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“THEY HAVE OPENED OUR MOUTHS”: INCREASING WOMEN’S SKILLS AND MOTIVATION FOR SEXUAL COMMUNICATION WITH YOUNG PEOPLE IN RURAL SOUTH AFRICA

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Abstract

Communication between parents and young people about sex has been identified as a positive influence on young people’s sexual behavior. This article presents findings from South Africa, where a social intervention to reduce levels of HIV and intimate partner violence actively promoted sexual communication between adults and young people.

We assessed this component of the program using quantitative and qualitative methods, collecting data through surveys, direct observation, interviews, and focus group discussions. Women participating in intervention activities reported sexual communication with children significantly more often than matched women in the control group (80.3% vs. 49.4%, adjusted risk ratio 1.59 (1.31-1.93). The content of communication with young people also appears to have shifted from vague admonitions about the dangers of sex to concrete messages about reducing risks.

The congruence between these findings and existing literature on parent-child sexual communication suggests that conceptual frameworks and programs from developed settings can be adapted effectively for resource-poor contexts.

Communication between parents and young people on sex has been identified as a positive influence on young people's sexual behavior (Halpern-Felsher, Kropp, Boyer, Tschann, & Ellen, 2004). Adolescents who have talked about sex and preventive measures with their parents appear less likely to engage in risky behavior, and this association has prompted implementation of sexual health interventions that explicitly encourage such dialogue (Fox & Inazu, 1980; Hutchinson, Jemmott, Jemmott, Braverman & Fong, 2003; Leland & Barth, 1993). With a few exceptions (Adu-Mireku, 2003; McBride et al., 2005; Odimegwu, Solanke & Adedokun, 2002; Zhang, Li, Shah, Baldwin, & Stanton, 2007), however, studies of parent-child communication have focused on developed countries, often using data from the United States and Australia.

This article presents research findings from a community-based, randomized control trial in South Africa that actively promoted open discussion of sex as part of a wider public health intervention. After reviewing the rationale for this component of the program, we describe the study's context and design and present qualitative and quantitative data specific to efforts to challenge barriers faced by women in discussing sex, relationships, HIV, and preventive methods with young people in their households and local communities.

HOW HOUSEHOLD COMMUNICATION AFFECTS BEHAVIOR

Numerous studies demonstrate a correlation between young people's reports of discussing sex with their parents with significantly lower levels of sexual risk-taking behavior compared with peers. Parent-child communication has been shown to be associated with a range of protective behaviors for sexual health, including delayed sexual debut (McBride et al., 2005), fewer sexual partners and use of condoms (Halpern-Felsher et al., 2004), and use of other contraceptives (Aspy et al., 2007; DiClemente et al., 2001). Analysis of the 1989 Secondary School Student Health Risk Survey administered to over 8000 high school students in the United States, for instance, found that students reporting having discussed HIV with their parents were significantly less likely to report having multiple partners and unprotected sex (Holtzman & Rubinson, 1995). In one of the few studies from developing countries, an adapted Youth Risk Behavior Survey was conducted in Accra, Ghana among 894 secondary school pupils (Adu-Mireku, 2003). Those who reported having "ever talked about HIV/AIDS with parents or other adults in the family" were 2.21 times more likely to report condom use at last sexual intercourse.

Researchers have also explored *what* parents discuss and *how* they approach sexual topics. Studies confirm that both the process and content of communication play a role in influencing young people's attitudes and practices (Dutra, Miller, & Forehand, 1999). Which parent is involved in the dialogue also makes a difference and both boys and girls generally rate mothers as better and more frequent communicators than fathers (Feldman & Rosenthal, 2000; Greene & Grimsley, 1990; Miller, Kotchick, Dorsey, Forehand & Ham, 1998). Young people also particularly value "openness" in discussing sex over judgmental lectures from their parents and other role models (Whitaker, Miller, May, & Levin, 1999). Kirkman, Rosenthal, and Feldman (2005) have warned, however, that "openness" is a poorly defined concept, likely to vary across contexts and even within parent-child relationships.

Measuring parent-child communication is further complicated by a common lack of agreement between reports from parents and children on how much communication, and on

which topics, has occurred. In surveys that compare parents' and children's responses, parents are more likely to report discussions about sex, both in terms of frequency and number of topics covered (Miller, Kotchick, Dorsey, Forehand, & Ham, 1998). Some authors have argued that children's reports deserve greater credence as they indicate the *perception* that communication has taken place, which may increase the likelihood of translating it into behavior (Fisher, 1989). On the other hand, studies using direct observation of parent-child conversations highlight that indirect and nonverbal forms of communication serve as an important conduit for parental values and messages regarding sex, particularly among fathers, but tend to be missed by quantitative methods (Lefkowitz, 2002).

Despite the complexities, parent-child communication about sex has become a recognised target for behavior change interventions (Oliver, Leeming, & Dwyer, 1998). Several national-level campaigns center around galvanizing parents to become more proactive, such as "Talking to Kids About Tough Issues" in the United States (Lefkowitz, Boone, Au, & Sigman, 2003) and "LoveLife" in South Africa (with the tagline "Love them enough to talk about sex"; see www.lovelife.org.za/parents/index.html). However, parents are rarely equipped with adequate experience or skills for broaching sexual topics. In contexts such as South Africa, mothers are often themselves sexually and socially disempowered and thus unable to assist their children in constructing positive and responsible sexual identities (Lesch & Kruger, 2005). Researchers have explicitly called for evidence-based programs that could offer the knowledge and skills required for effective parent-child dialogue:

Parents need to adopt an open and receptive approach when initiating conversations or responding to teenagers' questions. An open process of sexual communication involves parents' having adequate knowledge, being able to listen, talking openly and freely, and understanding the feelings behind questions posed by adolescents. (Miller et al., 1998, p. 222).

Where interventions have been evaluated, they suggest that education aimed at parents can raise their self-efficacy and responsiveness in addressing sensitive topics, increase the number of discussions reported by both parents and young people, and correlate to lower reported sexual risk taking (Anderson et al., 1999; Lefkowitz, Sigman, & Au, 2000; O'Donnell et al., 2005).

These studies have been primarily conducted in the United States, often as part of programs focused on delaying sexual debut and encouraging abstinence (O'Donnell et al., 2005; Oliver et al., 1998; Wu et al., 2003). They recommend assisting parents with content, style, and frequency of communicating sexual information and values and emphasize the need for such interventions to be culturally specific (Hutchinson et al., 2003). Furthermore, the fact that parents may not have adequate sexual knowledge themselves (Gallegos, Villarruel, Gomez, Onofre & Zhou, 2007), or perceive taboos around broaching sexual topics (Mbugua, 2007) suggests that interventions first need to address parental attitudes and skills. Hutchinson and Cooney (1998) have suggested that "parents should be assisted in examining their own values and knowledge related to sexuality and sexual risk, and their own sexual socialization and discomfort with sexual communication" (p. 193).

The research presented here, therefore, offers an opportunity to assess efforts to translate these lessons into an intervention aimed at stimulating improved household sexual communication in South Africa, which represents a very different cultural, epidemiological, and socioeconomic setting.

STUDY CONTEXT AND METHODS

The study area, Sekhukhuneland, is located in Limpopo Province, South Africa, and consists of densely settled rural villages. With few local employment opportunities, most households rely on remittances from family members who have migrated to urban areas, occasional manual or commercial labor, and state pension and childcare grants. A minority of households have access to piped water or electricity and quality of housing is poor. As in much of South Africa, sustained poverty has been accompanied by a deepening HIV epidemic. Statistics for the province showed an HIV prevalence rate among adults aged 15-49 years of 11.0 % in 2005 (Shisana et al., 2005).

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) is a community randomized controlled trial of a program integrating microfinance with participatory education addressing HIV and gender awareness. Women from the poorest half of households were eligible to participate in the intervention, which was administered in partnership with a South African microfinance initiative, the Small Enterprise Foundation. Women who joined the program were organized into “loan centers” comprising 40 participants. Within these centers, smaller “solidarity groups” of five women guaranteed one another’s loans, which were used to establish income generating projects. Mandatory fortnightly center meetings provided an opportunity for women to report back on their investments, request additional loan cycles, and make deposits into savings funds.

At these meetings, trained facilitators conducted interactive education and empowerment activities known as Sisters for Life (SfL). These included 10 structured sessions designed to stimulate awareness and discussion on issues related to gender inequalities, intimate partner violence, sexual health, and the role of culture in shaping behavioral norms (Table 1); these were followed by an open-ended phase of community mobilisation in which participant women worked together to identify local priority issues and develop appropriate responses.

Details of the intervention and evaluation study have been published elsewhere (Pronyk et al., 2006; RADAR, 2002a, 2002b), and in this article, we focus on the specific components of the program that encouraged participants to challenge barriers to engaging with young people about sex and sexual health. Whereas the overall intervention was based on the premise that both economic and psycho-social resources and skills are required to address the gender-based inequities behind South Africa’s HIV epidemic, the participatory activities aimed to influence specific behavioral norms at the individual, household, and community levels, including challenging cultural taboos surrounding talking openly about sex and sexuality. As this was such an explicit message within the SfL sessions, for the purposes of this evaluation we assume the SfL curriculum, rather than women’s participation in the microfinance scheme, would have been the primary driving force behind any increase in parent-child communication.

Throughout SfL sessions, trainers emphasised the importance of sharing key messages from the program with families, extended households, and the wider community. Diffusion of new knowledge and attitudes beyond the enrolled participants was an explicit objective of the intervention. The curriculum offered concrete skills in addition to engendering a supportive environment within the group. In particular, Session 9, “Empowering Change,” included opportunities to share communication strategies and previous experience, as well as practice different approaches to talking to young people about sex through a role-play exercise.

To assess the effects of this component of the program, we monitored four centers (120 women) throughout the SfL sessions. We observed all fortnightly meetings to elicit participants’ responses to the health education themes and activities. Data were collected

using flip charts, standardized forms to record the process and content of group discussions, and additional notes taken by the observer. Focus groups were also conducted with eight loan groups at two points in time: immediately after the 10 SfL sessions and 1 year later, upon completion of the community mobilization phase. These asked respondents to reflect on the acceptability of the participatory activities and group dynamics. Finally, to gain the perspectives of young people, 24 interactive workshops and 6 follow-up interviews examined young people's perceptions of the intervention and potential effects in their households and community. Transcripts and interviews were entered into the software package qSR N6 for data management, coding, and comparative thematic analysis.

These qualitative methods were nested within a cluster randomized trial collecting quantitative data at baseline and 2 years later in four intervention and four control villages. We successfully interviewed 387 women from intervention villages at 2-year follow-up (90% of those who joined the program), and 363 age and village type matched controls (84%) who would have been eligible to join the program if available in their village. In addition, we collected data from 443 young people aged 14-35 years (56% of those eligible) resident in the households of loan recipients and 427 (54%) young people from matched households.

Questionnaires asked about frequency of sexual communication in the household over the past 12 months, whether respondents felt "free/open" in discussing topics related to sex, and what topics were covered. Unlike in studies conducted in Western settings, we did not ask respondents to differentiate between conversations held with their *own* children or parents from those with other adults or young people residing in the household, as South African families often display an "extended" rather than nuclear structure that can include long-term fostering of nieces, nephews, and grandchildren. The qualitative data, however, suggests that seeking and/or providing sex-related information and advice occurred between young people and their mothers.

RESULTS

Table 2 presents the survey data at follow-up for participant and control cohorts of women and the young people residing in their households. For the purposes of this analysis, we excluded any young people who also were independently enrolled in the SfL program and thus include those who were only indirectly exposed to the program through contact with their mother or other senior female family member. These results are discussed below alongside qualitative data.

MOTHERS

Participants in the IMAGE program embraced the importance of opening lines of communication with local young people about sexual health. Throughout focus group discussions and interviews, women voiced new found commitment to sexual communication as one of the primary benefits from the integration of the Sisters for Life curriculum within a standard micro-credit package. Although the promise of economic assistance may have initially attracted them to the intervention, women repeatedly credited the program with instilling them with a heightened sense of responsibility for HIV prevention in their families, and inspiring them to respond proactively:

We need health talks. I realised that money alone is not enough. We should know about HIV so that our children can benefit. (Focus group discussion with solidarity group)

Material life should go hand in hand with knowledge. I am not only selling my vegetable but I have also taken upon myself to talk to my children about sexuality and life in general. (Observation of Loan Center meeting)

Survey data show an overall increase in the frequency and comfort levels of participants' efforts to convey the risk HIV poses to their community (see Table 2). At follow-up, the survey asked women to report any communication about sex and sexuality more generally with their or their friends' children. Women in the intervention group reported such communication with children significantly more often than matched women in the control group (80.3% vs. 49.4%; risk ratio, adjusted for age, marital status and parent-child communication at baseline, 1.59 95% confidence interval [CI] 1.31-1.93). Furthermore, more of the intervention group felt "free/open" discussing issues of sex and sexuality after the intervention compared with control women (86.0% vs. 62.0%, adjusted risk ratio 1.40 95% CI 0.60-3.27). The content of communication appeared to have shifted from vague admonitions about the dangers of sex to concrete messages about reducing risks. Among intervention participants reporting sexual communication with children, 97.6% and 58.2% had discussed condom use and HIV testing, respectively.

Women's reflections on the program demonstrate that they developed relevant motivation and skills over the course of Sfl's participatory activities. The process of this transformation can be grouped into three main pathways: (a) gaining increased knowledge and awareness about HIV, (b) recognizing their responsibility in protecting young people from current threats, and (c) receiving guidance and support for challenging cultural norms and taboos.

Gaining Awareness—Despite the extensive HIV epidemic in South Africa, many women in the program lacked reliable information on the disease and its transmission, or did not perceive links between biomedical facts and risks inherent in the normative behaviors of their communities. Many were initially hostile to receiving what they considered to be irrelevant information but moderated their attitude as they began to appreciate the scope of the threat.

Each time facilitator starts the session we would say "There she goes again with her condoms speech. We do not want to hear about condoms because we are too old for such things." Also talked about AIDS and our children, we were bored. But as time went by we realised the importance of the topics, particularly on condoms. (Focus group discussion with solidarity group)

A major driving force behind their intention to talk to their children about sex was access to new knowledge coupled with practical strategies for interpreting and disseminating it.

There are a lot of things I have learnt but there is one thing that stands out amongst them. Before I joined, I did not know about how the HIV virus affects people. I did not know that there is difference between HIV and AIDS. I did not know that HIV is a virus that causes AIDS. I did not know that AIDS is actually not a particular disease but it is any illness that affects you after the virus has eaten up all "the soldiers of our bodies" [immune cells]. We saw many role-plays that showed us how to communicate with children. These were useful skills. (Focus group discussion with solidarity group)

Although Session 9 explicitly addressed parent-child communication, Session 8, titled "Knowledge is Power" proved a crucial turning point for many participants. At the end of the activity, a guest speaker openly disclosed her HIV-positive status to present participants with an opportunity to engage with someone living with the virus. The positive women were of similar age to many of the participants' children, highlighting the risks facing their very

own families. In loan centers receiving visits, women reported feeling extremely moved by the visitors' full disclosures of their HIV status.

I remember when health facilitators brought the HIV-positive lady to the center. She looked so healthy and we could not believe it when she told us that she was HIV-positive. Most people thought HIV-positive people were skinny and sickly looking. We were scared because we found out that the virus can affect anyone indiscriminately. Most women began to believe that HIV is real. They began to realize that some of us could have it. I will never forget her face; it reminds me about the seriousness of the virus and the need for protection. (Focus group discussion with solidarity group)

As women's awareness grew, so did pride in their new knowledge and a concomitant sense of obligation to share it with others in the community:

We are lucky indeed because we have learnt something that many parents do not know. The virus is about sex and we know that our children are doing it at a very young age. So we have the responsibility to talk to them about it. We cannot escape it. It has come to stay. (Focus group discussion with solidarity group)

Desire to Protect—The growing sense of responsibility cited above dovetailed with existing maternal concern for their children's well-being and future. Women perceived numerous dangers facing young people in the modern world and expressed frustration that they did not feel equipped to guide their children through a safe transition. Learning to engage with young people in at least one area of their lives tapped into women's desire to help and protect their families:

We do talk to our children about it (HIV/AIDS). It is difficult but we have to if we want to save them. We know that children will be children. They like to do things their way but if we give them a choice then we are saving ourselves from blame in the future should something go wrong. There is a high rate of crime, rape and alcohol, and often the blame lies with the parents. (Focus group discussion with solidarity group)

It [talking to children] is difficult but it is something we have to face head on. As women and mothers and grandmothers we have the responsibility to protect our children against the virus. (Focus group discussion with solidarity group)

Yes it is my responsibility because if I do not, who will? Tell me, who will? With my daughters, I have to know and interact with their boyfriends and we should talk about these issues with them. (Observation of loan Center meeting)

These sentiments reached heightened urgency within one particular village, known for having problems with alcohol and drug abuse among young people and a high crime rate. Near the end of the SfL program, one participant's son committed suicide after his girlfriend reported him for assault to the police. This episode gravely affected the entire loan center group, and led to analysis of how the breakdown in parent-child communication contributed to many of the problems confronting young people. The women considered other recent suicides and noted that sexual relationships and their outcomes (such as unwanted pregnancy) had featured in several cases. They concluded that parents needed to play a clearer role in young people's lives, and many felt they should begin in their own households.

Identifying a need for change, however, did not remove the thorny issue that open discussion of sex and sexuality is generally considered "vulgar" and taboo in the local SePedi culture. As one woman summarized:

In our culture we were taught that sexual matters are discussed privately. It was unacceptable that a parent would sit down with his/her child and tell them about sex. It was not accepted here in our village. (Focus group discussion with solidarity group)

In the aftermath of the suicide, participants in the affected village were willing to acknowledge that current priorities must override outdated social mores. In the other intervention villages, Session 2, “Reflecting on Culture” helped stimulate awareness of how cultural expectations had come to shape restrictions against parent-child communication.

Breaking Taboos—Challenging these norms thus preoccupied women throughout the program, as barriers remained strong within the wider community, and among themselves. Older participants in particular were against open dialogue about sexuality, stating:

If you talk openly about sex, you are encouraging your children to have sex
(Observation of loan center meeting)

Younger women seemed more willing to change parenting practice and often made a link between how they had been brought up and problems they subsequently experienced. They made a conscious choice to raise their own children with a different code of conduct.

PM: If our parents opened up to us I think I would not have had a baby. If I knew before I would have gone to the clinic for prevention.

MT: I am not going to relate to my child the way I relate to my mother. My mother never used to tell me straight. If I come late at night she would say “ja you will get what you deserve.” But she will never say what it is that I deserve. I have to open up with my child because I will be saving her from being ignorant and naïve about issues that might affect her life. (Focus group discussion with solidarity group)

Unfortunately, however, not all women found relationships with their children conducive to such a departure from tradition. In some cases women could envision broaching sexual topics with their daughters but bridging the gender divide proved more difficult. They devised indirect strategies to convey specific messages without engaging in face-to-face conversation.

It is difficult to talk to a boy child. I use silent means like throwing condoms on his bed as a way of saying to him “use condoms all the time.” (Observation of loan center meeting)

I have a problem because I am afraid to directly talk to my boy child. But what I normally do is to write a piece of paper and put on his bed to read in his own time. I am having difficulties because all my children are boys. (Observation of loan center meeting)

In one loan center, to avoid the discomfort of confronting their own children, the women organized a “swap” so that a participant would facilitate a group of her peers’ children. Although this approach met with some success, women found that the strong sanctions against open communication affected young people as much as it did parents; other mothers expressed similar frustrations:

Most groups reported that although they are happy with what they have done, they still feel that they have not been victorious in the sense that children put up a ‘we know it all’ attitude, which they found hard to counteract. (Facilitator notes on one loan center).

Even when I try to talk to my daughter here at home about such things, she just leaves me alone saying “Oh Mom.” The issue is that she has a problem when I talk

about such things because she does not know how to engage me on such issues as I am not used to talking to her about vulgarities. (Interview with 54-year-old participant)

Interacting with adult children also seemed unrealistic for similar reasons. Having lost the opportunity while their sons and daughters were growing up, some participants decided to now concentrate on relationships with their grandchildren:

We have the responsibility on our hands for the well-being of our children. We have to talk to them. Some women have grown children and it becomes a problem to talk to them because they are old. But most of us live with grandchildren and we can make up the lost time with them. I found them easier to talk to than my grown up children. Children are easier to talk to because they are like blank pages. I do talk to my grandchildren about HIV and AIDS and they listen to me. (Focus group discussion with solidarity group)

By the end of the intervention, therefore, participants had adopted a range of approaches to discussing sex with local young people. They felt motivated to share newly acquired knowledge and deeply responsible for protecting young people from new dangers, as well as more comfortable in doing so after having developed and practiced skills for entering into dialogue or finding alternative means of communication.

YOUNG PEOPLE

To determine how participant women's intentions to address sexual health translated into the reality of child-parent interactions, we analyzed data collected throughout the study that touched on topics of sexual information, education, and communication. We found that young people exhibited a tremendous thirst for accurate information and felt parents would be an appropriate source of knowledge and advice, but that they also shared adults' reluctance to openly discuss sexual matters. Those who lived in the households of IMAGE participants, however, reported noticing substantial changes in both the content and process of their sexual communication efforts.

Seeking Knowledge—Through in-depth interviews, we explicitly asked young people about their attitudes to parent-child communication about sex. Most reacted positively, regardless of whether they came from IMAGE participant households but acknowledged that useful discussion on these topics was extremely rare.

Yes I think is good for parents to talk with their kids because our parents are old and they have experience about these things and they know everything, so it will be better if our parents can talk to their kids about sex and sexuality. Parents are afraid to talk to their kids because they think that if you talk to your kids about those things they won't respect them ... If you hear things from friends you will not take them serious but if it is your mother you will listen to her seriously. (Interview with 16-year-old girl)

It is our parents who should start talking to us ... because they are the ones who brought us into his world, so they must not be afraid of us. If our parents can start to talk to us about easier things it will make us or be easy for us to ask those deeper secrets we want to understand. (Interview with 21-year-old boy)

At the same time, however, young people expressed reservations about the likelihood of such communication. Particularly in the early states of the program, participants' children described limited rapport with their parents. In initial participatory activities, young people often ranked television, friends, schools, and clinics above parents as realistic sources of information and looked to others for guidance on sex and relationships.

To get right information I will ask another woman but not my mother because I am afraid of her. I will wait for her when she ask me whether I went to a clinic for family planning and is where I can be able to ask her something about sexuality. There is a problem because I can't talk to my mother but if she can start then I will be free to ask. (Interview with 16-year-old girl)

It is better if you have a brother, you can tell him and he can tell your mother because if your mother told you that girls will infect you so you must use condoms and later you got infected with [a sexually transmitted infection] she will shout at you that is why I was afraid to tell her the time I was sick. (Interview with 19-year-old boy)

These concerns, however, focused around the *style* of communication, which tended to be judgmental, proscriptive, and discouraging of young people's sexuality, rather than opposition to talking to parents *per se*. This left a window of opportunity for Sfl activities to target mothers' attitudes and approach and offer alternative models that might meet with greater approval from young people.

Perceptions of Change—Anecdotal evidence of improved communication with mothers accompanied implementation of Sfl sessions. Young people residing in IMAGE households noticed their mothers trying to broach sexual topics more often, and clarifying behavioral messages to make them more appropriate to HIV prevention:

My parent encourages me to use condoms always when we are with our boyfriends. Before ... she was not telling us anything because things like sex were secret but now she sometimes talks about condoms and diseases.

My mother was talking to us before joining ... saying that we should not get pregnant, we should go to school first so she was encouraging us more on using contraceptives like injections, but now she is saying we must use condoms because condoms prevent diseases and unwanted pregnancy. (Participatory activity with young people who live in households with IMAGE participants, from 2 villages)

The facilitators of participatory activities with young people also observed that the children of IMAGE participants often dominated discussions and displayed better awareness of sexual health than others and that they attributed their knowledge to their mothers.

They all agreed that it is not easy to talk to a parent about sexuality even on natural things like menstruation. However, one participant, whose mother is a SEF [Small Enterprise Foundation] member, argued that her mother used to tell them what they have learnt from SEF about HIV/AIDS. The other participants smiled as she was talking and I asked them, why are they smiling? They said... because they know what she was talking about because she would tell them all what her mother used to tell her. (Participatory session with young people)

The quantitative data from the surveys confirm greater household communication by young people aged 14-35 years in intervention households (measured as reported discussion of sex or sexuality in the past 12 months with parents, guardians or "other household members" excluding spouses or their own children). After excluding young people who were themselves direct recipients of the intervention, these young household residents still reported higher levels of communication compared with a matched cohort in control villages, although the effect was not statistically significant in a cluster level analysis (63.9% vs. 49.7%, risk ratio adjusted for age, sex and baseline communication, 1.27 95% CI: 0.79-2.05). Slightly more young people reported feeling comfortable discussing sex/sexuality in their homes, though this was also not significant (57.5% vs 43.6%, adjusted risk ratio 1.36 95% CI: 0.21-8.61). As found in other studies, fewer young people reported

communication with parents (50.8%) compared with participants' reports of communication with children (80.3%) although these figures are not exactly comparable, as young people were asked about communication with *either* parent and/or guardians, whereas women reported communication with their own *and/or* their friends' children.

DISCUSSION

The health and gender awareness component of the IMAGE intervention known as SfL successfully improved participants' motivation and skills in engaging with young people about sex and sexuality. Through a series of facilitated sessions that offered both new knowledge and opportunities for critical reflection, women came to the realisation that confronting cultural norms and taboos would be crucial to protecting their children from HIV infection. External events such as the suicide of a participant's son in one of the loan centers further solidified the group's resolve to become more proactive in their children's lives.

Although some participants viewed the open dialogue around sensitive issues with suspicion and disapproval at first, ultimately many women highlighted being able to talk to children with greater confidence as one of the most valuable contributions of IMAGE outside the economic benefits. This is reflected in survey data indicating a significant increase in the proportion of women at follow-up who report having talked about sexual issues with children compared with their matched controls. Qualitative evidence further demonstrates ways in which mothers moderated their approach to sexual communication, such as by adopting clear sexual health messages instead of vague admonitions, arranging to interact with peers' children rather than their own, and by utilizing a range of strategies for indirect, non-verbal communication.

Triangulating these findings with information elicited from local young people strengthens the evidence for change in participants' approach to discussing sexual topics. Young people focused on the process of communication, originally feeling apprehensive about the way in which parents tended to scold them or refer to sex in negative and moralistic terms. Over the life of the IMAGE program, however, young people noticed that their mothers or other relatives brought home new information and tailored their messages toward concrete advice regarding condom use and HIV testing.

Many of our results mirror findings from other studies of parent-child sexual communication. For example, we found a higher proportion of mothers reporting the occurrence of conversations about sex than among young people, and both groups made frequent reference to the need for "openness." Adults and young people alike perceived strong barriers to initiating dialogue on sensitive issues, particularly as these were traditionally seen as taboo and mothers would not have themselves experienced such conversations while growing up. This left them with a need for skills building that could address their lack of confidence and offer practical strategies for broaching new topics that they subsequently translated into action.

The congruence between these findings and much of the existing literature on parent-child sexual communication suggests that our attempts to develop an intervention based on the findings of program evaluations from developed country settings were successful. The SfL participatory sessions incorporated recommendations from decades of work already conducted on understanding and catalyzing positive relationships between parental communication about sex and safer behavior among adolescents. Despite the fact that South Africa represents not only a resource-poor context but also exhibits a very different socio-cultural and epidemiological profile from Western countries such as the United States and

Australia that predominate in relevant literature, activities designed to give parents skills, confidence, and accurate information on sexual health and its importance did seem to improve both frequency and quality of parent-child discussions of sensitive topics. Other recently published studies provide further evidence of the similarities in trends and barriers to household sexual communication in countries as diverse as Mexico (Gallegos et al., 2007) and China (Zhang et al., 2007). Given the breadth of evidence for how parents can positively influence young people's risk-taking behavior through appropriate communication strategies, the success of IMAGE in improving rural South African mothers' intentions and ability to address sexual health with young people holds promise for other intervention programs in a range of settings confronting an HIV epidemic.

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REFERENCES

- Adu-Mireku S. Family communication about HIV/AIDS and sexual behavior among senior secondary school students in Accra, Ghana. *African Health Sciences*. 2003; 3(1):7–14. [PubMed: 12789082]
- Anderson NL, Koniak-Griffin D, Keenan CK, Uman G, Duggal BR, Casey C. Evaluating the outcome of parent-child family life education. *Scholarly Inquiry of Nursing Practice*. 1999; 13(3):211–234.
- Aspy CB, Vesely SK, Oman RF, Rodine S, Marshall L, McLeroy K. Parental communication and youth sexual behavior. *Journal of Adolescence*. 2007; 30(3):449–466. [PubMed: 16750265]
- DiClemente RJ, Wingood G, Crosby R, Cobb BK, Harrington K, Davies SL. Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *Journal of Pediatrics*. 2001; 139(3):407–412. [PubMed: 11562621]
- Dutra R, Miller KS, Forehand R. The process and content of sexual communication with adolescents in two-parent families: Associations with sexual risk-taking behavior. *AIDS and Behavior*. 1999; 3(1):59–66.
- Feldman SS, Rosenthal DA. The effect of communication characteristics on family members' perceptions of parents as sex educators. *Journal of Research on Adolescence*. 2000; 10:119–150.
- Fisher TD. An extension of the findings of Moore, Peterson, and Furstenberg. (1986). Regarding family sexual communication and adolescent sexual behavior. *Journal of Marriage and the Family*. 1989; 51:637–639.
- Fox GL, Inazu JK. Patterns and out-comes of mother-daughter communication about sexuality. *Journal of Social Issues*. 1980; 36(1):7–29.
- Gallegos EC, Villarruel AM, Gomez MV, Onofre DJ, Zhou Y. Research brief: Sexual communication and knowledge among Mexican parents and their adolescent children. *Journal of the Association of Nurses in AIDS Care*. 2007; 18(2):28–34. [PubMed: 17403494]
- Greene AL, Grimsley MD. Age and gender differences in adolescents' preferences for parental advice: Mum's the word. *Journal of Adolescent Research*. 1990; 5(4):396–413.
- Halpern-Felsher BL, Kropp RY, Boyer CB, Tschann JM, Ellen JM. Adolescents' self-efficacy to communicate about sex: Its role in condom attitudes, commitment, and use. *Adolescence*. 2004; 39(155):443–456.
- Holtzman D, Rubinson R. Parent and peer communication effects on AIDS-related behavior among US high school students. *Family Planning Perspectives*. 1995; 27:235–240. [PubMed: 8666087]
- Hutchinson MK, Jemmott JB III, Jemmott LS, Braverman P, Fong GT. The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health*. 2003; 33(2):98–107. [PubMed: 12890601]

- Kirkman M, Rosenthal DA, Feldman SS. Being open with your mouth shut: The meaning of "openness" in family communication about sexuality. *Sex Education*. 2005; 5(1):49–66.
- Lefkowitz ES. Beyond the yes-no question: measuring parent-adolescent communication about sex. *New Directions for Child and Adolescent Development*. 2002; 97:43–56.
- Lefkowitz ES, Boone TL, Au T.K.-f, Sigman M. No sex or safe sex? Mothers' and adolescents' discussions about sexuality and AIDS/HIV. *Health Education and Research*. 2003; 18(3):341–351.
- Lefkowitz ES, Sigman M, Au T.K.-f. Helping mothers discuss sexuality and AIDS with adolescents. *Child Development*. 2000; 71(5):1383–1394. [PubMed: 11108102]
- Leland NL, Barth RP. Characteristics of adolescents who have attempted to avoid HIV and who have communicated with parents about sex. *Journal of Adolescent Research*. 1993; 8:58–76.
- Lesch E, Kruger L-M. Mothers, daughters and sexual agency in on low-income South African community. *Social Science and Medicine*. 2005; 61:1072–1082. [PubMed: 15955407]
- Mbugua N. Factors inhibiting educated mothers in Kenya from giving meaningful sex-education to their daughters. *Social Science and Medicine*. 2007; 64(5):1079–1089. [PubMed: 17258368]
- McBride DC, Freier MC, Hopkins GL, Babikian T, Richardson L, Helm H, et al. quality of parent-child relationship and adolescent HIV risk behavior in St. Maarten. *AIDS Care*. 2005; 17(Suppl. 1):S5–S54.
- Miller KS, Kotchick BA, Dorsey S, Forehand R, Ham AY. Family communication about sex: What are parents saying and are their adolescents listening? *Family Planning Perspectives*. 1998; 30(5): 218–222. [PubMed: 9782044]
- Odimegwu CO, Solanke LB, Adedokun A. Parental characteristics and adolescent sexual behavior in Bida Local Government Area of Niger State, Nigeria. *African Journal of Reproductive Health*. 2002; 6(1):95–106. [PubMed: 12476733]
- O'Donnell L, Stueve A, Agronick G, Wilson-Simmons R, Duran R, Jeanbaptiste V. Saving sex for later: an evaluation of a parent education initiative. *Perspectives on Sexual and Reproductive Health*. 2005; 37(4):166–173. [PubMed: 16380361]
- Oliver DP, Leeming FC, Dwyer WO. Studying parental involvement in school-based sex education: lessons learned. *Family Planning Perspectives*. 1998; 30(3):143–147. [PubMed: 9635264]
- Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C, et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: A cluster randomized trial. *The Lancet*. 2006; 368(9551):1973–1983.
- RADAR. Social Interventions for HIV/AIDS: Intervention with Microfinance for AIDS and Gender Equity. IMAGE Study Evaluation Monograph No.1. Rural AIDS and Development Action Research, School of Public Health, University of the Witwatersrand; Johannesburg, South Africa; 2002a.
- RADAR. Social Interventions for HIV/AIDS: Intervention with Microfinance for AIDS and Gender Equity. IMAGE Study Evaluation Monograph No. 2. Rural AIDS and Development Action Research, School of Public Health, University of the Witwatersrand; Johannesburg, South Africa; 2002b.
- Shisana, O.; Rehle, TM.; Simbayi, LC.; Parker, W.; Zuma, K.; Connolly, C., et al. South African National HIV Prevalence, HIV Incidence, Behavior and Communication Survey, 2005. HSRC Press; Cape Town, South Africa: 2005.
- Whitaker DJ, Miller KS, May DC, Levin ML. Teenage partners' communication about sexual risk and condom use: the importance of parent-teenager discussions. *Family Planning Perspectives*. 1999; 31(3):117–121. [PubMed: 10379427]
- Wu Y, Stanton BF, Galbraith JS, Kaljee L, Cottrell L, Li X, et al. Sustaining and broadening intervention impact: A longitudinal randomized trial of 3 adolescent risk reduction approaches. *Pediatrics*. 2003; 111(1):e32–e38. [PubMed: 12509592]
- Zhang L, Li X, Shah IH, Baldwin W, Stanton B. Parent-adolescent sex communication in China. *The European Journal of Contraception & Reproductive Health Care*. 2007; 12(2):138–147.

TABLE 1

Sisters for Life Training Sessions

Session	Title	Focus
1	Introductions	Help participants and facilitators get to know each other and the program Expectations and concerns Ground Rules
2	Reflecting on Culture	Consider traditional wedding songs, names and proverbs about women, exploring their content and meaning Girls' "do's and don'ts"—how gender roles and conditioning are reinforced from an early age
3	Gender Roles	Consider differential work loads and responsibilities of women and men Mapping out 24 hours in a woman's day – analyze how much of women's time is devoted to others and how much to themselves
4	Women's Work	Explore the implications of women's heavy workloads on health and 7 wellbeing Understand the difference between "sex" and "gender" Explore & challenge the notion of "culture" and how it reinforces gender roles and stereotypes
5	Our Bodies, Our Selves	Defining "womanhood" and what it means to be a woman Body mapping—becoming more comfortably speaking about the body, sexuality, and women's feelings about these Explore women's understanding of their bodies
6	Domestic Violence	Explore a range of experiences and witnessing of violence Explore attitudes, beliefs, and experiences of such violence – link how violence is perpetuated to prior sessions on gender roles and culture Role play: mother-in-law speaking to a daughter-in-law who has been beaten by her husband
7	Gender & HIV	Basic information Trends and statistics: women and HIV Explore reasons why women (esp. young women) are at high risk Link social context of women's risk to previous sessions
8	Knowledge is Power	Introduce VCT and where it is available Encourage women to think about VCT, reasons for testing, fears and concerns The reality of HIV: disclosure narrative by a person living with HIV/AIDS
9	Empowering Change	Explore why negotiating safer sex with a partner is difficult Explore why speaking to young people about sex and HIV is difficult Practice communication skills and exchange strategies and experiences Role-plays
10	Way Forward	Summary of and links between previous sessions Explore obstacles and opportunities for greater involvement of youth and men Discussions about next steps (community mobilization phase)

Note. VCT = voluntary counselling and testing. Table adapted from RADAR (2002b).

TABLE 2

Follow-up Survey Results Among Direct IMAGE Participants, Household Corésidents Aged 14-35 Years and Matched Controls 2 Years After Study Recruitment

	Women				Young People			
	IMAGE Participant		Matched Control		HOUSEHOLD RESIDENT OF IMAGE PARTICIPANTS		HOUSEHOLD RESIDENT OF MATCHED CONTROLS	
	n/N ^a	%	n/N [*]	%	n/N [*]	%	n/N	%
Communication with own or friends' children on sex/sexuality issues in past 12 months	294/366	80.3%	169/342	49.4%	—	—	—	—
Communication with parents, guardian or other household members (not spouse or own children) on sex/sexuality issues in past 12 months	—	—	—	—	283/443	63.9%	212/427	49.7%
Feel free/open to discuss sex/sexuality in the household	327/379	86.0%	220/354	62.0%	254/442	57.5%	186/427	43.6%
								Adjusted Risk Ratio (95% CI) Comparing Participants to Matched Controls ^a
								1.59 (1.31-1.93)
								1.40 (0.60-3.27)
								1.27 (0.79-2.05)
								1.36 (0.21-8.61)

* Adjusted for age, baseline measurement of communication and marital status (women) or sex (young people).

^aThere was a small amount of missing data for some questions.