THE RELATIONSHIP BETWEEN PARENT-CHILD COMMUNICATION ON SEXUALITY AND SEXUAL RISK BEHAVIORS AMONG ADOLESCENTS IN KASARANI, NAIROBI COUNTY

BY

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DECLARATION

This project paper is my original work and has not been presented for a degree in any other University

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DEDICATION

This project is dedicated to my father Moses Njaramba Mathai and nephew Jayson Njaramba for their support throughout the preparation of this Project.

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I thank God almighty for the wisdom, tenacity and grace to complete this project. All Glory and honor to him forever.

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May God bless you all.

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ABSTRACT

The study examined the relationship between sexuality communication between adolescents and their parents and sexual risk behaviors among adolescents in Kasarani sub-county, Nairobi County. Adolescence is a period where human beings grow from a child to an adult and which prepares children to adulthood and relationship between a parent and child is one of the longest and most influential relationships in an individual's life (McBride,1996). It is a period which is full of new discoveries and it also can be disorienting. It is at this stage where the young person comes up with a sense of independence and also having a self identity. This period from adolescent to adulthood comes with such issues as a feeling of independence and the need for self identity. It is at this stage in life that adolescents face tough choices regarding sexuality.

Adolescents are vulnerable because of several reasons. According to Alan Gultmacher Institute, 2010, adolescents have scant knowledge on issues of HIV infection, sexual issues and how to use condom and this puts them at a risk of HIV and other sexually transmitted diseases infection. Some strategies by the Government through the Ministry of Health have been put in place to give adolescents some skills and knowledge to prevent them from putting their health at risk. The strategies include counseling, education on sexual issues, some campaigns through the media and introduction of communication in the family about sexual matters. According to McBride, (1996), The communication between parents and their children on matters of sex is one of the most effective ways to reduce risky sexual behavior among adolescents. But in Kenya, most parents find it a challenge to answer a question on sexual matters from their adolescent children (Kirui, 2005).

This study found that those parents who had communication with their adolescent children were found to engage themselves in healthy behaviors on sexuality issues whereas those failed to engage the adolescent children in communication on sexual issues were involved in risky sexual behavior.

Definition of Key Terms

Adolescence: This is a transitional stage usually between the ages of 12 and 19 years when a young person is developing into an adult.

Behavior: Everything an organism does that involves act and or response to stimulation (CDC, 2012).

Sex: The biological characteristics that identify humans as male or female at birth. However, the biological features do not limit a person to being male of female because there are people with both features.

Sexuality: This is how people experience and express themselves as sexual beings. It is also the ability of people to have some experiences and reactions.

Parent-Adolescent Communication This is the way information (both verbal and non-verbal) is exchanged between parents and their adolescent children. It involves ability to pay attention to what others are thinking and feeling.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Deficiency Virus
MOH	Ministry of Health
WHO	World Health Organization
GOK	Government of Kenya

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Sexual risk behavior constitutes a social and economic menace to families and society at large, and it is one of the significant risk practices among adolescents in Kenya (Kirui, 2009). It is a tough period for the adolescents because it involves a lot of changes both physically and mentally. It is period when human beings move from childhood to adulthood. Young people aged between 10 – 19 years are at 39% Kenya's Population (Population census, 2010). One common feature to adolescence in many parts of the world is their potential vulnerability to HIV and other sexually transmitted diseases (STDs) and according to Rouse, 2012 it raises the question on the role parent's play in ensuring their children have sexual issues information.

In traditional Kenyan society, puberty was celebrated through rites of passages. This involved some ceremonies and rituals. Children at this stage were educated on sexual matters mostly by the grandparents in most Kenya's ethnic groups. It involved educating young girls on how to conduct themselves, what is expected of them in the society as well as their reproductive health. Boys too were taken through sexual education by their grandfathers and older people around them (Kirui, 2009).

But today issues like urbanization and education have made it impossible for the institutions which were traditionally used to give information on sexual matters. The extended family way of conducting family matters have gradually been done away with and instead there is a drive into an individual lifestyle (Makunya, 2010). People are now moving to modern towns in which relationships with their elders and people who can give advice is weakened. This has lead to

extended family being replaced by nuclear families where there are no elders, grandparents to guide the young people thereby creating a gap in how young people get information about sexual matters (Nukunya, 2010).

Young people are looking for information on sexual matters from other sources such as media and peers. Adolescents are gradually becoming comfortable with the other sources of information such as media and this is sometimes wrong and damaging information for example how to carry out an abortion (Hagan, 2009). Since 2012, the Government has done a lot planning to introduce education on sexual matters in the school curriculum although the implementation is slow and tenuous. On the other hand, teachers may not have the right training on sexuality matters hence they may fail to give it the right approach and this in return may not help the adolescent make the right decisions on sexual issues (Rouse, 2012). According to World Education Ghana, 2008 there was inconsistence in the manner in which sexuality information was given. Another study by Hagan, (2009) also found that although teachers had the right knowledge and skills, adolescents trusted their parents more for sexual issues information.

1.2 Problem Statement

With the growing in magnitude of HIV/AIDs burden in Kenya, there is need to understand the sexual unhealthy behaviors that put the young people at the risk of HIV/AIDS and other related diseases which are sexually transmitted as well as early pregnancies so as to come up with some interventions that promotes sexual healthy. According to Weinman, 2014, parents are considered to be in a special position to assist the adolescents develop responsible behaviors towards sex as well as to educate them into healthy sexual adults.

In most Kenyan communities, for parents to provide sex education to their children is a taboo. Most cultures prohibit parents from sharing sexuality issues with their children in the belief that doing so will promote promiscuity and premature exposure to sexual activities (Kirui, 2012). Kirui's study reported that it was a taboo and embarrassing to talk about sex. A recent global survey showed that Kenya has 4th highest HIV/Aids burden globally. 82% of global youth HIV/Aids burden is among the African youth. A survey by Ministry of Health (2018) indicates that there is a HIV crisis among the youth. 300,000 young people below 24 years are HIV+. 48 new infections are occurring everyday among this group and 46% of the young people have never tested therefore the likelihood of the figure being even higher which is an issue of serious concern. The HIV statistics in Kenya are worrying. The generation we hope to drive our economy is affected. Those we expect to take care of the elderly need care themselves and schools are sticking to the curriculum, parents are busy and churches are preaching the gospel (Christine Sadia,2018).

Annually health indicators of Kenyan adolescents prove that adolescents are continually engaging in unhealthy sexual behaviors (Ministry of Health, 2014). Sexual debut is as early as 11 years in females while among boys it is at 13 years (Njau 2009). Sexual debut of as early as 9 years has earlier been reported. HIV infections are highest in young people aged between 13 and 24 years (Kirui, 2012). Adolescents are also affected by STIs like Gonorrhea and syphilis at a higher rate than other groups of people (Ministry of Health, 2013). Condom use is also low among adolescents (Molly, 2017) and so adolescent fertility remains high (Njau, 2009). There is also an increase in indiscipline and rebellion in families (Kimamo,2003).

These indicators show that a large number adolescents are engage in sexual activities and that they are not using condoms to protect themselves. It also indicates that parents have a role to play in order to help adolescents adopt healthy sexual behaviors, attitudes and practices being the primary agents of socialization. Parents are the first source of sexual health education for their children (Klein et al., 2006) and evidence shows that adolescents prefer information on sexuality to come from their parents and also that there is greater willingness among youth to disclose information about sexual health concerns to parents (Somers & Surmann, 2009). Consequently, though the significance of Parents in sex education is emphasized, few studies seem to have explored parent-child communication on sexuality especially in Africa. Most of the statements in literature reviewed remain hypothesis that need to be tested. It is against this background that the study was formulated.

1.2 Purpose of the Study

The study was intended to determine the relationship between parent-child communication on sexuality and sexual risk behaviours among adolescents.

1.4 Objectives of the Study

The objectives of this study was;

i. To determine the relationship between parent-adolescent communication about sexual issues and sexual risk-taking behavior among adolescents;

ii. To investigate the relationship between the quality of parent-adolescent communication about sexual issues and sexual risk-taking behavior among adolescents;

iii. To assess the degree of openness in parent-adolescent communication on sexuality;

iv. To examine the sexual risk-taking behaviors of adolescents.

1.5 Research Questions

The research was guided by the following research questions;

i. What is the relationship between parent-adolescent communication about sexual issues and sexual risk-taking behavior by adolescents?

ii. What is the relationship between the quality of parent-adolescent communication about sexual issues and sexual risk-taking behavior by adolescents?

iii. What is the degree of openness in parent-adolescent communication on sexuality?

iv. What are the sexual risk-taking behaviors among adolescents?

1.6 Hypothesis of the Study

There is a significant relationship between parent-child communication and the risk sexual behavior in adolescence.

1.7 Justification of the Study

Sexual risk behavior that predisposes adolescents to unintended health outcomes is increasing and is of significant concern in Africa. A recent global survey showed that Kenya has 4th highest HIV/Aids burden globally. 82% of global youth HIV/Aids burden is among the African youth. A survey by Ministry of Health (2018) indicates that there is a HIV crisis among the youth. 300,000 young people below 24 years are HIV+. 48 new infections are occurring everyday among this group and 46% of the young people have never tested therefore the likelihood of the figure being even higher which is an issue of serious concern.

In a 2016 health survey of adolescent in Kenya reported that: approximately 49% had ever had sexual intercourse, 44% had had intercourse during the previous two months and 38% did not protect themselves by using a condom when they had sex. Also 27% had had sex with more than four people during their life. The research is necessitated by data which reports that the greatest HIV/AIDs burden globally occurs among the young people. The study sought to determine if there is a relationship between parent-adolescent communication on sexuality and sexual risk behaviors of the adolescents.

1.8 Significance of the Study

Findings and results may provide understanding on the impact of parent-adolescent discussion of sexual matters and provide valuable data for use in developing appropriate educational interventions. Also knowledge of the importance of parent-child communication on sexuality issues may have some influence on positive relationships between the adolescents and their parents and also good sexual behaviors of the adolescents. The main outcome on communication between parents and their children on sexual issues may be reduction of risky sexual behaviors such as delayed sexual debut, prevention of early pregnancy and sexually transmitted diseases. Adolescents' communication on sexuality issues with parents may be of help in that it might make it easier for them to discuss issues when they encounter problems in life and also improving their self-esteem.

1.9 Limitations of the Study

One the limitations of the study was that adolescents were the only ones who participated while there would have been some different responses from parents and teachers.

The majority of the participants were situated in Kasarani, Nairobi. Probably different results would have been obtained if the study was conducted elsewhere in the country. Also the study was conducted in an urban setting and probably different results would have been obtained if target group of adolescents was from both urban and rural settings.

The study explored sensitive matters of sexuality. It involved personal information of the parents and the adolescent's sexual behavior.

1.10 Assumptions of the Study

It was the assumption of the researcher that participants would understand the research questions and volunteer information based on their lived experiences without being economical with the truth. It was also assumed that the questionnaire used was the appropriate research instrument to understand participants' perceptions without possible bias. It was finally assumed that participants would show sincere interest in relaying their lived experiences and perspectives of the matter being investigated.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

It involves an analysis of literature that has been reviewed in relation to the study. In adolescence stage lack of the right information on sexuality issues coupled with lack of understanding of healthy and unhealthy behaviors on sexuality of the adolescents and the urge to experiment makes them vulnerable to risk sexual behaviors. With the increase of the HIV/AIDs infection in Kenya, there is need to consult adolescents in coming up with the solutions that enable the adolescents make the right sexual decisions (Akuno, 2018). The youth in Kenya are faced with the challenge in their transition from childhood to adulthood coupled with the growing HIV/AIDS burden (Kirui, 2007). Several interventions have been put to place to protect adolescents from early pregnancies and sexually transmitted diseases (STDs) by training adolescents on how to protect themselves from sexual risk taking behaviors. It involves educating parents on how to talk with their adolescent children (Dodge & Dittus, 2004). Parents are in a special place to assist their children to have good behaviors in their approach to sex and to help them grow into healthy adults sexually (Kruger, 2005). Despite the knowledge of risks involved in engaging in unhealthy sexual behaviors, adolescents are still engaging themselves in behaviors that puts them at the danger of being infected with HIV/AIDs and diseases which are sexually transmitted, and also early marriages (Malcom, 2004). A study done by Bhan et al. (2003) which had 80 adolescent girls of the ages between 16 and 20 years from 4 (four) educational institutions in Punjab. The results indicated that most girls did not have information on sexual issues. Those who had little information about it were not talking about it. In 2005,

Mohammadi et al. (2003) did a study from 1287 adolescents aged 14 to 18 who lived in Pathankot. The results revealed that there was high levels of sexual activities and and that there was very little knowledge on sexually transmitted diseases and use of contraceptives which was a big threat to the reproductive sexual health of the adolescents. Peer pressure among adolescents as well as media also posed a threat to the level of unhealthy sexual behaviors. An association was found between knowledge of sexuality matters and the attitudes young people had towards sexuality issues, how to use contraceptives and sexually transmitted diseases among young people (Falaye & Leon, 2000). This study had 934 high school adolescents and 324 adolescents who were working in an industry. The adolescents were between the ages of 14 and 29 years in Nigeria. According to Malcom, 2002, provision of information on sexuality and healthy sexual behaviors did not change to a great extent the attitudes did not change. On the contrary, the attitudes of the adolescents' were found to be more related in a great way to those values which are taught by their parents at home and also attitudes learned from the peers. Several factors were linked with sexual information the adolescents' had. They include their age, how educated their parents were, working of their parents, and the functioning of the adolescents family (Leon & Diaz 1998).

The section reviews literature about the dialogue that occurs between parents and their children who are at the adolescent stage on sexuality issues and the risk sexual behaviors among adolescents.

2.2 Adolescents in Kenya

One third of Kenyan population is young people aged 10 to 24 years (National Population Census, 2010). Earlier study has shown that unhealthy sexual behaviors results to such issues like HIV/AIDS , early marriages, early child birth among the young people between the ages of 12 and 18 years in Kenya, which calls for some attention. Adolescents and young adults in Kenya face reproductive health risks arising from cultural and parental pressures, inadequate health care services, and lack of education on sexual health, exposing the adolescents to sexual risk behaviors; female children are more affected than males (Were, 2009). Sexual health is more challenging to female adolescents in the northern and Rift valley parts, where early marriage is the norm and commonly practiced than other parts of the Country. A National Population data in 2013 reported that 23 percent of adolescents in northern Kenya were married at age 15 and 41 percent at age 18 years in Rift Valley. Kenyan's seek abortion yearly and one-third are adolescent, and 80 percent of the adolescents had abortion related complications (National Population Data, 2013).

According to Were (2009), there are several risks that results to an adolescents becoming active sexually . These factors include being unemployed, poverty and being involved in crime. There are also factors which are regarded as family risk including single parenthood, education level of the parents, family income, family support, adolescents supervision by the parent/guardian, attitudes of the parents/guardian, age of the parents at the birth of the child and other siblings sexual behaviors. There are also factors which are related to attitudes of the peers and their behavior for example peers being sexually active. Factors which are individual include

hormonal levels of the adolescents, physical maturity which is biological. Alcohol and drug use and also depression. Falaye, (2004) did a study which looked at factors that affect the attitudes and sexual behaviors of the adolescents. 510 adolescents from five secondary schools were involved in this study whose age was between 13 and 18 years. The results showed that alcoholism, skin colour, religion, social adjustment, parents education, parents' religion, and the economic status of the parent are some of the variables of sexuality behaviors and values.

2.3 Importance of Parent-Child Dialogue on Sexuality

A study by UNICEF Ghana, (2009) found that youth aged 13-19 years dialogue about sexuality with parents was important. The study observed that there was communication on sexuality between peers while there was minimal conversations about sexuality and this was believed to bring about a higher probability of teenage behaviors which are sexually risky.

Markham et al. (2010) did a study and found that parent-child sexuality communication will reduce sexual risk behaviors among teens. He found that several reasons support the need for parent-adolescent sexual health communication. This includes the fact that the period of adolescence occurs between childhood and adulthood and it is crowded with complex challenges such as peer pressure, media, poverty among others for risky behaviors. According to Health Department in the US, (2015), parents were the most-trusted in helping teens make healthy choices about sex and contraception.

2.4 Sexuality Information Sources

We are currently facing sex lawlessness where information of all kinds including information on sexuality is easily accessed by the young people from different sources such as media-radio,

television as well as print. All these avenues that channel this information is easily accessed by the adolescents. For example television and radio are sources of sexuality information which are easy to access and also to consume and are also easy to tune via mobile phone handset without any subscription charges (Botchway,2000). According to Synovate (2015) Kenya today has a big share of millions of young people who tune in to listen to the different programs which are usually aired on daily basis as the seek entertainment and information on matters the feel are of value to them. Ipsos (2014), found that this in return triggers reaction from Kenyan adults who question the nature and the amount of content which concerns sexuality information in the media. Some Kenyans especially those with adolescent children are calling for the ban on all the content than has sexuality information from the easily available media sources reasons being that such sexuality information imparts some values which negatively affect the young generation.

Melgosa (1999) did a study whose goal was to identify the various sources of information for young people on sexual matters and found that most adolescents have access to various sources of information on sexuality matters. The impact of the information varies depending on whether the adolescent is from urban or rural area. The main sources of information include school mates, friends, youth educators, television, radio, parents, teachers and health professionals. The sources vary in terms of credibility, accuracy of information and ease in obtaining the information. The study concluded that the interaction with adults, and especially parents and the members of the extended family, reduced the chances that an adolescent would engage in unsafe sex. At the same time the study found that adolescents had delayed sexual debut depending on the source of sexuality information.

2.5 Cultural Norms

In many countries of the world, sexuality communication is found to be a taboo (Pretorious, 1999). According to Pretoris (2003), several important things can be outlined about this understanding of the communication process. The communicants must be interested in the topic and also be in a position to produce some communication. For example, most African communities consider messages or communication on sexuality issues as a taboo. This means that it is a subject which should not be discussed. In such a circumstance interaction is not likely to happen. In that case communicants should have the ability to deliver messages to whom it is intended. It therefore calls for understanding of the main issues. Sometimes the understanding may not be there, for example guardian or a parent may be unable to communicate matters related to HIV/AIDS and other related diseased because they lack knowledge. Also communicant should have the confidence and trust in each other for effective delivery of message of communication (Botchway, 2003). In the case of parent-adolescent communication on sexual issues, adolescents may consider their parents/gurdians as not understanding, judgmental, and with little knowledge in the topic of discussion (Botchway, 2003). Such factors may cause ineffectiveness in the communication process or undermine the trust of the parents/guardian an a source of information (Kilgoz, 2001).

Pretorious study examined reasons why adolescents and their parents in Zimbabwe failed to engage in meaningful communication about sexual matters. A large percentage of the parents reported that it was a taboo and embarrassing to talk about sex. Parents also feared invading the teenager's private life. Similarly, adolescents too considered the communication a taboo, an embarrassment and an invasion of their privacy. They also believed that parents were not

interested in listening to them while some had a feeling that they already know enough. A study by World Education Togo, (2011) found that adults and parents have contended that providing sexuality information to adolescents can entice them into early sexual intercourse. Traditional sexuality education was limited to menstruation and growth of breasts among girls, and pubertal changes among boys. Detailed information on how things like pregnancy occurs was never discussed. Traditionally these topics were considered too dirty to be discussed (Melgosa, 1999). His study found that these believes were still held in different parts of Zimbabwe.

2.6 General Attitudes toward Communication on Sexuality

Kirkman et al, (2008) study on role of Parents in shaping the behavior of children found that although family and teachers were the sources of information on sexuality for adolescents, there were differing views on who should take the lead in teaching the adolescents about sexuality. He found that parents believed that sexual and reproductive health is a technical subject in which should be undertaken by a trained person. On the other hand teachers were of the view that teaching adolescents about sexuality was an intrusion on the jurisdiction of parents. More than half of the parents argued that teachers were in a better position than parents to teach adolescents about sexuality. They regarded the school as the arena for learning about biology which includes sexuality. Teachers also admitted that the curriculum permits them to discuss sexuality with the young people but the information given was limited to physiological processes.

2.7 Knowledgeability of the Parents

Kirby (2003) did a study where he looked for a correlation between guardians and parents dialogue on sex, the rate of teenage pregnancy, and the rate at which adolescents are infected

with diseases which are sexually transmitted. The study showed that many parents found it a challenge to discuss with their teenage children about sexuality.

He was of the opinion that if parents had the right skills they would be confident enough to talk to their teenage children about sexuality and this would have many positive effects on the adolescents including helping them protect their own sexual health.

He started several programs in the United States with the aim of helping parents to improve their ways of communicating with their teenagers about sex. The program was conducted at working places of the guardians or parents and this made it easy for them to learn more about the adolescents behavior as well as their sexual health.

That kind of communication was called 'discussing with parents and become a health adolescent', and it contained ten monthly three-hour sessions during morning hours at office compound. Twelve non-governmental organizations and non-profit organizations took part in the program with fourteen men and women in all the groups. The topics were; how to be in a good relationship with your child, the development of a child from adolescent to adulthood, communication skills, listening skills, dialogue on sexual matters with adolescent, helping an adolescent child make good decisions and skills development. The parents' were asked to send mail to report if there was an improvement in communication.

The feedback was very positive. A significant majority of the parents reported that they began communicating with their teen children about sex. However, only a small number recommended the program to a friend or coworker.

2.8 Theoretical Framework

Socialization theory is considered appropriate in this study due to the fact that it is through communication that adolescents are socialized from childhood to adulthood. Socialization occurs throughout our life, but some of the most important socialization occurs in childhood. It is a vehicle by which adolescents and their parents develop a relationship and hence gain social competence.

This study was guided by Degregory, (2009) theory of socialization which is credited with the identification of relevant issues in the socialization process. Socialization Theory is based on the assumption that human beings learn some behaviors, morals and values early in life from adult role models. The role models include parents, siblings and the community at large. The behaviors, values and attitudes learnt in childhood are later portrayed in adolescent stage and adulthood. The theory states that socialization is the way in which children or infants acquire knowledge and skills which are important to behave or act as a functioning member of a certain society. Human beings unlike other species, require social experiences in order to survive and learn a certain culture. Other species behavior is biologically set. Different cultural practices usually manifests in the behaviors, actions and customs of a whole social group, the most important manifestation of a culture is seen at the personal level. This usually occur after a person has been socialized by their guardians/parents, family, or some social networks.

In the theory communicants should be interested and able to produce the information in order for the communication to be effective. Interaction is only able to occur if parents do not consider communication on sexual issues a taboo. Those Participating in the communication must also be

able to deliver the message to everyone which requires the understanding of the subject of discussion. Communicants must also have trust and confidence in each other.

This model is adopted by this study mainly because it applies dialogical perspective to socialization. It is also seen as an interaction between some parties all of them with an ability to influence and change each other. This ensures that every person feels they make a contribution to the society in which they live in. This is because theoretically, socialization theory provides a basis for the current study of parent-adolescent sexual communication in relation to adolescent sexual behavior.

2.9 Conceptual Framework

This refers to how a researcher conceptualizes relationship between variables in a study and shows them graphically or diagrammatically. It shows Independent Variables and Dependent Variables and how they relate to or influence each other (Mugenda, 2004)

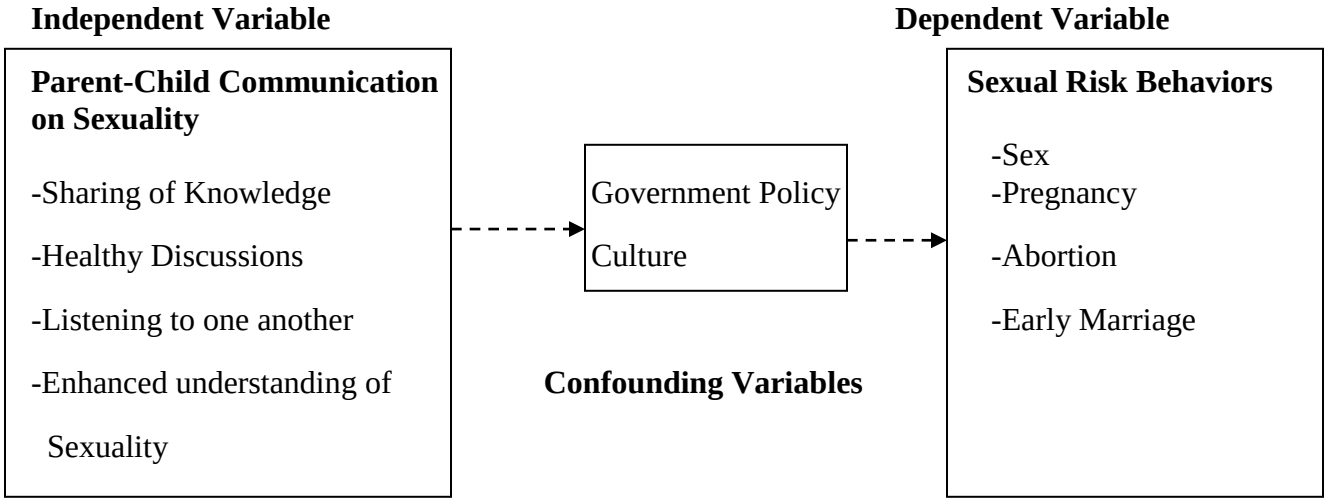

Figure 2.1 shows the interrelationship between Independent Variable (Parent-Child Communication on Sexuality) and the Dependent Variable (Sexual Risk Behaviors). The Independent variable was broken into sub-variables namely; the sharing of knowledge, Healthy discussions, Listening to one another and Enhanced understanding of Sexuality and the Dependent Variable (Sexual Risk Behaviors) resulting to indulgence in sex, pregnancy, abortion and early marriages.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

This study employed a descriptive survey research design to determine the relationship between parent-child communication on sexuality and sexual risk behaviors among adolescents in Kasarani, Nairobi County. This design helped in identifying and predicting the relationships in and between the variables of the study.

3.2 Site Selection and Description

The researcher purposively selected Kasarani Sub-county to carry out the study. Kasarani sub-county is an area that is problematic as far as adolescence and risk sexual behavior are concerned. This is according to a report by the Children's Department Office in Kasarani Sub-county (Children's Annual Report, 2016). According to this report, girls get pregnant and eventually go for early marriages that do not last long. Boys also father children at a tender age of between 14-17years.

3.3 Target Population

Singleton (1993) advises that the ideal setting for any study should be easily accessible to the researcher and should be that which permits instant rapport with the informants. Kasarani Sub-county was chosen because it is within the reach of the researcher and has the most number of Secondary Schools in Nairobi County (Ministry of Education, 2016).

The study targeted adolescents both male and female aged 14-17 years in three (3) different secondary schools within Kasarani Sub-county. The age group was selected because of ease of accessibility by the researcher and the selection was based on their perceived richness as a source of information. It is at this age that students get adjusted and become more liberal that adolescents are vulnerable to impulsive behaviors and risk-taking, partly due to rapid chemical changes in their brains (Steinberg, 2008). It is estimated that more than 3500 adolescents live in the area out of which approximately 1500 are between the age of 14-17 years (Population of Nairobi County by age Cohort, 2013).

3.4 Sampling Procedures

Stratified random sampling method was used to select schools which ensured that all different Sub-groups were adequately represented in the sample. The study population was first stratified according to school (Boarding or day school) and then simple random sampling method was used to select respondents (students) from various strata (form i, ii, iii and iv). Gay (2002) identifies random sampling as the best form of sampling as it allows all members of population to have an equal and unbiased chance of appearing in the sample.

3.5 Sample Size

In a descriptive research a sample size of 10-50% is acceptable (Mugenda & Mugenda, 2005). The study was carried out in 3 Secondary Schools within Kasarani Sub-County. The sample was taken from 151 adolescents from a population of 1500 adolescents aged between 14-17 years of the selected secondary schools. From each school 50 students were randomly selected to

participate in the study using simple random sampling. One of the schools had 51 respondents. The respondents were selected with the help of the teachers.

3.6 Data Collection Instruments

The main data collection tool for this study were questionnaires for the students. The questionnaires were hand delivered to the respondents with a covering letter within their schools. The teachers allowed 20-25 minutes to administer questionnaires to the students. The researcher explained that participation was voluntary and the information entered in the questionnaire was to be given the confidentiality it deserved. A Biographical questionnaire was used to collect personal information from the respondents which includes gender, age, race, religion, nationality, language, living arrangement, family status and adolescents' relationship with their parents. Three other questionnaires were used to measure the relevant variables.

1. Weighted Topics Measure of Family Sexual Communication Scale by Fisher (2006) was used to assess quickly and objectively the amount of communication about sexuality that had occurred between parents and adolescents. It showed the number of topics discussed and the extent of discussion. The instrument asked respondents to indicate on a Likert scale of 0 to 4, with 0 indicating none and 4 indicating a lot, the extent to which nine specific sexual topics had been discussed (pregnancy, fertilisation, intercourse, menstruation, sexually transmitted disease, birth control, abortion, prostitution, and homosexuality) with their parents.

2. Parent-adolescent Communication Scale (Dittus & Gordon, 2004). This was used to measure the quality and the degree of openness in the communication that took place between Parents and the adolescents.

3. Questionnaire about adolescent sexual risk-taking behaviors, which was taken from the HIV Risk Taking Behavior Scale (HRBS) (Ward& Wodak 2009) was used to measure the risk sexual behaviors.

3.7 Data Collection Procedures

Approval was sought from NACOSTI and letter from the University of Nairobi was sought. Permission to collect data from the sampled schools was sought from the Ministry of Education and County Education Office after which the respective school principals were called on to allow data collection from their schools. The researcher personally administered the research instruments.

3.8 Pilot Study

Pilot study was conducted in Kamiti Secondary School to assess validity and reliability of the research instrument. The data that was collected was analyzed in relation to the research objectives and questions. The piloting results were not to be included in the actual study. Pretesting of the questionnaires was done to check repetitiveness, ambiguity and length of the questionnaires and the corrections were made.

3.9 Data Analysis

Data was analyzed using descriptive statistics, that is, tables, percentages and frequency distribution. Chi-square was used to test the association between communication and risk sexual behaviors of adolescents.

3.10 Ethical Considerations

Anonymity and confidentiality were looked into on the information that the respondents gave and also respondents themselves. They were not required to write their names on the questionnaires sheets. Those that qualified for the study completed the informed consent and assent forms, and were allowed to ask questions to learn more about the essence of the research.

CHAPTER FOUR

DATA ANALYSIS

4.1 Introduction

This part provides the results of this study. The findings presented involve the relationship between parent-child communication on sexuality and sexual risk behaviors among adolescents in Kasarani Sub-county in Nairobi County.

4.2 Analysis of quantitative primary data

This includes the factor analysis for biographical information, analysis of biographical information, analysis of the ages of the respondents, analysis of respondents religion, analysis of objective one, analysis of objective two, analysis of objective three and analysis of objective four.

4.2.1 Factor Analysis for Biographical information

Factor analysis was used to determine the confounding variables that are the most relevant using the eigenvalue and contribution criterion. Five factors were identified as the most relevant for the study as indicated in Table 1 below. Selected factors had eigenvalues of greater than 1 and had cumulative contribution of 86.11%. The variables selected are “Gender”, “Age”, “Religion”, “Current living arrangements”, and “Amount paid for rent”. As indicates in Table 1, gender was the most relevant confounding variable. Besides having an eigenvalue of greater than 1, it has the highest size of the eigenvalue, meaning it was the most relevant.

Table 1: Factor analysis on the most relevant confounding variables

Factor	Eigenvalue	Difference	Proportion	Cumulative
Gender	4.92032	2.56158	0.3515	0.3515
Age	2.35874	0.13896	0.1685	0.5199
Religion	2.21978	0.74210	0.1586	0.6785
Current living arrangement	1.47768	0.39837	0.1055	0.7840
Amount paid for rent	1.07932	0.31011	0.0771	0.8611

4.2.2 Analysis of Biographical information

Introduction

The researcher analysed the genders of the respondents into males and females and the results were as indicated below.

Table 2: Proportions for gender of respondents

Gender	No. of Respondents	Proportion
Males	75	50.68%
Females	73	49.32%
Total Responses	148	98.01%
Non-response	3	1.99%

Table 2, indicates that there were 151 respondents who participated in the survey. The response rate for the question on the gender of the students was 98.01%. Males were the majority at 50.68% while females were the minority at 49.32%. The same information is presented in the histogram provided in Figure 1.

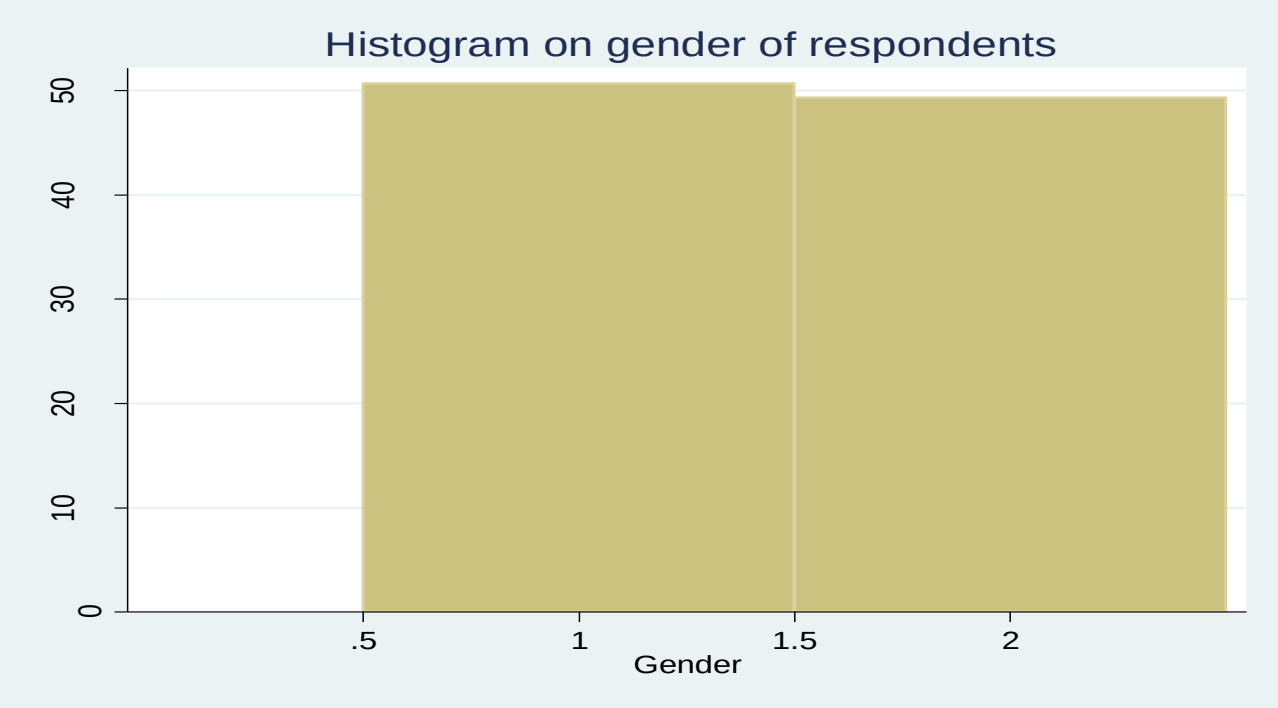

Figure 1: Histogram on gender respondents

4.2.3 Age of the Respondents

This shows various ages of the participants. The study aimed at 14-17 years of age.

Table 3: Proportions for age of respondents

Age	No. of Respondents	Proportion
14-15 years	62	41.33%
16-17 years	88	58.67%
Total Responses	150	99.34%
Non-response	1	0.66%

Table 3, indicates that there were 151 respondents who participated in the survey. The response rate for the question on the age of the students was 99.34%. Respondents aged between 16-17 years were the majority at 58.67% while those aged between 14-15 years were the minority at 41.33%. The same information is presented in the histogram provided in Figure 2.

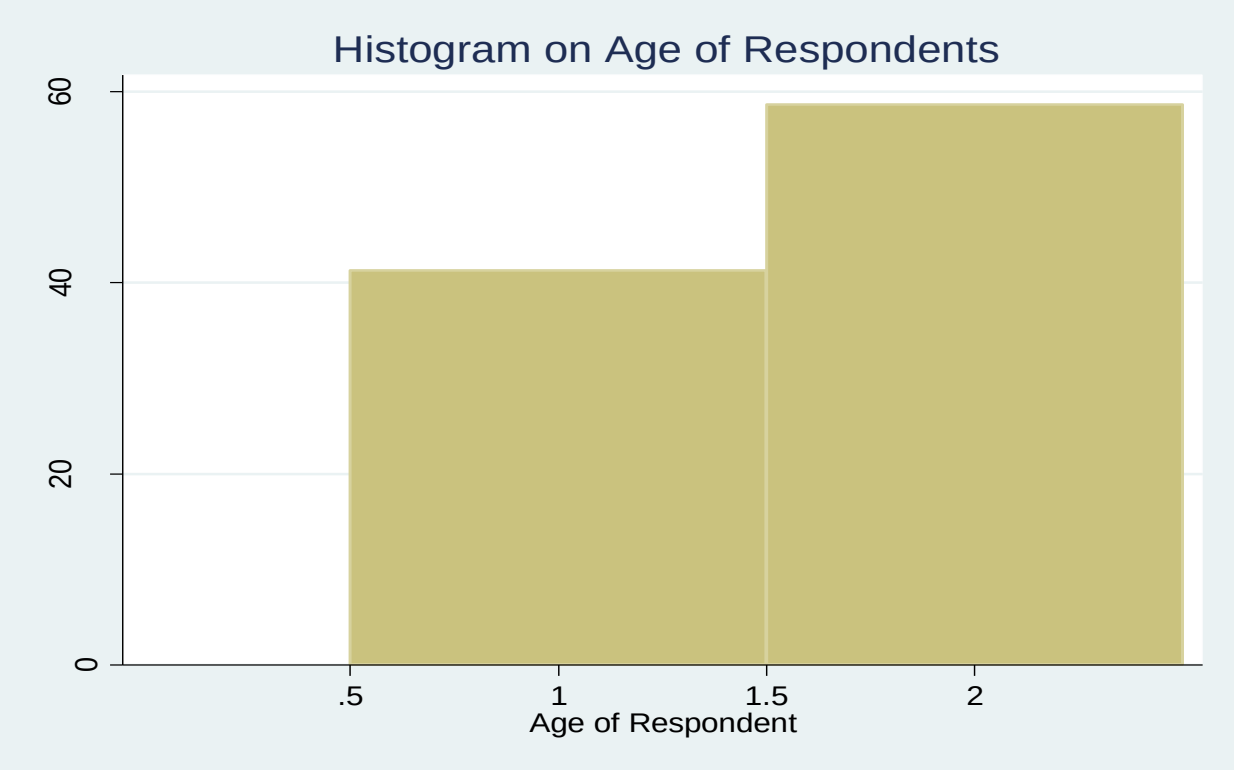

Figure 2: Histogram on age of respondents

4.2.3 Religion of the respondents

Different respondents were classified into various religions into which they belonged. The various religions included Christians, Muslims, Hindu, Jewish and any other.

Table 4: Proportions for respondents' religion

Religion	No. of Respndents	Proportion
Christian	113	76.9%
Muslim	26	17.7%
Hindu	7	4.8%

Jewish	0	0%
Others	1	0.6%
Total responses	147	97.4%
Non-response	4	2.6%

Table 4, indicates that there were 151 respondents who participated in the survey. The response rate for the question on the religion of the respondents was 97.4%. Respondents who are Christians were the majority at 76.9%. The second largest group comprised of Muslim at 17.7%. Hindu and those from other religions were the minority at 4.8% and 0.6% respectively. The same information is indicated on the histogram presented in Figure 3.

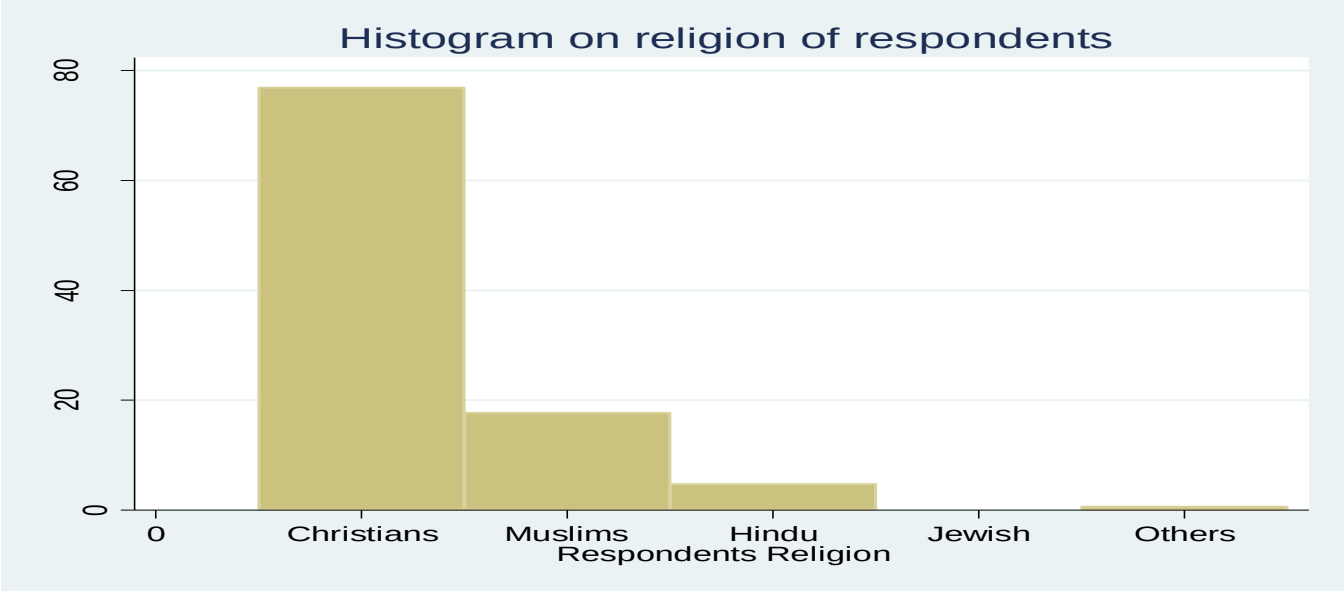

Figure 3: Histogram on religion of respondents

4.2.4 Living Arrangements of the Respondents

Different Adolescents had different living arrangements which included; school residence, live with the mother, live with the father, live with both parents, live alone and others.

Table 5: Proportions for respondents' current living arrangements

Current residence	No. of Respondents	Proportion
School residence	94	62.7%
With mother	19	12.7%
With father	5	3.3%
With both parents	25	16.7%
Alone	6	4.0%
Others	1	0.6%
Total responses	150	99.3%
Non-response	1	0.7%

Table 5, indicates that there were 151 respondents who participated in the survey. The response rate for the question on the current living arrangements for the respondents was 99.3%. Majority of the respondents 62.7%, live in school residence, compared to 12.7%, 3.3%,16.7%, 4.0%, and 0.6% who live with their mother, father, both parents, alone and with others respectively. The same information is contained in histogram in Figure 4.

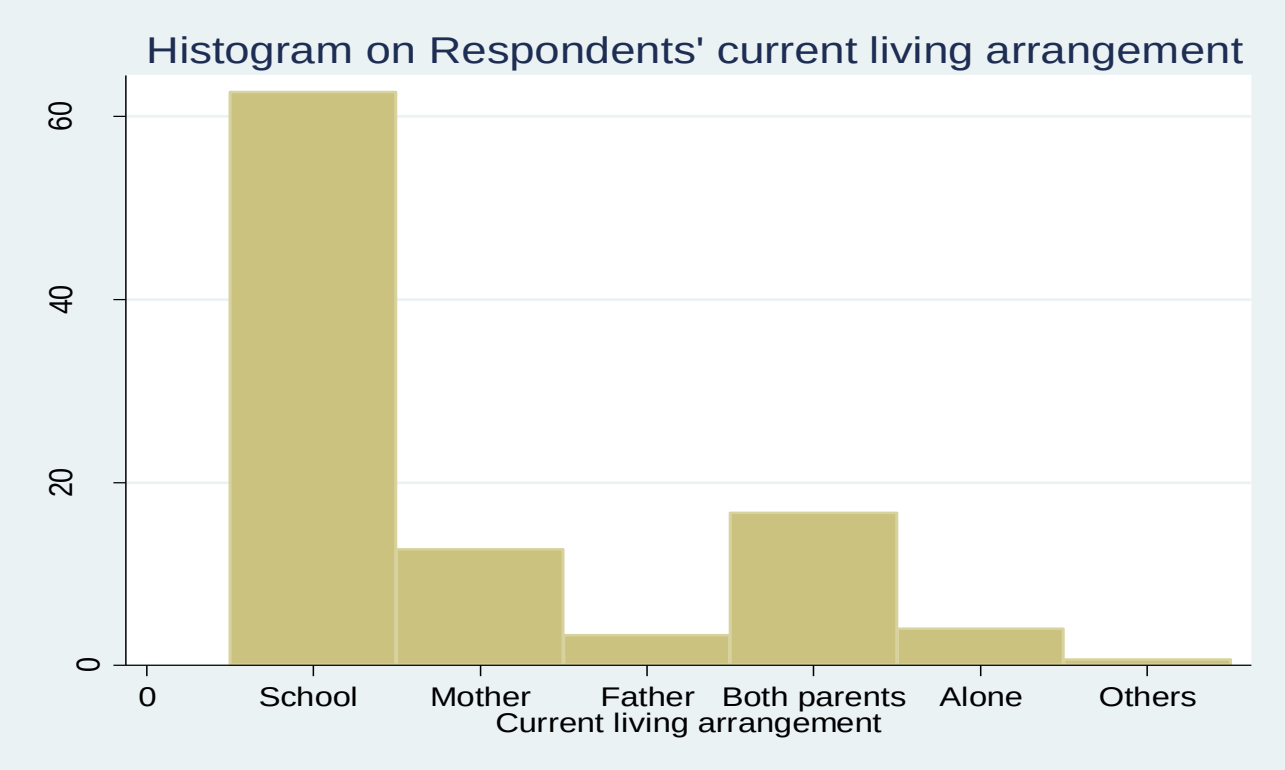

Figure 4: Histogram on respondent's current living arrangement

4.2.5 Respondents' Amount of Rent Paid

Some respondents who reported to live in rental houses were analysed according to the amount of money they paid for rent. Some respondents paid rent of Kshs.5000 and below, others paid between Kshs.6,000 and Kshs.10,000 while the rest paid above Kshs.10,000. This is shown in Table 6 and Figure 5.

Table 6: Proportions for respondents' amount of rent paid

Amount paid for rent (Ksh)	No. of Respndents	Proportion
≤5,000	13	20.3%
6,000≤R≤10,000	20	31.3%
>10,000	31	48.4%
Total responses	64	42.4%
Non-response	87	57.6%

Table 6, indicates that there were 151 respondents who participated in the survey. The response rate for the question on the amount of rent paid by the respondents was 42.4%. Majority of the respondents paid rent above Ksh10,000 while 31.3% and 20.3% paid rent between Ksh 6,000 and Ksh 10,000 and less than Ksh 5,000 respectively. The same information is indicated on the histogram presented in Figure 5.

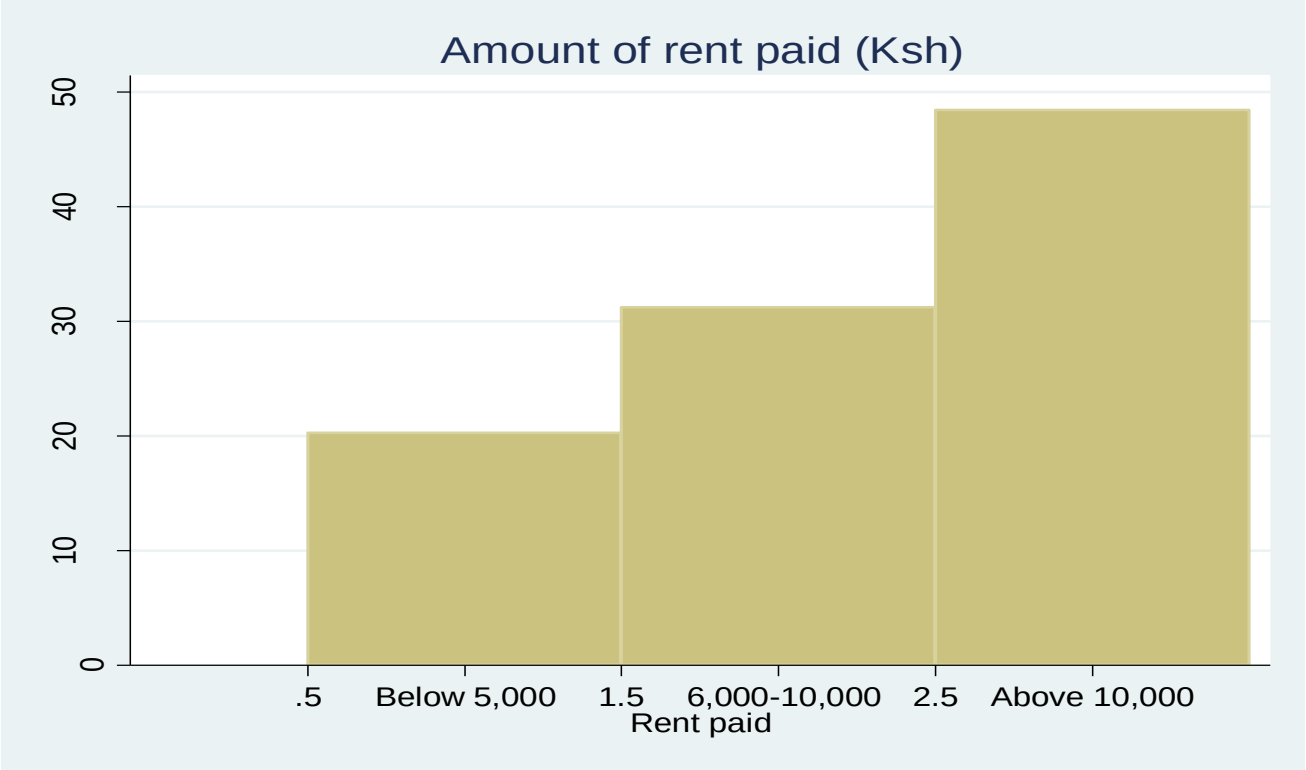

Figure 5: Histogram on rent paid by respondents

4.2.6 Analysis of objective one

The first objective sought to determine the relationship between parent-adolescent communication about sexual issues and sexual risk-taking behavior among adolescents. The sexual issues needing parent-adolescent communication were identified as pregnancy, fertilization, sexual intercourse, menstruation, sexually transmitted (venereal) diseases, birth control, abortion, prostitution, and homosexuality. Using Fisher (2006) scale, communication was classified into three categories. The categories are "No communication", "Less communication", and "More communication" between parents and adolescents. Sexual behavior, on the other hand, was classified into healthy and risky-taking sexual behavior.

A three way Chi-square was carried out to determine the relationship between parent-adolescent communication and the two types of sexual behaviors. The results of the three-way Chi-square are presented in Table 7.

Table 7: Three-way Chi-square on the relationship between parent-adolescent communication and risky sexual behavior

Risky sexual behavior	DF	Chi-Square statistic	P-value
No communication	150	82.0386**	0.054
Less communication	150	89.9902*	0.014
More communication	150	46.9782	0.799

Note: * and ** means significant at the 5% level of significance

Table 7 presents the results of the three-way Chi-square. Three sets of hypotheses were tested. The first set of hypothesis stated that there is no relationship between no parent-adolescent communication and risky sexual behavior. The second hypothesis stated that there is no relationship between low communication and risky sexual behavior. The third hypothesis stated that there is no relationship between more communication and risky sexual behavior. The first hypothesis was rejected at 5% level of significance (X^2=82.0386, p=0.054). There is statistically significant relation between not communicating about sexual issues and adolescents engaging in risky sexual behavior. The implication is that parents who do not communicate with their adolescent children about sexual issues are likely to have their children engaging in sexually risky behaviors.

The second hypothesis that stated that there is no relationship between less communication and sexually risky behavior was equally rejected at the 5% level of significance (X^2=89.9902, p=0.014). This meant that there is statistically significant relationship between less

communication and sexually risky behavior. Specifically, parents who engage in less communication with their adolescent children are likely to witness the children engage in sexually risky sexual behavior.

The third hypothesis that stated that there is no relationship between more communication and sexually risky behavior was not rejected at the 5% level of significance (X^2=46.9782, p=0.7990). The implication is that there is no statistically significant relationship between parents engaging in more communication and their adolescents engaging in sexually risky behaviors. It means that more communication plays an important role in helping adolescents to not engage in sexually risky sexual behaviors. Specifically, the results for this hypothesis mean that it is difficult for adolescents who communicate more with their parents to engage in sexually risky behaviors. The general conclusion from the analysis of objective one is that communication between parents and adolescents is very important in preventing sexually risky behaviors. This agrees with the findings of Kirui (2006) in Mombasa where he reported that those adolescents who have had communication with their parents on sexuality matters reported healthy sexual behaviors and that those who did not have any communication with their parents on sexuality matters had reported risky sexual behaviors such as early pregnancies and sexually transmitted diseases.

The relationship between parent-adolescent communication and healthy sexual behaviors was equally examined. The first set of hypothesis in this case stated that there is no relationship between no communication and healthy sexual behavior. The second hypothesis stated there is no relationship between low communication and healthy social behavior. The third hypothesis stated that there is no relationship between more communication and healthy sexual behavior. The findings of the three-way Chi-square are presented in Table 8.

Table 8: Three-way Chi-square on the relationship between parent-adolescent communication and healthy sexual behavior

Healthy sexual behavior	DF	Chi-Square statistic	P-value
No communication	150	45.7487	0.441
Less communication	150	41.7075	0.612
More communication	150	26.0674	0.956

In Figure 8 above, the three sets of hypotheses tested were not rejected at the 5% level of significance (X^2=45.7487, p=0.441), (X^2=41.7075, p=0.612), and (X^2=26.0674, p=0.956) respectively. The non-rejection of the first set of hypothesis tested in Table 8, means that adolescents who do not communicate with their parents about sexual issues are not likely to engage in healthy sexual behavior. In other words, it means that absence of communication between parents and adolescents about sexual issues does not make the adolescents engage in healthy in heathy sexual behavior.

The failure to reject the second and third sets of hypotheses tested in Table 8, points towards deviant behavior among adolescents. This is so because despite there being communication between the parents and the adolescents as indicated by the less communication and more communication, the adolescents are still not engaging in sexually healthy behaviors.

4.2.7 Analysis of objective two

The second objective sought to determine the relationship between the quality of parent-adolescent communication about sexual issues and sexual risk-taking behavior among adolescents. Using Parent-Adolescent Communication scale by Dittus & Gordon (2004), The

categories are “Low quality”, “Neutral”, and “High quality” between parents and adolescents. Sexual behavior, on the other hand, was classified into healthy and risky-taking sexual behavior.

A three way Chi-square was carried out to determine the relationship between the quality of parent-adolescent communication and the two types of sexual behavior. The results of the three-way Chi-square are presented in Table 9.

Table 9: Three-way Chi-square on the relationship between quality of parent-adolescent communication and Risky sexual behavior

Risky sexual behavior	DF	Chi-Square statistic	P-value
Low quality	150	191.5216	0.577
Neutral	150	122.2427	0.578
High quality	150	173.8468	0.363

Table 9 presents results of the three-way Chi-square for objective two that sought to determine the relationship between quality of parent-adolescent communication and risky taking behavior. Three sets of hypotheses were tested. The first set of hypothesis stated that there is no relationship between low quality of communication and sexually risky behavior among adolescents. The second set of hypothesis stated that there is no relationship between some quality of communication and sexually risky behavior among adolescents. The third hypothesis stated that there is no relationship between high quality of communication and sexually risky behavior among adolescents. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=191.5216, p=0.577), (X^2=122.2427, p=0.578), and (X^2=173.8468, p=0.363)

respectively. The findings from this section indicate that the quality of communication is not significantly associated with adolescents engaging in sexually risky behaviors.

The relationship between the quality of parent-adolescent communication and healthy sexual behaviors was also examined using a three way Chi-square. The first hypothesis stated that there is no statistically significant relationship between low quality of communication and healthy sexual behavior. The second hypothesis stated that there is no relationship between some quality of parent-adolescent communication and healthy sexual behavior. The third hypothesis stated that there is no relationship between high quality of communication and healthy sexual behavior. The findings are presented in Table 10.

Table 10: Three-way Chi-square on the relationship between quality of parent-adolescent communication and healthy sexual behavior

Healthy sexual behavior	DF	Chi-Square statistic	P-value
Low quality	150	140.5948	0.470
Neutral	150	59.6598	0.994
High quality	150	111.3209	0.702

Table 10 presents the three-way Chi-square on the relationship between quality of parent-adolescent communication and healthy sexual behavior. The three sets of hypotheses that were tested were not rejected at the 5% level of significance (X^2=140.5948, p=0.470), (X^2=59.6598, p=0.994), and (X^2=111.3209, p=0.702) respectively. The implication is that there is no statistically significant relationship between the quality of communication between parents and adolescents and the likelihood of adolescents engaging in healthy sexual behavior. The failure to

reject the second and the third sets of hypothesis point towards deviant behavior among adolescents because despite there being quality communication between adolescents and parents, the adolescents are still not engaging in healthy sexual behavior. The findings agrees with Malcom (2002) who reported that although there was information on healthy sexual behaviors between parents and adolescents, this did not to a great extent change the unhealthy sexual behaviors of the adolescents.

4.2.8 Analysis of objective three

The third objective sought to determine the relationship between the openness of parent-adolescent communication about sexual issues and sexual risk-taking behavior among adolescents. Using Parent-Adolescent Communication scale by Dittus & Gordon (2004), openness of communication was classified into three categories. The categories are "Low Degree openness", "Neutral", and "High Degree openness" between parents and adolescents. Sexual behavior, on the other hand, was classified into healthy and risky-taking sexual behavior.

A three way Chi-square was carried out to determine the relationship between the openness of parent-adolescent communication and the two types of sexual behavior. The results of the three-way Chi-square are presented in Table 11.

Table 11: Three-way Chi-square on the relationship between openness of parent-adolescent communication and risky sexual behavior

Risky sexual behavior	DF	Chi-Square statistic	P-value
Low Degree openness	150	191.5216	0.577
Neutral	150	122.2427	0.578
High Degree openness	150	173.8468	0.363

Table 11 presents the findings of three-way Chi-square on the relationship between quality of parent-adolescent communication and sexually risky behavior. Three sets of hypotheses were tested. The first hypothesis stated that there is no relationship between low openness in communication and sexually risky behavior. The second hypothesis stated that there is no relationship between Neutral openness in communication and sexually risky behavior. The third hypothesis stated that there is no relationship between high openness in communication and sexually risky behavior. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=191.5216, p=0.577), (X^2=122.2427, p=0.578), and (X^2=173.8468, p=0.363) respectively. The implication is that openness in communication between parents and adolescents about sexual issues is not associated with adolescents engaging in risky sexual behaviors.

The relationship between openness in parent-adolescent communication and adolescents engaging in healthy sexual behavior was also examined. Three sets of hypothesis were tested. The first set of hypothesis stated that low openness in communication between parents and adolescents about sexual issues has no relationship with adolescents engaging in healthy sexual

behavior. The second hypothesis stated that some openness in communication between parents and adolescents about sexual issues has no relationship with adolescents engaging in healthy sexual behavior. The third hypothesis stated that high openness in communication between parent and adolescents has no relationship with adolescents engaging in healthy sexual behavior.

Three-way chi-square was estimated and the results are presented in Table 12.

Table 12: Three-way Chi-square on the relationship between openness of parent-adolescent communication and healthy sexual behavior

Healthy sexual behavior	DF	Chi-Square statistic	P-value
Low Degree openness	150	140.5948	0.470
Neutral	150	59.6598	0.994
High Degree openness	150	111.3209	0.702

Table 12 presents the findings of three-way Chi-square on the relationship between openness of parent-adolescent communication and sexually healthy behavior. Three sets of hypotheses were tested. The first hypothesis stated that there is no relationship between low openness in communication and sexually healthy behavior. The second hypothesis stated that there is no relationship between some openness in communication and sexually healthy behavior. The third hypothesis stated that there is no relationship between high openness in communication and sexually healthy behavior. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=140.5948, p=0.470), (X^2=59.6598, p=0.994), and (X^2=111.3209, p=0.702) respectively. The implication is that openness in communication between parents and adolescents about sexual issues is not associated with adolescents engaging in healthy sexual

behaviors. The failure to reject to the second and the third hypotheses indicate the deviant behavior among adolescents in that despite there being openness in communication between them and their parents, they are still not engaging in sexually healthy behavior.

4.2.9 Analysis of objective four

The fourth objective sought to examine the sexual risk-taking behaviors of adolescents. This was realized through generation of proportions on sexual risk-taking behaviors of adolescents.

Table 13: Proportions of parent-adolescent communication and sexual behavior

Variable	Healthy sexual behavior		Risky sexual behavior	
No communication	144	95.4%	93	61.6%
Less communication	144	95.4%	93	61.6%
More communication	144	95.4%	93	61.6%

Table 13 presents the results for the number and proportions of respondents experiencing *no* communication, less communication, and more communication and who engaged in healthy and risky sexual behavior. Majority of the respondents reported to be engaging in overall healthy behavior at 95.4% compared to the minority, 61.6% who reported to be have engaged in risky sexual behavior.

Table 14 shows results of the respondents' number of sexual encounters they had in the last one month.

Table 14: Proportions on number of sexual encounters in the last month

Variable	No. of respondents	Proportion
None	74	52.9%
One	33	23.6%
Two	23	16.4%
3-5 people	8	5.7%
6-10 people	2	1.4%
More than 10 people	0	0%
Total responses	140	92.7%
Non-response	11	7.3%

In Table 14, there was total response rate of 92.7%. Majority of the respondents reported that they had n sexual partners in the last one month at 52.9%, followed by 23.65 and 16.4% who said they had one and two sexual encounters in the last one month respectively. The minority of the respondents, comprising of 1.4%, reported that they had between 6-10 sexual encounters in the last one month. The same information is presented in *Figure 6.* However, these findings were not supported by Kirui (2006) who reported that adolescents understands sexual behaviors that place them at the risk of HIV/AIDs and other sexually transmitted diseases as well as unwanted pregnancies.

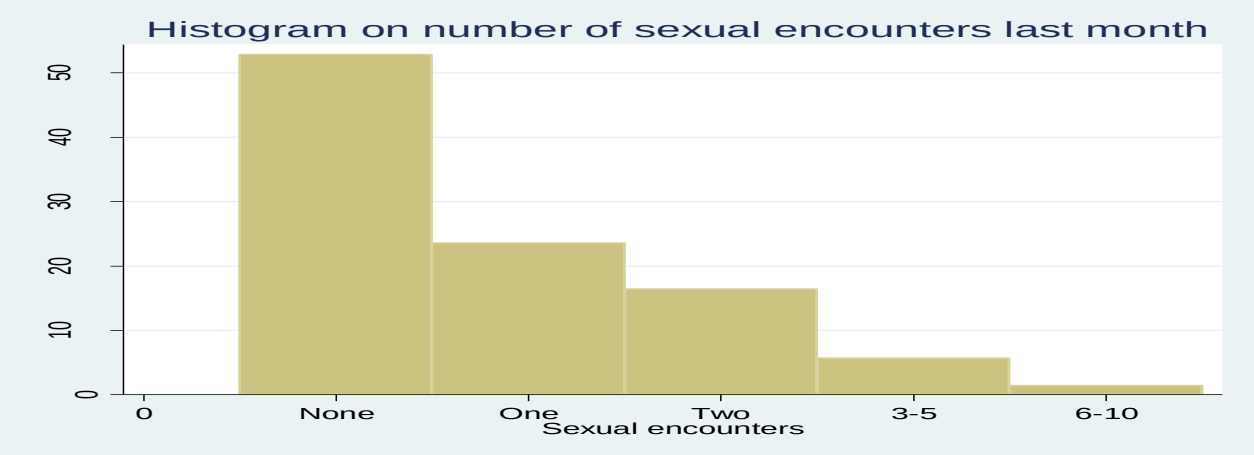

Figure 6: Histogram on number of sexual encounters last month

Table 15 shows the number of regular partners a respondent had in the last one month.

Table 15: Proportions on number of regular partners

Variable	No. of respondents	Proportion
Zero	29	50%
One	22	37.9%
Two	6	10.3%
Three and more	1	1.7%
Total responses	58	38.4%
Non-response	93	61.6%

In *Table 15*, majority of the respondents, 50%, indicated that they had zero regular partners, followed by 37.9% and 10.3% who reported they had one and two regular partners respectively.

The minority of the respondents reported they had three and above parts at 1.7% as shown. The same information is shown in *Figure 6.*

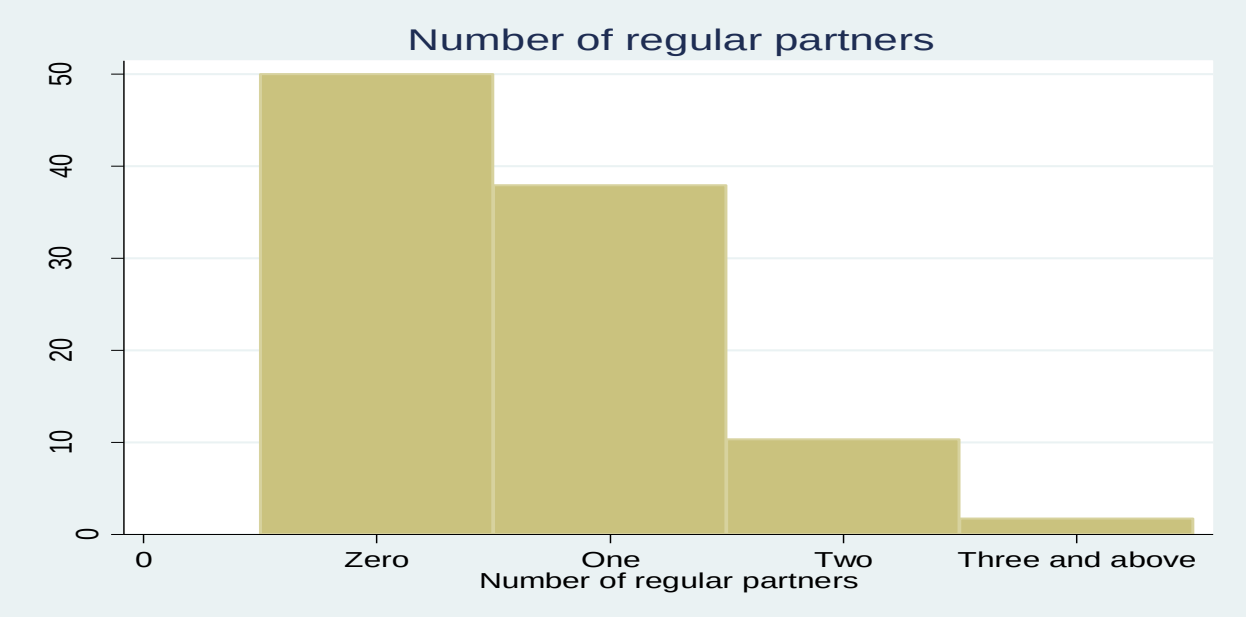

Figure 6: Histogram on number of regular partners

Table 16 reports on whether the respondents used condoms when having sex with their regular partners and the results indicates majority 47(59.5%) protected themselves.

Table 16: Proportions on usage of condoms with regular partners

Variable	No. of respondents	Proportion
Every time	47	59.5%
Often	6	7.6%
Sometimes	8	10.1%
Rarely	6	7.6%
Never	12	15.2%

Total responses	79	52.3%
Non-response	72	47.7%

In Table 16, there was 52.3% response rate. Majority of the respondents, 59.5%, reported they use condoms every time they have an encounter with their regular partners. This was followed by 15.2% and 10.1% of respondents who indicated that they never use condoms and/or they use them sometimes respectively as shown. The minority indicated that they often and rarely use condoms during encounters with their regular partners at 7.6% respectively as shown. The same information is shown in Figure 7.

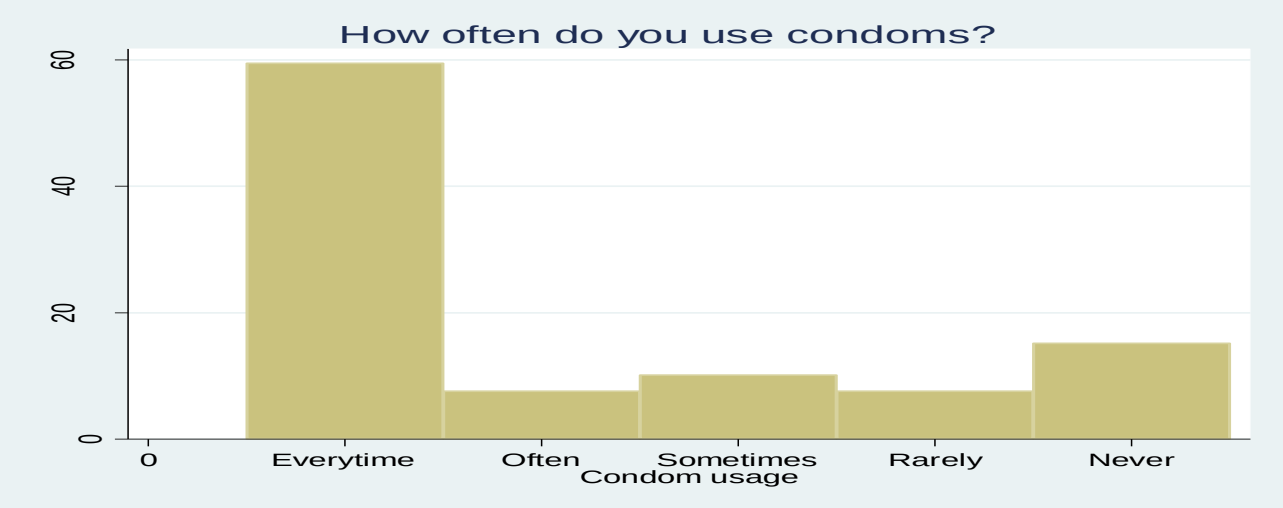

Figure 7: Histogram on frequency of condom usage

Table 17 shows the various proportions on respondents' usage of condom with the casual partners.

Table 17: Proportions on usage of condoms with casual partners

Variable	No. of respondents	Proportion
No casual partners	84	63.6%
Every time	36	27.3%
Often	0	0%
Sometimes	0	0%
Rarely	4	3.0%
Never	8	6.1%
Total responses	132	87.4%
Non-response	19	12.6%

In Table 17, there was response rate of 87.4% where the majority of the respondents indicated that they had no causal partners at 63.6%, followed by 27.3% who said they used condoms every time they had an encounter with casual partners. The minority of the respondents indicated that they rarely and never use condoms with their casual partners at 3.0% and 6.1% respectively. The same information is shown in Figure 9.

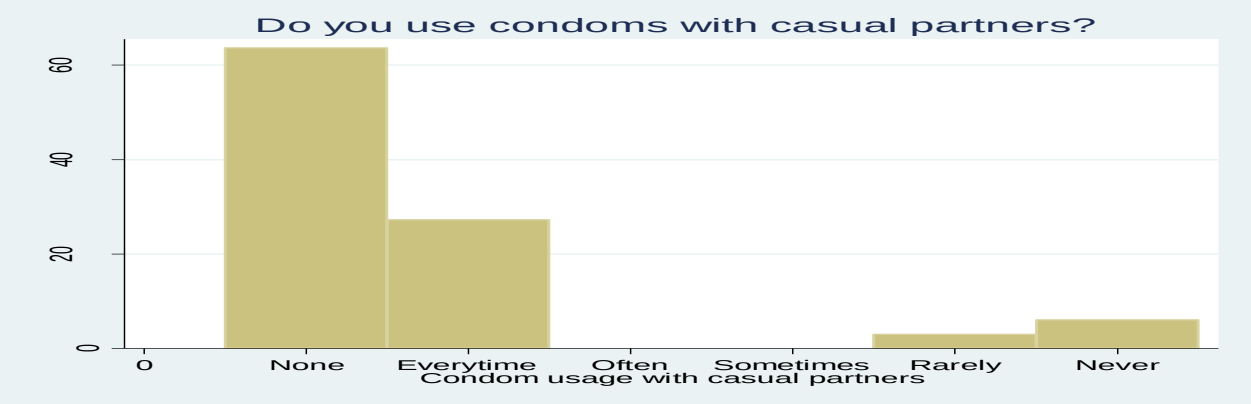

Figure 9: Histogram on condom usage with casual partner

Table 18 reports on whether the respondents practiced paid sex.

Table 18: Proportions on whether respondents practice paid sex

Variable	No. of respondents	Proportion
Yes	9	6.8%
No	124	93.2 %
Total responses	133	88.0%
Non-response	18	12.0%

In Table 18, there was response rate of 93.2% where the majority of the respondents indicated that they were not practicing paid sex at 93.2%. The minority of the respondents indicated that they were practicing paid sex at 6.8%. The same information is shown in Figure 10.

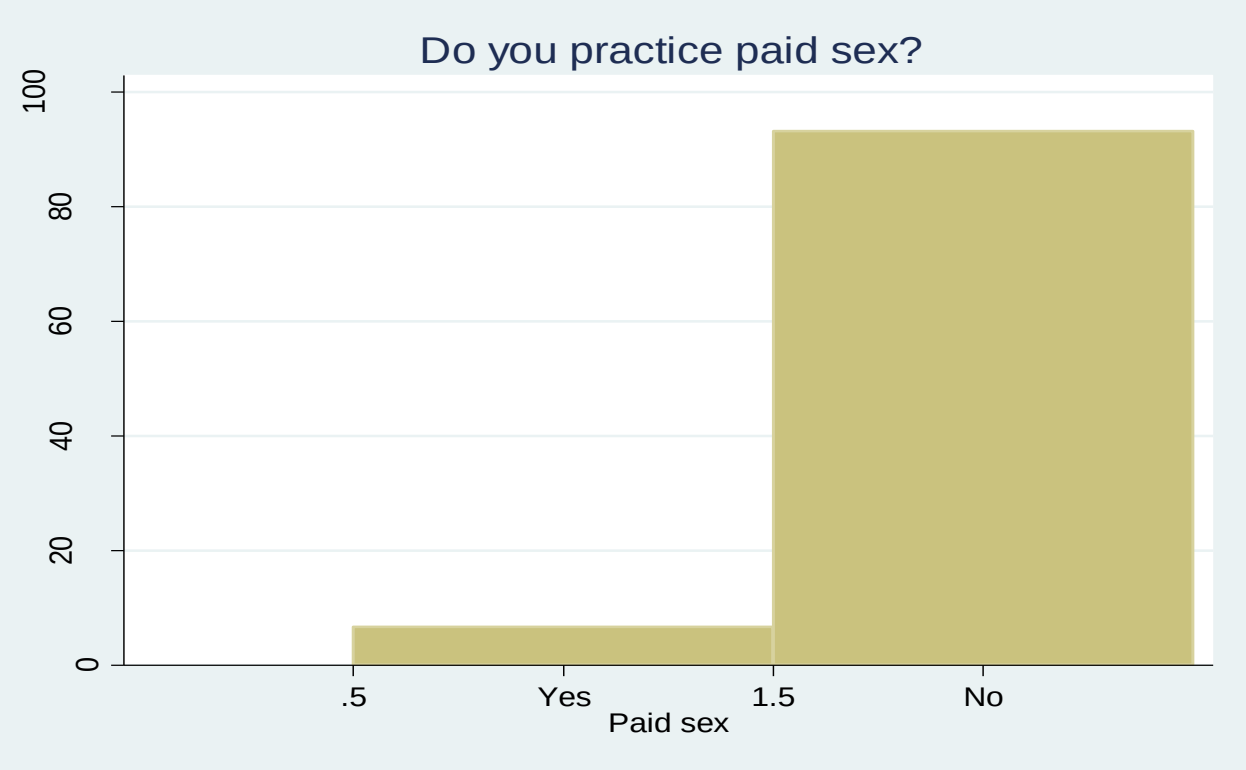

Figure 10: Histogram on whether respondent practices paid sex

Table 19 reports on whether respondents who practiced paid sex used condom to protect themselves

Table 19: Proportions on whether respondents use condoms when practicing paid sex

Variable	No. of respondents	Proportion
Everytime	11	28.9%
Often	4	10.5%
Sometimes	0	0%
Rarely	3	7.9%

Never	20	52.6 %
Total responses	38	25.2%
Non-response	113	74.8%

In Table 19, there was total response rate of 25.2% where the majority of the respondents indicated that they never used condoms when practicing paid sex at 52.6%, followed by 28.9% and 10.5% who said they used condoms every time and often respectively when practicing paid sex. The minority of the respondents indicated that they rarely use condoms when practicing paid sex at 7.9%. The same information is shown in Figure 10.

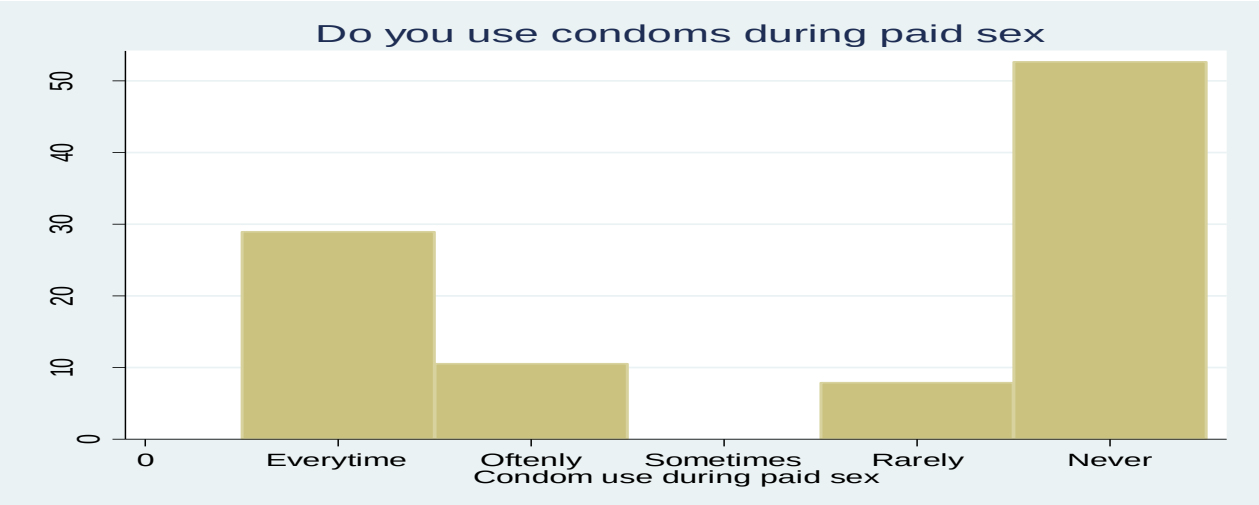

Figure 11: Histogram on whether respondents used condom during paid sex

Table 20 is the analysis of the respondents who reported to either practice anal sex or not.

Table 20: Proportions on whether respondents practice anal sex

Variable	No. of respondents	Proportion
Yes	11	8.1%
No	125	91.9%
Total responses	136	90.0%
Non-response	15	10.0%

In Table 20, there was total response rate of 90.0% where the majority of the respondents indicated that they do not practice anal sex at 91.9% compared to the minority, 8.1%, who indicated that they were practicing anal sex. The same information is shown in Figure 12.

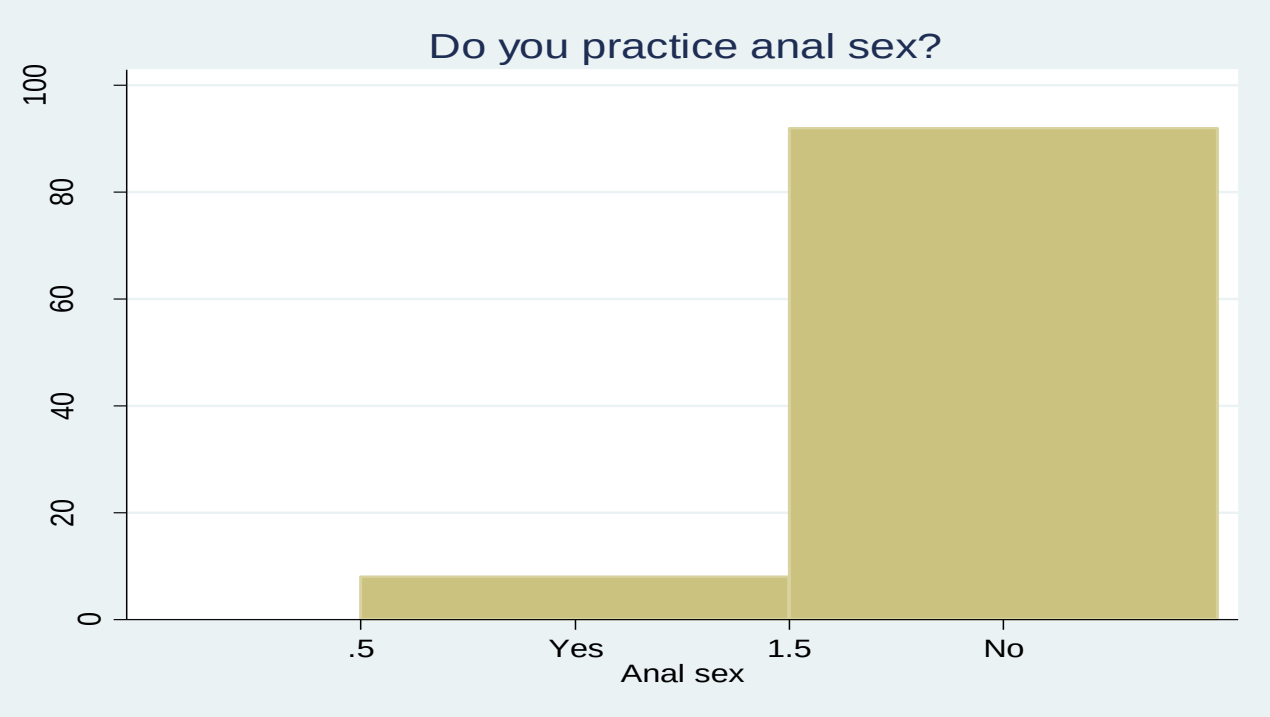

Figure 12: Histogram on whether respondent practices anal sex

Table 21 are results of various reasons why respondents practiced anal sex and the various reasons included that anal sex is satisfying, it is sweeter, some respondents said they do it for fun.

Table 21: Proportions on reasons why respondents practice anal sex

Variable	No. of respondents	Proportion
Satisfying	2	28.6%
Sweeter	4	57.1%
Fun	1	14.3%
Total responses	7	4.6%
Non-response	144	95.4%

In Table 21, there was total response rate of 4.6% where the majority of the respondents indicated the reason for practicing anal sex was because it is sweeter at 57.1%, followed by 28.6% who said they practiced anal sex because it was satisfying. The minority, 4.6%, said they practiced anal sex because it was fun. The same information is shown in Figure 13.

Figure 13: Histogram on the reasons for practicing anal sex

Table 22 reports on whether respondents used condom during anal sex and the various variables were every time, often, sometimes, rarely and never.

Table 22: Proportions on how often respondents used condom during anal sex

Variable	No. of respondents	Proportion
Every time	5	17.9%
Often	0	0.0%
Sometimes	2	7.1%
Rarely	3	10.7%
Never	18	64.3%

Total responses	28	18.5%
Non-response	123	81.5%

In Table 22, there was total response rate of 18.5% where the majority of the respondents indicated they never use condoms during anal sex, followed by 17.9% who said they use condoms every time they engage in anal sex, and 10.7% who said they rarely use condoms during anal sex. The minority, 7.1%, reported they use condoms sometimes during anal sex. The same information is shown in Figure 14.

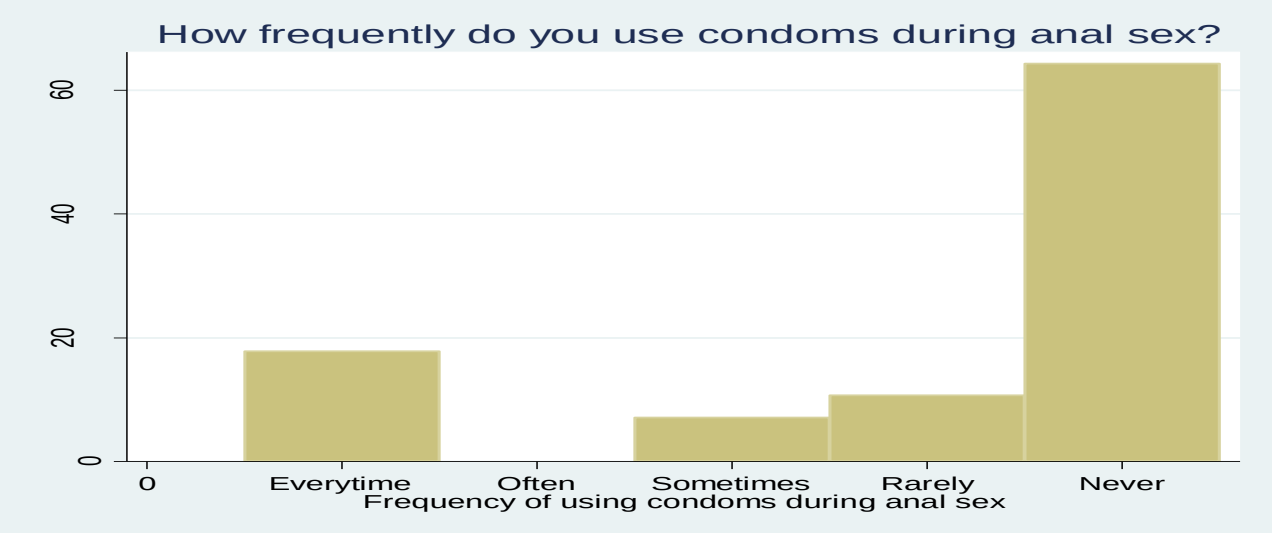

Figure 14: Histogram on frequency of using condoms during anal sex

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This part contains the findings summary form chapter four. It also includes conclusions and recommendations of the research which is in line with the objectives of the study. The findings would lead to conclusions on how best to instill good or healthy sexual behavior among adolescents.

5.2 Summary of the Findings

The aim of the research was to determine the relationship between parent-child communication on sexuality and sexual risk behaviours among adolescents. A recent global survey showed that Kenya has 4th highest HIV/Aids burden globally. A large number 82% of global youth HIV/Aids burden is among the African youth. A survey by Ministry of Health (2018) indicates that there is a HIV crisis among the youth. 300,000 young people below 24 years are HIV+. 48 new infections are occurring everyday among this group and 46% of the young people have never tested therefore the likelihood of the figure being even higher which is an issue of serious concern. The HIV statistics in Kenya are worrying. The generation we hope to drive our economy is affected. Those we expect to take care of the elderly need care themselves (Christine Sadia,2018).

According to Greg Mwaura (2018), we are not consulting the adolescents in coming up with solutions. He says that we should make young people to see the connection between cause and effect of HIV. The adolescents need to have adequate information to be able to make informed

decisions concerning sexual matters (Job Akuno, 2018). Job Akuno (2018) in his study also found that what is wanting in the war against risky sexual behaviors is capacity. We ought to have systems that enable people make the right sexual decisions. We should unpack information to different age groups in a way each group understands (Job Akuno, 2018).

A study done by Shtarkshall (2014) found that most children prefer information on sexual matters coming from their parents as compared to their teachers and peers. He found that parent-adolescent communication is an appealing source for influencing adolescents' knowledge and behavior because parents are an accessible and often willing source of information for their children. Risky sexual behaviors among adolescents has become an issue of concern in Kenya mainly because of the consequences of such behaviors on adolescents. This includes early marriages, school dropout due to unwanted pregnancies, sexually transmitted diseases.

The government of Kenya through the Ministry of Health has put in measures to overcome this challenge by supplying free male and female condoms and also trying to introduce sexuality matters in the education institutions but despite the interventions risky sexual behaviors among adolescents continue to increase.

The current study focused on four main aspects of parent-adolescent communication which are; parent-adolescent communication about sexual issues, quality, openness and sexual risk taking behaviors among adolescents.

5.2.1 Findings Related to Biographical Variables

The social demographic information of the study shows that the majority of the respondents were male at 75(50.68%) and 73(49.32%) were females. The findings also showed that all the adolescents who participated in the study were aged between 14-17 years of age. Majority were

between 16-17 years at 58.6% while those aged between 14-15 years were the minority at 41.33%. Most of the respondents were Christians at 76.9% followed by Muslims at 17.7%. Hindus and other religions were the minority at 4.8% and 0.6% respectively.

Majority of the adolescents lived in the schools (boarding schools) at 62.7% and a few lived at home either with their parents or alone. A few 12.7% lived with their mothers; 3.3% with their fathers; 16.7% lived with both parents and 0.6% lived alone. On the amount of rent paid majority of the respondents paid rent above Kshs.10,000; 31.3% paid between Kshs. 6,000 and 10,000 while 20.3% paid less than Kshs.5,000.

5.2.2 Findings Related to Parent-Adolescent Communication on Sexuality

The first objective was to determine the relationship between parent-adolescent communication about sexual issues and sexual risky behavior among adolescents where Fisher Scale (2016) was used. Using a three way chi-square the study found that parents who communicate with their adolescent children about sexual issues are likely to engage themselves in healthy sexual behaviour whereas those who did not engage their adolescent children in communication on sexual issues are likely to be involved in risky sexual behavior.

5.2.3 Findings Related to the Quality of Parent-Adolescent Communication on Sexual Issues and Sexual Risky Behaviors

On assessing the quality of communication between parents and adolescents on sexual issues and sexual risky behaviors where the categories of quality were low quality, neutral and high quality. Three way chi-square was used and the three sets of hypothesis were not rejected which stated that there is no relationship between low quality of communication and sexually risky behavior among adolescents. The second set of hypothesis stated that there is no relationship between

some quality of communication and sexually risky behavior among adolescents. The third hypothesis stated that there is no relationship between high quality of communication and sexually risky behavior among adolescents. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=191.5216, p=0.577), (X^2=122.2427, p=0.578), and (X^2=173.8468, p=0.363) respectively. This meant that despite there being quality communication on sexuality between parents and the adolescents, adolescents are still not engaging in healthy sexual behavior.

5.2.4 Findings Related to the Degree of Openness of Parent-Adolescent Communication on Sexual Issues and Sexual Risky Behaviors

Parent-adolescent scaly by Dittus & Gordon (2004) was used. The categories are "Low Degree openness", "Neutral", and "High Degree openness" between parents and adolescents. Sexual behavior, on the other hand, was classified into healthy and risky-taking sexual behavior. Three way chi-square was used.

Three sets of hypotheses were tested. The first hypothesis stated that there is no relationship between low openness in communication and sexually risky behavior. The second hypothesis stated that there is no relationship between Neutral openness in communication and sexually risky behavior. The third hypothesis stated that there is no relationship between high openness in communication and sexually risky behavior. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=191.5216, p=0.577), (X^2=122.2427, p=0.578), and (X^2=173.8468, p=0.363) respectively. The implication is that openness in communication between parents and adolescents about sexual issues is not associated with adolescents engaging in risky sexual behaviors. Also the relationship between openness in parent-adolescent communication and

adolescents sexual risky behavior was examined. The three sets of hypotheses were not rejected at the 5% level of significance (X^2=140.5948, p=0.470), (X^2=59.6598, p=0.994), and (X^2=111.3209, p=0.702) respectively. The implication is that openness in communication between parents and adolescents about sexual issues is not associated with adolescents engaging in healthy sexual behaviors. The failure to reject the second and the third hypotheses indicate the deviant behavior among adolescents in that despite there being openness in communication between them and their parents, they are still not engaging in sexually healthy behavior.

5.2.5 Findings Related to the Sexual Risk-Taking Behaviors of Adolescents

The study revealed that majority of the respondents reported to be engaging in overall healthy sexual behaviors at 95.4% compared to the minority at 61.6% who reported to have engaged in risky sexual behavior. The respondents were asked the number of sexual partners they had in the last one month. The highest number 74(52.9%) reported not to have had a sexual intercourse; 33(23.6%) reported they had one sexual partner; 23(16.4%) had two partners; 8(5.7%) had 3-5 sexual partners; 2(1.4%) had 6-10 sexual partners. This shows that adolescents are sexually active. The respondents were also asked the number of regular partners they had and 29(50%) reported not to have regular partners; 22(37.9%) said they had one regular partner; 6(10.3%) said they had two regular partners while 1(1.7%) said they had 3 or more sexual partners.

On the proportions of condom usage with regular parners 47(59.5%) said they used condom every time; 6(7.6%) said they often use condom; 8(10.1%) said they use condom sometimes; 6(7.6%) reported they rarely use condom while 12(15.2%) said they never used condom. There was response rate of 87.4% where the majority of the respondents indicated that they had no causal partners at 63.6%, followed by 27.3% who said they used condoms every time they had

an encounter with casual partners. The minority of the respondents indicated that they rarely and never use condoms with their casual partners at 3.0% and 6.1% respectively.

Respondents were asked if they practiced paid sex and 9(6.8%) reported they practiced paid sex while the majority 124(93.2%) reported they do not practice paid sex. In addition they were asked if they use condoms when practicing paid sex and 11(28.9%) reported they use condom every time they practice paid sex; 4(10.5%) said they often use condom when practicing paid sex; 3(7.9%) said they rarely use condom while 20(52.6%) said they never use condom when practicing paid sex.

Respondents were asked if they practiced anal sex where the majority 125(91.9%) of the respondents said they did not practice anal sex; 11(8.1%) said they practiced anal sex. Further, they were asked to give reasons why they practiced anal sex and 2(28.6%) said it is satisfying; 4(57.1%) said it is sweeter than other forms of sex while 1(14.3%) said they practice it for fun.

5.3 Conclusion

Even though the findings of this study cannot be generalized beyond the population interviewed, it reveals the extent of sexual risk behaviors among adolescents and challenges faced by the adolescents in regard to sexuality information availability. The process of parenting in the African family today is very different from what it was two or three generations ago. Today children are being raised in a very different family environment. Traditionally, parent's presence was generally considered very important. The shift from extended families to nuclear families, with the family institution increasingly becoming private, has really affected the adolescent in a negative way. The concepts of childhood and child rearing have changed dramatically through

centuries (Gander, 2001). It therefore, happens that bringing up adolescents or children is no longer a socially distributed role. Time spent with the adolescents by their parents is relatively less and families are struggling to cope with the time crunch which has affected social growth of the adolescents.

The general behavior of the adolescents is most likely healthy if they spend time with their parents. The changes that have occurred in the society have deprived adolescents parental presence. This has exposed the adolescents to numerous challenges. The unhealthy sexual behaviors by the adolescents examined in this study attests to this reality. The effects of unhealthy behaviors by adolescents are also societal hence the society must find alternative mechanisms to supplement the challenges of parenting process.

5.4 Recommendations

5.4.1 Recommendations for Addressing Parent-Adolescent Communication and Risky Sexual Behaviors by Adolescents

On the findings of this research and the above conclusion, the researcher recommends as follows:

The study has confirmed that parent-adolescent non-communication is significant and it is affecting the sexual risk taking behavior of the adolescents. This will ultimately be costly to society. Due to unavailability of natural mentors, there is need to institute programs which will build capacity and help the adolescents understand issues of human sexuality. There is need to institute supplementary programs, particularly planned mentorship programs which will provide comprehensive knowledge on sexuality matters.

Adequate funding in support of young people's programmes is needed. The government must strategically target their resources to interventions that respond to the specific situation of its young generation.

There is need for training programs targeting parents on effective adolescent parenting which should entail topics with tangible information including effective parent-adolescent communication on sexuality. The study established that most adolescents for instance are in boarding schools. The training will be important to parents in that they will be able to spend the little time they spend together with their children to address sexual issues and the behavior challenges that adolescents faces. Parents will also have a platform to share experiences among themselves on effective parenting.

The Government should also work towards reducing the current school syllabus load so as to enable schools to comfortably implement other holistic programs such as sexuality programs.

5.4.2 Recommendations for Further Research

Further research is needed to better understand the social context within which adolescents engage in risky sexual behaviors and the factors that drive adolescents to engage in sex work. Further studies should be done in other Sub-counties in other Counties since different Sub-counties have different geographical and social contexts, meaning that what may be true in Nairobi may not be necessarily true in Nakuru County which brings different research context.

Based on the findings of this study, it is clear that there is need to determine the accessibility of comprehensive sexuality information among adolescents and availability of friendly services such as condom availability.

Study findings have provided a strong support for the continued research of the communication process between parents and adolescents and how it has affected the behavior of the adolescents. In light of this, there is need for further research targeting a larger sample of adolescents in both urban and rural settings.

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APPENDICES

APPENDIX 1:

Introduction

My name is Peris Wangari Njaramba, a Master of Health Psychology student at the University of Nairobi Department of Psychology. In partial fulfillment of the requirements of the stated degree course, I am conducting a research Project on the relationship between parent-child communication on sexuality and sexual risk behavior among adolescents in this sub county and you have been selected for the study. I am kindly requesting you to fill the attached questionnaire to generate data required for this study. The information you give will be treated with confidentiality and will be purely used for academic purposes only. Thank you.

Appendix 2

Section A: Biographical Information

Questionnaire Serial No.: _____

Place of Interview: _____

Date of Interview: _____

Time of Interview: _____

Tick appropriately

1. Male ( ) Female ( )

2. Age (In years)

( ) 14 – 15 years ( ) 16 – 17 years

3. What is your religion?

( ) Christian ( ) Muslim ( ) Hindu ( ) Jewish ( ) Other (Specify) ----------

4. What is your current living arrangements?

( ) School Residence ( ) With Mother ( ) With Father ( ) With Both Parents ( ) Alone ( ) Others (Specify) …….

5. How much do you pay for rent?

( ) Kshs.5000 and below ( ) Kshs.6000 – Kshs. 10,000 ( ) Kshs.10,000 and above

6.a. How many brothers and sisters do you have?

( ) none ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 or more

b. Do you currently live with your brother(s) or sister(s)? ...

( ) yes ( )... no

7. a. Are your both parents alive?

( ) Yes ( ) No

b. If no, who is alive?

( ) Father ( ) Mother

c. If none of your parents is alive/available, whom do you stay with? ……
……

10. Who is the breadwinner in your family? ……

……

11. a. Do you hold discussions about sexuality with your mother?

( ) Yes ( ) No

b. If Yes, what do you talk about? ……

……..

……..

c. Do you hold discussions about sexuality with your father?

( ) Yes ( ) No

d. If Yes, what do you talk about? ……

……..

……..

12. In the past year, how often have you seen / spoken to your father?

( ) daily ( ) few times a week ( ) weekly ( ) monthly ( ) few times a year ( ) never

13. Which of your parents was mainly responsible for your upbringing?

( )mother ( ) father ( ) both

14. Whom do you feel closer to?

( ) mother ( ) father ( ) both

B. Parent-adolescent Communication Questionnaire

Part 1. The Weighted Topics Measure of Family Sexual Communication Scale (Fisher, 2006)

Using a scale from 0 to 4, with 0 = none and 4 = a lot, please indicate (circle) how much discussion you have had with your parent/s about the following topics.

_____Pregnancy	0	1	2	3	4
_____Fertilisation	0	1	2	3	4
_____Sexual Intercourse	0	1	2	3	4
_____Menstruation	0	1	2	3	4
_____Sexually transmitted (venereal) diseases	0	1	2	3	4
_____Birth control	0	1	2	3	4
_____Abortion	0	1	2	3	4
_____Prostitution	0	1	2	3	4
_____Homosexuality	0	1	2	3	4

C. Parent-adolescent Communication Questionnaire (Dittus & Gordon, 2004).

Using the scale below, please indicate how much you agree or disagree with EACH of the following statements about the communication between you and your parent/s. If you are unsure about the answer in terms of both parents, choose the one to whom you feel closer.

	Statement	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	I can discuss my beliefs with my parent/s without feeling restrained or embarrassed					
2.	Sometimes I have trouble believing everything my parent/s tell/s me					
3.	My parent/s is/are always a good listener/s					
4.	I am sometimes afraid to ask my parent/s for what I want					
5.	My parent/s has/have a tendency to say things to me which would be better left unsaid					
6.	My parent/s can tell how I'm feeling without asking					
7.	I am very satisfied with how my parent/s and I talk together					
8.	If I were in trouble, I could tell my parent/s					
9.	I openly show affection to my parent/s					
10.	When we are having a problem, I often do not talk to my parents					
11.	I am careful about what I say to my parent/s					
12.	When talking to my parent/s, I have a tendency to say things that would be better left unsaid					
13.	When I ask questions, I get honest answers from my parent/s					
14.	My parent/s tries/try to understand my point of view					
15.	There are topics I avoid discussing with my parent/s					
16.	I find it easy to discuss problems with my parent/s					
17.	It is very easy for me to express all my true feelings to my parent/s					
18.	My parent/s nags/bothers/nag/bother					

	me					
19.	My parent/s sometimes insult/s me when angry with me					
20.	I don't think I can tell my parent/s how I really feel about some things					
21.	My parent/s would not want to answer my questions about sex					
22.	My parent/s would only lecture me if I tried to talk to him/her/them about sex					
23.	I don't need to talk to my parent/s about sex; I know what I need to know					
24.	My parent/s do/does not know enough for me to want to talk with him/her/them about sex					
25.	My parent/s would not be honest with me if I talked with him/her/them about sex					
26.	My parent/s is/are too old to be able to relate to me about sex					
27.	I would only make my parent/s suspicious of me if I tried to talk to him/her/them about sex					
28.	It would be difficult to find a convenient time and place to talk to my parent/s about sex					
29.	My parent/s is/are just too busy to talk to me about sex					
30.	My parent/s would ask me too many personal questions if I tried to talk with him/her/them about sex					
31.	My parent/s do/does not want to hear what I have to say when it comes to sex					
32.	My parent/s and I would only argue if we were to talk about sex					
33.	My parent/s would be embarrassed talking to me about sex					
34.	I would have a difficult time being honest about my behaviour with my parent/s if we were to talk about sex					
35.	My parent/s would get angry if I tried to talk to him/her/them about sex					

C. Adolescent Sexual Risk-taking Behaviour Questionnaire

The next questions are about your sexual behaviour. By sex we mean oral, vaginal or anal sex, but NOT masturbation. When we talk about condoms, we mean both male and female condoms.

(Tick Appropriately)

1. How many people, including clients, have you had sex with in the last month?

A. None …….

B. One ……

C. Two ……. …….

D. 3-5 people……...

E. 6-10 people……..

F. More than ten people……..

2. How often have you used condoms when having sex with your regular partner(s)?

Number of regular partner(s) ( ) 0 ( ) 1 ( ) 2 ( ) 3 and more

(If you chose 0, skip Question 2)

A. Every time……

B. Often……..…….

C. Sometimes……..…….

D. Rarely……..……

E. Never…….……

3. How often have you used condoms when having sex with casual partners?

A. No casual partners …….....

B. Every time…….…….

C. Often…….…….

D. Sometimes…….…….

E. Rarely……

F. Never ……..……

4. Do you practice paid sex?

( ) Yes ( ) No

5. How often have you used condoms when you have been paid for sex in the last month?

a. Every time…….

b. Often…….

c. Sometimes…….……

d. Rarely……..……

e. Never ……..……

5. a) Do you practice anal sex?

( ) Yes ( ) No

b) What are your reasons for Practicing anal sex? .....

……

……

……

c) How often do you use a condom when practicing anal sex?

a. Every time…….

b. Often…….

c. Sometimes…….……

d. Rarely…………………………………………..………………

e. Never …………………………………………..………………

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KENYA

07th September 2018

NACOSTI
P.O. Box 30623 – 00100
NAIROBI

Dear Sir/Madam

RE: PERIS WANGARI NJARAMBA – REG. NO. C50/7601/2015

The above named person is a duly registered student in the Faculty of Arts at the University of Nairobi. She is seeking a research permit from your office.

Kindly accord her the necessary assistance to allow her collect data.

Thank you in advance for your cooperation.

Yours Sincerely,

DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF NAIROBI

Dr. Luke Odiemo,
Chairman,
Department of Psychology

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NAIROBI-KENYA

Ref: No. **NACOSTI/P/18/85695/25655**

Date: **13th October, 2018**

Peris Wangari Njaramba
University of Nairobi
P.O. Box 30197-00100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"The relationship between parent-child communication on sexuality and sexual risk behaviors among adolescents in Kasarani Nairobi County"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **12th October, 2019.**

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

Approved
16/10/2018

COUNTY COMMISSIONER
NAIROBI COUNTY
P. O. Box 30124-00100, NBI
TEL: 341666

The County Director of Education
Nairobi County.

Republic of Kenya

MINISTRY OF EDUCATION
STATE DEPARTMENT OF EARLY LEARNING AND BASIC EDUCATION

Telegrams: "SCHOOLING", Nairobi
Telephone; Nairobi 020 2453699
Email: rcenairobi@gmail.com
cdenairobi@gmail.com

When replying please quote

REGIONAL COORDINATOR OF EDUCATION
NAIROBI REGION
NYAYO HOUSE
P.O. Box 74629 – 00200
NAIROBI

Ref: RCE/NRB/RESEARCH/1/64/VOL.I **Date: 16th October, 2018**

Peris Wangari Njaramba
University of Nairobi
P. O. Box 30197 - 00100
NAIROBI

RE: RESEARCH AUTHORIZATION

We are in receipt of a letter from the National Commission for Science, Technology and Innovation regarding research authorization in Nairobi County on "***The relationship between parent-child communication on sexuality and sexual risk behaviors among adolescents in Kasarani Nairobi County***".

This office has no objection and authority is hereby granted for a period ending **12th October, 2019** as indicated in the request letter.

Kindly inform the Sub County Director of Education of the Sub County you intend to visit.

REGIONAL COORDINATOR OF EDUCATION NAIROBI 16 OCT 2018

JAMES KIMOTHO
FOR: REGIONAL COORDINATOR OF EDUCATION
NAIROBI

Copy to: Director General/CEO
National Commission for Science, Technology and Innovation
NAIROBI