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Community Perspectives on Parental/Caregiver Communication on Reproductive Health and HIV with Adolescent Orphans and Non-Orphans in Western Kenya

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Abstract

Studies show sexuality dialogue between parents or caregivers with their adolescent children can be a protective factor for engaging in risky sexual behaviours. This study aimed to understand the nature of parent and caregiver sexuality talks with non-orphans and orphans under their care in order to contribute to the knowledge base to inform adolescent and orphan sexual and reproductive health and HIV prevention policies and interventions. We used a cross-sectional qualitative study design with maximum variation sampling to purposively select study participants in three counties of the former Nyanza region in western Kenya. We held 14 focus group discussions with 78 adolescents aged 14-17 and 68 parents and caregivers of children aged 10-17. Thirteen key informant interviews were also held with individuals knowledgeable of issues affecting adolescents and orphans. We used deductive analysis to develop the question domains and coded the data based on our research questions and thereafter followed an inductive approach to review the data and identify emerging themes and patterns, from which we interpreted the findings and drew conclusions. Parents/caregivers-adolescents sexuality talk sometimes occurred but was perceived to be less likely with orphans than non-orphans. Mothers mainly initiated such talks through warnings and lectures about engaging in risky sexual behaviour, with adolescents usually being passive recipients of the messages. Hindering factor included generation gap, failure of some caregivers to bond with orphans under their care, religious/cultural norms, lack of sexuality information and communication skills, and spousal assumptions that the mother is responsible for parent-child communication on sexuality issues. We conclude that adolescent orphans and non-orphans lack an important source of information to help them make informed decisions on their sexuality. Policies and interventions targeting orphans and adolescents should equip parents/caregivers with sexuality knowledge and communication skills to enable them to dialogue on sexuality with adolescents.

Keywords: Adolescents; Orphans; Non-orphans; SRH/HIV; Parental/caregiver sexuality communication

Introduction

Studies show that good sexuality dialogue between parents and adolescents promotes a range of protective sexual behaviours such as delayed sexual debut, secondary sexual abstinence, and reduced number of sex partners [1-4]. Initiation of such conversation with children before sexual debut has been shown to be effective in reducing sexual risk behaviours among them [5,6]. In sub-Saharan Africa (SSA), living with birth parents has been shown to be a protective factor for adolescent sexual risk behaviour [2].

Children's living arrangements contribute to understanding parental and caregiver sexuality communication context. Those living with only one parent or not living with either parent are more likely than those in two-parent households to be sexually active, to have multiple concurrent sexual partners, and to have had casual sex in the previous year, and not used condoms [1,7-9]. In Kenya, nearly half of children aged less than 18 years do not live with both parents especially those aged 15-17 years at an elevated risk [10]. The former Nyanza Province is one of the former provinces with the lowest percentage of children living with both parents at 47% and the highest proportions of children not living with either parent at 17%. The area has a generalized HIV epidemic with resultant high rates of orphanhood [10]. The 2010 Constitution of Kenya divided the former Nyanza Province into six counties [11] that combine a number of former districts into one county as follows: 1) Kisii (Kisii Central, Kisii South, Masaba, Gucha,Gucha South), 2) Nyamira (Nyamira, Manga, Borabu), 3) Siaya (Siaya, Bondo and Rarieda), 4) Kisumu (Kisumu East, Kisumu West, Nyando), 5) Migori (Migori, Rongo, Kuria West and Kuria East), and 6) Homa Bay (Homa Bay, Rachuonyo and Suba.)

The breakdown in traditional sexuality socialization of adolescents by grandparents, aunts, uncles and the taboo that prohibits parent-adolescent sexuality dialogue have left adolescents without a dependable family level source of sexuality information [12,13]. The generalized poverty in the region, with more than half the population living below the poverty line, on one dollar per day (14) may also shift parents'/caregivers' focus to survival activities with limited attention to

sexual risk prevention not only for their children but also for themselves.

Numerous studies in sub-Saharan Africa (SSA) [15], mostly undertaken in southern African countries primarily South Africa [16,17] and Zimbabwe [18-21], have shown that orphans may be at greater risk of acquiring HIV and other sexually transmitted infections (STIs) than non-orphans due to heightened likelihood of experiencing coerced sex and exploitation through transactional sex. These transactions may be attributed to the psychosocial and economic distress resulting from loss of one or both parents [17,21]. It is, however, not clear from these studies whether parents/caregivers dialogue with or talk to their adolescent children about sexual and reproductive health (SRH) and HIV risk and prevention.

In order to build on the existing knowledge on parent-child sexuality dialogue and contribute to a better understanding of the contexts for responsive adolescent SRH and HIV prevention policies and interventions, this study explored community perceptions of parental/caregiver communication with adolescents on SRH/HIV in three counties of Nyanza region. The specific objectives of this paper are to: 1) establish whether parental or caregiver communication with adolescents on SRH/HIV occurs for orphans and for non-orphans, 2) identify barriers to effective parental/caregiver communication with adolescents about SRH/HIV issues, and 3) explore community recommendations to improve parental and caregiver communication on SRH/HIV.

Methods

Study setting and site selection

The study was conducted in three counties in specific former districts of study indicated in brackets as follows: Kisumu (Kisumu East and Kisumu West districts), Migori (Migori District), and Homa Bay (Homa Bay and Suba districts), western Kenya. The areas are predominantly inhabited by the Luo ethnic group and were purposively chosen in cognizance of an impending Cash Transfer (CT) pilot project intended to address the socioeconomic needs of orphaned and vulnerable children (OVC) households the districts. Data from the former districts were intended to provide additional insight into factors that may predispose adolescent OVC and non-OVC to sexual and reproductive health (SRH/HIV) risks and prevention needs. The CT is a government social protection pilot program for OVC that provides regular and predictable cash transfers to extremely poor families living with OVC to encourage fostering and retention of OVC within their families and communities, and to promote their human capital development. Using stratified sampling of districts, two constituencies (political boundaries each represented by a Member of Parliament) were randomly selected from each of the four former districts. For each constituency, a location (an administrative unit) was randomly chosen, within which one sub-location (the smallest administrative unit) was then randomly selected, giving a total of eight sub-locations for the study sites.

Study design and sample

This article is based on a larger cross-sectional qualitative study designed to explore factors perceived by communities to predispose adolescent orphans and non-orphans to risky sexual behaviour. A focus group discussion (FGD) and key informant interview (KII) guide was used to elicit community perspectives on household and sociocultural sexual risk factors for adolescent orphans and non-orphans. Question domains on parent/caregiver sexuality are shown in Table 1.

We used maximum variation sampling, a purposive selection of a heterogeneous sample that includes individuals with diverse characteristics and from multiple dimensions. Any patterns that emerge across the diverse set of individuals are considered valuable in describing experiences that are core to most individuals [22]. We recruited adult and adolescent FGD participants based on gender, age, their availability and willingness to participate in the discussions. Community leaders assisted in mobilization of participants who were subsequently verified by the interviewers. Additionally, adult participants were selected if living with a child/children aged 10-17 years and in either age range of 25-49 years or 50-75 years. Adolescent participants were selected if unmarried and aged 14-17 years. Key informants were selected on the basis that they had worked closely with the community and knew it well enough to discuss issues affecting the people, orphan households, orphans and adolescents in general. Orphan status was not used as a selection criterion in order to avoid any stigma among participants and allow free discussion. We included non-orphan adolescents to provide a better understanding of adolescent sexual risk in a generalized HIV, orphanhood and poverty context.

1. Where do adolescent orphans and non-orphans in this community get information about teenage pregnancy, sexually transmitted diseases and HIV risks and prevention?
2. Do parents/caregivers in this community dialogue with their adolescent children on sex related topics? Explain your answer.
3. What factors hinder/inhibit parental sexuality dialogue with their orphan and non-orphan children in this community?
4. In your opinion, what suggestions do you have to improve sexuality dialogue between parents/caregivers and adolescent?

Table 1: FGD and KII question domains associated with parental/caregiver–adolescent SRH/HIV communication.

Based on pre-test experience and available resources, our a priori sample targeted 8 adolescent FGDs divided equally by gender, and 7 adult FGDs, 4 with females and 3 with males in two age groups of 30-49 and 50-75. The expected number of FGDs was deemed to provide adequate information to answer the research questions. The expected and achieved FGDs are shown in Table 2. Adult males were less likely to be available due to nature of economic engagements that tend to take men further away from homes/villages thus the lower number of FGDs. Participants per FGD ranged between 8 and 12. The FGDs and KIIs in each study site ran concurrently. Overall, we conducted 14 FGDs with 147 participants; 6 FGDs with 69 parents/caregivers and 8 with 78 adolescents. We also held 13 KII with 5 community leaders, 3 health care workers, and 3 child welfare workers including a District Children's Officer (DCO) and 2 Area Advisory

Council (AAC) representatives (community level point persons on children's issues) and 2 adolescents.

	Adolescents			Parents/Caregivers			Total
	FGDs(n)	FGDs(n)	FGDs(n)	FGDs(n)	FGDs(n)	FGDs(n)	FGDs(n)
Expected	4(40)	4(40)	8(80)	3(30)	4(44)	7(74)	15(154)
Achieved	4(37)	4(41)	8(78)	2(24)	4(45)	6(69)	14(147)

Table 2: Focus group discussion samples.

Procedures

The institutional review boards of the Population Council, the Kenyatta National Hospital Ethics and Research Committee Review Board, and the Ministry of Science and Technology Nairobi, approved this study. Consent was obtained from parents/caregivers on their own behalf for those who participated in the study FGDs and KIIs and on behalf of minors aged 14-17 yrs. Assent was obtained from the minors for their participating in the study.

The FGDs and KIIs were conducted by ten trained and experienced qualitative interviewers who were divided into two groups of 5 interviewers each. The interviewers were of Luo ethnic background from communities other than the study areas to avoid any bias. The two teams were deployed to the two study sites within a county, conducted the data collection concurrently and moved from one county (district) to another until data collection was completed. Caregiver consent was sought first for the selected adolescents to participate before seeking the adolescent's assent. Discussions and interviews were conducted in Kiswahili, Dholuo or English depending on participants' language preference. All discussions were audio-taped with participants' consent and lasted 1 hour to 1 hour and 45 minutes. Activities were conducted at a central location within the community between 10 a.m. and 3 p.m. as this is the time they are commonly available between early morning and evening chores in the family farms and household respectively. The KIIs were conducted at a convenient place for the respondents with audio privacy.

Data management and analytical approach

All FGDs and KIIs were transcribed verbatim into MS Word, translated into English for those conducted in Kiswahili or Dholuo and analysed using Atlas ti. 5.2 [23,24]. We used both deductive and inductive analysis approaches. Analysis started with deductive approach where we developed the question domains and coded the data first based on our assumptions/ research questions. Thereafter, we used inductive approach where we 1) reviewed the data and begun to take note of emerging themes and patterns, and 2) based on other contextual insight and research we began to interpret and draw conclusions [25]. Parental/caregiver sexuality talk emerged as a theme with four sub-themes presented in this paper.

Results

Background characteristics

The parent/caregiver FGD sample of 69 participants comprised of 35% male and 65% female, in two age groups of 30-49 (48%) and 50-72 (52%). Overall, sixty one percent were married and 39% widowed with the majority having either primary (39%) or secondary education (36%). Of the 78 adolescent FGD participants, 47% were female and 53% male, all unmarried, aged 14-17 years and in-school with 62% and 38% in primary and secondary schools respectively. Of the 13 key informants two were in-school male and female adolescents aged 15 and 16 years respectively. The adult key informants were five community leaders, three child welfare workers including a DCO and two AAC representatives and three HCPs, all with an average age of 44 years and had either secondary or post-secondary education.

Parent/caregiver-adolescent discussion on sexuality

Four sub-themes on parental/caregiver-adolescent discussion with adolescents emerged: 1) attempts at parent/caregiver discussion of sexuality with adolescents, 2) absence of parent/caregiver discussion of sexuality with adolescents, 3) barriers to parental/caregiver discussion on SRH/HIV, and 4) participants' recommendations to strengthen parental/caregiver SRH/HIV communication with adolescent children, as described below.

Attempts at parent/caregiver discussion of sexuality with adolescents

Sexuality talk sometimes took place between parents/caregivers and adolescents. However, there emerged differences in parent/caregiver and adolescent perceptions of these talks. Caregivers perceived themselves as talking adequately and about SRH/HIV with young people contrary to adolescents who perceived absence of dialogue in these talks, citing them to be one-sided and full of warnings. The tone, when adults in interviews described how they talked with adolescents, appeared to concur with how adolescents perceived these sexuality talks. Mothers reported conducting such talks equally to adolescents under their care, irrespective of orphan and non-orphan status.

"We really warn our children while pointing at them but the current generation no longer listens to parents! You tell them there are diseases out there that kill, to be careful and to concentrate on their studies, but they feel they know it all." (Male parent/caregiver FGD)

"Parents just talk to their children to warn them but there is no dialogue between them. The children just sit and listen without any contribution or question." (Female adolescent, FGD)

When parent/caregiver-adolescent sexuality talk reportedly took place, it was always the mother who initiated the talk and often used local community examples to underscore the realities of engaging in early sexual behaviour. The talks were often triggered by a negative outcome of engaging in risky sexual behaviour it their community.

"Parents/guardians talk to adolescents, giving them examples of those who are already sick [with AIDS], unmarried pregnant girls and adolescent mothers, who did not heed their parents or caregivers…" (Female parent/caregiver, FGD).

A range of SRH/HIV topics mentioned in parental/caregiver talks included risks and prevention of SRH/HIV in general. Specific topics included HIV, abstinence, teenage pregnancy, and abortion, boy-girl relationship and menstruation.

Absence of parental/caregiver discussion of sexuality with adolescents

Interviews also suggested that there were instances where parent/caregiver-adolescent sexuality talk was absolutely absent. Apparently, some female caregivers did not care to discuss sexuality with orphans under their care while some fathers perceived such to be a woman's responsibility.

"So when parents and caregivers do not discuss such intimate issues with their children and orphans under their care, this can put the children in a state of vulnerability because they may not know how to protect themselves from sexual risks." (Female parent/caregiver, FGD).

Orphans were perceived to be at heightened risk of lack of caregiver talks on SRH compared to non-orphans as some female caregivers were reportedly not keen on such talks, a notion that reflected lack of bonding with the children.

"Some of our women are not friendly to the orphans we live with. Our wives do not talk to the adolescents about sexual risks such as teenage pregnancy, STI or HIV; it is women's duty to talk to children about such issues." (Male caregiver, FGD)

"Personally, I am an orphan living with my aunt. She has never talked to me about teenage pregnancy, STI or HIV risks." (Male adolescent, KII)

Barriers to parent/caregiver-adolescent sexuality communication

Generation gap was reflected in failure of parents/caregivers and adolescents to bond, especially between caregivers and orphans with orphans, making it difficult for them to dialogue about perceived sensitive topics such as sex. Lack of bonding was also manifested in parent/caregiver and adolescent embarrassment and fear to discuss sexuality with each other.

"If parents/caregivers are not close to or free with their children, it is difficult for them to communicate about sex related issues, to monitor their behaviour or movements closely and know when they are getting into problems or when they are at risk." (Male parent/caregiver, FGD)

"You find it embarrassing to talk to your parents because they are not free with you and so you may also not be free." (Female adolescent, FGD)

Parents and caregivers reportedly lacked adequate SRH/HIV information and sexuality communication skills to effectively dialogue on such issues with children. This was evidenced in how parents talked with adolescents, often in form of lectures and warnings, quarrels and threat without giving adolescents chance to contribute. Adolescents who were largely passive recipients.

"Sometimes the parents do not know how to discuss such issues because they are not informed. When they want to discuss about pregnancy, they don't have enough information about reproductive system, maybe the father does not know how to discuss it with a daughter if the mother is not there." (Female parents/caregivers, FGD)

Parental/caregiver characteristics such as being harsh, quarrelsome and/or authoritarian instilled fear in adolescents, thus hindering effective parent-child communication and increasing adolescent vulnerability to risky sexual behaviours with negative outcomes:

"A child can get into transactional sex to satisfy a need. This depends on how the parents communicate to the child when the child requests for something. Some parents are harsh when children ask for basic needs. This may drive the child to seek the same favour from a different person who will answer him or her politely. This might expose a child to sexual risks." (Female parent/caregiver, FGD)

Cultural taboo around parental/caregiver sexuality talks or dialogue reportedly contributed to absence of such talks.

"Some parents consider it a taboo to discuss sexuality matters with their children. Traditionally, Luo children were socialized on sex-related issues by their grandparents, and sometimes uncles and aunts. The situation has changed now with the breakdown of the traditional socialization process". (Female parent/caregiver, FGD)

Parental/caregiver sexual behaviour such as engaging in extramarital relations or having multiple sexual partners outside marriage, was perceived to influence adolescent behaviour negatively, thus compromising their moral authority to caution adolescents on similar behaviour.

"Some children copy behaviours of their parents [.....]. For example if a parent is known to have multiple sexual partners, he/she may 'have no voice' to reprimand the child or discourage the same behaviour the child sees them engage in." (Female parent/caregiver, FGD)

Parent/caregiver perception that younger adolescents aged 10-13 were too young for sexuality talk reportedly hindered sexuality talk between them.

Participants' recommendations to strengthen parent-child sexuality communication

Interviews suggested both parents/caregivers (mothers and fathers) should engage in sexuality dialogue with their orphan and non-orphan adolescents to engender dialogue and/or engagement; the need to inculcate a conducive family environment for parental/caregiver sexuality talks including strengthening parent/caregiver-adolescent bonding, especially between caregivers and orphans to inculcate a facilitative environment where they can talk freely and openly dialogue on sensitive issues such as sex.

"Today you have to be open and tell your children or child about these issues. Tell them not to have sex before marriage. I give practical examples of how I courted my wife till we got married, without having had sex." (Male parent/caregiver, FGD)

Interviews highlighted the need to equip parents/caregivers with SRH/HIV knowledge and communication skills. Adults who suggested that parents and caregivers should talk to adolescents also recommended that their communication skills be strengthened to effectively communicate with adolescents:

Parents and caregivers of today should know how to talk their daughters politely and convincingly to prevent teenage pregnancy (Female parent, FGD)

Adolescents expressed desire for parents and caregivers to give them SRH information, noting that a parent can make time to discuss such issues with their children. Besides parents and caregivers, male adolescents also recommended that teachers should also talk to young people about SRH.

"Parents are the ones closer to us and when at home they should take the initiative and when at school teachers should take the initiative." (Male adolescent FGD)

Discussion

In this qualitative paper we explored whether parent/caregiver-adolescent sexuality communication took place, barriers to such communication and community members suggestions for improving parental/caregiver communication. We found that some attempts at parent/caregiver and adolescent sexuality talk took place. However, the style of communication in the form of lectures, warnings and threats were often triggered by a negative outcome such as teenage pregnancy in their neighbourhoods. Parents/caregivers' belief that they talked to adolescents adequately about sexuality in the absence of dialogue showed ineffective parental/caregiver sexuality communication skills. Studies in neighbouring countries of Uganda [26] and Tanzania [27] also found similar parental communication styles with unmarried adolescents. The communication styles also consisted of warnings and threats and were also triggered by seeing or hearing something parents perceived as a negative experience such as death attributed to HIV and unmarried young person's pregnancy. Such a communication approach negatively influenced HIV prevention among adolescents.

We found that mothers often initiated and did most of the sexuality talk than fathers. The greater role of mothers than fathers in sexuality talks with adolescents is consistent with studies in other sub-Saharan Africa such as Nigeria, where mothers were the major initiators and communicators of sexuality education [28,29,30,31], and similarly in Rwanda [32] and Ghana [33] where mothers more frequently engaged in sexuality communication with adolescents than fathers.

Instances of absence of parent/caregiver sexuality talks with adolescents were common between adolescent orphans and their caregivers and between fathers and adolescents in general. While our study indicated some orphans and non-orphans did not receive sexuality information from their caregivers or parents, orphans were generally perceived to be at heightened risk of lack of such talks from their caregivers than non-orphans. Orphan-elevated risk to lack of caregiver sexuality dialogue is the only clear difference found in this study. It is likely that due to the generalised poverty and social obligation, caregivers are compelled to take on additional children but a parental-child bond fails to develop thus limiting communication and making sexuality talks even harder. There is a need to further investigate the factors that influence less likelihood of sexuality communication between orphans and their caregivers. A study on parent-child communication about HIV/AIDS in Kenya [34] found over one third of parents had never talked to their child about HIV/AIDS.

Lack of parental sexuality communication with adolescent children was gendered with men asserting that such communication is the responsibility of women. Similar attitudes were expressed by male respondents in a Rwanda study when describing men's role in parent-adolescent sexuality discussion [32]. Our finding suggests that men may not be prepared to engage in parental SRH/HIV talks with adolescents. Adolescent SRH interventions should be designed to involve both parents, with clearly defined roles for each to avoid leaving it to mothers only. This approach is likely to engage male parents and enhance their participation in sexuality dialogue with adolescents. A father's voice is often respected by household members including adolescents. His involvement in sexuality communication with adolescent children can reinforce what mothers communicate to children.

We found several barriers to parental/caregiver communication with adolescents on SRH, which have implications on the extent to which young people in our study community could learn about and embrace sexually safe behaviours. SRH/HIV risk prevention interventions should target lack of bonding between parents/caregiver and adolescents and especially between orphans and their caregivers, which was reflected in the form of embarrassment and fear about engaging in sexuality dialogue with each other (parents/caregivers and adolescents). Interventions should equally target parental/caregiver harshness which potentially exacerbates communication difficulties. Our findings on generation gap, lack of bond or closeness/openness between parents/caregivers and adolescents are consistent with other studies which have shown that young people who perceived their parents/caregivers as warm, caring, interested, and responsive, are more likely to postpone sexual debut and adapt secondary abstinence and [1,4,12,13,27,35,36] to use contraceptives/condoms [30-35]. Based on the findings, factors that promote lack of bonding ought to be explored in-depth to inform intervention design.

Cultural taboos and beliefs and the breakdown of the traditional sex education system previously done by grandparents, aunts, and uncles [36-44] inhibited sexuality dialogue between parents and their children. The influence of the taboo related to parent-child sexuality communication has been associated with parents' own traditional sexuality socialization that inhibits their ability to engage in such talks as evidenced in studies in sub-Saharan Africa including South Africa, Kenya and Uganda [36-45].

Another barrier to effective parental/caregiver sexuality communication was inadequate parental/caregiver SRH/HIV information and communication skills. This was demonstrated in the style of communication through warnings and lectures which adolescents felt were not participatory. The results also suggest parents' lack of understanding of their children's behaviour and a need for basic information about the developmental changes and basic information about effective parenting during the adolescent years [3,4]. Adolescents in Nigeria also identified inadequate HIV/AIDS knowledge on the part of parents as a barrier to parent-adolescent sexuality communication [46].

The perception of parents that adolescents aged 10-13 years are too young to be given information on sexuality hindered younger adolescents' access to important SRH and HIV/AIDS information at an early stage of puberty that could enlighten them on their body changes and what to do when the changes occur, including sexual risk and prevention.

Study participants' recommendations included the need for both parents to engage in parental/caregiver sexuality dialogue with adolescents to engender dialogue and or engagement; to nurture a conducive family environment for open and free sexuality dialogue; strengthening parent/caregiver–adolescent bond, especially for caregivers and adolescent orphans; and equipping parents with SRH/HIV knowledge and communication skills. These

recommendations suggest that parents, caregivers and adolescents understood their sexuality communication needs

Our study has various limitations that should be considered when interpreting the results. We did not explore enabling or motivating factors for parent/caregiver-adolescent sexuality communication that are as important as the barriers in understanding and informing appropriate strategies for addressing adolescent sexuality information needs. Community leaders assisted in identifying respondents using predetermined criteria. This may have biased the selection of participants and their responses. The study was conducted in a generalized poverty and HIV epidemic context. Such context may have influenced respondents' perception of parental/caregiver sexuality communication. However, the study results provide useful insights that can inform possible interventions and further research to strengthen parent/caregiver-adolescent sexuality communication.

Conclusions

In this study, we found that attempts at parental/caregiver sexuality talks with adolescent are made; however, their style of communication in form of warnings, lectures and/or threats without dialogue that are often unpopular with adolescents limits the usefulness of such talks. We found that orphans are less likely to receive sexuality information from their caregivers compared to non-orphans and their parents. Various factors hindered effective sexuality communication between parents/caregivers and adolescents including generation gap and failure to bond between adolescents and their parents/caregivers, lack of SRH knowledge and communication skills among parents and caregivers, cultural taboo of discussing sex with a child, and failure of male spouses to play a role in child socialization that should be key targets for interventions to improve parental/sexuality dialogue, engender the participation of minors in the dialogue and subsequently enable adolescent orphans and non-orphans make informed decisions on their sexual and reproductive health. The recommendations for improving parental/caregiver sexuality dialogue with adolescents that include strengthening parental SRH/HIV knowledge and communication skills, nurturing parents/caregivers-adolescent bond and creating a conducive family environment for sexuality dialogue shows parents, caregivers and adolescents know their needs and probably just need facilitation to carry these further through actionable interventions. We conclude that adolescent orphans and non-orphans in the household lack an important source of information to help them make informed decisions on their sexuality. It is essential that policies and interventions aim at equipping parents/caregivers with sexuality knowledge and communication skills to enable them to dialogue with adolescents effectively on sexuality.

Recommendations

Policy and interventions

Based on the results of this study, the following recommendations for improving parental/caregiver sexuality communication in the counties of Nyanza region are made:

Develop standard parent-child communication guidelines for parents and caregivers that should be informed by studies on parent-child communication. Based on results of this study and others the guidelines should:

Address generation gap, parent/caregiver bonding with adolescent orphans and non-orphans, cultural inhibitions to sexuality talks, parental/caregiver SRH and HIV knowledge and communication skills and male parent/caregiver involvement in SRH/HIV sexuality communication.

Inform capacity strengthening interventions to train both male and female parents and caregivers on SRH and HIV and on how to effectively communicate with their adolescent children on sexuality with a strong emphasis on male parent/caregiver involvement.

There is need to lobby policy makers and adolescent SRH/HIV service organizations to emphasize on parent-child sexuality communication component that are already included in the 2003-2015 Kenya Adolescent Reproductive Health and Development (ARHD) policy [47] and the follow-on ARHD Policy and interventions strategies update [48].

Further research

Our study found only one difference between orphans and non-orphans in relation to parents/ caregiver-adolescents sexuality dialogue – that orphan are at an elevated risk of lack of caregiver sexuality talk than non-orphans.

The lack of difference in all other factors suggest:

A need for further research with improved study design, multiple data collection methods and targeted questions that build on this study results and experiences.

The research should also explore adolescent living environments and how they relate with their parents or caregivers to provide a better understanding of factors that may facilitate or inhibit sexuality communication between them.

Explore facilitative factors for parent/caregiver –adolescent sexuality communication

Further exploration of how the identified hindering factors such as failure to bond, socio-cultural factors, and inadequate SRH/HIV knowledge and communication skills work to inhibit parental/caregiver sexuality communication are important to understand, as well as knowing which ones contribute most in hindering such communication.

Design an intervention study informed by this study and the suggested study recommendations to determine effective ways to improve parental/caregiver sexuality dialogue.

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