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Making a difference in adult–child relationships: Evidence from an adult–child communication intervention in Botswana, Malawi, and Mozambique

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A B S T R A C T

Girls are vulnerable to HIV in part because the social systems in which they live have failed to protect them. This study evaluates a program aimed at strengthening adult–child relationships to reduce girls' vulnerability to HIV in Botswana, Malawi, and Mozambique. In addition to an extensive process evaluation, a cross-sectional post-intervention survey was conducted in the three countries. The total sample size was 1418 adolescent girls (ages 11–18). Bivariate and multilevel, multivariate analyses were conducted to assess the association between adult program exposure and adult–child relationship improvement. In Botswana, Malawi, and Mozambique, girls whose mothers and fathers participated in the program, as compared to those whose parents did not participate in the program, were significantly more likely to report that their relationships with their parents had improved. Research has shown the important role that adults can play in the mitigation of youth risk taking behavior.

Introduction

Research demonstrates that adolescents who are emotionally attached to and feel that they are respected by adults, who have a sense of purpose, and who feel their active participation in family, school, and community activities is appreciated are less likely to act in ways that put them at risk of contracting HIV than are adolescents who do not enjoy these advantages (Blinn-Pike, 1999; Fors, Crepaz, & Hayes, 1999; Miller, 2002; Resnick et al., 1997). Referred to as assets-based or resiliency approaches, these approaches highlight the role of supportive, nurturing relationships in enabling adolescents to take measure of the risks and make positive choices.

There is growing evidence that social support from caring adults in the community can be a protective influence in adolescents' lives and may even compensate for the absence of other protective factors (Wolkow & Ferguson, 2001). Many researchers cite positive interpersonal relationships as a key factor in an adolescent's level of resiliency. Brown and Wells (2005) noted that having positive role models and positive friends is important, just as is having a close relationship with at least one person (Bogenschneider, 1996; Leffert et al., 1998). In a World Health Organization (2002) report on balancing the

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protective and risk factors in programming for adolescents, positive relationships with both parents and teachers were found to be protective factors against early sexual initiation.

Leffert et al. (1998) discuss several external assets that are important for adolescents, three of which are salient for this study. First, support for adolescents from all levels of the community – family, school, and neighborhood – is an integral factor in the positive development of adolescents. Tied to this is the need for positive family communication, supportive adult relationships in addition to parents and teachers, a caring neighborhood and school, as well as positive school experiences (Bogenschneider, 1996; Leffert et al., 1998; World Health Organization, 2002). A second protective factor is the level of youth empowerment at the community level. A community that values youth and views youth as resources helps adolescents resist engaging in high-risk behaviors. The third category of external assets is that of boundaries and expectations. When families, schools, and neighborhoods have clear rules and consequences and when adolescents are supervised in all spheres, adolescents are less likely to engage in risky behavior (Leffert et al., 1998; Miller, 2002).

In addition to the positive factors that can support adolescents and, thereby, reduce their vulnerability to adverse events or conditions, research has identified factors that undermine their resilience. Specifically, research has demonstrated that girls who live in households without adult supervision or with low parental supervision have higher rates of sexual activity and lower rates of condom use than do girls who live with adult supervision (Kelly & Parker, 2012; Miller, 2002). A cultural norm of no communication about sex (especially between mothers and/or grandmothers and girls) and a lack of sex education also render girls vulnerable to HIV (Bastien, Kajula, & Muhwezi, 2011; Bates et al., 2004; Mandevu, 1995).

The research linking parents efforts to communicate with their children about sexuality and its effect on children's risky sexual behaviors is mixed, there is some evidence for a reduction in risky sexual behaviors (Dutra, Miller, & Forehand, 1999; Karofsky, Zeng, & Kosorok, 2000; Whitaker & Miller, 2000) as well as research that shows no, and sometimes negative, effects (Akers, Holland, & Bost, 2011; Kirby & Miller, 2002). Interventions to improve parent–child communication about sexuality that have also measured change in children's risky sexual behaviors have found no effect in the United States (Akers et al., 2011; Kirby & Miller, 2002) but the findings, although based on a few studies, are much more promising in sub-Saharan Africa (Bastien et al., 2011).

The need for parent–child communication about sex in the three countries can be better understood in light of the level of exposure adolescent girls have to sex. In Botswana in 2008, 4% of females had their first sex at an age of less than 15 years. By ages 15–19, 59% of Botswana adolescent females had initiated sexual intercourse. Among those who had their first sexual encounter during ages 10–14, 34% used a condom, raising to 87% among those who had their first sex at ages 15–19 (Central Statistics Office (CSO), 2009). In Malawi in 2010, 18% of females initiated sex by age 15. This proportion increased to 60% just three years later – by age 18. Among those aged 15–19, 21% had ever used any method of family planning, 20% had used a modern family planning method, and 13% had used male condoms. Seven percent of women aged 25–49 gave birth by 15 while 65% were mothers by age 20. In fact, 26% of adolescents aged 15–19 in Malawi have begun childbearing. Approximately 8% of adolescent females aged 15–19 self-report having an STI or STI symptom (NSO & ICF Macro, 2011). In Mozambique in 2011, the median age at first sex for women aged 25–49 was 16. Among 15–19 year olds, 8% used a modern method with 5% using male condoms. Four percent of those females aged 15–19 have given birth, among those aged 20–49 58% gave birth by age 20. The median age of first birth was 19 years old. Seven percent of Mozambican adolescents 15–19 self-report having an STI or STI symptom (MISAU, INE, & ICFI, 2011).

There are several barriers to communication about sex between youth and parents. Parents don't initiate conversations about sex with their children for a variety of reasons, such as: no time, feeling embarrassed, fears that a conversation might motivate children to engage in sexual activity, and a "do as I say not as I do" concern (Fehringer, Babalola, Kennedy, Kajula, Mbwambo, & Kerrigan, 2012; Iliyasu, Aliyu, Abubakar, & Galadanci, 2012). Another barrier to conversations about sexuality between parents and children is the parent's lack of knowledge about sexuality, skills in bringing up and addressing sensitive topics with their children, as well as their own confidence in talking about the subject (Bastien et al., 2011).

Parents might also silently encourage sexual risk taking behavior among girls by refraining from inquiring where extra cash, food, clothes, cell phones or other consumable goods come from (Underwood, Skinner, Osman, & Schwandt, 2011). Parents might encourage sexual risk taking behavior less silently by pushing wealthy suitors on daughters (Fehringer et al., 2012).

Research has shown that when parents initiate conversations with their children they often initiate conversations about specific safer sex behaviors after youth have already initiated sexual intercourse (Bastien et al., 2011; Beckett et al., 2010); however, when parents talk with youth about the risks of sex prior to sexual initiation youth are more likely to use condoms at first sex and have fewer sex partners (Atienzo, Walker, Campero, Lamadrid-Figueroa, & Gutierrez, 2009; DiIorio, Pluhar, & Belcher, 2003). Programs to promote adult–child communication about sex might increase safer sex behaviors among youth by encouraging parents to initiate discussions prior to youth initiation of sexual activity.

When parents do talk to their children about sexuality the messages are often gendered – in that girls receive messages about setting sexual limits while boys receive messages about using precautions, such as condoms, when engaging in sexual activity (Bastien et al., 2011; DiIorio et al., 2003). In addition, researchers have consistently found that there is more mother–child communication about sexuality than father–child communication (Bastien et al., 2011; DiIorio et al., 2003). Furthermore, when data are disaggregated by gender, researchers report that mothers are more likely to talk to their daughters while fathers are more likely to talk with sons (DiIorio et al., 2003).

Evaluations of parent–child communication programs have shown that once parents have the tools to address sensitive sexual topics with their youth they are more confident and willing to initiate conversations about sexual health with their