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EXPERIENCES OF FEMALE CAREGIVERS WHO ATTENDED A JOINT HIV PREVENTION PROGRAMME (LET'S TALK) WITH ADOLESCENT GIRLS IN SOWETO

RESEARCH REP0RT SUBMITTED BY

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IN PARTIAL FULLFILLMENT OF THE REQUIREMENTS OF THE MASTER OF PUBLIC HEALTH DEGREE – SOCIAL AND BEHEVIOUR CHANGE COMMUNICATION AT THE WITS SCHOOL OF PUBLIC HEALTH

SUPERVISED BY

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June 2019

DECLARATION

I, **Sabastain Gunda,** declare that this research work on: **"Experiences of female caregivers who attended a joint HIV prevention Programme (Let's Talk) with adolescent girls in Soweto"** is my own original work**.** Any other work done by other people quoted herein has been properly acknowledged in the report.

The report is being submitted in partial fulfilment of the requirements for the degree of Master of Public Health, in the field of Social and Behaviour Change Communication, with The University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination in the aforementioned institution or any other university.

Name: Sabastain Gunda

Signature: 

Date: 06/06/2019

DEDICATION

This work is dedicated to my lovely wife, Auxilia Munhutu and our awesome children Makomborero and Nyeredzi Gunda.

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In everything I give thanks to God the Almighty for shaping and carving my academic and professional careers this far and further still in the future. I am extremely grateful for the supportive guidance I received from my supervisors Dr Sara Jewett Nieuwoudt & Dr Tintswalo Mercy Hlungwani. Special mention also goes to Professor Nicola Christofides for the ad-hoc constructive comments and encouragement to push through.

I have no words to describe my most sincere appreciation and gratitude to the respondents who were unstinting with their time and information without which this research would not be as rich. I also have special thanks to the management and staff at HIVSA and all the Community Based Organisations that allowed me the time and space to conduct this research. I am ever so deeply grateful. Special mention also goes to Yolisa Ndlovu for the sterling work in transcribing the interviews.

Through all this my beautiful wife Auxilia Munhutu stood by me and still had the time to give birth to our shining star Nyeredzi. I am eternally indebted.

Along the journey I also received loads of support from my 2016 MPH classmates including but not limited to Marshall, Fred, Mpho, Luyanda, Doctor Nobs, Maria, Lerato, Shoeshoe, Preethi and Tata. I have nothing but the best wishes for you, wonderful people.

ABSTRACT

Introduction

Many adolescent girls in South Africa face multiple risk factors to contracting and transmitting HIV. Some of the risk factors include poverty, gender inequity and poor caregiver-adolescent relationships. The steady rise of family-based interventions to prevent HIV infections among adolescent girls has necessitated the need for empirical evidence to gauge their acceptability and feasibility. This study explored the experiences of female caregivers who attended a joint HIV prevention Programme with adolescent girls in Soweto called Let's Talk.

Methods

This qualitative cross sectional study used in-depth interviews to gather data from caregivers involved in the Let's Talk Programme in August 2018. The study was conducted after completion of the programme. Simple random sampling was used to select four Community Based Organisations (CBOs) out of the twelve that implemented the Let's Talk Programme in Soweto. Twelve caregivers were purposively sampled from the four CBOs on the basis of their proficiency in English. Verbatim audio recording and written notes were used to capture raw data during the interviews. Data analysis was accomplished through manual categorization and coding the data into themes and sub themes.

Results

Caregivers experienced personal and social challenges that negatively affected their psycho-social adjustment, associated with traumatic life experiences like loss of loved ones and sexual abuse. Partly due to lack of parenting skills, caregivers experienced strained relationships with adolescents in their care. Through attending Let's Talk sessions social support networks available to the caregivers widened, ultimately leading to better caregiver-adolescent relationships. The improved caregiver-adolescent relationships were characterised by better communication, mutual respect and deeper exploration of SRH (including HIV & AIDS) topics. Overall, caregivers shared the perception that Let's Talk was beneficial.

Conclusion

Caregivers' positive perceptions of the Let's Talk Programme provide empirical evidence of acceptability to participants, effective implementation, and efficacy in facilitating desired outcomes (e.g., behaviour, attitudes and quality of caregiver-adolescent-relationships).

Key Words

Caregivers, parenting skills, Let's Talk, social support, adolescent girls, HIV prevention, Soweto.

LIST OF ABBREVIATIONS

AGs – Adolescent Girls

AGYW – Adolescent Girls and Young Women

AIDS – Acquired Immune Deficiency Syndrome

ART – Antiretroviral Treatment

ARVs – Antiretrovirals

BP – Blood Pressure

CBO – Community Based Organisation

CBT – Cognitive Behaviour Therapy

COPT - Complications of Pulmonary Tract

DREAMS – Determined Resilient Empowered AIDS free Mentored and Safe

GBV – Gender Based Violence

HIV – Human Immunodeficiency Virus

HIVSA – HIV South Africa

HTS – HIV Testing Services

IDI – In-depth Interview

IDUs – Intravenous Drug Users

KZN – KwaZulu Natal

LGBTIQ+ – Lesbians, Gays, Bi-sexual, Transgender, Intersex and Queer +

PI – Principal Investigator

RA – Research Assistant

PLHIV – People Living with HIV

RCTs – Randomised Controlled Trials

SANAC – South Africa National AIDS Council

SBCC – Social and Behaviour Change Communication

SCT – Social Cognitive Theory

SMS – Short Message Service

SRH – Sexual Reproductive Health

SRHR – Sexual Reproductive Health and Rights

STIs – Sexually Transmitted Infections

Wits HREC – Wits Human Research Ethics Committee

GLOSSARY OF TERMS

Acceptability:	The quality of being tolerated or allowed.
Adolescent girls:	Girls who have reached puberty, between the ages of thirteen and nineteen.
Caregivers:	Parents and/ or guardians who exercise parental, guardianship or caregiving responsibilities over children or adolescents in a specified household.
Consistent condom use:	The correct use of condoms during every penetrative sexual act.
Coping:	Personal resilience that allows a person to adjust to challenging life situations
Parenting skills:	Any set of abilities that enhances caregivers to perform parenting roles effectively.
Risky sexual behaviour:	Any sexual act that has the potential to lead to undesirable health outcomes.
Scale up:	Making the Let's Talk Programme available to a wider audience in different geographical locations.
Social support:	The perception and/or reality that one receives care and assistance from other people in and around his or her social network.
Young women:	Females who have gone past the puberty stage and are between the ages of nineteen and twenty-four.

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CHAPTER ONE: INTRODUCTION

This opening chapter serves to introduce the study firstly by giving the contextual background and a brief overview of the family based HIV prevention intervention, Let's Talk. The subsequent literature review explores the salient empirical evidence gathered from existing literature based on the study objectives. The literature review highlights the vulnerability of Adolescent Girls and Young Women (AGYW) to HIV infection in resource limited settings like Soweto, South Africa. The efficacy or otherwise of similar interventions against HIV infection for AGYW is also explored. The literature review is followed by the problem statement that informs the study's justification. The chapter ends with the study's overall aim and specific objectives.

1.1 BACKGROUND

Global estimates indicate that half the population of People Living with HIV (PLHIV) is infected during adolescence (1). South Africa remains one of the HIV hotspots in sub-Saharan Africa where 2000 weekly new infections occur among AGYW between 15 and 24 years (2, 3). At the onset of the epidemic bio-medical approaches dominated response interventions to HIV. Most of the interventions were implemented from clinical perspectives, thereby foregoing critical social protection factors (2-5).

Over the decades there have been steady thrusts to spread the ambit of HIV prevention beyond the bio-medical model to incorporate community and household empowerment approaches (6). Gendered HIV prevention and social protection interventions are now appreciated as a significant component of the basket of HIV prevention services that can be implemented at scale. A significant number of these interventions deliberately focus on households to bridge the caregiver-adolescent relational and communication divides in the context of HIV prevention. These community led responses have met with varying degrees of success in Southern Africa (7, 8). The family-based joint HIV prevention intervention under study is one such novel intervention developed in 2016 in South Africa (9), which is described in detail in the study methods.

Research has shown that HIV risk and social protective behaviours among adolescents can be explained through the quality of relationships between the adolescents and their caregivers (1, 7, 8). Adolescents tend to be at higher risk of HIV infection when

relationships with their caregivers are weak, dysfunctional or absent (1). Maximal protective benefits accrue when caregiver-adolescent relationships are responsive, focused and constructively nurtured (10, 11). The caregiver-adolescent relationship is therefore of paramount importance because of its proximal impact to the adolescents' risk and protective perceptions and behaviours (1).

1.2 LITERATURE REVIEW

1.2.1 The HIV epidemic in South Africa

Globally, South Africa has the biggest country HIV burden (12-14). In South Africa, 19% of adults between 15 and 49 years are living with HIV and about 7 million of the total population is HIV positive (15). New annual HIV infections have gone down 90 000 from 370 000 in 2016 to 260 000 in 2017 (15). Despite the decrease in new annual HIV infections, the country's HIV burden still remains very high especially in the provinces of KwaZulu Natal (KZN) and Gauteng (14-16).

HIV incidence and prevalence rates also remain high among women in specific age groups and other key populations (14-16) thereby forming conspicuous sub-epidemics (15). The South African HIV epidemic remains heavily skewed against adolescent girls and young women, with the highest incidence and prevalence rates recorded among females between 15 and 24 years old (6, 13-15). Other key populations for HIV infection and transmission in South Africa include female sex workers and their clients, migrant and mobile populations, Injecting Drug Users (IDUs), and Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) communities (6, 13-15). HIV infection and transmission among these key populations are subject to contextual and structural factors prevailing in South Africa.

1.2.2 Social and structural drivers of HIV among adolescent girls in South Africa

There is a wide range of social and structural factors that widen critical pathways for HIV acquisition and transmission in South Africa. These drivers include ubiquitous poverty, unemployment, poor education, migration, gender inequality, Gender Based Violence (GBV), harmful gender norms, as well as alcohol and drug use (13-15, 17-19). It is concerning that individually and in combination, the social and structural drivers of HIV

disproportionately affect more women (and by extension adolescent girls and young women) than men in South Africa (14, 15).

The economic landscape in South Africa is generally lopsided in favour of men to the economic detriment of women (6, 14, 15). Consequently, women, especially adolescents and young women, become sexually vulnerable to preying men in exchange for material and economic benefits (6, 14, 15). Studies have shown that some adolescent girls and young women engage in transactional sex because of poor educational outcomes that exclude them from formal employment opportunities (13, 14, 16). As a result of their poor social and economic status, adolescent girls and young women face multiple exposures to GBV, HIV infection, teenage pregnancy and dropping out of school (13, 14, 16, 20, 21).

When men's economic advantages are combined with engendered cultural traditions that promote harmful masculinities, the vulnerability of women to acquiring and transmitting HIV is increased (13-15). For instance, migrant truck driving males have been known to be key populations for HIV transmission. This is because they tend to use economic advantages from their employment to engage in unprotected transactional sex. Some of them also embrace harmful practices like violence and alcohol abuse culminating in refusal to use condoms with their long term partners at home (13, 14, 16). The complex interaction of social and structural drivers of HIV infection and transmission in South Africa result in reduction of health seeking behaviours among key populations as well as failure to adhere to different forms of treatment, especially Antiretroviral Treatment (ART) (13-16, 20, 21).

1.2.3 Personal HIV Risk factors and perceptions among adolescents in South Africa

As the previous section has shown, the complex interplay of social and structural determinants of HIV infection and transmission are most deleterious among adolescent girls and young women in poor communities. Some studies have shown that adolescents in poor communities tend to be more exposed to HIV infection; teenage pregnancies and dropping out of school due to the challenging environment they live in (14, 22). Over and above the social and structural determinants of HIV infection and transmission, there are more proximal risk factors and perceptions among adolescents that increase their vulnerability.

Early sexual debut

Numerous studies have established that adolescents in South Africa tend to have their sexual debuts before the age of 15 years (12, 13, 21, 23, 24). Some of the reasons advanced by adolescents for having early and regular sex at young ages include perceptions that sex is: fun, recreational, forms and reinforces identities, helps to maintain relationships, proves love to the other partner, relieves stress and that sex represents a status symbol among peers (12, 13, 18, 21, 23, 24). Vulnerability to HIV infection stems from, among other factors, inexperience in negotiating for safe sex (especially with sugar daddies) and poor skills in using protection like condoms (12, 13, 18).

Lack of and inconsistent condom use

Numerous studies have revealed risky sexual behaviours reported by adolescents; especially in resource limited and marginalized communities. In one study, 48% of high school adolescents reported to be sexually active and 43% of this group reported failure to use condoms during their last sexual activity in the previous three months (1). Adolescents perceived that using condoms affects sexual pleasure, made sexual intercourse painful, delayed sexual gratification, showed a lack of trust in the sexual partner and also suggested that partners who initiated condom use were HIV positive (12, 13, 18, 21). In some studies, adolescent females resisted condom use because they deliberately wanted to be pregnant to bind the relationship and to also fit in with their peers (12-14).

In Soweto, particularly risky sexual behaviour was observed whereby adolescents arranged group sex parties and had multiple sexual encounters with different partners in very short timeframes, like an evening or a weekend (12, 13). Alcohol and drug abuse including marijuana and other illicit drugs were binged on resulting in mental impairment to use protection like condoms (12, 13). Adolescent males were also observed to deliberately use alcohol and drugs to manipulate their female counterparts to engage in unprotected sex with multiple partners (12, 13). Studies elsewhere attributed poor condom use to poor knowledge about HIV transmission and prevention among adolescents (12, 13, 18). However, in one study in Soweto adolescents did not use condoms despite relatively high knowledge levels about HIV ranging between 72% and 78% (21).

Poor utilization of HIV Testing Services (HTS)

Adolescents have been observed to have negative perceptions towards HIV testing (6, 15, 21). In one study over 50% of the adolescents surveyed had never tested for HIV and had no intention to test in the near future (21). Adolescents feared a HIV positive diagnosis and had limited knowledge about ART; those that knew about ART expressed reservations about the pill burden for their entire lives (21). Adolescents' reluctance to test for HIV deprives them of the protective benefits of knowing one's HIV status, including a preponderance for using condoms in subsequent sexual encounters (12, 13, 18, 21).

1.2.4 Psychosocial challenges faced by caregivers

Caregivers in high HIV endemic areas face multiple psychosocial challenges that compromise their parenting skills and by extension the protective effects against HIV infection for adolescents (9, 25, 26). Some of the challenges include poverty, hardships, limited social support, family discord, chronic illnesses, children misbehaving, communication taboos around sex and HIV with adolescents and HIV positive status disclosure to children (9, 14, 25-30). In the light of these challenges, caregiver-adolescent relationships are usually sub-optimal, marked by tension and communication challenges.

Poverty

In South Africa, household poverty is a significant challenge confronting most caregivers in resource limited settings that also tend to be high HIV endemic areas (9, 25, 27). The poverty is usually manifested in the form of household food insecurity, poor nutritional status, shack dwellings and general financial hardships (9, 27). Household poverty is also usually compounded in the presence of HIV infected members in the household (9, 25, 27, 29, 30). Caregivers have reported challenges of adolescent girls and young women engaging in risky transactional sex with older men to escape from household poverty (15, 31, 32). However, there is evidence that the impact of HIV on household economic poverty has been ameliorated by the country's comprehensive ART Programme that has seen millions of caregivers regaining and maintaining full functional health (15).

Limited social support

Caregivers in resource limited settings like Soweto in South Africa often have to face the challenge of poverty with limited social support (25, 27, 29). This is usually because the social safety nets usually provided by the extended family have been eroded due to worsening economic conditions in the country (25, 27, 29). Increasing numbers of households are characterised by family discord precipitated by issues, including competition for scarce resources, accusations of witchcraft and other social strains (14, 32). The lack of social support leaves most caregivers stressed and with feelings of general inadequacy regarding their caregiving and parenting abilities (9, 25).

Adolescents' behavioural problems

Many studies have shown that most caregivers in poor settings like Soweto in South Africa often have to contend with problematic adolescent behaviours (9, 14, 19-21, 25, 30, 33-36). Some of the conspicuous adolescent behaviour challenges include risky sexual behaviours, teenage pregnancies, alcohol and substance abuse and general mood swings (9, 14, 19-21, 25, 30, 33-36). The situation is often worsened by the fact that caregivers lack the appropriate parenting skills to ameliorate these behavioural challenges. In frustration caregivers often resort to aggressive approaches including physical punishments that often result in even worse non-compliance behaviours (25, 35). Weakened relationships between caregivers and adolescents (especially females) open pathways for increased HIV risk as some of them run away from home to go and stay with boyfriends (14, 25, 35).

Caregivers' infection with HIV

Research has shown that most caregivers infected with HIV face mental health challenges including stress and depression arising from their own positive HIV status (9, 16, 25, 37, 38). Caregiver HIV infection has also been noted to create tension in the household due to accusations of infidelity as the cause of infection (9, 16, 25, 37, 38). In most cases the infected caregivers lack the skills to disclose their positive HIV status to their children. Some of the caregivers have reported fears of stigmatization and causing emotional difficulties for their children, including poor school performance (29, 30). Consequently, caregivers fail to engage adolescents on topics of sex and HIV because of unresolved negative feelings and

perceptions arising from their own infection. The situation is worsened by cultural and traditional taboos that discourage caregiver-adolescent communication on sex and HIV (14).

Communication taboos on sex and HIV topics

There are cultural and traditional barriers that inhibit family communication around sex and HIV topics especially among the African populations in South Africa (11, 14, 36, 39, 40). In many African cultures it is prescribed as disrespectful for adolescents to initiate sexual topics with elders and there are social sanctions against such behaviour; hence, such topics are often labelled taboo (11, 14, 36, 39, 40). African families have not been the unit expected to communicate with youth about sexuality. For instance, sexuality education occurred at the community level in Xhosa customary practices, organised by age (16, 41). The same authors (16, 41) argued that colonisation and the values accompanying its occurrence contributed to the cessation of such community practices.

Taboos on the subjects of sex and HIV prevention delay communication on the topics with most caregivers taking a reactive approach. Caregivers in parenting roles also fear that initiating discussions with adolescents on sex and HIV prevention will serve as an invitation for the adolescents to start engaging in sexual practices (14). Caregivers only start initiating often judgmental and aggressive communication on the subjects only after suspecting or knowing that their adolescents are sexually active (14, 20, 21, 41). In such cases the discussions tend to be ambiguous and lacking depth due to the caregivers apprehensions and lack of accurate knowledge around adolescent sex and HIV in general (14, 20, 21, 41). A study among the Xhosas in South Africa showed that family discussions on sexuality were avoided and on the rare occasions when they were discussed, they tended to be acrimonious largely due to cultural taboos (14).

When adolescents fail to fully explore sexual topics with their parents/caregivers, they often look up to their friends and peers to fill the gap; this can have negative consequences due to questionable information shared in the peer system (4, 14, 29). Ideally parent/caregiver–adolescent discussions on sexuality should precede sexual debut to promote adoption of protective behaviours, like delaying sexual debut and condom use with all sexual encounters (1).

1.2.5 Evidence from other caregiver-adolescent interventions

Several interventions have been established to bring parents together with children and adolescents to facilitate improved relationships. Some of the interventions include Sinovuyo Caring Families Programmes, Kgolo Mmogo, Stepping Stones and Skhkokho Supporting Success (18, 40). The interventions were group based and run in community settings by trained facilitators (16, 38-40). Most caregivers who attended these interventions reported positive benefits resulting from their attendance especially better relationships with their children and adolescents (16, 38-40).

Caregivers experiencing less social marginalisation

Significant numbers of caregivers reported feelings of less social marginalisation after attending joint interventions with adolescents (9, 25, 38, 42). This is because caregivers were able to share their psychosocial challenges in perceived safe spaces. Empathic discussions during the group sessions facilitated emotional and social bonds among the caregiver participants leading to the formation of new social systems in which the caregivers received emotional, informational and social support (9, 25, 38, 42). Interactions within the group system improved the caregivers' self-esteem and confidence and this helped the caregivers to form and strengthen social relationships with family and community members (9, 25, 38, 42). Consequently caregivers felt more integrated within their family and social circles and some caregivers reported less stigma and discrimination (5, 9, 25).

Improved caregivers' role modelling transmitted to adolescents

Attending combined interventions with adolescents has been shown to improve caregiver role modelling with the benefits spilling over to adolescents cared for (16, 38). Caregivers play critical role modelling, skills teaching and discipline administering roles that promote positive competent behaviours (10, 43, 44). Caregivers that exhibit healthy communication and relationship behaviours have been shown to have positive protective influences to adolescents in their care (43). Studies have shown that after attending structured interventions with adolescents, some of the positive behaviours transmitted to adolescents by caregivers through effective role modelling include assertiveness, negotiation skills and negative peer pressure resistance (1).

These qualities have been shown to have a positive impact on adolescent girls' self-efficacy to negotiate for condom use (1). It is therefore critical that parents/ caregivers role model effective communication through openness and genuineness for the information to be optimally received and utilized by the adolescents (10). When parental/ caregiver role modelling is coupled with effective limit setting and clarification of expectations, the protective effects on the adolescents tend to be maximised (11).

Improved HIV and AIDS Knowledge by caregivers and adolescents

Evidence shows that attending structured HIV prevention sessions increased the factual knowledge of both caregivers and adolescents regarding HIV and AIDS (16, 38). Both caregivers and adolescents reported that attending joint sessions managed to dispel some of the myths they held regarding HIV and AIDS etiology and transmission (14, 22, 23, 27, 40). As a result of increased knowledge caregivers and adolescents reported attitude changes towards the subject and reduced stigmatizing and discriminatory behaviours against PLHIV or people suspected to be infected (20, 23, 27, 39, 40). Increased knowledge levels on HIV and AIDS was also associated with increased confidence to talk about the subject with peers, both for caregivers and adolescents (24, 38, 42, 45, 46).

Improved caregiver-adolescent relationships

Interventions that brought caregivers and adolescents together resulted in improved relationships between caregivers and adolescents including other household members (5, 16, 40, 47, 48). This arose from improved self-regulation (impulse control and anger management) and communication skills reported by both caregivers and adolescents (5, 16, 40, 47, 48). At the same time adolescents exhibited more pro-social behaviours including respect and listening attentively to their caregivers while adolescents' problem behaviours significantly declined (9, 25, 38). These findings are important because high levels of connectedness between caregivers and their adolescents have protective qualities against risky sexual behaviours and possible HIV infection among adolescents (1).

Two critical dimensions concerning caregiver-adolescent relations include caregiver warmth and support (10, 11, 43, 44). Caregivers who display coercive and withdrawn qualities tend to have adolescents who are detached and they engage in risky sexual acts

earlier and more often (11, 43). Conflictual caregiver-adolescent relations often drive adolescents towards deviant peer groups, thus aggravating adolescents' chances of getting infected with HIV (1).

A recent study in South Africa revealed that a structured intervention involving caregivers and their children increased the confidence of the caregivers to discuss health topics, HIV status disclosure, sexual and reproductive health education, bullying and sexual abuse (28). Caregiver disclosure of positive HIV status had beneficial results to both caregivers and the adolescents in their care (28). In other studies, caregivers have appreciated structured interventions with their adolescents as they felt involved and empowered to intervene with their own children as opposed to having counsellors engaging with their children (38, 49, 50).

1.3 PROBLEM STATEMENT

Adolescent girls are one of the key populations at risk of HIV infection, accounting for 40% of new HIV infections every year (14). With such a high burden of HIV and AIDS in the background, the South African social fabric, especially the family system has been under considerable strain (7, 14). HIV and AIDS have contributed to the disintegration of family systems across southern Africa, including South Africa (2, 8, 14). Dysfunctional family structures devoid of parental figures have in turn been fertile grounds for HIV incidence and prevalence, disproportionately affecting adolescent girls (2, 8, 14). The added burden of poverty has left surviving caregivers (parents and/or guardians) disempowered to offer social protection to adolescent girls in their care against HIV infection (27, 32, 51).

In response a number of social protection interventions have been developed and implemented across South Africa over the years (16, 38-40). The Let's Talk Programme, developed and implemented starting in 2016, is therefore a relatively new family-based social protection intervention. The efficacy and acceptability of the programme in improving mental health and lowering HIV risky behaviour among adolescents has not been widely explored.

1.4 JUSTIFICATION

HIV and AIDS have brought drastic changes to the environment under which millions of orphans and vulnerable children are cared for in sub-Saharan Africa (25). This is because

most of the caregivers face a number of stressors, including widowhood and chronic illness that adversely impact the children under their care (25). Some family focused interventions have been observed to build adaptive and parenting skills of caregivers. Caregivers in such Programmes have reported reduced social marginalization; better family functioning; more positive feelings towards children under their care; and more pro-social behaviour from children they cared for (25).

The steady growth of family-focused interventions to prevent HIV infections have been welcomed (34, 39, 47) as these interventions complement bio-medical HIV prevention methods. As previously mentioned, the intervention under study is adding the number to the basket of family-focused social protection interventions already in existence. This study is therefore justified as it seeks to pick out the specific elements of the intervention under study that produce desirable outcomes for possible scale up. The study contributes to the body of scientific and empirical evidence on the experiences of caregivers who attended the Programme with their adolescent girls. The insights from this study may be potentially leveraged to inform other Social & Behaviour Change Communication (SBCC) family-focused interventions to prevent HIV infection among adolescent girls.

1.5 AIM AND OBJECTIVES

1.5.1 Study aim

To explore experiences of female caregivers who attended a joint HIV prevention programme with adolescent girls in Soweto (Let's Talk) to determine acceptability and make recommendations that would be relevant for informing scalability of the intervention to other populations or communities.

1.5.2 Study objectives

1. To describe socio-emotional challenges faced by caregivers before attending the intervention in Soweto.
2. To describe the social support systems available to the female caregivers after attending the intervention in Soweto.
3. To describe the female caregivers' parenting experiences after attending the intervention with adolescent girls in Soweto.

4. To describe the female caregivers' experiences in engaging adolescent girls on risky sexual behaviour after attending the intervention in Soweto.
5. To assess the acceptability and possible scale up of the intervention to other communities with similar characteristics like Soweto.

CHAPTER TWO: RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter two outlines the research methodology and processes followed to answer the research question. This is done by describing the study setting and design, the study population and sampling strategies used. A description of the data collection and analyses is the penultimate section that precedes discussion of the ethical considerations that were followed to protect the study participants from any form of harm.

2.2 STUDY SETTING

The study was carried out at four Community Based Organisations (CBOs) in Soweto where HIVSA implemented the Let's Talk Programme. HIVSA is a not for profit organisation which was established in 2002. HIVSA strives to empower individuals, communities and organisations by developing their capacity and resilience to effectively address socio-economic and health issues in the context of high HIV and AIDS prevalence with the ultimate vision of creating an HIV free generation (48).

The Programme was implemented in ten wards in Soweto (Figure 1). The areas covered include Diepkloof; Orlando; Meadowlands; Dobsonville; White City; Chiawelo; Zola and Emdeni. Soweto comprises formal and informal settlements situated about 15 kilometres southwest of Johannesburg, with an area of approximately 106 square kilometres (23). It represents South Africa's largest urban population, with an estimated three million residents with the majority (98%) identifying as black African (23, 26). The prevalence of HIV in Soweto is 15.2% among 15-49 year olds (14). Challenges facing youth in Soweto include: lack of job opportunities, high rates of school drop-out, especially among teenage girls due to pregnancy, drug and alcohol abuse and transactional sex which poses HIV transmission risks (14, 15).

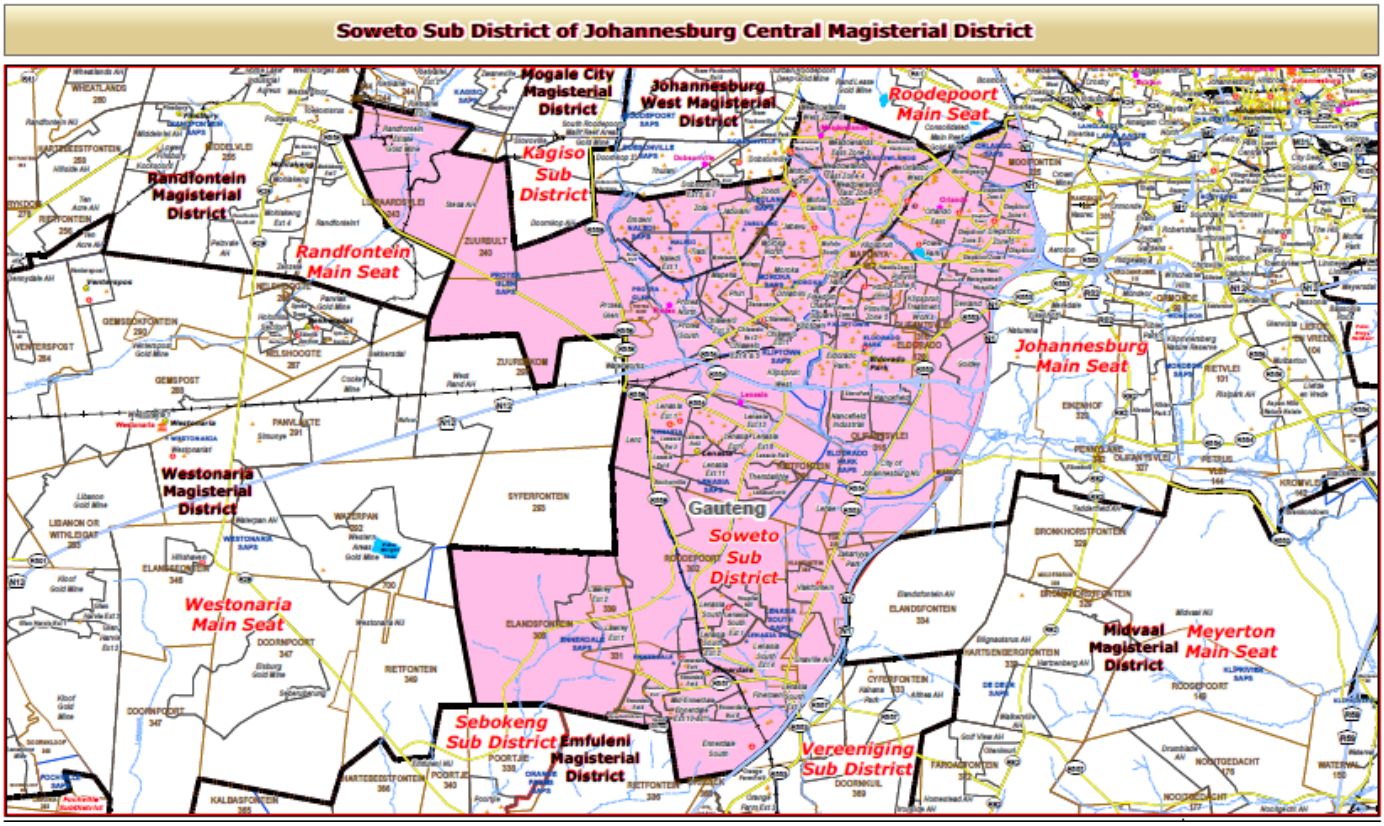


Figure 1: Map of Soweto, South Africa

Source [www.google.com/maps/places/Soweto] Accessed 22 March 2018

The four CBOs that participated in the study fall in the shaded area in the Soweto sub-district. Two of the CBOs were in Diepkloof, one was in Meadowlands and the other one in Emdeni.

2.3 STUDY DESIGN

A qualitative cross sectional design (52-54) was used to explore the experiences of female caregivers who attended the Let's Talk Programme with adolescent girls in Soweto. The study design was suitable because baseline data were not available and the qualitative approach allowed the Principle Investigator (PI) to get a detailed description of the experiences of the caregivers (53). As the intervention had already taken place with caregivers, the PI could only collect data at one point in time.

2.3.1 Overview of the Let's Talk Programme

Let's Talk applied Cognitive Behavioural Techniques (CBT) to explore socio-emotional challenges faced by parental caregivers. CBT is based on the premise that an individual's thoughts, feelings and behaviours all affect each other (55). Positive adjustments in one of

the domains (thoughts, feelings and/ or behaviours) have the potential to initiate positive adjustments in other domains as well and vice versa.

The Let's Talk Programme falls within a larger family-based intervention to prevent HIV jointly targeting AGYW called DREAMS. The Programme focuses on AGYW to make them **d**etermined; **r**esilient; **e**mpowered; **A**IDS free; **m**entored and **s**afe, hence the acronym. The larger DREAMS package of interventions includes condom promotion; HIV testing services; post-violence care; sexual reproductive health and rights services; social asset building; parenting Programmes; education subsidies and socio-economic combination approaches (6, 8). Let's Talk is the structured curriculum used to reach out to both female caregivers and adolescent girls in their care. In Let's Talk, caregivers refers to the person who has primary custody of the adolescent girls; this person can be the biological mother of the adolescent girls or an alternative, depending on the unique circumstances of every girl in the Programme (56).

Let's Talk is a weekly support group for caregivers caring for adolescents between 13 and 19 years old (56). The Let's Talk Programme comprises 12 sessions for caregivers; nine sessions for adolescents and four joint sessions combining caregivers and adolescents (56). The whole Programme is held in three phases (see Appendix 1a) and all the sessions (See Appendix 1b) are completed in about 17 weeks (56). Phase 1 is exclusively for caregivers and is designed to help caregivers confront and cope with their stress; build their resilience; improve communication skills; increase self-awareness and it equips caregivers with positive coping and adaptive behaviours (56).

Phase 2 of the Let's Talk Programme aims to help caregivers improve their parenting skills while also helping them to understand adolescents' behaviour (56). Adolescents join the Programme in Phase 2 and the goal is to improve their emotional and relationships management skills while also enhancing life planning skills (56). Like Phase 2, Phase 3 has separate and joint sessions for caregivers and adolescents (56). In Phase 3, the emphasis is on promoting healthy behaviours for adolescents in the context of HIV and their Sexual Reproductive Health and Rights (SRHR) with caregivers playing critical support roles (56). In Phase 3 both caregivers and adolescents are encouraged to forge supportive social networks and to engage in dialogue with their counterparts in similar situations (56).

The aim of Let's Talk is therefore to strengthen the caregiver-adolescent relationship through a gendered social protection model to prevent HIV infection among adolescent girls

in resource limited contexts (6). The model considers maternal HIV and AIDS statuses and resource limited environments as fertile ground for problematic adolescents' behaviour, heightening the adolescent girls' exposure to HIV infection (50). The experiences and adaptive behaviours of both female caregivers and their adolescent girls in a parenting relationship will therefore throw important light on the potential HIV infection pathways due to structural disadvantage and the effects of social protection on adolescent girls' risky sexual behaviours (7, 8).

2.4 STUDY POPULATION AND SAMPLING

The study population comprised female caregivers who had attended and completed all thirteen of the Let's Talk Programme sessions at the 12 CBOs in Soweto at least six months prior to the study. Approximately 1800 caregivers attended the Let's Talk programme across the 12 CBOs. Simple random sampling (52-54) was used to select the four CBOs out of the 12 that implemented the Let's Talk Programme in Soweto. Twelve caregivers were purposively sampled from the four CBOs from a pool of approximately 400 caregivers. To be eligible, caregivers needed to have at least one adolescent girl in their care. Basic spoken English language proficiency was also an inclusion criterion because the PI is an international student with rudimentary comprehension of local South African languages.

The PI therefore requested Let's Talk Facilitators at the four CBOs to select female caregivers who attended sessions who were able, willing and available to conduct in-depth interviews in English. By selecting the caregivers from multiple CBOs, it was hoped that getting participants over a wider geographic area would lead to more data variation.

2.5 DATA COLLECTION AND PREPARATION

The PI was responsible for data collection. Pre-testing of the data collection tool was done before the actual data collection. To pre-test the in-depth interview guide, the PI interviewed two caregivers who had attended the Let's Talk sessions. The PI was satisfied that the data collection tool was suitable for the study. Data collection was done in September 2017 after permission granted by HIVSA (Appendix 2) and ethical clearance by Wits Human Research Ethics Committee (HREC) was obtained in August 2017.

An in-depth interview (IDI) guide (with open ended questions) informed by study objectives was the primary data collection tool (Appendix 3). Data collection occurred at the CBOs in the form of IDIs. Note taking (memos) and audio recording were used to capture raw data during the interviews. The PI revised and added more flesh to the field notes immediately after each interview. After the twelfth interview, the PI was satisfied that there was enough data for analyses. As a result, the PI stopped the data collection activities. The PI conducted data quality checks by listening to the audio tapes before transcribing the data.

De-identification of data to maximize confidentiality was done during the transcription process. Audio data were transcribed by a Research Assistant (RA) after being trained by the PI. The PI wrote analytic memos in preparation for data coding (1). Data coding was manually done by the PI after deciding on the colour codes for themes and sub themes beforehand (53). Safe storage of raw data (audio tapes; field notes and transcripts) was ensured by locking the raw data in a locked cabinet after fieldwork. Raw data will be destroyed two years after publication of study findings or otherwise six years after the study (52, 54).

2.6 DATA ANALYSIS

Manual categorization and coding the data into themes and sub themes were major aspects of data analysis. Deductive data coding into themes and sub themes was based on the study objectives (52). Study objectives formed the basis of the themes, i.e. challenges faced by caregivers before Let's Talk; caregivers' support/coping systems; caregivers' parenting experiences after Let's Talk and caregivers' experiences in engaging adolescent girls on SRH issues after the Programme.

During data analysis, room was left for codes to also be developed inductively for emerging codes. Themes and sub themes were captured in the code book in table format (52-54), which were shared with supervisors for perusal and input. To minimize bias, the PI reached an agreement with a PhD candidate (Social Work) at the University of Pretoria to independently support with the coding process.

The PI used open, axial and selective coding. Open coding was used to generate concepts through breaking down, examining and comparing data (52) gathered from the in-depth interviews with the female caregivers. Through axial coding, two or more concepts

generated through open coding were subsumed into a category (52) representing the experiences of the female caregivers. A category became a core category/theme buttressing a number of categories through selective coding whereupon relationships between concepts and/or categories were explored; developed; refined and validated (52).

The PI also used the Framework approach to thematic analysis as a way of mapping and visualizing the data (52). In the Framework approach, an index of core and sub themes was represented in the matrix, thus aiding data visualization in preparation for writing up the analysis (52). This was also discussed with research supervisors.

2.7 STUDY ETHICS

Ethics clearance for this study was granted by the Wits HREC as stipulated in Ethics Certificate Number M170860 (See Appendix 4). All study participants were assigned pseudonyms for confidentiality purposes.

2.7.1 Avoidance of harm to participants

The purpose of the study was to explore the experiences of female caregivers who jointly attended an HIV prevention Programme with adolescent girls in Soweto. Some caregivers had emotional reactions as they reflected on their challenging experiences of handling difficult adolescents' behaviour; chronic illnesses; death and bereavement in the family and living with HIV. Practical steps were therefore taken to avoid emotional harm to the participants. Participating caregivers were well informed of the potential negative consequences that could arise from their involvement in the study and they were provided with the opportunity to withdraw from the study at any time through an information sheet (see Appendix 5).

Female caregivers who showed emotional reactions during interviews were given impromptu basic counselling on the spot by the PI who is a qualified Social Worker. Caregivers were informed that in cases where they needed on-going emotional support, Social Workers from HIVSA were available for referral support, with contact details provided for this in the information sheet. At the conclusion of every interview, participants were given the opportunity to express any feelings; thoughts; views or ask any questions arising from or related to the interview as part of debriefing. None of the caregivers who showed emotional reactions in the interviews took up the offer of on-going long term support.

2.7.2 Informed consent

The basis for informed consent stems from the need to respect the autonomy of study participants (54). Consideration was given to the participants' well considered choices and opinions to participate in the study voluntarily, fully aware that they were entitled to withdraw from the study at any time and for any reason they deemed fit and sufficient. To aid the foregoing, the PI fully explained (using the simplest yet most meaningful language possible) the broad research topic; who was undertaking and financing the research and why the research was being done, which was also summarised in the information sheet (Appendix 5). For the study, participants were required to provide written informed consent prior to participating in the research (Appendix 6). Separate informed consent was also sought to audio record the interviews (Appendix 7).

2.7.3 Confidentiality

The PI ensured that identities and records of study participants were kept confidential. Interviews with participants took place in offices at the CBO sites where no other people could hear what was discussed. Codes were used to identify participants and the participants' list and their code names are being stored separately in a locked cabinet file. Identifying details of the participants were removed from all transcripts and the transcripts and electronic recordings have been locked away in a cabinet. To maximize confidentiality, study locations (CBO sites) are not identified by name as this could lead to confidentiality breaches.

2.7.4 Debriefing participants

Debriefing sessions were conducted with the research participants at the end of every interview to give the participants opportunities to ask questions and clarify any issues including misconceptions they had from the study. This practice is recommended, as it allows participants to work through their experience of being involved in the study and its aftermath (53).

2.8 POSITIONALITY

I was employed by HIVSA as a Project Manager for the DREAMS Programme in Soweto. Part of my responsibilities were to oversee implementation of the Let's Talk programme in

the study area. The research participants in this study were therefore drawn from the population of programme beneficiaries I oversaw. To minimise the potential for researcher bias, I observed the highest standards of research ethics to the best of my ability during data collection, analysis and report write up. This included openly declaring my positionality (arising from my employment with HIVSA) to the interviewees and that I had a vested interest in the success of the Let's Talk programme. I declared to the interviewees that although I was working for HIVSA I needed the interviewees to be fully honest and objective with their responses to ensure the accuracy of study findings. I was also aware that as a male researcher interviewing female caregivers, there was potential for the caregivers to be selective with their responses or disclosures due to social desirability.

2.9 TRUSTWORTHINESS OF THE RESEARCH

Trustworthiness in qualitative research seeks to establish whether the study results are credible, transferrable, confirmable and dependable (55). In-as-far as credibility speaks to the truthfulness of the findings, the PI interviewed twelve caregivers and asked them to give truthful and honest responses to satisfy the highest academic standards. As the discussion section will later show, the findings in this study are similar to other findings from other settings with similar characteristics to Soweto hence the findings are transferrable to other communities sharing similar characteristics with Soweto.

Although the PI was employed by HIVSA, he was aware of his positionality and declared this to the interviewees whom he asked to provide truthful and objective responses. During data analysis the PI entered into an inter-coder agreement with a PhD student from the University of Pretoria to minimize bias in data analysis. This was done to establish the study's confirmability. A detailed study protocol was developed before the study was conducted outlining the steps and processes to be followed throughout the study. The PI is therefore confident that any other researcher can follow the study protocol and replicate the study and come up with consistent findings.

CHAPTER THREE: STUDY RESULTS

3.1 INTRODUCTION

The results of the study are presented in this chapter. Study results include socio-demographic characteristics of the female caregivers who attended Let's Talk as well as the themes and sub themes that emerged from data analysis. Study results are presented in response to study objectives that looked at challenges faced by caregivers before Let's Talk, support systems for caregivers, caregivers' parenting experiences after Let's Talk, caregivers' experiences with adolescents' SRH issues as well as the caregivers' overall perceptions of Let's Talk.

3.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

The age range of the participating female caregivers was 26 – 49 years old while the age range of adolescent girls they cared for was 11 – 19 years old. Regarding the highest level of education attained, nine caregivers had secondary education; two had tertiary qualifications while one had primary education. Eight caregivers had only one adolescent girl in their care while four cared for two adolescent girls. The most common relationship between female caregivers and the adolescent girls in their care was that of mother and daughter (nine) followed by aunt and niece relationship. All the female caregivers and adolescents in their care resided in Soweto. Table 1 below summarises the socio-demographic characteristics of the twelve caregivers who participated in the study.

Table 1: Summary of participants' (caregivers) socio-demographic characteristics

Caregivers' Pseudonyms	Ages	Education level	Number AGs	Ages AGs	Relationships with AGs	Residence in Soweto
Phumzile	26	Tertiary	2	14 & 17	Nieces	Diepkloof
Mpho	29	Secondary	1	13	Daughter	Diepkloof
Andile	33	Secondary	2	11 & 12	Daughter & niece	Diepkloof
Lerato	34	Secondary	1	14	Daughter	Emdeni
Thandeka	37	Secondary	1	15	Daughter	Meadowlands
Nthabiseng	41	Secondary	2	13 & 14	Daughters	Meadowlands
Boipelo	41	Secondary	1	16	Daughter	Emdeni
Ayanda	42	Tertiary	2	14 & 19	Daughters	Meadowlands
Fezile	43	Secondary	1	20	Daughter	Diepkloof
Akhona	46	Secondary	1	15	Niece	Dobsonville
Zodwa	48	Secondary	1	14	Daughter	Diepkloof
Lebohang	49	Primary	2	12 & 19	Daughters	Dobsonville

Themes and sub-themes

Figure 2 below shows the six themes that emerged from data analysis. The themes and sub-themes in Figure 2 are expanded upon in greater detail in the results chapter to explore and describe the experiences of female caregivers who attended Let's Talk jointly with adolescent girls in Soweto.

The first theme is the *Challenges* that afflicted female caregivers prior to Let's Talk. In light of the challenges, the second theme explores *Support systems* caregivers drew on before, during and after Let's Talk. The third theme presents the *Parenting skills* acquired by caregivers during the Let's Talk Programme. Caregivers' use of newly acquired skills resulted in *Improved relationships* with adolescents, the basis of theme four. *Observed positive behaviour changes* in adolescents are described as the fifth theme. The sixth theme explores the female caregivers' *Overall perceptions* of Let's Talk Programme as a way of wrapping up and thereby putting preceding sections in perspective.

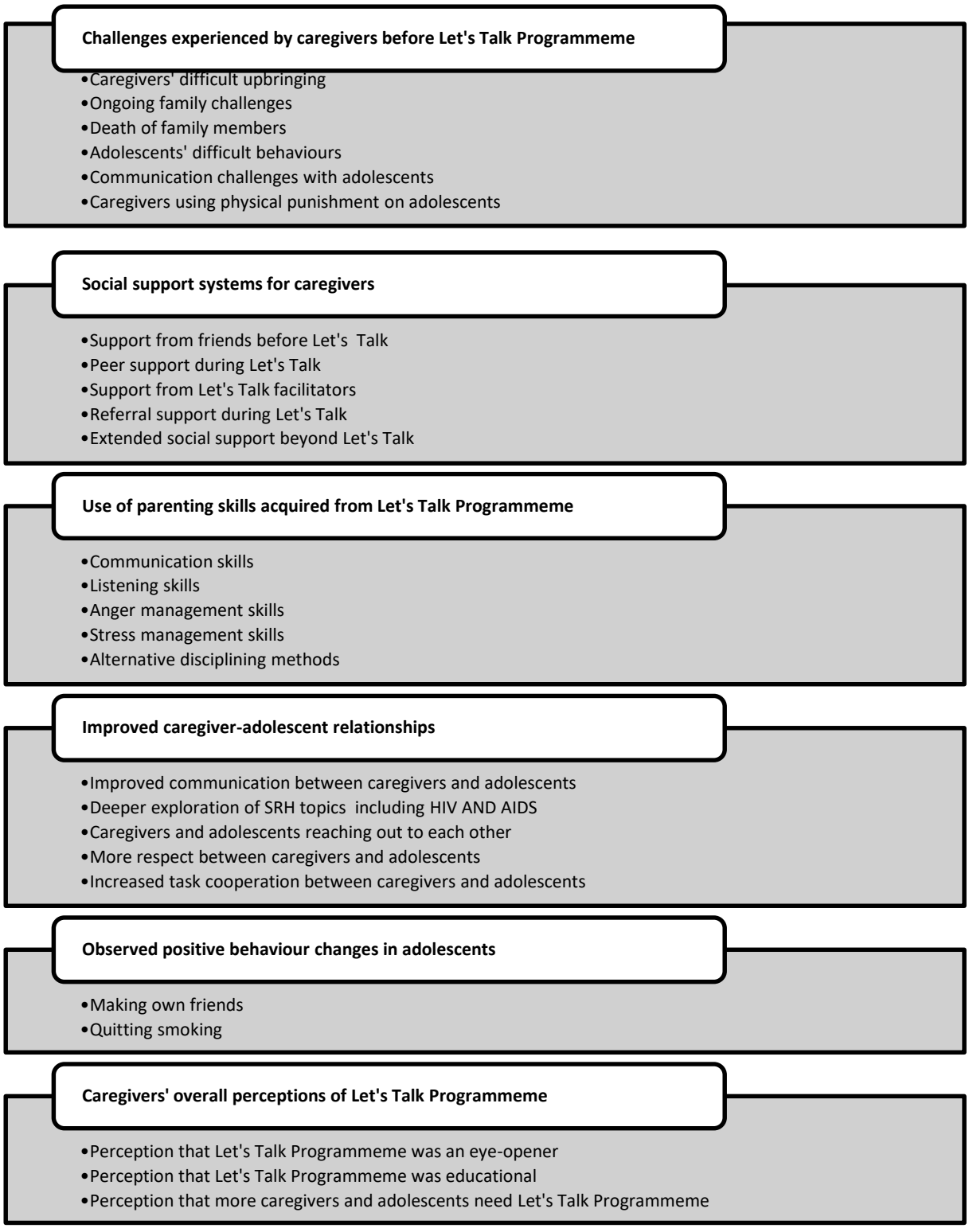


Figure 2: Thematic Framework

3.3 CHALLENGES EXPERIENCED BY CAREGIVERS BEFORE LET'S TALK PROGRAMME

Caregivers reported experiencing a variety of personal and social challenges that negatively affected their emotions and family functioning. Salient challenges experienced by caregivers before attending Let's Talk related to their difficult upbringing, sexual abuse, strained family and social relationships, loss of loved ones and dealing with adolescents' difficult behaviours. For some of the caregivers, Let's Talk afforded them their first opportunity to confront and talk about their challenges publicly, thus beginning to take the first steps towards personal healing and mending their social relationships. The next paragraphs highlight some of the pre-Let's Talk challenges experienced by the caregivers in more detail.

3.3.1 Caregivers' experiences of difficult upbringing

Difficult challenges experienced by caregivers while growing up centred on living without one or both parents. In the case of Boipelo (41), the absence of her mother affected her emotional and social adjustments as she described below:

> *…I did not grow up in a house with both parents. My family structure was not in a good way…It affected me a lot especially emotionally. I was not a strong person…I did not put myself out there. I was a very shy person.*

Another caregiver narrated her ordeal of growing up without her mother. In her case, the absence of a mother was linked to a series of other traumatic events, including rape. The lack of parental support made her plight even more difficult as she had to navigate the court processes on her own. Lerato (34) expressed her challenges as follows:

> *When I was a child we grew up without a mother…so I had that anger, and when I was 14 years I was raped and that is where I got the anger. It affected me a lot because I could not complete school. I dropped out in Grade 9…I tried to kill myself and did things I don't know and I did not communicate much at that time and I had my child through rape. He [man who raped her] was arrested, and when I attended the court I went alone. I told them at the court that my mother was not there and my grandmother who raised me was old and could not go with me. Nobody was there for me. That was the anger I had…because he [man who raped her] once pointed at*

me and said "you don't know me" and I started shaking, and I thought he was going to kill me, but he did not kill me at that time though he showed me a knife and now I thought he was really going to kill me.

One of the caregivers narrated how accusations of witchcraft against her mother while growing up resulted in her feeling shame and witnessing the once close-knit family disintegrating. Remembering her difficult childhood Zodwa (48) said:

My mother was very sick and had to go do the rituals of becoming a sangoma. Because she was not working she had to stay there for a very long time, for more than 10 years. We had no mother in the house and were depending on the aunts, uncles and grandfather. When my mother came back home it was not fun anymore because they were calling her names like 'witch' and so on. We started falling apart as a family, the close-knit family. We started being apart. Every time they would say something about my mom I would feel bad and start hurting…

Parental neglect was a common challenge experienced by the caregivers in their childhoods. Consequently, the caregivers' parenting and communication approaches were negatively affected due to the historical absence of parenting and communication role models. One of the caregivers, Nthabiseng (41) recalled how her mother was not actively involved as a parent:

…I feel bad because I didn't have a chance to be in my mother's arms…I used to tell my aunt that my mom wasn't hands-on with me. She thought my sisters would advise me about stuff as older girls, but they did not.

3.3.2 Caregivers experiencing on-going family challenges

During interviews, caregivers talked about ongoing challenges with their families that came up during their involvement with Let's Talk. A desire for reconciliation or communication was expressed. For instance, Ayanda (42) expressed her desire to let her brother know how deeply betrayed she felt related to his revealing secrets of a deep personal nature, which had led to her keeping emotional and social distance from him:

I trusted him with some things I thought I could only tell him and felt betrayed by what he did. He revealed some of the secrets I told him to a friend of mine. He told her some of the things I didn't want anyone to know… I don't think he knows how hurt I am. I just need to make him listen and open up to him and let him know my true feelings…

Other relationships the caregivers reported seemed beyond reconciliation, but affected their relationships with the adolescents in their care. For Thandeka (37) the experience of her husband cheating was so stressful that she could not cope at work, leading her to quit the job. Highlighting her experience Thandeka reported:

My relationship with the father of my children was a mess, my husband. He was cheating all-over this township… Like the major problem is that at work I couldn't cope and I had a miscarriage at work…Yes I had a miscarriage, and I decided to quit the job…I had a lot of things going into my mind then, when I realised that it wasn't how I must live. That anger I would take it out to the children most of the time because I don't know how to deal with the issues.

3.3.3 Death of family members

Death of a family member also emerged as an experience that was affecting caregivers due to ensuing feelings of loss and grief as well as the absence of breadwinners. For some, like Fezile (43), the loss of a partner who was the sole provider for the family brought challenges:

With me things are not good because I used to sit and think and ask myself what can I do to solve this problem I have, because I have a very big problem. Last year I lost the father of my two kids...so he was the one who was supporting us and doing everything for us, but after he left then I was not feeling ok...

Caregivers also reported that loss of loved ones was emotionally challenging. Ayanda (42) expressed the painful emotions she still feels when she talks about her mother who had recently passed on:

For me personally, I was going through a rough patch so they sent me to Lifeline. My mom was very sick last year. She was suffering from COPT (Complication of

Pulmonary Tract). She passed away last year and I didn't handle it well emotionally. It was draining…I am still experiencing those emotions and whenever I talk about her it's painful…I still cry a lot when I talk about my mom. We were very close.

3.3.4 Caregivers' experiences regarding adolescents' difficult behaviours

The majority of caregivers experienced significant challenges handling difficult behaviour by their adolescent children. The most mentioned challenging behaviours included stubborn tendencies, smoking weed (cannabis, a.k.a. dagga) and other drugs, having unprotected sex, getting pregnant and failing at school. The accounts by caregivers also revealed that most of the adolescents displayed multiple problem behaviours at once, heightening the caregivers' exasperation.

Adolescents' stubborn behaviours

During interviews most caregivers struggled with behaviour they deemed to be "stubborn" from their adolescents wherein interactions between caregivers and adolescents tended to be emotionally charged leading to poor parent-child communication as demonstrated by the account of Fezile (43):

Before I went for `Let's Talk` Programme I was having a big problem with my older child, the one who is twenty. She was stubborn, rude and when I talk with her she always fights, bang the door and storm outside.

Lebohang (49) also recounted her painful experience with her daughter who displayed multiple challenging behaviours that she could not handle leading to a vicious cycle of tension and fighting between mother and daughter:

My child used to go to school and come back home at whatever time she pleased and she would ignore me when I spoke to her and she was rebellious. When I ask or send her to do something for me she would refuse. She wanted to do as she willed and at her own time that suited her. It was painful to me and we would end up fighting and swearing at each other

Substance abuse

A number of caregivers struggled with the fact that their adolescents were smoking dagga and using other unknown substances and drugs. Caregivers especially feared that smoking and substance use would negatively affect the adolescents' school performance. Whereas some caregivers perceived smoking substances as a problematic behaviour mostly associated with boys, one caregiver Phumzile (26) experienced the challenge with her niece who smoked weed. Substance abuse was reported among both adolescent girls and boys, contrary to the perceptions of some caregivers. Lamenting her niece's smoking habits accompanied by stubbornness, Phumzile mentioned that:

> *We also used to get some complaints from school that she was smoking weed…She was so stubborn so much she couldn't listen when we talk to her. She would come home smelling of dagga, and we could smell it on her. And then she recently told me that the weed she was smoking she was smoking together with her boyfriend…I am worried…she is taking it to school as well and she has been found smoking it so this thing is ruining her life.*

Experiencing the same challenge was Ayanda (42) whose son smoked unknown substances. Ayanda was one of the caregivers who perceived that smoking substances was a male preserve, contrasting with Phumzile's experiences. This is how Ayanda put her experience across:

> *There's a difference in raising a boy child from a girl child…Yuh raising a boy child is so difficult. All they think of is smoking and doing all these nasty things…My son is turning seventeen. He's one of the people who taught me that parenting is very challenging…He has done many things which I can't even count. He is smoking and you don't even know what he is smoking.*

Teenage sex and pregnancy

Caregivers reported worries and suspicions about adolescent girls starting to date and having sex with boyfriends at an early age. The caregivers' feared that having sex (especially unprotected sex) at an early age exposed the adolescent girls to Sexually Transmitted Infections (STIs), including HIV, and teenage pregnancies potentially leading to

dropping out of school. There was consensus among the caregivers that school was the best opportunity for adolescent girls to better themselves and get out of poverty.

Teenage pregnancy was a fear expressed by multiple caregivers, which they linked to unsafe sex. In one instance, a caregiver's (Fezile) daughter became pregnant during a critical stage in her schooling. Her daughter was also failing at school. This is how Fezile (43) relived her frustrating experience:

> *The challenge I have is that she was pregnant. Then she was doing grade 12... And she failed and I was very angry because she got pregnant and failed at the same time and she was in grade 12... You see because before I used to talk to her and tell her that if you are an adolescent child you must use protection and do not go around with boys, but she did not want to listen to me. Then she fell pregnant. I was very angry … I cried and I was very angry and I asked myself why because I used to talk with her about sexual protection you understand…But she did that…I was thinking to take her clothes and kick her out.*

3.3.5 Communication challenges with adolescents

Before Let's Talk, most caregivers reported that communication with their adolescent children posed significant challenges. Communication dynamics between caregivers and adolescents tended to be marked by lack of communication, anger, tension, fear and physical aggression. As a result, the conversations caregivers described with their adolescents tended to be shallow and generally of poor quality.

Poor communication between caregivers and adolescents resulted in a vicious cycle. Poor communication elicited anger, frustration and sometimes physical punishment perpetrated by caregivers on adolescents. Consequently, adolescents would display behavioural challenges noted above thereby eliciting even more anger and frustration on the part of caregivers thus sustaining the vicious cycle. An observation was made in data analysis that most caregivers also lacked proper skills to engage adolescents on sexual subjects before attending the Let's Talk Programme. This often led to aggressive confrontation between caregivers and adolescents as the experience shared by Phumzile (26) shows:

> *She was always naughty and we once got her out at night with her boyfriend. She was preparing to sleep outside with the boyfriend and I ended up slapping her and her boyfriend. When I look at the age it's very early and we once had an incident that happened with Zoleka (pseudonym) that we found morning after pills inside her school bag. When we asked her she told us that they were for her friend. I then went asking one of her friends and I called Zoleka in front of her other friend and said to her `you are now caught so tell us the truth` and she cried and said she was afraid to tell me... I then asked her to tell me if the box belonged to her. She said yes. She had unprotected sex and was afraid she was going to fall pregnant.*

Poor communication between caregivers and adolescents also meant that discussions on SRH including HIV and AIDS could not meaningfully take place. Caregivers described their use of confrontational approaches in relation to already existing problems. As a result, anger, suspicion, frustration and sometimes physical punishment were major impediments to communication.

Lack of communication between caregivers and adolescents

Lack of communication between caregivers and adolescents was a common feature reported by caregivers. For example, Mpho (29) acknowledged that *"Before, the relationship wasn't good at all because my daughter wasn't free at all to talk with me some of the things. I could say that she wasn't that open".* Whereas some caregivers seemed unaware of the communication barriers between them and their adolescents, Nthabiseng (41) realised that her children avoided communicating with her because she tended to frighten them and expressed the desire to start having more meaningful conversations with her children when she observed:

> *I was shouting and fighting. I am not a hard person, but I was short tempered…I thought it was good that I frighten them...They were scared of me…They couldn't talk to me. We were just at home, just living, quiet to each other, not playing.*

Caregivers shouting at adolescents

Shouting was a common way caregivers used to describe communicating with the adolescents in their care. Caregivers reported that shouting tended to be their default

communicating style with adolescents. They attributed this to the way they were raised and socialised, hence they were not aware of alternative ways to reach out to their adolescents. For instance, Ayanda (42) remarked: *"Hey! I would blow the roof and everything would be a mess".* For most caregivers, adolescents' refusal or delays in doing household chores and breaking curfews precipitated the shouting and other aggressive behaviours.

Upon attending Let's Talk, there was realisation by the caregivers that shouting at adolescents was self-defeating and not effective because it did not result in the desired conforming behaviours. On the contrary, shouting tended to provoke equally acerbic responses from the adolescents thereby perpetuating a cycle of poor communication. This is illustrated by Fezile (43)'s account, in which she also acknowledges some of her other shortcomings in raising her adolescents:

> *If I wanted something I would shout and say: Why this? Why you did not do that? And she would shout back: You did not tell me on time! We used to talk like that. The communication was not good before. I am a shouting person. When it comes to my kids, I am not good and I`m a person who likes to hit almost all the time.*

3.3.6 Caregivers using physical punishment on adolescents

There was widespread use of physical punishment (often co-existing with shouting) by caregivers as a way of eliciting and enforcing good behaviour from adolescents. Caregivers justified this approach by arguing that they were also raised that way and were not aware of alternative disciplining techniques that would produce conformity better than physical punishment.

In most of the accounts about physical punishment, most caregivers were regretful of their behaviours like Mpho (29) who mentioned: "*…I used to beat her a lot when I am angry…I used to beat and beat her."* Mirroring Mpho's aggressive behaviour towards her daughter was Thandeka (37), who also expressed feelings of regret and guilt for always inflicting physical pain on her daughter: *"I'd shout and scream and throw the nearest item I find at her… I would grab her and shout at her, and she'd just cry. I regret and feel guilty about my past behaviour. If I had attended this Programme earlier, I would have treated her differently"*

3.4 SOCIAL SUPPORT SYSTEMS FOR CAREGIVERS

Before Let's Talk, most caregivers reported having limited social support systems. The most common form of social support was provided by one or two best friends. Social support networks available to the caregivers widened during Let's Talk sessions during which caregivers got chances to talk about challenging situations in their lives and provided moral and emotional support to each other. Other sources of social support for caregivers during Let's Talk sessions included the facilitators who ran the sessions. On some occasions caregivers were referred to other organisations for further support in the form of counselling. After the sessions some caregivers continued social interactions with fellow caregivers from Let's Talk by forming special friendships and engaging each other on social media. Deeper insights into the caregivers' experiences of social support before, during and after Let's Talk are provided in succeeding sections.

3.4.1 Social support from friends before Let's Talk

Friendships were the main source of support available to caregivers who were experiencing challenges in their lives before attending Let's Talk sessions. When approached, the friends were available to offer practical advice and listen to their counterparts venting their emotions. Friends were therefore a support and coping mechanism that assisted caregivers in emotional and social adjustment as illustrated by the experience of Ayanda (42).

> *Sometime early this year, I had a problem with my husband. He didn't want to pay for my daughter. She is in university doing her first year there. He didn't want to pay for her accommodation and I found out he was cheating in Limpopo, so I felt I needed to talk to someone, so I went to my friend and we talked…You know, she didn't say a lot. She just listened and I was whining and whining and she just listened.*

3.4.2 Support from peers for caregivers during Let's Talk

As highlighted in section 3.3, most caregivers came to Let's Talk experiencing various emotional and social challenges that hampered their psychosocial adjustment. Through the medium of Let's Talk groups, caregivers described being able to share their challenges with other people for the first time. Caregivers reported that they only started to embark on the

healing journey and solving different relationship challenges they had upon attending the Let's Talk Programme.

Moral support to reconnect with extended family

Upon sharing their challenges in the group many caregivers reported getting moral support and sometimes real advice to confront their challenging situations. In one case, Zodwa (48) reported how she got empowering support from fellow group members to reconnect with extended family members since her mother passed on:

> *Somebody was there to listen to me and they gave me ears…They made me see that I wasn't going home at all since my mother passed on. So since they talked to me I go home now and again when I have time to see my uncles and aunt. We have rebuilt that relationship again…I used to hate them a lot, and I did not even want to know them but today I have their contacts and I can share with them my problems. I can talk to them about a lot of things…Yes I do go home every day because I stay nearby. It's like a 5 minutes' walk and I never saw them in years, but now we are so close."*

Emotional support to confront painful childhood sexual abuse

Let's Talk offered broad emotional support to the caregivers, most of whom grew up with unresolved emotional challenges. The unresolved emotional challenges negatively affected the caregivers' social relationships and interactions especially with their adolescents. One of the caregivers, Lerato (34) narrated the happiness she experienced when shared in the sessions how she suffered sexual abuse as a teenager:

> *I was happy because I started to talk…I disclosed [sexual abuse] to the group because I still had the anger…so when they asked why the anger that is why I came out. I then shared everything about my childhood and what made me sad, and that I am now going for therapy…I got happiness [from sharing in the group], the support I got brought happiness because I could see the anger going away. They [group members] encouraged me to be strong, and comforted me, by saying things will be better and God will help me.*

Peer advice on anger management and physical punishment

Several of the interviewees acknowledged their long running challenges with managing their anger and how other Let's Talk participants discouraged aggressive communication and disciplining techniques. Caregivers appreciated the non-judgmental atmosphere in which they were able to share their anger management issues freely without other participants necessarily condoning such behaviour as demonstrated by Fezile's (43) account:

> *The support I received was good because some parents advised me that as you are a mother you must do this and that...so do not be angry too much and do not shout...So the other parents talked with me about that and advised me not to do that because sometimes that will send your child to the streets if you are always hitting her…We practised in the group how to talk to our children… They (facilitators) even gave us homework to practice talking with our children in the house.*

Positive reinforcement from other women

Positive reinforcement provided in the Let's Talk groups by peers gave caregivers opportunities to build and guide one another. Some caregivers cherished the fact that they managed to come together and shared common challenging experiences in the community like poverty and low educational attainment. The fellowship of being in the same space with other caregivers who used to be strangers was especially appreciated by Boipelo (41) who felt a sense of belonging as her narrative below shows:

> *Yes, there was a chance for us to share because I was in a group with other women my age that have children of the same age group. So there we could share with each other and even build each other. We realised that our experiences were similar so I got the chance to put it out there and receive positive responses and guidance from the facilitators.*

Safety in Let's Talk groups

The Let's Talk Programme provided a safe environment for participants to share their challenges and dreams for better futures in structured closed groups. Besides the

group rules that emphasised acceptance and non-judgmental tendencies, the participants felt they had a lot of common characteristics necessary for mutual and symbiotic growth. Participants started viewing each other more as assets and building blocks than just mere strangers in diverse and mixed townships. The account of Boipelo (41) brings the safety aspect in Let's Talk to the fore:

> *We did not laugh at each other regardless of what you were putting out there…We accommodated each other within the group…Because this neighbourhood has a lot of poverty, so when you come here it feels safe to mingle with certain people because we are sometimes prejudiced towards each other because of the clothes we wear. So when we are here we are treated equally. We don't need to be people that we are not, and even our educational levels are never reason to be treated differently.*

Sharing as healing

Feeling the safety guaranteed in the Let's Talk groups, a number of caregivers reported feeling healing after sharing their difficult challenges in the groups. This is because the caregivers had lived with the traumatic experiences all their lives and never had the opportunity to disclose their trauma with guarantees of acceptance and not being judged. This was particularly the case for Lebohang (49) who reported getting healing through sharing her challenges with other caregivers in the Let's Talk group:

> *I thanked them because my life was better since I had other parents to share my problems with and they also were able to share theirs. This really relieved me from the pain I was going through…This Programme healed a lot of my wounds.*

3.4.3 Support from Let's Talk facilitators

There were some caregivers who reported being more comfortable sharing and discussing their experiences with Let's Talk facilitators outside of the group setting. The privacy afforded by such engagements with facilitators was more appealing for the concerned caregivers as opposed to sharing in the group. Some caregivers preferred to receive some types of social support individually. One of the caregivers, Fezile (43) came to attend Let's Talk sessions while still grieving the passing of her partner. She opted to confide in and get grief support from the Let's Talk facilitator instead of sharing in the group.

Despite not have fully recovered yet, Fezile acknowledged the fact that grieving was a step by step process and that she would eventually heal.

3.4.4 Caregivers referred elsewhere for further support

There were some caregivers who were experiencing very challenging situations that needed further professional help in the form of counselling. After some considerations the facilitators and caregivers agreed on referrals for more professional support like Thandeka (37) who was referred to Social Workers:

> *I didn't know how to deal with stuff at first, but when I started with the sessions I asked that I be helped with counselling, because there were a lot of things in my mind, and things happening at home that were making me sick sometimes but now I know how to cope. From here they transferred me to somewhere else…It made me feel happier because I didn't know how to handle some situations.*

3.4.5 Extended social support for caregivers beyond Let's Talk

Many caregivers reported that the social bonds and friendships they established during Let's Talk outlived the programme. Six or more months after attending the session, some caregivers continued to benefit from such relationships through extended social and emotional support thus helping them cope better with challenging experiences. The experiences of Zodwa (48) highlight how some caregivers established strong bonds akin to a close knit family during Let's Talk and continued to benefit from such support networks after the sessions:

> *There's this lady by the name of Seiphati (pseudonym). We call each other every time…Seiphati used to have problems with the kids. I could go to her house and speak to her kids for her…The kids would come back late from school, and I would tell them about the risks of getting raped or abducted…Yes, there is a lot of change (observed in the children). They are even doing homework now.*

Learning new positive behaviours and unlearning old negative behaviours were aspects reported by some of the caregivers in order to access social support. For Mpho (29), she had to learn to express her feelings instead of bottling them inside:

> *I am one person who is very quiet. I let feelings bottle up and I would prefer to not tell anyone what I am going through…But after the Let's Talk, I've learnt so much. If I am not feeling good inside, I find someone I trust to share my feelings with. Then I could share my feelings…even if I am not good yet but I am on that process*

Some caregivers used social media to keep virtual contact with fellow participants after formal Let's Talk sessions came to an end. Such networks allowed the caregivers to continue offering and getting support from each other in case one of them experienced challenges. Boipelo (41) shared her experience of being part of a WhatsApp group after the Let's Talk Programme had ended:

> *Because of Let's Talk we still have groups where we talk to each other and send text messages on WhatsApp. We did not know each other though we stay in the same area. We then had the WhatsApp groups and sit-ins. It feels like we belong somewhere and we have people to share things you would not share with just anyone.*

3.5 USE OF PARENTING SKILLS ACQUIRED FROM THE LET'S TALK PROGRAMME

Previous sections highlighted how caregivers lacked parenting skills to mitigate difficult adolescent behaviours. This all changed for most caregivers who reported gaining important parenting skills like communication, listening, anger management, stress management and using alternatives to physical punishment. Consequently, many caregivers started observing positive changes in themselves regarding their approach to parenting after attending Let's Talk sessions. Caregivers reported that their parenting capabilities were enriched during the Let's Talk sessions.

3.5.1 Caregivers embracing better communication skills

Let's Talk is an intervention seeking to transform behavioural and sometimes traditional and cultural barriers that limit meaningful conversational engagements between caregivers and their adolescents. The Programme therefore has a deliberate focus on breaking barriers between caregivers and their adolescents within culturally acceptable limits. It was therefore not accidental that of the skills learnt during Let's Talk, the ability to communicate better with adolescents was mentioned the most by caregivers. The majority of caregivers also reported positive outcomes associated with better communication. For

instance, one of the caregivers, Ayanda (42) described how her new communication approach elicited good behaviours:

> *The most important skill is how to communicate…because it helps you not to get angry at the issues that arise when you are raising an adolescent. Before Let's Talk I would just raise my voice…Now I just let them know calmly what it is that I don't like or like…Now we talk, we talk about everything and they let me know that they understand what frustrates me…They listen and they do exactly what I want them to do and that makes me feel very happy.*

3.5.2 Caregivers improving listening skills

Communication as a two-way process was emphasised in the Let's Talk Programme. After attending the sessions, caregivers reported better appreciation of the need to talk to adolescents and equally allowing adolescents to also talk to them within acceptable bounds set by culture and tradition. Caregivers mentioned barriers to listening to their adolescents they had internalised as they were socialised. By talking to and listening to adolescents more, communication became bi-directional and more meaningful as revealed by Boipelo (41):

> *Before, I was a very strict person. I did not listen to my child. During the time I attended the Programme I could see that I needed to accommodate and listen to her…and after [Let's Talk] we could emotionally understand each other and I could come to her level…I was very strict because I grew up that way. There were no negotiations about things pertaining chores or curfew…Times have changed…so here we got an alternative way of doing things.*

3.5.3 Improved anger management skills

Most caregivers came to the Programme with unresolved anger of one kind or another and this impacted negatively on the caregivers parenting abilities. Multiple parents spoke about how the Let's Talk sessions taught them about better self-regulation and temperament management. Let's Talk exposed parents to the possible consequences of endless fights with adolescents. Akhona (46) described:

> *Before Let's Talk I used to have a lot of anger because I'm the type of person who expects a child to be obedient. If I tell a child don't do that and they do it anyway…then I would fight…But now I don't because Let's Talk taught me that it's not good to fight because the child might go away for good and you lose him or her.*

In addition to presenting the consequences of anger through attending Let's Talk sessions, caregivers learned anger management strategies. Nthabiseng (41) explained how this changed her relationship with her children:

> *I was shouting and fighting. I was short tempered…But after Let's Talk, I saw that it was not a good thing. It's not a good thing at all… now everything is smooth because they talk to me, even about things which I do that they don't like. I also talk to them more about things and what I don't like without shouting. I cool off before and talk to them after…They are not scared of me anymore but they respect me...Now it's very excellent.*

3.5.4 Caregivers implementing alternative disciplining methods

Another big change following Let's Talk was that caregivers reported ditching corporal punishment for alternative disciplining methods. Alternative disciplining methods were also reported to elicit the desired behaviours from adolescents better thereby rendering physical punishment unnecessary. This was exemplified by Thandeka (37):

> *Now I ask her to wash the dishes, but if she doesn't want, I will get up and wash my dishes. But I will warn her, if she doesn't want to do what I am asking her I am going to deduct her money and as I will be saying that she'd get up and wash them…I learnt it from Let's Talk. Because you don't have to hit your child, you have to discipline the child.*

3.6 IMPROVED CAREGIVER-ADOLESCENT RELATIONSHIPS

Previous sections have shown how caregivers started overcoming some of the challenges they faced before attending the Let's Talk Programme. Most of the caregivers also reported how they started implementing the parenting skills they acquired from the Programme. The positive behaviours displayed by caregivers were reciprocated by adolescents. As reported by the caregivers, skills acquired from Let's Talk by both caregivers

and adolescents helped to reframe communication and relationship dynamics in the households resulting in more harmonious living environments.

The improved caregiver-adolescent relationships were characterised by better communication, mutual respect, deeper exploration of SRH topics, caregivers paying more attention to adolescents and increased task cooperation. In this regard, Let's Talk successfully cut the negative vicious cycle of poor communication and negative relations between caregivers and adolescents described previously.

3.6.1 Improved communication between caregivers and adolescents

Reports by caregivers during the interviews confirmed that the caregivers' improved communication skills were reciprocated by adolescents. This therefore entrenched communication as a two-way process that resulted in caregivers and adolescents expressing emotions and view-points more freely without infracting against cultural tenets of respect towards elders. On the whole caregivers and adolescents started understanding each other better as Ayanda (42) shared:

> *We now communicate better and the one at North West used to be unable to express her emotions. She was the worst: tantrums and everything. But now she is better. Before Let's Talk it was a disaster…we are now at a point where we can communicate… The 21-year-old, she used to shout, but now she confronts her problems, asks me for help if she needs it, and we address it. She also will tell me if there's something she doesn't like.*

3.6.2 Deeper exploration of SRH topics including HIV and AIDS

Attending Let's Talk sessions allowed caregivers and adolescents to engage in deeper exploration of SRH topics including HIV and AIDS. For the first time most caregivers started having meaningful discussions about sex, contraceptives, HIV infection, ART, adherence to ART and disclosing HIV positive status. However, a few caregivers were still not comfortable engaging adolescents on these topics especially discussing sex and disclosing HIV positive status. This demonstrates that changing personal and social attitudes and perceptions to SRH issues happens in gradual stages. There therefore remains a need to provide SRH

information to adolescents when their caregivers have not yet reached a comfortable stage to discuss the topics.

Caregivers having open discussions with adolescents about sex

Caregivers reported that their knowledge about teenage sex increased as a result of attending Let's Talk. Coupled with the caregivers' improved communication skills, the caregivers' confidence to have fruitful discussions about sex and using condoms also increased. This allowed caregivers to have more open and permissive attitudes to discuss adolescents' sexuality issues. One such caregiver was Thandeka (37) who shared:

> *Yes, I do sit down with them and discuss these issues…Even this one, the boy, he used to have condoms inside the money box. I asked him what he is doing with them. He said to me, "No mom, I have to use condoms to be on the safe side, not on the wrong side".*

Some caregivers appreciated the Let's Talk Programme because adolescents were taught about sex and HIV earlier rather than later, thereby empowering adolescents to be assertive in their relationships. Some caregivers reportedly built on the foundation set by Let's Talk and continued having discussions with their adolescents on sex and HIV. Ayanda (42) elaborated:

> *Let's Talk has taught me how to address sexual issues because she is at that stage now boys are starting to notice her…In my house we now talk about anything: sex, boys, girls…If a boy wants to sleep with you and you feel that you're not ready then don't be forced into doing that. Sometimes they feel embarrassed, amazed that their mom is talking about these things but I say if I don't tell you these things, who will? For me the Programme is very good because they're teaching our kids how to be responsible and teaching them about everything, about sex, HIV and everything…Being open teaches your kids to be strong, they can handle any situation.*

Caregivers uncomfortable to discuss sex with adolescents

Despite the majority of caregivers reporting that they were now better able to communicate SRH issues with adolescents, a few caregivers reported that they were still

uncomfortable to engage adolescents in this regard. Some caregivers feared that starting any such discussions with adolescents might trigger undesirable sexual activity. These caregivers preferred taking a reactive stance to discussing sex and sexuality with adolescents to having open discussions beforehand. While acknowledging that it was her responsibility to engage adolescents on the SRH matters, Andile (33) who looked after an eleven-year-old daughter and twelve-year-old niece still argued:

> *We have not reached that point. Even me I haven't talked with them yet…The reason is that I haven't seen any actions which make me want to talk about it and I am afraid to start. Maybe if I see something I can start talking about it. I am afraid to start because what if they don't know anything about it and I start. It would seem like I am teaching them or I am putting them in the light of knowing about sex. While I am aware that even at school they are teaching them about sex, but I am not free to start…It's my responsibility but I think I need to see something on them so that I can be able to start. But for now there aren't any signs yet on them.*

Caregivers' discussions with adolescents regarding contraceptives

During interviews, most caregivers reported that they were now more open to discussing family planning and contraceptives like pills; injections and condoms with adolescents. This was because the caregivers were using knowledge and communication skills learnt from Let's Talk that improved their confidence and subject matter knowledge. For instance, Phumzile (26) whose two nieces were fourteen and seventeen years started playing a more active and permissive role in her seventeen-year-old niece's contraceptive use after realising that she sometimes engaged in risky sexual behaviour:

> *She has started to use family planning. She is injecting…but she said she is afraid to use that one at the moment but she was thinking of doing it because injecting makes her arrive late at school when she has to get the injection. So that is why she is considering implant…She used to ask me if a condom is safer than preventing with a pill or injection. She wanted to know which was safer for prevention. I told her that the condom is preventing STIs and pregnancy as well, but with an injection you can't prevent HIV and you will only be preventing pregnancy with pills and injection. Now when Zoleka (pseudonym) goes out I always tell her to take a condom…and she*

would respond by saying they were told in the programme to keep at least one condom with them because boys are naughty and things can happen.

Discussions on HIV and AIDS

Many caregivers reported that their knowledge about HIV transmission and prevention had increased as a result of attending Let's Talk Programme. As a result, caregivers pointed out that they were now better able to engage adolescents on topical HIV and AIDS aspects like testing for HIV, disclosing one's HIV positive status, adhering to ART and living positively with HIV. For instance, Phumzile (26) mentioned the central point of her discussions with adolescents regarding HIV prevention: "*You never sleep with someone without knowing their HIV status. Go for testing first and use protection".*

In other cases, adolescents were reported to feel comfortable to initiate discussions with their caregivers about HIV and AIDS. This was the case for Zodwa (48), whose fourteen-year-old daughter seemed to be correcting information about HIV transmission the mother had previously shared:

She came home from school one day and asked me if I know how people get AIDS. I said to her I think I know. She then said you are always telling us that we are going to have AIDS when we go out but you can't get AIDS by going out. She then told me that she learnt from school how a person gets AIDS…She then said you can't get AIDS from kissing a boy, or sharing a cup with him or sharing clothes with that person.

While many caregivers reported that their knowledge about HIV and AIDS had been boosted as a result of attending Let's Talk, hence making them more confident to engage adolescents on the topic, there were still a few caregivers who mentioned that they were still not comfortable to raise the subject. Mpho (29) who had a fourteen-year-old daughter was one such caregiver who shared:

About HIV and AIDS most of the things she learnt from Let's Talk. I never told her about HIV and AIDS…I think it's being scared or being ignorant or yes I can say that… I can say I didn't have a way to communicate the knowledge of HIV and AIDS to her…I was so scared but that knowledge I do have…I did learn some of the information but discussing with my daughter I never did. I think because of the relationship, being

uncertain of how she would react, afraid of how she would react…I don't know how to put it.

This quotation also demonstrates how parents fear for their children but are also uncertain of how their children perceive them as parents or how they might act on the information parents give them.

Let's Talk enabled some caregivers and adolescents to explore and communicate about HIV prevention and testing for HIV. This was one of the prevention pillars emphasised during the programme. Some caregivers felt empowered and comfortable enough to openly talk about the subject and encouraging adolescents to know their HIV status. Some of the caregivers went the extra step to actively encourage and support their adolescent girls to test for HIV during the Let's Talk Programme. Regular testing for HIV was a good practice advocated by some of the caregivers like Phumzile (26) who shared:

I once opened the conversation and I sat my sister and kids down and said that…you must be able to go to the clinic to find out what your status is so that you may know because today you may think you are HIV negative only to find out your test was during the window period and next when you go to test again to find that you are HIV positive…You can't trust anyone in this world because you can trust your partner only to find that he is cheating on you.

Parental disclosure of HIV positive status to children

The enhanced communication skills boosted the self-confidence of one of the caregivers to disclose her positive HIV status to her children after years of contemplating the matter. Though she acknowledged that disclosing her HIV status to her children was difficult, Fezile (43) felt relieved after the disclosure:

She used to see me every time at eight o' clock drinking pills and would ask me, mom why are you always drinking pills at eight o'clock? And then I would say to her time to tell you will come. Up until I told myself that I had to tell my daughter. I must not hide this from my daughter because she sees me each and every time I drink my pills and she asks herself why? And she will go outside to ask someone else, and she will be angry that I hide something from her only to hear it outside. I realised that would

cause her anger. I then started to sit her down and told her that I'm HIV positive. She said what! When? I told her 1998 and I started to drink pills, the very pills you see me drink all the time are ARVs. So she understands.

Whereas Fezile reported that she felt empowered to disclose her positive HIV status to her children after attending Let's Talk, Nthabiseng (41) did not feel ready to disclose to her children in the short term as she concluded her children were not yet ready both emotionally and mentally. She reached this decision of non-disclosure after testing the waters with her thirteen and fourteen-year-old daughters. This shows that parental HIV disclosure is still a complicated and sensitive process for some caregivers who have to weigh their options to disclose until the right time. In this regard, Nthabiseng (41) highlighted:

No I haven't disclosed my status because I thought that they'd be unable to participate at school. They might fall back because of being distracted by it. They'd be disturbed. I'll tell them when the time is right…after 15, 16, years. For now, it's not right. They're going to be left behind at school…When they see me stressed or not well it affects them quite negatively. That's why I don't want to tell them now. Yes, I am taking those ARVs in private but they know I am taking medication. They think it's for BP. They know I have BP. At some point I asked them indirectly: "What if I had HIV?" They said "Yoh mama, we're going to cry" I said ok and thought I will tell them when the time is right. I wanted to but thought it might be too early for them.

Discussions on ART adherence and positive living

Fighting stigma and discrimination associated with HIV and AIDS was one of the central goals of the Let's Talk Programme. ART adherence and positive living were embraced by most caregivers who reported that they freely accepted people infected and affected by HIV and AIDS, signifying victories against stigma and discrimination. Phumzile (26) is one of the caregivers who openly embraced the notions of ART adherence and positive living (although it must be pointed out that it could have been easier for her to speak from the perspective of one who was not infected):

I then told them that even when you contract that disease it`s not the end of the world though because you can always take ARVs and if you take your ARVs...because I`ve been told that you must take your ARVs, take care of yourself, eat healthy and

always make sure your pills are with you. When they say drink your pills at 20h00 it should be 20h00. So I already know about that and you must not think you are dying. It is still something you need to live with and you can share your status with your family or keep it to yourself.

However, fears of self-disclosure made by participants like Nthabiseng highlight that parents have genuine fears around how their children may react to an HIV positive status. As a result, such parents test the waters to determine the emotional and mental readiness of the children before full disclosure.

3.6.3 Caregivers and adolescents reaching out to each other

During interviews caregivers reported incidences whereby both caregivers and adolescents started reaching out to each other after the Let's Talk Programme. Caregivers started paying more attention to their adolescent children after attending Let's Talk sessions like they never used to do before. One of the caregivers, Mpho (29) started reaching out to her daughter:

After Let's Talk I could ask her about her feelings. I could ask her about how was her day and stuff like that. Yes, I think the relationship was now better than before… She would come and tell me about her problems.

On their part, adolescents reportedly started finding their caregivers more approachable after Let's Talk in line with the Programme's goal of breaking relational barriers between caregivers and adolescents. One of the caregivers, Fezile (43) mentioned her older daughter yearned to get the same attention and affection as her younger sibling:

Yesterday she called me and she was happy. I asked myself why, because she's a quiet person. She said mommy "ngikukhumbulile" (I miss you). Yes, and she said mommy when you come back from work you go to Portia (pseudonym and another child of the caregiver) *and touch Portia. You don't think about me. I'm your child…I then realised that at least she is adjusting now.*

3.6.4 Increasing task cooperation between caregivers and adolescents

The extent to which Let's Talk improved communication and relationships between caregivers and adolescents was evidenced by reports of caregivers and adolescents cooperating more on household tasks and chores. Before attending the Let's Talk Programme, many caregivers reported being somehow estranged from their adolescent children where cooperation on tasks was minimal, avoided or forced. This all changed after attending the Programme as most caregivers shared experiences of cooperating with their adolescents like Zodwa (48) remembered:

> *We share work in the house. Usually I do things for myself but this time she helps me clean the house…I like baking. She's always there baking with me because I'm selling cakes. She never used to help me but now I can even ask for her help when she returns from school to do other orders and she would gladly do so…We share everything these days. We go to church together. Before, she used to go with her friends. I would go alone, but now we go together…we also do laundry together.*

3.6.5 More respect between caregivers and adolescents

Caregivers shared experiences whereby their adolescents now showed respect to them. This contrasted with the stubborn behaviours most of the caregivers complained about before attending Let's Talk sessions. This attests to the beneficial effects of Let's Talk in fostering mutual respect between caregivers and adolescents as exemplified by Lebohang's (49) account:

> *She now respects me like how a child should respect her mother. My daughter does not sleep out anymore and she answers my calls now when I call her. Before Let's Talk she never even bothered to answer my call when I called her.*

As a sign of respect for adolescents, some of the caregivers started to apologise to adolescents for some of the mistakes they made. Mutual respect between adolescents and caregivers also promoted trust between the parties concerned. This was particularly the case for Phumzile (26) who decided to apologise to her niece as a way of regaining trust. As her account below shows, she was careful to apologise within well-defined limits in case her niece would want to take advantage of her in the future:

The moment I returned from work I went to her and I tried apologising because they taught us to mostly try to apologise...I went home and told her I am sorry for everything that I did to her. But I also told her that being sorry does not mean I am stupid because she is younger than me she thinks maybe I will come and apologise all the time. I told her that I am not stupid I am just trying to gain her trust again.

3.7 OBSERVED CHANGES IN ADOLESCENTS

The combined use of soft skills learnt from Let's Talk with new parenting behaviours resulted in caregivers observing pro-social behaviours in their adolescents. Adolescents were therefore empowered in their own right to make responsible decisions for instance regarding their health and making own friends.

3.7.1 Quitting smoking

Before attending Let's Talk sessions, a number of caregivers complained that their adolescents were abusing substances including marijuana and other unknown substances. Substance abuse was a source of concern to the caregivers involved. One particular caregiver, Phumzile (26) shared a story depicting positive behaviour change on the part of her niece who quit smoking after attending Let's Talk:

She was smoking a drug that could make her do things that she would not even think of doing when she was in her good state of mind. So as much as I am saying this is because I have seen a lot of change in [her]…Now she is always telling me `aunt I am no longer smoking and I have left my bad friends`. She is becoming a good person now.

3.7.2 Adolescents making own friends

Some caregivers shared experiences wherein their adolescents struggled to make friends before Let's Talk. However, after attending Let's Talk sessions some adolescents gained social skills and confidence to grow their social networks by building new friendships, as one of the caregivers Lerato (34) shared:

Her behaviour was aggressive, angry…She was unhappy and other times she would stay alone by herself. Her behaviour has changed and she likes to talk and she now

likes to play. She even goes with other children to study. Before, she never went with other children. She used to just stay at home and sleep…She is happy now.

3.8 CAREGIVERS' OVERALL PERCEPTIONS OF LET'S TALK PROGRAMME

All the caregivers involved in the study shared the perception that Let's Talk was a good Programme that was worth their while. Caregivers pointed out that the Programme was an eye-opener and this allowed them to become more self-aware. Caregivers also expressed the perception that Let's Talk was educational, replete with skills and lessons that reshaped their relationships with adolescents for the better. Most of the caregivers appreciated the life-changing experiences they encountered due to Let's Talk and wished for more caregivers to attend the Programme.

3.8.1 Let's Talk was an eye-opener

Most caregivers perceived Let's Talk as an eye-opening experience because they started appreciating matters like parenting styles, HIV and AIDS, self-awareness, communication skills and relationships with adolescents in novel ways. Most caregivers attributed positive behaviour and attitude changes they observed in themselves and their adolescents to the Programme. For instance, Ayanda (42) shared:

For me Let's Talk was an eye opener about some issues I didn't even think were important…Issues like HIV, communication with your child and sex issues…It was an eye opener because we didn't deal with situations in a good way. We were just repeating how we were raised: shouting, slapping and not talking and it was becoming a cycle.

Other caregivers started introspecting and reflecting on their part in dysfunctional relationships with their adolescents. One such caregiver was Lebohang (49) who realised:

As much as I was hurt by my child`s behaviour, they made me realise that I was also hurting her and some of the problems were caused by me. I never reflected on my own actions. I have learnt a lot because I now have better communication with my husband as well. He also gets surprised with my new approach to things. I used to think that I was always right, which was not the case.

3.8.2 Let's Talk was educational

Caregivers unanimously shared the perception that Let's Talk was educational and the topics covered during the Programme were relevant to their daily lives and experiences with adolescents. Most caregivers pointed out that they lacked information and skills to effectively parent adolescents and Let's Talk helped to bridge some of their parenting gaps. One such caregiver was Boipelo (41) who was convinced that:

> *The Let's Talk Programme educated both me and my daughter and it built our relationship to be more open. It strengthened everything that we had. We learnt communication, how to use money, in-house fighting, relationships, teenage pregnancy and drug abuse. A lot was covered. They [topics] were very relevant because my daughter is a teenager and it had a lot of impact and it was educational.*

3.8.3 More caregivers and adolescents need the Let's Talk Programme

After attending Let's Talk and learning new information and skills most caregivers believed that more caregivers needed to be enrolled into the Programme so that they could also learn. With strong conviction, Mpho (29) explained:

> *The only thing I could say is that Let's Talk is something good for the community. It must not stop. Some of the skills parents can learn from Let's Talk include the manner of approach, communication and listening skills because children need to be listened to. And the way you talk to the child is important. They need love. They need support. If you don't show them you love them, they'll go outside and look for love. Obvious, if they go outside to look for love, they become exposed to dangerous stuff. They get into drugs, some become HIV positive, fall pregnant, meet wrong people, anything can happen…It [Let's Talk] was relevant, like the part that spoke about HIV and AIDS because most of the young girls are exposed to that kind of environment and other young girls fall pregnant at an early age. So through better decision making, learnt from Let's Talk that could prevent the spread of HIV and AIDS.*

In the same vein, Boipelo (41) suggested that the programme be marketed better so that more people could benefit from the Programme:

> *It's only that it does not reach everybody and I also heard about it by chance and then I came and to find out it was such a good Programme but its marketing was not out there…For me there are more people who need it…Yes, let the Programme continue and let it reach more people especially in this area really needs it. We have a lot of girls that drop out of school and never make it to high school. There's a lot of teenage pregnancy and that is why I say Let's Talk does not reach everyone that needs it. There's also unemployment and we can equip our girls to see that they don't need boyfriends to buy things for them.*

Many caregivers queried why adolescent boys were not part of the Programme. They argued that boys are also vulnerable and would also benefit from the Let's Talk Programme like their female counterparts. This argument was especially driven home by Ayanda (42) when she contended:

> *Why are we only focusing on a girl child? I think the boy child needs a programme where they'll be taught all that we are teaching the girls: how to behave, how to treat girls, etc.… Boys also get raped. They get introduced to drugs and other bad things. By age eleven they're already introduced to things which are very risky and they end up having risky behaviour because of whatever they're smoking and whatever…Because if we take them and groom them in a session like this they'll be more informed and they'll know the consequences of their actions. The reason drug lords use them at a tender age is that they know they're vulnerable.*

CHAPTER FOUR: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This final chapter rounds off the study by discussing findings in this study vis-à-vis other study results on relatable topics. Conclusions are then drawn based on current and other study findings. Limitations of this study are noted. Based on the conclusions, recommendations are then suggested.

4.1 DISCUSSION

This research study aimed to explore experiences of female caregivers who attended the Let's Talk Programme to gauge acceptability and potential scale up of family-centred SBCC Programmes to prevent HIV among adolescent girls in South Africa. Study findings suggest that the Let's Talk Programme equipped caregivers with life and parenting skills that brought positive psychosocial benefits to themselves and to adolescents under their care. As a result of the expansion in their life and parenting skills sets, caregivers were better able to effectively communicate with their adolescents regarding HIV prevention issues. Evidence from the study therefore suggests that Lets' Talk is an acceptable and feasible family-centred intervention that can be expanded to other settings with similar characteristics to Soweto.

The positive experiences caregivers shared about Let's Talk are similar to other family-centred programmes. Let's Talk had transformative effects on the caregivers interviewed analogous to findings from interventions like Sinovuyo Families Matter Programme (11, 36, 39), Kgolo Mmogo (16, 38), and the Botsha Bophelo (21, 24) Programme interventions. By attending these interventions, caregivers worked on their socio-emotional challenges resulting in better psychosocial adjustment resulting in improved interpersonal, familial and social relationships. Such improved relationships allowed caregivers to access wider social support, learn parenting skills, and increased their confidence and self-efficacy regarding SRH and HIV and AIDS prevention issues. The next sections expand on specific SBCC elements of Let's Talk showing their relatability to other family-centered options as well as the broader range of HIV-prevention interventions.

4.1.1 Caregivers faced various challenges before attending Let's Talk Programme

Study findings have shown that the majority of caregivers faced significant socio-emotional challenges that negatively affected their emotional adjustment as well as their

thoughts and actions. Most caregivers reported being trapped in vicious circles of despondency and helplessness.

The socio-emotional challenges described by the caregivers in this study are consistent with those found in similar studies of caregivers living in HIV endemic and low resource communities (16, 25, 39). As in this study, other studies had comparable findings including reports of emotional ordeals emanating from caregivers' difficult upbringing, especially in the absence of mothers (28, 30). The absence of mothers seemed to open up other channels of abuse including traumatic sexual abuse leaving the affected caregivers with deep seated and unresolved anger, also found in other studies (28, 30). Other emotional difficulties faced by caregivers, such as ongoing family challenges like death, allegations of betrayal and infidelity in spousal relationships, to the detriment of their relational and parenting abilities have also been noted in the literature on HIV positive caregivers in low-income South African families (11, 16). This study made the novel finding that infidelity is being mentioned in a family-based intervention context and demonstrates that it influences parenting regardless of HIV status.

The way caregivers' affective and emotional states can result in negative parenting behaviours, like shouting and physical punishment, was another finding that has support in the literature. The unresolved emotional challenges faced by caregivers directly and indirectly affected their parenting styles (25, 36). The link between physically punishing children and unresolved deep seated anger from traumatic childhood events has been reported before (25, 41). Other studies also reported caregivers' aggressive communication styles marked by shouting and threats suggestive of unresolved chronic emotional challenges (38, 42), suggesting that this sample of caregivers was not unique.

These findings clearly showed the efficacy and soundness of the CBT theoretical framework that elicited the socio-emotional challenges reported by the caregivers (55, 57, 58). This is because CBT allowed heightened self-awareness through deep emotional reflection and introspection (55). This process allowed the caregivers to divulge the socio-emotional challenges they faced, leading caregivers and facilitators to confront and change depressive cognitive distortions and behaviours. As a result, caregivers started to regulate their emotions better, leading to more objective problem solving and coping strategies.

Co-existing challenges emerged as a particular challenge for caregivers. This has also been highlighted in other studies that for instance noted how teenage pregnancy in high density South African townships negatively affected school work as also reported in this study (12, 13). Other studies on adolescents' sexual behaviours in Soweto, South Africa, also identified links between substance abuse and school absenteeism and risky sexual behaviours (12, 24) mirroring findings in this study. This demonstrates that like their caregivers, adolescents also found themselves in vicious cycles of difficult behaviours that resulted from and led to other challenges, as other studies in Soweto found (12, 24).

Due to emotional maladjustment, poor parenting socialization and lack of skills, caregivers in this study could not effectively mitigate adolescents' problematic behaviours as supported by literature (25, 26). Rather, the caregivers often resorted to aggressive parenting behaviours leading to chronic antagonistic relations between caregivers and adolescents before attending the Let's Talk Programme. CBT embedded in the Let's Talk Programme interrupted these cycles of socio-emotional challenges faced by caregivers wherein negative emotions, thoughts and actions bound and reinforced each other.

4.1.2 Social support for caregivers was boosted during Let's Talk

Study results showed that social support options available to caregivers increased and improved during and after attending the Let's Talk Programme, corresponding to other study findings related to the same Programmes in South Africa and Kenya (9, 25). Due to the interpersonal nature of Let's Talk, most caregivers reported that they only started sharing their deep seated socio-emotional challenges and traumas in the safe environment provided by Let's Talk sessions. Findings on increased social support in this study are consonant with other studies that have shown that social group interventions boost social and emotional support for increased self-esteem, problem solving and more help seeking behaviours (5, 25, 59).

Let's Talk sessions were run in the form of closed groups. This, like the other studies, provided a safe interactive space conducive for meaningful mutually supportive dialogue among those facing similar challenges (5, 25, 59). The maintenance of the social support beyond Let's Talk group sessions is another feature identified in other studies in similar

environments (11, 21). This reinforces the claim that such interventions are capable of building internal momentum to sustain positive outcomes beyond project closure.

Like other studies (60, 61), this study has noted the organic formation and expansion of social support for caregivers facing similar challenges using the Short Message Service (SMS) platform and instant messaging services like WhatsApp. Social support available to caregivers outlived the formal Let's Talk sessions and continued on social media platforms like WhatsApp. Like the other studies in literature (60, 61) have observed, social media, SMS and instant messaging services like WhatsApp provide platforms for wider layering of social support. Social media platforms can therefore be strategically used to entrench and sustain desirable intervention outcomes (social support and caregivers' mental health) beyond formal group contact sessions.

4.1.3 Caregivers acquired parenting skills during Let's Talk Programme

The study findings show that caregivers acquired important parenting skills from the Let's Talk Programme. This finding is comparable to results from other studies (5, 23) that parenting skills specifically communication, listening and disciplining can be transferred through interventions. This was possible because Lets' Talk used a deductive educational approach whereby facilitators shared general parenting principles that caregivers applied in their parenting duties in the form of role plays (55).

Role plays during group sessions allowed facilitators to model desirable parenting behaviours for observation by caregivers. Caregivers also had chances to practice the desirable behaviours during role plays and got feedback from facilitators and caregivers. Role plays therefore provided valuable platforms for modelling and peer and social learning of desirable parenting behaviours. Caregivers were then given homework exercises focusing on particular parenting skills like active listening to practice and apply with their adolescents at home (55). Consequently, as in similar interventions (14, 39) caregivers improved their parenting skills including communication and listening as well as discipline techniques.

In line with Social Cognitive Theory (SCT)'s assertion that aspects of an individual's knowledge and behaviours can be impacted upon through observations in social interactions (38, 41), there is evidence that the Let's Talk Programme also successfully supplanted punitive parenting habits like shouting and hitting with more civil and

constructive engagements involving discussions and negotiations. This is because the Programme afforded caregivers opportunities to practice and receive constructive feedback to develop parenting skills and self-efficacy (55).

Constructive feedback to caregivers was complemented by numerous opportunities for self and peer evaluation through face-to-face group interactions in line with social comparison theory whereby people learn new skills and behaviours by comparing own behaviours against others. For instance as observed in other studies that used aspects of social comparison theory (6, 42, 62) the Let's Talk Programme provided a platform for the caregivers involved to evaluate the way they were parented vis-a-vis the way they were raising their children. When caregivers learnt desirable behaviours, routine self-affirmations embedded in the sessions helped caregivers to frame their parenting abilities more positively. Due to increased parenting knowledge, skills and competence, caregivers interviewed reported supervising and paying more attention to the socio-emotional needs of their adolescents more and better post the Let's Talk Programme.

Before, Let's Talk, most caregivers confessed that they were raising their children the way they were also raised because they knew no other viable option before the Programme. This demonstrates the power of socialisation (9, 25, 63) in the way the caregivers were parenting their children and adolescents. Findings in this study are consistent with other findings from literature (9, 42) that demonstrated that when presented with feasible parenting options, caregivers are malleable to adopt and effectively use the learned skills to counteract prior negative socialisation.

4.1.4 Caregiver-adolescent relationships improved during Let's Talk

Observations that interventions like Let's Talk can successfully improve caregivers-adolescent relationships are supported by literature (5, 14, 21). As noted in the Results chapter, caregivers faced numerous co-existing adolescent problematic behaviours before the Let's Talk Programme including stubbornness and risky sexual behaviours. This coincided with the time when the caregivers lacked the parenting skills to mitigate the challenging adolescent behaviours. By equipping caregivers with parenting skills and empowering adolescents with life skills (like communication and problem solving) Let's Talk

and similar interventions (5, 14, 21) supplanted often tumultuous caregiver-adolescent relationships with more civil and harmonious interactions.

The improved caregiver-adolescent relationships therefore give credence to the Let's Talk Programme's theory of change. Like similar focused interventions (33, 40), the Let's Talk theory of change anticipated that caregivers faced socio-emotional challenges that impeded their parenting capabilities (55). The Programme was therefore explicitly geared to provide caregivers with socio-emotional support to improve their mental health and psycho-social adjustments. As other studies in poor village settings in the Eastern Cape, South Africa and impoverished Jamaican townships (33, 40) improving caregivers' mental health and psycho-social adjustments tend to improve their parenting abilities and relationships with adolescents.

Although caregivers noted taboos related to talking about sex, which have been highlighted in previous studies (14, 28), the Let's Talk Programme helped overcome them in some instances. This is because Let's Talk, like previous family-centred interventions (14, 34, 46), increased caregivers and adolescents' knowledge and self-efficacy for deeper exploration of SRH topics despite cultural and traditional taboos that often hinder such discussions. As a result, caregivers and adolescents started openly engaging on topics about sex, contraceptives, HIV, AIDS, HTS, ART, positive living and disclosure of HIV positive status.

As in this study, it's been noted (14) that caregivers engaging adolescents on SRH topics shows that social norms or taboos about such discussions are in constant flux, with more caregivers disregarding them. This means that caregivers in this and other studies (14, 39) are challenging proscriptive cultural taboos for the benefit of their adolescents' health. This is significant in the context of high HIV incidence and prevalence in settings like Soweto (12, 24) where parental involvement has the potential protective effects against HIV infection (21, 24).

However, it has also been observed in this study that there still remains lingering reluctance by some caregivers to engage in sex, SRH, HIV and AIDS discussions or disclose their HIV positive status to their adolescents and children despite disclosure information and support provided during the Programme. This corresponds with other literature (11, 16) that confirmed fears of stigma and discrimination regarding HIV positive status still persist in

spite of social and behaviour change interventions to curtail the same. Over and above fears of stigma, it has been noted in this and another study (26) that some parents have genuine fear over their children's emotional safety therefore they decide to delay disclosure after testing the waters.

This shows that knowledge and information are necessary but not sufficient to overcome caregivers' fears (including stigma and emotional safety of own children) and anxieties around full maternal HIV positive status disclosure, thus entrenching secrecy within families (14). This is important to acknowledge because it highlights different stages caregivers are at in terms of adopting disclosure practices, according to Diffusion of Innovations (DOI) theory (64). According to the DOI theory, people fall within one of five adopter categories (innovators, early adopters, early majority, late majority and laggards) before fully adopting the desirable behaviour in question. Let's Talk therefore did well to have separate sessions with adolescents as this enabled them to get quality SRH information from somewhere, if not from parents.

The Let's Talk Programme builds participants' important life skills like self-confidence, self-efficacy and assertiveness to negotiate for and engage in safer sex behaviours. In particular Let's Talk helps participants in goal setting regarding life and career goals and SRH milestones like sexual debut (55). Parental role modelling and verbal persuasion were noted in this and other studies (21, 24) to boost HIV protective behaviours and improved health seeking behaviours (like testing for HIV and quitting smoking) leading to improved short and long term health outcomes for both caregivers and their adolescents.

4.1.5 Adolescents adopted positive behaviours after Let's Talk

Findings in this study suggest that caregivers' better parenting skills and improved caregiver-adolescent relationships had positive spill overs on adolescents' behaviours as other family-centred interventions recorded (21, 24). For instance, there were reports that formerly reclusive adolescents started making their own friends and adopted out-going behaviours. There is therefore evidence that Let's Talk equipped adolescents with new pro-social behaviours that enhanced their relationships with caregivers. This was possible because Let's Talk afforded adolescents opportunities for self and peer evaluation, behaviour modelling, social and peer learning of important skills including communication

and active listening as confirmed by other interventions (16, 38, 40, 42). Joint caregiver-adolescent task like building the tallest tower during group sessions got most caregivers and adolescents to kick start more meaningful relationships.

4.1.6 Caregivers had positive perceptions of the Let's Talk Programme

All caregivers interviewed had positive perceptions of the Let's Talk Programme. Dominant comments focused on the Programme's "eye-opening" and educational qualities. For these reasons most caregivers expressed that more caregivers and adolescents in settings like Soweto would benefit from the Programme. Many caregivers pointed out the Programme's potential to reduce teenage pregnancies and HIV infections among adolescents. This has been recorded in similar interventions like Sinovuyo, Botsha Bophelo and Stepping Stones (21, 39, 40).

Benefits mentioned for caregivers included better parenting skills and improved relationships with adolescents. Other family-centred interventions that employed educational and social learning approaches (9, 24) also pointed to improved parenting outcomes and confrontation of social norms and taboos (14) while still keeping to the bounds of cultural acceptability. The Let's Talk Programme therefore offers evidence that thorny social and health topics can be strategically and effectively challenged with minimal trade-offs and cultural discord.

4.2 LIMITATIONS

The study only covered a small geographic area of Soweto, hence the transferability of results beyond the study area must account for context. The cross sectional study design meant that participants were only interviewed at one specific point in time. As a result, the study could not ascertain the longevity of the positive experiences shared by the caregivers beyond the six months after attending the Let's Talk sessions. Interviewing participants on earlier challenges after they had already participated in the programme was a missed opportunity of collecting baseline data prior to intervention participation.

The PI was an employee of the organisation that implemented the Let's Talk Programme. The PI therefore had potential vested interest in the success of the Programme and so might have been biased to look for the positive experiences of the caregivers more

than the negative experiences. Being aware of the potential bias, the PI asked respondents to respond truthfully and worked closely with supervisors and another student to assess the rigour of data collection and analysis, throughout the course of the study.

Due to social desirability, the caregivers might have reported more on their positive experiences and downplayed the negative ones so that they could be viewed in a socially favourable light by the male interviewer (53). Purposively sampling caregivers with basic proficiency in English could have potentially biased the study findings. Interviewing participants in English potentially led to missing out on nuanced and richer caregiver experiences that would have been possible in their vernacular languages. English language proficiency could be a reflection of prior academic background and this could have impacted on family dynamics including parent – adolescent connectedness and communication styles. Therefore, academic background is a potential confounder in this study.

This study was conducted through in-depth interviews with female caregivers who attended the Let's Talk Programme with female adolescents in Soweto. This means that the experiences of the female adolescents were not directly captured in this study.

However, the study was not without strengths. The qualitative interviews with caregivers produced deep and rich important perspectives on issues that jointly affect them and their adolescents. Such topical perspectives include caregivers' challenges, communication with adolescents and adolescents' SRH in the context of high HIV prevalence characterising resource constrained settings like Soweto. The cross-sectional research design was also suitable because it allowed the student to interview the caregivers at one point in time.

4.3 CONCLUSIONS

This study explored the experiences of female caregivers who attended a joint HIV prevention Programme (Let's Talk) with adolescent girls in Soweto. The findings show that all the caregivers interviewed had positive experiences from attending the Let's Talk Programme. By virtue of attending the Programme most caregivers reported improved problem solving and emotional coping skills. This is important because most caregivers reported facing various challenges and lacked the skills and support to cope with the challenges before attending the Programme. The Let's Talk Programme therefore helped to

expand the psychosocial and emotional support systems available to the caregivers. There is evidence that increased support available to caregivers boosted their mental health and psychosocial adjustment that in turn led to better parenting practices.

Study findings also clearly show that there was marked improvement in the nature and quality and of caregiver-adolescent relationships after both attended the Let's Talk Programme. Caregivers attributed the improvement to their use of parenting skills acquired from Let's Talk including communication, listening, and anger and stress management skills. New caregiver-adolescent relationships were marked increased communication by both parties who also now reached out to each other more. Research results show evidence of mutual trust and respect between caregivers and adolescents post the Let's Talk Programme.

Significantly, the improved caregiver-adolescent relationships allowed for deeper exploration of SRH topics including HIV and AIDS among both parties. As other studies have shown, this is suggestive of the protective effects of warm caregiver-adolescent relationships against SRH risky behaviours. In this regard caregivers highlighted that some of the adolescents disclosed to them that they were already using condoms during sexual encounters. There is also evidence from the study that some of the caregivers stopped harmful behaviours like smoking. Let's Talk presented opportunities to both caregivers and adolescents to profile their risky healthy behaviours and replace them with healthier and desirable alternatives.

Positive perceptions of the Let's Talk Programme shared by caregivers provide robust evidence of acceptability to participants, effective implementation, and efficacy in facilitating desired outcomes (e.g., behaviour, attitudes and quality of relationships). Let's Talk was provided key insights regarding the socio-emotional challenges that often impede optimal parenting by caregivers. It is also clear from this study that positive relationships between caregivers and adolescents can be nurtured and sustained by bringing both caregivers and adolescents to literally talk about and resolve their mutual challenges. Consequently, more cordial relationships between caregivers and adolescents lead to more uptake of SRH services by adolescents thus boosting HIV prevention outcomes. The insights

from this study can therefore be leveraged to scale up the Let's Talk Programme in South Africa as one of the novel SBCC vehicles to prevent HIV infection among adolescent girls.

4.4 RECOMMENDATIONS

4.4.1 Programme recommendations

The Let's Talk programme needs to be up scaled in its current format within Soweto, as argued by most of the caregivers interviewed in this study. Let's Talk was designed to accommodate both male and female caregivers. In this study only female caregivers were interviewed because they participated in the DREAMS programme that focused exclusively on adolescent girls. Male caregivers can therefore be included in Let's Talk where there are no programmatic restrictions e.g. DREAMS. In such cases informed consent of both female and male caregivers will need to be sought at the outset.

The Programme can also be implemented in other poorly resourced and high HIV endemic settings like Soweto for both male and female adolescents in those areas to enjoy similar HIV protective benefits outlined above. The facilitators will need to make sure that the female and male adolescents concerned are more or less of the same maturity.

Study findings have shown that social media platforms can be strategically used to entrench and sustain desirable intervention outcomes (social support and caregivers' mental health) beyond formal group contact sessions. There is therefore a need to make social media interactions integral components of family-centred interventions like Let's Talk.

4.4.2 Recommendations for further research

For more robust evidence on the efficacy of Let's Talk in preventing HIV among adolescent girls, rigorous testing using randomized controlled trials (RCTs) are strongly recommended. It is therefore highly recommended that further research be conducted exclusively focusing on the first-hand experiences of the female adolescents to provide insightful effects the Let's Talk Programme had on them. A study that would test effectiveness with both caregivers and adolescent girls will also add to the body of empirical evidence regarding family-based HIV prevention programmes among adolescents.

4.5 IMPLICATIONS FOR POLICY AND PUBLIC HEALTH PRACTICE

4.5.1 Policy implications

Based on the empirical evidence from this and similar interventions, more resources (financial, human, technical assistance and capacity development) need to be invested in SBCC interventions like Let's Talk by government departments including DSD and the South Africa National AIDS Council (SANAC).

4.5.2 Public health implications

Transformative effects experienced by caregivers and adolescents in this study give credence to the value of combining caregivers and adolescents in joint HIV prevention interventions. Findings in this study have therefore reinforced that family focused interventions have more impact than working with adolescents and caregivers in isolation. Results in this study have demonstrated accrual of synergistic benefits when HIV prevention interventions consider the importance of family and household ecological circumstances. Such considerations as shown in this study result in more holistic and comprehensive HIV prevention SBCC interventions.

REFERENCES

1. Perrino T, González-Soldevilla A, Pantin H, Szapocznik J. The role of families in adolescent HIV prevention: A review. Clinical child and family psychology review. 2000;3(2):81-96.

2. Joint United Nations Programme on HIV/AIDS. The Gap Report. Geneva: UNAIDS. 2014.

3. Nabukalu D, Klipstein-Grobusch K, Herbst K, Newell M-L. Mortality in women of reproductive age in rural South Africa. Global health action. 2013;6.

4. Kennedy EC, Bulu S, Harris J, Humphreys D, Malverus J, Gray NJ. "These issues aren't talked about at home": a qualitative study of the sexual and reproductive health information preferences of adolescents in Vanuatu. BMC Public Health. 2014; 20(3).

5. Phetla G, Busza J, Hargreaves JR, Pronyk PM, Kim JC, Morison LA, et al. "They have opened our mouths": increasing women's skills and motivation for sexual communication with young people in rural South Africa. AIDS Education & Prevention. 2008;20(6):504-18.

6. Fleischman J, Peck K. Addressing HIV risk in adolescent girls and young women. CSIS Global Health Policy Center. 2015.

7. Cluver LD, Hodes RJ, Sherr L, Orkin FM, Meinck F, Lim Ah Ken P, et al. Social protection: potential for improving HIV outcomes among adolescents. J Int AIDS Soc. 2015;18(Suppl 6):20299.

8. Cluver LD, Orkin FM, Meinck F, Boyes ME, Sherr L. Structural drivers and social protection: mechanisms of HIV risk and HIV prevention for South African adolescents. Journal of the International AIDS Society. 2016;19(1).

9. Thurman T, Kidman R, Carton T, Chiroro P. Psychological and behavioral interventions to reduce HIV risk: evidence from a randomized control trial among orphaned and vulnerable adolescents in South Africa. AIDS care. 2016;28(sup1):8-15.

10. Cluver LD, Lachman JM, Ward CL, Gardner F, Peterson T, Hutchings JM, et al. Development of a Parenting Support Program to Prevent Abuse of Adolescents in South Africa

Findings From a Pilot Pre-Post Study. Research on social work practice. 2016:1049731516628647.

11. Lachman JM, Sherr LT, Cluver L, Ward CL, Hutchings J, Gardner F. Integrating evidence and context to develop a parenting program for low-income families in South Africa. Journal of Child and Family Studies. 2016;25(7):2337-52.

12. Dietrich J, Khunwane M, Laher F, de Bruyn G, Sikkema KJ, Gray G. "Group sex" parties and other risk patterns: A qualitative study about the perceptions of sexual behaviours and attitudes of adolescents in Soweto, South Africa. Vulnerable children and youth studies. 2011;6(3):244-54.

13. Dietrich J, Sikkema K, Otwombe KN, Sanchez A, Nkala B, de Bruyn G, et al. Multiple levels of influence in predicting sexual activity and condom use among adolescents in Soweto, Johannesburg, South Africa. Journal of HIV/AIDS & social services. 2013;12(3-4):404-23.

14. Kuo C, Atujuna M, Mathews C, Stein DJ, Hoare J, Beardslee W, et al. Developing family interventions for adolescent HIV prevention in South Africa. AIDS care. 2016;28(sup1):106-10.

15. SANAC. National Strategic Plan for HIV, TB and STIs 2017-2022. Pretoria2017.

16. Eloff I, Finestone M, Forsyth B. HIV/AIDS infected mothers' experience of a group intervention to enhance their children's behavior. South African Journal of Education. 2016;36(2).

17. Cluver LD, Orkin FM, Meinck F, Boyes ME, Sherr L. Structural drivers and social protection: mechanisms of HIV risk and HIV prevention for South African adolescents. Journal of the International AIDS Society. 2016;19(1):20646.

18. Dellar RC, Dlamini S, Karim QA. Adolescent girls and young women: key populations for HIV epidemic control. Journal of the International AIDS Society. 2015;18:19408.

19. Pettifor AE, Levandowski BA, MacPhail C, Padian NS, Cohen MS, Rees HV. Keep them in school: the importance of education as a protective factor against HIV infection among young South African women. International journal of epidemiology. 2008;37(6):1266-73.

20. Madiba S, Mokgatle M. Parents support implementation of HIV testing and counseling at school: cross-sectional study with parents of adolescent attending high school in Gauteng and North West Provinces, South Africa. AIDS research and treatment. 2016;2016.

21. Miller CL, Nkala B, Closson K, Chia J, Cui Z, Palmer A, et al. The Botsha Bophelo Adolescent Health Study: A profile of adolescents in Soweto, South Africa. Southern African journal of HIV medicine. 2017;18(1):1-10.

22. Crosby RA, Hanson A, Rager K. The protective value of parental sex education: A clinic-based exploratory study of adolescent females. Journal of Pediatric and Adolescent Gynecology. 2009;22(3):189-92.

23. Aarø LE, Mathews C, Kaaya S, Katahoire AR, Onya H, Abraham C, et al. Promoting sexual and reproductive health among adolescents in southern and eastern Africa (PREPARE): project design and conceptual framework. BMC Public Health. 2014;14(1):54.

24. Soon CN, Kaida A, Nkala B, Dietrich J, Cescon A, Gray G, et al. Adolescent experiences of HIV and sexual health communication with parents and caregivers in Soweto, South Africa. SAHARA-J:. 2013;10(3-4):163-9.

25. Thurman TR, Jarabi B, Rice J. Caring for the caregiver: evaluation of support groups for guardians of orphans and vulnerable children in Kenya. AIDS care. 2012;24(7):811-9.

26. Toska E, Gittings L, Hodes R, Cluver LD, Govender K, Chademana KE, et al. Resourcing resilience: social protection for HIV prevention amongst children and adolescents in Eastern and Southern Africa. African Journal of AIDS Research. 2016;15(2):123-40.

27. Hlabyago KE, Ogunbanjo GA. The experiences of family caregivers concerning their care of HIV/AIDS orphans. South African Family Practice. 2009;51(6):506-11.

28. Rochat TJ, Mkwanazi N, Bland R. Maternal HIV disclosure to HIV-uninfected children in rural South Africa: a pilot study of a family-based intervention. BMC Public Health. 2013;13(1):147.

29. Rotheram-Borus MJ, Lee MB, Gwadz M, Draimin B. An intervention for parents with AIDS and their adolescent children. American Journal of Public Health. 2001;91(8):1294-302.

30. Rotheram-Borus MJ, Lester P, Song J, Lin Y-Y, Leonard NR, Beckwith L, et al. Intergenerational benefits of family-based HIV interventions. Journal of Consulting and Clinical Psychology. 2006;74(3):622.

31. Hutchinson MK, Wood EB. Reconceptualizing adolescent sexual risk in a parent-based expansion of the theory of planned behavior. Journal of Nursing Scholarship. 2007;39(2):141-6.

32. Kidman R, Thurman TR. Caregiver burden among adults caring for orphaned children in rural South Africa. Vulnerable children and youth studies. 2014;9(3):234-46.

33. Katherine Hutchinson M, Kahwa E, Waldron N, Hepburn Brown C, Hamilton PI, Hewitt HH, et al. Jamaican mothers' influences of adolescent girls' sexual beliefs and behaviors. Journal of Nursing Scholarship. 2012;44(1):27-35.

34. Kennedy EC, Bulu S, Harris J, Humphreys D, Malverus J, Gray NJ. "These issues aren't talked about at home": a qualitative study of the sexual and reproductive health information preferences of adolescents in Vanuatu. BMC public health. 2014;14(1):770.

35. Löfgren J, Byamugisha J, Tillgren P, Rubenson B. The perspectives of in-school youths in Kampala, Uganda, on the role of parents in HIV prevention. African Journal of AIDS Research. 2009;8(2):193-200.

36. Shai NJ, Sikweyiya Y. Programmes for change: Addressing sexual and intimate partner violence in South Africa. South African Crime Quarterly. 2015;51:31-41.

37. Sikkema KJ, Dennis AC, Watt MH, Choi KW, Yemeke TT, Joska JA. Improving mental health among people living with HIV: a review of intervention trials in low-and middle-income countries. Global Mental Health. 2015;2.

38. Visser M, Finestone M, Sikkema K, Boeving-Allen A, Ferreira R, Eloff I, et al. Development and piloting of a mother and child intervention to promote resilience in young children of HIV-infected mothers in South Africa. Evaluation and program planning. 2012;35(4):491-500.

39. Cluver LD, Lachman JM, Ward CL, Gardner F, Peterson T, Hutchings JM, et al. Development of a parenting support program to prevent abuse of adolescents in South Africa: Findings from a pilot pre-post study. Research on social work practice. 2017;27(7):758-66.

40. Jewkes R, Wood K, Duvvury N. 'I woke up after I joined Stepping Stones': meanings of an HIV behavioural intervention in rural South African young people's lives. Health education research. 2010;25(6):1074-84.

41. McBride D, Freier M, Hopkins G, Babikian T, Richardson L, Helm H, et al. Quality of parent–child relationship and adolescent HIV risk behaviour in St. Maarten. AIDS care. 2005;17(sup1):45-54.

42. Wang B, Stanton B, Deveaux L, Li X, Koci V, Lunn S. The impact of parent involvement in an effective adolescent risk reduction intervention on sexual risk communication and adolescent outcomes. AIDS Education and Prevention. 2014;26(6):500-20.

43. Murray MT, Wessels IM. Parenting for Lifelong Health: from South Africa to other low- and middle-income countries. Responsive parenting: a strategy to prevent violence. 2014:49.

44. Ward C, Makusha T, Bray R. Parenting, poverty and young people in South Africa: What are the connections? ChildGauge. 2015:69.

45. Stanton B, Wang B, Deveaux L, Lunn S, Rolle G, Li X, et al. Assessing the effects of a complementary parent intervention and prior exposure to a preadolescent program of HIV risk reduction for mid-adolescents. American journal of public health. 2015;105(3):575-83.

46. Winskell K, Beres LK, Hill E, Mbakwem BC, Obyerodhyambo O. Making sense of abstinence: social representations in young Africans' HIV-related narratives from six countries. Culture, health & sexuality. 2011;13(8):945-59.

47. Dittus P, Miller KS, Kotchick BA, Forehand R. Why parents matter!: The conceptual basis for a community-based HIV prevention program for the parents of African American youth. Journal of Child and Family Studies. 2004;13(1):5-20.

48. Sherr L, Cluver LD, Betancourt TS, Kellerman SE, Richter LM, Desmond C. Evidence of impact: health, psychological and social effects of adult HIV on children. Aids. 2014;28:S251-S9.

49. Ebersöhn L, Eloff I, Finestone M, Van Dullemen I, Sikkema K, Forsyth B. Drawing on resilience: piloting the utility of the Kinetic Family Drawing to measure resilience in children of HIV-positive mothers. South African Journal of Education. 2012;32(4):331-48.

50. Eloff I, Finestone M, Forsyth B. HIV/AIDS infected mothers' experience of a group intervention to enhance their children's behavior. South African Journal of Education. 2016;36(2):01-10.

51. Desmond C, Bruce F, Tomlinson M, Marlow MB, Aber JL, Ouifki R, et al. Modelling the long-term impacts on affected children of adult HIV: benefits, challenges and a possible approach. AIDS. 2014;28:S269-S75.

52. Bryman A. Social research methods: Oxford university press; 2015.

53. De Vos A, Delport C, Fouché C, Strydom H. Research at grass roots: A primer for the social science and human professions. Van Schaik Publishers; 2011.

54. Joubert G, Ehrlich R, Katzenellenbogen J, Abdool Karim S. Epidemiology: a research manual for South Africa. Cape TownSouth Africa: Oxford University Press Southern Africa. 2007.

55. Thurman TR. Let's Talk programme for caregivers and adolescents: Implementation guide. 2016.

56. Thurman T. Let's talk programme for caregivers and adolescents: Implementation guide. 2016.

57. Bandura A. Social cognitive theory and exercise of control over HIV infection. Preventing AIDS: Springer; 1994. p. 25-59.

58. Glanz K, Rimer BK, Viswanath K. Health behavior and health education: theory, research, and practice: John Wiley & Sons; 2008.

59. Muhwezi WW, Katahoire AR, Banura C, Mugooda H, Kwesiga D, Bastien S, et al. Perceptions and experiences of adolescents, parents and school administrators regarding adolescent-parent communication on sexual and reproductive health issues in urban and rural Uganda. Reproductive health. 2015;12(1):110.

60. Moorhead SA, Hazlett DE, Harrison L, Carroll JK, Irwin A, Hoving C. A new dimension of health care: systematic review of the uses, benefits, and limitations of social media for health communication. Journal of medical Internet research. 2013;15(4).

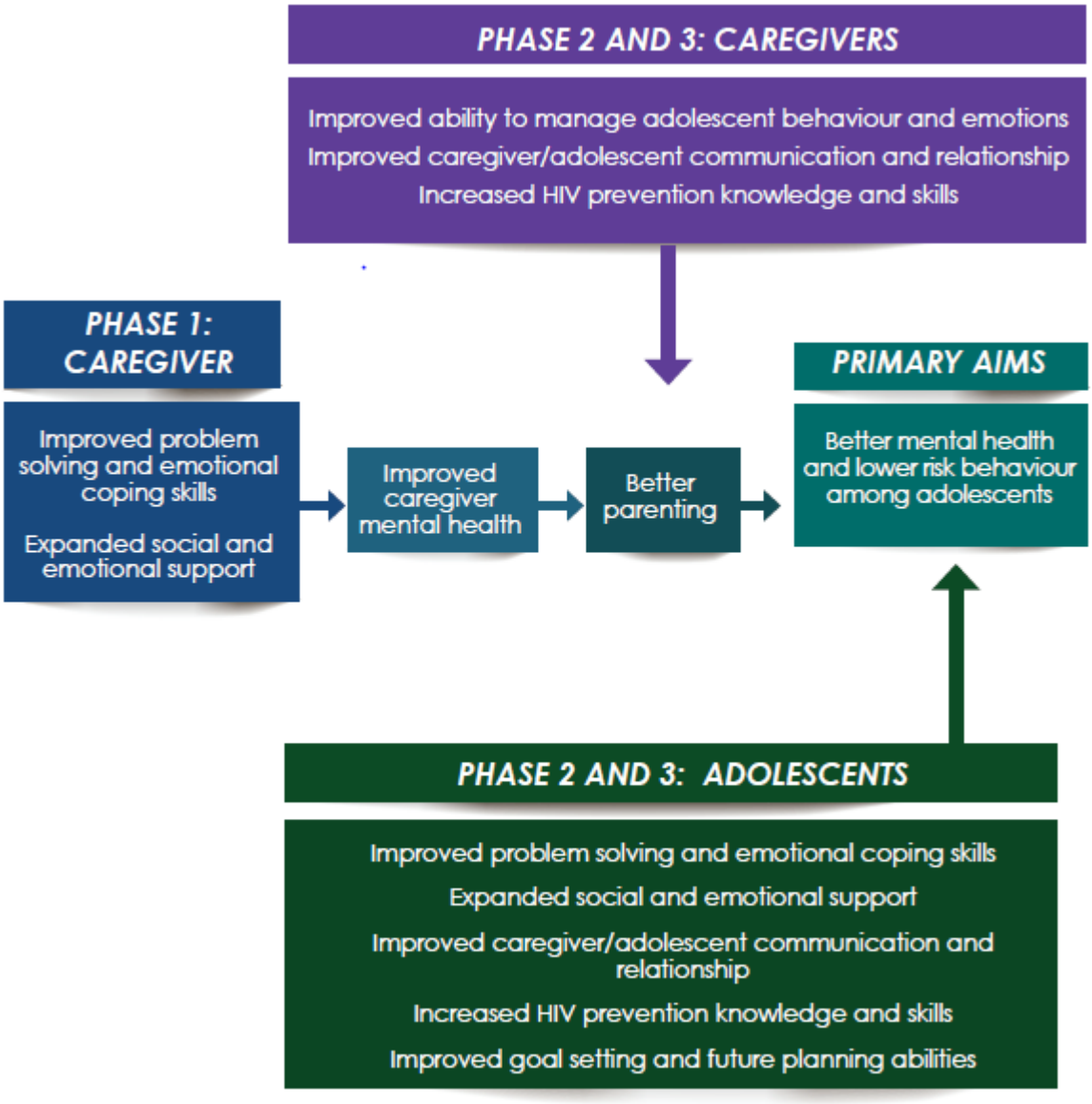
61. Osunyomi BD, Grobbelaar SSS. Integrating eHealth in HIV/AIDS intervention programmes in South Africa. South African Journal of Information Management. 2015;17(1):1-10.

62. Suls J, Wheeler L. Handbook of social comparison: Theory and research: Springer Science & Business Media; 2013.

63. Aluja A, del Barrio V, García LF. Relationships between adolescents' memory of parental rearing styles, social values and socialisation behavior traits. Personality and Individual Differences. 2005;39(5):903-12.

64. Rogers EM. Diffusion of preventive innovations. Addictive behaviors. 2002;27(6):989-93.

APPENDIX 1A: SCHEMATIC PRESENTATION OF LET'S TALK'S THEORY OF CHANGE



APPENDIX 1B: LET'S TALK SESSION OUTLINE

Session	**Caregiver Sessions**	**Adolescent Sessions**
Phase 1: Caregivers Matter		
1	Taking care of myself	*No Session for Adolescents*
2	Emotional awareness	
3	Coping with sadness	
4	Coping with anger	
Phase 2: Adolescents Matter		
1	Raising an adolescent	My strengths and goals
2	Effective communication	Effective communication
3	Helping adolescents cope with difficult emotions	Emotional awareness
4	Behaviour management with adolescents	Coping with sadness
5	*No Session for Caregivers*	Coping with anger
6 (JOINT)	Families working together	
7 (JOINT)	Positive family relationships	
Phase 3: Protecting the Future		
8	Adolescent risk taking	Sexual relationships
9	Communicating with adolescents about relationships and sexual health	Communicating about sex
10	Understanding HIV	HIV and STIs- Fact and fiction
11	Preventing and responding to crises	Condom use
12 (JOINT)	Future planning	
13 (JOINT)	Graduation and looking ahead	

APPENDIX 2: PERMISSION LETTER FROM HIVSA TO CONDUCT RESEARCH



HIV SA (NPC)

Omni Park, Block 3, 2nd Floor, 66 Sailor Malan Dr, Aeroton
PO Box 3869, Southgate, Johannesburg, 2082
TEL: +27 11 494 1900, Fax: +27 11 494 2635, Web: www.hivsa.com
Company Registration Number: 2002/006774/08
PBO Number: 930016997, NPO Number: 141-568

29 June 2017

HREC Medical
School of Public Health
University of the Witwatersrand (Education Campus)
27 St Andrews Road
Park town 2193

RE: PERMISSION FOR SABASTAIN GUNDA TO CONDUCT RESEARCH AT OUR ORGANISATION

Dear Members of HREC

On behalf of HIVSA, I am writing to formally indicate our awareness of the research proposed by Sabastain Gunda, a masters` student at Wits School of Public Health. We are aware that Sabastain Gunda intends to conduct his research by conducting in-depth interviews with twelve caregivers at four community based organisations that implemented the Let`s Talk Programme.

As Community Systems Strengthening Director, I am responsible for overseeing all Programmatic Monitoring; Evaluation; Research and Learning (MERL) at HIVSA and I am convinced that Sabastain Gunda`s research entitled, “Experiences of female caregivers who attended a joint HIV prevention Programme (Let’s Talk) with adolescent girls in Soweto” will contribute significant insights to HIVSA’s MERL repository. I hereby grant Sabastain Gunda permission to conduct his/her research at our organization.

If you have any questions or concerns, please feel free to contact my office on 011 494 1900 or naidooy@hivsa.com

Sincerely,

Yashmita Naidoo

Director – Community Systems Strengthening

APPENDIX 3: IN-DEPTH INTERVIEW GUIDE

Caregiver Participant ID# |___|___

Date of Interview: _____

Location: _____

Interviewer Name: Sabastain Gunda

Section A: Caregiver Demographic details

1. Please tell me your age…….

2. What is the highest level of education you have completed?

Primary	
Secondary	
ABET	
Tertiary	

3. How many Adolescent Girls (AGs) do you have under your care? ……..
4. What are their ages?

AG 1	
AG 2	
AG 3	
AG 4	

5. What is your relationship with the AGs under your care? (Please note that one caregiver might be related differently to any number of AGs under her care)

AGs	**Relationship with caregiver**
AG 1	
AG 2	
AG 3	
AG 4	

(If the caregiver is not the biological mother of the adolescent girl(s)' concerned, probe if she has or had biological children of her own)

Section B: In-depth questions

6. **How did you experience the Let's Talk Programme?**

   (First allow the caregiver to give open ended responses).

   When necessary probe for:

   - Topics that they recall being covered
   - Skills that they learned, e.g. problem solving, emotional coping skills
   - Support they received (social, emotional, instrumental, informational)

……

……

……

6. How have you experienced parenting your adolescent girl(s) before, during and after attending the Let's Talk Programme sessions?

(First allow the caregiver to give open ended responses).

When necessary probe for:

- Caregiver' management of own emotions in the parenting relationship
- Caregiver' management of behaviour in the parenting relationship
- Caregiver's management of adolescent's behaviour
- Caregiver's management of adolescent's emotions
- Communication dynamics between caregiver and adolescent(s)
- Adolescent girl(s)' problem solving skills
- Adolescent girl(s)'s emotional coping skills
- Adolescent girl(s)' expanded social support
- Adolescent girl (s)' expanded emotional support

……

……

……

7. What have been your experiences in responding to or addressing issues of sex with your adolescent girl(s) before, during and after attending the Programme?

(First allow the caregiver to give open ended responses).

When necessary probe for:

- Caregiver's HIV prevention knowledge and skills
- Adolescent girl(s)'s HIV prevention knowledge and skills
- Content and depth of discussions on Sexual and Reproductive Health
- Content and depth of discussions on HIV AND AIDS
- Responding to actual sexual risk behaviour that has happened

……

……

……

8. What were your experiences regarding the overall roll out of the Let's Talk Programme?

(First allow the caregiver to give open ended responses)

When necessary probe for:

- Mode of delivery
- Competence of the mentors
- Venue suitability
- Time and length of the sessions
- Quality of the manuals
- Thoughts on refreshments served

……

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.....

THANK YOU FOR YOUR TIME

APPENDIX 4 WITS HREC CLEARANCE CERTIFICATE

R14/49 Mr S Gunda

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M170860

NAME: (Principal Investigator)	Mr S Gunda
DEPARTMENT:	School of Public Health Medical School
PROJECT TITLE:	Experiences of female caregivers who attended a joint HIV prevention programme ("Let's Talk") with adolescent girls in Soweto
DATE CONSIDERED:	25/08/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Mlles S Nieuwoudt & TM Hlungwani
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	04/10/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially reviewed in **August** and will therefore be due in the month of **August** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

01/09/2017
Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX 5: INFORMATION SHEET FOR STUDY PARTICIPANTS

Study Title: Experiences of female caregivers who attended a joint HIV prevention Programme (Let's Talk) with adolescent girls in Soweto

Greeting and Introduction

Good day. My name is Sabastain Gunda and I would like to thank you for sparing your time to talk to me today. I am doing research on the experiences of female caregivers who attended a joint HIV prevention Programme (Let's Talk) with adolescent girls in Soweto. This research is a scientific process to get answers from caregivers like you regarding your experiences after attending the Let's Talk Programme with your adolescent daughter(s) or adolescent girl(s) in your care. In this study I would like to learn about your experiences of the Let's Talk Programme, specifically what you learned; your parenting experiences after attending the Programme and your experiences in engaging your adolescent girl(s)' on HIV prevention and sexuality since attending the Programme.

What is involved in the study?

You are only being asked to take part in a single in-depth interview. I may contact you in the future for a follow-up interview if I need to clarify anything, but that is very unlikely. You have been purposively selected to participate in the Programme because the Let's Talk Facilitators at the CBO reported that you may be comfortable to answer a number of open ended questions in English regarding your experiences after attending the Let's Talk Programme. You are one of twelve female caregivers who will (or already have) participated in the study. All the twelve study participants attended the Let's Talk Programme at one of the CBOs in Soweto supported by HIVSA – a local Non-Governmental Organisation.

Risks

There is a possibility of emotional reactions to some of the questions in this interview depending on your peculiar experiences. I have arranged for a Social Worker from HIVSA to offer debriefing and referral services should you need such services. You may contact me on 011 494 1900 and I will refer you to the Social Worker concerned.

Benefits

There is no material or financial benefits of participating in this study.

Participation is voluntary

Your participation in this study is voluntary and refusal to participate will involve no penalty or loss of benefits. You may withdraw from this study at any point in time without loss of benefits to which you may otherwise be entitled.

Reimbursements

You will be reimbursed R 100-00 to cover a meal and transport costs to and from the CBO for participating in this interview.

Confidentiality

All reasonable efforts will be made to keep your personal information confidential. I will use codes to identify participants and the participants' list and their code names will be stored separately in a locked cabinet file. Identifying details of the participants will be removed from all transcripts and the transcripts and electronic recordings will be locked away in a cabinet. Beyond myself, my research material, including the contents of this interview, may be inspected for quality control by Research Ethics Committee at Wits University. Finally, my research supervisors will have access to the full de-identified transcripts of the interviews for quality control purposes and analysis support.

Contact details of PI

For further information and/ or if you need to report any related adverse events arising from your participation in this study please contact me using the below details:

PI Name: Sabastain Gunda

Cell phone number: 078 9800 589

Work telephone: 011 494 1900

Email address: 471617@students.wits.ac.za or sabastaingunda@gmail.com

Contact person at faculty

For reporting of complaints/ problems and or commendations, please contact the person below:

Title & names: Professor Clement Penny

Work telephone: 011 717 2301

Email address: clement.penny@wits.ac.za

APPENDIX 6: CONSENT TO PARTICIPATE IN THE STUDY

I am inviting you to take part in an in-depth interview. For this research, I am collecting information that will help me understand your experiences during and after attending the Let's Talk Programme with your adolescent girl(s). I am going to collect the information by asking you a number of open ended questions, with no right or wrong answers. You have been selected for this interview because you successfully completed the Let's Talk Programme at this CBO.

As you will hear, the questions relate to your experiences with the adaptive/ coping strategies you learnt during the Programme; how you have experienced parenting your adolescent girl(s) before, during and after the Programme and your experiences in engaging your adolescent girl(s)' on HIV prevention and sexuality before, during and after attending the Programme. Completing this interview will take about one hour to an hour and a half. Your participation is voluntary and you may choose not to take part without being disadvantaged in any way.

If you agree to participate, you can choose to stop the interview at any time or to skip any questions you do not want to answer. If you have a question at any time, please feel free to ask me. Your name will not be used in any report, or given to anyone outside of the research process. I will make sure that the answers you provide will be kept confidential. In light of the information provided above, do you voluntarily consent or agree to participate in the study?

YES……. (Tick) **NO…**……. (Tick)

Participant Name and Surname …….

Participant signature (for consenting to participate in the study)

…….. Date…..

When participant says **YES**, proceed to request consent for audio recording (Appendix 3). If participant says **NO**, kindly thank her for her time and terminate the discussion courteously.

APPENDIX 7: CONSENT FOR AUDIO RECORDING

Thank you for agreeing to participate in this interview. I cannot possibly grasp all the information you are going to provide in this interview in memory and all the information you are going to provide will be critical for data analysis. For this reason, I am requesting permission to record this interview electronically. I will use the electronic recorder to transcribe the data in preparation for data analysis. There is a chance that some of the information you are going to provide in this interview will be quoted verbatim in the final report, but your identity will not be revealed whatsoever. Both the electronic recording and transcript will be kept in a lockable cabinet and will be destroyed two years after the study if published or six years after the study if it is not published. All identification details will be removed from the transcript to promote confidentiality.

Once again I bring it to your attention that absolute confidentiality cannot be guaranteed. I also once again bring it to your attention that my research material, including the contents of the electronic recording may be inspected for quality control by Human Research Ethics Committee at Wits University. Please feel free to ask me any questions that you may have. In light of the information above, do you give me consent to record the interview?

YES……. (Tick) **NO**…… (Tick)

If participant agrees to electronic recording, thank them and make them sign below. If participant objects to audio recording, thank them for their time and courteously terminate the discussion.

Participant Name and Surname …….

Participant signature (for consenting to audio recording)

…….. Date…..