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Parent-Adolescent Communication on Risky Sexual Behaviour: Facilitators
and Barriers in KwaZulu-Natal, South Africa

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and Barriers in KwaZulu-Natal, South Africa

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COLLEGE OF HUMANITIES

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ABSTRACT

The consequences of adolescent risk-taking behaviours such as HIV/AIDs, teenage pregnancies, STIs, and depression have become a challenging health concern not only to themselves but to society at large. The adolescent stage is a difficult period that, if not well-handled and managed, can lead to all these challenges. In South Africa, HIV prevalence rates and unplanned teenage pregnancies continue to remain high. In response to this, a study on parent-adolescent communication on adolescent risk-taking behaviours was undertaken. Parent-child communication about sexual reproductive health issues is identified as an effective means to tackle these risks and encourage self-efficacy as well as behavioural change among adolescents. This study investigated communication between parents and adolescents in relation to adolescent risky behaviours.

Via the theoretical framework of the Extended Parallel Process Model, the study identifies the perceived threats to which adolescents are exposed, regarding their involvement in risky sexual behaviours and their perceived susceptibility and perceived severity of the consequences of risky sexual behaviour. Use of the Rommetveit and Blakar Communication model and Theory of Adolescent Development aims to identify the approaches that parents adopt, which may either hinder or engender effective communication. Furthermore, approaches that encourage self-efficacy regarding healthy sexual behaviour as well as the possible reasons for adolescents' involvement in risky behaviours.

In-depth interviews were conducted among eight participants (four adolescents between the ages of 18-21 and four parents who have adolescents within this age range) from Mayville, Durban. Theoretical thematic analysis generated four themes in relation to the research questions. These include i) parent-adolescent perceptions towards adolescent risk-taking behaviours, ii) sex-talk: factors that influence parent-child communication about sex, iii) information sources for sexuality and risky behaviour issues, iv) approaches in parent-adolescent communication on sexual matters.

The findings show a correlation between parent-child communication and adolescent risky sexual behaviours. Though participants acknowledged the importance of parent-child communication on adolescent sexual decision-making processes, communications were

primarily characterised by threats, instructions, warnings and emphasis on the consequences of risky behaviours such as HIV, unplanned pregnancies. These were perceived by parents to encourage behavioural change among adolescents while adolescents perceived this to hinder communication with parents, thus, encouraging exposure to other channels of communication such as media and/or peers. When adolescents perceived themselves to be vulnerable to the consequences and knowledgeable about the severity of these consequences, it was perceived to dissuade them from the risks. This study also found that opportunistic communication (a communication approach where both parents and adolescents sought immediate use of opportunities to initiate sexuality discussions) characterised with open communication allows for close and friendly parent-child relationships, and is more likely to encourage healthy behaviours. Communications were found to be triggered by community occurrences, television, and school work. Although findings from the study revealed that parent-child communication transpires within the family, a myriad of factors were identified to have hindered effective communication that could encourage adolescent self-efficacy in the face of risks.

Overall, the study found that when parent-child communication is deficient, it negatively affects adolescent sexual decision making. On the other hand, when parents engage their adolescents in sex communication, using an open discussion approach, it tends to encourage adolescents to engage in positive behaviours.

Keywords: Risky sexual behaviour, Parent-adolescent communication, facilitators, barriers, Mayville, South Africa.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drugs
CCMS	Centre for Communication, Media and Society
CDC	Centre for Diseases Control and Prevention
DBE	Department of Basic Education
DOH	Department of Health
DramAidE	Drama in AIDS Education
EPPM	Extended Parallel Process Model
HCO	Healthy Children Organisation
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
KZN	KwaZulu-Natal
MCP	Multiple and concurrent partner
NAFCT	National Adolescent Friendly Clinic Initiative
NGO	Non-Governmental Organisation
PPFA	Planned Parenthood Federation of America
SA	South Africa
SGBTI	Sexual Gay Bisexual Transsexual Intersexual
SOGI	Sexual Orientation Gender Identity
STI	Sexually Transmitted Infection
TAD	Theory of Adolescent Development
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNPF	United Nations Population Fund
UZ	University of Zululand
WHO	World Health Organisation

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CHAPTER ONE

OVERVIEW OF THE STUDY

Introduction

This generation of adolescents faces greater health risks due to the prevalence of sexually transmitted infections (STIs), early sexual debut, *human immunodeficiency virus* (HIV), unplanned pregnancy, and risky lifestyles such as hoodlumism, alcoholism, and drug use. Adolescents are engaging in sexual activities at younger ages each year. Sexual intercourse, oral sex, and anal sex are on the increase. The rapid increase of risky lifestyles and sexual behaviours among adolescents could be attributed to media influence, peer pressure, community influence, and poor interpersonal relationships between parents and their children, among others (Loew and Thompson, 2011; Ntarangwi, 2012).

Victims are adolescents ranging from 10 – 24 years of age (Department of Primary Health Care and Disease Control, 1995; WHO, 2014; Healthy Children Organisation, 2015). These organisations group people between the ages of 10-24 as adolescents because this period is regarded as a critical transition, characterised by rapid growth and changes in their physical, psychological and behavioural patterns¹. However, this study will focus on late adolescents within the ages of 18-21. The late adolescent stage (18-21) is marked by a transition of thinking in which an individual transits from the cognitive stage of concrete operational that is, early stage of adolescence characterised with under-developed cognitive maturity required to fully comprehend and carry out some risk reduction strategies (Halpern, et al. 2000), to formal operational stage in which adolescents develop the ability to think conceptually and futuristically (Fantasia, 2009:19). With increased access to media and its concomitant messages via television, internet, magazines, and music, late adolescents are actively engaging in sexual words, actions, songs, and pictures whether at school, at home, or in public (Loew and Thompson, 2011).

Globally, young people were claimed to account for an estimated 35% of all new HIV infections among adults (UNAIDS, 2016). Although, new HIV infections are decreasing across the globe,

¹ Although there have been controversies on the precise age group for adolescents but for the purpose of this study, people within ages 18-21 (late adolescents) were regarded as the study adolescents.

Sub-Saharan Africa was reported to have accounted for about two-thirds of new HIV infections (UNAIDS, 2016). South Africa is said to be the “worst affected country” with regards to HIV with about seven million people living with HIV, making it the highest HIV prevalence country in the world (UNAIDS, 2016). South African National Survey Statistics in 2012 reported an increased HIV prevalence of 12.2% compared with the previous national survey in 2008 (10.6%) (HSRC, 2014). Out of eleven (11) districts in KwaZulu-Natal, seven (7) districts recorded HIV prevalence of 40% and above (Department of Health, 2015). Additionally, there has been a continuous increase in teenage pregnancies with about 30% reported among adolescents in South Africa despite the decrease in fertility rate (Willan, 2013). Accordingly, a 2014 South African General Household Survey reported that out of the estimated 93,978 female learners who got pregnant, 18,533 pregnancies were from adolescents in KwaZulu-Natal (Department of Education, South Africa, 2015).

There are many biomedical as well as social science and communication-oriented prevention interventions that aim to curb this risky sexual behaviour (Scalway, 2010). Parent-adolescent communication on sex education is one of these and has been reported to have positive impact on adolescent’s sexual behaviours (Phetla, *et al.* 2008). The relationship between an adolescent and his or her family is a crucial factor for sexual knowledge, values, and behaviours. The adolescent’s family is a primary social influence, which makes it imperative that parents discuss sexual risks and protective factors with their young ones (Howell, 2001). For instance, in order to avoid sexual infections and its risks, parent-child communication was found to delay sexual debut (McBride, *et al.* 2005), encourage fewer sexual partners and increase use of contraceptives (Aspy, *et al.* 2007; Halpern-Felsher, *et al.* 2004; DiClemente, *et al.* 2001).

Parents and / or guardians² are in a unique position to provide preventive measures through constant, regular, intimate interactions and monitoring of their adolescents (Manuel, 2013). Parents, as a child’s first contact, have the primary role of ensuring the optimal growth and development of their children by meeting their physical needs and providing them a safe,

² Parents and/ or guardians are stated for this study because in the context of (South) African home, the reality of the nuclear family (father, mother and children) is not always the norm. The concept of a nuclear family is not always peculiar to most South African families rather, there are grandmothers, aunties, uncles and other relatives that take up parental roles in the absence of adolescents’ biological parents (Eddy and Holborn, 2011). The South African family system will briefly be explained in chapter two and made mentioned of in chapter four.

nurturing and supportive environment that is conducive for positive behavioural patterns (Vandenhoudt, *et al.* 2010; Kincaid, *et al.* 2007). Therefore, through them, values, morals and important risk prevention messages - that could delay sexual debut and promote positive, healthy sexual relationships - could be communicated (Vandenhoudt, *et al.* 2010).

Effective sex education is more likely to reduce teenage risky sexual behaviours when combined with effective parent–adolescent communication on children’s sexuality issues (Burgess, *et al.* 2005). A multi-site study showed that 30.7% of the male adolescents surveyed from Cape Town preferred mothers as their communication partner and 22.1% preferred discussing sex issues with their fathers compared to other influencing factors (Namisi, *et al.* 2009). However, irrespective of the source (father or mother) of information, a cordial relationship between parent/guardian and child could reduce an adolescent’s risky sexual behaviour compared with other methods of communication.

In spite of the evidence that shows parents’ effective influence on adolescents’ reproductive health, sexuality and reduction of risks involved, many parents still avoid or struggle to have sex-related conversations. This is due to uncertainty or lack of confidence on how to best educate their children on topics such as sexual health and relationships, what to say, where conversation should take place and when to start interaction (Coffelt, 2010; Holman, 2014). Literature reviewed for this study attributes barriers of parent-adolescent communication to being shy, fear of physical punishment, lack of information and other socio-cultural, religious and economic barriers (Paulsen, *et al.* 2010; Wang, 2009; Mbugua, 2007; Kumi-kyereme, *et al.* 2000). This study therefore seeks to explore these possible barriers in the context of parents/guardians and adolescents in Mayville, Durban, KwaZulu-Natal. It is clear that the determinants of adolescents’ sexual risk-taking behaviour relate to wider social issues both in South Africa and Sub-Saharan Africa at large (Department of Basic Education, South Africa (DBE) 2009, 2014; Falaye, 2004; Institute of medicine and National Research Council, 2011; Kincaid, *et al.* 2007; Wang, 2009). As such, parent-adolescent communication should be cognisant of these cultural, social and moral factors. It is important that adolescents gain adequate knowledge and well-informed perceptions about sex; this is an aspect in which the parent-adolescent relationship or the family background plays an indispensable role. With this, adolescents will be able to knowledgeably

deal with sexual matters. However, the exact impact of parental communication on adolescents' sexual behaviour is unclear. In some studies, it was found that early parent-adolescent communication about sex was associated with the delay of sexual activity and less risky behaviours (Opara, *et al.* 2010; Wamoyi, *et al.* 2010). In other studies, a relationship was found with early onset of sexual activity and more risky behaviours (Bushaija, *et al.* 2013; Botchway, 2004).

Thus, to devise effective preventative programmes for adolescents, this study is poised at exploring and examining the parent-adolescent communication with regards to sexuality and risky lifestyles. This work illuminates the views and opinions of parents and adolescents on the way families deal with issues of adolescent risks, sexuality and sex education within the context of Mayville, Durban, KwaZulu-Natal.

This study aims to identify facilitators and barriers that play key roles in the communication between parents and adolescents. It also aims to identify the factors that adolescents are exposed to that may encourage risky sexual behaviours and to investigate how parents understand reasons behind adolescents' possible sexual risk-behaviour. Furthermore, it aims to identify parent-adolescent communication styles and tones used when discussing sexuality and risky behaviours.

In this chapter, the literature regarding the background and context of the research problem is presented. An overview of the objectives, key questions and rationale behind this study are discussed. The chapter also gives a brief account of the study's theoretical and methodological approaches.

Study Objectives

The overall objective of this study is to examine parent-adolescent communication about adolescents' sexual risk-taking behaviour. This aim is further divided into three specific objectives:

- i. To identify the factors that adolescents are exposed to that may encourage risky sexual behaviours. This will include gaining an understanding of adolescents' perceived susceptibility and perceived severity of the consequences of such behaviour;
- ii. To investigate parents' understanding when considering the reasons behind risky sexual behaviours;

- iii. To identify facilitators and barriers in the communication between parents and adolescents on sexual issues and risky behaviours; and
- iv. To identify the communication styles and tones adopted during parent-adolescent communication.

Research Questions

The key research questions that guide this study are:

- i. What forms of teenage risky behaviour are adolescents exposed to in Durban?
 - What are the perceived threats adolescents are exposed to regarding their involvement in risky sexual behaviours?
 - What are the adolescents' perceived susceptibility and perceived severity of the consequences of risky sexual behaviour?
- ii. What issues are identified as most difficult and easy to discuss and why?
 - What are the perceived barriers hindering parents and adolescents from communicating these issues effectively?
- iii. What are the styles that parents adopt in communicating and educating their adolescents?
 - Which approaches engender effective communication?
 - Which approaches hinder effective communication?
 - Which approaches encourage self-efficacy regarding healthy sexual behaviour?
 - Which approaches discourage self-efficacy regarding healthy sexual behaviour?

Background to the Study

Adolescents' risky lifestyle in South Africa is an important policy issue faced with diverse health and social problems (Kalule-Sabiti and Arkaah, 2014). Various risky activities such as drug overdose, excessive alcohol intake and lack of contraceptives, place adolescents at risk of contracting STIs, HIV and unwanted pregnancies. For instance, lack of contraceptives or ineffective contraceptive methods during sexual intercourse, increases the risk of unplanned pregnancies and risky abortions among adolescents (UNAIDS, 2012). An overall estimate of 26.8% was reported among South Africans who had accurate knowledge of sexual transmission and HIV prevention; about 24.3% young adults were reported to be more knowledgeable

(HSRC, 2014). Despite the awareness of consequences of these risks, adolescents have continued to engage in risky sexual behaviours that pose threats to their health (Ramulumo and Pitsoe, 2013; Ndebele, *et al.* 2012). Furthermore, lack of self-efficacy to practice safe sex, attitudes towards risky sexual behaviour, multiple sexual partners, age disparate, peer pressure, myths and cultural beliefs as well as socio-economic factors contribute to adolescents' risky sexual behaviours (DBE, SA.2014; Ndebele, *et al.* 2012; Botchway, 2004; Madlala, 2008).

In Sub-Saharan Africa, parent-child communication about sexuality is common in families and mainly on same sex basis. It is often characterized with warnings, threats and physical discipline and is triggered by seeing or hearing something a parent perceives as a negative experience (such as a death attributable to HIV or unmarried young person's pregnancy) (Wamoyi, *et al.* 2010).

However, the majority of parents are still constrained in communicating with their children due to lack of knowledge and restrictive gender and cultural norms. (Wamoyi, *et al.* 2010). Previous studies carried out to assess the extent of sexual communication between parents and their children identified a number of barriers in parent-adolescent sexuality communication. These ranged from socio-demographic characteristics such as sex, age, urban or rural residence, socio-economic status, parental level of education, religious affiliation and other household characteristics such as family size and marital status of the parents (Nundwe, 2012; Gumede, 2012; Bastien, *et al.* 2011, Phetla, *et al.* 2008; Botchway, 2004).

In South Africa, findings revealed that cultural and religious constructions of taboo silenced direct communication and restricted sexuality discussions within the family. Also, parents' age, low educational level, lack of knowledge, and discomfort in talking about sexuality were reported to restrict conversations with children about sex. The child's age and gender were also reported to be a consideration in approaching these conversations (Chaweewan, 2011; Gumede, 2011; Luckerth, 2007). Often, female adolescents preferred receiving sexuality information from their mothers, while male adolescents preferred discussions with their fathers, with the perception that communication would most likely be understandable and free (Namisi, *et al.* 2009). Many studies conducted in South Africa with regards to sexuality and parent-adolescent communication show that, although there is communication between each group, it is often not

effective enough to prevent risky behaviours (Phetla, *et al.* 2008; Namisi, *et al.* 2009). This could be because most parents do not know effective approaches to take when communicating with their children nor do they understand reasons for their risky behaviours. Likewise, a breakdown of the South African family system, poor parental control, a lack of monitoring care and absence, exposes adolescents to risky sexual behaviours (Brook, *et al.* 2006; Eddy and Holborn, 2001; Branje, 2012; Ndebele, *et al.* 2012). Many victims of physical abuse and sexual violence are adolescents. Research in 19 countries including South Africa has documented sexual abuse (ranging from harassment to rape and incest) among 7-34% of girls and 3-29% of boys (De Bruyn 1999). Additionally, evidence shows that victims of abuse may be more prone toward risk-taking behaviours which can increase their chances of exposure to HIV, STIs, and unwanted pregnancies (De Bruyn, 2000). More recently, a global estimate of 40 million children were subjected to abuse on a yearly basis. One in three girls experience sexual molestation before the age of 17, while one in six boys experience sexual molestation before the age 17 (Ark of Hope for children, 2016). In South Africa, an overall average of 51 cases of sexual abuse and violence are reported daily. One in three South African children have experienced some form of sexual abuse (Gender, *et al.* 2016). Likewise, findings from a self-administered questionnaire on the national prevalence of sexual abuse reported an estimate of 35.4% among young people (Gender, *et al.* 2016). All these risk factors cause adverse effects to adolescents' health and society at large.

In South Africa, the leading risk factors that have contributed to the burden of disease profile are unsafe sex/sexually transmitted infections (31.5%), interpersonal violence (8.4%) and alcohol and drug use (7%), of which these risky lifestyles were majorly reported among adolescents (Medical Research Council, 2008). In spite of the legislative and biomedical successes in positively influencing the trajectory of teenage pregnancy (DBE, South Africa, 2009), rates of teenage pregnancy remain unacceptably high (Willan, 2013; DBE, South Africa, 2014). In sub-Saharan Africa, only eight male condoms were available per year for each sexually active individual and access to condoms among young people were claimed to be less (UNAIDS, 2014). This would more likely increase HIV infection rates.

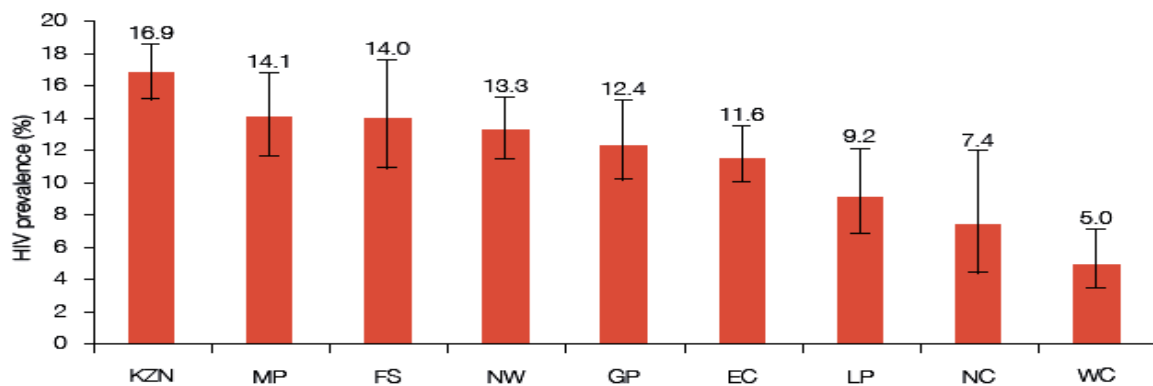
South Africa is challenged with the dual burden of high risky sexual behaviour and substance use (HSRC, 2009). A South African youth risk behaviour survey found that 13.3% of sexually active

adolescents reported using alcohol or drugs before sex. About 31.8% of adolescents reported drinking alcohol each month and a quarter reported to have over indulged themselves with alcohol (Reddy, *et al.* 2003). Also, data collected in Cape Town found that when adolescents use drugs they were more likely to have anal, vaginal and oral sex as well as getting pregnant or becoming responsible for a pregnancy (Pluddemann, *et al.* 2009).

As a result of the foregoing, this study documents previously identified factors that influence adolescents' risky sexual behaviours from past studies. It then elucidates the factors that Mayville adolescents are exposed to, that may encourage risky sexual behaviours, and provides an analysis of adolescents' perceived susceptibility and perceived severity of their behaviours as well as barriers to communication between parents and adolescents and communication approaches and tones.

HIV Prevalence in South Africa

National household surveys have previously shown that South Africa has the largest number of people living with HIV globally and that the HIV epidemic is generalised (HSRC, 2014). It has also been established that the epidemic is heterogeneous, with wide variations in HIV prevalence across age, race, sex, socio-economic status and geographical location (HSRC, 2009). The results of the analysis of HIV prevalence estimates by key demographic variables, suggest that the overall HIV prevalence differed substantially by province (HSRC, 2014) as shown in the figure below.



Key: KZN – KwaZulu-Natal, MP – Mpumalanga, FS – Free State, NW – North West, GP – Gauteng, EC – Eastern Cape, LP – Limpopo, NC – Northern Cape, WC – Western Cape

Figure 1.1: Overall HIV Prevalence by Province, South Africa 2012

Source: HSRC, 2014

According to the 2014 report released by Human Science Resource Council, among the nine provinces in South Africa, KwaZulu-Natal amounted to about 16.9% (HSRC, 2014). However, KwaZulu-Natal still has the highest HIV prevalence in the country; and as found in previous HSRC surveys (2005, 2009), the province continues to lead all nine provinces in terms of HIV prevalence. One of the most urgent crises facing the province is the unparalleled prevalence of HIV infection among its citizens. Provincial variation was evident, the top four high HIV-prevalence provinces being KwaZulu-Natal, Mpumalanga, Free State, and the North West, and the lowest, the Western Cape. However, the relative ranking of provinces by HIV prevalence has remained the same since 2005 (HSRC, 2014) (see Figure 1.1 above). At the district level, HIV prevalence is clustered in specific districts located mostly in KwaZulu-Natal, Mpumalanga, and the Free State, as well as some districts in the North West. (HSRC, 2014). Durban, which is the study location and one of the districts in KwaZulu-Natal, has an HIV prevalence of approximately 41.1% (Department of Health, 2015). Out of the eleven (11) districts in KwaZulu-Natal, seven (7) districts recorded HIV prevalence of 40% and above (Department of Health, 2015).

Geographical differences were found by locality type and also by province. Rural/informal area residents had a significantly higher HIV prevalence than urban formal area residents. With respect to locality type, HIV prevalence continues at a high rate in the informal urban areas compared to all other areas. eThekweni in KwaZulu-Natal and Ekurhuleni in Gauteng had the highest HIV prevalence, followed closely by Buffalo City, in the Eastern Cape. The Cities of Tshwane and Johannesburg each had HIV prevalence slightly lower than the national average, but not significantly so. The three metros that had lower HIV prevalence than the rest of the provinces (and the national average) are Nelson Mandela Metro in the Eastern Cape, Mangaung Metro in the Free State, and the City of Cape Town, which has the lowest recorded HIV prevalence (HSRC, 2014).

The incidence of infection was reported to be predominantly high among young people (HSRC, 2014; Kott, 2010). For adolescents aged between 15–24 years, the overall HIV prevalence in the

2012-2016 national HSRC survey was 7.1%. In 2012, the World Health Organisation (WHO) also showed high HIV prevalence rates of 17.9% among the general population between the ages of 15–49 in South Africa (WHO, 2012). Within the context of this high prevalence of HIV occurrence among adolescents in KwaZulu-Natal, it is important to examine adolescents' risky sexual behaviours in the area which place them at risk of contracting STIs or HIV and unwanted pregnancies.

Teenage pregnancy in South Africa

Teenage pregnancy constitutes yet another major problem in South Africa. A high percentage of young learners reportedly drop out of school due to pregnancy. Various socio-economic factors including family structure, environment, school dropout, poverty, unemployment and peer pressure contribute to adolescent's unintended pregnancies (DBE, South Africa, 2009:11; 2013:39). More so, WHO (2015) suggests that sexually active adolescent girls are less likely to use contraception even if it is widely available. The reason could be that girls are sometimes subjected to unwanted or coerced sex, which tends to be unprotected (WHO, 2015). All these factors exacerbated the high rates of teenage pregnancy in South Africa.

A 2014 national household survey conducted by the Department of Basic Education, S.A. indicated that approximately 2.7% of school learners had fallen pregnant. KwaZulu-Natal and Eastern Cape recorded the highest number of learners that fell pregnant in recent years, 18,533 and 15,870 respectively (DBE, SA, 2015). An Analysis of provincial trends of the EMIS data on teenage pregnancy revealed an increase in learner pregnancies between 2004 and 2008 which shows a concentration of learner pregnancies in the Eastern Cape, KwaZulu-Natal and Limpopo (Panday, *et al.* 2009). This shows that there had been a higher concentration of teenage pregnancies in KwaZulu-Natal. However, an overall estimate indicated 93,978 adolescent school learners to have fallen pregnant in 2014 compared with 2013 national survey; where about 99,000 female learners indicated that they had fallen pregnant (DBE, SA, 2015) (see Table 1.1 below). More importantly, the location of the study, Mayville, reported a high teenage pregnancy

rate of about 36% among adolescents³. As a result of this, there have been increased rates of school dropout among learners.

Province	2009		2010		2011		2012		2013		2014	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Eastern Cape	8 917	1.0	12 438	1.3	16 446	1.6	14 896	1.5	20 698	3.8	15 870	3.1
Free State	2 477	0.7	2 775	0.8	1 082	0.3	2 425	0.7	4 309	2.2	6 741	3.8
Gauteng	9 656	0.9	18 823	1.6	8 100	0.7	9 052	0.8	9 428	1.3	12 786	2.0
KwaZulu-Natal	16 124	1.1	16 997	1.2	14 428	1.0	18 680	1.3	26 468	3.0	18 533	2.3
Limpopo	14 854	1.7	25 321	2.7	21 016	2.5	11 134	1.3	13 941	2.5	15 818	3.2
Mpumalanga	6 660	1.1	8 088	1.4	5 377	0.9	14 155	2.5	11 854	3.4	11 298	3.8
North West	4 673	1.1	5 664	1.3	2 822	0.6	6 603	1.5	7 359	2.8	4 512	1.9
Northern Cape	778	0.5	1 574	1.1	403	0.3	1 543	1.1	1 173	1.5	1 388	1.9
Western Cape	6 710	1.2	2 951	0.5	1 505	0.3	3 189	0.5	3 811	1.1	7 033	2.1
National	70 848	1.1	94 630	1.4	71 179	1.1	81 678	1.2	99 041	2.5	93 978	2.7

Table 1.1: Percentage and number of female learners that fell pregnant, 2009 to 2014.

Source: Statistics South Africa General Household Survey, DBE own calculations, 2015

Adolescent sexual debut before age 15 is also on high increase (HSRC, 2014). Evidence from a longitudinal study conducted in South Africa found that early sexual debut among adolescents at age 15 for boys and 16 years for girls (Richter, *et al.* 2015). This has increased the probability of teenagers falling pregnant which is likely to increase the risk of HIV infection and other sexually transmitted diseases, as well as other sexual risky consequences (Richter, *et al.* 2015; Stöckl, *et al.* 2013). However, despite the awareness of the high rate of HIV infections and unwanted pregnancies, adolescents have continued to engage in risky sexual behaviours that pose a threat to their health. Although many studies have been conducted in South Africa with regards to sexuality and parent–adolescent communication, the rate of teenage pregnancy occurrence is still high in KwaZulu-Natal, hence, the researcher’s reason for choosing Mayville area of KwaZulu-Natal as study location.

Location of the Study Area

KwaZulu-Natal, the second largest province in South Africa, was established in 1994 when the Zulu Bantustan of KwaZulu and Natal Province were merged. It is located in the Southeast of the

⁴http://www.durban.gov.za/Document/City_Government/Media_Publications/Ezasegagasini_Metro_Gazette/2009/11%20September%202009%20Ezasegagasini%20Page%205.Pdf accessed on 24 May, 2016

country beside the Indian Ocean, sharing borders with the three other provinces and the countries of Mozambique, Swaziland and Lesotho (Heyevent, n.d). Its capital is Pietermaritzburg with Durban as its largest city. KwaZulu-Natal is divided into eleven districts. One of these, eThekweni (Durban and surrounding area), is a metropolitan municipality and the other ten are district municipalities.

Durban, the primary area of research has a population of approximately 10, 267, 300 (Statistics South Africa, 2011) with a land area of 94,361 square kilometres taking up 7.7% of South Africa's total land area. Durban has a large and diversified economy with strong manufacturing, tourism, transportation, finance and government sectors.

The study's participants are from Mayville (eThekweni District) which is a suburb located in the North Central part of Durban. Mayville suburb is a residential area situated five kilometres west of the Durban city centre. Mayville, an area which was initially dominated by chiefdoms such as the Nqondo clan and Ntuli clan is known for its rich cultural and political heritage. As a result of industrialisation and urbanisation, it attracted more people-Africans, Zulus as well as Indians to reside in the area. However, due to the housing problem, more shacks were built (South African history online, 2011). More recently, as a result of the development project in Durban, low-cost housing, heritage centres, clinics, schools, library, and community centres and over 90,000 homes have been constructed in the area. Mayville was selected as the study location because of high prevalence of adolescents' risky sexual behaviours (HSRC, 2014; Department of Health, 2015; Maverick, 2015:29).

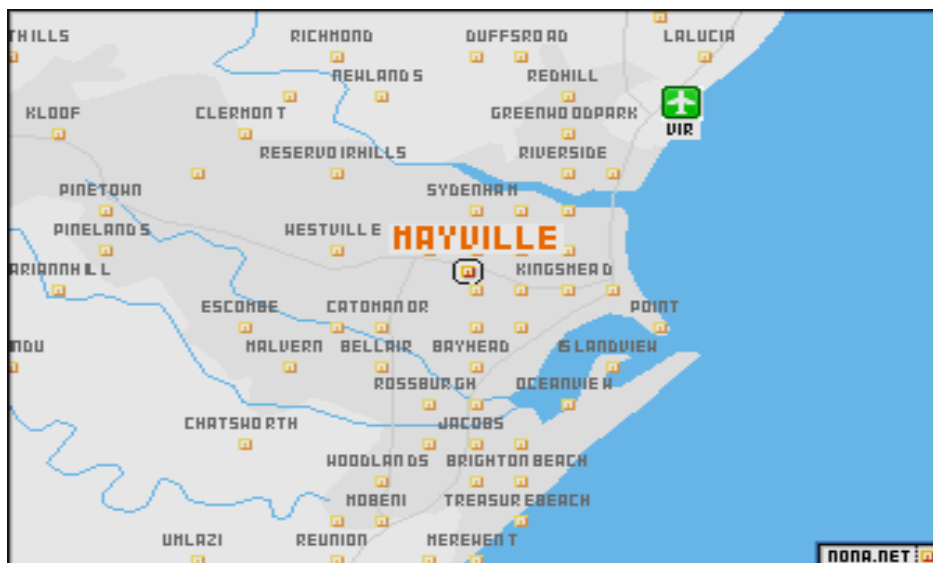


Figure 1.2. Map of Mayville, Durban Showing the Location of the Study Area

Source: <http://nona.net/features/map/placedetail.1015047/Mayville/> accessed on 19 June, 2017

The choice of the location is also based on the researcher’s accessibility to data. Data was collected through in-depth interviews with the help of the NGO, Drama in Aids Education (DramAidE) as the facilitator. The goal is to train young people about sexual health and equip them with the skills to inform and communicate with others using drama and theatre (Dalrymple, 2005; Cardey, *et al.* 2013). DramAidE was initiated in 1992 at the University of Zululand (UZ), as a project within the Department of Arts and Culture. Since then it has grown into a unit in the Department and is now also a unit in the Centre for Communication, Media and Society (CCMS) at the University of KwaZulu-Natal (UKZN) (Dalrymple, 2005).

In its methodologies, DramAidE uses drama, “to critically engage young people to communicate effectively about issues relating to sex, sexuality and HIV/AIDS” (Mugira, 2007:3). In so doing, it facilitates critical awareness and provides information on these health issues. DramAidE is a successful HIV/AIDS programme that has been well received in South Africa. Since its inception, DramAidE has been using the creative arts as an enterprise to communicate public health messages. Using performing arts and other participatory methodologies, DramAidE uses a bottom up approach where participants assume the responsibility for their own development and are viewed as agents of change (Dalrymple, 2005). DramAidE also uses peer education to train students in participatory techniques and advocacy initiatives to stage their own events at

tertiary institutions for HIV prevention, awareness, care and support (Cardey, *et al.* 2013). DramAidE focuses on creating a network of peer educators organized in clubs that practice safer sex and other positive behaviours. The clubs are meant to provide avenues for peer educators to undertake health promoting communication campaigns through action media that involves plays, posters, songs and dances that have been created by young people through a participatory process. It works within all educational institutions, primary, secondary and tertiary in KZN (Dalrymple, 2005; Cardey, *et al.* 2013; Mugira, 2007).

DramAidE began working in Mayville, May 2016. It was set up to reach out to the community and sensitise it on the issue of HIV/AIDs, Sexual Orientation Gender Identity (SOGI), Sexual Gay Bisexual Trans-sexual Intersexual (SGBTI), gender based violence and gender norms identification through organised forums. DramAidE started by mobilising the people through door-to-door outlet. Through stage drama, they engage the audience and interact on a discussed theme. Recently, they introduced stepping stone sessions where people are trained for 10 days and issued a certificate of attendance. Likewise, soccer sessions have also been introduced where the community is invited to watch, providing a platform from which DramAidE attempts to sensitise the people on HIV/AIDs prevention. The aim and objective is to use participatory drama and other interactive educational methodologies for HIV/AIDS, life-skills and sexuality-education. These methodologies are participatory, non-judgmental, culturally sensitive and accessible to all ages, levels of education and cultural backgrounds (Devex, n.d.). Other aims of the organisation include: i) reduce the HIV infection rate amongst South African youth, ii) promote gender awareness and equity, iii) promote better decision-making pertaining to relationships and health iv) reduce the stigma and discrimination around HIV/AIDS and v) initiate and establish clubs and support groups to promote healthy behaviours (Devex, n.d.).

DramAidE's mission has always been the prevention of the spread of HIV and was defined in 2001⁴ as follows: Informed by action-research, DramAidE strives to facilitate critical awareness, provide information and develop the skills to build a social movement towards an education that acknowledges the right to health and wellbeing for everyone. However, DramAidE aims to explore parent-adolescent communication with regards to sexuality and risky lifestyles in order to improve the effectiveness of preventative programmes for adolescents, coincide with the aim

⁴ This was disclosed by the DramAidE facilitator I worked with in soliciting for the study participants

of this study. This makes it a suitable facilitator for this research work because of the research relationship. DramAidE is a unit in the Centre for Communication, Cultural and Media Studies (CCCMS) at the University of KwaZulu-Natal (UKZN), they are right on the campus which gives the researcher easy access to it as a student in the department. More so, DramAidE will play a significant role during data collection via surveys and interviews.

Rationale for the Study and Significance

The rate of adolescent risky sexual behaviours and the spread of HIV, STIs and unintended pregnancies continue to be on the increase due to many factors including hoodlumism, alcoholism, drug use and early sexual debut. Globally, approximately one million young women aged 15-19 become pregnant yearly; the vast majority of these pregnancies are unplanned (WHO, 2015). Unprotected sexual intercourse and inconsistent or no condom use has been identified as one of the risky sexual behaviours adolescents involved in which is high among these age groups (Vukapi, 2016; WHO, 2015).

Globally, an estimated 2.1 million persons were newly infected with HIV in 2015 and Sub-Saharan Africa was the hardest hit with an estimated 25.5 million people living with HIV with vast majority- 46% of the new HIV infections - reported in east and southern Africa in 2015 (UNAIDS 2016). Of the total number of people living with HIV in South Africa, adolescents accounted for an estimated 25% of the new infections (HSRC, 2016). South Africa has approximately seven million people living with HIV with increased rate of incidence reported among young people (HSRC, 2014; Kott, 2010).

In South Africa, an overall estimate of 2.7% (93,972) school learners were reported to had fallen pregnant based on the 2014 national survey of which KwaZulu-Natal recorded the highest number of learners that fell pregnant in 2014 (DBE, South Africa, 2015). However, a major gap in the effort of curbing or preventing sexual risk behaviour among adolescents relates to the attention paid by parents who can directly influence adolescent behaviours (Griffin and Botvin, 2010). These findings emphasise the urgency of enabling parents to communicate with young adolescents in order to prevent further spread of HIV and to avoid unwanted pregnancies and other associated problems. Holistic and well-structured sexuality messages from parents to their children will help to prevent unhealthy sexual behaviour, prepare adolescents to have healthy attitudes and behaviour towards sex. On the other hand, a poor knowledge about sex, HIV, STIs

and contraceptives knowledge, coupled with the prevalence of sexual activities, impedes adolescents from adopting healthy sexual lifestyles.

Parents are the primary and most reliable source of information to adolescents on sexuality issues (Manuel, 2013). It is therefore pertinent to examine parent-adolescent communication about sexual risk-taking behaviour. Healthy development of adolescents is dependent upon several factors such as: the environment in which they live and grow. The family, as the first contact, plays a vital role in healthy adolescent development (Rafei, 2000). Parents have more influence on their children than other influential factors and as a result, they could model the positive lifestyles they want in their adolescents (Manuel, 2013). Parents were regarded as key socialising agents, having a unique way of engaging, shaping and preparing their children towards sexuality compared with other interventions that lack emotional and appraisal support (Manuel, 2013).

Previous scholarship highlights the general factors engendering and hindering parent-adolescent communication (Bastien, *et al.* 2011). It also provides analyses on risk influences amongst youth (Brook, *et al.* 2006; Anderson, *et al.* 2004; HSRC, 2014), their interpretation of pro-social health messaging (Mutinta, 2014) as well as risky sexual behaviour itself (Brook, *et al.* 2006; Mutinta, *et al.* 2013; HSRC, 2014). This literature will be reviewed in the next chapter.

This study goes further to investigate the issues most difficult to discuss between parents and adolescents. Additionally, the study investigates the approaches parents adopt in communicating with their adolescents within the context of Mayville, Durban, KwaZulu-Natal. Though, previous studies have identified different parent-adolescent communication styles (details in chapter two) which cut across mutually interactive communication, opportunistic communication, child initiated communication, avoidant communication, reactive communication (Gumede, 2011; Chaweewan, 2011; Mtikrakra, 2009; Mbugua, 2007; Rosenthal, *et al.* 1998) and tones such as threats, warning, instructions, cautions and so on (Bastien, *et al.* 2011). This study will further investigate if there is any relationship between parents' communication styles and adolescent's sexual activities. Furthermore, it will identify strengths and weaknesses in certain methods adopted by the study sample.

Moreover, this study will provide an in-depth understanding of factors that lead to sexual activities among adolescents and identify risks involved within a KwaZulu-Natal township

context. It will provide an analysis of the adolescents' perceived susceptibility and perceived severity of the consequences of sexual behaviour and the ways parents understand reasons for their adolescents' possible risky sexual behaviours.

Framing the study: Theoretical framework and Methodology

The study is framed by behavioural change communication (Rogers, 1983; Bandura, 1986; Witte, 1992; Maloney, *et al.* 2011). The behaviourist theory or model is an attempt to explain human personality. It is a framework of learning which believes that all behaviours are acquired based on the behavioural influences, cognitive factors and environmental influences (Bandura, 1986). The theory and models within behaviour change communication that will assist in reinforcing the subject matter of the study include: the: i) Extended Parallel Process Model (EPPM) (Witte, 1992; Maloney, *et al.* 2011), ii) Rommetveit and Blakar communication model (Blakar, 1984; 1992; Botchway, 2004) and iii) Theory of Adolescent Development (TAD) (Piaget, 1950; Erikson, 1969; Marcia, 1980, 1996, 2007; Bosma, 1992; Meeus, 1996; Luyckx, *et al.* 2008; Steinberg, 2008; Sokol, 2009).

Extended Parallel Process Model

The Extended Parallel Process Model (EPPM) (Witte, 1992) is a framework that attempts to explore how individuals react when faced with fear inducing stimuli. Adolescents are surrounded with diverse influential factors such as parents, peers, teachers and media, which tend to change them positively (when self-efficacy is encouraged) or negatively. This model expanded on fear-as-acquired drive model (Hovland, *et al.* 1953), Leventhal's fear control (Leventhal, 1970) and Roger's protection motivation theory (PMT) (Rogers, 1983). The EPPM, as a theoretical model of fear appeal messages, explains the successes and failures of previous fear appeals, then reincorporates fear as the central variable (Witte and Allen, 2000:611).

The EPPM is useful in this research as it assists in exploring the perceived susceptibility, severity and threat of risky sexual behaviour as well as the perceived barriers to effectively communicate these behaviours. The study also adopts the EPPM because it considers the centrality of self-efficacy in the face of threat, and encourages individuals to adopt a healthy behaviour.

Rommetveit and Blakar communication model

The Rommetveit and Blakar communication model (Blakar, 1992) recognises the need to consider factors that can engender or impede effective communication, putting into cognisance the four major elements of communication process - sender, medium, receiver and feedback. The Rommetveit and Blakar communication model (1984) is a dialogical perspective whereby interactions occur between two parties (Parents and adolescents) with each having influence on another (Blakar, 1984). The Rommetveit and Blakar communication model is adopted in this study because it addresses relevant issues of the communication process and explains communication as a two-way process whereby both sender (in the case of parent and adolescent) and receiver (in the case of adolescent and parent) interchange roles (Wang, 2009). This model therefore assists in the analysis of the various factors that affect sex communication between parents and adolescents.

Theory of Adolescent Development

The Theory of Adolescent Development (TAD) (Piaget, 1950; Erikson, 1968 Marcia, 1980; Steinberg, 2008; Sokol, 2009) is another framework that informs this study. The study incorporated various aspects of adolescent development theory with respect to adolescents' risky sexual behaviours and parent-adolescent relationship. TAD was adopted in order to understand and take cognisance of the changes in parent-adolescent communication during the transition from childhood to adolescence, and to understand the way children develop and learn. More importantly, it aims to understand the reasons for adolescents' involvement in risky sexual behaviours. Adolescence is characterised by a variety of biological changes that involve dramatic transitions in the physical, social, sexual, emotional, moral and intellectual and cognitive spheres (UKEssays, 2015; Becket, *et al.* 2010; Crockett, *et al.* 2003). Various factors such as intergenerational differences on sex issues, adolescent strive for autonomy, privacy, role diffusion (Laursen, 2012; Panday, *et al.* 2009; Steinberg, 2008; Botchway, 2004) were identified in this theory to create gap between parents/ caregivers and the adolescents.

Methodology

This study adopts a qualitative research approach that enables research participants to describe their experiences and express their opinions and thoughts about parent-adolescent sexual

communication. A descriptive phenomenological design (Husserl, 1931) is adopted because it relates to personal experiences and aids in the understanding of the social and psychological phenomena of the people involved, typified in this study by parents and adolescents (Welman and Kruger, 1999).

The sample population for this study is adolescents between the ages of 18 and 21; likewise, uneducated and low income earning parents who have adolescents of the ages of 18-21 were selected from Mayville Township. Purposive sampling was employed in selecting participants who are deemed a relevant population to the study (Seale, 2012). Data was therefore collected via one-on-one in-depth and open-ended interviews with four (4) adolescents who are between 18-21 years and four (4) parents who have adolescents above 18 years of age. Thus, the sample size for this study is eight (8) interview participants.

Thematic analysis (Braun and Clarke, 2006) serves as a check and guide during the course of data analysis. Thematic analysis, as a form of qualitative research, is defined as a process of pinpointing, examining and recording patterns within the data (Braun and Clarke, 2006). For this study, a theoretical thematic analysis that tends “to be driven by the researcher’s theoretical or analytic interest in the area” is employed (Braun and Clarke, 2006: 84). This form of thematic analysis tends to provide less of a “rich description of the data overall, and a more detailed analysis of some aspect of the data” (Braun and Clarke, 2006:84). The identified themes will then be discussed in the light of the identified theoretical framework introduced above.

Structure of the Study

This dissertation is divided into six chapters. Chapter one briefly introduced the background of the study both in terms of its problem statement and its location in the Mayville Township of KZN. It also introduced the work and value of DramAidE as a facilitator in this research. Part of the rationale and reason for this study is provided with reference to relevant past literature and statistics relating to adolescent pregnancy, early sexual debut and, HIV and AIDS prevalence in South Africa (specifically KZN), as consequences of risky sexual behaviour among adolescents. It also briefly notes some reasons for the lack of communication between adolescents and parents. This is discussed in more detail in chapter two. The theory, methodology and key research questions guiding the study were also delineated.

Chapter two gives an overview of the literature concerning sexual risk behaviours of adolescents and parent-adolescent communication thereof as well as parent-adolescent fear appeal messages. In order to contextualise this main discussion, it provides information on the prevalence and incidence of risky sexual behaviours in adolescents such as drug abuse, alcoholism, early sexual debut and transactional sex. Furthermore, it provides information on the consequences of these acts, such as unwanted pregnancy, STIs and HIV.

Chapter three explains the theoretical frameworks that guide the study and the relevance to the study as well as the criticisms. Each theoretical framework assists with making sense of the research questions and they include the Extended Parallel Process Model, Rommetveit and Blakar Communication model and Theory of Adolescent Development.

Chapter four delineates the qualitative methodological approach of the study with an explanation as to why the chosen techniques are suitable for this study. It provides details on the research design, sampling, data collection and the form of analysis to be adopted in the following chapter (chapter five) where findings are analysed. The limitations of the researcher's field experience are also outlined in chapter four.

Chapter five provides a discussion of the findings from the in-depth interviews that aimed to reveal the attitudes of parents and adolescents towards risky sexual behaviours and the barriers that prohibit or promote parental communication about sex with adolescents. An analysis of the findings will be organised thematically and in the light of the identified literature in chapter two and theory in chapter three.

Chapter six describes the overall conclusion emanating from the study, in response to the key questions as interpreted with the aid of previously discussed literature and theory. The dissertation concludes with the identification of areas for further research on the topic.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The previous chapter introduced the study that seeks to identify the risks to which adolescents are exposed and that may encourage risky sexual behaviours. This includes gaining an understanding with regards to the adolescent's perceived susceptibility and perceived severity of the consequences of such behaviour. It also aimed to identify facilitators engendering and barriers hindering parents and adolescents from communicating these risky sexual behaviours, as well as examine the approaches parents adopt in communicating and educating their adolescents on sexuality and its related topics. This chapter discusses the relevant literature that contextualises the study in terms of; adolescent sexual behaviour (Mutinta, *et al.* 2013; Madlala, 2008; Sychareun, *et al.* 2013), factors associated with adolescent sexual activities (Brook, *et al.* 2006, Anderson, *et al.* 2004), parent-adolescent communication (Branje, *et al.* 2012; Bastien, *et al.* 2011; Gumede, 2011; Rosenthal, *et al.* 1998), fear appeal in family communication on sexuality (Maloney, *et al.* 2011), factors engendering and hindering parent-adolescent communication (Bastien, *et al.* 2011; Gumede, 2011), Nature of communication in a typical African setting (Utley, 2008), (South) African parenting and sex education (Ntarangwi, 2012; Eddy and Holborn, 2011).

Adolescent Risky Sexual Behaviours

Globally, approximately 16 million adolescents aged 15-19; about one million under age 15 become pregnant every year (WHO, 2014). Of these, about three million engage in unsafe abortion, further placing their lives at risk (Chola, *et al.* 2015; WHO, 2014). Yearly, about three million adolescent girls undergo (unsafe) abortion, accounting for high rate of mortality (WHO, 2014). In South Africa, according to the 2015 annual school survey, over 15,000 pupils fell pregnant during the academic year (EWN, 2017). The rate of pregnancies at schools has become a major social challenge not only for the education sector, but also more importantly for national development (EWN, 2017). Reasons for abortion include shame, financial resources, fear of parents, punishment and limited access to reproductive information and advice (Chaweewan,

2011; Brown, *et al.* 2001). Similarly, in South Africa about 1.86 million more people are living with HIV than in 2008 of which adolescents aged 15-24 account for an estimate of 7.1% (Statistics South Africa, 2017; HSRC, 2016).

Risky sexual behaviors are defined as sexual activities that may expose an individual to the risk of Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus (HIV) and unplanned pregnancies (Famutimi and Oyetunde, 2014). Adolescence is a period accompanied with body changes, whereby most children become sensitive to sexuality and engage in sexual thoughts and acts (Becket, *et al.* 2010; Crockett, *et al.* 2003). Adolescence is divided into three developmental periods- early adolescence (10-13), middle adolescence (14-17) and late adolescence (18-early twenties) (Smetana, *et al.* 2006). This section therefore explored adolescent risky sexual behavior globally and then looked at these behaviors in the South African context.

Although sexuality and risky behaviours are characteristics of adolescence, these behaviours have become a major concern for parents, schools, health care professionals and researchers (Holman, 2014). The number of adolescents involved in risky sexual behaviour is increasing on a daily basis, exposing more of them to the dangers of sexually transmitted diseases and unwanted pregnancies. Influencing factors such as peers, media, and environment could partly be as a result of the misconceptions they have about sex, as could parents' attitudes and lack of or insufficient information about sex (Loew and Thompson, 2011). Alcohol intake, drugs use, smoking, dating violence, hoodlumism and even other emerging addictions such as gaming and the Internet, jointly contribute to early sexual activities among these age groups (CDC, 2009; Loew and Thompson, 2011:5).

The risky sexual behaviours that many young people engage in can result in unintended health challenges. According to the 2015 Youth Risk Behaviour Survey in the United States of America, 41% of high-school students reported ever had sexual intercourse, 30% had had sexual intercourse during the three months preceding the survey, 43% did not use condom during their last act of sexual intercourse and 21% were under the influence of alcohol and drugs before the last sexual intercourse while only 10% of sexually active students reported ever been tested for

HIV (CDC, 2016). The age at which adolescents attain puberty stage is faster. For instance, boys start between age 9-14years while girls start between 8-13years (UNAIDS, 2002). Data gathered among six Caribbean countries indicated that about one-fourth of the in-school adolescents had experienced sexual debut before age 15 (Peltzer and Pengpid, 2016). The earlier adolescent's sexual debut, the higher the rate of unwanted pregnancies, childbearing and STIs (Mmbaga, *et al.* 2012). Even though, there has been a progressive increase in the rates of condom use generally (WHO, 2014; Bankole, *et al.* 2007), inconsistent and incorrect usage and the likelihood that condoms are discontinued in longer term relationships were found to hinder the success of condom use programs (Niccolai, *et al.* 2004; Insabella, 2000). Young adults tend to use condoms with their sexual partners within a short period of their relationship while on an average, most adolescents ignore condom usage after 21 days of relationship (Niccolai, *et al.* 2004). It was also found that adolescents use condoms repeatedly with multiple sexual partners by turning it inside out (Schear, 1999 in Schear, 2006: 5).

According to Centre for Diseases Control and Prevention (CDC) survey, respondents who reported high intake of alcohol and substance use (drugs) indicated involvement in high sexual behaviours such as unprotected sex (CDC, 2010). Similar studies found that adolescents who reported high intake of alcohol and drug use were more likely to engage in sexual activities, have multiple sexual partners, early sexual debut and likelihood of not using contraceptives during sexual intercourse (CDC, 2006; Johnston, *et al.* 2006). All these behaviours make adolescents prone to unwanted pregnancies and STIs. Increased level of alcohol usage among adolescents has resulted to various sexual risks. As a result of their sexual urge, they tend not to use protective means (Smith, *et al.* 2007; Insabella, 2000; O'Donnell, *et al.* 1994). While adults view adolescents' behaviours as risk taking, adolescents, on the other hand, do not see their behaviour as risky but rather as unique, being independent, invulnerable, taking for granted the negative consequences of their actions (Hockaday, 2000).

In South Africa, young people are exposed to risks such as STIs, HIV/AIDS, as well as unwanted pregnancies. This owes to early and often risky sexual behaviours which, by consensus, appear to be as a result of different factors such as early sexual debut, unprotected sexual intercourse, multiple and concurrent partners (MCP), inconsistent or no contraceptive use, sexual intercourse for reward, alcohol consumption and drug use, and misconceptions they have

about sex (Motsomi, *et al.* 2016; Beksinska, *et al.* 2013; HSRC, 2012; Madlala, 2008). It is therefore pertinent for both parents and adolescents to disclose and discuss extensively, issues regarding sex and other risky behaviours.

There have been increases in the percentage of adolescents who had their sexual debut before the age of 15, especially among male adolescents (HSRC, 2014; Zuma, *et al.* 2010). This early onset of sexual activity has been reported to increase the risk of HIV infection (HSRC, 2014:115). About 11% of adolescents before age 15 were reported to be sexually active of which male adolescents reported higher percentage of sexual debut before age 15 compared to female adolescents (HSRC, 2014).

Furthermore, adolescents frequently do not practice safe sex. Unprotected sexual intercourse and inconsistent or no condom use has been identified as one of the risky sexual behaviours adolescents are involved in, with a high occurrence among these age groups (HSRC, 2014). Condom use has been identified as one of the most effective means to combat HIV, STIs and unintended pregnancies, especially among sexually active adolescents, yet, insufficiency, inaccessibility and unavailability of condoms are main challenges in South Africa (Vukapi, 2016; Nkosi, 2013). A 2012 national survey found that only 45.7% adolescents reported consistent condom usage (HSRC, 2014). Aside accessibility and availability challenges to lack of condom use, fear of rejection by adolescents' love partners and low risk of contracting HIV infections were found to have hindered contraceptives usage among South African adolescents (Madlala, 2008). Likewise, in the case of age disparate relationships, older partners were found to have erroneous beliefs that adolescents are more likely to be free from HIV infection because they are believed to be 'clean' and innocent. Conversely, the adolescents consider their older partners as being 'safe' because of the impression that they are more responsible and less likely to take risks than young men (Madlala, 2008).

Another risk behaviour in which adolescents engage are age disparate and multiple and concurrent sexual partners. Age disparate or intergenerational sex refers to the age difference between sex partners (Madlala, 2008). Sexual relationships have been identified as a driver of the HIV epidemic in South Africa. Older partners are more likely to be living with HIV, therefore

risking exposure to young people (Govender, 2013; Madlala, 2008). When young women engage in sexual relationships with older partners, they find it difficult to negotiate condom use (Gumede, 2011; Madlala, 2008). Likewise, among rural girls, poverty, unemployment and lack of education were found to have increased their involvement in age disparate relationships while material gains, fun, high status among peers were reasons why urban girls engage in this form of sexual relationship (Mutinta, 2014, Mutinta, *et al.* 2013; Madlala, 2008). Many teenagers and young adults fail to use condoms correctly and consistently based on the number of sexual partners they have, which is an important risk factor for sexually transmitted diseases and unwanted pregnancies (Mutinta, *et al.* 2013; Madlala, 2008). In addition, the larger the economic gap between the partners, the less likely condom use will be (Madlala, 2008).

Having multiple and concurrent sexual partners represents an important behavioural risk factor for STIs among adolescents and young adults, especially if they fail to use condoms correctly and consistently. Most adolescents do not have multiple concurrent sexual partners; however, because many adolescent relationships are of short duration, adolescents often have multiple sequential partners. A South African national survey (2012-2016) reported that about one fifth of young adults, especially females, are involved in a sexual relationship with partners older than them. An estimated 24.4% reported multiple sexual partners. However, more females reported dating older sexual partners rather than adolescent males (HSRC, 2014), while adolescent males are more likely than adolescent females to report multiple sexual partners and multiple concurrent partners (HSRC, 2014; Doyle, *et al.* 2012).

There is also a strong correlation between alcohol use and risky sexual behaviours such as multiple and concurrent sexual partners. As the number of reported alcohol-related behaviours increases, the adjusted proportion of respondents who had recently had multiple concurrent partners also increases (Mutinta, *et al.* 2013). Likewise, daily consumption of alcohol is associated with inconsistent condom use (Reis, *et al.* 2016). Adolescents who drink alcohol were found to be at an increased risk of unprotected sex, unplanned pregnancy and sexual assault (Morojele and Ransoomar, 2016; Mutinta, *et al.* 2013). Early alcohol consumption remains a health concern and binge drinking has continued to increase especially among females (Morojele and Ransoomar, 2016; Ransoomar, *et al.* 2012). Although, South Africa is considered to be a medium consumption country, in terms of per capita adult alcohol consumption, findings

indicated that those who drink appear to do so at bingeing levels of ≥ 5 drinks in one sitting (Morojele and Ransoomar, 2016; Peltzer, *et al.* 2011). At these levels, these individuals are very likely to engage in unsafe sexual acts.

Additionally, HIV positive status has been associated with adolescent risky sexual behaviour. Many adolescents do not know, nor are they interested, in checking their HIV status. This has contributed to increased HIV prevalence among adolescents. Sexual partners tend to trust themselves to the extent that they jettison the idea of finding out the HIV status of their partners. Compared with other age groups, adolescents aged 15-24 reported lesser percentage of HIV testing in a South African (2012-2016) national survey (HSRC, 2014). From the same study, in determining the perceived susceptibility of adolescents among South Africans, it was observed that most respondents believed they were not at risk of contracting HIV, which was one of the core reasons attributed to low status knowledge (HSRC, 2014).

As a general rule, adolescents are more likely to binge-drink, smoke cigarettes and engage in violent and other criminal behaviour, the majority of which are caused by the influence of alcohol or drug use. All these forms of risky behaviours put not only adolescents themselves at risk but other individuals of other ages.

Results of Adolescent Risky sexual behaviour

Many young people engage in sexual risk behaviours that can result in unintended health outcomes. The consequences of these sexual risk-taking behaviours place adolescents at risk of contracting HIV infections, other STIs and unplanned pregnancies. For example, a global estimate of 2.1 million persons were newly infected with HIV in 2015 (UNAIDS, 2016). Sub-Saharan Africa, which had the highest prevalence of HIV/AIDS, was reported to have an estimated 25.5 million living with HIV with vast majority- 46% of the new HIV infections - reported in East and Southern Africa in 2015 (UNAIDS 2016). Of the total number of people living with HIV in South Africa, according to a 2012-2016 national survey, adolescents accounted for an estimated 25% of the new infections; nearly a quarter of young women (HSRC, 2012).

Risky sexual behaviours also place adolescents at risk of unintended pregnancies in South Africa. Even though, according to the 2013 national survey, there was increase of about 5,063 in

the number of female school learners who fell pregnant (DBE, S.A, 2014), in the 2014 national survey an overall estimate of 2.7% (93,972) school learners were reported to have fallen pregnant, of which KwaZulu-Natal recorded the highest number of learners that fell pregnant in 2014 at 18, 533 (DBE, S.A, 2015). Consequently, incidences of STIs, HIV infections as well as unintended pregnancies are as a result of a child's first sexual intercourse, which is often unplanned or coercive sex (Manzani, 2001:44).

Globally, adolescent (unplanned) pregnancy has remained one of the core reasons for maternal and child death (WHO, 2016; 2014). Adolescent birth rate has remained on a high increase especially in the Sub-Saharan region (UNICEF, 2016; Sedgh, *et al.* 2015; Willan, 2013). Multi-faceted educational programmes such as DramAidE, love Life, B4udecide, Soul city, National Adolescent Friendly Clinic Initiative (NAFCI) and Soul Buddyz offer education, counselling, sexual orientation and different aspects of support services to increase adolescents' awareness of these sexual risks. Despite this, adolescent girls reporting pregnancies were increasing on a daily basis (DBE, S.A, 2015; Planned Parenthood Federation of America- PPF, 2013; Kost and Henshaw, 2012).

Adolescent susceptibility and severity to these risks

Perceptions of susceptibility to risks and the severity of harm caused by the risks of adolescents' risk-taking behaviours are key components for understanding people's motivation for engaging in behaviours that increase or decrease the risk of negative health consequences (Napper, *et al.* 2015). Susceptibility refers to the chances that one might be at risk of an unhealthy behaviour. Severity of a risky sexual behaviour refers to the extent or degree of consequences of a behaviour. The behavioural change perspective of the Extended Parallel Process Model (Witte, 1992) suggests that perceiving a negative consequence of a risk to be serious can increase self-efficacy (confidence in oneself to reduce or avert risk) of an adolescent in reducing the perceived risks towards behaviour.

Parents' perception of their adolescents' exposure to risks may be an important motivator of health communication with their adolescents (Katz, *et al.* 2012). When people are aware of the seriousness of HIV, they would be more inclined to engage in prevention and seek treatment interventions (HSRC, 2014: 97). However, young adults were reported to see themselves as

invulnerable to all these negative outcomes of risky sexual behaviours despite their knowledge about the consequences of these risky sexual behaviours (Nota, 2015; HSRC, 2014; Millstein and Halpern-Felsher, 2002). A study that sought to understand adolescents perception of risky behaviours found that adolescents, especially boys, reported invulnerability to sexual risks (Sychareun, *et al.* 2013). From the study, about two thirds of the respondents perceived themselves to be at no or low risk of STIs and HIV infection even though they reported they had unprotected sex, which could result in unplanned pregnancies, HIV and STIs (Sychareun, *et al.* 2013).

In South Africa, female adolescents were perceived to be more susceptible to HIV compared to males (HSRC, 2014: 87). According to the HSRC national survey, among the 15-24 age group, about 42.1% believed they would 'definitely not get infected', 39.3% perceived themselves as 'probably would not get infected', 16.2% believed they would probably get infected and 2.5% perceived themselves to be vulnerable to HIV (HSRC, 2014:88). Studies have attributed low perception of one's vulnerability to abstinence, being faithful to one's partner, never had sex, contraceptive usage, known HIV status, low level of knowledge about STIs and HIV, low knowledge of what should be considered risk factors for STI and HIV, misconceptions and erroneous views about HIV transmission, ignorance on how to apply their knowledge of disease transmission to assess their risk level every time they engage in sexual activity (Nota, 2015; HSRC, 2014; Sychareun, *et al.* 2013; Adedimeji, *et al.* 2007; Prata, *et al.* 2006). Likewise, adolescents' low vulnerability was attributed to their nonchalant attitude towards the risks of their behaviours. They tend to concentrate on the immediate effect or pleasure rather than the long-term consequences. Thus, they underestimate their personal risk of infections (Keller, 1993). On the other hand, studies found adolescent high susceptibility to risk were as a result of being sexually active, having multiple sexual partners and non-use of protective barriers (HSRC, 2014:90). Adolescent susceptibility was also attributed to age, culture, gender, HIV status, (Nota, 2015; Sychareun, *et al.* 2013; Sychareun, *et al.* 2011; Ward, *et al.* 2004).

There is also association between perceiving oneself to be at high risk, and having knowledge about the consequences of risky sexual behaviours. Adolescents who had high or sufficient knowledge about HIV/AIDs, perceive that they could be vulnerable to the risks because they understand that they might get infected if they get involved in risky sexual acts. While those who

were not knowledgeable might believe that only those who ‘look’ sick and skinny are at risk of transmitting sexual infections. This is a false and potentially risky perception (Sychareun, *et al.* 2013; Wamoyi, *et al.* 2010). A study in *Côte d’Ivoire* found that knowledge about sexual risks, as a form of self-empowerment, influences a person’s perception of risks and creates awareness that stimulates behavioural change (Zellner, 2003). On the other hand, some researchers found no significant correlation between knowledge and risk perception on sexual risks (Stringer, *et al.* 2004). Accurate knowledge about HIV transmission does not necessarily result in behavioural change or efforts to prevent HIV infection; however, it was found as a prerequisite for engaging in HIV prevention practices (HSRC, 2014:93). Nevertheless, it was suggested that when communicating with adolescents, parents should consider discussing specific risks and the potential differences between their own assessment of likelihood and severity with that of their adolescents. This could encourage behavioural change (Napper, *et al.* 2015).

Factors contributing to Adolescent Risky Sexual Behaviours

There are numerous psychological, socio-political and community related factors that influence young people’s sexual decisions. Across these factors, access to sex knowledge can have subsequent influences on health outcomes. Sex knowledge is the “inculcation of the moral attitude towards sex instincts” (Bhan, *et al.* 2004: 101). It dispels assumptions or false notions and provides comprehensive explanation for various aspects of sexuality (Bhan, *et al.* 2004). Sex education is important for adolescents in enhancing and facilitating their understanding about sexuality and reproductive health care. Holistic and well-structured sexuality messages help to prevent unhealthy sexual behaviour, prepare adolescents to have perfect attitudes and behaviour towards sex (Bhan, *et al.* 2004). On the other hand, poor level of sex, HIV, STIs and contraceptives knowledge and prevalence of sexual activities impedes adolescents from adopting healthy sexual lifestyles (Mohammadi, *et al.* 2006; Bhan, *et al.* 2004). Adolescents solicit sexual knowledge, values, beliefs, behaviours and information from range of sources cutting across schools, peers, media, family (Shtarkshall, *et al.* 2007).

Due to the amount of time that adolescents spend there, school plays an important part in sex education. (Loew and Thompson, 2011; Kirby and Laris, 2009; Shtarkshall, *et al.* 2007). Sex educational programmes are introduced in school curriculum in order to increase abstinence among school learners, delay first sexual debut and encourage condom or contraceptives usage

(Kirby and Laris, 2009). While some parents reported school based sex education to encourage adolescent sexual activities (Chikovore, *et al.* 2013), some parents often rely on schools to give sex education to their children due to various reasons; little or no knowledge of sex, being shy, embarrassment, past experiences (Wamoyi, *et al.* 2010; phetla, *et al.* 2008; Hollander, 2000; Rodgers, 1999). However, school teachers are often inadequately equipped and trained on topics about sex. They approach the subject in a formal lecture format, using vague or indirect words during discussion, which affects the adolescents' comprehension. (Botchway, 2004).

Adolescents also consider their peers as a source of information regarding sexuality and reproductive health, especially when parents deny them of such information (Hartenstein, 2012; Pistella and Bonati, 1998). This might most likely lead to inaccurate information, misinformation and erroneous beliefs about sex, which could have negative influence on their sexual decisions (Iliyasu, *et al.* 2012; Mturi, 2003; Connolly, *et al.* 2000). Even though intimate connections to peers and reliance on them have been associated with improved psychological health and social competence, higher rates of risky behaviours were also found as influence (Carter, *et al.* 2007). Peer pressure and influence has been identified as an indicator of adolescent early sexual behaviour (Vukapi, 2016; Govender, 2013; Brown, *et al.* 2006; Crockett, *et al.* 2003). Adolescents whose peers engage in sexual behaviours are more likely to be influenced in engaging in sexual acts (Sieving, *et al.* 2006). For instance, perceived values and behaviours of friends have been found to have a direct influence on adolescents' sexual debut (Sieving, *et al.* 2006), while a positive impact of peers on adolescents' sexual behaviour has been identified to have a healthy influence on adolescent sexual decision making (Mueller, *et al.* 2010).

Another source of sexual information is various media such as internet, television, magazines, movies, music, and other social media platforms for socialization mostly through the use of cell phones. Each of these platforms could either have adverse or positive effects on adolescents' sexual decisions, depending on the content of the transmitted information especially on sex topics. Even though parents are reluctant to discuss sex and reproductive health topics with their children and would rather rely on media for sex education, they still feel concerned about the various media content their young ones are exposed to and the influence of these platforms on them (Werner-Wilson, *et al.* 2004). As a result, they tend to censor and monitor media content by sitting and discussing with their adolescents while watching and/or listening to sexual content,

particularly from television programmes (Werner-Wilson, *et al.* 2004). Media has been perceived as a positive influence in shaping adolescents' sexual behavior because of its ability to present safe sex in attractive and explanatory visual form (Keller and Brown, 2002; Hartenstein, 2012).

There are many examples of entertainment education vehicles that attempt to mitigate risky sexual behaviour (Gesser-Edelsburg and Singhal, 2013) be it via television (Govender, *et al.* 2013; Tufte, 2008), radio (Papa, *et al.* 2000) and more recently digital games (Singhal, 2013). However, sex messages distributed via entertainment media that are not specifically geared towards pro-social behaviour may inadvertently encourage risky sexual behaviour by not portraying the dangerous consequences (Govender, 2013; Strasburger, 2005). As a result of media ubiquity and influence, media has become a powerful agent of socialisation. Adolescents are exposed to a multitude of messages and influences via the media, and particularly materials that have elements of sexuality in theme or nature. The effect of this on their emotional, physical and sexual development is not well understood from a scientific or clinical perspective but, at the very least, there is some evidence that proves that these images and messages are harmful to adolescents in the long term. It was however suggested that finding ways to prevent the media from promoting sexual content to young ones could be one such way to prevent early sexual activity and risky sexual behaviours among adolescents (Loew and Thompson, 2011; Bleakley, *et al.* 2009; Ward and Friedman, 2006).

Furthermore, a research conducted among African American adolescents found depression and hopelessness to be associated with adolescent risky sexual behaviours (Miller-Johnson, *et al.* 1999). Another cross-national study among young adults conducted in 24 countries in 2001/02 and 30 countries in 2005/06, indicated that possible risks associated with sexual behaviour were mainly linked to emotional and behavioural characteristics of the developmental phase (Gabhainn, *et al.* 2009). Behavioural problems including crime and conduct disorder and growing up with single parent were reported to lead to risky sexual lifestyles among adolescents (Doljanac and Zimmerman, 1998; Miller, *et al.* 1998). A qualitative study conducted among 633 adolescents from Durban found behavioural vulnerability, poor parent-child relationships, and poverty as indicators of adolescent's engagement in sexual risky lifestyles (Brook, *et al.* 2006).

Furthermore, declining cultural and religious influences, urbanisation, early age of sexual maturation, and increasing numbers of early marriages were influencing factors that contribute to adolescents' risky sexual behaviour (Falaye, 2004). In addition, incorrect knowledge of fertility period, wrong attitude towards premarital sex, no condom use, and inadequate knowledge on HIV and its prevention were contributory factors of adolescents' sexual behaviours (Udigwe, *et al.* 2014; Imaledo, *et al.* 2012).

Adolescents are more likely to engage in risky lifestyles such as unprotected sex, when they are under the influence of drugs or alcohol. Teenagers who smoke were more likely to drink; this could lead to risky sexual intercourse when they are intoxicated (Kaiser family foundation, 2002). A Kaiser family foundation study (2002) found that more than 80% of adolescents who reported alcohol and drug intake revealed that it had negative influence on them and often times prompted them to engage in sexual intercourse. This result was also similar to a study conducted among African American girls. It was reported that girls who reported high rates of substance use also indicated high rates of sexual behaviours (Wight, *et al.* 2006). In South Africa, early initiation into alcohol consumption was associated with high risk of attempted or actual forced sex among high school adolescents (Anderson, *et al.* 2004). From a national cross sectional study among South African school pupils, it was recorded that 11% of male and 4% of female adolescents had forced someone to engage in sex while 60% male and 71% female teenagers admitted to having been forced to have sex. This shows that adolescents who engage in alcohol intake were more sexually active and more likely to engage risky sexual behaviours.

Another determinant of adolescent's risky sexual behaviour is the issue of multiple sexual partners and age disparate relationships (HSRC, 2014). Sexual negotiation with older partners has been claimed to give little or no room for contraceptive use in preventing sexual risks, unintended pregnancies and infections (HSRC, 2014; Shisana, *et al.* 2005). As a result of poverty, sexual satisfactions, material gifts, financial benefits, social benefits, and many other countless motives, young adults (especially females) get involved with older partners (sugar daddies) and have multiple sex partners or even marry at a tender age (Beauclaire and Delva, 2013; UNICEF, 2013; loveLife, 2012; Booysen and Summerton, 2002). Risky sexual behaviours such as inconsistent condom use and sexual intercourse with multiple partners are relatively

common among adolescents in South Africa and this behaviour increases the risks of unplanned pregnancies and sexually transmitted infections particularly HIV/AIDS (Brook, *et al.* 2006). Be that as it may, in many African cultures, children's good behaviour including making good decisions and responsible choices about sexual activity is a role usually assigned to collective parenting.

Parent-adolescent sexuality communication

Studies indicate that adolescents want their parents' guidance on sexual matters and would prefer to discuss more with them rather than sourcing for this information from external factors such as peers, teachers, health centres and media (Somers and Surmann, 2004; Hacker, 2000). While most adolescents' decisions about sexual engagements are attributed to peers, media, and other pressures, making good decisions and responsible choices about sexual activity during these period are often the responsibility of parents (Manuel, 2013; Phetla, *et al.* 2008). This could probably be because parents play a critical role in the growth, development and sexual socialisation of their children.

Parent-adolescent communication has been found to curtail and link the relationship between other sources and adolescents' risk sexual behaviours. For instance, adolescents who reported frequent discussions with parents were perceived to be less likely influenced by other non-family or external sources (Bleakley, *et al.* 2009; Whitaker and Miller, 2000). A common African proverb, 'while there is little you can do about your ancestors, there is something you can do about your descendants,' is pertinent when it comes to what parents can do to protect young ones from the harmful consequences of adolescent risky sexual behaviours. There are various ways through which parents can be agents of sexual socialisation for children. They can play a critical role in conveying sexual information which may exert significant influence on adolescents' sexual attitude, values, beliefs and information on risky sexual behaviours. Parents may also provide a powerful model of open and honest communication about sexual health issues. Parental involvement through parent-adolescent sexual communication also presents education about sex, risky behaviours and reproductive health to young people.

Contrary, families characterised by little or no sex communication, poor parental monitoring, and little or no parent-adolescent friendly relationship were found to have contributed to an adolescent's sexual behaviour (Zimmer-Gembeck and Helfand, 2008). A longitudinal survey on adolescent healthy behaviour found that participants who reported feeling lack of parental care and love were more likely to report emotional distress, high sexual risky lifestyles and drug use (Resnick, *et al.* 1997). Likewise, independence from parental supervision or guidance, adolescents' co-habitation, poor family background or poverty were significantly found to have resulted to increased chances of adolescents to engage in risky sexual behaviours (Udigwe, *et al.* 2014:987).

Ultimately, Effective parent-adolescent communication has been proven to help adolescents build healthy and responsible sexual lifestyles, positive self-esteem and delay sexual debut (Bushaija, *et al.* 2013; Markham, *et al.* 2010; McNeely, *et al.* 2002). Although, parent-adolescent communication about sex and risky behaviours is claimed to be an effective way to protect young ones, studies revealed that parents rarely discuss sexuality and its related topics with their children, and when they do, discussions were perceived to be limited in certain topics (Gumede, 2011; Wamoyi, *et al.* 2010). A study of 120 Filipino-Americans on parent-adolescent communication frequency, reported greater frequency of talking about sex with friends than with parents (Chung, *et al.* 2007). Similarly, a Ghanaian study reported that parent-adolescent discussions about sexuality are not common in rural areas where it remains taboo to do so (Botchway, 2004). Parents tend to portray sexuality as 'dangerous, unpleasant, and unsavoury' in discussions with their children (Wamoyi, *et al.* 2010; Izugbara, 2008:575). To worsen the situation, in most cases, parents often have difficulties communicating issues about sexuality topics with their children (Gumede, 2011; Schear, 2006; Botchway, 2004). However, in cases where there is discussion, communication is often directed towards limited topics like abstinence, menstruation, HIV prevention, puberty and physical development (Manu, *et al.* 2015). Likewise, studies on parent-adolescent communication on sexuality reported that contraceptives were rarely discussed during interaction because parents thought discussion on prevention would encourage experimentation (Dessie, 2015; Wamoyi, *et al.* 2010).

In light of the foregoing, the level of parent-adolescent intimacy and effective sexuality communication could thus be associated with the structure of the family. As earlier said, the

family as the smallest unit of a society and child's first level of socialisation plays an indispensable role in a child's sexual relationship and wellbeing (Manuel, 2013). Therefore, the family system would either have a positive or negative influence on adolescent's sexual decision. Single parental care, divorce and inter-parental conflict would most likely lead to lower warmth and intimacy (Hetherington and Stanley-Hagan, 2002; KrishnaKumar and Buehler, 2000; Loeber, *et al.* 2000). Lower monitoring, parent-adolescent conflict and adolescents' inadequate knowledge about sexual and reproductive health topics were all characterised by single-parent families which would probably affect adolescents' sexual decisions (Branje, *et al.* 2012; Laird, *et al.* 2003; Loeber, *et al.* 2000).

Even though, parental conflicts are not the only factor that contributes to adolescent risk-taking behaviours or juvenile delinquencies, it is argued to contribute to these problems (Berlin, 2004). Children who grow up with their biological parents in an organised family system where both parents are present, tend to do better on a wide range of outcomes than children who grow up within dysfunctional families (Berlin, 2004; Branje, *et al.* 2012). Nevertheless, by establishing a good family structure, parents create a friendly atmosphere whereby adolescents can disclose information and avoid secrecy, particularly regarding sex. Thus, giving room for parental guidance in adopting healthy and positive sexual decisions and behaviours (Branje, *et al.* 2012). For an effective parent-adolescent communication, there is therefore a need to understand the content of an intended parent-adolescent message and ensure clear feedback from the senders (parent/adolescent) and receivers (adolescent/parent) respectively. Although, communication is complex, parents still need to guide their children in order to avoid risky sexual behaviours that could pose a threat to adolescents' health and wellbeing (Blake, *et al.* 2001).

Content of parent-adolescent sexuality communication

Although, not typical in practice, a broad range of topics have been found to be discussed during parent-adolescent communication including: abstinence, dating, menstruation, birth control, STIs and pregnancy, among others (Wamoyi, *et al.* 2010; Guilamo-Ramos, *et al.* 2006). The high prevalence of HIV has influenced parents to place more emphasis on HIV prevention during discussions. A study among rural South African parents reported that a majority of the parents talked with their teenagers about how to reduce risks, out of which 58% had talked with their adolescents about checking their status, while 98% of mother participants reported discussions

on contraception (Phetla, *et al.* 2008). Equally, a Tanzanian study reported that parents concentrated on HIV/AIDS topics during parent-adolescent communication because it was considered a disease associated with extreme suffering (Wamoyi, *et al.* 2010). Discussing communication priority, Nigerian parents believe that the most important topic that parents should provide to their children is life and relationship skills. The second priority is sexual health, such as STIs, and the third priority is personal hygiene (Akinwale, *et al.* 2009). Communication content is however noted to be gender sensitive whereby parents focus on abstinence and emphasise negative outcomes of sexual experiences with girls. Subsequently, issues related to condom use or the consequences of STIs and protection against them, were often discussed with male adolescents (Wamoyi, *et al.* 2010).

Parent-adolescent gender relationship

The socialising role of an African child into a good citizen is also gendered with the burden primarily placed on mothers. A mother's role in a child's development has been found to be indispensable, as reflected in a common Nigerian adage; a good child belongs to the father while a wayward child belongs to the mother. This implies that if the child is performing well, it belongs to the father and vice versa. In the same vein, if the child contracts a disease due to indulging in unhealthy sexual behaviour, the mother solely carries the burden. Thus, it becomes imperative for the mother to ensure that the child is positively influenced and encouraged to lead a healthy sexual life by discussing sex-related topics and the risks with them. Over the years, mother-child relationships have been perceived to be more intimate compared with father-child relationships. Fathers were perceived by adolescents to be authoritarians, to hold disciplinary roles and often seen as a model within the family to be consulted basically for material or/ and financial needs, not someone to share intimate feelings with (Botchway, 2004; Lewis and Lamb, 2003; Steinberg and Silk, 2002). Observable in the Nigerian context, fathers preferred to 'hustle' while the wives become stay-home mothers or at best opt for simple careers e.g. teacher (Western Nigeria), shop assistant (Eastern Nigeria) or full-time house wife (Northern Nigeria). Most times, fathers shift responsibilities to their mothers (Mtikrakra, 2009; Botchway, 2004; Kirkman, *et al.* 2001) and when fathers engage in such discussions, limited and restricted sexuality discussions with their male adolescents were perceived to occur (Botchway, 2004).

When adolescents felt embarrassed broaching topics with fathers, they often opted to discuss issues of a less sensitive nature compared with mother's discussions (Branje, *et al.* 2012; Mtikrakra, 2009; Botchway, 2004; Kirkman, *et al.* 2001). A study on parent-adolescent sexuality based on gender differences found that mothers, unlike fathers, were more involved in sex discussion with their children. In cases when fathers were reported to be involved, parent-adolescent discussions were discovered to be more frequent with the male child (Kunnuji, 2012). The study, however, found that parent-adolescent communication on sexuality did not reduce sexual behaviour neither did it increase it. However, there was a striking difference in the practice of safer sex between a child who engaged in such communication with parent(s) and those who did not have cordial parents-child communication (Kunnuji, 2012).

Mothers play major roles in sex education and can positively impact their daughter's sexual behaviours and decisions (Gumede, 2011; Hartenstein, 2012). As a result, trust is formed between parties and the adolescent is more likely to believe and accept parent instructions on sexuality (Gumede, 2011; Kapungu, *et al.* 2010). Mother-daughter relationships are characterised with high level of comfort during sexuality discussions which is influenced by the sex of both parent and child. In other words, female adolescents tend to disclose personal information to mothers because of gender influence (Crohn, 2010; Morgan, *et al.* 2010; Miller, *et al.* 1999). Likewise, male adolescents were perceived to be closer with their fathers (Zhang, *et al.* 2007; Botchway, 2004). Some studies found mother-daughter communication to be limited, ambiguous, indirect, uncomfortable and focus more on the biological aspect of sex (Gumede, 2011; Kapungu, *et al.* 2010; Wyckoff, *et al.* 2007; Rosenthal, *et al.* 1998). Nevertheless, relationships where female adolescents have close attachments to their fathers was perceived to be as a result of the level of fathers' involvement and affection at early stage of adolescence (Flouri and Buchanan, 2002). Also, father involvement was characterised as being overprotective of their daughters (Flouri and Buchanan, 2002).

However, a 2008 study in the United States found no causal relationship between parent-adolescent communication and an adolescent's sexual activities (Kim, 2008). The best moment of parent-child discussions on sexuality and its related topics (especially with male child) was between the ages of 15 and 19 although male adolescents were reported to receive less sex

education. This finding was based on male adolescents being able to take care of themselves, independent and traditional notion of having engaged in sex at earlier stage (Kunnuji, 2012).

Initiation of parent-adolescent sexual communication

Puberty is a period of change from childhood to adulthood which is accompanied with several physiological, social and psychological developments (Dessie, *et al.* 2015). It is a developmental period which increases adolescents' sexual drive and most likely exposes them to sexual risks (Jerman and Constantine, 2010). During this period, parents are expected to be closer and socialise more with their children because parental sexual communication with children is a primary medium through which sexual values, beliefs, expectations and knowledge could be transmitted (Jerman and Constantine, 2010; Sales, *et al.* 2008; Mbugua, 2007).

Communication on sexuality and risky behaviour between parents and adolescents might be initiated based on the child's age and gender (Chaweewan, 2011; Gumede, 2011; Luckeroth, 2007). Early communication is suggested as an essential factor for effective ongoing parent-adolescent sexual communication. It is suggested that the more parents discuss issues of sex, pregnancy, birth control, risky behaviours and sexually transmitted infections with their young ones, particularly at a younger age, the more likely they delay their sexual urge or debut and less likely to engage in risky sexual behaviours (Guilamo-Ramos, *et al.* 2012).

The effectiveness, quality and timing of parent-adolescent communication on sex topics is germane in shaping an adolescent's sexual behaviours, to adopt a healthy and positive sexual behaviour which could also delay their sexual debut (Schear, 2006). A survey on mother-daughter communication on sexuality found that parents who discuss sex inclusive, contraceptives before adolescent's first sexual experience were three times more likely to use condoms than those who started discussions after adolescent's first sexual experience (CDC, 2004). Some studies have suggested that sex initiation or education should be introduced between the ages of six to ten years (Pluhar, *et al.* 2008; Opara, *et al.* 2010). Similarly, Hollander (2000) in his study indicated that 90% of mothers interviewed suggested initiation of sexual discussion with their adolescents at age 14 or younger. However, each stage should have its limited release of information. Children as early as six years should have known body changes

between girls and boys and discussions on puberty, relationships and sex should be introduced at the age of 12 (Pluhar, *et al.* 2008).

However, it is argued in other studies that early parent-adolescent communication on sexuality tends to expose them to early sexual risks and encourage teenage experimentation of sexual acts (Regnerus, 2007). Similarly, some parents felt their adolescents were too young to know about sexuality issues such as condom use, HIV/AIDS, and relationships (Bushaija, *et al.* 2013). A study conducted in Ghana showed that sexual discussions with adolescents arouse their sexual interest early and such discussions were reported to be too sensitive to discuss with adolescents (Botchway, 2004). Likewise, a Tanzania study found that some parents tend to wait until their adolescents get to secondary school rather than elementary school due to the assumption that those in the elementary classes are not yet sexually active (Wamoyi, *et al.* 2010).

The timing of communication is essential and could be effective to avoid sexual debut, to reinforce protective factors, but may also facilitate behavioural change in those who are already sexually active (Downing, *et al.* 2011). Despite evidence showing the importance of parent-adolescent communication to alleviate sexual risks, parents still have difficulties that include knowing how and when to initiate the conversation, and who best to do so between the mother and the father. Another consideration that impedes this conversation is the uncertainty of how much privacy parents should accord to their adolescents (Bushaija, *et al.* 2013; Coffelt, 2010). This suggests that in order to promote communication between parents and adolescents, it would be necessary to address initiation of communication; timing of initiating discussion could identify either facilitators or barriers in the communication between parents and adolescents on sexual issues and risky behaviours. This is one of the primary objectives of this study as it will provide insight into whether early or late initiation encourages or hinders risky sexual behaviours. However, sexual communication should be a regular and normal subject in the family (Downing, *et al.* 2011; Natoshia, *et al.* 2011). Parents who discuss sex matters freely with their children were more likely to produce children who are comfortable discussing sex topics, putting into cognisance the content of the message and how it should be communicated (Miller, *et al.* 1998). It is therefore important to examine the communication styles and tones within the

family in order to grasp the relationship between parent-adolescent communication and adolescent risk-taking behaviours.

Communication Approaches and Tones

Sex talk is often one of the most challenging conversations for parents and adolescents during puberty (Holman, 2014:1). Parents and their adolescents face communication difficulties especially during this period and this could be due to the revolving nature of their relationship, communication styles and frequency to engage in meaningful and detailed conversation (Branje, *et al.* 2012). One of the challenges for successful and effective parent-adolescent communication regarding sexual risks and risky behaviour is the communication styles and tone adopted during discussions (Bastein, *et al.* 2011; Phetla, *et al.* 2008; Blake, *et al.* 2001). Positive communication on sexual risks between parents and adolescents, as they develop into adulthood and eventually become sexually active, assists adolescents in developing good morals, values and make healthy decisions (Drioane, 2014; Lagina, 2002). Such communication encourages adolescents to delay sexual debut and avoid unprotected sex, but there is lack of knowledge on how to initiate and phrase these discussions (Schear, 2006).

The processes (style and tone) and content of communication is pivotal in influencing adolescents' attitudes and practices of sexual acts (Phetla, *et al.* 2008; Dutra, *et al.* 1999). Parents are more likely to play important roles in shaping their children's perception of the world through the style(s) they adopt in communicating with their children (Maximo, *et al.* 2011; Phetla, *et al.* 2008). However, communication styles and tones adopted by parents vary based on who initiates and maintains sexual communication, the comfort level of parent and adolescent, the frequency of sexual communication, environment and matters arising during discussion (Rosenthal, *et al.* 1998). Observations from an interview conducted among 30 mothers on their perceptions of communication styles, content and frequency about sexuality discussions with their adolescents identified five (5) communication styles. They include; avoidance, reactive, opportunistic, child-initiated and mutually interactive (Rosenthal, *et al.* 1998). The knowledge of communication styles and tones provides information on types of communication that engenders or hinders effective communication and which styles encourage or discourage self-efficacy regarding healthy sexual behaviour.

The avoidance style of communication is characterised by both parents and adolescents being uncomfortable discussing sexual topics (Rosenthal, *et al.* 1998). During discussion, the subject is avoided, cut short or presented in generalized and non-personal terms (Moore and Rosenthal, 2006). Parents using this style are of the opinion that adequate sex education occurs at school. For instance, in a study conducted in Kenya, mothers tend to rely on school teachers, books and media to provide their adolescents with sex education (Mbugua, 2007). As such, vague language is used to discuss sex within the family rather than explicit terminologies which would aid adolescents' understanding and prevent them from sourcing information on sex issues from peers or being misled (Wamoyi, *et al.* 2010). Discussion could also be avoided through punishment. When adolescents believe that sexual discussions with their parents could result in punishment they withdraw due to fear (Chaweewan, 2011).

The reactive communicators are parents who bring up sex-related discussions when they perceive a pressing need based on the child's behavior. Even though reactive parents do not feel particularly confident discussing these topics, they fear that their children might feel embarrassed and at the same time concerned about how to get the message across. Not until adolescents appear to be getting serious with a romantic partner and/or experiencing body development, would parents initiate discussion (Gumede, 2011; Moore and Rosenthal, 2006). Most times such discussions are perceived to be one-sided (Rosenthal, *et al.* 1998).

The opportunistic communicators were characterised by parents who were willing to discuss sex-related topics with their adolescents, but did so once in a while. They sought shared occasions to initiate discussions, such as preparing meal, watching television programmes, family events and/or school assignments as a way to overcome anxiety and embarrassment (Gumede, 2011; Mtikrakra, 2011; Rosenthal, *et al.* 1998). This could probably be because they lack the knowledge on how to initiate discussion on sexual issues.

Another style identified was child-initiated communication (Rosenthal, *et al.* 1998). Parents in this category wait until their adolescents bring up the topic before discussing it. It is believed that when a child is ready to engage in sex-related discussion, the conversation would be more fruitful than when communication is parent-initiated. In contrast, a study carried out among

Nigerian women claimed that if children initiate sexual discussion it shows they are sexually active or might have been involved in risky sexual acts (Izugbara, 2008). Likewise, studies conducted in Kenya and Uganda argued that sexuality discussions with adolescents encouraged and exposed them to early sexual risks (Paulsen, *et al.* 2010; Ndyabangi and Kipp, 2001).

The last style identified by Rosenthal, *et al.* (1998) is mutually interactive in which sex-related conversations could be initiated either by the adolescent or the parent. This ideally allows for cordial relationships with both parties comfortable during discussion (Rosenthal, *et al.* 1998). This style grants openness, intimacy and emotionally based discussions. Parents work consciously to promote open communication and make time for their children to bring up issues, and to be good listeners. Family members should freely discuss any issue relating to sex and should be initiated by the child or parent at any time (Rosenthal, *et al.* 1998). This was suggested as the best communication style to reduce adolescents' risky sexual behaviours (Akintomide and Bada, 2013; Rosenthal, *et al.* 1998). However, in reality parents tend to dominate and initiate discussion (Izugbara, 2008), while young people on the other hand, perceive their parents to be too rigid, lacking knowledge of sex education, and preoccupied with activities that limit time for listening (Kumi-Kyereme, *et al.* 2007). In an exploratory study on parent-adolescent communication conducted in Uganda, findings claimed that parents employed an authoritative and didactic style of communicating with their adolescents for various reasons such as fear, their past experiences and background (Luwaga, 2004).

Aside from the above communication styles, parents' communication tones involved the use of instructions, threats and warnings (Wamoyi, *et al.* 2010; Izugbara, 2008; Kumi-kyereme, *et al.* 2007). In Tanzania, parent-adolescent communication was found to be characterized with the use of threats and warnings that may stifle further dialogue on sexual health and risk (Kajula, *et al.* 2013). In these cases, parents believe that giving warnings and instilling fear in their children about sexual reproductive health promotes abstinence (Luwaga, 2004). However, parenting with authority and an excessive control style, with little or no interpersonal communication, does little to mitigate adolescent risky sexual behaviours (Ream and Savin-Williams, 2005).

The good news is that recently, parents have realised the need to create more room for sex discussions with their children (Akintomide and Bada, 2013). In so doing, for effective communication in combating adolescents' risky sexual behaviours, there is a need to be mindful of the communication styles and tone.

Fear appeals in family communication on sexuality

In health communication, fear appeals are used in inducing 'fear' with the aim to encourage healthy behaviour. The objective is to motivate people (in the case of this study, adolescents) to engage in a healthy sexual behaviour such as safe sex, avoidance of multiple sexual relationships, and averting drug use and alcohol consumption through fear induced messages (Maloney, *et al.* 2011; Witte and Allen, 2000). The critique of fear appeals is that, although it presents the vulnerability to the risk, it may or may not suggest forms of protective action (De Hoog, *et al.* 2005). Fear appeal, as one of the variables of Extended Parallel Process Model, is included in this chapter but will further be discussed in chapter three. Although, EPPM pertains primarily to mass media, in the case of this study, EPPM was adopted as an important framework because it will assist in analysing the study's data, particularly with regards to the barriers and facilitators of effective communication.

The EPPM suggests that when people receive a serious threat and it induces them to become scared, they will be motivated to take action to reduce their fear. The ability to take action in reducing this fear is referred to as self-efficacy. According to this model, two constructs were proposed to predict the outcome of fear based communication message- threat (susceptibility + severity) and efficacy (response efficacy + self-efficacy). When an adolescent is aware of the extent and effect of a threat and perceives his or her vulnerability to this risk, the probability of withdrawing is based on his or her level of self-efficacy. However, when they perceive the reward of behaviour to be greater than their vulnerability to risk, it reflects a low self-efficacy for overcoming risks (Maloney, *et al.* 2011). Parents may not intentionally use fear appeals but it is important to discuss here as the effects of parents' communication patterns and tones inform fear appeal and may inadvertently have the same effect in the adolescents' analysis of the threat components.

In light of the foregoing, the communication patterns and flow adopted during sexual reproductive health and risky sexual behaviours conversations within the family and the level of relationship between parents and adolescents could lead to two outcomes-

- i. High perception of the risks
- ii. Low perception of the risks

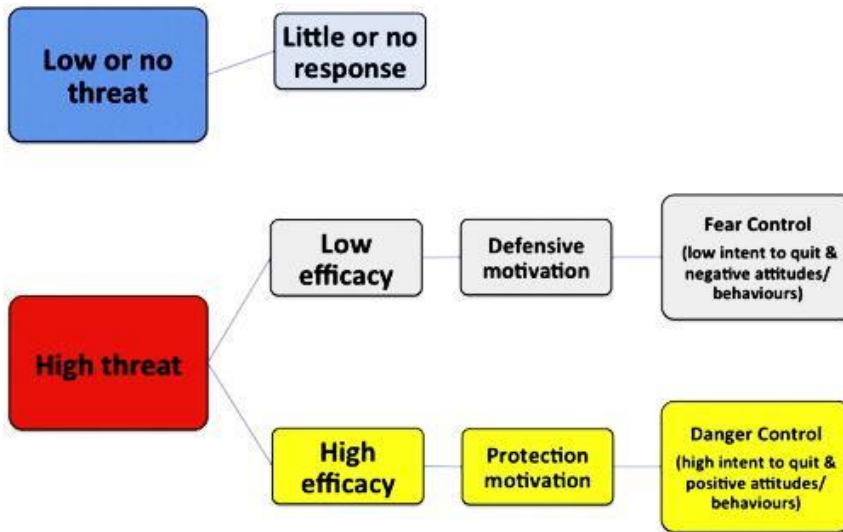


Figure 2.1: Extended Parallel Process

Source: Gould, Watt, Cadet-James and Clough 2014

High perceptions of risks occur when the adolescent perceives his or herself to be at risk of a significant threat while low perception is the belief that a threat is irrelevant and or/trivial which results to no motivation to process the message thus, ignoring the fear appeal (Witte and Allen, 2000). The degree to which an adolescent feels threatened regarding their communication with their parents will determine the motivation to act. In other words, when a child perceives a low threat in parent-adolescent communication, it could result to little or no response while a high threat in parent-adolescent communication could result in low or high efficacy (confidence in oneself to successfully perform the required action against risky sexual behaviours). The amount and quality of parent-adolescent sexual communication plays a significant role for adolescents to develop a high perception or low perception about risk thus encouraging self-efficacy in preventing these risks (Guilamo-Ramos, *et al.* 2006). As explained earlier, when adolescents

develop low self-efficacy as a result of communication barriers, they may fall victim of all these risky sexual behaviours.

When parents base their conversations on threat, or/ and are dominators of discussion, they perceive this to scare the child from involving in risky behaviour (Wamoyi, *et al.* 2010; Izugbara, 2008; Kumi-Kyereme, *et al.* 2007). Parents were also reported to adopt the use of examples of relatives who had died of AIDS and seeing someone they believe was HIV positive, for instance due to thinness to reiterate the severity of the disease (Wamoyi, *et al.* 2010). There have been arguments on adolescents' response to parents' communication patterns. While parents believe that their communication styles and tones, characterised with fear, encourage positive behaviour, adolescents perceive a threat in the conversation which may inadvertently encourage risky behaviours. It is reported that adolescents may 'act out' if the parents are being too inquisitive or if there is a threat of physical punishment. In this case adolescents become more private and rely on other sources of information. (Phetla, *et al.* 2008; Botchway, 2004; Luwaga, 2004).

More importantly, although there are contextual and structural factors that hinder or engender effective parent-adolescent communication; this study focuses more on the individual-related factors. However, acknowledging the influence of some of these contextual factors on an individual, such as cultural and religious factors, will be discussed in subsequent chapters.

Factors Engendering Parent-Adolescent Sexuality Communication

Studies indicate that effective parent-adolescent sex communication can lead to decreased adolescent risk-taking sexual behaviours and parent-adolescent discomfort (Wang, 2009; Burgess, *et al.* 2005). Cordial relationship and continuous communication between parents and their adolescents is of utmost importance to encourage safe sex and healthy behaviour among adolescents (Bushaija, *et al.* 2013). From a Ghanaian study conducted among parents and male adolescents, mutual trust and confidence were factors identified to ensure effective communication (Botchway, 2004). Effectiveness in parent-adolescent communication is ensured through trust and understanding which is established when parents and adolescents understand and recognise each other's perspectives about a subject matter (Botchway, 2004). Additionally, parent-adolescent communication can be effective when parents focus on good morals and praise good behaviours exhibited by their adolescents during sex communication. This could arouse

parents' willingness to engage in a clear sex discussion as well as encourage adolescents to openly discuss sex with their parents (Lasajo, *et al.* 2013).

Furthermore, when adolescents perceive that their parents are knowledgeable about issues such as sex, open communication would more likely occur (Bastien, *et al.* 2011). On the other hand, when parents are well informed and educated, they tend to be open and practical during discussions thus, encouraging parent-adolescent communication (Burgess, *et al.* 2005). It is therefore important for parents to have accurate information and support in order to feel more comfortable and confident that they possess the necessary communication skills to be effective in discussing sexuality with their adolescents (Nundwe, 2012; Burgess, *et al.* 2005).

The type of communication approach within the family is another factor that could engender effective parent-adolescent communication. When adolescents feel warm and loved by parents, effective and intense communication as well as close parent-adolescent relationship ensue. According to Rosenthal, *et al.* (1998), a mutually interactive communication approach which allows for open communication was perceived to be the best approach for effective conversation within the family. Thus, a critical evaluation of the kind of approach adopted within the family is essential for effective parent-adolescent communication and protection of adolescents in light of the risks associated with sexual experimentation (Phetla, *et al.* 2008). While studies have identified factors that engender effective communication, there are still factors that hinder effective parent-adolescent communication.

Factors Hindering Parent-Adolescent Sexuality Communication

Every family is bound by a relational culture (Wood, 1982) that guides its communication system. A family culture or communication system would determine if sex should be discussed in the family or not. A negative communication style would result in an unstable relationship between adolescents and parents or guardians to openly discuss reproductive health concerns (Ahlberg, *et al.* 2001). Even though studies have shown that communication does occur within the family, it was perceived that parent-adolescent discussion about sexual health is bound by traditional norms, religious beliefs, gender, fear, lack of information and lack of knowledge by parents on the issue (Tesfaye, *et al.* 2010; Regnus, 2005).

Parental lack of sex-related information or having little knowledge about sexuality topics inhibits effective parent-adolescent communication (Bushajja, *et al.* 2013; United Nations Population fund, 2000). Parents with low level of education are often limited on what to say with their children (Holman, 2014; Wamoyi, *et al.* 2010; Kumi-Kyereme, *et al.* 2007) while those with high level of education often resort to other means of communicating such as giving books to their adolescents to read (Nundwe, 2012). Most parents are reluctant to discuss sexuality information with their adolescents because of their perception that their adolescents would obtain information on sex elsewhere—peers, media, church, school counsellors (Gumede, 2011; Mtikrakra, 2009; Regnerus, 2007).

Further, adolescents often feel discomfort and anxious based on how their parents view them if they initiate discussion (Kumi- Kyereme, *et al.* 2007). The reluctance of adolescents to discuss sex with their parents could be as a result of parents been judgmental. A South African study among mothers and daughter in Bloemfontein revealed that adolescents felt discomfort in what their parents would feel about them when they approach them about sex topics (Gumede, 2011). Similar in another study, eight in ten adolescents were reported to have felt anxious about their parent's reactions thus, adolescents withdraw from discussing sexual matters with parents (Hollander, 2002). Likewise, fear of physical punishment and blame impeded children from communicating these topics with their parents (Phetla, *et al.* 2008). A systematic review of literature of parent-child communication about sexuality and HIV/AIDS in Sub-Sahara indicated that fear of physical punishment hindered adolescents from effectively communicating sexuality issues with their parents (Bastien, *et al.* 2011).

Conversely, parents are less likely to talk with their children about sex when they perceive that their children are not ready to hear about such topics and also if they have negative expectations of outcomes of discussions (Guilamo-Ramos, *et al.* 2008). Moreover, parents tend to focus on the negative outcome of adolescents' behaviours rather than working on the preventive aspects. For instance, a Tanzanian study indicated that parents rarely explain morality and good behaviour. Instead they concentrated more on the consequences of sex (Kajula, *et al.* 2013). Additionally, fear that sexuality discussions might push adolescents to experiment hindered parents from discussing with their children (Nundwe, 2012; Chaweewan, 2011; Mathew, *et al.*

2006) while some parents felt they might provide too much information at a particular age (Iliyasu, *et al.* 2012; Nundwe, 2012).

As a result of urbanisation and intergenerational differences, adolescents and parents often have conflicting points of view on sex topics (Ntarangwi, 2012; Botchway, 2004). "Urbanisation and modern economies have instigated a change in the livelihood practices of African families; the families are thus, readjusting to new ways of organizing social life" (Ntarangwi, 2012:2). This has shifted the role of parents as primary socialising agent to other external agents (Nundwe, 2012: 34; Ntarangwi, 2012:2-3). Likewise, when parents and adolescents have different worldviews about sex topics, conflict is bound to ensue hence, communication hindrance (Botchway, 2004). In explaining intergenerational differences or different worldviews, when parents discuss the issue of unprotected sexual intercourse, adolescents may erroneously perceive this as a signal that their parents might be thinking they are indulging in unprotected sex (Botchway, 2004).

The cultural beliefs a family holds concerning sex could also affect parent-adolescent communication within the family. Parents with strong cultural beliefs were perceived to view sex discussions as a taboo, shameful and dirty accompanied with discomfort (Wamoyi, *et al.* 2010; Mbugua, 2007; Luwaga, 2004). Some cultures, particularly African cultures, frown at sex communication within the family (Botchway, 2004). Not only is 'sex' found to be shameful by parents, society finds it to be an abomination for parents to talk with their children (Nundwe, 2012:33). It is however important in this era of the HIV epidemic societies for parents to re-examine their cultural norms particularly those that are not helpful in confronting the new challenges (Nundwe, 2012; Mtikrakra, 2009).

Religion is another factor that influences parent-adolescent sexuality communication within the family. Family religion determines the choice of sexuality topics during discussion. For instance, a study in Nigeria and among African-Americans reported the use of metaphors and euphemisms instead of direct and clear terminologies to explain the sexuality health issues (Williams, *et al.* 2015; Izugbara, 2008). According to Regnerus (2005:82), parents often use church attendance, church social groups and bible studies as mediums of socialisation rather than direct

conversation on sexuality with their adolescents. Although religious beliefs about sexuality can positively influence adolescent behaviour, devoted religious parents were less likely to discuss sex because of over dependence on religious values and beliefs (Regnerus, 2005:32). Parents shaped by religious values and beliefs tend to focus more on abstinence until marriage. Furthermore, they promoted patience, faithfulness and responsibility rather than contraceptives (Williams, *et al.* 2015:332; Regnerus, 2005:102). A Tanzanian study on the parent-child communication barrier reported the use of biblical and Quran verses to guide their children away from involvement in sexual risk behaviours (Nundwe, 2012: 29). From the study, religious parents were perceived to have totally refuted contraceptive usage discussion with their children and when they felt the need for discussion, they tended to use religious teachings rather than explicit communication about condom use (Nundwe, 2012). This was also similar to a Ghanaian study which found that religious parents reported premarital sex as sinful and immoral acts (Botchway, 2004). Parents from this study justified their claims by making implicit references to the bible (Botchway, 2004). It was however suggested that religious organisations should find more effective ways of teaching about prevention (Nundwe, 2012).

Nevertheless, effective communication is an essential building block of strong parent-adolescent relationship and therefore efforts should be made to find effective ways through which this can be encouraged. With respect to this, the study provides a description of communication and its roles in the typical African society since parent-adolescent discussion about sexual matters is bound by culture/traditional norms, religion, and urbanisation.

Nature of communication in a typical African setting

Traditional communication in a typical African setting involved the use of basic local resources such as poems, storytelling, metaphoric sayings, proverbs, folklores, singing, dancing and games to convey realistic messages that participants can relate to (Ntshwarang and Malinga–Musamba, 2015; Utley, 2008). Such communication is aimed at delivering a concise and effective message to a small group of people, especially within a large family in a big compound and often during a serene night setting around a central fire (Tuwe, 2016; Utley, 2008). Traditional communication relates to individuals through emotional appeal by raising events on situations encountered in the daily lives of people living in the vicinity. Aside from been used to entertain, it is seen as a tool

to encourage people to examine their personal behaviours and make changes to their behaviours and attitudes with regards to unhealthy behaviours (Utley, 2008).

In the past, discussion of sex between parents or caregivers and children was not considered normative in many African settings. It was perceived as a collective effort of the community where information was mainly conveyed during moonlight while young ones sat around the elders in the family (Bastien, *et al.* 2011). Although sex is a natural developmental process, many parents, cultures and societies frown at discussing sex with their adolescent children without destroying the fabric of the society or culture. The idea of traditional communication, such as storytelling, is embraced as a necessity to teach young people about sex education in a way that not only reflects the values of the family and society, but also enhances the sustainability of a balanced culture (Famutimi and Oyetunde, 2014).

Many African cultures have rituals that pass on sexuality information to their children. Storytelling, as a way of communicating sexual and reproductive health messages to young ones, was a shared event with children sitting in circle and participating in accounts of past deeds, beliefs, taboos and myths accompanied with singing, drumming, percussion instruments, clapping and dancing to arouse interest and leave a lasting memory of lessons learnt (Tuwe, 2016; Utley, 2008). These stories served as lessons for children and were believed to encourage them to grow up as responsible members of society. For instance, in a typical South African setting, after the long day, the children are made to sit around a fire and to listen to stories from the elderly ones. In the western part of Nigeria, these stories are referred to as Ere Osupa (tales by moonlight). Likewise, in Ghana, after a busy day, children from neighbourhoods are made to sit on the ground while an elderly person tells them ‘Ananse’ folktales, which are stories on how to live responsible lifestyles (Utley, 2008)⁵. It is expected that these stories would lead to behavioural change and are perceived as corrective measures for those practicing unhealthy behaviour.

(South) African Parenting and Sex Education

A common African adage, “it takes a whole village to bring up a child”, is often used when referring to a child’s socialisation. This implies that in a child’s development and upbringing, it

⁵ However, it should be noted that as a result of modernization and urbanization, these practices are absent in the urban areas and rarely occurs in the rural areas.

is not only the responsibility of the parents to nurture the child in adopting a healthy and positive behaviour but also that of the society. In South African family settings, the idea of a ‘nuclear family’⁶ is not always the norm, and it is usually characterised with extended family system where relatives and generations live together in a big compound. It is ‘patrilineal’, ‘patri virilocal’ and polygamous in nature (Eddy and Holborn, 2011:1; Ziehl, 2001 in Gumedé, 2011:46) thus, individual upkeep, monitoring and care, especially for the younger ones, is seen as a collective effort (Siqwana-Ndulo, 1998).

However, as a result of various influential factors such as repercussions of the apartheid system (particularly with regards to the migrant labour system that forced family member to live apart), urbanization, poverty, unemployment, weakened intergenerational relationships, changes in gender roles, and inequality, change in the structures of communal upbringing in the family is affected. These structures include female-headed households, child headed households and/ or older person (mainly grandmothers) and caregivers or guardians taking on parenting roles particularly in South Africa (Eddy and Holborn, 2011; Tayki, 2011; Meintjes, *et al.* 2009). The above-mentioned factors have resulted in the increase of the fertility rate, unwanted pregnancies, number of orphans and HIV prevalence, as well as the breakdown of family norms and traditions (Eddy and Holborn, 2011; Henn, 2005).

The breakdown of the African family structure has conceivably affected parent-adolescent closeness and sexual communication which, if present, can reduce adolescents’ risk-taking behaviours (Guilamo-Ramos, *et al.* 2012; Miller, 2002; Miller, *et al.* 2001). Compared with other institutional sources such as school-based class sessions or workshop for adolescents, parents have been indicated as important and primary source of sex information for children (Bleakley, *et al.* 2009). However, parents have neglected their roles as (primary) sex educators to their children. Nowadays, parents are too busy with other activities at the expense of the time needed to spend with their children. For instance, parents delegate child care cutting across social, physical and emotional needs to house helps thus giving room for little or no parental care and monitoring (Ntarangwi, 2012). This could, however expose adolescents to risky sexual behaviours.

⁶ A typical nuclear family refers to a family group consisting of two parents (father and mother) and their children.

Together, parenting and all other sources of information help adolescents gain knowledge and encourage them to make responsible choices about sexual activity. However, it is worrisome that in South Africa, there has been a decline in knowledge about HIV prevention from 2008 to 2012 (HSRC, 2014:117). It was reported that only about 26.8% of South Africans had in-depth and correct knowledge about HIV. Increased knowledge recorded among the 15-24 age group only amounted to 24.3%. The decline could be attributed to ineffective sexual risks prevention interventions and programmes or the decrease in the important work of campaign messages on these risks (HSRC, 2014:117). Consequently, the three most influential platforms for information regarding sex and its risks in South Africa are reported to be television, radio and print media. Other conventional methods such as flyers, bill boards, posters, signs on vehicles (especially commercial vehicles) were rated less in the 2012 national survey (HSRC, 2014). Even though, parents are the first contact a child makes and as such could be the primary source of information about sexual and reproductive health, few effective programs that help parents positively influence their children's sexual behaviour exist (Lagina, 2002). Many parents are faced with challenges on how to start communication with their adolescents on relationships, body development, puberty and sex. Despite the awareness of adverse consequences, adolescents have not ceased from engaging in risky sexual behaviours that pose threats to their health. Without the availability of necessary information and services with regards to reproductive health care, sex and its risks, improving adolescents' health care will remain a pipe dream (Omi, *et al.* 2006). This urges for effective sex education interventions.

Through a holistic sex education package, parents will be knowledgeable and able to confidently guide their children. Furthermore, adolescents will be able to understand their body development, their emotional feelings and sexual urges (Meenagh, 2003). When educational support and resources are provided for parents in order to be effective sex educators, there is an increased likelihood of sexual discussions to occur in the family which could eventually lead to healthy sexual decisions and behaviours among adolescents (Ballard and Gross, 2009). Programmes and interventions have been found to be more effective in training parents on sexual information which has helped in reducing sexual risks (Phetla, *et al.* 2008) To this claim, it was recommended that programmes and interventions for parents on how to be a good and efficient sex educators be: health, social and entertainment education programs and interventions targeted

towards healthy behavioural change in which parents could be involved. These include – female health with the ZAZI: Know Your Strength campaign⁷ (Vukapi, 2016), the reduction of multiple and concurrent partnerships with *Intersexions*⁸ (Govender, *et al.* 2013, and gender-based violence prevention with the Brothers for Life campaign⁹ (Mathew, 2012).

According to the National Centre for Chronic Disease Prevention and Health Promotion (CDC) (2009), STI prevention education should be developed with the active involvement of parents, should be locally determined and designed to meet the age and needs of the targeted audience, and be consistent with community values. While ensuring that the targeted audiences are provided with effective education to protect themselves from STIs, HIV and unwanted pregnancies, messages should be tailored towards the needs of young adults who are not engaging in sexual intercourse as well as those ones who are currently sexually active (CDC, 2009). It is also suggested that health promotion campaigns should be invigorated and structured towards educating people about STIs; people should be compelled to know their HIV status (HSRC, 2012; Bachanas, *et al.* 2002). The above-mentioned South African campaign has been doing this. For a successful effort to combat adolescent sexual risks there is need to harmonise the treatment and evidence-based social and behavioural prevention programmes (HSRC, 2014:117). Likewise, there is need for more parent-adolescent communicative strategies in South Africa in order to promote information about sexual relationships, emotional well-being with intention of reducing adolescents' risky sexual attitudes and behaviour. However, despite the various efforts to train and educate both parents and adolescents through the availability of different programmes, communication gaps still exist between parties-parents and their children especially as the child grow.

Conclusion

There has been rapid increase in concern and intervention on adolescents' sexuality and risky behaviours. Yet unprotected sexual intercourse, multiple and concurrent partners (MCP), early sexual debut, no or inconsistent contraceptive use, sexual intercourse for reward, alcohol consumption, and drug use are still sexuality and risky behaviours that are characteristics of

⁷ See <http://www.zazi.org.za/about-zazi.html> accessed on 18 August, 2017

⁸ See <http://www.intersexions.co.za/> accessed on 18 August, 2017

⁹ See <http://www.brothersforlife.org/> accessed on 18 August, 2017

adolescence stage. All these risky behaviours are as a result of bad influence from mass and social media, peer pressure, drug and alcohol abuse, early sexual debut, urbanisation, insufficient knowledge, poor parent-adolescent communication, poor family background among others.

Young people's sexual experience and risk-taking behaviours make them vulnerable to pressure, STIs, HIV and unplanned pregnancy. The consequences are far-reaching and include abortion, guilt, school dropout death. However, some studies found knowledge of risks to be associated with increased vulnerability. Young people are considered to be more vulnerable when they take the knowledge of these risks with levity by concentrating on the immediate effect or pleasure rather than the long-term consequences. On the other hand, some studies found that knowledge about sexual risks builds adolescents' self-efficacy. Adolescents who have high or sufficient knowledge about HIV/AIDs perceive that they could be vulnerable to the risks because they believe they might get infected when they get involved in risky sexual acts.

Parental-adolescent sexual communication provides education about sex and risky behaviours to adolescents. The content of which includes abstinence, dating, sexual risk behaviours, menstruation, birth control, STIs/AIDs, and pregnancy. Mutual trust, confidence, focusing on good morals, sound knowledge on sexuality matters are among the factors that engendered parent-adolescent communication while traditional norms such as religious beliefs, gender, fear, age, urbanisation, discomfort, lack of information and lack of knowledge by parents are those factors that hinder effective parent-adolescent communication.

There is need, therefore, to identify those risky sexual behaviours that adolescents are exposed to and adolescents' perceived susceptibility and severity of such. It is as important to identify facilitators and barriers to communication in a South African context and exploring the communication approaches that encourage self-efficacy and pro-social sexual behaviour. Chapter three discusses the theoretical framework that informs this study and will aid in analysing these issues.

CHAPTER THREE

THEORETICAL FRAMEWORK

Introduction

The previous chapter entails a comprehensive review of adolescent risky sexual behaviours as well as the issues that arise from parent-adolescent communication. This chapter outlines the theoretical framework employed for this study. The study is primarily informed by the behaviour change theories, particularly the Extended Parallel Process model (EPPM) (Maloney, *et al.* 2011; Green and Witte 2006; Witte 1992) and guided by the Rommetveit and Blakar Communication model (Botchway, 2004; Blakar, 1984) and the Theory of Adolescent Development (Piaget, 1950; Erikson, 1968; Marcia, 1980, 1996, 2007; Bosma, 1992; Meeus, 1996; Luyckx, *et al.* 2008; Steinberg, 2008; Sokol, 2009). These behaviourist models and theories explain human personality. They include theories of learning which purport that all acquired behaviours are based on cognitive factors as well as behavioural and environmental influences. Their relevance in investigating the facilitators and barriers of parent-adolescent communication and adolescent sexual risk-taking behaviours in Mayville, Durban is discussed below.

The chapter begins with the EPPM model as it contains the majority of concepts that informed the study's research questions (as well as concomitant interview questions) that centre on the perceived severity and susceptibility of the facilitators and barriers of parent-adolescent communication on sexual risks, from a behavioural communication perspective.

Extended Parallel Process Model (EPPM)

The Extended Parallel Process Model (EPPM), also known as threat management or fear management, was postulated by Kim Witte in 1992 to investigate how individuals react when faced with fear inducing stimuli (Witte, 1998; 1992). It proposed that the greater the threat in a message, the greater the fear aroused. The EPPM was adopted for this study because, further to the explanation above, it considers the centrality of self-efficacy in the face of threat. It assists in making sense of the study's data by exploring the perceived susceptibility, severity and threat of adolescents' risky sexual behaviour as well as perceived barriers to effectively communicate these risks between parent and adolescent.

Adolescents are highly motivated and one would assume that they have the self-efficacy¹⁰ to avoid risk (unwanted pregnancies, HIV/AIDs, STIs) when they are knowledgeable about how to reduce a risk that possess a threat to their health (Taukeni and Ferreira, 2016; HSRC, 2014; Sychareun, *et al.* 2013). It is therefore the position of parents to educate their young ones early enough before their exposure to external factors such as peers. On the other hand, when adolescents feel helpless about what to do in reducing these risks, they tend to control their fear through defensive avoidance or reactance which results to rejection of recommended message (Maloney, *et al.* 2011). Parents' communication approaches on sexuality topics in the form of fear appeals (e.g. threat, instructions, dialogue, persuasion, manipulation) which are not tailored on how to reduce these risks may become ineffective in actualising its main purpose (Phetla, *et al.* 2008). Parents (or caregivers) have been of the opinion that applying fear appeal in their communication with their children reduces involvement in risky behaviour especially when they (parents) portrayed the consequences of risky sexual behaviours in a 'scary' manner (Bastien, *et al.* 2011; Luwaga, 2004). Studies revealed that most parents make use of warnings, threats and instructions especially with the female adolescents during sexuality discussions. This is with the intention that the adopted communication styles and tones would prevent their adolescents from indulging in risky sexual behaviours and encourage self-efficacy in the face of threat (Izugbara, 2008; Kumi-Kyereme, *et al.* 2007). The EPPM then suggests that when people perceive a serious threat, and it induces them to become scared, they will be motivated to take action to reduce their fear.

The EPPM primarily explains the workings of fear appeals conjoined with self-efficacy at the level of the mass media (Doyore, *et al.* 2013; Murray-Johnson, *et al.* 2001; Stephenson and Witte, 1998; Witte, 1997). However, this study sees the relevance of the model in meeting its objectives stated above, as parents and the adolescents are both part of the mass media audience and thus are 'threatened' or 'feel fear' from these messages that they may carry with them into their interpersonal communication. This model therefore served as a guide in exploring the various fear appeal communication tools often used by parents with adolescents within the family setting.

¹⁰ "The perceived self-efficacy that one can exercise control over one's health habits" (Bandura, 2014: 144).

The EPPM expands on the existing fear appeal theories, namely; fear-as-acquired drive model (Hovland, *et al.* 1953), parallel process model (Leventhal, 1970) and protection motivation theory (PMT) (Rogers, 1983; 1975). According to Witte, fear appeal theories failed in their message because previous theorists focused on factors leading to fear appeal successes, neglecting their failures (Witte, 1994). Based on this model, fear appeal outcomes were previously categorised into two broad factors (Witte and Allen, 2000:609): i) acceptance of the message's recommendations (i.e., "attitudes, intentions, behaviours in line with their commendations") and ii) rejection of the message's recommendations (i.e., "defensive avoidance, reactance, denial").

The EPPM re-worked PMT's flaw of the inability to explain how and when people reject recommended behaviour by adopting perceived levels of the variables (i.e. susceptibility, severity, response efficacy and self-efficacy) which led to message acceptance and behavioural change (Murray-Johnson, *et al.* 2001:743). A study on the cognitive and emotional mechanisms underlying the success and failure of fear appeals indicated that a relationship between emotional fear and fear control responses could not be related to danger control responses while cognitions about the recommended messages was linked to danger control responses but unrelated to fear control response. Efficacy response was effective and perceived threat mediates between emotion, fear and behaviour. In other words, as illustrated in figure 3.1. below, cognition response was perceived to lead to successful fear control responses such as attitude and behavioural change through danger control processes. On the other hand, emotional mechanism leads to fear appeal failure such as defensive, reluctance or avoidance of recommended message through the fear control response (Witte, 1994).

However, in order for recommended fear-based messages to be effective in persuading people to adopt healthy behaviour, a moderately-high level of fear, high level of self-efficacy and response efficacy must be included in the message. When individuals perceive the fear appeal message to be higher than the response efficacy, the recommended message will not be effective (fear control processes) or the individual will give no response to the recommended message if s/he perceived the threat conveyed from the message as irrelevant or ineffective. However, when the perceived level of efficacy is higher than the perceived level of threat, the likelihood of adopting

the recommended message (danger control processes) (Witte, 1994). That is, the extent in which a person feels threatened by the recommended message will determine his or her fear control (defensive or avoidance mechanism) while one's self efficacy (ability to confidently reduce or prevent the threat) determines the action-taken (Maloney, *et al.* 2011:208).

A meta-analysis study that used EPPM to determine effective means to prevent hearing loss among coal Miners in Indiana, Pennsylvania and West Virginia provides a good example of the above key concepts in practice (fear control, danger control, cognition response and emotional mechanism). It observed that those who perceived hearing loss to be injurious to their health and believed the recommended behaviour to adopt a new hearing protection was effective, were more likely to make cognitive choices (cognition response) to engage in healthy behaviour (danger control outcome) while those who were scared and reluctant to confront the danger of hearing loss nor ready to think of alternatives were perceived to be more likely to reject recommended behaviours (fear control) (Murray-Johnson, *et al.* 2001). EPPM argues that very high fear-based messages that focus mainly on inducing fear are often ineffective which would most likely lead to maladaptive; this is due to the fact that "fear has been operationalised as anxiety" (Witte, 1992:330) (emotional mechanism). Based on its two central constructs of threat and efficacy, an individual's attitudinal, intentional and behavioural responses to fear appeal messages is predicted (Maloney, *et al.* 2011: 207).

EPPM Central Constructs and Variables

Threat exists as an external or environmental stimulus. In other words, threat is perceived as danger or harm that exists in the environment, known or unknown to the individuals (Maloney, *et al.* 2011). When an adolescent has knowledge that a threat exists based on his or her indulgence in risky sexual behaviours (e.g. unprotected sex), it means s/he perceives a threat (e.g. STIs, unwanted pregnancies). A risky sexual behaviour becomes habitual when adolescents perceive the reward of such act (e.g. pleasure derived, peer influence, gifts) to be greater than the perceived severity or susceptibility (Witte, 1992; Rogers, 1983). As a result, adolescents tend to shift their focus away from the threat and to the short-term pleasure they will enjoy. Thus, this model assists in making sense of this study's findings that explored parent and adolescent interpersonal communication on risky sexual behaviours that pose threats to

adolescents' health, and the forms of communication that aim to prevent these risks. The perceptions or views of people based on the threat of a behaviour results to actions and not the actual threat of the behaviour (Maloney, *et al.* 2011: 207). In other words, adolescents' opinions about a threat will spur them to take action in preventing the risks. If an adolescent perceives a low threat, the probability that s/he might get involved in risky sexual act but when such adolescent perceives that s/he could be vulnerable and perceives the severity of the consequences of these behaviours to health (HIV, STIs, unwanted pregnancies, and death), his or her ability to withdraw from risks hence, confidence in the face of threat. Two variables form the threat construct; the susceptibility variable and the severity variable.

The susceptibility variable is the perception an individual has on how the effect of not carrying out a recommended message would affect them or put him or her at risk. That is, the perception the individual has of how likely the risk of a certain behaviour would affect them (Murray-Johnson, *et al.* 2001:744). The severity variable is the perception an individual has about the extent of a threat as being harmful to his or her health (Murray-Johnson, *et al.* 2001:744).

Another reason for which the EPPM is useful to this study is that it not only focuses on communication that may involve fear but it will be used to acknowledge that there may be forms of communication between parents and adolescent that include efficacy. Witte, *et al.* (1996:320) defined efficacy as a construct pertaining to “the effectiveness, feasibility, and ease with which a recommended response impedes or averts a threat”. Efficacy exists as an environment or external stimulus. If an individual (adolescent) exhibits a high level of efficacy based on the effectiveness of the recommended messages, he or she would more likely have the ability to perform the recommended message (self-efficacy). For instance, an adolescent's belief that the contraceptives a parent may explain to them would prevent unplanned pregnancies or STIs (response efficacy). This construct determines the adaptive and/or maladaptive responses based on susceptibility/severity or response efficacy/efficacy (Maloney, *et al.* 2011:207). Efficacy messaging is effective when the communicator (parent) is able to increase the response efficacy message targeted towards self-efficacy (Witte, 1992; Rogers, 1983). Two variables form the efficacy construct; the response efficacy variable and the self-efficacy variable.

The response efficacy variable signals the individual's expectancy that carrying out recommended measures (e.g., condom use or abstinence) can prevent a threat (e.g., STIs, unplanned pregnancies) (Rogers, 1975; Witte, 1992:320). That is, an individual's belief (adolescent) that the recommended message (e.g. parent's transference of a fear appeal message) is effective (e.g. "I believe condoms prevent HIV contraction") (Witte, 1992: 332)

The self- efficacy variable is the individual's belief in his or her ability to execute recommended courses of action successfully (Witte, 1992:320; Rogers, 1975). That is, an adolescent's perceived ability to carry out a parent's recommended message (whether in the form of an instruction, threat, warning, persuasion, motivation, dialogue, and / or advice) in controlling sexual risk-taking behaviours. (e.g. "I think I can confidently and physically use condoms to prevent HIV contraction") (Witte, 1992: 332).

Based on these variables, three broad factors were predicted which explained the possible responses people may have to fear appeal messages. Adolescents will respond to any of the below responses depending on the interaction between their perceptions of the threat and their perception of efficacy to avert the threat (Maloney, *et al.* 2011: 206). These variables were introduced above and are danger control, fear control and no response. These variables are also reflected in figure 3.1 below.

Danger control relates to the perception an individual has about the impact of the severity and susceptibility and the ability to take necessary actions (efficacy). Danger control response is initiated when the perceived efficacy is higher than the perceived threat, thus, individual response to the danger of the behaviour. Fear control relates to the way in which an individual may perceive that the ability to control a risk is low, in which case s/he would likely take steps to control their fear even when the severity or susceptibility is perceived to be high. This may result in maladaptive change if the adolescent adopts a defensive or reluctant mechanism to avoid the fear-appeal messages. The defensive avoidance attitude occurs when individual resists the recommended message to reduce the effect of a threat regarding risky sexual behaviour(s) while reactance occurs when an individual (in the case of adolescent) perceives that the communicator (in the case of parent) is trying to manipulate him or her based on the recommended message.

The no response variable is the perception the individual has when the severity and susceptibility of the danger is low.

The variables discussed above will be considered in the study's analysis (Chapter five) and the ways in which they are reported by the interviewees to manifest in relation to risky sexual behaviour and communication on the topic.

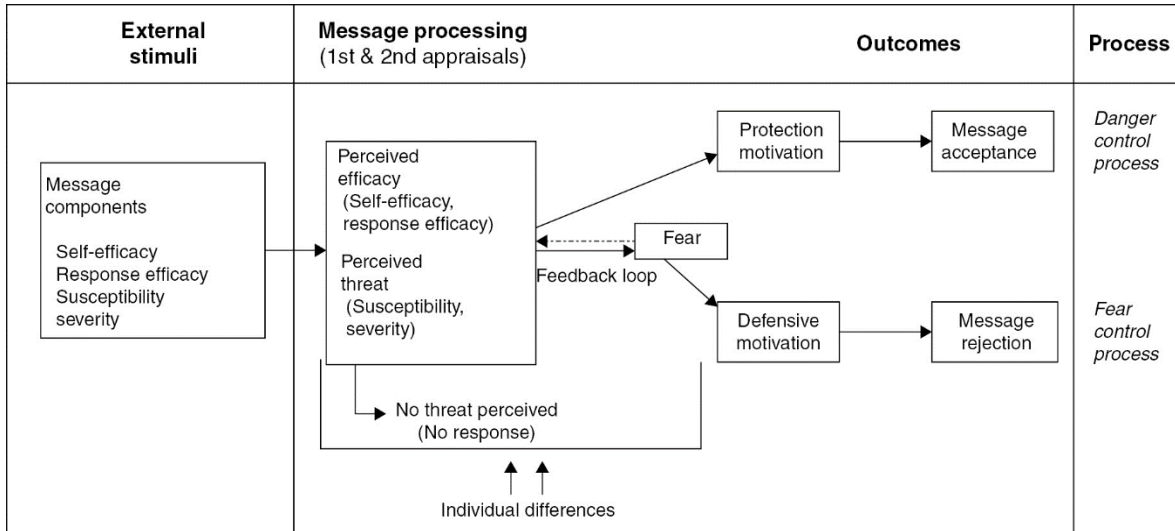


Figure 3.1: Witte's Extended Parallel Process Model (EPPM)

Source: Witte, 1992a

Operationalisation of EPPM variables

These variables are operationalized in various ways when an individual is faced with a message. From the above figure, EPPM explains the link between efficacy belief and emotional responses in determining individual behavioural actions. The evaluation of fear appeal begins with two appraisals of the message (severity + susceptibility or response efficacy + self-efficacy), which results in one of three outcomes (danger control, fear control or no response) (Maloney, *et al.* 2011:208; Witte and Allen, 2000:611). This is succinctly explained by Witte and Allen (2000: 611)

An individual first evaluates the threat of an issue from a message. If s/he perceived the threat conveyed by the message as irrelevant or ineffective, the lesser s/he is motivated to process the message further, and will definitely ignore the fear appeal (no response) but the more such individual sees s/he is at risks to a serious threat attached to the message, the likelihood s/he is

motivated to begin the second appraisal, that is, evaluation of the efficacy or effectiveness of the recommended response.

When a threat is described as and believed to be serious and relevant (e.g., “I’m at risk of contracting a terrible disease if I engage in unprotected sex”), an individual becomes frightened and this motivates them to take action(s) to reduce the fear (e.g., use of contraceptives, abstinence). In an analysis of HIV/AIDS in Uganda, a drastic reduction of about 66% between 1992 and 2002 was observed (Green and Witte, 2006:250; Shelton, *et al.* 2004). This was arguable the result of a fear appeal strategy that portrays AIDS as a deadly disease without cure (Okware, *et al.* 2001:1114). This measure instilled fear on the audience to accept a recommended healthy behaviour to abstain from sexual risk behaviours that could lead to AIDs (Byangire, 2002; Kaleeba, *et al.* 2000). However, “when an individual perceives that the threat is trivial or irrelevant, s/he is likely to ignore the preventive measure in the message” (Murray-Johnson, *et al.* 2001: 337). For instance, if an adolescent believes his or her risk-taking behaviour is ‘unique’, s/he would probably give no response to corrective measures. An individual’s perceptions of the intended message, based on his or her behaviour, influences how he or she would respond to such message and take action.

Accordingly, perceived efficacy (self-efficacy + response efficacy) determines whether people will become motivated to control the danger of the threat or control their fear about the threat (Witte and Allen, 2000:611). People are motivated to control the danger of behaviour and think about possible ways to lessen or remove the threat when they have confidence that they are able to carry out an effective recommended response advocated in the persuasive message against the threat successfully (i.e. high perceived self-efficacy and response efficacy). On the other hand, when people have low perceived response efficacy and low perceived self-efficacy, they are motivated to control their fear (because they are pessimistic about controlling the danger) and focus on eliminating their fear through denial (e.g. “I’m not at risk of contracting HIV, it won’t happen to me”), defensive avoidance (e.g. “the recommended message is just too scary, I’m simply not going to think about it”), or reactance (e.g., “my parents are only trying to manipulate me, I will ignore their recommended response of the message”) (Witte and Allen, 2000:611). Adolescents become victims of risky sexual behaviour (unwanted pregnancies, STIs) when they

lack a sense of self-efficacy and do not manage situations effectively, even though they know what to do and have the requisite skills.

EPPM suggests that health promotion messages work when they lead people to perceive themselves as being susceptible to a serious threat and to perceive themselves as able to perform the effective recommended response (Witte, 1998). In relation to this study, when parents employ the right communication styles and tones in communicating the consequences in such a way that it creates a manageable fear, coupled with efficacy, the likelihood to preventing risks by changing behaviour increases. This model assumes that in a communication message, high efficacy and moderate threat will lead to behavioural change. The high perceived severity and susceptibility to the threat motivates people to act and high perceived efficacy directs appropriate action (Witte, *et al.* 1998). Adolescents need to perceive themselves to be at risk of negative consequences (HIV, STIs, unwanted pregnancies) as a result of their risk-taking behaviours (unprotected sex) prior to behavioural changes to reduce these risks being made. Therefore, prevention of risky sexual behaviours aimed at adolescents' healthy behaviour and positive behavioural change should focus at increasing adolescents' perceptions of the outcome of these consequences (Baird, 2007).

Relevance of Extended Parallel Process Model for this study

The discussion above has pointed to the value of the EPPM to this study in describing the model itself, but this section serves as a summary. The EPPM has been used in different health promotion campaigns for behavioural change. Overall, fear appeal messages have been shown to be effective in different areas including HIV/AIDS (Murray-Johnson, *et al.* 2001; Witte, 1994), teenage pregnancy prevention (Witte, 1997), condom use (Doyore, *et al.* 2013), skin cancer prevention (Stephenson and Witte, 1998) awareness behaviours (Witte, *et al.* 1993) and so on. For this study in particular, the model is useful in describing adolescent perceived susceptibility and severity of their risk behaviours and the perceived barriers in communicating these risks as well as the effective communication style that encourage self-efficacy. Through the model, the study would be able to determine if family approaches during parent-adolescent communication encourages self-efficacy or inadvertently pushes them to more risks. An in-depth understanding of the fear appeal theory was of importance for the study as it addresses both parent and adolescents' perceptions of risk in relation to adolescents' involvement in risky sexual acts as

well as efficacy outcome which explains the reasons to adopt healthy behaviour. It comprehensively explains risk terms and structure, explains the cognitive 'operations' involved in the danger control side as a central variable of the model and identifies the relationship between threat and efficacy (Witte and Allen, 2000:609). These variables were used to explain reasons why adolescents reject or receive the information with regards to sexuality issues. This model guided the study in determining if parents' use of fear appeal in the communication message (threat, warning, instructions, motivation, persuasion, dialogue, advice, past experiences) with their adolescents and creates a sort of fear in adolescents alongside self-efficacy in the face of threat. The act of discussing sexuality with parents or caregivers is often times avoided (Phetla, *et al.* 2008) by young adults, so it is essential that the when communication does occur that styles and tone encourages self-efficacy.

Critiques of Extended Parallel Process Model

Just like most other theoretical models, the EPPM is not devoid of criticisms. It is argued that the EPPM fails to challenge the global health issues based on its cognitive bias (Dutta-Bergman and Doyle, 2005). The model, rather than putting into consideration the cultural values, is concerned with only cognitive factors that affect the individual. Its major focus is changing the beliefs of its targeted audience based on its recommended message (Witte, 1995). Though, there is value in its variables (severity, susceptibility, response efficacy and self-efficacy), health communication messages should be considered in conjunction with the cultural context, structural context, and community context among other factors (Dutta-Bergman, 2005). It conceptualizes health communication in the realm of rational action and on the basis of underlying beliefs of its audience (Dutta-Bergman, 2005; Airhihenbuwa, 1995; Lupton, 1994). Likewise, EPPM has been critiqued based on its de-contextualised bias in which health messages are taken from the context that surrounds it and provides a limited viewpoint for engaging in issues of global health (Dutta-Bergman, 2005). In other words, behaviour is isolated from a variety of contextual factors within which it is typically enacted (Dutta-Bergman, 2005). It is a monocentric theory which focuses on the individual-related factors and implications of behaviour change (Dutta-Bergman, 2005). Campaign designs and implemented messages are originated from a targeted individual behaviour which then becomes generalised (Salmon and Atkin, 2003). However, these generalisations may not always be applicable to differing contexts. In addition, in terms of decoding messages, audiences interpret messages according to their own experiences and natural

settings (Dutta-Bergman, 2004, 2005; Melkote, *et al.* 1995). Readings of these messages are thus always polysemic (Hall, 1973/1980).

The practical application of communication theories, as well as EPPM have been hindered based on the ways in which sender's intended messages are been interpreted by the receivers or audience. In other words, there is no assurance that the preferred health messages would be interpreted by the target audience as intended by the message producer. For EPPM, messages designed to ward off people from engaging in risky sexual behaviours, through its self-efficacy and efficacy responses, may not always be effective or perceived as effective by the audience when such messages are oppositionally (Hall, 1973/1980) by the audience or when the audience perceive threats from the message (Maloney, *et al.* 2011: 213). For example, a study conducted on AIDS-protective behaviour indicated high scores among individuals who perceived threats when exposed to severity and susceptibility of a hazard to self, while collectivistic individuals in groups perceived greater threat when exposed to severity and susceptibility of hazard as a group (Murray-Johnson, *et al.* 2001). Furthermore, the theoretical scope of the model has been able to justify its explanation and predicting reactions to fear appeals only, of which fear appeal messages are not always effective in adopting healthy behaviour during health campaign strategies or programmes (Maloney, *et al.* 2011:212; Green and Witte, 2006:245). It is therefore imperative that the different communication styles, with which messages are created, are taken into consideration. The following sections will introduce a communication model that will guide the study in exploring the communication aspects of the research questions.

The Rommetveit and Blakar communication model

This study adopted this model as part of its theoretical framework because it recognises the need to consider factors that can foster or hinder effective communication, taking into cognisance the traditional four major elements of the communication process namely; sender (parent/adolescents), medium (channels of communication, how sexual communication is transmitted), receiver (adolescent/parent) and feedback (response to ascertain comprehension of sender's message). It views communication as a purposeful activity of information exchange between two or more participants in order to convey or receive the intended meanings through a shared system of signs and semiotic rules (Douglas, nd.) It is worth noting here that in this

research, focus is on interpersonal communication which takes place between people who are interdependent and have some knowledge of each other.

The Rommetveit and Blakar communication model is a dialogical perceptive whereby interactions occur between two parties with each having influence on one another (Botchway, 2004). The model is suitable for this study to the extent that it is influenced by social constructivist thought which maintains that human development is socially situated and that knowledge is constructed through interaction with others (Botchway, 2004). As with this model of communication, parent-adolescent communication involves six (6) processes of interaction namely; i) Message production, ii) Encoding of message, iii) Decoding of message, iv) Processing and memory of received message, v) Sender's expectation of receiver's decoded message and vi) Receiver's listening on the premises of the sender.

This model serves as a foundation for the five stages of Albert Botchway's communication ingredients in order to examine where the communication problem(s) lies during parent-adolescent sexuality and risky behaviours communication.

More recently the Blakar communication model was extended by Albert Botchway (2004) who highlighted five important factors that explained the communication processes with regards to the six processes of communication interaction named above. Firstly, the communication process must involve active participation and willingness of the participants to produce feedback to the encoded message (Botchway, 2004). In a communication process, parties (parents and adolescents) must understand the intended context or message to ensure active participation and participants' willingness to be able to produce a message (feedback). If communication on sex related topics are prohibited in a family setting, it is evident that anything with regards to sex would not be discussed (Keller and Brown, 2002). Parents might have insufficient or no knowledge about reproductive health and sexuality issues. If parents are unable to clearly communicate sex topics with adolescents, it will affect the process of communication and willingness to give children information with regards to sexual issues. Adolescents may thus seek help elsewhere for better understanding which could be misleading if not from a reliable source.

Secondly, it is important for participants to establish mutual trust and confidence in order to ensure positive and effective communication (Botchway, 2004). If adolescents perceive a breach of trust with parents, it could weaken the communication as they may withhold crucial information from parents. Furthermore, many adolescents often lack strong and stable relationships with their parents or other adults to openly discuss reproductive health concerns (Ahlberg, *et al.* 2001). At times, parents' current or past experiences could cause a breach of communication especially if such experiences involve a parent's past risky sexual behaviour. Parents may either feel awkward and embarrassed to broach the topic (Rodgers, 1999), or that they are being hypocritical. In some cases, the adolescent may believe that as their parent undertook risky sexual behaviour it diminishes their authority in communicating health advice, as they are a bad example. On the other hand, in parent-adolescent sex communication, adolescents might view their parents as being judgmental, overly protective, inquisitive and disrespectful of their privacy (Botchway, 2004; Hollander, 2000). These could create a wall between parents and adolescents especially when they sense that their parents are trying to 'cage' them.

According to Botchway (2004), for communication to be effective, participants should have a common worldview about the message. For instance, when young adolescents ask questions on contraceptives or sex, parents might erroneously think they are engaging in sexual risks. Communication constraints could occur when both participants have different meanings to a particular subject or intergenerational differences. If a parent views sex as a sacred act which must be experienced after marriage and the child does not feel the same, this could cause disparities in the intended message and result in communication failure (Schear, 2006; Botchway, 2004). Nevertheless, for effective communication, participants must be able to understand and agree on each other's worldviews.

Communicants must also take into cognisance the body language and gestures produced by each other. Adolescents might withdraw when they perceive any form of threats from their parent's tone or reluctance to give satisfying answers to sex questions (Botchway, 2004). This could mean that such discussion is a taboo within the family context. For example, parents who speak in high or low tones, avert their eye contact and use negative body language could affect the child when he/she answers or asks such questions as regards sex (Botchway, 2004). Adolescents find it more

difficult to discuss sex with their parents because of fear of punishment and disappointment they might get from parents upon hearing they have engaged in a sexual act (Wamoyi, *et al.* 2010).

Lastly, the social and situational context of discussion is important for parent-adolescent communication. Parents might be willing to discuss sex education and in detail, but are confined because of cultural or religious factors. This often results to the use of unclear messages to transmit information (Botchway, 2004).

Relevance of the of the Rommetveit and Blakar Communication Model for this study

The strength of this model has been explained in detail above however, in summary, the Rommetveit and Blakar Communication Model is suitable to inform this study because it addresses relevant issues of the communication process and explains communication as a two-way process whereby both sender (in the case of parent and adolescent) and receiver (in the case of adolescent and parent) interchange roles (Wang, 2009). This model is suitable for this study that has, at its core, the question of barriers and facilitators both in the research questions as well as interview questions. As further illustrated by Botchway (2004), this model helps to explain barriers hindering and factors encouraging parents and adolescents from discussing sex topics. The five (5) steps identified by Botchway expands on the Rommetveit and Blakar six process communication model by identifying five steps, namely i) active participation and willingness to produce feedback ii) mutual trust and confidence iii) shared worldview iv) nonverbal cues v) social and situational content. These steps will be considered when analysing the data that reports on the communication process between the adolescent and parent.

Critique of Rommetveit and Blakar Communication Model

The Rommetveit and Blakar communication model is criticised as feedback from the receiver (in this case adolescents) is taken as less important compared to the sender's (parents) message. This occurs often when the sender (in place of the parent) asserts a high level of authority instead of establishing cordial and mutual relationship with their children. As such this study will identify the factors hindering and engendering cordial relationship between parents and adolescents.

When parents and adolescents are able to identify these barriers by seeing the subject matter through the same lens or world view, conflict may be avoided.

Being mindful of the above-mentioned critique that the adolescent is deemed less active in the communication process, this study is also informed by a theory that may shed some light on specific factors to consider regarding adolescent development.

Theory of Adolescent Development

Returning to social cognitive theories, the study also relies on the Theory of Adolescent Development (Piaget, 1950; Erikson, 1968; Marcia, 1980, 1996, 2007; Bosma, 1992; Meeus, 1996; Luyckx, *et al.* 2008; Steinberg, 2008; Sokol, 2009) in order to understand the underlying reasons for parent-adolescent communication gaps and the reasons for adolescents' certain risky sexual behaviours during the adolescence stage. The theory explains possible reasons for an increased rate of risky sexual behaviours among adolescents compared with other age groups. Adolescent development encompasses the cognitive, physical, moral, social and emotional domains of growth and change (Compas, *et al.* 1999). It is a period in which a child experiences a variety of biological changes that involves dramatic transitions in the physical, social, sexual and intellectual spheres (UKEssays, 2015).

In accordance with Jean Piaget's cognitive-developmental model, the late adolescent stage (18-21) is marked by a transition of thinking in which the individual moves from the cognitive stage of concrete operational stage to formal operational (Inhelder and Piaget, 1958). At the early stage (concrete operational stage), adolescents are more likely to make sexual decisions based on immediate satisfaction, rather than on the futuristic severity of the consequences of their actions and are unable to generate alternatives or identify possible consequences as readily as adults (Pedlow and Carey, 2004). Evidence in support of these stages showed that adolescents, predominantly at the early stage, still possess under-developed cognitive maturity required to fully comprehend and carry out some risk reduction strategies (Halpern, *et al.* 2000). Unlike the early stage, the late adolescence is characterised with formal operational period and is perceived as a stage in which adolescents develop the ability to think abstractly and futuristically (Fantasia, 2009:19). That is, a stage where adolescents systematically look into problems and test several

solutions (Sincero, 2013). The formal operational period (Fantasia, 2009:19 and Inhelder and Piaget, 1968:335-344) could be succinctly explained further as a:

Full transition of an adolescent into the operational stage which results in the ability to draw conclusions from available information and predict possible outcomes, reason theoretically, and understand more abstract concepts such as love and fidelity. This stage is characterised with high level of maturation of the nervous system which is as a result of the manifestation of cerebral transformation of the adolescent. At this stage, adolescents tend to assume adult roles.

This model is essential for this study in order to understand holistically an adolescent's development processes and reasons for their possible risks, especially at late adolescence. This theory has frequently been tested in determining the relationship between an adolescent's developmental appropriateness and sexual risks outcomes (Pedlow and Carey, 2004; Irwin and Millstein, 1992; Cole and Cole, 1989; Hamburg, 1986). Late adolescents (from which the sample for this study is drawn) were perceived to have a more developed reasoning capacity, consider probabilities, predict multiple behaviour alternatives and weigh consequences before making decisions; which are part of the fundamentals in sexual decision-making processes (AlBuhairan, *et al.* 2012; Cromer, 2011; Halpern, *et al.* 2000). However, despite this development, cognitive functioning still affects late adolescents' ability to appraise the threats associated with their risk-taking behaviours and capability to implement protective behaviours such as protected sex or abstinence (Steinberg and Chauffman, 1996; Inhelder and Piaget, 1958). This could be attributed to being less proficient at abstract thinking, which would most likely hamper adolescent reasoning capabilities such as using contraceptives during sex or considering the futuristic severity of the consequences of their behaviours (Kegeles, *et al.* 1988; Orr, *et al.* 1996). Furthermore, even though adolescents at this stage were perceived to have developed the ability to reason abstractly and consider cause-and-effect' of relationships, they were still found to have little experience in applying the necessary skills to decision-making especially when sexual arousal is high. Linking to the EPPM, this shows little or no self-efficacy to carry out recommended messages (Irwin, and Millstein, 1992) in the face of a threat.

Cognitive development during this stage involves egocentric thought (i.e., the belief that an adolescent is different from others) which probably influences adolescents' decision-making process thus, poor risk perception of their behaviours (Fantasia, 2009; Irwin and Millstein,

1992). Adolescent egocentrism tends to lead them to exhibit certain behaviours such as the inability to apply knowledge or necessary tactics for risk avoidance, feeling of constant scrutiny, personal myths, uniqueness of one's thoughts and feelings, self-consciousness, biased perception of risks and feelings of invulnerability to the consequences that might result from their behaviours (AlBuhairan, *et al.* 2012; Fantasia, 2009; Pedlow and Carey, 2004, Chapin, 2000). Based on this egocentrism, adolescents tend to see themselves as always right, argue their opinion on certain issues (such as sex), and are overdramatic and often think of only themselves (AlBuhairan, *et al.* 2012; Fantasia, 2009; Cromer, 2011).

From this model, it could be deduced that as adolescents move from one stage to the other, the ability to reason in a more thoughtful and mature manner ensues at the late adolescent stage (formal operational) (Steinberg and Cauffman, 1996). This could be due to the development of abstract reasoning which enables adolescents at this stage to consider hypothetical situations and future consequences of their actions. In other words, when adolescents are able to reason critically and consider the severity of the consequences of their behaviours on their future, rather than just the immediate effect, improving the chances of positive sexual decision making. Showing the importance of this stage on adolescents' sexual behaviours, Pedlow Teal and Carey Michael (2004) concluded that the developmental transition during adolescence should be put into consideration when developing and evaluating risk reduction intervention programmes.

During a child's puberty stage, three areas of potential upheaval are inevitable; i) conflict with parents, ii) mood disruptions and iii) risk behaviours (Arnett, 1999). As a result, increased risk-taking behaviours between childhood and adolescence was likened to changes around the time of puberty in the brain's socio-emotional system which leads to increased risky behaviour especially when exposed to peer pressure. A declined rate of risky behaviour between adolescence and adulthood was as a result of changes in the brain's cognitive control system that are, changes that improves an individual's capacity of self-control (Steinberg, 2008). These changes make adolescence (especially at the late stage) a time of intense vulnerability to risk and reckless behaviours (AlBuhairan, *et al.* 2012; Steinberg, 2008). This study's data that reports on these stages and associated risk-taking behaviour will be analysed in Chapter five.

The adolescence period is characterised with changes in frequency and content of parent-adolescent conversation and relationship, increased independence from family control, privacy,

increased peer influence and pressure, sexual awareness, identity information, and psychological and cognitive maturation (Igra and Irwin, 1996). Adolescents, especially at the late stage, engage in more risky behaviour (AlBuhairan, *et al.* 2012; Steinberg, 2008) because at this period the quality of time parents and adolescents spend together is reduced. With age, adolescents tend to disclose less information and increasingly keep secrets (Keijsers, *et al.* 2010; Keijsers, *et al.* 2009). However, it is, however, important for parents to exercise sizeable parental control and establish cordial and intimate relationships with their children (Crouter, *et al.* 1999).

It has been observed that parent-adolescent communication challenges do not stem from the parties being unable to engage in reasonable conversation, but rather from the change in the nature of their relationship as the child transits to adolescence (Collins, *et al.* 1997). Increased adolescent autonomy unavoidably affects the level of self-disclosure; intimate relationship, perception of privacy and responsibilities as well as their intergenerational differences which affect their worldviews (Laursen, 2012; Botchway, 2004). As a result of incongruent worldviews, which could be triggered by the global advances in adolescent's logical thought capacities about sex and reproductive health issues as well as its risks and knowledge, a degree of interpersonal communication difficulties and differences is bound to ensue (Laursen and Collins, 2009; Collins and Luebker, 1994).

A child's biological level of maturation is thus a factor to be considered when examining parent-adolescent relationships. The nature and processes of a child's maturation provokes the level of parent-adolescent intimacy and family communication (Laursen, 2012). The Maturationist models of adolescent development assumed that "a period of diminished closeness and heightened conflict accompanied with adolescent maturation continues until parent-adolescent relationships and roles are renegotiated" (Laursen and Collins, 2009:4). However, during this period, parents need to create an emotional atmosphere whereby adolescents are free to disclose any issues bothering them especially on related sex matters and its risks. A positive transformation in parent-adolescent relationship would result in declined conflict, increased closeness and more 'sophisticated' and 'constructive' social interactions (Laursen, 2012:4).

The oedipal urges (Sigmund Freud, 1949 and Anna Freud, 1958), which occur as a result of hormonal change during adolescence, was associated with adolescent delinquencies, declined parent-adolescent closeness as well as anxiety and impulse control problems (Cromer, 2011). In

the same vein, parent-adolescent conflicts and adolescent's withdrawal from parent and/or privacy was associated with adolescent's ego identity development and crisis and strives for autonomy (Cromer, 2011; Hazen, *et al.* 2008; Blos, 1979; Erikson, 1969). The term "identity" regarding adolescents gives reference to Erikson's (1950) eight stages of human development¹¹ where adolescents face the challenges of personal identity, role diffusion and identity confusion. The core variables of this theory are the acquisition of ego-identity and identity crisis; these become inevitable and important aspects during adolescence. In order to further get insight on reasons for adolescents' sexual risky-taking behaviours, understanding their perception about their identity is thus essential for this study. Identity, based on Stuart Hall sociological concept, is the interaction between self and the society. In search of 'self' identity, he explained that the real self (inner core or essence) is not autonomous and self-sufficient of its self to define the identity but is dependent on one's interaction with the society (Hall, 1996:597). In developing a stable sense of self, adolescents interact with the cultural worlds (values, meaning, symbols) and the identities which they offer as well as its applicability to their own world view (Hall, 1996:597). In other words, identity is formed when adolescents are able to access their personal attributes in and correlate these with the environmental factors (Vukapi, 2016; Sokol, 2009). "Identity refers to a sense of who one is as a person and as a contributor to society" and is what makes one "move with direction; it is what gives one reason to be" (Sokol, 2009:142). "In other words, the process of forming identity involves creating a coherent sense of self and who one is in relation to the world" (Sokol, 2009:145). "The fact that we project 'ourselves' into these cultural identities, at the same time internalizing their meanings and values, making them 'part of us', helps to align our subjective feelings with the objective places we occupy in the social and cultural world" (Hall, 1996:597). How an adolescent sees his or her self (subjectivity) and how s/he wants others to see him or her (representation) defines identity.

Adolescents' identity formation is a major event in the development of their personality as a result of their physical, cognitive and social factors that marks off this stage (Sokol, 2009). At this stage, adolescents were believed to more likely make important decisions that pertain to

¹¹ The eight stages include trust vs. mistrust, ii. Autonomy vs. shame, iii. Initiative vs. guilt, iv. Industry vs. inferiority, v. identity vs. role confusion, vi. Intimacy vs. isolation, vii. Generativity vs. stagnation, viii. Ego integrity vs. despair. However, this study will only consider the fifth stage (identity vs. role confusion as it pertains to adolescents from which the sample for this study is drawn. These variables will be considered in the study analysis (chapter five) in order to reflect possible reasons for adolescent risky behaviours and parent-adolescent conflicts.

various life domains including friendship, romantic relationships as well as their behaviours (Sokol, 2009). The search for self-discovery requires that the past, present as well as the future are interconnected for production of a meaningful self-concept. On the other hand, crisis is bound to occur during identity formation which requires adolescents to make decisions about their personality (Fantasia, 2009; Marcia, 1980). Their decisions could result in them either being able or unable to accept or refuse any potential alternate actions. “Successful decision occurs in an environment of high support from family, peer, and social groups” (Fantasia, 2009:21). However, when adolescents function outside a supportive environment, it could affect their ability to fully consider options for reasonable decision making behaviour (Fantasia, 2009; Marcia, 1980).

During identity formation, adolescents tend to drift away from their parents’ and childhood ideologies, and importantly, relinquish the fantasised possibilities of multiple, glamorous lifestyles (Vukapi, 2016). Different factors of identity formation cut across sexual decisions, environment, societal, biological, background, peers, and change in life circumstances. “The attitude and perception of norms and behaviours among peers has significant and consistent impact on adolescent sexual behaviour” (Vukapi, 2016:19). Peer influence can either have a positive or negative impact on adolescents’ sexual decision-making process. For instance, when an adolescent perceives his or her peers to engage in risk-taking behaviours, the adolescent may copy such tendencies. On the other hand, a positive behaviour exhibited by an adolescents’ peers will encourage positive behaviour especially in case of sexual intercourse (Panday, *et al.* 2009; Clark and Clark, 2007; Berk, 2003).

At preadolescence, teenagers struggle with their self-identities which often results in a lack of parental control, withdrawal, less companionship, relationship gap and lower feeling of satisfaction and acceptance of family norms (Loeber, *et al.* 2000; Larson, *et al.* 1996). Adolescents want to create a niche for themselves and need time to discover themselves to realise who they are and importantly, make deliberate choices and decisions as they set themselves apart from their parents or caregivers. The implication is that the individual tends not to take into account parental control, instead they see parental control and inquisitive style as invading their privacy. This results in a communication gap as their adolescents grow older. Besides this, adolescents also take advantage of their autonomy and privacy by systematically

withholding information from parents, especially on sex topics and its risks (Panday, *et al.* 2009; Smetana, *et al.* 2006).

Increasing autonomy during adolescence extends the range of social influences that affect sexual risk behaviour (Pedlow and Carey, 2004). Adolescence is accompanied with a crucial aspect of personal evolution that calls for a change from dependence to independence which lies mostly in the late adolescence stage. At the early stage, teenagers undergo attitude change such as opposing dependence on parents (King, 2004). Adolescents' desire for adult privileges such as autonomy, status and money are often denied to them. They feel disrespected by adults which results in conflict and fight for independence (Steffensmeier and Allen, 2000; Laursen, *et al.* 1998). Though, parent-adolescent conflicts during this period are perceived to help adolescents' individuality and autonomy development, high conflict could make the adolescence stage difficult for both parties even when the conflict is said to be beneficial (Steinberg, 1990).

The period of adolescent maturation weakens parental monitoring and control which results in increased adolescent autonomy (Laursen and Collins, 2009). This prompts adolescents to rely on other influencing factors such as media, peers for sexuality and reproductive health topics, as elaborated upon in Chapter two. Likewise, parents/care givers find it difficult to monitor their adolescents because of the quality of time adolescents spend with peers as compared with family. However, most parent-adolescent conflicts do not result in a long term negative impact on their relationship but poor conflict management strategies have been associated with adolescent maladjustment (Branje, *et al.* 2009). When this phase (pubertal maturation and individualisation) is completed, it is expected that parent-adolescent relationship becomes effective, conflicts are reduced as well as closeness re-established (Laursen, 2012). It is therefore important that parents strike a balance between their level of control and regulation with the adolescent's developmental needs. To know how to shape a child's development in a positive way, parents or caregivers must be ready to understand the way adolescents are hardwired.

Relevance of Theory of Adolescent Development for this study

This theory is adopted to frame this inquiry in order to understand the way children develop and learn. More importantly, the reasons for adolescents' involvement in risky sexual behaviours and why these risky sexual behaviours are more prevalent among these age groups.

The Erik Erikson's psychosocial theory of human development is considered in developing Theory of Adolescent Development because it covers the whole lifespan, and recognizes the contribution of biologic, cultural, societal, historical and environmental influences on the developmental process. (McLeod, 2013; Fantasia, 2009:19).

Critiques of the Theory of Adolescent Development

There has been much valid research conducted using the theory of adolescent development (Sokol, 2009; Fantasia, 2005; Pedlow and Carey, 2004; Steinberg, 2008) but there are still identifiable criticisms to this theory. The critiques are offered based on the two main proponents of this theory; namely Jean Piaget's cognitive or psychological view and Erik Erikson's psychosocial view. Though the theory has been identified as a helpful tool for parents and guardians in understanding and communicating with their adolescent, it has been inadequately understood because of the complexity of its terminologies. The theory fails to explicitly differentiate some of its tests. Its findings cannot be replicated because it is difficult to access the significance of its general findings (McLeod, 2013). Furthermore Dasen (1994) and Vygotsky (1978) argue that the cognitive development of a child is also dependent on cultural and social factors and not basically on cognitive development and biological maturation. Its narrow focus on psychological and physiological characteristics of an individual eschews various other socio-economic and political factors that affect parent-adolescent communication.

The researcher is aware of the value of a social ecological perspective that may consider these other factors in parent-adolescent communication. The use of the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid, *et al.* 2007) would be particularly useful here. However, as this study was approved as one designed from a behaviour change perspective it maintains its focus on the above-mentioned social cognitive theories, and the identified communication in order to achieve its research aims. Formally considering the many layers of influence included in the SEMCHB is beyond the scope of a Masters dissertation. However, where and how factors that lie behind the individual are reported by the study's interviewees, will be included in the findings and analysis of this dissertation. They will, however, be explained according to the three above mentioned models.

Conclusion

In conclusion, the above models and theory give light to the barriers hindering and engendering parents and adolescents from communicating on adolescent risky sexual behaviours and also the possible reasons for risk-taking behaviours. The EPPM (Witte, 1992, 1994, 2000) encourages individuals to adopt a healthy behaviour through recommended messages towards self-efficacy and also assists the researcher to explore the perceived threats of sexual risks to which adolescents are exposed. The theory determines the perceived susceptibility and severity of an adolescent's exposure to risky sexual behaviours by examining parent-adolescent communication and their perceptions of these risky sexual behaviours. The adapted Rommetveit and Blakar communication model (Botchway, 2004) provides the conceptual pathway of effective communication against which the data will be compared. The Theory of Adolescent Development sheds more light on the reasons for adolescents' risky sexual behaviours at the puberty stage. Conflict is bound to occur as a result of intergenerational differences between parents and their adolescents. However, effective communication can occur when there is mutual agreement and understanding between the parties involved. These frameworks are therefore relevant to this study as they assist in exploring how individuals respond to and act based on recommended messages and real-life experiences via their cognition processes. The next chapter presents and explains the methodological approach that gathered the data in response to these research aims.

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter outlines the methodological design, approach, and procedures used during data collection, as well as their relevance and applicability in exploring risky sexual behaviours and parent-adolescent communication. As illustrated in this study's methodological map below (Fig 4.1), the chapter begins with the research philosophies, paradigm, design and approach employed. This is followed by a description of the setting for data collection, selection and recruitment of study participants, and a description of the measuring instruments, procedures and the data analysis. Lastly the validity, reliability, ethical considerations and limitations are explained.

The key research questions that guided the study were:

- i. What forms of teenage risky behaviour are adolescents exposed to in Durban?
- ii. What issues are identified as most difficult to discuss and why?
- iii. What are the approaches parents adopt in communicating and educating their adolescents?

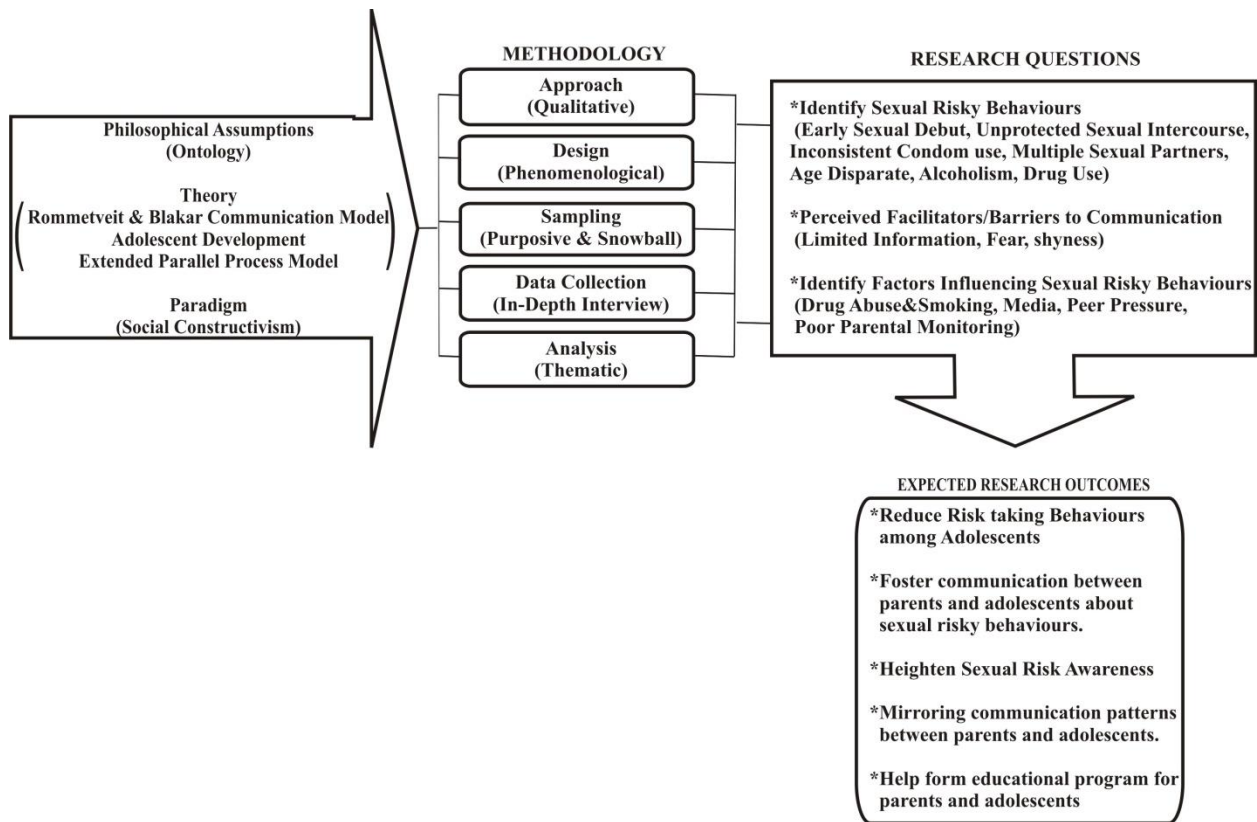


Figure 4.1: Methodology Map

Research Philosophical Assumptions, Paradigm and Design

Creswell (2007:15) explains five philosophical assumptions that guide a researcher's decision in selecting a study's approach. These are; ontology, epistemology, axiology, rhetorical and methodological. The choice of these assumptions has implications on the study design and data collection. The ontological perspective adopted for the study consists of a stance towards the nature of reality and its characteristics (Creswell, 2007). Ontology is concerned with the nature of reality; a system of belief that reflects humans and their interpretation of the real world (Neuman, 2014), which in this study is parent-adolescent communication on adolescent risky sexual behaviours.

This study is framed within a social constructivism paradigm which seeks the understanding of phenomena from participant's subjective meanings and experiences regarding adolescents' risk-taking behaviours (Creswell, 2007:20-21). The social constructivism paradigm accommodates the theory and models employed in this study (see chapter three). Within the paradigm employed,

meanings were interpreted based on the participating parents and adolescents' subjective points of views, experiences and suggestions. The study was carried out to explore their experiences on adolescents' risky sexual behaviours in correlation with their communication and their perceived knowledge or cognition of these risky sexual behaviours.

Research Design

A research design is the “conceptual structure within which research is conducted; it constitutes the procedures for collection, measurement and analysis of data” (Kothari, 2004: 31). There are various research designs in conducting qualitative research. These include narrative design, grounded theory, ethnography design, case study and phenomenological design. This study adopted a phenomenological design which seeks to describe adolescent risky sexual behaviours regarding their communication with parents or caregivers from the perspective of the people involved (parents and adolescents) (Welman and Kruger, 1999). Phenomenological research in this study describes the meanings of the phenomenon, parent-adolescent communication on adolescents' risky sexual behaviours based on several people who have similar experience about the phenomenon. Meanings of this phenomenon are formed from the interpretation or perception of various individuals' lived experiences (Creswell, 2007:59). It describes what participants have in common as they experience the study phenomenon.

There are two approaches to a phenomenological design; hermeneutic phenomenology (Van Manen, 1990) and empirical, transcendental or psychological phenomenology (Moustakas, 1994). Hermeneutic phenomenology focuses on the interpretation of audience responses. It is a research towards audience lived experiences (phenomenology) and the interpretation of texts (Van Manen, 1990:4). While hermeneutic phenomenology focuses more on interpretation, psychological phenomenology focuses more on the description of audience experiences. A phenomenological researcher tries, as much as possible, to withdraw from including his or her experiences and rather develops and depends on research participant experiences. Hence, transcendental means data on phenomenon is perceived as new or fresh from participants' experiences or perspectives towards the subject matter. As such, the researcher adopts new perspectives from the examined phenomenon (Creswell, 2007:60; Moustakas, 1994:34). This study therefore adopted a

hermeneutic phenomenology which describes participants' opinion on parent-adolescent communication on sexuality and risky behaviours.

Phenomenology takes into account subjective human interests and focuses on meanings rather than ordinary data. Adolescents are involved in diverse risky behaviours, cutting across smoking, drinking, multiple sexual partnerships, and unprotected sexual acts which pose threats in the form of -STIs, unplanned pregnancies and even death. Based on research, one of the most effective and best ways that risky behaviours can be reduced among young adults is, to a large extent, through parent-adolescent effective communication (Manuel, 2013; Bastien, *et al.* 2011; Phetla, *et al.* 2008). However, parents have been proven to shy away from effectively communicating these issues with their adolescents. These issues are everyday phenomenon that calls for attention. It is for this reason that the research was set to examine parents' and adolescents' perceptions and interpretations regarding adolescent risky sexual behaviour and their communication based on their lived experiences through a descriptive phenomenology.

In carrying out a descriptive phenomenology, the researcher identified the phenomenon to study; the facilitators and barriers of parent-adolescent communication on adolescent risky sexual behaviours and considered that the research questions would be answered using a phenomenological approach (Moustakas, 1994). The next step involves bracketing (*epoche*) the researcher's experiences in order to avoid bias or judgment (Creswell, 2007; Moustakas, 1994). Bracketing lessened the potentially harmful effects of biases that may taint the research process and helped the researcher to reach deeper levels of reflection across all the stages involved in the qualitative research (selecting a topic and population, designing the interview, collecting and interpreting data, and reporting findings) (Tufford and Newman, 2010:80). Gearing Robin (2004: 1430) explained bracketing as a "scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon". The researcher proceeded in the collection of data from suitable studied participants from the Mayville community. For in-depth analysis of parent-adolescent communication on adolescent risky sexual behaviours, the researcher transcribed participants' responses and analysed their experiences and perceptions. The next step involved the coding and analyses of data into quotes to reduce and 'cut-off' irrelevances. Themes were developed based on the codes that emerged from the raw data that is, individual's experiences (textual description),

context and situation that influence individual's experiences of parent and adolescent communication on sexuality (imaginative variation or structural description). The last step involved the researcher's experiences, context and situations that influenced her experiences on the field [researcher emphasis]. This affords the researcher to develop a composite write up that gives deeper understanding and essence of the topic. With regards to this procedure, the researcher was able to develop a *structural* description (how they experience the phenomenon based on the context or situation that surrounded their experiences) and a *textual* description of participants' experiences to arrive at the *essence* of the phenomenon [researcher emphasis]. In other words, Structural + Textual = essence of experience (Creswell, 2007: 60).

Research Approach

"Research approach is plans and the procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation" (Creswell, 2013:31). This is divided into three broad categories; qualitative research, quantitative research and mixed method research. As explained above, subjective meanings are socially and historically based. That is, meanings are formed based on researcher's interactions with the study participants and through their historical and cultural norms that surrounds them. This study was set to examine parent and adolescent perceptions, views, attitudes, notions, opinions and interpretation of adolescent risky sexual behaviour regards to parent-adolescent communication in a social context. It was on this notion that the researcher employed a qualitative research approach in order to give the best answers to the research questions outlined for the study.

"Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2013:32). This involves emerging questions and procedures, data collected from participants' setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. Unlike quantitative methods, qualitative research is "characterised by its aims which relate to understanding some aspect of social life, and its methods which (in general) generate words, rather than numbers, as data for analysis" (Brikci and Green, 2007:2). In qualitative research, data analysis involves identification of common issues or subjects and critical analysis of respondents' perceptions and responses in order to accomplish the study's aims and

objectives. It was also noted that “qualitative methods are often regarded as providing rich data about real life people and situations and being more able to make sense of behaviour and to understand behaviour within its wider context” (Vaus, 2001, p.5), which is the focus of this study. A qualitative methodological approach was therefore adopted because it enabled participants to describe their experiences and express themselves about the research phenomenon. It helped the researcher to gather a more detailed understanding of parent-adolescent communication on sexuality. This method thus aimed at providing an in-depth understanding of barriers hindering and facilitators engendering parent and adolescent communication, perceived threats to which adolescents are exposed regarding their involvement in risky sexual behaviours, perceived susceptibility and severity of the consequences of these risky behaviours and approaches that encourage self-efficacy regarding healthy behaviour.

Study location and time frame for data gathering

Data was collected from Mayville, a suburb in Durban, KwaZulu-Natal with a population of about 48,810 (as described in Chapter one). This location was selected because eThekweni district, (where Mayville is situated) was reported as one of the districts with the highest HIV prevalence (41.1%) in KwaZulu-Natal (Department of Health, 2015; HSRC, 2014). Over the years, the area has been characterised with crimes most especially among young adults. Besides the usual challenges that adolescents face, youth in Mayville are also exposed to risky behaviour such as drug abuse, prostitution, alcohol abuse, and hooliganism. Data gathering which included in-depth interviews took ten weeks (August-October 2016) as opposed the proposed four weeks. This was, however, due to some constraints as explained later under limitations to the study.

Selection of participants

Selection of participants is an essential research stage because of the significant influence it can have on the quality of research findings (Laerd, 2012). It is the process of selecting a considerable and manageable number of participants as a part to represent a whole in a study (Dawson, 2002:47). In order to overcome the challenge of studying the whole population, a small and more manageable number of parents and adolescents were selected. In this study, the researcher seeks to describe the phenomenon within a small group of people involving both parents and adolescents from Mayville through in-depth interviews.

The study adopted a non-probability sampling technique because of the nature and sensitivity of the research topic. This technique allows for a specific unit of the population who are relevant to the study. Using a non-probability technique, the selected sample of parents and adolescents were assumed to represent the population and were based on the researcher's subjective decision (Laerd, 2012). Purposive technique, a type of non-probability technique allowed the researcher to select participants who were deemed relevant population to the study (Seale, 2012). This is required when the researcher's goal is descriptive rather than a generalisation of a study sample (Dawson, 2002:48-49). The researcher's choice of selection was, therefore, not based on the total representation of the population but majorly on the participants' relevance to the study. In selecting a purposive sample, the focus was on particular characteristics of the selected population that are of interest, and are best able to answer the interview questions. The researcher recruited participants who seemingly had an understanding of questions asked, were willing to participate and willing to disclose information as the topic. Likewise, parents who had adolescents between 18-21 years and qualified adolescents who were between the ages of 18 and 21 years from the Mayville community were selected for the study because the research was purposively designed to explore adolescent sexuality and risk-taking behavioural issues in Mayville, Durban.

Sample Population and Size

The sample population adopted for the study comprised of late adolescents within the ages of 18 and 21 and parents who had adolescents between the ages of 18 and 21 from Mayville Township. Adolescents have been identified as children between the ages of 10 to 24 and are sub-divided into three stages – i) early adolescents (between the ages of 10 to 14), ii) middle adolescents (between the ages of 15 to 17) and iii) late adolescents (between the ages of 18 to 21) (HCO, 2015; WHO 2014). The selected participants included both male and female; father and mother. The decision to interview the adolescent in this age bracket was borne from the fact that at this stage their intellectual, emotional and social development begins to develop with their physical development (HCO, 2015). In other words, they would have been intellectually, emotionally and physically developed; sexual debut and arousal is likely to have occurred and the ability to fall in love and form romantic relationships ensues. Likewise, they have deeper understanding of the topic, they are able to express themselves, and are more exposed to these sexual risks (UNAIDS, 2012). Some researchers have argued that sex communication should be introduced at the early stage (Opara, *et*

al. 2010; Wamoyi, *et al.* 2010) leading to studies where early adolescents are interviewed for corrective measures. However, in this study, the aim is to find out from those who are already likely to have been exposed to and involved in these risks (late adolescents) and their reasons for such behaviour. Unlike early adolescents, who were perceived to be naïve and still in the process of identification and understanding themselves, older or late adolescents have an improved level of identity of themselves (explained in Chapter three via the Theory of Adolescent Development). When it comes to being involved in any risks, they consider themselves to be adults and feel they could take responsibility of their actions. The late adolescents are therefore in the best position to give accurate answers to the study questions.

A total of eight people participated in the study. The researcher conducted one-on-one interviews with four (4) adolescents - two (2) male who were 20 years and two (2) female who were 21 years at the time the interview was conducted. Likewise, four (4) parents - three (3) mothers and a father who had adolescents between 18-21 years were interviewed. Pseudonyms¹² were employed for the study to retain participants' anonymity.

For example, of the two males: "Bongo" aged 20 who is living with his aunty because of the death of his father; "Thambiso" aged 20, living with his aunty as a result of dysfunctional family were represented with T01, male adolescent and T02, male adolescent and of the two females: "Nandie" aged 21 living with her father; "Thabisile" aged 21 living with her sister were represented with T03, female adolescent and T04, female adolescent. For the parents, Priscilla, who is a single mother of a female adolescent aged 18; Gezani, a polygamist father of two male adolescents aged 18 and 21; Thando, a widow with 21 years adolescent; Chiliza, a single mother of one female adolescent aged 21 were represented with P01, mother; P02, father; P03, mother and P04, mother.

However, the interview did not require both parents (father and mother of adolescent) to be present as the inclusion criteria were that the parent was either a mother with adolescent(s) or a father with adolescent(s). This sample size was selected because the aim of this research was to understand the variety of reasons and the underlying processes that influence adolescent's risky sexual behaviours and not exactly on the presentation of data representation of a whole population. Equally, the study did not mandatorily include biological parents as the research does not require that they be related

¹² Pseudonyms are names given to participants to conceal their identity.

but rather aimed at gaining a general idea or knowledge of issues that are most prevalent in response to the three key questions. Additionally, the rationale for not including parents and adolescents who were blood-related was to enable participants to be free to express themselves since discussions were based on general perception of the subject matter and not particularly referring to individual's parents or adolescents, thus, ensuring objectivity and impartiality from participants. Likewise, the teenage participants were high school students while the parents or guardians interviewed were uneducated and low-income earners.

More importantly, based on the diverse forms of family structure within South Africa, most of the adolescents either stayed with their aunts, sisters or had a single parent due to death of one's parent or divorce. Even though, the initial objective of the study was to speak with adolescents living with their direct parents, the reality of the nuclear family (comprising of the father, mother and children) is not always the norm in South Africa (discussed in Chapter two). An increasing number of children are growing up without parents or live in single parent households. The increase in the number of homeless children, orphans, single mothers or fathers could be attributed to the prevalence of HIV/AIDS of family members, early pregnancy, death, and the effects of apartheid; particularly the migrant labour system, and poverty (Eddy and Holborn, 2011:1). Family life in South Africa is a complex structure in that the growing up of a child is not only the responsibility of the immediate parent but also that of the extended family as well as care-givers or guardians (Eddy and Holborn, 2011:1). In other words, the concept of a nuclear family is not definitive of most South African families. However, the absence of one's parent while growing up has a significance influence on the child's attitude towards sex and relationships (Eddy and Holborn, 2011:9). For this reason, the researcher included adolescent participants living with other family members, such as their aunts, sisters and uncles.

Recruitment of study participants

Recruitment of appropriate participants was facilitated by DramAidE “an independent non-governmental Organisation (NGO), that critically engages young people to communicate about HIV/AIDS through forum theatre and role plays inspired by Augusto Boal (1979)” (Cardey, *et al.* 2013:293). They implement campaigns, social dialogues, workshops, trainings and primarily focus on preventing risky sexual behaviour (Dalrymple and Botha, 2000) (see Chapter one), and were

instrumental in facilitating researcher access to both adolescents and parents in the Mayville community where the organisation has some programmes. The researcher's choice of location and participants was facilitated through the help of DramAidE. The researcher collected data from Mayville participants. Prior to data collection commencement, the researcher was introduced to a DramAidE facilitator at Mayville by DramAidE personnel from the University of KwaZulu-Natal in July 2016. This enabled the researcher to develop a rapport and become familiarised with the community; to solicit their assistance in conducting the study before proper interviews with participants. At the initial stage, the researcher, together with the facilitator, visited some participants in their homes to solicit their assistance as part of the study. However, this idea was unsuccessful because most of the participants were unwilling and busy. The researcher was later introduced to participants from the various community forums organised by DramAidE such as Stepping Stones. By attending some of these forums, the researcher was able to gain access and establish relationships with the participants. From the forums, the researcher was given an opportunity to address groups of adolescents and parents. Thereafter, volunteered members registered their names with their contacts. This eased the recruitment process and gave the researcher an opportunity to recruit participants that were deemed fit for interview.

After the initial introduction to participants at Cato Crest main library and Cato Crest primary school, Mayville in August 2016, a chain referral or snowball system was implemented. The chain referral system was useful in the recruitment strategy because the NGO Drama in Aids Education (DramAidE) (discussed in Chapter one) advised and introduced the researcher to participants from their organised forum who shared similar characteristics and met the requirements for the study. These initial interviewed participants on the other hand, recommended or introduced other participants who had similar experiences in order to make up for the required number of participants needed for the study (Morgan, 2008).

Data collection and Tools

The diagram below gives an overview of the researcher's stages of data collection.

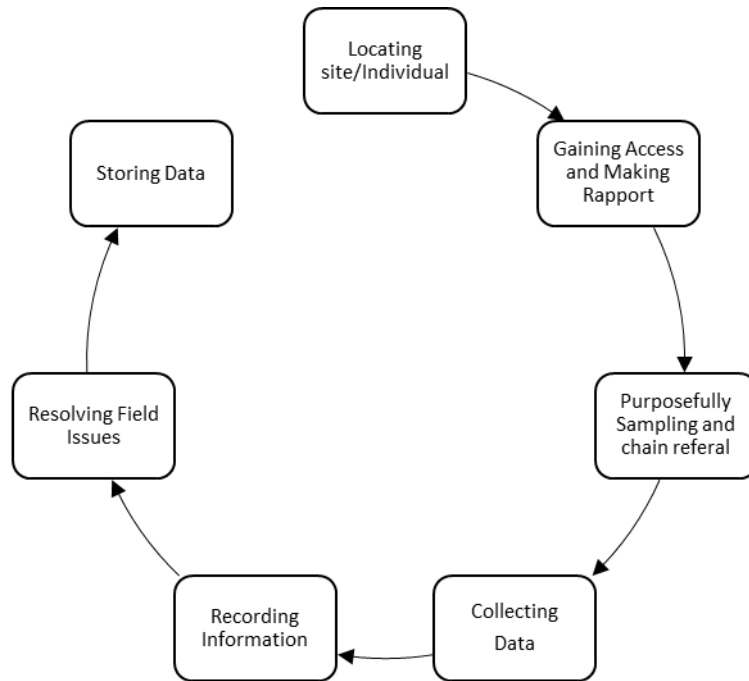


Figure 4.2: Data collection circle

Source: Adapted from Creswell, 2007: 118

In-depth Interviews

Data collection was achieved by in-depth interviews with parents and adolescents. The audio of interviews were recorded and written notes were taken on them. The interview was used to collect the primary data because it gives freedom to participants to express their ideas about the topic. Data was collected by the researcher with the help of a translator (this will be elaborated on below) and the exercise lasted for three months (August-October 2016).

Interviews were conducted following the seven steps of a qualitative interview investigation by Kvale (1991) namely: i) thematising, ii) designing, iii) interviewing, iv) transcribing, v) interpreting, vi) verifying and vii) reporting of the data. Table 4.1 outlines the steps and applicability to the study.

Kvale's Seven steps of an interviewing investigation and this study researcher's description of data gathering	
Steps	Description of steps by researcher
Thematising	Thematising is the “conceptual clarification and a theoretical analysis of the theme investigated and the formulation of the research question” (Kvale, 1991:87). This involves formulating the purpose of an investigation and describing the phenomenon to be studied before commencing the proper interview. The researcher for this study set out the aims and objectives and the research questions putting in mind who, why, what, when, where, how of the study as discussed in this chapter.
Designing	This involves obtaining the intended knowledge and taking into cognisance the moral implications of the study. The issue of adolescent risky sexual behaviour is a controversial topic that requires urgent attention because of the risks, not only to the adolescents but to the society at large. This also guided the choosing of location for data gathering since KwaZulu-Natal is one of the provinces in South Africa with a high rate of sexually transmitted diseases and risks.
Interviewing	In conducting an interview, researcher must have an interview guide with a reflective approach to the knowledge sought and the interpersonal relation of the interview situation. In order to ensure constituency among interviewees, the researcher went into the field with a semi-structured interview guide to ensure that it captures the study's aims and researcher questions (see appendix A for a copy of the interview guides).
Transcribing	This refers to the transcription of oral speech of interviews into written text for final report. It is the preparation of interview data for

	analysis. Participants were interviewed orally and information was recorded with the use of an audio tape which was later transcribed. All interview manuscripts - with adolescents and parents-were transcribed verbatim.
Analysing	Analysis was done on the basis of the research purpose, and nature of the data in the light of the study's theoretical framework. The researcher, as will be explained in the next section, adopts Braun and Clarke's (2006) steps of thematic analysis in analysing data.
Verifying	This involves ascertaining the generalisability, reliability and validity of the interview findings (to be further explained in a subsequent section)
Reporting	This means giving a holistic and comprehensive write up of the study findings and methods adopted; taking the ethical aspects into consideration and ensuring that results are readable products and realistic (see Chapter five).

Table 4.1: Seven steps of interview investigations

Source: Adapted from Kvale 1991:88

The informed consent forms (appendix B) were given to each participant before the commencement of the interview. This provided them the choice to use a pseudonym. Some of them preferred the use of pseudonym while others did not mind disclosing their identity. Nevertheless, for confidentiality, the researcher adopted pseudonyms for each participant. Additionally, a translator (in the case of the isiZulu speakers) accompanied the researcher to the study site in order to ensure that the interview questions were well understood by the participants. The translator employed was not only an isiZulu speaker but also familiar with the subject matter as she previously conducted a similar research in health communication amongst the Umnini community. This enabled a deeper understanding of the interview questions (in the case of the translator) and interpretation of questions to participants. The interview included open-ended questions which allowed participants to discuss issues beyond the confines of the set questions

(Kvale, 2008). Interviews were less than 50 minutes and also conducted in a location convenient for the interviewee. For the three mothers, interviews were conducted in their homes while one of the counsellor's offices beside Cato Crest library was used for the father. Likewise, since interviews with the adolescents took place on a Saturday, one of the classrooms at Cato Crest primary school was used.

While in the field, the researcher made use of an audio recorder and field notes with the permission of each participant (as indicated in the consent form, appendix B) in order to document the interview responses for data transcription and analysis. Immediately after collecting data from the participants, the researcher listened to the audio recorder over and over again to ensure that all necessary information about the phenomenon was captured. However, in the case of sexuality information that was not well captured from the father (P02), a follow up telephone interview was conducted on the 26th of August 2016 in order to retrieve the missed information. After the final field report, interview transcriptions were saved on a computer for data analysis. At the final completion of the dissertation, interview transcripts were stored (both in hard copy and CD).

Data Analysis

The collected interview data was manually analysed using thematic analysis. Thematic analysis, as a form of qualitative research analysis, is defined as a “method of identifying, analysing, and reporting patterns (themes) within data” (Braun and Clarke, 2006:6). In order to keep track of the research aims and questions, the researcher itemises the reports of the participants into different themes. As such, theoretical thematic analysis was adopted. Theoretical thematic analysis “is driven by the researcher's theoretical or analytic interest in the area, and was thus more explicitly analyst-driven” (Braun and Clarke, 2006:12). Thematic analysis served as a check and guide during the course of data analysis. The researcher personally transcribed data collected from the interviews to carefully preserve the core content, putting into consideration the research questions. This enabled the researcher to identify key issues emerging from diverse codes after a thorough reading of the material. This form of thematic analysis tends to provide less a rich description of the data overall, and more a detailed analysis of some aspect of the data” (Braun and Clarke, 2006:12). The identified themes were formed from the various codes and analysed based on the phases of thematic analysis as proposed by Braun and Clark (2006:79). The identified themes were then discussed in the light of the research questions, identified theoretical framework and reviewed

literature. Table 4.2 below lists each phase as suggested by Braun and Clarke (2006) (in the first column) and the way in which this study operationalised the phase (in the second column).

Phases of Thematic Analysis	
Phases	Description of the process
Familiarisation	<p>The researcher familiarised herself with the data through self-transcription of data. The audio records from the participants' interviews were listened to several times in order to accurately transcribe the information from participants. After transcription via Microsoft word, the researcher read and re-read the transcripts alongside taking note of salient ideas (as guided by the research questions and theory) through coloured highlights. In cases of omission and unclear statements, the researcher referred to the raw data again to correlate with the transcripts.</p>
Generating codes	<p>This involves gathering data that are relevant to each code and coding interesting and important features from data in an organised manner across the entire data set.</p> <p>Based on the transcribed data, the researcher developed different anchor codes manually in line with the research questions and objectives (see appendix C for a sample of interview transcript on how anchor codes were analysed). This process made it easier to identify and group codes. As each participant's transcripts were read through, a comment box labelled with different anchor codes were created to bring out these codes from the underlined and highlighted sentences (data). The researcher carefully took note and highlighted the key points that were emerging from the data. After, the anchors were 'cut' and 'pasted' in a new Microsoft word page for close observation and proper grouping.</p>

<p>Searching for themes</p>	<p>From the diverse volume of (anchor) codes, the researcher first collated by grouping relevant (anchor) codes that were related, then developed the sub-themes and themes according to their frequency and relevance to the study's aims and questions. This was made possible by reducing codes to identify salient themes in accordance with the study's objectives. For example, the codes of forms of adolescent risk-taking behaviours, forms of adolescent sexual risky-taking behaviours, factors that exposes adolescents to risky behaviours, susceptibility of adolescents to risky sexual behaviour, invulnerability of adolescents to risky sexual behaviour, degree of seriousness of the consequences, influence of risks on adolescent future and factors that exposes adolescents to risky behaviours identified in the transcripts were grouped into the theme of parent-adolescent perceptions towards adolescent risk-taking behaviours which is analysed in the light of the theoretical framework and literature review in the next chapter.</p>
<p>Reviewing themes</p>	<p>In reviewing the themes, the researcher checked that the themes correlate with the generated codes and the entire data set. Where overlapping or similar themes were observed, they were merged together as a theme instead of having sub-themes. Data was, however, grouped into sub-themes before identifying the themes that captures the main idea of the study. For example, the sub-themes of initiators of discussion on sexuality issues between parents and their adolescents, sexuality topics discussed between parents and their adolescents and causal factors affecting parent-adolescent communication on sexuality and reproductive health issues were grouped into the theme of factors that influence parent-adolescent communication about sex as presented in the next chapter.</p>
<p>Definition and Naming of Themes</p>	<p>Based on the on-going analysis or scrutiny (reviewing themes), the researcher refined the specifics of each theme and the overall description of the analysis to generate a clear definition and names that best capture each theme.</p>

Production of final report	The last step carried out by the researcher included a review of the data to get germane and clear examples or quotes that were of relevance to the final report. These quotes were then presented, explained and analysed with regards to the research questions, theories and literature (Chapter five).
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Table 4.2: Phases of Thematic analysis

Source: Adapted from Braun and Clark, 2006:87

Validity and Reliability

Reliability refers to the consistency of the results and validity determines whether the methods adopted for the study were able to yield a maximum result of the study's aims and research questions (Kvale, 1991:88). Validity is concerned with "issues of whether the research procedures can provide an accurate representation of reality" (Easterby-Smith, *et al.* 2003:53). Validity and reliability is ensured when the researcher is able to answer if the study clearly gains access to the experiences of those in the research setting and if there was transparency in how sense was made from raw data at the end of the data analysis. Validity is related to the appropriateness of the research instruments and reliability is set to determine whether the research design is capable of eliminating assumptions and the effect of extraneous variables (Easterby-Smith, *et al.* 2003:53). The concept of validity is usually concerned with measurement procedures, thus making it a controversial term in qualitative research such as this study. However, face validity was ensured in this study via a logical link between the study objectives and the key research questions that were then 'teased out' to create the actual interview questions. The face, content and construct validity of this study were ascertained by working closely with the supervisor who scrutinised the interview schedule and eliminated irrelevances, repetitions and ambiguous items to ensure that the instrument was suitable for the information required from the research aims. Rigour was also maintained by recruiting parents whose adolescents were within the speculated age bracket and adolescents who were qualified for the study with the established requirement. Another way the study ensured credibility was in the aspect of data analysis (Kvale, 1991: 111). The researcher ensured that participant's verbal statements were represented without alteration. Furthermore, the researcher allotted sufficient time for data gathering, analysis and editing to avoid mistakes.

Ethical Considerations

The nature of this study required that the study participants were keen to be involved in the study and provide information pertaining to parent-adolescent communication and adolescent risky sexual behaviours as well as their cognition of its consequences, their severity and susceptibility to these risks in order to give justification to the research questions and set aims and objectives.

Ethical consideration was an important aspect for the success of this study. The study ensured ethics by obtaining a gate keeper permission letter at the inception (see appendix D) to prove credibility of the field report. This gatekeeper approval was obtained from the DramAidE whose programme was the platform through which the study recruited individual participants, as explained above. The researcher was required to present the research proposal before the Centre for Communication, Media and Society review committee which comprised Professors, Doctors and students within the same discipline. Based on various comments that arose from the colloquium and proposal reviewers, the researcher was able to refine the research proposal until it was suitable to be submitted to the School of Applied Human Sciences Research and Higher Degree Committee for final approval. The ethical clearance form was sent to and received approval from the UKZN Humanities and Social Sciences Research Ethics Committee with protocol reference number- HSS/0867/016M. All participants who were involved in this study were provided with an informed consent (see appendix B) before the commencement of interviews and required to sign the consent form which stipulated briefly what the research entailed in order to ensure their consent and active participation. From this form, participants were made to understand that if at any point they decide to discontinue their participation in the research, it would not in any way have any indictment on their personality or cause any havoc. Furthermore, in cases where participants preferred pseudonyms, their real names were not disclosed. Also, confidentiality of participants was protected through the use of pseudonyms, as indicated in the signed consent form. The research consent form also indicated participant's permission to be recorded.

Limitations

The researcher encountered some constraints in the course of gathering data. These limitations include:

Location and Environmental Factor

The researcher encountered difficulties in securing a good conducive location for interviewing participants. The intended place for conducting the interview was not readily available. Some of the interviews were conducted in an open space or under the tree, making it difficult to hear absolutely everything very clearly on first listen. Hence the interviews were listened to several times, and the written field notes taken during the interview was consulted to fill in gaps. Also, it was observed that some of the participants felt a little uncomfortable because of people and other study participants that were close by, as a result, some topics may not have been discussed as fully as they would have been, had the private interview venue hire been honoured. Generally, the environmental noise served as distraction to the interviewees. On several occasions, interviews were cancelled and shifted because it rained for the duration of some of the scheduled interview days. This lengthened the period of the data collection.

Language barriers and Illiteracy

The illiteracy level is high among the participants and most of the residents were isiZulu speakers and were unable to express themselves fluently in English language. However, the translator was instrumental in slowly and calmly ensuring that both interviewer and interviewee understood each other.

Recruiting

Initially, the researcher found it difficult getting participants for the study because of the sensitivity of the subject. However, with the help of DramAidE personnel, qualified participants for the study were engaged for interview.

Conclusion

This chapter has delineated the qualitative phenomenological study that obtained data on adolescent risky sexual behaviour and parent adolescent communication via in-depth interviews

with purposively selected parents and adolescents from Mayville. It described the step-by-step procedures and methods used to collect and analyse data, as well as its ethical consideration and limitations to the study, with a note on how these limitations were addressed. The next chapter will analyse and discuss the findings from the study participants.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

Introduction

This study focuses on parent-adolescent sexual communication, adolescents' risk-taking behaviours and the relationship between these two facets. The previous chapter outlined the research methodology employed for this descriptive phenomenological study. This chapter presents and analyses the research findings. The chapter outlines possible factors that may encourage adolescent risky behaviours, adolescents' perceived susceptibility and severity of the consequences of their risky sexual behaviours as well as factors that facilitate and constrain the communication process between parents and adolescents on sexual issues and adolescents' risky behaviours. This analysis is generated from discussions on the findings through the lens of the study's guiding theory and models; Extended Parallel Process model (EPPM) (Maloney, *et al.* 2011; Green and Witte 2006; Witte 1992), the Rommetveit and Blakar Communication model (Botchway, 2004; Blakar, 1984) and the Theory of Adolescent Development (Piaget, 1950; Erikson, 1968; Marcia, 1980, 1996, 2007; Bosma, 1992; Meeus, 1996; Luyckx, *et al.* 2008; Steinberg, 2008; Sokol, 2009).

Key research questions that guided this study include:

- i. What forms of teenage risky behaviour are adolescents exposed to in Durban?
- ii. What issues are identified as most difficult and easy to discuss and why?
- iii. What are the approaches parents adopt in communicating and educating their adolescents?

To bring order, structure and meaning to a mass of collected data, the chapter is organised in accordance with the following corresponding themes that emerged from the findings in relation to the above questions:

- i. parent-adolescent perceptions towards adolescent risk-taking behaviours,
- ii. sex talk: factors that influence parent-adolescent communication about sex,
- iii. information sources for sexuality and risky behaviour issues,
- iv. Approaches in parent-adolescent communication on sexual matters,

The above themes were derived based on the subthemes. At the initial stage, anchor codes were developed. Anchor code is the process of assigning labels (phrase that capture features of a data) to transcripts in relation to the research questions (Adu, 2013; Saldana, 2009) (see appendix C). Subthemes were then developed based on the occurrence of times these codes occurred and the underlying meaning across codes in order to exclude irrelevant data (Adu, 2013). As a result of multiple subthemes, themes which could be a phrase or sentence describing more subtle and tacit processes were generated to address the research questions (Adu, 2013; Saldana, 2009). A theme formation layout table that summarises the anchor codes and (sub) themes is presented in appendix E.

Parent-adolescent perceptions towards adolescent risk-taking behaviours

This section explores the parents and adolescents' perceptions towards adolescent sexuality and risk-taking behaviours. It further examines the forms of teenage risky behaviours, factors that expose adolescents to these behaviours, as well as the susceptibility and severity of the consequences of the risks.

Perceived factors which the adolescent participants reported during the interview as influencing their involvement of sexual risk-taking behaviours included alcohol, unprotected sex, multiple sexual partnerships, and transactional relationships, among others. Previous studies found that risky sexual behaviours such as inconsistent condom use and sexual intercourse with multiple partners are relatively common among adolescents in South Africa and this behaviour increases the risks of unplanned pregnancies and sexually transmitted diseases particularly HIV/AIDS (Brook, *et al.* 2006; Madlala, 2008). However, this study reveals that the participant adolescents have had unprotected sex, more than one sexual partner, early debut to sex, and consumed alcohol and drugs. Both parents and adolescents emphasised the fact that these activities were prevalent and led to the spread of HIV, STIs and unwanted pregnancies and other consequences among adolescents. From the study, adolescents perceived that alcohol consumption led to unprotected sex or no contraceptive usage during sexual intercourse. They believed that these behaviours are the problem in the country as professed by a male adolescent;

Okay, what I can say is that once they (adolescents) are drunk, they do not think straight and they may have unprotected sex. This may bring deadly viral diseases and teenage pregnancies, which is the issue right now in the country (T02¹³, Male interview, 2016).

The consumption of alcohol was found to lead to irrational thinking which inhibits safe sex negotiation such as condom use thus increasing susceptibility to risky sexual threats. This finding is in agreement with other studies that found alcohol prior to intercourse to have influenced young adult's decision to engage in unprotected intercourse (Morojele and Ransoomar, 2016; Bryan, *et al.* 2007). According to the Extended Parallel Process model and Theory of Adolescent Development, adolescents become victims of risky sexual behaviour when they lack a sense of self-efficacy, they do not manage situations effectively, even though they know what to do and have the requisite skills (Fantasia, 2009; Witte and Allen, 2000; Irwin and Millstein, 1992).

This study also corroborates the HSRC national report on the behavioural determinants of adolescents' exposure to risky sexual behaviours in South Africa. Among the mentioned determinants were condom use, multiple sexual partners and age disparate relationships. As reflected in this study findings, these practices however not only affect adolescents' lives but also the parents and society in which they live. Specifically, HIV has impact on family relations and family economic situation. Many parents or caregivers find that they can no longer go to work as the disease progresses and their child's health deteriorates, this leads to low income generation. Their living conditions worsen, unemployment sets in and leads to extreme economic hardships. In addition, the parents and the immediate family members face psychological burden, stress and stigma. They feel depressed or sometimes angry, as they struggle with financial limitations. More so, the impact of HIV on adolescents reflect on the environment they live as the young affected adolescent will not be able to contribute enormously to the development of the society; their performance in school might reduce. In the society, even when they have all the knowledge that can benefit the people, they are faced with discrimination or stigmatization. This strengthens the need to look for possible ways to address these issues among adolescents. Even though adolescents mentioned various programs they attended, such as the ZAZI: Know

¹³ TO1, TO2, TO3, TO4; PO1, PO2, PO3, PO4 as will be mentioned subsequently in this chapter are the pseudonyms given to the interview participants. Please refer to chapter four, 'selection of participants' for more details.

Your Strength campaign, risky sexual behaviours among these age groups are still on the increase. It is therefore pertinent for various interventions targeted at adolescents to design their messages around these risks more. If these consequences were found to be predominantly high among young people (HSRC, 2014; Kott, 2010), what then influences their involvement in all these risks?

Determinants of risky adolescent behaviours

Several studies, including this one, have shown an increased rate of risky sexual behaviours to be predominantly high among young adults. Participants from this study provided useful insight into factors associated with risky adolescent behaviours and different reasons why adolescents experiment with sex at an early age. Discussions with both parents and adolescents identified common factors which cut across peer pressure, role modelling negative behaviours, negative influence of media, and cultural influences. Of the many factors that contributed to the motivation for adolescent risky sexual behaviours, participants attributed this to peer pressure, alcoholism, and drug use, as explained by a male adolescent;

Yes, others (adolescents) are taking drugs because of peer pressure. Like you've got four friends and all of your friends are smoking and drinking, If like for instance, you are sharing the same room, by the time they are drinking and smoking, they eventually end up convincing you too. (T01, Male interview, 2016).

The above view corresponds with previous findings that normative influence of peers is significant for adolescent sexual behaviour (Govender, 2013; Hartenstein, 2012; Peltzer, *et al.* 2011). A Kaiser family foundation study (2002) found that teenagers who smoke were more likely to drink which most likely led to risky sexual intercourse and more than 80% of adolescents who had reported alcohol and drug intake said it had negative influence on them and most likely prompted them to engage in sexual intercourse. Similarly, in relation to the Adolescent Development theory, one of the core factors of identity formation is the influence of peers. "The attitude and perception of norms and behaviours among peers has significant and consistent impact on adolescent sexual behaviour" (Vukapi, 2016:19). A negative behaviour of peers could affect an adolescent's behaviour thus inhibiting positive behaviours and self-efficacy in the face of threat (Panday, *et al.* 2009; Clark and Clark, 2007; Berk, 2003).

Furthermore, the respondents perceived that when adolescents have low self-esteem or confidence about their choices, they could easily be manipulated by their friends to engage in negative behaviours especially when they are surrounded with bad friends. This view was reflected upon by a male participant;

When adolescents lack confidence, low self-esteem, they get manipulated or persuaded easily and end up in bad behaviour (T01, Male interview, 2016).

Similarly, Loew and Thompson (2011) found that when adolescents get involved in drugs and alcohol, impaired decision-making skills reduce their judgment making abilities. When adolescents have low self-esteem or feel intimidated, it affects their sexual decision-making process. The Theory of Adolescent Development explains that although late adolescents have more developed reasoning capacity to predict multiple behaviour alternatives by weighing the consequences before involving in such risks, their cognitive functioning still affects their ability to appraise the threats associated with their risks and capability to implement protective measures (Albuhairan, *et al.* 2012; Cromer, 2011; Steinberg and Chauffman, 1996).

Parents are also influential factors in determining adolescents' involvement in risk-taking behaviours. Adolescents perceived their parents to lack in-depth knowledge about these issues of sexuality and risk-taking behaviours and how to sensitise them (T01, Male interview, 2016; T02, Male interview, 2016). In accordance to the EPP Model, parents' perceived self-efficacy in successfully communicating on the dangers of risky sexual behaviour is lower than the perceived threat and as a result they control their fear of communication by avoiding it, instead of controlling the danger of risky sexual behaviour in confidently warning their children. "If parent's efficacy appraisals lead to the self-perception that they do not have the efficacy to avert the threat, they will reduce their fear by engaging in fear control responses" (Maloney, *et al.* 2011:208). This in turn could affect adolescents' perceived self-efficacy to successfully avoid risks. When adolescents feel helpless about what to do in reducing these risk as a result of erroneous, insufficient or no knowledge, they tend to control their fear through defensive avoidance or reactance which results to rejection of recommended messages (Maloney, *et al.* 2011).

Some parents believed that lack of parental responsibilities or poor parental monitoring is a contributing factor to adolescent risky sexual behaviours. According to a mother, she said:

It is too much of freedom that I can say. They (parents) don't take much responsibility. They just say okay, my child is big enough meanwhile, the parents have to be behind and watch the patterns that the child is going (P04, Mother interview, 2016).

This negligence of parental roles was perceived to be a major determinant factor identified by some of the adolescents to have contributed to their risky sexual behaviours. Ntarangi Mwenda (2012) asserts that often times, parents delegate child care cutting across social, physical and emotional needs to house helps, maids or nannies as a result of their work force thus, giving room for little or no parental care and monitoring. This finding also corresponds with that of Udigwe, *et al.* (2014), Amoran and Fawole, (2008) and McNeely, *et al.* (2002) who found a lack of parental care, supervision and love to have led to emotional distress, high sexual risky lifestyles and drug use among adolescents. These findings support the theory of adolescent development. The challenges faced during parent-adolescent communication were attributed to the change in the nature of relationship as the child transits to adolescence (Collins, *et al.* 1997). As a result of these changes, adolescents strive for autonomy and for identity formation which most likely could lead to a parent-adolescent communication barrier as well as parents having a tendency to neglect their primary focus as a child's first contact for sex knowledge, values and behaviours to external factors such as peers, schools, media (Laursen and Collins, 2009; Panday, *et al.* 2009; Smetana, *et al.* 2006).

Participants also perceived the adolescent stage as a natural period that comes with its risks. This stage was found to result in high prevalence of risky sexual behaviours among adolescents. Also, this period was characterised with changes, excessive independence and privacy:

It's just the adolescent stage. Adolescent stage leads the child to go and do the sex. It is natural (P01, Mother interview, 2016).

This finding corroborates the explanations offered in the Theory of Adolescent Development on how adolescents' risk taking behaviours are a result of intergenerational differences on sex issues between parents and adolescents, adolescent strive for autonomy and excessive adolescent

privacy. According to this theory, during the puberty stage, increased risk-taking behaviours were likened to changes around this time in the brain's socio-emotional system which leads to increased risky behaviour. These changes resulted in intense susceptibility to risk and reckless behaviours (Imaledo, *et al.* 2012; Steinberg, 2008).

Beyond peer pressure and parental guidance, there are other powerful socialisation intuitions such as media, which is a determinant of adolescents' risky sexual behaviours. While media use is an integral part of the daily life of adolescents, there are a number of risks associated with social media use. Specifically, adolescents are exposed to sexual and 'illegal' content which can prompt their decision in engaging in risky sexual behaviours. One of the adolescents interviewed explained that it is media that determines adolescents' involvement in risky sexual behaviours.

I can say is media because we normally see that (risky behaviours) in media but I don't wanna judge media (T02, Male interview, 2016).

From the present study, it is evident that the media does not model sexual control which adolescents are susceptible to. Ideally, parents or caregivers are supposed to set boundaries and instil good morals, values and sex education in adolescents. When they fail to do so, adolescents become susceptible to media exploitation. Subsequently, adolescents could be misinformed as a result of the graphics and visuals that depict sexual acts without necessary precautions, resulting to their involvement in risky sexual behaviours.

Findings in support of this notion reported that depiction of risks and responsibilities such as ways of sexual prevention, actors getting STIs or pregnant from unsafe sex, or the psychological influences that come with early sexual initiation are rarely portrayed (Hertzler, 2016; Hust, *et al.* 2008). According to the theory of Adolescent Development, adolescents are at risks as a result of media content because of their under-developed cognitive skills that allow for critical analyses of messages and the ability to make decisions based on future outcomes (Cromer, 2011; Pedlow and Carey, 2004; Gruber and Grube, 2000). Even though adolescents from this study were found to be influenced by what they see, and what they see places a high premium on being involved in risky sexual behaviours, it should be noted that the media messages are read in conjunction with the adolescents' experiences and background and these messages do not have a uniform effect on all the adolescents because messages are polysomic (Hall, 1973/1980) and these different

meanings are also influenced by cognitive influences (Fantasia, 2009; Dutta-Bergman, 2004, 2005; Gruber and Grube, 2000; Melkote, *et al.* 1995). Nevertheless, the media might not totally depict negative behaviours as there have been controversies about the positive and negative influences of media on adolescents' risk-taking behaviours. It is therefore important to critically examine the influence of media on adolescents; is the media morally or legally bound to model sexual control?

Greater exposure to the media leads to the adoption of values, beliefs and behaviours that are portrayed particularly when they are shown to be reinforced by adverse consequences (Gruber and Grube, 2000). As such, sex messages distributed via entertainment media that are not specifically geared towards pro-social behaviour may inadvertently encourage risky sexual behaviour by not portraying its dangerous results (Govender 2013; Strasburger, 2005). It was suggested that simple exposure to risk-taking advertisements, such as alcohol, does not affect adolescent behaviour. Rather, the effects of this depends on the extent to which young people like and attend to them and this likeness could be facilitated by the Music and humour in such advertisements (Gruber and Grube, 2000; Grube, Madden and Friese, 1996). Similarly, previous studies supported the positive influence of the media on adolescents' because of its ability to present safe sex in attractive and explanatory visual form (Hartenstein, 2012; Keller and Brown, 2002). Likewise, parental involvement in determining desirable programmes, particularly on television, could be one of the best ways of tackling adolescents' risks (Canadian Paediatric Society, 2003). It was found that parents play an important role in their adolescent's social learning. Nevertheless, if parents' views are not explicitly discussed during this period, the essence of this medium in encouraging positive behaviour could be faulted (Canadian Paediatric Society, 2003). It is therefore important to examine media content and find possible ways media can be prevented from promoting risky sexual practices.

It was also found that negative role modelling and the environment in which a child grows influences adolescent's sexual behaviours. A parent who emphasised her view on this believed that adolescents are very observant:

When kids see that their role models does something wrong, they tend to wanna be like such person. Meanwhile, that little moment that you did something wrong and the kid was

watching you; the kid has already picked it up. You can correct yourself but in the eyes of the kid, it's something right that the child can do (P04, Mother interview, 2016).

Adolescents' role models could be within the family, among his or her peers or the media. As expressed by the majority of the parents, negative behaviours imitated by adolescents' role models made adolescents susceptible to the consequences of HIV and unwanted pregnancies. The Theory of Social Learning explains that the environment has a prominent role in modelling a child's behaviour (Bandura, 2002). When adolescents observe a model performing a behaviour and experience the consequences of that behaviour, after a while, that becomes reinforced through imitation (Hertzler, 2016; Bandura, 2002). This doubles the responsibility of the parents, in that, while they act as good role models, they also monitor other role models of their children. As established in the Theory of Adolescent Development, the adolescent stage is often characterised with privacy, secrecy and withdrawal from parental control as a result of identity formation (Cromer, 2011; Fantasia, 2009; Sokol, 2009). Adolescents' struggle with their self-identities most likely makes parental monitoring difficult (Loeber, *et al.* 2000; Larson, *et al.* 1996). Parents must however cleverly manage this stage in order to foster intimate relationships and avoid communication gaps.

Risk perception of adolescents' (in)susceptibility and severity to risky sexual behaviour

The long-term negative consequences of these behaviours were pointed out by participants. Identified consequences of adolescents' risky sexual behaviours from this study include unwanted teenage pregnancies, HIV, sexually transmitted diseases, abortion, early death, increased infant-mother HIV transmission, obnoxious vaginal discharge, sexual abuse, psychological disturbance, parent-adolescent conflicts, suicide, single parenthood, imprisonment, prostitution, negative addictions, crime indulgence and school dropout. Some of these consequences were indicated by two parents who perceived adolescents as susceptible to STI, unwanted pregnancies, abortion and damaged future:

STIs, pregnancies and people having abortions and you know, behind back doors abortions because now they(adolescents) are scared of going the right way (P04, Mother interview, 2016);

They (adolescents) end up getting involved in no condom (unprotected sex); as a result, they end up getting these diseases and pregnant. (When they are pregnant), they end up with no one (husbands in the nearest future) because they already have babies; their future get damaged (P02, Father Interview, 2016).

The developmental consequences of adolescent behaviours were found to have a negative impact on both the adolescents and the economic development of the nation. Young adolescents may drop out of school to focus on motherhood at the expense of development in areas such as formal education, vocational training, and personal growth. One of the interviewed mothers emphasised the psychological consequences on adolescents when they become pregnant. She said the young adolescents would be unable to cope in school which has led to increased rate of adolescent dropout among young female learners. Another male adolescent in support of this said:

Surely, these consequences will prevent them from reaching their goals in the future (T01, Male interview, 2016).

This is similar to a previous study by the South African Department of Basic Education. According to its study conducted in 2013, a high percentage and number of young school learners reportedly drop out due to pregnancy (DBE, SA, 2009:11; 2013:39). Increased rates of teenage pregnancies were, however, mainly attributed to socio-economic factors such as poverty, family structure, environment, unemployment and peer pressure.

Another risk factor pointed out by the participants, was that adolescents at the ‘concrete operational stage’ are perceived to be overwhelmed with feelings of guilt, shame and low self-esteem which might eventually make them commit suicide resulting in early death as pointed out by a male adolescent:

The result will be negative. They might lose themselves (to death) and for ladies, they might get pregnant and only found that they don't even know who the father is. This will affect them for the rest of their lives and some of them can commit suicide (T01, Male interview, 2016).

In accordance to Jean Piaget’s cognitive-developmental model, concrete operational stage is characterized with under-developed cognitive maturity which limits adolescents to fully

comprehend and carry out some risk reduction strategies (Pedlow and Carey, 2004; Halpern, *et al.* 2000).

A female adolescent also expressed her apprehension on the enormous psychosocial consequences:

It is serious because you might end up dead at early age and nowadays, if you go to the grave yard, you will see 1995, 1994, 1993(that is, the year when the dead people were born) and what is so shocking and sad is that our grandmothers are still alive. Why? Because we don't take care of ourselves, we just involve in negative things that are beyond us. Some of these consequences we cannot handle and before we realise, it will be too late to handle those situations. Like for instance, if you go to some hospital, you will see young people infected with HIV and AIDS (T03, Female interview, 2016).

The Extended Parallel Process model suggests that individuals' perceptions towards the consequences of their behaviours, perceptions of their susceptibility to these consequences as well as efficacy play a crucial role in their behaviours (Witte and Allen, 2000). Adolescents' awareness and knowledge about these consequences were perceived as important factors to reducing these risk-taking behaviours (Taukeni and Ferreira, 2016; HSRC, 2014; Sychareun, *et al.* 2013). This was supported by a parent statement:

I think if they (adolescents) can get more information, life skills and guidance about risks that they take and how it impact them, then that can change them from doing the bad things (P01, Mother interview, 2016).

Parents were of the opinion that when adolescents understand the degree or extent of the consequences of their actions and if they are exposed to the rudiments of sex, it could reduce negative behaviours. Sychareun, *et al.* (2013) deduces that these risks were significantly associated with having more knowledge about STIs and HIV. There is thus a need to encourage parents to improve communication with their young ones on the consequences of their risky acts in order to reduce diseases, death school drop outs among others:

But if we (parents) don't educate teenagers, this disease will spread all over (P02, Father interview, 2016).

The study findings also replicated that of Albert Botchway (2004) who asserted that sex information prevents risky sexual behaviours. However, Wamoyi, *et al.* (2010) found insufficient or no knowledge to have hindered parents from passing the information across.

Another important factor found to have placed adolescents at risk or heighten their susceptibility was their thinking or belief which is often controlled by their emotions. When it comes to sex, rational decision making does not always work as adolescents often base their thinking on their emotions. This hampers their ability to carry out responded messages in the face of threat. Adolescents from this study saw themselves to be invulnerable to all these negative outcomes of risks taken despite their involvement in risky sexual behaviour. They perceived sex to be a ‘fun’ affair and as a result, they do not engage in safe sex nor think about the consequences of their risky sexual actions. All the adolescents were of the view that adolescents engaged in risky sexual behaviours for the fun of it.

Sex is so refreshing that they have sex with their boyfriends of which they might even not use condoms and the result will be negative (T01, Male interview, 2016);

They do it for fun but they don't think at the end there will be a risk (T04, Female interview, 2016).

This erroneous belief exposes adolescents to potential risks which could be injurious to their health. As explained earlier in chapter three in reference to the Theory of Adolescent Development, adolescents were more likely to make sexual decisions based on immediate satisfaction, rather than on the futuristic severity of the consequences of their actions and are unable to generate alternatives or identify possible consequences as readily as adults (Fantasia, 2009; Pedlow and Carey, 2004).

Although the majority of adolescents reported that they had information on sex education and were fully aware of the fact that their continued engagement in risky sexual behaviour may result in a ruinous consequences, they placed much value in the aesthetic experience while engaging in sex, pleasurable feeling and momentary fun derived from sexual behaviour. This was pointed out, particularly in the following excerpt:

Then, normally I do not think of anything. You just wanna have fun. You don't care whether anything will happen or not. The only thing you wanna do is to have sex at the time. Whether is protected or not, you are not even concerned about that. You then start to think that this is my life; I should enjoy it in this way (T02, Male interview, 2016).

Literature on adolescents' awareness and knowledge on risky behaviours have identified the importance of knowledge for adolescents to be able to make rational decisions regarding sexual behaviour and protecting themselves against these consequences (Taukeni and Ferreira 2016; HSRC, 2014; Singh and Jain, 2009). The word "rational" stands out here. As the study's findings illustrate, the participating adolescents may have knowledge of the benefits of safe sex but these messages are often forgotten in the 'heat of the moment' as sex relates to emotions, and is not necessarily a rational act. It is for this reason that entertainment education, such as the *Intersexions* television series -which showcases the emotional dynamics of sexual relationships- may assist in curbing risky sexual relations. "*Intersexions*' educational component addresses a set of intervening cognitive, social and emotional variables, collectively referred to as "ideation¹⁴" (Govender, *et al.* 2013: 70). Audiences of serial programmes such as soap operas and telenovelas are known to identify with specific characters (King'ara, 2013, Tager, 1997, Tufte, 2000). Bandura (1986, 2002, 2004) social learning theory extends that these characters "demonstrate behaviour that engages with their emotions, facilitates mental rehearsal and ultimately role modelling of the new behaviour" (Govender, *et al.* 2013: 74).

Also mentioned, was a myth that once a female partner is on her menstrual period; neither she nor her partner is vulnerable to the risks. It was perceived that at this period, the female adolescent was clean and as such both the male and female were not susceptible to HIV or STI. This myth was vocalised by the male adolescents in particular and one of them recalls:

One of my friends told me that there is this time when a woman is on her periods, you can have sex with a lady. So, if she was on period on Monday, by Wednesday, we can have sex without using condoms (T01, Male interview, 2016).

¹⁴ Ideation refers to new ways of thinking, as well as the diffusion of those ways of thinking via social interaction within a social network (Cleland and Wilson 1987; Kincaid *et al.*, 2002).

On the severity of their risky acts, both parents and adolescents reported awareness of the gravity of these consequences on adolescents' health and life. Parents perceived adolescents to be more vulnerable. This was reflected in statements from both a female adolescent and a mother:

It is serious because you might end up dead in an early age (T03, Female interview, 2016);

It is serious because you know there is something in life that once you do it, you cannot forget about it. If a child has done an abortion, it's something that she will live with and sometimes, it will come back and hurt you (P04, Mother interview, 2016).

Adolescents found their behaviours to be acceptable, neglecting prior information towards positive behaviours. This finding corresponds with the Theory of Adolescent Development (Cromer, 2011; Inhelder and Piaget, 1968). Adolescent egocentric thought (i.e., the belief that an adolescent is different from others) influences adolescents' decision making process which leads them to exhibit certain behaviours such as inability to apply knowledge or the necessary tactics for risk avoidance, personal myths, uniqueness of one's thoughts and feelings, biased perception of risks and feelings of invulnerability to the consequences that might result from their behaviours, which in turn could lead to risky sexual behaviour (Fanatasia, 2009; Pedlow and Carey, 2004, Chapin, 2000). In spite of adolescent awareness of the severity of these consequences, they still take risks, making them more susceptible to the dangerous consequences:

As young people, we love to party, we love something that will make us happy like boyfriends and change boyfriends (T03, Female interview, 2016).

Adolescents at the late stage (18-21 years old) engage more in risky sexual behaviour (Steinberg, 2008). One reason for this is that at this period (preadolescence to late adolescence), the quality of time parents and adolescents spend together reduces over time. With age, adolescents tend to disclose less information and increasingly keep secrets (Keijsers, *et al.* 2009; Keijsers, *et al.* 2010). These changes make adolescents susceptible to risks and reckless behaviours (Steinberg, 2008).

However, all interviewed adolescents viewed themselves to be invulnerable to these threats because they saw themselves as being principled, demonstrating self-confidence in their ability to prevent risks. This was particularly demonstrated by the male participants who felt they were in charge during sexual intercourse. It was also found that they believed that less time with bad friends, sexual relationship with faithful partners, engaging in protected sex, and being valued in a relationship made them safe.

I don't smoke nor drink. I have values and principles that I follow. With these values, I have found the potential of living and the reasons of being a good person. I am not exposed to any consequences. I am in charge (man's world) and am using condoms. Chances are therefore few because I have selected the right friends who motivate me like Luwandise and I even know two life skills. So I know what I want in life, there are no chances of me doing all those kinds of stuffs (T01, Male interview, 2016).

The HSRC survey (2014) report also affirmed that adolescents perceived they were invulnerable because they were faithful to one partner (32.0%), trust in that partner (22.5%), abstaining from sex (21.3%), and using condoms (19.2%).

Another factor pointed out from the present study was family background. One parent perceived her adolescents to have little chance of exposure to these risk-taking behaviours because there had not been any traces of risky behaviours in the family lineage hence, she believed her adolescents were less vulnerable.

From the foregoing, it is evident that there is still a gap in the knowledge that adolescents have about sex issues. From the foregoing, it is evident that there is still a gap in the knowledge that adolescents have about sex issues. To further complicate the situation, even when they do possess correct knowledge, it may not necessarily have an affect on them. However, knowledge can be further entrenched at home. It is therefore important that adolescents are given early and accurate information, especially by parents and that communication within the family should encourage adolescent self-efficacy. As such, there is a need to examine communication content, approaches and barriers that hinder effective communication within the family.

Sex Talk: Factors that influence parent-adolescent communication about sex

Participants had varied views on initiators and common topics of sex and reproductive discussions between parents and their adolescents, as well as the causal factors affecting this communication. Observed together, participants' views evince gaps between parent and adolescent relationships, which constrain parent-adolescent sexuality communication.

Sexuality topics discussed between parents and their adolescents

Parent-adolescent communication about sexuality has been identified as a protective factor for a range of risky and sexual behaviours (Manuel, 2013; Weinman, *et al.* 2008; Adu-Mireku, 2003). It is also the principal means for parents to transmit sexual values, beliefs, expectations and knowledge to their adolescents (Jerman and Constantine, 2010; Mbugua, 2007). One of the primary interests for this study is the content of sexual discussions between parents and their adolescents and the comfort level that parents experience when discussing sexual topics with their adolescents in order to understand reasons for adolescents' risk-taking and nature of communication within the family. Participants from this study revealed that content of their discussion included several sexual topics such as; physical development, relationship, dating, STIs, pregnancy, condom, sex and masturbation (T02, Female interview, 2016; P03, Mother interview, 2016).

Findings suggest that the extent of parent-adolescent communication and relationship determines the openness and the type of sexuality and reproductive health issues that ensue between parents and adolescents. This finding resonated with that of Wamoyi, *et al.* (2010) who asserted that the level of family connectedness determines the type of communication that takes place within the family. The present study found that when adolescents were allowed to speak freely with their parents or care givers, trust, cordiality and intimate relationships are encouraged and adolescents avoid secrecy regarding any form of risky behaviours. This was supported by some of the adolescent participants:

One of my aunties is opened to me. She is like a friend, so she talks about everything and how to do things (behave) with a woman (T01, Male interview, 2016);

I speak everything with my sister because she's the one I trust. I speak openly (T04, Female interview, 2016).

Parents from this study emphasised their important roles as motivators for sexual discussions during their children's upbringing, especially during the adolescent stage. They indicated that they speak with their children on sexual matters and believed that their communication would help adolescents develop good morals and healthy behaviours. A parent affirmed the importance of doing so at an early age:

Yes, I usually talk with them. I usually tell her about sex and the risks; I usually tell her it is necessary to avoid early pregnancies, HIV. If you don't talk about this before she start sex, we will have many problems (P01, Mother interview, 2016).

Both parents and adolescents emphasised the importance of relationship discussions in reducing adolescent risk taking behaviours. Communication on relationships or 'love life' was identified as the most discussed issue because it was perceived to be influential for other sex topics.

Other issues also identified as commonly discussed were contraception, safe sex, abstinence, and teenage pregnancy. Contraceptive measures were often discussed because parents understood the stage that their children were at and that they are exposed to risks. Virtually all parents were of the opinion that imparting this knowledge to their adolescents will make them take necessary cautions when faced with risky sexual behaviours.

The topic I like is that she must protect herself because there is HIV outside (P03, Mother interview, 2016);

You should use protection every time. If you are not yet ready for marriage, you should always use condom (P02, Father interview, 2016).

Two interviewed parents pointed out the importance of discussing abstinence during parent-adolescent communication; however, only one mother out of the four participants reported discussing this with her adolescent. She said she discusses it and maintains her adolescent abstains using the-Umhlanga virgin ceremony programme.

Ya, I usually talk about the abstinence. Abstain because she's attending the umhlanga - The virgin ceremony (P01, Mother interview, 2016).

Previous research shows that contraceptives are rarely discussed during interaction because parents think discussion on prevention would encourage experimentation (Dessie, 2015; Wamoyi, *et al.* 2010). Overall, parents from this study did not feel competent to discuss these issues as identified above because of the thought that it might encourage risk behaviour.

Parents' major focus during communication was also perceived to be consequence-cantered. Although some of the parents said they discussed protection, their responses showed communication was more about sexual consequences than about preventive measures. It was believed that focusing on the consequences would prevent both their children and the family from encountering any problems. Although, parents' responses were affirmative when they were asked if they communicated with their children about sex, consequences were perceived to be briefly discussed to scare their adolescents. On the other hand, adolescents understood that their parents' interest in discussing threats to risky behaviours was to prevent them from making the same mistake they made while their parents were younger:

She (elder sister) had problem when she was dating, she got pregnant while dating. So, she does not want us to (make the same mistake) (T04, Female interview, 2016).

Open family discussion on sexual issues often leads to increased awareness and reduces risky sexual behaviours among adolescents. Participants identified some topics they felt easy to discuss and those they felt difficult to discuss. However, when parents and adolescents find it difficult to discuss sex and reproductive health issues, adolescents might be prone to these risks (Bastien, *et al.* 2011).

Two of the adolescent participants identified protected sex, condom usage, abortion and relationship issues to be easy while crime was identified by a father to be easy. One of the adolescents pointed out condom use to be an easy issue to discuss because of its accessibility; *"I think-condoms can be easy because now it's been found everywhere"* (T02, Male interview, 2016), whereas another identified protected/unprotected sex to be a difficult topic to discuss because when adolescents ask parents questions on protected/unprotected sex, parents were perceived to see them (adolescents) as irresponsible and probably experimenting with risks.

Even though, adolescents emphasised the importance of parents' communication, they still found it difficult to discuss these issues freely. Parent-adolescent discussion about some sexual issues rarely occurs and is bounded by lack of knowledge, fear, sociocultural norms, and parental concern that discussions about sex would encourage premarital sex. Generally, the participants (parents and adolescents) admitted that they found sex to be difficult to discuss

I don't speak about having sex and all those stuffs. I just speak about love life-is it possible to have one or two boyfriend, but sexual intercourse, I don't talk about my privacy (T03, Female interview, 2016);

Yoo! The part of sex (is difficult to discuss) because telling them about it might mean mum is telling me this is what mum and dad do; although, it's something that you really need to talk to the kids about (P04, Mother interview, 2016).

One of the parents admitted that it was very hard to discuss sex because of its sacredness and it was perceived to be a secretive or intimate discussion between married couples:

No ooo, the sexual thing is a secret thing and I don't speak to them easily. It is not easy to talk about sexual things all the time (P02, Father interview, 2016).

Menstruation was also identified by one of the parent participants to be difficult. The majority of the participating adolescents respected and identified the importance of parents or caregivers in their sexual decision and perceived their parents or caregivers as the primary source of sex information. However, the male adolescents did not see the importance of sex communication because they perceived themselves to have nothing to lose:

Okay, for me, as a man, this communication is not necessary because I can experience it myself (T01, Male interview, 2016).

This male adolescent believed that sexuality communication should rather be focused more on his sisters because females were easily and more susceptible to sexual risks. Similarly, parents differentiated their topics of discussion along the gender line as male adolescents were told to use contraceptives while female adolescents were told more to abstain. This was also similar to Dessie *et al.* (2015) who found more sexuality discussions with females compared to males because of the erroneous belief that females were usually more exposed to negative sexual

reproductive health outcomes. Sexuality discussion was linked with abstinence until marriage for females while male discussion was associated with sexual prowess (Wamoyi, *et al.* 2010).

Even though, parents were main sources of information on sexuality issues as reflected from this study, there is still a general silence between most parents and their adolescents as other studies have shown (Herman, *et al.* 2013; Chaweewan, 2011; Namisi, *et al.*, 2009). These studies assert that few parents discussed such issues with their adolescents because of the barriers affecting the discussion between them. Hence, factors affecting parent-adolescent discussion should be taken into account. The next topic will assess those factors that affect parent-adolescent communication.

Causal factors affecting parent-adolescent communication on sexuality and reproductive health issues

Both the adolescents and parents explained that it was difficult for them to communicate sex and reproductive health issues. Different opinions on the barriers that hindered parent-adolescent communication emerged. Major sources of constraints included fear; for the adolescent, it was fear of punishment. Some adolescents admitted that if they speak with their parents about sexual issues, their parents might punish them. When asked why they found sex topics difficult to discuss, one of the male adolescents retorted:

Yes, it's kind of difficult to communicate sex because she too have heard unprotected sex is bad and if I come to her and say unprotected sex is good and stuff, she might even 'shaya' (beat) me (T01, Male interview, 2016).

On the other hand, parents feared that they would direct their children to engage in sexual experimentation. Parents were concerned that talking to their adolescents about sex, puberty, condom use, STIs and HIV prevention and early pregnancy prevention may cause children to 'grow up too fast,' or may encourage adolescents to engage in risky sexual behaviours. Parents perceived that giving information might be misused or adolescents might give another meaning to the discussion as noted from a parental perspective:

It's difficult because sometimes I can say I started sex when I was 21 years, so if she is 23 years, she can say so you (my parent) started sex when you were 21 years, am matured to start now (P01, Mother interview, 2016).

This was supported by a female adolescent who admitted that their parents were afraid of sharing too much information as it may lead to adolescents becoming too knowledgeable about these issues which could give rise to their involvement in risk-taking behaviours:

Some parents don't because if they discuss sex problems with their children, they will think that sex is good. (T03, Female interview, 2016).

These findings were similar to Chaweewan (2011) findings on involvement of Thai parents in the sex education of their children, where he affirmed that both parents and adolescents were scared to broach topics because they believed that such information would expose their teenagers to sexual experimentation. A systematic review of studies on communication about reproductive health issues in sub-Saharan Africa also found fear of physical punishment, and the parent notion that communication with their children could warrant sexual exposures (Bastien, *et al.* 2011). Similarly, according to the fifth stage of Botchway communication process, communication is hampered when parents and adolescents do not take into cognisance the body language and gestures produced by each other. Adolescents might withdraw when they perceive any form of threats from their parents' tone (Bochway, 2004).

Gender and age barriers were other factors identified by participants. Young people were constrained in their communication with their parents due to restrictive gender and age. Female participants from the study preferred receiving sexuality information from their mothers, sisters or aunts while males preferred fathers, brothers or uncles. A female participant mentioned that difference in sexes hindered her from communicating with her sister's husband. Likewise, a male adolescent explained that he found it easier to discuss with his uncle than his aunty. For him, the uncle would understand him better and he would be free to disclose anything regarding sex:

Normally, I will not talk with my aunt but only with my uncle. This enables me to speak clearly because he is a man and am also a guy. He then can understand me well enough, while the female understands the things of the lady the most (T02, Male interview, 2016).

A parent expressed similar ideas, highlighting gender influence as a barrier as illustrated in his quote:

The ladies that I am speaking to now, I normally speak with them with the mother. I don't speak to them alone because they are of different sex. So, I have to sit with them with their mothers when am talking about sex. The mothers, they know how to clear the understanding of this communication with them. This will make them understand better. However, the boys are different from the girls (P02, Father interview, 2016).

Similarly, a multi-site study in Tanzania and South Africa among in-school adolescents on sexuality communication found that communication was linked with same sex. In their report, female adolescents preferred to receive sexuality information from their mothers, while among males there was a higher preference for fathers (Namisi, *et al.* 2009).

Likewise, a child's age or mental maturity level was identified by the participants to limit discussions on sexuality topics with their adolescents. The age for sexual communication was found to hinder parent-adolescent communication in one way or another. Adolescents perceived age as a barrier in communicating with their parents because they were of the notion that their parents believed they were still too young to know about such discussions. In the same vein, the reasons why parents communicated less or not at all with their children on sexuality issues was that many parents felt that the children were still too young. They thought it was not yet the time for them to know about these things and they perceived that it would initiate sexual practice. This was reiterated by a father who explained that communication was hindered "*because sometimes, the parents usually take the child as so small to talk about the sex with*" (P02, Father interview, 2016). Similarly, a mixed method study in Thailand reported that twenty-one teenagers of both sexes noted that their parents were of the notion that they were too young to be discussing sex education with them because their parents believed they have not been involved in any risky behaviour (Chaweewan, 2011).

Equally from this study, most of the participants indicated that communication should start at the early stage of adolescence, while few suggested a later stage of adolescence. Various reasons were given for supporting each stage. In support of the late initiation of sexuality communication, a male adolescent believed that parents were of the opinion that they were still young and information at the early stage would expose them to sexual risks. The findings

correlated with some of the studies conducted on parent-adolescent communication timing where they reported that early exposure to sex education encouraged early sexual debut (Gumede, 2011; Botchway, 2004; Wamoyi, *et al.* 2010).

In contrast, two adolescents (T02, Male interview, 2016 and T04, Female interview, 2016) and three of the parents supported early sexuality communication because it was believed that when adolescents are educated early, it would prevent sexual risks. The age ranges within this (early) stage that was noted were; 10 years for male adolescents as indicated by a father, 12 years as indicated by a mother while 13 years was indicated by a female adolescent. Going by this, a mother advised that, while introducing sexuality education to a child, it is imperative to be tactical on how the information is transferred; communication should be 'one step at a time'. That is, appropriate communication for each stage must be carefully selected. She suggested that communication on body development, menstruation, and types of friends should be introduced at the early stage of adolescence. Opara, *et al.* (2010) studies on mothers' perceptions of sexuality communication for children observed that 40.5% believed that 6-10 years was the ideal age to start sex education while 49% thought that the ideal age was 11-15 years. This showed a positive support for early to mid-initiation of sexuality topics and the need for parents to broach sexuality topics at early adolescent stage.

According to the Theory of Adolescent Development, adolescents especially at the late stage (18-21) engage more in risky behaviour (Steinberg, 2008) because during this period the quality of time parents and adolescents spend together reduces over time. At this stage, adolescents perceived themselves to be old enough to take decisions on their own thus, they perceived parents' decisions against theirs. This was due to their egocentric thoughts which made them think they were wise enough to take decisions and were mature enough to reason abstractly (Fantasia, 2009). It is, therefore, pertinent for parents to establish a friendly relationship at the early stage and expose them to sexuality discussion before the late stage.

Another inhibiting factor in parent-adolescent communication is parents being judgmental. Adolescents shared that their parents believe them to be virgins, so when their children discuss sexual issues with them, it is assumed that they are no longer virgins. This discouraged adolescents from initiating discussions with their parents. Parents also felt discussing this with

their children might make them feel uncomfortable. Parents are discouraged from having open communications about sex with their adolescents because they do not know how they will handle such questions. Moreover, adolescents felt inquiries about sex to their parents were disrespectful. They perceived their parents to feel embarrassed discussing these issues.

Sometimes, I don't [discuss sexual topics] because I feel sorry for her. I know if we are talking about that topic, it's going to be harder for me that oh, she is doing the sex (P03, Mother interview, 2016);

People of my age do discuss with their parents but not everything. They just discuss day-and day [what they felt is necessary] because they are scared of the embarrassment (T03, Female interview, 2016).

According to the Rommetveit and Blakar communication model, parents who are judgmental and over-protective create a sort of wall which hinders mutual trust and confidence in adolescents to disclose any information with their parents (Botchway, 2004; Hollander, 2000). Similar to this, in studies conducted in Ghana and India, it was reported that adolescents felt uncomfortable discussing these issues due to the thought of what their parents would say about them while parents reported discomfort due to shame, or shyness about holding such discussions with their children (Kumi-Kyereme, *et al.* 2007; Jejeebhoy and Santhya, 2011). A narrative study conducted among mothers-daughters from Mangaung Township in South Africa, reported feelings of embarrassment among parents. This was reported to be as a result of not knowing what to say and/ or how to answer questions posed by their daughters and perception to prevent putting their children in uncomfortable situations (Gumede, 2011). Embarrassment was however attributed to cultural background of the family where sex was seen as a taboo (Chaweewan, 2011).

Parents' perceptions on what or how they would respond when adolescents ask sex questions could also be associated to the level of their education. This barrier was commonly found by previous studies (Gumede, 2011; Tesfaye, *et al.* 2010; Mathew, *et al.* 2006). Adolescents from the present study perceived their caregivers as inadequately knowledgeable about sexuality topics and risky behaviours. They believed if their parents were knowledgeable enough, they would not avoid discussions with them. However, both parents and adolescents believed open

and exhaustive communication about these issues would encourage adolescents' positive decision making. Moreover, parents thought that reasons for early discussions could be due to knowledge while those with little or no knowledge were perceived to start discussions late. A mother gave reasons why parents do not communicate these issues with their children, or did not communicate at all, she mentioned illiteracy. To her, other parents who did not attend any educational institutions nor had any proper knowledge of sex communication, passed information given to them when they were young on to their children, irrespective of whether they were correct or not.

It depends on the way parents communicate. Some of the parents never went to school as a result; they use the methods that were used on them while they were young. So now, they find it difficult to change this method (P04, Mother interview, 2016).

It is noteworthy that the role of parents' personal beliefs or cultural background also limited communication between parents and their children on issues of sexuality. Cultural barriers have been reported to have an impact on parent-adolescent communication (Mtikrakra, 2009) and communications particularly on sex in African culture were found to be a taboo (Mtikrakra, 2009). In a typical African family, sex was seen as a taboo or as a sacred discussion which must be kept secret (Mtikrakra, 2009). As a result, it was found from the current study that discussions in this setting were characterised by warnings, instructions, and cautions that adolescents were expected to take in without questioning. A mother explaining her experience with her own mother while she was a teenager said her mother did not teach her about sex and when she found out these issues from school, they sounded new to her. This finding was similar to Luwaga, (2004), Gumede (2011) and Phetla, *et al.* (2008) who also found that family sexuality discussions were characterised with authoritative, instructions and warnings instead of proper discussion.

With regard to the Rommetveit and Blakar communication model, this is a setback to parent-adolescent effective sexuality communication. As noted by this model, when there is disruption in the flow of communication, deficiency in communication is bound to occur (Botchway, 2004). It is therefore important for interventions towards fostering parent-adolescent communication to explore possible ways these limitations can be tackled, particularly in this era of the HIV epidemic, abortion and low mortality rate.

Generational difference or difference in worldview was also identified as a determinant factor that hinders parent-adolescent communication. According to the Rommetveit and Blakar communication model, communication constraints occur when both parents and adolescents perceive different meanings to a particular subject (Botchway, 2004). Similarly, adolescents were reported to have their own views and want to enforce their own decisions, opposing the views of their elders as a way to prove their authority (Chaweewan, 2011). In line with the Adolescent Development Theory, adolescents' egocentrism tends to make them see themselves as always right, argue their opinion on certain issues (such as sex), thereby, opposing other opinions against theirs (AlBuhairan, *et al.* 2012; Fantasia, 2009; Cromer, 2011).

From the current study, a mother claimed that the new generational (modern) parents were not affected by this generational difference but the older parents were, which was a result of the level of their knowledge and perceptions about sex. As such these older parents were assumed to only possess archaic information. To her, new generational parents were perceived to be more educated and open with their children.

My mother is stupid and she is old. She doesn't know anything (T03, Female interview, 2016);

The teenagers don't understand these sexual risks but then, if you talking about these things, they sometimes think you are stupid. They usually say gone are those days, you are old (P01, Mother interview, 2016).

Similarly, Chaweewan (2011) reported that adolescents perceived their parents' views as old fashioned but were constrained by respect for their parents. It could be deduced that generational differences could have occurred as a result of urbanisation and improved ways of parent-adolescent communication. Compared to the present age of parent-adolescent communication where communication was perceived to be more opened and interactive, traditional communication in a typical African setting took various forms, cutting across poems, storytelling, metaphoric saying, proverbs, folklores, singing, dancing and games to convey realistic messages that participants can relate to when faced with risky challenges (Ntshwarang and Malinga–Musamba, 2015; Utley, 2008). In relation to this study, a father identified

“asidlale” which means let us play in Zulu culture¹⁵ as a form of traditional communication. Even though, “asidlale” is a children’s forum where elderly ones in the community make use of apple boxes containing games and activities as a means of early childhood development training and preparation for grade one, in this context, this study identified “asidlale” as a form of traditional communication where the elderly ones sit together with the children to pass across sexuality communication:

“Asidlale” is the time children are allowed to talk freely. While having “asidlale”, we discuss anything like the part of body which makes it easy for children to open the deep secrets in their hearts (P02, Father interview, 2016).

The father also added that basic topics such as sex, risky behaviours and its negative outcomes were often discussed during this time. Contrarily to the adolescents’ notion on traditional communication, he believed that when communication took this form, adolescents would be free to discuss any issue.

Also, a notable barrier is authoritative parenting style. Parents’ overreaction during discussions was perceived to be because they were authoritarians. A female adolescent viewed her father’s overprotectiveness to be as a result of his authoritative lifestyle.

There are sometimes I take it (her instructions) but most times, I don’t because I dint like when she gives me advice. I think she is kind of dictating to me; what to do and what not to do. As a result, I do as it suits me (T01, Male interview, 2016).

This was also supported by some of the parents even though, it was indicated that older parents were those perceived to be strict and they made use of instructions during discussion.

This study agreed with some of the studies conducted in South Africa (Gumede, 2015; Mtikrakra, 2009). However, Kajula *et al.* (2004) argued that authoritarian parents were different from authoritative parents. According to him, authoritarian parents were highly demanding and not responsive to their children. They expected their orders to be obeyed without explanation. On the other hand, authoritative parents were both demanding and responsive to their children.

¹⁵ <https://www.tnnetwork.org/blank-7> accessed on 4 October, 2017

When adolescents perceive their parents as domineering, it could create fear in them which might make them source information elsewhere. In tackling these hindrances, there must be about putting authoritarian parents into intervention programmes targeted at parent-adolescent communication.

Parental absence was another issue which limited sex communication within the family. The bond between children and their parents was reported to engender effective open communication compared to other sources (Manuel, 2013; Hartenstein, 2012). Therefore, parental absence could prevent adolescents from getting the right information and this could lead to risky sexual behaviours. A father from this study emphasised that when adolescents mingle with other peers who came from dysfunctional homes, particularly those whose parents are absent in their upbringing, such adolescents tend to misbehave and consider peers as their primary source of sex education. Likewise, a male adolescent said that when a child senses he or she is unloved or the atmosphere in which s/he lives is unfriendly, a communication barrier is bound to ensue. Conflicts between parents and their children also results to ineffective communication when there is poor relationship or a communication gap.

It can be concluded, based on these findings, that when these barriers are absent, risks among adolescents would most likely reduce. However, when parent-adolescent communication is inhibited by the various factors mentioned above, where then should adolescents turn to for information? It is therefore important to examine the various sources of parents' and adolescents' information.

Information sources for sex and risky behaviour issues

For the adolescents, the available sources of information were family members, friends, media, clinics and their personal experiences while sources of information for parents included clinics, school, community programs and media. The majority of the adolescent participants believed the family was the most trusted and reliable source of information. A male adolescent said he relied on his caregiver because he believed they loved him and wanted him to have a better future. Likewise, two female adolescents added that they saw their caregivers as good role models, who would not give them poor advice:

I can say a mother is like a sister, a brother, a friend to you. My mother is a good adviser to me. I respect and I take her advice and her advices do work for me. I carried on talking about this sexual behaviour because she (my mother) is a good adviser to me (T03, Female interview, 2016);

(I take) information from my sister because she is like a mother as I said and she is like my model (T04, Female interview, 2016).

However, adolescents' choice of sexuality communication with family members was dependent on that member's sex. For instance, one male adolescent identified his uncle as his source of information instead of his aunt because he could express himself more with the uncle. In support, a father said communicating with same sex family members encourages adolescents to freely open up during sexuality communication.

Although adolescents from this study identified family as their primary source of information, it was found that they still depend on other sources for different reasons as identified above (*causal factors*). Alternative sources of information included; peers, digital media (internet), schools, clinics, and non-governmental programmes from the community. Similarly, previous studies found that adolescents solicit sexual knowledge, values, beliefs, behaviours and information from a range of sources cutting across media, schools, peers, family (Shtarkshall, *et al.* 2007).

A common means through which adolescents obtained information was from their friends or school mates, as pointed out by some of the adolescents. This reliance was attributed to parental absence, or poor relationship between adolescents and parents as indicated by one of the female adolescents. In the same vein, another male adolescent indicated he obtained information from his friends because he had something to gain from their views on sex topics.

This is in accordance with findings from previous studies which reveal that adolescents consider their peers as sources of information regarding sexuality and reproductive health especially when parents deny them of such information (Hartenstein, 2012; Pistella and Bonati, 1998). Literature has identified the influence of peers on adolescent sexual decisions. While some perceived peers to have negative influences (Iliyasu, *et al.* 2012; Mturi, 2003), others argued positive influences of peers on adolescent (Carter, *et al.* 2007). However, parents or caregivers must endeavour to monitor the kind of friends their children associate with. As expressed by parents from the

present study, a good friend would encourage a positive behaviour while a negative friend would influence their behaviours negatively.

Media (television, radio, internet, newspaper, magazines) constitutes other channels of information for adolescents regarding sexuality matters (Loew and Thompson, 2011). With access to the internet, adolescents search for sensitive topics regarding sex issues, making it a likely source of sexual information.

Newspaper is not that enough information but it is affordable and not everybody has Television. Magazine is the best for me. I can go to clinic for information too but magazine is the best (T02, Male interview, 2016).

Interestingly, not only do adolescents obtain information from these channels, parents also do. Although parents reported willingness in giving their adolescents information; they were hindered by different barriers (as identified above). In order to fill this communication gap, parents still made efforts to get information from available programs and other means so as to educate their children:

I get information from reading books in the library and listening to radio. I have also been a community helper and worked at a children's home (P04, Mother interview, 2016).

It is therefore important for media programmes to facilitate sex education, targeted at rural and uneducated parents to encourage parents to communicate with their adolescents. Both parents and adolescents identified information from the clinic, community programmes or available NGOs as beneficial sources of information because:

At the clinic, there is a group called "counsellor" where the counsellors try to explain these information like all these diseases outside there to us (P03, Mother interview, 2016);

I took part in different programmes such as Hope to educate, ZAZI, World Changers, empowerment and so on while in school and when I finished school because there was all

the information which I need to get me a better man in the future (T02, Male interview, 2016).

Moreover, it is often said ‘experience is the best teacher’. Past experiences as a result of parents’ involvement in risky sexual behaviour were also identified by parents as their sources of information. Parents believed that when they use their past experiences as examples during communication, it could encourage positive behaviours. Similarly, when a mother was asked if she speaks with her adolescent about her life experience when she is discussing risky behaviours and sex topics, and if she thinks her life experience could encourage behavioural change and effectively improve their relationships, she said:

Yah, if am talking to my daughter, I tried to explain always, my life behaviour in the past. I think that maybe she will learn from me (P03, Mother interview, 2016).

Acceptably, adolescents from this study also believed their parents or caregivers’ past experiences could be effective for behavioural change. A male adolescent from this study whose caregivers were both HIV positive added that knowing his caregivers’ status only helped him to avoid risks. In support of this finding, a study conducted in South Africa affirmed that parents did not want their adolescents to experience the same mistakes that they had when they were growing up, therefore sharing how they became a young mother was believed to encourage their adolescents to avoid risk (Mtikrakra, 2009).

Although the majority of the parents from this study believed that their information was the most preferable and reliable, a mother acknowledges the school as the best source of information for adolescents because she believed school teachers would better explain issues. Various studies have signalled school as an important source of information because of the amount of time adolescents spend in school (Kirby and Laris, 2009; Loew and Thompson, 2011, Chaweewan 2011). However, some other studies have argued that schools are not always the most preferable information source (Chikovore, *et al*, 2013) as studies report that adolescents dislike their teachers due to unclear boundaries, lack of anonymity, embarrassment and poor training (Pound, *et al*, 2016).

Furthermore, the present study found that adolescent sources of information were associated with the type of information they want. This was illustrated in one of the male adolescents who

expressed his ease speaking with his elder brother on masturbation while protected sex was often discussed with his aunty.

Previous studies argued that holistic and well-structured sexuality messages would help to prevent unhealthy sexual behaviour, prepare adolescents to have perfect attitudes and behaviour towards sex (Bhan *et al*, 2004). It can be inferred from the present study that when parents deny adolescents these sexuality messages, they look elsewhere for such information. The attitudes and family communication styles could affect adolescents' reliance on the family as a primary source. It is therefore pertinent for families to identify the styles that would encourage free communication. These attitudes and styles are discussed in the next theme.

Approaches in parent-adolescent communication on sexual matters

This section focuses on the communication approaches within the family. This also elucidates the approaches that encourage effective parent-adolescent communication as well as approaches that both parents and adolescents perceived to engender and hinder self-efficacy. These are discussed under the following sub-themes that emerged from the findings.

Triggers of parent-adolescents' sexuality communication

Participants from this study identified and explained reasons and situations that often trigger sexuality topics within the family. The study participants identified the following triggers to discuss sex-related topics; relaxation time, watching television, project or assignments relating to sex, conducive mood, physical or behavioural change with age, and community events.

Both parents and adolescents identified watching television or films as triggers for sexuality communication. According to a male adolescent, communication was instigated while watching a movie or television programme with sexual scenes. On the other hand, a mother instigated sexual related topics when parental guidance is advised during a programme or film while a father identified the occurrence of crime on the television to prompt communication on risky sexual behaviours:

Okay, like for instance, if we are watching a movie and then that part when two people are having sex and then, as we have sisters, some of them will laugh and the topics will start from there (T01, Male interview, 2016);

Normally, if you want to watch a programme and then it says parental guidance, then the question comes up. Why parental guidance? From there, you start and you speak about these issues then my child also gives me his experiences in school... (P04, Mother interview, 2016).

It was believed that when communication took this form, it aided the adolescents' understanding via visual representations. Similarly, a study in South Africa found such parent-adolescent communication to have been triggered by television educational programs such as Soul City (Mtikrakra, 2009). However, Gumede (2011) argued that the content of the programmes problematises sex. Mothers from her study believed these programmes encourage risky sexual behaviours in the way it portrayed sex (Gumede, 2011).

Adolescents also perceived that their parents instigated communication when they observed changes in them. These changes could be behavioural changes, for example late nights out or physical changes like body development in puberty. A male adolescent said his uncle realised he was fully grown and should be informed about sex topics such as using protection. Likewise, he perceived that his uncle realised he must have been having girlfriends thus; he realised the need to discuss sex with him. This was supported by two mothers and a father who emphasised the need to trigger discussions with their adolescents because their adolescents were in their puberty stage which was believed to have been characterised with risky sexual acts:

You sometimes can feel that this girl is engaging in sexual acts. When you see the symptoms like coming home late, then I suspect that maybe she went out to have sex. Then, you try to warn her to change her lifestyles (P01, Mother interview, 2016);

...for girls, once they reach puberty, then you start talking to them- how to clean up, how to manage themselves, how to behave and then, because once you reach puberty, you are ready to become a mother (P04, Mother interview, 2016).

Luwaga (2004) supports that behavioural changes, physical changes and psychological changes noticed by parents in their adolescents prompted their discussions. Also, a qualitative study on parent-adolescent communication agreed that behaviours that occurred within the community were a means to start conversations (Mtikrakra, 2009).

It was also found that negative occurrences in the community triggered parent-adolescent communication. Both parents and adolescents said incidents incidence from the environment such as rape news prompted sexual related communications:

Noo! [Discussions cannot just start] There must be something that must put us together because we need to understand each other. We adopt talking about the sexual things if we hear sometimes a child is been raped somewhere or somehow, then, we end up having a meeting on that. We talk about these issues after we hear something connected with sex (P02, Father interview, 2016).

This finding is similar to that of Wamoyi, *et al.* (2010) who found out that parent-adolescent communication about sexuality was triggered by seeing or hearing something a parent perceived as a negative experience (such as a death attributable to HIV and unmarried young person's pregnancy).

Furthermore, discussions were found to ensue whenever there is relationship problem like break ups or misunderstandings between a boy and a girl. A mother was found to have triggered communication when she perceived a change in her child's mood. This was often linked to her daughter's relationship issues. She said she often realises a change in her mood after a fight or argument with her boyfriend. This was pointed out by another female adolescent who reported that when her boyfriend hurts her it prompted her to trigger communication with her elder sister.

Another impetus found to have triggered sexuality communication by parents was while helping with child's school project or assignments in relation to sexual topics. A mother perceived her adolescent to have asked her about an assignment because she (adolescent) wanted to test her knowledge about the topic. Parents habitually undervalue their children's sexual activities because often times, they waited for situations to initiate conversations (Gumede, 2011).

From this study, it can be seen that when parents and adolescents wait for certain situations before communication is triggered, there is a probability that risks may have occurred before the initiation of communication. A survey on mother-daughter communication on sexuality found that parents who discuss sex before an adolescent's first sexual experience were three times more

likely to use condoms than those who started discussions after adolescent's first sexual experience (CDC, 2003). However, effective communication could be ensured based on the styles and tones adopted within family. It is therefore important to examine communication styles and tones that encourage or discourage communication and self-efficacy.

Communication approaches and tones

As discussed in Chapter two, one of the challenges of positive and effective parent-adolescent sexuality communication can be traced to the communication styles and tones of discussions. Phetla, *et al.* (2008) and Luwaga, (2004) reveals that tone or voice, or employing a general talking style could affect the content and ease with which conversations occurred between parents and adolescents. Different approaches were, however, identified by parents in communicating with their young ones and reasons for these approaches were as well expressed.

Mutually interactive or counseling style was reported by some parents in this study. This was characterised with being open, honest and practical. Here, they were being blunt, real, and direct:

It depends on how you talk with the child. Like we usual sit and play in a silent room, then we will talk openly and she will talk openly while we are two but if there is someone else, she can't talk (P01, Mother interview, 2016).

Also, in this type of communication, both parents and adolescents found it easy and comfortable to discuss any topics regarding sex and other risky behaviours. This type of communication was characterised by honesty, freedom to come up with the discussion and intimate parent-adolescent relationships (Tesfaye, *et al.* 2010; Rosenthal, *et al.* 1998). It encouraged mutual understanding, close and cordial relationships which would most likely encourage positive and healthy adolescent behaviour (Mtikrakra, 2009; Rosenthal *et al.* 1998). When such a conducive atmosphere of communication is set in place, and both understand how communication works, adolescents were perceived to disclose more information.

It depends on how you talk it with the child. Like I use to sit- we usually sit and play in a silent room we can be two and then we will talk openly but if there is someone else, she can't talk (P01, Mother, interview, 2016).

According to Botchway (2004), in explaining the six communication processes within the Rommetveit and Blakar Communication model, participants must; be willing to produce feedback to the encoded message, establish mutual trust and confidence, have common worldviews, recognise body language, understand the social and situational context of discussion for parent-adolescent communication to be effective and productive.

Some parents strive to create a fun and humorous learning environment by using humour and jokes. Humor was often used as a gateway to conversation, a way to get their adolescent to relax and open up. This was viewed as a good “starting point” for conversation as one of the interviewed mothers noted. Conversely, in a study conducted by Wamoyi, *et al.* (2010), grandparents’ conversations were perceived to be humorous and characterised with jokes. It was argued that most of the young people who lived with their grandparents reported that they were closer to them than to their parents (Wamoyi, *et al.* 2010). However, the possibility that adolescents might take conversations with levity could be a weakness for this style.

The use of visual illustration was another style parents adopted in communicating with their children. It was believed that for better understanding of the subject matter, open communication and close relationships, parents need to show their children what they were explaining. A father explained that the way he discusses with his male adolescents, using practical illustrations made his style the best of all:

What I did especially to the boys, I did sit down with them from the age of 10 upwards. When am teaching them about sexual things, we used to bath together. During this time, I tell them about this apparent secret part of our bodies. I told them how those parts function and when it was the good time to use those parts. From there, I was able to advise them on having girlfriends and changing girlfriends. I encourage them to use condom. Now, I know they are making sex with condom. Though, I may not guarantee 100% but all the time, I encouraged using condom and without it, they would get into trouble (P02, Father interview, 2016).

It was found that both parents and adolescents sought clear atmosphere or opportunities to initiate discussions. This type of communication approach according to Rosenthal, *et al.* (1998)

was referred to as opportunistic style of communication. Parents and adolescents from the current study used school work, television programs or people's experiences as an opportunity to trigger communication. This could probably be because they lack the knowledge on how to initiate discussion on sexual issues. This style was found to limit discussions and selection of sexual topics to delve into since conversations were only based on situations. Even though the interviewees identified opportunistic communication approach as the best communication style for effective communication, this style has been thought to infrequently engender communication on sex topics (Rosenthal, *et al.* 1998).

Adolescent-initiated communication style was another style found to have occurred within the family. This style occurs when the parents wait deliberately for their adolescents to come up with risky behaviour and sex related topics. Communication would likely take this form because parents might be shy to broach topics and feeling of embarrassment both from them and their adolescents. Rosenthal *et al.* (1998) observed that parents adopt this style because they perceive conversation would be more effective when their adolescents initiate it. They also observed that when communication takes this form, the child will be willing to hear them and make use of their recommended messages than when it is the parent that initiated discussion. However, the implication of this style could be injurious to adolescents in that adolescents might have been involved in risks before informing their parents and exposed to other communication channels such as media and peers.

The last noticeable style identified was based on necessity. Necessity communication style occurs within the family when parents observe changes in their adolescents. Parents using this style could have intentionally waited for such changes as behaviour and physical development out of fear that their children might feel embarrassed and at the same time concerned about how to get the message across. This type of style could be disadvantageous in tackling adolescents' risky sexual behaviours because there could be a probability that risks might have occurred before a parent's corrective measures, especially when communication is prompted as a result of behaviour change. Most times such discussions are perceived to be one-sided (Rosenthal, *et al.* 1998).

Nevertheless, each communication approach has its disadvantages and advantages. As observed from this study, when parent-adolescent communication allows open discussions and

discourages privacy or secrecy, the likelihood of healthy sexual decision making is strengthened. It was, however, suggested that parents should be equipped on different parenting styles useful for sexual communication since there is no single or compulsory method of communication (Mtikrakra, 2009). Likewise, the Theory of Adolescent Development suggests the need for parents to study their adolescents closely. It argued that to know how to shape a child's development in a positive way, parents or caregivers must be ready to understand the way adolescents are hardwired. Similarly, as per the EPPM, communication should not be one-sided where parents only emphasise the risks, rather when parents include moderately high threat (susceptibility + severity) and high level of efficacy (response efficacy + self-efficacy), adolescents will be able to adopt positive and healthy behaviours even in the face of threatened behaviours (Witte, 1994; Maloney, *et al.* 2011).

Self-efficacy is important in the face of risky sexual behaviour. It is the confidence that an adolescent has in order to successfully perform an action (Witte and Allen, 2000). Generally, the different modes of passing on sex information to adolescents were; counselling, teaching, advising, dialogues, warning, shouting, threats or intimidation, physical discipline, gossips, quarrels and abuses (Bastien, *et al.* 2011). However, from the present study, common tones identified by participants included; threat, shouting, physical punishments, warnings, dictating, instructive, persuasive, advice and counsel:

If you ask the sex questions, you can't get the answer, instead she (mother) will shout at you. So you end up with no information about the sex (T01, Male interview, 2016);

Yes, although, if individual (adolescent) is doing bad thing, I had to shout at her...I hear sometimes when they are talking about fancy boys, then I end up warning them to stop talking about fancy boys because they will end up doing stupid things. I always tell them, you must not even ask something from any boy because you will be in trouble for it. Even to ask for a lift, or if you ask a boy to offer you 10 cents or 5 cents, that shows you want something from the boy (P02, Father interview, 2016);

Keep away from that girl. I want you to just concentrate on your studies and then you will see that at a later age, it's something that you would be doing but right now, concentrate

on your studies. This is what I want- I want As, I want Bs; girlfriends will be later (P04, Mother, interview, 2016).

Parents' tones during communication could encourage self-efficacy. Rommetveit and Blakar's communication model explained that parents' messages (often times, the sender) must be simple and appropriate for adolescents (in the place of receiver) to comprehend. According to this model, for effective communication, the four elements of communication (sender-message-receiver-feedback) must be taken into consideration in order to ensure understanding of the intended message. Although, participants identified the importance of communication, the result of this study showed that parents' tones of communication conveyed warnings, instructions, and threats about the negative outcomes of unprotected sex with little or no feedback from adolescents. Parents from this study however believed that when they make use of threats for instance, during communication, it would instil fear in their adolescents and could prevent them from engaging in these risks. According to the EPPM, employing fear appeal was perceived to reduce adolescents' risky sexual behaviour however, recommended fear-based messages would not be effective in persuading these adolescents to adopt healthy behaviour, if the level of fear is greater than the level of self-efficacy and response efficacy (Witte, 1992; Witte and Allen, 2006).

Adolescents on the other hand perceived that in order to prevent them from contracting sexually-related diseases, their parents make use of threats, warnings, instructions, punishment and caution. In so doing, they did not believe, for the most part, that the tones their parents used encouraged self-efficacy or behaviour change. Instead, they found that these common styles often created unnecessary fear which results in widening the communication gap. Similar results were found in Nigeria, South Africa and Ghana where the use of warnings, threats and instruction were reported to prevent adolescents from engaging in risky sexual behaviours (Izugbara, 2008; Phetla, *et al.* 2008; Botchway, 2006; Kumi-Kyereme, *et al.* 2007). However, adolescents faulted the styles and tones parents employed, saying that they have hindered friendly relationships and sexuality discussion (Phetla, *et al.* 2008). It was argued that most of these threatening tones employed by parents were as a result of their upbringing (Luwaga, 2004). Since their own parents used these styles and tones on them, they believed it could also work well for their own children (Luwaga, 2004). However, the implication of this might be harmful to parent-adolescent relationships because adolescents are exposed to alternative sources for

information. When adolescents realise that their parents or caregivers are strict on them, they would most likely not take their parents' advice keenly but rather resort to making use of these other sources as reflected in the study.

As explained in chapter three, Rommetveit and Blakar communication model is a two-way process where parents and adolescents are ideally meant to inter-change roles for effective communication. However, when parent-adolescent communication is bound by the negative aspects of the aforementioned tones and styles, there is a probability that communication will be unidirectional in nature and this would impede on effective parent-adolescent communication. Luwaga (2004) observed that sexuality communication was often done by parents while their children assumed the position of listening without questioning. Gumede (2011) also affirmed that when parents' communication tones are characterised with shouting, it undermines the communication process. It was also asserted that when adolescents feel threatened, they shut their ears to instructions given by their parents (Gumede, 2011). This was supported by the report from a mother who believed that a parent shouting at their children is detrimental:

Shouting does not solve the problem rather; make the child aware of both the good and bad options (P04, Mother interview, 2016).

Even though, the majority of the previous studies have considered communication styles with parent's communication tones (Bastien, *et al.* 2011), this study has been able to clearly differentiate these communication styles and tones and also stated the effect on parent-adolescent communication. This is imperative as a change in parenting styles and tones has been identified as fundamental factors in the protection of children in light of the risks and dangers associated with sexual experimentation (Phetla, *et al.* 2008).

Parents portrayed themselves to be open communicators but because of their communication styles and tones, their adolescents perceived them to be the opposite and as a result they shy away from communicating with their parents or taking their corrective measures.

Conclusion

Findings from this study revealed that the prevalence of risky sexual behaviours among adolescents is still on the increase and this has been attributed to different factors such as peers,

media, poor knowledge and so on. Not only were these consequences perceived to have immediate effect on the adolescent, the extent of these consequences was found to be a long-term cause which could affect their future. Since increased knowledge of the severity of these behaviours regarding the consequences on their future was found to encourage adolescents' self-efficacy and healthy behaviours, it is therefore important that they are adequately and intensely educated on sexual and related topics.

This study's findings have been able to establish the importance of parents as agents of change in adolescent healthy sexual decision making. The findings revealed that parents who discussed sex education effectively and intensely with their children were more likely to encourage self-reported responsible sexual behaviours. Despite the awareness of parents of their impact on adolescents' sexual decision-making process, diverse factors were found to inhibit discussions on sexuality and risks topics and affect the contents and comfort level of discussions within the family. Although the majority of the interviewed adolescents and parents identified parents/caregivers as the primary and trusted source of sex education, adolescents still relied on other sources for information. Furthermore, triggers, tones and styles of communication adopted within the family could have negative or positive effect on parent-adolescent communication. Sexuality communication was observed to be characterised by threats, instructions, and warnings. However, 'the opportunistic style' was more supported as the preferable style because it was believed to create a clear atmosphere and ease for initiation of sexuality and risks discussions.

From this study, adolescents' confidence in the face of risky sexual behaviours resulted in danger control response which in turn enhances their protective skills to reduce the likelihood of fear control response thus, leading to healthy behaviours. Self-efficacy which was perceived to be encouraged through adolescents' past experiences, parent-adolescent explicit communication and parent-adolescent communication styles and tones was found to be a significant variable for self-reported behavioural change. In all, intense and explicit parent-adolescent communication was perceived to more likely encourage healthy and positive behaviour as well as foster parent-adolescent relationship.

Finally, findings from this study are consistent with other studies that showed the importance of parent-adolescent communication and of providing parents with information on adolescent risky sexual behaviours. Adolescents in this study relied heavily on parents or caregivers for sexual information. They believed communication would be effective when parents use the best approaches and tones.

The next chapter provides a conclusion for the study.

CHAPTER SIX

CONCLUSION TO THE STUDY

This study explored parent-adolescent communication about adolescent risk-taking behaviours. The main objectives of the study were to identify the facilitators and barriers in the communication between parent and adolescents on sexual issues, investigate the parents' level of understanding when considering the reasons behind risky sexual behaviours, identify factors adolescents are exposed to that may encourage risky sexual behaviours, as well as gain an understanding of their perceived severity and susceptibility to such risks. The researcher sought to understand whether or not parent and adolescent communication on sexuality issues has any influence on adolescent risky sexual behaviours; and to investigate if their communication styles contribute to any behavioural change among adolescents.

Three theoretical frameworks were employed to guide the study; the Extended Parallel Process (Witte and Allen, 2000; Maloney, *et al.* 2011), Rommetveit and Blakar Communication model (Botchway, 2004; Blakar, 1992) and Theory of Adolescent Development (Sokol, 2009; Steinberg, 2008; Erikson, 1969; Piaget, 1950). The study adopted a qualitative approach using in-depth interviews with parents and adolescents in the Mayville area of Durban for data collection and thematic analysis. In this chapter, conclusions from this study, implications for practice as well as areas for future research are presented.

Summary of the findings

Using a theoretical thematic analysis, several conclusions regarding parent-adolescent communication on adolescents' risk-taking behaviours were drawn. These issues are organized under 4 identified themes including; i) parent-adolescent perceptions towards adolescent risk-taking behaviours, ii) sex-talk: factors that influence parent-adolescent communication about sex, iii) information sources for sexuality and risky behaviour issues, and iv) approaches in parent-adolescent communication on sexual matters. Data collection from Mayville participants revealed that alcohol consumption, drug intake, multiple sexual partners and unprotected sex are the most predominant risky (sexual) behaviours among adolescents. Of the many factors that participants identified to influence adolescent risky behaviours, peer pressure, negative influence

of media, and parental negligence were amongst the most cited. Also, there is a correlation between parent-adolescent communication on sex and adolescent risky sexual behaviours, specifically, the study was able to establish that when parents and adolescents communicate effectively, explicitly and early about sex and risky behaviours, adolescents would more likely be influenced to adopt a healthy and positive behaviours. The most discussed issues varied from physical development, dating/relationship issues, condom use, sex, STIs, and pregnancy.

Importantly, it was discovered from the study that adolescents' attitude towards sex played a major role in their sexual decision and acts. From the study, in making sexual decisions, adolescents based their thinking on emotions rather than on their ability to confidently resist risky sexual acts based on recommended messages. Sex was perceived by adolescents to be a 'fun' affair. As a result, when adolescents focus on the immediate pleasure at the expense of the long-term consequence, it heightens their susceptibility to risks. Even though the adolescence stage was perceived by parents from this study to be a natural stage that comes with its risks, participants from this study believed that adolescents' knowledge about the severity and effect of their consequences influences their sexual decision making process. Parents believed that when they reiterate the extent of these consequences in their communication using appropriate communication approaches or styles, adolescents are able to build self-efficacy in averting threats. Likewise, when adolescents see themselves to be vulnerable to the consequences, they tend to withdraw from risky sexual behaviours.

Although both parents and adolescents realised the importance of parent-adolescent communication in curbing and/ or reducing risky sexual behaviours, several factors such as fear, intergenerational differences, knowledge, parental absence, gender, and age emerged as reported factors that hinder communication. Parents claimed there is communication but findings revealed that communication was more on sexual consequences than on the preventive measures. Similarly, communication was gender-based, with more stringent measures given to female adolescents while male adolescents were engaged in little or no communication. Adolescents' choice of sexuality communication is dependent on member's gender, while female adolescents will more likely prefer their mothers; male adolescents give more preference to the fathers or male figure in the family for ease and explicit discussion of these issues. More importantly,

findings also revealed that the male adolescents often do not see the essence of this communication because it is believed they have nothing to lose and the idea of it being a 'man's world' makes them see themselves as less susceptible to risk because they perceive themselves to be 'in charge' during sexual intercourse. However, when parents and adolescents are able to tackle these issues, effective open communication was found to be encouraged which in turn influences positive sexual decision making.

Several ways were suggested in tackling these barriers; knowledge for example was perceived by both parent and adolescent participants as an effective way of tackling parent-adolescent sexual communication. It was also believed by both parent and adolescent participants that when parents are well grounded on sex education, they will be free to discuss sex-related issues with their adolescents. A striking finding was the issue of past experience which was suggested to influence adolescent behaviours. Adolescents from the study embraced the use of their parent's past experience during discussion. It was explained in the interviews that this would probably encourage them to not fall victim to risky (sexual) behaviours.

Additionally, the parents and adolescents identified different communication approaches that this study has labelled as the following; i) mutually interactive or counselling style, ii) use of humour and jokes, iii) use of visual illustration, iv) opportunistic, v) adolescent-initiated and vi) necessity approach. Participants revealed that an opportunistic approach was the best to engender self-efficacy and encourage effective communication because it creates a welcoming ambience to trigger communication. Since communication is triggered based on situations, it was believed that discussions on sex-related issues are easily instigated.

From the study, notable triggers of parent-adolescent communication were identified cutting across television viewing, school project or assignments especially in relation to sexual topics, adolescent relationship problems, negative occurrence in a community, observable changes by parents from their adolescents. Major triggers that encourage communication were during television programmes, news of occurrences such as rape or when adolescents are faced with relationship issues. The context in which these topics are discussed is very vital for effective communication. It was therefore suggested that when communication takes these forms, they could broach topics freely. Similarly, the study found that parent-adolescent communication

about sexuality is characterised majorly with warnings, threats and physical discipline which could be triggered by seeing or hearing something a parent perceived as a negative experience. Generally, this study has been able to establish the necessity of parent-adolescent communication on sexuality issues as an instructional approach for minimising adolescent risk-taking behaviours.

Implications for practice

There is need for more educational programmes and interventions that speak specifically to parents and educate them on sexuality matters. Most intervention programmes, like ZAZI: Know your strength and Hope 2 Educate, are centred on adolescents. However, parents should also be well informed so that they have the self-efficacy to freely communicate pro-social information and be knowledgeable of where assistance may be accessed. This will ensure adequate communication between parents and adolescents and also increase the frequency of discussion about sensitive topics, thus, improving the comfort level and the content of the discussion. As such, parents may be a national avenue for channelling and enforcing prevention messages to their adolescent children.

Areas for future research

Due to the negative consequences that risky sexual behaviours can have on an individual and society, it is important to continue research in this area. This study involved a small number of interviewees for the in-depth interviews but a larger number of participants may prove to be valuable. Research can further be carried out to examine the level of communication between parents and early adolescent within age 10 to 14 to predict risky sexual taking later in adolescence. It is assumed that adolescents within this age range that lack information about sexuality matters would be more likely to engage in risky sexual taking (Opara, *et al.* 2010; Wamoyi, *et al.* 2010; Pluhar, *et al.* 2008).

This study discovered that the belief of men being in charge of sexual relationships is an important issue that needs further research as to reasons why male adolescents often hold this belief (Nota, 2015; Wamoyi, *et al.* 2010; Botchway, 2004). This could assist in understanding the heightened susceptibility of adolescents to risk. Also, a reception analysis on entertainment

education programs, such as Brothers for Life, that attempt to address this issue could be considered a valuable tool for this avenue of research. Many studies and intervention programmes focus on young women as they are the most susceptible to HIV and STDS (Nota, 2015; Broecker and Hillard, 2009) and often carry the burden of teenage pregnancy with little support from the young father (Broecker and Hillard, 2009; Botchway, 2004). It is thus important that research explores the ways in which young men can understand their responsibility when it comes to looking after themselves and their partners. Furthermore, to explore the ways in which society can assist them in better dealing with this. Research should focus on young adolescents that may even be out of the age range of interventions such as Brothers for Life whose targets are men over the age of 30 years.

Further studies could explore the influence of culture on parent-adolescent communication. Although participants from this study reported increased knowledge and awareness of risks and consequences, some damaging cultural myths were discovered, particularly that a female partner in her menstrual period is clean and as such both partners are not susceptible to HIV or STIs if they have unprotected sexual intercourse. Culture as a resource to communication should also be further explored (see Dutta, 2008). This study identified that there is a particular cultural practice of “asidlale” that is valued as an opportunity for parent-adolescent communication on sexuality. It would be beneficial to identify if there are other similar local practices that could engender this. Associated with this suggestion is that a social ecological study that may consider contextual and cultural factors in parent-adolescent communication, could broaden this current study. The use of the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid, *et al.* 2007) would be particularly useful here.

Understanding the factors to which adolescents are exposed is necessary to shape prevention and intervention programs that suit the specific needs of adolescents and of parents. This study has been able to reveal those interpersonal factors and, maintaining its focus on the individual, also gained an understanding of the perceived severity and susceptibility of adolescent sexual behaviours. The result of this study, however, ratifies the notion that poor communication between parents and their adolescents is inherently linked with sexual risk taking. With this in mind, intervention programs that encourage or facilitate communication between parents and adolescents are important to decrease early sexual debut, reduce risk taking behaviours and

increase safe sexual practices, thereby reducing the high rate of incidence in South Africa, and even in other countries.

BIBLIOGRAPHY

- Adedimeji, A.A., Omololu, F.O., and Odutolu, O. (2007). HIV risk perception and constraints to protective behaviour among young slum dwellers in Ibadan, Nigeria. *J of Health, Popu and Nutri.* Vol. 25 (2) pp. 146-157.
- Adu, P. (2013). Qualitative analysis coding and categorizing. Available from: <https://www.slideshare.net/kontorphilip/qualitative-analysis-coding-and-categorizing> (Accessed 18th August, 2017).
- Adu-Mireku, S. (2003). Family communication about HIV/AIDS and sexual behaviour among senior secondary school students in Accra, Ghana. *Afr Health Sci.* Vol. 3. pp. 7–14.
- Ahlberg, B. M. Jylkas, E. and Krantz, I. (2001). Gendered construction of sexual risks: implications for safer sex among young people in Kenya and Sweden. *Reproductive health matters*, Vol. 9(17), pp. 26-36.
- Airhihenbuwa, C. (1995). *Health and culture: Beyond the Western paradigm*. Thousand Oak, CA. Sage publications.
- Akintomide, A. and Bada, T. (2013). How do they tell it to them? Parent-adolescent sexual communication patterns in Nigeria. *The online educational research journal.* pp. 1-14.
- Akinwale, O., Adeneye, A., Omotola, D., Manafa, O., Idowu, T. and Adewale, B. (2009). Parental perceptions and practices relating to parent-child communication on sexuality in Lagos, Nigeria. *Journal of Family and Reproductive Health.* Vol. 3(4). pp. 123–128.
- AlBuhairan, F. Areemit, R. Harrison. A. and Kaufman, M. (2012). Adolescent Psychosocial Development and Evaluation: Global Perspectives, In: O. Özdemir (Ed.), *Complementary Pediatrics*, InTech, Available from: <http://www.intechopen.com/books/complementary-pediatrics/adolescent-psychosocial-development-and-evaluation-global-perspectives> (Accessed 25th July, 2017).
- Amoran, O.E. and Fawole, O. (2008). Parental influence on reproductive health behaviour of youths in Ibadan, Nigeria. *Afr J. Med. Sci.* Vol. 37(1). pp. 21-27.

- Anderson, N., Ho-Foster, A., Mattis, J., Marokoane, N., Mashiane, V., Mhatre, S., Manasta, S., Ngxowa, N., Salcedo, M. and Sonnekus, H. (2004). National cross sectional study of views on sexual violence and risk of HIV infection and AIDs among South African school pupils. *British Medical Journal*. Vol. 329. pp. 952-954.
- Ark of Hope for children (2016). *Child Abuse Statistics*. (Online) Available at: <http://www.arkofhopeforchildren.org> (Accessed 26 September, 2016).
- Arnett, J.J. (1999). Adolescent storm and stress reconsidered. *America Psychologist*. Vol. 54. pp. 317-326.
- Aspy, C.B., Vesely, S.K., Oman, R.E., Rodine, S., Marshall, L. and McLeroy, K. (2007). Parental communication and Youth sexual behaviour. *Journal of Adolescence*. Vol. 30(3). pp. 449-466.
- Bachanas, P. J., Morris, M.K. Lewis-Gess, J.K., Sarett-Cuasay, E.J., Sirl, K., Ries, J.K. and Sawyer, M.K., (2002). Predictors of risky sexual behaviour in African American adolescent girls: implications for prevention intervention. *Journal of pediatric psychol.* Vol. 27(6). pp. 519- 530.
- Baird, L. (2007). *Influences on safe sex decision making in young women*. D.Clin. Psy. Thesis (Vol. 1). University College London.
- Ballard, S. M. and Gross, K. (2009). Exploring parental perspectives on parent-child sexual communication. *American Journal of Sexuality Education*. Vol. 4(1). pp. 40-57.
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, N.J. Prentice Hall.
- Bandura, A. (2004). *Health promotion by social cognitive means*. Stanford University. California.
- Bandura, A. (2002). Social cognitive theory in cultural context. *Applied Psychology*. Vol. 51(2). pp. 269-290.

- Bankole, A., Biddlecom, A., Guiella, G., Singh, S. and Zulu, E. (2007). Sexual Behavior, Knowledge and Information Sources of Very Young Adolescents in Four Sub-Saharan African Countries. *Afr. J. Reprod. Health*. Vol. 11(3). pp. 28-43.
- Bastien, S., Kajula, L.J. and Muhwezi, W.W. (2011). A Review of studies of Parent-child Communication about Sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health*. Vol. 8:25. pp. 1-17.
- Beauclaire, R. and Delva, W. (2013). Is younger really safe? A qualitative study of perceived risks and benefits of age-disparate relationships among women in Cape Town, South Africa. *PLoS ONE*. Vol. 8(11). pp. 1-8.
- Becket, Elliot, Kanouse, Corona, Ktein, and Schuster (2010). Timing of parent and child communication about sexuality relative to children's sexual behaviors. *Pediatrics* Vol. 25(1). pp. 34-42.
- Beksinska, M.E., Smit, A.J. and Mantell, J.E. (2013). Progress and challenges to male and female condom use in South Africa. *Journal of Sex Health*. Vol. 9(11). pp. 51-58.
- Berk, L.E. (2003). *Child Development*. Boston. Massachusetts: Allyn and Bacon.
- Berlin, G. (2004). "Testimony of Gordon Berlin" In: *The science Technology and Space sub-committee of the committee on commerce, Science and Transportation*. United State. pp. 1-11. Available at: http://www.mdrc.org/sites/default/files/testimony_6.pdf (Accessed 29 March, 2017).
- Bhan, N. B., Mahajan, P., and Sondhi, M. (2004). *Awareness regarding sex knowledge among adolescent girls (16-20 years)*. *Anthropologist*. Vol. 6(2). pp. 101-103.
- Blakar, R. (1984). *Communication: a social perspective on clinical issues*. Oslo: Universitetsforlaget.
- Blakar, R. (1992). Towards an Identification of Preconditions for Communication. In A.H. Wood (Ed.) *the Dialogical Alternative towards a Theory of Language and Mind*. Oslo. Scandinavian University Press, pp. 235 - 252.

- Blake, S. M., Simkin, L., Ledsky, R., Perkins, C., and Calabrese, J. (2001). "Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse" *Family Planning Perspectives* Vol. 33 (2). pp. 52-61.
- Bleakley, A., Hennessy, M., Fishbein, M., and Jordan, A. (2009). How sources of sexual information relate to adolescents' beliefs about sex. *American Journal of Health Behavior*. Vol. 33(1). pp. 37-47.
- Blos, P. (1979). *The adolescent passage*. New York: International Universities Press. *BMJ*. Vol. 6(9).
- Booyesen, F.R. and Summerton, J. (2002). Poverty, risky sexual behaviour, and vulnerability to HIV infection: evidence from South Africa. *Journal of Health, Population, and Nutrition*. Vol. 20(4). pp. 116-211.
- Bosma, H. (1992). Identity in adolescence: Managing commitments. In G. Adams, T. Gullotta, and R. Montemayor eds., *Adolescent Identity Formation*. Newbury Park, CA: Sage. pp. 91-121.
- Botchway, A.T. (2004). *Parent and adolescent males' communication about sexuality in the context of HIV/AIDS – A study in the Eastern Region of Ghana*. Master's. University of Bergen.
- Branje, S., Laursen, B. and Collins, W.A. (2012). Parent-child communication during adolescence. In: A.L. Vangelisti, ed., *handbook of family communication*, 2nd Ed. New York: Routledge. pp. 271-286.
- Branje, S., Van Doorn, M.D., Van der Valk, L.E. and Meeus, W.H.J. (2009). Parent-adolescent conflict, conflict resolution and adolescent adjustment. *Journal of Applied Developmental Psychology*. Vol. 30. pp. 195-204.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*. Vol. 3(2). pp. 77-101.
- Brikci, N., and Green, J. (2007). *A guide to using qualitative methods*. United Kingdom. MSF.

- Broecker, D. and Hillard, P. (2009). *Pregnancy in adolescence*. Glowm and Global Libr. Women's Med. Available at: http://www.glowm.com/section_view/heading/Pregnancy%20in%20Adolescence/item/413 (Accessed 21 Sept., 2017).
- Brook, D. W., Morojele, N. K., Zhang, C. and Brook, J.S. (2006). South African adolescents: pathways to risky sexual behaviour. *AIDS Education*. Vol. 18(3). pp. 259-272.
- Brown, A., Jejeebhoy, S. J., Shah, I., and Yount, K. M. (2001). *Sexual relations among young people in developing countries: Evidence from WHO case studies*. Geneva: World Health Organisation, Department of Reproductive Health and Research.
- Brown, J.D., L'Engle, W., Pardun, C.J., Guo, G., Kenneavy, K. and Jackson, C. (2006). Sexy media matter: exposure to sexual content in music, movies, television and magazines predicts black and white adolescents' sexual behavior. *Journal of pediatrics*. Vol. 117(4). pp. 1018-1027.
- Bryan A, Ray L.A, Copper M.L. (2007). Alcohol use and protective sexual behaviors among high-risk adolescents. *Journal of Studies on Alcohol and Drugs*. Vol. 68. pp. 327–335.
- Burgess, V., Dziegielewski, S.F., and Green, C. E. (2005). Improving comfort about sex communication between parents and their adolescents: practice-based research within a teen sexuality group. *Brief Treatment and Crisis Intervention*. Vol. 5(4). pp. 379-390.
- Bushaija, E., Sunday, F., Asingizwe, D., Olayo, R. and Abong, B. (2013). Factors that hinder parents from communicating sexual matters with adolescents in Rwanda. *Journal of health science*. Vol. 2(2), pp. 13- 19.
- Byangire, M.B. (2002). The advocacy hierarchy for HIV/AIDS prevention and control (Abstract). In: *Knowledge and commitment for action*. Barcelona: XIV International AIDS Conference.
- Canadian Paediatric Society (2003). Impact of media use on children and youth. *Paediatric Child Health*. Vol 8 (5). pp. 1-6.

- Cardey, S., Garforth, C., Govender, E. and Dyll-Myklebust, L. (2013). Entertainment education theory and practice in HIV/AIDS communication: a South Africa/United Kingdom comparison, *Critical Arts. South-North Cultural and Media Studies*, Vol. (27)3. pp. 288-310.
- Carter, M., McGee, R., Taylor, B. and Williams, S. (2007). Health outcomes in adolescence: associations with family, friends and school engagement. *Journal of adolescence*. Vol. 30(1). pp. 51-62.
- Center for Chronic Disease Prevention and Health Promotion (2016). *Youth Risk Behaviour Surveillance-United States, 2015*. (Online). United States: CDC, pp. 1-174. Available at: <https://www.cdc.gov/mmwr/volumes/65/ss/ss6506a1.htm#suggestedcitation> (Accessed 29 March, 2017).
- Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. (2009). *Health topics: Sexual health behaviors*. United States: CDC. Available at: www.cdc.gov/healthyyouth/sexualbehaviors/index.html (Accessed 05 March, 2016).
- Centers for Disease Control and Prevention (2004). *HIV/AIDS Surveillance Report, 2003* (Online) Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, Pp. 1-46, Available at: <http://www.cdc.gov/hiv/stats/hasrlink.htm> (Accessed 29 March, 2017).
- Chapin, J. R. (2000). Third-person perception and optimistic bias among urban minority at-risk youth. *Communication Research*. Vol. (27). pp. 51–81.
- Chaweewan, S. (2011). *The involvement of Thai parents in the sex education of their teenage children: a mixed methods study*. PhD. University of East Anglia School of nursing and midwifery.
- Chikovore, J., Nystrom, L., Lindmark, G. and Ahlberg, B. (2013). How can I gain skills if I don't practice? The dynamics of prohibitive silence against pre-marital pregnancy and sex in Zimbabwe. *PLoS ONE*, Vol. 8(1). pp. 1-7.

- Chola, L, McGee, S, Tugendhaft, A, Buchmann, E, and Hofman, K (2015). Scaling Up Family Planning to Reduce Maternal and Child Mortality: The Potential Costs and Benefits of Modern Contraceptive Use in South Africa. *PLoS ONE*. Vol.10 (6).
- Chung, P.J., Travis, R. Kilpatrick, S. Elliott, M., Lui, C. Khandwala, S. Dancel, T. Vollandt, L. and Schuster, M. (2007). Acculturation and Parent-Adolescent Communication about Sex in Filipino-American Families: A Community-Based Participatory Research Study. *Journal of Adolescent Health*. Vol. 40. pp. 543-550.
- Clark, C and Clark, D. (2007). *Disconnected: Parenting teens in my space world*: Baker Books.
- Cleland, J., and Wilson, C., (1987). Demand theories of the fertility transition: An iconoclastic view. *Population Studies*. Vol.41. pp.5-30.
- Coffelt, T. A. (2010). Is sexual communication challenging between mothers and daughters? *Journal of Family Communication*. Vol. 10. pp. 116–130.
- Cole, M. and Cole, S.R. (1989). *The development of children*. New York. WH. Freeman and co.
- Collins, W. A., Gleason, T., and Sesma, A., Jr. (1997). Internalization, autonomy, and relationships: Development during adolescence. In J. E. Grusec and L. Kuczynski (Eds.), *Parenting and children's internalization of values: A handbook of contemporary theory*. New York: Wiley. pp. 78–99.
- Collins, W. A., and Luebker, C. (1994). Parent and adolescent expectancies: Individual and relationship significance. In J. G. Smetana ed. *Beliefs about parenting: Origins and developmental implications*. San Francisco: Jossey-Bass. pp. 65–80.
- Compas, B.E., Hinden, B.R. and Gerhardt, C.A. (1999). Adolescent development and pathways to problem behaviour. *Annual Review Psychology*. Vol. 46. pp. 265-293.
- [Connolly, J., Furman, W., and Konarski, R. \(2000\). The role of peers on the emergence of heterosexual romantic relationships in adolescence. *Child development*. Vol. 71\(5\). pp. 1395-1408.](#)

[Creswell, J. W. \(2014\). *Research design: qualitative, quantitative and mixed methods approaches*, 4th ed. London. Sage publications.](#)

Creswell, J. W. (2003). *Research design: qualitative, quantitative and mixed methods approaches*, 2nd ed. London. Sage publications.

Creswell, J.W. (2007). *Qualitative inquiry and research design: choosing among five approaches*, 2nd ed. London. Sage publications.

[Crockett, L.J., Raffaelli, M. and Moilanen, K.L. \(2003\). Adolescent sexuality: behaviour and meaning In G.R. Adams and M.D. Berzonsku \(Eds.\) *Handbook of adolescence* Malden, M.A.: Blackwell. pp. 371-392.](#)

Crohn, H. (2010). Communication about sexuality with mothers and stepmothers from the perspective of young adult daughters. *Journal of Divorce and Remarriage*, Vol. 51(6), pp.348-365.

Cromer, B. (2011). Adolescent development. In R. Kliegman, R. Behrman, H. Jenson, and B. Stanton (Eds.), *Nelson Textbook of Pediatrics*. Philadelphia: Saunders Elsevier. pp. 649–660.

Crouter, A.C., Helms-Erikson, H., Updegeaff, K. and McHale, S. M. (1999). Conditions underlying parents' knowledge about children's daily lives in middle childhood: Between and within family comparisons. *Child Development*. Vol. 70 (1). pp. 246-259.

Dalrymple, L. (2005). Drama studies in the twenty-first century: Dangers and opportunities. *South Africa Theatre Journal*. Vol. 19(1). pp. 157-176.

Dalrymple, L. and Botha, P. (2000). *See you at 8: Mobilising young men; communication for action: A facilitator's guide to mobilizing young men to care*. Durban. DramAidE.

Dasen, P. (1994). Culture and cognitive development from a Piagetian perspective. In W. J. Lonner and R.S. Malpass (Eds.), *Psychology and culture*. Boston: Allyn and Bacon.

Dawson, C. (2002). *Practical research methods*. United Kingdom. How To Books publications.

De Bruyn, M. (2000). Gender, adolescents and the HIV/AIDS epidemic: the need for comprehensive sexual and reproductive health responses. *A paper presentation on expert group meeting on HIV/AIDS pandemic and its gender implications*. Windhoek, Namibia. Available at: <http://www.un.org/womenwatch/daw/csw/hivaids/De%20bruyn.htm> (Accessed 24 May, 2016).

De Bruyn, M., (1991). *Young Lives at Risk: Adolescents and Sexual Health*. Panos Briefing No. 35, London: Panos Institute London.

Department of Basic Education, South Africa (2009). Teenage pregnancy in South Africa with a specific focus on school-going learners. Pretoria. Department of Basic Education.

Department of Basic Education, South Africa (2014). *General Household Survey 2013 report: focus on schooling*. Pretoria. Department of Basic Education.

Department of Basic Education, South Africa (2015). *General Household Survey 2014 report: focus on schooling*. Pretoria. Department of Basic Education.

Department of Health (DOH). (2015). *The 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa*. Pretoria. National Department of Health.

Department of Primary Health Care and Disease Control (1995). *National Adolescent Health Policy*. Nigeria. Federal Ministry of Health.

Dessie, Y, Berhane Y, and Worku, A. (2015). Parent-Adolescent Sexual and Reproductive Health Communication Is Very Limited and Associated with Adolescent Poor Behavioral Beliefs and Subjective Norms: Evidence from a Community Based Cross Sectional Study in Eastern Ethiopia. *PLoS ONE* 10(7). pp. 1-14.

Devex, (n.d). *DRAMAIDE*. Available at: <https://www.devex.com/organizations/dramaide-10549> (Accessed 05 June, 2016).

- DiClemente, R.J., Wingood, G.M., Crosby R, Cobb B.K., Harrington K, and Davies S.L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *The Journal of Pediatrics*. Vol. 139. pp. 407–412.
- Doljanac, R., and Zimmermann, M. A. (1998). Psychosocial factors and high- risk sexual behaviour: race differences among urban adolescents. *Journal of Behavioural Medicine*, Vol. 21. pp.451-465.
- Douglas, H., (n.d). “*Communication*”. Online Etymology Dictionary. Available at: <http://www.etymonline.com/?term=communication> (Accessed 26 Feb., 2016).
- Downing, J., Jones, L., Bates, G., Sumnall, H. and Bellis, M. (2011). A systematic review of parent and family-based intervention effectiveness on sexual outcomes in young people. *Journal of Health Educ. Res.* Vol. 26(5). pp. 808-833.
- Doyle, A.M., Mavedzenge, S.N., Plummer, M.L. and Ross, D.A. (2012). The sexual behaviour of adolescents in Sub-Saharan Africa: Pattern and Trends from National Survey. *Tropical Medicine and International Health*. Vol. 17(7). pp. 796-807.
- Doyore F, Birhanu Z, Kebede Y, Dejene T, Jara D (2013). Are People Controlling the Danger or Fear for Condom Use as HIV/AIDS Preventive Message? An Evaluative Type of Study Based on Extended Parallel Process Model. *J AIDS Clin Res* Vol.4 (264). pp. 1-11.
- Drioane, E.A. (2014). Rewriting ‘the talk’ effects of parental communication on perceived comfortableness and willingness to have discussions with their children about sex. Master’s. University of Colorado.
- Dutta, M.J. (2008) *Communicating Health: A Culture-Centred Approach*. Cambridge: Polity Press
- Dutra, R., Miller, K. S., and Forehand, R. (1999). “The process and content of sexual communication with adolescents in two parent families: Associations with sexual risk-taking behavior”. *AIDS and Behavior*. Vol. 3(1). pp. 59-66.

- Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health communication*. Vol. 18(2). pp. 103-122.
- Dutta-Bergman, M.J. (2004). Primary sources of health information: comparisons in the domain of health attitudes, health cognitions and health behaviours. *Health communication*. Vol.16. pp. 273-288.
- Easterby-Smith, M., Thorpe, R. and Lowe, A. (2003). *Management Research: an introduction*. 2nd eds. London. Sage publications.
- Eddy, G. and Holborn, L. (2011). *First steps to healing the South African family*. Johannesburg. South African Institute of Race Relations.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.
- Erikson, E.H. (1950). *Childhood and society*. New York: W.W. Norton.
- Falaye, A. O. (2004). Predictive factors influencing the sexual behaviour of some Nigerian Adolescent. *IFE psychological*. Vol. 12(2), pp 17- 26.
- Famutimi, E. O., Oyetunde, M. O. (2014). Risky Sexual Behaviour among Secondary School Adolescents in Ibadan North Local Government Area, Nigeria. *Journal of Nursing and Health Science*. Vol. 3(3). pp. 34-44.
- Fantasia, H. C. (2009). Late Adolescents' Perceptions of Factors That Influenced Their Sexual Decision Making: A Narrative Inquiry. Ph.D. Boston College University.
- Freud, A. (1958). Adolescence. In: R. Eissler, H. Harman, and M. Kris (eds). *Psychoanalytic study of a child*. New York. International University Press. pp. 255-279.
- Freud, S. (1949). *Group psychology and the analysis of the ego*. New York. Bama.
- Flouri, E. and Buchanan, A. (2002). What predicts good relationships with parents in adolescence and partners in adult life: findings from the 1958 British birth cohort. *Journal of Family psychology*. Vol. 16. pp. 186-198.

- Gabhainn, S.N., Bbanm A., Boyce, W. and Godeau, E. (2009). How well protected are sexually active 15-year olds? Cross-National patterns in condom contraceptive pill use 2002-2006. *International Journal of public Health*. Vol. 54(2). pp. 209-215.
- Gearing, R. E. (2004). Bracketing in researcher: A typology. *Qualitative Health Research*. Vol. 14(10). pp. 1429-1452.
- Gender, L.A., Burton, P., Leoschut, L., Ward, C.L. and Llody, S. (2016). *Sexual abuse of Children and Adolescents in South Africa: forms, extent and circumstances*. UBS Optimus Foundation. South Africa.
- Gesser-Edelsburg, A. and Singhal, A. (2013). Enhancing the persuasive influence of entertainment-education events: rhetorical and aesthetic strategies for constructing narratives. *Critical Arts: South-North Cultural and Media Studies*. Vol. 27 (1). pp. 56-74.
- Govender, E.M. (2013). Processes and Participation in HIV and AIDs Communication: Using Body mapping to explore the experiences of young people. PhD. University of KwaZulu-Natal.
- Govender, E., Dyll-Myklebust, L., Delate, R., and Sundar, T. (2013). Social networks as a platform to discuss sexual networks: Intersexions and Facebook as catalysts for behaviour change, *The African Communication Research Journal: Using Entertainment Formats in Educational Broadcasting*. Vol. 6(1). pp. 65-88.
- Green, E.C. and Witte, K. (2006). Can fear arousal in public health campaigns contribute to the decline of HIV prevalence? *Journal of Health Communication*. Vol. 11. pp. 245-259.
- Griffin, K. W., and Botvin, G. J. (2010). Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents. *Child and Adolescent Psychiatric Clinics of North America*. Vol.19 (3). pp. 505–526. <http://doi.org/10.1016/j.chc.2010.03.005>.
- Gruber, E., Grube, J.W. (2000). Adolescent sexuality and the media: a review of current knowledge and implications. *West J Med*. Vol.172 (3). pp. 210–214.

- Grube, J.W., Madden, P.A., Friese, B. (1996). The effects of television alcohol advertising on adolescent drinking. In: *the annual meeting of the Research Society on Alcoholism*. Washington, DC.
- Guilamo-Ramos, V., Bouris, A., Lee, J., McCaethy, K. and Dittus. (2008). Parent-adolescent communication about sexuality intercourse: analysis of maternal reluctance to communication. *Health psychology*. Vol. 27(6), pp 760-769.
- Guilamo-Ramos, V., Bouris, A., Lee, J., McCaethy, K. and Dittus. (2012). Parental influence on adolescent sexual risk behaviours: a structured literature review. *Journal of Pediatrics*. Vol. 130(5). pp. 1313-1325.
- Guilamo-Ramos, V., Dittus, P., Jaccard, J., Goldberg, V., Casillas, E., and Bouris, A. (2006). The content and process of mother–adolescent communication about sex in Latino families. *Social Work Research*. Vol. 30. pp. 169–181.
- Gumede, N.A. (2011). Mother–Daughter Communication on Intimate Relationships: Narratives from Mangaung Township (Bloemfontein, South Africa). Masters’ Thesis. University Of Free State.
- Hacker, K. A. (2000). Listening to youth: teen perspectives on pregnancy prevention. *Journal of Adolescent Health*. Vol. 26. pp. 279-288.
- Hall, Stuart ([1973] 1980). 'Encoding/decoding'. In Centre for Contemporary Cultural Studies (Ed.): *Culture, Media, Language: Working Papers in Cultural Studies, 1972-79* London: Hutchinson, pp. 128-138.
- Halpern, C.T., Joyner K, Udry J. R. and Suchindran C. (2000). Smart teens don't have sex (or kiss much either) *Journal of Adolescent Health*. Vol. 26. pp. 213–225.
- Halpern-Felsher, B. L., Kropp, R. Y., Boyer, C. B., Tschann, J. M., and Ellen, J. M. (2004). Adolescents' self-efficacy to communicate about sex: Its role in condom attitudes, commitment, and use. *Journal of Adolescence*. Vol. 39. pp. 443-456.

- Hamburg, B. (1986). Subsets of adolescent mothers: Developmental, biomedical, and psychosocial issues. In: J. B. Lancaster, B. A. Hamburg, eds. *School-age pregnancy and parenthood: Biosocial dimensions*. New York: Aldine de Gruyter. pp. 115–154.
- Hartenstein, J (2012). *The impact of the mother-daughter relationship on their risky sexual behaviours of female adolescents*. Kansas State University.
- Hazen, E., Schlozman, S., and Beresin, E. (2008). Adolescent psychological development: A review. *Adolescent medicine*. Vol. 29(5). pp. 161-168.
- Healthy Children Organisation, (2015). *Stages of adolescence*. The American Academy of Pediatrics. Available at: <http://www.healthychildren.org/English/ages-stages/teen/pages/stages-of-adolescence.aspx> (Accessed on 5 April, 2016).
- Henn, C.M. (2005). *The relationship between certain family variables and the Psychological well-being of Black adolescents*. Ph.D. University of the Free State.
- Herman, L., Ovuga, E., Mshilla, M., Ojara, S., Kimbugwe, G., Adrawa, A. P., and Mahuro, N. (2013). Knowledge, Perceptions and Acceptability to Strengthening Adolescents' Sexual and Reproductive Health Education amongst Secondary Schools in Gulu District. *World Academy of Science, Engineering and Technology*. Vol. 7(7). pp. 1787–1802.
- Hertzler, L. (2016). How media content influences teenage behavior. Penn Current. Available at: <https://penncurrent.upenn.edu/research/how-media-content-influence-teenage-behaviour> (Accessed on 9 Sept., 2017).
- Hetherington, E.M., and Stanley-Hagan, M. (2002). Parenting in divorced and remarried families In: M. Bornstein (Ed). *Handbook of parenting* Vol. III. Mahwah, NJ: Lawrence Elbaum Associates. pp. 287-315.
- Heyevent (n.d). KwaZulu-Natal: about KwaZulu-Natal. Available at: <http://www.heyevent.co.za/venue/btq2bf4pppfd4a> (Accessed on 5 April, 2016).

- Hockaday, C. Crase, S. J., Shelly, M. C., and Stockdale, D. F. (2000). A prospective study of adolescent pregnancy. *Journal of Adolescence*. Vol.23. pp. 423-438.
- Hollander, D. (2000). "Has there been a talk about sex? Teenagers and their mothers often disagree." *Family Planning Perspectives*. Vol. 32(4). pp. 192-199.
- Hollander, D. (2002). "Their lips are sealed - FYI - parental knowledge of teenage sexual behavior." *Perspectives on Sexual and Reproductive Health*. Vol. 22. pp. 14-21.
- Holman, A. (2014). *How Adolescents perceive their Parents' Communication about Sex: Towards Reducing Adolescents Sexual Risk*. Unpublished doctoral dissertation. University of Nebraska-Lincoln, Nebraska.
- Hovland, C, Janis, I, and Kelly, H. (1953) *Communication and Persuasion*. New Haven, CT, Yale University Press.
- Howell, L. W. (2001). *Examining the relationship between adolescent sexual risk- taking and adolescents' perceptions of monitoring, communication and parenting styles in the home*. Unpublished master thesis. Virginia Polytechnic Institute and State University, Blacksburg, Virginia.
- Human Science Research Council (2009). *South African national HIV prevalence, incidence and communication survey 2008*. South Africa. HSRC Press.
- Human Science Research Council (2012). *South African National HIV prevalence, incidence and behaviour survey*. South Africa. HSRC press.
- Human Science Research Council (2014). *South African National HIV prevalence, incidence and behaviour survey*. South Africa. HSRC press.
- Husserl, E. (1931). *Ideas: general introduction to pure phenomenology*. (D. Carr. Trans). Evanston IL. Northwestern University press.

- Hust, S.J.T., Brown, J.D. and L'Engle, K.L. (2008). Boys will be boys and girls better be prepared: An analysis of the rare sexual health messages in young adolescents' media. *Journal of Mass communication and Society*. Vol.11. pp. 3-23.
- Johnston, L. D., O'Malley, P. M., Backman, J. G. and Schulenberg, J. E. (2006). *Monitoring the future national survey results on drug use, 1975-2006*. The University of Michigan, Bethesda, Maryland. National Institute on Drug Abuse.
- Igra, V. and Iriwin (JR.), C. E. (1996) Theories of Adolescent risk-taking behaviour. In R. J., Diclemente, W. B. Hansen, and L. E. Ponton. (Eds), *handbook of adolescent health risky behaviour*. New York: Springer. Pp. 35-51.
- Imaledo, J.A., peter-Kio, O.B. and Asiquo, E.O. (2012) Pattern of risky sexual behaviour and associated factors among undergraduate students of the University of Port Harcourt, River States, Nigeria. *Pan Africa Journal*. Vol. 12(97). pp. 1-9.
- Inhelder, B, and Piaget, J. (1958). The growth of logical thinking from childhood to adolescence: An essay on the construction of formal operational structures. New York: Basic Books.
- Insabella, G. M. (2000). Parental Negotiation of Autonomy and Relatedness and Its Direct and Indirect Influences on Adolescent Sexual Behaviour. Unpublished doctoral dissertation. University of Virginia, Charlottesville, Virginia.
- Irwin, C. E., Jr, and Millstein, S. G. (1992). Risk-taking behaviors and biopsychosocial development during adolescence. In: E.J. Susman, L.V. Feagans and W.J. Ray (eds). *Emotion, cognition, health, and development in children and adolescents*. Hillsdale NJ: Erlbaum. pp. 75–102.
- Izugbara, C.O. (2008). Home-based sexuality education: Nigerian parents discussing sex with children. *Youth and society Journal*. Vol. 39(4). pp. 575-600.
- Jejeebhoy, S. J. and K. G. Santhya. (2011). "Parent-child communication on sexual and reproductive health matters: Perspectives of mothers and fathers of youth in India." New Delhi: Population Council.

- Jerman, P and Constantine, N.A. (2010). Demographic and Psychological predictors of parent-adolescent communication about sex: A representative of statewide analysis. *Journal of Adolescent*. Vol. 349(10). pp. 1164-1174.
- Kajula, L. J., Sheon, N., Hein De Vries, Kaaya, S. F., Leif, E. and Aarø, (2013). Dynamics of parent-adolescent communication on sexual health and HIV/AIDS in Tanzania. *AIDS and Behaviour Journal*. Vol. 3(49). pp. 1-7.
- Kaleeba, N., Namulando, J., Kalinki, D. and Williams, G. (2000). *Open secret: people facing up to HIV and AIDS in Uganda*. London. Action Aids.
- Kalule-Sabiti, I. and Arkaah, Y. J. (2014). *Risky behaviour among high school adolescents in the North West Province, South Africa*. PhD. North West University, South Africa.
- Kapungu, C., Baptiste, D., Holmbeck, G., McBride, C., Robinson-Brown, M., Sturdivant, A., Crown, L. and Paikoff, R. (2010). Beyond the “birds and the bees”: Gender differences in sex-related communication among urban African-American adolescents. *Family Process*. Vol. 49(2), pp.251-264.
- Katz, M. L., Kam J.A., Krieger J. L., Roberto A. J. (2012). Predicting human papillomavirus vaccine intentions of college-aged males: An examination of parents’ and son’s perceptions. *Journal of American College Health*. Vol. 60. pp. 449–459.
- Kegeles, S.M., Adler, N.E. and Irwin, C. E., (1988). Sexually active adolescents and condoms: Changes over one year in knowledge, attitudes and use. *American Journal of Public Health*. Vol. 78. pp. 460–461.
- Keijsers, L., Branje, S., Frijns, T., Finkenauer, C., and Meeus, W. (2010). Gender differences in keeping secrets from parents in adolescence. *Developmental Psychology*. Vol. 46. pp. 293-298.
- Keijsers, L., Frijns, T., Branje, S.J.T., and Meeus, W. (2009). Developmental links of adolescent disclosure parental solicitation and control and control with delinquency: Moderation by parental support. *Developmental Psychology*. Vol 45. pp. 1314-1327.

- Keller, M. L. (1993). Why don't young adults protect themselves against sexual transmission of HIV? Possible answers to a complex question. *AIDS Education and Prevention*. Vol. 5. pp. 220–233.
- Keller, S. N. and Brown, J. D. (2002). "Media intervention to promote responsible sexual behavior." *Journal of Sex Research*. Vol. 39. pp. 121-138.
- Kim, C.C. (2008). *Teen sex: The parent factor*. Washington DC. The Heritage Foundation.
- Schear, K. (2006). *Factors that contribute to and constrain conversation between adolescent females and their mothers about sexual matters*. Florida International University. Available at: forumonpublicpolicy.com/archieve06/shear (Accessed 01 June, 2016).
- Kincaid, D, Figueroa M, Storey D and Underwood C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance*. Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.
- Kincaid, D.L, Figueroa, M.E, Storey, D. and Underwood, C. (2002). Communication and Behaviour Change: The role of Ideation. Johns Hopkins University, Centre for Communications Programs. In: *the Proceedings of the World Congress on Communication for Development* (Online) Rome Italy, 25-27 October.
- King'ara, G.N. (2013). Mining Edutainment from mainstream soap operas. *The African Communication Research Journal: Using Entertainment Formats in Educational Broadcasting*, Vol. 6(1). pp. 89-110.
- King, R.M. (2004). *Adolescence-Overview, historical background and theoretical perspectives*. King Psychology Network. Available at: <http://www.psyking.net>. (Accessed 01 Dec., 2016).
- Kirby, D., and Laris, B. A. (2009). Effective curriculum-based sex and STD/HIV education programs for adolescents. *Society for Research Child Development Perspectives*, Vol.3. pp. 21-29.

- Kirkman, M., Rosenthal, D. and Feldman, S. (2001). Freeing Up the Subject: Tension between Traditional Masculinity and Involved Fatherhood Revealed Through Communication about Sexuality with Adolescents. *Culture, Health and Sexuality*. Vol. 3(4). pp. 333-389.
- Kost, K and Henshaw, S. (2012). US teenage pregnancies, Birth and abortions, 2008: National trends by age, race and ethnicity. New York: Gutmancher institute A available at: <http://www.gutmacher.org/pubs/ust trends08.pdf>.on 15/02/2017.
- Kothari, C. R. (2004). *Research methodology methods and techniques, second edition*. New Delhi. New Age International Publications.
- Kott, A. (2010). Rates of recent sexual activity lessened among South African youth n risk-reduction program. *International Perspectives on Sexual and Reproductive Health Journal*. Vol. 36(4). pp. 213-214.
- Krishnakumar, A. and Buehler, C. (2000). Interparental conflicts and parenting behaviours: A meta-analytic review. *Journal of Family Relations*. Vol. 49. pp. 25-44.
- Kumi-kyereme, A., Awusabo-asare, K., Biddlecom, A. and Tanle, A., (2007). Influence of social connectedness, communication and monitoring on adolescent sexual activity in Ghana. *Africa Journal of reproduction health*. Vol. 11(3). pp. 133-149.
- Kunnuji, M. (2012). Parent-child communication in sexuality related matters in the city of Lagos, Nigeria. *Africa Development*. Vol. 37(3). pp. 41-58.
- Kvale, S. (1991). *Interviews: an introduction to qualitative research interviewing*. London. Sage publications.
- Kvale, S. (2008). *Epistemological issues of interviewing*. Thousand Oaks: Sage publications.
- Laerd Dissertation (2012). Sampling: the basics. (Online) Available at: <http://dissertation.laerd.com/sampling-the-basics.php> (Accessed 23 Feb., 2017).
- Laerd Dissertations (2012). Non- probability sampling. Accessed from <http://dissertation.laerd.com/non-probability-sampling.php> (Accessed 23 Feb., 2017).

- Lagina, N., (2002). *Parent-child communication: promoting sexually health youth*. (Online) Advocacy for youth. Available at: <http://www.advovatesforyouth.org>. (Accessed 03 May, 2016).
- Laird, R.D., Pettit, G.S., Dodge, K.A. and Bates, J.E. (2003). Change in parents' monitoring knowledge: Links with parenting, relationship quality, adolescent belief and antisocial behavior. *Social Development*. Vol. 12. pp. 401-419.
- Larson, R.W., Richards, M. H., Moneta, G., Holmbeck, G. and Duckett, E. (1996). Changes in adolescents' daily interactions with their families from ages 10 to 18: Disengagement and transformation. *Developmental Psychology*. Vol. 32. pp 744–754.
- Laursen B, Coy KC, and Collins WA. (1998). Reconsidering changes in parent-child conflict across adolescence: A meta-analysis. *Child Development*. Vol. 69. pp. 817-832.
- Laursen, B. (2012). Parent-child communication during adolescence. In A. L. Vangelisti. eds., *Handbook of family communication*. Ed. London: Lawrence Erlbaum Associates, Publishers. pp. 271-286.
- Laursen, B. and Collins. W.A. (2009). Parent-child relationship during adolescence: In Lerner, R.M and Steinberg, L. Eds, *handbook of adolescent psychology: Contextual influences on adolescent development* 3rd Ed. New York: Wiley publishers. pp. 1-42.
- Leventhal, H. (1970). Findings and theory in the study of fear communications. In Berkowitz, L. ed. *Advances in Experimental Social Psychology*. New York: Academic Press. pp. 119–186.
- Lewis, C. and Lamb, M.E. (2003). Fathers' influences on children's development: the evidence from two-parent families. *European Journal of Psychology of Education*. Vol. 18. pp. 211-228.
- Liyasu, Z., Aliyu, M., Abubakar, I. and Galadanci, H. (2012). Sexual and reproductive health communication between mothers and their adolescent daughters in Northern Nigeria. *Health Care for Women International*. Vol. 33(2), pp.138-152.

- Loeber, R., Drinkwater, M., Yin, Y., Anderson, S. J., Schmidt, L. C., and Crawford, A. (2000). Stability of family interaction from ages 6 to 18. *Journal of Abnormal Child Psychology*, Vol. 28, pp. 353–369.
- Loew and Thompson, B.J. (2011). Teens and risky sexual behaviour: what school counselors need to know? Masters' Thesis. University of Wisconsin-Stout.
- LoveLife. (2012). *Talking Points: A survey on HIV, sexual risk behaviour, and access to opportunity among young people in South Africa*. Johannesburg: loveLife.
- Luckerth, C. M. (2007). Parent-child communication: influences of maternal sexual experiences as a teenager on the occurrence of sexuality communication with their adolescent. Retrospective Theses and Dissertations. Iowa state University.
- Lupton, D. (1994). *Medicine as culture: illness, disease and the body in Western societies*. London. Sage Publications.
- Luyckx, K., Schwartz, S., Berzonsky, M., Soenens, B., Vansteenkiste, M., Smits, I., and Goossens, L. (2008). Capturing Ruminative Exploration: Extending the four-dimensional model of identity formation in late adolescence. *Journal of Research in Personality*. Vol. 42. pp. 58-82.
- Luwaga, L. (2004). Parent-adolescent communication on sexuality in the context of HIV/AIDS in Uganda: An exploratory study. Masters' Thesis. University of Bergen, Bergen-Norway.
- Madlala, S. L. (2008). *Sugar daddies and HIV: Is it really about money, money, money?* (Online) Human Science Resource Council. Available at: <http://www.hsrc.ac.za/en/review/september-2008/sugar-daddies> (Accessed 28 March, 2017).
- Maloney, E. R., Lapinski, M.K. and Witte, K. (2011). Fear appeals and persuasion: A review and update of the extended parallel process model. *Social and Personality Psychology Compass*. Vol. s (4). pp. 206-219.

- Manu, A. A., Mba, C. J., Asare, G. Q., Odoi-Agyarko, K., and Asante, R. K. O. (2015). Parent–child communication about sexual and reproductive health: evidence from the Brong Ahafo region, Ghana. *Reproductive Health*. Vol.12 (16). pp. 1-13.
- Manuel, p. (2013). *Parenting intervention on Adolescent sexual and reproductive health: A systematic review of the literature*. Masters’ Thesis. University of Ghana.
- Manzani, N. (2001). Sexual initiation and childbearing among adolescent girls in Kwazulu-Natal, South Africa. *Reproductive Health Journal*. Vol. 9(17). pp. 44-52.
- Marcia JE. (1980). Identity in adolescence. *Handbook of adolescent psychology*. Vol 9. pp. 159-187.
- Marcia, J. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*. Vol. 3. pp. 551-558.
- Marcia, J. (2007). Theory and measure: The identity status interview. In M. Watzlawik and A. Born (Eds.), *Capturing Identity: Quantitative and Qualitative Methods*. pp. 1-14. University Press of America, Inc., Lanham, Maryland.
- Markham, C.M., Lormand, D., Gloen, K. M., Peskin, M.F., Flores, B., Low, B. and House L.D. (2010). Connectedness as a predictor of social and reproductive health outcomes for youth. *Journal of adolescent health*. Vol.46 (3). pp.23-41.
- Mathew, R.M., Shugaba, A. I., and Ogala, W.N. (2006). Parents-adolescents communication and HIV/AIDS in Jos North Local Government Area plateau State, Nigeria. *Journal of Medical Sciences*. Vol. 6. pp. 537-545.
- Mathew, W. (2012). *Cutting into Perceptions: Investigating Men’s Understanding of Protection – through Medical Male Circumcision for HIV Prevention*. Masters Dissertation. The Centre for Communication, Media and Society. University of KwaZulu-Natal.
- Maverick Daily (2015). *Fact sheet: South Africa’s 2014/2015 murder and robbery crime statistics*. South Africa.

- Maximo, S., Tayaban, H., Cacadac, G., Cacanindin, M., Pugat, R., Rivera, M., and Lingbawan, M., (2011). Parents' communication styles and their influence on the adolescents' attachment, intimacy and achievement motivation. *International Journal of behavioural science*. Vol. 6(1). pp. 59-72.
- Mbugua, N. (2007). Factors inhibiting educated mothers in Kenya from giving meaningful sex-education to their daughters. *Journal of Soc. Sci. Med.* Vol. 64(5). pp. 1079-1089.
- McBride, D.C., Friere, M.C., Hopkins, G.L., Babikan, T., Richardson, L. and Helm, H. (2005). Quality of parent-child relationship and adolescent HIV risk behaviour in ST. Maarten. *AIDS care Journal*. Vol. 17 (1). pp. 5-54.
- McLeod, S. A. (2013). Erik Erikson. SimplyPsychology. Available at: www.simplypsychology.org/Erik-Erikson.html (Accessed 27 Feb., 2017).
- McNeely, C., Shew, M.L., Beuhring, T. Sieving, R. Miller, B.C. and Blum, R.W. (2002). Mothers' influence on the timing of first sex among 14- and 15year olds. *Journal of Adolescent Health* Vol. 31(3). pp. 256-65.
- Medical Research Council (MRC). (2008). *17 Risk factors: South African Comparative Risk Assessment – Summary Report*. Pretoria. MRC.
- Meenagh, J. (2003). Sex Education must teach more than biology, risk: Providing sex education for young people may very well be most valuable education of their entire lives. (Online) *SIECUS Rep.* Vol. 31(4). pp. 20-22.
- Meeus, W. (1996). Studies on identity development in adolescence: overview of research and some new data. *Journal of Youth and Adolescence*. Vol. 25. pp. 569-598.
- Meintjes, H. Hall K, Marera, D and Boulle, A. (2009). *Child-headed households in South Africa: A statistical brief*. Cape Town. Children's Institute, University of Cape Town.
- Miller, B. C. (2002). Family influences on adolescent sexual and contraceptive behaviour. *The Journal of Sex Research*. Vol. 39. pp. 22–27.

- Miller, B.C., Benson, B. and Galbraith, K. A. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Journal of Developmental Review*. Vol. 21(1) pp. 1-38.
- Miller, K. S, Forehand, R., and Kotchick, B. A. (1999). "Adolescent sexual behaviour in two ethnic minority samples: The role of family variables." *Journal of Marriage and the Family*. Vol. 61. pp. 85-98.
- Miller, K. S., Kotchick, B.A. Dorsey, Forehand, R. and Ham. (1998). Patterns of condom use among adolescents: the impact of mother-adolescent communication. *Journal of Public Health*. Vol.88. pp. 1542-1544.
- Miller-Johnson, S., Winn, D., Coie, J., Maumary, G., Hyman, C., Terry, D., and Lochman, J. (1999). Motherhood during the teen years: A developmental perspective on risk factors for childbearing. *Journal of development and psychopathology*. Vol. 11. pp. 85-100.
- Millstein, S.G. and Halpern-Felsher B.L. (2002). Perceptions of risk and vulnerability. *Journal of Adolescent Health*. Vol. 31(1S). pp. 10–27.
- Mmbaga, E.J., Leonard, F. and Leyna, G.H. (2012). Incidence and predictors of adolescent's early sexual debut after three decades of HIV interventions in Tanzania: a time to debut analysis. *PLoS One*. Vol.7 (7). pp. 1-9.
- Mohammadi, M.R., Mohammad, K., Farahani, F., Alikhani, S., Zare, M., Tehrani, F.R., Ramezankhani, A., and Alaeddini, F. (2006). Reproductive knowledge, attitudes and behavior among adolescent males in Tehran, Iran. *International Family Planning Perspectives*, Vol. 32(1), pp. 35-44.
- Moore, R., and Rosenthal, D. (2006). *Sexuality in adolescence: current trends*. New York: Routledge.

- Morgan, E., Thorne, A. and Zurbriggen, E. (2010). A longitudinal study of conversations with parents about sex and dating during college. *Developmental Psychology*. Vol.46 (1), pp.139-150.
- Morgan, D. L. (2008). *The SAGE Encyclopedia of Qualitative Research Methods*. London. SAGE Publications, Inc. pp. 816–817.
- Morojele, N.K. and Ransoomar, L. (2016). Addressing Adolescent alcohol use in South Africa. *S.Afr. Med. J.* Vol. 106960. pp. 551-553.
- Motsomi, K., Makanjee, C., Basera, T. and Nyasulu, P. (2016). Factors affecting effective communication about sexual and reproductive health issues between parents and adolescents in zandspruit informal settlement, Johannesburg, South Africa. *Pan Afr Med J.* Vol. 25 (120) pp. 1-7.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA. Sage publications.
- Mtikrakra, A. (2009). *Parent-adolescent communication on sexual related issues in the HIV/AIDS era*. Master's thesis: University of KwaZulu-Natal.
- Mturi, A. J. (2003). "Parent attitude to adolescent sexual behaviour in Lesotho". *African journal of reproductive health*, vol. 179(2), pp. 25-28.
- Mueller, T, Gavin L, Oman, R, Vesely, S, Aspy, C, Tolma, E, and Rodine, S. (2010). Youth Assets and Sexual Risk Behavior: Differences Between Male and Female Adolescents. *Health Education and Behavior*. Vol. 37(3). pp. 343–356.
- Mugira, F. (2007). Performing arts for hiv/aids communication some strengths and weaknesses. A case study of DramAidE's live Drama in KwaZulu Natal province of South Africa. Masters' degree of Communication for Development of Malmo University, Sweden.
- Mutinta, G., Govender, K. Gow, J. and George, G. (2013). An Investigation on Students' Risky Sexual Behavior at KwaZulu-Natal University, Durban, South Africa, American. *Journal of Sexuality Education*. Vol. 8(3) pp. 121-139.

- Mutinta, G. (2014). Students' Interpretations of the Messages Communicated by the Scrutinise Campus Campaign at the University of KwaZulu-Natal. *J. Communication*. Vol. 5(2). pp. 101-113.
- Murray-Johnson, L., Witte, K., Liu, W. and Hubbel, A. P. (2001). Addressing cultural orientations in fear appeals: promoting AIDS-protective behaviours among Mexican immigrant and African American adolescents and American and Taiwanese college students. *Journal of Health Communication*. Vol. 6. pp. 335-358.
- Namisi, F. S, Flisher A. J, Overland S., Bastien S., Onya H., Kaaya, S., and Aarø, E. L. (2009). Socio-demographic Variations in Communication on Sexuality and HIV/AIDS with parents, family members and teachers among in-school adolescents, a multi-site study in Tanzania and South Africa. *Scandinavian Journal of Public Health*. Vol. 37(2). pp. 65–74.
- Napper, L.E., Grimaldi, E.M. and LaBrie, W. J. (2015). Parents' and student' perceptions of college alcohol risk: the role of parental risk perception in intentions to communicate about alcohol. *Addict Behaviour*. Vol.42. pp. 114-118.
- Natoshia, M., Askelon, Shelly, C., Smith, S., Lowe, J., Denis, L. and Andsager, J. (2011). The Birds, the bees and the HPVS: what drives mothers' intentions to use the HPV vaccination as a chance to talk about sex? *Journal of pediatric health care*. Vol. 25(3). pp. 162-170.
- Ndebele, M, Kasese-Hara M. and Greyling M. (2012). Application of the information, motivation and behavioural skills model for targeting HIV risk behaviour amongst adolescent learners in South Africa, *SAHARA-J: Journal of Social Aspects of HIV/AIDS*. Vol. 9(1). pp. 37-47.
- Ndyanabangi, B and Kipp, W. (2001). Reproductive health of adolescent school students in Kabarole district, western Uganda: A qualitative study. *Journal of Health and Population in Developing countries*. Vol. 3 (2). pp. 1-12.

- Neuman, W.L. (2014). *Social research methods: qualitative and quantitative approaches* 7th ed. Edinburgh Gate. Pearson Education Ltd.
- Niccolai, L.M., Ethier, K.A., Kershaw, T.S., Lewis, J.B., Meade, C.S., and Ickovics, J.R. (2004). “New sex partner acquisition and sexually transmitted disease risk among adolescent females.” *Journal of Adolescent Health*. Vol. 34. pp. 216-223.
- Nkosi, S. (2013). *Condom usage declines in South Africa*. (Online) The South African Health News Service. Available at <https://www.health-e.org.za/2013/06/21/condom-usage-declines-in-south-africa/> (Accessed 22 Feb., 2017).
- Nota, P. B. (2015). A comparative study of students’ attitudes, preference and acceptance levels towards microbicide products; the tenofovir gel and the dapivirine ring at UKZN. Masters Dissertation. The Centre for Communication, Media and Society. University of KwaZulu-Natal.
- Ntarangwi, M. (2012). Introduction: parents’ involvement in children’s lives in Africa. *Africa Development*. Vol 37(3). pp. 1-18.
- Ntshwarang, P. and Malinga-Musamba, T. (2015). Oral communication: a gateway to understanding adolescents’ sexual risk behavior. *International Journal of Adolescence and Youth* Vol. 20(1) pp. 100-111.
- Nundwe, C.S. (2012). Barriers to communication between parents and Adolescents concerning sexual and reproductive health issues: A case study of kinondoni municipality, Tanzania. Master Dissertation. Muhimbili University of Health and Allied Sciences.
- O'Donnell, L., San Doval, A., Vornfett, R., and DeJong, W. (1994). Reducing Aids and other STDs among inner-city Hispanics: The use of qualitative research in the development of video-based patient education. *AIDS Education and Prevention*. Vol. 6. pp.140-153.
- O’Sullivan. L.F., Meyer-Bahlburg, H. F. L. and Watkins, B. X. (2001). Mother-Daughter Communication about Sex among Urban African American and Latino Families. *Journal of Adolescent Research*. Vol. 16 (3). pp. 269-292.

- Okware, S., Opio, A., Musinguzi, J. and Waibale, P. (2001). Fighting HIV/AIDS? Is success possible? *Bulletin of World Health Organization*. Vol. 79(12). pp. 1113-1120.
- Omi, S., Aziz, S. A., and Singh, A. R. (2006). *Investing in our future a framework for accelerating action for the sexual and reproductive health of young people*. Geneva: World Health Organisation.
- Opara, P, Eke G.and Akani, N. (2010). Mothers' perception of sexuality education for children. *Journal of Medicine*. Vol. 19(2), pp. 168-172.
- Orr, D. P., Langefeld, C.D., Katz, B. P. and Caine, V. A. (1996). Behavioral intervention to increase condom use among high-risk female adolescents. *Adolescent Medicine*. Vol. 128. pp. 288–295.
- Panday, S., Makiwane, M., Ranchod, C., and Letsoalo, T. (2009). *Teenage pregnancy in South Africa- with a specific focus on school-going learners*. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria: Department of Basic Education.
- Papa, M., Singhal, A., Law, S., Pant, S., Sood, M., Rogers, E. M. and Shefner-rogers, C.L. (2000). Social change: An analysis of paradoxical interaction, social learning, collective efficacy and paradoxical communication. *Journal of International Communication*. Vol. 50(4). pp. 31-35.
- Paulsen, M., Miller, K., Fasula, A., Vandenhoudt, H., Wyckoff, S., Ochura, J., Obong'o, C and Forehand, R., (2010). Factors associated with parent-child communication about HIV/AIDS in the United State and Kenya: a cross- cultural comparison. *AIDS behaviour Journal*. Vol. 14(5). pp. 1083- 1094.
- Pedlow, T. C. and Carey, M. P. (2004). Developmentally-Appropriate Sexual Risk Reduction Interventions for Adolescents: Rationale, Review of Interventions, and Recommendations for Research and Practice. *Ann Behav Med*. Vol. 27(3). pp. 172–184.

- Peltzer, K. and Pengpid, S. (2016). Early Sexual Debut and Associated Factors among In-school Adolescents in Six Caribbean Countries. *Journal of West Indian Med.* Vol. 64(4). pp. 351–356.
- Peltzer, K., Davids, A., and Njuho, P. (2011). Alcohol use and problem drinking in South Africa: findings from a national population-based survey. *Afr. Journal of Psychiatry.* Vol. 14. pp 30-37.
- Phetla, G., Busza, J., Harqreaves, J., Pronyk, P. Kim, J., Morison, L., Watts, C. and Porter, J. (2008). “They have opened our mouths”: increasing women’s skills and motivation for sexual communication with young people in rural South Africa. *AIDS Educ. Prev.* Vol. 20(6). pp. 504-518.
- Piaget, J., (1950). *The Psychology of Intelligence.* New York: Harcourt and Brace.
- Pistella, C.L., and Bonati, F.A. (1998). Communication about sexual behaviour among adolescent women, their family, and peers. *Families in Society,* Vol. 79(2), pp. 206-211.
- Planned Parenthood Federation of America- PPFA (2013). *Teenage pregnancy.* (Online) Available at: http://www.plannedparenthood.org/files/6813/9611/7632/Reducing_teen_Pregnancy.pdf (Accessed 15 Feb., 2017).
- [Pluddemann](#), A., [Flisher](#), A.J., [Mathews](#), C., [Carney](#), T. and [Lombard](#), C. (2009). Adolescent methamphetamine use and sexual risk behaviour in secondary school students in Cape Town, South Africa. *Drug and Alcohol Review.* Vol. 27 (6). pp. 687-692.
- Pluhar, E. I., DiIorio, C. K., and McCarty, F. (2008). Correlates of sexuality communication among mothers and 6-12-year-old children. *Child: Care, Health and Development.* Vol. 34(3), pp. 283-290.
- Pound, P, Langford, R, and Campbell, R. (2016). What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *BMJ.* Vol. 6(9). pp. 1-15.

- Prata, N., Morris, L., Mazive, E., Vahidnia, F. and Stehr, M. (2006). Relationship between HIV risk perception and condom use: evidence from a population-based survey in Mozambique. *Int Fam Plann Perspect.* Vol. 32 (4). pp. 192-200.
- Rafei, U. M. (2000). Striving for Better Health in South-East Asia. *Paper presented at the Inter-country Meeting on Child and Adolescent Health and Development.* Bali, South-East Asia Region: WHO.
- Ramsoomar, L., Morojele, N.K. and Alcohol and drug research Unit, Medical research council of South Africa (2012). Trends in alcohol prevalence, age of initiation and association with alcohol related harm among South Africa Youth: implications for policy. *SAMJ.* Vol. 102(7). pp. 2078-5135.
- Ramulumo, M. R. and Pitsoe, V. J. (2013). Teenage Pregnancy in South African Schools: Challenges, Trends and Policy Issues. *Mediterranean Journal of Social Sciences.* Vol 4(13) pp. 2039-2117.
- Ream, G. L. and Savin-Williams, R. C. (2005). "Reciprocal association between adolescent sexual activity and quality of youth-parent interactions." *Journal of Family Psychology.* Vol. 19(2). pp. 171-179.
- Reddy, S. P., Panday, S., Swart, D., Jinabhai, C. C., Amosun, S. L., James, S., *et al.* (2003). *Umthenthe Uhlaba Usamila: The South African Youth Risk Behaviour Survey 2002.* Cape Town. South African Medical Research Council.
- Regnerus, M. D. (2005). Talking about sex: Religion and patterns of parent-child communication about sex and contraception. *The Sociological Quarterly,* Vol. 46, pp. 79-105.
- Regnerus, M. D. (2007). *Forbidden fruit: Sex and religion in the lives of American teenagers.* New York: Oxford University Press.
- Reis, R.K, Melo E. S., and Gir, E. (2016). Factors associated with inconsistent condom use among people living with HIV/Aids. *Pub Med.* Vol.69 (1). pp. 40-46.

- Resnick, M. D., Bearman, P. S. and Blum, R. W. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *JAMA*. Vol. 278. pp. 823-832.
- Richter, L., Mabaso, M., Ramjith, J. and Norris, S.A. (2015). Early sexual debut: voluntary or coerced? Evidence from longitudinal data in South Africa - the Birth to Twenty Plus study. *South African Medical Journal*. Vol. 105(4). pp. 2078-5135.
- Rodgers, K. B. (1999). "Parenting processes related to sexual risk-taking behavior of adolescent males and females." *Journal of Marriage and the Family*. Vol. 61. pp. 99-109.
- Rogers, R.W. (1975). A protection motivation theory of fear appeals and attitude change. *Journal of Psychology*. Vol. 91. pp. 93-114.
- Rogers, R.W. (1983). Cognitive and psychological processes in fear appeals and attitude change: a revised theory of protection motivation. In J. Cacioppo and R. Petty (Eds.), *Social Psychophysiology*. New York: Guilford press. pp. 153-176.
- Rosenthal, D., Feldman, S., and Edwards, D. (1998). Mum's word: Mother's perspectives on communication about sexuality with adolescents. *Journal of adolescence*. Vol. 21. pp 727-743.
- Saldana, J. (2009). *The coding manual for qualitative researchers*. London. Sage.
- Sales, J. M., Milhausen R. R., Wingood, G. M., DiClemente, R. J., Salazar, R. F. and Crosby, R. A. (2008). Validation of a Parent-Adolescent Communication Scale for Use in STD/HIV Prevention Interventions. *Health Education Behavior*. Vol. 35. pp. 332-345.
- Salmom, C.T. and Atkin, C. (2003). Using media campaigns for health promotion. In T. L. Thompson, A.M. Dorsey, K. I. Miller and R. parrot (eds.) *Handbook of health communication*. pp. 449-472. Mahwah, N.J. Erlbaum.
- Scalway, T. (2010). Presenting the evidence for social and behavioural communication. *JHHESA*. South Africa.

Seale, C. (2012). *Researching Society and Culture*. 3rd Ed. London. Sage Publications.

[Sedgh, G.](#), [Finer, L.B.](#), [Bankole, A.](#), [Eilers, M.A.](#) and [Singh, S.](#) (2015). Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends. [Journal of Adolesc Health](#). Vol. 56(2). pp. 223-230.

Shelton, J., Halperin, D.T., Nantulya, V., Potts, M., Gayle, H.D. and Holes, K.K. (2004). Partner reduction is crucial for balanced “ABC” approach to HIV prevention. *British Medical Journal*. Vol. 328(7444). pp. 891-893.

Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S. and Pillay, V. (2005). South African national HIV prevalence, incidence, behaviour and communication survey. Cape Town: HSRC Press.

Shtarkshall, R. A., Santelli, S., and Hirsch, J. S. (2007). Sex education and sexual socialization: Roles for educators and parents. *Perspectives on Sexual and Reproductive Health*. Vol. 39. pp. 116–119.

Sieving, R.E., Eisenburg, M.E., Pettingell, S. and Skay, C. (2006). Friends’ influence on adolescents’ first sexual intercourse. *Perspectives on Sexual and Reproductive health*. Vol.38 (1). pp. 13-19.

Singhal, A. (2013). Introduction: Fairy tales to digital games: the rising tide of entertainment education. *Critical Arts: South-North Cultural and Media Studies*. Vol. 27 (1). pp. 1-8.

Singh, A and Jain S. (2009). Awareness of HIV and/or AIDS among school adolescents in Banaskantha district of Gujarat. *Health Popul. Perspect Issues*. Vol.32 (2). pp. 59–65.

Siqwana-Ndulo, N. (1998). Rural African family structure in the Eastern Cape Province, South Africa. *Journal of Comparative Family Studies*. Vol. 29(2), pp. 407-417.

Smetana, Campione-Barr and Matzger, (2006). Adolescent development in interpersonal and social contexts. *Annual Review Psychology*. Vol 57(1). pp. 255-284.

- Smith, A., Saewyc, E., Albert, M., MacKay, L., Northcott, M., and The McCreary Centre Society (2007). *Against the Odds: A profile of marginalized and street-involved youth in BC*. Vancouver, BC: The McCreary Centre Society.
- Sokol, J.T. (2009). Identity development throughout the lifetime: An examination of Eriksonian theory. *Graduate Journal of Counselling Psychology* Vol.1 (2). pp. 140-148.
- Somers, C. L., and Surmann, A. T. (2004). Adolescent references for source of sex education. *Journal of Child study*, Vol.34 (1). pp. 47.
- South African history online (2011). *History of Cato Manor*. Available at: <http://www.sahistory.org.za> (Accessed on 5 June, 2015).
- Statistics South Africa (2011). *South African Statistics*. Pretoria. Statistic South Africa.
- Steffensmeier, D, and Allan EA. (2000). Looking for patterns: Gender, age, and crime. In J. Sheley (ed.), *Criminology*. Belmont, CA: Wadsworth. pp. 85-127.
- Steinberg, L. (1990). *Adolescence*. New York: Knopf.
- Steinberg, L. (2008). A social Neuroscience perspective on adolescent risk-taking. *Dev. Rev.* Vol 28(1). pp. 51-58.
- Steinberg L, and Cauffman E. (1996). Maturity of judgment in adolescence: Psychosocial factors in adolescent decision-making. *Law and Human Behaviour*. Vol.20. pp. 249-272.
- Steinberg, L. and Silk, J. S. (2002). Parenting adolescents. In M.H. Bornstein (ed.) *Handbook of parenting*. Mahwah, N.J: Lawrence Erlbaum Associates.
- Stephenson, M. and Witte, K. (1998). Fear threat and perceptions of efficacy from frightening skin cancer messages. *Public Health Review*. Vol. 26. pp. 147-174.
- Stöckl, H, Kalra N, Jacobi J. and Watts C. (2013). Is early sexual debut a risk factor for HIV infection among women in Sub-Saharan Africa? A systematic review. *Journal of Reprod. Immunology*. Vol. 69(1). pp. 27-40.

- Strasburger, V.C. (2005). Adolescents, sex and media: oooo, babay, baby-AQ and A. *Adolescent Medicine Clinics*. Vol. 16. pp. 269-288.
- Stringer, E.M, Sinkala, M., Kumwenda, R., Chapman, V.V., Mwale, A., Vermund, S.H., Goldenberg R.L., and Stringer, S.A. (2004). *Personal risk perception, HIV knowledge and risk avoidance behavior, and their relationships to actual HIV serostatus in an urban African obstetric population. J Acquir Immune Defic Syndr*. Vol. 35 (1). pp. 60-66.
- Sychareun, V., Faxelid, E., Thomsen, S., Somphet, V., and Popenoe, R. (2011). Customary adolescent sexual practices among the Akha of northern Lao PDR: considerations for public health. *Cult Health Sex*. Vol. 14. pp. 1-14.
- Sychareun, V., Thomsen, S., Chaleunvong, K. and Faxelid, E. (2013). Risk perceptions of STIs/HIV and sexual risk behaviours among sexually experienced adolescents in the Northern part of Lao PDR. *BMC Public Health* Vol.13. pp.1126.
- Tager, M. (1997). Identification and interpretation: The Bold and the Beautiful and the urban black viewer in KwaZulu-Natal. *Critical Arts*. Vol. 11(1). pp. 95–119.
- Taukeni, S, and Ferreira R. (2016). HIV and/or AIDS awareness among adolescents in a South African at-risk rural community. *S Afr J HIV Med*. Vol. 17(1).
- Tesfaye, A. Y., Haji, K. B. and Abera, K. T. (2010). Factors affecting parent-adolescent discussion on reproductive health issues in Harar, Eastern Ethiopia: a cross-sectional study. *Journal of environmental and public health*. Vol. (20)14. pp. 1-8.
- Tiffany, A. (2011). Sex talk: factors that influence parent-child communication about sex. Master's and PhD. Eastern Michigan University.
- Tufford, L. and Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work*. Vol. 11(1). pp. 80-96.
- Tufte, T. (2008). Fighting AIDs with entertainment: Building on Soul City experience in South Africa. In: J.Servaes, ed. *Communication for Development and social change*. Los Angeles: Sage Publications. pp. 327-344.

- Tufte, T. (2000). *Living with the Rubbish Queen. Telenovelas, Culture and Modernity in Brazil*. Luton: University of Luton Press.
- Tuwe, K. (2016). The African oral tradition paradigm of storytelling as a methodological framework: employment experiences for African communities in New Zealand. In: *21st Century Tensions and Transformation in Africa* (Online) Auckland University of Technology (AUT). African Studies Association of Australasia and the Pacific (AFSAAP). pp. 1-18 Available at: <http://www.ecald.com/Portals/49/Docs/Publications/Tuwe%20African%20Storytelling%20Research%20Method.pdf> (Accessed 28 March, 2017).
- Udigwe, I., Adoju, p., Nwabueze, A., Adinma, E., Ubajaka, C. and Onwasigwe, C. (2014). Factors influencing sexual behaviour among female adolescents in Onitsha, Nigeria. *Open Journal of Obstetrics and Gynecology*. Vol. 4(10). pp. 987-995.
- UKEssays, (2015). Theories of adolescence. England. UKEssays. Available at: <http://www.ukessays.com> (Accessed 02 Dec., 2016).
- UNAIDS, (2012). *World AIDS report*. Geneva. UNAIDS.
- UNAIDS, (2014). *The gap report*. Geneva. UNAIDS.
- UNAIDS, (2016). *Fact sheet 2016*. (Online). Available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (Accessed 29 March, 2016).
- UNAIDS, (2016). *Global Aids Update*. Available at: http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf (Accessed 29 March, 2016).
- UNAIDS, (2016). *Core Epistemology slides, 2016*. Unaid. Aids information website. Available at: <http://www.aidsinformation.unaids.org/> (Accessed 16 September, 2016).

- United Nations Children's Fund (UNICEF), (2016). *Maternal health: Adolescent health*. (Online) Available at: <https://data.unicef.org/topic/maternal-health/adolescent-health/> (Accessed 27 Feb., 2017).
- United Nations Children's Fund (UNICEF), (2013). *Towards an AIDS-Free Generation – Children and AIDS: Sixth Stocktaking Report. 2013*. (Online) New York: UNICEF. Available at: https://www.unicef.org/media/media_71098.html (Accessed 29 March, 2017).
- United Nations Population Fund, (2000). *Lives together, worlds apart; men and women in a time of change*. Geneva: UNFPA.
- Utey, O. (2008). Keeping the tradition of African storytelling alive. (Online). Yale-New Haven Teachers Institute. Available at: <http://teachersinstitute.yale.edu/nationalcurriculum/units/2009/1/09.01.08.x.html> (Accessed 29 March, 2017).
- Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy*. Albany. State University of New York press.
- Vandenhoutd, H. Miller K. S. and Ochura J. (2010). Evaluation of a U.S. evidence-based parenting intervention in rural Western Kenya: from parents matter! To families matter! *AIDS Education and Prevention*. Vol. 22 (4). pp. 328-343.
- Vaus, D. (2001). *Research design in social research*. London. Sage Publications.
- Vukapi, Y. (2016). *“ZAZI-Know Your Strength”- A reception Analysis of contraceptive utilisation in correlation to unplanned and unwanted pregnancies among young female learners' in Umnini, KwaZulu-Natal*. Masters Dissertation. The Centre for Communication, Media and Society. University of KwaZulu-Natal.
- Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.

- Wamoyi, J., Fenwick, A., Urassa, M., Zaba, B. and Stones, W. (2010). Parent-child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. *Reproductive health*. Vol 7(6). pp. 1-18.
- Wang, Z. (2009). *Parent-adolescent communication and sexual risk-taking behaviour of adolescents*. Masters' Thesis. University of Stellenbosch.
- Ward, E.G., Disch, W.B., Levy, J.A., Schensul, J.J. (2004). Perception of HIV/AIDS risk among urban, low-income Senior-housing residents. *AIDS Educ Prev*. Vol. 16 (6). pp. 571-588.
- Ward, L. M., and Friedman, K. (2006). Using TV as a guide: Between television viewing and adolescents' sexual attitude and behaviour. *Journal of Research on Adolescence*. Vol.16. pp. 133-156.
- Weinman M, Small E, Buzi RS, Smith P. (2008). Risk Factors, Parental Communication, Self and Peers' Beliefs as Predictors of Condom Use Among Female Adolescents Attending Family Planning Clinics. *Child Adolesc Soc Work J*. Vol.25. pp. 157-170.
- Welman, J. C. and Kruger, S. J. (1999). *Research methodology for the business and administrative sciences*. Johannesburg, South Africa: International Thomson.
- Werner-Wilson, R.J. Fitzharris, J.L. and Morrissey, K.M. (2004). Adolescent and parent perceptions of media influence on adolescent sexuality. *Journal of Adolescence*. Vol. 39(154). pp. 303-313.
- Whitaker, D. J., and Miller, K. S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behaviour. *Journal of Adolescent Research*, Vol.15. pp. 251-272.
- WHO (2014). *Adolescents: health risks and solutions*. Geneva. WHO Press.

WHO (2014). *Fact sheet: Adolescent pregnancy*. (Online) Available at: <http://www.who.int/mediacentre/factsheets/fs364/en/> (Accessed 29 March, 2017).

[WHO \(2015\). *Adolescent pregnancy*](#). Geneva. WHO Press.

[WHO \(2016\). *Fact sheet: Maternal Mortality*](#). (Online) Available at: <http://www.who.int/mediacentre/factsheets/fs348/en/> (Accessed 29 March, 2017).

WHO (2016). *Adolescents: health risks and solutions*. (Online) Available at: <http://www.who.int/mediacentre/factsheets/fs345/en/> (Accessed 29 March, 2017).

WHO (2012). *Hormonal contraception and HIV: technical statement*. Geneva: Switzerland.

Wight, D., Williamson, L., and Henderson, M. (2006). Parental influences on young people's sexual behaviour: A longitudinal analysis. *Journal of Adolescence*. Vol. 29(4). pp. 473-494.

Williams, T., Pichon, L.C. and Campbell, B. (2015). Sexual Health Communication within Religious African-American Families. *Health Communication*. Vol. 30(4). pp.328-338.

Willan, S. (2013). A review of teenage pregnancy in South Africa- experiences of schooling, knowledge and access to sexual and reproductive health services partners in sexual health (PSH). Available at: <http://www.hst.org.za/publications/review-teenage-pregnancy-south-africa-experiences-schooling-and-knowledge-and-access-se> (Accessed 15 September, 2016).

Witte, K. (1992). Putting the fear back into fear appeals: the extended parallel process model. *Communication Monographs*. Vol.59. pp. 329-349.

Witte, A. and Allen, M. (2000). A Meta-Analysis of Fear Appeals: Implications for Effective Public Health Campaigns. *Journal of Health Education and Behaviour*. Vol. 27 (5). pp. 591-615.

- Witte, K. (1994). Fear control and danger control: A test of the extended parallel process model (EPPM). *Communication Monograph*. Vol., 61(2). pp. 113-134.
- Witte, K. (1997). Preventing teen pregnancy through persuasive communications: Realities, myths and the hard fact truths. *Journal of Community Health*. Vol. 22. pp. 137-154.
- Witte, K. (1998). Fear as motivator, fear as inhibitor: Using the extended parallel process model to explain fear appeal successes and failures. In P. A. Andersen and L. K. Guerrero (Eds.), *Handbook of communication and emotion: Research, theory, applications, and contexts*. San Diego, CA: Academic Press. pp. 423-450.
- Witte, K., Girma, B., and Girgre, A. (2003). Addressing the underlying mechanisms to HIV/AIDS preventive behaviors in Ethiopia. *International Quarterly of Community Health Education*. Vol. 21. pp. 163-176.
- Witte, k., Person, T.R., Vallabhan, S., Stephenson, M.T., Plugge, C. D., and Givenm V.K. (1993). Prevention tractor-related injuries and deaths in rural populations: Using a persuasive health message (PHM) framework n formative evaluation research. *Int. Quarterly of Community Health Edu*. Vol.19. pp 219-251.
- Wood, J. T. (1982). Communication and relational culture: Base for study of human relationships. *Communication Quarterly*, Vol. 30. pp. 75-84.
- Wyckoff, S., Miller, K., Forehand, R., Bau, J., Fasula, A., Long, N. and Armistead, L. (2007). Patterns of sexuality communication between preadolescents and their mothers and fathers. *Journal of Child Family Studies*, Vol. 17(5), pp.649-662.
- Zellner, S. L. (2003). Condom use and the accuracy of AIDS knowledge in Côte d'Ivoire. *Int Fam. Plann. Perspect*. Vol. 29 (1). pp. 41-47.
- Zhang, L., Li, X., Shah, I.H., Baldwin, W., and Stanton, B. (2007). Parent-adolescent sex communication in China. *The European Journal of Contraception and Reproductive Health Care*, Vol. 12(2). pp. 138-147.

Ziehl, S. (2001). Documenting changing family patterns in South Africa: A census data of any value. *African Sociological Review*. Vol. 5(2). pp. 36-62.

Zimmer-Gembeck, M.J. and Helfand, M. (2008). Ten years of longitudinal research on U.S. adolescent sexual behavior: Developmental correlates of sexual intercourse, and the importance of age, gender, and ethnic background. *Developmental Review*. Vol. 28. pp. 153-224.

Zuma, Setswe, Ketye, Mzolo, Rehle and Mbelle, (2010). Age at sexual debut: a determinant of multiple partnerships among South African youth. [*Afr. Journal of Reprod. Health*](#). Vol. 14(2). pp. 47-54.

APPENDIX A

INTERVIEW GUIDES

Adolescents

➤ Demographic Variables

Age Sex Religion Family type (parent marital status)

➤ Forms of teenage risky behaviours

What types of teenage risky behaviour do you think your friends could be exposed to?

Why do you think they get involved in these behaviours?

What do you think might happen to them if they engage in these sexual behaviours you have mentioned?

What risks do you think people of your age are exposed to when they engage in risky sexual behaviour?

How bad can the consequences of these behaviours be on the adolescents? Why?

What do you suggest can be done to avoid these consequences?

➤ Issues difficult to discuss

During discussions on sexual topics with parents, what do you think people of your age always talk about?

Do you find it difficult to talk with your parents on these topics? Why?

What topic do you think most people can also find difficult to discuss with their parents? Why?

What do you think prevent people of your age from discussing with their parents?

➤ Approaches adopted during communication

Do you always have sex discussions with you parents?

How do you discuss sex topics with you parents?

Probe: In what situations are these discussion always held?

Why these way?

Do you think the way some parents discuss sex topics with their children can affect communication between parents and children? How?

Do you think some parents do not discuss sex with their children? Why

Do you think this way of discussions is a good way to push or prevent adolescents to engage in sexual acts? Why?

Parents

➤ Demographic Variables

Sex Religion Family type

➤ Forms of teenage risky behaviour

What do you think about having sex talk with your teenagers?

Probe: Do you feel it is right or not?

Why?

What type of bad behaviours do you think young ones might be exposed to?

Do you think your communication with them can in any way prevent them from engaging in sex? How?

What danger do you think they can be exposed to when they have sexual relationship?

➤ Issues difficult to discuss

Do you have sex talk with your adolescent?

Probe: If Yes: What do you mostly talk on?

If No: Why?

What topic do you find difficult to discuss?

Probe: pregnancy, fertilization, intercourse, menstruation, AIDs, contraceptives, abortion, prostitution, homosexuality, crimes, smoking

Why do you find these topics difficult to discuss?

➤ Approaches Adopted during communication

How do you discuss sex topics with your adolescents?

Probe: In what situation do you choose to discuss these topics?

Do you think your adolescent keep sex secrets or their sexual relationships from you? Why?

Do you think the method you discuss these topics can affect you children from discussing with you?

What style or method do you think is good to communicate with your children that could avoid these bad behaviours?

Do you think this way is the best way to stop them from engaging in any bad behaviour? Why do you feel so?

APPENDIX B

INFORMED CONSENT FORM

TOPIC: PARENT- ADOLESCENT COMMUNICATION ON RISKY SEXUAL BEHAVIOUR: FACILITATORS AND BARRIERS IN KWAZULU- NATAL, SOUTH AFRICA.

Letter of invitation to participate in the study

Dear Sir/Madam

My name is Oluwatola Fasakin. I am collecting data as part of a research project. The project is conducted under the supervision of University of KwaZulu-Natal Centre for Communication and Media in Society (CCMS). The aim of the study is to explore parent and adolescent's perceptions on communication on risky sexual behaviour.

Participation in this study is voluntary. As a participant, you may withdraw from the research at any time without negative consequences. The interview will not be paid for in money, but a small token gift or appreciation may be given. In general, responses will be treated in a confidential manner. Confidential information will not be used without your permission. If you agree to be interviewed, we will request that you choose a pseudonym for the purposes of this research, so your real identity will not be revealed in the final reports. As a participant, you will be treated with respect and dignity.

We request the use of an audio-recorder in the interview. The data will be kept securely for five years for purposes of verification by my supervisor, DR. Lauren Dyll-Myklebust at the University of KwaZulu-Natal. Should you request, an electronic copy of the final projects will be sent to you on completion.

Your willingness to participate in this study will greatly be appreciated.

Details of the researcher and institution of research:

Researcher	Fasakin Oluwatola	+27-63-0856922	Tfash54@yahoo.com
Department	Centre for	031 2602505	http://ccms.ukzn.ac.za

	Communication and Media in Society (CCMS)		
Institution	University of KwaZulu-Natal (UKZN)	Howard College Campus, Masizi Kunene Ave, Glenwood, Durban, South Africa.	http://www.ukzn.ac.za
Supervisor	Dr. Lauren Dyll-Myklebust	+27-31-2602298	dyll@ukzn.ac.za
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Committee Clerk, UKZN Human Sciences Research Committee	Ms P. Ximba	+27-31-2603587	ximbap@ukzn.ac.za
<i>Please do not hesitate to contact any of the above persons, should you want further information on this research, or should you want to discuss any aspect of the interview process.</i>			
Key informant Interview		Focus Group Discussion	
<ul style="list-style-type: none"> I understand that the purpose of this interview is for solely academic purpose. The findings will be published as a thesis, and may be published in academic journals. 		Yes <input type="checkbox"/> No <input type="checkbox"/>	

<ul style="list-style-type: none"> I understand I may choose to remain anonymous. (Please choose whether or not you would like to remain anonymous.) 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand my name will be quoted. (Please choose whether or not you would prefer to have your remarks attributed to yourself in the final research documents.) 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I will not be paid for participating. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I reserve the right to discontinue and withdraw my participation any time. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to be frank to give the information. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to the use of any photographs that may be taken of me. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to the use of audio tape recorder during this interview 	Yes <input type="checkbox"/> No <input type="checkbox"/>
* By signing this form, I consent that I have duly read and understood its content.	

APPENDIX C

INTERVIEW TRANSCRIPT

Researcher: What do you think happens that may place people like you or other teenagers or your friends at the risks of getting HIV/AIDS, getting pregnant, or any other diseases?

Participant T02: okay, what I can say is that [1]once they are drunk, I can put it in that way, may be they do not think straightly and[2] they may go to unprotected sex and that may lead to virus diseases including death, teenage pregnancies, which is the issue right now in the country.

Researcher: Thank you. So, why do you think they get involved in all these behaviours? What lead them to all these behaviours. What made them drink, what made them get involve in unprotected sex?

Participant T02: What I can say is, may be if there is anything which they are participating in, maybe that will not happen but [1]maybe I can say is media cos we normally see that in media but I don't wanna judge media. [2]or maybe is even peer pressure cos what your friends are doing, they will influence you to do that thing which they are doing. They tell you to do stuffs but they will not tell you how to do it safely. There lies the main problem which is happening right now in this current situation.

Researcher: Talking about you now, why do you think you might get involved in all these risky behaviours as you mentioned earlier?

Participant T02: For me, am done with that and am not going back there anymore. I once did drink then but I have stopped now [1]because I said now I wanna go to follow the route of going to church and [2]also doing arts because if am doing arts, I won't be involve in any of those thing. I will be too busy to think about such behaviours.

Researcher: So why do you choose to follow God? Why do you choose to change your route?

Participant T02:[3] Is because I did so then, and I realized it was not paying anything for me. That is why I said I will rather do something that will help me because we only live once and if you live once, you should live your life to the fullest and[4] I understand that there is someone out there which is a young boy or girl looking up to me, saying I wanna be like that guy and if am doing a wrong thing or if he sees me one day coming drunk which means he will say that is the way. A saying in our language "it is easy to manipulate or to change the young mind" is reflected here.

Researcher: okay, what do you think might happen to them if they get involved in all this risky sexual behaviours you have mentioned? What are the end results?

Participant T02: [1]What normally does happen is that they might die cos there was one guy like three to four months back, who went to the reunion bouquet, a party organised once they have finished writing exams. He [3]died of a new drug which is popular now. Once this drug is consume, they might die, as the drug is very powerful I guess cos I don't know and I never tasted it and I don't think I will ever do so (giggle).

Researcher: okay, what risks do you think people of your age are exposed to when they engage in risky sexual behaviour? What risks are they exposed to when they engage in risky sexual behaviour?

Participant T02: [1]mostly of our youngsters do not like to condomize [2] leading to teenage pregnancies which is happening now. Probably around last year, it was reported that 10,000 scholars get pregnant every year which should not be that much. This shows that our youngsters are not having protective sex and that lead to teenage pregnancies [3]and also, they said it is the youngster which are affected with HIV more than the adults. Not only do we not protect ourselves, also [1]we do not want to abide with the knowledge given to us.

APPENDIX D

GATE KEEPER PERMISSION LETTER

DramAidE is a non-profit organisation established in 1992 and based at the Universities of Zululand and KwaZulu-Natal.
DramAidE has a long history of theatre and youth development work in the HIV/AIDS field.

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25 April 2016

The Head
Centre for Culture and Media Studies
University of KwaZulu-Natal
Howard College Campus
4001

Re: Permission to access information for Masters Research

DramAidE is a public health communication agency that was established in 1992. The organization is an outreach initiative project of the University of Zululand. It is affiliated to the Centre for Culture and Media Studies at the University of KwaZulu-Natal. The organisation uses participatory and interactive educational methodologies for HIV and Aids, life-skills and sexuality education to critical raise awareness and transfer skills.

Fasakin Tola, Masters in Social Sciences student 216024735, has proposed to conduct research on "Parent and Teenager communication on risky sexual behaviour".

I therefore grant permission to Fasakin Tola (student no: 216024735) to access information for her Masters Research.

Should you wish to contact the writer, please do not hesitate to contact me on 031-2601564/5.

Best regards,



Mkhonzeni Gumede

Project Director

DramAidE

C/o University of KwaZulu-Natal

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E-mail: gumedem3@ukzn.ac.za

APPENDIX E

THEME FORMATION LAYOUT TABLE

Anchor codes	Sub-themes	Themes
<ul style="list-style-type: none"> i. forms of adolescent risk-taking behaviours ii. forms of adolescent sexual risky-taking behaviours 	<p>Prevalence of adolescent risk-taking behaviours</p>	<p>Parent-adolescent perceptions towards adolescent risk-taking behaviours</p>
<ul style="list-style-type: none"> i. factors that exposes adolescents to risky behaviours 	<p>Factors identified as determinant for risky adolescent behaviours</p>	
<ul style="list-style-type: none"> i. susceptibility of adolescents to risky behaviour ii. (in)susceptibility of adolescents to risky behaviour iii. degree of seriousness of the consequences iv. influence of risks on adolescent future v. consequences of adolescents risky behaviour 	<p>Risk perception of adolescents' (in)vulnerability and severity to risky sexual behaviour</p>	
<ul style="list-style-type: none"> i. issues/Topics often discussed ii. topics easy to discuss 	<p>Sexuality topics discussed between parents and their adolescents</p>	

iii. topics difficult to discuss		sex talk: factors that influence parent-adolescent communication about sex
i. barriers to parent-child communication	Causal factors affecting parent-adolescent communication on sexuality and reproductive health issues	
i. adolescent sources of information ii. parent sources of information iii. parent-child (most) preferable source of information iv. reason for preferable source of information	Sources of information	information sources for sexuality and risky behaviour issues
i. prompter of communication	Triggers of parent-adolescents' sexuality communication.	

<ul style="list-style-type: none"> i. communication styles ii. Preferable communication style for risk avoidance iii. Reasons for identifiable communication styles iv. communication styles that encourage and discourage effective communication v. communication style that encourage and discourage self-efficacy 	<p>Communication styles and tones</p>	<p>Approaches in parent-adolescent communication on sexual matters</p>