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**COMMUNICATION  
BETWEEN MOTHERS AND  
THEIR ADOLESCENT  
DAUGHTERS ON THE  
SUBJECT OF SEXUALITY  
AND HIV/AIDS IN UGANDA**

**NAKKAZI DAMALIE**

**Gender Issues Research Report Series - no. 14**



**Organization for Social Science Research in  
Eastern and Southern Africa**

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# COMMUNICATION BETWEEN MOTHERS AND THEIR ADOLESCENT DAUGHTERS ON THE SUBJECT OF SEXUALITY AND HIV/AIDS IN UGANDA

**Abstract:** In this study, the researcher intended to investigate the role played by mothers in providing information to their adolescent daughters on the subject of sexuality and HIV/AIDS. Specifically, the researcher wanted to establish the content, context and frequency of communication between mothers and their adolescent daughters in recognition of the emerging important role parents have to play in providing safe sex education to their children.

The World Health Organization (WHO) 30 cluster 7 quota sampling method was used to select households of the respondents. In all, 210 households, consisting of 210 mothers and 210 daughters, were sampled equally from Rubaga and Kabulasoke study areas.

Closed and open-ended questionnaires and focus group discussions were employed to collect quantitative and qualitative data, respectively. Data entry and analysis was done using the EpiInfo-version 6 statistical computer package.

## Results

75.8% (138/182) mothers revealed that they talked to their daughters on the subject of sexuality and HIV/AIDS while 24.2% (44/182) reported that they did not discuss with them.

67.9% (125/184) daughters acknowledged their mothers' having talked to them about sexuality and HIV/AIDS. However, 32.1% (59/184) or a third of the daughters reported their mothers had never talked to them about sexuality and HIV/AIDS. The mean age of daughters at which mothers reported they initiated the discussion did not significantly differ from that reported by daughters ( $p= 0.923$ ). Significant differences were, however, noted on the frequency of communication as reported by mothers and their daughters ( $p= 0.008942$ ). The content of the messages given or received as reported by mothers and their daughter were more or less similar.

## 1. INTRODUCTION

### 1.1 Background to the Problem

In Uganda today, the number of sexually active adolescents is on the increase. Indeed, many parents, especially in this era of the deadly AIDS epidemic, are perplexed about what to do for their children. The general breakdown of society's moral values brought about by social strife since independence, coupled with the breakdown of the social infrastructure, including schools and health services, rural-urban migration, have changed adolescent sexual behaviour considerably. Today, it is no longer valued and necessary for a bride to be a virgin as it used to be in Ugandan tradition. Pre-marital sex

has become much more common. Traditionally, adolescent girls received sex education from a female family member, mostly an adult auntie or a grandmother. The event that led to this sex educational conversation was often the first menstruation. Girls would then get instructed on female hygiene, abstinence during menstruation, on how to please a man sexually and finally on the sexual act itself. Any sexual activity was only allowed after the girl got married. Tradition obliged women to keep their virginity until marital vows had been taken. Therefore girls had their first sexual experience at a much later age than nowadays.

The AIDS Control Program estimates that as of June 1993, women constituted 51.9% of AIDS cases. Another consequence of this has been deteriorating trends in infant mortality rates, in spite of aggressive efforts to immunize children, which can be attributed to the AIDS epidemic and the corresponding vertical transmission from mother to child. Article 12 of the Convention on Elimination of all forms of Discrimination Against Women (CEDAW 1995) committed state parties to intensify efforts in dissemination of information to increase public awareness of the risk of HIV infection and AIDS among women, and to the factors relating to the reproductive roles of women and their subordinate position in some societies, which makes them vulnerable to HIV. The article emphasized active participation of women in primary health care and aimed to enhance their role in health education and communication in the prevention of HIV/AIDS among others.

However, up to today, communication between parents and their children about sex and the risks involved has always been limited, partly because it is seen as a “taboo subject” and partly because parents do not see it as their duty to inform their children. In the past, it was seen as a duty of the members of the extended family. However, with the breakdown of strong extended family ties today, it has increasingly become necessary for the mothers to assume the role of providing sex education to their adolescent girls in particular and children in general.

### **1.2 Statement of the Problem**

Sexual health problems ranging from early pregnancies, abortions, sexually transmitted diseases and HIV/AIDS are among the major health problems affecting adolescent girls in Uganda today (Lubega et al. 1989). Risky sexual practices are common among adolescents with mean age for first sexual intercourse at 15.7 years for girls (Sentumbwe 1993). The incidence rate of HIV/AIDS has risen most rapidly among adolescents of the age group 15-19 years, especially girls. Adolescent girls have six times higher risk of getting infected with HIV than boys of their age. Almost 30% of girls between 15-21 years have reported to having an abortion (Agyei et al. 1990). The Beijing Declaration and Platform for Action (1995) recognized that adolescent girls need, but often do not have access to necessary health information and educational services as they mature. Counselling and access to sexual and reproductive health information and services for adolescents girls has been inadequate or lacking completely, and a young woman’s right to privacy, confidentiality, respect and informed consent has often not been considered. Adolescent girls are both biologically and psycho-socially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. The trend towards early sexual experience combined with a

lack of information and services increases the risk of unwanted and early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions.

Because of their high risk to sexual health problems and HIV/AIDS, there was need to explore the role mothers could play in providing information to the adolescents on the subject of sexuality and HIV/AIDS. There was also a need to establish the content; context and frequency of communication between mothers and their adolescent daughters in recognition of the emerging important role parents have to play in providing safe sex education to their children. This study investigated these issues.

### **1.3 Research Questions**

This study was designed to answer the following research questions:

- What role did mothers play in providing information to their adolescent daughters about sexuality and HIV/AIDS? In Which ways could this be improved to meet the desired goals?
- What is the content, context and frequency of communication between mothers and adolescent daughters about sexuality and HIV/AIDS?
- What factors impeded effective and harmonious communication about sexuality and HIV/AIDS between mothers and daughters?
- What were the other different sources of information about sexuality and HIV/AIDS for the adolescent girls?
- How did they differ in the kind of message that the different sources conveyed? Especially, what difference existed in the content and context of message between sources within the family and sources outside the family?
- Who are the other trusted persons and various potential sources of reliable information about sexuality and HIV/AIDS that could provide good sex education to adolescent girls?

### **1.4 Purpose and Objectives**

#### ***1.4.1 Purpose***

This study had both basic and applied purposes. As basic research, the theoretical findings aimed to add knowledge on how mothers and their daughters communicated on the subject of sexuality and sex education as it relates to HIV/AIDS. Intellectuals, policy makers and service providers could use the empirical findings. By establishing the role communication between mothers and daughters on the subject of sexuality and HIV/AIDS contributed to knowledge and adolescent sexual behaviour, the study attempted to situate the research within the imperative of policy and program analysis and would contribute towards policy and program formulation to improve on the benefits of effective communication between mothers and daughters.

#### ***1.4.2 Specific Objectives***

- To establish how communication between mothers and their adolescent daughters about sexuality and HIV/AIDS contributes to sex education as a whole, and

especially education about HIV/AIDS.

- To establish the content, context, occasion and frequency of communication between mothers and daughters about sexuality and HIV/AIDS
- To identify barriers to effective and harmonious communication between mothers and daughters, and how this could be improved.
- To identify the different sources from which adolescent girls obtain information about the subject of sexuality and HIV/AIDS.
- To determine the different (moral) messages which the different sources convey and establish the differences that might exist in the content and context of messages between sources within family and sources outside family.
- To identify other possible trusted persons who could give sex education, and education about sexuality and HIV/AIDS to girls, and the various other potential sources of reliable information on sex education.

### **1.5 Significance of the Study**

Over the years, there have been changes in societal values and attitudes. Some of the consequences of these changes have been that the age at which girls have their first sexual contact has gone down, with certain drastic consequences concerning the subject of sexuality and HIV/AIDS. Several factors have contributed to this; the most conflicting ideas about pre-marital sex, the increasing urbanization, emergence of migrant labour, and the phenomena of “sugar daddies” and westernisation among others.

Urbanization has led to looser family ties. Complete families no longer live close together. The implication to these recent developments has been that traditional sexual educators are not always in the close vicinity to give children advice on sexually related subjects. The grandmothers and aunts are no longer there to pass on traditional values about sex and sexuality. The consequence has been increased morbidity and mortality from sexual health problems among adolescents, including HIV/AIDS.

This study focused on daughters because they are more vulnerable to HIV/AIDS than their male counterparts for various reasons. First, women have less access to information on HIV/AIDS and STDs. They are less educated than men, and have higher illiteracy levels. At the same time they are over-burdened with work and have little or no access to meetings or programs about good health-seeking behaviour. Second, biologically, women are more vulnerable to HIV/AIDS, and younger girls more so than mature women. STD/HIV/AIDS intervention strategies worldwide created awareness but did not consider women vulnerability. Neither have strategies to solve women’s’ issues been considered. This research thus explored new innovative ways, which have emerged, to give access to young women and the girl child to HIV information and sex education within and out of their families to bridge this information gap. The study further examined the role mothers could play in communicating issues about sexuality and HIV/AIDS to their daughters.

## 1.6 Literature Review

Several KAP and behavioural studies have been done on the subject of sexuality and HIV/AIDS among adolescents and youth in Uganda (Lubega et al. 1989), Ankrah (1987), Bagarukayo (1990), Sentumbwe et al. (1993). However, most of these studies have focused on establishing statistical and factual biomedical knowledge (Kristiansen 1991) without seeking in-depth knowledge and sources of information. Most of these studies have focused on the subject of HIV/AIDS as an isolated problem paying little attention on how integral HIV/AIDS infection is to the whole subject of sexuality and sex education.

Many of these studies have sought quantitative data without seeking the more qualitative in-depth information such as the content and context in which this information is received (Kristiansen 1991). The traditional extended family system has been weakened and as such, the information and knowledge for adolescent girls from traditional sources such as aunts and grandmothers has also weakened. However, no research had been done to establish the new emerging role, mothers (and fathers) could play in communicating with their daughters (or children) on the subject of sexuality and HIV/AIDS now days. There was also a need to seek for more qualitative in-depth information by use of triangulation, that is, several methods of investigation like Focus Group Discussions and participant observation.

Previous studies reported the common sources of information about sexuality as being friends/peers (46%), parents/guardians (14%), teachers (12%), radio (11%), health workers (5%) and other sources constituted 60% (Sentumbwe et al. 1993). However, the studies did not give details on the actual information given, the content, context, occasion and frequency of information from those sources. Most studies contended on the need to include AIDS education in School Health Education (Ankrah et al. 1989; Abaho et al. 1991) and to improve teachers' ability to teach health education (Bagarukayo 1990). However, none of these studies examined the need and the role that could be played by mothers communicating to their daughters. According to the study by Sentumbwe et al. (1993), only 5% of the adolescents mentioned having ever discussed sexual matters with their parents. Mostly adolescents discussed such matters with friends (60%), other relatives (10%) while 25% did not discuss with any one. In most of these studies, parents were generally in favour of more education of their children about AIDS (Ankrah 1987), but had a negative attitude towards expanding the amount of sex education. This, therefore, suggested the need to study what information parents thought was useful to give to their children and under what circumstances.

As regards current patterns of sexual behaviour among adolescents, studies by Agyei et al. (1990) and Lubega et al. (1989) revealed that the majority of adolescents began their sexual activities at quite an early age. Premarital sexual experiences were common and the mean age at the first sexual intercourse was 15.1 years for males and 15.5 years for females. Almost one third of female respondents between 19 and 20 years had had an abortion. However, the observed knowledge about sexuality and STDs was not utilized for the prevention to any significant extent - either through sex abstinence or condom use (Lubega et al. 1989). Similar studies by Sentumbwe et al., (1993) among rural youth and

Makerere University students (1996) revealed similar findings. All these findings confirmed that risky sexual behaviours were prevalent among adolescents.

In an answer to why this was so, Faul-Doyle (1990) gave the best explanation. She contended that the danger of using schools to disseminate sex and AIDS information lay in the very nature of the formal education system, which put strong emphasis on paper qualification. Thus, the formal education system had either stagnated or been financially incapable. The only objective of parents, teachers and pupils alike, was to pass exams and gain qualification (Sentumbwe et al 1996). In this regard, issues of sexuality and HIV/AIDS, on which they were not examined, raised little interest. The implication to this was that a communication and information gap existed where children could not receive sex education in its right content and context.

Studies about communication between parents and their children concerning sex and the risks involved with it had been few. A study among rural parents revealed that only 16% of the respondents had talked about HIV/AIDS with their children. This reflected the traditional norm in Uganda that parents did not communicate with their children about sexual matters. However, with increasing urbanization and the resulting loosening of the extended family ties, there was need to examine the role mothers could play in communicating to their daughters about sexuality and HIV/AIDS. There was also a need to examine differences that may exist in the different sources of information within family, and sources out of the family, in order to identify communication and information gaps for improvement.

## **2. METHODOLOGY**

### **2.1 Design**

This was a cross-sectional descriptive study.

### **2.2 Setting and Location**

The study was carried out in two districts of Uganda, one urban, (Kampala) district and the other rural, (Mpigi) district. Rubaga division, located 3 km Southwest of the city centre and Kabulasoke sub-county located 120 km off Kampala-Masaka road, were selected for the study from Kampala and Mpigi districts respectively.

### **2.3 Study Population**

Respondents in the study comprised of girls aged 12-18 years and their mothers. Respondents were contacted through Women and Youth organizations, Local Councils and schools.

### **2.4 Sampling Frame**

The World Health Organization (WHO) 30 cluster 7 quota sampling method was used to select households of the respondents. The unit of enumeration was the household, from which respondents, a mother and adolescent daughter (12-18 years) were selected for the interview. In all, 210 households were sampled equally from both study locations giving a total of 210 mothers and 210 daughters.

In the field, the 15 clusters from each of the study locations were selected as follows: using a population and Housing Census (1991) list, the number of LC1 (Local Council area) were listed for both Rubaga division (Kampala district) and Kabulasoke sub-county (Mpigi district); each LC1 area consists of 15-25 households. There were 99 LC1's in Kabulasoke sub-county and 313 LC1's in Rubaga division. In determining the sampling interval, the following formula was used:

$$\frac{\text{Total Number of LC1}}{\text{-----}} = \text{Sample Interval}$$

$$15 \text{ Clusters}$$

For Kabulasoke this was:

$$\frac{99}{\text{-----}} = 6$$

$$15$$

For Rubaga this was:

$$\frac{313}{\text{-----}} = 20$$

$$15$$

A random number was chosen from the table of random numbers. The first cluster for Kabulasoke was Kibanga, which corresponded to the first random number. For Rubaga, the first cluster was Bulange A Part B, which corresponded to the first random number.

The identification of the other 14 clusters in each of the study areas were determined using the following formula:

$$\text{Cluster 1} + \text{Sampling Interval} = \text{Cluster 2}$$

$$\text{Cluster 2} + \text{Sampling Interval} = \text{Cluster 3}$$

All the 30 clusters from both study areas were selected using the above formula.

The following clusters were accordingly selected for Kabulasoke sub-county: Kibanga, Kigo 'B', Bukandula 'B', Mbuye, Nakulamudde 'A', Nakulamudde 'B', Mawuki East, Katete, Ntonwa, Namulaba, Kabulasoke 'A', Kabulasoke 'B', Kangumba, Kampaama and Kissamula West.

From Rubaga, the following were selected: Bulange A Part B, Mbuubi A, Lungujja Zone VIII B Kunsu, Mulira C, Bakuli Village C, Kisingiri B, Mengo Town B, Church Zone B, Central D Zone Part B, Central B Zone Part A, Central C Zone Part B, Wakaliga Zone Part A, Mawuya Zone Part B, Kabusu Zone B and Pope Paul Zone.

## **2.5 Data Collection Techniques**

Quantitative and qualitative research methods were used to collect data required for the study.

## **2.6 Research Instruments**

Two methods of data collection and extraction were employed, one following the other.

### **2.6.1 Questionnaire**

A pre-tested questionnaire developed in the English language and translated in a local vernacular was used to interview the respondents. It was pre-coded with both closed and open-ended questions combined that answered pertinent questions regarding communication between mothers and daughters, about the subject of sexuality and HIV/AIDS, the content, context, occasion, frequency, barriers to effective communication and other sources of information about sexuality within the family and outside the family. The questionnaire also sought to answer questions about the role played by this communication to the knowledge of girls regarding sexuality and HIV/AIDS and in what ways this could be improved. The trained research assistants conducted the interviews and the researcher herself provided constant supervision. The mothers and daughters were each interviewed separately.

### **2.6.2 Focus Group Discussions**

Six focus group discussions were conducted in all, two for mothers and four for daughters. Daughters were separated into ages 12-15 and 16-18 years in each of the districts. One focus group discussion was for rural mothers and one for urban dwelling mothers. Each focus group consisted of 7 to 8 respondents randomly selected from among those who participated in the questionnaire interview and lasted for approximately one and a half hours. The researcher, with assistance of a trained research assistant, facilitated focus group discussions. Focus group interviews were employed to sharpen ideas not received using the questionnaire interview and were used to promote understanding of the participants' perspective. They were employed to answer questions on how, when and in particular what mothers communicate to their daughters on the subject of sexuality and HIV/AIDS. They were characterized by extensive probing and open-ended questions that focused on participant's knowledge, feelings and experiences.

## **2.7 Data Entry and Analysis**

Data entry and analysis was done at the Centre for Peace Research under the supervision of a data manager. Quantitative data was entered and analysed using the Epi-Info version 6 statistical computer package. Analysis followed standard statistical guidelines using descriptive statistics. Means and their standard deviations were used for continuous variables. Frequencies and proportions were used to study the distribution of categorical variables. Contingency tables and their chi-square tests were used to test the significant association between categorical variables, whereas for continuous variables, the student t-test was used to test for significant differences.

Graphical displays like bar charts, histograms and pie charts were also used to illustrate distributions. Content analysis of qualitative data was done on selected full text responses to open ended questions and data from focus group discussions.

## **2.8 Quality Control**

### ***2.8.1 Training of Interviewers***

Five research assistants, all Social science graduates from Makerere University, were recruited and trained to collect data from the two study areas. They were trained in interviewing techniques and recording of responses and participatory research methods (focus group discussions). Training was in the form of a workshop and was facilitated by the researcher herself. During the training session, the questionnaire was explained and later pre-tested.

### ***2.8.2 Pre-testing the Questionnaire***

Ten mothers with their daughters were selected from each of the two study areas, making a total of forty respondents. These were mothers with daughters not included in the final study. The questionnaire was then pre-tested. After pre-testing and revising the questionnaire, copies of the final draft of the questionnaire were produced and made ready for data collection. The topic guide for the Focus Group Discussions was also revised and made available.

### ***2.8.3 Data Cleaning***

Data cleaning was done at the end of each working day and this involved cross checking all the completed questionnaires to make sure that all the questions were answered properly and clearly recorded. During data entry, an in-built check program within Epi Info version 6 was used to customize data entry and for automatic skip patterns.

### ***2.8.4 Coding***

A standard coding book was developed and later revised after administering the questionnaires. On the night or day after the interview, all questionnaires were verified. Another research assistant coded them and then the researcher coded them the second time while preparing data entry formats.

## **2.9 Approval of Research Proposal**

A jury selected by the Organization for Social Sciences Research for Eastern and Southern Africa (OSSREA), approved the research proposal. At the local level, permission to conduct the research was sought from the Local Council Executive, whereas, at the national level, approval was sought from the Uganda National Council of Science and Technology.

The purpose of the study was carefully explained to the respondents before the interviews. The respondents' identity was not required and it was clearly emphasized that the information collected from them would be treated with maximum confidentiality. Respondents were informed that they were free to answer or not, those questions that they felt were potentially embarrassing. The facilitator further explained the purpose of

the study to the respondents during focus group discussions and thanked them for having accepted to participate upon invitation.

### **2.10 Limitations of the Study**

The information was collected exclusively from mothers and their daughters who were willing to be interviewed.

## **3. RESULTS**

### **3.1 Socio-Demographics**

#### **3.1.1 Distribution of Respondents by Study Area**

A total of 186 adolescent daughters were used for the study. Of these, 56.5% (105 out of 186) were from Rubaga division in Kampala district while 43.5% (81/186) were from Kabulasoke sub-county in Mpigi district.

A total of 183 mothers were interviewed. 56.8% (104/183) were from Rubaga division (Kampala district) while (79/183) were from Kabulasoke sub-county (Mpigi district).

#### **3.1.2 Age Distribution**

The age range of most adolescent daughters was 13-19 years, who constituted over 94 % (171/182) of the adolescents interviewed. The mean age was  $15.335 \pm SD 2.015$ .

The majority of mothers, 83.2 % (144 /173), were between 30-50 years with a mean age of  $39.844 \pm SD 8.082$ , as shown in fig.2.

#### **3.1.3 Religious Affiliation**

Most of the respondents were affiliated to the Catholic faith (81-88%), followed in descending order by Protestants (44-46%), Moslems (44%), Seventh Day Adventist and others.

#### **3.1.4 Educational Status**

Most of the adolescent daughters interviewed had attained primary 47% (86/183) or secondary education 47.7% (91/183) while a few 3.3% (6/183) had not gone to school. Similarly, the majority of the mothers had their education levels skewed to primary, 43.7% (80/183) and secondary, 31.1% (57/183) levels with a few having attained tertiary education 10.9% (20/183). 14.2% (26/183) of the mothers had not been to school while over 85% of the adolescents interviewed were currently attending school. Many of the adolescent daughters were studying in day schools while those in boarding schools were mainly from urban (Rubaga division) families.

#### **3.1.5 Family Background**

Fifty percent of the daughters and their mothers were from a monogamous family setting while 25% were from polygamous or single parent families.

### **3.1.6 Employment Status of the Mothers**

The majority of mothers were farmers 44.8% (82/183), followed by housewives 20.8% (38/183), traders 18% (33/183) and professionals 12.6% (23/183).

## **3.2 Information on Sexuality and HIV/AIDS**

### **3.2.1 Sources of Information**

The major sources of information about sexuality and HIV/AIDS for adolescent girls were parents 32.3% (60/186), followed by friends 24.7% (46/183), radio 21.5% (40/186) and teachers 16.6% (31/183). Others were booklets 4.3% (8/186), health workers 3.2% (6/186) and youth club 1.6% (3/186).

### **3.2.2 Nature of Information Given**

A wide range of information about sexuality and HIV/AIDS was given to the adolescent daughters. The information ranged from issues regarding sexually transmitted diseases and HIV/AIDS 61.7% (113/186), to menstruation hygiene 57.5% (107/186), how to avoid men and premarital sex 56.9% (106/186), how to use a condom 32.3% (60/186), having one faithful partner 17.7% (33/186) and family planning methods 15.1% (28/186). Other information obtained concerned sex relationships 7% (137/186) and marriage life 6.5% (12/186).

Many daughters acknowledged that they had learned several lessons from the information obtained, most importantly about HIV/AIDS 41.5% (76/183), avoiding men and sexual abstinence 32.9% (60/183), responsible sexual behaviour 8.2% (15/183), using condoms 6.6% (12/183), avoiding pregnancy 5.5% (10/183), menstruation hygiene 2.5% (5/183) and others 1.1% (2/183). Three adolescents or 1.6% reported that they had not learnt any lesson from information they received.

## **3.3. Communication with Mothers**

### **3.3.1 Information Received from Mothers**

67.9% (125/184) daughters acknowledged their mothers' having talked to them on issues about sexuality and HIV/AIDS. However, 32.1% (59/184) or a third of the daughters reported that their mothers had never talked to them on issues about sexuality and HIV/AIDS.

### **3.3.2 Content of Information Received from Mothers**

Adolescents reported that their mothers talked to them on a wide range of sexual issues ranging from avoiding men and pregnancy 72.8% (91/125), to menstruation hygiene 63.2% (79/125), avoiding STDs and HIV/AIDS 60% (75/125), abstinence 22.4% (28/125), married life 13.6 (17/125), how to use a condom 6.4% (8/125) and the use of family planning 6.6% (8/125). During focus group discussions, some adolescents further revealed:

- "That AIDS kills" (12 year old adolescent).
- "Not to associate with men or have sexual relationships" (17 year old adolescent).
- "Not go to discotheques because they are bad" (14 year old adolescent).

### ***3.3.3 Occasions of the Discussions***

Adolescents were asked to describe the occasions on which mothers initiated the discussion about sexuality and HIV/AIDS. Most mothers, 68% (85/125), initiated the talk when their daughters started menstruation, followed by those who initiated the discussion when they lost a relative due to AIDS 36.8% (46/125). Other occasions on which the talk was initiated were when the mother thought her daughter had a boyfriend 23.2% (29/125), when a friend/relative became pregnant 22.4% (28/125), when the daughter was going away from home 9.6% (12/125), when the daughter became pregnant 4% (5/125), when the daughter wanted to get married 1.6% (2/125) and other occasions 4.8% (6/125). Four daughters or 3.2% (4/125) could not recall the occasion when the discussions were initiated. The mean number of times per month reported by daughters on which mothers talked to them about sex and AIDS was  $4.271 \pm SD 6.378$ . Some daughters described further the occasions on which such discussions were initiated:

- “When we unexpectedly lost some one from AIDS “ (14 year old adolescent).
- “During a capital radio program which encouraged the use of condoms, my mother told me to take heed not to sleep with a man without using a condom” (18 year old adolescent).
- “When a friend got a cut on her finger, my mother advised me to cover my hands with a cloth before dressing the wound because the friend was a suspected HIV infected person” (15 year old adolescent).

### ***3.3.4 Barriers to Communication with Mothers among Daughters***

Forty percent (50/125) of the daughters revealed that they found problems talking to their mothers on issues of sexuality and HIV/AIDS.

Adolescent daughters who reported that they experience some problems to talk to their mothers were asked to explain the nature of the problems they faced. Most of the daughters 42% (21/50) reported that they feared their mothers, followed by those who claimed that their mothers did not want to talk to them about sexual issues 24% (12/50) and that their mothers were too busy with their work 24% (12/50). Other explanations given were that the daughter was feeling shy to ask her mother 8% (4/50), the mother was not educated 4% (2/50) and others 8% (4/50). Adolescents who participated in focus group discussions emphasized their revelations:

- “Some of our mothers grew up promiscuous and out going and as a result they cannot start counseling their daughters on the same issue” (18 year old adolescent).
- “Some mothers feel shy and others have a feeling that we are still young” (12 year old adolescent).
- “Some mothers think that when you discuss HIV and sex to kids you are spoiling her and that the daughter may become inquisitive” (16 year old adolescent).

Adolescents who reported that they never discuss with their mothers on issues of sexuality and HIV/AIDS were asked to explain what hindered them. Most of them, 25.4% (15/59), said they did not know why they could not talk about sex issues. Other

reasons given were that the daughter was perceived to be still young to be engaged in such a discussion 22% (13/59), the daughter feared her mother 20.3% (12/59).

### **3.3.5 Role of Mothers in Accessing Information**

68.8% (121/177) of the adolescents reported their mothers' assisting them to obtain information about sexuality and HIV/AIDS while 31.6% (56/177) or one-third of the adolescents said they were not being assisted. Daughters revealed further from focus group discussions:

- "They give us booklets, news papers and magazines to read. They claim that gone are the days of sending daughters to sengas (aunties) since they can read" (16 year old adolescent).
- "My mother encourages me to listen to capital doctor, a radio program on sex education" (15 year old adolescent).
- "She encouraged me to go and watch AIDS drama like Ndiwurila" (18 year old adolescent).

Asked how mothers were assisting them to access the information, the majority, 76 % (92/121), reported that they talked to them directly. Other ways in which mothers helped their daughters were through encouraging them to watch television and listening to radio programmes 38.8% (47/121), provision of reading materials 34.7% (42/121), sending them to their aunties 24.8% (30/121) and a few to youth clubs 5% (6/121).

## **3.4 Communication from Outside the Family Source**

### **3.4.1 Other Sources of Information for Daughters**

Daughters acknowledged the presence of several other sources of information about sexuality and HIV/AIDS (Table I). Adolescents revealed that sources outside the family put more emphasis on issues concerning sexually transmitted diseases and HIV/AIDS 53.2% (99/186), avoiding men and sexual abstinence 32.8% (61/186), avoiding teenage pregnancy 9.8% (18/186), use of condoms 5.4% (10/186) and others. Some of these were further emphasized in focus group discussions:

- "Not to allow men to rape and take advantage of me" (14 year old adolescent).
- "Sex abstinence by avoiding discos, dark places and walking alone at night" (17 year old adolescent).
- "To carry condoms wherever one goes and to use condoms whenever one is having sex" (18 year old adolescent).

Adolescents were further asked whom they preferred to provide them with information about sexuality and HIV/AIDS. Most of them, 35.6% (68/186), preferred mothers, followed by aunties 26.9% (50/186), and friends 17.2 % (32/186). Others mentioned were older sister 14% (26/186), grandmother 10.8% (20/186) and teacher 9.8% (18/186). This is illustrated in fig. 5.

Table 1. Other common sources of information about sex and HIV/AIDS (n =186)

Other sources of information	Frequency	Percentage
Friends	100	53.8
Teachers/school club	89	47.8
Radio/TV/drama	84	45.2
Books/magazines/newspapers	50	26.9
Auntie/grandmother	43	23.1
Doctor/nurse/clinic	24	12.9
None	24	12.9
Seminars/ workshop	12	6.5
Elder sister	5	2.7
Youth club	3	1.6
Other	2	1.1

There were a number of good and reliable sources of information on sexuality and HIV/AIDS in the community acknowledged by the adolescents. These included health centers and clinics 20.6 % (36/175), mothers 12.4% (23/175), seminars 11.4% (20/175), Radio/ TV 10.3% (18/175), books and reading materials 9.1% (16/175), aunties 9.1% (16/185), school teachers 5.1% (9/175), peers 4%(7/175) and people living with HIV/AIDS 1.7% (3/175). 17.1% (30/175) reported that they do not know of any sources in their communities.

### 3.5 Communication with Daughters

#### 3.5.1 Communication from Mothers

75.8% (138/182) of mothers revealed that they talked to their adolescent daughters about the subject of sexuality and HIV/AIDS while 24.2% (44/182) reported that they did not discuss with them. Mean age at which most mother started to talk to their daughters was  $12.881 \pm SD 1.441$ .

#### 3.5.2 Content of the Information Given

73.9% (102/138) mothers revealed that they talked to their adolescent daughters on a number of issues concerning menstruation hygiene, avoiding pregnancy 73.1% (101/138), STDs and HIV/AIDS 70.2% (97/138), abstinence 65.9%(91/138), married life 10.1% (14/138), condom use 8% (11/138) and faithfulness 6.5%(9/138). Mothers who participated in focus group discussions further elaborated on the content of their discussions with their daughters:

- “We stress on the dangers of having sex with men and AIDS.”
- “I talked to her about family planning and condom use when I learnt that she had an abortion.”

### 3.5.3 Occasions of the Discussions

Mothers revealed that they started to talk to their daughters about sexuality and HIV/AIDS due to a number of reasons. Most mothers initiated the discussion after realizing that their daughters had reached puberty 75.4% (104/138). Other reasons were when the daughter was going away from home 15.9% (22/138), when their daughter was joining a boarding school 15.2% (21/138), when the daughter started to have boy friends 13% (18/138), when they lost a relative due to HIV/AIDS 8.7% (12/138) and when the daughter became pregnant 5.1% (7/138).

Mean number of occasions per month when mothers talked to their daughters about sexuality and HIV/AIDS was  $7.833 \pm SD 10.633$ . Mothers were further asked to describe the occasions on which they normally initiate such a talk. Many mothers reported that they start the talk any time 21.7% (30/138), followed by those who start the discussion while doing household work 16.7% (23/138). Other occasions reported by mothers were: after seeing a person infected with HIV/AIDS 14.5% (20/138), when the daughter misbehaves 10.4% (14/138), when she is seen with bad peers 8.7% (12/138), when they watch a television or listen to a radio program on AIDS 6.5% (9/138) and on other occasions. Mothers who participated in focus group discussions further described the circumstances as follows:

- “We use relevant circumstances to initiate the talk, say after death of a member in the community, misbehavior or showing the children people living with AIDS.”
- “Many of our daughters start their menstruation while at school so we rarely use this occasion to initiate the discussion.”

### 3.5.4 Communication Barriers for Mothers

Mothers were asked if they find any problem to talk to their daughters on issues of sexuality and HIV/AIDS. Most mothers 71.9% (97/135) reported they find no problems while 28.1% (38/135) admitted they find some problems that hinder them from effectively communicating with their daughters.

The main communication problem faced by mothers was shyness to talk to the daughter 68.4% (26/38), followed by those who reported that their daughters were stubborn and would not listen to them 34.2% (13/38). Other hindrances reported were that mother and daughter were not staying together 18.4% (7/38), mother did not know what to tell the daughter 15.8% (6/38), mother was very busy 10.5% (4/38) and others 5.3% (2/38). Mothers who participated in focus group discussions further revealed the problems they experienced:

- “Most parents are shy and find it difficult to talk and open up to their children.”
- “We fear to break our children’s innocence which may be a disadvantage because if exposed the child may be inquisitive to try and experiment.”

Mothers who reported that they never talked to their daughters were asked why they did not do so. Most of the mothers believed that their daughters were still young 38.6% (17/44). Others reported that they felt shy about such a discussion 11.4% (5/44), mother and daughter were not living together 9.1% (4/44), that it was not culturally permissible

4.5% (2/44), mother was very busy 4.5% (2/44) or mother trusted her daughter 4.5% (2/44), 9.1% (4/44) gave other reasons.

### **3.6 Other Sources of Information**

#### ***3.6.1 Role Played by Mothers***

Mothers reported that they assist their adolescent daughters in a number of ways to access information about sexuality and HIV/AIDS. The several approaches which they used included encouraging their daughters to listen to radio and television programs about sexuality and HIV/AIDS 46.7% (85/182), sending them to their aunts for sex education 35.7% (65/182), providing them with relevant books and magazines 26.9% (49/182), talking to them directly 13.2% (24/182), sending the daughter to a counselor 7.1% (13/182), sending her to women's club 5.5% (10/182), sending her to a health worker 1.1% (2/182), sending her to a pastor 1.1% (2/182) and others 4.4% (8/182). 12.1% (22/182) mothers reported that they did nothing to assist their daughters get the necessary information.

#### ***3.6.2 Information Provided***

Mothers were further asked what they thought their daughters learnt from these sources. Many of the mothers 50% (80/160) reported that their daughters learn a lot on issues ranging from STDs and HIV/AIDS, sexual abstinence 31.3% (50/160), good morals 21.9% (35/160), avoiding unwanted pregnancy 16.3% (26/160), hygiene 4.4% (7/160), condom use 0.6% (1/160) and others 6.15% (10/160). 5.6% (9/160) did not know what their daughters learn from these sources. Mothers who participated in focus groups further emphasized these: "Emphasis on the radio is put on HIV/AIDS and condom use and that AIDS is a disease without cure."

Most of the mothers 98.6% (137/139) were satisfied that their daughters received the right information from these sources:

- "At Namirembe cathedral the sengas (counselors) provide enough sex education."
- "They learn how AIDS is contracted and how to avoid contracting it."

Mothers gave reasons why they thought that their daughters had received the right information from sources outside the family. Most of them 34.3% (47/137) reported that their daughters were disciplined, while 17.5% (24/137) said the sources are professional or have experience in sex education 12.4% (17/137). 13.8% (19/137) mothers said that they talked directly to their daughters, 5.8% (8/137) reported that their daughters now talked to them when they have a problem, 5.1% (7/137) reported that their daughters are interested in radio and television programmes about sex education while 3.6% (5/137) reported that their daughters tell them they are not interested in boyfriends, 9.5% (13/137) gave other reasons.

#### ***3.6.3 Sources of Information Trusted by Mother***

Mothers were asked whom they recommended to give their daughters sex education. 72.5% (100/137) said they trusted the auntie, followed by the teacher 52.6% (72/137), the pastor 27.7% (38/137), and the counselor 24.1% (33/137). Other trusted persons mentioned included peers 7.3 % (10/137), the older sister 7.3% (10/137), health worker

5.1% (7/137) and others 2.9% (4/137). 5.8% (8/137) of the mothers said they did not trust anyone with their daughter. A mother who participated in focus group interviews further elaborated on their views:

“The topic of condom use should be left to the teachers in school to teach about their use so that the child can remain with some respect for the mother, because if the parent talks about it the child may view condom use (sex) as legitimate since the mother has advised its use.”

#### **3.6.4 Recommendations for Improving Mothers' Communication.**

Mothers made recommendations on how they could be assisted to better communicate with their adolescent daughters on the subject of sexuality and HIV/AIDS. 50.7% (70/138) recommended organizing training seminars and workshops for them in their communities, followed by those who suggested the provision of reading materials like booklets and pamphlets 23.2% (32/138). 8.7% (12/138) suggested introduction of educational radio and television programmes for them, 7.2% (10/138) suggested to be assisted by counselors or teachers 2.9% (4/138), 2.9% (4/138) suggested drama activities. 6.5% (9/138) did not have any suggestion to get assistance.

## **4. DISCUSSION**

### **4.1 Introduction**

The study of Communication between mothers and their adolescent daughters on the subject of sexuality and HIV/AIDS was carried out in Rubaga division in Kampala district and Kabulasoke sub-county located in Mpigi district. The data presented and discussed in this study was collected from adolescent girls aged 12-18 years and their mothers. The data was collected between July and August of 1997. Data entry, analysis and report writing was done in the subsequent period.

### **4.2 Socio-Demographics**

A total of 186 adolescent daughters and 183 mothers were interviewed from Rubaga division in Kampala district and Kabulasoke sub-county in Mpigi district, respectively. 94% of adolescent daughters were in the age group 13 - 19 years, with a mean age of 15 years. More than 30% of adolescent girls have reported to be already sexually active by this age. In the same age group, HIV infection rates are six times more in females than male counterparts nationwide. Adolescent girls, therefore, need correct information on sexuality and HIV/AIDS from their parents to reduce morbidity and mortality due to sexual health problems.

It was also noted that the majority of mothers were relatively young, which suggested that even the mothers conceived at an early age. Thus, the phenomena of initiation of sexual activity at an early age, early pregnancies and early birth have been passed on from one generation to another due to lack of adequate sex education from parents with whom children spend most of their time.

The majority of respondents were of the catholic faith, followed by Protestants and Moslems, which reflected the national picture in general.

Most adolescents had attained primary and secondary education. Most of the mothers had their education levels skewed to primary education and a few to secondary levels. Mothers could thus experience communication problems due to their low education level, since most of the literature being circulated on sex education nationwide is in the English language. There is, therefore, a need to design IEC materials in languages mothers with communication problems can understand so that they can pass on this to their daughters.

It was observed that 50% or half of the daughters were from single or polygamous family backgrounds. Single mothers are in most cases busy trying to fend for their families, which could have an impact on time given to adolescent problems. Polygamous families are also often unstable and may influence the content of moral communication between mothers and their daughters as mothers from both single and polygamous families may find it difficult to impart moral messages to their daughters when they themselves are not doing the same. Most mothers were peasant farmers and housewives, which would supposedly give them enough time with their daughters.

#### **4.3 Information on Sexuality and HIV/AIDS**

Many adolescent girls received their information from parents and peers. This suggests that there is a need to equip both mothers (parents) and peers (girls) with correct information on sexuality and HIV/AIDS which they can pass on to their children and peers. There is also a need to equip them with IEC skills to effectively pass over the information to recipients.

It was also noted that a wealth of information ranging from sexually transmitted diseases and HIV/AIDS, menstrual hygiene, sexual abstinence, condom use and family planning was learnt from these sources. The content of the information, if put in practice, would enable adolescents to lead a reasonable quality of reproductive health status. It was revealed that these sources put emphasis on sexual abstinence more than other safer sex life styles like condom use and other family planning methods.

#### **4.4 Communication with Mothers**

About 70% of mothers talked to their daughters about sexuality and HIV/AIDS. Most mothers started to talk to their daughters at the age of menarche (12 - 14 years). Most of the talk from mothers emphasized issues such as avoiding men, early pregnancies and menstruation hygiene.

It was also observed that with the coming of the AIDS epidemic in the past decade, mothers have taken on to warning their daughters from getting sexually transmitted diseases and HIV/AIDS mainly through abstinence and a few encouraging condom use. Mothers are also advising their daughters to avoid risky places such as discotheques and walking alone in dark places.

Many mothers use the occasion of their daughters' first menstruation to initiate the discussion on sexuality, since this is when they regard their daughters as having become sexually mature. However, many mothers also initiated the talk when they get evidence that their daughters have become sexually active. Tragedies like loss of a relative due to HIV/AIDS or unwanted pregnancy also provided mothers with opportunities to talk to

their daughters. On average, mothers talked to their daughters about once a week. About half of the mothers experienced communication problems with their daughters, which ranged from fear, shyness or busy schedules and perceiving sex education as not being culturally appropriate. Traditionally, in Ugandan culture, it was a member of the extended family such as an auntie or granny who provided sex education to daughters. Mothers have always taken it as not being their primary responsibility to give sex education to their daughters. Other mothers felt that their daughters were still young or feared exposing their daughters to information on sex matters, which could stimulate them into sexual activity. Over 30% of the daughters revealed that their mothers never talk to them on issues about sexuality and HIV/AIDS. Most of the daughters did not indeed know why their mothers never provided them with sex education.

The majority of mothers, however, assisted their daughters to obtain correct information on sexuality and HIV/AIDS by encouraging them to watch television and listen to radio programs, providing them with relevant literature such as booklets, magazines and newspapers and sending them to visit their aunts.

#### **4.5 Communication Outside Family Sources.**

There were a number of sources of information about sexuality and HIV/AIDS that adolescents could use. These sources included friends, teachers, films, books, newspapers, aunts, grandmothers, health workers and seminars among others. It was noted that many of these sources put emphasis on information regarding sexually transmitted infection, sexual abstinence and condom use. In spite of the presence of several sources of information on sexuality and HIV/AIDS, most of the adolescents still preferred to get this information from their mothers or auntie whom they trusted and felt comfortable with.

#### **4.6 Communication with Daughters**

The majority of mothers (75.8%) talked to their daughters on issues of sexuality and HIV/AIDS. The mean age of daughters at which mothers reported they initiated the discussion did not significantly differ from that reported by daughters ( $P = 0.923$ ).

The mothers' discussion put a lot of emphasis on issues of menstruation hygiene, avoiding early pregnancy, STDs, HIV/AIDS and sexual abstinence. Only a few mothers mentioned condom use and having one faithful partner. Traditionally, in many societies of Uganda, adolescent girls have been expected to keep their virginity till marriage. Thus, mention of condom use and faithfulness by mothers would be visualized as encouraging their daughters into sexual activity. It was also observed that a few mothers who discussed about family planning and condom use only did so after discovering that their daughters were already sexually active. It was further observed that many mothers were putting special emphasis on STDs and HIV/AIDS and how their daughters could avoid these, probably due to massive AIDS education campaigns that have been going on in Uganda. Many mothers, however, reported that they talked to their daughters more often than their daughters reported ( $P = 0.008942$ ) which could probably suggest that on a number of occasions the discussion could be so vague or indirect that the daughters did not perceive it as part of sex education. This, therefore, suggested imparting IEC skills to mothers so that they could effectively communicate to their daughters.

The discussion about sexuality and HIV/AIDS was started in diverse settings such as while doing household work, seeing a PLWAs, when the daughter misbehaved or while watching television or listening to a radio program. On the contrary, many mothers reported that their daughters often started menstruation while at school and as such rarely used this occasion to initiate the discussion.

About one third of mothers (28.1%) revealed that they find communication barriers with their daughters. Most of these barriers stemmed from a feeling of shyness to talking to their daughters while others reported that their daughters were quite stubborn and would not listen to them. A number of mothers admitted that they did not know what and how to talk to their daughters.

Mothers gave several recommendations on how they could be assisted to improve their communication skills with their daughters. These included organizing training seminars and workshops for them, provision of relevant literature, provision of educative radio and television programs among others.

#### **4.7 Other Sources of Information**

Mothers played a big role in accessing their adolescent daughters to information on sexuality and HIV/AIDS in addition to talking to them directly, mainly through encouraging them to benefit from TV and radio programs, sending them to their aunts for sex education and providing them with relevant literature. It was noted that many of these sources still, provided the same moral messages as mothers did talk to their daughters on issues such as STDs and HIV/AIDS, sexual abstinence, avoiding unwanted pregnancies. However, many of these sources put little emphasis on condom promotion, only mentioning it rarely in the context of HIV/AIDS prevention.

Many mothers had confidence that their daughters were receiving the right information from sources outside their families especially from aunts and counselors whom they claimed had enough experience in providing sex education. They cited examples, such as discipline of their daughters, openness of their daughters to them when they have adolescent problems and the special interest of the daughters in TV/radio sex education programs. Thus, majority of the mothers had confidence in aunts, teachers, counselors and pastors as other persons who could be trusted to provide sex education to adolescents. Mothers were of the view that controversial issues like condom use should be left to such persons to avoid a cultural and moral conflict in case they themselves discussed such issues with their daughters.

## **5. CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Conclusions**

- Times have changed, so are the societal values. Many adolescents begin sexual activity at an early age and also become mothers while still young. This exposes them to reproductive health problems including morbidity and mortality, and thus need sex education to be introduced to them at an early age.
- Most of the girl-children and mothers still have their education limited to primary and secondary levels. This implies that life skills in reproductive health

have to be introduced at these levels which they can use themselves and be able to pass them over in the future to their children.

- Many mothers are now facing the challenge of bringing up their daughters (and children) either as single mothers or in polygamous marriages. This exposes the daughter to her mother most of the time with minimal input from the father. In many such families, mothers are often too busy with day-to-day life hustles and are left with little time to attend to their adolescent daughters' health problems. .
- There are a number of sources of information about sexuality and HIV/AIDS in both urban and rural communities. Among all these, still parents, especially mothers have a central role in providing more moral messages where other sources may put less emphasis.
- Most mothers now talk directly to their daughters on issues of sexuality and HIV/AIDS. Others still make efforts to access their daughters to sex education messages available in their communities.
- Mothers talk to their daughters on a wide range of issues that have traditionally been taught to adolescents. However, with the emergence of the HIV/AIDS scourge, more emphasis is put on protecting adolescents on the dangers of acquiring this illness.
- Mothers use different occasions to give sex education messages to their daughters. On many of these occasions, a wide range of sexual and reproductive health issues are discussed and there are enough occasions at which mothers can provide sex education to their daughters.
- Both mothers and daughters experience communication problems talking on issues of sexuality and HIV/AIDS. The conflicting moral and cultural obligations greatly influence the kind of messages that mothers have to communicate to their daughters, while others lack the necessary skills to undertake this task.
- Where as the information adolescents get from their mothers and outside sources does not differ much in content, saliently, many of these sources still put little emphasis on condom promotion as a way of promoting adolescent sexual health.
- Many mothers still trust the traditional sources of providing sex education to adolescent girls. Up to date, many mothers still use aunties and counselors to provide sex education to their daughters.

## **5.2 Recommendations**

- Times have changed, so have life values. New innovations need to be made to catch up with the challenges of early initiation of sexual activity that has become so widespread among adolescents. Among these is the promotion of condom use among adolescent girls.
- The social-economic emancipation of the girl-child and the woman in general, still remains pivotal in addressing the social needs of women. If girls and indeed

women are to benefit from reproductive health life skills, literacy in general must continue to be up lifted among the girl-children.

- Parents and peers were focal in the provision of sex information to children. Many children follow what their parents or peers tell them or practice. Thus, interventions should make efforts to target parents and peers, as these are cost effective ways of passing on health education messages.
- Many parents lack skills to talk to their children on sex matters. Many express this as being shy, insufficient or even admitting of not knowing what and how to talk to their daughters. There is, thus, a need to equip mothers with appropriate IEC skills on sexuality and HIV/AIDS to better talk to their daughters.
- Traditional and out of the family sources have a role to play in communicating sex messages to adolescents, especially on issues that may attest moral and cultural values of society and these should continue to be exposed to adolescent children.

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