Lund University

Lund University Master of International Development and Management

May, 2011

TAKING A WALK WITH THE BIRDS AND THE BEES: A STUDY ON PARENT TEENAGER SEXUAL COMMUNICATION IN CHOMA, ZAMBIA

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Acknowledgements

After a long and grueling process, which included many hours of soul-searching, staring blankly at my computer screen, and contemplating what I should have for lunch, my thesis is finally ready to be submitted. This would not have been possible without the support from all of the people in my life, and this piece of academic verse is as much yours as it is mine.

First off, I would like to thank the whole LUMID staff for developing the program and giving me this awesome opportunity. Everyone was always more then willing to help me out in whatever I needed, whether it was Sanna letting us make multiple phone calls to Africa, or Agnes writing recommendation letters. All of this is greatly appreciated. A big thanks to my supervisor Kristina, who always gave me the perfect mix of praise and criticism, and kept things feeling light even when everything was feeling doomed. Also, a shout out to all the other LUMID students of Batch 4, who were always supportive, and helped make these last couple years a lot of fun.

I would also like to thank the whole PPAZ family for all of their support, and allowing me come and work with them in Zambia. I would especially like to thank the Choma crew, particularly Edgar, for making sure that I was always part of the team, and for making sure that I had plenty of Mosis. To Rodwell and Muchoya, thanks for always keeping the office lively with your bickering banter and questionable taste in music. Also, a special thanks to Kelvin, Osborne, Mike, Chuma, Mbweeda and the rest of the YMEP crew for setting up the focus groups and helping me out with the research. You guys made this process a whole lot easier.

A big thank you to my family for always supporting and believing in me, not only with this paper, but with all of the somewhat unconventional choices I have made that has lead me to this point. I know I don't always make things easy on you, but I know that you are always there for me and it means a lot. Finally, huge thanks to my awesome wife, Karin, for always being understanding and being patient with me through this whole thing. Most girls wouldn't be okay with their husband leaving for four months just three weeks after their wedding, but you are not like most girls. I still cannot believe how lucky I am to have found someone like you. Jag älskar dig.

To all those who I forgot to mention and again to those I have:

Thank You!
Mike

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Acronyms

AIDS- Acquired Immune Deficiency Syndrome

ART- Antiretroviral Treatment

CSO- Central Statistics Office

HIV- Human Immunodeficiency Virus

NGO- Non-Government Organization

PBC- Perceived Behavioral Control

PPAZ- Planned Parenthood Association of Zambia

PTSC- Parent Teenager Sexual Communication

RFSU- Swedish Association for Sexuality Education

SRH- Sexual Reproductive Health

SSA- Sub-Saharan Africa

STD- Sexually Transmitted Disease

TPB- Theory of Planned Behavior

UNDP- United Nations Development Program

UNICEF- United Nations Children's Fund

WHO- World Health Organization

YMEP- Young Men as Equal Partners

Abstract

This study was conducted in order to gain an in-depth understanding of Parent-Teenage Sexual Communication (PTSC) by focusing on a small town in Zambia. Recent studies have suggested that African parents are breaking traditions and beginning to speak with their children about the dangers associated with sexual risk, and this study aims to further what we know about how African parents and their children communicate on this subject. This is a qualitative study, in which the data was gathered through the use of focus groups, with adolescents and parents each interviewed in separate groups. The data was then analyzed using elements of the Theory of Planned Behavior; breaking PTSC into attitudes, external factors, and perceived behavioral control. The results indicate that parents in Zambia are attempting to initiate PTSC, primarily because of the dangers of HIV/AIDS and early pregnancy. Their primary message is abstinence, and they do not encourage the use of condoms or other prevention methods. The adolescents exhibited both fear and respect for their parents, and acknowledge that they do not feel they can be open with their parents, External factors such as taboo, gender and religion all play important roles in predicting PTSC in Zambia.

Word Count: 14,852

Chapter 1 - Introduction

1.1 Emergence of Parent Teenager Sexual Communication in Zambia

In recent years, a number of studies have suggested that Parent Teen Sexual Communication (PTSC) has a considerable effect on adolescent sexual behavior, and if done in the right way, could influence adolescents to make safer decisions concerning their sexual health. (Blake et al, 2001; Cha, Kim, Doswell, 2007; Schouten et al, 2006; Whitaker et al, 1999;). In Zambia, and Sub-Saharan Africa (SSA) as a whole, it has long been taboo for parents to talk to their children about anything concerning sex. Out of the thousands of tribes in SSA, one norm that is consistent with all of the tribes is the reluctance of adults to speak with their immediate offspring about sexual issues, as grandparents and village elders often performed this job (Mabunga, 2007). Traditionally in Zambia, extended families would live and stay together; meaning grandparents would easily be able to instruct their grandchildren on sexual issues (Simpson, 2003). However, as Zambian society progresses, individuals are becoming more focused on their own careers and wealth, and the traditional family structure is being replaced by a nuclear family structure where relationships with the extended family are weakened (Goode, 1963; Hagen, 1962: Inkeles, 1976;). With grandparents and village elders playing a lesser role, parents in Zambia are now taking on an even bigger role in the socialization of their children (Pillai & Barton, 1998).

This larger role indicates that parents in Zambia will now be faced with providing guidance to their children on their Sexual and Reproductive Health (SRH). With the expanding complexities concerning SRH that today's adolescents face, it is increasingly important to study and understand the channels of communication that adolescents share with their parents, in order to understand why they behave in the manner of which they do. This study attempts to look at how parents are adjusting to this new role of being responsible for teaching their children about SRH, and how their children are responding to this. The research was conducted in Choma, a small market town in Zambia's Southern Province, with the assistance of the Planned Parenthood Association of Zambia (PPAZ).

1.2 Research Problem

There are many dangers facing Zambian adolescents today concerning their sexual health. The most problematic by far is the HIV/AIDS virus, as today one out of every seven Zambian adults are HIV positive (World Health Organization {WHO}, 2007). Adolescents are at particular risk of contracting HIV, with half of all new reported infections between the ages of 15-19 (Agha & Van Rossem, 2004). In the fight against HIV, adolescents are also mentioned as an extremely important target group in that they are the ones who are still developing their personal beliefs, and they are also the ones forming new relationships and engaging in high-risk sexual behavior (Central Statistics Office {CSO}, 2010). Treatment options for people living with HIV/AIDS have improved over the last five years, with 66% of the people needing Anti-Retroviral Treatment (ART) receiving it. However, with ART programs becoming more successful, and more HIV positive Zambians are able to lead longer lives, this means that in the future there will be many more people than now living with HIV, and this will create a heavy burden on Zambia's already poor health facilities. Therefore, the more sustainable approach to fighting the AIDS epidemic is to improve prevention programs.

In addition to the problems associated with HIV, over 25% of teenage girls in Zambia become pregnant before their 19th birthday (CSO, 2010). Adolescent girls from ages 15-19 are twice as likely to die during pregnancy then girls over 20, and girls under 15 are five times more likely to die (Graczyk, 2007). Zambia has one of the world's highest maternal mortality rates, with 519 women dying out of every 100,000 births (Smith, 2010). There is also the problem of many girls dying from illegal abortion in Zambia (Koster-Oyekan, 1998). Zambia actually has one of the more liberal abortion policies in SSA, but it can still be very difficult for young girls to receive abortions because of high prices, far distances to hospitals, and the refusal of many doctors to grant abortions due to religious practices (ibid). It is estimated that for every 100,000 births, 120 girls die from illegal abortion, and over half of them are girls under the age of 18 (ibid).

An added problem is that even though almost all Zambia adolescents (94%) know that the dangers of risky sexual behavior can be prevented, they continue to engage in it (CSO, 2010). Of Zambian adolescents who are sexually active, only 30% of them reported to wearing condoms at first sex, and only around 30-40% wear them regularly (CSO, 2010). Zambian adolescents having sex with non regular partners is also on the rise, providing a troubling combination of sexually active adolescents having sex with more partners, and wearing less condoms (ibid).

Parents are in a unique position to help guide their children into healthy and responsible sexual adults, by providing positive and accurate information, and by promoting mature and safe decision-making (Miller et al, 1998). The WHO (2007) recently reported that parents are the key in improving adolescent health in developing countries, and that parents are always transmitting their values and expectations concerning sexuality, either consciously or unconsciously. Community leaders in Africa have said that parents must be the starting point for all sexual guidance, and that other sources of information such as schools and NGO's can only build upon the knowledge that children have obtained from home (Awusabu-Asare, Bankole, Kumi-Kyereme, 2008). Yet, even in this age of HIV/AIDS, a communication gap exists in Africa that prevents meaningful communication on sexual issues between parents and their children (Amuyunzu-Nyamongo et al, 2005). Parents in Africa acknowledge that they cannot speak with their children about these issues, and adolescents say they are often too scared to bring up these issues with their parents (ibid). In a region that is experiencing one of the worst public health epidemics known to man, parents need to be able to have an open relationship with their children concerning sexuality, yet this is often not the case.

1.3 Purpose of Study and Research Questions

Recent studies in other African countries have suggested that parents are making an increased effort to open up their relationship with their children in order to promote more responsible decision-making (Babalola et al, 2005; Biddlecom et al, 2009; Wamoyi et al, 2010). However, most of these studies only speak with the children, which could lead to an unbalanced picture of the situation, and makes it difficult to find out what is really

happening in these conversations. This study aims to gain a better understanding of this communication gap that exists between parents and their children in Zambia by interviewing them separately and cross-examining their responses. This will provide a more complete assessment of the ways in which PTSC takes place in the home, and also why it does not happen more frequently.

Additionally, the WHO (2007) has said that studies of this nature will be valuable in planning future youth SRH interventions, as many of these interventions are now being created with the intention of including the parents as an integral aspect. This study aims to identify key themes form PTSC in Zambia that could assist SRH interventions that are aimed at raising the involvement of parents.

In an attempt to strengthen the information on PTSC in Sub-Saharan Africa, this paper will explore the research question:

What is the nature of parent-teen sexual communication in Choma, Zambia?

Through exploring this question, this paper will delve into these sub-questions:

a) In which ways do the attitudes and beliefs of both parents and adolescents towards condoms influence PTSC?
b) What impact does social taboo, gender and religion play on both the quantity and quality of PTSC?
c) How does the perceived and actual knowledge of the parent affect PTSC?

1.4 Structure of Thesis

The structure of the thesis will be as follows: Chapter Two will present the methodology of the paper, including a brief introduction to Zambia, followed by description of the methods that were used to accomplish this study. Chapter Three will consist of a literature review that discusses what previous research from western countries has found on SRH, and a look into what new studies have found on PTSC in Sub-Saharan Africa.

Chapter Four will introduce the theoretical framework for this paper, The Theory of Planned Behavior, and describe how this theory will be utilized in the analysis. Chapter Five will the present the primary data analysis, while Chapter Six will present a final analysis and conclusion.

Chapter 2 - Background & Methods

2.1 Country Profile

Zambia is a landlocked country in the Southeastern region of SSA. For its size, it is sparsely populated, with an estimated 13.3 million inhabitants coming from more then 70 different ethnic tribes. Zambia has an incredibly young population with 47% of its population under the age of 15, making it a highly dependent nation (WHO, 2009). Its fertility rate remains one of the world's highest at 6.2% (ibid). It also is one of the most urbanized nations in SSA, with 38% of the population living in urban centers.

After gaining independence from the British in 1964, Zambia was well on its way to industrialization. It was the worlds third biggest producer of copper, and one of the richest countries in SSA (British Broadcasting Comapany, 2011). However, when the price of copper drastically fell in the 1970's, Zambia's economy was devastated, and turned one of Africa's most promising economies into what is today one of the world's poorest countries. According to the World Bank (2011), 68% of the population is living below the poverty line, and Zambia ranks near the bottom of the United Nations Development Program's (UNDP) Human Development Index (2010), ranking 166th out of 177 countries (WHO, 2009).

2.1.1 Health in Zambia

Despite being a relatively stable and peaceful country for the past fifty years, Zambia now ranks third to last in the world in life expectancy, with the average person only living 47.3 years (UNDP, 2010). This is actually worse than in 1980, when the average life expectancy was around 51 (WHO, 2009) This decline in general health can be attributed to two key factors. The first is that Zambia still has the 17th highest under-5

mortality rate, with 179 out of every 1000 children failing to make it to their fifth birthday (with 86 children failing to see even their first birthday) (UNICEF, 2010). The second factor has been the HIV/AIDS epidemic, which has decimated the Zambian population.

2.2 Methodology

This study aims to understand the nature the nature of PTSC in Zambia through an interpretivist approach. Interpretivism is described as a strategy, which requires the researcher to respect the differences between people and to understand the meanings that are important to them (Bryman, 2008; 366). It is also a strategy that is saying that in order to gain an understanding of a certain phenomenon, you have to study all of the parts that encompass it (Strauss & Corbin, 1990; 18). In this case, the study is aiming to utilize the interpretivist approach by studying both the views of the parent and the views of the adolescent with the intention of trying to uncover a truth which probably rests somewhere in between. Knowing how a parent interprets their children's sexual behavior and how a child perceives the parent's interpretation is very important when determining how they will communicate about SRH (Wamoyi et al, 2010).

2.2.1 Qualitative Design

This study adheres to a qualitative design as it seeks to answer questions about a social society by examining the individuals that occupy that particular setting (Berg, 2003; 7). It can be called more specifically an ethnographic approach, as in this situation the study is based on a specific cultural group (in this case Zambia adolescents and their parents), in their own domain, primarily by conducting interviews, and making observations based on this interaction (Creswell, 2007; 13). The qualitative method was useful in this study in that this research was most interested in the content and quality of PTSC in Zambia, and not necessarily what the results of these conversations merit.

2.2.2 Connection to Organization

The research for this study was performed while the researcher was interning for The Planned Parenthood Association of Zambia (PPAZ). This particular internship was

working with the Young Men as Equal Partners Program (YMEP), a project funded by the Swedish Association for Sexuality Education (RFSU). The peer educators who set up the focus group discussions were all youth leaders for the YMEP project, and have been with the project since it formally began in 2005 (RFSU, 2008). Before each focus group, the participants were made aware that this research was being done for educational purposes, and that these discussions were not a PPAZ or YMEP activity. The fact though that both the researcher and the organizers were associated with the organization allowed the participants to trust the proceedings, and allowed for a more open and free discussion. Besides assisting the organization of the focus groups, PPAZ or YMEP had no influence on the content of this research.

2.2.3 Selection of Site

The head office for the YMEP project is situated in Choma, a small market town in the Southern Province of Zambia. Basing the study in Choma had some distinctive advantages. The first is that although the center of Choma is quite commercial, the outlying residential areas are rural in their nature. Consequently the participants in the focus group were both from the city area and the rural area, which creates a better representation of Zambian Society as a whole. This would not be possible in any of the larger cities, as you would have to travel some distance to any rural area. The second advantage is that since PPAZ has access to a conference room in Choma, which the researcher was able to use in order to secure a quiet and practical location for the focus groups.

2.2.4 Data Collection

The two primary methods that were chosen to administer the research for this study were focus groups and the study of secondary data sources. The study of previous documents and literature in this case was important because by knowing the norms of PTSC from the rest of the world, it was easier to know when something stood out during this research, and thus would require further questioning. Government reports and statistics from Zambia were also heavily researched in order to develop an understanding of the sexual behavior exhibited by Zambia's youth.

Focus Groups were chosen as the main method of interviews for several reasons. With this topic, it seemed more relevant to look into how these people felt about communicating about this topic and the focus group is the best method because it forces people to probe into each other's opinion and question the reality of people's answers (Bryman, 2008; 473). Participants are often forced to challenge each other's answers as to why certain aspects of society are the way they are, and this aspect from focus groups gives the researcher a more realistic account of what people think (ibid; 473).

A second determinant for choosing the focus group setting is that since this could be seen as a controversial issue, participants tend to be more open in a group setting (Langford & McDonagh, 2003; 4). Once a participant knows that they are not alone in dealing with a sensitive issue, they speak more openly and honestly and one can discover information that would have remained hidden in a one-on-one situation (ibid; 4). Through working on previous assignments in Zambia, it was found that during individual interviews participants were often shy and quiet, but in a group setting they were much more active and outgoing.

2.2.5 Sampling

To select the participants for the focus groups, there was somewhat of a combination of convenience sampling and purposive sampling (Bryman, 2008; 458). Purposive sampling is finding participants who are relevant for the particular are of study, while convenience sampling takes participants that are convenient to the researcher. The focus groups were organized by asking the peer educators in PPAZ to organize groups of youths between the ages of 15-24, and groups of parents with at least one child in that same age range. The age range was determined by what the Zambian Sexual Behavior Report refers to as youths, and this age range was also what was allowed in the reproductive health clubs formed by the peer educators (CSO, 2010). The peer educators all have groups that they normally work with, and this is where most of the youth participants came from, while the parents were adults that the peer educators were familiar with.

While letting members of the organization select the participants for the focus groups may seem to be purely convenience sampling, this is not entirely true. PPAZ has peer educators that work in specific areas with a different demographic of subjects in each group. One peer educator works at an all girl Christian school, while a different one works only with adolescents from a more rural setting. As mentioned earlier, one of the advantages of placing the study in Choma is that it is possible, without travelling too far, to interview participants from both relatively both urban and rural settings. Therefore the peer educators were selected based on the adolescents that they normally work with, with the intention of talking to both adolescents and parents from different backgrounds.

Berg points out that the convenience sample can be an excellent source of gathering data quickly and inexpensively, which was both needed in this case (2004; 35). One negative that is normally associated with convenience sampling is that the participants are not an appropriate fit for the given study (Berg, 2004; 36). However in this case, all of the participants were appropriate in that they matched the ages that were requested of the subjects.

One side effect of using pre-existing groups was that many of the participants knew each other from previous meetings. This could be seen as controversial as some researchers believe that by having participants who are familiar with each other could contaminate the session based on familiar styles of interaction (Bryman, 2008; 482). However it is also likely that using pre-existing groups creates a more natural environment, where participants are more open and free to discuss their opinion (ibid; 482). Since this topic could be seen as some as uncomfortable, these pre-existing groups made it more comfortable for the participants and therefore more reliable data was attained.

There was also the question of how many people should be in each group. It has been said that when dealing with controversial subjects, it is better to have smaller groups, as it is more conducive to people sharing more personal information (Bryman 2008; 479). However there were two more important factors when deciding what would be the ideal number in each group. The first is the possibility of people not showing up, and the

second is the possibility of too many people showing up when they heard snacks were being handed out (both scenarios happened on different occasions). Therefore it was decided that six people should participate in each group, as it would still allow a group if a couple people didn't show, and would allow for a couple extra people to show up as well.

2.2.6 Focus Groups

During the process of data collection, ten focus groups were conducted. Six of the focus groups consisted of adolescents and the remaining four were conducted with parents who have kids in the adolescent age range (15-24). Of the adolescents that were interviewed, there were 24 boys and 21 girls, with ages ranging from 15-23, and the average age being 18. The groups with parents consisted of 15 mothers and four fathers. One of the groups with the adolescents was all girls, and two of the groups with the parents were all mothers, while all the rest of the groups were mixed. In the mixed groups, girls and boys spoke about the same amount and they seemed to be comfortable speaking in front of one another. In the mixed parent groups, mothers were a bit more vocal then the fathers, which can probably be attributed to the fact that they seemed to be more involved with the lives of their children.

Most of the sessions took place in a conference room at a local health clinic, which PPAZ has access to at certain times during the week. Before the start of each focus group, each participant was given a short questionnaire that consisted of about 10 short questions. This questionnaire had two primary purposes. The first was that it was an easy way of recording the age, sex, and some other basic facts about all of the participants. The second reason is that it helps validate the external reliability of the findings. The questionnaires asked the participants certain questions like "are you sexually active" and "do you regularly wear condoms." The answers to these questions were then cross analyzed with sexual behavior surveys in Zambia to make sure that these subjects were representative of Zambian adolescents as a whole.

After the questionnaires were completed, the discussion started with an introduction by the researcher and the peer educator, a brief description of the research assignment, and then the group members were asked to introduce themselves. This was designed for the participants to begin to feel comfortable in what some may see as an unnatural or potentially disconcerting situation (Berg, 2003; 134). The groups were also informed that their names were not going to be used in the research, and that it was important for all information shared in the group to be kept confidential. Ensuring confidentiality is crucial as participants will be apprehensive of answering honestly if they fear being exposed (Berg, 2003; 140).

For both the parents and the adolescents, a semi-structured questionnaire was designed to initiate the conversation points that were relevant for this research question. This included some intentional probes on certain questions with the intention of prolonging the conversation in the event that the participants are shy on a certain topic (Berg, 2003; 134). After each group, the responses were analyzed for interesting or surprising results, and these results were then followed up in the next session. The purpose of the questions in addition to jumpstarting the conversation and adding structure to the discussion was so that participant reaction could be compared throughout the different groups (Bryman, 2008; 483).

2.2.8 Quality Considerations

When evaluating the quality of qualitative research, it is important to look at the external reliability and the external validity of the study (Bryman, 2008; 376). The external reliability of the study is based on whether the study can be replicated with roughly the same results. Its is impossible to know if this study would be exactly replicable, but one measure to ensure that its external reliability could be argued for is that the study several focus groups were conducted in both urban and rural settings and that similar responses were obtained in each. Another measure that ensures external reliability is that the adolescents' sexual behavior, which was taken from the questionnaires, is consistent with the statistics from the 2009 Zambia Sexual Behavior Survey. This furthers the case that

the adolescents that participated in this survey are representative of adolescents from the rest of the country.

The external validity (or transferability) asks whether the findings can be generalized across social settings (Bryman, 2008; 376). This is again hard to prove from this study, as it was only tested in one setting, albeit with participants from different demographics. Therefore this study provides a thick description in the analysis, so the reader can make his or her own judgment whether the study is transferable.

2.2.9 Recording, Transcription, and Analysis

Dependability is important in qualitative research, and consequently all of the focus group discussions were recorded using the Guitar Band Program. In order to make sure that all the voices could be heard on the recording, it was important that all of the sessions take place indoors to reduce unwanted noise. It is critical to record focus group discussions because if you only take notes, you can lose one of the major advantages of the focus group, which is observing the way that people interact (Bryman, 2008; 476). It is also vital to record the interviews when conducting a focus group as to not break up the flow of the discussion by having people hold on while the researcher takes notes. The interviews were then later transcribed, making sure that nearly all words are transcribed, but leaving out uncertain phrases, repeated words, utterances, indication of voice inflections and pace of conversation (Macnaghten & Myers 2004; 73). It should also be noted that the focus groups were conducted mostly in English, but if the participant wanted to express something in their local language, they could do so and the peer educator would then translate to English.

After the transcriptions were completed, the data was then coded into three distinct groups that were pre-determined (Creswell, 2009; 184). The first group consisted of answers that were expected based on previous studies and common sense. The second group consisted of all the answers that went against the conventional knowledge on the subject and was not anticipated. The third group was all the responses that didn't fit in the previous two groups, and required further analysis. After the groups were formed, the

coding was used to form a small number of themes, which represent the major findings from the study.

2.2.10 Limitations

Research Bias- By using the pre-existing clubs that the peer educators had formed for the focus groups, it could be argued that the findings have a slight bias. The reason for this is that the participants (especially the youths interviewed) are already used to discussing these issues and could be more knowledgeable on these issues then the average Zambian youth.

Power Imbalance- Since the researcher was associated with PPAZ, a well-known SRH organization, and a foreigner from a visiting university, it can be assumed that some of the participants may not be as open with their answers than if there was an independent researcher from their own culture. They were all advised that this research was independent from PPAZ, but the fact that they knew that the researcher was working with the organization may have influenced some answers into what they thought was the correct response rather then the truth.

Limitations of Focus Groups- It should also be noted that the use of focus groups in research has its own limitations. It is often more common in focus groups for participants to express the views that are culturally expected of them than in individual interviews (Bryman, 2008; 489). In this study, at times it did seem like some members of the group were giving answers they thought were appropriate, or answers that made them look good in front of the other members of the group. This was especially the case whenever sexual activity was brought up; with boys being boastful and the girls acting shy. There was also the occasional problem of group effects, such as one participant doing most of the speaking, or people coming and not participating (Bryman 2008; 489).

2.2.11 Ethical Considerations

As this can be considered a tough subject to discuss, it is important to make sure that all ethical principles were followed when the data collection was being performed. All of the

participants were informed of the type of research that was being done before coming to the focus group and before the start of each group. Their names were kept anonymous, and they were instructed not to repeat any of the information they heard outside of the groups. This is especially important considering that many of the participants knew each other, and there is the danger of them speaking out about what the others said outside of the group. They were also all informed that the sessions would be recorded and transcribed later, and that if anyone objected to this, that they could speak to the researcher in private.

A further ethical concern that was taken into consideration was the age of the participants. In Zambia, the legal age of consent is 15, and PPAZ uses this as the age in which it is appropriate to talk to youth about sensitive issues. Therefore all participants in the focus groups were required to be over the age of 15. In order to compensate for the participants time, youths were compensated by receiving snacks and drinks, while the parents were compensated with a small sum of money.

Chapter 3 – Literature Review

3.1 – Parent-Teenager Sexual Communication in Western Countries

Studies on PTSC have been going on since the 1960's, but most research on this topic has been conducted after the AIDS outbreak in the 1980's. DiIorio, Pluhar, and Belcher (2003) conducted a study that looked at all research on this topic from 1980 until 2002, which encompasses 95 different studies. It should be noted that 92% of these studies were performed in the United States, with the remaining studies performed in Canada, Australia, and Mexico.

The following is a summary of their major findings. Parents are more likely to report that PTSC has taken place then adolescents are. Gender plays a key role in conversations, as mothers are more likely than fathers to talk to their children, and daughters are more likely to be talked to than sons. The major roadblocks that prevent conversation are

embarrassment, difficulty in accepting adolescent sexual behavior, and varying communication styles between the parents and adolescents. Knowledge, or the perception of knowledge, and the pre-existing quality of communication was a major indicator of predicting both content and quality of PTSC. Numerous studies have found a positive association between PTSC and adolescent sexual behavior, but other studies have found mixed findings, while others have found no associations (DiIorio, Pluhar, Belcher, 2002).

Sneed (2008) believes the reason that many researchers face problems when trying to find a positive association between PTSC and adolescent sexual behavior is that in many instances, parents will initiate PTSC when they are beginning to find clues that their child is sexually active. It could also be the case that adolescents seek out sexual advice from their parents after they have made their sexual debut. Both of these situations could distort studies to conclude that PTSC leads to a higher amount of adolescent sexual risk (Babaloa, Tambashi, Vondrasek, 2005; Fuglesang, 1997). However, Sneed argues that this is probably due to the fact that if adolescents are talking to their parents about sex, there is a good chance they are already having sex (Sneed 2008).

Bruckner and Bearman's (2005) study on virginity pledges is relevant in that it focuses on adolescents who are attempting to abstain from sex until marriage. They set out to see if adolescents who took a virginity pledge during adolescence had any effect on Sexually Transmitted Disease (STD) prevalence compared to adolescents who hadn't taken this pledge. It was estimated that in 1995, over 2.2 million adolescents had taken this pledge in the United States, and that these adolescents had demonstrated a significant delay to their transition to sex. However, what the study found was that adolescents who had taken the pledge had the same STD rates as other adolescents, even though they were exposed to less risk factors through their upbringing (ibid). They found that those who had taken the virginity pledge were less likely to use a condom at first intercourse, and that even though most had learned about STD's in school, they somewhat underestimated the risk of infection. The "True Love Waits" campaign, which promoted the virginity pledges, claimed that the only protection from STD's and pregnancy was abstinence and failed to promote condom use or birth control. The authors believe that this all-or-nothing

approach is potentially damaging to adolescents, as they are not given their entire set of prevention options (Bruckner & Bearman, 2005).

3.2 - Studies on Parent-Teenager Sexual Communication in Africa

Although there has not been a lot of research conducted on PTSC in Africa, a few recent studies have started to take a look at this topic. From these studies, we can begin to make some generalizations on the nature of PTSC in Africa, and see some common trends that previous research has highlighted. One consistent finding throughout most of the studies is that while PTSC does exist in Africa, it is still out of the ordinary for the average family to discuss these issues. In a multi-site study in Tanzania and South Africa, Namisi et al. (2009) found that the vast majority of youths had never communicated with their parents on sexual issues, and that most people believe that sexual issues should only be discussed between married adults. A similar study from the Ivory Coast found that only around 8% of adolescents had ever communicated with their parents about sex (Babaloa, Tambashi, Vondrasek, 2005).

In a 2007 study from Kenya, Njeri Mubunga looked into why parents (in this case educated mothers) were so reluctant in passing on information on sexual issues to their children, especially as the region was suffering through the HIV/AIDS epidemic. What she found is that there were three main factors that were getting in the way of parents speaking with their children: residual traditional barriers, influences from European Christianity, and reliance on other sources such as teachers and books. The residual traditional barriers allude to a time when many African tribes prohibited talks about sex between parents and their children. Adolescents relied on other relatives, such as grandparents, or village sponsors whose job it was to deliver sex education to young men and women during adult initiation rituals. Although most of these initiation rites no longer happen, and these formal restrictions on parental communication about sex are no longer in place, Mubunga (2007) still claims that it is taboo in most African circles for parents to speak with their children about sex.

In addition to traditional values, Mubunga has also found that the emergence of Christianity in Africa has made PTSC difficult. It was found during focus group discussions that the church forbade mothers from ever mentioning any "dirty words," which included anything to do with the male or female private parts. To get around this, it was found that parents often rely on other sources, such as teachers and books to educate their children on sex. Mubunga notes though that these other sources are not usually all that successful as "most of them are products of the same traditional African traditional socialization that inhibits their own parents from discussing sex with them." (2007). Adolescents have also expressed difficulty in communicating with teachers, as they are ashamed of speaking about these topics in their school (Amuyunzu-Nyamongo et al, 2005).

In the situations where parents are attempting to educate their children about sex, most of the emphasis seems to be on abstinence in order to avoid HIV and early pregnancies (Awusba-Asare, Bankole, Kumi-Kyerem, 2008; Babaloa, Tambashi, Vondrasek, 2005; Wamoyi et al, 2009). Most parents will engage in PTSC with the hope of scaring their children away from sex, which very rarely leads to any conversations on prevention methods other then abstinence (Awusba-Asare, Bankole, Kumi-Kyerem, 2008). Many parents believe that by exposing their children to condoms or birth control, they will increase the chance of them becoming promiscuous at an early age (ibid). Because of this, parents were listed as one of the three major barriers preventing community health services educating adolescents on sexual issues[1] (ibid). Conflicts have been reported between NGO's and parents during functions where condoms have been handed out or sexual education videos have been shown (ibid), and many parents believe that their children will become prostitutes if they are exposed to any sex education concerning condom use (Wamoyi et al. 2009).

Although various studies from Zambia have mentioned parents speaking with their children about sex, this research has found no previous studies devoted to this entirely.

[1] The other two barriers are the attitudes of the adolescents themselves and the communication gap between adolescents and adults (Awusba-Asare, Bankole, Kumi-

This study aims to present the reality of PTSC in Zambia, in order to compliment the existing literature on PTSC in Zambia, and to showcase if there any differences between PTS in Zambia and the rest of SSA.

3.4 Summary of Literature

When comparing PTSC in western countries and PTSC in Africa, a few key differences stand out. Barriers in communication such as embarrassment and communication gaps between parents and their children are universal, but traditional barriers (taboo) and religious messages in communication are much more evident in Africa. There is also distrust by parents of other sexual education in Africa, which is not evident in the literature of PTSC in western countries. What is interesting about this is that since parents in Africa distrust other sources of sexual education, they should be more likely to engage in PTSC with their children. However, African levels of PTSC remain very low, while rates from western countries are quite high (DiIorio, Pluhar, Belcher, 2002). To further understand the low rate of PTSC in Africa, this research will focus aspects of its analysis on the barriers mentioned above (taboo and Christianity) that are different from those found in western countries.

Chapter 4 – Theoretical Framework

4.1 The Theory of Planned Behavior

Attempting to predict an individual's health behavior can be somewhat of a harrowing task considering the amount of information one must consider. There is the individual's socio-economic background, religion, status in society, age, family surroundings, and countless other factors which will play into every decision that they will make. Behavioral theory can be used as a guide through the minefield, to help us structure our prediction methods in the field of health behavior. This paper has selected Azjen's Theory of Planned Behavior (1991) because of its proven ability to predict both sexual risk decision making in adolescents in SSA (Bryan, Kagee, Broaddus, 2006; Jemmott III

et al, 2007), and it is one of the few models which incorporate outside influences, such as parents (Hutchinson & Wood, 2007).

The core of the TPB states that all behavior is determined by the intentions of the individual (Azjen, 1991). The TPB then states that an individuals intention is determined by three factors; behavioral beliefs (attitude), subjective norms, and perceived behavioral control (PBC). This theory is an extension of an earlier behavioral model, The Theory of Reasoned Action (Azjen & Fishbein, 1980), which also states that people's intentions directly determine behavior, but that these intentions are only based on attitudes and subjective norms. What differentiates the TPB is the inclusion of PBC as an influence to ones intentions. PBC is the idea that one will be more likely to perform the behavior if he or she believes that they are able to perform that certain behavior well.

The inclusion of PBC has made the TPB widely used in predicting health behavior, especially those behaviors involved with sexual risk and condom use. It should also be noted that the inclusion of perceived behavioral control has also opened new ideas for intervention techniques, as PBC can be improved through "skill building, practice, positive re-enforcement and role modeling" (Hutchinson & Wood, 2007). These interventions that have worked to improve on adolescents PBC have been very effective in reducing sexual-risk behavior that can lead to HIV (Jemmott et al, 2007).

4.2 Utilization of the Theory of Planned Behavior

Although the TPB has been considered a valuable tool in helping to predict sexual risk behavior, it does have its limitations. Hutchinson and Wood (2007) acknowledge that one problem when using the TPB in analyzing PTSC, is that it is hard to characterize the subjective norms of the parents. Subjective norms refer to an individual's belief of how significant others will approve or disapprove of the behavior in question. However, parents will be less affected by subjective norms, in that they tend to act more out of the best interest of their children, and therefore be less influenced on how significant others perceive their actions. This study has found that external factors, such as cultural taboos,

religion and gender, can be substituted for subjective norms because that they play a more active role in influencing Zambian parent's behaviors than the parent's peers.

As this is a qualitative study, this research is more interesested in the content and qualtity of PTSC, and will use the TPB more as a structural model, and less as model used to predict behavior. This study is under the assumption that positive and healthy PTSC will lead to better decision making concerning sexual risk by the adolescent. This paper also takes the approach that in order to find the truth behind the parent's intentions, it is also vital to examine the views of their children. By examaning both the parents intentions, and the adolescent perception of those intentions, it should provide an accurate vision of PTSC in Zambia.

Chapter 5 - Analysis

This chapter will analyze the primary data collected for this research using the TPB. It will begin by briefly presenting the data from the questionnaires, and then be followed by an analysis of attitudes, external factors, and PBC concerning PTSC in Zambia.

5.1 Results from Questionnaires

On a survey that all participants filled out before every focus group, 49% of the adolescents reported to be sexually active, and of those that said they were sexually active the average age of sexual debut was 14.3. Only a little more then half of those that reported to be sexually active said that they used a condom every time that they had sex, while the others said that they used condoms only sometimes or never. Of the 45 adolescents surveyed, 26 of them said that they have spoken to their parents about sex often or sometimes, while the other 19 said that have rarely spoken to their parents about sex rarely or never.

Of the parents, all but two of them believed that their adolescent children were sexually active, even though some had kids that were only 15 or 16 years old. They also all reported that they speak with their children about sexual issues often or sometimes, and

all but three of them said that they felt comfortable speaking about sexuality with their children. When asked what they believed the appropriate age to begin talking about sexuality, the average age they reported was 12. They also mostly believed that their kids picked up most of their information on sex from their friends, with other answers including school, TV, and movies.

What is interesting when comparing the answers from the parents and the adolescents is that the parents were much more likely to report regular conversations about sexual issues taking place then the adolescents. All of the parents reported regular conversations, yet only a little more then half of the kids reported so. This coincides with DiIorio, Pluhar, and Belcher's (2003) finding that parents are much more likely to report sexual communication than adolescents. It is also interesting to note that although all of the parents reported talking to their kids about sex, none of them believed that their kids got most of their information from their parents.

5.2 Attitudes (Behavioral Beliefs)

The TPB believes that attitudes, or behavioral beliefs, are one of the three major determinants of ones intentions. Attitudes in the Theory of Planned Behavior are primarily based on the projected consequences that the particular action in question would bring about (Azjen, 1989).

5.2.1 General Attitudes

Both the parents and adolescents were asked in general how they felt when the topic of sex was brought up, and also if they felt that it was important that parents and their kids have these discussions. For parents this could be a major factor in predicting PTSC, as this study assumes if they feel that it is important to talk to their children about these issues, there is a much higher chance that these conversations will take place. For most of the parents, they seemed to think that it was their responsibility to speak with their children, and that these conversations were the only way to guarantee that their children received the right information. This somewhat represents a distrust that many of them had

with the local schools and NGO's in the area, with some believing that these other sources were not passing out the appropriate information.

> *We want to insure that they have the right information, and we want to have evidence that our children are taught the right things. Maybe at school or from an organization they will not receive the right information. So for me as a parent, I know that I will give them the right information (FGD9 24/11 P3).*

> *As a parent you have to be a good example. If the teachers are telling them to do this and this, they need to also hear it from a parent, or they will not understand (FGD10 30/11 P1).*

This idea that parents do not entirely trust outside sources to deliver information about sex to their children was previously written about Mbuya (2007) in her study on mothers in Kenya. She found that mothers, while advocating sexual education in schools, would often be distrustful of the teachers as they would have too much of a secular message, and teach about other prevention options other then abstinence. During the discussions in Choma, this also seemed to be the source of nervousness, as most of the parents reported to being devout Christians, and would prefer their children be taught sex education from a strict Christian viewpoint.

The parents not only trusted themselves more then outside sources to deliver information on sex, but they also believed that their kids trusted them more when they were either seeking information or wanting to share something that had happened to them. This seems to be based on the parent's belief that the adolescents trust their parents over their teachers or other sources of information.

> *I think that it's very important that this information comes from a parent because we have known them the longest, and if they don't give them the whole information then they won't trust us. And so then if*

they have a problem they will take it to somewhere else. It's not good if a child trusts its teacher more then its parents (FGD10 30/11 P5).

I think that is important that we speak with them, because many of the kids are shy with their teachers, but with us they are able to discuss these things (FGD8 24/11 P1).

These quotations represent somewhat of a different idea of what a parent's role should be in Zambia. Previous thought was that it was not the parent's place to deliver any sexual messages to their children (Mbuya, 2007). However, the parents from these interviews believed that it was not only appropriate to discuss these issues with their children, but that it was their responsibility to do so.

As much as the parents feel that their kids trust them as a source for sexual information, the kids said different. Most of the adolescents said that they feared bringing up these subjects with their parents, as many of them felt that if they were to ask questions or share any concerns, that their parents would think that they are already involved in sexual relations.

If you talk about sex with some of the other people (other relatives, friends) they may not think of you having sex. But if you talk about sexual issues with your parents, they will only think that you are having sex (FGD1 10/11 P2).

Looking at the relationship that we share with our parents, it's not that friendly of a relationship. They try and keep you away from certain issues, such as sex. If you try and bring up the issue with them about sex, they will ask you why are you bringing up this issue at this tender age. So in order to get around this, you talk about different things (FGD6 19/11 P1).

These two statements represent a general sense of fear that the adolescents reported when the subject of sex was brought up with their parents. Although a few of the adolescents said they had an open relationship with their parents, the overwhelming majority reported that they would much rather seek information from other sources than their parents. What was interesting though was that although they mostly had a negative association with the reality of PTSC, they were almost unanimous in believing that having these conversations with their parents was important and that they wished that these conversations were more frequent. There was the idea that they believed they could learn a lot from their parents, because they had gone through this situation before and were experienced.

5.2.2 Attitudes on Condoms

In understanding parent's attitudes when it comes to condom use, one can begin to have a clear idea on the nature of how they will instruct their children on sexual issues. In Zambia, only one-third of adolescents believe that their parents approve of condom use (CSO, 2010). This attitude by parents seem to be having an effect on their kids as well, as only 57% of Zambian adolescents support their friends using condoms (ibid). There is also a general distrust of the condom, as only half of all Zambians say that they believe condoms to be highly effective (ibid). Even some of Zambia's most highly regarded politicians still condemn the use of condoms. In 2001, Zambia's President Frederick Chiluba said, "I don't believe in condoms myself because it is a sign of weak morals on the part of the user" (Predrag, 2001). These factors all lead to negative attitudes towards condoms and could be why overall usage of condoms in Zambia is declining[2].

The parents that were interviewed seemed to have two schools of thought when it came to instructing their children; either you only preach abstinence and instruct that all sexual relations before marriage will only lead to problems, or you accept that most youths will be sexually active before marriage and they should be aware of all the prevention

[2] Condom use among youths, who had sex n the last year with a non-spouse, has fallen from 39% in 2000 to 36% in 2009 (CSO, 2010).

methods available. Most of the parents in Choma seemed to adhere to the first school of thought and were mostly objectionable to the condom.

All parents were asked how they would react or how they did react if or when they found their adolescent with a condom. These were a few of their responses:

> *I would get them together and tell them that this is wrong (FGD7 24/11 P3).*

> *Personally, I wouldn't like it. If I see a condom at my house, I wouldn't want it there (FGD8 24/11 P3).*

> *You can't feel okay. You feel bad because you have to conclude that your child has already started having sexual relations, and is continually doing so (FGD9 24/11 P3).*

The attitude towards the condom was overwhelming negative throughout talking with the parents, and they almost all said that finding a condom would disappoint them. What was interesting though was that there did not seem to be a distrust of the effectiveness of the condom, or much of the idea that the condom itself promotes sexual promiscuity. Instead, there was the idea that the condom represented an end of innocence to their child's life, and that their child would soon be dealing with the complexities and dangers of adulthood. This symbolic idea of what the condom represented seemed to turn the parents away from discussing it with their children, and therefore leaving abstinence as the only prevention method.

What is somewhat perplexing when analyzing the parents negative attitude towards the condom is that this view persists even though most of the parents believe that their adolescent children are sexually active. When the question was asked, "Would you be relieved to find your children with condoms, because at least you know that they were

being safe about it?"[3] most of the parents still felt that it was inappropriate for them to have condoms in the house. One can conclude that this attitude may lead their sexually active children to be afraid of bringing condoms in the house and may consequentially lower the chance of them wearing condoms during intercourse.

The adolescents were in turn asked how they feel their parents would react if they were to be found with a condom. They mostly said that they felt their parents would react negatively.

> *They would really get mad at me. In fact I could even get beaten. My parents would think that I was having sex (FGD1 10/11 P2).*
>
> *It would be a disaster. They would come to a lot of conclusions (FGD2 11/11 P2).*
>
> *If my parents caught me with a condom, they would think that I was having sex, and they would take the condom from me (FGD3 12/11 P3).*
>
> *For me, they did find me once with a condom, and the only thing they told me was that I should abstain from sex. I tried to explain that I am in a relationship, but my parents are stubborn and they can't understand (FGD3 12/11 P20).*

The adolescents seem to perceive that their parents will be upset if they found a condom purely based on the notion that the parents would think that their children are having sex. Now it is important to remember that in most cases, this is only a perception of what would happen if they were found with a condom, perhaps based on previous communication or the parent's general attitude. However the last statement above

[3] The author understands that this is somewhat of a leading question. However, this didn't seem to affect the participant's responses.

represents an actual encounter where the parents still disapproved of the condom even though the adolescent explained to the parents that he had a girlfriend and was sexually active. This belief from the parent seems to go against almost all SRH health messages in Zambia, which stress condom use every time an adolescent has sexual intercourse.

This fear that adolescents have of being caught with a condom in the house could again possibly lead to the situation mentioned above in which adolescents would not obtain condoms because of the fear of being caught with them, and could lead to a lower usage rate of condoms during intercourse. However, it was found in a recent African study that condom use was more prevalent among adolescents who lived with their parents compared to those who lived apart from them (Bankole et al, 2007). The reason for this was not based on communication from the parent, but rather based on parental monitoring, as the adolescents who knew their parents were watching their activities were more likely to protect themselves (ibid). This could be seen as somewhat of a contradiction to the findings from this study, or it could just mean that adolescents that live with their parents are just more responsible in general and in turn make better decisions.

Another reason why parental monitoring could mean that more adolescents wear condoms when living with their parents is a fear of the consequences of unprotected sexual actions. All of the adolescents were asked how they think their parents would react if they became pregnant or if they impregnated a girl. Although one would expect the parents to be disappointed, the answers that were given were quite severe.

> *They would beat me and then they would drop me off at the man's house (FGD1 11/10 P1).*

> *My mother has told me that if you get pregnant, before you tell me, you should take your suitcase and move in with the boy that got you pregnant (FGD4 11/18 P4).*

For me, they would stop supporting me (FGD5 11/18 P1).

What usually happens in African Culture when a girl becomes pregnant is that the parents will tell you to pack your bags and go live with your boyfriend, and not to return to the house (FGD6 11/19 P5).

Almost all of the girls who answered this question answered with a similar response, implying that their parents would either beat them, kick them out of the house, cut them off financially, or in many cases all three. The boys also expressed a lot of concern for this situation, although the consequences were more about letting the family down and losing respect from their parents, which seemed to trouble them a lot. Although this level of fear, especially by the girls, can be seen as a prevention method, it could also lead to other dangers such as unsafe abortion or problems from childbirth.

In this case though, the consequences that many of the adolescents fear would come to fruition in the case of early pregnancy could be exaggerated. Here is the case of one girl's sister after she had become pregnant while still a teenager.

My sister became pregnant, yet my mother let her stay, because regardless of her pregnancy she is still her daughter. And while she doesn't support the pregnancy, she looked at both the positives and the negatives. She knows that if she sends her out she would stop school, but if she stays at home she can continue school. And now my sister has finished her education (FGD6 11/19 P4).

When the parents were asked how they would react if their child became pregnant or impregnated someone else, their answers were more compassionate then the adolescents would have you believe. This discrepancy in perception is most likely due to a communication gap that exists in most Sub-Saharan African households (Awusabu-Asare, Bankole, Kumi-Kyereme, 2008). Although some of them had said that they had heard stories of parents running their kids out of the house, many said that they although

disappointed, they would continue to support their child and also help with the new grandchild.

> *We would not kick them out. In fact we would bring them in and make them feel closer to the family. In your heart you feel very bad but you don't want to show it. You should even escort her to the doctor (FGD9 24/11 P4).*

For the mother below, this was her response to her daughter's teenage pregnancy.

> *Initially it is so hard because your baby is having another baby. But what you have to do is just accept it and take that child for counseling. Both of them continue needing your support. As it stands now, my daughter will be going back to school next year. So we do not condemn her every day for what she has done, but we do remind her that if this if she was to repeat it again, this is what is going to happen. So as a parent we do accept it, but it's not easy to accept it (FGD10 30/11 P3).*

What we can see from this is that it seems that in some ways the parent's threats are worse then their actions. Parents lead their children to believe that if they misbehave sexually, the family will turn its back on them. However, the parents, while all saying they would be disappointed to find out about problems like early pregnancy, would stick by their children and support them. If organizations in the future try and work on PTSC, this idea of parents not abandoning their children could be used as ways to build trust between parent and child, and maybe alleviate some of the fears which in many cases seems to be preventing successful communication.

5.3 External Factors

After reviewing past literature and analyzing the data gathered from this research, it was found that the external factors that played the biggest part in predicting PTSC was

cultural taboo, gender norms, and religion. The three will be analyzed in how they relate to PTSC in Zambia.

5.3.1 The Idea of Taboo

When speaking to both parents and adolescents about the idea of PTSC, the word that came up the most was taboo. Taboo can be defined as "a social or religious custom prohibiting a particular practice or forbidding association with a particular person, place or thing (New Oxford American Dictionary, 2010). These taboos were traditionally not a problem, as adolescents were married quite young, which left them little time to experiment sexually (Kayongo-Male, Onyango, 1984). These are different times in Africa though, and many youths are looking for guidance to help avoid the many problems that can occur from irresponsible sex. Almost all of the adolescents that participated spoke of these taboos as a barrier to why PTSC is not more common in Choma.

> *Traditionally in Africa, sexual issues are only discussed by married people, so young people are ashamed of talking about these things. They are taboo (FGD2 11/11 P1).*

> *In our culture, it's a taboo to talk about sex with your parents. Once you reach the age of 25 or 26, and have completed your education then it could be okay. But it is a major taboo in our culture (FGD4 18/11 P3).*

> *This taboo comes from the traditions that we have in Africa. In many families it is prohibited to talk about sex or sensitive issues with your parents. Especially if you go in to the rural areas, you will not see kids talking about sex with their parents (FGD3 12/11 P2).*

As stated earlier, grandparents and older relatives were at one time responsible for instructing the youths on sexual issues. Although this is no longer technically the custom,

taboo has also caused many of the adolescents to seek advice about sex from other members of the family. Many of them said that they feel more comfortable with their grandparents or aunts and uncles.

> *I speak to my grandparents but not to my parents, I am not comfortable speaking with my parents (FGD5 18/11 P4).*

> *It's easier talking with your grandparents because they are more relaxed with you, more like your friends. Your parents are your elders (FGD2 11/11 P2).*

A study from Tanzania also found that adolescents were much more comfortable speaking with their grandparents and other older relatives then their parents (Wamoyi et al, 2010). They found that when grandparents spoke with their grandchildren about sex, the tone was much more humorous and playful then when those same adolescents spoke with their parents (ibid). However what the study also found was that while the adolescents felt more comfortable speaking with their grandparents, the grandparents knew very little about HIV/AIDS and modern contraception methods such as condoms or birth control pills, and therefore they were very limited to what information they could pass on (ibid). While no grandparents participated in the focus group discussions, it was evident that the younger parents had more knowledge on modern issues then the older parents, and judging by this, it is safe to assume that grandparents in Choma are probably not the ideal candidates to be passing on potentially life saving information.

Although the adolescents believed taboo was still a major barrier preventing meaningful PTSC, the parents themselves, while acknowledging that the taboo existed, seemed to downplay the role of it. They believed that while it wasn't traditional for parents to speak with their kids about sex, modern problems have made it more acceptable.

Let me just say, we Africans, we never used to talk about these things with our children. But nowadays it's a modern world and you can talk (FGD7 24/11 P1).

I feel that it is becoming less taboo (to have these conversations) because of HIV and other STI's, and the rise of the unwanted pregnancies (FGD8 24/11 P4).

I think that the taboo issue is getting finished. In the future, kids should feel more open (FGD9 24/11 P3).

In some ways it is unexpected that the adolescents considered the taboo on PTSC a larger barrier then the adults, considering that the parents are older and are closer related to traditions from past generations. There are a couple possible explanations for this. The first is that the adolescents said that in general that they felt it was important for kids to have an open relationship with their parents, but that they felt uncomfortable speaking with their parents about these issues. The taboo could then be seen as an excuse for why they should not bring up these issues with their parents. A second reason is that since parents are more likely to report that PTSC has taken place than adolescents, they would also be more likely to dismiss the taboo (DiIoria, Pluhar, Belcher 2003). The parents may think others would see them as irresponsible if they failed to speak about these important matters with their children based purely on cultural norms.

5.3.2 The Role of Gender

When studying PTSC it is important to look at gender, as it plays an instrumental role in both the quantity and quality of communication that takes place. Traditionally in Africa, it has been seen that when PTSC is present in the household, it is usually the mother who will talk to the girls, and the father who will talk to the boys (Wamoyi et al, 2010, Namisi et, 2009, Babaloa, Tambashe, Vondrask, 2005) Knowing who is conducting the communication is important because the messages conveyed by fathers and mothers can vary greatly and have an effect on sexual behavior. For example, Zambian males who

only live with their father and not their mother have a much earlier sexual debut then boys who have a mother in the house (Babaloa, Tambashe, Vondrask, 2005). Zambian girls who only live with their fathers though actually waited longer to have sex, proving that there seems to be a double standard when it comes to addressing sons and daughters (ibid).

All of the adolescents were asked if they felt more comfortable speaking about sexual issues with their mother or their father. The boys that responded predominantly said that they would rather speak with their father, as they felt they could relate better with him, as they were both males.

> *For me I am shy, but I can understand better from my father. I will be more comfortable and I will be fearless. For me it's just the same talking with a friend of the same sex (FGD5 18/11 P2).*

Surprisingly though, girls were much more mixed in their response. Some of the girls said that they would rather speak with their mother, but there were also many girls that responded said that they would rather speak about sex with their father. Many of the girls said that they were afraid that there mom would yell or even hit them if they brought up these issues.

> *I like to talk about these issues with my dad because my mom is more judgmental (FGD1 10/11 P2).*

> *I would rather talk with my dad. My mom hits me too much (FGD1 10/11 P3).*

Although this may seem surprising, it actually makes sense that girls would be slightly scared to speak with their mothers. The most common occurrence of PTSC in Africa is mothers talking to their daughters. Since we have seen in previous sections that parents

will often use fear as a prevention method, it could just be that the girls have had the most experience speaking with their mothers and those experiences may not have been positive. They may simply feel that they would be more comfortable speaking with their fathers about these issues because these conversations are much more rare and have not left them with a bad impression.

It was also mentioned that in general, parents are much tougher with the girls then the boys. In Zambia, being a man is often associated with sexual prowess, and therefore adults are usually easier on the boys when they get in some trouble involving sexual activity (Simpson, 2007). Both the boys and girls reported though that the parents would be much more strict when it came to the girls. When they were asked if their parents would act differently if they caught a son or a daughter with a condom, it was a nearly unanimous response.

> *Guys are more respected by our parents. A guy will not get beaten by his parents for talking about these issues with his parents because he is feared (FGD1 10/11 P3).*

> *If a girl is found with a condom, they will say that she is a prostitute. They will also want to know all the guys she is seeing, and it could raise a lot of questions about the girl (FGD2 11/11 P4).*

> *I think that they would be madder at me than my brother because they think that boys are more protected than girls. They think that boys better know how to use a condom than girls (FGD5 18/11 P3).*

The parents were asked the same question and also responded that they would respond harsher to their daughter than their son, but for different reasons. The reason that they gave is that their daughters could get pregnant and have to drop out of school, while their sons would not have to deal with this.

I think that we are always more strict with the girl because she can be pregnant at an early age. A boy can go out and use these condoms and will not become pregnant. But a girl, maybe she doesn't know how to use the condom and she will get pregnant (FGD7 24/11 P3).

According to our culture, a man is allowed to go out and do what he wants to do, but not for a girl (FGD8 24/11 P2).

These statements are troubling for a couple of reasons. The first is that by saying that it is only the girls problem when they become pregnant, it somewhat excuses the boys role in the situation, and sends a message to the boys that their actions will be of less consequence. If parents were to communicate the same prevention message to both their sons and their daughters, boys may take more responsibility both in the bedroom and when their partner experiences an early pregnancy. The second problem from these statements is the assumption that girls are not in control of their partners wearing condoms and that they don't know how they work. Even though the parents were nearly unanimous against condoms, they somewhat begrudgingly accept the fact that boys will use them during intercourse. However, by admitting that they feel that their daughters are unequipped to use condoms they are sending the message that boys should be in control when it comes to sex, and that the girls would be unable to force their partners to use condoms.

5.3.3 The Impact of Religion

When predicting behavior patterns in Zambia, it is crucial to include the role that religion plays. Zambia is a predominantly Christian nation, and 91% of Zambian adolescents have said that religion plays a very large role in their lives (Feldman et al, 2007). Religious organizations have been very active in the HIV/AIDS prevention movement, while almost exclusively mentioning abstinence as the only viable prevention method (Agha, Hutchinson, Kusanthan, 2006). Some researchers would say that these organizations have played a vital role in stabilizing HIV rates through many countries in SSA by only promoting abstinence and partner reduction (Green, 2001). However, others would argue

that by failing to teach condom use as a prevention method, they are increasing the risk of adolescents contracting HIV/AIDS (Feldman et al, 2007).

Although the specific topic of Christianity was not specifically discussed in the focus groups, the parents often spoke of the Church's message of abstinence only education.

> *We tell them to avoid sexual relationships before they get married because they can get diseases. We talk about abstinence (FGD7 24/11 P1).*

> *When talking about these things, I advise them to abstain from sex. When I noticed that they were older and had more sexual feelings, I told them that they should stay away from these feelings (FGD9 24/11 P4).*

> *You will feel uncomfortable with (your children) using a condom. Mine is a Christian home and I am trying to teach them what a Christian child is supposed to do (FGD10 30/11 P2).*

Although, only teaching your kids about abstinence can be seen as somewhat of a flawed message, it did seem to have an effect on the adolescents. While around half of the adolescents that participated in the focus groups were already sexually active, many of the others who spoke said that they wanted to wait until marriage before they had sex.

> *We just need to abstain from sex and wait until marriage to avoid these problems that face us (FGD1 10/11 P3).*

> *For me I think they would be disappointed me in me if they found out (to be having sex). I am a virgin, and I am the head of my family after my father, so I hope the younger ones will follow what I have done (FGD4 18/11 P1).*

Just the fact that there are adolescent males who speak up proudly in a group that they are a virgin shows some sign that the Christian movement for abstinence has had some effect on the psyche of the youth culture. In fact 73% of Zambian youth (15-24) believe that you should wait until marriage before having sex (CSO, 2010). Although most Zambians will have sex before marriage (CSO 2010), it is hard to deny that this idea of chastity has seeped into the mainstream Zambian conscious.

5.4 Perceived Behavioral Control

The third determinant of intention under the TPB, Perceived Behavioral Control, refers to the idea that an individual will be more likely to perform an activity if they perceive that they are able to perform that activity well. When focusing on parents ability to speak to their children on sexual issues, it is important to focus on a couple key factors; the actual and perceived knowledge that the parents have, and also if the adolescents perceive that their parents have the correct knowledge. It is also important for the adolescents to believe that their parents know what they are talking about or these talks will most likely not be very effective.

5.4.1 Knowledge in Zambia

The actual knowledge concerning sexual health and HIV was not tested through the focus groups, but through the Zambia Sexual Behavior Survey, we can get an idea of Zambians knowledge. To begin with, 99% of Zambians have at least heard of the HIV virus (CSO, 2010). The most popular prevention method that was mentioned was abstinence at 72%, with condoms next at 65%, and being faithful to one partner was third on the list at 47% (ibid). Only 23% of respondents were able to list all three of these prevention methods, (ibid). One interesting note is that these percentages are all down from the survey from 2005, signaling that prevention campaigns may be losing steam in Zambia. In summary, 57% of males and 44% of females reported having a comprehensive knowledge[4] of HIV/AIDS, which is again down from 2005 (ibid).

[4] Comprehensive knowledge of HIV according to the 2009 Zambia Sexual behavior survey consists of knowing that a) consistent condom use, and having only one faithful,

From these statistics, we can see that most Zambians have some idea on how to protect themselves from STI's and unwanted pregnancies. Their knowledge of course be greatly improved, but it seems that most Zambians would have the appropriate knowledge to speak with their children about these issues. It should be noted though that the difference in what parents (ages 25-49) know and what adolescents know is across the board very small (CSO, 2010). However, as long as the parents feel that they have the appropriate knowledge, these conversations are more likely to take place. Studies have shown that even if no knowledge is necessarily being transferred during PTSC, if it is done in a constructive way it can help adolescents make better decisions and communicate better with their partner (Whitaker et al, 1999).

5.4.2 Perceived Knowledge

All the parents were asked if they felt that they had the appropriate knowledge to talk to their kids about sexual issues. Of all the questions asked, this is the one with probably the most mixed responses. Some of the parents believed that they had the correct facts, while others said that they lacked knowledge when it came to technical issues.

> *We don't have the right information as far as STI's are concerned, or even in general information (FGD7 24/11 P7).*

> *I think that we have the right information, because we see a lot from the TV and newspapers (FGD8 24/11 P2).*

This was one of the hardest topics to get a feel for. It seemed through the discussions that most of the parents had a fairly good grasp on the big picture concerning their children's sexual health, but were less confident on some of the more specific issues. For example, the fact that many of them disapproved of condom use even though they knew their child

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uninfected partner can reduce the chances of HIV infection; b) a healthy looking person can be HIV infected; c) HIV can not be transmitted through mosquito bites; d) HIV cannot be transmitted thorough witchcraft.

was already sexually active, shows that there is a need to sensitize parents on different prevention methods.

The adolescents were also quite mixed when asked if they thought that their parents had the appropriate knowledge to talk to them about these issues. Many seemed somewhat unsure what to think, as they said the only instructions they have received from their parents was that sex was bad, and they should abstain until marriage. They did think however that it was important to speak about these issues with their parents because they see their parents as an experienced couple because have successfully found a partner and had children.

> *I think that if you talk to your parents about sex, they will lead you down the right road because they have been there before. They can tell you the dos and don'ts (FGD3 12/11 P2).*

> *I think that it is important to talk with your parents about these things because they can tell you the advantages and disadvantages of having sex, because they have been married (FGD4 18/11 P6).*

> *I think that it is important to listen to them because they have more experience then us, and they know what we are going through (FGD5 18/11 P7).*

The adolescents here seemed to value the actual experiences of their parents more then any guidance they had to offer regarding issues like condom use and abstinence. However, they seemed to think that PTSC will grow in Zambia and that future generations will be more successful in speaking with their kids because they have will be better educated on the issues, and this perceived knowledge would allow them to be more open in discussing these issues.

I think that since there is more information out there now on sexual and reproductive health, it will be easier for us to talk to our kids about these issues. If you let them experience it first, and then they open up to you, it will be too late by then. It is better to talk to them first, so they will know how to protect themselves (FGD3 12/11 P2).

I think that in the future it will be less of a taboo to talk to our children about these issues, because we are educated, and we will be more comfortable speaking about these things with our kids (FGD 12/11 P3).

These statements are positive in that they show that adolescents in Zambia today believe that their knowledge is increasing, and that they should be more knowledgeable than their parents. Even if certain external factors, such as cultural taboo and religion remain barriers to PTSC in the future, the fact remains that adolescents today will have higher control beliefs then parents in past generations, and this should lead to a higher degree of PTSC.

Chapter 6 - Conclusion

6.1 Summary and Return to the Research Question

This study aims to build on previous research on PTSC in Sub Saharan Africa, by looking into the nature of PTSC in Zambia. By using the Theory of Planned Behavior the following sub-questions have been analyzed:

a) In which ways do the attitudes and beliefs of both parents and adolescents towards condoms influence PTSC?
b) What impact does social taboo, gender and religion play on both the quantity and quality of PTSC?
c) How does the perceived and actual knowledge of the parent affect PTSC?

The following is summary of the results, followed by an overall analysis of the study.

Attitudes- Parents in general have a positive attitude towards PTSC based on what they feel is their responsibility to talk to their children due to the HIV/AIDS epidemic and the problems of early pregnancies. However, adolescents have a negative attitude towards PTSC, primarily due to a fear that by speaking with their parents about sex, their parents will suspect them of being sexually active. Adolescents are also afraid of being caught with a condom, based on their parent's negative attitude towards condoms. In addition, there was the fear of early pregnancy, as many females believed they would be beaten and kicked out of the house if they were pregnant.

External Factors- The parent's ideas behind PTSC seem to be based on three primary external forces; cultural taboos, gender based differences, and religion. The parents believe that the taboo is less important now then in the past, while the adolescents still feel that it is a barrier, and that it is easier to talk about sexual issues with their grandparents. The parents also have a double standard concerning their sons and daughters, often being harsher with their daughters because of their ability to become pregnant. Religion has an effect on both the parents and the adolescents, emphasizing parents to preach only abstinence to their children, while many of the adolescents emphasize the desire to abstain from sex until marriage, although very few Zambians actually do (CSO 2010).

Perceived Behavioral Control- Although some of the parents believe that they had the appropriate amount of knowledge to speak to their children effectively about sex, others felt they still need to be educated more on the issues. We know from previous surveys that the average Zambian knows about STI's and the dangers of them, but that a greater level of understanding may be needed. The adolescents feel that while their parents may not have the scientific knowledge, they have the experience of finding a partner and having children. This belief in their parents experience overrides most doubts of their technical knowledge.

From using these three indicators, we can make some general remarks about the nature of PTSC in Zambia. It seems that these conversations are taking place in many Zambian homes, mainly because many parents lack trust in other establishments such as the NGO's and schools and feel that it is there responsibility to deliver messages about SRH. Although these conversations are taking place, they may not be having a positive effect, as adolescents seem to be mostly afraid of their parents when it comes to discussing sex, and this is most likely leading to one-sided discussions rather than an open dialogue. Previous studies have shown that PTSC can only be an effective prevention method if both the parents and the children feel open to discussing the issues at hand (Whitaker et al, 1999). Until parents in Zambia are creating an environment where their children feel comfortable in communicating to them about issues that they are facing, PTSC will not be very effective.

It is also evident that parents are primarily only speaking about abstinence and the dangers of sex. The principal problem here is that most Zambian adolescents will have sex before they get married, and they may not be prepared to protect themselves in other manners. Now this study is not implying that adolescents in Zambia are unaware of condoms or other birth control methods. There are numerous NGO's and state campaigns both promoting and distributing condoms to adolescents. However, by discouraging condom use and not allowing them in the house in the house, parents are creating an environment in which their children are forced to be sneaky with items that could potentially be life saving. This could discourage condom use among adolescents living with their parents.

This idea of parents installing fear in the children could have some potential positive effects. It does seem that many of the adolescents believe that abstaining from sex until marriage is the moral thing to do. This is also linked to most Zambian adolescents being highly religious. While most adolescents will not abstain until marriage, it does appear that adolescents in Zambia are waiting longer to have sex then in previous years. The median age of sexual debut for adolescent boys has risen from 17.5 in 2000, to 19.5 in 2009, and the average age for adolescent girls has risen from 16.5 to 17.5 in the same

time frame (CSO, 2009). This is important because the longer that adolescents wait to have sex, the shorter the time is that they are vulnerable to contracting STI's or becoming pregnant. Now it is difficult to prove that PTSC has been the reason for this change, but it does correlate with the rising trend of PTSC.

On the other hand, fearing ones parents could have negative effects as well. Sexually active adolescents, who fear being caught with their partner, often resort to escaping to the bush to have sex (Amuyunzu-Nyamongo et al, 2005). By escaping to the bush, adolescents are less likely to use a condom then if they were to have sex in a bedroom (ibid). Girls in particular are also very afraid of becoming pregnant, because of the threat of physical violence from their parents or being thrown out of their house. While this could be seen as a prevention technique, it could lead to very dangerous consequences. Girls who underwent illegal abortions in Zambia mention that anger from ones parents as one reason why the pregnancy was unwanted (Koster-Oyekan, 1998).

6.2 Concluding Remarks

This study's findings show that parents in Zambia are breaking through traditional taboos and beginning to speak to their kids about sex, but they may need help in delivering meaningful messages. Future interventions should focus on making communication between parents and their kids more comfortable. This could be accomplished through workshops that teenagers and parents complete together to become more comfortable with each other. Adolescents in Zambia seem to have a tremendous amount of respect for their parents, but with this respect comes a fear of disappointing them, and this seems to be a barrier to meaningful communication.

Another important element that interventions need to think about is making sure that parents create an environment where condoms and birth control are allowed in the house. Previous interventions have shown that as long as abstinence is acknowledged as an important prevention method, it will be easier for parents to accept other prevention methods such as condoms and birth control (Campero et al, 2010). Zambian parents need to understand that abstinence messages can be used in order to delay sexual activity, but

that their children should also be taught about other prevention methods as well, and feel that it is acceptable for them to use these other methods. Condoms and birth control need to be seen not as signs of deviance, but rather as signs of responsibility. When parents in Zambia begin to grasp this idea, it could turn the current environment of fear to one of openness and honesty.

6.3 Lessons Learned

The research process for this study was a learning experience for the researcher, and looking back on it, there were a number of things that would have been conducted differently. This study could have benefitted from some one-on-one in depth interviews with experts in this area, in order to place the study in a larger context. For example, there are parents in some of the study areas known as "peer parents", who are there to help both adolescents and parents alike deal with the struggles of adolescent sexuality. These parents could have brought some more depth to the research subject that the focus groups were not quite able to achieve.

On the other hand, the focus groups were valuable in that the participants were very relaxed in this setting, and were able to talk about a candid subject very openly. They were able to have fun with the topic, and this relaxed atmosphere allowed for what felt like honest and truthful answers. One final thing looking back is that it would have been interesting to have focus groups with parents and their child together. Although they may not have been open as they were separate, it would have been interesting to see how they interact together.

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Appendix I: List of Focus Group Discussions and Participants

The Adolescents

Focus Group 1: Njassa Girls School, November 10, 2010

Participant 1- Female, 15	Participant 6- Female, 15
Participant 2- Female, 16	Participant 7- Female, 15
Participant 3- Female, 17	Participant 8- Female, 17
Participant 4- Female, 16	Participant 9- Female, 16
Participant 5- Female, 16	

Focus Group 2: Choma Rail Clinic, November 11, 2010

Participant 1- Male, 16	Participant 5- Male, 21
Participant 2- Male, 16	Participant 6- Male, 15
Participant 3- Male, 18	Participant 7- Male, 15
Participant 4- Male, 18	Participant 8- Female, 16

Focus Group 3: Choma Rail Clinic, November 12, 2010

Participant 1- Male, 19	Participant 4- Female, 20
Participant 2- Male, 20	Participant 5- Female, 21
Participant 3- Male, 20	

Focus Group 4: Choma Rail Clinic, November 18, 2010

Participant 1- Male, 18	Participant 6- Female, 18
Participant 2- Male, 20	Participant 7- Male, 17
Participant 3- Male, 20	Participant 8- Male, 17
Participant 4- Female, 18	Participant 9- Male, 16
Participant 5- Female, 16	

Focus Group 5: Choma Rail Clinic, November 18, 2010

Participant 1- Male, 18	Participant 5- Female, 20
Participant 2- Male, 18	Participant 6- Male, 18
Participant 3- Female, 17	Participant 7- Male, 18
Participant 4- Female, 17	Participant 8- Female, 22

Focus Group 6: Choma Rail Clinic, November 19, 2010
Participant 1- Male, 17
Participant 2- Male, 20
Participant 3- Male, 20
Participant 4- Female, 23
Participant 5- Female, 18

The Parents

Focus Group 7: PPAZ Champande Clinic, November 24, 2010
Participant 1- Female, 37
Participant 2- Female, 34
Participant 3- Female, 39
Participant 4- Female, 36

Focus Group 8: PPAZ Champande Clinic, November 24, 2010
Participant 1- Female, 40
Participant 2- Female, 42
Participant 3- Female, 35
Participant 4- Female, 42

Focus Group 9: Muchipapa Clinic, November 24, 2010
Participant 1- Male, 53
Participant 2- Male, 64
Participant 3- Female, 41
Participant 4- Female, 42
Participant 5- Female, 40
Participant 6- Female, 50

Focus Group 10: Choma Rail Clinic, November 30, 2010
Participant 1- Male, 49
Participant 2- Female, 41
Participant 3- Female, 36
Participant 4- Female, 38
Participant 5- Male, 37

Appendix II: Questions for Focus Groups

Questions for Adolescent Groups

1. How do you feel about talking to your parents or guardian about sexual issues?
2. For those that have never discussed the issue with their parents, what do you feel the barriers are?
3. In which ways do your parents have an effect on your sexual decisions?
4. What triggered your parents discussing sexual issues with you?
5. How do you think your parents would react if they had found condoms or other types of birth control in your room?
6. Have you heard about any traditional methods from you parents, grandparents or guardians? If so, what are these?
7. When talking about sexual issues with parents or guardians, what is generally the tone of the conversation?
8. What do you think would be the reaction from your parents or guardian if they found out that you were pregnant or had impregnated someone?
9. What topics are most usually discussed when talking about sex?
10. In which ways do you feel that its important for parents and their kids to discuss sexual issues?

Questions for Parent Groups

1. In which ways have you discussed sexuality with your children?
2. If you have discussed sexuality with your children, what topics did you discuss? Was there something that triggered the conversations?
3. How do your children react when you discuss these issues?
4. How would you react if you found a condom in your child's room?
5. How would you react if your child became pregnant, or impregnated someone else?
6. Why or why not do you feel it important to talk to your children about these issues?
7. Do you feel that you have the right information to discuss issues of sexuality with your children?
8. How would you react if your child came to you to discuss these issues?
9. Do you think you would react differently if you found out a son was having a sex compared to a daughter?
10. Do you feel more comfortable speaking to a child of the same sex as you?
11. How do you feel about the taboo in Zambia about not being able to discuss sexual issues with your children?