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A MODEL TO PROMOTE DIALOGUE ABOUT SEXUAL HEALTH BETWEEN TEENAGERS AND PARENTS/TEACHERS IN VHEMBE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA

by

Rachel Tsakani Lebese

Submitted in fulfilment of the requirements for the degree of

Doctor Curationis

Department of Advanced Nursing Science

University of Venda

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DECLARATION

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DEDICATION

This thesis is dedicated to:

- my late brothers, Gabriel Shihenya and Michael Khongoteri Nkondo.
- my late parents, Abert Ephraim and Louisa Lufuno Nkondo who supported me throughout my study but did not live to see it completed.
- My lovely son-in-law, Henneck Bill, who departed during the critical time of my finalising this study.

Special gratitude goes to my loving husband, Silas Lebese (Munyamatsi), my son Kulani and daughter-in-law Nkhensai Snikiwe Lebese, and my daughters Vuyisani Bill and Thembani. Thank you for your encouragement. I love you so much!

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ABSTRACT

Dialogue with teenagers about sexual health is of vital importance worldwide especially because of the HIV/AIDS pandemic, increased rates of sexually transmitted infections (STIs), high percentage of teenage pregnancies and parenthood and decreased levels of the use of contraceptives among the youth. These problems have also prompted governments, communities and individuals to introduce legislation, programmes and models of health promotion related to sexual health. The programmes and models that are available focus mainly on the prevention of disease, promotion of health, caring, nursing, behaviour change and community development. None of these programmes and models focused on how dialogue about sexual health between teenagers and parents/teachers could be promoted.

The report presented in this study unravels the different perspectives teenagers, parents and teachers have on sexual health and the ripple effect lack of or inadequate knowledge has on the sexual health of future generations, using Vhembe district as a point of reference.

The overall aim of this study was to develop a model to promote dialogue about sexual health among teenagers, parents and teachers in Vhembe District of Limpopo Province. The researcher had prolonged engagement with parents, teachers and teenagers.

Theory generation and a qualitative, exploratory, descriptive and contextual study were conducted. The study was conducted in two phases. During the first phase experiences of teenagers, parents and teachers in relation to sexual health dialogue were explored through focus-group and in-depth individual interviews. The researcher also used main questions as point of departure and more questions emanated from the discussion. Participants narrated their experiences and these experiences were reflected in words. Quotations were used to

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emphasize various aspects that were described. The results indicated that all stakeholders lacked the skills to engage with each other in a dialogue about sexual health. Culture and lack of knowledge were the main reasons for lack of dialogue about sexual health among teenagers, parents and teachers. Literature review was done to support the findings from the interviews.

The second phase involved the development of a model to promote dialogue about sexual health among teenagers, parents and teachers. The first step was to conduct a concept analysis of the concept "dialogue". The results of the concept analysis formed the basis for model development. The framework of Dickoff, James and Wiedenbach (1968:423) and Chinn and Kramer (1999:107-25) was used to classify, develop and evaluate the model.

The study recommendations were that cultural values, meanings and beliefs needed to be clarified by all participants for them to freely engage each other in a dialogue about sexual health. Active participation and collaboration by all stakeholders were necessary if meaningful dialogue was to be achieved. It would also be necessary to adapt the model from time to time so that it suited the prevailing climate.

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LIST OF ABBREVIATIONS

STIs	:	Sexually transmitted infections.
HIV	:	Human Immunodeficiency Virus.
AIDS	:	Acquired Immunodeficiency Syndrome.
WHO	:	World Health Organisation.
DENOSA	:	Democratic nursing of South Africa.

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ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Dialogue about sexual health with teenagers is of vital importance worldwide especially because of the HIV/AIDS pandemic, increased rates of sexually transmitted infections (STIs), the high percentage of teenage pregnancies and parenthood and decreased levels of contraceptive use among the youth. These problems have also prompted governments, communities and individuals to introduce legislation, programmes and models of health promotion related to sexual health. The programmes and models that were developed focused mainly on the prevention of disease, promotion of health, caring, nursing, behaviour change and community development. None of these programmes or models focused on how dialogue about sexual health could be promoted between teenagers and parents/teachers.

Teenagers are social beings with social needs, and parents and teachers have the responsibility of giving teenagers information about sexual health. This information, if provided, will assist teenagers to address their sexual needs. However, cultural values and norms may influence how parents/teachers communicate issues of sexual health to teenagers and most of the time cultural values and norms tend to inhibit this communication. This study sought to develop a model to promote dialogue about sexual health between teenagers and parents/teachers. The study was conducted in the rural villages of Vhembe district in Limpopo Province, South Africa.

A qualitative, explorative, descriptive, contextual and theory-generating study was conducted. Chapter one provides an orientation to the study, the

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background and rationale, problem statement, purpose and methodology of the study.

1.2 BACKGROUND AND RATIONALE

The reluctance of the populace to openly confront issues regarding sexuality has had a number of untoward effects. This social inhibition stands in the way of communication between parents and children and between sex partners, resulting in poor development and implementation of effective sexual health and HIV/AIDS education programmes (Wulf, 2004:2). Reluctance also perpetuates misconceptions about all sexual risks and ignorance about the consequences of taking risks and may encourage high-risk sexual practices. The silence that is experienced within communities about sexual health is also experienced within families and schools (Wulf, 2004:2).

Most parents and teachers talk to their children by giving orders or correcting them. This approach makes children learn to give orders and criticise and not to spend time in non-threatening conversation that helps people to understand one another (Wulf, 2004:2). Many children are said not to remember conversations with parents that were non-threatening, where their parents were not telling them what to do or what they did wrong. Parents are said not to ask children their opinion (Wulf, 2004:2). This indicates that there is a need for parents to engage their children in dialogue, where both parties contribute equally to the conversation since dialogue is valuable in helping family members understand and appreciate one another.

The lack of dialogue about sexual health between teenagers and parents/ teachers, especially in rural areas, is a matter of concern especially because of the HIV/AIDS epidemic, and the prevalence of sexually transmitted infections (STIs). Teenage pregnancy is another major problem as the prevalence is escalating each year (McCormick, 2004:4). Globally it is estimated that over 33

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million cases of sexually transmitted infections occur each year. Of this number more than 50% are reported among the youth (McCormick, 2004:4). Teenage pregnancy is also high worldwide, with about one million teenagers becoming pregnant each month, and 33% of them terminating the pregnancy (McCormick, 2004:4). The high number of teenage pregnancies may be attributed to the fact that teenagers have little access to free and confidential family planning, little communication with their parents and lack of knowledge regarding contraception on the part of parents. Low levels of education might also be the cause of high teenage pregnancy rates in the rural areas (Hopkins, 2004:16). In the study conducted by Maja (2007:75) about the involvement of males in promoting reproductive health, a significant number of males were found to have knowledge about contraceptives including condoms, but this knowledge did not influence the use of these methods to prevent unplanned and unwanted pregnancies. The following reasons were given for not using condoms: partner trust, diminished sexual satisfaction, condom breakage and lack of skill in using the condoms (Maja 2007:75). These parameters are espoused, within a broader context, as reflected below:

- Characteristics of teenage stage.
- Teenagers and their sexual health.
- Health services and teenage sexual practices.
- Dialogue.
- Models.
- Statistics related to reproductive health.

1.2.1 Characteristics of teenage stage

Gouws and Kruger (1994:113) and Morris (1988:408) describe this stage as a stage of "storm and stress"; and Mamwenda (1995:25) describes it as a stage for search and consolidation of identity which is characterised by great physical, social, emotional, physiological and psychological change. This stage often makes teenagers anxious, unbalanced and stressed because of the changes that

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occur. Therefore, when these changes occ[illegible] teenagers need to have good communication with parents and teachers in order to engage in dialogue about their sexuality. As teenagers try to find their own way, it would be beneficial if dialogue were well established between teenagers and parents/teachers for a better understanding of the intricacies involved in dealing with sexual issues.

During this phase reaction to family and school values is challenged as young people work out new ways of relating to the world as adults (Gouws & Kruger, 1994:113). Family influences diminish as teenagers begin to spend more time with their peers. Their relationships with children of their age group assume increasing importance, as relations with peers are highly significant for self-concept formation and self-actualization. During this phase teenagers are mostly in tertiary institutions and it has been noted that University life was said to gives this teenagers and opportunity to experiment and be adventurous. Experimentation was said to be in a form of sex, alcohol and drugs during University life (South African Regional University Association:19). Becoming emancipated and gradually loosening the ties of parental authority are major developmental tasks for the teenager. It is therefore important at this stage to ensure that teenagers have correct information so that when they share information they will have the correct information and not mislead each other. If dialogue is present between teenagers and parents/teachers, the teenagers can always engage parents/teachers in verifying information that they get from their peers. The following are the three objectives that can be pursued in the process of becoming independent (Gouws & Kruger, 1994:113):

- **Behavioural autonomy**

In pursuing this objective teenagers aspire to making their own decisions about their behaviour and actions. They like to decide how to spend their money and how to dress (Gouws & Kruger, 1994:113). Therefore teenagers can now also decide when to have a relationship with a person of the opposite sex and how far to take this relationship in terms of sexual intercourse and the use of protection

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and contraceptives. It is therefore critical that at this stage the teenager be given enough information about sexual health to enable him/her to make informed decisions and if dialogue is well established, parents and teachers can also be used as a source of information.

- **Emotional autonomy**

Teenagers mostly strive to be self-reliant, to control and accept responsibility (Gouws & Kruger, 1994:113). Emotional autonomy has not yet been reached and teenagers may get emotionally involved and tend to make hasty, uninformed decisions about their sexuality. Hence the importance of dialogue about sexual health at this stage and again parents and teachers will be there to assist since they will be talking to each other.

- **Moral and value autonomy**

Teenagers want to develop their own value systems to regulate their behaviour. They may even question and evaluate the parents' moral standards and values although parents' value systems usually serve as guidelines (Gouws & Kruger, 1994:113). As family influence on the teenagers decreases and autonomy sets in, parental advice is seen as old-fashioned and teenagers prefer to listen to their peers. Seeking autonomy may lead to uninformed decision-making that may often expose teenagers to unhealthy sexual behaviour and unintended pregnancy. It is therefore important for parents/teachers to promote dialogue between themselves and teenagers to empower them with knowledge that can assist them to make informed decisions.

1.2.2 Teenagers and their sexual health

The percentage of sexual activity of American teenagers has increased over the years. During the survey conducted in 1998, 56% of girls and 73% of boys were reported to have had sexual intercourse before the age of 18 years (Cebekhulu, Bekisiska & Erulkar 2001:10). Each year approximately one million young women aged 15-19 become pregnant and the vast majority of these pregnancies are unplanned (Cebekhulu, *et al.*, 2001:10). In South Africa, boys initiate sex at an

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earlier age than girls. The median age at first sex for boys is 16.5 years and for girls 17.5 years (Cebekhulu, *et al.,* 2001:10). Literature on studies of the sexual behaviour of African students *indicates* that 10% to 24% of black girls and 18% to 69% of black boys had already had sexual intercourse. 75% of grade ten to twelve learners were also found to be sexually active with 30% of them having had an average of three partners and nine sexual encounters the previous year (Grobler, Botma, Jacobs & Nel, 2007:36). It has also been noted with concern from International Women's Health Coalition (2008:3); UNAIDS (2005:6); Marcus, (2002:27) that female students (teenagers) at tertiary institutions prefer sexual relations with older men who presumably have multiple partners. In such a relationship the female teenager is said to be inexperienced in negotiating safe sex or avoiding forced sex.

The gender context is determined according to what is culturally defined as being feminine or masculine in sexual relationships. This unequal division of power was said to an influence in sexual health behaviour (Ferrante, 2003:314; Finchlescu, 2002:109). Findings from research also demonstrate how gender inequality may impact negatively on the vulnerability of females. The cultural prescription on females to be submissive, obedience, sexual subordinates and willingness makes women in particular to become more vulnerable to HIV infections (Van den Berg & Van Rooyen, 2007:208). An estimated 74% of involuntary sexual activities were also reported of girls younger than 14 years and 13% of 15 to 19-year-old females reported that they had been sexually abused (Kalmus, Davidson, Cohall, Laragus & Cassell, 2003:87). Sexual abuse has also been reported in males. In some studies about 25% of men reported having been sexually abused before the age of 13 years (Kalmus, *et al.*, 2003:87). In early 2002, about 40 men revealed having been sexually abused by Roman Catholic priests as children and teenagers (Adams & East, 2002:202). These studies and revelations exposed the vulnerability of teenagers and children to sexually transmitted infections including HIV/AIDS, teenage pregnancy and teenage parenthood, specifically because a person in a position of authority could force

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them to do things against their will, and their ability to negotiate sex was weak (Adams & East, 2002:202). Sexual health dialogue would improve the knowledge of teenagers about issues of sex and help them to open up and report forced sex as they would be informed about the procedures to be followed. It would also assist them to identify actions that could lead to sexual abuse as they would have been given information about it.

In South Africa different studies have also revealed that many of the girls were forced to have sex against their will or raped (Amoko, Buga, & Ncayiyani, 1996: 528; Jewkes, Maforah, Jordaan & Vundulu, 2001:734). Sexual health dialogue would assist teenagers to identify actions that may lead to their being molested or raped as they would have information about how to identify people who wanted to misuse them. If teenagers were able to talk about their sexual health with their parents/teachers, they would also be able to open up if they were raped and treatment would be initiated.

Sexually active teenagers had a tendency of entering into short-lived relationships. Reports also showed that sexually active teenagers had had four or more successive sexual partners (Dickson-Tetteth & Foy, 2000:3). In South Africa the majority of teenagers engaged in sexual activities in their early teens. Approximately 11 million episodes of STIs occurred each year, with over 50% of infections occurring among the youth (Dickson-Tetteth & Foy, 2000:3).

Teenagers were mostly reported to have been sexually involved for less than a year before visiting the health provider, while few visited the health provider a year or more after having started engaging in sexual intercourse. These delays were normally caused by lack of information about services available, fear of adult disapproval, unfriendly health services and vague concerns about the side effects of contraception (Dickson, *et al.*, 2000:3). Peers were reported to be the predominant source of information regarding visiting family planning services and issues of sexuality, whereas parents and teachers were ranked lower (Mfono,

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1998:182), highlighting the need to develop new ways of promoting dialogue about sexual health among them. Dialogue could also unravel the problems that teenagers may encounter when trying to access health care and family planning services as well as strategies for remedial action.

According to research conducted in Australia, the United Kingdom and the United States of America, the use of contraception and deciding to fall pregnant by teenagers are influenced by a variety of issues, for example:

- the availability of contraception
- pressure from the partner not to use the method
- the need to feel wanted
- the desire to have a child
- the ability to communicate effectively
- the influence of drugs and alcohol
- the influence of passion, trust, love and commitment (Ingham & Stone, 2002:192).

In Britain, low socio-economic status, poor educational achievement and peer influences are risk factors for teenage parenthood (Ingham & Stone, 2002:191). The social norms of individuals or groups with whom the adolescent is connected or with whom they interact affect the adolescent's sexual behaviour. If a teenager has parents, friends and a partner with high moral values, he/she is more likely to delay sexual intercourse and pregnancy than an adolescent who has parents, friends and a partner with low morals (Kirby, 2001:277).

1.2.3 Health services and teenagers' sexual practices

The teenagers in South Africa were often omitted from the reproductive health care system due to lack of accessibility, unfriendly health services or unavailability of resources (Kempner, 2003:4). The emphasis on sexual health was often placed on married couples as the youth were expected to bring their

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parents' consent when in need of family planning services (Kempner, 2003:4). The health personnel were often unfriendly towards teenagers trying to access family planning services. Unfriendly service could to a large extent have contributed to the lack of correct information dissemination to teenagers at a critical time of their development. Absence of parental approval and the attitude of health personnel may also have contributed to teenagers' ignorance on issues of sexual health and impacted on the rate of STIs, teenage pregnancy and teenage parenthood. These restrictions and unfriendly health services might also have contributed to low levels of dialogue among teenagers and parents/teachers.

Sexual health information from these services is often insufficient. The focus on sexual health education is sometimes missed in the different health care settings like STI and family planning clinics. In the STI clinic the top priority is treatment and prevention of further transmission and in family planning clinics the focus is on the prevention of unplanned pregnancy with different methods and these influence the extent to which teenagers are educated about issues of sexual health when they visit the health service (Kempner, 2003:5). In the study conducted by Mavundla and Williams (1999:62) it was also identified that health education by health professionals had not been of help to teenagers, although health education was supposed to address basic needs. This might be an indication that the available services may not be reaching the teenagers as expected as professionals are often too busy to have a fruitful conversation with teenagers or conduct effective health education. Research by MacNair-Semands, Cody and Simono (1997:734) indicate that there was a significant use of condoms and discussing safer sex with partners by college students after having been exposed to HIV and AIDS education. It is therefore important to strengthen the role of parents and teachers in educating teenagers about sexual health.

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Religious involvement of teenagers was also found to have an influence on teenagers' sexual behaviour (Kalmus, Davidson, Cohall, Laragus & Cassel, 2003:89). Teenagers who are involved in religious activities are said to be more likely to postpone high-risk sexual behaviour (Kalmus *et al.*, 2003:89). Sexual risk behaviours are also related to attitude and behavioural skills. Adolescents' attitude towards practising contraception, using condoms and becoming pregnant predict the likelihood that each will occur. Their attitude towards pregnancy affects the likelihood that they will practice contraception and use condoms (Kalmus *et al.*, 2003:89). As the church is another area where teenagers are found in large numbers, the church elders who are also parents can use the same model to promote dialogue about sexual health in youth group meetings and advise them to postpone sexual intercourse or provide them with advice on the use of condoms.

Cultural beliefs and attitudes also dominate the way of life in the rural areas, and influence how teenagers relate to their parents, teachers and elders in the community. Values and norms guide what can be discussed among different age groups (Mfono, 1998:124). The extent to which issues of sexual health ar e discussed among different age groups is also determined by their cultural practices. Mfono (1998:36) mentions the difficulties that parents experience in communicating with their children about sexual matters. Parents usually do not see their children as grown-ups who are ready to discuss or contemplate sexual involvement. It has also been identified that the information that parents give to their children regarding sexual matters is inadequate to equip teenagers to face pressures with regard to sexual matters (Mavundla & Williams, 1999:62).

The study conducted by Kempner (2003:5) revealed that adults were uncomfortable about adolescent sexuality and often tried to ignore the fact that their teenagers were sexual beings engaging in sexual behaviour. Teachers were reported to be experiencing discomfort during sexuality education in the classroom as sexuality education is viewed as encouraging sexual behaviour and

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experimentation. At the same time adults were said to be aware of high levels of STI and pregnancy among teenagers as well as the need to intensify sexuality education (Kempner, 2003:6).

Cultural practices impact to a certain extent on the degree to which information about sexual health is communicated to teenagers, especially in rural areas. Initiation schools do not give teenagers enough information about sexual health as most of the time, teenagers are expected to recite poems and sing songs (Mfono, 1998:124). It has also bee emphasised that knowledge alone is not enough to prevent HIV infections and that factors such as gender and culture should be considered (Levine & Ross, 2002:90). Hence it is necessary to develop a model that will assist parents/teachers to promote dialogue about issues of sexual health with teenagers, as knowledge about sexual health is vital in the prevention of sexual health problems.

Ingham and Stone (2002:51) describe how important it might be for parents to equip their children with skills to communicate and interact effectively with future sexual partners. Parents' willingness and ability to discuss sexuality openly and portray sex in a positive light throughout their children's lives appear to impact on both competence and confidence in their children (Ingham & Stone, 2002:55). In contrast, reluctance to talk about sexual matters and embarrassment in doing so may reinforce negative messages of unacceptability and prohibition (Ingham & Stone, 2002:56).

There is evidence that information about sexual health does not reach teenagers successfully and equally. In South Africa before 1994 the different houses of parliament that existed had different approaches to sex education in schools. The House of Assembly (for whites) had started to teach about sexuality, the House of Representatives (coloured) was starting, the House of Delegates (Indians) still had some cultural and religious problems. The blacks were excluded, yet they formed the majority of the population (Van der Elst, 1993:13). This meant that

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sex education in black schools did not take place, leaving black teenagers with little or no information about sexuality. Consequently, the problem is a legacy issue for blacks. This implies that they may not have had enough information or they might be afraid to initiate dialogue as it might be new to them.

In a study conducted in South Africa it was identified that the teaching of life skills in the formal classroom setting was absent, especially in the townships where HIV infections were high. Teachers were also reported to be negative towards the teaching of life skills in schools as they were often found to be the culprits who practised unsafe sexual activities with school children (James, 2002:176). The study also indicated a low level of research on the effects of programmes that were used to combat the spread of HIV/AIDS. This made it difficult for the people implementing the programme to have a sense of how and to what extent they were succeeding in influencing sexually-related behaviours (James, 2002:176).

1.2.4 Dialogue

Bohm, Factor and Garrett (1992:1) indicate that men and women are able to interact with each other, but their ability to talk together about subjects that matter to them most is difficult as it often leads to dispute, division and even violence. This indicates a defect in the processes of human thought and it also indicates the extent to which communication is difficult between people (Bohm, et al., 1992:1).

It is therefore important to use dialogue as it allows people to explore individual and collective pre-suppositions, ideas, beliefs and feelings that subtly control interactions without violence. Dialogue is also necessary because it enables individuals to understand each other and have fruitful discussions with both parties contributing and gaining from the discussions. Dialogue can best be used in the education of teenagers about issues of sexual health, as adults will not be forcing their views on the teenagers. Rassieur (1997:6) describes seven features

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that characterise successful dialogue. The characteristics describe essential attitudes and behaviours of participants, as well as characteristics of the dialogical process itself. The eight characteristics are the following:

- attentive and respectful valuing of the other;
- valuing the encounter and the relationship;
- being open to personal change;
- accepting the risks of self-disclosure;
- affirming the discipline of dialogue;
- seeking and communicating understanding;
- observing the boundaries of the relationship; and
- recognising the spiritual dimension of dialogue (Rassieur, 1997:6).

Based on the characteristics mentioned above one can assume that dialogue between teenagers and parents/teachers can easily be promoted if the discussions display the same characteristics.

1.2.5 Models

There are different models that have been designed to promote dialogue and describe how communication and group interaction takes place. Of all the models that the researcher consulted and studied there were none that had been designed to promote dialogue. The Population Health Model (Fano, Flynn & Tyminski, 2004:2) provides a holistic view of how to improve health, including nutritional health. The model describes the need to target various levels of society. It outlines a full range of health determinants that must be addressed and proposes different strategies to bring about change. This model focuses on how food can reach the needy. It is prescriptive because it does not allow room for people to decide on the type of food they would like to receive (Fano, *et al.*, 2004:2). The model can therefore not be used or adapted as it does not allow equal contribution from the parties involved. The envisaged model would require active contribution from both the teenagers and parents/teachers.

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The KwaZulu-Natal Health Promotion model by Uys, Majumdar and Gwele (2004:3) is an empowerment model based on five elements:

- empowering people through a systemic, planned, needs-driven curriculum;
- empowering people through the interactive method of teaching;
- promoting behavioural change through small-group support; and
- empowering people through linking with external sources (Uys, *et al.*, 2004:3).

This model does not explain the extent to which people contribute to the empowerment process and the dynamics involved, like power relations. For example, the model does not focus on the promotion of dialogue and therefore it does not answer the question under study.

The Learning-Service Community Partnership model by Cohen, Katako-Yahiro, Ratliffe & Tessier (2001:415) describes the partnership between the school of nursing and a community agency. Learning and service are two major areas of focus. The school of nursing develops a learning environment for students and at the same time it provides health services for clients and families in the community. Learning and service represent a reciprocal relationship (Cohen, *et al.*, 2001:415). This model does not address the partnership that is envisaged within a dialogical process, especially between teenagers and parents/teachers, but it is also noted that within a dialogical process there is a reciprocal relationship between two people and within this study it will be between teenagers and parents/teachers.

In the change model by Young-Ho (2004:526) intentional health behaviour adoption and maintenance is said to be a process which occurs over a period of time. The change model can occur through stages which are:

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- pre-contemplation where individuals are physically inactive and do not intend to initiate exercise within six months;
- contemplation, where individuals are inactive but will start exercise within six months;
- preparation, where individuals are irregularly active;
- action, where individuals have regularly engaged themselves in exercise for less than six months; and
- maintenance, where individuals have sustained regular exercise for more than six months.

This change model does not address the issue of dialogue and sexual health but it addresses how behaviour can change over a period of time through the change stages within this model. In this case one can say that the model brings to light the various stages teenagers can go through before initiating an action which may be sexual intercourse or the use of contraception, but how dialogue can be promoted remains unanswered (Young-Ho, 2004: 526). This model could, however, provide guidance when one wants to evaluate behaviour change.

1.2.6 Statistics related to reproductive health

It is estimated that in Sub-Saharan Africa ten million people between the ages of 15 and 24 have HIV/AIDS. In South Africa it is estimated that 29.1% of pregnant mothers are living with HIV/AIDS and about 61% die every day of HIV-related illnesses (World Epidemic Statistic, 2006:2). Data suggest that 60% of all new HIV infection occur among young people in the age group 15-24 years, whilst STIs were also found to be high (Givaudan, Leenen, van de Vijver, Poortinga & Pick, 2008:98). This statistics show that teenagers do not have enough information about sexual health to make informed decisions. This may be partly attributed to the fact that there is not enough dialogue about sexual health within communities. This makes teenagers more vulnerable. If teenagers are well informed about issues of sexual health they will make informed decisions and

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this may reduce the high rates of sexually transmitted infections and teenage pregnancy.

The fertility rate in South Africa is estimated to be one of the lowest in Sub-Saharan Africa, with fewer than three births per woman. At the same time, teenage child-bearing levels remain high. More than 30 percent of 19-year-old girls are reported to have given birth at least once (De Wet, Kaufman & Standler, 2000:1). From this research it can be assumed that teenagers in South Africa may not be using family planning services sufficiently or they may lack knowledge about sexual health, hence the need to develop a model that can assist parents and teachers to facilitate dialogue with teenagers about sexual health.

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In Vhembe district of Limpopo Province, the number of people treated for sexually transmitted infections was 37 055 during 2003. Of this number more than 50% were teenagers (*Health statistics*, 2003). From July 2003 to December 2003, Vhembe district had 4 172 births of which 2 072 were babies born to teenagers below the age of eighteen. The number of teenagers who terminated pregnancy during 2003 was 386 in one hospital in Vhembe district, and there were teenagers who sought this service more than once (*Health Statistics*, 2003). The above statistics indicate the extent of the problem within our communities and highlight the need to promote dialogue about sexual health with teenagers so that they can make informed decisions.

1.3 PROBLEM STATEMENT

The high rates of sexually transmitted infections, pregnancies and termination of pregnancies among teenagers might indicate that the methods employed to reach teenagers about sexual health are ineffective. There are different models which promote health, but a paucity of models that have been designed to promote dialogue about sexual health among teenagers, parents and teachers.

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Lack of knowledge exposes teenagers to sexually transmitted infections including HIV/AIDS, as well as teenage pregnancy and parenthood. It is therefore necessary to develop a model that will promote effective dialogue about sexual health among teenagers, parents and teachers in rural areas as this will assist teenagers to make informed decisions about their sexual practices, thus reducing the scourge of HIV/AIDS.

1.4 RESEARCH QUESTIONS

The study sought to address the following questions:

- What are the experiences of teenagers regarding sexual health dialogue between teenagers and parents/teachers in Vhembe district?
- What are the experiences of parents and teachers regarding sexual health dialogue between teenagers and parents/teachers in Vhembe district?
- What are the implications of cultural practices that exist in relation to sexual health dialogue between teenagers and parents/teachers in Vhembe district?
- How can dialogue about sexual health be promoted between teenagers and parents/teachers in Vhembe district within the context of HIV/AIDS?

1.5 PURPOSE OF THE STUDY

The purpose of this study was to develop a model that could promote dialogue about sexual health between teenagers and parents/teachers in Vhembe district, Limpopo Province, South Africa. The model would facilitate dialogue that would inform teenagers about sexual health so that they could make informed decisions on contraceptive use, prevention of teenage pregnancy, teenage motherhood and sexually transmitted infections including HIV/AIDS.

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1.6 OBJECTIVES OF THE STUDY

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The objectives of the study were as follows:

- to explore and describe the experiences of teenagers regarding sexual health dialogue in Vhembe district;
- to explore and describe the experiences of parents and teachers of sexual health dialogue in Vhembe district;
- to identify the role of cultural practices in sexual health dialogue between teenagers and parents/teachers in Vhembe district;
- to analyse emerging concepts derived from data analysis;
- to develop a model that would promote dialogue about sexual health between teenagers and parents/teachers in Vhembe district.

1.7 SIGNIFICANCE OF THE STUDY

The significance of this study was that it would assist with policy development and review of issues related to a reduction of the rate of STIs including HIV/AIDS, as well as teenage pregnancies and termination of pregnancies. Information would lead to better understanding of sexual health issues within the context of culture and practices as well as family planning and other programmatic issues, and to use developed guidelines to influence the development of the curriculum on life skills to inform teachers how they could improve dialogue on sexual health in schools.

1.8 PARADIGMATIC PERSPECTIVES

A paradigm is a worldview or ideology. A paradigm implies the standards or criteria for assigning value or worth to both the processes and the procedures of the discipline, as well as to the methods of knowledge development within a discipline (Chinn & Kramer, 1999:53). A paradigm is also defined as a set of beliefs that constitutes the researcher's perceptions regarding the nature of

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reality of the world as well as the researcher's perceptions of where he/she stands in the reality of the world (De Vos, Schurink & Strydom, 2001:12). The following paradigmatic perspectives will be described.

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1.8.1 Meta-theoretical assumptions

Meta-theory is defined as assumptions about reality (Brink, 2000:28). The researcher's point of departure was the assumption that teenagers are human beings with sexual needs, which need to be fulfilled. Teenagers are also unique beings who can make their own choices. Teenagers need to make informed decisions regarding fulfilment of this need. Education of teenagers about sexuality particularly by parents, teachers and peers, is of vital importance to assist them to make informed decisions about sexuality. The researcher believes that primary socialization of children starts at home where parents have the role of educating their children about issues of sexual health. Secondary socialization occurs at schools where teachers have the role of educating teenagers. The teenagers then internalize what they have been taught and this determines the decisions that they make about sexual involvement.

1.8.2 Theoretical assumptions

This study was conceptualized within Leininger's Sunrise Transcultural Health-Care model (Leininger, 1991:30). The model takes into consideration individuals and groups, their beliefs and value systems and these specific cultural practices form the basis or the means through which the delivery of satisfactory health care to the people can be accomplished. The goal of this theory is to provide cultural-congruent care. Leininger states that if one studies the meanings, forms and expressions of cultural care one can better understand care and predict the health or well being of individuals and families. The author further contends that from the client's worldview, social structure component and environmental factors three modes of culture-care decisions and actions can be predicted to guide nursing care. The three modes are cultural care preservation or maintenance, cultural care repatterning or restructuring and cultural care accommodation

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(Leininger, 1991:30). Through the use of Leininger's Sunrise model the researcher could discover meanings attached to how dialogue about sexual health could be promoted within specific cultural groups. One would also appreciate the local people's knowledge and identify how culture and local knowledge could be used to influence dialogue about sexual health between teenagers and parents/teachers.

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1.8.3 Methodological assumptions

Methodological assumptions are concerned with the nature and structure of the science of research, and include the preferences and assumptions of the research (Mouton, 1996:124; Mouton & Marais 1990:20). The purpose, methods and criteria for trustworthiness of the research are included. Methodological assumptions are made to direct the chosen design (Botes, 1995:5). A functional approach was envisaged for this research because the model that would be developed would be used to assist parents and teachers with how to engage teenagers in a dialogue about sexual health in schools, at home and within the community in Vhembe district. The involvement of teenagers in sexual health dialogue would assist teenagers to make informed decisions about sexual health. This would increase the use of contraceptives by teenagers; reduce the rate of sexually transmitted infections including HIV/AIDS, and increase teenage pregnancy, parenthood and termination of pregnancy.

1.9 DEFINITION OF CONCEPTS

The following concepts were central to this study and are defined as follows:

1.9.1 Teenager

The teenage stage is the time when a person transfers from childhood to adulthood and is commonly referred to as adolescence. It is usually characterised by turmoil as young people mature to become adults (Gouws & Kruger, 1994:113).

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A teenager is seen as a whole person who embodies dimensions of body, mind and spirit. The teenager is seen as functioning in an integrated, interactive manner with his/her environment to facilitate learning. The teenager is viewed as somebody who is also part of the family, group and community. In this study a teenager is a male/female between the ages of 13 and 19 years who is attending school and has a relationship with the person of the opposite or same sex. The word teenager was also based on the prefix teen.

1.9.2 Parent

A parent is a mother or father; one who sires or gives birth to and/or nurtures and raises offspring (Free Encyclopedia, 14/7/2009). A parent in this study is any person who is a parent to a child of 13 to 19 years.

1.9.3 Teacher

In education, a teacher is a person who educates others, often formally and ongoing, carried out by way of occupation or profession at a school or other place of formal education (Free Encyclopedia, 14/7/2009). In this study a teacher is an educator who has the responsibility of teaching life skills, guidance or sexuality education.

1.9.4 Dialogue

Dialogue is defined as a conversation between two or more people. It can also designate the exchange of ideas, especially on political level (Webster Dictionary, 1990:250). Dialogue is a way of exploring the roots of many crises that face humanity today (Bohm, Factor & Garrett, 1992:1). It enables inquiry into and understanding of the processes that fragment and interfere with real communication between individuals, nations and organisation (Bohm, *et al.*, 1992:1). Dialogue is an interactive process between two or more people. It indicates the mutual involvement among the people involved. Dialogue facilitates learning through the mobilization of resources, both internal and external.

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In this study dialogue is a two-way conversation between teenagers and teachers or teenagers and parents about sexual health.

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1.9.5 Sexual health

Sexual health is the experience of the ongoing process of physical, psychological and socio-cultural well-being related to sexuality. Sexual health is evidenced in the free and responsible expression of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognised and upheld (WHO: 1994).

In this study sexual health is defined as the ability to express one's sexuality free from the risk of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination. It means being able to have an informed, enjoyable, and safe sex life, based on a positive approach to sexual expression and mutual respect in sexual relations.

1.9.6 Sexual health dialogue

Sexual health dialogue is a two-way conversation about sexual health between teenagers and parents/teachers.

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1.10 RESEARCH APPROACH

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This research was conducted in two phases. See Table1.1.

Table1.1 Phases of this research.

PHASE	OBJECTIVE	DESIGN
One	Explore and describe the experiences of teenagers, parents and teachers about sexual health. Explore and describe experiences of parents/teachers about sexual health dialogue. Identify the implications of cultural health practices on dialogue. Analyse data derived from participants and control against relevant literature.	Qualitative interviews, exploratory, descriptive and contextual.
Two	Conduct concept analysis. Conceptualization. Develop a model to facilitate dialogue.	Analyse emerging concepts derived from data. Develop a conceptual framework and model based on conceptual framework of Dickoff and Wiedenbach. Evaluate the model according to Chinn and Kramer.

1.10.1 Phase one

1.10.1.1 Research design and methods

The research design for this study is qualitative, exploratory, descriptive, contextual and theory generative in nature.

- **Qualitative**

Qualitative research is a systematic, subjective approach used to describe life experience and give it meaning. It is exploratory and descriptive (Burns & Grove, 2001:61; Kvale, 1983:175; Polit & Hungler, 1995:50). This study was qualitative

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because the researcher used in-depth individual interviews and focus-group interviews to explore the experiences and perceptions of teenagers, parents and teachers.

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- **Exploratory**

According to Brink (2000:11), exploratory research strives to explore the dimensions of the phenomenon so that they provide more insight into its nature and the manner in which it manifests itself. This study was exploratory because the dimensions of the meaning of dialogue about sexual health were explored by identifying the nature of the phenomenon and the factors related to it. The perceptions of parents and teachers, and the experiences of teenagers were explored, using in-depth individual interviews, focus groups and observations.

- **Descriptive**

Description involves identifying and understanding the nature and attributes of the phenomenon and sometimes the relationship (Burns & Grove, 2001:95; Mouton & Marais, 1990:43, 44). This study was a descriptive, in-depth description of the experiences of teenagers and perceptions of parents and teachers with regard to how sexual health dialogue was promoted in Vhembe district.

- **Contextual**

Context is the body, world and concerns that are unique to each person within which the person can be understood (Burns & Grove, 2001:79). This study was contextual because it involved dialogue between teenagers and parents/teachers within the context of sexual health in the rural areas. The model developed would also promote sexual health dialogue between teenagers and parents/teachers about sexual health in the rural villages of the Vhembe district of Limpopo Province.

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- **Theory generation**

Theory was generated through conceptualization of the concept dialogues using the steps in Rodgers and Knafl (1993:78). The framework of Dickoff, James and Wiedenbach (1968:426) was used to classify concepts. These concepts formed the basis of the developed model and gave it meaning. The model was developed using the steps in Chinn and Kramer (1999:51).

- **Population and sampling**

- Population

Population is the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying (Brink, 2000:132). The population for this study was all the teenagers, parents and teachers in Vhembe district of Limpopo Province.

- Sampling

A sample is part or a fraction of the whole, or subset of a larger set, selected by the researcher to participate in the study. A sample consists of a selected group of elements or units from a defined population (Brink, 2000:134). The sampling process was twofold, namely sampling of villages and participants.

- Sampling of villages

The purposive sampling method was used to select villages to form part of this study. Two villages were chosen. One village was from the area that is occupied by predominantly Venda-speaking people and another village was from the area that is occupied by predominantly Tsonga-speaking people. This was done to identify whether there were any similarities and differences between the ways in which the two cultural groups engaged their teenagers in dialogue about sexual health. The sampling of different villages enhanced richness of data because of the cultural differences of the participants. The criteria set out in Chapter 2, Table 2.1 on the selection of villages were used to select participating villages.

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- **Sampling of participants**

The non-probability purposive sampling method was used to select teenagers, teachers and parents to participate in the study. The purposive sampling method is based on the judgment of the researcher regarding subjects or objects that are typical or representative of the topic being studied or who are especially knowledgeable about the question at issue (Brink, 2000:141). The purposive sampling method was selected for different groups based on the criteria set out in Chapter 2, Table 2.1.

- **Data collection**

Data collection is a process of collecting information which is needed in the study (Brink, 2000:141). In-depth individual interviews and focus-group discussions with teenagers and parents, and in-depth individual interviews with teachers were conducted. The purpose was to elicit the experiences of teenagers and the perceptions of parents/teachers about sexual health dialogue in Vhembe district. Observations of non-verbal cues were made during interviews and were noted as field notes. A detailed description of the data collection process is gi ven in Chapter 2.

- **Data analysis**

Qualitative data analysis involves working with a wealth of rich descriptive data (Mouton, 1996:169). Analysis means reconstructing the inherently significant structure and the self-understanding of individuals by staying close to the subject (Mouton, 1996:169). The coherence and meaning of data are more important than the meaning of specific parts. Data analysis is more holistic, synthetic and interpretative (Mouton, 1996:169). In this study the researcher developed structure and meaning from the volume of data generated during the interviews. Data analysis was done simultaneously with data collection (Creswell, 1994:142). In this study data was analysed according to Tesch's (in Creswell, 1994:142) eight steps of analysis. Detailed discussion of the steps is given in Chapter 2.

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- **Literature control**

This process was done after data analysis to develop a theory which would be in line with the research objectives. This ensured that there would be a good fit between data and relevant literature, providing a link between previous and the present research (Mdluli, 2005:50). Literature control was done to confirm the results of the investigation and the description of the life world of teenagers, parents and teachers in respect of sexual health dialogue in Vhembe district. Previous research was used to establish similarities as well as to determine the uniqueness of the present study during data analysis.

1.10.2 Phase two

1.10.2.1 Model development and evaluation

This phase involved conceptualization where concepts that emerged from data analysis and literature control were analysed and given meaning (Rodgers & Knafl, 1993:78). Steps were adapted and used during concept analysis. The framework of Dickoff, James and Wiedenbach (1968:426) was used to classify concepts. These concepts formed the basis of the developed model and gave it meaning. The model was developed using the steps in Chinn and Kramer (1999:51).

1.11. ETHICAL CONSIDERATIONS

Ethics is doing what is right and good during research. It is the application of all ethical principles to the research process (Denosa, 1998:2.3).

Ethics in research ensures that the

- human, humane, humanistic and moral reasons are upheld.
- credibility and trustworthiness of data is enhanced.
- researcher's authenticity is demonstrated (Denosa, 1998:2.3).

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The following ethical principles were adhered to closely.

- **Permission to conduct the study.**

The researcher sought permission to conduct this study from the following institutions:

- Department of Education and Culture
- The Chiefs of the villages
- The School Governing Bodies.

Ethical clearance from the University of Venda was also sought.

The letters that were written to the Department of Education and Culture and School Governing bodies ensured that access to the teachers at different schools was possible by the researcher. Letters were also written to the traditional leaders of different villages where parents and teenagers were to be interviewed. See Annexures A for requisition and B for permission granted.

- **The right to self-determination and justice is ensured**

The right to self-determination is based on the ethical principle of respect for persons. The researcher treated the participants as autonomous beings, with freedom to conduct their lives as they wished. The researcher informed participants about the proposed study. Participants were allowed to voluntarily choose to participate in the study and to withdraw at any time should they wish to terminate their participation. The researcher did not violate the right of the participants to self-determination by:

- coercion.
- covert data collection.
- deception (Burns & Grove, 2001:196; Denosa, 1998:2.3).

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- **Informed consent is obtained appropriately**

Participants made an informed decision regarding participation in the study. Informed consent relates to the participants' right to adequate and relevant information before the commencement of the study. The researcher explained the purpose of the study, the procedures involved, potential risks/benefits, how confidentiality was to be maintained and their right to withdraw from participation. The researcher's explanation was at the level of the participants' comprehension. The participants voluntarily gave consent if they were above 18 years of age. For participants younger than 18 years of age, consent was given by parents and after that they were also requested to give consent. A written consent form was used. See Annexure C (Burns & Grove, 2001:196; Denosa, 1998:2.3).

- **Right to privacy**

Privacy is the right an individual has to determine the time, extent and general circumstances under which personal information will be shared or withheld from others (Burns & Grove, 2001:196). Participants' private information was not shared without the individuals' knowledge or against their will. The researcher ensured that the participants did not lose their dignity, friendship, employment or face embarrassment or shame by fostering anonymous participation. The area where interviews were held was well prepared and aspects of privacy attended to. Interviews were also conducted during the participants' free time and this ensured that there was no interference with participants' work schedules, especially teachers. Participants were made aware of the use of audiotape and research assistants. The participants were also shown the stop button on the audiotape so that they could press the button if they felt the information they wished to disclose should not be recorded (Burns & Grove, 2001:196; Denosa, 1998:2.3).

- **Confidentiality**

Confidentiality is related to the researcher's management of private information shared by the participants that must not be shared with others without

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authorization by the participant (Burns & Grove, 2001:196). The researcher did not allow unauthorized persons who might be family members or other health professionals to have access to the raw data of the study. The participants' names or areas were not linked to the study. The participants' names were not used during data gathering. Codes were attached to the data when being recorded (Burns & Grove, 2001:196; Denosa, 1998:2.3).

- **Right to fair treatment**

The right to fair treatment is based on the ethical principle of justice, which holds that each person should be treated fairly. The researcher ensured that the population and the participants were selected fairly. The researcher adequately discussed the role of the participants and self in the study.

- **The right to protection from discomfort and harm**

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good, and above all, no harm. The researcher ensured that participants were comfortable by selecting a suitable venue, time and days. The researcher also guarded against embarrassing the participants during interviews because questioning and probing were done cautiously. The researcher ensured that participants did not incur financial losses by travelling to the area where focus-group int erviews were conducted. The researcher made sure that all focus-group interviews were conducted within walking distance of participants' homes, and individual interviews were conducted in the participants' homes. During the interviews the researcher was vigilant in assessing the participants' discomfort and nobody was referred for professional intervention (Burns & Grove, 2001:196; Denosa, 1998:2.3).

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1.12 MEASURES TO ENSURE TRUSTWORTHINESS

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Guba's model (Lincoln & Guba 1985:216-217) for ensuring and assessing trustworthiness was used for this study. Trustworthiness is a method of establishing rigour in qualitative research without sacrificing relevance. This was to ascertain that the outcomes of this study could be trusted and were reproducible. The four criteria that were used to ensure trustworthiness as identified by Guba were the following:

- **Truth value (credibility)**

Truth value asks whether the researcher has established confidence in the truth of the findings from the participants and the context in which the study is undertaken (Lincoln & Guba, 1985:216-217).

- **Applicability (transferability)**

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Lincoln & Guba, 1985:216-217).

- **Consistency (dependability)**

Consistency of the data considers whether the findings would be consistent if the inquiry were to be replicated with the same subjects or similar context (Lincoln & Guba,1985:216-217).

- **Neutrality (confirmability)**

Neutrality refers to the degree to which the findings are a function of the participants and conditions of the research and not of other biases, motivations and perspectives (Lincoln & Guba, 1985:216-217).

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1.13 LIMITATIONS OF THE STUDY

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The following were the limitations of this study.

This study was restricted to villages in Vhembe district only out of the five districts of Limpopo Province. The study was conducted among two ethnic groups, the Vhavenda and VaTsonga communities. The study data does not represent all cultural groups in Limpopo.

1.14 DISSEMINATION OF FINDINGS

The findings of this research project will be disseminated by the following methods:

- presentation of papers at national and international conferences, seminars and workshops;
- publications in accredited journals;
- presentation to the participants;
- presentations to relevant departments;
- feedback to organised structures of parents, teachers and teenagers.

1.15 POTENTIAL ARTICLES FOR PUBLICATION:

- Lebese, R., Davhana-Maselesele, M. and Obi, C.L. Theoretical and practical experiences of teenagers and perceptions of parents and teachers about sexual health within the context of the HIV and AIDS epidemic.
- Lebese, R., Davhana-Maselesele, M. and Obi, C.L. A model to promote sexual health dialogue among teenagers, teachers and parents in rural areas in the era of HIV and AIDS.

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- Lebese, R. Davhana-Maselesele, M. and Obi, C.L. Factors affecting sexuality education and the use of different family planning methods among teenagers in a rural setting in the era of HIV/AIDS.
- Lebese, R,, Davhana-Maselesele, M. and Obi, C. L. Strengthening family planning methods and practices and their anticipated impact on teenage STIs, pregnancies and termination: The role of males within a socio-cultural context.

1.16 OUTLAY OF CHAPTERS

CHAPTER 1: Orientation to the study.
CHAPTER 2: Research methodology
CHAPTER 3: Data analysis.
CHAPTER 4: Conceptualization
CHAPTER 5: Model development and evaluation
CHAPTER 6: Guidelines to operationalise the model
CHAPTER 7: Evaluation, justification, limitations, conclusion and recommendations.

1.16 SUMMARY

This chapter gave an overview of the study, which included the introduction, background of the study, problem statement, research questions and objectives. The research approach, design and methods were also described. Measures to ensure trustworthiness and ethical issues were also described. The next chapter gives a full description of the design and methodology of the study.

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CHAPTER 2

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RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

The previous chapter gave a detailed description of the overview of the study. This chapter focuses on the description of the rationale, the purpose, the research design and method as well as the trustworthiness of data. The researcher's choice of method to conduct the study was inductive. According to Mouton (1996:74), inductive reasoning begins with observation and not with a preconceived conclusion or major premise. To induce is to draw a conclusion from a number of particular facts also called the phenomena (self-exposing reality) or pieces of evidence. Conradie (2002:16) describes inductive reasoning as follows: "the conclusion in the inductive argument explains the facts, and the facts support the conclusion". Qualitative research strategy therefore forms the basis of this research design and method. The inductive approach is influenced by the Leiningers' theory which supports the idea of first looking at the world view to can provide congruent care in this case the model that is congruent to the cultural groups of Vhembe District.

2.2 RESEARCH RATIONALE

Teenagers are sexual beings, who have just matured and are anxious to experiment with their sexuality. It is unfortunate that most of the time teenagers start exploring their sexuality without enough information about sex, sexuality and sexual health. Their inexperience and lack of knowledge about sexuality may lead them to make uninformed decisions about sex and consequently be exposed to sexually transmitted infections including HIV/AIDS, and teenage pregnancy.

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Parents and teachers are key role players in making sure that teenagers receive enough information about sexuality as this will enable them to make informed decisions. The complexity of relationships, especially in the rural areas where culture still plays an important role, often makes teaching and dialogue impossible. This study attempted to answer the following question, 'How can dialogue about sexual health between teenagers and parents/ teachers in Vhembe district of Limpopo Province be promoted?'

2.3 PURPOSE OF THE STUDY

In this study the researcher's aim was to develop a model that could promote dialogue about sexual health between teenagers and parents/teachers in Vhembe district of Limpopo Province. Dialogue between teenagers and parents/teachers would enhance information transfer about sexual health and teenagers would be able to make informed decisions. The use of contraceptives by teenagers would improve; teenage pregnancy and sexually transmitted infections would be reduced.

2.4 OBJECTIVES OF THE CHAPTER

The objectives of this chapter were to

- describe the methodology of the study, and
- describe the process of concept analysis, model development and evaluation.

2.5 RESEARCH APPROACH

The research approach was guided by Leininger's Sunrise Trans-cultural model (Leininger, 1991:30). The model takes into consideration the worldview of the people under investigation and uses the outcomes to deliver congruent care. The approach of this study was to look at the worldview of the participants and this

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data formed the basis of model development. The worldview also assisted in developing a model that was congruent with the cultural practices of the participants (Leininger, 1991:30). This study was conducted in two phases. Phase one involved data collection from teenagers, teachers and parents to explore their experiences regarding dialogue about sexual health, data analysis and literature control. Phase two involved concept analysis, model development and evaluation. A summary of the research approach is given in Figure 2.1.

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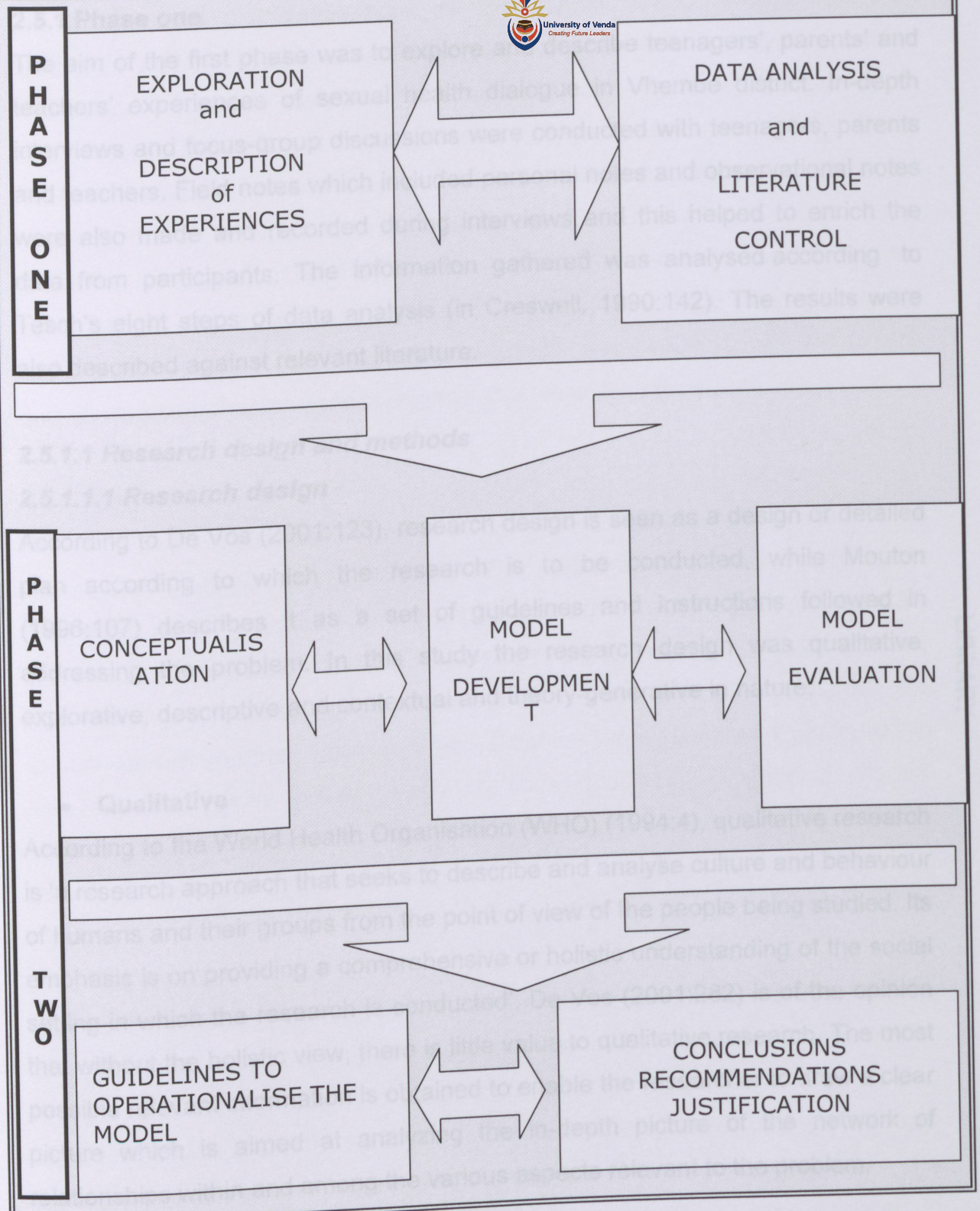

Figure 2.1 Phases of the research process

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2.5.1 Phase one

The aim of the first phase was to explore and describe teenagers', parents' and teachers' experiences of sexual health dialogue in Vhembe district. In-depth interviews and focus-group discussions were conducted with teenagers, parents and teachers. Field notes which included personal notes and observational notes were also made and recorded during interviews and this helped to enrich the data from participants. The information gathered was analysed according to Tesch's eight steps of data analysis (in Creswell, 1990:142). The results were also described against relevant literature.

2.5.1.1 Research design and methods

2.5.1.1.1 Research design

According to De Vos (2001:123), research design is seen as a design or detailed plan according to which the research is to be conducted, while Mouton (1996:107) describes it as a set of guidelines and instructions followed in addressing the problem. In this study the research design was qualitative, explorative, descriptive and contextual and theory-generative in nature.

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- **Qualitative**

According to the World Health Organisation (WHO) (1994:4), qualitative research is 'a research approach that seeks to describe and analyse culture and behaviour of humans and their groups from the point of view of the people being studied. Its emphasis is on providing a comprehensive or holistic understanding of the social setting in which the research is conducted'. De Vos (2001:282) is of the opinion that without the holistic view, there is little value to qualitative research. The most possible relevant information is obtained to enable the researcher to draw a clear picture which is aimed at analyzing the in-depth picture of the network of relationships within and among the various aspects relevant to the problem.

Qualitative research focuses on understanding the phenomena as a whole. The aim of the study was to explore the depth, richness and complexity inherent in

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the experiences and perceptions of the sexual health dialogue between teenagers and parents/teachers. The researcher wanted t o develop a richer understanding of how people viewed sexual health and how dialogue about sexual health between the teenagers and parents/teachers in Vhembe district could be facilitated. People were studied in their setting in order to discover the social world of cultures and languages by observing and talking to them (Halloway & Wheeler, 1996:17). The researcher also used main questions as her point of departure and more questions emanated from the discussion. Participants narrated their experiences which were reflected in words and quotations to emphasize various aspects that were described.

- **Exploratory**

The objective of qualitative design is to explore areas where limited or no information exists (Du Plooy, 2001:83). The researcher viewed the participants as experts as they knew their stories best and the researcher adopted a lay person's attitude towards them and invited the participants to share their stories with her. The dimensions of the meaning of sexual health were explored. The experiences of parents, teenagers and teachers were explored with regard to how dialogue about sexual health could be facilitated (Mouton & Marais, 1990:43). Literature was also explored extensively during literature control, conceptualization and model development.

- **Descriptive**

Descriptive research documents and describes the behaviour, events, beliefs, characteristics, attitudes, structures and processes that occur in a phenomenon. It gives complete and accurate information about the phenomenon that is being studied (Brink, 2000:10-11). The information was gained through in-depth individual interviews, focus-group discussions and observations. The documented information on the phenomenon was analysed and classified to provide new insights into it. To obtain a holistic understanding of the data collected, an in-depth description of the identified attributes was made. Again an

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in-depth description of experiences and perceptions of teenagers and parents/teachers with regard to how sexual health dialogue could be promoted in the Vhembe district areas was made. Accurate description during conceptualization formed an integral part of the study since rational statements were deductively analysed and stated. The model and guidelines for operationalizing were also described (Mouton & Marais 1990:43-44).

- **Contextual**

Mouton and Marais (1990:45) describe "contextual" as an ideograph research, in that it is uniquely descriptive within the context of the individual setting. This study was contextual because the researcher tried as far as possible to study people in their natural setting in order to understand the dynamics of human meaning as fully as possible. It is believed that human behaviour is influenced in many ways by the environment or setting in which it occurs (De Vos, 2001:280-281). Teenagers and parents were interviewed in their homes and teachers were interviewed at their schools. This study was conducted in Vhembe district of Limpopo Province. Teenagers, parents and teachers outside the selected study area were not included in this study. The study also focused on dialogue within the context of sexual health. Other forms of dialogue were not looked at.

- **Theory generation**

Theory generation involves conceptualization, model development and description of guidelines to operationalise the model and evaluation of the model. It also involves a directed, creative and rigorous structuring of dominant ideas that project a tentative, purposeful and systemic view of phenomena (Chinn & Kramer, 1991:72). This theory was generated within Dickoff *et al.*'s framework (1968:198).

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- **Population**

Population is the entire group of persons or objects that are of interest to the researcher or that meet the criteria the researcher is interested in studying (Brink, 2000:132). The population for this study was all teenagers, parents and teachers in Vhembe district of Limpopo Province.

- **Sampling**

A convenience sampling method was used to select Vhembe district as the researcher has is working in the district and this facilitated easy access which was financially manageable. The purposive sampling method was selected for different groups based on the criteria set out in Table 2.1. The sample size was determined by saturation of information, when the information started to repeat itself (De Vos, 2001:290). A total of 105 participants formed the sample of this study.

Table2.1 below provides a summary of how stakeholders were sampled. The stakeholder, sampling method and criteria, data collection method are indicated.

- **Exclusion criteria**

Teenagers who did not have a baby or relationship with the opposite sex were excluded on the basis that the researcher felt that their experiences might not give a clear picture of how teenagers, parents and teachers addressed problems related to dating and unplanned pregnancies. Parents who did not have a teenage child were also excluded as they might not have experience of raising a teenager.

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Table 2.1 Stakeholders, sampling methods, criteria and data collection

Stakeholders	Sampling methods and criteria		Data-collecting methods
Teenagers	• Purposive	• Between 13 and 19 years. • Had a relationship with opposite sex.	• In-depth individual interview. • Focus-group discussions. • Field notes
Parents	• Purposive	• Parent to a teenager. • Parent to a child who has given birth during teenage years. • Parent to HIV-positive teenager	• In-depth individual interview. • Focus-group discussions. • Field notes.
Teachers	• Purposive	• Involved in life skills. • Involved in sexuality education. • Involved in guidance teaching.	• In-depth individual interview. • Focus-group discussions. • Field notes

2.5.1.1.3 The research setting

Limpopo Province in South Africa is situated in the far northern part of South Africa. The province consists of five sub-districts, which are Capricorn, Mopani, Waterberg, Sekhukhune and Vhembe. This study was conducted in Vhembe district. Vhembe district is situated in the northern part of the province where it forms a border with both Mozambique on the eastern side and Zimbabwe on the northern side. The district is formed by the former Venda and Gazankulu homeland areas with a few white areas. It consists mainly of rural areas and a few suburban areas, with a high illiteracy rate. The main source of employment for people is on farms and in suburban areas.

2.5.1.1.4 Data collection

The researcher was an instrument and was involved in perceiving, reacting, reflecting, attaching meaning and recording. The researcher and the research assistant took field notes during interviews. The researcher was the instrument

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for collecting data. Data was collected through in-depth individual interviews, focus-group discussions and field notes. In-depth accounts which presented a lively picture of the participants' reality were densely presented in words as narratives, using individual quotes. This raw data of in-depth interviews were recorded in non-numerical form (Du Plooy, 2001:33).

- **In-depth individual interview**

This was a one-to-one interview between the researcher and the participants. The interview was free-flowing with its structure limited to the focus of the research. The interview was directed by three semi-structured questions for each stakeholder. The following semi-structured questions were asked during the interviews:

Teenagers

- How would you describe your experience in talking to parents/teachers about sexual health at home/school? (How is talking to parents/teachers about sexual health at home/school)?
- How do cultural practices influence the way in which you and your parents/teachers discuss sexual health?
- How can dialogue about sexual health be promoted among teenagers, teachers and parents?

Parent

- What are your experiences about sexual health dialogue with your teenage child? (How is talking about sexual health with your child)?
- How do cultural practices influence the way in which you and your teenage child discuss sexual health?
- What must be done in order to improve dialogue about sexual health between teenagers and their parents?

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Teachers

- How is sexual health taught at schools? (How is talking about sexual health at schools)?
- What are your views regarding cultural influence on the way in which you and learners discuss sexual health in class?
- How can dialogue about sexual health be promoted between teenagers and teachers?

The participants were encouraged to add information or to clarify certain aspects. Probe follow-up was used to increase detailed exploration (Brink, 1996:158). The aim of using unstructured interviews was to actively enter the worlds of people and to render those worlds understandable from the standpoint of a theory that is grounded in the behaviours, languages, definitions, attitudes and feelings of those being studied. The interviewer's contribution was limited. The role of the researcher was to introduce the theme, motivate participants to participate through probing and steer them tactfully back to the research topic (De Vos, 2001:300).

The researcher helped the participants to describe their lived experiences without leading the discussion. Interviews ended when participants believed that they had exhausted the description. The researcher always remembered to be centered on the data topic and avoided interrogating the participants. She treated participants with respect and sincere interest in the shared experiences. Data collection continued until the researcher believed that saturation had been achieved. Field notes were taken and an audiotape was used to capture information with the permission of the participants. Data was collected in Xitsonga and Tshivenda, depending on the language that the participants preferred so that it would be easier for the participants to express themselves. Data was then translated verbatim within 24 hours of collection (De Vos, 2001:300). Unstructured interviews were used because reality can be reconstructed from the world of the interviewee, the interviewer can obtain an insider view of the phenomenon and socially and personally sensitive topics such

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as deviant behaviour, problems in relationships, sexual behaviour and unemployment can be more openly discussed (De Vos, 2001:300).

- **The process of unstructured interview**

The process of unstructured interview was divided into five phases. Below are the phases that were followed when unstructured interviews were conducted.

- **Preparing for the interview**

The interviewer carefully studied related literature to enable her to define the concepts and assess data. The interviewer was also prepared emotionally because she was entering the world of the interviewees (De Vos, 2001:300).

- **Becoming acquainted: The initial relationship**

The interviewer projected herself in a way that evoked the least resistance in the interviewee. The basic principles of communication were adhered to. The interviewer was frank so as to overcome problems of interviewees giving false answers or ending an interview at any stage. The researcher gave her credentials so as to reassure the interviewees. The participants were made aware of the proposed investigation and how results would be utilized. The use of audiotape, taking of field notes, the interview venue, time and date were also discussed. The researcher strove to establish a cordial atmosphere during the interview so that the interviewees could speak freely. During this phase the interviewer also strove to bridge the social distance between them (De Vos, 2001:300).

- **Establishing a contractual relationship.**

The agreement was the outcome of the partnership that had developed between the two parties, which was based on growing mutual understanding. Interviewers and interviewees regarded each other as equals. The objectives of the interviewer and the interviewees became joint objectives and a compromise was

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reached between the needs of the interviewers and those of the interviewees (De Vos, 2001:300).

- **Establishing a relationship of trust**

Mutual trust ensured the co-operation of the interviewee and also improved the quality of collected data. The interviewers responded in a manner that showed that the interviewees were worthy of their disclosure and did not condemn or oppose the interviewees (De Vos, 2001:300).

- **Terminating the unstructured interview**

This stage occurred when the condition of the research agreement was met and the proposed objectives were achieved. The interviewer suggested ending the interview when it was realized that the interviewee did not have anything more to say. The interviewees were made aware of the expected duration of the research and the proposed date of release of the research report. The value of the information gathered was also communicated to the interviewee (De Vos, 2001:300).

- **Focus-group discussions**.

Krueger (1994:6) defines a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment free from interruptions. It is conducted with between seven and ten people led by the interviewer. The author maintains that the key principle in the formation of a focus group is homogeneity, which is determined by the purpose of the study (Krueger, 1994:6-7). The focus-group discussion was conducted with teenagers and parents as it was possible to get groups which were either from neighbors or as friends among these informants. These groups of teenagers and parents were however interviewed separately. Data gathering was conducted within the guidelines which Krueger (1994:6-7) described as follows: Preparation, techniques, skills and attitude of the focus-group facilitator.

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Process followed in conducting focus-group discussions

The following guidelines are described in relation to preparations, techniques, skills and attitude of the facilitator for conducting focus-group interventions.

- **Preparation**

Focus-group interviews were conducted after school and on Saturdays as this was convenient for teenagers attending school. It was therefore necessary for the researcher to obtain permission from the Department of Education, the School Governing Body and the principal. Interviews with parents were conducted in the home of one parent who had enough space. Focus-group discussions for teachers were not conducted as it was assumed that in-depth individual interviews would allow them to explain their experiences without feeling inadequate and this also guarded against teachers repeating the same experiences. The environment was made comfortable and conducive without any disturbance. The environment was non-evaluative and non-threatening with comfortable chairs placed in a circle to allow face to face interaction. Written permission was requested from the participants before the beginning of the focus-group interviews. An audiotape with a cassette in position was used with the participants' permission (Krueger, 1994:113).

The research assistant was in charge of the audiotape and had an extra cassette in case a replacement was required. The research assistant and the researcher formed part of the circle. Each of the participants was given a number to pin on themselves to avoid using names for the purpose of confidentiality. A flipchart board with pens was used to note consensus of the discussion. The group selected a scribe who was also a participant. The participants and the interviewer established ground rules to facilitate the smooth running of the discussion. The following ground rules were set:

- Cell phones to be switched off
- Members to respect each others' view point
- Members to allow one person to talk at a time

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- No refreshments during discussions.

The time limit depended entirely on the saturation of information gathered from the participants. Refreshments were provided during breaks (Krueger, 1994:113).

- **Techniques, skills and attitudes of the focus-group facilitator.**

The role of the researcher, the environment where the focus-group interviews were conducted and the role of the interviewer are described in the paragraphs that follow.

- **The role of the researcher**

The researcher arrived early enough to give the participants a warm welcome when they arrived. The researcher again welcomed the group and allowed the introduction of everyone present. The researcher introduced the research assistant and explained her role, which was to control the audiotape. The researcher further explained the purpose of the study and written consent forms were handed out to be signed before commencing the focus-group interview (Krueger, 1994:114).

During the focus-group interviews the researcher took field notes. The research assistant operated the audio- tape, which was placed in the middle of the circle to capture every participant's voice. The researcher asked three broad questions one at a time and always tried to steer the discussion back to the area of focus. The researcher also observed the group dynamics among the participants, such as non-verbal and verbal communication (Krueger, 1994:114).

- **The environment**

The focus-group interviews were conducted in a conducive environment. For example, during the interviews conducted at the homes of the participants care was taken to ensure that the place was quiet. A flipchart board with charts and

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pen was provided by the researcher. Participants were allowed to stand or adopt any position when they wished to emphasize something (Krueger, 1994:114).

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- **Field notes**

Field notes give an account of what happened and little or no interpretation is provided. The researcher used them as a piece of evidence in support of recorded experiences and as a record of context or situation. Notes that were used were observational notes, methodological notes and theoretical notes (De Vos, 2001:285-286).

- **Observational notes**

These are the who, what, when, where and how of human activity (De Vos, 2001: 285-286). Observations were noted regarding facial expressions in relation to certain experiences and this evidence was used to emphasize why dialogue was not present or how it was initiated.

- **Methodological notes**

These notes are mainly reminders, instructions and critical comments for the researcher (De Vos, 2001: 285-286). The researcher also made notes where certain procedures were not followed or adjusted.

- **Personal notes**

These are notes that were made by the researcher on the perceptions that were made on the behaviors that may have changed the interaction including the impact of the researcher on the setting if any.

- **Theoretical notes**

These are self-conscious, systemic attempts by the researcher to derive meaning from all observational notes. The researcher thought about what she had experienced and made whatever private declaration of meaning she felt would bear conceptual fruit. Patterns repeatedly found were identified and the

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researcher tried to explain the phenomena understudied within the relevant literature (De Vos 2001:285-286).

2.5.1.1.4 Data analysis

The data generated by qualitative methods are voluminous and this makes analysis difficult. Data analysis requires that the researcher be comfortable with developing categories, contrasting and making comparisons. It requires that the researcher be open to possibilities and see contrary or alternative explanations for the findings (Creswell, 1994:142). The data was analysed independently by the researcher and the independent coder who was deliberately selected on the basis of her expert knowledge of qualitative research and has a PhD in qualitative research. A protocol for data analysis was handed to the independent coder for guidance during data analysis. Tesch's method of open coding is described in the following paragraph: (Creswell, 1994:142).

- Get the sense of the whole

The researcher read through the transcript carefully. The ideas that came to mind were jotted down.

- Pick one document

The researcher picked the most interesting document which was also short and read through it again, trying to make sense of it and wrote thoughts in the margin.

- List the topics

When the researcher had completed the second step, a list of all the topics was made. Similar topics were then clustered and formed into columns that were arranged as major topics, unique topics and leftovers.

- Go back to the data

The researcher then took a list of topics and went back to the data. The different topics were abbreviated as codes and these codes were written next to appropriate segments of the book to see whether new categories and codes emerged.

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- Describe the topics

The researcher found the most descriptive word for each topic and turned them into categories. Topics that related to each other were grouped in order to reduce the number of categories.

- Abbreviate categories

The researcher made a final decision on the abbreviation for each category and alphabetized the code.

- Assemble the dates

The data which belonged to each category were assembled in one place and preliminary analyses were performed.

- Recoding

The researcher recoded existing data using Tesch's method (in Creswell, 1990: 142). After data analysis the phenomenon of absence of dialogue between teenagers and parents/teachers was identified and it was also supported by relevant literature. The results of this analysis formed the basis of the concept analysis and model development for the promotion of dialogue between teenagers and parents/teachers in Vhembe district of Limpopo Province.

2.5.1.2 Trustworthiness

Guba's model (Lincoln & Guba, 1985:216-217) for ensuring and assessing trustworthiness was used for this study. Trustworthiness is a method of establishing rigour in qualitative research without sacrificing relevance.

The four criteria that were used to ensure trustworthiness as identified by Guba were the following:

- Truth value (credibility)
- Applicability (transferability)
- Consistency (dependability)
- Neutrality (confirmability) (Lincoln & Guba, 1985:216-217).

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- **Truth value (credibility)**

Truth value asks whether the researcher has established the truth of the findings for the subjects or participants and the context in which the study is undertaken. It establishes how confident the researcher is with the truth of the findings based on the research design, participants and context. Credibility is also defined as the truth-value obtained from the discovery of human experiences as they are lived and perceived by the research participants (Lincoln & Guba, 1985:161).

The researcher ensured credibility by presenting accurate descriptions and interpretations of human experiences that people who also shared the experience would immediately recognise the descriptions. Prolonged engagement involved investing sufficient time to achieve certain purposes such as building trust and testing for misinformation (Lincoln & Guba, 1985:161) The researcher spent sufficient time with the participants by interviewing them more than once in individual interviews, verifying, summarizing and reflecting. Extended periods of engagement increased rapport and participants volunteered to give even sensitive information. The researcher used numerous interviews, reframing questions and observation periods to achieve this. The researcher also interviewed participants at different times, days and in different settings, which were at home, at school and in tribal offices and this enabled the researcher to sample all possible situations.

Reflexivity involved the researcher's understanding of the context in which the phenomenon of dialogue was occurring (Lincoln & Guba, 1985:161). The researcher used reflexivity to guard against being so much involved with the participants that she might have difficulty in separating her own experience from that of the participants. The researcher kept a field journal throughout the research process. In the journal were the daily schedule and logistics of the study. The researcher's thoughts, feelings, ideas and hypotheses generated by contact with the participants were also reflected. The frustrations, questions and problems concerning the whole research process were written down so that the researcher was aware of biases and preconceived assumptions.

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Data triangulation was ensured by using different data-collecting methods. The researcher collected data through observational notes, in-depth individual interviews and focus-group discussions with participants. The data that had been collected by various means was also compared. Multiple data sources were also used, which were teenagers and parents/teachers.

Member checking was ensured because the researcher revealed research material to the participants so that they could confirm whether the researcher had accurately translated the participant's point of view and this decreased the chances of misrepresentation. The researcher also discussed the research process and findings with impartial colleagues who had experience in qualitative research. The researcher also had extensive experience in the interviewing process. The researcher reframed, repeated questions or expanded questions on different occasions as the researcher was an instrument of collecting data, and had been adequately prepared in understanding qualitative studies (Lincoln & Guba, 1985:161).

- **Applicability (Transferability)**

Transferability refers to the degree to which the findings can be applied to another context and setting or with other groups (Lincoln & Guba, 1985:215). Transferability was ensured by densely describing the background information about the participants. The research context and setting were also described so as to allow others to assess how transferable the findings were. The purposive sampling technique was used to select participants who fitted the criteria described (Lincoln & Guba, 1985:215). The results together with supporting direct quotes from participants were also densely described.

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- **Consistency (dependability)**

The concept "dependability" implies traceable variability, that is, variability that can be ascribed to identified sources (Lincoln & Guba, 1985:216). The researcher adequately described the research methods. The researcher coded the data, waited for a certain period and then returned to recode the same data to ensure accuracy. The researcher made use of experts to check the research plan and implementation (Lincoln & Guba, 1985:216).

- **Neutrality (Confirmability)**

Neutrality refers to the degree to which the findings are a function solely of the participants and conditions of the research and not of other biases, motivations and perspectives (Lincoln & Guba, 1985:216). The researcher achieved this by prolonged engagement with participants during in-depth individual interviews, reflection and verification. Multiple data sources were used to ensure that the researcher's opinions were not reflected instead of the participants' views. An auditor who was the supervisor was appointed at the beginning of the project so that the nature of the audit trail could be determined (Lincoln & Guba, 1985:216).

2.5.2 Phase two

2.5.2.1 Model development and evaluation

This phase involved conceptualization, model development, model description and evaluation. In conceptualization concepts that emerged from data analysis and literature control were identified and analysed and these concepts formed the basis for model development. Concept analysis and model development were guided by the adapted phases as explained in Rodgers and Knafl (1993: 77-90) and Chinn and Kramer (1999:51). The framework of Dickoff, James and Wiedenbach (1968:423) was used to classify the concepts and model development was guided by Chin and Kramer (1999:51). The model was then operationalised by describing the guidelines.

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2.5.2.1.1 Conceptualization

According to Mouton (1996:119), conceptualization refers to clarification and analysis of the lay concepts in the study and to the way in which one's research is integrated into the body of existing theory and research. It also refers to the underlying theoretical framework that guided the research. Conceptualization is a thought process going on in one's minds when one gathers impressions or perceptions, identifies similarities and puts these similarities together to make up a single thought, which expresses the similarities and then gives them a name (Mouton, 1996:119).

Concepts that emerged from data analysis were analysed, described, interpreted and relationships between concepts and statements were constructed and this formed the basis of model development (Walker & Avant, 1995:39). Concept analysis was conducted according to eight steps in Rodgers and Knafl (1993:77-90) which are the following:

- Identification of the concepts of interest
- Identification of appropriate setting and sample for data collection
- Collecting relevant data to identify the attributes of the concept, along with surrogate terms, references, antecedents and consequences
- Identification of concepts related to the concept of interest
- Analysis of data regarding the above characteristics of the concept
- Conducting interdisciplinary or temporal comparisons
- Identification of the model case of the concept
- Identification of hypotheses and implications for further development.

For the purpose of this study the sixth and eighth steps were not used. Detailed descriptions are done in chapter 4.

2.5.2.1.2 Conceptual framework

The concepts were then classified using the elements of the practice model by Dickoff, *et al.* (1968:426). The survey list discussed within this theory, that is the

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agents, patiency, framework, terminus, procedure and dynamics, was used as a basis for the classification (Dickoff, *et al.*, 1968:426).

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Agent

An agent is a person or any other person/thing whose activity contributes towards realization of the goal (Dickoff, *et al.*, 1968:426). Different persons can perform different activities while striving towards the same goal (Dickoff, *et al.*, 1968:426). In this study the agents were parents and teachers whose main goal was to educate teenagers about sexual health.

Patiency

These are persons or (things) who receive action from agents and this activity contributes to a certain goal (Dickoff, *et al.*, 1968:426). In this study the patiency were teenagers who were receiving education from both parents and teachers.

Framework/context

The context is viewed from the aspect of the matrix of activity. To view an activity is to see it in relation to other things, including persons and other activities, and to see the interrelation of these other factors as constituting an organism, unity, or total context of activity (Dickoff, et al., 1968:426). The context within which this study was conducted was a mainly rural context within the school, family and the community.

Terminus/purpose

To treat activity from the aspect of terminus is to view activity from the perspective of the end point or accomplishment of activity (Dickoff, et al., 1968:426). The terminus for this study was the outcome of dialogue.

Procedure

This is to view the activity from the vantage point of the principle, rule, routine or protocol governing the activity. This is to emphasize the path, steps, pattern

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according to which the activity is performed (Dickoff, *et al.*, 1 968:426). The procedure was also guided by the outcome of the concept analysis.

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Dynamics

These are the power sources for the activity which can be chemical, physical, biological and psychological for any person or thing functioning as agent, patient or part of the framework in realizing the goal (Dickoff, et al., 1968:426).

2.5.2.1.3 Model development

A model is a symbolic depiction of reality. It provides a schematic representation of relationships among phenomena and uses symbols or a diagram to represent an idea. A model helps to structure the way any situation, event or group of individuals can be viewed (Chinn & Kramer, 1999:51).

In this study a model was used in the form of a diagram to represent how sexual health dialogue can be promoted between teenagers and parents/teachers in the rural areas of Limpopo Province in South Africa. Chapter five of this thesis discusses fully how the model for the promotion of dialogue is developed and presents a schematic representation of the model. It discusses in detail how the concepts in the diagram relate to each other (Chinn & Kramer, 1999:51).

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- **Formulating criteria for concepts**

Criteria provide guidelines for reorganizing experience that one needs to represent and to differentiate it from other similar instances. Criteria for the concept emerged gradually and continuously as definitions, various cases, other sources and varying contexts and values were considered. The criteria were refined so that they reflected the intended meaning. The criteria for the concepts that were used in the model were described to enhance meaning (Chinn & Kramer, 1999:69).

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- **Structuring and contextualizing the model**

This involved establishing systemic linkages between and among concepts resulting in formal theoretical structure. Choice of approach depended on the purpose for developing the model, what the researcher already knew or assumed to be true and the researcher's underlying philosophical ideas about the nature of nursing knowledge. The interrelationships between the data clusters guided the structure that the researcher created for the model (Chinn & Kramer, 1999:73).

- **Identifying and defining concepts**

In structuring the model the researcher identified concepts that formed the basis for the model. These concepts emerged from the data collected and the literature control. The researcher avoided abstract concepts as they carry a broad meaning and give a wide range of experience. In selecting concepts the researcher also thought of relationships among concepts so that the researcher was guided regarding which concepts to include. These relationships were based on previous research, existing models, philosophies and personal experience (Chinn & Kramer, 1999:75).

- **Identifying assumptions as part of the model**

Assumptions are underlying issues that are presumed to be true. They are not intended to be empirically tested for soundness, but they can be challenged philosophically and may be investigated empirically (Chinn & Kramer, 1999:76).

- **Clarifying the context**

This involves putting relationships among concepts within the context of the study (Chinn & Kramer, 1999:77). The context within which the model will be applicable will be the rural areas.

- **Designing relationship statements**

Relationship statements that describe, explain or predict the nature of the interaction between the concepts of the model were discussed (Chinn & Kramer,

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1999:77). The researcher described the relationship between identified concepts. A detailed explanation of how concepts interact within the model will be given in chapter four of this book.

2.5.2.1.4 Model description

Description of the model was facilitated by the following questions: What is the purpose of the model? How are concepts defined? What is the nature of the relationships? On what assumptions is the model built? What is the structure of the model? and, What is the purpose/procedure of the model? (Chinn & Kramer, 1999:84).

- **Overview of the model**

The researcher highlighted all elements and relational statements concerning how sexual health dialogue can be promoted between teenagers and parents/teachers in Vhembe district of Limpopo Province, South Africa. A schematic representation was made to show the main concepts and the relation statements to construct a model (Chinn & Kramer, 1999:84).

- **The purpose of the model**

The purpose of the model was to promote dialogue about sexual health between teenagers and parents/teachers in Vhembe district of Limpopo Province, South Africa (Chinn & Kramer, 1999:84).

- **Structure of the model**

The researcher described the assumptions on which the model was based, the main concepts and sub-concepts, the relational statements deduced and the nature of the structure. The description of the nature made it possible to follow the reasoning of the model in its entire graphic representation, to demonstrate the nature, and how colours were selected, to assist in emphasizing certain aspects (Chinn & Kramer, 1999:84).

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- **Process of the model**

The adapted model guided the description of the procedure to facilitate the dialogue among teachers, parents and teenagers in the rural areas. The description was based on the results of the views of parents, teenagers and teachers, conceptualization and the relational statements (Chinn & Kramer, 1999:93).

2.5.2.1.5 Model evaluation

Evaluation of the model was conducted according to the questions in Chinn and Kramer (1999:99-110) which are as follows:

How clear is the model?

How simple is the model?

How general is the model?

How accessible is the model?

How important is the model?

2.6 SUMMARY

This chapter described the detailed process of how the study was conducted in order to achieve the study objectives. The two phases of the research approach were described. The study design was qualitative, explorative, descriptive, contextual and theory generative in nature. Phase one consisted of exploration of experiences of teenagers and parents/teachers, phase two consisted of concept analysis, model development, model description and evaluation. Ethical considerations and trustworthiness were also described. Chapter three discusses data analysis, interpretation and literature control.

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CHAPTER 3

DATA ANALYSIS

3.1 INTRODUCTION

The previous chapter discussed the methodology that was used to conduct this study. In this chapter the analysis and interpretation of data is guided by Leininger's Sunrise model (Leininger, 1991:30). The researcher provided quotes in the discussion to give the worldview of the participants. Conclusions were drawn according to Leininger's three modes of decision making which are cultural care preservation or maintenance, cultural care repatterning or restructuring and cultural care accommodation (Leininger, 1991:30). This chapter aims to analyse, interpret and describe the data collected. Data was collected from teenagers and parents through in-depth individual interviews and focus-group interviews. In-depth individual interviews were conducted with teachers as each teacher had her own teaching style. To ensure openness about the issue, focus-group discussions were discouraged as teachers would not want to discuss how they engaged teenagers in dialogue about sexual health in front of other teachers. Literature control was done to validate the findings. The average time spent on in-depth individual interviews was about one hour and thirty minutes, and focus-group discussions lasted for about one hour and fifteen minutes. The total time spent on interviews was 42 hours and ten minutes.

3.2 OBJECTIVES OF THIS CHAPTER

The objectives of this chapter were

- to analyse raw data, and reduce it to themes, categories and sub-categories;
- to reflect participants' experiences and views through quotations from what they had said;
- to discuss findings in the light of relevant literature.

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3.3 DESCRIPTION OF THE SAMPLE

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Table 3.1 reflects the villages involved in the study, the number of teenagers, parents/teachers and the distance from each village where research was conducted. The table also indicates the number of people who participated in the study by means of focus-group discussions and in-depth individual interviews. The distance from each village was included because the researcher wanted to establish whether there would be a difference among villages that were near to the suburban area and those that were far away. The research results did not show a marked difference between villages near to or far from the suburban area. Data was collected in different months and the researcher moved from one village to the next when data saturation was reached.

Table 3.1 Villages, parents, teenagers, teachers and distance.

Village	Parents		Teenagers		Teachers	Distance from suburban areas
	Male	Female	Male	Female	Female	
MAUNGANI	1	13	10	8	2	10KM
NHLANIKI	2	8	10	12	1	70KM
NGOVE	1	17	7	10	3	20KM
TOTAL	4	38	27	30	6 from different schools	
GRAND TOTAL	105 PARTICIPANTS					

INTERVIEWS						
	PARENTS		TEENAGERS		TEACHERS	
GENDER	Male	Female	Male	Female	Male	Female
FOCUS GROUP INTERVIEWS	NONE	31	20	23	NONE	NONE
IN DEPTH INDIVIDUAL INTERVIEWS	4	7	7	7	NONE	6

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3.4 BIOGRAPHICAL INFORMATION

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The participants that were included in this study were mainly female. Among the parents only four participants were male. The fact that the number of male participants was low might have been caused by the fact that the interviews were conducted during the day when most men had to go to work. Another factor could be that most males worked far away from home and they only came back over weekends and at the end of the month. Eleven (11) parents were involved in in-depth individual interviews and thirty-one (31) were involved in focus-group discussions which were conducted three (3) times. The ages of parents ranged from 40 to 55 years of age. Among the teenagers 30 participants were female and 27 were male. Fourteen (14) teenagers were involved in in-depth individual interviews and forty-three (43) in focus groups which were conducted four times. Their ages ranged from 12 to 19 years. The numbers of parents and teenagers were large because of the focus groups. Only six teachers were interviewed through in-depth individual interviews. Two teachers were from primary schools and four were from secondary schools from the same villages where data from parents and teachers was collected. Their ages ranged between thirty-five (35) and fifty-six (56) years. All the teachers who participated in the study were female. This was due to the fact that male teachers were reluctant to teach sexual education subjects. The participants who participated in in-depth individual interviews were not included in focus-group interviews because the researcher felt that their interviews were long and did not want to interfere with their daily activities more than was necessary. The number of participants was determined by data saturation in each village. Table 3.2 provides the biographical information of participants.

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Table 3.2 Biographical information of participants

Participants	In-depth interviews	Focus group	Number of focus group	Age range of participants	Gender
PARENTS	11	31	3	40-55	4 male 38 female
TEENAGERS	14	43	4	13-19	27 male 30 female
TEACHERS	6	-	-	-	6 female

3.5 PRESENTATION AND DISCUSSION OF FINDINGS

Data was analysed using Tesch's eight steps of data analysis (in Creswell, 1990:145). Tables 3.1, 3.2 and 3.3 show the themes, categories and sub-categories that emerged from the analysis of raw data. Presentation of the data is done according to findings first from teenagers, then parents and teachers. Each group is analysed and discussed separately.

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Table 3.3 indicate the themes, categories and sub-categories that have emerged from teenagers data

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Table 3.3 Teenagers: themes, categories and sub-categories

THEMES	CATEGORIES	SUB-CATEGORIES
1. TEENAGERS 1.1 Teenagers expressed how they learn about sexual health.	Media influence on teenagers obtaining knowledge of sexual health	Television and film.
		Magazines and pornographic pictures
	Learning about sexual health from family/friends and siblings	Learning from peers
		Taught by family member or siblings
		Learning from at school
	Cultural implications for sexual health dialogue	Culture regards sexual issues as disrespectful
		Initiation schools are perceived as readiness for sex
1.2 Teenagers' views about sexual health dialogue	Views about person talking to them about sex	A person discussing sexuality is perceived as being wrong/corrupt
		Adult information is reliable and correct.
	Teenagers' expression of how dialogue about sexual health can be conducted	Discussions should start early at home
		Should not be taught to them by a person who is unknown/unfamiliar to them

3.5.1 Discussion of findings

The findings are discussed according to the different participants, namely teenagers, parents and teachers.

3.5.1.1 Teenagers

- THEME: Teenagers expressed how they learned about sexual health.

  This theme emerged from the data that reflected that teenagers learned about sexual health from different sources. It was also noted with concern

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that parents were not mentioned as the main source of information about sexual health. The following are the categories identified from the theme:

- Media influence on teenagers obtaining knowledge of sexual health
- Learning about sexual health from family/friends and siblings.
- Cultural implications for sexual health dialogue

- **Media influence on teenagers obtaining knowledge of sexual health**

During interviews teenagers said that there were different ways in which they learned about sexual health from the media. The media was cited as the main source of information, especially during this era of new democracy in South Africa where there was freedom of expression and easy access to television, magazines and even pornographic films or videos. The following were different ways in which teenagers said they learned about sexual health from the media:

- Magazines and pornographic pictures
  - ➢ Television and film

One participant said: *"You know, I have learnt a lot from television about sex, in some of the programmes. On etv there is this film called "Emanuel" where sexual issues especially intercourse is shown a to z. You know, we watch it at night when old people are asleep. In that programme you can see how a woman is handled when having sexual intercourse and this makes you to be prepared when you want to have sex with the woman. Hhhhh…..the television shows it step by step how this is done. You know sometimes I feel it is too much as when you are watching you get these feelings aaaa1!1!!! (laugh) You know what I mean. They normally play this programme late at night, I am telling you, you can't watch it with somebody older than you, it is too explicit.'*

Another participant said: *'Heee!!!!! I saw one film at my friend's house; it was about people doing it eeee!!!!! You know what I mean. They show you how people do it they don't hide anything it even gives you those feelings and if you are with a girl you just want to do it.'*

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Data indicate that teenagers get to know about sex from television, especially movies and films. They told how explicit some of the films were and this was said to motivate them to want to experiment with sex. Teenagers indicated that most of the time they tried to experiment with sex after seeing it on television or film. Teenagers indicated this after seeing a movie on television, especially those that were screened late at night like *Emanuel*, which they found to be very informative. These films were sometimes discussed with their peers at school and they even tried to practise what had been shown with their partners. This made them learn more about sex as their peers would add more information based on their different experiences.

Literature indicates that exposure of children to sex on television was found to have increased by 400 percent in the United States from 1976 to 1996. Such exposure has been found to affect adolescents' moral judgment and this is said to have contributed to the high level of pregnancy among the youth in the United States (Answers.com, 13.7.2007). Sex is said to be everywhere in the media and teenagers indicate that television, movies and other media are the leading sources of information about sex and sexuality (Malcolm, 2007:6). Television was also described in the study of the youths' perceptions about sexuality in Limpopo, South Africa as one of the factors which influenced teenagers' sexuality, as teenagers were said to believe that whatever was portrayed on television was normal or correct behaviour (Maluleke, 2007:11).

From what was described it was understood that teenagers got information about sex from television and this information was sometimes positive and negative. This might mean that parents should be aware of the type of information with which their teenage children came into contact so that they could assist them. It was also important for them to keep the lines of communication open as this would enable teenagers to discuss with them what they had seen.

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➢ Magazines and pornographic pictures

One participant said: *'You know, there are books and magazines which show positions and everything about sexual intercourse and one needs to practice these things otherwise you will appear to be a fool, so in order to be clever one needs to read about these things in the book. Do you think there can be a person who can teach you about sex? Ha!!!!!! That will be the day! You know, with magazines you do not have to be shy as you can read it alone in privacy without interference from anybody and this makes me relax and understand the contents much easier.'*

Another participant said: *'I so wish that there was enough information about issues of sexual health and contraceptives in the media; this could reduce the rate of teenage pregnancy. You know this can also reduce HIV/AIDS. Information about condoms is available but it is not enough as most of the teenagers use them without understanding.'*

Teenagers cited magazines and pornographic pictures as means through which information was acquired about sexual issues. Teenagers mentioned magazines such as *True Love* and *Bona* where there were articles in which sexual issues were discussed and they thought that these columns were informative. The media was also said to lack information about contraception, except information about the use of condoms to prevent infections. Teenagers felt that the media could also be a good source of information regarding sexual health, especially issues of contraception.

In the study by Hassan and Creatsas (2000: 121), television and other media communication articles were identified as the main source of information and misinformation about sexual health for teenagers. The media was said to be giving correct information especially when a health issue was addressed by a health professional. Misinformation was also said to be given by the same media when advertising or giving the wrong impression about a certain issue. Arousal of

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sexual desire was also described where teenagers indicated situations which made the control of one's sexual desires difficult, like sitting next to one's partner, caressing each other or watching a movie (Maluleke, 2007:14).

From what had been said it was apparent that teenagers relied on the media for most of their information about sexual health. It should therefore be noted that if television was their main source of information, there was a good deal of information that they would have which was incorrect, as different films were screened on television for different purposes. It was therefore noted with concern that sexually active teenagers got most of their information from different media sources. This information could sometimes be misleading and insufficient and this exposed them to sexual health risks.

- **Learning about sexual health from family/friends and siblings.**

Different situations in which teenagers found themselves were mentioned as sources of information for them. Almost none of the participants cited their parents as sources of information. The following were sub-categories that emerged from this category:

- Learning from peers
- Taught by family members and siblings
- Learning from school.

➢ Learning from peers

One of the participants said: *'There is a lot that we talk about as teenagers and most of the time we talk about sexual health issues. When we talk with friends about sexual intercourse I normally lie about it as I have not experienced it, so that my friends do not think that I am stupid. This often makes me feel inadequate and I really want to do it so that I can also feel important. Friends can isolate you if they are aware that you have not experienced what they know. So telling a lie makes you to belong to a group.'*

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Peers were mentioned as sources of information. Teenagers indicated that most of the time they discussed sex with peers. During these discussions, they needed to report their sexual intercourse experiences and if they had not experienced it they we re regarded as fools. They were also encouraged to do it (to have intercourse) so that they could be regarded as clever people. Teenagers also indicated that these practices/conversations put a lot of pressure on them as they often started engaging in sexual intercourse because they wanted to gain the approval of their peers.

In a study about "smart boys and sweet girls" in Thailand it was indicated that boys were said to be smart when they told stories about their sexual performance and conquests to their peers. These boys were said to be inspired as their status depended on stories of sexual performance and conquests. The Thai teenagers were found to have heightened sexual awareness and curiosity and gaps in sexual knowledge and life skills (Vutanont, Greehaigh, and Boyton, 2006:2072). In their study, Wood, Maforah and Jewkes (1998:8) also identified that peer pressure was another factor that influenced teenagers to engage in sexual relations. Most teenagers in this study indicated that engaging in sexual intercourse was used as a strategy to avoid ostracism. Having sex made teenagers belong to a group. The following measures were used to exclude teenagers who had not engaged in sexual intercourse: They were sent away when conversations about sex were started; sent away when talks about boys were engaged in as it was said they would not contribute or it was feared that they would tell their secrets (Wood, *et al.*, 1998:8).

Wood *et al.* (1998:12) also indicated in the study that teenagers gave wrong information about sex. Female participants in the study were found to give wrong and misleading information about sex to their peers. Information given included issues such as that sex was painful, sex did not feel right, during sex the man came on top of one, or sex was done at night. Inexperienced teenagers in the study indicated that this information was misleading as this meant that they did

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not know what to expect when they were to have sex. Wood *et al.* (1998:12) also indicated that some teenagers participated in sex out of curiosity. In another study white female teenagers who were virgins and had a friend who was not a virgin were found to be three times m ore likely to engage in/initiate sexual intercourse within the next three years (Billy & Undry, 1985). The study conducted by Maluleke (2007:11) found that peers were a major negative and positive influence on youth sexuality.

This is an indication of how teenagers succumb to peer pressure most of the time. It was also noted with concern that most of the time teenagers shared information that they themselves were not sure of. The necessary precautionary measures were also not taken and this might expose them to STIs, including HIV and AIDS. It was also noted that the same teenagers could be a good source of information for their peers if the information was correct and well known to the person transmitting it.

- Taught by family member and siblings

One participant said: '*You know, things do happen in the bedroom. My elder brother used to show me how it is done (laugh) I mean with the girl. He used to show me as demonstration on the bed using a pillow. He even showed me how to romance a girl before intercourse and he always said that he does not want me to be a fool. He even explained to me how enjoyable sex is and I just tried it and the girl I have tried with fell pregnant and she has a child. It is disturbing because I did it without protection, yoo!!! Life is tough (laugh).*'

Teenagers expressed how they were taught about sexual health by their siblings. It was noted with concern that the type of information that was given to teenagers was only about sexual intercourse. More important information such as the use of condoms or other forms of contraception was not given to them. Research indicates that children prefer to be taught about issues of sexual health by their peers rather than their parents. Children reported that they often felt

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embarrassed when they talked to parents about issues of sexual health (Ogle, Glasier, Riley, 2008:286).

- Learning from school

One participant said: *'I have learnt a lot about sexual health from school. Our ma'm is very good and patient. She taught us a lot even about rape and how to report to the police. My problem is that when you ask more questions in class they always laugh at you and this makes us to be afraid and not participate. When I started menstruating I did not have problems as she had already taught us. Hey she really helped me.'*

Most of the teenagers indicated that there was a lot that they were taught at school by teachers. The school was also the place where most of the information related to sexual health could be obtained. From the data that was collected it was found that learners were comfortable with female teachers as they were said to be patient and they were given all the information they required. It was also noted from the discussions that some of the teenagers were not free to discuss issues of sexual health with teachers as some of them said that they feared being labeled.

Research studies showed that girls were much more likely to discuss issues of sexual health with their mothers than their fathers (Ogle *et al.*, 2008:287). On the other hand, schools were reported to be ill prepared to teach sexuality education. The curriculum in the United Kingdom does not put pressure on the schools to teach sexual health as there are no examinations and sexual health is not a compulsory study area for trainee teachers. The result is that the impact of sexual health education in schools does not have a positive effect on teenagers and teenage pregnancy remains high (Evans & Tripp, 2006:96).

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- **Cultural implications for sexual health dialogue**

Participants indicated different roles that were played by culture in sexual health dialogue. Culture was said to influence the way in which children discussed issues of sexual health with parents. The role of culture in sexual health dialogue is discussed under the following sub-categories:

- Culture regards discussing sexual issues with adults as disrespectful.
- Initiation schools are perceived as readiness for sex.

➢ Culture regards discussing sexual issues with adults as disrespectful

One participant said: *'I don't actually know how I can start a dialogue about issues of sexual health with my parents as this is seen as disrespectful as one has been taught not to speak to adults about sex or anything that is vulgar so I do not expect my parents to talk to me about sex. A person needs to be clever and look for information yourself (phanda). You know, most of the time when you ask questions about sex to parents they think that you are already engaging in sexual intercourse.*

Teenagers indicated that it was difficult to talk to parents about sex as this was regarded as taboo, or something that one should not talk about with adults. Discussing sex with elders was also regarded as disrespectful. It was mentioned that culturally there were people who were expected to talk to teenagers about sexual health and those people were aunts in the family, not parents.

Research indicates that discussing sexuality is very difficult, especially between parents and children. Sexuality is said to be something that cannot be talked about in public but should rather be discussed with peers (Maluleke, 2007:9). According to research conducted in Kenya by Mbungua (2006:1089) society in that area and other parts of Sub-Saharan Africa has similar cultural barriers that deter members of one group (parents) from discussing matters of sex with members of the another age group (children or immediate juniors) or people of the opposite sex. In the same study it is also mentioned that this practice is found

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even in modern educated families who know about HIV and AIDS (Mbungua, 2006:1089). European Christian values were also said to have an influence on sex education as mothers were said to think that a good Christian should use clean language and this made them use metaphors which they hoped their children would understand (Mbungua, 2006:1089).

It was assumed that culture and religious factors influenced to a certain extent how parents/teachers communicated with teenagers about sex, and most of the time these factors inhibited more than they promoted dialogue. Peer discussions were expected to have a lot to do with sex education. This meant that it was very important for these teenagers to have correct information to share among themselves.

- Initiation schools are perceived as readiness for sex.

One participant said: *'You know, it is so exciting in initiation schools. You don't have to be ashamed of anything, people just mention everything, even private parts by names. The songs are also full of vulgar language and we are told that we are now adults, and when we come out of initiation we feel that we have grown up and we must do what adults do without questioning.'*

Teenagers also indicated that they received a lot of information about sex during initiation. They indicated that during initiation they were taught how they should handle people of the opposite sex especially during sexual intercourse, and how one should respond. This teaching made teenagers more inquisitive and eager to experiment. They indicated that in most instances teenagers became pregnant after attending initiation schools.

Research confirms that a lot of sexuality education happens when young girls and boys are initiated. Sponsors (who are mentors of initiates) are said to be permitted and mandated to give comprehensive sex education to initiates. Candid sex talks that are reinforced in songs with explicit sexual language are

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taught to initiates. Because dancing to these explicit songs is part of learning, dance becomes a means through which sex education is reinforced. The initiates are said to be married immediately after initiation (Mbungua, 2006:1082). Maluleke (2007:13) also found that initiation had both positive and negative effects. Some teenagers in this study thought that going through puberty rites (initiation) helped them to remain virgins while others felt that puberty rites were done very late as they were already sexually active and there was nothing new to learn (Maluleke, 2007:13).

Mulaudzi (2007:34) also describes how sex education is emphasized in initiation schools among the Vhavenda people. The researcher explains how the girl initiates are warned against engaging in sex at an early stage as this is described as going to deflower them. At the same time the girls are also taught about how to have sexual intercourse which can be said to be contradictory, as it might influence them to go out and experiment.

It has been gathered from data and literature reviewed regarding the role of initiation schools in sexuality education that there is some form of sexuality education that takes place in these schools. This education has also been found to be both negative and positive. The education given is in the form of song, dance and story telling. These forms of teaching can be powerful if the people doing the teaching are well informed and such education is well structured and intended to cover all aspects of sexuality education.

- THEME: Teenagers' views about sexual health dialogue

Teenagers' had both positive and negative responses regarding a person engaging them in a dialogue about sexual health. The following sub-categories emerged from the data:

- Views about the person talking to them about sex
- Views about how dialogue about sexual health could be initiated
- Views about the person talking to them about sex.

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- **Views about the person talking to them about sex**

Different views were given by teenagers regarding the person talking to them about sex. The following are the quotations and sub-categories of the views about the person talking to them about sex:

- The person who talks about sexuality with teenagers wants to corrupt them.

One participant said: *'Ma'm, you know most of the time if an adult talks to us about sex they always have a motive behind. Most of these adults have low morals and can easily rape or abuse you, that is why we always question the motive when an adult talks to us about sex especially if that person is a stranger. Ma'm sometimes adults talk about sex and give a person drugs so that they can rape you, hey it is dangerous.'*

Another participant said: *'It is not easy for an adult to talk to teenagers about sex, culture does not allow this; so if an adult can start to talk to me about sex one needs to be careful as these are people that can easily rape you, you know teenagers always prefer that adults who want to engage teenagers in sexual health dialogue should be people known and trusted by us.'*

Teenagers said that they regarded a person who always talked to them about sex as being corrupt or regarded that person as someone who would like to rape them if he was male. Teenagers said that most of the time when a person wanted to have sex with them they normally talked about sex playfully with the hope that he could have sex with them. They indicated that there was a high level of sexual abuse of children in the country hence they were always skeptical of a person talking to them about sex. Some of the teenagers indicated that people who were using drugs also used sex talk to lure them, so this made them view a person talking about sex with suspicion.

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Teenagers also indicated that adult information was not reliable as most of the time the adults who were open about sexual health dialogue were those who were promiscuous or unknown to the teenager. It was therefore noted that if the attitude of teenagers towards the person who taught them about sexual health was negative it was impossible for them to engage in a successful dialogue.

A European Christian principle that was imposed on Kenyans was also found to have a negative impact on sexuality education. The use of "dirty language" was discouraged, and most Kenyan Christians take offence at the mention of genitals or sexual intercourse. This tends to inhibit parents, teachers and leaders from talking openly about sex as it is regarded as morally wrong and they fear being labelled as promiscuous (Mbungua, 2006:1083). Culture and Christianity play a role in influencing people's views about the person talking to young people about sexual health issues. In the United Kingdom it was found that the majority of teachers were extremely uncomfortable with the idea of teaching sexual health. This was caused by cultural meanings that were attached to sexuality and in particular, adolescent sexuality. The legality of the specific curricular content was also found to be a problem for teachers (Evans & Tripp, 2006:96).

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- Adult information is always reliable and correct

One participant said: *'You know, parents want us to have good things, they always expect us to be obedient and succeed in life. There is no way that they can mislead us. Most of the time when they scold us and tell us not to engage in sexual intercourse our parents want to protect us. I have seen this at home. My sister used not to listen to them now she is having a baby without a father. Now my parents have the burden of looking after her child. That also taught me a lesson and I will listen to my parents.'*

Another participant said: *'Friends can easily mislead you. Sometimes friends can tell you a method of preventing pregnancy that is not proven. Most of the time you will find that the person that is advising you has a child and I always wonder*

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why the method has failed with her. This shows you that this person wants you to have a baby like her.'

Other teenagers felt that it was good when an older person taught them about sexual health. They indicated that there was no way that an older person would mislead them, especially if it was their parents or relatives. The parent was regarded as a person who had experience as he had also passed through this difficult time. Teenagers also felt that it would be wrong to rely on the information that they got from friends and magazines only. They indicated that most of the time the information that they got from friends was incorrect. It was indicated that most of the time peer information was misleading.

Literature about research on sexual issues among Malaysian boys also indicates that Malaysian boys would feel comfortable if parents could talk to them about these issues (Wah-Yun, Chirk-Jenn, Shaimi & Eng-Suan, 2007:290). This is contrary to research conducted by Ogle *et al.*, (2008:286) who found that children were not willing to discuss sexual health matters with their parents. Children reported being embarrassed about talking to parents about sexual health. Discussing intercourse was said to be impossible with parents. Adolescents' communicating with parents about sexual health was also found to be rare as they preferred to get information from youth workers or medical students. Adolescents were said to be embarrassed about discussing sexual health issues with parents hence the use of other people or services (Ogle et al., 2008:287).

- **Views about how dialogue about sexual health could be initiated**

Teenagers also mentioned different ways in which dialogue could be initiated between them and parents/teachers. The following were ways that were mentioned by teenagers:

- Discussions should start early at home
- They should be taught by a familiar person.

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➢ Discussions should start early at home

One participant said: *'You know, sexual health education should start early in life. The information will help a lot of children in dealing with issues such as rape, incest eeee ! I mean this information will also help us in asking relevant questions when one becomes a teenager. You know by the time a child becomes a teenager he/she will be at ease in engaging adults in sexual health discussions.'*

Teenagers felt that discussions about sexual health should start early in their lives when they had not even started having sex or even menstruating. They also indicated that sexual health education should be introduced to them by a person who had the role of teaching children about sexual health. It was felt that parents should initiate sexual health education early at home so that by the time they started menstruating or getting information from peers and schools they would have been exposed to such information at home.

Contrary to this, teenagers in a study about worksite-based parenting indicated that they did not like talking to their parents about sex as talking made them feel embarrassed, uncomfortable and nervous (Eastman, Corona, & Schuster, 2005:66). Teenagers in the study thought that if they talked to their parents about sex parents would get worried and nervous, thinking that they were engaging in sexual intercourse (Eastman, *et al.*, 2005:66).

➢ They should be taught by a familiar person.

One participant said: *'It is very difficult for us to trust information that is given to you by a person who is unfamiliar to you. Let me give you this example. If a teacher teaches you about issues of sexual health sometimes you doubt his intention. Hey!!!! Some of them want to sleep with you so I don't trust such information. It's better if it is a lady teacher as they are harmless. Strangers like male nurses ha!!! I am afraid.'*

Teenagers felt that they would appreciate it if the person teaching them about sexual health could be somebody familiar to them. From the discussions it was

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clear that teenagers needed to be taught about sexual health by people that they knew and trusted and these were family members. It was also found that teenagers were terrified of talking to strangers as they were said to sexually abuse them. This was contrary to what had been identified in some of the studies where teenagers indicated that they would be comfortable if sexual health was taught to them by youth workers or medical students, people other than their own parents (Ogle *et al.*, 2008:287). In the study among Thai teenagers Vuttanont, Greenhaigh, Griffin and Boyton, (2006:2079) found that peers were the preferred source of information as parents and teaches were said to have limitations as sex educators.

Concluding remarks

Concluding remarks are made in line with the theory of Leininger's Sunrise trans-cultural health care model three modes of providing congruent care are: cultural care preservation or maintenance, cultural care repatterning or restructuring and cultural care accommodation (Leininger, 1991:30).

- **Cultural care preservation**

The following aspects were found to be beneficial to the community hence the need to preserve. From this discussion it was noted that there was a general feeling among teenagers that sexual health dialogue should be started early in their lives. This gives the parents the primary role in educating their children about sexual health. Teenagers also indicated that there was a need to discuss sex with people whom they knew which meant that they needed to trust this person. Parents were therefore urged to take up their role as primary educators and inform their children about sexual health.

- **Cultural care repatterning or restructuring**

Data from teenagers also indicated that there was lack of education among teenagers about sexual health. This was evident from the type of information that they gave when interviewed. It was noted with concern that the teenagers always

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referred to sexual health as an act (intercourse) and there was no mention of other aspects such as rape, sexually transmitted infections and physical changes that happened in the bodies of girls and boys. There is need to change the manner in which teenagers are informed about issues of sexual health. Teenagers also need to change their view of sexual health as an act. Cultural values and norms were said to be the cause of lack of communication between teenagers and parents/teachers. It was also noted that culturally a relative who was an aunt was the source of information or the person who should give teenagers information about issues of sexual health.

The type of information given also revolved around the sexual act and not sexual health. Almost all the participant said that dialogue was absent and communication tended to be unilateral, from the aunt/parents/initiation schools to the teenagers, with no consideration for the teenagers' opinions. The other source of information which was the media also placed more emphasis on the sexual act, which meant that sexual health was addressed as an act (intercourse). It was also noted that neither teenagers nor parents/teachers had knowledge about sexual health. Parents and teachers needed more information about sexual health so that they in turn would be able to educate the teenagers adequately and be able to answer their questions.

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Table 3.4 indicate the themes, categories and sub-categories that have emerged from teachers data

Table 3.4 Teachers' themes, categories and sub-categories

THEMES	CATEGORIES	SUB-CATEGORIES
2.1 Teachers expressed difficulties when teaching learners about sexual health	Poor participation by learners	Feeling of being intimidated and fear of being labelled
		Learners are not comfortable with teachers present
	Failure to maintain discipline in class.	Pupils are often uncontrollable when shown pictures of private parts/genitals.
		Excessive workload and lack of material
		Minimal attention given to the subject by students
	Lack of resources; inaccessible information	Most of the time only one teacher is expected to teach all grades.
		Periods allocated too few.
		Lack of reading material, no libraries, failure of clinics to cope with students needing information and rude nurses
	Cultural influences on sexual education in class	Cultural inhibitions make it difficult to discuss certain issues like menstruation if you are a male teacher.
		Parents complain that bad things are taught to their children.
		Failure of pupils to get more information from the parents.
2.2 Teachers expressed how dialogue with teenagers could be initiated.	How dialogue should be conducted.	Dialogue to be conducted with a limited number of students at a time.
	Responsibility of initiating dialogue	All teachers to participate with more emphasis on subject teachers

3.5.1.2 Teachers

- THEME: **Teachers expressed difficulties when teaching learners about sexual health**

Teachers expressed how difficult it was to teach learners about sexual health. Data from teachers that described this difficulty was analysed and yielded the following categories:

- Poor participation by learners
- Failure to maintain discipline in class
- Lack of resources and inaccessible information

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- Cultural influences on sexual education in class

- **Poor participation by learners**

Teachers described how teenagers failed to participate during sexuality education. Lack of participation by learners was classified into the following two sub-categories:

- Feeling intimidated and fear of being labelled
- Learners were not comfortable with teachers present.

➢ Feeling intimidated and fear of being labelled

One participant said: *'When some of the students participate in class during sexual health education you can see how the other students look at them, you can also see the type of laughter that erupts when somebody has responded to a question.'*

Another participant said: *'One day after teaching sexual health in class one girl who was participating well in the discussions came to my office crying, she said that the other students in class had given her a name called "nyama ayi ndluli" (there is no meat that passes her) which means nothing passes her she sleeps with everybody. This girl was so hurt and ashamed even though she was innocent.'*

Another participant said: *'I once asked the student to tell me why they do not want to participate even when they are expected to write and they said that they know that I can identify their handwriting and this can make me to know who wrote what and label them.'*

The participant indicated that the students were not willing to participate during sexual education in class. It was indicated that most of the time students felt intimidated by fellow students and participants could be labelled by fellow students as "swifeve" (people who are promiscuous). Teachers also expressed

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that it was so difficult to teach teenagers as when questions were asked nobody wanted to answer them. Teachers also explained how they often changed strategies and asked students to write answers on paper to encourage them to participate. When answers were given teenagers did not feel at ease when they were supposed to write their names. Teenagers always feared that they would be judged by the type of information they gave.

In the study by Sekoe (2005:23), it is mentioned that obstructive and judgmental behaviour and moralizing among health workers was found to influence the health-seeking behaviour of the youth. This might also be applicable in class where teenagers were judgmental towards other teenagers who were participating. These attitudes by adults could also contribute a great deal to non-participation by learners as adults were often viewed by teenagers as being judgmental and obstructive. Maja (2007:45) describes the discomfort that the youth experience when they try to express their feelings and health care needs in the presence of older persons. It can therefore be assumed that poor participation by teenagers could also result from the presence of a teacher who is also an adult.

- Learners were not comfortable with teachers present

One participant said: *'Learners are not always comfortable when discussions about sexual health are conducted in our presence. When you go to the staff room to collect something learners participate well in my absence and when I come back everybody just keeps quiet. You can hear a pin drop. I don't know how I can motivate them to participate because I can see that they really would like to talk about this issue.'*

Another participant said: *'People from Love Life told me that it's better for me not to attend as students do not feel at ease when I am part of the discussions. I left the class that day and the report indicated that they had a fruitful discussion.'*

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During interviews with teachers it was expressed that when people from Love Life or nurses from the clinic visited the schools the students were always unwilling to participate when the teachers were present. The teenagers normally participated in the discussions when the teacher was not there. When the teacher returned the whole class kept quiet and there was no more participation. This was an indication that children were not so keen to talk about these issues when the teacher was present.

In the study on the perceptions of youth about sexuality it was identified that most of the youth were said to regard sexuality as a difficult matter to talk about especially with an adult. Sexual intercourse was said to be a private matter and discussions about it were said to be with peers and during initiation (Maluleke, 2007:9).

Based on the findings one could draw the conclusion that teenagers found it difficult to discuss issues of sexual health with adults. These barriers were also experienced in class when the teachers tried to teach them. It would therefore be necessary to examine all the barriers that inhibited discussions about sexual health to ensure that this education was successful.

- **Failure to maintain discipline in class**

Maintaining discipline in class was said to be difficult when discussions about sexual health were initiated. From data that was analysed the following sub-categories were identified:

- Learners were uncontrollable when shown pictures of private parts/genitals
- Excessive workload and lack of material
- Minimal attention given to the subject by students

➢ Learners were uncontrollable when shown pictures of private parts/genitals

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One participant said: *'The teenagers start to laugh the minute you start talking about sex and these learners sometimes can laugh for the whole period. This makes it difficult to teach as you end up not knowing why they are laughing for such a long time. You know, it is difficult to restart the lesson all over again and this makes the progress very slow.'*

Another participant said: *'This subject is very uncomfortable. One needs to be prepared to deal with different situations in class. The reaction of learners also determines the proceedings in class, so I think we as teachers need to be empowered to handle the learners. You should also remember that we are from the same culture where discussing sexual health is taboo, hence the discomfort when students start laughing in classes.'*

The participants indicated that most of the time the classes were uncontrollable as students started laughing the minute the teachers introduced the topic in class. Teachers expressed how uncomfortable they were when learners started laughing as they themselves were not yet comfortable with some of the topics and pictures that they showed to learners. They expressed how culture and the way they were brought up could have an influence on these feelings about the subject.

Information on sex education in public schools indicated that most of the teachers found themselves out of control when facing a room full of adolescent students. Most of the students were said to be immature and therefore titillated by the subject matter. This loose atmosphere was also said to be questioned by parents (The public school parents' network, nd).

- Excessive workload and lack of material

One participant said: *'This is an addition to the workload and this makes us not to cope with the workload that one has. One has to prioritise and most of the time sexual health education is not given priority as it is a non examination subject.'*

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Another participant said: *'There is so much need for sexual health education in the schools. I think the government should do something because of HIV/AIDS. There is need to inform the learners so they should provide posts specifically for sexual health education so that it can be successful as there will be teachers focusing on it only.'*

The number of periods was said to be too few because more periods were allocated to examination subjects. Participants also complained about their excessive workload as teachers who were involved in sexual health education were not given fewer subjects. The number of subjects given to them was the same as those not teaching sexual education. This made it difficult for those teachers as they had so many classes to teach. Most of the teachers explained how it would be easy for them to teach if they were given fewer subjects to teach. They showed much interest in their work but they indicated how difficult it was to plan as there was no time to plan and implement their plans to teach the subject.

This is supported by literature on the study conducted in Botswana by Berkhof, (2003:172) where students complained about teachers not being open enough. Lessons were also said to be infrequent with lack of audiovisual materials. Lack of materials was also cited by Hassan and Creatsas (2000:121) in their study as another problem that made sex education in schools ineffective. Most of the teachers involved in the study indicated that they needed training in sexuality education for them to be effective. Incorporation of sex education into the curriculum was also recommended as the school was also regarded as the area where formal education about sex should take place (Hassan & Creatsas 2000:121).

From the literature and findings of this research it was identified that there was a need for the Department of Education to look into sexual education at schools. The teachers that were fulfilling this role of educating pupils should be trained,

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and the courses that they needed for teaching to be effective should be supplied to them. The inclusion of sex education as an examination subject could be a solution that needed to be looked at as students would then take the subject seriously and study it. This was very important especially because of the HIV/AIDS epidemic. Unequal distribution of workload among teachers was also an indication of the little emphasis that was being placed on sex education in schools. For successful sex education the Department of Education should do the following:

- Supply materials that were needed to teach the subject.
- Make sex education an examination subject.
- Include sex education in the curriculum and
- Reduce the workload of sex education teachers.

➢ Minimal attention given to the subject by students

One participant said: *'You know, most of the time it is so difficult to plan the lesson as students are not keen to answer when I want to evaluate prior learning. You know, even if you ask them to give you topics that they would like to learn, this people will never, you know, never give you. So you do not know what is the necessary knowledge that they require.'*

Another participant said: *'It is so frustrating to teach this subject. You know, when you give learners a test to evaluate them, they simply do not read and they fail, almost everybody in class. When I asked them about their failure they are not even ashamed to tell me that they did not read because they were having a lot of work. This makes me helpless as I can see that they are not giving this subject enough attention.'*

Another participant s aid: *'Learners do not have patience or what can I say ummmmmm, they do not put effort to the subject. When you send them to look for information at the clinic they are always impatient and do not wait for the nurse to attend to them. When they go to the clinic and find that the nurse is still*

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busy they just go away. You know the nurse is also busy and they are short staffed.'

Participants indicated that it was very difficult to see whether the student knew anything about the subject. They indicated that most of the time they were unable to assess learners' level of knowledge as learners were not keen to give answers, even in writing. This lack of interest or participation also made it difficult for the teacher to plan and gather information that was going to be relevant to the group as there was lack of correct information about their prior knowledge.

Participants also explained how most of the time learners failed tests that they were given and when they were asked the reason for failing the learner always indicated that they had a lot of work to do and could not read. This proved to be demotivating to the teachers as they did not try other mechanisms to ensure participation and to pass the test. It was also indicated that sometimes students were referred to the clinic to gather information or to look for newspaper cuttings that addressed the subject under discussion. It was said that learners were not keen to look for information. When they visited the nurse at the clinic it was said that they were not patient enough to wait for the nurse who might be busy. They walked away if the nurse was not readily available.

Minimal attention to sexual health in the curriculum content was identified as a major handicap to sexual health education in the United Kingdom. Sexual health was a non-examination subject and not a compulsory study area for trainee teachers (Evans & Tripp, 2006:96).

- **Lack of resources and accessible information**

Teachers expressed problems related to resources. Both material and human resources were said to be scarce. This was expressed in the following categories:

- Teacher is expected to teach all grades

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- Periods allocated to the subject are too few.

➢ Teacher is expected to teach all grades

One of the participants said: *'When you look at the amount of work that you are expected to do and the number of classes that you must teach you just become discouraged and just don't go to class. It is very difficult to teach so many grades and the other people have lots of free periods to do their own things.'*

Another participant said: *'The number of our classes is very big. You know, this subject needs a lot of interaction. One does not need to give a lecture, so tell me how I can organise a class of sixty people. You are just deflated before you even start talking. I don't have a negative attitude but I mean the environment must allow or assist in making things possible.'*

Participants appeared despondent as they explained this issue. They indicated how difficult it was for them to teach all grades at school. They indicated that in most of the schools there would be more than one class per grade with a maximum of about sixty students. The number of students in each class was said to be a problem as they indicated that it was difficult for them to control these big classes. Participants also indicated that teaching all grades was exhausting to them as they moved more than once in the same grade. They felt that perhaps it would be better if one person handled one grade to increase the effectiveness of these lessons.

➢ Periods allocated to the subject were too few

One participant said: *'You know, these people can surprise you. They expect learners to have information about sexual health but they wouldn't dare give you time to teach it. Do they expect me to teach this after hours? Oh!! That will be the day. The level of pregnancies is also high and this tells you that these teenagers are not using condoms or contraceptives in these times of HIV and AIDS.'*

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The participants also expressed how difficult it was to get enough periods to teach sexual health. They explained how difficult it was to get sufficient periods allocated to sexual health education. They said that this exercise always frustrated them as when there was a subject that needed more time for teaching, the time for teaching sexual health education would be reduced. This showed that even the people in authority did not regard sexual health as an important subject for learners. Findings among the Thai teachers (Vuttanont, *et al.*, 2006: 2079) indicate that support by the head teacher (principal) enhanced delivery and uptake of school sex education.

- 'Lack of study materials

One participant said: *'I always pity the clinic when I send my students because I have a class of sixty pupils and there is only one clinic and I think it's very frustrating for nurses when they are expected to help students as they also have their own work to do. I think that is why they say that the clinic staff is rude.'*

Another participant said: *'The schools do not have enough information or reading materials for learners. There is no access to internet and where will I refer these learners to for information? I can sometime bring paper cuttings of information that I think could be helpful yooo!!! The same learners are so selfish they take those cuttings and do not bring them back. There is no control of who took what as I don't have enough time to control this. You see you are bound to be frustrated.'*

Another participant said: *'Sexual health is also a non-examination subject so our learners are exam oriented and they do not read anything that will not be examined. So this is also another factor that makes teaching the subject very frustrating. You know, learners sometimes ask to use your period for preparation for the test.'*

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Participants also indicated that it was very difficult to teach the subject as there was not enough study material. In most schools there was no access to the internet and there were no libraries. In the schools where the teacher accumulated pamphlets the students did not bring them back after borrowing them. Some of the participants indicated that they referred the students to the nearest clinic to look for information. Teenagers did not want to go to the clinic as they said that the clinic staff was rude to them every time they went there for information. Besides lack of reading material, it was said that teenagers did not read about sexual health as they knew that they would not be examined.

Research conducted in Thailand by Vuttanont *et al.* (2006:2079) suggested that teachers should be trained and supported. Training materials should also be developed locally for use by the teacher. The use of trained sexual health professionals to address the needs of teachers, parents and teenagers was also recommended. Lack of materials was cited by Elsheikh, Hassan, George and Creatsas, (2000:121) in their study as another problem that made sex education in schools ineffective. Most of the teachers involved in the study indicated that they needed training on sexuality education for them to be effective. Incorporation of sex education into the curriculum was also recommended as the school was also regarded as the area where formal education about sex should take place (Elsheikh, *et al.* 2000:121).

Material for learning and proper guidance on what to teach and at which level should be made available to teachers. This would assist them to teach what was regarded as being locally acceptable. The schools should also be visited by trained sexual health professionals to give talks and support to teachers involved in sex education. A good working relationship with the Department of Health should also be established to facilitate exchange of information and to keep the teacher abreast of the latest information on sexual health education.

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- **Cultural influences on sexual education in class**

One participant said: *'Oh this is difficult to explain. You know, one ends up not knowing what to teach and not to teach. I have been a learner as well and nobody taught me about sexual health and this makes it difficult for me to do it as my mind still believes that this should be done somewhere, by whom I don't know. This is something that pops up most of the times in my mind.'*

Another participant said: *'You know, blacks are culturally bound. There are the dos and don'ts about issues in society. The issue of sex is not discussed everywhere by anyone. There are people who are expected to do this job. So when I teach, sometimes at the back of my mind I ask myself, is this right? What will society, especially parents, say about me teaching their children about sex? And there is also HIV and AIDS. You know, this is a dilemma to me.'*

Another participant said: *'What worries me a lot is that when you talk openly with learners you sort of lose some of the dignity that you have with the learners, parents and fellow teachers. They give us names and you are said to be loose or promiscuous. This is hurting because you are just trying to help.'*

Cultural influence was also cited as a factor that inhibited sexual health dialogue. Culture still determines what and how teenagers and parents communicate, so most parents are not happy about teachers who discuss sexual issues with their children. Such a teacher is regarded as promiscuous and this shows how difficult it is for teachers to teach sexual health in schools. Most of the participants also indicated how their cultural background interfered with how they taught sexual health in class. It was indicated that they always had this feeling in the back of their minds that perhaps the information they were giving was too explicit or perhaps the information was not appropriate for the target group. It was also indicated that sometimes they asked themselves what the learners thought of them.

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In the study conducted in North Carolina by Kristin, Gizlice, Owen-O' Dowd Foust, Leone and Miller (2006: 2), it was identified that sexuality education had the support of the parents, although parents indicated that they would like to determine what was being taught to the pupils by the teachers. Although parents were said to be interested in determining what should be taught in schools, the study also found that parents were ignorant of the fact that their children were already receiving sexuality education in schools. This could be an indication that they did not regard the subject as being important (Kristin, Gizlice, Owen-O' Dowd Foust, Leone & Miller, 2006:2).

Elsheikh, *et al.* (2000:121) also identified in their study that parents and school administrators often disapproved when the sexual health curriculum included issues such as homosexuality, the use of condoms and abortion. One could conclude from these studies that there was a need to involve parents in the planning of the curriculum on sexual health education. This could also prevent pupils from getting conflicting information from parents and teachers. There was also a need to educate parents about sexual health and sensitize them to the need for teenagers to be given such information especially in this era of HIV and AIDS. It would also encourage parents to get involved in the education of their children by organizing workshops that would help to empower them about ways they could use to engage their teenagers in dialogue about sexual health.

- **THEME: Teachers' expression of how dialogue with teenagers could be initiated**

Teachers expressed different ways in which dialogue could be initiated. They also expressed the difficulties they experienced as they tried to engage teenagers in a dialogue. It was noted from the discussions that teachers also felt that they experienced a certain degree of uneasiness when they tried to engage

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teenagers in a dialogue about sexual health. What contributed to this uneasiness was the fact that they shared the same cultural beliefs as the communities they served. They were also brought up in a community where sexual issues could not be discussed with people younger than themselves and this inhibited the extent to which these sexual issues could be discussed.

In their study, Hayes, Changulucha, Ross, Gavyole, Todd, Abasi, Plummer, Wight, Mabey and Grosskurth (2005:435) emphasized that the person who provided sexual health information to teenagers had to be non-judgmental and welcoming to young people and constant information-giving should be maintained. This would assist teenagers as they would get used to the person and constant discussions would make them more informed and their interest could also be stimulated. Pokharel, Kulczycki and Shakya (2006:160) also indicated the importance of providing teachers with culturally congruent training on issues of reproductive health. Lessons were said to be less formal and with relevant teaching material they were said to be more effective.

- How dialogue should be conducted.

One participant said: *'the classes are very large and this makes dialogue impossible and most of the time one relies on the lecturing method. I think that if teenagers were to be engaged in a dialogue there should be reasonable numbers of students attending uuuu!!!! Maybe the class could be divided into smaller groups to facilitate dialogue. In large classes yo!!! They speak at the same time, nobody listens and there will be a lot of noise and teachers will not manage to control the students.'*

Another participant said: *'I think students can be grouped into smaller numbers and be given topics to study and thereafter a discussion around the topic can be initiated. I think this can work but we do not have libraries or internet to get more information to make the discussions more fruitful.'*

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It was evident from the discussions that teachers were overwhelmed by the large classes that they were expected to teach. These classes forced them to give lectures where students' opinions on and knowledge of specific aspects that were discussed were not shared and dialogue was absent. This might make teenagers feel that their opinions were not taken into consideration and might also make them reject the teachers' advice.

Research shows that lessons that are given to teenagers should be highly participatory and use of peer educators elected by classmates who could sometimes stimulate discussion can be beneficial (Hayes, *et al.*, 2005:435). Pokharel, *et al.* (2006:160) also recommend that classes be divided into groups of boys and girls and guest lecturers be used to assist teachers to allay discomfort with the topic. The use of participatory approaches was also recommended where the teenagers actively participated with the involvement of both the community and parents (Pokharel, *et al.*, 2006:160).

- Responsibility for initiating dialogue

➢ All teachers to participate with more emphasis on subject teachers

One participant said: *'If all the teachers were putting sexual health as one of their priority topics, teenagers would be getting enough information. Let's say in a week each teacher dedicated ten minutes of their time to sexual health discussions this could mean that in each subject the students learn they will be having forty minutes in a month and I think that would be more than enough.'*

Almost all participants felt that the responsibility of teaching teenagers about sexual health lay with all teachers. They expressed the difficulties that teachers who were tasked with sexuality education faced. These teachers were expected to teach all grades and they said it was exhausting. They said more teachers should be required to assist with sexuality education and the other teachers should also be encouraged to treat sexual health as a priority topic even when they are not responsible for the subject.

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Teachers might be reluctant to teach sexual health as indicated in the study conducted by Goldman (2007:378). It was found that student teachers felt that they did not have enough information about sexual abuse to identify children who were abused or to teach the subject to primary school children. It was also suggested that more emphasis should be placed on teaching teachers about sexual health issues during their pre-service training.

Concluding remarks

Concluding remarks are made in line with the theory of Leininger's Sunrise trans-cultural health care model three modes of providing congruent care are: cultural care preservation or maintenance, cultural care repatterning or restructuring and cultural care accommodation (Leininger, 1991:30). In the case of teachers almost all the manner in which sexual health education is given need to be repatterned.

- **Cultural care repatterning**

From the data that was collected from the teachers it was noted with concern that the teachers responsible for sexuality education in schools did not have the necessary resources to enable them to function as expected. Human resources were found to be a problem as most of the teachers were not willing to teach the subject. The teachers who were given the subject sexuality education to teach were also allocated other subjects. The teachers were also expected to teach sexuality education to all grades which resulted in overwork and led to stress. Material resources were also identified as a problem as books, pamphlets and libraries were not available in rural schools. Newspaper cuttings and magazines were not available as the majority of parents in the rural areas were either illiterate or poor or both and did not buy newspapers. This left teenagers with no sources of information. It was also identified that there was a lack of communication between parents and teachers, and teachers were blamed for teaching about sexual issues that the parents did not approve of. The is need to change the manner in which issues of sexual health are handled in schools in

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order to adequately inform teenagers. Teachers and parents should engage each other so that each party is aware of their roles in sexual health education. Teachers involved in sexuality education were identified as being caught in the dilemma between what they should teach and what they thought was not appropriate to teach. These feelings were rooted in the cultural values of their upbringing and the fact that it was possible that most of them had not received such education at school. According to the culture of the areas included in the study, discussions between teenagers and elders about sexual health were inappropriate and this might influence or be part of the dilemma that teachers were facing.

It would therefore be important for the model to address how the teachers were going to collaborate with parents in order to avoid instances where teachers were blamed for teaching explicit sexual information. Teachers would also be at ease with the subject as they would be aware that they had parental approval regarding the teaching of sexual health as the values would have been clarified with them beforehand. Discipline in class was also found to be a problem as teenagers were said to be uncontrollable when shown pictures of sexual organs. There were also reports of people who were participating in a discussion in class being labelled and stigmatized. Policies were said not to be supportive of sexuality education. It was said that teenagers did not put any effort into the subject as it was not an examination subject. A certain level of assessment needed to be put in place so that teenagers could pay attention to the subject and in the long run have information that would assist them to make decisions about sexual health.

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Table 3.5 indicate the themes, categories and sub-categories that have emerged from parents data

Table 3.5 Parents' themes, categories and sub-categories

THEME	CATEGORIES	SUB-CATEGORY
Parents' expression of events that stimulate them to engage teenagers in a dialogue about sexual health.	Physical development of teenagers.	Development of breasts, curves, starting to menstruate and breaking of the voice in males.
	Changes related to the lifestyle of a teenager	Change in behaviour
	Media influence	After hearing talks on radio/television or reading a pamphlet about HIV/AIDS
Parents' expressions of how they engage teenagers in a dialogue.	Parents' expectations after talking to their teenagers about sexual health.	Take the advice they give them.
		Not to fall pregnant or make a girl pregnant.
		Use of condoms.
		Teenagers to accept it when they accidentally fall pregnant.
	Use of indirect speech by parents when talking to teenagers.	Use of indirect speech by parents when talking to teenagers about sexual health.
	Use of teachable moments	Use of aunts to teach teenagers about sexual health
Factors that are seen to be contributing to teenagers' promiscuity.	Contributory factors	Explicit sexual information from schools
		Listening to radios and television
		Peer influence

3.5.1.3 *Parents*

THEME: Parents' expression of events that stimulate them to engage teenagers in a dialogue about sexual health.

Parents expressed how difficult it was for them to initiate dialogue with teenagers. Almost all parents interviewed said that dialogue about sexual health with teenagers was initiated as a reaction to specific things or occurrences. Occurrences that were identified as stimulators of sexual health dialogue were

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- physical development of teenagers
- changes related to the lifestyle of teenagers
- media influence.

- **Physical development of teenagers**

Observation of physical and physiological changes ranked high as stimulants for initiating a discussion. Most of the participants indicated that they usually observed their children for physical changes in their bodies as a determinant that the child was ready for reproducing. These developments were indicators to them that the child had grown and could fall pregnant or make somebody pregnant.

- Development of breasts, curves, starting to menstruate and breaking of the voice in males.

➢ Development of breast, curves, menstruation, and breaking of the voice in males

One participant said: *'You know, it is so difficult for a parent to talk to a child about issues of sex, especially us blacks who were taught that this is taboo. When I realized that my daughter has developed breasts and she wanted me to buy her a bra I thought that was a good opportunity for me to start talking to her about sexual health. I am telling you it was so difficult I could not look her in the eye.'*

One participant said: *'This is a difficult subject, with my daughter I kept on asking her if she has not seen something on her panty. I could not even tell that this something is blood I could not speak out that word. I also believe my girl was confused as well. The day that she saw this thing she came and said she was sick and when I was talking to her I ended up knowing that she has started menstruating. This was teaching by trial and error and it's not appropriate. I think*

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we need to be open, you know you want to but you are unable to bring out the words it is sooo!!!!!!!!!! difficult.'

Another participant said: *'My teaching was reactionary. One day when I was changing her bed linen I discovered spots of blood on the sheet. I called her and asked what these spots were. She was very shy to explain and she started crying. I then told her that if she sleeps with boys she will be pregnant.'*

Another participant said: *'With my elder daughter it started when she had her first menstruation. I had never talked to her about issues of sexual health or even developmental changes that she was going to experience in her body. You know, it caught me by surprise. One day, if I can still remember it was summer, she came back from school before time and was crying saying that she was in pain. She slept the whole day. The following morning when I was making her bed I realized that her linen was soiled with blood. I called her in and asked her what was happening. I was very harsh with her and demanded explanation, she never replied she just cried. I was also frightened, not knowing what to tell her. I just gave her sanitary pads.'*

The direct quotes from parents indicate that breast development, development of curves, menstruation and breaking of the voice in the case of boys are some of the signs that the parents use as a basis for talking to teenagers about sexual health. This can be a misleading sign as in some people breasts do not develop as expected and in some people who are overweight breasts tend to develop early. In a study conducted in North Carolina by Brown, Halpern, and Engle (2005:425), where the maturity of girls was linked to their interest in sexual issues, it was identified that early maturation of girls was linked to more interest in seeing sexual content movies, television and magazines than late maturing girls. In the light of these research results it can be concluded that parents might be right in associating physical development and readiness to start educating children about issues of sex. Maturing girls might as well interpret the messages

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they see in the media as approval for having sexual intercourse (Brown, *et al.*, 2005:425)

The parent's way of teaching was an indication that parents themselves were always on the lookout for those physical developmental changes so that they could initiate dialogue with their children. It was also assumed from these descriptions that most of the parents did not want their children to fall pregnant before time. If this was true it meant that they had a need to educate their children about sex but they did not know how to go about it and when. The model that was being developed would help them to be able to initiate dialogue. There was also a need to educate parents about these physical developments to enable them to teach their children before they experienced it. Parents needed to be proactive rather than reactionary in their sexual health education.

- **Changes related to the lifestyle of teenagers**

Observations were also made by parents on the behaviour of teenagers and their friends. Participants mentioned the following as indicators for readiness to initiate dialogue with teenagers:

- Change in behaviour
  - Change in behaviour of the teenager

One participant said: *'As a parent I need to be observant about what is happening around my child. You know it is easy to identify when your child has started to be naughty. When a child bathes a lot and wants to be neat at all times it means there is somebody who this child of mine is trying to attract or look smart for. There and then one should question this child about the new image change and warn him/her about the dangers of dating.'*

Another participant said: *'I always observe the type of friends that my girl has and I believe in the saying that says birds of the same feather fly together. If the child's friend is seen with boys or is pregnant this should be a warning sign for a*

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parent. This might mean that my child is also doing the same things so as a parent I start talking to my child there and then. You know, one of her best friends fell pregnant and I just told her point blank that I will never tolerate it if she goes around sleeping with boys. I will never allow her in my house if she falls pregnant you can see that I am poor.'

Another participant s aid: *'I started warning my daughter about boys when I discovered that her friend had given birth.'*

Another participant said: *'Tell me where a child goes to when it's dark at night. When my son started going out late and coming back after midnight I knew that he is sleeping around. So because of HIV and AIDS I took condoms from the clinic and I gave them to him. Every now and then I check them and you find that they are finished meaning that he is using them. This has helped because no girl has been brought to my house because he has impregnated her.'*

Another participant said: *'These children are free when they are with us and you are just discussing general things with them but when you start talking to them about sex or try to find out why they are always coming home late you will find that these children cannot look you in the eye then you must know that he/she has started sleeping around and this is normally accompanied by aggression. You end up not knowing what to do as parents.'*

Participants described how the teenagers always wanted to be neat and well groomed. They indicated that when a teenager bathed a lot parents should start suspecting that they had started having relationships with people of the opposite sex. Participants felt that if a child started bathing a lot and changing clothes it meant that the child wanted to be attractive to the opposite sex and this was said to be a warning sign that the teenager had started dating. It was also said to be observed how girls played with boys as this gave them an indication of whether

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they had started dating or not and thus gave them the opportunity to warn teenagers about the dangers of dating.

Participants also explained how they used the characteristics of their children's friends as an indicator of when to start to talk to their teenagers about sexual health. Characteristics that were noted were such as when their children's friend had started dating, fallen pregnant or even started coming home late. The teenagers were usually warned about such behaviour and its consequences.

Teenagers were also said to be shy when parents spoke to them, especially when they had already started to have sex. Participants described how the teenager would not look them in the eye when they had started having sexual intercourse. This was said to be caused by the fact that teenagers knew that having sex before marriage or at that age was wrong. Participants also indicated that they also started talking to the teenagers when they observed that they liked going out late at night and coming back very late or in the morning. It was when they were addressing this fact that they would start talking to them about sexual health. This was because it was assumed that the person who went out at night was visiting a sexual partner an d other problems like drug abuse might b e overlooked.

The difficulties in initiating dialogue that were expressed by parents are also expressed by physicians in the study by Elsheikh, *et al.* (2000:121) who also indicate that physicians feel ill equipped to counsel adolescents on issues of sexual health. Teenagers also reported that they had never been asked by the physicians about sexual issues even if the physicians knew that they were sexually active. On the other hand, in a study conducted among Costa Rican teenagers, parents were quoted as important sources of information (Stycos, 1987). It was also indicated in another study by Muller and Powers (1990:457), that the style of communication between parent and child, if perceived as friendly, attentive and open, has a positive influence on the use of contraceptives

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by teenagers. Participants indicated different aspects that stimulated them to talk with teenagers about sexual health. In contrast to parents' attitudes towards sexual health education where parents said that teaching was stimulated by observing certain changes in the teenagers' behaviour, research suggests that receiving formal sex education before first sex is associated with abstaining from sexual intercourse and delaying initiation of sexual intercourse (Mueller, Gavin & Kulkarni 2008:93). It should however be noted that according to some studies girls could successfully hide behaviours that they thought their parents would not approve of (Donnell, Stueve, Duran, Myint-U, Agronick, Doval & Wilson-Simmons 2008:501).

It was therefore noted with concern that it was not easy for parents to initiate dialogue with their teenage children. The parents tended to hide behind the observations that they had observed as a stimulus to start to talk to teenagers about sexual health. This might mean that sexual education was not given the priority it should be given. Negative perceptions could also be built in the teenager as parents associated dating and being with boys as something that was bad and should not be done. The labelling of friends that were dating or had delivered babies could also mean that dating and giving birth were wrong and teenagers might opt for termination of pregnancy should they fall pregnant. Parents should approach this topic with tact and this should be introduced early in life and they should gradually deepen the discussions as the children grow up. Dialogue about sexual health should involve more than just warning teenagers about the dangers of sexual intercourse. It was important to inform them well so that they could enjoy sexuality while taking the necessary precautions.

- **Media influence**

The media was also cited by participants as another major stimulant of dialogue about sexual health between them and teenagers. The following was one of the major influences of dialogue through the media:

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- Radio or television talks on HIV and AIDS

One participant said: *'Television and radio talks help us a lot because I normally take that occasion after these talks to talk my teenage children about sexual issues. It is easy you know, because you just follow up from the discussions that were on the media.'*

'One day I was so shocked about the type of pictures that I found in a book that my son had. The book consisted of all positions of having sexual intercourse that one can think of. I could not even confront him about this I was too ashamed, I did not know where to start.'

Participants indicated that most of the time dialogue was easily initiated when or after listening to radio or television talks about HIV and AIDS. This talk was used as a starting point. They explained how easy it was for them to initiate a dialogue as they just continued from what had been discussed on the radio. Radios were said to be very informative but the problem that was expressed was that most of the time they broadcast these when these children had gone to school and this sometimes made it difficult for them to restart a discussion. Participants also indicated that they sometimes found magazines that were too explicit in the rooms of their teenagers and this tended to worry them.

Studies indicated that parents initiated a discussion about sexual health when riding in a car, during a television show or when buying a book about which there would be a discussion after the teenager had read the book (Eastman, Corona, Ryan, Warsoky & Schuster, 2005:66). This was an indication that parents talked passively about sex with their children as this topic was not given proper attention. In a study conducted in North Carolina it was also identified that parents' level of education had an influence on sexual health education at home. It was identified that parents who were educated preferred to teach their children as they believed that they had sufficient information (Foust, Gizlice, Kristin & Miller, 2006:2). Participants also indicated that most of the time dialogue was

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easily initiated while or after listening to radio or television talks about HIV and AIDS. This talk was then used as a starting point.

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It could therefore be assumed that the fact that the study was conducted in the villages where most of the parents were illiterate and did not have sufficient information to teach teenagers contributed to the lack of interest and knowledge identified in the study. It was therefore noted that there was no dialogue about sexual health between teenagers and parents as teenagers were just warned about the dangers of dating and the warning did not give teenagers enough information to be in a position to make a decision about their sexual health. This was evidence that there was no dialogue about sexual health as parents tended to warn or tell teenagers what to do and teenagers were not given a chance to express their views. It was also noted that most parents talked about the dangers of falling pregnant, and other important issues regarding sexual health were not addressed.

- **Parents' expressions of how they talked to teenagers and their expectations.**

From the data on parents it was identified that parents had a way in which they talked to teenagers and they also had certain expectations after talking to them. The following were the two categories that emerged from parents' data in relation to their expectations and how they talked to teenagers:

- Parents' expectations after talking to teenagers
- Use of indirect speech by parents when talking to teenagers.

➢ Parents expectations after talking to teenagers

One participant said: *'I normally advise my son to use a condom when engaging in sexual intercourse and I sometimes bring them home for him to use, but to my surprise he has made a girl pregnant.'*

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Parents indicated that they had certain expectations after talking to teenagers about sexual health. They indicated that all the time they expected that teenagers should take their advice and not fall pregnant. It was also surprising that parents tended to rely on these discussions when they were not dealt with intensively. This was an indication of the extent to which these teenagers were being engaged in a dialogue which was minimal or absent, hence they did not adhere to what they were told. It was also possible that teenagers did not adhere to parental advice as parents tended to tell them what to do and how to behave. Donnell, *et al.* (2008:501) identified in their study that girls who reported that their parents oversaw their activities, set rules and communicated disapproval of risky behaviour were less likely to engage in alcohol use, disapproved conduct and early heterosexual behaviour related to early sexual initiation.

- Use of indirect speech by parents when talking to teenagers

One participant said: *'When a movie on television shows people kissing, cuddling or having sexual intercourse I immediately go away to sleep, go and do something else or switch off the television. I feel so much embarrassed by the whole thing. With my son I think the person responsible for his sex education is my husband but I also think that the school should teach them more as long as they are not explicit in their explanation. If the teachings are explicit it will influence them to want to experiment.'*

Another participant said: *'When my daughter started menstruating I just called her and told her that now that you have these big bilharzias, you should not run around with boys as you will become pregnant.'*

Another participant said: *'I sometimes get shy and go to sleep when I am busy watching television with my children and you start seeing people kissing and having intercourse. I can't watch these things with my children so I just go to sleep or ask them to switch off the television.'*

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Another participant said: *'When she came back I just told her that from that time she is not supposed to play or sleep with boys as this will make her pregnant. I could see that she was confused but there was no other way to tell her. When the other girl started menstruating the same approach was used but I was not fortunate with my second daughter because she fell pregnant and she has a baby now. My son also impregnated another girl who is still pregnant as she has not yet given birth. I am also worried about AIDS as this means they are not practising safe sex but how do I tell them yooo!!!!!!! It is a problem.'*

During interviews it was identified that parents make use of indirect speech when they talk about sex with children and this usually led to misinterpretation. Most of the parents interviewed referred to menstruation as big bilharzias which could be misleading to teenagers as these were not the same thing. Parents did not address teenagers in such a way that they would end up knowing what they were expected to do. An explanation of what was happening in their bodies when they menstruated was not given. It was also worrying that parents could not say directly what would happen after these girls had started menstruating. It therefore meant that if the girl had sex with the boy that would not be a problem as the main problem as advised by parents was not to play with them or to stay away from them. This could be very difficult for a teenager to understand as the parent was not direct in her speech. It was also noted that parents always talked about avoidance of pregnancy and emphasis was not placed on other sexual health issues. It was therefore important that parents should start addressing all aspects of sexual health.

Wood, *et al.* (1998:237) indicated that in their study teenagers reported that they were not given information about reproductive matters by their mothers beyond the warning that when they started menstruating they had to stay away from boys, as intergenerational transmission of sexual information was taboo. In Thailand girls were said to be dating without parental support and the life skills to negotiate coercive situations (Vuttanont, *et al.*, 2006:2079). The importance of

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school, peer and parental support of positive behaviour was found to be important in reinforcing positive lifestyles of teenagers (He, Kramer, Houser, Chomitz & Hacker, 2004:30). Parents should realize the role that they had to play in informing their children about sexual health. This would reduce the risks of abuse and contracting sexually transmitted infections.

Participants also indicated that teenagers' promiscuity was also influenced by the type of peers that they associated with because most of the time teenagers tended to copy what their peers did. One parent said during an interview, 'If your daughter goes around with people who do not have manners, she will be influenced and start behaving like them.' Participants also believed that explicit sexual information that teenagers got from school tended to influence them to become promiscuous as they would go around experimenting.

- Factors that are seen as contributing to teenagers' promiscuity.

One participant said: *'Yooo!!! Television is dangerous, our children watch it the whole day and some of the things that are shown there are embarrassing. Every time somebody is kissing a girl or trying to have intercourse with a girl. It is embarrassing. How can one watch these things! I even blame myself for having bought the television uuu!!! It is disgusting.'*

Parents believed that different factors contributed to teenagers' promiscuity such as access to radio and television. Participants believed that teenagers tended to copy what they saw on television, especially because everything was done publicly. This was an indication that in this family sexual health dialogue was not possible as the parents were not at ease with the subject.

Braun-Courville and Rajas (2009:5) confirm in their studies that adolescents who frequently visit sexually explicit websites are more likely to engage in high-risk sexual behaviours such as having multiple partners, and abusing substances during sex. These adolescents are also said to engage in sexually permissive

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behaviour and accept casual sex. Malulekе (2007:13) identified that the display and availability of condoms and exposure to some television programmes were viewed by parents as some of the factors that motivated teenagers to engage in sexual intercourse.

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Concluding remarks

Concluding remarks are made in line with the theory of Leininger's Sunrise trans-cultural health care model three modes of providing congruent care are: cultural care preservation or maintenance, cultural care repatterning or restructuring and cultural care accommodation (Leininger, 1991:30).

- **Cultural care repatterning**

Use of indirect language confused teenagers as their interpretation could be different from what the parents might think that they were communicating. It was also identified that parents had difficulty in initiating a dialogue as they had indicated that they mostly start talking about sexual health after hearing a radio talk or seeing something on television or observing physical changes in the teenager. This was found not to be useful as teenagers would have started engaging in sex by the time that these observations were made. It was also noted with concern that parents saw sexuality education as a way of promoting promiscuity among teenagers and this was also evident in the interviews with the teachers as teachers indicated that they were sometimes blamed by parents for giving children wrong information.

- Cultural care accommodation

Cultural norms and values may need to be accommodated although data from parents indicated that they experienced difficulties when they tried to communicate with teenagers about issues of sexual health. It was identified that the cultural values and norms of the community stood in a way of communication between teenagers and parents. There was a need for clarification of values to assist parents by easing the tensions related to sexuality education. The parents

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were also found to talk to their teenagers by directing them or telling them what to do or not to do. It was also found that parents used indirect language when they communicated with teenagers about sexual health.

3.6 SUMMARY

This chapter focused on data analysis and literature control. From the data that was analysed one could draw the conclusion that dialogue about sexual health between teenagers and parents/teachers was almost absent. Most of the literature that was reviewed also indicated that dialogue about sexual health with teenagers was a worldwide problem, and STIs, including HIV and AIDS, teenage parenthood and low use of contraceptives by teenagers remained a problem.

It was noted with concern that not all participants wanted to accept responsibility for giving information about sexual health. The level of information that parents and teachers had was not satisfactory as the teachers complained about material resources that were not available. Parents' data indicated that sexual discussions were referred to as an act, which left out other aspects of sexual health that were important. Sexuality education was also said to be occurring in initiation schools where it was taught in a different form. In the next chapter concepts that emerged during data analysis are analysed.

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CONCEPT ANALYSIS

4.1 INTRODUCTION

Chapter three discussed the results obtained from the interviews with reference to the literature. The aim of this chapter is to analyse the different concepts that emerged from the data analysis in chapter three. Analysis clarifies, refines or sharpens concepts, statements or theories (Chinn & Kramer, 1 999:74). The process of concept analysis involves dissecting the whole into parts for better understanding (Rodgers & Knafl, 1993:78). Concept analysis was necessary as the worldview of the concept would be used in the development of the model (Leininger, 1991:30). Dialogue is the concept that has emerged from data analysis.

4.2 OBJECTIVES OF THE CHAPTER

The objectives of this chapter were to

- analyse the concept "dialogue", using Rodgers and Knafl's steps (1993:78) and
- develop a graphic presentation of the dialogue process.

4.3 CONCEPT ANALYSIS

Chinn and Kramer (1995:74) define a concept as a "complex mental formulation of experience" and state that concepts are extracted from life experiences, clinical practice or research. The study concept "dialogue" is central to this study as it is a vehicle through which communication on sexual health between teenagers and parents/teachers can be promoted in Vhembe district of Limpopo

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province in South Africa. Concept analysis is described by Walker and Avant (1995:39) as a strategy to examine the attributes or characteristics of a concept through a rigorous process of analysis. Concept analysis was conducted using the adapted steps of Rodgers and Knafl, (1993:90) and Walker and Avant (1995: 39) which are the following:

- Identification of the concept of interest.
- Identification and selection of an appropriate setting and sample of data collection.
- Collection of data regarding the attributes of the concept along with surrogate terms, references, antecedents and consequences.
- Identification of the concept of interest.
- Analysis of data regarding the above characteristics of the concept.
- Identification of a model case (Rodgers & Knafl, 1993:90; Walker & Avant 1995:39).

4.3.1 Identification of the concept of interest

Walker and Avant (1995:40) describe identification of the concept as a way of choosing the concept that accurately describes the participants' experiences from the findings. The concept "dialogue" is identified as central to this study. It is central to this study as it was identified from the data that teenager, parents/teacher do have some form of communication about sexual health. This communication was identified as being lacking and often one way from the parents/teachers to teenagers. It was then concluded that dialogue should be the central concept as it will allow two way communications which will be interactive. Communication was almost one-way from parents/teachers to teenagers with teenagers as passive recipients. It was also identified that parents/teachers also communicated by using indirect language with teenagers and this was also identified as another problem that contributed to teenagers' lack of information regarding sexual health. Dialogue ensures that all parties involved participate, as it allows one to listen and respond in a proper way to the message that is being

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brought across. It was then identified that participants in sexual health education should engage each other in dialogue which meant that all people would actively participate as described by Rassieur (1997:6). In this study the meaning of the concept was important so as to facilitate the formation of a theoretical definition that would direct the description of the model to promote dialogue about sexual health between teenagers and parents/teachers.

Rassieur (1997:6) describes seven features that characterise successful dialogue. The characteristics describe essential attitudes and behaviours of participants, as well as characteristics of the dialogical process itself. The eight characteristics are the following:

- Attentive and respectful valuing of the other
- Valuing the encounter and the relationship
- Being open to personal change
- Accepting the risks of self-disclosure
- Affirming the discipline of dialogue
- Seeking and communicating understanding
- Observing the boundaries of the relationship and
- Recognising the spiritual dimension of dialogue (Rassieur, 1997:6).

4.3.2 Definition of the concept of interest

Dialogue is defined as a conversation between two or more people. It can also designate the exchange of ideas, especially on a political level (Webster's Desk Dictionary, 1990:250). Bohm (1996:6) describes dialogue as a Greek word 'dialogos', 'logos' meaning 'the word' or meaning of the word, and 'dia' meaning through (and not two). Dialogue can take place among a number of people and it is also said that one can have dialogue within oneself. This explanation suggests a stream of meaning flowing through, among and between us and new understanding may emerge and this is normally the glue that binds people together. In dialogue there is neither a winner nor an attempt to gain or to make a particular view prevail. Dialogue is a more common participation where the game

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is played with each other rather than against each other and therefore everybody wins. Dialogue is said to explore a wide range of human experiences, values, emotions, input of cultural myths, patterns of our thought processes and moment-to-moment experiences (Bohm, 1996:6).

Based on Bohm's (1996) explanation of dialogue, it means that dialogue starts even before the actual encounter between the parties involved. Dialogue exists within the self and this might influence what an individual brings when there is dialogue among individuals. It might also be useful for individuals to be aware of issues within the self that might influence the contact dialogue. Dialogue is also said to bring out new understanding between the parties involved and requires participation from parties involved. This might be useful in dialogue between teenagers and parents/teachers as information discussed will bring out new understanding and active involvement of the parties involved.

Isaacs (1996:1) defines dialogue as a unique form of conversation with the aim of improving collective inquiry processes, to produce coordinated actions among collectives and to bring about genuine social change. Dialogue involves free-flowing meaning in which profound collective insight and orientation appear and out of which people can take aligned and effective action (Isaacs, 1996:1). Isaac's definition of dialogue emphasizes collective inquiry which is the basis of this study as the dialogue requires the collective involvement of teenagers and parents/teachers with the ultimate aim of changing the behaviour of teenagers.

Smith (1998:120) describes dialogue as the process of discovering the meaning moving through a group of people. Through dialogue people are said to go through a set of community skills and guidelines by passing consciously through various stages of community building. Current beliefs and thinking are explored to discover new ground or to create new meaning in the community (Smith (1998:120). This type of dialogue will allow teenagers, parents and teachers to go through various stages to discover new meaning about sexual health as a

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group of people. Finding new meaning will involve exploration of current beliefs and thinking through self and community dialogue. Self-dialogue is dialogue that occurs within an individual and community dialogue is explained as dialogue that occurs between individuals.

Dialogue is further described as communication which is developmental and helps participants and their organisations to learn and grow. Dialogue is said to require open, honest, mutual interaction, authentic collaboration, trust, genuine self-reflection, clear and tacit ways of thinking and willingness to grow through risk (Bokeno, 2007:10). In this definition of dialogue it has been identified that communication needs to be developmental in nature as teenagers and parents/teachers need to develop their level of knowledge of and decision making in issues related to sexual health. The dynamics are required for the success of dialogues which are open and honest, with mutual interaction, authentic collaboration, trust, genuine self-reflection, and a clear and tacit way of thinking and willingness to grow through risk. It is very important for parties involved in dialogue about sexual health to discuss issues openly and with honesty, to be actively involved and have the ability to do genuine self-reflection.

Bokeno (2007:11) further identifies characteristics that are necessary for dialogue to occur which are holistic, explorative, emergent and dynamic. These are very important steps that teenagers and parents/teachers can go through when involved in a dialogue.

Holistic – This is where dialogue involves examining the unexamined values and assumptions that permeate decision making in learning how to learn. The teenagers and parents/teachers need to examine their own assumptions and beliefs about sexual health which are the basis for making decisions such as what to discuss, who should be involved in a dialogue and who should contribute to a dialogue. Beliefs about sexual issues need to be examined as these tend to

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determine the extent of the discussion in terms of what to discuss with teenagers given the rural cultural context of the study.

Explorative/appreciative – This involves the ability to listen to others and bracketing what a person knows. Exploration in a dialogue is also very important as it is expected of the people involved to listen to each other and bracket what they know in order to learn new things. People involved in a dialogue have the ability to listen, especially teenagers who are believed not to have satisfactory information regarding issues of sexual health due to lack of experience. Bracketing what people already know is very important as this may have a direct influence on issues being discussed.

Emergent – This characteristic involves the capacity of participants to understand each other to the extent of being able to interact together more than they have done before. This stage of emergence is very important as it involves the capacity of teenagers and parents/teachers to interact more freely than before when starting with a dialogue. This creation of a free environment will facilitate fruitful interaction without a feeling of being threatened which can hinder good dialogue.

Dynamics – For dynamics to be present in a dialogue one needs to know that it might involve 'self-destruction', which is the ability to take the perspectives of others rather than advocating for one's own views. Own thinking is exposed to the scrutiny of others, and this may lead to losing what one thought/believed was true. This means that for dialogue to occur there is a need for radical reorientation of how people think about human interaction. At this level participants in a dialogue need to agree or accept that there is a need to leave the past way of doing and take up new views to be able to arrive at a conclusion.

Ballantyne (2004:114) describes dialogue within industrial and business marketing as being deeper than transferring information. Dialogue is described

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as an interactive process of learning where mutual value in buyer-supplier exchanges is enhanced. It is reasoning together. The aim of this dialogue is to achieve deeper levels of understanding between those participating. Dialogical interaction needs people to be more aware of their routine thought patterns (Ballantyne, 2004:114). Dialogue as an interactive process means that people involved in dialogue should interact to give birth to new meaning and understanding. The teenagers' and parents/teachers' dialogue should also be an interactive process where all people involved contribute equally to the discussions for people to arrive at a common understanding.

Schwandt (2001:265) describes dialogue as a sequence of exchanges of messages or speech acts between two or more parties. These exchanges can take several forms that serve different purposes. The following are the different types of dialogue as identified by Schwandt (2001:266).

Information-seeking dialogue: In this situation, one party has the goal of finding information that the other party is believed to possess (Schwandt, 2001: 266). In this case it will be of vital importance for all parties involved in a dialogue, that is teenagers, parents and teachers, to seek information from each other as all parties involved are functioning at the same level and nobody will be regarded as having superior information. Parties involved in a dialogue will therefore see it as of importance to seek information from each other and rely on each other. This will also be vital for maintaining good relationships with teenagers as they need to feel that they can contribute equally to the discussions and that their inputs are valued.

Inquiry dialogue: The primary aim of this type of dialogue is to determine the facts relevant to a claim. This dialogue begins with an initial position that lacks a certain degree of knowledge, which must be overcome (Schwandt, 2001:266). This type of dialogue could be vital to teenagers as their lack of experience on

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issues of sexual health requires them to seek information from the people with experience who are teachers and parents.

Negotiation dialogue: In this type of dialogue the primary goal of each party is to advance its self-interest and the primary method is to bargain (Schwandt, 2001:266). Parents and teachers should be cautious and aware of the fact that teenagers could try to manipulate the situation and force them to agree to issues that are favourable to them and this might be detrimental to their sexual health.

Action-seeking dialogue: In this type of exchange one party seeks to bring about a specific course of action by the other party (Schwandt, 2001:266). This will be the main focus of dialogue with teenagers as parents' and teachers' aims are to give as much information to teenagers as possible so that the information assists them to make informed decisions about their sexual health.

The Argumentative/Persuasive dialogue or critical discussion: This kind of dialogue arises from a difference of opinion or an issue to be resolved that has (at least) two sides (Schwandt, 2001:267). Arguments in a dialogue with teenagers should be expected as teenagers will always want their opinions to be taken and parents and teachers should have strategies of handling such arguments so that all parties arrive at the best possible solution.

4.3.3 Identification and selection of appropriate setting and sample for data collection

An appropriate setting refers to the time period examined and types of literature included in the analysis (Rodgers & Knafl, 1993:90). The appropriate setting and context for this study is the community cultural context, the family and school where dialogue about sexual health between teenagers and parents/teachers is supposed to take place. The sample for analysis was drawn after relevant literature that discussed dialogue was studied, i.e. dictionaries, books and

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journals with both national and international descriptions were analysed to arrive at the theoretical definition. The theoretical definition directed the description of the model.

4.3.4 Collection of data regarding attributes of the concepts along with surrogate terms, references, antecedents and consequences

Rodgers and Knafl (1993:90) describe this step as a phase which reflects all possible sources that were reviewed in the clarification of the concept. Different literature was consulted in trying to get clarity regarding the concept of "dialogue". Among the literature consulted there were books, journal articles, subject dictionaries and internet searches. The researcher used primary and secondary sources in trying to gain more insight into the meaning of dialogue. The search strategy for these different sources was based on the term "dialogue" itself within different contexts as information of how dialogue is defined in sexual health was limited. In most of the literature found the definition of dialogue was somehow related or similar. Dialogue was described from an interactive perspective where focus or emphasis was placed on using dialogue as a mechanism of understanding issues among individuals. Dialogue was also discussed as a mechanism of learning together with the aim of reaching mutual agreement. Dialogue discussions also focused on pre- and post-genetic revolution civilizations. Dialogue was also discussed within organisational structures, as a basis for strategic planning and between customers and suppliers. Dialogue was said to occur within and between individuals. Understanding of dialogue was also sought from the cultural perspective where families interacted and from the educational perspective where interaction between a teacher and a student/pupil was described.

4.3.4.1 Identification and defining of attributes of the concept

Once the chief concepts had been identified and defined, defining attributes were listed, analysed and synthesized to form a definition of the main concept, namely

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dialogue. Listing of the defining attributes assisted with identifying the occurrence of a specific phenomenon in order to differentiate it from similar or related terms. In addition, defining attributes might change as the understanding of the concept improved or developed. Hence it was necessary to show clusters of the attributes most frequently associated with the concept to gain a broad insight into the concept (Chinn & Kramer, 1999:95).

4.3.4.2 Critical attributes of dialogue

- Dialogue should be an interactive process

Ballantyne (2004:114) describes dialogue as an interactive process of learning and reasoning together with the aim of achieving deeper understanding between those participating. Dialogue can reconcile and give meaning to what seems to be contrary. Dialogue is enhanced by querying other participants' assumptions and prejudices and confronting own assumptions and prejudices.

- Past thought can influence present thinking

Bohm (1996:51) agues that past thought stays on as a pervasive presence in current thinking as it guides or diverts current thinking. The past thought is said to have an ever-present tendency to create false coherence of the present. The past thought can distort the representation of current reality and stand as a block in the way of insightful perception. Dialogue is also said to be influenced by emotional state which can be uncertainty, fear and faith.

- Dialogue is said to start within the self

Based on Bohm's (1996:55) explanation of dialogue it means that dialogue starts even before the actual encounter between the parties involved. Dialogue within self exists and this might influence what an individual brings when there is dialogue between individuals. It might also be useful for individuals to be aware of issues within self that might influence the contact dialogue.

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The following is the function of dialogue:

- Dialogue assists in achieving deeper understanding through exploration and questioning between those participating (Bohm, 1996:55).

4.3.4.3 *Identification of surrogate terms*

Rodgers and Knafl (1993:83) define "surrogate" as a philosophical position that a concept may be expressed in different ways. During data collection it was revealed that surrogate terms for the word dialogue were

- conversation between people,
- exchange of ideas,
- exchange of messages,
- speech acts between people,
- meaning flowing among and through,
- common participation in game,
- free-flowing meaning, and
- interactive process of learning.

4.3.4.4 *Identification of references*

The actual situation to which the concept dialogue is applied is referred to as references (Rodgers & Knafl, 1993:83). The following are the basic principles of engaging in a dialogue:

- Suspension – this involves suspension of personal response, judgments and assumptions (Bell, 1996:20).
- Inquiry without – this is where one seeks clarity when another person speaks (Bell, 1996:20).
- Inquiry within – this involves asking self about what one wishes to communicate and its underlying beliefs (Bell, 1996:20).
- Equality – this is where collogues or participants support one another in a dialogue (Bell, 1996:20).

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- Openness – this is opposite to advocacy as it involves exploring ideas, thoughts, concepts and assumptions in order to make a deeper connection (Bell, 1996:20).

4.3.4.5 *Identification of antecedents*

Rodgers and Knafl (1993:83) define antecedents as aspects that normally precede the word and in this case they are dialogue especially in relation to sexual health. 'Antecedents are those events or incidents that must occur prior to the occurrence of the concept' (Walker & Avant, 1995:73). In linking this conceptual definition with practice, antecedents can be classified as those factors that facilitate the occurrence of a dialogue. Dialogue can only occur if the following antecedents are fulfilled: openness, honesty, mutual interaction; authentic collaboration; trust; genuine self reflection; exposure to tacit thinking; and willingness to grow through risk.

For dialogue to occur participants must be open to new information, honest in the type of information that they share with each other and they should develop a mutual trusting relationship. Both participants should be actively involved and have the ability to do self reflection and be willing to grow through risks.

4.3.4.6 *Identification of consequences*

Walker and Avant (1995:73) describe consequences as those events or incidents that occur as a result of the occurrence of the concept, which is the outcome of the concept. When this is linked to practice one should consider the consequences of dialogue. The consequences of dialogue are to achieve deeper understanding through exploration and questioning between those participating (Bohm, 1998:55). In this study the consequence of dialogue in sexual health between teenagers and parents/teachers was that teenagers would have better understanding and knowledge about sexual health. Sufficient understanding and knowledge would assist them in making informed decisions about sexual health.

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4.3.5 Identification of the related concepts of interest.

The following concepts were identified as concepts that were used interchangeably with the term dialogue: chat, talk, conversation, discussion and gossip (Bohm, 1998:55).

- **Chat**

According to Complete Wordfinder (1993:240), chat is defined as talk in a light familiar way, informal conversation. In the light of the description of dialogue it is important to reflect and ask questions to gain more understanding of the issues under discussion. It is therefore necessary to use dialogue to promote sexual health between teenagers and parents/teachers.

- **Talk**

Talk is described as conversation, communicating ideas by spoken words, to express or utter in words (Complete Wordfinder, 1993:1592). Talk is a more casual way of communicating where participants can either be sending a message across or expressing an idea. There is no need for deeper discussions where the participant's purpose is to find deeper common understanding of the matter as in a dialogue.

- **Conversation**

Conversation is described as an informal exchange of ideas by spoken words (Complete Wordfinder, 1993:313). In conversation the ideas are not questioned or carefully thought out, unlike in dialogue where participants sometimes even have dialogue within self in preparation of external dialogue. This means that in conversation participants do not have to question other people's thoughts and ideas and there is no need for one to explain fully to the other participants to reach common understanding.

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- **Gossip**

Complete Wordfinder (1993:647) describes gossip as easy and unconstrained talk or writing especially about a person or social incidents. It is idle talk or groundless rumours. This type of talk cannot be relied on, especially where issues o f sexual health need to be communicated to teenagers as it might misinform them and expose them to unhealthy sexual behaviour.

- **Communication**

Communication is defined as an act of imparting news. It is also a means of connecting different places such as a door, passage or road (Complete Wordfinder, 1993:287). The focus of communication is on imparting news or a means of connecting places. This is rather superficial when compared to dialogue as when the information is communicated the receiver is not expected to give back information or to interrogate the information sent to them. Most of the time the receiver and sender do not engage with the information being communicated to them. Communication as a passage connecting places serves as a passage and there is no engagement between the things passing through and the door, for example. Communication is on a more informal level than in a dialogue where in formation is shared by the people who are involved. In a dialogue where people do self-reflection, question other people's point of view and the information is discussed until both parties gain common understanding.

- **Discussion**

Complete Wordfinder (1993:416) describes discussion as conversation, especially on specific subjects, debate, an examination by argument which is either written or spoken. Although discussion offers a deeper type of conversation, it is identified that in discussion the participants can be competing in an argument under discussion. One party wants to win over the other. This is not in line with what is expected in a dialogue where all parties engage each

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other to gain more understanding and the best possible solution which is not in favour of any person.

4.3.6 Analysis of data regarding the characteristics of the concept "dialogue"

Data drawn from the definition of the term "dialogue" was analysed for similarities and differences. The researcher read through the meaning of dialogue in literature. Common words were underlined and clustered. Clusters were developed and themes were defined as reflected in Table 4.1.

The first theme can be described as *'requirements needed for dialogue to take place'*. In this theme the following antecedents were included in the cluster: openness, honesty, values, assumptions, mutual interaction, authentic collaboration, mutual trust, genuineness, self-reflection and willingness to grow. Based on the characteristics described by Bokeno (2007:11), the requirements match the characteristics holistically. Based on those characteristics one could say that these requirements were necessary where parties needed to do introspection as to assumptions, values, willingness to grow etc. because these assumptions, values, willingness to grow, etc., might influence the dialogue that they were going to engage in related to sexual health.

The second theme can be described as *'activities necessary for dialogue to take place'*. In this theme the following activities are necessary for dialogue to take place: interaction, dialogue including two or more people, participation by all parties, collective inquiry process and authentic collaboration. Based on the characteristics described by Bokeno (2007:11), the activities matched the characteristic emergent. In dialogue about sexual health the process involved the active participation of all parties involved and their willingness to share information. It was therefore noted that for dialogue about sexual health to be successful people involved should be willing to participate and share information.

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The third theme can be described as *'process of dialogue'*. In this theme the following processes were described as necessary for dialogue to take place, that is self-destruction, exposing own thinking to scrutiny, radical orientation to human interaction and bracketing own thinking and biases. Based on the characteristics described by Bokeno (2007:11), these processes matched the characteristics dynamic. The process of dialogue is not simple as it requires participants to expose self-information to the scrutiny of other people involved in a dialogue and most of the time one may need to get rid of one's own thinking and it is difficult to re-orientate oneself to new thinking and new ways of doing things. In sexual health dialogue every participant has their own information about sexual health and there is a need for bracketing to allow the self to be exposed to new knowledge about sexual health and if there is a need to adopt new ways as informed by the dialogical process.

The fourth theme can be described as *'meaningful dialogue'*. In this theme the following descriptions are necessary for dialogue to take place, that is, dialogue involves free-flowing meaning that brings about new understanding. Dialogue is also said to be meaning that flows through words. Based on the characteristics described by Bokeno (2007:11), this description matches the characteristics exploration/appreciation. This is the outcome of dialogue as all parties will reach new understanding. During sexual health dialogue the participants will start to experience free-flowing meaning as they reach the stage where dialogue brings about new understanding of and meaning to sexual health.

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Table 4.1 Analysis of the concept dialogue in the context of sexual health according to the four characteristics as described by Bokeno (2007:11).

CHARACTERISTIC PHASES OF DIALOGUE	THEME	CATEGORIES/CLUSTERS
Phase 1 (Holistic)	Requirements needed for dialogue to take place	Openness, honesty, values, assumptions, mutual interaction, authentic collaboration, mutual trust, genuineness, self-reflection and willingness to grow (Bokeno, 2007:11)
Phase 2 (Emergent)	Activities necessary for dialogue to take place	Interaction, dialogue includes two or more people, participation by all parties, collective inquire process and authentic collaboration. mutual interaction (Bokeno, 2007:11)
Phase 3 (Dynamic)	Process of dialogue	Self-destruction, exposing own thinking to scrutiny, radical orientation to human interaction and bracketing own thinking and biases (Bokeno, 2007:11)
Phase 4 (Exploration/appre-ciation)	Meaningful dialogue	Dialogue involves free-flowing meaning that brings about new understanding, dialogue was also said to be meaning that flows through words (Bokeno, 2007:11)

- **The process of dialogue**

Dialogue does not occur in a vacuum. There are different factors that need to be considered when successful dialogue is to be achieved. The linkage between these factors is explained in phases and an explanation of how each phase leads to the next is given.

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During the initial phase people engaging in a dialogue need to examine the antecedents which are factors that need to be examined before engaging in a dialogue. The factors that need to be clarified before engaging in a dialogue are: openness, honesty, values, assumptions, mutual interaction, authentic collaboration, mutual trust, genuineness, self-reflection and willingness to grow. If these factors are not clarified dialogue will be impaired and parties engaging in such a dialogue will never grow or gain.

After clarifying, parties need to be aware of activities that are necessary for the success of the dialogue which are interaction, presence of two or more people, mutual participation, collective inquiry process, authentic collaboration and mutual interaction. This means that it is very important for parties involved in a dialogue to actively participate by giving their views and selecting the best solutions or options.

During dialogue there are also processes that must take place for the success of dialogue which are self-destruction, which is the ability to take the perspectives of others rather than advocating for own views, exposing own thinking to scrutiny, radical orientation to human interaction and bracketing own thinking and biases. The final step or phase is when the dialogue process produces an outcome which is that dialogue involves free-flowing meaning that brings about new understanding.

4.3.7 Identification of a model case

Chinn and Kramer (1992:62) describe a model case as something which enables one to distinguish the essential from the non-essential features. Model cases can be drawn from literature, art or film or any other context in which the concept is accurately symbolized. A model case for this study was developed to reflect the real-life situation where dialogue took place. This scenario created greater understanding of the concept as it reflected how the concept was identified.

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- **Contrary case of parent**

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"You know, I have four children, one boy and three girls. Sexual-related issues are very difficult to talk about. You know with me it is even more difficult with my son. I can't open my mouth and talk about sex. With us black people it is taboo and unacceptable for an adult like me to talk to people younger than myself about sexual issues. Just think about it. How will these kids take me? What will they think of me? It is unthinkable. They will think that I am promiscuous or I am telling them to start sleeping around.

"When a movie on television shows people kissing, cuddling or having sexual intercourse I immediately go away to sleep, go and do something else or switch off the television. I feel so embarrassed by the whole thing. With my son I think the person responsible for his sex education is my husband but I also think that the school should teach them more as long as they are not explicit in their explanation. If the teachings are explicit it will influence them to want to experiment.

"With my elder daughter it started when she had her first menstruation. I had never talked to her about issues of sexual health or even developmental changes that she was going to experience in her body. You know it caught me by surprise. One day if I can still remember it was summer, she came back from school before time and was crying saying that she was in pain. She slept the whole day. The following morning when I was making her bed I realized that her linen was soiled with blood. I called her in and asked her what was happening. I was very harsh with her and demanded an explanation. She never replied, she just cried. I was also frightened not knowing what to tell her, I just gave her sanitary pads.

"When I talked to her father about it he suggested that I take her to her aunt who is the right person to explain to her about sexual issues. You know, traditionally the aunt is the person given the duty to teach children in the family about sexual health. I took her to her aunt's place and she stayed there for two days.

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"When she came back I just told her that from that time she is not supposed to play or sleep with boys as this will make her pregnant. I could see that she was confused but there was no other way to tell her. When the other girl started menstruating the same approach was used but I was not fortunate with my second daughter because she fell pregnant and she has a baby now. My son also impregnated another girl who is still pregnant as she has not yet given birth. I am also worried about 'AIDS' as this means they are not practising safe sex but how do I tell them? Yooo!!!!!!! It is a problem."

4.4 Dialogue about sexual health between teenagers and parents/teachers.

Dialogue is defined as a two way communication about sexual health between teenagers and parents/teachers which is a mutually interactive and developmental process with the aim of achieving new understanding and meaning.

4.5 SUMMARY

Chapter four discussed concept analysis according to the steps in Rodgers and Knafl (1993:90) and Walker and Avant (1995:39). The concept "dialogue" was defined according to the Oxford Dictionary and the subject. Data on dialogue was analysed and themes were developed. These gave clarity to how dialogue could be successfully utilized in the promotion of sexual health. The next chapter focuses on model development, using the framework of Dickoff *et al.* (1968:434-435).

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CHAPTER 5

CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT

5.1 INTRODUCTION

Dickoff *et al.*'s (1968:434-435) framework was used to integrate the results of the concept analysis and this formed the building blocks of the model. Among the six elements of the survey lists of Dickoff *et al.* (1968:434-435), dialogue is viewed as the path and pattern, steps according to which the activity is performed. Fruitful dialogue between parents/teachers and teenagers about sexual health will assist teenagers to make informed decisions about their sexual health, avoid STIs including HIV and AIDS, and unwanted parenthood.

5.2 OBJECTIVES OF THIS CHAPTER.

The objectives of this chapter were to

- classify activities according to Dickoff *et al.*'s six elements of the survey lists, and
- develop the model to promote dialogue about sexual health.

5.3 SIX ELEMENTS OF THE PRACTICE MODEL

The identified aspects that are used to survey the practical activity correspond to the following questions about the activity:

1. Context: In what context is the activity performed? The context specifies the environment within which dialogue will take place because it enables the activity to be viewed in relation to other things therefore the context within which dialogue will take place is the following: Cultural context, family context and school context.

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2. Agent: Who or what performs the activity? The agent describes the person or persons who are involved in realizing the goal. The agents contributing to the realization of dialogue are parents as primary educators and teachers as secondary educators.

3. Patiency/Recipients: Who or what is the recipient of the activity? These are persons who receive action from the agents and in this study recipients are teenagers.

4. Dynamics: What is the energy source of the activity (underlying dynamics) these are power sources for the activity or persons functioning in realization of the goal. The following are dynamics for dialogue: Power inequality, openness, honesty, mutual trust.

5. Procedure: What is the guiding procedure? The procedure specifies the path, steps and pattern according to which the activity is performed. The procedure for dialogue initiation involves values clarification, role identification, mutual interaction between teenagers and parents/teachers, collective inquiry, self-destruction, exposing own thinking to scrutiny and bracketing own biases.

6. Terminus/purpose: What is the end point of the activity? This is the end point or accomplishment of activity. The outcome of the activity will be achievement of meaningful dialogue where teenagers, parents and teachers in the rural areas engage each other in a dialogue about issues of sexual health and to have teenagers that are well informed about their sex and sexual health and enable them to make responsible decisions.

5.3.1 Framework/context

The context is viewed from the aspect of the matrix of activity; it is seen in relation to other things, including persons and other activities, and to see the interrelation of these other factors as constituting an organism, unity, or total context of activity (Dickoff, *et al.*, 1968:426). The context is constituted by the

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community cultural context, the family and schools within which dialogue about sexual health is expected to take place. There are common factors that have been identified within the entire context where dialogue is supposed to take place which are the following:

- the values, norms, attitudes and beliefs of all people involved which are based on their strong cultural beliefs;
- the clear description of roles for each person involved and acceptance of these roles;
- poor dissemination of information within communities which is reflected by lack of knowledge of the subject;
- poor strategies for initiating dialogue with teenagers about sexual health.

These factors influence the extent to which dialogue about sexual health is carried out by teenagers and parents/teachers and should therefore be taken into consideration.

5.3.1.1 Community cultural context

This context is regarded as important because the socio-cultural beliefs that are shared by the community have an influence on how dialogue between teenagers and elders should be conducted. The community socio-cultural beliefs where this study was undertaken impose certain rules on t he people who live in such communities. The role of members of the family with regard to discussions about issues of sexual health is also culturally determined. This context therefore interferes with the way in which dialogue can be initiated both at school and home. The community believes that it is taboo to talk about sex with teenagers as cultural practices do not allow that, and there is therefore absence of dialogue. The community also believes that dialogue about sexual health is mainly done during initiation when the child has reached puberty. It is also believed that the person who is best suited to talk to teenagers about sexual health is the aunt within families. This is disturbing because in most cases the aunt does not stay with the teenager, which means that this could be a once-off discussion without

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follow-up which is very important in reinforcing a lot of unclear issues about sexual health.

5.3.1.2 Family context

The family is one of the contexts within which dialogue about sexual health should take place. The context is characterised by the different roles that each person plays with regard to caring for the children. These roles include teaching children about different aspects of life including sexual health. It is very important to understand this context so that the model tries to address very important dynamics involved in engaging teenagers in dialogue about sexual health. The family context is also characterised by inequality between teenagers and parents. When these parties engage each other in a dialogue it would require them to function at the same level which can be difficult for the parent. The family also consists of the siblings, aunts and uncles who could be the source of both negative and positive influence on the teenager and there is a need to see how the other members of the family can be involved in such a dialogue to make it more effective.

5.3.1.3 School context

This is the context where teenagers receive formal education. Among the subjects that the teachers are expected to teach is sexuality education. The school context was found not to be conducive to teaching sexuality education. From the data analysed it was found that the number of periods given were too few, the workload was too much for one person, the materials needed to teach the subject were not available and the students were not keen to study the subject. All these factors did not promote an environment for successful dialogue between teenagers and teachers. The school context also functioned within the community cultural context and the cultural beliefs also impacted on how dialogue about sexual health was conducted in the schools. It should also be noted that teachers were also parents and therefore they were also influenced by

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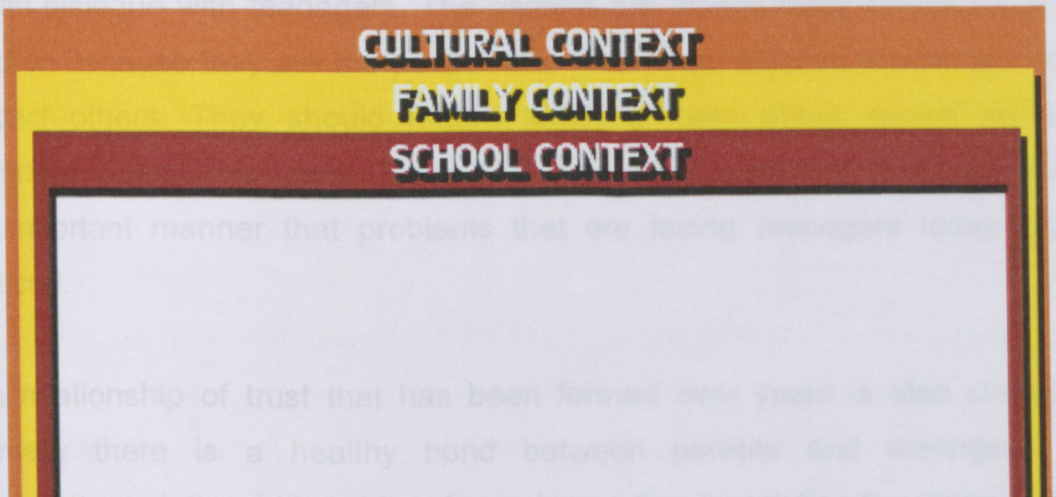
the family values and norms which influenced how they taught issues of sexual health at school.

Figure 5.1 Context Of Dialogue



5.3.2 Agents

Agents in this study were parents and teachers whose activities contributed towards realization of the goal. The goal for developing the model in this study was to promote dialogue about sexual health between teenagers and parents/teachers. Parents and teachers functioned as agents because they both had experience, skills and were educated regarding issues of sexual health. They had also gone through the teenage stage. The agents could also be classified into two categories, primary agents who were parents and secondary agents who were teachers.

5.3.2.1 Parents as primary educators

Parents, family and the community context define who they are and what their roles are. This means that the community and family cultural practices influence how, what and when they should discuss with their children related to sexual health.

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Parents are usually the first people with whom the children come into contact when they are born and this makes them good agents for promoting sexual health dialogue with teenagers. The parents are also primary educators of their children because they are the people who teach their children how to talk and to respect others. They should regard teaching them about sexual health as important as teaching them to talk. It is when sexual health is dealt with in such an important manner that problems that are facing teenagers today can be reduced.

The relationship of trust that has been formed over years is also strong and normally there is a healthy bond between parents and teenagers. This constructive relationship and bond also lays a firm foundation for dialogue about sexual health. The people involved in a dialogue should have a trust relationship to be able to have a fruitful dialogue. The trust relationship will also make teenagers trust the information that is given to them by their parents. This was also identified in the analysed data of teenagers as they also indicated that they would like to be taught about sexual health by a person they were used to. It is therefore correct to say that parents are primary agents in the promotion of dialogue about sexual health with teenagers.

5.3.2.2 Teachers as secondary educators

Teachers are the second people that children encounter in the education relationship. Teachers are expected to continue with the education of children after these children have started school. They are often regarded as parents. Their role is to impart knowledge to the learners. It is therefore important to give information that is going to ensure that they become responsible adults. Sexual health education is also central to this teaching so teachers should also engage teenagers in dialogue to minimize some of the problems like STIs, teenage pregnancy and parenthood. The model that is developed will assist the agents to initiate a dialogue about sexual health between teenagers and themselves.

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5.3.3 Patiency/Recipients

Patiency in this study is teenagers. These are persons (teenagers) who receive action from agents (parents/teachers) and this activity contributes to a certain goal (Dickoff, *et al*., 1968:426). The activity that is happening between agent and recipient is to engage each other in a dialogue about sexual health. The goal to be achieved by such an activity is that of teenagers achieving sexual health and this could prevent some of the problems like STIs, teenage pregnancy and parenthood.

Teenagers as recipients should acknowledge that dialogue about sexual health with parents and teachers is of importance to their sexual health. Teenagers should learn to trust parents and teachers and openly discuss sexual issues that affect their sexual health. They should learn to trust and rely on parents and teachers for correct information about sexual health. These teenagers should be assisted to talk and be able to initiate a dialogue about sexual health as this is very difficult given the cultural context within which this dialogue is expected to happen.

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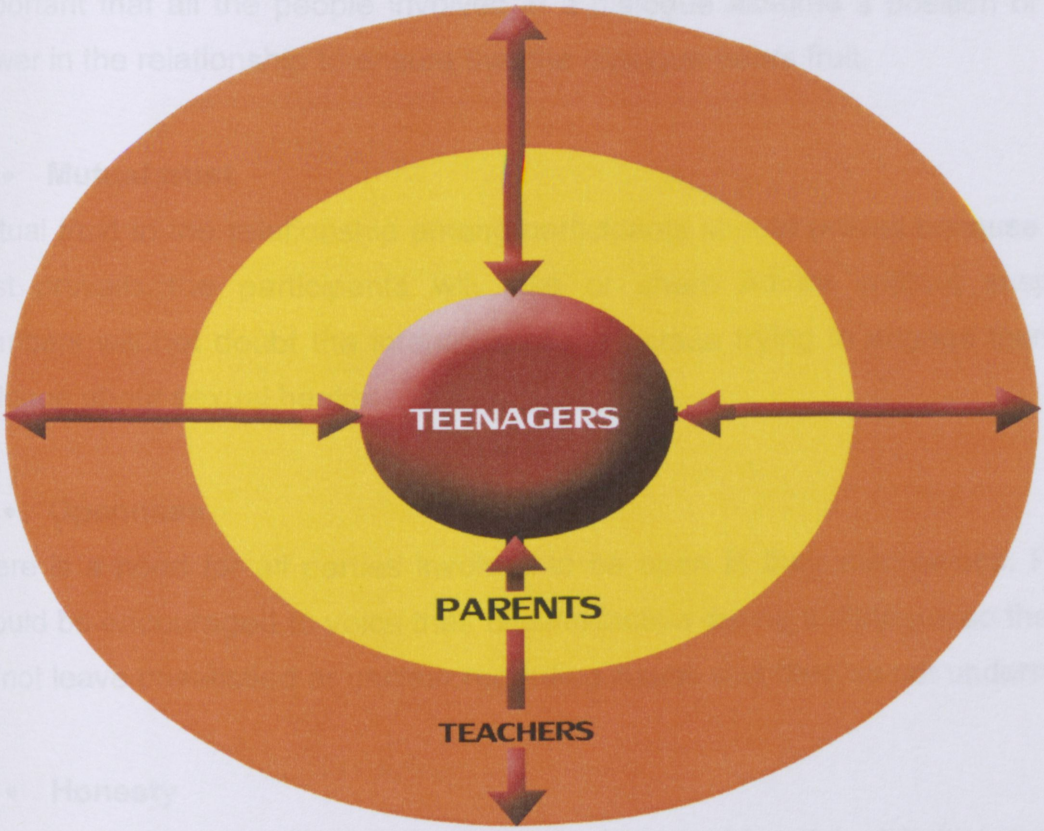
Figure: 5.2 Agents And Recipients



5.3.4 Dynamics

These are the power sources for the activity. They can be chemical, physical, biological or psychological for any person or thing functioning as agent, patient or part of the framework in realizing the goal (Dickoff, *et al.*, 1968:426). The dynamics of this study were power inequality, mutual trust, openness and honesty.

- **Power inequality**

The difference in power among the people involved in a dialogue can affect how dialogue is conducted. The teacher or parents as people with power can assume a position of authority which might leave the teenager with fear and might not

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contribute to the discussion. The parents and teacher may also tend to impose their values or practices on a teenager who is in a position of powerlessness. It is important that all the people involved in a dialogue assume a position of equal power in the relationship to ensure that the dialogue bears fruit.

- **Mutual trust**

Mutual trust in the relationship among participants should prevail because when trust prevails the participants will take or share advice without suspicion. Members will not doubt the intentions of the person trying to engage them in a dialogue about sexual health.

- **Openness**

There is a need for all parties involved to be open in their discussions. People should be encouraged to voice their dissatisfaction during a dialogue so that they do not leave unsatisfied or unclear regarding issues that they do not understand.

- **Honesty**

This is another dynamic that is crucial in the achievement of fruitful dialogue. People participating in a dialogue should never pretend to each other, like pretending to understand an issue while they do not. This will hamper the aim of the dialogue as teenagers will never have correct information about sexual health if they pretend that they understand while they do not. .

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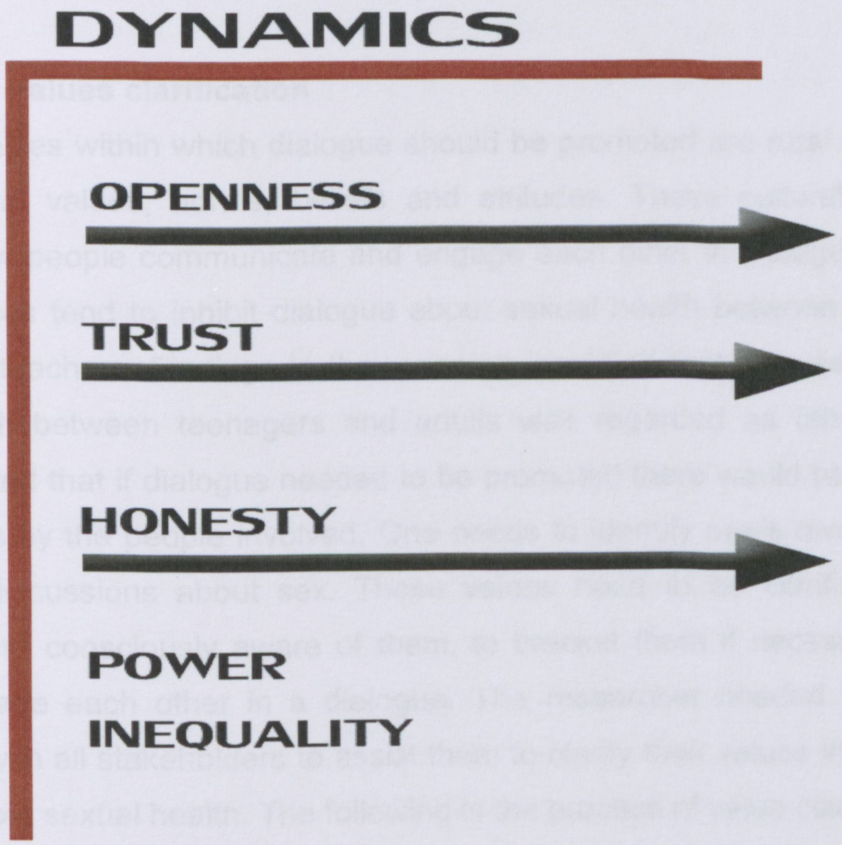
Figure: 5.3 Dynamics of dialogue



5.3.5 Procedure

This is to view the activity from the vantage point of the principle, rule, routine or protocol governing the activity, to emphasize the path, steps and pattern according to which the activity is performed (Dickoff, *et al.*, 1968:426). The activities that are viewed as being important to the promotion of dialogue about sexual health have been identified as the following:

- values clarification
- role identification
- mutual interaction
- collective inquiry

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- self-destruction
- exposing own thinking to scrutiny
- bracketing own thinking.

➢ **Values clarification**

The communities within which dialogue should be promoted are rural areas with strong cultural values, norms, beliefs and attitudes. These cultural practices influence how people communicate and engage each other in dialogue. Most of these practices tend to inhibit dialogue about sexual health between teenagers and parents/teachers. Findings in the research identified that discussing sex or sexual health between teenagers and adults was regarded as taboo. It was therefore noted that if dialogue needed to be promoted there would be a need to clarify values by the people involved. One needs to identify one's own values in relation to discussions about sex. Those values need to be clarified so that individuals are consciously aware of them, to bracket them if necessary, to be able to engage each other in a dialogue. The researcher needed to conduct workshops with all stakeholders to assist them to clarify their values in relation to dialogue about sexual health. The following is the process of value clarification.

- Prizing and cherishing
- Publicly affirming when appropriate
- Choosing alternatives
- Choosing after consideration of the consequences
- Choosing freely
- Acting with pattern, consistency and repetition (Simon, 1972:140).

➢ **Role identification**

Findings in this research identified that there were different roles that were played by different people in trying to inform teenagers about their sexual health. It would therefore be important that each party involved in assisting teenagers about their sexual health should be aware of the roles that were played by the

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other agents. The parents and teachers could find themselves blaming each other about what the other person was doing. It was important for parents/teachers to know what the role of the parent/teacher was in educating teenagers about sexual health. This would reduce tensions as each person would be aware of the other person's role. It was identified in this research that parents tended to worry about the information that teachers gave to their teenagers.

The role that was played by the aunts, uncles, siblings and peers in sexuality education should not be ignored. Their role should be acknowledged so that issues that were misleading could be easily corrected with them and the teenager as well. The role that was played by initiation schools in sexual health education needed to be identified and workshops should be conducted with them to strengthen their knowledge of sexual health and discourage practices that could be harmful.

- **Mutual interaction**

Dialogue should be a mutually interactive process. A successful dialogue cannot be achieved if other participants do not participate. Meaning and understanding can only be achieved by the ability of the participants to question and defend their contribution. The quality of dialogue is said to be measured by the ability of the participants to think and interact together in ways that they had not done before (Bokeno, 2007:12).

- **Collective inquiry**

Both participants including the community should collectively inquire from each other and look for more information to contribute to the dialogue about sexual health.

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- **Self-destruction**

In self-destruction the participants must be able to accept the perspective of others instead of rigidly advocating for their own perspectives that are tied to the self (Bokeno, 200712).

- **Exposing own thinking to scrutiny**

In exposing own thinking patterns to scrutiny one should be able to share whatever information one has to allow other people to scrutinize it and one runs the risk of losing a sense of what one believed to be true or right (Bokeno, 200712).

- **Bracketing own thinking**

Good dialogue also depends on the ability to suspend one's own thoughts, ideas and arguments in favour of listening to others. If one cannot put aside one's own version of what is real, right or possible in favour of other people's version then dialogue cannot be achieved (Bokeno, 200712).

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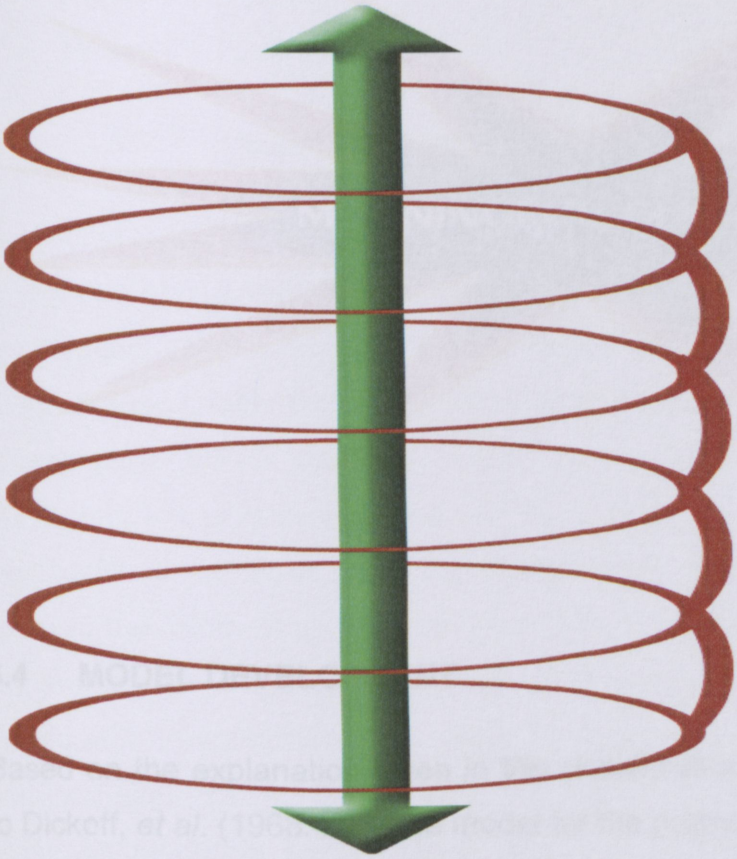
Figure: 5.4 Process of dialogue



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5.3.6 Terminus/purpose

To treat activity from the aspect of terminus is to view activity from the perspective of the end point or accomplishment of activity (Dickoff, *et al.*, 1968:426). The terminus for this study is to have teenagers, parents and teachers in the rural areas starting to engage each other in a dialogue about issues of sexual health, to have teenagers that are well informed to enable them to make responsible decisions about sex and sexual health. The model that has been developed is going to be a guideline for teenagers, parents and teachers on how they can initiate a dialogue about sexual health with each other.

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Figure: 5.5 Outcome of dialogue



5.4 MODEL DEVELOPMENT

Based on the explanation given in the classification of main concepts according to Dickoff, *et al.* (1968:426), the model for the promotion of dialogue about sexual health between teenagers and parents/teachers is discussed under the following headings as described by Chinn and Kramer (1999:84-98), which are: An overview of the of model, the purpose of the model, the structure of the model which consists of the following subcategories: assumptions of the model, concept definition, relation statement and nature of structure. Component description is followed by the description of the model process and evaluation.

5.4.1 An overview of the model

A model is a schematic representation that represents how dialogue will be promoted between teenagers and parents/teachers. The model will be explained in four phases which are:

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- Phase 1 - Holistic
- Phase 2 - Emergent
- Phase 3 – Dynamic
- Phase 4 – Exploration

➢ Phase 1 – Holistic

This is the initial stage of dialogue which involves the agent and the recipient. During this phase the agents and recipients re-examine values, meanings and assumptions as this unfolds the meanings and values that they already have about sexual health dialogue. The researcher assumes that the rural cultural context within which dialogue is supposed to take place influences the way in which an adult person who is a parent or teacher can discuss issues of sexual health with a teenager. These cultural beliefs tend to restrict the amount and depth of the information that can be shared between an adult and a teenager. It is therefore very important for the agent and recipient to re-examine their values, beliefs and meanings through values clarification so that they are aware of them and can also bracket them during a dialogue and be open to new information about sexual health. During this phase the agent and recipients are given time to re-examine themselves as individuals and in a group as teenagers, parents and teachers. The groups are then given time to present the outcomes of the examination and all participants are allowed to discuss the issues presented and assisted to overcome obstacles to dialogue that arose from the presentation. Individuals with issues that could not be shared but need attention are consulted individually to ensure confidentiality. The facilitator also engages participants in identifying the dynamics that could be involved in dialogue about sexual health between teenagers and parent/teachers. A discussion about these dynamics is encouraged so as to facilitate free discussion when parties engage in a dialogue. It is also expected that some of these dynamics emerge from the individual and group discussions during values clarification. The participants also come up with

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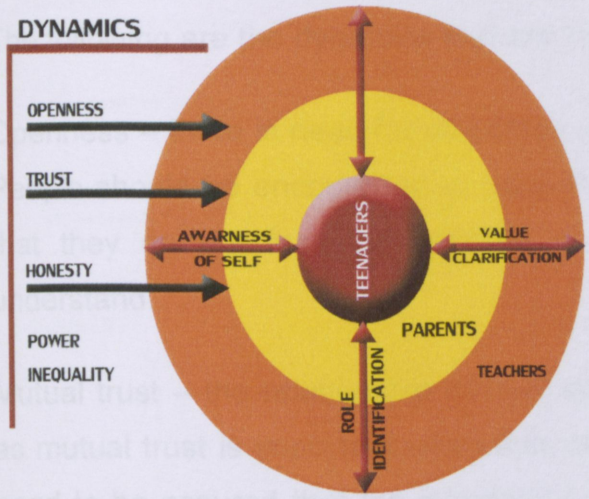
strategies how to deal with such problem or dynamics to facilitate meaningful dialogue.

FIGURE:5.6 HOLISTIC



PHASE 1: HOLISTIC

* AWARNESS OF SELF
* VALUE CLARIFICATION
* ROLE IDENTIFICATION

➢ **Phase 2 - Emergent**

The second phase involves the process of dialogue. Dialogue between teenagers and parents/teachers needs to be an interactive process where there is exchange of information. The exchange of information needs to be mutual with people exchanging information and participating equally in a dialogue. As point of departure the researcher gives the participants the definition of sexual health which is: 'the ability to express one's sexuality free from the risk of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination. It means being able to have an informed, enjoyable, and safe sex life, based on a positive approach to sexual expression and mutual respect in sexual relations'. Questions regarding the definition of sexual health are addressed. The participants' internal dialogue about sexual health is given recognition by first allowing participants to voice them if any and thereafter the participants are given four semi-structured questions to respond to. Participants are allowed to discuss this issue with more questions emanating from the discussions. Participants are encouraged to make notes on the observations that

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they might have made on how dialogue among them is unfolding, how they stimulate each other to get involved and what they think could be improved. This is where the dynamics that are involved in the interaction about dialogue need to be identified and successfully dealt with so that they do not hamper dialogue. The following are the dynamics that are identified:

Openness – there is need for all parties involved to be open in their discussions. People should be encouraged to voice their dissatisfaction during a dialogue so that they do not leave dissatisfied or unclear on issues that they do not understand.

Mutual trust – the relationship of trust should be fostered during this interaction as mutual trust is important when information that is sensitive is shared. People need to be assured that the information that they are sharing during a dialogue will be treated with utmost confidence.

Power differences – the power differences between the teenagers and the parent/teacher also pose a treat to dialogue. The participants need to be aware that they are interacting as equals during dialogue and they should refrain from adopting their roles as parent and teacher.

Honesty – this is another dynamic that is crucial in the achievement of fruitful dialogue. People participating in a dialogue should never pretend to each other like pretending to understand an issue when they don't. This will hamper the aim of the dialogue as teenagers will never have correct information about sexual health if they pretend that they understand while they do not.

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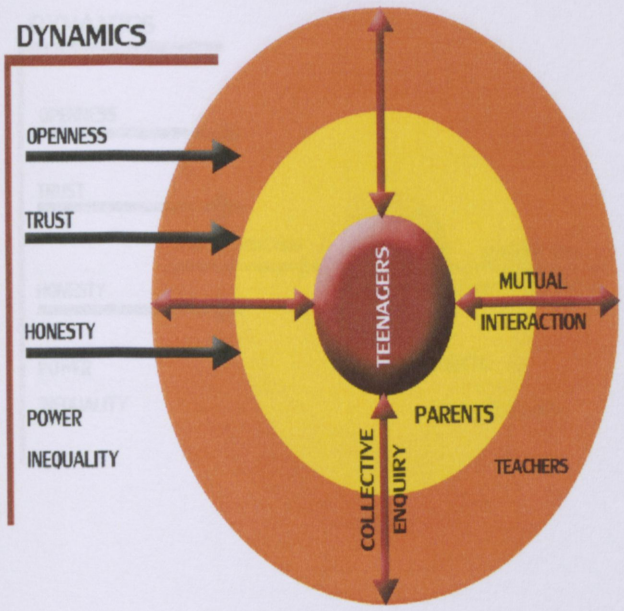
FIGURE:5.7 EMERGENT



PHASE 2: EMERGENT

* MUTUAL INTERACTION
* COLLECTIVE ENQUIRY

➢ **Phase 3 – Dynamics**

This is the stage where participants examine unexamined assumptions and this requires self-destruction. In self-destruction the participants are able to take the perspectives of other participants instead of advocating for their own perspectives. Participants must be able to expose their own thinking to the scrutiny of others and run the risk of losing what they always believed to be true. This will be useful as some of the participants might have wrong information about sexual health and this might be information that they have known for a long time and believed in. The success of dialogue is therefore achieved when old information is discarded and new information is taken.

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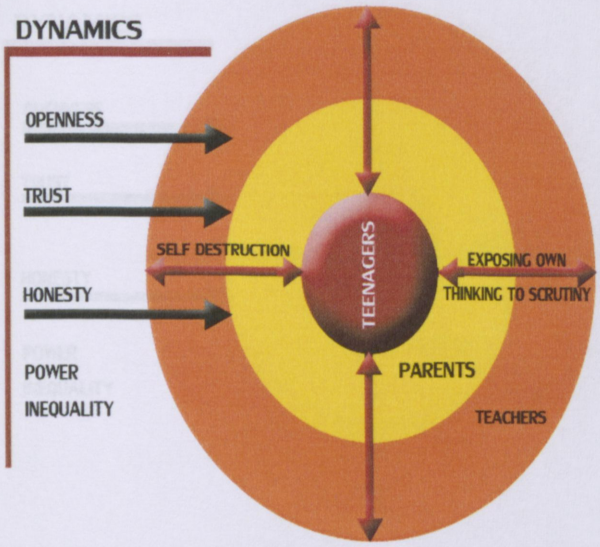
FIGURE:5.8 DYNAMICS



PHASE 3: DYNAMICS

* SELF DESTRUCTION
* EXPOSING OWN
THINKING TO SCRUTINY

➢ **Phase 4 - Appreciation**

During this phase, which is the outcome of the dialogical process, the agents and recipients must be able to engage each other in a dialogue. The desired effects of a dialogue should be identifiable on the part of the teenagers by being able to leave the practices that were believed to be risky and expose them to problems associated with sexual risk behaviour such as sexually transmitted infections, teenage pregnancies etc. This was the stage where meaningful dialogue was achieved as members would be able to expose their thinking to the scrutiny of others and let go of what they thought was true. Participants would also be encouraged to give their views about how the dialogue was conducted, their feelings and shortcomings. Strategies for dealing with problems that participants were raising should be addressed.

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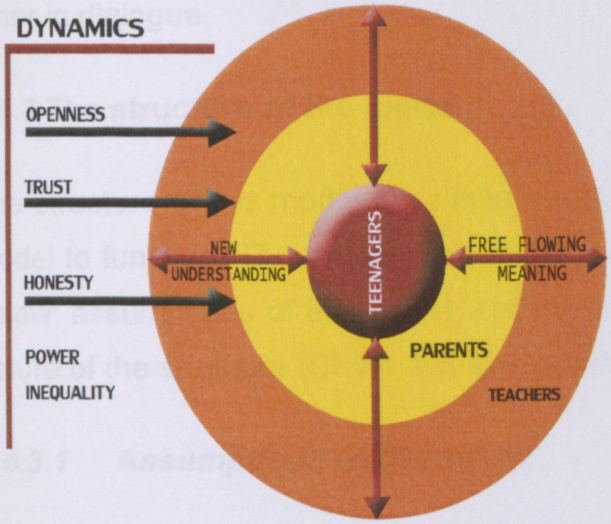
FIGURE:5.9 APPRECIATION



PHASE 4: APPRECIATION

* FREE FLOWING

MEANING

*NEW UNDERSTANDING

5.4.2 The purpose of the model

The purpose of this model was to promote dialogue about sexual health between teenagers and parents/teachers. It was envisaged that dialogue about sexual health between parents and teachers would be achieved through four stages as indicated in figure 5.1 which were:

- Phase 1 - Holistic
- Phase 2 – Emergent
- Phase 3 – Dynamics
- Phase 4 – Appreciation

The agents and recipients should interact with each other as they engaged each other in dialogue about sexual health by being able to identify their own beliefs and values before engaging in a dialogue and mutually participating in a dialogue and being aware of the dynamics of dialogue among themselves. They should also be able to do continuous evaluation of how dialogue among them was unfolding in order to improve with subsequent dialogues. All participants should

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be able to achieve meaningful dialogue where they could freely engage each other in dialogue.

5.4.3 The structure of the model

The structure of the model consisted of elements which were necessary for the model to function. The model was based on the following elements as described below: assumptions of the model, concept definition, relation statements and the nature of the structure (Chinn & Kramer, 1991:107-125).

5.4.3.1 Assumptions of the model

The following were the assumptions upon which this model was based:

- The agents and recipients had their own beliefs and meanings about sexual health dialogue between teenagers and parents/teachers.
- The cultural beliefs and attitudes influenced how dialogue could be initiated between teenagers and adults (parents and teachers).
- Each participant had internal dialogue within him/herself.
- Dialogue is an interactive dynamic process between participants.
- The dialogue process produced new meaning and understanding among participants.

5.4.3.2 Concept definition

The concepts that were central to this model were the following: the community cultural context, the family and school context; the parents and teachers who were agents; t he teenagers who were recipients; t he processes of dialogue which were interactive; the outcome of dialogue which was meaningful dialogue and the dynamics of dialogue which were openness, honesty, power imbalances and trust.

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Context - The community cultural context or environment which was in the rural areas and rooted in the culture, beliefs and values of the specific group. People in this context interacted and they shared the same beliefs and values about life and sexual health. The family context consisted of members of the nucleus family with their extended family members. The family was found within the cultural context and therefore shared the same values and meanings regarding sexual health. The school as an institution of education was also tasked with the responsibility of educating students about issues of sexual health. It was noted that the cultural context, values and meaning influenced the way in which teenagers and teachers engaged each other in dialogue within the school context.

Agents – The agents were the participants that were expected to initiate or facilitate dialogue with teenagers and were believed to have experience in issues of sexual health. In this context the agents were parents of the teenagers and teachers who were tasked with the duty of teaching sexuality education at schools.

Recipients – These were teenagers who were supposed to be given relevant information about sexual health to assist them in making informed decisions.

Interactive process – This was described as an interactive process of learning where mutual value in buyer-supplier exchanges was enhanced. It was reasoning together. The aim of this dialogue was to achieve deeper levels of understanding among those participating. Dialogical interaction needs people to be more aware of their routine and thought patterns (Ballantyne, 2004:114). The process of dialogue in this model was interactive in that both the agents and recipients should mutually participate in the dialogue to achieve richer understanding of sexual health. Participants needed to examine their own beliefs and meanings and to be aware of them to enhance dialogue that would allow them to achieve deeper understanding.

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Outcome of meaningful dialogue – This was the ultimate outcome of dialogue where agents and recipients could engage each other to achieve meaningful dialogue.

Dynamics – The dynamics were the underlying powers that may affect how dialogue took place and the outcomes of dialogue which were trust, honesty, teenage stage, power inequality and openness Figure 5.1 shows the diagrammatic representation of the model

5.4.3.3 Relation statement of the model

This is a description, explanation, or prediction of the nature of interaction between the concepts of the theory (Chinn & Kramer, 1995:96). The following relation statements were formulated for this model of promotion of dialogue about sexual health between teenagers and parents/teachers:

- Dialogue about sexual health was influenced by the context within which it existed, the context being community, cultural, family and school context.
- Fruitful dialogue could be initiated if the participants successfully examined their values and meanings about sexual health before engaging in a dialogue.
- Internal dialogue occurred within individuals and it tended to influence the external dialogue that the participants were going to have.
- Sexual health dialogue involved mutual interaction between teenagers and parents/teachers.
- Dynamics that drove the process of dialogue about sexual health between teenagers and parents/teachers were self-reflection, trust, honesty, power imbalance and openness.
- Successful interaction during dialogue would produce new understanding and meanings.

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5.5 THE NATURE OF THE STRUCTURE

The schematic presentation of the model in figure 5.1 tries to explain the relationship between the identified concepts.

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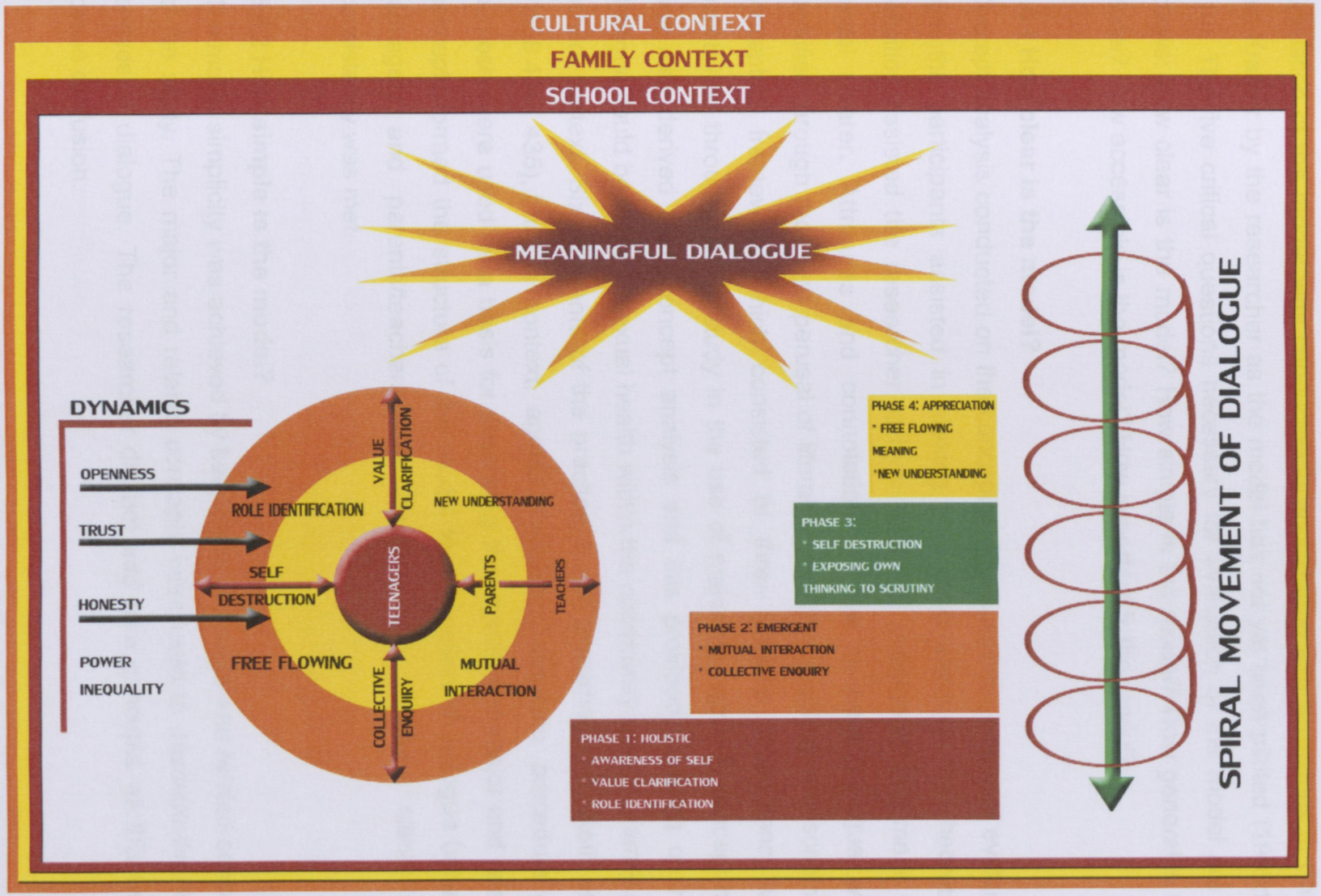
FIGURE: 5.10 A MODEL TO PROMOTE DIALOGUE ABOUT SEXUAL HEALTH BETWEEN TEENAGERS AND PARENTS/TEACHERS



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A model to promote dialogue about sexual health between teenagers and parents/teachers. R.T Lebese

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5.6 EVALUATION OF THE MODEL

Evaluation of the model was conducted in accordance with guidelines in Chinn and Kramer by the researcher as the model has not yet been piloted (1999:99-110). The five critical questions necessary for evaluation of the model are as follows: How clear is the model? How simple is the model? How general is the model? How accessible is the model? How important is the model?

5.6.1 How clear is the model?

Concept analysis conducted on the concept dialogue and the empirical evidence from the participants assisted in making the model clear as the theoretical definition assisted the researcher to form relational statements that made the model clearer. Attributes and connotations of the concept dialogue were identified through thorough perusal of literature and this assisted in describing a conceptual framework which consisted of three phases. Consistency was maintained throughout the study in the use of major concepts. A concept map was also derived from concept analysis and this provided meaning on how dialogue could be used in sexual health within the community cultural, family and school context. Six elements of the practice model according to Dickoff. *et al.* (1968:434; 435), t hat is context, agents, recipients, dynamic, procedure and purpose, were used as a basis for describing the model. The major and related concepts formed the structure of the model for promotion of dialogue between teenagers and parents/teachers and therefore the structural clarity and consistency was met.

5.6.2 How simple is the model?

The model simplicity was achieved by keeping to the major and related concepts of the study. The major and related concepts were used to describe the three phases of dialogue. The researcher did not add new concepts as this would cause confusion.

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5.6.3 How general is the model?

The model was described as a response to the need for teenagers and parents/teachers to start communicating about issues of sexual health. Empirical evidence indicated that it was very difficult for them to communicate. The model was therefore developed to assist them to engage each other in a dialogue about sexual health.

5.6.4 How accessible is the model?

The model would be made accessible to the villages where data was collected through workshops that would be conducted by the researcher where the model would be implemented and evaluated. Workshops would be conducted with teachers at schools where the study was conducted. The reproductive health directorate would be involved so that it would be easier to access other districts in the province. It would be possible to access the model through library search, publications in accredited journals, attendance of seminars, and national and international conference presentations.

5.6.5 How important is the model?

There is a high rate of STIs, including HIV and AIDS, among teenagers, also termination of pregnancies, teenage pregnancies, and parenthood and these rates have reached unacceptable levels. Teenagers were found not to have sufficient information about sexual health to assist them to make informed decisions about sexual health. It was also identified that parents and teachers were not communicating about issues of sexual health with teenagers. The model would promote dialogue about sexual health between teenagers and parents/teachers and would assist all participants involved to find it easier to initiate dialogue about sexual health. It was hoped that dialogue about sexual health would help to decrease the rate of STIs including HIV and AIDS, teenage pregnancy and parenthood.

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5.7 SUMMARY

This chapter focused on the description of the model to promote dialogue about sexual health between teenagers and parents/teachers. Emphasis was given to the following items in the description: overview, purpose and structure of the model were described. The structure of the model included assumptions on which the model was based, the definition of concepts, formulation of relation statements, the nature of the structure and description of the process. The model was evaluated in accordance with the criteria set out in Chinn and Kramer (1999:99-110). Chapter 6 focuses on the description of guidelines to operationalise the model, evaluation, limitations, justification for the study, recommendations, and the conclusion.

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GUIDELINES TO OPERATIONALISE THE MODEL

6.1 INTRODUCTION

The previous chapter focused on model development and evaluation of the model to promote dialogue about sexual health between teenagers and parents/teachers in the rural areas of Limpopo Province with special emphasis on Vhembe district. The purpose of this chapter is to describe the guidelines to operationalise the model.

6.2 GUIDELINES TO OPERATIONALISE THE MODEL

The final step in model development is the application of the model (Chinn & Kramer, 1999). Application of the model involves a description of guidelines to how the model is to be operationalised. The guidelines for the model to promote dialogue about sexual health between teenagers and parents/teachers will be described according to the practice model as presented in chapter 5 of this study. The six elements of the practice model are as follows:

- Guidelines pertaining to context
- The agents and recipients
- The procedure and dynamics and
- Outcomes or purpose of the dialogue.

6.2.1 Guidelines for the dialogical context

The following guidelines were derived from the data analysis and conceptualization of the context where dialogue was expected to take place in the rural areas of Vhembe district in Limpopo Province. The context where dialogue was expected to take place was the community, family and school.

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6.2.1.1 Guidelines for the community context

- Community-shared cultural norms and values related to sexual health education need to be reviewed by all stakeholders.
- Participation at the community level should be all-inclusive and promote active participation by community members.
- Workshops should be conducted to clarify values and assist community members to identify issues within cultural values that can be beneficial and non-beneficial.
- Community members should also develop strategies for collaboration between members of the community, the families and schools.
- Community members should be encouraged to develop support structures for teenagers seeking sexual health information.
- Strategies for strengthening the programme should be developed to ensure sustainability.
- Clear guidelines should be set for involving people with expertise during workshops to gain more current knowledge about issues of sexual health.
- Collaboration with reproductive health units including local clinics at community level should be encouraged as they could be used as resource centres for the community.
- The cultural initiation schools should be involved and issues of sexual health education should be given priority.
- The people who are in charge of or running the initiation schools should receive training through workshops where sexual health information is given.
- Collaboration with nurses at the local clinic should be encouraged where teenagers can go for assistance or information.
- Community members should receive training on effective communication and interpersonal skills as this is needed where people are supposed to work in groups to reduce conflict and help participants to manage their own emotions.

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- The participants should observe the rights of all participants including teenagers.

6.2.1.2 *Guidelines for the family context*

- Within families members should also engage each other in a values-clarification workshop where values and norms are examined for appropriateness and importance so that issues that are of less importance can be left out and some issues accommodated and repatterned according to Leininger's theory.
- The role of sexual health education within initiation schools should also be strengthened from the family viewpcint as members of the families are highly involved in running such schools and may have great influence over what activities should be included at initiation schools.
- Families should have well-defined roles in relation to sexual health education. It should also be stressed that issues of sexual health should involve every member of the family as family members need to share information and learn from each other as this is crucial in this era of HIV/AIDS.
- The family should also coordinate with the school through school governing bodies and community structures dealing with issues of sexual health to ensure that whatever they are teaching their teenagers or children is in line with what the children are taught in the schools and community. This will also ensure that the family members get current information from the experts and organisations found in the hospitals.
- Family members should also participate in community activities related to sexual health like attending workshops organised at community level or awareness campaigns. This will in turn ensure that family members receive up-to-date information about sexual health issues and share information that is correct.
- Families should also trust each other as lack of trust will not foster good sharing of information especially between teenagers and parents. Family

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members should ensure confidentiality of issues that have been shared with them as other members may share sensitive information that they feels cannot be shared with the whole family.

- Issues of power imbalances within the family should also be addressed. The adults who could be parents or uncles/aunts may feel that their views should be respected and therefore taken. Family members should always ensure that sexual health dialogue occurs where members are equal partners and all inputs are respected.
- Families also need to be open with regard to issues to be discussed. Openness will ensure that there is transparency regarding what needs to be discussed, what members' problems are or what members' knowledge regarding certain aspects is and this will facilitate fruitful information sharing and members will be free to discuss all issues.
- Honesty is another value that family members need to apply. Members who are honest will always speak the truth and be honest in their relationships and this includes being honest about the nature of their knowledge about sexual health. Dishonest family members will not practice safe sex and therefore the type of knowledge shared will not be true.
- Interaction between family members should be mutual with all members participating. The dialogue process should be characterised by active involvement of all members.
- The family as a unit should collectively inquire and look for information. Inquiry with regard to sexual health issues should never be left to one individual as this may make that individual stop participating as sometimes the person might feel overwhelmed and stop looking for information or sexual health resources that can be of help to them.
- There is a need for family members to attend workshops related to sexual health issues at community level or anywhere they can manage to go as this will furnish them with current information and may assist families to form networks.

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6.2.1.3 Guidelines for the school context

- The teachers, teenagers and school governing body members should be engaged in a values-clarification exercise. This is very important especially in the rural areas where culture still plays an important role and all participants need to clarify their values for fruitful participation.
- There is need to have roles that are well defined between members of staff. There should be teachers allocated to teach sexual health and the proportion of teachers to learners should be reasonable to allow good learner-teacher interaction. The role that the school governing body plays in sexual health should also be described as this will ensure that each person understands his/her role and encourages participation. The role of teenagers in sexual health education must also be defined for them to participate freely.
- The school curriculum needs to be reviewed to allow sexual health to be an examination subject so that learners can give it more time and attention for it to bear fruit. Sexual health needs to be given high priority especially because of the HIV/AIDS pandemic to ensure that both teachers and teenagers are healthy and live longer to be productive citizens.
- The workload should be evenly distributed among teachers. The teachers responsible for sexual health education should have their subjects reduced and they should not teach all the grades as this makes them unproductive.
- There should be coordination among the school, the family, community, and initiation schools regarding sexual health activities. This will ensure that whatever the teenagers learn at school is in line with what they receive from their families, initiation schools and communities. This will also strengthen the teachers who indicated in their responses that the community and families sometimes questioned the extent to which they engaged teenagers in issues of sexual health.

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- The school should seek expert knowledge from time to time so that they were up to date with current information and were aware of different reproductive health resources available to teenagers. This would assist during dialogue as the teacher would be a resource person.
- The school should participate in workshops related to sexual health that may be conducted at community level or within the Department of Education.
- The school should also introduce activities such as debates and awareness campaigns where teenagers actively participated to increase their knowledge of sexual health.

6.2.2 Guidelines on the agent and recipient

6.2.2.1 The agents

- The agent who could be either a parent or teacher, should be aware of his/her own values, beliefs and meaning about sexual health. These values need to be clarified so that they do not influence the way in which dialogue takes place between the parents/teachers and teenagers.
- The roles that are played by the agents need to be defined so that each one is aware of the duties of the other and the self to reduce conflict.
- The parents/teachers should create an environment conducive to dialogue with teenagers about sexual health without feeling threatened.
- The agents should assume the position where participants in a dialogue are treated as equals without assuming a position of power.
- The agents should strengthen coordination between the different institutions responsible for sexual health and ensure that there is vibrant dialogue about sexual health in their communities.

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- The agents should take it upon themselves to look for more information about issues of sexual health so that during dialogue about sexual health with teenagers they have enough information to resolve misunderstandings that teenagers might have and when agents display a high level of knowledge the teenagers might learn to trust them.
- The agents should continuously engage the teenagers in a dialogue about sexual health to cover a wide range of issues related to sexual health. Continuity would also stimulate more dialogue on sexual health which would be beneficial to both the teenager and parents/teachers.
- The agents should be willing to learn from the teenagers as they have a wealth of information that could be of benefit to them.

6.2.2.2 The recipients

- Teenagers as recipients should have a positive approach to dialogue about sexual health with parents and teachers for it to bear fruit. Their active participation stimulates the dialogical process and gives meaning and new understanding.
- The teenagers need to clarify their own values and norms related to sexual health so that it is easier for them to engage parents/teachers in a dialogue about sexual health.
- Teenagers need to be clarified about the role that they are expected to play to ensure that dialogue about sexual health with parents/teachers is beneficial to them.
- Teenagers need to belong to support groups within the communities and schools to get support when in a crisis.

6.2.3 Guidelines regarding the dynamics of dialogue

The dynamics that drive dialogue about sexual health between teenagers and parents are honesty, openness, power inequality and mutual trust. It should be

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borne in mind that if these dynamics are not addressed they can be negative or hinder dialogue. The guidelines to operationalise the dynamics of dialogue are described as follows:

- **Power inequality**

During a dialogue participants should ensure that they participate as equals especially on the part of parents and teachers where it is easy for the parents and teachers to assume a superior position. This can be threatening to teenagers and may influence them not to participate. Teenagers should avoid assuming a minor or subordinate position as this will affect their level of participation and retard dialogue.

- **Openness and honesty**

There is a need for all participants to be honest and open in their engagement with each other as it forms the foundation of a good working relationship. During the dialogue participants need to be open with regard to what they know and feel about sexual health to facilitate good fruitful engagement. The dialogical process should be based on the principle of transparency.

- **Mutual trust**

Lack of trust among the participants reduces the effectiveness of the dialogical process. Trust is a positive energy for dialogue as participants will be ready to share even sensitive issues. Trust can be facilitated by participant's ability to tell the truth and keep information shared with one another confidential. Participants should keep their promises and honour appointments to earn trust.

6.2.4 Guidelines regarding the process of dialogue

The process of dialogue involves describing the procedure that will be followed to initiate dialogue. The dialogical process is described in three phases. Phase 1 involves self-evaluation. Phase two deals with dialogue initiation and Phase 3

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deals with the outcome of the dialogical process. The guidelines for each phase are described separately.

6.2.4.1 Phase 1: Guideline for self-evaluation

The guidelines for self-evaluation involve values clarification and role identification.

- Values clarification

All participants who are parents, teachers and teenagers need to evaluate their own values, beliefs and meanings in relation to sexual health dialogue. This exercise is necessary because the cultural values, beliefs and meanings influence how dialogue about sexual health can be conducted between adults and teenagers. It is therefore necessary to examine these values and beliefs and clarify them before engaging in a dialogue to ensure that the dialogue is successful. Workshops will be conducted with the assistance of an expert in values clarification to assist the communities, families and schools.

- Role identification

Role identification is very important in the initial stages of dialogue as there are different people within communities, families and schools who are tasked with the responsibility of educating teenagers about sexual health. It is therefore necessary to identify the roles assigned to different stakeholders within the communities so that coordination is well fostered and this will reduce overlapping and conflicts.

6.2.3.2 Phase 1: Guidelines for dialogue initiation

The guidelines for dialogue initiation involve mutual interaction and collective inquiry process.

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- Mutual interaction

When dialogue is initiated there is need for mutual interaction as dialogue involves a two-way process between two or more people. Participants should be encouraged to actively participate in the discussion and should refrain from imposing their own thinking or ideas on other participants. All inputs should be acknowledged and discussed and participants should always strive to reach consensus. If consensus is not reached participants should agree on the time and date for the next meeting to further discuss the issue. Participants can also consult experts or reading materials to clarify issues that they do not have clear answers to. An atmosphere where parents, teachers or teenagers feel free to initiate a dialogue should be encouraged. The participants should also have knowledge of group dynamics that are energy-drivers of dialogue.

Collaboration between the school, family and community including initiation schools should be encouraged. This will facilitate the sharing of information and knowledge of what the other people are doing in relation to dialogue about sexual health. The skills that individuals have can also be shared across all stakeholders if there is coordination.

- Collective inquiry process

During dialogue initiation participants should collectively inquire information from each other that they need to be clarified on. It is envisaged that this is going to be difficult at first as participants will still fall back to stage 1 where they will need to re-clarify values. Participants are encouraged to learn from each other which can be difficult among parents and teachers as they always believe that they know everything and teenagers do not have knowledge about sexual health that can be shared.

It is also encouraged that should participants lack knowledge of specific aspects that are under discussion it would be advisable for all parties to look for more information from books, pamphlets or experts. Adults should always guard

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against letting only teenagers look for information as this may give the impression that they are assuming a higher role and possess more power than teenagers.

- Self-destruction
- Bracketing own thinking
- Exposing own thinking to scrutiny

6.2.5 Guidelines related to the spiral movement of the process

The process of dialogue from the stage of self-evaluation to the outcome stage takes a spiral movement. This is caused by the fact that participants do not achieve fruitful dialogue by only one engagement. It is an exercise that requires participants to move backwards and forwards as some failures may require participants to move back to the previous stage to facilitate smooth management of the next stage. The spiralling movement continues until participants can freely engage each other in a dialogue and new understanding and meaning can be derived from such engagement.

6.2.6 Guidelines in terms of the purpose or outcome of the model

The purpose of the model describes the outcomes that the model will achieve after its implementation. It promotes dialogue about sexual health between teenagers and parents/teachers and leads to the achievement of meaningful dialogue by participants and the creation of free-flowing meaning and new understanding. The participants will develop the skills of engaging each other in a dialogue. The evaluation of having achieved the level of meaningful dialogue will be determined as follows:

- Participants' are able to initiate dialogue about sexual health without feelings of guilt.
- Participants' are able to actively engage each other in a dialogue about sexual health.

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- All stakeholders, which are the family, school and community, are able to coordinate and work together harmoniously in striving to achieve meaningful dialogue about sexual health in their community.
- All participants share selflessly and exchange information about sexual health during a dialogue.
- Participants overcome their shyness and feelings of guilt about discussing issues of sexual health.
- Participants demonstrate a high level of openness and honesty when discussing a wide range of ideas about sexual health.
- Participants demonstrate the attitude of questioning and challenging different views during a dialogue.
- There is visible movement towards change in the participants' moral and value system in relation to sexual health.
- A support group or any type of group that is related to sexual health is established.
- There is an increase in the utilization of sexual health services in the community.
- The rate of teenage pregnancy, sexually transmitted diseases including HIV and AIDS decreases.
- Participants develop negotiation skills, communication skills and interpersonal skills that lead to the achievement of consensus about sexual health issues.

6.3 SUMMARY

Chapter 6 discussed the operationalisation of the model. The guidelines to operationalise the model were described in accordance with the elements of the practice model as described by Dickoff, *et al*. The elements of the practice model discussed were: the context, agents, recipients, dynamics, procedure and outcome (Dickoff, *et al*., 1968:423). Chapter 7 focuses on evaluation, justification, limitations, conclusion and recommendations.

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CHAPTER 7

EVALUATION, JUSTIFICATION, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

The previous chapter described how the model was going to be operationalised. This chapter focuses on the evaluation of the study in terms of its ability to meet the objectives set out in chapter 1. Justification of the study regarding its original contribution to the body of knowledge is given. The limitations, conclusion and recommendations in relation to the promotion of dialogue about sexual health between teenagers and parents/teachers is described.

7.2 EVALUATION OF THE STUDY

The study is evaluated against its rationale, purpose and objectives as set out in chapter one.

7.2.1 The rationale of the study

One of the main focuses of primary health care is reproductive health with more emphasis on the reproductive health of teenagers as the future leaders and workforce of the country. The focus on reproductive health is even more important because of the escalating rates of teenage pregnancy, and STIs, including HIV/AIDS. Central to addressing these reproductive problems is education. Government then introduced programmes and legislation that would address the sexual health problems of individuals and mainly teenagers. It was hoped that with education teenagers would be able to modify behaviour and exercise reproductive health practices that would in turn reduce the rates of teenage pregnancy and STIs, including HIV/AIDS. Education about sexual health mostly imposed ideas on teenagers and these might contribute towards rates remaining high despite education that was taking place. The study sought to

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introduce education through dialogue because it was believed that there was a need for all people who might be teenagers and parents/teachers to actively participate in and contribute to a dialogue and learn from each other. The relationship that was going to be established based on openness, honesty and trust would ensure that there was continuous dialogue and this would eventually lead to creation of an open discussion about issues of sexual health in the community that was rooted in culture.

Teenagers as sexual beings should also be given the opportunity to relate their sexual experiences, frustrations and imaginations without feelings of being threatened. This would in turn assist in giving parents an indication of what was happening in their children's lives. Dialogue would also give teenagers the platform to question and challenge other sexual health perspectives/practices and this would in turn assist them to develop some of the skills like assertiveness, communication skills, and interpersonal skills.

Parents are expected to be the primary educators of their children from birth and the study identified that they were reluctant or were not teaching their children about issues of sexual health at all. The parents were found to be reluctant because of their cultural values and beliefs in relation to sexual health and in most instances the aunt was the one to whom the responsibility of educating teenagers about sexual health was assigned. The parents would be assisted within the model by a values clarification and role identification exercise to deal with these issues that restricted them from engaging their children in dialogue about sexual health.

Teachers are secondary educators of children and their role in sexual health education needs to be addressed in terms of the curriculum which is not well defined. Sexual health should be given the same status as other subjects and should be an examination subject as this will make students give it equal attention as other examination subjects. The workload of teachers to whom educating teenagers about sexual health is assigned needs to be addressed in

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terms of the number of periods and the number of classes to be taught. Cultural aspects related to sexual health education also need to be addressed through coordination with other community structures involved in sexual health like initiation schools so that roles are clarified and overlapping is minimized.

Cultural values, beliefs and meanings, especially in the rural areas, are complex and strong so it is imperative that these issues be treated with sensitivity and respect by all stakeholders. The process of dialogue should be made as inclusive as possible and create a wider awareness. The principle of collective inquiry and mutual interaction should be made central to this dialogical process.

7.2.2 The purpose of the study

The overall purpose of this study was to develop a model to promote dialogue about sexual health between teenagers and parents/teachers and describe the guidelines to operationalise the model. The experiences of teenagers, parents and teachers were explored and compared with relevant literature and this formed the basis for identification and conceptualization of the concept which was done using Rodgers and Knafl's (1993:77-90) eight steps. The framework of Dickoff, *et al.* (1968, 426) was used to describe the model as the practice survey list formed the basis for model development. The model was described in accordance with Chinn and Kramer (1999:84).

7.2.3 The research study objectives

The research objectives that were set in chapter 1 are evaluated separately as follows:

- Objective 1, 2 and 3 - Exploration and description of experiences of teenagers, parents and teachers and identifying the role of cultural practices in sexual health dialogue.

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The first and second objectives were met during the first phase of this study. During the first stage experiences of teenagers, parents and teachers were explored through in-depth individual interviews and focus-group discussions. The central question directed the structure of the interviews and questions that emanated from the discussions were explored. Both types of interviews were used among teenagers and parents and only in-depth interviews were used with the sample of teachers as they were few and could not form a group for focus-group discussion. Data was analysed separately for each group of participants that is, teenagers, parents and teachers. The experiences were analysed according to Tesch's eight steps (in Creswell, 1990:145) and themes, categories and sub-categories emerged. Dense descriptions of these experiences were also done in the light of relevant literature. Central to the results elicited from the participants it was identified that sexual health was regarded by all participants as the act of engaging in sex which was an indication that many aspects that were important in sexual health were not attended to. It was also identified that culture played a restrictive role in the extent to which participants engaged each other in dialogues. Resources were also found to be limited in terms of access of the participants to valuable information with regard to sexual health. All participants were found to lack the skills necessary to initiate dialogue about sexual health with teenagers. The data drawn from these participants formed the basis for concept analysis and model development, hence the importance that this phase had on model development.

- Objective 4 – Conceptualization

Central to the study was the concept "dialogue". The concept "dialogue" was analysed according to the adapted steps in Rodgers and Knafl (1993:77-90). Dialogue ensured that all parties involved participated as it was identified as a feature which was absent in the participants' explanation of their experiences. It was also identified that the following characteristics were necessary in any interaction about sexual health between teenagers and parents/teachers: attentiveness, valuing of the other, being open to personal change, accepting the

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risk of self-disclosure, affirming the discipline of dialogue, seeking community understanding, observing the boundaries of the relationship, valuing the encounter of the relationship and recognising the spiritual dimension of dialogue. The appropriate setting where dialogue was supposed to take place was the community cultural, family and school context. The sample of data about dialogue was selected from dictionaries, books and national and international journals. A theoretical definition was derived from these definitions and the description directed the development of the model.

Attributes of the concept assisted in identifying the occurrence of a specific phenomenon. Other uses of the concept were identified and these assisted in the understanding of the concept. Surrogate terms, antecedents and consequences of the term were described and improved by clarifying the concept. Related concepts that were used interchangeably with the concept "dialogue" were also described. Data related to dialogue was analysed and themes and categories were developed. A model case from the parents' experiences was also described. Conceptualization therefore led to model development and description.

- Objective 5 – Model development and description

The results derived from objective 1 to 5 formed the basis for describing the model to promote dialogue about sexual health between teenagers and parents/teachers. The survey practice list of Dickoff, *et al.* (1968:426) was used as a framework for model development. Chinn and Kramer (1999:84) were used to describe and evaluate the model. Guidelines derived from all three phases were also described.

7.3 JUSTIFICATION OF THE ORIGINAL CONTRIBUTION OF THE RESEARCH STUDY TO THE BODY OF KNOWLEDGE

This research study is an original contribution to the body of knowledge in nursing with particular emphasis on sexual health education in the communities,

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families and schools. The following are the reasons given for this original contribution:

Empirically participants' experiences of dialogue about sexual health between teenagers and parents/teachers were explored and described. Analysis of experiences was done using Tesch's eight steps (in Creswell, 1990:145). Relevant literature and results were used in the shaping of the model that was developed. The concept "dialogue" was analysed systematically during concept analysis using the steps of Rodgers and Knafl (1993:77-90). The results drawn from the concept analysis revealed that dialogue is a conversation between two or more people, an exchange of ideas, especially on the political level (Webster's Desk Dictionary, 1990:250). Dialogue is also said to occur within oneself (Bohm, 1996:6). This explanation suggests a stream of meaning flowing among and through us and between us. New understanding may emerge and this is normally the glue that binds people together. Dialogue is said to explore a wide range of human experience, values, emotions, input of cultural myths, patterns of our thought processes and moment-to-moment experience (Bohm, 1996:6). Based on Bohm's explanation of dialogue it means that dialogue starts even before the actual encounter between the parties involved. Dialogue within the self exists and this might influence what an individual brings when there is dialogue between individuals. It might also be useful for individuals to be aware of issues within the self that might influence the contact dialogue. Dialogue is also said to bring new understanding between parties involved and requires participation of the parties involved. Dialogue improves collective inquiry processes through free-flowing meaning (Isaacs, 1996:1). Dialogue requires openness, honesty, mutual interaction, authentic collaboration, trust, genuine self-reflection, clear and tacit ways of thinking and willingness to grow through risk (Bokeno, 2007:10).

These results were presented in seminars and research forums and refined. The results of concept analysis gave direction to the development and description of the model. The theoretical definition of dialogue within sexual health is unique in the community, family and school context. The survey list of the practice model of

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Dickoff, *et al.* (1968:426) was used as a framework for model development. Chinn and Kramer (1999:84) were used to describe and evaluate the model. Guidelines for the original practice model to promote dialogue about sexual health between teenagers and parents/teachers were described in order to operationalise the model. The goal of dialogue about sexual health was to assist participants to have meaningful dialogue about sexual health. Model development on dialogue about sexual health was done in response to the WHO and the National Department of Health's need to promote sexual health among teenagers.

7.4 LIMITATIONS

The researcher received a great deal of support from the chiefs in charge of the villages from which participants were drawn. It was also very easy to get the sample for the study. The participants were willing to be interviewed and the topic drew much interest from the group. However, the following were found to be limitations to the study. The sample drawn from the teachers was small compared to the other groups and this was attributed to the fact that schools were far apart and the researcher could not get the teachers together in one place in order to conduct a focus-group discussion.

The empirical data was drawn from one district in Limpopo Province, and therefore the findings can only be transferable within the district. The researcher could not pilot the model and this will be done as part of the post-doctoral study. The model has therefore not yet been tested.

7.5 RECOMMENDATIONS.

Recommendations emanating from the study are made in terms of the guidelines that have been described for operationalising the model.

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7.5.1 Sexual health and dialogue within the community context

The community cultural values, beliefs and meanings forms an integral part of sexual health dialogue between teenagers and parents/teachers as these cultural aspects determine what and when sexual issues can be discussed. It is very important that the community as a whole should be involved in laying the foundation for sexual health dialogue to take place. Values-clarification exercises should be as inclusive as possible to make sexual health dialogue more acceptable to the community. The stakeholders in the community, whether they be traditional leaders, traditional healers, faith-based organisations, initiation school facilitators, primary health care services or ordinary community members, should be involved. The community should also be advised of the formation of a sexual health committee which is representative of all the people involved in sexual health education, including teenagers. The committee should be charged with the responsibility of facilitating the process and problem solving. The workshops on values clarification and evaluation of the process should be done frequently and where possible a programme drawn by the community members should be put in place to indicate how they would like the process to be monitored, supported and evaluated. Proposals may also need to be developed by the communities to seek funding for this initiative. The researcher's contact details would be given to the committee so that they could contact her when there was a need to clarify aspects related to the implementation of the model.

7.5.2 Sexual health and dialogue within the families

The parents as primary educators of their children should accept the role that they were expected to play in educating their children about sexual health. The lack of knowledge and skills required to engage teenagers in dialogue about sexual health that was identified during exploration of experiences should be addressed by providing training on how to initiate dialogue through values clarification, role identification, mutual interaction, collective inquiry and collaboration. There was a need to provide the families and the communities with

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materials that were written in their language. This would provide them with more information. A strategy needed to be worked out on how to make provision for members who were unable to read and write. Resource people should be available for them and the primary health care nurses and sexuality education teachers in the area could also be used. Collaboration with other families and stakeholders was also encouraged.

7.5.3 Sexual health and dialogue within the schools

Sexual health dialogue within schools should be encouraged. The curriculum needs to allow sexual health education to be an examination subject so that learners can give it the necessary attention. There is also need to distribute work evenly among teachers and sexual education periods need to be recognised as core work and not as additional work to what the teacher already has. Collaboration with other stakeholders in sexual health education should be fostered. The lack of knowledge and skills required to engage teenagers in dialogue about sexual health that was identified during the exploration of experiences should be addressed by providing training on how to initiate dialogue through values clarification, role identification, mutual interaction, collective inquiry and collaboration. There is a need to provide the schools with material that provides them with more information.

7.5.4 Dialogue as a process

The process of implementing a model to promote dialogue about sexual health between teenagers and parents/teachers should involve the running of workshops about how to use the model. Role-playing could also be used to assist participants to understand how dialogue could be initiated and conducted. Communities, families and schools could be encouraged to continue engaging each other in a dialogue about sexual health and to note problems identified as this could also help to refine the model to suit specific communities.

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This process of dialogue establishment needs to be sustained through well-organised, structured workshops that are conducted by community members or experts, including the researcher. Social support groups should also be formed to support groups or individuals who are trying to engage each other in dialogue about sexual health. Funding could also be sought to support such initiatives.

The process of how the implementation of the dialogue model is unfolding should also be monitored through review workshops and exploration of experiences of the people involved. This would assist with the refining of the model and addressing common problems encountered. Evaluation could also be done through monitoring of how sexual health services were being utilized by teenagers and keeping track of the rates of teenage pregnancies, STIs including HIV and AIDS.

7.5.5 Research

Sexual health is not static. It is a dynamic and complex phenomenon as new conditions emerge and methods of treatment change from time to time, and it is therefore imperative to keep pace with these changes in terms of conducting research in this area of study. The innovations and improvement in sexual health education depend on research and implementation of research results.

The following areas of research can be pursued in relation to this study:

- Experiences of dialogue about sexual health in urban areas and among educated parents.
- Piloting the model and evaluating it.
- Implementation of the model and exploring experiences of participants within a specific duration of time to assess its effectiveness.

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7.6 CONCLUSION

This chapter marks the conclusion of this study as it gives account of how the rationale, overall purpose and objectives of the study were achieved. Justification in terms of the original contribution of the study to the body of knowledge is also given. The limitations and recommendations of the study are also given. The study was challenging and interesting as it spoke to me as a parent of teenagers. Teenagers, parents and teachers were challenged to take the responsibility of sexual health education into their hands and as they implemented the model, to come up with more innovative ways in which sexual health information could be disseminated among themselves to overcome the sexual health problems that are engulfing the whole world.

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9. ANNEXURES

ANNEXURE A: REQUEST TO CONDUCT STUDY IN THE VILLAGE.

University of Venda
P/ Bag x5050
Thohoyanodou
0950

The Chief
Nkuri Village
Vhembe District
Limpopo Province

Sir/Madam

RE: Request to conduct research in Limpopo Province.

I hereby request for permission to conduct research in Nkuri village of Vhembe district of Limpopo Province.

I am a part-time Doctoral student in the Department of Advanced Nursing Science, University of Venda. As one of the requirements for a doctoral degree, I am required to conduct research and submit a thesis for my study.

The purpose of this research is to develop a model that will promote dialogue about sexual health among teachers, teenagers and parents in rural areas. In-depth individual interviews and focus group discussions will be conducted. During this interview you will be asked about your experiences and views with regard to sexual health dialogue among teenagers, parents and teachers in Nkuri village and how can dialogue about sexual health be promoted among the teenagers, teachers and parents?

A recorder will be used but information will be treated confidentiality. The final report containing anonymous quotations, will be available to all at the end of the study. There may be no direct benefit to the participants of the study but there

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may be changes on how parents, teachers and teenagers communicate about sexual health and eventual benefits such as reduction in HIV/AIDS.

Sincerely,

.....
R.T. Lebese

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ANNEXURE B - SAMPLE OF CONSENT FORM

TITLE OF THE STUDY

A MODEL TO PROMOTE DIALOGUE ABOUT SEXUAL HEALTH AMONG TEENAGERS, PARENTS AND TEACHERS IN VHEMBE REGION.

CANDIDATE: MRS.R.T. LEBESE

PROMOTOR: Professor Davhana- Maselesele

CO-PROMOTOR: Professor C. L. OBI

PREAMBLE

The purpose of this research is to develop a model that will promote dialogue about sexual health among teachers, teenagers and parents in the rural areas. In-depth individual interviews and focus group discussions will be conducted. During this interview you will be asked about your experiences and views with regard to sexual health dialogue among teenagers, parents and teachers in Mphephu village and how can dialogue about sexual health be promoted among the teenagers, teachers and parents?

A recorder will be used but information will be treated confidentially. The final report containing anonymous quotations, will be available to all at the end of the study. There may be no direct benefit to the participants of the study but there may be changes on how parents, teachers and teenagers communicate about sexual health and its eventual benefits such as reduction in HIV/AIDS cases, teenage pregnancies and motherhood and effective use of family planning methods.

I _____, on this day of _____ 2005 hereby consent to:

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1. being interviewed by _____ on the topic 'HIV/AIDS and rural teenagers: A model to promote dialogue about sexual health among teenagers, parents and teachers in Vhembe region'
2. follow up interviews if necessary
3. the interviews being audio-taped
4. the use of data derived from these interviews in a research report as she deems appropriate

I also understand that :

1. I am free to end my involvement or to recall my consent to participate in this research at any time.
2. Information given up to the point of my termination of my participation could however still be used by the researcher.
3. Anonymity is granted by the researcher and that data will under no circumstances be reported in such a way as to reveal identity.
4. More than one interview might be necessary.
5. No reimbursement will be made by the researcher for information given or my participation in this project.
6. I may refrain from answering questions should I feel these are an invasion of my privacy.
7. By signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the researcher.
8. I will give you the original copy of this agreement on signing it.

I hereby acknowledge that the researcher/interviewer has:

1. Discussed the aims and objectives of this research project with me
2. Informed me about the content of the agreement
3. Pointed out the implications of signing this agreement

In co-signing this agreement the researcher undertake to:

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1. Maintain confidentiality, anonymity and privacy regarding the interviewee's identity and information given by the interviewee.
2. Arrange in advance a suitable time and place for an interview to take place.
3. Safeguard the duplicate of this agreement

…… …… …… ……

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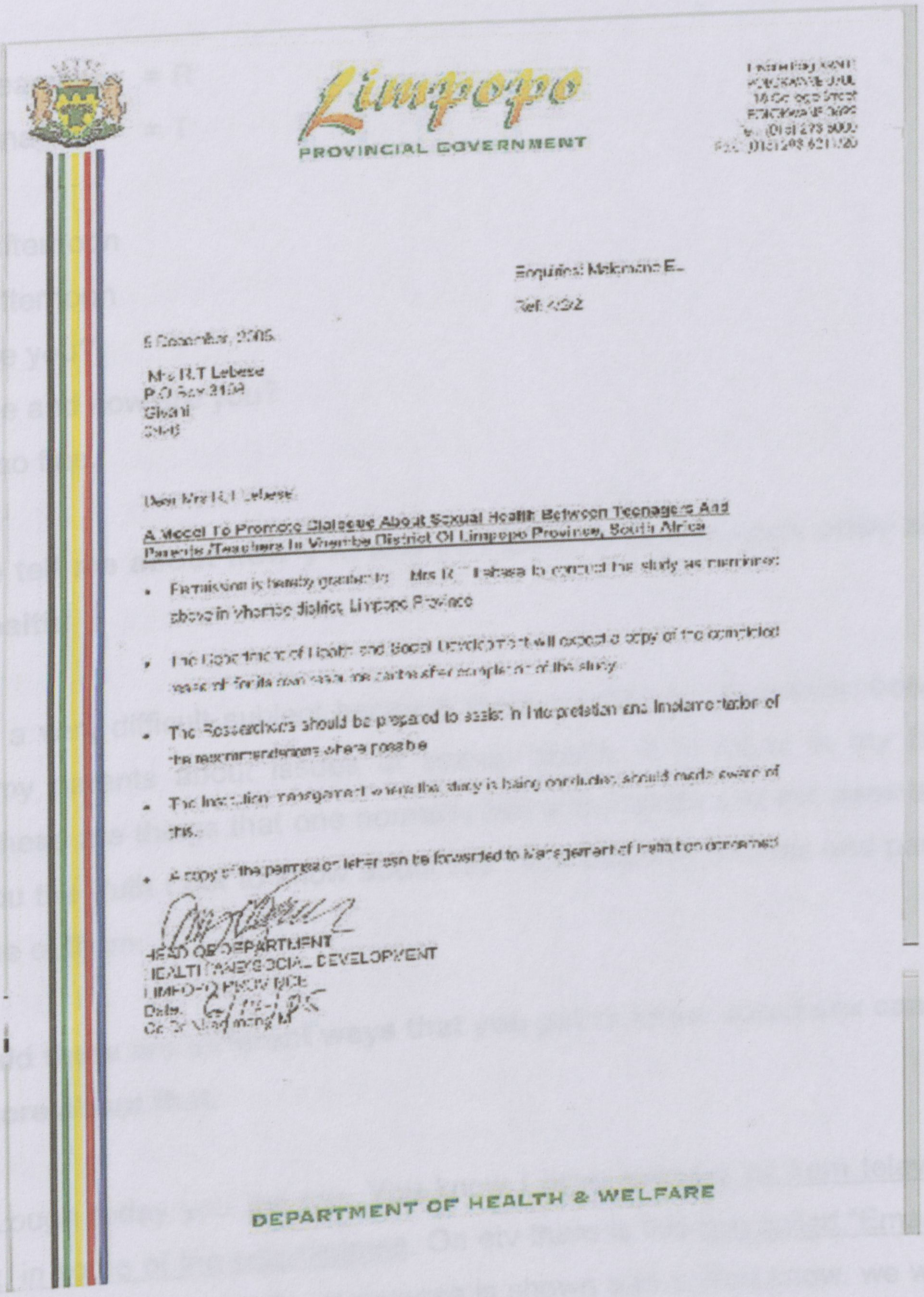
ANNEXURE C: Sample of permission letter



Limpopo
PROVINCIAL GOVERNMENT

[illegible]
[illegible]
[illegible]
[illegible]
Tel: (015) 278 [illegible]
Fax: (015) 298 [illegible]

Enquiries: Malomane E.

Ref: [illegible]

5 December, 2005

Mrs R.T Lebese
P.O Box 3104
Givani
[illegible]

Dear Mrs R.T Lebese

A Model To Promote Dialogue About Sexual Health Between Teenagers And Parents /Teachers In Vhembe District Of Limpopo Province, South Africa

- Permission is hereby granted to Mrs R.T Lebese to conduct the study as mentioned above in Vhembe district, Limpopo Province
- The Department of Health and Social Development will expect a copy of the completed research finds [illegible] after completion of the study
- The Researchers should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institution management where the study is being conducted should made aware of this.
- A copy of the permission letter can be forwarded to Management of Institution concerned

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE
Date: 6/12/05
Co Dr Malomane M

DEPARTMENT OF HEALTH & WELFARE

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INTERVIEW TRANSCRIPT: TRANSLATED FROM XITSONGA TO ENGLISH ON THE EXPERIENCES OF TEENAGERS ON DIALOGUE ABOUT SEXUAL HEALTH WITH PARENTS.

KEY: Researcher = R
Teenager = T

R. Good afternoon

T. Good afternoon

R. How are you?

T. I am fine and how are you?

R. I am also fine.

R. Please tell me about how you and you parents talk to each other about sexual health.

T. This is a very difficult subject because there is often no discussion between me and my parents about issues of sexual health. It is taboo in my family because these are things that one normally talk with friends and not parents. If I can tell you the truth I got to know about sex from different sources and parents are not one of them.

R. You said there are different ways that you get to know about sex can you tell me more about that.

T. Hey!! Lough today you got me. You know I have learnt a lot from television about sex, in some of the programmes. On etv there is this film called "Emanuel" where sexual issues especially intercourse is shown a to z. You know, we watch it at night when old people are asleep. In that programme you can see how a woman is handled when having sexual intercourse and this makes you to be prepared when you want to have sex with the woman. Hhhhh.....the television

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shows it step by step how this is done. You know sometimes I feel it is too much as when you are watching you get these feelings aaaa1!1!!! (laugh) You know what I mean. They normally play this programme late at night, I am telling you, you can't watch it with somebody older than you, it is too explicit.'

R. You said you can not watch it with somebody older than you so whom do you normally watch with?

T. 'Heee!!!!! I watch with friends and sometimes with my brother. One day I saw one film at my friend's house; it was about people doing it eeee!!!!! You know what I mean. They show you how people do it they don't hide anything it even gives you those feelings and if you are with a girl you just want to do it.' You know, there are also books and magazines which show positions and everything about sexual intercourse and one needs to practice these things otherwise you will appear to be a fool, so in order to be clever one needs to read about these things in the book. Do you think there can be a person who can teach you about sex? Ha!!!!!! That will be the day! You know, with magazines you do not have to be shy as you can read it alone in privacy without interference from anybody and this makes me relax and understand the contents much easier

R. You talked about watching films with friend and brother, is there anything that you can tell me about that?

T. I am close to my brother because we are just two boys in the family of six girls so we share a lot. (laugh) You know, things do happen in the bedroom. My elder brother used to show me how it is done (laugh) I mean with the girl. He used to show me as demonstration on the bed using a pillow. He even showed me how to romance a girl before intercourse and he always said that he does not want me to be a fool. He even explained to me how enjoyable sex is and I just tried it and the girl I have tried with fell pregnant and she has a child. It is disturbing because I did it without protection, yoo!!! Life is tough (laugh). With friends you

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know that there is always that influence from friends. There is a lot that we talk about as teenagers and most of the time we talk about sexual health issues. When we talk with friends about sexual intercourse it often made me feel inadequate and I really want to do it so that I can also feel important. So my brother helped me as after teaching me I participated in the discussions. Hey friends can isolate you if they are aware that you have not experienced what they know. So telling a lie makes you to belong to a group sometimes.

R. Hmm

T. I also learnt a lot from school Our ma'm is very good and patient. She taught us a lot even about rape and how to report to the police. My problem is that when you ask more questions in class they always laugh at you and this makes us to be afraid and not participate.

R. At the beginning of our discussion you said that it is taboo to talk to elders about sexual health can you please talk more about that?

T. You know I don't know but culture according to my understanding regards discussing sexual issues with adults as disrespectful. I don't actually know how I can start a dialogue about issues of sexual health with my parents as this is seen as disrespectful as one has been taught not to speak to adults about sex or anything that is vulgar so I do not expect my parents to talk to me about sex. A person needs to be clever and look for information yourself (phanda). You know, most of the time when you ask questions about sex to parents they think that you are already engaging in sexual intercourse. Initiation schools are also very informative. You know, it is so exciting in initiation schools. You don't have to be ashamed of anything, people just mention everything, even private parts by names. The songs are also full of vulgar language and we are told that we are now adults, and when we come out of initiation we feel that we have grown up and we must do what adults do without questioning.

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R. So initiation schools does help

T. YES!!!!! Initiation school does help a lot as one can freely talk about different sexual health related issues there. But one needs to be careful as sometimes adults do have bad motives especially if it is not a relative. Ma'm, you know most of the time if an adult talks to us about sex they always have a motive behind. Most of these adults have low morals and can easily abuse you, that is why we always question their motives when an adult talks to us about sex especially if that person is a stranger. Ma'm sometimes adults talk about sex and give a person drugs so that they can abuse you, hey it is dangerous so if an adult can start to talk to me about sex one needs to be careful as these are people that can easily rape you, you know teenagers always prefer that adults who want to engage teenagers in sexual health dialogue should be people known and trusted by us.

R. Do I understand you well when you say that you prefer an adult that you know who could be parents?

T. Yes I that is what I am saying. You know if information is given to me by my parents for instance I know that my parents want us to have good things, they always expect us to be obedient and succeed in life. There is no way that they can mislead us. Most of the time when they scold us and tell us not to engage in sexual intercourse our parents want to protect us. I have seen this at home. My sister used not to listen to them now she is having a baby without a father. Now my parents have the burden of looking after her child. That also taught me a lesson as I have a baby with another girl as I listened to my brother more than my parents. Friends can easily mislead you. Sometimes friends can tell you a method of preventing pregnancy that is not proven. Most of the time you will find that the person that is advising you has a child and I always wonder why the method has failed with her. This shows you that this person wants you to have a baby like him

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R. How do you think dialogue about sexual health can be initiated?

T. I think discussions about sexual health should start early at home. You know, sexual health education should start early in life. The information will help a lot of children in dealing with issues such as rape, incest eeee ! I mean this information will also help us in asking relevant questions when one becomes a teenager. You know by the time a child becomes a teenager he/she will be at ease in engaging adults in sexual health discussions. This should be done by a familiar person as it is very difficult for us to trust information that is given to you by a person who is unfamiliar to you.

R. THANK YOU VERY MUCH FOR YOUR TIME AND SHARING THIS EXPERIENCES WITH ME. IF THERE IS A NEED I MIGHT CONTACT YOU AGAIN. I HOPE ITS OKAY WITH YOU.

T. YES, I ALSO THANK YOU.

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INTERVIEW TRANSCRIPT: TRANSLATED FROM XITSONGA TO ENGLISH ON THE EXPERIENCES OF TEACHERS ON DIALOGUE ABOUT SEXUAL HEALTH WITH TEENAGERS.

KEY: Researcher = R
Teacher = T

R. Good afternoon
T. Good afternoon
R. How are you?
T. I am fine

R. Please tell me about how you as a teacher talk to teenagers in class about issues of sexual health.

T. Hey!! You know that is a difficult one, its like going up the hill. When one tries to engage them in a discussion about issues of sexual health most of the time there is poor participation from the learners. Poor participation is caused by fear that the teenagers have regarding participation. They normally say that there is a tendency of labeling a person who is participating during discussions about sexual health. You know when some of the students participate in class during sexual health education you can see how the other students look at them, you can also see the type of laughter that erupts when somebody has responded to a question. One day after teaching sexual health in class one girl who was participating well in the discussions came to my office crying, she said that the other students in class had given her a name called "nyama ayi ndluli" (there is no meat that passes her) which means nothing passes her she sleeps with everybody. This girl was so hurt and ashamed even though she was innocent. This lack of participation is also translated even in written form because the teenagers response to question asked in tests and assignments is also not satisfactory as I once asked the student to tell me why they do not want to

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participate even when they are expected to write and they said that they know that I can identify their handwriting and this can make me to know who wrote what and label them.

R. You said that learners are not comfortable about talking or writing about sexual health issues can you talk more about that.

T. Learners are not comfortable about discussing issues of sexual health when a teacher is present. Last time I still remember when people from Love Life told me that it's better for me not to attend as students do not feel at ease when I am part of the discussions. I left the class that day and the report indicated that they had a fruitful discussion. This other day as well there were nurses who came to conduct education on HIV and AIDS so I had to go to the staff room to collect something and learners participated well in my absence and when I come back everybody just keeps quiet. You can hear a pin drop. I don't know how I can motivate them to participate because I can see that they really would like to talk about this issue.

R. HMM

T. This is different in the lower classes in grade 7 and 8 where learners are still innocent. You know it is always difficult to control those learners. The teenagers start to laugh the minute you start talking about sex and these learners sometimes can laugh for the whole period. This makes it difficult to teach as you end up not knowing why they are laughing for such a long time. You know, it is difficult to restart the lesson all over again and this makes the progress very slow. I sometimes wonder why they are laughing and this also makes me uncomfortable as you know that we were brought up where one can not discuss such issues with people younger than yourself. Hey!!! This subject is very uncomfortable. One needs to be prepared to deal with different situations in class. The reaction of learners also determines the proceedings in class, so I

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think we as teachers need to be empowered to handle the learners. You should also remember that we are from the same culture where discussing sexual health is taboo, hence the discomfort when students start laughing in classes.'

R. You said that you need to be empowered on how to handle the class can you talk more about that.

T. You know this is very difficult for us who are doing sexuality education. Look at me now I have a lot of work to do, the workload is just excessive. I have to teach sexuality education and this is an addition to the workload that I have and this makes us not to cope with the workload. One has to prioritise and most of the time sexual health education is not given priority as it is a non examination subject. And as you can see there is so much need for sexual health education in the schools. I think the government should do something because of HIV/AIDS.

There is need to inform the learners so they should provide posts specifically for sexual health education so that it can be successful as there will be teachers focusing on it only. If attention is given to the subject by the government the learners will also be motivated to give more attention to the subject. You know the students are giving this subject minimal attention it is so frustrating to teach this subject. You know, when you give learners a test to evaluate them, they simply do not read and they fail, almost everybody in class. When I asked them about their failure they are not even ashamed to tell me that they did not read because they were having a lot of work.

This makes me helpless as I can see that they are not giving this subject enough attention. On the other hand learners do not have patience or what can I say ummmmmm, they do not put effort to the subject. When you send them to look for information at the clinic they are always impatient and do not wait for the nurse to attend to them. When they go to the clinic and find that the nurse is still busy they just go away. You know the nurse is also busy and they are short

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staffed so she can not give them her full attention. I always pity the clinic when I send my students because I have a class of sixty pupils and there is only one clinic and I think it's very frustrating for nurses when they are expected to help students as they also have their own work to do. I think that is why they say that the clinic staff is rude.

You know the schools do not have enough information or reading materials for learners. There is no access to internet and where will I refer these learners to for information? I can sometime bring paper cuttings of information that I think could be helpful yooo!!! The same learners are so selfish they take those cuttings and do not bring them back. There is no control of who took what as I don't have enough time to control this. You see you are bound to be frustrated.'

R. You said that they should go to the clinic to look for information and you are also overloaded can say more about that.

T. Jaaa!!!! They do go to the clinic for more information as we do not have the library and we rely on the clinic for information and pamphlets. Sometimes we send them because we do not have time to search for information and I am expected to teach all grades. This is soo!!! (sigh) difficult and w*hen* one looks at the amount of work that you are expected to do and the number of classes that you must teach you just become discouraged and just doesn't go to class. It is very difficult to teach so many grades and the other people have lots of free periods to do their own things. What makes matters worse is the number of students in each class. The numbers in our classes are very high. You know, this subject needs a lot of interaction. One does not need to give a lecture, so tell me how I can organise a class of sixty people. You are just deflated before you even start talking. I don't have a negative attitude but I mean the environment must allow or assist in making things possible.

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R. HMM

T. you will also think that I am complaining a lot. You know the number of periods allocated to the subject is also few as more periods are needed for examination subjects. You know, these people can surprise you. They expect learners to have information about sexual health but they wouldn't dare give you time to teach it. Do they expect me to teach this after hours? Oh!! That will be the day. The level of pregnancies is also high and this tells you that these teenagers are not using condoms or contraceptives in these times of HIV and AIDS. Sexual health is also a non-examination subject so our learners are exam oriented and they do not read anything that will not be examined. So this is also another factor that makes teaching the subject very frustrating. You know, learners sometimes ask to use your period for preparation for the test.'

R. HMM

T. Oh!! Culture is also another stumbling block as we are in the rural areas and culture is still a way of life and very important here in the rural areas. So one gets so frustrated as you try to teach this subject. Oh this is difficult to explain. You know, one ends up not knowing what to teach and not to teach. I have been a learner as well and nobody taught me about sexual health and this makes it difficult for me to do it as my mind still believes that this should be done somewhere, by whom I don't know. This is something that pops up most of the times in my mind. What worries me a lot is that when you talk openly with learners you sort of lose some of the dignity that you have with the learners, parents and fellow teachers. They give us names and you are said to be loose or promiscuous. This is hurting because you are just trying to help.

R. How do you think dialogue about sexual health can be initiated?

T.You know what? The classes are too large and this makes dialogue impossible and most of the time one relies on the lecturing method. I think that if teenagers

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were to be engaged in a dialogue there should be reasonable numbers of students attending uuuu!!!! Maybe the class could be divided into smaller groups to facilitate dialogue. In large classes yo!!! They speak at the same time, nobody listens and there will be a lot of noise and teachers will not manage to control the students. I think students can be grouped into smaller numbers and be given topics to study and thereafter a discussion around the topic can be initiated. I think this can work but we do not have libraries or internet to get more information to make the discussions more fruitful. I also think that if all the teachers were putting sexual health as one of their priority topics, teenagers would be getting enough information. Let's say in a week each teacher dedicated ten minutes of their time to sexual health discussions this could mean that in each subject the students learn they will be having forty minutes in a month and I think that would be more than enough.

R. DO YOU STILL HAVE SOMETHING TO SAY?

T. NO

R. THANK YOU VERY MUCH FOR YOUR TIME AND SHARING THIS EXPERIENCES WITH ME. IF THERE IS A NEED I MIGHT CONTACT YOU AGAIN. I HOPE IT'S OKAY WITH YOU.

T. YES.

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INTERVIEW TRANSCRIPT: TRANSLATED FROM XITSONGA TO ENGLISH ON THE EXPERIENCES OF PARENTS ON DIALOGUE ABOUT SEXUAL HEALTH WITH TEENAGERS.

KEY: Researcher = R

Parent = P

R. Good afternoon

P. Good afternoon

R. How are you?

P. I am fine

R. Please tell me about how you as a parent talk to teenagers about issues of sexual health.

P. Where do I start as you know that this is a difficult subject hey!!!? Normally it is very difficult for me to start talking about sexual issues out of the blue, so I always wait for the good moment. There are events that stimulate me to start to talk about issues related to sex. Issues like physical changes in the teenager. These are development of breasts, curves, starting to menstruate and breaking of the voice in boys. Hey (laugh) it is so difficult for a parent to talk to a child about issues of sex, especially us blacks who were taught that this is taboo. When I realized that my daughter has developed breasts and she wanted me to buy her a bra I thought that was a good opportunity for me to start talking to her about sexual health. I am telling you it was so difficult I could not look her in the eye. I told her that now that she has developed breast she should tell me when something happens but I could not tell her what this something is. I kept on asking her if she has not seen something on her panty. I could not even tell her that this something is blood I could not speak out that word. I also believe my girl was confused as well. The day that she saw this thing she came and said she was sick and when I was talking to her I ended up knowing that she has started

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menstruating. This was teaching by trial and error and it's not appropriate. I think we need to be open, you know you want to but you are unable to bring out the words it is sooo!!!!!!!!!! difficult.

R. Hmmm

P. I think we also need to be observant as parents so that we can advice our children properly. You know as a parent I need to be observant about what is happening around my child. You know it is easy to identify when your child has started to be naughty. When a child bathes a lot and wants to be neat at all times it means there is somebody who this child of mine is trying to attract or look smart for. There and then one should question this child about the new image change and warn him/her about the dangers of dating. I also observe the type of friends that my girl has and I believe in the saying that says birds of the same feather fly together. If the child's friend is seen with boys or is pregnant this should be a warning sign for a parent. This might mean that my child is also doing the same things so as a parent I start talking to my child there and then. You know, one of her best friends fell pregnant and I just told her point blank that I will never tolerate it if she goes around sleeping with boys. I will never allow her in my house if she falls pregnant you can see that I am poor.

R. Hmm are these the only events that stimulate your discussions about sexual health.

P. NO!!! I found radio television talks very helpful to me especially when they are discussing issues around sexual health and HIV and AIDS. These are major stimulants for me to initiate a discussion around sexual health. Television and radio talks help us a lot because I normally take that occasion after these talks to talk to my teenage children about sexual issues. It is easy you know, because you just follow up from the discussions that were on the media. And normally I expect my children to take advises regarding avoidance of STIs and HIV and AIDS as i always make it clear to them that this is for their own good. Sometimes

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television can be too explicit to an extent that you feel embarrassed so when a movie on television shows people kissing, cuddling or having sexual intercourse I immediately go away to sleep, or go and do something else or switch off the television. I feel so much embarrassed by the whole thing. With my son I think the person responsible for his sex education is my husband but I also think that the school should teach them more as long as they are not explicit in their explanation. If the teachings are explicit it will influence them to want to experiment.

R. How do you think dialogue about sexual health can be initiated with teenagers?

P. I think parents should take an initiative of engaging their children early in life, so that as the children grow up both parent and child would have got used to talking to each other about issues relates to sex. Once the parties are used to talking to each other about sex n/ I think it will be very easy for them to discuss even sensitive issues like rape and so on. The parents also need a lot of support from other people I don't know who, maybe nurses and teachers to give more information. I am not educated so I don't know most of the things and I will think that support is necessary for me as the resource person will always be there for me to refer my problems to. You see I don't even know what happens during menstruation so I can have more information from that person.

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