

**COMMUNICATION BARRIERS AROUND SEXUAL REPRODUCTIVE HEALTH (SRH) WITHIN
FAMILIES THAT LEAD TO INCREASE IN TEENAGE PREGNANCY AND VULNERABILITY TO
HIV/AIDS**

by

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

The increasing rate of teenage pregnancy and new HIV/AIDS infections among South African young girls became a driving force to investigate the nature of this phenomenon. Parent child communication on sexual reproductive health is found to be more effective to reduce early unwanted pregnancies and HIV/AIDS infection rate. Many parents who communicated sexuality issues with daughters has failed to discuss sensitive issues including; how HIV/AIDS and STDs are spread, condom use and physical development but do so on less sensitive issues like the consequences of unprotected sex. Communication between mothers and daughters on sexuality issues is affected by various factors. However, the goal of this study was to gain in-depth the communication barriers on sexual reproductive health issues between mothers and daughters, guided by the research question.

The objectives set for the study were to identify the existing knowledge on sexual reproductive health from mothers; to evaluate factors affects communication on SRH; to assess the messages regarding SRH provided to young girls; to determine the channels of communication on SRH between mothers and daughters; and to provide guidelines for effective communication strategies.

A descriptive explorative qualitative research study was done among twenty mothers of young girls in Khayamandi. A stratified random sampling was used to obtain information from mothers with the understanding they are the ones who tend to initiate conversations with daughters about sexual reproductive health issues. The study used an in-depth interview tool and focused on existing knowledge on sexual reproductive health issues, communication channels used, messages provided to young girls and provision of effective communication strategies that promotes healthy relationships. Qualitative data analysis was done to answer the questions. Data that emerged from the data analysis was coded and categorised into themes.

Findings from this study show most of the participants understood that communication on sexuality issues should involve enforcing safer sex HIV-related behaviors and pregnancy prevention. The most sensitive part of sexuality issues such as explanation on condom use; how HIV/AIDS and STDs are contracted as well as physical development of the child (puberty) are not discussed. Various factors identified as preventing communication include,

perceived attitude of young girls on receiving information; environmental, socio cultural and educational factors. A mutual feeling expressed is; communication requires highest level of education which some did not have. There was a fear that conversations will direct children to engage into sexual activities. Socio-cultural factors including taboos, blame and criticism from the community had negative impact on communication. Communication between mother and daughter on sexual reproductive health requires basic skill and knowledge on the subject. Barrier factors identified need to be researched among a larger group of mothers in different race and different parts of the country to add to the depth of the problem and to justify development of need based program intervention. There is emerging need to develop a goal directed intervention for empowering of mothers to communicate with young girls about the full range of sexual reproductive health issues,

OPSOMMING

Die toenemende tempo van tienerswangerskappe en nuwe MIV/Vigs-infeksie onder jong Suid-Afrikaanse meisies het as motivering gedien om die aard van hierdie verskynsel te ondersoek. Daar is bevind dat ouer-kind-kommunikasie oor gesondheidsaspekte van geslagtelike voortplanting meer doeltreffend is om vroeë, ongewenste swangerskappe te verminder en die tempo van MIV/Vigs-infeksie te verlaag. Baie ouers wat seksualiteitsake met hul dogters bespreek het, het versuim om sensitiewe seksaangeleenthede, soos hoe MIV/Vigs en geslagsoordraagbare siektes versprei word, kondoomgebruik en liggaamsontwikkeling, te bespreek, maar praat wel oor minder sensitiewe sake soos die gevolge van onbeskermd seks. Kommunikasie tussen moeders en dogters oor seksuele sake word deur verskeie faktore geraak. Die doel van hierdie studie was egter om, gerig deur die navorsingsvraag, 'n dieptebeeld van kommunikasiehindernisse tussen moeders en dogters te verkry ten opsigte van gesondheidsaspekte van geslagtelike voortplanting.

Die doelstellings vir die studie was om bestaande kennis van moeders oor gesondheidsaspekte van geslagtelike voortplanting (GGV) te identifiseer, om faktore te evalueer wat kommunikasie oor GGV affekteer, om die boodskappe oor GGV wat aan jong meisies deurgegee word te evalueer, om die kommunikasiekanale oor GGV tussen moeders en dogters te bepaal, en om riglyne vir effektiewe kommunikasiestrategieë te voorsien.

'n Beskrywende, ondersoekende, kwalitatiewe navorsingstudie is gedoen met twintig moeders van jong meisies in Kayamandi. 'n Gestratifiseerde, ewekansige steekproef is gebruik om inligting van moeders te verkry met die verstandhouding dat hulle die gesprek oor gesondheidsaspekte van geslagtelike voortplanting met dogters aanknoop. Die studie het 'n diepte-onderhoud as maatstaf gebruik en het gefokus op bestaande kennis oor gesondheidsaspekte van geslagtelike voortplanting, kommunikasiekanale wat gebruik is, boodskappe wat aan jong meisies oorgedra is en die verskaffing van effektiewe kommunikasiestrategieë wat gesonde verhoudinge bevorder. 'n Kwalitatiewe dataontleding is gedoen om die vrae te beantwoord. Die data wat uit die ontleding verkry is, is in temas gekodeer en gekategoriseer.

Bevindings uit hierdie studie toon dat die meeste van die deelnemers verstaan het dat kommunikasie oor seksualiteitsake die handhawing van veiliger seksuele gedrag met betrekking tot MIV en swangerskapvoorkoming moet behels.

Die sensitiefste deel van seksualiteitsaangeleenthede soos 'n verduideliking van kondoomgebruik, hoe MIV/Vigs en geslagsoordraagbare siektes (GOS) opgedoen word en die liggaamsontwikkeling van die kind (puberteit) word nie bespreek nie. Verskeie faktore is geïdentifiseer wat kommunikasie verhinder, soos die bespeurde houding van jong meisies wanneer hulle inligting ontvang, omgewings-, sosiaal-kulturele en opvoedkundige faktore. 'n Onderlinge gevoel wat uitgespreek is, is dat kommunikasie die hoogste vlak van opvoeding vereis, wat nie almal het nie. Daar is gevrees dat gesprekke daartoe sou lei dat kinders by seksuele aktiwiteite betrokke raak. Sosiaal-kulturele faktore soos taboes, verwyte en kritiek van die gemeenskap het ook 'n negatiewe impak op kommunikasie gehad.

Kommunikasie tussen moeder en dogter oor gesondheidsaspekte van geslagtelike voortplanting vereis basiese vaardigheid en kennis van die onderwerp. Hindernisfaktore wat geïdentifiseer is behoort onder 'n groter groep moeders van verskillende rasse en in verskillende dele van die land nagevors te word om die diepte van die probleem te belig en regverdig die ontwikkeling van 'n behoeftegebaseerde ingrypingsprogram. Daar bestaan 'n duidelike behoefte om 'n doelgerigte intervensie vir die bemagtiging van moeders te ontwikkel om oor die volle spektrum van gesondheidsaspekte van geslagtelike voortplanting met jong meisies te kommunikeer.

DEDICATION

I dedicate this study to my husband Nkosinathi Hlwempu and Dindili family. Thank you for their support during the period of my studies.

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

Effective communication regarding sexuality or reproductive health is more likely to reduce adolescent risk-taking sexual behaviours when combined with effective parent–adolescent communication about adolescent sexuality issues (Burgess et al, 2005:66). However, teenage pregnancy and HIV new infections could be an indication of unsafe sex practice as well as poor communication on SRH issues within families. Young adolescents were identified as being the most elevated risk for HIV infection (Aggleton, 1995:67). Due to the consequences of the HIV pandemic, parents are making attempts to communicate with their children about SRH. They are, however, limited by various factors which may include, *inter alia*, cultural barriers and lack of appropriate knowledge (Wamoyi et.al 2010: 2). Khayamandi Township is the area of the study which is mostly occupied by African people, they value cultural practices and that could hinder the process of communicating SRH within families.

The study strives to give a snapshot view of the factors affecting communication on Sexual Reproductive Health (SRH) within families. The focus is on communication channels, messages and provision of effective communication strategies that promotes healthy relationships. While much of the information on the subject has been gathered from the young teenagers, this study hopes to discover communication barriers from the mothers of Khayamandi Township who have daughters (whether or not they have had early pregnancies) through the in-depth interviews.

1.2 Background of the study

Teenage pregnancy has become a norm in South African society and Khayamandi Township has added to those affected societies (Ramcham 2007: 9). Risky sexual behaviours such as inconsistent condom use and sexual intercourse with multiple partners are relatively common among adolescents and youth in Sub-Saharan Africa. This behaviour increases the risk of unplanned pregnancies and the infection of sexually transmitted diseases and particularly HIV/AIDS (Brook et al., 2006:263). Generally, the problem of risky sexual

behaviours practice among adolescent is also a great concern in South Africa. Considering the study conducted by Department of Education in teenage pregnancy during 2009; more than 72 000 female teenagers in South Africa did not attend school in 2008, due to pregnancies encountered. It is also estimated that 5 868 of these girls were from KwaZulu Natal (Roberts 2006:12).

HIV/AIDS is the outcome of risky sexual behaviours. Globally, it has been estimated about 34 million people are living with HIV/AIDS (PLHIV) at the end of 2011, 69% of whom are in Sub-Saharan Africa, a region accounting for a mere 12% of the world's population (UNAIDS, 2012). Amongst all societies affected in the Western Cape, the incidence of teenage pregnancy is still a great concern in Khayamandi Township and it can be influenced by various factors ranging from economic, social, living conditions as well as education (Roberts 2006:13). Khayamandi is a township that is mostly occupied by African people who relocated from their places of origin to search for job opportunities and the majority of those have low level of education. Most of them come from Eastern Cape where cultural practices are valued and some do not allow parents to communicate sex with children (Ramcharm 2007:9). The estimations shows there are 33.000 people living in the area and 10% of the population are children under the age of 10 years with 65% living in shacks (Roberts 2006:13). The increasing population of Khayamandi is leading to the problem of overcrowding within families. In most cases privacy is also affected; children often grow up witnessing their parents and siblings sexual activities. This can lead to young children having a tainted view of sex and a normalization of having multiple sexual partners and being unprotected according to Roberts (2006:16). Social pressure as well as the gender based idea is that if a man demands something, a woman should submit (Roberts 2006:19). This idea is still practiced in African cultures and generally, poverty is a contributing factor for woman to act submissively. Despite having various structures in place to minimize the incidences of unwanted pregnancies among teenagers in the residential area of Khayamandi, the prevalence remains a social and economic problem.

1.3 Motivation of the research project

The inspiration for the study is centred from two aspects; the social work professional background as well as recommendations of previous studies conducted on the subject. The

social work profession exists for promotion, restoration, maintenance and enhancement of social functioning of individuals, families, group's organizations and communities by helping them to accomplish tasks, prevent and alleviate distress and use resources (Hepworth et.al 2002:5). Enhancement of positive communication on SRH within families is part of social intervention. Wilson et.al (2010) conducted a study on 'parent's perspectives on talking to pre-teenage children about sex'. About 131 of parents of children aged 10-15 in three cities in different regions of United States participated in focus groups. The interpretation of the focus group discussion was that, many parents and children, have only limited or no communication on the topic. Furthermore, the study revealed quantitative studies have found parents are less likely to talk to their children about sex if they perceive their offspring are not ready to appreciate the value of the topic.

Some researchers noted most of the studies conducted on parental influence on young people's sexual behaviour have collected information from them and not their parents and other family members. This can result in information bias with an unclear image of what is actually happening in families and as regards parent-child relationships and communication about sex (Wamoyi et.al 2010:13). Others have noted while there has been some research conducted on the relationship of parent-adolescent communication to the social and cognitive development of children and reproductive health issues, results tend to indicate the process is facing a number of barriers and nothing has been done to focus on what barriers tend to hinder parent-adolescent communication and its relationship to family functioning regarding reproductive health issues (Nudwe 2012:4). These are some of the reasons for this study to focus on interviewing parents as they can give a thorough reflection of communication barriers with children regarding sexual reproductive health.

Purdy (2001:52) is of the view when young people do not get information at home; they seek answers elsewhere namely, from peers, the media or their observations of other adults. This can lead to misinformation and the persistence of damaging myths, making young people vulnerable to unwanted and unprotected sexual experiences. The result may be unplanned pregnancy, sexually transmitted infections, and low self-esteem. Wamoyi et.al (2010:16-17) also reports in cultures where young people report wanting information from adult family members about sex and reproduction, educating parents and other family members can help adults feel more confident in addressing the reproductive health

questions and concerns of youth. Generally, it has been observed children in African cultures are reluctant to ask parents about sex related issues, sometimes they fear parents will perceive them as promiscuous. Bastien (2011:12) also highlighted from studies conducted in developing countries that sexuality education has the potential to positively impact knowledge, attitudes, norms and intentions, although sexual behaviour change has been more limited.

1.4 Problem statement

The problem statement is thus: What are the communication barriers around Sexual Reproductive Health (SRH) within families that lead to increase in teenage pregnancy and vulnerability to HIV/AIDS?

1.5 Objectives of the study

- To identify the existing knowledge on sexual reproductive health from mothers
- To evaluate factors affects communication on SRH
- To assess the messages regarding SRH provided to young girls
- To determine the channels of communication on SRH between mothers and daughters
- To provide guidelines for effective communication strategies that promotes healthy relationships on SRH

1.6 Research methodology

The paradigm used is directed towards the qualitative approach. Qualitative research is an explanatory research approach that depends on various types of personal data and investigates people in particular situations in their natural environment (Christensen et.al 2011:52-53). It also involves fields of observations and talking to the target population to gather information in a less structured way than quantitative method (Du Toid 2002:46). An interview guide with 13 open-ended questions for semi-structured interviews was used for the study. Stratified random sampling was used to select twenty mothers from Khayamandi Township who have daughters (whether or not they have had early pregnancies) from four ward areas (ward 12, 13, 14 and 15). This sampling method involves the division of population into mutually exclusive groups called strata and after a random sampling is

selected from each of the groups (Christensen et.al, 2011:154). A door to door visit was done in each ward area to select participants, every fourth house was selected. In-depth interviews were conducted with mothers to obtain information on existing knowledge on sexual reproductive health; factors affecting communication on sexual reproductive health; communication channels and the messages provided to children regarding sexual reproductive health. The responses of mothers regarding communication barriers on SRH are interpreted in this study. The research design has utilised content analysis of the information obtained during the face to face interviews. Data was explored in detail for common themes which were established through grouping the codes and categories.

1.7 Limitations of the study

Before the interview results are presented, it is important to consider the limitations of this study. Firstly, the findings can be affected that participants are recruited from one community which is Khayamandi. While the purpose of qualitative research such as this is not to generalise the findings but to describe and understand particular individuals in particular context (Christensen et al., 2011:362). Another limitation is it was conducted with mothers who have daughters (whether or not they have had early pregnancies); the information could have been explored from both mothers and fathers since they are in some cases present in child's upbringing life.

1.8 Outline of chapters

Chapter one – Introduction

Chapter two – Literature survey

Chapter three – Research methodology

Chapter four – Reporting of results

Chapter five – Conclusion and recommendations

This chapter outlined the nature of the study; hence the focus was on exploring communication barriers on sexual reproductive health issues from mothers raising young girls. Many studies conducted on parent-adolescent communication about sexuality issues

found that young adolescent females who reported less frequent communication about sexual topics with their parents reported less discussion with partners about STIs, HIV/AIDS, and using condoms and also reported lower self-efficacy to negotiate safer sex or refuse an unsafe sexual encounter (DiClemente et.al., 2001). Communication barriers identified will inform program developers about effective intervention strategies to enhance effective communication for mothers.

1.9 Conclusion

This chapter has provided information on how the investigation was carried out. A communication barrier on SRP within families was the area of investigation. The next chapter focuses on reviewing the literature; it provides information on what is currently known about the research topic and surrounding areas.

CHAPTER TWO

LITERATURE SURVEY

2.1 Introduction

Most previous studies conducted explored sexuality communication barriers from both parents and children or adolescents and less studies focused on mother daughter communication barriers. The review of literature was conducted on the barriers that affect communication on SRH between parents and children. Parent child sexuality communication is the concept appears mostly in the literature. The barriers can be grouped into four categories; socio-cultural barriers, educational barriers, environmental barriers and religious

Parent child sexuality communication is viewed as principal means of transmitting sexual values, beliefs, expectations and knowledge to the children (Jermain et.al 2010:1). Others perceive it as a protective factor for adolescent sexual and reproductive health, including HIV infection (Bestien 2011: 27). Some authors argued the content of parent child communication should include a range of topics such as; biological and developmental issues (puberty), values, healthy relationships, pregnancy and STD prevention (Beckett et.al 2010:36).

Researchers confirmed the increase in utilization of contraceptives, reduced chances of pregnancy among girls and reduced risk of HIV transmission among youth who report discussions about sex with their parents (Murphy, Roberts & Herbeck 2012:137). The assumption was raised to say, everyone has a hard time talking about sex at one time or another, whether it is answering a question about sex from own children, talking to the partner about a sexual issue, or asking a doctor a medical question related to sex (Jackson (2007: 36).

However, mothers are reported to be more likely than fathers to talk with their children about sex, the conversations are expected to influence adolescent sexual behaviour (Roberts et.al 2011:137). Adolescents and young adults are at greater risk of contracting

sexual transmitted infections (STIs) because they are more likely to have unprotected sex and to have multiple as well as high risk partners (Bacak 2011: 14). The practice of unsafe sex is linked to socio-economic factors which mostly affect unskilled woman with low levels of education; their last resort is commercialization of sex for monetary gain (Sithole 2001: 8). The studies conducted showed adolescent who discussed sex with parents were less likely to engage in unsafe sex behaviours (Wamoyi et.al 2010: 17). Sexual communication is more than a clear discussion of sexual intercourse it also encompasses discussion of nonsexual relationships, respect, sexual pleasure, decision making and many topics (Jerma et.al 2010:5).

2.2 Communication barriers on SRH within the families, socio -cultural practices

Schear's (2006) study explored factors that contribute to and constrain conversations between adolescent females and their mothers about sexual matters. The study revealed constraining socio-cultural discourse concerns the notion adolescence is a time of separation from parents in order to establish a sense of self and determine a place in society. Parents who indulge in this notion may pressure their teen to do what the adult perceive as in the best interest. The study does not specify the culture of this nature however; cultural beliefs emerged as communication barrier.

Some countries including South Africa and Zimbabwe, pervasive polygamy is practiced in certain areas. This involves parents giving away innocent young daughters in marriage to older men with several wives for monetary gains. Transaction of this nature happens without the girl's knowledge and consent. Early marriages and early sex of this nature expose young girls to high risk of contracting HIV/AIDS, especially where multiple partners are involved (Sithole 2001: 8-9). Such practices could limit parent communication on SRH issues as children are forced to early marriages for monetary gain. The multiplicity of sexual partners for man is supported by Swazi culture. A man who engages in multiple sexual encounters is called "ingwanwa" which means positive and widely accepted (Sithole 2001: 16). Promoting SRH in Swaziland can be viewed as disrespectful to cultural practices.

The article based on data collection in 1996 and 2003 in Kenya investigated the reasons why educated mothers do not give significant sex education to their daughters and they mentioned a many socio-cultural and religious barriers to sexual communication; residual

traditional, inhibitions due to European Christianity, reliance on sex education books and reliance on school teachers. The majority of mothers interviewed for the study indicated they themselves had not received pubertal or sex education from their own mothers and were thus inhibited to providing it to their own daughters due to residual barriers which fostered a sense of unease and avoidance concerning parent-child sexuality communication (Mbugua 2007). This spells out irrespective of educational levels of a mother; cultural beliefs could play a dominant role to prevent their sex communication with children.

The study conducted on parent-child communication about sexual and reproductive health in rural Tanzania revealed whilst mothers are limited to communicate sex issues with children, grandparents are not restricted in what they communicated with their male or female grandchildren and hence were not concerned about being careful with what they said. Cultural norms around communication about sex across generations seemed to be flexible with grandparents. However, it is also noted this flexibility could be attributed to the traditional role observed in many African cultures where grandparents were the main sex socializing agents for grandchildren. Although grandparents were comfortable discussing sex with their grandchildren, they had limited knowledge concerning HIV/AIDS prevention, modern contraception and condoms and thus were limited in what they could communicate (Wamoyi 2010: 12-13).

Another study was conducted in Windhoek-Namibia to assess what is talked about when parents discuss sex with children. The results of the study showed the majority of parents did not talk to children about sex. They indicated three reasons for not communicating sex with children; it was a taboo subject, it was too embarrassing and it is a private matter or uncomfortable and against tradition. Parents for cultural reasons are not normally expected to discuss sex with their biological children. One participant mentioned in the 'Oshiwambo culture' the grandmother is the one who may talk freely with the grandchildren and not the parents. However, some parents have recognized times have changed due to HIV/AIDS and the influence of Western culture and media (Nambambi et.al. 2011:124). It is clear some cultures still acknowledges the role of grandparents in communicating sexuality issues; however, the concern is their limited knowledge on the subject which could be a barrier.

2.2.1 Communication style, tone and messages

Murphy et.al (2012:143-144) conducted a study on HIV-positive mothers communication about safe sex and STD prevention with their children. The study revealed messages regarding safe sex and HIV are based on protecting oneself from STD's. The most common message in this area mothers gave their children was that condom can prevent STDs. Secondly messages were also based on giving factual information regarding STDs including HIV; avoiding pregnancy; empowering and respecting one; and communicating with sexual partners. In providing factual information, some parents informed their children about what they heard on the news where one out of every four girls who is sexually active has a sexual transmitted disease. Seemingly, the content of the message is informative; however, parents living with HIV/AIDS can be overprotective because of their own experiences. The tone used to send messages can be frightening as they do not want children to have the same experiences. The study continues to describe the messages conveyed including, parents encouraging their children not to make the same mistakes they made, parents drawing their experiences from HIV (the children observed their parents hospitalizations and fluctuating health).

Some of the studies conducted on sexual communication revealed it was always delivered as general warnings and the only time it was specific and directed was when talking about the consequences of premarital sex on their education. Although warning their daughters, they sometimes talked about their own experiences when they were young and 'losses' they experienced and received when they had unplanned pregnancy (Wamoyi 2010:5). Children can get used to such warnings and tend to ignore them especially in their adolescent stage where their interest is on exploring and experiencing (Louw et.al 1998:376). Also the impact might not be clear to them especially if their parents survived with those losses.

Dove et.al (2012:87) conducted a similar study to understand how family serve as sexual information sources, the messages adolescents recall from the family, and how this learning experiences affect sexual behaviour among at-risk young people. The study revealed with regard to the main message from family members the most identified ones adolescents recalled from their sexual learning experiences with family members included the risks

associated with sex such as STDs and unplanned pregnancies, protection (such as condoms, birth control methods, generic protection) and relationship advice including (waiting for special partner to have sex and cautions to girls regarding pressure to have sex which portray boys as only interested in sex and as likely to leave partners after having sex. In addition, risk associated messages made by parents were linked with the child's reputation. A 16 year old daughter confirmed a mother warned her not to have sex with a lot of men as that will ruin her reputation. The study did not explore communication barriers but could identify warning messages given to children that could impact on sex communication.

Another study on black mother-daughter communication about sexual relations found these mothers who discuss sex with daughters, the message they impart is 'don't have sex' because there will be negative consequences. Again it was found instilling fear is a strategy employed by some Black mothers to discourage their daughters from early sexual activity (Dennis et.al. 2012:4).

Several studies in the review suggested one of the most substantial challenges to positive and effective parent-child sexuality communication relates to the message and tone of discussion. As one study in Ghana found, communication often takes the form of instruction rather than dialogue (Bastein 2011: 16). Others have noted children in their teenage stage are mostly reluctant to comply with instructions and they become bored when instructed by parents (Louw et.al 1998:377).

2.2.2 Perceptions and beliefs of parents in communicating SRH with children

Jackson (2007:33) is of the view with few exceptions, individuals are all raved with some negative sex beliefs and these can be personal (being told your body is ugly or should only be used for protection or more universal sex is bad, it leads to immorality. These beliefs can act as a strong deterrent to talking about sex with children.

Wilson et.al (2010:58) conducted a study on parent's perspective on talking to preteen age children about sex. The study found the primary barrier identified was age, parents' perspective was their children are too young and not knowing how to talk to them about the subject. In addition, a positive parents-child relationship was perceived as a gate way to the discussion of sexual issues between parents and children.

Wamoyi's (2010:7) study on sexual communication with children revealed when parents were asked about how they felt talking about sex with their children, most of the male parents said they perceive it as shameful, immoral and encouraging the child to have sex. In addition, some parents held a strong belief that they should not discuss sexuality with their children. They felt that sexual issues are secret/confidential issues and not to be shared with ones parents (Wamoyi 2010: 10). The study did not specify the perceptions expressed by female mothers regarding sex communication, however, mothers are still regarded as primary care givers and therefore an opposing perception in this regard is expected from them.

In addition, Bastien (2011:26) reported a study conducted in Kenya found 38% of parents thought talking about sexuality encourages sex. Also the belief that discussing sexuality with children will lead to early sexual experimentation is documented by other studies.

2.2.3 Triggers and timing for communication

Dennis et.al (2012:217) study explored Black mother-daughter communication about sexual relations. The study found many Black mothers do not plan discussion about sexual topics with daughter and some of them postpone talking ever about the subject. In addition, the study also revealed if Black mothers do talk with daughters about sex, the impetus is often external factors, such as the onset of puberty, a daughter's first boyfriend, suspicion of a daughter's sexual activity, or the teen pregnancy of a relative or friend. The study did not explore communication barriers, however; external factors leading to sex conversations could serve as barrier especially if the approach used is inappropriate.

Wamoyi et.al (2010:11) explored sexual communication with children showing a similar finding that, parents mainly communicated with children after observing changes in their behaviours which they attributed to them having sex. The study continues to explain only one study reviewed investigated triggers for discussion about HIV/AIDS and it was reported parents frequently used examples of relatives who had died of AIDS to reiterate the severity of the disease. Other triggers for discussion reported by parents were radio programs, flyers, parental perceptions of risky sexual behaviour of seeing someone they believe was HIV positive.

2.2.4 Religion

Bacak (2011:3) mentioned religious individuals might be less knowledgeable about sexual and reproductive health issues than their non-religious peers due to restrictive norms in their respective families. Again, such upbringing encourages discussion on sexual morality while discouraging conversation about sexuality may also have a negative impact on the availability of relevant information.

Bastien (2011:14) reported European Christianity is discussed as influencing the type of language used to discuss sexuality, to explain for instance why metaphor and other linguistic devices are used to avoid direct communication and precise terminology which is perceived as being dirty.

2.2.5 Factors associated with sexuality communication

Davis et.al (2013:44) study explored communication on sexual health between Black youth and parents in Nova Scotia. The study found overcrowded homes where households are not necessarily based on kinship and unsupervised adolescent (due to parents having to work long hours) often result less communication on sexual reproductive health. However, parents can find it difficult to communicate sex related matters with their children in the presence of other people whom are not family relatives. Also the children might not open-up due to fear housemates will spread the information. It is obvious parents who work long hours are tired when they get home and possibly they might not be interested in such conversations.

Louw et.al (1998:423) is of the view family factors such as divorce; single-parent (especially single mother) families; family disintegration due to physical, sexual, drug and alcohol abuse and marital infidelity could influence parent child communication. In many instances, divorced parents are likely to develop drinking problems and that obviously makes them give more time to drinking than to their children.

Another study found young people living in rural areas reported more frequent communication about HIV/AIDS with both mothers and fathers than those living in urban areas. In addition, attending school and having a higher socioeconomic status were found to be associated with more frequent communication with parents. In a multi-site study

conducted in South Africa and Tanzania, higher socio-economic status was similarly found to be significantly associated with more frequent communication with parents in both of the South African sites, but not in Tanzania Namisi et.al (2009:42).

Some researchers reported young girls to be more likely to use condoms in sexual partnership that are shorter in duration. Once there is mutual trust and sense of mutual linking in the relationship, the utilization of condoms is reduced. It has been reported that on average, many adolescent stop using condoms after 21 days into the relationship (Schear 2006). Although perception was that young girls are ignorant towards healthy sexual behaviours, this raises a question of whether parents are communicating sexual reproductive health or not and the interest is on information provided to children. The study explored communication barriers on SRH, this will inform the planners and programmers to develop a goal directed intervention.

2.3 Conclusion

In conclusion, most of the studies reviewed explored sex communication from both parents, while others explored from young daughters and boys. However, studies did not precisely explored communication barriers but could indicate factors that can hamper sexual communication between parents and children. They provide a clear picture of what is discussed during sex conversation including messages provided to children, communication styles, triggers and timing of communication which could be linked to the spread of HIV/AIDS and teenage pregnancy among young girls. So far, studies conducted on sexual communication barriers between mothers and daughters in South Africa and other countries have not been found. Only one study by Schear (2006) explored factors that contribute to constrain, conversations between mothers and adolescent females. The three different studies by Dennis (2012), Mbugua (2007) & Murphy (2012) explored sex communication specifically from mothers-daughter and all are based in the African countries Windhoek-Namibia, Sub-Saharan-Kenya.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This study is set out to explore communication barriers on sexual reproductive health from mothers of Khayamandi Township who have daughters (whether or not they have had early pregnancies). This chapter provides information on how this investigation was carried out. Blaikie (1993:7) defines research methods as being the actual techniques and procedures used to gather and analyse data related to some research question or hypothesis. Denzin, et.al (2011:14) mentioned some of the research methods used and they range from the interview to direct observations, the use of visual materials or personal experiences. The problem statement, objectives, research approach and sampling are discussed in this chapter.

3.2 Problem statement

Dennis et.al (2012) reported mother-daughter communication about sex gives daughter resources allowing them to minimize risks and make informed, responsible choices about sexual activities. The emphasis placed is this sex communication is critical in an era when sexually transmitted diseases (STDs) affect millions of people and disproportionately affect minorities. Other researchers reported open, confident, responsive and consistent parental communication can lead to improvements in the level of consistent use of condoms and contraceptives (Davis et.al 2013:14).

Murphy et.al (2012:138) argued many mothers may not communicate with their children about sexual health. Maternal reluctance to communicate is associated with mothers reported lack of knowledge, discomfort/embarrassment, and lack of self-efficacy about talking with one's child. Discomfort experienced by parents in speaking about adolescent reproductive health can prevent effective reproductive health communication from occurring. Focus group data from Ghana also show young people are reluctant to discuss sexuality with their parents since they tend prefer to discuss these issues with their friends, because they feel shy and also because they may fear physical punishment for discussing sexuality (Nudwe 2012:4).

Since parents are not openly talking to children about sexual reproductive health, they are more likely to confront children on what they are doing concerning sexuality and this is mostly done in the African countries. The problem statement is thus: What are the communication barriers around Sexual Reproductive Health (SRH) within families that lead to increase in teenage pregnancy and vulnerability to HIV/AIDS?

3.3 Objectives of the study

- To identify the existing knowledge on sexual reproductive health from mothers
- To identify factors affects communication on SRH
- To assess the messages regarding SRH provided to young girls
- To assess the channels of communication on SRH between mothers and daughters
- To provide guidelines for effective communication strategies that promotes healthy relationships on SRH.

3.4 Research approach

The study embraced a qualitative research approach to explore communication barriers on sexual reproductive health from mothers who have daughters (whether or not they have had early pregnancies). Qualitative research focus on in-depth understanding and nature of human behaviour and then it enables to identify and describe the communication barriers on SRH among mothers of young girls. Others are of the view the approach focus on the qualitative aspects of the meaning, experiences and understanding and they study human experiences from the viewpoint of the research participants in the context in which the action takes place (Brink et.al.,2006 :113) This approach differs from quantitative approach which mostly relate to quantity or numbers (D’Cruz 2004:60).

A phenomenological approach was also used in this qualitative study. The approach examines human experiences through the description that are provided by the people involved (Brink et.al 2006:114)

Christensen et.al (2011:29) argues a qualitative approach is the one that collects some type of non-numerical data to answer a given research question. Non-numerical data entails facts statements made by a person during an interview, written records, pictures, clothing or observed behaviour. The approach is multi-method, meaning a variety of methods are used

to collect data. The interview method was used for this study to gather information from 20 mothers of Khayamandi. The approach helped to understand the insider's views, meaning participants had opportunity to share their own views concerning sex communication barriers with daughters. Again, in a qualitative approach the research question are allowed to change, during the study because this method is usually focused on exploring phenomena's in contrast, it typically does not allow changes of this type because the focus usually is on hypothesis testing (Christensen 2011:53). Research question for this study did not change, however, interview questions were rephrased where participants did not understand the terms used. Christensen et.al (2011) mentioned the weakness of qualitative research is the difficulty to generalize because the data are based on local, particularistic data. Another weakness is different qualitative researchers might provide different interpretations of the phenomena studied.

3.5 Sampling

The approach to sampling, however, differs with regards to the research strategy to be pursued (D'cruz 2004:99). The research aim was to identify the communication barriers in order to recommend the effective strategies that promote discussins on sexual reproductive health within the families. In order to identify the barriers 20 mothers of Khayamandi who have daughters (whether or not they have had early pregnancies) were selected to partake in an in-depth interview.

A stratified random sampling was used to obtain information from mothers with the understanding they are the ones who tend to initiate conversations with their daughters on issues concerning sexual reproductive health. The sampling method was utilized with the intention to select only 5 mothers per ward area who will represent the entire area population. In stratified sampling, the population is divided into mutually exclusive groups called strata, and then a random sample is selected from each of the groups (Christensen 2011:154). However, Khayamandi population was already grouped according to ward areas (from ward 12 to15). Five mothers of different households were selected randomly from each ward to represent the entire ward area zone. A door to door home visits was done; every fourth house with a mother was targeted to reach five participants per ward area and to reach the target of 20 mothers for the study provide detailed information concerning the

sampled population. A community-map received from ward counselors which demonstrates the areas covered by each ward was used as guide to select houses (see attachment A). Table 3.1 illustrates demographic characteristics of the participants.

Table 3.1**Demographic characteristics of research participants**

ID	Gender	Age	education	Religion	Occupation	Marital status	Child age
P1	Female	58	STD 6	Christian	unemployed	unmarried	19
P2	Female	49	STD 9	Christian	Domestic worker	married	16
P3	Female	32	STD10	Christian	Waitress	married	14
P4	Female	40	Diploma	Christian	Edu-care principal	married	16
P5	Female	35	STD 10	Christian	Prison wader	unmarried	12
P6	Female	37	Diploma	Christian	Teacher	married	11
P7	Female	43	Degree	Christian	Social work	married	14
P8	Female	43	STD 7	Christian	unemployed	married	17
P9	Female	41	STD3	Christian	unemployed	married	18
P10	Female	29	STD10	Christian	Shoprite	unmarried	12
P11	Female	38	STD 10	Christian	Pik'n pay	married	13
P12	Female	31	STD 10	Christian	Prison wader	unmarried	8
P13	Female	41	STD 10	Christian	Municipality cleaner	Unmarried	17
P14	Female	52	STD 6	Christian	Domestic worker	unmarried	11
P15	Female	39	STD 10	Christian	ADT security	unmarried	10

P16	Female	42	STD 8	Christian	Municipality cleaner	unmarried	9
P17	Female	40	STD9	Christian	Store cashier	unmarried	12
P18	Female	42	STD 9	Christian	Domestic worker	married	9
P19	Female	28	STD 10	Christian	unemployed	unmarried	10
P20	female	38	STD 9	Christian	unemployed	unmarried	9

This study aimed to assess communication barriers on sexual reproductive health issues from mothers who are raising young girls. Many studies conducted on parent communicating sexuality issues with children indicated that topic specific conversation (i.e., sexual initiation, condoms, STDs, abstinence) between parent- child pairs are more effective than global communication (for example 'just do it') in reducing sexual risk behavior (Dove et.al 2012:88). However, part of the study assessed messages provided to young girls about SRH and will be discussed in chapter four.

3.6. Conclusion

In conclusion, the study explored communication barriers on SRH from mothers of daughters in Khayamandi Township. Qualitative research approach was adopted for in-depth interviews. The approach used helped the participants to share experiences concerning communication on sexual reproductive health. Stratified random sampling applied in the study has guided the process of selecting participants. The next chapter provides a detailed report on findings of the study.

CHAPTER FOUR

REPORTING OF RESULTS

4.1 Introduction

The study explored communication barriers on sexuality issues from twenty mothers of Khayamandi Township who are raising daughters. In this chapter the results of the research are presented and discussed. The results have been organized according to each of the emerged objective themes and categories that were identified through the analysis of collected data to explore sexuality communication barriers. Within each of the themes, the results have been categorized into key topics. The data collected was recorded in the language of participants IsiXhosa and then translation was done word for word to English to confirm trustworthiness of the data. The data was transcribed and keywords were identified representing the codes, as listed in the table 4. 4. The five themes emerged from the data collected are listed and discussed in detail in 4.5

1. General knowledge about communicating sexual reproductive health with daughters among participants
2. Perceived barrier factors to communication on SRH with daughters
3. Perceptions about the attitude of young girls on receiving information of SRH from mothers
4. General attitude towards discussion of SRH with young girls
5. Suggestions on how to enhance effective communication on SRH for mothers

4.2 Problem statement

Previous researchers on social issues indicated sexual health problems such as HIV/AIDS and unplanned or unwanted pregnancies are prevalent among South African adolescents and this requires urgent attention (Nudwe 2012:4). Improving the effectiveness of preventative programs, contributive factors need to be identified. Hence this study attempts to investigate communication barriers between mothers and their daughters regarding sex reproductive health issues. The problem statement is thus: What are the communication barriers around Sexual Reproductive Health (SRH) within families that lead to increase in teenage pregnancy and vulnerability to HIV/AIDS?

4.3 Objectives of the study

- To identify the existing knowledge on sexual reproductive health from mothers
- To evaluate factors affects communication on SRH
- To assess the messages regarding SRH provided to young girls
- To determine the channels of communication on SRH between mothers and daughters
- To provide guidelines for effective communication strategies that promotes healthy relationships on SRH

4.4 Codes that emerged from the interviews

There were few concepts in the interviews that emerged in the codes which will be describes in table below. Direct quotes were used to support the results and are printed in italics

Table 4.1
Codes that emerged from the interviews

Code evidence	Example of quotation (source/number of interview in brackets)	Interpretation
Embarrassed	<i>I feel so embarrassed to talk, especially to use sexuality terms. She is very young than to me (participant 7)</i>	They feel embarrassed to use sexuality terms as they believe that their daughters are still young
understanding	<i>My daughter will think that I am an understanding mother.” (Interview participant 3:</i>	Some parents perception to communicate Sexuality issues is that daughters with perceive them as understanding mothers. For instance in case where they have done wrong, they will say “my mother will understand”
Blame and criticism	<i>I have shared the situation with church mothers; some were supportive whilst others blamed me for taking my daughter to the clinic for family planning injection. They said I should have told my daughter that no sex without marriage and that is in line with the church rules according to</i>	Some participants have experienced blame and criticism for their actions to prevent early pregnancies

	<i>them.</i> " (Interview participant 16)	
Privacy	<i>I have no privacy to talk to my daughter about sexuality issues, my neighbors will hear the conversation</i> (participant 2)	Some participants are still prevented by living condition to communicate sexuality issues with their daughters.
Old education	<i>My level of education is a barrier, I have old education which differs from current curriculum</i> (participant 1)	Some parents perceived level of education as a barrier to communication especially those with old curriculum education
Information	<i>"I do not have enough information on the subject because I cannot read and write."</i> (Interview participant 9)	Some parents associate their lack of communication with having insufficient information on the subject
Interpretation	<i>I always worry about her interpretation of information, I think she might give wrong interpretation therefore, I become reluctant to talk."</i> (Interview participant 11:	Some mothers are reluctant to communicate because they fear that daughters will give wrong interpretation of information provided.
Taboo	<i>my culture is a barrier because it is a taboo that a parent cannot talk sex subject with her daughter</i> (participant 6)	Some participants are still faced with cultural taboos though communicating SRH with children

4.5 Results according to objective themes

The study reveals all participants stated they know what communication on SRH is. However, they had varying ideas about what is meant by sexuality communication with young girls, messages provided as well as communication channels used. These are further explained as part of the five themes emerged from interviews

4.5.1 General knowledge about communicating sexual reproductive health with daughters among participants

The following was reported:

- **Sexual communication with young girls**

The majority of participants shared a common understanding of communication on SRH that it should involve; enforcing safer HIV-related behaviors and pregnancy prevention. They were also of the view pregnancy can be prevented by using injections provided by clinics and HIV/AIDS can be prevented by using condoms and abstinence.

“When a child has someone she “laugh with” (boyfriend), she must protect herself from contracting diseases like HIV/AIDS by using condoms “(Interview participant 16: age 42 years).

“It is not an easy subject though but when my daughter entered a dating stage, I told her to use protection to prevent HIV and STDs. A child must be told about the injections provided in clinics to prevent pregnancy” (Interview participant 20: age 38 years).

Two of twenty participants interviewed believed sexuality communication does not only involve prevention of risky sexual behaviors, it also includes instillation of positive behaviors to young girls. This was also the views of two participants concerning sexual communication with young girls.

“It is important for a young girl to know about the time to return back home in the evening” (Participant 15: 39).

“I told my daughter that she must not have a boyfriend older to her (sugar-daddy)” (participant 18: age 42 years).

Among all participants, two mothers came with a different understanding of sexual communication with young girls. The common understanding was communication should begin in the first menstrual period; a mother should explain what does menstruation means and accepted behaviors associated with menstruation. This differs from other participants in a sense that parents did not enforce safer HIV/AIDS related behaviors and pregnancy prevention. Pregnancy was emphasized as an outcome; hence preventative methods were not enforced. One participant said, *“I began communication with my daughter on her first menstrual period. Explaining what does menstruation mean, including cleanliness during periods. I continued to explain that if she sleeps with a boyfriend as from now, she will fall pregnant. I also told her that menstrual periods will occur every month” (Interview participant 11: age 38 years).*

When my daughter started her menstrual period called “ukuya exesheni” in Xhosa, I have explained to her that she is reaching the adult stage now and once she sleep with a boyfriend, pregnancy will occur (interview participant 1: age 58).

- **Messages provided to young girls about SRH**

Some of the messages provided to young girls include; (a) protecting oneself from HIV/AIDS and STDs (b) avoiding early pregnancies - mothers drawing on their experiences on early pregnancies (c) empowering and respecting oneself.

Protecting oneself: All research participants expressed common messages in this area that are given to young girls to protect themselves from contracting HIV/AIDS. Parents who had talked to their daughters (98%) about SRH and 2% never talked to their daughters had given the message that condoms can prevent HIV/AIDS.

"I tell her that condoms must be used to protect diseases" (Interview participant 13: age 41 years).

One participant went beyond giving messages about protection; she provided her nineteen year old daughter with condoms to use as needed. *"I fetch condoms from the clinic and give them to use"* (Interview participant 1: age 58 years).

Avoiding pregnancy: About five mothers mentioned the link between sexual intercourse and pregnancy with their daughters and even suggested prevention methods to their daughters. *"I told her if she sleep with her boyfriend (have sexual intercourse), she will fall pregnant."* (Interview participant 7: age 43 years)

"I told my daughter that when she decided to be sexually active, she must inform me so that I can take her to clinic for injection to prevent pregnancy" (Interview participant 16: age 42 years).

Safe sex and delayed sexual engagement was a strong message given to daughters to discourage unwanted pregnancies and pregnancies without marriages. Some mothers personalized this message, by sharing own experiences of early pregnancies and emphasis that they do not want the same for their daughters. *"I never had a child without marriage, so she must also wait until she gets married"* (Interview participant 9: age 41 years).

I told my daughter that she must get married before having a child and must not fall pregnant out of marriage like I did" (Interview participant 14: age 52 years).

Empowering and respecting oneself: An important message in this area was self-empowerment and respect. The importance of education was used to empower young girls not to have boyfriends while still young and attending school. *“I told my daughter that she must focus at school for now, she can have a boyfriend when she’s old.”* (Interview participant 17: age 40 years)

One participant guided her daughter about self-respect. *“I told my daughter that her sexual relationship must not be a public matter, to show everyone that she has got a boyfriend”* (Interview participant 1: age 58 years).

- **Communication channels used**

Out of twenty participants interviewed, eighteen of them have communicated SRH issues with their daughters. All of them had face-to-face verbal communication with their daughters. Three participants from those communicating SRH with their daughters are making use of close relatives and friends to send communication about SRH to their daughters; *“Sometimes I ask my friend to talk to her when she arrived home very late”* (Interview participant 4: age 40 years).

Another participant said; *“Sometimes I ask my sister because it is not an easy subject for me to communicate”* (Interview participant 13: age 41). Whilst participant five said, *“My mother is also taking a full responsibility to communicate with my daughter”* (interview participant 5: age 35 years).

One participant confirmed utilization of media to initiate conversations on SRH with her daughter; *“I allow my daughter to watch Television programs providing information on sexuality issues and after I will initiate conversation with her about such topics referring to specific incidences”* (Interview participant 11: age 38 years).

The two participants have never communicated sexuality issues with their daughter due to fear that they are still young. They shared a different view concerning communication channels with children about sexuality issues; one believed it is the responsibility of health care workers. *“Nurses are getting paid every month; they must teach our children about issues concerning their health not parents”* (Interview participant 20: 38 years). Another participant believed her mother gave no specific information on the subject;

she shared relating stories to bring cautious about risky sexual behaviors. *“Though I have gained more knowledge of sexuality issues during my studies, I think the old modern will work out for me, I will tell her similar stories and she will make her choices out of that”*(Interview participant 19: 28 years).

4.5.2 Perceived barrier factors to communication on SRH with daughters

There are various factors serving as barriers when communicating with daughters:

- **Cultural factors as barriers**

Seventeen participants who communicate SRH with their daughters and two participants who never discussed sexuality issues with their daughters confirmed there will be no cultural barriers to perform their duties. Three participants confirmed they do not believe in cultural practices therefore, it cannot stand as barrier.

“I do not perform any cultural rituals therefore it is not a barrier to communicate sexuality issues with my daughter” (interview participant 11: age 38 years).

The majority of participants expressed common view time has changed now, due to changes in life circumstances they are forced to talk to them about sexuality issues. *Even though my Xhosa culture is not a barrier, the situation out there forced us to talk to our children about sexuality issues* (Interview participant 3: age 32 years).

It is not a barrier to me but since we are faced with so many diseases, I have no choice but to talk (interview participant 8: age 43 years).

One participant affected by cultural beliefs indicated *“in my mpondo culture communication on SRH is still a barrier because it is a taboo that a parent cannot talk sexuality subject with a child”* (Interview participant 6: age 37 years).

However, her personal view was talking about sexuality issues with children is an individual choice therefore she cannot allow the culture to prevent her communication because it is for the benefit of her children. She also mentioned even her parents has never talked to her about sexuality behaviors but that did not prevent her to communicate with her daughter.

“It is my personal decision to talk to my children about sexuality issues because it will benefit them at the end of the day” (interview participant 6: age 37 years).

- **Educational factors**

Some mothers with low levels of education ranging from standard 3-9 indicated it tend to be a barrier to mother daughter communication concerning sexual reproductive health issues especially concerning sexuality topics. The common feeling expressed by two mothers was they have old information therefore; it might happen they give irrelevant information.

“With my level of education, I find it difficult to talk to my daughter because I have old education which differs from current education. It might happen that the message I am giving to my daughter about sex behaviors are not the right messages” (Interview participant 1: age 58 years).

“I do not have enough information on the subject because I cannot read and write” (Interview participant 9: age 41).

The majority of mothers with high level of education have indicated no educational barrier to sexual reproductive health with daughters. However, the common belief among seventeen of twenty mothers interviewed was providing knowledge to children about sexuality issues does not require them to have higher levels of education because information is provided through radios in all the languages.

“My level of education is not a barrier to me, basic information provided through media-radios, television is sufficient for parents” (Participant interviews 17: age 40).

Some mothers mentioned part of their professional trainings involve education on sexuality issues therefore are able to transform information to their daughters. *“Since I have attended health related courses, my knowledge regarding sexuality issues is sufficient”* (interview participant 19: age 28).

Since I am a qualified social worker, the knowledge and skills gained during my studies is sufficient for me. I also came across such situations whereby parents do not talk to their children about healthy sexual behaviors then I used the platform to motivate them to initiate

such conversation with their children. Through those experiences, I learned to practice what I preach to my clients” (interview participant 7: 43 years).

- **Social factors**

The majority of mothers who communicated sexual reproductive health issues with their daughters have identified social issues that impact negatively in the process of communicating sexual reproductive issues with their daughters. Some of the issues communicated includes, fear of blame by society and criticism from neighbor-mothers with limited knowledge regarding communicating sexuality issues with children. *“I once had argument with my neighbor; she said I attend church daily but have guts to talk sex issues with my daughter. She made me think its bad talking to my daughter about sexuality issues though I never stopped”* (Interview participant 14: age 52).

One mother shared her experience of blame by church mothers when her daughter was pregnant at the age of 16. *“I have shared the situation with church mothers; some were supportive whilst others blamed me for taking my daughter to the clinic for family planning injection. They said I should have told my daughter that no sex without marriage and that is in line with the church rules according to them”* (Interview participant 16; age 42).

- **Environmental factors**

The majority of mothers interviewed are living in overcrowded homes (shacks, hostels) where privacy is limiting conversations with daughters about sexuality issues. *“It is difficult to talk because my neighbors will hear the conversation. I do not have privacy in my shack”* (Interview participant 2: age 49 years).

My neighbors have tendency to listen especially when I confront my daughter about her behavior and sometimes they pass indirect comments relating to the conversations held with my daughter” (Interview participant 4: age 40 years).

A different view concerning living condition as barrier to communicate sexuality issues with children was expressed by an older mother who raised three daughters in an overcrowded shack. She shared her experience of sharing a shack with drinking mothers while raising her daughters. *“On my arrival to Cape Town, I had no choice but to stay with my home neighbor*

lady who had drinking problems, exchanging multiple sexual partners. My three daughters were exposed to sex life since that time even though the youngest was still young to understand that. When the time comes that I should start such conversation with my eldest daughter, I realized that it was not hard because she was familiar with sexuality terms because my housemates talked everything in their presence” (interview participant 1: 58 years).

However, mothers with better economic conditions who lives in the shacks preferred to take their children out for lunch to have private conversation with them about sexuality issues concerning them. Two participants said *“I took my daughter out for lunch on my pay-day then use the time to talk about things I like and don’t like concerning sexual behaviors”* (Interview participant 10: age 29 years).

“I live in a shack and it’s difficult to talk because neighbors can listen; I took my daughter out for lunch and use that as opportunity to talk to her about sexuality issues” (Interview participant 11: age 38 years).

Some parents ignored the issues of privacy and emphasized the importance of communication irrespective of their living conditions. *“My living condition is not a barrier to communicate sexuality issues with my daughter because it is important to talk about is irrespective of what other people think or say”* (Interview participant 17: age 40).

4.5.3 Perceptions about the attitude of young girls on receiving information of SRH from mothers

The majority of mothers who find it difficult to talk to young girls about sexuality issues expressed perceived attitudes concerning their discussion with daughters. The participant’s perception is their daughters will misinterpret the intentions for such conversations which are to promote positive and healthy sexual behaviors. They will think parents are encouraging them to be sexually active especially when they introduce condom use. One mother said, *“I always worry about her interpretation of information, I think she might give wrong interpretation therefore, I become reluctant to talk”*(Interview participant 11: age 38 years). *My daughter will think that I am motivating her to have boyfriends. My daughter will think that I am an understanding mother”* (Interview participant 3: age 32 years). Some

parents expressed the view their daughters will think parents do not trust them in terms of their sexual behavior. One mother initiated conversation when seeing a neighbor son dying of HIV/AIDS. She said *“after the death of my neighbor’s son due to HIV/AIDS, I told my daughter that she must not do the very same mistake of not using protection. My daughter replied; do you think I don’t know what is right for me”* (Interview participant 1: age 58 years)?

An opposing perception about the attitude of young girls was expressed by a graduate mother raising a fourteen year old girl. She said, *“I think my daughter will be happy to get the knowledge from me because she trusts her mother. She once asked me to advise her friend dating old sexual partner for monetary gain because she did not like the habit. The habit stopped after I had conversation with her friend and my daughter gave me credits for being the super- mom”* (Interview participant 7: age 43 years).

4.5.4 General attitude towards discussion of SRH with young girls

All participants interviewed showed a positive attitude towards communicating sexuality issues with daughters. They were of the view parents should learn to talk freely about sexuality issues so that children can learn to protect themselves from social problems like HIV/AIDS and early pregnancies.

One participant said *“it is better to talk to my daughter about sexuality issues because our children are faced with so many diseases like HIV/AIDS. I do not want my daughter to blame me when she contract HIV/AIDS”* Interview participant 7: age 43 years).

Two mothers have drawn from own experience of early/unwanted pregnancies to emphasize the importance of talking to children about sexuality issues

“I talk openly to my daughter about sexuality issues because I believe that mothers should do that. My mother never talked to me, I got the wrong information from a friend and that is why I fell pregnant at an early age” (Interview participant 10: age 29).

“As parents we need to talk to our children about sexuality issues because I fell pregnant in my early adult stage, hence I was not ready to be a mother yet. I blame my parents because they never talked to me about such issues (interview participant 11: age 38 year).

One mother also appreciated the role of teacher in education children about sexuality issues at school. She said *“I was very excited when my daughter said her school teacher taught them about sexuality issues, I believed that my daughter will make the right choices concerning her sexual life”* (interview participant 1: age 58).

4.5.5 Suggestions on how to enhance effective communication on SRH for mothers

Government/relevant professional intervention needed: The mothers believed with limited communication skills and lack of understanding of what should be communicated with children regarding sexual reproductive health, assistance from different key role-players and the Government is appreciated in this regard. Several other suggestions on how the Government and relevant key rope players could help to enhance positive communication with children. Some of the suggestions are:

1. Social workers should identify mothers making use of their services and provide group training on positive communication with children about sexuality issues
2. Religious leaders should encourage mothers to gather and share information about communicating sexuality issues with children and guide each other to the right direction
3. Government departments like social development should consider initiating programs directed to the enhance parent-child communication on sexual reproductive issues
4. Information on sexuality issues concerning children should be publicized in all languages to accommodate mothers with low level of education
5. Workshops, information session to be conducted by trained professionals like social workers in the community

Some parents felt parents should build a positive relationship with their children that will enhance positive communication on sexuality issues according to them one of the mothers said *“my daughter is like a friend to me that is why I am able to talk to her about everything, we watch TV educational programs together and after we comment based on what is showed on TV”* (interview participant 2: age 49 years).

The results obtained reflect the participant's knowledge; messages provided, communication channels used and other barrier factors in accordance with the research question and objectives of the study. In some instances, there were some similarities and differences in the information provided by participants. It can be concluded the majority of the mothers interviewed were fully aware of the problems hindering communication with daughters about sexuality issues. However, others have preferred to talk to their children irrespective of those hindering problems.

4.6 Conclusion

In this chapter, the results were presented and discussed. The data was transcribed and coded thereafter emerged five themes were developed. The research question was adequately answered regarding the communication barriers on sexual reproductive health between mothers and daughters. Chapter five will discuss certain limitations of the study and draw together the final conclusion, suggestions and recommendations

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter intend to provide an interpretation and evaluation of the findings from the empirical study, drawing conclusions relating to the research question. Recommendations are made based on the research findings. The objectives of this study were spelled out in the first chapter of this research report. The literature searched according to research topic was presented and the relevant research methodology and data analysis for the purpose of this study was described and discussed.

5.2 Problem statement

There has been research conducted on the relationship of parent-child communication to the social and cognitive development of children and reproductive health issues, results tend to indicate the process is facing a number of barriers and little has been done to focus on what barriers tend to hinder mother-daughter communication and its relationship to family functioning regarding reproductive health issues (Nudwe 2012:4). Cooper et.al (2000:417) suggested adolescents who experience the support of the families may feel freer to explore identity issues. The study explored communication barriers on sexual reproductive health between mothers and daughters.

5.3 Discussion of findings according to objectives

The aim of the study is to identify the communication barriers in order to recommend the effective strategies that promote contact on sexual reproductive health within the families. The following objectives were set out for the study:

- To identify the existing knowledge on sexual reproductive health from mothers
- To evaluate factors affects communication on SRH
- To assess the messages regarding SRH provided to young girls
- To determine the channels of communication on SRH between mothers and daughters

- To provide guidelines for effective communication strategies that promotes healthy relationships on SRH.

The discussion of the findings of the study in relation to each study objective follows:

5.3.1 General knowledge about communicating sexual reproductive health with daughters among participants

This objective was to identify the existing knowledge about communicating sexual reproductive health with daughters. Findings from this study show most of the participants understood that communication on sexuality issues should involve enforcing safer sex HIV-related behaviors and pregnancy prevention. Hence common understanding was pregnancy is prevented through family planning injections provided at clinics and HIV/AIDS avoidance of infections by using condoms and abstinence. This is supported by researchers who confirmed the increase in utilization of contraceptives reduces chances of pregnancy among girls and reduce HIV transmission among youth who report discussion about sex with their parents (Murphy, Roberts & Herbeck 2012:137). A similar pattern was noted from authors who believed communication on sexuality issues should involve topics such as; biological and developmental issues (puberty), values, healthy relationships, pregnancy and STD prevention (Beckett et.al 2010:36).

This implies mothers have a full understanding of how HIV/AIDS, STDs and early pregnancies are prevented though forms of transmissions are not mentioned as part of understanding what should be communicated to daughters. Some participants understood communication should not only involve prevention of sexual behaviors but should include the instillation of positive behaviors to young girls. In doing that positive value regarding healthy sexual behaviors are promoted. Others understood communication should begin during first menstrual periods and accepted behaviors during this encounter.

It can be concluded parents have a limited understanding of what communication on sexual reproductive health mean. Their focus is mostly on the prevention of diseases and limited on associated behaviors, biological and developmental issues (puberty). Educational programs are necessary to expand their knowledge in this regard.

5.3.2 Perceived barrier factors to communication on SRH with daughters

The majority of participants in the study identified some factors they perceive as barrier to communicate sexual reproductive issues with daughters. Some of these factors were identified in other studies examining communication on sexuality issues between parents and children and they include socio-cultural, environmental and educational factors. A major factor identified by participants is environmental factors including overcrowded families and housing. It is difficult for these women to talk freely to their children about sexuality issues because neighbors and housemates will listen to conversation and sometime pass negative comments. This is similar to the findings of the study by Davis et.al (2013:44), where researcher found overcrowded homes where households are not necessarily based on kinship and unsupervised adolescents (due to parents having to work long hours) often result in less communication on sexual reproductive health.

One of the fathers expressed a different view that overcrowding was a motivating factor on talking to children about sexuality issues. He shared his experience of sharing a house with a person who had drinking problems. The children were exposed to sexuality life at an early age therefore this was a familiar subject to them which does not necessary needs privacy to be discussed. This suggests that parents need supporting programs that will encourage them to communicate sexuality issues with children irrespective of their living conditions.

Social-cultural factor including, fear of blame and criticism from community members was expressed by most of the mothers interviewed. Some of the mothers have shared own experiences of blame and criticism from community for talking to their children about sexuality issues. The societal perception was they promoted sexual behaviors when talking to their daughters about sexuality issues. This is similar to the study by Bastien (2011: 26) where participants felt discussing sexuality with children leads to early sexual experimentation.

The role of traditional norms that limit communication between mothers and their daughters on issues of sexual reproductive health found to operate in other societies. In this study a cultural taboo was mentioned by one participant as barrier to communicate sexuality issues with daughters. Her culture did not allow her as a mother to discuss sexuality issues with children. There was a similarity with the Windhoek-Namibia study

reported in Namambi et.al (2011:124) where parents for cultural reasons are not normally expected to discuss sex with their biological children. The majority of the mothers have found due to the increasing spread of HIV/AIDS, they have no choice but to ignore cultural taboos and discuss sexuality issues with their daughters.

Education is a barrier in mother daughter communication. Mothers with low levels of education tend to limit their conversation on sexuality issues with daughters. The common belief was they have old curriculum education which makes them reluctant to talk. They believe they have limited knowledge on the subject. Some mothers believed communication on sexuality issues with daughters does not require high education because information is presented on media in all languages. This suggest mothers need to be educated, however it is not a prerequisite for communication on sexuality issues but rather an understanding of general information provided on media, radio stations and at clinics.

It can be concluded socio-cultural factors, environmental and educational factors are still barriers in some cases though a majority of parents decided to put them aside and do what is necessary for the child. Some of these issues resulted on parent's reluctance to provide information on sexuality issues to their daughters. Cognitive construction programs are necessary for the mothers to see the importance of communicating sexuality issues irrespective experienced barrier factors.

5.3.3 Communicated messages to young girls about sexual reproductive health

The research findings indicate all mothers are providing messages to their daughters concerning sexual reproductive health issues. Messages include protecting one self, avoiding pregnancies; mothers drawing from own experiences and empowering messages. This is similar to the findings of Murphy et.al (2012:143-144) where messages regarding safe sex and HIV are based on protecting oneself from STDs. The most common message in this area mothers gave their children was condoms can prevent STDs. Secondly messages were also based on giving factual information regarding STDs and HIV/AIDS. The only difference noted is mothers participated in the study did not give factual information regarding STDs and how HIV is contracted; their focus is mostly on protection and encouragement of delayed sex to avoid pregnancies.

Some of the mother empowered their daughters not to have boyfriends while studying. Importance of education was emphasized and used as empowering tools. This suggest mothers are sending positive messages though some referred to personal experiences to demonstrate the impact of non-compliance to sexual education messages provided by parents. It is important mothers should understand the importance of giving factual messages about sexual reproductive health issues and not only focuses on protections and prevention methods.

5.3.4 Communication channels used to communicate sexual reproductive health issues with young girls

The research findings indicate most participants used the face-to face verbal communication channel with their daughters. However, 10% of those are also making use of close friends and family member's to send the messages. One mother confirmed her utilization of media to initiate sexuality messages with her daughter. The utilization of extended family members was associated with cultural factors as Windhoek-Namibia Study by Nambambi et.al (2011:124) revealed a participant mentioned 'Oshiwambo culture' where grandmother is the one who may talk freely with the grandchildren about sexuality issues and not the biological parents. Some mothers who never discuss sexuality issues with daughters had a different view it is a responsibility of health care workers to communicate sexuality will be the best communication channel. This suggests though mothers used face-to-face verbal communication channel to send messages, knowledge on the dangers of relying on media and family members is necessary. Also the level of understanding sexuality issues of family members nominated to send the messages should be assessed by mothers.

5.3.5 Suggestions guidelines to enhance effective communication on SRH for mothers

In order to ensure effective communication of SRH, participants were of the opinion that formal intervention from health care system, social workers, church leaders and Government is required. The majority of mothers indicated they communicate with their daughters about sexuality issue but suggested government departments such as social developments must consider initiating educational programs directed to enhance parent child communication on the subject. Some parents experienced blame and criticism by church members for their communication with daughters on sexuality issues led to

unexpected results such as early pregnancies. They were of the view that religious leaders should be hands on and encourage mothers to gather and share information

5.4 Recommendations

The following recommendations are made from the findings of this study:

1. The finding as of the study show mothers are providing messages about sexual reproductive health issues to their daughter hence it is clear their focus is mostly on prevention and protecting children from HIV and early pregnancies. Trainings on provision of factual information during communication with children should be provided. Parents should be fully aware of what need to be discussed with a daughter concerning sexual reproductive health issues.
2. Again, some of the mothers were reluctant to talk to their children due to some factors identified. Cognitive restoration programs are needed for mothers to understand the necessity of their communication with children about sexuality issues.
3. An appropriate social survey on a large sample size is necessary to establish the magnitude of lack of the problem with mother daughter communication.
4. Mothers of different races should be included to enhance the richness of the information for the study.

5.5 Limitations

The following limitations were identified in this study:

The finding from this study may have been affected where participants were recruited from only one community of the same race. The purpose of qualitative research such as this is not to generalise the findings but to describe and understand particular individuals in a particular context (Christensen et al., 2011:362). Recruitment of participant's different communities with a different race could have enhanced the richness of the information gained.

Another limitation of the study was, research participants were only mothers who have daughters (whether or not they have had early pregnancies); the information could have

been explored from both mothers and fathers since they are in some cases present in a child's daily upbringing.

Again, the study was conducted among a small number of mothers, it was difficult to generalise its findings to the general population. A greater sample should be considered increasing the number of participants to then generalise findings to the greater population.

5.6 Conclusion

Communication between mother and daughter about sexual reproductive health is one of the most important exercises to bring cautious to young girls about what healthy sexual reproductive health mean. Parents in general find it difficult to talk to children about such issues. Various factors identified as preventing communication include, perceived attitude of young girls on receiving information; environmental, socio cultural and educational factors. Parents felt such communication requires highest level of education which some did not have. They feared these conversations will direct children to engage into sexual activities. Others were distracted by socio-cultural factors including taboos, blame and criticism from the community. Although mothers expressed a need for Government and professional intervention to enhance their knowledge and skills on sexual reproduction health communication, barrier factors identified need to be researched among a larger group of mothers in different race and different parts of the country to add to the depth of the problem and to justify development of need based program intervention.

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Appendix 1: Informed consent-English version



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

The communication barriers around Sexual Reproductive Health (SRH) within families that lead to increase in teenage pregnancy and vulnerability to HIV/AIDS

You are asked to participate in a research study conducted by Nolitha Dindili, from the Africa Centre for HIV/AIDS Management at Stellenbosch University as part of her research study for her MPhil in HIV/AIDS Management. You were selected as a possible participant in this study because as a mother of young girl, you are aware of the challenges that mothers encounter in communicating sexual reproductive health with children. Your contributions to the subject are valuable in order to equip all parents with necessary skills and knowledge to prevent HIV infection and early unwanted pregnancies.

1. PURPOSE OF THE STUDY

To identify communication barriers around sexual reproductive health from mothers of Khayamandi Township who have daughters (whether or not they have had early teenage pregnancies).

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Answer the interview questions anonymously
- For the in-depth interview, you will be required to answer a series of questions as required by the principal investigator

3. POTENTIAL RISKS AND DISCOMFORTS

Although there is no foreseeable risk, mothers whom their daughters have already had early pregnancies may experience some pain in sharing experiences. Others may experience discomfort in talking about sexual related matters and HIV. The researcher will clear up any misunderstandings that might arise during the interview. Furthermore, it is important to note that the information obtained from these interviews is confidential and only the researcher will have access to it. If the need for counseling should arise, the counselor Mrs.

Thandeka Makhomazi from Khayamandi child welfare can be contacted during working hours at 021-8872816 or 0729601615. She is a qualified senior social worker, rendering therapeutic/support services to families and children of Khayamandi Township.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The findings of the proposed study will give a clear indication on communication barriers to sexual reproductive health within families. The Department of Health and Social Development will benefit because education on communication skills on sexual reproductive health can be adapted and tailored to needs of parents and teenagers. The community itself will benefit in a sense that they might reconsider some of the factors that prevent them to communicate sex related issues with children.

5. PAYMENT FOR PARTICIPATION

No payments shall be received for participation in the study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of, no names or personal identifiers will be recorded in any of the data collection tools. In reporting the results, care will be taken not to report results in a way that would enable any participants to be identified and/or stigmatized in their views. Data will be stored in a safe place at all times. The researcher and her supervisor will be the only person having access to the data. This data will be destroyed after successful completion of the thesis, for the purpose for which it was collected. The anticipated period for destroying the data is after one (1) year.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you were selected to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer interview questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Nolitha Dindili (researcher) at: 021-8648075(w) 0731388841 (m) or ndindili@webmail.co.za
And Prof Elza Thomson (Supervisor) at: 0824946920 or elzathomson@gmail.com

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me, _____ by Nolitha Dindili in English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

Signature of Subject/Participant or Legal Representative

Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____
[*name of the subject/participant*] and/or [his/her] representative _____
[*name of the representative*]. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [*Afrikaans/*English/*Xhosa/*other*] and [*no translator was used/this conversation was translated into _____* by _____].



Signature of Investigator

2013/08/05
Date

Appendix 2: Informed consent-Xhosa version



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvenoot • your knowledge partner

STELLENBOSCH UNIVERSITY Imvume ngokuthatha inxaxheba kuphando-nzulu

lingxaki ezingumqobo ekuthetheni ngokuphandle ngempilo eyoyamene nesondo emakhaya ezithi zikhokelele ekwandeni kokukhulelwa kwabantwana abaselula kunye nokubasesichengeni kwabo kusuleleko yintsholongwane kagawulayo

Uyacelwa ukuba uthathe inxaxheba kwisifundo sophando-nzulu esikhokelwa ngu Nolitha Dindili, osuka kwiziko lolawulo lwentsholongwane kagawulayo kunye nesandulela ntsholongwane kwi Dyunivesithi yase Stellenbosch. Ukhethelwe esisifundo kuba nanjengomama wentombi esencinane, unokubanalo ulwazi lwemingeni athi umama ahlange nayo ekuthetheni ngempilo yesondo ebantwaneni. Igalelo lakho kulomba lubalulekile khonukuze kuxhotyiswe bonke abazali ngobugcisa nolwazi olubalulekileyo ukunqanda usuleleko kwintsholongwane kagawulayo kunye nokukhulelwa okungafunekiyo kumantombazana aselula.

1. Injongo yesifundo

Kukwalatha iingxaki ezingumqobo ekuthetheni phandle ngempilo ejikeleze ezesondo koomama base Khayamandi abanabantwana abangamantombazana (enoba abantwana babenako okanye ababanganako ukukhulelwa beselula).

2. Inkqubo

Ukuba uthe wathatha inxaxheba ngokuzikhethela kwesi sifundo umele ukwenza ezi zinto zilandelayo:

- phendula imibuzo yodliwano ndlebe ekhusini, ungadanga wawazisa amagama akho
- Ukuya nzulu kudliwano-ndlebe, ubani uzakufuneka aphenidule uthotho lwemibuzo efunwa okanye ebuzwa ngumphandi oyintloko (u-Nolitha Dindili).

3. Ubungozi onobulindela nezinto ezingakwenza ungaphatheki kakuhle

Nangona kungekho mingcipheko enobungozi ebonakalayo, oomama abanamantombazana athe akhulelwa esemancinci bangabuva ubuhlungu xa bebalisa ngokukhulelwa komntana. Abanye bangazifumanisa bemathidala ukuthetha ngemiba enxulumene nezesondo nempilo ngokujongise kugawulayo. Umphandi uzakuthi acacise konke ukunqondisani

ngokwentetha okunokuvula ngethuba lovavanyo olo. Ukwaleka oko, kubalulekile wazi ukuba ulwazi oluzakufunyanwa koluvavanyo luyimfihlo yaye iyakuba ngumphandi kuphela onokufikelela kulo. Ukuba kuye kwakhona ukudandatheka emphefumleni emva kovavanyo, unontlalontle ongu Nkosikazi Thandeka Makhomazi osuka kwiziko loonontlalontle iKhayamandi child welfare angakunceda ngamaxesha empangelo kulenombolo: 021-8872816 okanye 0729601615. Ungunontlalontle ovunyiweyo ngokusemthethweni, ekwahambisa neenkonzo zoncendo kumakhaya nakubantwana abakwilokishi iKhayamandi.

4. Inzuzo kwabathatha inxaxheba naseluntwini jikelele

Iziphumo ngesisifundo zizakuthi zibonise izithinteli kunxibelelwano olujongise kwimpilo yezesondo emakhaya. Isebe lezempilo kunye nelezentlalontle liyakuxhamla kwesisifundo kuba, imfundiso ngezakhono zokuthetha ngempilo yezesondo ingayamaniswa kwiimfuno zabazali kunye nabantwana abafikisa kwisigaba sobudala. Abantu basekuhlaleni bona bazakuzuzisa ithuba lokucingisisa ngezinto ezibangumqobo ekuthetheni ngezesondo kwakunye neminye mibandela enxulumene nesondo kubantwana.

5. Intlawulo ngokuthatha inxaxheba

Akukho ntlawulo ezakukhutshwa ngokuthatha inxaxheba kwesisifundo

6. imfihlakalo

Naluphina ulwazi oluzakuthi lufunyanwe kuwe ngokubhekisele kwesi sifundo luzakuhlala luyimfihlelo yaye luyakuthi lueliswe esidlangalaleni ngemvume yakho kuphela okanye ngokugunyaziswa ngumthetho. Olu lwazi luzakugcinwa luyimfihlelo ngokuthi silandele lemiqathango; akukho magama nankukacha ngawe ezizakuthi zishicilelwe nakwesiphina isixhobo esisetyenzisiweyo ukufumana olulwazi. Kwananjalo iziphumo zoluphando zizakukhutshwa ngokomnonophelo kwanangendlela ezakunceda ukuba lowo uthathe inxaxheba angazeki esidlangalaleni yaye angabilixhoba lokuhlukunyezwa ngenxa yembono zakhe azivelisileyo kwisifundo. Ulwazi olufunyenweyo luzakugcinwa kwindawo efihlakeleyo yaye ngumphandi kunye nekokheli yakhe kwesisifundo abazakufikelela kolu lwazi. Emva kokufezekisa injongo yesifundo, ulwazi olufunyenweyo noluthle lwasetyenziswa luyakukrazulwa, lulahlwe kwindawo enqabileyo apho lungenakuphida lubekumgangatho wokusetyenziswa kwakhona. Ulwazi olu luzakulahlwa kwisithuba esingangonyaka emva kokusetyenziswa kwalo kwinjongo yesifundo.

7. Ukuthatha inxaxheba kunye nokurhoxa

Unelungelo lokuzikhethela ukuba yinxaleye nokungabiyinxalenye yesi sifundo. Ukuba uthathe watyunjelwa ukuthath inxaxheba kwesi sifundo, unako ukuzikhwebula kuso ngaphandle kwayo nayiphina imiphumela. Usekwanako nokungayiphenduli eminye imibuzo koluvavanyo ongakukulungelanga ukuyiphendula ngelilixa useyinxalenye yesifundo umphandi unako ukukukhupha kwesi sifundo ukuba kukho iimeko ezivelayo ezinyanzelisa oko.

8. lindlela yokufumana abaphandi

Ukuba uthe wanemibuzo okanye imiceli mngeni ngesi sifundo, nceda uqhakamshelane no-Nolitha Dindili (umphandi) kulenombolo yomsebenzi: 021-8648075 nakwimfonimfono yesinqe 0731388841 okanye uthumele umyalezo kuledilesi ndindili@webmail.co.za Usenokuqhakamshelana nengcali emkhokela kwesisifundo u Nkskz Elza Thomson kulenombolo: 0824946920 okanye kuledilesi elzathomson@gmail.com

9. Amalungelo abantu abathatha inxaxheba kuphando

Unako ukurhoxisa isivumelwano sokuthatha inxaxhelba kwesi sifundo yaye asilotyala ukwenza oko. Awutyesheli yaye ungakhwebi ngalo yamthetho ngokuthatha kwakho inxaxheba kwesi sifundo. Ukuba unemibuzo ngokubhekise kumalungelo akho njengomthathi nxaxheba kwisifundo, ungaqhakamshelana nowasetyhini u Nkszn- Maléne Fouché kulenombolo, [mfouche@sun.ac.za; 021 808 4622] okwicandelo lophuhliso kwezophando.

Intsayino yomntu othatha inxaxheba okanye ummeli womthetho

Lomqulu wolwazi uthe wacalulwa nzulu kum _____ ngu Nolitha Dindili ngolwimi lam isiXhosa. Ndakwanikwa nethuba okuphosa imibuzo ethe yaphenduleka ngendlela ekholisayo.

Oku kukunika imvume ngokuzithandela, yokuthatha inxaxheba kwesi sifundo. Ndikwayinikiwe noxwebhu olubhaliweyo ngesi sivumelwano.

Igama lomthathi nxaxheba

Igama lommeli womthetho (ukuba liyafunmeka)

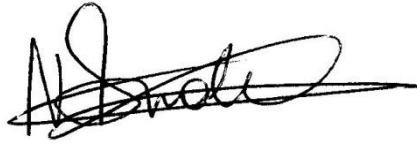
Intsayino yomthathinxaxheba okanye ummeli womthathinxaxheba

**umhla
wosayino**

Intsayino yomphandi

Ndiyaqinisekisa ukuba ulwazi oluqulathwe ngulomqulu ndilucacisile kumthathi nxaxheba u _____ [igama lomthathi nxaxheba] okanye nakummeli wakhe. _____ [igama lommeli]. Uye wakhuthazwa, ekwanikwa nexesha

elaneleyo lokubuza imibuzo. Lengxoxo iqhutywe ngesi Xhosa yaye akukho toliki ithe yabandakanywa ngethuba iqhubeka.

A handwritten signature in black ink, appearing to be a stylized name, possibly 'N. M. M. M.', written over a horizontal line.

Intsayino yomphandi

umhla wosayino

Appendix 3: Interview schedule- English version

Appendix A: Interview Guide

In-depth interview English Version for Parents

Basic information on the setting

1. Date of interview:
2. Time:
3. Interviewer name:

Self-introduction, name, general affiliation and the purpose of the study

To start the interview, it is vitally important to appreciate your commitment to participate in this research which we know that it will help us to understand the barriers to communicate sexual reproductive health issue with children. All the information discussed will be treated as confidential. It is also your right to indicate if you are not comfortable to answer the question or you need a break.

Introductory information of participant:

- **Age:**
- **Gender:**
- **Religion:**
- **Occupation:**
- **Marital status:**
- **Socio Cultural background:**
- **Living conditions (housing):**
- **Level of education:**
- **Language:**

Interview guide questions

1. Tell me about your understanding of communicating healthy sexual behaviours with young girls?

Probe: Where did you get the knowledge from?

-What is the importance of having information on the subject?

2. Do you communicate with your children about healthy sexual behaviours?

Probe: If no, who do you think is responsible to bring the subject to your children?

-What qualities does the nominated person have regarding the subject?

-Do you see any changes once the person has spoken to your child?

3. What kind of messages do you normally give in directing your child on sexual behaviour?

Probe: are they mostly relating to the behaviour that a child presents at that stage or are relating to the behaviour that is observed from other children in the community?

-do you think the messages are guiding the child to the accepted behaviours?

4. How do social problems like (death, HIV/AIDS, teenage pregnancy etc.) influence you to communicate sexual issues with your child?

5. How your level of education does helps you in discussing sex related topics like HIV/AIDS, early pregnancy and prevention methods with your child?

Probe: How did you get the knowledge on HIV, teenage pregnancy and prevention methods?

6. How traditional norms and practices do helps you to communicate sexuality with your child?

Probe: Does it allow you to talk about sex related matters with children?

- If not, who is given a responsibility to direct young girls about sexuality?
- Do you think he/she gives the right information?
- If no, why do you think so?

7. How your religion does help you in your communication with about sexual behaviours with your children?

Probe: does it allow you to talk about sexual behaviours with your children?

-if it does not, then how do you communicate with your child about sexual risk behaviours?

8. What role does your living conditioning have in communicating sexual reproductive health with children? (for instance, living in a hostel environment, living in shacks or in an overcrowded environment etc)

9. What other social problems do you think can prevent you to communicate positive sexual behaviours with children?
10. What personal feelings and thoughts do you have in communicating sexual reproductive health with children?

Probe: what impact do they have in communicating sexual behaviours with your child?
11. What personal beliefs do you have in communicating sexuality with your children?

Probe: what impact do they have in communicating sexual behaviours with the child?
12. What effect do age differences have in communicating sexual reproductive health with children?
13. What advise can you give to develop communication channels on SRH with young girls?

SIGNATURE OF RESEARCHER



DINDILI. N

Appendix 4: Interview schedule-Xhosa version

Udliwanondlebe olunzulu lubhalwe ngesi-xhosa ukulungiselela oomama

Inkcukacha ezingundoqo

1. Umhla wovavanyo
2. Ixesha
3. Igama lomvavanyi:

Ukuzazisa kunye nenjongo yoluphando

Ukuqalisa oluvavanyo, kubalulekile ukuba ndibulele ukuthatha kwakho inxaxheba yokuzibandakanya koluphando esilwaziyo ukuba lujongise ekubeni siqonde ngezinto ezingumqobo ekuthetheni nabantwana ngendlela zokuziphatha ngokwesondo. Nantonina esizakukuthetha apha kuzakuhlala kuyimfihlelo. Isekwililungelo lakho ukuvakalisa xa uziva ungalungelanga ukuphendula umbuzo okanye udinga ukuphumla ithutyana.

Iinkcukacha ngomvavanywa:

-iminyaka/ubudala:

-isini:

-inkolo ngokwenkonzo:

-iinkcukacha ngokomsebenzi:

-inkcukacha ngokutshata:

-inkolo ngokwamasiko:

-isimo sokuhlala/sentlalo (ngokwezindlu):

-izinga/inqanaba lemfundo:

Isikhokeli semibuzo yovavanyo

1. Ndixelele ngokolwazi lwakho ukuba kukuthini ukuthetha ngokuziphatha ngokwesondo kumantombazana aselula?

-ulufumenephi olulwazi?

-kubaluleke ngantoni ukubanalo ululwazi?

2. Ingaba ukhe uthethe namantwana bakho ngendlela zokuziphatha ngokwesondo?

-ukuba akunjalo, ngubani ocinga ukuba uselungelweni lokuthetha nabo ngalombandela ebantwaneni?

-sesiphi isakhono anaso lowo utyunjelwa ukuba athethe ngalombandela?

-ukhona umahluko othi uwubone emva kokuthetha kwakhe nomntana wakho?

3. Hlobo luni lwemiyalezo odla ngonguyidlulisa emntaneni ngendlela yokuziphatha ngokwesondo?

-ingaba yimiyalezo engqamene nendlela umntana athi aziphathe ngayo ngeloxesha okanye ingqamene nendlela yokuziphatha othi uyibone kubantwana abasekuhlaleni?

-ucinga lemiyalezo ingumkhombandlela emntaneni ngokwendlela efanelekileyo yokuziphatha?

4. ingaba zinefuthe elinjani kuwe iingxaki zasekuhlaleni (ezinjekokukhulelwa kwamantombazana aselula, isifo sikagawulayo kunye nokubhubha kwabantu) ekuthetheni nomntana ngokwendlela yokuziphatha ngesondo?

5. ingaba izinga lemfudo yakho likunceda kanjani ekuthetheni nabantwana nge mibandela kagawulayo, ukukhulelwa uselula kunye neendlela zokuzikhusela?

-Ulufumene njani ulwazi malunga nentsholongwane kagawulayo, ukukhulelwa kwamantombazana aselula kunye neendlela zokuzikhusela?

6. ingaba izithethe namasiko enziwayo zikunceda kanjani ukuthetha nabantwana ngendlela yokuziphatha ngokwesondo?

-ingaba ezizithethe ziyakuvumela ukuba uthethe ngezinto ezidingqament nesondo ebantwaneni?

-ukuba akunjalo, ngubani onikezwa uxanduva lokukhokela amantombazana aselula ngendlela zokuziphatha ngokwesondo?

-Ucinga ukuba ubanika ulwazi olulululo ngalombandela?

-ukuba akunjalo, kutheni ucinga ngolohlobo?

7. ingaba inkolo yakho ngokwecawe ikunceda kanjani ekutherheni nabanteana abaselula ngendlela yokuziphatha ngokwesondo?

- ingaba iyakuvumela ukuba uthethe nabantwana ngendlela zokuziphatha ngokwesondo?

-ukuba akunjalo, wenza njani ukuthetha nabantwana ngendlela zokuziphatha nabantwana ezinobungozi?

8. ingaba yeyiphi indima edlalwa yindawo yokuhlala ekuthetheni nabantwana ngendlela zokuziphatha ngokwesondo? (umzekelo, ukuhlala emaholweni, ematyotyombeni okanye endlini encinci ezele ngabantu)

9. Zeziphi ezinye iingxaki zokuhlala ocinga zingangumqobo ekuthetheni nabantwana ngendlela zokuziphatha ngokwesondo?

10. zeziphi iingcinga neembono othi ubenazo malunga nokuthetha nabantwana ngendlela yokuziphatha ngokwesondo?

-ingaba zinomthelela kanjani ekuthetheni nomntwana wakho ngendlela zokuziphatha ngokwesondo?

11. chaza ngenkolelo yakho malunga nokuthetha nomntwana malunga nendlela yokuziphatha ngokwesondo?

-Ingaba inomthelela kanjani ekuthetheni kwakho nomntwana ngendlela yokuziphatha ngesondo?

12. ingaba umahluko ophakathi kwakho nomntwana ngokweminyaka unomthelela onjani ekuthetheni ngendlela zokuziphatha ngokwesondo konmtana?

13. Ingaba zithini iingcebiso onokuza nazo ukuphuhlisa iindlela ekudluliswa ngayo imiyalezo malunga nempilo yesondo kumantombazana aselula?