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Students' Perceptions of the Effectiveness of Parental Practices on Youth Concerning HIV Prevention: An Exploratory Study at Howard College.

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DECLARATION

I, Nondumiso Mabaso, declare that:

1. The research reported in this dissertation, except where otherwise indicated, is my original research.
2. This dissertation has not been submitted for any other degree or examination at another university.
3. The dissertation does not contain other persons' data, unless specifically acknowledged as being sourced from other persons.
4. This dissertation does not contain another person's writing, unless specifically acknowledged as being sourced from other researchers.

Signed: ……

N. Mabaso (214566063)

Date: ……

Signed: ……

W. M. Hlengwa (Supervisor)

Date: ……

DEDICATION

This dissertation is dedicated to Almighty God, who is never silent to my prayers

And

To my mother, who instilled in me the virtues of perseverance, commitment and relentlessly and encouraged me to strive for excellence. May God grant you many years.

Acknowledgements

I humbly dedicate this effort to the following people:

1. My grandparents (Mr. & Mrs. Mabaso); the seed you planted in me is now visible. Thank You.
2. My friends, cousin Mbalenhle, my aunts, the Dlamini family and Mr. and Mrs. Shabalala; I don't have enough words to express my gratitude.
3. To my brother, Mukelani, this humble work is a sign of my appreciation to you.
4. My academic supervisor, Dr. Hlengwa, I value your expertise and support regarding this research.
5. To the University of KwaZulu-Natal; I am grateful for the opportunity afforded me to conduct this research study.
6. Lastly, to all the young university students that participated in this research, may this research study bring about change and positive influence in your lives.

ABSTRACT

Despite many efforts put forward such as the Stepping Stones (Jewkes et al., 2008), the Collaborative HIV Prevention and Adolescent Mental Health Programme- South Africa known as CHAMP+SA (Bhana et al., 2010) and the 90-90-90 strategy (Huerga et al., 2018) to fight against the HIV epidemic especially amongst the youths aged between 15 and 24, the number of HIV cases within this age group seem to be increasing. The purpose of this qualitative study was to explore how young students from the University of KwaZulu-Natal perceive and experience the effectiveness of parental involvement in the prevention of HIV amongst the youth. In this study, a semi-structured interview schedule was used to collect data. Interviews were recorded with the consent of the participants using an audio-recorder. Thematic analysis was utilised to analyse the collected data. The thematic analysis helped in the development of various themes and sub-themes. The main themes that emerged were: the strong relationship between parents and children, active parental participation, monitoring youth activities, participants' experiences and perceptions of the effectiveness of parental practices regarding HIV prevention amongst the youth, the role each parenting style plays in the prevention of HIV amongst youth, , and the impact of parental involvement in the prevention of HIV amongst the youth. The study found that parental practices and parenting styles were perceived as beneficial to the prevention of HIV amongst the youth, and factors that influence parental practices. The findings further showed that these factors can have either positive or negative impact on a child's behaviour in relation to HIV prevention.

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CHAPTER 1: INTRODUCTION

1.1 Introduction to the study

The family, peers, the school, neighbourhood, and broader social and cultural contexts have a significant influence on adolescent behaviuor (Bronfenbrenner, 1979). With family being especially influential (Wang et al., 2014), it is therefore set to take a pivotal responsibility in protecting the youth from being involved in risky behaviours (Willoughby & Hamza, 2011). Research indicates that communication (Wang et al., 2014), monitoring (Dittus et al., 2015), and punishing adolescents (Löfgren et al., 2009), are some of the practices parents adopt and use to influence ethical behaviour on adolescents. One of the reasons parents strive to instill good behaviour in adolescents is to ensure that they are protected against the deadly Human Immunodeficiency Virus (HIV). The reason for this is that HIV infection has become one of the most severe threats to the health of the youth (Bhana, McKay, Mellins, Petersen, & Bell, 2010). The onset of risky sexual behaviours is at the pre-adolescence stage, where adolescents are most likely to increase the frequency of sexual activity, have many sexual partners, and are less likely to negotiate protection, which may lead to contracting HIV (Paikoff et al., 1997).

In 2018, 1.7 million people were infected with HIV globally, totaling to 37.9 million people living with HIV by the end of the same year (UNAIDS, 2019). Of that 37.9 million people who are infected, 36.2 million were adults, and 1.7 million were children below the age of fifteen (UNAIDS, 2019). The majority of the people infected with HIV live in the developing world (Mbete, 2009). The Sub-Saharan region comprises only 12% of the world population (Kharsany & Karim, 2016). However, it has the highest number of HIV cases in the world (Kamali, 2010). At the end of 2018, the estimated number of people living with HIV within the Eastern and Southern African regions was around 20.6 million (UNAIDS, 2019). South Africa accounts for most infected people in Africa (Kharsany & Karim, 2016). The reported number of HIV cases seems to be increasing from those that were published in 2002 by Statistics South Africa. In 2018, about 7.52 million South Africans were living with HIV, which constitutes 13.1% of the total population (Statistics South Africa, 2018). The providence of KwaZulu-Natal has the highest number of people living with HIV (Statistics South Africa, 2018).

Researchers such as Bhana et al. (2010) and Biello, Mimiaga, Santostefano, Novak, and Meyer (2018) report that the most infected age group is the youth aged between 15 and 24. Also, the International Children's Center (1988) reports that about 80% of cases of HIV transmission were through sexual intercourse. Consistent with this finding, Kharsany and Karim (2016) identify heterosexual sex as one of the main modes of HIV transmission. Moreover, this age group (15 to 24) has the highest number of people living with HIV worldwide (Visser et al., 2018). It accounts for 40% of all new cases of infection every year (Visser et al., 2018). There are several reasons why the youth engage in early sexual and unprotected intercourse. These include the lack of knowledge about sexual reproductive health and lack of access to necessary resources (contraceptives) to protect themselves against contracting the virus (Butts et al., 2018). Therefore, different approaches can be utilised to fight the spread of the HIV epidemic amongst the youth. These prevention strategies can take a biomedical approach through the promotion of male circumcision (Kamali, 2010), the use of pharmacological pre-exposure prophylaxis (PrEP) (Biello et al., 2018), and vaginal microbicides (Kamali, 2010). Other approaches that can be utilised involve behavioral change interventions, such as media campaigns (for example, LoveLife), life skills in schools, (Paruk, Petersen, Bhana, Bell, & McKay, 2005) and parents-adolescents (or family-based) intervention programmes (Paruk, 2011).

The increase in the number of HIV infections among the youth has attracted several researchers (Bhana et al., 2010; Wang et al., 2014), exploring the effectiveness of parental practices regarding HIV prevention. However, very few studies, such as the one conducted by Löfgren et al. (2009) have further interrogated how adolescents perceive the effectiveness of these parental practices concerning HIV prevention. Therefore, there is a shortage of information from adolescents' perspectives, which could be advantageous to the development and implementation of parent-adolescent HIV prevention programmes. Nonetheless, a positive correlation between applying such parental practices (that is, communication, monitoring and use of punishment) and reduced adolescent risk-behaviour has been reported in several studies (Löfgren et al., 2009; Wang et al., 2014; Dittus et al., 2015).

Based on the above statistics, there is a need for more family-centred HIV interventions targeting the youth. Most of such responses have been developed and implemented in the United States of America (Bhana et al., 2010). However, researchers such as Visser et al. (2018) have called for

locally developed programmes since little is known about the effectiveness of the imported programmes. The few that have been tested locally include CHAMP+SA (Bhana et al., 2010) and the 90-90-90 strategy (Huerga et al., 2018). The strategies seem to have a positive impact because they have been modified to fit the local socio-cultural context and the results are promising.

This research examines practices adopted by parents concerning HIV prevention amongst the youth. These selected practices are used as protective behaviours that parents hope will play a vital role in the prevention of HIV amongst children. These practices include monitoring a child's behaviour, communicating about sexual reproductive health, and punishing wrong behaviour. Based on the available literature, adolescents' perceptions of parental practices regarding HIV prevention amongst the youth are unpacked. This study explores students' opinions (or the effectiveness) of these parental practices about HIV prevention amongst the youth. The findings from the study augment the scarce literature and help inform future interventions on parental support and HIV prevention for young adults.

1.2 Aim

This qualitative study aims to explore Howard College students' perceptions of the impact and effectiveness of parental practices on the youth with regards to HIV prevention.

1.3 Objectives

1. To explore students' perceptions regarding parental practices in relation to HIV prevention.
2. To identify the perceived benefits and limitations of different parental practices when it comes to HIV prevention.
3. To identify perceived factors that influence parental practices with regards to HIV prevention.

1.4 Research questions

1. What are students' perceptions regarding parental practices in relation to HIV prevention?

2. What are the benefits and limitations of different parental practices when it comes to HIV prevention?
3. What are the perceived factors that influence parental practices with regards to HIV prevention?

1.5 Thesis structure

Chapter 1 presented the background to and rationale for the study, aim, objectives, and research question. Outline of the entire document has also been presented.

Chapter 2 of this study presents literature on the topic. It includes literature on the types of parenting styles, types of protective strategies adopted by parents to protect children against contracting HIV and its outcome. The theoretical framework (Health Belief Model) is also discussed.

Chapter 3 is the methodology of the study. The study adopted qualitative research; therefore, the chapter describes in detail, all the steps that were taken from preparation time, data collection, data analysis and ethical considerations.

Chapter 4 reports the findings of the study, themes that emerged and sub-themes.

Chapter 5 is the discussion section, where the researcher discussed the themes that were reported in chapter 4. Themes are discussed in relation to the study's theoretical framework and objectives of the study. The findings included parental practices and parenting styles perceived as beneficial in the prevention of HIV amongst youths, and factors that influence parental practices.

Lastly, recommendations and the conclusion based on the findings are presented.

1.6 Chapter conclusion

The introductory chapter offered the background of the study. It included what has been said on the topic at hand and what has not yet been thoroughly researched. Since this is an introduction to the study, the overall importance of the review of this nature was highlighted. This chapter also entails the aim of the study, which is to explore perceptions of the University of KwaZulu-Natal

students on the role parents play, parental practices, and its effectiveness in the prevention of HIV amongst the youth. It also outlined the structure of the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Globally, youth between the age of 15 and 24 count for 40% of new HIV cases every year (Visser et al., 2018). These numbers are attributable to various reasons. Different strategies have been implemented to fight against the spread of the virus, especially amongst the youth. Parents play a vital role in children's socialisation, sexual health, and decisions they make toward sexual behaviour (Kajula, Darling, Kaaya, & De Vries, 2016). Furthermore, parental involvement impacts positively on HIV prevention programmes (Wang et al., 2014). Therefore, it is necessary to involve parents when implementing HIV programmes targeting the youth (Paruk et al., 2005; Wang et al., 2014). For parents to exert influence on a child the nature of a parent-child relationship needs to be in a good condition. That is, the strength of a relationship needs to be strong enough for a parent to be able to have an influence on a child (positive influence regarding HIV prevention related matters) (Darling & Steinberg, 1993). According to Darling and Steinberg (1993), the relationship between the two parties is enhanced by parents' practices (defined as parents' strict rules regarding particular behaviours).

The following sub-section introduces different parenting styles developed by Baumrind (1966). These are authoritative, authoritarian, permissive and neglectful parenting styles. Each parenting style influences parental practices and has a unique impact on a child's behaviour.

2.2 Authoritative parenting style

Authoritative parents lead children's behaviour rationally (Baumrind, 1966) and encourage a two-way conversation, share the reasoning behind rules set, and solicit objections when a child refuses to conform to the rules (Baumrind, 1966). This implies that these parents value a child's autonomy and promote open communication with them. Applying Maccoby and Martin's (1983) two orthogonal dimensions, authoritative parents exhibit high demandingness though they also exhibit high levels of responsiveness. This is because authoritative parents encourage and support a child's autonomy and show warmth. These competencies, as exhibited by authoritative parents, are beneficial to children and adolescents as they develop instrumental competency in them (Darling & Steinberg, 1993). For instance, Kajula et al. (2016) demonstrate that authoritative parenting on

children produces positive results because parents display warmth. Children appreciate kindness and, therefore, warmth is necessary and useful in producing the desired outcomes. This therefore implies that children whose parents adopt a more authoritative style of parenting are less likely to engage in behaviour(s) that make them susceptible to contracting HIV.

Although authoritative parents' encouragement of self-will and autonomy has been glorified, some studies report contradicting results, criticising parents who give children autonomy. Darling, Cumsille, and Peña-Alampay (n.d; cited in Baumrind, 2005) indicate a negative correlation between authoritative parenting and adolescent autonomy. In the study, adolescents believe that parents, as authority figures, are legitimate and the obligation to obey them is interpreted as an indication of psychological autonomy (Baumrind, 2005). Therefore, autonomy should be defined by how children (or participants at hand) understand it, rather than using Baumrind's conceptualisation even in different contexts where it is interpreted differently.

2.3 Authoritarian parenting style

Authoritarian parents are more controlling and assess the child's actions following a set of standard rules set by an authority figure (Baumrind, 1966). These parents value obedience, punishment, and the use of forceful measures to control a child's self-will in situations where a child's beliefs and behaviours conflict with theirs (Baumrind, 1966). This means that authoritarian parents do not allow children to have autonomy (that is, make own decisions), but force children to follow rules set by an authority figure. According to Maccoby and Martin's (1983) parenting dimension, these parents are more demanding, yet they are low in responsiveness, making it a less effective parenting style. This suggests that unlike authoritative parents, these parents do not show warmth or love towards children. Instead, they make demands and show no support in reaching those demands. They may demand that children take contraceptives without offering any support in ensuring that contraceptives are used and used correctly. To support this, Jackson (2002 cited in Pillay, 2008) reports that adolescents who are more exposed to authoritarian parenting are more likely to reject authority than those exposed to authoritative parenting.

In contrast, Odubote's (2008) comparative study between African American, European American, and Nigerian families, demonstrates that Nigerian parents have authoritarian attributes compared to the other groups. Still, their approach to parenting had positive outcomes for adolescents. Chao

(1994; cited in Paruk, 2011) found similar results in a study conducted in Asia. The argument is that the attributes found in authoritarian parents such as controlling, strictness, and so on may be interpreted as caring and parental involvement in the Asian culture. Therefore, parenting styles should be understood in terms of participants' context when researchers are working on the topic.

2.4 Permissive parenting style

Permissive parents do not use punishment (Baumrind, 1966). Instead, they accept and affirm when it comes to children's actions, impulses, and desires. Permissive parents see themselves at the same level as their children (Pillay, 2008). This therefore suggests that permissive parents do not play any active role in shaping a child's behaviour or encourage a child to obey rules set by authority figure(s). According to Maccoby and Martin (1983), this is a less effective parenting style because these parents tend to be low in demandingness, yet they are very responsive. This can have a detrimental impact on a child's behaviour because giving children too much freedom can have negative after-effects since children can initiate any risky behaviour without parents' supervision (Pillay, 2008).

In some cases, such behaviour may be risky and can lead to engaging in unsafe sexual intercourse, which can result in contracting HIV. For example, Kapungu et al. (2006) reported that the children (mostly boys) of permissive parents are most likely to exhibit early onset of pre-sexual risky behaviour. Literature that contradicts Kapungu et al. (2006) is minimal, proving that indeed being less demanding and more responsive has negative impact on a child's behaviour.

2.5 Neglectful parenting style

In addition to the three parenting styles by Baumrind (1966), is neglectful parenting style, which emerged later. Some scholars (see Maccoby & Martin, 1983) refer to it as avoidance style. Permissive parents are low in both responsiveness and demandingness (Maccoby & Martin, 1983). This suggests that parents who adopt this style are 'absent' in children's lives and they give no guidance on what is wrong and what is right. Harakeh et al. (2004, cited in Pillay, 2008) note that adolescents raised by permissive parents display low self-esteem, which leads to decreased resistance to peer pressure. Since neglectful parents do not show guidance (Pillay, 2008), children are then most likely to learn about sexual and reproductive sexual health from peers, information that may be incorrect, thus potentially leading to engagement in risky sexual behaviour. Studies

conducted by Paikoff et al. (1997) and Akande et al. (2008) report that the absence of a parent results in children spending more time with their peers and taking advice from them rather than receiving authentic information from parents. Therefore, parents' neglectful tendencies encourage children to look for (unreliable) sources that will attend to their needs. As a result, a child is most likely to use such information, which puts them at risk, including the risk of contracting HIV.

2.6 Protective strategies adopted by parents

The pre-adolescence stage is when children are more interested in situations that expose them to sexual situations (Paikoff, 1995; cited in Peikoff et al., 1997). Thus, parents adopt protective strategies to ensure that adolescents do not engage in risky behaviours, especially sexually related actions. Protective strategies parents usually choose are monitoring a child's activities, punishing wrong behaviour, and communicating about sexual and reproductive health. These parental practices can either have desirable or undesirable outcomes on a child. Below is a detailed discussion of research that has been done on this topic. As per the aim of this research, adolescents' perceptions of these parental practices will be discussed.

2.7 Monitoring as a parental practice and its impact on the youth

Monitoring involves parents tracking children's activities, their relationships with peers, supervision, and surveillance of behaviour (Kajula et al., 2016). According to Dittus et al. (2015), monitoring can be divided into two types. There is global monitoring (parent's knowledge of a child's whereabouts and activities) and sexual behaviour-specific monitoring (parental enforcement of rules about friends and dating). These parental practices play a crucial role in reducing risky sexual behaviours (Dittus et al., 2015).

In a study by Dittus et al. (2015), the results demonstrate that parental enforcement of rules about friends and dating (that is, sexual behaviour-specific monitoring) is strongly associated with delayed sexual intercourse during adolescence. For example, in Ghana, children who have high parental supervision are less likely to engage in early sexual intercourse (Adu-Mireku, 2003). This implies that monitoring who a child dates, sleeps with, et cetera, has a positive impact on the fight against the spread of HIV amongst the youth, since it results in delayed sexual engagement.

As children head towards the end of teenage years, parents loosen up and do not monitor them as they used to (that is, global monitoring). Borawski, levers-Landis, Lovegreen, and Trapl (2003) argue that as adolescents get older, parents allow them to bend rules to explore life during the unsupervised time. However, the study shows that these adolescents are most likely to be sexually active during those unsupervised time. In other words, allowing adolescents to have too much (free) time with friends or peers exposes them to situations that might lead to contracting HIV. Although these adolescents tend to be sexually active during such unsupervised times, they always use contraceptives (Borawski et al., 2003). Therefore, although sexual behavior-specific monitoring results in delayed sexual intercourse, not monitoring them is also not a bad thing since they take precautionary measures against contracting the virus.

Although literature shows that monitoring is beneficial to the young people in the fight against HIV, some challenges prevent parents from adopting and practicing it. Research points to poverty and single-parent households as the twin challenges that hinder parents from monitoring children. The problem that parents face regarding poverty is that in cases where more money is needed in the household, parents are forced to leave home for work (Mbete, 2010). This means that they spend more hours at work than at home with children. Paikoff et al. (1997) argue that this leaves children unsupervised, which may expose them to risky activities without any parent to warn them against such behaviour. On the other hand, in single-parent households, adolescents are likely to have sex at an early age. Jovic et al. (2014; cited in Lara & Abdo, 2016) show that adolescents from such households can have sex before they turn 16 years old. The reason for early engagement in sexual intercourse is that adolescents have one parent. If parents are not available to monitor their activities, no one steps in to ensure that adolescents are protected against risky behaviours, particularly engaging in unsafe sex that can lead to contracting HIV, such as engaging in unsafe sex. As a result, monitoring is not feasible for all parents, despite its positive outcomes.

There is limited literature that has focused on adolescents' perceptions of monitoring and the impact it has on their behaviour. For example, some adolescents perceive monitoring as a buffer against risky sexual behaviour (Kincaid et al., 2012, cited in Mahat, Scoloveno, & Scoloveno, 2016). This implies that adolescents do not perceive parents' monitoring as imposing, but as a way of protecting them against contracting HIV. In addition to monitoring, adolescents view warmth and emotional connection as necessary too. However, other adolescents perceive that although

parental monitoring is essential, it is not enough to predict early sexual behaviour (Paikoff et al., 1997). Therefore, adolescents' perception of parental monitoring should be taken into consideration since adolescents' behavioural outcome is based on how they perceive it.

2.8 Impact of punishment on a child's behavior

Punishing a child to prevent them from doing wrong is another practice parents adopt to deter adolescents from engaging in mischievous behaviour, mainly early and unsafe sexual intercourse. According to Paikoff et al. (1997), parents use punishment to prevent sexual activities from reoccurring if it has already happened and to enforce social norms. However, this parental practice does not produce desired results concerning adolescents' behaviour, which is practicing abstinence form sexual activities, and if they do partake in sexual activities, utilise protective measures put in place for their safety. These protective measures include Prep, Condoms and post-exposure prophylaxis amongst others. Research (Löfgren et al., 2009; Kajula et al., 2016) demonstrates that parental punishment has a detrimental outcome for children when it comes to the prevention of risky sexual behaviour. Punishment can also affect communication between a parent and a child. Paikoff et al. (1997) show that the use of discipline leads to failure to report severe cases such as rape because children who are punished regularly fear that they may be punished for being raped. In other words, punishment does not only result in bad behaviour, as it can also hinder parents from providing necessary medical health attention, such as post-exposure prophylaxis.

Moreover, the use of punishment by strict parents leads to children, especially girls, hiding sexual relationships, which further exacerbates their vulnerability to HIV (Löfgren et al., 2009). Although some prevention strategies (such as monitoring a child, discussed above) do have a positive impact on a child's behaviour, other approaches such as punishment promote undesired and detrimental behaviour(s).

2.9 Impact of communication on HIV prevention

Communication is one of the most researched parental practices when it comes to the prevention of HIV among young people. For communication to be effective, parents need to be adequately informed about the topic at hand. In this case, they need to be informed about HIV, its prevention strategies, and the most effective manner in which information should be delivered. Equally

important is that both parents and adolescents are fully involved from the beginning until the end, and they both participate in discussions. Research (Atienzo et al., 2009; Buzi, Smith & Weinman, 2009; Wang et al., 2014) shows that parent-child communication regarding sexual behaviour promotes healthy sexual decision-making and decreases adolescent involvement in risky sexual behaviour. In other words, communication, as a parental practice, effectively reduces the spread of HIV among youth. Fortunately, children, too, prefer to learn about sex and health from parents (Lara & Abdo, 2016). However, there are barriers to achieving this (that is, acquiring HIV related information from parents). The barriers include parents' lack of knowledge regarding HIV and its prevention measures.

Knowledge is one of the most effective tools that can be used to promote healthy behaviours and reduce risk-taking behaviours (Mahat et al., 2016). However, in modern times parents face a massive challenge of the generational knowledge gap. Parents feel disempowered due to lack of education (including lack of education about HIV) compared to children. This is more so among black South Africans, where parents are further shadowed by government and media messages that insert Western cultural information into the lives of children, through school and media exposure (Paruk, Petersen, Bhana, Bell, & McKay, 2005). On one hand, these messages empower children to play a role in protecting themselves against HIV, on the other hand, these messages conflict with traditional parental practices (such as disciplining a child using corporal punishment). This seem to be the results of the absence of renegotiated parental practices in the current democratic dispensation (Paruk et al., 2005).

There are other consequences of taking peers' advice over that of parents. Since parents lack knowledge about HIV, children end up taking incorrect sex-related information from peers (Muhwezi et al., 2015). Using such information may lead to careless behaviour such as engaging in unprotected sex, potentially leading to contracting the HIV. For this reason, Muhwezi et al. (2015) argue that parents play a huge role in ensuring that adolescents receive accurate and factual information before hearing it from their peers.

Knowledge and skills about HIV and sexual and reproductive health among the youth are essential but not enough. The most appropriate age at which parents should initiate sex talk is one of the most debated issues. Literature demonstrates that parent-child communication about sexual and

reproductive health results in fewer chances of adolescents engaging in sexual risk-taking (Wang et al., 2014; Biddlecom, Awusabo-Asare, & Bankole, 2009). This confirms the need and effectiveness of early initiation of sex-talk. In some cases, parents wait for signs such as when one starts to get involved with the opposite gender or someone from the neighbourhood gets pregnant or dies while trying to perform an abortion (Muhwezi et al., 2015). This is not ideal since some youths have their first sexual experience before they turn eleven years old (Nash et al., 2019). By the time parents start noticing the signs that a child is sexually active, a child might have already contracted HIV because it is unlikely that they will use protective measures since their initial sexual intercourse is before puberty. Delaying sexual talk by parents is perceived by young people as negligence and permitting such behaviour to occur (Löfgren et al., 2009). Therefore, it is argued that delaying sexual talk impedes the prevention of HIV among the youths because results demonstrate that delaying sexual talk promotes early engagement in risky sexual behaviour (Löfgren et al., 2009).

Research (Nash et al., 2019) indicates that many young girls and boys have their first sexual engagement before the age of eleven. It is therefore important that parents communicate with children early because withholding such information can increase the risk of contracting HIV and unwanted pregnancies (Santhya & Jejeebhoy, 2015). Although literature about the most productive period at which sex talk should begin, and parents' perception about the appropriate age for initiation of sex talk is available, it falls short at explaining adolescents' perception(s) regarding this topic. Such literature would be useful as adolescents are the receivers of this information. It is crucial to have youths' perspectives regarding the appropriate age for the initiation of sex talk; hence, this study aims to explore students' (youth's) perceptions of parental practices and their effectiveness in HIV prevention.

Studies done in an African context should consider a few factors when observing or interviewing adolescents about communication with parents on sex and HIV prevention. The reason is that the African context is unique from others in many ways. For example, sex-related topics are reserved for adults and married people across many cultures and religions in Africa (Namisi et al., 2009). This suggests that culture does not allow adults to have sex-related discussions with youths unless they are married or have reached a certain level of adulthood. Again, when these topics are discussed with adolescents and young adults, the talk is usually facilitated by aunts and uncles

(Kayongo-Male and Onyango, 1984; cited in Löfgren et al., 2009) rather than parents. In some parts of Africa, these extended family members or traditional sex educators are known as *ssengas* (Wamoyi, Fenwick, Urassa, Zaba& Stones, 2010). Mostly, these are paternal aunties who are culturally authorised persons to discuss sexual and reproductive health (Wamoyi et al., 2010). Therefore, these socio-cultural factors should be taken into consideration when exploring such topics within the African context. Culture may hinder parents from talking about sex with children as this may seem bizarre and uncomfortable to do. Also to be considered is that communication is one-directional; hence, there is limited literature on African the youth's perceptions on this matter. Youths are told to accept whatever information they are told without questioning it. Therefore, researchers should not only consider participants' context, but they should also give the voiceless an opportunity to voice their opinions and perceptions of communication as a parental practice and its effectiveness.

2.10 Theoretical framework

Brief history

The health belief model was developed in the early 1950s by social psychologists at the U.S. Public Health Services (Janz & Becker, 1984). They aimed to understand why people failed to do screening tests for early detection of asymptomatic diseases (for example, HIV in its early stages) and comply with prescribed medical regiments (Janz & Becker, 1984). In trying to find out answers, social psychologists tried to examine factors that encouraged and discouraged people from participating in programmes aimed at preventing or detecting diseases, such as screenings for tuberculosis (Glanz, Rimer & Viswanath, 2008). Based on their findings, they theorized that beliefs influenced people's readiness to change behaviour that exposes them to the disease, and what they believed they would benefit by trying to avoid it (Glanz et al., 2008).

Brief description of the Health Belief Model

This model addresses people's perceptions of the danger posed by a health issue at hand, their perceived benefits as a result of avoiding the threat, and factors that influence their decision to act (Glanz et al., 2008). Marteau (1989) asserts that the possibility of taking action is a result of an individual's perceptions of their susceptibility to the illness, how severe the disease is, and the

potential costs and benefits involved in taking action. Janz and Becker (1984) define what susceptibility, severity, and perceived benefits and barriers are. Susceptibility is defined as a person's subjective perception of the risk of contracting a disease. Severity refers to medical (or clinical) and social costs of the illnesses. Benefits are the effectiveness of different things available to help reduce the disease or its threat. Barriers refer to potentially harmful aspects of the disease (Janz & Becker, 1984).

Application of the Health Belief Model to HIV related cases

The Health Belief Model has been applied in different sets of health behaviours to explain change and maintenance of health-related behaviours and as a guiding framework for health behaviour interventions (Glanz et al., 2008). Later, the model was extended to study people's responses to symptoms and their behaviours in response to a diagnosed illness (Glanz et al., 2008). Other studies that have used the Health Belief Model include the one conducted by Bakker, Buunk, Siero, and van den Eijnden (1996) that interrogated the Health Belief Model's utility for predicting the intention to use condoms among gay and bisexual men. The model helped identify the purpose of using condoms among men, their cues to action, their perceived benefits of HIV preventative behaviour, and their perception of vulnerability to HIV infection for both younger and older men (Bakker et al., 1996).

Nefale (1999) explored psychological factors that motivate individuals to go for or reject HIV testing. Due to its predictive powers, the Health Belief Model was used to predict the motivation towards taking voluntary HIV tests. However, the results indicated that this model failed to predict what motivated the sampled individuals to test for HIV. Instead, it was psychological factors that predicted the decision to undertake an HIV test.

Another study aimed to explore the factors that influence the use of existing HIV/AIDS prevention methods among University of KwaZulu-Natal students (Ndabarora, 2009). The variables of the Health Belief Model were used as a predictor. The results indicated that the variables did not predict the utilisation of prevention (for HIV/AIDS) methods amongst students. However, this model helps identify the need to focus on removing identified barriers, avail and promote the necessary information about HIV prevention (Ndabarora, 2009).

Utilisation of the Health Belief Model in this study

This model perfectly fits this study because health motivation (prevention against HIV) is its central focus. It is also useful in addressing behavioural problems that evoke health concerns; for example, high-risk sexual behaviours that may lead to contracting HIV (Rimer & Glanz, 2005). The Health Belief Model is also useful in understanding what motivates students to avoid contracting HIV, based on the perception they hold regarding the virus.

The Health Belief Model consists of six constructs that acted as a useful framework for this research. They are:

- Perceived Susceptibility- this refers to one's belief in the chances of acquiring a disease (Nefale, 1999). In this case, prevention against HIV would depend on participants believe that they are at risk of contracting the virus.
- Perceived Severity- this refers to an individual's belief of the seriousness of a condition and its consequences (Nefale, 1999). HIV prevention depends on how participants perceive the seriousness of HIV and its consequences.
- Perceived Benefits- this is when an individual believes that taking action reduces their susceptibility to or the severity of the condition (Rimer & Glanz, 2005). This refers to participants' perceptions of whether they will benefit from taking action toward HIV prevention.
- Perceived Barriers- this refers to the barriers that may hinder one from taking action, such as costs (Rimer & Glanz, 2005). This may include factors such as the cost of contraceptives.
- Cue to Action- this refers to additional sources that play a role in HIV prevention for participants, such as media adverts that promote prevention against HIV, intervention programmes on campus et cetera.
- Self-efficacy- this last construct focuses on participants' own ability to successfully engage in safe sexual behaviours that do not make them susceptible to contracting HIV (Rimer& Glanz, 2005).

2.11 Chapter conclusion

This chapter presented the introduction to parental practices and the impact it has on youth regarding HIV prevention. It presented the background to the study, the gap in the literature and motivating factors which ignited the need to conduct this research. The study research questions, aim and objectives have also been presented. Thereafter, this chapter has reviewed literature that is relevant to the topic. Lastly, the theoretical framework adopted by this study has been outlined.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Research is a process that consists of steps that are used to collect and analyse information to gain deeper insights into the topic being examined (Creswell, 2011). In other words, research methodology is a vital tool that guides researchers throughout the process of gathering and analysing data in order to expand knowledge about a particular phenomenon.

This chapter describes the various procedures that were followed in exploring students' perceptions of parental practices and its impact in the prevention of HIV amongst youth. Therefore, this methodology chapter describes the nature of this research, data collection methods used to elicit the required information from the UKZN students who participated in the study, the representation of data and procedure of analysis.

3.2 Research approach and design

This study is qualitative. According to Flick, Kardorff, and Steinke (2004), qualitative research describes life-worlds 'from the inside out', that is, from participants' point of view. Adopting this stance helps contribute to a better understanding of social realities created by participants. This design allows the researcher to capture the richness of participants' experiences (Polkinghorne, 2005). To elicit thick description from participants (Neuman, 2011), qualitative researchers need to actively involve their participants in the study by first building rapport and credibility with them (Creswell, 2003).

In contrast to quantitative methods, qualitative research is a naturalistic, holistic and inductive (Blanche et al., 2006). This means that it researches the phenomenon as it unfolds without changing or manipulating it (Blanche et al., 2006). Furthermore, at the beginning of the research project, qualitative researchers do not know the specifics of data analysis (Neuman, 2014). Schatzman and Strauss (1973) explain that unlike quantitative researchers who have an advantage of predicting their analytical processes, qualitative researchers cannot refine or reorganise raw data by operations built initially into the design of research. That is the reason why qualitative research is often inductive (Neuman, 2014).

3.3 Interpretive Paradigm

Paradigms are techniques of interconnected ontological, epistemological and methodological assumptions that act as viewpoints that provide the rationale for the research and commit the researcher to specific data collection methods, observation, and interpretation (Blanche et al., 2006). Thus, they are crucial to research design because they influence both the nature of the research question and how the research should be conducted (Blanche et al., 2006). According to Creswell (2003), qualitative research is fundamentally interpretive. Thus, the researcher interprets the collected data, which includes the description of participants or setting, developing themes by examining data, interpreting the data and drawing conclusions based on their meaning personally and theoretically, stating lessons learned and recommending further questions to be explored. Adopting the interpretive paradigm fostered an understanding of students' subjective experiences of the impact of parental practices in the prevention of HIV in a manner that participants lived or experienced it and the meaning they attached to their experiences. Hence, its ontology asserts that reality is what people perceive it to be, how they experience it, and the meaning they assign to it (Neuman, 2014).

Despite the fact that data collection is time-consuming (Neuman, 2011), the qualitative interpretive research is advantageous because the approach it adopts to investigate the phenomenon under study is usually more open and encourages participant involvement than other researches that work with a large number of participants (Flick et al., 2008). Using qualitative research for this study helped the researcher get a detailed description of participants' experiences and that helped in answering the study's research questions.

3.4 Location of the study

This study was conducted at Howard College, one of the five campuses of the University of KwaZulu-Natal, in KwaZulu-Natal Province. The campus is situated in an urban area near Berea, Durban. The campus was opened 89 years ago (1931) following a kind donation by Mr. T. B. Davis. Howard College Campus offers a full range of degree options in the fields of Science, Engineering, Agricultural Studies, Law & Management Studies, Humanities, and Nursing. Like other UKZN campuses, Howard College offers various programmes that cater for students' different needs, including an on-site centre that deals with HIV-related matters, and an HIV clinic

that provides students with all the essential services (including contraceptives, free HIV testing and ARVs). The campus also has HIV programmes where they train students (to become peer educators) who then teach other students about HIV during their campus intervention programmes. The school health facilities have trained staff, including nurses and a doctor (who visits the campus once a week).

3.4.1 Entry into the Research Site

The researcher was part of the research site, as she was a registered student at the University of KwaZulu-Natal. Therefore, the researcher did not encounter any challenges regarding entry or access into the research field. Furthermore, the researcher did not go through the stages of 'the access ladder', as Neuman (2013) calls it.

3.5 Selection of participants

According to Creswell (2012), qualitative researchers identify their participants purposefully; they sample people who can best help the researcher understand the phenomenon under investigation. This type of sampling allows the researcher to select cases that illustrate the features or processes they are interested in. Creswell (2003) adds that when the researcher selects participants, they need to choose those who will provide the relevant information to answer the research questions. Hence, Blanche et al. (2006) argue that the selection of participants should not be based on convenience. Instead, this sampling type requires researchers to think critically about the parameters of the population they are interested in, and carefully choose their sample (Silverman, 2011), as opposed to selecting them randomly (Denzin & Lincoln, 1994). It is for this reason that non-probability sampling was utilised in this study.

3.5.1 Non-probability sampling

When selecting participants, non-probability purposive sampling mostly involves the researcher's judgment, guided by the purpose of the study (Showkat & Parveen, 2017). The purpose of the study was to explore students' perceptions of the effectiveness of parental practices with regards to HIV prevention among the youth. According to Creswell (2012), selected units need to elicit information that can help develop a detailed understanding of the phenomena being studied. The

researcher needed to select participants who had the necessary characteristics to answer the research questions. Therefore, the participants who were selected were those who lived with both parents in the same household (except for cases when they were at the University). To be able to conduct this research at the University of KwaZulu-Natal, the gatekeeper's permission was granted from the University Registrar. A gatekeeper is someone mandated to determine who can have access or denied access to the prospective participants (Terre Blanche & Kelly, 1999).

The researcher visited a few undergraduate lecture rooms at different schools and briefly described what the study was all about and the criteria one had to meet to be able to participate in the study. It was also briefly explained that participation was voluntary and that there were no incentives. Other participants were recruited at the undergraduate Local Area Networks (LANs) where there were posters with all the details needed to recruit participants, including the researcher's contact details that participants would use to contact the researcher, notifying her of their voluntary wish to participate. The participants were recruited in the first week of October 2019, when lectures were being contacted. However, as many participants were pulling out, the researcher was forced to recruit and do interviews at the same time, to avoid more participants pulling out.

Initially, the study intended to recruit 10 to 12 participants. However, data saturation was reached before reaching participant number 12. Therefore, the study used a sample of 10 undergraduate students from both genders. The ages of the participants ranged from 19 to 24 and registered with the University of KwaZulu-Natal, Howard College. Neuman (2013) explains that the principle in qualitative research is to gather cases until we reach saturation point, where information is gathered until marginal utility or incremental benefit for additional cases, levels off or drops significantly. The researcher knew data saturation was reached when there was no more new information.

3.6 Data collection method

Interviews were used as a data collection instrument. According to Punch (2014), in qualitative research, interviews are the most prominent data collection tool because they are best at exploring people's perceptions, meanings, how they define situations and how they construct reality. Since the study aimed to explore participants' perceptions of the phenomenon, interviews were helpful in eliciting the required information from the participants. Ten semi-structured interviews were conducted with participants, who were registered undergraduate students from Howard College

(UKZN). The interviews were done in a seminar room at the Department of Psychology and others were done in a quiet conference room at the campus' main library (E.G. Malherbe Library). Semi-structured interviews have some degree of predetermined order, but still ensure flexibility adopted by unstructured interviews (Clifford, Cope, Gillespie & French, 2016). However, interviews are time-consuming (Neuman, 2014). Overall, interviews, especially semi-structured interviews, were appropriate for this study because they allowed the researcher to engage with participants as they shared their experiences, perceptions and opinions regarding the impact of parental practices in relation to HIV prevention amongst youth.

3.6.1 Data Collection Instrument

When collecting data in qualitative research using interviews, the researcher is also part of the instruments of data collection. This means that qualitative researchers assume the role of a primary instrument for executing the dual task of collecting and analysing data (Terre Blanche & Kelly, 1999). In a qualitative study, the researcher rejects the possibility of objectivity (Swartz et al., 2016). This means that the researcher has an influence on data being collected. Hence, Patton (1990) refers to qualitative researchers as key data collection instruments. In order to prepare for the interviews, the researcher (as a key instrument) demonstrates critical reflexivity. It is crucial for researchers to critically reflect on the entire study to identify if anything could have distorted the findings (Swartz, de la Rey, Duncan, Townsend and O'Neill, 2016). Thus, researcher is responsible for ensuring that the study is free of any distortion. The interviews were rehearsed and the researcher read extensively on the skills that are necessary for qualitative research interviews, such as active listening, silence, follow-up questions and probing. Having done qualitative interviews before was useful since the researcher was able to reflect and work on improving her interviewing skills.

The researcher prepared an interview schedule. After a thorough review of literature, the researcher identified the knowledge gaps in the literature and thus formulated the research questions. The interview questions were what would help answer research questions. The interview schedule had questions such as: '*What are the factors that influence parental practices when it comes to HIV prevention?*'

3.6.2 Pilot study

A ‘dry run’ study was done to look for potential mistakes that might influence the collected data, consequently, affecting the overall findings of the study. The research recruited a small number of participants to test the clarity of the questions, if there were any ambiguities or if the questions were relevant. This also helped the researcher to improve interviewing skills.

During the pilot study, the interviews were also recorded to test the efficacy of the audio-recording tool. To prepare participants for the interview, the researcher asked a few socio-demographic questions, and then had a brief general discussion with participants to set the scene and to ease the nervousness. These were part of introductory questions meant to kick-start the interview before moving to the main questions. The researcher then used the interview schedule to ask direct questions in order to get participants’ direct responses. However, probing and follow-up questions were utilised based on participants’ responses. To ensure the accuracy of data collection, the researcher summarised what the participants were saying and allowed them to correct or clarify where they had misunderstood.

3.7 Data analysis

The data analysis process commences after the data collection process has been completed (Fox & Bayat, 2007). This study aimed to explore participants' understanding of parental practices and its impact in the prevention of HIV amongst youth through interviews. This was done using thematic analysis. Braun and Clarke (2006, p. 79) define it as "a method for identifying, analyzing, and reporting patterns (themes) within data". Each identified theme answered a research question. Those themes were identified using the bottom-up method (that is, inductively formulated), meaning that they were coded from raw data, rather than trying to fit them into a pre-existing coding frame (Braun & Clarke, 2006).

To formulate themes, Braun and Clarke’s (2006) six steps were used. These steps are as follows:

1. *Familiarisation with the data*

   Firstly, the researcher familiarised herself with raw data by listening to the audio recordings of the interviews for a couple of times before transcribing them. The researcher transcribed data herself, which helped her familiarise with data. The audio recordings were transcribed.

Then, the researcher engaged in the process of reading and re-reading raw data to further familiarise herself with data, while at the same time noting the initial codes.

2. *Generating the initial codes*

   This step involved generating labels for the essential features of the data which were relevant to the broad research questions guiding the analysis. Braun and Clark (2006, p. 88) explain that "coding is not simply a method of data reduction, it is also an analytic process, and so codes capture both a semantic and conceptual reading of the data". The process of reading raw data that was done in the previous step helped generate codes. The generated codes were grouped, and each group of codes had the content that answered the research questions. While coding, the researcher also looked for interesting features that were used to formulate the themes.

3. *Searching for themes*

   Braun and Clark (2006, p. 19) define a theme as "a coherent and meaningful pattern in the data relevant to the research question". Here, the researcher categorised the different codes (generated during the coding stage) into potential themes and collated all the relevant coded data extracts within the identified themes. The themes consisted of the participants' perceptions, experiences, and beliefs about parental practices regarding HIV prevention amongst youth. The themes were detected by categorising statements that had a connection with the research questions; researcher then searched for patterns of phrases and/or words between them. The researcher used a diagram to organise codes into themes. Some themes had sub-themes.

4. *Reviewing themes*

   Two things were reviewed during this phase. The first one was to read all the collated data for each theme and checked if they made a coherent pattern. This also involved checking if the themes were telling a convincing story about data. The nature of each theme was defined, and the connection between themes was established (Braun and Clark, 2006). Some themes that did not tell the same story were broken down into two distinct themes. Other themes that had similar meanings were combined into one meaningful theme. The

second reviewing involved checking if the themes worked with the data set and if any coding of data was missed in the initial stage.

5. *Defining and naming themes*

   The researcher then defined and refined themes that were presented for analysis. Actually, the researcher determined how each theme fitted into the overall broader story and resonated with the research questions. This also involved describing each theme in such a way that answered questions such as: "What story does this theme tell?" This determined how they were linked to the overall story encapsulated in the data (Carey, 2012). The researcher further formulated thematic statements linked to research findings and the relevant literature (Dlamini, 2016). It at this stage where themes (and sub-themes) were given names that represented the overall content or the story they told.

6. *Write-up*

   This was the final step suggested by Braun and Clark (2006). The final report provided concise, rich, and sound narratives that were extracted in the data. This type of data analysis was appropriate for this study because the themes that were formulated were not imposed, but rather emerged from the students' perceptions of parental role on HIV prevention.

The thematic analysis technique was highly relevant to this research as it allowed themes to be formulated from raw data rather than being imposed from the existing coding frame. These themes were a reflection of participants' experiences (Braun & Clark, 2006). Moreover, the technique allowed the researcher to answer the research questions guiding this study.

3.8 Trustworthiness

The study looked at four components namely: credibility, transferability, dependability and confirmability in order to ensure its trustworthiness.

(i) Credibility

According to Korstjens and Moser (2018), credibility is achieved when the research findings represent plausible information drawn from the participants' original data and is the accurate interpretation of their original data. In other words, credibility is concerned with the aspect of truth (which is internal validity in quantitative research). The researcher revisited the participants to ensure the accuracy of data that were collected, interpreted and presented. This was done to confirm the credibility of the study.

(ii) Transferability

Transferability refers to the degree to which the results of a qualitative research can be transferred to other settings or contexts with other respondents (Korstjens & Moser, 2018). Transferability was achieved through in-depth description of the participants, the geographical area of the study and through the comprehensive study methods detailed under the research methodology section.

(iii) *Dependability*

This involves the researcher's interpretation and evaluation of the findings, and the recommendations of the research as supported by data received from the study participants (Korstjens & Moser, 2018). Dependability was achieved by clearly describing all the steps the researcher took from the start, through the development and finally the reporting of the findings.

(iv) Confirmability

Korstjens and Moser (2018) define confirmability as the degree to which research findings could be confirmed by other researchers. The findings of this research were confirmed by the supervisor. Confirmability was also ensured through the process of reflexivity, which helped the researcher ensure that the results were not figments of the researcher's assumptions, but clearly derived from data.

3.9 Critical reflexivity

It is crucial for researchers to critically reflect on the entire study to avoid distorting the findings (Swartz et al., 2016). This means that researchers are responsible for ensuring that the study is free of any distortion. Critical reflectivity involves precise consideration of how the researcher's own

preconceived assumption influences the study (Watt, 2007). Since the researcher was a student aged 24 during the time of data collection (within 18 to 24 age range), it was necessary for the researcher to do critical reflection to ensure that the whole process was not distorted by own biases and assumptions. Carey (2009) argues that key forms of analytical reflectivity include questioning preconceived assumptions, prejudice or stereotypes made against any phenomenon under investigation. Using previous experience, the researcher critically reflected on the assumptions she might have had during this study.

3.10 Ethical considerations

In qualitative research, ethical considerations are crucial; therefore, they should be considered from the beginning until the end of the study (Willig, 2008). The vital purpose of research ethics is to protect participants' welfare (Blanche et al., 2006). The largest social science research organisation in Africa (The Human Science Research Council) established the necessary ethical standards for all research involving human participants (Blanche et al., 2006). Israel and Hay (2006) state that most leading universities in South Africa require that all Social Science research involving human participants be reviewed by an independent research ethics committee before data are collected. Before the study commenced, gatekeepers' permission was obtained and ethical consent from the Ethics Board of the University of KwaZulu-Natal for researching on humans. This study complied with the ethical standards of Social Science research, as stated by Rubin and Babbie (2013).

(i) Voluntary participation and informed consent

According to Blanch et al. (2006), this philosophical principle finds expression in most requirements for voluntary informed consent by all research participants. This means that the participation of people in the research should not be forced, but rather voluntary (Fox & Bayat, 2007). Voluntary consent is a kind of an autonomous act committed intentionally, without coercion or manipulation (Israel & Hay, 2006). However, in Social Science research, participants are free to withdraw from the study at any time they wish during the research (Fox & Bayat, 2007). To

gain the participants' informed consent, the researcher explained the nature, purpose, and how the research would benefit the participants. The researcher reiterated the point that this study was voluntary, and as a result, there would be no rewards provided for participating. The participants were also informed about their rights, including their right to pull out whenever they were no longer interested in participating in this study, even after they had signed the consent form. These ethical issues were addressed prior to the signing of the consent form to allow the participants to decide first if they would like to continue participating in the study. The participants who agreed to participate signed the consent form before the commencement of the interviews. Israel and Hay (2006) argue that the participants need to know that they are authorising the researcher to involve them in the research, but they also need to understand what they are consenting to. After the purpose of the study and participants' rights were explained, the researcher also explained that by signing the consent form, they were authorising the researcher to audio-record them during the interview. Since all the participants were conversant in English, all the consent forms were written in English. However, the researcher still used plain language (meaning, no terminologies or bombastic words were used). It consisted of all the necessary details regarding the nature and purpose of the study, details of both the researcher and the supervisor. Despite explaining what was included in the informed consent form, the participants were given a chance to read it and ask questions where they needed further clarification before signing.

(ii) Confidentiality

Neuman (2014) defines confidentiality as an ethical consideration that seeks to protect those being studied by hiding their identity from the public, not releasing any information that could unmask anonymity of the participants. This could be done by presenting data in an aggregated form (Neuman, 2014). This study adopted the method mentioned by Rubin and Babbie (2013), where the researcher identifies a participant's response but promises not to disclose it to the public. Therefore, confidentiality was maintained by hiding participants' identities through use of, pseudonyms. Only the researcher and the supervisor had access to participants' identities. Individual interviews were preferred to focus group discussions to further uphold the principle of confidentiality. Interviews were audio-recorded and stored in the supervisor's locked and secured cupboard. Data are stored there for five years, after which it will be destroyed. All these ethical issues were explained to participants before they signed the consent form.

(ii) Nonmaleficence

This principle requires the researcher to ensure that no harm befalls participants as a direct or indirect result of this research (Blanche et al., 2006). Fox and Bayat (2007) add that to avoid harming participants, researchers should avoid putting them in risky situations, whether physically or psychologically. Harm includes wrongs, meaning that in some cases, the participants may not be harmed as a result of the research, but they can be wronged (Macklin, 2002; cited in Blanche et al., 2006). For example, deception is fundamentally wrong; hence, it should be avoided wherever possible (Herrera, 2002). Participants' confidentiality was maintained to avoid harm. No deception was done to participants, and the instruments used for this study were reviewed and approved by the University Ethics Committee. The study intended to do no harm to participants, and none of the participants expressed physical, emotional, or psychological harm resulting from this research.

3.11 Limitations of the study

One major limitation of the study is the unfair racial representation. Although the university population is dominated by Black students, the initial aim of the study was to recruit participants from diverse races. However, the researcher recruited not only Black South African students, but also students from other African countries.

3.12 Chapter Conclusion

This chapter discussed research methods and research procedure adopted in this study. The study took a qualitative research approach and interpretive paradigm to understand participants' perceptions of the impact of parental practices concerning HIV prevention amongst youth from their point of view. The study was done at Howard College, one of the five campuses of the University of KwaZulu-Natal. The chapter also provided step-by-step details of how participants were recruited, how data were collected, the instruments used, the period, and location of data collection. The thematic analysis technique was used to analyse data, using Braun and Clark’s (2006) six steps of thematic analysis. All ethical considerations were followed, as highlighted in

this chapter. This was done to avoid harming the participants. The limitations of the study were also discussed.

CHAPTER 4: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter begins by presenting the socio-demographics of the participants (Table 4.1).The study hoped to answer research questions which guided the research as discussed in Chapter 1. The utilisation of research questions resulted in the emergence of major themes and sub-themes which will be discussed in this chapter. The major themes that emerged were: the strong relationship between parents and children, active parental participation, monitoring youth activities, participants' experiences and perceptions of the effectiveness of parental practices regarding HIV prevention amongst the youth, types of parenting styles and their role in the prevention of HIV amongst the youth, and the impact of parental involvement in the prevention of HIV amongst the youth.

4.2 Socio-demographics of the participants

Table 4.1

Pseudonyms	Gender	Age	Race	College	Year of Study
Participant 1	Male	20	B	Agriculture. Engineering & Science	2
Participant 2	Female	19	B	Health Science	1
Participant 3	Female	21	B	Law & Management Studies	3
Participant 4	Female	22	B	Humanities	3
Participant 5	Female	20	B	Law & Management Studies	2
Participant 6	Male	23	B	Humanities	3
Participant 7	Female	23	B	Health Science	3
Participant 8	Male	19	B	Humanities	1
Participant 9	Male	22	B	Humanities	2
Participant 10	Male	24	B	Agriculture Engineering & Science	3

The study consisted of a total of 10 participants who were registered as full-time students at the University of KwaZulu-Natal during the data collection period (October to November 2019). The gender was balanced, with five male participants and five female participants. Participants' ages ranged from 19 to 24. However, race was not evenly represented as all the participants were Black Africans. This was due to the delay in data collection, since data collection occurred around exam period. Many students who were recruited initially pulled out, to prepare for exams. Despite the challenges faced during the recruitment and data collection, the researcher was able to recruit participants from different colleges within the campus. Since the study focused on the perceptions of undergraduate students, the participants were recruited from First Year to Third Year students.

4.3 A strong relationship between parents and children

The participants indicated that parents play a significant role in a child's sexual health. However, it is the strength of their relationship that is more important. The findings demonstrate that close relationships have a positive outcome on the children. Consequently, the absence of such a close bond results in young people contracting HIV, as reported by Participant 4 who stated:

> *"I think parents should always have a close relationship with children because I've realised that most young people, don't have that close relationship with parents, that is why they end up getting infected by this disease."*

A strong relationship could be formed if there is emotional connection between parents and children. Participant 10 stated:

> "Y*ou see, you can't be in a relationship with someone you don't have a connection with. The same applies here. I strongly believe that if a child has a strong relationship with parents, there is no way he or she may act recklessly. You know the relationship where parents do their utmost to be a parent, to be there emotionally. The child also needs to put an effort, in order to create such kind of connection with the parent."*

The closeness between parents and children can also be formed and strengthened by trust. If there is no trust, the relationship is weakened, and children are likely to seek that trust or satisfaction from intimate relationships. This is noted in Participant 5's statement:

"Our parents don't trust us. They feel like if they trust us, we will disappoint them. They don't understand that we can't have that parent-child relationship that we're supposed to have if they

have negative assumptions about us even before we give them reasons to assume so. Anyone would get tired of being criticised for things they've never done and look for someone who will appreciate and trust them."

4.4 Active parental participation

The participants expressed the importance of the active role parents play in the prevention of HIV as opposed to just having conversations about the virus. Parents should play an active role as adults and as people whose responsibility is to guide the youth to the right direction. Participant 5 stated:

> *"I think that other than talking, parents should be a bit more active. They need to understand or accept that when a child is having sex and then take it from there. Maybe, take a child to the clinic where they can talk to the professional about prevention strategies, and other useful information they can get from the clinic. I don't know if this is too much but they should also consider buying the right condoms for them, not those free ones from the government, because we all know that they are not 100% safe. Well, all condoms aren't 100% safe, but you see if a parent is involved in that way, they can teach a child a thing or two about which ones are safer. Some parents don't know anything about safe and unsafe condoms, but that's where they need to be realistic as parents regarding the safety of their children, that is, taking them to the clinic. The services being offered at public clinics are free; thus, even poor parents can access such information. But even if they are made to pay a small amount, it would be nothing compared to the safety of their children."*

This suggests that as much as having a strong relationship or providing a child with information is fundamental, parents should also provide relevant and useful resources that are vital in the prevention of HIV. As noted by participants, parents can help by actively providing contraceptives (mostly condoms) and information about how to use them and explain the advantages of using them and the disadvantages of not using them. Based on these findings, some parents engage in topics regarding sexual and reproductive health, but the information they are sharing with children is not enough. It lacks content in terms of how to use such information in practice. Participant 1 shared that:

> "*It is my parents' responsibility to teach me about condoms, what they are, how to use them, why using them, thus breaking the stereotypes around condom use such as that sex is not enjoyable when you're wearing a condom. Telling me that I should protect myself against HIV or I shouldn't impregnate a girl doesn't make any sense to me, they should be more practical."*

Based on participants' experiences and perceptions, parents should complement their emotional support (that is, building a strong and open relationship with children) with physical support. Once they have taught them about preventative strategies, they find means of availing themselves to their children's disposal.

Not only do most participants prefer learning from parents about sexual and reproductive health and HIV prevention, they also prefer that parents are the ones who emphasise and advocate HIV testing. Participant 1 indicated how parents can incorporate discussion about HIV testing when discussing sex and HIV related topics:

> *"Then they should introduce me to the topic of HIV testing since contraceptives, particularly condoms, are not 100% safe. Girls can be taught that pills and injections are for the prevention of pregnancy, but they need to be tested for HIV. We boys also need to go for testing because if, for example, my girlfriend is using injection, we definitely avoid using condoms."*

Participants preferred a situation where parents model the behaviour they expect from their children. To that end, Participant 6 said:

> *"If a parent always dates different sexual partners, I think that sort of behaviour is bad because it shows that a child should also bring all these different men into the house or bringing all these different women to the house. At the end of the day, children think that it is okay when it isn't okay. You should just stick with one person.*"

Participant 6 further elaborated on the problems of displaying 'bad' behaviour in the presence of a child:

> *"It normalises promiscuous behaviour. For instance, as a mother, you introduce different men to your child, the child may end up modelling such behaviour."*

From a psychological perspective, the Social Learning Theory posits that children learn behaviour by observation, in most cases, by observing parents' behaviour (Bandura, 2001). Some participants stated that they valued parents' opinion more than anyone else's. For example, Participant 4 stated:

> *"I feel that our parents need to speak to us about the prevention of HIV and AIDS and the educational system must not be the only avenue through which such matters that involve HIV and AIDS are addressed. Our parents should play their role as well."*

Most participants reported similar feelings regarding observed behaviour. They looked up to

parents, which also included observing their sexual relationships. They also felt that parents, in general, should be children's role models who mirror how children should behave with regards to HIV prevention. The same was also expressed regarding HIV testing, as stated by Participant 9:

> *"Well, I think to ensure that HIV is prevented in a community, first, you can't tell a child to go for HIV testing when you haven't done it yourself. You have to say 'this is my result' regardless of the status. You'll have to know your status because so many people are dying out there."*

In addition to having a strong parent-child relationship and parents being active agents in the prevention of HIV, parents should also be role models who model appropriate behaviour for children. Such behaviour includes demonstrating that one should have one sexual partner at a time, going for HIV testing, and so on.

4.5 Monitoring youths' activities

When participants were asked about measures that can be adopted by parents to protect children from contracting the HIV, they emphasised global monitoring. Participant 1 stated that:

> *"There's a lot that parents can do if they have a good relationship with their children. This helps parents to know when children are going out, what they are doing, and with whom. I really don't think it is appropriate for a child to be out and about, doing things without parents' knowledge. You see, if a parent knows where the child is or is planning to go to, for example, if they are going to a night party, parents get to sit down with the child and take them through what happens at these kinds of parties and how they should behave."*

Although they were not told to choose between the two types of monitoring reported by Dittus, et al. (2015) (that is, Global Monitoring which refers to parent's knowledge of a child's whereabouts and activities, and Sexual Behavior-Specific Monitoring referring to parental enforcement of rules about friends and dating), participants' sentiments suggest that parents' knowledge of children's whereabouts could help them regulate the places where their children frequent, thus minimising risky situations such as engaging in unsafe sexual activities without a parent's knowledge.

Very few participants touched on both global monitoring and sexual behaviour-specific monitoring. For example, Participant 10 said that:

> "*This is complicated because at a certain point in life, a child will do whatever they want, whenever they want to. However, before that, it is the parents' responsibility to ensure they guide a child in the right direction. They keep an eye on a child so that*

they can tell them whether what they are doing is right or wrong; hence, they will show them the right thing to do. The problem is that some parents don't even know what children are up to. I think parents should know where, when and what children are doing, and how they are doing it. For example, if a parent allows a child to go to a party, a friend's party maybe, they need to control them in a way that is age-appropriate for that child. Also, they should check the child's friends because they may be a bad influence to a child. Again, if a child is having sex, they need to know the person they are dating so that they can advise them if that is the right person or not. They also need to keep track of the contraceptive children use if they are having sex to determine if the children are only protecting themselves against pregnancy or against HIV as well. So, basically, keeping an eye on a child is a huge responsibility that parents should really take into consideration."

This was surprising since even those participants who reported that they held helpful conversations about sex and dating with parents did not mention that parental enforcement of rules about dating and sex could be useful to other parents if they were to adopt it. The reason for this seems to be explained by participants' cultural beliefs. All participants were Black Africans. Based on their cultural beliefs, parents hardly talk about sex and dating with children (Kayongo-Male & Onyango, 1984; cited in Löfgren et al., 2009; Wamoyi et al., 2010). Participant 3 held similar beliefs:

"Though times have changed, some things have not yet changed. I feel that as Africans, we need to change. We take time to adapt to change, especially if that change conflicts with what we believe in. Parents know that HIV kills; hence, they should be doing something such as warning, educating, doing whatever it takes to ensure the protection of children. However, they aren't doing anything because African beliefs bar parents from talking about sex with a child but look at what is happening to us."

Most participants based some of their responses not on personal experiences and the way they were raised, but on the context in which they lived, the 'Black African's cultural context'. In this context, it is still taboo to discuss sex and dating with parent(s). Participant 10 stated that:

"Some parents, such as fathers will notice that his child, especially his daughter is doing something wrong, maybe around puberty stage, he does not sit her down and talk to her. Instead he reports that to her mother, but he is a parent too. That affects a child. She will end up searching for that love from outside of her home and for sure, she'll have sex, most likely unsafe sex. I'm not saying my parents are perfect, they did lack here and there in terms of parenting, but some parents act like their kids aren't theirs."

Culture was mentioned a few times as playing a role in parent-child relationships and the prevention of HIV amongst the youth. In this case, some strategies that parents adopt or reject are

mostly influenced by their cultural context, which may lead to adverse results in a child's behaviour.

4.6 Participants' perceptions and personal experiences

Some participants reported having had conversations about HIV with parents, while others reported that they did not have such conversations with parents. Therefore, this major theme was divided into two sub-themes: participants' perceptions and personal experiences, and participants' responses based on their perceptions.

Participants who had discussions about HIV with parents reported the content of discussion, conversation with mothers, onset of communication, first sex-education between participants and parents, and the overall effect of parental support on participants.

4.6.1 Content of discussion

Some participants noted that they had conversations about sex with parents. However, for many, such conversations were not directly about HIV prevention, but sex in general, not getting pregnant or impregnating a girl before they finish school. Emphasis was on reaching their academic goals first. Participant 7 stated how the conversation between her mother and herself would unfold:

> *"The conversation was not really about HIV but on falling pregnant before I'm ready to have a child or falling pregnant when I'm still chasing my dreams and getting life together. Yeah, I would say, but all in all it does touch on HIV since condom use is a part of barriers to getting infected with HIV and AIDS."*

When parents talk about sexual health, they do not talk about HIV, but about the dangers of falling pregnant at a young age and totally abstaining from sex. The findings demonstrate that for parents, giving warnings about engaging in sexual activities and falling pregnant at a young age would consequently protect children from the risk of contracting HIV. This was noted by Participant 1, who stated, thus:

> *"Another thing is that they are more concerned about us not having kids and my sisters not getting pregnant than preventing HIV. They know how dangerous HIV is, but still, they avoid topics about condoms and they just focus on us being successful."*

While parents know about the severity of HIV, they seem to place more emphasis on being academically successful and having good morals. These are the values they instill in children, with

the hope that if they practise what they are teaching them (that is, focusing on school and on being a good child, which also includes abstinence), they will consequently benefit academically and they will not be infected with HIV.

4.6.2 Conversation with mothers

There was a slight difference between the number of females and males who received sex education from their mothers. More female participants reported that they talked about HIV and sexual and reproductive health topics with mothers. Participant 8 reported that:

> *"It's my mom who basically talks about HIV and sexual issues. My dad just tends to be quieter, leaving Mom to take charge of everything at home. So, it's mostly my mother who is more active than my father."*

Due to cultural reasons, fathers do not discuss topics relating to puberty, especially those that concern their daughters. Instead, discussions relating to sexual and reproductive health of their daughters usually take place in social spaces dominated by women. Participant 7 indicated that:

"My father never really discusses HIV issues with me."

She further elaborated:

> *"It doesn't only have to be the females. Fathers should also talk to us about such things. Things such as culture shouldn't stand in our way as far as HIV-related issues are concerned. So, they should be open. In fact, they shouldn't be scared of talking about such things. So, there should be an open relationship and talk about such things such as sexual and reproductive health for us to understand what is happening around us*."

4.6.3 Onset of communication

Many parents fear that sex education will lead to early experimentation and the corruption of children (Nambambe & Mufune, 2011). Contrary to this thinking, most participants who reported having held discussions about sexual and reproductive health with parents indicated that they started talking about the subject around early teenage years. Participant 2 intimated that she started having these conversations with her mother:

> *"I was about 13 years old, and at that age, I was able to reason, and most importantly, I had attained puberty. So, it's very important to talk to your child about these kinds of*

diseases when they enter that phase of their lives."

Even those participants who reported that they had not discussed sexual and reproductive health issues with parents agreed that talking to a child at a younger age is important and that is the perfect time to do so. Participant 3 stated:

> *"For girls, discussions around sexual and reproductive health should start when they start their periods. So, that would be around thirteen or fourteen years and the same applies for boys."*

The overall age range that participants thought was perfect for initial sex education was from the age of 10 to 15 years, for both girls and boys. That is the time when puberty starts as their bodies start to change. This is also the time when they become exposed to the dating world, as stated by Participant 1:

> *"I think before they finish primary school, maybe grade 6 or 7, I'm not sure but I think that's like around 12 or 13 years. Sex education should begin before high school, because that's when they start dating. Feelings towards the opposite sex start to develop. So, sex education should start before the children start dating."*

4.6.4 First sex education between participants and parents

It is the responsibility of parents to initiate topics around sex and sexual education. This prepares a child for changes that will occur in his or her body or changes that have already occurred in their bodies. The findings demonstrate that even if parents engage in sexual education at an early age, they still avoid talking about HIV and AIDS. Participant 5 said that:

> *"We do talk with my mom. She first talked about safe sex and sexual and reproductive health when I had my first periods. Although she didn't say anything about HIV, she just talked about sex and the changes that will occur to my body and how I should clean myself and basically how to behave myself when I'm experiencing my periods. I'm not sure, but I think I was in Grade 11 when she started touching on other topics, including HIV, boys and all that."*

Some parents look at the age of the child before considering sex-related topics to discuss. As Participant 5 explained above, the topics to be discussed bordered on sex and puberty as well as HIV and AIDS. Participant 7 had a similar experience:

"Okay, my mother hasn't really spoken to me about HIV up until this age. Nonetheless, she did talk to me about making sure that I don't fall pregnant at an early age, which means that I should consider safe sex and also abstain from unprotected sex."

Male participants stated that discussions about HIV were triggered by situations when someone they knew was HIV positive. Such conversations were usually around other people's narratives instead of being direct and specific. Participant 6 stated that:

"My parents tell me stories of, maybe, family members who are ill. How they got infected and how they pass the disease, and all that. So, it's always like stories about maybe friends who have it or people that have passed on as a result of the disease!"

Thus, mothers of boys tend to use close people's experiences to initiate talk about HIV. They use other people as examples to demonstrate the seriousness of HIV. The participants expressed that though these discussions were not direct, they were helpful as discussions became real due to familiarity with individuals used as examples.

4.6.5 Overall effect of parental support on participants

The overall effect of parental involvement in a child's life is positive, despite that parents do not usually talk about HIV prevention directly. Participant 1 stated:

"I think it has helped me in ways. I now know that if I engage in unprotected sex, I will fall pregnant and simultaneously contract HIV. So, it has helped me protect myself against HIV. Contracting HIV and AIDS is real, although my parents have never really got to that point of talking about HIV, but you know I'm grown now. The things they taught me ended up helping me. Indeed, I dodged the bullet."

Parental involvement helped some participants to go for HIV testing since knowing one's HIV status is crucial in the prevention of HIV and to avoid its spread, once one has been found to be HIV positive. Participant 4 stated that:

"Well, it has helped me because I now know that whenever I am engaging in sexual intercourse with my partner, I should always use protection because may not know the status of my sexual partner. So, one of the things that we also do is getting tested after every six months!

Other participants felt that parental involvement was crucial because if children did not get this information from parents, they would get it from other sources which may be unreliable. Participant 8 stated that:

"If there's not enough communication at home, obviously as a child you're going to look to other people for advice, maybe your friends, people that you see out of your family, people that you associate with. That may be detrimental because friends always pressurize you to do all those bad things, such as drinking alcohol, having sex with multiple sexual partners. All those things occur if there's a lack of communication at home in terms of parents telling children what to do, how to do it. Precisely, children are going to look elsewhere for those things"

This therefore proves the usefulness of parental involvement in the prevention of HIV amongst the youth.

4.7 Participants who did not receive parental support

Some participants reported that they had not engaged in any form of sex-related communication or sexual and reproductive health education with parents. Participant 3 stated that:

"My parents don't do anything. I've never had sex-related talks with them. I've never had a prevention talk with either of my parents. So, they just do nothing."

The participants had to find their own ways of learning about HIV and methods of prevention. For example, Participant 9 said:

"Honestly, my parents are very secretive when it comes to sexual intercourse. So, there is no clear communication or pep talk about sexual intercourse in my family. As children, we do our own research about HIV and AIDS. They never really sat down with us and talk about HIV and AIDS."

Nambambu and Mufune, (2011) argue that some parents fear that educating children about sex will lead to experimentation and the corruption of children. Although participants did not specify why parents feared to talk about sex, they felt that parents were scared of having such discussions with them. Participant 9 shared that:

"So, I think they are scared of opening up to us about HIV and AIDS since there are so many people who have died of HIV and AIDS I would say that maybe they would protect us but in the meantime, they are capable of holding important information because they are the ones who experiencing the brunt of HIV and AIDS since they are older than us."

The participants noted that they had other sources of information such as television and radio programmes that provided them with the necessary information. Some programmes such as *LoveLife* had been created to change the behaviour of the youth (Paruk et al., 2005). Participant 10 shared his experience, saying that:

> *"We grew up watching shows like Soul City, and people from LoveLife would come and teach us about the changes that our bodies would undergo as we grow up. We were told about wet dreams, changes in our voices, condoms, HIV and some other valuable stuff. Girls had their discussions where they'll talk about things like how to use pads. I think they even got pads for free. I was young at the time because I was still at primary school, but towards its end. What they taught us, me in particular, was helpful because I may get infected with AIDS by mistake. It won't be due to carelessness. I don't think they still have such programmes for kids whose parents don't teach them about puberty, especially Black kids. I think they need such programmes."*

A few participants learned about HIV prevention from friends. However, they found that the information they learned from them was crucial in their lives concerning prevention against HIV. In the absence of parental involvement in the preventing HIV, participants who used friends as their safe sex educators reported that the knowledge they gained was beneficial to them. For example, Participant 1 said:

> *"As boys, we talk about sex, condoms, and all that kind of sexual stuff. You just need to choose the right crowd. Of course we're having sex, but if you are young and maybe you hang out with people who're a bit more experienced than you, they will give you hints and teach you a thing or two about safe sex. You just need to associate with people who have dreams and direction in life, as they will give you useful information and urge you to use condoms. Fortunately, I had that kind of support, and yeah, that is fine."*

The participants reported that Life Orientation in schools also taught them about HIV. Participant 9 expressed how Life Orientation helped him since his parents were not free to talk about the prevention of HIV:

> *"I'm just trying to let you know that I have information about HIV because I have studied it in Life Orientation at high school level."*

Participant 4 also narrated her experience, thus:

> *"I feel like sometimes the educational sector is one of the best things that help people especially young children to be aware of sexual and reproductive health."*

She added that:

> *"It seems our parents are afraid of deliberating on sexual and reproductive health, I know but it's the educational sector and schools that help children, through Life Orientation to understand issues around the prevention of HIV and AIDS"*

Extended family members play an important role in educating young people about HIV prevention. The participants acknowledged that they received some valuable lessons from their extended family members. For example, when asked if she was bothered by the reality of her parents not educating her about sex and HIV prevention, Participant 7 said:

> *"It's not necessarily so, because in school I was taught about these issues by my aunts, my own sisters and brothers. So, I don't think that has affected me in any way because I was able to get education outside of the home environment."*

While parental involvement was found to be effective and beneficial to the participants, there were other sources that were reported to be helpful, such as schools and intervention programmes that target the youth.

4.8 Types of parenting style and their role in the prevention of HIV amongst the youth.

Parenting styles refer to techniques in which parents practise parenting (Askelson et al., 2012). Akers et al. (2011) argue that parental approaches have a tremendous impact on adolescents. Participants mentioned the following characteristics of parental practices that are beneficial to the youth and those that are a limitation in the prevention of HIV amongst the youth.

4.8.1 Strict parenting

Participants were not hesitant to criticise strict parenting and its effect on the prevention of HIV among the youth. Strict parents were criticised and perceived as playing a huge role in influencing children to approach sex-related situations. Participant 2 stated that:

> *"It does have an influence because like I've said, if you're a strict parent your children become too afraid to talk to you and they end up doing things without contemplating their consequences. They start engaging in sexual activities without knowing the dangers."*

Since participants valued healthy communication in parent-child relationship, they argued that strict parenting is a barrier to communication about sex and HIV prevention. This may result in adolescents engaging in unsafe sexual activities. When asked about parenting styles that are a limitation in the youths' prevention measures against HIV, Participant 6 elaborated that:

> *"Being strict involves not letting a child go out with friends and stuff. Consequently, the minute that the child gets a chance to get out, they start experimenting with sex because the parent would have been holding them back so much."*

This suggests that strictness acts as a barrier to parent-child communication and the open relationship suggested by participants as crucial in HIV prevention amongst the youth.

4.8.2 Less strict parents (permissive parents)

Participants expressed the feeling that parents who have an open relationship with their children, who allow communication from both parties and discuss social matters such as HIV, are helpful when it comes to the prevention of HIV amongst the youth. Participant 7 stated:

> *"An open parent-child relationship is needed though it should not be too open in a sense that undermines parents' authority. A parent is a parent and a child is a child. Nonetheless, there are certain circumstances when parents should talk to me about things like sex, HIV and AIDS. Parents should be prepared to tackle anything that is affecting our society, particularly the youth. My parents are not afraid of talking about such things; so, I would say it's an open and flexible relationship."*

However, participants acknowledged the need for a parent to have a certain level of strictness. Participant 8 stated that:

> "*They should maintain a certain level of strictness that is neither too rigid nor too lax. Parents should give children some form of autonomy in things that they can do but, children need to consult with them. There is need for a good communication between parents and children. You shouldn't be scared of talking to your parents because you think you are going to be punished. At the same time, parents ought to be in control but not too strict. They should maintain a moderate level of strictness to allow open space for children to be expressive and feel comfortable to talk to them. That is what I think."*

They also felt that as much as there should be an open relationship between a parent and a child, there should be boundaries as well. Participant 3 explained that:

"At some point, there has to be a line that separates a mother from a daughter. When you do anything wrong, the parent should tell you that it's wrong and should not hesitate to put the child back into line, thus putting the child into line is tantamount to guiding the child to prevent them from being infected with HIV, or any other form of exposure to the pandemic."

Findings suggest that parents should maintain moderate strictness and avoid extreme strictness. They should be a parent in a sense that they still need to give guidance, but they should strike a balance between elements of strictness and relaxation.

4.8.3 Laid back parents

It is the responsibility of parents to guide children's behaviour, be responsible for activities they engage in and evaluate if they are appropriate for them. Participant 1 stated that:

"There are those parents who just don't care. I think my parents fall under that category when it comes to HIV. As a parent, you need to be aware of your child's life and the activities going on in their lives. Kids are capable of doing what they want, and parents won't even notice and they don't even care."

Parents should not only pay attention to what children are doing, but it is also their responsibility to ensure they instill the right values in their children. Participant 8 stated that:

"I think some parents are too laid-back. Such parents do not take the initiative to instill some morals in their children. In most cases, those kinds of children become deviants bereft of any norms and values they live up to. They do whatever they want whenever they want, going out drinking, partying, and doing all sorts of things because their parents do not bother to reprimand them."

Parents should monitor children's activities, especially those that exacerbate their susceptibility to HIV. They also need to teach them about social values. The interviews revealed that children of neglectful parents lack values. Hence, Steinberg et al. (1994 cited in Kajula et al., 2016) contend that such children may end up engaging in activities that are detrimental to their health.

4.8.4 Too permissive parents (neglectful parents)

Too permissive parents, according to these findings, give children too much freedom. These parents allow children to be in environments that expose them to risky behaviours such as excessive drinking, which can lead to engaging in unprotected sexual intercourse. Participant 10 stated that:

"Some parents do notice wrong things that children do, such as drinking and engaging in sex at a young age, but they afford their children too much freedom, allowing them to explore life. While this may be understandable, it is baffling to find that they allow a 10-year-old to drink on New Year's Eve; the next thing is drinking every month-end, and so on. Resultantly, the child goes clubbing at the age of 13 or 14, and that is the age at which children start to develop sexual feelings. The next thing is having sex, especially unprotected one."

These findings are in line with Pillay's (2008) assertion that permissive parents leave their children to be in control of their actions. Children of permissive parents have the freedom to initiate any behaviour without parental supervision. Participant 5 explained:

"Such a parenting style allows children to do stuff they shouldn't be doing. I know parents are supposed to accept that we date at some point but allowing a 14-year-old to go out with a guy just because she's in high school is equally risky. That usually results in teenage pregnancy and perhaps HIV."

This parenting style is detrimental to children's sexual and reproductive health. It can be said that these parents are irresponsible since they do not assume their role as guardians. On the other hand, the children are left with the burden of figuring things out themselves. This can be detrimental to children's health since they are most likely to take too risky actions, some of which may lead to exposure to HIV.

4.9 Individual choice

As noted above, some participants felt that parents' involvement in the prevention of HIV is crucial, while others believed that other sources of information were advantageous too. Other participants opined that ultimately, the decision to engage in safe sex is an individual's prerogative. Participant 1 stated that:

"Yeah, we know how dangerous HIV is, but most young people still seem not to care about that reality. There are HIV campaigns, adverts, awareness programmes, and some such stuff, and some parents talk about it, but young people continue to make their own decisions."

Participant 6 added that:

"I think, at the end of the day it's an individual's choice. I mean, as adults, it's your choice! If you decide to be reckless with your life, you know the adverse consequences. So, I think parents can tell you so much, they can tell you not to do this, or that, to use

a condom, to go for HIV testing, but at the end of the day, it's your choice. I think it's really up to the person."

Participant 1 explained further:

"If you have a dream and a vision about your life, you should not jeopardise that dream, even if your parents had not discussed with you about it. If it means wearing a condom, you will because you know that if you become a father at an early age or if you get infected with HIV, you won't attain your goals. Although other people do risk their lives by not protecting themselves during sexual intercourse, but if they are ambitious, they would never purposefully risk their lives. So, you'll do whatever it takes to make it a success. I want to be an engineer, although I still have a few years left before I finish, and yes, I am active, but never without a condom because I can't risk it. That's a decision I took on my own, no friends or family were involved when I took this decision."

For participants in this study, not only is self-confidence an important determinant for engagement in safe sex (and the prevention of HIV), but academic attainment is also an influence since one would not do anything to risk achieving those goals.

4.10 The impact of parental involvement in the prevention of HIV amongst the youth

A few factors that influence parental involvement when it comes to the prevention of HIV include parents' cultural beliefs, religion, and background. These can have a positive and negative influence on the way parents raise their children, especially when it comes to sexual and HIV-related topics.

4.10.1 Role of culture in the prevention of HIV amongst the youth

Some parents do not educate their children about sex. Due to cultural beliefs and values, some of these parents still insist that children only become sexually active when they get married. Participant 2 noted that:

"Most of the times, culture creates a big boundary between a child and a parent. It does not have leniency when it comes to a parent and a child engaging in certain societal issues. So, to a certain extent, culture has a bad influence."

Therefore, culture sometimes hinders parents from fostering parent-child communication bordering on sexual issues. Culture also influences which parent participates in educating a child about sexual and reproductive health. Participant 7 stated that:

> *"You know how traditional men are. Culturally, they are the head of the family, and you'll find that as a head they are not doing anything to head children in the right direction. Parents and children should reconsider some cultural norms, especially those that do not benefit children."*

However, the findings also demonstrate that culture also has a positive impact on the prevention of HIV. For example, Participant 8 pointed out that:

> *"I come from a Zulu family. Zulu families always emphasise respect and dignity. You should respect yourself and other people; so, if you do that, you won't involve yourself in multiple sexual relationships because of the respect you have for yourself and other people."*

The effect of parental practice on HIV prevention amongst the youth also depends on the type of cultural practice that parents adopt. Some cultural practices have positive outcome while others can be detrimental to a child.

4.10.2 Influence religion has on parents with regards to HIV prevention amongst youth

Participant 10 expressed how religious values have helped him in the prevention of HIV:

> *"Ours is a very religious family. We go to church every Sunday where we get those motivational talks. So it becomes very effective in terms of how you conduct yourself, socially."*

While religion was noted by participants as playing a role in the reduction of HIV, it is important to acknowledge that its main focus is not on preventive measures for sexually active youth. Rather, it focuses on instilling good moral values such as abstinence from sex. For the sexually active children, the lack of information can potentially expose them to HIV.

4.10.3 Parents' level of education

Parents' education has an influence on parental practices concerning the prevention of the HIV. Based on participants' responses, parents' education has a positive influence on the prevention of HIV and sexual and reproductive health among the youth. As stated by Participant 2:

> *"A parent who's aged sixty years and above but educated can be able to talk about*

those things because she has learned about them from school and other people around the world. Such parents do not find it difficult to talk with their children about health issues and other dangers children may face when they grow up."

This suggests that educated parents are more likely to overcome cultural and social barriers that inhibit open parent-child relationships. A healthy parent-child relationship makes communication about sex and HIV prevention easier. Participant 10 intimated that:

"I come from a very traditional family that values our culture. However, since my parents are professionals, with higher educational attainment, they are able to break some of our cultural norms. Is'bonelonje (just an example), *despite being a boy, I often discuss HIV-related issues with my mother. Our culture doesn't promote such discussions, but since she's educated, she can bend some rules, if I may call it. Although most of the time the discussions don't centre around me per se, but I've learned a few things from our discussions."*

When asked if he thought his parents' educational status was the reason why they talked about such topics, Participant 10 said:

"I doubt they would be doing this if they weren't educated. Education, especially higher education, trains you to be open to other ideas and to think critically. Though they're very cultural and traditional, and they haven't changed some of their cultural behaviours and beliefs, I think they saw that people are dying, perhaps they saw that they need to warn us as children about the dangers of HIV and other sexually transmitted diseases."

Participant 7 argued that having an educated father would have probably changed the situation in terms of sex education parents impart to their children.

"My father is not really an educated person. Therefore, it's not the same concerning other parents who are educated. Educated parents talk to kids about such things, but not to me since my father is not an educated man".

Participants agreed that parental education fosters sustainable parent-child communication particularly about HIV and safe sex. As discussed in the first theme (the strong relationship between parents and children), participants advocated a strong and open parent-child relationship as this positively impacts a child's behaviour in relation to HIV prevention. Therefore, the more educated the parent is, the more likely that the communication will be smooth and two-directional.

4.11 Chapter Conclusion

This chapter thematically presented the findings from collected data. It discussed the experiences of Howard College students regarding their parents' role in HIV prevention. This chapter further discussed participants' perceptions of the parenting styles which are beneficial to and the ones that are a hindrance to the prevention of HIV amongst the youth. Participants also discussed the factors that influence parental practices and their consequences with regard to HIV prevention amongst the youth. There were positive results amongst the participants whose parents ensured that their children were protected against HIV. However, it was also indicated that parents are not the only agents that can be helpful in the fight against HIV amongst the youth. Other external sources such as the extended family, media programmes, and Life Orientation lessons in schools were mentioned as equally helpful.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings within the context of the themes that were presented in the previous chapter. This chapter will link the findings with the most prominent aspects of the model used as a theoretical framework. The findings will also be discussed in relation to the study's aims and objectives.

5.2 A strong relationship between parents and children

A close relationship between parents and children, combined with open, positive and frequent talk about sex is associated with adolescents' abstinence, postponement of sexual debut, having fewer sexual partners, and more consistency contraceptive use (Rhucharoenpornpanich et al., 2012). Thus, closeness, a satisfying relationship, and responsive parents appear to create the kind of environment that is open and results in clear communication between parents and children regarding communication about sexual and reproductive health. The participants echoed similar sentiments, that a strong and close relationship between a parent and a child is necessary as it allows a parent to be deeply involved in a child's life. However, for this kind of a relationship to form, there are components that need to be present, thus emotional connection and trust. Baumrind (1993) argues that emotional support and two-way communication, coupled with other factors, are very helpful in developing in children and adolescents instrumental competency that is characterised by a balance between societal and individual needs and responsibilities. Similarly, participants felt that trust and closer parent-child bond had a positive influence on them. A close relationship with parents allowed them to be confident in themselves and be able to trust the decisions they make regarding sexual health choices.

5.3 Active parental participation

Both parents and the youth know about the importance of using contraceptives in the prevention of HIV. However, some parents still believed in stereotypes surrounding the use of contraceptives especially for young adults. The study findings demonstrate that parents steer away from educating

children about contraceptives, and if they do, the information is rather scanty. Although parents talk about the dangers of having unprotected sex, it is action that is lacks, such as taking a child to the clinic not only to get contraceptives, but also to learn about the different types of these contraceptives, their side effects and other necessary information that could be useful to the youth in the prevention of HIV. Lescano et al. (2009) reported similar findings, that some parents talk about HIV prevention with their children; however, they do not give specific details in terms of how to go about protecting themselves.

This suggests that having a strong parent-child relationship alone is inadequate. Parents should also provide relevant and useful resources that are vital in the prevention of HIV. As highlighted in the participants' utterances, this includes providing contraceptives (mostly condoms) and the information on how to use them and the advantages and the disadvantages of not using them. Based on the findings of this study, some parents engaged in topics covering sexual and reproductive health, but the information they share is not enough. It lacks specifics in terms of how to use such information in practice. It is therefore important that parents and families equip themselves with information on voluntary counselling and testing (VCT) to support young people's decisions to partake in HIV testing (Denison et al., 2008).

5.4 Monitoring youths 'activities

The pre-adolescence stage is a period where children are more interested in situations that expose them to sexual activities (Paikoff, 1995; cited in Paikoff et al., 1997). Therefore, if they find themselves in unmonitored situations or if they spend a large amount of time with their peers, they are more likely to ultimately engage in sexual activities (Paikoff et al., 1997). Participants held similar opinions about parental monitoring in the prevention of HIV. The findings demonstrated that lack of attention to a child's whereabouts contributes to the youth's susceptibility to HIV infection. Therefore, it is apt to state that adopting global monitoring has a positive impact on the behaviour of the youth when it comes to the prevention of HIV.

There was not much emphasis on the importance of enforcing rules regarding dating and sex, compared to the global form of monitoring. This may be explained by the fact that culture is a fundamental practice-regulating factor for many Africans. Parental practices are therefore influenced by one's culture, including deciding which aspects of a child's life parents decide to

monitor.

5.5 Participants' perceptions and personal experiences

5.5.1 Content of discussion

When having discussions about young people's sexual health, parents tend to focus on body changes and dating. Communication about sensitive topics such as sexual intercourse, condoms, birth control, HIV and AIDS, and other sexually transmitted diseases is not common (Rhucharoenpornpanich et al., 2012). The findings reveal that during discussions on sexual and reproductive health, parents normally talk about pregnancy and school. Parents' use of warnings against pregnancy and how it could jeopardise ones' future is a way of also indirectly warning children about HIV. This is so because abstinence and the use of condoms necessarily become part of discussions on pregnancy-prevention. This was perceived as efficacious in the prevention of HIV since parents emphasised the positive outcomes deriving from taking preventive actions. However, while the practice of warning is used by many parents, it does not always produce the required outcomes (Kajula et al., 2016).

The findings also show that lack of knowledge about HIV and its prevention strategies was an issue for parents. This suggests that some parents wish to participate in parent-child sex education, but they lack the necessary information. This was perceived as a barrier since many young people wish to take action to protect themselves against HIV, but parents lack adequate knowledge.

5.5.2 Conversation with mothers

Mothers were found to be more likely to communicate about sex education than fathers (Lescano, Brown, Raffaelli, & Lima, 2009). Similarly, the findings show that of those participants who communicate about sex education and prevention against HIV, the conversations were usually between them and their mothers. Culture plays a role behind mothers being parents who are mostly active in sex education with children. In many African cultures, fathers are not expected to discuss matters that relate to puberty, especially of their daughters. Instead talks relating to sexual reproductive health of their daughters take place in social spaces, with women as key players (Muhwezi et al., 2015). However, times have changed; there are no longer many social spaces

where children can learn about puberty and HIV. Still the study found that the little effort that mothers put into sexual and reproductive talk has a positive impact in the prevention of HIV as participants were appreciative of how they turned out despite the absence of the fatherly role in the discussion.

5.5.3 Onset of communication

Parents tend to delay communication on sexual issues until they believe that children are old enough to learn about it (Tipwareerom & Weglicki, 2017). This increases the risk of contracting sexually transmitted infections, including HIV, at a very young age. The study sought to find out the age at which participants start talking about such topics. The findings demonstrate that starting at an early age, before puberty, is mostly preferred. Reason being that this is the age where a child's body starts to change. This is the age where the severity of susceptibility to the viruses is perceived as high, including susceptibility to HIV. Warning and educating a child about what is happening and what to expect allows parents to monitor every step of a child's development. Participants who did not hold such discussions also preferred that the onset of communication regarding such topics start at an early age. The participants agreed that ages between 10 and 15 years are acceptable for both girls and boys to start having talks about sex and HIV prevention. It can be concluded that having such talks at an early age can be advantageous to parents since it makes it easier for them to move to deeper topics as the child grows. All in all, the findings demonstrate the need for parents to get used to talking about sex-related topics, staring at a young age to enhance the child's protection against HIV.

5.5.4 First sex education between participants and parents

A large number of parents tend to initiate sex talk at the beginning of puberty when girls start menstruating, getting involved with the opposite gender, or once someone from the neighbourhood is pregnant or dies while trying to perform abortion (Muhwezi et al., 2015). This suggests that parents need some sort of trigger for them to start having sex education conversations with their children. This trigger differs for girls and for boys. The study found that unlike in girls, where sex education begins after menstruation, for boys, parents tend to use the experiences of close people to initiate talk about sex and HIV.

It is common for parents to initiate safe sex talk based on a child's age (Askelson, Campo & Smith, 2012). This means that parents evaluate the kind of topic to discuss based on child's age. They want to make sure the child is able to understand what they are saying.

5.6 Overall effect of parental support on participants

Sexual health-centred communication between parents and children serves as a protective factor that influences youths' sexual behaviour (Rhucharoenpornpanich et al., 2012). The study explored if having communication about sexual health was helpful or not. The findings demonstrate that although parents did not focus directly on HIV, what they taught children was helpful since they were able to protect themselves against HIV from early teenage years. The participants highlighted that they still remembered what they learned from parents and they found it more helpful than what they learned from other sources such as school.

The findings reveal that not many parents educate children about HIV, but instead, they give warnings about unsafe sex. However, this lack of information does not have a negative impact on children's behaviour regarding HIV prevention. Although the participants were no longer living full-time with their parents, the information they learned at home was still useful in influencing their decisions regarding HIV prevention. Therefore, it can be concluded that teaching a child about safe sex in general and focusing on educational success can also have positive outcomes with regards to HIV prevention. However, there is still a need for parents to be equipped with information on HIV and pass it on to their children.

5.7 Participants who did not receive parental support

Despite many children preferring to learn about HIV from parents (Lara & Abdo, 2016), the findings show that not all parents engage in sex-education with their children (Lara & Abdo, 2016). The results show that some participants taught themselves about HIV through searching for information from school, intervention programmes, relatives and peers. The Health Belief Model demonstrates that other sources of information can be utilised in preventing HIV, and participants in this study confirmed this position.

The findings demonstrate that television programmes such as Soul City have been a major source of information on HIV for young people. It can be argued that due to the fact that many of the

characters were young people (such as Dimpho Miya, Mandla Maponya, Menzi Maponya, Thembi Gumede amongst others) showing challenges faced by young people, it was easier for participants to relate and to learn from the show. School subjects such as Life Orientation have also been a key source of information for some participants whose parents did not teach them anything about sex or HIV and HIV prevention.

Getting sex information from peers has been criticised for high likelihood of being incorrect (Muhwezi et al., 2015). However, the findings in this study revealed that peers can positively influence each other. They contradict those reported by Muhwezi et al. (2015), revealing that in some cases (that is, in the absence of parental involvement), peers can be helpful in providing the relevant peer-to-peer information on HIV prevention.

In some parts of Africa, sex education is facilitated by extended family members or traditional sex educators known as *ssengas* (Wamoyi et al., 2010). It is therefore not uncommon for young girls and boys to learn about sex and related topics (including HIV) from extended family members than hearing it from parents. The results show that information from extended family members is often accurate and authentic and the participants found it useful.

Parents are important but they are not the only ones who can provide the necessary information regarding sex and HIV prevention. Aggleton and Campbell (cited in Nambambi & Mufune, 2011) state that the most important determinant of adolescent sexual health, particularly safe sex is social support, especially support from the family. This also explains why socially isolated young people have poor sexual health. Therefore, it is not always a matter of an emotionally absent parent or a parent who does not engage in parent-child sex dialogue, but about relevant and sufficient information. Information from external sources is often useful for children whose parents lack the necessary knowledge on HIV (Lescano et al., 2009).

5.8 Types of parenting styles and their role in the prevention of HIV amongst youth

Different styles of parenting have been reported in the findings and the impact they have on a child's behaviour:

5.8.1 Strict Parenting

The strictness reported here is an authoritarian style of parenting as identified by Baumrind (1966). According to Baumrind (1966), authoritarian parents are more controlling, value obedience, punishment, and the use of forceful measures to control a child's self-will during situations where a child's beliefs and behaviours conflict with theirs. Baumrind (1966) asserts that restricting a child's autonomy leads to rebellion. Similar sentiments were expressed in this study. Similarly, Kabiru et al. (2010) found that adolescents who perceived that parents allowed them less autonomy (an authoritarian style of parenting), were more likely to engage in high-risk sexual behaviours. In this study, strictness was perceived as a negative aspect because it does not project love and warmth towards a child, resulting in the child being rebellious. However, other studies conducted by Odubote (2008), Chao (1994), cited in Paruk (2011) have reported positive behavioural outcomes for children whose parents were strict, contradicting the results from this study. Therefore, it can be argued that parental strictness has different outcomes for children. The outcomes depend on how the child perceives that strictness.

5.8.2 Less strict parents (permissive parents)

An authoritative parenting style refers to parents who encourage a two-way conversation, share the reasoning behind rules set, and solicit objections when a child refuses to conform (Baumrind, 1966). Parents should assert strictness with restraint. Their level of strictness should be flexible to allow a child to approach them whenever they need support. This, according to Askelson et al. (2012), provides room for the discussion of sex-related topics necessary for HIV prevention. Steinberg and Gray (1999) found three components that are common across authoritative parents; autonomy support, structure, and warmth. Although findings did not mention structure, the participants reiterated the need for parents to give children autonomy, developing a warm and open type of a relationship that allows communication. Although the findings stress the necessity of being less strict, there was an acknowledgement that some level of strictness and authority from parents is necessary. The *'strict but not too strict'* and *'be in control'* were some of the parental practices the participants perceived as beneficial. Similar to Maccoby and Martin (1983), the findings demonstrate that an authoritative parenting style is the most effective style compared to

the other three parenting styles. Therefore, it can be concluded that the authoritative parenting style has the most positive influence on a child's behaviour in relation to HIV prevention.

5.8.3 Laid-back parents (neglectful parents)

The pre-adolescence stage is a period where children are more interested in situations that expose them to sexual activities (Paikoff, 1995, cited in Paikoff et al., 1997). They are most likely to find themselves in unmonitored situations, without the presence or knowledge of a parent. Similarly, Steinberg et al. (1994, cited in Kajula et al., 2016) found that the outcome of such parental neglect is associated with risky behaviours such as early sexual engagement, drinking alcohol and partaking in unsafe sex, which all could lead to contracting HIV. The characteristics of this parenting style are related to what Baumrind (1966) calls the permissive parenting style.

5.8.4 Too permissive parents

Another type of parenting style identified by Baumrind (1966) is the permissive parenting style. Amongst other things, these parents negotiate rules, rarely make orders, do not play an active role in shaping the behaviour of children, and do not encourage children to obey rules set by others other than themselves (Baumrind 1966). As the study has reported, parental guidance is crucial in the prevention of HIV amongst the youth. Being too permissive and having no sense of rules or boundaries results in a child making decisions without carefully considering the consequences since there is no parent's voice 'ringing' in their mind. The study found that being too permissive has detrimental outcomes especially when a child is becoming a teenager, as peer pressure is high. The absence of parental guidance was found to be a key reason for engagement in risky behaviours including those that could result in contracting HIV at a young age.

5.8.5 Individual choice

A meta-analysis of studies done by Black, Sun, Rohrbach and Sussman (2011) focusing on STI/HIV prevention suggested that condom use self-efficacy is one of the strongest and most consistent predictors of condom use. The results demonstrate that parents can have an impact (a positive impact) in the prevention of HIV amongst youth, however, it is up to an individual to decide what they want to do regarding HIV prevention. Black et al. (2011) define self-efficacy in this context as confidence in one's ability to successfully use a condom during sexual intercourse.

Strong levels of self-efficacy result in better goals that people set for themselves and a stronger commitment to achieving them (Bandura, 2001). The findings show that participants in the study had strong levels of self-efficacy. They are most likely to try to avoid contracting HIV as this would jeopardise the academic goals they have set for themselves. Based on the findings, these are choices they made for themselves, driven by personal goals. Therefore, high levels of self-efficacy as defined by the Health Belief Model are able to help one make choices for HIV prevention.

5.9 The impact of parental involvement in the prevention of HIV amongst youth

5.9.1 Role of culture in the prevention of HIV amongst the youth

Cultural norms are one of the socio-economic factors that influence young people's susceptibility to HIV (Wamoyi et al., 2011). Similarly, the findings of this study demonstrate the perception of culture as one of the factors that influence parental practices when it comes to HIV prevention. The topic on sex is something that is reserved for adults and married people across many African cultures and religions (Namisi et al., 2009). For example, the findings demonstrate that fathers' avoidance of sex talk with both daughters and sons is related to a lack of cultural practices that encourage fathers to have such conversations. Although times have changed, communication about sex between a parent and a child remains the same as the study shows that culture plays a role in the way parents approach such situations.

However, since African culture emphasises respect, it has a positive impact on the behaviour of young people in some cases since it emphasises respect for oneself and others. This respect includes a commitment not to deceive others, including one’s partner, which is something crucial in relationships and in the prevention of HIV for both the youth and married people. This suggests that culture can have both a positive and negative influence on the prevention of HIV. Therefore, promoting cultural beliefs and practices that advocate self-respect and respect for others should be prioritised by those implementing interventions of such nature. They should also educate target population about letting go of some cultural beliefs such as that sex topics are taboo and reserved for certain people and how this may help combat the spread of HIV amongst the youth.

5.9.2 Influence religion has on parents with regards to HIV prevention amongst youth

There is a link between religion and the risk of HIV (Lescano et al., 2009). Religion has been reported as a protective factor against HIV since it emphasises delay of sexual debut, abstinence, and monogamy, which minimise the risk of HIV (Lescano et al., 2009). The idea of instilling good morals and preaching of the word of God also produces good behaviour and helps keep many young people grounded. This is despite the findings that religion can have a negative impact on the prevention of HIV since it goes against sex-education for unmarried people (Namisi et al., 2009). The findings from this study demonstrate that religion may be a useful tool in the prevention of HIV amongst young people. Hence, parents take their children to church so they may learn about values and morals. While religion does not directly focus on HIV prevention, it is the values that it advocates that consequently help in the prevention of HIV.

5.9.3 Parents' level of education

Raffaelli & Green (2003 cited in Lescano et al., 2009) found that parents with more education communicated more with children. Likewise, the findings in this study demonstrated that parents who are educated tend to have more conversation with children. This is because they are exposed to information that illiterate parents do not have access to. Further, educated parents are able to evaluate if cultural and religious practices have positive outcomes for children in relation to HIV prevention. Educated parents are able to weigh the severity of their children's susceptibility to HIV. Therefore, education acts as an instrument that positively influences parents' attitudes regarding HIV and its severity.

5.10 What are Students' perceptions regarding parental practices about HIV prevention?

It was found that participants perceive various parental practices as beneficial in the prevention of HIV amongst youth. These practices include parents forming a strong relationship with children, actively participating in events happening in children's lives, monitoring children's whereabouts and activities, communication, and the overall parental support. A strong relationship between a parent and a child is one of the parental practices that allow communication which is necessary for enabling parents to educate children about HIV. When there is a strong bond between parent and child, parents do not only talk about safe sex and HIV, but also expose children to services that are

useful such as accessing contraceptives and HIV testing. Monitoring youths' whereabouts may enable parents to know what children are up to, when, and how they are behaving. This allows parents to monitor whether activities children engage in are safe and age appropriate. Overall, parental involvement was correlated with positive outcomes in a child's behavior. Although it does not delay first sexual engagement, it does, however, increase youth's knowledge about the dangers of the virus, increases use of contraceptives and youth voluntarily testing for HIV. It should, however, be added that some participants' parents did not do anything to ensure their safety against HIV. They perceived that parental practices are not the only thing that can help youth against the HIV epidemic. They cited other sources such as advice from extended family members, friends, media and school (Life Orientation). These sources were also associated with positive outcomes concerning the prevention of HIV. More participants felt that parental practices are necessary hence it was beneficial.

5.11 What are the benefits and limitations of different parental practices for HIV prevention?

Participants reported four types of parenting, three were beneficial and one was a limitation. Parents who are strict but with leniency, parents who show love and affection for children, and parents who allow them some level of autonomy were perceived as beneficial. Their children are not scared of them, they can communicate with parents whenever they need to, and they get the 'best' advice from parents when it comes to safe sex. These are in contrast to parents who are too strict. They were perceived by participants as being the reason why some children misbehave. They were found to be too controlling and fail to let children grow on their own while guiding them in the right direction. Hence when children get a chance at freedom, they misuse it. The participants felt that when parents are too strict, there is no relationship and communication yet these are some of the necessary parental practices in the prevention of the HI-Virus amongst youth.

As much as participants highlighted parents' need to monitor children, they also perceived neglectful parental practices as a limitation. These parents tend to not pay attention to activities children engage in, some of which may be too risky for a child or they may find themselves in risky situations they may not know how to handle. A parent was perceived as an agent that monitors such situations. Lastly, parents who allow children too much freedom were perceived as

the reason why some young people contract the virus at an early age because they are exposed to many risky situations they are too young to handle.

It should also be mentioned that participants felt that although these parental practices have an impact on a child's behavior, at the end of the day, deciding to protect oneself against HIV is an individual choice. Parents (or other sources that teach about HIV) can only do so much, but if an individual is not ready to change their behavior, not much can be done to persuade them to embrace HIV prevention practices.

5.12 What are the perceived factors that influence parental practices with regards to HIV prevention?

The study found that various factors influence parental practices with regards to HIV prevention. These include culture, religion and parents' level of education. Perceptions on culture are that it may have both a positive and negative impact. It can be a hindrance to parent-child communication about sexual health and HIV education since some cultural beliefs view this as taboo. Other cultural beliefs do not promote cross-gender communication which may have a detrimental effect on the child. However, other cultural beliefs such as advocacy for self-respect and respect for others have a positive impact on a child's behavior. Religion has a positive impact as it advocates for good morals. Despite these positive aspects, culture and religion were viewed as having some flaws in that they do not specifically focus on HIV prevention practices for youths that are sexually active. Their emphasis on good moral values such as abstinence may lead to risky exposure to HIV for youths that break the moral code.

Education has a positive impact on parental practices because even if a parent may not work in the health field, their education enables them to seek information that could be helpful to children. Educated parents were found to be less strict. They can bend some cultural beliefs that are a limitation in the prevention of HIV amongst young people, and are more likely to be comfortable to engage in parent-child conversations about HIV.

5.13 Recommendations

This study hopes to positively influence different groups and sectors, hence it suggests the following recommendations for parents, the youth, future research and for the university.

5.13.1 Parents

When developing interventions on topics about parental involvement and the prevention of HIV amongst young people, parents should be equipped with skills and knowledge about HIV and safe sex. This will help to ensure that when they educate children about HIV and safe sex, the content of their discussion is direct and focused, rather than just emphasizing good values and morals as a way of preventing youth from contracting HIV.

Parents are also not the only agents that can be used to fight against the HIV epidemic amongst the youth. More focus should be directed at other effective agents such as peers, extended family, media and school programmes aimed at teaching the youth about HIV and its prevention strategies.

5.14 Further research and interventions

Cultural beliefs were found to be a barrier that hinders parent-child sex education. This study recommends that researchers first use education and information to break cultural beliefs that inhibit parent-child sex discussions. This should be the first thing before trying to educate parents about how to communicate with children about such topics.

Considering that there is limited literature on youth's perceptions of parental practices in relation to HIV prevention, it is recommended that future researchers also include this as it is crucial in trying to flatten the curve of HIV prevalence amongst young people.

5.14.1 The university

This research recommends that the University puts more effort into the already implemented HIV programmes within the University since some students do not get support from parents. Extra programmes can be useful to those students.

5.15 Chapter Conclusion

This researched aimed to explore effectiveness students' perceptions of their parental practices regarding HIV prevention. A sample of ten students from the University of KwaZulu-Natal (Howard College) was utilised for this study. The findings and themes that emerged were reported and discussed and research questions were answered. The findings revealed that parental practices such as having a strong relationship with a child, playing an active role in the prevention of HIV could have a positive outcome in the prevention of HIV amongst young people. Similar to Wang et al (2014), monitoring a child's activities was also perceived as beneficial in the prevention of HIV amongst youth. The study also found that adopting different parenting styles has an impact in the prevention of HIV amongst youth. The study demonstrated that different factors also influence parental practices and can either have detrimental impact on youth (that is, increasing their susceptibility to HIV) or it can be a useful tool in the fight against HIV amongst youth. Although parents ought to take a pivotal responsibility in protecting youth from being involved in risky behaviors (Willoughby & Hamza, 2011), the study argues that it is a fallacy to assume that all parental practices adopted by parents results in youth that is responsible when it comes to the prevention of HIV. Furthermore, the study challenges the notion that parents are the only tool that can be utilised in the fight against HIV amongst youth. In cases where parents are not present in a child's life (when they are either dead or absent), schools, intervention programs and other family members can step in and play the parental role. Based on the findings, the role played by additional sources of information is beneficial in the prevention of HIV amongst youth. Moreover, these additional sources of information are beneficial (in the fight against HIV) in situations where parents lack information regarding the prevention of HIV. Overall, participants served immensely in illustrating the effectiveness of parental practices on youth concerning HIV prevention.

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Appendix A: Ethical Clearance

UNIVERSITY OF
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20 September 2019

Miss Nondumiso Mabaso (214566063)
School Of Applied Human Sc
Howard College

Dear Miss Mabaso,

Protocol reference number: HSSREC/00000391/2019
Project title: Students Perceptions of their Parental Practices in Relation to HIV Prevention: An Exploratory Study at Howard College.

Full Approval – Expedited Application

This letter serves to notify you that your application received on 30 August 2019 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid for one year from 20 September 2019.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

Yours sincerely,

[redacted]

Dr Rosemary Sibanda (Chair)

/spm

Appendix B: Informed Consent Letter

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date:

Dear Potential Participant.

My name is Nondumiso Mabaso from the School of Applied Human Science (Psychology Department-Health Promotion), College of Humanities, Howard College campus. Contact number: 0722001150, email: 214566063@stu.ukzn.ac.za

You are being invited to consider participating in a study that involves research on your experiences and perception with regards to HIV prevention. The aim and purpose of this research is to explore students' perception of parental practices in relation to HIV prevention. The study is expected to enroll 10 to 15 students, both females and males from Howard college. It will involve one-on-one interviews between the researcher and the participant that will be recorded. Interviews will ask non-sensitive questions about your perceptions and experiences on parental practices and prevention against HIV. The duration of your participation if you choose to enroll and remain in the study is expected to last for about an hour or more. The study is not funded by anyone.

The study does not involve any risk. This study will provide no direct benefits for participating, instead it will inform future interventions on parental support and HIV prevention on young adults.

This research is not of sensitive nature. Thus, no harm may be experienced as a result of participating. However, should there be any psychological or emotional discomfort, you will be referred to the school's HIV clinic or student council.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at 214566063@stu.ukzn.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Participation to this study is voluntary, no incentives will be provided for your participation. If you decided to participate, you may withdraw from this study at any point, even after signing the consent form, and without providing any explanations. There will be no penalties or loss of treatment for withdrawing from being part of this study.

Interviews will be done on campus, when you are available. Therefore, no costs may be incurred as a result of participating in this study.

Your confidentiality will be maintained throughout the research. Only you and researcher will be present during an interview. The final report will not consist of your real identity. Instead, pseudo names will be used to protect you. Interviews will be audio recorded. Only the researcher and the supervisor will have access to the recordings. It will be safely stored in the supervisor's locked and secured cupboard for the period of five years, then after, it will be destroyed.

CONSENT (Edit as required)

I
(Name)_____
_ have been informed about the study entitled Students' Perceptions of their Parental Practices in Relation to HIV Prevention: An Exploratory Study at Howard College by Nondumiso Mabaso.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 214566063@stu.ukzn.ac.za

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview YES / NO

_____ _____
Signature of Participant **Date**

_____ _____

Signature of Witness **Date**
(Where applicable)

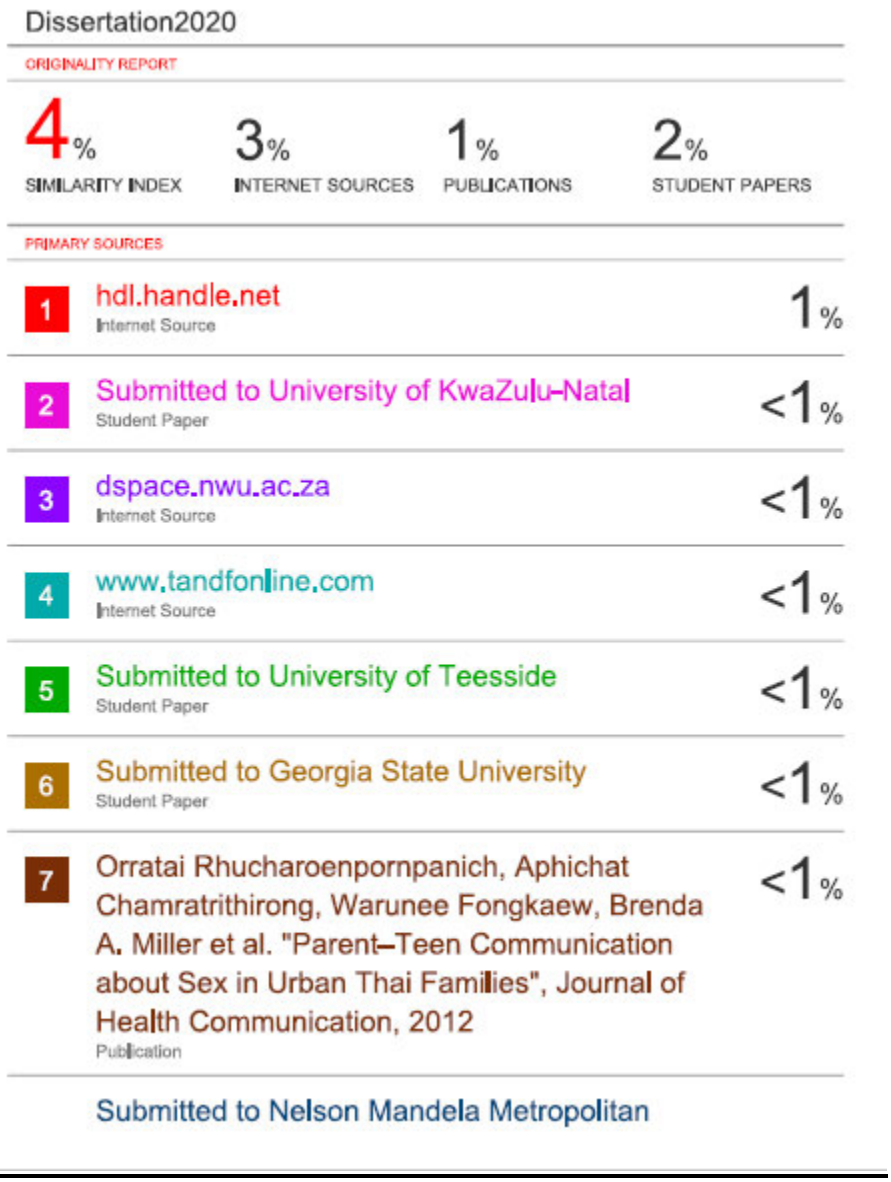
_____ _____

Signature of Translator **Date**
(Where applicable)

Appendix C: Interview Schedule

1. What do your parents do to ensure that you are protected against HIV?
2. What do you perceive is the role that parents can play in relation to HIV prevention amongst youth?
3. Based on the way you were brought up, how has that helped you in prevention against HIV?
4. Looking at the way parents raise their children; do you think it influences how those children prevent themselves against HIV? *Justify.*
5. Which type of parenting do you think is beneficial in helping children with regards to prevention against HIV? *Justify.*
6. Which type of parenting do you think is a limitation in helping children with regards to prevention against HIV? *Justify.*
7. What are the factors that influence parental practices when it comes to HIV prevention?
8. How do you think these factors affect the way parents handle the topic of HIV prevention amongst youth? *In a positive or negative way, Justify.*

Appendix D: Turnitin Report



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