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MATERNAL ATTITUDES OF BLACK WOMEN TOWARDS CONDOM USAGE BY THEIR TEENAGERS IN LIGHT OF HIV AND AIDS

By

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RESEARCH REPORT

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DECLARATION

I, Tintswalo Khosa declare that this research report is my own work. It is being submitted for the degree of Master of Clinical Psychology in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

T Khosa

Signature

12 Day of April 2005

Dedicated with love and gratitude to my husband and daughter.

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ABSTRACT

The purpose of the study was to investigate and understand the maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. The study was conducted with women from Tembisa who have teenage children. The attitude theory (Allport, 1935) was decided upon as the main theoretical basis. The reason for this decision was based on the simplicity of the theory as well as the fact that research into the applicability of the theory to Black South African's is needed.

The attitude theory identifies three categories of attitude namely, affect, cognition and conation (the behavioural intent). It is based on the assumption that to understand attitude, it is needed that all three aspects are considered and understood as it is difficult to isolate and manipulate one component independently without considering the other components. Based on this theory a semi-structure questionnaire was developed to ascertain the attitudes of the mothers. The questionnaire focused on three areas namely, the first cluster considered mother's attitudes towards sex among teenagers. The second cluster of questions explored the perceptions of mothers of condom usage by teenagers. The third cluster of questions focused on the general feelings of mothers towards sexual discussions with their teenagers as well as their beliefs about the impact of such discussions. The nature of the study can essentially be classified as empirical research involving qualitative data-collection methods and content analysis.

The sample consisted of ten Black women from Tembisa. All the women came from a similar background as they all live in Tembisa, a township outside of Johannesburg, South Africa. The following conclusions were made from the results of the study. Broadly speaking, it was found that although mothers were sensitive to the idea of their teenagers using condoms; they agreed that their use when engaging in sexual activities was the only way of ensuring protection from HIV and AIDS. It was also shown that there is a need for sexual education specifically focusing on condom usage with the mothers. In addition, it was found that mothers believed that the home and the school should play a dual role in educating teenagers about sex, HIV and AIDS as well

as condom usage. For the mothers, the initiation of discussions about sexuality was largely dependent on a range of factors. Firstly, it appeared that mothers who had their own fears about sex found it difficult to discuss the same with their teenagers. This resulted in discussions about sexuality, HIV and AIDS and condom usage arising "accidentally". Secondly, mothers displayed a fear of condoning sex that created a sense of tension between the plight of prevention and protection in comparison to promiscuity. This appeared to delay discussions with some of the mothers where deliberate considerations were made based on questioning the appropriate age for engaging teenagers in discussions.

Thirdly, there was ambivalence towards teenagers having condoms in their possession because of the implications attached. Fourthly, the response to teenagers having condoms was to have discussions with them. The question that is raised is whether the timing of the discussion could be late if conducted only when the teenager has condoms in their possession. Fifthly, mothers verbalized a willingness to discuss sexuality and condoms with their teenagers when teenagers asked about these issues. It appeared that the responsibility to discuss sex and condom usage was placed in the teenager's domain to facilitate discussions with the mother. Finally, mothers acknowledged that teenagers needed to feel comfortable before meaningful discussions could occur. There was recognition that knowledge is power such that mothers feared that such knowledge could lead their teenagers to becoming curious about sex. Several implications arising from these research findings and recommendations of both future research and policy makers in South Africa have been discussed.

KEY WORDS:

AIDS, HIV, Condom usage, Adolescent / Teenager, Mother and Maternal attitudes.

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CHAPTER 1

1.1 INTRODUCTION

Historically, South Africa has had a difficult and a turbulent past. This history might be relevant to the explosive spread of HIV and AIDS in the region (Berry, 2004). Briefly, apartheid was legislated into force in the 1950s, with the prohibition of mixed marriages, and the categorisation of separate areas in which different races could live (Berry, 2004). Sex between different ethnic groups was prohibited. In 1955 the African National Congress (ANC) demanded equal political rights, and in 1956 Nelson Mandela and other political activists were arrested for high treason (Berry, 2004). A period of increasing unrest followed, arising from the increasingly militarised discrimination growing in South Africa. It was during this chaotic time, in 1982, that the first cases of HIV were diagnosed in South Africa (Berry, 2004).

In 1990, Nelson Mandela was released from prison. On the 27 April 1994, South Africa had its first democratic election where all people from all races had a chance to vote for the first time (Khosa, 1999). As this process unfolded and later as the country began rebuilding itself, many feelings and expectations were realised for the first time. In the year 2004, the country celebrated a decade of democracy. However, South Africa as a liberated country is facing numerous challenges. One of the biggest challenges has been the prevalence and spread of HIV and AIDS. To this end, South Africa has been battling to find ways to manage the disease and to curb its spread. Prevention campaigns have been mainly targeted on using condoms as a form of protection (Berry, 2004).

More than 20 years ago, doctors identified the first cases of AIDS in San Francisco and New York. Now there are an estimated 42 million people living with HIV or AIDS worldwide, and more than 3 million die every year from AIDS-related illnesses (Samuels, 2003). Half of all new HIV infections in the United States occurred in people under 25 years of age, and thousands of U.S. teens become

infected with HIV each year. It is believed that the South African situation is similar if not worse to that of the United States (Fredrikson & Kanabus, 2004). As the medical community learns more about how the HI-virus works, they have been able to develop drugs to inhibit it. These drugs have been successful in slowing the progress of the disease, and people with the disease now live much longer. But there is still no cure for HIV and AIDS (Fredrikson & Kanabus, 2004).

Sub-Saharan Africa is the region of the world that is most affected by HIV & AIDS (Samuels, 2003). An estimated 25.4 million people are living with HIV and approximately 3.1 million new infections occurred in 2004 (Fredrikson & Kanabus, 2004). In just the past year the epidemic has claimed the lives of an estimated 2.3 million people in this region. Around 2 million children under 15 years old are living with HIV (Fredrikson & Kanabus, 2004).

The extent of the epidemic is only now becoming clear in many African countries, as increasing numbers of people with HIV are now becoming ill. In the absence of massively expanded prevention, treatment and care efforts, the AIDS death toll on the continent is expected to continue rising before peaking around the end of the decade (Fredrikson & Kanabus, 2004). This means that the worst of the epidemic's impact on these societies will be felt in the course of the next ten years and beyond. Its social and economic consequences are already being felt widely not only in health but in education, industry, agriculture, transport, human resources and the economy in general. The vast majority of people living with HIV/AIDS in Africa are between the ages of 15 and 49, in the prime of their working lives (Fredrikson & Kanabus, 2004).

There is growing evidence that prevention efforts can be effective, and this includes initiatives in some of the most heavily-affected countries. Overall a massive expansion in prevention efforts is needed, although there is not one proven way to prevent new infections. It was reported in 2001, that the overall provision of condoms to sub-Saharan Africa is only 4.6 per man per year (Berry, 2004). Another 1.9 billion condoms need to be provided if all countries are to have

the same amount of condoms (Fredrikson & Kanabus, 2004). One analyst found that twenty-four billion condoms per year are the minimum requirement to protect sexually active people against HIV/AIDS, while only six to nine billion are actually used (Gardner, 1999). Other experts estimated the need for an additional 1.9 billion condoms for all African countries to reach the level of provision of the six African countries that currently provide the highest level of condoms per man per year (Shelton & Johnston, 2001). However, although supplying condoms is important in the fight against HIV and AIDS, a long-term approach to preventing its spread by targeting the youth and teenagers is needed. There is a need to address the context in which HIV and AIDS exist. HIV-related stigma and discrimination remains an enormous barrier to effectively fighting the HIV and AIDS epidemic in Africa (Fredrikson & Kanabus, 2004). The fear and prejudice that lies at the core of the HIV/AIDS discrimination needs to be tackled at both community and national levels.

Tackling HIV/AIDS in South Africa is not an easy task. The long-term planning to slow the epidemic and reduce its impact needs to be highlighted. One of the best ways to tackle HIV/AIDS as stated above is prevention (Haupt & Kane, 2000). This also means enabling the more than 90% of Africans to protect themselves against infection. Therefore, more resources are needed to combat HIV/AIDS. However, if there are no resources to be used, innovative solutions need to be developed at lower cost. These efforts may be small but they will still play a role before sufficient resources are in place. Innovative and culturally-specific approaches are needed to deal with any aspect of HIV/AIDS (Fredikson & Kanabus, 2004). According to Berry (2004), 90% of people in South Africa know the dangers of HIV and how it is transmitted, yet infection rates continue to rise.

In August 2004, the Government of South Africa through the cabinet approved the Cabinet Operational Plan for Comprehensive Treatment and Care for HIV and AIDS (Berry, 2004). An important factor outlined in the plan is the fact that the there is a need to reinforce prevention campaigns so that the 40 million South

Africans not infected remain negative (Berry, 2004).

It is believed that one of the biggest challenges to combating HIV and AIDS is to address the social responses that accompany the epidemic namely, fear, denial, stigma and discrimination. This involves broadly addressing the attitudes that people have towards the disease. It is envisaged that the relationship between the mother and her children from an early stage is a very important one with regards to imparting values and norms. To this end, the mother's attitudes towards HIV and AIDS would be very important as it's believed that her attitudes would inform how she discusses the issue of HIV and AIDS, with her children. This study will seek to explore the attitudes of mothers towards condom usage by teenagers in light of HIV and AIDS. It is believed that the dynamics of mother-child communication about sexuality could be a useful resource to schools and university based sexuality programmes either by way of supporting such programmes or through actively becoming part of the extracurricular programmes (Berry, 2004).

1.2 PROBLEM STATEMENT

Broadly, the focus of the study is that, due to the escalation of the virus amongst teenagers (Webb, 1997) and the fact that most of the prevention campaigns are centred on using condoms as a form of protection (Aita, 2002), there is a need to explore maternal attitudes towards condoms. It is envisaged that the mother's attitude, due to her pivotal role in development, might be influential in terms of whether teenagers consider using condoms when engaging in sexual relationships. According to Koppers (1994) and Bostock (1982) parental opinion is central and crucial in shaping any adolescent contraceptive policy as programmes where parents were involved had relatively successful implementations. It is further believed that parents influence their children's behaviour through a socialization process, that their support in matters of sexuality and contraception will be valuable in trying to prevent the consequences of unprotected sex.

The study will explore the attitudes of mothers towards the use of condoms by their teenagers in light of HIV and AIDS. Secondly, this study will also explore the belief that, central to the issue of HIV and Aids, is a need for open discussions about sex, HIV and AIDS between teenagers and their parents, specifically the mothers. It is believed that where a sufficient bonding process has been successfully achieved between the mother and the child, discussions about sex later on in teenage years are feasible (Stevens-Long & Cobb, 1983)

According to the Mail & Guardian newspaper (2004), 50 613 502 people were infected with HIV worldwide by 5 February 2003. Furthermore, about 375 670 South Africans were expected to die from HIV/Aids in 2003, an increase of more than 30% from the estimated 219 660 Aids-related deaths in 2000, according to projections by the Human Sciences Research Council (HSRC) reported to Parliament's Social Development Committee (Samuels, 2003). As the numbers of HIV and AIDS infected people especially young people increase, the potential impact that the disease may have on the country cannot be ignored. Webb (1997) contends that the fastest rate of infection is amongst women between the ages of 15 – 34 years.

Numerous educational and awareness campaigns through the media and through the schooling system have been launched in an attempt to curb the disease (Webb, 1997). However, despite the numerous campaigns that have been launched, HIV infections are increasing at an alarming rate. According to Rotheram (2005), it is estimated that more than half of all new infections occur before the age of 25 years, acquired through unprotected sex. It is believed by AIDS researchers that infections occur because teenagers do not have the necessary knowledge of how they can protect themselves (Rotheram, 2005). Although teenagers may acknowledge their fears about HIV and AIDS, many do not perceive themselves at risk and thus lack accurate information about the circumstances that put them at risk (Rotheram, 2005). It is believed that, although educational campaigns through the media and schools are important, one way to

enhance their impact is to encourage HIV and AIDS discussions at a family level to sustain and reinforced the knowledge already received.

It is pivotal to note that there has been limited research conducted in this area. To this end, this study is exploratory in nature. Disparate bodies of research will be put together in trying to understand the different areas of concern central to condom usage by teenagers. Maternal attitudes towards the use of condoms become central to whether open discussions are facilitated at the family level.

1.3. PURPOSE AND CONTRIBUTION OF THIS STUDY

This study will attempt to explore maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. This will be done by utilizing data collected when mothers were interviewed. The interviews conducted were done by using a semi-structured questionnaire. The questionnaire was structured by focusing on the following areas:

- Attitudes of mothers towards sex by teenagers.
- The mother's perceptions of condom usage by teenagers.
- Attitudes towards open discussion about sex, condom usage and HIV and AIDS by mothers.
- What mothers would do on finding out that their teenagers were sexually active.

It is hoped by the researcher that the study will make some contribution to the fight against HIV and AIDS. The research could become the backbone or starting point to designing a programme to educate and sensitise mothers about condom usage that is currently advocated as an important form of protection against HIV and AIDS.

1.4 DEFINITION OF TERMINOLOGY

For clarification, certain concepts that are frequently used in this study are defined. The terms will be defined with respect to their relevance in the study:

1.4.1 AIDS

AIDS is caused by the HIV virus (human immunodeficiency virus). HIV destroys a type of defense cell in the body called a CD4 helper lymphocyte. Normally these lymphocytes are part of the body's immune system, the defense that fights infectious diseases. But as HIV destroys the lymphocytes, people with the virus begin to get serious infections that they normally would not, where they become immune deficient. The name for this condition is acquired immunodeficiency syndrome (AIDS) (Hubley, 2002).

1.4.2 HIV

This is a virus that is transmitted from an infected person to another person through blood, semen vaginal fluids, and breast milk. The virus is spread through high-risk behaviors including: unprotected oral, vaginal, or anal sexual intercourse, sharing needles, such as those used when inject drugs (Hubley, 2002).

1.4.3 Condom usage

The male condom is a sheath worn on the erect penis to prevent the exchange of body fluids during sexual intercourse (Weller and Davis, 2003). Condoms are used as a mechanism to protect sexually active people from contracting the HIV virus. A condom acts as a barrier or wall to keep blood, or semen, or vaginal fluids from passing from one person to the other during intercourse. They are

plastic like tubes that are inserted on the penis of the male shortly before sexual intercourse begins. Female condoms are also available where the female inserts the plastic like tube on her vagina to act as a barrier method of prevention (Weller & Davis 2003).

1.4.4 Maternal attitudes

Broadly, maternal attitudes in this study can be understood as the mother's blend of beliefs and values that would encompass her feelings about condom usage by teenagers in relation to her own values (Berry, 2004).

1.4.5 Adolescent / Teenager

Any boy or girl who is 10 to 19 years (van Coeverden, de Groot, Greathead, 1991).

1.4.6 Mother

A female of whatever marital status who has a child aged 10 to 21 years (only female parents with teenagers were included in this study).

1.5 OVERVIEW OF THE DISSERTATION

This chapter provides an introduction to the dissertation as well as a description of the problem. The aims and purpose of the study as well as the various concepts frequently used are outlined.

The second chapter covers the theoretical basis of the attitude theory. The application thereof is also discussed.

The third chapter deals with an overview of the South African context of HIV and

AIDS and it's implication in the wider socio-economic context in South Africa. This understanding provides a foundation for understanding teenage development and maternal attitudes towards condom usage.

In the fourth chapter the research methodology used in the study is discussed. The nature of the study, description of the research and the questionnaire used for the study will be outlined.

The research results will be discussed in Chapter Five. This is done by using the content analysis approach.

Chapter Six will be a discussion and the summary of the results as well as the recommendations arising from the study. Conclusions stemming from the discussion will also be made.

CHAPTER 2

ATTITUDE THEORY

2.1 INTRODUCTION

The aim of the attitude theory was to give insight into what encompassed a particular attitude. This involved understanding the implications of the attitudes for an example to what extent do attitudes inform behaviour. It is envisaged that in this way, people could find explanations, environmental and personal, relating to how a person reacts to a particular stimuli as well as the behaviour that could be expected from the person. In other words, what could be expected with regards to the person's feelings, overt and covert behaviour and reactions in a particular situation? This would also include characteristics leading to positive or negative reactions in that situation.

Most writers have tried to understand behaviour in different situations. Stevens (1980) explained that attitudes are certain kinds of overt and verbal behaviour from where we construct a picture of inner unobservable attitudes. Attitude theory was one of the major social psychology theories that have emerged since the early thirties. This study intended to use attitude theory as a basis on which to develop a theoretical model of attitudes to understand mother's attitudes towards the use of condoms by their teenagers. The discussion of the attitude theory started with a brief discussion of the background of the attitude theory. This was followed by the three working theories that make up the attitude theory namely, the one factor model of attitudes, the two components view of attitudes and lastly, the three components / tripartite view of attitudes. The main constructs of the different models were highlighted throughout.

2.2 ATTITUDE CONSTRUCT

According to Allport (1935), an attitude is a mental and neutral state of readiness organized through experience, exerting a directive or dynamic influence upon the person's response to all objects and situations with which it is related. Stevens (1980) maintains that an attitude might be seen as a blend of beliefs and values that would encompass a feeling about that particular object in terms of one's assumed relationship with one's values. Stevens (1980) states that attitudes are certain kinds of overt and verbal behavior from where we construct a picture of unobservable inner attitudes. There have been contradictory reports regarding whether attitudes inform behavior. There are those who advocate that there is a firm relationship between attitudes and behavior and those that advocate the opposite (Stevens, 1980). In trying to resolve this issue, three theories of attitudes have emerged. A discussion of the different models of attitude will follow.

2.3 ATTITUDE THEORIES

2.3.1 The one factor model of attitudes

This model treats an attitude as a single dimension of an affect for or against an object. Although it does not completely refute the tripartite model (discussion to follow), the three components of cognitive, affect and behavior are seen as external to the attitude. This model identifies four categories of attitude namely; affective, cognition, conation (behavioral intention) and behavior (Fishbein & Ajzen, 1975). However, only the affect is considered to be attitude. The building blocks of cognition in some instances such as beliefs about a social event would be considered in this case, as being the base from which attitude is formulated. As a result, although definitions of attitudes identify four components, only the affective component is measured and treated as an attitude (Fishbein, 1967).

For the purposes of the current study, we needed to understand the thinking

behind why discussions about sex and HIV AIDS are fostered at a family level. We also needed to explore the reasons why such discussions do not take place. It is believed that this understanding would shed some light into the mother's attitudes towards these issues. Karz & Stotland (1972) maintained that the cognitive processes are beliefs, intentions to act that constitute the conative process and behavior that were important to consider in this study and thus needed to be understood as building blocks of attitudes. As an example, this would allow for the exploration of underlying beliefs that impact on the mother's fears for initiating discussions.

Rokeach (1970), said that one component of an attitude was difficult to isolate and manipulate independently from a second component. One of the questions used in the study i.e. how mothers would feel and do if they became aware of the fact that their teenagers are in possession of condoms illustrates this as it explores both the affective as well as the behavioural components of the attitude that was essential to the study. Therefore this theory was not considered to be appropriate in the current study as the different components need exploration i.e. cognitive, affective and the behavioral components. This argument leads us to the second model of attitude namely the two-component view.

2.3.2 The two-component view of attitudes

Unlike the one factor model, the two factor model contended that an attitude consist of two components namely cognition and affect. Karz and Stotland (1972) were of the opinion that true attitudes had cognitive and affective components although they needed not include the conative (behavioral) component. To this end, attitudes were two conceptually independent, yet empirically-related constructs consisting of both the affective and cognitive components. Therefore, attitudes referred only to an affective process that can be of a negative or positive value, attached to the stimulus. The cognitive processes are beliefs; intentions to act that constitute the conative process and behavior that constitutes the outcome

(Karz & Stotland, 1972).

This model distinguishes between attitudes, beliefs, intentions and outcomes providing a useful context where one can speculate about the behavior of people based on their attitudes. Furthermore, the model allowed for normative social pressures to be taken into account, as an intention for an outcome of a specific behavior was both an attitude and a subjective norm towards performance of that behavior (Foster & Nel, 1992). The above is important in an HIV and AIDS study where the individual's attitudes towards the disease invariably affect their attitudes towards condom usage that was heavily influenced by stigma as well as by other's perceptions and opinions.

As said in this theory, attitude refers only to an affective process that can be of a negative or positive value, attached to the stimulus. Therefore the reasons behind the positive or negative value attached to the stimulus were not explored. This theory was limiting in this study as the study considers more than the value attached to the stimulus. Important consideration was made of the influences behind mother's feelings about sex, sexual education and more importantly, condom usage. Furthermore, it did not consider the hindrances that existed to why open discussions were not fostered at the family level that was a very important component of the study that lead us to the third model of attitude.

2.3.3 The three-component / tripartite view of attitudes

In comparison to the two other models covered above, the three component model is widely used by social psychologists (Pratkanis & Greenwald, 1989). According to this theory, an attitude was considered to have three components namely the affective, cognitive and the conative or behavioral (Rosenberg & Hovland, 1979). Therefore, an attitude is a response that can be observable or not observable and can be an event, idea or people.

In the current study, the affective component was the feelings and emotions the person experiences towards an event (Oskamp, 1988). An example of the affective cluster of questions tapped into the perceptions mothers of condom usage i.e. what mothers would do if they became aware of the fact that their teenagers were in possession of condoms explores this component. The cognitive component consisted of the person's ideas and beliefs about the event as well as the knowledge and beliefs about whether what has happened whether true or false (Rosenberg & Hovland, 1979). The first two questions on the perception about condom usage cluster namely, what mothers believed was function of condoms and who should use them explored the cognitive part of the model. The behavioral component referred to overt actions, behavioral intentions or verbal statements regarding the event (Eiser & van der Pligt, 1977). An example of the affective component was whether mothers had initiated sexual discussions with their children and what had prompted the discussions.

The discussion above illustrated that the three components of attitude, was important in attempting to understand the relationship between the attitude and the behavior. This was true because individuals could hold the same attitude measured by one index and have a different attitude on the unmeasured components. Therefore, according to Katz and Stotland (1972), not all attitudes had a behavioral component. They further went on to say that all three components, cognitive, affective and behavioral predominance could vary greatly. For an example, some attitudes could be stronger on the affective component or be weaker on the behavioral component. As a result, the link between the attitude and behavior was hard to establish because some attitudes did not have the behavioral outlets that would illustrate the relationship (Katz & Stotland, 1972). Thus according to Taylor (1998), even if the attitude could result in a specific behavior, the behavior could not necessarily be illustrated or shown.

Unlike the one component model of attitudes where the emphasis was only on affective component and the two component theory where the focus was on the

cognitive and affective components only, for the purposes of this study, the three components theory could be appropriately used as the different components were well considered. The cognitive aspect was that of knowledge. This knowledge was in two forms: knowledge of HIV and AIDS and how it was transmitted and knowledge about the function of condoms. The conative or behavioral intent was represented at two levels; one being of mothers indicating what they would do should they discover that their children have embarked on sexual activities and what they would do on finding out that their teenagers were using condoms when engaging sexually. This allowed for the evaluation of the behavioral intent particularly whether this would lead to open discussion about sex, HIV and AIDS. Finally, the affective component would be reflected by the attitudes of the mothers measured in two scales: feelings towards teenagers having sex and attitudes towards the use of condoms. A diagrammatical representation of the different components was tabled as follows:

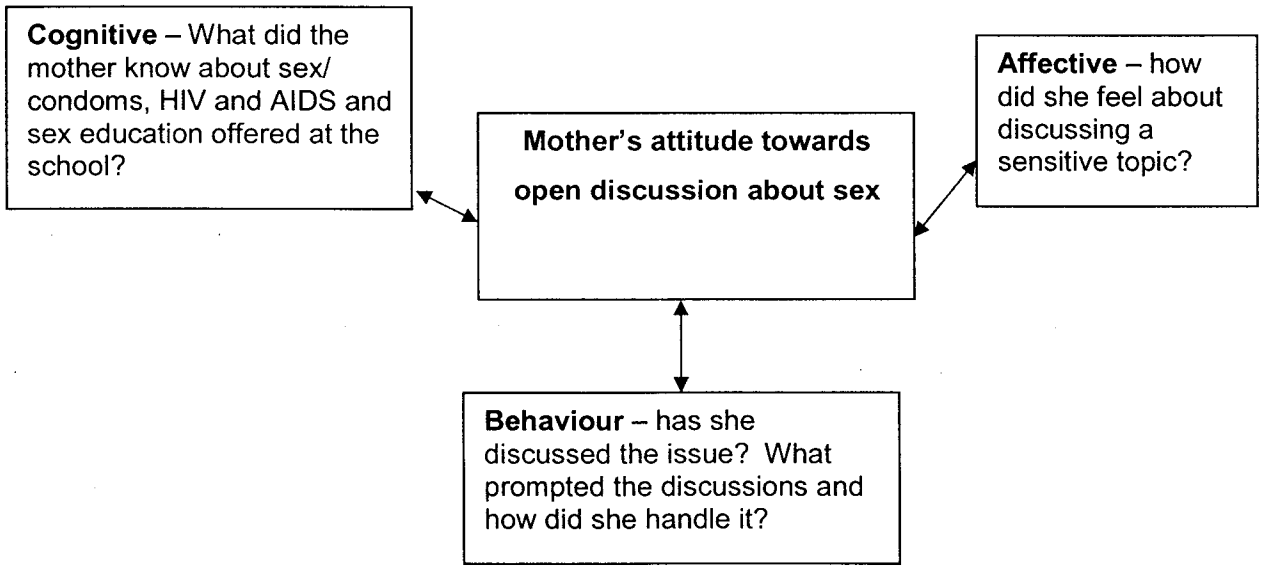

Figure 2.3.3.1 The three-component view of attitudes

Through the use of the three-component view of attitudes, understanding of the

attitudes of mothers towards HIV and AIDS, the use of condoms by their teenagers and their attitudes towards open discussions about sex and HIV and AIDS could begin to be made. The discussion above showed that AIDS has become the greatest killer in recent times making prevention amongst teenagers crucial and paramount. This further implied that ways to get teenagers that are sexually active to start using condoms becomes very important. To this end, sex education alone will not be able to alleviate the problem, meaning that discussions at the family level should be harnessed and encouraged (Berry, 2004).

2.4. CONCLUSION

The three-component theory of attitude aimed at providing an integral explanation of why people in certain situations behave and act in the way they do. This included understanding the beliefs, values encompassed in a feeling about a particular object. Three models have been identified in exploring whether a relationship exists between attitudes and behaviour. The one factor model identified four categories of attitude namely affect, cognition, conation and behaviour but only considers the affective component as attitude, that would be limiting as this would allow for exploration of the perception cluster of questions and not explore the attitudes towards sex amongst teenagers cluster as well as excluding the exploration of some of the questions on the open discussion questions cluster. The two-component model maintained that there are only two components of attitude namely, cognition and affect that is limiting in that the behavioural component that was important for this study as it seeked to explore what mothers would do based on their attitudes was not accounted. The three-component or tripartite view of attitudes was considered to be appropriate for exploring the issues in this study. This model considered an attitude to be made up of three components that was cognitive, affective and conative or behavioural. This model was based on the premise that all the components of an attitude were equally important as three components varied greatly. This allowed for a deeper understanding of mother's attitudes towards sex, their perceptions of condom

usage and exploring the question of whether open discussions are harnessed and encouraged at a family level that is crucial for this study.

CHAPTER 3

TEENAGE DEVELOPMENT

3.1 INTRODUCTION

The emergence and rapid spread of HIV and AIDS both in South Africa and worldwide created the need to find ways to curb the disease. According to Samuels (2003), AIDS kills more than 3 million people a year around the world with most deaths occurring in Africa. Although an abundance of medical research has been conducted, a cure is yet to be found. Numerous educational campaigns have been employed to make people aware of the need to protect themselves and their children against AIDS. In South Africa, campaigns such as Love Life have been used to target parents and communities by using celebrity personalities such as the former president Nelson Mandela, Tim Modise, a television personality, and public figure and a political leader Patricia de Lille in using slogans such as "Love them enough to talk about sex" as an encouragement for parents to talk to their children (Aita, 2002).

Webb (1997) contended that HIV and AIDS research had been for the most part directed towards people living with HIV and AIDS and that less has been done in assessing the attitudes pertaining to the disease, specifically attitudes towards condom usage. This study attempted to uncover the attitudes held by mothers towards the use of condoms by their teenagers under the backdrop of HIV and AIDS and to explore whether the attitude encouraged or discouraged open discussion about sex, HIV and AIDS.

In reviewing the literature, the two major issues for discussion were firstly, the impact of HIV and AIDS on sex education. Secondly, the role of the mother in educating teenagers about sex was explored. Teen sexuality was discussed as the

foundation for addressing condom usage.

3.2 SOUTH AFRICAN CONTEXT OF HIV and AIDS

In contextualizing the present study, it was important to understand the current state of the epidemic in the South African environment. AIDS is believed to have become the greatest killer of human kind in the 21st Century. Koffi Anan, the UN Secretary-General, said that the AIDS pandemic would claim many lives than ever before in 2003 and claim more lives in 2004 and 2005 (Samuels, 2003).

With regards to the size of the problem, Hubley (2002) noted the following globally:

- Over 14 000 new infections a day occurred in the year 2000.
- More than 95% of these are in developing countries.
- 1600 are in children under the age of 15 years of age.
- Over half of the infected adults are under 25 years.
- There are 5.3 million new infections a year.
- The total number of people living with HIV/AIDS is 36.1 million.
- Deaths due to HIV and AIDS in 2000 totaled 3 million – of which 500 000 were children.
- Total deaths due to HIV/AIDS since the beginning of the epidemic are 21.8 million.

The South African population is made up of 40 million people, with 35% of the people being under 15 years old. The effects of the former apartheid system are apparent, with a historically neglected primary health care sector, low levels of education, and high levels of domestic violence, crime, and sexual coercion. HIV/AIDS is at epidemic proportions. The latest world population data sheet of the United States based Population Reference Bureau estimates that South Africa's population will drop from 44 million in 2004 to 35 million in 2025 and to 32, 5 million in 2050 a 26% decline due to the scourge of HIV and AIDS (Haupt & Kane, 2000).

Almost 20% of South African adults are infected with HIV, totaling 4.7 million people, the highest country total in the world (Haupt & Kane, 2000).

Life expectancy has already dropped from 65 to 56 years and will continue to drop over the next decade, owing largely to HIV/AIDS. By 2010 life expectancy was projected to be 37 years for females and 38 years for men (Brown, 2005). New infections are being reported at a rate of 1,700 a day (2/3 among 15 to 20 year olds). By 2010 the national infection rate was projected to reach 25%, confirming the region of Southern Africa as the centre of the worlds AIDS epidemic. Although the government recognized AIDS prevention as a priority issue and the non-governmental organization (NGO) sector is carrying out many innovative programs, scaling-up and coordination of programs have been problematic (Brown, 2005). This is important in that more youth-oriented programmes are needed to curb the disease.

The main route for the spread of HIV is through sexual intercourse between two people when one of them is carrying the virus, (Hubley, 2002). Although the HIV virus can also be transmitted in other ways such as from mother to the foetus during pregnancy or delivery and by use of a syringe or needle infected with the virus, the focus of this discussion will be on the virus being transmitted through: semen or vaginal fluid during sexual intercourse, (Roleff & Cozic, 1998). South Africa's hope to curb this deadly disease is still through prevention and protection from being infected with the disease.

3.2.1 Perception of condoms in South Africa

It appeared that there is a level of resistance to the use of condoms by Black males and females for personal and cultural reasons. Reasons included the belief that people will perceive them to be "loose" should they use condoms (Wilson, Lavelle & Houd, 1990). Some people believe that the use of condoms could create doubts in their partner's minds with regards to commitment and

faithfulness. It is further felt by some that condoms limited sexual pleasure (van Aswegen, 1995). In terms of the religious standpoint regarding condom usage, Christian leaders in South Africa have condemned as "blasphemous, appalling and demeaning" an advertisement of a condom on television (Daily Dispatch Correspondent, 1994). It is with these factors in consideration that the study was conducted.

3.3 PHYSICAL DEVELOPMENT

To conceptualize this study, it was important that an understanding of the development of the teenager as well as the relationship that existed between the mother and the teenager were examined. This was important specifically in understanding the influence that the mother had on that development. According to Devenish, Funnell & Greathead (1992), teenage years were marked by numerous developmental tasks that teenagers had to negotiate.

According to Neinstein (1996), adolescence was a biopsychosocial process that commenced before the onset of puberty and lasted until the termination of growth. It was further mentioned that at the age of 11 years, the female body begins to become womanly, with noticeable growth of pubic hair and hair under the arms. In addition, hormones are produced by the pituitary glands (oestrogen and progesterone) that work with ovaries that are responsible for the sexual development of a female. During this period, for the man the testes, epididymus and prostate increase sevenfold and the phallus usually doubles in size (Neinstein, 1996). To understand the adolescence stage, it was important to understand the context that makes the progression from childhood to teenager possible: the pubertal stage.

Puberty can be understood as the transitional process from childhood to adulthood. Waddell (2000) maintained that puberty was a time when bodily changes occur more rapidly than during any other period of life. Puberty was also the period in

which reproduction becomes possible (Schuster & Asburn, 1980). According to Schuster and Asburn (1980) due to the fact that ovulation and spermatogenesis are internal processes, it became difficult to identify the precise onset of puberty. This was because of the primary and secondary sexual development that accompanied endocrine changes that occurred in the reproductive system (Schuster & Asburn, 1980).

According to Schuster and Asburn (1980), the menarche phase was one of the important landmarks of female puberty whilst for boys the onset of wet dreams was used as an arbitrary division between prepubertal and postpubertal boys. Neinstein (1996) maintained that the age of menarche depended on such factors as race, socioeconomic status, nutrition and culture. To this end, the onset of puberty was later in rural areas and in larger families.

This rapidity of changes brought with it enormous psychological upheaval (Wadell, 2000). Waddell (2000) contended that although traditionally it was thought that the physiological and emotional states and changes coincided. Discrimination had been made more recently between the kinds of bodily changes that initiated the onset of puberty and the mental and emotional shifts in states of mind for an example, the physical ability to have a baby was distinct from the emotional readiness to have a boyfriend or girlfriend.

Waddell (2000) pointed out that although the recognized years of puberty could fall between the ages of twelve and fourteen or fifteen, it needed to be recognized that the 'psychic' part of psycho-sexual changes were found in the overall development of the personality. For this reason, it was difficult to distinguish between puberty and adolescent stages as the nature of adolescence and its course is organised around the responses to the upheaval of puberty (Waddell, 1998). To this end, a breakdown of the different aspects of development that encompasses the adolescence stage will follow:

3.3.1 The adolescent

Due to the numerous physical changes that the adolescent experienced, the negotiation i.e. physical changes that occurred were challenging and required extensive support from parents. These changes could be categorised into physical (sexual) and the emotional negotiation involving developing relationships with people outside of the home environment. The teenager needed to resolve social dilemmas including identity resolution both on a social and personal level. A discussion pertaining to the three areas of negotiation namely, the physical, social and emotional aspects will follow.

3.3.1.1 Physical

Welman (2000) maintained that adolescence has been defined as the process in motion in both growth and development where growth meant growing bigger and development meant the quantitative addition of experiences and challenges beginning from infancy and ending in a qualitative and abrupt change in adulthood. Adolescence can be described as a complex adjustment on the child's part to these major physical changes (Waddell, 2000). Neinstein (1996) maintains that physical development in adolescents can be defined as the period of life where there is an appearance of secondary sexual characteristics as well as a termination and an ending of somatic growth.

3.3.1.2 Social

Due to the nature of teenage years, the need to belong to a group becomes greater and teenagers may change their behavior in order to conform to the group's standards. As a result, the teen might start to follow the group's choices and decisions and not their own (Stevens-Long & Cobb, 1983). This conformity to the group might be an attempt to further separate from the family.

3.3.1.3 Emotional

Furthermore, teenagers search for answers to questions about who one is, what one's identity is, and thus examining their values, beliefs and practices learned in childhood (Walton, 1995). According to Waddell (2000), adolescence is now regarded as highly important in a person's development as essential aspects of the personality become shaped and eventually organised into a more coherent and stable sense of self. Waddell (2000) contends that the challenges of adolescence and its resolution are viewed as making a central contribution to a person's future life in terms of his character and the growth of the personality.

According to Walton (1995), adolescence is described as a stormy period for the family as the young adolescent can indulge in risk-taking behaviour such as unprotected sex as a challenge to the authority of his or her parents a quest for adventure or simply as a result of peer pressure. For the purposes of this study, these issues need to be explored further as for the adolescent; the psychic agenda is a demanding one. The negotiation involves a resolution of the relationship between the adult and infantile structures, the transition from life in the family to life in the world, the finding and establishing of an identity especially in the sexual term as well as the capacity to manage separation, loss and choice, independence and disillusionment with life on the outside (Walton, 1995)

This might be accompanied by an increased involvement in heterosexual relations manifested by dating activity, sexual experimentation and intercourse (Neinstein, 1996). In the middle adolescence phase where the teen is approximately between the ages of 14 –17, there might be a feeling of omnipotence and immorality, leading to risk-behaviour that is a factor in the increase in pregnancies, and sexually transmitted diseases (Neinstein, 1996).

According to Neinstein (1996), the transition from childhood to adulthood does not occur by a continuous, uniform synchronous process. It is maintained that

biological, social, emotional and intellectual growth could be asynchronous. In addition, the need for development, although arising from individual needs, might be influenced further by societal demands (Goddard, 1986). Individual needs encompass the need for the individual to meet certain milestones such as accepting one's body and learning to use it effectively. Societal needs include the achievement of independence from parents as well as the acquisition of appropriate masculine and feminine roles. Other examples would be the need for the adolescent to develop intellectual skills and concepts necessary for civic competence. In addition, the adolescent would need to establish sexual, ego, vocational and a moral identity, as well as to reach conformity with adolescent peer values, codes and dress in an attempt to further separate from the family to mention a few examples (Goddard, 1986).

3.4 TEENAGE SEXUALITY

The notion of the adolescent stage as a necessary period for the restructuring of the personality is a recent way of understanding this troubled and exciting time (Waddell, 2000). From the beginning of psychology, adolescence was understood to be an important period of development. According to Freud (1917), adolescence came to be defined as the time where particular changes take place. It entails a re-working of the infantile sexual impulses so that they are integrated into the more intimate and loving aspect of sexual relationships. Freud (1917) characterised this integration into three stages, the crystallization of sexual identity, the finding of a sexual partner and the bringing together of the two main stems of sexuality, the sensual and the tender.

As this process unfolds, anatomical, physiological and endocrinological changes occur. These changes involve fundamental alterations to the known self. This might give rise to renewed conflicts for example, between conscious thoughts and the unconscious impulses attached to these new physical sensations. Whether these disturbances are felt to be manageable will depend on the quality

of the original containment of infantile impulses and feelings by the mother (Waddell, 2000). At times, the conflicts are experienced as "too much" and thus needing to be expelled. In this process, old conflict especially those of infancy and of oedipal struggles are reworked (in the context of genital drives). These are conflicts that will test the quality of early containment and internalization.

In understanding the processes of containment and internalization, Steiner (1996) maintained that the object (mother) is used as a container to collect, integrate and give meaning to disparate parts of the self. Bion (1962) suggested that in this process, the infant is relieved of anxiety that provides a sense of being understood. The infant is left with a sense of being able to be separate from the mother as well as developing a capacity to think and judge for him or herself. The discussion above illustrates the importance of the role of the mother in the process of containment (the ability of the mother to help the infant digest and understand the outside stimuli by firstly digesting it and feeding it back to the infant in a manageable form) that is important in terms of how the teenager masters the adolescent stage as the earlier challenges are revisited during the adolescent stage (such as working through the memories of a lost object and thus regaining independence) (Wadell, 2000). It is envisaged that if the teenager is not able to discuss pertinent issues regarding difficulties he or she has about the changes outlined, he or she will seek assistance and guidance from peers and not from the mother. To this end, the teenager is left exposed to strong peer influences that are not mitigated by an older person in the form of the mother. These influences could be of a sexual nature that would leave the teenager exposed to engaging sexually at a young age.

Goosen and Klugman (1996) contend that sexuality is a form of expression that starts at birth and continues throughout life. They however, maintain that the society and culture of the person will heavily influence one's conception of sexuality despite one's biological sex. Neinstein (1996) took this argument further and focused on the adolescent phase. The adolescent phase will be

understood in this context as the backbone that characterizes the teenage years, where there is an upsurge of curiosity on one's body and in other peer's bodies (Neinstein, 1996). Depending on the phase of adolescence the teenager is at, there might be a level of sexual energy with a need and yearning for physical contact. This might be accompanied by some denial about the consequences of the sexual behaviour (Neinstein, 1996). It is therefore important to understand the changes that a teenager has to go through in light of the campaigns made to educate teenagers and adults about HIV and AIDS i.e. the campaign to abstain from engaging sexually. In light of this discussion, the question needs to be asked, is abstaining feasible when the teenager is undergoing the changes outlined.

3.5 SEX EDUCATION

In a country where HIV infection among the youth has increased, sex education is paramount. It was reported by the Department of National Health and Population Development in 1993 that 550 people are infected with HIV daily. The rate of infection was expected to rise to 2.8% for men and by 4% for women in 1995 (Cooper, et al.1994). This figure is envisaged to have increased drastically over the last years (Preston – Whyle, 1995). It was further found in Flisher, Cruz, Eaton, Makona and Pillay (1999), in a risk taking behavior study of the Cape Peninsula high school students, that 17.4% of the students reported previous episodes of heterosexual intercourse with the median age of first intercourse being 15.1 years. These results together with the results found by the NPPHCN (National Progressive Primary Health Care Network) in Flisher et al (1999) in a study involving youth of all ages with an age group of 10 -20 years, where it was concluded that the average age of first intercourse is 15 years for females and 14 years for males are very concerning. There is a grave need to educate teenagers about sex and condom usage as a form of protection from this devastating disease.

Numerous studies have been conducted in South Africa to ascertain the level of adolescent knowledge on issues of HIV and AIDS. Studies such as those conducted by Everatt and Orkin (1993), Naidoo, Van Aswegen, cited in the review of literature by Flisher, Ziervogel, Chalton, Leger, Robertson (1993), conducted with school going youth in the ages 14 – 20 year age from Cape Peninsula documented that there is a high overall awareness of AIDS, the serious nature of the infection, the risk of death and also the modes of transmission of AIDS. Flisher et al. (1993) in his review of research conducted in the areas of condom usage as a form of prevention found that only 10% of students were currently using condoms. In addition he found that only 11.4% had ever used a condom.

Kau (1991) found that of male high school students aged between 13-18 years, only 24.5% used a condom. Similarly, Karim, Karrim, Preston - Whyle, Sakar, (1992) found in their study combining all races of high school teenagers aged 15-19 that 47% of them had used a condom once in their lives. Similar findings were reported by Nicholas (1994) in a survey conducted with 2 206 Black South African students that 16.3% indicated that they did not use condoms during sexual intercourse. Karrim et al. (1992) found that students were not using condoms to any significant degree as they felt that condoms limited sexual pleasure, condom use indicated a lack of trust in one's partner's faithfulness, that it challenged the male ego and that it indicated that one has a STD (sexually transmitted diseases). It was further found in the same study that there was a perception that condom use was not well understood and that people felt that they were not accessible or available when required.

The research conducted indicated that there is need for more efforts to be made to appeal to teenagers to use condoms. This study was one way to enhance the use of condoms by teenagers by way of using mothers to facilitate the dissemination of information. LoveLife (2000) conceded by using an epidemiological projection model that improvements could be made on the

prevalence of HIV and AIDS if condom usage could be increased by 15% in 2000. This further showed the need to increase the use of condoms with teenagers as a way of curbing the spread of the epidemic.

From the research conducted that evaluated the impact of attending sexual education at the school level, it was suggested that traditional sex education programmes in schools have had little or no affect either positively or negatively in altering the age onset of frequency of adolescent sexual activity (Stout, Stout & Rivara, 1989). According to Van der Elst (1993) who questioned whether sex education had an impact on sexual knowledge and attitudes through a study involving 12-19 year attending Family Clinics in Cape Town, found that sex education did not change participant's knowledge or attitudes. A quantitative review of risk reduction interventions conducted by Kim, Stanton, Lix, Dickersin, Gallowaith, (1997) found out of 40 studies that there had been some reduction in risk taking behavior in the sample. An 88% report of statistically significant improvement in knowledge as well as a 73% improvement in the use of condoms was found.

Nicholas (1994) maintained that due to the sociopolitical context of South African Blacks, Black teenagers are vulnerable to sexually-related problems e.g. the high prevalence of rape in the township and incest. This has further been exacerbated by the disparity of allocation of resources to Blacks and Whites at all educational levels has resulted in a lack of formal sex education in the Black schools. It was believed that most Black schools provided very poor guidance to their pupils resulting in sex education in schools becoming the exception. Furthermore, parents as well as religious leaders attacked the introduction of sex education in South African Indian schools where fears of children being corrupted were verbalised (Chothia, 1993).

Cilliers (1989) maintains that all school departments that were consulted supported the idea of schools as a means of AIDS prevention, however, this was

not fully supported within the communities (Kagan, 1989). Some education programmes were initiated in the 1990's. However, these programmes faced opposition from parents and others (Gevisser, 1993). It appears that different programmes are implemented within the different provinces within South Africa. However, television programmes on sexuality were initiated to focus on youth education. However, there is a level of censorship on sex education where books that are freely available in overseas countries were banned in South Africa (Burman & Preston-Whyte, 1992).

Currently, it appeared that there was a shortage of information pertaining to publicised literature on sexual education. Van der Elst (1993) related the problem to the newness of the field. However of the programmes implemented at the schools, Stout (1989) maintained that the courses lacked a measurable effect. In a joint initiative of the Department of Health and Education's Life Skills and an HIV/ AIDS program, it was found that only 40% of the schools had implemented the programme while 20% reported partial implementation. It was found that some of the provinces in particular Kwa-zulu Natal and the Eastern Cape Province had not started with implementation (Naidoo, 2000). The challenges to the programme according to teachers were difficulties due to time constraints, personal difficulties with the subject matter and credibility with the student population. For these reasons, the need for the responsibility of sexual education should be shared amongst the various institutions including family, the school, social and religious groups.

The difficulties and challenges faced within the school system regarding sex education suggested that discussions fostered by mothers at a family level were paramount in assisting the assimilation of knowledge about sex, condoms and HIV and AIDS given through the school programmes. Rotheram and Lyons (2005) suggested that although the federal policy in the USA supported widespread implementation of abstinence only education as a form of preventing HIV transmission, little scientific evidence suggested that these programmes

work. It was suggested that only comprehensive sex education is effective in protecting adolescents from pregnancy and sexually transmitted illnesses at first intercourse and during later sexual activity (Rotheram & Lyons, 2005). Furthermore, although giving information at the schools will be helpful, it might not be sufficient.

A joint report by Unicef, Unaids and WHO (2003), said that educating young people about HIV and giving them skills in negotiating, conflict resolution, decision-making amongst other skills could improve their self-confidence and their ability to make informed choices including postponing sex until when they are mature to protect themselves from HIV. At this point, it became important that the parents, and specifically the mother, is close to the teenager and gives the necessary guidance. Stevens-Long & Cobb (1983) contended that adequate sex education from parents had a positive contribution to psychological adjustment and reduced the risk of premarital pregnancy. Aita (2002) said that good parent-child communication including having an open discussion about sex was vital to combat HIV infection in South Africa.

It has been found that discussions encompassing providing information, encouraging abstinence, promoting condom usage for those who are sexually active, encouraging fewer sexual partners, and teaching sexual communication skills to name a few examples has been most effective in keeping sexually active adolescents disease free (Rotheram et. al, 2005). Discussions at home with the mother that allowed for exploration and clarification on these issues that might not be feasible to explore in a school context were also found to be helpful. What this current research seeks to answer was the impact of the mother's attitudes on sex, condom usage specifically as a form of protection from HIV and AIDS, as well as exploring what fostered or hindered discussions at the home situation.

Without accessible reasonable treatment it becomes important that prevention become the main focus for overcoming this fatal disease. Although research is

currently underway to investigate the development of a vaccine against HIV and AIDS, the development of a vaccine is not easy. In addition, the testing of the vaccine for effectiveness and safety is a long process (Hubley, 2002). Without accessible reasonable treatment it becomes important that prevention becomes the main focus for overcoming this fatal disease. Thus the role of sex education becomes urgent and paramount.

3.6 THE ROLE OF MOTHERS IN SEX EDUCATION

As discussed above, there was a great need for mothers to talk openly about sex and sexuality to their teenagers as a means to reducing HIV infection. It was however, evident that many mothers disapproved of sex education in schools but did not take responsibility for sensible sex education in the home (Stevens-Long & Cobb, 1983). Open discussions would encourage teens to engage actively with sexual issues and get information about the issues. Webb (1997) dispelled the notion that talking with teenagers caused them to initiate sex earlier and therefore increasing promiscuity. Aita (2002) said that it had been shown that the opposite become true when, not talking with the teenager's increased curiosity about sex and therefore increased promiscuity.

Children have indicated that they would like to receive information about sex from their parents however, many mothers were unable or unwilling to meet this need (Stevens-Long & Cobb, 1983). According to Love Life (Aita, 2002), less than half of South African parents talked to their children about sex. It was apparent that parent's difficulty to talking with their children could be lying at the heart of dealing with HIV and AIDS. This study attempted to investigate the attitudes underlying this finding. Possible reasons were given by Stevens-Long & Cobb (1983) who said that part of the difficulty could be that the mothers themselves have never had sexual discussions with their own parents and therefore did not know what information to give their own children. In addition, the difficulties experienced in terms of communicating about issues pertaining to sexuality was a phenomena in

patriarchal societies as such communication was considered to be taboo, was associated with shame and guilt (Sapire, 1986). The lack of communication and engagement with the issues resulted in parents being uninformed and thus lacking adequate knowledge about sex that made it difficult for them to address the issues critically when asked by their children. Due to such lack of communication at home, adolescents tried to access the information from other people such as peers and media.

According to Webb (1997), mothers that did talk to their children did so infrequently and therefore did this as a once-off event. However, children were subjected to peer pressure through the media and through curiosity to engage in sex which rendered the once off discussions about sex redundant as the pressure was consistent and ongoing. It was believed that due to the stigma attached to the disease, parent's battled to discuss HIV and AIDS with their children. It was thus imperative that further research is conducted to understand the reasons underlying the closeness that exists on the matters of sex and specifically HIV and AIDS.

3.7 CONCLUSION

Due to the fact that an HIV and AIDS cure is yet to be found, it is concluded that the most important challenge for South Africa today was for people, specifically teenagers, to protect themselves from contracting HIV. This was in the backdrop of physiological, physical, emotional and social factors that needed resolution during the adolescent stage that teenagers have to go through. It has also been found that although schools have embarked on educating teenagers about condom usage, the role of the mother in fostering discussion at the home level were paramount if gains were to be realized in the fight against HIV and AIDS. Furthermore, the mother was needed to mitigate over and guide the teenager as he or she negotiated the different stages of adolescence in light of the challenges brought about by the HIV pandemic (Nicholas, 1994).

It was important to acknowledge the fact that this area of study had not been extensively researched. To this end, the study was exploratory in nature such that it had been important to put disparate bodies of research together namely, attitudes, HIV and AIDS, teenager sexuality and development, sex education and the mother's role in sex education to gain some understanding of the issues.

This research focused on answering the following questions with regards to maternal attitudes towards condom usage in light of HIV and AIDS. The first cluster of questions was on understanding the attitudes of mothers towards sex. The question that was covered was firstly, what mothers believe to be the role of sex education at home and at the school? Secondly, mothers were asked whether they have initiated sexual discussions between themselves and their teenagers and what had prompted the discussions.

The second cluster of questions explored the following perception of mothers on condom usage. The following questions were covered:

1. The view of mothers about the function of condoms as well as answering the question of who should use them?
2. How mothers would feel if they become aware of the fact that their teenagers are in possession of condoms?
3. How they would respond if they found their son in comparison to daughters being in possession of condoms?
4. Their feelings towards daughter's teenagers in comparison to son's teenagers using condoms when engaging in sexual activities?
5. What do they believe is the role of the schools in comparison to the role of the mothers towards educating teenagers about condoms?
6. What their opinion was towards the availability of condoms to teenagers e.g. in public toilets and at schools?
7. What type of questions they would encourage about condoms in discussions with their teenagers?

8. What type of questions they would discourage about condoms in discussions with their teenagers?
9. What impact they think such discussion would have on their relationship with their teenagers?
10. What questions they would encourage and discourage about HIV and AIDS?
11. What they would do if they found out about that their teenagers were sexually active?

CHAPTER 4

METHODOLOGY

4.1 INTRODUCTION

This chapter covered the information pertaining to the design of the study, the setting of the study, sampling, interviews, data collection and ethical considerations.

4.2 RESEARCH DESIGN

The nature of this study could essentially be classified as empirical research involving qualitative data-collection methods and content analysis. The content analysis was considered to be the most appropriate method for this study as the study seeked to enquire on the perceptions and experiences of mothers that was construed by their experiences (de Vos, Strydom, Fouche, Poggepoel & Schurink, 1998). Bryman (1988) contended that the qualitative method allowed for the description, the analysis of culture and behavior of those studied, which was central to this study. It was envisaged that the cultural factor was important in this study as it played an important role in the attitudes of mothers due to the issues of socialization and race that are significant to the South African context. As a result, the study relied on the individual's voices and interpretations by using semi-structured interviews (Locke, Spirdus & Silverman, 1993).

4.3 SETTING OF THE STUDY

The study was conducted in Tembisa, a township located in the Gauteng region, on the Eastern part of Johannesburg in South Africa. South Africa is found in the Southern part of the African continent. It is a country with a population of 44.8

(Census, 2001). It is a comparatively large country, covering 1,221,042 square kilometers and with an estimated population of about 40 million. The country is comprised of large, crowded cities and sparsely-populated rural areas (Berry, 2004). The average density of the population is at 29 people per square kilometer, with 59.5% of these in urban areas and 40.5% of these in rural areas (Berry, 2004). Some parts of the country are very isolated and underdeveloped. Although the urban townships normally found next to big cities are semi-developed, there is a shortage of resources and infrastructure. This lack of infrastructure is one of several factors that make it difficult to get a clear picture of the HIV / AIDS prevalence (Berry, 2004). Tembisa is the second biggest township in Johannesburg. Gauteng where Tembisa is located makes up 19.7% of the population. Johannesburg is the biggest city as well as the business hub of South Africa (Census, 2001).

4.4 SAMPLING PROCEDURE

A combination of snowball and maximum variation sampling was used for this study, as people from a homogenous background were asked to volunteer for the research. Women from the Tembisa community were approached by the researcher through the assistance of teachers from the neighbouring schools namely, Tembisa High School and Phumolong Primary School. Women were asked to refer other women from the community through "word of mouth". Mothers were also encouraged to refer other mothers when they could not partake in the study. The aim of the study was to review commonalities in experience that has shaped women's attitudes towards condom usage in Tembisa.

4.5 SAMPLE

The participants in the study were ten Black women from Tembisa in the East Rand who are parents to teenage children. The women who presented for the interviews had teenagers ranging between the ages of 12 to 18. Two women of

the mothers had children aged 20 and 21. It was felt that due to the fact that they each had younger teenagers; they were eligible for participation in the study. Parents were advised about the project at parents meetings held at a high school in Tembisa.

Due to the multiple languages currently spoken in Tembisa, all interviews were held in English. Therefore, participants were asked to be literate, as they were required to give informed consent as a prerequisite to being part of the study. Finally, participants partaking in the study needed to be prepared to talk about their experiences. This was communicated to the parents in preparation for the study.

Due to the nature of the study it was envisaged that the subject matter could be difficult for some mothers to talk about that it was important to foster a working relationship with the schools. To this end, buy-in from the teachers identified to help with identifying the sample was facilitated by ensuring that they understood what the researcher was aiming to do. This required that the researcher spent time at the schools, explaining the purpose of the study and some potential benefits that could be achieved for South Africa from a study of HIV and AIDS and specifically the use of condoms as a form of prevention and protection. The selection of the participants was based on receiving the first ten participants. Because all respondents were self-selected, all who volunteered were seen as eligible and no other prescriptions were made.

The one consideration made in choosing women was that it was believed that mothers play a primary care giver role in the development of children due to the attachment process that takes place in early development. It was envisaged that at this early stage, the relationship that is established between the mother and her baby would inform later interpersonal relationships (Waddell, 2000). It was envisaged that such a bond would continue throughout the development years. It was therefore hypothesized that teenagers who felt comfortable to discuss sensitive issues with their mothers than fathers (Stevens-Long & Cobb, 1983).

This was compounded by the fact that most fathers are "breadwinners" in the South Africa environment that was initially dominated by the migrant labour system that, they are away from home for longer periods. It should however, be qualified that more women are becoming "breadwinners". There has been an increase of single parent families predominantly led by women and this research intended to accommodate these families.

Furthermore, the Black community in Tembisa had been chosen because of its accessibility to the researcher. It was also motivated by the need for the degree of homogeneity within the sample and therefore the demographic variable of the race was kept constant. The study required that women had access to information and therefore having some exposure to HIV and AIDS campaigns and has gained some knowledge about the disease.

4.6 PROCEDURE

It was arranged with teachers from Tembisa High school and Phumolong Primary Schools that all mothers interested to be involved in the study would communicate with the teachers. Once the first ten mothers had communicated that they wanted to partake in the study, arrangements were made to meet for the interviews. Due to the fact that five mothers had teenagers attending school, the teenagers were asked to inform their mothers about meeting the researcher on a specific date, time and venue. Although only three of the mothers arrived for the said interviews, these mothers were asked about other mothers who could partake in the study and through this process, five other mothers were ascertained.

The mothers who did not arrive for the interviews were not followed up and considered to have withdrawn from the study. The Phumolong school teacher then suggested four other mothers who had subsequently contacted the school as they heard through word of mouth about the study. These women were then contacted and arrangements to meet for the interview were made.

4.7 DATA COLLECTION

Data was gathered by use of a semi-structured interview. The interviews were done face-to-face with the researcher and the participants. Interviews were conducted during the late November and early December 2003. Although a teacher from the Phumolong Primary school offered that interviews be conducted at her home, it was expressed that interviews be held only with the researcher and the interviewee alone in the room. All interviews were arranged that only the interviewee and the researcher be present at a time. Thus arrangements were made with the mothers to meet at the teacher's home for the interviews. Each interview took approximately 45 minutes. The researcher started by addressing the information sheets (Appendix, A), then the informed consent (Appendix, B) by way of each mother giving a signature to be interviewed and to tape recorded (see Appendix B).

4.8 INTERVIEW SCHEDULE

The interview was structured according to three clusters. The first cluster of questions focused on the mother's attitudes towards sex among their teenagers. This included asking the mothers about their knowledge and attitudes towards HIV and AIDS. The second cluster of questions explored the perceptions of mother on condom usage by their teenagers. The third cluster of questions focused on the general feelings of mothers towards sexual discussions with their teenagers as well as their beliefs about the impact of such discussions. This question also seeks to examine whether open discussions about sex, HIV and AIDS were fostered at a family level. Hindrances to having open discussions were also explored. Lastly an additional question was asked to explore what mothers would do if they found out that their teenagers were sexually active (see Appendix A for an interview schedule).

4.9 ETHICAL CONSIDERATIONS

An information sheet, informed consent letter coupled with the consent form to be tape-recorded were given to the participants before the start of the interviews (see Appendix B). In terms of potential benefits from participation were concerned, participants were issued with information pamphlets about HIV and AIDS that gave guidance on how to conduct open discussions about sex, HIV and AIDS with their children teenagers. They were also given the contact numbers for LoveLife an organization that specializes in HIV and AIDS consultation.

Before the study was conducted, ethical clearance (see Appendix D) was ascertained from the Faculty of Humanities University of Witwatersrand. The requirements for clearance specified by the ethics committee entailed that participants gave informed consent to participate in the study, that participants gave consent to be interviewed as well as to be tape recorded, that confidentiality and anonymity be ascertained before the study was conducted.

These requirements were addressed in the study as participants were given an information sheet (see Appendix B) detailing the purpose of the study. The information sheet included information pertaining to the fact that participation in the study was voluntary and that they could withdraw from the study at any point without any negative consequence to them. Participants were also notified that they might not at any point be forced to give their opinions or answer questions they do not wish to answer. Each participant was allocated an acronym as a form of identity to ensure that they remained anonymous and that their responses remained confidential. In addition, confidentiality was ensured as tapes containing the responses ascertained from the interviews, were destroyed once transcriptions were completed (see attached Appendix C).

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question and the answer received. Thereafter the information particularly the answers was understood in consideration of the mother who answered the question. In this regard, the answer was understood in terms of the mother, the number of teenagers she had, the gender of the teenagers as well as their age. The gender component was important as it was found that this allowed for a distinction to be made particularly in relation to the mothers feelings ascertained for the different questions.

The information tabled above allowed for a synopsis of each mother to be made that gave a good understanding of the mother and the teenager to sort further. This allowed for ambivalence and contradictory information to be identified specifically as some of the questions are closely related i.e. the question of what is the role of the home in comparison to the schools with regards to educating teenagers about sex. This question is similar to the question: what is the role of the home in comparison to the role of the school regarding condoms.

Information was also categorized and understood in terms of similarities and differences. This allowed for both positive and negatives responses for each of the questions to be identified. Themes and summaries were extrapolated. This involved understanding the responses according to the attitude theory's perspective, the feelings and action reported to have been taken by the mother. Contradictory results were also identified and reported.

4.10.1 Presentation and initial formulation of data

All ten mothers were allocated acronyms starting from A – J as a form of reference to ensure confidentiality. Direct quotations from the transcripts will be referenced in by use of the acronym and the line in the transcript for an example, A9 would mean interviewee number one, line 9 of the transcript. Full transcripts are contained in the Appendix C.

The following table gives a breakdown of the profile of teenagers involved including their sex and age.

Number of teenagers	Sex	Age
2 (A.2)	Girls (A.4)	17 & 12 years
1 (B.2)	Girl (B.2)	12 years
1 (C.2)	Boy (C.2)	13 years
1(D.4)	Boy (D.4)	14 years
2 (E.2)	Boys (E.2)	21 &18 years
1(F.2)	Girl (F.3)	18 years
1(G.2)	Boy (G.2)	14 years
3 (H2)	Boy & Girls (H.4)	Boy (20), 13 & 18 years girls
1 (I.2)	Boy (I.2)	15 years
2(J.3)	Boys (J.3)	16 & 21 years

Table 4.1 Age, gender and the number of teenagers whose mother's participated in the study.

All responses were identified by the letter allocated to the mother. There were 10 mothers that participated in the study identified by the Letter allocated to each one as A – J. Six mothers had had one teenager each whilst two of the mothers had two teenagers each. One mother had 3 teenagers. The ages of the teenagers ranged from 12–21 years with the majority of the teenagers falling between the ages of 13–16 years. Of the mothers who participated, there was a gender breakdown of five girls and nine boys.

CHAPTER 5

RESULTS & DISCUSSION

5.1 INTRODUCTION

This chapter described findings as well as a discussion of the findings. Diverse opinions and responses were received from the mothers in answering the different questions. The discussion addressed in detail the different clusters of questions covered namely, the mother's attitude towards sex, the perception of mothers of condom usage and their responses to questions regarding having open discussions about condoms with their teenagers. It was important that all the questions asked explored the different aspects of the three components theory of attitude namely, the cognitive, behavioural and the affective. It was noteworthy that although a number of studies have been conducted on the use of condoms by teenagers, there was a shortage in studies conducted in review of maternal attitudes towards condom usage (Preston-Whyte, 1995 & Karrim et al., 1992). To this end, comparisons are difficult to make due to the shortage of research in this area.

5.2 UNDERSTANDING THE ATTITUDES OF MOTHERS TOWARDS SEX

These questions tapped into mother's beliefs about the role of sex education at home and at school. The aim was to explore the cognitive and the affective components of the three components model of the attitude theory. The cognitive in terms of how mothers understand the roles and functions of the two institutions and affective in that their beliefs and opinions were also explored.

5.2.1 What do you believe is the role of sex education at home and at school?

In responding to this question, some mothers focused more on describing the role of the home. It was on exploration that they described the difference in opinion between the role of the school and that of the home. According to the results received, 80% (A7, B8, C5, D6, E4, F4, I3, J6) of the mothers involved in the study felt that the two institutions of home and school had different roles to play. Mother C went further and mentioned the fact that because she was uncomfortable to talk about sex with her children, the school should take the responsibility to educate teenagers about sexuality. The following extracts from the transcript illustrate this points:

> "I think sex education should start at home. When they go outside and hear something else, then they should always come back home to ask and say that somebody says one, two. Three, four, is it true? At school, they deal with it but it's like they let them know that they can have sex, but at home, you should let them know that they can do it but my hope is that you won't do it before you get married". Mother B (B8)

> "Yes, I think so because at school, it should be general knowledge and at home it should be more concentration on the individual. At school, they talk to them in general". Mother C (C5)

> "I am not free to talk to them at home about sex. I am shy to talk about it at home. The school I believe should play a prominent role to teach our children about sex". Mother H (H6)

Varied reasons were given with regards to why there was a difference in opinion about the two institutions. Mother H (cited on H6) contends that it was difficult to engage in a discussion with her teenager because initiating the subject was difficult. Of the 80% of the mothers who maintained that the schools and the home have two different roles to play, 50% of the mothers maintained that sexual education should start at home (B8, C5, D4, F4, and J6). According to these mothers, the home situation should focus on taking complete responsibility to give sexual education to their children that should include addressing issues of puberty

and sexuality (D6). This would allow the teenager's individual needs to be addressed and catered for on a one to one basis. Furthermore, this home situation would allow the teenager to check facts either heard from other children or at school with the mother. Moreover, this would allow the mother to set boundaries with the teenager that would be difficult to do in a school environment as quoted from the mothers on D12, G3, and H5:

> "I think that children should hear about all these things from us as their mothers. The schools should rubber stamp what we have already told them". (D12)

> "I don't see a difference between the two environments. We should not shy away from difficult things that we have to discuss with our children at this stage". (G.3)

> "I believe that the role for both environments is to educate the teenagers about unsafe, unprotected sex and the implications of having unprotected sex. We also have a role to play of encouraging them not to be sexually active before marriage". (H. 5)

The mothers G (stated on G3) and mother H (stated on H5) maintained that both the home and the school should play an equally responsible role regarding sex education. It appeared from this discussion that there were varying, and at times, confused and disparate views relating to the roles of the school and the home regarding educating teenagers about sex. Ideally, mothers recognized that allowing their teenagers to talk freely about sex would be beneficial, but there was a lack of evidence to show that mothers allowed their teenagers to talk about sex in a non-judgmental way that allowed for transparency and openness. A theme that came through was that mothers maintained that both environments (home and school) should tap into different aspects of education pertaining to sex where the home environment played a primary role and the school playing a secondary role.

It appeared that one of the main reasons for those mothers who believed that the school should play a primary role in educating the teenagers was the fact that they found it hard to open up to their teenagers out of fear of talking about sex. As stated before, the reason underlying this could be the difficulties experienced in

terms of communicating about issues pertaining to sexuality that was considered in patriarchal societies to be taboo, and thus associated with shame and guilt (Sapire, 1986). This lack of communication and engagement with the issues resulted in parents being uninformed and thus lacked adequate knowledge about sex that made it difficult for them to address the issues critically when asked by their children (Sapire, 1986). However, as said above, it was strongly felt by some mothers that the home environment should introduce the topic of sex that would allow the teenagers to further expand through the school environment. Of the mothers who contended that the home and the school had two different roles to play in educating children about sex, consensus was not found when they were asked whether they have initiated sexual discussions with their teenagers.

It was possible that mothers perceived different roles for home and school with regards to educating teenagers about sex because of their general understanding of adolescent socialization based on their experiences. According to Devenish, Funnell & Greathead (1992), the nature of teenage years involved the process of teenagers moving away from the closeness of home to becoming closer to a group of friends and peers. This brought with it a change in behavior that the mother might not have been accustomed. Teenagers became independent and thus spent more time outside of home than being at home.

In some cases, the need for independence resulted in the teenager becoming rebellious and thus made it difficult for the mother to communicate with him or her (Preston-Whyte, 1995). As a result some mothers assumed that due to the fact the teenager was difficult at home, the schools needed to take responsibility for sex education. Secondly, mothers conceded that it was difficult for them to initiate sexual discussion with their teenagers (A5) such that some of the mothers felt that the schools should play a bigger role in imparting sexual education (A7, E4). This finding was also borne out by Karim, Karim and Preston-Whyle (1992) when they found that parents were unwilling to discuss sex with their children both because they were uncomfortable and because they thought it would promote sexual

activity.

It was also possible that due to the fact that the teenagers were at an age where life issues were discussed with peers, the initiation of discussions by teenagers with their parents where they ask questions decreased (Preston-Whyte, 1995). Furthermore, teenagers invariably discussed sexual matters with friends than with parents. Other mothers although they recognized the need for the teenager to gain some independence from them, saw themselves as the primary point of contact for sex education.

The responses received for this question addressed two components of the three components theory of attitude. The cognitive component was addressed in that mothers believed that the home environment should focus on specific issues of puberty and sexuality. Furthermore, the home environment should also allow for teenagers to check and assess the information received at school with the mother. In addition, mothers believed that the two environments should play different roles. The affective component was addressed when mothers maintained that it was difficult to initiate the subject of sex with their teenagers. Mothers battled to talk out of fear that this could leave their teenagers unable to manage the information received that could lead to a lack of control. However, mothers also felt that talking about sex with their teenagers could be beneficial if managed appropriately. Behaviorally, this question did not allow for adequate space to account for whether there was evidence that mothers have engaged in discussions with their teenagers (Rosenberg & Hovland, 1979).

5.2.2 Have you initiated sexual discussions between yourselves and your teenagers, and what prompted the discussions?

In answering this question, a number of factors were cited as having prompted discussions. According to the responses received, 80% (B4, C6, D7, E5, F5, H7, I4 and J7) of the women interviewed maintained that they have initiated

discussions with their children. The different reasons for having initiated discussions with the teenagers and not having initiated discussions addressed the cognitive component of the attitude model. Mothers maintained that they initiated discussions with teenagers for the following reasons, the age of the teenager, the topic arising in a discussion by chance, HIV and AIDS including personal exposure to the epidemic, the teenagers prompting the discussion themselves and when the subject was addressed through the media as some of the reasons that prompted discussions. The fear of the teenagers knowing too much that could lead to a lack of control was cited as a reason why discussions had not been initiated with the teenagers.

It appeared that the age of the teenager determined for 30% (G4, I4, J8) of the women when to initiate a sexual discussion with their teenagers. For Mother J who had two teenage children aged, 16 and 21, it was felt that both her teenagers were old enough that gave her confidence to engage in discussions with them. This was collaborated by Mother I (cited on I4) who pointed out that her son is 15 years old, she felt that it was an opportunistic time for her to have a sexual discussion with him. It was noteworthy that although the age of the teenager allowed these parents to engage in the said discussion, for some of the mothers, age was a hindrance to engaging in a sexual discussion. In considering that puberty stage begins from the age of approximately 12 years, discussions with their teens were paramount (Neinstein, 1996). Based in these findings, mothers were having discussions with their teenagers late if discussions were considered after the age of 13 years.

It was further found in a study conducted by Naidoo (2000) with high school students, that the age of the first sexual intercourse was 13.27 years. This was further borne out in a study conducted by Flisher, Ziervogel, Charton, Leger, Robertson (1993) where it was reported that the median age of first intercourse was 15.1 years. These findings make it important that mothers started these discussions earlier rather than later with their teens. Mother J quoted on J8 stated

and Mother C (quoted on C6) in their responses illustrated the sense of ambivalence that characterized the responses received:

"I saw that they are big. I realized that if I did not talk about it with them, they could get themselves into dangerous situations without knowing. I felt that they needed to know about how they could protect themselves from diseases and pregnancy". (J.8)

"When it crops up on television, we don't talk about it as in sitting down. We tend to start talking if something has come up somewhere". (C6)

For some mothers, it appeared that the fear of HIV and AIDS as well as personal exposure to the HIV virus was felt to have been important denominators to initiating a sexual discussion with their children. Cognitively, as expressed by mother J (cited on line J.8), it was felt that her teenagers would be in danger without HIV and AIDS knowledge that she believed discussions would help them to protect themselves. To this end, she felt it important to share with them her knowledge about the HIV and AIDS that they could use to protect themselves from diseases as well as pregnancy. Mother D (quoted on D.7) felt that the crux of whether she talked to her children came about when a relative who lived with them got infected with HIV and AIDS. This state of affairs made it urgent for her to talk to her children to ensure that they could protect themselves from the HIV virus.

"Yes, when my cousin got infected, I felt that I needed to talk to my son about the dangers in relation to HIV and AIDS". (D.7)

However, 20% (A10, G4) of the women in the study had not initiated sexual discussions with their children. Two areas of concern namely the age of the child and the fear of giving teenagers too much information that could lead to lack of control were cited as the two pertinent reasons that stopped parents from initiating sexual discussions. According to the mother (quoted on line E.5), fear of lack of control made it difficult for her to trust that her children would be able to take responsibility for the information offered to them as seen below:

"Yes since the whole issue of HIV and AIDS came to the fore. For an example, when the children are out of the house, you don't know what they do that is why it's important that you talk about the dangers out there". (E5)

It appeared that for this mother, sex was seen very much as a dangerous thing. It is possible that sex for this mother is seen as a dangerous activity in light of HIV and AIDS. However, the mother might have had difficult sexual experiences herself that could have impacted on her feelings regarding her children's sexuality.

"No I haven't initiated sexual discussion with my teenager. I have been telling myself that my son is too young. I have been thinking of starting to discuss these types of things when he is 15 years old". (G.4)

Rotheram & Lyons (2005) negates the belief that discussion about sex could led to an increase in sexual activity and contends that a comprehensive sexuality education programme that discussed the appropriate use of condoms did not accelerate sexual experiences. Evidence suggested that such programmes increased the number of adolescents who abstained from sex and delayed the onset of their first sexual intercourse. This information needed to be cascaded down to mothers as it is important for them to know.

Furthermore, it appeared from the study that the media played a significant role in determining when mothers initiate sexual discussions. According to the responses, 20% (C6, F5) of the mothers initiated discussions with their teenagers when the subject came up on television or in magazine articles. At a time when HIV and AIDS have claimed many lives in recent years, the subject of HIV and AIDS is under discussion more than ever before specifically in the media (Rotheram & Lyons, 2005). This finding was encouraging in that although only a small number of mothers took action when the subject was discussed in the media, some action was taken by the mothers.

It appeared that most mothers interviewed had initiated discussions with their

teenagers about sex for various reasons. Although the age (G4, I4, J8) of the teenager determined in most cases why discussions were initiated, the issue of HIV and AIDS was an important contributor to having discussions (E5, D7, J8). Mothers who gave this reason maintained that it was urgent that their teenagers had information about the disease to equip them with knowledge that could save their lives. In conclusion, it was noteworthy that the age of the teenager either encouraged or discouraged the mother to initiate discussions about sex with her teenagers. In addition, the fear that the teenager could know too much and thus be rendered unable to manage the information was also given as an important reason for not initiating discussions.

The three components of the attitude model were addressed in this question. It was noteworthy that the affective component was addressed when mothers accounted their reasons for not engaging in discussions namely that they feared that their teenagers would know too much that could lead to a lack of control. The cognitive component of the model was accounted for when mothers gave reasons for having engaged in discussions namely, that they felt that their teenagers were old enough to engage in discussions, fear of HIV and AIDS and a sense that their teenagers would be in danger without the necessary knowledge. The behavioural component was evident in that 80% (B4, C6, D7, E5, F5, H7, I4 and J7) of the mothers contend that they have initiated sexual education with their teenagers.

5.3 UNDERSTANDING THE PERCEPTION OF MOTHERS ON CONDOM USAGE

The second cluster of questions tapped into the view of mothers and their understanding of the function of condoms specifically asking who should use condoms.

5.3.1 What in your view is the function of condoms? Who should use them?

For 90% of the mothers involved in the study, the main function of condoms was for protection against sexual diseases mainly HIV and AIDS (A11, B12, C8, D8, G5, H8, I6, and J9). This protection, according to 20%, of the women allowed for safe sex (B12, F6). Only 20% of the mothers mentioned that condoms were also a protection from unplanned pregnancy. Furthermore, the mothers felt that both teenagers and adults involved in sexual activities should use condoms (C9, H8, and I5). Only one mother maintained that she did not know much about condoms or how they worked (E7).

However a strong theme of having a proviso or conditions became apparent with regards to the use of condoms where mothers felt that their "teenagers should also be self-loving and preserving at the same time" (J.9). This was also collaborated by the mother B (quoted on B.12) that the use of condoms should not replace the plight for celibacy. She maintained that condoms should not be used to encourage multiple sexual encounters. It was expressed that although there should be an emphasis and encouragement on using condoms, this should be coupled with building a sense of self-respect and dignity where teenagers are made aware that they should aim to preserve themselves as the first aim.

> "It's the only way for them to have sex, but as a parent, I don't want to lie, I won't encourage my daughter to use condoms because at the end of the day, it would say that we sleep around and we simply use condoms and we don't care anymore". (B.12)

The mothers in this study strongly maintained that condoms were an important protection mechanism from sexual diseases specifically HIV and AIDS. A small number of mothers (D8, I6) felt that it could also be used as a form of contraception. It is possible that the media campaigns mainly targeting HIV and AIDS prevention have influenced this finding. This might be due to the fact that the shift has moved from the focus on early pregnancy to HIV and AIDS. An example of one of the most publicized media campaign has been that of LoveLife.

LoveLife aims to delay first sex, reduce the number of partners people have, and encourage people to practice safer sex (Berry, 2004). However, the LoveLife campaign has been criticised in some circles for sexualising the epidemic that might also have influenced the finding of condoms being seen mainly as protection from HIV and AIDS (Berry, 2004). Mothers were of the opinion that there should be an emphasis and encouragement on using condoms, this should be coupled with building a sense of self-respect and dignity where teenagers are made aware that they should aim to preserve themselves as the first aim. Thus the emphasis was on discouraging sexual activity.

This question addressed both the cognitive and the affective components of the attitude theory. The cognitive aspect was evidenced when 90% (A11, B12, C8, D8, G5, H8, I6, and J9) of the mothers maintained that condoms are a form of protection against sexual diseases including HIV and AIDS thus allowing for safe sex. It was further emphasized by the mothers that for these reasons, there should be a concerted effort to encourage the use of condoms. The affective component of the model was particularly evidenced when mothers stressed the need for a proviso or conditions that should be attached to the use of condoms. It was felt that there was a need to build a sense of dignity that should be accompanied by a discouragement to engaging in sexual activities. It appeared that there could be a willingness to accept that condoms have a function to play but that mothers are very uncomfortable to put this into action. The next area that was explored was with regards to the action mothers would take on finding out that their teenagers are in possession of condoms.

5.3.2 How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms.

In answering this question, a breakdown of 30% (E8, I7 and J10) of the mothers having positive feelings and 70% (A13, B15, C10, D9, F7 G9 and H9) having negative feelings was articulated on how they would feel if they found their

teenagers in possession of condoms. 70% of the mothers articulated that they would be angry, upset and frustrated if they found out that their teenagers were in possession of condoms:

"I would feel sick, oh, I would feel very bad. It would mean that she does have a boyfriend. I would sit her down and talk to her about HIV and pregnancy. I would be very upset with her and disappointed". (F.9)

"That would disturb me. I will be very upset. *It would make me aware of the fact that they are sexually active*. I would ask them what they are doing with condoms. Although I know that my role is to advise them to equip them to make the right decision, I would tell them that at their age, they are not supposed to have sex" (G.9)

These responses tapped into the affective component of attitudes described in Pratkanis & Greenwald (1989) where the mothers expressed their feelings and opinions, such as when the mother above described that she would be disturbed and upset. There seems to be a feeling by the mothers of being disappointed on finding out that their teenagers are sexually active. Mother F went further in her (quoted on F9) response where she gave some indication that she associated sexual activity with having a girlfriend that invariably could mean that there is some level of commitment between the teenagers. Naidoo (2000) challenged this assumption when it was found in a study conducted with grade 10 pupils in Lenasia, Eldarado Park, and Ennerdale schools in Johannesburg when students were found to have multiple sexual partners. Flisher (1993) found that the median number of weeks since the most recent coital episode was 6.6 at which, 76.6% had known their partner for 7 days. Therefore the assumption made here by the mother might not be feasible. Mothers needed to acknowledge that teenagers did not necessarily equate the need for sexual interaction with having a relationship such that this could be a focus of discussion where teenagers are encouraged to know their partners well before sexual interaction was commenced.

On the other hand, mothers maintained that they would feel relieved that their

teenagers were taking responsibility for their lives (E8, I7, and J11). According to 30% (E8, I7, and J11) of the mothers, they would be happy that their teenagers are not only protecting themselves from diseases but also that they would be protecting themselves from early responsibilities such as an early pregnancy or making a girl pregnant. In addition, for 20% (A13, H9), of the mothers, said that for their teenagers to have condoms on their possession would signal that they are considering having sex or have started having sexual encounters hence the need for condoms. When asked about what they would do about finding their teenagers in possession of condoms, 70% (A12, B15, C11, D9, F9, G8 and H9) of the mothers maintained that they would engage in a discussion. The content of the discussion included talking specifically about HIV and pregnancy in an attempt to impart knowledge and advice to the teenagers (F9).

It was important for 20% of the mothers that the discussion should be open and thus felt that they would need to take some time to ensure that their teenagers were comfortable that would require them to foster a supportive environment. This response might be indicative of the fact that there is an expectation that discussions might be difficult for the teenager. It was possible that the mother might be projecting her own fear on the teenager. In addition, it appeared from the responses that mothers have good intentions in that they would take action. However, it might be important to consider that mother's might have felt some pressure to respond in some way to the question asked specifically in an interview context such as this.

> "I would call him, and make him very comfortable and to help him to be open to me and for me to make him understand that he needs to be responsible for what he is doing to himself and to God. And because he is a boy, he is in control". (C.11)

Two mothers expressed a religious perspective where, mother C (quoted on C11) maintained that she would express a need to take control of the situation as well as to emphasize that her son should take responsibility for himself and to God. Mother J (quoted on J.11) gave a similar response when she maintained that she

would have a discussion with her teenagers focusing on the Christian bible teachings about sexuality. It is possible that the socialization issues stemming from organized religion might have influenced this response. The increase in the number of churches and church organizations in the South African environment and their involvement in the struggle to combat HIV and AIDS might have also played a role in this response (Hogan, 1982). Although mother D (quoted on D.9) agreed with the above views regarding having a discussion with her son to address issues pertaining to HIV and AIDS. She went further and contended that she would ensure that condoms were made available to her son and thus would leave condoms in his room for easy access. This response by mother D, taps into the behavioural component of the attitude model where the mother takes action by way of making condoms available.

> "That is why I say that I can even leave a box of condoms in his room. I am not promoting sex but I am simply saving his life". (D.9)

Ambivalence characterized the responses received from the mothers. It appeared that there was a difference in response with two opposing views expressed by mothers namely, some mothers expressing frustration and anger on the one side and others expressing relief on the other side. It appeared that there is some consensus with regards to how mothers would deal with the situation namely that mothers would seek to have a discussion with their teenagers. Mothers appeared to acknowledge that they needed to foster and encourage an open discussion to equip their teenagers with knowledge (cognitive component of attitude theory as the need was to impart knowledge to teenagers). In addition, it was noteworthy that for most of the mothers the aim of the discussion was seen as a way to emphasize abstinence from sexual activity before marriage and thus imparting morals and values.

The responses to this question have employed the attitude theory extensively as all the three components of affective, cognitive and behavioural components were explained. Cognitively, mothers maintained that for teenagers to have condoms in

their possession would mean that they are taking responsibility for their lives. Furthermore, it would be an indication that they are protecting themselves from early responsibilities such as early pregnancy that necessitated the need to engage in discussions in an attempt to impart knowledge and advice.

However, affectively, mothers anticipated that discussions about sex could be difficult. There was an equal breakdown of 50% of the mothers having positive feelings about finding their teenagers in possession of condoms whilst the other 50% of the mothers verbalised negative feelings. The 50% of the mothers that verbalised negative feelings mentioned that they would be angry, upset and frustrated whilst the other half verbalised that it would be a sign of relief for their teenagers.

It appeared that there was a disconnection between what mothers say cognitively in answering this question in relation to what they say they would feel (affective) about the same issue. Although they verbalised that condoms meant that teenagers were taking responsibility for their lives, mothers affectively responded by saying that they would emphasize that they needed to take responsibility for themselves and to God that signals that there could be a feeling that using condoms is not enough as a form of protection. Furthermore, although mothers said that condoms would be used to protect themselves from early responsibility such as early pregnancy, there is a sense of shock when mothers maintained that condoms would signal a consideration to have sex or that they are having sexual encounters. Behaviourally, 70% of the mothers conceded that they would engage their teenagers in discussion where they would address issues of HIV and pregnancy. However, there was a sense of mothers being "crippled" by the discovery of condoms with the teenagers that needed to be acknowledged.

5.3.3 How would you respond if you found your son vs. your daughter being in possession of condoms?

A sense of shock, unhappiness, anger and frustration and a feeling that the teenager was being careless was articulated by 50% of the mothers (A11, B15, C10, G9 and I8). It was noteworthy that for both mothers who had teenage sons and daughters gave the same sense of disappointment on finding their teenagers in possession of condoms. Karim et. al. (1992) found that parents were unwilling to discuss sex with their children both because they were uncomfortable and feared that such discussions could encourage sexual behaviour. As stated above, Rotheram et al. (2005) refuted this idea and maintained that research on teenager's sexual behaviour shows that comprehensive sexuality education that discusses the appropriate use condoms does not accelerate sexual experiences. Evidence according to these writers suggested that such programmes have increased the number of teenagers who abstain from sex and also delayed the onset of sexual intercourse.

It appeared that mothers recognised that the presence of condoms would facilitate a discussion about condom usage with her teenager. Thus, there was an acknowledgement that condoms had a role to play. Although condoms are external, physical objects, they could be a causal factor in external dialogues that have implications in the internal world of the teenager. However, mothers seemed to need an external prompt by way of finding condoms to initiate discussions. It appeared that due to the reactionary nature of the discussions, discussions were not focused, resulting in a "hit and miss" attempt to discuss condoms. 20% (D10, J11) of the mothers with teenage boys maintained that for their teenagers to have condoms in their possession would be good to ensure protection.

> "I think that it would be good if boys use condoms if they are not able to rely on the teachings of the bible". (J13)

It appeared from the above responses specifically from Mother J (quoted on J13)

that there is a negative perception of teen sexuality specifically when the one considers the moral values imparted through religion. Hogan (1992) stated that religion had a profound effect on sexuality in the history of man. It is known that for reproduction to take place there was a need for sexual interaction. However, the bible in an attempt to impart values and morals has designated sex as an activity that should take place between a married man and a woman for reproduction purposes.

For 60% of the mothers, finding their teenagers in possession of condoms would open a channel for discussion. It was noteworthy that half (30%) of the mothers with teenage boys and the other half (30%) with girls all felt that this would open discussions (A12, B15, C11, E9, F10, I8). However, there was also an acknowledgement by some mothers that for their teenagers to have condoms in their possession was a good thing in that this would ensure their protection from diseases (C10, F10). It was interesting to note that there appeared to be some consensus regarding how to respond namely that mothers felt that this would open discussion between themselves and their teenagers where they could emphasize responsibility.

It was important to note that cognitively, although there was an acknowledgement by mothers that condoms have a role to play with mothers maintaining that condoms would ensure that teenagers would be protected from diseases, there was also a negative perception of teen sexuality. Behaviourally, mothers acknowledged that the presence of condoms would facilitate discussions about condoms. Mothers conceded that this would open a channel for discussion. However, a discrepancy by way of ambivalence was found in that affectively, both mothers of boys and girls articulated a sense of disappointment in finding their teenagers with condoms. 50% (A12, B15, C10, E9, I8) of the mothers articulated they would be shocked, unhappy, angry and thus feeling that the teenagers are being careless.

5.3.4 How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

In responding to this question, 60% (C13, D10, E10, F11, G10 and H11) of the mothers maintained that they did not see a difference between the sexes and that the same standard should prevail. It was found from the study that 70% (A12, C13, D10, E10, H11, I9, J13) of the mothers maintained that it would be good for their teenagers to take responsibility and taking the initiative to use condoms. However, a gender stereotype was verbalized by some of the mothers who said that they accepted that boys should use condoms if they are planning to engage in sexual activity (I9). However, it was said that girls need to be self-preserving and self-loving such that it was emphasized that they needed to abstain from sex (J13). However some mothers acknowledged that they could not control their teenager's behaviour. This sense was collaborated by Mother H (quoted on H11) who has both girl and boy teenagers. She expressed that it was better when the teenagers use condoms. As mentioned by Mother H below (on H11), it appears that there was enormous fear that mothers have in relation to teenage sexuality. Although the aim was not to negate differences between ethnic groupings, generally, there was fear that could have been influenced by the religious and cultural beliefs in that many cultures specifically the Black South African culture prizes virginity among women even though they might not give the same respect to male virginity (Bromwich & Parsons, 1990).

> "I don't like to talk about sex out of fear that it might make these kids aware of sex and thus want to try it. Although I don't want to think about it, I do think that if they are going to have sex, it was better that they use condoms". (H11)

As described above, Mother H went further and said she does not want to think about it. It appeared that the fear to think about sex and condoms could be related to the fact that if she thought about it then she would have to do something about it. Perhaps rooted in this fear was a fear to acknowledge that their teenagers are reaching a certain level of development that could render

them powerless. In contrast 30% (B10, F11, and G10) of the mothers maintained that teenagers should abstain from engaging in sexual activities until marriage.

> "We must tell our children to practice sex after marriage. Teenagers should wait until marriage". (F11)

One mother (Mother G, on G4), maintained that she would discourage and disallow the use of condoms. These feelings could be understood from the point of view that the cultural background of the mother could have played an important role in influencing her to feel this way. This mother was of the opinion that her influence would have some impact in her teenager's behaviour in that she verbalized that she would not allow them to use condoms. However, this could be difficult to realize in that as mentioned above, teenager due to their emotional and physiological and physical development are beginning to develop their own views and independence (Walton, 1995). Thus it was possible that her opinions and wishes might not be readily accepted by the teenagers who are faced with peer pressure and their own needs of independence (Walton, 1995).

The dominant theme that came through was that mothers felt that the same standard should be applied to both sexes that is in contradiction with the cultural standpoint that prizes virginity among women and does not give the same prize of virginity for men (Bromwich & Parsons, 1990). They expressed that they would encourage their teenagers to use condoms when they engaged in sexual activities specifically when they recognized that they could not fully control the teenager's behaviour. However, there was a need to acknowledge that adolescent's values and attitudes evolve out of their relationships with their parents and peers, as well as their social and cultural experiences to which they have been exposed (Gruber & Chamber, 1987). Furthermore, mothers expressed that using condoms was a sign of taking responsibility that needed to be fostered. In this way teenagers begin to disengage from their mothers in order to construct their identity that was separate from the mother's. In this vein, mothers would encourage their teenagers to abstain from sexual activity until

later in life.

This question addressed the affective and behavioural components of the three components model of the attitude theory. It appeared that there was enormous fear related to the issue of teen sexuality. The fear was mainly in that mothers feared that their teenagers could lose control that would render them powerless in enforcing discipline. Thus, although mothers mentioned that the same standard should be maintained for both the male and female teenagers, a sexual stereotype was found affectively when mothers maintained that it was acceptable for teenager boys to use condoms when engaging sexually in comparison to when they verbalised the need for teenage girls to be self-preserving and self-loving and thus urging them to abstain from sexual activity.

5.3.5 What do you believe is the role of the schools in comparison to the role of the mother towards educating teenagers about condoms?

In responding to this question, 50% (B20, C15, D12, G11 and I10) of the mothers maintained that the home should take responsibility for educating teenagers about condoms. Therefore the schools should address outstanding issues that the teenagers need additional information. In this way, the schools become a sounding board where information could be confirmed and questioned. 30% (E11, F12 and J14) of the mothers maintained that both the home and the school environment should play an equal role in educating teenagers about condoms.

In contrast, 20% (A16, H12) of the mothers contend that it might be difficult for the teenagers to disclose things at home such that they might be freer to express themselves at school. As a result it might be easier to educate teenagers at school, as it was believed that teenagers would not disclose at home if they were sexually active. It was unclear whether this perception was feasible in the South African context where sex education was recently been introduced at the schools (Berry, 2005). It was the researcher's belief that if it was difficult for the teenager

to disclose their sexuality to his or her mother, how easy would it be for that teenager to disclose to a teacher, an authority figure?

It was hypothesised that perhaps this could be related to a cultural issue of fearing to discuss issues of sexuality because of fear and be uncomfortable that related to the fact that mothers might feel unable to address the issue with their teenagers and thus shift the responsibility to the school. It was possible that not all the schools are equipped to address issues pertaining to sexuality at the level expected by the mothers due to the fact that the schools lacked the resources and qualified teachers. Furthermore, further training was needed for the teachers to equip them in educating teenagers. In addition, in a study conducted by Stout (1989) to review school sexuality courses, it was found that the schools sex education programmes lacked a measurable effect.

It was further suggested from the study that a classroom course is not able to change sexual behaviours in a direction that is opposite to the adolescent's sexual world that is moulded by television, movies, music, advertising, peer groups and adult role models (Stout, 1989). To this end, the mothers might be taking an uninformed risk of putting the responsibility on the schools and not on themselves. Having said that this, the schools are not precluded from giving teenagers practical skills by way of activities and through facilitating debates to allow for information sharing. The responses given on this question are similar to what was received when mothers were asked about their beliefs on the role of sex education at home and at school. As per the quotes below, mothers verbalised their beliefs of their role in educating teenagers about condoms in comparison to the role of the schools.

> "I think that children should hear about all these things firstly from us as their mothers. The schools should rubber stamp what we have already told them". (D12)

> "Both the school and the mother should teach the teenagers about condoms". (J14)

Opposing views were expressed by mothers with regards to the role they play in comparison with the role of the school. Although there was a small amount of mothers who felt that there should be an equal role played by the different environments as stated above, it appeared that there was agreement that both environments should play an active role in educating teenagers about condoms. However, to some extent, mothers seemed to want to share this responsibility of sexual education with the schools. Mothers seemed to expect that in situations where they find it difficult to open up to their teenagers, the schools should take the responsibility of educating the teenagers.

> "The schools can use activities to educate the children about condoms. With their mothers, kids will not disclose that they are sexually active. So I think that the school should play a bigger role in educating children about sex". (H12)

However, this perception is problematic as the South African school system regarding sexual education is at an infancy stage where some of the schools are starting to introduce sex education programmes (Gevisser, 1993). Thus, the expectation by the mothers could leave their teenagers without proper input and education that could leave them exposed as it were.

This question tapped into the cognitive component of the three components model of attitude where mothers felt that they should take the responsibility to educate teenagers about sex. They went further to say that both environments should play an equal active role in educating teenagers about condoms.

5.3.6 What is your opinion towards the availability of condoms to teenagers e.g. in public toilets and schools?

In answering this question, 60% (B21, C16, D13, E12, H13 and I12) of the mothers maintained that it was good to make condoms available to teenagers at public places. For 20% (B21, D13) of the mother's the feeling that teenagers are sexually active at a young age appears to have influenced this finding. For

Mother C (cited in line C13, see Appendix C), the reality was that teenagers engage sexually that needs to be acknowledged. This view was further expressed by mother E (on line E12) who contended that abstaining from not having sex was difficult and that it would be better for the teenager to use condoms if they were to engage sexually. In the risk taking behaviour study conducted with Cape Peninsula high school students by Flisher et al. (1993), 17.4% of the teenagers reported a previous episode of heterosexual intercourse.

This finding suggested that there was a frequency of interaction that teenagers might hide from their parents their sexual involvement. According to Mother H (cited on H13), teenagers are secretive about their sexual behaviour. Therefore it would be better for teenagers to have condoms available at venues where they would not need to ask permission to access condoms from their parents. However, although the government has been promoting the availability of condoms in some public places such as in toilets, this practice was not widespread (Flisher et al., 1993). It was unclear whether this practice has been extended to schools where teenagers do have access. It was believed that most schools especially in the townships do not have access to condoms as readily as it was suggested here. According to Matthews in Flisher et al. (1993) in a study conducted with urban high school students, it was found that only 11.4% had ever used a condom that could be a result of unavailability of condoms or a result of their perception of condoms. Mothers verbalised the following with regards to availability of condoms:

> "I think that's great because like I said, we cannot stop them; so if condoms are freely available, let them get them because we are not there when they do these things". (B21)

> "Because the teenagers might want to use condoms but be afraid to ask their parents so that if the condoms are available in other places, then my son would be able to access condoms". (I13)

In contrast to this view, 40% (A18, F13, G12 and J15) of the mothers disagreed

with the above and maintained that condoms should not be given in public toilets. According to the mother A (quoted on A19), condoms should not be provided at public toilets even to adults as she felt that this was inappropriate. It was felt that rather, condoms should be provided at Health Care Centres where a holistic approach could be adopted to educate and give information about safe sex. Although this would be ideal, when considering the fact that some teenagers are secretive about their sexual activity, accessing condoms from a public health facility might be very difficult.

"I think that it is wrong. They should not give them at the schools. I think that it is very, very wrong. The children have gone to school to learn and not to use condoms". (G12)

In summary, although some mothers felt that condoms should not be readily available to teenagers at public places, it appeared that for most of the mother interviewed for this study, there is an acknowledgement of the fact that it would be difficult to directly influence teenager's sexual behaviour. To this end, it became important especially in light of the fact that teenager appeared to engage sexually at a young age that they have access to condoms in private where they would not need the consent of a parent. It was further recognised that teenagers can be secretive about their sexual status, that having condoms available becomes one of the ways to promote safe sex. Although some mothers expressed the view that it was wrong to have condoms available in public places, an ambivalent perception was expressed where the mothers acknowledged the need to have condoms available for teenagers without needing the mother's approval. The suggestion made was that perhaps condoms could be made available at Health Centres where knowledge could be imparted together with the condoms.

The cognitive component of the three component theory of attitude was addressed when mothers acknowledged the idea that teenagers engage sexually. They further maintained that abstaining from sexual activity is difficult hence it is better for teenagers to use condoms when engaging sexually. To this

end, it was felt that condoms should be available at Health centres where a holistic approach could be adopted to educate and impart knowledge at the same time.

In terms of the affective component, 60% of the mothers felt that condoms should be made available in public places. However, 40% disagreed and maintained that condoms should not be made available publicly. It appeared that consensus is found in terms of mothers responses cognitively to the issues at hand, but affectively, mothers disagreed in their responses to this question. This raised questions on what the implications of the dissonance found in the responses?

5.3.7 What type of questions would you encourage about condoms in discussions with your teenagers?

For the mothers interviewed, there was a sense of needing to be open with their teenagers that came through for 90% (A20, B23, C17, D14, E13, F14, G14, I14 and J16) of the mothers. In response to a realisation that teenagers engaged in sexual behaviour, mothers expressed that they would engage them in discussion. This finding suggested that mothers would prefer to react to a perception of sexual activity rather than taking a proactive approach. It appeared that currently, although mothers say that they would encourage teenagers to discuss sexuality with them, there seemed to be a difficulty in talking about the issues. In most of the responses the affective component of attitudes was expressed more regularly where mothers verbalised how they would feel that clouded the teenager's feelings.

This proactive approach would allow them to be non-judgemental in discussing the sexuality and condom usage. It was noteworthy that 40% (A20, B23, G14 and I14) of the mothers felt that they would encourage their teenagers to ask them any questions. Behaviourally, mothers wanted to encourage their teenagers to ask about how condoms are used, when and how they could be

used, as well as their effectiveness. It was also felt that teenagers should be encouraged to ask about condoms reliability and safety. Mother B (quoted on B23) maintained that she would encourage her teenager to ask her about whether she (herself) uses condoms. Only one mother (H6) maintained that she would not encourage her children to ask her questions.

> "I would encourage all the questions my teenagers might have. I would like them to be open with me and to ask me whatever they want to ask". (E13)

It appeared from the study that there was willingness and a wish to be open by the mothers that would encourage their teenagers to ask them about condoms. For most mothers (mothers, B, C, D, E, F, G, I, J) interviewed, it was important for them that their children ask them any questions they might have about condoms particularly question pertaining to use as well as the effectiveness of condoms. There was also openness to some degree from mothers to disclose their own experience of condoms to their teenagers. However, it was questionable whether in reality; there was a real encouragement by the mothers for the teenagers to discuss sexuality and condoms with teenagers. It appeared that there was a difficulty in discussing the issues as the mothers appear uncomfortable. This uncomfortable ness might be influenced by religion and culture, a fear that teenagers would know too much, as well as a fear of not knowing what to do when they found that their teenagers are sexually active (E5, G4). Thus the behavioural and affective components of the three components model of attitude theory were addressed in this question.

5.3.8. What type of questions would you discourage about condoms in discussion with your teenagers?

In answering this question 80% (A21, B23, C17, D15, E14, F15, G15 and I15) of the mothers maintained that they would not discourage any questions from their teenagers. It was noteworthy that for the Mother H (quoted on H15), allowing her teenagers to ask questions about condoms could give them a sense that they

could be sexually active. To this end, she maintained that they should not have any of this information, as she did not believe that they should be sexually active.

"I don't think there will be anything I would discourage for her to ask me". (B23)

In contrast, the mother quoted on J17 maintained that she would discourage her teenagers to ask her when they could start using condoms. She also felt that she would discourage questions about when she started having sex as she felt that that would be too personal for her.

In terms of the three components model, this question elicited the affective component in the responses. It appeared that mothers feared the implications of engaging in discussion as it was felt that teenagers might see such discussions as permission to be sexually active. Some mothers verbalised that teenagers should not ask them any questions about sex.

"Why should they be sexually active? I don't like it". (H15)

In conclusion, ambivalence characterised the findings in relation to this question. It appeared that although the majority of the mothers in this study did not want to discourage their teenagers from addressing issues pertaining to condoms such that mothers expressed that they would encourage all questions from their teenagers, some mothers were opposed to encouraging discussions.

5.3.9. What impact do you think such discussions would have on your relationship with your teenagers?

From the responses received, 40% (B25, D16, E15 and G16) of the mothers maintained that having open discussions with their teenagers about condoms and sex would encourage openness between them and their teenagers. Behaviourally, for those who had initiated discussion, the feeling was that this had allowed them to address and talk openly about pertinent issues in the teenager's

life. In this way, the teenager had different choices from which to choose. For 30% (A23, C18 and I16) of the mothers having open discussions had created closeness between them and their teenagers. Mother F (quoted on F16), contended that it had built a strong bond between her and her teenagers as it fostered freedom of expression and a sense of transparency between the teenager and the mother (I16, J18). Accordingly, this facilitated preparation for life in general as it highlighted to the teenager's potential dangers that might come with engaging in sexual activities. As per the quotes stated below, 20% of the mothers felt that having discussion has built trust between them and their teenagers that has further enhanced their relationship.

"I can say that it has helped to build a strong bond between us". (F16)

"They would trust me more". (A22)

One mother believed that having discussions with teenagers allowed for her to become the teenager's role model. This was questionable in light of the fact that teenagers tend to desire to move away from the mother in an attempt to finding their own identity that challenges the said identification with the mother (Karrim, et al., 1992). The discussion above suggested that mothers in the study believed that teenagers benefited positively by having open discussions with them as it facilitated that they could ask any questions they had about condoms. In addition, mothers felt that having these discussions had fostered a sense of trust, openness and closeness between the teenagers and their mothers. It was felt that this allowed for transparency between teenagers and mothers as well as a feeling that teenagers are better prepared for life. It was the present writer's view that this finding should be qualified by saying that these feelings by the mothers might be wishes that they have about their engagements with their teenagers. This might not have been tested by the mothers, thus further research needs to be done to investigate how the teenagers felt after such discussions.

The behavioural component of the model was evidenced in that mothers have

initiated discussions with their teenagers. The cognitive component was verbalised in that mothers believed that discussions were important as it was crucial for preparing their children for life in general. The affective component was evidenced in that mothers believed that their teenagers benefited positively to having open discussions.

5.3.10 What questions would you encourage and discourage about HIV and AIDS?

In answering this question, a feeling of the mothers needing to be permissible and open to their teenagers came through. All the mothers maintained that they would not discourage any question in relation to HIV and AIDS. It is important to note that the mothers who indicated specifically what questions they would encourage also maintained that they would not discourage anything. 40% (B27, D17, G17 and H17) of the mothers contend that they would encourage their teenagers to ask them everything they need to ask about HIV and AIDS. 50% (A24, E16, F17, G17 and I17) of the mothers collaborated this view and maintained that they would focus on issues pertaining to transmission and protection that taps onto the behavioural component of the three components model.

> "I would encourage questions around transmission. I would not discourage any questions". (E16)

20% (C20, J19) of the mothers maintained that it would be important for them to emphasize a sense that teenagers should not discriminate against people with HIV and AIDS. However, disclosing one's HIV status still resulted in grave consequences for those who disclose in South Africa (Berry, 2004). In 1998 Gugu Dlamini, an AIDS activist in Durban, disclosed that she was HIV positive on world AIDS day. She was beaten to death by her neighbours (Berry, 2004). Although this incident happened a number of years ago, these kinds of reactions have set the tone that has resulted in people fearing to disclose their status that has further fuelled the epidemic. Mother J (quoted on J19) went further to

maintain that she felt it important that her teenagers should recognize that they would need to be accommodative to each other as a family that would ensure that they looked after each other should any member of the family be infected by HIV and AIDS. The stigmatisation described above might make things difficult to put in practice a sense of safety for the family members to disclose their status to each other.

Both the affective and behavioural components of the model was evident in the responses to this question particularly when mothers verbalised a sense of needing to be open to allow their teenagers to ask them all the questions they might have that corresponded with a sense of needing to be open and transparent regarding HIV and AIDS.

5.3.11. What would you do if you found out that your teenagers are sexually active?

In answering this question, mothers expressed contrasting views. 60% (B30, C21, D18, F18, G18 and I20) of the mothers maintained that they would have a discussion with their teenagers that would cover issues pertaining to HIV and AIDS, and sex in general where they would advocate that teenagers take responsibility for their behavior. 80% (A26, B30, C21, D18, F18, G18, I20 and J21) of the mothers maintained that they would use this opportunity to give guidance to the teenagers by focusing on highlighting taking responsibility for consequences and stressing the importance of abstinence. Of the 80%, 20% (E17, I20) of the mothers maintained that they would be accepting and understanding towards their teenagers whilst emphasizing caution. 20% (A26, J21) of the mothers maintained that they would emphasize Christian beliefs by way of teaching bible principles:

> "Wow, then I would have to play a mother's role. I would say that she is active, and then we better talk about it because I can't change that. So we would have to talk about sex, HIV and AIDS and pregnancy". (B30)

"Issues of HIV and AIDS should be discussed on a daily basis. I would continue to talk about the issues with him over and over again". (D18)

"Oh, I would be so disappointed. But I will talk to her. I would try to get her to see the disadvantages of engaging in sex i.e. pregnancy, HIV and AIDS". (F18)

The religious response stated by the mother (A26, J21) above could be rooted in the medieval belief where any artificial methods of contraception were ethically disapproved. The Catholic Church, Islam and Jehova Witness religions see sex solely for procreation and thus should not be interfered with (de Villiers, 1985). However, in recent times, there seems to be some disagreement about these issues as seen on a television interview where Bishop Desmond Tutu stated that condom use was permissible for people to protect themselves against HIV and AIDS. This stood in opposition to what the pope and the Roman Catholic Church says. However these positions might be shifting with time as more and more people are affected by HIV and AIDS.

Mother B (quoted on B30) says that she would have to play the mothers role if she found out that her teenager was sexually active. She mentioned that playing a mothers role would entail discussing sex, HIV and AIDS as well as pregnancy. The question was what informs this perception of the role of the mother? It was possible that the cultural influence, education and religion amongst other factors might have influenced this perception. It was believed that factors of the level of education, the class the mother occupies in society, religion play an important role in informing people's perception of issues pertaining to sexuality, condoms, HIV and AIDS (Christopher, 1987). According to Christopher (1987), educational aspiration and parental education are associated with use or non-use of contraceptives including condoms. Furthermore, it was believed that people who are educated are flexible and open to the use of contraception including condoms (Foster, 1994).

The belief and behaviour of people towards health care are governed by cultural beliefs. Cultural reservations, myths, misconceptions, superstitions and half-truths about contraception (it was believed that a similar circumstance was found in relation to condoms) are based on opinions that are at times ill-informed rather than knowledge, affect condom usage (Sapire, 1986). Examples of myths would be the idea that if contraception (and here we include condoms) was not available, teenagers would not be sexually active before marriage nor be promiscuous (Braveman & Strasburger, 1989).

Therefore it would be helpful to explore this further as the perception of the role of the mother in the 21st century would shed some light on how mothers perceive their role in relation to HIV and AIDS. Two mothers had a different view as they maintained that they would be hurt, surprised and disappointed if they found out that their teenagers were engaging in sexual activity.

> "That would be very hurting for me. Those are not my teachings. I teach them not to be sexually active at a young age. I don't know what I would do. I told them that if they get HIV and become positive, it would be difficult for me to be supportive to someone who chooses this at such a young age". (H18) – Ages of the children are 20, 13 & 18 years

As stated on the quote above, Mother H (quoted on H18), advocates that she would stress that she would not be supportive of these choices in the event of the teenager getting infected by HIV and AIDS. This finding might be rooted in the fear and stigma associated with HIV and AIDS in South Africa. Based on the assumption that free medication is not yet available on a large scale for the majority of the people although efforts are currently underway to change this, it is possible that the mother might fear that she might have to take the responsibility of seeing to the physical needs of the patient that might be difficult (Berry, 2004).

Affectively mothers emphasized that they would be hurt, disappointed and surprised in finding out that their teenagers are sexually active. Behaviourally, mothers maintained that they would have discussions as a form of intervention

where they would cease the opportunity to give guidance by focusing on emphasizing the need to take responsibility for actions and thus stress abstinence.

5.4 SUMMARY AND CONCLUSION

Broadly speaking, ambivalence characterized the results attained from the study. It appeared that mothers believed that they have an important role to play with regards to educating their teenagers about sex and condoms. Although the time of initiation of sexual discussions varied for most of them, there was a belief by the majority of the mothers that they should be the starting point to initiate such discussions. It appeared that although mothers conceded that they would be shocked even upset about finding out that their teenagers had condoms in their possession, they also acknowledged that they could not fully and completely influence their teenager's behavior. To this end, they felt that they needed to foster openness by way of engaging in discussion with their teenagers about condoms and sex. In addition, they felt that they needed to allow teenagers to ask any questions they had in an attempt to impart as much knowledge as possible.

It was noteworthy that even though mothers felt that they needed to be open about sex and condom usage, mothers expressed that there needed to be a proviso that would emphasize abstinence as well as a wish that their teenagers should be self-preserving first and foremost before embarking in sexual activities. Mothers said that it was not a good thing to have condoms provided in public toilets. Another mother verbalized that she would be angry and frustrated if she found her teenagers in possession of condoms but at the same token maintaining that the use condoms when engaging sexually was a positive thing. To illustrate this further, it was mentioned that the use of condoms was good practice in that it promotes safe sex but also verbalized that she would feel sick and upset if she found her teenagers in possession of condoms, thus although condoms are a

good idea, they should not personally affect her or her teenagers.

Mother G maintained that mothers should discuss issues of sexuality with their teenagers. However she conceded that she had not initiated sex education with her 15-year old teenager. She maintained that she would be happy if she found her son in possession of condoms as this would mean that her son knows about condoms. It appears that there could be a shift in responsibility as this mother appears comfortable with her son being given the necessary information about condoms without her involvement. Mother H also expressed a fear that her initiating sexual discussions could result in her teenagers wanting to try out sex. As a last resort to stopping sexual interaction, mothers maintained that they would use bible teachings to discourage sexual interaction.

This discussion illustrates the diversity of the answers given by the mothers. It appears that although some of the mothers intend to be open to their teenagers about sex and condom usage, there are barriers with regards to the extent of their openness. It appears that mothers fear the consequences that could result from sexual interactions even if condoms are used. Some mothers are of the opinion that teenagers should be self-preserving and thus should not engage sexually at all. However, it is important to consider that teenagers do engage sexually more and more at a young age (Karrim, et. al, 1992). To date, condoms are the only mechanisms for protection hence the need for mothers to open up and discuss sex with their teenagers.

Disparate and confused views were reported by mothers (even those who had same sex teenagers i.e. female teenagers) when considering where sex education should be initiated. In addition, mothers contradicted themselves by verbalizing that they would be open to engage in sexual discussions that tap onto the cognitive component of the attitude theory whilst reporting that they would be disappointed on their teenagers if they found them in possession of condoms that addresses the affective component of the model. This was especially evident in

that according to the three components model of attitude, mother's appeared accommodative to the idea of discussing condoms and sexuality. However, affectively, mothers were oppositional and uncomfortable to put in practice by way of engaging in discussions (that is what they verbalised cognitively). The behavioural component of the model although addressed in some respect specifically in the questions that asked what mothers would do, it was not fully addressed in this study as the teenagers responses would have been able to provide adequately for this component.

CHAPTER 6

FINDINGS AND RECOMMENDATIONS

6.1 INTRODUCTION

In this chapter a summary of the findings of the research as well as the recommendation will be outlined. Firstly, the findings will be discussed followed by the recommendations.

6.2 RESEARCH FINDINGS

As discussed in Chapter Five, in the first cluster of questions that explored the attitudes of mother's towards sex education, the majority of the mother's maintained that there was a difference in roles between the home and the school environments. Within this sample, half of them felt that sexual education should start at home. It was believed by mother's that issues such as puberty and sexuality should be explored. Mothers maintained that this would allow for individual needs of the teenager to be addressed. In addition, it was said that this would promote a good mother and teenager relationship.

Furthermore, mothers and their teens can agree on boundaries and limits that would be difficult to implement at a school environment. From the results attained, there was recognition by mothers that allowing the teenagers to talk freely about sex with them would be beneficial. Therefore, the home was seen as the primary base where the subject of sex could be introduced followed by the school where the knowledge could be expanded upon. However, it appeared that although mothers wished to be able to discuss these issues at home as a first point of contact, they were hesitant to engage in these discussions.

In contrast, a quarter of the mothers (20%) contended that both the home and the school should be in partnership by way of playing an equal role regarding education of teenagers about sex resulting in diffusion of responsibility. Although consensus was not reached with regards to where sex education should start, it appears that mothers recognized the need to educate teenagers about sex.

Furthermore, most of the women interviewed in this study had initiated sexual discussions with their teenagers (80%). Varied reasons were given to how the discussions were prompted. The most important reason given that determined when discussions were initiated was the age of the teenager. However, consensus was not reached with regards to what is the appropriate age to initiate discussions. Other reasons given were that the subject of sex came about in discussions unintended or in unrelated conversation. HIV and AIDS including personal exposure to the epidemic as well as when the teenagers prompted discussions were also given as reasons that necessitated mothers to engage in discussions. For some mothers, discussions were initiated through the influence of media such as when the subject was discussed on television or through a newspaper etc. Strikingly, mothers did not give themselves as having been the source of the discussions by way on initiating discussions out of their own will.

A hindrance to initiating discussions experienced by the mothers was a fear that their teenagers would know too much that could result in a lack of control. It appears that for these mothers, sex was viewed as a dangerous thing that needed them to be protective of their teenagers. This could be the influence of the mother's own beliefs and experiences of her own sexuality. For these mothers, knowledge does not equal power, but becomes the opposite in that it becomes something that is feared in that the expectation is that there will be negative consequences. However, in consideration of the levels of HIV and AIDS infection rates, these fears need to be addressed and managed for effective HIV and AIDS prevention to work. Secondly, age was also cited as another reason why discussions had not been initiated with teenagers. Some mothers felt that their teenagers were young to

discuss sex with them.

When exploring the function of condoms and who should use them, almost all the mothers (90%) maintained that the main function of condoms is protection against sexual diseases mainly HIV and AIDS. It was believed that this protection allowed for safe sex to take place. In comparison, a small proportion (20%) of women maintained that condoms were also a protection mechanism from pregnancy. However, although there was a recognition that condoms can be used as a form of protection, a proviso that teenagers should be self-loving and self-preserving was emphasized. In essence the mothers contend that the use of condoms should not replace the plight of celibacy and that this should be encouraged first before teenagers are encouraged to use condoms. It was, therefore, emphasized that although there should be an encouragement to use condoms if teenagers are going to engage sexually, this should be coupled with building a sense of self-respect and dignity first. It was hypothesized that this could be an influence of media, religion or even education of the mothers. However, it appeared that the implication of needing to self-love is to abstain from sex, thus implying that loving oneself means you would not have sex.

It was important to note that media campaigns especially the LoveLife campaign emphasises that condom use is directly related to self-love and self-preservation which is in contradiction to the finding in this research which suggests that self-love explicitly excludes condom usage. Further exploration was needed, as alignment between mother's beliefs and the media campaigns is needed if HIV and AIDS prevention programmes are going to be effective. It was possible that the mother understands how condoms function was not adequate. As a result, training focusing on the purpose of condoms and how they work was needed to address these difficulties.

A breakdown of half of the mothers articulating positive feelings on finding out that their teenagers were having condoms in their possession was found. Mothers

expressed a sense of relief and happiness as this would be a demonstration that teenagers are taking responsibility for their lives. In contrast, the other half of the mothers maintained that they would be angry and frustrated if they found their teenagers in possession of condoms. They maintained that this would signal that they are considering having sex or have started engaging in sexual activities. Broadly speaking, in response, mothers felt that they would need to engage their teenagers in discussion in an attempt to give them knowledge and advise about sex and condoms.

A gender stereotype was found when mothers were asked how they would react if they found their teenage daughters in comparison to teenage sons in possession of condoms. Mothers who had male teenagers were accepting to them having condoms than mothers who had female teenagers. Mothers to teenage boys (70%) felt they could not control their teenager's behaviour hence the feeling that it was good for their teenagers to take responsibility and the initiative to use condoms. Although mothers to teenage girls maintained that their girls could use condoms, there was a sense that a proviso should be articulated that they should be self-preserving first. In comparison, a minority of mothers (30%) pointed out that teenagers should abstain from sex until marriage. Only a small number of mothers (10%) maintained that teenagers should be discouraged and disallowed from using condoms.

With regards to the role of the home in comparison to the role of the school in educating teenagers about condoms, of the sample interviewed, almost half of the number of mothers (40%) maintained that the home should take responsibility for educating teenagers about condoms. The other half of mothers (40%) contended that it might be difficult for the teenagers to discuss issues of sexuality at home hence the need for the schools to play a prominent role of imparting knowledge. However, it was unclear whether a teenager that was unable to discuss these issues with his or her mother would be able to discuss sexual issues with someone who is an authority figure such as a teacher at a school.

On answering the question of availability of condoms in public venues, differing views were found. Some of the mothers expressed a view that teenagers are secretive about their sexual behaviour such that having condoms publicly was good as it facilitated availability. However, some of the mothers disagreed with this view (40%) and maintained that condoms should not be available at public venues but should be available at public health facilities where education can be given to the teenagers. The question that was raised with this view was whether there is a diffusion of responsibility by the mothers where the responsibility for educating teenagers about condom usage was left with the health centres.

A need to be open with their teenagers about condoms was expressed by the majority of the mothers (90%). An important issue was that mothers felt that they should encourage their teenagers to ask questions in discussions with regards to how condoms are used, when and how they could be used. In addition, mothers expressed that they would not discourage their teenagers from asking any questions. It appeared that although mothers maintain that they would be open with their teenagers about sex and condom usage, it is conditional in that it is reliant on the teenagers asking questions first. It was possible that this could be rooted on the traditional definition of a mother in some cultures particularly in traditional Black culture where issues of sexuality have been placed on the teenager and not on the mother – teenager space (Burman & Preston – Whyte, 1992). As explained before, issues of sexuality and condom usage are by in large in these communities regarded as taboo and thus. In other words, the teenager must initiate the discussion rather than the mother initiating. Even so, the teenager might be seen to be disrespectful when asking the mother about issues of sexuality.

A dominant theme that came through when mothers were asked about HIV and AIDS was that they expressed a need to be open to any questions their teenagers might need to ask. Specific areas to explore with their teenagers were issues of transmission and protection. The mother's way of responding on finding out that

their teenagers were being sexually active was by having discussions with them where they would emphasized taking responsibility. This finding was also found by Naidoo (2000) where it was found in a study with high school students from Lenensia that students did discuss issues pertaining to sexuality with their mothers and that positive improvements were evident after discussions were held.

Importantly, when reviewing the questions and responses in relation to the three components theory of attitude, it was found that there was a discrepancy and no-alignment between what mothers verbalised in relation to the cognitive and affective components of the model. The cognitive component part of the model taps into what mothers know and think about the different issues covered namely condom usage, HIV and AIDS. The affective component addressed the mother's feelings about these issues. It appeared that mothers can think about the issues particularly the possession of condoms and their usage and can say that they are important as a form of protection from HIV and AIDS. However, there was a sense of disbelief, shock, hurt and anger to name some of the feelings the mothers verbalised in relation to their teenagers having condoms in their possession as well as using them. Behaviourally, the mothers seemed prepared and capable to intervene although this appears to be in reaction to having found condoms in teenager's possession rather than having discussions proactively with their teenagers.

6.3 RECOMMENDATIONS

The following recommendations have been generated from the research:

6.3.1 Sex education including condom usage for mothers is important

South Africa is currently in a crisis due to the spread of HIV and AIDS as more and more people are infected by the disease daily (Berry, 2004). This creates a huge challenge for the health systems, economic development as active members of the

economic community are infected. In the current research, the average age of teenagers whose mother's participated in the study was between the ages of 12–16 years. Naidoo (2000), states that the mean age of the first sexual encounter is 13.27 years. Furthermore, they engaged in sexual intercourse at a mean interval of every 42 days (6 weeks). The ages suggested above corresponds with the ages of the teenagers whose mothers participated in the research.

Although the mothers in the study had on the majority initiated some discussions with these teenagers, it has been found in the study that discussions happened infrequently. The study facilitated the recognition that education about condoms as a form of prevention needs to be cascaded to the teenagers by the mothers. Rotheram et al. (2005) suggested that programmes developed for the youth to prevent HIV and sexually transmitted diseases should focus on providing clear definitions of the behaviour targeted for change. Hence the mother's knowledge specifically on the ability to talk to the teenager about the targeted and desired behaviour becomes crucial. Secondly, they should focus on maximizing a range of positive and lasting health outcomes. The mother's role and her ability to impart this knowledge become parâmount. This was important in view of the fact that it is unclear whether sex education at the schools was conducted regularly as the different schools might function on numerous different systems. In addition, sex education might be broadly focused at the high school level. However, the above discussion has illustrated that children today engage in sexual activities at an early age such that discussion should start earlier on whilst teenagers are at primary school level.

This research has shown that for sex education and the use of condoms as a form of protection to be effective, it should become an integral part of discussions between mothers and their teenagers. Broadly speaking, mothers have no control with regards to the frequency and depth of sex education given to their teenagers at the schools as the majority of the schools use different approaches and systems. But the crux of the matter was that mothers would have control on the

knowledge they give their teenagers at home. From the results found in this research, discussions about sex and condom usage happen haphazardly and infrequently. There was a need for mothers on the one hand to have adequate knowledge on the issues and to have frequent meetings with their teenagers to discuss these issues.

As shown in the discussion, mothers have an opportunity of affording their teenagers with sex education, HIV, AIDS and condom usage due to the existing relationship they have with their teens as well as the envisaged time that they might have at home with them. Naidoo (2000) found that by the time students are exposed to sexuality counseling at schools, 46% of boys and 9.9% of girls had already had sexual intercourse. Therefore, the need for the mother to begin these discussions earlier becomes crucial and paramount. It was believed that through this early contact at home where the teenager is more comfortable, the mother can discuss issues of how, when, where as well as the consequences that might be associated with sex.

This can only be possible if the mother has knowledge about these issues herself. Therefore, it becomes crucial that training modules encompassing the issues of sex education, HIV, AIDS and condom usage are developed, emphasised and implemented with mothers. These programmes should include practical usability information i.e. how condoms work etc. This would assist mothers who have difficulties with their own sexuality that invariably affects how they deal with sexual issues with their teenagers to address some of their own questions and difficulties. Once mothers were equipped with the necessary knowledge, it was envisaged that this would go some way in influencing their attitudes towards condoms that would have an impact on their teenager's attitudes. These efforts could be supported by the use of focused groups where mothers come together to discuss their situations and lessons learnt out of having discussions with their teenagers.

6.3.2 Continued application of attitude theory on condom usage

The attitude theory (as discussed in Chapter Two) aimed to understand certain unobservable inner attitudes from which we could construct a picture of possible overt and covert behaviour. Thus, the attitude theory seeks to understand the relationship between people's attitudes and their behaviour. In other words, it might be said that if we understand people's attitudes about a particular phenomenon, we might be able to predict how they would behave. This is important in this study as the mother's attitudes would affect her behaviour particularly with regards to whether she initiates discussions about sex, condom etc. with her teenagers.

As discussed in Chapter Two, the three components model of attitudes explored the affective component that addresses the feelings and emotions the person experiences about a particular phenomenon, the cognitive component would consist of the person's ideas and beliefs about whether what has happened is true or not. The behavioural component refers to overt actions and behavioural intentions regarding the event (Rosenberg & Hovland, 1979).

More research is needed to further explore the relationship between attitude and behaviour by way of using all the different components that exist. Further studies will need to be done on other aspects that could affect attitudes such as cultural, religious, racial differences that exist in the South African context where differences of backgrounds are profound.

In the Black township context where there is a lack of expertise on how to go about affording people with knowledge and information, the proposed model in chapter two can give relief to the communities as information can be easily focused on the different components identified, such as affective, cognitive and behavioural. It was envisaged that a programme that was designed to tap into the mothers

attitudes towards, sex, HIV and AIDS as well as condom usage would go a long way in making the concepts accessible to the mothers that would in turn make them accessible to the teenagers.

In addition, the three components model of attitude theory would be helpful when applied to future research with teenagers as it taps into the cognitive component of what teenagers might know and believe about sex, condoms, HIV and AIDS, in comparison to the affective aspect that will focus on their feelings about the issues and lastly, behaviorally, that could focus on their beliefs about these issues (sex, condoms and HIV and AIDS).

6.3.3 Further study of the attitude theory namely the two components model of attitude

It was found in the responses to the questions asked that mothers responses were mainly addressing the two components of the theory namely the cognitive and the affective components. It would be helpful that future research to investigate the reasons behind the focus on the two components. It was possible that due to the sensitivity of the issues addressed in the study that mothers invariably become emotionally and hence the focus on the two components.

6.3.4 Advocacy of the use of condoms to sexual active teenagers is needed

Naidoo (2000) maintained that interventions such as by giving information to teenagers about sexuality did not stop students from having intercourse or delay their onset of sexual activity. To this end, there was a need for mothers to advocate the use of condoms when discussing sexuality with their teenagers.

Therefore, although mothers might be cautious about whether discussing condom usage with their teenagers might increase the need for sexual activity, there was a need for awareness that not discussing the issue will not ensure abstinence. To

this end, teenagers should be encouraged to source condoms if they consider the possibility of engaging sexually.

6.3.5 Criticisms of the current research

It would have been valuable to have ascertained biographical information about the mothers who participated in the study specifically information about their occupations, working mothers vs. housewives, religious background, the level of education, marital status, the number of children they have as this information might have informed their attitudes about condom usage. It was believed that due to the fact that women who participated in the study were all illiterate might have caused a bias in the study such that women who are illiterate could have given different answers. In addition, all the participants had volunteered to be part of the study. This meant that these women were prepared to talk about their experiences that could be very different from having people who were forced to be in the study.

The mother's knowledge of HIV and Aids should have also been explored to confirm their level of understanding regarding HIV and AIDS. Furthermore, due to the small sample used in the study, the results found in the study cannot be generalized to the broader community. Furthermore, the study was conducted in Tembisa that was not representative of other mothers in Johannesburg, South Africa.

The results found in the study were dependent on the honesty and accuracy of the responses given by the mothers. At times, it might be possible that the pressure of being interviewed for university purposes might have put mothers under pressure to give certain responses in an attempt to help the student. Therefore at times, the answers might have reflected their wishes and not their current behaviour.

Furthermore, the study used for the most part the attitude model as a theoretical base for the study. Although the attitude model was well researched by social

psychologists in the 1980's, limited research has been conducted in the later years. A comparison of theories such as an in-depth analysis of the understanding of attitudes in the psychodynamic or systemic theory would have been valuable.

6.3.6 Future research

South Africa has been said to be facing a crisis with regards to HIV and AIDS. It is believed by some analysts (Berry, 2004) that further devastating implications of this disease are yet to be felt in the economic spheres as more and more people die. There was a belief that more young people are getting infected although massive campaigns of educating people about HIV and AIDS as well as condom usage have been launched. Therefore creative and alternative ways to curb the disease are needed urgently in South Africa.

It was unclear what the number, content and context of sexuality campaigns that have been developed have been targeted at mothers as research conducted in this area is minimal. It was thus envisaged that more effort needs to be invested in educating mothers about HIV and AIDS. It was believed by the current writer that the relationship between the mother and her children from the time of birth to adulthood cannot be understated as the bonds are normally very important. However, there needed to be acknowledgement that due to the prevalence of HIV and AIDS, mothers die leaving their children behind. In these cases, indeed the mother's role was taken on by an older sibling, grandparents or relatives. It was believed that even in these cases the role of the primary caregiver is important and thus need recognition.

To this end, this bond can also be used to curb this devastating disease. Therefore, the education talked about here, although helpful and important to the mother, needed to be positioned as educating and awareness that she needs to cascade down to her teenagers. In this way, it could be possible for the mothers to be more receptive to the idea as issues of stigmatization and fear about the

disease can be minimised. Further research is needed to develop a practical programme that could use the principles outlined that could be taken through to the different communities in the country. Secondly, further research is needed to investigate the teenager's attitudes towards mothers discussing sex, HIV and AIDS as well as condom usage with them.

6.4 CONCLUSION

A survey of current research on HIV and AIDS shows that extensive research has been conducted to a large extent has focused on HIV and AIDS (Berry, 2004). Research has been scarce in the areas of condoms usage and the attitudes people have of condoms. This study attempted to investigate maternal attitudes towards condom usage by teenagers in light of HIV and AIDS.

To this undertaking, 10 mothers with teenage children located in Tembisa were interviewed. The results showed that mothers although sensitive to the idea of their teenagers using condoms broadly agreed that the use of condoms when engaging in sexual activities was the only way of ensuring protection from HIV and AIDS. However, it was also shown that there is a need for sexual education specifically focusing on condom usage with the mothers. The researcher believed that with proper implementation of education programmes with the mothers to educate them about condoms, a positive attitude towards their use can be enhanced and thus yielding a greater benefit to the teenagers.

The results ascertained in this study can be classified into two broad categories. Firstly, it was found that mothers believe that the home and the school should play a dual role in educating teenagers about sex, HIV and AIDS as well as condom usage. Secondly, for the mother's, the initiation of discussions about sexuality was largely dependent on the following factors. Firstly, the fear of HIV and AIDS heavily influenced the mother's attitude towards sex in general. It appeared that mothers who might be having their own fears about sex found it difficult to discuss

the same with their teenagers. This resulted in discussions about sexuality, HIV and AIDS and condom usage arising "accidentally". In addition, mothers displayed a fear of condoning sex that created a sense of tension between the plight of prevention and protection in comparison to promiscuity. It appeared that mothers held unrealistic beliefs that appeared naïve that fed into delaying discussion with their teenagers. This was especially illustrated by Mother H, whose teenagers are aged 21, 18 and 13. She maintained that her children should not think about sex as she considered them too young.

Thirdly, it was found that condoms were seen to have one function namely, that they were a protection mechanism from diseases specifically HIV and AIDS. From this point of view, most mothers knew about condoms. There was ambivalence towards teenagers having in their possession condoms because of the implications attached. Their response to teenagers having condoms was to have discussions with them. The question that was raised was whether the timing of the discussion could be late if conducted only when the teenager had condoms in their possession. To this end, there was a need for mothers to take a proactive role in ensuring that they educate their teenagers about condoms before the teenagers ask them. It appeared that mothers verbalized a willingness to discuss sexuality and condoms with their teenagers when teenagers asked about these issues. The mothers acknowledged that teenagers need to feel comfortable before meaningful discussions can occur. Lastly, there was recognition that knowledge was power as mothers feared that such knowledge could lead their teenagers to become curious about sex that could leave them powerless. Similarly, knowledge about condoms would empower the mothers that would in turn help them to empower their teenagers.

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REFERENCES

Aita, J (2000). *LoveLife campaign attempts to save youth from HIV and AIDS.* Retrieved February 2003 from the World Wide Web: http://www.usembassy.it/file2003-11/alia/a0113009.htm.

Ajzen, I. & Fishbein.M.L. (1980). *Attitudes, personality and behavior.* Milton Keynes: Open University Press.

Allport, G.W. (1935). Attitudes. In C. Murchinson (Ed). *Handbook of social psychology.* Worcester (Mass): Clarke University Press.

Berry, S. (2004). *South African HIV and AIDS statistics.* Retrieved January 2005 from the World Wide Web: http://www.avert.org/aidssouthafrica.htm.

Bion, W.R. (1962). *Learning from experience.* London: Heinemann.

Burman, S. & Preston – Whyte, E. (1992). *A questionable issue: Illegitimacy in South Africa.* Cape Town: Oxford University Press.

Braverman, P.K., Strasburger, V.C. (1989). Why adolescent gynecology. Pediatrician and pelvic Examinations. *Peditric Clinics North Am.* **36** (3): 471 – 487.

Bromwich, P. & Parsons, T. (1990). *Contraception: The Facts.* Oxford: Oxford Press.

Bryman, M. (1994). *Analyzing qualitative data.* London: Routledge.

Campbell, O. (1993). "Under 20" clubs after straight talk about sex". *Family Health International.* **14**, 2, 30 – 31.

Census (2001). *Statistics South Africa Census.* Retrieved February 2005 from the

World Wide Web: http://www.statssa.org.

Christopher, E. (1987). *Sexuality and Birth Control in community work.* London: Tavistock Publications.

Chothia, F. (1993). Storm over school sex education. *Weekly Main.*

Cilliers, C.D. (1989). The role of the school in the Republic of South Africa in the prevention of AIDS – A situation analysis. *South African Journal of Education*, **1**: 1 – 6.

Cooper, C.R., Hamilton, H., Mashabela, S., Mackay, E., Sidiropoulos, C., Gordon – Brown, S., Murphy, S., Frielinghaus, J. (1994). *Race relations survey 1993 / 1994.* Johannesburg: South African Institute of race relations.

DeVilliers, V.P. (1985). *TienerjarigeSwangerskappe.* Paarl Hospital.

De Vos, P., Strydom C., Fouche, N., Poggepoel, F. & Schurink, S. (1998). *Research at Grassroots: A primer for the caring professionals.* Pretoria: Van Schaik.

Devenish, C., Funnell, G. & Greathead, E. (1992). *Responsible teenage sexuality: A manual for teachers, youth leaders and health professional.* Academica. Pretoria.

Doyle, P.R. (1991). *AIDS in South Africa: The demographic and economic implications. Part 1: The impact of AIDS in the South African population.* The Centre for Health Policy, University of the Witwatersrand, Johannesburg.

Eiser, J. R. & Van Der Pligt, J (1988). *Attitude and decision.* London: Routledge.

Erasmus J. (1996). *South Africa's nine provinces: A human development profile. Development Bank of Southern Africa.* Midrand. http://www.hst.orh.za/healthstats

World Wide Web: http://www.statssa.org.

Christopher, E. (1987). *Sexuality and Birth Control in community work.* London: Tavistock Publications.

Chothia, F. (1993). Storm over school sex education. *Weekly Main*, **1**: 6 -12.

Cilliers, C.D. (1989). The role of the school in the Republic of South Africa in the prevention of AIDS – A situation analysis. *South African Journal of Education*, **1**: 1 – 6.

Cooper, C.R., Hamilton, H., Mashabela, S., Mackay, E., Sidiropoulos, C., Gordon – Brown, S., Murphy, S., Frielinghaus, J. (1994). *Race relations survey 1993 / 1994.* Johannesburg: South African Institute of race relations.

DeVilliers, V.P. (1985). *TienerjarigeSwangerskappe.* Paarl Hospital.

De Vos, P., Strydom C., Fouche, N., Poggepoel, F. & Schurink, S. (1998). *Research at Grassroots: A primer for the caring professionals.* Pretoria: Van Schaik.

Devenish, C., Funnell, G. & Greathead, E. (1992). *Responsible teenage sexuality: A manual for teachers, youth leaders and health professional.* Academica. Pretoria.

Doyle, P.R. (1991). *AIDS in South Africa: The demographic and economic implications. Part 1: The impact of AIDS in the South African population.* The Centre for Health Policy, University of the Witwatersrand, Johannesburg.

Eiser, J. R. & Van Der Pligt, J (1988). *Attitude and decision.* London: Routledge.

Erasmus J. (1996). *South Africa's nine provinces: A human development profile. Development Bank of Southern Africa.* Midrand. http://www.hst.orh.za/healthstats

Gardner, R. (1999). Closing the condom gap. *Population Reports*, Series H, 9. Baltimore: Johns Hopkins University School of Public Health, Population Information Program. Available at: www.jhuccp.org/pr/h9edsum.shtml.

Gebhard, P.H. (1997). "The acquisition of basic sex information". *The Journal of sex research*, **13**: 13 – 21.

Gevisser, M. (1993). "Sex in the schoolroom – But it's safer". *Weekly mail Education Supplement*.

Goddard, J. (1986). *Adolescents in perspective*. Nursing RSA. **1**, 6, 25 – 27.

Goosen, M & Klugman, B. (1996). The *South African Woman's Health Book*. Oxford University Press: Cape Town.

Gordon, C. (1996). Adolescent decision making: broadly based theory and its application to the prevention of early pregnancy. *Adolescent*, **31**, (123), 561 – 584.

Gruber, E.Y. & Chambers, C.V. (1987). *Adolescence*. XXII, **87,** 661 – 669.

Haupt, A. & Kane, T.K. (2000). *Population Reference Bureau's population handbook*. 4th International Ed. Washington DC. Population Reference Bureau. http://www.statssa.gov.za/census01

Hoffman, M.A. (1991). Counselling the HIV-infected client: a psychological model for assessment and intervention. *The Counselling Psychologist,* **19**, 467-542.

Hogan, M. R. (1982). *Influences of Culture on sexuality.* Nursing Clinics of North America. **17**, 3, 365 – 375.

Freud, S. (1916). *Wit and it's relation to the unconscious.* Kegan and Trench: London.

Gardner, R. (1999). Closing the condom gap. *Population Reports*, Series H, 9. Baltimore: Johns Hopkins University School of Public Health, Population Information Program. Available at: www.jhuccp.org/pr/h9edsum.shtml.

Gebhard, P.H. (1997). "The acquisition of basic sex information". *The Journal of sex research*, **13**: 13 – 21.

Gevisser, M. (1993). "Sex in the schoolroom – But it's safer". *Weekly mail Education Supplement.*

Goddard, J. (1986). *Adolescents in perspectiv*e. Nursing RSA. **1**, 6, 25 – 27.

Goosen, M & Klugman, B. (1996). The *South African Woman's Health Book.* Oxford University Press: Cape Town.

Gordon, C. (1996). Adolescent decision making: broadly based theory and its application to the prevention of early pregnancy. *Adolescent,* **31**, (123), 561 – 584.

Gruber, E.Y. & Chambers, C.V. (1987). Negotiating the adolescent years. *Adolescence.* XXII, **87,** 661 – 669.

Haupt, A. & Kane, T.K. (2000). *Population Reference Bureau's population handbook.* 4th International Ed. Washington DC. Population Reference Bureau.
http://www.statssa.gov.za/census01

Hoffman, M.A. (1991). Counselling the HIV-infected client: a psychological model for assessment and intervention. *The Counselling Psychologist,* **19**, 467-542.

Hogan, M. R. (1982). *Influences of Culture on sexuality.* Nursing Clinics of North

America. **17**, 3, 365 – 375.

Hubley, J. (2002). *The AIDS Handbook: A guide to the prevention of AIDS and HIV.* Macmillan Publishers: United Kingdom.

Kaplan, M.E. & van den Worm, Y. (1993). The relationship between South African adolescent's Knowledge and fear of AIDS and their attitudes towards people who have AIDS. *The Journal of Social Psychology*, **133**: 581-583.

Karim, A.Q., Karrim, S.S., Preston – Whyle, E.(1992). Teenagers seeking condoms at family planning services. *South African Medical Journal.* **82**: 360 – 362

Karim, A.Q., Karrim, S.S., Preston - Whyle, E., Sakar, N. (1992). Reason for the lack of condom use among high school students. *South African Medical Journal.* **82**: 107 - 110.

Karz, D. & Stotland, E. (1972). A preliminary statement to theory of attitude structure and change. In S. Koch (Ed.). *Psychology: A study of a science.* New York: McGraw Hill.

Kau, M. (1991). *Sexual behaviour and contraceptive use by adolescent pupils in the Republic of Buphutatswana Curations.* **11** (4), 9 - 11

Kim, N., Stanton, B., Lix, D., Dickersin, K., Gollowaith, J. (1997). Effectiveness of the 40 Adolescent AIDS – Risk Reduction Intervention: *A Quantitative Review Journal of adolescent health.* **20**, 204 – 215.

Khosa, T. (1999). Career decisions of rural high school students. *Masters Thesis.* Rand Afrikaans University. Johannesburg.

Klugman, B. (1994). How much is enough? New ground. *The Journal of development & the environment.* **15**: 7 – 9

Preston – Whyte, E.M. (1995). "Half-way there: anthropology and intervention-oriented AIDS research in Kwazulu/ Natal, South Africa". *In Han ten Brummelhuis and Gilbert Herdt, ed. Culture and sexual risk: anthropological perspectives on AIDS.* Amsterdam: Gordon and Breach Science Publishers.

Rokeach, M. (1970). *Beliefs, attitudes and values*: A theory of organization and change. San Franscisco: Jossey-Bass.

Rosenberg, M.J. & Hovland, C.I. (1979). Cognitive, affective and behavioral components of attitudes. In M.J. Rosenberg. (Ed), *Attitude organization and change.* New Haven: Yale University Press.

Rosenthal, R. & Rosnow, R. (1991). *Essentials of behavioral research.* New York: McGraw Hill, Inc.

Rotheram, M. J. & Lyon, M.E. (2005). *Based on the research, comprehensive sex education is more effective at stopping the spread of HIV infection.* Retrieved March 2005 from the World Wide Web: http://www.apa.org/releases/sexeducation.html.

Samuels, G. (2003). Aids Today: A *metropolitan AIDS research communiqué*. Retrieved March 2004 from the World Wide Web: http://www.aidsinfo@metropolitan.co.za

Sapire E, K(1986). Contraception and sexuality in Health and disease. Johannesburg: Mcgraw-Hill Book Company.

Steiner, J. (1996). The aim of psychoanalysis in theory and in practice. *International Journal of Psychoanalysis*, **77**: 1073 – 1083.

Stevens J. 1990 (March). South African Comment: Sexually Transmitted Disease. *Medicine International,* **72**:5-7.

Stevens-Long J. & Cobb N. J. (1983). *Adolescence and early adulthood.* Los Angeles: Mayfield Publishing Company, California State University.

Stout, W., Stout, M.D., Rivara, F.P. (1989). Schools and sex education: Does it work. *Pediatrics.* **83**, 3, 375-379.

Taylor, G. (1991). AIDS: the real cost to employers. *Human Resource Management.* **6**: 23-28.

Titscher, S., Meyer, M., Wodak, R., & Vetter, E. (2000). *Methods of text and discourse analysis.* London: SAGE.

Van Coeverden de Groot, H.A., Greathead, E.A. (1991). Adolescent sexuality, education and contraception. *South African Journal of Cont. Med Educ.* **9** (11): 1369 - 1377.

Van der Elst, E. (1993). *A sexuality training programme for guidance counselor trainees: A qualitative inquiry and evaluation.* **3**, 6 – 23.

Waddell, M. (2000). *Inside lives.* Prentice Hall International Inc: London.

Walton, A. (1995). *Puberty.* Lippincott: Philadelphia.

Webb, D. (1997). *HIV and AIDS in Africa.* Pluto Press. David Philip, Cape Town.

WHO/UNAIDS. (2001). *The Male Latex Condom: Condom Programming Fact Sheets.* Geneva: Available at: www.unaids.org/publications/documents/care/mcondoms/JC003-MaleCondom-FactSheets.pdf.

World Health Organization & United Nations, *AIDS*, 2003.

APPENDIX A
INTERVIEW GUIDE

Introduction questions

1. How many teenage children do you have and what is their sex?
2. How old are they?

Attitudes towards sex amongst teenagers questions

3. What do you believe is the role of sex education at home and at school?
4. Have you initiated sexual discussions between yourself and your teenagers? What prompted the discussions?
5. If not, what stopped you from having such a discussion?

Perceptions about condom usage questions

6. What in your view is the function of condoms? Who should use them?
7. How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?
8. How would you respond if you found your son vs. your daughter being in possession of condoms?
9. How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?
10. What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?
11. What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

Open discussion questions

12. What type of questions would you encourage about condoms in discussions with your teenagers?
13. What type of questions would you discourage about condoms in discussion with your teenagers?
14. What impact do you think such discussions would have on your relationship with your teenagers?
15. What questions would you encourage and discourage about HIV and AIDS?

Additional Questions

16. What would you do if you found out that your teenage children were sexually active?

APPENDIX B

FACULTY OF HUMANITIES ETHICS COMMITTEE CLEARANCE CERTIFICATE

INFORMATION SHEET AND CONSENT FORMS

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (NON-MEDICAL)
Ref: R14/49 Khosa

CLEARANCE CERTIFICATE **PROTOCOL NUMBER** H03-07-10

PROJECT Maternal Attitudes of Black Women Towards Condom Usage by their Teenagers in Light of HIV and AIDS

INVESTIGATORS Ms T Khosa

DEPARTMENT Psychology, Wits University

DATE CONSIDERED 03-07-30

DECISION OF THE COMMITTEE *

Approved unconditionally

This ethical clearance is valid for 2 years and may be renwed upon application.

DATE 03-10-31 **CHAIRMAN** ..... (Dr GR McLean)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Ms G Haiden
Dept of Psychology, Wits University

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DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. ***I agree to a completion of a yearly progress report.***

This ethical clearance will expire on 1 February 2005

DATE ..... SIGNATURE .....

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

INFORMATION SHEET

Hi. My name is Tintswalo Khosa and I am a Masters in Clinical Psychology student in the Department of Psychology at the University of the Witwatersrand. I am conducting research on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS.

I would like to ask you to participate in this study. I require approximately 1 hour of your time to have an interview with me. By partaking in the interview, I would also like you to grant me permission to use your responses in my study.

Your participation in this study is completely voluntary and no negative consequences will arise for non-participation. Please note that your responses will be anonymous since you are not required to submit any identifying information. Participants will be notified that may also choose to withdraw their at any point and may at no point be forced to offer their opinions or answer questions that they do not want to, or may be hesitant about or questions that they feel may raise feelings of discomfort. Your responses will be treated with the utmost confidentiality and will not be shown to anyone other than the researchers involved in the study. You may choose to withdraw at any stage without penalty.

Given my undertaking of anonymity and confidentiality, I ask that you respond as openly and honestly as possible. Please note that I am interested in *your* response to each question – there are no right or wrong answers.

Please keep this letter and clarify at the beginning of the interview should you have any questions. Should you require further information, please feel free to contact me. My details appear below. Should you feel that any of the material in the interview raises personal concerns for you, with which you would like assistance, you can contact LoveLife on 0800 121 100.

Your participation in this study would be greatly appreciated.

Yours sincerely

Tintswalo Khosa
072 620 6881

e-mail address – khosat@hse.pg.wits.ac.za

INFORMED CONSENT FORM

I hereby consent to participate in this study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I understand that my responses will remain anonymous and confidential. I am aware of the ethical issues involved including the fact that I am free to withdraw from the study at any time without penalty.

Signature

INFORMED CONSENT TO BE TAPE-RECORDED FORM

I hereby consent to the audio tape-recording of my responses for the study of maternal attitudes towards condom usage by teenagers in light of HIV and AIDS conducted by Tintswalo Khosa.

Signature

APPENDIX C

TRANSCRIPTS

1. Interview with A

T = Researcher

A = Interviewee

T1: Thank you for partaking in the study. As per the letter that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

A1: No I am fine, I am a bit anxious.

T2: How many teenage children do you have?

A2: 2

T3: How old are you teenagers?

A3: 17 and 12

T4: What are their sexes?

A4: Girls

T5: What do you believe is the role of sex education at home; do you believe there is a role to educate your children about sexual issues at home?

A5: There is a need but it's difficult to call a spade a spade.

T6: What makes it difficult? What is most difficult?

A6: It's to initiate a sexual discussion.

T7: Do you believe there is a role for the schools to teach children about sex?

A7: Yes.

T8: Do you feel that the school should be playing a bigger role in terms of sex education?

A8: Yes.

T9: How do you feel that the difficulty of talking about sex can be solved at home?

A9: It can start at school.

T10: Have you started sexual discussions with your children?

A10: No

T11: What do you believe is the role of condoms when engaging sexually?

A11: They should be used to prevent the spread of HIV and AIDS.

T12: How would you feel and behave if you found out that your teenagers are in possession of condoms? How would you respond?

A12: Would sit them down and talk to them.

T13: What would you say to them when talking to them?

A13: The fact that they have condoms is telling me that something is going on. So I would talk to them.

T14: How would you feel if you found out that your teenage daughters are sexually active and that they are using condoms?

A14: It would be painful but I can't run away from it.

T15: And what would you do in that situation?

A15: Maybe I will try to get some books about sex.

T16: What do you believe is the role of schools in comparison to you as a mother in terms of educating your children about sex and condoms?

A16: It's not the same. Because at school it's much easier than as a parent.

T17: What do you think the school should be concentrating on and what you as a mother should be concentrating on? Is there a specific difference?

A17: Schools should talk about sex as a whole. Mother could concentrate on relationships.

T18: How do you feel about the fact that condoms are available in public toilets? How do you feel about that? Do you think it's a good or bad thing?

A18: It's a bad thing.

T19: So in your opinion they should take out those condoms and should only be available to adults only.

A19: Yes, but even to adults, not in public toilets.

T20: Going back to discussions about condoms and sex, what type of questions, would you encourage about condoms and what type of questions would you discourage when having discussions with your children? Let's start with what you would encourage.

A20: When do we use condoms and how.

T21: Are there any questions you would discourage?

A21: Not really.

T22: What do you think such discussions about condoms and sex, how do you feel those discussions would impact on your relationships with your children?

A22: They would trust me more.

T23: So you think that it would bring you closer to your children, by way of trust?

A23: Yes.

T24: What type of questions of questions would you encourage your teenagers to ask you about HIV and AIDS?

A24: How do we get it and how do we prevent it.

T25: Are there questions you would discourage them from asking you about HIV and AIDS?

A25: No.

T26: What would you do if you found out that your teenagers are engaging in sex?

A26: I would start by teaching them the word of God.

T27: What do you believe that teaching them that would do?

A27: As a parent I am representing God.

T28: And so they should try and follow what God has wanted them to do.

A28: Yes.

T29: All right, thank you very much. How did you find the questions?

A29: It was difficult. The topic as a whole is not easy.

T30: I thank you that even though you found the questions difficult, you persevered and completed the interview. Thank you very much A for your time and assistance with this research.

2. Interview with B

T = Researcher

B = Interviewee

T1: Thank you for partaking in the study. As per the letter that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

B1: No I am fine. I do not have any questions.

T2: How many teenage children do you have?

B2: I have one and she is a girl.

T3: How old is he?

B3: She is twelve years old.

T4: What type of a relationship do you have with her?

B4: It's a very close relationship. We have an open relationship and we discuss most things together, things that I believe is right for her age I discuss them with her. Things we discuss are mainly around issues of peer pressure and how to deal with it, and what to do when finding oneself in that type of a situation. The other day, we talked about relationships, because as Christians, she thought that she couldn't have a boyfriend. I said to her that you can have a boyfriend but you cannot go to bed with your boyfriend, it was about that.

T5: So issues pertaining to dating and relationships, you discuss.

B5: Yes.

T6: What was her reaction to that when you talked specifically when you told her that she can have a relationship but that she cannot have sex with her boyfriend?

B6: She understood. She couldn't believe it when I told her that she could have a relationship. I said to her that it would be fine as long as I had met her boyfriend and that I had meet her boyfriend's parents so that we could help them with their relationship. I also said that it's fine for her if she wants to marry at an early age because I think that it is biblical, hence God wanted people to marry at an early age because Go was trying to prevent HIV and AIDS in that way. It doesn't mean that you should have kids, but you are able to have sex but in a protected way. So she was okay with it.

T7: It sounds like your daughter might have been relieved by the discussion.

B7: She was relieved and she was okay with it and that's when I asked her if she had a boyfriend and she said no mama. I said to her that at the time when she has one, I think that I should be the first person to know.

T8: What in your opinion is the role of sex education at home and at the school?

B8: At home, I think sex education should start at home. When it starts at home, when they go outside and hear something else, then they should always come back home to ask and say that somebody says 1,2,3,4, is it true. At school, they deal with it but it's like they let them know that they can have sex, but at home, you should let them know that they can do it but my hope is that you won't do it before you get married.

T9: So it's like from what you are saying, at school, they make them aware of the facts and dangers of sex, it sounds like at home, you would like to set the boundaries.

B9: Yes, you should set the boundaries.

T10: What prompted the discussion?

B10: I don't know what it was we were talking about. We just started talking about it.

T11: With regards to condoms and sex, what do you believe is the role of condoms and who is eligible to use them?

B11: Yes they should be used because it is the only way.

T12: It's the only way.

B12: It's the only way for them to have safe sex, but as a parent I don't want to lie, I won't encourage my daughter to use condoms because at the end of the day it would say that we sleep around and we simply use condoms and we don't care anymore.

T13: So your problem with condoms is that yes, it's a good way of protecting themselves but it might encourage multiple sexual encounters.

B13: Because at the end of the day, you would know that I won't have AIDS. It shouldn't be about AIDS only.

T14: What should it be about?

B14: It should be about love because if they use condoms then they might be just having sex for fun.

T15: How would you feel and react if you found out that your teenage daughter has condoms in her possession?

B15: I would be shocked, but at the same time it would help me in being able to talk to her about it, find out if she is or planning to engage sexually then talk about it.

T16: So basically, your response would be to talk about it with her.

B16: Yes.

T17: Would you feel differently if you had been a son that you found condoms on? Say it was a boy child, would you feel differently as in the way you would feel about your daughter.

B17: Yes, I think I would feel differently because as a woman, I tend to believe that it is boys who make girls do something that they wouldn't necessarily do. So as a mother, I would play a responsible role to do something in a responsible way because sometimes we let them do things and say, they are boys, let them be boys. I believe that mothers should not be doing that. It's us who are supposed to change the mindset of our boys because as women we are the ones who have gone through a lot of pain.

T18: So are you saying that you wouldn't encourage your son to use condoms?

B18: No I wouldn't encourage my son to use condoms. I would talk to my son and I would also like to know my son's girlfriend.

T19: So is it your position that teenagers should abstain from sex.

B19: Yes, abstaining, abstaining. But the thing is that we won't stop them but if they play it safe then it's fine.

T20: What do you believe is the role of schools vs. your role as a mother regarding educating your teenagers about condoms?

B20: I think with regards to education it should start at home. It shouldn't be left for other people to teach our children. It should start at home. The schools should attend to the outstanding questions, but I think that the parents should answer all the questions and when the children go to the schools, they should know what to tell the teachers from what their parents told them.

T21: What is your opinion towards the availability of condoms to teenagers in public places i.e. public toilets and schools?

B21: I think that's great because like I said, we cannot stop them; so if condoms are freely available, let them get them because we are not there when we do these

things.

T22: What type of questions would you encourage or discourage about condoms?

B22: I don't get the question.

T23: When you have discussions about condoms with your teenager, what kind of questions would you encourage or discourage about condoms?

B23: I don't think there will be anything I would discourage for her to ask me. I would encourage all sorts of questions such as questions about when to use a condom, whether condoms are safe, and whether I use condoms (laughs).

T24: You would want your daughter to ask you that?

B24: Yes I would want my daughter to ask me so that she can see that it doesn't have to be used by only unmarried people only because I believe that even in marriage, people should use condoms.

T25: How do you feel, I know that you have already had discussions with your daughter about sex, what do you think has been the impact of that discussion with your daughter on your relationship.

B25: I think that she is open and she knows that she can talk to me about anything. I was trying to build trust between the two of us because as a girl I had my sister to talk about issues of a sexual nature and I think that helped me a lot because my sister answered all the questions. So in her case, she is the only child, I should be answering all the questions she might have.

T26: In terms of HIV and AIDS, have you been able to talk about that with your daughter?

B26: Only when she asks questions from school.

T27: Are there particular questions that you encourage or discourage about HIV and AIDS?

B27: No, I encourage everything. The thing is there are some things they do not ask us and we are scared to initiate.

T28: What type of things?

B28: Sometimes you wish that your child could come and ask you that mommy, can you tell me about sex so that you would be able to talk about other things that she doesn't know.

T29: What stops you from initiating those discussions?

B29: You feel that it is too much, that you might open Pandora's box. That you are going too far and that you shouldn't be doing it. I wish that it were coming from her so that I would be answering her questions. I wouldn't like to send then wrong impression to her.

T30: What would you do if you found out that your teenager is sexually active?

B30: Wow, then I would have to play a mother's role. I would say that she is active, then we better talk about it because I can't change that. So we would have to talk about sex, HIV and AIDS and pregnancy.

T31: Would your approach be to be open about it and talk rather?

B31: I know that I would be angry as a parent and also as a woman because I would understand that she might have felt vulnerable to somebody who might have taken advantage of that. So there, I would have to understand her and say to her that we shouldn't do things because some people want us to do those things, so let's talk about sex.

T32: Thank you very much for your participation in this study, we have completed all the questions I had to ask you. How did you find the interview?

B32: No, the interview was challenging. It made me realize that there is a lot that I am not doing although I have done some work with my daughter, there is a lot I still need to be doing.

T33: Do you have any questions that you need to ask me?

B33: No I do not have any questions.

T34: Perhaps things you might need clarity on specifically HIV and AIDS.

B34: No, I don't have questions.

T35: Thank you for the participation on this study. I have brought brochures on HIV and AIDS; please help yourself to a pack. There are also numbers for the Love Life parent line should you need to contact them in future. Thank you again for partaking in the study.

3. Interview with C

T = Researcher

C = Interviewee

T1: Thank you for partaking in the study. As per the letter that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

C1: No.

T2: How many teenage children do you have and what is their sex?

C2: One male.

T3: How old is he?

C3: He is thirteen.

T4: What type of a relationship do you have with him?

C4: It's an open relationship because we talk about things around us.

T5: What do you believe is the role of sex education at home and at school? Do you believe there is a difference in terms of the two?

C5: Yes, I think so because at school, it should be general knowledge and at home it should be more concentration on the individual. At school, they talk to them in general.

T6: Have you initiated sexual education with your teenager?

C6: When it crops up on television, we don't talk about it as in sitting down. We tend

to start talking if something has come up somewhere.

T7: How do you find such discussions with your teenager?

C7: It makes me feel relieved, because I feel that I have done something responsible at that time.

T8: We are going to start talking about condoms now, what in your view is the function or role of condoms when engaging sexually?

C8: They are there to help us prevent the spread of HIV and AIDS.

T9: Who should use them?

C9: Everyone, teenagers and adults. Whoever is involved in sexual activities?

T10: How would you feel if you found out that your teenager is in possession of condoms?

C10: I would be angry and frustrated. Would ask myself what condoms are doing in his possession?

T11: How would you respond?

C11: I would call him, and make him very comfortable and to help him to be open to me and for me to make him understand that he needs to be responsible for what he is doing to himself and to God. And because he is a boy, he is in control.

T12: Would you feel differently if it were your teenage daughter who was in possession of condoms?

C12: No, it would be the same.

T13: How do you feel about teenage boys vs. teenage girls using condoms when engaging in sexual activities?

C13: I think it's okay for them to be responsible and take initiative to use condoms.

T14: And how do you feel about boys?

C14: It's the same.

T15: What do you believe is the role of you as the mother in comparison to the school educating your children about sex and condoms? Is there a difference in terms of the roles?

C15: I think so, because as a mom, you have a lot of time and it should be you're responsible to educate your children. Teacher can educate the children but perhaps once in month when you have so much time with your children.

T16: How do you feel about the fact that condoms are available at schools and public toilets?

C16: Sometimes I feel that they are encouraging the children to have sex, but on the other hand, I feel that the children are engaging sexually and that perhaps it' s okay for the condoms to be available.

T17: What type of questions would you encourage and discourage about condoms?

C17: Encourage, I would encourage my child to use condoms if he wants to engage sexually. I won't discourage anything.

T18: What do you believe is the impact of a discussion about condoms on your relationship with your teenager?

C18: I think it would make us able to talk about anything because the topic of condoms is very sensitive, so it would bring us closer together.

T19: With regards to HIV and AIDS, have you been able to talk about it with your son.

C19: Yes we have.

T20: When you have discussions about condoms with your teenager, what kind of questions would you encourage or discourage about condoms?

C20: I would encourage not to look at people infected as being different, and not to

think of him as different.

T21: What would you do if you found out that your teenage son is sexually active?

C21: I would be firstly; I think we would talk about it, and to make him realize that he was in control of the situation and that he will need to be responsible of the consequences that might follow.

T22: So you would encourage him to take responsibility for his actions.

C22: Yes, even to himself and to God. And that we can hide away from mommy but not from God.

T23: I have completed my questions. How did you find the interview?

C23: It was hard. The interview was an eye opener that we need to talk about this more to our children.

T24: Thank you so much C for your participation in this study. I will leave you with the contact numbers for the LoveLife Parent Line where you can contact them should you have any questions on HIV and AIDS.

4. Interview with D

T = Researcher

D = Interviewee

T1: Thank you for partaking in the study. As per the letters that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

D1: I am interested in this topic because my cousin got infected with HIV and AIDS whilst she was staying here with me. So because of that, I started talking to my son about the issues of HIV and AIDS. She slept with a guy who was infected with HIV and AIDS whilst she lived here. This guy was a tenant in one of the rooms that I hire out. He used to come to me and complained that he was ill. I told my cousin about the fact that the guy was infected especially when I realised that she was starting to befriend this guy. She unfortunately did not believe m and I think she thought that I wanted him for myself and that I was just jealous. She went ahead and slept with him.

T2: It sounds like a very sad situation with your cousin.

D2: It is and the unfortunate thing is that it irreversible.

T3: Is she sick at the moment.

D3: She was very sick at some stage but now she is much better.

T4: How many teenage children do you have and what sexes are they?

D4: I have one son.

T5: How old is he?

D5: He is 14 years old

T6: What do you believe is the role of sex education at home and at school?

D6: We know that some parents are shy to talk to their children about the issues of HIV and AIDS and it's transmission. The schools need to educate the children about all the issues. I have a nurse friend (he is male) who told me about this girl who started menstruating. Shortly afterwards, instead of the mother talking to her about sex, she simply sent her to the clinic to get an injection to prevent pregnancy. What this mother is saying is that she promotes the child to have sex for as long as she does not fall pregnant. I think that the mothers should talk about the whole process, why girls menstruate and why boys do not menstruate. The children should know that there is nothing wrong with menstruating.

T7: Have you initiated sexual discussions between yourself and your son? What prompted the discussion?

D7: Yes, when my cousin got infected, I felt that I needed to talk to my son about the dangers in relation to HIV and AIDS.

T8: What in your view is the function of condoms and who should use them?

D8: They are mainly used to protect pregnancy as well as the spread of different sexual diseases. I think that they should be used by everybody both married and unmarried people. For an example, when I used to stay with my husband, I used them because I did not know if I could trust my husband.

T9: How would you feel if you became aware of the fact that your teenager is in possession of condoms?

D9: It would hurt me and I would need to call my son and speak to him about it. I would encourage him to be open about it and to not be scared to talk to me about what is happening in his life. When a child is told that it is poison to do something, then they want to feel whatever is forbidden to them. That is why I say that I can

even leave a box of condoms in his room. I am not promoting sex but I am simply saving hi life.

T10: How would you respond if you found your son vs. your daughter being in possession of condoms?

D10: I think it would be good. In the olden days when we were young we did not have any of the problems that we experience today. You would only see when a girl would be pregnant that she is sexually active. Now they have to protect themselves.

T11: How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

D11: The thing is that you can't stop them from engaging in sex. If both girls and boys are not able to stop themselves then it is better that they protect themselves rather than going into sex without protection.

T12: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

D12: I think that children should hear about all these things firstly from us as their mothers. The schools should rubber stamp what we have already told them.

T13: What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

D13: We know that kids of today become sexually active at a very young age. We also know that HIV and AIDS is spreading like wild fire. When our children have been told about the risks involved and they still choose to continue to have sex, then they should use condoms.

T14: What type of questions would you encourage about condoms in discussions with your teenagers?

D14: Any questions he might have.

T15: What type of questions would you discourage about condoms in discussion with your teenagers?

D15: I will not discourage any questions. I would like him to ask me whatever questions he might have.

T16: What impact do you think such discussions would have on your relationship with your son?

D16: He will know that my mother taught me this, and that I was able to see some of the things myself. Thus, he will know that my mother wanted me to have choices in life so that he would be able to choose for himself what is right and what is wrong. I also see myself as my son's role model so that I try to live a good and clean life to set a good example to my son.

T17: What questions would you encourage and discourage about HIV and AIDS?

D17: I would encourage every question he might have and I would not discourage any questions.

T18: What would you do if you found out that your teenage children were sexually active?

D18: Issues of HIV and AIDS should be discussed on a daily basis. I would continue to talk about the issues with him over and over again.

T19: I have asked you all the questions I had planned to ask you. Are there any questions you would like to ask me?

D19: Regarding me saying that I would put a box of condoms in my son's bedroom. Do

you think I would be wrong to do that?

T20: D, you know, I don't know if there is a right or wrong answer to your question. I have given you the number for Lovelife at the end of the letter that I gave you. I can only give you my opinion that your putting the box of condoms in your view will save your son's life. So if you believe that would help him, I would say go ahead and do it. Thank you very much for participating in this study.

5. Interview with E

T = Researcher

E = Interviewee

T1: Thank you for partaking in the study. As per the letters that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

E1: No, I don't have any questions at this time.

T2: How many teenage children do you have and what is their sex?

E2: I have two teenage boys.

T3: How old are they?

E3: The one is 21 and the other one is 18 years old.

T4: What do you believe is the role of sex education at home and at school?

E4: The schools have to take it very seriously. Most schools are mixed schools that boys and girls interact with each other on a regular basis. They do things together and that before they start experimenting with sex, it is important that they should be told about sex.

T5: Have you initiated sexual discussions between yourself and your children?

E5: Yes since the whole issue of HIV and AIDS came to the fore. For an example, when the children are out of the house, you don't know what they do that is why it's important that you talk about the dangers out there.

T6: What prompted the discussions?

E6: As I say, this thing is becoming so common that there is nothing else they talk

about on TV and radio except HIV and AIDS. It's spreading so rapidly and it's becoming so common that you have to tall your children to be careful.

T7: What in your view is the function of condoms? Who should use them?

E7: I don't know much about condoms because in our time, there wasn't that much to do with condoms.

T8: How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?

E8: Taking into consideration of the problems caused by HIV and AIDS, I would favour them to have condoms than not to have them because of the danger associated with HIV.

T9: How would you respond if you found your son vs. your daughter being in possession of condoms?

E9: In both situations I would talk to them that although condoms are available and that they can use them, they should not become careless because of them and that they should continue to be alert.

T10: How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

E10: I think they should both use condoms if they are going to be sexually active.

T11: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

E11: I think that the school and us mothers should have the same role with regards to sexual education. We should both teach, and talk to our children as soon as they reach their teenage years to make them aware of the challenges ahead.

T12: What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

E12: I think that it is a good thing taking into account of HIV and AIDS. We know that

abstaining is not easy. If the condoms are available, that will go a long way into solving the problem.

T13: What type of questions would you encourage about condoms in discussions with your teenagers?

E13: I would encourage all the questions my teenagers might have. I would like them to be open with me and to ask me whatever they want to ask.

T14: What type of questions would you discourage about condoms in discussion with your teenagers?

E14: I wouldn't discourage any questions.

T15: What impact do you think such discussions would have on your relationship with your teenagers?

E15: I think that they have become more open to me about the issues they go through as teenagers. They can now talk about what worries them.

T16: What questions would you encourage and discourage about HIV and AIDS?

E16: I would encourage questions around transmission. I would not discourage any questions.

T17: What would you do if you found out that your teenage children were sexually active?

E17: I would not be surprised because children of today start being sexually active from 13 to 14 years of age. It's not like in the olden days where it was seen as taboo and considered to be a terrible thing. One has to be prepared for these types of things. I would tell them to be careful and to reiterate it over and over again. One thing I know is that you cannot stop them once they have started.

T18: Do you have any questions you would like to ask me?

E18: Do you think that I am in the right track regarding how I think about these issues?

T19: I have attached at the end of the page Lovelife's parent line number. You can contact them if you have any questions with regards to the issues we discussed today. It would be very difficult for me to tell you whether what you are doing is right or wrong. I would say that since you have started talking to your children, perhaps to continue talking openly with your children regarding the issues we discussed today has been beneficial to your relationship with them thus far. Thank you very much for your participation in this study,

6. Interview with F

T = Researcher

F = Interviewee

T1: Thank you for partaking in the study. As per the letters that I have given to you earlier my name is Tintswalo, I am doing a study on maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. I have some questions that I would like to go through with you. Please indicate as we go along if you have any problems with the questions by way of not understanding anything I ask or if you have concerns about the questions asked. Do you have any questions or concerns before we start?

F1: I don't have any questions at this time. I am nervous about the interview.

T2: How many teenage children do you have and what is their sex?

F2: I have one

T3: How old is she?

F3: She is 18 years old.

T4: What do you believe is the role of sex education at home and at school?

F4: At home you need to talk about sex and to help the child understand whatever he or she needs to understand about sex, what it is and when to practice it.

T5: Have you initiated sexual discussions between yourself and your children? What prompted the discussions?

F5: Yes, although we don't have discussions everyday. Say sometimes when I have seen an article on the magazine. That is when we would have a discussion.

T6: What in your view is the function of condoms? Who should use them?

F6: To practice safe sex.

T7: How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?

F7: That would mean that she does have a boyfriend and that she has not been honest with me about whether she has a relationship or not.

T8: No, not necessarily, I just mean if you found out that she had condoms.

F8: I don't want her to have condoms.

T9: How would you respond?

F9: I would feel sick, oh, I would feel very bad. It would mean that she does have a boyfriend. I would sit her down and talk to her about HIV and pregnancy. I would be very upset with her and disappointed.

T10: How would you respond if you found your son vs. your daughter being in possession of condoms?

F10: I just have my daughter so I can only talk about her.

T11: How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

F11: We must tell our children to practice sex after marriage. Teenagers should wait until marriage.

T12: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

F12: There should be no difference. At school learners are free with their teachers than the way they are with their mothers that makes it important to educate learners about sex at the schools.

T13: What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

F13: If I were the president, I would discourage the use of condoms.

T14: What type of questions would you encourage about condoms in discussions with

your teenagers?

F14: I would encourage all questions.

T15: What type of questions would you discourage about condoms in discussion with your teenagers?

F15: I won't discourage any questions.

T16: What impact do you think such discussions would have on your relationship with your teenagers?

F16: I can say that it has helped to build a strong bond between us.

T17: What questions would you encourage and discourage about HIV and AIDS?

F17: I would encourage my daughter to ask me questions about how HIV and AIDS can be contracted.

T18: What would you do if you found out that your teenage children were sexually active?

F18: Oh, I would be so disappointed. But I will talk to her. I would try to get her to see the disadvantages of engaging in sex i.e. pregnancy, HIV and AIDS.

T19: We have come to the end of the interview, do you have any questions that you would like to ask me.

F19: No, I do not have any questions.

T20: Thank you very much F for taking the time to participate in this study.

7. Transcript G

T = Interviewer

G = Interviewee

T1: Thank you for partaking in the study. You have read the information sheet provided. Do you have any questions that you would like to ask me before we start with the interview?

G1: No I don't have any questions.

T2: How many teenage children do you have and what is their sex?

G2: I have one boy and he is 14 year old. My daughter is younger because she is 6 years old.

T3: What do you believe is the role of sex education at home and at school?

G3: I don't see a difference between the two environments. We should not shy away from difficult things that we have to discuss with our children at this stage.

T4: Have you initiated sexual discussions between yourself and your son? What prompted the discussion?

G4: No I haven't. I have been telling myself that my son is too young. I have been thinking to start discussing these type of things with him when he is 15 years of age.

T5: What in your view is the function of condoms?

G5: It's used to protect us from diseases affecting people now such as HIV, Syphilis.

T6: Who should use them?

G6: Youth and adults should use them.

T7: How would you feel and do if you became aware of the fact that your teenage son is in possession of condoms?

G7: I would feel happy that he knows about condoms. It would mean that somebody has taught him about condoms and I won't be surprised.

T8: What would you do in that case?

G8: I will ask him about the condoms. I would ask him where he got them, what is their use. I would also like to know why he has the condoms.

T9: You told me earlier that you have a daughter who is slightly younger. Would you feel differently if you had a daughter and the daughter had the condoms?

G9: I believe that both girls and boys should have condoms.

T10: How do you feel about girl teenagers in comparison with boy teenagers using condoms when engaging in sexual activities?

G10: I would not allow them to use the condoms. They should try and concentrate on their schooling. It is important for them to know the use of condoms but they should not use them.

T11: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

G11: I personally prefer that parents start educating our teenagers about condoms. Parents can explain to their children more for an example, if you don't use condoms, you are going to suffer and get sick. At school they should teach the children about not using the condoms until they are much older.

T12: What is your opinion towards the availability of condoms to teenagers e.g. in public toilets and schools?

G12: I think that it is wrong. They should not give them at the schools. I think that it is very, very wrong. The children have gone to school to learn and not to use condoms.

T13: And what do you think about their availability at public toilets?

G13: I think that it is wrong to have them at public toilets at the malls. They are not supposed to use them there either.

T14: What type of questions would you encourage about condoms in discussions with your teenager?

G14: I would like my son to ask me about what is their use, why one should wear a condom when engaging sexually.

T15: What type of questions would you discourage?

G15: I would not discourage any questions.

T16: What impact do you think such discussions would have on your relationship with your teenager?

G16: I think that once we start having these discussions, our relationship would become more open.

T17: What questions would you encourage and discourage about HIV and AIDS?

G17: We have spoken about HIV and AIDS. I would encourage my son to ask me questions about where and how do you get HIV and AIDS. I would encourage him to ask me whatever questions he has. I would not discourage any questions.

T18: What would you do if you found out that your teenager is sexually active?

G18: I will call him and talk to him about it.

T19: What would you say to him?

G19: I would discourage him from continuing with this behaviour.

T20: G, I have covered all the questions I had that I wanted to cover with you. Do you have any questions for me at this time?

G20: I don't have any questions. This has made me think a lot about whether I am doing enough about these issues.

T21: G thank you so much for you're input and frank responses about quite a difficult subject. Thank you.

8. Interview with H

T = Researcher

H = Interviewee

T1: Thank you for taking part in this study. I appreciate giving me you time. You have read the information sheet about what the study is about and what you can expect from the process. As per the information sheet, my name is Tintswalo Khosa. I am currently busy with my Masters degree at Wits University. As part of the course, I am doing research on the maternal attitudes towards HIV and AIDS. Before we start, are there any things you would like to clarify or questions that you might have?

H1: No I don't have any questions.

T2: How many teenage children do you have and what is their sex?

H2: I have 3 children.

T3: What are their sexes?

H3: I have two girls and 1 boy.

T4: What are their sexes?

H4: The boy is 20, and the girls are 13 and 18 years.

T5: What do you believe is the role of sex education at home and at school?

H5: I believe that the role for both environments is to educate the teenagers about unsafe, unprotected sex and the implications of having unprotected sex. We also have a role to play of encouraging them not to be sexually active before sex.

T6: What is the difference between the home and the school in terms of their role?

H6: I am not free to talk to them at home about sex. I am shy to talk about it here at home. The school I believe should play a prominent role to teach our children about sex.

T7: Have you initiated sexual discussion between yourself and your teenagers?

H7: My daughter told me that I am not open about sex, and felt that we do not talk about sex at all. The problem is that I am not free to talk about it. So because of my daughter saying this, it opened up the discussion a bit. My daughter initiated the discussion. Maybe there was a discussion at the school that prompted her to start talking about it, I don't know.

T8: What in your view is the function of condoms and who should use them?

H8: The role of condoms and function is to prevent the spreading of the virus. Because adults sometimes split, they should use condoms as well as everybody who is sexually active.

T9: How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?

H9: That would disturb me. I will be very upset. It would make me aware of the fact that they are sexually active. I would ask them what they are doing with condoms. Although I know that my role is to advise them to equip them to make the right decision, I would tell them that at their age, they are not supposed to have sex.

T10: How would you respond if you found your son vs. your daughter being in possession of condoms?

H10: It would be the same.

T11: How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

H11: I don't like to talk about sex out of fear that it might make these kids aware of sex and thus want to try it. Although I don't want to think about it, I do think that if they are going to have sex, its better that they use condoms.

T12: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

H12: The schools can use activities to educate the children about condoms. With their mothers, kids will not disclose that they are sexually active. So I think that the school should play a bigger role in educating children about sex.

T13: What is your opinion towards the availability of condoms to teenagers e.g. in public toilets and at the school?

H13: A teenager would be sexually active but would not tell you. I feel that it is better when they get condoms there because they would not bring them to the house, at least it would mean that they are having safe sex.

T14: What type of questions would you encourage about condoms in discussions with your teenagers?

H14: Would not encourage them anything.

T15: What type of questions would you discourage about condoms in discussion with your teenagers?

H15: Why should they be sexually active? I don't like that. I wish that if it was possible, they would listen to me not to practice sex if it was possible.

T16: What impact do you think such discussions would have on your relationship with your teenagers?

H16: There was no impact.

T17: What questions would you encourage and discourage about HIV and AIDS?

H17: I would encourage them to ask me anything they want to know.

T18: What would you do if you found out that your teenage children are sexually active?

H18: That would be very hurting for me. Those are not my teachings. I teach them not to be sexually active at a young age. I don't know what I would do. I told them that if they get HIV and become positive, it would be difficult for me to be

supportive to someone who chooses this at such a young age.

T19: I have completed all the questions that I wanted to go through. Do you have any questions for me?

H19: I am I wrong to not want to talk about sex with them. I was once asked by a lady to talk to her teenagers about sex. Later on those teenagers feel pregnant. I then felt guilty about this and thought that maybe when you talk about sex with them, you actually begin to give them ideas.

T20: I am wondering whether it is possible that perhaps those teenagers had already had sexual encounters, that its possible that their falling pregnant had very little if at all to do with you.

H20: It's possible, but I just could not forgive myself for it. When I was younger, I went to the clinic for something. Whilst I was there, the sister gave me contraceptive pills. Because my father was a priest, one day my mother found the pills in my wardrobe. Instead of talking to me about it, she went to church and I just heard her talking about this in front of the congregation. I was so embarrassed because I was not even sexually active at the time. From then on, sex was just this subject that I feared more than anything.

T21: That must have been a very traumatic experience for you. It must have been devastating and embarrassing for you.

H21: It was (paused, we then talked about this for a while and then I thanked her for partaking in the study).

9. Interview with I

T = Researcher

I = Interviewee

T1: How many teenage children do you have and what is their sex?

I1: I have one boy.

T2: How old is he?

I2: He is 15 years old.

T3: What do you believe is the role of sex education at home and at school?

I3: At home, our role is to educate the children about sex. It is to help them to know more about sex, to know the dangers of having sex and thus equipping them with knowledge. At school, they should be taught about when is the right time to start engaging in sexual activities. They should know about the advantages and disadvantages of having sex especially because of diseases and how to protect themselves against those diseases.

T4: Have you initiated sexual discussions between yourself and your children? What prompted the discussions?

I4: Yes I have. Because of age, I saw that he is growing at 15 years, I felt that it was the right time to talk about it.

T5: What in your view is the function of condoms? Who should use them?

I5: Everybody should use them. Anybody who is sexually active should protect themselves from diseases except if you have tested and found that you are negative, and then you can have sex without the condom.

T6: What is their function?

I6: It works as a protection aid from diseases and pregnancy.

T7: How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?

I7: I can be happy because it would mean that he is protecting himself against diseases. And it means that he is not ready of making a girl pregnant or to get married or to having a baby.

T8: How would you respond if you found your son vs. your daughter being in possession of condoms?

I8: I would not be happy if I had a daughter and found her having condoms because I will not want her to have sex before the age of 21 and to have sex before marriage. If she falls pregnant or catch HIV boys can run away from the responsibility and thus disturb her future. She would then be left alone to take care of the baby alone so that makes it worse for girls than boys.

T9: How do you feel about girl teenagers vs. boy teenagers using condoms when engaging in sexual activities?

I9: I think that it is good when boys use condoms because they are the ones confusing girls in most cases. They will tell girls not to use condoms in an attempt to get them pregnant. Whatever situation, girls must not be confused. They should always use condoms.

T10: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

I10: At school, it is easy for children to be confused by their peer groups. At home, mothers must talk to their girls so that they should be free to ask questions at home. If children are scared to ask questions, they will then rely on what they hear at school.

T11: Please clarify it for me; what role do you see the school playing towards educating teenagers about condoms?

I11: The teachers at the school must give topics so that teenagers can debate about condoms to allow children to get different viewpoints from their teens. This would

then allow them to compare what they are told at school and what they are told at home. Also teenagers might prefer to hear things from teachers than what they hear at home. They might also be uncomfortable to discuss certain things with their parents and thus feel comfortable to be open at the school.

T12: What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

I12: I think it's good.

T13: What makes you feel that it is good?

I13: Because the teenagers might want to use condoms but be afraid to ask their parents so that if the condoms are available in other places, then my son would be able to access them.

T14: What type of questions would you encourage about condoms in discussions with your teenagers?

I14: How to use condoms, I would encourage my son to ask me any questions.

T15: What type of questions would you discourage about condoms in discussion with your teenager?

I15: I would not discourage any questions.

T16: What impact do you think such discussions would have on your relationship with your teenager?

I16: I think that he would be free to talk about sex that would be helpful for both of us to talk about. It would create closeness between my son and me.

T17: What questions would you encourage and discourage about HIV and AIDS?

I17: I would not discourage any questions. I would encourage my son to ask me many things in order to know more about HIV and AIDS, how it is transmitted, and how one can go about protecting themselves against it. I would also encourage him to ask me about how one can care for people who are already infected.

T18: What would you do if you found out that your teenage children were sexually active?

I18: I will be surprised, thereafter, I would teach him more about sex.

T19: What type of things would you teach him?

I19: I would teach him the right and the wrong ay of having sex.

T20: I am not sure if I am clear about what you mean.

I20: Things like who should have sex, I would like to show him that he is young to be engaging in sex and that when he starts having sex, he should be grown up and be able to take a financial responsibility for whatever might happen such as having a baby should that happen.

T21: I, I have covered all the questions I needed to go through. Thank you very much your frankness throughout the interview, do you have any questions that you would like to ask me.

I21: No I don't have any questions at this stage.

T21: Well, thank you very much for partaking in this study. The number for LoveLife has been mentioned on the letter that I have given you. Please contact them should you have any questions at a later stage. Thank you again for partaking in the study.

Interview with J

T = Researcher

J = Interviewee

T1: Before we begin, I wanted to take the time to thank you very much for giving me this opportunity to ask you a number of questions pertaining to the research I am conducting about Maternal attitudes towards condom usage by teenagers in light of HIV and AIDS. As you have seen the information sheet, I wondered if you had any questions or things you might have wanted to clarify about the research.

I1: No, I don't have any questions at this time.

T2: As per the letter says, the research is completely confidential and none of the information received will be quoted as directly given by you in the actual research report.

I2: No that's fine.

T3: How many teenage children do you have and what is their sex?

J3: I have two boys.

T4: How old are they?

J4: The one is 16 and the other one is 21 years old.

T5: What do you believe is the role of sex education at home and at school?

J5: I think that children will be free to express their emotions and feelings at home, so it is important that they are made aware of the positive and negative aspects related to sexual behaviour and engaging in sexual activities. This will in turn give them choices in their own lives.

T6: And the school, what do you believe is the role of the school regarding sex education?

J6: The school should give the children knowledge and thus expose them to being sexually responsible and what is responsible behaviour regarding sex.

T7: Have you initiated sexual discussions between yourself and your children?

J7: Yes I have.

T8: What prompted the discussions?

J8: I saw that they are big. I realised that if I did not talk about it with them, they could get themselves into dangerous situations without knowing. I felt that they needed to know about how they could protect themselves from diseases and pregnancy.

T9: What in your view is the function of condoms?

J9: It is a form of prevention. Although it is not a permanent thing because what is important is that if a person loves himself or herself they should be able to take care of themselves and keep themselves clean. So I normally tell them that they should be self-loving but if they cannot do that then they should use condoms when they engage in sexual activity.

T10: Who should use them?

J10: Both men and women

T11: How would you feel and do if you became aware of the fact that your teenagers are in possession of condoms?

J11: I would talk to them about what the bible says about sex. If they do not want to do what the bible asks us to do, I would understand that perhaps this is the only way that they can protect themselves.

T12: How would you respond if you found your son vs. your daughter being in possession of condoms?

J12: I would feel the same way I said about my boys. But if I had girls, I would feel differently. I think that girls should try harder to not engage in sex at a young age. I believe that a girl should try harder to take care of herself and not make herself dirty. She should try to stay clean.

T13: How do you feel about girl teenagers vs. boy teenagers using condoms when

engaging in sexual activities?

J13: I think that it would be good if boys use condoms if they are not able to rely on the teachings of the bible. But girls I believe should be self-preserving and try to abstain from sex at an early age.

T14: What do you believe is the role of schools in comparison to the role of mothers towards educating teenagers about condoms?

J14: Both the school and the mother should teach the teenagers about condoms. At home, they might not be free to talk to their mothers about sex, so at school, it is important that they are taught because maybe they would be free to express themselves.

T15: What is your opinion towards the availability of condoms to teenager's e.g. public toilets, schools?

J15: It is not a good thing to have condoms at the schools. Condoms should not be allowed at the schools. For an example, it should not be allowed at primary school. Condoms should be made available at Health Centres where children can also get guidance about them.

T16: What type of questions would you encourage about condoms in discussions with your teenagers?

J16 I would like my sons to ask me about what are condoms, whether they could rely on condoms all the time.

T17: What type of questions would you discourage about condoms in discussion with your teenagers?

J17: Sometimes if they ask me questions about at what age they can start using condoms. At times it is embarrassing when they ask me about when I started having sex.

T18: What impact do you think such discussions had on your relationship with your teenagers?

J18: It promoted transparency between us. I also think that it gave them a sense of being ready to face life. They can understand the dangers that are out there. They know that engaging in sexual activities could interfere with their lives and studies.

T19: What questions would you encourage and discourage about HIV and AIDS?

J19: I would encourage them to ask me about what would be my reaction should someone at home be diagnosed with HIV and AIDS. I would also like them to ask me about how they should react if they found out that I was infected with HIV and AIDS. I would encourage them to look after themselves. I would also encourage them to have one relationship and to stick to that one girlfriend.

T20: What would be your reaction?

J20: I would be supportive and caring to my children if they found out that they have the virus. I would also encourage the same from them.

T21: What would you do if you found out that your teenage children were sexually active?

J21: I will tell them again about what the bible teaches about sex. But I would also tell them that since they choose to engage in sex, they should try and keep one partner and that they should use condoms. I would encourage them to introduce me to their girlfriends who I would expect to see all the time if they want to bring a girlfriend over.

T22: I have covered all the questions I wanted to ask you. Do you have any questions you wanted to ask me?

J22: No, there is nothing at the moment for me.

T23: I have included Lovelife's parent line number on the information sheet should questions arise later. Please contact them. Thank you so much for giving me this time to go through this interview with you. Thank you again.

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Wits University

Student Fees Account

01-JAN-2009 - 30-SEP-2009

Person Number : 0704073N **Name: Lorraine Sebole** **Opening Balance: -29.24**

Invoice No	Invoice	Invoice Desc			Description	Amount
1394208	03-FEB-09	Copyright Fee				90.00
1397776	04-FEB-09	Tuition Fees			ANAT1000 Anatomy & Functional Anatomy	2,440.00
1397777	04-FEB-09	Tuition Fees			LING2003 Phonetics II	2,810.00
1397778	04-FEB-09	Tuition Fees			LING2004 Psycholinguistics II	2,810.00
1397779	04-FEB-09	Tuition Fees			PSYC2001 Cognition and Social Psychology II	3,080.00
1397780	04-FEB-09	Tuition Fees			PSYC2004 Personality and Developmental Psychology II	3,080.00
1397781	04-FEB-09	Notes and Unit Packs			ANAT1000 Anatomy & Functional Anatomy	21.00
1397782	04-FEB-09	Notes and Unit Packs			LING2003 Phonetics II	90.00
1397783	04-FEB-09	Notes and Unit Packs			LING2004 Psycholinguistics II	90.00
1397784	04-FEB-09	Notes and Unit Packs			PSYC2001 Cognition and Social Psychology II	130.00
1397785	04-FEB-09	Notes and Unit Packs			PSYC2004 Personality and Developmental Psychology II	130.00
1599235	13-FEB-09	SUN RES Accommodation Fee				8,915.00
1599236	13-FEB-09	SUN RES Accommodation Fee				8,915.00
1615167	17-FEB-09	SUN Res Meal Charge				11,355.90
1680511	17-MAR-09	Club and Society Fees			His People Subs 2009	200.00
1727526	28-APR-09	Interest Charges				284.24
1744697	20-MAY-09	SUN RES Telephone Levy				495.00
1760471	28-MAY-09	Interest Charges				240.36
1791213	30-JUN-09	Interest Charges				218.50
1840326	28-JUL-09	Interest Charges				179.55
1848810	05-AUG-09	Receipts duplicated in error			Standard Bank pmt date 05/08/09 - ID	3,600.00
1858910	28-AUG-09	Interest Charges				82.13
665980	03-MAR-09				665880 Standard Bank	-3,500.00
810163	04-SEP-09				809095 Standard Bank	-3,600.00
754978	03-JUL-09	0704073N	SUN CITY	730	0191 Standard Bank	-3,600.00
789568	05-AUG-09	0704073N	SUN CITY	216	0219 Standard Bank	-3,600.00
789710	05-AUG-09	0704073N	SUN CITY	216	0219 Standard Bank	-3,600.00
737361	03-JUN-09	0704073N	SUN CITY	869	0166 Standard Bank	-3,600.00
719416	07-MAY-09	0704073N	RUSTENBURG	404	0143 Standard Bank	-3,600.00
642115	16-FEB-09	0704073N	SUN CITY	143	0080 Standard Bank	-6,000.00
595388	22-JAN-09	0704073N	SUN CITY	417	0059 Standard Bank	-6,000.00
701649	06-APR-09	0704073N	SUN CITY	016	0120 Standard Bank	-3,600.00
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