Caregivers' Awareness of and Support for Sexuality Education and Life Orientation in Secondary Schools in Durban, South Africa

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ABSTRACT

The study focuses on caregivers' support for their children's assimilation, practice and reinforcement of sexuality education taught in their schools.It is hoped that caregiver support will assist in reducing high rates of HIV and teenage pregnancy in KwaZulu-Natal, a province in South Africa. Focus group discussions which were semi-structured were conducted with six caregivers per four schools of different poverty quintiles in KwaZulu-Natal. This qualitative data was analysed by using Thematic Content Analysis.Caregivers selected were representative of the different socio-economic statuses categorised as Poverty Quintile two to five in the Umlazi district of KwaZulu-Natal. The study's results are that caregivers are generally unaware of sexuality education being offered in schools nor the Life Orientation curriculum. Should caregivers be made aware of the sexuality education and the Life Orientation curriculum, they would attach more importance to it and more likely to support it. It is recommended that awareness for sexuality education and Life Orientation for caregivers be created by the schools via communication such as meetings and letters. In marginalised communities, more resources should be provided to schools to increase their ability to communicate with the caregivers of learners, to increase awareness of sexuality education and LO.

Keywords: Adolescent Health; Caregivers; Health Communication; Health Education; Health Promotion; HIV/AIDS.

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Introduction

Many youth in South Africa are sexually active with a national survey revealing that this is applicable to 33% of youth aged 12 to 17 years (South African National AIDS Council (SANAC), 2017). Various studies indicate that the period during which South African youth are most likely to contract HIV is during or immediately following their secondary schooling years (Dessie, Berhane & Worku, 2015; SANAC, 2017). Youth in KwaZulu-Natal (KZN) between the ages of 15 and 24 years have a high risk of contracting HIV and AIDS (Coetzee et al., 2014; De Lange, Mitchell & Khau, 2012). According to Coetzee et al. (2014), 20.5% of youth in KZN are already HIV-infected. In 2015, KZN recorded 26000 teenage pregnancies and is the province with the highest teenage pregnancy rate (Harrison, Newell, Imrie & Hoddinott, 2010; SANAC, 2017). In order to diminish the rates of teenage pregnancy, HIV and AIDS, and STIs in youth in South Africa, standardized school-based sexuality education to all senior-primary and secondary-school youth in South Africa, has been implemented within the life-skills curriculum, namely, Life Orientation (LO). Sexuality education via the LO curriculum aims for risky sexual behaviour prevention in youth. It aims to accomplish this through improving learners' abilities to make healthy decisions for themselves and others (Beksinska, 2014; Harrison et al., 2010). The sexuality education curriculum became a mandatory component of the South African school curriculum in 1996, (Department of Education, 1999). Currently, LO and sexuality education is taught within all public schools in South Africa (Department of Health (DoH) and Department of Basic Education (DBE), 2013). The sexuality education programme is facilitated by trained LO educators (Finegood, Raver, DeJoseph & Blair, 2017).

Learners' support for and interest in the messages presented in the sexuality education component of the LO

curriculum is influenced by the school environment in terms of their educators', school staffs' and principals' promotion of the programme. Studies have established that there is a directly proportionate relationship between the school climates' support of the schools' sexuality education programme and learners' enthusiasm for the programme, and their resultant implementation of the messages in their personal lives (Brown, 2013;Beksinska, 2014).

Despite ongoing evaluations and improvements to the sexuality education programme, it has not been as successful in achieving its aims (Brown, 2013; Makina et al., 2017;Steffenson, Pettifor, Seage, Rees & Cleary, 2011). This may be due to a number of reasons pertaining to relevance of content, type of pedagogy, a sole reliance on LO educators, the repetitive nature of the subject, presentation of the subject as an academic one; amongst other reasons (Francis& DePalma, 2015; Makina et al., 2017). Findings from sexuality education studies have established that learners who learn the same messages, but which are reiterated by a number of different sources, are more likely to be impacted by the messages and internalize them with a higher likelihood of practicing them in their daily lives.

One of the most impactful sources have been noted to be learners' caregivers (Makina et al., 2017; Steffenson et al., 2011). Caregivers are integral in reiterating the sexuality education messages taught by the school and in providing supervision and guidance to their children, which will assist in the practical implementation of the sexuality education messages in their personal lives (Beksinska, 2014; Namisi et al., 2009).Caregivers are also usually from the same community as their children and are usually aware of their communities' particular challenges to the implementation of safe and healthy sexual behaviour in their children's lives; and can thus guide their children in applying the sexuality education messages in a way which is relevant to them.

For this to occur, caregivers need to be aware of and supportive of the sexuality education as taught via the LO curriculum, so that they can be collaborative partners with the school and their children's LO educators; in order to enable their children to make healthy choices regarding their sexual behaviours and attitudes (Bigala, Oladipo & Mabille, 2015; Namisi et al., 2009).

Purpose or aims

The study sought to explore caregivers' awareness of and support for the sexuality education programme and the LO curriculum wherein it is delivered.

Theoretical Framework

Bronfenbrenner's Ecological Systems Theory is a useful perspective which acts a lens to view the school environments' contextual factors' impact on caregivers' capacities as an influencer of their children's sexual attitudes and practices (Bronfenbrenner, 1979). Figure 1 below indicates how youth development, particularly, their sexual development is impacted by various environmental levels and factors.

Microsystem: The immediate context that the individual lives and interacts socially in, and is made up of their family, school, neighbourhood and peers. The individual actively creates their contexts and receives their experiences within this context. Caregivers are a major component of the microsystem of their children's lives and shape their children's perspectives of sexuality and their reactions to sexuality education. They are a source of sexuality education to their children and are usually the first influencers in their children's lives. However, during the adolescent years, adolescents are likely to engage with other influencers in their lives; such as their peers, educators and other community members; who may also be consulted as a source of sexuality education. Caregivers remain essential influencers in this

regard and are usually a protective factor for engagement in risky sexual behaviour for their children.

Mesosystem: The relationship between Microsystems, such as between educators' and learners' peers, educators' and learners' caregivers , and learners' caregivers and learners' peers. For the purposes of the study, the school's sexuality education in relation to the family's sexuality education is reviewed. The Mesosystem is vital for this study as it focuses on caregivers' relationships with their children's LO educators and other related school staff and vice versa.The importance of these relationships for adolescent well-being and the prevention of their engagement in risky sexual behaviours is inherently formed from the collaborative relationship between the school staff and caregivers. Caregivers' reinforcement of the messages taught in school-sexuality education enables the messages to be more impactful in adolescents' lives. Caregivers' abilities to monitor and supervise their children, as well as provide support for the practical applicability of the messages in their children's lives are further supportive factors which enables school-sexuality education to be practically impactful in adolescents' lives.

Exosystem: The geographic environment around the school and social support network that the school offers. An individual's experiences are affected by factors which are out of their control. The geographic areas surrounding the school may have an impact on engagement in risky sexual and other risky behaviours by adolescents. The geographic environment may have hidden spaces which facilitate engagement in risky behaviours due to the lack of caregivers' or the schools' supervision. It may thus facilitate non-awareness of risky behaviour engagement by the school and caregivers. Rape and gender-based violence may also be facilitated in such geographic areas. The support network, such as schools' security guards, neighbourhood watches, the local police and other involved community members; form a supportive

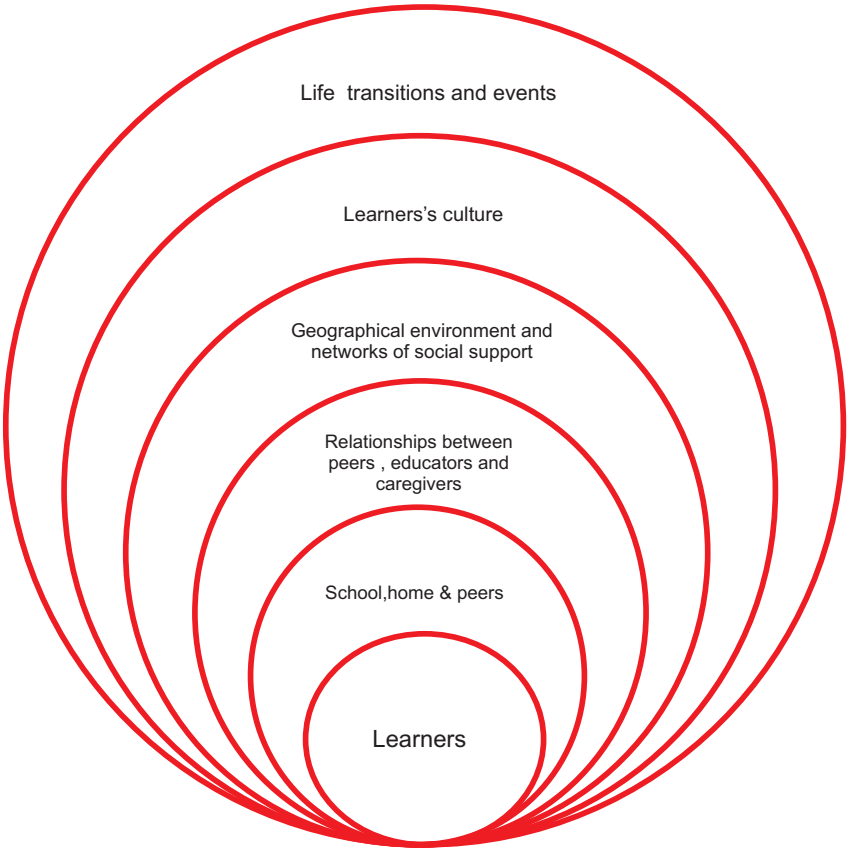
network for the protection of adolescents from being harmed. Furthermore, they create awareness for certain geographic areas as being used for risky behaviour engagement by adolescents, to their caregivers and the schools.

Macrosystem: This is the cultural and ideological environment which encompasses the other systems. The Macrosystem is composed of the common heritage which influences the social and political beliefs of the individual's culture. Adolescents' cultural beliefs about sex may be shaped by their cultural heritage. In the context of this study, the South African context has a mixed cultural heritage such as Zulu, other African heritages, British, Dutch, Indian and a mixture of these heritages. These cultural heritages may impact how conservative and open to communicating about sexuality, caregivers are with their children and vice-versa, as well as the values that caregivers impart to children regarding their sexual beliefs and attitudes. The cultural heritage of educators may also influence them to experience their own values and morals as enhancing or impeding the process of teaching sexuality education to adolescents. The more open to communicating about sexuality education caregivers are with their children, the less likely adolescents will be to engage in risky sexual and other risky behaviours.

Chronosystem: The last level is the trajectory of an individual's life which includes major life evolutions, and historical and environmental events, that transpire during development. The resultant impact is visible in the changes in an individual's interaction with others. Adolescents go through major physical and psychological changes during their teenage years as they progress from a dependent child to an independent adult. They consult new sources of information and form their own opinions and attitudes while forming their own identities. Their identities regarding attitudes to sexuality and sexual engagement would also form a component of this identity. The role of their caregivers are

to guide them in the process of self-discovery and identity formation. They should allow their adolescent children the freedom to grow and form their own ideas about sexuality however, they should provide guidance to their children on how to make healthy choices for themselves and for others who may be impacted by their decisions.

Figure 1: The Application of Bronfenbrenner's Ecological Systems Theory



Materials and Methods

Study setting

KZN was selected as the province in South Africa since it has the highest rates of teenage pregnancy, HIV and AIDS, STIs and risky sexual behaviours by youth (SANAC, 2017). The Umlazi district within KZN was selected as it had the highest HIV prevalence in the country from 2008 to 2016, and the matriculation pass rate was lower than all other provinces in South Africa in the same time period (DoH and DBE, 2013). The sample was selected via stratification according to Poverty Quintiles (PQs) within the district of Umlazi, with a school from each PQ. PQs range from one to five, with the lower the PQ, the lower the economic status of the school. Therefore, PQ1 and PQ2 schools are considered the most disadvantaged schools, while PQ3 schools are regarded as being of average economic status; and PQ4 and PQ5 schools possess the highest economic status. PQs are the Department of Education's classification of schools by their communities, in order to provide financial assistance to them, in an effort to equalise education standards across South Africa (DoH and DBE, 2013). Due to the closest PQ1 school being located on the outskirts of the district and much further away from the other schools, the intention was not to compromise data-quality and the assumption was that the PQ2 school would incorporate the challenges of the PQ1 school and would be representative of the economically disadvantaged schools in the district.

Study permission

The Humanities and Social Science Research Ethics Committee of the University of KwaZulu-Natal, South Africa and the Regional Department of Education were consulted in order to receive permission to conduct data collection within schools. The ethical standards were performed in accordance with the ethical

standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study. The ethical principles of autonomy, voluntariness, anonymity, the right to withdraw and that no answers were incorrect, were adhered to throughout the study. No mention was made of any of the participants in the writing up of results. All participants received an orientation to the study, the expectations of them and the ethical principles which included the signing of the letters of informed consent prior to the focus group discussions. Further emphasis was placed on the protection of the identities regarding the audio taping of the focus group discussions and participants signed a separate clause providing their permission for this. All the participants signed their informed consent forms, and none refused to participate.

Research design

The study used qualitative semi-structured focus group discussions to understand the role of caregivers regarding the contextual factors which enabled/disabled them in supporting the schools' sexuality education programme's and LO curriculum's aims (Babbie & Mouton, 2005; Braun & Clarke, 2006). Due to its explorative nature, a qualitative research design was used. Qualitative research supported the flexibility required to understand different viewpoints to the phenomena (Babbie & Mouton, 2005). Furthermore, focus group discussions were used due to their ability to engage and obtain data from the perspectives of different stakeholders'. Focus group discussions also allow for participants to engage with others during their interviews and therefore, provide more insight and rich data on how they communicate about their perceptions of the school environment, LO and the school sexuality education programme; in a personal and communal manner. Focus group discussions which were semi-structured were specifically used, as they allowed for

question-standardization across schools, however, flexibility in the discussion was maintained regarding individual participant's responses (Babbie & Mouton, 2005). Pilot testing of the focus group discussion was conducted with four different participants from the PQ2 school as it was proposed that if the guide was pitched at the English proficiency level of participants from the most rural school. This helped adust instruments in line with participants comments.

Sampling

The eligible sample for the study were caregivers of learners in four schools representative of PQ2 to PQ5, who had children in Grade nine and/or 11 in these schools; since these particular grades may capture the transition noted by studies which indicate that the national estimates of HIV incidencerises distinctly amongst youth aged 12 to 14 years (2%) and 15 to 19 years (6.7%) (Coetzee et al., 2014). The realised sample were caregivers who responded to the letters requesting possible participation in the focus groups discussions. The participants were sent invitations to participate in the study with the total number of participants approached being N=100. Learners in eligible grades from selected schools were randomly selected to pass on the letters of request to participate in the study, to their caregivers. The letters were transferred to the caregivers from their children and thereafter, their caregivers subsequently returned them to the school, through submitting them directly to the schools' receptionists or sending it with their children to the schools' receptionists. A few days after the deadline date for submission in the recruitment letters was reached, the researcher fetched the acceptance or decline from the schools' receptionists. The researcher thereafter telephoned the caregivers who were interested in participating in the study as per their consent on the letters. Interest to participate in the study was indicated by 21 caregivers and all were enlisted to take part in the

focus group discussions. Six participants of these 21 did not attend the focus group discussion. One focus group discussion was conducted in each of the four schools. There were N=3 caregivers present in the PQ2 school's focus group discussion and four caregivers in each of the focus group discussions from the PQ3,PQ4 and PQ5 schools (N=4). The total realised sample size was N=15. For the purposes of standardisation across schools and participants, all focus group discussions were conducted by the same researcher, who had no connection to the schools.

Socio-demographic characteristics of the sample

Fifteen participants attended the focus group discussions. Only females were in attendance, despite the recruitment letters being sent to all eligible caregivers, regardless of gender and the focus groups being set at a time initiated by caregivers. Caregivers had a child or children in Grade nine and/or 11 in the school. Table 1 presents the sample's demographics in further detail.

Data collection

Focus group discussions were conducted post school hours, at a time arranged and agreed upon by the researcher and the caregivers. A duration of 45 minutes was allocated for the completion of focus group discussions. All the recordings were transcribed into transcripts in a verbatim manner.

Data analysis

Thematic Content Analysis was used to analyse the data in accordance with the procedure indicated by Braun and Clarke (2006):(1) A portion of the comments was read and repeatedly read,(2) A coding frame was developed to explain the comments' thematic content and(3) All comments had codes assigned to them. NVivo 10.1 was used to generate the coding frame. Two coders from the research team, then tested the trustworthiness and

Characteristics	Number	Percentage (%)
Gender		
Female (only)	15	100%
Ages groups (Mean age =39)		
30-40	10	67%
41-50	5	33%
Race		
White	4	27%
Black African	7	47%
Indian	3	20%
Coloured (mixed ethnicity)	1	6%
Home language		
English	4	27%
Afrikaans	4	27%
Zulu	7	46%
Religious affiliation		
Christian	12	80%
Hindu	3	20%
Highest level of education		
Matriculation	8	53%
Bachelor's Degree	7	47%
Grade of Child(ren)		
Grade 9	9	50%
Grade 11	9	50%
Gender of Child(ren)		
Male	6	33%
Female	12	67%

validity of assigning codes (Babbie & Mouton, 2005; Hanson et al., 2005). Three major themes were identified: (1) Awareness of sexuality education and LO in schools,(2) De-prioritisation of LO and (3) Caregivers' support for sexuality education. Themes are individually recorded; however, the researchers are aware that

they are interconnected.

Results

Awareness of sexuality education and LO in schools

Almost all of the caregivers interviewed were not aware that sexuality education was a component of LO in their child's schooling curriculum, nor that sexuality education was taught at school. Awareness of LO by caregivers is limited merely to the knowledge that the subject LO exists. Most caregivers seemed to lack information about the content of the subject's curriculum and were not aware that sexuality education was being taught via the LO curriculum. These views are illustrated by the words of various caregivers from different PQ schools:

> *No, I know (that) there is a subject called LO, but I do not know what it is (LO) about and I do not know what it is or means. My daughter did not tell me what is in LO (Participant 11, PQ4).*
>
> *No, I am just saying that if she is doing (having) sex, then it is not like the school has (an) input in what she's doing. The school doesn't teach them about that. (Participant 7, PQ3).*
>
> *Yes, I know about LO, but I am not too sure what it is about exactly but I do not think they teach about sex in school (Participant 12, PQ5).*
>
> *I know (that) there is LO, but I do not know what is in that (the) subject. They do not teach sex, I think (Participant 3, PQ2).*

De-prioritisation of LO

The lack of awareness or limited knowledge of the content of LO and sexuality education may be attributed to caregivers' de-

prioritisation of LO. This could be ..... of LO as since they perceive it as a subject of little or no value. This seems to be the current status that is attached to sexuality education and LO. Caregivers, regardless of the school quintile their child(ren) attended, perceived LO as being less valuable, in comparison to more academic subjects. Caregivers from various PQ schools reported the following:

> *She (participant's daughter) needs help in other subjects. She is doing good (well) in LO so I am not worried about that (Participant 8, PQ3).*
>
> *LO is not a subject she (participant's daughter) needs in university so to me it is not that (as) important as her other subjects (Participant 3, PQ2).*
>
> *I only know that it is not as important as other subjects. My son tells me how easy it is and then he doesn't do the homework or study for it, but I see his grade in the report and he does well. I asked him what it is about and he said (that it is) something about life skills and how to live your life in the real world. So, to me it sounds like that (the) counselling lesson we had in school… So, when we go for the parents meeting, we do not talk to the LO teacher as we can rather spend that time on his other subjects (Participant 12, PQ5).*

Caregivers' support for sexuality education

Caregivers' support for sexuality education and LO is impacted by their awareness of the subject and curriculum. Although most caregivers are not aware of the content of the LO curriculum as the source through which sexuality education is taught in schools, some caregivers are aware of the school providing sexuality education. These caregivers expressed a relief that the school is taking partial responsibility for sharing of this information on their

behalf. If they were not aware but presented with the prospect of having sexuality education at schools, caregivers were supportive of it. None had any objections to sexuality education being taught to their children and were comfortable and happy with its delivery to their children. Caregivers support for the sexuality education is shown in the following:

> *I was not sure what this (the subject) LO was, but then I asked my daughter about it and it seems like something good to have for the kids, especially at this age. I think it also helps me as I do not have to tell my child everything about sex from scratch. It takes that initial awkwardness away (Participant 12, PQ5).*

> *Yes coz (because) I am not talking (have not spoken) to my child about that (sex), I am happy (that) they are teaching (them) about sex because they can learn how they can get pregnant or HIV and the school teaches them to use the condoms and be safe. Or they must not do sex at all (Participant 11, PQ4).*

> *If they did teach sex at the school, I would be very happy coz (because) it would help us (Participant 9, PQ3).*

Discussion

The findings of the study indicate that most caregivers reported that they were not aware of sexuality education and the contents thereof, however, the few who were aware, indicated that they were grateful as it addresses a topic which they are reluctant to talk about with their children. Those who were not aware of sexuality education being taught at schools also indicated their positive support for the topic, should it be offered in school. Caregivers' lack of awareness of the sexuality education curriculum is supported by international studies (Bundick & Tirri, 2014; Coetzee et al., 2014). The importance of caregivers' awareness of

sexuality education and how it is delivered is critical for their involvement in the process and contribution to message content (Finegood et al., 2017; Steffenson et al., 2011). According to Steffensonet al. (2011), the first step for caregiver support is through creating awareness in caregivers of the means through which sexuality education is delivered. Consistency between the messages promoted by the school and those provided by the caregiver creates reinforcement of the messages in learners' lives at the school and in their personal lives (Bond et al., 2007; De Lange et al., 2012). It also reduces the responsibility of the school as the sole prescribed source of sexuality education to learners (Bigala et al., 2015; Bundick & Tirri, 2014; Coetzee et al., 2014). This indicates the importance of the collaboration and liaison between educators and caregivers for learners' sexual and overall health and wellbeing (Bronfenbrenner, 1979) with the child's Mesosystem.

The study also revealed a somewhat indifferent and uncritical attitude by caregivers towards the sexuality education which the school provides and its impact on their children. This may be regarded as a positive outcome as sexuality education can be taught with no objections. However, caregivers' indifference provides no guidance for adjusting the relevance of sexuality education to their children. The study's findings also demonstrated a reliance on the school in providing their children's sexuality education and sexuality education was perceived as relieving caregivers of their role in providing sexuality education to their children. Even if caregivers possessed comprehensive details regarding sexuality education, it is uncertain as to whether they would be able to communicate these messages because of the reported lack of caregiver-child communication. A concerning challenge is that in cases where caregivers attempted to talk to their children about LO and the schools' sexuality education, they seemed to receive a paucity of feedback on the topic from their children.

Caregivers reported that LO is not an examination subject and academically non-challenging;as obtaining high marks is not a problem. Therefore, the perceived status of LO as compared to other subjects, is low and thusless effort may seem warranted for caregivers to learn more about LO. As such, caregivers may not see educators for LO during caregiver meetings so that they could possibly learn more about this subject through the LO educators, since they are not receiving this information from their children. This illustrates the importance of the Mesosystem and in particular, the relationships between learners and their caregivers, and caregivers and their children's educators for the promotion of adolescent risky behaviour reduction (Bronfenbrenner, 1979).

The study had a number of limitations

The study may have been biased by the collection of data in spoken and written English. The study noted that there were a number of non-native-English-language-speaker participants and therefore, pilot tests were conducted to gauge the participants' comprehension and communication levels. The instrument and letters of informed consent were pitched at the lowest level. All schools were English-medium schools; therefore, most caregivers were able to converse in English. A further limitation is the small sample size and participants being selected from those who responded. The results may therefore demonstrate findings from involved caregivers with a motivation to be involved in their child's school. Male participants were absent from the data, despite the recruitment letters being sent to all eligible caregivers and accommodation for the caregivers' respective availability being made. The findings have been interpreted with a consideration for the skewed gender.

Implications for school based educational programmes

The promotion of school-based sexuality education should be conducted by South African schools and the South African

government as they are key structural institutions responsible for the enhancement of caregivers' social roles as sources of sexuality education to their children and sources of support for the schools' sexuality education. Schools should enable caregivers to become more aware of the sexuality education messages and the medium through which it is being taught in the hopes that they may attach value to sexuality education and the LO curriculum. Awareness for sexuality education and LO for caregivers should be created by the school in the form of communication such as meetings and letters. Awareness should also be created for caregivers on the importance of reiterating the messages taught in LO and sexuality education, as well as the monitoring and supervision of their children in a bid to support these messages. Caregivers can thereby reinforce the messages taught to learners and enable them to be practically applicable in learners' lives and in their community-context;as caregivers are usually from the same community as their children and would be aware of the particular challenges and opportunities available to them (Steffenson et al., 2011). Awareness for the importance of male caregiver' involvement in their children's personal and schooling lives should be created to enhance equality in collective responsibility for adolescent well being in communities. Male caregivers play a vital role in supporting school-sexuality education through communication and by being role models to their children (Coetzee et al., 2014). In marginalised communities, more resources should be provided to schools to increase their ability to communicate with the caregivers of learners in order to increase awareness of sexuality education and LO.

Further research could be conducted into caregivers' relationships with LO educators and the schools' policies on creating awareness or communicating with caregivers regarding their children's sexuality education and LOin order to improve on the health education offered by the school and enhance collective wellbeing in these marginalised communities.The school can form

collaborative relationships with caregivers in order to provide a more supportive network and environment which disables adolescents' engagement in risky sexual and other risky behaviours. They can assist each other in creating awareness for geographic environments which enable risky behaviour engagement and to put the relevant prevention measures in place.

LO educators and schools may also make caregivers aware of the need for open communication with their children on sexual matters and the possible content that they could communicate on, with the children. The rest of the community may form a part of this network and could further create awareness for the promotion of healthy behaviour in youth. LO educators can therefore share the responsibility of sexuality education to adolescents in communities, with caregivers and other community members.

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