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'A difficult conversation': community stakeholders' and key informants' perceptions of the barriers to talking about sex and HIV with adolescents and young people in KwaZulu-Natal, South Africa

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Abstract

Adolescence and young adulthood are important periods of transition and therefore for action and intervention to ensure future sexual and reproductive health (SRH). Caregiver-adolescent communication about sex and sexuality is a protective factor for SRH, but there are often barriers to this. Adults' perspectives are limited within the literature but important as they should lead this process. This paper uses exploratory qualitative data from in-depth interviews with 40 purposively sampled community stakeholders and key informants to explore their insights into the perceived, experienced or expected challenges adults' experience when having these conversations within a high HIV prevalence, South African context. Findings suggest that respondents recognised the value of communication and were generally willing to try it. However, they identified barriers such as fear, discomfort and limited knowledge and perceived capacity to do so. They show that in high prevalence contexts adults grapple with their own personal risks, behaviours and fears that may affect their ability to have these conversations. This demonstrates the need to equip caregivers

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Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

with the confidence and ability to communicate about sex and HIV, alongside managing their own complex risks and situations to overcome barriers. It is also necessary to shift the negative framing of adolescents and sex.

Keywords

inter-generational communication; sex; adolescents; young people; South Africa

Background

In sub-Saharan Africa (SSA), as many as 1.7 million adolescents and young people (typically defined as those 10–19 years old) are already infected with HIV (UNAIDS 2022). Despite promising declines in new HIV infections in this age group, HIV incidence remains high (UNAIDS 2021; Pettifor et al. 2018). Young women are at particular risk of HIV infection, with around 25% of new infections occurring in those aged 15–24 years old (Kharsany et al. 2015; Bekker and Hosek 2015; Human Sciences Research Council 2018). In KwaZulu-Natal province, South Africa young women are especially vulnerable to HIV and antenatal studies show that women 16 years old or younger already have an 11.5% HIV prevalence (Abdool Karim, Baxter, and Birx 2017). This population is therefore increasingly the focus of HIV prevention efforts and interventions to ensure that those born without HIV, remain uninfected (Cluver et al. 2016; Bekker and Hosek 2015; Dellar, Dlamini, and Karim 2015; Pettifor et al. 2018).

Engaging adolescents and young people with HIV and Sexual and Reproductive Health (SRH) interventions and information is important because many are experiencing a period of significant cognitive, psychological and physical development and change coinciding with puberty, sexual maturity and sexual debut (Marhefka et al. 2009; Pettifor et al. 2018; UNAIDS 2021). Young people and adolescents must navigate and make decisions about their sexual health while being at high risk of multiple SRH outcomes including unwanted and unplanned pregnancy, and sexually transmitted infections (STIs) including HIV (Shisana et al. 2009; Pettifor et al. 2013; Christofides et al. 2014; Pettifor et al. 2018). Furthermore, many adolescents and young people live in social settings where dominant social norms are conservative with respect to sexuality, and where discussion about sex is avoided (Whitaker et al. 1999; Patton et al. 2016).

Caregiver-adolescent sex and sexuality communication has been identified as a protective factor for adolescent risk behaviours, particularly sexual risk, and can protect SRH (Bastien, Kajula, and Muhwezi 2011; Pettifor et al. 2018; Bhana and Bachoo 2011). Evidence from South Africa and Tanzania showed that in-school young people aged 12 – 15 years who reported communication from their caregiver(s) about sex and sexuality were more likely to report condom use (Namisi et al. 2013). However, while such communication has protective benefits for SRH, evidence from the same contexts suggests that despite preferences for their caregivers to communicate about sexuality-related issues, rates of caregiver-child communication were very low (Namisi et al. 2009; Coetzee et al. 2014). Recent research exploring adult perceptions of caregiver-adolescent communication about sex suggests

that the demographic characteristics of caregivers restricted communication with children, including their age, education levels and rural residence (Vilanculos and Nduna 2017). In addition, cultural and religious structures, personal knowledge and discomfort also affect parent's ability to have these conversations (Vilanculos and Nduna 2017). Research with adults in a rural South African context has shown that adults perceive their children to be modern, and themselves to be traditional, making intergenerational communication about issues of sex and lifestyle difficult (Nilsson et al. 2020). Other research focused on maternal HIV disclosure has found that mothers felt a lack of capacity to have conversations with their children about sex-related issues but knew it was necessary, while not being sure how to initiate and conduct these discussions (Mkwanazi, Rochat, and Bland 2017).

This paper explores adults' perceptions of barriers to communication between caregivers and adolescent children about sensitive issues; particularly sex, sexuality and risk associated with HIV. Despite extensive research focused on adolescent and young people's risk and increased prevalence of HIV within this group, there is limited in-depth qualitative research from adults' perspective. In addition, there is limited evidence from a high HIV, rural and peri-urban South African context, where there is relatively widespread access to antiretroviral treatment, reduced mortality and perceived reductions in stigma and discrimination (Bastien, Kajula, and Muhwezi 2011; Coetzee et al. 2014; Goodnight et al. 2014; Soon et al. 2013).

This paper is informed by the work of Guilamo-Ramos et al. (2008) who built on the work of Fishbein et al. (2001) to develop a theory to explain the factors that moderate behavioural intentions or the decision to undertake a behaviour. This theory has been successfully applied to explorations of caregiver-adolescent communication about sex in highly income contexts (Grossman, Charmaraman, and Erkut 2016; Guilamo-Ramos et al. 2008). The framework includes five key moderating factors that influence the intention or decision of a caregiver to communicate with an adolescent or young person about sex or issues relating to sexual risk. These factors include the perceived advantages and disadvantages of engaging in the behaviour, normative influences, whether the behaviour is consistent with a person's self-image, emotionality and self-efficacy beliefs (Guilamo-Ramos et al. 2008). The framework acknowledges that the importance and influence of each factor may vary amongst different populations and contexts (Guilamo-Ramos et al. 2008). This research provides important insights into the challenges adults experience or expect to experience when talking to young people about sex and relationships and provides important lessons for the development of a family-based HIV intervention that formed the basis for this research.

Methods

Study Setting

The Vulindlela area is located 150km west of Durban, KwaZulu-Natal, South Africa and consists of both peri-urban and rural communities. Vulindlela is an HIV endemic area with a population prevalence of 36.7% (Kharsany et al. 2018). Access to primary health care is through primary healthcare clinics, mobile healthcare clinics and supported by a network of community health care workers. The South African Human Science Research Council's (HSRC) Centre for Community-Based Research Unit is based within

the Vulindlela community, and all field-based assistants are resident within the community, are fluent in both isiZulu and English (the working language in South Africa) and have an excellent knowledge of local social norms and practices. The unit maintains close links with the community through a community research support group and include staff who act as community liaison. All members of the research team are South Africans, and all were resident within and had spent most of their working lives in KwaZulu-Natal at the point of data collection.

Procedures

This paper makes use of formative qualitative data collected as part of preparation for a Family-based HIV Counselling and Testing intervention (FBHCT). This family intervention builds upon previous home-based HIV testing and counselling for adults (Knight et al. 2015; van Rooyen et al. 2013) by aiming to improve HIV testing and counselling and health care uptake for all members of the household. The intervention design is described in detail elsewhere (van Rooyen et al. 2016).

A combination of convenience and purposive sampling was used to identify 40 adults (20 community stakeholders and 20 key informants) from rural and peri-urban communities. To be eligible to participate in the study, community stakeholders had to be >18 years old, male or female, and self-identify as representatives of families within the community with insight into family dynamics and first-hand experience of family functioning. To sample stakeholders, a comprehensive information sharing session was completed with all potential participants by an outreach team within the community, either through door knocking or attendance at community gathering places. All potential participants were screened for the inclusion criteria and approached to participate in the study. All those approached were willing to participate. Many community stakeholders were the primary caregivers of children and adolescents within their households and so they were able to reflect on this experience in their interviews. Key informants were sampled purposively by the research team based on community recommendations or existing community knowledge as people who could provide a professional and community perspective as well as facilitate the triangulation of the data. They included social workers, teachers and health care providers who were recruited through direct contact by the research team.

The interview guides were developed by the research team which included first language isiZulu researchers living within the community under study. Input into the appropriateness of the translation of the guides was obtained from a community research support group to ensure local collaboration and context sensitivity. Following written informed consent, semi-structured one-on-one qualitative interviews were used to understand family and community dynamics relevant to intervention development, including addressing family and intergenerational communication about sensitive issues such as sex and HIV.

All interviews were conducted by two trained and experienced interviewers fluent in English and isiZulu who were residents of the local community. Despite this, interviewers had no previous relationship with participants and explained the purpose of the research. The interviews took place in comfortable and private locations and were audio-recorded. Each took about an hour to complete. Interviews took place in isiZulu and were conducted where

possible by an interviewer of the same gender as the respondent. All recorded interviews were transcribed in isiZulu and translated into English by staff members at the HSRC. Transcripts underwent quality checks by a research assistant fluent in both languages. Participants were offered a small reimbursement for their time or travel. Approval for the study was obtained from the HSRC Research Ethics Committee (REC 10/20/11/13).

Data Analysis

This paper considered adult perceptions about intergenerational communication. Data were coded in multiple iterations by two different researchers (NVdP; NN) in consultation with the first author (LK) to ensure dependability. Iterative framework analysis was conducted using codes derived from the research questions and those emerging from the data using NVivo 10. Review of the key themes was undertaken by all team members to finalise codes and gain consensus.

Feedback on the study findings occurred through regular community feedback sessions conducted on the site to ensure that there was member checking and the community felt that the results reflected local realities, thereby enhancing the validity of the results. Key thematic areas concerning intergenerational communication were derived from the codes (Braun and Clarke 2006).

The results from the perspective of the adults sampled were categorised according to the five key moderating factors identified within the chosen analytic framework. These factors, presented as themes, were: 1) perceived advantages and disadvantages of having conversations about sexuality with adolescents; 2) social norms associated with discussions about sex and sexuality; 3) adults' perceived self-efficacy in having these discussions with adolescents and young peopele, considered here as the perceived confidence to undertake the behaviour; and 4) consistency with personal concepts of the self and self-image (Guilamo-Ramos et al. 2008; Grossman, Charmaraman, and Erkut 2016).

In this study, emotion, the factor in the model that refers to the emotional reaction that may affect a caregiver's decision to have a conversation with a young person about sex, is not discussed as a separate theme, as it mediated all the other components of the model.

Results

Demographics

A total of 40 semi-structured interviews were completed, 20 with stakeholders and 20 with key informants. The mean age of the stakeholders was 37 years (range: 26–63 years), and 40.5 years for key informants (range: 24–77 years). Basic demographic information about the sample is provided in Table 1. Findings relevant to the four major themes as mentioned above are detailed below.

Advantages and disadvantages of conversations

Adults interviewed in the study noted that they believed there were both advantages and disadvantages to communications about sex and sensitive issues with adolescents. In general, there was a recognition that communication between caregivers and adolescents

about sensitive issues (in particular sex and sexual risk) was important and necessary and therefore advantageous to ensure adolescents and young people were safe.

> …and that's where the parent must talk to their child and tell the child about the dangers [of sex] because other parents don't talk to their children about sex.
>
> (Key informant 1, male, 35 years)

When discussing the advantages of communication about sex, adults spoke about the importance of protecting adolescents from the 'dangers' they associated with sex such as unintended pregnancy or acquisition of an STI and making this the focus on their communications rather than promoting positive sexuality messages.

> I must now sit them down and tell them that you see when you have started this, you should be aware of this and that [the risks], so that you are protected [from risk] like this and that.
>
> (Stakeholder 1, male, 62 years)

Therefore, despite this recognition of the value of these conversations, the tone their content was largely about highlighting risk and discouraging sex and sexual behaviours.

For several stakeholders and key informants, hesitancy about communication was linked to the perceived disadvantages of having these conversations. One very clear and specific disadvantage was the perception that if parents spoke to their adolescent children about sex, this might encourage adolescents to start having sex. As one stakeholder said:

> Some parents are still stuck in the past, they think that if they call the child to come and have a talk with them, they are changing the child and their way of thinking and this will cause them to start doing [sexual] things, you see.
>
> (Stakeholder 2, female, 38 years)

While clearly a perceived disadvantage it is also important to note that the responses show that this disadvantage emerges because of *fears of encouraging sex*:

> …. most parents are afraid to talk to their children about sex issues because they tell themselves that if they talk about those things, they will be telling their children to have sex.
>
> (Stakeholder 3, male, 20 years)

This fear that talking about sex might encourage sexual debut may be specifically underpinned by social beliefs that sex discussions encourage sexual behaviour. While many of the stakeholders framed these beliefs as out-of-date and belonging in 'the past', they still had a strong influence on caregivers' decisions to have conversations about sex and HIV. This may be driven by fear that early sexual activity may be seen as the fault of the caregiver.

Social norms

The data showed that social norms were linked to a generally negative framing of young people and sex, as something to be discouraged and not normalised. Several respondents made statements along the lines of "we [Black African] people do not talk about sex with

our children" to support this argument. This suggests that respondents felt that caregivers might be influenced by traditional norms around intergenerational communication about sex, which was not supported, fostered or encouraged.

> Not all of us are ready and it's how we were taught when growing up that you cannot talk to the child about sex matters, that's how we were raised
>
> (Key informant 2, female, 77 years)

Adult caregivers suggested that their discomfort with having conversations about sex and sexuality often stemmed from poor role modelling from their own parents who were influenced by traditional social norms – highlighting the importance of social learning and modelling for sustaining conservative social norms – even if these may belong "to the past" as mentioned earlier.

> [You] find others are afraid of addressing this thing with a child because it embarrasses them like this and that. Because if you also recall the olden days, I think you were also still young, we wouldn't just talk about issues, in my time, as I have said that I was born in 1976, issues about sleeping with boys were not addressed.
>
> (Stakeholder 2, female, 38 years)

Gender norms also influenced the expectation about whose responsibility it was to have sensitive discussions. Caregivers felt that most often discussions about sex and sexuality were considered the responsibility of mothers:

> Mothers, it is always mothers. The only thing dads are likely to do is yell at the child or admonish them….so it is the mothers who have the discussions.
>
> (Stakeholder 4, female, 49 years)

Overall, social norms suggested that discussions about sex with AYP were socially unacceptable. Social norms around adolescent sexual activity were frequently framed by adult respondents as misbehaviour, deviant and unacceptable ('bad behaviour'; 'naughty', 'not behaving well') and something they were clearly told not to do. The focus was therefore mostly on making adolescents and young people aware of and, ideally, afraid of the many risks associated with having sex, and stressing how having sex may jeopardise future goals.

> …it is warning him…Telling him about certain things that might scare him from what he is doing so that he can have a future.
>
> (Stakeholder 5, female, 62 years)

> …so, you have to try and protect that child in a certain way, so you can scare him so that he can see that this thing [sex] is not right. Because they are old enough to understand what is being said.
>
> (Stakeholder 1, male, 62 years)

This negative framing meant that discussion about sex often focused on protection as *preventing sex completely*, rather than promoting *safer sex*. In many cases, the purpose of this was to ensure abstinence was maintained. Further, many respondents felt that sex

discussions were especially inappropriate with younger adolescents, and that they should only take place once children had reached a certain age.

> …at home they talk to kids from 18 upwards but when you are still young [under the age of 18 years] you are told not to do these things [have sex].
>
> (Stakeholder 3, male, 20 years)

The choice of the age here seems arbitrary when considered in developmental terms but is likely linked to the fact that the age of 18 is legally considered adulthood in South Africa. Therefore, the selection of this age may suggest support for broader social norms which position sex in adulthood as acceptable, while sex in adolescence is unacceptable.

Perceived confidence in ability

Self-efficacy beliefs or the perceived confidence in the ability to communicate about sex and sexuality-related issues appeared to influence whether caregivers had conversations about sex with adolescents. Negative perceptions of skills and a lack of confidence in their capacity to have difficult conversations appeared to make caregivers less likely to have them even if the advantages of such conversations were acknowledged. There was also fear surrounding discussion of sex. This was linked to concerns about stimulating their child's interest in sex, unease or embarrassment about having these conversations, and feeling unequipped to manage these conversations when they did happen.

Feeling unable to manage conversations around sex was raised by both stakeholders and key informants. They highlighted how many adults felt ill-equipped to raise sexual health issues with adolescent children and lacked the skills or knowledge to have informed discussions.

> I think that some parents are lacking the necessary knowledge, they are not educated enough to broach this topic with their kids. I think that if the parents had enough information in order for them to be able to pass on the information to their kids; that might help.
>
> (Stakeholder 6, female, 31 years)

Beyond lacking knowledge, key informants highlighted how caregivers fear having sensitive discussions. There was a strong feeling that caregivers required more support, education and information to enable them to talk about sex and sexuality with their children. Sometimes it was easier for caregivers to rely on others such as the teachers at school to do this work.

> The 12- to 18-year-olds do understand and they know about sex, and they also know about HIV/AIDS because they are being taught at school. If only we could also teach them at home…but now, we're waiting for teachers at school to teach them for us while we can also talk to them as parents about this.
>
> (Key informant 2, female, 77 years)

Caregivers supported the view that other people may be better equipped for the conversations and were therefore better placed than themselves to do so, despite an acknowledgement that caregivers may be the best people to do this, if they have the capacity to do so.

> …not that I should focus on my household but just to be able to help them as a family member but when there are things that need direct attention, for it to be dealt with by this person who is not from our home.
>
> (Stakeholder 7, female, age unknown)

Interestingly, some respondents felt that discussions would be simpler for them if they were to have them with children other than their own. One mother spoke about how she found it easier to talk in a detailed way about sensitive topics with other adolescents rather than her own with whom she struggled:

> … I am the type that says things the way they are but now when I talk to my own, I don't know how can I put it but it is difficult. I summarise it "hey you are running after girls too soon" but when I talk to the one that is not my own it easy to tell them everything.
>
> (Key informant 3, female, 36 years)

This again suggests an acknowledgement of the importance of these conversations and a possible willingness to have them, but a lack of comfort when talking to one's own children. It could also indicate difficulty acknowledging early sexual activity among one's own children and the transgression of social norms this may signal.

Self-confidence in the ability to have conversations may be mediated through the gender of the adult-adolescent conversation. Some adults spoke about how they found it difficult to communicate with a young person of the opposite sex and related this to comfort and capacity to discuss the required issues.

> I think on this situation girls should talk with their mothers because mothers have experienced that these things have happened to them as well as males supposed to speak with their fathers because they know what they are going through.
>
> (Stakeholder 3, male, 20 years)

In general, there was a sense that fears about intergenerational conversations and the inability to have them was linked to the adults' own anxieties, along with concerns about feeling poorly equipped emotionally or in terms of having sufficient information.

Consistency with self-image

The ways in which the caregiver evaluated themselves and their own self-image appeared to inform the decision to have a conversation that is potentially at odds with their own self-image. Within this high HIV risk setting, the influence of adult caregivers and key informants' experiences of, and negotiations with, their own risk emerged as a potential barrier to having challenging conversations with adolescents. Being faced with the need to talk about sexual risk and HIV was highlighted as a potential personal problem for adults who felt that doing so might force them to acknowledge or address their own behaviour.

> You see maybe I am a mother, [the boyfriends] they come and go (change frequently). You see that. So, she does not know how to communicate regarding these things because she is not a good role model to children. She shies away from [talking about sex].

(Key informant 4, female, 40 years)

Being a good role model was particularly problematic in situations where adults might be HIV positive and faced with not only sensitive conversations about sex but also the possibility of needing to disclose their HIV status and facing potential stigma from their child:

> … when it comes to HIV, they still associate it with behaving badly, so the parent thinks that the child will think that my mother has this disease that means that she was not behaving well.

(Key informant 5, female, 34 years)

Adults' own risk and the need to have difficult conversations about sex were also raised when the child's HIV status may need to be disclosed.

> The person will find out [their child's HIV status] and be afraid to say. Maybe he or she will be afraid that the children will say, 'oh I got this from you.'

(Key informant 3, female, 36 years)

In addition, the HIV-status of the caregiver also impacted discussion about risk in adolescents.

> …maybe [the caregiver] thinks that there will be a change in behaviour of the children when she tells them that 'I am positive' because of the way HIV came on us people…it came as something like punishment, that if you do not behave well then you will be HIV positive.

(Key informant 5, female, 34 years)

This suggests that while difficult, some adults may want to discuss their own previous sexual health challenges as a means of stressing the importance of careful sexual health decision-making in their children. One respondent spoke personally about the fact that his experiences and personal choices when he was younger had facilitated conversation with his daughter:

> … because we also have taken the wrong decisions, even her I don't want her to fall for those things, you see that.

(Stakeholder 8, male, 36 years)

Discussion

This paper explored adult stakeholders and key informant perceptions of barriers to parents and caregivers having conversations with adolescents and young adults about sensitive issues, particularly sex, sexuality and risk associated with HIV (Vilanculos and Nduna 2017; Nilsson et al. 2020).

Despite recognition of the importance and advantages of intergenerational communication about sex, fear of encouraging sexual activity was highlighted as a key perceived disadvantage. However, evidence from the literature indicates that this belief is not based on fact and that intergenerational communication can have a protective effect (Poulsen et al.

2010; Wamoyi et al. 2010), mediating delays in sexual debut and encouraging adolescents and young people to adopt protective behavioural practices (Wamoyi et al. 2010; Bastien, Kajula, and Muhwezi 2011). Linked to this fear was an overwhelmingly negative framing of adolescents' and young people's sexual behaviour as a bad and unacceptable thing, underpinned by strong traditional and moral values and attitudes (Bhana, Crewe, and Aggleton 2019; Nilsson et al. 2020). Unlike previous findings from rural South Africa where this fear was linked to a moral dissonance between adults and children and a divide between moralistic traditional views and modern liberal views about sex (Nilsson et al. 2020), our findings seem rooted in fears of the perceived consequences associated with adolescent sex. Our results show for adults, adolescents' and young people's sexuality is linked to concern about the risk of HIV, STIs and pregnancy, and the fear that more open communication about sex may encourage sex and lead to consequences perceived as evidence of social norms transgression.

Like findings from other qualitative studies in South Africa, our study found that while inter-generational communication about sex and HIV may happen, the content of these conversations influences adolescents' and young people's SRH decision making and subsequent behaviour (Goodnight et al. 2014; Coetzee et al. 2014; Bastien, Kajula, and Muhwezi 2011). Existing evidence suggests that when they happen intergenerational conversations are likely to be very one-sided, moralistic and focused on abstinence, risk and the dangers of sex (Vilanculos and Nduna 2017). By seeing adolescents and young people as misbehaving, and not following instructions or guidance, adults may in some ways absolve themselves from blame or the responsibility for having more in-depth and nuanced conversations about risk and sexual health. Appropriate interventions to encourage more open, factual, and honest two-sided communication about sex, pleasure and SRH risk must address caregivers' denial and fear of their children's sexuality (Thurman et al. 2020; Kuo et al. 2016).

Challenging existing traditional norms and beliefs related to intergenerational communication about sex and HIV risk is particularly important given the high HIV incidence among younger age cohorts in sub-Saharan Africa (Human Sciences Research Council 2018). Young women and adolescent girls in this context are at risk of being in age disparate relationships, increasing their disempowerment and vulnerability to gender-based violence (UNAIDS 2022). They may not feel well equipped to negotiate safer sex and therefore face a burden in a context they are unprepared for. Adults cand play an important role in empowering young women with the knowledge and skills early on to help them make sexually responsible choices and/or provide a safe space in which adolescents can seek help. Thus, adults need to understand that adolescence and youth are transitional developmental periods in which preparation for adulthood and autonomy should be encouraged (Pettifor et al. 2018), and that sexual exploration is developmentally normative (Gevers et al. 2013). Interventions, such as those that are family based, should provide caregivers with the knowledge and skills to manage these conversations.

Respondents indicated that their own caregivers did not provide adequate information about SRH and were unwilling to have intergenerational conversations. This perpetuates poor communication cycles, entrenches traditional social norms concerning adolescents'

and young people's sexuality, and affects adults' perceived self-confidence. In this study., a perceived lack of capacity, including the skills and ability to overcome fears and embarrassment were barriers to honest conversations about SRH (Edwards et al. 2020). Gender norms that suggest that these discussions should be facilitated by a parent or caregiver of the same gender may also mean that some caregivers feel unable to have conversations with children or young people of the opposite sex. Adults need to see themselves as agents of change who can engage and educate young people. Concerns regarding discomfort associated with caregiver sex/gender could be alleviated by leveraging traditional norms, particularly related to raising children communally with othere family or community members identified to fulfil the task (Bhana, Crewe, and Aggleton 2019). These positive interactions could lead to changes in how adolescents and young people engage with their own children one day (Edwards et al. 2020).

Underpinning respondents' reactions and responses in this study was concern related to parents' and caregivers' self-image as responsible adults. This relates particularly to the high-risk context in which they live, and caregivers own perceived or real risk behaviour and SRH outcomes. This particularly novel finding links back to adults' perceived self-confidence and fears both on behalf of the younger generation and about having these challenging conversations. Where the caregiver is HIV positive, data highlight how this can act as an opportunity to frame HIV as a reality that exists in many family units in the South African context but may also lead to stigma and the perceived destruction of a caregiver's identity as responsible and sexually careful (van Rooyen et al. 2016). This was demonstrated via two narratives present in our data: first that caregivers living with HIV may perceive themselves (or may be viewed) as "bad" role models, which perpetuates HIV stigma; and second, that positive framing and presenting their HIV positive diagnosis to others provides an opportunity to educate and model positive SRH behaviour. Programmes and interventions to support intergenerational communication about these issues should be underpinned by education and information on how caregivers can navigate their own safety and perceived risk as well as positively frame their interactions about these issues with adolescents and young people.

Limitations

The nature of the sampling in this study means that adult perspectives were sought from both those with specific positions in the community (key informants) and from the general adult community members (stakeholders) sampled for their membership in families. The sampling was not purposive in selecting adults who were themselves parents or the caregivers of adolescents and young people and this latter form of sampling might have elicited more and possibly richer data. Despite this, many key informants and stakeholders were parents or caregivers and did reflect on their own personal experiences.

The small ungeneralisable sample and lack of purposive sampling means that it was not possible to disaggregate results by age, gender or geographical context. Future research should investigate these possible differences. Enquiry focused on the experiences and perceptions of the current caregivers of adolescents and young people would also help validate the results of this study making them more generalisable.

The research question guiding this work concerned the feasibility and acceptability of developing an FBHCT intervention and therefore issues addressed in this paper were not the primary focus of the data collection. Despite this, the data drawn upon were extensive and sufficient to draw some important and interesting conclusions

Conclusion

A promising advantage identified during the analysis was respondents' acknowledgement that intergenerational conversations could be useful in reducing adolescents' and young people's vulnerability to negative SRH outcomes and a generally expressed willingness to try and have these. However, respondents also noted how fear, discomfort and embarrassment, together with limited knowledge about sensitive topics and lack of self-confidence, made things difficult. The results highlight the need for future research to design programmes that equip caregivers with the confidence and ability to have conversations about sex and HIV to overcome these barriers. There also needs to be a shift in the negative framing of adolescents, young people and sex. Uniquely, the study highlights that in high prevalence contexts adults are forced to grapple with their own personal risks, behaviours and fears when it comes to intergenerational discussion about sex. Where adults are negotiating their own complex sexual relationships, risk and in some cases HIV status, interventions should be designed to address their needs and provide support and skills to be able to have intergenerational communication about sex and HIV.

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References

Abdool Karim Quarraisha, Baxter Cheryl, and Birx Deborah. 2017. "Prevention of HIV in Adolescent Girls and Young Women: Key to an AIDS-Free Generation." JAIDS Journal of Acquired Immune Deficiency Syndromes 75 (1): S17–S26. doi:10.1097/QAI.0000000000001316. [PubMed: 28398993]

Bastien S, Kajula Lj, and Muhwezi Ww. 2011. "A Review of Studies of Parent-Child Communication about Sexuality and HIV/AIDS in Sub-Saharan Africa." Reproductive Health 8 (1). BioMed Central Ltd: 25. doi:10.1186/1742-4755-8-25. [PubMed: 21943095]

Bekker Linda-Gail, and Hosek Sybil. 2015. "HIV and Adolescents: Focus on Young Key Populations." Journal of the International AIDS Society 18 (2(Suppl 1)): 20076. doi:10.7448/IAS.18.2.20076.

Bhana Arvin, and Bachoo Shaneel. 2011. "The Determinants of Family Resilience among Families in Low- and Middle-Income Contexts: A Systematic Literature Review." South African Journal of Psychology 41 (2): 131–139. doi:10.1177/008124631104100202.

Bhana Deevia, Crewe Mary, and Aggleton Peter. 2019. "Sex, Sexuality and Education in South Africa." Sex Education 19 (4): 361–370. doi:10.1080/14681811.2019.1620008.

Braun Virginia, and Clarke Victoria. 2006. "Using Thematic Analysis in Psychology." Qualitative Research in Psychology. 3 (2): 77–101. doi:10.1191/1478088706qp063oa.

Christofides Nicola J, Jewkes Rachel K, Dunkle Kristin L, McCarty Frances, Jama Shai Nwabisa, Nduna Mzikazi, and Sterk Claire. 2014. "Risk Factors for Unplanned and Unwanted Teenage

Pregnancies Occurring over Two Years of Follow-up among a Cohort of Young South African Women." Global Health Action 7 (August): 23719. [PubMed: 25150027]

Cluver Lucie Dale, Orkin Frederick Mark, Meinck Franziska, Boyes Mark Edward, and Sherr Lorraine. 2016. "Structural Drivers and Social Protection: Mechanisms of HIV Risk and HIV Prevention for South African Adolescents." Journal of the International AIDS Society 19 (1): 20646. doi:10.7448/IAS.19.1.20646. [PubMed: 27086838]

Coetzee Jenny, Dietrich Janan, Otwombe Kennedy, Nkala Busi, Khunwane Mamakiri, van der Watt Martin, Sikkema Kathleen J., and Gray Glenda E. 2014. "Predictors of Parent-Adolescent Communication in Post-Apartheid South Africa: A Protective Factor in Adolescent Sexual and Reproductive Health." Journal of Adolescence 37 (3): 313–324. doi:10.1016/j.adolescence.2014.01.006. [PubMed: 24636691]

Dellar Rachael C, Dlamini Sarah, and Karim Quarraisha Abdool. 2015. "Adolescent Girls and Young Women: Key Populations for HIV Epidemic Control." Journal of the International AIDS Society 18 (2(Suppl 1)): 19408. doi:10.7448/IAS.18.2.19408. [PubMed: 25724504]

Edwards Taygen, Mkwanazi Ntombizodumo, Mitchell Joanie, Bland Ruth M., and Rochat Tamsen J.. 2020. "Empowering Parents for Human Immunodeficiency Virus Prevention: Health and Sex Education at Home." Southern African Journal of HIV Medicine 21 (1). doi:10.4102/sajhivmed.v21i1.970.

Fishbein Martin, Triandis Harry C, Kanfer Frederick H, Becker Marshall, Middlestadt Susan E, and Eichler Anita. 2001. "Factors Influencing Behavior and Behavior Change." In Handbook of Health Psychology, edited by Baum Andrew, Revenson Tracey A. and Singer Jerome E., 3–17. New York: Psychology Press. doi:10.4324/9781410600073.

Gevers Aník, Mathews Cathy, Cupp Pam, Russell Marcia, and Jewkes Rachel. 2013. "Illegal yet Developmentally Normative: A Descriptive Analysis of Young, Urban Adolescents' Dating and Sexual Behaviour in Cape Town, South Africa." BMC International Health and Human Rights 13 (1): 31. doi:10.1186/1472-698X-13-31. [PubMed: 23841894]

Goodnight Bradley, Salama Christina, Grim Elizabeth C, Anthony Elizabeth R, Armistead Lisa, Cook Sarah L, Skinner Donald, and Toefy Yoesrie. 2014. "Perceived Control and Communication about Sex: A Study of South African Families." African Journal of AIDS Research 13 (1): 31–36. doi:10.2989/16085906.2014.892016. [PubMed: 25174513]

Grossman Jennifer M, Charmaraman Linda, and Erkut Sumru. 2016. "Do as I Say, Not as I Did." Journal of Family Issues 37 (2): 177–197. doi:10.1177/0192513X13511955.

Guilamo-Ramos Vincent, Jaccard James, Dittus Patricia, and Collins Sarah. 2008. "Parent-Adolescent Communication About Sexual Intercourse: An Analysis of Maternal Reluctance to Communicate." Health Psychology 27 (6): 760–769. doi:10.1037/a0013833. [PubMed: 19025272]

Human Sciences Research Council. 2018. HIV Impact Assessment Summary: The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Vol. 2017.

Kharsany Ayesha B M, Cawood Cherie, Khanyile David, Lewis Lara, Grobler Anneke, Puren Adrian, Govender Kaymarlin, et al. 2018. "Community-Based HIV Prevalence in KwaZulu-Natal, South Africa: Results of a Cross-Sectional Household Survey." The Lancet. HIV 5 (8): e427–e437. doi:10.1016/S2352-3018(18)30104-8. [PubMed: 30021700]

Kharsany Ayesha Bm, Frohlich Janet a, Yende-Zuma Nonhlanhla, Mahlase Gethwana, Samsunder Natasha, Dellar Rachael C, Zuma-Mkhonza May, Abdool Karim Salim S, and Abdool Karim Quarraisha. 2015. "Trends in HIV Prevalence in Pregnant Women in Rural South Africa." JAIDS Journal of Acquired Immune Deficiency Syndromes 70 (3): 289–295. doi:10.1097/QAI.0000000000000761. [PubMed: 26186507]

Knight Lucia C., Van Rooyen Heidi, Humphries Hilton, Barnabas Ruanne V., and Celum Connie. 2015. "Empowering Patients to Link to Care and Treatment: Qualitative Findings about the Role of a Home-Based HIV Counselling, Testing and Linkage Intervention in South Africa." AIDS Care 27 (9): 1162–1167. doi:10.1080/09540121.2015.1035633. [PubMed: 25923366]

Kuo Caroline, Atujuna Millicent, Mathews Catherine, Stein Dan J., Hoare Jacqueline, Beardslee William, Operario Don, Cluver Lucie, and Brown Larry K.. 2016. "Developing Family Interventions for Adolescent HIV Prevention in South Africa." AIDS Care 28 (sup1): 106–110. doi:10.1080/09540121.2016.1146396. [PubMed: 26916841]

Marhefka Stephanie L., Mellins Claude Ann, Brackis-Cott Elizabeth, Dolezal Curtis, and Ehrhardt Anke A.. 2009. “Perceptions of Adolescents’ Sexual Behavior Among Mothers Living with and Without HIV: Does Dyadic Sex Communication Matter?” Archives of Sexual Behavior 38 (5): 788–801. doi:10.1007/s10508-007-9284-y. [PubMed: 18188687]

Mkwanazi Ntombizodumo B., Rochat Tamsen J., and Bland Ruth M.. 2017. “The Amagugu Intervention: A Qualitative Investigation into Maternal Experiences and Perspectives of a Maternal HIV Disclosure Support Intervention in Rural South Africa.” Health Policy and Planning 32 (9). Oxford Academic: 1231–1240. doi:10.1093/heapol/czx056. [PubMed: 28981662]

Namisi Francis Sande, Aarø Leif Edvard, Kaaya Sylvia, Onya Hans E, Wubs Annegreet, and Mathews Catherine. 2013. “Condom Use and Sexuality Communication with Adults: A Study among High School Students in South Africa and Tanzania.” BMC Public Health 13 (1): 874. doi:10.1186/1471-2458-13-874. [PubMed: 24053420]

Namisi Francis Sande, Flisher Alan J, Overland Simon, Bastien Sheri, Onya Hans, Kaaya Sylvia, and Aarø Leif Edvard. 2009. “Sociodemographic 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 37 Suppl 2 (July 2007): 65–74. doi:10.1177/1403494808086986. [PubMed: 19493983]

Nilsson Bo, Edin Kerstin, Kinsman John, Kahn Kathleen, and Norris Shane A.. 2020. “Obstacles to Intergenerational Communication in Caregivers’ Narratives Regarding Young People’s Sexual and Reproductive Health and Lifestyle in Rural South Africa.” BMC Public Health 20 (1): 791. doi:10.1186/s12889-020-08780-9. [PubMed: 32460806]

Patton George C., Sawyer Susan M., Santelli John S., Ross David A., Afifi Rima, Allen Nicholas B., Arora Monika, et al. 2016. “Our Future: A Lancet Commission on Adolescent Health and Wellbeing.” Lancet 387 (10036): 2423–2478. doi:10.1016/S0140-6736(16)00579-1. [PubMed: 27174304]

Pettifor Audrey, Bekker Linda-gail, Hosek Sybil, DiClemente Ralph, Rosenberg Molly, Bull Sheana S, Allison Susannah, Delany-Moretlwe Sinead, Kapogiannis Bill G, and Cowan Frances. 2013. “Preventing HIV Among Young People.” JAIDS Journal of Acquired Immune Deficiency Syndromes 63 (Supplement 2): S155–S160. doi:10.1097/QAI.0b013e31829871fb. [PubMed: 23764629]

Pettifor Audrey, Stoner Marie, Pike Carey, and Bekker Linda Gail. 2018. “Adolescent Lives Matter: Preventing HIV in Adolescents.” Current Opinion in HIV and AIDS 13 (3): 265–273. doi:10.1097/COH.0000000000000453. [PubMed: 29528850]

Poulsen Melissa N., Miller Kim S., Lin Carol, Fasula Amy, Vandenhoudt Hilde, Wyckoff Sarah C., Ochura Juliet, Obong’o Christopher O., and Forehand Rex. 2010. “Factors Associated with Parent–Child Communication About HIV/AIDS in the United States and Kenya: A Cross-Cultural Comparison.” AIDS & Behavior 14 (5): 1083–1094. doi:10.1007/s10461-009-9612-4. [PubMed: 19763811]

Shisana O, T Rehle L Simbayi C, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, et al. 2009. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008 A Turning Tide Among Teenagers? Cape Town: HSRC Press.

Soon Christine N., Kaida Angela, Nkala Busi, Dietrich Janan, Cescon Angela, Gray Glenda, and Miller Cari L.. 2013. “Adolescent Experiences of HIV and Sexual Health Communication with Parents and Caregivers in Soweto, South Africa.” SAHARA-J: Journal of Social Aspects of HIV/AIDS 10 (3–4): 163–169. doi:10.1080/17290376.2014.902769.

Thurman Tonya R., Nice Johanna, Visser Maretha, and Luckett Brian G.. 2020. “Pathways to Sexual Health Communication between Adolescent Girls and Their Female Caregivers Participating in a Structured HIV Prevention Intervention in South Africa.” Social Science & Medicine 260: 113168. doi:10.1016/j.socscimed.2020.113168. [PubMed: 32717662]

UNAIDS. 2021. Young People and HIV. Geneva: UNAIDS.

UNAIDS. 2022. Dangerous Inequalities: World AIDS Day Report. Geneva: UNAIDS. http://www.wipo.int/amc/en/mediation/rules.

van Rooyen Heidi, Barnabas Ruanne V, Baeten Jared M, Phakathi Zipho, Joseph Philip, Krows Meighan, Hong Ting, Murnane Pamela M, Hughes James, and Celum Connie. 2013. “High HIV Testing Uptake and Linkage to Care in a Novel Program of Home-Based HIV Counseling and

Testing with Facilitated Referral in KwaZulu-Natal, South Africa." Journal of Acquired Immune Deficiency Syndrome 64 (1): 1–8. doi:10.1097/QAI.0b013e31829b567d.

van Rooyen Heidi, Essack Zaynab, Rochat Tamsen, Wight Daniel, Knight Lucia, Bland Ruth, and Celum Connie. 2016. "Taking HIV Testing to Families: Designing a Family-Based Intervention to Facilitate HIV Testing, Disclosure, and Intergenerational Communication." Frontiers in Public Health 4: 154. doi:10.3389/fpubh.2016.00154. [PubMed: 27547750]

Vilanculos Esmeralda, and Nduna Mzikazi. 2017. "'The Child Can Remember Your Voice': Parent–Child Communication about Sexuality in the South African Context." African Journal of AIDS Research 16 (1): 81–89. doi:10.2989/16085906.2017.1302486. [PubMed: 28367742]

Wamoyi J, A Fenwick, 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 7 (6): 1–18. doi:10.1186/1742-4755-7-6. [PubMed: 20429906]

Whitaker Daniel J., Miller Kim S., May David C., and Levin Martin L.. 1999. "Teenage Partners' Communication About Sexual Risk and Condom Use: The Importance of Parent-Teenager Discussions." Family Planning Perspectives 31 (3): 117. doi:10.2307/2991693. [PubMed: 10379427]

Zaidi Jaffer, Grapsa Erofili, Tanser Frank, Newell Marie-Louise, and Bärnighausen Till. 2013. "Dramatic Increase in HIV Prevalence after Scale-up of Antiretroviral Treatment." AIDS 27 (14): 2301–2305. doi:10.1097/QAD.0b013e328362e832. [PubMed: 23669155]

Table 1:

Study ample demographics

		Stakeholders (N=20)	Key Informants* (N=20)
Age	Mean age (range) in years	37 (26–63) Men: 38.3 (26–63) Women: 35.3 (28–49)	40.5 (24–77)
	Median Age	36	35.5
		% (n/N)	**% (n/N)**
Sex	Male	60.0 (12/20)	
	Female	40.0 (8/20)	
Education	Secondary %(n/N)	80.0 (8/10)	23.5 (4/17)
	Tertiary %(n/N)	20.0 (2/10)	76.5 (13/17)

* Sex data was not collected for the key informants