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Abstract

Communication about sexual health between parents and adolescents has been shown to have a protective influence on behaviours that reduce the risk of HIV transmission. This study explored experiences of HIV and sexual health (HSH) communication between parents and/or caregivers and adolescents in an urban HIV-endemic community in Southern Africa. Adolescents (aged 14–19 years) were recruited from the Kganya Motsha Adolescent Centre and the Kliptown community between June and August 2009. Qualitative data were collected through focus group discussions ($n = 10$ adolescents) and semi-structured interviews ($n = 31$ adolescents). In total, 41 adolescents (56% female, 44% male, mean age = 17.2) participated in the study. Adolescent participants identified emotional, physical and sociocultural barriers to initiating HSH communication with parents and caregivers including fear of verbal warnings, threats and physical assault. Adolescents also expressed a desire for mentorship around HSH communication beyond abstinence and peer-based information. Public health interventions need to support adolescents' access to bi-directional HSH information from adult mentors that address the lived realities of adolescents beyond expectations of abstinence.

Keywords: adolescent, parent–adolescent communication, qualitative, sexual health, HIV prevention, South Africa

Résumé

Il a été démontré que la communication au sujet de la santé sexuelle entre les parents et les adolescents a une influence protectrice sur les comportements qui réduisent le risque de transmission du VIH. Cette étude a exploré des expériences du VIH et la santé sexuelle (VSS) communication entre les parents et/ou aidants et adolescents dans une communauté urbaine endémique du VIH en Afrique méridionale. Des adolescents (âgés 14–19 ans) ont été recrutés à partir du centre adolescent de Kganya Motsha (CAKM) et de la communauté de Kliptown entre juin et août 2009. Des données qualitatives ont été rassemblées par le groupe de discussion (adolescents $n = 10$) et des entrevues semi-structurées (adolescents $n = 31$). Au total, 41 adolescents (56% de femmes, 44% des hommes, âge moyen = 17,2) ont participé à l'étude. Les participants adolescents ont identifié les obstacles émotifs, physiques et socioculturels pour entamer la communication VSS avec des parents et des aidants comprenant la crainte des avertissements verbaux, des menaces et de l'aggression physique. Les adolescents ont également exprimé un désir d'obtenir du mentorat autour de la communication VSS au-delà de l'abstinence et de l'information par les pairs. Les interventions de

santé publique doivent soutenir l'accès des adolescents à l'information VSS bidirectionnelle des mentors adultes qui adressent les réalités vécues par les adolescents au-delà des attentes d'abstinence.

Mots clés: adolescent, communication parent-adolescent, qualitative, santé sexuelle, prévention du VIH, Afrique du Sud

Introduction

Youth aged 15–24 years account for an estimated 42% of new HIV infections in people aged 15 and older. Nearly 80% of young people living with HIV live in sub-Saharan Africa, highlighting the critical importance of youth-focused HIV prevention strategies in this region (UNAIDS 2012). In South Africa, the overall HIV prevalence among youth aged 15–24 is 8.7% (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, *et al.* 2009). Adolescents are a key population for HIV prevention because during this stage of development, sexual behaviours are generally initiated and risk patterns established (Meschke, Bartholomae & Zentall 2000).

Parents play an important role in influencing adolescent sexual decision-making and behaviour, including access to information about HIV and sexual health (HSH) (Whitaker & Miller 2000). Positive communication between parents and youth about sex has been identified as influencing behaviour, including increased contraceptive use and delayed sexual debut, particularly for females (Halpern-Felsher, Kropp, Boyer, Tschann & Ellen 2004; Markham, Lormand, Gloppen, Peskin, Flores, Low, *et al.* 2010; Miller, Benson & Galbraith 2001), and increased willingness to participate in HIV prevention trials (Otwombe, Dietrich, Sikkema, de Bruyn, van der Watt & Gray 2009). However, research shows that there are numerous aspects of communication that determine its effectiveness and ability to influence risk behaviour, including qualities of the source (parent) and recipient (adolescent), content of the message, how the message is communicated, and the context (Bastien, Kajula & Muhwezi 2011; Jaccard, Dodge & Dittus 2002; Poulsen, Miller, Lin, Fasula, Vandenhoudt, Wyckoff, *et al.* 2010). While most parents and children desire open, direct and mutually valued discussions about sexuality, studies show that communication tends to be unidirectional, top-down and negative (Bastien *et al.* 2011; Wamoyi, Fenwick, Urassa, Zaba & Stones 2010).

Despite a prevailing high incidence of HIV among youth, comprehensive and correct knowledge about HIV among young people remains low (UNAIDS 2010). Research shows that despite increasing knowledge about HIV prevention among young people, in 15 of the countries with the highest HIV prevalence, including South Africa, less than half can correctly answer five basic questions about HIV and its transmission (UNAIDS 2010). Furthermore, evidence shows that despite widespread exposure to HIV prevention messages among South African adolescents, perceptions of HIV vulnerability remain low (de Bruyn, Skhosana, Robertson, McIntyre & Gray 2008; Sayles, Pettifor, Wong, MacPhail, Lee, Hendriksen, *et al.* 2006; Simbayi, Kalichman, Jooste, Cherry, Mfecane & Cain 2005). While some parent-adolescent communication about HSH may be occurring, accurate and relevant knowledge among adolescents is lacking (Mbugua 2007; Phetla, Busza, Hargreaves, Pronyk, Kim, Morison, *et al.* 2008; Wamoyi *et al.* 2010).

Parent-adolescent communication has been studied widely across different contexts (Bastien *et al.* 2011; DiClemente, Salazar & Crosby 2007; Hadley, Brown, Lescano, Kell, Spalding, DiClemente, *et al.* 2009). However, a recent literature review of studies on parent-child communication regarding sexual health revealed a lack of qualitative studies exploring mechanisms of parent-adolescent communication in Sub-Saharan Africa (Bastien *et al.* 2011). We undertook this qualitative study to explore adolescent perspectives on HSH communication with parents and/or caregivers. The goal of this study is to contribute new information regarding adolescent HSH information seeking behaviours to better understand gaps in knowledge and opportunities for positive mentorship among adolescents living in HIV-endemic communities.

Methods

Setting

This study was conducted at the Kganya Motsha Adolescent Centre (KMAC) in Kliptown, Soweto, South Africa, between June and August 2009. KMAC, an affiliate of the Perinatal HIV Research Unit (PHRU), is the first adolescent-only health centre in the region that provides comprehensive sexual and reproductive health services, including HIV testing, to adolescents (14–19 years) and young adults (20–24 years). KMAC serves a diverse group of adolescents, many of whom have been personally affected by HIV in their community. The PHRU, a research division of the University of the Witwatersrand in Johannesburg, is one of the largest HIV research and clinical care centres in Africa, located at Soweto's Chris Hani Baragwanath Hospital. Soweto is a collection of formal and informal communities located 9.3 miles southwest of Johannesburg, with an area of approximately 41 square miles. It represents South Africa's largest urban population, with an estimated three million residents (City of Johannesburg 2010).

Eligibility and recruitment

Adolescents were eligible to participate if they were between 14 and 19 years old and were current residents of Soweto. Participants were selected through convenience sampling methods from both KMAC and the Kliptown community by KMAC study staff and through word-of-mouth, as they were readily available and convenient to the research team. We informed participants that the research aimed to explore experiences of communication about HSH between parents and/or caregivers and adolescents. All participants provided written informed consent (or assent for those ≤ 18 years) for participation and audio-recording. No adolescents refused consent for participation in this study. Participants were provided with an honorarium of 50 ZAR for their time and transportation costs.

Data collection

All participants first completed a brief demographic questionnaire, which collected information on age, gender, parents' marital status and head of household. Data were collected through focus group discussions (FGDs) and individual semi-structured interviews (SSIs). Initially, two FGDs ($N = 10$) were conducted, one with female adolescents and the other with male adolescents, to pretest the SSI questions and as a method of data triangulation. Questions that posed potential bias in influencing respondents' answers were rephrased or removed. Subsequently, semi-structured individual interviews were carried out with a revised interview guide. Each FGD lasted approximately one hour and SSIs approximately 45 minutes, and were held in a private room within KMAC. Focus groups and interviews were led by local trained multilingual research facilitators, and participants responded in their preferred language including Zulu, Sotho, Xhosa, and English.

Interviews were guided by open-ended questions using a semi-structured topic guide. The interviews were informal and conversational allowing participants to explain their experiences and understanding in their own words. A set of probes based on initial responses were used where necessary. In an attempt to minimize the influence of response bias, research facilitators were trained to remain neutral and to reinforce to participants that there were no right or wrong answers. Questions explored adolescent experiences of initiating HSH communication with their parents and/or caregivers, as well as the content and the quality of the information shared during communication. Key questions included:

- Who in your family would you go to ask questions about sex?
- Who else do you get your sexual health information from, if not your parents?
- What kind of HIV-related sexual health information do you get from your parents? For example, does this information include sex? pregnancy? HIV?
- How do your parents communicate sexual health information with you?

Data analysis

FGDs and SSIs were audio-recorded and transcribed verbatim by research staff. Interviews conducted in a local language were translated into English during transcription. Transcripts were hand coded by two independent reviewers and compared for consistency of repeated observations. Coders used a grounded theoretical approach in which themes and codes emerge from the data (Corbin, Strauss & Strauss 2008). The transcripts were independently and individually analysed to create a basic description of the messages conveyed by adolescents in FGDs and SSIs. Keywords and phrases were identified and grouped into subthemes, which were collapsed and integrated into more complete categories. Categories were integrated using axial coding, whereby the reviewers worked to understand connections between categories and their subthemes. Recurrent themes were identified and coding differences were resolved through discussion and

agreement between members of the research team. This process was repeated until the data reached theoretical saturation where no new categories emerged. Data were arranged according to identified themes to allow reviewers to note differences and similarities and relevant quotes were selected where necessary to illustrate key themes.

Ethical considerations

Participant confidentiality was ensured throughout the study where possible. Due to the inherent nature of focus groups, participants were informed that anonymity and confidentiality could not be fully guaranteed; however, participants were encouraged not to share discussions outside of the FGD. Unique identifiers were used for all study documents to conceal participant identities. The study was granted ethical approval by the University of Witwatersrand Human Research Ethics Committee (South Africa) and the Behavioural Research Ethics Board of the University of British Columbia (Canada).

Results

Socio-demographic characteristics

In total, 41 adolescents (mean age 17.2, $SD = 1.4$, range 14–19 years) participated in the study (refer to Table 1). Two separate FGDs with adolescents [one with males ($n = 4$) and one with females ($n = 6$)] and 31 SSIs (18 male adolescents, 23 female

Table 1. Characteristics of adolescent participants ($n = 41$).

| Characteristic | Males | Females | Total |
|----------------------------------|-------------|-------------|-------------|
| Sex | 18 (43.9) | 23 (56.1) | 41 |
| Mean age (SD) | 17.3 (1.1) | 17.1 (1.5) | 17.2 (1.4) |
| <i>Parents' marital status</i> | | | |
| Married | 9 (50.0) | 8 (34.8) | 17 (41.5) |
| Single | 2 (11.1) | 9 (39.1) | 11 (26.8) |
| Separated | 2 (11.1) | 4 (17.4) | 6 (14.6) |
| Divorced | 3 (16.7) | 1 (4.3) | 4 (9.8) |
| Widowed | 2 (11.1) | 1 (4.3) | 3 (7.3) |
| <i>Head of household</i> | | | |
| Mother | 7 (38.9) | 12 (52.1) | 19 (46.3) |
| Father | 4 (22.2) | 7 (30.4) | 11 (26.8) |
| Grandmother | 3 (16.7) | 2 (8.7) | 5 (12.2) |
| Sister | 2 (11.1) | 1 (4.3) | 3 (7.3) |
| Uncle | 2 (11.1) | 0 (0.0) | 2 (4.9) |
| Brother | 0 (0.0) | 1 (4.3) | 1 (2.4) |
| Mean age, head of household (SD) | 44.5 (15.1) | 44.8 (11.8) | 44.7 (13.0) |
| Median household members (IQR) | 4 (4, 5) | 5 (4, 6) | 5 (4, 6) |
| Median household rooms (IQR) | 4 (3, 4.8) | 4 (2, 4.5) | 4 (2, 5) |

Note: Results presented as frequency (%) unless noted. Percentages may not equal 100% due to rounding.

adolescents) were conducted over the period of the study. The majority of adolescents identified as being of Zulu (46.3%) or Tsonga (19.5%) ethnicity and speaking Zulu (41.4%) or Xhosa (17.1%) as a primary language. Almost half (46.3%) of the adolescents reported their mother as being the head of the household, compared to a grandparent (12.2%) or a sibling (10%).

Adolescents desire HSH communication with adults

Adolescents expressed their desire to talk with their parents and/or caregivers when they were struggling with a personal issue and wanted information and advice related to sex and relationships. One 16-year-old female stated: 'I wish we could talk about ways in which to handle relationships, for example if I do have a relationship I would like to know how to make sure that the boy is not abusive.' Mothers, in particular, were common sources of sexual health information; however, adolescents did not always feel that their parents were equipped with the skills or knowledge to discuss issues beyond abstinence. A 19-year-old male said:

Parents should talk about the sensitive things like HIV, sex and so on like when you want to have sex use a condom and that make sure you know the status of the person you want to have sex with whether it's a female or male.

Adolescents reported that parents' unwillingness to discuss sensitive topics sometimes led to uncertainty and fear when faced with a difficult situation. One 19-year-old male described,

... the time that the condom bust while I was having sex so I asked myself should I go and tell [my parents] because I was scared but then decided not to and that if the girl got pregnant I would deal with it.

Disconnect between HSH information offered by parents and/or caregivers and adolescents' lived experiences

Many adolescents not only desired more communication about HSH with their parent(s), but also expressed the need for practical and accurate information that reflected their lived experiences. For example, one 17-year-old male expressed his desire to feel safe telling his family members he was engaging in unsafe sexual behaviour:

My wish is to tell them every single thing about my sexual life, for example, like 'today I had sex without a condom,' so that if I get sick in the future they would know that maybe I have AIDS. Even though I feel comfortable with other people telling me about AIDS, I wish though it could come from my parents.

Many adolescent participants said that communication with parents regarding sexual health was unidirectional and did not necessarily leave open the possibility for discussing topics other than HIV/AIDS and abstinence. As one young woman, aged 14 and seeking advice about sex from her mother said, 'She told me not to have sex until I finish school, she told

me to finish school first before having sex.' A 17-year-old male described how he sought sexual health advice from his father, saying 'I asked him, am I at the right stage to start having sex and he told me that I should focus on finishing school first and now is not the right time.' Unidirectional dialogue that focused on school completion prior to initiating sexual relationships was common in this sample. The sexual health communication that did occur between parents and adolescents commonly focused on unplanned pregnancy and the shame that this would bring to the family. For example, a 17-year-old male describes:

I talked to my dad about pregnancy, but it was not in a sense that he was giving me knowledge, but it was more like a warning, like 'don't involve yourself in sexual intercourse, cause you will get a girl pregnant.'

This same young man suggested that his dad would sometimes relay information in a frightening and misleading manner:

... he did not put it in a direct way; he was beating around the bush. Like sometimes he would say AIDS kills, so don't date girls, and that paints a picture that all females are bad and are a high risk to get infected ...

Furthermore, communication between parents and adolescents often fell short of giving adolescents practical information with respect to preventing negative health outcomes. As one 18-year-old male said, 'I've talked with my parents about teenage pregnancy, HIV ... I am afraid to ask my parents about how to use a condom.'

Unidirectional and abstinence-based communication with parents and caregivers often led adolescents to seek information from other, less reliable sources. Some adolescents reported that because they were unable to access their parents for HSH information, they relied on sibling or peer-based information. As one 14-year-old female said,

[my sister] tells me that sex for kids at my age is not right but when I am around the age of 16 it's okay to have sex. I don't understand, because people say you can start sex at anytime, right?

Another 17-year-old female commented on mixed messages between family members as posing challenges to making healthier sexual choices: 'When I'm talking to my mother I'm getting the right advice. When I'm asking my brother he said not to use a condom.' Likewise, a 17-year-old male, who lived at home under the supervision of his older sister, described how his father and sister provided conflicting information on condom use:

You see my father always tells me that you should use a condom every time you have sex to protect yourself from AIDS, on the other hand my sister tells me you should not use a condom because you won't feel anything. She says using a condom is like blocking your nose and then smelling flowers.

Emotional and physical barriers to initiating HSH communication with parents and caregivers

Most of the adolescents expressed emotional and sometimes physical barriers to initiating conversations about HSH with their parents and caregivers. For example, one 18-year-old male said, 'I don't think that if I were to talk to them about HIV or AIDS they would support me.' Another young man, aged 19, stated,

I stay with my granny and uncle, but when I ask them about HIV and AIDS they become sensitive, it is as if they are angry and so I also become shy to ask them about such issues. I don't become free.

Some adolescents identified angry or violent reactions from parents as a barrier to initiating conversations regarding sex. As one 16-year-old male: 'When I ask my father I am scared because I think that he's going to hit me; why I am knowing about sex?' Another 18-year-old female described her mother's violent assault upon finding out she had sex for the first time and justified the violence: 'I thought about it [sex] and told myself what I did was wrong and I deserve what she did to me.' Adolescents' demonstrated fear of discussing sexual health may be reinforcing peer-based myths. For example, one 18-year-old female discussed how she did not speak to any adults about sex and believed that early sex initiation was important for sexual health: 'The thing is that if you don't have sex until a certain age your bones will get too stiff and it will be sore when you do it.'

Sociocultural barriers to sexual health communication between generations

Adolescents suggested that perceived traditional values held by parents were a barrier to open dialogue about HIV between themselves and their parents. 'I talk a lot to my parents but when it concerns like HIV they say nothing to me because of things like traditional values,' said an 18-year-old male. Similar concerns were also articulated by adolescents regarding broader sexual health issues, for example, one 19-year-old male said, 'I asked my granny that at 16 is it okay if I can sleep with a girl and my granny said no ... sex before marriage is a sin.'

Many adolescents also suggested that the idea of discussing HIV and/or sexual health matters with parents would be a sign of disrespect. As one 19-year-old female adolescent said,

There are things that I don't talk to [my parents] about like sex. I stay away from that especially when I'm around them because of the respect I show them ... my father is old school [traditional/conservative] so I can't discuss with him.

Adolescent experiences of positive HSH communication with trusted adults in the community setting

While some adolescents were engaging in HSH communication with their parents or caregivers, many relied on people outside the household, such as friends and school teachers, to discuss

topics related to sexuality. Some adolescents said that they did not trust their peers for reliable information and would instead seek out HSH communication with elders and/or extended family members or community leaders such as pastors. Communication about sex appeared to be more open between adolescents and other relatives who were not their parents and/or immediate caregivers. For example, one 19-year-old male explains:

When it comes to relationships I would say that it is my granny [that I get information from]. The thing about my granny is that she guides me and she would tell me that if I want to be with a girl, I should take time to know her first and don't rush into having sex.

Another 18-year-old male identified his group leader at church as someone he goes to for information: 'Sometimes we go around the circle and ask [him] questions.'

Discussion

In this study, we qualitatively examined the experiences of HSH communication between parents and adolescents in Soweto, an urban setting in Johannesburg, South Africa. This topic is of particular importance for the post-apartheid generation of young people in South Africa who, despite having adequate knowledge about HIV and prevention, experience individual, social and structural influences that contribute to high risk behaviours and vulnerability to HIV (Bray, Gooskens, Moses, Kahn & Seekings 2010; Simbayi *et al.* 2005). Qualitative findings from this study revealed that adolescents identify multiple barriers to HSH communication. Findings were discussed with respect to five main themes: (1) Adolescents desire HSH communication with adults; (2) Disconnect between HSH information offered by parents and/or caregivers and adolescents' lived experiences; (3) Emotional and physical barriers to initiating HSH communication with parents and caregivers; (4) Sociocultural barriers to sexual health communication between generations; and (5) Adolescent experiences of positive HSH communication with trusted adults in the community setting. Despite these barriers to communication, adolescents expressed positive perceptions on how to improve future HSH discussions. Our research adds to the growing body of literature on the role of family communication in influencing positive sexual behaviours and supports future development of culturally specific approaches to sexual health education in the South African context.

Existing literature shows that, while peer education approaches are popular among students, they are not always effective. Rather, there is evidence that shows that interventions that engage adult role models as mentors are effective in building positive social relationships, reducing social isolation and fostering healthy behaviours among young people (Hallman, Govender, Roca, Pattman, Mbatha & Bhana 2007; Mantell, Harrison, Hoffman, Smit, Stein & Exner 2006; Schenk, Michaelis, Sapiano, Brown & Weiss 2010). There is a need for more effective HSH communication that extends beyond peer and family contexts to include community supports and resources. Programmes that involve and support families, such as healthcare facilities

and religious and community organizations play an important role in facilitating platforms for parents and children to communicate effective and accurate HSH information.

Studies from across Africa suggest that challenges to effective parent–adolescent sexuality communication most commonly include communication style and tone; in rural South Africa, findings suggest that communication style and negative attitudes towards young people are the biggest barriers to communication (Bastien *et al.* 2011; Phetla *et al.* 2008). In addition to parents, extended family members such as grandparents, aunts, uncles, elders and community leaders such as pastors, should be included in HIV prevention strategies and be provided with skills and accurate information to further communicate HSH information. This reflects the important role of the extended family in the sexual socialization of adolescents in South Africa (Bastien *et al.* 2011).

Existing family-level interventions highlight the importance of effective sexual health communication between parents and adolescents in offering appropriate information and reducing sexual risk (Diiorio, Pluhar & Belcher 2009). In particular, the importance of open and skilled discussions about sexuality and risk and the inclusion of communication skills training for parents (Diiorio *et al.* 2009). It is important for parents to have bold, honest and frank conversations with their children about HSH at an early age, before sexual initiation (Downing, Jones, Bates, Sumnall & Bellis 2011). Positive parental communication can offer emotional and social support to adolescents who may otherwise need to rely on peers (Tenkorang, Rajulton & Maticka-Tyndale 2009). Other research provides evidence that parents who are perceived by youth as skilled, comfortable and open in discussing sexual health issues are more likely to promote healthy sexual behaviour, including condom use (Diiorio *et al.* 2009).

Educational programmes and interventions must focus not only on the content of what is discussed, but also the process of how it is discussed (Hadley *et al.* 2009). Research has shown that factors influencing the presumed effect of parent–adolescent communication on adolescent sexual behaviours include communication style, content, frequency, sex/age of adolescent and timing (Eisenberg, Sieving, Bearinger, Swain & Resnick 2005). Furthermore, studies have shown that cross-sex (father–daughter and mother–son) and cross-generation differences in communication exist (Crosby, DiClemente, Wingood, Cobb, Harrington & Davies 2001; Remes, Renju, Nyalali, Medard, Kimaryo, Changalucha, *et al.* 2010; Wamoyi *et al.* 2010). In particular, mothers are more commonly cited as the primary parent involved in sexual communication and have discussions more frequently with daughters than with sons (Guzmán, Schlehofer-Sutton, Villanueva, Dello Stritto, Casad, & Feria 2003; Hutchinson, Jemmott, Jemmott, Braverman & Fong 2003). Despite the importance of these factors, there has been very little research to date, including research that considers the social and contextual influences that shape young people's experiences of sex and sexuality.

Our findings suggest that even though both parents and adolescents in Soweto acknowledge the difficulties of HSH communication, they desire more opportunities to discuss these issues in

a safe and positive manner. To address current challenges in HSH communication, gaps in knowledge regarding HSH must be addressed and different means for culturally appropriate communication in the South African context need to be further investigated. This may involve a closer examination of existing social media sources and innovative HIV prevention campaigns in South Africa to help youth and parents understand the context of HIV in their communities, and furthermore, opportunities for facilitated discussion between adolescent, family, and community members regarding HSH. Such discussions should consider all members in an adolescent's extended familial and community setting, be proactive rather than reactive, and empower adolescents to make healthy decisions as they become sexually active. Providing both adolescents and parents with basic HSH knowledge and communication and negotiation skills will facilitate future discussions between parents and adolescents on sexual health issues, and positively influence adolescent sexuality.

Limitations

The youth population in Soweto is very heterogeneous. Study participants were conveniently selected from one site in a large urban township; therefore, these results may not be representative of the experiences of all adolescents in Soweto or in South Africa. Additionally, this study qualitatively examined the experiences of parent–adolescent HSH communication. The research team did not obtain data on sexual behaviours nor ask participants to disclose information on their HIV status, past pregnancies or birth control. Further research that incorporates analysis of demographic information and data on sexual risk behaviour will likely paint a more comprehensive picture of adolescent sexual risk behaviour in this population.

Conclusion

Adolescents in sub-Saharan African are particularly vulnerable to HIV infection simply by growing up in HIV-endemic communities and remain an important target population for sexual health interventions. Worldwide, and in particular in South Africa, there have been many accomplishments in recent years with regard to sexual communication between adolescents, teachers and peers (Harrison, Newell, Imrie & Hoddinott 2010). However, challenges in HSH communication still exist. This study highlights practical examples of sexual communication experienced between parents and adolescents in the Sowetan context. Future research needs to explore means for supporting parents and adolescents in HSH communication, beyond abstinence, to include dialogue that occurs outside of the parent–adolescent relationship with extended family members and adult mentors, and the exchange of messages that focus on positive sexual health outcomes. Evidence-based public health programmes targeting HSH communication for adolescents are critical for empowering adolescents towards healthy sexual relationships. Increasing and enhancing effective communication that addresses the lived realities of adolescents has the potential to positively influence sexual health among adolescents in South Africa.

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