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COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SEXUAL AND REPRODUCTIVE HEALTH IN THE TSHWANE DISTRICT

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DECLARATION

Student No: 98244435

I, Christina Linky Manthipa Mabena, hereby declare that: **"COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SEXUAL AND REPRODUCTIVE HEALTH IN THE TSHWANE DISTRICT"** is my original work. It has not been submitted at any other institution before any degree or examination. All the sources used and quoted were acknowledged by means of complete references in the text and bibliography.

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Christina Linky Manthipa Mabena Date

DEDICATION

It is with great gratitude that I dedicate this study in memory of my late parents:
My father:

- Mr Johannes Mabiletsa Mabena
- Dad, you always encouraged me to reach for the sky, and I know and believe that wherever you are, you are proud of this achievement.

To my mother:

- Catherine Mokgethoa Mabena
- Mom, thanks for teaching me to work hard and strive for the best.
- Nothing comes cheap in life.
- You always said: "*Let education be the key to your success in life, and the rest will follow*".

AND

To my siblings

- Paulina, Martha, Jeremiah, Mmasechaba and Dora.
- Mpho, Thabang, Tshepang, Oakantswe and Phoenix.
- My pillar of strength, thanks for being there for me.
- Your valuable support, encouragement and wish me for the best.
- Being there for me when things were very bad does not go unnoticed.

MISSION ACCOMPLISHED

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"In memory of Dr R Rikhotso (co-supervisor), may his soul rest in eternal peace."

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ABSTRACT

Grandparenting is a new global social phenomenon emerging whereby grandparents take part in caring for their grandchildren. Grandparent headed families occur due to various societal factors, including the death of parents due to accidents, teenage parenting and other limitations that prevent parents from raising their children. The grandparents are then responsible for being primary caregivers to their grandchildren when they also have their challenges. The aim and objectives of the study were to develop communication guidelines to support grandparent headed families regarding sexual and reproductive health.

This study was conducted in two phases. Phase 1: a qualitative, descriptive phenomenological and contextual research design was conducted to explore and describe the experiences of the grandparents, grandchildren and primary health nurses regarding sexual and reproductive health in the Tshwane District of the Gauteng Province, South Africa. A non-probability, purposive and snowballing sampling method was used to select twelve (12) Primary Healthcare nurses, eleven (11) grandparents and thirteen (13) grandchildren. Data was collected through in-depth interviews and analysed using Giorgio's five steps. Ethical consideration was adhered to by ensuring anonymity, confidentiality, privacy and signed consent to participate in the study. Measures to ensure trustworthiness adhered to were credibility, confirmability, transferability, dependability, authenticity, reflexivity and bracketing. The findings of the study revealed: Four (4) essences (themes) and twelve (12) constituents (categories) emerged from the transcribed data when Primary health care nurses shared their lived experiences. The four themes are PHCNs' experiences of sexual reproductive health communication, Primary health care nurses' s experiences of factors facilitating sexual reproductive health communication, primary health care nurses' s experiences of sexual reproductive health communication barriers and Primary health care nurses' recommendations for SRH communication promotion.

Four (4) essences and ten (10) constituents emerged from the transcribed data, emanating from the grandparents' shared experiences. The four themes were Grandparents' experiences of SRH communication, Grandparents' experiences of factors facilitating SRH communication and Grandparents' experiences of SRH family communication barriers. Grandparents' experiences of SRH family communication barriers and Grandparents' recommendations for SRH communication promotion.

Four (4) main essences and nine (9) constituents emerged from the transcribed data from the grandchildren experiences. The four essences from the grandchildren were: Grandchildren's experiences of SRH communication, Grandchildren's experiences of factors facilitating SRH communication, Grandchildren's experiences of SRH family communication barriers and Grandchildren's recommendations for SRH communication promotion. The findings for Phase 1 formed the basis of the development of guidelines.

In Phase 2, the Delphi technique was used, and experts in the field were identified to provide information regarding the development of guidelines that will be used to support grandparent headed families regarding sexual reproductive communication. A non-probability sampling method was used to identify the panel of experts knowledgeable about SRH, including academics, policymakers and other stakeholders. The development and validation of the guidelines were done based on the AGREE II (2010) instrument. A consensus was reached in round 2. Round 3 was used for validation and as a form of feedback.

Keywords: communication, grandparent headed families, guidelines, sexual and reproductive health

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LIST OF ABBREVIATIONS/ACRONYMS

Abbreviation/ acronym	Meaning
AIDS	Acquired Immunodeficiency Syndrome
AGREE	Appraisal of Guidelines for Research and Evaluation
AYFS	Adolescent Youth friendly services
CPD	Continuous Professional Development
CoT	City of Tshwane
CTOP	Choice on termination of pregnancy
DBE	Department of Basic Education
DoH	Department of Health
DSD	Department of Social Development
GBV	Gender based violence
HCP	Health Care Professional
HIV	Human Immunodeficiency Virus
IPV	Intimate partner violence
GP	Gauteng Province
GPF	Grandparent headed families
ISHP	The Integrated School Health Policy
MDG	Millennium Development Goals
NAFCI	The National Adolescent Friendly Clinic Initiative
NCS	National Core Standards
NEI	Nursing Education Institution
NSP	National Strategic Plan
PHC	Primary Health care
PHCN	Primary Health care nurse
SANC	South African Nursing Council
SANAC	South African National Aids Council
SAPS	South African Police Services
SEM	Socio-ecological Model
STIs	Sexually transmitted infections
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
SDG	Sustainable Development Goal
TOP	Termination of pregnancy
WBOTS	Ward Based Outreach teams
WHO	World Health Organization

CHAPTER 1

BACKGROUND OF THE STUDY

1.1 INTRODUCTION

The grandparent-headed family (GPF) is a global phenomenon that presents a context of the generational gap regarding sexual reproductive health (SRH). According to Achen et al (2022:1), SRH communication is a socio-cultural exercise that is necessary between grandparents and grandchildren in grandparent-headed families. The United States of America (USA) census data for 2010 estimated that 2.6 million grandparents parented 5.4 million children. A study conducted in the United Kingdom (UK) by Buchanan and Rotkirch (2018:131) also revealed an increase in grandparents caring for their grandchildren. The (ibid) further indicates that 44% of those are grandmothers, 42% are grandfathers, and the remaining 14% are parents who care for their children with minimal assistance from grandparents. Several studies conducted on the African continent asserts that the HIV/AIDS endemic affects the wellbeing of people negatively, leaving extended family members, including grandparents, to take over parenting roles (Glaser et al., 2018:238; Chambers et al., 2017:22; Bulanda & Jendrek, 2016:138; Rutakumwa et al., 2015:2121; Woods, 2015:7; Clottey, Scot & Alfonso, 2015:2).

According to Di Gessa, Glaser and Tinker (2016:166), 58% of grandmothers and 49% of grandfathers look after their grandchildren in Europe. These grandparents are prepared to provide vital support to their grandchildren despite facing their own financial, physical, emotional and psychological challenges (Jang 2023:266). In addition, and Simmonds et al 2021:1 states that grandparent-headed families are steadily growing. The (ibid) further asserts that grandparents view this practice as beneficial, although, in most cases, this role is conducted without any financial assistance from the parents. According to Mafumbate (2019:10) and (Kalpana & Rosalina 2018:169) posits these grandparents impart norms and values that are crucial to the grandchildren's lives possess a wealth of SRH knowledge which is beneficial for socialization of their grandchildren.

According to Jang (2023:267) GPF emerged due to societal factors such as urbanisation, teenage pregnancy, substance abuse, death due to HIV-related conditions and accidents. Children are then left in the custody of extended families, especially grandparents, who resume parental roles. The study also observed that when parents as caregivers are expected to work far from home, they leave their children with their grandparents. In the

absence of parents, grandparents resume the role of primary caregivers to their grandchildren and therefore expected to address SRH issues when the need arise.

Communication within the GPF is viewed as a priority, as families need to converse openly about SRH issues. Parents, including grandparents, acknowledge that open communication about SRH reduces risky behaviours among adolescents (Azie et al 2023:1;Mekie et al 2020:2; Kusheta et al*.,* 2019:1;Mekonen et al., 2018:2).The researchers noted that grandparents were confronted by barriers that impede open communication due to cultural constraints, where discussions on sexuality issues with children are regarded as taboo. Little is known about the extent of sexual reproductive health (SRH) knowledge grandparents possess hence, researchers identified the need to develop guidelines to assist grandparents in communicating SRH issues with their grandchildren (Deger 2018:007).

According to Simmonds et al. (2021:2), older women play a pivotal role through role modelling behaviour and talking openly about SRH topics to protect their children. Several studies have also confirmed that grandparents, as caregivers, can enhance behavioural change through open communication with their grandchildren (Mcharo, Mayaud and Msuya 2021:2;Wallbaum et al 2018:2).According to Coall, Hilbrand and Hertwig (2014:1), grandparents are viewed as valued health promoters within families, and their presence is beneficial to their grandchildren's lives, thus the researcher aimed to develop guidelines that will assist grandparents in communicating SRH, including Human Immunodeficiency Virus and Acquired immunodeficiency virus HIV/AIDS awareness. However, studies have shown that despite adolescents being sexually active, many parents, including grandparents, fear communicating openly about sexual-related issues due to a lack of age-appropriate vocabulary and skills (Adam et al 2020:2; Kuo et al*.,* 2020:109; Nmadu et al 2020:2; Yibrehu and Mbwele 2020:6). Thus, the researcher aimed to develop guidelines that will assist the grandparents in communicating about SRH issues, including HIV/AIDS awareness, to their grandchildren. The researcher is of the opinion that once the grandparents are supported and empowered, they will be able to communicate openly with their grandchildren, which will further strengthen the self-confidence of the grandchildren. They will be able to make informed decisions.

Several factors that hinder open communication within families, such as culture, fear and lack of knowledge, were identified by both adolescents and grandparents (Abdissa and Sileshi 2023:8; Bikila et al 2021:2; Adam et al 2020:2; Mekonen et al., 2018:5). Communication between adolescents and grandparents reduces early sexual debut.

However, even though communication takes place in most families, the communication is characterised by warnings, threats and physical discipline (Bikila et al 2021: Titiloye & Ajowun, 2017:106; Ayehu, Kassaw & Hailu, 2016:2; Muhwezi et al*.,* 2015:15). As a result, the researcher saw it fit to develop communication guidelines that will assist grandparents, grandchildren and PHC nurses to communicate openly about SRH issues.

During the master studies, the researcher explored and described the HIV/AIDS awareness perceptions within families in one of the Northwest Province (NWP) villages and identified several GPFs affected by the endemic. These GPFs narrated how they struggle to communicate HIV/AIDS prevention to their grandchildren, thus, the need to support them. The grandparents were never exposed to HIV/AIDS as young adults. Hence, they find it challenging to communicate about SRH. The age gap that exists also poses many challenges regarding communication on SRH and HIV/AIDS prevention, and professional support is needed (Le Grand & Jemmott, 2013:1). Based on this experience, the researcher realised that it was necessary to develop communication guidelines for primary healthcare nurses to support GPF regarding SRH.

1.2 PROBLEM STATEMENT

Grandparents raising their grandchildren as primary caregivers have become a global issue (Kamangu, John & Nyakoki, 2017:45). A 2020 General household survey conducted in South Africa (SA) attests that an estimated 14.9 % of households contained three generations, while 4,5% were grandparent headed houses in which grandparents live with their grandchildren. The report further indicated that extended families were more common in rural areas at 48.9% as compared with urban areas at 30.4%.As such, adolescents under grandparents' care might miss the chance for sexual and reproductive health communication due to barriers arising from the lack of communication and culture. The above was observed in the PHC settings with the rate of teenage pregnancy, STIs recorded in the clinic including challenges experienced by grandparents who care for their greatgrandchildren whilst their teenage mothers are at school. Based on this, the researcher noted the absence of sexual reproductive health communication between grandparents and grandchildren. Whilst it is evident that there is a growing number of grandparents taking up the responsibility of caring for their grandchildren as parents are absent due to death, urbanisation, ill health and teenage parenting (Makiwane, Gumede & Makiwane, 2017:271). This role change has become a societal problem as grandparents are expected to afford care to their grandchildren and give parental love while they also have their own needs (Xu & Chi, 2016:1).

Barriers include, among others, a lack of information about sexuality, culture, traditional norms and religious beliefs. These barriers hinder open communication about SRH issues, which are considered taboo (Bekele et al 2022:8;Nketia 2022: 1598; Motsomi et al*.,* 2016:4; Seif et al*.,* 2016:524). Grandparents' silence on SRH issues also exacerbates the grandchildren's challenges, leading to grandchildren resorting to peers for clarity when seeking information. Due to the extensive age gap, grandparents may be silent or uneasy about discussing SRH issues with their grandchildren. The age gap challenges PHC nurses to support grandparents in SRH communication with their grandchildren (Wallbaum et al 2018:2). According to Wang et al. (2015:1), even though GPF is increasing, little attention is given to the role played by grandparents concerning SRH communication with their grandchildren.

Grandparents are a source of knowledge and can instil the norms and values in their grandchildren to enable them to grow into responsible adults (Boshkova, Shastina & Shatunova, 2018:284; Seloilwe et al*.,* 2015:2). However, presently, grandparents face some challenges as they care for their adolescent grandchildren and are expected to communicate about SRH issues, including HIV prevention, which may be challenging to handle because, in their era, SRH topics were perceived as adult talks (Bikila et al 2021:2). The same authors states that literacy level of the grandparents may also play a role when it came to SRH communication, as lack of knowledge contributes to poor parent-child communication on SRH issues. Therefore, it was necessary to support families to engage in health promotion SRH communication which empower individuals, families and the community to make informed decisions on matters that affect their health which ultimately prevent SRH related complications..

According to Chinyanganya & Muguti (2013:46-48), one of the effective ways of intervention is to impart SRH education to young people through effective communication. Communication has been identified as an important tool that a grandparent can utilise to educate or engage with their grandchildren to instil values and norms to promote good health (Othman et al 2022:314;Mekie et al 2020:1;Wallbaum et al 2018;1). Failure to communicate SRH effectively may result in social and economic challenges, increasing the strain on the household (Deger 2018:007; Haakonde et al., 2018:219).

Although grandparents are primary sources of information on SRH issues in GPF, there is protracted silence between most grandparents and their teenage grandchildren on this matter (Muhwezi et al., 2015:3). The authors state that socio-cultural barriers must be

addressed to promote effective family communication. The researcher is of the opinion that these young children need to be empowered to make informed decisions related to sexual and reproductive issues, thus reducing new infections and teenage pregnancy. Therefore, it is necessary to develop communication guidelines for primary health nurses to support grandparent-headed families regarding sexual and reproductive health.

1.3 RATIONALE OF THE STUDY

SRH communication has been identified as the most vital protection factor to prevent sexual risk taking behaviours. Thus, grandparents have to communicate with their grandchildren (Taddele, Jera & Hunie, 2018:204; Jain & Singhal, 2017:232). Once the grandchildren are empowered about SRH, sexually transmitted illnesses (STIs), teenage pregnancy and HIV&AIDS will be addressed. Several studies have been conducted locally and internationally regarding HIV/AIDS prevention. Still, little has been done to emphasise the importance of SRH communication within the grandparent headed families (Wang et al., 2015:1). GPF must be supported to strengthen open communication between grandparents and their grandchildren. Nkwashu and Mafukata (2015:1076) state that the education of a child is believed to be the cornerstone of successful adult life, and this could be achieved through effective communication about SRH issues, thus promoting a healthy life for the individual, families and the community at large. In this study, grandparent-grandchild communication is crucial because these grandchildren stay with their grandparents.

1.4 SIGNIFICANCE OF THE STUDY

The significance of the study was to reveal the experiences of the grandparents, grandchildren and PHC nurses regarding communication about sexual reproductive health. The findings of the study assisted in developing communication guidelines for primary healthcare nurses to support grandparent headed families regarding SRH, including teenage pregnancy. The significance of this study is outlined in clinical practice, family health nursing, nursing education and nursing research.

1.4.1 Clinical Practice

High quality healthcare provider-client communication is viewed as the backbone of the art of Nursing Science (Kwame & Petrucka 2021:1). PHC nurses are expected to raise awareness about SRH communication within the grandparent headed families (GPF).. Therefore it was important to identify barriers that hinder open communication between the healthcare providers and the clients so that misconceptions are corrected. Purpose of the

guidelines was to assist PHCNs to provide quality SRH service and promote SRH communication within the grandparent headed families. In this study, the guidelines will also be used as a point of reference during service delivery. These guidelines is one of the interventions that will play a major role in attaining universal health coverage on SRH promotion. Kwame & Petrucka (2021: emphasised that respectful communication between the nurse and the client reduce uncertainty, enhance client or patient engagement on matters that affect their health leading to informed decision making, adherence to treatment etc.

1.4.2 Family Health Nursing

There is a need to support grandparents to communicate freely about SRH issues with their grandchildren. Misconceptions were identified and can be corrected through health promotion. The empowerment of these GPFs may yield positive results whereby both grandparents and grandchildren become knowledgeable about SRH and thus make informed decisions. Grandparents could transfer norms and values to the grandchildren without any hindrances, as open communication is viewed as a protector when it comes to SRH matters. The guidelines will assist the PHCNs to build rapports to create an enabling environment for both grandparents and grandchildren; use communication skills during history taking will assist to gather data that will be used to formulate a diagnoses, provide appropriate treatment and give non drug management to ensure that the treatment is well taken. The family will understand and respect the clients beliefs (religion or cultural) not to impose any decision and allow the client (family) to make an informed decision.

1.4.3 Nursing Education

Curriculum development includes Family Health Nursing, where family communication is emphasised, and families are supported when they encounter problems regarding open communication regarding SRH**.** Cultural issues are debated, and taboos are addressed to enhance open and effective family communication. Health promotion is the baseline for the prevention of risky behaviours. Review of SRH module which must include SRH communication as one of the objectives to be achieved. SRH communication can add value to nursing and education of Primary health care nurses following the new program SANC regulation R635. Well trained PHCNs will be able to engage or promote SRH communication within the families. PHCNs must be prepared to be able to handle sensitive topics with ease not forgetting being cultural sensitive and the importance of value clarification should also be promoted during training.

1.4.4 Nursing Research

More research is needed to come up with strategies that can be used to assist GPFs as they communicate about SRH issues. Studies need to be conducted to address challenges experienced by grandparents and grandchildren regarding SRH communication. To provide evidence based nursing care that emanates from research (experiences of the participants who provided recommendations to assist in improvement of care and they can be reviewed at any given time when new information surface.

1.5 RESEARCH QUESTIONS

The study was guided by the following research questions in two phases:

Phase 1

- What are the experiences of grandparents regarding sexual and reproductive health communication with their grandchildren?
- What are the experiences of grandchildren regarding sexual and reproductive health communication with grandparents?
- What are the experiences of Primary Health Nurses regarding the promotion of sexual and reproductive health communication with grandparents and grandchildren?

Phase 2

- How will the content of the communication guidelines for primary health nurses ensure effective communication between grandparents and grandchildren regarding sexual and reproductive health?

1.6 AIM OF THE STUDY

The aim of the study was to develop communication guidelines that PHC nurses may use to support grandparent headed families with communication about sexual and reproductive health.

1.7 OBJECTIVES OF THE STUDY

The specific objectives that formed the basis of this study were formulated according to the two study phases:

Phase 1:

- To explore and describe the experiences of grandparents regarding sexual and reproductive health communication with grandchildren.
- To explore and describe grandchildren's experiences regarding sexual and reproductive health communication with grandparents.
- To explore and describe the experiences of primary healthcare nurses regarding the promotion of SRH communication with grandparents and grandchildren.

Phase 2:

- To develop communication guidelines for primary healthcare nurses to support grandparent headed families with communication about sexual reproductive health.

1.8 CONTEXT OF THE STUDY

This study was conducted in the Tshwane district of the Gauteng province, in communities where grandparents are residing with their grandchildren. The grandchildren were of school going age. The study was done in the residential places of the grandparent families and four (4) primary health facilities where twelve (12) PHC nurses were based see table 3.1.These settings were natural, relaxed and not controlled (Polit & Beck 2017:147; Brink, van der Walt & van Rensburg, 2018:47).

1.9 CONCEPT CLARIFICATION

1.9.1 Adolescence is defined as a stage which is characterised by rapid physical, biological, emotional, psychological and intellectual growth (Dawood, 2015:1). Nkwashu and Mafukata (2015:1077) further view adolescence as a period of development that is marked by experimentation and engagement in new activities, including sexual relations. In this study, an adolescent is a school going grandchild aged 18 to 22 years who stays with their grandparent(s) in the absence or presence of their parents.

1.9.2 According to the Children's Care Act (Act No.38 of 2005), a **caregiver** is any person, other than the parent or guardian, who factually cares for a child. In this study, a caregiver is a grandmother or grandfather who stays with the grandchild(ren) in the presence or absence of the parents.

1.9.3 Family communication is defined as a mutual process where family members interact with one another in sharing information and regulating what needs to be known in life (Wang et al., 2018:2). In addition, Li and Wang (2015:135) view family communication as a source

of intimacy and adaptability among family members. In this study, family communication is between the grandparents and grandchildren as they communicate about SRH issues, such as teenage pregnancy, family planning and HIV/AIDS.

1.9.4 Grandparent is the biological parent or stepparent of the grandchildren's father or mother (Martin, 2016:12). In this study, a grandparent was a grandmother or grandfather who is aged 36 years and above who was staying/caring for adolescent grandchildren aged 18-21 years who were still going to school.

1.9.5 Kredo et al. (2016:123) define **guidelines** as a convenient way of packaging evidence and presenting recommendations to decision makers. The purpose of this study was to develop guidelines based on the data derived from Phase One for PHC nurses to support GPFs in communicating about SRH. In this study, guidelines are principles and recommendations for PHC nurses to support grandparents in communicating with their grandchildren about SRH.

1.9.6 Parents are defined as all those who provide significant and primary care for adolescents over a significant period of the adolescents' life without compensation, such as parents, grandparents, including other caretakers (Kusheta et al., 2019:3). In this study, grandparents were the primary caregivers to their grandchildren in the presence or absence of the biological parents.

1.9.7 According to the Nursing Act No.33 (2005:25), a professional nurse is a person who is qualified, competent and able to practice comprehensive nursing independently, further considering their scope of practice. **A Primary health care nurse** is a professional nurse with a basic nursing qualification in General Nursing and an additional qualification in Clinical Nursing health assessment, diagnosis, treatment and care, as stipulated in the South African Nursing Council (SANC), Regulation 48 including Postgraduate diploma in Primary health care SANC Regulation 635. In this study, a PHC nurse is any registered nurse who works in the community or the primary health facilities, offers the first level of health care to families and conducts home visits in the Tshwane district.

1.9.8 According to Shewasinad et al. (2016:131), sexual reproductive health is the ability to develop and grow into a responsible person and further enjoy sexual life without any harm. It Sexual reproductive health is further viewed as "a person's right to a healthy body and the autonomy, education and healthcare to freely decide who to have sex with and how to avoid sexually transmitted infections or unintended pregnancy. Sexual health is an integral part of

overall health and well-being, ensuring everyone can have pleasurable and safe sexual experiences,freeof coercion, discrimination or health risks."https://www.msichoices.org/what-we-do/learn/what-is-sexual-and-reproductive-health/#. In this study, SRH is the ability of the grandchildren to maintain a healthy sex life throughout their lifespan through open and effective communication with their grandparents.

1.10 DELINEATION OF THE STUDY

The study was limited to grandparent headed families concerning SRH communication between grandparents and grandchildren within the Tshwane District. The focus was on the shared lived experiences of grandparents, grandchildren and PHC nurses regarding SRH. The grandchildren were school going and between the ages of 18-22, and the grandparents should be 36 and above, as the researcher was more concerned about their experiences regarding SRH. The PHC nurses were based in the PHC facilities and communities where grandparents and grandchildren consult regarding SRH. The study was conducted in residential places and selected PHC facilities in the Tshwane district of the Gauteng province**.**

1.11 ASSUMPTIONS OF THE STUDY

A paradigm is defined as a set of acceptable beliefs that guide the research and is based on philosophical assumptions (Gray et al., 2017:49; Polit & Beck, 2017:19; Brink et al., 2018:22). According to Lincoln and Guba in Creswell (2014:23), there are five research paradigms namely: Positivism, Post-positivism, Critical theory, Constructivism and Participatory.

The current study used a constructivist paradigm to capture, explore and describe grandparents' experiences regarding communication about SRH with their grandchildren. This was done to better understand the lived experiences of the grandparents and grandchildren and included primary health nurses who were in contact with them. People construct their understanding and knowledge of the world through experience and reflection on those experiences (Marjan, 2017:28). Paradigms are systems that are defined in three dimensions, namely, ontology, epistemology and methodological assumptions (Durkheim & Painter, 2014:40). A detailed description of the paradigmatic assumption underpinning this research study is discussed in Chapter 3.

1.12 RESEARCH DESIGN

In this study, a qualitative approach and phenomenology were used as theoretical frameworks. Creswell (2013), cited in Marjan (2017:27), states that phenomenology focuses on the participants' life experiences and the meaning they make of their experiences. According to several authors (Durkheim & Painter, 2014:40; Koopman, 2015:2), this approach was introduced by Husserl and was further developed by Heidegger. This framework enabled the researcher to interview the participants and for them to share their lived experiences and reflect on the meaning they provided.

In this study, the researcher conducted face-to-face phenomenological interviews with the grandparents, grandchildren and PHC nurses for them to share their lived experiences about SRH communication. Bracketing enabled the researcher to understand why the participants attach meaning to their experiences. The interviews were audio-recorded, thus allowing the researcher to listen to them during data analysis. Themes, categories and sub-categories emerged from the analysed data refer Chapter 4 and 5 of the study.

1.13 ROLE OF THE RESEARCHER

The researcher is an experienced Community health nurse and Primary health care nurse who lectures and accompanies students to various Primary health facilities in the Tshwane district. The researcher was also the primary data collection instrument and avoided preconceived ideas during data collection through bracketing (Botma et al*.,* 2016:203; Teherani et al*.,* 2015:669; Creswell, 2013:207). The services of a research assistant were employed to assist the researcher during the data collection stage. The researcher obtained permission to conduct the study from all the relevant authorities before the commencement. The researcher identified a social worker who assisted with a list of grandparents headed families who met the inclusion criteria in the Tshwane district. The researcher selected the participants who met the inclusion criteria and were willing to participate in the study. The study was conducted in two phases. Phase 1 was the empirical data, and Phase 2 was the development of guidelines. Phase 1 was a qualitative descriptive phenomenology, where the experiences of the grandparents, grandchildren and PHC nurses were explored and described. Phase 2 was the development of communication guidelines for PHC nurses to support grandparent headed families regarding SRH.

1.14 OVERVIEW OF THE RESEARCH METHODOLOGY

A detailed discussion of the methodology of this study is outlined in Chapter 3 (Phase 1) and Chapter 6 (Phase 2). Below is a brief overview of the method used.

1.14.1 Phase 1

A qualitative descriptive phenomenology and contextual approach were employed in Phase 1 to answer or address the research questions. The goal of phenomenology was to describe or interpret the meaning of the experiences in terms of what was experienced and how it was experienced. In this study, the researcher tried to understand the lived experiences through a detailed description of the people being studied: the grandparents, grandchildren and PHC nurses in the Tshwane District of the Gauteng Province.

A descriptive phenomenology design guided by the constructivist philosophical assumptions where the worldview arose from the actions, situations and consequences rather than the antecedent conditions were utilised. According to Gray et al. (2017:65), phenomenology is based on the philosophical foundation that embraces the research methods of listening to individuals as they share their lived experiences. It further analyses verbal and non-verbal communication to understand the lived experiences to attach meaning. Botma et al. (2016:190) view experiences as beliefs, perceptions, memories, judgements and evaluations, including everything related to body actions. In this study, the researcher listened to lived experiences of the grandparents, grandchildren and PHC nurses regarding SRH communication, then analysed the collected data to better understand participants' experiences.

Research methods are the specific ways the researcher follows in conducting the study (Gray et al., 2017:683). These included population, sampling, data collection and data analysis. Brink et al. (2018:116) define a population as the entire group of people who interest the researcher. The population in Phase 1 consisted of families who stayed in the Tshwane district, including registered nurses in Tshwane district Primary health facilities. The target population was GPF and PHC nurses in the Tshwane district. In this study, the target population consisted of grandparents staying with school going grandchildren between the ages of 18 to 21.

Sampling is selecting a group of people, events or other elements with which the researcher wants to conduct a study (Gray et al., 2017:691). A non-probability, purposive and snowballing sampling method was used to select the participants in grandparent headed

families and PHC nurses (Gray et al*.,* 2017:345; Polit & Beck, 2017:499). In this study, purposeful sampling assisted the researcher in selecting the sample based on the knowledge of the phenomenon under study, whereas snowballing assisted in expanding the sample size (Brink et al*.,* 2017:126). The researcher identified a social worker who helped with a list of grandparents headed families within the community. The families that met the inclusion criteria and were willing to participate in the study were included (Moser & Korstjens, 2018:10; Botma et al., 2016:126).

Data collection is the precise and systemic path researchers follow to gather the information that enables answering the research questions (Gray et al., 2017:675). A pilot study was conducted with one of the families with the same characteristics as the families who participated to test the tool used and make necessary adjustments.

Data was collected through in-depth individual face-to-face unstructured interviews, observation of non-verbal communication and writing of field notes (Moser & Korstjens, 2018:13). An audio tape was used to capture all the data (Botma et al*.,* 2016:206). Participants were allowed to share their lived experiences and opinions about SRH communication (Polit & Beck, 2017:509). The participants were informed about the presence of the research assistant. The interviews were conducted in either English, Setswana or Sepedi, depending on the home language of the respondents. The researcher used various communication skills during interviews, such as probing, listening, paraphrasing, clarification and silence. Average interviews lasted for thirty minutes, but continued until data saturation was reached (Moser & Korstjens, 2018:11; Gray et al., 2017: 352; Polit & Beck, 2017:744).

Interviews were transcribed verbatim, and those conducted in Setswana and Sepedi were translated into English before the data analysis process. Giorgios' phenomenological method of data analysis was followed (Holroyd, 2001:2). The researcher listened to the audiotape repeatedly and transcribed all the information to get a sense of the whole. Reflective remarks were made to understand the essence of the participants' lived experiences as they were shared. Raw data from individual participants were summarised. The researcher and the independent coder worked together until a consensus was reached. The analysed data was further shared with the lead supervisor for validation. Themes, categories and sub-categories emerged from the analysed data.

1.14.2 Phase 2

Phase 2 addressed the development of communication guidelines to support grandparent headed families regarding SRH in the Tshwane district of the Gauteng province. The findings from Phase 1 formed the basis for developing the guidelines and were supported by the literature. The researcher drafted the guidelines using the AGREE II instrument based on the empirical data from the participants in Phase 1.

Delphi techniques were used where subject experts in the SRH were involved in validating the drafted guidelines. The Delphi technique/method is used to measure the judgement of several experts in a certain field to make a decision (Polit & Beck, 2017:725). This study was an interactive process aimed at getting a range of opinions or views from a group of experts. It was facilitated by the researcher to maintain objectivity (Hu et al., 2016:5). Delphi technique was conducted until data saturation was reached.

The population consisted of 14 knowledgeable experts with experience in sexual and reproductive health. In this study, the experts comprised academics, policymakers and other national and international stakeholders who are conversant with SRH (McMillan, King & Tully, 2016:659). The participants' identities were kept confidential to provide accurate answers or inputs based on their experience and knowledge. Purposive and snowballing sampling methods were used to select the participants (Polit & Beck, 2017:499). In this study, participants were experts and knowledgeable about SRH, with an experience of 3-5 years in the field (Polit & Beck, 2017:417).

The questionnaire, which contained open-ended questions, was used to collect data (Gray et al., 2017:417). Polit and Beck (2008), cited in Botma et al. (2018:253), state that open-ended questions allow the participants to give their views independently without being influenced. All the participants were given an information leaflet about the study and what was expected from them. All the participants signed a consent form before participating in the study. The drafted guidelines were in a questionnaire format and were emailed to all the participants for interrogation and input. Inputs were returned to the researcher for refinement and consolidation (McMillan et al., 2016:658). Data collection was done until saturation was reached.

The researcher refined the guidelines according to all the submitted inputs and sent the refined drafted guidelines to the participants for further input during the next round. The participants reached a consensus when no more inputs were presented, and then the

researcher analysed the final draft. Data analysis comprised qualitative analysis, which generated themes from open-ended questions, and quantitative analysis to develop statistical analysis (Botma et al*.,* 2018:254). The development and validation of the guidelines were based on the AGREE II (2010) instrument. According to Brouwers et al. (2016:1), AGREE II is a standard used to assess the methodological quality of practice guidelines for appropriateness and transparency (Tejani et al., 2017:655; Novo et al., 2016:213).

1.14.3 Ethical Considerations

Ethics is defined as a system of values that ensure that the rights of the research participants are protected (Polit & Beck; 2017:727). The study involved the participation of human beings whose rights needed to be protected as required by the Constitution of the Republic of South Africa. In recognition of human rights, the fundamental principles outlined in the Belmont Report were applied throughout the study (Gray et al., 2017:162; Polit & Beck, 2017:139). The three fundamental ethical principles: Beneficence, respect for human dignity and justice, are discussed below.

1.14.3.1 Permission to conduct the study.

The researcher ensured that permission to conduct the study was acquired from the respective authorities, as highlighted below:

- The study was submitted to the University of Pretoria Ethics Committee, and an approval certificate was issued: Protocol No: 45/2020 refer Annexure A
- The Tshwane Child Welfare refer Annexure C
- City of Tshwane Research Committee refer Annexure B
- Department of Health Research Committee
- Participants were given information and signed a consent form before the commencement of data collection refer Annexures D,E,F

1.14.3.2 Beneficence

This principle expects the researcher to ensure the safety of all the participants by minimising harm and producing benefits for the participants (Polit & Beck, 2017:139). The right to freedom from harm and discomfort includes preventing exploitation by not exposing the participants to unnecessary risks (Polit & Beck, 2017:139). The researcher ensured that the information the participants provided was not used against them and was treated as confidential. The researcher ensured that participants who became emotional when sharing their experiences were referred to the social worker for debriefing (Polit & Beck, 2017:149).

The participants were also provided with the researcher's contact details in case they needed to be referred at a later stage. The researcher ensured that the average interviews lasted for thirty minutes to sixty minutes. The research assistant assisted with monitoring of the time allocated for each interview and where the interview went over sixty minutes, the researcher did not stop the participants from providing information. This ensured that participants are allowed to provide rich and thick data at their own free will without any disturbance. In this study, all the participants continued with the interviews until saturation was reached, they verbalised that they were comfortable sharing information. Participants were reminded about the service of a social worker should the need arise. The participants were assured that all the information would be kept in a locked safe as a means of protection, and unique codes were used in the reports to prevent the identity of the participants. The researcher also signed a declaration for the storage of all the documents.

The Disaster Management Act (Act No 57 of 2002) intended to provide for:

"*An integrated and coordinated disaster management policy that focuses on preventing or reducing the risk of disasters, mitigating the severity of disasters, emergency preparedness, rapid and effective response to disasters and post-disaster recovery".* The President of the country, Mr Cyril Ramaphosa, declared a national state of the disaster which consisted of five (5) alert levels whilst mitigating the severity and preparedness of the country in dealing with COVID-19. The researcher ensured that the Disaster Management Act: Regulations related to COVID-19 were adhered to protect all participants. In this study, the researcher ensured that during information sharing, all the participants wore masks, sanitised their hands and maintained social distancing.

1.14.3.3 Respect for human dignity

This principle includes the right to self-determination and full disclosure. The participants had the right to withdraw at any given time without being victimised. The participants were given information about the study so that they could make an informed decision regarding their participation. A detailed information leaflet written in the participants' preferred language was issued to individual participants, who were also allowed to ask questions (Polit & Beck, 2017:140). The participants were given three to four weeks to review the information leaflet to make an informed decision. In this study, participation was voluntary.

1.14.3.4 Justice

The principle of justice deals more with the right to fair treatment and privacy. The participants were selected based on the requirements of the study, not on their vulnerability

(Polit & Beck, 2017:141). The researcher provided information and issued an information leaflet (Annexure D,E,F) to all the participants so that they could make an informed decision about their willingness to participate. The consent was signed before the commencement of data collection when the participants were ready to proceed with the interviews, where they shared their lived experiences regarding SRH. Each participant was issued a consent form. In this study, special codes are used to identify the participants, i.e., P1GF1 meaning participant 1 who belongs to grandparent family number 1 and the reports were written in such a way that participants were not linked to the information provided (Gray et al., 2017:168; Polit & Beck 2017:147).

1.15 STRUCTURE OF THE THESIS

The structure of this thesis is outlined as follows:

Chapter 1: Background of the study
Chapter 2: Literature Review
Chapter 3: Research Design and Methodology
Chapter 4: Presentation of the findings from Phase 1
Chapter 5: Discussion of the findings, literature synthesis and control
Chapter 6: Development and Description of the Guidelines in Phase 2
Chapter 7: Conclusion of the findings, validation and description of the guidelines with recommendations, limitations, implications and conclusions.

1.16 SUMMARY

Chapter 1 provided an overview of the research study regarding SRH communication. It also provided the background, problem statement, purpose and objectives, the significance of the study, research questions and clarification of concepts. A summary of the research methodology, according to each phase, was also described and ethical considerations were addressed. Chapter 2 provides a detailed review of the literature relating to the phenomenon under study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter covers the literature reviewed. Polit and Beck (2017:733) define a literature review as the critical summary of the research on the topic of interest that is often prepared to contextualise the research problem. Brink et al. (2018:59) state that in qualitative research, the literature review is done after data collection and data analysis to prevent contamination of the study. Polit and Beck (2017:87) state that qualitative researchers have different viewpoints about the literature review as some are associated with their traditions, and highlight the following views:

- The grounded theory literature review is done after data collection. Researchers only turn to literature when they seek to relate the findings to the theory prior to the findings.
- On the other hand, in ethnography, literature reviews are done at the onset of the study to better understand the phenomena to be explored (Brink et al., 2018:59).
- The same authors further indicate that in historical research, an extensive literature review is done to develop a research question and a source of data to explain a phenomenon over a period of time.
- Munhall, cited in Polit and Beck (2017:87), states that Phenomenologists often undertake a literature review at the onset of the study to look for experiential descriptions of the phenomenon under study and expand understanding. Gray et al. (2018:252) concur that a brief literature review should be conducted to establish the need for the study.

Based on the above explanations, the researcher followed the phenomenological approach, according to Polit and Beck (2017:87), to better understand sexual reproductive health communication within grandparent headed families. In this study, the literature review was done to express the established knowledge about SRH communication to support grandparent headed families. This assisted the researcher to understand what was already done. This chapter also provides information on the strategies followed by the researcher to conduct a literature search.

2.2 PURPOSE OF LITERATURE REVIEW

The purpose of the literature review is not to list all the published material but to evaluate, interpret and synthesise the information the researcher has gathered. This further assists in preventing duplication of the work other researchers have already done (Brink et al*.,* 2018:58; Polit & Beck, 2017:111; Maggio, Sewel & Artino, 2016:297). The literature review is done to enable the researcher to integrate what is done by previous authors and to come up with new information or a body of knowledge. Winchester and Salji (2016:1) state that a literature review is done to develop research ideas and consolidate all that is known about the topic to identify gaps the current study will cover. Furthermore, Maggio et al. (2016:297) state that a literature review assists the researcher in providing context about the topic under study, identifying innovation and ensuring that professional standards are met and maintained.

2.3 SIGNIFICANCE OF LITERATURE REVIEW

The significance of the literature review is to gather a thorough knowledge of the subject matter regarding SRH communication within grandparent health families to identify gaps and come up with solutions to the problems identified in previous studies. Maggio et al. (2016:297) state that a proper literature review increases the likelihood of designing a more relevant, adaptable and generalisable study to maximise impact. The researcher is of the opinion that developing communication guidelines for PHC nurses to support grandparent headed families regarding SRH will positively impact the life of both the grandparents and grandchildren. Empowering both grandparents and grandchildren will assist in the reduction of adolescent risky sexual behaviour. Mudavanhu (2017:19) confirms that a literature review enables the researcher to justify the proposed study and its contribution to the body of knowledge.

In this study, gaps from previous SRH related studies were identified. Furthermore, the study was conducted to provide solutions and a new body of knowledge to enhance health promotion and disease prevention (Ajayi et al., 2020:4; Ali et al., 2018:4; Heward-Mills et al., 2018:6). The statements mentioned above were in line with the researcher's aims and objectives in trying to explore and describe the experiences of grandparents, grandchildren and PHC nurses regarding SRH communication and come up with new solutions and a new body of knowledge.

2.4 METHODOLOGY

Baumeister et al., cited in Snyder (2019:324), identified three methods to conduct a literature review: systematic, integrative and narrative or semi-systematic literature reviews.

- **Systematic literature review**

The systematic literature review has been defined as a process of identifying and critically appraising, collecting and analysing data from the research. Tawfik et al. (2019:1) view a systematic literature review as a systematic method used to summarise evidence on a question with a detailed and comprehensive study plan. A meta-analysis, a statistical method, was used to analyse the data meaning appropriate for quantitative data, according to Liberati et al*.* (2009*),* cited in Snyder (2019:324). According to Hanley & Cutts (2013:3), a literature review is a research process designed to overcome bias due to its rigorous nature and to systematically review literature in a particular area of study.

Higgins and Green (2008), as cited in Cutts (2013:4), provide several characteristics of the systematic literature review, and among others, these include:

- A systematic literature review is a type of literature review that has a clear set of objectives that guide the study.
- The methodology should be explicit and systematic in identifying all the studies that meet the eligibility criteria.
- There is also the verification of assessment outcomes and the systematic presentation of the findings.

- **Integrative literature review**

An integrative literature review is done to assess, critique and synthesise the literature in a way that enables new theoretical frameworks. The integrative review includes both qualitative and quantitative studies. An integrative literature review intends to address new and emerging topics. Its main purpose is to develop a theoretical framework rather than coming up with an overview of the study (Christmal & Gross, 2017:13). De Souza, da Silva and De Carvalho (2010:105) state that an integrative literature review is the most comprehensive methodological approach which includes both experimental and non-experimental studies to understand the analysed phenomenon. However, it has been noticed that a combination of several methodologies may cause some bias, lack of rigour and inaccuracy. An integrative literature review should start with identifying the problem, including its related concepts, to facilitate the extraction of data from primary sources.

Furthermore, it should outline search strategies and inclusion and exclusion criteria to assess the relevance of the primary sources (Madhani et al., 2014:3).

- **Narrative or semi-systematic literature review**

A narrative or semi-systematic literature review or traditional review is designed for topics studied by various researchers within diverse fields. The purpose of a narrative or traditional literature review is to assist the researcher to identify gaps or inconsistencies in the research study (Byrne, 2016:1). The four types of narrative literature reviews are defined by Onwuegbuzie and Frels (2016:24):

  - **The theoretical literature review** is more concerned with the theory or framework used in the study, including how the study is shaped around that theory or framework.
  - **The methodological literature** review looks at the strengths and weaknesses of the method used and provides what may be done in the near future.
  - **The historical literature review** focuses on reviewing research studies throughout a certain period of time. This process places the research in a historical context (over a period of time) to identify new developments about the topic under study. In this study, previous studies were reviewed to identify gaps, prevent duplication and come up with new information.
  - **The general literature review** provides a review of the most critical aspects of the current knowledge of the topic understudy. It forms the introduction of the study and includes the research objectives, problem statement and the researcher's arguments. The researcher is of the view that a general literature review assisted in providing relevant narratives.

A traditional or narrative review provides a broad overview of a research topic with no clear methodological approach. In this study, a narrative literature review was followed due to the qualitative nature of the study. Themes or concepts were identified to interrogate SRH communication within the grandparent headed families and create a scope for future research.

2.4.1 Literature Sources

The following is the summarised process undertaken by the researcher in the compilation of this chapter. The system model, which consists of three (3) stages, was followed, and the stages have been depicted in Figure 2.1.

2.4.2 Stages of Literature Review

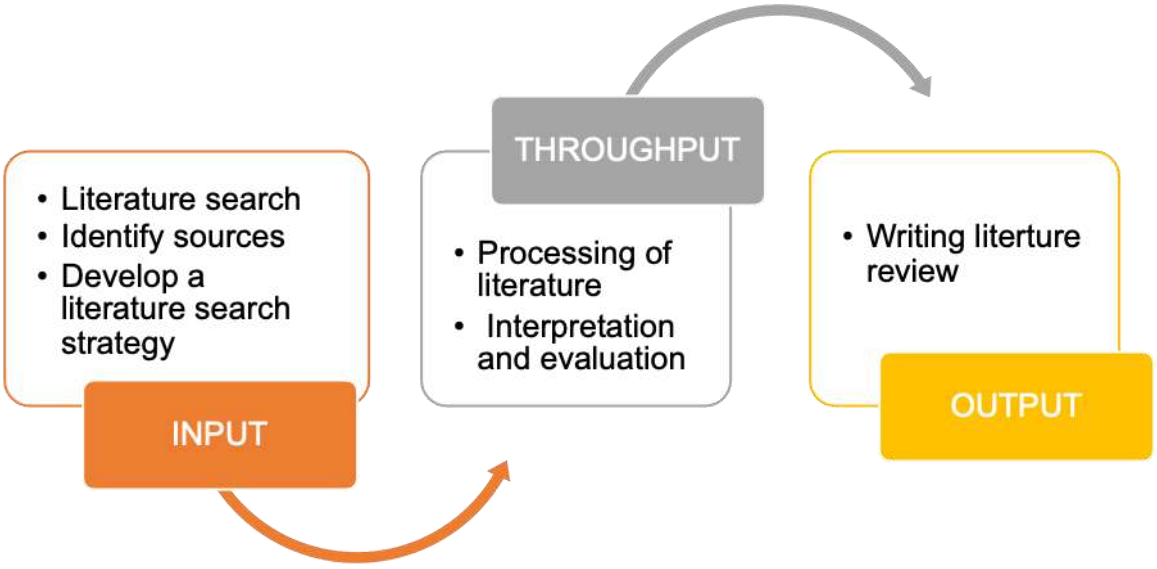

Figure 2.1: ***A systems model of literature review*** (Gray et al., 2018:126)

- **Input**

Input is the process that is followed for searching for sources that are relevant and related to the phenomena under study (Gray et al*.,* 2018:126; Brink et al*.,* 2018:64). In this context, inputs are all the searches done in the form of books, journals, protocols, health standards, Acts and regulations, including relevant articles related to SRH.

The inclusion criteria:

- Publications dated between 2016 and 2023.
- Publications from articles and journals
- Publications written in English.
- The population of interest included the family, grandparents, grandchildren and healthcare providers.

Exclusion criteria

- Publications before 2016
- Publications that were not relevant to the study
- Publications written in other languages.

2.4.3 Search Strategy

The researcher used the electronic database as the main source of the literature search, and the following databases were utilised: Google Scholar, PubMed, National Library of Medicine (Medline), EBSCOhost and Cumulative Index to Nursing and Allied Health Literature (CINAHL). The researcher included other materials, such as books, newspapers, theses and dissertations related to communication regarding sexual reproductive health within families. The information collected was between 2016 and 2023 to ensure it was current. The timeframe that was used during data collection assisted the researcher to limit the sample size (Polit & Beck, 2017:89). The researcher used the following keywords during the literature search: “adolescent, teenagers, young people”, “communication”, “communication within the family”, “family”, “grandparent; caregiver”, “grandparent headed families”, “sexual reproductive health” and “health care provider”.

- **Throughput**

Throughput is all the processes that entail reading, critical appraisal, analysing and synthesising the literature that has been retrieved. The process assisted the researcher to come up with the articles that were gathered; to assist in formulating an understanding of what other researchers have done and identifying the gaps (Gray et al., 2018:133-135). In this study, the researcher read through the articles, checking for relevance and usability to determine the suitability of the source to the topic under study and continued to critically review all the decisions taken to reach a conclusion and/or recommendations.

- **Output**

According to Gray et al. (2018:136), the output is the process followed when a literature review is compiled or written. The following discussion entails the arguments gathered to provide information about literature that was found regarding sexual reproductive health within families. Figure 2.1 consists of six (6) concepts identified during the analysis of the reviewed literature, namely, family, communication, culture, sexual reproductive health, healthcare providers and the legal aspects related to SRH. These concepts are interrelated and are discussed in detail. The concepts form the basis of the information needed to develop the SRH communication guidelines that will support PHC nurses, grandparents and grandchildren. Each concept is described in detail and how it impacts the study.

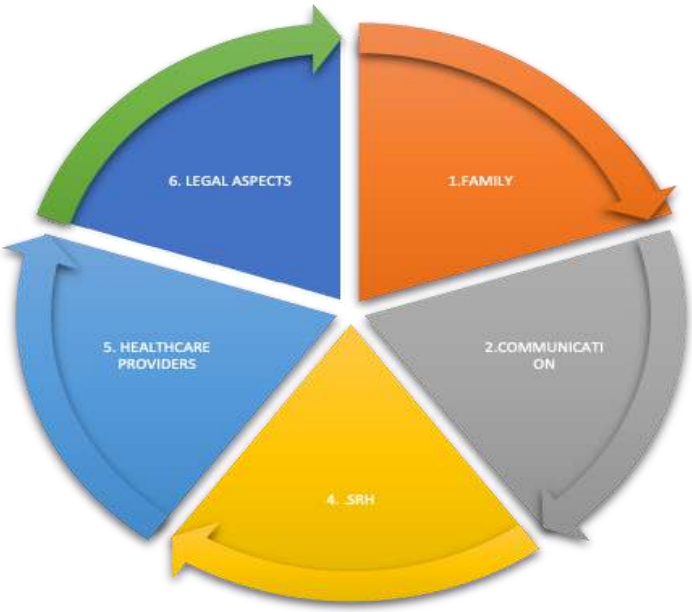

Figure 2.2: ***Flow chart for the SRH discussions***

2.5 DISCUSSIONS OF FINDINGS FROM LITERATURE REVIEW

The discussion covers the following headings: family, communication, culture, SRH, healthcare providers and legal aspects that impact SRH.

2.5.1 Family

Townsend and Morgan (2017:200) define a family as two or more individuals who depend on each other for emotional, physical and economic support. Several types of families exist within the community, e.g., the nuclear family, which consists of either parents or a single parent with children, and an extended family, which consists of the nuclear family and other family members, including grandparents. Extended families, especially grandparents, are valued because of their life experiences and wisdom (Mafumbate, 2019:10; Townsend & Morgan, 2017:204; Friedman, Bowden & Jones, 2003:10). In this study, a family is a grandparent headed family residing with grandchildren in the presence or absence of biological parents.

The family has been identified as the source of help in health-related matters as part of their socialisation, whereby they instil values and norms in the children (Agudile et al., 2020:37; Neme & Dereje, 2020:15; Bireda & Pillay, 2017:109; Friedman et al., 2003:51). Therefore, the family through its communication role is expected to engage in health promotion topics including those topics that are perceived as being sensitive namely SRH communication.

2.5.1.1 Parents

Habte et al. (2017:3) define parents as biological parents, stepparents, or foster parents. However, in this study, a parent is the grandparents staying with their grandchildren, aged 18-21, in the presence or absence of the biological parents. In a study by Feyisa et al. (2020:417), a parent is a child's guardian who is expected to guide and support the child throughout their lifespan. This study uses parents, guardians, caregivers, and grandparents interchangeably.

Several studies affirm the role played by parents in the dissemination of sexual reproductive information through words, behaviour, and values that they convey to the children (Maimunah, Afiatin & Helmi, 2019:170; Ashcraft & Murray, 2017:8; Habte et al*.,* 2017:12; Marcel et al., 2017:9). Louw and Louw (2015:346) state that a strong parent-child attachment plays a pivotal role in the life of an adolescent, not only by supporting the adolescent but by providing a secure base and freedom to explore in life.

Studies conducted in Kenya by Maina, Ushie and Kabiru (2020:1), George and Kungu (2020:208); Lachman et al*.* (2016:13) confirm the need for parents to be empowered with SRH information and effective communication strategies to enable them to engage freely with their children regarding SRH matters. Several studies conducted in Ethiopia also emphasise the need to support parents with SRH information (Adam, Demissie & Gelagay, 2020:2; Feyisa et al*.,* 2020:416; Yibrehu & Mbwele, 2020:8; Kusheta et al., 2019:2; Meikie et al., 2019:4; Taddele, Jara & Hunie, 2018:204; Busi & Chea, 2017:1952). However, a study by Lantos et al. (2019:12) recommended further research to check the content of SRH discussions and examine ways to support future parents and teen communication regarding SRH. A study conducted in Uganda by Ndugga et al (2022:11) revealed that most parents are not aware when is the right time for children to learn about sexuality issues. In addition, Mcharo et al (2021:4) delayed initiation of SRH discussion lead to these childing seeking information from other sources other than their parents. This may pose a problem because discussion with peers will exacerbate SRH related problems because they are not well informed.

2.5.1.2 Grandparent

Grandparents acknowledge several benefits of raising their grandchildren as they possess a significant role within the family through their wisdom and experience (Mafumbate, 2019:12; Kalpana & Rosalina, 2018:169; Munz, 2017:41; Pulgaron et al., 2016:6). According to

Statssa (2023), from 2017-2022, Gauteng Province (GP) saw an increase of over 242,000 older persons, followed by Western Cape (WC) with over 135,000. The same report highlighted that 19.7% of black African elderly are staying in skip generation households, and the female headed families top the list in KwaZulu-Natal (KZN), Mpumalanga (MP) and the Eastern Cape (EC). However, in the same period, GP experienced an influx of 24.8% of older persons migrating from other provinces (Statssa, 2023:10).

Several studies confirmed that grandparents, especially grandmothers, are primary caregivers to their grandchildren in the absence and presence of the biological parents, and as such, they are expected to discuss SRH topics with the grandchildren (Simmonds et al., 2020:2; Shirinda & Schultz, 2019:1). The same authors further reveal that these grandparents need new parenting strategies to be able to deal with the current social and cultural issues.

2.5.1.3 Adolescent

An adolescent is an individual in the age group 10-19, and a youth is in the age group 15-24 (Najafi-Sharjabad & Haghighatjoo, 2019:10542). In South Africa (SA), young people are individuals between the ages of 15-34 (Statssa, 2017:4). In addition, Busi and Chea (2017:1947) highlight the three (3) groups of youths: 10-14-year-olds are regarded as teenagers; 15-19-year-olds are regarded as an early adolescent, and 20-24-year-olds are considered as post-adolescents. In this study, the following words: adolescent, youth and teenager, are used interchangeably. These individuals are faced with challenges that are related to their developmental stages, which result in risk-taking behaviour which are detrimental to their overall health (Biswas, 2020:1; Pourkazemi et al*.,* 2020:1; Envuladu et al., 2017:58; Kurebwa, 2017:21; Ajike & Mbegbu, 2016:17).

Risky sexual behaviours are sexual behaviours that increase adolescents' probabilities of contracting or transmitting STIs and include the occurrences of unwanted pregnancies (,Anchen, Atekyereza and Rwabukwali 2021:1; Ngwenya, 2016:453).On the other hand, Ayawolowo, Ayawolowo and Afolabi (2020:7) indicate that multiple sexual partners, intergenerational sexual relationships and inconsistent condom use predispose adolescents to unwanted pregnancies, STIs and HIV/AIDS.

A study conducted in Australia on the Health Belief Model (HBM) and risk behaviours among adolescents revealed that despite exposure to the internet and the availability of SRH information, rates of STIs continue to rise (O'Dwyer et al., 2019:64; Kassahun et al*.,* 2019:1).

The researcher is of the view that more should be done to ensure that healthy SRH is promoted among adolescents and young adults.

Early sexual activity predisposes the adolescent to STIs, including HIV/AIDS. The Joint United National (UN) report on HIV/AIDS reveals that 30% of adolescents presented with new HIV infections, whereas 15% of adolescents already live with the HI virus (Ojebuyi, Fagmigbe & Akinola, 2019:1). In addition, several studies affirm that Sub-Saharan Africa remains the region with the highest new HIV infections amongst the adolescents aged 15-24 years (Agudile et al*.,* 2020:36, Dlamini et al*.,* 2017:1). The researcher perceives early sexual indulgence as a health concern which needs to be addressed through open communication. In this study, the researcher opted for the age group between 18-21 years, both males and females. Within this group, the study looked at those still attending school. The researcher wanted to under the grandchildren's experiences about Sexual reproductive communication with their grandparents.

2.5.2 Communication

Communication is an interactive process of transmitting information between two and more people, and it further consists of verbal and non-verbal communication (Townsend & Morgan, 2018:148; Jureddi & Brahmaiah, 2016:114). In this study, communication is an exchange and sharing of knowledge, ideas and other information concerning SRH issues among adolescents and their parents (Habte et al., 2017:3). According to Friedman et al. (2003:249), communication is a process of sending and receiving messages between human beings. The (ibid) states that communication can be written, spoken or through the media. The researcher perceives communication as an important tool that should be utilised between the grandparents and the grandchildren in their discussion of SRH matters.

2.5.2.1 Family communication

Family communication is viewed as the ability to discuss and attend to the changing needs, feelings and desires of family members (Mbachu et al., 2020:2). Furthermore, Adam et al. (2020:2) posit that parent-adolescent communication is a fundamental process through which parents convey ideas, values, beliefs, expectation, information and knowledge. In this context, family communication is simple communication between parents and adolescents regarding SRH issues within an enabling environment that is non-judgemental. Randolph et al. (2017:1) state that clear communication between parents and young people about SRH produces positive results and is reflected by high rates of sexual abstinence, condom use and intentions to delay sexual intercourse. Ngwenya (2016:459) asserts that young people

who receive clear and accurate SRH information tend to delay their sexual debut. The researcher believes that once the grandchildren are well-informed, they can make informed choices regarding their sexual reproductive behaviour. Therefore, the study intends to use family communication as a strategy that can assist to create SRH awareness within grandparent headed families.

The researcher concurs with studies that view parent-child communication as a protective mechanism against young adult's risky sexual behaviour (Agudile et al., 2020:47; Othman et al., 2020:3; Neme & Dereje, 2020:1; Nilsson et al., 2020:2). In other studies, the scholars are specific about the SRH topics that the adolescent and the parents address, and these include unwanted pregnancy, contraception, STIs including HIV, pre-marital sex, condom use, puberty and the menstrual cycle (Neme & Dereje, 2020:15; Feyisa et al*.,* 2020:417; Habte et al., 2017:3).

In this context, family communication is sharing information, beliefs and values between PHC nurses, grandparents and grandchildren regarding SRH, which includes teenage pregnancy, pre-marital sex, contraception, the menstrual cycle, STIs including HIV and termination of pregnancy. The information will empower grandparents and grandchildren, leading to delayed sexual debut, reduced teenage pregnancy and new HIV infections.

Habte et al. (2017:14) recommend providing information and education to adolescents and parents to increase awareness regarding sexual reproductive health. This is in line with the patient rights charter and the Batho-Pele principles. The provision of SRH information will ensure that adolescents make informed decisions. However, a study conducted in Bulawayo found that parents acknowledge communication with their adolescent but prefer using indirect communication methods such as idiomatic expressions, which pose a serious problem because the adolescent may not understand what is expected of them (Svodziwa, Kurete and Ndlovu, 2016:68).

Several studies acknowledge a body of knowledge about parent-child sexual reproductive communication, mainly between the mother and the daughter. However, limited or fewer studies have been done about father and son sexual communication (Agudile et al., 2020:48; Harris, Fantasia & Courtney, 2018:11; Busi & Chea, 2017:1951). On the other hand, Chane and Cherie (2018:421) indicate that there is evidence that adolescents do have discussions with their parents regarding SRH. However, a greater percentage take place between the adolescent and their peers. Busi and Chea (2017:1952) affirm that adolescents

and young adults are not discussing sexuality issues with their parents. According to the findings of a study conducted in Nigeria, parents acknowledge the importance of parent-child communication, however, it was found that it does not take place (Mbachu et al., 2020:9).

From the above deliberations, the researcher is of the opinion that more needs to be done regarding SRH communication, especially considering the HIV/AIDS statistics, teenage pregnancy, STIs and gender-based violence (GBV).

2.5.2.2 Sources of SRH Information

The following sources of SRH information have been identified and discussed; parents, school, religion/spirituality, healthcare providers, media and peers.

- **Parents as sources of SRH information**

Parents, as the primary socialisation agents, have a role to play to instil SRH norms, values and beliefs in the children so that they become responsible parents in the future (Ahari et al., 2020:1; Mafumbate, 2019:8; Chepkoech, Khanyasa & Ogola, 2019:19; Svodziwa et al., 2016:64). In contrary Seif, Kohi and Mashiro (2019:2) posit that parents tend to use threats and physical discipline as a form of SRH communication to maintain adolescents' virginity as a measure to prevent teenage pregnancy. South Africa (SA), like other countries, reflects the same findings (Nilsson et al*.,* 2020:9). In addition, the study conducted in Jordan on parent-child communication about SRH found several issues that affect communication among family members namely: educational leve of the grandparents, content of the information ,religious and cultural beliefs of the grandparents. These include parents not being comfortable discussing SRH with their children, and this increases the lack of open communication (Othman et al., 2020:68). On the contrary, Vongsavanh, Lan and Sychareun (2020:58) view parent and adolescent SRH communication as a strategy that enhances safe sexual behaviours, including delaying sexual debut.

Several studies reveal that teens tend to be reluctant to talk with their parents, fearing being judged, hence they prefer discussions with other extended family members (Ahari et al., 2020:1; Grossman et al., 2019:10; Coast et al., 2019:9; Ngwenya, 2016:458). The researcher supports open communication about SRH issues because parents are viewed as primary socialisation agents. Open communication within families encourages family members to share information about SRH. Once young people are empowered, they can make informed decisions. Parents need accurate SRH information, including support, to be comfortable and confident in delivering effective sexual related communication (Sunarsih et

al., 2020:2; Taddele, Jara & Hunie, 2018:203). Therefore, the suggested guidelines will assist grandparents and grandchildren to communicate about SRH. Dialogue between grandparents and grandchildren will contribute to better decision-making and informed SRH choices.

- **School as a source of SRH information**

Schools have been identified as another source of SRH information sharing through the inclusion of Life Orientation (LO) in the curriculum. LO is a standardised, compulsory subject facilitated by teachers in Grades 10 to 12. The purpose is to address the SRH topics, such as menstruation, teenage pregnancy and STIs (Govender, Naidoo & Taylor, 2019:14). Alimoradi et al. (2017:89) argue that schools should assist in the reinforcement of sexual reproductive health information, including norms and values. However, it has been established that teachers are also uncomfortable teaching the subject (Zulu et al., 2019:7).

The school was recommended as an effective setting that could assist in the reduction of risky sexual behaviour by the inclusion of SRH in the curriculum (Kazdouh et al., 2019:15; Svodziwa et al., 2016:69). This is supported by Mokwena and Morabe (2016:5), who established that the role of the school, and parents in promoting abstinence is the only option in the prevention of STIs and teenage pregnancy. The Department of Health (DoH) also developed a Policy on Adolescent and Youth Health, a standard driven approach that assists in promoting and wellbeing of adolescents and young adults. This policy can be used in conjunction with the Integrated School Health Policy (DoH, 2017:6).

Through their collaborative effort, the DoH and the Department of Basic Education (DBE) launched the National Policy on HIV, STI and TB. The reason for launching the policy was to address the SRH needs of school going adolescents and young people (Bamford, 2017:3). This policy was further strengthened by the introduction of the Integrated School Health Policy (ISHP), which ensures that the health needs of school going children are addressed (Bam, 2018:2; DBE, 2012:10). These policies created an enabling environment for learners, LO teachers and school health nurses to discuss health related matters including SRH. Hastuti et al. (2018:2) agree that school-based programmes have increased knowledge about SRH. In contrast, some teachers view the inclusion of sexuality education in the school curricula as role shifting because parents, as primary caregivers, are supposed to initiate SRH communication with their children (Deshmukh & Chaniana, 2020:61; Mturi & Bechuke, 2019:138; Mpondo et al., 2018:47; Alimoradi et al., 2017:85; Wanje et al., 2017:7). The researcher is of the opinion that teachers also need to be supported by attending

workshops on health-related topics. Teachers who are well informed about SRH related topics will be able to deliver content which will assist the grandchildren in sharing information with their grandparents.

The researcher perceives the school as a very important source of information as learners spend most of their time at school (Kedzior et al., 2020:214; Zulu et al., 2019:2). It can also be viewed as a reinforcement of what parents discuss with the adolescents or young people. The literature reveals that to close the gap created by barriers within the family, learners who are challenged by a lack of open SRH communication within their families tend to rely on teachers for support (Mturi & Bechuke, 2019:136; Zulu et al., 2019:5; Ram et al*.,* 2019:3; Breuer & Mattson, 2016:4).In contrary despite the role played by the school on SRH promotion, the school environment may contribute to negative outcomes whereby these teenagers are sexually abused by male teachers which can be detrimental to the adolescent which is a violation of the adolescent's SRHR (Thirugnanasampanthar et al 2023:2).

- **Religion as a source of SRH information**

Religion is one of the social institutions that provides a special focus on adolescent SRH through its moral building approach. The provision of moral guidelines ensures that one must abide by, e.g., the Ten Commandments. Religion and spirituality encourage abstinence and discourage sex before marriage (Chepkoech et al., 2019:20; Louw & Louw, 2013:295). Townsend (2018:123) concurs that religious practices are grounded in the teachings of spirituality, which discourages sex before marriage. Involvement in religious institutions enhances the chances of young people making friends with peers with a restrictive attitude towards sex before marriage, thus delaying sexual relations.

In a study conducted in Baltimore City (USA), it was found that churches were a preferred place for adolescent sexual health education where church based adolescent sexual health programmes are feasible and desirable (Powel et al., 2017:8). However, Kamangu, John and Nyakoki (2017:46) identify religion as a stumbling block towards parents' failure to communicate SRH issues with the teenagers as sexual activities before marriage is viewed as a sin. In addition, Motsomi et al. (2016:4) reveal that parents' religious beliefs guide what to discuss with their adolescents' children (I Corinthians, 6:18-20; II Corinthians, 7:2; 1 Thessalonians, 4:3-4:2; Corinthians, 12 & 21; 2 Timothy, 2:22; Ephesians, 5:3). Parents tend to be selective on the SRH topic that they want to discuss with their children which is in line with the religious expectations (Othman, 2019:319).

The study conducted in Zimbabwe on spiritual parenting within African Pentecostalism highlighted that in these churches, spiritual parents are regarded as being more important than the biological parents as there is a belief that they are mentors, advisors and guardians (Barbara & Kizito, 2021:29; Heward-Mills et al., 2018:4; Dube, 2017:4). These studies conclude that the engagement of faith leaders in SRH related issues display a significant influence on the individual and the congregation as a whole. This influence also adds to social and environmental factors that can lead to a higher probability of behavioural change. Similarly, Nsubuga et al. (2016:10) recommend involving religious leaders in SRH discussions to reduce unintended pregnancies. Some studies also reveal that religious beliefs have a very strong influence on the non-use of contraceptive methods (Barro et al., 2021:2; Oszie et al., 2021:2; Sundararaja et al., 2019:6).

Non-utilisation of contraceptive methods predisposes adolescents to unwanted pregnancies, especially once sexually active. From the biblical perspective, adolescents or young adults are still viewed as children who should not indulge in sex (Barbara & Kizito, 2021:29). Magezi (2016:2) posits that the church needs to be clear on its social responsibility and come up with ways on how to fulfil those responsibilities. The current study also considers the role the church could play regarding SRH communication, thus contributing to the reduction of STIs, HIV/AIDS, teenage pregnancy and other SRH related ailments. On the contrary, a study on demythologising factors associated with HIV/AIDS among Pentecostals reveals that churches are encouraged to promote SRH (Mokgatle, 2018:1). The same author indicates that the only effective way of dealing with SRH issues is through open communication. Therefore, developing communication guidelines will benefit the families, the community and the PHC nurses.

The researcher agrees that the involvement of youth in bible studies and youth activities within the church may assist in reinforcing SRH education. Adolescents and young people can attend religious classes where they are taken through the bible and youth camps to understand the role that the church plays in shaping their way of life.

- **Healthcare providers as sources of SRH information**

Healthcare providers have been identified as the source of SRH information due to their significant knowledge regarding SRH matters (Vongsavanh et al., 2020:61; Martel, 2017:23; Mbeba et al.,2016:2; Svodziwa et al.,2016:69).The healthcare providers may be uncomfortable and unprepared to handled SRH issues, and this may pose a problem and push young people away from the PHC settings (Madeleine, 2018:90). The researcher is of

the view that HCPs who are knowledgeable, non-judgemental and approachable will be beneficial for the provision of SRH education.

According to Jonas et al. (2018:11), health care workers' beliefs, motivations and behaviours affect the adequate provision of SRH services. These challenges impact the provision of SRH services to adolescents and include conflicting personal norms and values regarding the services. The authors further indicate challenges that impact SRH service delivery, such as lack of resources, lack of proper skills in performing procedures like TOP, shortages of staff and their value systems that clash with professional values (Jonas et al., 2018:10). The researcher concurs that value clarification should be emphasised. The HCPs must be able to separate personal beliefs from workplace norms and practices.

Ayawolowo et al. (2020:8), however, indicated that school health nurses should exercise their advocacy role and take the lead in helping adolescents to identify SRH related risks, including possible consequences of their sexual reproductive choices. The researcher is of the view that HCPs and school health nurses, as co-ordinators of health care, should be capacitated to manage SRH matters effectively and efficiently.

- **Media as a source of SRH information**

The media has also been identified as a source of information through the provision of youth programmes (Binu et al., 2018:9; Motsomi et al., 2016:3). Ekpenyong and Turnwait (2016:97) recommend that social media be included as a factor in sexual education. Social media has been identified as a rapidly emerging field or strategy that could be used for sexual health promotion (Gabarron & Wynn, 2016:13). However, Sagnia, Gharoro and Isara (2020:1) maintain that parents are worried about the role played by the internet and social media towards SRH because the media increases the distance between the adolescent and the parent. Adolescents might rely solely on what they view on social media and the internet without verifying information with their parents.

Mokwena and Morobe (2016:86) view media, especially television (TV), as a contributor to sexual activities because it provides considerable sexual information without highlighting the risks. These risks are related to sexual activities because adolescents could practice what is shown on TV, predisposing them to unsafe sexual practices. However, adolescents perceive media as the appropriate communication channel because of their serious interest in technology; this may be a challenge for grandparents who are not knowledgeable about technology (Chepkoech et al., 2019:21).

Based on the abovementioned arguments, the researcher is of the view that the media plays a pivotal role in SRH information dissemination, especially when adolescents are faced with the challenge of accessing SRH information or lack of SRH communication from their caregivers. The media can also initiate open communication about SRH where there is evidence of good parent-child relations. However, there is still a need to provide adequate and correct information regarding SRH to adolescents, grandparents or caregivers, teachers, including religious leaders.

- **Peers as a source of SRH information**

A peer is a companion of the same age group and developmental level (Louw & Louw, 2014:146). The (ibid) further state that adolescents have an intense desire to belong, thus their involvement with their peer groups because they share a lot of common challenges which they can communicate without hindrances. These group formations consist of their own rules, which may be different from what is done within their families, and this may create positive or negative outcomes (Essack, Toohey & Strode, 2016:195; Mokwena & Morobe, 2016:84). This is supported by studies conducted in Ethiopia and Kenya on sources of information on reproductive health among adolescents (Neme & Dereje, 2020:18; Yibrehu & Mbwele, 2020:6; Chepkoech et al., 2019:20; Chane & Cherie, 2018:412; Mekonen et al., 2018:6). These scholars allude that adolescents prefer to talk with their peers as opposed to their parents. Fear of having an open SRH communication with parents leads to adolescents seeking information from their peers. The researcher believes that peers will exacerbate the SRH problems due to a lack of appropriate information. The parents share a similar sentiment, as evidenced by their concern about the after-effects of risky sexual behaviours that may have lifelong effects (Mbachu et al., 2020:7).The inputs from participants may assist in creating guidelines that will address the challenges that peers have on SRH communication and further correct misleading information that leads to risky sexual behaviours.

A study conducted in Sub-Saharan Africa on health promotion and prevention of teenage pregnancy revealed that despite health promotion measures being put in place, teenage pregnancy remains a health concern (Gunawardena, Wondwossen and Yaya, 2019:2).

2.5.2.3 Barriers to communication within the families

- **Culture**

Several studies identified parent education, culture and fear as barriers to parent adolescent SRH communication (Mphuthi & Kris, 2020:32; Chane & Cherie, 2018:1950; Busi & Chea,

2017:1952). A study conducted in Ethiopia regarding parent-adolescent communication on SRH found that parent-adolescent communication on SRH was not a common practice due to cultural constraints (Yibrehu & Mbwele, 2020:1). Uganda, Kenya, Rwanda, and Tanzania also encounter similar barriers regarding parent-child communication (Kamangu, John & Nyakoki, 2017:49). Parents and children in SA also identified family communication regarding sex being a taboo and this impacts on family communication, parenting, and discipline (Kuo et al., 2020:107; Eshete & Shewasinad, 2020:826; Chane & Cherie, 2018:421; Kyillen et al., 2018:8; Ngwenya, 2016:458). Also, parents' resistance to engage in SRH communication with young people impedes open communication needed to address young people's concerns (Nurachman et al., 2019:197). The researcher is of the view that addressing the sociocultural barriers will enhance open communication within grandparent-headed families.

- **The educational level of grandparents**

The educational level of the parents is also identified as a barrier that influences parent-child communication and creates a challenge for the adolescents who expect their parents to provide SRH information (Feyisa et al*.,* 2020:5; Meikie et al., 2019:6; Kamangu et al., 2017:46; Svodziwa et al., 2016:66). According to Ram, Andajania and Mohammadnezhad (2020:5), parents acknowledge the fact that they have limited knowledge about SRH topics and skills to approach the subject hence they prefer the involvement of the school.

Furthermore, a lack of SRH information or limited SRH information perpetuates beliefs, taboos and negative attitudes that hinder open communication about sexual reproductive health issues (Busi & Chea, 2017:1951). However, in Ghana, parents exhibited a high knowledge of adolescent development but low knowledge about contraceptive use (Baku, Agbemafle & Adanu, 2017:2). The educational level of the parents has an impact on parent-adolescent communication and further depends on the parent's perception about SRH communication within the family (Kamangu et al*.,* 2016:47). Parents who are knowledgeable about SRH matters can discuss SRH topics with young people (Yibrehu & Mbwele, 2020:8; Baku, Agbemafle & Adanu, 2017:9).

The researcher is of the opinion that both grandparents and grandchildren can be capacitated regarding SRH topics so that they can have open discussions. It is anticipated that the higher the level of education, the better communication there is between grandparents and grandchildren regarding SRH. This may yield a positive influence in the

formulation of the guidelines because of the contributions from the HCPs, grandparents and grandchildren.

- **Language**

Jureddi and Brahmaiah (2016:115) identified language as a barrier, especially with the terminology used if the recipients do not understand it. In certain cultures, the use of idiomatic expressions makes it easy to communicate SRH issues (Seif et al., 2019:2; Mpondo et al., 2018:47). Motsomi et al. (2016:1) identified age-appropriate respectful vocabulary and skills as barriers that impede open communication regarding SRH within families. A study conducted in GP in the context of parent-child communication about sexuality and HIV prevention revealed that parents' harsh and ambiguous tone was perceived as a barrier to effective SRH communication (Mabunda & Madiba, 2017:171). The use of warnings, threats and ambiguous language by parents instils a lack of confidence and fear, which does not protect the adolescent from making poor SR choices (Mbachu et al., 2020:9). The researcher concurs that a harsh and ambiguous tone impacts negatively on the grandparent-grandchild relationship. As such, the formulation of guidelines may positively influence the language used. Therefore, it is important to ensure that the language used in the guidelines does not create further barriers.

- **Health system related factors**

There are health related barriers that hinder adolescents or young adults from utilising and accessing reproductive health services in the PHC facilities. The identified issues are related to access, quality care and communication.

  - Issues related to access to health care services.

Non-utilisation of the SRH service due to unfriendly healthcare providers, who are judgemental and lack confidentiality when handling and/or caring for adolescents (Abuosi & Anaba, 2018:203). The health-related factors also exacerbate fear and poor utilisation of SRH services, which infringes the adolescents' right to access SRH services as stipulated in the constitution.

  - Standing in long queues

Standing in long queues with adults who may know adolescents or young people contributes to adolescents' or young adults' non-utilisation of healthcare facilities. The long waiting time of clients (adolescents or young people) was identified as a key factor in the access or

utilisation of PHC facilities. For example, pregnant adolescents follow the same process that adults who visit the Antenatal clinic for a routine check-up (Abuosi & Anaba, 2018:202).

- Operational hours

Inflexible and inconvenient operational hours also contribute to the non-utilisation of health facilities. A study conducted in Ghana on barriers to access and use of adolescent health services revealed that operating hours were not favourable to adolescents and young people (Abuosi & Anaba, 2018:201). According to Nmadu et al. (2020:4), inconvenient opening hours of the clinics were identified as a major hindrance for adolescents accessing RHS as the hours coincide with the time when they are at school.

- Lack of accurate information

Failure of HCPs to provide adolescents with accurate information about all the services rendered at the clinic contributes to poor access and non-utilisation of the SRH services (Ababor, Tesso & Cheme, 2019:5; Abuosi & Anaba, 2018:203). Lack of knowledge or information predisposes adolescents to be vulnerable to unsafe sexual behaviours and inappropriate SR choices, which may have detrimental effects on their life (Kyilleh, Tabong & Konlaan, 2018:8). The authors further state that lack of knowledge is associated with early sexual initiation which leads to unwanted pregnancy, including HIV/AIDS, unsafe abortions and maternal and foetal complications. The researcher is of the view that the adolescents, like any other citizen, should have the right to SRH information to make an informed decision. Therefore, the development of communication guidelines will assist to enhance open communication as a preventative tool.

- Issues related to quality service/shortage of resources.

There are quality care related issues that contribute to poor access or non-utilisation of healthcare facilities, namely, the shortage of staff, shortage of treatment and lack of confidentiality. Lack or absence of the necessary suppliers in the clinic results in non-adherence to treatment, which encourages adolescents to lose trust in SRH services (Abuosi & Anaba, 2018:201). Literature confirmed that shortage of staff and medication is another challenge that impedes the provision of quality SRH care to adolescents and predisposes them to unwanted pregnancies (Nmadu et al., 2020:5; Mwaisaka et al., 2020:2; Envaladu et al., 2017:5). The researcher is of the view that shortage of staff needs to be addressed so that quality SRH care is rendered to the adolescents and the grandparents who may need support from the HCPs in dealing with the challenges that are experienced by the adolescents (grandchildren).

- Issues related to communication.

The unsympathetic and judgemental attitude displayed by HCPs encourages the non-utilisation of SRH services. The use of ambiguous language where the adolescents do not understand and feel disrespected also perpetuates the non-utilisation of the SRH services (Abuosi & Anaba, 2018:203). In addition, a study conducted in Nigeria on barriers to adolescents' access and utilisation of reproductive health services revealed that adolescents feared discussing sexual health problems with HCPs (Nmadu, Mohammed & Usman, 2020:4). The researcher is of the view that the failure of the HCPs to have an open, non-judgemental attitude and poor listening skills prevents young people from visiting health facilities. The HCPs must ensure that they use the language that the client understands, and they must be allowed to ask clarity-seeking questions. The developed guidelines should be constructed so that they are accessible to all.

- **Barriers created by the adolescent.**

There are client-related factors that hinder access or utilisation of healthcare facilities. Failure of young people to seek timeous help in case they have SR challenges that could be avoided by approaching the HCPs for advice or information (Abuosi & Anaba, 2018:203). The adolescent may have preconceived ideas about the HCPs or the role of the clinics, which may not be accurate, resulting in a negative perception of the healthcare facility.

According to Lenkokile, Hlongwane and Clapper (2019:202) and Madeleine (2018:81), providing the necessary SRH information to the grandparents and grandchildren is important, considering their rights, confidentiality and cultural sensitivity. The researcher is of the view that for young people to utilise healthcare services, the healthcare facility needs to be accessible, acceptable and youth friendly.

2.5.3 Culture

Culture is defined as a way of doing things, accompanied by shared beliefs, feelings and knowledge that guide people's conduct and is being passed from one generation to the next (Townsend, 2018:106). Culture plays an important role in SRH, as communication within the grandparent-headed families, and it is also crucial that the HCPs, especially nurses, should be aware of the cultural influence that may affect the individual SRH behaviour. Cultural beliefs and practices impact how individuals respond to their environment during wellness and ill health.

HCPs must be able to provide culturally appropriate care whereby clients' beliefs are considered (Townsend, 2018:108). Tanzania and Cote d'Ivoire struggle to combat socio-cultural barriers that impact negatively on SRH within families (Kapetanovic et al., 2020:1228; Kone, 2018:10; Kamangu, et al., 2017:47). Kuo et al. (2020:109) affirm that cultural constraints impact on SRH communication between parents and children which is something that needs to be addressed through capacity building of the individual, family and the community.

On the other hand, culture has been identified as a barrier to open communication regarding SRH due to the perceived privacy of sexual matters (Adam et al., 2020:2; Ngwenya, 2016:456). Several studies have attested to culture as a barrier because parents view sexual matters as topics that can be discussed by adults, not children (Yibrehu & Mbwele, 2020:6; Kinaro et al., 2019:7; Landa & Fushai, 2018:2; Seif, Kohi & Mselle, 2016:524; Motsomi, Makanjee & Nyasulu, 2016:5). Hence the need to support families regarding SRH communication (Yibrehu & Mbwele, 2020:6; Kinaro et al., 2019:7; Landa & Fushai, 2018:2; Seif, Kohi & Mselle, 2016:524; Motsomi, Makanjee & Nyasulu, 2016:5). The researcher believes that culture needs to be respected, however, cultural barriers need to be addressed to ensure that SRH interventions yield positive results. The formulation of SRH communication guidelines should include content that addresses the attitude of the HCPs to promote a healthy lifestyle among adolescents and young people.

2.5.4 Sexual Reproductive Health

Sexual Reproductive Health is defined as a state of complete physical, mental and social wellbeing in all matters relating to reproduction (Ram et al., 2019:1; Kurebwa, 2017:3). Ngwenya (2016:453) maintains that SRH, in the primary context, entails the provision of information, counselling, prevention of STIs and prevention of unwanted pregnancies. Odo et al. (2018:2) highlight that the SRH needs of adolescents are being underserved, yet adolescents constitute a large proportion of the population and are faced with many physiological challenges caused by their transition from childhood to adulthood. Galappaththi-Arachchige et al. (2018:9) affirm that risky sexual behaviours result in a high prevalence of teenage pregnancy, HIV/AIDS and STIs among young women, which are detrimental to their health.

Provision of adolescent-friendly sexual reproductive services is beneficial to teenagers, and they will make use of those services (Zulu et al., 2018:2; Kurebwa, 2017:26). In contrast, the study conducted in Ethiopia found that the main barrier to accessing local SRH services was

lack of SRH information and the negative attitudes displayed by HCPs (Ababor, Tesso & Cheme, 2019:5). The authors concluded that the adolescent is deprived of services. The researcher is of the opinion that there are still HCPs who contribute to barriers regarding access to SRH services and information provision. The HCPs must be supported through in-service training and workshops to improve their knowledge and offering of SRH services. Therefore, the SRH guidelines must also address HCPs' support on how they can ensure that the services they offer are targeted at adolescents and young people.

2.5.4.1 Sexual Reproductive Health Rights

According to the World Health Organisation (WHO), Sexual and Reproductive Health Rights (SRHR) is defined as “a state of physical, emotional, mental and social wellbeing about all aspects of sexuality and reproduction” (DoH, 2018:2). Gebresilassie et al. (2019:16) define SRHR as rights for all the people to make informed choices on sexuality and reproduction. These rights are enshrined in section 27 of the Constitution, which states that “*everyone has the right to have access to health care services, including reproductive health care*". Everyone in SA has a right to access services and the freedom to make free and responsible decisions and choices about their bodies.

Sexual and Reproductive Health Rights are an umbrella term for several important human rights afforded to everyone, including adolescents. According to Ramiyad and Patel (2016:105), adolescents are challenged by a lack of knowledge about the legal framework related to TOP, SRHR and contraceptive methods, including emergency contraceptive methods to prevent unwanted pregnancy.

The researcher is of the opinion that the lack of SRH information impedes progress in the implementation of collaborative strategies that are geared toward SRH promotion and improving the knowledge and health of young people. Therefore, developing the guidelines will highlight the legal framework that enhances the provision of SRH and must be made known by the grandparents, grandchildren and HCPs.

2.5.5 Healthcare providers

The role of healthcare providers in SRH is to advise the adolescent and parents about SRH information and refer them to appropriate resources (Ashcraft & Murray, 2017:9; Ngwenya, 2016:457). However, in New Zealand, it is evident that the healthcare providers are not confident about the education received and are not experienced in managing youth health, leading to difficulty in engaging with youths about sexual health issues (Martel, Crawford &

Riden, 2017:22). A study conducted in Nepal emphasised the importance of well-trained HCPs to address the importance of confidentiality and the attitudes of the HCPs (Pandey, Seale & Razee, 2019:1). In a study conducted in Ghana, it was found that the HCPs' attitudes have been identified as a reason for non-utilisation of the healthcare facilities and recommended planning for adolescent health care interventions (Abuosi & Anaba, 2018:205).

However, in a study conducted in Zimbabwe, Wilcox et al. (2020:1) state that by 2030, there will be a global shortage of healthcare workers, impacting service delivery. Another study conducted in SA found that facilities had essential components for general service delivery, but the adolescent specific service provisions were lacking, violating their rights (James et al., 2018:1).

In the current study, attributes of PHC nurses will be tabled to ensure that proper training and steps are taken to address staff attitudes. The provision of SRH information will contribute to the fulfilment of young people's health rights and wellbeing. This aligns with the Ottawa Charter, which emphasises the importance of health promotion programmes to enhance healthy living and lifestyle modification (Vasuthevan & Mthembu, 2017:63). The Ottawa Charter emphasises the importance of good health and achieving equity in health promotion. All the health promotion activities must be tailored to address the lack of SRH communication between grandparents and grandchildren. Strengthening health promotion strategies could yield good results, benefiting all individuals, families and the community. The researcher is of the view that the collaborative effort of all stakeholders in meeting the needs of adolescents will yield positive outcomes.

2.5.6 LEGAL ASPECTS THAT IMPACT ON SEXUAL REPRODUCTIVE HEALTH

The legislative framework that impacts SRH is discussed under the following headings: Acts, policies, theories and models. The researcher is of the opinion that the inclusion of the legal framework will assist the PHC nurses, grandparents and grandchildren in understanding the importance of legal aspects related to SRH to promote an enabling environment for the grandparents and grandchildren.

2.5.6.1 ACTS

- **Constitution of the Republic of South Africa Act No 108 of 1997**

According to the Constitution of South Africa (SA) (Act No 108 of 1997), section 27(a), "*everyone has the right to have access to health care service including reproductive health*

care". The (ibid) further states that "*everyone in SA has a right to access services and the freedom to make free and responsible decisions and choices about their bodies".*

Despite the right to access as stipulated in the constitution, access barriers by adolescents and young people contribute to non-utilisation of the provided SRH services (Smith et al., 2019:1). The access barriers identified are fear of lack of privacy, fear of physical examination and anticipation of embarrassment. In addition to this, Mulaudzi et al. (2018:2) identified other access barriers such as lack of confidentiality, long waiting times, inconvenient operating times, fear of parents finding out about their visit to the clinic, including attitudes of healthcare workers, which also contribute to failure to utilise the SRH services.

Studies conducted in Rwanda, Zimbabwe, Nigeria, Kenya and Ethiopia on access to SRH information also confirmed that access to information, education and services plays an important role in the promotion of Sexual Reproductive Health Rights (SRHR) (Ndayishimiye et al., 2020:9; Coast, 2019:2; Mutea et al., 2019:1; Odo et al., 2018:3; Ngwenya, 2016:458). The researcher is of the opinion that young people can make informed decisions once they are well informed. Despite the stipulations by the Constitution on the right to access health care services, adolescents still have challenges accessing SRH services (Ngilangwa et al*.,* 2016:1).

- **The National Health Act (Act No 61 of 2003)**

The Act is aligned with section 27(a) of the Constitution regarding the right to access health care services. The Act works in combination with the other legislation promulgated in parliament relevant to the study, such as the Nursing Act (Act No 33 of 2005) and the Choice to Termination of Pregnancy Act (Act No 92 of 1996).

Amongst other obligations, the Act creates a system to train, retain and further build capacity to provide health care services in SA. The Diploma in Clinical Health Assessment, Treatment and Care, which R48 regulates, is offered by several Nursing Education Institutions (NEIs) and contains modules on SRH, contraception, and the Choice to Termination of Pregnancy Act, including the Adolescent. These modules are discussed in detail however, little is said about SRH communication within families. The researcher is of the view that the inclusion of family communication regarding SRH in the curricula will add value to the capacitation of HCPs. Nurses are placed in various health settings, such as hospitals, Primary Health Care (PHC) facilities, and schools, where they execute their daily nursing activities for clients,

such as grandparents and grandchildren. Maria et al. (2017:1) affirm that nurses care for adolescents and young adults in various settings, and access to SRH information can be enhanced through an open and non-judgemental approach.

The researcher is of the idea that the involvement of well-trained PHC nurses will assist to ensure that the guidelines are well developed, validated and implemented to enhance SRH communication. In this study, the PHC nurses stationed at the Tshwane district PHC facilities will share their experiences regarding SRH communication with grandparents and their grandchildren.

Section 18 of the Act stipulates a procedure to be followed to lay a complaint to address service delivery dissatisfactions that healthcare users may experience. This section concurs with the Batho-Pele principles, which require that clients express their dissatisfaction with the care rendered and further encourage healthcare providers to welcome complaints to identify shortcomings. The above statement highlights the importance of redress and value to enhance customer satisfaction.

The Act ensures that quality care is rendered to the citizens through the development and implementation of the National Core Standards (NCS), which are spearheaded by the Office of the Health Standards and Compliance (OHSC). Mukinda, Belle and Schneider (2020:2) state that healthcare providers must show commitment and dedication and suppress their self-interest for the benefit of clients, in this case, the grandparents and grandchildren, with regard to SRH communication.

The Act further protects the rights of the citizens through the establishment of the National Health Research Ethics Council and Regional Ethics committees which ensures that researchers adhere to ethical principles by issuing approval letters before any research can be conducted in the health establishments. The researcher ensured that permission to conduct the study in the Tshwane district was approved before the commencement of any data collection, as evidenced by the following:

- University of Pretoria approval letter: 45/2020 (**Annexure A)**
- Tshwane Child Welfare approval letter (**Annexure C)**
- Department of Health Gauteng/approval letter: 24/2020 **(Annexure B)**
- Permission was further requested from the participants. (**Annexures D, E &F**).

The researcher has an obligation to protect the rights of the participants by adhering to the Code of Ethics and the application of the fundamental ethical principles (Brink et al., 2018:27). The development of the guidelines considered the ethical principles as fundamental in the provision of SRH services and the rights of all the participants are respected.

- **The Nursing Act (Act No 33 of 2005)**

The Act regulates the registration and practice of nursing in SA by ensuring that all the nurses are registered with the South African Nursing Council (SANC) and remain in good standing to ensure that the public's health is protected. The same standards are followed by other regulatory bodies like the Nursing and Midwifery Board of Australia (NMBA), Nursing and Midwifery Council (NMC), Australian Health Practitioners Regulation Agency (AHPRA), Lesotho Nursing Council (LNC), Health Professionals Council of Namibia (HPCNA). All the healthcare providers who participated in this study worked in the PHC settings and were registered with SANC. They have met the minimum training requirements in theory and clinical practice and were declared competent before being awarded the Clinical Health Assessment, Diagnosis, Treatment and Care qualification.

SANC further accredits all the Nursing Education Institutions (NEIs) and programmes to ensure that quality nursing education is rendered to the people of SA (Nursing Act, Act No 33 of 2005). The inclusion of SRH in the Curriculum of the Nursing Programmes that are offered in the NEIs plays a major role in empowering the healthcare providers who are empowered to discuss RH issues with grandparents and grandchildren (Iqbal et al., 2017:12). The Nursing Act supports the constitutional rights of South Africans. Mathibe-Neke (2020:2) applauded the SANC for introducing Continuous Professional Development (CPD) which assists to ensure that nurses remain knowledgeable and ethically conscious about the provision of health care.

- **The Choice on Termination of Pregnancy Act (Act No 92 of 1996)**

The Choice on Termination of Pregnancy Act (Act No 92 of 1996) was promulgated in 1996 and amended in 2008. Teffo and Rispel (2017:2) reveal that SA has made remarkable progress with the establishment of Termination of Pregnancy (TOP) services in healthcare facilities. The authors further noted that the capacitation of HCPs will address the challenges displayed by the negative attitude of HCPs towards TOP service provision.

The TOP service provision is one of the strategies that address the SRH needs of women, and this was in line with Millennium Development Goal (MDG) No.5 (Teffo & Rispel 2017:1). The authors indicate that MDGs were followed by the inception of the Sustainable Development Goals (SDGs) which emphasised the importance of universal access to SRH care services as a way to curb maternal deaths. These SDGs pledged not to leave anyone behind, and all the challenges experienced by PHC nurses, grandparents and grandchildren will gradually be addressed (Melesse et al*.,* 2020:1). The SDGs were adopted by all United Nations (UN) member states in 2015. One of the benefits of the SDGs is to improve the health of the inhabitants of all countries, including SRH. These SDGs strive to improve health through public participation (Mensah, 2019:10; Nunes, Lee & Riordan, 2016:1). These SDGs are seventeen (17) in number, and SDG No.3 is relevant to this study. SDGs Nos. 3 and 4 are concerned with health promotion and lifelong learning. Therefore, developing the guidelines will enhance the empowerment of grandparents, grandchildren and PHC nurses in understanding the purpose of the Choice on Termination of Pregnancy Act (CTOPA).

According to Ramakuela et al. (2016:1), SA, like many other countries, is experiencing a high teenage pregnancy rate regardless of the free contractive services offered at healthcare facilities. The (ibid) reveals that adolescents face many challenges that drive them to opt for TOP, irrespective of its consequences. The South African Government is applauded for its substantive protection of citizens through the promulgation of the constitution and the CTOPA. These policies address the right to access SRH services, including termination of pregnancy (Pizzarossa & Durojaye, 2019:51; Wojcicki, 2017:2). McQuoid-Mason's (2020:722) study on SA legislative reforms reveals that the CTOPA stipulates that pregnant children of any age may consent to termination of pregnancy without the knowledge or permission of their parents.

The researcher is of the opinion that the actions of the teenagers may have an impact on the relationship between the grandparent as a guardian or parent and the grandchild. This is because, in the context of Christianity, abortion or the termination of pregnancy is viewed as a sin before God. However, Denberu, Alemsegen and Segni (2017:48) highlighted that when a young woman faces challenges, such as desertion by the family, boyfriend or was raped, she will resort to induced abortion, regardless of her beliefs. The above findings concur with the findings of studies on experiences leading to the choice of termination of pregnancy amongst teenagers (Mothiba, Muthelo & Mabaso, 2020:495; Rajoo, 2019:19; Ramakulela et al., 2016:6; Ramiyad & Patel, 2016:105).

The researcher is of the view that more education is needed on SRH services offered in PHC facilities, including the referral system, in case the facility does not render such service, e.g., TOP. The decision of the adolescent or young person must be respected by the HCP, who must ensure that a non-judgemental approach is used. The researcher affirms that HCPs should inform both grandparents and grandchildren about all the SRH services offered in the PHC settings, including CTOP, as this will assist in the reduction of unsafe abortions. The acquired knowledge will also assist in the eradication of myths and misconceptions related to the TOP. According to Teffo and Rispel (2017:2), SA has made remarkable progress with the number of health facilities providing TOP services and staff capacity building, despite ongoing challenges regarding negative provider attitudes. However, little is known about the psychosocial issues faced by the HCP offering abortion/TOP services. The researcher posits that these HCPs need extensive support from policymakers, healthcare managers and other interest groups. The SRH communication guidelines should consider and respect the decision of all the participants, irrespective of religious affiliation and education level.

- **Domestic Violence Act (Act No 116 of 1998)**

This Act succeeded the Prevention of Family Violence Act 133 of 1993. It was promulgated in 1998 with its main focus on preventing violence as a response to high incidences of domestic violence in SA. The WHO (2018) stated that healthcare providers are mandated to report child and adolescent sexual abuse to designated authorities which can be observed in intimate partner violence (IPV) and other address gender-based violence (GBV). Poor communication or gender imbalances predispose the adolescent to IPV, increasing the risk of participating in unprotected sexual activities due to fear of negotiating safe sex practices. GBV is viewed as a serious violation of human rights. The researcher believes that if the adolescent and the caregivers are knowledgeable about services available within the community, they can report any sexual abuse to the relevant authorities to minimise GBV.

2.5.6.2 Other policies that impact Sexual Reproductive Health

The following discussion is about policies that impact Sexual Reproductive Health.

- **South Africa's National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022**

The National Strategic Plan (NSP) is the fourth plan published by the South African National Aids Council (SANAC). The development of the document was informed by the successes and challenges of the 2012-2016 plan; its purpose was to address the gaps identified in the previous NSP documents to ensure that quality service is provided to South Africans. The

City of Tshwane (CoT) has been identified as one of the districts with a high HIV and TB burden (DoH, 2019:16). Adolescents, especially girls, have been identified as the vulnerable population that remains affected by the HIV epidemic (DoH, 2019:4). The physiological development of adolescence predisposes them to risky sexual behaviour that leads to STIs and HIV/AIDS. The PHC nurses can render preventative care in line with the national health strategic plan and contribute effectively toward achieving sustainable development goals.

Amongst the enablers that were identified within the NSP, the researcher selected the following because of their relevance to the study:

- ❖ Focusing on social and behaviour change communication will be supported by developing the guideline on SRH communication.
- ❖ Building a robust social system includes strengthening and supporting families and communities to decrease the rate and risk of transmission.
- ❖ The family identified as the socialisation agent and health promoter of a healthy SRH lifestyle.

- **National Adolescent and Youth Policy 2017**

This policy document highlights the importance of the Adolescent Youth Friendly Services (AYFS). AYFS is a standard driven approach to provide quality care to youths and adolescents (DoH, 2017:2). The first National Policy Guideline for Youth and Adolescents was developed and implemented in 2011. It was followed by the National Adolescent and Youth Policy 2017 after consultation with all the stakeholders. It is aligned with other national and international policies aimed at improving youth and adolescents' health. The policy highlights the importance of health promotion, which is critical to the health of adolescents and youth (Sunarisih et al., 2020:5; Basil et al., 2017:7). The policy state that "*health promotion programmes need to focus on individual behaviours, complemented by support, education, empowerment and health service delivery programmes based in schools, families and communities (including traditional and religious systems*)".

- **The National Adolescent Friendly Clinic Initiative (NAFCI)**

NAFCI is an accredited programme designed to improve the quality of adolescent health services at the primary health care level. The NAFCI aimed to engage the public sector to provide SRH services for adolescents and further address the barriers that impact SRH service delivery (James et al., 2018:2). This initiative attempted to address several issues that affect adolescents including training of staff, provision of youth friendly services and

peer support programmes. e.g., Love life projects (Smith et al., 2018:680). This initiative was adopted to measure adolescent services against predetermined standards.

- **Adolescent Youth Friendly Services (AYFS)**

Adolescent youth friendly service is an approach that was promoted by the DoH and its partners as a means to address adolescent needs (James et al., 2018:1). These are high quality services that should be accessible, appropriate, acceptable, and affordable to adolescents. Services should be able to attract and retain adolescents to improve their SRH. The researcher is of the opinion that the inception of the adolescent youth friendly service (AYFS), driven by HCPs who are approachable, knowledgeable and non-judgemental, will encourage access and utilisation of the healthcare service.

According to James et al (2018:2) the provision of non- judgemental HCPs who are ready to address their challenges including capacitation HCPs which impede effective provision of SRH care to adolescents and grandparents.

The researcher perceives that the capacitation of HCPs regarding adolescent SRH issues will assist the HCPs in building their confidence and thus provide quality SRH service. Several studies on the provision of AYFS (2020:2) allude that the provision of AYFS depends on the availability, accessibility and quality of the SRH service (Ndayishimiye et al., 2020:2; Mazur, Brindis & Decker, 2018:2; Kurebwa, 2017:26; Ayike, Valerie & Mbegbu, 2016:17). The adolescents will be able to make use of the services without fear and the grandparents will be able to request assistance should the need arise. Therefore, the guidelines will be developed to address the challenges that the grandparents, grandchildren and the HCPs experience.

- **The Integrated School Health Policy, 2012**

Through its initiative to address the health needs of the school going children/youths, SA implemented the Integrated School Health Policy, which is an output of a collaborative effort of the DoH and the DBE. However, there is non-compliance with the collaboration and integration of other stakeholders for the delivery of school health services, as stipulated in the ISHP (Rasesemola, Matshoge & Ramukumba, 2019:1). The authors highlight that non-compliance leads to the alienation of parents who should play a vital role regarding SRH promotion. Although parents perceive the importance of open parent-adolescent communication, the researcher is of the opinion that the non-involvement of parents will

retard the initiative and the reinforcement of social norms and values regarding SRH (Pulgaron et al., 2017:6).

- **National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2012**

The National Contraception and Fertility Planning Policy and Service Delivery Guidelines were promulgated in 2012. The document aimed to prioritise contraception and fertility planning in SA (DoH, 2012:4). The researcher is of the view that access to safe and effective contraceptive methods is one of the pivotal aspects of reproductive health, which forms part of awareness. The National Youth Risk Behaviour Survey conducted in 2008 revealed that 37% of learners in Grades 8-11 had already been involved in sexual activities. 17% of the youths reported that they had not used any contraceptive methods. The same document indicated that condom use, and oral contraceptive methods were commonly used. (Mbachu et al., 2021:3; DoH, 2012:23). It is the responsibility of the HCPs to ensure that proper and accurate counselling is provided to the adolescents about all the contraceptive methods, modes of action and side effects. The provision of information will assist the adolescents to make informed decisions and choices regarding the method that best suits their needs (Todd & Black, 2020:37; Makola et al., 2019:6; Onasoga et al., 2016:59).

- **Batho Pele Principles**

The policy framework was established to transform service delivery and client satisfaction. Vasuthevan and Mthembu (2017:36) affirm that good service delivery leads to happy customers and employee satisfaction. The following principles were outlined: consultation, service standards, access, redress, value for money, information, openness and transparency, innovation, and rewards, including customer impact. These principles require that the HCP treat clients with respect and dignity and must be known to provide SRH information (Barati et al*.,* 2019:315).

PHC nurses must be knowledgeable and give clients information so that they can make informed decisions on their SRH health issues. Furthermore, this will allow the grandparents and grandchildren to complain about the quality of care provided if not satisfactory. Access to information plays a pivotal role because PHC nurses are viewed as a support system for those needing health related information. According to Sunarish (2020:1), in Indonesia, the unavailability of accurate SRH information has resulted in young people seeking information from other sources. Once grandparents and grandchildren are well informed about SRH related matters, open communication within the grandparent headed families will be

enhanced. The researcher is of the view that the HCPs must embrace and apply the Batho Pele principles concerning SRH service provision to promote the utilisation of the service.

2.5.6.3 Theories

- **Erickson's developmental theories**

Erickson is the first theorist to identify the importance of the identity formation of an individual according to different developmental stages. According to Louw and Louw (2015:342), Erickson's developmental theory states that for an adolescent to form an identity, all the psychological crises of the previous developmental stage must have been resolved. The authors identified the following themes important to identity formation: gender roles, relationships, marriage, religion, politics, own value system, independence from parents, social responsibility, and work roles that lead to the development of an adolescent. Failure to complete or satisfy the above tasks will result in an adolescent with a poor sense of identity and confusion. Rageliene (2016:104) states that the process of forming an identity is a critical phenomenon during the life of adolescents as the adolescents spend most of their time with their peers rather than with their parents. Peer relationships are very influential and lead to strong peer attachment, which can negatively or positively affect the adolescent's life.

The researcher is of the opinion that during the adolescent stage, young people question numerous conventions and authorities. They feel more comfortable in the company of their peers as opposed to the company of parents, as stipulated in Erickson's developmental theory. Communication regarding SRH is viewed as a protective factor, and parents or caregivers are expected to talk to the adolescents. However, reality has shown that it is not a simple task. The school, as the secondary source of information by including LO in the school curricula, can assist in disseminating SRH information. The researcher perceives that the collaborative effort between parents, teachers, and HCPs will influence SRH promotion.

- **The Socio-ecological Model (SEM)**

The socio-ecological model is a multi-system that consists of layers, i.e., individual, family, community and society, as depicted in Figure 2.3. In this model, the family is seen as a system in the ecosystem which is the basic unit of the community. The following multisystem perspective is needed for proper articulation and understanding of the determinants of adolescents and young people's risky sexual behaviours concerning the promotion of SRH communication with grandparent headed families (Agudile et al., 2020:36; Kyilleh et al., 2018:2).

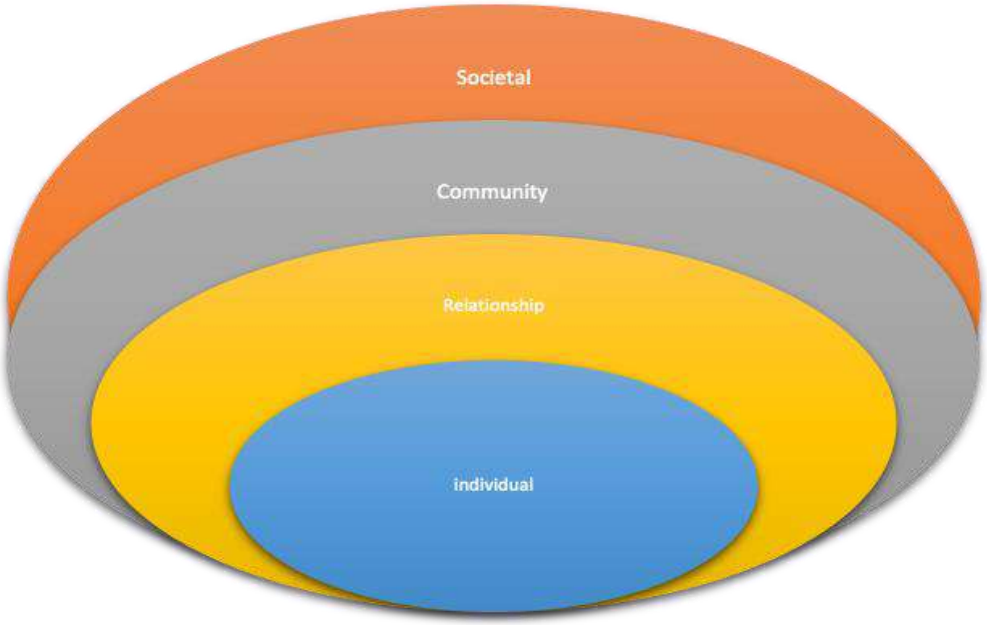

Figure 2.3: The socio-ecological model of adolescent reproductive health choices and factors influencing the choices *(Kyilleh, Tabong & Konlaan, 2018:3)*

- At the individual level, several factors were identified as contributing to risky sexual behaviours, such as lack of SRH information, poor parent-child communication, non-utilisation of SRH services and inaccessible legislation (Ezenwaka et al., 2020:4). Possible interventions to improve sexual health and reduction of risky behaviours need to be put in place to enhance the SRH promotion that the adolescent need (Kazdouh et al*.,* 2019:9; Marcel et al*.,* 2017:5).
- At the relationship level: Relationships with parents, peers and significant others influence SRH communication. SRH communication can either be positive or negative. Positive and supportive SRH communication will encourage a positive attitude to SRH, whereas negative SRH communication may exacerbate risky sexual behaviours. Good adolescent-parent relationship is the foundation that will promote open communication regarding SRH within the grandparent-headed family (Othmann et al., 2020:314; Maina et al., 2020:1; Sagnia, 2020:1; Kazdouh, et al., 2019:12). Positive role modelling by parents will enhance responsible adults in the society. Healthy parent-adolescent relationships form a basis for open communication relating to SRH matters.
- At the community level, reinforcing norms and values for safe practices and access to SRH services is crucial. The researcher embraces the saying, "*It takes a village to raise a child,"* socialising the children to be good adults. Interest groups (*Not in my*

name) who fight against abuse, gender-based violence (GBV) also assist in raising awareness and empowering a wide variety of people (Kazdouh et al., 2019:13). The researcher is of the opinion that the involvement of other stakeholders (religious leaders and other community leaders) will provide support to young people in addressing the SRH challenges with which they are faced.

- At the societal level, developing policies related to SRH will help adolescents realise their human rights. Reinforcement of the policies implemented in the PHC facilities, such as NSP and ISHP, is required. Policymakers are responsible for engaging adolescents and young people when developing policies that affect their health to ensure their buy-in and compliance. The role played by media outlets in discussing or displaying content on SRH is crucial. However, the media may also be viewed as a facilitator of early sexual behaviour by exposing the adolescent to sexual matters that are regarded as taboo (Kazdouh et al., 2019:13).

Adolescents and their grandparents are part of families based in the communities, and these layers interact with one another to achieve positive SRH outcomes. The researcher believes that the engagement of all stakeholders in addressing the barriers will yield significant results on SRH-related challenges experienced by adolescents and young people. Therefore, developing communication guidelines regarding SRH within grandparent headed families will assist to address the challenges revealed by other researchers.

2.6 SUMMARY OF THE CHAPTER

The literature review was conducted to explore and describe the experiences of grandparents, grandchildren and PHC nurses regarding SRH communication to develop communication guidelines in the Tshwane district of SA. SRH remains a health problem and a concern that needs to be addressed by all stakeholders. As indicated, intersectoral collaboration will play a pivotal role in the development of appropriate interventions that will assist both the grandparents and grandchildren in SRH communication.

Building enabling environments for both grandparents and grandchildren will ensure that SRH and human rights are realised, and this requires interventions that will work at different levels. Strengthening and capacity building will ensure that HCPs are well informed about SRH and its management, as a result, offer a quality service to the grandparent headed families. The inclusion of the legislative frameworks showed the protective public policy measures that apply to SRH. Chapter 3 discusses the research design and methodology of the study.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

Chapter 3 discusses the researcher's paradigmatic perspective, including the methodology of the study. The discussion in this chapter is structured around research design, population, sampling, data collection and data analysis, including measures to ensure trustworthiness. The study aimed to explore and describe the experiences of grandparents, grandchildren and PHC nurses to develop communication guidelines to support grandparent families regarding SRH.

3.2 PARADIGMATIC PERSPECTIVE OF THE STUDY

3.2.1 Research Paradigm

A paradigm is a set of assumptions that characterise a particular way of viewing the world (Gray et al., 2017:686; Botma et al., 2016:40; De Vos et al., 2016:40). In addition, Polit & Beck (2017:9) concur that paradigms are a set of assumptions or beliefs about fundamental aspects of reality that provides the philosophical framework that guides research enquiries. According to Khatri (2020:1435), the research paradigm was perceived as the theoretical or philosophical ground for the research. Brink et al. (2018:20) posit that a paradigm was a lens through which the researcher approaches and interprets reality.

The paradigmatic perspective of the study was discussed in terms of phenomenology within the constructivist paradigm, followed by the specific philosophical assumptions of phenomenology. This study followed the constructivist philosophical paradigm because of its qualitative nature, which is discussed in detail below (Table 3.1) (Neubauer, 2019:92; Adom et al., 2016:2).

3.2.2 Philosophical Assumptions

Assumptions are fundamental principles that are believed to be true without proof or verification (Brink et al., 2018:22; Polit & Beck, 2017:9). Brink et al. (2018:22) further state that assumptions determine the researcher's understanding of concepts, definitions, purposes and relationships.

- **Importance of assumptions in this study**

The researcher assumes that SRH communication will assist in the promotion of healthy sexual practices and the reduction of risky sexual behaviours. The different types of assumptions include ontological, epistemological and methodological.

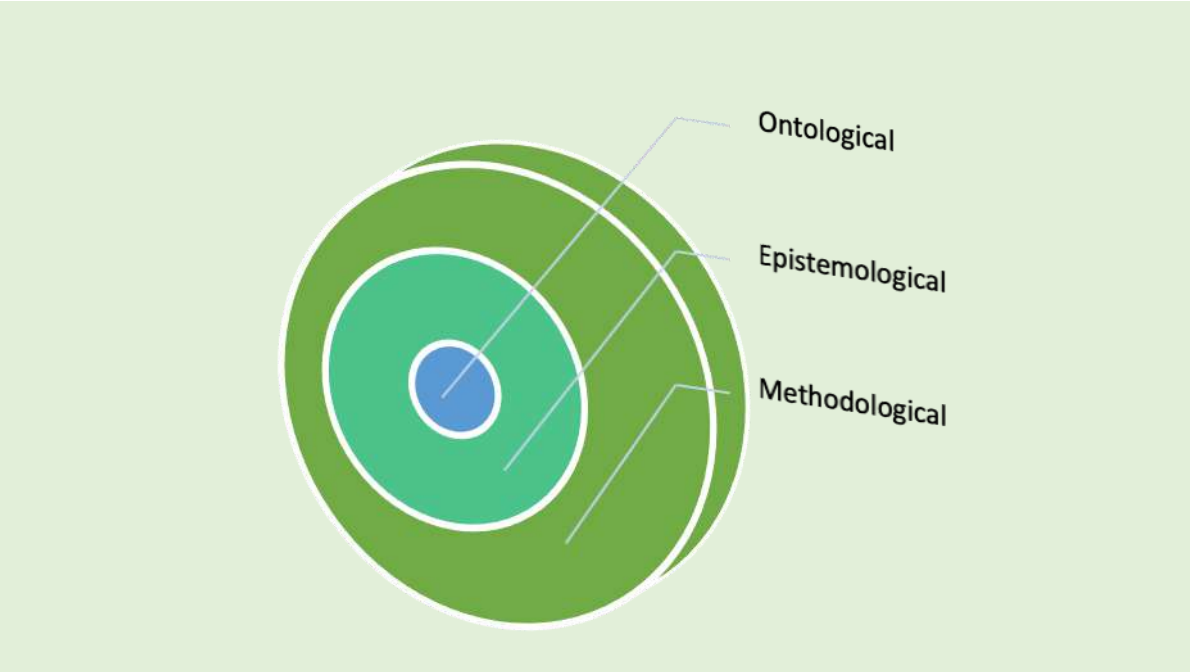

Figure 3.1: ***The ontological, epistemological and methodological assumptions***

3.2.2.1 Ontological assumptions

Ontology is the nature of the researcher's beliefs about the nature of reality and its characteristics (Khatri, 2020:1436; Kivunja & Kuyini, 2017:27; Rehman & Alharthi, 2016:51; Botma et al., 2016:40). Reality is subjective because it is from the perspective the individual engaged as such it is multiple or varied (Adom, Yeboah & Ankran, 2016:5). Furthermore, the researcher gathered meaning of the events through interaction with the participants in a natural setting. In this study, the researcher interacted with the participants in their place of work and residential places in the CoT. The relevant question to be answered is "*What is the nature of reality*" (Ataro, 2020:20; Brink et al., 2018:19; Polit & Beck, 2017:10). The researcher assumed that multiple realities exist for different people and meaning is constructed by people looking at how people interact with the world therefore, each person experiences reality differently (Streubert & Carpenter, 2011:20). Ontology helped the researcher to recognise the certainty about the nature and existence of matters that are being researched.

The researcher conducted a qualitative study to embrace multiple realities. Multiple forms of evidence that the participants provided were used to develop themes from what they shared with the researcher regarding SRH communication (Neubauer et al., 2019:92). The ontological assumption that the researcher made regarding SRH communication was from the PHC nurses, the grandparents and grandchildren not from the researcher's point of view. This study intended to understand how PHC nurses, grandparents and grandchildren view their experiences. The purpose of investigating the meaning constructed by the different participants was to develop guidelines on SRH communication to ensure that open communication is enhanced.

The researcher assumed that SRH communication is perceived as a sensitive topic. It may be challenging for participants to share their lived experiences in a group (family interview); hence unstructured phenomenological, individual face-to-face interviews were conducted. However, the researcher also considered that there might be a possibility that some participants would not want to discuss or share their experiences because sexual related topics are viewed as private or taboo and are meant only for adults. The researcher took into consideration the ethical obligations and respected the participants' decision not to discuss sexual related issues as they were informed during the information session about their right to withdraw from the study at any given time (Brink et al., 2017:29; Gray et al., 2017:162; Polit & Beck, 2017:140). Unstructured phenomenological individual face-to-face interviews were conducted with the PHC nurses, grandparents and grandchildren to gain an in-depth and detailed description of the life world experiences regarding SRH communication. The researcher set aside her preconceived ideas, beliefs and values to allow the multiple realities of the participants' life world experiences to emerge.

3.2.2.2 Epistemological assumptions

Epistemology is a branch of philosophy that deals with the nature of knowledge (Khatri, 2020:1437; Kivunja & Kuyini, 2017:28). The authors further state that epistemological assumptions focus on the format and structure of knowledge rather than the content. In addition, epistemology focuses on the nature of the knowledge and how the researcher looks and makes sense of the world (Ataro, 2020:20; Bradshaw, Atkinson & Doody, 2017:3). The same authors state that from the constructivist perspective, knowledge is viewed as being subjective, personal, unique and flexible especially where the researcher engages with the participants. The question that was addressed was: *"What is the relationship between the researcher and the phenomenon that is being studied?"*

In this study, epistemology intended to understand the participants' experiences regarding SRH communication. Due to the nature of the phenomenon under investigation, epistemology describes how SRH communication is anchored in the world by allowing the participants to share their lived experiences. Polit and Beck (2017:10) posit that the researcher interacts with participants during data collection, and the findings are viewed as the outcome of the interactive process.

The researcher bracketed her preconceived ideas regarding SRH communication within the families, thus allowing the participants to share their lived experiences. The researcher trusted that the experiences of the PHC nurses, grandparents and grandchildren could only be explored through an exhaustive interaction with the participants. The interviews enabled the researcher to examine and describe the meaning of SRH communication. The researcher gained in-depth knowledge and a rich description of the experiences of all the participants. The interactive processes between the researcher and the participants yielded findings that emanated from the participant's shared lived experiences.

3.2.2.3 Methodological assumptions

The methodological assumptions relate to the procedures that are followed when conducting a research study (Khatri, 2020:1437; Kivunja & Kuyini, 2017:28). The researcher ensured that all the research processes were followed: methods and design, which are qualitative, descriptive phenomenological and contextual in nature. Furthermore, other processes that included non-probability sampling methods, namely purposive and snowballing, sampling, data collection and analysis, were followed by the presentation of the findings at a later stage (Okesina, 2020:60; Kathri, 2020:1437; Bradshaw et al., 2017:3). In this study the researcher's main data collection instrument was open ended questions that allowed the participants to respond to the questions which were in line with qualitative research method (Brink et al., 2018:104).

3.2.3 Phenomenology within a constructivist paradigm

The philosophy of phenomenology resides within the naturalistic or constructivist paradigm (Rodriguez & Smith, 2018:96). Researchers in constructivist traditions emphasises the inherent complexities of human and their ability to shape and create their own experiences (Okesina, 2020:60; Polit & Beck, 2017:12). De Vos et al. (2016:8) state that social constructivists believe that individuals seek understanding of the world they live and work in thus develop a subjective meaning of their own experiences. The (ibid) further state that reality can be socially and personally constructed, evidenced by the interactive process

between the researcher and the participants during data collection. This study used different data collection approaches to elicit rich data regarding SRH communication as participants shared their life experiences.

The researcher posed a broad question allowing the participants to construct the meaning of the situation so they could share their lived experiences through their interaction with the researcher (De Vos et al., 2016:8). Even though the settings were different. However, they shared being comfortable, relaxed and familiar with their environment.

3.2.4 Historical Overview of Phenomenology

Munhall (2012), cited in Farrell (2020:2), asserts that researchers should know the history and the philosophical underpinnings of phenomenology to produce reach phenomenological research findings. Phenomenology is rooted in the philosophical traditions that Husserl and Heidegger developed. Phenomenology is a research approach uniquely positioned to assist researchers in learning from the experiences of others (Mwadulo & Odoyo, 2020:37; Brink et al., 2018:105). Holloway and Wheeler (2010:213) indicated three streams of phenomenology; the descriptive Phenomenology of Husserl, the Hermeneutic phenomenology of Heidegger and the existentialist phenomenology of Merleau-Ponty. The focus of this is on transcendental or descriptive phenomenology.

3.2.4.1 Edmund Husserl Transcendental phenomenology (1859-1938)

Edmund Husserl, a German Mathematician, is regarded as the father or founder of phenomenology (Neubauer et al., 2019:92; Qutoshi, 2018:215; Kalaldeh, Shosha & Salameh, 2018:43; Christensen, Welch & Barr, 2017:113). The authors highlight that phenomenology was developed to define the philosophical method. It is an approach that deals with understanding people's lived experiences. Phenomenologists believe that there is an essence that can be understood from the lived experiences of those who have experienced or lived in it. Farrell, 2020:2; Polit & Beck, 2017:4 both authors assert that essence is what makes a phenomenon. Husserl's philosophy emphasises describing the meaning of human experiences (Qutoshi, 2018:219). According to Husserl, the researcher needs to bracket all the preconceived ideas and beliefs throughout to ensure the credibility of the findings study (Ramsook, 2018:15).

3.2.4.2 Martin Heidegger Hermeneutic phenomenology (1889-1976)

Martin Heidegger, who was Husserl's student, challenged Husserl's idea of reduction. He believed that human beings could find the significance of the meaning of their own

experiences (Farrell, 2019:3; Qutoshi, 2018:215). His philosophy is interpretive nature as it focuses on the importance of meaning. Furthermore, Hermeneutic phenomenology argues that the researcher cannot bracket but instead recognise that the researcher cannot distance herself from their life world (Neubauer et al., 2019:94; Rodriguez & Smith, 2018:96). Farrell (2019: 3) further highlights Heidegger's discomfort about Husserl's presupposing the subject-object where external objects confront the ego. He further argued that meaning is inherent within lived experiences. Rodriguez & Smith (2018:98) posit that the researchers' experiences and interpretation of the collected data are interwoven. The most important concept of hermeneutics is the hermeneutic circle of understanding which reflects or asserts that all understandings are inherently circular (Ramsook, 2018:15).

3.3 CONTEXT OF THE STUDY

The study was conducted in selected wards and clinical facilities in the Tshwane District. The City of Tshwane (CoT), is a category A municipality in the Gauteng Province. It is the largest metropolitan municipality comprising seven Regions, 105 wards and 210 councillors. CoT was established in 2000 and incorporated Metsweding, Dinokeng tsa Taemane and Bronkhorstspruit. This incorporation comprises a population of 3.3 million, covering 6 345 m2. It is a multicultural area, and the principal languages that prevail are English, Afrikaans, Sepedi, Sesotho, Setswana, isiZulu, Xitsonga, Tshivenda and isiNdebele.

The participants who participated in the study spoke mainly Setswana, Sepedi and English, working or residing in the CoT District. The grandparent families were found in their natural settings, and the PHC nurses were in their working environment. All the participants were relaxed as the settings were not threatening (Gray et al., 2017:353; Polit & Beck, 2017:464). The researcher was not in control of the interview time as participants were allowed to freely decide on their availability for the information giving session and individual interviews.

In the residential areas, the researcher allowed the participants to identify a suitable place where the individual face-to-face interviews would take place without any disturbance, and the PHC nurses utilised their consulting rooms as a suitable place where individual face-to-face interviews were conducted (Polit & Beck, 2017:47; Gray et al., 2017:45).

This study was conducted in the following two phases:

Phase 1: Exploration and description of SRH communication within the grandparent-headed families in the City of Tshwane district.

Phase 2: Development of Guidelines for PHC nurses to support grandparent-headed families in the City of Tshwane district.

3.4 PHASE 1: EXPLORATION AND DESCRIPTION OF SEXUAL REPRODUCTIVE HEALTH COMMUNICATION WITHIN THE GRANDPARENT-HEADED FAMILIES IN THE TSHWANE DISTRICT

3.4.1 Research design

Research design is the blueprint the researcher follows in conducting a study to answer the research questions (Okesina, 2020:67). A qualitative, descriptive phenomenological contextual design was employed in Phase 1.

3.4.1.1 Qualitative Design

A qualitative approach is an investigation done in a holistic and in-depth fashion by collecting rich data using flexible research designs (Polit & Beck, 2017:741). The main purpose of conducting an intensive investigation was to provide a view of reality that was important to the participants rather than the views of the researcher (Streubert & Carpenter, 2011:48). Mohajan (2018:1) views qualitative research as a social action that is more concern about how people interpret and make sense of their experiences to understand social reality. However, Jootun et al., (2009:44), cited in Palaganas, Sanchez, Molintas & Caricativo (2017:430) allude that the aim of qualitative research is to have a better understanding of how meanings are constructed, and the way participants use the experience to construct reality. On the other hand, Gray et al. (2017:25) summarised qualitative research as a systematic, interactive, subjective and naturalistic approach appropriate for exploring and describing the life experiences from the perspective of the person or people involved. The researcher opted for a qualitative approach because some research questions on SRH communication within grandparent headed families could not be answered quantitatively (Busetto, Wick & Gumbinger, 2020:11).

Qualitative research allowed the researcher to explore in-depth richness and complexities that are inherent in the lives of the participants, i.e., grandparents, grandchildren and PHC nurses regarding SRH communication (Gray et al., 2017:62). Queiros, Faria & Almeida (2017:370) views qualitative approach as a strategy that is more concern about experiences of people rather than numbers, measurements including statistics. In this study, the

participants shared their lived experiences with the researcher about SRH communication through an interactive process whereby questions were asked, followed by probes, and participants could share their lived experiences.

The qualitative approach assisted the researcher in eliciting rich data from the grandparents, grandchildren and PHC nurses regarding SRH communication as data was generated from all the participant's lived experiences (De Vos et al., 2016:348). The researcher tried to examine the participants' experiences from their point of view to describe and attach meaning to their lived experiences regarding SRH communication.

The Characteristics of qualitative research are further summarised and applied to the study as discussed below a to j (Brink et al., 2018:104; Mohajan, 2018:17 Polit & Beck, 2017:463; De Vos et al., 2016:65).

a) Researcher as a primary instrument of data collection

In qualitative research, the researcher is the key instrument of data collection and analysis and plays a pivotal role by conducting interviews, observation and field notes. In this study, the researcher formed an integral part of the research process to have a better understanding of the information that was provided by the participants (Brink et al., 2018:104; Botma et al., 2016;182; Streubert & Carpenter, 2011:49). The researcher kept focus on learning what the participants hold about the problem, not the meaning that the researcher brings to the study. The researcher had a responsibility to ensure that ethical considerations were adhered to, ensuring that ethical approval is granted before the actual data collection commences (Protocol 45/2020, permission from Tshwane child welfare and Gauteng Research committee) (De Vos et al., 2016:332). The researcher requested the renewal and amendment of the ethical letter to ensure that the validity of the ethical approval letter was compliant.

b) Natural setting

A natural setting is an uncontrolled real-life environment which is not manipulated (Brink et al., 2018:47; Gray et al., 2017:684; Polit & Beck, 2017:736). Aspers & Corte (2019:142 confirm that qualitative researchers conduct their studies in their naturalistic settings attempting to make sense of the phenomena in terms of the meaning the participants bring. For this study, the natural location was determined to be the residential area of the grandparent headed families (GPHF) and the work environment of the PHC nurses in CoT. The settings were non-threatening and allowed the participants to be relaxed during data

collection (Mohajan, 2018.17; Khaldi, 2017:21; Gray et al., 2017:352). Prior arrangements or permission to access the settings was arranged with the respective authorities before the actual data collection was done, i.e., UP Ethics Committee approval, Department of Health, CoT and DSD in Tshwane District refer (**Annexures A,C,B**). The researcher ensured that enough time was spent with the participants in the research setting allowing the participants to share their lived experiences, and the researcher was able to observe the non-verbal communication and compile field notes.

c) Interactive process

Data was collected directly from the participants through an interactive process between the researcher and the participants who met the inclusion criteria and were willing to participate in the study. The researcher focused on the individual face-to-face in-depth interviews, observation, and field notes as the data collection methods to better understand the participant's thoughts, experiences, attitudes and behaviour about SRH communication. These data collection methods assisted the researcher in eliciting rich, thick data from the participants, which also assisted in deriving essential elements and constituents during data analysis (Polit & Beck, 2017:531**)**.

d) Humanistic

A qualitative approach is humanistic; it focuses on the personal, subjective and experiential basis of knowledge (Polit and Beck 2017:13). In phenomenology, the data is from the lived experiences of the participants. Qualitative research is used to understand people's beliefs, behaviour, experiences, attitudes and environmental interactions. In this study, the researcher tried to understand the participants' experiences regarding SRH promotion within the family context.

e) Purpose of Qualitative Research

The purpose of qualitative research was to get an in-depth description and understanding of the people's beliefs, actions, attitudes and assumptions about SRH communication within the grandparent family context (Brink et al., 2018:104). The researcher wanted to respond to the research question using the participants' narratives, not numerical ones, to explore and understand the meaning the participants pose about the phenomenon under study (Busetto, Wick & Gumbinger, 2020:1).

f) The Rationale of the Research

The rationale of the research was not to generalise the findings but rather to understand them in context. The researcher conducted this study to explore and describe the lived experiences of the PHC nurses, grandparents, and grandchildren on SRH communication.

g) Triangulation

Qualitative research focuses on discovery and understanding, which requires flexibility in the research design. This design was flexible because multiple methods were used to examine the same question, namely population and data collection techniques (Brink et al., 2018:84). In this study, three (3) groups of populations and several data collection methods were used to enhance triangulation. Polit and Beck (2017:563) posit that triangulation assists the researcher in capturing a completer and more contextualised portrait of the participants. Brink et al. (2018:84) posit that triangulation assumes that any inherent bias originating from the researcher or method will be neutralised. Four types of triangulations used in research are data triangulation, investigator triangulation, method triangulation and theory triangulation (Brink et al., 2018:84).

However, in this study, the researcher used data triangulation whereby data was collected from the participants and field notes (Polit & Beck, 2017:563). Time triangulation was used, whereby data was collected at different times of the day. Data from PHC nurses was collected during the day at the facilities, whereas data from families was collected conveniently at a time suitable for each participant. Some interviews were held during the day, whereas some were in the afternoon or evening (Polit & Beck, 2017:563). In-person triangulation data was collected from participants; PHC nurses, grandparents, and grandchildren (Polit & Beck, 2017:563). In this study, the method of triangulation whereby multiple data collection methods was employed through in-depth interviews, observations and field notes (Polit & Beck, 2017:564).

h) Reflexivity

The researcher in qualitative research adopts a reflexive position. Yao and Vital (2018:197); Ramsook (2018:22); Polit and Beck (2017:508) define reflexivity as the researcher's engagement in self-reflection to understand better how the researcher's lens affects the research study due to the interaction between the researcher and the participants. The researcher kept focusing on learning what the participants shared about the problem, not the meaning that the researcher brought to the study. Furthermore, the researcher had to understand the impact of own values and beliefs that may influence the findings and

credulity of the study. Notes were taken regarding the participants' comments and the researchers' thoughts during data collection. In this study, the participants shared their lived experiences regarding SRH communication.

i) Ongoing data collection and analysis

Data collection and analysis were conducted simultaneously, as is expected in a qualitative approach (De Jonckheere & Vaughn, 2019:5; Brink et al., 2018:180; Gray et al., 2017:256; Botma et al., 2016:220). Giorgio's data analysis method was followed, which resulted in the formation of themes, sub-themes and quotes. Immersion refers to the researcher's involvement, including time spent in data analysis (Gray et al., 2017:270; Botma et al., 2016:230). In this study, the raw data was transcribed verbatim so that the researcher could read the transcript repeatedly to better understand the participants' shared views. This allowed the researcher to be immersed in the data whereby essences and constituents emerged from the analysed data on SRH communication within the families.

j) Presentation of data

In qualitative research, data is presented in a narrative form than in numeric form because of person-to-person interaction whereby participants shared their lived experiences using words (Gray et al., 2017:251; Streubert & Carpenter, 2011:28). The presentation of data was done in terms of essential elements and constituents that emerged from the raw data that was gathered during data collection and analysis. Elaborate. The detailed presentation of the findings will be dealt with in Chapter 4 and Chapter 5.

3.4.1.2 Phenomenology as a Qualitative Research Method

A phenomenology is an approach that is used to explore the day's life experiences of people (Farrell, 2020:1; Mwadulo & Odoyo, 2020:38; Mohajan, 2018:8)***.*** Phenomenology is one of the qualitative research approaches that the researcher has identified as being appropriate and uniquely positioned to support this study by exploring and describing the experiences of PHC nurses, grandparents and grandchildren regarding SRH communication in Tshwane District, GP (Neubauer, Witkop & Varpio, 2019:91; Christensen et al., 2017:113). In this study, the researcher used phenomenological design as the aim was to explore and describe the experiences of PHC nurses, grandparents and grandchildren regarding SRH communication. Therefore, phenomenology was carefully chosen to assist in the development of new understandings of human lived experiences relying on first-hand information obtained from the participants through individual face-to-face interviews (Schneider, Coates & Yarris, 2017:375).

The purpose of utilising phenomenology was to gain a deeper understanding of the meaning of SRH communication from the perspective of the PHC nurses, grandparents and grandchildren in CoT (Sloan & Bowe, 2014:4). Neubauer et al. (2019:91) state that a detailed study is undertaken to discover new information or understanding to have a better insight into a particular phenomenon of interest from the lived experiences of participants. In addition, Kalaldeh et al. (2017:43) highlight that phenomenology deals with the world as it is lived by the person meaning there is an individual who experiences the phenomenon. The researcher opted for phenomenology as the approach that allowed the individual experiences to be understood in a manner that provided a universal description. In addition, phenomenological researchers base their designs on either Hussler's or Heidegger's point of view that the person and the world in which that person exists may differ.

The keywords applicable to phenomenology are explained below to ensure the reader understands the fundamental principles. The methodological keywords related to the study, namely consciousness, experience and phenomenon, are discussed below.

Consciousness: Consciousness is a state of being aware of any object or something within oneself, such as thoughts, feelings, memories or sensations (Hashim & Ramadhan, 2019:2)**.** The authors assert that consciousness cannot be touched or felt. It controls our emotions, ourselves and our sense of how it thinks it is suitable**.** According to Christensen, Welch & Barr (2017:113), conscious human experiences are experiences of the world, and the world gives meaning to these experiences**.** According to Husserl, consciousness is the basis for experience and further described human consciousness as the "wonder of wonders" (Farrell, 2020:2). In this study, the participants were able to verbalise their conscious experiences regarding SRH communication, hence the researcher opted for individual phenomenological interviews or conversations.

Experience: According to Neubauer, Witkop and Varpio(2019:91), the goal of phenomenology is to describe the meaning of this experience in terms of what was experienced and how it was experienced. In addition, Gray et al. (2017:66) posit that phenomenologists perceive a person as constantly interacting with the environment, making meaning of experiences in that context. In the context of this study, participants shared their lived experiences regarding SRH communication.

Phenomenon: A phenomenon is a situation observed to exist, especially whose explanation is in question. Oshodi et al. (2019:2) highlight that phenomenology doesn't dictate the

phenomena but rather seeks to understand how phenomena present themselves to consciousness and the elucidation of the descriptive process. In this study, the researcher focused on SRH communication as the phenomenon under study. The researcher was able to bracket all the preconceived ideas and beliefs throughout the research process, as emphasised by Husserl.

3.4.1.3 Characteristics of Phenomenology

Phenomenology as a method has got four characteristics, namely: descriptive, reduction, essence and intentionality.

a) Descriptive

The main aim of phenomenology is to describe the phenomenon under study, which will further include emerging emotions, thoughts, and actions of human beings. Oshodi et al. (2019:2) posit that Giorgi highlights that description is the acknowledgement that a "given" needs to be described precisely as it appears and nothing to be added nor subtracted. In contrast, interpretation is viewed as the adoption of a non-given factor to help account for what is given in experience.

b) Reduction/Phenomenological reduction

Reduction is a process in which assumptions and prejudices about the phenomena are delayed ensuring that biases do not pollute the descriptions of the observations. The researcher must adopt the attitude of phenomenological reduction (Oshodi et al., 2019:3). In this study, the phenomenological reduction was understood as setting aside all the preconceived ideas and values about SRH communication.

In this study, the researcher prepared a detailed description of the phenomenon under study. Bracketing necessitates the interactive process that prepares, evaluates and provides systematic, ongoing feedback through the safekeeping of reflective journals where the researcher wrote about her observations, feelings and conflicts, including assumptions (Dolfer & Stierand, 2020:1; Polit & Beck, 2017:471). The researcher set aside all the preconceived ideas, beliefs and views about SRH communication to ensure the authenticity of the data captured from the participants.

c) Essence

Essence is the core meaning of individual experiences in certain phenomena as they are and explicates a phenomenon of interest. Dalberg (2006:3) asserts that essences are when one experiences the world essence is realised. In this study, essential elements or meanings

(themes) of the analysed data were grouped, followed by constituents that emerged from the analysed data.

d) Intentionality

Intentionality is the correlation between noema and noesis that direct interpretation of the experiences. Intentionality means the humans' minds ability to refer to objects outside of itself (Christensen, Welch & Barr, 2017:114). The same authors further assert that intentionality is ascribed to the mental state, such as perceptions, beliefs or desires. Sunder et al. (2018:734) indicate that understanding lived experiences is closely linked to the intentionality of consciousness. These authors posit that intentionality encompasses the idea that our consciousness is always directed towards something, meaning that when we experience something, the “thing” is experienced as “something” that has meaning for us.

In this study, the researcher focused on the essential meaning of the experiences of PHC nurses, grandparents, and grandchildren in sexual reproductive health promotion. These experiences were valuable because they were understood as the participant’s consciousness of the social meaning of the phenomenon under study.

3.4.1.4 Descriptive phenomenological design

Descriptive phenomenology was chosen for its pure description of the people’s experiences and not based on the researcher’s interpretation of participants’ descriptions (Oshodi et al., 2019:2; Christensen, Welch & Barr, 2017:133). The researcher was guided by descriptive phenomenology to capture the reality of the phenomena by probing the subjective consciousness of the individual (Pardell-Domiguez et al., 2021:3; Alshawish, Qadous & Yemen, 2020:15). Descriptive phenomenology involves the following strategies: bracketing, intuiting, analysing and describing. They are discussed in detail below.

a) Bracketing

Bracketing is a process of identifying and holding in abeyance preconceived beliefs, values, views and opinions about the phenomenon under study (Brink et al., 2018:105; Gray et al., 2017:672; Polit & Beck, 2017:471). Bracketing entails the interactive process that prepares, evaluates and provides systematic, ongoing feedback about the effectiveness through the safekeeping of reflective journals where the researcher wrote observations, feelings and conflicts, including assumptions (Polit & Beck, 2017:471). In addition (Greening, 2019:90) posits that bracketing is the central component of phenomenological reduction. Bracketing requires that the researcher remains neutral with belief or disbelief in the phenomenon's

existence. In this study, the researcher allowed the participants to share the meaning of their experiences without any inference. Thus, rich data was generated. Furthermore, bracketing assisted the researcher in concentrating on what the participants shared rather than previous knowledge about SRH. Bracketing was crucial in the research process, especially during data collection and analysis, whereby the researcher had to put aside all preconceived beliefs, thus allowing the participants to share their lived experiences regarding SRH communication (Ataro, 2020:20).

b) Intuiting

Intuiting is a step in descriptive phenomenology that occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it (Polit & Beck, 2017:417). Intuiting enabled the researcher to become immersed in the phenomenon under investigation. In this study, the researcher was the primary data collection instrument, listened to the recorded interviews, transcribed and analysed the data, which agrees with the characteristics of phenomenology (Greening, 2019:90; Gray et al., 2017:270; Botma et al., 2016:230). The researcher used communication skills and techniques to probe information from the participants without being judgemental and avoided criticising what the participants shared regarding SRH communication. This allowed the participants to provide rich, thick data. The researcher acquired an understanding of the phenomenon involved in SRH communication as described by the PHC nurses, grandparents and grandchildren. Open-ended clarifying questions were used to ensure the participants elicited rich data as they shared their experiences regarding SRH communication.

c) Analysis

Analysing in qualitative research is an active and interactive process whereby the researcher scrutinises and reads the data repeatedly, searching for meaning and understanding (Polit & Beck, 2017:531). Prior to analysis, the researcher ensured that the verbatim transcriptions of the recorded interviews were accurate and vividly reflected the interview experience (Polit & Beck, 2017:531). In qualitative studies, data analysis occurs simultaneously rather than after data collection. The search for themes and concepts commenced from the moment data was collected. Analysis assisted the researcher in identifying the essence of the phenomenon under investigation based on the data obtained; also exploring the relationship and connection with adjacent phenomena. In this study, the researcher invested fully in the data and spent extensive time reading to make sense of what the participants shared during data collection (Greening, 2019:90; Gray et al., 2017:270).

Phenomenological analysing involves identifying the essence of the phenomenon under investigation based on the data obtained and on how the data was presented. At this point, the researcher listens to, compares and contrasts descriptions of the phenomenon under study. This allows for the identification of recurring themes (essence) and interrelationships (Alshawish et al., 2020:75; Hasanvand et al., 2016:69). As the researcher listened to the descriptions of the experience of SRH communication then, themes or essences began to emerge. In this study, Giorgio's data analysis method was followed, and the stages are listed below:

- Assuming a phenomenological attitude
- Reading interviews to attain a sense of the whole.
- Determination of the primary meaning units
- Transforming meaning units into psychological statements
- Synthesise of psychological General or Essential structure of experience based on constituents.

d) Describing

Describing is the final step, and the aim is to communicate and describe (in writing and verbally) distinct, critical elements of the phenomenon, thereby communicating to others what the researcher has found (Greening, 2019:90). Describing enabled the researcher to refrain from attempting to describe the participant's experience prematurely and was viewed as a common methodological error associated with phenomenology (Streubert & Carpenter, 2003:61).

In this study, phenomenological describing involved classifying all critical elements of essences common to the lived experience of SRH communication and explaining the essences that emerged during data analysis. This chapter provides the specific philosophical assumptions of phenomenology (3.2.3) and a historical overview of Phenomenology (3.2.4).

3.4.1.5 Contextual design

In a contextual research strategy, the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton, 1998:133). Burns and Grove (2003:32) point out that contextual studies focus on specific events in "naturalistic settings". Naturalistic settings are uncontrolled real-life situations, sometimes called field settings that occur without manipulation (Gray et al., 2017:684; Polit & Beck, 2017:736). This study was conducted in the PHC facilities and the residential areas of the families. In-depth, phenomenological interviews or conversations were conducted with the PHC nurses, grandparents and

grandchildren, who were purposively sampled according to the inclusion criteria and were willing to participate in the study. The relationship between the participants and context was intense, whereby they managed to share their in-depth experiences of SRH communication.

3.5. PHASE 1: RESEARCH METHOD

In this phase, population, sampling, data collection, and data analysis will be discussed in detail.

3.5.1 Population

Population refers to all the individuals that meet the inclusion criteria to participate in a study (Gray et al., 2017:687; Polit & Beck, 2017:739). The current study consists of three population groups: PHC nurses, grandparents and grandchildren within CoT. Table 3.1 depicts the profile of population 1 (PHC nurses).

Table 3.1: Profile of participants (Population 1)-PHC nurses

NUMBER	PARTICIPANTS	AGE	GENDER	NO OF YEARS IN PHC FACILITY	PHC TRAINED YES /NO	AREA	INTERVIEW AREA	NO OF CHILDREN
1.	M (HCP1)	49	M	18	Yes	CoT	Work	**3**
2.	PS (HCP2)	61	F	7	Yes	CoT	Work	**2**
3.	M (HCP3)	41	F	5	Yes	CoT	Work	**2**
4.	KM (HCP4)	36	F	3	Yes	CoT	Work	**3**
5.	SM (HCP5)	49	F	5	Yes	CoT	Work	**3**
6.	M(HCP6)	59	F	32	Yes	CoT	Work	**3**
7.	M (HCP7)	29	F	4	Not yet	CoT	Work	**1**
8.	TN (HCP8)	37	F	4	Not yet	CoT	Work	**1**
9.	TVB(HCP9)	29	F	6	Yes	CoT	Work	**0**
10.	TM (HCP10)	37	F	11	Yes	CoT	Work	**2**
11.	SH (HCP11)	37	F	7	Yes	CoT	Work	**1**
12.	T (HCP12)	26	F	4	Yes	CoT	Work	**0**

Population 1 consisted of registered nurses in the PHC facilities in the CoT District. All the PHC nurses were stationed in PHC facilities and rendered first level care to the community, as depicted in Table 3.1 above. Twelve (12) participants participated in the study. Ten of the PHC nurses who participated in the study hold a qualification in Clinical Nursing Science, Health Assessment, Diagnosis, Treatment and care (Government Notice R48 of), and two (2) are still awaiting to go for training however, they hold a qualification Diploma or a Degree in Education and Training of a Nurse (General, Psychiatric and Community) and Midwifery Leading to Registration (Government Notice Regulation No. 425 of 22 February 1985 as amended). All the participants have been in the PHC setting for more than two (2) years, which is a reasonable period to acquire the necessary knowledge and experience of all the services rendered in a PHC facility. The participants were aged between 26-61 years, which assisted the researcher in gathering rich data from their personal experiences as healthcare providers and some as parents. The participants were allowed to choose the language they felt comfortable and all preferred to speak English. Participants preferred to be interviewed in their consultation rooms, which afforded privacy and were convenient for interaction with the participants.

Population 2 consist of grandparents that are residing in the CoT District, as depicted in Table 3.2 below.

Table 3.2: Profile of participants (Population 2)-Grandparents

FAMILY NUMBER	PARTICIPANTS	AGE	GENDER	MARITAL STATUS	EDUCATIONAL LEVEL	WORKING YES /NO	PENSIONER	AREA	INTERVIEW AREA	ATTRITION
1.	GP	77	F	Widow	Form 3	No	√	CoT	Home	Participated up to the end
2.	GP	62	F	Single	Form 2	No	√	CoT	Home	
3.	GP	91	F	Widow	Form 3	No	√	CoT	Home	
4.	GP	70	F	Divorced	Form 5	No	√	CoT	Home	
5.	GP	80	F		Std 6	No	√	CoT	Home	
	GPM	90	M	Married			√	CoT	Home	√
6.	GP	86	F	Widow	Std 6	No	√	CoT	Home	√
7.	GP	62	F	Single	Std 5	No	√	CoT	Home	Participated till the end
8.	GP	67	F	M	Std 10	No	√	CoT	Home	
9.	GP	61	F	Single	Graduate	No	√	CoT	Home	
10.	GP	59	F	Married	Std 10	Yes	×	CoT	Home	

Population 2: consisted of grandparents staying with their grandchildren in CoT. Families were identified from the list provided by the social worker, and some were identified by the participants who participated in the study through snowballing. Eleven (11) participants were eligible to participate in the study however, two (2) withdrew their participation in the study. Nine (9) participants continued their participation. The participants were aged from 59-91 years. Most families consisted of grandmothers, with only one family that consisted of both the grandmother and grandfather.

Population 3 consisted of grandchildren residing in the CoT District, as presented in Table 3.3 below.

Table 3.3: Profile of participants (Population 3)-Grandchildren

FAMILY NUMBER	PARTICIPANTS	AGE	GENDER	EDUCATIONAL LEVEL	WORKING YES /NO	PENSIONER	AREA	INTERVIEW AREA	ATTRITION
1.	GC	18	F	Grad 11	No	x	CoT	Home	Participated till the end
	GC	18	F	Grad 12	No	x	CoT	Home	
	GC	20	M	Grad 12	No	x	CoT	Home	
2.	GC	18	M	Grade 11	No	x	CoT	Home	
3.	GC	21	M	Post Matric	No	x	CoT	Home	
4.	GC	18	F	Grade 12	No	x	CoT	Home	
5.	GC	22	F	Post Matric	No	x	CoT	Home	
6	GC	20	F	Grad12	No	x	CoT	Home	
	GC	19	F	Grad 12	No	x	CoT	Home	
	GC	18	F	Grad 12	No	x	CoT	Home	
7.	GC	18	M	Grade 10	No	x	CoT	Home	√
8.	GC	18	F	Grade 12	No	x	CoT	Home	Participated till the end
9.	GC	21	M	Post Matric	No	x	CoT	Home	
10.	GC	18	M	Grade 12	No	x	CoT	Home	√

Population 3: consisted of grandchildren staying with their grandparents in the presence or absence of their biological parents. All grandchildren are aged 18-22 and are still attending school from grade 10 to post matric. The grandchildren (adolescents) were fourteen (14), eight (8) females and six (6) males, and two (2) withdrew from the study due to ill health.

3.5.2 Sampling methods

To access the participants, purposive and snowballing sampling methods were used. Sampling involves the selection of events, behaviour or a group of people that will be used for conducting a study (Gray et al., 2017:329; Polit & Beck, 2017:743; Sharma, 2017:749; Botma et al, 2016:199). A purposive, non-probability sampling method was used as the main technique to identify potential participants from the list of grandparents headed families received from the social worker who was based in the Tshwane district (Brink et al., 2018:126; Ramsook, 2018:16; Ngozwana, 2018:21; Polit & Beck 2017:502; De Vos et al., 2016:358).

Purposive sampling was found to be suitable because the researcher wanted to have a better understanding of the experiences of PHC nurses, grandparents, and grandchildren regarding sexual reproductive communication. The researcher deliberately considered PHC nurses, grandparents and grandchildren because they were able to provide extensive information regarding SRH communication based on their lived experiences (Gray et al, 2017:344; Botma et al., 2016:199; De Vos et al., 2016:232; Palinkas et al., 2015:2). The utilisation of purposive sampling assisted the researcher in selecting appropriate participants who managed to provide rich data that was needed to gain insight and discover new meaning on SRH communication within families and from the PHC nurses (Johnson, Adkins & Chauvin, 2020: 141; Vasileiou et al., 2018:2; Gray et al., 2017:352; Botma et al., 2016:206). In this study, the researcher used the participants identified through purposive sampling that have the same characteristics and were willing to participate in the study (Botma et al., 2016;201).

Purposive sampling was further supplemented by snowballing, which assisted the researcher in expanding the pool of participants (Sharma, 2017:752; Gray et al., 2017:346; Botma et al., 2016:201; De Vos et al., 2016:233). Cohen et al 2009 cited in Ngozwana (2018:21), expressed snowballing as the selection of participants through recommendations from other participants who bears the same characteristics and possess the relevant knowledge. The participants approached the potential referrals to make sure that they were

interested in the study before their names were shared with the researcher, as suggested in Polit and Beck (2017:493).

In terms of the preparation to access the participants, it was crucial for the researcher to meet all the gatekeepers in person to facilitate relationship building and negotiation of access to participants (Dempsey et al., 2018:481; Ngozwana, 2018:21). The researcher negotiated visits with the district managers and PHC managers requesting permission to conduct the study in the PHC facilities (Dempsey et al, 2018:480; Gray et al, 2017:277). This was followed by the visit to different families who were also granted permission. All the participants were informed about the duration of the interviews however, some of the PHC nurses indicated that 30-45 minutes would be too much as they are also expected to reach their daily targets. The researcher took cognisance of the PHC nurses, and their decision was also respected but allowed to respond to the interview questions. The current study included PHC nurses, grandparents and grandchildren who had experienced the phenomenon under study.

3.5.2.1 Sample size

In qualitative studies, the sample size is based on informational needs hence data saturation (Polit & Beck,2017:497; Gray et al, 2017:352). The focus of qualitative research is on the quality of information obtained from the person. However, in phenomenology, the sample size turns out to be small because the purpose is to elicit information to achieve an understanding of the participant's point of view (Polit & Beck, 2017:499; De Vos et al., 2017:348). In contrast, Burns and Groove posit that a small number can lead to inadequate information, which may affect the quality of findings. The researcher employed phenomenology as all the participants had to have experienced the phenomenon, and they must be able to articulate what it is like to have lived the experience (Gray et al, 2017:499). The saturation of data is determined by the sample size. Saturation is a point of informational redundancy where there is no additional or new information derived from the participants (Johnson, Adkins & Chauvin, 2020:141; Vasileiou et al., 2018:2; Polit and Beck, 2017:60; Gray et al., 2017:255; Botma et al., 2016 200; Gentles et al., 2015:1781). In the qualitative approach, saturation is also seen as the criterion that determines the sufficiency of the sample size. In this study, three populations were used, namely PHC nurses, grandparents and grandchildren. Participants were allowed to share their lived experiences without any fear or intimidation.

Population 1 consisted of twelve (12) individual face-to-face interviews conducted with the PHC nurses, and data saturation was reached with the 10th participant however, the researcher added two more participants however, there was no new information that could be provided (Gray et al., 2017:352).

Population 2 consisted of 11 grandparents, two (2) withdrew from the study. Nine (9) grandparents were interviewed individually to provide their experiences regarding SRH communication with their grandchildren from the twelve (12) grandparent headed families who met the inclusion criteria and were willing to participate in the study. The researcher took into consideration the issue of the sample size, as suggested in Vasileiou et al (2018:2) and Polit and Beck (2017:506).

Population 3 consisted of grandchildren 13 grandchildren who were eligible for the study. Eleven (11) grandchildren were interviewed individually to share their experiences regarding SRH communication with their grandparents.

Literature advises that in phenomenological studies, the researcher engages with a small number of participants to provide rich descriptions of human experiences, not for generalisation of the findings of the study.

- **Inclusion criteria**

The following inclusion criteria were used to determine who should participate in the study:

- Grandparents and grandchildren residing in the Tshwane district who were willing to participate and gave consent.
- Grandparent families comprise grandparents aged 35 and above who are staying with or caring for grandchildren aged 18 to 22 years who are still attending school.
- Grandparents and grandchildren who can speak English, Setswana and Sepedi, as the researcher, are comfortable with these languages.
- The Primary healthcare nurses based in the PHC facilities and communities in selected clinics in the Tshwane district and with two years of experience were willing to participate in the study.

- **Exclusion criteria**

The following exclusion criteria were followed:

- Grandparent families who were not willing to participate.
- Grandparent families who were not residing in the Tshwane district.

- Grandparent families who stay with grandchildren aged below 18 years and above 22 years.
- Grandparents below 35 years old.
- Grandchildren who were not attending school.
- Grandchildren below 18 years were not recruited to participate in the study.
- PHC nurses with less than two years of experience.
- Grandparents and grandchildren speaking other languages other than English, Sepedi and Setswana.

3.5.3 Data Collection

Data collection is outlined as the process of gathering data from the participants to answer the research question and achieve the study objectives (Brink et al., 2018:133; Gray et al., 2017:675; Polit & Beck, 2017:725). Barret and Twyaross (2018:63) posit that the qualitative data collection method allows the researcher to understand the experiences of participants better and explore the decisions made.

The data collection methods used in the study are in-depth interviews, observation and field notes and the use of a digital audio recorder. The following factors were taken into consideration: access to participants, information session, pilot study and interviews.

a) Access to participants

Population 1 consisted of PHC nurses based in the PHC facilities in CoT. The clinics were identified from a list of clinics in the CoT database. PHC nurses were recruited from five (5) PHC settings in the Tshwane District. A written request was submitted to the authorities prior to scheduling appointments with relevant authorities, including individual PHC managers. The researcher was well conversant with the location of each clinic identified for the study. The researcher viewed CoT as an ideal field because it was accessible and relevant, and the researcher was able to move freely without any hindrances (De Vos et al., 2016:332). The researcher managed to gain entry into the sites that were deemed suitable for the study after permission was granted by the relevant authorities, namely the UP-Ethics Committee, DoH & CoT (Polit & Beck, 2017:168; Botma et al., 2016:12). The researcher contacted the facility managers of each clinic, secured an appointment to request permission to conduct the study in each identified clinic. They were informed about the permissions granted by all the relevant authorities (**Annexures A & B)**. All the facility managers granted permission and further assisted with the identification of suitable participants.

Populations 2 and 3 consisted of all the grandparents and grandchildren staying together in CoT. Permission was acquired from the Tshwane Child Welfare prior to gaining entry (**Annexure A & C)**. The researcher contacted a social worker who is based at Tshwane Child Welfare to assist with the identification of grandparent headed families in Tshwane District (Polit & Beck, 2017:168). The researcher went through the list and identified all the participants who met the inclusion criteria. A preliminary tour was done to gain familiarity with the area where the participants reside in preparation for data collection (Polit & Beck, 2017:519). The researcher visited the families to introduce herself in preparation for the actual data collection phase and requested contact numbers for setting up appointments. Once they agreed to participate in the study, appointments were made with each family taking into consideration everyone's availability or commitments as the interviews were individual face-to-face for individual participants.

b) Information session

The information sharing session was held with all the participants prior to the actual data collection process, whereby the process of the study unfolded. The researcher introduced herself to the participants and informed them about the purpose of the study. The demographic information of each participant was collected to assess if they met the inclusion criteria and were willing to participate in the study (Tables 3.1, 3.2 & 3.3). All participants were informed about the importance of giving consent, and their rights were also stipulated. The researcher further highlighted the use of the audio recorder which will only be used when explicit consent has been obtained from the participants, the taking of field notes and the presence of the research assistant during data collection. Furthermore, the participants were informed about all the ethical steps that were taken to ensure that the ethical principles were adhered to and including the protection of the participants (Approval letter 45/2020; GP 202007_005) see (**Annexure A,C,B)**. All the participants were provided with the information leaflet, which contained the contact details of both the researcher and supervisors in case there was some clarity seeking questions (**Annexures D.E & F**). The issue of confidentiality was also emphasised, as evidenced by the use of pseudonyms (GP1F3) see Chapter 4. (4.5).

c) Pilot interview

A pilot interview is a prerequisite for the successful execution and completion of a research project (De Vos et al., 2016:394). A pilot interview was conducted to refine the data collection tools. The researcher conducted one pilot interview with each population group using similar participants, settings and data collection and analysis techniques to those of

the proposed study. The outcomes were discussed with the supervisor, and the interview schedule was refined process then, data collection and analysis commenced. However, the findings were not included in the study.

- **Venue**

The venue for the research was as follows:

For population 1: PHC facilities in the CoT were identified as suitable venues for data collection. The nurses preferred to make use of their individual consultation rooms in the facilities. The sitting arrangement was also arranged to ensure that COVID-19 health protocols are adhered e.g., well-ventilated, and social distancing was created by having a table between the participant and the researcher the venues were also noise free. Wearing masks and sanitising hands were also encouraged throughout the interviews. Most interviews were conducted during the day with minimum disruptions (Dempsey, Dowling, Larkin & Murphy, 2018:484).

For populations 2 and 3: The residential areas of families in CoT were identified as suitable venues for data collection (Gray et al., 2017:259). In this study, the participants were offered an opportunity to be interviewed in a location suited to them, and each participant within the family chose a comfortable room that created a relaxed atmosphere, with no noise, well-ventilated with enough lighting, two chairs and a small table that also assisted in creating social distancing, wearing of masks and sanitising were also encouraged (Dempsey, Dowling, Larkin & Murphy, 2018:484; Gray et al., 2017:259). Some of the interviews were conducted in the afternoon as per participant's requests. There was a contingency plan in place in case of load shedding, which happened while the interviews were in progress. Candles and battery-operated lamps were put in place and readily available. Some appointments had to be cancelled, especially when load shedding started before the commencement of the interview and rescheduled for another day.

- **Time frame**

Data collection was collected from November 2020 to July 2021. Each interview lasted for 20-45 minutes, depending on the availability of information that the participant wanted to share until there was no more new information from the participant.

- **Building rapport and trust**

Building rapport and trust was vital in this study to have a trusting relationship to gain the cooperation of all participants (De Vos et al., 2016:343). The researcher visited the families

in their residential places, and safety measures had to be taken into consideration because of the Covid19 pandemic. Their researcher ensured that the visits were done when the restrictions were lifted and allowed, whereby the country was on Alert Level 2.

The researcher introduced herself and the research assistant to the participants and explained her role, the purpose of the study, the participant's rights, interviews, permission to conduct the study, and the benefits of the study, including the use of the audiotape during data collection. The researcher thanked each participant for their keenness to contribute to the study and the valuable information they shared on SRH issues.

The participants were requested to identify a room which was suitable and comfortable for them for data collection. A well-ventilated room was chosen to ensure that health protocols were adhered to. The researcher spent 30-60 minutes with each family providing information about the study and all the processes that will be followed. An information leaflet in the language that the participant preferred contained the details of what will happen and was issued to individual participants. Contact numbers were requested from the participants, which were used to set up appointments. Consent forms were also issued for them to grant permission to participate in the study (**Annexure D & E**). The researcher and the participants scheduled appointments depending on the availability of each participant. Some interviews were cancelled due to the participant's other commitments, and the researcher had to reschedule the appointments.

d) Interviews

The interview is an exchange of information between the researcher and the participants because of the interactive nature of the qualitative approach (De Vos et al., 2016:342; Botma et al., 2016:205). DeJonckheere and Vaughn (2018:1) posit that in-depth interviews are attempts to understand the world from the participant's point of view, unfold the meaning of the people's experiences, to uncover their lived experiences prior to scientific explanation. In this study, interviews were more conversational, face-to-face interaction with each individual participant. Some questions were repeated to create a better understanding and prevent uncertainties that may have influenced the response from the participants. Botma et al. (2016:206) posit that interviewing does not only involve a description of experiences but also involves the reflection of the descriptions. The interview guide was followed, which consisted of the number of questions that were asked (**Annexure G, H & I)** (Brink et al., 2018:144). An interview guide refers to a set of pre-determined open-ended questions that guides the interview and do not dictate the interview (Botma et al., 2016:209).

The below questions were posed:

- *What are the experiences of grandparents regarding sexual and reproductive health communication with their grandchildren?*

- *What are the experiences of grandchildren regarding sexual and reproductive health communication with grandparents?*
- *What are the experiences of Primary health nurses regarding the promotion of SRH communication with grandparents and grandchildren*?

The interview guide assisted in ensuring consistency because all the participants were asked the same questions, which were followed by probes and the use of communication skills to elicit more information (De Vos et al., 2016:352). Probes are defined as a technique that was used to get detailed and reflective information from participants as they share their lived experiences regarding SRH communication (Polit & Beck, 2017:740). These communication skills included probing, paraphrasing, listening and clarification. The interviewing process lasted for 20-45 minutes, depending on the participant's eagerness to share their lived experiences. There two types of interviews that were used in qualitative research are semi-structured interviews and unstructured interviews, also known as in-depth interviews (Brink et al., 2018:143; Botma et al., 2016:206). In this study, the researcher opted to use in-depth interviews to collect data from the participants to elicit rich data about the lived experiences of the grandparents, grandchildren and PHC nurses regarding SRH communication (De Vos et al., 2016:348; Streubert & Carpenter, 2011:34).

- **In-depth /unstructured interviews**

In-depth interviews are unstructured, direct and personal interviews the researcher used with each participant, which allowed participants to talk freely and take the initiative in the discussion (Queiros et al., 2017:378; Paradis et al., 2016:263; Streubert & Carpenter, 2011:24). The researcher chose in-depth or unstructured interviews because they are preferred interview method for phenomenology and allowed the flow of questions (Gray et al, 2017:259; Polit & Beck, 2017:471; Schneider et al., 2017:375). The purpose of in-depth interviews was not to get answers but rather to understand the experiences of other people and the meaning that is being attached to those experiences (De Vos et al., 2017:348; Botma et al., 2016:207). The researcher anticipated that the questions would incorporate current and past experiences, which would include the implications in the lives of the participants when they share their lived experiences regarding SRH communication.

In this study, in-depth interviews assisted the researcher in getting rich information through probes, justification of previous answers, establishing a connection between several topics related to SRH and the use of other communication techniques (Queiros et al., 2017:378). Interviews were conducted in the PHC facilities where the nurses are based and the residential places of the grandparent families. Face-to-face interviews were beneficial as follow-up questions could be asked and non-verbal communication captured. This enabled the researcher to explore and describe the experiences of participants regarding SRH communication in detail. This was done to ensure a rich, detailed description of information was provided.

- **Digital voice recorder**

The digital recorder was used to capture and store data to enhance trustworthiness and for later use during data analysis. The researcher ensured that the voice recorder was in good working order, and the participants were also aware of its usage (De Vos et al, 2016:359; Botma et al., 2016:214). It was significant for the researcher to ensure that extra batteries were made available in case there was an electricity problem as the CoT was experiencing load shedding. The use of the digital voice recorder assisted in eliminating biases as the researcher could refer to the recorder where necessary (Gray et al, 2017:260). The research assistant was also shown how to operate the audio tape during the interviews, this allowed the researcher to concentrate on the interviews (Polit & Beck, 2017:508; Botma et al., 2016:214).

The researcher conducted the interview to ensure consistency and in-depth information was collected from all the participants. In this study, one-on-one interviews were conducted with PHC nurses, grandparents and grandchildren this allowed participants to provide a wealth of information than the telephonic interviews. Therefore, the researcher's intention was to collect in-depth information from the participants through individual face-to-face interviews to obtain the reality from the lived experiences of the PHC nurses, grandparents and grandchildren. Participants shared their own personal views and opinions regarding SRH communication.

- **Communication techniques**

The researcher posed a grand tour question that was flexible, allowing the researcher to use probes to ensure that additional questions and information were derived from the discussion (Queiros et al., 2017:378; Polit & Beck, 2017:509). The researcher ensured that the participants were relaxed and allowed them to use their preferred language for easy

communication, and an initial broad question was asked: "*Tell me about your experiences regarding sexual reproductive health communication".* This broad question was followed by:

- **What are your experiences regarding SRH**…?

In this study, the use of open-ended questions allowed the participants to share their lived experiences regarding SRH communication. An interview guide was used as a basis for the researchers probing strategy. The researcher ensured that questions that were asked moved from general to specific and were asked in such a way as to assist in eliciting in-depth information using probes.

- **Debriefing session**

The researcher listened and observed for any emotional change that the participants could display as they shared their lived experiences. Each participant was asked if they needed any counselling or emotional support however, they verbalised that there was no need however, the researcher provided them with contact numbers should there be a need for emotional support (Alshawish et al., 2020:75). Follow up calls were made to assess if they are still ok. None of the participants contacted the researcher for referral for emotional support. All participants were thanked for participating in the study.

3.5.4 Data Analysis

Data analysis is the systematic organisation, synthesis and eliciting of meaning from the collected data (Gray et al., 2017:675; Polit & Beck, 2017:725; Botma et al., 2016:220). It is a dynamic and interactive process to critically scrutinise the collected data. In this study, data analysis was done concurrently with data collection, and it was a labour-intensive activity that required creativity and hard work (Johnson, Adkins & Chauvin, 2020:143). Qualitative data takes the form of narrative material as the verbatim dialogue between the researcher and the participants, field notes including observations that were done during data collection (Brink et al., 2018:180; Polit & Beck, 2017:530). After data collection, the researcher transcribed all the recordings in preparation for data analysis (Johnson et al., 2020:142; Oshodi et al., 2020:4; Govender, 2018:84; Polit & Beck, 2017:531). The transcripts ranged from four (4) to 30 pages resulting in more than 300 pages that needed to be read, reread, analysed and interpreted (Polit & Beck, 2017:530; Streubert & Carpenter, 2011:45) **(Annexures P, Q & R)**.

In this study, the researcher attempted to understand the meaning of the experiences of the PHC nurses, grandparents and grandchildren regarding SRH communication based solely on what was presented in the data. The researcher transcribed verbatim and analysed data

before discussing it with the supervisor (Alshawish et al., 2020:75). The transcripts that were in Sepedi and Setswana were further sent for translation into English, and the researcher ensured that she also went through all the transcripts to check for accuracy.

3.5.4.1 Giorgio's five steps of data analysis

Step 1: The process started with the researcher listening to the recordings and reading the written data from the transcripts repeatedly to have a global sense of the data. Reading all the transcripts allowed the researcher to become immersed in the data (Greening, 2019:90; Bradfield et al., 2019:5; Brink et al., 2018:180; Gray et al., 2017:270; Polit & Beck, 2017: 471). In phenomenology, the researcher is expected to bracket all the preconceived ideas and ensure that the participants' lived experiences are viewed through their lens (Oshodi et al., 2019:3; Isabirye & Makoe, 2018:3). Bracketing allowed the researcher to remain neutral with belief and disbelief of the existence of the phenomenon under study.

Step 2: According to Giorgio, the whole description should be broken into constituents, therefore, identifying meaning units. The researcher ensured that meaning units were not interrogated.

Step 3: During this stage, the researcher interrogated the meaning units to gain a fuller understanding of what the participants shared during data collection. Isabirye and Makoe (2018:4) posits that at this stage, it is important to build a coherent structure of meaning of the meaning units. The meaning units were grouped into clusters.

Step 4: This step involves understanding, judgements of relevance and organisation of the constituents of the lived experience that has been described. Themes (essences) and categories (constituents) emerged from the analysed data shared by individual participants Refer tables 4.4,4.5 and 4.5 for details of themes and categories (Oshodi et al., 2019:4; Isabirye & Makoe, 2018:4).

Step 5: Involves synthesis and integration of all the descriptions to establish commonalities and differences in the meaning constituents (Oshodi et al, 2019:4; Isabirye & Makoe, 2018:5).

The transcribed data was later shared with the independent coder, who is experienced in qualitative data analysis, before discussing them in terms of the available literature (Johnson, Adkins & Chauvin, 2020:143). **(Annexures S)** refer 3.6.1.2.

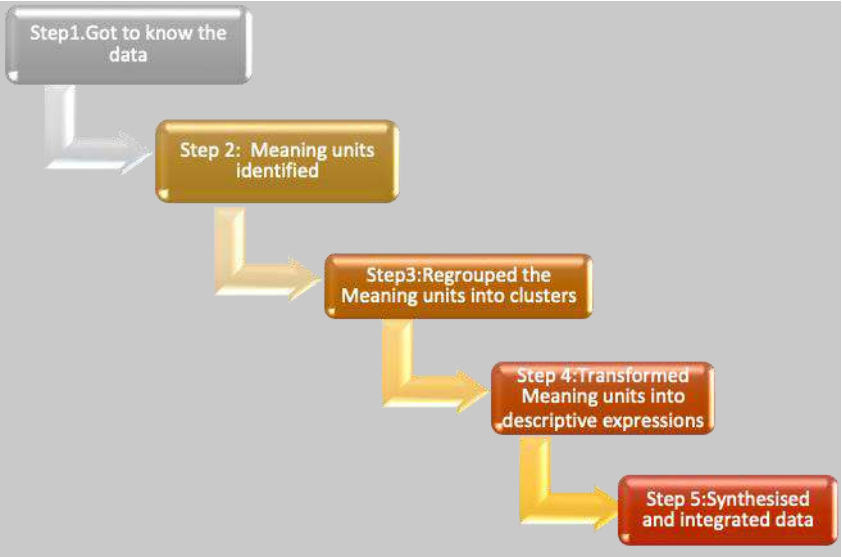

Figure 3.2: ***Summary of Giorgio's data analysis processes (Isabirye & Makoe, 2018:3)***

3.6 RIGOR OF THE STUDY

Rigour implies ensuring congruency between the philosophical foundation, methods, and approaches to produce trustworthy findings (Gray et al., 2017:691). Brink et al. (2018:110) assert that rigor indicates openness, relevance, epistemological and methodological congruence, thoroughness in data and the analysis processes, including the researcher's self-understanding. The following criteria for establishing trustworthiness will be used: reflexivity, bracketing, credibility, dependability, confirmability, transferability and authenticity.

3.6.1 Rigour in Qualitative Research (Trustworthiness)

Trustworthiness is defined as the degree of confidence qualitative researchers have in their data and analysis, assessed using the criteria of credibility, transferability, dependability, confirmability, and authenticity (Oshodi et al., 2019:4; Brink et al., 2018:157; Polit & Beck, 2017:747; Botma et al., 2016:230).

3.6.1.1 Credibility

Credibility refers to confidence in the truth of the data and interpretations (Ramsook, 2018:20; Polit & Beck, 2017:559; Botma et al., 2016:231). The researcher ensured that there was true value in the findings of the study relating to the discovery of the truthful meaning and interpretations of SRH communication and its implications for family health. It emphasises carrying out the investigation in such a way that people can easily believe in the findings. In this study, credibility was ensured through the following techniques: prolonged

engagement, persistent observation, triangulation and peer briefing, including member checks.

- **Prolonged engagement**

Prolonged engagement means the time that the researcher invested during data collection to have an in-depth understanding of the participants when they share their lived experiences regarding SRH communication in the natural setting (Polit & Beck, 2017:740; Adom et al., 2016:6; Botma et al., 2016:231). The researcher engaged the participants telephonically to set up appointments for the initial meeting to discuss the study and request their involvement in the study. The researcher had to build rapport with each participant to gain the participants' trust. For population 1: The researcher met with each facility manager to get permission, gain access, identify participants and secure appointments with individual PHC nurses. For populations 2 and 3: Each family was visited, and each participant indicated his/her availability the researcher had to respect the participant's decision and an agreement was reached with each participant.

The researcher visited the participants at their natural settings i.e., PHC facilities where the PHC nurses work and the residential places of grandparent families. For the PHC nurses, the interviews were conducted in their workplace and grandparent families' interviews were conducted at the residential places in the CoT. Each facility was allocated a day according to the appointment schedules permitted by facility managers in PHC facilities. Time sampling was purposefully adhered to avoid confusion and the researcher confirmed appointments to ensure participants were ready. However, some participants cancelled their appointments due to personal commitments. The prolonged engagement was also enhanced by visiting the participants for information sharing and the actual data collection sessions. Additional two (2) months were spent on data collection and transcribing the individual interviews from recorded verbatim to transcribed data. Due to the massive data collected, the researcher ensured each data was interrogated this resulted in more time allocated to go through the data repeatedly trying to generate themes and categories.

- **Triangulation**

Triangulation is defined as the use of multiple sources of data to increase trust in the authenticity of the conclusions (Ramsook, 2018:20; Polit & Beck, 2017:161). The researcher used triangulation to ensure that the credibility of this study was established. In this study, several data collection methods were used to elicit thick and rich data from the participants. Data was collected from multiple settings, namely the PHC facilities and the residential

places of families, and it was further collected at different times, namely: for PHC nurses, it was during the day at their places of employment, whereas with families, it was collected at different times depending on the availability of individual participant.

The researcher had to be flexible to accommodate all the participants (Polit & Beck, 2017:564). Purposive sampling and snowballing also ensured that participants were identified based on their characteristics specified in the inclusion criteria and their willingness to participate in the study. This assisted the researcher in the identification of participants who met the inclusion criteria and were willing to participate in the study (Brink et al., 2018:159).

- **Member checking**

The researcher ensured that member checking was done on an ongoing as data was taken to the participants to verify the correctness of the findings (Brink et al., 2018:158; Polit & Beck, 2017:564). Polit and Beck (2017:564) further reiterate that member checking is a very significant technique for establishing the credibility of the study. In this study, most participants were willing to participate in this process, even though they felt that it was a difficult topic to engage with, but it was perceived as valuable in health promotion. The transcribed audio recorded data was verified with some of the participants to verify the content of collected data (Ramsook, 2018:20). The integration of thirty (30) unstructured interviews and captured field notes enhanced the credibility of the study.

- **Peer review and debriefing**

The researcher perceived peer review and debriefing as other quality enhancement strategies which involved external reviewers (Polit & Beck, 2017:568). After the transcription of data from Sepedi and Setswana to English, the transcribed transcripts were shared with the supervisors and the independent coder. Both the supervisors and the independent coder had experience in qualitative research for the verification of translated data (Brink et al., 2018:159).

- **Reflexivity**

I had to acknowledge that I am part of the study and had to do self-reflection about my biases, preferences fear about the study (Johnson et al., 2020:138; Ramsook, 2018:21). Polit and Beck (2017:164) posit that self-awareness and introspection enhance the quality of the study. The researcher ensured that self-awareness and introspection were done throughout the process, and all the fears, speculations, and biases were noted in the

reflective journal. To enhance the quality of the study, all the interviews were audio recorded to ensure objectivity and neutrality and avoid biases.

- **Researcher's credibility and authority**

The researcher was the main data collection instrument and further transcribed verbatim the data onto transcripts which were used during data analysis (Brink et al, 2018:104; Korstjens & Moser, 2017:278; Botma et al., 2016:182). At the time of the study, the researcher was a lecturer teaching Community Nursing Science and Primary Health care, where SRH was presented to both basic and post basic students in one of the Nursing Education Institutions (NEIs) in Gauteng (GP).

The researcher holds a master's degree in Community Nursing Science and was previously involved in qualitative research. The researcher attended several workshops organised by the University of Pretoria's Nursing Department for knowledge enrichment. The researcher also attended some of the virtual research platforms and gathered knowledge which assisted in strengthening her research knowledge. The supervisors also offered support throughout the process and ensured that frustrations and anxieties were allayed. The researcher was able to bracket all the preconceived ideas about SRH communication, and reflexivity was applied in the study, whereby reflective notes were recorded in the reflective journal.

3.6.1.2 Dependability

Dependability refers to evidence that is consistent and stable (Brink et al., 2018:159; Ramsook, 2018:21; Polit & Beck, 2017:559). In this study, dependability was achieved through conducting a pilot interview to determine whether the research questions and interviews were clear before the main data collection phase was done. The audio-recorder was used to ensure that data collection was recorded accurately to yield consistent results, the same questions were asked to all the participants and field notes were taken to ensure that the non-verbal cues were recorded correctly regarding the participant's experiences regarding SRH communication. Another process that was followed to ensure the dependability of this study was the involvement of an independent coder, triangulation and audit trail, as portrayed below:

- **Independent coder**

In this study, an independent coder assisted with data analysis and verification. Both the researcher and the independent coder reached a consensus regarding the findings of the study. The same was shared with the supervisors for further comments and approval.

Themes (essences) and categories (constituents) emerged from the analysed data, and the findings are presented in Chapter 4. Discussions and literature synthesis are detailed in Chapter 5.

- **Triangulation**

Polit and Beck (2017:572) express that triangulation is the process whereby multiple referents are used to conclusions about the truth. The researcher used multiple data collection methods to gather data, namely: in-depth interviews, observation, and field notes. Person triangulation whereby multiple participants were used to validate the data. In this study, data was collected from the PHC nurses, grandparents and grandchildren who were interviewed individually. Snowballing and purposive sampling were used to sample participants willing to participate in the study to share their lived experiences.

- **Audit trail**

An audit trail is the documentation of the research path from the start to the end (Ramsook, 2018:22). The researcher conducted individual in-depth interviews to elicit rich and thick data from the participants. The raw data was analysed, themes and categories emerged, and quotes were used to support the themes and categories. The presentation of the findings is discussed in detail in Chapters 4 and 5. Peer reviews were conducted by the supervisors and colleagues for methodological correctness. The supervisors' experience and expertise were critical in reviewing the data collection; analysis processes and valuable comments were provided.

3.6.1.3 Confirmability

Confirmability refers to objectivity, the potential for congruence between two independent people about the accuracy and relevance of data (Ramsook, 2018:21; Polit & Beck, 2017:559). In this study, confirmability was achieved by ensuring that data represent the information that the participants provided and the interpretation of it displays a true reflection of what was said by the participants regarding SRH communication, not the researcher's imagination (Johnson et al, 2020:142; Polit & Beck, 2017: 560). Confirmability was ensured through triangulation, audit inquiry and reflexivity, which are discussed below:

- **Triangulation**

Triangulation is defined as the use of multiple sources to draw conclusions about what constitutes the truth (Brink et al., 2018:157; Polit & Beck, 2017:179). The use of multiple populations, namely PHC nurses, grandparents and grandchildren, enhanced confirmability

because data was elicited from diverse populations with different views (Ramsook, 2018:20). The use of the audio recorder and transcribed verbatim confirmed that data collected originated from the participants. The field notes were also taken and integrated into the analysis of the data to support the themes and categories that emerged during data analysis.

- **Audit inquiry**

In this study, the supervisors, who are experienced qualitative researchers, provided guidance throughout the research process. Audit inquiry enhances the adequacy of the data and the interpretation of the study (Ramsook, 2018:22). In addition, Polit and Beck (2017:568) posit that audit inquiry entails scrutiny of the collected data and supporting documents by the external reviewer to ensure that the findings are worthy of confidence in the study.

- **Reflexivity**

Reflexivity is defined as the researchers' ability to reflect their own biases, values and assumptions in writing into the research to maintain the integrity of the study (Ramsook, 2018:22; Sunder et al., 2019:737). Polit and Beck (2017:164) states that reflexivity consists of two aspects: an acknowledgement that the researcher is part of the setting, context or social phenomenon under study and self-reflection about own biases, preferences and fears about the research biases. The researcher ensured that a personal reflective journal was kept where the researcher's observations, thoughts, and feelings were written down. In this study, both the researcher and participants reflected on the phenomenon under study. The researcher ensured that reflexivity was maintained throughout the process and that the reader understood the context of the findings.

3.6.1.4 Transferability

Transferability refers to the extent to which qualitative findings can be transferred to other settings or groups, with the role of the researcher being to provide detailed descriptive information that allows readers to make inferences and extrapolate the findings to other settings (Ramsook, 2018:21; Sunder et al., 2019:737; Polit & Beck, 2017:745). Transferability is enhanced through thick descriptions, purposive sampling and data saturation.

- **Thick descriptions**

Thick descriptions entail the collection and provision of a sufficiently detailed description of data within a given context and the provision of the report (Brink et al., 2018:158). Multiple

sources were used to collect data which assisted in eliciting rich and thick data, which further enabled other researchers to evaluate the applicability of the data to another context.

- **Purposive sampling**

In this study, transferability was ensured through the sampling of participants based on inclusion criteria provision of rich and thick data regarding SRH communication between grandparents, grandchildren and PHC nurses until data saturation was reached (Ramsook, 2018:16).

- **Data saturation**

In this study, data saturation was reached when no new information emerged from all the participants (Brink et al., 2018:160; Moser & Korstjens, 2018:11; Polit & Beck, 2017: 503). Data saturation determines the adequacy of the sample and data that is rich and thick.

3.6.1.5 Authenticity

Authenticity is a mechanism by which the researcher ensures that the findings of the study are real, true, or authentic (Pardell-Dominguez, 2021:4). Polit and Beck (2017:720) further views authenticity as the extent to which qualitative researchers fairly and faithfully show a range of different realities in collection, analysis and interpretation of data. In this study, the researcher explored and described the experiences of the grandparents, grandchildren and PHC nurses regarding SRH communication. The tone and feel of the participants emerged after being audio-recorded and transcribed verbatim for further utilisation during data analysis. All the interviews were conducted in the participant's naturalistic environment in the Tshwane district.

3.6.1.6 Reflexivity

Reflexivity is self-reflection relating to phenomena under study and acknowledgement of the researcher's setting (Ramsook, 2018:22; Polit & Beck, 2017:164). Self-reflexivity was vital to ensure that the study was not compromised. In this study, the researcher critically reflected on the self and took note of own opinions and values that could influence data collection and analysis. Every participant's view was taken as an individual experience and attached meaning to what was experienced regarding SRH communication. The researcher respected the participant's cultural and religious beliefs, whereby some participants verbalised their discomfort about the topic under study, and their unwillingness to participate was respected (Johnson, Adkins & Chauvin, 2020:142). The researcher respected the participants' decision

to withdraw from the study at any given stage of the study, as it was indicated in the information leaflet.

3.6.1.7 Bracketing

Bracketing is a state of avoiding the researcher's preconceived ideas that may have an influence on what is being studied (Brink et al., 2018:105). Fung and Chien (2013:1) affirm that through bracketing, the researcher was not able to influence the understanding of the participants regarding the phenomenon under study. In this study, the researcher was able to put aside all that was known about the topic and allowed the participants to share their lived experiences regarding SRH communication. The researcher listened and recorded the participants when they shared lived experiences regarding SRH communication in an open manner without any influence or biases.

The researcher ensured that the research processes were explained in detail and that the findings of the study are detailed in Chapter 4.

3.7 PHASE 2 THE DEVELOPMENT OF COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SRH IN TSHWANE DISTRICT, GAUTENG PROVINCE

Phase 2 of the study focused on the development and validation of proposed guidelines titled: **Development of communication guidelines to support grandparent headed families regarding SRH in Tshwane District, Gauteng Province**. The methodology and processes used to develop the guidelines are shared below in 3.8. The development of the guidelines emanates from the empirical data collected in Phase 1 of the study.

3.8 THE PROCESS OF GUIDELINE DEVELOPMENT AND VALIDATION

Guidelines are defined as systematically developed statements that are proposed to affect decisions that are made by HCPs, policymakers and healthcare consumers to address healthcare matters (Tetreault et al., 2019:544). These guidelines assisted the HCPs in making informed decisions regarding health matters, including SRH. The researcher provided a detailed process that was followed for the development and validation of the proposed guidelines for PHC nurses to support grandparent headed families regarding SRH communication in the Tshwane District. The findings in Phase 1 formed the basis for the development of the guidelines, and extensive literature synthesis was used to support the collected data. An extensive literature review was conducted in Chapter 2 of this study to enable the researcher to integrate what was done by the previous authors and come up with

new information or a body of knowledge. As affirmed by Winchester and Salji (2016:1), the literature review was done to develop research ideas, consolidate all that is known about the topic, and identify gaps.

The main objective of Phase 2 of this study was to develop communication guidelines for Primary Healthcare nurses to support grandparent families regarding sexual reproductive health. PHC nurses can use these guidelines to promote SRH communication within families to address SRH related issues.

3.8.1 Attributes for Appraisal of the Guidelines

There are numerous attributes that could be used in the appraisal of the quality of the proposed draft guidelines, namely: validity, reliability, clarity, applicability, completeness, effectiveness, flexibility, relevance, acceptability, rigour, and editorial independence (Agree 2010:2003-2013;Institute of Medicine 1990) However, in this study, the criterion that was used to evaluate or appraise the proposed guidelines are validity, reliability, clarity, and applicability.

Table 3.4: ***Attributes used for validation of the developed guidelines.***

No	ATTRIBUTES	DESCRIPTIONS
3.8.1.1.	Validity	**Validity** is defined as the degree to which an instrument measures what it is intended measure (Polit & Beck, 2017:747). In this study validity of the guidelines was ensured by using Delphi technique to enable the panel of experts to provide experts opinion or inputs in SRH promotion. In addition, Habibi et al (2014:10) state that the validity of the results depends on the knowledge and competence of the panel members.
3.8.1.2.	Reliability	**Reliability** is the capacity of the guidelines to yield similar outcomes when applied in similar circumstances (Naisola-Ruiter, 2022:95; Polit & Beck, 2017:742).
3.8.1.3.	Clarity	**Clarity** means the quality of the guidelines must be clear, easily understandable, logical and unambiguous. In this study, the guidelines are written in simple language and are understandable. The panel members affirmed the drafted guidelines.
3.8.1.4.	Applicability	**Applicability** entails that the guidelines should reflect the target population and be easy to apply.

3.8.1.5.	Completeness	**Completeness** implies the ability of the guidelines to show extensive understanding of PHCN's support regarding SRH communication to grandparents and grandchildren.
3.8.1.6.	Effectiveness	**Effectiveness** is perceived as the ability of the guidelines to have an expected effect in SRH service delivery. In this study the guidelines might enable the PHC nurses to provide support regarding SRH communication to grandparents and grandchildren.
3.8.1.7.	Flexibility	The guidelines should be adaptable and **flexible** to suit the needs of the grandparent headed families" regarding SRH communication.
3.8.1.8.	Relevance	The **relevance** of the proposed guidelines should be related to promotion of SRH communication within families. The relevance of the guidelines was confirmed by the panel of experts.
3.8.1.9.	Acceptability	The guidelines should be **suitable** to satisfy the support needs of the grandparent headed families regarding SRH communication. They should also be in line with the vision and mission of the DoH. The acceptability of the guidelines was further confirmed by the Delphi experts through the validation process.
3.8.1.10.	Rigor	**Rigor** is the process used to gather and synthesis evidence including guideline validation (Brouwers et al, 2010:10). The following criteria was used to ensure rigor of the guidelines: systematic methods that was used to gather information, the findings were presented in Chapter 4; discussions which were controlled with literature in Chapter 5. The strengths and limitation of the study presented in Chapter 7. The guidelines were validated by the expert participants through Delphi technique to ensure acceptable quality of the guidelines.
3.8.1.11.	Documentation	All the processes that unfolded in the research study were recorded. In this study all the **records** were treated as confidential and kept for future reference.
3.8.1.12.	Review and updating of the Guidelines	Guidelines are reviewed and updated in 3-5 years depending on the event of the time.

3.8.2 Phase 2 Research Design

In phase 2 of this study, the Delphi technique was used as a data collection method whereby a panel of experts were identified to participate in the validation process of the proposed draft guidelines (Msibi et al., 2018:2; Habibi et al., 2014:91). Several authors defined Delphi technique as an anonymous iterative process that involves expert judgement of SRH issues with the aim of reaching consensus (Tengan & Aigbavboa, 2017:1968; Latif et al., 2016:3; Habibi et al, 2014:8). Furthermore, Niederberger and Spanger (2020:2) perceive Delphi technique as a structured group of communication processes in which complex issues are deliberated by a group of experts, where knowledge is uncertain or incomplete and is evaluated by a panel of experts using an iterative process. In this study, the Delphi technique was used to ensure high quality guidelines through the experts' knowledge, expertise, competence and experience in a series of three rounds.

Naisola-Ruiter (2022:91) describes the Delphi technique as a qualitative, quantitative and mixed method approach because the collection of expert opinions is regarded as qualitative, and the plotting of results which are numeric are regarded as quantitative. Phase 2 of the study was also directed by the Theoretical framework of Delphi, which is illustrated in Figure 3.7 and discussed in detail in 3.8.3 below.

3.8.3 The theoretical framework of Delphi

According to Habibi et al. (2014:9), the major weakness of the Delphi technique is the lack of a theoretical framework. However, the below framework depicts the application of the Delphi techniques in this study. Several processes are requirements for the application of the Delphi technique; composition and sample size; the gathering of expert opinion; Determining the level of consensus; Statistical group response, including Controlled feedback, which is shared and illustrated below in Figure 3.6.

- **Requirements for application of the Delphi technique**
    - The main objective of the Delphi technique was to get expert judgement/opinion, which enhances group consensus in order to achieve the results.
    - Anonymity during data collection is another feature that allows freedom of expression without intimidation from the group. In this study, documents were emailed to individual expert participants for each participant to express his/her views without any influence.

- **Composition and sample size**

  There is no strict rule regarding the sample size, and sample size varies according to the nature of the topic to be covered. Purposive and snowballing sampling methods were used to identify twenty-two (22) suitable participants to assist with the evaluation, modification and validation of the proposed communication guidelines that will be used to support PHCNs regarding SRH. These expert participants were selected based on their vast knowledge, experience and their valuable insight into SRH promotion. Only 14 of the identified participants indicated their willingness to participate in the study, and this was confirmed by the signed consent form, which was returned to the researcher. The profile of the participants is shared in Chapter 6 of this study (Table 6.4).

- **Gathering of expert opinion**
  - Experts met the inclusion criteria and were knowledgeable and had experience in health or SRH related issues, as indicated in (Table 6.4).
  - Better to use individuals with diverse experiences than a homogenous group. In this study, all participants are Registered nurses working in diverse health facilities who have an interest in SRH promotion and provision.
  - A Likert scale was used to gather expert opinion, which has numbers 1=strongly disagree, 2=disagree, 3 =agree, 4=strongly agree. The Likert scale had a space at the end of each guideline where comments/views were written.
  - The criterion used is validity, reliability, clarity, and applicability, as indicated in Table 3.5 below.

- **Determining the level of consensus**
  - All the participants rated the guidelines against the set criterion and provided comments/suggestions to assist the researcher in refining the guidelines. This process followed a series of three (3) rounds, and feedback was provided after every round. Some authors argue that consensus can be reached between 2 or 3 rounds depending on the nature of the topic.

- **Statistical group response**
  - A spreadsheet was developed to document the responses, which indicated the number of participants who disagreed with those who agreed with the proposed guidelines **(see Annexures L, M & N)**.

- **Controlled feedback**
    - The researcher played a vital role in ensuring that after every round, the responses were gathered, and the researcher, as the facilitator, had to read through all the comments/inputs and suggestions, and this assisted in refining the proposed guidelines before being sent back to all the participants. This allowed each participant to review her initial inputs or retain the inputs.

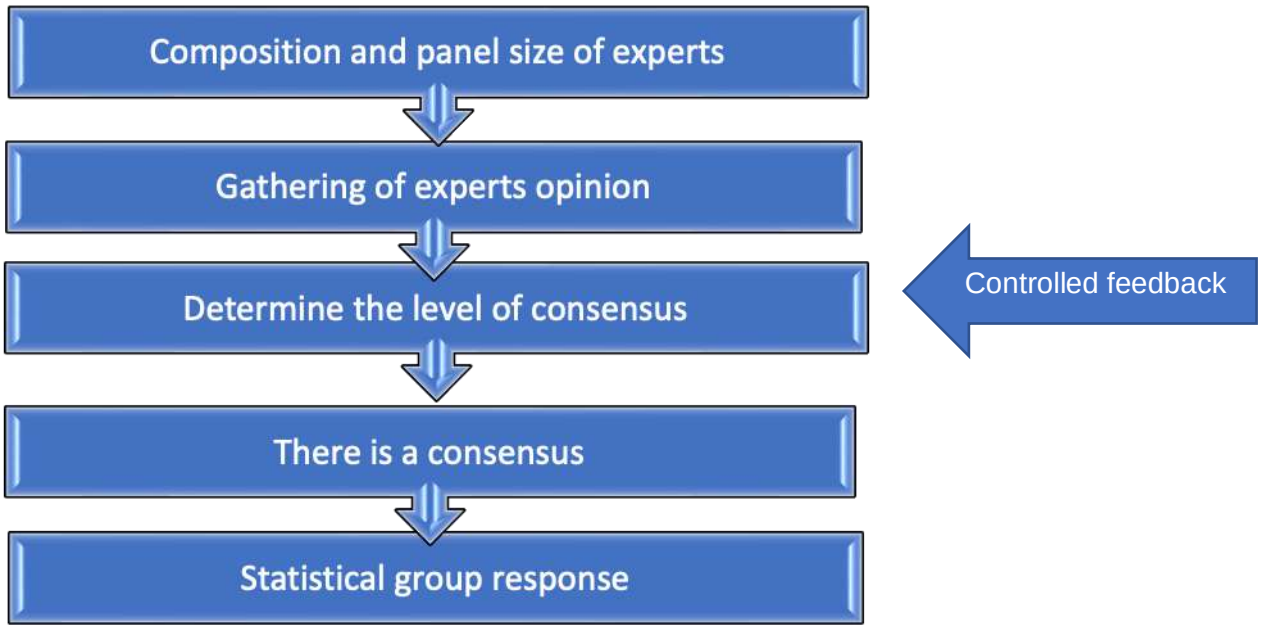

Figure 3.3: ***Theoretical framework of the Delphi Technique (Habibi et al., 2014:9)***

3.8.3.1 Features of the Delphi Technique

Schmalz et al. (2021:2) and Silva and Montilha (2021:3) identify four main features of Delphi, namely: anonymity, iteration, controlled feedback and statistical group response, which are shared below:

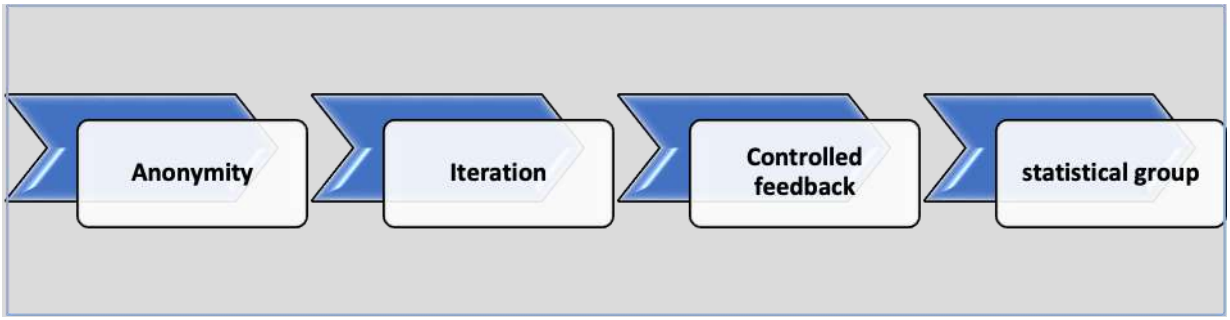

Figure 3.4: ***Main features of the Delphi technique***

Anonymity: has been identified as the primary characteristic because it allows each participant to express their views or thoughts without being pressured by other group members (Naserrudin et al., 2022:2; Massaroli et al., 2017:5; Avella, 2016:309). Anonymity prevents embarrassment, inhibitions and intimidation that can arise from face-to-face discussions or information sharing. In addition, Nystrim and Kaartem (2022:129) posit that anonymity reduces the risks of the dominance of other participants/individuals and further provides room for the exposition of thoughts not prohibited by social expectations. In this study, the researcher ensured that documents were emailed to each individual participant and that all the personal details were treated as confidential.

Iterations: Iterations are repeated processes that expert participants follow to generate opinions that are gathered for the refinement of the proposed guidelines. Three (3) rounds were used for engagement with experts participants. In this study, the draft document of the proposed guidelines was sent to individual expert participants for expert opinion, comments, or ratings, which were used to refine the guidelines until a satisfactory consensus was reached between the participants and the researcher (See Chapter 6). This process enabled the expert participants to be able to stipulate more perceptive opinions ensuring that their views are analysed, and they reflect on them in order to maintain or alter them (Naserrudin et al., 2022:2; Massaroli et al., 2017:6; Tengan & Aigbavboa, 2017:1970; Avella, 2016:309). Furthermore, Lecours (2020:4) states that the iteration process assists participants in reviewing and reconsidering their thoughts in order to reach a consensus.

Controlled feedback: Allowed the panel members to apply their thoughts before responding, the researcher, as the facilitator, provided feedback regarding opinions or comments raised by panel members until a consensus was reached (Naserrudin et al, 2022:2; Silva & Montilha, 2021:3; Massaroli et al., 2017:3; Avella, 2016:309).

Statistical analysis: Ensures that opinions or responses generated by each participant are members (Massaroli et al., 2017:3; Naserrudin et al., 2022:2). Statistical procedures were used to analyse the data which emanated from Delphi rounds. A spreadsheet was developed for recording the responses according to individual participants' opinions, either strongly disagree or disagree, marked 1 or 2 and for agree and strongly agree it was marked 3 or 4. The consolidated marked sheet was also developed to reflect the number of participants who disagreed versus those who agreed until a consensus was reached (**Annexures L, M & N).**

3.8.4 Population

The population consisted of all nurses with experience in health care, SRH, research and guideline development and work in diverse health environments as district managers, facility managers, academics, and nurse educators (Figure 3.6). In this study, expert participants possessed diverse nursing qualifications, which are registerable with the South African Nursing Council (SANC). All expert participants are Registered nurses with diverse knowledge about SRH being academia, training and development, PHC nurses and managers at PHC facilities, including at the district level (Figure 3.4). These panel members were identified as appropriate participants for the study because they meet the inclusion criteria and poses the qualification, experience and knowledge regarding SRH to provide excellent expert opinion in the validation process of the guidelines (Naserrudin et al., 2022:6). The below table depicts all the criterion that the researcher requested.

Table 3.5 Profile of Participants

NO	NAME AND SURNAME	OCCUPATION	EMPLOYER	PROFESSIONAL AND ACADEMIC QUALIFICATIONS	EXPERIENCE IN THE FIELD OF HEALTH CARE/ SRH/ RESEARCH/ GUIDELINE DEVELOPMENT
1.					

3.8.5 Sampling

The purposive and snowballing sampling method was used to identify the participants to participate in Delphi rounds (Msibi et al., 2018:3). All the participants who met the inclusion criteria were issued with information leaflets, invitation letters, requests for their biographical data and the proposed guidelines which contained information about the study. All the documents were emailed to individual participants to ensure anonymity. All participants signed a consent form to confirm their willingness to participate in the study, which was emailed back to the researcher. Snowball sampling was used to increase the pool of expert participants (Gray et al., 2017:346; De Vos et al., 2016:233). The inclusion and exclusion criteria are shared below.

The following inclusion criteria were used to determine who should participate in Delphi rounds:

- Healthcare providers (PHC nurses) with an experience of 5 years and more in a PHC setting.
- Managers who are based in the PHC settings or District settings, which are designated to enhance SRH service provision.
- Academia who are in the university or Nursing Colleges who facilitate SRH or participate in research studies, including guideline development.
- Professional development - may be based at regional training centres.
- Policymakers (nurses) who can ensure that changes and policies are implemented in the PHC facilities.
- Nurses who are in the nursing regulatory body.

The exclusion criteria entail:

- Those who did not want to participate in Delphi rounds.
- Participants who did not fit in the above-mentioned categories.

3.8.6 Data Collection and Analysis

The researcher discussed data collection and analysis: data collection instrument, pilot testing and the series of Delphi rounds.

3.8.6.1 Data collection instrument

A data collection instrument was developed for experts to evaluate and assess if the drafted guidelines are appropriate/suitable for SRH and for them to add their comments, and they were used for validation of the proposed guidelines as depicted in **Annexure O**. The instrument contained the instructions, the proposed guidelines, the rating scale and the assessment criteria for ratings. A 4 Likert scale was employed as illustrated below and indicated numbers as 1 = for strongly disagree, 2 =disagree, 3 =agree, and 4 =strongly agree. Each guideline was evaluated based on its validity, reliability, clarity, and applicability. Space was provided for any comments, recommendations, or suggestions that the expert participants perceived as valuable to developing and validating the guidelines.

3.8.6.2 Pilot testing

The pilot test is a small version of the population that is used to assess the feasibility of a study (Stockley et al., 2017:1). Pilot testing was conducted with two (2) participants who evaluated or assessed the proposed guidelines. Invitation letter, information letter, request

for biographic data and the proposed guidelines were emailed to each participant (**Annexure J & K - Profile of participants Table 3.4**). They were expected to read through the proposed guidelines and rate the quality of each guideline according to the following criteria: agree, strongly agree, disagree, and strongly agree. The participants were expected to tick the appropriate box, comment on the provided spaces and return to the researcher. The researcher went through the responses with minimal adjustments. According to the analysis, the participants understood what they expected of them, and the response rate was very good.

3.8.6.3 Round 1

The researcher drafted the preliminary guidelines which emanated from the participants' empirical findings in Phase 1. The proposed draft guidelines and other documents, namely: the invitation letter, information leaflet and request for biographical data were emailed to individual participants for each to provide their opinion without any influence from other participants. The proposed preliminary guidelines were accompanied by an instrument that was supposed to assess or evaluate the drafted guidelines **(Annexure O)**. A four (4) Likert scale was used for rating the proposed guidelines. This enabled the participants to rate the quality of each guideline. The instrument had instructions that directed the participants to go through each guideline and then to use the provided scale to indicate if they 1= strongly, disagree 2= disagree, 3= agree, 4= strongly agree and further provide comments on the provided spaces below each guideline. The criteria used are validity, reliability, clarity and applicability, as detailed in Table 3.5. A spreadsheet was developed to record each participant's ratings, and a summary of consolidated ratings was also compiled to display the number of participants who disagreed versus those who agreed **(Annexure L)**. The researcher reviewed all the provided responses, analysed and recorded them on a spreadsheet and refined the proposed guidelines in preparation for round 2 **(see Annexure M)**.

3.8.6.4 Round 2

The time to return documents to the researcher was adjusted from three (3) to five (5) working days affording participants to go through the questionnaire and provide their expert opinion. The researcher sent the proposed modified guidelines to the participants for further evaluation and modification. Reminders were sent after five days (5) to encourage the participants to respond. The researcher reminded them that their responses were valuable for this study to encourage the participants to provide feedback and discourage attrition. The questionnaire was emailed back to the researcher for further refinement, if any. The

participants returned the questionnaire to the researcher, who recorded the ratings on the spreadsheet. Upon analysis, it was noted that all the participants agreed with the proposed guidelines, meaning consensus was reached in round 2.

3.8.5.5 Round 3

Round three (3) was used as a final and validation round for validation because participants anonymously agreed on the modified guidelines. The same expert participants who formed part of evaluating the guidelines were used to validate the final draft of the guidelines. The rationale for involving the same participants it's that they were part of the modification **(see Annexure M)**.

3.9 SUMMARY OF THE CHAPTER

Chapter 3 presented and discussed the research design and methods used to conduct this study. **Phase 1**: A qualitative, descriptive phenomenological and contextual design was explained in detail. Data collection and analysis processes were also presented with motivations. Population and sampling methods were also described in detail. The rigor of the study was also provided. **Phase 2**: Development of communication guidelines to support grandparent headed families regarding SRH communication which includes the following discussions: guideline development processes for validation of guidelines, research design population, sampling, Delphi rounds and data analysis.

Chapter 4 presents the empirical findings which emanated from the exploration and description of sexual reproductive communication within the grandparent headed families in the Tshwane District.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS: PHASE 1

4.1 INTRODUCTION

This chapter presents the introduction, the overview purpose of the study, the objectives of the study, a summary of the methodology, a summary and characteristics of the population, the presentation, interpretations, and discussion. Chapter 4 also discusses the findings of Phase 1 that stem from the analysed phenomenological data, as well as the field notes that were recorded by the researcher. Interviews were conducted according to the preferred language of the participants in English, some in Setswana and Sepedi. The researcher ensured that the Setswana and Sepedi transcripts were translated into English. All the interviews were audio recorded and later transcribed verbatim. For population one, the interviews were conducted in their place of work and for population two (2), the interviews were conducted in their residential areas in the CoT. The verbatim quotes from the PHC nurses, grandparents and grandchildren were included to ensure the trustworthiness of the study.

4.2 THE PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to develop SRH guidelines to support grandparent-headed families in the Tshwane district.

4.2.1 Objectives of the study

- To explore and describe the experiences of grandparents regarding sexual and reproductive health communication with grandchildren.
- To explore and describe the experiences of grandchildren regarding sexual and reproductive health communication with grandparents.
- To explore and describe the experiences of Primary Healthcare nurses regarding the promotion of SRH communication with grandparents and grandchildren.

4.2.2 Participants involved in the study.

The participants were sampled according to the inclusion criteria as outlined in Chapter 3. All the participants met the inclusion criteria and were also willing to participate in the study. The participants included three different groups, namely, grandparents, grandchildren and PHC nurses who were identified as suitable for this study because of their lived experiences regarding SRH communication. The sample size of each group of participants is illustrated in

figure 4.1, see Tables 4.1, 4.2 and 4.3 for the full profile of all the participants. Purposive and snowballing sampling was used to select participants who had experienced the phenomenon under study. They were all from the City of Tshwane Metropolitan District.

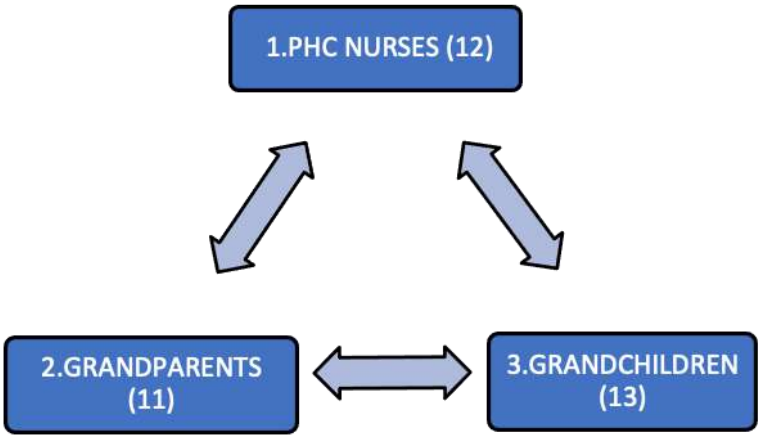

Figure 4.1. Different groups of participants

4.2.2.1 Rationale for the Choice of three groups of Participants

The rationale for choosing three different groups of participants is explained in Figure 4.2. These participants enabled the researcher to have individual communication with each participant as it was envisaged that rich thick data would be gathered. The rationale for the choice of the three different groups of participants is explained in Figure 4.2.

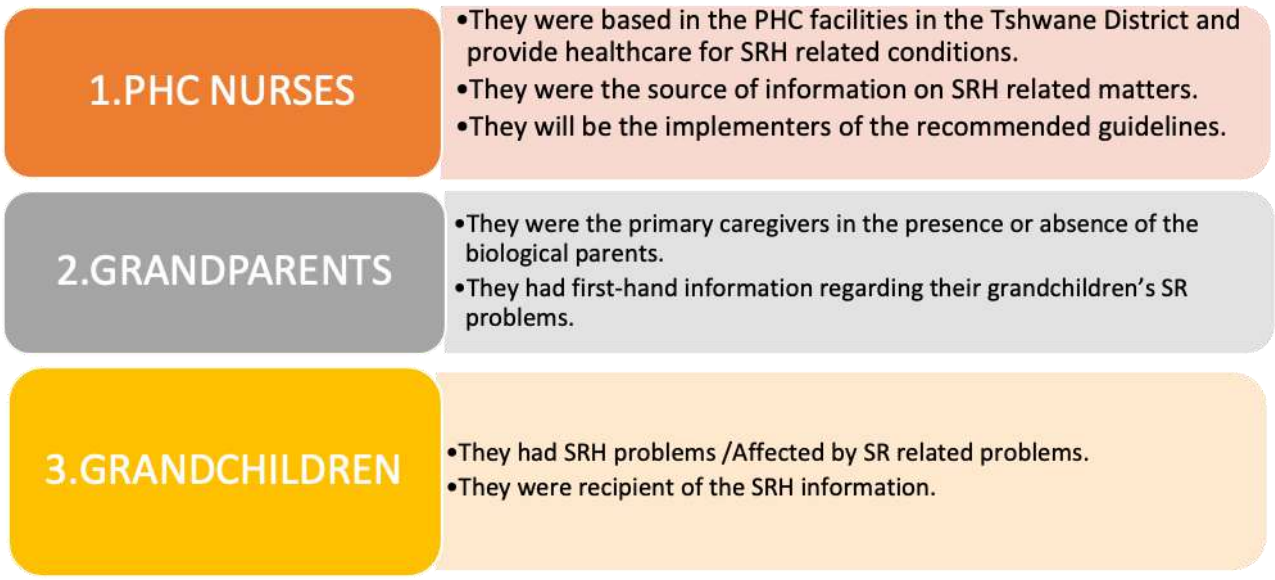

Figure 4.2. The rationale for the choice of the three different groups of participants

4.2.2.2 Demographic Characteristics

A detailed overview of the participants is presented below in Tables 4.1,4.2 and 4.3.

Table 4.1: Profile of participants (Population 1)-PHC nurses

NUMBER	PARTICIPANT	AGE	SEX	NO OF YEARS IN THE PHC FACILITY	PHC TRAINED YES /NO	AREA	INTERVIEW AREA	NO OF CHILDREN
1.	M (HCP1)	49	M	18	Yes	CoT	Work	**3**
2.	PS (HCP2)	61	F	7	Yes	CoT	Work	**2**
3.	M (HCP3)	41	F	5	Yes	CoT	Work	**2**
4.	KM (HCP4)	36	F	k3	Yes	CoT	Work	**3**
5.	SM (HCP5)	49	F	5	Yes	CoT	Work	**3**
6.	M(HCP6)	59	F	32	Yes	CoT	Work	**3**
7.	M (HCP7)	29	F	4	Not yet	CoT	Work	**1**
8.	TN (HCP8)	37	F	4	Not yet	CoT	Work	**1**
9.	TVB(HCP9)	29	F	6	Yes	CoT	Work	**0**
10.	TM (HCP10)	37	F	11	Yes	CoT	Work	**2**
11.	SH (HCP11)	37	F	7	Yes	CoT	Work	**1**
12.	T (HCP12)	26	F	4	Yes	CoT	Work	**0**

a) **Population 1** consisted of registered nurses working in the PHC facilities in the City of Tshwane (CoT) District. All the PHC nurses were stationed in PHC facilities and rendered first level care to the community of Tshwane, as depicted in Table 4.1 above. Twelve (12) participants participated in the study. Ten of the PHC nurses who participated in the study have qualified in Clinical Nursing Science, Health Assessment, Diagnosis, Treatment and Care (Government Notice R48 of), and two (2) are still awaiting to go for training however, they hold a qualification Diploma or a Degree in the Education and Training of a Nurse (General, Psychiatric, and Community) and Midwifery Leading to Registration (Government Notice Regulation No. 425 of 22 February 1985 as amended). All the participants have been in the PHC setting for more than two (2) years which is a reasonable period to acquire the necessary experience of all the services that are rendered in a PHC facility. The participants were aged between 26-61 years which assisted the researcher to gather rich data from their personal experiences as healthcare

providers and some as parents. The participants were allowed to choose to speak the language in which they felt comfortable, and all preferred to speak English. Participants preferred to be interviewed in their consultation rooms, which afforded privacy and were convenient for interaction with the participants.

b) Population 2 consists of grandparents who are residing in the City of Tshwane (CoT) District. as depicted in Table 4.2 below:

Table 4.2: Profile of participants (Population 2)-Grandparents

FAMILY NUMBER	PARTICIPANTS	AGE	GENDER	MARITAL STATUS	EDUCATIONAL LEVEL	WORKING YES /NO	PENSIONER	AREA	INTERVIEW AREA	ATTRITION
1.	GP	77	F	Widow	Form 3	No	√	CoT	Home	
2.	GP	62	F	Single	Form 2	No	√	CoT	Home	
3.	GP	91	F	Widow	Form 3	No	√	CoT	Home	
4.	GP	70	F	Divorced	Form 5	No	√	CoT	Home	
5.	GP	80	F	Married	Std 6	No	√	CoT	Home	
	GPM	90	M	Married	Std 6	No	√	CoT	Home	√
6.	GP	86	F	Widow	Std 6	No	√	CoT	Home	√
7.	GP	62	F	Single	Std 5	No	√	CoT	Home	
8.	GP	67	F	M	Std 10	No	√	CoT	Home	
9.	GP	61	F	Single	Graduate	No	√	CoT	Home	
10.	GP	59	F	Married	Std 10	Yes	×	CoT	Home	

Population 2 consisted of grandparents who were staying with their grandchildren in CoT. Families were identified from the list that was provided by the social worker and some were identified by the participants who participated in the study through snowballing. Eleven (11) participants were eligible to participate in the study, however two (2) withdrew from participation in the study. Nine (9) participants were willing to continue participation in the study. The participants were aged 59-91 years. Most of the families consisted of grandmothers with only one family that consisted of both the grandmother and grandfather.

c) Population 3 consisted of grandchildren who are residing in the City of Tshwane (CoT) District. Table 4.3 depicts the profile of population 3.

Table 4.3: Profile of participants (Population 3)-Grandchildren

FAMILY NUMBER	PARTICIPANTS	AGE	GENDER	EDUCATIONAL LEVEL	WORKING YES /NO	PENSIONER	AREA	INTERVIEW AREA	ATTRITION
1.	GC	18	F	Grad 11	No	x	CoT	Home	
	GC	18	F	Grad 12	No	x	CoT	Home	
	GC	20	M	Grad 12	No	x	CoT	Home	
2.	GC	18	M	Grade 11	No	x	CoT	Home	
3.	GC	21	M	Post Matric	No	x	CoT	Home	
4.	GC	18	F	Grade 12	No	x	CoT	Home	
5.	GC	22	F	Post Matric	No	x	CoT	Home	
6	GC	20	F	Grad12	No	x	CoT	Home	
	GC	19	F	Grad 12	No	x	CoT	Home	
	GC	18	F	Grad 12	No	x	CoT	Home	
7.	GC	18	M	Grade 10	No	x	CoT	Home	√
8.	GC	18	F	Grade 12	No	x	CoT	Home	
9.	GC	21	M	Post Matric	No	x	CoT	Home	
10.	GC	18	M	Grade 12	No	x	CoT	Home	√

Population 3: consisted of grandchildren who were staying with their grandparents in the presence of their biological parents. All grandchildren are aged 18-22 and are still attending school from grade 10 to post matriculation. The grandchildren (adolescents) were fourteen (14) - eight (8) females and six (6) males and two (2) withdrew from the study due to ill health.

4.3 FINDINGS OF THE STUDY AND SUMMARY OF ESSENCES AND CONSTITUENTS OF PHC NURSES

The findings were based on the lived experiences of all the participants, as shared in their own voices during the phenomenological conversations. Giorgio's data analysis method was employed, and data were transcribed verbatim. The researcher analysed data which was

shared with the supervisor and an independent coder. The consensus was reached between the researcher and the independent coder on the essential meaning (themes) and the constituents (categories) that emerged from the phenomenological conversations. The study findings are presented according to the different groups of participants. An overview of the essence and constituents of this study are discussed below (Tables 4.4, 4.5 & 4.6).

4.4 SUMMARY OF ESSENCES AND CONSTITUENTS OF PHC NURSES

These findings are based on the lived experiences of the PHC nurses as they shared their views. The PHC nurses are the healthcare providers for the SRH related conditions. They are, therefore, expected to provide information (health education) on SRH related matters.

Four (4) essences (themes) and twelve (12) constituents (categories) emerged from the transcribed data (Table 4.4). The researcher's interpretations are written in normal font, and verbatim quotations are in Italics. The quotes of PHC nurses are included to support the essence and constituents. The participants in this group are abbreviated as PHCN followed by a number. The essences (themes) and constituents (categories) of PHC nurses are discussed below:

Table 4.4: ***Summary of Essences and Constituents of PHCNs***

No.	THEMES (ESSENCES)	CATEGORIES (CONSTITUENTS)
4.4.1	PHCNs experiences of SRH communication	• PHCNs experience of benefits of the promotion of SRH communication.
		• PHCNs experiences of family SRH communication.
4.4.2	PHCNs' experiences of factors facilitating SRH communication	• Grandchildren's SRH knowledge from other sources.
		• PHCNs' competency.
		• PHCNs' collaboration and referral to other stakeholders.
4.4.3	PHCNs' experiences with SRH communication barriers	• Family related barriers o Emotional o Cultural o Religious o Barriers between grandparents and grandchildren

		• Health care system related barriers
4.4.4	PHCNs' recommendations for SRH communication promotion	• Capacitation of PHCNs
		• Capacitation of grandparents
		• PHCNs' facilitation of open and applicable SRH communication
		• PHCNs' facilitation of SRH educational group interventions
		• Stakeholder collaboration

4.4.1 ESSENCE 1: PHC NURSES' EXPERIENCE OF SRH COMMUNICATION

One of the essences that emanated from the study was the PHC nurses' experience of SRH communication. In this study of PHC nurses, the experience of SRH communication was perceived as being beneficial to the promotion of the health and wellbeing of adolescents. This is important in ensuring health promotion, and disease prevention, leading to the improved wellbeing of the family as stipulated in SGD 3.

Subsequently, the essence of the PHC nurses' experiences is discussed under the two (2) constituents that emerged from the analysed data: These constituents include PHC nurses' experience of the benefits of the promotion of SRH communication and PHC nurses' experiences of SRH family communication.

- **PHC Nurses' experiences of the benefits of the promotion of SRH communication**

PHC nurses' experience of the benefits of promotion of SRH communication emerged as the first constituent under the theme PHC nurses' experiences of SRH communication. Participants perceived that SRH communication will reduce sexual reproductive health problems that affect teenagers, such as teenage pregnancy, STIs including HIV/AIDS and Gender based violence (GBV). One of the participants said that they are going to provide information to improve grandparents' and grandchildren's knowledge and thus engage in SRH matters without any fear. On the same note, another PHC nurse indicated that the empowerment of the families will assist in reducing sexual offence crimes that are occurring in the communities.

The abovementioned statements are supported by the following quotations from several participants**:**

"Open communication will assist to reduce teenage pregnancy, and early sexual relations including HIV/AIDS." (PHCN 1).

“We’re going to improve the knowledge on prevention of teenage pregnancy, STIs and SRH related problems that affect teenagers” (PHCN 4).

“I think it will reduce this crime that is happening firstly, and the children will know, the fear will be less because this will be reduced because of the knowledge they have acquired.” (PHCN 6).

“The benefits will be minimising the teenage pregnancy, the STIs, the HIV, all those illnesses sexually transmitted, and the future will be better if the child cannot be someone's burden especially when is still at school” (PHCN 7).

PHCN 8 concurred by indicating that parents or grandparents must be role models for their children to promote good behaviour, as expressed by the following quote:

“Communication is having a point of reference as charity begins at home. One can also relate to the topic based on her own experience. Being a good role model, it will be easy to guide your children...” (PHCN 8).

PHCN 11 indicated that open communication regarding SRH prolongs the youthful lifestyle of the children and assists in reducing teenage pregnancy, HIV/AIDS and GBV:

“Benefits of talking openly about the sexual reproductive health prolongs the youthful lifestyle of the grandchild if you talk about everything that concerns peer pressure, sex part, family planning, risks of being pregnant” (PHCN 11).

“It is a very important subject that will assist in reducing teenage pregnancy, HIV infections including gender-based violence within the community” (PHCN 11).

The participants indicated the importance of open SRH communication between grandparents and grandchildren which will assist in decision making. Empowerment of teenagers will assist them to make an informed decision on matters that affect their SR issues, thus reducing incidences of teenage pregnancies, including HIV/AIDS. Role modelling was identified as another crucial factor as teenagers copy what their parents do.

- **PHC nurses' experiences of SRH family communication**

Primary health care (PHC) nurses' experience emerged as the second constituent of PHC experiences of SRH communication. Participants verbalised grandparents as sole guardians of their grandchildren who are expected to guide their grandchildren through SRH family communication. They shared the following statements:

"Then the grandparents will be called in and discuss in front of the grandchildren that they are sole guardians of this child because if you don't guide this child at home the child will be guided at the streets, and I don't think that's what you want" (PHCN 1).

"At the clinic, I am also open with the individual when I talk about it, especially with teenagers. I also educate the grandparents to take care of their grandchildren where it is relevant, where the situation is there…" (PHCN 2).

"We usually invite the grandchildren and the grandparents together so we can give the grandparents information so they can also understand what's going…" (PHCN 3).

Participants were delighted to see grandparents and grandchildren accessing and utilising services that are rendered at the clinic. The respect for the client's belief system and social values were also taken into consideration thus providing facts and correcting misconceptions regarding SRH issues when the need arises. Participants asserted that:

"I will acknowledge their belief system but provide them with facts, which will include information about available contraceptive methods, teenage pregnancy and its effects, gender-based violence…" (PHCN 5).

"I'm very happy because seeing clients coming to the clinic seeking help or information. The grandparent will just say sister this one has started dating it means they want me to introduce the topic". (PHCN 7).

"As a nurse, I identify those who need help and sit with them and ask questions without being judgemental so that they can open up…" (PHCN 8).

One of the participants reported that sometimes grandparents are not ready to talk about SRH so they engage them in the SRH talks to prevent unwanted pregnancies as they are the ones who will take care of their great grandchildren.

"if the grandparents are not interested in the sex talk sometimes, I convince them that after everything that is going to happen you are caring for this grandchild you still going to care for the great grandchild …" (PHCN 11).

PHC nurses emphasised the importance of grandparent's guidance on SRH issues to ensure that their grandchildren are well informed. Open communication is perceived as the cornerstone of a healthy family on matters affecting health promotion.

4.4.2 ESSENCE 2: PHC NURSES' EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

PHC nurses' experiences of factors facilitating SRH communication emerged as a second essential element of PHC nurses' experiences of SRH communication. These essential elements further exposed three constituents namely: grandchildren's experiences of SRH knowledge from other sources, PHCNs' competency and PHCNs' collaboration and referral to other stakeholders.

- **Grandchildren's SRH knowledge from other sources**

Most PHCNs acknowledge that grandchildren receive SR information from other sources, such as the school, social media, including peers, as indicated in the following quotes:

"some its better these days because they get information from the school, so we just rub stamp on what they have received from school and provide clarity" (PHCN 1).

"They are more informed I think the educational background also plays a role, so they can respond to any question that comes their way. They are also assisted by Life Orientation " (PHCN 7).

"True, we just need to reinforce what they have learned at school" (PHCN 7).

Other participants concurred by indicating that media, peers and school assist in giving reproductive talks to grandchildren which makes it easy for grandparents to engage with their children in SR talks. This was further supported by PHCNs below:

"You know with social media in place, it has brought a platform where it becomes easier as a parent to discuss sexual reproductive health, like for example, you " (PHCN 1).

"They usually say they got information from their peers or at school, not from the grandparents" (PHCN 8).

Participants alluded that regardless of the information that the grandchildren receive from other sources, reinforcement of positive SRH values through open communication is needed.

"I think they still need information, although somewhere somehow especially from the grandchildren most of them they just need reinforcement because in most cases when we talk with them is like they know" (PHCN 5).

The participants highlighted that there is still a need for SRH information provision for both grandparents and grandchildren. In addition, PHC nurses posit that there is a need for

reinforcement to ensure that SRH is well understood in ensuring that health promotion is realised.

- **PHC nurses' competency**

PHC nurses' competency emerged as the second constituent of PHC nurses' experiences of factors facilitating SRH communication. There were diverse perceptions about PHCNs' competency regarding SRH communication. Some PHCNs indicated that they were privileged to acquire knowledge from working with youth, from the training whereas others still felt they are not competent to deal with the subject. Some participants reported that SRH was a difficult topic to discuss with grandparents or grandchildren. They reported that since they were trained in PHC and Community Nursing Science, they are now able to talk freely about the topic. This was confirmed by the following quotes:

"What I can say is back then, there were some topics that were even harder to discuss about but with the changes that came in, I see those that are coming back from PHC trying to sit down and discuss the status of the things they do at home and longing to see things being different" (PHCN1).

'"But for me, it wasn't difficult to do it since I've done my PHC training I've only worked with TB and chronic until right now I'm working with SRH. So can provide the necessary information" (PHCN 3).

"I have acquired some knowledge from the Community Nursing subject that I did at the college, and we are being sent for courses or programmes. We are empowered" (PHCN 7).

PHCNs 5 and 6 concurred by indicating that, even when they are rendering other services, they talk about SRH to young female clients (patients). As such, sexual health education is also offered by young nurses who understood it better and it is effective.

"No, I don't have any challenges, hence I'm saying like giving family planning. In most cases, I am the one who introduces family planning, but every patient of childbearing age doesn't leave my consultation room without that information.'' (PHCN 5).

"It has improved, even though there are some who are still like that but mostly now we do have young nurses that's why I'm saying they are the ones handling the youth, so a lot has improved even with the older ones because we do go for training." (PHCN 6).

Some of the PHC nurses verbalised that they felt privileged to work with youths and that made it easier for them to work and understand the youths who visit the PHC facilities in need of SRH information and other services, as depicted by the following quotes*:*

"The fortunate part is I was privileged to work with the youth, going to where they gather and discuss whatever topic that they have according to their programme and we coming to the clinic, there's a very big difference" (PHCN 1).

"Though there are those healthcare providers who are very well dedicated and doing their job with passion. They ensure that the client is treated with respect regardless of age. In case they request any service from the clinic appropriate information is provided" (PHCN 8).

Workshops and in-service training sessions are provided to equip PHC nurses with the knowledge that assists with altering attitudes that inhibited access and utilisation of the PHC facilities.

"even though there is a great improvement on our attitude because we are being in-serviced or developed on how to treat our clients meaning customer service..." (PHCN 7).

"I think the workshops, and in-service training also assist us with new developments that we can apply to our daily work" (PHCN 11).

PHC nurses play a vital role in handling difficult topics such as SRH. Personal and professional development ensures that these nurses are well capacitated to ensure the delivery of quality SRH services and to also improve the attitudes of the nurses.

- **PHC nurses' collaboration and referral to other stakeholders**

Collaboration, with referral to other stakeholders, emerged as the third constituent of PHC nurses' experiences of factors facilitating SRH communication.
PHCN 7 reported that clients are been referred to social workers for further investigation as expressed by the following quotes:

"so mostly I refer them, they used to be accompanied by the friend or boyfriend to family planning so when they want to terminate, they don't want to be disappointed. Otherwise, when it's a teenage pregnancy we refer to the social worker for further investigation... so that the social worker can intervene" (PHCN 7).

The same participant indicated that school health nurses are also invited to address SRH related issues, as indicated below:

"School health sisters are invited so that they can communicate with them at school and further give them information about SRH, immunisation and they conduct awareness campaigns" (PHCN 7).

One participant also said:

"We have health promoters, who help us in planning and carrying out these events to reach out to people. They have committees, such as clinic committees, and they come with other people of which some of them are sponsors who assist them with open days" (*PHCN 9*).

All the participants acknowledge that an appropriate referral system can improve the relationship between primary healthcare providers and secondary health care specialists. According to the participants, a referral is viewed as a process whereby an HCP refers clients to another level of the health system or another health worker with expertise.

4.4.3 ESSENCE 3: PHC NURSES' EXPERIENCES OF SRH COMMUNICATION BARRIERS

PHC nurses' experiences of communication barriers emerged as the third essential element of PHC nurses' experiences. During the analysis of data, several factors emerged as barriers to open SRH communication within the grandparent-headed families, namely, family related barriers and healthcare system related barriers.

- **Family related barriers**

Family related barriers emerged as the first constituent of PHC nurses' experiences of SRH communication barriers. Emotional, cultural, and religious barriers between grandparents and grandchildren were identified. This is shared below:

  - **Emotional barriers**

All the participants expressed fear as the main barrier to SRH communication within the grandparent-headed families. These participants stated that:

"or the grandchild is afraid to discuss the issues of sexuality with the grandparents because that would indicate that now she's starting to be involved with the opposite sex or same sex in relation to relationships, so there uh, it's not there" (PHCN1).

"The other reason that I have picked up is she was afraid of discussing with the granny and even afraid of friends what will they think of her" (PHCN 5).

"They say they fear being judged or being seen as being disrespectful, so they rather sneak out without being seen by the parents" (PHCN 7).

The PHC nurses shared their experiences regarding the emotional barriers that they came across in the health facility and it is evident that the grandchildren are having challenges regarding SRH communication with their grandparents. Fear results in grandchildren not being able to talk or respond positively to SR related questions because of the presence of the grandparent in the consulting room.

The participants revealed that some of the grandchildren are faced with physiological changes, and they have a problem as to how they will divulge the information or challenges to their grandparents, thus resorting to dishonesty. The participants alluded that:

"The child is also a teenager, she is surprised to be reaching that type of stage that is also new to her, and maybe she didn't even mean to get to that stage, so she doesn't know how to divulge the information, that is why she decided maybe to lie" (*PHCN* 2).

"Think grandchildren are not able to open up to discuss sexual related stuff with their grannies, in a way according to my experience your granny is like your mother, you're able to open up and talk freely about activities like sexual reproductive stuff" (PHCN 4).

Other emotional barriers emerged that impact open SRH communication: Fear of being judged by their own friends, the stigma that they already dated, feeling of being disrespectful to their parents and fear of utilising the health facilities due to the attitudes of the healthcare providers.

Participant 7 expressed the following:
"*Some are afraid of their own friends because they are being judged and discouraged from terminating their pregnancies without telling their parents. Adolescents have got challenges like teenage pregnancy, STIs, unsafe abortions because they fear to come to the clinic, others are on ARTs." (PHCN 7).*

"Remember some see us as elderly people whom they find difficult to discuss regarding these sexual topics. Others are afraid of being scolded by us, nurses. Well, that is how we are being labelled" (*PHCN* 7).

PHCN 10 verbalised that it was not an easy topic to discuss with elderly people as expressed below:
"It is not an easy topic to discuss openly with an elderly person. Okay, it's very difficult to talk with adults if you have started seeing someone." (*PHCN* 10).

Fear to utilise the health facilities due to the attitude of the nurses also plays a role in instilling fear in the grandchildren because they also perceive PHC nurses as their elders. On the contrary, some nurses are approachable, professional and non-judgemental to the grandchildren (adolescents) who execute their duties diligently.

One of those nurses expressed that:
"It is something that's been said from when I was young that nurses are rude and inconsiderate, but for now, yes that's still happening but we can't say all nurses are like that. As individuals, we all have our different attitudes and if I'm good everything will be good and if I'm rude then there'll be more problems in the clinic" (*PHCN* 9).

- **Cultural barriers**

Culture and cultural beliefs emerged as an inhibitor in addressing issues related to sexuality. Participants verbalised that discussing sexual related issues with children is still seen as a taboo as evidenced by the following quotations:

"*that's why I said that it is a taboo to discuss sexuality with your children or with your grandchildren"* (*PHCN* 1).

"*and also, culture, the people are still respecting virginity so sex before marriage is ground up on lack of knowledge and resistant to change.*" (*PHCN* 3).

"As much as it sounds like a taboo because maybe previously such topics were never discussed with children because they were regarded as adult talks. Previously it wasn't done" (*PHCN* 10).

Participants indicated that discussing sexually related topics with children is perceived as offensive hence it is a problem for some grandparents to deal with the matter. PHC nurses allege that in the olden days, families relied on other socialisation agencies to instil social values regarding SR issues as depicted below:

"in the olden days, they would expect me as a man to go to the mountain where they are going to teach me about how the process of becoming a man and the ladies, they would go to the lady's initiation to be taught how to become a woman" (PHCN 1).

"On culture, even though is fading away anyway but in some areas, it's still there where the family still chose a boyfriend or girlfriend for you. That will be the upbringing they'll be preparing you to be the wife or husband of somebody" (PHCN 6).

The same participants highlighted that:
"Yes, initiation schools because they believe it is where teenagers are being taught about adulthood. Though they never explain what happens at the initiation schools as it is viewed as being something that you cannot talk about with any person" (PHCN 6).

On the other hand, participants indicated that language can also create a barrier to open communication because there are no appropriate words that can be used to discuss SRH sues within families. Participant 6 further alluded that:

'Sometimes language can be the cause because they don't know how to discuss sexuality issues because it seems as if they are being disrespectful. From the religious or cultural point of view, it's not easy because of the private nature of the subject because when you talk to" (PHCN 6).

"They don't because remember during their time they never discussed these topics with their parents" (PHCN 8).

The discussions confirm that culture is still a challenge to SRH communication because SRH talks are still regarded as private matters. Participants revealed that it is difficult to have open SRH communication because it was never done in the olden days. It was revealed that, previously, people used to go to initiation school to be taught about manhood and womanhood which are never discussed openly.

- **Religious barriers**

Religious barriers emerged as another barrier to SRH communication, as expressed by the participants during the phenomenological conversations. PHCNs asserted that grandparents stick to their religious beliefs which are perceived as moral builders.

It was confirmed that:
"You know the grandparents usually go with belief. Grandparents will usually believe that maybe you must have sex after marriage, it may be due to their religion that's why or according to their culture maybe it says sex before marriage they believe in virginity. These days children are more free people" (PHCN 3).

"Yah, in churches and other religions you know that we're not supposed to be with a boy or sleep with a boy before marriage, so others don't take it what can I say... it is evidenced by the number of teenage pregnancies that we see in the clinic" (PHCN 6).

“Most don't believe in the termination of pregnancy because they will always refer you to the bible, the Ten Commandments "thou shall not kill" (PHCN 9).

“Secondly, you have the religious belief whereby sex before marriage is not acceptable” (*PHCN* 11).

PHCNs 1 and 10 acknowledge that religion is a barrier to SRH communication, as revealed by the following quotes:

‘The other barriers that might be there about sexuality; culture can influence that and also… I don't know whether I can put culture in religious practice because it can be a barrier to that” (PHCN 1).

“Things like religion, culture and educational level of the grandparents are some of the barriers that I can think of. They are a very serious stumbling block towards open communication within families” (*PHCN* 10*).*

Participants highlighted those religious beliefs have both positive and negative impacts on SRH promotion. Religion is perceived as a moral builder that assists in shaping the SR wellbeing of grandchildren where abstinence is emphasised. On the other hand, it is a barrier that hinders SRH promotion, e.g., termination of pregnancy may be viewed as a sin without considering the reasons related to the termination of pregnancy or the psychological impact on the person who wants to terminate her pregnancy.

- **Barriers between grandparents and grandchildren**

Some participants revealed that there are barriers between grandparents and grandchildren emerged, such as no clear communication, fear, lack of trust, and lack of age-appropriate language as depicted below:

‘‘*There is no clear communication or good communication between the two with regard to sexual reproductive health because of it can be maybe practice or age difference between the two, so it’s either the grandparents don’t know”* (*PHCN* 1).

‘‘*Yes, it means they don’t talk about these topics from the look of things”* (*PHCN* 7).

‘But some of the grandparents are clueless especially the ones from the poor families whereby at home there’s no communication about sexual health” (PHCN 11).

Fear and lack of trust were identified as barriers to SRH communication between grandparents and grandchildren that impede SRH communication**.** These fears and lack of trust are confirmed by the following quotes**:**

"*so now that barrier is still there so they are afraid or they can't talk openly, they will just use phrases that are not direct to, and you will find that the child does not understand that my grandfather or my grandmother is talking about"* (*PHCN* 1).

"*These children will be afraid to even ask the granny about something they see on TV whilst they are watching TV. Where do you start? They are afraid that the granny will even share the problem with the aunty next door so it means no privacy will make the child keep to"* (*PHCN* 8).

'When a child maybe slept with a boy without any consent they won't even go and tell the grandparent because they may be viewed as being promiscuous without even listening to the child. Its true lack of open communication creates a lot of problems that need to be addressed" (*PHCN* 10).

One participant revealed that a lack of age-appropriate language contributes to a lack of communication between the grandparents and grandchildren because some grandparents do know, but they do not know how to present it to the children.

"*They are knowledgeable, but the problem is how to bring it out to their children"* (*PHCN* 1).

Several PHCNs highlighted that grandparent's resort to riddles that the grandchildren may not understand. The participants expressed their observations as indicated by the following quotes:

"*According to my experience, there are communication barriers may be due to age, the grandparents are not open to communicating with grandchildren, usually, they speak in hiding or riddles where you find that the children don't understand what they've been told or what the grandparents are saying"* (*PHCN* 3).

"*They may use the language that the children may find it difficult to understand'" (PHCN 9).*

"They would say I don't want to see you with boys without giving reasons. Some even say children of today don't respect their elders they just stand with boys without any fear" (*PHCN* 10).

PHCN 8 mentioned that lack of open communication between grandparents and grandchildren was also revealed as a barrier to SRH communication hence the grandchildren prefer to go to the clinic to seek SRH information.

"There isn't much communication between grandchildren and grandparents the way I see. Why I say that is because these children come to the clinic to seek information because they don't discuss any sexuality issue at home" (*PHCN* 8).

PHC nurses identified several barriers that hinder open discussion regarding sexual related issues. It was further revealed that there are positive and negative factors, such as religious beliefs and practices. Lack of age-appropriate language where idiomatic expressions or riddles are used which may be difficult to interpret or understand my grandchildren.

- **Health care system related barriers**

Healthcare systems related barriers emerged as the second constituent of PHC nurses' experience of SRH communication barriers. Several participants shared their views regarding what they have observed in their work environment which hinders SRH promotion.

PHCNs expressed the following concerns:
"When I talk about the attitude of the healthcare personnel, there are times when you find that I would say the way we talk to them" (PHCN 1),

"Yes, some do ridicule children that come for reproductive health in school uniform, some do ridicule them whereas at that time it is a very sensitive time where we should sit down with the child and give them information rather than to ridicule and be judgemental." (PHCN 2).

"Sometimes you find a teenager coming to the clinic… Instead of giving information on that, I start being judgemental, why sex at 15 years? such things'" (PHCN 3).

PHCNs asserted that there is still a need for nurses to be educated about the impact of negative attitudes towards SRH care service delivery. PHCN's behaviour discourages young people from attending the clinic and getting the necessary services.

Some of the participants highlighted that more concentration is on the girl child and nothing much about the boy child when both are faced with more or less the same challenges.

"The boys…, and them too, because it's very important for us not to neglect the boys because these two they're together and they must know what they're doing. So, it is very important to treat them equally so" (*PHCN* 4).

“To tell the truth, even the nurses who go to schools don't focus much on the boys but on the girls..., if you come as a 13-year-old we talk about prevention and all that, but truly speaking we never touch on the male children, to ask if they've started indulging in sexual intercourse and if they're using protection or not” (*PHCN* 9).

Several participants pointed out that there are other healthcare system related barriers that contribute to poor SRH provision, namely, the attitude of shortage of staff, unfavourable daily programmes, including lack of enough time, as expressed by the following quotes:

“You know what, what I'm thinking it's not a question per se, but my mind has run to services like what is happening in the clinic and several services are being brought to the clinic that is very good to the community, but a shortage of staff is another barrier that causes non-utilisation of the clinics by the adolescents” (PHCN 1).

“So mostly now because it might be because of staff shortage you find that it’s not easy for that person to go outside and provide services or educate them” (PHCN 2).

“Think maybe because we're having a shortage of nurses, to take out that role so that we can ensure that everything is well balanced you understand, yah” (PHCN 4).

“At times we have a shortage of staff which makes us unable to assist the patients fully and at times you find that we don't have some of the methods or there is a delay in delivery” (*PHCN* 11).

Some of the participants highlighted lack of time or insufficient time allocation as another factor that hinders SRH promotion, as expressed by the following quotes:

“*The problem could just be maybe we don't stay long to get questions and answers and everything because of the institution but we do” (PHCN 2).*

“I can say we don't, because most of the time there's no time to do all these things that's why we rely most on Ward based outreach teams (WBOTs)” (PHCN 3).

“They are not because most of the time health education is given in the morning when the clinic is still full and in the afternoon, we are rushing to ensure that everyone reaches her daily target” (*PHCN* 10).

Another participant indicated that the lack of privacy and stigma are the other factors that also hinder quality SRH provision for both the grandparents and grandchildren, as indicated by PHCN 5 below:

"*can you start with me or quickly proceed with the family planning as some will be concerned that they are about to do family planning closer to a chronic room whereby they may feel their privacy being compromised and be heard by other patients in nearby consultation rooms who came to consult for* " (*PHCN* 5).

Addressing all the health-related barriers will be beneficial because it will increase the utilisation of SRH services to enhance SRH promotion. Participants indicated that there are inequalities that need to be addressed to achieve positive outcomes on SRH promotion and further prevention of GBV, teenage pregnancy, and STIs, including HIV.

4.4.4 ESSENCE 4: PHC NURSES' RECOMMENDATIONS FOR SRH COMMUNICATION PROMOTION

Primary healthcare nurses' recommendations for SRH communication emerged as the fourth essential element. There are five (5) constituents that emerged from the analysed data, namely, capacitation of PHC nurses, capacitation of grandparents, PHC nurses' facilitation of open SRH communication and applicable SRH communication, PHC nurse's facilitation of SRH educational group interventions, including stakeholder collaboration.

- **Capacitation of PHC nurses**

Capacitation of PHC nurses plays a crucial role in ensuring that the SRH information is disseminated accurately and correctly. Participants posit that it was important to provide health related information in the language that the client understands, as reflected in the quote to follow:

"*When you are a well-trained primary health nurse and also trained about public speaking you need to consider the education of the crowd that you are addressing, you'll be able to give the relevant information as a primary healthcare nurse to the very crowd or the group that you'll be communicating with, you won't just come here and just speak out the menstrual cycle" (PHCN* 2).

However, other PHCNs feel that not enough has been done to ensure that they are well informed about SRH subjects. In addition, another participant verbalised that in the four-year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery programme, SRH modules are not given enough attention, unlike in the Clinical Health Assessment, diagnosis, treatment, and care programme which is very intense. The following attest to the abovementioned statements:

"*You know at a PHC level, to tell you the truth, we were given a book as thick as this and we were told to read from chapter one up to six and tomorrow come and present these topics than just like that and then any questions just like that. I would feel if maybe a company dealing with reproductive health opening clinic, comprehensive training on TOP of what we got from the PHC that will be very beneficial to us*" (*PHCN* 2).

"I did a comprehensive diploma (D4), but I don't think it was enough because we're doing a lot of stuff, I think if maybe they can just allocate maybe a dedicated year for just sexual reproductive health so that we can be able to just focus" (*PHCN* 4).

Another participant further highlighted that the issue of silence toward SRH communication must be addressed. The participant highlighted that:

"I also think this thing of silence must also stop because it doesn't help us, we need to talk openly so. I also forgot to mention that maybe nurses also need to be workshopped on customer service" (*PHCN* 10).

More attention needs to be given to the curricula of all the programmes to ensure that SRH modules are well presented. Frequent workshops and in-service training are conducted to keep all the PHCNs informed about all the current SRH matters.

- **Capacitation of grandparents and grandchildren**

PHCNs revealed that there is a need for both grandparents and grandchildren to be empowered to promote SRH within families. Grandparents as socialising agents and health promoters need to be well informed to be able to provide proper guidance to their grandchildren. The participants confirmed that:

"What I would advise them first thing with the guidelines is to consider that not all of us are known to the highest level, some of the grannies they're willing to, they love their grandchildren, they're willing to teach them but they are challenged by the fact that they cannot read and write, so illustrations are going to be part of the guidelines to accommodate those that cannot read" (*PHCN* 2).

"I feel they need to have more information about the importance of sexual reproductive health, grandparents need to be knowledgeable to discuss with their grandchildren about STIs, teenage or unwanted pregnancies, so they need to be well informed because they are the caregivers" (*PHCN* 5).

“and I think we also need to educate and involve the parents. So that it can be easy for them to talk with their children remember some didn’t go to school” (*PHCN* 7).

PHCNs identified strategies that can enhance the empowerment of the grandchildren, as expressed below:

“*They should get a way of reaching to the child step by step like that until where they can now comprehend everything*” (*PHCN* 2).

“*I think we must also be youthful so that they can listen as if you put them aside and try to talk like we used to do, they won't listen” (PHCN 6).*

“First of all, we have to identify those who need assistance so that will be provide the necessary information. Approach them with respect and be very understanding so that you gain their trust. Have open days or campaigns to give information” (*PHCN* 8).

“Maybe there must be awareness campaigns whereby grandchildren and grandparents can be given information about all services that are available in the community, e.g., the Crisis centre where the rape victim could go on her own and seek help” (*PHCN* 10).

The grandparents must be made aware that even though the grandchildren are regarded as children, they are human beings with rights. They have the right to access information.

“encourage them to be open and the grandparents must know that a child is also a person who makes mistakes and that things are changing, they must be open to learning more about these things and listen to nurses, read health books.” (*PHCN* 9).

“This means grandparents must also understand that even though adolescents are regarded as children they also have the right to” (PHCN 10).

“even our laws allow a 12-year-old to seek information on matters that affect their health. Remember the Batho-Pele principles and the client’s rights charter. The right to information” (*PHCN* 10)

Participants affirmed that the educational level of grandparents is crucial because it was evident that those grandparents with a good educational background can talk with their grandchildren unlike the ones with a poor educational background as indicated below:

“*The only grandparents who are easy to talk to are those grandparents who are a bit educated or a bit enlightened”* (*PHCN* 11).

The same participant attests that cultural issues need to be addressed to enhance SRH communication within families, as expressed in succeeding quotes:

"I think if maybe if we enlighten these grandparents that culturally we do understand that they are not supposed to sit and talk about these things, but they are happening, and most children are falling pregnant at a young age because of lack of communication at home" (*PHCN* 11).

Empowerment of grandparents will assist grandparents to be knowledgeable about SRH and its legislation for them to be change agents within families. These were confirmed as:

"I think even the grandparents need to be more open to discussing sexual issues with their grandchildren. They also need to be empowered because we are not sure if they know or not" (*PHCN* 10).

"And these grandchildren should also know that if you are 18 and then you are pregnant the baby is coming with the demands so as a minor you are not working you won't be able to meet those demands, meaning if I am a grandparent staying with you and your mother who is also not working and the salary" (PHCN 11).

PHC nurses emphasised that support for grandparents is needed to ensure that open communication is enhanced, and their morale is also boosted. Both grandparents and grandchildren must be provided with SRH information.

- **PHC nurses' facilitation of open SRH communication and applicable SRH communication**

Primary healthcare nurses as facilitators of open SRH communication emerged as a constituent of PHC nurses' recommendations for SRH communication promotion.
Participants shared their views in the succeeding quotes:

"if yes we had enough staff it was going to be very easy and profitable guidelines that will be directed freely to them and that will be even to healthcare workers as in that we work in our delegated (areas) places" (*PHCN* 1).

"*pamphlets must be everywhere with the information about STI, condom use…eh dating, when dating what must you do because communication is key because they are dating, they must be there, the adverts they must be there for them to be able to read. Manage any barrier"* (*PHCN* 7).

Despite the role played by culture regarding SRH issues, the PHCNs reported that it is important to continue providing health related information to enhance good health as highlighted by the following quotes:

"in our African culture is a bit tricky but as a health care provider I have a role to accomplish by giving information related to health promotion, I'll have to learn to just open up and just discuss everything and call a spade a spade" (*PHCN* 4).

"Grandparents may not be comfortable or believe in sexual reproductive communication but as health care workers we must try to assist where the need arises. It's very important" (PHCN 5).

"*Yes, mam though being a health care provider one has to face the topic head on to provide accurate information*" (*PHCN* 7).

Several participants alluded that attitude as barriers, including other factors that contribute to non-utilisation of the healthcare services, must be addressed. The quotes are shared below:

"Think that is all about barriers especially our attitudes towards eh… especially what we say to the young girls you see, not to scare them away from the clinic..." (*PHCN* 5).

"Try to be approachable and non-judgemental for them to come to me once they encounter problems" (*PHCN* 8).

"As nurses, we must be non-judgemental, open and be willing to provide information to both the grandparents and grandchildren" (*PHCN* 10).

Some of the participants affirm that open communication must be encouraged to address all the SR challenges that may have been experienced by either the grandparents or the grandchildren.

"or the ones who started dating they can start talking about sexual reproductive health with the parent. We can educate them because at this age when they start showing signs that they've started dating or maybe at the age of 12 years." (*PHCN* 7).

‘‘*Nowadays we really need to discuss openly such topics because at least we are well informed" (PHCN* 8).

"if one comes to the clinic for help, then we can sit down with them and explain to the child and the grandparent that they must be open to speak about this.'' (*PHCN* 9).

Several participants are of the opinion that these grandchildren should abstain until they are responsible enough to make informed decisions regarding SR issues, as revealed by the following statements:

"*Mam, in my opinion, children must abstain until they are responsible enough. Of course, this will also depend on if they are well informed about sexual related topics. We must also not forget that they have a right to information" (PHCN 10).*

"*I think before they start seeing their menses or when the parents start seeing changes on their bodies. They should start with the topics explaining what is happening to their bodies and also making them aware of their rights, e.g., not to allow anyone to touch their bodies and to report such to their parents" (PHCN 11).*

Participants acknowledge the need for the facilitation of SRH communication to enable the grandparents and grandchildren to have an open discussion on SR issues.

- **PHC nurse's facilitation of SRH educational group interventions**

PHC nurses are in contact with the grandparents and grandchildren at the clinic, the school, even at home where the WBOTs surface**.** The participants share their views:

"if we can start the clubs where they are going to be guided, they can approach this topic with their grandchildren so that they can give them information so that even the children can understand the information that they are given so that they can have questions on whatever is being discussed freely" (*PHCN* 1).

"*We can start a youth club where we will be teaching our children or if not us there are NGOs that provide youth activities whereby, we can invite them to the clinic and we send word of mouth or leaflets to invite children to come to the clinic on those specific dates for activities*" (*PHCN* 3).

"Maybe we can just form some support groups, for them and like have sessions with them and discuss issues to address their problems" (*PHCN* 4).

One of the participants confirmed that health talks can assist in the prevention of disease and promotion of health, as stated in the following quote**:**

"*Having health talks at the clinics can help with health promotion"* (*PHCN* 3).

"*We can promote health education…but to the grandparents also. We can go to schools and educate children; TVs also give them a bit of information but we're not sure whether*

everyone has a television or those who have televisions watch programmes related to health or not." (*PHCN* 9).

Peers were also identified as another education group that play a crucial role in SRH promotion. Grandchildren prefer to talk with their peer groups who may not be having appropriate responses as expressed by PHCN 6 below:

"I think peers want to talk to peers, they talk with ease, and they agree even though some of them are out of line". (*PHCN* 6).

Participants posit that there is a need to facilitate educational strategies to create awareness regarding SRH promotion. Some strategies that have been identified by participants are Awareness campaigns, youth clubs, health related pamphlets that could also assist in raising awareness within the communities through the guidance of the PHC nurses.

- **Stakeholder collaboration**

Stakeholder collaboration emerged as the fifth constituent of PHC recommendations for SRH communication promotion**.** Participants highlighted the importance of youth groups, including WBOT SRH promotion as evidenced by the quotations to follow:

"Like youth groups in the community. A working relationship let's say that your supervisors can come and indicate that we have this group of young people" (PHCN 1).

"*I think involving ward based and outreach teams and you must also have a positive attitude towards these children"* (*PHCN* 3).

Youth groups that are found in the community have been identified as one of the stakeholders that can join hands with the PHC nurses in identifying the health challenges and needs of the adolescents.

PHCNs affirmed that LO plays an important role in the provision of basic SR information and another participant suggested that LO must commence at Grade 7.

"*I think LO has a very good impact because children are given basic information about sexual reproductive health topics. Teachers should just reinforce sexual reproductive health in their teachings"* (*PHCN* 4).

"*I think it must start at the school including primary school grade 7*" (*PHCN* 7).

Grandchildren (learners) and grandparents as human beings may also be faced with some social challenges that would need the intervention of social workers. PHC nurses, through their referral system, can refer grandparents or grandchildren when the need arises.

"…or refer them to social workers who may also conduct home visits" (*PHCN* 8).

The participants highlighted that a multidisciplinary approach will be able to strengthen SRH promotion. These efforts will also assist in the reduction of GBV, risky sexual behaviours, and teenage pregnancy, including STIs.

4.5 SUMMARY OF ESSENCES AND CONSTITUENTS OF GRANDPARENTS

The findings were based on the lived experiences of the grandparents as they shared their own views. The grandparents, as socialisation agents, are expected to discuss sexual related issues with their grandchildren who are under their care in the presence or absence of the biological parents.

Four (4) essences and ten (10) constituents emerged from the transcribed data (Table 4.5). The quotes of grandparents are included to support the essence. Participants in this group are abbreviated as GP followed by a number and alphabet F for family and a number. The essences and constituents of grandparents are discussed below:

TABLE 4.5: ***Summary of Essences and Constituents of Grandparents***

No	ESSENCES (THEMES)	CONSTITUENTS (CATEGORIES)
4.5.1.	Grandparents' experiences of SRH communication	• Grandparents' experiences of benefits of promotion of SRH communication
		• Grandparents' experiences of current SRH communication/practices
		• Grandparents' experiences of SRH family communication strategies
4.5.2.	Grandparents' experiences of factors facilitating SRH communication	• Grandparents' acceptance of SRH communication responsibilities
		• Grandparents as sources of SRH knowledge.
4.5.3.	Grandparents' experiences of SRH family communication barriers	• Emotional barriers
		• Religious/cultural/practices barriers
		• Grandparent's misconceptions (lack of knowledge) of SRH
		• SRH communication barriers between grandparents and grandchildren
4.5.4.	Grandparents' recommendations for SRH communication promotion.	• Capacitation of grandparents and grandchildren

4.5.1 GRANDPARENTS' EXPERIENCES OF SRH COMMUNICATION

Grandparent's experiences of SRH communication emerged as the first essential meaning (element) and was further divided into three (3) constituents, namely, grandparents' experiences of benefits of promotion of SRH communication, grandparents' experiences of current SRH communication/practices and grandparents' experiences of SRH family communication strategies. Constituents that emerged are supported by quotes that highlight the voices of the participants.

- **Grandparents' experiences of benefits of promotion of SRH communication**

Grandparents, as participants, revealed their experiences about the benefits of SRH promotion within the families. The same sentiment was shared by the PHC nurses. One of the participants stated that these children must be knowledgeable because there are consequences to everything they do. The experiences of grandparents were expressed in the following quotes:

"So much, because they must know and not just jump into things, they must also know that there are consequences to everything they do. It is important" (GP1F2).

"Is it not that I tell myself that these children are growing up and they can do what we have been talking about like, not date, drink alcohol, just go to school because you are still young". (GP1F3)

"Is to talk to these children so as they can understand because sometimes when we talk to these children they do not understand, and they end up being ignorant" (GP1F8).

Grandparent 4 expressed feelings of anger in the next quotes:

"*I got extremely mad when I heard the other day saying that one of the men that stays not far from where we are, is trying to ask her out. And my expression was What are you saying? I then reassured her not to worry about it, and that I'll solve it" (GP1F4).*

Grandparents expressed their views regarding the benefits of SRH promotion as they are expected to provide first-hand SRH information to their grandchildren. Participants highlighted that they expect these children to go to school, not to date or drink alcohol. One of the participants, GP1F4 was angered by a man who wanted to date her granddaughter who was still attending school. The above quotes suggest that grandparents believe that open communication assists in the reduction of SRH problems.

- *Grandparents' experiences of current SRH communication/beliefs/practice*

Grandparents' experiences of the current SRH communication/beliefs/practices emerged as the second constituent of grandparent's experiences of SRH communication. Grandparents shared their various views regarding their experiences of current SRH communication/beliefs/practices as revealed in the next quotes:

"I experience young people who listen and love themselves, I think maybe they were not loved when they were growing up, I don't know, when the boy says, "I love you", the girls get crazy, they get crazy, and they can do anything that the boy…" (GP1F1).

"*They love money too much. Back then, a child would rush back home to report a stranger who wanted to call them or ask for a favour. With today's kids, she won't even talk, she'll just puts the money in her pockets''* (GP1F4).

"I once told some girl who my grandson had brought into the house to stop coming to my house because they were having sexual intercourse while they are still very young" (GP1F7).

Grandparents find it very difficult to convince or discourage their grandchildren not to go out at night because of fear to be kidnapped. The other factor that was revealed by another grandparent is the wearing of revealing clothes. Grandparents expressed a feeling of unhappiness regarding the behaviour of their children as expressed by the following quotations:

"*Mainly I find it very difficult to convince them not to go out at night. They must not go out at night, but they never listen to what I tell them. They come back home very late" (GP1F4).*

"*We didn't wear the same revealing clothes as those are worn today" (GP1F4).*

"*I have once seen him with a girl in the house. In the bedroom. It left me with a heavy heart. I was disappointed"* (GP1F7).

Grandparents' experiences of the current SRH communication/beliefs//practices create a disturbing situation because they are expected to be health promoters when they have their own preconceived ideas regarding adolescents sexual related issues as depicted below:

"Their behaviour seems as though they are locked up in prison and they bank on such things to get out and they end up being uncontrollable" (GP1F1).

"But how will they know such information because the sooner they start talking, they talk about boys. They are destroying their future" (GP1F4).

Some participants indicated that some of the laws of the country contribute to some of the behaviours that are exhibited by the grandchildren.

"*Yeah, we'll let them continue with their rights then" (GP1F4).*

"I'm not sure when did this legislation come into effect. Maybe last year or when… about five years ago, just not certain about the year. A law that said a child can go and sign for themselves when they want to do an abortion. I think the age that was accepted was from twelve or eleven years" (GP1F10).

Participants expressed some concerns about the current SRH communication/beliefs/ practices, also referring to some of the laws of the country. The concerns may also impede or delay SRH promotion within families. Wearing revealing clothes and going out at night is not well received by grandparents and they are not comfortable with that.

- **Grandparents' experiences of SRH family communication strategies**

Grandparents have identified some strategies that can be used to facilitate SRH communication within grandparent-headed families. From the participants' point of view, several strategies have emerged such as television (TV) as the initiator of the conversation, one-on-one talks as expressed by the statements to follow:

"I just tell them a mouth full, and they know about this. I don't beat around the bush, I tell" (GP1F4).

"Yah, sometimes when we are watching TV and you see something related to that you try and open up a discussion around it" (GP1F5).

"But I do reprimand them if I see that there is something that is out of line, and I tell them exactly what behaviour I expect from them" (GP1F10).

Grandparents had to come up with strategies that can assist in SRH to ensure that their grandchildren are well taken care of. Grandparents are willing to discuss or share SRH information with their grandchildren.

4.5.2 ESSENCE 2: GRANDPARENTS' EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

Grandparents' experiences of factors facilitating SRH communication emerged as the second essence of the experiences of grandparents regarding the promotion of SRH communication with grandparents and grandchildren**.** Two constituents emerged that

support the essential meaning, namely, grandparents' acceptance of SRH communication responsibilities and grandparents as sources of SRH knowledge.

- **Grandparents' acceptance of SRH communication responsibilities**

Grandparents, as elderly people, have accepted SRH communication responsibilities in the reduction of SR challenges that the grandchildren may come across**.** Participants shared their views as follows:

*"So, it's very important to have such talks with the children, even with my grandchildren. Even if its boys or girls, you must tell them what is right and what's wrong" (*GP1F4*).*

*"I feel encouraged to talk to them and I ask them to listen to and take my advice. I feel encouraged and hopeful. If they can just follow my advice while I'm still alive." (*GP1F5*).*

*"There are times when I'm having a conversation with my grandson... I always try to explain to him and encourage him to have these sexual talks with me" (*GP1F7*).*

One participant highlighted the importance of getting information from the grandparents as expressed below:

*"I see no problem communicating with them because from what we have learned with the age it's better to learn from home than to get it outside information outside which most of the time it's wrong, so I don't see a problem communicating" (*GP1F9*).*

Participants affirm their responsibility to engage in SR talks with the grandchildren. Grandparents concur with the importance of open SRH communication within families. Failure to provide information to the grandchildren will drive them to go and seek information outside which may be misleading.

- **Grandparents as sources of SRH knowledge**

Grandparents as sources of SRH knowledge emerged as the second constituent of grandparent's experiences of factors facilitating SRH communication. Several participants had positive or neutral experiences of SRH information that is derived from other sources that also play a crucial role in SRH promotion. The following quotation attests to the statement above:

"I have had an opportunity where I got to meet the social workers from the child welfare which was the first company in our community to introduce me to the social working system then going into families and introducing me to other social workers… They had a project, it was named "An eye to children" but because it started in Cape Town… Then that project

taught me about this SRH communication and how to identify different behaviours…" (GP1F1).

"So, I get this information from the television set. They showed it on TV. It teaches our kids to see what is happening currently. But not those films that are out of line. They know that I don't want that in my house" (GP1F4).

"Yes, I normally call other grannies to come and ask them to share their views with me. So that we can reprimand these kids so that they can stop misbehaving. They must try to look up to us instead" (GP1F5).

"*From TV, from reading books and pamphlets, from attending health talks at clinics*" (GP1F9).

Several grandparents posit that SRH communication between grandparents and grandchildren is a tool that assists in the transmission of values, norms, beliefs and expectations about SRH matters**.** Grandparents shows willingness to engage their "grandchildren regarding SRH promotion as illustrated by the statements to follow**:**

'*I feel that I am old enough now, I can talk to my grandchildren about these things and that they must be careful. I tell them that they have started dating, they do these things but, they deny it and such things. They can understand" (*GP1F2*).*

"They should take care of themselves by protecting themselves from contracting these illnesses and diseases. Yes, they understand" (GP1F3).

*"Oh, so the benefits are, I can see that what I'm telling her it's relevant and she understands. I'm also happy because she listens to what I tell her. And she can see what I'm trying to show her. As a joke neh?" (*GP1F4*).*

SRH communication has been identified as a strategy that can be used to address sexual related challenges that affect adolescents. Subsequently, grandparents as primary caregivers need to be supported to be able to support their grandchildren and advise accordingly. Participants revealed that they acquired the information from the TV, support groups, and nurses at the clinic. The participants seek guidance from the clinic to protect their grandchildren from sexual related illnesses.

Visitors from the Department of Health (DoH) created time to provide information to the grandparents and the grandchildren so that they are well informed about current sexual related issues. The following expressions are from grandparents:

"Uh in many cases, we are visited by the people from the clinic. So, we communicate with the department in many cases, and they do come and explain" (GP1F8).

*"Yes, besides having kids, there are illnesses that may make you regret some of the choices you have taken in your life. They have a positive attitude; however, they tend to focus only on girls. Yeah, their work is 100% but they only focus on girls" (*GP1F8*).*

*"One of the Doctors helped me when I told them that one of my grandchildren was naughty, and I took her to him, and they helped me with that challenge. So that this child cannot fall pregnant and finish their schooling first" (*GP1F5*)*

Grandparents indicated the importance of collaborating with other stakeholders to acquire SRH information. In addition, some of the participants highlighted they are old enough to provide the necessary information to their grandchildren. PHC nurses are expected to capacitate the grandparents on all current SRH matters. It is assumed that grandchildren will be able to open up to the PHC nurses, not to their grandparents.

4.5.3. ESSENCE 3: GRANDPARENTS' EXPERIENCES OF SRH FAMILY COMMUNICATION BARRIERS

Grandparents' experiences of SRH family communication barriers emerged as the third essential element. Four (4) constituents emerged namely: emotional barriers, religious/cultural/parental barriers, grandparents (mis)conceptions (lack of knowledge) of SRH communication including SRH communication barriers between grandparents and grandchildren.

- **Emotional barriers**

Emotional barriers emerged as the first constituent of grandparents' experiences of SRH family communication. Shame has been identified as a feeling that impedes SRH communication as revealed by the next quote:

*"I think that the teachings that I give them when they went out and did wrong things, they now experiencing the consequences of their wrongdoing, then they feel ashamed to tell me but, before now I had care workers who were trained who used to talk to them" (*GP1F1*).*

Another grandparent verbalised that she feels very hurt because the grandchildren do not take her seriously when she talks with them or even reprimands them regarding unacceptable behaviours as explained by Participant 2.

"I do talk to them about it but, they do not take it seriously. I also tell them about these tattoos, that I do not like them, and even if I die, you must never do them. I do tell them about sexual stuff because they are already grown up, but they do not consider it serious, they just laugh so" (GP1F2).

*"I feel very hurt because, I do not know what is in their hearts and what they think because they do not take it seriously. They think I am just joking" (*GP1F2*)*

Several grandparents verbalised that they do advise their grandchildren about the danger of the diseases, as depicted in the next quotes:

"It is painful, as I am their aunt, I tell them that these illnesses and diseases are dangerous"" (GP1F3).

"And it's painful that when you try to open up to them, they avoid talking to you by all means" (GP1F4).

However, another grandparent verbalised that they are afraid of telling them how they feel about some of their actions. Grandparents end up not knowing what to do.

"Yes, and in many instances, we are afraid to tell them how we feel about some of the actions they are taking because they tend to answer the way they want. Which is inappropriate. We end up not knowing what to do at the end" (GP1F10)

Participants expressed some emotions that hinder open SRH communication. Several participants seem to be worried or concerned about the danger of SR related illnesses or conditions that may affect their grandchildren.

- **Religious/cultural/practices barriers**

Religious/cultural/practices barriers emerged as the second (2) constituent of grandparents' experiences of SRH family communication barriers. One of the grandparents explained that his father was a priest, and he was very strict that such topics were never discussed. In addition, some of the participants articulated the following quotes:

"My parents were very strict and secondly my father was a priest, so everything was done the biblical way. They preached about respect and sex before marriage was not allowed" (GP1F2).

"It doesn't sit well with me. According to the bible, abortion is the same as murder. And according to the Ten Commandments, even if the sin is small, you are still regarded as a sinner" (GP1F10).

On the same note, one grandparent verbalised that her grandchildren are lucky because she does talk with them regarding SR issues even though their parents may not be happy about what she does. The following quotes were shared by one of the grandparents:

"And now, we can no longer be evasive as grandparents. But in terms of our African culture, it's like cursing. If we allow such conversations to take place with our kids, then it will be as if we are encouraging them to have sexual intercourse" (GP1F8).

"They are lucky I do talk with them unlike in the olden days our parents didn't talk about these topics" (GP1F2).

Another grandparent verbalised that when talking about SR issues, it is as if one is swearing because there is no appropriate language that can be used to ensure that these grandchildren understand. The concern is highlighted in the next quotes:

"Mm and now this is rooted in our minds. It becomes as if you're swearing and cursing whenever you have such discussions with the kids. We see it as swearing" (GP1F8).

*"In our Sesotho language, if we do talk about it, then we tell them that this is bad and not allowed in our culture" (*GP1F8*).*

Fear of the impact of termination of pregnancy is highlighted below by GP1F10:

"What if at a later stage you can't conceive after marriage?" (GP1F10).

The grandparents shared their various emotions regarding their experiences of SRH family communication barriers. The above quotes revealed that grandparents are willing to participate in improving the SRH of their grandchildren, but their fears hinder them; this further manifests because of a lack of information or knowledge regarding SRH related issues. There is a need to create awareness and educate the grandparent about the current SRH issues.

- **Grandparent's misconceptions (lack of knowledge) of SRH**

Grandparents' misconceptions (lack of knowledge) of SRH emerged as the third constituent of the grandparents' experiences of SRH family communication barriers. Lack of open SRH communication perpetuates a lot of sexual related challenges which manifest in most

families. The following statements demonstrate the misconceptions that grandparents have regarding SRH issues.

"But now with what is being eaten, like eggs and cheese. Things like yoghurts or things like that. These are some of the things that stimulate kids to be hyper and sexually active" (GP1F7).

"The only challenge is that our generation today they don't have a conscience. They don't. Immediately when you decide to teach them about sex, they then go all out to experiment and then the results will be allegations that they were raped" (GP1F8).

Participants revealed that the food that these children are eating is encouraging them to be sexually active. Other participants further indicated that teaching them leads to grandchildren going out to experiment with what they were told.

- **SRH communication barriers between grandparents and grandchildren**

SRH communication barriers between grandparents and grandchildren emerged as the fourth constituent of the grandparents' experiences regarding SRH family communication barriers**.** Grandparents alleged that they do talk with their grandchildren, but they do not take them seriously, they do not listen, and they are stubborn, as presented by the following statements:

"Sometimes when you talk to them about this, they feel like you are disturbing them in a way. When you tell them not to go around with this girl, she is of no good to you they do not listen" (GP1F3).

"They do understand but there are certain things that I feel that they just don't understand properly when I tell them. Mainly because they feel that most of the things, I'm telling them are outdated. They say the information is outdated" (GP1F4).

"But they do not open up they do not present themselves to listen to you. Even though whether they listen or not one tries to continue talking to them. You simply say they will take what they take as long as I have spoken to them" (GP1F9).

One grandparent posited that due to the generation gap, she is unable to talk or discuss SR topics with her grandchildren, they do not listen. Grandparents perceive their grandchildren as being secretive and these secrets hinder open communication regarding SRH communication.

"In today's life we're living, things are not well. Our kids are hiding secrets, our grandchildren are also hiding secrets. They are very secretive'" (GP1F4).

"We as the older generation. It's still a challenge to have discussions of sexual and reproductive health topics" (GP1F8).

"I feel that having this conversation with them it's like trying to force a donkey to drink water when in fact, it does not want to" (GP1F10).

Failure of grandparents to explain in detail about sexually related topics emerged as one of the factors that creates a barrier because grandchildren may not understand what the consequences of the risky sexual behaviours entail, as shown by the following quotes:

"It's like when the girl comes to share with their elders what is happening to her body, she ends up being threatened and warned to stay as far as possible from boys". (GP1F8).

"When I talk with them, I have to make indirect examples and not say things as they really are" (GP1F10).

Grandparents alluded that it is not easy to discuss sex related topics with the grandchildren even though they try, as indicated in the following quotes:

"It is very hard for us to sit them down and explain the meaning of sex and the consequences thereof" (GP1F8).

"Huh, to be honest, it is difficult for me to talk about sexual health conversations with them" (GP1F10).

The above quotations revealed that there are barriers between grandparents and grandchildren that need to be addressed so that proper education can be provided and further strengthen SRH promotion within families. As parents, they further perceive their grandchildren as being disrespectful, not listening to them when they advise or discuss SR issues with them.

4.5.4 ESSENCE 4: GRANDPARENTS' RECOMMENDATIONS FOR SRH COMMUNICATION

Grandparents' recommendations for SRH communication emerged as the fourth (4) essential element with one constituent, namely, the capacitation of grandparents and grandchildren.

- **Capacitation of grandparents and grandchildren**

Recommendations were received from the grandparents who highlighted the need for their capacitation and for their grandchildren so that they can be updated on the current SRH issues. Grandparents revealed the need to participate in the SRH discussions, as asserted by the next quotes:

*"it is important for health workers to go out into their community and not get help only when you want their help because we only go there when we are sick and when you are not sick you do not go there'" (*GP1F1).

"You as health workers need to tell all the grannies about this issue and tell us where to meet and have that conversation with other grannies" (GP1F7).

"You know things change, especially on the sexual rehabilitation aspect. Some methods are coming in, diseases you know, yesterday's diseases are not today's diseases so the support we need from the PHC nurses" (GP1F9)

Some of the grandparents revealed that they never came across education that is provided to young boys which is a matter of concern. The young boys also need to be capacitated regarding SRH because they are also affected, as highlighted by the succeeding quotes**:**

"*And we can gladly meet someone who will be willing to assist us with our grandchildren*." (GP1F7).

"But personally, I haven't seen or witnessed education that is aimed at teaching young boys from the beginning about what is really happening. So, this is a very serious issue which needs to be attended to" (GP1F8).

In addition, some grandparents requested that grannies who are in the same situation must come together and assist with advice on SRH matters.

"*All the grannies who are heading such families must give us advice on how to solve this issue"* (GP1F7).

"*We must do away with toxic masculinity where one gender will dominate the other gender and want only their voices to be heard"* (GP1F8).

Another grandparent, who shared the same sentiments with the previous grandparent, verbalised that she has opened a foundation that should bring other grandparents together

to share information and further address the issue of GBV, as highlighted in succeeding quotes:

"I have opened a foundation. My foundation will focus on young girls and boys. I am not going to exclude anybody from it. *Issues of rape must be investigated in its entirety because it's possible for girls to seduce boys and we need to get to the bottom of how that happened as well. …We want to get to the root cause of what causes this gender-based violence and deal with it appropriately"* (GP1F8).

Grandparents also need to collaborate with other sectors to address some of the SR issues, as attested by the quotes below:

"Oh okay, Mm. This life would be better if these kids could listen to the advice, we give them. And also, you as government officials, if you could find ways to intervene and help us with these kids" (GP1F4).

"*I wish the government would allocate social workers to us. I want the government to stop making our kids victims all the time and lend us their ear and listen to what we also have to say as grandparents*" (GP1P10).

However, some grandparents revealed that their views as grandparents or parents are being neglected by the government and they are even afraid of disciplining their grandchildren in fear of being incarcerated, as reflected by the succeeding quotes:

"So that we can move forward with a solution, So, that we can reduce the pressure we are dealing with on a daily basis". (GP1F5).

"*And to find us being incarcerated because we were disciplining our children*" (GP1F10).

"Because now, I feel as if our views are neglected as grandparents and only the views of our grandchildren are taken into consideration when it comes to such topics" (GP1F10).

From the above quotations, it is evident that grandparents have identified some challenges and came up with some recommendations that could be of help in addressing SRH issues. Sectors need to join hands in addressing SRH issues.

4.6 SUMMARY OF ESSENCES AND CONSTITUENTS OF GRANDCHILDREN

The findings were based on the lived experiences of grandchildren as they are affected by SRH problems and are the recipients of the SRH information. Four (4) main essences and nine (9) constituents emerged from the transcribed data (Table 4.6). The quotes of grandchildren are included to support the essence. Participants in this group are abbreviated as GC followed by a number and alphabet F for family and a number. The essences and constituents of grandchildren are discussed below.

TABLE 4.6: ***Summary of Essences and Constituents of Grandchildren***

ESSENCES	CONSTITUENTS
4.6.1 Grandchildren's experiences of SRH communication	• Grandchildren's experiences of benefits of SRH communication.
	• Grandchildren's experiences of SRH family communication contents.
4.6.2. Grandchildren's experiences of factors facilitating SRH communication	• Grandchildren's positive experiences of SRH family communication.
	• Grandchildren's positive/neutral experiences of SRH information from other sources.
4.6.3. Grandchildren's experiences of SRH family communication barriers	• Emotional barriers.
	• SRH communication barriers between grandparents and grandchildren.
	• Grandchildren's negative experiences of SRH communication from other sources.
4.6.4. Grandchildren's recommendations For SRH communication promotion	• Educational interventions
	• Grandchildren's needs for SRH communication

4.6.1 ESSENCE 1: GRANDCHILDREN'S EXPERIENCES OF SRH COMMUNICATION

Grandchildren's experiences of SRH communication emerged as the first essence with two (2) constituents: Grandchildren's experiences of the benefits of SRH communication and grandchildren's experiences of SRH family communication content. The two (2) constituents are discussed below:

- **Grandchildren's experiences of benefits of SRH communication**

Grandchildren acknowledge that it is beneficial to communicate openly about SRH related issues. The same sentiment was shared by both the PHCNs and grandparents. The grandchildren's experiences are expressed through the following cues:

"My experiences are that I feel it is good to talk about sexual reproductive health for us to understand what we do not understand or what we don't know and get to know what we didn't know" (GC1F1).

"I think as teenagers we need information from our parents before we get the information from other people"" (GC2F1).

"I feel that it is a good thing for me to be able to learn and experience more about reproductive health because, they are older people, and they know more about this, and they indicate the consequences of every decision taken regarding this" (GC1F2).

The grandchildren shared their experiences with more emphasis on the effects of open communication with their grandparents. Furthermore, participants identified grandparents as being valuable in the provision of SRH information because of their previous experiences and knowledge about SR matters.

- **Grandchildren's experiences of SRH family communication contents**

Grandchildren further shared their experiences of SRH family communication content. Several grandchildren acknowledged that grandparents have discussed SR issues with them as revealed by the next quotes:

"Yes, she told me it is not a good thing because when you are at school you can't concentrate and then you end up falling back with your schoolwork" (GC1F2).
"she does she always tells us, if you know yourself that you are sexually active you must take care of yourself… You need to make sure that you prevent" (GC1F5).

"she just tells us that one day we will have our own children and to look out for boys not to deceive us (girls). She was telling us boys are dangerous and we must wait until we finish school and get stable employment…enjoy life…" (GC1F8).

The following quote indicates the way grandchildren should handle GBV without fear. The views of GC1F5 were expressed as follows:

"*let's say am dating someone and he beats me up…I need to make a decision even if I love that person, I got to decide to say maybe you leave that person or you open an assault case*" (GC1F5).

Both girls and boys verbalised that they feel good engaging with grandparents regarding SR related topics, so they understand and make informed decisions. The content was more on the importance of prevention, the importance of education and information about the prevention of GBV. Other topics discussed were the promotion of abstinence, delaying early sexual debut, and promotion of condom use, including the consequences of risky sexual behaviours.

4.6.2 GRANDCHILDREN'S EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

Grandchildren's experiences of factors facilitating SRH communication emerged as the second essential element. Two constituents emerged, namely, Grandchildren's positive experiences of SRH family communication and grandchildren's positive/neutral experiences of SRH information from other sources.

- **Grandchildren's positive experiences of SRH family communication**

Grandchildren indicated their experiences regarding SRH communication which is positive. Several grandchildren shared their positive experiences of SRH communication, as revealed by the succeeding testimonials:

"I feel happy because I get to be open to them and they also get to be open to me and tell me about what is happening around them and in life" (GC1F2).
"Yes, we are able to talk and sometimes it is very difficult, she was not like this before, but she is very open" (GC1F5).
"*She encourages us to be independent and respectable as human beings. She teaches us every single day about challenges that life comes with and prepares us for the future" (GC1F8).*

Contrary to the above, one participant verbalised that she never had a such conversation with either her grandparent or mother as highlighted in the next quotes:

"I haven't had like any conversation with my grandparent or mother" (GC2F8).

Grandchildren appreciate the role played by their grandparents regarding the provision of SRH information. Once empowered, they should be able to make informed decisions and

lead a healthy sexual lifestyle. It was also evident that there is still no open communication between grandchildren and the grandmother which needs to be addressed through the capacitation of parents.

- **Grandchildren's positive/neutral experiences of SRH information from other sources**

Grandchildren further shared their views about positive/neutral experiences that they got from other sources.

"*Usually, women from the Siyaqoba come to our school to teach us about this, how to abstain from sexual activities and everything about sexual health"* (GC1F1).

"she said she doesn't want me to get pregnant whilst am still at school. My mother is taking good care of me so, I must listen to her and not to repeat the same mistake she did" (GC2F1).

"we discuss about a lot… Maybe if you are pregnant, you can take your baby elsewhere if you don't want to have that baby. You must not abort the baby …" (GC1F4).

Most of the participants identified other sources where they can get information easily, e.g., the internet, school, family members and friends, as reflected in the next quotes:

"it means I must go out to seek information from the internet which is easy to access at your own time" (GC1F1).
"Yes, otherwise I rely on the information I get from school, the internet and at times from my friends" (GC1F2).

"I feel comfortable talking with my sisters and my aunt those are the people that I feel comfortable talking to about such topics" (GC1F3).

Grandchildren revealed that there are other sources that they had to explore to increase their knowledge on SRH matters. However, grandchildren acknowledge information received from the Siyanqoba group, the internet, and school, including their peers.

4.6.3 ESSENCE 3: GRANDCHILDREN'S EXPERIENCES OF SRH FAMILY COMMUNICATION BARRIERS

Grandchildren identified several barriers that hinder open SRH communication within the families, namely, emotional barriers, SRH communication barriers between grandparents

and grandchildren, including grandchildren's negative experiences of SRH communication from other sources.

- **Emotional barriers**

Some emotional barriers that hinder open SRH family communication are expressed below:

"I don't feel ok or even feel free talking with my grandmother about this topic because am afraid of her" (GC1F1).

"I don't discuss such topics with my granny because it would mean am disrespecting her so it's best to refrain from asking question" (GC2F1)
"*I feel like she is going to judge me, or she is going to suspect something*" (GC1F4).

Fear and feeling of being judged were revealed by several participants. The abovementioned discussions indicate the variant reasons that grandchildren had which hinders open SRH communication within the family.

- **SRH communication barriers between grandchildren and grandparents**

Some barriers have been identified between grandparents and grandchildren regarding SRH communication**.** Lack of devoting time to discussing SRH issues impedes SRH promotion. Some of the participants perceive open SRH communication as a sign of being disrespectful as depicted by the following quotes from the grandchildren:

"Normally we talk about the bible but when I move from there she usually likes to talk with girls where she'll tell them how to grow up and mature in a good way" (GC3F1).
"I have never tried talking with my grandparents about sexual reproductive health because I feel like it is uncomfortable, and it is somehow disrespectful" (GC1F3).
"yeah, it is awkward, and she doesn't want to discuss it she feels like it is very disrespectful" (GC2F6).

The above statements confirm the challenges faced by both grandchildren and grandmothers regarding SRH communication. Therefore, there must be some actions that are taken to ensure that the challenges are addressed fully.

- **Grandchildren's negative experiences of SRH communication from other sources**

Despite the information that could be retrieved or learned from other sources regarding SRH communication, there were negative experiences that grandchildren identified that hinder open communication on SRH promotion, as depicted in the next quotes:

"*Yes, the Life Orientation teacher doesn't really like talking a lot about it*" (GC1F1)**.**
"Some nurses come to our school and discuss some topics with us, but the information is not enough" (GC2F1).

"mama couldn't tell us on one-on-one like come to you have a talk with you" (GC3F1).

The abovementioned concerns indicate that even though grandchildren are trying to have open communication, there are still barriers that hinder that open communication within the families.

4.6.4 ESSENCE 4: GRANDCHILDREN RECOMMENDATIONS FOR SRH COMMUNICATION PROMOTION

Grandchildren indicated their recommendations for the promotion of SRH communication. Two constituents emerged namely: educational interventions and grandchildren's needs for SRH communication.

- **Educational interventions**

Grandchildren shared their views and recommendations that could be of assistance in SRH promotion within families, as reflected in the next quotes:

"*Maybe programmes that can be introduced to educate us about these topics and how to handle them*" (GC2F1).

"I think we can have programmes for teenagers to discuss about this and let others who don't know about it also come because some don't have information …" (GC1F6)

*"I like to speak with people who have matured enough people who can say things that can benefit me'" (*GC3F1).

Grandchildren recommended the need for the development of programmes for the education of teenagers and engagement with other stakeholders for reinforcement of SRH promotion.

- **Grandchildren's needs for SRH communication.**

Grandchildren's needs for SRH communication needs emerged as the second constituent and are supported by the succeeding quotes:

"Having open communication with granny will assist" (GC1F1).
"Information about menstruation, body changes even though am not sexually active, but I feel I have the right to know" (GC2F1).

“At the end of the day, I feel I do because I feel I need to talk with her she is an elder and she has been there …” (GC1F5).

Contrary to the above, another participant is of the view that they are not supposed to be forced to learn the subject at school since people perceive life differently.

“I still believe that not everyone must be forced to learn the subject since we are different and process information differently” (GC1F8).

The participants confirmed that open communication with grandparents will enhance the provision of knowledge that will assist grandchildren to make informed decisions regarding SRH. The above discussions indicate that teenagers have the right to information, as stipulated in the Batho Pele principles and the ASRHR.

4.7 DISCUSSION OF FIELD NOTES

Field notes were taken to complement the other data collection methods that the researcher followed to prevent the distortion of information and forgetting of important cues. The value of taking field notes was explained to all the participants to allay anxiety to ensure that all participants were relaxed. The researcher was granted permission to take field notes and record audio interviews.

In this study, the researcher captured the participant's expressions and changes in position, including moods, which could not be provided by the voice recorder. The notes were intended to be read as evidence that gives meaning and assistance in the understanding of the phenomenon under study as highlighted below. Field notes consisted of personal, observational and methodological notes; they are discussed accordingly.

4.7.1 Personal notes

Personal notes are comments about the researchers' own feelings in the field (Polit & Beck 2017:522; Botma et al., 2016:218). On the first day of data collection, everything went well and PHC nurses were ready to discuss the topic. Participants adhered to the appointments though a few participants verbalised that the time allocation was too long because they must see clients. The reception was good, the researcher reported at the Facility manager's office and was then accompanied to the venue where interviews were conducted. The staff was welcoming and friendly. Staff had a schedule that was followed until all the participants were done with the interviews. The researcher was very excited about the flow of the conversation with PHC nurses. PHC nurses verbalised that it was their responsibility to

ensure that information is provided to the grandparents and grandchildren, as stipulated by several legislative frameworks.

The researcher had to visit individual families, each participant chose the date and time, based on everyone's availability. Participants were friendly and welcoming. Covid-19 protocols were also adhered to; there was a sanitiser, wearing masks though they were allowed to take them off because there was enough social distancing, and the room was well ventilated. The interviews were mostly conducted in the lounge with minimal disturbances.

In most cases, the grandparent and the grandchild were interviewed on the same day, in some cases, grandparent and grandchildren were not interviewed on the same date due to their commitments. The researcher had to be flexible to ensure that their decisions are respected then appointments were rescheduled. The researcher felt emotionally concerned when participants verbalised that there is no open communication or if communication is there, it is not enough. Although sexual related topics are regarded as being private matters, the researcher deliberately set aside her preconceived ideas about the topic and continued to display a neutral and professional attitude. The researcher listened to the individual participant regarding SRH communication which seemed to be a difficult topic to discuss openly, especially within the families.

4.7.2 Observational notes

These are objective descriptions of observed events and conversations: information about actions and dialogue that could not be captured using the audio recorder. During the interview, some participants were openly showing how they felt about SRH communication. The observational notes assisted the researcher to understand the participant's behaviour, habits and social interaction with their environment. Some participants, especially grandchildren, took some time to provide the necessary answer as they verbalised that it was a difficult question because they do not discuss sexual related topics with their grandparents.

Participants were issued with the interview guide so that they could prepare themselves; this assisted the participants to relax, and they were spontaneous with their responses. However, one of the grandparents requested to withdraw from the interview because she felt uncomfortable discussing sexual reproductive issues citing her cultural and religious beliefs. Her decision was respected, and she was given the researcher's contact number should she change her mind. However, she never called.

There were diverse responses; some participants verbalised that they do not discuss such topics with their grandchildren because they never discussed such topics with their parents. On the other hand, some participants perceived the discussion as a good thing because times have changed, and children need to be informed or given first-hand information by the parents referring to the idiom that says: *"Charity begins at home."*

PHC nurses were very open and willing to provide information based on their daily personal experience as parents and at work as healthcare providers. It was evident that a lot needs to be done to ensure that SRH promotion is enhanced. Most of the participants verbalised that there is a need to capitate the PHCNs so that they can provide an efficient and effective SRH service delivery to their clients.

4.7.3 Methodological notes

Methodological notes are the researcher's notes about the methods that were used during data collection (Polit & Beck 2017:735). The researcher used individual in-depth interviews to capture the participants' lived experiences regarding SRH communication because of the sensitive nature of the topic under discussion. The individual interviews were considered relevant to the process because each participant managed to elicit rich data that was related to SRH communication and its impact on family communication. The researcher is of the view that the use of probes and other communication methods stimulated the participants to provide a wealth of information regarding sexual reproductive communication.

4.8 CONCLUSION

In this chapter, the findings were presented, interpreted and supported by verbatim quotes from the participants. The experiences of PHC nurses, grandparents and grandchildren were explored and suggestions were made, despite the different opinions on the challenges or experiences**.** Field notes were also described. All participants shared the same sentiment regarding open SRH discussions, and it was also evident that all need to be capacitated. Barriers were also identified, and participants had to come up with recommendations to address the challenges that impede open SRH communication. Chapter 5 provides a detailed discussion of findings, literature synthesis and control.

CHAPTER FIVE

DISCUSSION OF FINDINGS, LITERATURE SYNTHESIS AND CONTROL

5.1 INTRODUCTION

Chapter 4 presented and described the findings of the study. The focus was on the essence of Primary Healthcare nurses (PHCNs), grandparents and grandchildren regarding their experiences with sexual reproductive health (SRH) communication. These essences were supported by constituents. Chapter 5 presents the discussion of the findings, literature synthesis and control.

5.2 DISCUSSIONS ON THE DEMOGRAPHICS OF THE PARTICIPANTS

This study consisted of three population groups which are discussed in Chapter 4 (See Tables 4.1, 4.2 & 4.3). The demographics of each population group are discussed in the paragraphs below.

5.2.1 Demographics of PHCNs

The discussion on the profile of the PHC nurses focused on gender, age, and number of years at the PHC facility, including their nursing education training. Twelve (12) PHC nurses participated in the study. There was an uneven balance of distribution of gender as most participants were female. This is in line with the historical background of nursing, as nursing has been portrayed as a feminine profession since the era of Florence Nightingale (Mao, Cheong & Tam, 2021:1; Palma, Oducado & Palma, 2020:203; Kaur, Chinkweta & Langley, 2018:83). In relation to age, the oldest participant was 61 while the youngest was 26 years old. A study conducted in KZN by Tlou and Hlongwane (2021:3) state that younger healthcare providers are more likely to promote SRH services to adolescents freely, as compared to their older colleagues. The number of years in PHC facilities ranged from four to 32 years; this demonstrates that their participants had a reasonable experience to provide information regarding SRH promotion. Hlongwane et al. (2021:3) further indicate that experience in practice has been shown to have an influence on SRH provision including prescribing of contraceptives.

All participants were based at PHC facilities in the Tshwane district and all the interviews were conducted at the facilities where they were based. Another criterion was to have an idea if the PHCNs have children which would also have an impact on how they approach SRH communication in their workplaces. Ten (10) PHCNs had children of their own and two (2) reported not having children.

5.2.2 Demographics of grandparents

The discussion on the profile of the grandparents focused on age, gender, marital status, employment status, educational level, and attrition rate (Refer to Chapter 4 Table 4.2). The demographics of grandparents are discussed below.

Ten (10) families were identified, however, only one family consisted of a grandfather and a grandmother. Two (2) participants withdrew from participating in the study. Most of the participants were females rather than males which is consistent with the findings on the demographics of the PHNCs. Grandmothers emerged as the main gender that care for their grandchildren in the presence or absence of biological parents. There was a deviant distribution about the marital status of the grandparents, some were married, some were widowed, and some were single which provided a balance of all the marital statuses. In relation to age, the oldest participant was 90 with the youngest was 59 years old. This shows the wealth of knowledge the grandparents possess concerning all aspects of life, including SRH.

All participants were residents of the city of Tshwane and all the interviews were conducted at their residential areas which created a relaxed atmosphere for the participants. Most participants were not working but earning an old age grant as a means of income with only one who was self-employed but was in the process of applying for her old age grant. The findings of the study revealed the varied educational backgrounds of the participants. These variations range from a graduate to the least with standard 5. The findings further revealed that all the grandparents possess an educational level that influences SRH communication (Fanta et al., 2016:47).

5.2.3 Demographics of grandchildren

The discussion on the profile of the grandchildren focused on age, gender and educational level, including attrition rate (Refer to Chapter 4 Table 4.3). The demographics of grandchildren are discussed below:

The profile consisted of ten (10) families with a different number of grandchildren who resides in each family. A total of fourteen (14) were recruited to participate in the study and two (2) male participants withdrew from the study. Eight (8) females and four (4) males shared their experiences regarding SRH communication within the families. The age group of grandchildren ranged from 18 years to 22 years, and all were still attending school. All the participants were still attending school from Grade 10 to post-matriculation education. All the

participants were residents of CoT and living with their grandparents in the presence or absence of their biological parents.

5.3 DISCUSSION OF THE ESSENCE, CONSTITUENTS AND LITERATURE SYNTHESIS

The researcher conducted individual phenomenological interviews with PHCs, grandparents and grandchildren who had experience with SRH communication within families. The identified essences and constituents are discussed according to each population group, namely, PHCNs, grandparents and grandchildren.

Literature synthesis was done to enrich the findings of this study. The literature further created a better understanding of the essence and constituents of the study. The findings of the study described and explored the essence of the participants regarding SRH communication to develop guidelines to support grandparent-headed families in the Tshwane district.

5.3.1 DISCUSSION OF PHCNS' ESSENCE AND CONSTITUENTS

5.3.1.1 ESSENCE 1: PHC NURSE'S EXPERIENCES OF SRH COMMUNICATION

The literature synthesis in respect of the essences of the PHCNs experiences of SRH communication are discussed in subsections below:

- **PHCNs' experience of benefits of promotion of SRH communication**

In this study, it was found that PHCN nurses play a pivotal role in the provision of quality care to individual health needs of males and females. These needs include sexual development, STIs including HIV, a variety of contraceptive methods including prevention of pregnancy (Kapoor et al., 2022:2; Sause-Ortega et al., 2021:2; Engelen et al., 2020:192). Maria, Guilamo-Ramos and Villaruel (2017:1) state that nurses care for adolescents on a daily basis in a variety of settings where health education is provided. Primary health care is the first level of contact with clients and PHCNs play a vital role in the provision of a variety of health care at this level (Du et al., 2019:12; Mcallister, 2019:1; Smith et al., 2018; Barbian, Dalla Nora & Schaefer, 2016:2), such as sexual reproductive health care. In support of the SRH promotion, several authors revealed that the engagement of grandparents and grandchildren in SRH-related matters creates awareness of their fundament health (Maria et al., 2017:4; Mataboge, Beukes & Nolte, 2016:68). From the above statements, the findings revealed the role played by PHCNs in SRH service delivery, which is beneficial in the creation of an enabling environment for grandparents and grandchildren. Furthermore, increased access and full utilisation of SRH services is a positive outcome which assists in

accessing the information on contraception, emergency contraception, condom promotion, termination of pregnancy, including the prevention of GBV.

The participants indicated that open SRH communication between grandparents and grandchildren is beneficial to ensure the SR wellbeing of adolescents. This is in line with the WHO's definition of SRH as a state of physical, emotional, mental, and social wellbeing to sexuality (Biswas, 2020:1; De Lacy, 2019:46; Kurebwa, 2017:22; DoH, 2019:7). The same authors further emphasise that PHC nurses should provide an effective and efficient SRH service to the grandparents and grandchildren. To provide such services, PHC nurses need to have knowledge and skills to approach the subject with ease (Osei et al*.,* 2019:2; Maria et al*.,* 2017:6). Several authors have indicated that various aspects of SRH knowledge should be practised by nurses to execute their daily activities, namely, history taking, diagnoses, prescribing of treatment, including health education (Alshahrani, 2020:227; Lloyd, 2018:82; Maria et al., 2017:6).

The participants mentioned that communication is used as a point of reference where topics are based on the participants' own experiences. Several authors revealed that communication is perceived as a vehicle that can be used by parents to instil sexual reproductive health norms and values to teenagers (Bikila et al., 2021:1; Purwanti et al., 2021:2; Harris, Fantasia & Castle, 2018:3; Habte et al., 2017:3). Therefore, Adolescent Reproductive Health can be managed by strengthening SRH communication within families through the involvement and support of PHCNs (Taboon et al., 2018:2). The SRH communication provides information that promotes abstinence and delaying sexual debuts thus allowing individuals to make informed decisions (Bikila et al., 2021:1; Feyissa et al., 2020:416; Vongsavanh, Lan & Sychareun, 2020:1). Several authors share the same sentiments with the PHCNs who posit that open SRH communication within families does not only benefit the adolescent but benefits all the family members in this instance, the grandparents and the community at large (Usonwo, Ahmad & Curtis-Tyler, 2021:2; Mlambo, Silen & McGrath, 2021:1; Osei et al., 2019:1; Kyilleh et al., 2018:2; Fanta et al., 2016:58). In contrast, Hlongwane et al. (2021:5) highlight that studies conducted in SA, Kenya and Zambia revealed that HCPs appear to be comfortable to advise adolescents about abstinence rather than on SRH. In summary, PHCNs perceive open SRH communication as being beneficial for SRH promotion and will add value to the health of the families and the community.

PHCNs, in this study, perceived SRH communication as being beneficial to the reduction or elimination of SRH related problems. These problems, amongst others, include teenage pregnancy, sexually transmitted illnesses (STIs), including HIV/AIDS, unsafe abortions and gender-based violence (GBV). This finding concurs with the study that was conducted in Jordan, where the results show that HCPs must be knowledgeable on SRH related issues to ensure that the SRH needs of adolescents are taken care of (Kapoor et al., 2022:2). The studies by Saus-Ortega et al. (2021:2) and Engelen et al. *(*2020:192) also revealed that the curriculum should be reviewed to ensure that the SRH content covers the basic knowledge that is needed by nurses to ensure that quality SRH care is provided. Hence, Mbachu et al. (2021:6) and Venketsamy and Kinear (2020:11) suggest that the acquired knowledge should assist both adolescents and grandparents to correct any SRH related myths and misconceptions that hinder SRH communication. In summary, PHCNs perceive open SRH communication within families as being beneficial for SRH promotion.

Participants have found that another form of communication that was seen as being effective is parental role modelling which is associated with positive health behaviour as children copy what parents do. PHCNs further indicated that communication is used as a point of reference as charity begins at home. Several authors support the notion as the family is viewed as the primary source of SRH information (Maina et al., 2020:1; Sagnia et al., 2020:6; Devlin, Wright & Fenton, 2018:10; Habte et al., 2017:2). From the above discussion, it is evident that the family is expected to lay a good foundation during the socialisation process to ensure that these grandchildren become good role models for their grandchildren. Therefore, PHCNs must ensure that both grandparents and grandchildren are empowered and supported to enhance open SRH communication within families in the Tshwane district.

The findings of the study revealed that PHCNs specified their obligation in provision of SRH information which is line with Batho pele principles and the SRHR which expects PHCNs to give SRH information to both grandparents and grandchildren. The same understanding has been argued by the participants in the study on Sexual Health Communication between HCPs and adolescents in the West (Engelen et al., 2020:192). In addition, these findings are in line with the SRH rights which are enshrined in section 27 of the Constitution of RSA (Constitution of Republic OF South Africa, 1996:1247). These rights address the provision of essential health services, and the prevention of STIs, including HIV/AIDS (McGranahan et al., 2021:1; Brown et al., 2019:326).

- **PHCNs' experiences of SRH family communication**

Participants alluded that grandparent, as guardians or parents, are perceived as health promoters who are expected to instil good SRH norms and values during the socialisation of adolescents (teenagers). Nmadu et al. (2019:6) mention that family norms influence an individual's behaviour. Other authors view open SRH communication as a cornerstone of a healthy family lifestyle. SRH communication is a health promotion strategy that enhances healthy lifestyle standards (Feyisa et al., 2020:416; Maina, Ushie & Kaburi, 2020:2; Motsomi et al., 2016:1). The findings of this study reveal that despite the challenges experienced by both grandparents and grandchildren regarding SRH communication, PHCNs still encourage open SRH communication within families. The PHCNs in the current study believe that open SRH communication will yield a positive impact on the prevention and reduction of SR related problems in the Tshwane district.

PHCNs indicated that at times, grandparents are not ready to engage in sex talks with their grandchildren. A study on the role played by parents and culture revealed that cultural beliefs and practices regard sex talks as inappropriate and impermissible (Mpondo et al., 2018:47). This is not out of the ordinary as in African cultures, it is common not to openly discuss sexually related topics with children (Biswas, 2020:1; Najafi-Sharjabad & Haghighatjoo, 2019:10542; Kusheta et al., 2019:2; Newton-Levinson et al., 2016:9). Sex talk is part of communicating SRH issues, and it means that the grandparents should openly discuss SRHs with their grandchildren.

It was established that the grandparents in this study try to communicate SRH issues through idioms and riddles, which results in miscommunication. Lack of appropriate or proper words in the language/s might be the reason for the grandparents' use of idiomatic and riddled expressions. The grandchildren may struggle to understand the meaning and interpretation of those idiomatic and riddled expressions. Therefore, cultural beliefs, amongst other religious beliefs, are some of the reasons that open communication between adults and the children are non-existent. Moreover, the PHCNs, as adults and parents, suggested a need for a non-judgemental, approachable attitude that enhances open SRH communication within families.

From the above discussion, the researcher concurs with the findings where it is deduced that the creation of an enabling environment will boost open SRH communication within families.

5.3.1.2 ESSENCE 2: PHC NURSES' EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

The findings of the current study revealed factors such as grandchildren's SRH knowledge derived from other sources, PHCNs' competency and PHCNs' collaboration with referral to other stakeholders as additional role players towards SRH promotion. These factors were found to assist in facilitating SRH communication. The following discussion of the essence and constituents is also supported by the literature.

- **Grandchildren's SRH knowledge from other sources**

The findings of the study revealed that grandchildren receive SRH information from other sources, such as the school, radio, television and social media, including their peers. In agreement, Deshmukh and Chaniana (2020:61) show that most young people use the media to educate themselves on the issues of SRH. In addition, the study conducted in the Gambia identified the radio, Google and web-based channels as platforms which the young people use to learn openly about SRH (Sagnia et al., 2020:6). The finding shows that social media has created a platform where young people can easily find access to SRH related information. Several authors applaud the use of social media platforms as innovative ways of disseminating SRH information (Tauty et al., 2022:2; Martin et al., 2020:2; Najafi-Sharjabad & Haghighatjoo 2019:10547). In contrast, several studies still acknowledge parents as the key source of SRH information for adolescents (Maina et al., 2020:1; Agudile et al., 2020:47; Othman et al., 2020:3; Neme & Dereje 2020:1; Nilsson et al., 2020:2).

Literature on SRH communication reveals that parents can adopt the role of SRH educator if they are provided with the necessary support (Vongsavanh et al., 2020:1; Seif, Kohi & Moshiro 2019:11; Kusheta et al., 2019:2). Intersectional collaboration of all the stakeholders who have the best interest of the grandchildren regarding SRH communication is required in the strengthening of SRH service provision within Tshwane district. PHCNs posit that regardless of the information that the grandchildren receive from other sources, reinforcement of positive SRH values through open communication at home is paramount. Thus, the combination can work better, in which the adult family members should be present when the children are learning from the media, such as radio, TV and online, to guide and coach them.

In SA, young people learn SRH from health facilities, parents, peers, movies, TV, and social media (Motsomi et al., 2016:3). Formal education and Initiation schools were found to be another source of SRH communication. For example, in the study conducted in Malawi,

initiation schools were listed as a source of SRH communication, in which traditional expectations and sexual expectations are taught to the initiates (Nash et al., 2019:3). The formal education (western) was also identified as a source of SRH communication by the study on adolescent-parent communication on sexual and reproductive health issues among secondary school students, in Gambia (Sagnia et al., 2020:6). This is also supported by a study conducted in Tshwane district by Dibakwane and Peu (2018:7) which reveals the importance of an Integrated School Health Policy (ISHP) which must be included as a package in SRH promotion within schools.

Reproductive health education is perceived as a cost-effective means of addressing SRH matters and has been shown to have an impact on the reduction of risky sexual behaviours (Joseph et al., 2021:1; Beech & Sayer 2018:296). The DoH, through the implementation of school health services, assists in the provision of preventative, promotive and rehabilitative services through early screening, treatment and referral of school-going children when the need arises (DoH 2012;17). The development of the SRH communication guidelines in CoT will assist PHCNs to support grandparent-headed families regarding SRH.

- **PHC nurses' competency**

It was revealed in this study that PHCNs are not competent with the technical skills, knowledge and attitudes to sufficiently facilitate SRH communication. In view of the findings, there is a need for competent PHCNs to manage SRH related problems. Lukewich et al. (2020:1078) reiterate that competent PHCNs are needed to provide care and collaborate with other stakeholders to address pressing health related issues. PHCNs play an integral role in the prevention of diseases and the promotion of health. SA, like any other Sub-Saharan country, is faced with the quadruple burden of disease, including other SRH related challenges that need competent PHCNs. There is a need for knowledgeable PHCNs who are prepared to address and execute their duties diligently to ensure that both grandparents and grandchildren are involved in SRH communication.

The South African Nursing Council (SANC) education and training guidelines for postgraduate programmes define competence as the ability of the practitioner to integrate the professional attributes including knowledge, skills, judgement, values, and beliefs to perform as a specialist in all practice settings which include the PHC settings (SANC, 2020:5). This means that PHCNs are expected to facilitate advocacy and provide support regarding SRH promotion to the clients, families and the community. Some participants revealed that the acquired Community Nursing Science and Primary Health Care

qualification assisted them to deal with SRH topics which are regarded as being hard to handle. Therefore, competent PHCNs are essential for the provision of quality SRH guidance to individuals, families, and the community (Basar et al., 2021:470; Sari et al., 2021:1090; Osei et al., 2019:2). These PHCNs must have the knowledge and skills to render SRH service to all users. This is affirmed by a study by Donna, Maria and Pleson (2021:6) where it is argued that technical skills, knowledge, and the positive attitude of nurses are required for the promotion of effective and efficient SRH provision. Several authors also cited PHCNs as key frontline healthcare professionals in the provision of quality health care, including SRH (Sari et al., 2021:1088; Osei et al., 2019:1; Smith et al., 2018:848). There is a need for knowledgeable PHCNs who will ensure the realisation of Sustainable goal No 3 (SDG 3).

Some of the PHCNs indicated that SRH was a difficult topic to deal with because of its sensitive nature. Several studies concur with the findings that nurses are also faced with challenges that impede SRH provision in PHC facilities (Aling, Lindgren & Okenwa-Emegwa 2021:254; Engelen et al., 2020:191; Jonas et al., 2018:1). The findings further revealed that although nurses interact with clients daily, some still feel that there is a need for further training on SRH. Several studies reveal that nurses are experiencing challenges with SRH provision which exacerbates the SRH knowledge deficit (Gausman et al., 2021:9, Jonas et al., 2018:2). As such, PHCNs have acquired knowledge that enables them to overcome the difficulties encountered during SRH service delivery (Afrizal et al., 2019:2; Javadnoori et al., 2016:606). The PHCNs are expected to provide the first level of care, as stipulated in the Alma Ata declaration (Sari et al., 2021:1090; Du et al., 2019:2; Smith et al., 2018;848). Therefore, PHCNs are expected to address all the health needs of the grandparents and grandchildren to promote SRH within families in the Tshwane district.

On the other hand, some of the PHCNs in this study verbalised that they felt privileged to work with young people as that has made it easier for them to understand the youths that visit the PHC facilities needing information and other services. The provision of a youth-friendly service that is managed by youth-friendly staff members is beneficial to SRH promotion. PHCNs are valuable sources of information to students (adolescents), teachers and grandparents because of the knowledge they possess.

The findings of the study indicated that PHCNs are content about the service that they render to clients which reflects their dedication and passion for SRH promotion. PHCNs stated that workshops and in-service training play a vital role in ensuring that they are equipped with current SRH knowledge. Current knowledge includes new contraceptive

methods, SRH related legislative frameworks and strategies to deal with GBV. Several authors have indicated that the health and education sectors should work together to enhance quality SRH promotion (Basar et al., 2021:470, Mbachu, Agu & Onwujekwe 2020: 95). Joining hands on SRH related issues will assist in the promotion of SRH, thus reducing health-related risks which may be exacerbated by lack of SRH knowledge. Intersectoral collaboration is another strategy that can be used to improve SRH provision. Therefore, the introduction of Continuous Professional Development (CPD) will assist to keep PHCNs updated on health-related matters, including SRH promotion services.

- **PHC nurses' collaboration and referrals to other stakeholders**

The PHCNs in the current study experienced collaborative efforts in addressing the SRH related issues. The efforts were evidenced by referral to other sectors, namely, social workers, police, etc., which play a very important role in addressing sexual related challenges and ensuring that health outcomes are achieved. In confirmation, the study by Okeyo, Lehmann and Schreider (2020:2) reveals that the crucial role of fostering collaborative learning and open communication is through engagement processes which lead to the formulation of common goals. In this study, the researcher perceives collaboration as a continuity of care through proper referral systems, and this is in line with the norms and standards for implementation of the Youth Friendly Services (YFS). The quality of teamwork is associated with the provision of quality SRH care, including the safety of the healthcare users (Rosen et al., 2018:3). In addition, Unis, Nilsson and Bjuresafer (2021:2) confirm that interprofessional collaboration is beneficial for promoting SRH. The same authors reveal that professional experience challenges due to the complexity of the collaboration and increased workload.

In this study, PHCNs acknowledged that an appropriate referral system can improve the relationship between primary healthcare providers and secondary healthcare specialists. According to the participants, the referral is viewed as a process whereby a healthcare worker refers clients to another level of the health system or another healthcare worker with expertise (Give et al., 2019:6).

Little is known about the engagement of grandparents and grandchildren in trying to resolve some of the SRH related challenges. Further collaboration is needed with parents, including other sectors that have an interest in SRH provision to join hands and support SRH provision to support the adolescents towards SR related problems. However, there are conflicting laws that impede SRH provision, e.g., the Termination of Pregnancy Act (TOP Act). The grandparents who perceive TOP as a sin would not allow their grandchildren to go through

the procedure thus infringing on the SRHR of the adolescent. The participants further indicated that the age of consent to termination of pregnancy where parents' permission is not required is another factor. This factor is not well accepted by most grandparents who perceive their grandchildren as young and are supposed to concentrate on their education, rather than engaging in sexual activities. Adolescents and grandparents must engage in such issues to raise awareness and enrich the knowledge regarding SRH provision. Adolescents must understand their rights and responsibilities to ensure that they make informed decisions. On the other hand, grandparents must be made aware of laws.

5.3.1.3 ESSENCE 3: PHCNs EXPERIENCES OF SRH COMMUNICATION BARRIERS

The findings of the current study revealed some barriers that were experienced by PHCNs regarding SRH communication, namely, family related and health care related barriers which are discussed below. Essences and constituents of PHCNs experiences of SRH communication barriers are highlighted in Table 5.3 below.

- **Family related barriers**

PHCNs participants revealed several family-related barriers that hinder open SRH communication within the grandparent-headed families. These are emotional-related barriers, cultural-related barriers, religious-related barriers, including barriers between grandparents and grandchildren. The barriers are discussed below.

  - *Emotional related barrier*

PHCNs participants expressed fear as the main barrier to SRH communication within families. This emanates from the cultural and religious beliefs that exist in various societies where sexual talks are not encouraged. The researcher concurs with the findings because fear has a negative impact on SRH communication. After all, adolescents are unable to share their challenges with their grandparents. The participants revealed that children feel ashamed to initiate sexual related topics with their parents. This was confirmed in the study conducted in Iran regarding barriers of youth accessing Sexual Reproductive Health Information and Services (Najafi-Sharjabad & Haghighatjoo, 2019:10545). On the contrary, PHCNs indicated that grandparents, as the sole guardians of their grandchildren, are expected to guide their grandchildren through open discussions about SRH related issues.

The findings of the study further revealed that grandchildren fear talking with their grandparents who may perceive them as being promiscuous or disrespectful. Therefore, grandchildren resort to sneaking out without being seen by their grandparents. However, Yibrehu and Mbwele (2020:3) posit that open and respectful SRH communication among

grandparents and grandchildren is an effective strategy to address SRH concerns within families. On the same note, PHCNs revealed that grandchildren were observed not to be responding positively to SR related questions in the presence of grandparents, hence the individual face-to-face interviews with grandchildren to communicate freely without any hindrances. Grandparents were requested to wait in the waiting area affording the grandchildren privacy to discuss their challenges with the PHCNs. Despite the steps taken by PHCNs to ensure that grandchildren are offered privacy, most grandchildren still perceive PHCNs as their elders.

PHCNs affirmed that adolescents are faced with physiological challenges, and they are unable to talk with their grandparents, thus resorting to being dishonest. The findings revealed that fear is the main barrier to SRH communication. Several authors have indicated that the family is expected to instil SRH related norms and values in their children as part of their socialisation to grow into responsible adults but there are emotional-related barriers that hinder open SRH communication (Agudile et al., 2020:37; Neme & Dereje 2020:15; Ahari et al., 2020:1; Bireda & Pillay, 2019:109).

Fear of being scolded by nurses in clinics emerged as another factor that hinders SRH communication. The negative attitude of PHCNs leads to poor access and utilisation of SRH services within PHC facilities. The same sentiments were shared in a study that was conducted by Jonas et al. (2018:2). In addition, Kwame and Petrucka (2020:1) reveal that poor communication among nurses can be detrimental to the quality of care, nursing practices and safety, which suggests that communication competence should be a required skill in the nursing profession, especially to enhance or promote SRH communication within families. Based on the above discussion, more research needs to be conducted to interrogate the impact of fear originating from nurses' behaviour on SRH communication within families.

- *Cultural related barriers*

The findings of the study revealed that culture and cultural beliefs are inhibitors of open SRH communication within families. The participants revealed that sexual talks are still regarded as a taboo which has a negative impact on the management of SRH related problems. Culture plays a significant role in influencing sexual reproductive health because of the socialisation process that adolescents undergo where some behaviours are seen as culturally unacceptable, such having multiple sexual partners (Achen et al., 2021:2; Nmadu et al., 2020:2; Kinaro et al., 2019:3). Several authors have revealed that due to cultural

barriers, sexual reproductive discussions are still prohibited, and such talks are regarded as a taboo or private matters that are sacred for married people (Nmadu et al., 2020:2; Yibrehu & Mbwele 2020:6; Landa & Fushai 2018:2: Motsomi et al., 2016:4). Some participants revealed that regardless of open communication being advocated for the reduction of sexual related problems, some parents are of the view that open talks result in adolescents practicing what was discussed (Simmonds et al., 2021:1; Sagnia, Gharoro & Isara, 2020:2). On the contrary, several studies have revealed that open SRH promotion leads to abstinence and delay in sexual activities (Wudineh et al., 2021:2; Osonwu et al., 2021:1; Maina et al., 2020:11; Mbachu et al., 2020:2).

The findings of this study revealed that despite the role played by culture in the prevention of sex talks, there is still a need to have open SRH communication between grandparents and grandchildren. Furthermore, the researcher is of the view that the lack of age-appropriate language needs to be investigated, i.e., comfortable language has to be developed and used to promote open and non-complicated conversations within families (Maina et al., 2020:2; Motsomi et al., 2016:2). The researcher is of the view that awareness creation on SRH matters will assist both grandparents and grandchildren to have open SRH dialogues. PHCNs further indicated that in the past, initiation schools were used as institutions where people were taught about the transition into manhood and womanhood, unfortunately the discussions are regarded as confidential matters.

- *Religious related barriers*

PHCN participants revealed that grandparents adhered to their religious beliefs which are regarded as moral builders where sex before marriage is discouraged and include the prohibition of TOP. The findings of the study revealed diverse perceptions about religion being a moral builder and inhibitor as sexual discussions are limited to adults only. Religious belief and practices guide parents on what should be discussed with the children and as such, SRH, because of sexual related topics, is intended for married people (Motsomi et al., 2016:4).

Religion emerged as another barrier that impedes SRH promotion, as revealed by some PHCNs who alleged that most grandparents do not believe in termination of pregnancy. Reference is made to several scriptures in the bible whereby termination of pregnancy is perceived as a sin (Exodus 20:13; Psalm 139:1; Ecclesiastes 11:5). Believers may perceive TOP as a disgrace without taking into consideration the adverse effects of the pregnancy and the wellbeing of both the mother (an adolescent) and the baby. However, this will be in contravention of the rights of an individual who may have been sexually assaulted and

needs a termination of pregnancy (TOP). This may increase the rate of backstreet abortions which may be detrimental to the health of the adolescent.

The researcher is of the view that grandparents and grandchildren must be made aware of the different legislative frameworks that have been promulgated to resolve some of the SRH related challenges or problems. The acquired knowledge will assist the grandparents to support their grandchildren, thus encouraging the utilisation of SRH services in the Tshwane District. In addition, failure to provide SRH information leads to sexual reproductive challenges, namely, teenage pregnancy, STIs including HIV/AIDS which occur due to risky sexual behaviours (Alomair et al., 2020:1; Keto, Tilahun & Mamo 2020:2; Alimoradi et al., 2016:3).

The Ministry of Basic Education has identified the religious sector as one of the stakeholders to be consulted when the implementation of Comprehensive Sexuality Education (CSE) is revisited, considering the increase in teenage pregnancies that emerged during the pandemic (SANC 1; 31.08.202). The minister reflected on her concern about the impact of teenage pregnancy on school-going children which perpetuates poverty and disrupts the development of young people. The researcher concurs with the concerns raised and supports collaborative efforts taken by another department in the promotion of SRH. Joining hands with other sectors in resolving SRH health related issues will yield positive health-related outcomes.

- *Barriers between grandparents and grandchildren*

It was revealed in this study that there is no communication between grandparents and grandchildren due to the lack of an easy language that can be used for SRH communication due to the sensitivity of the topics and the lack of adequate SRH knowledge. PHCNs further indicated that some grandparents have the knowledge, but they do not know how to approach the topic and thus resort to the use of idiomatic expressions or ambiguous language to engage in SR talks with their grandchildren (Mbachu et al., 2020:9; Motsomi et al., 2016:7). These idiomatic expressions pose a problem because they are not well understood by the grandchildren. Several authors indicated that idiomatic expressions are used as a way of enhancing SRH communication with adolescents (Seif et al., 2019:2; Mpondo et al., 2018:43). The use of idiomatic expressions is a confirmation that SRH related topics are not easy to deal with. Therefore, there is a need for age-appropriate language that can be used to enable open SRH communication between grandparents and grandchildren.

The participants revealed that fear and lack of trust were acknowledged as barriers to open SRH communication between grandparents and grandchildren. It became evident that fear deters grandchildren from asking clarity-seeking questions on matters related to SRH. The findings further revealed that other positive practices distinguish religion as a moral builder, namely, delaying sexual debut or promoting abstinence. However, even though abstinence is promoted, adolescents still need to be provided with information on SRH.

- **Health care system related barriers**

Several health care related barriers that impede SRH communication were identified. The negative attitudes of nurses, shortage of staff, inadequate time allocation and gender inequality play a crucial role in effective SRH service delivery in health facilities. The abovementioned health care system related barriers that were observed by the PHCNs are discussed below.

  - *The attitude of staff members*

Some of the participants confirmed that there are PHCNs who are still judgemental towards adolescents who seeks SRH related services which result in fear to utilise PHC facilities or to seek treatment for SRH related illnesses (Abuosi & Anaba, 2019:203). Several studies have revealed that the attitude of nurses plays a critical role in the failure to access or utilised SRH care services (Gausman et al., 2021:2; Robert et al., 2020:428; Javadnoori et al., 2016:607). The researcher is of the view that continuous awareness must be instituted so that PHCNs are well-informed about their attitudes towards SRH provision. The findings of a study conducted in Egypt reveal that the attitude of nurses is associated with a lack of knowledge where nurses fail to provide the required SRH related information (AbdoRabo, Hassan, SalamBelal & Manal Abdalla Gaheen, 2019:18). However, the study further indicates that not all PHCNs are negative towards SRH promotion; there are those who are willing and working hard to provide a non-judgemental SRH service to adolescents. In addition, Nmadu, Mohamed and Usman (2019:7); Jonas et al. (2018:2) mentioned that the creation of an unfavourable environment is informed by the PHCNs' experiences and values which are inherited from their cultural beliefs, religious beliefs and their experience as parents. There is a consensus that PHCNs should create an enabling environment that is youth friendly to improve access to and full utilisation of the SRH services. As a result, Osei et al. (2019:1) and Habte et al. (2017:14) noted that PHCNs' provision of quality SRH services plays a pivotal role in strengthening the capacity of the entire health care system. From the above discussion, it is evident that the negative attitudes of staff members

contribute to poor utilisation of SRH services which exacerbates SRH problems, e.g., risky sexual behaviours which contribute to STIs, teenage pregnancy and unsafe abortions.

- *Shortage of staff*

PHCNS participants revealed that enough staff is needed to ensure that SRH information is enhanced. PHCNs, in this study, experience shortages of staff who can provide SRH. They indicated that a shortage of staff contributes to the failure to provide quality health care to clients and non-utilisation of SRH services. According to the IHSP, the school health team should be led by a professional nurse responsible for the co-ordination and implementation of the school health service. However, in addressing staff shortages, the PHCNs stationed at healthcare facilities should assist in delivering services, including SHR promotion to the school going children (Mutshutshi and Munyai 2022:2;Sidamo et al 2021:4883).

The shortages of staff impact on SRH provision as less time is allocated or given to clients. Staff shortages have a negative impact on universal coverage and denies clients their constitutional right of access to services, including SRH. This is evidenced in non-compliance which infringe on the sexual reproductive rights of the adolescents and perpetuate sexual related problems. Shortage of staff means that PHCNs fail to provide grandparents and grandchildren with appropriate SRH information. A 2016 study by Mataboge, Beukes and Nolte on the experiences of clients and HCPs regarding the provision of reproductive health services in the Tshwane district reveal that the South African Human Resources for Health Strategy for the Health Sector has confirmed growth numbers of since 2002. However, the shortages still exists when linking demand versus population growth.

- *Inadequate time allocation*

The PHCNs highlighted that lack of time or insufficient time allocation is a factor that impedes SRH promotion to adolescents as not enough time is allocated to addressing their concerns and/or problems. In confirming this, Jonas et al. (2018:1) agree that nurses are faced with challenges such as clinic operating hours. A study conducted in Ghana by Abuosi and Anaba (2019:201) indicate that inconvenient operating hours contribute to poor or non-utilisation of PHC facilities where school-going adolescents could be getting SRH information. Ward based teams were also recommended to assist with the promotion of SRH promotion within families. According to clinic programmes, health education is given in the morning when school-going children are at school which needs to be investigated or reviewed. Some of the PHCNs revealed that the school-going children visit the clinic in the afternoon and as such, little time is given to health education, as per the clinic programmes.

- *Gender inequality*

The findings of the study revealed that even though SRH promotion is initiated, the focus is on the girl rather than the boy child. Several studies have revealed that girls are more vulnerable to SRH problems, however, there is a need to investigate the issue of boys who are partners to these girls (Ferguson, Mathur & Armstrong, 2021:1; Pourkazem et al., 2020:2; Galappththi-Arachchige et al., 2018:1). A study conducted in Ghana by Yibrehu and Mbwele (2020:7) asserts that SRH issues are being shared by girls rather than boys. This is a serious concern as boys are excluded from all the SRH related interventions and this creates a challenge of gender inequality. Participants in this study, also revealed that there is more concentration on the girl child than the boy child which has an impact on resolving some of the SRH related problems or challenges. The study conducted in Tshwane by Shabani and Tshitangano (2019:3) confirm that most studies on SRH focus on girls. The same authors state that there are no SRH services that are designed for boys, and this is a concern because adolescent boys also experience SRH problems.

A study conducted in SA by Khuzwayo, Douglas and Mchunu (2020:2) confirms that for several decades, sexual and reproductive health services have ignored boys and put more emphasis on reactionary responses to address SRH related problems, as such, have targeted girls and young women. The same authors reiterate that most males capitalised on masculinity, thus engage in risky sexual activity. Shabani (2020:85) reveals that male involvement in SRH issues is poor, compared to their female counterparts which has a negative impact on SRH decision making. This is further influenced by cultural norms and values that boys learn from their parents and society.

- *Lack of privacy and stigma*

The participants in this study highlighted that lack of privacy and stigma hinders quality SRH provision for both grandparents and grandchildren. Stigma and discrimination are perceived as interrelated concepts that depict unfair or unequal treatment which has a negative impact on the provision of sexual reproductive health (Hussein and Ferguson 2019:12; Stangl et al., 2019:2). Mohammadi et al. (2016:1) perceive stigma as a mark or sign of disgrace which usually elicits negative attitudes to individuals, thus exacerbating the non-utilisation of SRH services.

5.3.1.4 ESSENCE 4: PHCNs' RECOMMENDATIONS FOR SRH COMMUNICATION PROMOTION

PHCNs came up with recommendations that could assist in improving SRH promotion within families. The recommendations which emerged from the analysed data are capacitation of PHCNs, capacitation of grandparents, PHCNs facilitation of open and applicable SRH communication, PHCNs facilitation of SRH education group interventions and stakeholder collaboration. Essence 4 of PHCNs experiences and its constituents are depicted below.

- **Capacitation of PHCNs**

The findings of the study revealed the importance of providing SRH related information in the language that the clients understand. PHCNs are regarded as the main role players in SRH provision because of their experience, knowledge, the desire to give appropriate and relevant health education to both grandchildren and grandparents. The SRH information incorporates different contraceptive methods, and the prevention of the spread of STIs, including HIV/AIDS, and to encourage abstinence to those who are not yet sexually active.

The literature shows that there is an increase in the rate of sexual and reproductive health (SRH) issues among young people in Sub-Saharan Africa (Ahinkorah et al., 2021:2; Odo et al., 2018:2; Yakubu and Salisu 2018:2; Kassa et al., 2018:2). The increase in teenage pregnancies suggests the need for adequate attention to be paid towards adolescents' sexual and reproductive health knowledge and PHCNs who are prepared to provide SRH knowledge.

PHCNs acknowledge that there are competent nurse practitioners, however, more needs to be done to capacitate the PHCNs in rendering quality SRH care. The researcher agrees that more competent and well-trained PHCNs are needed to maintain the required standard of nursing to ensure that both grandparents' and grandchildren's health needs are addressed. PHCNs must be well informed so that they can provide SRH information to all clients. AbdoRabo, Hassan, SalamBelal & ManalAbdallaGaheen (2019:12) emphasise that nurses need to possess deep knowledge and a high level of sensitivity when dealing with sexual related issues. The researcher specified that due to the sensitive nature of the subject, PHCNs should always ensure that confidentiality is maintained to encourage full utilisation of SRH services.

The findings further revealed that more attentions should be given to the curriculum developers to ensure that SRH modules are included, facilitated, and practiced.

- **Capacitation of grandparents and grandchildren**

PHCNs participants revealed that there is a need to empower both grandparents and grandchildren to promote SRH within families. PHCNs indicated that not all grandparents are well informed about SR related issues, but they are willing to teach or instil SR related norms and values in their grandchildren. The researcher is adamant that PHCNs should provide information to both grandparents and grandchildren, as stipulated in Batho-Pele principles and the patients' rights charter. The Batho-Pele principles advocate for clients' right to information regarding including other principles like redress, courtesy, value for money, openness, and transparency on health-related issues (Mataboge, Beukes Nolte and 2016:1).These principles address the right to SRH information, SRH services and consultation which are enshrined in the Constitution of the Reproductive of South Africa . The DoH, through the implementation of the Patients' Rights charter was geared to protect and promote the health standards for the people of SA.

PHCNs identified several strategies that could be employed to enhance the empowerment of grandchildren. The strategies include individual health education and awareness campaigns. Over and above that, PHCNs affirmed that the educational level of grandparents plays a crucial role in SRH promotion. The participants indicated that children who discuss SRH related issues with their grandparents tend to delay sexual activities. This is supported by the findings of Ram, Andajani and Mohammadnezhad (2020:2) and Ojebuyi et al. (2019:3) which reveal that there is delayed sexual activity in adolescents who are informed. They indicate that informed adolescents tend to make informed decisions regarding their sexual reproductive health issues.

Finally, the participants revealed that grandchildren must be approached with respect and their SRHR must be understood so that appropriate information can be provided for them to make informed decisions. The participants further attested that the empowerment of both grandparents and grandchildren will be beneficial in strengthening SRH knowledge and creating an enabling environment that is suitable to both parties.

- **PHCNs facilitation of open and applicable SRH communication**

PHCNs are required to facilitate SRH communication through engagement with all the role players so that SRH awareness is created within families and communities (Ramalepa 2023:1). For the PHCNs to facilitate open and applicable SRH communication, the educational level of the grandparents must also be taken into consideration. Therefore, grandparents need to be supported and equipped with information that will encourage open

dialogue between grandparents and grandchildren. PHCNs also indicated their willingness to assist the grandparents to ensure that the topics are approached and delivered with ease. All cultural barriers must be addressed to eradicate myths and misconceptions.

- **PHCNs facilitation of SRH educational group interventions**

The findings of the study revealed several interventions that could be employed to facilitate SRH education. The interventions include health education, youth clubs and support groups, including peers. These interventions are regarded as beneficial to the dissemination of SRH information which assists with the provision of health promotion information.

From what was said, the first source of information is peers and plays a crucial role in SRH promotion and the benefits are to enhance the knowledge, attitude and skills of adolescents (Akuiyibo, Anyanti & Anosike, 2021:2; Ozaydin et al., 2020:81). The authors indicate that this is since peers tend to imitate behaviours of role models, they also feel free to share sensitive information with each other. This is consistent with findings of several studies that acknowledge that peer education has proven to be an effective strategy of SRH promotion (Akuiyibo et al., 2021:2; Yibrehu & Mbwele, 2020:6; Chepkoech et al., 2019:20; Chane & Cherrie, 2018:412). On the other hand, peers may be viewed as having insufficient or misleading SRH information which can predispose grandchildren to risky behaviours (Govender, Naidoo & Taylor, 2019:14). Several studies have shown that youth clubs and support groups can manage sensitive topics which address SRH related issues with ease and further foster self-esteem (Duly et al., 2021:135; Meherali et al., 2021:364). Teenagers tend to be relaxed and learn more by viewing videos showing real life situations and these should be coupled with youth clubs' meetings where clarifications are provided (Chirwa-Kambole et al., 2020:2). Participants of the current study identified the need to facilitate educational strategies to create awareness regarding SRH promotion. The researcher acknowledges that PHCNs play a crucial role in raising awareness due to the knowledge they possess regarding health-related issues, including SRH.

- **Stakeholder collaboration**

The findings of the study identified several stakeholders who play an important role in SRH promotion, namely youth groups, Ward based outreached teams, SRH promotion and teachers. All the role players in SRH promotion must join hands to ensure that the provision of SRH is sustained. Close collaboration between the DoH, DBE and the Department of Social Development (DSD) has been identified as stakeholders that assist in the promotion of SRH promotion (Thongmixay et al., 2019:2).

The findings of the current study concur with Maina et al. (2020:12) and indicate that access to SRH information must be consistent and co-ordinated at all levels. In support of the abovementioned statements, Govender et al. (2019:14) further highlight that universal access to SRH, echoed in SDG3, can be achieved through collaborative efforts among stakeholders. The participants further identified a multidisciplinary approach, as stipulated in the ISHP identified, namely, community participation, learner participation, PHC facility level, including school level, as depicted below:

- *Community participation*

The study revealed that grandparents and grandchildren, as community members, should take an active role in matters that affect their well-being. The ISHP (2012:23) indicated that community participation through all the structures can assist in health promotion and dissemination of information that is beneficial to the health and well-being of school-going children. The grandparents might gain more knowledge through their active involvement and participation in SRH matters with other community members (Zuma et al., 2020:1068). The above discussion confirms the aims and objectives of this study where communication guidelines should be developed to support grandparent-headed families within the Tshwane district. This can be further enhanced through the active involvement of School Governing Bodies (SGBs), faith-based organisations, and traditional leaders within the communities.

- *Learner participation*

The ISHP (2012:16) further highlights that learner participation is encouraged to ensure that grandchildren contribute towards SRH promotion with better understanding. Understanding SRH better may assist young people to make informed decisions with regards to matters that affect their health (Leekuan et al 2022:2). The findings of this study revealed that a multidisciplinary approach is crucial to strengthen SRH promotion. These efforts may assist in the reduction of SRH related challenges and further encourage adolescents to be able to engage openly with both PHCNs and grandparents.

- *PHC level*

PHC facilities play a vital role in the provision of SRH provision to both grandparents and grandchildren. The school health nurses visiting respective school should refer young people when the need arise to ensure continuity of care (DoH, 2012:18). However, these services were affected by the Covid 19 pandemic which resulted in the closure of schools (DoH Annual Report, 2020/2021). It is, therefore, necessary to resuscitate the services, and plan on how to offer this service beyond the COVID-19 pandemic.

- *School*

PHCNs affirmed that LO plays a pivotal role in the provision of SR information to school-going children. Participants suggested that LO must commence in Grade 7 because of its impact in the reduction of risky behaviours. Some participants indicated that SRH should start at primary school during LO and Life skills, where grandchildren will be conscientious about their body changes. Govender et al. (2019:14) support the inclusion of LO and Life skills in the school syllabus as a strategy that assists in the reduction of risky sexual behaviours. Moreover, teachers are the main role players in the delivery of SRH promotion or sex education in schools (Ocran, 2021:154; Govender et al., 2019:15). The same authors are however, concerned about the challenges that the teachers face in the delivery of sex education because of socio-cultural norms that oppose sex education programmes.

In this study, PHCNs indicated that LO assists the grandchildren to acquire SRH knowledge. This was confirmed by several authors who indicated that the DBE incorporated LO in the school curriculum as a form of foundation for SRH promotion (Venketsamy & Kinear, 2020:2; Grossman, Jenkins & Richer, 2018:1; ISHP 2012:17). Literature expresses that LO, as a holistic study of the self, the self in the society, should assist students to make informed, morally responsible, and accountable decisions about their health-related matters (Mturi & Bechuke, 2019:136; Ngabaza, Shefer & Maclean, 2016:71). In this instance, teachers should spearhead the subject which most parents fail to address at home (Ramalepa, Ramukumba & Masala-Chokwe, 2021:1; Deshmukh & Chaniana, 2020: 61). However, Joseph et al. (2021:2) are concerned that some teachers are not comfortable with the subject matter because they are also parents to the students. This creates a dilemma that influences the delivery of content or information on SRH (Ocran, 2021:154; Joseph et al., 2021:7; Zulu et al., 2019:8). Therefore, teachers need to be supported to ensure that SRH promotion is enhanced.

Drawing from the above discussion, it is obvious that some SRH topics are not easy to handle at home or at school, hence the children seek information from platforms other than at home. These other sources can misguide or mislead the young people thus increase the chances of perpetuating risky sexual behaviours which are detrimental to their health. On the contrary, a study by Javadnoni et al. (2016:1) indicates that SRH education is not the responsibility of teachers but of school health nurses, as indicated in the ISHP. This statement disagrees with the collaboration efforts that need to be employed by PHCNs for continuity of care, as discussed earlier in 5.3.

- *Legislation*

Legislation alone cannot solve the SR related challenges. However, McGranahan et al. (2021:9) indicated that methods focusing on legal empowerment for health promotion must be applied in SRH promotion to ensure that all the role players are conversant with all these interventions. However, there are conflicting SRH related laws that are beneficial to the health and protection of adolescents.

5.3.2 DISCUSSION OF GRANDPARENTS' ESSENCE AND CONSTITUENTS

5.3.2.1 ESSENCE 1: GRANDPARENTS' EXPERIENCES OF SRH COMMUNICATION

The discussions and literature are synthesised in respect of the essence of the experiences of grandparents regarding SRH communication who share their experiences of SRH communication within families. Essence 5 of grandparents and its three (3) constituents are deliberated below.

- **Grandparents' experiences of the benefits of promotion of SRH communication**

The findings from the grandparents revealed that there are benefits of SRH communication within families. This finding is like what the PHCNs indicated. Hence, there is a need to encourage open communication on SRH issues.

Grandparents are the backbone and support system of families because of the wealth of knowledge they possess. In addition, in the African culture, grandparents are perceived as parents and take part in the socialisation process of their grandchildren in the presence or absence of their biological parents (Adam et al., 2021:2). The participants indicated that information received from parents that assists in the reduction of risky sexual behaviours is beneficial to the wellbeing of the adolescents. Several authors are in support of the finding (Usonwu et al., 2021:10; Mpondo 2018:43; Noe et al., 2018:2; Fanta et al., 2016:57). The grandparents further indicated that children need to know and understand what is happening in life to make an informed decision to grow to become responsible adults. The study conducted in Kenya, on adolescent-parent communication, attests that children who are well informed about SRH issues turn out to be responsible adults (Usonwu et al., 2021:11). In addition, Nurachmann et al. (2019:195) confirm that understanding SRH, in general, is essential to make an informed decision regarding SRH. Moreover, grandparents in our study emphasised the importance of providing first-hand information because failure to give information will lead to grandchildren seeking information from other sources.

- **Grandparents' experiences of current SRH communication/practices**

The findings revealed that there were diverse views about the grandparents' experiences on the current SRH communication/beliefs and practices. Grandparents indicated that they find it difficult to discourage or convince their grandchildren not to go out at night. Despite the diverse views, society expects grandparents to share SRH information with their grandchildren as a way of protecting them from risky sexual behaviours. Therefore, grandparents must increase their communication with their grandchildren on SR related engagements for the grandchildren to be well informed (Adam et al., 2021:2; Noe et al., 2018:2; Oluyemi et al., 2017:41). However, they are still challenged as most want to apply the strategies that were used in their upbringing, in the way they have raised with their grandchildren.

Lack of SRH communication has always been attributed to the subject being perceived as a private matter, also because grandparents expect their grandchildren to be concentrating on their schoolwork, not adult matters (Mpondo, 2018:43). Despite this, the grandparent's perceptions are they are expected to be health promoters. Some of the grandparents were not comfortable with some of the laws which tend to perpetuate behaviours that are displayed by the grandchildren, namely, the provision of TOP and contraceptives. In this regard, some grandparents viewed TOP or abortion as a sin. This also due to their cultural or religious beliefs, as indicated earlier by the PHCNs. The cultural or religious beliefs and practices challenges affect SRH provision because grandparents opposing such service may result in the adolescent resorting to unsafe abortions which may be detrimental to their health.

Grandparents used themselves as the point of reference and shared their discomfort about the revealing clothes that their grandchildren tend to wear. From the grandparents' perspective, revealing clothes means a lack of respect, a sign of promiscuity and further invitation to SR problems e.g., sexual assaults. In this regard, sexual assaults may not be seen as a violation of one's sexual well-being but rather as something that the adolescents invited.

Some of the grandparents expressed anger when they discovered that the older men wanted to date their grandchildren. The study conducted in Tanzania and Uganda by Wamoyi et al. (2018:2) probed age disparate sex where older men are in relationships with younger women. The findings reveal that adolescents and younger women are in such relationships for financial and emotional support not taking into consideration the exploitation

and abuse to which they are exposed (Dana, Adinew & Sisay, 2019:2; Wamoyi et al., 2018:8). Another study conducted in SA revealed that adolescents and younger women were willing to take risks in return for financial support (Ranganathan et al., 2018:2). It is evident that such relationships expose adolescents to gender based violence, STIs including HIV/AIDS, unwanted pregnancies because they cannot enforce condom use.

In support of the grandparents' experiences of current SRH practices, the Minister of Basic Education, Mrs Motshekgoa, reflects on her concern about the impact of teenage pregnancy on the school-going child which perpetuates poverty and disrupts the development of young people (SABC 1). This discussion emanated from the increased teenage pregnancies reported during Covid 19 lockdown period (Chimbindi et al., 2022:163). Kenya is another country that also experienced a spike in teenage pregnancy during lockdown (Zulaika et al., 2022:2). A study conducted in Zimbabwe (Ndlovu, Makoni & Gundani 2022:104) reveal that teenage pregnancy was caused by a lack of sex education and lockdown restrictions which resulted in poor utilisation of SRH services.

- **Grandparents' experiences of SRH family strategies**

The findings of the study revealed that grandparents' participant identified other strategies that could be used to assist in the facilitation of SRH communication within families. Several strategies were like those identified by PHCNs. The difference was that television was regarded as the initiator of conversation on SRH within families. They mentioned that when watching TV and SRH issues arise, they get a chance to guide the adolescents, the parental guide (PG) indicated makes it even easier for them to discuss what is being watched. Grandparents show their willingness to engage their grandchildren regarding SRH promotion. The participants who did, stated that they do not beat about the bush when they discuss SR related topics.

5.3.2.2 ESSENCE 2: GRANDPARENTS' EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

Grandparents' experiences of factors facilitating SRH communication were supported by their acceptance of the SRH communication responsibilities and their role as sources of SRH knowledge. The identified factors are deliberated below.

- **Grandparents' acceptance of SRH communication responsibilities**

The findings of this study revealed that grandparents, as elderly people, have accepted SRH communication responsibilities in the reduction of SRH challenges that grandchildren may

face. Grandparents are of the view that it is their responsibility to ensure that their grandchildren know what is right and what is wrong, regarding SRH matters.

Although there are socio-cultural factors that impede sexual reproductive communication within families, grandparents have accepted their role and responsibilities toward SRH promotion. This finding is in line with the findings of the study by Motsomi et al. (2016:5), in which the participants indicated that open sexual communication is perceived as a protector factor. Grandparents support the importance of engaging their grandchildren in sex talks. They believe that sex talks offer adults an opportunity to pass their beliefs, norms and values to their children and further provide a supportive environment to ensure that their grandchildren transit into responsible adulthood (Fanta et al., 2016:57; Noe et al., 2018:2; Mpondo, 2018:43; Cassidy et al., 2018:2). This practice qualifies grandparents as health promoters, educators who are willing to engage with SRH related topics to empower their grandchildren, meanwhile they also gain more knowledge on current SRH related issues.

- **Grandparents as sources of SRH knowledge**

The findings revealed that grandparents regard themselves as the backbone of the family. They indicated that they possess wisdom accumulated from life experiences, such as being historians, loving companions, and caregivers to their grandchildren. The same finding was reported by Mafumbate (2019:12); Kalpana and Rosalina (2018:169) and Pulgaron et al. (2016:6). On the contrary, Nurachmah et al. (2019:197) identified several challenges that impede SRH communication which include the resistance of the parents, attitudes of the adolescents, communication gap between adults and adolescents as factors that hinder open communication regarding SRH related matters. The same authors posit that parent-based approaches could be effective strategies that can improve SRH communication.

The researcher could deduce that the grandparents are willing to discuss SRH issues with their grandparents. However, they need to be supported with the knowledge to be able to respond to all the challenges that may emanate from the discussions.

Several studies are in support of grandparents as the backbone of the family who play a vital role in the upbringing of their grandchildren (Aventin et al., 2020:2; Maina et al., 2020:1). Simmonds et al. (2020:2) and Shirinda and Schultz (2019:1) are of the opinion that for the grandparents to cope with grandchildren in this era, they need new parenting strategies. The strategies should be able to deal with the current social and cultural issues which may be different to what they are used to. The new strategies may assist them to openly address health related challenges, including SRH challenges.

The findings also revealed that most grandparents acquired their knowledge from reading books, watching television and support groups within the communities, including nurses at the clinic. The grandparents indicated that the acquired knowledge assists to protect their grandchildren from any risky behaviour. Grandparents further expressed joy and appreciation when grandchildren listen to them and approach them for any clarity on SRH issues (Aventin et al., 2020:2; Maina et al., 2020:1).

In addition, the grandparents indicated that they are happy to join other stakeholders to acquire information that assists in the promotion of health. Therefore, PHCNs must capacitate grandparents to be able to engage in SRH talks with their grandchildren. From the above discussion, it is obvious that SRH communication is a tool that can be used to instil values and beliefs in their grandchildren including corrections of SRH related misconceptions.

5.3.2.3 ESSENCE 3: GRANDPARENTS' EXPERIENCES OF SRH FAMILY COMMUNICATION BARRIERS

The findings of the study revealed various barriers that were experienced by grandparents, namely, emotional, religious/cultural/parental practices which are consistent with what the PHCNs have shared earlier. These barriers are discussed in detail below.

- **Emotional barriers**

Several participants indicated that there are emotional barriers when it comes to SRH family communication. Grandparents indicated that emotional barriers emanate from the failure of the grandchildren to adhere to what the grandparents expect (Maina,Ushie and Kabiru 2020:2;Nilsson et al 2020:2;Sagnia,Gharoro and Isara 2020:1).The feelings of being hurt and disappointment were revealed by one of the participants who alluded that she does talk with the grandchildren, but she does not know what is in their hearts and minds. Drawing from the grandparent's comments, it is obvious that they do talk with the grandchildren, but little is known about the content of the conversation. It was also evident that grandparents are worried about the SRH related health challenges with which their grandchildren are faced.

Furthermore, grandparents revealed that they get frustrated when grandchildren become disobedient because they expect them to conform to their teachings.

- **Religious/cultural/parental barriers**

The findings of this study revealed that religious and cultural beliefs, including parental barriers, has an impact on SRH promotion. Grandparents referred to their upbringing which moulded them, and this was further revealed by one of the participants who verbalised that her father, a priest, was very strict and every discussion they had was based on the bible as the moral builder. Termination of pregnancy (TOP) is perceived as a sin and is against the Ten Commandments which emphasise that no one should kill (Kamangu et al., 2017:47). Due to these barriers, access and utilisation of TOP services might not be acceptable.

According to the African culture, any SRH related talks are regarded as taboo and parents perceive sexual talks with their grandchildren as factors that encourage sexual indulgence or experimentation (Adam et al., 2021:2; Kamangu et al., 2017:47). However, grandchildren, like any other person, have the right to information about SRH. This SRHR is enshrined in section 27 of the Constitution and stipulates that “everyone has the right to have access to the health care service including reproductive health care (Constitution of the Republic of South Africa, 1996:1247). Grandparents should be informed about all the SRH services that are rendered, including the legislative frameworks that are relevant to SRH provision.

The study revealed that there is no appropriate language that can be used to explain the concept of SRH. Grandparents are worried and concerned about the SRH language, to them it seems like swearing or cursing whenever they try to communicate or address SRH related problems. Hence, the use of idiomatic expressions that may be difficult to understand and interpret by the grandchildren.

Therefore, the PHCNs should support grandparents through the creation of an enabling environment and language that will be conducive to open SRH communication. The creation of SRH awareness will assist in the eradication of barriers; this promotes an effective and efficient SRH service delivery.

- **Grandparents' (mis)conception of SRH communication**

The findings of this study revealed that the lack of open communication regarding SRH issues is a result of the (mis)conceptions attached to SRH related matters. Some grandparents reported that open communication will lead to grandchildren experimenting with what was discussed rather than perceiving open communication as a strategy that can assist in the reduction of risky sexual behaviour. According to Kyilleh, Tabong and Konlaan (2018:2), the adolescent stage is characterised by physiological and psychological changes,

including experimenting with sexual activities. The same authors further state that the adolescents' knowledge and access to SRH services are crucial to understand their physiological and psychological changes and what to do when they experience sexual desires. Osonwu, Ahmad and Curtis-Tyler (2021:1) argue that effective SRH communication between grandparents and grandchildren promotes safe sexual behaviours.

Therefore, misconceptions need to be addressed through effective health communication so that SRH communication can be accepted within families. Capacitation of grandparents needs to be addressed to correct all the misconceptions and myths that impede SRH promotion.

- **SRH communication barriers between grandparents and grandchildren**

The SRH communication barrier between grandparents and grandchildren was identified by the grandparents. Some of the grandparents reported that they do talk with their grandchildren, but the grandchildren do not take them seriously. The generational gap might be the contributory factor, leading to a lack of open sexual talks or engagement with the grandchildren who may feel embarrassed to discuss their sexual issues with their grandparents. Cultural and religious beliefs play a major role in the lack of open communication regarding SRH promotion within families (Nmadu et al., 2022:2; Adam et al., 2021:2; Kamangu et al., 2017:47; Motsomi et al., 2016:4). On the other hand, grandchildren posit that grandparents do not explain SRH information in detail. The provision of insufficient information might create a serious problem for the grandchildren. This becomes a barrier when the grandchildren are afraid to ask follow-up questions that will assist in the clarification (Yibrehu & Mbwele, 2020:2). From the discussions, it was evident that SR related talks are not easy topics that grandparents felt comfortable to discuss with the grandchildren. Despite the evidence of barriers that hinder open SRH communication, grandparents still perceive today's generation as being disrespectful.

5.3.2.4 ESSENCE 4: GRANDPARENTS' RECOMMENDATIONS FOR SRH COMMUNICATION PROVISION

The findings of the study indicated that grandparents came up with recommendations that will assist in improving SRH promotion within families. Essence 4 of PHCN grandparents' experiences and their constituents are depicted below. Grandparents envisaged that the capacitation of both grandparents and grandchildren will ensure that SRH information is shared and understood within families.

- **Capacitation of grandparents and grandchildren**

The findings of the study revealed that grandparents saw the need for both grandparents and grandchildren to be capacitated to have a common understanding of SRH promotion. Grandparents were of the view that their involvement in SRH discussions will be beneficial to enhance their knowledge so that correct SRH information can be provided to their grandchildren. Several authors concur with the views of the grandparents and suggest that future interventions should improve parents' discomfort in addressing their children's sexuality issues (Faludi & Rada, 2022:12; Seif, Kohi & Moshiro, 2019:11). Once capacitated, they will be able to handle any challenge, utilising the knowledge they possess to enhance open SRH dialogues within families.

From the discussion, it was evident that grandparents may not understand some of the changes that are taking place because of a lack of proper consultations and awareness. However, Faludi and Rada (2022:12) argue that grandparents will be able to identify barriers and obtain skills that will assist them to promote healthy sexual behaviours. It was encouraging to hear about the willingness of grandparents to be involved in SRH promotion as this will assist them to acquire knowledge that will assist them to correct myths and misconceptions regarding SRH promotion.

5.3.3 DISCUSSION OF GRANDCHILDREN'S ESSENCE AND CONSTITUENTS

5.3.3.1 ESSENCE 1: GRANDCHILDREN'S EXPERIENCES OF SRH COMMUNICATION

The discussion and literature synthesis in respect of the essence of the experiences of grandchildren regarding SRH communication are shared below. The findings of the study revealed that grandchildren had experiences regarding their SRH communication with their grandparents. The benefits of SRH communication and SRH family communication contents were found to be important in the promotion of SRH communication within families in the Tshwane district and the experiences are shared below.

- **Grandchildren's experiences of benefits of SRH communication**

The grandchildren indicated that they benefit from SRH communication. This finding is inconsistent with the experiences that were shared by the PHCNs and grandparents regarding SRH communication**.** Grandchildren acknowledge the benefits of open communication with grandparents that will increase their knowledge to make informed decisions regarding SRH related issues. Grandchildren revealed that they prefer to get first-

hand information from their grandparents. Furthermore**,** grandchildren posit that grandparents have been identified as being valuable in the provision of SRH information because of their knowledge about SRH related matters. The findings of the current study concur with Seif, Kohi and Moshiro (2018:2), attesting to the role played by grandparents in SRH promotion which is beneficial to the grandchildren.

- **Grandchildren's experiences of SRH family communication contents**

Grandchildren, in this study, acknowledged that they had open communication with their grandparents at times, which enabled them to approach grandparents when confronted with some SR related challenges. However, some of the grandchildren felt that the communication is not as expected but related to them as threats and warnings (Yibrehu & Mbwele, 2020:2; Motsomi et al., 2016:3). The grandchildren indicated that some of the topics that the grandparents would talk about are the importance of protection against STIs, especially to those who were already sexually active. For those who are already sexually active, the grandparents encouraged them to use condoms and further highlighted the consequences of risky sexual behaviours. Donne, Hoeks and Jansen (2017:636) indicate that safe sex communication is of vital importance in the reduction of risky sexual behaviours. The same authors reveal that safe sex communication may be perceived as a taboo topic that cannot be spoken about. Safe sex practices take steps to prevent transmission of STIs through the usage and promotion of barriers, e.g., condoms. In addition, Thepthien and Celyn (2022:2) emphasise that the concept of safe sex must be promoted before an adolescent becomes sexually active to prevent the harmful consequences of unsafe sex.

The other topics that the grandparents talk about are the importance of sexual abstinence which will delay sexual debut. Several studies revealed that abstinence is one of the SRH related topic that adolescents receive from their parents (Klu et al., 2022:7; Ramchandrani et al., 2018:3). The benefits of abstinence are the reduction of risky behaviours which contribute to the prevention of STIs, including HIV/AIDS and unwanted pregnancy (Mokwena & Morabe 2016:80). The same authors allude that other communities practice virginity testing to enhance abstinence, especially among female adolescents. Knowledge about SRH related issues will assist adolescents to make informed decisions with better understanding and they will also be able to correct any misconceptions.

The participants uttered that the content of the discussion emphasised the importance of education and information about gender-based violence (GBV). Several studies have

indicated that GBV against youth has been identified as a global health concern that needs to be addressed vigorously (Racionero-Plaza et al., 2021:1; Perrin et al., 2019:1; Edberg et al., 207:2). Oparinde and Matsha (2021:1) indicated that women and girls are targeted in the cycle of GBV. However, a study conducted by Thobejane, Mogorosi and Luthada (2018:1) on gender-based violence against men argue that men are also affected, though they never share their experiences in fear of stigmatisation. According to the South African Police Service (SAPS) crime report for 2019/2020, more than 146 sexual offences were committed every day, and this was very concerning. Open communication regarding GBV and its effects on individuals will create awareness and foster an element of respect on the individual. Drawing from the data, it is evident that grandparents encourage grandchildren to handle gender-based violence without fear. Both boys and girls felt good to be engaged in SRH related issues that affect them without imposing any decision on them.

5.3.3.2 ESSENCE 2: GRANDCHILDREN'S EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

The findings from the grandchildren showed positive experiences of SRH family communication and grandchildren's positive/neutral experiences of SRH information from other sources. The identified factors are reflected and discussed below.

- **Grandchildren's positive experience of SRH family communication**

The findings of the study revealed that grandchildren had positive experiences of SRH family communication. The grandchildren gave positive responses with regards to SRH family communication. They indicated that the grandparents encouraged them to be educated and become independent adults before engaging in sexual activities as well as to have respect for other human beings. The grandchildren positively appreciated the role played by grandparents in this regard. The findings are in line with the findings of the 2017 study conducted in East Africa on barriers to parent-child communication on sexual and reproductive health issues, which attest that open and supportive parent-adolescent sexual communication can postpone or delay sexual activity and support healthy sexual socialisation. Therefore, grandchildren grow into responsible adults (Kamangu et al., 2017:49). Although some of the grandchildren did not find value in communication because it carries threats and warnings, information sharing is important because it assists in the capacitation of both grandparents and grandchildren.

This was evident when some grandchildren verbalised that they felt good to have an opportunity to engage their grandparents on SRH related topics to be able to make informed decisions.

- **Grandchildren's positive/neutral experiences of SRH information from other sources**

Grandchildren identified other sources that assist in SRH provision, namely, schools, the internet, other family members, NGOs, and their peers. The school, internet and friends were identified as sources where SRH information is accessed. This finding concurs with the results of the study that was conducted in SA showing that media and other family elders provide SRH information (Motsomi et al., 2016:5). The grandchildren in this study verbalised and wished that they need grandparents to be the first source of SRH information, while information from other sources could be used as reinforcement. This was found to be in line with the study conducted in Egypt, Saudi Arabia, and Jordan, which indicate that children preferred parents or elders to be their source of SRH information (Othman et al., 2020:314). On the other hand, some of the grandchildren still felt uncomfortable discussing SRH related topics with their grandparents and then resorted to open communications with other family members, namely, their older sisters (Klu et al., 2022:2) However, Motsomi et al. (2016:4) revealed that communication is taking place but is interrupted by younger siblings as parents prefer to talk with older children in the absence of younger siblings.

5.3.3.3 ESSENCE 3: GRANDCHILDREN'S EXPERIENCES OF SRH FAMILY COMMUNICATION BARRIERS

Just like PHCNs and grandparents, the grandchildren experienced SRH family communication barriers. Grandchildren identified barriers that hinder SRH family communication as emotional and communication barriers between grandparents and grandchildren, including grandchildren's negative experiences of SRH communication from other sources.

- **Emotional barriers**

Grandchildren expressed their concerns regarding the emotional barriers that hinder open SRH communication within families. Grandchildren indicated that despite the benefits of open SRH communication, they still verbalised that they are unable to engage with grandparents because it would mean that they are disrespecting their grannies. In addition, grandchildren showed fear of the possibility of being judged by the grandparents if they must openly inform their grandparents about the SRH information needs (Usonwu et al., 2021:10).

Fear results in teenagers seeking information from other sources who may not have experience, resulting in high incidences of risky behaviours. The abovementioned discussions confirm the various reasons that hinder open SRH communication.

- **SRH communication barriers between grandchildren and grandparents**

The findings from the grandchildren show that grandparents do not devote time to discuss SRH issues with their grandchildren and this hinders the SRH communication between them. Several authors highlighted that most parents felt uncomfortable discussing sexual issues with their children (Usonwu et al., 2021:8; Kusheta et al., 2019:2). The grandchildren indicated that instead of grandparents talking about SRH related, they discuss the bible. This finding was confirmed by a study conducted by Usonwu et al. (2021:8) where sex talks were perceived as being against biblical teachings with emphasis being on abstinence. Grandchildren believe more action needs to be taken to alleviate the grandparents' anxieties, especially when they are expected to have the sex talk with their grandchildren. On the other hand, some grandchildren still perceive SRH discussions with their grandparents as being disrespectful. The issue of the generational gap might be the reason for this thought. Adam et al. (2021:2) reveal that grandchildren and grandparents belong to different generations which makes it difficult to understand each other. However, several authors still maintain that adolescents need adults, especially parents, to spend quality time with them to engage in such talks (Kusheta et al., 2019:2; Kamangu et al., 2017:4).

- **Grandchildren's negative experiences of SRH communication from other sources**

Grandchildren, as participants, revealed that even though there are sources that assist with SRH information, there are still negative experiences with that open SRH communication. The grandchildren agree with the PHCNs that even though LO has been identified as an SRH source, there are teachers who are challenged to teach them because they treat them as their children. Several studies conducted in SA reveal that the personal background of teachers has an influence on the way the content is delivered or interpreted which has an impact on the empowerment of learners regarding SRH (Mturi & Bechuke, 2019:136; Swanepoel & Beyers, 2019:8). The authors further show that some teachers still fear discussing sexuality issues openly with learners.

The grandchildren also indicated that nurses who are supposed to assist, still display a negative attitude towards SRH promotion which makes it difficult for grandchildren to utilise the SRH services at the PHC facilities. The findings of a study conducted in Spain reveal that there is still resistance from nurses regarding SRH communication with clients, hence

the demonstration of negative attitudes towards SRH promotion (Leyva-Moral et al., 2020:407). Nurses are expected to ensure that both grandchildren and grandparents are supported to participate in SRH promotion.

5.3.3.4 ESSENCE 4: GRANDCHILDRENS' RECOMMENDATIONS FOR SRH COMMUNICATION PROMOTION

Grandchildren also made some recommendations that can assist in SRH promotion, namely, educational interventions and grandchildren's needs for SRH communication which are depicted below. Grandchildren's recommendations are needed to be taken into consideration in the development of guidelines because of their SRH rights to make informed decisions on their own health. Therefore, essence 4 of grandchildren and its constituents are depicted and discussed below.

- **Educational interventions**

Grandchildren are of the view that programmes to assist in understanding sexual reproductive health should be introduced. They further suggested that other stakeholders should reinforce SRH promotion in a friendly manner that will encourage further engagements in decision making on matters that affect teenagers and young adults. The findings of a study conducted in Slovakia reveal that the involvement of nurses in SRH promotion is highly appreciated by the youths because they can ask questions and get answers (Pavelova et al., 2021:8). In addition, another study conducted in Morocco reveal that a successful programme should target multifaceted factors that affect the adolescents/youth's sexual behaviours (Kardouh et al., 2019:2).

- **Grandchildren's needs for SRH communication.**

The findings of the grandchildren suggest a need to support them with information to understand their growth and development. Maina et al. (2020:12) affirmed that grandchildren must be provided with knowledge and a conducive space where they can be able to engage in sex talks with their parents. The same authors highlighted that once the adolescents (grandchildren) are informed, they will be able to negotiate safe sex. A study conducted in Sweden revealed that PHCNs must be accessible to be able to provide proper support to adolescents (Unis et al., 2021:423). The grandchildren indicated the need to be taught how to approach grandparents for advice on SRH related challenges because of their wealth of information. On the contrary, some grandchildren felt they must not be forced to learn about LO or sexual related topics when they are not interested in sexual issues.

5.4 CONCLUSION

In this chapter, an extensive literature synthesis was provided. Based on the discussions, it is evident that there is a need for the capacitation of PHCNs, grandparents and grandchildren on factors regarding SRH communication. All factors that impede SRH communication must be addressed to ensure that open SRH communication happens. It is envisioned that the creation of an enabling environment within PHC facilities will enhance access and utilisation of SRH services and address SRH issues within families. Chapter 6 focuses on the development of guidelines, validation and description of the preliminary guidelines for communication guidelines to support grandparent headed families regarding SRH.

CHAPTER 6

DEVELOPMENT AND THE DESCRIPTION OF THE GUIDELINES IN PHASE 2

6.1 INTRODUCTION

Chapter 5 covered a discussion of findings, literature synthesis and control which integrated the findings of the study. Essences and constituents regarding SRH communication within the grandparent headed families were discussed and supported by the available literature. This chapter focused on Phase 2 of the study, which is the development of guidelines for PHCNs to support grandparent headed families regarding SRH communication in Tshwane District.

The development of guidelines was based on the empirical data from Phase 1 of this study which included the experiences of the PHCNs, grandparents and grandchildren in the City of Tshwane. The literature supported these discoveries, as highlighted in the previous chapter (see Chapter 5). The guidelines were developed by selecting suitable statements from the distinguished data which emanated from the lived experiences of PHCNs, grandparents and grandchildren. The draft guidelines were developed in accordance with the guiding features which direct the development of guidelines as discussed in Chapter 3; the summary of all the essences and constituents of PHCNs, grandparents and grandchildren as exhibited in Chapter 4 (see Table 4.1, Table 4.2 & Table 4.3) and supported with literature in Chapter 5. The researcher developed the framework for PHCNs which integrated the empirical findings from Phase 1 of this study, as depicted in Figure 6.1. The researcher used some information from the grandparents' and grandchildren's findings to strengthen the formulation of the guidelines for the PHCNs (Table 6.1). This was confirmed by a study conducted by Peters et al (2022:2) concerning trends in guideline development, which emphasised that clinical guidelines should incorporate recommendations grounded on accessible findings. The discussion below focused on the summarised information provided by grandparents and grandchildren (Table 6.1).

6.2 SUMMARY OF INFORMATION FROM GRANDPARENTS AND GRANDCHILDREN

Grandparents and grandchildren shared their experiences and provided valuable information as presented in Chapter 4, summarised below in Table 6.1 and the detailed discussion of findings was supported with literature as presented in Chapter 5. The rationale for the inclusion of grandparents and grandchildren was indicated in Chapter 4 (4.3.1). The

researcher used some of the information to strengthen the formulation of the proposed SRH communication guidelines.

TABLE 6.1 SUMMARY OF INFORMATION GATHERED FROM GRANDPARENTS AND GRANDCHILDREN (PHASE 1)

CONSTITUENTS OF GRANDPARENTS (GP)	ESSENCES OF GP'S AND GC'S	CONSTITUETS OF GRANDCHILDREN (GC)
• GP's experiences of benefits of SRH communication	**Grandparents/grandchildren's experiences of SRH communication**	• Grandchildren's experiences of benefits of SRH communication
• GP's experiences of current SRH communication practices		• Grandchildren's experiences of family communication content
• GP's experiences of family communication strategies		
• GP's acceptance of SRH communication responsibilities	**Grandparents/grandchildren's experiences of Factors facilitating SRH Communication**	• GC's positive experiences of SRH communication
• GPs as sources of SRH knowledge		• GC's positive/neutral experiences of SRH information from other sources
• Emotional barriers	**SRH family communication barriers**	• Emotional barriers
• Religious/cultural/parental barriers		• SRH communication barriers between grandparents and grandchildren
• GP's misconceptions/lack of knowledge		• GC's negative experiences of SRH communication from other sources
• SRH communication barriers between grandparents and grandchildren		
• Emotional barriers	**Grandparent's/grandchildren's experiences of SRH family communication barriers**	• Emotional barriers
		• SRH communication barriers between grandparents and grandchildren
• Religious/cultural/parental barriers		• GC's negative experiences of SRH communication from other sources
• GP's (mis) conceptions/lack of knowledge of SRH communication		
• SRH communication barriers between grandparents and grandchildren		
• Capacitation of grandparents and grandchildren	**Grandparents/grandchildren's recommendations for SRH communication**	• Educational interventions
		• GC's needs for SRH communication

Grandparents and grandchildren shared the same essences with some differences in the constituents of the findings. The researcher included the views or experiences of the grandparents and grandchildren in developing the guidelines by using some of the information to strengthen the development of the guidelines. This is in line with a study by Peters et al. (2022:2), which specified that guidelines must include recommendations based on the best available evidence. The inclusion of the grandparents' and grandchildren's views is in line with the application of Domain 1 of AGREE, which deals with the scope and purpose of guideline development (Seto et al., 2017:3; Novo et al., 2016:213). In this study, the objective was to develop communication guidelines to support grandparent headed families regarding SRH communication.

The researcher is of the view that the development of the guidelines will most likely promote healthy sexual practices, reduce risky sexual behaviours, and create awareness regarding open SRH communication within families, including the legal frameworks around SRH promotion.

6.3 FRAMEWORK

The Framework comprises the essences and constituents of PHCNs, processes utilised by PHCNs to support grandparent headed families regarding SRH communication which yielded five (5) guidelines as presented in figure 6.1. These represent the adapted framework that guided the researcher in the development and validation of the proposed guidelines.

6.3.1 Framework that guided the formulation of preliminary guidelines.

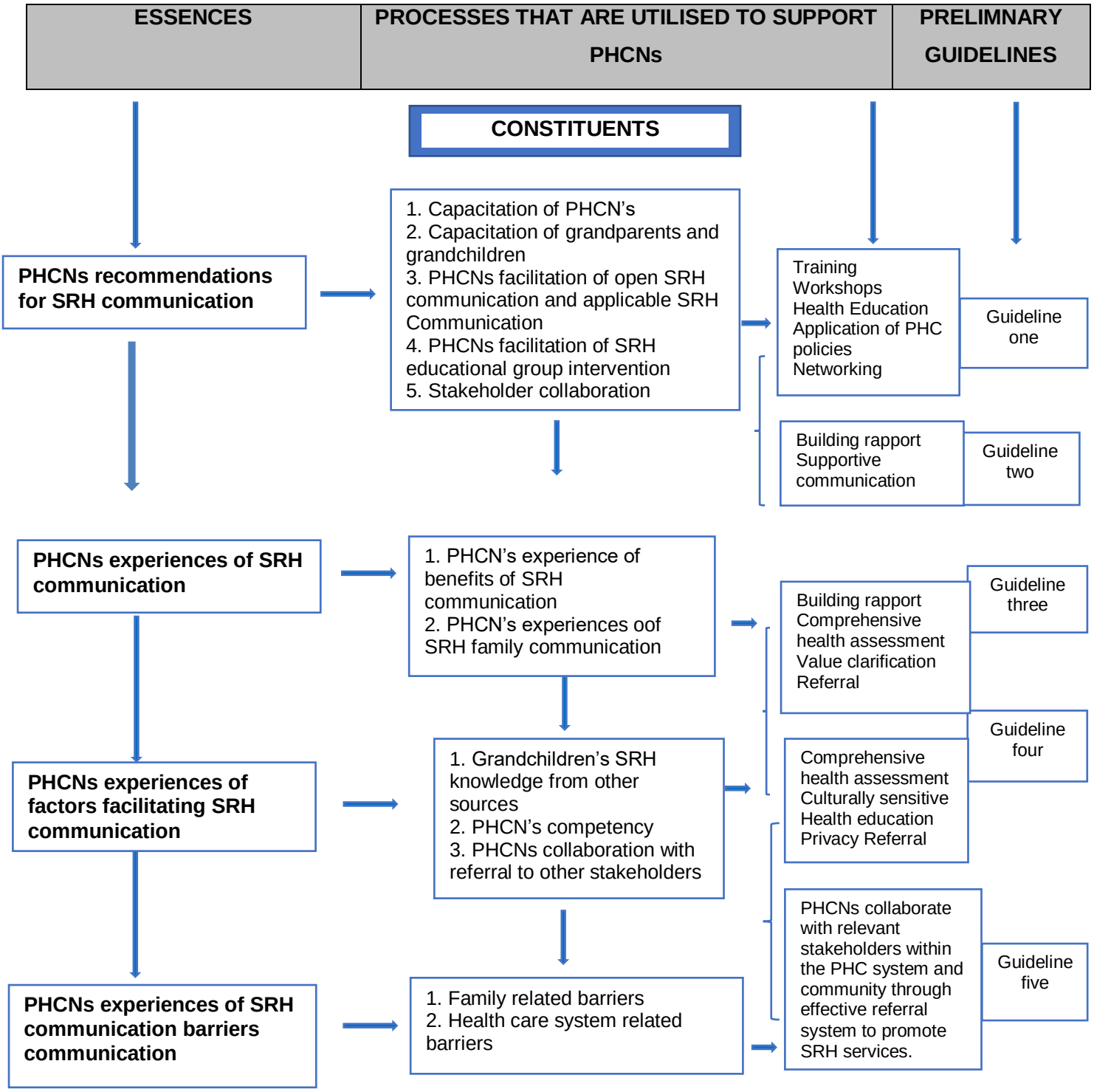

Figure 6.1: ***Framework of the integration of empirical findings that guided the formulation of the preliminary guidelines for PHCNs.***

6.3.2 PRELIMINARY GUIDELINES FOR PHCNs

The preliminary guidelines were informed by the findings of participants in Phase 1 of this study. The researcher drafted five (5) guidelines below.

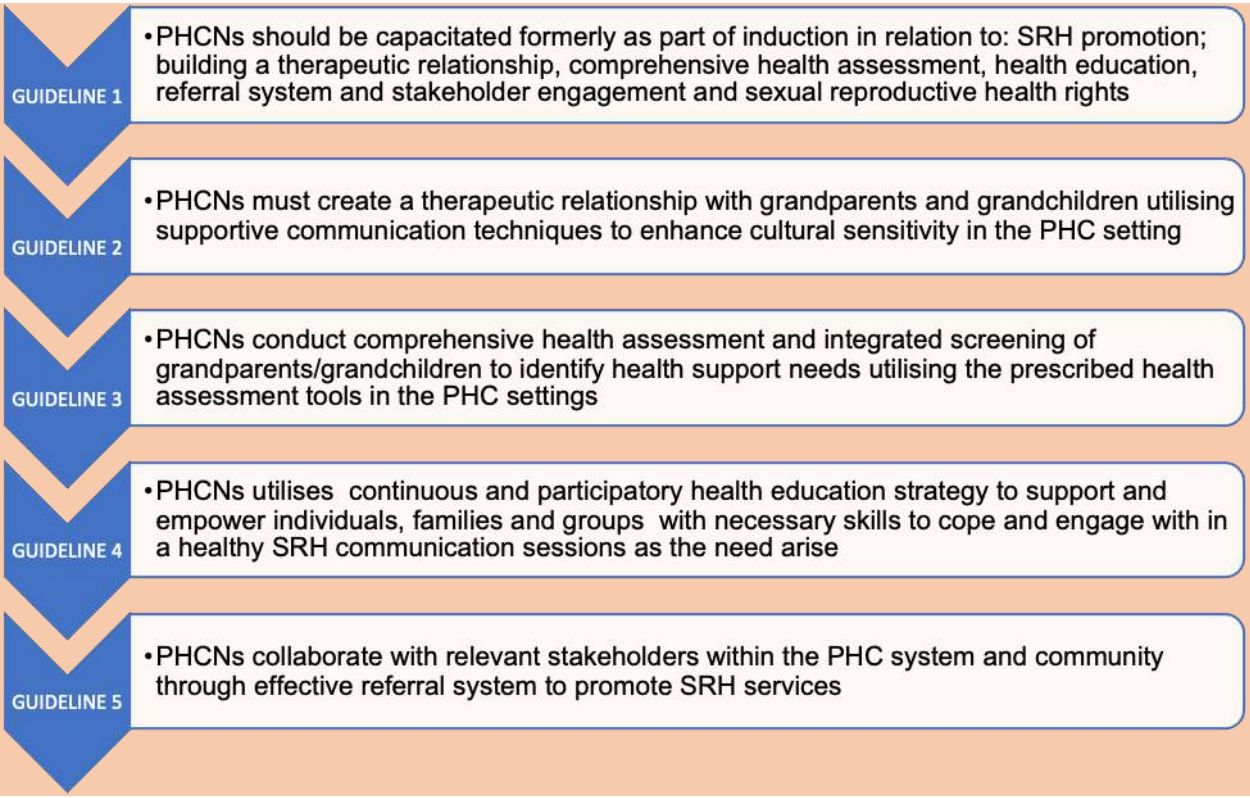

Figure 6.2: ***Presentation of the draft preliminary guidelines***

6.4 KNOWLEDGE DEVELOPMENT IN NURSING

Nursing is a continuously developing profession that commands lifelong learning, which requires exceptional skills. Nursing is a multifaceted profession that needs a combination of theory and practice to meet the minimum requirements of a Nursing qualification. According to Curtis et al. (2016:863) and Chapman et al. (2008), reflection enables health professionals to share knowledge and information with others to benefit practice. Nursing research is conducted to expand knowledge to improve patient care and good health outcomes. Brink et al (2018:1) reiterate that HCPs need knowledge on which to base their practice thus, a solid foundation must be fostered during the training of nurses. Garcia et al. (2014:2) mention that scientific knowledge is in constant change therefore, current information is needed to add to the body of knowledge that is already in existence. In addition, Peters et al. (2020:1) and Curtis (2016:863) affirm that there is a rapid growth in research evidence which forces healthcare professionals to remain current with the latest discoveries from published

research. Salarvand et al. (2020:2255) posit that healthcare professionals should seek necessary information/knowledge to improve the quality of care rendered to consumers. Furthermore, Polit & Beck (2017:7) posit that nurses make clinical decisions based on acquired knowledge from many sources, including research, textbooks and clinical experience. In this study, the developed SRH communication guidelines will create awareness and further assist PHCNs in supporting grandparent headed families in dealing with SRH issues.

The involvement of experts with diverse knowledge assisted in the refinement and validation of the proposed guidelines to ensure that quality guidelines are developed and implemented (Naserrudin et al., 2022:2). Several authors state that Primary Health Care (PHC) is where the client (grandparent or grandchild) has first contact with the health system which comprises of a range of health interventions, e.g., SRH promotion, health education, contraceptives methods, termination of pregnancy, teenage pregnancy, child abuse including domestic violence (Seretlo and Mokgatle 2022:1; Ramalho et al., 2019:11). It is evident that PHCNs plays a very crucial role in ensuring that both grandparents and grandchildren are empowered on SRH related matters through information sharing strategies. Their right to information on the issues that affect their wellbeing is paramount, as affirmed in the Constitution of the Republic of South Africa (Act No 108 of 1997). The findings of the study also confirmed the need for empowerment of the PHCNs, grandparents and grandchildren regarding SRH related matters, especially SRH communication, which is still perceived as a taboo to engage with elderly people regarding sexual related issues within families.

The participants in this study highlighted the benefits of promoting SRH communication within families and perceived it as a protector factor. Open communication was perceived as a crucial strategy that can reduce SRH related challenges, including gender-based violence (Agudile et al., 2020:37; Neme & Dereje, 2020:15; Maimunah, Afiatin & Helmi, 2019:170). Provision of SRH related information assist in decision making, which will reduce some of the SRH related health problems experienced by an individual, families and the community. The grandchildren perceived grandparents as sole guardians and are expected to provide SRH information to their grandchildren.

6.5 DEVELOPMENT OF GUIDELINES

To support PHCNs in promoting SRH communication, the researcher envisioned that developing guidelines was crucial to encourage healthy lifestyles within families. This study

was conducted in two (2) phases: Phase 1 focused on the empirical study that dealt with the exploration and description of SRH communication within grandparent headed families, and Phase 2 deals with the development of communication guidelines to support PHCNs regarding SRH within families. The primary purpose of Phase II was to develop communication guidelines to support grandparent headed families regarding SRH in Tshwane District. Guidelines are perceived as systematically developed statements that are proposed to affect decisions made by HCPs, policymakers and healthcare consumers (De Leo & Bloxsome, 2022:2; Tetreault et al., 2019:544). Furthermore, guidelines are regarded as systematically developed evidence-based statements which assist in decision making for healthcare providers and healthcare users in making informed decisions (Perreira, et al., 2022:2; Petkovic, et al., 2020:3; Peters, et al., 2020:1). Therefore, guidelines were systematically developed, and participants were permitted to make applicable appropriate decisions regarding SRH communication within families. Several authors affirmed that healthcare guidelines are recommendations that are developed to inform decision making among health professionals, consumers, including all stakeholders in healthcare provision (Peters et al., 2020:1; Florez et al., 2018:1; Kowalski et al., 2018:1). In addition, Kredo et al. (2016:123) defined guidelines as a set of structures that can be used to guide users. In this study, the communication guidelines are structures that will assist the PHCNs in supporting grandparents and grandchildren regarding SRH.

Clinical practice guidelines (CPGs) are described as a summary of the best scientific evidence HCP use to provide evidence-based care for healthcare consumers (De Leo & Bloxsome, 2022:9; Salarvand et al., 2020:2256). Therefore, the researcher intended to draft SRH communication guidelines for PHCNs to support grandparent headed families in Tshwane District (see Figure 6.2). Subsequently, guidelines were developed because of the concerns or findings that confirmed the need for SRH communication within families in the Tshwane district, as confirmed by a study conducted by Deo Leo et al. (2023:9). In addition, the WHO describe guidelines as any document that contains recommendations about health interventions, which further stipulates what should be done (WHO, 2014:1). In addition, the WHO and Pan American Health Organization (2018:16) pronounce that guidelines intend to assist the systems by improving knowledge through provision of evidence-based information; inform decision makers about appropriate interventions; modify clinical practice standards by seeking improved quality care for the population and increase the impact of health outcomes. De Leo and Bloxsome (2022:2) identify a range of common purposes for guideline development, namely the inclusion of best practice standards, provision of benchmarks for clinical audits, striving for improvement of quality healthcare providers and

providing guidance on clinical practices. Piggott et al. (2021:42) and Kredo et al. (2017:2) further state that health guidelines are perceived as key knowledge translation tools to implement evidence into practice that various stakeholders use.

The proposed guidelines are based on the expert opinions observed during the Delphi rounds, whereby expert knowledge and experience were anonymously shared during the refinement and validation process. In this study, guidelines will serve as recommendations proposed by all the participants in Phase 1, which encouraged SRH communication within the grandparent headed families. These draft guidelines were developed to support PHCNs in the promotion of SRH communication within the grandparent headed families in CoT. The main purpose was to ensure that grandparents are supported regarding open SRH communication with their (adolescent) grandchildren. In addition, Kowalski et al. (2018:1) further highlighted that guidelines should contain evidence-based recommendations to appraise healthcare decision making processes in addressing health related challenges.

In this study, the guidelines will be implemented by the PHCNs in the primary health care settings or schools hence the need for capacitation of PHCNs. Hoffmann-Eber et al. (2018:2) posit that the quality of the guidelines must be ensured through rigor and transparency, as confirmed by choice of expert participants and anonymity to ensure that expert participants do not influence each other's responses. In the context of this study, these guidelines could assist in addressing SRH related matters whilst taking into consideration the cultural and religious beliefs/practices of the grandparents and grandchildren, as SRH topics are regarded as taboo and/or private matters. Peu (2008:194) affirms that guidelines could be used to guide the process of health promotion. In this study it entails the promotion of SRH communication, which allows open SRH engagements within grandparent headed families.

In this study, guidelines are regarded as standards and recommendations to be used by PHCNs to support grandparent headed families regarding SRH communication, and the outcome of their implementation could promote a healthy SRH lifestyle. De Leo et al. (2023:9) and Cassidy et al. (2021:2) indicated that guidelines emerged as a key tool for translating evidence into practice and an effective strategy for improving the health outcomes of individuals, families and the community. These guidelines will assist the PHCNs in supporting grandparents and grandchildren regarding SRH promotion. The development of the guidelines was done in accordance with the principles of guideline development and validation, AGREE II instrument and through expert anonymous opinion sharing to reach a consensus during the Delphi rounds.

6.5.1 Guiding attributes for the development and validation of guidelines

The researcher observed several attributes related to guideline development to ensure quality guidelines. The attributes are validity, reliability, clarity, applicability, completeness, effectiveness, flexibility, relevance, acceptability, rigor and editorial independence. In this study, the researcher identified attributes discussed below in Table 6.2.

TABLE 6.2: ***Attributes for Guideline Development***

NO	CRITERION	EXPLANATION
1.	**Validity**	Validity deals with the ability of the instrument to measure what they purport to measure (Polit & Beck, 2017:161; Brink et al, 2018:151; Botma et al, 2016:231). The guidelines have strong research evidence which emanated from the participants in Phase 1 of the study which assisted the expert participants in Phase 2 to validate the proposed guidelines regarding SRH communication within the grandparent headed families. The validation of the guidelines was conducted by expert participants following a series of Delphi rounds. The expert knowledge and experiences of the participants played a vital role in the evaluation, modification and validation process (Habibi, Sarafrazi & Izadyar, 2014:10). A pilot testing was conducted with two (2) participants who met the inclusion criteria to assess the need for questionnaire adjustment and to address any procedural issues (Naserrudin et al., 2022:7; Brink et al., 2018:161; Massaroli et al., 2017:6). The questionnaire that was developed from preliminary guidelines were sent to the participants and had timeframes which directed them when to return the responses. The other reason for the pilot test was to adjust or improve the questionnaire before sending it out to a pool of expert participants. A reminder was sent to both participants to complete and return the questionnaire. The researcher went through the returned questionnaire, with minimal adjustment from the two (2) participants who were anonymous and geographically apart from each other.
2.	**Reliability**	Polit and Beck (2017:179) and Brink et al. (2018:155) define reliability as the capacity of an instrument to yield similar outcomes when applied to a similar situation. This criterion deals with the accuracy and consistency of information obtained from a study. The preliminary guidelines emanated from the empirical data in Phase 1 and were supported by literature refer to Chapter 5. The Delphi technique was used as a data collection instrument whereby anonymous expert participants from diverse geographical settings were invited to participate in the guideline validation process (Msibi et al., 2018:2; Botma et al., 2016:253). The participants were chosen because of their knowledge, experience, expertise and skills. They were asked to participate in the guideline validation process through a series of Delphi rounds. The same instrument was emailed to all.

		the participants who indicated their willingness to participate in Delphi rounds by signing and returning the consent forms. Reliability was achieved by ensuring that all fourteen (14) participants used the same instrument to rate the given criteria.
3.	**Clarity**	The guidelines should be clear, simple, easily understandable unambiguous and specific to the situation and population to which it applies. In this study, the guidelines were developed for PHCNs to support grandparent headed families regarding SRH. The guidelines were drafted and sent to expert participants for validation.
4.	**Applicability**	The guidelines should clearly indicate the target population and be easy to apply. In this study, the target population is grandparents and grandchildren as recipient of SRH promotion information and they could be used by PHCNs as implementors to support grandparents and grandchildren regarding SRH promotion at PHC facilities. Upon implementation the guidelines should have a measurable impact because they were exposed to a panel of experts who anonymously provided inputs until consensus was reached as represented in figure 6.4.
5.	**Relevance**	The guideline should be related to the matter at hand which is SRH promotion. The guidelines are relevant in terms of the PHCNs support for grandparent headed families regarding SRH to encourage open communication between grandparents and grandchildren. The relevancy is crucial to promotion of a healthy sexual reproductive health, reduction of risk sexual behaviours and understanding the legal framework that relates to SRH promotion.
6.	**Flexibility**	The guidelines are flexible to suit diverse age groups or contexts which are the clients are based. The design and development of the guidelines focused on the participants experiences including their recommendations as shared in table 6.1 which displayed the summary of information from grandparents and grandchildren.
7.	**Review of the guidelines**	The Guidelines will be reviewed as the need arise or every three (3) to five (5) years (De Leo and Bloxsome, 2022:9).

6.6 OVERVIEW OF STRUCTURE AND APPLICATION OF THE AGREE II INSTRUMENT

The Appraisal of Guidelines for Research & Evaluation (AGREE) II instrument is an internationally known tool used to evaluate the quality and reporting of practice guidelines (Brouwers et al., 2016:). These instruments consist of six (6) domains, namely: scope and purpose, stakeholder involvement, the rigor of development, clarity of presentation, applicability and twenty-three (23) appraisal items, each with a specific criterion (Hatakeyama et al., 2019:2; Zhang et al., 2019:4, Hoffmann-Eber et al., 2018:1). The

researcher identified domain 1-5 that were applied to this study. Domain 6 was excluded because it talks more about the competing interests of the guideline developers and the funding bodies, as such, it was deemed irrelevant. The structure and the application of AGREE II domains are below in Table 6.2.

6.6.1 The Application of the Agree II Domains

There AGREE II consist of six (6) domains which were adapted from the Appraisal of Guidelines for Research & Evaluation II instrument (The AGREE Next Steps, 2010; Consortium, 2009: Updated, 2013). However, the researcher used five (5) domains instead of six (6). The domains are scope and purpose, stakeholder involvement, the rigor of guideline development, clarity of presentation and their applicability. The Domains, the focus of the domain, including the application to the study, are discussed in Table 6.1 below.

TABLE 6.3: ***AGREE II DOMAINS***

DOMAINS	FOCUS OF THE DOMAIN	APPLICATION OF THE DOMAIN TO THE STUDY
DOMAIN 1: Scope and purpose	The domain focusses on the overall aims of the guidelines, the specific health questions, and the target population.	• The scope and the purpose of the guidelines are well-defined. • The purpose of this study was to develop communication guidelines to support PHCNs regarding SRH within grandparent headed families. • The researcher ensured that the research questions covered by the guidelines were addressed. • The scope of the guidelines emanated from the preliminary findings in Phase 1: the essences and constituents of PHCNs, grandparents and grandchildren as presented in Chapter 4 and discussed in Chapter 5. • The population to whom the guidelines apply are described throughout the study. • However, the researcher used the findings discovered from the experiences of grandparents and grandchildren to strengthen the formulation of the guidelines (Table 6.1).
DOMAIN 2: Stakeholder involvement	The domain is concern about the extent to which the guidelines are developed by the appropriate stakeholders and represent the views of its intended users.	• This step deals with stakeholder involvement in the development and validation of the guidelines and representation of the views of the PHCNs, grandparents and grandchildren who are the intended users. • The researcher identified the appropriate expert participants to participate in Delphi process to share, deliberate and reach consensus to achieve the study purpose. • Each panel member was invited and signed a consent form which indicated their willingness to participate in the Delphi rounds.

		• The panel members were required to provide individual opinion and exercise their freedom of expression without any external pressure. • Anonymity and feedback played a crucial role during this phase. • Experts were invited to participate in Phase 2 of the study whereby they evaluated, modified and validated the development of the proposed guidelines, made inputs until they reach consensus (Hoffmann-Eber et al., 2018:2). These experts were selected purposely based on their qualification, years of experience which are highlighted in table 6.3. The experts signed a consent to ensure that their participation is voluntary, and they were also provided with an information leaflet to have a clear understanding of what is expected of them.
DOMAIN 3: Rigor of development	This domain related to the processes that are used to gather and synthesis evidence including the methodology that was used to articulate recommendations and update them.	• Rigor denotes the quality of evidence offered in a study by striving to make good decisions to produce highest possible quality towards patient or client care. • The researcher applied the methodology that was followed to ensure rigor: Delphi technique was used for modification and validation of the guidelines. • The preliminary guidelines were drafted by the researcher and sent out to the expert participants for evaluation, modification and validation and provide comments or inputs. • Delphi panellist rated the guidelines to ensure validity and reliability of the proposed guidelines. • Reliability was ensured by other PHCNs interpreting, applying and implementing the same guidelines in CoT district. • Hoffmann et al (2018:5) indicated that rigor is regarded as the strongest indicator of quality in guideline development

DOMAIN 4: Clarity of presentation	This domain deals with language, structure and format of guidelines.	• The researcher ensured that the language used was simple, clear, easily identifiable and specific. • The proposed guidelines were drafted in English which was appropriate because all the expert participants were well conversant with the language. And contact numbers were reflected on the information leaflet for clarity seeking questions in case there was a need. • The Delphi panellist determined the extent of the guidelines for being logic, precise and user friendly. Comments were provided and were used for modification of the guidelines.
DOMAIN 5: Applicability	This domain pertains to the likelihood of barriers and facilitators to implementation, strategies to improve uptake and resource implications of applying the guidelines	○ The guidelines are applicable to the target population: PHCNs, grandparents and grandchildren. ○ The applicability of the guidelines was confirmed by the ratings that the panellist provided in a series of rounds until consensus was reached in round 2 of Delphi. ○ PHCNs identified some barriers that hinders SRH communication within families namely: family related barriers and Health care system related barriers which need to be addressed as discussed in Chapter 5. ○ All the expert participants shared their opinions/thoughts/views which assisted in the evaluation, modification and validation of each guideline. ○ Implementation will be done after approval by the relevant authorities and workshops/in-service trainings can be conducted to capacitate the PHCNs regarding the implementation of the guidelines.

6.7 METHOD OF GUIDELINE DEVELOPMENT, CONSOLIDATION AND REFINEMENT

6.7.1 Research design: Delphi technique

In Phase 2, the Delphi technique was the appropriate research design because the aim was to collect data from experts based on their judgement and reach a consensus to develop guidelines from the empirical findings that emerged from Phase 1 of the study (Botma et al, 2026:253). Goodairzi et al. (2016:220) define Delphi as a qualitative research method which uses experts' judgement for decision making to obtain consensus. Naisola-Ruiter (2022:1) pronounces the Delphi technique as a qualitative, quantitative and mixed method approach because the collection of expert opinions is regarded as qualitative, whilst plotting the results, which are numeric, is regarded as quantitative. On the other hand, Massaroli et al. (2017:3) refer to the Delphi technique as a mixed method because it permits diverse research strategies for data collection and analysis.

Polit and Beck (2017:725) define the Delphi technique/method as a tool that is used to measure the judgement of several people who are experts in a certain field to decide on matters of concern. In addition, Vogel et al. (2019:2575) confirmed that the Delphi technique has proven to be a reliable tool in developing future orientated research or providing a better understanding of certain issues. Furthermore, Niederberger and Spanger (2020:2) express the Delphi technique as a structured group of communication processes in which complex issues are deliberated by experts, where knowledge is uncertain or incomplete and evaluated by a panel of experts using an iterative process. In this study, the complex problem or challenge was SRH communication between grandparents and grandchildren. Several authors affirmed that in the Delphi technique, the panel of experts are geographically far from each other and share the same sentiments on an issue of concern and ensure that consensus is reached where there are different views (Schmalz et al., 2021:1; Msibi et al., 2018:1; Botma et al., 2016:253; Avella, 2016:306).

The primary purpose of the Delphi technique is to generate reliable consensus views from a group of experts through a collaborative process characterised by controlled feedback (Nasa, Jain & Juneja, 2021:117; Massaroli et al., 2017:3; Habibi, Sarafrazi & Izadyar, 2014:8). In this study, it was done in a series of three rounds (3). The involvement of experts was in line with Domain 2 of AGREE II, which relied on stakeholder involvement and assisted with the development evaluation, modification and validation of the proposed guidelines. The experts' participants shared their knowledge and expertise regarding SRH promotion anonymously until consensus was reached in Delphi rounds number two which was facilitated by the researcher, with round three used for validation of the same guidelines.

Naserrudin et al. (2022:2) define consensus as a general agreement of a predetermined group of experts and is considered most reliable because of the controlled feedback from experts in a series of rounds. In addition, Polit and Beck (2017:244) allude that consensus is achieved through multiple iterations. In this study, iterations were shown by presenting participants with a questionnaire and they had to indicate their ratings and provide comments/opinions in a series of rounds and the researcher provided feedback after each round. Furthermore, MacMillian, Kind and Tully (2016:655) affirm that Delphi is used to develop guidelines with health professionals hence the researcher identified experts in the field to make valuable contributions towards the development of SRH communication guidelines. Schmalz et al. (2021:2) and Silva and Montilha (2021:3) identified four main features of Delphi, namely, anonymity, iteration, controlled feedback and statistical group response, detailed in Chapter 3.

This phase consists of an interactive process that is aimed at getting a range of opinions or views from a group of experts and was facilitated by the researcher to maintain objectivity (Massaroli et al., 2017:6; Hu et al., 2016:5). In this study, experts in SRH field shared their views which assisted in the modification and validation of the draft guidelines. This allowed participants to reflect and reconsider or adjust their thoughts based on their anonymity to provide valuable comments and ensured that each participant was not pressured by other group members. In the Delphi technique, the researcher is regarded as a planner and later a facilitator as opposed to being a research instrument in other qualitative studies (Avella, 2016:307;318). The author states that the most critical role of being a facilitator is to control the debate and be non-judgmental when consolidating the views of the panel members. Delphi technique is conducted in rounds until all the panel members reach a consensus or come to an agreement. The purpose of Delphi, the role of the researcher and the panel of experts were discussed below.

6.7.1.1 Purpose of the Delphi Technique

The researcher opted for the Delphi technique to ensure that there is knowledge sharing amongst experts, its cost effective, simple and flexible, every participant has freedom of expression and participants are from diverse geographical locations and settings (Silva & Montilha, 2021:13). In addition; Kluge, Ringbeck & Spinler (2020:3) allude that Delphi is vital in gaining different perspectives from participants to avoid biases. In this study, expert participants verified the findings that were used for the formulation of guidelines through an iterative process. All the participants provided their opinions or views regarding the quality of the proposed guidelines by using the rating scale that was provided and further provided

comments. The draft guidelines were sent to the researcher for refinement. The researcher sent the clean document to all the expert participants for further comments until consensus was reached.

The role of both the researcher and the expert participants in the Delphi technique are highlighted below:

6.7.1.2 Role of the Researcher

The role of the researcher is detailed below:

- The researcher initiated and facilitated the Delphi process.
- Developed a questionnaire with instructions, a rating scale, a criterion for the proposed guidelines and a space for comments at the end of each guideline.
- Established the criteria for the selection of expert participants.
- Invited the participants by sending invitation letters accompanied by the information leaflet, consent forms and proposed guidelines with instructions that the participants followed.
- Formulated and drafted five (5) preliminary guidelines based on empirical findings in Phase 1.
- Preliminary guidelines were sent to all the participants, and the questionnaire was returned to the researcher to consolidate their views/opinions.
- Controlled feedback in a series of rounds was provided to all the expert participants participating in the Delphi rounds.
- The guidelines were refined and emailed back to all the expert participants until a consensus was reached.

6.7.1.3 The role of the expert participants

- The expert participants read the information leaflet and signed a consent form to indicate their willingness to participate in the Delphi rounds.
- Individual expert participants reviewed the provided guidelines, rated them according to the rating scale provided and commented before they were sent back to the researcher.
- The refined guidelines were returned to the participants for further review of their opinions or thoughts for amendment or retention of their initial decision until consensus was reached.
- The expert participants shared their knowledge, experience on SRH promotion and guidelines developed to ensure that quality guidelines are developed.

6.7.2 Research Methodology

In Phase 2, the methodology focused on population, participant selection, sample size and data collection through the Delphi rounds. Phase 2 of this study was also directed by the theoretical framework of Delphi, as detailed in Chapter 3.

6.7.2.1 Population and Sampling

The population is the entire group of persons that is of interest to the research and meets the inclusion criteria (Brink et al., 2018:116; Polit & Beck, 2017:56; Botma et al., 2016:6). In this phase, the participants were purposively identified because of their knowledge and experience on SRH and guidelines development. Snowballing was used to widen the sample size by asking participants to identify other key role players. Both sampling snowballing and purposive methods were used to ensure that participants with expertise were identified and invited to participate in the development, modification and validation of the guidelines. Expert participants were knowledgeable and competent and provided valuable opinions as representatives in the field (Naserrudin et al., 2022:2). All the participants provided their position, qualifications, occupation, employer, including experience around healthcare, SRH, guidelines development or academia (Table 6.4).

6.7.2.2 Sample size

Several studies indicated that there is no standard size for panel members, and the size may vary from 10 to 100 depending on the nature of the topic or SRH related problems (Nasa, Jain & Juneja (2021:118; Avella 2016:308). Vogel et al. (2019:2576) affirm that a minimum of 12 participants is considered sufficient to enable consensus, whereas a larger sample size provides diminishing returns regarding the validity of the findings. MacMillian (2016:5) was in support of the suggested sample size of 15 participants, which is viewed as adequate. On the contrary, Naserrudin et al. (2022:6) state that there is no consensus in the literature on the precise number of participants in the Delphi technique; however, twelve (12) or more are regarded as being sufficient, whilst less than six (6) is regarded as insufficient. According to Massaroli et al. (2017:5), the sample size was viewed as a critical point because of a need for diverse expert opinions, whereby the larger the number of expert participants, the greater the reliability of the results. On the other hand, the same authors reiterate that the large number of participants hinders the breakdown of the analysis of various opinions that individual panel members raised.

Stakeholders were used or involved in the recruitment process through snowballing sampling technique, which assisted in expanding the sample size (Lecours, 2020:5). The

descriptive information of the panel members assisted the researcher in defining the sample, as presented in Table 6.4. Twenty-two (22) experts were identified, but only fourteen (14) expert participants agreed to participate in the Delphi rounds to evaluate, modify and validate the proposed guidelines. All the expert participants are registered nurses from diverse healthcare environments: PHC facilities, PHC District office, Nursing Education Institutions (NEIs), regional training centres and the regulatory body South African Nursing Council (SANC). Individual panel members possess qualifications with vast experience in SRH promotion and guideline development. All the participants were issued an information leaflet and signed a consent indicating their willingness to participate in the Delphi process (rounds) (**Annexure J).** The table below reflects the profile of the expert participants.

TABLE 6.4: ***DESCRIPTIVE INFORMATION OF THE PANEL EXPERTS***

NO	OCCUPATION	EMPLOYER	PROFESSIONAL AND ACADEMIC QUALIFICATIONS	EXPERIENCE IN THE FIELD OF HEALTH CARE/ SRH/ RESEARCH/ GUIDELINE DEVELOPMENT
1.	Deputy Director	Gauteng Department of Health	Diploma in General Nursing Diploma in Midwifery B (Cur) Nursing Admin & Community Health Nursing Diploma in Nursing Education Masters in clinical Fields of study Currently busy with PhD minimal experience in guideline development	-35 years' experience in the Nursing environment Inclusive of the Head Office (GDoH). -Experience in the Medical Aid Industry, hospital management section -Research as part of master's degree
2.	Academic Head of the Department (Community Nursing Science & Primary Health Care)	Gauteng Department of Health	-Masters in nursing education -Honours in Health studies -Clinical Nursing, Diagnosis, Treatment and Care (R48) -Currently busy with PhD studies	-Academic HOD=3 years -PHC nurse = 5 years -Nurse Educator and facilitated theory and clinical component of the reproductive Health module for R425 Levels 3 & 4 = 5 years Professional officer = 2 years Professional nurse =16 years

3.	Retired Nurse Educator	Gauteng Department of Health Part time at Sefako Makgatho University	-General Nurse -Midwife -Community Health Nurse -Critical Care Nursing -Nursing Education -Clinical Nursing Science, Health Assessment, Treatment and Care Postgraduate Diploma in Public Health	-1997-2002 lecturer R425 -2003-2017 lecturer R48 Developed study guides for Short Course on Sexual reproductive Health and facilitated the program. -Clinical facilitator at SMU from 2020 till to date
4.	Professional advisor	South African Nursing Council (SANC)	-Master's degree in nursing education -B cur Education et Admin -Post graduate Midwifery and Neonatal Science -Diploma in Comprehensive Nursing	2002-2012 Pretoria West Hospital 2012-2013 Kalafong Hospital 2013-2014 Medi Clinic 2014-2019 S.G Lourens Nursing College 2019 to date curriculum evaluator

5.	Deputy Director: Professional Development	Gauteng Department of Health -Central Office	-Diploma in Nursing Science and Midwifery -B Cur (I get A) -Diploma in Occupational Health Nursing -Higher Certificate in Health management -Certificate in Primary Health Care -Certificate in Assessor -Certificate in Moderation -Accredited BLS Provider -Accredited BLS Instructor	-Clinical Program Coordinator: Child Health (Tshwane District Health Office 2006-2013) -MCWH manager: Tshwane District Health Office 2013-2016 -Regional Training Centre Manager: 2016-2017 Deputy Director: Professional Development: Gauteng Provincial office (2018 to date)
6.	Senior lecturer	Gauteng Department of Health	-General Nurse (community and Psychiatry) and Midwifery -Bachelor's Degree -Master's degree	-5 years as a Professional nurse -18 years as a Nurse Educator -Quality Assurance -Researcher -Curriculum evaluation
7.	Retired nurse educator	Part time at TUT	-General Nurse -Midwife -Community Health Nurse -Nurse Education -Nursing Administration -Bachelors in nursing	-1986-1990 Kalafong Hospital -1991-1996 PAH -1996-2017 Nurse Educator- -General Nursing Science -Community Nursing S 100-200 -Midwifery

8.	PHC nurse	CoT	-B Tech in Nursing	-PHC Nurse 10 years
9.	Manager: CPD	SANC	-PhD -Masters -Nursing Edu -Nursing Admin	-Nurse Educator 25 years -Manager: CPD
10.	Professional Nurse Lecturer	S.G Lourens Nursing Campus	-Master of Nursing Science in Clinical Field -Nursing Education -Nursing Admin -Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care	-Lecturer 2008-2022 (Facilitating learning in class and clinical including SRH) -Professional Nurse, Nurse clinician and Midwife (CHCs) -PHC nurse
11.	Lecturer	Tshwane University of Technology	-Doctor of Philosophy	-7 years Lecturer
12.	Acting Senior manager-	SANC	-Master's degree in nursing	-31 years -Curriculum evaluator -Nurse Educator
13.	Senior lecturer	Gauteng Department of Health	-Master of Nursing Science in Clinical Field -General Nurse -Community Nursing -Nursing Education	-34 years -Nurse Educator Community Nursing Science (100 & 200)
14.	Facility Manager	City of Tshwane	-Registered Nurse	-35 years PHC nurse Facility manager

Table **6.4** present the descriptive information of the panel members who participated in the evaluation, modification and validation of the final draft of the guidelines. According to the analysis, all fourteen (14) experts participants were registered nurses who are registered with South African Nursing Council (SANC) but working in diverse health environments, namely: District office; PHC setting; Regional training centre (RTC), Nursing Education Institutions (NEIs)-nursing college, University of Technology & University, SANC. All the participants were females, this is confirmation of the historical background of nursing, which indicated that nursing had been a feminine profession ever since the time of Florence Nightingale, who regarded women as carers (Mao, Cheong & Tom, 2021:1; Palma et al, 2020:203; Kaura et al., 2018:83; Ndou & Moloko-Phiri, 2018:1). However, Ndou and Moloko-Phiri (2018:6) further state that the existing gender stereotype in nursing must be addressed in order to change the perception and encourage more males in the nursing profession as this will also address the issue of staff shortages.

Of the fourteen (14) expert participants,two (2) hold doctoral qualifications, seven (7) hold a Masters Degree and five (5) hold a Bachelor's Degree in Nursing Science. The years of experience ranged from 7 to 39 years. The abovementioned analysis confirms that the expert participants are knowledgeable, skilful and have vast knowledge in nursing, and their opinion is valuable. All the panel members are well conversant with English thus, there was smooth communication between the researcher and the participants; this further assisted the researcher in ensuring that the language used in the guidelines is in line with criterion 3 presented in Table 6.2.

6.7.2.3 Data collection instrument

The researcher developed a data collection instrument. The instrument included instructions that guided the expert participants on what was expected. In this study, the guideline appraisal tool was developed to ensure methodological rigor and transparency as stipulated by Hoffmann et al. (2018:2). A 4-point Likert scale was used to indicate if the domain or guidelines are valid, reliable, clear, and applications using the rating scale: (1) to strongly disagree (2) disagree (3) agree (4) strongly agree (**See Annexure**). Space was provided at the end of each guideline for participants to provide inputs or suggestions or recommendations.The tool was piloted with two (2) participants who met the inclusion criteria but who were not included in the main study. Pilot experts provided the researcher with feedback within the stipulated timeframe. Upon analysis minimal adjustment were done before it was sent to panel of expert participants for Round 1.

6.7.2.4 Data Collection and Analysis

Data collection consisted of a series of Delphi rounds, as depicted in Figure 6.3 below.

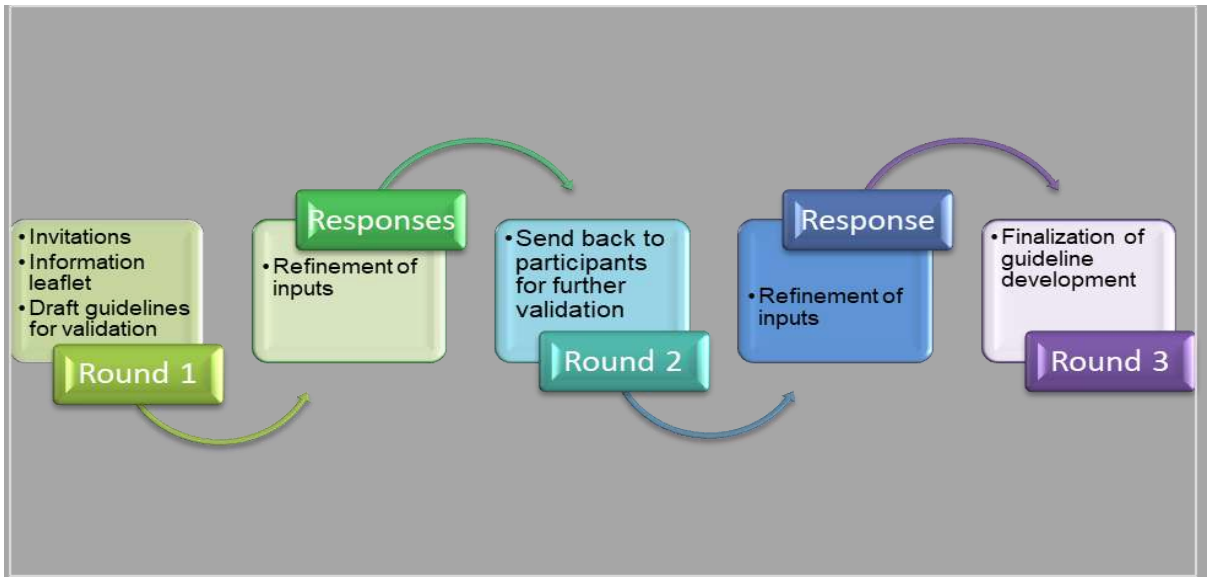

Figure 6.3: ***Represent the series of Delphi rounds.***

- **Delphi Round One (1)**

In the first round, the researcher emailed the invitation letter, information leaflet which stipulated the title of the study, the objectives, including the summary of the findings, consent forms. The researcher highlighted the return date for the completed documents. The instrument had instructions and included the draft preliminary guidelines, and the rating instrument with spaces to allow expert participants to comment **(Annexure O)**. From the twenty-two (22) participants that were identified, only fourteen (14) participated in Delphi rounds, as confirmed by signed consent forms which were returned to the researcher by email. A 4-point Likert scale was utilised by the participants to rate the quality of the guidelines and provided comments on the provided space as stipulated by Hoffmann et al. (2018:2). The participants rated each domain or guidelines against the provided criterion: validity, reliability, being clear and its applicability using the rating scale: (1) -to strongly disagree (2) -disagree (3)-agree and (4) strongly agree as depicted in **Annexure O**.

The researcher gave participants a week to work on the preliminary guidelines and return the tool to the researcher for analysis and refinement. The response rate was terribly slow, and a reminder was sent out to all the identified participants. Several authors admit that Delphi is a very slow process (Schmalz et al., 2021:3; Veugelers et al., 2020:2). However, Schmalz et al. (2021:10) reveal that to avoid low response, the distribution of questionnaires

should not overlap with holidays. This was confirmed by the sequence of events during the first round of Delphi, whereby the questionnaire was sent to participants during the month of December month which has a lot of public holidays. Most participants provided work email addresses which contributed to the delays. All the same, participants acknowledged the importance of the participation and provided feedback as requested.

Reminders were resent and only two (2) out of twenty-two (22) participants responded. Several reminders were sent to encourage participants to respond, and the researcher reminded each participant that their views were crucial for the refinement of the guidelines (Tengan & Aigbavboa, 2017:1968). These reminders assisted the researcher in maintaining participants' engagement in the evaluation and modification process, and participants were continuously thanked for their valuable contributions. Ultimately from the twenty-two (22) participants, fourteen (14) responded, two (2) declined, citing conflicting roles, and six (6) never responded despite reminders that were sent. The researcher respected their right to participation and withdrawal at any given time, as indicated in the information leaflet (**Annexure J**).

As feedback was received from the participants, the researcher developed a spreadsheet where the ratings for each guideline were plotted as directed by Hall et al. (2018:3). This enabled the researcher to observe the response rate and the outcome of the ratings whether the participants agree or disagree with the formulated guidelines. Some participants rated the guidelines and provided comments, whilst others only rated the guidelines without any comments despite the numerous requests for comments. The researcher went through all the submitted feedback, including the ratings. The researcher formulated a modified questionnaire based on the comments or inputs received from the expert participants for preparation of round 2 of Delphi (Botma et al., 2016:254). According to the findings of Delphi round one (1) there was no consensus **(see Annexure L)**. Tengan & Aigbavboa (2017:1972) states that there is no single consensus in one approach that encouraged the researcher to refine the guidelines in preparation for round two (2).

- **Delphi Round Two (2)**

The researcher emailed a cover letter whereby participants were thanked for their valuable contributions and requested input and provided with instructions regarding the process of evaluation and modification of the proposed guidelines, including the summary of the consolidated ratings from all the panel experts. The questionnaire had space for comments at the end of each guideline. The researcher ensured summary of the results was shared

with the participants for further evaluation (Goodarzi et al., 2016:222). The areas that have been modified were highlighted in red to alert the participants about the changes that took place. After several reminders, the instruments were returned to the researcher for analysis and refinement.

During this round, it was established that none of the participants strongly disagreed or disagreed with the modified guidelines. According to the developed spreadsheet, it was clear that the participants agreed with all the aspects of the guidelines **(see Annexure M)**. Participants reached a consensus in round two (2). All the ratings were recorded on a spreadsheet, and a consolidated list was compiled, which highlighted the final ratings. It was established that 13 participants agreed and strongly agreed with the modified guidelines, and one (1) participant didn't respond despite several reminders. The consensus was reached in round two (2).

- **Delphi Round three (3)**

Round 3 was regarded as the final validation stage of the proposed guidelines. See 6.9 below for more information.

6.8 DEVELOPED GUIDELINES

Five (5) drafted guidelines were formulated by the researcher, evaluated, modified and validated by the panel of experts through the Delphi rounds discussed above. Each expert participant anonymously and provided feedback without any influence from other participants. Finally, all the collective views and opinions gave rise to the final five (5) guidelines presented below. Each guideline is followed by the rationale for its inclusion and the actions needed for implementation of the guidelines.

6.8.1 Name of Guidelines

The key purpose of this study was the ***development of communication for PHNCs to support grandparent headed families regarding SRH in Tshwane district***. These guidelines were drafted and formulated based on the empirical data from Phase 1 and extensive literature control (see Figure 6.2). The panel of experts played a vital role in the evaluation and modification of the guidelines in a series of Delphi rounds until a consensus was reached in round 2. In this study, the Delphi rounds were used for modification and validation of the guidelines.

6.8.2 Aims of the Guidelines

The guidelines were developed to:

- To enhance and promote the implementation of the communication guidelines for PHCNs to support grandparent headed families regarding SRH.
- Function as a tool to provide SRH services and encourage utilisation of SRH services.
- Create an enabling environment for grandparents and grandchildren to resolve SRH related problems.
- Create awareness of contemporary issues related to SRH, including legislative frameworks that both the PHCNs can utilise to manage SRH related problems.

6.8.3 Scope of the Guidelines

The scope and purpose of the guidelines are related to the overall aim of the study, the specific research questions, and the target population (Brouwers et al., 2017:11). In this study, the scope and purpose of the guidelines are explained in Domain one (1) of the AGREE II (Table 6.3). The research questions and objectives of the study are indicated in Chapter 1, respectively. The five (5) preliminary guidelines were formulated based on the empirical findings in Phase 1.

6.8.4 Description of the Guidelines

The rationale and specific actions of each guideline are discussed in detail in the below section. Trustworthiness of the development process, implementation and review of the guidelines are shared below.

The guidelines were drafted and formulated based on the empirical data in Phase 1 of the study and were supported by extensive literature control (Figure 6.2). The researcher formulated the five (5) draft guidelines validated by the expert participants who participated in the evaluation and modification process. The preliminary guidelines were sent to the panel members, and some came back with comments. The changes on the guidelines were highlighted to make the panel members aware of the alterations made. The rationale for including the grandparents and grandchildren was explained in Chapter 4 (4.3.1). Each guideline has an accompanying action to motivate its existence, including actions to be taken by the users. The proposed guidelines are discussed below:

GUIDELINE 1: PHCNs should be capacitated as part of induction or in-service training regarding SRH promotion in relation to building a therapeutic relationship, comprehensive health assessment, health education, referral system, stakeholder engagements, sexual reproductive health rights including Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and more (LGBTQIA+) people.

(a) Rationale:

Participants in this study recommended the need for capacitation of PHC nurses to understand their role in promotion of SRH communication within the grandparent headed families. Capacitation of PHCNs guaranteed that PHCNs understood their role and can implement the guidelines appropriately. It is imperative that PHCNs are capacitated to enhance the promotion of efficient and effective SRH services in the PHC settings. This put them in a better position to support grandparents headed families to have open communication regarding SRH related topics. The findings of this study revealed that PHCNs are regarded as main role players in SRH promotion because of the knowledge, experience and skills they have acquired in their training, Inservice training and workshops. In addition, the National Adolescent and youth health Policy (2017) advocates for the provision of in-service training for PHCNs to enable the promotion of SRH communication within families. In this study, Table 4.1 of Chapter 4 presented the years of experience of PHCNs who are experienced and knowledgeable on addressing the health needs of all the healthcare consumers (Taskin et al., 2020:95).

PHC is the people's first contact with the health system and is aimed at the provision of comprehensive, accessible and cost-effective care throughout the client's life span (Du et al, 2019:12; Mcallister, 2019:1, Smith et al., 2018:3; Barbian, Dalla, Nora & Schaefer, 2016:2). PHCNs must be knowledgeable to provide quality SRH care to all clients (Osei et al, 2019:2). Therefore, capacitation is perceived as the key strategy to equip PHCNs with knowledge and assist them to be comfortable in managing sensitive topics with ease. The said notion was confirmed by a study conducted in the Western Cape by Zambodia, Williams and Ricks (2021:1), who alluded that PHCNs must be optimally capacitated to be able to provide quality care. Michael et al. (2018:2) emphasise that PHC is a nurse led and doctor supported service, which means the PHCNs must be efficient and competent to perform their duties.

PHCNs are perceived as critical role players in the creation of enabling environment for clients to seek advice, information or even treatment when confronted with SRH related problems, thus promoting effective and efficient SRH services (Seretlo & Mokgatle 2023:1; Akazili et al., 2020:3). Nurses play a pivot role in the improving the health standards hence there is a need for constant update of theory and clinical knowledge in SRH promotion which include curriculum reviews to include new information (Chaghari et al., 2017:27). Taskin et al. (2019:98) posit that HCPs plays a vital role in the provision of SRH services to all individuals regardless of their sexual orientation.

Building rapport assists in the eradication of negative attitudes of HCPs that exacerbates the non utilisation of SRH services. Seretlo and Mokgatle (2022:1) indicate that cultural and religious factors had been cited for poor interaction with LGBTQIA+ clients. In addition, several authors revealed that the capacitation of PHCNs will resolve stigmatisation and discriminatory issues that are experienced by LGBTQIA+ clients seeking SRH related services (Kemery, 2021:1; McNeil, McAteer & Jepson 2021:3; Taskin et al., 2020:95).

Action:

- Provision of Inservice training for all the PHCNs in the clinic for personal and professional development.
- Induction program for all the newly employed PHCNs in the PHC setting in relation to SRH promotion, including contemporary issues emerging in society.
- The researcher is of the view that if nurses have adequate knowledge and attitude towards SRH promotion, open SRH communication with grandparents headed families will be enhanced, and the following topics should be covered.
    - building therapeutic relationships, comprehensive health assessments, health education, referral system, stakeholder engagements and sexual reproductive health rights, including LGBTQIA+ people. This will also include other SRH related contemporary issues.
- Perform skills audit to identify knowledge, skills and competencies to determine the need for personal and professional development.
- Advocate for modular training courses offered within the PHC facilities or through the regional training centres (RTCs).
- Develop SOPs that will assist in scheduling training programmes or meetings for information sharing and peer mentoring.
- Development of coaching programs to strengthen the application of the new knowledge.

- Plan and enhance workshops for PHCNs.
- Continuous in-service training could be conducted in the PHC setting or through the Regional Training centres to enhance personnel development.
- On-the-job training and mentoring can be adopted as another strategy for capacitating PHCNs within the PHC facilities.
- Networking with other role players interested in SRH promotion within families. The CHW can also be robbed in to disseminate the information during their home visits.
- Advocate for Continuing Professional Development (CPD) activities that ensure PHCNs are updated on all current SRH related matters.

GUIDELINE 2: PHCNs to establish rapport with grandparents to relate how SRH communication was debated in the previous era.

(a) Rationale:

The PHCNs are expected to build a therapeutic relationship with the grandparents and grandchildren to enhance open communication. SRH is still viewed as a private matter though the findings of this study revealed that there are benefits of SRH communication which play a pivotal role in promoting healthy SRH relations. Fakhr-Movahedi et al. (2016:267) state that communication plays a pivotal role in SRH promotion, and it is perceived as an essential tool that assists nurses in recognising the client's health needs. PHCNs must utilise supportive communication techniques and skills to address barriers and misconceptions regarding SRH.

In addition, Bright and Reeves (2022:2670) perceive therapeutic relations as being an integral part of SRH promotion because they allow open communication between the nurse and the client. Kwame and Petrucka (2021:1) further state that effective communication between the PHCNs and the clients is fundamental to ensuring optimal health outcomes. The use of communication skills to ensure that data collection is done correctly for correct diagnosis and treatment.

PHCNs should also be cognisant of culturally sensitive topics regarded as taboo based on individuals' beliefs, culture and religion. The findings of this study revealed that culture and cultural beliefs are inhibitors of open SRH communication within families. Therefore, PHCNs must find out from the grandparents how SRH communication was deliberated in the previous (Achen et al., 2021:2; Nmadu et al., 2020:2; Kinaro et al., 2019:3). The researcher believes that using communication skills is crucial in promoting SRH communication; further

requires respect for families' cultural and religious beliefs in enforcing open communication. The PHCNs must be good listeners and apply observational skills to assess the readiness to engage in sexual talks, which is perceived as a private matter coupled with barriers/misconceptions that hinder open communication. Sekgobela, Peu and de Waal (2020) alluded that PHCNs have to create/establish rapport and trust, creating an enabling environment for open SRH communication within families.

PHCNs should be able to allow grandparents to share or debate how SRH matters were handled previously.

(b) Action:

PHCN's approach:

- Establish rapport, greet the client, show respect, and display a non-judgmental attitude.
- Identify a private room where the grandparent/grandchild will be comfortable and ensure that whatever is discussed will remain personal and confidential. Still, where the need to be referred to another therapist, the client must be informed.
- Maintain eye contact to show the client that you are interested in what you are discussing, being there, and using listening skills to the grandparent's/grandchildren's concerns. Allow the grandparent/grandchild to verbalise their concerns without interrupting the conversations.
- Show empathy by understanding the client's situation and being non-judgmental. This will assist the client to open.
- Be a good listener and repeat what the client has said to verify the provided information.
- Display a non-judgmental attitude so that the client can open and provide the necessary data to assist in making a diagnosis and treatment.
- Use non-verbal communication not to distract the client but show interest in what the client is saying.
- Acknowledge the belief system of the grandparents/grandchildren, as this will influence effective communication.

GUIDELINE 3: PHCNs to conduct history taking to identify grandparents' belief systems and their cultural practices in relation to SRH communication.

(a) Rationale:

PHCNs are the first contact with the clients (grandparents/grandchildren) in the PHC setting. Several authors have indicated that in the execution of their daily duties, PHCNs must take a correct and appropriate history, perform health assessments, do tests, diagnose and manage the client with drug and non-drug management (Alshahrani, 2020:227; Lloyd, 2018:82; Maria et al, 2017:6). Grandchildren may present with SRH related problems which may require health intervention. Proper history taking must be done to collect the relevant data and observations to exclude abnormalities. Faustinella (2020:250) reveals that inspection and clinical observation are vital to comprehensive health assessment as they lead to precise diagnosis and treatment. In this study, the PHCNs are expected to collect data through history taking and vital signs and perform a physical examination to come up with a correct diagnosis.

In addition, Falchenberg et al. (2021:207) posit that based on the humanistic and caring perspective of PHCNs are expected to assess clients, determine their condition, and come up with an intervention plan to ensure that their health needs are met. The findings of this study revealed that culture and cultural beliefs are inhibitors of open SRH communication within families. Therefore, PHCNs must find out from the grandparents how SRH communication was deliberated in the past when such talks were still regarded as being a taboo or private matter (Achen et al., 2021:2; Nmadu et al., 2020:2; Kinaro et al., 2019:3). Through effective communication skills and techniques PHCNs should be to collect data regarding the grandparents' beliefs and cultural practices that were employed towards SRH communication within families. As guardians, the grandparents should be able to share the information with the PHCNs to understand their role in promoting SRH.

Myths and misconceptions should be corrected, and open communication should be perceived as a tool that will be used to disseminate SRH information to families. A positive and non-judgmental attitude of PHCNs should be encouraged as that will yield good outcomes regarding SRH promotion.

(b) Action:

PHCNs approach:

- Create a therapeutic environment that will enhance open communication.
- Ask relevant questions from the grandchildren/grandparent.
- Take vital signs to exclude any abnormality.
- Conduct a physical examination to identify any physical problems and treat them accordingly.
- Ensure privacy for both grandparents and grandchildren.
- Manage (drug and non-drug management- Promote condom use, treat the partner and VCT.

GUIDELINE 4: PHCNs utilise continuous and participatory health education strategy to support grandparent headed families regarding SRH communication.

(a) Rationale:

The participants recommended that grandparents and grandchildren be capacitated to ensure they are knowledgeable to make informed choices and decisions on SRH related matters. PHCNs are the primary source of information because of their experience, competency and skills acquired during their training and personal development. Therefore, they play a vital role in the dissemination of health-related information. Health education is a strategy that could be employed to correct misconceptions and eradicate barriers that impede open communication between grandparents and grandchildren regarding SRH. The main purpose of the provision of health education is to empower grandparents and grandchildren to influence their attitudes towards informed decision making (Ramalepa, 2023:2; Raghupathi, 2020:2; Ramkilowan, 2016:63). Based on the humanistic nature of nursing PHCNs are expected to promote health and alleviate suffering (Falchenberg et al., 2021:207).

PHCNs should strive to promote the life of individuals, families and communities through health education. PHCNs have the capacity and opportunity to disseminate SRH information to grandparents and grandchildren in various settings, namely PHC facilities, schools, within communities as part of outreach programmes (Maria et al., 2017:2). Steyn et al. (2016:2) define participation as the active involvement of affected populations in decision making, implementation, management and evaluation of policies, programmes and services. Therefore, the active involvement of grandparents and grandchildren in SRH promotion enhances health literacy for both grandparents and grandchildren to be well informed on SRH related matters to make informed decisions. Maria et al. (2017:2) state that nurses can

use their unique knowledge and skills to positively impact SRH promotion within families through health education.

Even though it should be continuous, the creation of health education slots in the clinic ensures that all the clients get health information. Other modalities can also be used to reinforce the provided information, e.g., support groups, pamphlets, health videos and role play that can be done during open days.

(b) Action:

PHCNs approach:

- Ensure that health education is provided on an ongoing basis to ensure that grandparents and grandchildren are empowered on health-related issues that affect their health.
- A non-judgmental approach and culturally sensitive attitude must always be displayed to encourage full utilisation of the SRH services.
- Creating an enabling environment ensures that clients are well informed about all the services rendered at the PHC facilities.
- Ensure that grandparents and grandchildren are actively involved and participate during the health education process, whereby questions are allowed, and answers are provided.
- The use of understandable language for both the grandparents and the grandchildren assists in disseminating information.

GUIDELINE 5: PHCNs collaborate with relevant stakeholders within the PHC system through an effective referral system to promote SRH services.

(a) Rationale:

Collaboration is an important aspect of health care whereby health providers come together to render service to users. Sekgobela et al. (2020:5) highlighted that collaboration is the joint effort of various roles played by diverse groups in SRH promotion. Ramalepa (2023:2) confirms that collaboration with the DBE and DOS to promote SRH is very important however, the results of the study revealed that PHCNs provide health education when learners visit the clinics through youth friendly services that target teenagers. Therefore, PHCNs need to collaborate with the school healthcare nurses, the ward-based nurses who visit the grandparents at home, the social workers, the pastoral care services, the police and

the community to enhance SRH promotion. Their diverse expertise ensures that individuals are treated when addressing their health needs.

Twine et al. (2016:1) posit that stakeholder involvement in health-related matters benefits the PHCNs and the community because of the joint effort in addressing health concerns and eradicating some health risks. A family centered approach may be adopted to ensure that SRH related outcomes are enhanced. PHCNs must engage clients and their families to achieve positive outcomes and ensure their experiences and knowledge are considered (Kwame and Petrucka, 2021:1).

Maslow's theory of needs forms the basis for understanding human motivation. Grandparents as guardians need to understand the challenges of caring for young people, they must find ways of motivating them. Creating an enabling environment assists the grandparents to accommodate and accept all the SRH related contemporary issues, e.g., LGBTQIA+ people.

The introduction of PHC re-engineering, which consists of streams of health care services which focused on: (1) implementation of ward based primary health care, (2) strengthening school health services, (3) and establishment of the district clinical specialists who focus on maternal, child health and non-communicable diseases. The ward-based outreach teams (WBOTS) could also assist with dissemination of SRH information as they execute their daily duties within communities.

(b) Action:

PHCNs approach:

- Establish clear communication channels between all role players.
- Develop guidelines for coordination and collaboration initiatives to strengthen partnerships with all stakeholders.
- Involvement of the community (grandparents and grandchildren) on matters that affect their wellbeing (family day, health awareness days, etc).
- The roles of each stakeholder must be clarified and well explained so that grandparents/grandchildren can make informed decisions.
- Work with other multidisciplinary team members to appropriately refer grandparents/ grandchildren and promote an efficient referral system.

- They should be made aware of the services available in the community that can be utilised to address SRH related issues, e.g., GBV the grandparent/grandchild must know where to go without fear.
- Creating an enabling environment will encourage the utilisation of services in the community.
- Cultural sensitivity and the non-judgmental attitude of all the stakeholders will play a pivotal role in achieving the objectives of this study.

6.9 VALIDATION OF THE FINAL GUIDELINES

Delphi rounds were used in the validated process of the final draft guidelines by thirteen (13) expert participants who participated in the previous two rounds. In this study, validation was done in round three (3) and regarded as the final round after consensus was reached in round two (2). Goodairzi et al. (2016:223) confirmed that three (3) iterative rounds are sufficient for arriving at a high level of group agreement. The purpose was to ensure the judgement of the panel members. It also served as a feedback session for all the participants, representing the outcome of the Delphi rounds, including confirmation of consensus. The guidelines were validated for their relevancy, applicability, simplicity and importance in the SRH communication in which all the thirteen participants agreed with the stated information. The above discussions defined the end of the iteration rounds, including developing, modifying and validating the final draft guidelines.

To ensure the guidelines remain current, they must be reviewed within 3-5 years after implementation.

6.10 TRUSTWORTHINESS IN THE DEVELOPMENT OF THE GUIDELINES

To enhance trustworthiness in guideline development, the researcher ensured that the findings of the study were discussed in the context of the relevant literature shared in Chapter 5 of this study. These findings were used in formulating the proposed draft guidelines, as presented in Figure 6.2. The process followed for developing the guidelines was discussed in detail (see 6.5 of this chapter). To enhance credibility. Purposive and snowballing sampling was used to select the expert participants who participated in the Delphi process to evaluate, modify and validate the guidelines. A panel of experts were selected based on their knowledge, experience and interest in SRH promotion. The descriptive information of all the expert participants is outlined in Table 6.4. Twenty-two (22) participants were invited to participate in the Delphi rounds, an information leaflet which

contained all the details about the study was emailed to individual participants, and fourteen (14) participants who were willing to participate in the Delphi rounds signed and returned the consent form. A questionnaire with a 4-point Likert scale was developed to rate the proposed guidelines against the following criterion: validity, reliability, clarity and applicability. A series of Delphi rounds were followed until a consensus was reached.

6.11 GUIDELINE DISSEMINATION AND IMPLEMENTATION

The final stage of the developed guidelines is disseminating and implementing the proposed guidelines. The researcher will compile and share a report with the DoH, District and PHC managers in the City of Tshwane in accordance with the Tshwane Research Committee. Different platforms could be used to disseminate the guidelines, such as workshops, research presentations and publications on the departmental websites. The findings of this study will also be shared with the DoH (the Directorate which deals with SRH) so that they can be made aware of the issues that emerged from this study. Journal articles will be compiled, and presentations will be made at national and international conferences to share the research findings.

6.12 REVIEW OF GUIDELINES

According to the WHO (2012:52), the guideline date for review should be indicated, considering the pace at which the topics change or in case any new information emerges. The current guidelines will be revised after three (3) to five (5) years following adoption and implementation (De Leo & Bloxsome, 2022:9).

6.13 SUMMARY OF THE CHAPTER

Chapter 6 covered phase 2 of this study, which focused on developing and validating the communication guidelines for PHCNs to support grandparent-headed families regarding SRH in the Tshwane District of the Gauteng Province. The framework, which comprised the essences and constituents of the PHCNs, and the processes that were utilised by PHCNs to support grandparent headed families regarding SRH communication were developed. Five (5) draft guidelines emanated from the empirical findings of Phase 1 were also presented. A summary of the information gathered from grandparents and grandchildren was also tabulated. Guiding attributes for developing and validating the guidelines were discussed in detail. The overview of the structure and application of the AGREE II instrument and the Delphi technique, which led to the modification and validation of the draft guidelines, were

presented. Chapter 7 presents the conclusions from the findings, the validation and the description of the guidelines' limitations, implications and conclusions.

CHAPTER 7

SUMMARY OF THE STUDY FINDINGS, RECOMMENDATIONS, CONTRIBUTIONS TO THE BODY OF KNOWLEDGE, LIMITATIONS, SELF-REFLECTION AND FINAL CONCLUSIONS

7.1 INTRODUCTION

The purpose of this study was to develop guidelines to support PHCNs regarding SRH within the grandparent headed families in the City of Tshwane District of the Gauteng Province. The study was carried out in two (2) phases and described in six (6) chapters. Chapter 1 introduced the study and presented background information focusing on the need to develop communication guidelines for PHCNs to support grandparent headed families regarding SRH in Tshwane District, Gauteng Province. Topic related literature review was extensively deliberated in Chapter 2. The research design and methodology of the two (2) phases were extensively addressed in Chapter 3. To achieve the study's aims and objectives, a qualitative, descriptive phenomenological contextual design was employed in Phase 1. The research paradigm and the philosophical underpinnings that drive the study were also presented. Chapter 4 presented and described the findings of the study.

The focus was on the essence of Primary healthcare nurses (PHCNs), grandparents and grandchildren regarding their experiences with sexual reproductive health (SRH) communication. Constituents supported these essences. Chapter 5 covered a discussion of findings, literature synthesis and control which integrated the findings of the study to provide a fuller understanding of the phenomena under study. Chapter 6 covered Phase 2 of this study, which focused on developing and validating the communication guidelines for PHCNs to support grandparent-headed families regarding SRH in Tshwane District, Gauteng Province. A framework comprised the essences and constituents and processes utilised by PHCNs to support grandparent headed families regarding SRH communication was developed. Five (5) draft guidelines emanated from the empirical findings of Phase 1 were presented. A summary of the information gathered from grandparents and grandchildren was also tabulated. The overview of the structure and application of the AGREE II instrument and the Delphi technique were also presented.

7.2 OVERVIEW OF THE STUDY AND SUMMARY OF THE STUDY FINDINGS

The overview of the study includes the findings of phases 1 and 2. The aim of this study was *to develop communication guidelines for PHCNs to support grandparent headed families*

regarding SRH in the Tshwane District of the Gauteng Province. To achieve this aim, the study was presented in two (2) phases. Each phase consists of its own unique objectives. Phase 1 dealt with the exploration and description of sexual reproductive health communication within the grandparent headed families in the Tshwane district, whereby a qualitative, descriptive, and contextual design was used. The findings delivered valuable data, enabling the researcher to formulate five (5) guidelines to promote SRH communication within families. Some of the information from grandparents and grandchildren outlined in **Table 6.1** was used to strengthen the formulation of the guidelines. The findings of Phase 1 were presented in Chapter 4; contextualised and synthesised using relevant literature to gain a fuller understanding of the phenomena under study (Refer to Chapter 5). Phase 2 focused on the formulation and development of the guidelines. The objectives and the summary of the findings are outlined in the sub-sections below.

7.2.1 Phase 1: Empirical data

The objectives for Phase 1 (PHCNs) of this study were to:

- ***To explore and describe the experiences of Primary Healthcare Nurses regarding the promotion of SRH communication with grandparents and grandchildren.***

The researcher conducted individual phenomenological interviews with PHCs, grandparents and grandchildren. Individual phenomenological interviews were conducted to gather data from the PHCNs to achieve the objectives of the study and answer the researcher's questions. The phenomenological interviews were conducted in the PHC facilities where PHCNs engage with health users daily. The findings of the study yielded four (4) essences and twelve (12) constituents, which emerged from the analysed data and are presented in Chapter 4 of this study. The summary of the four (4) essences is presented in 7.2.1.1 below.

7.2.2 Summary of Phase 1 Findings (Primary Healthcare nurses)

7.2.2.1 THEME 1: PHCNS EXPERIENCES OF SRH COMMUNICATION

The findings of this study revealed PHCNs as important role players in SRH promotion through their shared lived experiences regarding SRH communication, and two constituents emerged. PHCNs' experiences of SRH communication occurred as the first essence with two constituents: PHCNs' experience of the benefits of promoting SRH communication and PHCN's experiences of family SRH communication.

7.2.2.1.1 PHCNs' experience of benefits of the promotion of SRH communication

Primary health care is the first level of contact with clients. PHCNs play a vital role in providing a variety of health care services, including SRH promotion PHCNs promote SRH through health education in the health facilities to create awareness and prevent SRH related problems. Both grandparents and grandchildren perceived PHCNs as sources of information. The findings of the study revealed that open SRH communication between grandparents and grandchildren is beneficial to enhance the SR wellbeing of adolescents. When both grandparents and grandchildren are well informed, they can easily share SRH information without hindrances. The findings of the study revealed that the provision of SRH promotion improves grandparents' and grandchildren's knowledge and understanding, thus, behaviour modification is enhanced. Therefore, PHCNS must create an enabling environment which promotes access and full utilisation of SRH services in the Tshwane District. To provide such services, PHC nurses must have the knowledge and skills to approach the subject easily. It was evident that SRH communication offers information that promotes abstinence and delayed sexual debuts allowing individuals to make informed decisions.

7.2.2.1.2 PHCNs' experiences of family SRH communication

Grandparents as guardians or parents are perceived as health promoters therefore, they are expected to instil good SRH norms and values during the socialisation of the adolescent (teenagers). Socialisation is enhanced through open communication regarding SRH related matters. PHCNs must play a crucial role in ensuring that grandparents are well equipped with information to handle this sensitive topic. The findings of this study revealed that open SRH communication is a cornerstone of a healthy lifestyle. However, PHCNs indicated that at times grandparents are not ready to engage in sex talks with their grandchildren due to their cultural or religious beliefs, which preach abstinence and still believe that sexual discussions are not permissible within families, especially with children who should be concentrating on their schoolwork, not adult issues. These may exacerbate teenage pregnancy, backstreet abortions and HIV/AIDS. PHCNs further revealed that in trying to communicate, grandparents' resort to idioms, expressions and riddles, which create a challenge because grandchildren are unfamiliar with the language. Therefore, there is evidence pointing out that cultural and religious beliefs are some of the reasons that there is no open communication between grandparents and children. Therefore, PHCNs must display a non-judgemental attitude that enhances open SRH communication within families.

7.2.2.2 THEME 2: PHCNS' EXPERIENCES OF FACTORS FACILITATING SRH COMMUNICATION

The findings of this study revealed that other sources of information play a vital role towards SRH promotion, namely: Grandchildren's SRH knowledge from other sources, PHCNs' competency and PHCNs' collaboration with and referral to different stakeholders.

7.2.2.2.1 Grandchildren's SRH knowledge from other sources

PHCNs revealed that grandchildren receive SRH information from other sources, including their peers, school, radio, television and social media. The findings of this study revealed the crucial role played by schools through the inclusion of Life Orientation (LO) in the curriculum. Schools have been identified as institutions that assists in the re-enforcement of the SRH norms and values to the school going children (Ndugga et al., 2023:2). There is also a concern about the high numbers of teenage pregnancies despite LO in school and the availability of youth friendly services at PHC (Sagnia et al., 2020:7).

Digital social media platforms were applauded for offering an innovative way of disseminating SRH information within families (Ndugga et al., 2023:2; Sagnia et al., 2020:6). The findings of this study exposed that grandchildren find it easier to access SRH information from the digital platforms. However, PHCNs still acknowledge parents as the main sources of SRH information (Sagnia et al., 2020:6). The authors also confirmed that peers, radio and television are other sources identified to educate and create awareness regarding SRH promotion. However, information from peers and digital or social media may be incorrect and misleading leading to poor SRH outcomes (Ndugga et al., 2023;2).

PHCNs advocate that reproductive health education is a cost-effective means of addressing SRH matters to create awareness for both grandparents and grandchildren. The of Health (DoH), through the implementation of school health services, assists in the preventive, promotive and rehabilitative services for school going children. PHCNs discovered that collaborative efforts between the DoH and the DBE play a paramount role in SRH promotion, thus assisting in reducing adolescent risky behaviour. Therefore, developing the SRH communication guidelines in CoT will assist PHCNs in supporting grandparent headed families regarding SRH.

7.2.2.2.2 PHCNs' Competency

PHCNs’ competencies were a prominent proposal made by the participants in this study. Participants viewed competency to promote SRH as one of the skills required to properly

engage in SRH communication within families. The findings agree with PHCNs provision of support to grandparents and grandchildren in promoting SRH communication within the grandparent headed families. Knowledgeable PHCNs will ensure that sustainable goal No 3 (SDG No 3) is realised. Participants reported that even though PHCNs interact with clients daily, some PHCNs still feel there is a need for future training on SRH. Participants in this study support the notion that PHCNs play an important role in SRH promotion because of their daily interaction with patients more than any other health professional. These participants also support that nurses treat patients with SRH related problems through history taking, assessments, physical examination and diagnosis, including non-drug and drug management. The inclusion of SRH communication in the PHC curricula will add value to the capacitation of PHCNs, thus improving SRH service delivery. The acquired knowledge will assist in addressing the health needs of families, which leads to behaviour modification.

The introduction of Continuous Professional Development (CPD) will assist PHCNs to be updated on health-related matters, including SRH. Manley, Martin, Jackson and Wright (2018:134) indicate that the main purpose of the introduction of CPD was to attempt to improve professionals' knowledge and competencies. In this context, CPD will enhance the knowledge, competencies and skills of PHCNs regarding SRH promotion. Despite the issue of PHCs competencies, the participants also revealed that PHCNs are also faced with challenges that may impede SRH promotion and service delivery.

7.2.2.2.3 PHCNs' collaboration and referral to other stakeholders

PHCNs revealed that collaborative effort with other stakeholders was important to ensure a proper and efficient referral system in addressing SR related problems. The positive impressions PHCNs provided in this study align with those by Unis et al (2021:2) and Rosen et al (2018:3), who acknowledge the benefits of interprofessional collaboration in SRH promotion. The findings of this study revealed that PHCNs maintain that an appropriate referral system improves the relations between primary health providers and secondary health specialists. A referral is viewed as a process whereby HCP refer clients to another level of the health care system or another health worker with expertise, namely nurse specialists, doctors, social workers and psychologists, for continuity of health service provision (Give et al., 2019:6). PHCNs must also be knowledgeable about all the SRH related legal frameworks which emanate from conflicting laws which may impede or hinder SRH promotion, e.g., children of any age may consent without the knowledge of the parents or guardians. Grandparents may be against the TOP and perceive termination of pregnancy as a sin because it is against their religious and cultural beliefs.

7.2.2.3 THEME 3: PHCNS' EXPERIENCES OF SRH COMMUNICATION BARRIERS

PHCNs' experiences of SRH communication emerged as the third essential meaning. The current study revealed some barriers experienced by PHCNs that hinder SRH communication. Barriers, challenges and obstacles have been identified as hindrances to SRH communication within families (Ndugga et al., 2023:9; Duby et al., 2022:8). According to the findings of this study, some barriers were shared by PHCNs regarding SRH communication are family and health related barriers.

7.2.2.3.1 Family related barriers

The family is the primary socialisation institution that plays a crucial role in shaping the adolescent's sexual behaviour. However, PHCN highlighted obstacles that hinder open SRH communication within families. The essences of PHCNs' experiences of SRH communication barriers yielded four families (4) family related constituents which are emotional, cultural, religious and barriers between grandparents and grandchildren which are summarised below:

- **Emotional related barrier:** Fear was expressed as the main barrier towards SRH communication within the grandparent headed families. Similarly, the participants realised that fear was a significant factor that impedes SRH communication between grandparents and grandchildren due to societal expectations whereby sexual talks are regarded as taboo or private matters (Wakjira & Habedi, 2022:6; Yibrehu & Mbwele, 2020:6; Kinaro et al, 2019:7; Landa & Fushai, 2018:2). PHCNs highlighted that fear has a negative impact towards SRH promotion as evidence by grandchildren being unable to share any SR information with their grandparents fearing to be seen as being promiscuous (Duby et al., 2022:11). On the contrary PHCNs assume grandparents as guardians should have sex talks with their grandchildren because they are perceived as health promoters and socialisation agents (Nyirandegeya, Rugema & Katende, 2022:21; Nketia, 2022:1598). The authors further affirm that there are perceptions that sexuality issues should be discussed through third parties or extended families. It was also evident from the study that fear doesn't not only emanate from grandparents, adolescent experience fears as well, which some PHCNs exacerbate with non-accommodative attitudes towards adolescents who come to the clinic requesting SRH interventions. Nurses' Attitudes must also be corrected to ensure that adolescents and grandparents can raise their concerns without any judgement.

- **Cultural related barrier:** Culture and cultural beliefs emerged as another obstacle to SRH communication within the grandparent headed families. In the African culture, communication about sexual issues is still viewed as a taboo (Nyirandegeya et al., 2022:31; Nketia, 2022:1598; Nmadu et al., 2020:2; Yibrehu & Mbwele, 2020:6). Despite the cultural barriers, grandparents are expected to have open SRH communication with their grandchildren to provide first hand SRH information (Sagnia et al., 2020:2). There is still need for age-appropriate language to enable grandparents to have sex talks with the grandchildren comfortably. The initiation schools were also applauded for their contribution to SRH promotion, where adolescents were taught about the transition to adulthood (manhood or womanhood) however, little is known about the content of their discussions.
- **Religious related barrier:** Participants revealed the diverse role of religion as a moral builder and as a hindrance of SRH. Religious beliefs of grandparent's impact SRH provision, e.g., the termination of pregnancy is perceived as a sin regardless of the circumstances which lead to the adolescent being pregnant, which may have a detrimental effect on the adolescent's emotional and psychological state. Grandparents may not be aware of legislative frameworks permitting TOP services available in the facilities/hospitals. On the other hand, religion discourages sex before marriage, thus promoting abstinence which prevents STIs, teenage pregnancy and HIV/AIDS (Achen et al., 2020:9). The is researcher is of the view that more awareness campaigns need to be done, and churches as a moral builder to join hands in the promotion of SRH.
- **Barriers between grandparents and grandchildren:** The findings of the study revealed that there are grandparents who still believe that sexual reproductive health issues are sensitive. Therefore, they still feel uncomfortable sharing such information with their grandchildren (Nyirandegeya et al., 2022:31). Grandchildren fear asking questions because they may be seen as being promiscuous, whilst grandparents may feel SRH communication encourages promiscuity (Duby et al., 2022:11; Sagnia, Gharoro & Isara, 2020:6). The same authors reveal that other grandparents are knowledgeable but do not know how to approach the subject or engage with their grandchildren. The participants in this study revealed that the use of idiomatic expressions is a sign that SR related topics are still not easy to handle, this was confirmed by several studies (Ndugga et al., 2023:7; Mbarushimana, 2022:5; Sagnia et al., 2020:1). Generational gap is another issue that exacerbate discomfort as adolescent may view the grandparents as being rigid and outdated and may not see

the importance of engaging them on SRH related issues or discussions (Duby et al., 2022:16). Therefore, it is prudent for PHCNs to capacitate both grandparents and grandchildren.

7.2.2.3.2 Health care system related barriers

The findings of this study revealed that healthcare system related barriers impede SRH promotion, namely: the attitude of staff members, shortage of staff, time allocation, gender inequality, lack of privacy and stigma.

- **The attitude of staff members:** Participants revealed that PHCNs' attitude seriously impacts SRH promotion, access and utilisation of SRH services (Abuosi & Anaba, 2018:205). The researcher is of the opinion that continuous professional development plays an important role in the capacitation of PHCNs in addressing the issue of attitudes that arise due to lack of knowledge. However, some PHCNs are trying their best to improve their knowledge and skills for improved service delivery and client satisfaction.
- **Shortage of staff Inadequate:** The findings of the study revealed that a shortage of staff contributes to poor service delivery and non-utilisation of SRH services in the PHC facilities (Mwaisaka et al., 2020:2; Nmadu, 202:5), which is a violation of the client's rights as suggested by the Bill of Rights. This contributes to the perpetuation of SRH related problems that grandparents and grandchildren experience.
- **Inadequate time allocation:** Inadequate allocation of time emerged as a health-related factor that hinders quality time for providing information on SRH promotion and addressing the concerns of grandparents and grandchildren. The findings of the study also revealed that school going children visit the health facility after school while the clinic programme health education is given in the mornings whilst they are at school (Nmadu et al., 2020:4; Abuosi & Anaba, 2018:201). However, PHCNs in this study suggested that health education should be given at any given time to ensure that opportunities are not missed.
- **Gender inequality:** The participants were concerned about gender inequality, whereby SRH promotion focuses more on girls than boys. This was confirmed by several studies which revealed that girls are more vulnerable to SR-related challenges than boys however, there is a need to consider the SRH needs of boys (Shabani & Tshitangano, 2019:3). Achen et al (2022:1) allude that restrictive gender norms predispose adolescent boys to risky sexual behaviours thus making their counterparts

to be vulnerable. Therefore, the researcher recommends that more research be done to focus on boys' experiences regarding SRH promotion.

- **Lack of privacy, confidentiality, stigma and discrimination**: The issue of privacy and confidentiality must be addressed to increase the utilisation of SRH services. (Hussein & Ferguson, 2019:2, Stangl et al., 2019:2).

7.2.2.4 PHCNs' Recommendations for SRH communication promotion

The recommendations emanate from the findings of the study where five (5) constituents emerged. The recommendations shared below will benefit the provision of quality SRH services for grandparents and grandchildren**.**

7.2.2.4.1 Capacitation of PHCNs

- Capacitation of PHCNs emerged as a crucial factor in disseminating SRH related information in the PHC facilities.
- Participants showed a willingness to share SRH information. However, they need to capacitate to handle all the SRH related matters.
- Well trained PHCNs can provide the necessary information so that grandparents and grandchildren are well informed. Creating an enabling environment that promotes access and full utilisation of the SRH services.
- Participants further stated the need for a review of SRH modules to include SRH communication within families whereby nurses will be empowered about the approach to gather information during history taking and provide appropriate health advise.
- History taking tools should be reviewed to include SRH communication, whereby communications will be used to gather information on SRH communication, identify barriers and provide interventions.

7.2.2.4.2 Capacitation of Grandparents

- The participants verbalised that grandparents need to be empowered to strengthen their confidence to be able to engage in sex talks with their grandchildren.
- The grandparents should also be made aware of emerging SRH contemporary issues, which need their preparedness to handle the theme/s without fear.
- Creating support groups could also play a major role in promoting information sharing and managing concerns and questions.

7.2.2.4.3 PHNs' facilitation of open and applicable SRH communication

- The participants revealed that having open and applicable SRH communication with grandparents and grandchildren is crucial. Use simple, straightforward and well understood language by all the role players.
- The implementation of the guidelines will assist PHCNs in providing support to grandparent headed families regarding SRH promotion. Assist grandparents where the need arises.
- Privacy and confidentiality are encouraged to promote the full utilisation of the SRH services.

7.2.2.4.4 PHNs' Facilitation of SRH educational group interventions

- Participants indicated that frequent engagement with grandparents and grandchildren on SRH related matters would create awareness and health literacy of health matters affecting individuals, families, and the community.
- Support groups and peer teachings assist in providing information to make informed decisions.

7.2.2.4.5 Stakeholder collaboration

- Stakeholder collaboration emerged as another strategy that could be used to promote SRH within families.
- Collaborations amongst various stakeholders such as the DBE through the provision of LO and school health services, doh through the implementation of IHSP, DSD through social programmes and South African Police Service (SAPS) are crucial.
- Ward based Outreach teams visit families in the communities to assist in disseminating information.

7.2.3 SUMMARY OF INFORMATION FROM GRANDPARENTS AND GRANDCHILDREN

The objectives below guided the data collection for population two (2), which consisted of grandparents (see Table 3.2); subsequently, population three (3) consisted of grandchildren, as outlined in Chapter 3 (Table 3.3). The sample size of thirteen (13) grandparents was identified, and two (2) withdrew from participating in the study; on the other hand, fourteen (14) grandchildren were identified and two (2) withdrew due to ill health. The right to participate and withdraw from participating in the study at any given time was indicated on the information leaflet as indicated by several authors as a right to self-determination, which the researcher respected (Brink et al., 2018:29; Polit & Beck, 2017:140; Botma et al., 2016:17).

The objectives for grandparents and grandchildren are as follows:

- ***To explore and describe grandparents' experiences regarding sexual and reproductive health communication with grandchildren.***
- ***To explore and describe grandchildren's experiences regarding sexual and reproductive health communication with grandparents.***

Grandparents and grandchildren also participated in the study and shared their lived experiences regarding SRH communication within the grandparent headed families. The findings revealed valuable information that the researcher needed to explore and describe to assist in formulating the proposed guidelines. The findings are presented in Chapter 4, and the discussion is outlined in Chapter 5 of this study. The motivation for including grandparents and grandchildren is indicated in Chapter 4 (4.3.1) of this study. Some of the information derived from the findings were used to strengthen the formulation of the proposed SRH communication guidelines for PHCNs to support grandparent headed families in the Tshwane District of the Gauteng Province.

7.3 PHASE 2: THE DEVELOPMENT AND VALIDATION OF COMMUNICATION GUIDELINES FOR PHCNS TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SRH IN THE TSHWANE DISTRICT OF THE GAUTENG PROVINCE

The objective for Phase 2 was:

- ***To develop communication guidelines for primary healthcare nurses to support grandparent families regarding sexual reproductive health***.

7.4 DESCRIPTION OF THE FINAL GUIDELINES

The summary of the process that was followed by the researcher when developing the guidelines was dealt with in Chapter 6. The detailed steps followed in developing these guidelines are outlined in Chapter 6 of this study. The description of the guidelines comprised of the following sections:

- The title of the guidelines
- The aim of the guidelines
- Scope of the guidelines
- Structure of the guidelines
- Trustworthiness in guideline development
- Validation of guidelines
- Guidelines dissemination and implementation

- Guidelines review

7.4.1 Introduction

The sections introduce the developed guidelines. The title of the guidelines is**:**

***"COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SEXUAL AND REPRODUCTIVE HEALTH IN THE TSHWANE DISTRICT"*.**

7.4.2 The aims of the study

The aim of the study was to develop communication guidelines for PHC nurses to support grandparent headed families regarding sexual and reproductive health in the Tshwane District of the Gauteng Province.

7.4.3 The Scope of the Guidelines

The scope of the guidelines covers the PHCNs, PHCN facility managers, including other members of the disciplinary health team in PHC facilities.

7.4.4 The developed guidelines

Five (5) guidelines emerged from a need to promote SRH communication to reduce SR related problems within families. These guidelines are depicted in Chapter 6 (6.8.4), accompanied by the rationale and the PHCNs' actions.

Guideline 1: PHCNs should be capacitated as part of induction or in-service training regarding SRH promotion concerning building a therapeutic relationship, comprehensive health assessment, health education, referral system, stakeholder engagements, sexual reproductive health rights, including LGBTQIA+.

Guideline 2: PHCNs to establish rapport with grandparents to relate how SRH communication was debated in the previous era**.**

Guideline 3: PHCNs to conduct history taking to identify grandparents' belief systems and their cultural practices in relation to SRH communication.

Guideline 4: PHCNs utilise continuous and participatory health education strategy to support grandparent headed families regarding SRH communication.

Guideline 5: PHCNs collaborate with relevant stakeholders within the PHC system through an effective referral system to promote SRH services.

7.4.5 Trustworthiness in guideline development

To enhance trustworthiness in guideline development, the researcher ensured that the findings of the study were discussed in the context of the relevant literature, as outlined in Chapter 5. The methodological designs and methods were discussed in detail in Chapter 3. Pilot testing was done to check if there were any flaws in the data collection instrument and are adjustments were made before the tool was used for data collection for Phase 1 refer to Chapter 3 (3.5.3), and for Phase 2, refer to Chapter 6 (6.7.2.3). The formulation of the five (5) draft guidelines was informed by the findings from Phase 1, which consisted of essences and constituents. To enhance credibility. Purposive and snowballing sampling was used to select participants from Phase 1 of the study and the selection of a panel of experts who participated in Phase 2. The Delphi technique was used to evaluate, refine and validate the guidelines. These experts were selected based on their knowledge, experience and interest in SRH promotion and guideline development. Table 6.4 in Chapter 6 outlines the panel members' biographical information. The expert participants provided valuable comments, inputs and recommendations, which played a major role in refining and validating the guidelines. An invitation letter, information leaflet and a questionnaire were emailed to individual expert participants to ensure anonymity. The panel members used the AGREE II rating scale to refine and validate the guidelines. A questionnaire with a 4-point Likert scale was developed to rate the proposed guidelines against the following criterion: validity, reliability, clarity and applicability. Returned signed consent forms indicated the participants' willingness to participate in Phase 2 of the study.

7.4.6 Validation of guidelines

Delphi rounds were used in the validated process of the final draft guidelines by all the expert participants who participated in the previous two rounds. In this study, validation was done in round three (3) and regarded as the final round after consensus was reached in round two (2). Three (3) iterative rounds are sufficient for arriving at a high level of group agreement. The purpose was to confirm the judgement of the panel members. It also served as a feedback session for all the participants, representing the outcome of the Delphi rounds, including confirmation of consensus. The expert participants showed interest and actively engaged throughout the Delphi rounds. The above discussions defined the end of the iteration rounds, including developing, modifying and validating the final draft guidelines. The expert participants used a variety of attributes to evaluate and validate the guidelines, namely: validity, reliability, clarity, applicability, rigor and stakeholder involvement to enhance the quality of the guidelines. A four (4) Likert scale was used to rate the guidelines against

the criterion where 1-strongly disagrees, 2-disagree, 3-agree and 4-strongly agree. Expert participants provided anonymous ratings as discussed in Chapter 6 of this study (**Annexure O**). A series of Delphi rounds were followed until consensus was reached in round 2, and round 3 was used to validate the guidelines.

7.4.7 Review and update the guidelines.

This section describes the process that will be followed to review and update the guidelines. The guidelines may be reviewed or updated upon the emergence of new evidence. The current guidelines will be revised after three (3) to five (5) years following adoption and implementation by the City of Tshwane District.

7.4.8 Guideline Dissemination and Implementation

The final stage of the developed guidelines is the dissemination and implementation of the proposed guidelines. The report will be shared with all the relevant bodies, and an article will be submitted for publication. The researcher will share the findings at various research platforms during information sharing, namely conferences and seminars where the researcher may be invited to present the research and its findings.

7.5 RECOMMENDATIONS

The future recommendations derived from the discussions of the findings and the identified limitations are as follows:

7.5.1 Recommendations for PHCNs

- Implementation of CPD should be fast-tracked to enhance SRH promotion within PHC facilities.
- Review SRH modules to include SRH communication, benefits, strategies, identification of challenges and mitigation actions.
- Improve the SRH service to include complaints and compliments on the implementation of the service.
- More time should be provided to allow engagements with clients who need information or services and the availability of teaching materials in the language that the client understands.
- Plan regular meetings with PHCNs to evaluate the effects of SRH communication and committee meetings or awareness campaigns in committees for information sharing and feedback on their experiences.
- Intersectoral collaboration is paramount towards SRH promotion.

- The issue of staffing and time allocation must be addressed with facility managers.

7.5.2 Recommendations for Grandparents

- Healthcare users must be provided with information to make informed decisions.
- Establishment of support groups whereby grandparents may gather to discuss their challenges or benefits in resolving SR related challenges.
- Request feedback from grandparents regarding their experiences on encouragement to engage with their grandchildren regarding SR related challenges.

7.5.3 Recommendations for Grandchildren

- **Education intervention** emerged as the constituents highlighted by the participants in this continuation of support for LO teachers on matters that could be challenging.
- **Grandchildren's needs for SRH communication**: Grandchildren can be afforded an opportunity to learn about their growth and development in the PHC facilities, whereby PHCNs will provide more information as reinforcement of what parents and teachers have already taught in class and at home. A non-judgmental attitude is required to promote full utilisation of the SRH services.

7.5.4 Recommendations for future nursing research

- Further research is required on the experiences of fathers on SRH promotion because most of the participants in Phase 1 were females more than males.
- A mixed method research design requiring a larger population is necessary because this study used descriptive phenomenology, and the sample size was very small.
- Further research can be conducted to understand the consequences of barriers towards SRH promotion/communication within families.

7.6 IMPLICATIONS

The findings of the study have the following implications for nursing practice, nursing research and nursing education.

7.6.1 Implications for nursing practice

There is a need to support grandparent headed families regarding SRH promotion for families to talk openly about sexuality issues without any hindrances. The implications for nursing practice are highlighted below**:**

- The guidelines could inform the development of educational information, education and communication material for promoting SRH with individuals, families and the community.
- Implementing the developed guidelines could strengthen all the avenues to reduce risky sexual behaviours within the family context.
- Continuous health education to empower families regarding SRH promotion entails the importance of abstinence, condom use, voluntary counselling and treatment, early detection of STIs and adherence to treatment.
- Review of the history taking form to accommodate questions on SRH promotion to determine whether SRH communication is taking place within families.
- Re-enforcement of Batho Pele principles to address issues of PHCNs attitudes.
- Creating an enabling environment for open SRH promotion discussions and talks.
- Awareness campaigns for creating alertness about legal frameworks that address SRH related problems, e.g., the Choice on Termination of Pregnancy Act.
- Collaborative efforts to address Gender Based Violence within families.
- Implement CPD to ensure that PHCNs are updated about current and contemporary SRH related issues.

7.6.2 Implications for future nursing education

- Review of curricula-inclusion of SRH communication within families in the SRH module to ensure that nurses know how to handle SRH promotion within families.
- Tacking emerging SRH contemporary issues to create awareness within families and the community.
- Nurses to be gender sensitive and provide appropriate gender care
- Re-enforcement of the legislative framework and its applicability on SRH promotion.
- The following issues are to be emphasised during the training of nurses to ensure that the subject is dealt with appropriately in addressing the diverse cultural practices:
    - Cultural awareness and cultural competency
    - Value clarification
    - The attitude of nurses is influenced by cultural beliefs and practices.

7.6.3 Implications for nursing research

- More research needs to be done on father adolescent SRH promotion/communication.

- Future research should be conducted about SRH communication within families to create awareness and promote SRH for individuals, families and the community.
- Research to explore and describe the experiences of the LGBTQIA+ regarding SRH.
- A research study to explore and describe the experiences of the LGBTQIA+ regarding SRH promotion in the PHC facilities.
- The perception of grandparent headed families regarding the LGBTQIA+ on SRH promotion.

7.7 CONTRIBUTIONS TO THE BODY OF KNOWLEDGE

Nursing research is defined as a systematic enquiry designed to generate trustworthy evidence about issues of importance to the nursing profession, nursing practice, nursing education and nursing administration (Brink et al., 2018:3; Polit & Beck, 2017:3). The researcher affirms that scientific knowledge is in constant change thus the current study will add value to the body of knowledge on SRH related matters. The empirical data informed the formulation and development of the five (5) guidelines outlined in Chapter 6. This study will create awareness, especially on barriers that impede SRH communication within families, to reduce SR related problems which grandparents and grandchildren are struggling with. These guidelines will assist in preventing and promoting SRH within families and further encourage open dialogue regarding SR related topics, contemporary issues and challenges, including SRH related legislative frameworks. The implementation of the recommendations will also add value to the education and training of nurses. History taking tools must also be reviewed to accommodate questions on SRH communication within families to determine what is being discussed and correct or provide further education on SRH promotion.

7.8 LIMITATIONS OF THE STUDY

Irrespective of the positive results that were yielded by this study, some limitations were observed, as highlighted below:

The purposive sample was limited to the City of Tshwane (CoT), Gauteng Province (GP), which is one of the nine provinces in South Africa (SA), and CoT is one of the three (3) metros in GP. As a result, the findings are limited to the setting involved. These findings are area-specific and could not be applied to other settings.

Three groups of the population were identified for the collection of data. However, data was collected from twelve (12) PHCNs, nine (9) grandparents and fourteen (14) grandchildren.

All these participants met the criteria and were willing to participate in the study. However, the sample size was determined by data saturation, and the chosen sample size does not allow transferability. The small sample size prevented the researcher from generalising the findings (Duby et al., 2022:18). All the PHCNs worked at the PHC facilities with more women than males. One male PHCN participated in this study, which does not represent all the male PHCNs in PHC facilities. The selection of the participants for this study was limited to grandchildren of school going age. In contrast, the inclusion of adolescents who are out of school could also be beneficial. Grandmothers led most of the grandparent headed families than grandfathers. The views of the grandfathers could add value to the findings of this study, the selection was a missed opportunity which should be taken into consideration when conducting studies of this nature in future.

Grandparent headed families belonged to Bapedi and Batswana but other ethnic groups in CoT, however, they were not included in this study. Grandparent headed families from other ethics groups with different cultural practices, values and practices may describe the different contexts of SRH communication within families. Therefore, the guidelines might only be transferred to similar settings.

This study was carried out as a requirement for PhD programme; therefore, it was constrained by participants, financial resources and limited time. The time was also hindered by Covid 19, which resulted in the President declaring it a state of emergency with immediate lockdown, preventing the researcher from visiting families and accessing the PHC facilities for face-to-face data collection. The researcher had to wait until the lockdown was eased to be able to commence with data collection, and this added more time for gathering data. Sometimes participants cancelled the scheduled appointments due to personal commitments, and appointments had to be rescheduled, leading to some participants not being interested in the study anymore.

7.9 PERSONAL REFLECTIONS OF THE RESEARCHER

The researcher acknowledges that adolescents are exposed to intense changes, e.g., anatomical and physiological changes, which affect their psychosocial wellbeing leading to sexual risk-taking activities**.** These activities lead to teenage pregnancy, unsafe abortions and sexually transmitted infections (STIs), including HIV/AIDS, which can be detrimental to the grandchildren staying with the grandparents in the presence or absence of the biological parents. Parent-child communication plays a vital role in promoting SRH within families; this was confirmed by literature, which maintains that parents are the primary sources of SRH

communication. In addition, other sources of SRH information play a crucial role in the provision of SRH.

As a Nurse Educator in one of the nursing colleges in the Tshwane district, the researcher facilitates Community Nursing Science and Primary healthcare programmes, which have a module on SRH. It is an intense module which includes history taking and health assessment. Family planning, termination of pregnancy, management of ailments including STIs and drug and non-drug management. One of my responsibilities is to teach SRH and simulate some of the procedures before students can be taken to clinical facilities for work integrated learning whereby theory and clinical correlation are done. Students are issued with workbooks and must cover a certain number of cases to gain some experience. I have also realised that mentoring is vital in internalising what is taught in class. At the ultimate end, assessments (formative and summative) should be done to assess if the students have mastered all the skills including SRH related skills.

During my master's study, I looked at the perceptions of families regarding HIV/AIDS within families. Among the families I came across was a grandparent-headed family that shared their views about HIV/AIDS. I then realised there was a need to research SRH communication within grandparent-headed families. I felt the development of guidelines for PHCNs to support grandparent headed families would create SRH awareness within families. My passion for family health prompted me to seek information and literature, encouraging me to pursue my doctoral studies to reduce SRH related problems. Furthermore, the literature review also assists me in improving my knowledge which I can utilise during curriculum review or in information sharing platforms.

The University of Pretoria approved the submitted proposal in February 2020 (Protocol 45/2020). Permission was also sought from the City of Tshwane and Child Welfare, who deal with grandparent headed families. Child Welfare gave me permission to conduct the study, and later City of Tshwane Research Committee permitted me to conduct the study in Tshwane District PHC facilities. Since it was a qualitative study, it was a must that I conduct individual face-to-face interviews with the participants who were willing to participate. The researcher adhered to the ethical principles, namely anonymity (confidentiality) and informed consent, respected the participants' right to participate and maintained a high level of integrity during the study (Brink et al., 2018:3; Polit & Beck, 2017:139).

I also identified several grandparents headed families from the list that I received from Child Welfare. Individual families were contacted, appointments were set, and I went to the families at their residential places. Grandparents and grandchildren were seen individually, and each had to indicate their availability. Dates were diaries also ensured that the safety measures were adhered to, and the use of masks and sanitisers was emphasised per Covid 19 Regulations. Grandparents and grandchildren have interviewed at the comfort of the participants' residential places at various times during the week, over weekends, as per participants' request and availability.

Essences and constituents were developed with the help of the independent coder and confirmed with my supervisors. Giorgio's data analysis method was used to develop essences and constituents. As the researcher, I remained neutral with my beliefs and disbelief regarding my background in SRH and allowed all the participants to share their lived experiences and generate rich data. Communication skills and techniques were used to ask questions, probe, and seek clarity when the need arose.

The findings of Phase 1 of this study informed the formulation of the empirical guidelines. The Delphi technique was used to evaluate, refine and validate the guidelines. The process commenced in December 2022 and was completed in April 2023.

This study taught me the importance of the Delphi technique, which I will utilise in my job to get expert opinions on matters that affect the education and training of nurses. Furthermore, I strengthened my report writing and communication skills and analytic thinking with a diverse group of people with different backgrounds, positions and expertise which impacted the development of the guidelines.

7.10 FINAL CONCLUSION

This study was guided by its aims to explore and describe the experiences of PHCNs, grandparents and grandchildren regarding SRH communication to develop guidelines for PHCNs to support grandparent headed families regarding SRH communication.

The study was conducted in two phases. To attain the aims and objectives of this study, a qualitative, descriptive phenomenological contextual design was used to answer the research questions and was done in Phase 1 of this study. Several issues were revealed that needed to be addressed to ensure SRH promotion is raised within the grandparent headed families. SRH communication was perceived as a protector factor because

knowledgeable families can make informed decisions, have open SRH engagements, and thus lead to healthy living. Then in Phase 2, Delphi techniques were used to refine and validate the guidelines. Recommendations emanated from the findings of this study, and limitations that unfolded were also shared at the end.

Based on the findings of this study, it can be concluded that the objectives of the study have been achieved. Guidelines for PHCNs to support grandparent headed families can be implemented to ensure SRH awareness is created within families. The researcher made recommendations based on the research findings to the relevant bodies, and this report will be shared with the relevant bodies. A research article will be submitted for publication.

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ANNEXURES

ANNEXURE A: UP ETHICS APPROVAL LETTER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

13 April 2023

Approval Certificate
Annual Renewal

Dear Mrs CLM Ratshwafo,

Ethics Reference No.: 45/2020 – Line 7
Title: Communication guidelines to support grandparent headed families regarding sexual and reproductive health in Tshwane District

The **Annual Renewal** as supported by documents received between 2023-03-29 and 2023-04-12 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2023-04-12 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2024-04-13.
- Please remember to use your protocol number (45/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

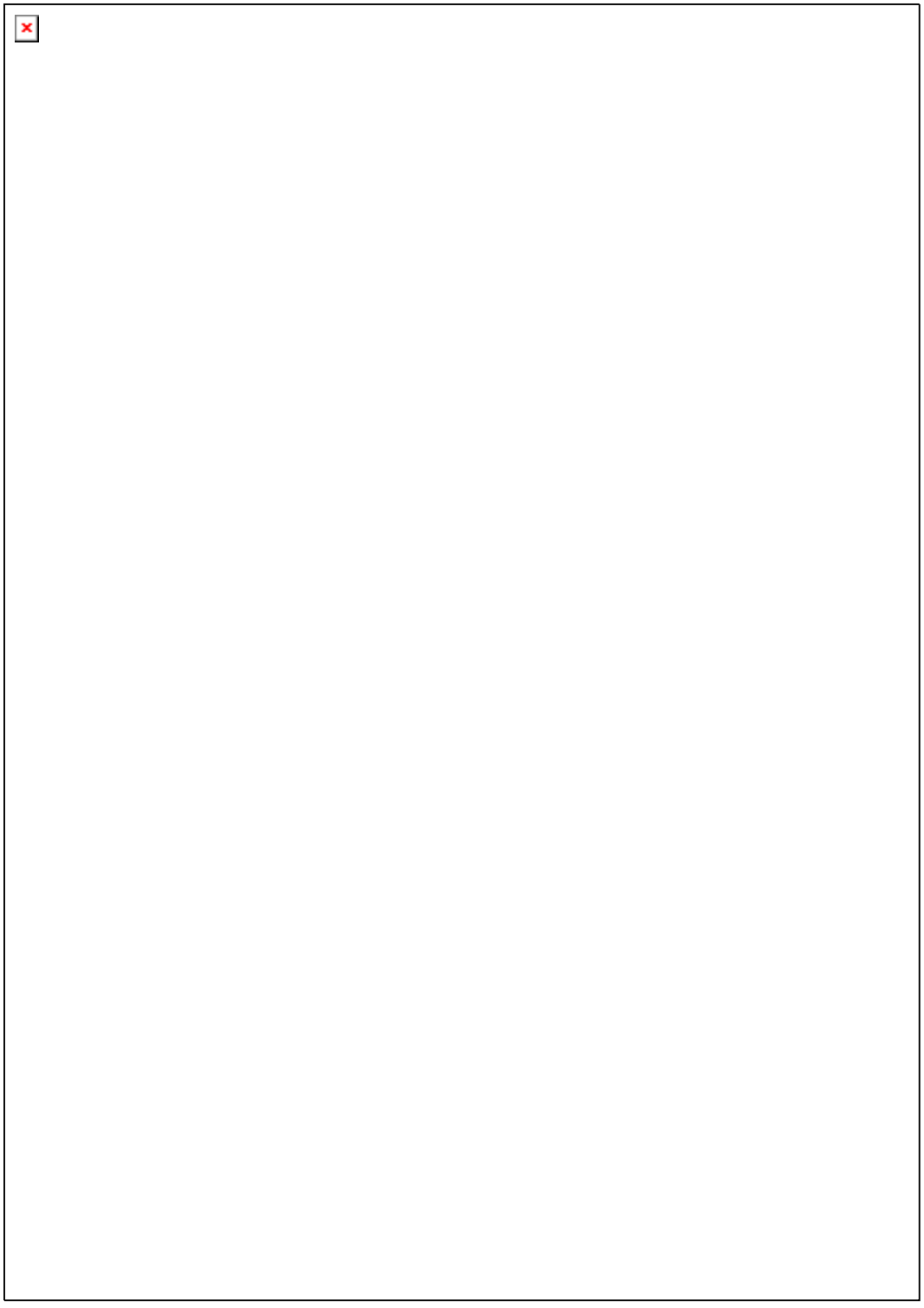
On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
Deputy Chairperson *of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

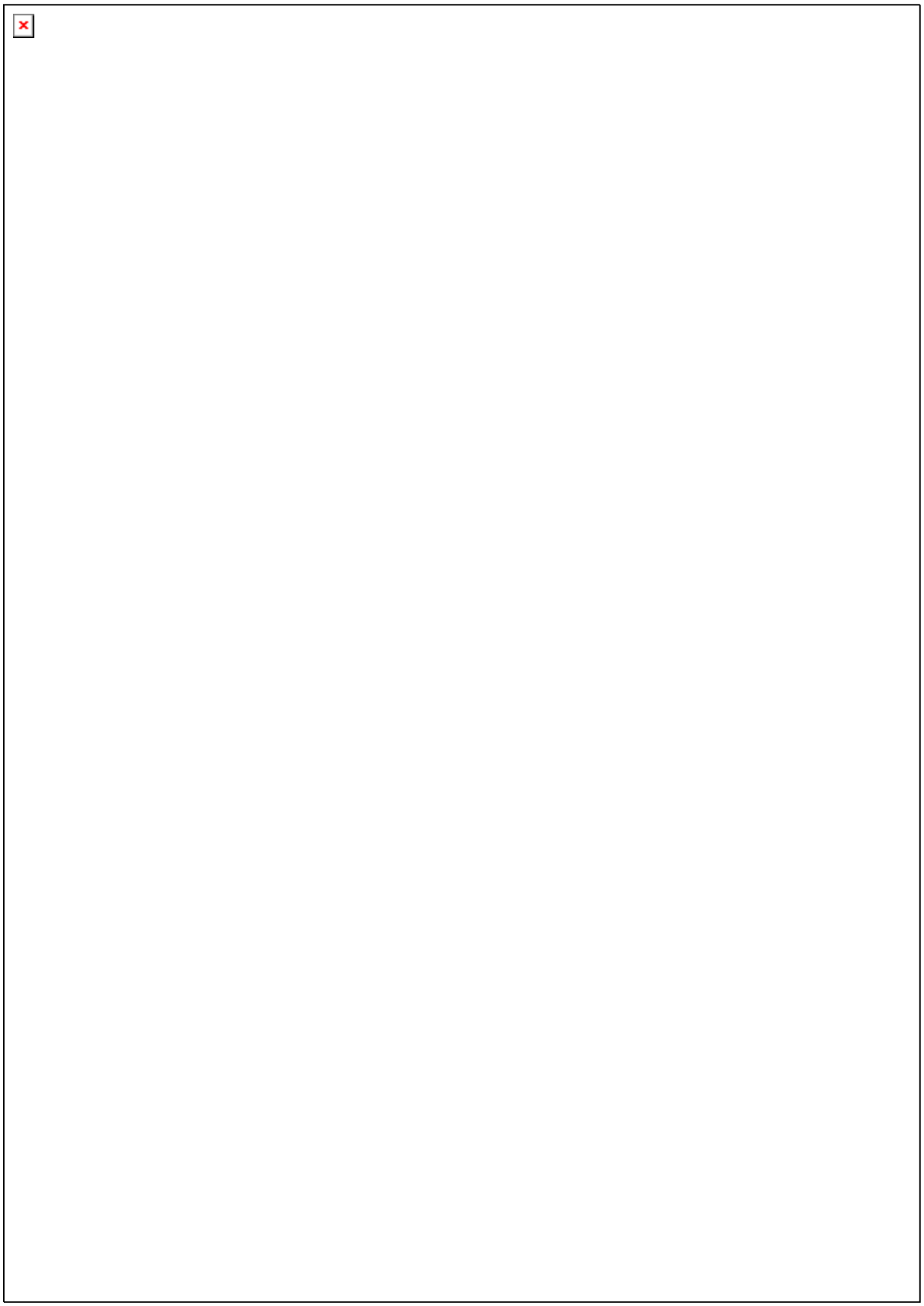
Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel +27 (0)12 356 3084
Email: deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE B: COT PERMISSION LETTER



ANNEXURE C: CHILD WELFARE PERMISSION LETTER



ANNEXURE D: GRANDPARENTS

PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT

Title of the study	*Communication guidelines to support grandparent headed families regarding sexual and reproductive health*
Principal investigator	Ms CLM Ratshwafo (98244435)
Institution	University of Pretoria
Contact details	012 426 9599(day) 082 263 0342 (day) & after hours

Dear Participant, Mrs/Ms……

1. **INTRODUCTION**

You are invited to participate in a research study that forms part of a doctoral degree. This information leaflet will assist with giving you the relevant information so that you can make an informed decision. Before you agree to take part in the study, it is important to fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator. You should not agree to take part unless you are completely satisfied about the information given.

2. **THE NATURE AND THE PURPOSE OF THIS STUDY**

The purpose of the study is to develop communication guidelines to support grandparent headed families regarding sexual reproductive health in the Tshwane district. You have been identified as a very important source of information thus you have been approached to take part in this study.

3. **EXPLANATION OF PROCEDURES TO BE FOLLOWED**

The participants in this study will comprise of grandparents who are staying and caring for their grandchildren in the Tshwane district. Individual face to face interviews will be conducted in your residential place and at the time that is convenient to you. The individual interviews will be conducted in the language that you will be comfortable with i.e., English, Northern Sotho or Setswana. With your permission, the interviews will be recorded on a recording device to ensure that no information is missed and later typed to be analysed. The investigator will also be accompanied by a research assistant. An average interview will be thirty minutes.

The researcher will ask about sexual and reproductive health communication within the grandparent families. Guidelines will be developed based on your responses. The researcher will not question you about you're HIV status. Participation will be voluntary and any you will be allowed to withdraw from the study at any given time without giving any explanation.

4. RISKS AND DISCOMFORTS

The only possible risks and discomforts is to discuss sexual reproductive issues which may cause emotional discomforts. You may not feel well to talk about sexual issues. You will not be asked about your HIV status nor forced to divulge your HIV status or that of your grandchildren. The investigator will not force you to continue with the interview when you feel you cannot talk anymore. An average interview will be thirty minutes.

5. POSSIBLE BENEFITS ABOUT THE STUDY

You will be given an opportunity to verbalise your experiences regarding communication regarding sexual and reproductive health with your grandchildren. However, you will not receive any direct benefit as a result of your participation. The findings of the study will assist the investigator to develop guidelines that will assist you to be able to talk about sexual reproductive health with your grandchildren.

6. COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study**.**

7. WHAT ARE YOUR RIGHTS AS A PARTICIPANTS?

You can take part in the study only if you wish to do so. You can refuse or stop taking part at any given time without giving any reason and your withdrawal will not affect you in any way. You will not be forced to divulge their HIV status.

8. HAS THE STUDY RECEIVED ANY ETHICAL APPROVAL?

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has

been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides researcher how to conduct research. The researcher can give you a copy of the Declaration if you wish to read it.

9. **INFORMATION AND CONTACTS**

If you have any questions about this study, you should contact: Ms CLM Ratshwafo the principal investigator at the following numbers: 012 426 9599 or 082 263 0342.Alternatively, you may contact my supervisors Prof M.D Peu at telephone numbers: 012 356 3177 and Dr I Ramavhoya at 012 356 3163

10. CONFIDENTIALITY

All the information and records obtained during this study will be kept strictly confidential. The investigator will not use your name, house number or any form of identification to identify you. A fictitious code number which will be used to identify you in the study, any publication, report or other research output.

The records from your participation may be reviewed by people responsible for making sure that the research is done properly including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise records that identify you will be available only to people working on this study, unless you give permission for other people to see the records. All hard copies information will be kept in a locked facility at the South African Nursing Council 62 Pretorius Street Arcadia Pretoria for a minimum of 15 years and only the research team will have access to this information.

11. CONSENT TO PARTICIPATE IN A STUDY

- I have received and read the information leaflet regarding the study in the language that I understand, or the investigator had read to me in the language that I understand about the above information before signing this consent.
- I confirm that the person who is requesting my consent has told me about the nature of the study, risks, discomforts, process and benefits of the study.
- I am aware that the information obtained in the study including the personal information will not show my identity to anyone and in any document.
- I have had adequate time to ask questions and am willing to take part in the study.

- I understand that I have the right to stop participating in the study at any given time and my leaving will not disturb the study.
- I am participating willingly.
- I have received and signed a copy of this informed consent agreement.

……. …….
Participant's name Date

…… ……
Participant's signature Date

…….. ……
Investigators name Date

…….. ……
Investigators signature Date

…….. ……..
Witness's Name Date

…… ……
Witness s signature Date

I understand that the individual face to face interviews or discussions will be audio taped. I give consent that it may be audio taped.

YES / NO

ANNEXURE E: GRANDCHILDREN

PARTICIPANT INFORMATION AND INFORMED CONSENT DOCUMENT

Title of the study	*Communication guidelines to support grandparent headed families regarding sexual and reproductive health*
Principal investigator	Ms CLM Ratshwafo (98244435)
Institution	University of Pretoria
Contact details	012 426 9599(day) 082 263 0342 (day) & after hours

Dear Participant, Mrs/Ms……

1. INTRODUCTION

You are invited to participate in a research study that forms part of a doctoral degree. This information leaflet will assist with giving you the relevant information so that you can make an informed decision. Before you agree to take part in the study, it is important to fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator. You should not agree to take part unless you are completely satisfied about the information given.

2. THE NATURE AND THE PURPOSE OF THIS STUDY

The purpose of the study is to develop communication guidelines to support grandparent headed families regarding sexual reproductive health in the Tshwane district. You have been identified as a very important source of information thus you have been approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The participants in this study will comprise of grandchildren who are staying with their grandparents in the Tshwane district. Individual face to face interviews will be conducted in your residential place and at the time that is convenient to you. The individual interviews will be conducted in the language that you will be comfortable with i.e., English, Northern Sotho or Setswana. With your permission, the interviews will be recorded on a recording device to ensure that no information is missed and later typed to be analysed. The investigator will also be accompanied by a research

assistant. An average interview will be thirty minutes. The investigator will ask about sexual and reproductive health communication within the grandparent families. Guidelines will be developed based on your responses. The investigator will not question you about you're HIV status. Participation will be voluntary, and you will be allowed to withdraw from the study at any given time without giving any explanation.

4. RISKS AND DISCOMFORTS

The only possible risks and discomforts is to discuss sexual reproductive issues which may cause emotional discomforts. You may not feel well to talk about sexual issues. You will not be asked about your HIV status nor forced to divulge your HIV status. The investigator will not force you to continue with the interview when you feel you cannot talk anymore. An average interview will be thirty minutes.

5. POSSIBLE BENEFITS ABOUT THE STUDY

You will be given an opportunity to verbalise your experiences regarding communication regarding sexual and reproductive health with your grandparents. However, you will not receive any direct benefit as a result of your participation. The findings of the study will assist the investigator to develop guidelines that will assist you to be able to talk about sexual reproductive health with your grandparents.

6. COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study**.**

7. WHAT ARE YOUR RIGHTS AS A PARTICIPANTS?

You can take part in the study only if you wish to do so. You can refuse or stop taking part at any given time without giving any reason and your withdrawal will not affect you in any way. You will not be forced to divulge your HIV status.

8. HAS THE STUDY RECEIVED ANY ETHICAL APPROVAL?

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last

update: October 2013), which guides researcher how to conduct research. The researcher can give you a copy of the Declaration if you wish to read it.

9. INFORMATION AND CONTACTS

If you have any questions about this study, you should contact: Ms CLM Ratshwafo the principal investigator at the following numbers: 012 426 9599 or 082 263 0342.Alternatively, you may contact my supervisors Prof M.D Peu at telephone numbers: 012 356 3177 and Dr I Ramavhoya at 012 356 3163.

10. CONFIDENTIALITY

All the information and records obtained during this study will be kept strictly confidential. The investigator will not use your name, house number or any form of identification to identify you. A fictitious code number which will be used to identify you in the study, any publication, report or other research output.

The records from your participation may be reviewed by people responsible for making sure that the research is done properly including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise records that identify you will be available only to people working on this study, unless you give permission for other people to see the records. All hard copies information will be kept in a locked facility at the South African Nursing Council 62 Pretorius Street Arcadia Pretoria for a minimum of 15 years and only the research team will have access to this information.

11. CONSENT TO PARTICIPATE IN A STUDY

- I have received and read the information leaflet regarding the study in the language that I understand, or the investigator had read to me in the language that I understand about the above information before signing this consent.
- I confirm that the person who is requesting my consent has told me about the nature of the study, risks, discomforts, process and benefits of the study.
- I am aware that the information obtained in the study including the personal information will not show my identity to anyone and in any document.
- I have had adequate time to ask questions and am willing to take part in the study.
- I understand that I have the right to stop participating in the study at any given time and my leaving will not disturb the study.

- I am participating willingly.

……. …….
Participant's name Date

…… ……
Participant's signature Date

…….. ……
Investigators name Date

…….. ……
Investigators signature Date

…….. ……..
Witness's Name Date

…… ……
Witness s signature Date

I understand that the individual face to face interviews or discussions will be audio taped. I give consent that it may be audio taped.

YES / NO

ANNEXURE F: PHC NURSES

PARTICIPANT INFORMATION AND INFORMED CONSENT DOCUMENT

Title of the study	*Communication guidelines to support grandparent headed families regarding sexual and reproductive health*
Principal investigator	Ms CLM Ratshwafo (98244435)
Institution	University of Pretoria
Contact details	012 426 9599 (day) 082 263 0342 (day) & after hours

Dear Participant, Mrs/Ms……

You are invited to participate in a research study that forms part of a doctoral degree. This information leaflet will assist with giving you the relevant information so that you can make an informed decision. Before you agree to take part in the study, it is important to fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator. You should not agree to take part unless you are completely satisfied about the information given.

2. THE NATURE AND THE PURPOSE OF THIS STUDY

The purpose of the study is to develop communication guidelines to support grandparent headed families regarding sexual reproductive health in the Tshwane district. You have been identified as a very important source of information thus you have been approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The participants in this study will comprise of PHC nurses who are based in the PHC facilities in the Tshwane district. Individual face to face interviews will be conducted with you in the health facility where you are based and at the time that is convenient to you. The individual interviews will be conducted in the language that you will be comfortable with i.e., English, Northern Sotho or Setswana. With your permission, the interviews will be recorded on a recording device to ensure that no information is missed and later typed to be analysed. The investigator will also be accompanied by a research assistant. An average interview will be thirty minutes. The investigator

will ask about sexual and reproductive health communication between grandparent and grandchildren. Guidelines will be developed based on your responses. The investigator will not question you about the HIV status of your clients. Participation will be voluntary and any you will be allowed to withdraw from the study at any given time without giving any explanation.

4. **RISKS AND DISCOMFORTS**

The only possible risks and discomforts is to discuss sexual reproductive issues which may cause emotional discomforts. You may not feel well to talk about sexual issues. You will not be asked about the HIV status of your clients (health care users) nor forced to divulge their HIV status. The investigator will not force you to continue with the interview when you feel you cannot talk anymore. An average interview will be thirty minutes.

5. POSSIBLE BENEFITS ABOUT THE STUDY

You will be given an opportunity to verbalise your experiences regarding communication regarding sexual and reproductive health with grandparents and grandchildren. However, you will not receive any direct benefit as a result of your participation. The findings of the study will assist the investigator to develop guidelines that will assist you promote/enhance communication regarding sexual reproductive health with your clients/health care users (grandparents and grandchildren).

6. COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study**.**

7. WHAT ARE YOUR RIGHTS AS A PARTICIPANTS?

You can take part in the study only if you wish to do so. You can refuse or stop taking part at any given time without giving any reason and your withdrawal will not affect you in any way. You will not be forced to divulge their HIV status.

8. HAS THE STUDY RECEIVED ANY ETHICAL APPROVAL?

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has

been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides researcher how to conduct research. The researcher can give you a copy of the Declaration if you wish to read it.

9. INFORMATION AND CONTACTS

If you have any questions about this study, you should contact: Ms CLM Ratshwafo the principal investigator at the following numbers: 012 426 9599 or 082 263 0342.Alternatively, you may contact my supervisors Prof M.D Peu at telephone numbers: 012 356 3177 and Dr I Ramavhoya at 012 356 3163

10. CONFIDENTIALITY

All the information and records obtained during this study will be kept strictly confidential. The investigator will not use your name, house number or any form of identification to identify you. A fictitious code number which will be used to identify you in the study, any publication, report or other research output.

The records from your participation may be reviewed by people responsible for making sure that the research is done properly including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise records that identify you will be available only to people working on this study, unless you give permission for other people to see the records. All hard copies information will be kept in a locked facility at the South African Nursing Council 62 Pretorius Street Arcadia Pretoria for a minimum of 15 years and only the research team will have access to this information.

11. CONSENT TO PARTICIPATE IN A STUDY

- I have received and read the information leaflet regarding the study in the language that I understand, or the investigator had read to me in the language that I understand about the above information before signing this consent.
- I confirm that the person who is requesting my consent has told me about the nature of the study, risks, discomforts, process and benefits of the study.
- I am aware that the information obtained in the study including the personal information will not show my identity to anyone and in any document.
- I have had adequate time to ask questions and am willing to take part in the study.

- I understand that I have the right to stop participating in the study at any given time and my leaving will not disturb the study.
- I am participating willingly.

……. ……..
Participant's name Date

…… ……
Participant's signature Date

…….. ……
Investigators name Date

…….. ……
Investigators signature Date

…….. ……..
Witness's Name Date

…… ……
Witness s signature Date

I understand that the individual face to face interviews or discussions will be audio taped. I give consent that it may be audio taped.

YES / NO

ANNEXURE G: INTERVIEW SCHEDULE (GRANDPARENTS)

TITLE OF THE STUDY: *Communication guidelines to support grandparent headed families regarding sexual and reproductive health in Tshwane District*

PRINCIPAL INVESTIGATOR *:* Ms CLM Ratshwafo (98244435)

Grand tour questions :

- Tell me about your experiences regarding communication about SRH.
    - The questions requires that the participants describe his/her experiences about SRH communication.
- What are your experiences regarding communication about SRH with your grandchildren?
    - The question requires that the participants describe his/her experiences regarding communication about SRH with the grandchildren.

Sub questions:

- What are your challenges regarding sexual reproductive communication with your grandchildren?
    - The question requires the participants to describe their challenges regarding sexual reproductive communication with their grandchildren.
- How do you feel communicating SRH with your grandchildren?
    - The question requires the participants to express their personal feelings regarding sexual reproductive communication with their grandchildren.
- What support do you need from the PHC nurses regarding SRH communication with your grandchildren?
    - The question requires the participants to explain the support they need from the PHC nurses regarding SRH communication with the grandchildren.
- What is your opinion about SRH communication within the grandparent families?
    - The question requires the participants to explain their opinion about SRH communication between grandparent (s) and grandchild (ren)

- How do you feel about the support that you received from the PHC nurses regarding SRH communication?

    - The question requires the participants to express their personal feelings regarding the support that was received from the PHC nurses addressing SRH communication within the grandparent families.
- How would you have liked the PHC nurses to support you regarding SRH communication?

    - The question requires the participants to describe the strengths and/or weaknesses of the support provided by the PHC nurses regarding SRH communication.

Signature of the Principal investigator: …….

Date: ……

ANNEXURE H: INTERVIEW SCHEDULE (GRANDCHILDREN)

TITLE OF THE STUDY: *Communication guidelines to support grandparent headed families regarding sexual and reproductive health in Tshwane District*

PRINCIPAL INVESTIGATOR *:* Ms CLM Ratshwafo (98244435)

Grand tour question :

- Tell me about your experiences regarding communication about SRH.
    - The questions requires that the participants describe his/her experiences about SRH communication.
- What are your experiences regarding communication about SRH with your grandparents?
    - The question requires that the participants describe his/her experiences regarding communication about SRH with their grandparents.

Sub questions:

- What are your challenges regarding sexual reproductive communication with your grandparent(s)?
    - The question requires the participants to describe their challenges regarding sexual reproductive communication with their grandparent(s)
- How do you feel communicating SRH with your grandparent(s)?
    - The question requires the participants to express their personal feelings regarding sexual reproductive communication with their grandparent(s)
- What support do you need from the PHC nurses regarding SRH communication with your grandparent(s)?

- The question requires the participants to explain the support they need from the PHC nurses regarding SRH communication with the grandparent(s)

- What is your opinion regarding SRH communication within the grandparent families?
    - The question requires the participants to explain their opinion about SRH communication between grandparent (s) and grandchild (ren)

- How do you feel about the support that you received from the PHC nurses regarding SRH communication?

    - The question requires the participants to express their personal feelings regarding the support that was received from the PHC nurses addressing SRH communication within the grandparent families.
- What support do you expect from the PHC nurses to support you regarding SRH communication?
    - The question requires the participants to describe the strengths and/or weaknesses of the support provided by the PHC nurses regarding SRH communication.

  Are there questions that you think I should have asked?

Signature of the Principal investigator:

Date: …

ANNEXURE I: SCHEDULE (PHC NURSES)

TITLE OF THE STUDY: *Communication guidelines to support grandparent families regarding. Sexual and reproductive health in Tshwane District*

PRINCIPAL INVESTIGATOR *:* Ms CLM Ratshwafo (98244435)

Grand tour questions :

- Tell me about your experiences regarding SRH communication with n grandparents and grandchildren.
    - The questions requires that the participants describe their experiences about SRH communication with grandparents and grandchildren.
- What are your experiences regarding SRH communication with grandparents and grandchildren?
    - The question requires that the participants describe their experiences regarding SRH communication with grandparents and grandchildren.

Sub questions:

- How do you feel communicating SRH with the grandparents and grandchildren?
    - The question requires the participants to express their personal feeling regarding sexual and reproductive communication with the grandparents and grandchildren.
- What are you challenges/barriers regarding SRH communication with grandparents and grandchildren?
    - The question requires the participants to describe the challenges/barriers they identified regarding SRH communication between grandparents and grandchildren.

- State the training that you undergone regarding SRH?
    - The question requires the participants to provide information about their knowledge about SRH.
- What will be the benefits of SRH communication within the grandparent headed families?
    - The question requires the participants to state the benefits of SRH communication between the grandparents and the grandchildren.

- Enlist the information that must be included in the guidelines to assist grandparent families to communicate about SRH communication?
    - The question requires the participants to enlist the information that must be included in the guidelines to support grandparent headed families.
- What can be done by PHC nurses to enhance or promote open communication about SRH topics within the grandparent headed families?
    - the question requires the views of the participants to promote open communication about SRH within the grandparent headed families.
- Is the anything that you would like to tell me regarding SRH communication that we didn't talk about?
    - The question requires the participants to provide extra information regarding SRH communication within the grandparent headed families.

- Are there questions that you think I should have asked?

Signature of the Principal investigator:
Date: …

ANNEXURE J: EXPERT

Dear Expert

TITLE OF STUDY: COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SEXUAL REPRODUCTIVE HEALTH IN TSHWANE DISTRICT

PRINCIPAL INVESTIGATOR	Ms CLM Ratshwafo (98244435)
INSTITUTION	University of Pretoria
CONTACT NUMBERS	Tel no. 012 426 9599
	Cell no. 082 263 0342

Dear Expert Participant

1. INTRODUCTION

I am a doctoral student at University of Pretoria and for the fulfilment of the doctoral degree am expected to conduct research. Am expected to develop communication guidelines to support grandparent headed families regarding sexual reproductive health. This is an invitation to participate in phase 2 of this study as an expert: You will be expected participate in the development and validation of the guidelines. The development of the preliminary guidelines emanated from the empirical data collected in phase 1 and supported by literature sources.

This information leaflet will help you decide if you want to participate in the study. Before you agree to participate in this study you should fully understand what is involved. If you have any questions that the leaflet does not address, please do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about the procedures involved.

2. THE NATURE AND PURPOSE OF THE STUDY

You as an expert are very important source of information for validating and refining the guidelines. An expert is any individual who is qualified with tremendous knowledge and understanding of SRH and guidelines development. In this phase experts includes national and international experts, academics, primary health care nurses including PHC managers, those in government and non-government organizations. It is hoped that the PHC nurses will use the guidelines to support grandparent headed families. The invitation is for you the to participate in a knowledge sharing session using the Delphi technique.

3. EXPLANANTION OF PROCEDURES TO BE FOLLOWED

The study involves developing and validating of the draft guidelines proposed by the researcher using the Delphi technique to ensure guidelines high quality**.** I have identified you as a possible participant in this exercise because of your expertise in the field of sexual reproductive health (SRH) and be able to address the issues appropriately. The researcher is the facilitator of the Delphi rounds, and it is expected that not more than three rounds will be sufficient to obtain consensus on the content of the guidelines.

Should you agree to participate in the study kindly note the below:

- All the correspondence will be done through email.
- As a participant you will be provided with the draft preliminary guidelines by the researcher
- In the first round you will be expected to read through the guidelines, complete the rating scale regarding the validity and reliability of the proposed guidelines and comment.
- You will be expected to refine the draft guidelines and the controlled feedback will be given to each expert participant.
- Each participant will be afforded an opportunity to generate additional understanding with possible additions or withdrawals in the later iterations.
- The researcher envisage three rounds of data collection until consensus is reached among experts.
- Experts that will participate in the study will remain anonymous to one another and your input will be regarded as confidential.
- You will be requested to make recommendations to improve the guidelines.
- The researcher will consolidate all the inputs and sent back to you to make further recommendations if you wish to do so.

- You will be expected to sign and scan the consent form and the rated guidelines back to the researcher.

4. RISK AND DISCOMFORT

There are no risks in participating in this study however the only discomfort involved is the time it will take to review the guidelines, which will not be longer than 60 minutes of your time per session.

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5. POSSIBLE BENEFITS OF THIS STUDY

There will be no monetary benefits to you participating in this study. However, your participation will help in refining the guidelines for PHC nurses to support grandparent headed family regarding SRH communication**.** You will also gain more knowledge and insight into the guideline development from other experts, and this will promote personal and professional growth.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT

Your participation in this study is voluntary. You can refuse to participate in the study or withdraw at any given point without giving a reason or decline to respond to any issues raised. This will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study received a written approval from the Research Ethics Committee of the faculty of Health Sciences at the University of Pretoria (Protocol 45/2020). The contact details of the Research Committee 012 354 1677 or 012 354 1330.The study has been structured in accordance with the Declaration of Helsinki which deals with the recommendations guiding research involving human subjects. The copy of the Declaration may be obtained from the investigator should you wish to review it.

8. INFORMATION AND CONTACT PERSON

The contact person for this study is Ms CLM Ratshwafo (principal researcher). If you have any questions contact me on cell number: 082 263 0342 or you may contact my supervisors during office hours: Prof MD Peu 012 354 2133, Prof I Ramavhoya 015 268 3966 and Prof M Rasweswe 084 668 0056

9. COMPENSATION FOR PARTICIPATING IN THE STUDY

There will be no compensation.

10. CONFIDENTIALITY

All correspondence and records obtained from the expert participants will be kept private and confidential. Results will be published in such a way that participants remain unidentifiable.

Kindly note that your participation will highly be appreciated.

ANNEXURE K: INFORMED CONSENT FOR EXPERT PARTICIPANT

INFORMED CONSENT FOR EXPERT PARTICIPANT

I confirm that the person asking my consent to participate in the study informed me about the nature, process, risks, discomfort and benefits. I have also received, read and understood the above written information about the study. I have been given an opportunity to ask questions and have no objections to participate in the study. I am aware that the results of the study including personal details will be anonymous. I am participating willingly, and I understand that there is no penalty should I wish to discontinue, and withdrawal will not affect me in any way. I hereby consent voluntarily to participate in the study.

…….	…….
Participant's name	Date
……	…….
Participant's signature	Date
……...	……
Researcher's name	Date
…….	…….
Researcher's signature	Date
……...	…….
Witness's Name	Date
……	…….
Witness s signature	Date

ANNEXURE L: SUMMARY SHEET OF THE RATED GUIDELINES ROUND 1

ROUND	CRITERIA															
Rating scale 1= Strongly disagree 2= Disagree 3= Agree 4= Strongly	VALIDITY				RELIABILITY				CLARITY				APPLICABILITY			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Guideline 1		1	4	9		1	6	7		2	4	8			3	11
Guideline 2		1	1	12		1	5	8		3	1	10		1	2	11
Guideline 3		1	2	11		1	4	9		2	4	8			2	12
Guideline 4		1	1	12		1	2	11		1	2	11		1	2	11
Guideline 5		1	0	13		1	0	13		1	0	13		1	0	13

Colour code: **Disagree** Agree

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ANNEXURE M: SUMMARY SHEET OF THE RATED MODIFIED GUIDELINES ROUND 2

ROUND	CRITERIA															
Rating scale 1= Strongly disagree 2= Disagree 3= Agree 4= Strongly	VALIDITY				RELIABILITY				CLARITY				APPLICABILITY			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Guideline 1			4	10			6	8			5	9			3	11
Guideline 2			5	9			5	9			4	10			2	12
Guideline 3			3	11			5	9			3	11			3	11
Guideline 4			4	10			4	10			4	10			3	11
Guideline 5			2	12			2	12			2	12			2	12

Colour code: **Disagree** Agree

ANNEXURE N: SUMMARY SHEET OF THE RATED MODIFIED & VALIDATION OF GUIDELINES ROUND

ROUND	CRITERIA															
Rating scale 1= Strongly disagree 2= Disagree 3= Agree 4= Strongly	VALIDITY				RELIABILITY				CLARITY				APPLICABILITY			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Guideline 1			3	8			1	10			2	9			1	10
Guideline 2			5	6			4	7			4	7			2	9
Guideline 3			2	9			3	8			3	8			3	8
Guideline 4			3	8			3	8			4	7			3	8
Guideline 5			2	9			2	9			2	9			2	9

Colour code: **Disagree** Agree

ANNEXURE O: INSTRUMENT FOR VALIDATION OF DRAFT GUIDELINES

INSTRUCTIONS:

- Rate the proposed guidelines according to the provided criteria.
- Put an X in the correct criteria block.
- Be free to critically analyse and evaluate the proposed guidelines.
- Indicate any area that needs modification and write comments and suggestions in the provided space below the proposed guidelines.
- Kindly return the completed questionnaire within three (03) working days.

Guidelines

Rating scale	Criteria															
1. =Strongly disagree 2. =Disagree 3. =Agree 4. =strongly agree	**Validity** The guideline produces the desired results based on reality. The guideline will enable the PHCNs to support grandparents and grandchildren regarding SRH promotion within families.				**Reliability** Given the same situations the PHCNs would interpret and apply the guideline in the same way to maintain consistency.				**Clarity** The guideline is clear, easily understandable, explicit and reasonable.				**Applicability** Target population is clearly stated: PHC nurses working in PHC settings rendering service to grandparents and grandchildren.			
GUIDELINE 1	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PHCNs should be capacitated formerly as part of induction in relation to: SRH promotion; building a therapeutic relationship, comprehensive health assessment, health education, referral system, and stakeholder engagement and Sexual reproductive health rights																
COMMENTS:																
GUIDELINE 2	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PHCNs must create a therapeutic relationship with grandparents and grandchildren utilizing supportive communication techniques to enhance cultural sensitivity in the PHC setting																
COMMENTS:																

GUIDELINE 3	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PHCNs conduct comprehensive health assessment and integrated screening of grandparents/grandchildren to identify health support needs utilizing the prescribed health assessment tools in the PHC settings**.**																
COMMENTS:																
GUIDELINE 4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PHCNs utilizes continuous and participatory health education strategy to support and empower individuals, families and groups with necessary skills to cope and engage with in a healthy SRH communication session as the need arise																
COMMENTS:																
GUIDELINE 5	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
PHCNs collaborate with relevant stakeholders within the PHC system and community through effective referral system to promote SRH services																
COMMENTS:																

ANNEXURE P: INTERVIEW WITH A GRANDPARENT

INTERVIEW WITH A GRANDPARENT

Researcher: Good day grandma.

Participant: Good day mam.

Researcher: How are you?

Participant: I am good and how are you?

Researcher: I am fine.

Researcher: Granny my name is Linky Ratshwafo, I am a doctoral student at University of Pretoria, and I am currently busy with a research study whereby I am expected to collect information from grandmothers who live with their grandchildren regarding sexual reproductive health. Do you understand?

Participant: I do.

Researcher: Okay. Before I can start with the interview, do you give me permission to continue with the interview?

Participant: Yes.

Researcher: Okay. To show that you've granted me permission to interview you I'm going to give you a form to sign as evidence of your consent.

Participant: Okay.

Researcher: The other thing is that our conversation is going to be audio-recorded so that can assist me when I do my data analysis at a later stage.

Participant: Okay.

Researcher: Do not worry as during the conversation I'll be writing down some notes. It will not be about you but about something I want to remind myself at a later stage.

Participant: Okay.

Researcher: Dou you have any question that you want to ask before we start?

Participant: No.

Researcher: I just want to tell you that this conversation will take about 20 to 30 minutes.

Participant: Okay.

Researcher: Since you don't have any questions, we can start with our first question. What are your experiences regarding sexual reproductive health communication, like your overall experience?

Participant: About my life?

Researcher: Yes.

Participant: I grew up in the villages whereby when you are growing as a young person you have to respect every elder irrespective of whether you know or you don't know, how you approach elders, even if you were just walking with a boy the two of you must separate as elderly people should not see you walking like you don't respect them.

Researcher: Okay

Participant: That is how we grew up.

Researcher: Okay

Participant: And we were taught that sex before marriage is a sin, like it's a shame. The whole village will know that a child from a certain family doesn't have manners, she walks with boys in front of people, and it will come to pass that it will be difficult for her to get married because everyone would've known her for being out of order. You need to respect yourself and your elders.

Researcher: Okay.

Participant: The experience I've had for the past 21 years that I've been in this orphanage being with girls and boys, now children think sex is just a play.

Researcher: From what I heard you say, you said that in the olden days, you were taught that you must respect the elderly. You couldn't just walk with freely with a boy, so it means when other people see you, they'll say you are disrespecting.

PARTICIPANT: Yes.

Researcher: Tell me what are your experiences regarding this sexual reproductive health communication with your grandchildren?

Participant: I thank God that I grew up in a Christian family and I grew up with values, and continuing in Christian walk I found out that life in Christian families and other families is different.

Researcher: What do you mean by not being the same?

Participant: As Christians, we have some activities at church. There is youth services and youth camps where you are taught that your body is a temple, you don't just open up for a boy and you get pregnant before marriage, that very much shameful, you shame your parent, the whole place, your mothers. You have shamed them.

Researcher: What is your actual experience about talking to these grandchildren about sexual reproductive health?

Participant: I experience young people who listen and love themselves, I think maybe they were not loved when they were growing up, I don't know, when the boy says, "I love you", the girls get crazy, they get crazy and they can do anything that the boy says, let's do this and the do it. I think maybe it's like as some are orphans, some are neglected, maybe it's because they did not get parental love, so everyone that says "I love you" they take it as love which is not.

Researcher: From what you're saying, you mean someone who was not loved at a tender age has got a problem when it comes to sexual reproductive health, is that what you mean?

Participant: Yes.

Researcher: What are your challenges as a granny, regarding sexual reproductive health communication with your grandchildren?

Participant: With my biological grandchildren, I can say I thank God for the values we grew up with because even my daughters, God has blessed me with six daughters. I never experienced an illegitimate child, they all got married and started having children in their marriages. With the children here that I received, raised, and live with so different that to speak about these things, they do not listen to you, they go out, they listen to what their peers say, they follow their peers, and they get lost. Those who never really listen to me they never finish metric, they run away from here. I have more than 30 children -whom I fostered-who finish their matric, went to university and some are working and married. I was involved in lobola negotiations of some of them and I have had men come here saying "I've seen a girl here" then I will call the relatives of the girl to come and be part of the girl's marriage.

Researcher: from what I here, granny is more of a Christian and respect the Christian values, which you think they mould a person.

Participant: So much that is where I was grounded as a girl.

Researcher: Okay. I heard you talking about peer pressure. Can you tell me more about the influence it has on sexual reproductive health?

Participant: It has a lot of influence because, “if one is doing it, so why can’t I?”, and when they come back here my gates are always locked. They have no time to go out and when a boy comes and hoots at the gate, it is like a chance for her to go out. Their behaviour seems as though they are locked up in prison and they bank on such things to get out and they end up being uncontrollable.

Researcher: What are your fears regarding sexual reproductive health communication?

Participant: My fear is, once a female child is sexually active, first is diseases and secondly an illegitimate child, of which they themselves came here because there is not help for them in the families, no background that can support her to grow, acquire education and other things. So now when she is started having sex and she can get infected even though there is medication for those infections and diseases, they no more die, they can live with it if they are careful, taking care of themselves and taking medication. But there can be a child, you are an orphan too, who is going to take care of the child, who does the child belong to, because even you yourself needed a parent and a place to stay, so where will the child go. That is my fear.

Researcher: Have you ever had one of your grandchildren having an illegitimate child?

Participant: Yes.

Researcher: How did you feel after you had noticed or heard that your grandchild is pregnant?

Participant: I felt that it was a disappointment. With me, it was my third daughter’s child who was a very brilliant and smart child got pregnant when she was 16 yrs. After giving birth, her mother told her to go back to school and she went back to school, the following year she got pregnant again. Her mother told her that she had to go look for a job after she has finished her matric and work for her children. It was a disturbing thing for me as it was much of a disappointment because, she was not mine, if she were mine, I would have told her to go back to school. Her actions now caused her to be a nobody and coming to think of how brilliant she is, it is so painful.

Researcher: I understand your frustration and disappointment granny. Where do you get the information about sexual reproductive health because as of now things are changing, and there is a lot of information?

Participant: I have had an opportunity where I got to meet the social workers from the child welfare which was the first company in Place x to introduce me to the social working system then going into families and introducing me to other social workers, so that when such things happen in your marriage, relationship, or family you can come to us to get help. They had a project, it is named “XX” but, because it started in a certain Town by the name of “Xy”. Then that project taught me about this SRH communication and how to identify different behaviours from girls and when to act on them by making them aware of the consequences that come with different behaviours and how to help them.

Researcher: I understand granny and that was very good. Do you ever go to the clinic for more information?

Participant: Actually, now we do not have to go there, especially in my environment since 2001 when I moved from my house and came here. The nurses from clinics come.

Researcher: What information do they share with you?

Participant: They always tell me not to crack my head, if a child starts doing this and that just bring it to us so as we can talk to her because she will not be open to you but, she will be able open to us. That is what I have experienced so far and even these young adults, I have had one who came to our church and said mama you have so many teachers, I am touched can you please allow me to talk to them, and I agree, because as a young adult I went through many things, and I want/like to share my experiences with them.

Researcher: Your efforts are well appreciated, at least you are able to share what you know with the teenagers, and this really assist with the sharing of information.

Participant: Yes. One of the grandchildren said, I got raped when I was young, so I want to talk to them about such experiences. Some of them after they had sex they come and tell me that they are experiencing things that they have not experienced but, they were able to talk to me. I arranged for them to get to a clinic because they were so afraid to tell me what they did or what happened to them, instead they will

come and tell me they might be having flu and they might need to go to the clinic. As they keep it in, they end up being damaged inside and I really thank the nurses for their help.

Researcher: So, these children come to you and ask to go to the clinic?

Participant: Yes.

Researcher: Are you openly talking to then about this or is it that they are the ones coming to you?

Participant: I think that the teachings that I give them when they went out and did wrong things, they now experiencing the consequences of their wrongdoing, then they feel ashamed to tell me but, before now I had care workers who were trained who used to talk to them.

Researcher: In your opinion, do you think communicating about sexual reproductive health is beneficial to these grandchildren?

Participant: So much, because they must know and not to just jump into things, they must also know that there are consequences to everything they do. It is important.

Researcher: We spoke about the support you get from the clinics and their availability to helping these children.

Participant: And their support.

Researcher: Yes. Do you perhaps have a question you want to ask or something you want to add on to what we have talked about or maybe have not talked about?

Participant: What I want to add is that it is important for health workers to go out into their community and give information to community members because some only go to the clinic when they are sick and when one is not sick you won't go to the clinic.

Researcher: From what you said, you mean healthcare workers are not visible in the community?

Participant: Yes.

Researcher: So, it is important for them to go and visit families?

Participant: Yes. it touches my life so much that in the informal settlements, girls get pregnant at the age of 13 yrs. and why, it is a one roomed house divided by a curtain, the parents are sleeping on the other side of the curtain, they can hear everything going on, on the other side of the curtain. Even if a female child has or has not had sex, she wants to do it and when she has started menstruating it

becomes worse that on day, she is going to do it. At the age of 14yrs she gets pregnant and gives birth, and it so hard and terrible to take in. It is much better when both the parents of the teen mom are present but at times it is not possible and it very hard breaking.

Researcher: It is heart-breaking.

Participant: In some cases, you will find that, that person was living in rural areas, moved to Gauteng and has 2 or 3 children, then she ends up living in an informal settlement, she gets a boyfriend, brings him to the house, introduces him to her children then they go to the bedroom. The children do not like nor accept him which leads to children having babies at a young age. After the mother has found out about her child being pregnant at that young age, she does not know what to do nor can she chase the boyfriend out and say I need to take care of my children since they are now falling apart or going astray, it just goes on.

Researcher: It means parents must be role models to their children and talking to the children about sexual issues for them to understand. For me, identifying or approaching grandparents, I was just looking at the issue of being a grandmother who has experienced a lot when it comes to these things and being able to communicate with your grandchildren about it, if ever the parents are unable to do that.

Participant: Yes.

Researcher: From my side, I think you have given me a lot of information and it is valuable information for this study, and I appreciate your participation.

Participant: Thank you.

Researcher: In case you do not have any other questions or addition, I would like to thank you for your time and allowing me to come and have a chat with you.

Participant: You are welcome.

Researcher: What I will do is, if ever I need some more information, I will contact you and come back for this valuable information.

Participant: You are welcome.

Researcher: Thank you very much.

Participant: it's my pleasure, Sister.

ANNEXURE Q: INTERVIEW WITH GRANDCHILD

TRANSCRIPT GRANDCHILD

Researcher: Good day Y

Participant: Good day mam

Researcher: My name is Linky Ratshwafo I am a doctoral student from University of Pretoria and one of the requirements is to conduct interview to find out about sexual reproductive communication between grandchildren who stays with their grannies. As a requirement I have obtained all the permissions to conduct the study from all the relevant authorities. You still remember the leaflet that I gave you to read and ask question where you didn't understand.

Participant: Ok mam I have read the information leaflet and I don't have any questions.

Researcher: Ok further note that the interviews will take 30-45 minutes and feel free to ask questions, but you are more than welcomed to share as much information. Further note that a voice recorder will be used to capture our discussion which will be transcribed later. Am also accompanied by the research assistant who will be operating the audio recorder so that I can concentrated on the discussions.

Participant: OK I understand, and I also agree to take part in this study.

Researcher: Y, further note that I will be writing notes on my notebook those are my key points just to remind me of what we have spoken about. You have to just continue.

Participant: Ok mam

Researcher: Do you maybe have any question that you need to ask before we start with the discussion?

Researcher: Tell me about your experiences regarding sexual reproductive health

Participant: What a difficult topic... I don't know where to start... This is difficult for me because I haven't experienced anything I don't have a boyfriend, so I feel there is nothing to worry about.

Researcher: Ok… What are your experiences regarding sexual reproduction health communication between you and your grandmother?

Participant: I feel okay.

Researcher: What do you mean when you say that “you’re okay”?

Participant: When people tell me about sex, why I should act differently towards what I don’t know, I also want to know what it is.

Researcher: As it is, you want to know more about sexual reproductive health?

Participant: Yes. But I don’t discuss such topics with granny because it would mean am disrespecting her so it’s best to refrain from asking questions.

Researcher: What do you mean by disrespecting her?

PARTICIPANT: Where will I start as I said its best to keep quiet

Researcher: You mean you are afraid of discussion such topics with you granny?

Participant: Yes, otherwise I rely on the information I get from school, internet and at times from my friends.

Researcher: What information to you have and do you feel it’s enough?

Participant: Information on menstruation, body changes even though am not sexually active, but I feel I have the right to know. Lack of information usually leads to a lot of mistakes that happens in life.

Researcher: What could be challenges of having an open communication with your granny?

Participant: I think fear to be judged and seeing as if am being forward when I only need information.

Researcher: How do you feel about that?

Participant: Its very scary……. how are you going to approach the subject? Am really afraid.

Researcher: How do you feel, talking to your grandmother about sexual reproductive health?

Participant: I’ve never spoke to my grandmother about such things. I have already explained that am afraid. I don’t even know where to start.

Researcher: What makes you to feel the way you are explaining to me?

Participant: It’s embarrassing, because it’ll be as though I’m already doing all those Honestly speaking, I don’t feel comfortable talking to my grandmother about it.

Researcher: But have you ever spoke to your grandmother about it?

Participant: Never.

Researcher: Does your grandmother talk to you about things like this?

Participant: She's never had a conversation with us about such things.

Researcher: From what you are saying there is no communication about sexual related topics

Participant: In your opinion what is you view regarding failure or lack of open communication regarding this topic

Participant: I think as teenagers we need information from our parents before we get the information from other people**.** But now I can't even start the conversation with my granny. Unlike my mother who would always encourage me to be educated and have children when am self-sufficient and not do the mistake she has done

Researcher: What did she tell you?

Participant: Most of the time my mother tells me not to have sex as I'll end up being pregnant or sick.

Researcher: What's your respond to what your mother tells you?

Participant: I listen to what she tells me.

Researcher: Didn't you ask her why she's saying that?

Participant: I only asked her once.

Researcher: What did she say?

Participant: She said she doesn't want me to get pregnant while I'm still in school. My mother is taking good care of me so, I have to listen to her and not repeat the same mistake she did.

Researcher: Now that you're staying with your grandmother, how is your relationship with her?

Participant: I only started living with her this year in February so, am still adjusting to living with her and learning to know her. Remember she is very strict and I'm afraid of her.

Researcher: Why are you afraid of her?

Participant: I don't know but, I just can't.

Researcher: In your opinion what should be done to create an open atmosphere between yourself and your granny?

Participant: Maybe programmes that can be introduced to educate us about these topics and how to handle them. Not to be afraid to ask questions and understanding

the current lifestyle. The other thing is there are nurses who come at our school and discuss some topics with us.

Researcher: What do they teach you about?

Participant: They teach us about how we as girls can get STIs at toilets and what we should do when using public toilets.

Researcher: As you've said that health nurses come to your school, do you think the information which they are giving to you is enough or is it still lacking?

Participant: The information is not enough.

Researcher: What do you mean by it not being enough?

Participant: I feel like there are some of the things they're not telling us.

Researcher: What are those things?

Participant: Some people don't feel comfortable talking about sex.

Researcher: According to what you've said, you mean even the nurses who teach you about these topics, cannot teach you more about things which are not comfortable?

Participant: There are some questions that we ask, and they'll tell us not to ask about such.

Researcher: Do you mean they still have a challenge speaking with you about this topic when they are expected to provide information?

Participant: Yes.

Researcher: What do you think could be done for you to get more information?

Participant: Maybe we can get more information from the clinic just visit and seek information.

Researcher: Yes. Isn't that you said your teachers at school don't give you enough information and the nurses don't come, what could be done to ensure that sexual reproductive information is provided to teenagers?

Participant: I think it is just a matter of being knowledgeable and understanding that times have changed and it's a must that teenagers are provided with the necessary information that will improve their health

Researcher: Ohk I hear what you are saying.

Participant: Yes, I further rely on my friends because I have friends who are already having sex and they tell me how it feels. Meaning if we can't get information from our grannies, nurses at the clinic we will need to seek information ourselves.

Researcher: Can you explain to me your experiences that friends share with you.

Participant: Some of them are bad influence, like they tell me that I too should have sex feel how it is and some tell me that I'm okay the way I am, and I should not have sex or not to get into sexual relations.

Researcher: How does that make you feel?

Participant: Because I want to protect myself, I listen to those who tell me not to have sex or a sexual relation want someone who can guide me and tell not to do this and this and that.

Researcher: Who have you identified as that person that can guide you when you transit to womanhood?

Participant: It's my mother.

Researcher: So, you mean there's no other person besides your mother, whom you can talk to?

Participant: Oh… There is. It's my friend because I trust her.

Researcher: From what we have discussed what do you want to see happening?

Participant: I want someone to come and tell us more about sexual reproductive health so that we know what is wrong or right.

Researcher: How do you feel about not having someone who can give you information?

Participant: I feel like they don't have time for us and that they don't take good care of us.

Researcher: Is there any questions that you want to ask me?

Participant: No, I think I have provided you with the information

Researcher: I would like to thank you for sharing your experiences with me and also the time that you have taken. In case you have information that you feel it's important to share with me please feel free to call me at any given time.

Participant: Ok thanks.

Researcher: Further note that whatever we have discussed will be treated as being confidential. Do you think you may need referral for counselling please feel free to tell me so that I can arrange for referral?

Participant: No, I think am ok no need for counselling we were just talking

Researcher: If there are no questions that you want to ask me, thank you for your time and the information you've given me.

Participant: Okay.

END

ANNEXURE R: INTERVIEW WITH PHCN

Transcribed Interview [PHCN]

Researcher: Tell me about your experiences regarding Sexual Reproductive Health communication with grandparents and grandchildren.

Participant: There is no clear communication or good communication between the two with regard to sexual reproductive health because of it can be maybe practice or age difference between the two, so it's either the grandparents don't know how to approach the grandchild with regard to sexuality or the grandchild is afraid to discuss the issues of sexuality with the grandparents because that would indication that now she's starting to be involved with the opposite sex or same sex in relation to relationships, so there uh, it's not there.

Researcher: You mean there is no communication?

Participant: Yes, it's not there.

Researcher: Ok I hear what you are saying.

Researcher: What are your experiences as a PHC Nurse regarding this matter?

Participant: Uhm, the question is on the practice or personally? like……

Researcher: On the practice……. yes

Participant: On the practice I have met few whom I have discovered that they can't talk about the issue of Sexual Reproductive Health even at home, some they brought the children here at the clinic but uhm, not in a way of discussing the issue of Sexual Reproductive Health but with the intension of saying "I've brought this child for prevention", why for prevention, we want to know why you brought this child for prevention?, "I just see her coming late every day or these days she started coming late", did you discuss with the child what's going to happen? "No", you ask her, did you discuss the risks of late coming? Things like that, and find that she didn't discuss anything, I just brought her here so that you could talk with her. Then the grandparents will be asked to go outside so that we talk with the child, and of which the child will become open but at first it will be hard, until I talk as if we are the same

age group and that's when the child will realise that she might as well open up. With the status of being a nurse and when they come in here, some swear at you some also come with a negative attitude because they expect negative response from us, at the end we realise that the child didn't receive any information on Sexuality, some its better this days because they get information the from school so we just rub stamp on what they have received from school and provide clarity where they've got questions and don't understand it well. Then the grandparents will be called in and discuss in front of the grandparents that they are sole guardians of this child, because if you don't guide this child at home the child will be guided at the streets and I don't think that's what you want, because if we continue to practise or to do it as if it's a taboo to discuss about sexual reproductive health with our children then we are going to get the opposite result of what we wished for.

Researcher: Okay, if I may ask, what do you mean by being a taboo?

Participant: I mean like when isn't it than in the olden days, they would expect me as a man to go to the mountain where they are going to teach me about how the process of becoming a man and the ladies, they would go to the lady's initiation to be taught how to become a woman. So now because of civilisation and the access even to healthcare facilities, you find that most they no longer go there so it is the responsibility of the parents at home to discuss the issue of sexual reproductive health with their children or grandchildren, so now that barrier is still there so they are afraid or they can't talk openly, they will just use phrases that are not direct to, and you will find that the child does not understand that my grandfather or my grandmother it talking about, so that why they need to take it more seriously, you find that it's, that's why I said that it is a taboo to discuss sexuality with your children or with your grandchildren.

Researcher: I heard you talking about a barrier, as a PHC nurse how do you think this barrier can be eradicated sort of or how can we deal with this barrier of fear?

Participant: We can start a youth club where we will be teaching our children or if not us there are NGOs that provide youth activities whereby we can invite them at the clinic and we send word of mouth or leaflet to invite children to come to the clinic on those specific dates for activities, like physical activities, education in the clinic and on the other side of the premise we can also have clubs and some may be

related to their medical condition and some related to physical activities where at the end of those physical activities a healthcare worker can sit down with them, discuss about this thing will get their fears, we will alley their anxiety, we will ensure them how important it is to discuss the issues of sexual reproductive health with their grandchildren and on the other side of the young children I believe because some of the things I observed when I grow up looking at my father, now I realise that he was an experienced man whom I can rely to and of which it is what we wish that even grandchildren can rely to their grandfathers to discuss what so ever they've gained.

Researcher: From what I am hearing, do you think the grandparents are knowledgeable enough to provide such information to the grandchildren?

Participant: They are knowledgeable but the problem is how to bring it out to their children, hence I said if we can start the clubs where they are going to be guided definitely how they can approach this, their grandchildren how they can give them information so that even the children can understand the information that they are given so that they can have questions or can question on whatever is being discussed freely.

Researcher: I heard you saying the grandparents are afraid of saying things directly and they end up using idioms, can you clarify further?

Participant: Like, for an example if it's a girl it will be told that don't go during the night it is not safe or it is dangerous like, if I went out one day and I didn't see anything or the danger of the night, tomorrow I'll want to go out but if you indicate to the child that you know what that kind of me going out at night there's one, two, three, four, for example; you can meet someone or a group of boys that can rape you and when I talk of rape I talk of one, two, three, four, and sometimes they can talk like that seeing that this girl is a win over, to come straight, sit down and talk to her; now your behaviour indicates that now you have a boyfriend and if you're having a boyfriend it does not end up from telling you I love you, there will be a tie where you're going to be sleeping together and the end result will be a baby if you're not on contraceptives, so there are a lot that are being used which at the end of the day you realise that they're not clear to the children, don't sleep with boys you'll get pregnant, and then the girl will ask themselves because at home there's not enough rooms and in the same room we sleep with boys but we're not getting raped, and then now you

see it's not clear also, but that if we come open to them we discuss about sexuality until we reach the stage where we discuss about sex.

Researcher: Sr..., at some point you speak about the attitudes of the healthcare providers or the primary healthcare nurses, what do you mean?

Participant: When I talk about the attitude of the healthcare personnel, there are times where you find that, I would say the way we talk to them, we don't switch immediately to their level so that they can understand us, because at times we fail even to identify their fears so that we can make them relax and we provide the service that the child needs freely. The other thing it the way we talk, it can bring fear even though it is not negative but the way I present myself, to another one you'll find that it's fine and they won't be intimidated. To a child you find that the tone of my voice can cause the child to be scared and not open up. The questions that we ask, to the young ones you find that they are threatening because we didn't lay a foundation first, to say relax what we're going to discuss here is one, two, three, four, and is related to what you came here for, for an example if the girl is here for prevention then we discuss about reproductive health so that when she gets out of this office she has the knowledge not to say I want to prevent but now I won't fall pregnant and she'll have the whole information with regard to sexuality.

Researcher: I can here that you're doing a very good job of educating them, what information are you giving specifically to this youths?

Participant: To young people we discuss about sexuality, where we discuss about a girl, the reproductive system, we discuss a boy, and its reproductive system. We try to discuss the issue of the functions in boy's reproductive system and then we discuss the issue of now when it comes to puberty, what's going to happen, the changes that are going to happen to girls and to boys then exerting to adulthood, so you talk about what's going to happen, when we talk of loving each other, one, two, three, four, and what's next. And to discuss about taking ownership of whatever decision that they take because it is going to affect their future or their careers or their family and such.

Researcher: Okay, as you were talking, you keep on saying "one, two, three, four", what do you mean?

Participant: It's just that I don't want, its mannerism sort of, but what I mean is like to elaborate whatever we're discussing about and also like indicating that what I've said before is not the only answer if I've given the answer.

Researcher: Okay, as we were discussing the barriers and the challenges about the fears of the grandparents and even the fears that the grandchildren may be having, what other barriers do you think of?

Participant: The other barriers that might be there with regard to sexuality; culture can influence that and also… I don't know whether I can put culture in religious practice because it can be a barrier to that.

Researcher: What type of barrier under religious practice?

Participant: Let's say maybe I'm in church and they tell me that sex is a sin before marriage and then now I'm a young boy and there's a girl that I see and once you say sex is a sin before marriage it means we are not going to discuss anything in relation to sex or sexuality. At least now in the social media there are a lot of discussions with regard to sexuality and it's better because also it was……the message that was displayed in the former days was also a barrier because most of the information was hidden.

Researcher: At some point you asked me about… When we started with the challenges, you said "on a personal capacity", how do you feel, what are your personal experiences with sexual reproductive health with children? I know that as an elder person you're also faced with this, hence I've asked how many children do you have, you've got a 16years old, and how do you approach?

Participant: You know with social media in place, it has brought a platform where it becomes easier as a parent to discuss about sexual reproductive health, like for an example; you…..at times the questions that they ask it's hard to discuss with them about it on looking at the age gap that, it becomes easy with social media because now they know how to ask you a question and where you won't come up with stories that they do not know because most of the things that they ask they no know and it's… I don't know whether it's becomes easy because I'm a healthcare worker, because I can start a topic with a group of boys like for an example; my son who is 16 has got friends who are 17, 18, 16, we can discuss about maybe sexuality or sexual reproductive health questions in a group form or even at home when we're

sitting watching T.V and he'll tell you first maybe hah this girl is better than that one then I ask; are you sure, what do you mean? Oh, this action one, two, three, four, five, six; hah this guy is not treating well, what do you mean this guy is not treating well girls? No, because he's disrespectful, it's like he does not see the worth of that girl, he's playing with her, he's not serious in the relationship; what is it that he's supposed to do to show that he's serious in that relationship? He should treat her well and not to scold her like as if she's a child. The way he treats her in front of his friends shows that he's in control, he's the boss of the… yeah things like that, so it's easy, even on the girls side, I don't have girls but there are girls at home, my cousin they've got daughters, you sit down and discuss about it and sometimes I push them to discuss about them because when I could hear maybe my cousins complaining that oh she's doing this and that, I say come I just want you and me alone I don't want anyone, lets discuss about what they are talking about, what's happening to you in your body then yah there will be tension because now it's an elder and is presenting it and I'll say no, no matter how afraid you are I will discuss it with you because it's happening and if you don't have good guidance, you'll slip down and fall, and tomorrow when we say what were you doing, what are you going to say? So now I want to give you information, I want to understand you, so that we can be able to go on this journey together because, if you're afraid of me and I'm afraid of you who's going to help you, who's going to guide you? The friend on the streets? They're going to guide you and they might guide you wrongly and while we are here, I usually indicate to them that as a healthcare worker there are children that I meant that are like you at your age that I guide and because I'm not afraid to guide them why should I be afraid to guide you? And they become open to me not because it's they're just wide away in time, it's because they want information, they want knowledge so how can I leave you here at home when I get give you this information which I know tomorrow will benefit you? So that's why I'm saying it's maybe easy because I'm a healthcare worker.

Researcher: It has become easy for you to interact with them. From what you're saying Mr. Mabaso, I've identified that you're an open person who is able to communicate freely with both the clients at the clinic and the children at home. If I may further ask, since you said that you've undergone the PHC training, do you think

the programme has covered everything, do you think there are some components that are still lacking that may be added that can be beneficial to sexual reproductive health?

Participant: What I can say is back then, there were some topics that were even harder to discuss about but with the changes that came in, I see those that are coming back from PHC trying to sit down and discuss the status of the things they do at home and longing to see things being different. What might be a challenge is that it might not be the package of PHC training but the relationship between the healthcare system and the NGOs that are dealing with sexual reproductive health. If that gap can be bridged I think there will be a lot more than we have now, if we look at it now we can create and get a working relation within a short period of time, one, two, three, four, you find that that gap is broken because they're standing alone and we have our own problems and at the end of the day you find that someone somewhere somehow we have a clash, now you're standing there alone, we're standing here and when they get stuck there they can send there or come to the clinic instead of letting the healthcare intervene so that it can be easy for the young people to be open, like coming to the clinic is another environment going to where they meet as a youth, let's say youth club it's another environment. The fortunate part is I was privileged to work with the youth, going to where they gather and discuss whatever topic that they have according to their programme and we coming to the clinic, there's a very big difference because when they are there they are very open, so mostly now because it might be because of staff shortage you find that it's not easy for that person to go outside and provide services or educate them.

Researcher: Sr……. I heard you talking about a gap, and I missed something there.

Participant: There's a gap between the groups.

Researcher: Which groups if I may ask?

Participant: Like youth groups that are in the community. A working relationship can be formalised, let's say that your supervisors can come and indicate that we have this group of young people who have got 56 young people that we provide them with one, two, three, four, or what we provide to them it's education with regard to sexual reproductive health with regard to do the homework's things like that. At the end of the day that relationship can be created but as time goes on, now you'll start asking

yourself where they are? What happened? And then you find that they've got other problems and they are running now, they are far from the clinic.

Researcher: Where are the programmes held or are they organised by the NGOs?

Participant: Yes

Researcher: Do you have them around?

Participant: Yes, we have them around but some because of funds they are disburdened.

Researcher: What do you think the benefits of sexual reproductive communication, what benefit will it bring to the families?

Participant: The benefits that will be there it's we….isn't it that most of the time we are afraid that if let's say for an example a girl falls pregnant, now the burden of raising a child will be on the granny and then that will be definitely because that girl is still a child it means the granny is going to be a mother now, and now it's going to be put a financial strain in the family, you might find that there's no one working and they're relying on grants now, also in some families you find that there is a challenge of space and now the girl was a girl yesterday, today it's a mother now it becomes a challenge now.

Researcher: Since I said at the beginning, we're going to develop grandparents on sexual reproductive health communication, what other information do you think can be included in those programmes with all those guidelines?

Participant: I think… what can it be?

Researcher: Isn't that we want to promote sexual reproductive health communication within families right, what do you think as a parent and as a healthcare provider?

Participant: As a parent... eish…

Researcher: It's not a problem sir, if there's nothing that comes into your mind. I don't know, from your side do you have any questions you want to ask, or do you want to add anything that comes into your mind? Anything that you can think of.

Participant: Okay, what I may ask that comes to mind is these guidelines is like going to be introduced like an… if not all of it then part of it in this post.

Researcher: At this point and time, my target was for the PHC healthcare facility, but I can still recommend the utilisation thereof. Remember we still have the school health nurses and I can also approach the school healthcare nurses.

Participant: Okay.

Researcher: Yes.

Participant: You know what, what I'm thinking it's not a question per say, but my mind has run to services like at the clinic and which they were brought in to say that a few services where we'll be taught and where they will be realigned, there'll be a fast queue and things like that. It met a challenge because of shortage of staff, if yes we had enough staff it was going to be very easy and profitable guidelines that will be directed freely to them and that will be even to healthcare workers as in that we work in our auditioned places, so was going to assist us that when I go to that service if it is my turn to go t that service I'll go through the guideline and I'll understand that and how to approach it things like that and with the mind to make them relax.

Researcher: Do you have any other question that you maybe want to add or subtract?

Participant: No.

Researcher: It was a fruitful discussion we've had. Thank you, Sir.

Participant: Thank you mam.

ANNEXURE S: CODING CERTIFICATE

Dr Annatjie van der Wath (M Cur, PhD) annavdw@mweb.co.za

CODING CERTIFICATE

Qualitative Data Analysis

This serves to confirm that Annatjie van der Wath has co-coded the following qualitative data: Interviews with 11 grandchildren, 9 grandparents and 12 primary health care nurses for the study:

PROMOTION OF SRH COMMUNICATION WITH GRANDPARENTS AND GRANDCHILDREN

I declare that the candidate, Christina Ratshwafo, and I have reached consensus on the major themes and categories as reflected in the findings during a consensus discussion.

Annatjie van der Wath (M Cur, Ph D) annavdw@mweb.co.za

ANNEXURE T: EDITING CERTIFICATE

Unit 3 West Square Business Park
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14 June 2023

TO WHOM IT MAY CONCERN

This serves to confirm that I have edited and made the necessary corrections and emendations to the thesis:

COMMUNICATION GUIDELINES TO SUPPORT GRANDPARENT HEADED FAMILIES REGARDING SEXUAL AND REPRODUCTIVE HEALTH IN THE TSHWANE DISTRICT

by

CHRISTINA LINKY MANTHIPA MABENA

Sincerely

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