The perceived impact of a skills training workshop supported by the book, *HIV & AIDS*, on grandmothers' communication with pre-adolescent and adolescent grandchildren in their care about sex, sexuality and HIV and AIDS in Alexandra

Jane Simmonds

Student Number: 8803746X

6 June 2016

Supervisor:

Dr Nicola Christofides

A research report submitted to the School of Public Health, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Public Health.

Declaration

I, Jane Simmonds, declare that this research report is my original work. It is submitted in partial fulfilment of the requirements for the degree of Master of Public Health, in the field of Social and Behaviour Change Communication, in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination to this or any other university.

6 June 2016

Abstract

Introduction:

HIV continues to be a major public health issue in South Africa with young people still at high risk. Evidence suggests that children who have lost one or both parents are at greater risk of acquiring HIV. South African grandmothers, and other older family members, are increasingly responsible for raising grandchildren in the absence of parents. Conversations about sex, sexuality and HIV and AIDS need to be part of growing up. Sexual reproductive health (SRH) communication between parents and their children has been shown to promote safer sexual choices. Where grandmothers, and other older family members, are the primary care givers, this responsibility is shifting to them. There are a number of barriers, including cultural beliefs, self-efficacy, age and gender that impede SRH conversations between older caregivers and the children they care for. The overall aim of this study was to explore the phenomenon of an group of grandmothers in Alexandra in communicating about sex, sexuality and HIV and AIDS with the pre-adolescent and adolescent children that they care for, before and subsequent to a skills training workshop on sex, sexuality and HIV and AIDS.

Materials and methods:

This was a qualitative evaluation study that explored the experiences of grandmothers or older caregivers when talking to their grandchildren or children in their care about sex, sexuality and HIV and AIDS before and after a brief intervention over seven months. This study drew on a phenomenological approach using content analysis.

The intervention consisted of a two-hour training workshop using the book, HIV & AIDS by Marina Appelbaum as a tool to facilitate SRH communication. Data collection occurred at three points in time. The study used convenience sampling and ten grandmothers or older female caregivers who were the primary caregivers of pre-adolescent and adolescent grandchildren aged 10 to 18 years volunteered to participate in the study. Of the ten participants, six women participated in a focus group three weeks after the skills training workshop. Five of the ten women from the baseline interviews were interviewed a second time three to six months after the skills training workshop. Data was collected utilising individual in-depth interviews pre- and three to seven months post intervention, and through a focus group discussion three weeks post intervention. Thematic analysis was conducted and inductive codes and themes were identified from the interviews.

Results:

Grandmother and older caregiver conversations about SRH matters with pre-adolescent and adolescent grandchildren and children in their care were hindered by a number of factors. These included taboo and cultural issues; the personal experiences of the grandmothers with SRH communication during their childhood; the generation gap; gender; the lack of self-efficacy regarding SRH content; knowledge about HIV and AIDS and how to actually speak about sex, sexuality and HIV and AIDS. In addition, a number of other hardships in the grandmothers' and older caregivers' lives were barriers to making having these SRH conversations a priority. The intervention highlighted that grandmothers and older caregivers appreciated the need to have these conversations with their grandchildren and children in their care and were prepared to overcome these barriers in order to promote safer sexual behaviour for the grandchildren. The skills training workshop helped to shift the fears about SRH communication and the participants responded very positively to the skills training workshop expressing how much more confident they felt about addressing SRH topics after the intervention. In addition, self-efficacy was strengthened with participants reporting that they had attempted SRH conversations with the children in their care after the skills training workshop. However, the grandmothers and older women felt that further training was required for them. In addition, they felt that skills training workshops for their grandchildren were also needed.

Conclusions:

Overall, the findings in this study demonstrated the value and need for interventions to facilitate SRH communication between grandmothers and older caregivers and the grandchildren and children in their care. As grandmothers and older women are committed and involved primary caregivers of the children in their care, and in spite of numerous barriers to SRH conversations, they are prepared to speak to their grandchildren about this topic. In addition, they recognise the value of this communication in keeping their grandchildren and children in their care healthy and promoting safer sexual choices. In light of the active role played by grandmother in raising grandchildren, SRH interventions are needed to assist the role of grandmothers in talking about sex, sexuality and HIV and AIDS. The skills training workshop made a significant contribution to increasing SRH communication although participants recommended that additional workshops were required for themselves and the grandchildren and children that they care for. In addition, interventions need to recognise the day-to-day difficulties experienced by grandmothers and older women in bringing up third generation children.

Acknowledgements

First and foremost, I offer my immense gratitude to my supervisor, Dr Nicola Christofides. Not only has Dr Christofides opened my mind to new ideas and a new career, but she has encouraged and supported me through my developing passion and love for Public Health when, at times, it threatened to overwhelm me.

In addition, I would like to express my thanks to Thuli Shongwe for conducting the interviews; to Dumisani Mbatha for translating and transcribing the interviews; to Ingrid Moloi of Ratang Bana for providing me with the environment in which to conduct my research and to Darlington Ndlovu for his support and tireless editing.

I would like to specially acknowledge the following:

Marina Appelbaum, without whose book, *HIV & AIDS*, and friendship and support, this thesis would not have been possible

Norman Manoim and my children, Emma Jordi and Alex Jordi, who have lived with me for the past three years under varying circumstances – some more trying than others

My mother, Janet Simmonds, who is the grandmother I know best – thank you for always being there as a friend, a mother and a grandmother

My final and greatest thanks go to the grandmothers of Ratang Bana- the Gogos. Your strength, dignity and leadership are an inspiration. I have learnt humility, trust, belief and faith from you. In the face of the hardship that you endure on a daily basis, you found the time to work with me. Thank you for your support and time

"A house without a grandmother is like a road that goes nowhere."

Senegalese proverb

Dedication

This paper is dedicated to my father, Frank Simmonds, an educator, teacher and pursuer of knowledge, justice and equality. For ten years before he died, my father worked in education in Alexandra under the auspices of the Alexandra Education Committee. His lifelong commitment to education and social justice has found itself in me, in my passion for the field of Public Health. Thank you, Pa, for giving me the opportunity to do and be anything I wanted to be and believed in.

"When an old person dies it is as though a whole library had burned down."

Amadou Hampâté Ba, Malian philosopher 1900– 1991

Acronyms

HIV Human immunodeficiency virus

AIDS Acquired immunodeficiency syndrome

ECD Early childhood development

LO Life Orientation

SASSA South African Social Securities Association

SRH Sexual reproductive health

UNICEF United Nations Childen's Emergency Fund

USAID United States Agency for International Development

UNESCO United Nations Educational, Scientific and Cultural Organisation

Contents

Declaration ..... *ii*

Abstract ..... *iii*

Acknowledgements ..... *v*

Dedication ..... *vi*

Acronyms ..... *vii*

Contents ..... *viii*

Tables ..... *xii*

Chapter 1: Introduction *1*

1.1 Introduction **1**

1.2 Description of Intervention **4**

1.2.1 Information about the book, *HIV & AIDS* 6

1.3 Statement of the Problem **7**

1.4 Justification for the study **7**

1.5 Aims and objectives **8**

Chapter 2: Literature review *10*

2.1 Role of parent-child sexuality communication in promoting safer adolescent sexual practices **10**

2.2 Historical perspective on parent-child communication about sex in South Africa **14**

2.3 Family as a source of sexual and HIV and AIDS information **15**

2.4 Interventions to reach parents in order to reduce adolescent sexual risk behaviour and evidence of what works **18**

2.5 Grandmothers as sex, sexuality and HIV and AIDS communicators? **22**

2.6 Context of being an older primary care giver **23**

2.7 Interventions and Grandmothers **23**

Chapter 3: Methodology *26*

3.1 Study design....26

3.2 Study setting....26

3.3 Study population/Respondants?....26

3.4 Study sample.... Error! Bookmark not defined.

3.5 Data collection....27

3.6 Data processing methods and data analysis....30

3.7 Ethical considerations....31

Chapter 4: Results....33

4.1 Socio demographic characteristics of participants....33

4.2 How do gogos become parents ...again?....35

4.3 Relationships with extended family....37

4.4 Stress on gogos....38

4.4.1 Financial stress.... 38

4.4.2 Administrative stressors.... 38

4.4.3 Health and ageing.... 40

4.4.4 Housekeeping.... 41

4.4.5 Psycho-social stress.... 41

4.5 Context for communication about sex, sexuality and HIV and AIDS between gogos and the children in their care at baseline....43

4.5.1 Gogos' perceptions of their grandchildren's behaviour.... 43

4.5.2 Importance of education and attending school.... 45

4.5.3 Gogo's perceptions of grandchildren's friends.... 47

4.5.4 Safety and wellbeing of grandchildren.... 48

4.6 Barriers to talking about sex, sexuality, HIV and AIDS at baseline....50

4.6.1 Feelings about talking about sex, sexuality and HIV and AIDS.... 50

4.6.2 Limited skills and SRH knowledge of the gogos.... 52

4.6.3 Cultural barriers.... 53

4.6.4 Gender Barriers.... 54

4.6.5 Generation barrier.... 54

4.6.6 The role of school in sex education.... 55

4.7 Talking about menstruation 56

4.8 Existing HIV and AIDS and sex and sexuality conversations at baseline 57

4.8.1 Baseline strategies used by gogos to talk about sex, sexuality and HIV and AIDS 57

4.9 Additional sources of HIV/AIDS, sex and sexuality information at baseline 62

4.9.1 Extended family 62

4.9.2 Church 62

4.9.3 Government clinics 63

4.9.4 Friends 63

4.10 Concept of skills training workshop 64

4.11 Experiences and perceptions of the gogos of the GOgogoGO skills training workshop and sexuality communication with children in their care at home after the skills training workshop. 66

4.11.1 Positive feelings about talking experienced by the gogos after skills training workshop 67

4.11.2 Improved openness and building trust in communication between gogos and grandchildren 68

4.11.3 Condom conversations 71

4.11.4 Importance of skills building in adults and not only increasing knowledge 72

4.11.5 Barriers and challenges to talking about sex, sexuality and HIV and AIDS after the skills training workshop 73

4.12 New things learnt by the gogos 79

4.12.1 Gogo sexual health and condom use 79

4.12.2 Female condoms 79

4.12.3 Exclusive breastfeeding 79

4.12.4 “Chewing Gum Choice” 80

4.13 Need for a skills training workshop for adolescents 80

4.14 Additional conversations between gogos and grandchildren after the skills training workshop 83

4.15 Talking about menstruation 84

Chapter 5: Discussion 85

5.1 Day-to-day experiences of the gogos 86

5.1.1 Financial, emotional, physical and social difficulties facing the gogos 86

5.2 Gogos' experiences of sex, sexuality and HIV and AIDS communication with adolescent and pre-adolescent children in their care 89

5.2.1 Barriers to SRH communication between the gogos and their grandchildren 89

5.2.2 Enabling factors for SRH communication 91

5.3 Do gogos count as parents 94

5.4 Sources of information about SRH issues 95

5.4.1 Role of gogos as advisors 95

5.4.2 Role of school 96

5.4.3 Role of peers 96

5.4.4 Role of older males in sexual health conversations with pre-adolescent and adolescent children in their care 97

5.4.5 Role of the church, other family and community members 98

5.5 Perceived impact of 'GOgogoGO' skills training workshop 98

5.6 Feedback and thoughts on the skills training workshop "GOgogoGO" 99

5.7 Limitations 100

Chapter 6: Conclusion and recommendations 103

6.1 Conclusion 103

6.2 Recommendations 105

6.2.1 Increased support for older caregivers 105

6.2.2 Improved healthcare 106

6.2.3 Easier access to financial assistance 106

6.2.4 Increase the childcare grant for unemployed caregivers of children. 107

6.2.5 Government policy 107

6.2.6 Additional income 107

6.2.7 Listen to the older caregivers 107

6.2.8 Schools 108

6.2.9 Clinic access and support 108

6.2.10 Skills training workshop recommendations and future interventions 109

References 110

APPENDICES A-I 113

6.3 Appendix A 113

Information Sheet for Participants 113

6.4 Appendix B 116

Informed consent form to participate in study 116

6.5 Appendix C 117

Informed consent form – Audio tape 117

6.6 Appendix D 118

Informed consent form – Audio-Visual tape 118

6.7 Appendix E 119

Communication between grandmothers and their grandchildren 119

6.8 Appendix F 120

Communication between grandmothers and their grandchildren 120

6.9 Appendix G 122

Communication between grandmothers and their grandchildren 122

6.10 Appendix H 123

Socio-demographic questionnaire 123

6.11 Appendix I 125

Ethics approval form 125

Tables

Table 1: Socio-demographic characteristics of Gogos 33

Chapter 1: Introduction

1.1 Introduction

"*The people in our families who used to support us are all gone. I am taking care of children all over again for a second time."* Thulisile Dladla, Swaziland (p17) (1)

The promotion of well-being, health and education of children in developing countries is a global priority for governments, local and international aid organisations and civil society groups (2). The majority of development programmes to address this tend to have targeted children, occasionally mothers and sometimes, both parents (2). Very few community health programmes in the past have worked specifically with, and identified grandmothers, as 'resource persons' (2). Grandparents in all societies often contribute significantly to the growth and development of children (2). According to a report published in 2005 by the United States Agency for International Development (USAID), the role that grandmothers can play in the wellbeing of grandchildren needs to be recognised (2). Even with the low numbers of programmes using grandmothers as key audiences of health promotion projects, results and outcomes of these programmes have been positive (2).

In Africa, many grandmothers have become the primary caregivers of orphaned children (3). According to UNICEF and other global partners, an orphan is defined as a child who has lost one or both parents (4). As the result of HIV and AIDS, many children's mothers and fathers, have passed away (5). Traditionally, African culture has relied on the social order of extended families, with close-knit and supportive roles surrounded by communities providing stability and security (1, 5). With the mortality of adults in their 20s, 30s and 40s, many of these traditional family networks have been compromised (3, 5-8). In the face of this collapse in social structure and the traditional culture of the extended family, orphaned children have become the responsibility of the older generation (3, 5-8). Community members, consisting of older people and grandparents, have taken over the sole responsibility of caring for these children regardless of the limitations of their own personal health, capacity and resources (1).

Recent statistics estimate that the HIV prevalence in the total population in South Africa is 10.9% (9). More than 60% of all new infections in sub-Saharan Africa are estimated to be among young people, aged 16-24 years (10). The high prevalence of HIV infection among young people, fuelled by high risk sexual behaviour, which includes inconsistent and incorrect condom use, early sexual debut and multiple partners, is the focus of HIV prevention efforts (11). Although HIV prevalence in South Africa has decreased among young people aged 15 to 24 from 10.3% in 2005 to 8.6% in 2008 (9),

young people remain vulnerable as adolescence is a time of experimentation with sexual activity and subsequently a high-risk period for HIV infection (12). In addition, adolescence is a time when sexuality and sexual behaviour is shaped (13). Interventions that encourage the development of healthy sexual norms among adolescents can lead to a reduction in risk taking behaviour (13).

Social and cultural transformations have effected changes in adolescents' sexual behaviour and increased sexual risk behaviour, and is putting many adolescents, especially young women, at risk through vulnerable sexual relationships (14). Research on the role of communication between parents and their children in the development and decision making of their adolescent children's sexual behaviour and subsequent reduction of HIV incidence, has established the importance of parent-child sexuality communication (15). Changing patterns and values in society, along with a lack of accurate information about sex, sexuality and HIV and AIDS, have contributed to making talking about sex within the family difficult for parents (14). With the increasing influence of media on adolescents and the increased opportunity for exposure to risk, parents are encouraged to speak to their children openly about sexuality and sexual reproductive health issues (SHR) prior to sexual debut (16).

The HIV epidemic has led to the diversification of family structure, roles and norms resulting in different child caring patterns (5). These changes in child caring patterns are resulting more and more in the globally growing social phenomenon of multigenerational families (3). In the USA, grandparents are increasingly parenting grandchildren as a result of HIV and AIDS resulting in a significant increase in "skipped generation" families (17). In Africa in the past, multigenerational families traditionally existed when older people were cared for and "absorbed" into their extended families as they become more dependent on support and care from younger family members as they aged (7). As part of this extended family group, grandparents cared for and raised their grandchildren, sharing the responsibility with the parents of these grandchildren (7). In South Africa, historically, there have been "skipped" generation families as grandparents raised grandchildren in the absence of parents as a result of apartheid, labour migration and the Group Areas Act (5) which often resulted in parents not living with their children. This was usually done with the financial aid and support of the working parents of the grandchildren (7).

Due to the impact of HIV and AIDS, the system of older people being cared for and supported by their extended families as they aged, has changed due to the large numbers of older people who are now sole caregivers (7). This significant change in child caring patterns has resulted in older adults or grandparents providing primary care without the support of their children and other kin due to the loss of these young adults (7). In South Africa, since the onset of HIV and AIDS, the number of

skipped generation households, where orphaned children are most likely to live in households headed by older adults, has increased (7). In many instances, elderly grandparents reside with their grandchildren (7). Monasch and Boerma (2004) state that 60% of orphans in South Africa are living in households headed by grandparents (18). According to Kimuna and Makiwane (2007), in Mpumalanga, older people were the primary breadwinners in nearly 76% of multigenerational households, including skipped-generation households (6).

Grandparents are increasingly facing the challenge of sexual reproductive health (SRH) communication with the grandchildren in their care (19). There are few studies on how grandparents cope with sexuality communication with adolescent grandchildren (19). In the United States, "youths of colour" living with their grandparents are at a particularly high risk of practising risky sexual behaviour and of subsequent HIV infection (20). Grandchildren raised by grandparents are more likely to have unprotected sex than children raised by one or both of their biological parents (21). Subsequently there is a need to identify ways to increase communication among grandparents and grandchildren in order to reduce HIV incidence in adolescents (22).

According to a study by Makiwane et al. (2004)- , 66% of the elderly in Mpumalanga, South Africa, were carers of orphans with kin relations (7). The impact of HIV and AIDS has resulted in changes in social constructions which now expect kin relations, particularly grandparents, to absorb orphaned children (8). The existence of the notion of the extended family in African culture is strong and children are not left uncared for even if their biological parents have died (3, 5, 23). Increasingly, older women are caring for children orphaned by AIDS (5). Even in households with adult males and females, women tend to be more responsible for childcare and therefore are more likely than men to care for orphans (23). A report prepared for USAID (2005) looked at the role of senior women in children's overall development, including education, in Africa, Asia, Latin America, the Pacific, Aboriginal Australia, and Native North America (2). In this report, the term "grandmothers" was used to refer "to experienced, senior women in the household who are knowledgeable about all matters related to the health, development and well-being of children and their mothers. This includes not only maternal and paternal grandmothers, but also aunts and other older women who act as advisors to younger men and women and who participate in caring for children" (pix) (2).

Programmes and initiatives using an intergenerational approach to assist these older women in their roles as primary caregivers in skipped generation families need to be established (5). Due to the fact that large numbers of children are being cared for by older women in South Africa, the intervention below was designed to facilitate SRH communication between older women and the children in their care.

1.2 Description of Intervention

GOgogoGO is an intervention designed to enhance communication about sex, sexuality and HIV and AIDS between older women and pre-adolescent and adolescent children or grandchildren in their care. This group of women, often referred to as 'gogos', can include biological grandmothers, aunts and unrelated older women who are the primary caregivers of children. Not all the children cared for by older adults are AIDS orphans, but are third generation children with or without living parents and with older women as the primary care givers. For the purposes of this intervention and the collection of results, the group of older women who participated were referred to as 'gogos' and the children being cared for were referred to as 'grandchildren' whether they be biological grandchildren, biologically related children or unrelated younger children.

The intervention consisted of a two hour skills training workshop where a facilitator discussed, shared and guided the participants in the importance of speaking to their pre-adolescent and adolescent grandchildren about sex, sexuality and HIV and AIDS. Although a two-hour session is short for a behaviour change intervention, this intervention was focused on familiarising the participants with the book and how to communicate with children in their care about sex, sexuality and HIV and AIDS. It was not the intention of the intervention to provide extensive knowledge and facts on HIV and AIDS for the grandmothers, but rather to share with the participants how to speak about sex, sexuality and HIV and AIDS with children in their care.

Around 30 women who were aware of the session through their association with Ratang Bana, a community-based organisation in Alexandra, Johannesburg, attended. The group included a younger mother and women with no children who wanted to learn more on the topic of HIV and AIDS. The training was marketed as "How to talk to your children about sex, sexuality and HIV and AIDS". The skills training workshop used the book, *HIV & AIDS* by Marina Appelbaum, (previously published under Marina Coleman in 2009), as a tool to facilitate communication about SRH and HIV and AIDS (24).

The skills training workshop consisted of a two-hour session presented by Marina Appelbaum and an assistant. During the first hour, the facilitator discussed and shared factual content about adolescent sex and sexuality. She explained the realities about sexual experimentation and development and the biology behind these changes. The content in the skills training workshop relating to sex and sexuality discussion was open and non-judgemental. The facilitator took a pragmatic approach to sexuality and the reality that adolescents are dealing with a physical process that is in itself

complicated, but also an exciting physiological time with appropriate feelings of desire. Much use was made of anecdotal and humorous stories and examples discussing the different words and names in different languages and local slang to describe body parts, sexual activities, desirable partners and what all these words mean. By opening up the reality of sex, and making a space where people could feel safe, laugh and learn, the participants relaxed and began to share their stories. They responded with warmth and humour to the openness of the facilitator. The session took on the form of a group of mothers and women who were casually meeting to discuss issues rather than a lecturing-type environment. This 'gentleness' in the space of chatting and sharing as concerned mothers worked very well in eliciting feedback and interaction from the participants.

Once the tension and nerves around the fact of talking about sex and adolescent sexuality were broken, the facilitator used this open and relaxed space to talk about and share correct and accurate information about HIV and AIDS, using the book as reference source. The participants were able to select either an English, Setswana, isiZulu or isiXhosa version of the book. The content and drawings in the book are the same in all the translations and although the training was in English, some participants selected a version of the book in their home language in order to make it easier to share the book with children. The book was used a as resource to strengthen the knowledge and understanding of HIV and AIDS of the participants.

The following sections of the book were dealt with in detail: "Facts about HIV in Sub-Saharan Africa" (pp12-13) with special focus on heterosexual sex being the main transmission pathway of HIV; the fact that women are three times more vulnerable to infection than men; that young people, aged15-24, are the most at risk group (mention was also made that older women are becoming an increasingly vulnerable group due to the low targeting of HIV and AIDS information they receive); the difference between HIV and AIDS (pp 6-7); "Who can get HIV" and "How do you get HIV" (pp14-29) and "How does HIV spread?" (pp 36-37)(24).

The second hour of the skills training workshop was used to discuss techniques on how to speak to adolescents about sex, sexuality and HIV and AIDS. The facilitator discussed approaches and different skills needed to have open and honest communication about sex and HIV and AIDS with adolescents. Role-plays and interaction were part of this session.

Sections discussed in detail in the second half of the skills training workshop were: "Resistance to using condoms" (pp 43-49) and "What are genitals?" (pp 50-51) (24). In the training on resistance to using condoms, much humour was used to unpack the excuses why people do not want use condoms and possible responses to these excuses opening up a space which made talking about

condoms easier. The "What are genitals?" section was an important part of the session as the participants were taught through this section the value of using the correct names for body parts. The importance of this is that if you can name your body parts correctly and clearly, you can more confidently talk about them and negotiate sexuality and desire and sexual behaviour and health. Reference was also made to the fact that these are "your" body parts and that any kind of non-consensual contact was inappropriate. By being clearly able to differentiate and identify parts of the body and genitals, individuals can have a greater say in controlling sexual behaviour whether consensual or not. The correct words also made it easier to talk about genitals with the group. Each gogo was given a copy of this book to take home.

1.2.1 Information about the book, *HIV & AIDS*

The book is a short, cartoon-based resource book on HIV and AIDS. It is a simple and accurate resource and guide that covers issues of HIV and AIDS. In a country where 18,1% of the population are regarded as functionally illiterate, (25) the book uses cartoons to make the book user friendly and easier to read and understand. Comic books have been used to educate readers in a number of social issues, due to the powerful nature and popularity of the medium (26). The book was written in response to a lack of user-friendly and easily accessible HIV and AIDS content. In the author's experience, HIV and AIDS content is usually text heavy and didactic. The book, *HIV & AIDS*, aims to change this by being in a cartoon-based format making it more appealing to read and the content more accessible.

The book deals with the origins of HIV and AIDS; the difference between HIV and AIDS; transmission of the virus and protective behaviour; resistance to condoms and an explanation of the stages of HIV and AIDS. Difficult words are translated into Sotho, Afrikaans and Zulu making the content even more accessible. In addition, there is a test at the back of the book; a section on your rights and helpline numbers. The skills training workshop content is different to other sex education workshops as it focuses on grandmothers and older women and how to use the book as a tool to facilitate SRH communication between these older caregivers and the children that they care for.

Although this book has not been empirically evaluated for efficacy and effectiveness, over 360 000 copies of this book have been sold and distributed. Anecdotal feedback has consistently been positive with demand for the book continuing to increase. The book has been distributed since 2009 as part of various interventions to reduce the incidence of HIV and AIDS. These interventions have tended to be workplace-based and peer-educator led within large corporations and mining houses. In this research, the book was used as a tool to facilitate communication between primary caregivers and their children in their care about sex, sexuality, HIV and AIDS. The study focused on older

caregivers, the gogos, and the orphaned third generation children, the grandchildren, for whom they are caring.

1.3 Statement of the Problem

Adolescents have increased vulnerability to HIV infection (9, 11). Due to the impact of HIV and AIDS and its resultant mortality, many children find themselves being looked after by their grandparents as opposed to their parents (3). Much research has been done on the role of parents in reducing HIV incidence in their children but in the face of the growing phenomenon of children being looked after by their grandparents, research needs to be done in this area (22). These multigenerational families are often marginalised from predominant social, economic and political systems and this has resulted in grandparents needing support in this 'caring for grandchildren role (17).

In addition to the marginalisation experienced by grandparents caring for their grandchildren, grandparents experience intergenerational confict (8). This conflict has been referred to as the 'generation crash (27). Skills and knowledge sharing between the older and younger generations could lessen intergenerational conflict and improve family relationships (8). There is a need to identify means to increase communication amongst grandparents and pre-adolescent and adolescent grandchildren to reduce the HIV incidence in the children that they care for (22).

1.4 Justification for the study

There is evidence that parental and family involvement in sexuality and sex communication reduces sexual risk behaviour (11, 14-16, 28, 29). In the absence of parents, there is the reality that SRH conversations should take place between grandparents and grandchildren. Generational differences do present their own specific challenges to grandparents who may not feel prepared to deal with these conversations (19). In addition, there are a lack of resources to assist and prepare grandparents for these conversations, which makes this more difficult (19). The skills training workshop was designed to facilitate this process and the book, *HIV & AIDS*, by Marina Appelbaum (24) was a resource and tool to make this easier.

Research on the process of grandparent-grandchild sexual communication is limited (22, 30-32). Many sexuality communication studies in the USA have focused on parents and their adolescent children whereas few have looked at grandparents and their adolescent grandchildren (22, 31). In the United States of America, African American grandparents are playing an increasingly pivotal role

in the functioning of families (33). However, communication-based interventions addressing sex and sexuality awareness do not take this into account (31).

In South Africa, there is very little research regarding factors and interventions that influence communication about sex between grandparents and their grandchildren (30). There is some research on the role of caregivers and how they relate to children in their care about SRH issues and mention is made of the fact that caregivers are not always biological parents (30, 34). Soon et al. (2011) looked at how adolescents in Soweto relate to their parents and caregivers about sex and sexuality and the adolescents' experiences but not at the experiences of the caregivers (34). In this study, youth participants identified a need to be able to communicate with adults about HIV and sexual behaviour in a bi-directional manner. An unpublished study that looked at grandparents' or grandmothers' SRH communication in particular was research conducted on grandparents communicating with their grandchildren in the Eastern Cape for a Masters of Arts degree (35). This study found that grandparents were unsuccessful in communicating SRH matters to youth and that grandparents should be supported in communicating sexual matters to their grandchildren.

1.5 Aims and objectives

The overall aim of this study was to explore the phenomenon of an group of grandmothers in Alexandra Township, Johannesburg, in communicating about sex, sexuality and HIV and AIDS with the pre-adolescent and adolescent children that they care for, before and subsequent to a skills training workshop, supported by the book, *HIV & AIDS,* on sex, sexuality and HIV and AIDS in 2014.

The specific study objectives were:

1) To explore the contexts of grandmother communications about sex, sexuality and HIV and AIDS with pre-adolescent and adolescent grandchildren in Alexandra Township, Johannesburg, in 2014.
2) To explore the context of the grandmothers' lives in which communication with pre-adolescent and adolescent grandchildren in their care about sex, sexuality and HIV and AIDS occurs, or not, in Alexandra Township, Johannesburg, in 2014.
3) To explore the grandmothers' experiences and perceptions about talking to pre- adolescent and adolescent grandchildren in their care about sex, sexuality and HIV and AIDS, prior to participation in a skills training workshop, GOgogoGO at Ratang Bana, a community centre in Alexandra Township, Johannesburg, in 2014.

4) To explore the perceptions and experiences of the skills training workshop, GOgogoGO, with the grandmothers and subsequent communication with pre-adolescent and adolescent grandchildren in their care, within the home environment, in Alexandra Township, Johannesburg, 2 to 3 months after the skills training workshop in 2014.

Chapter 2: Literature review

The literature review was conducted using a number of search engines including EBSCOHost, PubMed and Google Scholar. The electronic databases of the libraries of the University of the Witwatersrand were accessed and a number of electronic journals were searched. A manual search was not conducted. The search terms used included "grandparents care of grandchildren"; "grandmothers care of grandchildren"; "grandparents sexual communication with grandchildren"; "grandmothers sexual communication with grandchildren"; " HIV and AIDS conversations between grandmothers and grandchildren" and "sexuality conversations between grandmothers and grandchildren." Since there are very few reported studies referring to grandmothers communication about sex, sexuality and HIV and AIDS, the search was extended to include "parents" in the relevant search terms listed above. The limiter of English as a language was applied.

2.1 Role of parent-child sexuality communication in promoting safer adolescent sexual practices

The family is the primary source of socialisation for adolescents and can exert a strong influence on sexual attitudes and behaviours (29). Sexual socialisation is regarded as the process by which youth become aware of and develop sexual behaviours (36). As a result, parents can contribute to the sexual socialisation of their children and provide correct and factual knowledge and information for their children regarding sexuality and sexual decision making (16).

A systematic review of parent and family-based interventions on the effectiveness of healthy sexual outcomes in young people conducted by Downing et al. (2011) found that interventions addressing communication about sex and sexuality that focused on parents reported inconsistent results in reducing adolescent sexual risk behaviour (37). Interventions that were parent-based, i.e. the target population was parents, resulted in improved parent-child sexuality communication when compared to those that were family–based which showed no evidence of effectiveness. These interventions focussed primarily on children but both parent and children were included in the intervention (37). The review did find that sexuality communication can be responsive to interventions and that interventions addressing a number of multiple risk behaviours may result in reducing sexual risk behaviours (37). Research by Fehringer et al. (2013) conducted in high-income countries suggests that in situations where parents speak to their children more openly and more often about sexual behaviour, there is a greater likelihood of children engaging in safer sexual practices (28). Most of the research that was included in the review were studies conducted in the global north (37).

Research conducted by Bastien et al. (2009) found that African-based trials on SRH communication reported positive findings in terms of increased frequency and parental feelings of comfort around sexual health discussions (38). Akers et al. (2011) established that parents' sexuality communication with their adolescent children improved in quality, frequency, and ease (39). Parents experienced improved self-efficacy in talking to their children about sexuality after interventions (39). Improving and enabling parent protective behaviours, though sexual health training interventions for their children, have been shown to reduce adolescent sexual risk behaviour (32). These include delayed sexual debut, reduced partners and an increase in uptake of condoms (28, 40). According to Nyamambedha et al. (2003), parent-child communication has been associated with a range of behaviour patterns which are conducive to safe sexual practices (23).

There are a limited number of qualitative studies on the role of sexuality communication between parents and their children in sub-Saharan Africa (28). Many of those that have been done relate to the dangers, threats and need for discipline about sex and sexuality (28). Wamoyi et al. (2010) found that parents manage their children's sexual behaviour by controlling and monitoring their children (41). This was not successful due to challenges, for example, making time available to spend with children and monitoring behaviour (41). The authors recommended that there is a need for interventions to improve parenting skills for improved sexuality communication with their children for positive sexuality guidance and improved parenting (41). Instead of sex being seen as a negative activity, parents need to take the time to help adolescents develop the skills to develop self-empowered and self-regulating sexual behaviour (41).

There are a number of issues that parents and caregivers are confronted with when attempting to hold sexuality-based conversations with adolescents. These include gender, age, traditional and cultural values and generational conflict (42). Research by O'Sullivan et al. (2001)reported that mothers often focus on the negative aspects of sexual activity and the negative consequences (43). The messages received by girls from their mothers highlight the risks involved with sexual activity and emphasise the responsibility placed on girls to set limits with boys and avoid sexual encounters (43). This is often accompanied by girls placating their mothers that they intend to avoid sex and to focus on completing school and achieving career goals (42).

In two studies conducted with mothers regarding their own learning experiences of SRH matters, these mothers were asked to reflect on their own experiences of learning about sex as adolescents (44, 45). According to these studies, more than half (60%) of the sample responded that they had never had a meaningful discussion with their parents (44) and women reported that their memories of sexuality communication with their mothers as being mostly limited, unspoken, nonverbal and

negative, focussing on warnings and rules (45). These findings suggest that parents may not have role models to inform their engagement with their children. With this in mind, parents need to be exposed to training regarding the value of comprehensive and accurate sex and sexuality communication between themselves and their children.

Critical to communication about sex is the process and style of this communication (15, 34, 42). Research conducted by Bastien et al. (2011) found that discussions about sex and sexuality between parents and their children tended to be "authoritarian and uni-directional, characterized by vague warnings rather than direct open discussion" (p1) (15). DiIorio et al. (2001) reported that parents found sexuality communication difficult due to embarrassment, communication styles and feeling uncomfortable about acknowledging and accepting their children's sexuality (42).

Parents and children reported that taboos, insufficient skills and knowledge and cultural norms are barriers to open conversations about sex and sexuality (15). A number of aspects have been identified to promote and facilitate communication between adults and children. These included the type of content: the need for frequent discussion; helpful triggers for discussion; factors to hinder or promote conversations; positive perceptions of communication styles and preferences and barriers to communication (15).

Content that was discussed between parents and children included AIDS, condoms, abstinence, sexual debut and peers (42). DiIorio et al. (2003) reported that the most frequent conversations between parents and their children were on menstruation, reproduction, pregnancy and birth as well as HIV and sexual values (42). Less frequently spoken about were wet dreams, erections, masturbation and termination of pregnancy (42). The types of adults with whom adolescents spoke, included guardians, "other adults", extended family members, parents, aunts, uncles, mothers and fathers (15). Regarding the preferences of the adolescents about conversations with parents about sex and sexuality, adolescents preferred to hold these conversations with adults of the same sex (15). Gender played a significant role as to who the child spoke to, with mothers talking more to their children than fathers; mothers speaking more to their daughters than sons and fathers speaking more to their sons (42). However, mothers are often seen as too judgemental and adolescents would rather speak to other female family members (15).

Triggers for sexuality communication included relatives and family members who had died of AIDS, social media, radio programming, flyers, parental perceptions of high-risk sexual behaviour or belief that an individual might have HIV (15). Factors that promoted sexuality communication included perceptions by the parents that the children were ready to learn about sex and sexuality, whether

the parent or adult caregiver felt enabled to give this information with the correct skills and knowledge, if they had the confidence to have this conversation, gender issues and timing of sexual debut (15). Knowledge or the perception of knowledge, a sense of comfort and ease in the parent's attitude to this content and conversation and the communication style and tone were found to be substantial challenges or enablers to conversations about sex between adults and children (15, 42). Studies reviewed by Bastien et al. (2011) showed the following: sexuality conversations tend to be based on instruction rather than dialogue; parents tend to be the dominators and initiators of this communication; the conversation is generally unidirectional; judgemental, prescriptive and negative towards adolescent sexuality and many parents view these conversations as shameful, taboo and immoral (15).

Barriers to sexuality communication from a parental perspective include perceptions that this type of conversation is not normative behaviour in many African cultures (15). The reasons for this include residual traditional barriers; Christianity imposed inhibitions and a dependence on educational books to teach about sex (15). In addition, many mothers have not received sexual education themselves (15, 44, 45), from either their own parents or schools; there is a belief that talking about sex encourages sexual behaviour among children; adults and parents feel that children are too young to learn about sex and there is an assumption by parents that children learn sexuality information at school (15).

Adolescents experienced their own barriers when speaking to adults and their parents in particular (15). These included the perception that parents did not know enough about sex and HIV and AIDS; lacked knowledge about adolescent sexuality and were too busy with other issues – work, housekeeping, financial strain – to talk about sex (15) . Conversations about sex and sexuality could lead to conflict and arguments and that conversations could create suspicion in parents about possible sexual behaviour in the child (15). Youth frequently discuss menstruation and dating relationships with their parents (42). Adolescents tended to prefer to discuss sexual issues with their peers because of feelings of shyness in front of, and fear of physical punishment, from their parents (15). They also experienced feelings of guilt about sexual behaviour (15). Topics that adolescents did not frequently discuss with their parents included their fathers' attitudes to sex, erections and masturbation (15). These barriers not only impacted on conversations about consensual sexual activity, but impacted on the reporting of non-consensual or forced sex (15).

2.2 Historical perspective on parent-child communication about sex in South Africa

In the past, many communities in South Africa regarded the onset of puberty as something to be celebrated, with adolescent sexuality being dealt with openly (36). A number of cultures guided their adolescents through puberty and sexual development, relying on immediate and extended family, local groups and communities to manage this (36). However, the most powerful influence in this pubescent stage was the role of the peer group, which managed sexuality through peer pressure and initiation (36). As a result, neither parents nor elders had a specifically defined role in this stage and peer groups took on supervisory and guiding roles monitoring each other and putting in place sexual behaviour limitations (36).

Both amaZulu and Pedi adolescents experienced comprehensive sexual socialisation from their peer groups (36). According to Delius and Glaser (2002), in Xhosa communities, "adults played at best a marginal role" (p36) in the sexual education which young boys received from their peers (36). Although older women in Pondo communities conducted virginity tests on adolescent girls, this was resented by the younger women, resulting in peer groups resisting forms of adult monitoring whether from parents, older generations or local chiefs (36). This resistance to adult involvement in adolescent sexual development and education continued to grow in response to the changes in past rural South African lifestyles, due to conquest, migration and urbanisation.

With the arrival of Christianity, Christian morality and modernity, previously acceptable cultural practices of dealing with developing sexuality between adolescents became "shameful" and "secret" (36). Christianity restricted the role of peer groups and contributed to shaping an "inter-generational silence on sexual matters which became especially damaging as other forms of sexual education withered" (p37) (36). In addition, as a result of the work of Christian missionaries in the first half of the 20th century, sex increasingly became a taboo subject that was not to be spoken about (36).

In urban areas such as Alexandra in the 1950s and 1960s where some of the women who participated in this research were growing up during this time, children were regularly exposed to sexual activities due to lack of privacy and living conditions. Parents were sexually active in the same rooms as their children, older siblings were having sex at home and films began to show sexual relationships (36). Even with sexual behaviour being so highly visible, it was not spoken about between parents and their children. In addition, due to labour migration, city-born children were not able to interact with rurally-based grandparents who might have been able to provide a supportive role in sexual guidance (36).

Traditional and cultural practices of initiation and peer group organisations and the management of adolescent sexuality collapsed in urban areas during the 1950s. Intergenerational sexual education ceased and urban adolescents began to learn about sex from each other without the frameworks of cultural practices supported by peer group-based organisations (36). In urban areas, in particular, older generations were looked down on by the younger generation and were seen to have no educative or guiding role. Any attempt to advise youth by adults regarding sexual behaviour, would probably have been dismissed, as the 1940s and 1950s saw a breakdown in the authoritative role of parents and elders in urban societies (36). Parents were working and spending time away from home and extended family relationships were limited due to migration and apartheid. As a result, "intergenerational instruction had all but collapsed, as had sanctions against seduction and impregnation"(p46) (36).

This situation continued into the 1970s when many of the gogos' children would have been growing up. Young people disparaged the roles and authority of parents and elders due to their perception of the elders and parents' acceptance of and compliance with apartheid. In an attempt to regain control and authority, many urban children were sent to rural secondary schools by their parents. At these schools, adolescents experienced very strict controls over sexuality and sexual development with discussion of sexual issues regarded as taboo and strict punishment following any form of sexual activity (36).

In some cases, the extended family, including grandparents and aunts, had been regarded as the facilitators or distributors of sexual knowledge and skills to adolescents. However, with urbanisation and social change, these communication structures, too, had become compromised (15). In addition, sexuality discussions between parents and children in sub-Saharan Africa are often regarded as taboo (15). These particular developments in the sexual socialisation of adolescents have contributed to the present situation that adults and youth find themselves in regarding conversations about sex and sexuality.

2.3 Family as a source of sexual and HIV and AIDS information

The positive role parents can play in promoting safe sexual practices has been established through a number of studies (11, 12, 15, 16, 27, 28). Although parents are expected to provide correct and factual knowledge and information regarding sexuality and sexual decision making, in many South African societies this model for sexual communication has become corrupted and non-functioning (36).There is a need for family-based intervention programmes to address barriers to sexuality

communication, such as embarrassment, as well as concerns by parents that sexual communication results in early sexual debut (16, 31). Parents need to be taught, through interventions, how to talk with their children about sex, sexuality and sexual health, including HIV and AIDS (16, 28, 40).

However, programmes addressing parents only are not enough. As mentioned in the introduction, during apartheid, grandparents looked after grandchildren while their parents migrated to urban areas in search of work and income but parents were still involved in the raising of their children (5). With the changes in society due to AIDS-induced mortality, many grandparents throughout Africa are now increasingly finding themselves in a primary caregiver role to their grandchildren requiring them to raise these children alone (3).

Due to the components and dynamics of family systems in different socio-cultural contexts often not being adequately assessed, many Northern-based development agencies have used concepts of nuclear families for societies in the global South (2). This resulted in many interventions targeting "parents", which can be defined narrowly as children's mothers and fathers, and these focus mostly on women of reproductive age or on the mother-child dyad (2). There has been limited focus on how other 'non-parental' family actors outside this mother/father-child dyad, can be included to promote child development strategies and interventions (30, 32). According to research done by Aubel (2005) on a number of interventions based on projects looking at child development, in almost all cases, senior household members, including grandparents, are not consulted at initial assessment or design of community-oriented strategies (2).

With so many traditional family and community structures in transition, especially in South Africa, it is critical to involve experienced, senior family members in programmes for the benefit of children and their families (30). Not only are many households missing mother or father parental figures, but also by identifying only children or the mother/father–dyad, programmes receive a limited vision of the household system of which children are a part (30). There is increasing research to show the importance of the roles of all household actors in addition to parents, in particular mothers, to include older siblings, men and senior women, and how these roles relate to children's well-being (2). Due to the increasing research on the roles of household members, other than parents and mothers, there is a small but growing field of research on family- based HIV prevention strategies (30).

Preliminary results from a pilot study conducted by Armistead et al. (2014), on a family-based HIV intervention for South African youth has contributed to increasing the body of research on how culturally competent family-based interventions can contribute to HIV prevention in this age group

(30). Intergenerational social networks, for example families, have been shown through this research to hold promise for the reduction in HIV infection in South African youth (30).

Looking at how culture, history, family, and sexuality education intersect in South Africa, it became apparent how imperative it has become to consider the changing role of extended families (30). Traditional processes of extended family and peer networks in adolescent sexuality awareness and learning have been disrupted by a number of factors – colonisation, Christianity, urbanisation, apartheid's legacies (36) and the loss of generations due to AIDS (5). Peers without attachment to, and knowledge of, traditional adolescent sexuality processes are now the main source of sex education for adolescents resulting in significant misinformation (34, 36). The intervention reported on by Armistead et al. (2014) therefore emphasized parental involvement in youth sex education which is a notion that is relatively new for South African families (30). In addition, the project looked at general parenting skills that had positive outcomes in HIV prevention amongst South African youth (30). This is significant as improved parent–child relationship quality has been shown to be an important enabler for healthy parent–child sex communication (46).

The intervention reported increased levels of comfort in relation to the parents' ability and confidence in discussing sex and sexuality issues (30). This demonstrated a move towards overcoming well-established, traditional and cultural proscriptions against parent–child communication about sex (47). In addition, youth who participated in the intervention also felt that their parents were more participative and available to them regarding sexuality conversations post intervention (30). Youth also reported that they found their parents responsive to discussions about sex after the intervention and significantly, these effects were present at 6-month follow-up (30).

These results suggest that families present an opportunity for HIV prevention among South African youth (30). Positive responses to recruitment and the intervention efforts, intervention participation and evaluation in this pilot study indicated that there is a need and interest amongst South African families for strategies that can contribute to reducing HIV incidence in the youth that protect youth from HIV (30). Moreover, participants favourably evaluated the intervention experience and process. Of the parent sample in the study, 24% consisted of senior women- 18% were the child's grandmother or great grandmother, 6% were aunts and 7% were regarded as 'other' (30).

2.4 Interventions to reach parents in order to reduce adolescent sexual risk behaviour and evidence of what works

A number of different types of interventions have been designed and implemented in efforts to reach parents in order to reduce adolescent sexual risk behaviour (32, 48). These include community-based, school-based and workplace-based programmes. The success of these interventions can be measured through the number of parents reached or potential to reach; whether the intervention met its objectives; increased parent-child communication and/or reduced risk factors or improved protective factors regarding adolescent sex behaviour i.e. delayed sexual debut, an increase in condom use, or a reduction in multiple concurrent partners (48).

Despite evidence of the importance of the role of parents in promoting safe adolescent sexual behaviour, many interventions about sex, sexuality and HIV and AIDS target the adolescents only, with a limited or no role for parents (49). According to Eastman et al. (2006), these adolescent-targeted interventions do not result in prolonged behaviour change (49). There is the possibility that programmes working with parents might have more long term effects on behaviour changes and sustaining these changes (49). Parents are generally the adults with whom the adolescent has the most contact and interaction, and they are usually highly invested in their children's lives, health and wellbeing (49). The gap in programmes for "custodial grandparents" is noted in research by Santa Maria et al. (32).

Biological parents and primary caregivers, be they grandparents or other senior members of community, are probably the adults most familiar with their child's behaviour and attitudes. Parents can have long term impact on adolescent behaviour, whereas adolescent programmes tend to just be short term interventions (49). According to Kirby and Miller (2002), successful interventions to promote parent-teen communication need to increase effective communication between parent and child, reduce discomfort when talking about the topic and lead to a reduction in sexually risky behaviour by adolescents (48). In addition, parents have now become regarded as the preferred option as sources of sexuality information for their children (42).

Santa Maria et al. (2015) investigated whether improving parent-child communication about sexual health and parental monitoring adolescent behaviour resulted in the intended outcomes of increased parent-child sexuality communication, increased comfort when talking about sexuality and improved self-efficacy (32). This research looked mostly at interventions with minority parents using multiple group sessions (average 7 hours), self-paced learning and a large theory component (32). This review of interventions established that parent-based interventions, using innovative delivery approaches, can be effective in improving SRH communication with adolescents (32).

Interventions have tried to reach parents through community organisations, faith organisations, places of employment, schools, parents' tertiary education institutions, "one-shot" programmes, multiple community events and intensive multi-session programmes (48). These interventions targeted parents only, parents and youth together and/or youth only. They involved the development of content, courses, booklets, guides, TV programmes and videos amongst others (48). Most interventions targeted minority group parents of adolescents younger than 16 and took place either in the community or involved self-paced learning at home (32). There were multiple group sessions, parent only sessions, joint parent-adolescent sessions and separate parent and child sessions (32).

Multi-session programmes for adolescents and parents jointly have the advantage of presenting content and information to both the groups resulting in both parents and adolescents increasing their knowledge (48). They provide an opportunity to model discussions in the workshop environment resulting in increased comfort; provide an opportunity of immediate and subsequent conversation and are regarded as a comfortable space because the participants know they are expected to be talking about sex and everyone is doing so (32, 48). Studies reported in Kirby and Miller (2002) confirmed that joint sessions increased participants' communication about sexuality and increased comfort with the topic (48). Santa Maria et al. (2015) reported similar findings with multiple sessions but proposed that self-paced, easily accessible and disseminated content (e.g. internet or computer-based) did not have consistently weaker outcomes than those involving high dose delivery (e.g. multiple interactive sessions) (32). The problem arises on how to ensure that this increased communication continues (48).

Sessions for adults at the work place have the advantage of facilitating recruitment and retention if the intervention consists of repeated sessions (49). Multi-session programmes for parents usually focus on improving knowledge, attitudes and skills of parents resulting in greater self-efficacy when speaking about sex (49). This leads to more effective communication by helping parents develop parenting and communication skills (49). In an evaluation of a work place intervention, Eastman et al. (2006) reported that it was possible to promote healthy adolescent sexual behaviour and reduce sexual risk behaviour through the parents-only intervention as parents were reached easily during lunch hour at the work place (49).

Evaluations of parent-based interventions have indicated that these can result in improved communication styles of mothers (48). Mothers listened more after these interventions, spoke less, were less judgemental and asked more open ended questions of their children (48). This led to increased discussion about dating and sexuality, resulting in adolescents finding it easier to speak to

parents (48). An evaluation by Blachman (1991) of a one day workshop for parents of mentally challenged adolescents, found that the workshop did not result in a significant increase in parents' knowledge about sexuality (50). However, the workshop did result in significant changes in attitudes towards adolescent sexual behaviour and sexual education (50). The parents also reported a significant increase in their perception of their own self-efficacy and effectiveness as sexuality educators with regard to their adolescent children (50).

School-based programmes for parents of students in sex/HIV education classes have been used as well. Schools have access to the nearly all youth globally and 60 % of youth are school-going at sexual debut (51). The majority of children have HIV and sex education at school and some programmes have tried to reach parents through students and school programmes where parent classes are aligned with students' sex and HIV classes (32). In addition, school homework assignments in sexuality and HIV education which are to be done at home with parents and children, as well as tertiary sexuality classes for adults, have shown an increase in adolescent-adult sexuality communication (48). There is a role of school in adolescent sexuality learning and parental involvement in school- based sexuality and learning should be encouraged (37).

Home-based programmes for teens and parents, consisting of videos and written materials, have appeal in that they do not require attendance at skills training workshops (32, 48). Materials on their own may result only in a slight increase in parents' knowledge (48). These materials might briefly and slightly result in an increase in motivation to communicate but this does not extend much further (48). The advantage of home-based interventions being low cost might mean these interventions are cost effective, even if they have low impact (48). However, parents of high risk adolescents are not likely to read the written content available, nor embrace changes in communication (48).

Communities that are using grassroots organising to increase parent-child communication through community activities to promote communication changes, are becoming more popular (48). Grassroots organisations promote adult consensus and a joint drive to protect sexually active youth (48). Results have shown increased encouragement and uptake of contraceptives and improved knowledge and skills to communicate more effectively about sexual behaviour (48).

Media campaigns, using TV broadcasts, community radio, posters, outdoor billboards, guidebooks, flyers, brochures to promoting communication, have also been used. Together with interventions based on student homework assignments, media campaigns reach the greatest number of adults and parents (48). This is partly due to the fact that many parents are unwilling and/or unable to

attend evening or weekend sessions outside their homes. This presents many interventions outside homes with significant challenges, including paternal attendance as fathers are even less likely than mothers to attend these types of workshops (48).

According to Kirby and Miller (2002), the majority of designs discussed above have a positive impact on parents' knowledge and skills and comfort levels regarding talking about adolescent sexuality and HIV and AIDS (48). In addition, results indicated that they led to increased sexual communication in the short term (48). The multi-session projects for parents and children together and school-based sessions with homework assignments were most likely to increase parent-child communication. As early as 1985, Hamrick (1985), in a study of different types of family life education, looked at the different combinations in which to conduct this training, and concluded that training for parents and adolescents together was most effective at increasing parent child communication (52) .

In the systematic review conducted by Santa Maria et al. (2015) most of the interventions were 'resource- and dose-heavy' relying on multiple face-to-face sessions and extensive resources (32). This creates problems in terms of funding, quality management, training and manuals as well as retention and recruitment problems (32). Since the research could not establish a significant disadvantage in having self-paced learning with less face to face time and easier distribution of content, it suggested the option for increased use of technology e.g. computers (32). Technologically disseminated interventions could rely on Internet, cell phones and Wi-Fi reducing barriers and increasing retention and recruitment providing the participants with 'real-time' personalised learning (32). This form of active and engaged learning has the added benefit of being more easily accessible to low-income households than group-based multi-session interventions (32, 53, 54). Sexuality communication programmes need to do more than merely increase parent-child communication about sexuality (32). They should also go about finding ways to influence sexual behaviour going into the future. Kirby and Miller (2002) and Santa Maria et al. (2015) both acknowledged the importance of positive outcomes in sexuality conversations and sustaining these outcomes (32, 48). Since one of the aims of these interventions would be to increase communication over time, Kirby and Miller suggested a need for booster sessions (48). Santa Maria et al. (2015) proposed other parental constructs like parental nurturing, supportiveness, parental attitudes and monitoring and quality of the relationship between parents and their children be addressed and improved (32). Programmes that can promote improved adult-child connections and supervision and monitoring of behaviour and activities which will result in appropriate responses by both parents and adolescents to sexual behaviour will be more effective long term than just increasing sexuality communication (32, 48).

2.5 Grandmothers as sex, sexuality and HIV and AIDS communicators?

It has been shown that empowering key figures within the family, including grandmothers, can have a positive impact on the children's well-being (2). According to Aubel (2005), successful interventions make use of the strengths of communities, families, and social structures already present in those communities to achieve the best outcomes for children (2). The role of grandmothers in childcare in low and middle income countries has been largely ignored and given little attention, However, with increased parenting responsibilities and the global phenomena of multi-generational and intergenerational parenting and households, more and more older women are becoming responsible for the daily care and upbringing of third generation children.

As mentioned earlier, there is little available research on the role of grandmothers and SRH conversations. In research conducted in Soweto which looked at adolescent experiences of HIV and sexual health communication with parents and caregivers which included grandmothers, Soon et al. (2013) looked at how adolescents relate to their caregivers in SRH conversations and not the experiences of the adults (34). This is one of the few studies that looked at the experiences of grandmothers regarding sexuality communication with grandchildren in South Africa (30). In a study from the United States, Brown et al. (2000) reported that African-American grandparent caregivers were unprepared to discuss topics regarding sexuality and sexual health with their grandchildren (19). Another United States-based study conducted in 2008 found that African American grandparents required assistance communicating with their grandchildren (22). In addition, the grandparents were from a generation where discussing topics of sexuality was linked to embarrassment (31).

Given this evidence that suggests that addressing SRH communication between grandparents and grandchildren can have positive effects, interventions are needed to facilitate skills for grandparents to discuss sexuality topics including HIV/AIDS with their grandchildren. In addition, adolescent grandchildren raised in grandparent headed households were more likely to engage in unprotected sexual intercourse than children raised by their parents (55). In a United States-based study, Cornelius et al. (2008) found that grandparent responses were in fact more positive to this type of discussion than those of grandchildren (22). Grandparents thought talking about sex would not encourage sexual behaviour and that families were a forum in which to discuss sex (22). In this research, grandparents wanted educational and skills building sessions to develop self-efficacy regarding the sexuality communication process (22). In a study in Malawi involving parents, providing skills on how to discuss sex was important, as the participants felt inadequate when

discussing sex (40). Study participants expressed that they did not "know" how to talk about sexual health issues, indicating a need to teach individuals how to have these types of conversations (40).

2.6 Context of being an older primary care giver

Grandmothers need to play a number of roles as the primarycaregivers of third generation children including providing for the children's basic needs and to guide and 'parent' the children (17). Grandparents have begun to experience varying social, physical, emotional and economic costs resulting from these new parenting responsibilities (17). Grandparents' normative age-related developmental tasks can be affected by primary parenting responsibilities in middle or late life and these can have an impact on the health and well-being of grandparents (17). A study by Kelley et al. (2000) found that up to 30% of African American grandmothers and great grandmothers experienced negative psychological outcomes due to the new role of parenting grandchildren and that this warranted interventions (56).

At a conference conducted by the Stephen Lewis Foundation, the African Grandmothers Tribunal, grandmothers from around Africa reported on their caregiving experiences and expert witnesses concluded that the burden of care can be overwhelming for grandmothers (1). Not only are healthcare services for the elderly themselves often inadequate and difficult to access, they often lack basics, such as food, shelter, clothing and security (1). In addition, older people are often ignored by their own communities and community-based projects and mainstream development programmes, funded by government, do not take into account the social capital, skills and experience that older adults could bring to planning and delivering interventions, due to the at fact they are old and "unseen" (1). According to Siphiwe Hlope, Executive director of Swaziland Positive Living, the only way to improve the quality of life for grandmothers and the children in their care, is to take into account the understanding of grandmothers as "whole human beings" (1). The realities of grandmothers' lives, like access to finance, support and the exhausting hard work of caring for a second or third generation of children needs to be taken into account when putting in place programmes (1).

2.7 Interventions and Grandmothers

In order to increase the likelihood of successful outcomes, community interventions should focus on the community and the existing roles, values, and resources at local levels and should include

grandmothers (2). However, the role of grandmothers and their potential as community leaders in child care and promotion of children's development, using their social status and social networks, has received limited attention (2).

A number of programmes have shown how empowering and strengthening the role of grandmothers can increase a community's social capital and result in sustained community action for children's development (2). In order to include grandmothers in programmes working with child care and development, policies are needed to ensure grandmothers' involvement (2, 17). This can be done by placing the cultural roles and values of grandmothers as a foundation for programme design; respect for elders and their experience and acknowledging the social capital of grandmothers (2). In a small number of interventions already in place, grandmothers' roles have been identified as part of the programmes on interventions looking at early childhood development, primary school education, maternal and child health and nutrition, child hygiene, and HIV/AIDS (2).

Especially in South Africa, with such high numbers of children being cared for by older adults or grandparents (7), interventions looking to find ways to reduce HIV incidence in the adolescent population need to view grandmothers as key actors in the 'new', restructured family systems and as an invaluable resource for promoting healthy adolescent sexual behaviour. These interventions need to be based on community and social assets (2). A number of key international agencies, including UNICEF and UNESCO, advocate strengthening the capacity of family members to respond to children's needs, there is no direct reference to grandparents as key players (2). Even where policies encourage including grandmothers, there is very limited transference of this into practice (2).

According to the USAID report (2005) on the role of grandmothers in learning, a review of available literature makes the point that there are grandmothers in all cultures and communities; that they have significant experience and influence regarding the emotional, intellectual and physical well-being of their grandchildren and they show strong commitment to promoting the well-being of children, their mothers and families (2). Very few programmes have identified clearly, and involved, grandmothers as key actors in the programmemes, in spite of the significant roles played by grandmothers in communities and child care (2).

Education or knowledge-sharing programmes in particular have shied away from including grandmothers as a priority community group, rather focusing on younger mothers (2). The small number of interventions that were identified as making use of grandmothers in some way, dealt mostly with child development issues including early childhood development (ECD), primary education, new born health, maternal and child health and nutrition, and HIV/AIDS (2). These

projects, which have made use of grandmothers' roles and past experience and actively involved the grandmothers resulting in empowering their knowledge and skills, have resulted in very positive feedback from grandmothers, from other members of the community, and from project and development agency employees (2). In most cases, the active participation of the grandmothers seems to have resulted in improved intervention outcomes (2).

A number of factors have influenced the low levels of inclusion of grandmothers as key actors in community childcare interventions and strategies (2). In the past, grandmothers have not been seen as a target group for interventions, as many development organisations hold negative biases against grandmothers related to their age, inability to learn and resistance to change (2). In addition, usually, the models used as a basis in the design of childcare and community programmes have been developed in the western world. As a result, these interventions tend to focus on the more established and recognised role of 'mothers' and sometimes 'parents,' and do not recognise the traditionally significant role and influence of elder members of communities in most non-western societies (2). According to Aubel (2005), research has shown that interventions using non-formal education approaches with grandmothers to build on existing knowledge have been well received (2). Grandmothers have been receptive to these models as they have supported their perception as leaders and advisors in the communities, especially with regard to childcare.

In Mpumalanga, a province in South Africa, out of 63% of matrifocal, multigenerational households, 76% of older people are the sole providers of household necessities and caring for grandchildren in increasingly skip-generation households (6). Considering statistics like this, research, although limited, has shown that grandparents are receptive and successful at being key players in child care outcomes and grandmothers and older members of the community in South Africa must be targeted by interventions aimed at reducing HIV incidence in adolescence

Chapter 3: Methodology

3.1 Study design

This was a qualitative evaluation study that explored the experiences of grandmothers when talking to their grandchildren about sex, sexuality and HIV and AIDS before and after a brief intervention. The study drew on a phenomenological approach. This approach to qualitative research focuses on the participants' lived experience of a phenomenon. Participants were interviewed at three different time points in the course of the study.

3.2 Study setting

The study took place in Alexandra at the premises of Ratang Bana. Ratang Bana (meaning a future for the future of our children/love the children) is a registered Non-Profit Organisation based in Alexandra. The organisation has many different projects. Its primary role is the upliftment and support of children infected or affected by HIV and AIDS. The centre also has a food garden and a Gogos (grannies) Support Group. On Thursdays, grandmothers attend activities at the centre. These include reading groups and lessons, vegetable gardening, recycling projects, craft, sewing, and baking (57) .

Alexandra was established as a township in 1912 for black South Africans and is situated in close proximity to the center of Johannesburg. It covers an area of over 800 ha. Alexandra is densely populated with high levels of unemployment, poverty and crime. Since the end of Apartheid, there has been a significant population increase in Alexandra from within South Africa and neighbouring African countries, from people seeking employment in Johannesburg. This has resulted in overcrowding and the growth of informal settlements and backyard shacks (58).

3.3 Study population and sample

The study population consisted of all grandmothers and older women living in Alexandra, who were the primary caregivers for adolescent or pre-adolescent children aged 10 to 18 years old and who attended the Ratang Bana activities in 2014.

A convenience sampling strategy was implemented to identify participants for the study. A briefing on the study was given to members of Ratang Bana by the researcher and participants volunteered themselves for the study after self-identifying as grandmothers. These respondents were a sample of ten (10) grandmothers or older female care giversand relatives who attended Ratang Bana's "GOGO

Days". These "GOGO Days" are Thursday afternoon activities based at Ratang Bana for grandmothers and older women. These grandmothers or older women spoke and understood English and were the primary caregivers of pre-adolescent and adolescent grandchildren aged 10 to18 years. Gogos who had had previous exposure to the book *HIV & AIDS* by Marina Appelbaum and the skills training workshop previously held at the centre were excluded from the study.

Ten women were interviewed at the baseline. Of these ten participants, six women participated in a focus group after the skills training workshop. Five of the ten women from the baseline interviews were interviewed a second time three to seven months after the skills training workshop.

Although the intention of the research was to explore the experiences of grandmothers and their perceptions of a skills training workshop addressing HIV and AIDS, the women who were recruited were not all biological grandmothers of the children for whom they were caring. The term '*grandmother*' has been replaced by 'gogo' throughout the results section as 'gogo' is being used to represent an older adult looking after third generation children that are referred for the purposes of this research as 'grandchildren'. However, it must be noted that the participants in the study all self-identified as grandmothers looking after pre-adolescent and adolescent grandchildren.

3.4 Data collection

Most of the in-depth interviews were conducted by the primary data collector, who was a middle aged, black woman, through a combination of pre- and post- intervention in depth interviews and a post- intervention focus group discussion. These techniques were selected to allow optimum data collection. The in-depth interviews provided an opportunity for the participants to respond in private to a difficult and complicated topic. The focus group discusion allowed participants to discuss and share their ideas about the skills training workshop. These techniques complemented each other in providing both a secure and private space to talk about personal feelings, thoughts and experiences in the in-depth interviews as well as to share ideas and opinions in a more open discursive environment during the focus group. The approach to conducting the interviews was informal and conversational. The interviews were semi-structured using interview guides with questions and probes.

Pre-intervention data was collected through in depth individual interviews over a period of a month before the skills training workshop. Ten in depth interviews were conducted at baseline by the primary data collector. The data was collected by the primary data collector who spoke the

vernacular languages of participants attending Ratang Bana. These included Setswana and isiZulu. The in-depth interviews at baseline were guided by a list of questions supported by probes (see Appendix E) which looked at understanding the relationship between grandmothers and the grandchildren in their care; the feelings of the grandmothers about talking about sex, sexuality and HIV and AIDS; their past experiences of talking to their grandchildren about sex, sexuality and HIV and AIDS and if they had never spoken to them, the reasons for this. The data was collected at either Ratang Bana or in the home of the participant. The primary data collector collected this data which was audio taped. The audio tapes were then translated as required during transcribing by the trained assisstant researcher who was trained by the researcher on the purpose of the research study and the data collection methods. The research assistant spoke both Setswana and isiZulu

Post-intervention data was collected through a focus group discussion and five in depth interviews. The focus group discussion was conducted three weeks after the skills training workshop by the primary data collector using a focus group guide to ascertain the feelings of the participants about the skills tranining workshop (see Appendix F). The particpants were asked about how they had felt before attending the skills training workshop and their expectations of the workshop; their experiences of the skills training workshop and what, if anything, changed for them at the skills training workshop in terms of their feelings and what they learnt. These topics were discussed in the focus group at the premises of Ratang Bana by participants and audio taped. The content was then translated and transcribed by the research assisstant.

Five in-depth post-intervention interviews where conducted over the course of three to six months after the skills training workshop. Four of these interviews were conducted by the primary data collector and the fith one was conducted by the research assisstant. These interviews used an in depth interview guide to collect information of the experiences of the grandmothers in talking about sex. Sexuality and HIV and AIDS with their grandchildren after the skill based workshop (see Appendix G). The data from this was collected by the primary data collector in four interviews and by the research assistant in the final interview due to the unavailabilty of the primary data collector. The interviews took place at Ratang Bana and at the homes of the participants depending on their availability. The in-depth interview guide addressed topics regarding the participants' thoughts and feelings on the skills training workshop; the feelings of the particiapnts on the book, *HIV & AIDS* and if they had used the book; if things between the participants and their grandchildren had changed since the workshop and the experiences, if any, of the participants in talking to their grandchildren about sex, sexuality and HIV and AIDS since the skills training workshop. The data was audiotaped and was translated by the research assistant.

The head of Ratang Bana in Alexandra, Ingrid Moloi, granted permission to conduct the study and provided verbal and written consent. The researcher and assistant approached the group of grandmothers who came to the centre (Ratang Bana) on Thursdays as part of a gogo enrichment project to explain the study and introduce themselves. Information about the study was shared in a group session and an information sheet (see Appendix A) was left with potential participants. It was made clear that this was a voluntary study and that any information collected would be for the purposes of the study

Interviews were held in the second 'container room' on the premises of Ratang Bana, which is private and designated for counselling at the centre, or at the homes of the individual participant depending on convenience or need. The researcher audio-recorded the in depth interviews with the informed consent of participants. The research assistant did the translation and transcribed all interviews and the focus group discussion.

Basic socio-demographic information such as age, education i.e. years of formal schooling, number, age and sex of grandchildren was collected, as well as source of income e.g. foster grants, pensions or other streams (see Appendix H). Contact details were obtained for the follow up interviews. This sheet was kept separately from the consent forms, audio-recordings and transcripts in a locked cupboard.

The interviews were guided by a pre-tested, interview guide with a scripted introduction, which was read at the beginning of each in depth interview and the focus group discussion. This was done to remind the participants of the voluntary nature of the research and its purposes. The interview guides were pre-tested in order to ascertain if they worked to elicit discussion on the areas of interest for this research study. Two members of the community who were not part of the sample were recruited for the pretesting. Changes were made to the guides after the pre-testing. This research tool consisted of open-ended, non-directive questions, moving from the general to the specific (see Appendices E, F, G).

As expected, the first round interviews took roughly an hour as rapport, trust and a relationship needed to be established between the participant and the researcher. In addition, the topic was difficult and needed some time to discuss. The focus group discussion was more of a 'report back' on feelings and experiences about the skills training workshop. It was anticipated that these interviews would contain the most data, due to the fact that trust and rapport would have been established between the interviewer and the participants. However, these interviews tended to be shorter. The researcher and research assistant battled to find participants who had attended both the baseline in

depth interviews, the skills training workshop and the focus group discussion for the follow up interview. After extensive effort, only five of the original baseline participants were interviewed. The research assistant, as opposed to the principal interviewer, conducted one of these interviews due to the unavailability of the principal interviewer. These interviews were intended to take place two to three months after the skills training workshop but in fact took place over a longer time frame due to, with the final interview taking place seven months after the skills training workshop due to availability of the gogos. This availability was impacted by weather, home commitments, health of the participants and also the fact that the participants were primary caregivers so could not come if a child was sick or on school holidays or at home.

The interviews before the skills training workshop explored the context of the gogos' lives in which sexuality communication with their grandchildren occurs, or does not occur. In addition, the baseline interviews explored the experiences and perceptions of the gogos about talking about sex, sexuality and HIV and AIDS with their grandchildren at baseline and was conducted before the skills training workshop. The focus group discussion explored the gogos' impressions of the skills training workshop and was conducted three weeks after the skills training workshop. In the third round of interviews, the researcher focused on the perceptions and experiences of the gogos talking about sex, sexuality and HIV and AIDS with their grandchildren within the home environment since attending the skills training workshop and receiving a copy of the book, *HIV&AIDS*.

The skills training workshop was video recorded in order for the researcher to document the content and discussion of the skills training workshop. This was done in order to provide information that would inform the further development of the skills training workshop and personal feedback for the facilitator. However, the video was not included as a data source for this study as this was outside the scope od the study.

3.5 Data processing methods and data analysis

The study made use of a thematic content data analysis approach. The audio recordings of the in depth interviews were listened to by the research assistant in order to get a general feel and understanding of the interviews before transcription. The audio recordings of the interviews were transcribed verbatim after translation when needed and converted into Word documents and imported in MaxQDA for coding and analysis. The analysis was inductive, developing codes and themes arising from the interviews. These transcripts, in Word format, were re-read for accuracy. The transcripts were read in full before being coded for an overall impression of the data. The

researcher was the only person involved in coding the data and in the subsequent analysis of the data. However, data and coding was discussed with the supervisor on a number of occasions to ensure quality and to clarify interpretation and definitions. Statements from the transcripts were extracted and categorised. A code was assigned to each idea or category. Memos were written throughout the process of coding.

Primary coding was inductive meaning that codes emerged from the transcripts. The codes were grounded in the data. Later patterns in the data were identified and themes were developed. The patterns and themes were §reviewed and interpreted. Relevant salient quotes for each emergent theme were selected to support each theme during the process of writing up.

3.6 Ethical considerations

The Human Research Ethics Committee at the University of the Witwatersrand approved the research- approval number M130755. The approval form is included in Appendix I. The research was conducted within the ethics guidelines of the University of the Witwatersrand. An informed consent process (see Appendices B, C and D) was undertaken after recruitment, prior to commencing the first interview. Participants were informed what the purpose of the study was and that participation was voluntary and that they could choose to leave the study at any time. Their non-participation in the study did not affect their participation in any activities at Ratang Bana.

The participants were not reimbursed for their participation as interviews were conducted at the participants' homes or in the course of the participants' regular attendance in activities at Ratang Bana. Subsequently transport money was not required. Refreshments were not served at the focus group discussion as part of this research as food is available at Ratang Bana for grandmothers on the GOGO Days.

Participation in this study was voluntary and participants were able to leave at any time without having to provide an explanation or reasons. Participation in GOgogoGO or in any Ratang Bana initiatives was not compromised if a participant chose to leave the study. Each study participant was assigned a unique identification number so that individuals could not be linked to transcripts The contact information, which had names and phone numbers (for follow up interviews), has been kept in a separate folder by the interviewer and a unique identification number has been allocated to each participant. Participants provided written consent if they agreed to participate in the study and a separate consent form for the audio-recording of the interview. All data collected is being stored

under password protection with only the researcher and the supervisor having access. The data will be stored under password protection for two years after publication of the study and then destroyed.

Chapter 4: Results

4.1 Socio demographic characteristics of participants

Two of the ten women who participated in the study were biological grandmothers and the others were aunts, great aunts, foster mothers, an adoptive mother and a caring older woman from the community who played the role of "gogo". The women interviewed sometimes cared for a combination of biological grandchildren, biologically-related children and other third generation children.

The socio-demographic characteristics of the participants are presented in Table 1. The average age of the women who participated in the study was 60.3 years, with a range from 52-77 years. The average number of children being cared for by each gogo was three. There were 36 children in total, 18 male and 18 female being cared for by the gogo-figures in the study. The average age of the children was 13.5 years with a range from 2 to 21. None of the gogos were actively seeking employment and thus, were unemployed. Their sources of income were mainly grants and a few had some form of self-generated income. This self-generated income took the form of home baking and selling, rentals and charitable support.

Table 1: Socio-demographic characteristics of Gogos

PSEUDONYM	AGE	NUMBER OF DEPENDANTS	AGES OF CHILDREN IN GOGOS CARE	SOURCE OF INCOME	TOTAL INCOME DISCLOSED IN INTERVIEW
Thoko	63	1	11	– Senior Citizen grant – Foster Care Grant	R2150
Thuli	60	3	21,19,17	– Baking and Selling Scones – Foster Care	R840

				Grant	
Bontle	52	2	19,3	– Social Welfare Grant	R320
Sindi	59	4	15,8,5,2	– Rent Income – Social Welfare Grant	R320
Florence	74	2	21,15	– Senior Citizen Grant – Social Welfare Grant	R1670
Bongi	60	2	17, 4	– Not disclosed	-
Lerato	59	2	16,13	– Social Welfare Grant – Help from Ratang Bana	R320
Agnes	58	3	18,14,13	– Social Welfare Grant – Monthly Stipend from Projects	R820

Mercy	54	2	14,11	– Foster Care Grant	R840
Faith	77	2	21,13	– Foster Care Grant – Senior Citizen Grant	R2190

4.2 How do gogos become parents …again?

The gogos gave varied and sometimes complicated reasons for why they were the primary caregiver to and looking after children that were not their own. Most of the children being cared for were orphans with no parents. Two gogos had daughters that had died as a result of AIDS. Some of the children in the gogos care had parents who were alive and were living elsewhere for work or economic reasons. Some of the children were living with their grandparents because it was perceived this was in the best interests of the children.

Florence and Bongi were the only biological grandparents. Although Florence was looking after two of her daughter's children, she felt the need to mention that they had different fathers. *"My daughter was their mother … the thing is they had different fathers."* Bongi has looked after her daughter's child since he was two years old. Her daughter died of AIDS. The father was never involved and had also died.

Thuli spoke about losing three children over five years. One of these children died in a car accident. She was caring for three children whose mother was alive, as well as three orphaned grandsons. Sindi was looking after the child of her brother's only daughter. She began caring for the child because she felt that someone "needs to step in" to look after children when they are not doing well and struggling with academic performance.

> "*You know how we are as mothers … things became difficult when her sister (child's aunt) passed on. It seemed to even affect the child. I soon received news that the child was doing poorly at school. I then intervened and asked that the child be brought to me so I could take care of him."* – Sindi (59, caregiver of four children)

Sindi also referred to the cultural practice of the "*passing on*" of children. Should mothers "*become widows at a young age, you often pass your children to a custodian [often family] to take care of them*". In this case, the child was passed on to her sister, but children were often looked after by other members of the family.

Bontle, a great grandmother had her own mother's help looking after the grandchildren, but when her mother died, Bontle became the sole caregiver. Bontle explained that she was a great-grandmother at 62. This she explained was due to what she perceived to be sexually irresponsible behaviour of her children and grandchildren: "*I'm a great-grandmother. These kids are naughty*."

Lerato was also caring for a child whose mother was alive, as well as two orphaned nieces. She referred to the nieces as her grandchildren when in fact "*they are my sister's children*". Both the children were completely dependent on her for everything. She regarded them as her own children and she is responsible for seeing to their daily needs.

> *"It is as if they are my own children … I must ensure they eat, drink, are clothed and go to school."* – Lerato (59, caregiver of two children)

Lerato also cared for a third child, a girl. It was not clear from the interviews if this child was biologically related to her. This child does have a mother. However, the mother was not able to be an active and consistent caregiver as she is "*not being around as she is sick and always in hospital*".

Agnes did not refer to any blood relationship with the three children she looked after. She was also the only participant in the study who referred to a male partner, describing herself and her male partner, *"the man of the house," as their "sole custodians".* After the parents of the children she looked after died, Agnes took them in. The parents were not married and the mother died a year before the father.

> *"So they had no place to stay or anyone to take care of them. I then decided to take care of them and live with them. They didn't have any other alternative and they were still too young."* – Agnes (58, caregiver of two children)

Mercy was a foster parent who wanted to take care of children as a *"mother figure*" after the loss of her son. She felt the need to adopt children and to look after them even while her biological son was alive. She explained that there *"is often no reason for you to even do something as basic as cooking for there is no-one to cook for. That is not how I was raised. I then came with this solution – to be a foster parent".* After her biological son died, Mercy told her family that she was going to adopt

children. There were children within the extended family who needed looking after, but to avoid family conflict, she adopted children through the Jo'burg Child Welfare's Foster Care and Re-integration Department in Fox Street, Johannesburg.

> *"There are children in my family that I could have taken in but opted to avoid the almost definite feud it would create one day, so I decided to go get my own "children" who would be my "struggle" and my struggle only."* – Mercy (54, caregiver of two children)

To meet the criteria of the Foster Care and Re-integration Department, Mercy resigned from her job at Checkers, as it "*demanded I be at work on Saturdays and Sundays and I felt that would be to the children's disadvantage".*

4.3 Relationships with extended family

Three of the gogos mentioned the role of the extended family in relation to looking after grandchildren. In most cases, the gogo herself could be defined as part of the extended family.

Thoko's granddaughter experienced a combination of positive and negative interactions with her aunt and male cousin. Although her aunt would sometimes buy things for Thoko's granddaughter when she was shopping for her son, the granddaughter did not get on well with her male cousin. He would shout at her, which "*is the reason why you never find me [the granddaughter] at home".*

Thuli spoke about a family member whom she describes as the *"uncle*" of her grandsons. She had a good relationship with him and she is able to rely on him to talk to her grandsons if necessary. He was married, church going and had his own home. He was seen as role model for the family.

> *"He is the one who I often call when I need to call them to order ... He would be able to speak. I use him as an example almost all the time. He's like the standard. He's a churchgoer and the perfect example …"* – Thuli (60, caregiver of 3 children)

Agnes's grandchildren had a very poor relationship with their extended family on their late father's side. The family had no social interaction with the children and gave no support in the form of food, clothes, school fees or money. In fact, the family had hindered Agnes from accessing childcare grants for the children by refusing to give her the father's Death Certificate.

4.4 Stress on gogos

An important contextual issue to emerge was that the gogos experience stressed from a number of sources. These included finances, health, the physical toll of childcare and housekeeping, emotional and psychological stress, the hopelessness of trying to access grants and government services and the difficulties of looking after a different and often troubled generation.

4.4.1 Financial stress

"It's not enough, I am not coping." – Sindi (59, caregiver of four children)

Financial stress was a huge stressor on the gogos. Most were dependent on grants: the Grant for Older Persons of R1250 is available to South African citizens over sixty; Foster Care Grants of R800 per child cover children under 18 and Welfare Grants of R260 per child are payable as child grants. None of the gogos were employed full-time or in relationships with employed partners or had breadwinners in the family. Only three of the ten gogos, Thoko, Florence and Faith, received Grants for Older Persons. A further three received a Child Support Grant. Thuli, Mercy and Faith received Foster Child Grants. Two children of the children that Thuli looked after are no longer eligible for the grants, as they are over eighteen. Bontle and Lerato received grants that they did not identify. Thuli commented on the importance of grants as a source of income for the grandmothers because *"in our household there is no one who is employed."* The expenses that the gogos spoke about mainly were food, electricity, transport and clothes.

Apart from the grants, some of the gogos supplemented their income from certain informal sector work: Thuli made and sold scones; Sindi rented out rooms and Agnes got a monthly stipend from helping in community projects. One gogo, Lerato, mentioned that she received help from Ratang Bana in the form of food parcels. Mercy was using her skills at craft and sewing and her enjoyment of sewing to generate an income to be *"surviving since I resigned*" from Checkers to look after her foster children.

4.4.2 Administrative stressors

Accessing government grants and government support was a significant source of stress for gogos. Difficulties included errors in documents, delayed services, transport costs, unavailability of documentation and missing records.

Thuli explained her problems regarding accessing a Grant for Older Persons because of a clerical error. The Department of Home Affairs had confused her and her sister's dates of birth. She is actually already 60 but in her identity book it gives the wrong year of her birth which *"suggests I'm*

only turning fifty-nine this year, meaning I will only be eligible the following year". This means that Thuli will "*still have to endure this and the following year until I receive the senior citizen's grant".*

Bontle spoke about how the Foster Care Grant she was receiving was stopped as the child is over eighteen but she was still at school. She could get the grant re-instated but must provide documentation from the school proving that her granddaughter was a registered student. This was causing her stress.

Missing or incomplete documentation was mentioned as another hurdle to accessing government welfare grants. Sindi had been able to get the Child Welfare Grant for her grandchildren but required unabridged birth certificates for Foster Care Grants. There were to be a number of complications in getting unabridged birth certificates.

> *"It is difficult. It is not easy…They [Home Affairs]) say the reason why they make it difficult is because us people are crooks. Let's say, my or your sister passes on. You would then take the certificate of your child…hey, you have the same surname…and claim that the mother of your child has passed on (so you can receive whatever grant there is for such circumstances). That is why they want all the information, so they can conclusively tell that the children are of the deceased mother."* – Sindi (59, caregiver of four children)

According to Sindi, a particular requirement of the unabridged birth certificate is that it needed to contain the identities of both the mother and father. This does not in fact appear to be the case legally according to the South African Social Securities Association (59) (SASSA) but Sindi explained that this was proving to be a problem for her case. When her daughter registered the birth of her baby at Home affairs, she *"didn't state who the father was as there wasn't anyone in the picture to begin with".*

The actual logistical issue of getting to the Department of Home Affairs was an added physical and financial stress on the gogos. Sindi had been there and back twice already this year and had not been able to return yet to try again. It is *"costly…as I went there in November …I still haven't returned"*. Florence spoke about how she *"struggled"* to get a grant for her granddaughter. She described it as a *"tough journey"* requiring her to *"wake up really early in the morning to go apply… In the wee hours of the morning, to ensure I get service."* Even with this effort, she was never able to get a grant for her grandson. This was a *"long and tiresome process",* complicated further for Florence due to the fact that the grandchild's mother was receiving a grant for the child when she died. This was stopped after the mother's death and Florence had to reapply.

In addition to these problems related to child grants, Florence experienced a delay in receiving her pension. Even though she stopped working in 2007 and was entitled to a pension, she only started receiving her pension in 2008 or 2009. This made things more difficult financially, as her granddaughter would ask for money, whereas Florence was trying to save.

> *"This girl would also annoy me, demanding money every now and again. Not realising that I wanted to put away a portion so she can get to University… put aside between R100 and 150 at the bank."* – Florence (74, caregiver of two children)

Agnes, too, discussed the problem of missing documentation. In order to apply for a foster care grant, Agnes believed that applicants need to provide the birth and death certificates of both parents. Although according to SASSA it is not the case that the birth certificates of both the parents are required, both death certificates are (59). She had been not been able to get the death certificate from the father's family as the family *"is rude and unkind towards us".* She was *"afraid*" to ask for the certificate. In addition, Agnes received no support from the grandchildren's father's family. Even though her daughter lived with her in-laws and took care of them, and they seemed to have some assets, a house, they did not help with her burial and did not communicate with or see the grandchildren. They did not enquire regarding their needs for food and clothes or offered any assistance or support. Even with such uninvolved and absent family from the father's side, the father's Death Certificate was still required.

> *"The fact remains, when you apply for a Foster Care Grant they require you to have all the above mentioned documentation…Those are the exact things they ask when you apply…When you claim to not know the father, they'll tell you there is no way you don't know the fact. … You know him."* – Agnes (58, caregiver of three children)

4.4.3 Health and ageing

> *"These kids are ageing us."* – Bontle (52, caregiver of 2 children)

A number of gogos discussed their age, their feelings about ageing and the impact that looking after grandchildren was having on their age and health. Bontle brought up the issue that although she described herself as *'young'* (aged 52), she commented that the children were making her feel old. Looking after grandchildren was making her tired. Even though she was a grandmother, she was not able to access a pension grant, as she was not yet 60. Thuli also mentioned this frustration experienced in waiting to receive a pension. There seemed to be a feeling of having to hold out, of wanting and needing to age, to get to 60 in order to get the pension.

"We are now approaching the senior citizen pension, yet we are still so young … we'll get there. They say persevere." – Bontle (52, caregiver of two children)

4.4.4 Housekeeping

"You don't even know the half of it... "I work as though I have been hired. You wouldn't say it's my house." – Sindi (59, caregiver of four children)

Thoko and Sindi talked in detail about their experiences of housekeeping and the stresses of trying to keep their grandchildren and their houses clean. Thoko was extremely conscious of the importance of cleanliness of bed linen. She was distressed by marks left by her granddaughter while she sleeps. This resulted in Thoko having to share her bed with her other grandchild who refuses to share a bed with her sister.

"I was very upset this morning. I wake up and I changed the sheet cover and the pillow-cases. …When she sleeps she sometimes drools …leaves marks on the sheet-cover… The other [grandchild] will not agree to sleep …together in this room so I can sleep alone. The one I live with wants to sleep with her grandmother all the time." – Thoko (63, caregiver of one child)

As a result, Thoko found herself having to do extra washing. This washing was done by hand and in a big bowl. Because of her health and age, Thoko had to wash sitting down "*because I cannot stand for long*". This hand washing created additional work for her. In addition, she had to hang the washing before she was "*able to wash myself and make breakfast... I then head here [Ratang Bana]*".

Sindi described what she perceived as her seemingly endless role of parenting. On weekdays, this included waking herself and the four children at 5am, ensuring they were all bathed and preparing and packing school lunches. This she regarded as what is expected of her. She feels as though she "*works as though I have been hired… You wouldn't say it's my house."* She felt that her duties were endless and left her no time.

"That's my responsibility...You don't even know the half of it. I cannot afford to even disappear to take a nap. Five minutes, I'm being called "gogo-gogo-gogo". All the time ***(hehehehe!)*** *Iyoh!"* – Sindi (59, caregiver of four children).

4.4.5 Psycho-social stress

The gogos experienced emotional stress from a number of sources. These included the loss of their own children, parenting and child raising concerns, loneliness, lack of privacy and a number of social issues.

Thoko identified herself as part of a group of gogos whose children had died from AIDS: "We are gogos who have been left by our children, who have passed on due to this disease." Thuli had "four children … of whom three passed away and only one is still alive".

Sindi mentioned the challenges she experienced since the death of her husband and the child's aunt in looking after her three grandchildren and another child because of the responsibility of them being *"all dependent on me"*. Bongi had received assistance and support from her own mother in raising her first-born's son until he was two. Then her mother died and Bongi explained how it is very lonely raising the children on her own.

The gogos also discussed a number of parenting issues such as the stress of teenage pregnancy and fear of abortion, the difficulties of raising children, the challenges of looking after disabled and sick children, and their hopes and aspirations for their grandchildren.

When she noticed her granddaughter's pregnancy, Bontle did not want her to have an abortion. She committed herself without hesitation to raising the great-grandchild, although her granddaughter did not want the baby. Bontle said to her: "*If this pregnancy exists, please do not abort … You said to me you do not want this child. I will raise him."*

Mercy, Agnes and Florence were dealing with grandchildren who have emotional issues. Mercy described her adopted grandson as being troublesome and having issues with anger. Agnes was concerned about the hurt and damage that her grandchildren have experienced from witnessing their mother being ill over a long stretch of time. Florence's granddaughter (15) had amenorrhea which the doctor ascribed to stress. Florence battled to communicate with her granddaughter, who often ignored her. Florence gave her granddaughter pocket money and could not understand what could be causing this stress as she tried her best to get her all she needed and wanted.

In addition to caring for three biological grandchildren, Thuli spoke about the challenges of looking after a disabled eight-year-old and her two-and-a-half year old twin brothers. The mother of these three children was alive, but was unable to care for the children. Looking after this disabled child was a huge strain on Thuli.

> *"She does not walk; she does not speak; she is just a human. She is even mentally unfit … There was a time when two weeks passed and she was not well. We didn't know what was wrong with her. She would not eat anything. She wouldn't speak either. We would force her to eat; even so you could see she was in pain."* – Thuli (60, caregiver of three children)

A number of gogos expressed hopes that their grandchildren would complete school and possibly have tertiary education. Bontle had not expected her granddaughter to fall pregnant, thinking she *"would finish school, like she had dreamed about".* Thuli negotiated with her grandson's private school that he would remain there rather than going to a township school, although there was no money for fees. This grandson was accepted into university in 2014, but was not able to register because of a lack of finances. All these things had become *"stressful"* for her.

Privacy and respect, or rather the lack thereof, was another issue raised by a number of gogos. Thoko and Sindi felt they were continually being overwhelmed by the requirements of their grandchildren and their presence, with Thoko wanting to sleep alone and Sindi wanting to *"disappear".* Bontle commented on the endless comings and goings of her granddaughter's friends. She made the observation that it was her house and the children should be using their phones to arrange to meet elsewhere and not in her house. She found their behaviour disrespectful as "*It is an elder's home and ought to be treated with respect.*" Respect was a recurring theme throughout the interviews.

The gogos also have had to deal with interfamilial and interpersonal issues. Agnes discussed the disagreements between her daughter's family and the family of the father of her daughter's children. Even though she knows the family, as they were from the same *"homeland*", her family did not get along with the father's family. This had resulted in her not being able to get additional government grant money for foster care because she was unable to produce the father's death certificate. This was because she "*became afraid to request for the father's Death Certificate. …I am unable to manage solely on this grant money*."

4.5 Context for communication about sex, sexuality and HIV and AIDS between gogos and the children in their care at baseline

4.5.1 Gogos' perceptions of their grandchildren's behaviour

The gogos' narratives indicated that they felt concerned about their grandchildren's wellbeing and were actively involved in their lives. They were aware of 'teenage' issues affecting their grandchildren such as the importance of airtime, fashion and money. The gogos spoke easily about their relationships with the children in their care.

Most of the gogos described good relationships with their grandchildren. In the instances where the gogos were unhappy with a particular behaviour or attitude of a grandchild, the gogos mostly felt that they were able to address their grandchildren's misbehaviour through talking to them. There

was a pattern of 'talking' to or telling their grandchildren what to do rather than listening to them. They valued their grandchildren doing their homework and studying, doing housework, being respectful, attending school, participating in sports and having positive friendships.

Thoko described the relationship with her granddaughter (aged 11) as a good and close relationship, describing her as *"adorable" and "respectful."* They had an open relationship and Thoko's granddaughter discussed her behaviour choices and *"problems"* with her. Thuli described all three of the adolescent boys (aged 17, 19 and 21) in her care as respectful. Even the one who *"frightens"* her and was difficult to parent, as he was always on the streets, was *"still well-mannered"* and went to school.

According to Bontle, her 19-year-old granddaughter's behaviour had improved recently. Previously, she used to go out *"gallivanting"* a lot at night and came home late. After Bontle discussed this behaviour with her and appealed to her to stop doing it, *"all she does now is study*". Sindi described how she encouraged her son to spend time at home. She tried to "*explain and teach*", through her conversations with him and she has deduced that being away from home was what leads to bad behaviour in children.

> *"I've established that the reason behind a child getting involved in many [bad] things is him spending time away from home."* – Sindi (59, caregiver of four children)

Lerato enjoyed a good relationship with her grandson (aged 16). She was *"glad"* as when she speaks to him, he *"listens"* and was co-operative. Since Mercy adopted two children, she did not know who their parents were and what personality traits they might have inherited from their parents or, in fact, if they even have the same parents. She wonders, in particular, if they had the same father, as the boy displayed anger and frustration, whereas the girl's behaviour was good and she listened. Mercy was pragmatic about parenting and the complications it brought.

> *"We can't expect them to be angels but they are good children."* – Mercy (54, caregiver of two children)

However, in addition to these descriptions of close relationships, a number of gogos described some experiences of negative behaviour in the home. This included frustration about household chores not being done and itinerant behaviour and disrespectful *"comings and goings".* Even when a relationship was largely described positively, participants expressed some frustration, particularly related to the completion of chores or staying out beyond curfew. Even though Thoko had described her granddaughter as '*adorable' and 'respectful'*, she expressed frustration at her granddaughter's

(aged 11) lack of cleaning up and doing chores that were expected, as well as caring for her personal belongings. She would hide things and lie about washing her lunch box and did not take care of her shoes and socks.

Thuli's grandson's (aged 19) behaviour was described as *"troublesome*" but she seemed resigned to it. Sometimes he did not perform his household chores as expected and chose rather to go out: *"He's naughty and likes being on the streets"*. Bontle described her relationship with her granddaughter (19) as *"mostly good"*, other than the issue of going out and returning late over weekends. Bontle explains her understanding of her granddaughter's (aged 19) problematic behaviour as due to her going through the adolescent *"stage".*

Bongi described how her 17 year old grandson finishes school at 3 p.m. but previously used to not return home until later, which was unacceptable to her. She resolved this by having a meeting where she had to "lay down our home's rules". Mercy said that the 11 year old boy that she was fostering *"fights"* and was "*aggressive".* She found this behaviour difficult to understand and it "*really hurts*" her. She had been advised that this could possibly be from previous experiences of abuse and bullying whilst in a children's home. She took him to the local clinic and he was receiving treatment for this.

4.5.2 Importance of education and attending school

School and the value of learning and a good education were important themes for the gogos that emerged during the interviews. The gogos all discussed school issues and were aware of and involved in the school performances of their grandchildren. The gogos were pro-active and were prepared to take action to remedy problems around schooling as and when they arose. The child Sindi looked after (aged 15) was described as a "*dimwit"* by his teachers before she brought him to Alexandra to take care of him, and his marks improved subsequently. Sindi felt that his poor marks were due to the stress of losing his aunt (he had gone to live with her after his mother died) and they had improved due to the care and support he was now getting in Alexandra.

> *"When he got here, he did so well at school that you would have found it difficult to believe that it's the same boy who was said he ought to leave school."* – Sindi (59, caregiver of four children)

Thoko enlisted the help of a Matric student from her church to help her granddaughter (aged 11) with homework. Although the granddaughter presented as able and knowledgeable in the class, she battled to complete her work on time in the classroom and to do homework. Thoko was very

pleased with the awards her daughter received for English, an award for Cleanliness and an award for Traditional Dance.

Florence encouraged her granddaughter (aged 15) to study and stay at home instead of socialising. It took determination and it was a struggle for her especially at a time when her granddaughter did not want to work after school and rather wanted to go off with friends. Florence was very proud of the bursary that was awarded to her granddaughter, despite criticism from community members.

> *"She studied diligently and did well … I would get spoken [told] off that I was keeping my grandchild locked up but I would let them talk. Look now she's gotten a bursary. I would tell her to not listen to what people have to say. "You should just focus on the gift you have been given and ignore all the critics. You work hard and study".* – Florence (74, caregiver of two children)

The other gogos also supported their grandchildren's school achievements, the role of schooling and school. Bontle's granddaughter (aged 19) continued to study at school while coping with the challenges of being a young, school-going, single mother while Bontle helps by looking after her baby. In addition, even though her granddaughter was too ill to write her final matric exams, she has continued her studying at a local Technical College. Bongi described her grandson (aged 17) as doing well at school. She had no complaints about his schoolwork and neither did the school. Mercy spoke about how her adopted granddaughter (aged 14) participates actively in sport and drama at school. She was doing well at school and *"really likes it"*. The school that Agnes' grandchildren went to had been very supportive of the younger grandchildren she looks after, but did not help with the older one. The school gave the younger children food, uniforms and school shoes.

There were a number of other grandchildren who were experiencing problems of varying levels at school. Thuli's grandson (aged 19) has had to repeat a number of years. He was in Grade 9 but should be in Grade 12. According to Thuli, he had repeated every grade at school due to his "*mischievous behaviour*". She referred to him always "*being on the streets*". This worried her and although he attended school, it was not clear from the interview if his behaviour was problematic at school, as well as out of school.

Lerato's grandson (aged 16) had passed every year except for last year. He was sixteen turning seventeen and it appeared from the interview with Lerato that he had become difficult recently. She explained that he "*doesn't always want to study or listen*" and she thought that this could be linked to age and the fact that he was a boy. She described him as "*a bit of a nuisance*" but felt that the problems are appropriate for his age and sex.

Florence' granddaughter (aged 15) had irregular menstrual periods which the doctor diagnosed as being caused by stress. Florence did not know what the source of the stress was but suspected it might be due to school or financial pressures. She had spoken to the school social worker who suggested that the cause could be that "*the food at school is not that good*". It was not clear if this was a problem related to nutrition or the granddaughter's preference for certain types of food.

4.5.3 Gogo's perceptions of grandchildren's friends

"When they [friends] say: "Let's go!" she tags along." – Bontle (52, caregiver of 2 children)

The role of friends in adolescents' lives was referred to by most of the participants in the study. Gogos saw this role in both positive and negative lights. Male and female friends could have either good or bad influences on the grandchildren. However, the influence of male friends was mostly perceived in a positive light when male friends were sports partners, with soccer being the dominant sport. Girls' friends were seen as more problematic as they tended to encourage more risky and less open behaviour encouraging the granddaughters to go out late at night after dressing up and behaving in questionable ways. The gogos tended to view relationships between female friends to be more about behaviour, including sexual or questionable behaviour as opposed to healthy activities between boys and their friends like sport.

Florence, Bontle and Lerato commented on the influence, role and impact of friends in their grandchildren's lives. Florence regarded her granddaughter's friends as *"bad company*" who caused her to nearly fall "*off track*", as her granddaughter (aged 15) would go out with them every afternoon after school. Now Florence waited for her to return from school, made sure she ate something and then ensured she does school work. Bontle said that her granddaughter (aged 19) *"doesn't have good friends"* and that they "*all do funny things*". She also expressed concern about what she perceived as her granddaughter being susceptible to peer pressure and "*tagging*" along with her friends.

Lerato appeared to have conflicting views concerning the friends of her grandchildren, depending on the role that they play in that particular grandchild's life. Her comments regarding her grandchildren's friends tended to have a gendered focus, with female friends were regarded as a problem, whereas male friends were not. When speaking about the male friends of her grandson (aged 13), Lerato spoke positively. She explained how she perceived her grandson's friends as a good influence and that she trusted them and they played soccer together. He used his spare time with his friends to play soccer and not to *"misbehave"*. He "*loves*" his soccer and "*when he is with his friends,[she] "know[s] that they are somewhere practising or something of that sort.*"

However, Lerato saw the friends of her granddaughter, (aged 16) in a negative light. Female friends were seen as dangerous and a threat to the health and future of her granddaughter.

> *"The friends you keep are not good for you. They are focused on boys and you will end up either pregnant or with some sort of disease." – Lerato (59, caregiver of two children)*

Lerato voiced strong feelings about the friends of her grandchildren and the responsibility gogos carry to ensure that their grandchildren have friends who have a positive influence on the behaviour of their grandchildren. If these friends have negative influences on their grandchildren, gogos would find it difficult to control or end these friendships.

> *"Another issue is the friends they choose to keep. You must find out what the kind of friends your child keeps … So you know whether it is necessary to separate your child from his/her friends …Finding out what type of friends they are is important. If they are in too deep in the friendship, it is near impossible getting them out of that friendship."* – Lerato (59, caregiver of two children)

4.5.4 Safety and wellbeing of grandchildren

> "*You know how we are as mothers."* – Sindi (59, caregiver of 4 children)

The physical safety and wellbeing of the grandchildren was an important theme brought up by eight of the ten women interviewed. Safety was viewed as physical safety from harm and also safety from the risk of pregnancy. Wellbeing included both physical and emotional dimensions. This concern for the safety of the grandchildren appears to be premised out of genuine love, and a concern and a desire to protect the grandchildren from harm and hurt. As Mercy described in her interview, she had a *"fondness for children"* and even resigned from her job when she *"felt that would be to the children's disadvantage"*. The gogos regarded their role as caregivers in a serious light. A number of the grandparents regarded the children that they cared for as their own children. A significant effort was made by the gogos to ensure that the children in their care were safe and well cared for.

Florence, Bontle and Bongi recounted how they had been battling with grandchildren not coming home at an hour acceptable to them which raised concerns about safety. Bontle's granddaughter (19) would go out at night with friends that Bontle did not approve of, expecting Bontle to look after her daughter and waking up to let her in when she arrived home. However, after discussing this with her granddaughter and explaining that she was not doing this to discipline her but because she loved her, Bontle had seen an improvement in her granddaughter's behaviour.

> *"She would then apologise. I would tell her that she cannot keep on apologising. I love her. I'm not just reprimanding you, I would like for you to take heed of my instructions/pleas. She's better now."* – Bontle (52, caregiver of two children)

Bongi's grandson (aged 17) was not returning home from school in the afternoons. Bongi explained that since he lived in her house and under her roof, he had to abide by her rules. As Bongi is a born-again Christian and attends church, she told her grandson "*he ought to come as well. Fortunately, he attends church now*".

Not only did Florence speak about how she did not always know where her granddaughter (aged 15) was, she spoke about her concern when her granddaughter returned home late. She thought this placed her granddaughter at risk.

> *She sometimes returns at unacceptable times … 8 … 9 p.m. and I will ask her where she's from … It doesn't sit well with me, as I don't know what she's doing or getting*. – Florence (74, caregiver of two children)

Like Florence, Thoko spoke about the need to know where her 11-year-old granddaughter was in order to keep her safe. Thoko used extra cash income received to pay for transport **"***so she can be safe*", because she perceived the area in Alexandra in which they lived to be unsafe for her granddaughter to walk to and from school. In addition, when her granddaughter played, she needed to make sure that by "*five o'clock to six, I know you're at your friend's place so when I call you back I don't struggle to find you*".

The emotional wellbeing of the grandchildren was also important to the gogos. Agnes's grandchildren experienced living with their parents while they were ill with AIDS. Agnes was sensitive to the trauma the two young children experienced in watching both their parents die and the "*suffering*" caused by this "*deadly disease*". As a result, she felt she could not discuss issues of HIV and AIDS and sex with them, saying, "*I cannot go there with them …*".

Concern over the wellbeing of children who were not biological grandchildren was also reflected strongly throughout the interviews. When she learnt that her brother's child had lost his aunt with whom he was living after his mother died, Sindi, as a "*mother*", intervened and took responsibility for him even though this was during what she referred to as a "*challenging*" time as her husband died at this time.

Sindi and Lerato mentioned their parental responsibilities in terms of looking after their grandchildren. Looking after such young children (aged 2, 5, 8, and 15), Sindi needed to ensure that they were ready for school every day. Even though two of the children had a mother, she was unemployed and Sindi found herself making sure that all is prepared for school in the mornings.

> *"If you were to find me during a weekday, I normally have to wake up at five o'clock. Some still need to be bathed. I have to still to prepare and pack their lunch-packs … That's my responsibility."* – Sindi (59, caregiver of four children)

Like Sindi, Lerato was looking after her orphaned nieces and a child who had a mother but she was ill and in hospital a lot of the time. These three children (aged 18, 14 and 12) were completely dependent on Lerato. She took them to school, fed them, clothed them and took care of them. She regarded them as "*my own children*". This she did with the aid of a grant and support from Ratang Bana.

4.6 Barriers to talking about sex, sexuality, HIV and AIDS at baseline

Most of the participants expressed negative feelings about talking about sex, sexuality and HIV and AIDS. As Sindi explained that this topic was very difficult to speak about. She articulated the feelings of most of the gogos when she explained that speaking to her grandchild about sexuality and HIV and AIDS was not something one would do just once which made it even harder. There would need to be repeated and new conversations: "*I know it will not just end here, with these ones…There are more growing up.*"

Structural and contextual barriers played a significant role in how effective gogos were in their communication with their grandchildren about sex, sexuality, HIV and AIDS. These included past experiences, which were informed and defined by perceived culture, gender, age and the generation gap and the perceived role of school and teachers in sex education.

4.6.1 Feelings about talking about sex, sexuality and HIV and AIDS

> *"Hey lady, that's going to be difficult. That is going to be really difficult."* – Sindi (59, caregiver of four children)

All the gogos commented on the difficulty of speaking to their grandchildren about sex, sexuality and HIV and AIDS. Sindi recounted that she had spoken to her own children about sex in the past. She voiced her frustration at the fact that her children had had unplanned pregnancies in spite of the

fact that she had spoken to them. She now regarded these past SRH unsuccessful as it *"failed us, because now we have these children [grandchildren] in the yard"*. The gogos seemed to find it easier to talk about *"taking care of oneself"* in the sense of not picking up diseases in general terms and staying away from boys. However, they seemed to realise that this is no longer enough. As Bongi explained, *"How things are today is nothing like they used to be in my time."*

Lerato talked about trying to discuss issues that were not spoken about to her when she was growing up and how difficult this makes talking about HIV and AIDS, and sex and sexuality.

> *"Now you must discuss issues [that] weren't discussed with you and therefore aren't open about is a bit difficult … When the time to discuss it all of these topics … you feel overwhelmed and somewhat defeated."* – Lerato (59, caregiver of two children)

Agnes and Sindi described the grief their grandchildren experienced due to the loss of their parents. Sindi's grandnephew's distress at the loss of his mother followed by his aunt's death was reflected in his poor school performance. Agnes recounted how she felt anxious to discuss HIV and AIDS with her grandchildren, fearing it would upset them due to the experience of them having witnessed their parents dying.

> *Perhaps if I talk about it, I will touch wounds that haven't fully healed as yet."* – Agnes (58, caregiver of three children)

A number of participants mentioned feelings of fear, shame and experiences of corporal punishment at the hands of their parents linked to their own sexual experiences growing up. Florence described the way her parents used fear and threats to steer her understanding of sex when she was growing up. She was also told falsehoods about where babies came from: *"in suitcases delivered by nurses"*. Although she acknowledged that today's generation is far better informed, knowing that babies come from the "*stomach*", sex was still a very difficult topic for them to discuss.

> *"We are still ashamed to discuss certain issues. Sex this and that. It is difficult finding ways to tackling these issues as we never had such conversations nor was it ever taught to us at school."* – Sindi (59, caregiver of four children)

Florence expressed strong opinions about the importance of talking about sex to her granddaughter (aged 15). She had included her sister, an aunt, in this role. Together they had been speaking to her about not getting involved with boys and "*taking care*" which appeared to be a euphemism for not having sex at all. Florence acknowledged that neither she nor her granddaughter has actually spoken

about love, boyfriends and sex due to fear: "*I would be lying if I said I have. I am afraid though [of her grandchild becoming pregnant]*." However, Florence's sister had taken her to a family planning clinic where she received a birth control injection. The gogo perceived that the contraceptive would keep her "safe" i.e. not pregnant. Yet, there had been no discussion about sex, nor was the granddaughter seen as "*responsible enough"* to take the pill as she was "*still young*".

Regarding discussing topics like sex and HIV and AIDS with her grandson (aged 16), Lerato explained that she felt she would not be able to do so.

> *"Hey … that's another issue in itself. I haven't been able to sit him down and discuss it. I don't think I would be able to discuss it with them."* – Lerato (59, caregiver of 2 children)

She would have liked the children to learn about HIV and AIDS and sex at school and felt that if the children are taught about this at school in large groups, then they would feel less uncomfortable. She recounted how she found it difficult to speak to her grandchildren on this topic and usually relied on the "older sisters" to do this. In addition, Lerato felt that when she tried to bring up the subject, her grandson got "*uncomfortable*" and tried to close down the conversation as soon as possible, saying he knew everything already from school.

Sindi and Agnes expressed their concerns about speaking to their grandchildren about sex as they were brought up with the belief that this would encourage sexual activity.

> *"You see in our times, our parents felt if you taught a child about sex you were promoting the idea."* – Sindi (59, caregiver of four children)

4.6.2 Limited skills and SRH knowledge of the gogos

> "*The problem is that, I would not know what to say."* – Bongi (60, caregiver of two children)

A number of gogos spoke about their lack of experience, knowledge and skills on this topic. There were a number of reasons for this. These included cultural reasons, discomfort talking to their boys and lack of information from either their own parents or schools and teachers. There was a feeling that the gogos did not know enough and were not prepared to be able to talk about sex, sexuality and HIV and AIDS. Although Sindi acknowledged that today's generation was far better informed regarding sexual knowledge, sex was still a very difficult topic for her to discuss.

> *"It is difficult finding ways to tackling these issues as we never had such conversations, nor was it ever taught to us at school. It was never spoken of. If one were to initiate a discussion about sex, I don't know where to even begin*." – Sindi (59, caregiver of four children)

Even though Bontle's granddaughter (aged 19) has had a baby and therefore been sexually active, the issue of the pregnancy did not provide an opportunity for Bontle to discuss sex, contraception and HIV and AIDS further with her granddaughter, although she repeatedly mentioned other STIs. Before she fell pregnant, Bontle had not considered discussing pregnancy:

> *"I didn't expect her to fall pregnant … I thought she would finish school, like she had dreamt about doing … You see all of that, I hadn't thought of [pregnancy] but the diseases I've told her over and over again."* – Bontle (52, caregiver of 2 children)

Sindi explained how she had tried to speak to her daughters about sex rather than hitting them as her parents had hit her. Although she knew "*we were not supposed to hit them*", she had also hit her children in addition to trying to speak to them about SRH issues. Sindi's daughters had fallen pregnant while they were still young (aged 20 and 22) and unmarried. Sindi regarded this as evidence of how she had "*failed*" to communicate with her daughters about sex.

Another issue that was raised was that of how to talk to boys. Although the influence of gender on communication processes was generally regarded as a contextual and structural issue, these gogos did not have the skills or knowledge as women, to speak to their grandsons about issues particularly pertaining to males. Sindi described how boys would "*puzzle*" her as she had no experience with them. In addition, conversations with male children tended to be held between men and boys. She explained that "*honestly I don't know what I would say*" to a boy and this conversation would be far more difficult for her to have with her grandson (15), due to the fact that he is a boy.

4.6.3 Cultural barriers

> *"In our culture, we are not used to that."* – Sindi (59, caregiver of four children)

A number of gogos brought up the cultural issues as a barrier to talking about sex, sexuality and HIV and AIDS with their grandchildren. Talking to grandchildren about sex was not something that gogos traditionally did. As a result they felt uncomfortable and lacked confidence. Sindi explained how in her culture, they were "*not used to talking about something...we are not used to that*." Lerato described the difficulty of trying to break down cultural barriers when these issues have never previously been discussed.

> *"Now you must discuss issues that weren't discussed with you and therefore you aren't open about, is a bit difficult."* – Lerato (59, caregiver of two children)

When Sindi wanted to speak to her own children, she explained that she found it difficult. In her experience, people would rely on the help and intervention of older women from the church to speak to young girls in the community when they became adolescents.

> *"It was not easy when it came to my children, because I wanted to talk to them. Like when they grew up and got into the adolescence stage of a young woman. In my church, we would call upon the Mamas [older women] to sit the girl down and explain to them."* – Sindi (59, caregiver of four children)

Communication about sex was not something Sindi had experienced during her own adolescence, due to the perception that parents should not discuss sex with their children, because talking about sex would encourage or enable sexual activity. Sindi believed that she could move beyond her culture and the constraints of this regarding SRH communication. She felt strongly that in order to save the lives of people, learning and knowledge needed to be embraced. She stated that cultural beliefs restricting the sharing of open and factual information about sex, sexuality and HIV and AIDS needed to be rejected and that gogos need to move beyond cultural norms and address these issues with their adolescent or pre-adolescent grandchildren.

> *"There isn't a…there isn't a culture that I'm committed to, to the point where I would say, I don't do this, I don't do that, because of my culture. Knowledge I do seek because culture doesn't work anymore … It doesn't work, death comes."* – Sindi (59, caregiver of four children).

4.6.4 Gender Barriers

A number of gogos raised the issue of gender norms when speaking to grandchildren about sex and sexuality. There seemed to be an understanding that women would speak to girls and men would speak to boys about this topic. Not only did Sindi raise issues that women face speaking to grandsons and boys, she went on to say that "*black people are extremely secretive*" about discussing their parenting experiences. Consequently, she spoke about how she finds it difficult to access help and advice from other caregivers on how to deal with male issues and boys. These conversations with boys tend to be held with men with Sindi explaining how, "*We are used to boy children being spoken to by a man*."

4.6.5 Generation barrier

Respect for the older generation was a theme that emerged during the interview. Agnes explained her anxiety about talking about sex, sexuality and HIV and AIDS with her grandchildren in terms of respect. She felt that the grandchildren were still young and that she would lose respect in the eyes

of her grandchildren if she spoke to them on this topic. In addition, she feared they would regard it as approval to participate in sexual activity.

> *"If I speak to them about such issues, they will end up taking you for granted. Isn't it, Gogo can speak to me about this so…they'll over step their boundary"* – Agnes (58, caregiver of three children)

Sindi mentioned that the issue of age and generation regarding the generation gap as a possible reason for distance and limited communication about sex, sexuality, HIV and AIDS between her and her grandchildren. She explained that her grandchild (aged 9) was not as close to her in her role as his "gogo" as he would have been to his mother.

> *"That is going to be really difficult, especially when they are not your child [biological child]. There is no way of going beyond the fact that I'm not his mother*." – Sindi (59, caregiver of four children)

4.6.6 The role of school in sex education

A number of gogos referred to the sex education or sex information that children received at school. They generally viewed it as comprehensive. Most children did not seem to want to engage with the gogos when they tried to speak to their grandchildren about sex and HIV and AIDS issues at home saying they already knew this "stuff" from school.

> *"She told me, she knows. She told me that they learn about it at school. "I know all about these things, they teach them at school" she'd say."* – Bontle (52, caregiver of two children)

Lerato felt strongly that it would be more beneficial for the children to learn about sex at school, as they would be more likely to ask questions in a group than individually. She perceived that it is easier to assess knowledge and content from questions asked by the child at school than if the child just keeps quiet.

> *"When I'd ask him questions he won't respond, he'll keep quiet. He doesn't feel free. So I reckon, when they are taught in school by a teacher in their masses, they are able to ask questions freely … it's always a good sign when you teach a child something and they ask where they don't fully understand… when you [the gogo] speak them all they say is Yes! Yes! Yes! They just agree [for the sake of agreeing]. You can tell that they become rather uncomfortable, so it's better I keep quiet. It's as good as not doing a thing. [It gets frustrating when] you just talk to them and they don't respond*." – Lerato (59, caregiver of two children)

Interestingly, Thoko commented how the children were taught at school not to engage with sex and sexuality as "*they are taught at school to turn off the television if such a scene appears".*

While some of the gogos felt that schools should be responsible for teaching about sex, sexuality, HIV and AIDS, according to the gogos, the grandchildren themselves relied on school as a source of this information. This also meant that the grandchildren could use the content taught at school as an excuse to avoid conversations with their gogos. Bontle's granddaughter (aged19) told her: *"I know all about these things, they teach them at school*." However, the granddaughter fell pregnant at 17 despite the information gained from school.

4.7 Talking about menstruation

The gogos mentioned that issues around menstruation are difficult to talk about. Mercy said that when she was growing up, no one taught her about menstruation. The issue had been viewed as a taboo:

> *"Teachers, then, had to play both the mother and teacher role where they would teach us tricks on how to signal that we were on our cycles by placing a bandage around our leg somewhere and all of that."* – Mercy (54, caregiver of two children)

Mercy had given her granddaughter (aged 14) a pack of sanitary towels and explained the signs of menstruation. Mercy saw this as different to her own experiences of puberty where menstruation would never have been spoken about between parents and children. However, she had not explained the details of puberty and menstruation to her granddaughter. Mercy still regarded this as a topic to be kept hidden as a result of her upbringing.

> *"They [our parents] wouldn't know how to even explain where the blood comes from, for instance. It is unlike today where these children will just say Ma, may I please have a pad [sanitary towel] and money … I have told her not to tell any of her friends if she were to go on her cycles. It is her secret."* – Mercy (54, caregiver of two children)

Menstruation, pads and the disposal of pads were regarded by Mercy as an issue that needs to be taken seriously by the community. Menstruating girls needed to show respect for themselves and others and dispose of used pads properly, because as menstruation was a private, hidden issue in the minds of Mercy and other adults involved in keeping the schools clean.

"*Well, I see there being carelessness of some sort. We've been to some school cleaning and we found [used] pads on the floor and it took us by surprise because we knew it as a secretive thing."* – *Mercy* (54, caregiver of two children).

4.8 Existing HIV and AIDS and sex and sexuality conversations at baseline

Although the gogos' conversations at baseline about sex, sexuality and HIV and AIDS were limited in content and frequency, some were taking place. These conversations often took place as part of other conversations such as those around pregnancy, contraception and puberty. Sindi expressed the need for these SRH conversations by acknowledging that the current situation regarding health and sexual practices places her grandchildren at high risk of HIV infection and there was a need to speak to adolescents with this in mind.

4.8.1 Baseline strategies used by gogos to talk about sex, sexuality and HIV and AIDS

Although an overwhelming number of participants had not spoken to their grandchildren in detail or with confidence about HIV and AIDS, sex and sexuality, there had been a number of conversations about puberty and adolescence, STIs, the causes of parents' death, sex on TV, the 'threat' of boys and contraception and pregnancy. These could be perceived as 'gateway' discussions to conversations about sex, as they tended to be around issues that dealt with sex, HIV and AIDS and sexuality, although not the topic, directly.

4.8.1.1 *Physical development and the onset of puberty*

A number of gogos acknowledged the need to speak to their grandchildren about puberty. Sindi recognised that the growth in her grandson (aged15) represented his progression from boyhood into manhood. This, in itself, justified her speaking to him about issue of sex, sexuality, HIV and AIDS as she could "*tell he's nearing that stage*," from "*how tall he is*".

Bongi said that she should be talking to her grandson (aged 17) about HIV and other STIs and how they were contracted now that her grandson was seventeen. Hoping that he was not yet sexually active, she had not done so. She referred to sexual behaviour as being "*naughty*", rather than viewing it as normal, appropriate adolescent change and development.

"*Yes it's the time, I should be telling him…I was hoping he wouldn't have started with being naughty, but I will speak to him."* – Bongi (60, caregiver of two children)

Thoko saw adolescence as a cause for concern and she expressed fear at the changes brought about in her granddaughter (aged 11) as a result of puberty. This included a fear of rape and "*things of that sort*". Thoko explained that her granddaughter was "*of that age of dating*" and she had "even started with her cycles".

4.8.1.2 *Avoidance of "Diseases"*

Gogos seemed to find it easier to talk about sex in relation to avoiding diseases. However, Bongi realised that "*how things are today is nothing like they used to be in my time*" and that this was no longer sufficient with the social and health issues they faced. Like Bongi, Sindi acknowledged the difference in the current situation as opposed to when she was growing up. It was important for her to speak to her grandchildren with the high risk of HIV infection facing adolescents and the need to speak to adolescents more with this in mind as "*in those times HIV was not as widespread as it is today*". Lerato expressed her belief that any sexual interaction with boys will result in sexually transmitted infections: "*If you sleep with them, you will pick up diseases.*"

4.8.1.3 *AIDS as cause of parents' death*

Thoko and Agnes who disclosed the cause of the death of the grandchildren's mothers was from AIDS, referred to the stigma attached to the death of their daughters because it was AIDS. Thoko did not want her granddaughter (aged 11) to hear about it from "*outsiders*". Agnes was afraid to talk to her granddaughter (aged 18) about it as *"it would be as if I am speaking negatively about her [the mother]".*

Agnes believed that the experience of her grandchildren seeing the suffering and illness of both their parents being ill would have given them an opportunity to learn about HIV and AIDS as they watched their parents die. Because of this first-hand experience, Agnes felt she did not need to speak to her grandchildren (aged 13, 14,18) directly about sex, sexuality, and HIV and AIDS

> *"As long as they were old enough to witness and were able to put two and two together and learn a lesson from that experience. They saw it with both eyes and saw how "deadly" this disease is and how it took their mother and their father."* – Agnes (58, caregiver of three children)

Thoko had introduced the topic of HIV and AIDS to her granddaughter (aged 11) in the context of the cause of her mother's death. Thoko felt that explaining to her granddaughter that her mother had died from AIDS would help her granddaughter to understand the threat of HIV and AIDS. She also expressed her belief that the dangers of high risk sexual behaviour with multiple partners could be demonstrated to her granddaughter by the sexual behaviour of her daughter. Thoko believes that

her daughter contracted "the virus" through "*explore[ing] the playing field*". Her daughter had heard about HIV and that it was caused by "*sleeping with boys without using condoms*". Thoko had not been able to discuss any further biological or physical facts about sex, sexuality or HIV and AIDS with her own daughter, telling the interviewer that she "*hadn't gotten that far*".

4.8.1.4 *Influence of TV, media and social media*

Television plays an interesting role in terms of a source of information and knowledge about sex and HIV and AIDS. Not only did the gogos mention that sex happens on TV, but biological and physical information was gleaned from TV.

> *"She also knows…they see these things on television (**hmmm….**). Even how birth takes place, they see these things on television. They see."* –Thoko (63, caregiver of one child)

Issues relating to life choices and experiences that result from sexual behaviour that are portrayed on TV are used by gogos to introduce and discuss these topics with their grandchildren. Mercy spoke about how she would "even use some soap we watch, *Scandal,* pointing out the complications that arise from teenage pregnancy and its burdens/challenges". Thoko said that she was able to discuss that sex involves a girl sleeping with a boy and that it happened on TV and that this was something children saw on TV all the time.

> "*I tell her that sex is…her even sees on television, that a boy … that a girl sleeps with a boy. Eh!"* – Thoko (63, caregiver of one child)

Thoko emphasised that she did not just leave her granddaughter watching TV without explaining what sex actually was. However, this was in fact not the case as she acknowledged that it is hard to discuss that sleeping with a boy means that the penis enters the vagina and that she "*actually has not told her that*".

Mercy was the only gogo who brought up the issue of social media during the interview whilst discussing the role of friends in learning about sex and HIV and AIDS. She spoke about the risks associated with "virtual" chatting to people you did not know. She has discussed the dangers of social media and meeting up strangers befriended on social platforms with her adopted children.

> *"What I have spoken to her is this cellphone chatting business of theirs… tweeting or googling or whatever it's called. These people you talk to, you don't see. One day, they will ask you where you live – you'll direct them; they'll ask to meet – you'll meet at… and you'll find an old man who will waste your time. They'll win you over by a measly two-hundred to*

buy airtime, which you will have to "payback" – where you'll be left with burdens that will outweigh that two or five-hundred rand he would have offered you." – Mercy (54, caregiver of two children)

4.8.1.5 *The perceived "danger" of boys*

The gogos were concerned about the safety of their granddaughters in terms of the "threat" posed to them by boys. A number of gogos referred to boys being perceived as the threat rather than the sexual behaviour. The majority of gogos perceived boys as having only one agenda with regards to girls and that was to have sex. Sex with boys was regarded only as something that would result in sexually transmitted infections and pregnancy.

"Boys only want one thing, they only want sex. If you sleep with them, you will pick up diseases [STIs]." – Lerato (59, caregiver of two children)

Thoko explained that her conversations with her granddaughter (aged 11) often revolved around safety, and linked to safety is the issue of staying away from boys and playing only with girls.

"I need you to take good care of yourself and keep clear of boys when you play. When you play, play with girls." – Thoko (63, caregiver of one child)

"*Taking care*" was also mentioned by Florence as an important aspect of being safe for girls. Like Thoko, Florence explained that "taking care" meant not getting involved with boys. Florence referred to her fear of her granddaughter (aged 15) falling pregnant as the result of "boys" and boys were a source of trouble and problems.

"She must not get involved with a boy. She must stay away. She should not be close with boys as they aren't good. Others will come to you to spite you … Sometimes boys will have a hidden agenda, wanting to dispel her from her so-called high and mighty, I've got a bursary high-horse and impregnate her just in efforts to "humble her". So she needs to beware of that." – Florence (74, caregiver of two children)

Florence also explained how "taking care" of oneself as a girl, also involved her 15 year old granddaughter listening to her advice and that of her sister (the aunt). Florence believed that by staying away from boys and completing matric, her granddaughter would achieve independence.

"Yes, if she heeds our instructions. She needs to take care of herself and complete her Grade 12. I told her the other day that I will be content if she can just complete her Matric, as she

will be able to work and provide for herself. She won't need to depend on anyone." – Florence (74, caregiver of two children)

4.8.1.6 *Contraception and pregnancy*

Three gogos discussed contraception and pregnancy. Sindi talked about how she ensured that her daughters went to the clinic to get birth control injections and how she would continually monitor and observe her daughters in terms of pregnancy risks. Florence and her sister also ensured that her granddaughter (aged 15) received birth control injections. Although Bontle had bought her granddaughter (aged 19) female condoms, these remained unused.

Bontle's 19 year old granddaughter was sexually active and had a three year old child. Bontle explained how she had repeatedly tried to discuss HIV and AIDS with her granddaughter. She expressed frustration at her granddaughter's lack of interest in a disease which Bontle herself regarded as serious.

> *"I've told her over and over again … this disease she is not interested in it. She does not consider it. I believe it is a dangerous disease."* – Bontle (52, caregiver of two children)

Bontle also spoke about how she had brought reading material and female condoms for her grandchildren and asked them to read this information and to use the condoms and to not just agree with her just because she was speaking to them about it. The female condoms had not been used and were still on top of the fridge and the granddaughter (aged 19) "*does not even consider all of that … that she'll get sick". Bontle said, "If she were to become sick, she doesn't care. It would be my problem*".

Mercy's granddaughter (aged 14) discussed sex and pregnancy with Mercy of her own accord, but this conversation did not include the topic of HIV and AIDS. Mercy's granddaughter expressed to Mercy how she felt that her school colleagues who were in relationships should rather be doing other things than being involved with each other.

> *"'They walk each other home after school. They are wasting each other's time because in no time, they'll be carrying a child.'"* – Mercy's granddaughter to Mercy

4.9 Additional sources of HIV/AIDS, sex and sexuality information at baseline

During the research conducted, a number of sources of sexual information were revealed by the gogos in addition to, or in some cases, in place of themselves. The extended family, the church, friends and school were identified as important sources of information about HIV and AIDS and sexual knowledge.

4.9.1 Extended family

The extended family relationships tended to be those between uncles and nephews and aunts and nieces, with gender playing a role in who spoke to whom. Gogos and other female family members, usually older, generally spoke to girls. Florence and her sister had "*been telling her, her aunt and I*" to not become sexually involved with a boy. No mention was made about grandfathers speaking to grandsons in any of the interviews. Only one gogo, Agnes, made reference to a male partner.

Thuli described how she relied on an "*uncle*" to speak to her three grandsons (aged 17,19, 21) and that he would be happy to do so. She was happy to ask him to speak to her grandsons as he is highly regarded.

> *"Well, there is an uncle of theirs who I believe could speak to them. He wouldn't have problem. He's also a devout man, who goes to church and has his own home. He is married. He was in a relationship with her for quite some time before they married. He is the one who I often call when I need to call them to order."* – Thuli (59, caregiver of three children)

However, this communication did sometimes also cross genders and more than one generation. Older sisters were referred to as a resource used by Lerato to share sexual information with her grandson (aged 13)..

> "*As we would call the elderly women from church, they would talk to them. It is easier for your child to listen to instruction from another parent, instead of talking to you as their parent."* – Sindi (59, caregiver of four children)

4.9.2 Church

According to the participants, church was perceived as playing an important role in the dissemination of HIV and AIDS information and sexual behaviour. The grannies believed that church "*teaches*" and "*speaks*" about these issues and church attendance results in "*learning*" as church is seen as a respected place of learning. The gogos made use of projects that were run by the church to

share HIV and AIDS and sexual behaviour awareness for adolescents and to increase knowledge in their grandchildren.

> *"That's the reason we asked him to join the church's youth [young people's fellowship] so they can teach him all these things."* – Bongi (60, caregiver of two children)

In additon, elderly, unrelated women from the church community were also relied on by the gogos to 'instruct' their grandchildren.

> "*As we would call the elderly women from church, they would talk to them. It is easier for your child to listen to instruction from another parent, instead of talking to you as their parent."* – Sindi (59, caregiver of four children)

4.9.3 Government clinics

Government clinics were mentioned by only two of the participants during the interview process. In both instances, clinics were mentioned in the context of contraception and family planning for the granddaughter. Sexual health, STIs and HIV was not an issue of concern at the time, although Sindi acknowledges that HIV is now an extensive problem.

> *"I also, had my eyes open at all times and would take them to the clinic to get their injections to prevent them from falling pregnant. However, those times HIV was not as widespread as it is today."* – Sindi (59, caregiver of four children)

4.9.4 Friends

Although the role of friends in the social and sexual behaviour of their grandchildren was commented on by most gogos, only Sindi referred directly to her son learning about sex and sexual behaviour from his friends. She does not necessarily see this as a bad thing, but does express concern.

> "*Even if he doesn't have the knowledge as yet, his friends will speak and expose him to it…. I am concerned that he will eventually be exposed to them [ideas about sex], through friends."* – Sindi (59, caregiver of two children)

4.10 Concept of skills training workshop

> "*If one were to initiate a discussion about sex, I don't know where to even begin. We'd need a plan of how to approach it."* – Mercy (54, caregiver of 2 children)

The gogos were overwhelmingly in support of the idea of a skills training workshop to facilitate conversations about sex, sexuality, HIV and AIDS. Only one gogo, Lerato, felt it more important that the grandchildren attend the skills training workshop rather than the gogos. Otherwise, the gogos were very receptive to the idea of being 'taught' or 'upskilled' on how to initiate and start these conversations with their grandchildren, by a trained facilitator with the skills on how to talk about this topic.

> *"What would help me … is that you could teach me how to facilitate a thorough and deeper conversation because you have knowledge on how I could tell a child about these things*." – Thoko (63, caregiver of one child)

Bontle and Thuli discussed how they wanted to learn how to approach their grandchildren on this topic with more success. Thuli's grandchildren (aged 17, 19, 21) felt "*targeted*" when she spoke to them. She expressed that her concern that they did not want to acknowledge the existence of HIV and AIDS.

> *"Yes, it would because it would teach us how to approach these children about this topic. Purely because these kids will just brush you off as soon as they sense you bringing that topic up."* – Thuli, (63, caregiver of three children)

Bontle felt that the skills training workshop would help her speak to her granddaughter (aged 19) as she has tried, unsuccessfully, to share literature with her and to speak to her about SRH issues. Sindi was "i*nterested*" in attending the skills training workshop to try and find a way to make SRH conversations "*perhaps easier, for me to talk about it, I would try*". She wanted to speak to her grandchildren (aged 3, 5, 6, 15) about this topic but found it just too challenging. Sindi expressed having the additional problem of having a grandson (aged 15) when she had never had a son, and she felt particularly concerned about speaking about male "*private parts*" as men usually spoke to the boys. However, since there were no men around for Sindi to go to for assistance, she would have liked to have attended the skills training workshop to make speaking to her grandson easier. She felt that "*If it were to be explained and taught to me how to… I don't think it would be difficult*."

Even though the "GOgogoGO" skills training workshop would not be the first HIV and AIDS-related skills training workshop that Florence has attended, she still wanted to go, as things from the original

skills training workshop could well have been forgotten, as they were done a "*long time ago*". In addition, she wanted to attend this one as well in order to help get conversations going. Like the other gogos, she expressed a desire to learn in order to try and help improve communication

> *"I am willing to learn. If it will help, I am keen. As long as she'll teach us I am happy to attend."* – Florence (63, caregiver of three children)

Lerato felt that the grandchildren should be the ones being taught. She believed if it was "*possible, you ought to take them and teach them*". She agreed that that it would be "*fine"* to train and teach the grandparents, but she made the point that there was value in teaching children and assessing their knowledge and understanding through the questions they asked. If possible, she wanted the training to be aimed at the grandchildren in order to make communication with them easier.

> *"Teaching us would be fine, but it's always a good sign when you teach a child something and they ask where they don't fully understand. … Instead of them, always saying: We know this and that. They taught us that at school. Then they keep quiet and you're left unsure [whether they really know as much as they claim]…"* – Lerato (59, caregiver of two children)

Lerato felt that by training and teaching the grandchildren to speak to their grandparents, it would make communication between the two groups easier. She explained how she found the lack of interaction between herself and her grandchildren frustrating and cultural barriers made it difficult for her to reach out to them. She felt that she needed improved interaction and responses from the grandchildren to facilitate communication.

> *"Hmmm, what do I need … Maybe, [my issue is that] I get frustrated by their lack of response. Maybe, it's the … I find it difficult to break the barriers set up by our cultures where all of this was never discussed before (Yes.) Now you must discuss issues that weren't discussed with you and therefore aren't open about is a bit difficult. … When the time to discuss it all of these topics I turn to engage in these issues, you feel overwhelmed and somewhat defeated.]"* – Lerato (59, caregiver of two children)

Lerato had the perception that schools had become the source of information for adolescents now on SRH issues. Her grandchildren regularly responded that they know everything already saying, "*No ma, we heard all of this in school*." Although this made speaking to grandchildren very difficult, Lerato was not against a skills training workshop aimed at the gogos teaching gogos how to have these discussions in their homes. She did acknowledge that it "*would be helpful… It would teach one what to say*."

Mercy strongly expressed that she would "*like*" to attend the skills training workshop and would "*really appreciate*" it. She regarded speaking to her granddaughter about SRH issues as "*difficult*." Her experience of sex education while she was growing up was based on fear and mistruths that were controlled by her parents. She felt unable to discuss issues about sex as it was a topic that she found difficult and if she were to talk about it, she would not know where to start.

> *"I would like to attend this workshop because when we were growing up we only had threats from our parents to steer us, which did frighten us. ... We are still ashamed to discuss certain issues. Sex this and that. It is difficult finding ways to tackling these issues as we never had such conversations nor was it ever taught to us at school. It was never spoken of. If one were to initiate a discussion about sex, I don't know where to even begin. We'd need a plan of how to approach it."* – Mercy (54, caregiver of two children)

4.11 Experiences and perceptions of the gogos of the GOgogoGO skills training workshop and sexuality communication with children in their care at home after the skills training workshop.

The gogos had come to the skills training workshop knowing that the skills training workshop was aimed at developing skills in communicating about sex, sexuality and HIV and AIDS. Thoko explained that she had come hoping "*that the skills training workshop would be very helpful in aiding us to have a conversation with our grandchildren about the different diseases and all*". In addition, she mentioned how "*discouraged*" she often had felt trying to speak to her grandchildren in the past. Sindi agreed with Thoko and the interviewer that she had come to the skills training workshop expecting to improve her communication skills on this topic. She reiterated what had been mentioned many times in the baseline interviews about the difficulties facing gogos speaking to children about sex, sexuality and HIV and AIDS, especially due to cultural and past experiences.

> *"Yes, I would also say so. It was not easy for us to speak to these children. In our time, children weren't spoken to on this topic. We were taught (at the skills training workshop) on how to observe their mood before initiating the conversation. As it is already difficult initiating the conversation, you don't want to do it at the wrong time."* – Sindi (59, caregiver of four children)

Patience effectively summarised the feelings of the gogos after the skills training workshop about the role SRH skills training workshops could play in communication and relationships between gogos and their grandchildren. She believed that they could provide the opportunity to facilitate

communication between different generations and reduce frustration and misunderstanding between older and younger generations. In addition, these skills training workshops could provide an environment for older people to teach younger people, who could then share this learnt information with their peers, promoting care and safe behaviour between themselves.

> *"Workshops help a lot. At times when we speak to them we anger them; we reprimand them and they sulk. These workshops help because they all learn from what I've taught them and can even take care of one another."* –Patience (58, caregiver of three children)

All the participants reported that they enjoyed the skills training workshop and felt empowered by it. Generally there was positive feedback on the skills training workshop. However, subsequent to the skills training workshop, a number of issues and barriers to SRH communication were raised by the gogos in the focus group discussion and the in depth interviews. These included generational conflict; the need for regular SRH communication; the dismissive attitude of adolescents to being spoken to about this topic; the need for periodic and repeat training and the need for skills training workshops targeting the grandchildren.

4.11.1 Positive feelings about talking experienced by the gogos after skills training workshop

> "*I am no longer scared*." – Thuli (60, caregiver of three children)

The feeling of being able to speak, of being empowered to talk about this topic, was an important outcome of the skills training workshop. All the gogos interviewed expressed an opinion on how their feelings on conversing with their grandchildren about sex, sexuality and HIV and AIDS had changed since the skills training workshop and how it had become easier.

> "*Yes, before I was scared/shy but now I can open up. You know us black people are afraid of talking about this, but now I can."* – Thuli (60, caregiver of three children)

Thuli spoke about how she felt she had the "*courage*" to speak to her grandchildren. She had been aware of and taken action about HIV and AIDS before the skills training workshop by previously providing her grandsons with condoms. Although this had been independent to the training, she felt since the skills training workshop that she could speak about HIV and AIDS as opposed to just making condoms available. Patience described how after the skills training workshop, "*my heart was rest at ease because I left feeling I could speak to my grandchildren*". She felt she had been "*taught*" how to "*speak*" to her grandchildren. She explained how prior to the skills training workshop, she "*had been*

worried that I wouldn't be able to have this conversation with my grandchildren, but now I feel I can".

Bongi recounted how she felt "*relieved*" after speaking to her grandchildren after the skills training workshop, as "*it seems what I spoke to them about will help them*". This made her feel "*happy*". She perceived that her grandchildren had embraced her conversation and she was "*glad it sunk in*". Thuli described how her feelings about SRH communications had changed since the skills training workshop.

> *"I was unable. It weighed down on me. I did not know how to tackle the situation but ever since the workshop – having learnt the importance of them knowing and learning from us is. Without our guidance and counsel, she'll steal a kiss and a bit more and get sick."* Thuli – (60, caregiver of three children)

There was a feeling of empowerment and improved self-efficacy following the skills training workshop. Previously, Thoko had only "*heard of speaking*" on this topic to children. She had "*struggled*" communicating SRH information to her own children as well as her grandchildren. As a result of the skills training workshop, Thoko declared "*but now I can speak*". Thoko felt that the skills training workshop had benefitted her a "*whole lot*". Like Thoko, Thuli felt that the impact of the skills training workshop had been positive and empowering.

> "*It is easier. It has helped me a lot. I could not speak freely and even manage to get a response from her, but now I do. I didn't know how to initiate the conversation. I had even struggled with my own children, but now I can speak to her."* – Thuli (60, caregiver of three children)

4.11.2 Improved openness and building trust in communication between gogos and grandchildren

A number of gogos spoke about the change in their relationships with their grandchildren after the skills training workshop. They discussed how they were able to speak more openly with them which made their relationships easier and that they realised that trust was important in the relationship.

Thoko explained that she perceived the change in her daughter's behaviour was as a result of "*improving*" the way that they speak to each other since the skills training workshop. This change in communication style between Thoko and her granddaughter has meant that Thoko has started

sharing information that she learnt at the skills training workshop with her granddaughter and this has resulted in her granddaughter coming home safely and on time.

> *"She used to come late but since having spoken to her – after the various things I learnt at the workshop and taught her – she comes home on time. She would rather be very early and be back at half past five [17:30] than be late."* – Thoko (63, caregiver of one child)

In addition, since the skills training workshop, Thoko's granddaughters' attitude to talking about sex had changed. Instead of a dismissive attitude, the granddaughter appeared to have a more reassuring response for her gogo saying, "*No, Gogo don't worry …*"**.** Her school-based information seems to fit in with a standard Life Orientation lesson where, according to Thoko's granddaughter, the children have been taught "*what happens when you are pregnant, what happens when you get your periods, as they also sometime give us sanitary towels*".

During feedback after the skills training workshop, Thuli spoke at length about how she had been able to discuss the cause of death of her daughter with her grandson which she attributed to the skills training workshop as attending the skills training workshop had made it "*easier*" for her. Previously, she had only been able to talk to him about her dying "*but not the cause of death".*

> "*Yes, I was always afraid of causing him pain. I told myself, I would let him grow up [mature] and then would I tell him."* – Thuli (60, caregiver of three children)

Thuli further recounted how since the skills training workshop, she has been able to explain to her grandson how, as a family, they were ignorant of what was happening when her daughter got sick seventeen years ago and that "*we didn't know all of this in '98 [1998]*". She only found out that her daughter had HIV "*when we got to the hospital and were told that she had the virus*". The skills training workshop provided a space for Thuli to reflect on her own feelings about her daughter's illness and death.

The gogos expressed how they had come to realise since the skills training workshop that they had to start trusting their grandchildren. As Thuli explained, it was no longer possible to supervise her grandson's behaviour continually. She needed to have given him the information to make safe choices and then she would have to rely on him to make those decisions on his own.

> *"The truth is that, I cannot be with him all the time and when I'm not with him – I rely on what I have told him about protecting himself."* – Thuli (60, caregiver of three children)

All the gogos spoke about conversations and discussions that they had had with their grandchildren since the skills training workshop. Bongi recounted how she now "*continually*" spoke to her grandchildren about HIV and testing as result of the skills training workshop and training. As a result of this, one of her grandsons had been for HIV testing which she regarded as "*progress*".

> *"I was happy with the workshop. There has been a bit of progress since. One of them even went to get tested at the clinic. I continually ask them."* – Bongi (60, caregiver of two children)

Although Bongi mentioned that her other grandson had not yet gone for testing, she was prepared to give him time to decide to do this but she was strongly encouraging him to go. According to her, for her grandchildren to live a "*long life*", they needed to go for regular testing to take personal responsibility for their own and their partner's behaviour.

> *"If he wants to live [a long life] he needs to go for these check-ups every three-months or so. They should all do it and continually know their status. Yes, they may be good and alive but it is important for them to keep on checking where they stand as life will still carry on and they will continue to live, even beyond what I can see and supervise. It is important to check, as you may not always know what the girl gets up to or what you get up to, so you should go and check [get tested] frequently."* – Bongi (60, caregiver of two children)

Thuli explained how before the skills training workshop, she had not spoken to her grandchildren about sex, sexuality, HIV and AIDS, fearing that this would irritate them. This proved not to be the case when she did actually speak to them after the skills training workshop as she found her grandchildren receptive. They were able to share a two-way conversation discussing personal experiences. Thuli went on to say that the skills training workshop helped "*break the barrier*" about communication regarding this topic. From a position of not knowing how to deal with certain difficult topics, the advice given at the skills training workshop proved "*beneficial*".

> *"I had doubts because I reckoned I would try to speak to them and probably be bothering them or annoying them. However, when I did speak to them they were free and open about speaking to me about this topic. They were even open to speak to me about what they had seen. I told them how things were nowadays. We even used examples from in and around our community about how poor decisions had led to the demise of many. When you don't take care of yourselves this is how it turns out and so on – I would say."* – Thuli (60, caregiver of three children)

Thuli was the only one of the gogos with grandsons who spoke to her grandsons about the danger of "*chasing girls*". In all other interviews, boys had been viewed as the source of pregnancy and sexually transmitted diseases. She acknowledged the importance of "*warning*" boys of the consequences of not protecting themselves. Thuli's advice to her grandson included focusing on school and not rushing into things with girls. She used his uncle as a role model for her grandson to aspire to, as he had completed his studies, as opposed to trying to be like his peer group.

Bongi made the point that when she spoke to her grandchildren about sex, sexuality and HIV and AIDS after the skills training workshop, it was not in a prohibitive or restrictive manner. It was in a manner of sharing knowledge to enable her grandchildren to make their own "*wise*" choices as she could not continually be with them controlling their decisions. In addition, Bongi acknowledged that sex is a behaviour that adolescents participate in, but that they needed to "*protect*" themselves.

> *"I would tell them I am not giving them restrictions and what not but asking that they be wise in their actions. I acknowledge that I cannot possibly be with them wherever they go, they may be with girls doing whatever they do because these children usually rush into things but all I can do is ask them to protect themselves."* – Bongi (60, caregiver of two children)

After the skills training workshop, Bongi explained that she was prepared to accept that "*boy and girl relation is inevitable*" and her grandchildren would be involved in sexual relationships as a normal life process. However, they needed to "*protect themselves…by continually getting tested and always using condoms*".

4.11.3 Condom conversations

A number of participants spoke to their grandchildren about condoms and the use of using condoms following the skills training workshop. Thuli acknowledged the "*truth*" of the reality regarding her grandson's behaviour that she "*cannot be with him all the time and when I'm not with him – I rely on what I have told him about protecting himself*". According to her, "*protecting*" himself meant "*He must get condoms and learn how to use them correctly.*"

Thoko had had a discussion with her granddaughter that involved bilateral communication that was positive. She explained to her granddaughter (aged 11) the importance of condom use safe sex and the reality of growing up and sexual behaviour.

"You see now, you're oldish. If a boy asks you to come to him – plus you're still young – do not agree. Even when you are of age and you meet up with a boy, it is of importance that you too, make use of condoms. This is to ensure you both protect one another. If not, it is easy to get this sickness (HIV). She agreed and had a thing of her own to say." – Thoko (63, caregiver of one child)

Thuli explained how she had spoken pragmatically and openly to her grandson about safe sex and condom use. Not only did she now feel able to encourage him to take condoms with him in his pocket every time he went out, she was able to discuss aspects of safe sexual practices with him.

"*What I tell him is that when he has relations with a girl, what is important is that when you are both old enough to have sex and first get tested together – to ensure you both are aware of your status. You will find that the girl has been around …* ***I: But what about when they engage?*** *They must use a condom!* ***I: So you emphasised that they must use a condom?*** *Yes. That is what safe sex entails."* – Thuli (60, caregiver of three children)

Thuli spoke how behaviour change and conversations about condom use with her grandson exposed the possible awkwardness of the generation gap, age and respect issue. Even though she anticipated that her grandson would not want to be seen taking condoms by his gogo when he goes out, she has had the conversation with him to defuse the embarrassment and to enable the behaviour of him taking the condoms.

"Yes, I was able to tell him about it a little. Every time you go out – because I will not always be with you – you must have them in your pocket. You will say, "I won't be seen doing all of this, especially by you Gogo" then you pick up these diseases." – Thuli (60, caregiver of three children)

4.11.4 Importance of skills building in adults and not only increasing knowledge

Although Thuli had attended a HIV/AIDS skills training workshop she had never been able to speak to anyone about what she had learnt during the skills training workshop session. The previous skills training workshop had given her the information and knowledge, but not the skills to share this. She told the interviewer that the GOgogoGO skills training workshop was "*very helpful*" in this regard.

"*I once attended and received a certificate for. So I know but I had never spoken to (the grandchildren) before."* – Thuli, 60, caregiver of three children)

Sindi discussed her attempts to speak to her grandchildren. She had embraced the concept of the skills training workshop that gogos need to have SRH conversations with grandchildren and has started talking to them about these issues. However, she found her grandson non-responsive and unreceptive to her attempts to communicate.

> "*Yes, I haven't gotten there as yet. I am still trying to speak to him about the diseases out there to see what type of person he is. With that I still feel like I'm speaking to a rock."* – Sindi (59, caregiver of four children)

Thuli expressed how she now appreciated the importance of adults, in this instance the gogos, in actively speaking to and "*educating*" adolescents. This needed to be done in order to empower children to make their own informed choices about sexual behaviour and protection, as adults cannot control their behaviour all the time,

> *"We can't afford to sit back and say nothing will happen. These children go out when we aren't in sight and do things so we need to at least educate them before we let them be on their own and do things on their own. You see they go out alone…you can't possibly expect to know what they do. They just need to protect themselves."* – Thuli (60, caregiver of three children)

4.11.5 Barriers and challenges to talking about sex, sexuality and HIV and AIDS after the skills training workshop

Although all the gogos commented positively on the outcomes of the skills training workshop in terms of improving communication between themselves and their grandchildren about sex, sexuality and HIV and AIDS, it was apparent that this conversation remained difficult. Although a number of changes had taken place in terms of improving communication and some behavioural changes had occurred, several months after the skills training workshop barriers and challenges remained in place that continued to hinder the ease with which gogos spoke to their grandchildren on this topic. Some gogos expressed concerns about issues that they felt still needed to be dealt with. There was some continued frustration at the inability to communicate with grandchildren and some misunderstandings of key messages were evident in the narratives.

Sindi and Patience both believed that speaking to the grandchildren is not enough. There was a concern that the grandchildren tended to avoid the issue by pretending that they understand it, rather than seeking out answers and getting clarity from the gogos.

> *"Some children you speak to but you can tell it was not enough. It does not "hit the spot". Instead, they would rather pretend as if they understand everything and leave in their confusion. They don't take it as seriously as they should."* – Sindi (59, caregiver of four children)

4.11.5.1 ***Not always easy initiating a conversation***

In spite of the increased self-efficacy and courage to speak to the children, voiced by a number of gogos after the skills training workshop due to what they experienced as "*learning*" and being "*taught*" as a result of the skills training workshop, a number of gogos still found SRH communication difficult.

Lerato spoke about how she continued to experience problems with speaking to her grandchildren about SRH. Lerato's grandson would not engage with her at all on this topic. Whenever she tried to bring it up, he told Lerato how she "*talk a lot about this*". He then would say "*yes, yes, yes*" to "*brush*" Lerato off and then "*walks away*". The interviewer suggested that this might be because he felt Lerato was unable to speak about this and therefore he could not speak to her about it. Lerato had not yet "*been able to speak to him (her grandson) about sex*". She explained she had only "*touched on the fact that there are many illnesses out there and he needs to beware of them*". She expressed concern about his behaviour as he was "*gallivanting*" at night and he should "*take care of himself*". This was the only reference made during the interviews of the need for a boy to be "*taking care of himself*" which was a framing that usually referred to girls. Since he played soccer regularly, Lerato suspected that he used soccer and soccer practice as an excuse for being out at night.

Thoko commented on how difficult it remained to actually speak about SRH issues to her grandchildren. Thoko's grandchildren would say, "*But ma, they teach us these things at school. We even know where babies come from."* The grandchildren did not want to listen to her.

> *"We did learn enough, but our children are still very hard headed. When you try to initiate the conversation you get a speedy dismissive response. They will tell how much they are well-learned when it comes to the topic and how you need not speak to them as they are already aware of everything you are about to tell them. You find yourself discouraged."* – Thoko (63, caregiver of one child)

Although Sindi also said she did not find it difficult to speak to her grandchildren, she found that they do not want to listen. This could translate into a skills issue of Sindi's knowledge and transfer of knowledge or her communication style and manner of speaking. Most of this information and conversation between Sindi's grandchildren appeared to revolve around issues of basic hygiene –

not sharing spoons, washing hands before eating and hand washing after using the toilet. There was knowledge and conversation about not touching blood and that you could get a "*disease*" from blood.

> "*You see even when they are here at home and they see one of them bleeding, they will say: don't touch him. If you're going touch him you need to put on hand-gloves or you will pick up his disease."* – Sindi (59, caregiver of four children)

4.11.5.2 *"The generation crash"*

The generation gap barrier and the challenge of dismissive attitudes towards the gogos continued to persist in some gogos' experiences. Sindi and Lerato both spoke about the difficulties in trying to get their grandchildren to not only listen, but also to choose to follow the behaviour spoken about. Sindi explained how she did not find it difficult for her to talk to her grandchildren, but she felt that they did not listen. They heard one thing at home but followed the examples of their friends outside the house.

> *"For me, it is not difficult to talk to my kids, but our kids do not want to listen. You can tell him or her something here in the house but when he is going outside to the friends, they teach their way of living*." – Sindi (59, caregiver of four children)

Sindi suspected some of her grandchildren's responses, which included laughter, could have been due to the fact she was "*gogo*" and that they were possibly embarrassed: "*Since it came with Gogo, they would laugh when they see some of the things.*"

The gogos shared their feelings regarding the generational gap between themselves and their grandchildren. This generation gap manifested itself, not only in age, but also in different styles of communication and understanding between the two different generations. Although Patience felt she had learnt how to speak to her grandchildren, she felt there is a need for this communication to be reciprocal in order to facilitate understanding.

> *"You taught us how to speak them, and I believe they also need to be taught how to speak to us. There is a gap between us that needs to be bridged. They need to learn how to speak to us so we can understand one another."* – Patience (58, caregiver of three children)

4.11.5.3 *Uncertainty about what is the "right" age to have SRH conversations*

The issue of the age of the grandchildren impacting their ability to understand conversations about sex, sexuality, HIV and AIDS was a new theme brought up in the feedback interviews by Sindi. This

had not been raised before. As Sindi explained she accepted she needed to have SRH conversations with her grandchildren as discussed in the training. However, on speaking to them, she felt that in fact they were just unable to understand the concepts of sex and sexuality.

> "*As I said, they haven't grasped the concept yet… When I explain to them, I realised that it has no it was told us – we must start to talk to them. I started to talk to them… only thing that I can notice is that it is still too difficult for them to listen [and grasp the concept] … It has not registered. Their minds haven't gotten to that point yet."* – Sindi (59, caregiver of four children)

Sindi explained she was not afraid to discuss it with them "since I was taught that I'm not supposed to be scared". However she explained that she had "*tried speaking to them but realised that yes they do hear me but do not fully understand yet."* She believed the concept or sex and sexuality is too "difficult" for her grandchildren. Since the grandchildren were fifteen, eight, five and two, the concept of sex would not be appropriate for the two year old grandchild and would need to be handled sensitively and carefully with the five year old and eight year old. However the grandchildren learnt many things that *"they understand well…Things such as transferring of diseases they understand."* Sindi explained that *"it is only issues pertaining to sex that they do not understand as yet".* Even though she felt that her grandchildren are too young to learn about the 'concept' of sex, they can still benefit from being spoken to.

> "*Another thing I have to mention is that they do listen; it is just that they are still young. It has been helpful, however to have spoken to them*." – Sindi (59, caregiver of four children)

4.11.5.4 ***Culture***

As in the interviews before the skills training workshop, the concept of culture and cultural barriers remained a barrier to SRH conversations.

Sindi continued to refer to the culture of sex not being spoken about by her parents "*in our times*" referring to when she was an adolescent. Her sources of information as a child had been from what she "*read*" or saw "*on the streets*". She believed that children of today, in particular, the grandchildren, are "*lucky*" as they would be spoken to about sexual issues whilst still young as a result of having been "*told*" to do so at the skills training workshop.

4.11.5.5 ***Feelings of discouragement***

Thoko expressed how the gogos continue to be discouraged by their grandchildren's comments regarding already knowing everything about sex, sexuality, HIV and AIDS. Thuli felt that outside

facilitators would not receive the same "*petty*" excuses that the gogos receive. The grandchildren used reasons like "*soccer*" and "*church choir*" to avoid talking to their gogos about these topics. Many gogos regarded the grandchildren's comments about knowing everything as disrespectful. Sindi said they were "*not prepared*" for these comments and she felt that the grandchildren would not be so disrespectful to a "*stranger*" i.e. an outside facilitator.

> "*I've been told, Gogo; please remember that we weren't born in your times. We are born-free and we know all about these things. We find ourselves not prepared to even hear such statements. However, I don't believe they'd be as dismissive to a "stranger".*" – Sindi (59, caregiver of four children)

Thuli expressed her exhaustion about looking after her grandchildren. She explained that they now needed to take responsibility for themselves and their sexual behaviour in order to avoid STIs, HIV and AIDS and unplanned pregnancies. She felt she had done "*enough*":

> *"I have taken care of them, it's enough. They need to take good care of themselves and lead good, healthy lives. They can never go wrong protecting themselves, as it prevents unwanted pregnancies, as well as any STIs or even HIV. They should take good care of themselves. They must also beware not to impregnate anyone, as it comes with many responsibilities"* – Thuli (60, caregiver of three children)

4.11.5.6 *Misunderstandings about men*

Although most of the gogos reported positive and helpful conversations as a result of the skills training workshop, Thuli did speak to her granddaughter in a negative and threatening manner about men. Thuli felt that the skills training workshop had taught her how to speak to her granddaughter about the "*threat of men*" and the "*cruelty*" of the world. This was not the intention of the skills training workshop.

> *"It taught me how to speak to her and tell her all about how cruel the world is out there. More especially when you're a girl child. A male figure could easily lure you in offering you snacks of some sort only to have him rape and kill you."* – Thuli (60, caregiver of three children)

4.11.5.7 *The role of adults in SRH communication*

Sindi expressed how she now appreciated the importance of adults, in this instance the gogos, actively speaking to, informing and "educating" adolescents. She felt this needed to be done in order to empower children to make their own informed choices about sexual behaviour and

protection as adults could not control their behaviour all the time, especially as they mature. Thuli expressed a similar sentiment.

> "*We can't afford to sit back and say nothing will happen. These children go out when we aren't in sight and do things so we need to at least educate them before we let them be on their own and do things on their own. You see they go out alone…you can't possibly expect to know what they do. They just need to protect themselves."* – Thuli (60, caregiver of three children)

4.11.5.8 *Gogos reception of content from GOgogoGO skills training workshop*

> *"Now they [the gogos] will know and understand as opposed to being fearful."* – (Patience, 58, caregiver of three children)

By the end of the skills training workshop, the gogos felt that they had learnt skills in how to communicate, the value of improved SRH communication and the importance of the role that they can play in this communication. Gogos became aware of the importance of speaking to their grandchildren openly and honestly and that in doing so, they were providing their grandchildren with the information and knowledge to protect themselves. In addition, gogos learnt new information about keeping themselves safe, female condoms, exclusive breastfeeding and choice.

In the group discussion, Thoko expressed how she felt they "*did learn enough*" and Patience reported how the skills training workshop "*taught us how to speak [to] them*". Patience commented on the value of having factual content and knowledge regarding sex, sexuality and HIV and AIDS shared with them. This meant the gogos could share this correct content and knowledge with their grandchildren. In her experience, Patience's parents had used punitive and fear-based techniques to prevent sexual behaviour when she was growing up rather than providing her with accurate information.

> "*Just like in our time, instead of being taught the "what's" and the "how's" we were told not to and told scary stories in efforts to keep us from any mischievous behaviour. Now they will know and understand as opposed to being fearful."* – Patience (58, caregiver of three children)

Thoko explained how at the skills training workshop, she had learnt "*that children ought to be taught about these various sicknesses so they can protect themselves from them*". She learnt the importance of talking to her grandchildren about STIs and HIV and AIDS in order to keep them safe from infection.

4.12 New things learnt by the gogos

In addition to the fact that the skills training workshop had gone well in terms of what the gogos had learnt regarding skills and content in speaking to their grandchildren, the gogos also learnt things of benefit to themselves. A number of gogos spoke about the things that they had learnt in the session that they had not known about before. This included personal sexual health, the existence of female condoms and facts about exclusive breastfeeding and how to avoid transmission of HIV through blood at an accident scene.

4.12.1 Gogo sexual health and condom use

Patience commented on how she had learnt about keeping herself safe as an older woman and to use condoms. Thuli explained that the reason for this is that *"we would never know where the man has been before".*

> *"We even learnt that we too need to protect ourselves as the elderly. Irrespective of age, when we have sex we should also use protection."* – Sindi (59, caregiver of four children)

4.12.2 Female condoms

Female condoms were something that the gogos, attending the focus group, were not aware of or had exposure to information about. Both Patience and Thuli remarked that even though they had learnt about female condoms, they would not be able to speak to their grandchildren about them. Patience explained that it "would be difficult for me" to speak about them. When Thuli was asked if she would be able to discuss them with her grandsons, she responded, "I don't think so." Thuli's reason for this was that the female condom was "difficult to explain." Sindi explained that the gogos "don't know how it works or how you put it on". In addition, it appeared that there are very few female condoms available to the community. Thoko described them as "scarce". Patience had asked her grandchildren about them but they said they had not seen them "around" although they had heard of them. Patience herself had not seen them in the community or the clinics.

> "*I myself haven't seen them around anywhere. I've been to clinics and just like them [her grandchildren] have not seen them. They have heard of them but haven't seen them."* – Patience (58, caregiver of three children)

4.12.3 Exclusive breastfeeding

The information on exclusive breastfeeding for six months was also new to the group. Patience discussed in the focus group that she "*liked what they taught us on breastfeeding*" with regard to an

HIV positive mother and breastfeeding. As Patience explained, the gogos "*didn't know that a baby had to be exclusively breastfed for six months...we learnt a lot*". In addition to being told that babies could only be exclusively breastfed by HIV positive mothers, Thuli mentioned the importance of having this rule "*explained*" to them and the value of understanding the rule.

4.12.4 "Chewing Gum Choice"

The gogos particularly enjoyed an activity with the facilitator known as "Chewing Gum". In this activity, the gogos visually experienced the irony of electing to not share already chewed chewing gum due to a fear of germs but how people are not afraid of sharing "*free sex without protection*". Patience went as far as to ask the facilitator to share the activity at her church group. Thuli recounted how she had shared this exercise with her grandchildren to demonstrate how people don't share chewed chewing gum because they regard it as "*disgusting*" and did not want germs yet they not have the same restraint regarding sex and STIs.

> "*Yes, I even shared this with the children and told them…you see, be careful. I even did the illustration myself and they too were as shocked and disgusted as we were."* – Thuli (60, caregiver of one child)

4.13 Need for a skills training workshop for adolescents

While Lerato had been the only gogo to express at baseline that the grandchildren needed their own skills training workshop with their own facilitator and training, subsequent to the skills training workshop, Sindi had a similar view. She felt that the grandchildren would learn more from attending their own skills training workshops and this would be beneficial to the grandchildren.

> *"That's why I am of the firm belief that these children need to be present at these workshops so they can respond themselves. I know for a fact that he won't want to speak to me so. I know he will be more open and share how he feels [at a skills training workshop]"* – Sindi (59, caregiver of four children)

However she did acknowledge that changes that occurred in their conversations about these topics. She described how "*things are better than before. Things are not the same…they try to understand most things*".

Sindi also brought up the generation gap as another reason for the grandchildren to have their own skills training workshops. She explained that she felt that her grandchildren regard her as a "*granny*" who was just "t*alking*" and that they did not listen to her or pay attention to her because of her age.

> *"The only thing they know is that I'm a granny. So a granny is talking everything. This is because their parents are not talking about this thing. That is why. It is strange for them to listen to this but on my own I've tried. There is one we were talking about, who doesn't want to come back to my home, is because he wants to be free. That is why I asked.... [the interviewer] to have a workshop straight away to talk to them."* – Sindi (59, caregiver of four children)

A number of gogos mentioned the importance of a separate or additional skills training workshop for the grandchildren. They expressed their feelings that when they tried to talk to their grandchildren, they were "*always told that they learn about all of this at school*". As Patience suggested "*maybe a talk from the study team would be received with more receptive ears*". Patience made the point in the group discussion that the grandchildren need to be spoken to "*periodically*" and that it would be more "*helpful…that children would rather speak to a stranger than to me".*

In addition, Patience proposed that the grandchildren could be spoken to individually within the skills training workshop and training environment. This would be similar to a clinic environment. She feels that the grandchildren might feel more "*comfortable*" speaking to outsiders about issues around HIV and AIDS, sex and sexuality i.e. the skills training workshop facilitators.

> *"I say this because they may feel more comfortable to speak to you [instead of us], and who knows what may come up? They may say – hey I want to get on family-planning contraceptives but am afraid of my gran – and you may be able to help them. So that may help a lot."* – Patience (58, caregiver of three children)

Patience further suggested two separate skills training workshops - one for the gogos and one for the grandchildren - followed by a combined skills training workshop for both groups. For others gogos, there was some scepticism about this combined group. Sindi felt the grandchildren would not feel "*comfortable*" in a combined group and the gogos could sabotage the skills training workshop. Thoko explained this further saying that neither the grandchildren nor the gogos would participate openly and that the grandchildren could undermine the session.

> *"They [the grandchildren] will just say, hey these gogos? Let's rather keep quiet … They [the gogos] want to hear what we would say…. They [the grandchildren] are clever…. When they [the grandchildren] ask us [the gogos] we'll keep quiet."* – Thoko (63, caregiver of one child)

Sindi also welcomed the idea of a skills training workshop for children as she was experiencing a problem trying to speak about behaviour to her older grandchild, a boy of fourteen, who did not want to be disciplined or have his movements restricted.

> *"There is one we were talking about, who doesn't want to come back to my home, is because he wants to be free. That is why I asked ... to have a workshop straight away to talk to them."* – Sindi (59, caregiver of four children)

She felt that a skills training workshop for the grandchildren would help support the gogos. This would help facilitate SRH conversations between gogos and grandchildren as the grandchildren would have more content and knowledge on the topic. They would feel more familiar with it and trusting of the agenda of the conversation when approached by the grandparents.

> *"That is why I asked that if it is possible for there to be a workshop where they are spoken to, where there can be more detail and substantiation to what you have taught. So they don't get there and not have a reference because it was not spoken of in the household. So they are able to tie together what Gogo was talking about is in fact true."* – Sindi (59, caregiver of four children)

Lerato continued to feel, as she had at baseline, very strongly about the need for a separate skills training workshop for the grandchildren. She felt most frustrated at the fact that a second skills training workshop for the grandchildren that she had asked for at the baseline interview had not yet happened. She remembered at the baseline interview "*agreeing*" with the interviewer "*that we believed it would be better if these children attended these workshops themselves…has that failed to happen or what?"*

Lerato explained how she continued to feel that her grandchildren, in particular, her grandson, did not show any comprehension or engagement when she spoke to them, even after she had attended the skills training workshop. She perceived there to be a general communication problem between herself and her grandson as what she says "*goes in through one ear and out the other*." He did not share anything with her easily, including neutral subjects like a leadership conference without her "*having to pester him to get any form of response*". She expressed desperation at this situation and acknowledged that communication has not improved. She felt that access to the book *HIV & AIDS* by

Marina Appelbaum and a skills training workshop with an independent facilitator would be her only hope for him to learn about sex, sexuality, HIV and AIDS.

> *"What can I do? I feel they still need this workshop where they can get those books as well. I know communication is still difficult so I need him to be able to speak to someone else. If he struggles to speak to me about a conference on leadership how can he speak to me about one on sex?"* – Lerato (59, caregiver of two children)

4.14 Additional conversations between gogos and grandchildren after the skills training workshop

A number of gogos reported back at the discussion and in the interviews that they had been able to have open conversations with their grandchildren following the skills training workshop. Thuli had arranged a family meeting with her grandchildren about sex, sexuality, HIV and AIDS after the skills training workshop that she planned to hold with her sister. When it was time to have the meeting, she had had to do it on her own. She described how even though she was anxious about it due to being on her own, she still had the "courage" to discuss the content of the book, *HIV & AIDS*.

> *"We discussed the danger of leading a reckless life with different partners and the ramifications of unprotected sex. Highlighting the fact that it is useless to claim that you use condoms and all but you don't and expect me to take care of you later."* – Thuli (60, caregiver of three children)

Although Patience related to the group that she had not managed to have SRH conversations with her granddaughters, she had been able to speak to her grandson. This was due to the fact that he was home more than her granddaughters. However, his response to her was that he knew this information from school and was old enough to know what she was telling him. In addition, she had established he already had his own condoms.

> *"He would tell me I understand, as they had been taught about it at school. I recall when I reprimanded him about being out until late and he said, No mama, I'm not a child… Then I searched under his bed I found condoms. So he said he understood as they had been taught all of this at the Special School."* – Patience (58, caregiver of three children)

Patience also discussed high risk sexual behaviour using truck drivers as an example (this is in the book) saying to them "*you see if you don't take care of yourself what will happen?*"

4.15 Talking about menstruation

With regards to speaking about puberty, Lerato's granddaughter was eleven and had not started her menstrual cycle yet**.** Lerato explained that she felt that she had started preparing her granddaughter for it by "*briefly*" speaking to her about it. This was done in response to her granddaughter bringing home sanitary towels from school. Lerato felt that this indicated that the school is teaching them about menstruation.

> *"I have (started speaking to her). The schools have started teaching them because she's brought home sanitary towels so I could tell they teach them and so I too have briefly spoken to her about it."* – Lerato (59, caregiver of two children)

Chapter 5: Discussion

This research project has set out to examine the experiences of older women, referred to as gogos, in the communication of sex, sexuality and HIV and AIDS with the pre-adolescent and adolescent children in their care prior to a skills training workshop and the perceived impact of the skills training workshop supported by the book, *HIV & AIDS,* in Alexandra between February 2014 and January 2015. Specifically, the research explored the context of gogos' lives in which SRH communication with the pre-adolescent and adolescent grandchildren in their care occurred; the gogos' experiences and perceptions of SRH conversations when talking to the pre- adolescent and adolescent grandchildren in their care prior to participation in an HIV and AIDS skills training workshop and the perceptions and experiences of the skills training workshop with the gogos and subsequent communication post the skills training workshop with the pre-adolescent and adolescent grandchildren in their care within the home environment,

As early as 2002, research conducted by Delius and Glaser (2002) showed an "alarming failure of communication between parents and children on sexual issues" (p27) (36). As shown in this study, the proscription and taboo that sexuality conversations between adults and children face is a significant barrier although the gogos in this study were prepared to make real efforts to address the difficulties faced with SRH communication. Grandparents and older members in the community who are primarycaregivers of children, and bringing up children are fulfilling parental roles and therefore must be regarded as de facto parents. For this reason, they need to become part of, if not particularly targeted by, interventions to improve children's' SRH outcomes.

The discussion will look at a number of issues that are reported in the results section in Chapter 4. These will include the day to day experiences and context of the gogos in caring for their grandchildren; the gogo's experiences of SRH communication prior to and after the skills training workshop; can gogos be equated with parents and the different roles of the gogos, school, peers, older males, church, other family members and community members in SRH issues and information and feedback on the skills training workshop. The first two issues, namely the day to day experiences and context of the gogos in caring for their grandchildren; and the gogo's experiences of SRH communication prior to and after the skills training workshop will make use of the Ecological Model to help interpret and understand the results.

The Ecological Model makes use of the core concept that health behaviour has multiple levels of influence and that that the multiple layers contribute to a certain behaviour; a change in this

behaviour) and result in improved health outcomes. These layers include 'intrapersonal (biological, psychological), interpersonal (social, cultural), organizational, community, physical environment and policy" (p466) (60). It is important to note that influences can intersect between these different levels (60). Behaviour change, in this case, improved and regular SRH communication between gogos and grandchildren, is most likely to occur when factors associated with all levels are conducive to, and supportive of, this change.

5.1 Day-to-day experiences of the gogos

According to Aubel (2005) and findings reported in the Grandmothers' Tribunal (2013) the responsibilities and impact of caring for grandchildren is a source of significant stress on grandparents (1, 2).This was consistent with findings in this study that found the burden of care for these gogos was overwhelming at times. They faced pressures of meeting the basic needs of housing, education and food for the children in their care. Although this study did not look at the emotional and psychological needs of the children and gogos themselves, it was apparent that the impact of losing children and parents is a significant issue within these family groups.

It became apparent during the course of the research that many conversations between the gogos and their grandchildren were often impacted on or affected by contextual experiences of the gogos and the daily burden of care they were experiencing trying to look after a third generation of children who were without parents.

5.1.1 Financial, emotional, physical and social difficulties facing the gogos

Many of the issues brought up by the gogos were the same as those often referred by the African grandmothers at the Grandmothers' Tribunal (1) and in a number of studies on experiences of older caregivers (5, 7, 17, 56). Like the older caregivers and grandmothers in research in South Africa, the gogos in this sample where under significant pressure and stress as a direct result of being the primary caregivers for their grandchildren (6-8). These included financial, emotional, physical issues which will discussed in light of the Ecological Model.

5.1.1.1 *Individual Level*

Age, exhaustion, lack of hope and a sense of being overwhelmed and sometimes defeated were issues faced by the sample. According to Kelley and Whitely (2000), these feelings can result in negative emotional consequences for the grandmother (56). Normative age related tasks could be compromised through this second-round primary parenting responsibility having an impact on the health and wellbeing of the gogos (56). Emotional strain and issues were not explored in this study

but a number of gogos expressed hardship and loneliness in the role of primary caregiver to orphaned and vulnerable children. This could result in exposing and making the gogos less effective caregivers that would warrant further inventions.

5.1.1.2 *Interpersonal level*

Interpersonal level challenges included relationships across the different generations and within the community itself. These contextual issues combined with the perceived dismissal from the grandchildren when attempting to initiate conversations about sex and HIV and AIDS could easily shut down attempts by the gogos to have SRH conversations with their grandchildren. However, a number of gogos referred to the extended family as a source of support and information about HIV and AIDS and sexual knowledge, with a number of the gogos being extended family members themselves. This supports research by Bastien et al. (2011) that adolescents spoke to extended family members, including aunts and uncles, about HSH issues (15). The study further supports Bastien et al. (2011) that the extended family relationships tended to be those between uncles and nephews and aunts and nieces as the gogos spoke about using aunts or their sisters to speak to the girls in their care and uncles with the boys in their care (15).

In many Sub-Saharan African countries the extended family, including grandparents and aunts, was regarded in some instances as sources of sexual knowledge and skills to adolescents (8). In South Africa, as reported by Delius and Glaser (2002), traditionally a number of cultures had guided adolescents through puberty and sexual development, relying on immediate and extended family, local groups and communities to manage this (36). However, due to changes in South Africa and these communities, extended family relationships were limited due to migration and apartheid (36). In South Africa, these communication structures have become compromised due to urbanisation and social change (36). So although in the past there was a culture of communication about sexuality in South African societies, the experiences of the gogos did not reflect this. Instead they demonstrated the “new” culture of SRH issues not being spoken about, or being spoken about with difficulty.

This study supports research by Armistead et al. (2014) that it has become imperative to examine the changes in family composition in sexuality education in South Africa (30). Soon et al. (2013), Armistead et al. (2014) and Santa Maria et al. (2015) have all commented on the importance of the extended family and caregivers other than parents (30, 32, 34). A number of the studies in the review conducted by Bastien et al. (2011) included terms like ‘guardians’, ‘other adults’ and ‘household’ members when discussing SRH communication, indicating the importance of the role of the extended family in the sexual socialisation of adolescents in Sub-Saharan Africa (15). The gogos

spoke about the need for support and shared responsibility in the raising of the children in their care and the loneliness that they experienced. They referred to their mothers, sisters and aunts and uncles as partners in SRH communication with children.

5.1.1.3 *Organisational/Community/Public Policy Level*

Many grandparents or senior members of the community, who take care of third or even fourth generation children, need support and help at organisational, community and public policy level with regard to this 'caring for grandchildren' role (17, 22). These multigenerational families are often marginalised from mainstream social, economic and political systems (17). Due to the challenges at community level, grandmothers and senior female members of the community are finding themselves increasingly having to take care of children whose parents are deceased or unable to care for them, regardless of their own personal ability, capacity, strength and financial resources (5, 7).

The gogos experienced significant difficulties in terms of access to government grants and financial support and government based care and follow-up. All of the gogos in the sample relied on government grants for income for childcare and there were a number of barriers to accessing these grants. These included the actual cost of getting to government facilities to apply for and collect grants; the laws and requirements regarding required documentation; the accessing and availability of these documents; clerical errors and administrative issues.

Perceptions of how to communicate about SRH issues were impacted by the gogos' personal experiences and growing up and perceived cultural norms. All the gogos spoke about the complicated and difficult conversations about SRH that they had experienced both from their parents and a t a school level due to normative beliefs and culture. These experiences of the gogos due to their adolescent experiences had translated into challenges and barriers to SRH communications as primary caregivers to third generation children. There was little evidence about speaking about actual sexuality and more evidence of speaking about avoiding sex and the risk of diseases. There was no discussion between the gogos about 'age appropriate or normative' adolescent relationships with the opposite sex or about sexual desire and attraction. Sex was spoken about as "naughty" and undesirable and to be avoided.

Due to the difficult context surrounding SRH communication, many gogos felt that schools and teachers should have the role of sexuality education through Life Orientation classes. In addition to schools taking on this role, a number of gogos wanted to leave SRH conversations to an independent

space like skills training workshops for the children themselves or combined skills training workshops.

5.2 Gogos' experiences of sex, sexuality and HIV and AIDS communication with adolescent and pre-adolescent children in their care

The gogos' experiences of sex, sexuality and HIV and AIDS communication with the children in their care at baseline was extremely limited and fraught with issues of lack of knowledge and poor self-efficacy which impact on a individual level in the ecological model. Although SRH conversations after the skills training workshop remained difficult and were still faced with a number of barriers, there was a shift in the gogos' understanding of adolescent sexual behaviour and their confidence and acceptance regarding these conversations and the need to hold them indicating a change in the individual and interpersonal levels. Very little change was experienced at the community, organisational and policy levels which was to be expected as this was a personal and interpersonal-based intervention.

5.2.1 Barriers to SRH communication between the gogos and their grandchildren

5.2.1.1 *Individual level barriers*

According to previous research, mothers reported that their own learning experiences of sexuality based on conversations with their own mothers had not been 'meaningful' (44) and that they were mostly 'negative', and focussed on warnings and rules (45). Additional research found that learning about sex and sexuality as children often occurs in terms of negative messaging and threatening terms (46). Not only had the gogos in this study experienced SRH conversations with their own parents that were negative and punitive, they had found themselves as parents in the same types of negative conversations with their own children, and now as grandmothers or gogos, speaking to pre-adolescent and adolescent children about sexual health and sexuality. Although the research is reasonably old from 1993 (45) and 1997 (44), it is interesting to note that this phenomenon of SRH communication has remained the same up till now. Although all the women in the sample interviewed talked about their personal experiences of the limited communication about sexuality between themselves and their own parents, this is group of gogos was prepared to try and change this in the interests of protecting their grandchildren.

After a study conducted by Limaye et al. (2012) in Malawi, it was reported that parents felt inadequate and expressed how they "did not know" what to say about sex and sexuality due to limited skills on how to talk about this topic, in addition to limited SRH knowledge (40). These

Malawian parents expressed and showed a need on how to have these conversations which was also exhibited by the gogos in the sample from Alexandra. The gogos wanted educational and skills building sessions to develop self-efficacy regarding SRH communication.

Before the skills training workshop, the majority of gogos expressed how difficult the topic of sex, sexuality and HIV and AIDS would be to talk about with their grandchildren to the extent that most of them had never addressed it with the children in their care. After the skills training workshop, all the gogos expressed feeling more able to discuss SRH issues with their grandchildren. Although different levels of comfort were experienced by the gogos, there was a general improvement in the confidence and perceived ability of and the need for gogos to speak to their grandchildren about sex, sexuality and HIV and AIDS.

5.2.1.2 *Interpersonal level barriers*

A number of gogos mentioned how their parents had not spoken to them about sex when they were growing up as they feared the sexual discussion and knowledge would lead to sex. Although research found that parents feared speaking to children about sexual behaviour as this would promote sexual activity (15, 43), a study by Cornelius et al. (2008) found that grandmothers did not fear that talking about sex would promote sexual behaviour by their grandchildren and these grandmothers in fact embraced the idea of talking to their grandchildren about sex (22). Conversations with the gogos in this study are consistent with this research as no mention was made by the gogos in this study that this fear was a barrier for them to have sexuality communications with their grandchildren or children in their care.

SRH communication in Africa is difficult as many communities regard puberty and sex and sexuality conversations as taboo (15). Traditional values and cultural norms are seen by the gogos as barriers to open conversations about sex. These included perceptions by the gogos that sexual behaviour was a 'naughty' thing. The gogos had experienced very limited conversations whilst growing up which often contained misinformation if they occurred at all.

This difficulty about discussing issues related to puberty, sex, sexuality and HIV and AIDS continued as the gogos continue to face the same barriers when speaking to third generation children in their care. The personal adolescent experiences of sexual health learning of the gogos resulted in all the gogos expressing their lack of confidence and ability to acknowledge, confront or discuss the difficult and uncomfortable topic and issues of adolescent sexual behaviour. This supports the literature view that parental involvement in sexual communication is a new notion for South African families (30). The fact that only one gogo had had any HIV training exposure before this skills training workshop

supports research that very few programmes target grandmothers with most studies looking at traditional mothers.

5.2.1.3 *Community Level barriers*

According to research on adult–child HSH communications by Bastien et al. (2011) and DiIorio et al. (2003) the gender of the parent and the child appeared to play an predominant role for both the parent and the child in whether SRH discussions took place (15, 42). Women tended to speak to girls and men tended to speak to boys (15, 42). The gogos themselves did not express preferences related to which gender child they spoke to but they did comment on the fact that it was the social norm for men to speak to boys and for women to speak to girls. This cultural practice in reality made things difficult for gogos to speak to boys. Although the gogos were prepared to try and speak across gender, they expressed that they just did not know how to do this.

The feelings of the grandchildren were not collected in this study, but it is possible they would also prefer to speak to the same gender as conversation between boys and gogos often deflected to school as source, dismissing the gogo.

The 'generation crash', referred to by Wijngaarden and Schaeffer (2005), was mentioned by a number of gogos (27). This intergenerational conflict is also discussed by Nyasani et al. (2009), who examined the experiences of grandparents providing care to grandchildren in Richards Bay (8). In Nyasani's et al.'s study, grandmothers identified problems with child discipline and disharmony in the intergenerational relationship between themselves and the grandchildren they were fostering (8). These same issues were experienced by the gogos in the sample and added to the problems and barriers around HSH communication between gogos and their grandchildren.

The research by Nyasani et al. (2009), showed that skills and knowledge sharing between the different generations could reduce intergenerational conflicts, resulting in improved family relationships (8). A number of grandmothers in the study wanted to have skills and knowledge-based skills training workshops for both themselves and the adolescents both separately or jointly. They felt strongly that this would result in improved knowledge and trust between the gogos and the grandchildren, as the source of the content regarding SRH was common.

5.2.2 Enabling factors for SRH communication

As a result of the research conducted by Bastien et al. (2011), a number of aspects were identified to promote and facilitate communication between adults and children (15). These included the type of content, triggers for communication, the manner of communication and the levels of comfort experienced by the parents in talking about sex, sexuality and HIV and AIDS (15).

5.2.2.1 *Individual level enablers*

It was demonstrated in this study, as after the skills training workshop, the gogos expressed the perception that they had the confidence, knowledge, and ability to have SRH conversations with their grandchildren. An increase in self-efficacy has been shown to result in increased SRH communication (32, 39). They also felt as though they were doing the right thing to have these conversations and, in fact, had even been given the 'permission' and had been 'told' to talk about it. This enabled them to embrace the idea about overcoming taboos and personal and cultural proscriptions about talking about sex.

The results of this study are consistent with the findings by Brown et al. (2000) that African American grandmothers are unprepared to discuss topics regarding sexuality and sexual health with their grandchildren (19). Findings in research by Cornelius et al. (2008) that grandparents require assistance with sexuality communication with their grandchildren (22) are supported by the expressed feelings of the gogos in the sample. Cornelius et al. (2008) found that grandparents are receptive to discussing sex and sexuality with their grandchildren but experience different levels of comfort in these conversations (22). For some gogos in this study, talking about SRH issues was easier than for others as personal experiences impacted on self-efficacy and confidence. Many parents are from a generation where discussing sexuality topics linked to embarrassment (15, 42). This was supported by this study with the gogos expressing discomfort regarding this topic.

5.2.2.2 *Intrapersonal level enablers*

According to Soon et al. (2013) adolescents are looking for guidance regarding SRH communication that goes further than abstinence and peer-based information (34). Traditionally, communication about sexual health and behaviour tends to be uni-directional and top down from the adults to the child (15). In addition, according to research done by Soon et al. (2013), adolescents are looking for bi-directional SRH information from close adult role models that deals with the actual realities of adolescents and adolescent sexual behaviour and that is not based only on adult expectations on abstinence (34). Although this study did not examine the expectations and desires of the grandchildren regarding what they required from SRH communication with their grandparents, it became apparent from the interviews with the gogos that the grandchildren responded positively to a more bilateral conversation than an authoritative and prescriptive discussion.

According to a review of studies of parent-child communication about sexuality in Sub-Saharan Africa conducted by Bastien et al. (2009), common topics spoken about between parents and children include HIV and AIDS, the use of condoms, abstinence, the role of peers, 'sexuality issues', and "sexuality matters (38, 42). In research conducted by DiIorio (2003), menstruation,

reproduction, birth, pregnancy, HIV and AIDS and sexual values are spoken about (42). Both Bastien and DiIorio report that topics spoken less about included termination of pregnancy and wet dreams, erections and masturbation (38, 42). According to DiIorio (2003), many parents found it difficult to acknowledge and accept adolescent sexuality (42).

These findings were reflected in the responses in of the gogos in Alexandra. One of the gogos in the sample spoke about her granddaughter having had a baby and that she had asked the granddaughter to "keep" the baby and that she, the gogo would look after the baby. There did not appear to have been meaningful conversation about abortion and the options available to pregnant teenagers. There was no reference made by the grandmothers to masturbation or even possible enjoyment of sex and sexuality.

Triggers for SRH communication need to be useful and frequent (38). According to Bastien (2009), triggers included examples of family infected, radio programmes, flyers, and parental perception over risky sexual behaviour (38). Also mentioned as factors associated with sexuality communication were urbanisation, the perception that the age or time was right to discuss SRH topics and that the children were ready to learn and the SRH knowledge and self-efficacy of the parents (38).

The data collected in this study is supporting of these findings conducted in previous research. Only one gogo had had any HIV training exposure before this skills training workshop and she had not 'known' how to transfer this information to her grandchildren. A number of the gogos referred to it "being time" to speak to their grandchildren about sex, sexuality and HIV and AIDS. This was related to the gogos acknowledging the growth or growing up of their grandchildren due to them entering adolescence and the physical changes this was bringing. However, due to varying levels in the sense of discomfort experienced by the gogos, the conversations had not yet taken place. The death of parents from AIDS was another trigger for the gogos for HIV and AIDS conversations.

The communication style and tone of discussion used in sex and a sexuality conversation is a significant facilitator or detractor for increased communication between parents and their children on this topic (15, 42). Parents need to be taught how to talk to their children. This can be addressed through skills training workshops and interventions. The gogos felt empowered and enthused by the skills training workshop. Improved communication leads to an improved parent-child relationship that contributes to healthy parent-child sex communication (46, 61). According to Bastien (2009) and Armistead et al. (2024) the comfort levels of the parents when speaking about sex are important in promoting SRH conversation between adults and children (30, 38).

5.2.2.3 *Organisational/community level enablers*

As Cornelius et al. (2009) has reported, there is a pressing need for interventions to facilitate sex and sexuality communication and shared communication between parents and their children (22). The grandmothers in the Cornelius et al. (2009) research expressed their desire to attend skills training workshops and to get support from each other and the difficulties of being and feeling alone (22). These attitudes were reflected in responses to gogos in Alexandra by their coming to skills training workshops knowing what the content would be and what a difficult and taboo topic it is and wanting more skills training workshops and interaction. In addition, according to Cornelius et al. (2009), grandmothers were more positive about this type of discussion than their grandchildren (22). The dismissive responses from their grandchildren that many gogos experienced when trying to talk about sex, sexuality and HIV and AIDS further support the results of the study by Cornelius et al. (2009) (22).

Research conducted by Aubel (2005) showed that the concern that grandmothers might be biased and unable to adapt to modern practices and new ideas as a possible reason that interventions did not make use of older people as drivers in community and family-based interventions (2). This stereotype of grandmothers as being conservative and resistant to change, appears unfounded and not a cause for concern in this study. The gogos showed they were interested in increasing their knowledge of current and new ideas about child development, in particular sexuality, through their strong commitment to the growth and future of their grandchildren. The 'future', in particular future opportunities for their grandchildren as a result of good and completed education, was seen by the gogos as something to focus on and aim for.

A number of gogos referred to the role of the extended family, the church and the wider community played in supporting gogos in SRH conversations with their grandchildren. This finding supports research by Aubel (2005) that interventions need to acknowledge the role of the strength of communities, families and social structures already present in the community- church, uncles, aunts, older siblings, other older women in community (2).

5.3 Do gogos count as parents

The gogos in the sample provided care and parenting to the children they looked after. In addition, they appeared to love and care deeply for the children they looked after and many regarded them as their own children and treated them as such. The commitment of grandmothers to the well-being of their grandchildren, identified in the 2005 USAID report (2), was supported by this study. The gogos

demonstrated a strong commitment to the children in their care whether they are blood relations or not. The gogos had influence in the emotional, intellectual and physical well-being of the grandchildren and a strong commitment to their safety. This was evidenced in the care they provided; their focus on schooling and belief in education; their attendance at the skills training workshop to deal with a particularly difficult and complicated topic and the fact that the gogos in the sample were prepared to suspend their cultural practices and beliefs regarding what they perceived to be normative sexual education and behaviour to embrace a new approach of open communication to SRH issues.

The gogos are aware of parenting issues and current and social issues affecting their grandchildren. They are in the main, pragmatic and open minded about the current realities facing them and their grandchildren. The grandmothers spoke easily about their relationships with the children in their care. This supports the view taken by Aubel (2005) about expanding the traditional parent-child dyad used in interventions to include grandmothers and older women in the community (2). The results of this study support the findings in Armistead et al. (2014) and Soon et al. 2013 that families present an opportunity for HIV prevention among South African youth (30, 34). As was demonstrated in the research by Armistead et al. (2014) 31% of 'parents' raising children in their study were actually not biological parents supporting statistics that large numbers of children being brought up by adults who are not their parents (30, 34). In this study, 20% of the gogos were in fact biological grandmothers.

Research by Armistead et al. (2014) shows the importance of including grandmothers and other child-caring adults in interventions which help lower HIV incidence in youth (30). As evidenced by the care-giving role of gogo in this study, and their time and commitment to bringing up their grandchildren and their embracing of dealing with the difficult topics of sex, sexuality and HIV and AIDS, this study supports the position in research by Armistead et al. (2014) that intergenerational social networks show promise in the reduction of HIV infection (30).

5.4 Sources of information about SRH issues

According to the gogos, they and the pre-adolescent and adolescent children that they looked after, used and relied on a number of sources for information on sex, sexuality and HIV and AIDS.

5.4.1 Role of gogos as advisors

A number of responses of the gogos supported the findings of Aubel that the gogos felt that their place in society, community and families as 'advisors' in child development was being 'diminished'

(2). Church and school in particular were regarded as important sources of HSH information. Other members of the extended family or community regarded as reliable were also used by the gogos to help HSH communication. The role of peers, although often mentioned, seemed to be more in a behavioural sense rather than as a source of sex, sexuality and HIV and AIDS information. Peer pressure to behave in a particular way was regarded by the gogos as undermining their role as "parent' to the grandchildren.

5.4.2 Role of school

Life Orientation as a subject has been introduced as part of the school curriculum in South Africa. This provides an opportunity to introduce topics of negotiating relationships, sex, sexuality and HIV and AIDS. Most of the gogos in the sample had to deal with responses from their grandchildren on how they had already learnt about sex and sexual health issues at school. Many grandchildren used the fact that they had learnt about this "already" at school as a reason not to have to discuss it further with their gogos. However, it is not clear if these responses from the grandchildren are excuses to avoid an embarrassing topic or if they are genuine opinions of established knowledge. According to the grandchildren, they had learnt about menstruation, puberty, sex, condoms and pregnancy at school.

According to Soon et al. (2013) despite widespread exposure to HIV prevention messages for adolescents in South Africa, adolescent vulnerability perception is low (34). Since the majority of South African children attend school and therefore attend life orientation lessons, there must be a breakdown in messaging between Life Orientation instruction and translation into practice and behaviour change. Further support is needed from parents (34), and in this case, gogos.

The majority of children have HIV and sex education at school and some programmes have tried to reach parents through students and school programmes where parent classes are aligned with students' sex and HIV classes (32). In addition, school homework assignments in sexuality and HIV education which are to be done at home with parents and children, as well as tertiary sexuality classes for adults, have shown an increase in adolescent-adult sexuality communication (48).

5.4.3 Role of peers

The gogos did not tend to identify peers as a main source of HSH information for their grandchildren despite research by Bastien et al. (2011) and DiIorio et al. (2003) which found that adolescents prefer to discuss sexual issues with peers, due to embarrassment and shyness in front of their parents (15) and that peers have been identified as significant sources of sexual socialisation and information (42). Only one gogo commented on peers as a source of sexual information directly for

her grandson, saying that she expected her grandson to learn about sexual information from his friends.

However, peers were seen by the gogos as problematic in terms of the influence and impact of their behaviour on their grandchildren. As reported by Delius and Glaser (2002), although traditionally the role of peers and peer groups was the most powerful influence during the pubescent stage about sexuality managed through peer pressure and initiation, these cultural and traditional practices sexuality learning collapsed in the 1950s in urban areas (36). As a result, peers began to learn from each other without cultural practices, resulting in changed sexuality and sexual behaviour with sanctioning against pregnancy, sexuality and sexual behaviour becoming non-existent. Parents were working and spending time away from home (36). The gogos felt that their grandchildren were susceptible to peer pressure. A number of grandmothers commented on the negative role of friends and this was often linked to the gender of the grandchild and the friends.

Gogos felt that their granddaughters were often led astray by peers resulting in them going out late at night and not coming home from school in the afternoons to do school work or on time due to the influence of girlfriends. Girl friends were regarded as a source of 'trouble' and the gogos tend not speak favourably of their granddaughter's friends.

The friends of grandsons were seen both in a positive and negative light. One gogo commented on how her grandson's friends who were involved in sport were regarded as positive influences and soccer was a positive friends-based activity. However, male friends were also seen by one of the gogos as possible negative influence on the grandson's school work as the gogo felt her grandson was trying to be like his peer group and this was distracting him from school.

5.4.4 Role of older males in sexual health conversations with pre-adolescent and adolescent children in their care

The role of male relatives or grandfathers did not emerge as a theme in this study. Some of the gogos spoke about the need for men to talk to boys about sex, sexuality and HIV. Even before the impact of HIV and AIDS, in most African communities, grandfathers or male elders have not traditionally been responsible for caring for grandchildren (2, 7). This practice has continued into the present situation with senior female members of communities carrying the responsibility of caring for children in a primary care giver capacity (2, 5-7). This was supported in this study where only one gogo referred to a male partner. It must be noted also that the study did not specifically look at the role of grandfathers or senior men in the community. This is not to say that older males or fathers do not have a role to play in safer sexual behaviour and choices of their children.

5.4.5 Role of the church, other family and community members

Church was regarded as a reliable source of SRH information by the gogos. In the literature reviewed, the role of the church was not regarded as significant other than in research by Cornelius et al. (2008)(22). This research conducted using five churches from which to recruit participants and looked at whether churches would be good venues for SRH programmes and the development of a 'church-based' sexuality programme. The participants felt that churches could be used as such and churches needed to develop programmes for grandmothers and their grandchildren to facilitate SRH conversations. The gogos felt that churches and church groups played a positive role sharing in SRH information with their grandchildren and were happy for their grandchildren to learn about these topics through the church. In fact, some gogos sent their grandchildren to the church for this purpose, yet no gogo mentioned the role of the church in their personal SRH conversations with their grandchildren.

5.5 Perceived impact of 'GOgogoGO' skills training workshop

Although a number of gogos were lost to attrition at the post skills training workshop interview phase, the feedback on the skills training workshop was positive. All the gogos welcomed the skills training workshop and its content, even though this content was seen as taboo and difficult to talk about. Most of the gogos in the sample experienced positive outcomes in terms of the possibility for improved communication about sex, sexuality and HIV and AIDS with the children in their care. All the gogos, in both the focus group discussion and the post-skills training workshop in depth interviews, expressed improved feelings of empowerment and self-efficacy in communicating with the children in their care about sex, sexuality and HIV and AIDS. Three gogos did actively take steps to change their sexuality communication patterns with their grandchildren following the skills training workshop. This took the forms of increased conversations, discussions, providing condoms and sharing of the book. Two gogos voiced concern regarding their grandchildren's ability to understand the complexities of the concept of sex at their current ages. However, both these gogos acknowledged the importance of sexuality conversations and suggested ways (additional and separate skills training workshops for the grandchildren) for their grandchildren to facilitate sexuality communication between themselves and the children.

5.6 Feedback and thoughts on the skills training workshop "GOgogoGO"

All of the gogos enjoyed the skills training workshop and regarded it as a learning experience. The gogos felt empowered after the skills training workshop and felt able to go and talk to their grandchildren. They experienced relief after the skills training workshop. However, in line with research conducted by Kirby and Miller (2002), single session workshops for just a single target group are possibly the weakest design to facilitate the aim of improved sexuality communication between parents and their children(48).

The gogos' comments and suggestions on the skills training workshop indicated their feelings about the skills training workshop. Although it was enjoyed and viewed as a positive experience, the gogos felt that changes could be made to make this skills training workshop more effective. Their suggestions were in line with research by Kirby and Miller (2002), Santa Maria et al. (2015) and Eastman et al. (2006) that multi session workshops that include both sessions for adults and children where the most successful (32, 48, 49). The gogos expressed a desire for the grandchildren to attend their own skills training workshop so they could be given the same in formation as the gogos - making them less 'suspicious' of the gogos' knowledge. There was some discussion about a shared skills training workshop with the advantage of these being due to the fact that they result in immediate increased and open communication as everyone knows that they are expected to be talking about sex, with some gogos expressing reservations to this idea.

The gogos expressed the need for additional training sessions and joint sessions. They felt that although their personal knowledge about HIV and AIDS and adolescent sexuality had been increased, they still felt the need for the grandchildren to attend their own skills training workshop to complement and support their own increased knowledge. Self-efficacy regarding having sexuality conversations was greatly improved after the skills training workshop but the gogos felt there was still space for more skills building.

Different types of programmes have been designed and implemented in attempts to reduce adolescent sexual risk behaviour. Research conducted by Eastman et al. (2006), Bastien et al. (2011) and Kirby and Miller (2002) concluded that interventions using parents to promote sexuality communication with their children can be successful in a number of areas (15, 48, 49). The outcomes of this communication might vary from intervention to intervention, and not always be the main general aim of promoting safe sexual behaviour, but none of the interventions experienced negative outcomes. The skills training workshop experienced by the gogos supported the position of Kirby and Miller (2002) about the importance of working with parents, in this case, grandmothers and other caregivers (48). As reported by Eastman (2006), there is the possibility of more long term

effects in adolescent behaviour change as a result of training parents but that one day interventions are probably too short (49). This point was supported by the gogos who felt they would have liked further training for themselves, in addition to skills training workshops for their grandchildren.

Although Hamrick (1985) had identified training of adults and children together as the most effective way to increase parent-child communication (52), some gogos felt that a joint skills training workshop between themselves and their grandchildren could be an option but other gogos felt that combined sessions would not work as the two groups would not speak openly in front of each other or indeed, participate.

The medium of a hard copy of a book was well received by the gogos. Although research by Santa Maria et al. (2015) identified a possible problem with resource heavy i.e. book- bound interventions because of the cost of books and multiple face to face sessions (32), this did not seem to be an issue with the gogos. They liked having a book to take home and enjoyed the idea of the possibility of sharing the book with the children in their care. The possibility of using computers and Internet as a workshop forum as suggested by Santa Maria et al. (2015)(32) was not looked at but all the gogos had cell phones and some had smart phones. This could provide an opportunity to expand the programme and training though SMS, WhatsApp and other cell phone based technology in the future as this communication method is easily accessible in low-income households, as evidenced by research by Santa Maria et al. (2015) (32) and the personal experiences of the gogos.

The attrition in the sample experienced in trying to get follow up interviews could possibly be indicator of difficulty facing repeated skills training workshops - weather, home commitments, health are especially big issues with older women, also they are primarycaregivers so could not come if a child was sick or on school holidays or at home. Eastman's research on workplace based multiple sessions had the advantage of facilitating retention and recruitment points that made matters easier, but gogos Thursday regular attendance was still problematic.

5.7 Limitations

There were a number of limitations with this study that need to be considered in light of the findings. These include attrition in the number of participants from baseline to follow up interviews, the collection of data and the role of the researcher. The researcher is female, white, middle class, a Masters student at a tertiary institution and has independent links to Ratang Bana. These attributes of the researcher did not impact on aspects of the data collection as the data was not collected by

the researcher herself but by the primary data collector. However, the researcher acknowledges that her interpretation of the findings and the coding of data could have been affected by these attributes in the following ways: the researcher is already aware of the difficulties experienced by the participants; the researcher is sympathetic to parenting issues and motherhood and care giving being the mother of adolescent children herself, and the researcher already had established relationships with some of the participants prior to the commencement of the research.

The researcher is of the opinion that social desirability in the responses given by the participants was not a limitation as the data collection was not conducted by the researcher herself. It is possible that recall bias did occur as the skills and content that the grandmothers had learnt from the workshop may have faded by the time post-intervention interviews were held as the post intervention interviews did occur over a longer time frame than anticipated. It should also be noted that the findings may not be transferable to other grandmothers or older caregivers in Alexandra but may be transferable to other grandmothers and older caregivers in a similar context.

It proved be difficult to collect data from all participants over the two-three months of follow up. It was hoped that all participants would be available a three time points- baseline in depth interviews, the focus group discussion after the skills training workshop and the in depth interviews a few months after the skills training workshop. Not all participants took part in all three sessions with only six of the sample interviewed at baseline attending the skills training workshop and therefore being eligible for the focus group discussion post the skills training workshop. Attrition was also experienced by the end of the research as five of the original ten participants were not available for the second in depth interviews due to them leaving Alexandra or no longer being part of Ratang Bana and not wanting to participate in the third round of interviews.

It proved to be more difficult than expected to collect data. Numerous trips and meetings and locations were scheduled in an attempt to collect data. The narratives collected during the in depth interviews at both baseline and post skills training workshop were rich and extensive. The discussion in the focus group was not as deep, but provided a commentary by the gogos about the skills training workshop itself.

In addition, the participants all came from the same centre, Ratang Bana. This could have resulted in the gogos either being embarrassed to share intimate details with each other in the focus group or in them sharing a common understanding of the issue being researched and limiting individual expression.

Another possible limitation was the direct link that the researcher has to the book, *HIV & AIDS*. She is a work partner and close friend of the author, Marina Appelbaum. She was involved in the content editing of the book during its writing; she is responsible for sales, marketing and distribution of the book and she conducts training in a number of environments using the book to facilitate communication about sex, sexuality and HIV and AIDS. However, the researcher remained cognisant of this during the research, the data analysis and interpretation and feels that a reflexive interpretation of the data occurred.

Chapter 6: Conclusion and recommendations

6.1 Conclusion

There are a number of reasons, as highlighted by this study, why older people in the community become primary caregivers for young children, including the death or absence of parents. Many of the grandchildren being cared for by the gogos in this study were being cared for by someone other than a biological parent due to the impact of HIV and AIDS. Older women who have very limited resources often fulfil this caregiving role. Consequently, they need to receive support for this role.

Communication between parents and their children has been shown to promote safer adolescent sexual behaviour and choices and this can result in a lower HIV incidence in a particularly vulnerable South African group - youth between the ages of 15 and 24 (9). Since many senior members of the extended family are bringing up third generation children due to the significant loss of parents in South Africa because of AIDS, these older caregivers need to take on the role of sex, sexuality and HIV and AIDS communicators in place of parents.

This research has demonstrated that future programme to improve the sexual health outcomes of children and adolescents should look at accessing the social capital and the capacity of older caregivers in order to promote increased SRH communication between adults and children. In spite of a number of contextual and personal barriers, the gogos in this study actively embraced the concept of talking to their grandchildren as a means to facilitate safer sexual choices in these pre-adolescents and adolescents.

Programme working with older caregivers need to consider their, health, access to finances and support and psycho-social and administrative stressors. While not all of these stressors are particular to being older, for example, trying to access government childcare grants is an issue that caregivers and mothers of all ages face in South Africa, the aspect of being older makes so many of these stressors much more difficult and complicated. These gogos are tired - some of them have been looking after children for 40 years and yet they continue to do so with commitment and passion. They are faced with a 'double' generation gap; they are often dismissed as out of touch and 'old' by their grandchildren; they are faced with competing behaviours, attitudes and pressures from their grandchildren's peers and they often feel alone and heavily burdened by this second round or even third of parenting. In addition, they have to deal with and manage their personal grief and loss over losing their own children, in addition to managing grandchildren who are experiencing their own suffering and pain at having lost their parents.

These gogos are faced with limited resources, in particular, limited finances. South Africa has a system of state-funded policies to alleviate and address childcare financial stress in the form of Child Support Grants of R800 per child and Foster Child Grants of R260 per child. In addition, many of the gogos are entitled to Grants for Older Persons of R1250 per month. However, accessing these grants in terms of administrative paperwork, requires documentation, meeting the necessary criteria and going to Home Affairs offices to apply for these grants is a huge challenge for the gogos.

Although the gogos were enthusiastic about the need for SRH conversations, talking about sex, sexuality and HIV and AIDS remains extremely difficult for older caregivers. The gogos expressed their discomfort, anxiety and lack of knowledge and skills regarding addressing this subject with their grandchildren. This was due to historical and cultural practices where these types of conversations were regarded as taboo and unacceptable. Sexual knowledge and practices were traditionally shared through established peer group structures, which relied on intact family and community structures.

The gogos in this study, although lacking in confidence and self-efficacy before the skills training workshop to speak to their grandchildren about SRH issues were pragmatic and open-minded about the need to do so. The reality of the impact of HIV and AIDS on their own children and extended family and their experiences of the loss and suffering that this had caused to themselves and the children that they now cared for was a stimulus for them to overcome the cultural norms and taboo of not talking about sex and sexuality with children. This resulted in them being prepared to look for a way to deal with this topic openly and effectively with their grandchildren.

The GOgogoGO skills training workshop was successful as a space in which to demystify and open up the concept of talking about sex. The gogos enjoyed the skills training workshop and felt empowered by the content and training and they felt they could address SRH issues with their grandchildren after the training. The majority of gogos attempted to do so. Some attempts were more successful than others. The skills training workshops also filled knowledge gaps among the gogos themselves.

The gogos made suggestions on how to improve the skills training workshop and the outcomes of the training and these should be considered in future intervention designs. A number of gogos felt that one skills training workshop was not sufficient and that training only the gogos and not the grandchildren was not enough. There was a general feeling that the grandchildren remained ‘suspicious’ of advice from the gogos and felt more comfortable with information they had received from school. The gogos felt that by including the grandchildren in the training and interventions, they would be more receptive of information from the gogos.

6.2 Recommendations

There are a number of recommendations that have arisen as a result of this research. Programme need to start identifying other spaces to open up regular communication outside traditional mother or father/ child dyads (2). The gogos demonstrated the characteristics identified in the USAID report, as those required to make them effective and active key role players in sex, sexuality, HIV and AIDS communication skills training. They were prepared to take on new content and behaviour; they did not fear leaving traditional and cultural approaches behind them; they appreciated the need for changed behaviour and had the perceived self-efficacy to do this and to use their existing social capital within the community and households to promote communication (2).

This research supported the findings of the USAID report (2005) that the term "grandmothers" can be extended to include a varying group of older or senior women caring for second generation children (2). Future projects and research needs to work with this reality and not exclude itself to the role of biological grandmothers. All older female caregivers are very important resources in the community. New intervention methodologies to work with these senior women need be designed in order to improve and support the role of these women. New intervention frameworks need to look at the social context and experiences of the older caregivers; their roles and relationships in the households that they run that influence attitudes and practices related to raising third generation children.

6.2.1 Increased support for older caregivers

Future studies and research needs to look at ways to support these grandmothers and senior men and women in the community. The gogos needed support and it is of significance to understand the whole experience of the gogos in order to look at how to improve and facilitate SRH conversations in the older caregiver-child dyad. The demand for the care and support of these children is often overwhelming for older child carers, resulting in increasing poverty as a result of medical and funeral costs in addition to the loss of labour faced by the family. This urgently requires these carers to receive greater financial and emotional support (1).

Increased value needs to be placed on the grandparents or older caregivers. They require, and should be entitled to, improved support, access to education, training, finances, grants and personal health care. Healthier older people live longer and perform better as care givers. Therefore, older caregivers in the community, regardless of whether they are related by blood or not to the children in their care, need to be recognised and the stress that this role brings to them needs to be acknowledged. Improving the capacity of the family unit and general wellbeing of the household members can reduce intergenerational dependency between grandmothers and grandchildren.

6.2.2 Improved healthcare

Grandmothers need to have easier access to healthcare for themselves. This can include physiological wellbeing as well as psychological wellbeing. The gogos at Ratang Bana are part of a community-based organisation that offers them support. This support is mostly in the form of food packs but could be extended to healthcare, including monthly visits from primary healthcare facilities to see grandmothers about specifically age related illnesses and poor health. Age related illness like arthritis, hypertension and diabetes can usually be managed relatively easily and if this is done and monitored at Ratang Bana, this would free up time in state clinics and time for the gogos to perform other tasks related to child rearing.

Sessions based on parenting, intergenerational skills and communication skills, especially with regard to SRH are needed to improve outcomes for these older caregivers. The gogos spoke about the 'generation crash' and how this resulted in them often being ignored or dismissed by their grandchildren. Skills training workshops acknowledging this at Ratang Bana, and facilitated by social workers with training in third generation parenting, will contribute to make the psychological stress of the grandmothers less.

6.2.3 Easier access to financial assistance

The accessing of government grants is a huge source of stress and anxiety in grandmothers. Government policy needs to look at ways to make accessing these grants easier, more possible and less onerous. With a large amount of population data now being managed on and entered into computerised records, it should be possible to reduce 'hard-copy' proof and requirements in the form of printed certificates. A number of possibilities exist here:

Clarify perceptions in government offices and for the gogos on the perceived requirement that the death certificates of both parents are needed. Applicants for grants should only have to produce the death certificate of one parent with an affidavit as to the death or absence or inability to earn of the other parent. This affidavit could be from the police supported by documents from a priest, the funeral parlour, bank, employer, church, police.

Lower the pension age requirement of older people who are caring for orphaned or vulnerable children or increase the childcare grant. Many caregivers depend hugely on their pension, due at 60, to help raise their grandchildren due to the pension amount being higher than the child grants. A large number of older caregivers of third generation children are in fact not yet 60 and are waiting to turn 60, yet are caring for children and need these funds.

6.2.4 Increase the childcare grant for unemployed caregivers of children.

Make accessing Home Affairs to receive these grants easier, less time consuming, less in costs like transport and opportunity costs and more efficient resulting in actually issuing of grants. This can be done by monthly visits by the Department of Home Affairs to places where older people meet-stokvels, community organisations (like Ratang Bana), churches, schools where the Department can facilitate grant applications and the provision of missing documentation, especially in instances where the required documents are in another town or province.

Ensure that identification and records of the caregiver are in order, facilitating age related or disability related pay outs.

6.2.5 Government policy

Changes in government policy and programme development, relating to older people in general and older caregivers, male and female, need to occur. Further research needs to be conducted in order to address the government systems' issues raised by this research. Government, in particular, needs to look at addressing factors that impede successful care giving. As stated by a grandmother delegate at the Grandmothers Tribunal in Vancouver in 2013, government "needs to start talking with us…, more, so they know what the real problems are." (p18) (1).

6.2.6 Additional income

Grandmothers need more income security. There is a need to look at projects to stimulate income generation and increased income for grandmothers in addition to government grants. Many older caregivers are not debilitated or incapacitated by age and are still able to work. As a result of this thesis project, an income generation project was set up at Ratang Bana for caregivers. This project involves the making of blankets to be sold. It has resulted in an increase in income for the individual blanket makers of between 50-200%. In addition, a portion of the funds raised by the blanket makers is given to Ratang Bana, resulting in the improvement of the support and facilities offered by Ratang Bana to the community. This has also resulted in the blanket makers being able to 'give back' to Ratang Bana increasing self-empowerment and less of a sense of dependency

6.2.7 Listen to the older caregivers

Many past child development programmes have focused on the child-mother dyad. Grandmothers and older caregivers need be involved in the research, design and creation of programme. Projects need to engage grandmothers in the design and delivery of community-based care. The experience of older caregivers varies greatly from that of younger caregivers and by talking to and listening to

grandmothers, it is possible to acknowledge the individual age-related differences in experiences between parents and grandparents.

This can be done by conducting research into the experiences and acknowledging the huge role played by older caregivers in raising third generation children in South Africa, and globally, today. Information can be collected by holding meetings, interviews, discussion groups at community organisation, churches, stokvels and other already established meeting places for older people. Asking and listening to grandmothers' responses are needed before designing programme based on the more traditional mother- child dyad.

Successful programmes need to make use of the existing strengths of communities, families, and social structures, including grandmothers or caregivers who are not biological parents, in order to provide the best for children. By implementing strategies aimed at caregivers other than parents, the children's and the caregivers needs are best going to be met, resulting in more effective child caring and less stress.

6.2.8 Schools

The majority of these children should be at school. A number of gogos in the research commented on the role of school in SRH awareness with their grandchildren. As a result, schools need to look at a way to work with the children, the teacher and the grandmothers to facilitate HSH communication and not to shut it down or dismiss it as experienced by a number of the gogos in this sample.

This can be done through school-based interventions aimed at including and working with grandparents. Talks can be given at schools to grandparents, allowing them to become familiar with the Life Oreintation (LO) curriculum and the content shared at school. Teachers need to be alerted to the fact that such large numbers of children are being raised by grandparents or older caregivers and the issues that could arise for children from this.

6.2.9 Clinic access and support

Only two grandmothers in the sample mentioned state clinics and access to primary health care for their grandchildren. Clinics need to become more adolescent friendly and receptive to treating youths. There could be a specific project consisting of weekly afternoon sessions focusing in particular on adolescent healthcare, SRH communication and information and adolescent counselling. There needs to be a positively viewed relationship between caregivers, clinics and adolescents, rather than one of distrust and distance.

Clinics and community organisations can also set up skills training workshops on resisting peer pressure and emotional support groups for orphaned and vulnerable children. The grief and stigma experienced by orphaned children need to be addressed.

6.2.10 Skills training workshop recommendations and future interventions

Although the GOgogoGO skills training workshop was enjoyed by the gogos, their feedback and suggestions can be used to make changes in the skills training workshop format. Future skills training workshops could either look at a joint once-off skills training workshop with both grandparent and grandchildren attending or at two or three skills training workshops with a single separate skills training workshop for grandparents and grandchildren and followed by a joint skills training workshop.

Due to the fact that all the grandmothers had cell phones, cell phones could become a medium for intervention follow up and support. Support groups could be in the form of chat rooms using mixit and group chats using WhatsApp.

Development agencies and staff need to acknowledge that biases against grandmothers related to age and their perceived inability to learn new things and resistance to change are not fair or reasonable. Models for programme need to be designed, specifically for communities recognising the important role of elders in these communities. Globally, families and communities acknowledge the important and influential role of grandmothers in the development and growth of children. However, education and behaviour change interventions especially relating to SRH topics and conversations have not given this role the consideration it deserves in terms of using grandmothers or elders as key actors in these projects. Future programme and interventions need to look at using a systems approach in the programmeme design. This should involve an assets-based approach respecting cultural structures, the roles and values of the older caregivers as a keystone for programme design, respect for elders and their experience and social capital.

References

1. AfricanGrandmothers Tribunal. Seeking justice at the frontline of the AIDS crisis: Report of the African Grandmothers Tribunal. Vancouver The Stephen Lewis Foundation, 2013.
2. Aubel J. Grandmothers: A learning institution. Washington, DC: United States Agency for International Development, 2005.
3. International H. Building Blocks, Africa-wide briefing notes, Supporting older carers Brighton: International HIV/AIDS Alliance, 2004.
4. UNICEF. Orphans 2008 [Available from: http://www.unicef.org/media/media_45279.html.
5. Makiwane M, Kwizera SA. An investigation of quality of life of the elderly in South Africa, with specific reference to Mpumalanga Province. Applied Research in Quality of Life. 2006;1(3-4):297-313.
6. Kimuna SR, Makiwane M. Older People as Resources in South Africa. Journal of Aging & Social Policy. 2007;19(1):97-114.
7. Makiwane M, Schneider M, Gopane M. Experiences and needs of older persons in Mpumalanga. South Africa: Human Sciences Research Council. 2004.
8. Nyasani E, Sterberg E, Smith H. Fostering children affected by AIDS in Richards Bay, South Africa: a qualitative study of grandparents' experiences. Ajar-African Journal of Aids Research. 2009;8(2):181-92.
9. Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, et al. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? . Cape Town: HSRC, 2009.
10. van der Maas F, Otte WM. Evaluation of HIV/AIDS secondary school peer education in rural Nigeria. Health Education Research. 2009;24(4):547-57.
11. Eaton L, Flisher AJ, Aarø LE. Unsafe sexual behaviour in South African youth. Social Science & Medicine. 2003;56(1):149-65.
12. M. J. Adolescence. Chichester John Wiley; 1998.
13. Selikow T, Ahmed N, Flisher AJ, Mathews C, Mukoma W. I am not ``umqwayito'': A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. Scandinavian Journal of Public Health. 2009;37(2):107-12.
14. Fongkaew W, Fongkaew K, Muecke M. HIV/sexual and reproductive health program for HIV prevention: the youth-adult partnership with schools approach. J Med Assoc Thai. 2006;89(10):1721-32.
15. Bastien S, Kajula LJ, Muhwezi WW. A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. Reproductive Health. 2011;8:8-25.
16. Rhucharoenpornpanich O, Chamratrithirong A, Fongkaew W, Miller BA, Cupp PK, Rosati MJ, et al. Parent–Teen Communication about Sex in Urban Thai Families. Journal of Health Communication. 2011;17(4):380-96.
17. Burnette D. Grandparents Raising Grandchildren in the Inner City1997.
18. Monasch R, Boerma J. Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries. 2004:S55–65.
19. Brown EJ, Jemmott LS, Outlaw FH, Wilson G, Howard M, Curtis S. African American grandmothers' perceptions of caregiver concerns associated with rearing adolescent grandchildren. Archives Of Psychiatric Nursing. 2000;14(2):73-80.
20. Gillespie S, Kadiyala S, Greener R. Is poverty or wealth driving HIV transmission? AIDS. 2007;21:S5-S16.
21. Hayslip B, Kaminski PL. Grandparents Raising Their Grandchildren: A Review of the Literature and Suggestions for Practice. The Gerontologist. 2005;45(2):262-9.
22. Cornelius JB, LeGrand S, Jemmott L. African American Grandparents'and Adolescent Grandchildren's Sexuality Communication. Journal of family nursing. 2008;14(3):333-46.

23. Nyambedha EO, Wandibba S, Aagaard-Hansen J. "Retirement lost"-the new role of the elderly as caretakers for orphans in Western Kenya. Journal Of Cross-Cultural Gerontology. 2003;18(1):33-52.
24. Appelbaum M. HIV & AIDS. Johannesburg: Jacana Media; 2013.
25. Africa SS. Statistics South Africa. General household Survey, May 2011 Pretoria: Statistics South Africa, 2012.
26. Bekowitz J, Packer T. Heroes in the Classroom: Comic Books in Art Education. Art Education. 2001;54(6):12.
27. Wijngaarden J, Shaeffer S. The Impact of HIV/AIDS on Children and Young People: Reviewing Research Conducted and Distilling Implications for the Education Sector in Asia. Discussion Paper No. I. Bangkok: UNESCO Asia and Pacific Regional Bureau for Education

; 2005.
28. Fehringer JA, Babalola S, Kennedy CE, Kajula LJ, Mbwambo JK, Kerrigan D. Community perspectives on parental influence on engagement in multiple concurrent sexual partnerships among youth in Tanzania: implications for HIV prevention programming. AIDS Care. 2013;25(2):207-14.
29. Miller KS, Levin ML, Whitaker DJ, Xu X. Patterns of condom use among adolescents: the impact of mother-adolescent communication. American Journal of Public Health. 1998;88(10):1542-4.
30. Armistead L, Cook S, Skinner D, Toefy Y, Anthony ER, Zimmerman L, et al. Preliminary results from a family-based HIV prevention intervention for South African youth. Health Psychology: Official Journal Of The Division Of Health Psychology, American Psychological Association. 2014;33(7):668-76.
31. Cornelius JB, LeGrand S, Jemmott LS. African American Grand families' Attitudes and Feelings about Sexual Communications: Focus Group Findings. The Journal of the Association of Nurses in AIDS Care : JANAC. 2009;20(2):133-40.
32. Santa Maria D, Markham C, Bluethmann S, Mullen PD. Parent-Based Adolescent Sexual Health Interventions And Effect on Communication Outcomes: A Systematic Review and Meta-Analyses. Perspectives on Sexual & Reproductive Health. 2015;47(1):37-50.
33. Watson JA RS, Development TIJoAaH. African-American grandmothers as health educators in the family. 60. 2005;4:343-6.
34. Soon CN, Kaida A, Nkala B, Dietrich J, Cescon A, Gray G, et al. Adolescent experiences of HIV and sexual health communication with parents and caregivers in Soweto, South Africa. SAHARA-J: Journal of Social Aspects of HIV/AIDS. 2013;10(3-4):163-9.
35. Mangxola W. Grandparents' experience of communicating sexual matters to the youth. : University of South Africa; 2007.
36. Delius P, Glaser C. Sexual Socialisation in South Africa: A Historical Perspective. African Studies. 2002;61(1):27-54.
37. Downing J, Jones L, Bates G, Sumnall H, Bellis MA. A systematic review of parent and family-based intervention effectiveness on sexual outcomes in young people. Health Education Research. 2011;26(5):808-33.
38. Bastien S, Leshabari M, Klepp K. Exposure to information and communication about HIV/AIDS and perceived credibility of information sources among young people in northern Tanzania. African Journal of AIDS Reearch. 2009;8(2):213-22.
39. Akers AY, Holland CL, Bost J. Interventions to improve parental communications about sex: a systematic review. Pediatrics. 2011;127(3):294-510.
40. Limaye RJ, Rimal RN, Mkandawire G, Roberts P, Dothi W, Brown J. Talking About Sex in Malawi: Toward a Better Understanding of Interpersonal Communication for HIV Prevention. Journal of Public Health Research. 2012;1(2):117-25.

41. Wamoyi J, Fenwick A, Urassa M, Zaba B, Stones W. Parent-child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. Reproductive Health. 2010;7(6).
42. DiIorio C, Pluhar E, Belcher L. Parent-Child Communication About Sexuality. Journal of HIV/AIDS Prevention & Education for Adolescents & Children. 2003;5(3-4).
43. O'Sullivan L, Meyer-Bahlburg H, Watkins B, . Mother-daughter communication about sex among urban African American and Latino families. Journal of Adolescent Research. 2001;1(16):269–92.
44. King B, Lorusso J. Discussions in the the home about sex: Different recollections by parents and children. Journal of Sex and Marital Therapy. 1997;23(1):52-60.
45. Brock LJ, Jennings GH. Sexuality education: What daughters in their 30s wish their mothers had told them. Family Relations. 1993;42(1):61-5.
46. Miller K, Forehand R, Kotchick B. Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. Journal of Marriage and the Family. 1999;61 85-98.
47. Zimmerman L. South African youth and parents: a mixed methods examination of family communication about sex, HIV, and violence. 2011.
48. Kirby D, Miller BC. Interventions designed to promote parent-teen communication about sexuality. New Directions for Child and Adolescent Development. 2002;2002(97):93-110.
49. Eastman KL, Corona R, Schuster MA. Talking parents, healthy teens: a worksite-based program for parents to promote adolescent sexual health. Preventing Chronic Disease. 2006;3(4):A126-A.
50. Blachman S. Evaluation of a Sex Education Workshop for Parents of Adolescents and Young Adults with Mental Retardation. 1991.
51. Control CfD. Surveillance Summaries. Morbitity Mortality Weekly Report. 2002;5(48).
52. Hamrick M. Parent-Adolescent FLE: An Evaluation of Five Approaches. Family Life Educator. 1985;4(1):12-5.
53. Lightfoot M. HIV prevention for adolescents: Where do we go from here? American Psychologist. 2012;67(8):661-71.
54. Mitchell SJ, Godoy L, Shabazz K, IB H. Internet and Mobile Technology Use Among Urban African American Parents: Survey Study of a Clinical Population. Journal of Medical Internet Research. 2014;16(1).
55. Minkler M, Fuller-Thomson E. African American Grandparents Raising Grandchildren: A National Study Using the Census 2000 American Community Survey. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. 2005;60(2):S82-S92.
56. Kelley SJ, Whitley D, Sipe TA, Crofts YB. Psychological distress in grandmother kinship care providers: the role of resources, social support, and physical health. Child Abuse & Neglect. 2000;24(3):11-21.
57. Maloi I. In: simmonds J, editor. Conversation ed. Alexandra Township: Ratang Bana; 2014.
58. Project Spotlight. Alexandra Township, Johannesburg, South Africa. [Available from: http://web.mit.edu/urbanupgrading/upgrading/case-examples/overview-africa/alexandra-township.html.
59. South African Social Securities Association. Phone call ed2016.
60. Sallis JF, Owen N, Fisher EB. Health Behaviour and Health Education. Fourth ed. San Farancisco: Jossey-Bass; 2008.
61. Miller K, Forehand R, Kotchick B. Adolescent sexual behaviour in two ethnic monorities: The role of family variables. Journal of Marriage and the Family. 1999;61:85-98.

APPENDICES A-I

6.3 Appendix A

Information Sheet for Participants

Good day and welcome. My name is Jane and this is my research assistant, Thuli. Dumasani will help with the translation and writing out of our interviews. Thank you for giving me your time. I am a Masters student at the University of the Witwatersrand and I am studying Public Health. I am researching communication between grandmothers and their teenage grandchildren on sex, sexuality and HIV and AIDS. I want to find out ways to improve this communication and how to make it easier for you as a grandmother.

You are invited to participate in this study at Ratang Bana. You should not agree to take part in this study unless you fully understand what is asked of you and you are completely happy with all the processes involved in the study. If you have any questions about the study or do not understand the information, please ask me or my assistant.

Purpose of study

The purpose of this study is to find out your feelings and experiences of talking to your adolescent grandchildren about sex, sexuality and HIV and AIDS. There is very little information available on this topic in South Africa. We want to learn more about this to find ways to improve communication and to make it easier for you to speak to your teenage grandchildren about sex, sexuality and HIV and AIDS.

Procedures of this study

In order to collect this information, I will ask you to take part in two in depth interviews, a focus group interview and a skills training workshop. An in depth interview is like a meeting with just you and me and the assistant where I will ask you questions about your feelings and experiences. The focus group interview will be like a discussion group with all of you after the skills training workshop. I will ask for your consent before we start the interview. There are no wrong or right answers to the questions; I want to know about you and your feelings and experiences. During the interviews, I will be using this digital voice recorder to record what you say. No one will hear the recording of the interviews except for me, the assistant, the translator and my supervisor at the university. My supervisor is Nicola Christofides.

After the interview we will write down word for word what was said in the interview. I will be using these written notes to give me information to write my research report. Your name will not be

written in the notes and no one will be able to tell from the written notes what you say or do. These notes will be kept locked up and anything you tell me in them will be anonymous and be confidential. These audio tapes will be destroyed at the end of the project.

With your permission, I will use this video camera to record the skills training workshop. The skills training workshop will be a two hour skills training workshop where Marina Coleman, who is the author of a book on HIV and AIDS, will speak to a group of 20-30 grandmothers. She will speak to you about teenage sex, sexuality and HIV and AIDS. She will share information and facts with you and she will want to hear about your experiences. I will not be at the skills training workshop. We would like to record the skills training workshop so we can watch it and improve our skills training workshops in the future. It will give useful information and feedback to Marina Coleman about what you think. This video will be destroyed after this feedback has been collected and analysed. The video will not be shown to anyone accept me and Marina Coleman and we will keep the content confidential. However, we cannot be sure that the other participants will keep the information from the skills training workshop confidential even though Marina will ask for this at the start of the skills training workshop. Remember you do not need to answer any question that makes you feel uncomfortable or say anything that will make you feel uncomfortable.

Benefits

You will get no direct benefits from being in this study, other than a copy of this book, *HIV & AIDS* by Marina Coleman. However, the information that you share with us will hopefully be helpful in understanding and improving communication between grandmothers and their teenage grandchildren that they look after.

Participation

Your participation in this study is entirely voluntary. You can leave the study at any time without having to give a reason or experience any consequences. Some questions might be personal and difficult for you to answer so please remember; you do not have to answer a question if it makes you uncomfortable. You will be free to leave any of the 3 interviews or the skills training workshop at any time.

Costs

There is no cost to you for participating in this study.

Ethical approval

This study has been given ethical approval by the Human Ethics Committee of the University of the Witwatersrand. The reference number for this study is ***R14/49***. This committee makes sure that my research respects your dignity and rights. If you have questions about you rights as a research participant or complaints about this study, you can contact the Chairperson of the University of Witwatersrand, Human Research Ethics Committee, which is an independent committee to help protect the rights of research participants, at (011) 717-2230.

The contact details for the Human Research Ethics Committee are:

Prof P Cleaton-Jones, HREC (Medical) Chairman

Ms Zanele Ndlovu/Mrs Anisa Keshav, Administrators

011 717 1252/011 717 2700

Email: zanele.ndlovu@wits.ac.za / anisa.keshav@wits.ac.za

Information and contact person

If you have any questions about the research, you may contact me

Jane Simmonds Cell 0832303655 or email janesimmonds@mweb.co.za

6.4 Appendix B

Informed consent form to participate in study

I hereby confirm that Jane has given me information to my satisfaction about participating in this study. She has explained to me the purpose, procedures involved, the risks and benefits and my rights as a participant in this study.

I have received the information sheet for the study and I have had enough time to read it on my own and ask questions. The questions I have asked about taking part in this study have been answered to my satisfaction.

Jane has told me that the information I give and share in this study, together with information from other participants, will be anonymously processed into a research report and scientific publications. I am aware that this report, and any publications from it, will be shared with the other participants and Jane will keep me informed about the progress of the research.

I am aware that it is my right to withdraw my consent to be part of this sudy at any time and without any prejudice. I hereby, freely and voluntarily give my consent to participate in this study.

Participant's name ……(please print)

Participant's signature …… Date……

Researcher's name ……(please print)

Researcher's signature …… Date……

Witness's name ……(please print)

Witness 's signature …….. Date……

6.5 Appendix C

Informed consent form – Audio tape

I hereby confirm that Jane has given me information to my satisfaction about participating in this study. She has explained to me the purpose, procedures involved, the risks and benefits and my rights as a participant in this study.

I am aware my voice will be recorded in the in depth interviews. I have been told that only the research team will hear the audio recordings. I have been told that the audio recordings will be kept locked up and confidential and destroyed at the end of the project.

I am aware that it is my right to withdraw my consent to be part of this study at any time and without any prejudice. I hereby, freely and voluntarily give my consent to be audio-taped in this study.

Participant's name ……(please print)

Participant's signature …… Date……

Researcher's name ……(please print)

Researcher's signature …… Date……

Witness's name ……(please print)

Witness 's signature …….. Date……

6.6 Appendix D

Informed consent form – Audio-Visual tape

I hereby confirm that Jane has given me information to my satisfaction about participating in this study. She has explained to me the purpose, procedures involved, the risks and benefits and my rights as a participant in this study.

I am aware the skills training workshop I have agreed to attend will be video-taped. I have been told that only Marina Coleman and Jane will see the video recordings. I have been told that the video recordings will be kept locked up and confidential and destroyed at the end of the project.

I am aware that it is my right to withdraw my consent to be part of this study at any time and without any prejudice. I hereby, freely and voluntarily give my consent to be video-taped in this study.

Participant's name ……(please print)

Participant's signature…… Date……

Researcher's name ……(please print)

Researcher's signature…… Date……

Witness's name ……(please print)

6.7 Appendix E

Communication between grandmothers and their grandchildren

Interview Guide 1(for in depth interview before skills training workshop)

1)Tell me about your grandchildren and your relationship with them

Probes

- activities- things they do
- needs- demands/requirements from grandchildren on grandmothers
- problems- school attendance, respect, and disobedience

2) How do you feel about talking to your grandchildren about sex and HIV and AIDS

Probes

What could make it easier to talk to your grandchildren, if anything

What are the difficulties, if any

Who should talk to children about sex and HIV and AIDS

3) Tell me about the last time you spoke to your grandchildren about sex and HIV and AIDS, if at all

4) If you have you never spoken to them- tell me the reasons

6.8 Appendix F

Communication between grandmothers and their grandchildren

Interview Guide 2 (for focus group discussion

2-3 weeks after skills training workshop)

How did you feel about attending the skills training workshop before it started?

Probes

What were you expecting from the skills training workshop?

Tell me about the skills training workshop and your experiences

Probes

What did you like about the skills training workshop?

What did you not like?

-

What changed for you at the skills training workshop, if anything?

Probes

-what did you learn

-what did you feel

What are your initial thoughts about the book, *HIV & AIDS*?

Probes

-what will you do with it, if anything?

6.9 Appendix G

Communication between grandmothers and their grandchildren

Interview Guide 3 (for in depth interview 2-3 months after skills training workshop)

You attended the skills training workshop a couple of months ago. What are your thoughts about the skills training workshop since you attended?

What are your thoughts about the book HIV & AIDS?

How have you used it, if at all?

Have things been the same or different since you attended the skills training workshop?

Tell me about any experiences talking to your grandchildren about sex and HIV and AIDS since the skills training workshop, if you've had a chance to talk to them

Probes

- How do you feel about talking to your grandchildren about sex and HIV and AIDS after the skills training workshop?

    - has there been a change in your feelings

    -describe changes

6.10 Appendix H

Socio-demographic questionnaire

How old are you? _____

How many grandchildren are you caring for as a primary caregiver? _____

Tell me about each child

	How old is each child?	Is the child a boy or girl?	Is child in school?
Child 1		Boy 1 Girl 0	Yes 1 No 0
Child 2		Boy 1 Girl 0	Yes 1 No 0
Child 3		Boy 1 Girl 0	Yes 1 No 0
Child 4		Boy 1 Girl 0	Yes 1 No 0
Child 5		Boy 1 Girl 0	Yes 1 No 0

What was the highest standard or grade that you finished at school? _____

What is the monthly income of your household?

Less than R500

R501-R1000

R1001-R2000

R2001-R3000

R3001-R4000

R4001-R5000

More than R5001

What is the source of your household income (tell me all the different sources)?

Foster grant Yes 1 No 0

Pension Yes 1 No 0

Wages Yes 1 No 0

Money from family members Yes 1 No 0

Other Please specify: _____

What is the main language that you speak at home?

Zulu

South Sotho

North Sotho

Xhosa

Other Specify: _____

Do you live with a husband or boyfriend? Yes 1 No 0

If yes, how involved is your husband/boyfriend involved in the grandchildren's lives?

Very involved

Somewhat involved

Not at all involved

=Appendix I

Ethics approval form

R14/49 Ms Jane Simmonds

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130755

NAME: (Principal Investigator)	Ms Jane Simmonds
DEPARTMENT:	School of Public Health University of Witwatersrand Ratang Bana,71 Martin Manzi St Alexandra
PROJECT TITLE:	The Perceived Impact of a Skills Training Workshop Supported by the Book, "HIV & Aids" on Grandmothers' Communication with their Pre-Adolescent and Adolescent Grandchildren, in their care about Sex, Sexuality & HIV & AIDS in Alexandra
DATE CONSIDERED:	26/07/2013
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Nicola Christofides
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	18/09/2013

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

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES