada, irisi, ero ati isesi lawujo ti o maa nsele ninu aye eniyan.

1a. What have you discussed with your child about growth and development?
Kini ohun ti oti ba omo re so lori idagbosoke ati ilosiwaju?

____

____

1b. Who initiated this discussion? Tani o da oro yi sile?

- [ ] both parents/obi mejeji
- [ ] father/baba
- [ ] mother/iya
- [ ] child/omo
- [ ] others (specify)/omiran (so pato) ______________
- [ ] Topic never discussed with child
N ko ti ni ijiroro lori koko oro yii pelu omo mi

1c. What was the reason for initiating the discussion?
Kini idi ti o fi bere ijiroro yii?

____

____

1d. If there was no discussion yet, why?
Ti o ba se po oko ti ba omo yin ni ijiroro lori koko oro yii, kini o faa?

____

____

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

2a. What have you discussed with your child about pregnancy?
Kini ohun ti o ti ba omo re so lori oyun ati omo bibi?

2b. Who initiated this discussion? Tani o da oro yi sile?

- ☐ both parents/obi mejeji
- ☐ father/baba
- ☐ mother/iya
- ☐ child/omo
- ☐ others (specify)/omiran (so pato) ______________
- ☐ Topic never discussed with child
  N ko ti ni ijiroro lori koko oro yii polu omo mi

2c. What was the reason for initiating the discussion?
Kini idi ti e fi bere ijiroro yii?

2d. If there was no discussion yet, why?
Ti o ba se pe eko ti ba omo yin ni ijiroro lori koko oro yii, kini o fa?

3a. What have you discussed with your child about preparation for parenting?
Kini nkan ti to ti ba omo re so lori imurasile fun isabiyamo?

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

3b. Who initiated this discussion? Tani o da oro yi sile?

- [ ] both parents/obi mejeji
- [ ] father/baba
- [ ] mother/iya
- [ ] child/omo
- [ ] others (specify)/omiran (so pato) ____________________
- [ ] Topic never discussed with child
  N ko ti ni ijiroro lori koko oro yii pelu omo mi

3c. What was the reason for initiating the discussion?
Kini idi ti e fi bere ijiroro yii?

____

____

3d. If there was no discussion yet, why?
Ti o ba se pe eko ti ba omo yin ni ijiroro lori koko oro yii, kini o faa?

____

____

4a. What have you discussed with your child about veneral diseases?
Kini nkan ti o ti ba omo re so lori arun ti o je mo ibalopo?

____

____

4b. Who initiated this discussion? Tani o da oro yi silo?

- [ ] both parents/obi mejeji
- [ ] father/baba
- [ ] mother/iya

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

☐ child/omo

☐ others (specify)/omiran (so pato) ____________

☐ Topic never discussed with child
N ko ti ni ijiroro lori koko oro yii pelu omo mi

4c. What was the reason for initiating the discussion?
Kini idi ti e fi bere ijiroro yii?

____

____

4d. If there was no discussion yet, why?
Ti o ba se pe eko ti ba omo yin ni ijiroro lori koko oro yii, kini o faa?

____

____

5a. What have you discussed with your child about the use of contraceptives?
Kini nkan ti o ti ba omo re so lori awon ohun elo ti ki je ki oyun duro fun omo re?

____

____

5b. Who initiated this discussion? Tani o da oro yi sile?

☐ both parents/obi mejeji

☐ father/baba

☐ mother/iya

☐ child/omo

☐ others (specify)/omiran (so pato) ____________

☐ Topic never discussed with child
N ko ti ni ijiroro lori koko oro yii pelu omo mi

UNIVERSITY OF IBADAN LIBRARY

5c. What was the reason for initiating the discussion?
Kini idi ti e fi bere ijiroro yii?

____

____

5d. If there was no discussion yet, why?
Ti o ba se pe eko ti ba omo yin ni ijiroro lori koko oro yii, kini o faa?

____

____

6a. What have you discussed with your child about induced abortion?
Kini nkan ti o ti ba omo re s lori oyun amomose?

____

____

6b. Who initiated this discussion? Tani o da oro yi sile?

- [ ] both parents/obi mejeji
- [ ] father/baba
- [ ] mother/iya
- [ ] child/omo
- [ ] others (specify)/omiran (so pato) ______________
- [ ] Topic never discussed with child
  N ko ti ni ijiroro lori koko oro yii pelu omo mi

6c. What was the reason for initiating the discussion?
Kini idi ti o fi bere ijiroro yii?

____

____

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

6d. If there was no discussion yet, why?
Ti o ba se pe eko ti ba omo yin ni ijiroro lori koko oro yii, kini o faa?

____

____

7. At what age do you consider a child to be matured for discussion on items 1-6 above?
Dede ojo ori wo ni o ro pe o ye ki omo dagba to fun iforowero lori awon koko oro ti o wa ni ibere kini si ikefa?

☐ below 10 years

☐ 11-13 years

☐ 14-16 years

☐ 17-19 years

☐ 20 years and above

8. Who do you think is in the BEST position to educate children on sexual matters?
Tani owa laaye to DARAJU lati da omo leko lori oro ti oje mo ibalopo omo eniyan?

☐ mother/iya

☐ father/baba

☐ religious leaders/olori esin

☐ school teachers/oluko

☐ health workers/onise eto ilera

☐ others (specify)/elomiran (so pato) ________________

9. Give reasons for your choice in question 8.
So idi ti o fi mu ohun ti omu ni ibeere kejo.

____

____

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

10. Which of the following sources of sex education do you consider good?
Ewo lo dara ninu awon orisun to wa fun eko nipa iablopo awon eniyan?

☐ peer group or friends/ore tabi ojulugba

☐ magazines/iwe ati gbadegba

☐ novels/iwe itan aroso

☐ schools/ile iwe

☐ radio, television/ero asoromagbesi tabi mohunmaworan

☐ parents/obi

☐ grandparents/awon obi agba

11. What guidance, if any, does your religion offer about teaching young people about human sexuality?
Kini ilana ti esin re fi sile nipa kiko awon odo ni ibalopo omo eniyan?

____

____

12. Are there any rites recommended by your culture for adolescent children?
Nje eto kan wa ti asa re yan fun awan odo langba?

☐ yes/beeni ☐ no/beeko

If yes, what do these entail?
Ti o ba je beeni, kini eto naa da le lori?

____

____

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX 2

FEDERAL REPUBLIC OF NIGERIA
1991 POPULATION CENSUS
(provisional results)

OYO STATE

L.G.A. Name	Males	Females	Total
Afijio	33,998	36,317	70,315
Akinyele	69,576	70,011	139,587
Egbeda	64,110	64,888	128,998
Ibadan North West	72,489	74,270	146,759
Ibarapa	28,849	28,165	57,014
Ido	27,918	27,975	55,893
Ifedapo	117,153	113,560	230,713
Ifeloju	53,204	51,962	105,166
Irepo	73,046	59,446	132,492
Iseyin	84,225	86,364	170,589
Kajola	86,887	85,401	172,288
Lagelu	32,895	35,837	68,732
Ogbomosho	80,356	85,678	166,034
Ogo-Oluwa	17,782	18,473	36,255
Oluyole	45,418	45,602	91,020
Ona-Ara	59,789	62,598	122,387
Orelope	44,385	38,170	82,555
Oriri	47,918	45,520	93,438
Oyo	137,740	137,294	275,034
Surulere	33,307	34,402	67,709
Ibadan North East	133,609	139,370	272,979
Ibadan South East	112,144	115,721	227,865
Ibadan South West	137,064	136,944	274,028
Ibadan North	151,838	149,101	300,939
TOTALS	1,745,720	1,743,069	3,488,789

Note: Ogbomosho comprises Ogbomosho North and South.

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT

APPENDIX 3

CONFIRMATION OF NUMBER OF HOUSES IN APATA

Ibadan Municipal Government

Treasury Department

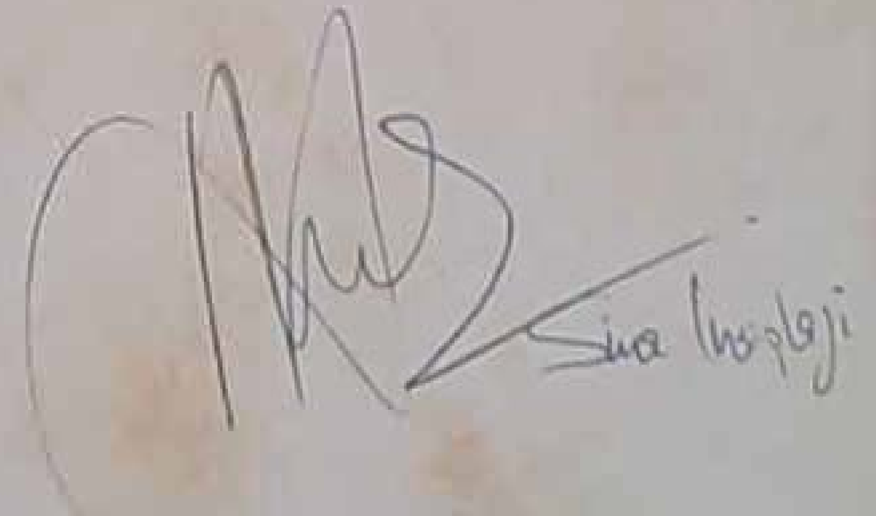
MAPO HILL,
IBADAN.
TEL. (022) 41847

Date 14 ...3... 1991

Your Ref: ....

Our Ref: IMG/A2/426

I Confirmed that average number of houses at Apata are 1900 (One thousand nine hundred) houses.



Sina Inaolaji

UNIVERSITY OF IBADAN LIBRARY

AFRICA DIGITAL HEALTH REPOSITORY PROJECT